LOUISIANA DEPARTMENT OF HEALTH

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

External Quality Review Technical Report

for

Humana Healthy Horizons

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 (SBHS), 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 16, 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 16, 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 16, 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 16, 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 Humana Healthy Horizons (HUM) conducted with Louisiana Medicaid managed care throughout SFY 2025.

Validation of Performance Improvement Projects

HUM 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 HUM 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 HUM's performance measures confirmed compliance with the standards of 42 CFR §438.330(a)(1). The results of the validation activity determined that HUM 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 HUM's certified HEDIS compliance auditor, HSAG found that HUM 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, HUM had 47 indicators that performed greater than the NCQA national 50th percentile benchmark, 69 that performed lower than the NCQA national 50th percentile benchmark, and three indicators that were not compared to the NCQA national 50th percentile benchmark because the reported rates were *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	33%	85%
II	Member Rights and Confidentiality	100%	99%
III	Member Information	72%	69%
IV	Emergency and Poststabilization Services	100%	99%
V	Adequate Capacity and Availability of Services	43%	52%
VI	Coordination and Continuity of Care	83%	85%
VII	Coverage and Authorization of Services	95%	93%
VIII	Provider Selection	68%	70%
IX	Subcontractual Relationships and Delegation	67%	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	84%	90%
XIV	Program Integrity	100%	97%
Total Compliance Score		**83%**	

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 HUM 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

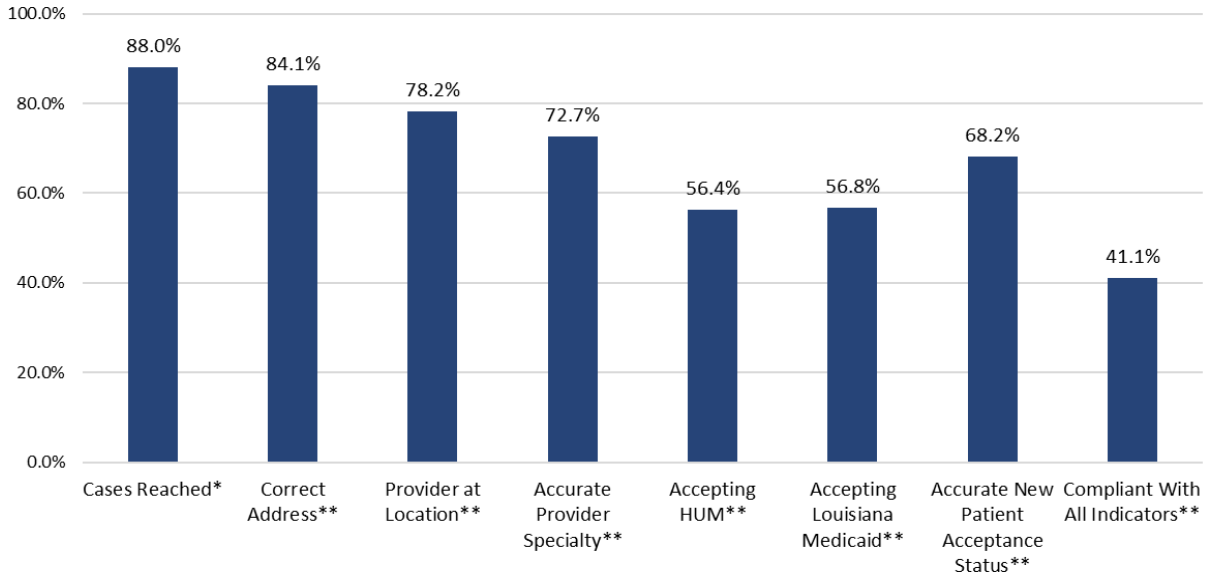
Concerns	Findings
Acceptance of Louisiana Medicaid was low.	Overall, 56.8 percent of providers accepted Louisiana Medicaid.
Acceptance of HUM was low.	Overall, 56.4 percent of providers accepted HUM.
Specialty provider type was incorrect in the provider directory.	Overall, 72.7 percent of providers confirmed the specialty listed in the online provider directory was accurate.
Overall accuracy of the new patient acceptance status was low.[1]	Overall, 68.2 percent of providers confirmed the new patient acceptance status in the online provider directory was correct.
Affiliation with the sampled provider was low.	Overall, 78.2 percent of the locations confirmed affiliation with the sampled provider.
Address information was incorrect.	Overall, 84.1 percent of respondents reported that HUM'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 56.8 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 HUM acceptance exhibited the lowest match rates, with all indicators exhibiting a match rate at or below 88.0 percent.

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

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



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

HUM's aggregate Q1 and Q2 weighted PDV compliance scores by specialty provider type ranged from behavioral health at 28.7 percent to obstetricians/gynecologists (OB/GYNs) at 50.7 percent.

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 HUM 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, 36.8 percent of the locations confirmed affiliation with the sampled provider.
Acceptance of new patients was low.	Overall, 42.1 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, 42.1 percent of providers accepted Louisiana Medicaid.
Acceptance of the MCO was low.	Overall, 43.9 percent of providers accepted the requested MCO.
Specialty provider type was inaccurate in the provider data.	Overall, 73.7 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	86.7%	84.6%	76.9%	46.2%	38.5%	38.5%	23.1%
Dermatologists	85.0%	94.1%	76.5%	29.4%	29.4%	29.4%	23.5%
Orthopedic Surgeons	84.4%	96.3%	70.4%	51.9%	51.9%	51.9%	51.9%
Total	**85.1%**	**93.0%**	**73.7%**	**43.9%**	**42.1%**	**42.1%**	**36.8%**

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

HUM's weighted first provider access survey compliance scores by specialty provider type ranged from 28.9 percent (allergists) to 59.4 percent (orthopedic surgeons).

NAV Audit

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

Table 1-8—HUM 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
Gastroenterology	Rural
Ophthalmology	Rural
Orthopedics (Adult)	Rural
Orthopedics (Pediatric)	Rural
Otorhinolaryngology/Otolaryngology	Rural
Physicians and licensed mental health practitioners (LMHPs) who specialize in pregnancy-related and postpartum depression or related mental health disorders	Rural
Physicians and LMHPs who specialize in pregnancy-related and postpartum substance use disorders (SUD)	Rural

Provider Type	Urbanicity
Psychiatric Residential Treatment Facilities (PRTFs) (Level 3.7 Withdrawal Management [WM]) and Other Specialization (Pediatric Under Age 21)	All

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

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

Table 1-9—HUM 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%	96.97%
Urgent Non-Emergency Behavioral Health Care	48 hours (2 calendar days)	90%	77.78%
Non-Urgent Routine Behavioral Health Care	14 calendar days	70%	61.11%

Encounter Data Validation

Information Systems Review

The IS review provides self-reported qualitative information from HUM 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	HUM	Note
Encounter Data Sources and Systems	—	None.
Payment Structures	—	None.

IS Review	HUM		Note
Encounter Data Quality Monitoring			
Processes for Encounters Collected by Subcontractors	✓	X	Strengths were for NEMT and vision encounters. Weakness was for dental encounters.
Quality Monitoring on Encounters Collected by Subcontractors	X		Weaknesses were for dental, NEMT, pharmacy, and vision encounters.
Quality Monitoring on Encounters Collected by HUM	✓		Strength included all four types of data quality checks.
% of Encounters Initially Rejected and Not Yet Accepted by LDH	✓	X	Strength was for pharmacy encounters, and weaknesses were for NEMT and vision encounters.

Administrative Profile

The administrative profile analyzes LDH's encounter data, for HUM, 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	✓	✓	—	✓
Encounter Data Timeliness				
Lag Between MCO Payment Date and Received Date by LDH	X	X	X	—
Field-Level Completeness and Accuracy				
% Present	—	—	X	—
% Valid	X	✓	X	X
Encounter Referential Integrity				
Encounter vs Enrollment	—			—
Medical/Dental vs Pharmacy Encounter	—			
Encounter vs Provider	—			X

Administrative Profile	Professional	Institutional	Dental	Pharmacy
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 HUM'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, HUM's 2025 general child achievement score was statistically significantly higher than the 2025 NCQA national average and the 2024 achievement score for *Rating of Health Plan*.

Behavioral Health Member Satisfaction Survey

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

Overall, HUM's 2025 adult and child achievement scores were not statistically significantly higher or lower than the 2024 achievement scores or Healthy Louisiana SWA. Several measures had less than 100 respondents. HUM should continue to focus on increasing response rates to the Behavioral Health Member Satisfaction Survey for its adult and child 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 HUM earned 3.5 stars for the Overall Rating. Additionally, HUM earned 4.0 stars for the Patient Experience composite, including 4.0 stars for both the Satisfaction with Plan Physicians and Satisfaction with Plan and Plan Services subcomposites,

demonstrating strength for HUM in these areas. HUM also earned 5.0 stars for the Equity subcomposite and 4.0 stars for the Children and Adolescent Well-Care, Other Preventive Services, and Diabetes subcomposites, demonstrating strength for HUM in these areas. However, HUM earned 2.5 stars for both the Women's Reproductive Health and Behavioral Health—Care Coordination subcomposites, 2.0 stars for the Reduce Low Value Care subcomposite, and 1.0 star for the Cancer Screening subcomposite, demonstrating opportunities for improvement for HUM 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 HUM, 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 HUM 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, HUM collaborated on improvement strategies, meeting at least quarterly with LDH and other MCOs, throughout the year. HUM 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 HUM 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, HUM 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 HUM's final PIP validation results and confidence ratings delivered by HSAG in April 2025.

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

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	100%	100%	*High Confidence*	*Not Assessed*[4]		
Behavioral Health Transitions of Care	100%	100%	*High Confidence*	33%	100%	*Moderate Confidence*
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	100%	100%	*High Confidence*	100%	100%	*High 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*	100%	100%	*High 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 HUM'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 HUM'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: 263 D: 607	43.33%	— —	—	— —	—	*Not Assessed*
Syphilis screening during weeks 28 to 32 of pregnancy.	N: 97 D: 211	45.97%	— —	—	— —	—	*Not Assessed*
*Syphilis screening at delivery.**	N: 1 D: 644	0.16%	— —	—	— —	—	*Not Assessed*
Syphilis screening at any time during pregnancy or at delivery.	N: 508 D: 644	78.88%	— —	—	— —	—	*Not Assessed*
Syphilis screening during the first trimester.	N: 137 D: 165	83.03%	— —	—	— —	—	*Not Assessed*
Syphilis screening during the first trimester for all live births.	N: 317 D: 644	49.22%	— —	—	— —	—	*Not Assessed*
Syphilis screening during the third trimester for all live births.	N: 422 D: 640	65.94%	— —	—	— —	—	*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 HUM'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: 183 D: 1,417	12.91%	N: 310 D: 1,565	19.81%+ ▲	— —	—	*Not Assessed*
Follow-Up After Hospitalization for Mental Illness (FUH)—Total, 30 Days	N: 406 D: 1,417	28.65%	N: 586 D: 1,565	37.44%+ ▲	— —	—	*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 7 Days	N: 39 D: 274	14.23%	N: 60 D: 313	19.17%+	— —	—	*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 30 Days	N: 57 D: 274	20.80%	N: 100 D: 313	31.95%+ ▲	— —	—	*Not Assessed*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 7 Days	N: 79 D: 613	12.89%	N: 54 D: 478	11.30%	— —	—	*Not Assessed*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 30 Days	N: 122 D: 613	19.90%	N: 89 D: 478	18.62%	— —	—	*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 2-6 displays data for HUM'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: 137 D: 3,064	4.47%	N: 256 D: 3,808	6.72%+ ▲	— —	—	*Not Assessed*
Fluoride varnish application by PCP for children aged 19 months–2 years	N: 335 D: 4,611	7.27%	N: 355 D: 3,201	11.09%+ ▲	— —	—	*Not Assessed*
Fluoride varnish application by PCP for children aged 3–5 years	N: 403 D: 10,506	3.84%	N: 337 D: 6,014	5.60%+ ▲	— —	—	*Not Assessed*
Fluoride varnish application by PCP for all children aged 6 months–5 years	N: 875 D: 18,181	4.81%	N: 948 D: 13,023	7.28%+ ▲	— —	—	*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 2-7 displays data for HUM'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: 3,647 D: 18,497	19.72%	N: 5,842 D: 17,620	33.16%+ ▲	— —	—	*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 HUM'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: 2,700 D: 4,894	55.17%	N: 3,188 D: 5,368	59.39%+ ▲	— —	—	*Not Assessed*
Persons screened for HIV during the measurement year among persons with past or present (injection) drug use	N: 1,077 D: 2,810	38.33%	N: 1,769 D: 4,058	43.59%+ ▲	— —	—	*Not Assessed*
Persons screened for HIV during the measurement year among persons with risk factors related to sexual mode of transmission	N: 2,408 D: 4,073	59.12%	N: 3,748 D: 5,622	66.67%+ ▲	— —	—	*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: 5,395 D: 76,165	7.08%	N: 6,848 D: 58,626	11.68%+ ▲	— —	—	*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 HUM'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	• MCO unaware of pregnant enrollees	• HUM incentivized contracted providers to submit notification of pregnancy to MCO.
Behavioral Health Transitions of Care	• Lack of timely notification of hospital admission and lack of control over hospital discharge processes	• HUM is notified of inpatient admissions through alerts received in Guiding Care, as well as through utilization management prior authorizations. • HUM developed a report to identify any enrollees that had an ED visit. Additionally, CM reviews the ED high utilizer report regardless of CM status, and those enrollees are assigned to a case manager to offer CM services.

PIP Topic	Barriers	Interventions
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	• Lack of PCP knowledge about enrollees with a care gap or how to apply fluoride varnish	• HUM sent gap in care reports to providers to make them aware of enrollees with a care gap.
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	• Provider knowledge of care gaps and closure opportunities	• HUM educated providers on using Compass to view enrollee care gaps as well as the process for gap closure through attestation or uploading medical records.
Screening for HIV Infection	• Lack of provider knowledge of enrollees that have an HIV screening care gap and screening recommendations	• Quality/provider relations representatives from HUM met with provider groups to provide education on Centers for Disease Control and Prevention recommendations for screening.

MCO Strengths, Opportunities for Improvement, and Recommendations

For HUM, the following strengths were identified:

- The MCO developed and carried out a methodologically sound design for all five PIPs that facilitated valid and reliable measurement of objective indicator performance over time. **[Quality]**
- The MCO conducted and reported accurate analyses and interpretation of performance indicator results for all five PIPs. **[Quality]**
- The MCO carried out interventions for all five 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 five PIPs. **[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 five PIPs. **[Quality]**
- For all four PIPs assessed for achieving significant improvement (*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*, and *Screening for HIV Infection*), some of the MCO's reported performance indicator results demonstrated statistically significant improvement from baseline to the most recent remeasurement. **[Quality, Timeliness, and Access]**

- For three PIPs assessed for achieving significant improvement (*Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years*, *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees*, and *Screening for HIV Infection)*, all of the MCO's reported indicator results demonstrated statistically significant improvement from baseline to the most recent remeasurement. **[Quality, Timeliness, and Access]**

For HUM, the following opportunity for improvement was identified:

- For one PIP (*Behavioral Health Transitions of Care*) assessed for achieving significant improvement, some but not all of the MCO's reported indicator results demonstrated statistically significant improvement from baseline to the most recent remeasurement. **[Quality, Timeliness, and Access]**

For HUM, the following recommendation was identified:

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

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

Table 3-1—HUM Compliance With IS Standards—MY 2023 and MY 2024 Comparison

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

Table 3-2 through Table 3-5 display a summary of HUM'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—HUM 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	—	15.12%^	20.54%^	22.05%^
Within 30 Days of Discharge[I]—Total	—	32.48%^	39.36%^	42.18%^
Follow-Up After Emergency Department Visit for Mental Illness				
Within 7 Days of Discharge—Total	—	15.15%^	22.07%^	23.02%^
Within 30 Days of Discharge[I]—Total	—	22.35%^	36.21%^	38.77%^
Follow-Up After Emergency Department Visit for Substance Use				
Within 7 Days of Discharge—Total	—	8.95%^	12.25%^	15.66%^
Within 30 Days of Discharge[I]—Total	—	14.86%^	19.48%^	25.41%^
Follow-Up After High-Intensity Care for SUD				
Within 7 Days of Visit or Discharge—Total	—	—	51.93%+	59.23%+
Within 30 Days of Visit or Discharge—Total	—	—	62.94%+	70.77%+
Plan All-Cause Readmissions[B]				
*Observed Readmissions (Numerator/Denominator)**	—	NA	8.89%	10.05%
Expected Readmissions Rate	—	NA	8.32%	8.53%
Observed-to-Expected (O/E) Ratio (Observed Readmissions/Expected Readmissions)[*]	—	NA	1.0686+	1.1771^
Depression Screening and Follow-Up for Adolescents and Adults—Electronic Clinical Data System (ECDS)				
Depression Screening—Total	—	0.08%^	0.00%^	3.31%^
Follow-Up on Positive Screen—Total	—	NA	NA	73.57%+
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	92.86%+	86.21%+	85.11%+
Diabetes Monitoring for People With Diabetes and Schizophrenia	—	70.69%^	68.42%^	75.60%+
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	—	NA	NA	82.56%+
Metabolic Monitoring for Children and Adolescents on Antipsychotics—ECDS				
Blood Glucose Testing—Total	—	—	50.56%^	53.68%^
Cholesterol Testing—Total	—	—	26.67%^	28.43%^
Blood Glucose and Cholesterol Testing—Total	—	—	26.11%^	27.26%^
Lead Screening in Children	—	43.59%^	69.83%^	70.87%+
Colorectal Cancer Screening[I]—ECDS	—	—	22.03%^	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	—	77.37%^	87.35%+	86.26%+
Counseling for Nutrition—Total	—	63.02%^	72.75%^	70.74%^
Counseling for Physical Activity—Total	—	60.34%^	69.83%+	66.86%^
HIV Viral Load Suppression[I]	—	73.46%	81.25%	82.24%
Low-Risk Cesarean Delivery (Cesarean Rate for Low-Risk First Birth Women)[*,I]	—	23.54%	24.11%	26.37%
Chlamydia Screening in Women				
Total	—	66.75%+	67.31%+	66.43%+
Controlling High Blood Pressure[I]	—	69.10%+	66.67%^	65.03%^
Statin Therapy for Patients With Cardiovascular Disease				
Received Statin Therapy—Total	—	83.02%+	70.68%^	82.62%+
Statin Adherence 80%—Total	—	67.42%^	75.53%+	71.14%^
Glycemic Status Assessment for Patients With Diabetes				
Glycemic Status >9.0%[,I]*	—	27.25%+	27.98%+	28.35%+
Glycemic Status <8.0%	—	66.91%+	66.67%+	64.86%+
Eye Exam for Patients With Diabetes	—	54.74%+	53.77%^	59.29%+
Blood Pressure Control for Patients With Diabetes	—	71.78%+	69.34%^	69.65%^
Pharmacotherapy for Opioid Use Disorder	—	61.18%+	36.44%+	34.64%+
Initiation and Engagement of SUD Treatment				
Initiation of SUD Treatment—Total	—	59.40%+	59.61%+	59.26%+
Engagement of SUD Treatment—Total	—	26.91%+	25.67%+	27.37%+
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	—	67.65%+	68.37%+	64.29%+
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	—	64.55%+	45.72%^	61.49%^
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—ECDS				
Initiation Phase	—	NA	43.93%^	45.46%^
Continuation and Maintenance Phase	—	NA	46.60%^	52.86%^
Antidepressant Medication Management				
Effective Acute Phase Treatment	—	72.53%+	66.58%+	60.88%^
Effective Continuation Phase Treatment	—	61.54%+	54.23%+	45.44%^

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
Appropriate Treatment for Children With Upper Respiratory Infection (URI)	—	99.68%+	86.32%^	81.90%^
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	98.14%+	64.73%+	52.98%^
Use of Imaging Studies for Low Back Pain	—	70.31%^	66.92%^	68.86%^
Cervical Cancer Screening[I]	—	30.17%^	40.15%^	57.33%^
Asthma Medication Ratio				
5–11 Years	—	NA	69.64%+	65.73%^
12–18 Years	—	NA	77.08%+	63.52%^
19–50 Years	—	NA	68.42%+	63.12%+
51–64 Years	—	NA	73.68%+	65.14%+
Total	—	NA	72.05%+	64.22%+
Appropriate Testing for Pharyngitis				
3–17 Years	—	—	86.22%^	82.73%^
18–64 Years	—	—	80.76%+	78.29%+
65 Years and Older	—	—	NA	60.61%+
Total	—	—	84.95%+	81.44%^
Topical Fluoride for Children				
1–2 Years	—	2.27%	2.57%	6.04%
3–4 Years	—	0.88%	0.74%	7.59%
Total	—	1.50%	1.62%	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—HUM 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	—	53.57%^	62.07%^	75.53%^
45–64 Years	—	57.41%^	69.09%^	83.48%+
65 Years and Older	—	88.09%+	65.03%^	77.97%^
Total	—	55.59%^	64.21%^	78.09%+

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	—	80.05%^	77.62%^	83.83%^
Postpartum Care	—	76.64%^	79.56%^	81.62%^

Table 3-4—HUM 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	—	NA	61.96%^	64.83%+
15 Months–30 Months	—	NA	66.54%^	72.42%+
Child and Adolescent Well-Care Visits				
3–11 Years	—	50.03%^	54.00%^	60.45%^
12–17 Years	—	46.88%^	48.54%^	56.11%+
18–21 Years	—	22.23%^	26.96%^	32.68%+
Total	—	44.11%^	48.03%^	54.58%^
Antibiotic Utilization for Respiratory Conditions				
3 Months–17 Years	—	—	30.11%^	34.05%+
18–64 Years	—	—	23.39%^	29.16%+
65 Years and Older	—	—	13.24%^	20.07%+
Total	—	—	28.00%+	32.26%+
Enrollment by Product Line				
Less than 1 Year	—	3,460	3,978	37,522
1–4 Years	—	13,205	12,501	141,537
5–9 Years	—	17,315	15,815	182,737
10–14 Years	—	16,022	14,764	176,938
15–17 Years	—	9,640	9,006	109,211
18–19 Years	—	5,918	5,085	60,260
20–24 Years	—	12,564	9,650	111,685
25–29 Years	—	10,160	8,492	93,717
30–34 Years	—	9,487	7,855	92,906
35–39 Years	—	7,835	7,019	82,628
40–44 Years	—	6,440	6,016	72,625
45–49 Years	—	4,579	4,644	56,774

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
50–54 Years	—	3,824	4,005	48,838
55–59 Years	—	3,629	3,917	48,549
60–64 Years	—	3,392	3,865	48,032
65–69 Years	—	692	139	1,704
70–74 Years	—	392	55	620
75–79 Years	—	277	32	306
80–84 Years	—	212	NA	200
85–89 Years	—	120	NA	86
90 Years and Older	—	105	NA	65
Unknown	—	NA	NA	NA
Total	—	129,267	116,874	1,366,940
Language Diversity of Membership				
Spoken Language Preferred for Health Care—Health Plan	—	0.00%+	0.00%^	51.08%+
Spoken Language Preferred for Health Care—CMS/State	—	98.73%+	99.71%+	47.98%+
Spoken Language Preferred for Health Care—Other Third-Party	—	1.27%+	0.29%+	0.94%+
Preferred Language for Written Materials—Health Plan	—	0.00%+	0.00%^	51.25%+
Preferred Language for Written Materials—CMS/State	—	98.73%+	99.71%+	24.75%+
Preferred Language for Written Materials—Other Third-Party	—	1.27%+	0.29%+	24.00%+
Other Language Needs—Health Plan	—	0.00%+	0.00%^	46.39%+
Other Language Needs—CMS/State	—	0.00%+	0.00%+	20.61%+
Other Language Needs—Other Third-Party	—	100.00%+	100.00%+	33.00%+
Spoken Language Preferred for Health Care—Percent English	—	96.07%+	97.05%+	97.19%+
Spoken Language Preferred for Health Care—Percent Non-English	—	2.66%^	2.66%^	1.86%^
Spoken Language Preferred for Health Care—Percent Declined	—	0.00%+	0.00%+	0.00%+
Spoken Language Preferred for Health Care—Percent Unknown	—	1.27%^	0.29%^	0.95%^
Language Preferred for Written Materials—Percent English	—	96.07%+	97.05%+	65.15%^
Language Preferred for Written Materials—Percent Non-English	—	2.66%^	2.66%^	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	—	1.27%^	0.29%^	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	—	0.00%+	0.00%^	44.31%+
Race—CMS/State	—	35.56%^	49.83%+	41.33%^
Race—Other Direct	—	0.01%+	0.00%+	1.69%+
Race—Direct Total	—	35.57%^	49.84%^	87.33%+
Race—Indirect Total	—	0.00%+	0.00%+	1.14%+
Race—Unknown Total	—	64.43%+	50.16%+	11.53%^
Ethnicity—Health Plan	—	0.00%+	0.00%^	35.42%+
Ethnicity—CMS/State	—	50.03%+	64.42%+	36.27%+
Ethnicity—Other Direct	—	0.00%+	0.00%+	9.66%+
Ethnicity—Direct Total	—	50.03%^	64.42%^	81.35%^
Ethnicity—Indirect Total	—	0.00%+	0.00%+	4.26%+
Ethnicity—Unknown Total	—	49.97%+	35.58%+	14.39%+
Race: White—Ethnicity: Hispanic or Latino	—	0.00%^	0.00%^	3.01%+
Race: White—Ethnicity: Not Hispanic or Latino	—	32.62%+	32.30%+	32.21%+
Race: White—Ethnicity: Asked but No Answer	—	0.00%+	0.00%+	0.01%+
Race: White—Ethnicity: Unknown	—	0.45%^	0.11%^	2.86%+
Race: White—Ethnicity: Total	—	33.07%^	32.41%^	38.09%^
Race: Black or African American—Ethnicity: Hispanic or Latino	—	0.00%^	0.00%^	3.34%+
Race: Black or African American—Ethnicity: Not Hispanic or Latino	—	0.01%^	15.05%+	37.02%+
Race: Black or African American—Ethnicity: Asked but No Answer	—	0.00%+	0.00%+	0.00%+
Race: Black or African American—Ethnicity: Unknown	—	0.71%+	0.18%^	3.99%+
Race: Black or African American—Ethnicity: Total	—	0.72%^	15.23%^	44.36%+

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
Race: American Indian or Alaska Native—Ethnicity: Hispanic or Latino	—	0.00%^	0.00%^	0.09%+
Race: American Indian or Alaska Native—Ethnicity: Not Hispanic or Latino	—	0.00%^	0.00%^	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	—	0.63%+	0.61%+	0.21%+
Race: American Indian or Alaska Native—Ethnicity: Total	—	0.63%+	0.61%+	0.77%+
Race: Asian—Ethnicity: Hispanic or Latino	—	0.00%^	0.00%^	0.12%+
Race: Asian—Ethnicity: Not Hispanic or Latino	—	0.00%^	0.00%^	1.53%+
Race: Asian—Ethnicity: Asked but No Answer	—	0.00%+	0.00%+	0.00%+
Race: Asian—Ethnicity: Unknown	—	1.14%+	1.56%+	0.40%+
Race: Asian—Ethnicity: Total	—	1.14%^	1.56%^	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	—	0.00%^	0.00%^	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	—	0.01%+	0.02%+	0.01%+
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Total	—	0.01%^	0.02%^	0.04%^
Race: Some Other Race—Ethnicity: Hispanic or Latino	—	0.00%^	0.00%^	0.53%+
Race: Some Other Race—Ethnicity: Not Hispanic or Latino	—	0.00%^	0.00%^	1.30%+
Race: Some Other Race—Ethnicity: Asked but No Answer	—	0.00%+	0.00%+	0.00%+
Race: Some Other Race—Ethnicity: Unknown	—	0.00%^	0.00%^	0.70%+
Race: Some Other Race—Ethnicity: Total	—	0.00%^	0.00%^	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	—	0.02%^	0.01%^	0.99%^
Race: Unknown—Ethnicity: Not Hispanic or Latino	—	0.00%^	0.00%^	3.02%+
Race: Unknown—Ethnicity: Asked but No Answer	—	17.39%+	17.05%+	1.54%+
Race: Unknown—Ethnicity: Unknown	—	47.02%+	33.10%+	5.98%+
Race: Unknown—Ethnicity: Total	—	64.43%+	50.16%+	11.53%^
Race: Total—Ethnicity: Hispanic or Latino	—	0.02%^	0.01%^	8.36%^
Race: Total—Ethnicity: Not Hispanic or Latino	—	32.63%^	47.36%^	75.70%+
Race: Total—Ethnicity: Asked but No Answer	—	17.39%+	17.05%+	1.55%+
Race: Total—Ethnicity: Unknown	—	49.97%+	35.58%+	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—HUM 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	—	133	76
< NCQA National 50th Percentile Benchmark	—	132	74
NCQA National Benchmark Unavailable	—	12	5
Total	**—**	**277**	**155**

* The "Total" row presents the count of all HEDIS measure indicators that could be reported by HUM 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 HUM, the following strengths were identified:

- HUM'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 HUM 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]**
- HUM'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 HUM was effective with facilitating appropriate post-discharge planning and care coordination. **[Quality]**
- HUM'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 HUM was effective in ensuring that adult members on antipsychotics were screened for diabetes to facilitate monitoring and promote positive health outcomes. **[Quality]**
- HUM's rates on the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total* and *Counseling for Physical Activity—Total* measure indicators were above the NCQA national 50th percentile benchmark for MY 2024. These results suggest that HUM was effective 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]**
- HUM'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 HUM effectively coordinated with providers to facilitate annual follow-ups with and screening of sexually active members. **[Quality]**
- HUM's rate on the *Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total* measure indicator was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that HUM was effective in coordinating with providers to ensure that members with clinical atherosclerotic cardiovascular disease (ASCVD) adhere to statin therapy to effectively manage their condition. **[Quality]**
- HUM's rates on the *Glycemic Status Assessment for Patients With Diabetes* measure indicators were above the NCQA national 50th percentile benchmark for MY 2024. These results suggest that HUM was effective in coordinating with providers to help members control their blood sugar levels, reducing the risk of complications. **[Quality]**
- HUM's rate on the *Pharmacotherapy for Opioid Use Disorder* measure was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that HUM effectively coordinated with providers to engage members with opioid use disorder in continuous treatment with pharmacotherapy, increasing the chance for positive outcomes. **[Quality]**

- HUM'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 HUM 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]**
- HUM'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 HUM 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]**
- HUM's rates on the *Antidepressant Medication Management* measure indicators were above the NCQA national 50th percentile benchmark for MY 2024. These results suggest that HUM was effectively 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]**
- HUM's rate on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that HUM ensured that providers effectively prevented or minimized the prescribing of antibiotics for members with a diagnosis of bronchitis or bronchiolitis. **[Quality]**
- HUM's rates on the *Asthma Medication Ratio* measure indicators were above the NCQA national 50th percentile benchmark for MY 2024. These results suggest that HUM effectively coordinated with providers to help members with persistent asthma manage this treatable condition. **[Quality]**
- HUM's rates on the *Appropriate Testing for Pharyngitis—18–64 Years* and *Total* measure indicators were above the NCQA national 50th percentile benchmark for MY 2024. These results suggest that HUM was effective in coordinating with providers to ensure that adult members diagnosed with pharyngitis receive a group A streptococcus test to aid in minimizing use of antibiotics. **[Quality]**
- HUM's rate on the *Antibiotic Utilization for Respiratory Conditions—Total* measure indicator was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that HUM was effective in coordinating with providers to ensure that members diagnosed with a respiratory condition were not inappropriately dispensed an antibiotic. **[Quality]**

For HUM, the following opportunities for improvement were identified:

- HUM'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 HUM 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]**
- HUM'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, HUM'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 HUM 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]**

- HUM's rate on the *Depression Screening and Follow-Up for Adolescents and Adults—ECDS—Depression Screening—Total* measure indicator was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that HUM has room for improvement in coordinating with providers to ensure adolescent and adult Medicaid members are properly screened for depression, enabling timely follow-up care. **[Quality]**
- HUM'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 HUM has room for improvement in ensuring that adult members on antipsychotics have their diabetes monitored to promote positive health outcomes for this population. **[Quality]**
- HUM'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 HUM has room for improvement in its coordination with providers to effectively monitor blood glucose and cholesterol in child and adolescent members on antipsychotics. **[Quality]**
- HUM's rate on the *Lead Screening in Children* measure was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that HUM has room for improvement in ensuring that children under 2 years of age were adequately receiving lead blood testing to ensure they maintained limited exposure to lead. **[Quality]**
- HUM's rate on the *Colorectal Cancer Screening—ECDS* measure was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that HUM has room for improvement in ensuring that members 45 to 75 years of age have appropriate screening for colorectal cancer. **[Quality]**
- HUM's rate on the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* measure indicator was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that HUM has room for improvement in coordinating with providers to ensure that child and adolescent members are receiving appropriate counseling to reduce the risk for obesity and prevent adverse health outcomes. **[Quality]**
- HUM's rate on the *Controlling High Blood Pressure* measure was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that HUM has room for improvement in coordinating with providers to help members manage their blood pressure, reducing their risk for heart disease and stroke. **[Quality]**
- HUM's rate on the *Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total* measure indicator was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that HUM has room for improvement in coordinating with providers to ensure that members with ASCVD receive statin therapy to manage their condition, reducing the risk of adverse outcomes. **[Quality]**
- HUM's rate on the *Eye Exam for Patients With Diabetes* measure was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that HUM has room for improvement

in coordinating with providers to ensure that adult members with diabetes receive a retinal eye exam to screen for diabetic retinal disease. **[Quality]**

- HUM'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 HUM has room for improvement in coordinating with providers to help adult members with diabetes adequately control their blood pressure. **[Quality]**
- HUM'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 HUM 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]**
- HUM's rates on the *Follow-Up Care for Children Prescribed ADHD Medication—ECDS* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest that HUM has room for improvement in coordinating with providers to initiate and maintain appropriate follow-up visits for children prescribed ADHD medication. **[Quality, Timeliness, and Access]**
- HUM'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 HUM has room for improvement in coordinating with providers to ensure that a diagnosis of URI does not result in an antibiotic dispensing event for members. **[Quality]**
- HUM'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 HUM has room for improvement in ensuring that providers properly order imaging studies. **[Quality]**
- HUM's rate on the *Cervical Cancer Screening* measure was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that HUM has room for improvement in coordinating with providers to ensure that women ages 21 to 64 years receive appropriate, early detection cancer screening. **[Quality]**
- HUM's rate on the *Appropriate Testing for Pharyngitis—3–17 Years* measure indicator was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that HUM has room for improvement in coordinating with providers to ensure that child and adolescent members diagnosed with pharyngitis receive a group A streptococcus test to aid in minimizing use of antibiotics. **[Quality]**
- HUM'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 HUM 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]**
- HUM'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 HUM 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 American Academy of

Pediatrics and the American College of Obstetricians and Gynecologists. **[Quality, Timeliness, and Access]**

- HUM's rates on the *Well-Child Visits in the First 30 Months of Life* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest that HUM has room for improvement in coordinating with PCPs to ensure that children are seen within the first 30 months of life to assess and influence members' early development. **[Quality and Access]**
- HUM'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 HUM 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]**
- HUM's rates on the *Antibiotic Utilization for Respiratory Conditions—3 Months–17 Years*, *18–64 Years*, and *65 Years and Older* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest that HUM has room for improvement in coordinating with providers to ensure that members diagnosed with a respiratory condition are not inappropriately dispensed an antibiotic. **[Quality]**

For HUM, 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 HUM 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 HUM. HUM 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—Depression Screening—Total* measure indicator, HSAG recommends that HUM engage with providers to encourage depression screening for adolescents and adults. HUM 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 to increase depression screenings. **[Quality]**
- To improve performance on the *Diabetes Monitoring for People With Diabetes and Schizophrenia* measure, HSAG recommends that HUM work with providers to identify and address barriers to diabetes monitoring for adult members on antipsychotics. HUM 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 to improve diabetes monitoring for this population. **[Quality]**
- To improve performance on the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—ECDS* measure indicators, HSAG recommends that HUM 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 *Lead Screening in Children* measure, HSAG recommends that HUM engage with providers to encourage lead blood testing for child members. HUM 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 to increase lead screening in children. **[Quality]**
- To improve performance on the *Colorectal Cancer Screening—ECDS* measure, HSAG recommends that HUM work with providers to identify and address barriers to colorectal cancer screening for members ages 45 to 75 years old. HUM 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—Counseling for Nutrition—Total* measure indicator, HSAG recommends that HUM 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. HUM 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 HUM work with providers to identify and address barriers to effective blood pressure management in members. HUM 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, HUM 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 *Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total* measure indicator, HSAG recommends that HUM work with providers to identify and address barriers to receiving stating therapy among members with ASCVD. HUM 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 member education on the importance of statin therapy. **[Quality]**
- To improve performance on the *Eye Exam for Patients With Diabetes* measure, HSAG recommends that HUM work with providers to identify root causes and trial interventions to encourage members with diabetes to get screened for diabetic retinal disease. HUM could also consider expanding on existing strategies that focus on disease and chronic condition management, and evaluating and expanding current and/or new member outreach and engagement initiatives. **[Quality]**
- To improve performance on the *Blood Pressure Control for Patients With Diabetes* measure, HSAG recommends that HUM work with providers to identify and address barriers to effective blood

pressure management for diabetic members. HSAG also recommends that HUM 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. HUM 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 *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measure, HSAG recommends that HUM 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. HUM 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 *Follow-Up Care for Children Prescribed ADHD Medication—ECDS* measure indicators, HSAG recommends that HUM work with providers to identify and address barriers to initial follow-up visits with children prescribed ADHD medication. HUM 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, Timeliness, and Access]**
- To improve performance on the *Appropriate Treatment for Children With URI* measure, HSAG recommends that HUM work with providers to trial solutions to reduce antibiotic dispensing to treat URI. HUM 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 HUM focus its efforts on decreasing unnecessary imaging for low back pain. HSAG also recommends that HUM 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 HUM work with providers to identify and address barriers to cervical cancer screening for women ages 21 to 64 years old. HUM 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 *Appropriate Testing for Pharyngitis—3–17 Years* measure indicator, HSAG recommends that HUM work with providers to trial solutions to ensure that child and adolescent members diagnosed with pharyngitis are administered a group A streptococcus test to prevent the inappropriate prescribing of antibiotics. HUM 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 *Adults' Access to Preventive/Ambulatory Health Services* measure indicators, HSAG recommends that HUM work with PCPs to identify and address barriers to preventive or ambulatory visits for adult members. HUM 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 HUM work with providers to identify and address barriers to timely and adequate prenatal and postpartum care. HSAG recommends that HUM 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 *Well-Child Visits in the First 30 Months of Life* measure indicators, HSAG recommends that HUM work with providers to identify and address barriers to well-child visits for members within the first 30 months of life. HUM could also consider data analysis and stratification across key demographics (i.e., race, ethnicity, 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-child visits. **[Quality and Access]**
- To improve performance on the *Child and Adolescent Well-Care Visits* measure indicators, HSAG recommends that HUM work with providers to identify and address barriers to well-care visits for child and adolescent members. HUM 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]**
- To improve performance on the *Antibiotic Utilization for Respiratory Conditions—3 Months–17 Years*, *18–64 Years*, and *65 Years and Older* measure indicators, HSAG recommends that HUM work with providers to identify and address circumstances resulting in the inappropriate dispensing of an antibiotic to treat members diagnosed with a respiratory condition. HUM 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]**

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 16, 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 HUM. 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	3	6	3	33%
II	Member Rights and Confidentiality	24	24	24	0	0	100%
III	Member Information	19	18	13	5	1	72%
IV	Emergency and Poststabilization Services	13	13	13	0	0	100%
V	Adequate Capacity and Availability of Services	15	14	6	8	1	43%
VI	Coordination and Continuity of Care	12	12	10	2	0	83%
VII	Coverage and Authorization of Services	23	21	20	1	2	95%
VIII	Provider Selection	19	19	13	6	0	68%
IX	Subcontractual Relationships and Delegation	6	6	4	2	0	67%
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	31	6	1	84%
XIV	Program Integrity	18	18	18	0	0	100%
Total Compliance Score		**227**	**217**	**181**	**36**	**10**	**83%**

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 HUM, the following strengths were identified:

- HUM achieved a 100 percent compliance score for Standard II—Member Rights and Confidentiality, demonstrating appropriate member rights protections, privacy practices, and confidentiality controls consistent with regulatory and contractual requirements. **[Quality and Access]**
- HUM 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]**
- HUM 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 and Access]**
- HUM 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]**
- HUM 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 LDH. **[Quality]**
- HUM 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 HUM, the following opportunities for improvement were identified:

- HUM's compliance review demonstrated low compliance with Standard I—Enrollment and Disenrollment Requirements and Limitations (33 percent). **[Quality and Access]**
- HUM did not have a written process that ensures all required information is provided to members and potential members in a manner and format that may be easily understood and is readily accessible. **[Quality]**
- HUM's member handbook did not utilize definitions that aligned with State definitions, the time frame for filing a grievance, instructions in Spanish on how a member can access auxiliary aids and services, and information regarding SBHS. **[Quality]**
- HUM's electronic directory did not include the provider's website uniform resource locator (URL). **[Quality]**

- HUM'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 HUM provides it upon request within five business days. **[Quality]**
- HUM did not monitor its provider network to ensure adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical or mental disabilities. **[Quality and Access]**
- HUM did not demonstrate that it provides female members with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive healthcare services. **[Quality and Access]**
- HUM did not monitor that its network includes sufficient family planning providers to ensure timely access to covered services. **[Quality and Access]**
- HUM 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]**
- HUM 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]**
- HUM did not monitor that its network providers make the services included in the contract available 24 hours a day, seven days a week, when medically necessary. **[Quality, Timeliness, and Access]**
- HUM 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]**
- HUM did not ensure it offers an appropriate range of preventive, primary care, specialty services, and long-term services and supports (LTSS) that is adequate for the anticipated number of members for the service area as well as 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. **[Quality]**
- HUM's file review demonstrated noncompliance with timely completion of the initial health needs assessment. **[Quality and Timeliness]**
- HUM did not 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]**
- HUM did not ensure its notices of adverse benefit determination (ABD) meet state-required reading levels. **[Quality]**
- HUM did not have a policy that indicated discrimination is not occurring in the credentialing and recredentialing processes. **[Quality]**
- HUM did not verify a history of professional liability claims that resulted in settlement or judgment paid on behalf of the practitioner within 180 calendar days of the credentialing decision. **[Quality]**
- HUM's credentialing and recredentialing process did not ensure primary source verification of the Louisiana Adverse Actions List. **[Quality]**

- HUM did not have procedures and policies that include language regarding the ongoing monitoring of practitioner complaints and quality issues between recredentialing cycles and how it takes appropriate action against practitioners when it identifies occurrences of poor quality. **[Quality]**
- HUM did not verify and confirm that every provider is in good standing with State and federal regulatory bodies and confirm that the provider has been reviewed and approved by an accrediting body. **[Quality]**
- HUM did not ensure that all its contracts or written arrangements indicate that the delegate agrees 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]**
- HUM did not ensure that all contracts or written arrangements comport with the required federal and State language of this requirement, which is exacting. **[Quality]**
- HUM its policies and procedures to include the requirement that with the written consent of the member, a provider or an authorized representative may request a State fair hearing (SFH) on behalf of the member. **[Quality]**
- HUM's policy did not include the requirement for appeals of the time period or service limits of a previously authorized service have been met. **[Quality]**
- HUM's policy did not include requirements related to authorizing or providing disputed services promptly after an authorization decision is reversed. **[Quality]**
- HUM's policy did not include the requirements that the grievance and appeal records are accurately maintained in a manner accessible to the State and available upon request to CMS, and contain all federal requirements. **[Quality]**

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

- HUM must consult its compliance review results and develop its corrective actions related to Standard I—Enrollment and Disenrollment Requirements and Limitations. **[Quality and Access]**
- HUM must implement a written process that ensures all required information is provided to members and potential members in a manner and format that may be easily understood and is readily accessible. **[Quality]**
- HUM's member handbook must utilize definitions that align with State definitions, the time frame for filing a grievance, instructions on how a member can access auxiliary aids and services, and information regarding SBHS. **[Quality]**
- HUM's electronic directory must include the provider's website URL. **[Quality]**
- HUM 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]**
- HUM 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 limited English proficiency or physical or mental disabilities. **[Quality and Access]**

- HUM must demonstrate, through policy, that it provides female members with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive healthcare services. **[Quality and Access]**
- HUM 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]**
- HUM 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]**
- HUM 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]**
- HUM must monitor, through its data analysis, that its network providers make the services included in the contract available 24 hours a day, seven days a week, when medically necessary. **[Quality, Timeliness, and Access]**
- HUM must ensure its network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities. **[Quality and Access]**
- HUM must ensure it offers an appropriate range of preventive, primary care, specialty services, and LTSS that is adequate for the anticipated number of members for the service area as well as 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. **[Quality]**
- HUM 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]**
- HUM 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]**
- HUM must ensure its notices of ABD meet state-required reading levels. **[Quality]**
- HUM must develop a policy that the MCE may not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification by developing a policy. **[Quality]**
- HUM must verify a history of professional liability claims (from the malpractice carrier or the National Practitioner Databank [NPDB]) that resulted in settlement or judgment paid on behalf of the practitioner within 180 calendar days of the credentialing decision. **[Quality]**
- For credentialing and recredentialing, HUM must verify the State sanctions, restrictions on licensure, and limitations of scope of practice within 180 days of the credentialing decision. Additionally, HUM must verify in all states where the practitioner provides and/or provided care to members within the most recent five-year period available. **[Quality]**

- HUM must have procedures and policies that include language regarding the ongoing monitoring of practitioner complaints and quality issues between recredentialing cycles and how it takes appropriate action against practitioners when it identifies occurrences of poor quality. **[Quality]**
- HUM must verify and confirm that every provider is in good standing with State and federal regulatory bodies and confirm that the provider has been reviewed and approved by an accrediting body. Should the provider not be accredited, HUM must conduct an on-site quality assessment **[Quality]**
- HUM must ensure that all its contracts or written arrangements indicate that the delegate agrees 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]**
- HUM must ensure that all contracts or written arrangements indicate comport with the required federal and State language of this requirement, which is exacting. **[Quality]**
- HUM must ensure that with the written consent of the member, a provider or an authorized representative may request an SFH on behalf of the member. **[Quality]**
- HUM must ensure that its policies include requirements related to recovering the cost of services furnished to the member while the appeal and SFH were pending if the final resolution of the appeal or SFH is adverse to the member. **[Quality]**
- HUM must ensure that its policy includes the requirement for appeals of the time period or service limits of a previously authorized service have been met. **[Quality]**
- HUM's policy must include the requirement that if HUM or the SFH officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, HUM authorizes or provides the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. **[Quality]**
- HUM's policy must include the requirement that the grievance and appeal records are accurately maintained in a manner accessible to the State and available upon request to CMS, and contain all federal requirements. **[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 16, 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 HUM providers by specialty provider type.

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

Table 5-1—Response Rate and Indicator Match Rates for HUM 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%	41	91.1%	43	95.6%	42	93.3%	20	44.4%	20	44.4%	15	33.3%
Pediatrics	41	82.0%	35	85.4%	28	68.3%	24	58.5%	27	65.9%	27	65.9%	11	26.8%
OB/GYNs	46	92.0%	39	84.8%	37	80.4%	36	78.3%	29	63.0%	29	63.0%	21	45.7%
Specialists (any)	45	90.0%	37	82.2%	35	77.8%	33	73.3%	28	62.2%	28	62.2%	16	35.6%
Behavioral Health (any)	43	86.0%	33	76.7%	29	67.4%	25	58.1%	20	46.5%	21	48.8%	13	30.2%
Total	**220**	**88.0%**	**185**	**84.1%**	**172**	**78.2%**	**160**	**72.7%**	**124**	**56.4%**	**125**	**56.8%**	**76**	**34.5%**

[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 HUM'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	15	30.7%
Pediatrics	50	21	50.0%
OB/GYNs	50	23	50.7%
Specialists (any)	50	20	45.3%
Behavioral Health (any)	50	11	28.7%
Total	**250**	**90**	**41.1%**

[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 HUM by specialty provider type.

Table 5-3—Response Rate and Indicator Match Rates for HUM 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	13	86.7%	11	84.6%	10	76.9%	6	46.2%	5	38.5%	5	38.5%	3	23.1%
Dermatologists	17	85.0%	16	94.1%	13	76.5%	5	29.4%	5	29.4%	5	29.4%	4	23.5%
Orthopedic Surgeons	27	84.4%	26	96.3%	19	70.4%	14	51.9%	14	51.9%	14	51.9%	14	51.9%
Total	**57**	**85.1%**	**53**	**93.0%**	**42**	**73.7%**	**25**	**43.9%**	**24**	**42.1%**	**24**	**42.1%**	**21**	**36.8%**

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

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

Appointment Type	Wait Time (in Days)	Percentage of Appointments Meeting Compliance Standard
Allergists	17	66.7%
Dermatologists	84	66.7%
Orthopedic Surgeons	5	100%

Table 5-5 presents HUM'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	15	3	28.9%
Dermatologists	20	4	31.7%
Orthopedic Surgeons	32	14	59.4%
Total	**67**	**21**	**44.3%**

[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 HUM by network adequacy standard type.

Table 5-6—Summary of HUM 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 HUM. Of these indicators, 100 percent received *High Confidence* ratings.

Access Standards

Table 5-7 contains the percentage of members HUM 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—HUM 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	98.7%
	Rural	100% ↑
Pediatrics (Family/General Practice; Internal Medicine)	Urban	99.0%
	Rural	100% ↑
Federally Qualified Health Centers (FQHCs)	Urban	90.4%
	Rural	97.3%
Rural Health Clinics (RHCs)	Urban	19.6%
	Rural	99.9%
Acute Inpatient Hospitals	Urban	86.6%
	Rural	98.6%
Laboratory	Urban	96.2%
	Rural	86.8%

[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: Dec 17, 2025.

Provider Type	Urbanicity	Percentage of Members With Access
Radiology	Urban	98.9%
	Rural	98.5%
Pharmacy	Urban	18.9%
	Rural	50.8%
Hemodialysis Centers	Urban	99.0%
	Rural	99.0%
OB/GYNs (access only for adult female members ages 21 and over)	Urban	95.5%
	Rural	95.0%
Allergy/Immunology	Urban	99.9%
	Rural	97.0%
Cardiology	Urban	99.9%
	Rural	100% ↑
Dermatology	Urban	99.9%
	Rural	98.8%
Endocrinology and Metabolism (Adult)	Urban	98.8%
	Rural	99.9%
Endocrinology and Metabolism (Pediatric)	Urban	98.9%
	Rural	99.9%
Gastroenterology	Urban	99.9%
	Rural	100% ↑
Hematology/Oncology	Urban	99.9%
	Rural	99.7%
Nephrology	Urban	99.9%
	Rural	99.9%
Neurology (Adult)	Urban	99.9%
	Rural	99.9%
Neurology (Pediatric)	Urban	99.9%
	Rural	99.9%
Ophthalmology	Urban	99.9%
	Rural	100% ↑
Orthopedics (Adult)	Urban	99.9%
	Rural	100% ↑
Orthopedics (Pediatric)	Urban	99.9%
	Rural	100% ↑
Otorhinolaryngology/Otolaryngology	Urban	99.9%
	Rural	100% ↑
Urology	Urban	99.9%
	Rural	99.7%

Provider Type	Urbanicity	Percentage of Members With Access
Psychiatrists	Urban	94.5%
	Rural	91.8%
Physicians and LMHPs who specialize in pregnancy-related and postpartum depression or related mental health disorders	Urban	99.9%
	Rural	100% ↑
Physicians and LMHPs who specialize in pregnancy-related and postpartum SUD	Urban	99.9%
	Rural	100% ↑
Behavioral Health Specialist (Advanced Practice Registered Nurse—Behavioral Health [APRN-BH] specialty, Licensed Psychologist or Licensed Clinical Social Worker [LCSW])	Urban	98.6%
	Rural	99.6%
PRTFs (Level 3.7 WM) and Other Specialization (Pediatric Under Age 21)	All	100% ↑
American Society of Addiction Medicine (ASAM) Level 1	Urban	88.5%
	Rural	45.1%
ASAM Level 2.1	Urban	89.0%
	Rural	45.1%
ASAM Level 2 WM	Urban	77.3%
	Rural	3.2%
ASAM Level 3.1 (Adult over age 21)	Urban	86.3%
	Rural	3.7%
ASAM Level 3.1 (Pediatric under age 21)	All	94.7%
ASAM Level 3.2 WM (Adult over age 21)	Urban	79.2%
	Rural	41.0%
ASAM Level 3.2 WM (Pediatric under age 21)	All	82.8%
ASAM Level 3.3 (Adult over age 21)	Urban	82.9%
	Rural	8.4%
ASAM Level 3.5 (Adult over age 21)	Urban	93.7%
	Rural	73.5%
ASAM Level 3.5 (Pediatric under age 21)	All	95.7%
ASAM Level 3.7 (Adult over age 21)	Urban	95.7%
	Rural	72.9%
ASAM Level 3.7 WM (Adult over age 21)	Urban	99.9%
	Rural	80.1%
Inpatient Psychiatric Hospital (Free Standing Psychiatric Hospital; Distinct Part Psychiatric Unit)	Urban	99.7%
	Rural	86.1%

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	99.1%
	Rural	99.9%

Provider-to-Member Ratios

HSAG assessed HUM'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 HUM'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—HUM 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)	8.63%	Yes
Combined Pediatrics (1:1,000 child members)	6.01%	Yes

HSAG assessed HUM's results for statewide provider-to-member ratios by specialty provider type and determined that HUM'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—HUM Statewide Provider-to-Member Ratios by Specialty Provider Type

Specialty Provider Type	Indicator	Statewide Ratio	Compliant
OB/GYNs	1:10,000	0.52%	Yes
Allergy/Immunology	1:100,000	0.06%	Yes
Cardiology	1:20,000	0.39%	Yes
Dermatology	1:40,000	0.11%	Yes
Endocrinology and Metabolism	1:25,000	0.09%	Yes
Gastroenterology	1:30,000	0.21%	Yes
Hematology/Oncology	1:80,000	0.27%	Yes
Nephrology	1:50,000	0.19%	Yes
Neurology	1:35,000	0.27%	Yes
Ophthalmology	1:20,000	0.22%	Yes

Specialty Provider Type	Indicator	Statewide Ratio	Compliant
Orthopedics	1:15,000	0.26%	Yes
Otorhinolaryngology/Otolaryngology	1:30,000	0.18%	Yes
Urology	1:30,000	0.15%	Yes

HSAG assessed HUM's results for behavioral health providers to determine the accessibility and availability of appointments and determined that HUM 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—HUM 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%	96.97%
Urgent Non-Emergency Behavioral Health Care	48 hours (2 calendar days)	90%	77.78%
Non-Urgent Routine Behavioral Health Care	14 calendar days	70%	61.11%

MCO Strengths, Opportunities for Improvement, and Recommendations

For HUM, the following strengths were identified:

- Overall, 93.0 percent of respondents in the provider access survey confirmed the sampled address was correct. **[Quality and Access]**
- No strengths were identified in the PDV, as all indicators had match rates below 90 percent.
- HUM actively worked to recruit providers including using mobile health clinics and providers who agreed to provide care within members' homes. Additionally, HUM provided quality incentives to healthcare providers and developed a maternity shared savings program, which rewarded providers for meeting metrics for prenatal and postpartum care. **[Quality and Access]**

For HUM, the following opportunities for improvement were identified:

- Acceptance of HUM was inaccurate with 56.4 percent of providers in the PDV and 43.9 percent of locations in the provider access survey accepting HUM. Additionally, 56.8 percent of providers in the PDV and 42.1 percent of locations in the provider access survey accepted Louisiana Medicaid. **[Quality and Access]**
- Overall, only 72.7 percent of providers in the PDV and 73.7 percent of locations in the provider access survey confirmed the specialty was accurate. **[Quality and Access]**

- Overall, acceptance of new patients was relatively low with 68.2 percent of providers in the PDV and 42.1 percent of locations in the provider access survey accepting new patients. **[Quality and Access]**
- Provider affiliation varied by survey type with 78.2 percent of PDV locations and 36.8 percent of provider access survey locations confirming the sampled provider was at the location. **[Quality and Access]**
- Of the limited number of cases that offered an appointment, 66.7 percent of allergist cases and 66.7 percent of dermatologist cases were within the wait time compliance standards. **[Timeliness and Access]**
- Compliance scores varied by survey type with overall compliance scores of 41.1 percent for the PDV and 44.3 percent for the provider access survey. **[Quality and Access]**
- Compliance scores also varied by provider type with behavioral health having the lowest compliance score at 28.7 percent and OB/GYNs having the highest compliance score at 50.7 percent for the PDV. For the provider access survey, allergists exhibited the lowest compliance score at 28.9 percent, and orthopedic surgeons exhibited the highest compliance score at 59.4 percent. **[Quality and Access]**
- HUM had several issues that required corrections for reporting, including that HUM initially calculated network adequacy based upon member ZIP Codes as opposed to using member addresses as required by LDH; HUM did not separate reporting for adult and pediatric populations for the provider types of metabolism/endocrinology, neurology, and orthopedics as defined in the contractual standards; and HUM used an incorrect distance standard for ASAM Level 2 WM. **[Quality]**

For HUM, the following recommendations were identified:

- LDH should provide HUM with the case-level PDV and provider access survey data files (i.e., flat files) and a defined timeline by which HUM will address provider data deficiencies identified during the PDV reviews and/or provider access survey. **[Quality and Access]**
- In addition to updating provider information, HUM 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]**
- HUM 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]**
- HUM 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 HUM to confirm office outreach and confirmation of provider information. **[Quality and Access]**
- HUM should strengthen its compliance review process when producing required network adequacy reporting and collaborate with LDH to ensure alignment with 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, primary source verification (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 HUM completed the LDH-approved questionnaire supplied by HSAG through the Universal Survey Tool (UST). HSAG identified follow-up questions based on HUM's original questionnaire responses, and HUM responded to these specific questions. To support its questionnaire responses, HUM submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from HUM 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 HUM.

Table 6-1—EDV Results for HUM

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• HUM 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. • HUM reported methods to identify duplicate claims. • HUM and its subcontractors were responsible for the collection and maintenance of the provider information. In addition, HUM and its subcontractors integrated the Medicaid member enrollment files into their systems for claim processing.
Payment Structures	• HUM reported a wide range of pricing methodologies that varied by encounter type and subcontractors. • HUM 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	• HUM stated that it had subcontractors for dental, NEMT, pharmacy, and vision encounters. For the NEMT and vision encounters collected by these subcontractors, HUM 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. Conversely, HUM did not store its dental subcontractor data nor review its dental subcontractor data either before or after submission. • For encounters collected by subcontractors, HUM and/or its subcontractors noted that they performed completeness and accuracy checks on dental, NEMT, and vision encounters along with reconciliation with financial reports checks on NEMT and vision encounters. However, HUM and/or its subcontractors did not note claim volume or timeliness checks on dental, NEMT, pharmacy, or vision encounters. • For encounters collected by HUM, HUM noted that it performed claim volume, completeness and accuracy, timeliness, and reconciliation with financial reports checks. • Based on HUM's responses to the questionnaire, the percentage of encounters that were initially rejected and not yet accepted by LDH varied from 0.8 percent (pharmacy encounters) to 8.9 percent (vision encounters).
Administrative Profile	
Encounter Data Completeness	• HUM displayed consistent encounter volume per 1,000 MM, payment amount PMPM, and TPL payment amount PMPM for professional, institutional, and dental encounters throughout the measurement year. For pharmacy encounters, the above metrics increased toward the end of the measurement year because pharmacy services were carved out until October 28, 2023. During the carve-out period, pharmacy claims for linked members were referred to fee-for-service. • HUM had a rate of duplicate encounters of less than 1.0 percent for the professional, institutional, and pharmacy encounter types. Dental encounters had a rate of duplicate encounters of 1.9 percent.
Encounter Data Timeliness	• Within 60 days, HUM submitted 47.0 percent of professional, 15.1 percent of institutional, 11.1 percent of dental, and 90.8 percent of pharmacy encounters to LDH after the payment date.
Field-Level Completeness and Accuracy	• All key data elements in HUM's encounter data had a relatively high or reasonable rate of population (i.e., percent present) except the Oral Cavity Code field for HUM's dental encounters. • HUM 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

Analysis	Key Findings
	encounter types. Refer to the opportunities for improvement section below for the list of data elements needing HUM's attention.
Encounter Referential Integrity	• No major concerns were noted for HUM 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 HUM's submitted medical/dental and pharmacy encounters, only 90.0 percent and 78.3 percent were identified in the provider data, respectively.
Encounter Data Logic	• HUM had 17.3 percent of members with both medical/dental and pharmacy encounters throughout the measurement year. • HUM had 50.1 percent of members who were continuously enrolled in the measurement year.

MCO Strengths, Opportunities for Improvement, and Recommendations

For HUM, the following strengths were identified:

- For the encounters collected by HUM, it noted that it performed claim volume, completeness and accuracy, timeliness, and reconciliation with financial reports checks on encounters. **[Quality and Timeliness]**
- HUM reported less than 1.0 percent of pharmacy encounters as initially rejected and not yet accepted. **[Quality]**
- HUM had low duplicate rates for professional encounters (0.6 percent), institutional encounters (0.6 percent), and pharmacy encounters (<0.1 percent). **[Quality]**
- For institutional encounters, HUM had all key data elements populated with at least 95.0 percent of valid values. **[Quality]**

For HUM, the following opportunities for improvement were identified:

- **Quality Checks for Subcontractor Data**:
  - Dental: HUM noted that it did not store its dental subcontractor data or review them before or after the data were submitted to LDH. In addition, neither HUM nor its dental subcontractor performed claim volume, timeliness, or reconciliation with final reports checks on the dental encounters. **[Quality and Timeliness]**
  - NEMT and Vision: For the encounters collected by its NEMT and vision subcontractors, HUM 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. However, neither HUM nor its NEMT and vision subcontractors performed claim volume or timeliness checks on the NEMT or vision encounters. **[Quality and Timeliness]**

  - Pharmacy: HUM noted that neither HUM nor its pharmacy subcontractor performed claim volume, completeness and accuracy, timeliness, or reconciliation with financial reports checks. **[Quality and Timeliness]**
- Among the five MCOs with a vision subcontractor, HUM had the highest percentage of vision encounters initially rejected and not yet accepted by LDH, at 8.9 percent. Additionally, among the six MCOs with an NEMT subcontractor, HUM had the highest percentage of encounters initially rejected and not yet accepted by LDH at 7.3 percent. **[Quality]**
- HUM submitted only 47.0 percent of professional encounters, 15.1 percent of institutional encounters, and 11.1 percent of dental encounters to LDH within 60 days from the payment date. **[Timeliness]**
- The LDH-submitted data did not contain any values for the Oral Cavity Code field for HUM's dental encounters. **[Quality]**
- HUM had the following data elements with less than 95.0 percent of valid values: **[Quality]**
  - Professional Encounters: *National Drug Codes (NDCs)* (93.8 percent)
  - Dental: *Rendering Provider NPI* (94.0 percent)
  - Pharmacy: *Billing Provider NPI* (37.4 percent) and *Prescribing Provider NPI* (88.6 percent)
- For referential integrity, HUM had a low percentage of providers in the pharmacy encounter file who were also in the provider data at approximately 78.3 percent. **[Quality]**

For HUM, the following recommendations were identified:

- HUM and/its subcontractors should develop a comprehensive suite of encounter data quality monitoring reports to assess the accuracy, completeness, and timeliness of encounter data received from its four subcontractors. **[Quality and Timeliness]**
- HUM should build a process with LDH and its vision and NEMT subcontractors to ensure that rejected vision and NEMT encounters will be submitted to LDH with correct information. **[Quality]**
- HUM should monitor its encounter data submission to LDH to ensure professional, institutional, and pharmacy encounters are submitted to LDH in a timely manner after payment. **[Timeliness]**
- For dental encounters, HUM should work with LDH to decide whether HUM should submit values (if any) for the Oral Cavity Code field to LDH. **[Quality]**
- HUM 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]**
- HUM should work with LDH to ensure both entities have an accurate and complete database of contracted providers for pharmacy encounters. **[Quality]**

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 17, 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, NEMT 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 17, 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 HUM's 2023, 2024, and 2025 adult achievement scores.

Table 7-1—Adult Achievement Scores

Measure	2023	2024	2025
Rating of Health Plan	—	73.50%	82.39%
Rating of All Health Care	—	NA	81.00%
Rating of Personal Doctor	—	NA	89.60%
Rating of Specialist Seen Most Often	—	NA	NA
Getting Needed Care	—	NA	NA
Getting Care Quickly	—	NA	NA
How Well Doctors Communicate	—	NA	NA
Customer Service	—	NA	NA

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

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

Table 7-2—General Child Achievement Scores

Measure	2023	2024	2025
Rating of Health Plan	—	NA	92.13% ▲ ↑
Rating of All Health Care	—	NA	NA
Rating of Personal Doctor	—	NA	91.51%
Rating of Specialist Seen Most Often	—	NA	NA
Getting Needed Care	—	NA	NA
Getting Care Quickly	—	NA	NA
How Well Doctors Communicate	—	NA	NA
Customer Service	—	NA	NA

A minimum of 100 respondents is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of respondents are denoted as NA (Not Applicable).
↑ *Indicates the 2025 score is statistically significantly higher than the 2025 NCQA national average.*
▲ *Indicates the 2025 score is statistically significantly higher than the 2024 score.*
— indicates that data are not available.

MCO Strengths, Opportunities for Improvement, and Recommendations

For HUM, the following strengths were identified:

- For the adult population, HUM'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, HUM's 2025 achievement score was statistically significantly higher than the 2025 NCQA child national average for one measure, *Rating of Health Plan*. **[Quality]**
- For the general child population, HUM's 2025 achievement score was statistically significantly higher than the 2024 achievement score for one measure, *Rating of Health Plan*. **[Quality]**

For HUM, the following opportunity for improvement was identified:

- For the adult and general child populations, HUM'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 HUM, the following recommendation was identified:

- HSAG recommends that HUM continue to focus on increasing response rates to the CAHPS survey for the adult and general child populations so there are greater than 100 respondents for each measure. **[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 HUM and the Healthy Louisiana SWA.

Table 8-1—Adult Achievement Scores for HUM

Measure	2023	2024	2025	Healthy Louisiana SWA
Rating of Health Plan	NA	53.13%+	62.12%+	57.88%
How Well People Communicate	NA	95.36%+	90.30%+	91.16%
Cultural Competency	NA	50.00%+	81.82%+	86.01%+
Helped by Counseling or Treatment	NA	59.38%+	70.15%+	70.38%
Treatment or Counseling Convenience	NA	81.82%+	86.57%+	88.13%
Getting Needed Treatment	NA	70.97%+	78.79%+	81.75%
Help Finding Counseling or Treatment	NA	50.00%+	66.67%+	50.82%
Customer Service	NA	66.67%+	80.00%+	70.81%
Helped by Crisis Response Services	NA	58.33%+	75.00%+	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.
NA indicates that data are not available.

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

Table 8-2—Child Achievement Scores for HUM

Measure	2023	2024	2025	Healthy Louisiana SWA
Rating of Health Plan	NA	66.67%+	65.91%+	63.63%
How Well People Communicate	NA	95.37%+	90.13%+	91.03%
Cultural Competency	NA	—	100.00%+	92.57%+
Helped by Counseling or Treatment	NA	66.67%+	65.91%+	61.01%
Treatment or Counseling Convenience	NA	88.89%+	86.36%+	88.86%
Getting Needed Treatment	NA	88.89%+	81.82%+	78.93%
Help Finding Counseling or Treatment	NA	—	0.00%+	38.57%+
Customer Service	NA	75.00%+	83.33%+	71.71%+
Getting Professional Help	NA	77.78%+	81.40%+	87.75%
Help to Manage Condition	NA	88.89%+	79.55%+	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 MCO's score was not reported due to insufficient data.
NA indicates that data are not available.

MCO Strengths, Opportunities for Improvement, and Recommendations

For HUM, the following strength was identified:

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

For HUM, the following opportunity for improvement was identified:

- For the adult and child populations, HUM'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, Timeliness, and Access]**

For HUM, the following recommendation was identified:

- HSAG recommends that HUM continue to focus on increasing response rates to the Behavioral Health Member Satisfaction Survey for adult and child populations so there are greater than 100 respondents for each measure. **[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 HUM, the following strength was identified:

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

For HUM, the following opportunity for improvement was identified:

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

For HUM, the following recommendation was identified:

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

10. Quality Rating System

Results

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

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

Composites and Subcomposites	Star Rating
Overall Rating*	**3.5**
Patient Experience	**4.0**
Getting Care	Insufficient Data
Satisfaction with Plan Physicians	4.0
Satisfaction with Plan and Plan Services	4.0
Prevention and Equity	**3.0**
Children and Adolescent Well-Care	4.0
Women's Reproductive Health	2.5
Cancer Screening	1.0
Equity	5.0
Other Preventive Services	4.0
Treatment	**3.0**
Respiratory	3.5
Diabetes	4.0
Heart Disease	3.0
Behavioral Health—Care Coordination	2.5
Behavioral Health—Medication Adherence	3.5
Behavioral Health—Access, Monitoring, and Safety	3.0
Reduce Low Value Care	2.0

*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.
Insufficient Data indicates that the plan was missing most data for the composite or subcomposite. 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.

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

MCO Strengths, Opportunities for Improvement, and Recommendations

For HUM, the following strengths were identified:

- For the Patient Experience composite, HUM earned 4.0 stars for the Satisfaction with Plan Physicians and Satisfaction with Plan and Plan Services subcomposites. Both subcomposites are based on HUM member responses to CAHPS survey questions, demonstrating HUM members are satisfied with their providers and their health plan and the services it provides. **[Quality]**
- For the Prevention and Equity composite, HUM earned 5.0 stars for the Equity subcomposite, demonstrating strength for HUM related to collecting language preferences and race/ethnicity information from their members. HUM also earned 4.0 stars for the Children and Adolescent Well-Care and Other Preventive Services subcomposites, demonstrating strength for HUM related to documenting BMI percentiles in children and providing chlamydia screenings for young women. **[Quality and Access]**
- For the Treatment composite, HUM earned 4.0 stars for the Diabetes subcomposite, demonstrating strength for HUM related to diabetic care. **[Quality]**

For HUM, the following opportunities for improvement were identified:

- For the Prevention and Equity composite, HUM earned 2.5 stars and 1.0 star for the Women's Reproductive Health and Cancer Screening subcomposites, respectively, demonstrating opportunities for improvement for HUM related to women receiving timely prenatal and postpartum care and providing cervical and colorectal cancer screenings. **[Quality, Timeliness, and Access]**
- For the Treatment composite, HUM earned 2.5 stars and 2.0 stars for the Behavioral Health—Care Coordination and Reduce Low Value Care subcomposites, respectively, demonstrating opportunities for improvement for HUM to ensure members receive timely follow-up after hospitalizations and ED visits for behavioral health conditions and to ensure members with low back pain do not receive unnecessary imaging tests. **[Quality, Access, and Timeliness]**

For HUM, 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 17, 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 HUM's performance in providing quality, timely, and accessible healthcare services to Louisiana's Medicaid and CHIP members. HSAG provides HUM'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 all four PIPs assessed for achieving significant improvement, some of HUM's reported performance indicator results demonstrated statistically significant improvement from baseline to the most recent remeasurement. **[Quality, Timeliness, and Access]** • For three PIPs assessed for achieving significant improvement, all of HUM's reported indicator results demonstrated statistically significant improvement from baseline to the most recent remeasurement. **[Quality, Timeliness, and Access]**
PMV	• HUM 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]** • HUM ensured that providers appropriately prescribed antibiotics to members with a respiratory condition and prevented or minimized the prescribing of antibiotics for members with bronchitis or bronchiolitis. **[Quality]**
Compliance	• HUM scored 100 percent for six standards in the CR, indicating that HUM's policies and procedures were generally compliant with contract requirements, and staff were generally knowledgeable about the requirements, policies, and procedures. **[Quality]**
NAV	• Overall, 93.0 percent of respondents in the provider access survey confirmed the sampled address was correct. **[Quality and Access]** • HUM actively worked to recruit providers including using mobile health clinics and providers who agreed to provide care within members' homes. Additionally, HUM provided quality incentives to healthcare providers and developed a maternity shared savings program, which rewarded providers for meeting metrics for prenatal and postpartum care. **[Quality and Access]**
EDV	• HUM reported less than 1.0 percent of pharmacy encounters as initially rejected and not yet accepted. **[Quality]**

Overall MCO Strengths	
	• HUM had low duplicate rates for professional encounters (0.6 percent), institutional encounters (0.6 percent), and pharmacy encounters (<0.1 percent). **[Quality]** • For institutional encounters, HUM had all key data elements populated with at least 95.0 percent of valid values. **[Quality]**
CAHPS and Behavioral Health Member Satisfaction Survey	• For the general child population, HUM's 2025 CAHPS achievement score was statistically significantly higher than the 2025 NCQA child national average for one measure, *Rating of Health Plan*. **[Quality]** • For the general child population, HUM's 2025 CAHPS achievement score was statistically significantly higher than the 2024 achievement score for one measure, *Rating of Health Plan*. **[Quality]** • No substantial strengths were identified for the Behavioral Health Member Satisfaction Survey. **[Quality, Timeliness, and Access]**
CMPE	• HUM successfully completed remediation actions to address the CAP findings. **[Quality]**

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

Overall MCO Opportunities for Improvement	
PIP	• For the *Behavioral Health Transitions of Care* PIP, some but not all of HUM's reported indicator results demonstrated statistically significant improvement from baseline to the most recent remeasurement. **[Quality, Timeliness, and Access]**
PMV	• HUM 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]** • HUM had room for improvement in coordinating with providers to help adult members with diabetes receive a retinal eye exam and adequately control their blood pressure. **[Quality]** • HUM had room for improvement in coordinating with providers to ensure that members receive timely and adequate prenatal and postpartum care. **[Timeliness]** • HUM had room for improvement in coordinating with providers to ensure that children are seen within the first 30 months of life and to ensure that children and adolescents receive appropriate well-care visits. **[Quality and Access]**
Compliance	• HUM scored 33 percent for Standard I—Enrollment and Disenrollment Requirements and Limitations, demonstrating the need to improve policies and procedures related to enrolling and disenrolling members. **[Quality and Access]** • HUM scored 43 percent for Standard V—Adequate Capacity and Availability of Services, demonstrating the need to improve compliance with network access standards. **[Quality and Access]**

Overall MCO Opportunities for Improvement	
NAV	• No strengths were identified in the PDV, as all indicators had match rates below 90 percent. The provider access survey demonstrated low compliance (44.3 percent). The PDV revealed several opportunities for improvement related to location, accuracy of specialty, and accuracy of acceptance of HUM, Louisiana Medicaid, and new patients. **[Quality and Access]**
EDV	• Among the five MCOs with a vision subcontractor, HUM had the highest percentage of vision encounters initially rejected and not yet accepted by LDH at 8.9 percent. Additionally, among the six MCOs with an NEMT subcontractor, HUM had the highest percentage of encounters initially rejected and not yet accepted by LDH at 7.3 percent. **[Quality]** • HUM had four data elements with less than 95.0 percent of valid values. **[Quality]** • For referential integrity, HUM had a low percentage of providers in the pharmacy encounter file who were also in the provider data at approximately 78.3 percent. **[Quality]** • HUM submitted only 47.0 percent of professional encounters, 15.1 percent of institutional encounters, and 11.1 percent of dental encounters to LDH within 60 days from the payment date. **[Timeliness]**
CAHPS and Behavioral Health Member Satisfaction Survey	• For the adult and general child populations, HUM's scores were not statistically significantly lower than their corresponding 2025 NCQA national averages or HUM's 2024 achievement scores for any measure; therefore, no substantial weaknesses were identified. **[Quality, Timeliness, and Access]** • No substantial opportunities were identified for the Behavioral Health Member Satisfaction Survey. **[Quality, Timeliness, and Access]**
CMPE	• HUM 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, HUM should review intervention evaluation results to determine if each intervention is having the desired impact and how interventions can be revised to increase effectiveness. HUM should also revisit barrier analyses for each PIP to evaluate whether additional barriers need to be	Goal 4: Promote wellness and prevention

Overall MCO Recommendations		
EQR Activity	**Recommendation**	**Associated Quality Strategy Goals to Target for Improvement**
	addressed by new or revised interventions to drive outcomes improvement. **[Quality, Timeliness, and Access]**	
PMV	• HUM 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]** • HUM should work with providers to identify root causes and trial interventions to encourage members with diabetes to get screened for diabetic retinal disease and to identify and address barriers to effective blood pressure management for diabetic members. **[Quality]** • HUM should work with providers to identify and address barriers to timely and adequate prenatal and postpartum care. **[Quality, Timeliness, and Access]** • HUM should work with providers to identify and address barriers to well-child visits (within the first 30 months of life) and well-care visits for child and adolescent members. **[Quality and Access]**	Goal 2: Improve coordination and transitions of care Goal 3: Facilitate patient-centered, whole-person care Goal 4: Promote wellness and prevention Goal 5: Improve chronic disease management and control
Compliance	• HUM must consult its CR results and develop its corrective actions related to Standard I—Enrollment and Disenrollment Requirements and Limitations. **[Quality and Access]** • HUM must ensure compliance with network access standards. **[Quality]**	Goal 1: Ensure access to care to meet enrollee needs
NAV	• In addition to updating provider information, HUM should conduct a root cause analysis to identify the	Goal 1: Ensure access to care to meet enrollee needs

Overall MCO Recommendations		
EQR Activity	**Recommendation**	**Associated Quality Strategy Goals to Target for Improvement**
	nature of the data mismatches for PDV. **[Quality]** • HUM 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]**	
EDV	• HUM and/its subcontractors should develop a comprehensive suite of encounter data quality monitoring reports to assess the accuracy, completeness, and timeliness of encounter data received from its four subcontractors. HUM should also build a process with LDH and its vision and NEMT subcontractors to ensure that rejected vision and NEMT encounters will be submitted to LDH with correct information. **[Quality]** • HUM should monitor its encounter data submission to LDH to ensure professional, institutional, and pharmacy encounters are submitted to LDH in a timely manner after payment. **[Quality]** • HUM 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]** • HUM should work with LDH to ensure both entities have an accurate and complete database of contracted providers for pharmacy encounters. **[Quality]**	Goal 7: Pay for value and incentivize innovation Goal 8: Minimize wasteful spending
CAHPS and Behavioral Health Member Satisfaction Survey	• HUM should focus on increasing response rates to the CAHPS survey for the adult and general child populations so there are greater than 100 respondents for each measure.	Goal 3: Facilitate patient-centered, whole-person care

Overall MCO Recommendations		
EQR Activity	**Recommendation**	**Associated Quality Strategy Goals to Target for Improvement**
	• HUM should focus on increasing response rates to the Behavioral Health Member Satisfaction Survey for the adult and child populations so there are greater than 100 respondents for each measure. **[Quality, Timeliness, and Access]**	
CMPE	• HUM should continue the efforts documented in its CAP responses to ensure compliance with contractual CM requirements. **[Quality and Timeliness]**	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 HUM completed in response to the EQRO's SFY 2024 recommendations. Furthermore, HSAG assessed HUM'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 Performance Improvement Projects (PIPs), HSAG recommended that the MCOs review intervention evaluation results to determine whether each intervention is having the desired impact and how interventions can be revised to increase effectiveness. The MCOs 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 HHH implemented new and revised initiatives across all PIPs to address identified barriers and recommendations. For Behavioral Health, real-time notifications and 72-hour post-discharge outreach were established, supported by transitional care management, provider/member incentives, transportation assistance, and telehealth exploration. Congenital Syphilis interventions included member education through branded materials, provider incentives for timely screening, and STI testing at community events, alongside targeted outreach and provider education on American College of Obstetricians and Gynecologists (ACOG) guidelines. Cervical Cancer Screening (CCS) initiatives featured Go365 member incentives, provider gap-closure incentives, monthly Gap in Care (GIC) reports, automated outreach campaigns, and partnerships for well-woman events and mobile screening. HIV screening efforts focused on offering testing at community events, distributing educational materials, planning mobile testing in underserved regions, and engaging providers through GIC reports and Centers for Disease Control and Prevention (CDC) guideline education. For Fluoride Varnish, interventions included monthly GIC reports, provider education on billing and clinical guidance, Smiles for Life training promotion, branded educational materials for parents, and partnerships for fluoride varnish applications at pediatric events, with plans for mobile dental services and gap-closure days.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Performance improved across all measures, demonstrating measurable gains attributable to implemented initiatives. Behavioral Health follow-up rates increased significantly for Follow-Up After Hospitalization for Mental Illness (FUH) and Follow-Up After Emergency Department Visit for Substance Use (FUA), surpassing PIP targets, while Follow-Up After Emergency Department Visit for Mental Illness (FUM) showed steady upward trends. Congenital Syphilis screening improved across multiple intervals, including first-trimester and delivery-related measures, reflecting positive impact from provider incentives and member education. CCS rates rose substantially, exceeding the annual target, supported by strong provider engagement and member

incentive utilization. HIV Screening indicators showed consistent improvement across high-risk populations, with notable gains among individuals with injection drug use and sexual transmission risk factors, while overall outreach and provider engagement strengthened. Fluoride Varnish application rates increased across all age groups, with the oldest cohort surpassing its target and overall measure trending upward, supported by enhanced provider education and community engagement. These improvements confirm that interventions were effective in driving outcomes.
Identify any barriers to implementing initiatives: Common barriers included technology and operational constraints, such as lack of automated outreach systems, incomplete data capture for scheduled visits, and delays in implementing mobile services. Behavioral Health faced challenges with stigma, transportation, and partial Health Information Exchange (HIE) coverage, while Congenital Syphilis and HIV Screening encountered member-level barriers related to awareness and stigma, as well as provider knowledge gaps. Cervical Cancer Screening was hindered by limited access to OB/GYN providers, member confusion about screening requirements, and logistical issues in hosting gap-closure events. Fluoride Varnish barriers included parental knowledge gaps, provider concerns about billing and scope of practice, and difficulty securing mobile dental partnerships. Across all PIPs, resource limitations and inconsistent event-level data collection further impacted outreach effectiveness.
Identify strategy for continued improvement or overcoming identified barriers: HHH will implement automation for member outreach and enhance data capture for scheduled visits to improve efficiency and accuracy. Behavioral Health strategies include expanding telehealth options, formalizing transportation reporting, and strengthening provider education. Congenital Syphilis efforts will focus on standardized reporting for outreach, additional sexually transmitted infection (STI) testing events, and reinforcing provider adherence to screening guidelines. CCS plans include expanding mobile screening, refining event planning, and continuing provider incentives and education. HIV Screening strategies involve scaling mobile testing in underserved regions, intensifying stigma-reduction campaigns, and leveraging automated outreach tools. For Fluoride Varnish, HHH will expand partnerships with dental schools for mobile services, integrate fluoride varnish into routine pediatric care, and standardize event-level reporting.
HSAG Assessment


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

Recommendation
HSAG recommended HUM evaluate performance measures with rates below the NCQA national 50th percentile.
Response
Describe initiatives implemented based on recommendations: The HHH team leverages the HEDIS BI Suite to monitor all Medicaid HEDIS measures and benchmarks, ensuring data-driven improvement strategies. In alignment with HSAG's recommendation, we prioritize measures performing below the NCQA 50th percentile, including those rated "1" or "2" in Health Plan ratings. While the 50th percentile serves as a baseline, our long-term strategy targets the 66th percentile as part of the Path to 4 Stars initiative. Current efforts include focused interventions on low performing measures with short term goals of 2% year over year improvement for withhold measures, Provider and member engagement strategies were also deployed to close gaps in care. These initiatives position us to meet compliance requirements and achieve sustained performance

gains. These initiatives strengthen compliance, improve quality ratings, and position HHH to achieve higher Star performance, driving member satisfaction and competitive advantage in the Medicaid market.

Identify any noted performance improvement as a result of initiatives implemented (if applicable): Following the implementation of targeted initiatives, HHH has achieved measurable progress across several priority areas. Measures previously rated "1" or "2" have demonstrated significant upward movement toward the NCQA 50th percentile, with some achieving double-digit percentage point gains. For measures tied to withholds, we met or exceeded the majority of 2% year-over-year improvement targets, validating the effectiveness of our focused strategies. Enhanced provider engagement and member outreach have contributed to closing gaps in preventive services and chronic condition management, while progress toward the 66th percentile reflects advancement on our Path to 4 Stars. These improvements underscore the impact of data-driven interventions and position HHH for continued success in quality performance.

Identify any barriers to implementing initiatives: Challenges encountered include data interoperability issues, provider resource constraints, and member engagement barriers. Variability in provider adoption of new processes and member responsiveness to outreach have also impacted the pace of improvement.

Identify strategy for continued improvement or overcoming identified barriers: HHH will continue to refine its strategies by leveraging agile portfolio management and continuous prioritization processes to rapidly address barriers as they arise. Enhanced data integration efforts are underway to improve interoperability, and further provider and member engagement initiatives are planned. The use of Lean Business Case methodology will continue to guide resource allocation and strategic alignment, ensuring sustained focus on improving measures below the NCQA 50th percentile.

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:
HHH utilizes real-time Admission, Discharge, Transfer (ADT) reports to outreach members who are visiting the Emergency Department (ED) for BH conditions. Additionally, transitional care management is in place to engage members prior to discharge and facilitate warm handoffs to licensed mental health professionals who can complete follow up assessments and resolve gaps in care. Provider education was strengthened through quarterly newsletters and advisory council discussions, while ATLAS Treatment Finder was promoted to improve provider access to urgent aftercare appointments. Additionally, medication reconciliation processes were standardized, and outreach protocols were expanded to include 72-hour post-discharge follow-up calls for all members, regardless of case management status.

Identify any noted performance improvement as a result of initiatives implemented (if applicable): Performance improved across most behavioral health follow-up indicators. Follow-up after hospitalization within 7 and 30 days showed consistent increases over the past three quarters, surpassing targets. Follow-up

after ED visits for substance use also demonstrated notable improvement, exceeding targets for both 7-day and 30-day measures. Follow-up after ED visits for mental illness increased but remains below target, indicating progress but continued need for intervention. Intermediate process measures, such as notification capture and outreach, also improved significantly, reflecting stronger coordination of workflows.

Identify any barriers to implementing initiatives:
Barriers included incomplete documentation of scheduled follow-up visits and inability to systematically record enhanced discharge plan sharing. Technology gaps, such as HIE participation. Member-level challenges included transportation issues, stigma associated with behavioral health care, and inaccurate contact information. Operational constraints, including reliance on manual processes for ED notifications and delayed vendor reporting for transportation utilization, further complicated implementation.

Identify strategy for continued improvement or overcoming identified barriers: HHH plans to expand scheduled-visit documentation and reporting capabilities, continue to explore automated outreach platforms for appointment reminders, and enhance HIE integration for real-time notifications. Transportation reporting will be formalized through a monthly framework, and provider engagement will continue via newsletters, advisory councils, and education on best practices for timely follow-up. Telehealth options remain a priority for future planning, with interim strategies including virtual outreach by mental health professionals to bridge access gaps. These strategies aim to strengthen coordination between providers and the MCO, reduce barriers to care, and maintain momentum toward meeting and exceeding performance targets.

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.

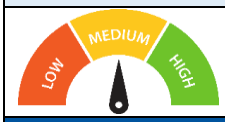
Response

Describe initiatives implemented based on recommendations:
In response to the recommendation to improve performance on post-discharge planning and care coordination, HHH has continued the following interventions: Transition Coordination Care Management program that attempts to engage providers and members in discharge plan development and execution which includes care coordination; Utilization Reviewers convey availability to assist all hospital staff with discharge/transition planning needs with new authorization requests. New initiatives that HHH have implemented include educating provider groups/health systems on how to connect with HHH for discharge planning and care coordination through JOC meetings, association meetings, guidance in the provider newsletter. Specific language around discharge planning assistance is being added to HHH provider site next month.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
Providers outreach with what is categorized as challenging discharges continues, but there has been no noted increase in volume of providers accepting offers of assistance or specifically reaching out for assistance.

Identify any barriers to implementing initiatives:
Providers are not responding to offers of assistance or reaching out for assistance with discharge planning and/or care coordination any more frequently than what has been experienced in the past.

Identify strategy for continued improvement or overcoming identified barriers:
HHH is planning to attempt partnerships with BH inpatient units for onsite Licensed Mental Health Professional Care Manager and staff weekly touch base meetings/rounds to assist facility staff with discharge planning needs for HHH members.

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: HHH plans to educate providers by disseminating clinical guidelines for acute low back pain, share performance data for this measure with high volume provider groups, and collaborate with designated provider groups to identify and trial solutions.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Not applicable
Identify any barriers to implementing initiatives: There are no barriers identified at this time.
Identify strategy for continued improvement or overcoming identified barriers: HHH will conduct data analysis and provide regular feedback to providers, adjusting strategies as needed to support sustained improvement.
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: In 2026, HHH will implement education initiatives to reduce unnecessary cervical cancer screenings for adolescent females. This intervention will include provider-focused education emphasizing current clinical guidelines, appropriate screening age, and documentation of best practices. For members and caregivers, HHH will launch an education campaign through community events and printed materials to clarify that cervical cancer screening is not recommended for adolescents and to explain alternative preventive care options.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Although this initiative is planned for 2026, similar education-based strategies have historically led to reductions in inappropriate screenings. The expectation is that provider education combined with member awareness will decrease the rate of non-recommended cervical cancer screenings among adolescents, aligning performance with national guidelines and improving measure compliance.
Identify any barriers to implementing initiatives: Potential barriers include provider resistance to changing established workflows, limited time for training, and member misconceptions about preventive care needs.

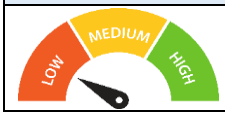
Additionally, ensuring consistent messaging across multiple communication channels and addressing cultural or language differences may require additional resources and coordination.
Identify strategy for continued improvement or overcoming identified barriers: To sustain improvement and overcome barriers, HHH will integrate the 2026 education initiative into its PIP reporting framework. Member outreach will use culturally sensitive messaging and leverage trusted community partners to reinforce education. The plan will also monitor provider adherence through reporting and provide feedback loops to support continuous improvement in the measure.
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 HUM with the case-level PDV and provider access survey data files (i.e., flat files) and a defined timeline by which HUM 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: Upon receipt of case-level PDV and provider access survey data files, Humana initiates a structured process involving Provider Relations representatives and Network Operations team members. This collaborative approach enables the prompt identification and correction of any errors, supporting the ongoing accuracy of provider data. Additionally, Humana conducts regular audits of provider data on a monthly and quarterly basis to proactively monitor and enhance data accuracy. These measures support ongoing compliance and continuous improvement in provider directory management.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): A dedicated Contract Workgroup has been established to proactively identify and resolve issues related to contracting, system loads, and credentialing. This initiative aims to maintain the accuracy, consistency, and integrity of network data across all platforms.
Identify any barriers to implementing initiatives: A barrier Humana has identified is the inconsistency in provider office call center procedures and staff training. These differences can result in members receiving inaccurate information regarding provider participation and availability, which may lead to disruptions in their access to essential providers within Humana's network. Addressing this challenge remains a key focus to ensure reliable member support and accurate provider data.

Recommendation
Another barrier to implementing initiatives is the substantial volume of provider data within Humana's systems that require regular auditing. This large data set increases the complexity and resource demands associated with maintaining accurate and up-to-date provider information.
Identify strategy for continued improvement or overcoming identified barriers: Humana continues to work closely with its provider partners to identify and address issues within provider call centers. Through this collaborative approach, Humana ensures that call center staff at each provider office are educated and made aware of how to accurately respond to questions regarding provider participation and availability. This ongoing partnership helps to improve directory accuracy and member access, but challenges may remain due to differences in call center protocols and staff turnover. Continued communication and targeted training are key to overcoming these barriers and supporting consistent, reliable information for members. Humana recently hired two full-time employees who are dedicated solely to auditing provider loads. By focusing on ongoing audits, these employees will help to proactively identify and correct inaccuracies in provider information, which directly addresses barriers related to outdated or incorrect directory data. This approach not only supports regulatory compliance but also enhances member experience by improving access to accurate provider information within Humana's network. To sustain and build upon this improvement, regular review of audit findings, incorporation of feedback from both providers and members, and continuous training for staff involved in directory management will also occur.
HSAG Assessment

Recommendation
HSAG recommended that HUM 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: Upon receipt of case-level PDV and provider access survey data files, Humana initiates a structured process involving Provider Relations representatives and Network Operations team members. This collaborative approach enables the prompt identification and correction of any errors, supporting the ongoing accuracy of provider data. Additionally, Humana conducts regular audits of provider data on a monthly and quarterly basis to proactively monitor and enhance data accuracy. These measures support ongoing compliance and continuous improvement in provider directory management.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): A dedicated Contract Workgroup has been established to proactively identify and resolve issues related to contracting, system loads, and credentialing. This initiative aims to maintain the accuracy, consistency, and integrity of network data across all platforms.
Identify any barriers to implementing initiatives: A barrier Humana has identified is the inconsistency in provider office call center procedures and staff training. These differences can result in members receiving inaccurate information regarding provider participation and availability, which may lead to disruptions in their access to essential providers within Humana's network. Addressing this challenge remains a key focus to ensure reliable member support and accurate provider data.

Recommendation
Another barrier to implementing initiatives is the substantial volume of provider data within Humana's systems that requires regular auditing. This large data set increases the complexity and resource demands associated with maintaining accurate and up-to-date provider information.
Identify strategy for continued improvement or overcoming identified barriers: Humana continues to work closely with its provider partners to identify and address issues within provider call centers. Through this collaborative approach, Humana ensures that call center staff at each provider office are educated and made aware of how to accurately respond to questions regarding provider participation and availability. This ongoing partnership helps to improve directory accuracy and member access, but challenges may remain due to differences in call center protocols and staff turnover. Continued communication and targeted training are key to overcoming these barriers and supporting consistent, reliable information for members. Humana recently hired two full-time employees who are dedicated solely to auditing provider loads. By focusing on ongoing audits, these employees will help to proactively identify and correct inaccuracies in provider information, which directly addresses barriers related to outdated or incorrect directory data. This approach not only supports regulatory compliance but also enhances member experience by improving access to accurate provider information within Humana's network. To sustain and build upon this improvement, regular review of audit findings, incorporation of feedback from both providers and members, and continuous training for staff involved in directory management will also occur.
HSAG Assessment

Recommendation
HSAG recommended that HUM 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: Humana has implemented several initiatives. The Provider Relations and Provider Engagement teams actively educate providers on proper member benefit verification processes during initial onboarding. Additionally, ongoing education is provided during regular meetings to reinforce best practices and ensure providers understand how to efficiently verify member eligibility. These efforts are designed to reduce administrative burdens on members and improve access to care by promoting consistency and accuracy in eligibility verification across provider offices.
Identify any noted performance improvement as a result of initiatives implemented (if applicable):
Identify any barriers to implementing initiatives: Barriers to implementing initiatives include providers not consistently utilizing available tools and the frequent turnover of provider office staff. These factors can hinder the effectiveness of training efforts and the adoption of best practices for accurate provider data management.
Identify strategy for continued improvement or overcoming identified barriers: A strategy for continued improvement and overcoming identified barriers includes ongoing provider education and the implementation of quarterly provider townhall meetings beginning in 2026. These initiatives are

Recommendation
designed to facilitate regular communication, address emerging challenges, and ensure providers remain informed of best practices and process updates, thereby supporting network accuracy and member access.
HSAG Assessment


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

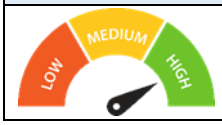
Recommendation
HSAG recommended that HUM focus on increasing response rates to the CAHPS surveys and the behavioral health member satisfaction survey.
Response
Describe initiatives implemented based on recommendations: As a newer managed care organization (MCO) with a smaller membership base compared to other MCOs, HHH implemented strategic oversampling to enhance our CAHPS survey response volume. Accurate contact information is essential for improving survey response rates to ensure they reach the intended recipients promptly. Our member services team is committed to maintaining accurate contact information for our members. Once the information is updated, our system is refreshed accordingly, and these changes are integrated across relevant platforms. Please note that behavioral health (BH) surveys are administered by the state; therefore, our ability to influence outcomes in this area is limited.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): In 2025, the child and adult survey response rate increased.
Identify any barriers to implementing initiatives: There are no barriers identified at this time.
Identify strategy for continued improvement or overcoming identified barriers: HHH plans to increase our CAHPS oversample rate in 2026. To support ongoing improvement, we will maintain collaboration with the CAPHS work group to evaluate processes and identify future enhancements.
HSAG Assessment


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

Recommendation
None identified.

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 HUM's HEP submission from July 2025.

Health Equity Plan

HSAG reviewed HUM'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

FOCUS AREA 1-Ensuring the Delivery of Services in a Culturally Appropriate and Effective Manner

A. Changes to participants, if applicable
Not applicable
B. Activities accomplished between January and June 2025
1. Cultural Competency Training From January-June 2025, seven (7) new Humana Healthy Horizon Medicaid Associates have been onboarded and completed comprehensive onboarding that included 6.5 hours on cultural competency. *2. Culturally and Linguistically Appropriate Services (CLAS) Training*

[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.

Humana Healthy Horizons in Louisiana (HHHLA) launched education on to how to deliver Culturally and Linguistically Appropriate Services (CLAS) for all Associates. All HHHLA Associates must complete the training within 30 days of their hire date or during the annual Humana compliance training period from June 2, 2025- August 20, 2025

3. 2025 CLAS Work Plan Goals

HHHLA launched a cross-departmental CLAS work group that works to develop a CLAS work plan which includes Medicaid CLAS wide goals, language services goals, health disparities goals and provider network responsiveness goals. The goals and updates are listed below:

- Goal 1: By December 2025, Humana Healthy Horizons in Louisiana will present CLAS updates to all members, providers and community partners at the four quarterly Member Advisory Committee on the status of the CLAS program to solicit feedback on CLAS operations and services.
  - Presented the CLAS workplan and goals at the Quarter 1 Member Advisory Committee on March 22, 2025.
  - Presented the CLAS workplan goals at the Quarter 2 Member Advisory Committee on June 14, 2025.
  - Monthly Health Equity Committee meetings to review all CLAS goals, cultural competency goals/data and any other ongoing CLAS Medicaid wide business.
- Goal 2: By December 2025, increase the number of males that are within controlled blood pressure compliance by 2 percentage points.
  - Auditing males on the gap list that use supplemental data to be submitted for gap closures.
- Goal 3: By December 2025, at least 3% of Providers will be in compliance with cultural competency training.
  - Hosting two in person and on demand Provider Cultural Competency training for Louisiana Medicaid Providers in partnership with The Trusted Provider Network and other MCOs in the state: 1. "Using Ethics to Dismantle Cultural Encapsulation for Healthcare Professionals" Friday, June 13, 2025, and "The Policy Roots of Health Inequities: Understanding Social Determinants of Health" Monday, June 23, 2025.
- Goal 4: Increase the number colorectal cancer screening by 2 percentage points among American Indian/Alaska Native and members.
  - Auditing the Alaska Indian and Alaska Native colorectal cancer members on the gap list to use supplemental data to be submitted for gap closures.
- Goal 5: Increase the number of Spanish speaking members by 2% whose glycemic status is under 8%.
  - Prioritizing targeted marketing efforts aimed at Spanish-speaking members who meet the enrollment criteria and stand to benefit from the Ochsner Digital Medicine/RPM program.
  - Monthly meetings with Ochsner to progress monitor program enrollment, data and goals.

C. Activities expected to be accomplished by December 2025

1. Cultural Competency Training

HHHLA will require any new associates onboard between July and December to complete an annual cultural competency training.

HHLA will continue to promote Cultural Competency/ Health Equity Training for Providers.

2. CLAS Training

All Humana Healthy Horizon Medicaid Associates in Louisiana will have to complete CLAS training as part of the annual initial compliance and ethics training by August 20th, 2025. 3. CLAS 2025 Work Plan From July-December, HHHLA will continue working towards the following and completing CLAS plan goals, strategies and tactics. ○ Increase participation among Medicaid providers who complete at least one (1) CME on health equity beyond CLAS and implicit bias. ○ Two additional Member Advisory Committee Meetings planned for Q3 and Q4 this year. ○ Host a gap in care in closure event to increase colorectal cancer screening among American Indian/Alaska Native Members. ○ Obtain provider feedback through Provider Relations engagements and the Provider Advisory Council (PAC) meetings quarterly. ○ Promote remote diabetes patient monitoring to Spanish-speaking members to increase participation in the Ochsner Digital Medicine Program. ○ Hosting a Provider Day event with a focus on diabetes care with emphasis on outreach, education and services in Spanish. ○ Increase the number of males that are in controlled blood pressure compliance.
D. Progress, challenges, and/or delays in achieving measurable objectives and/or milestones thus far in 2025
None anticipated

FOCUS AREA 2-Engaging Diverse Families to Design Services and Interventions that Integrate Care an Address Childhood Adversity and Trauma

A. Changes to participants, if applicable
Not applicable
B. Activities accomplished between January and June 2025
1. *Adverse Childhood Experiences (ACES) Educator Training* HHHLA has two trained Associates that completed the LDH OPH Bureau of Family Health ACE Educator program. 2. *ACES Education for Parents and Educators* Humana Healthy Horizons hosted 2 ACE Parent, Educator and/or trauma trainings in regions 1 (New Orleans)20 participants, region 2 (Baton Rouge) 10 participants, region 7(Bossier/ Caddo) 69 participants, totaling 99 in participants thus far this year.
C. Activities expected to be accomplished by December 2025
HHHLA will continue to host ACE Parent, Educator and/or trauma trainings across Louisiana with at least one training completed in each of the 9 regions by 12/31/2025.
D. Progress, challenges, and/or delays in achieving measurable objectives and/or milestones thus far in 2025
None Anticipated

FOCUS AREA 3: Obtaining and Incorporating Input from Enrollees who have Disparate Health Outcomes

A. Changes to participants, if applicable
Not applicable

B. Activities accomplished between January and June 2025
Six scholarships have been awarded to students at Dillard University School of Population Health under Dr. Rebecca Red to conduct research on health disparities and outcomes across the nine regions of Louisiana. Over the course of one year, these students will investigate demographic health disparities by engaging with residents of various communities to tell their story. Their research will culminate in a poster project aimed at highlighting the critical outcomes faced by Louisiana communities. This initiative not only fosters academic growth among the students but also aims to raise awareness and promote dialogue around these significant health, racial and social issues.
C. Activities expected to be accomplished by December 2025
From July-December the students will continue their yearlong research and then present their findings at the National Social Work Conference, where they will have the opportunity to discuss their results in a poster session. Furthermore, the students will present their comprehensive findings to HHHLA, contributing valuable insights into the pressing issues of health disparities within the state.
D. Progress, challenges, and/or delays in achieving measurable objectives and/or milestones thus far in 2025
None Anticipated

FOCUS AREA 4: Ensuring that Enrollees Test Outward Facing Communications for Understanding and Cultural Appropriateness

A. Changes to participants, if applicable
Not applicable
B. Activities accomplished between January and June 2025
HHHLA hosted the first quarter Member Advisory Committee (MAC) in March 2025 and is scheduled to host the second quarter MAC meeting on June 14, 2025. During these meetings, participants review electronic and printed materials and provide feedback on the look, feel and content of the materials. Participants also are presented all the CLAS goals for feedback. To date, the MAC attendees did not have feedback to share about the materials or CLAS goals this year.
C. Activities expected to be accomplished by December 2025
The upcoming MAC meeting date are listed below: • Quarter 3: Region 5 – Lake Charles • Quarter 4: Region 8 – Monroe
D. Progress, challenges, and/or delays in achieving measurable objectives and/or milestones thus far in 2025
None anticipated

FOCUS AREA 5: Partnering with Community- Based Organizations to address Social Determinants of Health-Related Needs

A. Changes to participants, if applicable
Not applicable
B. Activities accomplished between January and June 2025 Humana Healthy Horizons in Louisiana donated to the following community-based organizations to address social determinants of health-related needs as outlined below.
American Health Association is the nation's oldest and largest voluntary health organization dedicated to fighting heart disease and stroke. The mission is to be a relentless force for a world of longer, healthier lives. Although funding was officially received in May, the AHA proactively used the

preceding months to build a strong operational foundation. The program is intended to serve pregnant women, with a primary focus on Black women who experience higher rates of maternal health challenges. It also aims to support Hispanic and Asian women, particularly those at increased risk for hypertension and other chronic health conditions. The initiative will initially launch in the Greater New Orleans area, with plans to expand to more regions in the following year.

Community Foundation of North Louisiana brings people and resources together to solve problems and enhance our community. Our mission is to promote philanthropy and improve the quality of life in the North Louisiana community by serving as a permanent and growing resource of expertise and funds.

- Step Forward Initiative is ensuring success for every child in North Louisiana. Step Forward's Parent ACEs Talk series educates parents and caregivers about Adverse Childhood Experiences (ACEs), toxic stress, prevention strategies, and building resilience. Through these sessions, participants gain practical tools and supportive experiences that help them overcome adversity. This leads to better emotional, social, and academic outcomes for their children, ultimately fostering healthier, more successful communities. On May 17, 2025, Step Forward participated in the Basic Necessities Community Baby Shower to promote Parent ACEs Talks to expecting mothers. Over 200 attendees were reported, with 69 mothers visiting the Step Forward table to receive information on brain development and the Parent ACEs Talk series.

Dillard University School of Population and Health Sciences students explore the intersection of social, biological, and environmental elements of health to become positive change agents. Although the official launch of the youth substance misuse prevention program is set for July 1, the first half of the year was dedicated to laying a strong foundation. The team also prepared the IRB protocol for submission. These efforts align with the program's mission to reduce adolescent drug misuse through education and community-based strategies. The program targets adolescents aged 12–18, with a focus on African American and Black youth, while also engaging Latinx, Asian, and multiracial populations. It is inclusive of all genders and centers on Gentilly-area schools, with outreach to other high-need communities in the New Orleans metro area.

Fathers On A Mission (F.O.A.M.) is one of the only nonprofit organizations that cater to empowering men to become better father figures within their community. We connect Fathers with workplace opportunities, community resources, and opportunities to build relationships through our Project Family Build wraparound program.

- Educational/Support Classes Weekly "Responsible Fatherhood" classes
  attended weekly classes -85
  fathers enrolled in wraparound program- 59
- Community Engagement Events including a Father/Daughter Dance
  fathers/children in attendance- 84
- Health Promotion Mental health counseling services
  accessed mental health counseling- 25
- Financial Literacy Workforce development pathways
  joined workforce pathways- 23
  earned certifications-27
  Secured employment- 22
- Direct Assistance ID recovery, food, diapers, clothing, transportation
  received direct assistance- 36

Demographic information of the participants:

Race	
African American	96%
Hispanic	4%

Gender-Male	100%
Age Group	19-45; majority 25-35
Parish of Residence	East Baton Rouge Parish

Open Health and Pennington Biomedical have partnered to implement a comprehensive school-based intervention program aimed at addressing childhood obesity through a combination of innovative community health care and cutting-edge research. This collaborative initiative targets middle school students in grades 6 through 8, with a goal to enroll 35 participants who meet specific eligibility criteria. Students must have a baseline Body Mass Index (BMI) above the 95th percentile for their age and sex, indicating obesity as defined by national health standards. By focusing on this high-risk group, the program seeks to deliver tailored interventions that promote healthier lifestyles, improve metabolic health, and reduce obesity-related risks.

Second Harvest Food Bank leads the effort to end hunger and strengthen food security across 23 parishes in South Louisiana. Each year, it provides nutritious food to over 280,000 individuals facing food insecurity, while also connecting them to programs that address the root causes of hunger through advocacy, education, and disaster response.

- Makin' Groceries Mobile Market objective is to address the inequity in access to healthy food in Greater New Orleans, Acadiana, Southwest Louisiana, and the health inequities that are associated with food insecurity, with a particular emphasis on diet-related chronic disease.
  - 40 stops made by the Makin' Groceries Mobile Market in 10 parishes: Acadia, Calcasieu, Evangeline, Iberia, Jefferson, Lafayette, Orleans, St. Landry, St. Martin, and Vermilion.
  - 2,000 transactions completed by shoppers at the Makin' Groceries Mobile Market.
  - 40,000 pounds of fresh, nutritious food sold at discounted rates at the Makin' Groceries Mobile Market, equivalent of 33,333 meals.
  - 253 people were impacted by 6 nutrition education activities at the Mobile Market, including SNAP outreach.

Demographic information of the participants:

Race	
African American	54%
White	45%
Asian	1%
Ethnicity	
Hispanic	6%
Non-Hispanic	94%
Gender	
Male	34%
Female	66%
Age Group	
Seniors (65+)	58%
Under 65	42%
Parish of Residence	Acadia, Calcasieu, Evangeline, Iberia, Jefferson, Lafayette, Orleans, St. Landry, St. Martin, and Vermilion Parishes

Three O'Clock Project will be providing fresh produce boxes to families to support sustainable growth and health equity in Baton Rouge. During the first half of the year, the Three O'clock Project focused on launching and establishing the Food Rescue Kitchen initiative.

- Food Rescue Kitchen The team finalized the project plan, secured necessary funding, and purchased and installed essential kitchen equipment at St. Luke Episcopal Church. Key staff were hired and trained in food safety and meal preparation, and standard operating procedures were developed for food collection, cooking, and delivery. A food collection network was established through partnerships with at least ten local food donors, and the project began producing and distributing nutritious frozen meals. On average, 1,500 heart-healthy meals were delivered per month to families in need across the city. The team also initiated monitoring and evaluation processes, tracking food rescued, meals produced, and recipients served, while gathering community feedback to refine the program

Volunteer for Youth Justice provides trauma-informed advocacy, intervention, diversion, mentoring, and leadership services for at-risk children and youth.

- Family Resource Program (FRC) served a total of 937 individuals, with adults making up the largest group (386), followed by children ages 0–10 (314), and youth ages 11–17 (236). In terms of gender, 555 clients identified as female, 353 as male, and 28 individuals did not specify a gender. The FRC implemented a variety of impactful activities during this period, including parenting classes, life skills workshops, neighborhood meetings, and health fair participation each contributing to stronger family engagement, improved parenting, and expanded access to vital resources.

Xavier University of Louisiana mission is to contribute to the promotion of a more just and humane society by preparing its students to assume roles of leadership and service in a global society. As the nation's only historically Black and Catholic university, Xavier continues to lead in STEM and health sciences education. National rankings highlight Xavier's strong output of African American graduates in Chemistry, Biological Sciences, and professional health degrees. The institution remains committed to access, excellence, and equity in education.

- Scholarship Support – Focused on students in Pre-Health programs, particularly graduate-level Physician Assistant (PA) students, to build a pipeline of future healthcare professionals.
- Institutional Support – Contributions through the "Give.Love.Xavier" campaign strengthen the university's overall capacity and long-term sustainability.
- Career Services – Investment in Xavier's Office of Career Services supports workforce development and job readiness for students entering healthcare and related fields.

C. Activities expected to be accomplished by December 2025

American Heart Association:

Maternal Health: New Mom Kits Initiative:

- Distribute up to 100 New Mom Kits to pregnant women in regions 1, 2, and 9.
- Deliver maternal health education sessions focused on cardiovascular risk factors, self-monitoring blood pressure, and emergency preparedness.
- Provide Infant CPR kits and training to caregivers.
- Conduct nutrition education sessions using *Healthy for Good™* and *EmPOWERED To Serve™*.
- Screen participants for nutrition insecurity and connect them to WIC, SNAP, and Mom's Meals.
- Make infrastructure improvements at one food pantry to enhance access to fresh, nutritious foods (Regions 1, 2, 9)

Chat & Chew: A Healing Space for Maternal and Mental Health -Thursday, July 3, 2025, the American Heart Association (AHA) and Humana will take part in a culturally immersive, community-focused event hosted by the National Medical Association (NMA) at the Contemporary Arts Center in New Orleans. The event is expected to attract 100 to 150 attendees, primarily Black women ages 25 to 55, and will serve as a meaningful platform to raise awareness about maternal and mental health disparities.

Community Foundation of North Louisiana:
• Develop the Bonding and Brain Building program to support early childhood development and caregiver engagement.
• Continue raising awareness about:
  ○ Adverse Childhood Experiences (ACEs) trainings
  ○ Suicide prevention strategies and resources
• Plan and host a TAC Mental Health Summit to engage youth in mental wellness education and advocacy.
• Disseminate a mental health survey to students attending:
  ○ Caddo Parish high schools
  ○ Additional youth audiences

Dillard University School of Population and Health Sciences throughout both phases, the program will work toward its goals of educating 500 adolescents, increasing knowledge about drug misuse by 25%, building strong community partnerships, and empowering peer educators to lead sustainable prevention efforts. Phase 1: Preparation (July–August) Key activities include: • Submitting the IRB application and securing approval • Finalizing partnerships with schools and community organizations • Training peer educators and facilitators • Distributing educational materials to partner sites Phase 2: Implementation (September–December) Activities will include: • Launching school-based workshops and community education sessions • Conducting peer-led discussions at five partner sites • Administering pre- and post-surveys to evaluate knowledge gains • Collecting attendance logs and participant feedback for continuous improvement
Fathers on A Mission (F.O.A.M.) • Continuation of "Cooking with Dads" quarterly events. • Ongoing: Weekly Responsible Fatherhood Classes. • Expansion of mental health and substance abuse intervention services under onboarded Clinical Social Worker. • Workforce certification, placement, and follow-up support for 50+ additional fathers.

Open Health and Pennington Biomedical
• Adapt the PROPEL Intensive Lifestyle Intervention for middle school students
• Regular health monitoring (BMI, blood pressure, glucose, cholesterol, A1c).
• Deliver sessions in both individual and small group formats, led by Community Health Workers (CHWs), to:
  ○ Engage families in a supportive environment.
  ○ Bridge clinical care with home-based support.
• Provide behavioral education and connect families to community resources.
• Healthy food deliveries to families at scheduled intervals.
• Facilitate access to community assets such as the YMCA.

Second Harvest Food Bank • 120 stops made by the Makin' Groceries Mobile Market in 10 parishes: Acadia, Calcasieu, Evangeline, Iberia, Jefferson, Lafayette, Orleans, St. Landry, St. Martin, and Vermilion. • 6,000 transactions completed by shoppers at the Makin' Groceries Mobile Market. • 100,000 pounds of fresh, nutritious food sold at discounted rates at the Makin' Groceries Mobile Market, the equivalent of 83,333 meals.

• 750 people impacted by nutrition education activities at the Mobile Market, including SNAP outreach.
Three O'clock Project will focus on expanding its operations and deepening its impact across Baton Rouge. The team plans to increase food rescue efforts by partnering with additional local suppliers, which will support the goal of scaling meal production to 2,500 nutritious frozen meals per month. Continuous monitoring will track key metrics such as food volume rescued, meals produced, and families served, while community feedback will guide ongoing improvements in service delivery. A comprehensive evaluation will be conducted to assess the program's outcomes, including reductions in food waste and increased meal accessibility for underserved families. To close out the year, the team will prepare a final report summarizing lessons learned, challenges faced, and recommendations for future expansion. A community event will also be hosted to celebrate the project's impact and raise awareness about food insecurity and sustainable solutions.
Volunteers for Youth Justice • Family Resource Program (FRC) anticipates serving an additional 470 individuals through ongoing programming. In partnership with Humana, the FRC will co-host health-focused events aimed at increasing family stability, strengthening parenting skills, improving access to health and wellness services, and deepening community connections. Expected outcomes include stronger parent-child relationships, increased engagement in support services, and improved health literacy among families in underserved neighborhoods.
Xavier University of Louisiana in the second half of 2025, Xavier University will continue to advance its scholarship, institutional, and career support initiatives. Additional scholarship funds will support students, particularly first-generation graduate students in healthcare programs who face financial challenges, helping them stay on track academically. Xavier is also increasing its presence at regional job fairs, further elevating the visibility of its students and graduates. These efforts reflect Xavier's ongoing commitment to health equity, access, and academic excellence in preparing diverse leaders in science and healthcare.
D. Progress, challenges, and/or delays in achieving measurable objectives and/or milestones thus far in 2025
None anticipated

FOCUS AREA 6: Recruiting, Developing, and Promoting Diverse talent at Humana Healthy Horizons Louisiana

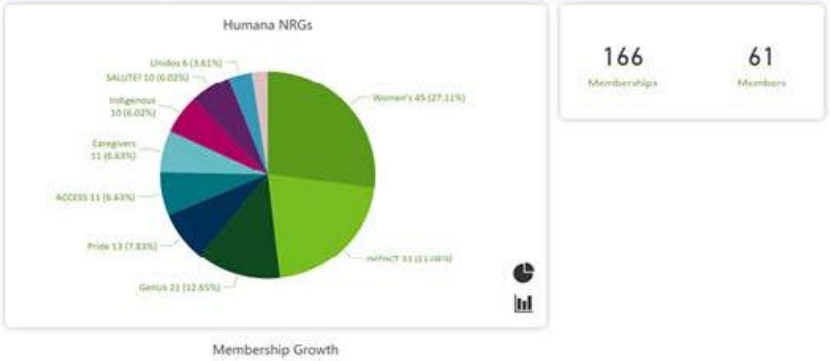
A. Changes to participants, if applicable
Not applicable
B. Activities accomplished between January and June 2025
HHHLA added seven additional Associate between January and June 2025. HHHLA associate demographics continue to reflect the diversity of Louisiana. Of the 191 Associates, here are the demographics by race/ethnicity and gender:

Race/Ethnicity	
Asian	0%
Black	57%
Hispanic/Latino	5%
Do Not Wish to Answer	1%
Two or More Races	4%
White	33%
Unknown	1%

Sex	
Female	92%

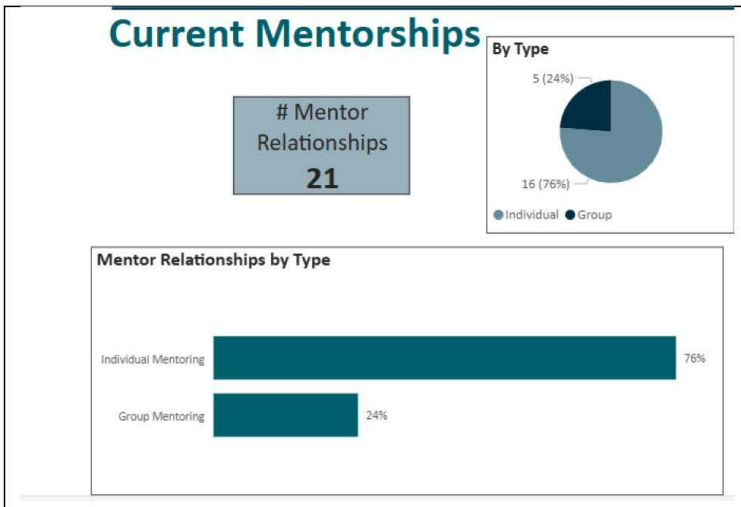
Male	8%

In Louisiana 61 Medicaid Associates have joined ten different Humana Network Resource Groups (NRGs) that provide personal, experience-based forums for exchanging ideas, building community, and driving measurable business outcomes. NRGs help HHHLA see through their diverse lenses while making business decisions. NRGs are associate-led and associate driven groups that work to impact Humana's culture, marketplace, and communities where we serve.



On June 24, 2025, HHHLA's Health Equity Committee is hosting an informational for all Medicaid Associates to learn more about the ten Network Resources Groups (NRGs) that are associate-led and associate driven groups that work to impact Humana's culture, marketplace and communities where we serve.

Humana Mentoring Program: There are 21 current HHHLA Associates that participate individual, group and peer to peer mentoring. The mentoring program seeks to encourage associates to learn from one another, maintain a thriving professional community, and reinforce a culture of learning. The program creates a mutually beneficial learning partnership. Mentors share skills, experiences, and expertise. Mentees gain critical skills, achieve development goals, and forge a path towards leadership.



C. Activities expected to be accomplished by December 2025
HHHLA will continue to encourage existing and new Associates to join Network Resource Groups and sign-up for mentoring and/or to provide mentorship. HHHLA will establish a Associate Engagement Committee in July 2025: Mission Statement: To foster a positive, inclusive, engaging workplace culture by organizing initiatives that support associate satisfaction, recognition and communication always keeping Humana's core values at the center: Being Caring, Curious and Committed. Goals/ Objectives: Serve as voice for the associates to leadership Promote a culture of appreciation and inclusion (caring/curious) Plan and support events and programs (committed) Gather and relay feedback Increasing associate engagement
D. Progress, challenges, and/or delays in achieving measurable objectives and/or milestones thus far in 2025
None anticipated

FOCUS AREA 7: Developing a Pipeline for Diverse Health and Social Service Providers

A. Changes to participants, if applicable
Not applicable
B. Activities accomplished between January and June 2025
Between January and June 2025, HHHLA donated to Louisiana colleges and universities to offer scholarships, and academic supports continue to expand the pipeline to recruit diverse health and social service professionals including:

• Dillard University- Scholarships for School of Population Health Sciences • Xavier University of Louisiana- Scholarships for Physician's Assistant students
C. Activities expected to be accomplished by December 2025
Between July and December, HHHLA will convene scholarship recipients to understand the impact that scholarships have had on student success. HHHLA is pleased to announce the hosting of a Symposium that will convene representatives from colleges and universities, as well as the Louisiana Workforce Commission. The primary focus of this event will be to address the pressing healthcare shortage currently facing Louisiana. During the Symposium, we will explore collaborative efforts with educational institutions, including the provision of scholarships, participation in career days, and opportunities to engage with students. This initiative aims to foster meaningful discussions on how we can collectively enhance the healthcare workforce in our state.
D. Progress, challenges, and/or delays in achieving measurable objectives and/or milestones thus far in 2025
None anticipated

FOCUS AREA 8: Supporting enrollees through Diverse Community Health Worker, Peer Support Specialist and Doula Programs.

A. Changes to participants, if applicable
Not applicable
B. Activities accomplished between January and June 2025
1. Community Health Workers HHHLA has seven (7) Community Health Workers on staff. The Community Health Workers link members to health and social determinants of health resources. They also attend community outreach events to engage with members. HHHLA partnered with the Louisiana Primary Care Association and PASO to train five bilingual English/Spanish-speaking community health workers to link Spanish-speaking women at FQHCs to health and social determinants of health resources. *2. Peer Support Specialists* HHHLA has two Peer Support Specialists on staff who have experience with mental health and substance use disorders. The HHHLA PSS work with members to link them to mental health, substance use, and social determinants of health resources. Since January, the two PSS have received 23 referrals for support services. *3. Doulas* Since January 2025, 9 HHHLA members received doula services. HHHLA is collaborating with the other MCOs and LMAA to host a session with doulas to explore the opportunities and challenges to reaching more women with doula services.
C. Activities expected to be accomplished by December 2025
Between July- December, to increase access and utilization of doula services, we are working with the other MCOs and LMAA and/or the March of Dimes to host an information session with doulas on how to educate expectant mothers about the availability of doula services, providers about what doulas offer, and simplify the process for doulas to work with MCOs.

D. Progress, challenges, and/or delays in achieving measurable objectives and/or milestones thus far in 2025
None anticipated

FOCUS AREA 9: Reducing Maternal and Child Health Disparities for Black Enrollees and their Newborns

A. Changes to participants, if applicable
None
B. Activities accomplished between January and June 2025
1. HumanaBeginnings Care Management. Humana Healthy Beginnings provides a Nurse care manager during and after pregnancy to provide comprehensive assessment to determine health care needs, offer health education, support to understand health benefits, linkages to care and social determinants of health services, lactation support, family planning information and services, and a free portable crib or car seat, and disaster preparedness support. HHHLA members can enter HumanaBeginnings pregnancy Care Management through self-referrals, Notification of Pregnancy from providers, and/or calling Member Services. HHHLA also provides education about HumanaBeginnings care management program at community events including community baby showers. *2. Go365 Rewards*- Pregnant women and new moms are eligible for Go365 rewards including • $25 in rewards for having one (1) prenatal visit during the first trimester or within 42 days of enrollment • $25 in rewards for having one (1) postpartum visit between seven (7) and 84 days after delivery, once per pregnancy • Up to $120 in rewards for taking infants and toddlers to well-child visits   ○ Members will earn $20 in rewards per well-child visit, up to 6 well-child visits *3. Doula Services*-HHHLA offers doula services as an in-lieu of service. Pregnant members can receive services from a doula, including five (5) prenatal visits, three (3) postpartum visits, and one (1) visit for labor and delivery. HHHLA has an initiative to increase the number of Doulas that are licensed in the state. *4. Linkages to Home Visiting and Community Based Services*- HHHLA partners with community-based organizations to offer access to health education, home visiting, community health workers, and other information resources and supports ○ Family Connects- Home visiting for mothers who deliver at Touro or Ochsner Baptist Hospital in New Orleans ○ Healthy Start- Partner with Healthy Start New Orleans, Family Road of Greater Baton Rouge, and Healthy Start CenLa to link mothers to home visiting, case management, health education, and resources during pregnancy and in the post-partum period ○ Nurse-Family Partnership- Home visiting for first time mothers ○ Parents as Teachers-Home visiting for pregnant women or parenting families with children 36 months and younger.
C. Activities expected to be accomplished by December 2025
Woman's Health Initiative: We will start high risk rounds with staff looking at NOP, NICU admits, and predictive modeling tools.

Possible Potential Pilot: Pomelo Health will conduct a pilot of 100 members over 12 months to augment Obstetrics and Gynecological provider care with virtual care with a team of health professionals.
D. Progress, challenges, and/or delays in achieving measurable objectives and/or milestones thus far in 2025
None Anticipated

FOCUS AREA 10: Improving Child and Adolescent Health

A. Changes to participants, if applicable

None

B. Activities accomplished between January and June 2025

1. *Go365 Campaigns and Benefits*- HHHLA runs direct mail and email campaigns from January-December to encourage well-child visits. In addition, members can earn rewards for completing annual wellness visits as follows:

- Well-child visits 0-15 months up to $120 in rewards
  - Complete 6 well-child visits ($20 in rewards per well-child visit)
- Well-child visits 16-30 months up to $30 in rewards
  - Complete 2 well-child visits ($15 in rewards per well-child visit)
- Well-child visit Ages 3-20 $25 in rewards

2. Community Events

HHHLA also hosts community and member-facing events to increase well-child visits.

Name of Event	Event Date	Region	Parish	Topic
EBR Food Bank -MLK Volunteer Sort & Pack	1/11/2025	2	East Baton Rouge	Volunteer Day
NHS Cafe Meeting	1/15/2025	4	Lafayette	Community Resources
MLK Fest 2025	1/17/2025	2	East Baton Rouge	Marketing; Nutrition
The Rock Family Center Church Community Health Fair	1/18/2025	7	Caddo	Blood Pressure Screenings; A1C screenings; Wellness; Blood Glucose Chec
MLK Day Resource Fair	1/20/2025	7	Caddo	STDs; Oral Hygiene; Blood Pressure Screenings; Wellness; Child Health; Women's Health; Men's Health; Blood Glucose Checks; Community Resour
Blood Drive Event	1/20/2025	4	Saint Landry	Community Resources; Screenings
National Day of Racial Healing Film	1/21/2025	8	Ouachita	Immunizations; Wellness

Screening & Discussion: The Immortal Life of Henrietta Lacks				
National Maternal Health Awareness Day Event	1/23/2025	4	Lafayette	Maternal Health
Maternal Health Summit	1/24/2025	6	Rapides	Maternal Health
CSFP Food Distribution In Lafayette	1/30/2025	4	Lafayette	Food Insecurity
Morehouse General Hospital Health Fair & Blood Drive	2/5/2025	8	Morehouse	Blood Pressure Screenings; A1C screenings; Mental Health; Substance Cholesterol Screenings; Wellness
Silent Powerhouse Sunset Soiree	2/6/2025	1	Orleans	Mental Health; Marketing; Wellness; Women's Health
Blurred Lines: A Clear Vision into Ethics,	2/7/2025	2	East Baton Rouge	Mental Health
Grant Delpit 2025 Community Day Event	2/7/2025	1	Orleans	Immunizations; Blood Pressure Screenings; A1C screenings; Marketing; Child Health; Community Resources
Saturday Family Fiesta: Health and Wellness	2/8/2025	8	Ouachita	Heart Health; Blood Pressure Screenings; Mental Health; Substance Abuse; N Wellness; Child Health; Women's Health; Men's Health; Community Resources
Ouachita Parish Healthy Community Coalition	2/11/2025	8	Ouachita	Wellness; Food Insecurity
I Care Festival	2/14/2025	8	Ouachita	Tobacco Cessation; Mental Health; Substance Abuse; Wellness; Community Resources; Homeless
Pediatric Dental Program	2/14/2025	3	Saint John the Baptist	Fluoride Varnish
Joint Task Force Meeting	2/18/2025	8	Morehouse	Domestic Violence
Community Health &	2/18/2025	3	Terrebonne	Breast Cancer; Colorectal Cancer; Screenings

Resources Event				
Community Baby Shower	2/19/2025	4	Saint Landry	Maternal Health; Marketing
HHH Heart Health: Empowering Lives Through Wellness and Prevention	2/20/2025	4	Vermilion	Nutrition; Community Resources; Screenings
Central Louisiana Vaping Town Hall	2/20/2025	6	Rapides	Tobacco Cessation
Union Parish Community Outreach Meeting	2/21/2025	8	Union	Wellness; Food Insecurity
Moms on a Mission Health & Wellness Fair	2/22/2025	7	Caddo	Blood Pressure Screenings;A1C screenings; Cholesterol Screenings; Wellness
Crisis Response Coalition Meeting	2/26/2025	7	Caddo	Mental Health; Women's Health; Men's Health
Behavioral Healthy Symposium	2/27/2025	2	East Baton Rouge	Mental Health
Kick Off to Nutrition Month: From Heart to Health	2/28/2025	8	Union	Nutrition
12th ICare Prevention Summit	2/28/2025	2	East Baton Rouge	Mental Health
3rd Annual Love Yourself Event	3/8/2025	4	Lafayette	Mental Health; Marketing; Wellness; Women's Health
LDCC Community Resource Fair	3/10/2025	8	Madison	Blood Pressure Screenings; Mental Health; Substance Abuse; Wellness; Community Resources
LDCC Community Resource Fair	3/12/2025	8	Franklin	Blood Pressure Screenings; Mental Health; Substance Abuse; Wellness; Community Resources
Black Wellness Expo	3/15/2025	8	Lincoln	Heart Health; Mental Health; Substance Abuse; Wellness; Women's Men's Health; Community Resources

14th Annual Autism Awareness 5K/Family Fun Day	3/15/2025	3	Saint Mary	Autism
Blurred Lines: A Clear Vision into Ethics	3/15/2025	2	East Baton Rouge	Mental Health
Prevention on the Go	3/17/2025	3	Saint Mary	Breast Cancer; Colorectal Cancer; Skin Cancer
HHH Community Baby Shower	3/17/2025	8	Madison	Maternal Health; Baby Shower
Health & Wellness Fair	3/19/2025	3	Lafourche	STDs; HIV; Blood Pressure Screenings
LDCC Community Resource Fair	3/19/2025	8	Ouachita	Blood Pressure Screenings; Mental Health; Wellness; Community Resources
Louisiana 2025 National Child Passenger Safety Technician Certification Training	3/19/2025	4	Lafayette	Community Resources; Safety
Louisiana 2025 National Child Passenger Safety Technician Certification Training	3/20/2025	4	Lafayette	Safety
Louisiana 2025 National Child Passenger Safety Technician Certification Training	3/21/2025	4	Lafayette	Safety
TRUCE 2025	3/22/2025	8	Franklin	Suicide Prevention; Safety
Louisiana 2025 National Child Passenger Safety Technician	3/22/2025	4	Lafayette	Safety

Certification Training				
HHH Community Baby Shower	3/25/2025	8	Franklin	Maternal Health; Baby Shower
Resilience Development	3/29/2025	7	Caddo	ACEs talk; Opioid
Beneath a Sapphire Sky	3/29/2025	1	Orleans	Child Health
Joint Task Force Meeting	4/1/2025	8	Morehouse	Domestic Violence
HHH Volunteer Opportunity for Community Health Workers	4/3/2025	2	East Baton Rouge	Volunteer Day
Autism Awareness Day	4/5/2025	9	Saint Tammany	Autism
Ouachita Parish Healthy Community Coalition	4/8/2025	8	Ouachita	Wellness; Food Insecurity
LDCC Community Resource Fair	4/9/2025	8	Morehouse	Blood Pressure Screenings; Mental Health; Substance Abuse; Wellness; Community Resources
Joint Task Force Meeting	4/10/2025	8	West Carroll	Domestic Violence
Joint Task Force Meeting	4/14/2025	8	East Carroll	Domestic Violence
Region 8 Community Outreach Team Meeting	4/14/2025	8	Ouachita	Wellness; Food Insecurity
Easter Fest	4/15/2025	7	Caddo	Child Health; Community Resources
IYKYK Healthy Hygiene Habits and Body Positivity Workshop	4/15/2025	4	Lafayette	Oral Hygiene; Marketing; Body Hygiene
LDCC Community Resource Fair	4/15/2025	8	Lincoln	Disaster Preparedness; Blood Pressure Screenings; Mental Health; Substance Abuse; Community Resources
7th Annual Wellness Fair	4/19/2025	9	Saint Tammany	Mental Health; Marketing; Wellness

Youth Leadership Seminar	4/21/2025	4	Evangeline	Marketing; Child Health
LDCC Community Resource Fair	4/22/2025	8	Jackson	Blood Pressure Screenings; Mental Health; Substance Abuse; Wellness; Community Resources
YWCA Lead Program End of Year Celebration	4/23/2025	7	Caddo	Disaster Preparedness; Substance Abuse; Child Health
HHH with Step Forward Youth Mental Health and ACEs training	4/24/2025	7	Caddo	ACEs talk; Mental Health
Northwest Louisiana Technical Community College Counseling Service Health and Resource Fair	4/24/2025	7	Webster	Mental Health; Community Resources
5th Annual Driving out Cancer Golf Tournament	4/25/2025	9	Saint Tammany	Cancer
Special Needs Expo 2025`	4/26/2025	9	Saint Tammany	Mental Health; Autism; Marketing; Wellness; Community Resources
3rd Annual Community Health Fair	4/26/2025	2	East Baton Rouge	Marketing; Wellness
3rd Annual Rosia's Walk and Health Fair	4/26/2025	6	Rapides	Sickle Cell
Live Well Delta	4/26/2025	8	Ouachita	Breast Cancer; Colorectal Cancer; Prostate Screenings
LDCC Community Resource Fair	4/29/2025	8	Ouachita	Blood Pressure Screenings; Mental Health; Substance Abuse; Wellness
Health and Mental Health Advisory Committee Meeting	4/30/2025	4	Lafayette	Mental Health; Marketing

Child Safety Technician Enhancement Training	5/1/2025	4	Lafayette	Community Resources; Safety
The Big Bash 2025	5/1/2025	2	East Baton Rouge	Mental Health; Marketing
HHH /Southern University Nursing School Baby Shower	5/2/2025	2	East Baton Rouge	Nutrition; Wellness
HHH with Step Forward Youth Mental Health and ACEs training	5/2/2025	7	Caddo	ACEs talk; Mental Health
Children's Miracle Network Hospitals	5/3/2025	5	Calcasieu	Child Health
HHH with Step Forward Bouncing Back ACEs talk	5/5/2025	7	Caddo	ACEs talk
Sickle Cell Support Group	5/6/2025	6	Rapides	Sickle Cell
SU AG Center Presents: A Health Fair	5/7/2025	8	Morehouse	Immunizations; Heart Health; Blood Pressure Screenings; A1C screenings; Wellness
2025 Impact Luncheon	5/8/2025	2	East Baton Rouge	Wellness; Women's Health
HHH Ace Education	5/9/2025	1	Orleans	ACEs talk
HHH with Step Forward Youth Mental Health and ACEs training	5/10/2025	7	Caddo	ACEs talk; Mental Health
Women's Health Day & Retreat 2025	5/12/2025	2	East Baton Rouge	Women's Health
Region 8 Community Outreach Team Meeting	5/12/2025	8	Ouachita	Wellness; Food Insecurity
Mental Health & Wellness Fair	5/13/2025	9	Saint Tammany	Mental Health; Wellness

HHH Summer Safety Event	5/13/2025	8	Morehouse	Disaster Preparedness
Ouachita Parish Healthy Community Coalition	5/13/2025	8	Ouachita	Wellness; Food Insecurity
Open Health Mental Health Fair	5/14/2025	2	East Baton Rouge	Mental Health
HHH with Step Forward Youth Mental Health and ACEs training	5/14/2025	7	Caddo	ACEs talk; Mental Health
Union Parish Community Outreach Meeting	5/16/2025	8	Union	Wellness; Food Insecurity
HHH Mental Health & Blood Pressure Event	5/20/2025	4	Lafayette	Blood Pressure Screenings; Cholesterol Screenings; Community Resources
Avoyelles Community and Youth Coalition Meeting	5/20/2025	6	Avoyelles	Wellness; Food Insecurity
HHH Community Baby Shower	5/21/2025	4	Vermilion	Maternal Health; Mental Health; Marketing
Drug Awareness Day	5/23/2025	7	Caddo	Blood Pressure Screenings; A1C screenings; Substance Abuse; Opioid
5th Annual Bridging the Gap Community Resource Fair	5/23/2025	2	East Baton Rouge	Mental Health
HHH Colon Health Matters; Get Screening	5/27/2025	2	East Baton Rouge	Colorectal Screening
Med Camps Volunteer	5/28/2025	8	Lincoln	Marketing; Volunteer Day
Crisis Response Coalition Meeting	5/28/2025	7	Caddo	Mental Health; Women's Health; Men's Health

HHH "Healthy Childhood, Healthy Future"	5/31/2025	6	Rapides	Immunizations; Mental Health; Nutrition; Childhood Obesity; Child Health
Motherhood Wounds: Hope for Healing Summit	5/31/2025	8	Ouachita	Maternal Health; Mental Health

C. Activities expected to be accomplished by December 2025
1. Go 365 Campaigns- Between July and October, HHHLA runs an additional email and direct mail campaign to encourage well-child visits and immunizations. *2. Community Events*-We continue to partner with community-based organizations and provider groups to increase access to well-child visits and immunizations.
D. Progress, challenges, and/or delays in achieving measurable objectives and/or milestones thus far in 2025
None anticipated

Cultural Responsiveness and Implicit Bias Training

2. **Cultural Responsiveness and Implicit Bias Training.** 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

1. *HHHLA Associate Training*

Humana Healthy Horizons in Louisiana partnered with Rhodes College Institute for Equity and Public Scholarship (Rhodes College) to provide training on cultural responsiveness and implicit bias for all HHHLA associates and network providers. Rhodes College aims to produce measurable reductions in the clinical determinants of health disparities through deep awareness of the social determinants and health disparities.

The learning objectives for this curriculum include:

1. Understand how and why unjust social conditions cause illness and disease for stigmatized populations.
2. Be able to identify and intervene in their own practice and with colleagues when bias leads to unequal care.
3. Learn to practice equity-oriented, person-centered care that helps individuals seeking clinical services feel valued and welcome.
4. Learn how policy affects health and how to be an effective advocate for better policies.

From January- June 2025, 7 additional Humana Healthy Horizon Louisiana Medicaid Associates have completed one or both two-part training series: "Justice is Part of the Job," and "Bias and the Promise of Equitable, Person-Centered Care," Health Equity Educational offerings. To date, all HHHLA Medicaid Associates have completed the training.

Following part one of the training HHHLA associates completed a survey which consisted of nine questions to evaluate the effectiveness of the videos, curriculum, exercises, and live group discussions to measure their understanding and commitment of health equity concepts. The survey of nine Likert scale questions received 73 responses in total. For all questions, somewhere between 96% and 99% of respondents chose "agree" or "strongly agree," which provided a strong indication that the training was well received.

Humana also offers a Health Equity Basics course to all Humana employees. This course will address the need to increase awareness of basic health equity concepts, empowering Humana associates/clinicians to demonstrate Humana's Health First principle of Healthy Customer by providing the right care to our most vulnerable populations. In addition, providing baseline knowledge of health equity to associates is a crucial step towards Humana's Health Equity mission to establish health equity as a key business and culture driver and embed it into Humana products, services and partnerships to improve health outcomes of communities, associates and members, and enable our providers to deliver optimal care.

Learning Objectives:
* Define health equity
* Discuss how health equity matters and how it translates into our current healthcare system
* Recognize the factors that affect a person's health
* Describe who is most impacted by health inequities
* Recognize key factors that lead to health inequities
* Outline some actions to take to address health inequities
* Post-Test/Course Evaluation

2. Provider Training

HHHLA has partnered with Healthy Blue, Louisiana Health Care Connections, and United HealthCare to offer a three-part Health Equity education series online on-demand to Medicaid providers through Trusted Provider Network (TPN). HHHLA is encouraging providers in our network to complete at least one part of the three-part video series by 12/31/2025. To date, 3 Network providers have completed at least one Health Equity Education course since January 2025.

HHHLA in partnership with TPN, United HealthCare and Louisiana Healthcare Connections is also providing the following Provider Trainings:

"Using Ethics to Dismantle Cultural Encapsulation for Healthcare Professionals" Friday, June 13, 2025 (1 Continuing Education Hours) The goal of this workshop is to provide attendees with an understanding of thoughts and behaviors that may align with cultural encapsulation and to give them effective strategies to apply an ethical and culturally competent foundation to their work as healthcare professionals. This course will provide a guide for culturally competent work in the healthcare profession. An explanation of cultural encapsulation will be provided, along with a thorough discussion and application of the areas of cultural competence related to racism, sexism, classism, heterosexism, ageism, ableism, and spiritual/religious bias. Foundational ethical principles will be reviewed to outline the ethical responsibilities associated with providing culturally competent care to patients in the healthcare profession.

"The Policy Roots of Health Inequities: Understanding Social Determinants of Health" Monday June 23, 2025 (1 Continuing Education Hour) This workshop aims to provide attendees with a thorough understanding of how both historical and contemporary policies have influenced the social determinants of health (SDOH), leading to systemic inequalities in health outcomes. Participants will learn to assess the role of policies across various sectors critically, recognize their effects on marginalized communities, and explore actionable strategies for reform to promote health equity. This workshop will explore how social and economic policies have influenced the conditions in which people live, work, and age—conditions that directly affect health outcomes. By examining historical and contemporary policies, the session will highlight how systemic

inequities in housing, education, and employment have contributed to health disparities. Attendees will gain a deeper understanding of how policy decisions shape the social determinants of health, perpetuate inequities, and explore opportunities for reform that promote health equity.

Humana also offers annual Medicaid Provider Compliance Training. To date, 12 Medicaid Provider groups have completed Humana Cultural Competency Training.

B. Additional trainings expected to be conducted by December 2025

Humana Healthy Horizons in Louisiana will continue to work with TPN, the other MCOs and health systems across the state of Louisiana to strongly encourage participation in Health Equity/cultural competency education. They will provide additional in person and on demand cultural competency training throughout the year.

C. Modifications the MCO has made or intends to make to training content, format, etc. based on participant feedback and lessons learned to date

Based on the results from the associate and provider satisfaction surveys from the Health Equity education, we do not believe we need to make any substantial changes now.

D. Is the MCO on track to meet training goals set in the MCO's Health Equity Plan? If not, please describe why not.

Per Section 2.2.2.7.2 of the MCO Model Contract, HHHLA is on track to provide initial and ongoing staff training that includes an overview of contractual, state and federal requirements specific to individual job functions. HHHLA will also ensure that all staff members having contact with members or providers receive initial and ongoing training on health equity and social determinants of health, beyond Culturally and Linguistically Appropriate Services (CLAS) requirements and with regard to the appropriate identification and handling of quality-of-care concerns.

Since health equity education beyond CLAS standards is encouraged but not required for providers, it is challenging to increase participation in the training among providers.

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 CY 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)

Stratify MCO Results on Attachment H Measures

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Healthy Humana Horizons in Louisiana has attached the following data in response to question 3a: MY 2024 HEDIS and Non-HEDIS Race/Ethnicity and Rural/Urban Template.

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.

HHHLA is working with our Medicaid Clinical Analysis and Evaluation team to understand our baseline data for measures from Attachment H and stratify those measures by race, ethnicity, language, disability status, geography, and gender.

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.

HHHLA is collaborating with our Member Services Team to collect and verify more comprehensive race, ethnicity, language, disability status, gender and geography data as members call in to our call center for other support and as we make outbound welcome calls to new members. Currently, 40% of the demographic information we receive from 834 files is missing and we are working to close the gap on that information.

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

To date, one of the barriers to implementing our Health Equity plan is getting buy-in from in-network providers to complete health equity to receive initial and ongoing training on health equity and social determinants of health, beyond Culturally and Linguistically Appropriate Services (CLAS) requirements and with regard to the appropriate identification and handling of quality-of-care concerns. While training is strongly encouraged, it is not required for Network Providers. HHHLA along with our MCO partners at Louisiana Health Care Connections, United HealthCare, and Healthy Blue are committed to offering free CMEs on health equity beyond CLAS standards in partnership with TPN. However, the training is not required for providers who accept Medicaid.