LOUISIANA DEPARTMENT OF HEALTH

State Fiscal Year July 1, 2022–June 30, 2023

External Quality Review Technical Report

for

Aetna Better Health

April 2024

HSAG HEALTH SERVICES ADVISORY GROUP

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Acknowledgments and Copyrights

1. Executive Summary

Introduction

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires states that contract with managed care organizations (MCOs), prepaid ambulatory health plans (PAHPs), and prepaid inpatient health plans (PIHPs) (collectively referred to as "managed care entities [MCEs]" in this report) for administering Medicaid and Children's Health Insurance Program (CHIP) programs to contract with a qualified external quality review organization (EQRO) to provide an independent external quality review (EQR) of the quality, timeliness, and accessibility of services provided by the contracted MCEs. Revisions to the regulations originally articulated in the BBA were released in the May 2016 Medicaid and CHIP Managed Care Regulations,[1-1] with further revisions released in November 2020.[1-2] The final rule is provided in Title 42 of the Code of Federal Regulations (42 CFR) Part 438 and cross-referenced in the CHIP regulations at 42 CFR Part 457. To comply with 42 CFR §438.358, the Louisiana Department of Health (LDH) has contracted with Health Services Advisory Group, Inc. (HSAG), a qualified EQRO.

The Louisiana Medicaid Managed Care Program

The day-to-day operations of the Louisiana Medicaid managed care program are the responsibility of the Bureau of Health Services Financing within LDH, with oversight of specialized behavioral health services, 1115 Substance Use Demonstration Waiver, and the Coordinated System of Care Waiver provided by the Office of Behavioral Health (OBH). In addition, the Bureau of Health Services Financing receives support from other LDH "program offices"—Office of Public Health (OPH), Office of Aging and Adult Services (OAAS), and Office for Citizens with Developmental Disabilities (OCDD). Louisiana Medicaid managed care provides services to over 1.8 million Louisianans, which is approximately 39 percent of the State's population.

The current MCE contracts are full-risk capitated Louisiana Medicaid managed care contracts. Under the authority of a 1915(b) waiver from the Centers for Medicare & Medicaid Services (CMS), LDH contracts with six Healthy Louisiana MCOs to provide physical and behavioral health care, including Humana Healthy Horizons, which started on January 1, 2023; and two dental PAHPs to provide dental services for Louisiana's Medicaid and CHIP members. Additionally, under the authority of a

[1-1] Centers for Medicare & Medicaid Services. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, May 6, 2016. Available at: https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered. Accessed on: Dec 14, 2023.

[1-2] Centers for Medicare & Medicaid Services. Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care, November 13, 2020. Available at: https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care. Accessed on: Dec 14, 2023.

1915(b)/1915(c) waiver from CMS, OBH contracts with a single behavioral health PIHP, Coordinated System of Care (CSoC), to help children with behavioral health challenges who are at risk for out-of-home placement. The MCEs contracted during state fiscal year (SFY) 2023 (July 1, 2022–June 30, 2023) are displayed in Table 1-1.

Table 1-1—Louisiana's Medicaid MCEs

MCE Name	Plan Type	Services Provided	Service Region	Acronym or Abbreviated Reference
Aetna Better Health	MCO	Behavioral and physical health	Statewide	ABH
AmeriHealth Caritas Louisiana	MCO	Behavioral and physical health	Statewide	ACLA
Healthy Blue	MCO	Behavioral and physical health	Statewide	HBL
Humana Healthy Horizons (new plan as of 01/01/2023)	MCO	Behavioral and physical health	Statewide	HUM
Louisiana Healthcare Connections	MCO	Behavioral and physical health	Statewide	LHCC
UnitedHealthcare Community	MCO	Behavioral and physical health	Statewide	UHC
DentaQuest USA Insurance Company (DentaQuest)	PAHP	Dental	Statewide	DQ
Managed Care North America	PAHP	Dental	Statewide	MCNA
Magellan of Louisiana	PIHP	Behavioral health services for children and youth with significant behavioral health challenges	Statewide	Magellan

Scope of External Quality Review

As set forth in 42 CFR §438.358, HSAG conducted all EQR-related activities in compliance with the CMS EQR Protocols released in February 2023.[1-3] For the SFY 2023 assessment, HSAG used findings from the mandatory and optional EQR activities to derive conclusions and make recommendations about

[1-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, February 2023*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 14, 2023.

the quality, timeliness, and accessibility of healthcare services provided by each MCE. Table 1-2 depicts the EQR activities conducted for each plan type.

Table 1-2—EQR Activities Conducted for Each Plan Type

EQR Activities	Description	CMS EQR Protocol	MCO	PAHP	PIHP
Performance Improvement Project (PIP) Validation	This activity verifies whether a PIP conducted by an MCE used sound methodology in its design, implementation, analysis, and reporting, and whether the PIP demonstrated significant improvement in performance.	Protocol 1. Validation of Performance Improvement Projects	✓	✓	✓
Performance Evaluation and Improvement	This activity assesses whether the performance measures calculated by an MCE are accurate based on the measure specifications and State reporting requirements.	Protocol 2. Validation of Performance Measures	✓	✓	✓
Compliance Reviews (CRs)	This activity determines the extent to which a Medicaid and CHIP MCE is in compliance with federal standards and associated state-specific requirements, when applicable.	Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations	✓	✓	✓
Network Adequacy and Availability Validation (NAV)	This activity assesses the extent to which an MCE has adequate provider networks in coverage areas to deliver healthcare services to its managed care members.	Protocol 4. Validation of Network Adequacy*	✓	✓	✓
Consumer Surveys: CAHPS-A and CAHPS-C	This activity reports the results of each MCO's CAHPS survey to HSAG for inclusion in this report.	Protocol 6. Administration or Validation of Quality of Care Surveys	✓		
Behavioral Health Member Satisfaction Survey	This activity assesses adult members with a behavioral or mental health diagnosis and child members with a mental health diagnosis who have received behavioral health services and are enrolled in an MCO.	Protocol 6. Administration or Validation of Quality of Care Surveys	✓		
Case Management Performance Evaluation (CMPE)	This activity evaluates case management (CM) services to determine the number of individuals, the types of conditions, and the impact that CM	Protocol 9. Conducting Focus Studies of Health Care Quality	✓		

EQR Activities	Description	CMS EQR Protocol	MCO	PAHP	PIHP
	services have on members receiving those services.				
Quality Rating System (QRS)	This activity evaluates and applies a rating to measure the quality of care and performance of the MCOs to provide information to help eligible members choose an MCO.	Protocol 10. Assist With Quality Rating of Medicaid and CHIP MCOs, PIHPs, and PAHPs	✓		

**Protocol 4. Validation of Network Adequacy* was released in February 2023; therefore, full implementation will occur with the 2024 NAV activities.

Report Purpose

To comply with federal healthcare regulations at 42 CFR Part 438, LDH contracts with HSAG to annually provide to CMS an assessment of the performance of the State's Medicaid and CHIP MCEs, as required at 42 CFR §438.364. This annual EQR technical report includes results of all EQR-related activities that the EQRO conducted with Louisiana Medicaid MCEs throughout SFY 2023. This EQR technical report is intended to help the Louisiana Medicaid managed care program:

- Identify areas for quality improvement (QI).
- Ensure alignment among an MCE's Quality Assessment and Performance Improvement (QAPI) requirements, the State's quality strategy, and the annual EQR activities.
- Purchase high-value care.
- Achieve a higher performance healthcare delivery system for Medicaid and CHIP beneficiaries.
- Improve the State's ability to oversee and manage the MCEs with which it contracts for services.
- Help the MCEs improve their performance with respect to the quality, timeliness, and accessibility of care.

Definitions

HSAG used the following definitions to evaluate and draw conclusions about the performance of each Louisiana Medicaid MCE in each of the domains of quality, timeliness, and access.

Quality	Timeliness	Access
as it pertains to the EQR, means the degree to which an MCO, PIHP, PAHP, or primary care case management (PCCM) entity (described in §438.310[c][2]) increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics; the provision of services that are consistent with current professional, evidence-based knowledge; and interventions for performance improvement.	as it pertains to EQR, is described by NCQA to meet the following criteria: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation." It further discusses the intent of this standard to minimize any disruption in the provision of healthcare. HSAG extends this definition to include other managed care provisions that impact services to members and that require a timely response from the MCO (e.g., processing expedited member appeals and providing timely follow-up care).	as it pertains to EQR, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (network adequacy standards) and §438.206 (availability of services). Under §438.206, availability of services means that each state must ensure that all services covered under the state plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs in a timely manner.

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. Federal Register Vol. 81 No. 18/Friday, May 6, 2016, Rules and Regulations, p. 27882. 42 CFR §438.320 Definitions; Medicaid Program; External Quality Review, Final Rule.
[2] National Committee for Quality Assurance. *2013 Standards and Guidelines for MBHOs and MCOs.*

Methodologies

Requirement 42 CFR §438.364(a)(1) describes the manner in which (1) the data from all activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed, and (2) conclusions were drawn as to the quality, timeliness, and accessibility of care furnished by each MCO.

Aggregating and Analyzing Statewide Data

HSAG follows a four-step process to aggregate and analyze data collected from all EQR activities and draw conclusions about the quality, timeliness, and accessibility of care furnished by each MCO, as well as the program overall. To produce Healthy Louisiana's MCO aggregate SFY 2023 EQR technical report, HSAG performed the following steps to analyze the data obtained and draw statewide conclusions about the quality, timeliness, and accessibility of care and services provided by the MCOs:

Step 1: HSAG analyzed the quantitative results obtained from each EQR activity for each MCO to identify strengths and weaknesses in each domain of quality, timeliness, and access to services furnished by the MCO for the EQR activity.

Step 2: From the information collected, HSAG identified common themes and the salient patterns that emerged across EQR activities for each domain and drew conclusions about overall quality, timeliness, and access to care and services furnished by the MCO.

Step 3: From the information collected, HSAG identified common themes and the salient patterns that emerged across all EQR activities related to strengths and opportunities for improvement in one or more of the domains of quality, timeliness, and access to care and services furnished by the MCO.

Step 4: HSAG identified any patterns and commonalities that exist across the program to draw conclusions about the quality, timeliness, and accessibility of care for the program.

Louisiana's Medicaid Managed Care Quality Strategy

In accordance with 42 CFR §438.340, LDH implemented a written quality strategy for assessing and improving the quality of healthcare and services furnished by the MCEs to Louisiana Medicaid managed care members under the Louisiana Medicaid managed care program. Louisiana's Medicaid Managed Care Quality Strategy (quality strategy) dated June 2022 is guided by the Triple Aim of the National Quality Strategy.

LDH's mission is to protect and promote health and to ensure access to medical, preventive, and rehabilitative services for citizens of the State of Louisiana. The Louisiana Medicaid managed care program is responsible for providing high-quality, innovative, and cost-effective healthcare to Medicaid members.

Goals and Objectives

The quality strategy identified goals and objectives that focus on process as well as achieving outcomes. The goals and supporting objectives are measurable and take into consideration the health status of all populations served by the Louisiana Medicaid managed care program.

The quality strategy identifies the following three aims and eight associated goals:

Better Care: Make healthcare more person-centered, coordinated, and accessible so it occurs at the "Right care, right time, right place."

Goal 1: Ensure access to care to meet enrollee needs

Goal 2: Improve coordination and transitions of care

Goal 3: Facilitate patient-centered, whole-person care

Healthier People, Healthier Communities: Improve the health of Louisianans through better prevention and treatment and proven interventions that address physical, behavioral, and social needs.

Goal 4: Promote wellness and prevention

Goal 5: Improve chronic disease management and control

Goal 6: Partner with communities to improve population health and address health disparities

Smarter Spending: Demonstrate good stewardship of public resources by ensuring high-value, efficient care.

Goal 7: Pay for value and incentivize innovation

Goal 8: Minimize wasteful spending

Quality Strategy Evaluation[1-4]

Strengths

LDH considers the quality strategy to be its roadmap for the future. Overall, the quality strategy represents an effective tool for measuring and improving the quality of Louisiana's Medicaid managed care services. The quality strategy promotes identification of creative initiatives to continually monitor, assess, and improve access to care, the quality of care and services, member satisfaction, and the timeliness of service delivery for Louisiana Medicaid managed care members. Additionally, LDH's initiatives tie to the quality strategy aims, goals, and objectives. The quality strategy strives to ensure members receive high-quality care that is safe, efficient, patient-centered, timely, value- and quality-based, data-driven, and equitable.

LDH conducts oversight of the MCEs in coordination with the quality strategy to promote accountability and transparency for improving health outcomes. The MCE should be committed to QI and its overall approach, and specific strategies will be used to advance the quality strategy and incentive-based quality measures.

Recommendations

HSAG's EQR results and guidance on actions assist LDH in evaluating the MCEs' performance and progress in achieving the goals of the program's quality strategy. These actions, if implemented, may assist LDH and the MCEs in achieving and exceeding goals. In addition to providing each MCE with specific guidance, HSAG offers LDH the following recommendations, which should positively impact the quality, timeliness, and accessibility of services provided to Medicaid members:

- HSAG recommends LDH consider a change in metric benchmarks so the MCEs can strive toward a consistent performance level. HSAG recommends LDH remove the target objectives and improvement objectives and establish benchmarks for all MCEs that align with nationally recognized quality measures (e.g., NCQA Quality Compass, CMS Adult and Child Core Sets) or the State's performance published in the CMS Annual State Measure Trends Snapshot, Chart Packs for the Child Core Set and Adult Core Set, or the State Profile pages on Medicaid.gov.

[1-4] Health Services Advisory Group, Inc. Medicaid Managed Care Quality Strategy Evaluation, Review Period: March 20, 2022–March 19, 2023, July 2023. Louisiana Department of Health. Available at: https://ldh.la.gov/assets/docs/MQI/Strategy/MQIStrategyEvaluation.pdf. Accessed on: Dec 12, 2023.

- HSAG recommends LDH consider using the measurement year (MY) 2023 reported rates in the 2024 quality strategy evaluation, which could include MY 2021 through MY 2023 results in order to include the most current data for evaluation.
- HSAG recommends LDH remove the duplicate objective, promote healthy development and wellness in children and adolescents.
- HSAG recommends LDH consider adding the objectives, improve overall health and promote reproductive health objectives, to the quality strategy.
- HSAG recommends LDH continue to collaborate with the MCOs to support adequate QI capacity, skills, and resources to support current and future PIPs. HSAG recommends LDH continue to meet regularly with the MCOs and share best practices for identifying QI goals, objectives, and interventions. Furthermore, LDH could consider incorporating a similar mechanism for the PAHPs to collaborate on current and future PIPs. HSAG also recommends LDH consider hosting a forum in which the MCEs could discuss programwide solutions to overcome barriers. These QI activities provide opportunities to improve population health by implementing best practices and addressing barriers and challenges.
- HSAG recommends LDH identify expectations for improvement targets over a three-year period. Current target improvements compare to the previous measurement year and do not consider the baseline measurement year.
- HSAG recommends the MCEs consider whether there are disparities within their populations that contributed to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. HSAG recommends the MCEs target QI interventions to reduce the identified disparities.
- HSAG recommends LDH consider working with the MCEs to share performance measure best practices and identify interdependencies across measures.
- HSAG recommends LDH consider a contract statement for all MCEs that the MCE's quality initiatives must be designed to help achieve the goals outlined in the quality strategy. Currently only the MCOs have this contract requirement.
- HSAG recommends LDH consider removing aim statements from the quality strategy. CMS defines "quality strategy goals" as SMART (specific, measurable, attainable, relevant, and time-bound), high-level managed care performance aims that provide direction for the State. CMS defines quality strategy (SMART) objectives as measurable steps toward meeting the State's goals that typically include quality measures.

Overview of External Quality Review Findings

This annual EQR technical report includes results of all EQR-related activities for Aetna Better Health (ABH) conducted with Louisiana Medicaid managed care throughout SFY 2023.

Validation of Performance Improvement Projects

With the start of HSAG's EQRO contract with LDH in March 2023, HSAG initiated PIP validation training and technical assistance activities to assist LDH, ABH, and other MCOs in transitioning to HSAG's PIP validation process and methodology. ABH actively worked on PIPs throughout SFY 2023, and PIP validation activities were initiated. LDH required ABH to conduct PIPs on the following five state-mandated topics during SFY 2023:

- *Behavioral Health Transitions in Care*
- *Ensuring Access to the COVID-19 [coronavirus disease 2019] Vaccine Among Healthy Louisiana Enrollees*
- *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years*
- *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees*
- *Screening for HIV [human immunodeficiency virus] Infection*

At the time this report was drafted, HSAG's first validation cycle of ABH's PIPs was in progress and is scheduled to be completed in SFY 2024; therefore, final validation findings, including assessment of indicator results, interventions, strengths and opportunities, and recommendations will be reported in next year's annual EQR technical report.

Validation of Performance Measures

HSAG's validation of ABH's performance measures confirmed compliance with the standards of Title 42 CFR §438.330(a)(1). The results of the validation activity determined that ABH was compliant with the standards of Title 42 CFR §438.330(c)(2).

Information Systems Capabilities Assessment

Based on a review of the final audit reports (FARs) issued by ABH's certified HEDIS compliance auditor, HSAG found that ABH fully met the standard for all seven of the applicable NCQA HEDIS information systems (IS) standards.

HEDIS—Quality, Timeliness, and Access

HSAG's analysis was based on comparison of HEDIS measures/measure indicators to the MY 2022 NCQA national 50th percentile, which served as the benchmark. A total of 47 measures, comprising 89

measure indicators, were selected for analysis. Of the 89 measure indicators, 11 were not reported in Quality Compass and were therefore removed from the respective analyses due to lack of a benchmark.

Of the 78 HEDIS measures/measure indicators with an associated benchmark, ABH had 20 that performed greater than the NCQA national 50th percentile benchmark, and 58 that performed lower than the NCQA national 50th percentile benchmark. Detailed results are shown in Section 3—Validation of Performance Measures.

Assessment of Compliance With Medicaid Managed Care Regulations

In HSAG's CR, ABH received a compliance score of 42.9 percent for Standard I—Enrollment and Disenrollment, indicating that, overall, ABH has improvement to make in compliance with this standard.

HSAG also reviewed ABH's corrective action plans (CAPs) from the LDH-approved 2022 CR. ABH achieved compliance in 34 of 36 elements from the 2022 CAPs, demonstrating positive improvements in implementing CAPs from 2022. ABH must implement the remaining approved CAPs for the two elements for which compliance was not achieved.

Validation of Network Adequacy

HSAG's provider directory validation (PDV) indicated that, overall, the provider information maintained and provided by ABH was poor, which impacted access to care due to the inability of members to find a provider that delivered the requested services. Table 1-3 provides a summary of the findings from the study.

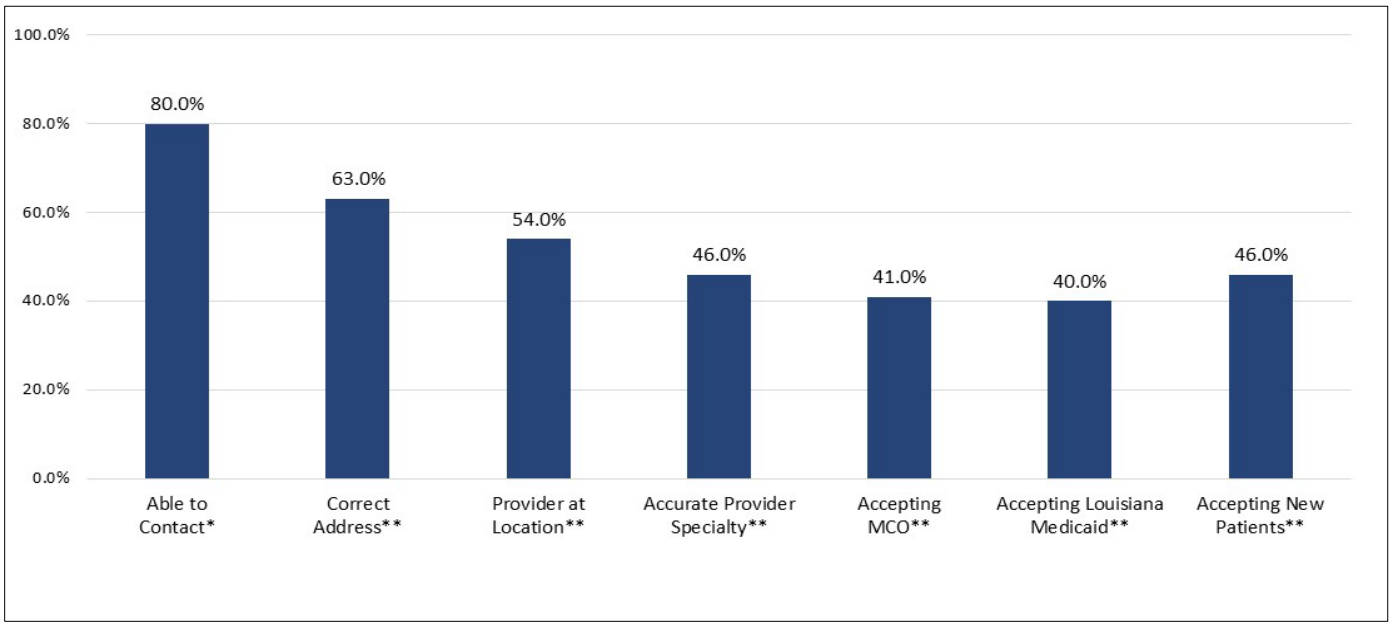
Table 1-3—Summary of Findings

Concerns	Findings
Acceptance of Louisiana Medicaid was inaccurate.	Overall, 40.0 percent of providers accepted Louisiana Medicaid.
Acceptance of the MCO was inaccurate.	Overall, 41.0 percent of providers accepted the requested MCO.
Provider's specialty in the provider directory was incorrect.	Overall, 46.0 percent of providers confirmed the specialty listed in the online provider directory was accurate.
Overall acceptance of new patients was low.	Overall, 46.0 percent of providers accepted new patients; however, only providers listed as accepting new patients in the online provider directory were selected for the PDV reviews.
Affiliation with the sampled provider was low.	Overall, 54.0 percent of the locations confirmed affiliation with the sampled provider.
Address information was incorrect.	Overall, 63.0 percent of respondents reported that ABH's provider directory reflected the correct address.

While the overall PDV response rate was relatively high at 80.0 percent, once contacted, the offices reported varying degrees of match rates for the online provider directory information. Accuracy of new patient acceptance, Louisiana Medicaid acceptance, and ABH acceptance exhibited the lowest match rates, with all indicators exhibiting a match rate below 65.0 percent.

Figure 1-1 presents the summary results for all sampled ABH providers.

Figure 1-1—Summary Results for All ABH Providers



*The denominator includes all sampled providers.
**The denominator includes cases reached.

ABH's weighted PDV compliance scores by specialty type ranged from 28.0 percent (behavioral health) to 41.3 percent (pediatrics).

Quarter 2 through Quarter 4 PDV and provider access survey results were not final at the time of reporting. Final results from these activities will be included in the SFY 2024 EQR technical report.

For geographic access (GeoAccess), ABH reported the percentage of members having access within required distance standards for 22 physical health provider types and 19 behavioral health provider types. Data were reported for a total of 32 physical health GeoAccess standards (10 of the physical health provider types were reported separately for the urban and rural populations) and 34 behavioral health GeoAccess standards (15 of the behavioral health provider types were reported separately for the urban and rural populations). For the entire SFY 2023, ABH only met four of 32 physical health GeoAccess standards and two of 34 behavioral health GeoAccess standards.

Consumer Surveys: CAHPS-A and CAHPS-C

HSAG compared ABH's 2023 achievement scores to their corresponding 2022 achievement scores and the 2023 NCQA national averages to determine whether there were statistically significant differences.

Overall, ABH's 2023 achievement scores revealed strengths in the general child population. For the general child population, results revealed achievement scores for *Getting Needed Care* and *How Well Doctors Communicate* were statistically significantly higher than the 2023 NCQA national averages.

Furthermore, opportunities for improvement were not identified for ABH's adult and general child populations, as ABH's 2023 achievement scores were neither statistically significantly lower in 2023 than 2022 nor statistically significantly lower than the 2023 NCQA national average on any measure.

Behavioral Health Member Satisfaction Survey

HSAG compared ABH's 2023 achievement scores to the 2023 Healthy Louisiana statewide average (SWA) to determine whether there were statistically significant differences. Overall, ABH's adult and child 2023 scores were not statistically significantly higher or lower than the Healthy Louisiana SWA; therefore, no strengths or opportunities for improvement were identified. However, several measures had less than 100 respondents. ABH should focus on increasing response rates to the behavioral health member satisfaction survey for its adult and child populations.

Case Management Performance Evaluation

During SFY 2023, HSAG and LDH collaborated to determine the scope, methodology, data sources, and timing of the CMPE. HSAG will conduct the focus study in SFY 2024. Results, including conclusions, strengths, and opportunities for improvement, will be reported in the SFY 2024 EQR technical report.

Quality Rating System

Figure 1-2 displays the 2023 Health Plan Report Card, which presents the 2023 rating results for each MCO. The 2023 Health Plan Report Card shows that, for the Overall Rating, ABH received 3.5 stars. ABH received 5.0 stars and 4.0 stars for the Satisfaction with Plan Physicians and Behavioral Health—Access, Monitoring, and Safety subcomposites, respectively, demonstrating strength for ABH in these areas. However, ABH received 2.0 stars for the Prevention composite, including 1.5 stars for the Children and Adolescent Well-Care subcomposite. Further, ABH also received 2.0 stars and 1.0 star for the Respiratory and Behavioral Health—Care Coordination subcomposites, respectively, demonstrating opportunities for improvement for ABH in these areas.

Figure 1-2—2023 Health Plan Report Card

Issued 09/2023

Healthy Louisiana

2023 HEALTH PLAN REPORT CARD

The ratings below compare the performance of Louisiana's Medicaid health plans. This report card shows the results of care in the areas of Consumer Satisfaction, Prevention, and Treatment, and can aid you and your family when deciding on a health plan.

PERFORMANCE KEY	Lowest	Low	Average	High	Highest	Insufficient Data
	★	★★	★★★	★★★★	★★★★★	—

	Aetna Better Health	AmeriHealth Caritas Louisiana	Healthy Blue	Humana Healthy Horizons	Louisiana Healthcare Connections	UnitedHealthcare Community Plan
Overall Rating	★★★½	★★★½	★★★½	*New	★★★	★★★½
CONSUMER SATISFACTION						
Overall Consumer Satisfaction	—	★★★★	★★★★	*New	★★★	★★★★
Getting care: How easily and quickly did members get appointments, preventive care, tests, and treatments?	—	★★★½	★★★½	*New	★★½	★★★★
Satisfaction with plan physicians: How happy are members with their primary care doctors?	★★★★★	★★★★	★★★★	*New	★★★½	★★★★
Satisfaction with plan services: How happy are members with their health plan and their overall care?	★★★½	★★★★	★★★★½	*New	★★★	★★★★½
PREVENTION						
Overall Prevention	★★	★★★	★★★	*New	★★½	★★★
Children/adolescent well-care: Do children and adolescents receive vaccines and weight assessments?	★½	★★½	★★½	*New	★★	★★½
Women's reproductive health: Do women receive care before and after their babies are born?	★★★	★★★	★★★	*New	★★½	★★★

Continued on next page...

Figure 1-2—2023 Health Plan Report Card (cont.)

	Aetna Better Health	AmeriHealth Caritas Louisiana	Healthy Blue	Humana Healthy Horizons	Louisiana Healthcare Connections	UnitedHealthcare Community Plan
Cancer screening: Do female members receive important cancer screenings?	★★★	★★★½	★★★	*New	★★★½	★★★★
Other preventive services: Do members receive important preventive services?	★★½	★★★½	★★★	*New	★★★	★★★
TREATMENT						
Overall Treatment	★★★	★★½	★★★	*New	★★½	★★★
Respiratory: Do people with respiratory issues get the services/treatments they need?	★★	★★	★★½	*New	★★½	★½
Diabetes: Do people with diabetes get the services/ treatments they need?	★★★½	★★★	★★★½	*New	★★	★★★★
Heart disease: Do people with heart disease get the services/ treatments they need?	★★★	★★★	★★	*New	★★½	★★★
Behavioral health—care coordination: Do people with behavioral health issues get the follow-up care they need?	★	★½	★½	*New	★½	★½
Behavioral health—medication adherence: Do people with behavioral health issues stay on prescribed medications?	★★★	★★½	★★	*New	★★★	★★
Behavioral health—access, monitoring, and safety: Do people on behavioral health medications receive the services/ monitoring they need?	★★★★	★★★	★★★½	*New	★★★	★★★★
Risk-adjusted utilization: Do members who are discharged from the hospital have unplanned readmissions within 30 days?	★★★	★★★	★★★	*New	★★★	★

This report card is reflective of data collected between January 2022 and December 2022.

**Due to Humana Healthy Horizons being a new plan in 2023, data are not available yet. Humana Healthy Horizons will be included in future health plan report cards.*

The categories and measures included in this report card are based on the 2023 National Committee for Quality Assurance (NCQA) Health Plan Ratings and LDH required measures lists. When feasible, categories and measures were kept consistent with the prior year's health plan report card, but some measures and categories were removed due to data availability. Any analysis, interpretation, and conclusions based on the data is solely that of the author. Anyone desiring to use or reproduce the materials must obtain approval from LDH.

2. Validation of Performance Improvement Projects

Results

SFY 2023 was the first year that HSAG was contracted as the EQRO for LDH. HSAG's EQRO contract with LDH was initiated in March 2023, and HSAG initiated PIP validation transition activities, training, and technical assistance activities the same month. During SFY 2023, HSAG worked with LDH to transition the MCOs to HSAG's PIP validation process and methodology. ABH actively worked on PIPs throughout SFY 2023, and HSAG initiated validation activities for ABH's PIPs. At the time this report was drafted, HSAG's first validation cycle of the ABH's PIPs was in progress; therefore, final validation findings, including assessment of indicator results, interventions, strengths and opportunities, and recommendations will be reported in next year's annual EQR technical report.

LDH required the MCOs, including ABH, to carry out PIPs to address five state-mandated topics during SFY 2023. Table 2-1 summarizes the PIP topics carried out by ABH in SFY 2023.

Table 2-1—SFY 2023 MCO PIP Topics and Targeted Age Groups

PIP Topic	Targeted Age Group
Behavioral Health Transitions in Care	• 6 years and older • 13 years and older
Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees	• 5–11 years • 12–15 years • 16 years and older
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	• 6 months–18 months • 19 months–2 years • 3–5 years
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	• 21–64 years
Screening for HIV Infection	• 13 years and older • 15–65 years

For each PIP topic, ABH collaborated on improvement strategies, meeting at least monthly with LDH and other MCOs, throughout the year. ABH also submitted updates on improvement strategies and interim indicator results for each PIP topic quarterly that were reviewed by HSAG and LDH. HSAG provided feedback and technical assistance on PIPs to LDH and ABH at group and one-on-one meetings throughout the contract year.

Table 2-2 summarizes key PIP validation milestones that occurred from March through June 2023, the end of SFY 2023.

Table 2-2—SFY 2023 MCO PIP Activities

PIP Activities and Milestones	Dates
HSAG provided training to LDH and the MCOs on HSAG's PIP validation process and templates	March–April 2023
Monthly collaborative PIP meeting with LDH, the MCOs, and HSAG	March 2023
Monthly collaborative PIP meeting with LDH, the MCOs, and HSAG	April 2023
The MCOs submitted Quarter 1 PIP updates	April 2023
Monthly collaborative PIP meeting with LDH, the MCOs, and HSAG	May 2023
Monthly collaborative PIP meeting with LDH, the MCOs, and HSAG	June 2023
The MCOs submitted PIP proposals to HSAG for initial review and feedback	June 2023

In SFY 2024, ABH will submit draft PIP reports for initial validation in January 2024 and the final PIP reports for final validation in March 2024. HSAG will complete the first annual validation cycle in April 2024.

Validation Results and Confidence Ratings

Table 2-3 summarizes ABH's PIP validation results and confidence ratings. The initial validation cycle for ABH's PIPs was in progress at the time this report was drafted; therefore, final validation ratings will be reported in next year's annual EQR technical report.

Table 2-3—PIP Validation Results and Confidence Ratings

PIP Topic	Validation Rating 1: PIP Demonstrated Adherence to Acceptable Methodology	Validation Rating 2: PIP Demonstrated Significant Improvement
Behavioral Health Transitions in Care	To be reported in SFY 2024	To be reported in SFY 2024
Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees	To be reported in SFY 2024	To be reported in SFY 2024
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	To be reported in SFY 2024	To be reported in SFY 2024
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	To be reported in SFY 2024	To be reported in SFY 2025
Screening for HIV Infection	To be reported in SFY 2024	To be reported in SFY 2025

Performance Indicator Results

ABH will report final calendar year (CY) 2023 indicator results in January through March 2024. HSAG will validate the performance indicator results in SFY 2024, and the final performance indicator results for each PIP topic will be included in next year's annual EQR technical report. Table 2-4 summarizes the measurement period that is being completed in CY 2023 and which results will be reported in SFY 2024.

Table 2-4—Measurement Periods in CY 2023 by PIP Topic

PIP Topic	Measurement Period in CY 2023
Behavioral Health Transitions in Care	Remeasurement 1
Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees	Remeasurement 1
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	Remeasurement 1
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	Baseline
Screening for HIV Infection	Baseline

Interventions

ABH will report final 2023 QI activities and interventions in January through March 2024. Table 2-5 includes barriers and interventions ABH initially reported early in the validation cycle initiated at the end of SFY 2023. ABH will report updated QI activities and interventions in SFY 2024, and HSAG will complete the assessment of ABH's QI activities and interventions when the validation cycle is completed in SFY 2024. An updated summary of ABH's interventions for each PIP topic will be included in next year's annual EQR technical report.

Table 2-5—Barriers and Interventions Reported by ABH for Each PIP Topic

PIP Topic	Barriers	Interventions
Behavioral Health Transitions in Care	• Lack of timely notification for hospital discharge • Providers do not receive details of enrollee's diagnosis and discharge plan • Enrollees not aware of the importance of follow-up care	• Electronic health information exchange of admissions, discharges, and transfers • Enrollee outreach to facilitate CM engagement and follow-up visits

PIP Topic	Barriers	Interventions
Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees	• Lack of access to the COVID-19 vaccine • Enrollees may not remember to obtain the second dose of a two-dose vaccine series	• Targeted enrollee outreach to increase awareness on vaccine access and availability • Distribution of eligible enrollee lists and vaccination site lists to primary care providers (PCPs) and facilitation of referrals as needed • Enrollee outreach to eligible enrollees to provide reminder for second vaccine dose
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	• Lack of PCP training in varnish application • Lack of enrollee parent/guardian understanding of benefits and importance of fluoride varnish treatment	• Provider outreach and education to include enrollee care gaps, clinical guidelines, training opportunities, and provider reimbursement information • Outreach and education of enrollee parents/guardians on obtaining fluoride varnish from a PCP
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	• Lack of enrollee awareness of the importance of cervical cancer screening • Enrollees may not remember to schedule annual preventive appointments, which include cervical cancer screening	• Targeted enrollee and community-based educational outreach on cervical cancer screening • Text message reminder campaign for enrollees to schedule preventive services and screenings
Screening for HIV Infection	• Lack of enrollee knowledge on importance of HIV screening and on resources for obtaining screening	• Text message campaign to provide education for enrollees on the importance of HIV screening and on how to access screening services • Community-based distribution of educational materials to promote HIV screening awareness

MCO Strengths, Opportunities for Improvement, and Recommendations

HSAG will report statewide strengths, opportunities for improvement, and recommendations for ABH's PIPs in next year's annual EQR technical report, when HSAG has completed the first annual validation cycle for ABH's PIPs in SFY 2024.

Methodology

Objectives

The purpose of conducting PIPs is to achieve—through ongoing measurements and intervention—significant, sustained improvement in clinical or nonclinical areas. This structured method of assessing and improving MCO processes was designed to have favorable effects on health outcomes and member satisfaction.

The primary objective of PIP validation is to determine each MCO's compliance with requirements set forth in 42 CFR §438.240(b)(1), including:

- Measurement of performance using objective quality indicators.
- Implementation of systematic interventions to achieve improvement in performance.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

The goal of HSAG's PIP validation is to ensure that LDH and key stakeholders can have confidence that any reported improvement is related and can be reasonably linked to the QI strategies and activities the MCO conducted during the PIP. HSAG's scoring methodology evaluated whether the MCO executed a methodologically sound PIP.

Technical Methods of Data Collection

HSAG, as the State's EQRO, validated the PIPs through an independent review process. In its PIP evaluation and validation, HSAG used CMS' EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023 (CMS Protocol 1).[2-1]

HSAG's evaluation of each PIP includes two key components of the QI process:

1. HSAG evaluates the technical structure of the PIP to ensure that the MCO designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., PIP Aim statement, population, sampling techniques, performance indicator, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 15, 2023.

2. HSAG evaluates the implementation of the PIP. Once designed, a PIP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the MCO improves indicator results through implementation of effective processes (i.e., barrier analyses, interventions, and evaluation of results).

Description of Data Obtained

HSAG's methodology for PIP validation provided a consistent, structured process and a mechanism for providing the MCOs with specific feedback and recommendations. The MCOs used a standardized PIP Submission Form to document information on the PIP design, completed PIP activities, and performance indicator results. HSAG evaluated the documentation provided in the PIP Submission Form to conduct the annual validation.

How Data Were Aggregated and Analyzed

Using the PIP validation tool and standardized scoring, HSAG scored each PIP on a series of evaluation elements and scored each evaluation element within a given activity as *Met*, *Partially Met*, *Not Met*, *Not Applicable (NA)*, or *Not Assessed*. HSAG designated some of the evaluation elements pivotal to the PIP process as "critical elements." For a PIP to produce valid and reliable results, all critical elements needed to achieve a *Met* score. HSAG assigned each PIP an overall percentage score for all evaluation elements (including critical elements), calculated by dividing the total number of elements scored as *Met* by the sum of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculated a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*.

In alignment with CMS Protocol 1, HSAG assigned two PIP validation ratings, summarizing overall PIP performance. One validation rating reflected HSAG's confidence that the MCO adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. HSAG based this validation rating on the scores for applicable evaluation elements in steps 1 through 8 of the PIP validation tool. The second validation rating was only assigned for PIPs that have progressed to the Outcomes stage (Step 9) and reflected HSAG's confidence that the PIP's performance indicator results demonstrated evidence of significant improvement. The second validation rating is based on scores from Step 9 in the PIP validation tool. For each applicable validation rating, HSAG reported the percentage of applicable evaluation elements that received a *Met* score and the corresponding confidence level: *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*. The confidence level definitions for each validation rating are as follows:

1. **Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Steps 1 Through 8)**
   a. *High Confidence*: High confidence in reported PIP results. All critical evaluation elements were *Met*, and 90 percent to 100 percent of all evaluation elements were *Met* across all steps.

b. *Moderate Confidence*: Moderate confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 percent to 89 percent of all evaluation elements were *Met* across all steps.
c. *Low Confidence*: Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Partially Met*.
d. *No Confidence*: No confidence in reported PIP results. Across all steps, less than 65 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Not Met*.

2. Overall Confidence That the PIP Achieved Significant Improvement (Step 9)

a. *High Confidence*: All performance indicators demonstrated *statistically significant* improvement over the baseline.
b. *Moderate Confidence*: One of the three scenarios below occurred:
   i. All performance indicators demonstrated improvement over the baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over the baseline.
   ii. All performance indicators demonstrated improvement over the baseline, **and** none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
   iii. Some but not all performance indicators demonstrated improvement over baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over baseline.
c. *Low Confidence*: The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator **or** some but not all performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
d. *No Confidence*: The remeasurement methodology was not the same as the baseline methodology for all performance indicators or none of the performance indicators demonstrated improvement over the baseline.

HSAG analyzed the quantitative results obtained from the above PIP validation activities to identify strengths and weaknesses in each domain of quality, timeliness, and accessibility of services furnished by each MCO. HSAG then identified common themes and the salient patterns that emerged across the MCOs related to PIP validation or performance on the PIPs conducted.

How Conclusions Were Drawn

PIPs that accurately addressed CMS Protocol 1 requirements were determined to have high validity and reliability. Validity refers to the extent to which the data collected for a PIP measured its intent. Reliability refers to the extent to which an individual could reproduce the project results. For each completed PIP, HSAG assessed threats to the validity and reliability of PIP findings and determined whether a PIP was credible.

To draw conclusions about the quality, timeliness, and accessibility of care and services provided by the MCOs, HSAG assigned each PIP topic to one or more of these three domains. While the focus of an MCO's PIP may have been to improve performance related to healthcare quality, timeliness, or accessibility, PIP validation activities were designed to evaluate the validity and quality of the MCO's process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. In

addition, all PIP topics were assigned to other domains as appropriate. This assignment to domains is shown in Table 2-6.

Table 2-6—Assignment of PIPs to the Quality, Timeliness, and Access Domains

PIP Topic	Quality	Timeliness	Access
Behavioral Health Transitions in Care	✓	✓	✓
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	✓	✓	✓
Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees	✓		✓
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	✓	✓	✓
Screening for HIV Infection	✓	✓	✓

3. Validation of Performance Measures

Results

Information Systems Standards Review

The MCO's independent certified HEDIS compliance auditor determined that the rates reported by the MCO were calculated in accordance with NCQA's defined specifications and there were no data collection or reporting issues identified.

Based on a review of the FARs issued by ABH's independent certified HEDIS compliance auditor, HSAG found that ABH fully met the standard for all seven of the applicable NCQA IS standards. It should be noted that while the standards were fully met, IS 7.0 Data Integration and Reporting had the following findings:

- Corrections were needed to the mapping between the originating data sources and integration files. Inovalon advised that any update to the race and ethnicity data would need to occur after the integration of the medical review data and that introducing updated administrative data may inadvertently impact measure eligible populations. Due to potential impact to measure eligible populations, the update to the race and ethnicity mapping was deferred to MY 2023. The auditor determined that this issue did not introduce any bias to the final reported summary rates.

ABH's compliance with each of the IS standards is outlined in Table 3-1.

Table 3-1—ABH Compliance With IS Standards—MY 2022

IS Standard	ABH
IS 1.0 Medical Services Data	Met
IS 2.0 Enrollment Data	Met
IS 3.0 Practitioner Data	Met
IS 4.0 Medical Record Review Processes	Met
IS 5.0 Supplemental Data	Met
IS 6.0 Data Preproduction Processing	Met
IS 7.0 Data Integration and Reporting	Met

Performance Measures

For SFY 2023, LDH required each contracted MCO to collect and report on 47 HEDIS measures, which includes 89 total measure indicators for HEDIS MY 2022 specified in the provider agreement. The measurement set includes 11 incentive measures. Table 3-2 displays the 89 measure indicators required

by LDH. **Red** cells indicate that the measure fell below the NCQA national 50th percentile, **green** cells indicate that the measure was at or above the NCQA national 50th percentile. Table 3-2 through Table 3-5 display a summary of ABH's HEDIS measure performance.

Table 3-2—ABH HEDIS Effectiveness of Care Measures—MY 2022

HEDIS Measure	ABH	SWA
Follow-Up After Hospitalization for Mental Illness		
Within 7 Days of Discharge	17.29%	19.52%
Within 30 Days of Discharge[I]	35.27%	38.33%
Follow-Up After Emergency Department Visit for Mental Illness		
Within 7 Days of Discharge	20.18%	22.45%
Within 30 Days of Discharge[I]	33.57%	36.52%
Follow-Up After Emergency Department Visit for Substance Use[B]		
Within 7 Days of Discharge	22.24%	17.19%
Within 30 Days of Discharge[I]	33.81%	27.70%
Plan All-Cause Readmissions*		
Observed Readmissions (Numerator/Denominator)	10.37%	10.15%
Expected Readmissions Rate	9.79%	9.57%
Observed-to-Expected (O/E) Ratio (Observed Readmissions/Expected Readmissions)	1.0594	1.0603
CAHPS Health Plan Survey 5.1H, Adult (Rating of Health Plan, 8+9+10)	76.09%	80.81%
CAHPS Health Plan Survey 5.1H, Child (Rating of Health Plan—General Population, 8+9+10)	86.45%	86.41%
Depression Screening and Follow-Up for Adolescents and Adults		
Depression Screening (Total)	0.00%	1.00%
Follow-Up on Positive Screen (Total)	0.00%	58.25%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	83.33%	82.78%
Diabetes Monitoring for People With Diabetes and Schizophrenia	63.26%	67.47%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	67.65%	76.14%
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
Blood Glucose Testing	56.23%	54.46%
Cholesterol Testing	30.70%	28.80%
Blood Glucose and Cholesterol Testing	30.70%	28.05%
Lead Screening in Children	62.04%	63.59%

HEDIS Measure	ABH	SWA
Childhood Immunization Status		
Diphtheria, Tetanus, and Acellular Pertussis (DTaP)	61.56%	68.23%
Polio Vaccine, Inactivated (IPV)	81.51%	87.00%
Measles, Mumps, and Rubella (MMR)	80.29%	84.34%
Haemophilus Influenzae Type B (HiB)	79.32%	84.33%
Hepatitis B	83.45%	88.75%
Varicella-Zoster Virus (VZV)	80.29%	84.35%
Pneumococcal Conjugate	64.48%	68.57%
Hepatitis A	77.62%	80.70%
Rotavirus	65.69%	66.63%
Influenza	25.06%	26.49%
Combination 3[I]	57.66%	62.44%
Combination 7	50.36%	53.35%
Combination 10	17.27%	20.30%
Immunization Status for Adolescents		
Meningococcal	76.89%	83.48%
Tetanus, Diphtheria, and Pertussis/Tetanus and Diphtheria (Tdap/Td)	76.40%	84.30%
Human Papillomavirus (HPV)	30.17%	39.08%
Combination 1	75.91%	83.26%
Combination 2[I]	29.68%	38.69%
Colorectal Cancer Screening[I]	31.85%	33.81%
Flu Vaccinations for Adults Ages 18 to 64	33.33%	36.62%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
Body Mass Index (BMI) Percentile Documentation	77.62%	72.22%
Counseling for Nutrition	66.67%	62.46%
Counseling for Physical Activity	62.29%	55.47%
HIV Viral Load Suppression[B, I]	80.62%	79.04%
Low-Risk Cesarean Delivery (Cesarean Rate for Low-Risk First Birth Women)[*,I]	26.67%	26.61%
Chlamydia Screening in Women		
Total	59.22%	63.13%
Breast Cancer Screening	54.72%	55.83%

HEDIS Measure	ABH	SWA
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers to Quit	71.93%	73.05%
Discussing Cessation Medications	46.49%	48.84%
Discussing Cessation Strategies	46.43%	47.04%
Controlling High Blood Pressure[I]	59.85%	57.62%
Statin Therapy for Patients With Cardiovascular Disease		
Received Statin Therapy—Total	81.37%	80.66%
Statin Adherence 80%—Total	73.65%	67.86%
Hemoglobin A1c Control for Patients With Diabetes		
Poor HbA1c Control (>9.0%)[,I]*	33.09%	38.96%
HbA1c Control (<8.0%)	56.20%	52.48%
Eye Exam for Patients With Diabetes	52.31%	53.85%
Blood Pressure Control for Patients With Diabetes (<140/90 mm Hg) (BPD)	61.31%	59.93%
Pharmacotherapy for Opioid Use Disorder	34.26%	27.67%
Initiation and Engagement of Substance Use Disorder (SUD) Treatment		
Initiation of SUD[B]	60.02%	60.37%
Engagement of SUD[B]	25.54%	25.62%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	67.24%	63.46%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	55.81%	53.17%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication		
Initiation Phase	43.29%	42.65%
Continuation and Maintenance Phase	60.00%	55.44%
Antidepressant Medication Management		
Effective Acute Phase Treatment	60.92%	55.83%
Effective Continuation Phase Treatment	45.35%	38.18%
Appropriate Treatment for Children With Upper Respiratory Infection	79.17%	79.64%
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	51.77%	51.85%
Use of Imaging Studies for Low Back Pain[B]	69.73%	71.31%
Non-Recommended Cervical Screening in Adolescent Females[*]	0.58%	1.81%
Cervical Cancer Screening[I]	52.07%	56.53%
Self-Reported Overall Health (Adult)	34.59%	27.63%
Adult—Very Good	22.70%	18.98%

HEDIS Measure	ABH	SWA
Adult—Excellent	11.89%	8.65%
Self-Reported Overall Health (Child General)	79.57%	73.27%
Child General—Very Good	35.48%	36.17%
Child General—Excellent	44.09%	37.10%
Self-Reported Overall Health (Child CCC)	61.91%	59.04%
Child CCC —Very Good	38.10%	36.64%
Child CCC— Excellent	23.81%	22.40%
Self-Reported Overall Mental or Emotional Health (Adult)	45.65%	38.64%
Adult—Very Good	25.00%	22.37%
Adult—Excellent	20.65%	16.27%
Self-Reported Overall Mental or Emotional Health (Child General)	72.92%	65.65%
Child General—Very Good	32.13%	28.34%
Child General—Excellent	40.79%	37.31%
Self-Reported Overall Mental or Emotional Health (Child CCC)	41.63%	40.97%
Child CCC—Very Good	22.49%	24.08%
Child CCC—Excellent	19.14%	16.89%

[*] Indicates a lower rate is desirable.
[B] Indicates a break in trending between the most recent year and the prior year.
[I] Incentive Measure.
Green: ≥ NCQA national 50th percentile benchmark; red: < NCQA national 50th percentile benchmark.

Table 3-3—ABH HEDIS Access to/Availability of Care Measures—MY 2022

HEDIS Measure	ABH	SWA
Well-Child Visits in the First 30 Months of Life		
First 15 Months	58.55%	59.52%
15 Months–30 Months	61.09%	63.95%
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	62.73%	70.84%
45–64 Years	75.53%	80.13%
65 Years and Older	71.82%	75.93%
Total	67.43%	73.65%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care[C]	76.40%	82.86%
Postpartum Care[C]	80.05%	77.00%

[C] Indicates a caution in trending between the most recent year and the year prior.
Green: ≥ NCQA national 50th percentile benchmark; red: < NCQA national 50th percentile benchmark.

Table 3-4—ABH HEDIS Use of Services Measures—MY 2022

HEDIS Measure	ABH	SWA
Child and Adolescent Well-Care Visits		
3–11 Years	50.72%	54.57%
12–17 Years	43.09%	51.26%
18–21 Years	22.79%	27.04%
Total	43.80%	48.34%
Ambulatory Care		
Outpatient Visits/1,000 MM	4,303.35	4,930.50
Emergency Department Visits/1,000 MM[*]	745.11	746.42

[*] Indicates a lower rate is desirable.
Green: ≥ NCQA national 50th percentile benchmark; red: < NCQA national 50th percentile benchmark.

Table 3-5—ABH HEDIS Measures Summary—MY 2022

Measure Status	ABH
≥ NCQA National 50th Percentile Benchmark	20
< NCQA National 50th Percentile Benchmark	58
NCQA National Benchmark Unavailable	11
Total	89

MCO Strengths, Opportunities for Improvement, and Recommendations

For ABH, the following strengths were identified:

- ABH's performance for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure ranked above the NCQA national 50th percentile benchmark and SWA. Lack of appropriate care for diabetes for people with schizophrenia or bipolar disorder who use antipsychotic medications can lead to worsening health and death. Addressing these physical health needs is an important way to improve health, quality of life, and economic outcomes downstream.[3-1] **[Quality]**

[3-1] National Committee for Quality Assurance. Diabetes and Cardiovascular Disease Screening and Monitoring for People With Schizophrenia or Bipolar Disorder (SSD, SMD, SMC). Available at: https://www.ncqa.org/hedis/measures/diabetes-and-cardiovascular-disease-screening-and-monitoring-for-people-with-schizophrenia-or-bipolar-disorder/. Accessed on: Dec 18, 2023.

- ABH's performance for both *Statin Therapy for Patients With Cardiovascular Disease* measure indicators ranked above the NCQA national 50th percentile benchmark and SWA. Cardiovascular disease is the leading cause of death in the United States. Statin therapy is important because having unhealthy cholesterol levels places people at significant risk for developing atherosclerotic cardiovascular disease (ASCVD). Because statins are a class of drug that lowers blood cholesterol, statins of moderate or high intensity are recommended for adults with established clinical ASCVD.[3-2] **[Quality]**
- ABH's performance for the *Pharmacotherapy for Opioid Use Disorder* measure ranked above the NCQA national 50th percentile benchmark and SWA. Pharmacotherapy has been identified as a critical part of treatment for individuals with opioid use disorder (OUD). Encouraging pharmacotherapy is critical because individuals with OUD who engage in treatment with pharmacotherapy are less likely to exhibit withdrawal or craving symptoms and use illicit opioids, and are more likely to remain in treatment and engage in mental health therapy.[3-3] **[Quality]**
- ABH's performance for the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* measure ranked above the NCQA national 50th percentile benchmark and SWA. Although antipsychotic medications may serve as effective treatment for a narrowly defined set of psychiatric disorders in children and adolescents, they are often prescribed for nonpsychotic conditions for which psychosocial interventions are considered first-line treatment. Safer, first-line psychosocial interventions may be underutilized, and children and adolescents may unnecessarily incur the risks associated with antipsychotic medications.[3-4] **[Quality]**
- ABH's performance for both *Antidepressant Medication Management* measure indicators ranked above the NCQA national 50th percentile benchmark and SWA. Effective medication treatment of major depression is important because it can improve a person's daily functioning and well-being and can reduce the risk of suicide.[3-5] It is also notable that ABH was the only MCO to achieve this target benchmark. **[Quality]**

[3-2] National Committee for Quality Assurance. Statin Therapy for Patients With Cardiovascular Disease and Diabetes (SPC/SPD). Available at: https://www.ncqa.org/hedis/measures/statin-therapy-for-patients-with-cardiovascular-disease-and-diabetes/. Accessed on: Dec 18, 2023.

[3-3] National Committee for Quality Assurance. Pharmacotherapy for Opioid Use Disorder (POD). Available at: https://www.ncqa.org/hedis/measures/pharmacotherapy-for-opioid-use-disorder/. Accessed on: Dec 18, 2023.

[3-4] Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP). Available at: https://www.ncqa.org/hedis/measures/use-of-first-line-psychosocial-care-for-children-and-adolescents-on-anti-psychotics/. Accessed on: Dec 18, 2023.

[3-5] National Committee for Quality Assurance. Antidepressant Medication Management (AMM). Available at: https://www.ncqa.org/hedis/measures/antidepressant-medication-management/. Accessed on: Dec 18, 2023.

For ABH, the following opportunities for improvement were identified:

- ABH's performance for the *Follow-Up After Hospitalization for Mental Illness*, *Follow-Up After Emergency Department Visit for Mental Illness*, and *Follow-Up After Emergency Department Visit for Substance Use* measures ranked below the NCQA national 50th percentile benchmark for all indicators, with both the *Follow-Up After Hospitalization for Mental Illness* and *Follow-Up After Emergency Department Visit for Mental Illness* measure indicators falling below the SWA. The importance of providing follow-up care for these measures is critical to improving patient outcomes and decreasing the likelihood of re-hospitalization,[3-6] ensuring fewer repeat emergency department (ED) visits, improved physical and mental function, and increased compliance with follow-up instructions,[3-7] as well as a reduction in substance use, future ED use, hospital admissions and bed days,[3-8] respectively. **[Quality, Timeliness, and Access]**
- ABH's performance for the *Lead Screening in Children* measure ranked below the NCQA national 50th percentile benchmark and SWA. If not found early, exposure to lead and high blood lead levels can lead to irrevocable effects on a child's physical and mental health. Because children who are exposed to lead often have no obvious symptoms, lead poisoning often goes unrecognized. Screening for lead is an easy way to detect an abnormal blood lead level in children.[3-9] **[Quality]**
- ABH's performance for the *Childhood Immunization Status* and *Immunizations for Adolescents* measures ranked below the NCQA national 50th percentile benchmark and SWA for all indicators. Childhood and adolescent immunizations are the best defense against vaccine-preventable diseases, a number of which are serious and potentially life threatening. Vaccination coverage must be maintained in order to prevent a resurgence of vaccine-preventable diseases.[3-10,3-11] **[Quality and Access]**
- ABH's performance for the *Flu Vaccinations for Adults Ages 18 to 64* measure ranked below the NCQA national 50th percentile benchmark and SWA. Influenza is a common and contagious respiratory illness caused by a set of viruses that can result in serious complications or death. The best protection against flu is to get the annual flu vaccine.[3-12] **[Quality]**

3-6 National Committee for Quality Assurance. Follow-Up After Hospitalization for Mental Illness (FUH). Available at: https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/. Accessed on: Dec 18, 2023.

3-7 National Committee for Quality Assurance. Follow-Up After Emergency Department Visit for Mental Illness (FUM). Available at: https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-mental-illness/. Accessed on: Dec 18, 2023.

3-8 National Committee for Quality Assurance. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA). Available at: https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-alcohol-and-other-drug-abuse-or-dependence/. Accessed on: Dec 18, 2023.

3-9 National Committee for Quality Assurance. Follow-Up After Emergency Department Visit for Mental Illness (FUM). Available at: https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-mental-illness/. Accessed on: Dec 18, 2023.

3-10 National Committee for Quality Assurance. Childhood Immunization Status (CIS). Available at: https://www.ncqa.org/hedis/measures/childhood-immunization-status/. Accessed on: Dec 18, 2023.

3-11 National Committee for Quality Assurance. Immunizations for Adolescents (IMA). Available at: https://www.ncqa.org/hedis/measures/immunizations-for-adolescents/. Accessed on: Dec 18, 2023.

3-12 National Committee for Quality Assurance. Flu Vaccinations (FVA, FVO). Available at: https://www.ncqa.org/hedis/measures/flu-vaccinations/. Accessed on: Dec 18, 2023.

- ABH's performance for the *Appropriate Treatment for Children With Upper Respiratory Infection* and *Avoidance of Antibiotic Treatment in Adults for Acute Bronchitis/Bronchiolitis* measures both ranked below the NCQA national 50th percentile benchmark and SWA. The misuse of antibiotics can have adverse clinical outcomes, so ensuring the appropriate use of antibiotics for individuals will help them avoid harmful side-effects and possible resistance to antibiotics over time.[3-13,3-14] **[Quality]**
- ABH's performance for the *Use of Imaging Studies for Low Back Pain* measure ranked below the NCQA national 50th percentile benchmark and SWA. Unnecessary or routine imaging for low back pain is not associated with improved outcomes, and exposes patients to unnecessary harms such as radiation and further unnecessary treatment, so it is important to avoid imaging for patients when there is no indication of an underlying condition.[3-15] **[Quality]**
- ABH's performance for the *Cervical Cancer Screening* measure ranked below the NCQA national 50th percentile benchmark and SWA. Cervical cancer was one of the most common causes of cancer death for American women; effective screening and early detection of cervical pre-cancers have led to a significant reduction in this death rate.[3-16] **[Quality]**
- ABH's performance for the *Adults' Access to Preventive/Ambulatory Health Services* measure ranked below the NCQA national 50th percentile benchmark and SWA for all indicators. Healthcare visits are important because they provide an opportunity for individuals to receive preventive services and counseling, as well as help them to address acute issues or manage chronic conditions.[3-17] **[Quality and Access]**
- ABH's performance for the *Child and Adolescent Well-Care Visits* measure ranked below the NCQA national 50th percentile benchmark and SWA for all four indicators. Well-care visits are important, particularly with children and adolescents, because they provide an opportunity for providers to influence health and development, providing a critical opportunity for screening and counseling.[3-18] **[Quality and Access]**

For ABH, the following recommendations were identified:

- HSAG recommends that ABH focus its efforts on increasing timely follow-up care for members following discharge. ABH should also consider conducting a root cause analysis for the *Follow-Up*

[3-13] National Committee for Quality Assurance. Appropriate Treatment for Upper Respiratory Infection (URI). Available at: https://www.ncqa.org/hedis/measures/appropriate-treatment-for-upper-respiratory-infection/. Accessed on: Dec 18, 2023.
[3-14] National Committee for Quality Assurance. Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB). Available at: https://www.ncqa.org/hedis/measures/avoidance-of-antibiotic-treatment-for-acute-bronchitis-bronchiolitis/. Accessed on: Dec 18, 2023.
[3-15] National Committee for Quality Assurance. Use of Imaging Studies for Low Back Pain (LBP). Available at: https://www.ncqa.org/hedis/measures/use-of-imaging-studies-for-low-back-pain/. Accessed on: Dec 18, 2023.
[3-16] National Committee for Quality Assurance. Cervical Cancer Screening (CCS). Available at: https://www.ncqa.org/hedis/measures/cervical-cancer-screening/. Accessed on: Dec 18, 2023.
[3-17] National Committee for Quality Assurance. Adults' Access to Preventive/Ambulatory Health Services (AAP). Available at: https://www.ncqa.org/hedis/measures/adults-access-to-preventive-ambulatory-health-services/. Accessed on: Dec 18, 2023.
[3-18] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Dec 18, 2023.

After Hospitalization for Mental Illness, *Follow-Up After Emergency Department Visit for Mental Illness*, and *Follow-Up After Emergency Department Visit for Substance Use* measures and implementing appropriate interventions to improve performance, such as providing patient and provider education or improving upon coordination of care following discharge. **[Quality, Timeliness, and Access]**

- HSAG recommends that ABH focus its efforts on increasing lead capillary or venous blood tests for children prior to their second birthday. ABH should also consider conducting a root cause analysis for the *Lead Screening in Children* measure and implementing appropriate interventions to improve performance, such as incorporating lead blood tests into well-child examinations when possible. **[Quality]**
- HSAG recommends that ABH focus its efforts on increasing immunizations for children. ABH should also consider conducting a root cause analysis for the *Childhood Immunization Status* and *Immunizations for Adolescents* measures and implementing appropriate interventions to improve performance that are evidenced-based and address barriers such as parent dissatisfaction, provider capacity, or appointment accessibility. ABH should also consider inclusion of parent/guardian and provider participation when evaluating root causes of measure performance. **[Quality and Access]**
- HSAG recommends that ABH focus its efforts on increasing flu vaccinations for adults. ABH should also consider conducting a root cause analysis for the *Flu Vaccinations for Adults Ages 18 to 64* measure and implementing appropriate interventions to improve performance, such as outreach campaigns, vaccination reminders, and expanding upon locations to access vaccinations. **[Quality]**
- HSAG recommends that ABH focus its efforts on appropriate treatment of respiratory conditions. ABH should also consider conducting a root cause analysis for the *Appropriate Treatment for Children With Upper Respiratory Infection* and *Avoidance of Antibiotic Treatment in Adults for Acute Bronchitis/Bronchiolitis* measures and implementing appropriate interventions to improve performance, such as patient and provider education. **[Quality]**
- HSAG recommends that ABH focus its efforts on decreasing unnecessary imaging for low back pain. ABH should also consider conducting a root cause analysis for the *Use of Imaging Studies for Low Back Pain* measure and implementing appropriate interventions to improve performance, such as addressing provider behaviors, provider incentives, and addressing member expectation with education. **[Quality]**
- HSAG recommends that ABH focus its efforts on increasing cervical cancer screenings among women. ABH should consider conducting a root cause analysis for the *Cervical Cancer Screening* measure and implementing appropriate interventions to improve performance, such as offering screenings at more locations or expanding clinic and screening hours. **[Quality]**
- HSAG recommends that ABH focus its efforts on addressing preventive services to address acute conditions. ABH should consider conducting a root cause analysis for the *Adults' Access to Preventive/Ambulatory Health Services* measure and implementing appropriate interventions to improve performance, such as patient and provider education, outreach campaigns, and sending reminders. **[Quality and Access]**
- HSAG recommends that ABH focus its efforts on increasing well-child visits for children and adolescents. ABH should consider conducting a root cause analysis for the *Child and Adolescent*

Well-Care Visits measure and implementing appropriate interventions to improve performance, such as patient and provider education, outreach campaigns, incentives for members upon completion of well-child visits, and sending reminders. **[Quality and Access]**

Methodology

Objectives

In accordance with 42 CFR §438.330(c), states must require MCOs to submit performance measurement data as part of their QAPI programs. The validation of performance measures is one of the mandatory EQR activities that the state Medicaid agencies are required to perform according to the Medicaid managed care regulations.

The primary objectives of the performance measure validation (PMV) process were to:

1. Evaluate the accuracy of performance measure data collected by the MCO.
2. Determine the extent to which the specific performance measures calculated by the MCO (or on behalf of the MCO) followed the specifications established for each performance measure.
3. Identify overall strengths and areas for improvement in the performance measure calculation process.

Technical Methods of Data Collection

CMS' EQR *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity,* February 2023,[3-19] specifies that, in lieu of conducting a full on-site Information Systems Capabilities Assessment (ISCA), the EQRO may review an assessment of the MCO's IS conducted by another party. If an MCO is accredited by NCQA, the MCO will have received a full IS assessment as part of its annual HEDIS Compliance Audit by an NCQA HEDIS Compliance Audit licensed organization (LO). In this case, HSAG would request and review the MCO's NCQA HEDIS Record of Administration, Data Management, and Processes (Roadmap), FAR, and the data submission tool in lieu of conducting an on-site assessment.

The validation process is described separately for the HEDIS and non-HEDIS measures that the MCOs report.

[3-19] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 18, 2023.

HEDIS Measure Validation

The MCOs that report HEDIS measures to NCQA must undergo an audit of their data conducted by an NCQA HEDIS Compliance Audit LO. For these HEDIS measures, HSAG reviews the rates submitted on the NCQA reporting tool (Interactive Data Submission System [IDSS]), which is audited prior to submission, and the FAR, which is completed by the LO and describes the process used to produce the measure rates and any problems that the MCOs experienced in the HEDIS process. Included in the FAR are the measures deemed *Not Reportable* due to biases in the calculation process.

HSAG used the results of the audit to report the results of each measure reported to LDH. Using information provided in the FAR and, if necessary, additional documentation (i.e., NCQA HEDIS Roadmap), HSAG prepared a report indicating the measure results for each of the MCOs that are required to report to LDH. Measures deemed *Not Reportable* were flagged. SWAs were computed, and NCQA Quality Compass benchmarks were provided as well. Results for the prior two years were provided for trending, when appropriate. Any issues in reporting any measure (e.g., medical record abstraction issues) were noted and, if LDH requested any other statistical analyses, the results were included in the report.

Non-HEDIS Measure Validation

For state-specific measures and standardized non-HEDIS measures (e.g., the Prevention Quality Indicators), University of Louisiana Monroe (ULM), contracted by LDH, conducted the audit. Measures that did not pass validation were deemed *Not Reportable*, and the reasons for this designation (e.g., unresolved source code issues) were noted. If LDH requested any other statistical analyses, the results were included in the report. ULM conducted the validation for non-HEDIS measures, and HSAG provided assistance when needed.

Description of Data Obtained

HSAG used the FAR and the MCO rates provided on the IDSS file as the primary data sources. The FAR included information on the MCOs' IS capabilities, findings for each measure, supplemental data validation results, medical record review validation results, results of any corrected programming logic (including corrections to numerators, denominators, or sampling used for final measure calculation), and opportunities for improvement. The FAR included final determinations of validity made by the auditor for each performance measure. The IDSS file detailed all rates that were submitted to NCQA and whether the auditor deemed them to be reportable. The IDSS file is "locked" by the auditor so that no changes can be made to the results.

How Data Were Aggregated and Analyzed

In accordance with the MY 2022 NCQA HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5, the LOs evaluated compliance with NCQA's IS standards. NCQA's IS standards detail the minimum requirements of an MCO's IS, as well as criteria that must be met for any manual

processes used to report HEDIS information. For each HEDIS measure, the MCO was evaluated on how its rate compared to the NCQA Quality Compass MY 2022 national 50th percentile Medicaid HMO benchmark.

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of care and services that each MCO provided to members, HSAG evaluated the results for each performance measure and the MY 2022 performance levels based on comparison to the NCQA national 50th percentile benchmark percentile to identify strengths and weaknesses and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the MCO's Medicaid members.

To draw conclusions about the quality, timeliness, and accessibility of care provided by the Medicaid MCOs, HSAG assigned each of the components reviewed for PMV to one or more of three domains of care. This assignment to domains of care is depicted in Table 3-6. The measures marked *NA* are related to utilization of services.

Table 3-6—Assignment of Performance Measures to the Quality, Timeliness, and Access Domains

Performance Measure	Quality	Timeliness	Access
Childhood Immunization Status—DTaP, *IPV*, *MMR*, *HiB*, *Hepatitis B*, *VZV*, *Pneumococcal Conjugate, Hepatitis A*, *Rotavirus*, *Influenza*, *Combination 3*, *Combination 7*, and *Combination 10*	✓		✓
Immunization Status for Adolescents—Meningococcal, *Tdap/Td*, *HPV*, *Combination 1*, and *Combination 2*	✓		
Colorectal Cancer Screening	✓		
Cervical Cancer Screening	✓		
Follow-Up After Hospitalization for Mental Illness—Within 7 Days of Discharge and *Within 30 Days of Discharge*	✓	✓	✓
Follow-Up After Emergency Department Visit for Mental Illness—Within 7 Days of Discharge and *Within 30 Days of Discharge*	✓	✓	✓
Follow-Up After Emergency Department Visit for Substance Use—Within 7 Days of Discharge and *Within 30 Days of Discharge*	✓	✓	✓
Hemoglobin A1c Control for Patients With Diabetes—Poor HbA1c Control (>9.0%) and *HbA1c Control (<8.0%)*	✓		
Controlling High Blood Pressure	✓		
HIV Viral Load Suppression	✓		
Low-Risk Cesarean Delivery (Cesarean Rate for Low-Risk First Birth Women)	✓		

Performance Measure	Quality	Timeliness	Access
Child and Adolescent Well-Care Visits—3–11 Years, *12–17 Years*, *18–21 Years*, and *Total*	✓		✓
Well-Child Visits in the First 30 Months of Life—First 15 Months and *15 Months–30 Months*	✓		✓
Adults' Access to Preventive/Ambulatory Health Services—20–44 Years, *45–64 Years*, *65 Years and Older*, and *Total*	✓		✓
Ambulatory Care—Outpatient Visits/1,000 MM and *Emergency Department Visits/1,000 MM*	NA	NA	NA
Plan All-Cause Readmissions—Observed Readmissions, *Expected Readmissions*, and *O/E Ratio*	✓		
CAHPS Health Plan Survey 5.1H, Child (Rating of Health Plan, 8+9+10)	✓		
CAHPS Health Plan Survey 5.1H, Child (Rating of Health Plan—General Population, 8+9+10)	✓		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	✓		
Diabetes Monitoring for People With Diabetes and Schizophrenia	✓		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	✓		
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing, *Cholesterol Testing*, and *Blood Glucose and Cholesterol Testing*	✓		
Prenatal and Postpartum Care—Timeliness of Prenatal Care and *Postpartum Care*	✓	✓	✓
Lead Screening in Children	✓		
Flu Vaccinations for Adults Ages 18 to 64	✓		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation, *Counseling for Nutrition*, and *Counseling for Physical Activity*	✓		
Chlamydia Screening in Women—Total	✓		
Breast Cancer Screening	✓		
Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*	✓		
Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total and *Statin Adherence 80%—Total*	✓		
Blood Pressure Control for Patients With Diabetes	✓		
Eye Exam for Patients With Diabetes	✓		

Performance Measure	Quality	Timeliness	Access
Pharmacotherapy for Opioid Use Disorder	✓		
Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD and *Engagement of SUD*	✓	✓	✓
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	✓		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	✓		
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase and *Continuation and Maintenance Phase*	✓	✓	✓
Antidepressant Medication Management—Effective Acute Phase Treatment and *Effective Continuation Phase Treatment*	✓		
Appropriate Treatment for Children With Upper Respiratory Infection	✓		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	✓		
Non-Recommended Cervical Screening in Adolescent Females	✓		
Depression Screening and Follow-Up for Adolescents and Adults	✓		
Self-Reported Overall Health (Adult)—Adult—Very Good and *Adult—Excellent*	✓		
Self-Reported Overall Health (Child General)—Child General—Very Good and *Child General—Excellent*	✓		
Self-Reported Overall Health (Child CCC)—Child CCC—Very Good and *Child CCC—Excellent*	✓		
Self-Reported Overall Mental or Emotional Health (Adult)—Adult—Very Good and *Adult—Excellent*	✓		
Self-Reported Overall Mental or Emotional Health (Child General)—Child General—Very Good and *Child General—Excellent*	✓		
Self-Reported Overall Mental or Emotional Health (Child CCC)—Child CCC—Very Good and *Child CCC—Excellent*	✓		
Use of Imaging Studies for Low Back Pain	✓		

4. Assessment of Compliance With Medicaid Managed Care Regulations

Results

In CY 2022, the first year of a new three-year review cycle, LDH's former EQRO conducted a CR covering a review period of CY 2021 and most of the federally required standards. In CY 2023, HSAG conducted a CR for Standard I—Enrollment and Disenrollment (this standard had not been included in the prior year's CR), thereby completing the required evaluation for the administrative and compliance process in a three-year period. LDH plans to use CY 2024 for remediation and to prepare for a new CR cycle. Table 4-1 presents an overview of the results for ABH.

Table 4-1—Summary of CR Scores for the Three-Year Review Period: CY 2021-CY 2023[1,2]

Standard Name	2021	2022	2023
Enrollment and Disenrollment	n/a	42.9%	
Member Rights and Confidentiality	93.0%		
Member Information			
Coverage and Authorization of Services	98.5%		
Emergency and Post-Stabilization Services			
Availability of Services	99.2%		
Assurances of Adequate Capacity and Services	100%		
Coordination and Continuity of Care	91.6%		
Provider Selection	97.8%		
Subcontractual Relationships and Delegation	100%		
Practice Guidelines	100%		
Health Information Systems	100%		
Quality Assessment and Performance Improvement Program	98.6%		
Grievance and Appeal Systems	100%		
Program Integrity	95.8%		

[1] Grey shading indicates the standard was not reviewed in the calendar year.

[2] Bold text indicates scores that were determined by HSAG. All other scores were determined by LDH's former EQRO. HSAG's scoring methodology included three levels: *Met*, *Not Met*, and *Not Applicable*.

During the 2023 CR, ABH received a compliance score of 42.9 percent for Standard I—Enrollment and Disenrollment, which identified ABH has opportunities for improvement. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed. For any elements HSAG scored *Not Met*, ABH is required to submit a CAP to bring the element into compliance with the applicable standard(s).

Follow-Up on Previous Compliance Review Findings

LDH contracted HSAG to assess the remediation ABH conducted as a result of the deficiencies identified in the prior year's CR (conducted by LDH's previous EQRO). ABH was issued a CAP and required to remediate each element as recommended by the previous EQRO. During this year's virtual partial compliance audit, HSAG reviewed the recommendations made by the previous EQRO and ABH's response. ABH submitted additional documentation or implemented policies and procedures to meet requirements. ABH also completed a response document to describe its remediation efforts for each element. HSAG then assessed all remediation elements to determine if compliance with requirements had been met and assigned a final score. Table 4-2 presents an overview of the results for ABH.

Table 4-2—Summary of Scores for the CAP From the CY 2021 Review

	Total Elements in CAP	Number of Elements		Total Compliance Score From CAP
		M	*NM*	
Follow-Up on CAPs From Prior CR	36	34	2	94.4%

M=*Met*, ***NM***=*Not Met*
Total Elements in CAP: The total number of elements within the CAP from the CY 2021 review. This represents the denominator.
Total Compliance Score From CAP: The overall percentages of the number of elements that received a score of *Met* (1 point) then dividing this total by the total number of elements.

ABH achieved compliance in 34 of 36 elements from the LDH-approved 2022 CR CAPs. ABH must implement the remaining approved CAPs for the two elements for which compliance was not achieved.

MCO Strengths, Opportunities for Improvement, and Recommendations

For ABH, the following strength was identified:

- ABH's policies and procedures ensured that ABH did not inappropriately request disenrollment of a member because of an adverse change in the member's health status, utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs. **[Quality and Access]**

For ABH, the following opportunity for improvement was identified:

- ABH's policies and procedures failed to include all requirements in Standard I—Enrollment and Disenrollment. **[Quality and Access]**

For ABH, the following required action and recommendation were identified:

- ABH must revise its policies and procedures to include all requirements in Standard I—Enrollment and Disenrollment as detailed in the CR report. **[Quality and Access]**

Methodology

Standards

Table 4-3 delineates the CR activities as well as the standards that were reviewed during the first two years of the three-year CR cycle. In addition, HSAG conducted a follow-up review of each MCO's implementation of CAPs from the CY 2021 CRs.

Table 4-3—Summary of CR Standards

Standard	Year One (CY 2021)			Year Two (CY 2022)		
	MCO	PAHP	PIHP	MCO	PAHP	PIHP
Standard I—Enrollment and Disenrollment				✓	✓	✓
Standard II—Member Rights and Confidentiality	✓	✓	✓			
Standard III—Member Information	✓	✓	✓			
Standard IV—Emergency and Poststabilization Services	✓	NA				✓
Standard V—Adequate Capacity and Availability of Services	✓	✓	✓			
Standard VI—Coordination and Continuity of Care	✓	✓	✓			
Standard VII—Coverage and Authorization of Services	✓	✓	✓			
Standard VIII—Provider Selection	✓	✓	✓			
Standard IX—Subcontractual Relationships and Delegation	✓		✓		✓	
Standard X—Practice Guidelines	✓	✓	✓			
Standard XI—Health Information Systems	✓	✓	✓			
Standard XII—Quality Assessment and Performance Improvement	✓	✓	✓			
Standard XIII—Grievance and Appeal Systems	✓	✓	✓			
Standard XIV—Program Integrity	✓	✓	✓			

HSAG divided the federal regulations into 14 standards consisting of related regulations and contract requirements. Table 4-4 describes the standards and associated regulations and requirements reviewed for each standard.

Table 4-4—Summary of CR Standards and Associated Regulations

Standard	Federal Requirements Included[1]	Standard	Federal Requirements Included
Standard I—Enrollment and Disenrollment	42 CFR §438.3(d) 42 CFR §438.56	Standard VIII—Provider Selection	42 CFR §438.12 42 CFR §438.102 42 CFR §438.106 42 CFR §438.214 42 CFR §438.602(b) 42 CFR §438.608 42 CFR §438.610
Standard II—Member Rights and Confidentiality	42 CFR §438.100 42 CFR §438.224 42 CFR §422.128	Standard IX—Subcontractual Relationships and Delegation	42 CFR §438.230
Standard III—Member Information	42 CFR §438.10	Standard X—Practice Guidelines	42 CFR §438.236
Standard IV—Emergency and Poststabilization Services	42 CFR §438.114	Standard XI—Health Information Systems	42 CFR §438.242
Standard V—Adequate Capacity and Availability of Services	42 CFR §438.206 42 CFR §438.207	Standard XII—Quality Assessment and Performance Improvement	42 CFR §438.330
Standard VI—Coordination and Continuity of Care	42 CFR §438.208	Standard XIII—Grievance and Appeal Systems	42 CFR §438.228 42 CFR §438.400– 42 CFR §438.424
Standard VII—Coverage and Authorization of Services	42 CFR §438.210 42 CFR §438.404	Standard XIV—Program Integrity	42 CFR §438.608

[1] The CR standards comprise a review of all requirements, known as "elements," under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard XIII—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).

Objectives

Private accreditation organizations, state licensing agencies, and state Medicaid agencies all recognize that having standards is only the first step in promoting safe and effective healthcare. Making sure that the standards are followed is the second step. The objective of each virtual review was to provide meaningful information to LDH and the MCOs regarding:

- The MCOs' compliance with federal managed care regulations and contract requirements in the standard areas reviewed.

- Strengths, opportunities for improvement, recommendations, or required actions to bring the MCOs into compliance with federal managed care regulations and contract requirements with the standard areas reviewed.
- The quality, timeliness, and access to care furnished by the MCOs, as addressed within the specific areas reviewed.
- Possible additional interventions recommended to improve the quality of the MCOs' care provided and services offered related to the areas reviewed.

Technical Methods of Data Collection

To assess the MCOs' compliance with regulations, HSAG conducted the five activities described in CMS' EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity,* February 2023.[4-1] Table 4-5 describes the five protocol activities and the specific tasks that HSAG performed to complete each activity.

Table 4-5—Protocol Activities Performed for Assessment of Compliance With Regulations

For this protocol activity,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Conducted before the review to assess compliance with federal managed care regulations and LDH contract requirements: • HSAG and LDH collaborated to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG developed and submitted CR tools, report templates, and agendas, and sent review dates to LDH for review and approval. • HSAG forwarded the CR tools and agendas to the MCOs. • HSAG scheduled the virtual reviews to facilitate preparation for the reviews.
Activity 2:	**Perform Preliminary Review**
	• HSAG conducted an MCO pre-virtual review preparation session to describe HSAG's processes and allow the MCOs the opportunity to ask questions about the review process and MCO expectations. • HSAG confirmed a primary MCO contact person for the review and assigned HSAG reviewers to participate. • During the MCO pre-virtual review preparation session, HSAG notified the MCOs of the request for desk review documents. HSAG delivered a desk review form, the CR tool, CAP implementation review tool, and a webinar review agenda via HSAG's Secure Access File Exchange (SAFE) site. The desk review request included

[4-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 18, 2023.

For this protocol activity,	HSAG completed the following activities:
	instructions for organizing and preparing the documents to be submitted. The MCO provided documentation for the desk review, as requested. • Examples of documents submitted for the desk review and CR consisted of the completed desk review form, the CR tool with the MCO's section completed, policies and procedures, staff training materials, reports, minutes of key committee meetings, and member and provider informational materials. • The HSAG review team reviewed all documentation submitted prior to the scheduled webinar and prepared a request for further documentation and an interview guide to use during the webinar.
Activity 3:	**Conduct MCO Virtual Review**
	• HSAG conducted an opening conference, with introductions and a review of the agenda and logistics for HSAG's virtual review activities. • During the review, HSAG met with groups of the MCO's key staff members to obtain a complete picture of the MCO's compliance with Medicaid and CHIP managed care regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the MCO's performance. • HSAG requested, collected, and reviewed additional documents, as needed. • HSAG conducted a closing conference during which HSAG reviewers summarized preliminary findings, as appropriate.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the 2023 LDH-approved CR Report Template to compile the findings and incorporate information from the CR activities. • HSAG analyzed the findings and calculated final scores based on LDH-approved scoring strategies. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to LDH**
	• HSAG populated and submitted the draft reports to LDH and the MCOs for review and comments. • HSAG incorporated the feedback, as applicable, and finalized the reports. • HSAG included a pre-populated CAP template in the final report for all requirements determined to be out of compliance with managed care regulations (i.e., received a score of *Not Met*). • HSAG distributed the final reports to the MCOs and LDH.

Description of Data Obtained

The following are examples of documents reviewed and sources of the data obtained:

- Committee meeting agendas, minutes, and reports
- Written policies and procedures
- Management/monitoring reports and audits
- Narrative and/or data reports across a broad range of performance and content areas
- Records for delegation
- Member and provider materials

How Data Were Aggregated and Analyzed

HSAG aggregated and analyzed the data resulting from the desk review, virtual interviews conducted with key MCO personnel, and any additional documents submitted as a result of the interviews. The data that HSAG aggregated and analyzed included the following:

- Documented findings describing the MCO's performance in complying with each standard requirement.
- Scores assigned to the MCO's performance for each requirement.
- The total percentage-of-compliance score calculated for each standard.
- The overall percentage-of-compliance score calculated across the standards.
- Documentation of the actions required to bring performance into compliance with the requirements for which HSAG assigned scores of *Not Met*.
- Recommendations for program enhancements.

Based on the results of the data aggregation and analysis, HSAG prepared and forwarded draft reports to LDH and to each MCO's staff members for their review and comment prior to issuing final reports.

HSAG analyzed the quantitative results obtained from the above compliance activity to identify strengths and weaknesses in each domain of quality, timeliness, and access to care furnished by each MCO. HSAG then identified common themes and the salient patterns that emerged across MCOs related to the compliance activity conducted.

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and access to care provided by the MCOs, HSAG assigned each of the components reviewed for assessment of compliance with regulations to one or more of those domains of care. Each standard may involve assessment of more than one domain of care due to the combination of individual requirements within each standard. HSAG then analyzed, to draw

conclusions and make recommendations, the individual requirements within each standard that assessed the quality, timeliness, or access to care and services provided by the MCOs. Table 4-6 depicts assignment of the standards to the domains of care.

Table 4-6—Assignment of CR Standards to the Quality, Timeliness, and Access Domains

CR Standard	Quality	Timeliness	Access
Standard I—Enrollment and Disenrollment	✓		✓
Standard II—Member Rights and Confidentiality			✓
Standard III—Member Information			✓
Standard IV—Emergency and Poststabilization Services		✓	✓
Standard V—Adequate Capacity and Availability of Services		✓	✓
Standard VI—Coordination and Continuity of Care	✓	✓	✓
Standard VII—Coverage and Authorization of Services		✓	✓
Standard VIII—Provider Selection	✓	✓	✓
Standard IX—Subcontractual Relationships and Delegation	✓		
Standard X—Practice Guidelines	✓		
Standard XI—Health Information Systems	✓		✓
Standard XII—Quality Assessment and Performance Improvement	✓		
Standard XIII—Grievance and Appeal Systems	✓	✓	✓
Standard XIV—Program Integrity	✓	✓	✓

Results

Provider Access Surveys

The provider access survey results were not final at the time of reporting. Provider access survey results will be included in the SFY 2024 EQR technical report. At the time of reporting, HSAG and LDH finalized the first semiannual provider access survey methodology, and HSAG conducted the survey telephone calls.

Provider Directory Accuracy

This section presents the results from the Quarter 1 PDV for all sampled ABH providers by specialty type. Quarter 2 through Quarter 4 PDV results were not final at the time of reporting and will be included in the SFY 2024 EQR technical report.

Table 5-1 illustrates the survey disposition and response rates for ABH by specialty type.

Table 5-1—Survey Dispositions and Response Rates for ABH by Specialty Type

Specialty Type	Sampled Cases	Respondents	Refusals*	Bad Phone Number**	Unable to Reach***	Response Rate
Total	**125**	**100**	**1**	**13**	**11**	**80.0%**
Internal Medicine/Family Medicine	25	22	0	2	1	88.0%
Pediatrics	25	21	0	3	1	84.0%
Obstetrics/Gynecology (OB/GYN)	25	19	1	2	3	76.0%
Specialists (any)	25	21	0	3	1	84.0%
Behavioral Health (any)	25	17	0	3	5	68.0%

* This includes offices that refused to participate, or the representative did not have enough information to answer the survey questions.
** This includes reaching a disconnected number, fax number, nonmedical facility, or billing office that was unable to transfer/provide corrected number.
*** This includes reaching a voicemail, busy signal, continuous ringing, and/or extended hold time after three attempts.

Table 5-2 illustrates the indicator match rates for ABH by specialty type.

Table 5-2—Indicator Match Rates for ABH by Specialty Type

Specialty Type	Correct Address		Provider at Location		Confirmed Specialty		Accepted MCO		Accepted Louisiana Medicaid		Accepted New Patients	
	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)
Total	**63**	**63.0%**	**54**	**54.0%**	**46**	**46.0%**	**41**	**41.0%**	**40**	**40.0%**	**46**	**46.0%**
Internal Medicine/Family Medicine	15	68.2%	13	59.1%	9	40.9%	10	45.5%	9	40.9%	10	45.5%
Pediatrics	17	81.0%	14	66.7%	14	66.7%	12	57.1%	12	57.1%	13	61.9%
OB/GYN	3	15.8%	6	31.6%	4	21.1%	5	26.3%	5	26.3%	6	31.6%
Specialists (any)	17	81.0%	10	47.6%	9	42.9%	5	23.8%	5	23.8%	8	38.1%
Behavioral Health (any)	11	64.7%	11	64.7%	10	58.8%	9	52.9%	5	25.0%	9	52.9%

Table 5-3 presents ABH's PDV weighted compliance scores by specialty type. Please see the network adequacy validation (NAV) methodology for the weighted compliance score calculation criteria.

Table 5-3—PDV Weighted Compliance Scores by Specialty Type

Specialty Type	Total	Compliant[1]	Weighted Compliance Score
Total	**125**	**21**	**27.5%**
Internal Medicine/Family Medicine	25	3	26.7%
Pediatrics	25	9	41.3%
OB/GYN	25	2	29.3%
Specialists (any)	25	2	12.0%
Behavioral Health (any)	25	5	28.0%

[1] Compliant providers include providers in which all indicators match between the online provider directory and the information obtained during the survey call to the sampled location.

Table 5-4 presents ABH's reasons for noncompliance.

Table 5-4—Reasons for Noncompliance

Reason	Count	Rate (%)
Noncompliant providers	**104**	**83.2%**
Total reasons for noncompliance	**124**	**Not Applicable**
Provider does not participate with MCO or Louisiana Medicaid	14	11.2%
Provider is not at site	32	25.6%
Provider not accepting new patients	8	6.4%
Wrong telephone number	0	0.0%
No response/busy signal/disconnected telephone number (after three calls)	24	19.2%
Representative does not know	1	0.8%
Incorrect address reported	29	23.2%
Address (suite number) needs to be updated	8	6.4%
Wrong specialty reported	8	6.4%

GeoAccess Provider Network Accessibility

ABH's contract with LDH (effective dates January 1, 2023–December 31, 2025) requires ABH to comply with the following GeoAccess standards:

- Travel distance to adult primary care (family/general practice, internal medicine, Federally Qualified Health Center [FQHC], Rural Health Center [RHC], and pediatric primary care (pediatric practices, family/general practice, internal medicine, FQHC, RHC):
  - Urban—10 miles
  - Rural—30 miles
- Travel distance to acute inpatient hospitals
  - Urban—10 miles
  - Rural—30 miles
- Travel distance to ancillary care (laboratory and radiology):
  - Urban—20 miles
  - Rural—30 miles
- Travel distance to ancillary care (pharmacy and hemodialysis):
  - Urban—10 miles
  - Rural—30 miles

- Travel distance to specialty care (OB/GYN and psychiatrists):
  - Urban—15 miles
  - Rural—30 miles
- Travel distance to all other specialty care (except behavioral health care):
  - Urban—60 miles
  - Rural—60 miles
- Travel distance to licensed mental health specialists (advanced practice registered nurse [APRN], psychologist, licensed clinical social worker [LCSW]):
  - Urban—15 miles
  - Rural—30 miles
- Travel distance to pediatric psychiatric residential treatment facilities (PRTFs) (mental health and American Society of Addiction Medicine [ASAM]):
  - Urban—200 miles
  - Rural—200 miles
- Travel distance to ASAM levels of care (LOCs) (both urban and rural):
  - ASAM LOC 1 (adult and pediatric 1):
    - Urban—15 miles
    - Rural—30 miles
  - ASAM LOC 2.1 (adult and pediatric)
    - Urban—15 miles
    - Rural—30 miles
  - ASAM LOC 2 Withdrawal Management (WM) (adult and pediatric)—60 miles
  - ASAM LOC 3.1 (adult)—30 miles
  - ASAM LOC 3.1 (pediatric)—60 miles
  - ASAM LOC 3.2WM (adult and pediatric)—60 miles
  - ASAM LOC 3.3 (adult)—30 miles
  - ASAM LOC 3.5 (adult)—30 miles
  - ASAM LOC 3.5 (pediatric)—60 miles
  - ASAM LOC 3.7 (adult)—60 miles
  - ASAM LOC 3.7WM (adult)—60 miles
- Travel distance to psychiatric inpatient hospital services (free standing, distinct psychiatric unit):
  - Urban—90 miles
  - Rural—90 miles
- Travel distance to behavioral health rehabilitation services (legacy and non-legacy agency):
  - Urban—15 miles
  - Rural—30 miles

Table 5-5 presents the percentage of members ABH reported having access within the required distance standard for the reporting period of July 1, 2022, through June 30, 2023, for the physical health provider types depicted in Attachment F of ABH's contract with LDH.

Table 5-5—GeoAccess Results for ABH—Physical Health

Provider Type	Region	Standard	Reporting Period 07/01/22—12/31/22	Reporting Period 01/01/23—06/30/23
Adult Primary Care	Urban	10 miles/100%	98.6%	98.7
	Rural	30 miles/100%	100%	100%
Pediatric Primary Care	Urban	10 miles/100%	98.7%	98.9%
	Rural	30 miles/100%	100%	100%
FQHCs	Urban	10 miles/100%	91.7%	92%
	Rural	30 miles/100%	99.9%	99.8%
RHCs	Urban	10 miles/100%	74.5%	75.6%
	Rural	30 miles/100%	100%	100%
Acute Inpatient Hospitals	Urban	10 miles/100%	88.9%	88.4%
	Rural	30 miles/100%	99.9%	99.9%
Ancillary Care—Laboratory	Urban	20 miles/100%	92.8%	92.7%
	Rural	30 miles/100%	64.2%	61.9%
Ancillary Care—Radiology	Urban	20 miles/100%	98.3%	97.9%
	Rural	30 miles/100%	93.4%	93.1%
Ancillary Care—Pharmacy	Urban	10 miles/100%	98.2%	98.3%
	Rural	30 miles/100%	100%	100%
Ancillary Care—Hemodialysis	Urban	10 miles/100%	90.4%	89.8%
	Rural	30 miles/100%	95.9%	95.2%
Specialty Care—OB/GYN	Urban	15 miles/100%	97.3%	96.9%
	Rural	30 miles/100%	95.5%	94.5%
Allergy/Immunology	Urban or Rural	60 miles/100%	94.6%	94.5%
Cardiology	Urban or Rural	60 miles/100%	99.9%	99.9%

Provider Type	Region	Standard	Reporting Period 07/01/22—12/31/22	Reporting Period 01/01/23—06/30/23
Dermatology	Urban or Rural	60 miles/100%	97.3%	97.1%
Endocrinology and Metabolism	Urban or Rural	60 miles/100%	98.9%	99.0%
Gastroenterology	Urban or Rural	60 miles/100%	99.9%	99.9%
Hematology/Oncology	Urban or Rural	60 miles/100%	95.9%	95.9%
Nephrology	Urban or Rural	60 miles/100%	97.2%	97.2%
Neurology	Urban or Rural	60 miles/100%	99.9%	99.9%
Ophthalmology	Urban or Rural	60 miles/100%	99.9%	99.9%
Orthopedics	Urban or Rural	60 miles/100%	99.9%	99.9%
Otorhinolaryngology/ Otolaryngology	Urban or Rural	60 miles/100%	99.9%	99.9%
Urology	Urban or Rural	60 miles/100%	99.9%	99.9%

Meets the required distance standards
Results of 99.0% or higher

Table 5-6 presents the percentage of members ABH reported having access within the required distance standard for the reporting period of July 1, 2022, through June 30, 2023, for the behavioral health provider types depicted in Attachment F of ABH's contract with LDH.

Table 5-6—GeoAccess Results for ABH—Behavioral Health

Provider Type	Region	Standard	Quarter 1 07/01/22—09/30/22	Quarter 2 10/01/22—12/31/22	Quarter 3 01/01/23—03/01/23	Quarter 4 04/01/23—06/30/23
Specialty Care—Psychiatrists	Urban	15 miles/100%	96.5%	96.9%	97.0%	96.9%
	Rural	30 miles/100%	97.1%	98.2%	98.4%	94.6%
Behavioral Health Specialists	Urban	15 miles/100%	98.6%	99.0%	98.1%	99.4%
	Rural	30 miles/100%	99.9%	99.9%	99.5%	100%
All Prescribers	Urban	15 miles/100%	97.4%	98.3%	98.7%	98.9%
	Rural	30 miles/100%	99.9%	99.9%	99.4%	100%
Pediatric PRTF	Urban or Rural	200 miles/100%	100%	100%	100%	100%
ASAM LOC 1	Urban	15 miles/100%	NR	NR	74.5%	71.9%
	Rural	30 miles/100%	NR	NR	49.6%	37.8%
ASAM LOC 2.1	Urban	15 miles/100%	NR	NR	75.2%	72.4%
	Rural	30 miles/100%	NR	NR	48.2%	38.5%
ASAM LOC 2WM	Urban	60 miles/100%	NR	NR	60.9%	60.1%
	Rural	60 miles/100%	NR	NR	14.8%	14.5%
ASAM LOC 3.1 Adult	Urban	30 miles/100%	NR	NR	72.3%	72.0%
	Rural	30 miles/100%	NR	NR	27.6%	28%
ASAM LOC 3.1 Pediatric/Adolescent	Urban or Rural	60 miles/100%	NR	NR	90.1%	81.9%
ASAM LOC 3.2WM Adult	Urban	60 miles/100%	NR	NR	83.4%	61.7%
	Rural	60 miles/100%	NR	NR	60.1%	42.6%
ASAM LOC 3.2WM Pediatric/Adolescent	Urban or Rural	60 miles/100%	NR	NR	82.6%	62.3%
ASAM LOC 3.3 Adult	Urban	30 miles/100%	88.3%	83.5%	73.8%	73.2%
	Rural	30 miles/100%	50.1%	39.2%	31.7%	31.7%
ASAM LOC 3.5 Adult	Urban	30 miles/100%	94.3%	91.1%	64.7%	63.7%
	Rural	30 miles/100%	53.7%	49.0%	9.1%	9.1%

Provider Type	Region	Standard	Quarter 1 07/01/22—09/30/22	Quarter 2 10/01/22—12/31/22	Quarter 3 01/01/23—03/01/23	Quarter 4 04/01/23—06/30/23
ASAM LOC 3.7 Adult	Urban	60 miles/100%	69.9%	79.6%	81.1%	80.8%
	Rural	60 miles/100%	56.0%	67.0%	56.1%	49.3%
ASAM LOC 3.7WM Adult	Urban	60 miles/100%	98.1%	94.4%	81.2%	80.9%
	Rural	60 miles/100%	92.7%	78.6%	51.0%	48.1%
ASAM LOC 3.5 Pediatric	Urban or Rural	60 miles/100%	99.4%	96.7%	82.7%	59.1
Inpatient Psychiatric	Urban	90 miles/100%	99.9%	100%	99.9%	99.9%
	Rural	90 miles/100%	100%	100%	100%	100%
Medication-Assisted Treatment (MAT)	Urban	15 miles/100%	94.5%	95.7%	96.5%	96.4%
	Rural	30 miles/100%	88.3%	88.6%	94.3%	91.8%
Behavioral Health Rehabilitation	Urban	15 miles/100%	NR	NR	0%	95.2%
	Rural	30 miles/100%	NR	NR	0%	90.1%

Meets the required distance standards
Results of 99.0% or higher
NR—Not Reported; MCOs were not required to report these ASAM LOCs prior to January 2023.

ABH submitted network reports and gap analysis through the state fiscal year. ABH attributed some reporting of low network compliance to data issues as it began to contract with and report on new behavioral health network types. To address data issues, ABH reported re-implementing a provider crosswalk to standardize provider types and specialties. ABH reported that correctly categorizing providers improved accuracy of reporting numbers of providers within specific ASAM LOCs.

ABH reported short-term interventions to address real network gaps included use of single case agreements (SCAs) and short-term letters of agreement (LOAs), as well as contracting with providers out of the service area when needed.

ABH reported long-term interventions to address real network gaps included efforts to convert SCAs and LOAs to permanent contracts where possible, considering enhanced reimbursement rates for selected provider types, and encouraging providers to expand licensing to add additional ASAM LOCs to their system of care.

MCO Strengths, Opportunities for Improvement, and Recommendations

For ABH, the following strengths were identified:

- Based on the PDV results, strengths were not identified for ABH. **[Quality and Access]**
- For GeoAccess, ABH achieved above 99 percent for six of 10 physical health provider types reported separately for rural standards. For the 12 specialty types reported with urban and rural results combined, ABH achieved above 99 percent for seven provider types (in both reporting periods). **[Quality and Access]**
- For all four quarters, ABH achieved GeoAccess results above 99 percent for four behavioral health provider types for rural areas. **[Quality and Access]**

For ABH, the following opportunities for improvement were identified:

- Acceptance of Louisiana Medicaid had an overall match rate at 40 percent across all provider types in the PDV. **[Quality and Access]**
- Acceptance of the MCO had an overall match rate at 41 percent across all provider types in the PDV. **[Quality and Access]**
- Overall, 46 percent of providers confirmed the specialty listed in the online provider directory was accurate. **[Quality and Access]**
- Overall, 46 percent of providers confirmed they were accepting new patients; however, only providers listed as accepting new patients in the online provider directory were selected for the PDV reviews. **[Quality and Access]**
- Affiliation with the sampled provider was low in the PDV, with 54 percent of the locations confirming affiliation with the sampled provider. **[Quality and Access]**
- Accuracy of the location's address was low, with 63 percent of PDV respondents confirming ABH's provider directory reflected the correct address. **[Quality and Access]**
- ABH demonstrated a shortage of RHCs in urban areas, with GeoAccess results below 80 percent. **[Quality and Access]**
- ABH reported that less than 70 percent of members in rural areas had access within the required GeoAccess distance standard for Ancillary Care—Laboratory. **[Quality and Access]**
- ABH did not meet any GeoAccess standards for any ASAM or MAT provider types. **[Quality and Access]**

For ABH, the following recommendations were identified:

- LDH should provide ABH with the case-level PDV data files (i.e., flat files) and a defined timeline by which it will address provider data deficiencies identified during the PDV reviews (e.g., provider specialty, MCO acceptance, and Louisiana Medicaid acceptance). **[Quality and Access]**

- In addition to updating provider directory information, ABH should conduct a root cause analysis to identify the nature of the data mismatches for PDV study indicators that scored below 90 percent. **[Quality and Access]**
- For provider types that did not meet GeoAccess standards, ABH should contract with additional providers, if available, or continue to implement strategies for expanding the provider network such as enhanced reimbursement or encouraging providers to expand licensing to add additional ASAM LOCs. **[Quality and Access]**
- ABH should conduct an in-depth review of provider types for which GeoAccess standards were not met, with the goal of determining whether failure to meet the standard(s) resulted from a lack of providers or an inability to contract with providers in the geographic area. Analyses should evaluate the extent to which ABH has requested exemptions from LDH for provider types for which providers may not be available or willing to contract. **[Quality and Access]**
- ABH should evaluate whether offering additional telehealth services could increase compliance with GeoAccess standards. **[Quality and Access]**

Methodology

Objectives

The purpose of NAV activities is to evaluate the sufficiency of the provider network as reported by the MCO, ensure the sufficiency of the network to provide adequate access to all services covered under the contract for all members, and provide recommendations to address network deficiencies.

Technical Methods of Data Collection

In February 2023, CMS released updates to the CMS EQR protocols, including the newly developed NAV protocol. As established in the 2016 final rule, states must begin conducting the NAV activity at 42 CFR §438.358(b)(1)(iv) no later than one year from the issuance of CMS' EQR *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023 (CMS Protocol 4).[5-1] This means that by February 2024, HSAG will begin conducting NAV activities in accordance with CMS Protocol 4 and will report results in the EQR technical report due April 30, 2025.

Provider Directory Validation

To conduct the NAV analysis, HSAG utilized the MCOs' online provider directories to locate and extract provider data elements. Trained interviewers collected survey responses using a standardized script to validate survey indicators pertaining to provider data accuracy, such as telephone number, address, provider specialty, provider affiliation with the requested MCO, provider's acceptance of Medicaid, and accuracy of new patient acceptance.

Provider Access Survey

To conduct the NAV analysis, each MCO used the data request document prepared by HSAG to identify providers potentially eligible for survey inclusion, and to submit provider data files used to populate its online provider directory to HSAG. At a minimum, the data elements requested for each provider included: provider name, Medicaid identification (ID), National Provider Identification (NPI) number, provider specialty, physical (practice) address, telephone number, provider taxonomy code, and whether or not the provider accepted new patients.

Upon receipt of the data files, HSAG assessed the data to ensure alignment with the requested data file format, data field contents, and logical consistency between data elements. HSAG also assessed the distribution of provider specialty data values present in each MCO's data to determine which data values attributed to each provider domain.

[5-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 20, 2023.

GeoAccess Provider Network Accessibility Assessment

The MCO was required to submit network analysis reports, GeoAccess mapping and tables, network gap analysis reports, and development plans depicting interventions or activities designed to address identified gaps in the networks. The MCO used GeoAccess mapping software to calculate compliance with contractual distance standards for each required provider type. HSAG compared each MCO's GeoAccess compliance reporting to the contractual standards.

Description of Data Obtained

HSAG, with approval from LDH, conducted the following network adequacy monitoring tasks during CY 2023:

1. PDV, to validate the MCOs' online provider directories to ensure members have appropriate access to provider information. HSAG utilized the MCOs' online provider directories to locate and extract provider data elements required to conduct the survey component of the PDV activity.
2. Provider access survey, to determine the accuracy of the managed care network information supplied to Healthy Louisiana members using the MCOs' provider data files and to ensure that Louisiana provider networks are following the established LDH standard for office-hour appointments. HSAG utilized the MCOs' provider data files used to populate their online provider directories to conduct the survey component of the provider access survey activity.
3. HSAG assessed the GeoAccess Provider Network Accessibility reports and tables, and Gap Analysis reports submitted by each MCO to LDH.

How Data Were Aggregated and Analyzed

Provider Directory Validation

For each sampled case, HSAG compared the MCOs' provider directory values to the information obtained via the survey call for the following list of indicators. All items must match exactly, except for common United States Postal Service (USPS) standard abbreviations and naming conventions (e.g., E and East or 1st and First).

- Telephone number
- Address
- Office affiliation with the sampled provider
- Accuracy of provider specialty
- Provider affiliation with the requested MCO
- Provider's acceptance of Louisiana Medicaid
- Accuracy of new patient acceptance

HSAG used the following validation responses to assess each indicator:

- Yes, the information matched between the online provider directory and the survey call.
- No, the information did not match between the online provider directory and the survey call.

Using the results of the PDV, HSAG calculated a compliance score for each MCO. The criteria in Table 5-7 were used to calculate the weight of each noncompliance survey outcome.

Table 5-7—Noncompliance Reasons and Weighting

Noncompliance Reason	Weight
Provider does not participate with MCO or Louisiana Medicaid	3
Provider is not at site	3
Provider not accepting new patients	3
Wrong telephone number	3
No response/busy signal/disconnected telephone number (after three calls)	3
Representative does not know	3
Incorrect address reported	2
Address (suite number) needs to be updated	1
Wrong specialty reported	1
Refused to participate in survey	0

Table 5-8—Weighted Noncompliance Criteria

Weighted Noncompliance Scores	
Numerator	The numerator is the sum of all provider noncompliance scores for the MCO. Each provider record received a noncompliance score based upon the reasons for noncompliance in Table 5-7. If multiple noncompliance criteria are met, the noncompliance criterion with the largest weight was used.
Denominator	The denominator is the number of provider records multiplied by 3.

Weighted compliance score equation:

MCO's weighted compliance score = 1 – the weighted noncompliance score

Compliance: The MCOs were compliant if their weighted compliance score was ≥ 75 percent **or** have a weighted compliance score ≥ 50 percent **and** have improved by ≥ 2 percentage points from the previous quarter.

Provider Access Survey

Using a survey script approved by LDH, HSAG validated the following information pertaining to provider data accuracy:

- Telephone number
- Address
- Accuracy of provider specialty
- Provider affiliation with the requested MCO
- Provider's acceptance of Louisiana Medicaid
- Accuracy of new patient acceptance
- Sampled provider at location
- Appointment availability

Using the results of the survey, HSAG calculated a compliance score for each MCO. The criteria in Table 5-9 were used to calculate the weight of each noncompliance survey outcome.

Table 5-9—Noncompliance Reasons and Weighting

Noncompliance Reason	Weight
Provider does not participate with MCO or Louisiana Medicaid	3
Provider is not at site	3
Provider not accepting new patients	3
Wrong telephone number	3
No response/busy signal/disconnected telephone number (after three calls)	3
Representative does not know	3
Incorrect address reported	2
Address (suite number) needs to be updated	1
Wrong specialty reported	1
Refused to participate in survey	0

Table 5-10—Weighted Noncompliance Criteria

Weighted Noncompliance Scores	
Numerator	The numerator is the sum of all provider noncompliance scores for the MCO. Each provider record received a noncompliance score based upon the reasons for noncompliance in Table 5-9. If multiple noncompliance criteria are met, the noncompliance criterion with the largest weight was used.
Denominator	The denominator is the number of provider records multiplied by 3.

Weighted compliance score equation:

MCO's weighted compliance score = 1 – the weighted noncompliance score

Compliance: The MCOs were compliant if their weighted compliance score was ≥ 75 percent **or** have a weighted compliance score ≥ 50 percent **and** have improved by ≥ 2 percentage points from the previous quarter.

GeoAccess Provider Network Accessibility Assessment

HSAG used a standard reporting table to aggregate the GeoAccess mapping results for each provider type. HSAG determined whether the results for each provider type were compliant or noncompliant with the contract standards. HSAG then reviewed each MCO's reports to determine whether the MCO developed interventions to address network deficiencies.

How Conclusions Were Drawn

HSAG determined that results of network adequacy activities could provide information about MCO performance related to the quality, timeliness, and access domains of care. For example, HSAG determined that GeoAccess mapping not only provides insight into whether the access to specific providers is sufficient, but also that if network gaps exist, the quality of care a member receives may be impacted if care is received by nonqualified providers or not received at all. HSAG used analysis of the network data obtained to draw conclusions about Healthy Louisiana member access to particular provider networks (e.g., primary, specialty, or behavioral health care) in specified geographic regions. The data also allowed HSAG to draw conclusions regarding the quality of the MCOs' ability to track and monitor their respective provider networks.

To draw conclusions about the quality, timeliness, and accessibility of care provided by the Medicaid MCOs, HSAG assigned each of the components reviewed for NAV activities to one or more of three domains of care. This assignment to domains of care is depicted in Table 5-11.

Table 5-11—Assignment of NAV Activities to the Quality, Timeliness, and Access Domains

NAV Activity	Quality	Timeliness	Access
PDV	✓		✓
Provider Access Survey	✓	✓	✓
GeoAccess Provider Network Accessibility Assessment	✓		✓

Results

Table 6-1 presents ABH's 2022 and 2023 adult achievement scores.

Table 6-1—Adult Achievement Scores for ABH

Measure	2022	2023
Rating of Health Plan	76.87%	76.09%
Rating of All Health Care	NA	75.68%
Rating of Personal Doctor	NA	84.56%
Rating of Specialist Seen Most Often	NA	NA
Getting Needed Care	NA	NA
Getting Care Quickly	NA	NA
How Well Doctors Communicate	NA	91.80%
Customer Service	NA	NA

A minimum of 100 respondents is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of respondents are denoted as *Not Applicable (NA)*.

↑ *Indicates the 2023 score is statistically significantly higher than the 2023 NCQA national average.*
↓ *Indicates the 2023 score is statistically significantly lower than the 2023 NCQA national average.*
▲ *Indicates the 2023 score is statistically significantly higher than the 2022 score.*
▼ *Indicates the 2023 score is statistically significantly lower than the 2022 score.*

Table 6-2 presents ABH's 2022 and 2023 general child achievement scores.

Table 6-2—General Child Achievement Scores for ABH

Measure	2022	2023
Rating of Health Plan	87.13%	86.45%
Rating of All Health Care	91.24%	88.30%
Rating of Personal Doctor	92.26%	92.27%
Rating of Specialist Seen Most Often	NA	NA
Getting Needed Care	NA	89.56% ↑
Getting Care Quickly	NA	86.59%
How Well Doctors Communicate	94.85%	95.88% ↑
Customer Service	NA	NA

A minimum of 100 respondents is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of respondents are denoted as *Not Applicable (NA)*.

↑ *Indicates the 2023 score is statistically significantly higher than the 2023 NCQA national average.*
↓ *Indicates the 2023 score is statistically significantly lower than the 2023 NCQA national average.*
▲ *Indicates the 2023 score is statistically significantly higher than the 2022 score.*
▼ *Indicates the 2023 score is statistically significantly lower than the 2022 score.*

MCO Strengths, Opportunities for Improvement, and Recommendations

For ABH, the following strengths were identified:

- For the adult population, ABH's scores were not statistically significantly higher in 2023 than 2022 nor statistically significantly higher than the 2023 NCQA national average on any measure; therefore, no strengths were identified.
- For the general child population, ABH's scores were statistically significantly higher than the 2023 NCQA national average for *Getting Needed Care* and *How Well Doctors Communicate*. **[Quality and Access]**

For ABH, the following opportunities for improvement were identified:

- For the adult and general child populations, ABH's 2023 achievement scores were not statistically significantly lower than in 2022, and scores were not statistically significantly lower than the 2023 NCQA national average on any measure; therefore, no opportunities for improvement were identified.

For ABH, the following recommendation was identified:

- HSAG recommends ABH monitor the measures to ensure significant decreases in scores over time do not occur. **[Quality, Timeliness, and Access]**

Methodology

Objectives

The CAHPS activity assesses members' experiences with an MCO and its providers, and the quality of care they receive. The goal of the CAHPS surveys is to provide feedback that is actionable and will aid in improving members' overall experiences.

Technical Methods of Data Collection and Analysis

The MCOs accomplished the technical method of data collection by administering the CAHPS 5.1H Adult Medicaid Health Plan Survey to the adult Medicaid population, and the CAHPS 5.1H Child Medicaid Health Plan Survey (with the Children with Chronic Conditions [CCC] measurement set) to the child Medicaid population. The MCOs employed various methods of data collection used for the CAHPS surveys, such as mixed-mode (i.e., mailed surveys followed by telephone interviews of non-respondents) and mixed-mode and Internet protocol methodology (i.e., mailed surveys with an Internet link included on the cover letter followed by telephone interviews of non-respondents). In addition, some MCOs had an option for members to complete the survey in Spanish and Chinese. Adult members and parents/caretakers of child members completed the surveys from February through May 2023, following NCQA's data collection protocol.

The CAHPS 5.1H Medicaid Health Plan Surveys included a set of standardized items (40 items for the CAHPS 5.1H Adult Medicaid Health Plan Survey and 76 items for the CAHPS 5.1H Child Medicaid Health Plan Survey with CCC measurement set) that assessed members' experiences with care. The survey categorized questions into eight measures of experience. These measures included four global ratings and four composite measures.[6-1] The global ratings reflected patients' overall experiences with their personal doctor, specialist, MCO, and all healthcare. The composite measures were derived from sets of questions to address different aspects of care (e.g., *Getting Needed Care* and *How Well Doctors Communicate*).

For each of the four global ratings, HSAG calculated the percentage of respondents who chose a positive experience rating (a response value of 8, 9, or 10 on a scale of 0 to 10). For each of the four composite measures, HSAG calculated the percentage of respondents who chose a positive response. CAHPS composite measure response choices were "Never," "Sometimes," "Usually," or "Always." A positive response for the composite measures was a response of "Usually" or "Always."

[6-1] For this report, the 2023 Child Medicaid CAHPS results presented are based on the CAHPS survey results of the general child population only (i.e., results for children selected as part of the general child CAHPS sample). Therefore, results for the CAHPS survey measures evaluated through the CCC measurement set of questions (i.e., five CCC composite scores and items) and CCC population are not presented in this report.

For this report, HSAG included results for a CAHPS measure even when the NCQA minimum reporting threshold of 100 respondents was not met. Caution should be exercised when interpreting results for those measures with fewer than 100 respondents. HSAG used a cross (+) to denote CAHPS scores with fewer than 100 respondents. Additionally, for this report, HSAG compared the adult and general child Medicaid populations' survey findings to the 2023 NCQA CAHPS adult and general child Medicaid national averages.[6-2]

HSAG compared each measure rate to the 2023 NCQA national average and identified a statistically significant difference by using the confidence interval for each measure rate. Information provided below the figures discusses statistically significant differences between each measure rate's lower and upper confidence intervals and the 2023 NCQA national average.

Description of Data Obtained

The CAHPS survey asks adult members or parents/caretakers of child members to report on and to evaluate their/their child's experiences with healthcare. The survey covers topics important to members, such as the communication skills of providers and the accessibility of services. The MCOs contracted with a CAHPS vendor to administer the survey to adult members and parents/caretakers of child members. The CAHPS survey asks about members' experiences with their MCO during the last six months of the measurement period (i.e., July through December 2022).

The MCOs' CAHPS vendors administered the surveys from February to May 2023. The CAHPS survey response rate is the total number of completed surveys divided by all eligible members of the sample. A survey received a disposition code of "completed" if at least three of the designated five questions were completed.[6-3] Eligible members included the entire sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, were invalid (they did not meet the eligible population criteria), had a language barrier, or were mentally or physically incapacitated (adult Medicaid only). The survey also identified ineligible members during the process. The survey vendor recorded this information and provided it to HSAG in the data received.

How Data Were Aggregated and Analyzed

HSAG performed a trend analysis of the results in which the 2023 achievement scores were compared to their corresponding 2022 achievement scores to determine whether there were statistically significant differences. Statistically significant differences between the 2023 achievement scores and the 2022 achievement scores are noted with directional triangles. An MCO's score that performed statistically significantly higher in 2023 than 2022 is noted with a black upward (▲) triangle. An MCO's score that performed statistically significantly lower in 2023 than 2022 is noted with a black downward (▼)

6-2 National data were obtained from NCQA's 2023 Quality Compass.

6-3 A survey was assigned a disposition code of "completed" if at least three of the following five questions were completed for adult Medicaid: questions 3, 10, 19, 23, and 28. A survey was assigned a disposition code of "completed" if at least three of the following five questions were completed for child Medicaid: questions 3, 25, 40, 44, and 49.

triangle. An MCO that did not perform statistically significantly higher or lower between years is not denoted with a triangle.

Additionally, HSAG compared MCO scores to the NCQA national averages to determine if there were any statistically significant differences. An MCO that performed statistically significantly higher than the 2023 NCQA national average was denoted with a green upward (↑) arrow.[6-4] Conversely, an MCO that performed statistically significantly lower than the 2023 NCQA national average was denoted with a red downward (↓) arrow. An MCO that did not perform statistically significantly higher or lower than the 2023 NCQA national average was not denoted with an arrow.

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of care and services that each MCO provided to members, HSAG compared each MCO's 2023 survey results to the 2023 NCQA national averages to determine if there were any statistically significant differences. HSAG drew conclusions concerning quality of care, timeliness of care, and/or access to care by evaluating the questions included in each of the global ratings and composite measures presented in this report and relating the questions to the definitions of the three domains. This assignment to the domains is depicted in Table 6-3.

Table 6-3—Assignment of CAHPS Survey Measure Activities to the Quality, Timeliness, and Access Domains

CAHPS Survey Measure	Quality	Timeliness	Access
Rating of Health Plan	✓		
Rating of All Health Care	✓		
Rating of Personal Doctor	✓		
Rating of Specialist Seen Most Often	✓		
Getting Needed Care	✓		✓
Getting Care Quickly	✓	✓	
How Well Doctors Communicate	✓		
Customer Service	✓		

[6-4] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2023.* Washington, DC: NCQA, September 2023.

7. Behavioral Health Member Satisfaction Survey

Results

Table 7-1 presents the adult 2023 achievement scores for ABH and the Healthy Louisiana SWA.

Table 7-1—Adult Achievement Scores for ABH

Measure	2023	Healthy Louisiana SWA
Rating of Health Plan	56.12%	58.96%
How Well People Communicate	91.59%	90.06%
Cultural Competency	90.91%+	73.77%+
Helped by Counseling or Treatment	64.03%	67.65%
Treatment or Counseling Convenience	89.21%	86.70%
Getting Needed Treatment	75.91%	77.08%
Help Finding Counseling or Treatment	38.46%+	47.04%
Customer Service	57.89%+	67.14%+
Helped by Crisis Response Services	63.64%+	76.09%

Scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a measure, caution should be exercised when interpreting results.
↑ *Indicates the 2023 score is statistically significantly higher than the 2023 Healthy Louisiana SWA.*
↓ *Indicates the 2023 score is statistically significantly lower than the 2023 Healthy Louisiana SWA.*

Table 7-2 presents the child 2023 achievement scores for ABH and the Healthy Louisiana SWA.

Table 7-2—Child Achievement Scores for ABH

Measure	2023	Healthy Louisiana SWA
Rating of Health Plan	52.63%+	62.67%
How Well People Communicate	93.12%+	92.54%
Cultural Competency	—	97.85%+
Helped by Counseling or Treatment	58.97%+	58.20%
Treatment or Counseling Convenience	97.44%+	89.52%
Getting Needed Treatment	79.49%+	77.36%
Help Finding Counseling or Treatment	37.50%+	41.85%+
Customer Service	50.00%+	61.54%+
Getting Professional Help	87.18%+	88.83%
Help to Manage Condition	87.18%+	85.94%

Scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a measure, caution should be exercised when interpreting results.
↑ *Indicates the 2023 score is statistically significantly higher than the 2023 Healthy Louisiana SWA.*
↓ *Indicates the 2023 score is statistically significantly lower than the 2023 Healthy Louisiana SWA.*
—*Indicates the MCO's score was not reported due to insufficient data.*

MCO Strengths, Opportunities for Improvement, and Recommendations

For ABH, the following strengths were identified:

- For the adult and child populations, ABH did not score statistically significantly higher than the 2023 Healthy Louisiana SWA on any measure; therefore, no strengths were identified.

For ABH, the following opportunities for improvement were identified:

- For the adult and child populations, ABH did not score statistically significantly lower than the 2023 Healthy Louisiana SWA on any measure; therefore, no opportunities for improvement were identified.

For ABH, the following recommendations were identified:

- HSAG recommends ABH monitor the measures to ensure significant decreases in scores over time do not occur. **[Quality, Timeliness, and Access]**
- HSAG recommends ABH focus on increasing response rates to the behavioral health member satisfaction survey for both populations so there are greater than 100 respondents for each measure. This can be achieved by educating and engaging all employees to increase their knowledge of surveys and providing awareness to members during the survey period. Additionally, member-facing teams, such as the customer service team, could consider asking members if they know about the behavioral health member satisfaction survey and, if they received the survey, what barriers may prevent them from responding to the survey. These questions can be asked during routine contacts with members or when members outreach to ABH. The information provided by these members could be shared with LDH to help identify solutions to address low response rates. **[Quality, Timeliness, and Access]**

Methodology

Objectives

The primary objective of this activity is to gather direct feedback from Healthy Louisiana adult members and parents/caretakers of child members who received behavioral health services regarding their experiences and the quality of the services they received. The survey covers topics that are important to members, such as the communication skills of people they saw for counseling or treatment and the accessibility of behavioral health services. This feedback will aid in improving overall experiences of adults and parents/caretakers of child members who receive behavioral health services.

Technical Methods of Data Collection and Analysis

To conduct the activity, HSAG, with support from LDH, developed and administered a custom behavioral health member satisfaction survey to the Healthy Louisiana MCO members. The survey was administered to adult members and parents/caretakers of child members identified as having three or more specified outpatient behavioral health encounters during the measurement period. All adult members and parents/caretakers of sampled child members completed the survey from July to September 2023.

The adult and child behavioral health member satisfaction survey included one global measure question, one composite measure, and 11 individual item measures. The global measure (also referred to as global rating) reflects overall member experience with the MCO. The composite measure is a set of questions grouped together to address a specific aspect of care (i.e., *How Well People Communicate)*. The individual item measures are individual questions that look at different areas of care (e.g., *Cultural Competency* or *Helped by Counseling or Treatment*).

For the global rating, HSAG calculated the percentage of respondents who chose a positive experience rating (i.e., a response of 9 or 10 on a scale of 0 to 10). For the composite measure, HSAG calculated the percentage of respondents who chose a positive response. The composite measure response choices were "Never," "Sometimes," "Usually," or "Always." A positive response for the composite measure was a response of "Usually" or "Always." For the individual item measures, HSAG calculated the percentage of respondents who chose a positive response (i.e., "Usually/Always," "Yes," "A lot," or "Not a problem").

For this report, HSAG included results for a measure even when there were less than 100 respondents. Caution should be exercised when interpreting results for those measures with fewer than 100 respondents. HSAG used a cross (+) to denote scores with fewer than 100 respondents.

Description of Data Obtained

The behavioral health member satisfaction survey asked adult members or parents/caretakers of child members to report on and to evaluate their/their child's experiences with behavioral health services. HSAG requested sample frame data files from each MCO that included the following information related to each member of the eligible population: name, gender, date of birth, mailing address, telephone number, primary language, race, and ethnicity. HSAG utilized information received in the sample frame data files to conduct the behavioral health member satisfaction survey.

How Data Were Aggregated and Analyzed

HSAG compared the MCO-specific results to the total MCO program average to determine if the results were significantly different. The total MCO program results were weighted based on the eligible population included in each MCO. An MCO that performed statistically significantly higher than the program average was denoted with an upward black (↑) arrow. Conversely, an MCO that performed statistically significantly lower than the program average was denoted with a downward black (↓) arrow. An MCO that did not perform statistically significantly different than the program average was not denoted with an arrow. Comparisons to national data could not be performed given the custom nature of the survey instruments administered.

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and access to care and services provided by the MCOs, HSAG assigned the measures evaluated in the behavioral health member satisfaction survey to one or more of these three domains. This assignment to domains is shown in Table 7-3.

Table 7-3—Assignment of Behavioral Health Member Satisfaction Survey Measures to the Quality, Timeliness, and Access Domains

Behavioral Health Member Satisfaction Survey Measure	Quality	Timeliness	Access
Rating of Health Plan	✓		
How Well People Communicate	✓		
Cultural Competency	✓		
Helped by Counseling or Treatment	✓		
Treatment or Counseling Convenience			✓
Getting Counseling or Treatment Quickly	✓	✓	
Getting Needed Treatment	✓		✓
Barriers to Counseling or Treatment	✓		✓
Help Finding Counseling or Treatment	✓		✓

Behavioral Health Member Satisfaction Survey Measure	Quality	Timeliness	Access
Customer Service	✓		
Crisis Response Services Used			✓
Receipt of Crisis Response Services			✓
Helped by Crisis Response Services	✓		
Getting Professional Help	✓		✓
Help to Manage Condition	✓		

8. Case Management Performance Evaluation

Introduction

States may direct their EQROs to conduct focus studies for QI, administrative, legislative, or other purposes. Focus studies may examine clinical or nonclinical aspects of care provided by MCOs and assess quality of care at a specific point in time. LDH contracted with HSAG to conduct a focused CMPE to evaluate the MCO's compliance with the CM provisions of its contract with LDH and determine the effectiveness of CM activities.

Activities Conducted During SFY 2023

During SFY 2023, HSAG and LDH collaborated to determine the scope, methodology, data sources, and timing of the CMPE. HSAG will conduct the focus study, which will commence in SFY 2024, in accordance with CMS EQR *Protocol 9. Conducting Focus Studies of Health Care Quality: An Optional EQR-Related Activity*, February 2023.[8-1]

At the time of this report, the CMPE had not been completed. Results, including conclusions, strengths, and opportunities for improvement, will be reported in the SFY 2024 EQR technical report.

Methodology

Objectives

LDH requires the Healthy Louisiana MCO reporting of data on CM services to determine the number of individuals, the types of conditions, and the impact that CM services have on enrollees receiving those services. LDH established CM requirements to ensure that the services provided to enrollees with special health care needs (SHCN) are consistent with professionally recognized standards of care. To assess MCO compliance with CM elements, LDH requested that HSAG evaluate the MCOs' compliance with the CM provisions of their contracts with LDH, including the rates of engagement in CM; the specific services offered to enrollees receiving CM; and the effectiveness of CM in terms of increasing the quality of care, increasing the receipt of necessary services, and reducing the receipt of potentially unnecessary services such as acute care.

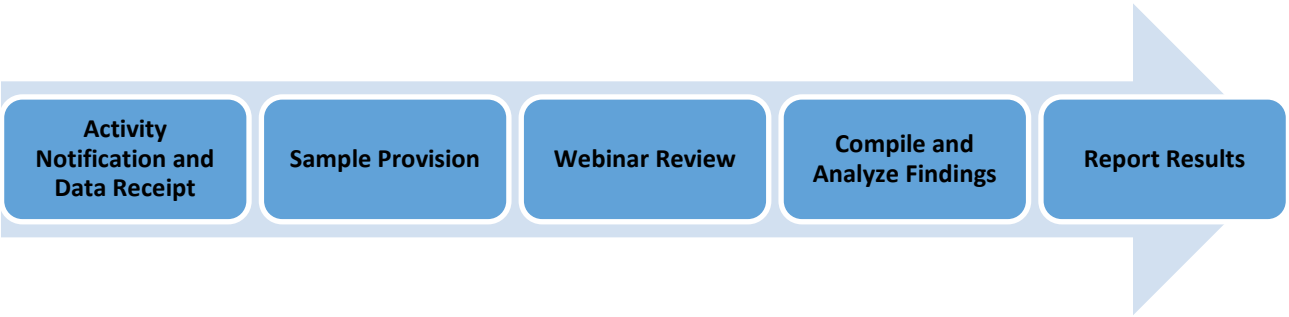
HSAG's CMPE review tool will comprehensively address the services and supports that are necessary to meet enrollees' needs. The tool will include elements for review of CM documentation and enrollee care

[8-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 9. Conducting Focus Studies of Health Care Quality: An Optional EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 19, 2023.

plans to ensure that they are consistent with a person-centered approach to care planning and service delivery and that outcomes are being achieved or progress is being made toward their achievement. The CMPE review tool will include MCO contract requirements, evaluation criteria of those requirements, and reviewer determinations of performance.

Review Process

HSAG's CM Review process will include five activities:



Activity 1: Activity Notification and Data Receipt

To initiate the CM Review, HSAG will conduct an activity notification webinar for the MCOs. During the webinar, HSAG will provide information about the activity and expectations for MCO participation, including provision of data. HSAG will request the LA PQ039 Case Management report from each MCO.

Table 8-1—Activity 1: Activity Notification and Data Receipt

For this step,	HSAG will…
Step 1:	**Notify the MCOs of the review.**
	HSAG will host a webinar to introduce the activity to the MCOs. The MCOs will be provided a timeline, review tools, and a question and answer (Q&A) document post-webinar. HSAG will provide assistance to all MCOs prior to the review, including clear instructions regarding the scope of the review, timeline and logistics of the webinar review, identification of expected review participants, and any other expectations or responsibilities.
Step 2:	**Receive data universes from the MCOs.**
	HSAG will review the data received from the MCOs for completeness.

Activity 2: Sample Provision

Upon receipt of each MCO's LA PQ039 Case Management report, HSAG will review the data to ensure completeness for sample selection. To be included in the sample, the enrollee must meet the following criteria:

- Have a classification of "SHCN-MED," "SHCN-BH," or "SHCN-BOTH." HSAG will identify these enrollees by the "reason identified for case management" field provided in the LA PQ039 Case Management report.
- Current CM span began on or before June 1, 2023. HSAG will identify these enrollees by the "date entered case management" field provided in the LA PQ039 Case Management report.
- Enrollees with a CM span of at least three months. HSAG will identify these enrollees by utilizing data from the "date entered case management" and "date exited case management" fields provided in the LA PQ039 Case Management report.

Enrollees who are identified by the MCOs for CM but not enrolled will be excluded from the sample. HSAG will exclude any enrollees identified in the "members identified, but not enrolled" field in the LA PQ039 Case Management report.

In future review years, HSAG will collaborate with LDH to determine any changes to the sampling criteria, including exclusions such as enrollees who were selected for the review the year prior.

Based on the inclusion criteria, HSAG will generate a random sample of 110 enrollees for each MCO, which includes a 10 percent oversample to account for exclusions or substitutions. HSAG will provide each MCO with its sample 10 business days prior to the webinar review. The MCO will be given five business days to provide HSAG with any requests for exclusions or substitutions. If the oversample is not large enough to obtain the necessary sample size, HSAG will select additional random samples to fulfill the sample size. The final sample of cases (100 total) will be confirmed with the MCO no later than three business days prior to the webinar review.

Table 8-2—Activity 2: Sample Provision

For this step,	HSAG will…
Step 1:	**Identify enrollees for inclusion in the sample.**
	HSAG will utilize the data provided in each MCO's LA PQ039 Case Management report.
Step 2:	**Provide the sample to the MCOs.**
	HSAG will provide the 100-enrollee sample and 10-enrollee oversample to each MCO 10 business days prior to the webinar review. The sample will be provided via HSAG's SAFE site.
Step 3:	**Finalize the sample.**
	The MCOs will provide HSAG with any requests for exclusions or substitutions to the sample within five business days of receipt of the sample file from HSAG. HSAG will provide the final sample of 100 enrollee cases to each MCO no later than three business days prior to the webinar.

Activity 3: Webinar Review

HSAG will collaborate with the MCOs to schedule and conduct webinar reviews with key MCO staff members to:

- Ensure understanding of terminology and documents used by the MCO to record CM activities.
- Review sampled cases to determine compliance with contractual requirements.

The webinar review consists of several key activities:

- Entrance Conference: HSAG will dedicate the first 15 minutes of each webinar to introduce the activity and the HSAG review team, and to provide key logistics of the review. HSAG will review documentation naming conventions with the MCO to ensure understanding of the information that will be displayed by the MCO and reviewed during the activity.
- Case Review: HSAG will conduct a review of each sample file. The MCO's CM representative(s) will navigate the MCO's CM system and respond to HSAG reviewers' questions. The review team will determine evidence of compliance with each of the scored elements on the CM Review tool. Concurrent interrater reliability will be conducted by the HSAG team lead to respond to questions from the review team in real time so that feedback can be provided to the MCO, and any discrepancies addressed, prior to the end of the review.
- Leadership Meeting (optional): HSAG will schedule a meeting with the MCO and LDH to discuss the progress of the review and provide preliminary findings. The meeting will also allow HSAG to confirm information that may be needed to complete the review of cases, and for the MCO to ensure understanding of LDH's expectations.
- Exit Conference: HSAG will schedule a 30-minute exit conference with the MCO and LDH. During the exit conference, HSAG will provide a high-level summary of the cases reviewed, preliminary findings, and recommendations to address opportunities for improvement.

Table 8-3—Activity 3: Webinar Review

For this step,	HSAG will…
Step 1:	**Provide the MCOs with webinar dates.**
	HSAG will provide the MCOs with their scheduled webinar dates. HSAG will consider MCO requests for alternative dates or accommodations.
Step 2:	**Identify the number and types of reviewers needed.**
	HSAG will assign review team members who are content area experts with in-depth knowledge of CM requirements who also have extensive experience and proven competency conducting case reviews. To ensure interrater reliability, HSAG reviewers are trained on the review methodology to ensure that the determinations for each element of the review are made in the same manner.

For this step,	HSAG will…
Step 3:	**Conduct the webinar review.**
	During the webinar, HSAG will set the tone, expectations, and objectives for the review. MCO staff members who participate in the webinar reviews will navigate their documentation systems, answer questions, and assist the HSAG review team in locating specific documentation. As a final step, HSAG will meet with MCO staff members and LDH to provide a high-level summary and next steps for receipt of findings.

Scoring Methodology

HSAG will use the CM Review tool to record the results of the case reviews. HSAG will use a two-point scoring methodology. Each requirement will be scored as *Met* or *Not Met* according to the criteria identified below. HSAG will also use a designation of *NA* if the requirement is not applicable to a record; *NA* findings will not be included in the two-point scoring methodology.

Met indicates full compliance defined as the following:

- All documentation listed under contract requirements was present in the case file.
- Cases reviewed met the scoring criteria assigned to each requirement.
- Cases reviewed had documentation that met "due diligence" criteria.

Not Met indicates noncompliance defined as either of the following:

- Cases reviewed did not meet the scoring criteria assigned to each requirement.
- Not all documentation was present.

Not Applicable (NA) indicates a requirement that will not be scored for compliance based on the criteria listed for the specific element in the Review Tool and Evaluation Criteria document.

HSAG will calculate the overall percentage-of-compliance score for each of the requirements. HSAG calculated the score for each requirement by adding the score from each case, indicating either a score of *Met* (value: 1 point) or *Not Met* (value: 0 points), and dividing the summed scores by the total number of applicable cases. Data analysis will also include aggregate performance by domain.

Reporting of Abuse, Neglect, or Exploitation (ANE)

If, during the review process, a reviewer identifies potential ANE of an enrollee, HSAG will report the concern to the MCO immediately upon identification and to LDH within 24 hours of identification. If the reviewer identifies a potential health, safety, or welfare concern that does not rise to the level of an ANE, HSAG will report the concern to the MCO and LDH at the identification of the concern and no later than the end of the webinar review.

Activity 4: Compile and Analyze Findings

Following the webinar review, HSAG will compile and analyze findings for each MCO. Findings will include performance by domain and each scored element. Additional data gathering information may be compiled to inform analysis and results (e.g., program information such as the total number of enrollees in CM during the lookback period).

Domain and Element Performance

Findings will be compiled into domains, which represent a set of elements related to a specific CM activity (e.g., assessment, care planning). Domain performance is calculated by aggregating the scores for each element in the domain and dividing by the total number of applicable cases. Domain performance scores provide a high-level result to inform analysis of opportunities for improvement.

Analysis of scored element performance allows for targeted review of individual elements that may impact overall domain performance. Individual element performance scores will be used to inform analysis of specific opportunities for improvement, especially when an element is performing at a lower rate than other elements in the domain.

Analysis of findings will include identification of opportunities for improvement.

Activity 5: Report Results

HSAG will develop a draft and final report of results and findings for each MCO. The report will describe the scores assigned for each requirement, assessment of the MCO's compliance by domain, and recommendations for improvement. Following LDH's approval of the draft report, HSAG will issue the final report to LDH and each MCO.

How Conclusions Were Drawn

Upon completion of the activity, HSAG will provide results for each MCO in three performance domains: Assessment, Care Planning, and Enrollee Interaction and Coordination of Services. Each domain includes scored elements, displayed in Table 8-4, which demonstrate each MCO's compliance with contractual requirements.

Table 8-4—Assignment of CMPE Measures to the Quality, Timeliness, and Access Domains

CMPE Measure	Quality	Timeliness	Access
The enrollee's initial health needs assessment was completed within 90 calendar days of enrollment.		✓	
The enrollee's initial comprehensive assessment was completed within 90 calendar days of identification of SHCN.		✓	

CMPE Measure	Quality	Timeliness	Access
A reassessment was completed in person quarterly with the enrollee.		✓	
A plan of care (POC) was developed within 30 calendar days of identification of risk stratification.		✓	
A POC was developed within 90 calendar days of identification of risk stratification.		✓	
The MCO developed and implemented a person-centered care plan reflective of the most recent assessment and included all enrollee goals, needs, and risks as well as the formal and informal supports responsible for assisting the enrollee with the POC.	✓		
The POC was updated per the enrollee's tier schedule.		✓	
The POC was updated when the enrollee's circumstances or needs changed significantly, or at the request of the enrollee, their parent or legal guardian, or a member of the multidisciplinary care team.	✓		
The MCO developed a multidisciplinary care team, including the case manager, enrollee and/or authorized representative, and members based on the enrollee's specific care needs and goals.	✓		✓
The multidisciplinary care team was convened at regular intervals required for the enrollee's tier level.		✓	
The case manager made valid timely contact, or due diligence is documented in the enrollee's record.		✓	
For enrollees demonstrating needs requiring coordination of services, the case manager coordinated needed care/services, actively linking the enrollee to providers; medical services; and residential, social, community, and other support services.	✓		✓

Results

The 2023 (CY 2022) QRS results for ABH are displayed in Table 9-1.

Table 9-1—2023 (CY 2022) QRS Results

Composites and Subcomposites	ABH
Overall Rating*	**3.5**
Consumer Satisfaction	**Insufficient Data**
Getting Care	Insufficient Data
Satisfaction with Plan Physicians	5.0
Satisfaction with Plan Services	3.5
Prevention	**2.0**
Children and Adolescent Well-Care	1.5
Women's Reproductive Health	3.0
Cancer Screening	3.0
Other Preventive Services	2.5
Treatment	**3.0**
Respiratory	2.0
Diabetes	3.5
Heart Disease	3.0
Behavioral Health—Care Coordination	1.0
Behavioral Health—Medication Adherence	3.0
Behavioral Health—Access, Monitoring, and Safety	4.0
Risk-Adjusted Utilization	3.0

**This rating includes all measures in the 2023 Health Plan Report Card as well as an Accreditation bonus for those MCOs that are NCQA Accredited.*
Insufficient Data indicates that the plan was missing most data for the composite or subcomposite.

ABH received an Overall Rating of 3.5 points, with 3.0 points for the Treatment composite and 2.0 points for the Prevention composite.

MCO Strengths, Opportunities for Improvement, and Recommendations

For ABH, the following strengths were identified:

- While ABH did not have sufficient data for the Consumer Satisfaction composite, ABH received 5.0 points for the Satisfaction with Plan Physicians subcomposite and 3.5 points for the Satisfaction with Plan Services subcomposite. Both subcomposites are based on ABH member responses to CAHPS surveys questions, demonstrating ABH members are satisfied with their MCO and providers. **[Quality]**
- For the Treatment composite, ABH received 4.0 points for the Behavioral Health—Access, Monitoring, and Safety subcomposite, demonstrating strength for ABH related to care for adults and children using antipsychotics, and children using ADHD medication. ABH also received 3.5 points for the Diabetes subcomposite, demonstrating strength for ABH for diabetic care. **[Quality, Access, and Timeliness]**

For ABH, the following opportunities for improvement were identified:

- For the Prevention composite, ABH received 1.5 points for the Children and Adolescent Well-Care subcomposite, demonstrating opportunities for improvement for ABH related to immunizations for children and adolescents. **[Quality and Access]**
- For the Treatment composite, ABH received 2.0 points for the Respiratory subcomposite, demonstrating opportunities for ABH to ensure appropriate treatment of upper respiratory infections. ABH received 1.0 point for the Behavioral Health—Care Coordination subcomposite, demonstrating opportunities for ABH to ensure timely follow-up after hospitalizations and ED visits for mental illness. **[Quality, Access, and Timeliness]**

ABH should reference the recommendations made in Section 3—Validation of Performance Measures and Section 6—Consumer Surveys: CAHPS-A and CAHPS-C as the 2023 Health Plan Report Card reflects HEDIS and CAHPS results.

Methodology

Objectives

HSAG was tasked with developing a QRS to evaluate the performance of the five Healthy Louisiana Medicaid MCOs (i.e., ABH, ACLA, HBL, LHCC, and UHC) relative to national benchmarks and assign ratings to each MCO in key areas. The 2023 Health Plan Report Card is targeted toward a consumer audience; therefore, it is user friendly, easy to read, and addresses areas of interest for consumers.

Technical Methods of Data Collection

HSAG received MY 2022 CAHPS member-level data files and HEDIS IDSS data files from LDH and the five MCOs. The *HEDIS MY 2022 Specifications for Survey Measures, Volume 3* was used to collect and report on the CAHPS measures. The *HEDIS MY 2022 Technical Specifications for Health Plans, Volume 2* was used to collect and report on the HEDIS measures.

Description of Data Obtained

HSAG received the final, auditor-locked HEDIS IDSS data files from each of the MCOs, as well as the CAHPS member-level data files and summary reports. HSAG also downloaded the 2022 (MY 2021) Quality Compass national Medicaid all lines of business (ALOB) benchmarks for this analysis.[9-1]

How Data Were Aggregated and Analyzed

Using the HEDIS and CAHPS measure results for each MCO, HSAG calculated MCO ratings in alignment with NCQA's 2023 Health Plan Ratings Methodology, where possible, for the following composites and subcomposites:[9-2]

- Overall
- Consumer Satisfaction
  - Getting Care
  - Satisfaction with Plan Physicians
  - Satisfaction with Plan Services

[9-1] 2022 (MY 2021) Quality Compass national Medicaid ALOB benchmarks were used since LDH requested a finalized report card by October 1, 2023, and 2023 (MY 2022) Quality Compass national Medicaid ALOB benchmarks were not available until September 29, 2023.

[9-2] National Committee for Quality Assurance. 2023 Health Plan Ratings Methodology. Available at: https://www.ncqa.org/wp-content/uploads/2022/12/2023-HPR-Methodology_12.14.2022.pdf. Accessed on: Dec 19, 2023.

- Prevention
  - Children and Adolescent Well-Care
  - Women's Reproductive Health
  - Cancer Screening
  - Other Preventive Services
- Treatment
  - Respiratory
  - Diabetes
  - Heart Disease
  - Behavioral Health—Care Coordination
  - Behavioral Health—Medication Adherence
  - Behavioral Health—Access, Monitoring, and Safety
  - Risk-Adjusted Utilization

For each measure included in the 2023 Health Plan Report Card, HSAG compared the raw, unweighted measure rates to the 2022 (MY 2021) Quality Compass national Medicaid ALOB percentiles and scored each measure as outlined in Table 9-2. For the *Plan All-Cause Readmissions* measure, HSAG followed NCQA's methodology for scoring risk-adjusted utilization measures.

Table 9-2—Measure Rate Scoring Descriptions

Score	MCO Measure Rate Performance Compared to National Benchmarks
5	The MCO's measure rate was at or above the national Medicaid ALOB 90th percentile.
4	The MCO's measure rate was at or between the national Medicaid ALOB 66.67th and 89.99th percentiles.
3	The MCO's measure rate was at or between the national Medicaid ALOB 33.33rd and 66.66th percentiles.
2	The MCO's measure rate was at or between the national Medicaid ALOB 10th and 33.32nd percentiles.
1	The MCO's measure rate was below the national Medicaid ALOB 10th percentile.

HSAG then multiplied the scores for each measure by the weights that align with NCQA's 2023 Health Plan Ratings. For each composite and subcomposite, HSAG calculated scores using the following equation:

$$Composite\ or\ Subcomposite\ Rating = \frac{\sum(Measure\ Rating * Measure\ Weight)}{\sum(Measure\ Weights)}$$

To calculate the Overall Rating, HSAG calculated a weighted average using the weighted measure-level scores previously calculated. HSAG also added 0.5 bonus points to scores for MCOs that were Accredited or had Provisional status, and 0.15 bonus points for MCOs that had Interim status. These bonus points were added to the Overall Rating before rounding to the nearest half-point.

For the Overall Rating and each composite/subcomposite rating, HSAG aligned with NCQA's rounding rules and awarded scores as outlined in Table 9-3.

Table 9-3—Scoring Rounding Rules

Rounded Score	5	4.5	4.0	3.5	3.0	2.5	2.0	1.5	1.0	0.5	0.0
Score Range	≥4.750	4.250–4.749	3.750–4.249	3.250–3.749	2.750–3.249	2.250–2.749	1.750–2.249	1.250–1.749	0.750–1.249	0.250–0.749	0.000–0.249

How Conclusions Were Drawn

For the 2023 Health Plan Report Card, HSAG displayed star ratings based on the final scores for each rating. Stars were partially shaded if the MCO received a half rating (e.g., a score of 3.5 was displayed as 3.5 stars).

10. MCO Strengths, Opportunities for Improvement, and Recommendations

HSAG used its analyses and evaluations of EQR activity findings from SFY 2023 to comprehensively assess ABH's performance in providing quality, timely, and accessible healthcare services to Louisiana's Medicaid and CHIP members. HSAG provides ABH's strengths, opportunities for improvement, and recommendations in Table 10-1 through Table 10-3.

Table 10-1—Strengths Related to Quality, Timeliness, and Access

Overall MCO Strengths	
Quality	• ABH demonstrated a strength in women's screenings, as rates for the *Chlamydia Screening in Women* and *Breast Cancer Screening* measures were at or above the 50th percentile. This suggests women were receiving screenings which are important for prevention, improved outcomes, and reduction of complications. • ABH demonstrated adequate management for some chronic diseases as evidenced by rates for the *Statin Therapy for Patients With Cardiovascular Disease*, *Hemoglobin A1c Control for Patients With Diabetes*, and *Eye Exam for Patients With Diabetes* measures at or above the 50th percentile. The results suggest that providers were providing quality care for chronic conditions such as cardiovascular disease and diabetes. • Strengths in behavioral health included rates for the *Initiation and Engagement of Substance Use Disorder Treatment*, *Antidepressant Medication Management*, and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* measures at or above the 50th percentile. This suggests ABH members with OUD initiated and engaged in treatment, and ABH members with major depression (who were newly treated with antidepressant medication) remained on their medication for the recommended time periods. In addition, children and adolescents received psychosocial care as first-line treatment before being newly started on antipsychotic medications. • Caregivers of ABH child members were satisfied with the communication of their children's doctors, as rates for *How Well Doctors Communicate* were significantly higher than the 2023 NCQA national average.
Timeliness	• No strengths identified.
Access	• In CR, ABH met requirements 3, 4, and 5 of Standard I—Enrollment and Disenrollment, including policies that ensured members were not disenrolled based on health status, utilization of services, diminished mental capacity, or uncooperative behavior. • Caregivers of ABH child members reported it was easy to get the care, tests, treatment, and appointments with specialists as needed. This was evidenced by *Getting Needed Care* results that were statistically significantly higher than the 2023 NCQA national average.

Table 10-2—Opportunities for Improvement Related to Quality, Timeliness, and Access

Overall MCO Opportunities for Improvement	
Quality, Timeliness, and Access	• ABH had challenges in following up and managing the care of members that accessed the hospital or ED for mental illness and substance abuse. ABH's performance for the *Follow-Up After Hospitalization for Mental Illness*, *Follow-Up After Emergency Department Visit for Mental Illness*, and *Follow-Up After Emergency Department Visit for Substance Use* measures ranked below the NCQA national 50th percentile benchmark for all indicators. The *Follow-Up After Hospitalization for Mental Illness* and *Follow-Up After Emergency Department Visit for Mental Illness* measure rates also fell below the SWA. • ABH's performance for both *Initiation and Engagement of Substance Use Disorder Treatment* measure indicators ranked above the NCQA national 50th percentile benchmark and SWA.
Quality	• ABH demonstrated opportunities to improve critical aspects of preventive care for children and adolescents. The *Childhood Immunization Status* and *Immunization Status for Adolescents* measure rates were below the 50th percentiles, suggesting that children and adolescents were not receiving these immunizations. Rates were also low for the *Lead Screening in Children* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures, meaning opportunities were missed to test children under 2 years of age for lead poisoning, and to assess the BMI of children and adolescents and provide nutrition and counseling. The *Child and Adolescent Well-Care Visits* measure indicator rates were also below the 50th percentile, indicating that providers missed the opportunity to influence health and development by providing critical screenings and counseling. • ABH demonstrated weakness with screening women for cervical cancer. The rate for the *Cervical Cancer Screening* measure was below the 50th percentile. As one of the most common causes of cancer death for American women, effective screening and early detection is crucial.[10-1] In addition, the rate for the *Non-Recommended Cervical Screening in Adolescent Females* measure was below the 50th percentile. This indicates adolescent females were screened unnecessarily for cervical cancer, which may result in unnecessary tests and treatment and deter those members from receiving screenings as adults.
Access	• The results of several EQR activities indicate opportunities for ABH to improve access to care for its members. ABH only met a total of six GeoAccess standards, and the provider directory information maintained and provided by ABH was poor. Rates for the *Adults' Access to Preventive/Ambulatory Health Services* measure indicators were lower than the NCQA national 50th percentile benchmark as well as several other HEDIS measures related to access (*Childhood Immunization Status*, *Follow-Up After Hospitalization for Mental Illness*, *Follow-Up After Emergency Department Visit for Mental Illness*, *Follow-Up After Emergency Department Visit for Substance Use*, *Child and Adolescent Well-Care Visits*).

[10-1] American Cancer Society. Key Statistics for Cervical Cancer, Revised January 12, 2023. Available at: https://www.cancer.org/cancer/cervical-cancer/about/key-statistics.html. Accessed on: Dec 19, 2023.

Table 10-3—Recommendations

Overall MCO Recommendations	
Recommendation	**Associated Quality Strategy Goals to Target for Improvement**
ABH should conduct a root cause analysis for the *Follow-Up After Hospitalization for Mental Illness*, *Follow-Up After Emergency Department Visit for Mental Illness*, and *Follow-Up After Emergency Department Visit for Substance Use* measures and implement appropriate interventions to improve performance, such as providing patient and provider education and enhancing communication and collaboration with hospitals to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs.	Goal 1: Ensure access to care to meet enrollee needs Goal 2: Improve coordination and transitions of care Goal 3: Facilitate patient-centered, whole-person care
ABH should convene a focus group to conduct root cause analyses to determine barriers to child and adolescent members accessing preventive care. The focus group should include parent/guardian and provider participation as well as subject matter experts. The focus group should recommend evidenced-based interventions that address barriers. ABH should consider holistic and novel interventions that aim to increase preventive care rates rather than reiterating previous interventions focused on specific topics or short-term campaigns.	Goal 1: Ensure access to care to meet enrollee needs Goal 4: Promote wellness and prevention Goal 7: Pay for value and incentivize innovation
ABH should conduct a root cause analysis to determine barriers to women receiving cervical cancer screenings and implement appropriate interventions to improve performance. This analysis should consider whether unnecessary adolescent screenings are impacting adult women's willingness to receive screening as well as consider whether there are disparities within its population that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. In addition, ABH may compare strategies used to encourage members to receive screening for breast cancer as rates were better for that measure.	Goal 1: Ensure access to care to meet enrollee needs Goal 4: Promote wellness and prevention
To improve access to care, ABH should adopt a programmatic approach to identify barriers to access across all aspects of Medicaid operations. A planwide taskforce should include provider network staff members, subject matter experts for the access-related HEDIS measures that performed poorly, utilization management staff members, and other members as determined by ABH. The taskforce should include key community stakeholders to identify barriers/facilitators to members accessing preventive and follow-up care. ABH should consider multi-tiered approaches such as: • Reviewing provider office procedures for ensuring appointment availability standards.	Goal 1: Ensure access to care to meet enrollee needs Goal 6: Partner with communities to improve population health and address health disparities

Overall MCO Recommendations	
• Conducting "secret shopper" provider office surveys. • Evaluating member use of telehealth services to determine best practices or opportunities to improve access that may be reproduceable. • Conduct drill-down analyses of access-related measures to determine disparities by race, ethnicity, age group, geographic location, etc.	

11. Follow-Up on Prior Year's Recommendations

Regulations at 42 CFR §438.364 require an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR §438.310[c][2]) has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR. LDH required each MCO to document the follow-up actions per activity that the MCO completed in response to SFY 2020–2021 recommendations. Table 11-1 through Table 11-7 contain a summary of the follow-up actions that ABH completed in response to the previous EQRO's SFY 2022 recommendations. Furthermore, HSAG assessed ABH's approach to addressing the recommendations. Please note that the responses in this section were provided by the plans and have not been edited or validated by HSAG.

EQRO's Scoring Assessment

HSAG developed a methodology and rating system for the degree to which each health plan addressed the prior year's EQR recommendations. In accordance with CMS guidance, HSAG used a three-point rating system. The health plan's response to each EQRO recommendation was rated as *High*, *Medium,* or *Low* according to the criteria below.

High indicates *all* of the following:

- The plan implemented new initiatives or revised current initiatives that were applicable to the recommendation.
- Performance improvement directly attributable to the initiative was noted *or* if performance did not improve, the plan identified barriers that were specific to the initiative.
- The plan included a viable strategy for continued improvement or overcoming identified barriers.

A rating of *high* is indicated by the following graphic:

Medium indicates one or more of the following:

- The plan continued previous initiatives that were applicable to the recommendation.
- Performance improvement was noted that may or may not be directly attributable to the initiative.
- If performance did not improve, the plan identified barriers that may or may not be specific to the initiative.
- The plan included a viable strategy for continued improvement or overcoming barriers.

A rating of *medium* is indicated by the following graphic:

Low indicates one or more the following:

- The plan did not implement an initiative or the initiative was not applicable to the recommendation.
- No performance improvement was noted *and* the plan did not identify barriers that were specific to the initiative.
- The plan's strategy for continued improvement or overcoming identified barriers was not specific or viable.

A rating of *low* is indicated by the following graphic: 

Table 11-1—Follow-Up on Prior Year's Recommendations for PIPs

1. Prior Year Recommendations from the EQR Technical Report for Performance Improvement Projects:
Recommendations
PIP 3: Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Vaccine-Eligible Enrollees: Persons 18 Years of Age or Older – Previous EQRO recommends that the MCO use Microsoft Excel formulas to calculate rates to the nearest hundredth to limit calculation and rounding errors.
Response
Describe initiatives implemented based on recommendations: Excel formulas have been used.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Approximate 4% increase 2023 YTD in adults receiving the COVID initial vaccine compared to 2021 and 2022.
Identify any barriers to implementing initiatives: Pediatric population has shown the lowest growth in 2022.
Identify strategy for continued improvement or overcoming identified barriers: Campaign messages continue to be pushed out to enrollees who have not received the initial dose or boosters of the COVID vaccine.
HSAG Assessment


Table 11-2—Follow-Up on Prior Year's Recommendations for Performance Measures

2. Prior Year Recommendations from the EQR Technical Report for Performance Measures:
Recommendations
ABHLA should target interventions to improve rates for the measures that fell below the NCQA 50th percentile.
Response
Describe initiatives implemented based on recommendations: Childhood Immunization Status (CIS) – A campaign was launched in 2023 to outreach to CIS members with noncompliance in Combo 7 and 10 to complete the recommended course of vaccinations in an effort to improve related outcomes. An additional rolling campaign is being designed to begin working with enrollees 42 days after birth to encourage desired outcomes prior to the enrollee being in the CIS denominator. Immunizations for Adolescents (IMA) – An outreach campaign targeting 10-12 year old enrollees was put in place to encourage completion of the recommended course of vaccines to improve related outcomes. By focusing on an age range broader than the HEDIS tech spec range, a longer period for enrollee compliance is achieved, increasing the likelihood of compliance. Follow-up after Hospitalization for Mental Illness (FUH)/Follow-up After Emergency Department Visit for Mental Illness (FUM) – ABHLA has engaged with a Louisiana based Behavioral Health (BH) telehealth provider to assist with scheduling appointments and close gaps for BH HEDIS measures requiring follow up appointments. Prenatal and Postpartum Care (PPC) – An ongoing campaign has been designed to outreach members with gaps for postpartum in order to close gaps timely. This is in addition to the Case Management (CM)/Community Health Workers (CHW) programs supporting prenatal care, which include baby showers and a diaper bag. A doula service is also going into place in 2023. Controlling High Blood Pressure (CBP)/Blood Pressure Control for Patients with Diabetes (BPD)/Hemoglobin A1c Control for Patients with Diabetes (HBD) – 2 staff were added to ABHLA Quality Management (QM) in the role of Quality Provider Liaison (QPL) with the purpose of providing education and increased communication to providers related to Quality outcomes. Within this education, proper use of CPT II coding related to hypertension (blood pressure) and diabetes (HbA1c) so information can be collected administratively it a reoccurring theme in all provider visits.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The IMA campaign in particular lead to a noted increase in 2023, as our preliminary administrative results have already demonstrated a 3.5% improvement over our 2022 final rate based on September 2023 data. Other outcomes are anticipated to become more apparent as end of year data becomes available in 2024.
Identify any barriers to implementing initiatives: The largest barrier remains accurate contact information for members. Secondary to that would be limited appointment availability for routine care. Lastly, proper use of CPT II codes by providers puts an increased burden on Hybrid to find compliance for data that can easily be reported administrative.
Identify strategy for continued improvement or overcoming identified barriers: Expansion of the provider network for both PCP services and specific specialties (OB/GYN) is a constant challenge our provider network team is focused on. Education on proper coding practices as a key driver for our QPL team with expansion into other areas identified as having poor coding practices.
HSAG Assessment


Table 11-3—Follow-Up on Prior Year's Recommendations for Compliance With Medicaid Managed Care Regulations

3. Prior Year Recommendations from the EQR Technical Report for Compliance With Medicaid Managed Care Regulations:
As described in Section 4—Assessment of Compliance With Medicaid Managed Care Regulations, LDH contracted with HSAG to validate ABH's remediation of the deficiencies identified in the prior year's CR CAP. HSAG reviewed ABH's responses and the additional documentation they submitted to assess whether compliance had been reached. The details of this follow-up are included in Appendix B.

Table 11-4—Follow-Up on Prior Year's Recommendations for Network Adequacy

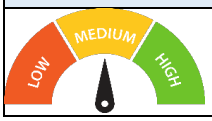
4. Prior Year Recommendations from the EQR Technical Report for Validation of Network Adequacy:
Recommendations
ABHLA should work together with Laboratory in Rural and RHC in Urban to improve network access.
Response
Describe initiatives implemented based on recommendations: The plan continuously works to evaluate the network using a regional and parish-based approach. A monthly network development review is conducted to assess our network's ability to meet future projections on enrollee needs, evaluate current needs, and invite participation from providers and other stakeholders on network composition, operations, and quality improvement.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
Identify any barriers to implementing initiatives: NA
Identify strategy for continued improvement or overcoming identified barriers: NA
HSAG Assessment


Table 11-5—Follow-Up on Prior Year's Recommendations for CAHPS

5. Prior Year Recommendations from the EQR Technical Report for Validation of Quality of Care Surveys – CAHPS Member Experience Survey:
Recommendations
None identified.

Table 11-6—Follow-Up on Prior Year's Recommendations for the Behavioral Health Member Satisfaction Survey

6. Prior Year Recommendations from the EQR Technical Report for the Behavioral Health Member Satisfaction Survey:
Recommendations
None identified.

Table 11-7—Follow-Up on Prior Year's Recommendations for the Quality Rating System

7. Prior Year Recommendations from the EQR Technical Report for MCO Quality Ratings:
Recommendations
None identified.

Appendix A. MCO Health Equity Plan Summary

For the annual EQR technical report, LDH asked HSAG to summarize information from ABH's Health Equity Plan (HEP) submission from January 2023.

Health Equity Plan

HSAG reviewed ABH's HEP submitted January 2022. In the section titled "RFP Response Related to Proposed Health Equity Approach and Experience to Date," HSAG summarized and organized each MCO's response into the following topics, for comparison among MCOs—Stated Goals; Policies and Procedures; Staffing and Resources; Leveraging Data; Social Determinants of Health; and Community, Provider, and Member Engagement Initiatives. For the other sections of the HEP, HSAG organized the discussions in this report as each MCO presented the topics in its own HEP. Therefore, comparison across MCOs for the "Health Equity Plan Development Process," "Health Equity Action Plan by Focus Area," "Plan to Conduct Cultural Responsiveness and Implicit Bias Training," and "Stratify MCO Results on Attachment H Measures" sections of the HEP is not possible.

RFP Response Related to Health Equity Approaches and Experience

HSAG summarized and organized ABH's Request for Proposal (RFP) responses into a standard set of topics as follows:

Stated Goals

ABH reported the following programmatic goals in its HEP:

- Ensure an equitable approach to emphasize and prioritize health equity in the MCO and ensure alignment with the State's priorities.
- Improve enrollee's health, reduce disparities, and address social determinants of health (SDOH).
- Understand health disparities in various communities to determine what is needed to address healthcare concerns in each community.
- Base its approach on understanding the systemic needs related to health equity, improving approaches to achieving health equity, and providing solutions to address identified needs.
- Increase access to culturally responsive care by:
  - Addressing transportation, physical safety, food insecurity, and housing needs
  - Engaging enrollees
  - Partnering with LDH, community-based organizations (CBOs), and other MCOs
  - Implementing provider and staff health equity training

- Accelerate the efforts of LDH and community partners to improve access to health and social needs for members that suffer racial, ethnic, linguistic, disability, and geographic disparities.
- Focus primarily on closing racially, ethnically, and linguistically different (RELD) and geographic (GEO) disparity gaps.
- Have a culturally diverse and aware staff.
- Engage with families from diverse racial and ethnic backgrounds when designing services for children and adolescents.
- Explore and expand statewide and local partnerships with culturally specific programs.

Policies and Procedures

ABH reported the following: organizational policies and procedural program components:

- The ABH Health Equity Action Plan was created utilizing the Plan-Do-Study-Act (PDSA) method while staying in alignment with ABH's population health management programs, the Louisiana Medicaid Managed Care Quality Strategy, the NCQA Health Equity Standards, and LDH's HEP and framework.
- As required by CMS Section 508, ABH provides all enrollee materials in alternative formats and provides auxiliary aids for the Deaf and American Sign Language (ASL) users:
  - An education campaign was launched to inform enrollees and providers how to access the available ASL interpretations.
  - Closed captioning for virtual committee meetings has also been made available.
- ABH Enrollee Services staff were equipped to assist enrollees with selecting primary care providers (PCPs) who are culturally responsive to lesbian, gay, bisexual, transgender, queer, intersex, asexual and more (LGBTQIA+) enrollees and enrollees from specific racial, ethnic, cultural, and religious groups.
- Network adequacy was continually assessed for access-related issues through inspection of the grievance and appeals data.
- ABH created the following value-added benefits to increase member access to transportation and selected services:
  - Adult Dental
  - Adult Vision
  - Aetna Better Care Program
  - After-school programs
  - Alternatives to Opioids
  - Asthma home benefit
  - Blood Pressure Monitor
  - Calming Comfort Collection
  - Enhanced Transportation

  - Home-delivered Meals
  - Job & Life Skills Courses
  - HiSET (High School Equivalency Test) Certification
  - My Maternity Companions
  - My Maternity Matters
  - Newborn Circumcision
  - Over the Counter (OTC)
  - Pyx Health
  - Respite care for individuals experiencing homelessness
  - Safe Home Support
  - Sickle Cell Benefit
  - Tobacco Cessation Program
- Supplemental questions pertaining to health equity were added to surveys specifically for CAHPS to gather feedback and more information on the enrollee's state related to health equity.
- ABH has begun reimbursing network providers for screening for SDOH needs and for submitting applicable diagnosis codes (Z codes) on claims.
- ABH also developed a robust list of resources and workflows to strengthen referral systems in addressing SDOH.
- ABH initiated and implemented an interactive electronic communication program in the summer of 2021 that alerts, tracks, and connects enrollees to receive immediate assistance during disaster events in real time, before, during, and after a disaster.
- ABH ensures that each functional area with outward-facing communications tests potential publications with enrollees for understanding and conveyance of the intended message, as well as cultural appropriateness.

Staffing and Resources

ABH reported that its leadership is committed to prioritizing health equity by driving goals holistically, formulating a vision and mission for the whole organization to follow, and integrating them into the operations of each department, staffing, and relationships with partners to ensure achievement of goals and continuity. Examples include:

- ABH has dedicated health equity administrator and project manager positions whose primary focus is SDOH.
- The health equity administrator will chair the Culturally and Linguistically Appropriate Services (CLAS) Committee, which is designed to promote diversity, equity, and inclusion, and the Health Equity Task Force, which is an active work group utilized to analyze data. The Quality Management director and chief medical officer (CMO) will support the Health Equity Administrator in these efforts.

- ABH achieved the NCQA Multicultural Health Care Distinction in January 2022.
- ABH mentors diverse interns throughout the year in an effort to provide opportunities, especially to minorities.
- New ABH staff are trained on Louisiana culture, regional RELD disparities, SDOH, and the initial Striving for Health Equity training.
- Staff and providers are trained on CLAS standards and cultural responsiveness.
- ABH has developed a peer support services (PSS) program and is working to create a PSS dashboard that will be incorporated into a larger behavioral health dashboard.
- ABH will use a certified health coach who will assist enrollees in achieving heart-healthy solutions as well as in addressing obesity issues, through education, coaching activities, nutrition planning, and referral to appropriate resources.
- ABH promotes staff participation in colleague resource groups (CRGs) to have a culturally diverse and aware staff. Examples include:
  - aNative
  - Asian Professional Network Association (APNA)
  - Black Colleague Resource Group (BCRG)
  - Capabilities
  - Juntos
  - PRIDE+
  - Women Inspiring Success and Excellence (WISE)
- Enrollees have access to the findhelp.org and Pyx Health platforms (via the website) and the CM department shares resources (in-person, mail, SMS) to assist members in real time.

Leveraging Data

ABH reported the following:

- ABH collects and integrates RELD-stratified data and listens to providers, enrollees, and partners to inform health equity goals and initiatives.
- By collecting and analyzing data, ABH was able to focus efforts on getting an increased number of White non-Hispanic enrollees in Region 5 vaccinated (based on the data, this ethnic group had the lowest number of Medicaid recipients being vaccinated).

Social Determinants of Health

ABH reported the following:

- ABH meets with CBO leaders quarterly through the CBO round table to review and consistently address barriers on all social determinants of health.
- ABH hires community health workers (CHWs), PSSs, and doulas.

- ABH created a work group comprised of representatives of each of ABH's departments participating in analyzing disparities based on SDOH factors and results.

Community, Provider, and Member Engagement Initiatives

ABH reported the following:

- ABH engages with enrollees, providers, and partners to interpret data and stratifications, and incorporate lessons learned to improve and reduce RELD and health disparities.
- ABH nurtured partnerships with major healthcare organizations, LDH, the Louisiana National Guard, State and local health departments, faith-based organizations, and other various community-based organizations, specifically those with culturally specific programs, such as:
  - Louisiana Perinatal Quality Collaborative (LaPQC)
  - Lactation Consultant Certification Services
  - Sista Midwife Productions
  - Reaching Our Sisters Everywhere (ROSE)
  - March of Dimes
- ABH sponsors an enrollee advisory council and a provider advisory council (both with a virtual attendance option).
- By using enrollee feedback from the Enrollee Advisory Committee (EAC) in conjunction with data that is stratified by RELD and GEO reports, ABH can design the programs and initiatives that will have the greatest impact in the community and with enrollees.
- ABH formed a new partnership with two Historically Black Colleges and Universities (HBCUs) in Louisiana to increase routine HIV screening among Black students and Medicaid-eligible young people of color.
- ABH developed a program designed to reduce disparities among Black men who may suffer from undiagnosed high blood pressure.
- ABH meets monthly with tribal leaders to hear and respond to concerns and includes tribal representatives in applicable committees.
- ABH collects information from providers via a quarterly survey and analyzes the results to plan for increased access and to assist with accessibility issues.
- Through a provider webinar series, ABH makes available continuing education for providers and promotes awareness of implicit biases and the impact on healthcare policy and processes.
- ABH sponsors monthly CBO events in all nine regions and focuses grants and partnerships to communities that are facing the greatest health disparities.
- ABH distributes informative material to the community on a regular basis.
- ABH participates in the Louisiana Healthy Communities Coalition network.
- ABH works in collaboration with Volunteers of America (VOA) to sponsor events designed to increase screening rates among Black individuals.

- ABH engages in outreach efforts to improve enrollee engagement (mailings, calls, Early and Periodic Screening, Diagnostic and Treatment [EPSDT] flyers at community events, text campaigns, and community immunization outreach events).
- School-based partnerships that began in Quarter 1 2022 were designed to increase access to care through telemedicine and provide virtual counseling in schools in the Ville Platt community. ABH plans to expand to additional regions.

Health Equity Plan Development Process

ABH reported completing the following steps in developing the HEP:

- Conducting a comprehensive review of internal and external factors such as:
  - Organizational systems and ABH's capacity to create strategies specific to the different populations being served
  - Internal policies, operations, and organizational structure
  - Staffing
  - Organizational vision, mission, and goals
  - Technological resources and processes
  - Provider behaviors
  - Access
  - Enrollee behaviors
  - Performance on accreditation standards
  - Environmental issues
  - Organizational and community resources
  - Private sector operations
  - Vendor processes
- Performing a root cause analysis (RCA) for each topic area under review (listed above).
- Using RELD and GEO data to capture unequal social, environmental, and economic conditions.
- Analyzing SDOH, with attention to systemic racism and implicit biases.
- Determining action needed.
- Dedicating resources needed to complete the actions.

Health Equity Action Plan by Focus Area

Table A-1 describes ABH's focus areas, goals and objectives, strategies, activities planned, and participants needed to address each focus area:

Table A-1—Addressing Focus Areas

Focus Area	Goals	Objectives	Strategies	Activities	Participants
A. Organizational Readiness	• Building a diverse staff • Incorporate diversity and inclusion into hiring	• Increase trainings to quarterly by December 2023	• Assess staffing, policies, and committee memberships	• Identify opportunities to improve diversity, equity, inclusion, or humility	• Health Equity administrator • All ABH staff
B. Race, Ethnicity, Language, Gender Identity, and Sexual Orientation Data	• Promoting diversity, equity, and inclusion among staff • Develop systems to collect individual level data • Data collection • Privacy protections	• Increase the number of staff members who completed trainings to 100 percent by December 2023 • ABH's ability to include all data is to be determined based on 834 file content • Analyze population health program and initiatives and develop action items by December 2023 • Compliance with privacy policies (ongoing)	• Strive for health equity training • Collect data on race, ethnicity, language, gender identity, and sexual orientation • Population assessment • Include confidentiality statement in each meeting	• Provide at least one employee training on: – Culturally and linguistically appropriate practices – Reducing bias – Promoting inclusion • Receive and store individual-level data • Develop methods for assessing needs • Maintain policies and procedures regarding proper use of data	• Health Equity administrator • All ABH staff • Quality Management staff • Informatics staff • LDH
C. Access and Availability of Language Services	• Assess written documents • Ensure timelines and	• Analyze, monitor, and trend language line	• Analyze language line services	• Provide vital information in threshold languages	• Member services staff • Providers

Focus Area	Goals	Objectives	Strategies	Activities	Participants
	quality of translation • Offer language services to providers • Notify members and providers about language services	utilization and timeliness (ongoing) • Track and monitor language translation training—quarterly • Review and revise member services and provider relations training materials by December 2023	• Review and analyze practitioner training on translation services • Ensure enrollees and providers are aware of free language assistance and how to use it	• Use competent interpreter services • Support practitioners with language services • Offer practitioner training • Annually distribute written notices in English and in up to 15 non-English languages	• Provider engagement, outreach, relations staff
D. Practitioner Network Cultural Responsiveness	• Assess availability of information • Enhance network responsiveness	• Integrate and track Medicaid provider and group agreement checklist, credentialing form, provider information changes into the ABH website, to facilitate response to requests for printed member materials (completion to be determined) • Increase the capacity of ABH to meet members' cultural and	• Identify provider language availability using the portal to assist enrollees in choosing the right care • Build a work group to address network capacity tracking and monitoring	• Collect information about languages spoken by providers and language services available at each practice • Publish practitioner languages and services in the physician directory • Collect practitioner race and ethnicity data • Provide practitioner race and ethnicity on request • Analyze the capacity of the network to meet member language and cultural needs	• Health Equity Administrative staff • Provider Engagement, Outreach, and Relations staff, • Member Services staff

Focus Area	Goals	Objectives	Strategies	Activities	Participants
		language needs by December 2023		• Develop and implement a plan to address identified gaps	
E. CLAS Programs	• Maintain a program description • Annual evaluation	• Annually assess the Health Equity program and the quality management departmental activities (ongoing) • Revise and analyze the cultural competency evaluation and related activities (ongoing)	• Create a comprehensive plan to integrate Health Equity into all areas of the MCO • Formulate a work group and committee to monitor and track activities	• Strive to achieve the overall objective for serving a culturally and linguistically diverse population • Involve culturally diverse enrollees in identifying and prioritizing opportunities for improvement • Strive to achieve measurable goals for the improvement of CLAS and reduction of healthcare disparities • Adhere to the annual work plan described in the program description • Monitor for goal achievement • Seek annual approval of the program description by the governing body • Annual evaluation of the CLAS program to include: – Description of completed and	• Health Equity Administrative staff • Quality Management staff

Focus Area	Goals	Objectives	Strategies	Activities	Participants
				ongoing activities – Trending of measures – Analysis of results and barrier analysis – Review and evaluation of results by community representatives – Evaluate the overall effectiveness of the program	
F. Reducing Healthcare Disparities	• Report stratified measures • Use data to assess and monitor disparities and services • Use data to measure CLAS and disparities	• Close social and healthcare disparities in the stratified measures with developed metrics aligned with each measure (ongoing) • Monitor and track activities using data to create or revise program (ongoing) • Analyze and track the results of the surveys to inform necessary actions (ongoing) • Track and monitor the Health Equity work plan, the cultural	• Use a PDSA cycle to review rates, analyze outcomes, and determine next actions for each metric • Incorporate surveys throughout the contract timeline • Review and analyze activities pertaining to social and health disparities	– Stratify the following HEDIS measures by race and ethnicity to determine if healthcare disparities exist – Colorectal Cancer Screening L – Controlling High Blood Pressure – HbA1c Control for Patients With Diabetes Prenatal and Postpartum Care Child and Adolescent Well-Care Visits (combos 2 and 3) – Percentage of low birth weights for postpartum	• Health Equity Administrative staff • Quality Management staff • HEDIS team • Informatics staff • Health Equity Task Force

Focus Area	Goals	Objectives	Strategies	Activities	Participants
		competency evaluation, and the Health Equity Task Force work plan (ongoing)		women ages 21 to 44 – HIV viral load suppression – Cervical cancer screening – Follow up after an Emergency Department (ED) visit for mental illness (30 days) – Follow up after an ED visit for Substance Use (30 days) – Follow up after hospitalization for mental illness (30 days) • Analyze measures (HEDIS and/or CAHPS) of clinical performance by race, ethnicity, language, gender identity, and/or sexual orientation • Analyze social disparities in health data • Annually assess: – Utilization of language services for organization functions – Individual experience with language services for organization functions	

Focus Area	Goals	Objectives	Strategies	Activities	Participants
				– Staff experience with language services for organization functions – Individual experience with language services during healthcare encounters • Annually: – Identify and prioritize opportunities to reduce health disparities and improve CLAS – Implement at least one intervention to address a disparity and improve CLAS – Evaluate effectiveness of an intervention designed to reduce disparity and improve CLAS	

Plan to Conduct Cultural Responsiveness and Implicit Bias Training

ABH reported the following activities designed to conduct cultural responsiveness and implicit bias training:

- Use a vendor to make trainings available to providers for continuing education.
- Communicate the availability of trainings through the ABH Provider Relations team, the provider manual, the provider newsletter, network contracting, the Provider Advisory Council, the CLAS Committee, and the Quality Practice Liaisons (QPLs).

- Train enrollees and provider-facing staff through partnerships and initiatives with community partners. Training to include the Striving for Health Equity and Poverty Simulation.
- Use a holistic approach to increase awareness of the provide network in all ABH departments.
- Build training and resources that are aligned with the goals of health equity and ABH's CRGs.
- Refresh the current behavioral health provider file to include LGBTQIA+ provider resources.
- Contact enrollees with a severe and persistent mental illness diagnosis to educate them on resources and support.
- Regularly distribute an electronic enrollee newsletter for all enrollees receiving behavioral health services. The newsletter contains articles of coping, support, and resources available.
- Collect and publish in the provider directory information about:
  - Provider languages spoken.
  - Language services available at the practices.
  - Practitioner race/ethnicity data (collects this data and releases upon request).

Stratify MCO Results on Attachment H Measures

For this section of the HEP, ABH did not provide stratified rates for the measures; however, ABH indicated that it uses Inovalon Converged Quality software to generate the numerators and denominators for rate calculation, then combines the data with GEO and RELD data into a dashboard to assess disparities. ABH did not indicate whether it has the capability to stratify HEDIS measure results by race, ethnicity, or other demographic factors.

Appendix B. Compliance Review Remediation Follow-Up

Appendix B includes ABH's response to the CAP recommendations made by the previous EQRO for addressing deficiencies from the prior year's CR and HSAG's findings after reviewing ABH's responses and additional documentation. Please note that the responses in this section were provided by the plans and have not been edited by HSAG.

Recommendations
Requirement - *Prenatal Care Services. The MCO shall assist all pregnant members in choosing a pediatrician, or other appropriate PCP, for the care of their newborn babies before the beginning of the last trimester of gestation. In the event that the pregnant member does not select a pediatrician, or other appropriate PCP, the MCO shall provide the member with a minimum of fourteen (14) calendar days after birth to select a PCP prior to assigning one.* The policy provided addresses detailed pre-natal care and education for the pregnant member. It does not address the selection of a pediatrician or other appropriate PCP be the beginning of the last trimester. ABH should add the required language to relevant policies.
Response
Describe initiatives implemented based on recommendations: ABH updated policies to include this requirement. A weekly pregnancy report is utilized to outreach to members to offer Case Management engagement and assist with obtaining providers.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
Identify any barriers to implementing initiatives: NA
Identify strategy for continued improvement or overcoming identified barriers: NA
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement - *A person-centered integrated plan of care developed by the MCO care manager shall be completed within thirty (30) calendar days of provider treatment plan development that includes all medically necessary services including specialized behavioral health services and primary care services identified in the member's treatment plans (individualized treatment plans are developed by the provider(s)) and meet the requirements above.* Of the 10 case management files reviewed, four (4) files met the requirement and six (6) files were not applicable. Of the 10 behavioral health case management files reviewed, one (1) file met the requirement, seven (7) files were not applicable, and two (2) files did not meet the requirement. This requirement is addressed by the Integrated Care Management Policy on page 14. ABH should ensure that plans of care are developed for all eligible members.

Response
Describe initiatives implemented based on recommendations: Enhanced training to this requirement, monthly audits of staff, Case Management review dashboard with staff on monthly calls, increased staffing.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
Identify any barriers to implementing initiatives: NA
Identify strategy for continued improvement or overcoming identified barriers: NA
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement - *The MCO shall be responsible for ensuring: Member's health care needs and services/care are planned and coordinated through the MCO PCP and/or behavioral health provider.* Of the 10 case management files reviewed, five (5) files met the requirement, four (4) files were not applicable, and one (1) file did not meet the requirement. Of the 10 behavioral health case management files reviewed, four (4) files met the requirement, four (4) files were not applicable, and two (2) files did not meet the requirement. This requirement is addressed by the Integrated Care Management Policy on page 26. ABH should ensure establish communication with identified PCP/providers to ensure proper care coordination.
Response
Describe initiatives implemented based on recommendations: Updated/enhanced care plan letter to providers, sharing care plans with provider and will call providers if there is an urgent need, enhanced staff training, monthly audits of staff on this requirement.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
Identify any barriers to implementing initiatives: NA
Identify strategy for continued improvement or overcoming identified barriers: NA
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement - *Care coordination and referral activities, in person or telephonically depending on member's acuity, incorporate and identify appropriate methods of assessment and referral for members requiring both medical and behavioral health services. These activities must include scheduling assistance, monitoring and follow-up for member(s) requiring medical services and coordination for members requiring behavioral health services.* Of the 10 case management files reviewed, seven (7) files met the requirement and three (3) were not applicable. Of the 10 behavioral health case management files reviewed, five (5) files met the requirement, four (4) files were not applicable, and one (1) file did not meet the requirement. This requirement is addressed by the Integrated Care Management Policy on pages 20 through 23. ABH should ensure staff are properly trained to execute care coordination outreach activities.

Response
Describe initiatives implemented based on recommendations: Case management audit tool and processes have been updated. Monthly audits of staff on this requirement.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
Identify any barriers to implementing initiatives: NA
Identify strategy for continued improvement or overcoming identified barriers: NA
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement - *Patients with a condition that causes chronic pain and have five (5) or more ED visits in the most recent 12-month period for chief complaint of pain are contacted by the MCO for a pain management plan and this plan will be shared with the patients' PCP, the patient, and relevant ED staff.* Of the 10 case management files reviewed, one (1) file met the requirement and nine (9) files were not applicable. Of the 10 behavioral health case management files reviewed, all 10 files were not applicable. This requirement is not addressed in the submitted policy and procedures. The member handbook describes an alternate pain management program for all members, consisting of three chiropractic visits and acupuncture services, but this is not a specialized pain management plan for the specific population described in this requirement. ABH should create a policy, procedure, or program description to address this requirement.
Response
Describe initiatives implemented based on recommendations: Case Management updated its Identification of Candidates for Care Management tool. An analytics report was created specific to this element to identify membership related to this requirement on a monthly basis.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
Identify any barriers to implementing initiatives: NA
Identify strategy for continued improvement or overcoming identified barriers: NA
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement - *Ensure each member is provided with information on how to contact the person designated to coordinate the services the member accesses.* Of the 10 case management files reviewed, all 10 files met the requirement. Of the 10 behavioral health case management files reviewed, seven (7) files met the requirement, one (1) file was not applicable, and two (2) files did not meet the requirement. This requirement is partially addressed by the ICM Welcome Member Letter Template; however, a policy or procedure is still needed for full compliance. ABH should create a policy or procedure to address this requirement. Additionally, ABH should ensure staff follow outreach protocols to members.

Response
Describe initiatives implemented based on recommendations: Case Management internal procedures were updated to address the 72-hour post-discharge follow-up requirement. Monthly audits of staff are conducted to ensure adherence to this requirement.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
Identify any barriers to implementing initiatives: NA
Identify strategy for continued improvement or overcoming identified barriers: NA
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement- *Care managers follow-up with members with a behavioral health related diagnosis within 72 hours following discharge.* Of the 10 behavioral health case management files, one (1) file met the requirement and nine (9) files were not applicable. The submitted policy and desktop procedure addresses discharges, but does not specify the diagnosis or timeframe stipulated in this requirement.
Response
Describe initiatives implemented based on recommendations: 2022 desktop with BH timeframes was reviewed and states 24-48 hours for follow up. Monthly audits of staff are conducted to ensure adherence to this requirement.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
Identify any barriers to implementing initiatives: NA
Identify strategy for continued improvement or overcoming identified barriers: NA
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement - *For the behavioral health population, provide aftercare planning for members prior to discharge from a 24-hour facility.* The Discharge Planning Policy is in regard to post-discharge care, which does not address this requirement (aftercare planning prior to discharge). Additionally, the Coordination of Member Care Policy references annual activities conducted to coordinate care, which does not address this requirement. ABH should create a policy, procedure, or program description to address this requirement.
Response
Describe initiatives implemented based on recommendations: Case Management team created an internal procedure to speak to Transitions between Care Settings. Monthly audits are conducted to ensure adherence to this requirement.

Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
Identify any barriers to implementing initiatives: NA
Identify strategy for continued improvement or overcoming identified barriers: NA
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement - *The individualized treatment plans must be: 6.19.4.1 Developed by the member's primary care provider and/or other lead provider as appropriate, with member participation, and in consultation with any specialists caring for the member. For SHCN members, the treatment plan shall be submitted to the member's MCO no later than 30 days following the completion of the initial assessment or annual reassessment.* Of the 10 case management files reviewed, two (2) files met the requirement, seven (7) files were not applicable, and one (1) file did not meet the requirement. Of the 10 behavioral health case management files reviewed, one (1) file met the requirement, seven (7) files were not applicable, and two (2) files did not meet the requirement. This requirement is addressed by the Integrated Care Management Policy on page 23. ABH should collaborate with PCP/providers to obtain treatment plans for eligible members.
Response
Describe initiatives implemented based on recommendations: Updated/enhanced care plan letter to provider regarding sharing of information and seeking information; sharing care plans with provider and will call providers if there is an urgent need; enhanced staff training; monthly audits of staff on adherence to this element.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
Identify any barriers to implementing initiatives: NA
Identify strategy for continued improvement or overcoming identified barriers: NA
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement - *In any instance when the member presents to the network provider, including calling the MCO's toll-free number listed on the Member's ID card, and a member is in need of emergency behavioral health services, the MCO shall instruct the member to seek help from the nearest emergency medical provider. The MCO shall initiate follow-up with the member within forty-eight (48) hours for follow-up to establish that appropriate services were accessed.* This requirement is partially addressed in the member handbook and in the Supporting Members in Crisis Policy on pages 5 through 6; however, this documentation does not address the follow-up timeframe stipulated by the requirement. ABH should edit the policy to include all parts of the requirement.

Response
Describe initiatives implemented based on recommendations: Supporting Members in Crisis policy was updated to include this timeframe.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
Identify any barriers to implementing initiatives: NA
Identify strategy for continued improvement or overcoming identified barriers: NA
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement - *Develop capacity for enhanced rates or incentives to behavioral health clinics to employ a primary care provider (physician, physician's assistant, nurse practitioner, or nurse) part- or full-time in a psychiatric specialty setting to monitor the physical health of patients.* This requirement is partially addressed by the provider contract template; however, a policy or procedure is needed to demonstrate full compliance. During the post-onsite submission, ABH provided a statement that said, "ABH does not provide Providers with internal ABH policies. Therefore, the provider contract is ABH's preferred method of communicating of provider incentives or enhanced rates." However, an internal policy, procedure, or program description to instruct MCO staff to execute this requirement is needed, not a policy to the provider. ABH should create a policy, procedure, or program description to address this requirement.
Response
Describe initiatives implemented based on recommendations: ABHLA Provider Relations and Operations teams are currently discussing how to implement this initiative.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
Identify any barriers to implementing initiatives: NA
Identify strategy for continued improvement or overcoming identified barriers: NA
HSAG Assessment
The documents submitted by the MCO did not address the recommendation from the 2022 CR, and the MCO was unable to demonstrate compliance during the virtual review. The MCO must address this recommendation to remediate the finding.
Recommendations
Requirement - *The MCO shall submit Case Management Program policies and procedures to LDH for approval within thirty (30) days from the date the Contract is signed by the MCO, annually and prior to any revisions. Case Management policies and procedures shall include, at a minimum, the following elements,* The Policy, Development, Revision, Execution, and Maintenance Policy addresses the internal process by which ABH develops policies, but it does not include the external approval process detailed in this requirement. The Act 319 Policy Notice to LDH Process addresses the requirement; however, due to the document date, it cannot be accepted as part of this review. ABH should continue to implement the Act 319 Policy Notice to LDH Process to meet this requirement.

Response
Describe initiatives implemented based on recommendations: ABHLA has continued to submit appropriate policies to LDH for posting and public comment period.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
Identify any barriers to implementing initiatives: NA
Identify strategy for continued improvement or overcoming identified barriers: NA
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement - *The MCO shall submit Chronic Care Management Program policies and procedures to LDH for approval within thirty (30) days of signing the Contract, annually and previous to any revisions. The MCO shall develop and implement policies and procedures that.* The Policy, Development, Revision, Execution, and Maintenance Policy addresses the internal process by which ABH develops policies, but it does not include the external approval process detailed in this requirement. The Act 319 Policy Notice to LDH Process addresses the requirement; however, due to the document date, it cannot be accepted as part of this review. ABH should continue to implement the Act 319 Policy Notice to LDH Process to meet this requirement.
Response
Describe initiatives implemented based on recommendations: ABHLA has continued to submit appropriate policies to LDH for posting and public comment period.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
Identify any barriers to implementing initiatives: NA
Identify strategy for continued improvement or overcoming identified barriers: NA
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement - *For service authorization approval for a non-emergency admission, procedure or service, the MCO shall notify the provider verbally or as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.* Nine (9) of 10 files met the requirements. Case 1 was marked as concurrent and urgent and appears it was received 3/19 but not decided until 3/22/2021. This requirement is addressed in the Concurrent Review/Observation Care policy and procedure but only partially met as part of the file review. Case one (1) was concurrent urgent. ABH should ensure the file type is accurately captured and timeframes met.

Response
Describe initiatives implemented based on recommendations: ABHLA's Case Management team created an action plan to address the delay in processing.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
Identify any barriers to implementing initiatives: NA
Identify strategy for continued improvement or overcoming identified barriers: NA
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement - *In the event a provider indicates, or the MCO determines, that following the standard service authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours after receipt of the request for service.* Nine (9) of 10 files met the requirements. Case 1 was marked as concurrent and urgent and appears it was received 3/19 but not decided until 3/22/2021. This requirement is addressed in the Concurrent Review/Observation Care policy and procedure but only partially met as part of the file review. Case one (1) was concurrent urgent. ABH should ensure the file type is accurately captured and timeframes met.
Response
Describe initiatives implemented based on recommendations: ABHLA's Case Management team created an action plan to address this requirement.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
Identify any barriers to implementing initiatives: NA
Identify strategy for continued improvement or overcoming identified barriers: NA
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement - *The MCO shall establish and follow a documented process for credentialing and re-credentialing of network providers [42 CFR §438.12(a)(2).The MCO must have a written credentialing and re-credentialing process that complies with 42 CFR §438.12, §438.206, §438.214, §438.224, §438.230 and NCQA health plan Accreditation Standards for the review, credentialing and re-credentialing of licensed, independent providers and provider groups with whom it contracts or employs and with whom it does not contract but with whom it has an independent relationship. An independent relationship exists when the MCO selects and directs its members to see a specific provider or group of providers. These procedures shall be submitted to LDH within sixty (60) calendar days after contract amendment, when a change is made, and annually thereafter by contract year.*

Three (3) of five (5) initial credentialing files met the NCQA health plan accreditation standards. A date of written notification for two (2) credentialing files was not available resulting in IPRO being unable to determine whether the timeliness standard was met. Five (5) of five (5) re-credentialing files met the NCQA health plan accreditation standards. This requirement is addressed in ABH's Practitioner Credentialing/Recredentialing Policy. ABH should ensure that the organization's time frame for notifying applicants of initial credentialing decisions does not exceed 60 calendar days from the Credentialing Committee's decision.
Response
Describe initiatives implemented based on recommendations: ABHLA's credentialing team met and confirmed its 60-day timeframe as evidenced in Policy No QM 54-Practitioner Credentialing, Recredentialing. There is now a database that notes the date the letter was sent but have updated the letter itself to indicate the date of credentialing, as well as the date of notification.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
Identify any barriers to implementing initiatives: NA
Identify strategy for continued improvement or overcoming identified barriers: NA
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement - *All written materials must be clearly legible with a minimum font size of ten-point, preferably twelve-point, with the exception of Member ID cards, and or otherwise approved by LDH.* This requirement is not addressed by the member materials policy. ABH should update the member materials policy to include this requirement.
Response
Describe initiatives implemented based on recommendations: Policy A-LA 4500.20 Member Materials Standard was updated to reflect this requirement.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
Identify any barriers to implementing initiatives: NA
Identify strategy for continued improvement or overcoming identified barriers: NA
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement - *If a person making a testimonial or endorsement for a MCO has a financial interest in the company, such fact must be disclosed in the marketing materials.* This requirement is not addressed by any policy or procedure. ABH should update the member materials policy to include this requirement.

Response
Describe initiatives implemented based on recommendations: ABHLA policies A-LA 4600.05 and 4600.40 were updated the with the required language
Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
Identify any barriers to implementing initiatives: NA
Identify strategy for continued improvement or overcoming identified barriers: NA
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement - *All written materials must be in accordance with the LDH "Person First" Policy, Appendix NN.* This requirement is not addressed by any policy or procedure. ABH should update the member materials policy to include this requirement.
Response
Describe initiatives implemented based on recommendations: ABHLA policy A-LA 4500.20 Member Materials Standards was updated to reflect this requirement.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
Identify any barriers to implementing initiatives: NA
Identify strategy for continued improvement or overcoming identified barriers: NA
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement - *The quality of materials used for printed materials shall be, at a minimum, equal to the materials used for printed materials for the MCO's commercial plans if applicable.* This requirement is not addressed by any policy or procedure. ABH states that they have no commercial plans in Louisiana, however the state requirement belongs in a policy. ABH should update the member materials policy to include this requirement.
Response
Describe initiatives implemented based on recommendations: ABHLA Policy 4600.83 Print and Mailing was updated to reflect this required language.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
Identify any barriers to implementing initiatives: NA
Identify strategy for continued improvement or overcoming identified barriers: NA

HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement - *Except as indicated, the MCO may develop their own materials that adhere to requirements set forth in this document or use state developed model member notices. State developed model notices must be used for denial notices and lock-in notices.* This requirement is not addressed by any policy or procedure. ABH should update the member materials policy to include this requirement.
Response
Describe initiatives implemented based on recommendations: ABHLA policy A-LA 4600.05 Member Communications was updated to reflect this requirement.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
Identify any barriers to implementing initiatives: NA
Identify strategy for continued improvement or overcoming identified barriers: NA
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement - *Written materials must also be made available in alternative formats upon request of the potential member or member at no cost. Auxiliary aids and services must also be made available upon request of the potential member or member at no cost. Written materials must include taglines in the prevalent non-English languages in the state, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDY telephone number of the MCO's member/customer service unit. Large print means printed in a font size no smaller than 18 point.* This requirement is partially addressed in the Member Notice of Primary Care Practitioner (PCP) / Practitioner Termination policy. The MCO should add the provisions regarding TTY/DTY and font size to the policy.
Response
Describe initiatives implemented based on recommendations: ABHLA policy A-LA 4500.25 Interpreter and Translation Services was updated to include the required language.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
Identify any barriers to implementing initiatives: NA
Identify strategy for continued improvement or overcoming identified barriers: NA
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.

Recommendations
Requirement - *The MCO shall make a good faith effort to give written notice of a provider's termination to each member who received their primary care from, or was seen on a regular basis by the terminated provider. When timely notice from the provider is received, the notice to the member shall be provided within fifteen (15) calendar days of the receipt of the termination notice from the provider.* This requirement is partially addressed in the Member Notice of Primary Care Practitioner (PCP) / Practitioner Termination policy. ABH should build the "within 15-day notice to member" into the policy.
Response
Describe initiatives implemented based on recommendations: ABHLA policy A-LA 4500.12 Member Notice of Primary Care Practitioner (PCP) Termination was updated to reflect this requirement.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
Identify any barriers to implementing initiatives: NA
Identify strategy for continued improvement or overcoming identified barriers: NA
HSAG Assessment
The documents submitted by the MCO did not address the recommendation from the 2022 CR, and the MCO was unable to demonstrate compliance during the virtual review. The MCO must address this recommendation to remediate the finding.
Recommendations
Requirement - *The MCO shall provide notice to a member or the parent/legal guardian and the involved state agency, as appropriate, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. The written notice shall be provided within seven (7) calendar days from the date the MCO becomes aware of such, if it is prior to the change occurring. Failure to provide notice prior to the dates of termination will be allowed when a provider becomes unable to care for members due to illness, a provider dies, the provider moves from the service area and fails to notify the MCO, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster. Under these circumstances, notice shall be issued immediately upon the MCO becoming aware of the circumstances.* This requirement is partially addressed in the Member Notice of Primary Care Practitioner (PCP) / Practitioner Termination policy. ABH should build the "written notice within 7 calendar days from the date it becomes aware of a provider's unavailability" into the policy.
Response
Describe initiatives implemented based on recommendations: ABHLA policy A-LA 4500.12 Member Notice of Primary Care Practitioner (PCP) Termination was updated to include this required language.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
Identify any barriers to implementing initiatives: NA
Identify strategy for continued improvement or overcoming identified barriers: NA

HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement - *Identification of any restrictions on the enrollee's freedom of choice among network providers;* This requirement is partially addressed by the Provider Manual. ABH should incorporate this requirement into a policy.
Response
Describe initiatives implemented based on recommendations: ABHLA policy A-LA 6300.20 Provider Directory Updates was updated to reflect the required language.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
Identify any barriers to implementing initiatives: NA
Identify strategy for continued improvement or overcoming identified barriers: NA
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement - *Identification of hours of operation including identification of providers with non-traditional hours (Before 8 a.m. or after 5 p.m. or any weekend hours).* This requirement is partially addressed by the Provider Manual. ABH should incorporate this requirement into a policy.
Response
Describe initiatives implemented based on recommendations: ABHLA policy A-LA 6300.20 Provider Directory Updates was updated to include the required language.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
Identify any barriers to implementing initiatives: NA
Identify strategy for continued improvement or overcoming identified barriers: NA
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement - *The MCO shall reduce underutilization of services in areas including, but not limited to HIV and Syphilis screening in pregnant women, use of long-acting reversible contraceptives, appropriate pain management approaches in patients with sickle cell disease, and behavioral therapy for ADHD and other disorders for children under age 6.* This requirement is partially addressed in the Quality Assessment Performance Improvement 2022 Program Description on page 6 and the Quality Assessment Performance Improvement Program Evaluation on page 38.

In addition, the Quality Assessment Performance Improvement Program Evaluation 2021 recommends 2022 program changes to address sickle cell anemia on page 41, and in the Healthy Louisiana Billing and Ordering Guidance for Long Acting Reversible Contraceptives; however, documentation was lacking to support the requirement to address behavioral therapy as a first line treatment independent of pharmacotherapy for ADHD and other disorders for children under age 6 years. The MCO should develop and implement a policy regarding behavioral therapy as a first line treatment independent of pharmacotherapy for children younger than 6 years of age. The MCO has responded that they will implement an ADHD work group to address behavioral therapies for ADHD and other disorders under age 6, was well as develop and implement policies and provider education programs.
Response
Describe initiatives implemented based on recommendations: ABHLA updated policy A-LA 7600.07 Pharmacy Prior Authorization, to address the recommendations. Additionally, the Quality team has implemented an ADHD workgroup to address behavioral therapies for ADHD and other disorders. The workgroup has created parent and provider toolkits and provider education.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
Identify any barriers to implementing initiatives: NA
Identify strategy for continued improvement or overcoming identified barriers: NA
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement - *The MCO shall reduce overutilization of services and medications through policies such as, but not limited to, prior authorization for prescription of ADHD drugs to children younger than six years of age.* This requirement is partially addressed in the Attention Deficit Hyperactivity Disorder Medical Clinical Policy bulletin on page 2 which states, "ABH considers pharmacotherapy and behavioral modification medically necessary for treatment of ADHD"; however, ABA as a first-line treatment for ADHD for children younger than 6 years of age independent of pharmacotherapy is not specifically addressed in the Attention Deficit/Hyperactivity disorder Medical Clinical Policy bulletin because this document states on page 6, "Psychotherapy is covered under ABH mental health benefits if the member also exhibits anxiety and/or depression." The MCO should develop and implement a policy regarding behavioral therapy as a first line treatment independent of pharmacotherapy for children younger than 6 years of age. The MCO has responded that they will implement an ADHD work group to address behavioral therapies for ADHD and other disorders under age 6, was well as develop and implement policies and provider education programs.
Response
Describe initiatives implemented based on recommendations: ABHLA updated policy A-LA 7600.07 Pharmacy Prior Authorization, to reflect the recommendations. ABH reinstated the ADHD task force to address behavioral therapies for ADHD and other disorders under age 6, as well as develop and implement policies and provider education programs.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
Identify any barriers to implementing initiatives: NA

Identify strategy for continued improvement or overcoming identified barriers:
NA

HSAG Assessment

The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.

Recommendations

Requirement - *The MCO shall increase the alignment of assessment and treatment with best practice standards through policies including increasing the use of evidence- based behavioral therapies as the first-line treatment for ADHD for children younger than six years of age, and other methods to increase the alignment with best practices for ADHD care for all children and particularly for children under age six.*
This requirement is partially addressed in the Quality Assessment Performance Improvement 2022 Program Description on page 6 and the Applied Behavioral Analysis (ABA) Provider Quality Monitoring Plan; however, ABA as a first-line treatment independent of pharmacotherapy for ADHD for children younger than 6 years of age is not specifically addressed in the Attention Deficit/Hyperactivity Disorder Medical Clinical Policy bulletin because this document states on page 6, "Psychotherapy is covered under ABH mental health benefits if the member also exhibits anxiety and/or depression." The MCO should develop and implement a policy regarding behavioral therapy as a first line treatment independent of pharmacotherapy for children younger than 6 years of age. The MCO has responded that they will implement an ADHD work group to address behavioral therapies for ADHD and other disorders under age 6, was well as develop and implement policies and provider education programs.

Response

Describe initiatives implemented based on recommendations:
ABHLA updated policy A-LA 7600.07 Pharmacy Prior Authorization, to address the recommendations. The Quality team added this item to a workgroup and it is the subject of ongoing discussion. The workgroup has created parent and provider toolkits and provider education.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
NA

Identify any barriers to implementing initiatives:
NA

Identify strategy for continued improvement or overcoming identified barriers:
NA

HSAG Assessment

The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.

Recommendations

Requirement - *The MCO, as well as its subcontractors and providers, shall comply with all federal requirements (42 C.F.R. §1002) on exclusion and debarment screening. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as the result of this Contract shall screen their owners and employees against the federal exclusion databases (such as LEIE and System for Award Management). Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by the State and/or the MCO dependent upon the entity that identifies the payment of unallowable funds to excluded individuals.*
This requirement is partially addressed in policy 3000.42 Excluded Individual. The screening of owners and employees against federal exclusion databases is included in both 2021 and 2022 versions of the policy. The refunding of funds made to excluded individuals is not included in the policy. ABH should include the refunding of funds made to excluded individuals in a policy.

Response
Describe initiatives implemented based on recommendations: The plan updated policy A-LA 3000.42 Excluded Individuals to address this deficiency.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
Identify any barriers to implementing initiatives: NA
Identify strategy for continued improvement or overcoming identified barriers: NA
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement - *The MCO will require new employees to complete and attest to training modules within thirty (30) days of hire related to the following in accordance with federal and state laws: MCO Code of Conduct Training Privacy and Security – Health Insurance Portability and Accountability Act Fraud, waste, and abuse identification and reporting procedures Federal False Claims Act and employee whistleblower protections Procedures for timely consistent exchange of information and collaboration with LDH; Organizational chart including the Program Integrity Officer and full-time program integrity investigator(s); and Provisions that comply with 42 CFR §438.608 and 438.610 and all relevant state and federal laws, regulations, policies, procedures, and guidance (including CMS' Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks) issued by Department, HHS, CMS, and the Office of Inspector General, including updates and amendments to these documents or any such standards established or adopted by the state of Louisiana or its Departments.* This requirement is partially addressed in the CVS Health Code of Conduct and in policy A-LA 3000.20 Compliance Training and Education. The timeliness portion of this requirement, that the MCO will require new employees to complete and attest to training modules within thirty (30) days of hire is not included in documentation provided for review. ABH should include that the MCO will require new employees to complete and attest to training modules within thirty (30) days of hire in a policy.
Response
Describe initiatives implemented based on recommendations: Policy A-LA 3000.20 Compliance Training and Education was updated to include necessary language.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
Identify any barriers to implementing initiatives: NA
Identify strategy for continued improvement or overcoming identified barriers: NA
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement - *Federal Financial Participation (FFP) is not available for services delivered by providers excluded by Medicare, Medicaid, or CHIP except for certain emergency services.* The policy 3000.42 Excluded Individuals effective during the 2021 review period does not address this

requirement. While it is addressed in policy 3000.42 Excluded Individuals 2022, the Revised date of this document is indicated as 04/12/2022, which is outside the review period. No action is required by ABH, as this issue was self-identified and added to the updated policy.
Response
Describe initiatives implemented based on recommendations: Policy A-LA 3000.42 Excluded Individuals was updated based on recommendations.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
Identify any barriers to implementing initiatives: NA
Identify strategy for continued improvement or overcoming identified barriers: NA
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement - *The MCO is responsible for the return to the State of any money paid for services provided by an excluded provider.* The policy 3000.42 Excluded Individuals effective during the 2021 review period does not address this requirement. While it is addressed in policy 3000.42 Excluded Individuals 2022, the Revised date of this document is indicated as 04/12/2022, which is outside the review period. No action is required by ABH, as this issue was self-identified and added to the updated policy.
Response
Describe initiatives implemented based on recommendations: Policy A-LA 3000.42 Excluded Individuals was updated to include recommendations.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
Identify any barriers to implementing initiatives: NA
Identify strategy for continued improvement or overcoming identified barriers: NA
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement - *In the event LDH or its agent initiates a review on a network provider, a notification shall be sent to the MCO Special Investigation Unit (SIU) designee. The LDH notification of the intent to review shall include: provider name, NPI, city, and provider type, allegation or issue being reviewed, procedure codes or NDCs under review, date range for dates of service under review, and amount paid. The MCO shall have ten business days to indicate whether the claims were corrected or adjusted prior to the date of the notification from the Department. If the State does not receive a response from the MCO within ten business days, the State may proceed with its review.* This requirement is not addressed, as the ABH SIU Policy Dependence Statement effective during the 2021 review period does not address this requirement. While it is addressed in DRAFT A-LA Aetna SIU Policy Dependence Statement, the Revised date of this document is indicated as 07/12/2022, which is outside the review period. No action is required by ABH, as this issue was self-identified and added to the updated policy.

Response
Describe initiatives implemented based on recommendations: The plan updated Aetna SIU Policy Dependence document and policy A-LA 3000.42 Excluded Individuals, based on the recommendations.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
Identify any barriers to implementing initiatives: NA
Identify strategy for continued improvement or overcoming identified barriers: NA
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement - *In the event the State or its agent investigates or audits a provider or member within the MCO's Network, the MCO shall comply with document and claims requests from the State within fourteen (14) calendar days of the request, unless another time period is agreed to by the MCO and State. Document requests do not include medical records that shall be obtained from the provider.* This requirement is partially addressed in policy 002 MCD SIU Overview. The timeliness portion of this requirement, where the MCO shall comply with document and claims requests from the State within fourteen (14) calendar days of the request is not included in documentation provided for review. Additionally, although this requirement is partially addressed in CVS Health Healthcare Anti-Fraud Plan, since the effective date is listed as 2/1/2022 which is outside the review period, it cannot be considered for compliance. Timeliness of responding to a request is not addressed in either document. ABH should include that the MCO shall comply with document and claims requests from the State within fourteen (14) calendar days of the request, unless another time period is agreed to by the MCO and State in a policy.
Response
Describe initiatives implemented based on recommendations: The plan updated Aetna SIU Policy Dependence documented based on the recommendations.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
Identify any barriers to implementing initiatives: NA
Identify strategy for continued improvement or overcoming identified barriers: NA
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement - *The MCO shall not remit payment for services provided under this contract to providers located outside of the United States. The term "United States" means the fifty (50) states, the District of Columbia, and any U.S. territories.* Although this requirement is addressed in A-LA Policy no. 6300.11, the Revised date is indicated as 02/14/2022, which is not within the review period, and cannot be considered for review. No action is required by ABH, as this issue was self-identified and added to the updated policy.

Response
Describe initiatives implemented based on recommendations: Per recommendation, no additional action was required, as policy was already updated.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
Identify any barriers to implementing initiatives: NA
Identify strategy for continued improvement or overcoming identified barriers: NA
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.