LOUISIANA DEPARTMENT OF HEALTH

State Fiscal Year July 1, 2024–June 30, 2025

External Quality Review Technical Report

for Healthy Blue

March 2026

HSAG HEALTH SERVICES ADVISORY GROUP

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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] with further revisions released in November 2020.[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 (CSoC) 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 and two dental PAHPs to provide dental services for Louisiana's Medicaid and CHIP members. Additionally, under the authority of a 1915(b)/1915(c) waiver from CMS, OBH contracts with a single behavioral

[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 12, 2025.

[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 12, 2025.

health PIHP, CSoC contractor, to help children with behavioral health challenges who are at risk for out-of-home placement. The MCEs contracted during state fiscal year (SFY) 2025 (July 1, 2024–June 30, 2025) are displayed in Table 1-1. Of note, no MCEs are exempt from EQR.

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	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.[3] For the SFY 2025 assessment, HSAG used findings from the mandatory and optional EQR activities to derive conclusions and make recommendations about 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)	The audit activity assesses the accuracy of the state-defined network adequacy indicators reported by the MCEs; evaluates the collection of provider data, reliability and validity of network adequacy data, methods used to assess network adequacy, and systems and processes used; and determines the overall phases of design, data collection, analysis, and interpretation of the network	Protocol 4. Validation of Network Adequacy	✓	✓	✓

[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 3, 2025.

EQR Activities	Description	CMS EQR Protocol	MCO	PAHP	PIHP
	adequacy indicators, as set forth by the State. Additionally, this activity evaluates the accuracy of provider directory information submitted by the MCOs and determines appointment availability information by conducting telephone surveys among a sample of providers.				
Encounter Data Validation (EDV)	This activity validates the accuracy and completeness of encounter data submitted by an MCO.	Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan	✓	✓	✓
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	✓		
CAHPS Dental Survey	This activity reports the results of each PAHP's CAHPS Dental Survey 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 services have on members receiving those services.	Protocol 9. Conducting Focus Studies of Health Care Quality	✓		
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	✓		

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 2025. 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.[1]	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."[2] 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]

[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 2025 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 opportunities for improvement 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 the overall quality, timeliness, and accessibility of 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 members under the Louisiana Medicaid managed care program). Louisiana's Medicaid Managed Care Quality Strategy (quality strategy) dated September 2023 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 Medicaid managed care program in Louisiana 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[4]

Strengths

Overall, the quality strategy serves to effectively measure and improve the quality of Louisiana's Medicaid managed care services. LDH's initiatives are tied to the quality strategy aims, goals, and objectives. The quality strategy also promotes identification and implementation of initiatives to monitor, assess, and improve access to care, quality of care, and timeliness of service delivery for

[4] Health Services Advisory Group, Inc. Louisiana Department of Health. Medicaid Managed Care Quality Strategy Evaluation, Review Period: March 20, 2024–March 19, 2025, November 2025. Louisiana Department of Health. Available at: https://ldh.la.gov/assets/docs/MQI/LA_2025_QSE-Report_F1.pdf. Accessed on: Dec 12, 2025.

Louisiana Medicaid members. LDH plans to incorporate goals from the National Quality Strategy in the quality strategy in the future. LDH oversees the MCEs in coordination with the quality strategy to promote accountability and transparency for improving health outcomes. LDH has an MCO contract requirement that the MCO should be committed to QI. Each MCO is required to be NCQA accredited and to conduct HEDIS performance measure reporting. LDH still plans to include the requirement for a commitment to QI in the PAHP contract.

The EQRO has identified the following strengths:

- In support of Goal 3, "Facilitate patient-centered, whole-person care," the MCEs demonstrated strong adherence to PIP methodology, with most projects scoring 100 percent on critical validation elements and achieving *High Confidence* ratings related to proper study design, data collection, and intervention planning.
- In support of Goal 1, "Ensure access to care to meet enrollee needs," LDH has established comprehensive network adequacy standards and monitoring processes that support access to care, as demonstrated by strong performance across multiple plan types. All MCEs met or exceeded provider-to-member ratio requirements and key behavioral health timeliness standards, and the PIHP achieved *High Confidence* ratings across all validated indicators with full compliance on appointment access standards. These results reflect a solid oversight structure and a generally adequate provider network to support timely access to behavioral and medical services for most members statewide.

Recommendations

The EQRO has identified the following recommendations for the quality strategy:

- To improve programwide performance in support of LDH's quality strategy goals, HSAG recommends that LDH:
  - Establish clear, system-level performance goals within the quality strategy to define the intended direction and outcomes of improvement efforts.
  - Select a streamlined, high-impact set of priority measures that will serve as key indicators of progress toward these goals, reducing the overall number of measures and focusing improvement on LDH's highest priorities.
  - Ensure all goals and objectives—including those related to PAHPs and PIHPs—are supported by corresponding performance measures within the quality strategy.
  - Define baselines for the selected priority measures to support ongoing measurement, monitoring, and evaluation of performance over time.
  - Refine the measure set by eliminating retired, not reportable, and not applicable measures.
  - Align the quality withhold incentive program with the streamlined priority measure set to ensure that financial incentives are focused on the measures most critical to advancing LDH's system-level performance goals.

  - Strengthen the quality withhold incentive program to be outcome focused, ensuring that withhold payments are earned for demonstrated improvement or sustained high performance on priority measures.

- To improve programwide performance in support of LDH's quality strategy goals, HSAG recommends that LDH increase its quality strategy evaluation to a three-year period. The evaluation of the effectiveness of the quality strategy should be conducted within the previous three years.
- To target improvement in Goal 2, "Improve coordination and transitions of care," HSAG recommends that LDH work with the MCOs to improve follow-up after emergency department (ED) and hospital visits for mental health and substance abuse.
- To target improvement in Goal 4, "Promote wellness and prevention," HSAG recommends that LDH work with the PAHPs to increase the percentage of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) enrollees receiving preventative dental services.
- To target improvement in Goal 4, "Promote wellness and prevention," HSAG recommends that LDH use Medicaid data and performance measure results to identify populations with low rates of preventive and screening services, and require targeted outreach and interventions from the MCEs to increase completion of recommended services.
- To target improvement in Goal 3, "Facilitate patient-centered, whole-person care," HSAG recommends that LDH strengthen oversight of member-experience performance by aligning CAHPS priorities with the quality strategy's goals and requiring the MCEs to determine factors contributing to persistently low or stagnant CAHPS scores, and implement focused improvement strategies while promoting interventions shown to improve access, communication, and member engagement.
- To target improvement in Goal 1, "Ensure access to care to meet enrollee needs," HSAG recommends that LDH require the MCEs to achieve and maintain accurate, complete, and up-to-date provider directories by establishing clear data quality standards, enforcing routine audits, and imposing corrective actions when minimum accuracy thresholds are not met.
- To target improvement in Goal 1, "Ensure access to care to meet enrollee needs," HSAG recommends that LDH strengthen oversight and collaboration with the dental PAHPs to improve network adequacy in parishes that did not meet distance standards by developing targeted remediation plans, prioritizing recruitment in high-need areas, and implementing ongoing monitoring to ensure members can obtain timely dental care across urban and rural regions.
- To target improvement in Goal 1, "Ensure access to care to meet enrollee needs," HSAG recommends that LDH strengthen monitoring and follow-through on corrective actions for recurring operational deficiencies related to non-emergency medical transportation (NEMT) timeliness and provider payment to ensure compliance with contract requirements and prevent member access barriers.
- To target improvement in Goal 4, "Promote wellness and prevention," HSAG recommends that LDH collaborate with the MCEs and providers to improve timely access to prenatal and postpartum care and reduce preventable adverse birth outcomes. Efforts should focus on identifying and addressing barriers to early and continuous prenatal care, implementing provider-level interventions to promote appropriate delivery practices and reduce low-risk cesarean rates, and enhancing outreach and care coordination to support postpartum follow-up and healthy birth outcomes.

Actions on External Quality Review Recommendations

The EQRO identified the following recommendations for the quality strategy during the last review period, March 20, 2023–March 19, 2024. These recommendations included how LDH could target goals and objectives in the quality strategy to better support improvement in the quality, timeliness, and accessibility of healthcare services furnished to Medicaid managed care members. Table 1-3 includes the recommendations that the EQRO made to LDH to support program improvement and progress in meeting the goals of the quality strategy. The State's responses regarding implemented improvement activities were edited for grammatical and stylistic changes only.

Table 1-3—EQRO Recommendations and LDH Actions

EQRO Recommendations for Review Period March 20, 2023–March 19, 2024	LDH Actions
To improve programwide performance in support of LDH's quality strategy goals, HSAG recommended that LDH identify a measure to align with the following objectives: • Ensure appropriate hospice onboarding and transitioning from palliative care to hospice. • Promote early initiation of palliative care to improve quality of life. • Promote health development and wellness in children and adolescents. • Advance specific interventions to address social determinants of health (SDOH). • Advance value-based payment arrangements and innovation. • Ensure members who are improving or stabilized in hospice are considered for discharge.	LDH has alternative mechanisms to monitor and track these objectives and declines to add new performance measures at this time.
To target improvement in Goal 3, "Facilitate patient-centered, whole person care," HSAG recommended that LDH include performance measures for the PAHPs and PIHP in the quality strategy.	LDH agrees with this recommendation and has made this change in the upcoming Quality Strategy revisions.
To target improvement in Goal 3, "Facilitate patient-centered, whole person care," HSAG recommended that LDH continue to implement a PIP collaboration process for the PAHPs to collaborate on current and future PIPs.	LDH agrees and will incorporate the PAHPs into the MCO PIP process beginning in calendar year (CY) 2026. The PAHPs will use the same submission guidelines and timeline and will also attend quarterly PIP meetings.
To improve programwide performance in support of LDH's quality strategy goals, HSAG recommended that LDH continue to work with the MCEs during PIP and Medicaid Advisory Committee (MAC) meetings to discuss best practices for performance measures. During these discussions, LDH could focus on specific performance	LDH currently works with the MCOs collaboratively during quarterly PIP meetings. LDH works with all MCEs at quarterly MAC meetings. The MAC consists of

EQRO Recommendations for Review Period March 20, 2023–March 19, 2024	LDH Actions
measures in the quality strategy that have not met improvement objectives and target objectives.	MCE chief medical officers. Best practices are discussed frequently. In addition, LDH meets with the MCO CEOs and other support staff during quarterly business reviews to discuss recommendations and best practices.
To improve MCO performance in Goal 6, "Partner with communities to improve population health and address health disparities," HSAG recommended that LDH dedicate time in established meetings with the MCOs to discuss their health equity plans (HEPs) and the progress being made through quality interventions to reduce health disparities.	LDH attends MCO quarterly QAPI Committee meetings, where its HEP components and progress being made toward HEP goals are discussed. LDH also reviews and approves the MCOs' QAPI Plan and related progress reports annually and provides feedback to the MCOs as needed. LDH also provides feedback to the MCOs on their twice-yearly HEP submissions.
To improve programwide performance in support of LDH's quality strategy goals, HSAG recommended that LDH update performance measures in the quality strategy to align with the requirements in the Performance Measure Submission Guide for the MCOs.	LDH agrees. These updates were made in the pending revised Quality Strategy.
To target improvement in Goal 1, "Ensure access to care to meet enrollee needs," HSAG recommended that LDH assess MCO failure to provide NEMT and have the MCOs implement interventions to improve provision of NEMT and ensure it is timely and accessible.	LDH agrees and also assesses MCO failure to provide NEMT and requires the MCOs to implement interventions to improve provision of NEMT and ensure it is timely and accessible.
To improve programwide performance in support of LDH's quality strategy goals, HSAG recommended that LDH assess areas of noncompliance that resulted in an MCO receiving a notice of monetary penalty. This assessment should identify root causes for noncompliance and then work to identify appropriate interventions to eliminate noncompliance and improve performance.	LDH agrees and already assesses areas of noncompliance that resulted in an MCO receiving a notice of monetary penalty, including identifying root causes and planned interventions through a corrective action plan (CAP).
HSAG recommended that LDH report rates for the following measures included in Appendix B of the quality strategy: • *Enrollment by Product Line* • *Language Diversity of Membership* • *Race/Ethnicity Diversity of Membership*	MCOs are already required to report these measures. They are not included on the Medicaid Quality Dashboard because they are statistical in nature and not performance based.

Overview of External Quality Review Findings

This annual EQR technical report includes results of all EQR-related activities for Healthy Blue (HBL) conducted with Louisiana Medicaid managed care throughout SFY 2025.

Validation of Performance Improvement Projects

HBLHBL actively worked on PIPs throughout SFY 2025, and reported CY 2024 performance indicator results for PIP validation in January 2025. HSAG conducted PIP validation activities from February through April 2025. LDH required HBL to conduct PIPs on the following state-mandated topics during SFY 2025:

- *Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees*
- *Behavioral Health Transitions of Care*
- *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*

Validation of Performance Measures

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

Information Systems Capabilities Assessment

Based on a review of the final audit reports (FARs) issued by HBL's certified HEDIS compliance auditor, HSAG found that HBL fully met the standard for all four 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 2024 NCQA national 50th percentile, which served as the benchmark. A total of 44 measures, comprising 185 measure indicators, were selected for analysis. Of the 185 measure indicators, 29 were excluded from comparisons to NCQA national 50th percentile benchmarks: five indicators were excluded from the analysis because they were not reported in Quality Compass for MY 2024; 24 indicators were excluded from the analysis because their rates were not percentages and a percentage point difference could not be determined.

Of the 156 HEDIS measures/measure indicators with an associated benchmark, HBL had 49 indicators that performed greater than the NCQA national 50th percentile benchmark, 66 that performed lower than the NCQA national 50th percentile benchmark, and one indicator that was not compared to the NCQA national 50th percentile benchmark because the reported rate was *Not Applicable (NA)* (i.e., small denominator). Detailed results are shown in Section 3—Validation of Performance Measures.

Assessment of Compliance With Medicaid Managed Care Regulations

During 2025, HSAG reviewed 14 standards which represented all federal standards pursuant to 42 CFR Part 438. HSAG identified opportunities for improved performance and associated recommendations as well as areas requiring corrective actions. For any standard demonstrating less than 100 percent compliance, the MCOs must develop a CAP to address each requirement found to not exhibit full compliance.

Table 1-4—Summary of CR Scores for the Review Period: CY 2024

Standard #	Standard Name	CY 2024	MCO Average Results
I	Enrollment and Disenrollment Requirements and Limitations	100%	85%
II	Member Rights and Confidentiality	96%	99%
III	Member Information	67%	69%
IV	Emergency and Poststabilization Services	92%	99%
V	Adequate Capacity and Availability of Services	57%	52%
VI	Coordination and Continuity of Care	83%	85%
VII	Coverage and Authorization of Services	100%	93%
VIII	Provider Selection	89%	70%
IX	Subcontractual Relationships and Delegation	50%	64%
X	Practice Guidelines	100%	97%
XI	Health Information Systems	100%	96%
XII	Quality Assessment and Performance Improvement	100%	100%
XIII	Grievance and Appeal Systems	86%	90%
XIV	Program Integrity	100%	97%
Total Compliance Score		**88%**	

Validation of Network Adequacy

Provider Directory Validation

LDH paused the provider directory validation (PDV) activity for CY 2024; therefore, the PDV results shown are aggregate results for the Quarter (Q)1 and Q2 CY 2025 activity only. Aggregate Q1 through Q4 results will be presented in the SFY 2026 EQR technical report. HSAG's PDV indicated that, overall, the aggregate Q1 and Q2 provider information maintained and provided by HBL was inaccurate. Table 1-5 provides a summary of the aggregate Q1 and Q2 findings from the study.

Table 1-5—Summary of PDV Findings

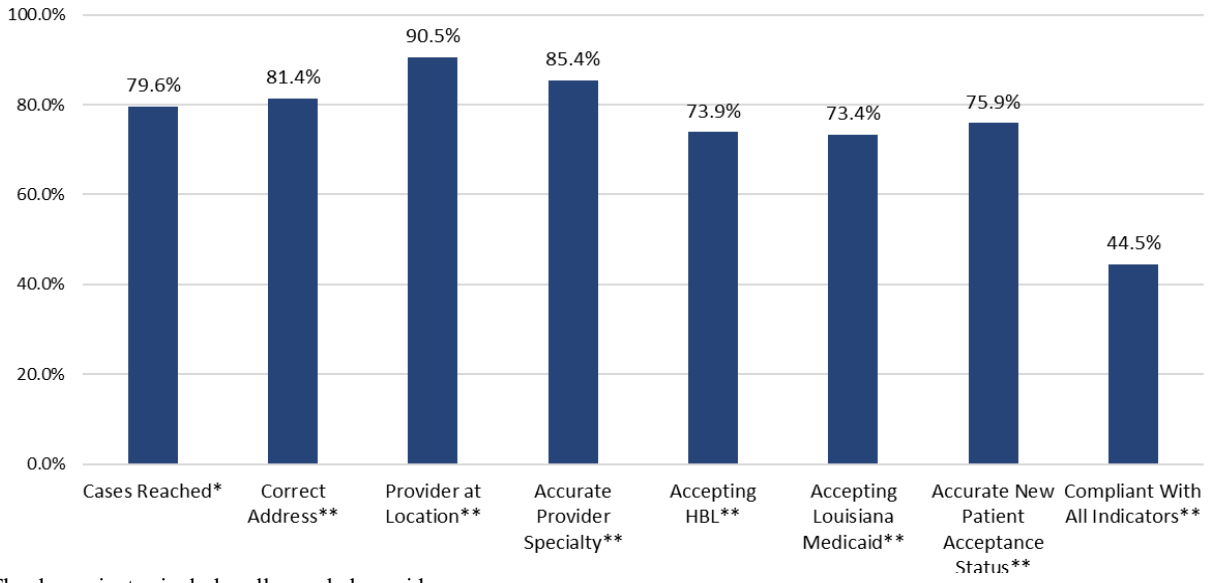
Concerns	Findings
Acceptance of Louisiana Medicaid was low.	Overall, 73.4 percent of providers accepted Louisiana Medicaid.
Acceptance of HBL was low.	Overall, 73.9 percent of providers accepted HBL.
Specialty provider type was incorrect in the provider directory.	Overall, 85.4 percent of providers confirmed the specialty listed in the online provider directory was accurate.
Overall accuracy of the new patient acceptance status was low.[1]	Overall, 75.9 percent of providers confirmed the new patient acceptance status in the online provider directory was correct.
Address information was incorrect.	Overall, 81.4 percent of respondents reported that HBL's provider directory reflected the correct address.

[1]Since sampled cases were not limited to providers accepting new patients, match rates include respondents who confirmed the new patient acceptance status noted in the online provider directory was correct.

While the overall PDV response rate was relatively high at 79.6 percent, once contacted, the offices reported varying degrees of match rates for the online provider directory information. Accuracy of the provider's new patient acceptance status, Louisiana Medicaid acceptance, and HBL acceptance exhibited the lowest match rates.

Figure 1-1 presents the aggregate Q1 and Q2 summary results for all sampled HBL providers.

Figure 1-1—Summary Results for All Sampled HBL Providers



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

HBL's aggregate Q1 and Q2 weighted PDV compliance scores by specialty provider type ranged from 27.3 percent for obstetricians/gynecologists (OB/GYNs) to 66.0 percent for pediatrics.

Provider Access Survey

LDH paused the provider access survey activity for CY 2024; however, HSAG conducted two surveys in CY 2025. The survey results shown in this report are for the first biannual 2025 survey only. HSAG's first provider access survey of 2025 indicated that, overall, the provider information maintained and provided by HBL was inaccurate. Table 1-6 provides a summary of the findings from the study.

Table 1-6—Summary of Provider Access Survey Findings

Concerns	Findings
Affiliation with the sampled provider was low.	Overall, 41.4 percent of the locations confirmed affiliation with the sampled provider.
Acceptance of new patients was low.	Overall, 55.2 percent of providers accepted new patients; however, only providers listed as accepting new patients in the provider data were selected for the survey sample.
Acceptance of Louisiana Medicaid was low.	Overall, 55.2 percent of providers accepted Louisiana Medicaid.
Acceptance of the MCO was low.	Overall, 55.2 percent of providers accepted the requested MCO.
Specialty provider type was inaccurate in the provider data.	Overall, 89.7 percent of providers confirmed the specialty listed in the provider data was accurate.

Table 1-7 presents the first provider access survey call outcomes.

Table 1-7—Provider Access Survey Call Outcomes

Specialty	Able to Contact[1]	Correct Address[2]	Offering Services[2]	Accepting MCO[2]	Accepting Medicaid[2]	Accepting New Patients[2]	Confirmed Provider[2]
Allergists	90.9%	100%	100%	90.0%	90.9%	90.0%	60.0%
Dermatologists	73.3%	95.5%	90.9%	45.5%	45.5%	45.5%	40.9%
Orthopedic Surgeons	63.4%	88.5%	84.6%	50.0%	50.0%	50.0%	34.6%
Total	**70.7%**	**93.1%**	**89.7%**	**55.2%**	**55.2%**	**55.2%**	**41.4%**

[1] The denominator includes all sampled providers.
[2] The denominator includes cases reached.

HBL's weighted first provider access survey compliance scores by specialty provider type ranged from 26.0 percent (orthopedic surgeons) to 54.5 percent (allergists).

NAV Audit

Table 1-8 contains the provider types, at the statewide level, by urbanicity, for which HBL achieved the 100 percent threshold for 100 percent of members to have access.

Table 1-8—HBL Distance Requirements Met by 100 Percent of Members With Access by Provider Type and Urbanicity

Provider Type	Urbanicity
Adult Primary Care Provider (PCP) (Family/General Practice; Internal Medicine)	Rural
Pediatrics (Family/General Practice; Internal Medicine)	Rural
Cardiology	Rural
Endocrinology and Metabolism (Adult)	Rural
Endocrinology and Metabolism (Pediatric)	Rural
Gastroenterology	Rural
Neurology (Adult)	Rural
Neurology (Pediatric)	All
Orthopedics (Adult)	Rural
Orthopedics (Pediatric)	Rural

HSAG assessed HBL's results for statewide provider-to-member ratios by provider type and determined that HBL's statewide results met LDH-established requirements.

HSAG assessed HBL's results for behavioral health providers to determine the accessibility and availability of appointments and determined that HBL met one of the LDH-established performance goals for three reported appointment access standards, as displayed in Table 1-9.

Table 1-9—HBL Appointment Access Standard Compliance Rates for Behavioral Health

Type of Visit	Access/Timeliness Standard	Performance Goal	Compliance Rate
Emergency Care	24 hours, 7 days/week within 1 hour of request	90%	87.4%
Urgent Non-Emergency Behavioral Health Care	48 hours (2 calendar days)	90%	86.6%
Non-Urgent Routine Behavioral Health Care	14 calendar days	70%	86.8%

Encounter Data Validation

Information Systems Review

The IS review provides self-reported qualitative information from HBL about its encounter data processes. Table 1-10 summarizes the strengths and weaknesses from the IS review. Cells with a "✓" indicate a strength, cells with an "X" indicate a weakness, and cells with an "—" indicate neither a noteworthy strength nor a weakness. For detailed descriptions about the strengths and weaknesses, refer to Section 6—Encounter Data Validation.

Table 1-10—Summary of Strengths and Weaknesses From IS Review

IS Review	HBL		Note
Encounter Data Sources and Systems	—		None.
Payment Structures	—		None.
Encounter Data Quality Monitoring			
Processes for Encounters Collected by Subcontractors	✓	X	Strengths were for dental, NEMT, palliative care, and vision encounters. Weakness was for pharmacy encounters.
Quality Monitoring on Encounters Collected by Subcontractors	✓	X	Strengths were for NEMT, and vision encounters and weaknesses were for palliative care and pharmacy encounters.
Quality Monitoring on Encounters Collected by HBL	—		None.
% of Encounters Initially Rejected and Not Yet Accepted by LDH	✓	X	Strength was for NEMT, pharmacy, and vision encounters. Weakness was for professional (i.e., non-subcontractor) encounters.

Administrative Profile

The administrative profile analyzes LDH's encounter data, for HBL, for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Table 1-11 summarizes the strengths and weaknesses stratified by encounter type. Cells with a "✓" indicate a strength, cells with an "X" indicate a weakness, and cells with an "—" indicate neither a noteworthy strength nor a weakness. For detailed descriptions about the strengths and weaknesses, refer to Section 6—Encounter Data Validation.

Table 1-11—Summary of Strengths and Weaknesses From Administrative Profile

Administrative Profile	Professional	Institutional	Dental	Pharmacy
Encounter Data Completeness				
Monthly Encounter Volume per 1,000 MM	—	—	—	—
Monthly Payment Amount PMPM	—	—	—	—
TPL Payment Amount PMPM	—	—	—	—
% of Duplicate Encounters	✓	✓	X	✓
Encounter Data Timeliness				
Lag Between MCO Payment Date and Received Date by LDH	X	X	—	—
Field-Level Completeness and Accuracy				
% Present	—	—	—	—
% Valid	X	✓	X	X
Encounter Referential Integrity				
Encounter vs Enrollment	—			—
Medical/Dental vs Pharmacy Encounter	—			
Encounter vs Provider	X			X
Encounter Data Logic				
% of Members Who Had an Encounter	—	—	—	—
Member Enrollment Continuity	—	—	—	—

MM = Member Months; PMPM = Per Member Per Month; TPL = Third Party Liability

Consumer Surveys: CAHPS-A and CAHPS-C

HSAG compared HBL's 2025 achievement scores to its corresponding 2024 achievement scores and the 2025 NCQA national averages to determine whether there were statistically significant differences.

Overall, HBL's 2025 general child achievement scores were statistically significantly higher than the 2025 NCQA national averages for *Getting Needed Care* and *Getting Care Quickly*.

Behavioral Health Member Satisfaction Survey

HSAG compared HBL's 2025 achievement scores to the 2025 Healthy Louisiana statewide average (SWA) and 2024 scores to determine whether there were statistically significant differences.

Overall, HBL's 2025 child achievement scores were statistically significantly higher than the 2024 achievement scores for *Rating of Health Plan*, *How Well People Communicate*, *Treatment or Counseling Convenience*, and *Getting Professional Help*. In addition, HBL's 2025 child achievement score was statistically significantly higher than the 2025 Healthy Louisiana SWA for *Rating of Health Plan*. Several measures for the child population had less than 100 respondents. HBL should focus on increasing response rates to the Behavioral Health Member Satisfaction Survey for all its populations.

Case Management Performance Evaluation

During SFY 2025, HSAG conducted a review of the MCO's actions to address CAP findings, as identified during the SFY 2024 reviews.

The MCO demonstrated an opportunity for improvement with elements related to ongoing scheduled CM activities. Specific findings and recommended actions were provided to the MCO through HSAG's CAP process. The MCO successfully completed remediation actions to address the CAP findings, and the CAP was closed in October 2024.

HSAG will assess the MCO's implementation of remediation actions during the SFY 2026 reviews.

Quality Rating System

Figure 1-2 displays the 2025 Health Plan Report Card, which presents the 2025 rating results for each MCO. The 2025 Health Plan Report Card shows that HBL earned 4.0 stars for the Overall Rating. Additionally, HBL earned 4.0 stars for the Patient Experience composite, including 4.5 stars for the Satisfaction with Plan Physicians subcomposite and 4.0 stars for both the Getting Care and Satisfaction with Plan and Plan Services subcomposites, demonstrating strength for HBL in these areas. HBL also earned 5.0 stars for the Equity subcomposite and 4.0 stars for the Other Preventive Services, Diabetes, and Behavioral Health—Access, Monitoring, and Safety subcomposites, demonstrating strength for HBL in these areas. However, HBL earned 2.5 stars and 2.0 stars for the Behavioral Health—Medication Adherence and Heart Disease subcomposites, respectively, demonstrating opportunities for improvement for HBL in these areas.

Figure 1-2—2025 Health Plan Report Card

Issued 07/2025

Healthy Louisiana

2025 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 Equity, 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	★★★★	★★★★
PATIENT EXPERIENCE						
Overall Patient Experience	★★★½	★★★★	★★★★	★★★★	★★★★½	★★★½
Getting care: How easily and quickly did members get appointments, preventive care, tests, and treatments?	★★★	★★★½	★★★★	—	★★★★½	—
Satisfaction with plan physicians: How happy are members with their primary care doctors?	★★★★	★★★★★	★★★★½	★★★★	★★★★½	★★★½
Satisfaction with plan and plan services: How happy are members with their health plan and their overall care?	★★★★	★★★★½	★★★★	★★★★	★★★★½	★★★★
PREVENTION AND EQUITY						
Overall Prevention and Equity	★★★	★★★½	★★★½	★★★	★★★★	★★★½
Children/adolescent well-care: Do children and adolescents receive weight assessments?	★★★	★★★	★★★	★★★★	★★★★	★★★★
Women's reproductive health: Do women receive care before and after their babies are born?	★★	★★½	★★★	★★½	★★★½	★★★½

Continued on next page...

Figure 1-2—2025 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 members receive important cancer screenings?	★★★½	★★★½	★★★	★	★★★★½	★★★½
Equity: Do health plans collect race, ethnicity, and language information from their members?	★★★½	★★★★★	★★★★★	★★★★★	★★★★★	★★★½
Other preventive services: Do members receive important preventive services?	★★★★	★★★★	★★★★	★★★★	★★★★	★★★★
TREATMENT						
Overall Treatment	★★★½	★★★½	★★★	★★★	★★★½	★★★½
Respiratory: Do people with respiratory issues get the services/treatments they need?	★★½	★★½	★★★	★★★½	★★½	★★½
Diabetes: Do people with diabetes get the services/ treatments they need?	★★★★	★★★★½	★★★★	★★★★	★★★½	★★★★
Heart disease: Do people with heart disease get the services/ treatments they need?	★★★	★★★	★★	★★★	★★★★	★★★½
Behavioral health—care coordination: Do people with behavioral health issues get the follow-up care they need?	★★½	★★½	★★★	★★½	★★½	★★½
Behavioral health—medication adherence: Do people with behavioral health issues stay on prescribed medications?	★★★★	★★★	★★½	★★★½	★★★★	★★★★½
Behavioral health—access, monitoring, and safety: Do people on behavioral health medications receive the services/ monitoring they need?	★★★	★★★½	★★★★	★★★	★★★	★★★½

	Aetna Better Health	AmeriHealth Caritas Louisiana	Healthy Blue	Humana Healthy Horizons	Louisiana Healthcare Connections	UnitedHealthcare Community Plan
Reduce low value care: Do members with low back pain receive unnecessary imaging tests?	★★★	★★★	★★★	★★	★★★	★★

*This rating includes all measures in the report card as well as an Accreditation bonus for those MCOs that are NCQA Accredited.

*Insufficient Data indicates that the plan was missing the majority of data for the composite.

*This report card is reflective of data collected between January 2024 and December 2024.

*The categories and measures included in this report card are based on the 2025 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. The Risk-Adjusted Utilization category was removed because changes in the way the data were calculated and reported prevented comparisons to national data. 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 2025 (review period) was the third year that HSAG was contracted as the EQRO for LDH. LDH required the MCOs, including HBL, to carry out PIPs to address five state-mandated topics that were validated during SFY 2025. Table 2-1 summarizes the PIP topics carried out by HBL in SFY 2025.

Table 2-1—SFY 2025 MCO PIP Topics and Targeted Age Groups

PIP Topic	Targeted Age Group
Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees	• No restrictions
Behavioral Health Transitions of Care	• 6 years and older • 13 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, HBL collaborated on improvement strategies, meeting at least quarterly with LDH and other MCOs, throughout the year. HBL 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 HBL at group and one-on-one meetings throughout the contract year.

Table 2-2 summarizes key PIP validation milestones that occurred from July 2024 through June 2025, the end of SFY 2025.

Table 2-2—SFY 2025 MCO PIP Activities

PIP Activities and Milestones	Dates
Monthly collaborative PIP meetings with LDH, the MCOs, and HSAG	July–December 2024
The MCOs submitted Q2 2024 PIP updates	July 2024
The MCOs submitted Q3 2024 PIP updates	October 2024
Quarterly collaborative PIP meetings with LDH, the MCOs, and HSAG	January–June 2025
The MCOs submitted draft PIP reports to HSAG for validation	January 2025
The MCOs submitted Q1 2025 PIP updates	April 2025
HSAG provided draft PIP report validation findings to the MCOs	February 2025
The MCOs submitted final PIP reports to HSAG for validation	March 2025
HSAG provided final PIP validation reports to the MCOs	April 2025

In SFY 2026, HBL will submit draft PIP reports for initial validation in January 2026 and the final PIP reports for final validation in March 2026. HSAG will complete the third annual validation cycle in April 2026.

Validation Results and Confidence Ratings

Table 2-3 summarizes HBL's final PIP validation results and confidence ratings delivered by HSAG in April 2025.

Table 2-3—SFY 2025 PIP Validation Results for HBL

PIP Topic	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees	92%	88%	*Low Confidence*	*Not Assessed*[4]		
Behavioral Health Transitions of Care	71%	78%	*Low Confidence*	100%	100%	*High Confidence*
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	100%	100%	*High Confidence*	33%	100%	*No Confidence*
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	100%	100%	*High Confidence*	100%	100%	*High Confidence*
Screening for HIV Infection	100%	100%	*High Confidence*	33%	100%	*Moderate Confidence*

[1] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[2] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

[4] **Not Assessed**—HSAG did not assess Validation Rating 2 as the MCO reported the baseline data only for the PIP.

Performance Indicator Results

Table 2-4 displays data for HBL's *Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees* PIP.

For Table 2-4 through Table 2-8, gray shaded cells with an — represent data that will be updated in future remeasurement years, and green shaded cells with a + represent any improvement over the baseline results.

Table 2-4—Performance Indicator Results for HBL's *Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees* PIP

Performance Indicator	Baseline (01/01/2024 to 12/31/2024)		Remeasurement 1 (01/01/2025 to 12/31/2025)		Remeasurement 2 (01/01/2026 to 12/31/2026)		Sustained Improvement
Syphilis screening during the first pregnancy examination.	N: 473 D: 984	48.07%	— —	—	— —	—	*Not Assessed*
Syphilis screening during weeks 28 to 32 of pregnancy.	N: 298 D: 695	42.88%	— —	—	— —	—	*Not Assessed*
*Syphilis screening at delivery.**	N: 1 D: 1,006	0.10%	— —	—	— —	—	*Not Assessed*
Syphilis screening at any time during pregnancy or at delivery.	N: 958 D: 1,006	95.23%	— —	—	— —	—	*Not Assessed*
Syphilis screening during the first trimester.	N: 681 D: 707	96.32%	— —	—	— —	—	*Not Assessed*
Syphilis screening during the first trimester for all live births.	N: 708 D: 1,006	70.38%	— —	—	— —	—	*Not Assessed*
Syphilis screening during the third trimester for all live births.	N: 698 D: 1,006	69.38%	— —	—	— —	—	*Not Assessed*

N–Numerator D–Denominator

*The syphilis screening at delivery rate is underreported due to bundled billing.

Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation activities, which occurred between January and March of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-5 displays data for HBL's *Behavioral Health Transitions of Care* PIP.

Table 2-5—Performance Indicator Results for the *Behavioral Health Transitions of Care* PIP

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Remeasurement 2 (01/01/2024 to 12/31/2024)		Sustained Improvement
Follow-Up After Hospitalization for Mental Illness (FUH)—Total, 7 Days	N: 1,183 D: 6,113	19.35%	N: 1,205 D: 6,047	19.93%+	N: 1,610 D: 6,316	25.49%+ ▲	*Not Assessed*
Follow-Up After Hospitalization for Mental Illness (FUH)—Total, 30 Days	N: 2,285 D: 6,113	37.38%*	N: 2,206 D: 6,047	36.48%	N: 2,736 D: 6,316	43.32%+ ▲	*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 7 Days	N: 197 D: 1,070	18.41%	N: 236 D: 1,136	20.77%+	N: 226 D: 1,008	22.42%+ ▲	*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 30 Days	N: 325 D: 1,070	30.37%	N: 405 D: 1,136	35.65%+ ▲	N: 390 D: 1,008	38.69%+ ▲	*Yes*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 7 Days	N: 149 D: 1,597	9.33%	N: 403 D: 2,129	18.93%+ ▲	N: 294 D: 1,743	16.87%+ ▲	*Yes*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 30 Days	N: 234 D: 1,597	14.65%	N: 600 D: 2,129	28.18%+ ▲	N: 455 D: 1,743	26.10%+ ▲	*Yes*

N–Numerator D–Denominator

▲ Designates a statistically significant improvement over baseline results ($p < 0.05$).

*Percentage was calculated from the MCO's reported numerator and denominator. The MCO's reported baseline percentage could not be replicated using the reported numerator and denominator values.

Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation activities, which occurred between January and March of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-6 displays data for HBL's *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years* PIP.

Table 2-6—Performance Indicator Results for the *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years* PIP

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Remeasurement 2 (01/01/2024 to 12/31/2024)		Sustained Improvement
Fluoride varnish application by primary care provider (PCP) for children aged 6–18 months	N: 497 D: 12,112	4.10%	N: 232 D: 33,509	0.69%	N: 67 D: 7,549	0.89%	*Not Assessed*
Fluoride varnish application by PCP for children aged 19 months–2 years	N: 1,233 D: 19,645	6.28%	N: 225 D: 54,200	0.42%	N: 82 D: 17,080	0.48%	*Not Assessed*
Fluoride varnish application by PCP for children aged 3–5 years	N: 1,010 D: 40,446	2.50%	N: 245 D: 122,656	0.20%	N: 62 D: 39,206	0.16%	*Not Assessed*
Fluoride varnish application by PCP for all children aged 6 months–5 years	N: 2,740 D: 72,203	3.79%	N: 702 D: 210,365	0.33%	N: 211 D: 63,835	0.33%	*Not Assessed*

N–Numerator D–Denominator

Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation activities, which occurred between January and March of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-7 displays data for HBL's *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees* PIP.

Table 2-7—Performance Indicator Results for the *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees* PIP

Performance Indicator	Baseline (01/01/2023 to 12/31/2023)		Remeasurement 1 (01/01/2024 to 12/31/2024)		Remeasurement 2 (01/01/2025 to 12/31/2025)		Sustained Improvement
The percentage of women aged 21–64 years who were screened for cervical cancer	N: 32,114 D: 75,714	42.41%	N: 28,449 D: 56,997	49.91% +▲	— —	—	*Not Assessed*

N–Numerator D–Denominator
▲ Designates a statistically significant improvement over baseline results ($p < 0.05$).
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation activities, which occurred between January and March of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-8 displays data for HBL's *Screening for HIV Infection* PIP.

Table 2-8—Performance Indicator Results for the *Screening for HIV Infection* PIP

Performance Indicator	Baseline (01/01/2023 to 12/31/2023)		Remeasurement 1 (01/01/2024 to 12/31/2024)		Remeasurement 2 (01/01/2025 to 12/31/2025)		Sustained Improvement
Persons screened for HIV during the measurement year among pregnant persons or persons with encounters for labor and delivery	N: 8,289 D: 12,391	66.89%	N: 3,208 D: 6,485	49.47%	— —	—	*Not Assessed*
Persons screened for HIV during the measurement year among persons with past or present (injection) drug use	N: 5,469 D: 19,431	28.14%	N: 5,005 D: 20,240	24.73%	— —	—	*Not Assessed*
Persons screened for HIV during the measurement year among persons with risk factors related to sexual mode of transmission	N: 5,764 D: 8,893	64.82%	N: 3,634 D: 5,528	65.74%	— —	—	*Not Assessed*

Performance Indicator	Baseline (01/01/2023 to 12/31/2023)		Remeasurement 1 (01/01/2024 to 12/31/2024)		Remeasurement 2 (01/01/2025 to 12/31/2025)		Sustained Improvement
Persons ever screened for HIV among all others aged 15 to 65 years without a diagnosis of HIV infection	N: 21,728 D: 234,488	9.27%	N: 29,518 D: 281,203	10.50% +▲	— —	—	*Not Assessed*

N–Numerator D–Denominator

▲ Designates a statistically significant improvement over baseline results ($p < 0.05$).

Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation activities, which occurred between January and March of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Interventions

Table 2-9 summarizes HBL's final CY 2024 barriers and interventions.

Table 2-9—Barriers and Interventions Reported by PIP Topic

PIP Topic	Barriers	Interventions
Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees	• Enrollee lack of early pregnancy awareness • Lack of timely prenatal care • MCO unaware of pregnant enrollees	*The MCO had not progressed to initiating interventions in 2024.*
Behavioral Health Transitions of Care	• Enrollees forget to schedule appointments • Providers' lack of resources to schedule timely appointments	• Enhance hospital-to-MCO workflow for notification of hospital and ED admissions, discharges, and transfers • Text message campaign to provide assistance with scheduling follow-up appointments
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	• Lack of enrollee education and access to appointments • Lack of provider education	• Community outreach events for enrollees • Provider outreach and education using care gap report, American Academy of Pediatrics (AAP) guidelines on fluoride use to prevent dental caries, LDH bulletin on fluoride varnish training reimbursement and course requirements, and Well-Ahead Louisiana resources

PIP Topic	Barriers	Interventions
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	• Lack of provider awareness of Centers for Disease Control and Prevention (CDC) screening guidelines and recommendations • Lack of enrollee knowledge of the screening recommendations	• Face-to-face meetings with PCPs and OB/GYNs to provide education and share gaps in care reports • Enrollee outreach to provide scheduling assistance for a preventive PCP or OB/GYN visit • Educational text campaign for enrollees not in CM to provide information on screening guidelines
Screening for HIV Infection	• Enrollee fear of screening results • Lack of enrollee awareness on importance of HIV screening and CDC recommendations	• Developed an educational HIV screening outreach campaign for enrollees in CM • Worked with a vendor to carry out an educational HIV screening text campaign for enrollees not in CM • Collaborated with analytical staff to create an HIV screening gaps in care report for provider distribution

MCO Strengths, Opportunities for Improvement, and Recommendations

For HBL, the following strengths were identified:

- The MCO carried out interventions for four PIPs that had the potential to address identified barriers and improve performance indicator results. **[Quality]**
- The MCO collected, analyzed, and reported intervention-specific effectiveness data to monitor the progress and impact of interventions throughout the most recent measurement period for all PIPs. **[Quality]**
- For three of the four PIPs (*Behavioral Health Transitions of Care*, *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees*, and *Screening for HIV Infection*) assessed for achieving significant improvement, at least some of HBL's reported performance indicator results demonstrated statistically significant improvement from baseline to the most recent remeasurement. **[Quality, Timeliness, and Access]**
- For two of the PIPs (*Behavioral Health Transitions of Care* and *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees*) assessed for achieving significant improvement, all of HBL's reported performance indicator results demonstrated statistically significant improvement from baseline to the most recent remeasurement. **[Quality, Timeliness, and Access]**

For HBL, the following opportunities for improvement were identified:

- For one PIP, *Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees*, HBL's documented population description did not align with the statewide PIP design. **[Quality]**
- For one PIP, *Behavioral Health Transitions of Care*, HBL's narrative interpretation of Remeasurement 2 indicator results did not explain why HBL revised the performance indicator results in the final PIP documentation. **[Quality]**
- For one PIP (*Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years*) assessed for achieving significant improvement, none of HBL's reported indicator results demonstrated statistically significant improvement from baseline to the most recent remeasurement, and for one other PIP (*Screening for HIV Infection*) some but not all of HBL's reported indicator results demonstrated statistically significant improvement from baseline to the most recent remeasurement. **[Quality, Timeliness, and Access]**

For HBL, the following recommendations were identified:

- HBL should align the documented population description for each PIP with the statewide PIP design documented in the PIP charter, and the description should remain unchanged for the duration of the project, to ensure comparability of results. **[Quality]**
- HBL should ensure that the calculation of performance indicator results is based on data pulled at the same time for each annual measurement period to ensure that results are comparable across measurement periods. If HBL must revise previously reported performance indicator results, an explanation for the revisions should be reported as part of the narrative interpretation of results to ensure an accurate interpretation of changes in results over time. **[Quality]**
- To facilitate significant outcomes improvement for all PIPs, the MCO should review intervention evaluation results to determine if each intervention is having the desired impact and how interventions can be revised to increase effectiveness. The MCO should also revisit MCO-specific barrier analyses for each PIP to evaluate whether additional barriers need to be addressed by new or revised interventions to drive outcomes improvement. **[Quality, Timeliness, and Access]**

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 the CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 1).[5]

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.

[5] 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 12, 2025.

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 the CMS EQR 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)**
   - *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.
   - *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.
   - *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*.
   - *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)**
   - *High Confidence*: All performance indicators demonstrated *statistically significant* improvement over the baseline.
   - *Moderate Confidence*: One of the three scenarios below occurred:
     - All performance indicators demonstrated improvement over the baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over the baseline.
     - All performance indicators demonstrated improvement over the baseline, **and** none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
     - Some but not all performance indicators demonstrated improvement over baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over baseline.
   - *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.
   - *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 opportunities for improvement in each domain of quality, timeliness, and access to 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 the CMS EQR 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 2-10.

Table 2-10—Assignment of PIPs to the Quality, Timeliness, and Access Domains

PIP Topic	Quality	Timeliness	Access
Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees	✓	✓	✓
Behavioral Health Transitions of Care	✓	✓	✓
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 Infection	✓	✓	✓

3. Validation of Performance Measures

Results

Information Systems Capabilities Assessment

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 HBL's independent certified HEDIS compliance auditor, HSAG found that HBL fully met the standard for all four of the applicable NCQA IS standards.

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

Table 3-1—HBL Compliance With IS Standards—MY 2022, MY 2023, and MY 2024 Comparison

IS Standard	MY 2022	MY 2023	MY 2024
IS R—Data Management and Reporting (formerly IS 6.0, IS 7.0)	Met	Met	Met
IS C—Clinical and Care Delivery Data (formerly IS 5.0)	Met	Met	Met
IS M—Medical Record Review Processes (formerly IS 4.0)	Met	Met	Met
IS A—Administrative Data (formerly IS 1.0, IS 2.0, IS 3.0)	Met	Met	Met

Performance Measures

In SFY 2025 (review period), LDH required each contracted MCO to collect and report on 44 HEDIS measures, which included 185 total measure indicators for HEDIS MY 2024 specified in the provider agreement. The measurement set included nine incentive measures: seven HEDIS and two non-HEDIS incentive measures. Table 3-2 through Table 3-4 display 179 of the 185 HEDIS measure indicators required by LDH, excluding six CAHPS indicators also required by LDH.

Table 3-2 through Table 3-5 display a summary of HBL's HEDIS measure performance. Red shaded cells with a **^** indicate that the measure fell below the NCQA national 50th percentile, while green shaded cells with a **+** indicate that the measure was at or above the NCQA national 50th percentile.

Table 3-2—HBL HEDIS Effectiveness of Care Performance Measures—MY 2022, MY 2023, and MY 2024 Comparison

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
Follow-Up After Hospitalization for Mental Illness				
Within 7 Days of Discharge—Total	20.35%^	23.27%^	25.62%^	22.05%^
Within 30 Days of Discharge[I]—Total	39.26%^	41.13%^	43.61%^	42.18%^
Follow-Up After Emergency Department Visit for Mental Illness				
Within 7 Days of Discharge—Total	21.35%^	24.63%^	23.00%^	23.02%^
Within 30 Days of Discharge[I]—Total	36.44%^	41.69%^	39.20%^	38.77%^
Follow-Up After Emergency Department Visit for Substance Use				
Within 7 Days of Discharge—Total	16.87%^	13.28%^	16.88%^	15.66%^
Within 30 Days of Discharge[I]—Total	27.70%^	21.45%^	26.12%^	25.41%^
Follow-Up After High-Intensity Care for Substance Use Disorder (SUD)				
Within 7 Days of Visit or Discharge—Total	—	—	62.84%+	59.23%+
Within 30 Days of Visit or Discharge—Total	—	—	73.36%+	70.77%+
Plan All-Cause Readmissions[B]				
*Observed Readmissions (Numerator/Denominator)**	9.76%	9.32%	9.00%	10.05%
Expected Readmissions Rate	9.56%	9.40%	8.41%	8.53%
*Observed-to-Expected (O/E) Ratio (Observed Readmissions/Expected Readmissions)**	1.0214^	0.9911^	1.0703+	1.1771^
Depression Screening and Follow-Up for Adolescents and Adults—Electronic Clinical Data System (ECDS)				
Depression Screening—Total	0.00%	NR	0.37%^	3.31%^
Follow-Up on Positive Screen—Total	0.00%	NR	43.86%^	73.57%+
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	82.84%+	84.08%+	85.23%+	85.11%+
Diabetes Monitoring for People With Diabetes and Schizophrenia	66.89%^	72.14%+	73.75%^	75.60%+
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	73.42%^	79.75%+	79.07%^	82.56%+
Metabolic Monitoring for Children and Adolescents on Antipsychotics—ECDS				
Blood Glucose Testing—Total	—	—	55.33%^	53.68%^
Cholesterol Testing—Total	—	—	30.90%^	28.43%^
Blood Glucose and Cholesterol Testing—Total	—	—	29.47%^	27.26%^
Lead Screening in Children	62.86%+	64.73%+	70.56%+	70.87%+
Colorectal Cancer Screening[I]—ECDS	—	—	38.96%^	45.44%+

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
Body Mass Index (BMI) Percentile Documentation—Total	77.13%^	76.89%^	83.70%^	86.26%+
Counseling for Nutrition—Total	62.53%^	64.23%^	71.78%^	70.74%^
Counseling for Physical Activity—Total	55.96%^	59.61%^	67.15%^	66.86%^
HIV Viral Load Suppression[I]	80.86%	83.48%	81.52%	82.24%
Low-Risk Cesarean Delivery (Cesarean Rate for Low-Risk First Birth Women)[*,I]	26.97%	26.32%	26.95%	26.37%
Chlamydia Screening in Women				
Total	60.72%+	64.50%+	65.63%+	66.43%+
Controlling High Blood Pressure[I]	53.77%^	56.93%^	61.31%^	65.03%^
Statin Therapy for Patients With Cardiovascular Disease				
Received Statin Therapy—Total	80.54%+	83.00%+	82.46%+	82.62%+
Statin Adherence 80%—Total	63.87%^	57.89%^	60.06%^	71.14%^
Glycemic Status Assessment for Patients With Diabetes				
Glycemic Status >9.0%[,I]*	37.47%+	30.66%+	30.66%^	28.35%+
Glycemic Status <8.0%	53.77%+	62.29%+	63.75%+	64.86%+
Eye Exam for Patients With Diabetes	55.23%+	55.47%+	58.39%+	59.29%+
Blood Pressure Control for Patients With Diabetes	64.48%+	63.50%^	67.64%^	69.65%^
Pharmacotherapy for Opioid Use Disorder	22.62%^	24.55%^	21.81%^	34.64%+
Initiation and Engagement of SUD Treatment				
Initiation of SUD Treatment—Total	65.35%+	58.91%+	60.07%+	59.26%+
Engagement of SUD Treatment—Total	28.52%+	25.02%+	27.41%+	27.37%+
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	65.71%+	64.93%+	65.35%+	64.29%+
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	47.03%^	50.89%^	51.60%^	61.49%^
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—ECDS				
Initiation Phase	—	—	46.56%^	45.46%^
Continuation and Maintenance Phase	—	—	62.17%+	52.86%^
Antidepressant Medication Management				
Effective Acute Phase Treatment	55.41%^	55.53%^	52.42%^	60.88%^
Effective Continuation Phase Treatment	37.51%^	37.60%^	35.38%^	45.44%^

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
Appropriate Treatment for Children With Upper Respiratory Infection (URI)	79.93%^	80.11%^	81.85%^	81.90%^
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	52.80%^	52.78%^	54.44%^	52.98%^
Use of Imaging Studies for Low Back Pain	71.66%^	69.31%^	68.56%^	68.86%^
Cervical Cancer Screening[I]	53.37%^	50.61%^	53.04%^	57.33%^
Asthma Medication Ratio				
5–11 Years	—	80.20%+	68.76%+	65.73%^
12–18 Years	—	78.00%+	73.37%+	63.52%^
19–50 Years	—	76.56%+	74.38%+	63.12%+
51–64 Years	—	75.98%+	76.18%+	65.14%+
Total	—	77.55%+	73.03%+	64.22%+
Appropriate Testing for Pharyngitis				
3–17 Years	—	—	83.71%^	82.73%^
18–64 Years	—	—	79.74%+	78.29%+
65 Years and Older	—	—	NA	60.61%+
Total	—	—	82.32%^	81.44%^
Topical Fluoride for Children				
1–2 Years	—	5.60%	7.88%	6.04%
3–4 Years	—	7.93%	10.58%	7.59%
Total	—	6.79%	9.13%	6.82%

[*] Indicates a lower rate is desirable.
[B] Indicates a break in trending between the most recent year and the prior year.
[I] Incentive Measure.
For HEDIS measures: *NA* indicates that the denominator was too small (i.e., less than 30) to report a valid rate, *NR* indicates that the MCO did not report the measure, and *NQ* indicates that the MCO was not required to report the measure.
— is presented for measures that were not reported by the MCOs in MY 2022 and/or MY 2023 and indicates that MY 2022 and/or MY 2023 rates are not available for those measures.

Table 3-3—HBL HEDIS Accessibility/Availability of Care Performance Measures—MY 2022, MY 2023, and MY 2024 Comparison

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	69.98%+	68.95%^	73.88%^	75.53%^
45–64 Years	79.52%^	78.32%^	81.51%^	83.48%+
65 Years and Older	75.56%^	69.42%^	73.93%^	77.97%^
Total	72.84%^	71.81%^	76.34%^	78.09%+

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	85.07%+	82.97%^	84.18%^	83.83%^
Postpartum Care	78.47%+	78.59%^	81.02%^	81.62%^

Table 3-4—HBL HEDIS Use of Services and Health Plan Descriptive Information Performance Measures—MY 2022, MY 2023, and MY 2024 Comparison

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
Well-Child Visits in the First 30 Months of Life				
First 15 Months	58.59%+	62.83%+	62.19%^	64.83%+
15 Months–30 Months	62.53%^	70.09%+	73.24%+	72.42%+
Child and Adolescent Well-Care Visits				
3–11 Years	51.96%^	55.27%^	60.25%^	60.45%^
12–17 Years	47.63%^	50.25%^	54.36%^	56.11%+
18–21 Years	24.80%+	26.05%^	30.36%^	32.68%+
Total	45.52%^	48.13%^	53.52%^	54.58%^
Antibiotic Utilization for Respiratory Conditions				
3 Months–17 Years	—	—	33.68%+	34.05%+
18–64 Years	—	—	29.12%+	29.16%+
65 Years and Older	—	—	19.65%+	20.07%+
Total	—	—	31.73%+	32.26%+
Enrollment by Product Line				
Less than 1 Year	—	7,727	7,520	37,522
1–4 Years	—	25,724	24,697	141,537
5–9 Years	—	29,59	28,293	182,737
10–14 Years	—	27,981	26,286	176,938
15–17 Years	—	17,499	16,425	109,211
18–19 Years	—	10,822	9,295	60,260
20–24 Years	—	29,150	21,093	111,685
25–29 Years	—	29,039	21,675	93,717
30–34 Years	—	28,245	21,241	92,906
35–39 Years	—	23,917	18,438	82,628
40–44 Years	—	20,891	16,095	72,625
45–49 Years	—	15,779	12,437	56,774

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
50–54 Years	—	14,108	10,577	48,838
55–59 Years	—	13,439	10,437	48,549
60–64 Years	—	12,677	10,358	48,032
65–69 Years	—	507	315	1,704
70–74 Years	—	142	124	620
75–79 Years	—	67	63	306
80–84 Years	—	53	49	200
85–89 Years	—	NA	NA	86
90 Years and Older	—	NA	NA	65
Unknown	—	NA	NA	NA
Total	—	307,397	255,446	1,366,940
Language Diversity of Membership				
Spoken Language Preferred for Health Care—Health Plan	—	100.00%+	98.09%+	51.08%+
Spoken Language Preferred for Health Care—CMS/State	—	0.00%^	1.91%^	47.98%+
Spoken Language Preferred for Health Care—Other Third-Party	—	0.00%+	0.00%+	0.94%+
Preferred Language for Written Materials—Health Plan	—	100.00%+	99.32%+	51.25%+
Preferred Language for Written Materials—CMS/State	—	0.00%^	0.68%+	24.75%+
Preferred Language for Written Materials—Other Third-Party	—	0.00%^	0.00%^	24.00%+
Other Language Needs—Health Plan	—	100.00%+	100.00%+	46.39%+
Other Language Needs—CMS/State	—	0.00%+	0.00%+	20.61%+
Other Language Needs—Other Third-Party	—	0.00%^	0.00%^	33.00%+
Spoken Language Preferred for Health Care—Percent English	—	98.00%+	98.53%+	97.19%+
Spoken Language Preferred for Health Care—Percent Non-English	—	1.74%^	1.38%^	1.86%^
Spoken Language Preferred for Health Care—Percent Declined	—	0.00%+	0.00%+	0.00%+
Spoken Language Preferred for Health Care—Percent Unknown	—	0.26%^	0.09%^	0.95%^
Language Preferred for Written Materials—Percent English	—	98.00%+	98.53%+	65.15%^
Language Preferred for Written Materials—Percent Non-English	—	1.74%^	1.38%^	1.31%^

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
Language Preferred for Written Materials—Percent Declined	—	0.00%+	0.00%+	0.00%+
Language Preferred for Written Materials—Percent Unknown	—	0.26%^	0.09%^	33.54%+
Other Language Needs—Percent English	—	0.00%+	0.00%+	37.76%+
Other Language Needs—Percent Non-English	—	0.00%+	0.00%+	0.57%+
Other Language Needs—Percent Declined	—	0.00%+	0.00%+	0.00%+
Other Language Needs—Percent Unknown	—	100.00%+	100.00%+	61.67%^
Race/Ethnicity Diversity of Membership				
Race—Health Plan	—	93.30%+	95.47%+	44.31%+
Race—CMS/State	—	0.05%^	0.03%^	41.33%^
Race—Other Direct	—	0.00%+	0.00%+	1.69%+
Race—Direct Total	—	93.35%+	95.50%+	87.33%+
Race—Indirect Total	—	3.18%+	3.05%+	1.14%+
Race—Unknown Total	—	3.47%^	1.45%^	11.53%^
Ethnicity—Health Plan	—	92.20%+	99.60%+	35.42%+
Ethnicity—CMS/State	—	0.00%^	0.00%^	36.27%+
Ethnicity—Other Direct	—	0.00%+	0.00%+	9.66%+
Ethnicity—Direct Total	—	92.20%+	99.60%+	81.35%^
Ethnicity—Indirect Total	—	7.61%+	0.35%+	4.26%+
Ethnicity—Unknown Total	—	0.19%^	0.04%^	14.39%+
Race: White—Ethnicity: Hispanic or Latino	—	0.23%^	0.09%^	3.01%+
Race: White—Ethnicity: Not Hispanic or Latino	—	41.96%+	42.15%+	32.21%+
Race: White—Ethnicity: Asked but No Answer	—	0.02%+	0.02%+	0.01%+
Race: White—Ethnicity: Unknown	—	0.05%^	0.00%^	2.86%+
Race: White—Ethnicity: Total	—	42.27%^	42.27%^	38.09%^
Race: Black or African American—Ethnicity: Hispanic or Latino	—	0.07%^	0.02%^	3.34%+
Race: Black or African American—Ethnicity: Not Hispanic or Latino	—	44.01%+	46.44%+	37.02%+
Race: Black or African American—Ethnicity: Asked but No Answer	—	0.01%+	0.01%+	0.00%+
Race: Black or African American—Ethnicity: Unknown	—	0.03%^	0.01%^	3.99%+
Race: Black or African American—Ethnicity: Total	—	44.12%+	46.49%+	44.36%+

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
Race: American Indian or Alaska Native—Ethnicity: Hispanic or Latino	—	0.01%^	0.00%^	0.09%+
Race: American Indian or Alaska Native—Ethnicity: Not Hispanic or Latino	—	0.75%+	0.78%+	0.47%+
Race: American Indian or Alaska Native—Ethnicity: Asked but No Answer	—	0.00%+	0.00%+	0.00%+
Race: American Indian or Alaska Native—Ethnicity: Unknown	—	0.00%^	0.00%^	0.21%+
Race: American Indian or Alaska Native—Ethnicity: Total	—	0.76%+	0.78%+	0.77%+
Race: Asian—Ethnicity: Hispanic or Latino	—	0.07%+	0.00%^	0.12%+
Race: Asian—Ethnicity: Not Hispanic or Latino	—	5.96%+	4.99%+	1.53%+
Race: Asian—Ethnicity: Asked but No Answer	—	0.00%+	0.00%+	0.00%+
Race: Asian—Ethnicity: Unknown	—	0.00%^	0.00%^	0.40%+
Race: Asian—Ethnicity: Total	—	6.03%+	5.00%+	2.04%+
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Hispanic or Latino	—	0.00%+	0.00%^	0.01%^
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Not Hispanic or Latino	—	0.02%+	0.04%^	0.02%^
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Asked but No Answer	—	0.00%+	0.00%+	0.00%+
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Unknown	—	0.00%+	0.00%+	0.01%+
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Total	—	0.02%^	0.04%^	0.04%^
Race: Some Other Race—Ethnicity: Hispanic or Latino	—	0.22%+	0.05%^	0.53%+
Race: Some Other Race—Ethnicity: Not Hispanic or Latino	—	3.10%+	3.91%+	1.30%+
Race: Some Other Race—Ethnicity: Asked but No Answer	—	0.00%+	0.00%+	0.00%+
Race: Some Other Race—Ethnicity: Unknown	—	0.01%^	0.00%^	0.70%+
Race: Some Other Race—Ethnicity: Total	—	3.33%+	3.97%+	2.54%+
Race: Two or More Races—Ethnicity: Hispanic or Latino	—	0.00%+	0.00%+	0.27%+
Race: Two or More Races—Ethnicity: Not Hispanic or Latino	—	0.00%+	0.00%+	0.13%+
Race: Two or More Races—Ethnicity: Asked but No Answer	—	0.00%+	0.00%+	0.00%+

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
Race: Two or More Races—Ethnicity: Unknown	—	0.00%+	0.00%+	0.24%+
Race: Two or More Races—Ethnicity: Total	—	0.00%+	0.00%+	0.64%+
Race: Unknown—Ethnicity: Hispanic or Latino	—	0.35%^	0.09%^	0.99%^
Race: Unknown—Ethnicity: Not Hispanic or Latino	—	3.03%+	1.33%+	3.02%+
Race: Unknown—Ethnicity: Asked but No Answer	—	0.00%+	0.00%+	1.54%+
Race: Unknown—Ethnicity: Unknown	—	0.09%^	0.03%^	5.98%+
Race: Unknown—Ethnicity: Total	—	3.47%^	1.45%^	11.53%^
Race: Total—Ethnicity: Hispanic or Latino	—	0.94%^	0.27%^	8.36%^
Race: Total—Ethnicity: Not Hispanic or Latino	—	98.83%+	99.65%+	75.70%+
Race: Total—Ethnicity: Asked but No Answer	—	0.04%+	0.04%+	1.55%+
Race: Total—Ethnicity: Unknown	—	0.19%^	0.04%^	14.39%+
Race: Total—Ethnicity: Total	—	100.00%+	100.00%+	100.00%+
Race: Asked but No Answer—Ethnicity: Hispanic or Latino	—	0.00%+	0.00%+	0.00%+
Race: Asked but No Answer—Ethnicity: Not Hispanic or Latino	—	0.00%+	0.00%+	0.00%+
Race: Asked but No Answer—Ethnicity: Asked but No Answer	—	0.00%+	0.00%+	0.00%+
Race: Asked but No Answer—Ethnicity: Unknown	—	0.00%+	0.00%+	0.00%+
Race: Asked but No Answer—Ethnicity: Total	—	0.00%+	0.00%+	0.00%+

* Indicates a lower rate is desirable.
For HEDIS measures: *NA* indicates that the denominator was too small (i.e., less than 30) to report a valid rate, *NR* indicates that the MCO did not report the measure, and *NQ* indicates that the MCO was not required to report the measure.
— is presented for measures that were not reported by the MCOs in MY 2022 and/or MY 2023, and indicates that MY 2022 and/or MY 2023 rates are not available for those measures.

Table 3-5—HBL HEDIS Performance Measure Summary—MY 2022, MY 2023, and MY 2024 Comparison

Measure Status	MY 2022	MY 2023	MY 2024*
≥ NCQA National 50th Percentile Benchmark	30	162	78
< NCQA National 50th Percentile Benchmark	48	112	72
NCQA National Benchmark Unavailable	11	12	5
Total	**89**	**286**	**155**

* The "Total" row presents the count of all HEDIS measure indicators that could be reported by HBL for MY 2024, excluding indicators with a rate of *NA* (i.e., denominator too small for a valid rate), *NB* (i.e., MCO did not provide the health benefit), *NR* (i.e., MCO did not report on the indicator), or *NQ* (i.e., MCO was not required to report the indicator). The "≥ NCQA National 50th Percentile Benchmark," "< NCQA National 50th Percentile Benchmark," and "NCQA National Benchmark Unavailable" rows present the count of indicators with reportable rates, for each MCO, that met the comparison criteria. For MY 2024, measure indicators with a rate of *NA* (i.e., denominator too small for a valid rate), *NR* (i.e., MCO did not report on the indicator), or *NQ* (i.e., MCO was not required to report the indicator) are excluded from the comparison rows because their results are not comparable to NCQA benchmarks.

MCO Strengths, Opportunities for Improvement, and Recommendations

For HBL, the following strengths were identified:

- HBL'S rates on the *Follow-Up After High-Intensity Care for SUD* measure indicators were above the NCQA national 50th percentile benchmark for MY 2024. These results suggest that HBL was effective in coordinating with providers to ensure that adolescent and adult members diagnosed with SUD who were discharged from an inpatient setting or visited a residential treatment or withdrawal management center received timely and adequate follow-up care to manage their conditions. **[Quality, Timeliness, and Access]**
- HBL's rate on the *Plan All-Cause Readmissions—O/E Ratio* measure indicator was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that HBL was effective with facilitating appropriate post-discharge planning and care coordination. **[Quality]**
- HBL's rate on the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that HBL was effective in ensuring that adult members on antipsychotics were screened for diabetes, resulting in positive health outcomes for this population. **[Quality]**
- HBL's rate on the *Lead Screening in Children* measure was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that HBL was effective in ensuring that children under 2 years of age were adequately receiving lead blood testing to ensure they maintained limited exposure to lead. **[Quality]**
- HBL's rate on the *Chlamydia Screening in Women—Total* measure indicator was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that HBL effectively coordinated with providers to facilitate annual follow-ups with and screening of sexually active members. **[Quality]**
- HBL's rate on the *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%* measure indicator was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that HBL effectively coordinated with providers to help members control their blood sugar levels, reducing the risk of complications. **[Quality]**
- HBL's rate on the *Eye Exam for Patients With Diabetes* measure was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that HBL effectively coordinated with providers to ensure that adult members with diabetes received a retinal eye exam to screen for diabetic retinal disease. **[Quality]**
- HBL's rates on the *Initiation and Engagement of SUD Treatment* measure indicators were above the NCQA national 50th percentile benchmark for MY 2024. These results suggest that HBL effectively coordinated with providers to initiate treatment for members with a new SUD episode and engaged these members in subsequent SUD services or medications within 34 days of their visit to initiate SUD treatment. **[Quality, Timeliness, and Access]**
- HBL's rate on the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* measure was above the NCQA national 50th percentile benchmark for MY 2024.

This result suggests that HBL effectively coordinated with providers to ensure the use of psychosocial care as first-line treatment for children and adolescents recently started on antipsychotic medications. **[Quality]**

- HBL's rates on the *Asthma Medication Ratio* measure indicators were above the NCQA national 50th percentile benchmark for MY 2024. These results suggest that HBL effectively coordinated with providers to help members with persistent asthma manage this treatable condition. **[Quality]**
- HBL's rates on *the Antibiotic Utilization for Respiratory Conditions* measure indicators were above the NCQA national 50th percentile benchmark for MY 2024. These results suggest that HBL was effective in coordinating with providers to ensure that members diagnosed with a respiratory condition were not inappropriately dispensed an antibiotic. **[Quality]**

For HBL, the following opportunities for improvement were identified:

- HBL's rates on the *Follow-Up After Hospitalization for Mental Illness* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest that HBL has room for improvement in its coordination with providers to ensure that members hospitalized for mental health issues receive adequate follow-up care after hospital discharge to reduce the risk of re-hospitalization. **[Quality, Timeliness, and Access]**
- HBL's rates on the *Follow-Up After Emergency Department Visit for Mental Illness* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. Additionally, HBL's rates on the *Follow-Up After Emergency Department Visit for Substance Use* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest that HBL has room for improvement with properly managing the care of patients discharged after an ED visit for mental illness and for substance use, as they are vulnerable after release. **[Quality, Timeliness, and Access]**
- HBL's rates on the *Depression Screening and Follow-Up for Adolescents and Adults—ECDS* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest that HBL has room for improvement in coordinating with providers to ensure adolescent and adult members are screened for depression and have timely follow-up care after a positive depression screen. **[Quality]**
- HBL's rate on the *Diabetes Monitoring for People With Diabetes and Schizophrenia* measure was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that HBL has room for improvement in ensuring that adult members on antipsychotics have their diabetes monitored to promote positive health outcomes for this population. **[Quality]**
- HBL's rate on the *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* measure was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that HBL has room for improvement in ensuring that adult members with cardiovascular disease and schizophrenia who are on antipsychotics have their cholesterol monitored to promote positive health outcomes. **[Quality]**
- HBL's rates on the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—ECDS* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These

results suggest that HBL has room for improvement in its coordination with providers to effectively monitor blood glucose and cholesterol in child and adolescent members on antipsychotics. **[Quality]**

- HBL's rate on the *Colorectal Cancer Screening—ECDS* measure was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that HBL has room for improvement in ensuring that members 45 to 75 years of age have appropriate screening for colorectal cancer. **[Quality]**
- HBL's rates on the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest that HBL has room for improvement in coordinating with providers to ensure that child and adolescent members are having their weight and BMI monitored, and are receiving appropriate counseling to reduce the risk for obesity and prevent adverse health outcomes. **[Quality]**
- HBL's rate on the *Controlling High Blood Pressure* measure was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that HBL has room for improvement in coordinating with providers to help members manage their blood pressure, reducing their risk for heart disease and stroke. **[Quality]**
- HBL's rate on the *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status >9.0%* measure indicator was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that HBL has room for improvement in coordinating with providers to help members control their blood sugar levels, reducing the risk of complications. **[Quality]**
- HBL's rate on the *Blood Pressure Control for Patients With Diabetes* measure was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that HBL has room for improvement in coordinating with providers to help adult members with diabetes adequately control their blood pressure. **[Quality]**
- HBL's rate on the *Pharmacotherapy for Opioid Use Disorder* measure was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that HBL has room for improvement in coordinating with providers to engage members with opioid use disorder in continuous treatment with pharmacotherapy to increase the chance for positive outcomes. **[Quality]**
- HBL's rate on the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measure was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that HBL has room for improvement in coordinating with providers to ensure that members with schizophrenia or schizoaffective disorder are dispensed and remain on an antipsychotic medication for at least 80 percent of their treatment period. **[Quality]**
- HBL's rates on the *Antidepressant Medication Management* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest that HBL has room for improvement in coordinating with providers to treat adult members diagnosed with major depression with antidepressant medication and help members remain on antidepressant medication for at least 84 days (Acute Phase) and through 180 days (Continuation Phase). **[Quality]**
- HBL's rate on the *Appropriate Treatment for Children With URI* measure was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that HBL has room for

improvement with ensuring that a diagnosis of URI does not result in an antibiotic dispensing event for members. **[Quality]**

- HBL's rate on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that HBL has room for improvement with ensuring that providers effectively prevent or minimize the prescribing of antibiotics for members with a diagnosis of bronchitis or bronchiolitis. **[Quality]**
- HBL's rate on the *Use of Imaging Studies for Low Back Pain* measure was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that HBL has room for improvement with ensuring that providers properly order imaging studies. **[Quality]**
- HBL's rate on the *Cervical Cancer Screening* measure was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that HBL has room for improvement in coordinating with providers to ensure that women ages 21 to 64 years receive appropriate, early detection cancer screening. **[Quality]**
- HBL's rates on the *Adults' Access to Preventive/Ambulatory Health Services* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest that HBL has room for improvement in coordinating with PCPs to ensure that adult members are engaging in preventive or ambulatory visits to manage their health and avoid adverse outcomes. **[Quality and Access]**
- HBL's rates on the *Prenatal and Postpartum Care* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest that HBL has room for improvement in coordinating with providers to ensure that members receive timely and adequate prenatal and postpartum care, in alignment with guidance provided by the AAP and the American College of Obstetricians and Gynecologists. **[Quality, Timeliness, and Access]**
- HBL's rates on the *Child and Adolescent Well-Care Visits* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest that HBL has room for improvement in coordinating with providers to ensure that adolescent members receive appropriate well-care visits to provide screening and counseling. **[Quality and Access]**

For HBL, the following recommendations were identified:

- To improve performance on 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* measure indicators, HSAG recommends that HBL work with providers to identify barriers to timely follow-up care and trial solutions to improve coordination of care following discharge among providers and between providers and HBL. HBL could also consider data analysis and stratification across key demographics (i.e., race, ethnicity, age, and ZIP Code) to identify disparities and implement targeted interventions, such as providing patient and provider education or improving upon coordination of care following discharge. **[Quality, Timeliness, and Access]**
- To improve performance on the *Depression Screening and Follow-Up for Adolescents and Adults—ECDS* measure indicators, HSAG recommends that HBL work with providers to identify and address barriers to depression screening in members. HBL could also consider data analysis and

stratification across key demographics (i.e., race, ethnicity, age, and ZIP Code) to identify disparities and implement targeted interventions, such as providing patient and provider education on the relevance of depression screening and follow-up care. **[Quality]**

- To improve performance on the *Diabetes Monitoring for People With Diabetes and Schizophrenia* measure, HSAG recommends that HBL work with providers to identify root causes and trial interventions to ensure that members on antipsychotics have their diabetes monitored to prevent adverse outcomes for this population. **[Quality]**
- To improve performance on the *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* measure, HSAG recommends that HBL work with providers to identify root causes and trial interventions to ensure that members on antipsychotics have their cholesterol levels monitored to prevent adverse outcomes for this population. **[Quality]**
- To improve performance on the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—ECDS* measure indicators, HSAG recommends that HBL work with providers to identify root causes and trial interventions to ensure that children and adolescents with ongoing antipsychotic medication use have appropriate metabolic testing completed annually to appropriately manage their conditions. **[Quality]**
- To improve performance on the *Colorectal Cancer Screening—ECDS* measure, HSAG recommends that HBL work with providers to identify and address barriers to colorectal cancer screening for members ages 45 to 75 years old. HBL could also consider data analysis and stratification across key demographics such as race, ethnicity, and ZIP Code to identify disparities and implement targeted interventions. **[Quality]**
- To improve performance on the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators, HSAG recommends that HBL work with PCPs to identify and address barriers to primary care visits for children and adolescents in need of weight assessment and education on healthy habits. HBL could also consider data analysis and stratification across key demographics (i.e., race, ethnicity, age, and ZIP Code) to identify disparities and implement targeted interventions, such as patient and provider education, outreach campaigns, and sending reminders. **[Quality]**
- To improve performance on the *Controlling High Blood Pressure* measure, HSAG recommends that HBL work with providers to identify and address barriers to effective blood pressure management in members. HBL could also consider expanding on existing strategies that focus on disease and chronic condition management, which may include providing at-home devices, such as blood pressure monitoring devices, to hypertensive members; evaluating and expanding current and/or new member outreach and engagement initiatives; and offering provider education and engagement opportunities such as webinars and newsletters on hypertension management best practices. Additionally, HBL could consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions. **[Quality]**
- To improve performance on the *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status >9.0%* measure indicator, HSAG recommends that HBL work with providers to identify and address barriers to blood glucose management. HBL could also consider expanding on existing strategies that focus on disease and chronic condition management, evaluating and expanding

current and/or new member outreach and engagement initiatives, and offering provider education and engagement opportunities such as webinars and newsletters on best practices in blood glucose management. Additionally, HBL could consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions. **[Quality]**

- To improve performance on the *Blood Pressure Control for Patients With Diabetes* measure, HSAG recommends that HBL work with providers to identify and address barriers to effective blood pressure management for diabetic members. HSAG also recommends that HBL expand on existing strategies that focus on disease and chronic condition management, which may include providing at-home devices, such as blood pressure monitoring devices to hypertensive members; evaluating and expanding current and/or new member outreach and engagement initiatives; and offering provider education and engagement opportunities such as webinars and newsletters on hypertension management best practices. HBL could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions. **[Quality]**
- To improve performance on the *Pharmacotherapy for Opioid Use Disorder* measure, HSAG recommends that HBL engage with providers to encourage the use of pharmacotherapy to treat members with opioid use disorder. HBL could also consider data analysis and stratification across key demographics (i.e., race, ethnicity, age, and ZIP Code) to identify disparities and implement targeted interventions, such as provider and/or member education on the importance of pharmacotherapy. **[Quality]**
- To improve performance on the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measure, HSAG recommends that HBL work with providers to identify and address barriers to the dispensing of antipsychotic medications to members with schizophrenia or schizoaffective disorder, and barriers to adherence to antipsychotic medications. HBL could also consider data analysis and stratification across key demographics (i.e., race, ethnicity, age, and ZIP Code) to identify disparities and implement targeted interventions, such as provider education on the importance of medication adherence. **[Quality]**
- To improve performance on the *Antidepressant Medication Management* measure indicators, HSAG recommends that HBL work with providers to identify and address barriers to prescribing antidepressant medication to adult members with major depression and helping members remain on antidepressant medication for the appropriate amount of time. HBL could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions. **[Quality]**
- To improve performance on the *Appropriate Treatment for Children With URI* measure, HSAG recommends that HBL work with providers to trial solutions to reduce antibiotic dispensing to treat URIs. HBL could also work with providers to review noncompliant claims to ensure there were no additional diagnoses during the appointment that justified the prescription of an antibiotic. **[Quality]**
- To improve performance on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure, HSAG recommends that HBL work with providers to trial solutions to reduce or prevent the prescribing of antibiotics for members with a diagnosis of bronchitis or bronchiolitis. HBL could

also work with providers to review noncompliant claims to ensure there were no additional diagnoses during the appointment that justified the prescription of an antibiotic. **[Quality]**

- To improve performance on the *Use of Imaging Studies for Low Back Pain* measure, HSAG recommends that HBL focus its efforts on decreasing unnecessary imaging for low back pain. HSAG also recommends that HBL work with providers to trial solutions to reduce the inappropriate ordering of imaging studies. Appropriate interventions to improve performance may include addressing provider behaviors, provider incentives, and addressing member expectation with education. **[Quality]**
- To improve performance on the *Cervical Cancer Screening* measure, HSAG recommends that HBL work with providers to identify and address barriers to cervical cancer screening for women ages 21 to 64 years old. HBL could also consider data analysis and stratification across key demographics (i.e., race, ethnicity, age, and ZIP Code) to identify disparities and implement targeted interventions, such as offering screenings at more locations or expanding clinic and screening hours. **[Quality]**
- To improve performance on the *Adults' Access to Preventive/Ambulatory Health Services* measure indicators, HSAG recommends that HBL work with PCPs to identify and address barriers to preventive or ambulatory visits for adult members. HBL could also consider data analysis and stratification across key demographics (i.e., race, ethnicity, age, and ZIP Code) to identify disparities and implement targeted interventions, such as patient and provider education, outreach campaigns, and sending reminders. **[Quality and Access]**
- To improve performance on the *Prenatal and Postpartum Care* measure indicators, HSAG recommends that HBL work with providers to identify and address barriers to timely and adequate prenatal and postpartum care. HSAG recommends that HBL consider implementing interventions such as offering provider education and engagement opportunities, including educational webinars and newsletters on prenatal and postpartum health services, and piloting a member incentives program designed to encourage engagement in timely prenatal and postpartum care services. **[Quality, Timeliness, and Access]**
- To improve performance on the *Child and Adolescent Well-Care Visits* measure indicators, HSAG recommends that HBL work with providers to identify and address barriers to well-care visits for children and adolescents. HBL could also consider data analysis and stratification across key demographics (i.e., race, ethnicity, age, and ZIP Code) to identify disparities and implement targeted interventions, such as patient and provider education, outreach campaigns, sending reminders, and incentives for members upon completion of the well-care visits. **[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

The CMS EQR *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity,* February 2023,[6] 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.

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

[6] 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 12, 2025.

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 2023 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 2024 national 50th percentile Medicaid health maintenance organization (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 2024 performance levels based on comparison to the NCQA national 50th percentile benchmark percentile to identify strengths and opportunities for improvement and determine whether each strength and opportunity for improvement impacted one or more of the domains of quality, timeliness, or access. Additionally, for each opportunity for improvement, 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
Colorectal Cancer Screening—ECDS	✓		
Cervical Cancer Screening	✓		
Follow-Up After Hospitalization for Mental Illness—Within 7 Days of Discharge—Total and *Within 30 Days of Discharge—Total*	✓	✓	✓
Follow-Up After Emergency Department Visit for Mental Illness—Within 7 Days of Discharge—Total and *Within 30 Days of Discharge—Total*	✓	✓	✓
Follow-Up After Emergency Department Visit for Substance Use—Within 7 Days of Discharge—Total and *Within 30 Days of Discharge—Total*	✓	✓	✓
Follow-Up After High-Intensity Care for SUD—Within 7 Days of Visit or Discharge—Total and *Within 30 Days of Visit or Discharge—Total*	✓	✓	✓
Glycemic Status Assessment for Patients With Diabetes—Glycemic Status >9.0% and *Glycemic Status <8.0%*	✓		
Controlling High Blood Pressure	✓		
HIV Viral Load Suppression	✓		
Low-Risk Cesarean Delivery (Cesarean Rate for Low-Risk First Birth Women)	✓		
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*	✓		✓

Performance Measure	Quality	Timeliness	Access
Adults' Access to Preventive/Ambulatory Health Services—20–44 Years, *45–64 Years*, *65 Years and Older*, and *Total*	✓		✓
Plan All-Cause Readmissions—Observed Readmissions (Numerator/Denominator), *Expected Readmissions*, and *O/E Ratio (Observed Readmissions/Expected Readmissions)*	✓		
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—ECDS—Blood Glucose Testing—Total, *Cholesterol Testing—Total*, and *Blood Glucose and Cholesterol Testing—Total*	✓		
Prenatal and Postpartum Care—Timeliness of Prenatal Care and *Postpartum Care*	✓	✓	✓
Lead Screening in Children	✓		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*	✓		
Chlamydia Screening in Women—Total	✓		
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	✓		
Pharmacotherapy for Opioid Use Disorder	✓		
Initiation and Engagement of SUD Treatment—Initiation of SUD—Total and *Engagement of SUD—Total*	✓	✓	✓
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—ECDS—Initiation Phase and *Continuation and Maintenance Phase*	✓	✓	✓
Antidepressant Medication Management—Effective Acute Phase Treatment and *Effective Continuation Phase Treatment*	✓		
Appropriate Treatment for Children With URI	✓		

Performance Measure	Quality	Timeliness	Access
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	✓		
Depression Screening and Follow-Up for Adolescents and Adults—ECDS—Depression Screening—Total and *Follow-Up on Positive Screen—Total*	✓		
Use of Imaging Studies for Low Back Pain	✓		
Asthma Medication Ratio—5–11 Years, *12–18 Years*, *19–50 Years*, *51–64 Years*, and *Total*	✓		
Appropriate Testing for Pharyngitis—3–17 Years, *18–64 Years*, *65 Years and Older*, and *Total*	✓		
Topical Fluoride for Children—1–2 Years, *3–4 Years*, and *Total*	✓		
Antibiotic Utilization for Respiratory Conditions—3 Months–17 Years, *18–64 Years*, *65 Years and Older*, and *Total*	✓		
Enrollment by Product Line	NA	NA	NA
Language Diversity of Membership	NA	NA	NA
Race/Ethnicity Diversity of Membership	NA	NA	NA

4. Assessment of Compliance With Medicaid Managed Care Regulations

Results

Table 4-1 presents an overview of the results of the 2025 CR for HBL. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in the following Methodology section. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all standards.

Table 4-1—Summary of Scores for Each Standard

Standard #	Standard Name	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
I	Enrollment and Disenrollment Requirements and Limitations	12	9	9	0	3	100%
II	Member Rights and Confidentiality	24	24	23	1	0	96%
III	Member Information	19	18	12	6	1	67%
IV	Emergency and Poststabilization Services	13	13	12	1	0	92%
V	Adequate Capacity and Availability of Services	15	14	8	6	1	57%
VI	Coordination and Continuity of Care	12	12	10	2	0	83%
VII	Coverage and Authorization of Services	23	21	21	0	2	100%
VIII	Provider Selection	19	19	18	1	0	95%
IX	Subcontractual Relationships and Delegation	6	6	3	3	0	50%
X	Practice Guidelines	6	6	6	0	0	100%
XI	Health Information Systems	9	9	9	0	0	100%
XII	Quality Assessment and Performance Improvement	13	11	11	0	2	100%
XIII	Grievance and Appeal Systems	38	37	32	5	1	86%
XIV	Program Integrity	18	18	18	0	0	100%
Total Compliance Score		**227**	**217**	**191**	**26**	**10**	**88%**

M=*Met*, ***NM***=*Not Met,* ***NA***=*Not Applicable*

Total Elements: The total number of elements in each standard.

Total Applicable Elements: The **total** number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

MCO Strengths, Opportunities for Improvement, Required Actions, and/or Recommendations

For HBL, the following strengths were identified:

- HBL achieved a 100 percent compliance score for Standard I—Enrollment and Disenrollment Requirements and Limitations, demonstrating nondiscriminatory enrollment and contractually compliant disenrollment processes under LDH oversight. **[Quality and Access]**
- HBL achieved a 100 percent compliance score for Standard IV—Emergency and Poststabilization Services, demonstrating that it had adequate processes in place to ensure access to, coverage of, and payment for emergency and poststabilization care. **[Quality, Timeliness, and Access]**
- HBL achieved a 100 percent compliance score for Standard VII—Coverage and Authorization of Services, demonstrating consistent and clinically driven authorization and ABD notification processes within required authorization time frames as well as compliance with coverage definitions and medical necessity and utilization management standards. **[Quality, Timeliness, and Access]**
- HBL achieved a 100 percent compliance score for Standard X—Practice Guidelines, demonstrating evidence-based adoption, annual review, provider involvement, LDH approval, broad dissemination, and consistent application in clinical and operational processes. **[Quality]**
- HBL achieved a 100 percent compliance score for XI—Health Information Systems, demonstrating effective data collection, validation, reporting, encounter submission, and interoperability aligned with federal and State requirements. **[Quality and Access]**
- HBL achieved a 100 percent compliance score for Standard XII—Quality Assessment and Performance Improvement, demonstrating a robust QAPI program with effective governance, performance measurement, and under- and overutilization monitoring; LDH-approved PIPs; and timely reporting to the LDH. **[Quality]**
- HBL achieved a 100 percent compliance score for Standard XIV—Program Integrity, demonstrating a compliant program integrity framework with strong governance; fraud, waste, and abuse (FWA) controls; timely overpayment and service verification processes; rigorous provider screening; and complete reporting and disclosures to LDH. **[Quality]**

For HBL, the following opportunities for improvement were identified:

- HBL did not demonstrate how it ensured compliance with member rights by its employees and providers. **[Quality]**
- HBL's member handbook did not use definitions that aligned with LDH definitions or include language that notifies the member that written translation is available in prevalent languages. **[Quality]**
- HBL did not ensure that its member materials include information on how to request auxiliary aids and services. **[Quality]**
- HBL did not make a good faith effort to give written notice within required time frames to members regarding termination of contracted providers. **[Quality, Timeliness, and Access]**

- HBL did not ensure its member handbook includes time frames for filing a grievance, the filing process for appeals, and information regarding specialized behavioral health services (SBHS). **[Quality]**
- HBL's website did not include language informing the member that information that is available in electronic form is available in paper form without charge upon request and that HBL provides it upon request within five business days. **[Quality]**
- HBL did not ensure that it limits charges to members for poststabilization care services to an amount no greater than what HBL would charge the member if he or she had obtained the services through HBL. **[Quality and Access]**
- HBL did not monitor its provider network to ensure adequate access to all services for all members, including those with physical disabilities. **[Quality and Access]**
- HBL did not ensure that its network includes sufficient family planning providers to ensure timely access to covered services. **[Quality and Access]**
- HBL did not require its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. **[Quality and Access]**
- HBL did not ensure that its network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service (FFS) if the provider serves only Medicaid members. **[Quality, Timeliness, and Access]**
- HBL did not ensure its network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities. **[Quality and Access]**
- HBL did not maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area in accordance with the State standards. **[Quality and Access]**
- HBL's CMPE file review demonstrated noncompliance with timely completion of the initial health needs assessment. **[Quality and Timeliness]**
- HBL's CMPE file review demonstrated noncompliance with completion of timely in-person reassessments for Tier 2 and Tier 3 enrollees. **[Quality and Timeliness]**
- HBL did not verify its providers have been reviewed and approved by a primary source verification (PSV) accrediting body. **[Quality]**
- HBL did not ensure that all contracts or written arrangements comply—and that all delegates agreed to comply—with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions, and rules, policies, procedures, manuals, the State Plan, and Waivers. **[Quality]**
- HBL's written delegation agreements did not comply with the federal or State language, which is exacting. **[Quality]**
- HBL did not always follow the proper procedures to resolve each grievance and provide timely notification nor have a policy and procedure regarding extending the grievance resolution time frame and providing notice. **[Quality and Timeliness]**

- HBL's policy and processes allowed for the same decision-maker to be used for appeals, contrary to requirements. **[Quality]**
- HBL's policy did not include that in the case of an expedited appeal denial, the MCE shall provide oral notice to the enrollee by close of business on the day of resolution. **[Quality]**

For HBL, the following required actions and/or recommendations were identified:

- HBL must improve its documentation for how the MCE ensures member rights are protected. **[Quality]**
- HBL must ensure that its member handbook uses definitions that are aligned with State definitions and include language that notifies the member that written translation is available in prevalent languages. **[Quality]**
- HBL must ensure that its member materials include information on how to request auxiliary aids and services. **[Quality]**
- HBL must make a good faith effort to give written notice of termination of a contracted provider, within required time frames, to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. [**Quality, Timeliness, and Access]**
- HBL must ensure its member handbook includes time frames for filing a grievance, the filing process for appeals, and information regarding SBHS. **[Quality]**
- HBL must inform members on the website that information provided electronically is available in paper form without charge upon request and provide it upon request within five business days. **[Quality]**
- HBL must ensure that it limits charges to members for poststabilization care services to an amount no greater than what HBL would charge the member if he or she had obtained the services through HBL. **[Quality and Access]**
- HBL must monitor, through the collection and analysis of data, its provider network to ensure adequate access to all services for all members, including those with physical disabilities. **[Quality and Access]**
- HBL must demonstrate, through monitoring and data analysis, that its network includes sufficient family planning providers to ensure timely access to covered services. **[Quality and Access]**
- HBL must require its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. **[Quality and Access]**
- HBL must ensure that its network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid FFS if the provider serves only Medicaid members. **[Quality, Timeliness, and Access]**
- HBL must ensure, through monitoring and data analysis, that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities. **[Quality and Access]**

- HBL must maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area in accordance with the State standards. **[Quality and Access]**
- HBL must conduct an initial screening of each member's needs within 90 calendar days of the effective date of enrollment for all new members, including subsequent attempts if the initial attempt to contact the member is unsuccessful. **[Quality and Timeliness]**
- HBL must monitor and conduct an in-person quarterly reassessment of each member's needs as required by assessed tier level, including subsequent attempts if the initial attempt to contact the member is unsuccessful. **[Quality and Timeliness]**
- For credentialing and recredentialing, HBL must verify its providers have been reviewed and approved by a PSV accrediting body. **[Quality]**
- HBL must ensure that all contracts or written arrangements comply—and that all delegates agree to comply—with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions, and rules, policies, procedures, manuals, the State Plan, and Waivers. **[Quality]**
- HBL must ensure that all contracts or written arrangements indicate in regard to its conflict of laws provisions with the required federal and State language of this requirement, which is exacting. **[Quality]**
- HBL must follow required procedures to resolve each grievance and provide timely notification or have a policy and procedure regarding extending the grievance resolution time frame and providing notice. **[Quality and Timeliness]**
- HBL must include policy language and follow required procedures when HBL extends the grievance resolution time frame not at the request of the member, to make reasonable efforts to give the member prompt oral notice of the delay. **[Quality and Timeliness]**
- HBL must revise and implement its policy to adhere with the federal requirement that the individual making decisions on appeals not be involved in any previous level of review or decision making. **[Quality]**
- HBL must revise its policy to include that in the case of an expedited appeal denial, the MCE shall provide oral notice to the enrollee by close of business on the day of resolution. **[Quality]**

Methodology

Objectives

According to 42 CFR §438.358, a state or its EQRO must conduct a review within a three-year period to determine the MCEs' compliance with standards set forth in 42 CFR Part 438. To complete this requirement, HSAG, through its EQRO contract with LDH, performed CRs of the six MCOs, two PAHPs, and one PIHP contracted with LDH to deliver services to Louisiana Medicaid managed care members.

During the 2025 CR process, LDH requested that HSAG review the performance of the MCEs for compliance with all regulations at 42 CFR Part 438 and applicable state-specific requirements. Table 4-2 outlines the division of standards reviewed for CY 2021, CY 2022, CY 2023, and CY 2024.

Table 4-2—CR Standards

Standard	CFR	CY 2021			CY 2022			CY 2023*	CY 2024		
		MCO	PAHP	PIHP	MCO	PAHP	PIHP	MCEs	MCO	PAHP	PIHP
Standard I—Enrollment and Disenrollment Requirements and Limitations	§438.56				✓	✓	✓	-	✓	✓	✓
Standard II—Member Rights and Confidentiality	§438.100 §438.224	✓	✓	✓				-	✓	✓	✓
Standard III—Member Information	§438.10	✓	✓	✓				-	✓	✓	✓
Standard IV—Emergency and Poststabilization Services	§438.114	✓	NA				✓	-	✓	✓	✓
Standard V—Adequate Capacity and Availability of Services	§438.206 §438.207	✓	✓	✓				-	✓	✓	✓
Standard VI—Coordination and Continuity of Care	§438.208	✓	✓	✓				-	✓	✓	✓
Standard VII—Coverage and	§438.210	✓	✓	✓				-	✓	✓	✓

Standard	CFR	CY 2021			CY 2022			CY 2023*	CY 2024		
		MCO	PAHP	PIHP	MCO	PAHP	PIHP	MCEs	MCO	PAHP	PIHP
Authorization of Services											
Standard VIII—Provider Selection	§438.214	✓	✓	✓				-	✓	✓	✓
Standard IX—Subcontractual Relationships and Delegation	§438.230	✓		✓		✓		-	✓	✓	✓
Standard X—Practice Guidelines	§438.236	✓	✓	✓				-	✓	✓	✓
Standard XI—Health Information Systems	§438.242	✓	✓	✓				-	✓	✓	✓
Standard XII—Quality Assessment and Performance Improvement	§438.330	✓	✓	✓				-	✓	✓	✓
Standard XIII—Grievance and Appeal Systems	§438.228	✓	✓	✓				-	✓	✓	✓
Standard XIV—Program Integrity	§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).
* No CR was conducted for CY 2023 for the Louisiana MCEs.

This report presents the results of the 2025 CR, review period CY 2024 (January 1, 2024–December 31, 2024). LDH and the individual MCEs use the information and findings from the CRs to:

- Evaluate the quality, timeliness, and accessibility of healthcare services furnished by the MCEs.
- Identify, implement, and monitor system interventions to improve quality.
- Evaluate current performance processes.
- Plan and initiate activities to sustain and enhance current performance processes.

Technical Methods of Data Collection

Prior to beginning the CR, HSAG developed data collection tools, referred to as "CR tools," to document the review. The content in the tools was selected based on applicable federal and state-specific regulations as they related to the scope of the review. The review processes used by HSAG to evaluate the MCEs' compliance were consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 3).[7]

For each of the MCEs, HSAG's desk review consisted of the following activities.

Pre-Virtual Review Activities

- Collaborated with LDH to develop the scope of work, CR methodology, and CR tools.
- Prepared and forwarded to each of the MCEs a detailed timeline, description of the CR process, document request packet, and a post-interview follow-up document.
- Scheduled the virtual review with the MCE.
- Hosted a pre-virtual review preparation session with all MCEs.
- Generated a sample of cases for file reviews.
- Conducted a desk review of supporting documentation the MCE submitted to HSAG.
- Followed up with the MCE, as needed, based on the results of HSAG's preliminary desk review.
- Developed an agenda for the virtual review interview sessions and provided the agenda to the MCE to facilitate preparation for HSAG's review.

Virtual Review Activities

- Conducted an opening conference, with introductions and a review of the agenda and logistics for HSAG's review activities.
- Interviewed MCE key program staff members.
- Conducted an IS review of the data systems that the MCE used in its operations, applicable to the standards under review.
- Conducted a closing conference during which HSAG reviewers summarized their preliminary findings, as appropriate.
- Discussed the post-interview follow-up document that lists the additional documentation requested by HSAG.

[7] 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 15, 2025.

Post-Virtual Review Activities

- Conducted a review of additional documentation submitted by the MCE.
- Documented findings and assigned each element a score (*Met* or *Not Met*) within the CR tool, as described in the Data Aggregation and Analysis section below.
- Prepared an MCE-specific report and CAP template for the MCE to develop and submit its CAPs for each element that received a *Not Met* score.

Data Aggregation and Analysis

HSAG used scores of *Met* and *Not Met* to indicate the degree to which the MCE's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to an MCE during the period covered by HSAG's review. This scoring methodology is consistent with the CMS EQR Protocol 3.

Met indicates full compliance defined as *all* of the following:

- All documentation listed under a regulatory provision, or component thereof, is present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.
- Documentation, staff responses, file reviews, and IS reviews confirmed implementation of the requirement.

Not Met indicates noncompliance defined as *one or more* of the following:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interviews, but documentation is incomplete or inconsistent with practice.
- Documentation, staff responses, file reviews, and IS reviews do not demonstrate adequate implementation of the requirement.
- No documentation is present, and staff members have little, or no knowledge of processes or issues addressed by the regulatory provisions.
- For those provisions with multiple components, key components of the provision could not be identified and any *Not Met* findings would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

From the scores that it assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each standard and an overall percentage-of-compliance score across the standards. HSAG calculated the total score for each standard by totaling the number of *Met* (1 point) elements and the number of *Not Met* (0 points) elements, then dividing the summed score by the total number of applicable elements for that standard.

HSAG determined the overall percentage-of-compliance score across all areas of review by following the same method used to calculate the scores for each standard (i.e., by summing the total values of the scores and dividing the result by the total number of applicable elements).

HSAG conducted file reviews of the MCE's records for appeals, CM, delegation, grievances, organizational credentialing, practitioner credentialing, and service authorization denials to verify that the MCE had put into practice what the MCE had documented in its policies. HSAG selected 10 records with an oversample of two records for appeals, grievances, and service authorization denials from the full universe of records provided by the MCE. HSAG selected 10 records for CM with an oversample of five records for the PAHPs and PIHP. HSAG selected five records with an oversample of one record for organizational credentialing and practitioner credentialing from the full universe of records provided by the MCE. HSAG selected three records with an oversample of one record for delegation from the full universe of records provided by the MCE. The file reviews were not intended to be a statistically significant representation of all the MCE's files. Rather, the file reviews highlighted instances in which practices described in policy were not followed by MCE staff members. Based on the results of the file reviews, the MCE must determine whether any area found to be out of compliance was the result of an anomaly or if a more serious breach in policy occurred. Findings from the file reviews were documented within the applicable standard and element in the CR tool.

To draw conclusions about the quality, timeliness, and accessibility of care and services the MCE provided to members, HSAG aggregated and analyzed the data resulting from its desk and virtual review activities. The data that HSAG aggregated and analyzed included:

- Documented findings describing the MCE's progress in achieving compliance with State and federal requirements.
- Scores assigned to the MCE'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.
- Documented actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Not Met*.
- Determined opportunities for improvement, recommendations, and corrective actions required based on the review findings.

Description of Data Obtained

To assess the MCE's compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the MCE, including, but not limited to:

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.

- Management/monitoring reports and audits.
- Narrative and/or data reports across a broad range of performance and content areas.
- Files for file review.
- Member and provider materials.

HSAG obtained additional information for the CR through interactions, discussions, and interviews with the MCE's key staff members. Table 4-3 lists the major data sources HSAG used to determine the MCE's performance in complying with requirements and the time period to which the data applied.

Table 4-3—Description of MCE Data Sources and Applicable Time Period

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during and after the site review	January 1, 2024–December 31, 2024
Information obtained through interviews	August 2025–September 2025
Information obtained from a review of a sample of files	January 1, 2024–December 31, 2024

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 opportunities for improvement 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 the MCOs related to the compliance activity conducted.

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of 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 accessibility of care and services provided by the MCOs. Table 4-4 depicts assignment of the standards to the domains of care.

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

CR Standard	Quality	Timeliness	Access
Standard I—Enrollment and Disenrollment Requirements and Limitations	✓		✓
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 Directory Validation

HSAG conducted Q1 and Q2 PDV reviews from January through April 2025 (review period). This section presents the aggregate results from the Q1 and Q2 CY 2025 PDV for all sampled HBL providers by specialty provider type.

Table 5-1 illustrates the response rate and indicator match rates for HBL by specialty provider type.

Table 5-1—Response Rate and Indicator Match Rates for HBL by Specialty Provider Type

Specialty Provider Type	Response Rate		Correct Address		Provider at Location		Confirmed Specialty		Accepted MCO		Accepted Louisiana Medicaid		Confirmed New Patient Acceptance Status[1]	
	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)
Internal Medicine/ Family Medicine	45	90.0%	39	86.7%	40	88.9%	40	88.9%	30	66.7%	30	66.7%	30	66.7%
Pediatrics	46	92.0%	39	84.8%	46	100.0%	45	97.8%	39	84.8%	39	84.8%	42	91.3%
OB/GYNs	28	56.0%	24	85.7%	24	85.7%	19	67.9%	19	67.9%	19	67.9%	18	64.3%
Specialists (any)	45	90.0%	36	80.0%	41	91.1%	38	84.4%	32	71.1%	32	71.1%	39	86.7%
Behavioral Health (any)	35	70.0%	24	68.6%	29	82.9%	28	80.0%	27	77.1%	26	74.3%	22	62.9%
Total	**199**	**79.6%**	**162**	**81.4%**	**180**	**90.5%**	**170**	**85.4%**	**147**	**73.9%**	**146**	**73.4%**	**151**	**75.9%**

[1] Sampled cases were not limited to providers accepting new patients. Match rates include respondents who confirmed the new patient acceptance status noted in the online provider directory was correct.

Table 5-2 presents HBL's PDV weighted compliance scores by specialty provider type. Please see the NAV methodology for the weighted compliance score calculation criteria.

Table 5-2—PDV Weighted Compliance Scores by Specialty Provider Type

Specialty Provider Type	Total	Compliant[1]	Weighted Compliance Score
Internal Medicine/Family Medicine	50	20	43.3%
Pediatrics	50	30	66.0%
OB/GYNs	50	11	27.3%
Specialists (any)	50	23	54.0%
Behavioral Health (any)	50	13	32.0%
Total	**250**	**97**	**44.5%**

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

Provider Access Survey

HSAG conducted the first provider access survey from April to May 2025 (review period). This section presents the results from the first CY 2025 provider access survey for all sampled providers by MCO and specialty provider type.

Table 5-3 illustrates the response rate and indicator match rates for HBL by specialty provider type.

Table 5-3—Response Rate and Indicator Match Rates for HBL by Specialty Provider Type

Specialty Provider Type	Response Rate		Correct Address		Offered Requested Services		Accepted MCO		Accepted Louisiana Medicaid		Accepted New Patients		Provider at Location	
	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)
Allergists	10	90.9%	10	100%	10	100%	9	90.0%	9	90.9%	9	90.9%	6	60.0%
Dermatologists	22	73.3%	21	95.5%	20	90.9%	10	45.5%	10	45.5%	10	45.5%	9	40.9%
Orthopedic Surgeons	26	63.4%	23	88.5%	22	84.6%	13	50.0%	13	50.0%	13	50.0%	9	34.6%
Total	**58**	**70.7%**	**54**	**93.1%**	**52**	**89.7%**	**32**	**55.2%**	**32**	**55.2%**	**32**	**55.2%**	**24**	**41.4%**

Table 5-4 illustrates the average new patient wait times and appointments meeting compliance standards for HBL by appointment type.

Table 5-4—Average New Patient Wait Times and Appointments Meeting Compliance Standards for HBL by Appointment Type

Appointment Type	Wait Time (in Days)	Percentage of Appointments Meeting Compliance Standard
Allergists	59	50.0%
Dermatologists	99	28.6%
Orthopedic Surgeons	23	80.0%

Table 5-5 presents HBL's provider access survey weighted compliance scores by specialty provider type. Please see the NAV methodology for the weighted compliance score calculation criteria.

Table 5-5—Provider Access Survey Weighted Compliance Scores by Specialty Provider Type

Specialty Provider Type	Total Providers Surveyed	Compliant[1]	Weighted Compliance Score[2]
Allergists	11	6	54.5%
Dermatologists	30	9	33.3%
Orthopedic Surgeons	41	9	26.0%
Total	**82**	**24**	**32.5%**

[1] Compliant providers include providers for which all indicators match between the online provider directory and the information obtained during the survey call to the sampled location.
[2] The compliance scores in this section represent the weighted compliance score for each MCO and specialty and are not a calculation of the compliant providers divided by the total. The criteria in Table 5-11 and Table 5-12 of the Methodology section were used to calculate the weight of each noncompliance survey outcome.

NAV Audit

This section presents the results from the CY 2024 (review period) NAV audit.

Network Adequacy Indicator-Specific Validation Ratings

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the MCE's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each MCE according to the CMS EQR *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023 (CMS

EQR Protocol 4).[8] Table 5-6 presents a summary of the NAV validation ratings for HBL by network adequacy standard type.

Table 5-6—Summary of HBL Validation Ratings by Standard Type

Network Adequacy Standard Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias	Could Not be Validated
Time and Distance	100%	0%	0%	0%	0%
Provider-to-Enrollee Ratios	100%	0%	0%	0%	0%
Access and Availability	100%	0%	0%	0%	0%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 96 indicators for HBL. Of these indicators, 100 percent received *High Confidence* ratings.

Access Standards

Table 5-7 contains the percentage of members HBL reported with access at the statewide level, by provider type and by urbanicity. LDH established a 100 percent threshold for MCOs when determining requirements met with distance standards. Results that achieved the 100 percent threshold are shaded green and marked with an up arrow.

Table 5-7—HBL Distance Requirements Met by Percentage of Members With Access by Provider Type and Urbanicity

Provider Type	Urbanicity	Percentage of Members With Access
Adult PCP (Family/General Practice; Internal Medicine)	Urban	98.9%
	Rural	100% ↑
Pediatrics (Family/General Practice; Internal Medicine)	Urban	99.2%
	Rural	100% ↑
Federally Qualified Health Centers (FQHCs)	Urban	88.2%
	Rural	99.9%
Rural Health Clinics (RHCs)	Urban	48.0%
	Rural	99.9%
Acute Inpatient Hospitals	Urban	89.0%
	Rural	99.9%
Laboratory	Urban	99.5%
	Rural	99.9%

[8] 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: July 14, 2025.

Provider Type	Urbanicity	Percentage of Members With Access
Radiology	Urban	98.7%
	Rural	99.6%
Pharmacy	Urban	95.7%
	Rural	99.9%
Hemodialysis Centers	Urban	0.0%
	Rural	5.1%
OB/GYNs (access only for adult female members ages 21 and over)	Urban	97.6%
	Rural	99.9%
Allergy/Immunology	Urban	99.9%
	Rural	99.1%
Cardiology	Urban	99.9%
	Rural	100% ↑
Dermatology	Urban	99.9%
	Rural	97.9%
Endocrinology and Metabolism (Adult)	Urban	98.7%
	Rural	100% ↑
Endocrinology and Metabolism (Pediatric)	Urban	98.7%
	Rural	100% ↑
Gastroenterology	Urban	99.9%
	Rural	100% ↑
Hematology/Oncology	Urban	99.9%
	Rural	99.7%
Nephrology	Urban	99.9%
	Rural	99.5%
Neurology (Adult)	Urban	99.9%
	Rural	100% ↑
Neurology (Pediatric)	Urban	100% ↑
	Rural	100% ↑
Ophthalmology	Urban	99.9%
	Rural	99.9%
Orthopedics (Adult)	Urban	99.9%
	Rural	100% ↑
Orthopedics (Pediatric)	Urban	99.9%
	Rural	100% ↑
Otorhinolaryngology/Otolaryngology	Urban	99.9%
	Rural	99.9%
Urology	Urban	99.9%
	Rural	99.6%

Provider Type	Urbanicity	Percentage of Members With Access
Psychiatrists	Urban	92.3%
	Rural	80.9%
Physicians and licensed mental health practitioners (LMHPs) who specialize in pregnancy-related and postpartum depression or related mental health disorders	Urban	99.4%
	Rural	85.7%
Physicians and LMHPs who specialize in pregnancy-related and postpartum SUD	Urban	8.2%
	Rural	13.1%
Behavioral Health Specialist (Advanced Practice Registered Nurse—Behavioral Health [APRN-BH] specialty, Licensed Psychologist or Licensed Clinical Social Worker [LCSW])	Urban	98.1%
	Rural	99.9%
Psychiatric Residential Treatment Facilities (PRTFs) (Level 3.7 Withdrawal Management [WM]) and Other Specialization (Pediatric Under Age 21)	All	99.9%
American Society of Addiction Medicine (ASAM) Level 1	Urban	53.6%
	Rural	8.7%
ASAM Level 2.1	Urban	45.9%
	Rural	3.3%
ASAM Level 2 WM	Urban	0.0%
	Rural	0.0%
ASAM Level 3.1 (Adult over age 21)	Urban	88.3%
	Rural	27.7%
ASAM Level 3.1 (Pediatric under age 21)	All	35.7%
ASAM Level 3.2 WM (Adult over age 21)	Urban	38.8%
	Rural	18.2%
ASAM Level 3.2 WM (Pediatric under age 21)	All	68.6%
ASAM Level 3.3 (Adult over age 21)	Urban	58.6%
	Rural	48.0%
ASAM Level 3.5 (Adult over age 21)	Urban	78.6%
	Rural	56.3%
ASAM Level 3.5 (Pediatric under age 21)	All	12.5%
ASAM Level 3.7 (Adult over age 21)	Urban	71.3%
	Rural	69.2%
ASAM Level 3.7 WM (Adult over age 21)	Urban	65.8%
	Rural	63.5%
Inpatient Psychiatric Hospital (Free Standing Psychiatric Hospital; Distinct Part Psychiatric Unit)	Urban	99.1%
	Rural	98.6%

Provider Type	Urbanicity	Percentage of Members With Access
Mental Health Rehabilitation (MHR) Agency (Community Psychiatric Support and Treatment; Psychosocial Rehabilitation; and Crisis Intervention—MHR Agency [Legacy MHR], Behavioral Health Rehab Provider Agency [Non-Legacy MHR]; Mental Health Clinics)	Urban	73.9%
	Rural	45.2%

HSAG assessed HBL's results for combined adult PCP and combined pediatrics provider-to-member ratios at the statewide level. The statewide level consists of nine LDH regions, which indicated HBL's statewide results met or exceeded LDH-established requirements. Table 5-8 displays the statewide combined adult PCP and combined pediatrics provider-to-member ratios.

Table 5-8—HBL Statewide Combined Adult PCP and Combined Pediatrics Provider-to-Member Ratios

Provider Type	Indicator	Compliant
Statewide Combined Ratio		
Combined Adult PCP Full-Time Equivalents (FTEs) (1:1,000 adult members)	1.68%	Yes
Combined Pediatrics (1:1,000 child members)	2.89%	Yes

HSAG assessed HBL's results for statewide provider-to-member ratios by specialty provider type and determined that HBL's statewide results met or exceeded LDH-established requirements. Table 5-9 displays the statewide provider-to-member ratios by specialty provider type and indicator.

Table 5-9—HBL Statewide Provider-to-Member Ratios by Specialty Provider Type

Specialty Provider Type	Indicator	Statewide Ratio	Compliant
OB/GYNs	1:10,000	0.19%	Yes
Allergy/Immunology	1:100,000	0.02%	Yes
Cardiology	1:20,000	0.15%	Yes
Dermatology	1:40,000	0.04%	Yes
Endocrinology and Metabolism	1:25,000	0.03%	Yes
Gastroenterology	1:30,000	0.07%	Yes
Hematology/Oncology	1:80,000	0.06%	Yes
Nephrology	1:50,000	0.05%	Yes
Neurology	1:35,000	0.09%	Yes
Ophthalmology	1:20,000	0.06%	Yes

Specialty Provider Type	Indicator	Statewide Ratio	Compliant
Orthopedics	1:15,000	0.11%	Yes
Otorhinolaryngology/Otolaryngology	1:30,000	0.07%	Yes
Urology	1:30,000	0.05%	Yes

HSAG assessed HBL's results for behavioral health providers to determine the accessibility and availability of appointments and determined that HBL met one of the LDH-established performance goals for three reported appointment access standards. Table 5-10 displays the performance measure, threshold, LDH-established performance goal, and achieved compliance rate.

Table 5-10—HBL Appointment Access Standard Compliance Rates for Behavioral Health

Type of Visit	Access/Timeliness Standard	Performance Goal	Compliance Rate
Emergency Care	24 hours, 7 days/week within 1 hour of request	90%	87.4%
Urgent Non-Emergency Behavioral Health Care	48 hours (2 calendar days)	90%	86.6%
Non-Urgent Routine Behavioral Health Care	14 calendar days	70%	86.8%

MCO Strengths, Opportunities for Improvement, and Recommendations

For HBL, the following strengths were identified:

- Overall, 93.1 percent of respondents in the provider access survey confirmed the sampled address was correct. **[Quality and Access]**
- In the provider access survey, 100 percent of the respondents confirmed the location provided allergist services and 90.9 percent confirmed the location provided dermatologist services. **[Quality and Access]**
- Overall, 90.5 percent of the locations in the PDV confirmed affiliation with the sampled provider. **[Quality, and Access]**
- HBL demonstrated robust programs to increase its provider network. HBL contacted providers regularly to add them to the network, conducted outreach to provide assistance in updating educational requirements, and provided incentives to add providers to the network particularly for maternal health and behavioral health. **[Access]**

For HBL, the following opportunities for improvement were identified:

- Acceptance of HBL was inaccurate with 73.9 percent of providers in the PDV and 55.2 percent of locations in the provider access survey accepting HBL. Additionally, 73.4 percent of providers in the PDV and 55.2 percent of locations in the provider access survey accepted Louisiana Medicaid. **[Quality and Access]**
- Overall, only 85.4 percent of providers in the PDV confirmed the specialty was accurate. Additionally, 84.6 percent of orthopedic surgeon locations in the provider access survey confirmed the specialty was accurate. **[Quality and Access]**
- Overall, acceptance of new patients was relatively low with 75.9 percent of providers in the PDV and 55.2 percent of locations in the provider access survey accepting new patients. **[Quality and Access]**
- Of the locations reached, 41.4 percent of provider access survey locations confirmed the sampled provider was at the location. **[Quality and Access]**
- Of the limited number of cases that offered an appointment, 50.0 percent of allergist cases, 28.6 percent of dermatologist cases, and 80.0 percent of orthopedic surgeon cases were within the wait time compliance standards. **[Timeliness and Access]**
- Compliance scores varied by survey type with an overall compliance score of 44.5 percent for the PDV and 32.5 percent for the provider access survey. **[Quality and Access]**
- Compliance scores also varied by provider type with OB/GYNs having the lowest compliance score at 27.3 percent and pediatrics having the highest compliance score at 66.0 percent for the PDV. For the provider access survey, orthopedic surgeons exhibited the lowest compliance score at 26.0 percent, and allergists exhibited the highest compliance score at 54.5 percent. **[Quality and Access]**
- HBL initially did not report hemodialysis centers in its network adequacy reporting as required by LDH; however, HBL resubmitted results to include these providers. **[Quality]**

For HBL, the following recommendations were identified:

- LDH should provide HBL with the case-level PDV and provider access survey data files (i.e., flat files) and a defined timeline by which HBL will address provider data deficiencies identified during the PDV reviews and/or provider access survey. **[Quality and Access]**
- In addition to updating provider information, HBL should conduct a root cause analysis to identify the nature of the data mismatches for PDV and provider access survey study indicators that scored below 90 percent. **[Quality and Access]**
- HBL should consider conducting a review of the offices' eligibility verification requirements to ensure these barriers do not unduly burden members' ability to access care timely. **[Timeliness and Access]**
- HBL should conduct outreach to its providers to ensure the providers and/or their offices routinely submit up-to-date information on all pertinent provider indicators (e.g., active providers, telephone number, new patient acceptance). LDH could consider developing time frames and monitoring

procedures (e.g., provider portals, data submissions) for HBL to confirm office outreach and confirmation of provider information. **[Quality and Access]**

- HBL should strengthen its review processes to ensure inclusion of all LDH provider type reporting standards and indicators and collaborate with LDH to ensure alignment with LDH expectations. **[Quality]**

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.

In accordance with 42 CFR §438.350(a), states that contract with MCOs, PIHPs, and PAHPs, collectively referred to as "MCEs," are required to have a qualified EQRO perform an annual EQR that includes validation of network adequacy to ensure provider networks are sufficient to provide timely and accessible care to Medicaid and CHIP beneficiaries across the continuum of services.

The objectives of the validation of network adequacy are to:

- Assess the accuracy of the LDH-defined network adequacy indicators reported by the MCOs.
- Evaluate the collection of provider data, reliability and validity of network adequacy data, methods used to assess network adequacy, and systems and processes used.
- Determine an indicator-level validation rating, which refers to the overall confidence that an acceptable methodology was used for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators, as set forth by LDH.

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 the CMS EQR Protocol 4. Therefore, in February 2024, HSAG began conducting NAV activities in accordance with the CMS EQR Protocol 4 and will report results in the EQR technical report due April 30, 2025.

Provider Directory Validation

HSAG conducted PDV reviews from January through April 2025. 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, specialty provider type, provider affiliation with the requested MCO, provider's acceptance of Medicaid, and accuracy of new patient acceptance status.

Provider Access Survey

HSAG conducted the first provider access survey from April to May 2025. 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 Identifier (NPI) number, specialty provider type, physical (practice) address, telephone number, provider taxonomy code, and whether 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 specialty provider type data values present in each MCO's data to determine which data values attributed to each provider domain.

NAV Audit

HSAG collected network adequacy data from the MCOs via a secure file transfer protocol (SFTP) site and via virtual NAV audits. HSAG used the collected data to conduct the validation of network adequacy in accordance with the CMS EQR Protocol 4.

HSAG conducted a virtual review with the MCOs that included team members from the EQRO, MCO staff, and staff from vendors, if applicable. HSAG collected information using several methods, including interviews, system demonstrations, review of source data output files, PSV, observation of data processing, and review of final network adequacy indicator-level reports. The virtual review activities performed for each MCO included the following:

- Opening meeting
- Review of the Information Systems Capabilities Assessment Tool (ISCAT) and supporting documentation
- Evaluation of underlying systems and processes
- Overview of data collection, integration, methods, and control procedures
- Network adequacy source data PSV and results
- Closing conference

HSAG conducted interviews with key MCO staff members who were involved with the calculation and reporting of network adequacy indicators.

Description of Data Obtained

HSAG, with approval from LDH, conducted the following network adequacy monitoring tasks during CY 2025:

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 prepared a document request packet that was submitted to each MCO outlining the activities conducted during the validation process. The document request packet included a request for documentation to support HSAG's ability to assess each MCO's IS and processes, network adequacy indicator methodology, and accuracy of network adequacy reporting at the indicator level. Documents requested included an ISCAT, a timetable for completion, and instructions for submission. HSAG worked with the MCOs to identify all data sources informing calculation and reporting at the network adequacy indicator level. HSAG obtained the following data and documentation from the MCOs to conduct the NAV audits:
   - IS data from the ISCAT
   - Network adequacy logic for calculation of network adequacy indicators
   - Network adequacy data files
   - Network adequacy monitoring data
   - Supporting documentation, including policies and procedures, data dictionaries, system flow diagrams, system log files, and data collection process descriptions

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 specialty provider type

- Provider affiliation with the requested MCO
- Provider's acceptance of Louisiana Medicaid
- Accuracy of new patient acceptance status

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 5-11 were used to calculate the weight of each noncompliance survey outcome.

Table 5-11—Noncompliance Reasons and Weighting

Noncompliance Reason	Weight
Provider does not participate with MCO or Louisiana Medicaid	3
Provider is not at site	3
New patient acceptance mismatch	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 provider type reported	1
Refused to participate in survey	0

Table 5-12—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 5-11. If multiple noncompliance criteria were 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.

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 specialty provider type
- 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 5-13 were used to calculate the weight of each noncompliance survey outcome.

Table 5-13—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 provider type reported	1
Refused to participate in survey	0

Table 5-14—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 5-13. If multiple noncompliance criteria were 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.

NAV Audit

HSAG assessed each MCO's ability to collect reliable and valid network adequacy monitoring data, use sound methods to assess the adequacy of its managed care networks, and produce accurate results to support the MCO's and State's network adequacy monitoring efforts.

HSAG used the CMS EQR Protocol 4 indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that the MCO used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

How Conclusions Were Drawn

Provider Directory Validation/Provider Access Survey

HSAG determined that results of network adequacy activities could provide information about MCO performance related to the quality, timeliness, and access domains of care. 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 5-15.

Table 5-15—Assignment of NAV Activities to the Quality, Timeliness, and Access Domains

NAV Activity	Quality	Timeliness	Access
PDV	✓		✓
Provider Access Survey	✓	✓	✓

NAV Audit

HSAG calculated each network adequacy indicator's validation score by identifying the number of *Met* and *Not Met* elements recorded in the HSAG CMS EQR Protocol 4 Worksheet 4.6, noted in Table 5-16.

Table 5-16—Validation Score Calculation

Worksheet 4.6 Summary
A. Total number of *Met* elements
B. Total number of *Not Met* elements
Validation Score = A / (A + B) x 100%
Number of *Not Met* elements determined to have significant bias on the results.

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the MCO's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. The overall validation rating refers to HSAG's overall confidence that acceptable methodology was used for all phases of data collection, analysis, and interpretation of the network adequacy indicators. The CMS EQR Protocol 4 defines validation rating designations at the indicator level, which are defined in Table 5-17 and assigned by HSAG once HSAG has calculated the validation score for each indicator.

Table 5-17—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	*High Confidence*
50.0% to 89.9%	*Moderate Confidence*
10.0% to 49.9%	*Low Confidence*
Less than 10% and/or any *Not Met* element has significant bias on the results	*No Confidence*

Significant bias was determined based on the magnitude of errors detected and not solely based on the number of elements *Met* or *Not Met*. HSAG determined that a *Not Met* element had significant bias on the results by:

- Requesting that the MCO provide a root cause analysis of the finding.
- Working with the MCE to quantify the estimated impact of an error, omission, or other finding on the indicator calculation.
- Reviewing the root cause, proposed corrective action, timeline for corrections, and estimated impact, within HSAG's NAV Oversight Review Committee, to determine the degree of bias.
- Finalizing a bias determination within HSAG's NAV Oversight Review Committee based on the following threshold:
  - The impact biased the reported network adequacy indicator result by more than 5 percentage points, the impact resulted in a change in network adequacy compliance (i.e., the indicator result changed from compliant to noncompliant or changed from noncompliant to compliant), or the impact was unable to be quantified and therefore was determined to have the potential for significant bias.

By assessing each MCO's performance and NAV reporting process, HSAG identified areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG also provided a recommendation to help target improvement.

To draw conclusions about the quality, timeliness, and accessibility of care provided by the Medicaid MCOs, HSAG assigned each of the standards reviewed for NAV activities to one or more of three domains of care. This assignment to domains of care is depicted in Table 5-18.

Table 5-18—Assignment of NAV Audit Activities to the Quality, Timeliness, and Access Domains

NAV Standard	Quality	Timeliness	Access
Provider: Enrollee Ratio	✓	✓	✓
Distance	✓	✓	✓
Access and Timeliness Standards	✓	✓	✓

6. Encounter Data Validation

Results

Representatives from HBL completed the LDH-approved questionnaire supplied by HSAG through the Universal Survey Tool (UST). HSAG identified follow-up questions based on HBL's original questionnaire responses, and HBL responded to these specific questions. To support its questionnaire responses, HBL submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from HBL regarding its encounter data processes.

The administrative profile analyzed LDH's encounter data for completeness, timeliness, and accuracy by evaluating data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of LDH's data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 6-1 provides a list of multifaceted analyses conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of LDH's encounter data from HBL.

Table 6-1—EDV Results for HBL

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• HBL and its subcontractors demonstrated their capability to collect, process, and transmit encounter data to LDH, as well as develop data review and correction processes that can respond to quality issues identified by LDH. • HBL reported methods to identify duplicate claims. • HBL and its subcontractors were responsible for the collection and maintenance of the provider information. In addition, HBL and its subcontractors integrated the Medicaid member enrollment files into their systems for claim processing.
Payment Structures	• HBL reported a wide range of pricing methodologies that varied by encounter type and subcontractors. • HBL collected and verified TPL information, processed payment based on TPL information, and submitted TPL information to LDH via the encounter data.

Analysis	Key Findings
Encounter Data Quality Monitoring	• HBL stated that it had subcontractors for dental, NEMT, palliative care, pharmacy, and vision encounters. For the encounters collected by the subcontractors, HBL noted that it stored and reviewed encounter data before submission to LDH, did not modify the data before submission, and reviewed the encounters after submission to LDH except for the review of encounter data before or after submission to LDH on pharmacy encounters. • HBL and/or its subcontractors noted that they performed claim volume, completeness and accuracy, timeliness, and reconciliation with financial reports checks on these encounters collected by subcontractors except the claim volume checks on dental, palliative care, and pharmacy encounters; the completeness and accuracy check on pharmacy encounters; the timeliness check on palliative care and pharmacy encounters; and reconciliation with financial reports on palliative care encounters. • For encounters collected by HBL, HBL noted that it performed completeness and accuracy, timeliness, and reconciliation with financial reports checks. • Based on HBL's responses to the questionnaire, the percentage of encounters that were initially rejected and not yet accepted by LDH varied from 0.3 percent (NEMT and vision encounters) to 11.2 percent (professional [non-subcontractor] encounters).
Administrative Profile	
Encounter Data Completeness	• HBL displayed consistent encounter volume per 1,000 MM, payment amount PMPM, and TPL payment amount PMPM for professional, institutional, dental, and pharmacy encounters throughout the measurement year. • HBL had a rate of duplicate encounters of less than 1.0 percent for professional, institutional, and pharmacy encounter types. For dental encounters, HBL had a relatively high rate (5.5 percent) of duplicate encounters.
Encounter Data Timeliness	• Within 60 days, HBL submitted 77.9 percent of professional, 74.4 percent of institutional, 93.8 percent of dental, and 97.2 percent of pharmacy encounters to LDH after the payment date.
Field-Level Completeness and Accuracy	• All key data elements in HBL's encounter data had a relatively high or reasonable rate of population (i.e., percent present). • HBL had all key data elements populated with at least 95.0 percent of valid values in institutional encounters, while there was at least one data element with an accuracy rate below 95.0 percent for the other three encounter types. Refer to the opportunities for improvement section below for the list of data elements needing HBL's attention.

Analysis	Key Findings
Encounter Referential Integrity	• No major concerns were noted for HBL when evaluating the integrity between medical/dental/pharmacy encounters and member enrollment data, or between medical/dental encounters and pharmacy encounters. • Of all identified provider NPIs in HBL's submitted medical/dental and pharmacy encounters, only 87.0 percent and 67.0 percent were identified in the provider data, respectively.
Encounter Data Logic	• HBL had 58.2 percent of members with both medical/dental and pharmacy encounters throughout the measurement year. • HBL had 68.0 percent of members who were continuously enrolled in the measurement year.

MCO Strengths, Opportunities for Improvement, and Recommendations

For HBL, the following strengths were identified:

- For the encounters collected by its subcontractors (dental, NEMT, palliative care, and vision), HBL noted that it stored and reviewed encounter data before submission to LDH, did not modify the data before submission, and reviewed the encounters after submission to LDH. In addition, HBL and/or its NEMT and vision subcontractors noted that they performed claim volume, completeness and accuracy, timeliness, and reconciliation with financial reports checks on the corresponding encounters. **[Quality and Timeliness]**
- HBL reported less than 1.0 percent of NEMT, pharmacy, and vision encounters as initially rejected and not yet accepted. **[Quality]**
- HBL had low duplicate rates for professional encounters (<0.1 percent), institutional encounters (0.3 percent), and pharmacy encounters (0.0 percent). **[Quality]**
- For institutional encounters, HBL had all key data elements populated with at least 95.0 percent of valid values. **[Quality]**

For HBL, the following opportunities for improvement were identified:

- **Quality Checks for Subcontractor Data**:
  - Palliative Care: HBL noted that neither HBL nor its palliative care subcontractor performed claim volume, timeliness, or reconciliation with financial reports checks on the data. **[Quality and Timeliness]**
  - Pharmacy: For the pharmacy encounters collected by its subcontractor, HBL noted it did not review them before or after the data were submitted to LDH. In addition, neither HBL nor its pharmacy subcontractor performed claim volume, completeness and accuracy, or timeliness checks on the data. **[Quality and Timeliness]**

- Among the seven MCEs with professional encounters, HBL had the second highest percentage of encounters initially rejected and not yet accepted by LDH, at 11.2 percent. **[Quality]**
- HBL had the highest duplicate encounter rate (5.5 percent) among the MCEs with dental encounters. **[Quality]**
- HBL submitted only 77.9 percent of professional encounters and 74.4 percent of institutional encounters to LDH within 60 days from the payment date. **[Timeliness]**
- HBL had the following data elements with less than 95.0 percent of valid values: **[Quality]**
  - Professional Encounters: *National Drug Codes (NDCs)* (93.2 percent)
  - Dental: *Rendering Provider Taxonomy Code* (71.6 percent)
  - Pharmacy: *Prescribing Provider NPI* (92.3 percent)
- For referential integrity, among all MCEs, HBL had the second lowest percentage of providers in the medical/dental encounter file who were also in the provider file, at 87.0 percent. In addition, HBL had the lowest percentage of providers in the pharmacy encounter file who were also in the provider file, at 67.0 percent. **[Quality]**

For HBL, the following recommendations were identified:

- HBL should develop a comprehensive suite of encounter data quality monitoring reports to assess the accuracy, completeness, and timeliness of encounter data received from its palliative care and pharmacy subcontractors. **[Quality and Timeliness]**
- HBL should build a process with LDH to ensure that rejected professional encounters will be submitted to LDH with correct information. **[Quality]**
- HBL should review its system for identifying and handling duplicates for dental encounters. Identification and appropriate handling of duplicate encounters is crucial for accurate financial and actuarial calculations. **[Quality]**
- HBL should monitor its encounter data submission to LDH to ensure professional and institutional encounters are submitted to LDH in a timely manner after payment. **[Timeliness]**
- HBL should investigate the root causes for data elements with less than 95.0 percent of valid values (i.e., those listed in the opportunities for improvement section) to improve accuracy. **[Quality]**
- HBL should work with LDH to ensure both entities have an accurate and complete database of contracted providers for medical/dental and pharmacy encounters.

Methodology

Objectives

Accurate and complete encounter data are critical to the success of a managed care program. Therefore, LDH requires its contracted Medicaid MCEs to submit high-quality encounter data. LDH relies on the quality of these encounter data submissions to accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information.

During CY 2024–2025, LDH contracted with HSAG to conduct an EDV study consisting of the following two activities:

- IS review—assessment of LDH's and the MCEs' IS and processes. The goal of this activity was to examine the extent to which LDH's, and the MCEs' IS infrastructures are likely to collect and process complete and accurate encounter data. This activity corresponds to Activity 1: Review State Requirements and Activity 2: Review the MCP's [Managed Care Plan's] capability in the CMS EQR *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, February 2023 (CMS EQR Protocol 5).[9]
- Administrative profile—analysis of LDH's electronic encounter data completeness, accuracy, and timeliness. The goal of this activity was to evaluate the extent to which the electronic encounter data in LDH's data warehouse are complete, accurate, and submitted by the MCEs in a timely manner for encounters with dates of service from January 1, 2023, through December 31, 2023. This activity corresponds to Activity 3: Analyze Electronic Encounter Data in the CMS EQR Protocol 5.

Technical Methods of Data Collection

Information Systems Review

To ensure the collection of critical information, HSAG employed a three-stage review process that included a document review, development and fielding of a customized encounter data assessment, and follow-up with key staff members.

- **Stage 1—Document Review:** HSAG conducted a thorough desk review of existing documents related to encounter data initiatives/validation activities currently put forth by LDH. Documents requested for review included data dictionaries, process flow charts, data system diagrams, encounter system edits, sample rejection reports, work group meeting minutes, LDH's current encounter data submission requirements, and other relevant materials. The information obtained

[9] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: 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 15, 2025.

from this review was important for developing a targeted questionnaire to address important topics of interest to LDH.

- **Stage 2—Development and Fielding of Customized Encounter Data Assessment:** HSAG first evaluated the MCEs' most recent ISCA, if available, to assess whether the information is complete and up to date. This process allowed these activities to be coordinated across projects, preventing duplication, and minimizing the impact on the MCEs. HSAG then developed a questionnaire customized in collaboration with LDH to gather information and specific procedures for data processing, personnel, and data acquisition capabilities. Where applicable, this assessment also included a review of supplemental documentation regarding other data systems, including enrollment and provider data. Lastly, this review included specific topics of interest to LDH. For example, the reviews included questions regarding how MCEs ensure their subcontractors are submitting timely, complete, and accurate encounter data.

  The questionnaire for LDH had similar domains; however, it focused on LDH's data exchange with the MCEs.

  HSAG created a different questionnaire for each MCE program (MCO, PAHP, PIHP) and submitted the appropriate questionnaire to each MCE to collect information. Additionally, since there were nine MCEs included in the study, HSAG distributed the questionnaire via an online tool to streamline collection of the responses.
- **Stage 3—Key Informant Interviews:** After reviewing responses to the questionnaires, HSAG followed up with key LDH and MCE information technology personnel to clarify any questions from the questionnaire responses.

Administrative Profile

HSAG assessed final adjudicated encounters with service dates from January 1, 2023, through December 31, 2023. In addition, the EDV study used member demographic/enrollment data and provider data to evaluate the validity of key data elements in the encounter data. HSAG used the monthly data extracts submitted by LDH's fiscal agent contractor (FAC) between January 2023 and December 2024 for the analysis.

Once HSAG received data files from LDH, HSAG conducted a preliminary file review to ensure that the submitted data were adequate to conduct the evaluation. The preliminary file review included the following basic checks:

- Percentage present—Required data fields were present on the file and had values in those fields.
- Percentage of valid values—The values were as expected (e.g., valid International Classification Diseases, Tenth Revision, Clinical Modification [ICD-10-CM] codes in the diagnosis field).
- Referential integrity checks—Data sources could be joined with each other based on unique identifiers present in both data sources.

Once the final data were received and processed, HSAG conducted a series of analyses for five key metrics listed in the section below.

At a high level, HSAG calculated rates for each metric by encounter type (i.e., 837 Professional [837P], 837 Institutional [837I], 837 Dental [837D], and National Council for Prescription Drug Programs [NCPDP]). HSAG evaluated these metrics at the statewide level and by MCE. If results indicated data quality issue(s), HSAG conducted additional investigations to determine whether the issue was for a specific category of service (e.g., inpatient, nursing facilities), provider type (e.g., vision vendor, non-emergency transportation vendor), sub-population, etc. HSAG documented all noteworthy findings in the aggregate report.

Metrics for Encounter Data Completeness

HSAG evaluated encounter data completeness through the following metrics:

- Monthly encounter volume (i.e., visits) by service month (i.e., the month when services occur): If the number of members remained stable and there were no major changes to members' medical needs, the monthly visit/service counts should have minimal variation. A low count for any month may indicate incomplete data. Of note, instead of the claim number, HSAG evaluated the encounter volume based on a unique visit key. For example, for an office visit, the visit key was based on the *Member ID*, *Rendering Provider NPI*, and *Date of Service* values.
- Monthly encounter volume (i.e., visits) per 1,000 member months by service month: Compared to the metric above, this metric normalized the visit/service counts by the member counts. Of note, HSAG calculated the member counts by month for each MCE based on the member enrollment data extracted by LDH.
- Paid amount PMPM by service month—This metric helps LDH determine whether the encounter data are complete from a payment perspective.
- TPL paid amount PMPM by service month—This metric helps LDH determine whether the encounter data are complete from the TPL payment perspective.
- Percentage of duplicate encounters

Metrics for Encounter Data Timeliness

HSAG evaluated encounter data timeliness through the following metrics:

- Percentage of encounters received by LDH within 360 days, from the payment date, in 30-day increments: This metric helps LDH to evaluate the extent to which the MCEs are in compliance with LDH's encounter data timeliness requirements (i.e., submit encounters within 30 days of adjudication).
- Claims lag triangle to illustrate the percentage of encounters received by LDH within two calendar months, three months, …, and such from the service month: This metric allows LDH to evaluate how soon LDH may use the encounter data in the data warehouse for activities such as performance measure calculation and utilization statistics.

Metrics for Field-Level Completeness and Accuracy

HSAG evaluated whether the data elements in the final paid encounters are complete and accurate through the two study indicators described in Table 6-2 for the key data elements listed in Table 6-3. In addition, Table 6-3 shows the criteria HSAG used to evaluate the validity for each data element. These criteria are based on standard reference code sets, or referential integrity checks against member or provider data.

Table 6-2—Study Indicators for Percent Present and Percent Valid

Study Indicator	Denominator	Numerator
Percent Present: Percentage of records with values present for a specific key data element.	Total number of final paid encounter records based on the level of evaluation noted in Table 6-3 (i.e., at either the header or detail line level) with dates of service in the study period.	Number of records with values present for a specific key data element based on the level of evaluation (i.e., at either the header or detail line level) noted in Table 6-3.
Percent Valid: Percentage of records with values valid for a specific key data element.	Number of records with values present for a specific key data element based on the level of evaluation (i.e., at either the header or detail line level) noted in Table 6-3.	Number of records with values valid for a specific key data element based on the level of evaluation (i.e., at either the header or detail line level) noted in Table 6-3. The criteria for validity are listed in Table 6-3.

Table 6-3—Key Data Elements for Percent Present and Percent Valid

Key Data Elements	837P Encounters	837I Encounters	837D Encounters	NCPDP Encounters	Criteria for Validity
Member ID[H]	✓	✓	✓	✓	• In member file • Enrolled in a specific MCE on the date of service
Detail Service From Date[D]	✓	✓	✓		• Detail Service From Date ≤ Detail Service To Date • Detail Service From Date ≤ Paid Date
Detail Service To Date[D]	✓	✓	✓		• Detail Service To Date ≥ Detail Service From Date • Detail Service To Date ≤ Paid Date
Date of Service[D]				✓	• Date of Service ≤ Paid Date

Key Data Elements	837P Encounters	837I Encounters	837D Encounters	NCPDP Encounters	Criteria for Validity
Billing Provider NPI[H]	✓	✓	✓	✓	• In provider data when service occurred • Meets Luhn formula requirements
Rendering Provider NPI[H]	✓		✓		• In provider data when service occurred • Meets Luhn check digit formula requirements
Attending Provider NPI[H]		✓			• In provider data when service occurred • Meets Luhn check digit formula requirements
Referring Provider NPI[H]	✓	✓	✓		• In provider data when service occurred • Meets Luhn check digit formula requirements
Prescribing Provider NPI				✓	• In provider data when service occurred • Meets Luhn check digit formula requirements
Rendering Provider Taxonomy Code[H]	✓		✓		• In standard taxonomy code set • Matches the value in provider data
Attending Provider Taxonomy Code[H]		✓			• In standard taxonomy code set • Matches the value in provider data

Key Data Elements	837P Encounters	837I Encounters	837D Encounters	NCPDP Encounters	Criteria for Validity
Primary Diagnosis Codes[H]	✓	✓			In national ICD-10-CM diagnosis code sets for the correct code year (e.g., in 2023 code set for services that occurred between October 1, 2022, and September 30, 2023)
Secondary Diagnosis Codes[H]	✓	✓			In national ICD-10-CM diagnosis code sets for the correct code year
Current Procedural Terminology (CPT)/ Healthcare Common Procedure Coding System (HCPCS) Codes/Current Dental Terminology (CDT) Codes[D]	✓	✓	✓		In national CPT, HCPCS, CDT code sets for the correct code year (e.g., in 2023 code set for services that occurred in 2023)
Procedure Code Modifiers[D]	✓	✓			In national standard code set or in the origin and estimation modifier list[10]
Tooth Number[D]			✓		In national standard code set
Tooth Surface[D]			✓		In national standard code set
Oral Cavity Code[D]			✓		In national standard code set
Primary Surgical Procedure Codes[H]		✓			In national ICD-10-CM surgical procedure code sets for the correct code year
Secondary Surgical Procedure Codes[H]		✓		.	In national ICD-10-CM surgical procedure code sets for the correct code year

[10] Healthy Louisiana. Medicaid Managed Care Entities System Companion Guide, Version 1, June 18, 2025. Available at: https://ldh.la.gov/assets/medicaid/MCE_System_Companion_Guide/HLA_MCE_SCG_v.1.pdf. Accessed on: Dec 15, 2025.

Key Data Elements	837P Encounters	837I Encounters	837D Encounters	NCPDP Encounters	Criteria for Validity
Revenue Codes[D]		✓			In national standard revenue code sets for the correct code year
Type of Bill Codes[H]		✓			In national standard type of code set
NDCs[D]	✓	✓		✓	In national NDC code sets
Submit Date[D]	✓	✓	✓	✓	MCE Submission Date (i.e., the date when the MCE submits encounters to LDH) ≥ MCE Paid Date
MCE Paid Date[D]	✓	✓	✓	✓	MCE Submission Date (i.e., the date when MCE submit encounters to LDH) ≥ MCE Paid Date
Detail Paid Amount[D]	✓	✓	✓	✓	Zero or positive
Detail TPL Paid Amount[D]	✓	✓	✓	✓	Zero or positive

[H] Conduct evaluation at the header level.
[D] Conduct evaluation at the detail level.

Metrics for Encounter Data Referential Integrity

HSAG evaluated if data sources could be joined with each other based on whether a unique identifier (e.g., unique member ID, unique provider NPI) was present in both data sources (i.e., unique member IDs that were present in both the encounter data and member enrollment files) through the key study indicators described in Table 6-4. If an encounter contained more than one NPI (e.g., attending provider NPI and billing provider NPI on an institutional encounter), HSAG included both unique NPIs in the analysis.

Table 6-4—Key Indicators of Referential Integrity

Data Source	Indicator
Medical/Dental Encounters vs Member Enrollment	• Direction 1: Percentage of Members With a Medical/Dental Encounter Who Were Also in the Enrollment File • Direction 2: Percentage of Members in the Enrollment File With a Medical/Dental Encounter

Data Source	Indicator
Pharmacy Encounters vs Member Enrollment	• Direction 1: Percentage of Members With a Pharmacy Encounter Who Were Also in the Enrollment File • Direction 2: Percentage of Members in the Enrollment File With a Pharmacy Encounter
Medical/Dental Encounters vs Pharmacy Encounters	• Direction 1: Percentage of Members With a Medical/Dental Encounter Who Also Have a Pharmacy Encounter • Direction 2: Percentage of Members With a Pharmacy Encounter Who Also Have a Medical/Dental Encounter
Medical/Dental Encounters vs Provider File	• Direction 1: Percentage of Providers in the Medical/Dental Encounter File Who Were Also in the Provider File • Direction 2: Percentage of Providers in the Provider File Who Were Also in the Medical/Dental Encounter File
Pharmacy Encounters vs Provider File	• Direction 1: Percentage of Providers in the Pharmacy Encounter File Who Were Also in the Provider File • Direction 2: Percentage of Providers in the Provider File Who Were Also in the Pharmacy Encounter File

Metrics for Encounter Data Logic

Based on the likely use of the encounter data in future analytic activities (e.g., performance measure development/calculation), HSAG used logic-based checks to ensure the encounter data appropriately support additional activities.

- Percentage of members with a medical encounter, pharmacy encounter, both medical and pharmacy encounters, or neither from January 1, 2023, through December 31, 2023.
- Continuous member enrollment to identify the length of time members were continuously enrolled during the measurement year. This assessment provided insight into how well encounter data may be used to support future analyses, such as HEDIS performance measure calculations. For instance, many measures require members be enrolled for the full measurement year, allowing only one gap of up to 45 days.

Description of Data Obtained

Information Systems Review

Representatives from each MCE completed the LDH-approved questionnaire and then submitted their responses and relevant documents via the UST to HSAG for review. Of note, the questionnaire included an attestation statement for each MCE's chief executive officer or responsible individual to certify that the information provided was complete and accurate.

Administrative Profile

Data obtained from LDH included:

- Claims and encounter data with dates of service from January 1, 2023, through December 31, 2023.
- Member demographic and enrollment data.
- Provider data.

How Data Were Aggregated and Analyzed

Information Systems Review

Questionnaire responses were collected and stored in a secure database maintained by HSAG. HSAG compiled responses from the received LDH- and MCE-specific questionnaires and assembled the information in Microsoft Excel workbooks. Responses were analyzed based on their relationship to the IS review EDV measures.

Administrative Profile

After consultation with LDH, HSAG used the data tables provided by LDH to create encounter, member demographic, member enrollment, and provider data files that contained the variables necessary for analysis. To analyze the data, HSAG prepared charts and figures to evaluate the pre-determined study metrics.

How Conclusions Were Drawn

Information Systems Review

HSAG made conclusions based on the CMS EQR Protocol 5, the MCE contracts, LDH's current encounter data submission requirements (e.g., companion guides), and HSAG's historical experience working with other states regarding the IS review.

Administrative Profile

To draw conclusions about the quality of each MCE's encounter data submissions to LDH, HSAG evaluated the results based on the predefined study and/or key metrics described above. To identify strengths and weaknesses, HSAG assessed the results based on its experience in working with other states in assessing the completeness, accuracy, and timeliness of the MCEs' encounter data submissions to LDH. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality of encounter data submitted to LDH.

Table 6-5—Assignment of EDV Measure Activities to the Quality, Timeliness, and Access Domains

EDV Measure	Quality	Timeliness	Access
IS Review: Encounter Data Sources and Systems	✓	✓	
IS Review: Payment Structures	✓		
IS Review: Encounter Data Quality Monitoring	✓	✓	
Administrative Profile: Encounter Data Completeness	✓		
Administrative Profile: Encounter Data Timeliness		✓	
Administrative Profile: Encounter Data Accuracy: Field-level Completeness and Accuracy	✓		
Administrative Profile: Encounter Data Referential Integrity	✓		
Administrative Profile: Encounter Data Logic	✓		

7. Consumer Surveys: CAHPS-A and CAHPS-C

Results

Table 7-1 presents HBL's 2023, 2024, and 2025 adult achievement scores.

Table 7-1—Adult Achievement Scores

Measure	2023	2024	2025
Rating of Health Plan	87.63%	75.25%	81.77%
Rating of All Health Care	79.41%	85.50%	79.44%
Rating of Personal Doctor	87.50%	86.79%	88.41%
Rating of Specialist Seen Most Often	NA	NA	NA
Getting Needed Care	80.58%	82.57%	NA
Getting Care Quickly	81.45%	NA	NA
How Well Doctors Communicate	93.43%	95.56%	NA
Customer Service	NA	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 NA (Not Applicable).

Table 7-2 presents HBL's 2023, 2024, and 2025 general child achievement scores.

Table 7-2—General Child Achievement Scores

Measure	2023	2024	2025
Rating of Health Plan	83.17%	89.36%	88.89%
Rating of All Health Care	87.90%	89.58%	89.71%
Rating of Personal Doctor	92.82%	91.75%	92.34%
Rating of Specialist Seen Most Often	NA	NA	NA
Getting Needed Care	NA	NA	89.49% ↑
Getting Care Quickly	90.29%	88.81%	91.77% ↑
How Well Doctors Communicate	93.90%	95.11%	93.73%
Customer Service	NA	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 NA (Not Applicable).
↑ *Indicates the 2025 score is statistically significantly higher than the 2025 NCQA national average.*

MCO Strengths, Opportunities for Improvement, and Recommendations

For HBL, the following strengths were identified:

- For the adult population, HBL's 2025 achievement scores were not statistically significantly higher than the 2025 NCQA adult national averages or the 2024 achievement scores for any measure; therefore, no substantial strengths were identified. **[Quality, Timeliness, and Access]**
- For the general child population, HBL's 2025 achievement scores were statistically significantly higher than the 2025 NCQA child national averages for two measures: *Getting Needed Care* and *Getting Care Quickly*. **[Quality, Timeliness, and Access]**

For HBL, the following opportunity for improvement was identified:

- For the adult and general child populations, HBL's 2025 achievement scores were not statistically significantly lower than their corresponding 2025 NCQA national averages or the 2024 achievement scores for any measure; therefore, no substantial weaknesses were identified. **[Quality, Timeliness, and Access]**

For HBL, the following recommendation was identified:

- HSAG recommends that HBL focus on increasing response rates to the CAHPS survey for its adult and general child populations so there are greater than 100 respondents for each measure by educating and engaging all employees to increase their knowledge of CAHPS using customer service techniques, oversampling, and continuing to provide awareness to members and providers during the survey period. **[Quality, Timeliness, and Access]**

Methodology

Objectives

The CAHPS activity assesses adult members' and parents'/caretakers' of child members experiences with an MCO and the quality of care that they/their children 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

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 nonrespondents) 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 nonrespondents). 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 2025, following NCQA's data collection protocol.

The CAHPS 5.1H Medicaid Health Plan Surveys included a set of standardized items (39 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.[11] 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."

[11] For this report, the 2025 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 did not include results for a CAHPS measure if the NCQA minimum reporting threshold of 100 respondents was not met. Additionally, for this report, HSAG compared the adult and general child Medicaid populations' survey findings to the 2025 NCQA CAHPS adult and general child Medicaid national averages.[12]

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 2024).

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.[13] Eligible members included the entire sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, 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 2025 achievement scores were compared to their corresponding 2024 achievement scores to determine whether there were statistically significant differences. Statistically significant differences between the 2025 achievement scores and the 2024 achievement scores are noted with directional triangles. An MCO's score that performed statistically significantly higher in 2025 than 2024 is noted with a black upward triangle (▲). An MCO's score that performed statistically significantly lower in 2025 than 2024 is noted with a black downward triangle (▼). An MCO that did not perform statistically significantly higher or lower between years was 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 2025 NCQA national average was denoted with a black upward arrow (↑).[14] Conversely, an MCO that performed statistically significantly lower than the 2025 NCQA national average was denoted with

[12] National data were obtained from NCQA's 2025 Quality Compass.

[13] 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.

[14] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2025.* Washington, DC: NCQA, September 2025.

a black downward arrow (↓). An MCO that did not perform statistically significantly higher or lower than the 2025 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 2024 survey results to the 2025 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 7-3.

Table 7-3—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	✓		

8. Behavioral Health Member Satisfaction Survey

Results

Table 8-1 presents the 2023, 2024, and 2025 adult achievement scores for HBL and the Healthy Louisiana SWA.

Table 8-1—Adult Achievement Scores for HBL

Measure	2023	2024	2025	Healthy Louisiana SWA
Rating of Health Plan	59.03%	53.38%	57.25%	57.88%
How Well People Communicate	93.23%	93.65%	91.58%	91.16%
Cultural Competency	61.54%+	85.71%+	92.31%+	86.01%+
Helped by Counseling or Treatment	69.86%	72.73%	71.64%	70.38%
Treatment or Counseling Convenience	84.83%	90.08%	90.91%	88.13%
Getting Needed Treatment	80.28%	83.33%	80.15%	81.75%
Help Finding Counseling or Treatment	45.83%+	56.52%+	65.22%+	50.82%
Customer Service	64.29%+	80.00%+	73.91%+	70.81%
Helped by Crisis Response Services	71.43%+	70.59%+	82.61%+	72.26%

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.

Table 8-2 presents the 2023, 2024, and 2025 child achievement scores for HBL and the Healthy Louisiana SWA.

Table 8-2—Child Achievement Scores for HBL

Measure	2023	2024	2025	Healthy Louisiana SWA
Rating of Health Plan	55.97%	66.41%	90.91%+▲↑	63.63%
How Well People Communicate	90.83%	90.81%	100.00%+▲	91.03%
Cultural Competency	90.00%+	90.00%+	—	92.57%+
Helped by Counseling or Treatment	54.20%	55.38%	45.45%+	61.01%
Treatment or Counseling Convenience	85.82%	85.27%	100.00%+▲	88.86%
Getting Needed Treatment	71.43%	76.74%	81.82%+	78.93%
Help Finding Counseling or Treatment	60.00%+	52.63%+	—	38.57%+
Customer Service	68.75%+	60.00%+	50.00%+	71.71%+
Getting Professional Help	86.57%	86.72%	100.00%+▲	87.75%
Help to Manage Condition	82.58%	88.28%	81.82%+	83.38%

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 2025 score is statistically significantly higher than the 2025 Healthy Louisiana SWA.*

▲ *Indicates the 2025 score is statistically significantly higher than the 2024 score.*

—*Indicates the MCO's score was not reported due to insufficient data.*

MCO Strengths, Opportunities for Improvement, and Recommendations

For HBL, the following strengths were identified:

- For the adult population, HBL's 2025 achievement scores were not statistically significantly higher than the 2024 achievement scores or the Healthy Louisiana SWA for any measure; therefore, no substantial strengths were identified. **[Quality, Timeliness, and Access]**
- For the general child population, HBL's 2025 achievement scores were statistically significantly higher than the 2024 achievement scores for the following measures: *Rating of Health Plan*, *How Well People Communicate*, *Treatment or Counseling Convenience*, and *Getting Professional Help*. **[Quality and Access]**
- For the child population, HBL's 2025 achievement score for *Rating of Health Plan* was statistically significantly higher than the 2025 Healthy Louisiana SWA. **[Quality]**

For HBL, the following opportunity for improvement was identified:

- For the adult and child populations, HBL's 2025 achievement scores were not statistically significantly lower than the 2024 achievement scores or Healthy Louisiana SWA for any measure; therefore, no substantial opportunities for improvement were identified. **[Quality]**

For HBL, the following recommendation was identified:

- HSAG recommends that HBL focus on increasing response rates to the Behavioral Health Member Satisfaction Survey for all populations so there are greater than 100 respondents for each measure. HBL could increase its response rate by educating and engaging all employees to increase their knowledge of the Behavioral Health Member Satisfaction Survey using customer service techniques, oversampling, and providing awareness to members and providers during the survey period. **[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

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 June to August 2025.

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 performed a trend analysis of the results in which the 2025 achievement scores were compared to their corresponding 2024 achievement scores to determine whether there were statistically significant differences. Statistically significant differences between the 2025 achievement scores and the 2024 achievement scores are noted with directional triangles. An MCO's score that performed statistically significantly higher in 2025 than 2024 is noted with a black upward triangle (▲). An MCO's score that performed statistically significantly lower in 2025 than 2024 is noted with a black downward triangle (▼). An MCO that did not perform statistically significantly higher or lower between years was not denoted with a triangle.

Additionally, 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 accessibility of 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 8-3.

Table 8-3—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	✓		

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

9. Case Management Performance Evaluation

Results

During SFY 2025, HSAG conducted a review of the MCO's actions to address CAP findings, as identified during the SFY 2024 reviews. In addition, HSAG and LDH collaborated to determine the scope, methodology, data sources, and timing of the SFY 2026 CMPE.

The MCO successfully completed remediation actions to address the CAP findings, and the CAP was closed in October 2024.

HSAG will assess the MCO's implementation of remediation actions during the SFY 2026 reviews.

MCO Strengths, Opportunities for Improvement, and Recommendations

For HBL, the following strength was identified:

- The MCO successfully completed remediation actions to address the CAP findings. **[Quality]**

For HBL, the following opportunity for improvement was identified:

- The MCO demonstrated an opportunity for improvement with elements related to ongoing scheduled CM activities. **[Timeliness]**

For HBL, the following recommendation was identified:

- The MCO must continue the efforts documented in its CAP responses to ensure compliance with contractual requirements. **[Quality]**

Results

The 2025 (CY 2024) QRS results for HBL are displayed in Table 10-1.

Table 10-1—2025 (CY 2024) QRS Results for HBL

Composites and Subcomposites	Star Rating
Overall Rating*	**4.0**
Patient Experience	**4.0**
Getting Care	4.0
Satisfaction with Plan Physicians	4.5
Satisfaction with Plan and Plan Services	4.0
Prevention and Equity	**3.5**
Children and Adolescent Well-Care	3.0
Women's Reproductive Health	3.0
Cancer Screening	3.0
Equity	5.0
Other Preventive Services	4.0
Treatment	**3.0**
Respiratory	3.0
Diabetes	4.0
Heart Disease	2.0
Behavioral Health—Care Coordination	3.0
Behavioral Health—Medication Adherence	2.5
Behavioral Health—Access, Monitoring, and Safety	4.0
Reduce Low Value Care	3.0

*This rating includes all measures in the 2025 Health Plan Report Card as well as an Accreditation bonus for those MCOs that are NCQA Accredited.
Please note that HSAG removed the *Plan All-Cause Readmissions* (PCR) measure and the Risk-Adjusted Utilization subcomposite from the 2025 report card analysis because NCQA recommended a break in trending so comparisons to the national average could not be performed.

HBL earned an Overall Rating of 4.0 stars, with 4.0 stars for the Patient Experience composite, 3.5 stars for the Prevention and Equity composite, and 3.0 stars for the Treatment composite.

MCO Strengths, Opportunities for Improvement, and Recommendations

For HBL, the following strengths were identified:

- For the Patient Experience composite, HBL earned 4.5 stars for the Satisfaction with Plan Physicians subcomposite and 4.0 stars for both the Getting Care and Satisfaction with Plan and Plan Services subcomposites. These subcomposites are based on HBL member responses to CAHPS surveys questions, demonstrating HBL members are satisfied with their providers, their health plan and the services it provides, and they get the care they need. **[Quality and Access]**
- For the Prevention and Equity composite, HBL earned 5.0 stars for the Equity subcomposite, demonstrating strength for HBL related to collecting language preferences and race/ethnicity information from their members. HBL also earned 4.0 stars for the Other Preventive Services subcomposite, demonstrating strength for HBL related to providing chlamydia screenings for young women. **[Quality and Access]**
- For the Treatment composite, HBL earned 4.0 stars for the Diabetes and Behavioral Health—Access, Monitoring, and Safety subcomposites, demonstrating strength for HBL related to diabetic care and care for adults and children using antipsychotics, members with a new SUD episode, and children using newly prescribed ADHD medication. **[Quality, Timeliness, and Access]**

For HBL, the following opportunity for improvement was identified:

- For the Treatment composite, HBL earned 2.5 stars and 2.0 stars for the Behavioral Health—Medication Adherence and Heart Disease subcomposites, respectively, demonstrating opportunities for improvement for HBL to ensure members with depression and opioid use disorder stay on prescribed medications and ensure that members with hypertension control their high blood pressure and members with cardiovascular disease remain on their statin medications. **[Quality]**

For HBL, the following recommendation was identified:

- The MCEs were directed to reference the recommendations made for PMV and CAHPS as the Health Plan Report Card reflects HEDIS and CAHPS results. HSAG did not make additional recommendations specific to the QRS activity.

Methodology

Objectives

HSAG was tasked with developing a QRS to evaluate the performance of the six Healthy Louisiana Medicaid MCOs (i.e., ABH, ACLA, HBL, HUM, LHCC, and UHC) relative to national benchmarks and assign ratings to each MCO in key areas. The 2025 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 2024 CAHPS member-level data files and HEDIS IDSS data files from LDH and the six MCOs. The *HEDIS MY 2024 Specifications for Survey Measures, Volume 3* was used to collect and report on the CAHPS measures. The *HEDIS MY 2024 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 2024 (MY 2023) Quality Compass national Medicaid all lines of business (ALOB) benchmarks for this analysis.[15]

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 2025 Health Plan Ratings Methodology, where possible, for the following composites and subcomposites:[16,17]

- Overall
- Patient Experience
  - Getting Care
  - Satisfaction with Plan Physicians
  - Satisfaction with Plan and Plan Services

[15] 2024 (MY 2023) Quality Compass national Medicaid ALOB benchmarks were used since LDH requested a finalized report card by August 5, 2025, and 2025 (MY 2024) Quality Compass national Medicaid ALOB benchmarks were not available until August 29, 2025.

[16] NCQA. 2025 Health Plan Ratings Required HEDIS, CAHPs, and HOS Measures. Available at: https://wpcdn.ncqa.org/www-prod/2025-HPR-List-of-Required-Performance-Measures_April-2025-Update.pdf. Accessed on: Dec 15, 2025.

[17] Please note that eight measures from NCQA's Health Plan Ratings measure list were not included in the 2025 report card measure list given that the MCOs are not required to report them for MY 2024.

- Prevention and Equity
  - Children and Adolescent Well-Care
  - Women's Reproductive Health
  - Cancer Screening
  - Equity
  - 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
  - Reduce Low Value Care

For each measure included in the 2025 Health Plan Report Card, HSAG compared the raw, unweighted measure rates to the 2024 (MY 2023) Quality Compass national Medicaid ALOB percentiles and scored each measure as outlined in Table 10-2. For the *Race/Ethnicity Diversity of Membership*, *Language Diversity of Membership*, and *Plan All-Cause Readmissions* measures, HSAG followed NCQA's methodology for scoring race/ethnicity diversity measures, language diversity measures, and risk-adjusted utilization measures, respectively.

Table 10-2—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 2024 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 10-3.

Table 10-3—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 2025 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).

11. MCO Strengths, Opportunities for Improvement, and Recommendations

HSAG used its analyses and evaluations of EQR activity findings from SFY 2025 to comprehensively assess HBL's performance in providing quality, timely, and accessible healthcare services to Louisiana's Medicaid and CHIP members. HSAG provides HBL's strengths, opportunities for improvement, and recommendations in Table 11-1 through Table 11-3.

Table 11-1—Strengths Related to Quality, Timeliness, and Access

Overall MCO Strengths	
PIP	• For three of the four PIPs assessed for achieving significant improvement, at least some of HBL's reported performance indicator results demonstrated statistically significant improvement from baseline to the most recent remeasurement. **[Quality, Timeliness, and Access]**
PMV	• HBL was effective in coordinating with providers to ensure that adolescent and adult members diagnosed with SUD received timely and adequate follow-up care after discharge from a treatment setting; engage members with opioid use disorder in continuous treatment with pharmacotherapy; and initiate treatment for members with a new SUD episode and engage these members in subsequent SUD services or medications. **[Quality, Timeliness, and Access]** • HBL effectively coordinated with providers to help members with diabetes control their blood sugar levels and receive a retinal eye exam to screen for diabetic retinal disease. **[Quality]**
Compliance	• HBL scored 100 percent for six standards in the CR, indicating that HBL's policies and procedures were generally compliant with contract requirements, and staff were generally knowledgeable about the requirements, policies, and procedures. **[Quality]**
NAV	• Overall, 93.1 percent of respondents in the provider access survey confirmed the sampled address was correct. **[Quality and Access]** • Overall, 90.5 percent of the locations in the PDV confirmed affiliation with the sampled provider. **[Quality, and Access]**
EDV	• HBL reported less than 1.0 percent of NEMT, pharmacy, and vision encounters as initially rejected and not yet accepted; had low duplicate rates for professional encounters, institutional encounters, and pharmacy; and had key data elements populated with at least 95.0 percent of valid values for institutional encounters. **[Quality]**
CAHPS and Behavioral Health Member Satisfaction Survey	• For the general child population, HBL's 2025 CAHPS achievement scores were statistically significantly higher than the 2025 NCQA child national averages for two measures: *Getting Needed Care* and *Getting Care Quickly*. **[Quality, Timeliness, and Access]**

Overall MCO Strengths	
	• For the general child population, HBL's 2025 CAHPS achievement scores were statistically significantly higher than the 2024 achievement scores for the following measures: *Rating of Health Plan*, *How Well People Communicate*, *Treatment or Counseling Convenience*, and *Getting Professional Help*. **[Quality and Access]** • For the Behavioral Health Member Satisfaction Survey, no substantial improvements were identified. **[Quality, Timeliness, and Access]**
CMPE	• HBL successfully completed remediation actions to address the CAP findings. [**Quality**]

Table 11-2—Opportunities for Improvement Related to Quality, Timeliness, and Access

Opportunities for Improvement	
PIP	• For one PIP (*Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years)* assessed for achieving significant improvement, none of HBL's reported indicator results demonstrated statistically significant improvement from baseline to the most recent remeasurement, and for one other PIP (*Screening for HIV Infection*), some but not all of HBL's reported indicator results demonstrated statistically significant improvement from baseline to the most recent remeasurement. **[Quality, Timeliness, and Access]**
PMV	• HBL had room for improvement to ensure that members hospitalized or accessing the ED for mental illness or substance abuse receive adequate follow-up care. **[Quality, Timeliness, and Access]** • HBL had room for improvement in ensuring that providers effectively prevent or minimize the prescribing of antibiotics to children with URIs and adults with bronchitis or bronchiolitis. **[Quality]**
Compliance	• HBL scored 57 percent for Standard V—Adequate Capacity and Availability of Services, demonstrating the need to improve compliance with network access standards. **[Quality]** • HBL scored 5 percent for Standard IX—Subcontractual Relationships and Delegation, demonstrating the need to ensure that all contract or written arrangements include State and federal requirements. **[Quality]**
NAV	• The PDV revealed several opportunities for improvement related to the accuracy of the specialty and the accuracy of the acceptance of HBL, Louisiana Medicaid, and new patients. **[Quality]** • The provider access survey demonstrated overall low compliance (32.5 percent). **[Quality and Access]**
EDV	• HBL had opportunities to improve reporting from its palliative care and pharmacy subcontractors. **[Quality and Timeliness]**

Opportunities for Improvement	
	• HBL had the highest duplicate encounter rate (5.5 percent) among the MCEs with dental encounters. **[Quality]** • HBL submitted only 77.9 percent of professional encounters and 74.4 percent of institutional encounters to LDH within 60 days from the payment date. **[Timeliness]** • HBL had several data elements with less than 95.0 percent of valid values. **[Quality]**
CAHPS and Behavioral Health Member Satisfaction Survey	• For both CAHPS and the Behavioral Health Member Satisfaction Survey, no substantial opportunities for improvement were identified. **[Quality, Timeliness, and Access]**
CMPE	• HBL demonstrated an opportunity for improvement with elements related to ongoing scheduled CM activities. [**Timeliness]**

Table 11-3—Recommendations

Overall MCO Recommendations		
EQR Activity	**Recommendation**	**Associated Quality Strategy Goals to Target for Improvement**
PIP	• To facilitate significant outcomes improvement for all PIPs, the MCO should review intervention evaluation results to determine if each intervention is having the desired impact and how interventions can be revised to increase effectiveness. The MCO should also revisit MCO-specific barrier analyses for each PIP to evaluate whether additional barriers need to be addressed by new or revised interventions to drive outcomes improvement. **[Quality, Timeliness, and Access]**	Goal 4: Promote wellness and prevention
PMV	• HBL should work with providers to identify barriers and improve coordination of follow-up care following discharge from the hospital or ED for members with mental illness and substance use. **[Quality, Timeliness, and Access]**	Goal 2: Improve coordination and transitions of care Goal 4: Promote wellness and prevention

Overall MCO Recommendations		
	• HBL should work with providers to prevent or reduce antibiotic dispensing to treat URIs in children and adults with bronchitis or bronchiolitis. **[Quality]**	
Compliance	• HBL must ensure compliance with network access standards. **[Quality]** • HBL must ensure its credentialing and recredentialing processes comply with State and federal requirements. **[Quality]** • HBL must complete its CAP to resolve all *Not Met* findings from the CR.	Goal 1: Ensure access to care to meet enrollee needs Goal 7: Pay for value and incentivize innovation
NAV	• In addition to updating provider information, HBL should conduct a root cause analysis to identify the nature of the data mismatches for PDV. **[Quality]** • HBL should conduct outreach to its providers to ensure the providers and/or their offices routinely submit up-to-date information on all pertinent provider indicators. **[Quality]**	Goal 1: Ensure access to care to meet enrollee needs
EDV	• HBL should develop a comprehensive suite of encounter data quality monitoring reports to assess the accuracy, completeness, and timeliness of encounter data received from its palliative care and pharmacy subcontractors. **[Quality]** • HBL should build a process with LDH to ensure that rejected professional encounters will be submitted to LDH with correct information and monitor its encounter data submission to LDH to ensure professional and institutional encounters are submitted to LDH in a timely manner after payment. **[Quality]** • HBL should review its system for identifying and handling duplicates	Goal 7: Pay for value and incentivize innovation Goal 8: Minimize wasteful spending

Overall MCO Recommendations		
	for dental encounters. Identification and appropriate handling of duplicate encounters is crucial for accurate financial and actuarial calculations. **[Quality]** • HBL should investigate the root causes for data elements with less than 95.0 percent of valid values to improve accuracy. **[Quality]**	
CAHPS and Behavioral Health Member Satisfaction Survey	• HBL should focus on increasing response rates to the CAHPS survey for its adult and general child populations and the Behavioral Health Member Satisfaction Survey so there are greater than 100 respondents for each measure by educating and engaging all employees to increase their knowledge of the surveys using customer service techniques, oversampling, and continuing to provide awareness to members and providers during the survey period. **[Quality, Timeliness, and Access]**	Goal 3: Facilitate patient-centered, whole-person care
CMPE	• HBL should continue the efforts documented in its CAP responses to ensure compliance with contractual requirements. **[Quality]**	Goal 2: Improve coordination and transitions of care

12. 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 2023–2024 recommendations. Table 12-1 through Table 12-9 contain a summary of the follow-up actions that HBL completed in response to the EQRO's SFY 2024 recommendations. Furthermore, HSAG assessed HBL'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 12-1—Follow-Up on Prior Year's Recommendations for PIPs

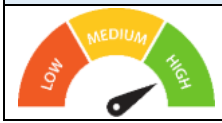
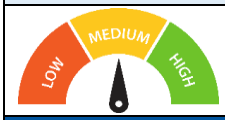
Recommendation
To facilitate significant outcomes improvement for all PIPs, HSAG recommended that HBL review intervention evaluation results to determine whether each intervention is having the desired impact and how interventions can be revised to increase effectiveness. HBL should also revisit MCO-specific barrier analyses for each PIP to evaluate whether additional barriers need to be addressed through new or revised interventions to drive outcomes of improvement.
Response
Describe initiatives implemented based on recommendations: HBL has introduced brainstorming sessions within the monthly PIP workgroups, involving cross-functional teams, to explore strategies for enhancing the effectiveness of interventions. HBL continues to consistently review barrier analyses for each PIP during PIP workgroup meetings, where both provider-facing and member-facing teams contribute their feedback.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Currently monitoring and analyzing engagement metrics such as open rates, response rates, and opt-out rates to identify patterns and pinpoint areas for improving the "Text Campaign" intervention.
Identify any barriers to implementing initiatives: HBL faced a minor setback with this initiative because some data was incomplete, necessitating the re-running of certain reports to ensure accuracy.
Identify strategy for continued improvement or overcoming identified barriers: HBL will continue to review and refine the initiative by completing timely reviews and communicating through our established feedback loop.
HSAG Assessment


Table 12-2—Follow-Up on Prior Year's Recommendations for Performance Measures

Recommendation
HSAG recommended that HBL evaluate performance measures with rates below the NCQA national 50th percentile.
Response
Describe initiatives implemented based on recommendations: Healthy Blue continuously seeks initiatives for annual improvement by thoroughly analyzing performance metrics. We leverage value-based contracts to identify areas for additional support, aiming to guide members to physician offices through outreach methods like texts, emails, calls, and personal visits. Additionally, we conduct regional deep dives to implement targeted strategies, collaborating closely with local doctors.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): CIS Combo 3 2.19%, Prenatal Postpartum 2.43%, CCS 2.43%, CBP 4.38%, EED 2.92%, FUH 2.48%, FUA 4.67%
Identify any barriers to implementing initiatives: We encountered members opting out of text campaigns, enabling us to avoid contacting those who frequently do not engage or attend their appointments.
Identify strategy for continued improvement or overcoming identified barriers: We are collaborating more with providers to encourage members to attend their appointments. Our observations indicate that members are more likely to respond to or receive text messages from their physicians.
HSAG Assessment

Recommendation
To improve performance on the *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, and Follow-Up After Emergency Department Visit for Substance Use—Within 7 Days of Discharge and Within 30 Days of Discharge* measure indicators, HSAG recommended that the MCOs work with providers to identify barriers to timely follow-up care and trial solutions to improve coordination of care following discharge among providers and between providers and the MCOs.
Response
Describe initiatives implemented based on recommendations: While HBL consistently fosters thought-provoking collaboration with providers during clinical rounds and routine meetings to address barriers to timely follow-up, Healthy Blue has recently formed a new partnership with a statewide in-home medical group. This partnership aims to serve high and emerging risk patients by delivering integrated in-home medical and behavioral care, conducting health assessments, and coordinating follow-up. A vital aspect of this initiative is developing solutions for ensuring timely follow-up.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Given the recent implementation of these initiatives, we have not yet observed measurable improvements in performance. However, we are closely monitoring key performance indicators and expect to see positive trends

as the initiatives gain traction, and more data becomes available. We remain committed to evaluating progress and making any necessary adjustments to achieve our desired outcomes.

Identify any barriers to implementing initiatives:
To date, the only minor barrier has been coordination challenges linked to social drivers of health (SDOH)—for example, transportation insecurity limiting members' ability to attend post discharge behavioral health (BH) appointments after inpatient stays, as well as intermittent phone/internet access, language and health literacy needs, unstable housing, and competing work/caregiver demands that delay timely follow up.

Identify strategy for continued improvement or overcoming identified barriers:
Healthy Blue proactively addresses social drivers of health by implementing targeted strategies and leveraging internal resources to connect members with essential services, ensuring a holistic approach to care and support.

HSAG Assessment



Recommendation

To improve performance on the *Plan All-Cause Readmissions—O/E Ratio* measure, HSAG recommended that the MCOs work with providers to improve post-discharge planning and care coordination.

Response

Describe initiatives implemented based on recommendations:
Healthy Blue have identified hospitals (both PH and BH) in Louisiana that have higher than expected readmission rates. An Outreach Care Specialist (OCS) or a Community Health Worker (CHW) is assigned to meet with Healthy Blue members with a likelihood of re-admission to ensure that he/she has follow-up appointments scheduled along with transportation.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
Appointments following hospitalization have increased.

Identify any barriers to implementing initiatives:
One hospital with high readmission rates currently restricts Healthy Blue OCS from on-site access, limiting our ability to engage beyond making phone calls. This presents challenges in effectively managing care transitions.

Identify strategy for continued improvement or overcoming identified barriers:
Healthy Blue will persist in making calls to members and conducting home visits for those we are unable to visit in the hospital.

HSAG Assessment



Recommendation

To improve performance on the Use of *Imaging Studies for Low Back Pain* measure, HSAG recommended that the MCOs focus their efforts on decreasing unnecessary imaging for low back pain. HSAG also recommended that the MCOs work with providers to trial solutions to reduce the inappropriate ordering of imaging studies.

Response
Describe initiatives implemented based on recommendations: Healthy Blue disseminates materials and educates healthcare providers on clinical guidelines and best practices for managing low back pain and encouraging appropriate imaging practices among providers. HBL also continues to inform providers on our Chronic Pain Management program, which assists and connects members with resources for chronic pain.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): In our ongoing evaluation, we continue to await measurable performance improvement. However, we remain committed to closely monitoring this initiative's progress and identifying opportunities to enhance outcomes.
Identify any barriers to implementing initiatives: HBL continues to experience the challenge of raising awareness of available services.
Identify strategy for continued improvement or overcoming identified barriers: Healthy Blue will continue to educate both members and providers on the importance of appropriate service utilization through our website, Provider Newsletters, Medical Advisory Committees, Health Education Advisory Committees (consumer focused), and member text campaigns.
HSAG Assessment

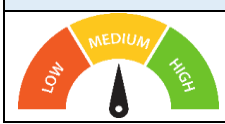
Recommendation
To improve performance on the *Non-Recommended Cervical Screening in Adolescent Females* measure, HSAG recommended that the MCOs work with providers to trial solutions to reduce or avoid unnecessary cervical cancer screenings for adolescent females.
Response
Describe initiatives implemented based on recommendations: Healthy Blue is committed to promoting high-quality care by providing comprehensive clinical guidelines and best practices related to the appropriate screening for cervical cancer. Our approach is aligned with evidence-based recommendations to ensure that screenings are conducted efficiently and effectively, enhancing overall patient safety and optimizing health outcomes. Our Provider Success Team continues to share resources and provide education regarding this initiative.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Through this initiative, Healthy Blue has successfully expanded educational outreach, enabling more providers to become well-informed about the cervical cancer screening measure. This ongoing effort supports the delivery of high-quality healthcare and the alignment of clinical practices with current evidence-based standards.
Identify any barriers to implementing initiatives: No barriers have yet been identified with implementing these initiatives.
Identify strategy for continued improvement or overcoming identified barriers: No strategy is needed at this time due to no barriers listed above.
HSAG Assessment


Table 12-3—Follow-Up on Prior Year's Recommendations for Compliance With Medicaid Managed Care Regulations

Recommendation
A CR was not conducted last year; therefore, HSAG did not have prior year recommendations.

Table 12-4—Follow-Up on Prior Year's Recommendations for Network Adequacy

Recommendation
HSAG recommended that LDH provide HBL with the case-level PDV and provider access survey data files (i.e., flat files) and a defined timeline by which HBL will address provider data deficiencies identified during the PDV reviews and/or provider access survey (e.g., provider specialty, MCO acceptance, and Louisiana Medicaid acceptance).
Response
Describe initiatives implemented based on recommendations: Healthy Blue has streamlined provider onboarding and data validation processes using Availity. The health plan reviews existing contracts to validate services providers that are contracted for and outreached for new licenses when needed. For deficiencies in provider data, Healthy Blue's Elixir processes utilizes third party sources such as LexisNexis, Google, and other source systems to validate data and update any providers. Furthermore, utilizing Availity's Provider Data Management Tool Healthy Blue requests of providers for real-time data through re-validation prompts and other incorporated workflows that facilitate accurate data capture from the outset. Healthy Blue has also a Return-to-Field strategy which has led to an increase in the number of in-person provider encounters, further creating opportunities to validate data accuracy.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): There has been an improvement in the accuracy and reliability of provider data. These enhancements have led to more effective dissemination of the Provider Access Survey invitations, ensuring a higher response rate and providing a more comprehensive data set for evaluating provider access issues.
Identify any barriers to implementing initiatives: Barriers to implementing these initiatives have been providers' failure to submit updates and change requests prior to changes or at all, provider resistance to adopting digital solutions, resistance to using Availity specifically, resistance to self-service solutions, and the pervasiveness of incorrect information in third-party systems (e.g., Google also has a bad phone number). Furthermore, if providers do not receive the survey due to bad demographic data, then they cannot respond to correct the error.
Identify strategy for continued improvement or overcoming identified barriers: To overcome the above barriers, a strategy focusing on continuous education and communication with providers about the importance of maintaining current data is key. Regular training sessions on the use of Availity tools, combined with a feedback loop to providers when discrepancies are found, help mitigate data integrity issues. Furthermore, setting up a dedicated team to continuously monitor and reconcile data from various sources (Elixir) can help ensure prompt and consistent updates, addressing synchronization challenges effectively.
HSAG Assessment


Recommendation
HSAG recommended that HBL conduct a root cause analysis to identify the nature of the data mismatches for PDV and provider access survey study indicators that scored below 90 percent.
Response
Describe initiatives implemented based on recommendations: Once scores are received, providers who are non-compliant are placed on a corrective action plan that highlights deficiencies on the surveys and providers are asked to advise on the corrections and/or updates they made to improve compliance. Outreach attempts are made to providers to reinforce education on access and availability standards. Healthy Blue implemented and educated providers to utilize Availity's Provider Data Management tool, which allows providers to self-serve to manage, update, and change their data seamlessly in real-time.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): While analysis is ongoing and not subject to be completed until early 2026, Healthy Blue has seen notable improvement on compliance based on consistent education of the network. Based on office staff turnover, Healthy Blue saw the need to re-educate providers more frequently.
Identify any barriers to implementing initiatives: Challenges include non-responsive providers and lack of effective communication from providers. Frequent administrative turnover in providers' offices has also acted as a barrier to improving compliance.
Identify strategy for continued improvement or overcoming identified barriers: Strategies to continue improvement and overcome these barriers include continued outreach and increased face-to-face visits. Additionally, our Provider Enrollment tool in Availity Essentials allows providers to update their own demographic information and attest to the accuracy of current information on a periodic basis. Healthy Blue continues to stress the importance of self-service abilities within Availity to improve data accuracy.
HSAG Assessment

Recommendation
HSAG recommended that HBL consider conducting a review of the offices' eligibility verification requirements to ensure these barriers do not unduly burden members' ability to access care.
Response
Describe initiatives implemented based on recommendations: Healthy Blue has implemented processes to validate eligibility verification and enrollment in the Gainwell portal of existing and new providers.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Providers who have not enrolled are flagged for contracting and network participation. This process also inhibits reimbursement to providers who have not completed their enrollment and limits the number of providers lacking appropriate licensing and credentials from seeing Healthy Blue members.
Identify any barriers to implementing initiatives: Provider follow-up to invitations for enrollment. Providers broadband access limitations. (Providers are still using dial-up modems or who do not use an EHR system.) Providers lack proficiency in navigating portal or IT generally.
Identify strategy for continued improvement or overcoming identified barriers: Healthy Blue educates providers on partners in their region that can provide internet access (e.g., libraries, hospitals, etc.)

HSAG Assessment

Recommendation
HSAG recommended that LDH review its reporting templates against the contractual language to align with and more accurately reflect the LDH-desired population stratifications by urbanicity and adult and pediatric populations to ensure consistent reporting by the MCEs.
Response
Describe initiatives implemented based on recommendations: While LDH has not updated attachment F reporting templates, following completion of the NAV audit Healthy Blue made changes to its reporting methodology to separate urban and rural for Endocrinology/Metabolism, Neurology and Orthopedics to improve data reporting for adequacy.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Healthy Blue is now able to demonstrate urban and rural access to care for adults and pediatrics for specialties that were previously combined.
Identify any barriers to implementing initiatives: Lack of definitions provided by LDH.
Identify strategy for continued improvement or overcoming identified barriers: Continuous monitoring of templates and contractual changes to update reporting requirements.
HSAG Assessment
An HSAG auditor assessment of the MCO's intervention was not required, as no prior recommendation had been issued.

Table 12-5—Follow-Up on Prior Year's Recommendations for EDV

Recommendation
Encounter data validation was a new activity; therefore, HSAG did not have prior year recommendations.

Table 12-6—Follow-Up on Prior Year's Recommendations for CAHPS

Recommendation
None identified.

Table 12-7—Follow-Up on Prior Year's Recommendations for the Behavioral Health Member Satisfaction Survey

Recommendation
HSAG recommended that HBL conduct root cause analyses or focus studies to determine why parents/ caretakers of child members perceive an overall lack of quality of care and services, such as poor communication or services, or a lack of quality of care from their providers or health plan staff. HBL could consider whether there are disparities within its population that contribute to the lower performance in a

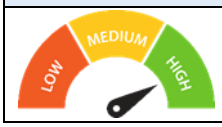
Recommendation
particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, HBL should implement appropriate interventions to improve the performance related to the care members need.
Response
Describe initiatives implemented based on recommendations: In response to HSAG's recommendation, Healthy Blue conducted a thorough root cause analysis, which identified key opportunities to enhance provider education through webinars and other resources designed to improve patient experience. Additionally, Healthy Blue reviews member feedback from Post Provider Visit surveys to continually assess and refine the quality of care and member satisfaction.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): By sharing feedback from the Post Provider Visit Surveys, providers have developed a heightened awareness of patient needs and are expressing a commitment to adopting more efficient care processes. Additionally, they are motivated to implement their own surveys to further engage with and respond to patient feedback.
Identify any barriers to implementing initiatives: No barriers have been noted at this time.
Identify strategy for continued improvement or overcoming identified barriers: No strategy is needed at this time due to no barriers listed above.
HSAG Assessment


Table 12-8—Follow-Up on Prior Year's Recommendations for Case Management Performance Evaluation

Recommendation
None identified.

Table 12-9—Follow-Up on Prior Year's Recommendations for QRS

Recommendation
The MCEs were directed to reference the recommendations made for PMV and CAHPS as the Health Plan Report Card reflects HEDIS and CAHPS results. HSAG did not make additional recommendations specific to the QRS activity.

Appendix A. MCO Health Equity Plan Summary

For the annual EQR technical report, LDH asked HSAG to summarize information from HBL's HEP submission from July 2025.

Health Equity Plan

HSAG reviewed HBL's HEP[18] submitted July 2025. HSAG organized the discussions in this report as each MCO presented the topics in its own HEP. Therefore, comparison across the MCOs for the "Development and Implementation of Focus Areas," "Cultural Responsiveness and Implicit Bias Training," and "Stratify MCO Results on Attachment H Measures" sections of the HEP is not possible.

Development and Implementation of Focus Areas

1. **For each Focus Area and each Goal within the Focus Area, please summarize activities, participants, and progress to date consistent with your MCO's submitted Health Equity Plan.** Please note:
   a. Changes to participants, if applicable
   b. Activities accomplished between January and June 2025
   c. Activities expected to be accomplished by December 2025
   d. Progress, challenges, and/or delays in achieving measurable objectives and/or milestones thus far in 2025

A. Focus Area: Chronic Diseases

A1 Goal (1)	**Improving rate of blood pressure control (BP <140/90) in the Black population**		
Participants:	Black members with diagnosed hypertension (HTN)	**Changes to Participants:**	No change to participants.
Strategy:	• Improve messaging and communications. • Case Management-focused engagement. • Leverage provider involvement. • Whole Health approach to addressing social drivers. • Value Added Benefits, Member Rewards, Member Incentives. • Community engagement and partnerships. • Promote digital solutions to increase access.		
Activity:	• Outreach to members via text and IVR to provide information around controlling blood pressure and being connected to a provider, as appropriate.		

[18] Please note that the narrative within the "MCE Response" section was provided by the MCE and has not been altered by HSAG except for formatting.

	• High-touch in-person outreach to members who fall into below current initiatives: ○ High ED Utilizers with no well-visits: purpose to outreach and educate members with excessive ED visits per year and no wellness visits within 2 years, and connect members to CM and PCP, as well as assist in scheduling preventive care appointments, as needed and as appropriate. ○ Potentially pregnant members in need of an OB screener: purpose to identify and outreach OB members with no completed OB screener and who have at least one co-morbidity. ○ Unable to reach face to face CM: ▪ Post Acute: purpose to provide in person outreach to home visits for members upon discharge from acute facility within areas of Lafayette, Baton Rouge, and Shreveport to address barriers of care and SDoH upon discharge. ▪ DOJ: purpose to identify members who are at risk for SNF placement and have 2 occurring co-morbidities and a serious mental illness, with goal to connect to CM and secure PCP appointment to address needs and gaps in care. ▪ Pregnant: purpose to identify and outreach in-person to unable to reach potentially pregnant members with goal to connect to CM and address gaps in care. ○ Homelessness/Food insecurity: purpose to identify and outreach members experiencing homelessness and/or food insecurities identified through use of Z codes. • Social Determinants of Health (SDOH) focused outreach initiative via telephone, text, virtual, email, mail, system generated messaging, and physical visit. Initiative offers in-home care coordination for members to improve their access to healthcare services. The focus is on connecting members with the necessary resources and support to manage their healthcare needs effectively, and often includes personalized care planning, facilitating communication between patients and healthcare providers, assisting with scheduling appointments, arranging transportation to medical visits, and addressing social determinants of health that might affect their well-being. The goal is to ensure that members receive comprehensive and continuous care to enhance their overall health outcomes. This initiative focuses on hyper-local strategies, leveraging technology, and partnering with community-based organizations (CBOs). • Tiered Case Management provides additional structure and support to managing the health of members throughout their changing health and healthcare needs. The goal of the Tiered Case Management program is to provide high quality, culturally competent case management services. The program provides support and assistance to members with multiple and/or complex conditions. Licensed Clinical/Professional Case Managers, Community Health Workers and Outreach Care Specialist collaborate, evaluate, advocate for, and educate members by assessing, evaluating, and developing care plans to ensure care is received at the most appropriate time and setting. The case management process fosters improved member health outcomes and self-care management. ○ The four tiers are: Wellness and Prevention, Low Risk, Medium Risk, and High Risk. Wellness and Prevention tier has gaps in care reminders, well visit reminders, etc. Low Risk tier is for care coordination and evaluation. Medium Risk tier is for complex case management and transition of care.

	High Risk tier is for highest needs, complex case management, transition of care, etc. • Twice daily MD-led integrated discharge planning rounds implemented with goals to establish a comprehensive and integrated approach that enhances provider collaboration, promotes improved member-provider relationships, and ensures effective discharge planning and follow-up care coordination. This collaboration between Healthy Blue and the acute facility aims to create an enhanced internal integrated process that fosters increased provider collaboration. ○ The twice daily MD-led rounds include the integrated behavioral health (BH) and physical health (PH) teams, as well as multidisciplinary representation, including but not limited to housing specialist, utilization management, case management, integrated collaborative care team and associates. ○ During the rounds, there is a daily review of the integrated inpatient census, including both BH and PH, with deployment of in-person resources to participating acute facilities to members as appropriate and per collaborative and multidisciplinary discussions, based on unique member needs. ○ Healthy Blue Louisiana associates are able to refer members to available programs, as appropriate and as needed. This initiative promotes improved relationships between members and providers through targeted clinical interventions and real-time discharge planning. ○ The in-person outreach care associates can aid in discharge planning and in performing warm transfer via phone call to Healthy Blue Case Managers, as needed and as appropriate. Having the ability to connect with members while inpatient increases the chances of making a meaningful connection with members. ○ Chronic condition diagnosis driving acute admission, including but not limited to, hypertension is considered when deploying in person resources and CM outreach. ○ Community health worker is deployed to acute facility to engage member upon admit, in effort to reduce readmission by assisting members to connect to PCP, clinical case management, and provide support and resources for discharge planning. Healthy Blue implemented the deployment of in-person resources, as appropriate, to engage with members face to face upon admit to participating acute facilities, in an effort to reduce readmission rates by assisting members to connect to their Primary Care Physician (PCP) or assist in connecting members without a PCP to PCP services. • Continue to offer and enroll providers into Pay for Quality (P4Q) program, as appropriate, which incentivizes rural health providers with 500 or fewer members for meeting goals related to measures such as, but not limited to, controlling blood pressure. • Continue to educate Healthy Blue associates, members, and providers on value-added benefits and healthy rewards related to heart health • Continue to partner with the Truth Initiative to provide EX Program for tobacco and nicotine cessation to provide culturally sensitive material for quit smoking and vaping campaigns, education, and awareness on tobacco and vaping cessation.

	• Partner with Community Based Organizations (CBOs) and faith-based organizations (FBOs) to promote healthy lifestyles, utilize trusted messengers for culturally tailored communications and member feedback. • Continue to partner with Geaux Get Healthy Clinical Program focused on addressing food insecurity within the community it serves by way of education, hands on training, grocery store tours, all while collecting data for research and to inform change. • Launched ED Reduction In Lieu Of Services (ILOS) pilot in state regions 4 and 5 on February 10, 2025, with Acadian Health.
Measurable Objective:	• Decrease Black/White disparity for HTN by 1% YOY.
Activities Accomplished between January and June 2025:	• Text and IVR campaigns for controlling blood pressure. ○ Between January through April of 2025, Healthy Blue attempted to enroll 17,220 members in text and IVR campaign for controlling blood pressure. ▪ 47,579 SMS messages were delivered with 19,838 unique link clicks tracked. ▪ 1,293 outbound IVR calls were placed. ○ Between January through April of 2025, Healthy Blue attempted to enroll 97,549 members in text campaign for healthy rewards. ▪ 195,043 SMS messages were delivered • Healthy Rewards - Healthy Blue continues to offer Healthy Rewards incentives for members with a hypertension diagnosis and continues to refill their medications: ○ Between January to April 2025, 131 members received Healthy Rewards incentive for refilling high blood pressure medication • High-touch Outreach to members who fall into current initiatives: ○ January 2025: 355 attempted field visits made for Healthy Blue members with monthly reach rate of 31%. ○ February 2025: 324 attempted field visits made for Healthy Blue members with monthly reach rate of 40%. ○ March 2025: 330 attempted field visits made for Healthy Blue members with monthly reach rate of 35%. ○ April 2025: 341 attempted field visits made for Healthy Blue members with monthly reach rate of 32%. • Social Determinants of Health (SDOH) focused outreach initiative via telephone, text, virtual, email, mail, system generated messaging, and physical visit. Initiative offers in-home care coordination for members to improve their access to healthcare services. The focus is on connecting members with the necessary resources and support to manage their healthcare needs effectively, and often includes personalized care planning, facilitating communication between patients and healthcare providers, assisting with scheduling appointments, arranging transportation to medical visits, and addressing social determinants of health that might affect their well-being. The goal is to ensure that members receive comprehensive and continuous care to enhance their overall health outcomes. This initiative focuses on hyper-local strategies, leveraging technology, and partnering with community-based organizations (CBOs). ○ Outreach and completed by month between January to May 2025: ▪ January – total 7,279 outreaches attempted on 1,256 members, and 376 initial assessments completed. ▪ February – total 10,309 outreaches attempted on 1,709 members, and 416 initial assessments completed.

	▪ March – total 20,716 outreaches attempted on 1,442 members, and 706 initial assessments completed. ▪ April – total 30,515 outreaches attempted on 1,683 members, and 625 initial assessments completed. ▪ May – total 20,571 outreaches attempted on 1,159 members, and 698 initial assessments completed. • Pay for Quality has 23 provider TINs enrolled. • Digital platform offered to members to provide education on hypertension and the possibility of leading to heart failure if not appropriately controlled. Platform provides access to educational materials and resources, as well as bidirectional communication with case managers. • Quality staff prioritized outreach to providers during this time with a focus on obtaining completed CBP information submitted. • Deployment of in-person resources to 1,288 members in acute care who were identified from twice daily, MD led, integrated rounds. • Launched ED Reduction In Lieu Of Services (ILOS) pilot in state regions 4 and 5 on February 10, 2025 with Acadian Health. Pilot program works to extend primary care physician's (PCP) practice into homes, offering treatment at home, and providing the ability to address non-medical drivers of health. Pilot program provides mobile urgent treatment to members aged 13 and older for a wide array of non-life-threatening medical conditions with the intent of avoiding an unnecessary ER visit while also working to connect members to PCPs and provider specialists, as appropriate. Pilot program has two workflows: ○ Acute Care at Home is an on-demand service for patients who require same day care within one hour. It serves as alternative care for non-traumatic hospitalizations for sick but stable patients who would otherwise seek care at the ER. A member who is reporting an acute exacerbation of chronic disease (including but not limited to hypertension, diabetes, asthma) is referred to Acadian Health by their provider, and an initial visit is scheduled. Once arriving on scene and conducting a comprehensive patient assessment, Acadian Health communicates with the PCP to report findings and request direction for care. Treatment is ordered, administered, and results and records are made available to the patient's PCP through Acadian Health's electronic health record. ▪ Based on weekly data reporting from Acadian Health to Healthy Blue, Acadian Health has performed 28 Acute Care at Home visits to Healthy Blue members between dates of service 2/10/25-5/31/25. • Of those 36 visits: ○ 33 visits resulted in treat-in-place and no need to transport member to ED services ○ 3 visits resulted in need to transport member to ED for emergency services ○ Clinic at Home is a proactive visit which is scheduled in advance, usually 24 hours ahead of time. This allows providers to extend their specialty practice into patients' homes, offering after hours and weekend support and the ability to address non-medical drivers of health. MCOs identify patients who qualify for the program, obtain patient consent, and notify patient's PCP. Patients are enrolled via

	Acadian Health's online portal. The initial visit is completed, including all assessments and screenings, to identify needs, and a second visit is scheduled. Acadian Health connects with patient's case manager to coordinate plan and community resources to address patient needs and goals of care. Treatment is ordered, administered, and results and records are made available to the patient's PCP through Acadian Health's electronic health record. ▪ Based on weekly data reporting from Acadian Health to Healthy Blue, Acadian Health has performed 199 Clinic at Home visits to Healthy Blue members between dates of service 2/10/25-5/31/25. • Provider Communications. ○ January 2025 topics: ▪ Updates to correct coding editing ▪ Announcing Health Perks — Earn rewards for your healthcare activities ▪ Enhance billing and coding accuracy with new Payment Integrity training ○ February 2025 topics: ▪ 2025 Clinical Quality in Practice webinar series ▪ LDH Informational Bulletin 25-2 January 31, 2025 Emergency Room Utilization Reduction Pilot Program ▪ Resources to support diverse patients and communities ○ March 2025 topics: ▪ ER Utilization Reduction Pilot Program ▪ Provider Educational webinars ▪ Technical difficulties: My Diverse Patients ▪ CAHPS improve patient experience ▪ HEDIS Desktop Reference Guide 2025 ▪ HEDIS ECDS ▪ Rx Medication Review Beta Blocker Erratic Refill Message ○ April 2025 topics: ▪ Reminder: appointment availability and access-to-care standards ▪ Pay for Quality P4Q 2025 LA ▪ CPT Category II codes ▪ cardio respiratory endocrine coding ▪ HEDIS ECDS Coding Booklet 2025 ▪ LA CPT Cat II Codes with Incentives ▪ INVITE Provider Education Apr-June 2025 ▪ HEDIS Cat II Coding Bulletin 2025 ▪ HEDIS Coding Booklet 2025 ○ May 2025 topics: ▪ Coding Validation: Medicaid ▪ HEDIS P4Q Flier 2025 LA ▪ You are invited: care provider educational webinars ▪ Enhancing your learning experience: latest updates in Provider Pathways • Community

	○ Community Event, "Healthy Living Resource Fair" in Rapides Parish with Alexandria Mall to bring education to the community, while also providing the following: ▪ Blood Pressure and Blood Sugar Checks ▪ Fitness Inspiration ▪ CPR Demonstration ○ Community event, "Makin' Groceries Mobile Market" in Calcasieu Parish with Second Harvest Food Bank. ○ Community event, "MLK Food Packing" in Orleans Parish with Second Harvest Food Bank and the New Orleans Saints. ○ Community event, "MLK Food Packing" in Lafourche Parish with Good Samaritan Food Bank and Louisiana Blue. ○ Food packing event in Bossier Parish with Louisiana Blue and Entergy to pack 10,000 meals. ○ Community event, "MLK Parade and Resource Fair" in St. Tammany Parish with One Covington-Future Leaders of Louisiana. ○ Community event, "Re-Entry Job Readiness Resource Fair" in Evangeline Parish with St. Landry – Evangeline United Way. ○ Community event, "Makin' Groceries Mobile Market" in Calcasieu Parish with SWLA Center for Health Services and Second Harvest Food Bank. ○ Community event, "Makin' Groceries Mobile Market" in Evangeline Parish with Second Harvest Food Bank. ○ Community event, "Makin' Groceries Mobile Market" in Acadia Parish with Second Harvest Food Bank. ○ Healthy Blue Listening Session in Ouachita Parish with community leaders. ○ Healthy Blue Listening Session in Caddo Parish with community leaders. ○ Community event, "Health Equity regional CBO Listening Sessions" in Rapides Parish with Louisiana Public Health Institute. ○ Healthy Blue Tribal Listening Session in Calcasieu Parish with Attakapas Eagle Tribe. ○ Healthy Blue Tribal Listening Session in Calcasieu Parish with Chitimacha Tribe. ○ Community event, "Makin' Groceries Mobile Market" in St. Landry Parish with Second Harvest Food Bank. ○ Food Pantry distribution in DeSoto Parish with HGM Community Development Corporation. ○ Community event, "4th Annual Health and Wellness Day" in Orleans Parish with Top Box Louisiana to provide 100 food boxes to address food insecurity. ○ Community event, "Makin' Groceries Mobile Market" in Calcasieu Parish with Second Harvest Food Bank. ○ Community Event, "You're only as good as you feel" in Rapides Parish with Rapides Parish Library. ○ Community event, "Dillard University 17th Annual Housing, Health/Community Resource Fair" in Orleans Parish with Dillard University. ○ Community, "Rebuilding Together New Orleans" in Jefferson Parish with Rebuilding Together New Orleans for workforce development. ○ Community, "Hotel Hope" in Orleans Parish with Hotel Hope.

	○ Community event, "Open Health Foundation" in East Baton Rouge Parish with Open Health Care Clinic to support providing access for all to affordable, quality healthcare. ○ Community event, "Louisiana Empty Bowls" in Caddo Parish with Northwest Food Bank of Louisiana. ○ Community, "Christian Service Program" in Caddo Parish with Christian Services Program for the food pantry program. ○ Community, "Crescent City Classic Wellness Expo" in Orleans Parish with Grace at the Green Light. ○ Community Event, "NAMI Walk" in St. Tammany Parish with NAMI St. Tammany for Mental Health Walk. ○ Community event, "Tribal Powwow" in Avoyelles Parish with Tunica-Biloxi Tribe. ○ Community, "Geaux Get Healthy" in East Baton Rouge Parish with Geaux Get Healthy Clinical Program at Our Lady of the Lake Regional Medical Center.
Activities expected to be accomplished by December 2025:	• Member and provider education • Text and IVR campaigns for controlling blood pressure. • Continue to work towards expanding the number of acute facilities participating in the enhanced discharge planning integrated program with in-person case management. • Continue to offer and promote healthy rewards for high blood pressure medication refill. • Provider Communications. ○ June 2025 topics: ▪ Bridging the gap: enhancing medication adherence for better health outcomes ▪ Learn about members' rights and responsibilities ▪ Navigating health with confidence through the Complex Case Management Program ▪ Utilization management: prioritizing appropriate care and transparency • Community ○ Community event, "Makin' Groceries Mobile Market" in Calcasieu Parish with Second Harvest Food Bank. ○ Community event, "Makin' Groceries Mobile Market" in St. Landry Parish with Second Harvest Food Bank. ○ Community Event, "NAMI Walk" in St. Tammany Parish with NAMI St. Tammany for Mental Health Walk. ○ Community Event, "12th Annual Capital Area Transit System Health Fair" in East Baton Rouge Parish with Capital Area Transit System and Our Lady of the Lake Mary Bird Perkins. ○ Food Pantry distribution in DeSoto Parish with HGM Community Development Corporation.
Progress, challenges, and/or delays in achieving measurable objectives and/or milestones thus far in 2025	Progress. • Continue to be dedicated to ensuring members complete Health Needs and Risks Assessments. • Increased number of provider TINs in Pay for Quality program which incentivizes rural providers for meeting health goals. • Increased access to acute facilities for enhanced, in-person outreach. Challenges.

	• Ensuring providers accurately document the work done for controlling blood pressure. • Ensuring providers' emails are included in the provider communications, in addition to the general office email address. Delays. • Appropriate coding of controlling blood pressure.		
A2 Goal (2)	**Improving rate of diabetic control (HbA1c <8%) in the Black population**		
Participants:	Black members diagnosed with diabetes (DM)	**Changes to Participants:**	No change to participants.
Strategy:	• Improve messaging and communications. • Whole Health approach to addressing social drivers via VABs and incentives. • Community engagement and partnerships. • Case Management-focused engagement. • Leverage provider involvement. • Value Added Benefits, Member Rewards, Member Incentives. • Promote digital solutions to increase access.		
Activity:	• Outreach to members via text and IVR to provide information around controlling blood glucose and being connected to a provider, as appropriate. • High-touch in-person outreach to members who fall into below current initiatives: ○ High ED Utilizers with no well-visits: purpose to outreach and educate members with excessive ED visits per year and no wellness visits within 2 years, and connect members to CM and PCP, as well as assist in scheduling preventive care appointments, as needed and as appropriate. ○ Potentially pregnant members in need of an OB screener: purpose to identify and outreach OB members with no completed OB screener and who have at least one co-morbidity. ○ Unable to reach face to face CM: ▪ Post Acute: purpose to provide in person outreach to home visits for members upon discharge from acute facility within areas of Lafayette, Baton Rouge, and Shreveport to address barriers of care and SDoH upon discharge. ▪ DOJ: purpose to identify members who are at risk for SNF placement and have 2 occurring co-morbidities and a serious mental illness, with goal to connect to CM and secure PCP appointment to address needs and gaps in care. ▪ Pregnant: purpose to identify and outreach in-person to unable to reach potentially pregnant members with goal to connect to CM and address gaps in care. ○ Homelessness/Food insecurity: purpose to identify and outreach members experiencing homelessness and/or food insecurities identified through use of Z codes. • Social Determinants of Health (SDOH) focused outreach initiative via telephone, text, virtual, email, mail, system generated messaging, and physical visit. Initiative offers in-home care coordination for members to improve their access to healthcare services. The focus is on connecting members with the necessary resources and support to manage their healthcare needs effectively, and often includes personalized care planning, facilitating communication between patients and healthcare providers, assisting with scheduling appointments, arranging transportation to medical visits, and addressing social determinants of health that		

	might affect their well-being. The goal is to ensure that members receive comprehensive and continuous care to enhance their overall health outcomes. This initiative focuses on hyper-local strategies, leveraging technology, and partnering with community-based organizations (CBOs). • Healthy Rewards Member Incentives for diabetic A1c screening, diabetic retinal eye exam, and completion of diabetic management quiz. • Integrated Case Management platform has health-based alerts, such as but not limited to, retinal eye exam for diabetic members when due. The alerts prompt Healthy Blue CMs to discuss the health-based alert and offer assistance in coordinating closure of that gap, as needed and as appropriate. • Tiered Case Management provides additional structure and support to managing the health of members throughout their changing health and healthcare needs. The four tiers are: Wellness and Prevention, Low Risk, Medium Risk, and High Risk. The goal of the Tiered Case Management program is to provide high quality, culturally competent case management services. The program provides support and assistance to members with multiple and/or complex conditions. Licensed Clinical/Professional Case Managers, Community Health Workers and Outreach Care Specialist collaborate, evaluate, advocate for, and educate members by assessing, evaluating, and developing care plans to ensure care is received at the most appropriate time and setting. The case management process fosters improved member health outcomes and self-care management. Wellness and Prevention tier has gaps in care reminders, well visit reminders, etc. Low Risk tier is for care coordination and evaluation. Medium Risk tier is for complex case management and transition of care. High Risk tier is for highest needs, complex case management, transition of care, etc. • Twice daily MD-led integrated discharge planning rounds implemented with goals to establish a comprehensive and integrated approach that enhances provider collaboration, promotes improved member-provider relationships, and ensures effective discharge planning and follow-up care coordination. This collaboration between Healthy Blue and the acute facility aims to create an enhanced internal integrated process that fosters increased provider collaboration. ○ The twice daily MD-led rounds include the integrated behavioral health (BH) and physical health (PH) teams, as well as multidisciplinary representation, including but not limited to housing specialist, utilization management, case management, integrated collaborative care team and associates. ○ During the rounds, there is a daily review of the integrated inpatient census, including both BH and PH, with deployment of in-person resources to participating acute facilities to members as appropriate and per collaborative and multidisciplinary discussions, based on unique member needs. ○ Healthy Blue Louisiana associates are able to refer members to available programs, as appropriate and as needed. This initiative promotes improved relationships between members and providers through targeted clinical interventions and real-time discharge planning. ○ The in-person outreach care associates can aid in discharge planning and in performing warm transfer via phone call to Healthy Blue Case Managers, as needed and as appropriate. Having the ability to connect

	with members while inpatient increases the chances of making a meaningful connection with members. ○ Chronic condition diagnosis driving acute admission, including but not limited to, diabetes is considered when deploying in person resources and CM outreach. ○ Community health worker is deployed to acute facility to engage member upon admit, in effort to reduce readmission by assisting members to connect to PCP, clinical case management, and provide support and resources for discharge planning. Healthy Blue implemented the deployment of in-person resources, as appropriate, to engage with members face to face upon admit to participating acute facilities, in an effort to reduce readmission rates by assisting members to connect to their Primary Care Physician (PCP) or assist in connecting members without a PCP to PCP services. • Continue to educate Healthy Blue associates, members, and providers on value-added benefits and healthy rewards related to heart health • Continue to partner with the Truth Initiative to provide EX Program for tobacco and nicotine cessation to provide culturally sensitive material for quit smoking and vaping campaigns, education, and awareness on tobacco and vaping cessation. • Partner with Community Based Organizations (CBOs) and faith-based organizations (FBOs) to promote healthy lifestyles, utilize trusted messengers for culturally tailored communications and member feedback. • Continue to partner with Geaux Get Healthy Clinical Program focused on addressing food insecurity within the community it serves by way of education, hands on training, grocery store tours, all while collecting data for research and to inform change. • Continue to offer and enroll providers into Pay for Quality (P4Q) program, as appropriate, which incentivizes rural health providers with 500 or fewer members for meeting goals related to measures such as, but not limited to, controlling blood glucose (A1c), compliance with eye exam for diabetes. • Work to increase the number of providers incentivized for eye exams for diabetes through Pay for Quality VBP which incentivizes rural health providers with 500 or fewer members. • Work to expand community partnerships with diabetes focused CBOs. • Leverage community champions and trusted messengers for peer-to-peer messaging and community feedback. • Launched ED Reduction In Lieu Of Services (ILOS) pilot in state regions 4 and 5 on February 10, 2025 with Acadian Health.
Measurable Objective:	• Decrease Black/White disparity for DM by 1% YOY.
Activities Accomplished between January and June 2025:	• Text and IVR campaigns for comprehensive diabetes care. ○ Between January through April of 2025, Healthy Blue attempted to enroll 17,343 members in text and IVR campaign for comprehensive diabetes care. ▪ 44,499 SMS messages were delivered with 20,201 unique link clicks tracked. ▪ 771 outbound IVR calls were placed. • Healthy Rewards ○ Between January to April 2025: ▪ 714 members received Healthy Rewards incentive for completing diabetic A1c screening

	▪ 616 members received Healthy Rewards incentive for completing diabetic retinal eye exam ▪ 152 members received Healthy Rewards incentive for completing diabetes management quiz • High-touch Outreach to members who fall into current initiatives: ○ January 2025: 355 attempted field visits made for Healthy Blue members with monthly reach rate of 31%. ○ February 2025: 324 attempted field visits made for Healthy Blue members with monthly reach rate of 40%. ○ March 2025: 330 attempted field visits made for Healthy Blue members with monthly reach rate of 35%. ○ April 2025: 341 attempted field visits made for Healthy Blue members with monthly reach rate of 32%. • Social Determinants of Health (SDOH) focused outreach initiative via telephone, text, virtual, email, mail, system generated messaging, and physical visit. Initiative offers in-home care coordination for members to improve their access to healthcare services. The focus is on connecting members with the necessary resources and support to manage their healthcare needs effectively, and often includes personalized care planning, facilitating communication between patients and healthcare providers, assisting with scheduling appointments, arranging transportation to medical visits, and addressing social determinants of health that might affect their well-being. The goal is to ensure that members receive comprehensive and continuous care to enhance their overall health outcomes. This initiative focuses on hyper-local strategies, leveraging technology, and partnering with community-based organizations (CBOs). ○ Outreach and completed by month between January to May 2025: ▪ January – total 7,279 outreaches attempted on 1,256 members, and 376 initial assessments completed. ▪ February – total 10,309 outreaches attempted on 1,709 members, and 416 initial assessments completed. ▪ March – total 20,716 outreaches attempted on 1,442 members, and 706 initial assessments completed. ▪ April – total 30,515 outreaches attempted on 1,683 members, and 625 initial assessments completed. ▪ May – total 20,571 outreaches attempted on 1,159 members, and 698 initial assessments completed. • Digital platform offered to members to provide education on diabetes and the potential risk for complications if not appropriately controlled. Platform provides access to educational materials and resources, as well as bidirectional communication with case managers. • Deployment of in-person resources to 1,288 members in acute care who were identified from twice daily, MD led, integrated rounds. • Pay for Quality has 23 provider TINs enrolled. • Quality staff prioritized outreach to providers during this time with a focus on obtaining completed information submitted for diabetes related measures including but not limited to, blood pressure control for patients with diabetes (BPD), eye exam for patients with diabetes (EED), glycemic status assessment for patients with diabetes (GSD). • Launched ED Reduction In Lieu Of Services (ILOS) pilot in state regions 4 and 5 on February 10, 2025 with Acadian Health. Pilot program works to extend primary care physician's (PCP) practice into homes, offering treatment at home, and

	providing the ability to address non-medical drivers of health. Pilot program provides mobile urgent treatment to members aged 13 and older for a wide array of non-life-threatening medical conditions with the intent of avoiding an unnecessary ER visit while also working to connect members to PCPs and provider specialists, as appropriate. Pilot program has two workflows: ○ Acute Care at Home is an on-demand service for patients who require same day care within one hour. It serves as alternative care for non-traumatic hospitalizations for sick but stable patients who would otherwise seek care at the ER. A member who is reporting an acute exacerbation of chronic disease (including but not limited to hypertension, diabetes, asthma) is referred to Acadian Health by their provider, and an initial visit is scheduled. Once arriving on scene and conducting a comprehensive patient assessment, Acadian Health communicates with the PCP to report findings and request direction for care. Treatment is ordered, administered, and results and records are made available to the patient's PCP through Acadian Health's electronic health record. ▪ Based on weekly data reporting from Acadian Health to Healthy Blue, Acadian Health has performed 28 Acute Care at Home visits to Healthy Blue members between dates of service 2/10/25-5/31/25. • Of those 36 visits: ○ 33 visits resulted in treat-in-place and no need to transport member to ED services ○ 3 visits resulted in need to transport member to ED for emergency services ○ Clinic at Home is a proactive visit which is scheduled in advance, usually 24 hours ahead of time. This allows providers to extend their specialty practice into patients' homes, offering after hours and weekend support and the ability to address non-medical drivers of health. MCOs identify patients who qualify for the program, obtain patient consent, and notify patient's PCP. Patients are enrolled via Acadian Health's online portal. The initial visit is completed, including all assessments and screenings, to identify needs, and a second visit is scheduled. Acadian Health connects with patient's case manager to coordinate plan and community resources to address patient needs and goals of care. Treatment is ordered, administered, and results and records are made available to the patient's PCP through Acadian Health's electronic health record. ▪ Based on weekly data reporting from Acadian Health to Healthy Blue, Acadian Health has performed 199 Clinic at Home visits to Healthy Blue members between dates of service 2/10/25-5/31/25. • Provider Communications. ○ January 2025 topics: ▪ Updates to correct coding editing ▪ Announcing Health Perks — Earn rewards for your healthcare activities

	▪ Enhance billing and coding accuracy with new Payment Integrity training ○ February 2025 topics: ▪ Diabetes Management with HEDIS ▪ 2025 Clinical Quality in Practice webinar series ▪ LDH Informational Bulletin 25-2 January 31, 2025 Emergency Room Utilization Reduction Pilot Program ▪ Resources to support diverse patients and communities ○ March 2025 topics: ▪ ER Utilization Reduction Pilot Program ▪ Provider Educational webinars ▪ Technical difficulties: My Diverse Patients ▪ CAHPS improve patient experience ▪ HEDIS Desktop Reference Guide 2025 ▪ HEDIS ECDS ○ April 2025 topics: ▪ Register for our next webinar: Enhancing Diabetes Management — Focus on Standardized Metrics ▪ Reminder: appointment availability and access-to-care standards ▪ Pay for Quality P4Q 2025 LA ▪ CPT Category II codes ▪ cardio respiratory endocrine coding ▪ HEDIS ECDS Coding Booklet 2025 ▪ LA CPT Cat II Codes with Incentives ▪ INVITE Provider Education Apr-June 2025 ▪ HEDIS Cat II Coding Bulletin 2025 ▪ HEDIS Coding Booklet 2025 ○ May 2025 topics: ▪ Coding Validation: Medicaid ▪ HEDIS P4Q Flier 2025 LA ▪ You are invited: care provider educational webinars ▪ Enhancing your learning experience: latest updates in Provider Pathways • Community ○ Community Event, “Healthy Living Resource Fair” in Rapides Parish with Alexandria Mall to bring education to the community, while also providing the following: ▪ Blood Pressure and Blood Sugar Checks ▪ Fitness Inspiration ▪ CPR Demonstration ○ Community event, “Makin’ Groceries Mobile Market” in Calcasieu Parish with Second Harvest Food Bank. ○ Community event, “MLK Food Packing” in Orleans Parish with Second Harvest Food Bank and the New Orleans Saints. ○ Community event, “MLK Food Packing” in Lafourche Parish with Good Samaritan Food Bank and Louisiana Blue. ○ Food packing event in Bossier Parish with Louisiana Blue and Entergy to pack 10,000 meals. ○ Community event, “MLK Parade and Resource Fair” in St. Tammany Parish with One Covington-Future Leaders of Louisiana.

	○ Community event, "Re-Entry Job Readiness Resource Fair" in Evangeline Parish with St. Landry – Evangeline United Way. ○ Community event, "Makin' Groceries Mobile Market" in Calcasieu Parish with SWLA Center for Health Services and Second Harvest Food Bank. ○ Community event, "Makin' Groceries Mobile Market" in Evangeline Parish with Second Harvest Food Bank. ○ Community event, "Makin' Groceries Mobile Market" in Acadia Parish with Second Harvest Food Bank. ○ Healthy Blue Listening Session in Ouachita Parish with community leaders. ○ Healthy Blue Listening Session in Caddo Parish with community leaders. ○ Community event, "Health Equity regional CBO Listening Sessions" in Rapides Parish with Louisiana Public Health Institute. ○ Healthy Blue Tribal Listening Session in Calcasieu Parish with Attakapas Eagle Tribe. ○ Healthy Blue Tribal Listening Session in Calcasieu Parish with Chitimacha Tribe. ○ Community event, "Makin' Groceries Mobile Market" in St. Landry Parish with Second Harvest Food Bank. ○ Food Pantry distribution in DeSoto Parish with HGM Community Development Corporation. ○ Community event, "4th Annual Health and Wellness Day" in Orleans Parish with Top Box Louisiana to provide 100 food boxes to address food insecurity. ○ Community event, "Makin' Groceries Mobile Market" in Calcasieu Parish with Second Harvest Food Bank. ○ Community Event, "You're only as good as you feel" in Rapides Parish with Rapides Parish Library. ○ Community event, "Dillard University 17th Annual Housing, Health/Community Resource Fair" in Orleans Parish with Dillard University. ○ Community, "Rebuilding Together New Orleans" in Jefferson Parish with Rebuilding Together New Orleans for workforce development. ○ Community, "Hotel Hope" in Orleans Parish with Hotel Hope. ○ Community event, "Open Health Foundation" in East Baton Rouge Parish with Open Health Care Clinic to support providing access for all to affordable, quality healthcare. ○ Community event, "Louisiana Empty Bowls" in Caddo Parish with Northwest Food Bank of Louisiana. ○ Community, "Christian Service Program" in Caddo Parish with Christian Services Program for the food pantry program. ○ Community, "Crescent City Classic Wellness Expo" in Orleans Parish with Grace at the Green Light. ○ Community Event, "NAMI Walk" in St. Tammany Parish with NAMI St. Tammany for Mental Health Walk. ○ Community event, "Tribal Powwow" in Avoyelles Parish with Tunica-Biloxi Tribe. ○ Community, "Geaux Get Healthy" in East Baton Rouge Parish with Geaux Get Healthy Clinical Program at Our Lady of the Lake Regional Medical Center.

Activities expected to be accomplished by December 2025:	• Member and provider education • Team dedicated to support Pay for Quality and non-VBP providers to provide additional support to the program • Text and IVR campaigns for controlling blood glucose. • Continue to offer and promote healthy rewards for completing diabetic A1c screening, diabetic retinal eye exam, and diabetes management quiz. • Continue to work towards expanding the number of acute facilities participating in the enhanced discharge planning integrated program with in-person case management. • LDH ED Reduction ILOS pilot in state regions 4 and 5 with Acadian Health will conclude in August 2025. • Provider Communications. ○ June 2025 topics: ▪ Bridging the gap: enhancing medication adherence for better health outcomes ▪ Learn about members' rights and responsibilities ▪ Navigating health with confidence through the Complex Case Management Program ▪ Utilization management: prioritizing appropriate care and transparency • Community ○ Community event, "Makin' Groceries Mobile Market" in Calcasieu Parish with Second Harvest Food Bank. ○ Community event, "Makin' Groceries Mobile Market" in St. Landry Parish with Second Harvest Food Bank. ○ Community Event, "NAMI Walk" in St. Tammany Parish with NAMI St. Tammany for Mental Health Walk. ○ Community Event, "12th Annual Capital Area Transit System Health Fair" in East Baton Rouge Parish with Capital Area Transit System and Our Lady of the Lake Mary Bird Perkins. ○ Food Pantry distribution in DeSoto Parish with HGM Community Development Corporation.
Progress, challenges, and/or delays in achieving measurable objectives and/or milestones thus far in 2025	Progress. • Ability to launch LDH ILOS pilot with all 6 Medicaid MCOs. • Continue to be dedicated to ensuring members complete Health Needs and Risks Assessments. • Increased number of provider TINs in Pay for Quality program which incentivizes rural providers for meeting goals related to controlling blood glucose. • Increased access to acute facilities for enhanced, in-person outreach. Challenges. • Helping members to see the importance of glucose monitoring. Delays. • Finding continued partnerships with FBO and CBOs to emphasize the need for community events highlighting glucose screening.

B. Focus Area: Maternal and Child Health

B1 Goal (1)	**Improving pregnancy outcomes for Black members and their newborns**

Participants:	Black pregnant members and their newborns	**Changes to Participants:**	No change to participants.
Strategy:	• Provider Incentive Programs, Leverage provider involvement. ○ OB Quality Incentive Program (OB QIP). ○ Pay for Quality (P4Q). • Case Management (CM)-focused engagement; dedicated OB and pediatric (including NICU) CM. • Increased testing for sexually transmitted infections (STI) for priority populations with health equity needs. • Promote digital solutions to increase access. • Improve messaging and communications. • Whole Health approach to addressing social drivers. • Value Added Benefits, Member Rewards, Member Incentives. • Community engagement and partnerships. • In-person outreach to members needing OB Screener completed and have been unable to be contacted via telephonic, electronic, or other approved non-in-person methods. • Direct referrals to Community Doula Program for BIPOC (Black Indigenous People of Color) population.		
Activity:	• Integrated Case Management platform has health-based alerts, such as but not limited to, timely prenatal and postpartum care visits when due. The alerts prompt Healthy Blue CMs to discuss the health-based alert and offer assistance in coordinating closure of that gap, as needed and as appropriate. • Digital maternal health platforms offered for education, engagement, and increased access care and resources: ○ Provide educational materials and resources related to maternal health and child health. ○ Provide bidirectional communication with case managers. ○ Provide 24/7 access to multidisciplinary care team covering women's health, primary care, perinatal dietitians, behavioral health, lactation consultants, doulas, and pediatrics, including neonatology. ▪ offer comprehensive virtual prenatal and postpartum care in collaboration with Healthy Blue and our members' established in-person provider. ○ Members with both standard risk and high-risk pregnancies are eligible for digital platforms • In-person outreach to members needing OB Screener completed and have been unable to be contacted via telephonic, electronic, or other approved non-in-person methods. • Social Determinants of Health (SDOH) focused outreach initiative via telephone, text, virtual, email, mail, system generated messaging, and physical visit. Initiative offers in-home care coordination for members to improve their access to healthcare services. The focus is on connecting members with the necessary resources and support to manage their healthcare needs effectively, and often includes personalized care planning, facilitating communication between patients and healthcare providers, assisting with scheduling appointments, arranging transportation to medical visits, and addressing social determinants of health that might affect their well-being. The goal is to ensure that members receive comprehensive and continuous care to enhance their overall health outcomes. This initiative focuses on hyper-local strategies, leveraging technology, and partnering with community-based organizations (CBOs).		

	• Launched ED Reduction In Lieu Of Services (ILOS) pilot in state regions 4 and 5 on February 10, 2025, with Acadian Health. • Continue to offer Mindoula's clinical suite of programs, including but not limited to the Substance Exposed Pregnancy Program and the Interpersonal Violence Reduction Program, to qualifying members as appropriate, with goal of having improved birth outcomes. ○ Mindoula provides telephonic and on-the-ground outreach to establish contact with members and offer enrollment into the most appropriate program based upon member needs. ○ Programs included are Interpersonal Violence Reduction program (IVRP), Med/Psych Management Program (PHMP), Substance Exposed Living Program (SELP), Substance Exposed Pregnancy Program (SEPP), Adolescent & Young Adult Suicide Prevention Program (SPP). ○ The Mindoula programs promote improved member outcomes, along with decreased ER utilization and admissions. • Direct referrals to Community Doula Program for BIPOC (Black Indigenous People of Color) population. • Enhance CHW workforce to help locate and engage Black pregnant members to improve referral process into Doula Program. • Continue sponsorships of community events across the state. • Educate providers and members about healthy rewards and incentives, and VABs. • Continue to offer OB QIP and Pay for Quality to qualifying providers across the state. • Provide maternity care coordination and case management services with targeted health information and modalities based on acuity level to high-risk members.
Measurable Objective:	Decrease Black/White disparity 1% YOY for: • Pre-term birth • Low birth weight • C-section rate
Activities Accomplished between January and June 2025:	• Partnered with Louisiana Department of Health's Statewide Nurse Educator to bring quarterly in-person education and training to Healthy Blue providers. Training and education focused on syphilis, congenital syphilis, HIV, and the importance of following evidence-based, best practice recommendations for screening, treatment, and follow up. ○ Q1 2025 was held in Monroe, LA. ○ Q2 2025 is scheduled for Baton Rouge, LA. • Text and IVR campaigns for prenatal care and postpartum care. Text message campaigns for timely prenatal care with reminders to make and keep appointments. Text message campaigns for postpartum care with reminders to make and keep appointments. ○ Between January through April of 2025, Healthy Blue attempted to enroll 1,420 members in text and IVR campaign for prenatal care and postpartum care. ▪ 4,726 SMS messages were delivered with 1,019 unique link clicks tracked. ▪ 13 outbound IVR calls were placed. • Healthy Rewards ○ Between January to April 2025: ▪ 55 members received Healthy Rewards incentive for completing 1st prenatal care visit

	▪ 28 members received Healthy Rewards incentive for completing postpartum care visit ▪ 128 members received Healthy Rewards incentive for completing sexually transmitted infections screening. • Value Added Benefits (VAB) ○ Between January to April 2025: ▪ 70 members who participated in the maternal and early childhood visiting program received crib and/or car seat VAB ▪ 582 members who participated in the maternal and early childhood visiting program received family planning support VAB • Continue with in-person outreach to members needing OB Screener completed and have been unable to be contacted via telephonic, electronic, or other approved non-in-person methods. • Social Determinants of Health (SDOH) focused outreach initiative via telephone, text, virtual, email, mail, system generated messaging, and physical visit. Initiative offers in-home care coordination for members to improve their access to healthcare services. The focus is on connecting members with the necessary resources and support to manage their healthcare needs effectively, and often includes personalized care planning, facilitating communication between patients and healthcare providers, assisting with scheduling appointments, arranging transportation to medical visits, and addressing social determinants of health that might affect their well-being. The goal is to ensure that members receive comprehensive and continuous care to enhance their overall health outcomes. This initiative focuses on hyper-local strategies, leveraging technology, and partnering with community-based organizations (CBOs). ○ Outreach and completed by month between January to May 2025: ▪ January – total 7,279 outreaches attempted on 1,256 members, and 376 initial assessments completed. ▪ February – total 10,309 outreaches attempted on 1,709 members, and 416 initial assessments completed. ▪ March – total 20,716 outreaches attempted on 1,442 members, and 706 initial assessments completed. ▪ April – total 30,515 outreaches attempted on 1,683 members, and 625 initial assessments completed. ▪ May – total 20,571 outreaches attempted on 1,159 members, and 698 initial assessments completed. • Continue to send direct referrals to Community Doula Program for BIPOC (Black Indigenous People of Color) population. • Continue to offer digital platforms to members to provide education on maternal and child health. ○ Digital Platform with 24/7 access to multidisciplinary care team covering women's health, primary care, perinatal dietitians, behavioral health, lactation consultants, doulas, and pediatrics, including neonatology. ▪ March 2025 enrollment and engagement data for 24/7 access digital platform showed: • 733 members engaged • 54% of those engaged identify as Black, Latinx, or Native American • 23% of those engaged live in a rural area designation • 49% of interactions with 24/7 virtual care team occurred outside of clinic hours

	• 100% of members referred to Healthy Blue OB Case Management ○ Platforms provide access to educational materials and resources. ○ Bidirectional communication with case managers. ○ Digital platform for maternal health allows members to monitor their needs and education at their own time and pace, with interactive chat involvement with the clinical teams based on member needs. Members who are high risk will get push notifications on certain educational videos and interactives to participate in to improve the quality of member care, while also linking the member back member services for any provider requests. • Pay for Quality has 23 provider TINs enrolled. OB QIP has 20 provider TINs enrolled. • Quality staff prioritized outreach to providers during this time with a focus on obtaining completed information submitted for timely prenatal care. • OB Case management has been able to increase the number of high-risk members receiving care coordination through the enhanced predictive model, which allows members to be identified sooner for case management. ○ Predictive modeling identifies high-risk pregnant members earlier, and the data is continually updated with medical and social indicators of risk, including race as a risk factor. OB CM with continued predictive modeling to include high risk diagnosis for African American pregnancies, especially those first-time pregnancies to educate on the prevalence of hypertension in African Americans. • Continue to offer Mindoula's clinical suite of programs, including but not limited to the Substance Exposed Pregnancy Program and the Interpersonal Violence Reduction Program, to qualifying members as appropriate, with goal of having improved birth outcomes. ○ Per March 2025 reporting, Healthy Blue had the following counts of members enrolled in SEPP by month: ▪ 111 members in January 2025 ▪ 107 members in February 2025 ▪ 100 members in March 2025 • 35 Health Related Social Needs (HRSN) assessments completed • 610 text message engagements • 584 phone engagements • 72 video call engagements • 5 email engagements ○ Per March 2025 reporting, Healthy Blue had the following counts of members enrolled in IVRP by month: ▪ 424 members in January 2025 ▪ 451 members in February 2025 ▪ 562 members in March 2025 • 213 HRSN assessments completed • 605 text message engagements • 1,631 phone engagements • 12 video call engagements • 292 email engagements • 30 mail engagements • 9 in-person engagements • Provider Communications. ○ January 2025 topics: ▪ Updates to correct coding editing

	▪ Announcing Health Perks — Earn rewards for your healthcare activities ▪ Enhance billing and coding accuracy with new Payment Integrity training ○ February 2025 topics: ▪ 2025 Clinical Quality in Practice webinar series ▪ LDH Informational Bulletin 25-2 January 31, 2025 Emergency Room Utilization Reduction Pilot Program ▪ Resources to support diverse patients and communities ▪ LDH Informational Bulletin 25-5 February 21, 2025 Donor Human Milk Banks Provider Enrollment Exemption ○ March 2025 topics: ▪ State communication: Provider to Provider Consultation Line Perinatal Mental Health TeleECHO Series ▪ 2025 Perinatal teleECHO ▪ Pomelo Peds Brochure ▪ ER Utilization Reduction Pilot Program ▪ Provider Educational webinars ▪ Technical difficulties: My Diverse Patients ▪ CAHPS improve patient experience ▪ HEDIS Desktop Reference Guide 2025 ▪ HEDIS ECDS ○ April 2025 topics: ▪ Reminder: appointment availability and access-to-care standards ▪ Pay for Quality P4Q 2025 LA ▪ Pomelo Peds Brochure ▪ CPT Category II codes ▪ HEDIS ECDS Coding Booklet 2025 ▪ LA CPT Cat II Codes with Incentives ▪ INVITE Provider Education Apr-June 2025 ▪ HEDIS Cat II Coding Bulletin 2025 ▪ HEDIS Coding Booklet 2025 ▪ Caregiver Perinatal Depression Screening Pilot ○ May 2025 topics: ▪ Coding Validation: Medicaid ▪ HEDIS P4Q Flier 2025 LA ▪ You are invited: care provider educational webinars ▪ Enhancing your learning experience: latest updates in Provider Pathways • Community ○ Event, “Maternal Health Symposium” in Rapides Parish with The Family Tree Information, Education, and Counseling Center. ○ Community Event, “Together Tuesday” in Rapides Parish with LSU Ag Center Rapides Parish. ○ Community event, “Pregnant and Postpartum Women – Valentine’s Treat” in St. Tammany Parish with The Ness Center. ○ Community event baby shower in St. Landry Parish with St. Landry-Evangeline United Way. ○ Community event baby shower in Calcasieu Parish with Zeta Phi Beta Sorority. ○ Community event, “Early Head Start Wellness Fair” in Orleans Parish with Boys Town Louisiana to provide infant and toddler health tips, breastfeeding and

	postpartum support, wellness and developmental screenings, healthcare and dental services, as well as resources and education. ○ Community baby shower in St. Landry Parish with Opelousas General Community Hospital. ○ Support of "Count the Kicks" statewide app for expectant parents to track baby movement. ○ Community event, "Mother's Day Event" in Orleans Parish with Housing Authority of New Orleans. ○ Community baby shower in Orleans Parish with Training Grounds. ○ Support of Community Birth Companions doula services in Opelousas Parish with Community Birth Companions. ○ Support of Sista Midwife Productions for statewide doula capacity building program.
Activities expected to be accomplished by December 2025:	• Continue partnership and collaboration with Louisiana Department of Health's Statewide Nurse Educator to bring quarterly in-person education and training to Healthy Blue providers. Training and education focused on syphilis, congenital syphilis, HIV, and the importance of following evidence-based, best practice recommendations for screening, treatment, and follow up. • Healthy Blue to co-host second annual Maternal Health and Equity Summit with following day Ultimate Community Baby Shower in November 2024 with trusted women's health provider and trusted community-based organization (CBO). The Summit will provide education and training to professionals with professional continuing education credits available for MDs, RNs, and SWs. The women's health provider and CBO are also co-hosts for Healthy Blue's annual Ultimate Baby Shower that is scheduled for the day after the professional Summit. • Member and provider education • Team dedicated to support Pay for Quality and non-VBP providers to provide additional support to the program • Text and IVR campaigns for timely prenatal and postpartum care. • Continue to offer and promote healthy rewards for timely prenatal care visit, timely postpartum care visit, and screening for sexually transmitted infections. • Continue to offer access to digital platforms. • Continue to offer enrollment into Mindoula's suite of programs, as appropriate. • Provider Communications. ○ June 2025 topics: ▪ Bridging the gap: enhancing medication adherence for better health outcomes ▪ Learn about members' rights and responsibilities ▪ Navigating health with confidence through the Complex Case Management Program ▪ Utilization management: prioritizing appropriate care and transparency • Community ○ Community event, "Car Seat Check" in Vermillion Parish with Abbeville General Hospital. ○ Community baby shower in Calcasieu Parish with New Life Counseling Pregnancy Center. ○ Community baby shower in Lafourche Parish with Crossroads Resources Pregnancy Center.
Progress, challenges, and/or delays	Progress. • Continued partnerships with community partners who support improved outcomes for maternal and child health.

in achieving measurable objectives and/or milestones thus far in 2025	• Ability to offer 24/7 virtual care team support to maternal and postpartum members increases access to maternal providers regardless of where the member lives. • Going live with ED Reduction ILOS Program offers increased opportunity for maternal members in state regions 4 and 5 to be connected to care. Challenges, Delays. • Doula services available as In Lieu of Service (ILOS). Healthy Blue continues to review the offered ILOS with ultimate goal of being able to offer doula ILOS to Healthy Blue members.

C. Focus Area: Wellness and Prevention

C1 Goal (1)	**Improving rates of well-child visits and vaccination rates for children and adolescents**		
Participants:	Children and adolescents eligible for well-child visits and vaccinations (EPSDT population)	**Changes to Participants:**	No change to participants.
Strategy:	• Leverage healthcare systems in school environments. • Improve messaging and communications. • Whole Health approach to addressing social drivers via VABs and incentives. • Community engagement and partnerships. • Case Management-focused engagement. • Value Added Benefits, Member Rewards, Member Incentives.		
Activity:	• Text and IVR campaigns for well-visit reminders, lead screening information, and information on healthy rewards. • High-touch in-person outreach to members who fall into below current initiatives: ○ High ED Utilizers with no well-visits: purpose to outreach and educate members with excessive ED visits per year and no wellness visits within 2 years, and connect members to CM and PCP, as well as assist in scheduling preventive care appointments, as needed and as appropriate. ○ Potentially pregnant members in need of an OB screener: purpose to identify and outreach OB members with no completed OB screener and who have at least one co-morbidity. ○ Unable to reach face to face CM: ▪ Post Acute: purpose to provide in person outreach to home visits for members upon discharge from acute facility within areas of Lafayette, Baton Rouge, and Shreveport to address barriers of care and SDoH upon discharge. ▪ DOJ: purpose to identify members who are at risk for SNF placement and have 2 occurring co-morbidities and a serious mental illness, with goal to connect to CM and secure PCP appointment to address needs and gaps in care. ▪ Pregnant: purpose to identify and outreach in-person to unable to reach potentially pregnant members with goal to connect to CM and address gaps in care. ○ Homelessness/Food insecurity: purpose to identify and outreach members experiencing homelessness and/or food insecurities identified through use of Z codes.		

	• Social Determinants of Health (SDOH) focused outreach initiative via telephone, text, virtual, email, mail, system generated messaging, and physical visit. Initiative offers in-home care coordination for members to improve their access to healthcare services. The focus is on connecting members with the necessary resources and support to manage their healthcare needs effectively, and often includes personalized care planning, facilitating communication between patients and healthcare providers, assisting with scheduling appointments, arranging transportation to medical visits, and addressing social determinants of health that might affect their well-being. The goal is to ensure that members receive comprehensive and continuous care to enhance their overall health outcomes. This initiative focuses on hyper-local strategies, leveraging technology, and partnering with community-based organizations (CBOs). • Integrated Case Management platform has health-based alerts, such as but not limited to, well-child visits for members when due. The alerts prompt Healthy Blue CMs to discuss the health-based alert and offer assistance in coordinating closure of that gap, as needed and as appropriate. • Fliers for Back-to-School Events (community events). • Expanding community programs in schools care centers. • Generating community demand for vaccination through outreach, tracking, education, incentives, education, and case management as well as reminder and recall system. • Drill down into data by race, geography, etc. to better focus efforts on existing disparities for all measures. • Collaborate with Public School System to provide enhanced connection to community resources aimed to support health and prevent disease.
Measurable Objective:	Increase HEDIS rates 1% YOY for: • Combo 3 • Combo 2 • WCV • W30
Activities Accomplished between January and June 2025:	• Text and IVR campaigns for well visits, lead screening in children, child and adolescent immunizations, EPSDT overdue. ○ Between January through April of 2025, Healthy Blue attempted to enroll 61,072 members in text and IVR campaign for well visits, lead screening in children, child and adolescent immunizations, EPSDT overdue. ▪ 91,424 SMS messages were delivered with 12 unique link clicks tracked. ▪ 1,743 outbound IVR calls were placed. • Healthy Rewards ○ Between January to April 2025: ▪ 443 members received Healthy Rewards incentive for completing adolescent well visit ▪ 444 members received Healthy Rewards incentive for completing childhood wellness visit ▪ 195 members received Healthy Rewards incentive for completing well child visits in the first 0-15 months of life ▪ 149 members received Healthy Rewards incentive for completing well child visits in the first 15-30 months of life • Value Added Benefits (VAB) ○ Between January to April 2025: ▪ 18 members aged 10-18 completed the online enrichment course ▪ 36 members aged 10-18 who completed well visits received gift card to buy books

	▪ 44 members aged 10-18 who completed well visits received personal care items • Caddo Parish Public School System partnered with Healthy Blue to implement Pennington Biomedical Research Center's "Greaux Healthy School Health Program" for the 2024-2025 School Year. • High-touch Outreach to members who fall into current initiatives: ○ January 2025: 355 attempted field visits made for Healthy Blue members with monthly reach rate of 31%. ○ February 2025: 324 attempted field visits made for Healthy Blue members with monthly reach rate of 40%. ○ March 2025: 330 attempted field visits made for Healthy Blue members with monthly reach rate of 35%. ○ April 2025: 341 attempted field visits made for Healthy Blue members with monthly reach rate of 32%. • Social Determinants of Health (SDOH) focused outreach initiative via telephone, text, virtual, email, mail, system generated messaging, and physical visit. Initiative offers in-home care coordination for members to improve their access to healthcare services. The focus is on connecting members with the necessary resources and support to manage their healthcare needs effectively, and often includes personalized care planning, facilitating communication between patients and healthcare providers, assisting with scheduling appointments, arranging transportation to medical visits, and addressing social determinants of health that might affect their well-being. The goal is to ensure that members receive comprehensive and continuous care to enhance their overall health outcomes. This initiative focuses on hyper-local strategies, leveraging technology, and partnering with community-based organizations (CBOs). ○ Outreach and completed by month between January to May 2025: ▪ January – total 7,279 outreaches attempted on 1,256 members, and 376 initial assessments completed. ▪ February – total 10,309 outreaches attempted on 1,709 members, and 416 initial assessments completed. ▪ March – total 20,716 outreaches attempted on 1,442 members, and 706 initial assessments completed. ▪ April – total 30,515 outreaches attempted on 1,683 members, and 625 initial assessments completed. ▪ May – total 20,571 outreaches attempted on 1,159 members, and 698 initial assessments completed. • Provider Communications. ○ January 2025 topics: ▪ Updates to correct coding editing ▪ Announcing Health Perks — Earn rewards for your healthcare activities ▪ Enhance billing and coding accuracy with new Payment Integrity training ○ February 2025 topics: ▪ 2025 Clinical Quality in Practice webinar series ▪ LDH Informational Bulletin 25-2 January 31, 2025, Emergency Room Utilization Reduction Pilot Program ▪ Resources to support diverse patients and communities ▪ LDH Informational Bulletin 25-4 January 31, 2025, JYNNEOS Vaccine (CPT 90611) ○ March 2025 topics:

	▪ State communication: Provider to Provider Consultation Line Pediatric Mental Health TeleECHO Series ▪ LDH Informational Bulletin 25-6 February 28, 2025: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Comprehensive Dental Benefit ▪ Now Recruiting Pediatric Healthcare Providers, Caregiver Perinatal Depression Screening Learning Collaborative ▪ State communication: Provider to Provider Consultation Line Perinatal Mental Health TeleECHO Series ▪ 2025 Perinatal teleECHO ▪ 2025 Pediatric teleECHO ▪ Pediatric Wellness EPSDT ▪ Pomelo Peds Brochure ▪ ER Utilization Reduction Pilot Program ▪ Provider Educational webinars ▪ Technical difficulties: My Diverse Patients ▪ CAHPS improve patient experience ▪ HEDIS Desktop Reference Guide 2025 ▪ HEDIS ECDS ○ April 2025 topics: ▪ Reminder: appointment availability and access-to-care standards ▪ Pay for Quality P4Q 2025 LA ▪ Pomelo Peds Brochure ▪ CPT Category II codes ▪ HEDIS ECDS Coding Booklet 2025 ▪ LA CPT Cat II Codes with Incentives ▪ INVITE Provider Education Apr-June 2025 ▪ HEDIS Cat II Coding Bulletin 2025 ▪ HEDIS Coding Booklet 2025 ▪ Psych Hub - Autism Training Email ▪ Vaccines for Children Program ▪ Caregiver Perinatal Depression Screening Pilot ▪ HEDIS Well Child and Immunizations Coding Bulletin 2025 ○ May 2025 topics: ▪ Coding Validation: Medicaid ▪ HEDIS P4Q Flier 2025 LA ▪ You are invited: care provider educational webinars ▪ Enhancing your learning experience: latest updates in Provider Pathways • Community ○ Community event, "Faces to FACES series" in Orleans Parish with We Grow Everything We Touch to focus on adverse childhood experiences. ○ Community Play Area in Calcasieu Parish with Prien Lake Mall to provide back to school support. ○ Community event, "Baptist Community Health 3rd Annual Eggstavaganza" in St. Bernard Parish with Baptist Community Health Services Pediatric Clinic. ○ Community Event, "3rd Annual Inclusive Egg Hunt" in Jefferson Parish with Autism Society of Greater New Orleans. ○ Community event, "Celebration of the Young Child" in Orleans Parish with WYES TV, Delgado Care, and Development of Young Children Department.

	○ Support of EverFi statewide for mental health programming in schools, specific to health priorities such as nutrition, vaping, physical activity, mental health, specific focus on rural communities. ○ Support of "Calming Corners" in Orleans Parish with Boys and Girls Club of Metro Louisiana. ○ Support of Louisiana School-Based Health Alliance 28th annual Conference in Rapides Parish with Louisiana School-Based Health Alliance. ○ Support of Access Health School-Based asthma health initiative in Orleans Parish with Access Health Louisiana for nebulizers and tubing for children diagnosed with asthma in the school-based health centers. ○ Community event "Iberia Mass Head Start Registration Event" in Iberia Parish with Prime Time Head Start Acadiana. ○ Community event "Jeanerette Mass Head Start Registration Event" in Iberia Parish with Prime Time Head Start Acadiana. ○ Community event, "Pregnant and Postpartum Women – Valentine's Treat" in St. Tammany Parish with The Ness Center. ○ Community event, "Early Head Start Wellness Fair" in Orleans Parish with Boys Town Louisiana to provide infant and toddler health tips, breastfeeding and postpartum support, wellness and developmental screenings, healthcare and dental services, as well as resources and education. ○ Support of Kiwanis of Southwest Louisiana in Calcasieu Parish with Kiwanis Club of Southwest Louisiana to support: ▪ Kiwanis International & District Foundations ▪ Kiwanis Christus Children's Fund ▪ Read Around the World – M J Kaufman Elementary ▪ Salvation Army Bell Ringing ▪ Bring Up Grades (BUGs) – M J Kaufman Elementary ▪ Kiwanis Baby Shower ▪ ABC Pregnancy Resource Center ▪ New Life Counseling Center Donations ▪ SWLA Safe Sleep Task Force ▪ Golden Rule – Area Elementary Schools ▪ Christmas Family Sponsorship ▪ Big Brothers Big Sisters ○ Healthy Blue associates packed 250 backpacks with personal hygiene items for foster care children within the community in Jefferson Parish. ○ Support of Cultivating Youth in Orleans Parish to work to eliminate childhood trauma, restore healing, prevent violence, and reduce obesity for youth 8-18 through physical activity, mental health, education, and mentorship.

Activities expected to be accomplished by December 2025:	• Text and IVR campaigns for well visits, lead screening in children, child and adolescent immunizations, EPSDT overdue. • Provider Communications. ○ June 2025 topics: ▪ Bridging the gap: enhancing medication adherence for better health outcomes ▪ Learn about members' rights and responsibilities ▪ Navigating health with confidence through the Complex Case Management Program ▪ Utilization management: prioritizing appropriate care and transparency • Community ○ Community event "Iberia Mass Head Start Registration Event" in Iberia Parish with Prime Time Head Start Acadiana. ○ Community event "Jeanerette Mass Head Start Registration Event" in Iberia Parish with Prime Time Head Start Acadiana. ○ Community event, "Back to School event" in Rapides Parish with Rapides Parish Library. ○ Support of Calming Corners in Calcasieu Parish with Big Brothers Big Sisters of Southwest Louisiana. ○ Support of Boys and Girls Club of Metro Louisiana in Orleans Parish. ○ Community event, "DePaul A Date with Dat" in Orleans Parish with DePaul Community Health Centers to provide 100 box lunches. ○ Community event "Teche and Healthy Blue Back to School Event" in Terrebonne Parish with Teche Action Clinic at Houma to provide 300 school supply kits. ○ Community event, "Back to School Bash with Healthy Blue" in Lafayette Parish with State Representative Themi Chassion to provide 500 school supply kits. ○ Community event, "Back to School Event with Healthy Blue" in St. Landry Parish with State Representative Dustin Miller to provide 400 school supply kits. ○ Community event, "Evangeline Parish Back to School" in Evangeline Parish with Evangeline Community Action Agency. ○ Support of "Teen Leadership Retreat" in Tangipahoa Parish with Village of Hope Louisiana. ○ Community event, "Back to School event with Healthy Blue and Hispanic Apostolate" in Jefferson Parish with Hispanic Apostolate Archdiocese of New Orleans to provide 500 school supply kits. ○ Community event, "Back to School" in Calcasieu Parish with Prien Lake Mall to provide 500 school supply kits. ○ Community event, "Healthy Blue & City of Franklin's Back to School Bash" in St. Mary Parish with City of Franklin for 500 school supply kits. ○ Community event, "Back to School" in Calcasieu Parish with Families Helping Families of Southwest Louisiana to provide 100 school supply kits to be distributed to individuals with special needs. ○ Community event, "Healthy Blue Back to School with Tech Plug" in Orleans Parish with Tech Plug to provide 200 school supply kits to Boystown Parent Orientation.

Progress, challenges, and/or delays in achieving measurable objectives and/or milestones thus far in 2025	Progress. • Regular collaborative meetings between Caddo Parish Public School System and Pennington Biomedical Research Center to meet agreement on strategic plan. • Encouraging Pediatricians to continue to discuss the importance of well-child visits. Challenges. • Emphasizing the importance of well child visits for parents as children begin to age. Delays. • None noted at this time.		
C2 Goal (2)	**Improving rates of colorectal cancer screenings in the male population**		
Participants:	Male population forty-five and over	**Changes to Participants:**	No change to participants.
Strategy:	• Targeted messaging, utilizing trusted messengers for peer-to-peer information sharing. • Leverage provider influence to increase screenings. • Community engagement and partnerships. • Case Management-focused engagement. • Healthy Rewards Member Incentives.		
Activity:	• Outreach to members via text and IVR to provide information around colorectal cancer screening importance and being connected to a provider, as appropriate. • Continue to offer Healthy Reward member incentive for completion of colorectal cancer screening. • Integrated Case Management platform has health-based alerts, such as but not limited to, colorectal cancer screening due for members. The alerts prompt Healthy Blue CMs to discuss the health-based alert and offer assistance in coordinating closure of that gap, as needed and as appropriate. • Social Determinants of Health (SDOH) focused outreach initiative via telephone, text, virtual, email, mail, system generated messaging, and physical visit. Initiative offers in-home care coordination for members to improve their access to healthcare services. The focus is on connecting members with the necessary resources and support to manage their healthcare needs effectively, and often includes personalized care planning, facilitating communication between patients and healthcare providers, assisting with scheduling appointments, arranging transportation to medical visits, and addressing social determinants of health that might affect their well-being. The goal is to ensure that members receive comprehensive and continuous care to enhance their overall health outcomes. This initiative focuses on hyper-local strategies, leveraging technology, and partnering with community-based organizations (CBOs). • Continue to pursue partnerships with CBOs & faith-based organizations to increase screening rates and generate community feedback. • Train CHWs on prevention and disease processes. • Continue to offer and enroll providers into Pay for Quality (P4Q) program, as appropriate, which incentivizes rural health providers with 500 or fewer members for meeting goals related to measures such as, but not limited to, colorectal cancer screening.		
Measurable Objective:	• Decrease male/female disparity 1% YOY.		
Activities Accomplished between	• Text and IVR campaigns for colorectal cancer screening. ○ Between January through April of 2025, Healthy Blue attempted to enroll 18,320 members in text and IVR campaign for colorectal cancer screening.		

January and June 2025:	▪ 54,706 SMS messages were delivered. ▪ 1,548 outbound IVR calls were placed. • Healthy Rewards ○ Between January to April 2025, 42 members received Healthy Rewards incentive for completing colorectal cancer screening • Social Determinants of Health (SDOH) focused outreach initiative via telephone, text, virtual, email, mail, system generated messaging, and physical visit. Initiative offers in-home care coordination for members to improve their access to healthcare services. The focus is on connecting members with the necessary resources and support to manage their healthcare needs effectively, and often includes personalized care planning, facilitating communication between patients and healthcare providers, assisting with scheduling appointments, arranging transportation to medical visits, and addressing social determinants of health that might affect their well-being. The goal is to ensure that members receive comprehensive and continuous care to enhance their overall health outcomes. This initiative focuses on hyper-local strategies, leveraging technology, and partnering with community-based organizations (CBOs). ○ Outreach and completed by month between January to May 2025: ▪ January – total 7,279 outreaches attempted on 1,256 members, and 376 initial assessments completed. ▪ February – total 10,309 outreaches attempted on 1,709 members, and 416 initial assessments completed. ▪ March – total 20,716 outreaches attempted on 1,442 members, and 706 initial assessments completed. ▪ April – total 30,515 outreaches attempted on 1,683 members, and 625 initial assessments completed. ▪ May – total 20,571 outreaches attempted on 1,159 members, and 698 initial assessments completed. • Pay for Quality has 23 provider TINs enrolled. • Provider Communications. ○ January 2025 topics: ▪ Updates to correct coding editing ▪ Announcing Health Perks — Earn rewards for your healthcare activities ▪ Enhance billing and coding accuracy with new Payment Integrity training ○ February 2025 topics: ▪ 2025 Clinical Quality in Practice webinar series ▪ LDH Informational Bulletin 25-2 January 31, 2025 Emergency Room Utilization Reduction Pilot Program ▪ Resources to support diverse patients and communities ○ March 2025 topics: ▪ ER Utilization Reduction Pilot Program ▪ Provider Educational webinars ▪ Technical difficulties: My Diverse Patients ▪ CAHPS improve patient experience ▪ HEDIS Desktop Reference Guide 2025 ▪ HEDIS ECDS ○ April 2025 topics: ▪ Reminder: appointment availability and access-to-care standards ▪ Pay for Quality P4Q 2025 LA ▪ CPT Category II codes ▪ HEDIS ECDS Coding Booklet 2025

	▪ LA CPT Cat II Codes with Incentives ▪ INVITE Provider Education Apr-June 2025 ▪ HEDIS Cat II Coding Bulletin 2025 ▪ HEDIS Coding Booklet 2025 ○ May 2025 topics: ▪ Coding Validation: Medicaid ▪ HEDIS P4Q Flier 2025 LA ▪ You are invited: care provider educational webinars ▪ Enhancing your learning experience: latest updates in Provider Pathways • Community ○ Community event, "Community Health and Resource Fair" in Terrebonne Parish with Terrebonne Health Unity to provide breast cancer screenings, colorectal cancer screenings, and liver screenings. ○ Community event, "Prevention on the Go!" in Franklin Parish with Mary Bird Perkins Cancer Center – Winnsboro to provide cancer screenings to the community.		
Activities expected to be accomplished by December 2025:	• Member and provider education • Text and IVR campaigns for colorectal cancer screenings. • Continue to offer and promote healthy rewards for colorectal cancer screening. • Team dedicated to support Pay for Quality and non-VBP providers to provide additional support to the program. • Provider Communications. ○ June 2025 topics: ▪ Learn about members' rights and responsibilities ▪ Navigating health with confidence through the Complex Case Management Program ▪ Utilization management: prioritizing appropriate care and transparency • Community ○ Community event, "Prevention on the Go!" in East Carroll Parish with Mary Bird Perkins Cancer Center – Lake Providence to provide cancer screenings to the community. ○ Community event, "Prevention on the Go!" in Madison Parish with Mary Bird Perkins Cancer Center – Tallulah to provide cancer screenings to the community. ○ Community event, "Prevention on the Go!" in Catahoula Parish with Mary Bird Perkins Cancer Center – Jonesville to provide cancer screenings to the community.		
Progress, challenges, and/or delays in achieving measurable objectives and/or milestones thus far in 2025	Progress. • Active participant in Taking Aim at Cancer in Louisiana collaborative. • Ongoing collaborative discussions with American Cancer Society. • Increased number of provider TINs in Pay for Quality program which incentivizes rural providers for meeting health goals. Challenges. • Historically low return rate on self-screening at-home colorectal cancer screening kits. Delays. • None noted at this time.		
C3 Goal (3)	**Improving uptake of preventative dental services for children**		
Participants:	Children ages 6 months through	**Changes to Participants:**	No change to participants.

	5 years who received fluoride varnish application by their PCP		
Strategy:	• Increase accessibility to preventative services. • Build awareness of the importance of oral health and its association to overall health. • Provider engagement and behavior reinforcement. • Text campaign		
Activity:	• Increase access to fluoride varnish in alternative settings outside of dental office by supporting PCPs in providing application in their offices. • Conduct member outreach to educate parents of each child on the Member Fluoride Varnish Care Gap report about oral hygiene and the importance of fluoride (e.g., toothpaste, varnish). • Conduct provider educational outreach to each PCP with patients on the Member Fluoride Varnish Care Gap Report and support by distributing educational materials. • Text campaign targeted to members on the fluoride varnish care gap report.		
Measurable Objective:	• Increase the percentage of children ages 6 months through 5 years who received fluoride varnish application by their PCP 1% YOY.		
Activities Accomplished between January and June 2025:	• Provider education and guidance on achieving certification through LDH Smiles for Life Program. • At community events, member materials are distributed, and education provided, while also collaborating with and participating in events with community partners to further outreach and educate members on fluoride varnish application. • Member Fluoride Varnish Care Gap Report, with a version organized by PCP, identifies all Healthy Blue members ages 6 months through 5 years who have not received any fluoride varnish application by their PCP (CPT code 99188) or dentist (CDT code D1206 or D1208) during the baseline year. The gap report identifies missed opportunities by reporting the number of PCP visits for each child on the list. Based on care gap report, identify providers who need outreach and education. ○ Q1 2025 Quality driven PIP tracking for fluoride varnish application by PCP data stratified by age, gender, race, and ethnicity, and showed 30% of members in the denominator for capturing fluoride varnish application by PCP identified as Black and 24.64% identified as White. • Text campaign for fluoride. ○ Between January to May of 2025, 23,052 members were attempted to enroll in text campaign for fluoride, 18,746 were enrolled, showing about 81% enrollment rate. • Provider Communications. ○ January 2025 topics: ▪ Updates to correct coding editing ▪ Announcing Health Perks — Earn rewards for your healthcare activities ▪ Enhance billing and coding accuracy with new Payment Integrity training ○ February 2025 topics: ▪ 2025 Clinical Quality in Practice webinar series ▪ Resources to support diverse patients and communities ○ March 2025 topics:		

	▪ LDH Informational Bulletin 25-6 February 28, 2025: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Comprehensive Dental Benefit ▪ Provider Educational webinars ▪ Technical difficulties: My Diverse Patients ▪ CAHPS improve patient experience ▪ HEDIS Desktop Reference Guide 2025 ▪ HEDIS ECDS ○ April 2025 topics: ▪ Reminder: appointment availability and access-to-care standards ▪ CPT Category II codes ▪ HEDIS ECDS Coding Booklet 2025 ▪ LA CPT Cat II Codes with Incentives ▪ INVITE Provider Education Apr-June 2025 ▪ HEDIS Cat II Coding Bulletin 2025 ▪ HEDIS Coding Booklet 2025 ○ May 2025 topics: ▪ Coding Validation: Medicaid ▪ You are invited: care provider educational webinars ▪ Enhancing your learning experience: latest updates in Provider Pathways • Community ○ Community event, "Early Head Start Wellness Fair" in Orleans Parish with Boys Town Louisiana to provide infant and toddler health tips, breastfeeding and postpartum support, wellness and developmental screenings, healthcare and dental services, as well as resources and education.
Activities expected to be accomplished by December 2025:	• Provider Communications. ○ June 2025 topics: ▪ Learn about members' rights and responsibilities • Continuing to work towards partnering with FQHC with dental mobile unit for Health Blue Community events to provide fluoride varnish applications during events for children aged six months to five years of age to further increase access.
Progress, challenges, and/or delays in achieving measurable objectives and/or milestones thus far in 2025	Progress. • Increased opportunities to outreach and educate provides on fluoride varnish application. • Continuing to make progress toward indicator goals. Challenges. • Age group 3-5 years has been challenging for fluoride varnish application in PCP office, as this age group typically has an established dental home. • Parental hesitance around fluoride varnish application. Delays. • None noted at this time.

D. Focus Area: Health Equity Promotion and Education

D1 Goal (1)	**Creating momentum to address root causes of health inequity and impact on health outcomes**		
Participants:	Louisianians (health plan associates and providers included) interested in	**Changes to Participants:**	No change to participants.

	understanding, addressing, and impacting health and racial disparities		
Strategy:	• Address beliefs, biases, behaviors, historical and current systems that create disparities in health outcomes and social drivers of health		
Activity:	• Education, training, participation in public events, participation in Healthy Blue's Health Education Advisory Committee (HEAC). • Staff training. • Provider training. • Community education.		
Measurable Objective:	• 100% health plan staff training on HE training.		
Activities Accomplished between January and June 2025:	• Healthy Blue's Health Education Advisory Committee (HEAC) gives members and the community a platform to provide quarterly feedback about the Health Plan. Participants include, but are not limited to, Healthy Blue members, member advocates, community partners, community providers, Healthy Blue associates. • Q1 2025 HEAC meeting presented educational information on Health Equity. ▪ Health Equity information presented for discussion and feedback included, but were not limited to: • Defining common terms in Health Equity: health equity, health disparities, population health, SDoH. • Reviewing noted health disparities in Louisiana, using the March of Dimes report card for birth outcomes as an example. • Reviewed Healthy Blue's strategic, whole health and health equity by design approach to improving health outcomes. • Provided examples of where Healthy Blue members can obtain access to resources, using screenshots from Healthy Blue's member website for visual aid. • Reviewed Health and Healthcare Literacy and provided examples of Healthy Blue resources that can assist members in finding access to care, such as using Healthy Blue's Sydney Health mobile app to find in network providers, calling member services for assistance, navigating the member website, scheduling transportation for medical appointments. • Defined social risk and social need, reviewed examples of each, and provided information as to how Healthy Blue members can compete a health and / or social needs assessment. • Discussed the importance of being able to solicit member feedback in the member advisory calls and provided the 2025 HEAC schedule. • Health Equity is scheduled to present on Health Equity at Q2, Q3, and Q4 2025 HEAC meetings. • Provider Communications. • February 2025 topics: ▪ Resources to support diverse patients and communities ▪ LDH Informational Bulletin 25-2 January 31, 2025, Emergency Room Utilization Reduction Pilot Program • March 2025 topics: ▪ Technical difficulties: My Diverse Patients		

	▪ CAHPS improve patient experience ▪ ER Utilization Reduction Pilot Program • April 2025 topics: ▪ Reminder: appointment availability and access-to-care standards ▪ INVITE Provider Education Apr-June 2025 • May 2025 topics: ▪ You are invited: care provider educational webinars ▪ Enhancing your learning experience: latest updates in Provider Pathways • Healthy Blue's Cultural Competency Facilitator offers trainings to Healthy Blue providers year-round. • Cultural competency training for providers, including office staff, is member focused, and can include: ▪ The importance of cultural awareness and cultural sensitivity in our daily lives. ▪ Importance of understanding and appreciation of diversity. ▪ Myths about people, places and things are prevalent in our society. During the training participants will examine some of the false truths that can influence an individual's view of the world. ▪ Demonstrate basic cultural competency skills that the participant can use to enhance and improve the interactions they have with co-workers, consumers, and the general public. ▪ Importance of the members' beliefs about illness and health, and about traditional home remedies that may impact what the provider's treatment methodology is trying to accomplish. ▪ Methods and styles of communication that are effective with respect to culture, language, and literacy levels in order to support a positive interaction between the patient, providers, and office staff, as well as Plan staff. ▪ How to access language support services for members, and how to interact with limited English proficient (LEP) patients during in-person visits. ▪ How to access language assistance resources available from the Health Plan, including language identification cards. ▪ Documenting members' preferred language in the medical record. ▪ Maintaining request or refusal of interpreter services in the medical record. ▪ Discouraging the use of family and friends, particularly minors, as interpreters. ▪ Assisting members with filing a complaint or grievance. • Components: ▪ Introduction to health equity ▪ Health disparities experienced by people with disabilities ▪ Maternal health disparities ▪ Addressing healthcare disparities for people who identify as Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, and Asexual (LGBTQIA+) ▪ Cultural humility in healthcare, including role of implicit bias in healthcare/health outcome disparities ▪ Provider resources and education • Community

	• Community Event, "Healthy Living Resource Fair" in Rapides Parish with Alexandria Mall to bring education to the community, while also providing the following: ▪ Blood Pressure and Blood Sugar Checks ▪ Fitness Inspiration ▪ CPR Demonstration • Community event, "Makin' Groceries Mobile Market" in Calcasieu Parish with Second Harvest Food Bank. • Community event, "MLK Food Packing" in Orleans Parish with Second Harvest Food Bank and the New Orleans Saints. • Community event, "MLK Food Packing" in Lafourche Parish with Good Samaritan Food Bank and Louisiana Blue. • Food packing event in Bossier Parish with Louisiana Blue and Entergy to pack 10,000 meals. • Community event, "MLK Parade and Resource Fair" in St. Tammany Parish with One Covington-Future Leaders of Louisiana. • Community event, "Re-Entry Job Readiness Resource Fair" in Evangeline Parish with St. Landry – Evangeline United Way. • Community event, "Makin' Groceries Mobile Market" in Calcasieu Parish with SWLA Center for Health Services and Second Harvest Food Bank. • Community event, "Makin' Groceries Mobile Market" in Evangeline Parish with Second Harvest Food Bank. • Community event, "Makin' Groceries Mobile Market" in Acadia Parish with Second Harvest Food Bank. • Healthy Blue Listening Session in Ouachita Parish with community leaders. • Healthy Blue Listening Session in Caddo Parish with community leaders. • Community event, "Health Equity regional CBO Listening Sessions" in Rapides Parish with Louisiana Public Health Institute. • Healthy Blue Tribal Listening Session in Calcasieu Parish with Attakapas Eagle Tribe. • Healthy Blue Tribal Listening Session in Calcasieu Parish with Chitimacha Tribe. • Community event, "Makin' Groceries Mobile Market" in St. Landry Parish with Second Harvest Food Bank. • Food Pantry distribution in DeSoto Parish with HGM Community Development Corporation. • Community event, "4th Annual Health and Wellness Day" in Orleans Parish with Top Box Louisiana to provide 100 food boxes to address food insecurity. • Community event, "Makin' Groceries Mobile Market" in Calcasieu Parish with Second Harvest Food Bank. • Community Event, "You're only as good as you feel" in Rapides Parish with Rapides Parish Library. • Community event, "Dillard University 17th Annual Housing, Health/Community Resource Fair" in Orleans Parish with Dillard University. • Community, "Rebuilding Together New Orleans" in Jefferson Parish with Rebuilding Together New Orleans for workforce development. • Community, "Hotel Hope" in Orleans Parish with Hotel Hope. • Community event, "Open Health Foundation" in East Baton Rouge Parish with Open Health Care Clinic to support providing access for all to affordable, quality healthcare.

	• Community event, "Louisiana Empty Bowls" in Caddo Parish with Northwest Food Bank of Louisiana. • Community, "Christian Service Program" in Caddo Parish with Christian Services Program for the food pantry program. • Community, "Crescent City Classic Wellness Expo" in Orleans Parish with Grace at the Green Light. • Community Event, "NAMI Walk" in St. Tammany Parish with NAMI St. Tammany for Mental Health Walk. • Community event, "Tribal Powwow" in Avoyelles Parish with Tunica-Biloxi Tribe. • Support of "Geaux Get Healthy" in East Baton Rouge Parish with Geaux Get Healthy Clinical Program at Our Lady of the Lake Regional Medical Center.
Activities expected to be accomplished by December 2025:	• Healthy Blue to co-host second annual Maternal Health and Equity Summit with following day Ultimate Community Baby Shower in November 2024 with trusted women's health provider and trusted community-based organization (CBO). The Summit will provide education and training to professionals with professional continuing education credits available for MDs, RNs, and SWs. The women's health provider and CBO are also co-hosts for Healthy Blue's annual Ultimate Baby Shower that is scheduled for the day after the professional Summit. • Healthy Blue to host cultural competency training by Healthy Blue's Cultural Competency Facilitator for Healthy Blue associates. • Provider Communications. ○ June 2025 topics: ▪ Learn about members' rights and responsibilities • Community ○ Community event, "Makin' Groceries Mobile Market" in Calcasieu Parish with Second Harvest Food Bank. ○ Community event, "Makin' Groceries Mobile Market" in St. Landry Parish with Second Harvest Food Bank. ○ Community Event, "NAMI Walk" in St. Tammany Parish with NAMI St. Tammany for Mental Health Walk. ○ Community Event, "12th Annual Capital Area Transit System Health Fair" in East Baton Rouge Parish with Capital Area Transit System and Our Lady of the Lake Mary Bird Perkins. ○ Food Pantry distribution in DeSoto Parish with HGM Community Development Corporation.
Progress, challenges, and/or delays in achieving measurable objectives and/or milestones thus far in 2025	Progress. • Continued education is planned for Healthy Blue associates regarding cultural competency for later this year. Challenges. • Recent federal language around deprioritizing diversity, equity, and inclusion may impact the low provider participation in cultural competency training. • Ensuring providers not only complete Health Equity trainings, but also that provider office staff complete the training and grasp what creating a culturally sensitive environment entails. Delays. • Decreased Provider participation in cultural competency training.

E. Focus Area: SDOH Screening and SDOH Gap Closure ("Closing the Loop")

E1 Goal (1)	**Identifying and addressing gaps in social care needs for health plan members**		
Participants:	All members	**Changes to Participants:**	No change to participants.
Strategy:	• Internal system improvements. • Increased utilization of Community Health Workers (CHW). • Expand range of screening tools. • Leverage and incentivize providers and CBOs.		
Activity:	• Implemented process to identify "unable-to-reach" members who have not completed the Health Needs Assessment (HNA) – monitored dashboard. • Queues to triage and address members with SDOH gaps. • Social Determinants of Health (SDOH) focused outreach initiative via telephone, text, virtual, email, mail, system generated messaging, and physical visit. Initiative offers in-home care coordination for members to improve their access to healthcare services. The focus is on connecting members with the necessary resources and support to manage their healthcare needs effectively, and often includes personalized care planning, facilitating communication between patients and healthcare providers, assisting with scheduling appointments, arranging transportation to medical visits, and addressing social determinants of health that might affect their well-being. The goal is to ensure that members receive comprehensive and continuous care to enhance their overall health outcomes. This initiative focuses on hyper-local strategies, leveraging technology, and partnering with community-based organizations (CBOs). • Integrated Collaborative Care Model to include more providers • SDOH PIP program. • Find Help program for providers of social care (CBOs). • CM integrated platform allows member services associates to complete HNAs, rather than requiring a transfer to the CM team.		
Measurable Objective:	• Increase percentage of members receiving help for SDOH needs 2% YOY.		
Activities Accomplished between January and June 2025:	• Case Managers address SDoH needs as part of standard care coordination. • The CM queues fully integrate the HNA into the CM system, including SDoH alerts in the system. These alerts help CM to engage members as early as possible and connect them to the most appropriate resources at the most appropriate time. • Healthy Blue recognizes that barriers in communication, lack of knowledge, and lack of access to available community resources impact our members' quality of life. We also realize that our members need support from community-based organizations (CBOs) in addition to their health insurance plan. We want to be the link that supports both our CBO partners and Healthy Blue members, and to bridge the communication gap. Healthy Blue strives to support the community organizations that are making a difference in the lives of our members each day, and this is why we have established the trusted network of CBOs through findhelp. ○ Healthy Blue Case Management (CM) team members use findhelp.org and refer to Outreach Care Specialists (OCS) and Community Health Workers (CHW) to help with barriers related to SDoH. ○ Integrated CM platform that allows linkage to findhelp for resource referrals. ▪ Members have access to findhelp platform and are able to self-refer. ○ Annual associate training on Resource Link 101 (findhelp annual training) completed with 100% compliance. • Social Determinants of Health (SDOH) focused outreach initiative via telephone, text, virtual, email, mail, system generated messaging, and physical visit. Initiative offers in-home care		

coordination for members to improve their access to healthcare services. The focus is on connecting members with the necessary resources and support to manage their healthcare needs effectively, and often includes personalized care planning, facilitating communication between patients and healthcare providers, assisting with scheduling appointments, arranging transportation to medical visits, and addressing social determinants of health that might affect their well-being. The goal is to ensure that members receive comprehensive and continuous care to enhance their overall health outcomes. This initiative focuses on hyper-local strategies, leveraging technology, and partnering with community-based organizations (CBOs).

- Outreach and completed by month between January to May 2025:
  - January – total 7,279 outreaches attempted on 1,256 members, and 376 initial assessments completed.
  - February – total 10,309 outreaches attempted on 1,709 members, and 416 initial assessments completed.
  - March – total 20,716 outreaches attempted on 1,442 members, and 706 initial assessments completed.
  - April – total 30,515 outreaches attempted on 1,683 members, and 625 initial assessments completed.
  - May – total 20,571 outreaches attempted on 1,159 members, and 698 initial assessments completed.

- From January-May 2025, 288 distinct users utilized the Healthy Blue findhelp site.
  - 1,183 distinct searches performed on the Healthy Blue findhelp site
  - 1, 396 interactions took place
  - 111 connections were made
  - 77 referrals were placed for 36 distinct seekers
    - 4 referrals have responses
    - 73 not yet helped

Most searched terms Jan-May 2025, Healthy Blue findhelp site	Most searched term domain	Percentage of total searches attributed to term
food pantry	food	10.43%
help pay for utilities	housing	10.43%
dental care	health	6.81%
help find housing	housing	5.49%
help pay for housing	housing	5.27%
government food benefits	food	3.07%
food delivery	food	2.74%
temporary shelter	housing	2.52%
primary care	health	1.98%
meals	food	1.76%
transportation	transit	1.65%
emergency food	food	1.54%
long-term housing	housing	1.21%
housing vouchers	housing	1.10%
help pay for food	food	1.10%

	Most Referred to Organizations during Jan-May 2025 by Organization, Healthy Blue findhelp site	program
	Blessed Francis Xavier Seelos Catholic Church	Seelos Ministry of Hope Program
	Louisiana Housing Corporation (LHC)	Low Income Home Energy Assistance Program (LIHEAP)
	Sankofa NOLA	Food Pantry
	The New Orleans Council on Aging (NOCOA)	Power to Care
	Volunteers of America Greater Baton Rouge	David Jackson O'Quin Drop-In Center
	Avoyelles Progress Action Committee, Inc.	Low-Income Home Energy Assistance Program (LIHEAP)
	St. Tammany Parish Department of Health and Human Services Community Action Agency - Slidell	Homelessness Services
	Catholic Services of Acadiana	Monsignor Sigur Center
	The Northlake Homeless Coalition (NHC)	Coordinated Access & Assessment
	SMILE Community Action Agency	Emergency Assistance
	DePaul Community Health Centers	Diabetes Institute
	National Multiple Sclerosis (MS) Society of Louisiana	Support Groups
	South Central Louisiana Human Services Authority (SCLHSA)	Primary Care Services
	Capital Area Human Services (CAHS)	Addiction Recovery Residential Services - Capital Area Recovery Program (CARP)
	Louisiana Office of State Fire Marshal (SFM)	Operation Save a Life
	Lafourche Parish Office of Community Action (OCA)	USDA Commodities
	Catholic Charities of North Louisiana	Emergency Rent and Utilities Assistance
	Stand Up Wireless	StandUp Lifeline Wireless
	Rays of Sonshine (ROS)	The Zone
	Entertainment Community Fund	Entertainment Assistance Program
	Healing Place Church	Food Pantry
	United Christian Outreach, Inc.	Food Pantry
	Capital Area Agency on Aging, Inc.	Entergy Utility Assistance
	New Roads Housing Authority	HUD Public Housing Program
	Jackson Hand Of Change	Outpatient Behavioral Health Services
	Benton United Methodist Church	Benton Methodist Food Pantry
	Dr. Leo S. Butler Community Center	Dr. Leo S. Butler Community Center
	Catholic Charities of Southwest Louisiana - Diocese of Lake Charles (CCSWLA)	Utilities Assistance
	Ouachita Multi-Purpose Community Action Program (OMCAP)	Low Income Home Energy Assistance Program (LIHEAP)
	SMILE - Acadia Jeff Davis Community Action Agency	Low-Income Home Energy Assistance Program (LIHEAP)
	The Salvation Army of NWLA (Shreveport)	Merkle Center of Hope
	Broadmoor Improvement Association (BIA)	SNAP Assistance and Case Management
	The Outreach Center	The Lighthouse Shelter for Women and Children
	Mom's Meals	Mom's Meals - Medically tailored meals delivered nationwide

Depaul USA	Temporary Housing
Fireweed Collective	Support Groups
Baton Rouge Office of Social Services (OSS)	Community Service Block Grant (CSBG)
Southeast Community Health Systems (SCHS)	Women, Infants & Children (WIC)
Louisiana Workforce Commission	Independent Living Program
Gethsemane Church of God in Christ	Food Pantry
Lowernine.org	Food Pantry
The Arc of Greater New Orleans (ArcGNO)	In-Home Services - Supported Independent Living Program
Catholic Charities of Acadiana (CCA)	St. Joseph Diner-Lunch
New Orleans Community Fridges	Community Fridges
Baton Rouge Primary Care Collaborative, Inc. (BRPCC)	Optometry Program
Solomon House	Brown Bag Program
Autism Speaks	Autism Response Team (ART)
City Of Central Food Bank	Food Bank
mRelief	SNAP (Food Stamps) Assistance
Volunteers of America - Southeast Louisiana	Project for Assistance in Transition for the Homeless (PATH)
St. Bernard / St. Francis Food Pantry	Food Pantry
Living Waters Outreach Ministry	Drop-In Center for Women
The Hub: Urban Ministries	The Hub
Care Help of Sulphur, Inc.	Client's Choice Food Pantry
Calhoun Church Of Christ	Calhoun Church Of Christ
Algiers Point Free Lil Pantry	Blessing Box
Autism Society of America	National Helpline
Total Community Action, Inc. (TCA)	Low-Income Home Energy Assistance Program (LIHEAP)
Greater Baton Rouge Food Bank	Mobile Distributions
The Food Bank of Central Louisiana	Food Assistance
Salvation Army - Baton Rouge	Food Box Program
EnTouch Wireless	Lifeline Cell Phone Service
SMILE Community Action Agency	Low-Income Home Energy Assistance Program (LIHEAP)
Top Box Foods	Top Box Foods - Healthy Blue

- Between January-May 2025:
  - 3,362 unique, incentive assessments were placed on 3,091 members as part of the SDOH PIP.
    - Assessment types included:
      - Adverse Childhood Experience (ACE) Questionnaire – 617 assessments
        - 6% responded, "yes" to, "Has the child's biological parent or any caregiver ever had, or currently has a problem with too much alcohol, street drugs or prescription medications use?"
        - 5% responded, "yes" to, "Has your child ever seen, heard, or been a victim of violence in your neighborhood, community, or

school? (for example, targeted bullying, assault, or other violent actions, war, or terrorism)"
    - 3% responded, "yes" to, "Has your child ever lacked appropriate care by any caregiver? (for example, not being protected from unsafe situations, or not cared for when sick or injured even when the resources were available)"
    - 3% responded, "yes" to, "Has your child experienced discrimination? (for example, being hassled or made to feel inferior or excluded because of their race, ethnicity, gender identity, sexual orientation, religion, learning differences, or disabilities)"
- PRAPARE Tool – 2,745 assessments
    - 11% identified as Black or African American
    - 4% responded, "less than high school degree" to, "what is the highest level of school that you have finished?"
    - 4% responded, "no" to, "Do you feel physically and emotionally safe where you currently live?"
    - 3% responded, "yes" to, "In the past year, have you or any family members you live with been unable to get (UTILITIES) when it was really needed?"
    - 2% responded, "yes" to, "in the past year, have you or any family members you like with been unable to get (FOOD) when it was really needed?
    - 2% responded, "yes" to, "in the past year, have you or any family members you live with been unable to get any of the following when it was really needed? (Medical, Dental, Mental Health, Vision)"
    - 1% responded, "I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)" to "what is your housing situation today?"
    - 1% responded, "yes" to, "Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?"

- 1,220 unique, incentive referrals were placed on 553 members as part of the SDOH PIP.
    - 621 unique referrals were closed as "got help" for 238 unique members as part of the SDOH PIP.

Most commonly searched term as part of Healthy Blue SDOH PIP between Jan-May 2025	domain	Percentage of total searches
help pay for utilities	housing	23%
help find work, skills & training	work	8.62%
skills & training, help find work	education	7.61%
food pantry	food	5.75%
transportation for healthcare	transit	4.74%
temporary shelter, short-term housing	housing	1.87%
short-term housing, temporary shelter	housing	2%
clothing, clothing vouchers	goods	2%
help pay for childcare	money	1%
help pay for housing	housing	1.29%

clothing	goods	1%
help pay for food	food	1%
help find work, skills & training, GED/high-school equivalency	work	1%
government food benefits, meals, help pay for food, food delivery, food pantry	food	1%
GED/high-school equivalency, help find work, skills & training	education	1%

- Provider Communications.
  - February 2025 topics:
    - Resources to support diverse patients and communities
    - LDH Informational Bulletin 25-2 January 31, 2025, Emergency Room Utilization Reduction Pilot Program
  - March 2025 topics:
    - Technical difficulties: My Diverse Patients
    - CAHPS improve patient experience
    - ER Utilization Reduction Pilot Program
  - April 2025 topics:
    - Reminder: appointment availability and access-to-care standards
    - INVITE Provider Education Apr-June 2025
  - May 2025 topics:
    - You are invited: care provider educational webinars
- Community
  - Community Event, "Healthy Living Resource Fair" in Rapides Parish with Alexandria Mall to bring education to the community, while also providing the following:
    - Blood Pressure and Blood Sugar Checks
    - Fitness Inspiration
    - CPR Demonstration
  - Community event, "Makin' Groceries Mobile Market" in Calcasieu Parish with Second Harvest Food Bank.
  - Community event, "MLK Food Packing" in Orleans Parish with Second Harvest Food Bank and the New Orleans Saints.
  - Community event, "MLK Food Packing" in Lafourche Parish with Good Samaritan Food Bank and Louisiana Blue.
  - Food packing event in Bossier Parish with Louisiana Blue and Entergy to pack 10,000 meals.
  - Community event, "MLK Parade and Resource Fair" in St. Tammany Parish with One Covington-Future Leaders of Louisiana.
  - Community event, "Re-Entry Job Readiness Resource Fair" in Evangeline Parish with St. Landry – Evangeline United Way.
  - Community event, "Makin' Groceries Mobile Market" in Calcasieu Parish with SWLA Center for Health Services and Second Harvest Food Bank.
  - Community event, "Makin' Groceries Mobile Market" in Evangeline Parish with Second Harvest Food Bank.
  - Community event, "Makin' Groceries Mobile Market" in Acadia Parish with Second Harvest Food Bank.
  - Healthy Blue Listening Session in Ouachita Parish with community leaders.
  - Healthy Blue Listening Session in Caddo Parish with community leaders.

	○ Community event, "Health Equity regional CBO Listening Sessions" in Rapides Parish with Louisiana Public Health Institute. ○ Healthy Blue Tribal Listening Session in Calcasieu Parish with Attakapas Eagle Tribe. ○ Healthy Blue Tribal Listening Session in Calcasieu Parish with Chitimacha Tribe. ○ Community event, "Makin' Groceries Mobile Market" in St. Landry Parish with Second Harvest Food Bank. ○ Food Pantry distribution in DeSoto Parish with HGM Community Development Corporation. ○ Community event, "4th Annual Health and Wellness Day" in Orleans Parish with Top Box Louisiana to provide 100 food boxes to address food insecurity. ○ Community event, "Makin' Groceries Mobile Market" in Calcasieu Parish with Second Harvest Food Bank. ○ Community Event, "You're only as good as you feel" in Rapides Parish with Rapides Parish Library. ○ Community event, "Dillard University 17th Annual Housing, Health/Community Resource Fair" in Orleans Parish with Dillard University. ○ Community, "Rebuilding Together New Orleans" in Jefferson Parish with Rebuilding Together New Orleans for workforce development. ○ Community, "Hotel Hope" in Orleans Parish with Hotel Hope. ○ Community event, "Open Health Foundation" in East Baton Rouge Parish with Open Health Care Clinic to support providing access for all to affordable, quality healthcare. ○ Community event, "Louisiana Empty Bowls" in Caddo Parish with Northwest Food Bank of Louisiana. ○ Community, "Christian Service Program" in Caddo Parish with Christian Services Program for the food pantry program. ○ Community, "Crescent City Classic Wellness Expo" in Orleans Parish with Grace at the Green Light. ○ Community Event, "NAMI Walk" in St. Tammany Parish with NAMI St. Tammany for Mental Health Walk. ○ Community event, "Tribal Powwow" in Avoyelles Parish with Tunica-Biloxi Tribe. Support of "Geaux Get Healthy" in East Baton Rouge Parish with Geaux Get Healthy Clinical Program at Our Lady of the Lake Regional Medical Center.
Activities expected to be accomplished by December 2025:	• Continue to reach out to CBOs and offer enrollment into Trusted Network. • Continue to meet monthly with FindHelp and collaborative team to review FindHelp utilization trends, progress towards goals, and ongoing strategic planning. • Continue to reinforce the need for Health Plan associates to refer members to CBOs and programs on FindHelp platform rather than only sharing the information of the CBO and program. • Provider Communications. ○ June 2025 topics: ▪ Learn about members' rights and responsibilities • Community ○ Community event, "Makin' Groceries Mobile Market" in Calcasieu Parish with Second Harvest Food Bank. ○ Community event, "Makin' Groceries Mobile Market" in St. Landry Parish with Second Harvest Food Bank. ○ Community Event, "NAMI Walk" in St. Tammany Parish with NAMI St. Tammany for Mental Health Walk. ○ Community Event, "12th Annual Capital Area Transit System Health Fair" in East Baton Rouge Parish with Capital Area Transit System and Our Lady of the Lake Mary Bird Perkins.

	○ Food Pantry distribution in DeSoto Parish with HGM Community Development Corporation.
Progress, challenges, and/or delays in achieving measurable objectives and/or milestones thus far in 2025	Progress. • Ongoing and continued education to CBOs on the need to update final status of referral in order for the loop to be closed. • Ongoing and continued education to CM to increase referrals to programs rather than only sharing information for programs without placing referral. Challenges. • CBOs need to update final status of referral in order for the loop to be closed. This must be done in findhelp by the CBO to show the member got help. Delays. • Delays in CBOs closing the loop. We continue to educate CBOs on importance of closing loops.

Cultural Responsiveness and Implicit Bias Training

2. **Cultural Responsiveness and Implicit Bias Training.**[1] Please describe:
    a. Staff and provider trainings conducted (e.g., training components, number and type of attendees, length of training and format) between January and June 2025
    b. Additional training expected to be conducted by December 2025
    c. Modifications the MCO has made or intends to make to training content, format, etc. based on participant feedback and lessons learned to date
    d. Is the MCO on track to meet training goals set in the MCO's Health Equity Plan? If not, please describe why not.

Staff and Provider Trainings	
Staff Trainings between January and June 2025:	**Provider Trainings between January and June 2025:**
Healthy Blue ensures that all staff members having contact with members or providers receive initial and ongoing training on health equity and SDOH, beyond Culturally and Linguistically Appropriate Services (CLAS) requirements and with regard to the appropriate identification and handling of quality-of-care concerns. Monthly Associate Listening Sessions • On a monthly basis, Healthy Blue hosts virtual Associate Listening Sessions open to all associates. • These sessions are held quarterly for Managers and Leaders and 3 times a year (beginning, middle, and end of year) for Senior Leadership.	Healthy Blue is dedicated to contracting with providers and other health professionals who value and are committed to serving a diverse population, and can meet the cultural, ethnic, racial, and linguistic needs demonstrated by our members. Cultural awareness helps one modify their behaviors to respond to the needs of others while maintaining a professional level of respect and objectivity. To support this effort, Healthy Blue offers and provides cultural competency training during orientation and on an ongoing basis in a variety of formats (webinars, online

• The listening sessions are conducted by the Whole Health Director and results are discussed with the Plan President, Chief of Staff, and HR Business Partner. • The sessions have the ability to conduct real-time polls with participants. Ongoing Leaders Leading and Learning Healthy Blue leaders conduct regular Leading and Listening sessions with associates that address important topics such as our culture, perspective taking, inclusive leadership, and racial and social injustices. • Healthy Blue's strong leadership commitment and a variety of programs have strengthened inclusion and diversity at Healthy Blue, including inclusive leadership and unconscious bias training for our leaders. ○ This training offers practical strategies and management processes to minimize bias and promote more objective decision-making. *How Social Factors Impact Health Outcomes – SDOH in LA.* Healthy Blue understands the impact of social factors on individual health and personal outcomes and why using person-centered approaches is best practice when working with people as it allows us to see the whole person in the context of family and community, and how we can connect the people we support with appropriate resources. • Training provided to Health Plan staff as part of Health Equity CLAS goal to provide SDoH training. *Annual Cultural Competency Refresher* – Scheduled to launch on 6/23/2025 with 90 days to complete. Healthy Blue expects our associates to perform their roles in a multiculturally competent way. • Healthy Blue associates are required to complete our "Cultural Competency Refresher" eLearning program, which focuses on the ways cultural backgrounds and diversity of experiences affect the needs and expectations of our healthcare consumers. *Annual LGBTQIA+ Inclusive Practices* – Scheduled to launch on 6/23/2025 with 90 days to complete. • Healthy Blue educates associates and leaders about inclusive ways to make associates and members who identify as LGBTQIA+ feel respected and valued at Healthy Blue, including practices that facilitate gender transition in the workplace, adoption assistance for our associates who wish to expand	resources in the provider portal, individual training as needed). The training curriculum builds the skills necessary to deliver knowledgeable and accessible assistance and services to people of all cultures and abilities. • Cultural competency training for providers, including office staff, is member focused, and can include: • The importance of cultural awareness and cultural sensitivity in our daily lives. • Importance of understanding and appreciation of diversity. • Myths about people, places and things are prevalent in our society. During the training participants will examine some of the false truths that can influence an individual's view of the world. • Demonstrate basic cultural competency skills that the participant can use to enhance and improve the interactions they have with co-workers, consumers, and the general public. • Importance of the members' beliefs about illness and health, and about traditional home remedies that may impact what the provider's treatment methodology is trying to accomplish. • Methods and styles of communication that are effective with respect to culture, language, and literacy levels in order to support a positive interaction between the patient, providers, and office staff, as well as Plan staff. • How to access language support services for members, and how to interact with limited English proficient (LEP) patients during in-person visits. • How to access language assistance resources available from the Health Plan, including language identification cards. • Documenting members' preferred language in the medical record. • Maintaining request or refusal of interpreter services in the medical record. • Discouraging the use of family and friends, particularly minors, as interpreters. • Assisting members with filing a complaint or grievance. • Components: • Introduction to health equity • Health disparities experienced by people with disabilities

their family, and our Safe Space Allyship program that educate associates about how to be an active ally and interact with individuals who identify as LGBTQ+ in a thoughtful, respectful, and caring way.	• Maternal health disparities • Addressing healthcare disparities for people who identify as Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, and Asexual (LGBTQIA+) • Cultural humility in healthcare, including role of implicit bias in healthcare/health outcome disparities • Provider resources and education Partnership with LDH Statewide Nurse Educator for 2025 • Partnered with Louisiana Department of Health's Statewide Nurse Educator to bring quarterly in-person education and training to Healthy Blue providers. Training and education focused on syphilis, congenital syphilis, HIV, and the importance of following evidence-based, best practice recommendations for screening, treatment, and follow up. ○ Q1 2025 was held in Monroe, LA. ○ Q2 2025 is scheduled for Baton Rouge, LA.
Additional Trainings	
Additional staff trainings expected to be conducted by December 2025: Associate Listening Sessions. • On a monthly basis, Healthy Blue hosts virtual Associate Listening Sessions open to all associates. • These sessions are held quarterly for Managers and Leaders and 3 times a year (beginning, middle, and end of year) for Senior Leadership. Implicit Bias Lunch and Learn. • Healthy Blue's Cultural Competency Facilitator to host Lunch and Learn on the topic of Implicit Bias for Healthy Blue associates.	Additional Provider trainings expected to be conducted by December 2025: • Healthy Blue to co-host second annual Maternal Health and Equity Summit with following day Ultimate Community Baby Shower in November 2024 with trusted women's health provider and trusted community-based organization (CBO). The Summit will provide education and training to professionals with professional continuing education credits available for MDs, RNs, and SWs. The women's health provider and CBO are also co-hosts for Healthy Blue's annual Ultimate Baby Shower that is scheduled for the day after the professional Summit.
Modifications Identified for Trainings	
Modifications the MCO has made or intends to make to training content, format, etc. based on participant feedback and lessons learned to date:	Staff Training. • Associate Listening Sessions. ○ Based on feedback from associates during the listening sessions, we have continued the use of interactive polls to the listening sessions for participants to engage with during the call, and we have decreased the time of the call from one hour monthly to one half hour monthly. Provider Training.

	• Healthy Blue continues to offer cultural competency training to providers.
Status of Training Goals	
Is the MCO on track to meet training goals set in the MCO's Health Equity Plan? If not, please describe why not.	Healthy Blue is on track to meet training goals set in the Health Equity Plan.

Stratify MCO Results on Attachment H Measures

3. **Stratified Results on Select Attachment H Measures (Measure #55)**
    a. *Legacy MCOs*—Please summarize the baseline information for the measures in Attachment H (Measure #55) below, including any stratifications of data from MY 2024 where available.
        i. **Pregnancy:** Percentage of Low Birthweight Births, Contraceptive Care – Postpartum Women Ages 21–44, Prenatal and Postpartum Care (PPC), Low-Risk Cesarean Delivery (LRCD)
        ii. **Child:** Well Child Visits in the First 30 Months of Life, Child and Adolescent Well-Care Visits (WCV)
        iii. **Adult:** Colorectal Cancer Screening, HIV Viral Load Suppression, Cervical Cancer Screening
        iv. **Behavioral Health**: Follow-Up After Emergency Department Visit for Mental Illness (within 30 days), Follow-Up After Emergency Department Visit for Substance Use (within 30 days), Follow-Up After Hospitalization for Mental Illness (within 30 days), Initiation and Engagement of Substance Use Disorder Treatment (IET)
    b. *All MCOs* – Please summarize your activities and data collection efforts to stratify and report results for Attachment H measures (Measure #55) for CY 2025 performance.
    c. *Non-legacy MCOs* – If the MCO cannot provide stratified results on one or more measures in #55 listed above for MY24, please describe challenges in providing stratified data for each measure.

Please note that information on the following measures will be included in the final submission: Percentage of Low Birthweight Births, Contraceptive Care – Postpartum Women Ages 21–44, Low-Risk Cesarean Delivery (LRCD), HIV Viral Load Suppression.

Data Collection Methodology

Data Collection Methodology (Admin [A], Hybrid [H], or ECDS [E])												
W30	WCV	COL-E	CCS	FUH-30-Day	FUM-30 Day	FUA-30 Day	IET	PPC	HVL-AD	LBW-CH	CCP-AD	LRCD
A	A	E	H	A	A	A	A	H	A	A	A	A

Geography Definitions

PARISH	GEOGRAPHY
ACADIA	URBAN
ALLEN	RURAL
ASCENSION	URBAN
ASSUMPTION	RURAL
AVOYELLES	RURAL

BEAUREGARD	RURAL
BIENVILLE	RURAL
BOSSIER	URBAN
CADDO	URBAN
CALCASIEU	URBAN
CALDWELL	RURAL
CAMERON	RURAL
CATAHOULA	RURAL
CLAIBORNE	RURAL
CONCORDIA	RURAL
DESOTO	RURAL
EAST BATON ROUGE	URBAN
EAST CARROLL	RURAL
EAST FELICIANA	RURAL
EVANGELINE	RURAL
FRANKLIN	RURAL
GRANT	RURAL
IBERIA	RURAL
IBERVILLE	RURAL
JACKSON	RURAL
JEFFERSON	URBAN
JEFFERSON DAVIS	RURAL
LAFAYETTE	URBAN
LAFOURCHE	URBAN
LASALLE	RURAL
LINCOLN	RURAL
LIVINGSTON	URBAN
MADISON	RURAL
MOREHOUSE	RURAL
NATCHITOCHES	RURAL
ORLEANS	URBAN
OUACHITA	URBAN
PLAQUEMINES	URBAN
POINTE COUPE	RURAL
RAPIDES	URBAN
RED RIVER	RURAL
RICHLAND	RURAL
SABINE	RURAL
ST. BERNARD	URBAN
ST. CHARLES	URBAN
ST. HELENA	RURAL
ST. JAMES	URBAN
ST. JOHN	URBAN
ST. LANDRY	URBAN

ST. MARTIN	URBAN
ST. MARY	RURAL
ST. TAMMANY	URBAN
TANGIPAHOA	RURAL
TENSAS	RURAL
TERREBONNE	URBAN
UNION	RURAL
VERMILION	RURAL
VERNON	RURAL
WASHINGTON	RURAL
WEBSTER	URBAN
WEST BATON ROUGE	URBAN
WEST CARROLL	RURAL
WEST FELICIANA	RURAL
WINN	RURAL

Pregnancy: Percentage of Low Birthweight Births, Contraceptive Care – Postpartum Women Ages 21–44, Prenatal and Postpartum Care (PPC), Low-Risk Cesarean Delivery (LRCD)

Percentage of Low Birthweight Births – will be included in final submission.

Contraceptive Care – Postpartum Women Ages 21–44 – will be included in final submission.

Prenatal and Postpartum Care (PPC)

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator by Medical Records	Numerator By Supplemental	Rate
Prenatal and Postpartum Care: Timeliness of Prenatal Care	Total	411	411	318	28	0	84.18%
	Race						
	White	188	188	145	13	0	84.04%
	Black or African American	188	188	145	13	0	84.04%
	American Indian and Alaska Native	4	4	4	0	0	100.00%
	Asian	15	15	12	2	0	93.33%
	Native Hawaiian or Other Pacific Islander	0	0	0	0	0	#DIV/0!
	Some Other Race	0	0	0	0	0	#DIV/0!
	Two or More Races	0	0	0	0	0	#DIV/0!
	Asked but No Answer	0	0	0	0	0	#DIV/0!
	Unknown	16	16	12	0	0	75.00%

	Ethnicity						
	Hispanic or Latino	2	2	2	0	0	100.00%
	Not Hispanic or Latino	409	409	316	28	0	84.11%
	Declined Ethnicity	0	0	0	0	0	#DIV/0!
	Unknown Ethnicity	0	0	0	0	0	#DIV/0!
	Sex						
	Male	0	0	0	0	0	#DIV/0!
	Female	411	411	318	28	0	84.18%
	Unknown	0	0	0	0	0	#DIV/0!
	Geography						
	Rural	130	130	96	8	0	80.00%
	Urban	277	277	219	20	0	86.28%
	Unknown	4	4	3		0	75.00%
Validation Check	Total Race	411	411	318	28	0	
	Total Ethnicity	411	411	318	28	0	
	Total Sex	411	411	318	28	0	
	Total Geography	411	411	318	28	0	
	Category	**Eligible Population**	**Denominator**	**Numerator By Admin**		**Numerator By Supplemental**	**Rate**
Prenatal and Postpartum Care: Postpartum Care	Total	411	411	282	51	0	81.02%
	Race						
	White	188	188	133	24	0	83.51%
	Black or African American	188	188	126	24	0	79.79%
	American Indian and Alaska Native	4	4	3	0	0	75.00%
	Asian	15	15	12	1	0	86.67%
	Native Hawaiian or Other Pacific Islander	0	0	0	0	0	#DIV/0!
	Some Other Race	0	0	0	0	0	#DIV/0!
	Two or More Races	0	0	0	0	0	#DIV/0!
	Asked but No Answer	0	0	0	0	0	#DIV/0!
	Unknown	16	16	8	2	0	62.50%
	Ethnicity						
	Hispanic or Latino	2	2	0	1	0	50.00%

	Not Hispanic or Latino	409	409	282	50	0	81.17%
	Declined Ethnicity	0	0	0	0	0	#DIV/0!
	Unknown Ethnicity	0	0	0	0	0	#DIV/0!
	Sex						
	Male	0	0	0	0	0	#DIV/0!
	Female	411	411	282	51	0	81.02%
	Unknown	0	0	0	0	0	#DIV/0!
	Geography						
	Rural	130	130	92	18	0	84.62%
	Urban	277	277	186	33	0	79.06%
	Unknown	4	4	4	0	0	100.00%
Validation Check	Total Race	411	411	282	51	0	
	Total Ethnicity	411	411	282	51	0	
	Total Sex	411	411	282	51	0	
	Total Geography	411	411	282	51	0	

Low-Risk Cesarean Delivery (LRCD) – will be included in final submission.

Child: Well Child Visits in the First 30 Months of Life, Child and Adolescent Well-Care Visits (WCV)

Well Child Visits in the First 30 Months of Life

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate
Well-Child Visits in the First 30 Months of Life: First 15 Months	Total	6,130	6,130	3,789	23	62.19%
	Race					
	White	2,202	2,202	1,462	4	66.58%
	Black or African American	2,792	2,792	1,652	14	59.67%
	American Indian and Alaska Native	27	27	18	0	66.67%
	Asian	83	83	54	0	65.06%
	Native Hawaiian or Other Pacific Islander	11	11	8	0	72.73%
	Some Other Race	822	822	505	4	61.92%
	Two or More Races	1	1	0	0	0.00%
	Asked but No Answer	0	0	0	0	#DIV/0!
	Unknown	192	192	90	1	47.40%
	Ethnicity					

	Hispanic or Latino	2	2	1	0	50.00%
	Not Hispanic or Latino	6,128	6,128	3,788	23	62.19%
	Declined Ethnicity	0	0	0	0	#DIV/0!
	Unknown Ethnicity	0	0	0	0	#DIV/0!
	Sex					
	Male	3,098	3,098	1,904	12	61.85%
	Female	3,032	3,032	1,885	11	62.53%
	Unknown	0	0	0	0	#DIV/0!
	Geography					
	Rural	1,654	1,654	1,016	5	61.73%
	Urban	4,437	4,437	2,754	18	62.47%
	Unknown	39	39	19	0	48.72%
Validation Check	Total Race	6,130	6,130	3,789	23	
	Total Ethnicity	6,130	6,130	3,789	23	
	Total Sex	6,130	6,130	3,789	23	
	Total Geography	6,130	6,130	3,789	23	

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate
Well-Child Visits in the First 30 Months of Life: 15 Months - 30 Months	Total	4,226	4,226	3,088	7	73.24%
	Race					
	White	1,424	1,424	1,006	6	71.07%
	Black or African American	1,715	1,715	1,210	1	70.61%
	American Indian and Alaska Native	16	16	12	0	75.00%
	Asian	391	391	285	0	72.89%
	Native Hawaiian or Other Pacific Islander	6	6	5	0	83.33%
	Some Other Race	622	622	524	0	84.24%
	Two or More Races	1	1	1	0	100.00%
	Asked but No Answer	0	0	0	0	#DIV/0!
	Unknown	51	51	45	0	88.24%
	Ethnicity					
	Hispanic or Latino	5	5	3	0	60.00%
	Not Hispanic or Latino	4,220	4,220	3,084	7	73.25%
	Declined Ethnicity	1	1	1	0	100.00%
	Unknown Ethnicity	0	0	0	0	#DIV/0!
	Sex					
	Male	2,204	2,204	1,629	4	74.09%
	Female	2,022	2,022	1,459	3	72.30%

	Unknown	0	0	0	0	#DIV/0!
	Geography					
	Rural	1,169	1,169	791	2	67.84%
	Urban	3,010	3,010	2,276	5	75.78%
	Unknown	47	47	21	0	44.68%
Validation Check	Total Race	4,226	4,226	3,088	7	
	Total Ethnicity	4,226	4,226	3,088	7	
	Total Sex	4,226	4,226	3,088	7	
	Total Geography	4,226	4,226	3,088	7	

Adolescent Well-Care Visits (WCV)

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate
Child and Adolescent Well-Care Visits	Total	88,943	88,943	47,558	41	53.52%
	Race					
	White	34,569	34,569	17,393	24	50.38%
	Black or African American	44,643	44,643	24,022	13	53.84%
	American Indian and Alaska Native	621	621	298	0	47.99%
	Asian	4,893	4,893	3,111	1	63.60%
	Native Hawaiian or Other Pacific Islander	41	41	25	0	60.98%
	Some Other Race	3,379	3,379	2,274	3	67.39%
	Two or More Races	3	3	3	0	100.00%
	Asked but No Answer	0	0	0	0	#DIV/0!
	Unknown	794	794	432	0	54.41%
	Ethnicity					
	Hispanic or Latino	334	334	205	0	61.38%
	Not Hispanic or Latino	88,599	88,599	47,347	41	53.49%
	Declined Ethnicity	10	10	6	0	60.00%
	Unknown Ethnicity	0	0	0	0	#DIV/0!
	Sex					
	Male	45,215	45,215	23,911	20	52.93%
	Female	43,728	43,728	23,647	21	54.13%
	Unknown	0	0	0	0	#DIV/0!
	Geography					
	Rural	25,721	25,721	12,860	10	50.04%
	Urban	62,340	62,340	34,427	28	55.27%
	Unknown	882	882	271	3	31.07%

Validation Check	Total Race	88,943	88,943	47,558	41	
	Total Ethnicity	88,943	88,943	47,558	41	
	Total Sex	88,943	88,943	47,558	41	
	Total Geography	88,943	88,943	47,558	41	

Adult: Colorectal Cancer Screening, HIV Viral Load Suppression, Cervical Cancer Screening

Colorectal Cancer Screening

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Medical Records	Numerator By Supplemental	Rate
Colorectal Cancer Screening (ECDS)	Total	29,328	29,328	1,111	85	10,230	38.96%
	Race						
	White	13,747	13,747	520	34	4,680	38.07%
	Black or African American	12,310	12,310	491	45	4,289	39.20%
	American Indian and Alaska Native	227	227	11	0	75	37.89%
	Asian	2,123	2,123	60	5	875	44.28%
	Native Hawaiian or Other Pacific Islander	6	6	0	0	1	16.67%
	Some Other Race	853	853	28	1	294	37.87%
	Two or More Races	0	0	0	0	0	#DIV/0!
	Asked but No Answer	0	0	0	0	0	#DIV/0!
	Unknown	62	62	1	0	16	27.42%
	Ethnicity						
	Hispanic or Latino	37	37	1	0	20	56.76%
	Not Hispanic or Latino	29,289	29,289	1,110	85	10,210	38.94%
	Declined Ethnicity	2	2	0	0	0	0.00%
	Unknown Ethnicity	0	0	0	0	0	#DIV/0!
	Sex						
	Male	12,851	12,851	403	37	3,838	33.29%
	Female	16,477	16,477	708	48	6,392	43.38%
	Unknown	0	0	0	0	0	#DIV/0!

	Geography						
	Rural	8,268	8,268	289	16	2,671	35.99%
	Urban	20,828	20,828	811	66	7,520	40.32%
	Unknown	232	232	11	3	39	22.84%
Validation Check	Total Race	29,328	29,328	1,111	85	10,230	
	Total Ethnicity	29,328	29,328	1,111	85	10,230	
	Total Sex	29,328	29,328	1,111	85	10,230	
	Total Geography	29,328	29,328	1,111	85	10,230	

HIV Viral Load Suppression - will be included in final submission.

Cervical Cancer Screening

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Medical Records	Numerator By Supplemental	Rate
Cervical Cancer Screening	Total	411	411	204	11	3	53.04%
	Race						
	White	191	191	88	5	1	49.21%
	Black or African American	196	196	104	5	2	56.63%
	American Indian and Alaska Native	2	2	1	0	0	50.00%
	Asian	16	16	10	0	0	62.50%
	Native Hawaiian or Other Pacific Islander	0	0	0	0	0	#DIV/0!
	Some Other Race	0	0	0	0	0	#DIV/0!
	Two or More Races	0	0	0	0	0	#DIV/0!
	Asked but No Answer	0	0	0	0	0	#DIV/0!
	Unknown	6	6	1	1	0	33.33%
	Ethnicity						
	Hispanic or Latino	0	0	0	0	0	#DIV/0!
	Not Hispanic or Latino	411	411	204	11	3	53.04%
	Declined Ethnicity	0	0	0	0	0	#DIV/0!
	Unknown Ethnicity	0	0	0	0	0	#DIV/0!
	Geography						
	Rural	108	108	43	4	1	44.44%
	Urban	301	301	160	7	2	56.15%
	Unknown	2	2	1	0	0	50.00%

Validation Check	Total Race	411	411	204	11	3	
	Total Ethnicity	411	411	204	11	3	
	Total Geography	411	411	204	11	3	

Behavioral Health: Follow-Up After Emergency Department Visit for Mental Illness (within 30 days), Follow-Up After Emergency Department Visit for Substance Use (within 30 days), Follow-Up After Hospitalization for Mental Illness (within 30 days), Initiation and Engagement of Substance Use Disorder Treatment (IET)

Follow-Up After Emergency Department Visit for Mental Illness (within 30 days)

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate
Follow-Up After Emergency Department Visit for Mental Illness (Within 30 Days)	Total	1,000	1,000	346	46	39.20%
	Race					
	White	395	395	138	18	39.49%
	Black or African American	547	547	180	27	37.84%
	American Indian and Alaska Native	7	7	3	0	42.86%
	Asian	14	14	6	0	42.86%
	Native Hawaiian or Other Pacific Islander	1	1	0	0	0.00%
	Some Other Race	33	33	18	1	57.58%
	Two or More Races	0	0	0	0	#DIV/0!
	Asked but No Answer	0	0	0	0	#DIV/0!
	Unknown	3	3	1	0	33.33%
	Ethnicity					
	Hispanic or Latino	2	2	1	0	50.00%
	Not Hispanic or Latino	998	998	345	46	39.18%
	Declined Ethnicity	0	0	0	0	#DIV/0!
	Unknown Ethnicity	0	0	0	0	#DIV/0!
	Sex					
	Male	518	518	175	25	38.61%
	Female	482	482	171	21	39.83%
	Unknown	0	0	0	0	#DIV/0!
	Geography					
	Rural	219	219	79	12	41.55%
	Urban	764	764	261	34	38.61%
	Unknown	17	17	6	0	35.29%
Validation Check	Total Race	1,000	1,000	346	46	
	Total Ethnicity	1,000	1,000	346	46	
	Total Sex	1,000	1,000	346	46	
	Total Geography	1,000	1,000	346	46	

Follow-Up After Emergency Department Visit for Substance Use (within 30 days)

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate
Follow-Up After Emergency Department Visit for Substance Use (Within 30 Days)	Total	1,742	1,742	452	3	26.12%
	Race					
	White	807	807	249	1	30.98%
	Black or African American	840	840	175	2	21.07%
	American Indian and Alaska Native	14	14	3	0	21.43%
	Asian	47	47	11	0	23.40%
	Native Hawaiian or Other Pacific Islander	0	0	0	0	#DIV/0!
	Some Other Race	31	31	14	0	45.16%
	Two or More Races	0	0	0	0	#DIV/0!
	Asked but No Answer	0	0	0	0	#DIV/0!
	Unknown	3	3	0	0	0.00%
	Ethnicity					
	Hispanic or Latino	2	2	0	0	0.00%
	Not Hispanic or Latino	1,740	1,740	452	3	26.15%
	Declined Ethnicity	0	0	0	0	#DIV/0!
	Unknown Ethnicity	0	0	0	0	#DIV/0!
	Sex					
	Male	1,027	1,027	247	1	24.15%
	Female	715	715	205	2	28.95%
	Unknown	0	0	0	0	#DIV/0!
	Geography					
	Rural	415	415	94	0	22.65%
	Urban	1,306	1,306	354	3	27.34%
	Unknown	21	21	4	0	19.05%
Validation Check	Total Race	1,742	1,742	452	3	
	Total Ethnicity	1,742	1,742	452	3	
	Total Sex	1,742	1,742	452	3	
	Total Geography	1,742	1,742	452	3	

Follow-Up After Hospitalization for Mental Illness (within 30 days)

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate
Follow-Up After Hospitalization for Mental Illness (Within 30 Days)	Total	6,334	6,334	2,539	223	43.61%
	Race					
	White	3,142	3,142	1,281	120	44.59%
	Black or African American	2,808	2,808	1,096	92	42.31%
	American Indian and Alaska Native	42	42	24	0	57.14%
	Asian	111	111	48	4	46.85%
	Native Hawaiian or Other Pacific Islander	0	0	0	0	#DIV/0!
	Some Other Race	197	197	84	5	45.18%
	Two or More Races	0	0	0	0	#DIV/0!
	Asked but No Answer	0	0	0	0	#DIV/0!
	Unknown	34	34	6	2	23.53%
	Ethnicity					
	Hispanic or Latino	15	15	4	0	26.67%
	Not Hispanic or Latino	6,317	6,317	2,534	223	43.64%
	Declined Ethnicity	2	2	1	0	50.00%
	Unknown Ethnicity	0	0	0	0	#DIV/0!
	Sex					
	Male	3,467	3,467	1,253	96	38.91%
	Female	2,867	2,867	1,286	127	49.28%
	Unknown	0	0	0	0	#DIV/0!
	Geography					
	Rural	1,560	1,560	620	53	43.14%
	Urban	4,682	4,682	1,892	166	43.96%
	Unknown	92	92	27	4	33.70%
Validation Check	Total Race	6,334	6,334	2,539	223	
	Total Ethnicity	6,334	6,334	2,539	223	
	Total Sex	6,334	6,334	2,539	223	
	Total Geography	6,334	6,334	2,539	223	

Initiation and Engagement of Substance Use Disorder Treatment (IET)

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate
	Total	10,347	10,347	6,215	0	60.07%

Initiation and Engagement of Substance Use Disorder Treatment: Initiation of SUD Treatment	**Race**					
	White	5,265	5,265	3,267	0	62.05%
	Black or African American	4,519	4,519	2,628	0	58.15%
	American Indian and Alaska Native	79	79	46	0	58.23%
	Asian	283	283	151	0	53.36%
	Native Hawaiian or Other Pacific Islander	0	0	0	0	#DIV/0!
	Some Other Race	190	190	115	0	60.53%
	Two or More Races	0	0	0	0	#DIV/0!
	Asked but No Answer	0	0	0	0	#DIV/0!
	Unknown	11	11	8	0	72.73%
	Ethnicity					
	Hispanic or Latino	6	6	3	0	50.00%
	Not Hispanic or Latino	10,338	10,338	6,211	0	60.08%
	Declined Ethnicity	3	3	1	0	33.33%
	Unknown Ethnicity	0	0	0	0	#DIV/0!
	Sex					
	Male	5,815	5,815	3,717	0	63.92%
	Female	4,532	4,532	2,498	0	55.12%
	Unknown	0	0	0	0	#DIV/0!
	Geography					
	Rural	2,703	2,703	1,559	0	57.68%
	Urban	7,514	7,514	4,582	0	60.98%
	Unknown	130	130	74	0	56.92%
Validation Check	Total Race	10,347	10,347	6,215	0	
	Total Ethnicity	10,347	10,347	6,215	0	
	Total Sex	10,347	10,347	6,215	0	
	Total Geography	10,347	10,347	6,215	0	

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate
Initiation and Engagement of Substance Use Disorder Treatment: Engagement of SUD Treatment	Total	10,347	10,347	2,836	0	27.41%
	Race					
	White	5,265	5,265	1,619	0	30.75%
	Black or African American	4,519	4,519	1,099	0	24.32%
	American Indian and Alaska Native	79	79	13	0	16.46%
	Asian	283	283	58	0	20.49%
	Native Hawaiian or Other Pacific Islander	0	0	0	0	#DIV/0!

	Some Other Race	190	190	42	0	22.11%
	Two or More Races	0	0	0	0	#DIV/0!
	Asked but No Answer	0	0	0	0	#DIV/0!
	Unknown	11	11	5	0	45.45%
	Ethnicity					
	Hispanic or Latino	6	6	1	0	16.67%
	Not Hispanic or Latino	10,338	10,338	2,835	0	27.42%
	Declined Ethnicity	3	3	0	0	0.00%
	Unknown Ethnicity	0	0	0	0	#DIV/0!
	Sex					
	Male	5,815	5,815	1,777	0	30.56%
	Female	4,532	4,532	1,059	0	23.37%
	Unknown	0	0	0	0	#DIV/0!
	Geography					
	Rural	2,703	2,703	704	0	26.05%
	Urban	7,514	7,514	2,101	0	27.96%
	Unknown	130	130	31	0	23.85%
Validation Check	Total Race	10,347	10,347	2,836	0	
	Total Ethnicity	10,347	10,347	2,836	0	
	Total Sex	10,347	10,347	2,836	0	
	Total Geography	10,347	10,347	2,836	0	

4. **Please share other comments/observations on your Health Equity progress since the submission of the MCO 3.0 Health Equity Plan:**

Feedback Relating to Implementation of Health Equity Progress since Year-End 2024 Plan	
Comments Observations Barriers	• Presidential Executive Orders (EO) have had impacts on health equity structure in the USA. EO commencing reduction of federal bureaucracy – CMS terminates its Health Equity Advisory Committee. Federal funding pause and grant caps affect health equity programs and research. Closure of HHS office of Climate Change and Health Equity with staff on administrative leave and online resources related to health impacts from climate change removed. Significant downsize of CMS Office Minority Health. EO redefines "sex" as strictly binary (male/female) based on biological attributes at conception, mandates federal agencies use "sex" instead of "gender," prohibits the use of federal funds to promote "gender ideology," requires official documentation to reflect biological sex, rescinds previous policies that recognized gender identity. ○ Federal actions suggest there is a rising risk of using "health equity" and related terms. ○ Healthy Blue continues to offer Cultural Competency training to in network providers; however, Healthy Blue has noted a sharp decline to participation since Year-End 2024 Plan. This sharp decline has resulted in no participation in the Cultural Competency training.