LOUISIANA DEPARTMENT OF HEALTH

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

External Quality Review Technical Report

Aggregate Report for the Healthy Louisiana Managed Care Organizations

March 2026

HSAG HEALTH SERVICES ADVISORY GROUP

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Introduction

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

The Louisiana Medicaid Managed Care Program

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

The current MCE contracts are full-risk capitated Louisiana Medicaid managed care contracts. Under the authority of a 1915(b) waiver from the Centers for Medicare & Medicaid Services (CMS), LDH contracts with six Healthy Louisiana MCOs to provide physical and behavioral health care and two dental PAHPs to provide dental services for Louisiana's Medicaid and CHIP members. Additionally, under the authority of a 1915(b)/1915(c) waiver from CMS, OBH contracts with a single behavioral

[1] Centers for Medicare & Medicaid Services. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, May 6, 2016. Available at: https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered. Accessed on: Jan 14, 2026.

[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: Jan 14, 2026.

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: Jan 14, 2026.

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, 2023–March 19, 2024, November 2024. Louisiana Department of Health. Available at: https://ldh.la.gov/assets/docs/MQI/Strategy/MQIStrategyEvaluation.pdf. Accessed on: Jan 14, 2026.

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 aggregated results of all EQR-related activities for six of the MCEs that serve as Louisiana Medicaid's MCOs conducted with the Louisiana Medicaid managed care program throughout SFY 2025.

Validation of Performance Improvement Projects

The MCOs 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 the MCOs 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 the MCOs' performance measures confirmed compliance with the standards of 42 CFR §438.330(a)(1). The results of the validation activity determined that each MCO 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 each MCO's independent certified HEDIS compliance auditor, HSAG found that all MCOs were determined to be fully compliant with all four of the applicable NCQA information systems (IS) standards and produced HEDIS rates that were reportable to NCQA.

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 comparison 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 and percentage rates, LHCC demonstrated the highest performance with 78 indicators performing greater than the NCQA national 50th percentile benchmark, and with ABH also demonstrating higher performance with 67 indicators performing greater than the NCQA national 50th percentile benchmark. HUM had the most indicators that performed lower than the NCQA national 50th percentile benchmark (69 indicators). 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 MCEs 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	ABH CY 2024	ACLA CY 2024	HBL CY 2024	HUM CY 2024	LHCC CY 2024	UHC CY 2024	MCO Average Results
I	Enrollment and Disenrollment Requirements and Limitations	100%	100%	100%	33%	100%	78%	85%
II	Member Rights and Confidentiality	100%	96%	96%	100%	100%	100%	99%
III	Member Information	67%	67%	67%	72%	67%	72%	69%
IV	Emergency and Poststabilization Services	100%	100%	92%	100%	100%	100%	99%
V	Adequate Capacity and Availability of Services	71%	64%	57%	43%	60%	14%	52%
VI	Coordination and Continuity of Care	92%	83%	83%	83%	92%	75%	85%
VII	Coverage and Authorization of Services	100%	100%	100%	95%	100%	62%	93%
VIII	Provider Selection	32%	79%	89%	68%	84%	63%	70%
IX	Subcontractual Relationships and Delegation	50%	67%	50%	67%	67%	83%	64%
X	Practice Guidelines	100%	100%	100%	100%	100%	83%	97%
XI	Health Information Systems	100%	100%	100%	100%	100%	78%	96%
XII	Quality Assessment and Performance Improvement	100%	100%	100%	100%	100%	100%	100%
XIII	Grievance and Appeal Systems	97%	86%	86%	84%	100%	84%	90%
XIV	Program Integrity	100%	100%	100%	100%	94%	89%	97%
Total Compliance Score		**87%**	**88%**	**89%**	**83%**	**91%**	**77%**	

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 the MCOs showed a low level of agreement between the MCOs' online provider directories and the information obtained during the telephone calls to the providers' offices. Table 1-5 provides a summary of the aggregate Q1 and Q2 findings from the study.

Table 1-5—Summary of PDV Findings

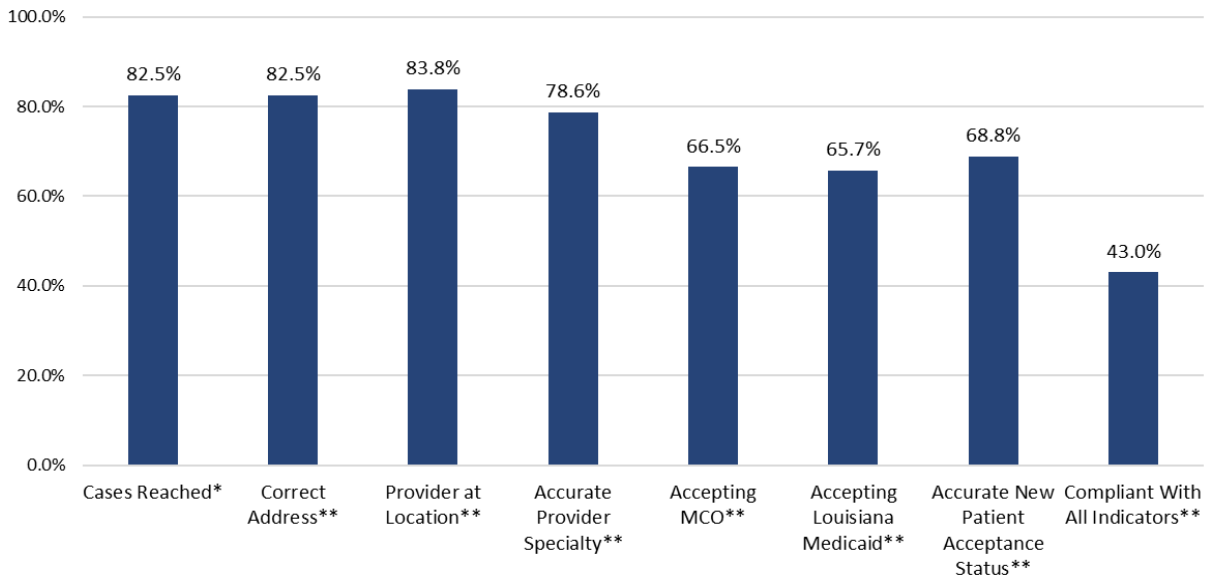
Concerns	Findings
Acceptance of Louisiana Medicaid was low.	Overall, 65.7 percent of providers accepted Louisiana Medicaid.
Acceptance of the MCO was low.	Overall, 66.5 percent of providers accepted the requested MCO.
Overall accuracy of the new patient acceptance status was low.[1]	Overall, 68.8 percent of providers confirmed the new patient acceptance status in the online provider directory was correct.
Specialty provider type was incorrect in the provider directory.	Overall, 78.6 percent of providers confirmed the specialty listed in the online directory was accurate.
Address information was inaccurate.	Overall, 82.5 percent of locations confirmed the address listed in the online directory was accurate.
Affiliation with the sampled provider was low.	Overall, 83.8 percent of the locations confirmed affiliation with the sampled provider.

[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.

The overall response rate was 82.5 percent, and once contacted, the offices reported varying degrees of match rates for the online provider directory information. The accuracy of Louisiana Medicaid acceptance, MCO acceptance, and new patient acceptance status exhibited the lowest match rates. Overall, only 43.0 percent of providers were compliant with all indicators. All match rates are dependent on the rate of exact matches as confirmed by the office representative.

Figure 1-1 presents the aggregate Q1 and Q2 summary results for all sampled providers and the percentage compliant with all PDV indicators.

Figure 1-1—Summary Results for All Sampled Providers



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

Table 1-6 presents the aggregate Q1 and Q2 weighted PDV compliance scores by MCO. Please see the NAV Methodology for the weighted compliance score calculation criteria.

Table 1-6—PDV Weighted Compliance Scores

MCO	Total	Compliant[1]	Weighted Compliance Score
ABH	250	43	23.1%
ACLA	250	116	52.3%
HBL	250	97	44.5%
HUM	250	90	41.1%
LHCC	250	103	46.5%
UHC	250	121	50.8%
Total	**1,500**	**570**	**43.0%**

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

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 the MCOs showed a low level of agreement between the MCOs' provider data and the information obtained during the telephone calls to the providers' offices. Table 1-7 provides a summary of the findings from the study.

Table 1-7—Summary of Provider Access Survey Findings

Concerns	Findings
Contact information was inaccurate.	Overall, 6.9 percent of the sampled telephone numbers reached a location that was not a medical facility, 4.4 percent were disconnected, and 0.8 percent reached a fax machine.
Affiliation with the sampled provider was low.	Overall, 43.9 percent of the locations confirmed affiliation with the sampled provider.
Acceptance of new patients was low.	Overall, 54.4 percent of providers accepted new patients; however, only providers listed as accepting new patients in the provider data were selected for the survey sample.
Acceptance of Louisiana Medicaid was low.	Overall, 55.8 percent of providers accepted Louisiana Medicaid.
Acceptance of the MCO was low.	Overall, 56.3 percent of providers accepted the requested MCO.
Appointment availability was low.	Overall, 22.4 percent of locations offered an appointment. Orthopedic surgeon visits resulted in the lowest rate of appointments offered at 15.5 percent. Overall, 63.9 percent of appointments were within the compliance standard.
Average appointment wait times are outside LDH's contract standard of 30 calendar days.	Overall, the average wait time to an appointment was 53 calendar days. Dermatologist visits exhibited the longest wait times at 105 calendar days.
Overall compliance rates were low.	Overall, the weighted compliance score was 42.4 percent. Orthopedic surgeons exhibited the lowest compliance score at 38.3 percent. Among the MCOs, HBL exhibited the lowest compliance score at 32.5 percent.

Table 1-8 presents the first provider access survey call outcomes.

Table 1-8—Provider Access Survey Call Outcomes

Specialty Provider Type	Able to Contact[1]	Correct Address[2]	Offering Services[2]	Accepting MCO[2]	Accepting Medicaid[2]	Accepting New Patients[2]	Confirmed Provider[2]	Offered Appointment[2]
Allergists	85.6%	94.1%	85.1%	75.2%	74.3%	72.3%	52.5%	29.7%
Dermatologists	80.3%	95.1%	87.3%	53.9%	53.9%	52.0%	45.1%	26.5%
Orthopedic Surgeons	71.8%	93.5%	73.8%	46.4%	45.8%	45.2%	38.1%	15.5%
Total	**77.5%**	**94.1%**	**80.6%**	**56.3%**	**55.8%**	**54.4%**	**43.9%**	**22.4%**

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

Table 1-9 and Table 1-10 present the first provider access survey weighted compliance scores by specialty provider type and MCO, respectively.

Table 1-9—Provider Access Survey Weighted Compliance Scores by Specialty Provider Type

Specialty Provider Type	Total Number of Providers Surveyed	Compliant[1]	Weighted Compliance Score[2]
Allergists	118	52	51.4%
Dermatologists	127	46	41.7%
Orthopedic Surgeons	234	64	38.3%
Total	**479**	**162**	**42.4%**

[1] Compliant providers include providers for which all indicators match between the MCO provider data 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 5-10 and Table 5-11 of the Methodology section were used to calculate the weight of each noncompliance survey outcome.

Table 1-10—Provider Access Survey Weighted Compliance Scores by MCO

MCO	Total Number of Providers Surveyed	Compliant[1]	Weighted Compliance Score[2]
ABH	78	11	42.3%
ACLA	86	48	58.5%
HBL	82	24	32.5%
HUM	67	21	44.3%

MCO	Total Number of Providers Surveyed	Compliant[1]	Weighted Compliance Score[2]
LHCC	88	29	34.8%
UHC	78	29	42.3%
Total	**479**	**162**	**42.4%**

[1] Compliant providers include providers for which all indicators match between the MCO provider data 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 5-10 and Table 5-11 of the Methodology section were used to calculate the weight of each noncompliance survey outcome.

NAV Audit

HSAG assessed the MCOs' provider-to-member ratios and determined that all MCOs met or exceeded LDH-established thresholds across all provider types.

HSAG assessed the MCOs' submitted distance report results and noted that for several provider types, there was a notable difference between one or two MCOs and the remaining MCOs for the reported percentage of member access. Table 1-11 lists the MCO or MCOs that had at least a 25-point difference in member access, by provider type and urbanicity, as compared to the next closest MCO's member access.

Table 1-11—MCOs With a 25-Point or Greater Deficit of Member Access Compared to the Next Highest MCO's Level of Member Access, by Provider Type and Urbanicity

Provider Type	Urbanicity	MCO and Member Access Percentage	Next Highest MCO and Percentage of Member Access
Laboratory	Rural	ABH (44.4%)	HUM (86.8%)
Pharmacy	Urban	HUM (18.9%)	HBL (95.7%)
	Rural	HUM (50.8%)	HBL (99.9%)
Hemodialysis Centers	Urban	HBL (0.0%)	ABH (89.5%)
	Rural	HBL (5.1%)	ABH (95.2%)
Endocrinology and Metabolism (Pediatric)	Rural	UHC (65.6%)	ABH (99.1%)
Neurology (Pediatric)	Urban	UHC (0.0%)	ABH, ACLA, HUM, LHCC (99.9%)
	Rural	UHC (0.0%)	LHCC (97.7%)

Provider Type	Urbanicity	MCO and Member Access Percentage	Next Highest MCO and Percentage of Member Access
Physicians and licensed mental health practitioners (LMHPs) who specialize in pregnancy-related and postpartum substance use disorders (SUD)	Urban	HBL (8.2%)	ACLA (79.5%)
	Rural	ACLA (34.6%) HBL (13.1%)	LHCC (80.9%)
American Society of Addiction Medicine (ASAM) Level 1	Urban	HBL (53.6%)	HUM (88.5%)
	Rural	HBL (8.7%) HUM (45.5%)	ACLA (92.8%)
ASAM Level 2.1	Urban	HBL (45.9%)	ACLA (86.6%)
	Rural	HBL (3.3%) HUM (45.1%)	ACLA (81.8%)
ASAM Level 2 Withdrawal Management (WM)	Urban	HBL (0.0%)	ACLA (75.8%)
	Rural	HBL (0.0%) HUM (3.2%)	UHC (69.3%)
ASAM Level 3.1 (Pediatric under age 21)	All	HBL (35.7%)	UHC (80.5%)
ASAM Level 3.2 WM (Adult over age 21)	Urban	HBL (38.8%)	UHC (65.7%)
ASAM Level 3.5 (Pediatric under age 21)	All	HBL (12.5%)	HUM (95.7%)
ASAM Level 3.7 (Adult over age 21)	Rural	HBL (69.2%) HUM (72.9%)	LHCC (92.8%)
ASAM Level 3.7 WM (Adult over age 21)	Urban	HBL (65.8%)	ABH (94.1%)
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)	Rural	HBL (45.2%)	ABH (94.7%)

HSAG assessed the appointment timeliness standards and determined that for the three behavioral health indicators reported to LDH through the LA 359 report template, one MCO, ABH, met all three of the required compliance rates for the three timeliness standards, and one MCO, ACLA, met none. Table 1-12 displays each behavioral health provider access and timeliness indicator by visit type and the MCOs that met the specific indicator.

Table 1-12—MCOs That Met Behavioral Health Provider Access and Timeliness Goals, by Indicator

Type of Visit	Access/Timeliness Standard	MCOs That Met Performance Goal
Emergency Care	24 hours, 7 days/week within 1 hour of request	ABH, HUM
Urgent Non-Emergency Behavioral Health Care	48 hours (2 calendar days)	ABH
Non-Urgent Routine Behavioral Health Care	14 calendar days	ABH, HBL, LHCC, UHC

Encounter Data Validation

Information Systems Review

The IS review provides self-reported qualitative information from the MCOs about their encounter data processes. Table 1-13 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. In addition, cells with both "✓" and "X" indicate that there was a strength for at least one category of service, as well as a weakness for at least one category of service. For detailed descriptions about the strengths and weaknesses, refer to Section 6—Encounter Data Validation.

Table 1-13—Summary of Strengths and Weaknesses From IS Review

IS Review	ABH	ACLA	HBL	HUM	LHCC	UHC
Encounter Data Sources and Systems	—	—	—	—	—	—
Payment Structures	—	—	—	—	—	—
Encounter Data Quality Monitoring						
Processes for Encounters Collected by Subcontractors	✓	✓	✓ X	✓ X	X	✓ X
Quality Monitoring on Encounters Collected by Subcontractors	✓	✓	✓ X	X	✓ X	✓ X
Quality Monitoring on Encounters Collected by MCOs	—	X	—	✓	X	✓
% of Encounters Initially Rejected and Not Yet Accepted by LDH	✓ X	✓	✓ X	✓ X	✓ X	✓ X

Administrative Profile

The administrative profile analyzes LDH's encounter data 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 1-14 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 1-14—Summary of Strengths and Weaknesses From Administrative Profile

Administrative Profile	Encounter Type	ABH	ACLA	HBL	HUM	LHCC	UHC
Encounter Data Completeness							
Monthly Encounter Volume per 1,000 MM	All	—	—*	—	—	—	—
Monthly Payment Amount PMPM	All	—	—*	—	—	—	—
TPL Payment Amount PMPM	All	—	—*	—	—	—	—
% of Duplicate Encounters	Professional	✓	✓	✓	✓	✓	✓
	Institutional	✓	✓	✓	✓	✓	✓
	Dental	✓	*	X	—	X	✓
	Pharmacy	✓	✓	✓	✓	✓	✓
Encounter Data Timeliness							
Lag Between MCE Payment Date and Received Date by LDH	Professional	—	✓	X	X	—	✓
	Institutional	—	—	X	X	X	—
	Dental	✓	*	—	X	X	✓
	Pharmacy	✓	✓	—	—	✓	✓
Field-Level Completeness and Accuracy							
% Present	Professional	—	—	—	—	—	—
	Institutional	—	—	—	—	—	—
	Dental	X	*	—	X	X	—
	Pharmacy	—	—	—	—	—	—
% Valid	Professional	X	X	X	X	X	X
	Institutional	✓	✓	✓	✓	X	X
	Dental	X	*	X	X	✓	✓
	Pharmacy	X	✓	X	X	X	✓
Encounter Referential Integrity							
Encounter vs Enrollment	All	—	—*	—	—	—	—
Medical/Dental vs Pharmacy Encounter	All	—	—*	—	—	—	—
Encounter vs Provider	Medical/Dental	X	—*	X	—	—	—
	Pharmacy	X	X	X	X	X	✓

Administrative Profile	Encounter Type	ABH	ACLA	HBL	HUM	LHCC	UHC
Encounter Data Logic							
% of Members Who Had an Encounter	All	—	—	—	—	—	—
Member Enrollment Continuity	Not Applicable	—	—	—	—	—	—

MM = Member Months; PMPM = Per Member Per Month, TPL = Third Party Liability
*ACLA had no dental encounters with dates of service in 2023 in LDH's data warehouse

Consumer Surveys: CAHPS-A and CAHPS-C

HSAG compared the 2025 Healthy Louisiana statewide average (SWA) achievement scores to its corresponding 2024 achievement scores and the 2025 NCQA national averages to determine whether there were statistically significant differences.

Overall, the 2025 Healthy Louisiana SWA adult achievement score was statistically significantly higher than the 2025 NCQA adult Medicaid national average for *Rating of All Health Care*. Additionally, the 2025 Healthy Louisiana SWA general child achievement scores were statistically significantly higher than the 2025 NCQA child Medicaid national averages for *Getting Needed Care* and *Getting Care Quickly*.

Behavioral Health Member Satisfaction Survey

HSAG compared the 2025 Healthy Louisiana SWA achievement scores to the corresponding 2024 scores to determine whether there were statistically significant differences. Overall, the 2025 Healthy Louisiana SWA adult and child achievement scores were not statistically significantly higher or lower than the 2024 achievement scores; therefore, no strengths or opportunities for improvement were identified.

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

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

Case Management Performance Evaluation

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

The MCOs demonstrated an opportunity for improvement with elements related to ongoing scheduled CM activities. Specific findings and recommended actions were provided to the MCOs through HSAG's

CAP process. The MCOs successfully completed remediation actions to address the CAP findings, and the CAPs were closed in October 2024.

HSAG will assess the MCOs' 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, for the Overall Rating, five of the six MCOs (ABH, ACLA, HBL, LHCC, and UHC) earned 4.0 stars, while HUM earned 3.5 stars. Performance was highest within the Patient Experience composite, with most MCOs earning 4.0 stars or more. Performance was lowest within the Treatment composite, with no MCOs earning a rating higher than 3.5 stars.

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

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

Aggregate Results

SFY 2025 (review period) was the third year that HSAG was contracted as the EQRO for LDH. LDH required the MCOs 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 each MCO.

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	• Not applicable
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, the MCOs collaborated on improvement strategies, meeting at least quarterly with LDH, throughout the year. The MCOs 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 the MCOs 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 meeting 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, the MCOs will submit the 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 the MCOs' final PIP validation results and confidence ratings delivered by HSAG in April 2025.

Table 2-3—SFY 2025 PIP Validation Results for Each MCO

MCO	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]
ABH	*Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees*	92%	88%	*Low Confidence*	*Not Assessed*[4]		

MCO	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]
	Behavioral Health Transitions of Care	93%	100%	*High Confidence*	75%	100%	*Moderate Confidence*
	Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	93%	100%	*High Confidence*	67%	100%	*Moderate Confidence*
	Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	86%	78%	*Low Confidence*	100%	100%	*High Confidence*
	Screening for HIV Infection	93%	100%	*High Confidence*	33%	100%	*Moderate Confidence*
ACLA	*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*	25%	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*	33%	100%	*Moderate Confidence*

MCO	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]
HBL	*Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees*	92%	88%	*Low Confidence*	*Not Assessed*[4]		
	Behavioral Health Transitions of Care	71%	78%	*Low Confidence*	100%	100%	*High Confidence*
	Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	100%	100%	*High Confidence*	33%	100%	*No Confidence*
	Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	100%	100%	*High Confidence*	100%	100%	*High Confidence*
	Screening for HIV Infection	100%	100%	*High Confidence*	33%	100%	*Moderate Confidence*
HUM	*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	100%	100%	*High Confidence*	100%	100%	*High Confidence*

MCO	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]
	Rates Among Healthy Louisiana Enrollees						
	Screening for HIV Infection	100%	100%	*High Confidence*	100%	100%	*High Confidence*
LHCC	*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*	50%	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*	33%	100%	*Moderate Confidence*
UHC	*Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees*	83%	88%	*Low Confidence*	*Not Assessed*[4]		
	Behavioral Health Transitions of Care	100%	100%	*High Confidence*	33%	100%	*Low Confidence*
	Fluoride Varnish Application to Primary	100%	100%	*High Confidence*	67%	100%	*Moderate Confidence*

MCO	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]
	Teeth of Enrollees Aged 6 Months to 5 Years						
	Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	100%	100%	*High Confidence*	100%	100%	*High Confidence*
	Screening for HIV Infection	100%	100%	*High Confidence*	33%	100%	*Moderate Confidence*

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

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

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

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

Performance Indicator Results

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

For Table 2-4 through Table 2-33, gray shaded cells with an — represent data that will be updated for future remeasurement years, and green shaded cells with a + represent any improvement over the baseline results.

Table 2-4—Performance Indicator Results for ABH'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: 2,228 D: 2,559	87.07%	— —	—	— —	—	*Not Assessed*
Syphilis screening during weeks 28 to 32 of pregnancy.	N: 759 D: 2,342	32.41%	— —	—	— —	—	*Not Assessed*
*Syphilis screening at delivery.**	N: 3 D: 2,560	0.12%	— —	—	— —	—	*Not Assessed*
Syphilis screening at any time during pregnancy or at delivery.	N: 2,228 D: 2,560	87.03%	— —	—	— —	—	*Not Assessed*
Syphilis screening during the first trimester.	N: 1,533 D: 2,080	73.70%	— —	—	— —	—	*Not Assessed*
Syphilis screening during the first trimester for all live births.	N: 1,533 D: 2,560	59.88%	— —	—	— —	—	*Not Assessed*
Syphilis screening during the third trimester for all live births.	N: 1,684 D: 2,557	65.86%	— —	—	— —	—	*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 ACLA's *Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees* PIP.

Table 2-5—Performance Indicator Results for ACLA'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: 740 D: 1,467	50.44%	— —	—	— —	—	*Not Assessed*
Syphilis screening during weeks 28 to 32 of pregnancy.	N: 476 D: 967	49.22%	— —	—	— —	—	*Not Assessed*
*Syphilis screening at delivery.**	N: 10 D: 1,570	0.64%	— —	—	— —	—	*Not Assessed*
Syphilis screening at any time during pregnancy or at delivery.	N: 1,472 D: 1,570	93.76%	— —	—	— —	—	*Not Assessed*
Syphilis screening during the first trimester.	N: 365 D: 971	37.59%	— —	—	— —	—	*Not Assessed*
Syphilis screening during the first trimester for all live births.	N: 468 D: 1,570	29.81%	— —	—	— —	—	*Not Assessed*
Syphilis screening during the third trimester for all live births.	N: 449 D: 1,570	28.60%	— —	—	— —	—	*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 2-6 displays data for HBL's *Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees* PIP.

Table 2-6—Performance Indicator Results for HBL's *Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees* PIP

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

N–Numerator D–Denominator

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

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

Table 2-7 displays data for HUM's *Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees* PIP.

Table 2-7—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 2-8 displays data for LHCC's *Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees* PIP.

Table 2-8—Performance Indicator Results for LHCC'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: 1,894 D: 8,377	22.61%	— —	—	— —	—	*Not Assessed*
Syphilis screening during weeks 28 to 32 of pregnancy.	N: 2,575 D: 6,067	42.44%	— —	—	— —	—	*Not Assessed*
*Syphilis screening at delivery.**	N: 20 D: 8,384	0.24%	— —	—	— —	—	*Not Assessed*
Syphilis screening at any time during pregnancy or at delivery.	N: 7,555 D: 8,384	90.11%	— —	—	— —	—	*Not Assessed*
Syphilis screening during the first trimester.	N: 4,597 D: 5,700	80.65%	— —	—	— —	—	*Not Assessed*
Syphilis screening during the first trimester for all live births.	N: 4,599 D: 8,384	54.85%	— —	—	— —	—	*Not Assessed*
Syphilis screening during the third trimester for all live births.	N: 4,483 D: 8,384	53.47%	— —	—	— —	—	*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 2-9 displays data for UHC's *Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees* PIP.

Table 2-9—Performance Indicator Results for UHC'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: 805 D: 3,895	20.67%	— —	—	— —	—	*Not Assessed*
Syphilis screening during weeks 28 to 32 of pregnancy.	N: 34 D: 63	53.97%	— —	—	— —	—	*Not Assessed*
*Syphilis screening at delivery.**	N: 7 D: 4,786	0.15%^	— —	—	— —	—	*Not Assessed*
Syphilis screening at any time during pregnancy or at delivery.	N: 3,318 D: 4,786	69.33%	— —	—	— —	—	*Not Assessed*
Syphilis screening during the first trimester.	N: 1,776 D: 3,422	51.90%	— —	—	— —	—	*Not Assessed*
Syphilis screening during the first trimester for all live births.	N: 2,107 D: 4,786	44.02%	— —	—	— —	—	*Not Assessed*
Syphilis screening during the third trimester for all live births.	N: 1,491 D: 5,199	28.68%	— —	—	— —	—	*Not Assessed*

N–Numerator D–Denominator

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

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

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

Table 2-10 displays data for ABH's *Behavioral Health Transitions of Care* PIP.

Table 2-10—Performance Indicator Results for ABH's *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: 469 D: 2,845	16.49%	N: 567 D: 3,162	17.93%+	N: 636 D: 3,245	19.60%+ ▲	*Not Assessed*
Follow-Up After Hospitalization for Mental Illness (FUH)—Total, 30 Days	N: 968 D: 2,845	34.02%	N: 1,132 D: 3,162	35.80%+	N: 1,287 D: 3,245	39.66%+ ▲	*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 7 Days	N: 85 D: 451	18.85%	N: 117 D: 585	20.00%+	N: 102 D: 483	21.12%+	*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 30 Days	N: 141 D: 451	31.26%	N: 190 D: 585	32.48%+	N: 170 D: 483	35.20%+	*Not Assessed*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 7 Days	N: 115 D: 903	12.74%	N: 291 D: 1,312	22.18%+ ▲	N: 155 D: 903	17.17%+ ▲	Yes
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 30 Days	N: 166 D: 903	18.38%	N: 431 D: 1,312	32.85%+ ▲	N: 257 D: 903	28.46%+ ▲	Yes

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 2-11 displays data for ACLA's *Behavioral Health Transitions of Care* PIP.

Table 2-11—Performance Indicator Results for ACLA's *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: 715 D: 4,053	17.64%	N: 741 D: 3,790	19.55%+▲	N: 610 D: 3,250	18.77%+	*No*
Follow-Up After Hospitalization for Mental Illness (FUH)—Total, 30 Days	N: 1,389 D: 4,053	34.27%	N: 1,408 D: 3,790	37.15%+▲	N: 1,280 D: 3,250	39.38%+ ▲	*Yes*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 7 Days	N: 159 D: 722	22.02%	N: 117 D: 565	20.71%	N: 97 D: 478	20.29%	*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 30 Days	N: 243 D: 722	33.66%	N: 179 D: 565	31.68%	N: 167 D: 478	34.94%+	*Not Assessed*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 7 Days	N: 252 D: 1,469	17.15%	N: 141 D: 1,158	12.18%	N: 123 D: 848	14.50%	*Not Assessed*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 30 Days	N: 424 D: 1,469	28.86%	N: 230 D: 1,158	19.86%	N: 215 D: 848	25.35%	*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 2-12 displays data for HBL's *Behavioral Health Transitions of Care* PIP.

Table 2-12—Performance Indicator Results for HBL's *Behavioral Health Transitions of Care* PIP

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

N–Numerator D–Denominator
▲ Designates a statistically significant improvement over baseline results ($p < 0.05$).
*Percentage was calculated from the MCO's reported numerator and denominator. The MCO's reported baseline percentage could not be replicated using the reported numerator and denominator values.
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation activities, which occurred between January and March of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-13 displays data for HUM's *Behavioral Health Transitions of Care* PIP. For HUM, CY 2023 was the baseline measurement period for this PIP topic because the MCO began operations for the Louisiana Medicaid Program on January 1, 2023.

Table 2-13—Performance Indicator Results for HUM's *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 2-14 displays data for LHCC's *Behavioral Health Transitions of Care* PIP.

Table 2-14—Performance Indicator Results for LHCC's *Behavioral Health Transitions of Care* PIP

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Remeasurement 2 (01/01/2024 to 12/31/2024)		Sustained Improvement
Follow-Up After Hospitalization for Mental Illness (FUH)—Total, 7 Days	N: 1,673 D: 9,156	18.27%	N: 1,717 D: 8,592	19.98%+ ▲	N: 1,634 D: 7,724	21.15%+ ▲	*Yes*
Follow-Up After Hospitalization for Mental Illness (FUH)—Total, 30 Days	N: 3,551 D: 9,156	38.78%	N: 3,444 D: 8,592	40.08%+	N: 3,321 D: 7,724	43.00%+ ▲	*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 7 Days	N: 401 D: 1,804	22.23%	N: 349 D: 1,593	21.91%	N: 279 D: 1,318	21.17%	*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 30 Days	N: 679 D: 1,804	37.64%	N: 598 D: 1,593	37.54%	N: 493 D: 1,318	37.41%	*Not Assessed*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 7 Days	N: 462 D: 2,912	15.87%	N: 309 D: 2,336	13.23%	N: 268 D: 1,861	14.40%	*Not Assessed*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 30 Days	N: 759 D: 2,912	26.06%	N: 509 D: 2,336	21.79%	N: 455 D: 1,861	24.45%	*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 2-15 displays data for UHC's *Behavioral Health Transitions of Care* PIP.

Table 2-15—Performance Indicator Results for UHC's *Behavioral Health Transitions of Care* PIP

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Remeasurement 2 (01/01/2024 to 12/31/2024)		Sustained Improvement
Follow-Up After Hospitalization for Mental Illness (FUH)—Total, 7 Days	N: 1,595 D: 7,632	20.90%	N: 1,432 D: 7,065	20.27%	N: 1,311 D: 6,230	21.04%+	*Not Assessed*
Follow-Up After Hospitalization for Mental Illness (FUH)—Total, 30 Days	N: 2,931 D: 7,632	38.40%	N: 2,619 D: 7,065	37.07%	N: 2,464 D: 6,230	39.55%+	*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 7 Days	N: 351 D: 1,469	23.89%	N: 268 D: 1,322	20.27%	N: 239 D: 991	24.12%+	*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 30 Days	N: 541 D: 1,469	36.83%	N: 429 D: 1,322	32.45%	N: 383 D: 991	38.65%+	*Not Assessed*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 7 Days	N: 495 D: 3,021	16.39%	N: 308 D: 2,198	14.01%	N: 244 D: 1,576	15.48%	*Not Assessed*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 30 Days	N: 785 D: 3,021	25.98%	N: 482 D: 2,198	21.93%	N: 382 D: 1,576	25.24%	*Not Assessed*

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

Table 2-16 displays data for ABH's *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years* PIP.

Table 2-16—Performance Indicator Results for ABH's *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: 152 D: 3,300	4.60%	N: 135 D: 3,478	3.88%	N: 207 D: 3,792	5.46%+	*Not Assessed*
Fluoride varnish application by PCP for children aged 19 months–2 years	N: 291 D: 4,060	7.16%	N: 281 D: 4,450	6.31%	N: 369 D: 3,932	9.38%+ ▲	*Not Assessed*
Fluoride varnish application by PCP for children aged 3–5 years	N: 280 D: 6,680	4.19%	N: 262 D: 7,080	3.70%	N: 245 D: 5,574	4.40%+	*Not Assessed*
Fluoride varnish application by PCP for all children aged 6 months–5 years	N: 723 D: 14,040	5.15%	N: 678 D: 15,008	4.52%	N: 821 D: 13,298	6.17%+ ▲	*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 2-17 displays data for ACLA's *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years* PIP.

Table 2-17—Performance Indicator Results for ACLA's *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: 295 D: 5,651	5.22%	N: 281 D: 3,315	8.48%+ ▲	N: 311 D: 3,467	8.97%+ ▲	*Yes*
Fluoride varnish application by PCP for children aged 19 months–2 years	N: 585 D: 5,670	10.32%	N: 683 D: 5,965	11.45%+	N: 789 D: 5,485	14.38%+ ▲	*Not Assessed*
Fluoride varnish application by PCP for children aged 3–5 years	N: 622 D: 11,073	5.62%	N: 520 D: 9,007	5.77%+	N: 576 D: 8,373	6.88%+ ▲	*Not Assessed*
Fluoride varnish application by PCP for all children aged 6 months–5 years	N: 1,502 D: 22,358	6.72%	N: 1,484 D: 18,287	8.12%+ ▲	N: 1,676 D: 17,325	9.67%+ ▲	*Yes*

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 2-18 displays data for HBL's *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years* PIP.

Table 2-18—Performance Indicator Results for HBL's *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years* PIP

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

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

Table 2-19 displays data for HUM's *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years* PIP.

Table 2-19—Performance Indicator Results for HUM's *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 2-20 displays data for LHCC's *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years* PIP.

Table 2-20—Performance Indicator Results for LHCC's *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: 1,612 D: 14,780	10.91%	N: 2,014 D: 15,383	13.09%+ ▲	N: 1,716 D: 10,255	16.73%+ ▲	*Yes*
Fluoride varnish application by PCP for children aged 19 months–2 years	N: 1,205 D: 19,605	6.15%	N: 1,448 D: 19,548	7.41%+ ▲	N: 1,085 D: 10,623	10.21%+ ▲	*Yes*
Fluoride varnish application by PCP for children aged 3–5 years	N: 858 D: 22,133	3.88%	N: 946 D: 22,215	4.26%+ ▲	N: 574 D: 10,334	5.55%+▲	*Yes*
Fluoride varnish application by PCP for all children aged 6 months–5 years	N: 3,675 D: 56,518	6.50%	N: 4,408 D: 57,146	7.71%+ ▲	N: 3,375 D: 31,212	10.81%+ ▲	*Yes*

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 2-21 displays data for UHC's *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years* PIP.

Table 2-21—Performance Indicator Results for UHC's *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: 647 D: 16,029	4.04%	N: 517 D: 12,368	4.18%+	N: 602 D: 9,751	6.17%+ ▲	*Not Assessed*
Fluoride varnish application by PCP for children aged 19 months–2 years	N: 1,306 D: 22,170	5.89%	N: 1,174 D: 21,191	5.54%	N: 1,162 D: 18,577	6.26%+	*Not Assessed*
Fluoride varnish application by PCP for children aged 3–5 years	N: 1,367 D: 52,878	2.59%	N: 1,338 D: 49,387	2.71%+	N: 1,323 D: 48,871	2.71%+	*Not Assessed*
Fluoride varnish application by PCP for all children aged 6 months–5 years	N: 3,320 D: 91,077	3.65%	N: 3,029 D: 82,946	3.65%+	N: 3,087 D: 77,179	4.00%+ ▲	*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 2-22 displays data for ABH's *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees* PIP.

Table 2-22—Performance Indicator Results for ABH's *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: 14,749 D: 30,785	47.91%	N: 13,946 D: 26,922	51.80%+ ▲	— —	—	*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 2-23 displays data for ACLA's *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees* PIP.

Table 2-23—Performance Indicator Results for ACLA's *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: 18,158 D: 36,891	49.22%	N: 13,920 D: 25,788	53.98%+ ▲	— —	—	*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 2-24 displays data for HBL's *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees* PIP.

Table 2-24—Performance Indicator Results for HBL's *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees* PIP

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

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

Table 2-25 displays data for HUM's *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees* PIP.

Table 2-25—Performance Indicator Results for HUM's *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 2-26 displays data for LHCC's *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees* PIP.

Table 2-26—Performance Indicator Results for LHCC's *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: 46,964 D: 89,499	52.47%	N: 43,277 D: 75,051	57.66%+ ▲	— —	—	*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 2-27 displays data for UHC's *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees* PIP.

Table 2-27—Performance Indicator Results for UHC's *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: 28,000 D: 137,209	20.40%	N: 46,556 D: 110,555	42.11%+ ▲	— —	—	*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 2-28 displays data for ABH's *Screening for HIV Infection* PIP.

Table 2-28—Performance Indicator Results for ABH's *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: 2,154 D: 3,776	57.04%	N: 2,219 D: 3,254	68.19%+ ▲	— —	—	*Not Assessed*
Persons screened for HIV during the measurement year among persons with past or present (injection) drug use	N: 3,225 D: 9,390	34.35%	N: 3,050 D: 8,954	34.06%	— —	—	*Not Assessed*
Persons screened for HIV during the measurement year among persons with risk factors related to sexual mode of transmission	N: 5,238 D: 10,890	48.10%	N: 5,259 D: 11,022	47.71%	— —	—	*Not Assessed*
Persons ever screened for HIV among all others aged 15 to 65 years without a diagnosis of HIV infection	N: 25,261 D: 79,552	31.75%	N: 25,524 D: 68,574	37.22%+ ▲	— —	—	*Not Assessed*

N–Numerator D–Denominator

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

Table 2-29 displays data for ACLA's *Screening for HIV Infection* PIP.

Table 2-29—Performance Indicator Results for ACLA's *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: 3,496 D: 5,038	69.39%	N: 3,089 D: 4,491	68.78%	— —	—	*Not Assessed*
Persons screened for HIV during the measurement year among persons with past or present (injection) drug use	N: 2,405 D: 6,628	36.29%	N: 2,243 D: 5,825	38.51%+ ▲	— —	—	*Not Assessed*
Persons screened for HIV during the measurement year among persons with risk factors related to sexual mode of transmission	N: 3,568 D: 5,624	63.44%	N: 2,811 D: 4,597	61.15%	— —	—	*Not Assessed*
Persons ever screened for HIV among all others aged 15 to 65 years without a diagnosis of HIV infection	N: 9,916 D: 110,751	8.95%	N: 8,003 D: 90,412	8.85%	— —	—	*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 2-30 displays data for HBL's *Screening for HIV Infection* PIP.

Table 2-30—Performance Indicator Results for HBL's *Screening for HIV Infection* PIP

Performance Indicator	Baseline (01/01/2023 to 12/31/2023)		Remeasurement 1 (01/01/2024 to 12/31/2024)		Remeasurement 2 (01/01/2025 to 12/31/2025)		Sustained Improvement
Persons screened for HIV during the measurement year among pregnant persons or persons with encounters for labor and delivery	N: 8,289 D: 12,391	66.89%	N: 3,208 D: 6,485	49.47%	— —	—	*Not Assessed*
Persons screened for HIV during the measurement year among persons with past or present (injection) drug use	N: 5,469 D: 19,431	28.14%	N: 5,005 D: 20,240	24.73%	— —	—	*Not Assessed*
Persons screened for HIV during the measurement year among persons with risk factors related to sexual mode of transmission	N: 5,764 D: 8,893	64.82%	N: 3,634 D: 5,528	65.74%	— —	—	*Not Assessed*
Persons ever screened for HIV among all others aged 15 to 65 years without a diagnosis of HIV infection	N: 21,728 D: 234,488	9.27%	N: 29,518 D: 281,203	10.50% +▲	— —	—	*Not Assessed*

N–Numerator D–Denominator

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

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

Table 2-31 displays data for HUM's *Screening for HIV Infection* PIP.

Table 2-31—Performance Indicator Results for HUM's *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*
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

Table 2-32 displays data for LHCC's *Screening for HIV Infection* PIP.

Table 2-32—Performance Indicator Results for LHCC's *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: 10,679 D: 14,450	73.90%	N: 9,178 D: 12,701	72.26%	— —	—	*Not Assessed*
Persons screened for HIV during the measurement year among persons with past or present (injection) drug use	N: 7,803 D: 26,295	29.67%	N: 6,621 D: 23,303	28.41%	— —	—	*Not Assessed*
Persons screened for HIV during the measurement year among persons with risk factors related to sexual mode of transmission	N: 20,917 D: 51,895	40.31%	N: 17,970 D: 47,572	37.77%	— —	—	*Not Assessed*
Persons ever screened for HIV among all others aged 15 to 65 years without a diagnosis of HIV infection	N: 42,423 D: 163,580	25.93%	N: 36,894 D: 131,143	28.13%+ ▲	— —	—	*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 2-33 displays data for UHC's *Screening for HIV Infection* PIP.

Table 2-33—Performance Indicator Results for UHC's *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: 9,192 D: 14,163	64.90%*	N: 8,849 D: 13,428	65.90%* +	— —	—	*Not Assessed*
Persons screened for HIV during the measurement year among persons with past or present (injection) drug use	N: 6,494 D: 18,691	34.74%*	N: 6,077 D: 17,854	34.04%*	— —	—	*Not Assessed*
Persons screened for HIV during the measurement year among persons with risk factors related to sexual mode of transmission	N: 14,067 D: 23,190	60.66%*	N: 12,180 D: 20,529	59.33%*	— —	—	*Not Assessed*
Persons ever screened for HIV among all others aged 15 to 65 years without a diagnosis of HIV infection	N: 90,225 D: 90,998	99.15%*	N: 100,095 D: 100,728	99.37%* +▲	— —	—	*Not Assessed*

N–Numerator D–Denominator
▲ Designates a statistically significant improvement over baseline results ($p < 0.05$).
*HSAG rounded percentage to the second decimal place.
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 2-34 through Table 2-39 summarize the MCOs' CY 2024 barriers and interventions.

Table 2-34—Barriers and Interventions Reported by ABH for Each PIP Topic

PIP Topic	Barriers	Interventions
Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees	• Lack of provider strategies for addressing stigma regarding syphilis screening during pregnancy	• Provider education on methods for reducing the stigma of syphilis screening when delivering prenatal care • Provider outreach/education on recommended timing of syphilis screening during pregnancy (first prenatal visit, early third trimester, and at delivery)
Behavioral Health Transitions of Care	• Lack of timely notification for hospital discharge	• Improve timeliness of notification for hospital admission and discharge by increasing the number of hospital inpatient admissions for which the MCO received admission, discharge, transfer (ADT) data exchange for behavioral health-related emergency department (ED) visits and hospital stays
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	• Lack of PCP training in varnish application • Lack of enrollee parent/guardian understanding of benefits and importance of fluoride varnish treatment	• Educate PCPs on the practice of applying fluoride varnish in the office setting and appropriate documentation of Current Procedural Terminology (CPT) code 99188 • Worked with providers to ensure that fluoride varnish treatments are occurring in the office • Enhanced enrollee outreach and education with dental provider appointment scheduling
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	• Enrollees are transient and cannot be contacted by either telephone call or mail	• Identifying and outreaching non-compliant enrollees through M-pulse to provide education and reminders to schedule cervical cancer screening appointments • Enrollee outreach through educational materials/trifolds and screenings during community events in various regions throughout the state

PIP Topic	Barriers	Interventions
Screening for HIV Infection	• Lack of enrollee knowledge on importance of HIV screening and on resources for obtaining screening	• Provided enrollees with educational materials on HIV statistics and HIV screening guidelines

Table 2-35—Barriers and Interventions Reported by ACLA for Each PIP Topic

PIP Topic	Barriers	Interventions
Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees	• Lack of enrollee knowledge on importance of timely prenatal care • Lack of motivation or completing priorities to receiving prenatal care	• Enrollee outreach/education on importance of timely prenatal care with syphilis screening • Enrollee incentive for obtaining prenatal care during pregnancy
Behavioral Health Transitions of Care	• Lack of hospital participation in health information exchange • Provider difficulty in identifying patients needing follow-up care • Lack of enrollee access to care	• Utilization of ADT notification report of inpatient admits from FUH population • Utilization of ADT notification report of emergency department (ED) admits or discharges from FUM and FUA populations • Utilization of ADT notification report to determine CM notification of ED admits or discharges from FUM and FUA populations
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	• Lack of access to a dental provider • Lack of provider knowledge that fluoride varnish applications can be done in a PCP office	• Enhanced enrollee outreach and education • Enrollee outreach to facilitate dental appointment scheduling • EPSDT enrollee outreach and education to establish a dental home and facilitate dental provider appointment scheduling
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	• Lack of enrollee knowledge of multiple health conditions and importance of obtaining screening or that screening is due • Providers do not consistently recommend screening for enrollees	• Enhanced outreach to assist enrollees with scheduling cervical cancer screening • Outreach and education to provider offices on the availability of gaps in care reports and enrollee and provider incentives, and to assist with any other barriers reported by the provider offices

PIP Topic	Barriers	Interventions
		• Q4 provider push with Q4 provider incentive offered outside of Quality Enhancement Program, incentive outreach, and education
Screening for HIV Infection	• Lack of enrollee knowledge regarding HIV screening guidelines and risk factors • Lack of access to providers • Providers are not aware of their assigned enrollees' HIV screening status or screening guidelines	• Enhanced outreach for HIV screening for enrollees 15–64 years of age without a diagnosis of HIV • Enhanced telephonic outreach to provide education on HIV screening guidelines for age group 13–20 years and assists with appointment scheduling • Provider education regarding HIV screening guidelines during pregnancy to identify barriers and to notify providers of their enrollees who need screening

Table 2-36—Barriers and Interventions Reported by HBL for Each PIP Topic

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

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

Table 2-37—Barriers and Interventions Reported by HUM for Each 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.

Table 2-38—Barriers and Interventions Reported by LHCC for Each PIP Topic

PIP Topic	Barriers	Interventions
Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees	• Lack of enrollee knowledge on importance of timely prenatal care • Lack of provider strategies for addressing stigma regarding syphilis screening during pregnancy • Lack of provider knowledge regarding the importance of timely syphilis screening during pregnancy	• Enrollee outreach/education on importance of timely prenatal care with syphilis screening • Provider education on methods for reducing the stigma of syphilis screening when delivering prenatal care • Provider outreach/education on recommended timing of syphilis screening during pregnancy (first prenatal visit, early third trimester, and at delivery)
Behavioral Health Transitions of Care	• Limited behavioral health provider participation in ADT feeds/applications • Short time window between enrollee discharge and required follow-up visits to provide follow-up care support	• Enhanced hospital-to-MCO workflow for notification of hospital admissions, discharges, and transfers • Linkage to aftercare with behavioral health providers prior to discharge from hospital • Provide critical enrollee information to aftercare behavioral health providers within three days of enrollee's discharge through

PIP Topic	Barriers	Interventions
	• Lack of engagement from enrollees with SUD in follow-up care	provider-friendly, automated processes
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	• Lack of PCP training in fluoride varnish application • Lack of provider knowledge regarding fluoride varnish application recommendations and opportunities for reimbursement • Lack of access to primary care and dental care related to socioeconomic factors and geographic location of residence	• Provider outreach and education using care gap report, AAP guidelines on fluoride use to prevent dental caries, LDH bulletin regarding reimbursement and course requirements/link, and Well-Ahead Louisiana resources • Provided PCPs with customized list of enrollees for whom fluoride varnish application was indicated • Targeted support in scheduling PCP and/or dental provider appointments for Black/African-American enrollees residing in Region 1 and Region 8
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	• Lack of enrollee awareness of the importance of cervical cancer screening • Lack of provider knowledge of proper coding to capture screening	• Enhanced MCO enrollee outreach for enrollees with no cervical cancer screening (care gap) and assisted with appointment scheduling at OB/GYN • Enhanced MCO enrollee outreach and education on cervical cancer screening via text messages • Conducted provider outreach and education on cervical cancer screening guidelines and billing/coding guidelines
Screening for HIV Infection	• Lack of enrollee knowledge on importance of HIV screening and on resources for obtaining screening • Enrollee's lack of transportation to screening appointments	• Enhanced MCO outreach providing appointments scheduled for HIV screening for pregnant enrollees, enrollees who use drugs, and enrollees with sexual transmission risk factors • Provider engagement and education regarding updated clinical practice guidelines for HIV screening, provider incentives, current enrollee incentives, billing/coding guidelines, and gaps in care report distribution

Table 2-39—Barriers and Interventions Reported by UHC for Each PIP Topic

PIP Topic	Barriers	Interventions
Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees	• Potential provider knowledge deficits regarding congenital syphilis screening recommendations and infection rates • Lack of timely prenatal care	• Provider education on methods for reducing the stigma of syphilis screening when delivering prenatal care • Provider outreach/education on recommended timing of syphilis screening during pregnancy (first prenatal visit, early third trimester, and at delivery) • Enrollee outreach/education on importance of early pregnancy awareness/notification • Enrollee incentive for obtaining prenatal care during pregnancy
Behavioral Health Transitions of Care	• Lack of timely notification for hospital discharge • Difficult to engage enrollees in follow-up treatment	• Enhanced hospital-to-MCO workflow for notification of hospital and ED admissions, discharges, and transfers through analyzing ADT feeds • Linked enrollees to aftercare with behavioral health providers prior to discharge from hospital or ED • Outreach and assistance in securing follow-up appointments for enrollees after ED discharge for mental health or SUD diagnoses
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	• Lack of PCP training in fluoride varnish application	• Provider education on the availability and use of care gap reports to identify enrollees due for fluoride varnish application • Targeted outreach calls for enrollee groups with fluoride varnish application disparities (enrollees residing in Region 1, Native American/Indian enrollees, Alaskan Native enrollees, Native Hawaiian or Pacific Islander enrollees, and enrollees in foster care)

PIP Topic	Barriers	Interventions
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	• Lack of enrollee awareness of guidelines for cervical cancer screening • Lack of provider awareness of cervical cancer screening guidelines and reporting requirements	• Educational outreach to all enrollees, and for enrollee subgroups with identified disparities, to provide education on cervical cancer screening and Medicaid transportation benefits • Distribution of provider education materials and toolkit on cervical cancer screening
Screening for HIV Infection	• Lack of enrollee and provider knowledge on guidelines for HIV screening and on resources for obtaining screening	• Provided enhanced CM outreach for HIV screening education for all eligible pregnant enrollees in CM • Provided enhanced CM outreach for HIV screening education to all eligible enrollees 15–65 years of age in CM

Statewide MCO Strengths, Opportunities for Improvement, and Recommendations

For the MCOs statewide, the following strengths were identified:

- The MCOs participated in regular collaborative meetings with LDH, facilitated by HSAG, to share lessons learned, explore effective improvement strategies, learn new approaches to QI, and explore solutions to barriers related to the five statewide PIP topics. **[Quality]**
- The MCOs carried out interventions for the PIPs that had the potential to address identified barriers and improve performance indicator results. **[Quality]**
- The MCOs collected, analyzed, and reported intervention-specific effectiveness data to monitor the progress and impact of interventions throughout the most recent measurement period for the PIPs. **[Quality]**
- For the *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees* PIP, all MCOs' reported performance indicator results demonstrated statistically significant improvement at Remeasurement 1 compared to baseline results. **[Quality, Timeliness, and Access]**

For the MCOs statewide, the following opportunity for improvement was identified:

- For three of the four PIP topics assessed for achieving significant improvement (*Behavioral Health Transitions of Care*, *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years*, and *Screening for HIV Infection*), not all of the MCOs' reported indicator results

demonstrated statistically significant improvement from baseline to the most recent remeasurement. **[Quality, Timeliness, and Access]**

For the MCOs statewide, the following recommendation was identified:

- To facilitate significant outcomes improvement for all PIPs, the MCOs should review intervention evaluation results to determine if each intervention is having the desired impact and how interventions can be revised to increase effectiveness. Each 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]**

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: Jan 15, 2026.

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 accessibility of services furnished by each MCO. HSAG then identified common themes and the salient patterns that emerged across the MCOs related to PIP validation or performance on the PIPs conducted.

How Conclusions Were Drawn

PIPs that accurately addressed 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 2-40.

Table 2-40—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

Aggregate Results

Information Systems Capabilities Assessment

HSAG reviewed the FARs produced for each MCO by the MCO's independent certified HEDIS compliance auditor to ensure that each MCO calculated its rates based on accurate data and according to NCQA's established standards.

The FARs include information on the MCOs' IS capabilities, findings for each measure, supplemental data validation results, medical record review validation (MRRV) results, results of any corrected programming logic (including corrections to numerators, denominators, or sampling used for final measure calculation), and opportunities for improvement. HSAG analyzed the MCOs' HEDIS MY 2024 results and evaluated each MCO's current performance levels in reference to NCQA's Quality Compass national Medicaid percentiles.

HSAG evaluated each MCO's IS to verify accurate HEDIS reporting. As part of the evaluation, each FAR, which contained the licensed organization's (LO's) assessment of IS capabilities, was reviewed. The IS evaluation focused on aspects of the MCOs' systems that could affect the HEDIS Medicaid reporting set.

In accordance with the MY 2024 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. The final audit results included final determinations of validity made by the independent certified HEDIS compliance auditor for each performance measure. The Interactive Data Submission System (IDSS) file detailed all rates that were submitted to NCQA and whether the LO deemed them to be reportable.

HSAG used the FAR and the MCO rates provided on the IDSS file as the primary data sources. Based on a review of the FARs issued by each MCO's independent certified HEDIS compliance auditor, HSAG found that the MCOs were determined to be fully compliant with all four of the applicable NCQA IS standards. HEDIS rates produced by the MCOs were reported to NCQA.

The MCOs' compliance with IS standards are highlighted in Table 3-1 through Table 3-6.

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

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

Table 3-2—MCO Compliance With IS Standards—MY 2022, MY 2023, and MY 2024 Comparison for ACLA

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

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

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

Table 3-4—MCO Compliance With IS Standards—MY 2023 and MY 2024 Comparison for HUM*

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

* HUM started a three-year Louisiana Medicaid managed care contract effective January 1, 2023.

Table 3-5—MCO Compliance With IS Standards—MY 2022, MY 2023, and MY 2024 Comparison for LHCC

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

Table 3-6—MCO Compliance With IS Standards—MY 2022, MY 2023, and MY 2024 Comparison for UHC

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

Performance Measures

In SFY 2025 (review period), LDH required each contracted MCO to collect and report on 44 HEDIS measures, which included 185 total measure indicators for HEDIS MY 2024 specified in the provider agreement. The measurement set included nine incentive measures. Table 3-7 through Table 3-9 display for each MCO the 185 measure indicators required by LDH.

Table 3-7 through Table 3-9 display a summary of the MCOs' HEDIS measure performance. Rates in red shaded cells with a ^ indicate the measure or SWA performance fell below the NCQA national 50th percentile, and rates in green shaded cells with a **+** indicate that the measure or SWA performance was at or above the NCQA national 50th percentile

Table 3-7—MCO HEDIS Effectiveness of Care Performance Measures—MY 2023 and MY 2024 Comparison

	MY 2023							MY 2024						
HEDIS Measure	**ABH**	**ACLA**	**HBL**	**HUM**	**LHCC**	**UHC**	**SWA**	**ABH**	**ACLA**	**HBL**	**HUM**	**LHCC**	**UHC**	**SWA**
Follow-Up After Hospitalization for Mental Illness														
Within 7 Days of Discharge—Total	18.61%^	19.82%^	23.27%^	15.12%^	20.70%^	20.73%^	20.67%^	19.64%^	19.01%^	25.62%^	20.54%^	22.14%^	21.54%^	22.05%^
Within 30 Days of Discharge[I]—Total	37.03%^	38.49%^	41.13%^	32.48%^	41.60%^	39.16%^	39.62%^	39.66%^	40.09%^	43.61%^	39.36%^	44.68%^	40.86%^	42.18%^
Follow-Up After Emergency Department Visit for Mental Illness														
Within 7 Days of Discharge—Total	20.76%^	20.59%^	24.63%^	15.15%^	22.39%^	22.84%^	22.26%^	21.19%^	21.60%^	23.00%^	22.07%^	22.07%^	26.01%^	23.02%^
Within 30 Days of Discharge[I]—Total	33.39%^	31.59%^	41.69%^	22.35%^	38.24%^	37.68%^	36.83%^	35.81%^	36.50%^	39.20%^	36.21%^	38.49%^	41.84%^	38.77%^
Follow-Up After Emergency Department Visit for Substance Use														
Within 7 Days of Discharge—Total	15.38%^	12.51%^	13.28%^	8.95%^	13.42%^	14.40%^	13.46%^	18.19%^	14.32%^	16.88%^	12.25%^	14.96%^	15.49%^	15.66%^
Within 30 Days of Discharge[I]—Total	24.59%^	20.50%^	21.45%^	14.86%^	21.89%^	22.92%^	21.75%^	29.66%^	25.00%^	26.12%^	19.48%^	25.19%^	24.54%^	25.41%^
Follow-Up After High-Intensity Care for SUD														
Within 7 Days of Visit or Discharge—Total	NQ	NQ	NQ	NQ	NQ	NQ	NQ	60.04%+	61.91%+	62.84%+	51.93%+	56.29%+	57.49%+	59.23%+
Within 30 Days of Visit or Discharge—Total	NQ	NQ	NQ	NQ	NQ	NQ	NQ	71.90%+	73.08%+	73.36%+	62.94%+	66.99%+	71.21%+	70.77%+
Plan All-Cause Readmissions[B]														
*Observed Readmissions (Numerator/Denominator)**	11.18%	10.73%	9.32%	NA	10.06%	10.37%	10.13%	11.02%	10.18%	9.00%	8.89%	10.12%	10.98%	10.05%
Expected Readmissions Rate	10.38%	10.04%	9.40%	NA	9.62%	10.00%	9.77%	8.78%	8.72%	8.41%	8.32%	8.42%	8.67%	8.53%
*Observed-to-Expected (O/E) Ratio (Observed Readmissions/Expected Readmissions)**	1.0778^	1.0691^	0.9911^	NA	1.0460^	1.0376^	1.0368^	1.2557^	1.1677^	1.0703+	1.0686+	1.2024^	1.2661^	1.1771^

HEDIS Measure	MY 2023							MY 2024						
	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Depression Screening and Follow-Up for Adolescents and Adults—Electronic Clinical Data System (ECDS)														
Depression Screening—Total	6.47%+	—	—	—	—	—	—	6.47%+	2.81%^	0.37%^	0.00%^	6.17%+	2.33%^	3.31%^
Follow-Up on Positive Screen—Total	83.33%+	51.12%^	NR	NA	NR	74.14%+	62.50%^	94.56%+	55.32%^	43.86%^	NA	76.00%+	57.75%^	73.57%+
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	85.69%+	84.73%+	84.08%+	92.86%+	83.89%+	83.96%+	84.36%+	86.44%+	84.59%+	85.23%+	86.21%+	84.90%+	84.63%+	85.11%+
Diabetes Monitoring for People With Diabetes and Schizophrenia	70.70%^	71.29%+	72.14%+	70.69%^	73.32%+	72.74%+	72.29%+	75.79%+	77.26%+	73.75%^	68.42%^	77.61%+	75.08%+	75.60%+
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	83.33%+	80.00%+	79.75%+	NA	81.91%+	82.43%+	81.53%+	86.84%+	85.96%+	79.07%^	NA	82.52%+	83.75%+	82.56%+
Metabolic Monitoring for Children and Adolescents on Antipsychotics—ECDS														
Blood Glucose Testing—Total	60.00%+	54.61%^	57.96%+	NA	52.36%^	55.96%^	54.92%^	52.57%^	53.75%^	55.33%^	50.56%^	52.85%^	54.29%^	53.68%^
Cholesterol Testing—Total	30.00%^	25.00%^	31.27%^	NA	25.93%^	30.19%^	28.09%^	27.08%^	27.75%^	30.90%^	26.67%^	27.55%^	28.75%^	28.43%^
Blood Glucose and Cholesterol Testing—Total	29.38%^	24.42%^	30.48%^^	NA	24.86%^	29.38%^	27.21%^	25.30%^	26.50%^	29.47%^	26.11%^	26.51%^	27.65%^	27.26%^
Lead Screening in Children	67.64%+	69.83%+	64.73%+	43.59%^	68.13%+	64.24%+	66.40%+	71.53%+	66.67%^	70.56%+	69.83%^	72.75%+	70.80%+	70.87%+
Childhood Immunization Status														
Diphtheria, Tetanus, and Acellular Pertussis (DTaP)	70.32%^	71.28%+	72.51%+	57.69%^	70.45%^	72.75%+	71.31%+	NQ	NQ	NQ	NQ	NQ	NQ	NQ
Polio Vaccine, Inactivated (IPV)	88.32%+	87.53%+	87.83%+	79.17%^	87.42%+	86.37%+	87.17%+	NQ	NQ	NQ	NQ	NQ	NQ	NQ
Measles, Mumps, and Rubella (MMR)	84.43%^	86.28%+	88.08%+	75.64%^	86.33%+	85.16%+	86.06%+	NQ	NQ	NQ	NQ	NQ	NQ	NQ
Haemophilus Influenzae TypeB (HiB)	86.86%+	85.44%+	85.89%+	77.24%^	85.92%+	85.40%+	85.66%+	NQ	NQ	NQ	NQ	NQ	NQ	NQ

HEDIS Measure	MY 2023							MY 2024						
	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Hepatitis B	90.02%+	90.29%+	89.78%+	81.41%^	90.35%+	86.86%+	89.20%+	NQ	NQ	NQ	NQ	NQ	NQ	NQ
Varicella-Zoster Virus (VZV)	84.67%+	85.77%+	89.05%+	77.24%	86.44%+	85.40%+	86.30%+	NQ	NQ	NQ	NQ	NQ	NQ	NQ
Pneumococcal Conjugate	67.40%^	70.76%^	73.97%+	58.65^%	69.52%^	71.53%+	70.65%^	NQ	NQ	NQ	NQ	NQ	NQ	NQ
Hepatitis A	80.78%^	84.15%+	87.10%+	77.56%^	83.73%+	82.73%+	83.82%+	NQ	NQ	NQ	NQ	NQ	NQ	NQ
Rotavirus	63.99%^	66.61%^	63.02%	62.18%^	63.61%	63.99%	63.96%^	NQ	NQ	NQ	NQ	NQ	NQ	NQ
Influenza	25.30%^	20.30%^	23.11%^	14.74%^	20.46%^	21.17%^	21.26%^	NQ	NQ	NQ	NQ	NQ	NQ	NQ
Combination 3[I]	63.02%^	64.95%+	67.88%+	51.60%^	63.80%^	65.94%+	64.96%+	NQ	NQ	NQ	NQ	NQ	NQ	NQ
Combination 7	50.85%^	55.46%^	54.74%^	45.1%^	52.45%^	53.77%^	53.34%^	NQ	NQ	NQ	NQ	NQ	NQ	NQ
Combination 10	17.03%^	16.04%^	19.22%^	8.65%^	15.61%^	15.33%^	16.16%^	NQ	NQ	NQ	NQ	NQ	NQ	NQ
Immunizations for Adolescents														
Meningococcal	79.32%^	84.67%+	83.21%+	81.31%^	86.60%+	87.59%+	85.85%+	NQ	NQ	NQ	NQ	NQ	NQ	NQ
Tetanus, Diphtheria, and Pertussis/Tetanus and Diphtheria (Tdap/Td)	79.08%^	85.40%+	83.45%^	81.31%^	87.10%+	88.08%+	86.29%+	NQ	NQ	NQ	NQ	NQ	NQ	NQ
Human Papillomavirus (HPV)	37.96%+	45.00%+	41.61%+	34.42%^	39.18%+	45.26%+	41.77%+	NQ	NQ	NQ	NQ	NQ	NQ	NQ
Combination 1	78.59%^	84.67%+	83.21%+	80.71%^	86.36%+	87.35%+	85.64%+	NQ	NQ	NQ	NQ	NQ	NQ	NQ
Combination 2[I]	37.47%+	44.77%+	41.61%+	34.12%^	38.87%+	45.01%+	41.53%+	NQ	NQ	NQ	NQ	NQ	NQ	NQ
Colorectal Cancer Screening*[I]*—ECDS	43.21%+	44.95%+	40.60%+	67.18%+	44.28%+	43.82%+	43.44%+	48.65%+	48.16%+	38.96%^	22.03%^	52.24%+	45.01%+	45.44%+
Flu Vaccinations for Adults Ages 18 to 64	—	—	—	—	—	—	—	NQ	NQ	NQ	NQ	NQ	NQ	NQ
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents														
Body Mass Index (BMI) Percentile Documentation—Total	80.05%^	75.37%^	76.89%^	77.37%^	81.51%^	83.21%+	80.09%^	82.24%^	80.29%^	83.70%^	87.35%+	89.29%+	87.10%+	86.26%+
Counseling for Nutrition—Total	65.69%^	64.39%^	64.23%^	63.02%^	70.56%^	58.39%^	64.97%^	71.53%^	68.61%^	71.78%^	72.75%^	69.34%^	72.26%^	70.74%^

HEDIS Measure	MY 2023							MY 2024						
	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Counseling for Physical Activity—Total	63.50%^	62.20%^	59.61%^	60.34%^	59.12%^	50.85%^	57.89%^	70.32%+	66.42%^	67.15%^	69.83%+	64.72%^	68.13%^	66.86%^
HIV Viral Load Suppression[I]	85.13%	80.81%	83.48%	73.46%	81.99%	82.05%	82.26%	84.27%	82.43%	81.52%	81.25%	82.48%	81.68%	82.24%
Low-Risk Cesarean Delivery (Cesarean Rate for Low-Risk First Birth Women)[*,I]	27.93%	25.06%	26.32%	23.54%	27.18%	26.41%	26.35%	25.63%	27.38%	26.95%	24.11%	26.78%	26.41%	26.37%
Chlamydia Screening in Women														
Total	64.55%+	64.32%+	64.50%+	66.75%+	67.37%+	65.49%+	65.84%+	65.00%+	66.28%	65.63%+	67.31%+	67.27%+	65.98%+	66.43%+
Breast Cancer Screening	—	—	—	—	—	—	—	NQ	NQ	NQ	NQ	NQ	NQ	NQ
Controlling High Blood Pressure[I]	63.26%^	60.80%^	56.93%^	69.10%+	60.34%^	61.80%^	60.47%^	64.23%^	66.91%^	61.31%^	66.67%^	68.61%+	63.26%^	65.03%^
Statin Therapy for Patients With Cardiovascular Disease														
Received Statin Therapy—Total	82.75%+	83.76%+	83.00%+	83.02%+	81.94%+	82.82%+	82.74%+	81.91%+	84.93%+	82.46%+	70.68%^	81.71%+	83.65%+	82.62%+
Statin Adherence 80%—Total	75.15%+	68.02%^	57.89%^	67.42%^	74.18%+	61.52%^	66.40%^	72.59%+	63.64%^	60.06%^	75.53%+	76.96%+	77.51%+	71.14%^
Glycemic Status Assessment for Patients With Diabetes														
Glycemic Status >9.0%[,I]*	33.33%^	33.09%+	30.66%+	27.25%+	31.63%+	23.60%+	29.55%+	25.79%+	28.22%+	30.66%^	27.98%+	29.68%+	26.03%+	28.35%+
Glycemic Status <8.0%	59.61%+	59.61%+	62.29%+	66.91%+	61.56%+	70.07%+	63.65%+	67.40%+	66.42%+	63.75%+	66.67%^	63.02%+	65.94%+	64.86%+
Eye Exam for Patients With Diabetes	46.96%^	51.09%^	55.47%+	54.74%+	59.37%+	54.74%+	55.06%+	58.64%+	53.28%^	58.39%+	53.77%^	66.42%+	55.47%^	59.29%+
Blood Pressure Control for Patients With Diabetes	62.29%^	64.48%^	63.50%^	71.78%+	63.02%^	70.07%+	65.25%^	68.86%^	72.02%+	67.64%^	69.34%^	69.10%^	71.29%^	69.65%^
Pharmacotherapy for Opioid Use Disorder	38.41%+	34.07%+	24.55%^	61.18%+	34.11%+	21.85%^	29.53%+	41.14%+	33.01%+	21.81%^	36.44%+	40.31%+	39.07%+	34.64%+
Initiation and Engagement of SUD Treatment														
Initiation of SUD Treatment—Total	61.26%+	65.10%+	58.91%+	59.40%+	49.81%+	60.16%+	57.95%+	61.47%+	65.29%+	60.07%+	59.61%+	54.87%+	59.09%+	59.26%+
Engagement of SUD Treatment—Total	26.94%+	30.10%+	25.02%+	26.91%+	15.87%+	28.17%+	24.37%+	28.84%+	31.55%+	27.41%+	25.67%+	24.60%+	28.06%+	27.37%+

HEDIS Measure	MY 2023							MY 2024						
	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	68.80%+	56.83%^	64.93%+	67.65%+	61.74%+	65.02%+	63.06%+	63.64%+	61.01%^	65.35%+	68.37%+	61.91%^	68.20%+	64.29%+
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	58.31%^	57.23%^	50.89%^	64.55%	60.69%^	51.27%^	55.72%^	60.75%^	59.37%^	51.60%^	45.72%^	67.28%+	68.84%+	61.49%^
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—ECDS														
Initiation Phase	43.17%^	49.75%+	45.21%^	NA	44.21%^	46.24%+	45.52%^	44.35%^	49.73%+	46.56%^	43.93%^	43.95%^	45.53%^	45.46%^
Continuation and Maintenance Phase	63.39%+	56.83%+	53.66%+	NA	51.43%^	58.55%+	54.23%+	53.77%^	57.09%+	62.17%+	46.60%^	51.43%^	51.07%^	52.86%^
Antidepressant Medication Management														
Effective Acute Phase Treatment	61.92%^	56.31%^	55.53%^	72.53%+	59.73%^	55.90%^	57.61%^	66.52%+	57.30%^	52.42%^	66.58%+	63.27%^	63.69%^	60.88%^
Effective Continuation Phase Treatment	46.12%+	38.89%^	37.60%^	61.54%+	42.60%^	36.41%^	39.77%^	51.49%+	39.02%^	35.38%^	54.23%+	48.13%+	49.73%+	45.44%^
Appropriate Treatment for Children With Upper Respiratory Infection (URI)	79.68%^	80.00%^	80.11%^	99.68%+	80.12%^	80.14%^	80.50%^	81.93%^	81.59%^	81.85%^	86.32%^	82.13%^	80.78%^	81.90%^
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	50.75%^	54.77%^	52.78%^	98.14%+	51.12%^	48.99^	51.81%^	52.79%^	54.73%^	54.44%^	64.73%+	52.74%^	49.50%^	52.98%^
Use of Imaging Studies for Low Back Pain	67.96%^	69.88%^	69.31%^	70.31%^	69.11%^	69.60%	69.31%^	68.30%^	71.01%+	68.56%^	66.92%^	69.83%^	67.72%^	68.86%^
Non-Recommended Cervical Screening in Adolescent Females*	0.50%^	2.45%^	0.67%^	1.33%^	2.05%^	2.51%^	1.85%^	—	—	—	—	—	—	—
Cervical Cancer Screening[1]	48.66%^	56.27%^	50.61%^	30.17%^	58.64%+	56.45%^	53.47%^	52.62%^	58.39%+	53.04%^	40.15%^	65.21%+	58.15%+	57.33%^
Asthma Medication Ratio														
5–11 Years	84.14%+	80.10%+	80.20%+	NA	79.44%+	68.99%^	76.33%+	64.33%^	64.12%^	68.76%+	69.64%+	63.84%^	66.67%^	65.73%^
12–18 Years	85.71%+	72.42%+	78.00%+	NA	74.41%+	59.53%^	69.59%+	72.62%+	66.94%+	73.37%+	77.08%+	64.37%^	58.33%^	63.52%^

HEDIS Measure	MY 2023							MY 2024						
	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
19–50 Years	74.73%+	71.56%+	76.56%+	NA	72.27%+	56.98%^	68.05%+	70.72%+	69.36%+	74.38%+	68.42%+	63.25%+	55.25%^	63.12%+
51–64 Years	81.82%+	69.89%+	75.98%+	NA	69.43%+	55.61%^	67.00%+	75.54%+	68.65%+	76.18%+	73.68%+	66.28%+	55.65%^	65.14%+
Total	79.36%+	73.49%+	77.55%+	NA	74.21%+	60.16%^	70.18%+	70.47%+	67.34%+	73.03%+	72.05%+	64.06%+	59.27%^	64.22%+
Appropriate Testing for Pharyngitis														
3–17 Years	NQ	NQ	NQ	NQ	NQ	NQ	NQ	85.64%^	72.38%^	83.71%^	86.22%^	83.34%^	84.64%^	82.73%^
18–64 Years	NQ	NQ	NQ	NQ	NQ	NQ	NQ	79.76%+	61.54%^	79.74%+	80.76%+	80.72%+	79.78%+	78.29%+
65 Years and Older	NQ	NQ	NQ	NQ	NQ	NQ	NQ	NA	NA	NA	NA	NA	NA	60.61%+
Total	NQ	NQ	NQ	NQ	NQ	NQ	NQ	83.49%^	69.63%^	82.32%^	84.95%+	82.62%^	83.29%^	81.44%^
Topical Fluoride for Children														
1–2 Years	1.42%	6.32%	5.60%	2.27%	6.54%	2.24%	4.76%	1.63%	8.73%	7.88%	2.57%	7.98%	2.75%	6.04%
3–4 Years	0.64%	9.66%	7.93%	0.88%	10.52%	0.93%	6.32%	0.65%	12.49%	10.58%	0.74%	12.13%	0.95%	7.59%
Total	1.00%	7.97%	6.79%	1.50%	8.55%	1.56%	5.56%	1.13%	10.68%	9.13%	1.62%	10.09%	1.82%	6.82%
Oral Evaluation, Dental Services														
0–2 Years	NA	NA	NA	NA	NA	NA	NA	NQ	NQ	NQ	NQ	NQ	NQ	NQ
3–5 Years	NA	NA	NA	NA	NA	NA	NA	NQ	NQ	NQ	NQ	NQ	NQ	NQ
6–14 Years	NA	NA	NA	NA	NA	NA	NA	NQ	NQ	NQ	NQ	NQ	NQ	NQ
15–20 Years	NA	NA	NA	NA	NA	NA	NA	NQ	NQ	NQ	NQ	NQ	NQ	NQ
Total	NA	NA	NA	NA	NA	NA	NA	NQ	NQ	NQ	NQ	NQ	NQ	NQ

* 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, *NQ* indicates that the MCO was not required to report the measure, and *R* indicates the measure was retired.
— is presented for measures that NCQA retired for MY 2024 and were not reported by the MCOs.
Caution is recommended when comparing HUM's MY 2023 rates to the LDH target rates or other MCOs' rates due to HUM's limited period as an MCO in Louisiana.

Table 3-8—MCO HEDIS Access to/Availability of Care Performance Measures—MY 2023 and MY 2024 Comparison

HEDIS Measure	MY 2023							MY 2024						
	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Adults' Access to Preventive/Ambulatory Health Services														
20–44 Years	67.99%^	68.12%^	68.95%^	53.57%^	76.80%+	75.53%+	71.25%^	74.72%^	71.91%^	73.88%^	62.07%^	79.04%+	79.57%+	75.53%^
45–64 Years	80.95%^	79.39%^	78.32%^	57.41%^	84.67%+	84.90%+	80.87%^	83.88%+	81.99%^	81.51%^	69.09%^	86.51%+	87.10%+	83.48%+
65 Years and Older	68.44%^	76.08%^	69.42%^	88.09%+	82.46%+	74.54%^	79.46%^	76.24%^	80.56%^	73.93%^	65.03%^	82.48%^	79.16%^	77.97%^
Total	72.59%^	71.66%^	71.81%^	55.59%^	79.11%+	78.57%+	74.25%^	78.03%^	75.29%^	76.34%^	64.21%^	81.24%+	82.10%+	78.09%+
Prenatal and Postpartum Care														
Timeliness of Prenatal Care	81.02%^	80.33%^	82.97%^	80.05%^	78.83%^	87.59%+	82.12%^	77.37%^	76.19%^	84.18%^	77.62%^	85.64%^	87.10%+	83.83%^
Postpartum Care	77.37%^	73.77%^	78.59%^	76.64%^	77.62%^	77.37%^	77.27%^	76.40%^	81.27%^	81.02%^	79.56%^	83.45%+	80.78%^	81.62%^

Caution is recommended when comparing HUM's MY 2023 rates to the LDH target rates or other MCOs' rates due to HUM's limited period as an MCO in Louisiana.

Table 3-9—MCO HEDIS Use of Services and Health Plan Descriptive Information Performance Measures—MY 2023 and MY 2024 Comparison

HEDIS Measure	MY 2023							MY 2024						
	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Well-Child Visits in the First 30 Months of Life														
First 15 Months	68.42%+	65.05%+	62.83%+	NA	63.17%+	66.33%+	64.44%+	66.87%+	63.50%+	62.19%^	61.96%^	65.77%+	66.68%+	64.83%+
15 Months–30 Months	70.22%+	69.78%+	70.09%+	NA	70.49%+	69.64%+	70.10%+	71.07%^	72.05%^	73.24%+	66.54%^	72.32%+	74.35%+	72.42%+
Child and Adolescent Well-Care Visits														
3–11 Years	54.70%^	57.12%^	55.27%^	50.03%^	59.98%+	58.94%^	57.47%^	58.14%^	59.52%^	60.25%^	54.00%^	61.60%^	62.36%+	60.45%^
12–17 Years	50.85%^	53.65%+	50.25%^	46.88%^	56.83%+	56.04%+	54.10%+	52.65%^	55.03%+	54.36%^	48.54%^	57.77%+	58.55%+	56.11%+
18–21 Years	27.60%^	28.92%+	26.05%^	22.23%^	32.59%+	30.21%+	29.30%+	30.77%^	32.54%+	30.36%^	26.96%^	34.78%+	33.65%+	32.68%+
Total	48.72%^	51.04%^	48.13%^	44.11%^	54.23%+	52.93%+	51.39%^	52.20%^	53.81%^	53.52%^	48.03%^	56.02%+	56.46%+	54.58%^
Antibiotic Utilization for Respiratory Conditions														
3 Months–17 Years	NQ	NQ	NQ	NQ	NQ	NQ	NQ	33.08%+	33.91%+	33.68%+	30.11%^	30.11%^	35.01%+	34.05%+
18–64 Years	NQ	NQ	NQ	NQ	NQ	NQ	NQ	27.99%+	28.31%+	29.12%+	23.39%^	23.39%^	30.09%+	29.16%+

HEDIS Measure	MY 2023							MY 2024						
	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
65 Years and Older	NQ	NQ	NQ	NQ	NQ	NQ	NQ	19.12%+	22.88%+	19.65%+	13.24%^	13.24%^	21.28%+	20.07%+
Total	NQ	NQ	NQ	NQ	NQ	NQ	NQ	30.75%+	32.01%+	31.73%+	28.00%+	28.00%+	33.24%+	32.26%+
Ambulatory Care														
Outpatient Visits/1,000 Member Years	4,490.94+	4,494.01+	5,103.55+	3,422.64^	5,253.10+	5,420.48+	4,958.45+	—	—	—	—	—	—	—
*Emergency Department Visits/1,000 Member Years**	774.29^	732.55^	729.10^	559.12+	762.05^	758.06^	735.72^	—	—	—	—	—	—	—
Inpatient Utilization—General Hospital/Acute Care														
Maternity—Days/1,000 Member Years—10–19 Years	18.18+	30.40+	32.31+	27.64+	27.27+	NQ	28.03+	—	—	—	—	—	—	—
Maternity—Days/1,000 Member Years—20–44 Years	119.74^	147.31+	143.70+	133.39+	171.84+	NQ	149.64+	—	—	—	—	—	—	—
Maternity—Days/1,000 Member Years—45–64 Years	3.04+	2.10+	0.88^	2.27+	1.97+	NQ	1.85+	—	—	—	—	—	—	—
Maternity—Days/1,000 Member Years—Total	65.55+	80.47+	85.16+	76.06+	88.82+	NQ	82.50+	—	—	—	—	—	—	—
Maternity—Discharges/1,000 Member Years—10–19 Years	6.53+	10.17+	11.12+	9.37+	9.65+	NQ	9.72+	—	—	—	—	—	—	—
Maternity—Discharges/1,000 Member Years—20–44 Years	43.12^	52.99+	52.75+	50.04+	63.18+	NQ	54.81+	—	—	—	—	—	—	—
Maternity—Discharges/1,000 Member Years—45–64 Years	0.64+	0.66+	0.36+	0.71+	0.63+	NQ	0.56+	—	—	—	—	—	—	—
Maternity—Discharges/1,000 Member Years—Total	23.48^	28.68+	31.10+	28.18+	32.50+	NQ	30.03+	—	—	—	—	—	—	—
Maternity—Average Length of Stay—10–19 Years	2.78+	2.99+	2.91+	2.95+	2.82+	NQ	2.88+	—	—	—	—	—	—	—
Maternity—Average Length of Stay—20–44 Years	2.78+	2.78+	2.72+	2.67+	2.72+	NQ	2.73+	—	—	—	—	—	—	—
Maternity—Average Length of Stay—45–64 Years	4.78+	3.16^	2.45^	3.18^	3.13^	NQ	3.29+	—	—	—	—	—	—	—

HEDIS Measure	MY 2023							MY 2024						
	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Maternity—Average Length of Stay—Total	2.79+	2.81+	2.74+	2.70+	2.73+	NQ	2.75+	—	—	—	—	—	—	—
Surgery—Days/1,000 Member Years—Less than 1 Year	571.55+	315.98+	370.01+	283.82+	616.39+	NQ	463.70+	—	—	—	—	—	—	—
Surgery—Days/1,000 Member Years—1–9 Years	25.02^	23.41^	44.47+	13.53^	39.42+	NQ	33.47+	—	—	—	—	—	—	—
Surgery—Days/1,000 Member Years—10–19 Years	34.62+	31.24+	31.35+	18.52^	36.85+	NQ	32.49+	—	—	—	—	—	—	—
Surgery—Days/1,000 Member Years—20–44 Years	133.18+	103.34^	101.72^	82.79^	110.61	NQ	106.78+	—	—	—	—	—	—	—
Surgery—Days/1,000 Member Years—45–64 Years	370.27+	359.41^	328.32^	344.01^	379.07+	NQ	356.86^	—	—	—	—	—	—	—
Surgery—Days/1,000 Member Years—65–74 Years	259.16^	266.28^	371.28^	622.78+	288.59^	NQ	393.71^	—	—	—	—	—	—	—
Surgery—Days/1,000 Member Years—75–84 Years	616.49+	695.44+	1,170.53+	1,050.05+	651.36+	NQ	944.71+	—	—	—	—	—	—	—
Surgery—Days/1,000 Member Years—86 Years and Older	1,922.33+	NA	0.00^	548.66+	508.73+	NQ	584.92+	—	—	—	—	—	—	—
Surgery—Days/1,000 Member Years—Total	154.00+	112.99^	127.42+	95.80^	124.12+	NQ	123.56+	—	—	—	—	—	—	—
Surgery—Discharges/1,000 Member Years—Less than 1 Year	22.30+	17.48+	18.25+	13.58^	23.45+	NQ	19.95+	—	—	—	—	—	—	—
Surgery—Discharges/1,000 Member Years—1–9 Years	3.42+	3.39+	3.76+	2.16^	3.91+	NQ	3.54+	—	—	—	—	—	—	—
Surgery—Discharges/1,000 Member Years—10–19 Years	4.64+	3.96+	4.65+	3.01^	4.66+	NQ	4.35+	—	—	—	—	—	—	—
Surgery—Discharges/1,000 Member Years—20–44 Years	14.90+	13.28^	14.13+	10.82^	15.65+	NQ	14.26+	—	—	—	—	—	—	—

HEDIS Measure	MY 2023							MY 2024						
	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Surgery—Discharges/1,000 Member Years—45–64 Years	42.51^	42.99^	40.53^	41.26^	45.86+	NQ	42.97^	—	—	—	—	—	—	—
Surgery—Discharges/1,000 Member Years—65–74 Years	40.77^	34.73^	38.67^	65.75+	27.20^	NQ	42.16^	—	—	—	—	—	—	—
Surgery—Discharges/1,000 Member Years—75–84 Years	57.35+	73.98+	58.95+	107.42+	66.81+	NQ	87.74+	—	—	—	—	—	—	—
Surgery—Discharges/1,000 Member Years—85 Years and Older	145.63+	NA	0.00^	50.34^	59.85+	NQ	51.79+	—	—	—	—	—	—	—
Surgery—Discharges/1,000 Member Years—Total	16.89+	13.48^	15.50+	11.42^	14.23+	NQ	14.43+	—	—	—	—	—	—	—
Surgery—Average Length of Stay—Less than 1 Year	25.63+	18.08+	20.28+	20.89+	26.29+	NQ	23.24+	—	—	—	—	—	—	—
Surgery—Average Length of Stay—1–9 Years	7.32^	6.91^	11.83+	6.26^	10.08+	NQ	9.44+	—	—	—	—	—	—	—
Surgery—Average Length of Stay—10–19 Years	7.47+	7.89+	6.74^	6.16^	7.90+	NQ	7.46+	—	—	—	—	—	—	—
Surgery—Average Length of Stay—20–44 Years	8.94+	7.78+	7.20^	7.65+	7.07^	NQ	7.49+	—	—	—	—	—	—	—
Surgery—Average Length of Stay—45–64 Years	8.71+	8.36^	8.10^	8.34^	8.27^	NQ	8.31^	—	—	—	—	—	—	—
Surgery—Average Length of Stay—65–74 Years	6.36^	7.67^	9.60+	9.47+	10.61+	NQ	9.34+	—	—	—	—	—	—	—
Surgery—Average Length of Stay—75–84 Years	10.75+	9.40+	19.86+	9.78+	9.75+	NQ	10.77+	—	—	—	—	—	—	—
Surgery—Average Length of Stay—85 Years and Older	13.20+	NA	0.00^	10.90+	8.50+	NQ	11.29+	—	—	—	—	—	—	—
Surgery—Average Length of Stay—Total	9.12+	8.38^	8.22^	8.39^	8.72+	NQ	8.56+	—	—	—	—	—	—	—

HEDIS Measure	MY 2023							MY 2024						
	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Medicine—Days/1,000 Member Years—Less than 1 Year	464.15+	447.26+	401.07+	405.50+	399.89+	NQ	414.29+	—	—	—	—	—	—	—
Medicine—Days/1,000 Member Years—1–9 Years	39.66+	38.43+	42.21+	21.95^	46.78+	NQ	40.91+	—	—	—	—	—	—	—
Medicine—Days/1,000 Member Years—10–19 Years	20.27^	29.34+	28.69+	15.86^	31.44+	NQ	27.72^	—	—	—	—	—	—	—
Medicine—Days/1,000 Member Years—20–44 Years	117.49+	117.80+	100.58^	73.77^	119.05+	NQ	108.57+	—	—	—	—	—	—	—
Medicine—Days/1,000Member Years—45–64 Years	349.97^	442.70+	361.46^	315.29^	440.18+	NQ	393.48^	—	—	—	—	—	—	—
Medicine—Days/1,000 Member Years—65–74 Years	614.41+	396.53^	344.98^	1,000.39+	313.52^	NQ	550.81^	—	—	—	—	—	—	—
Medicine—Days/1,000 Member Years—75–84 Years	272.40^	547.47^	412.6^3	1,302.16+	567.85^	NQ	921.88+	—	—	—	—	—	—	—
Medicine—Days/1,000 Member Years—85 Years and Older	2,446.60+	NA	455.36^	2,008.39+	389.03^	NQ	1,617.67+	—	—	—	—	—	—	—
Medicine—Days/1,000 Member Years—Total	142.36+	137.61+	132.55+	99.99^	129.83^	NQ	129.96^	—	—	—	—	—	—	—
Medicine—Discharges/1,000 Member Years—Less than 1 Year	65.78+	78.27+	74.93+	60.70^	82.28+	NQ	75.93+	—	—	—	—	—	—	—
Medicine—Discharges/1,000 Member Years—1–9 Years	9.27^	11.42+	12.08+	7.37^	13.50+	NQ	11.75+	—	—	—	—	—	—	—
Medicine—Discharges/1,000 Member Years—10–19 Years	4.64^	7.36+	7.14+	4.24^	9.11+	NQ	7.45+	—	—	—	—	—	—	—
Medicine—Discharges/1,000 Member Years—20–44 Years	22.06^	26.16+	20.98^	15.51^	26.84+	NQ	23.27^	—	—	—	—	—	—	—

HEDIS Measure	MY 2023							MY 2024						
	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Medicine—Discharges/1,000 Member Years—45–64 Years	62.99^	81.79^	65.98^	61.02^	85.85+	NQ	73.88^	—	—	—	—	—	—	—
Medicine—Discharges/1,000 Member Years—65–74 Years	90.27^	89.73^	69.61^	174.72+	58.17^	NQ	99.37^	—	—	—	—	—	—	—
Medicine—Discharges/1,000 Member Years—75–84 Years	71.68^	103.58^	101.05^	208.26+	108.56^	NQ	158.65+	—	—	—	—	—	—	—
Medicine—Discharges/1,000 Member Years—85 Years and Older	203.88+	NA	107.14^	186.24+	89.78^	NQ	164.51^	—	—	—	—	—	—	—
Medicine—Discharges/1,000 Member Years—Total	26.11^	28.34^	26.52^	19.72^	28.47+	NQ	26.76^	—	—	—	—	—	—	—
Medicine—Average Length of Stay—Less than 1 Year	7.06+	5.71+	5.3 5+	6.68+	4.86^	NQ	5.46+	—	—	—	—	—	—	—
Medicine—Average Length of Stay—1–9 Years	4.28+	3.36+	3.50+	2.98^	3.47+	NQ	3.48+	—	—	—	—	—	—	—
Medicine—Average Length of Stay—10–19 Years	4.37+	3.99+	4.02+	3.74^	3.45^	NQ	3.72^	—	—	—	—	—	—	—
Medicine—Average Length of Stay—20–44 Years	5.33+	4.50+	4.79+	4.76+	4.43+	NQ	4.67+	—	—	—	—	—	—	—
Medicine—Average Length of Stay—45–64 Years	5.56+	5.41+	5.48+	5.17+	5.13+	NQ	5.33+	—	—	—	—	—	—	—
Medicine—Average Length of Stay—65–74 Years	6.81+	4.42^	4.96^	5.73+	5.39^	NQ	5.54+	—	—	—	—	—	—	—
Medicine—Average Length of Stay—75–84 Years	3.80^	5.29^	4.08^	6.25+	5.23^	NQ	5.81+	—	—	—	—	—	—	—
Medicine—Average Length of Stay—85 Years and Older	12.00+	NA	4.25^	10.78+	4.33^	NQ	9.83+	—	—	—	—	—	—	—
Medicine—Average Length of Stay—Total	5.45+	4.86+	5.00+	5.07+	4.56^	NQ	4.86+	—	—	—	—	—	—	—

HEDIS Measure	MY 2023							MY 2024						
	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Total Inpatient—Days/1,000 Member Years—Less than 1 Year	1,035.71+	763.24+	771.07+	689.32+	1,016.28+	NQ	877.99+	—	—	—	—	—	—	—
Total Inpatient—Days/1,000 Member Years—1–9 Years	64.68+	61.84+	86.69+	35.49^	86.20+	NQ	74.37+	—	—	—	—	—	—	—
Total Inpatient—Days/1,000 Member Years—10–19 Years	73.07+	90.99+	92.35+	62.03^	95.55+	NQ	88.24+	—	—	—	—	—	—	—
Total Inpatient—Days/1,000 Member Years—20–44 Years	370.41+	368.44+	346.00^	289.95^	401.50+	NQ	364.98+	—	—	—	—	—	—	—
Total Inpatient—Days/1,000 Member Years—45–64 Years	723.27^	804.21+	690.66^	661.57^	821.22+	NQ	752.20^	—	—	—	—	—	—	—
Total Inpatient—Days/1,000 Member Years—65–74 Years	873.57^	662.81^	716.26^	1,623.17+	602.12^	NQ	944.52^	—	—	—	—	—	—	—
Total Inpatient—Days/1,000 Member Years—75–84 Years	888.89^	1,242.91^	1,583.16+	2,352.21+	1,219.21^	NQ	1,866.59+	—	—	—	—	—	—	—
Total Inpatient—Days/1,000 Member Years—85 Years and Older	4,368.93+	NA	455.36^	2,557.05+	897.76^	NQ	2,202.59+	—	—	—	—	—	—	—
Total Inpatient—Days/1,000 Member Years—Total	348.13+	309.98+	327.43+	250.83^	318.35+	NQ	315.49+	—	—	—	—	—	—	—
Total Inpatient—Discharges/1,000 Member Years—Less than 1 Year	88.07+	95.75+	93.18+	74.28^	105.73+	NQ	95.88+	—	—	—	—	—	—	—
Total Inpatient—Discharges/1,000 Member Years—1–9 Years	12.68^	14.81+	15.84+	9.53^	17.41+	NQ	15.29+	—	—	—	—	—	—	—
Total Inpatient—Discharges/1,000 Member Years—10–19 Years	15.80^	21.48+	22.91+	16.62^	23.43+	NQ	21.53+	—	—	—	—	—	—	—
Total Inpatient—Discharges/1,000 Member Years—20–44 Years	80.08^	92.43+	87.86^	76.38^	105.67+	NQ	92.34+	—	—	—	—	—	—	—

HEDIS Measure	MY 2023							MY 2024						
	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Total Inpatient—Discharges/1,000 Member Years—45–64 Years	106.13^	125.44+	106.87^	102.99^	132.34+	NQ	117.41^	—	—	—	—	—	—	—
Total Inpatient—Discharges/1,000 Member Years—65–74 Years	131.04^	124.46^	108.29^	240.47+	85.37^	NQ	141.53^	—	—	—	—	—	—	—
Total Inpatient—Discharges/1,000 Member Years—75–84 Years	129.03^	177.56^	160.00^	315.67+	175.37^	NQ	246.39+	—	—	—	—	—	—	—
Total Inpatient—Discharges/1,000 Member Years—85 Years and Older	349.51+	NA	107.14^	236.58+	149.63^	NQ	216.30^	—	—	—	—	—	—	—
Total Inpatient—Discharges/1,000 Member Years—Total	61.55+	62.98+	66.65+	51.53^	66.27+	NQ	63.75+	—	—	—	—	—	—	—
Total Inpatient—Average Length of Stay—Less than 1 Year	11.76+	7.97+	8.28+	9.28+	9.61+	NQ	9.16+	—	—	—	—	—	—	—
Total Inpatient—Average Length of Stay—1–9 Years	4.63+	4.23+	4.03^	3.73^	4.95+	NQ	4.10^	—	—	—	—	—	—	—
Total Inpatient—Average Length of Stay—10–19 Years	5.10+	4.18^	5.47+	3.72^	4.08^	NQ	4.86+	—	—	—	—	—	—	—
Total Inpatient—Average Length of Stay—20–44 Years	4.63+	3.99+	3.94+	3.80+	3.80+	NQ	3.95+	—	—	—	—	—	—	—
Total Inpatient—Average Length of Stay—45–64 Years	6.81+	6.41+	6.46+	6.42+	6.21+	NQ	6.41+	—	—	—	—	—	—	—
Total Inpatient—Average Length of Stay—65–74 Years	6.67^	5.33^	6.61^	6.75+	7.05+	NQ	6.67^	—	—	—	—	—	—	—
Total Inpatient—Average Length of Stay—75–84 Years	6.89+	7.00+	9.89+	7.45+	6.95+	NQ	7.58+	—	—	—	—	—	—	—

HEDIS Measure	MY 2023							MY 2024						
	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Total Inpatient—Average Length of Stay—85 Years and Older	12.50+	NA	4.25^	10.81+	6.00+	NQ	10.18+	—	—	—	—	—	—	—
Total Inpatient—Average Length of Stay—Total	5.66+	4.92+	4.91+	4.87^	4.80^	NQ	4.95+	—	—	—	—	—	—	—
Enrollment by Product Line														
Less than 1 Year	2,691	5,150	7,727	3,460	11,905	8,498	39,430	3,184	3,787	7,520	3,978	11,144	7,909	37,522
1–4 Years	11,152	20,015	25,724	13,205	48,863	35,729	154,688	10,762	17,003	24,697	12,501	45,028	31,545	141,537
5–9 Years	14,314	23,939	29,593	17,315	61,390	48,063	194,614	14,248	21,253	28,293	15,815	59,027	44,102	182,737
10–14 Years	12,278	22,337	27,981	16,022	60,025	48,805	187,448	11,529	19,945	26,286	14,764	58,545	45,869	176,938
15–17 Years	7,821	13,656	17,499	9,640	35,848	29,427	113,890	7,468	12,427	16,425	9,006	35,569	28,315	109,211
18–19 Years	4,714	8,181	10,822	5,918	20,567	16,987	67,190	4,257	6,961	9,295	5,085	19,357	15,306	60,260
20–24 Years	11,250	17,206	29,150	12,564	41,722	32,834	144,726	9,202	12,229	21,093	9,650	34,416	25,096	111,685
25–29 Years	11,619	13,753	29,039	10,160	30,569	24,721	119,861	9,773	9,523	21,675	8,492	25,375	18,877	93,717
30–34 Years	11,975	13,567	28,245	9,487	29,615	25,021	117,909	10,596	9,669	21,241	7,855	24,377	19,168	92,906
35–39 Years	10,415	11,853	23,917	7,835	25,187	22,937	102,144	9,328	8,807	18,438	7,019	21,259	17,777	82,628
40–44 Years	9,114	10,296	20,891	6,440	22,294	21,081	90,116	8,146	7,632	16,095	6,016	18,424	16,312	72,625
45–49 Years	7,249	8,036	15,779	4,579	17,049	16,300	68,991	6,485	6,117	12,437	4,644	14,310	12,782	56,774
50–54 Years	6,982	6,878	14,108	3,824	14,789	14,740	61,320	5,949	5,072	10,577	4,005	11,873	11,362	48,838
55–59 Years	7,116	7,176	13,439	3,629	14,718	14,428	60,505	6,016	5,316	10,437	3,917	11,703	11,161	48,549
60–64 Years	7,057	6,623	12,677	3,392	13,907	13,567	57,221	6,106	5,122	10,358	3,865	11,493	11,089	48,032
65–69 Years	261	267	507	692	1,161	507	3,396	196	196	315	139	528	331	1,704
70–74 Years	86	82	142	392	170	174	1,046	68	69	124	55	145	159	620
75–79 Years	46	38	67	277	74	90	592	43	NA	63	32	60	79	306
80–84 Years	NA	NA	53	212	48	55	421	NA	NA	49	NA	38	46	200
85–89 Years	NA	NA	NA	120	NA	NA	224	NA	NA	NA	NA	NA	NA	86
90 Years and Older	NA	NA	NA	105	NA	NA	173	NA	NA	NA	NA	NA	NA	65

HEDIS Measure	MY 2023							MY 2024						
	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Unknown	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Total	136,199	189,108	307,397	129,267	449,932	374,001	1,585,904	123,405	151,198	255,446	116,874	402,700	317,318	1,366,940
Language Diversity of Membership														
Spoken Language Preferred for Health Care—Health Plan	0.00%+	39.04%+	100.00%+	0.00%+	0.00%+	0.00%+	23.84%+	0.00%^	45.70%+	98.09%+	0.00%^	96.75%+	0.00%^	51.08%+
Spoken Language Preferred for Health Care—CMS/State	100.00%+	60.93%^	0.00%^	98.73%+	99.91%+	100.00%+	76.01%^	100.00%+	54.27%+	1.91%^	99.71%+	0.00%^	100.00%+	47.98%+
Spoken Language Preferred for Health Care—Other Third-Party	0.00%+	0.04%+	0.00%+	1.27%+	0.09%+	0.00%+	0.15%+	0.00%+	0.03%+	0.00%+	0.29%+	3.25%+	0.00%+	0.94%+
Preferred Language for Written Materials—Health Plan	0.00%+	38.51%+	100.00%+	0.00%+	0.00%+	0.00%+	23.78%+	0.00%^	45.10%+	99.32%+	0.00%^	96.75%+	0.00%^	51.25%+
Preferred Language for Written Materials—CMS/State	100.00%+	61.45%+	0.00%^	98.73%+	99.91%+	0.00%^	52.79%+	100.00%+	54.87%+	0.68%+	99.71%+	0.00%^	0.00%^	24.75%+
Preferred Language for Written Materials—Other Third-Party	0.00%^	0.04%^	0.00%^	1.27%+	0.09%+	100.00%+	23.43%+	0.00%^	0.03%^	0.00%^	0.29%+	3.25%+	100.00%+	24.00%+
Other Language Needs—Health Plan	0.00%+	0.16%+	100.00%+	0.00%+	0.00%+	0.00%+	19.20%+	0.00%^	0.16%^	100.00%+	0.00%^	96.75%+	0.00%^	46.39%+
Other Language Needs—CMS/State	100.00%+	99.79%+	0.00%+	0.00%+	99.91%+	0.00%+	47.96%+	100.00%+	99.79%+	0.00%+	0.00%+	0.00%+	0.00%+	20.61%+
Other Language Needs—Other Third-Party	0.00%^	0.06%^	0.00%^	100.00%+	0.09%^	100.00%+	32.83%+	0.00%^	0.05%^	0.00%^	100.00%+	3.25%+	100.00%+	33.00%+
Spoken Language Preferred for Health Care—Percent English	0.00%^	96.88%+	98.00%+	96.07%	98.36%+	98.24%+	89.10%+	98.14%+	96.12%+	98.53%+	97.05%+	95.48%+	98.35%+	97.19%+

HEDIS Measure	MY 2023							MY 2024						
	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Spoken Language Preferred for Health Care—Percent Non-English	0.00%^	3.05%^	1.74%^	2.66%^	1.55%^	1.76%^	1.78%^	1.81%^	3.85%^	1.38%^	2.66%^	1.33%^	1.65%^	1.86%^
Spoken Language Preferred for Health Care—Percent Declined	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+
Spoken Language Preferred for Health Care—Percent Unknown	100.00%+	0.07%^	0.26%^	1.27%^	0.09%^	0.00%^	9.12%+	0.06%^	0.03%^	0.09%^	0.29%^	3.18%+	0.00%^	0.95%^
Language Preferred for Written Materials—Percent English	0.00%^	96.87%+	98.00%+	96.07%+	98.36%+	0.00%^	66.23%+	0.00%^	96.10%+	98.53%+	97.05%+	95.48%+	0.00%^	65.15%^
Language Preferred for Written Materials—Percent Non-English	0.00%^	3.06%+	1.74%^	2.66%^	1.55%^	0.00%^	1.37%^	0.00%^	3.87%^	1.38%^	2.66%^	1.33%^	0.00%^	1.31%^
Language Preferred for Written Materials—Percent Declined	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+
Language Preferred for Written Materials—Percent Unknown	100.00%+	0.07%^	0.26%^	1.27%^	0.09%^	100.00%+	32.40%+	100.00%+	0.03%^	0.09%^	0.29%^	3.18%^	100.00%+	33.54%+
Other Language Needs—Percent English	98.11%+	98.17%+	0.00%+	0.00%+	98.36%+	0.00%+	47.18%+	0.00%+	98.17%+	0.00%+	0.00%+	95.48%+	0.00%+	37.76%+
Other Language Needs—Percent Non-English	1.84%+	1.78%+	0.00%+	0.00%+	1.55%+	0.00%+	0.80%+	0.00%+	1.78%+	0.00%+	0.00%+	1.33%+	0.00%+	0.57%+
Other Language Needs—Percent Declined	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+
Other Language Needs—Percent Unknown	0.06%^	0.06%^	100.00%+	100.00%+	0.09%^	100.00%+	52.02%^	100.00%+	0.05%^	100.00%+	100.00%+	3.18%^	100.00%+	61.67%^
Race/Ethnicity Diversity of Membership														
Race—Health Plan	0.00%+	35.80%+	93.30%+	0.00%+	0.00%+	0.00%+	22.17%+	0.00%^	41.24%+	95.47%+	0.00%^	76.24%+	0.00%^	44.31%+

HEDIS Measure	MY 2023							MY 2024						
	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Race—CMS/State	66.39%+	53.72%^	0.05%^	35.56%^	88.86%+	72.12%+	56.65%^	86.12%+	49.10%+	0.03%^	49.83%+	10.79%^	87.31%+	41.33%^
Race—Other Direct	0.00%+	0.00%+	0.00%+	0.01%+	1.59%+	0.00%+	0.43%+	0.00%+	0.00%+	0.00%+	0.00%+	5.99%+	0.00%+	1.69%+
Race—Direct Total	66.39%^	89.52%+	93.35%+	35.57%^	90.44%+	72.12%^	79.25%+	86.12%+	90.34%+	95.50%+	49.84%^	93.02%+	87.31%+	87.33%+
Race—Indirect Total	0.00%+	0.00%+	3.18%+	0.00%+	0.00%+	0.00%+	0.61%+	5.88%+	0.00%+	3.05%+	0.00%+	0.00%+	0.00%+	1.14%+
Race—Unknown Total	33.61%+	10.48%^	3.47%^	64.43%+	9.56%^	27.88%+	20.14%+	8.00%^	9.66%^	1.45%^	50.16%+	6.98%^	12.69%^	11.53%^
Ethnicity—Health Plan	0.00%+	41.41%+	92.20%+	0.00%+	0.00%+	0.00%+	22.63%+	0.00%^	45.82%+	99.60%+	0.00%^	40.04%+	0.00%^	35.42%+
Ethnicity—CMS/State	72.75%+	8.93%^	0.00%^	50.03%+	2.16%^	97.02%+	35.49%+	71.91%+	14.33%^	0.00%^	64.42%+	7.58%^	86.18%+	36.27%+
Ethnicity—Other Direct	0.00%+	0.00%+	0.00%+	0.00%+	8.10%+	0.00%+	2.20%+	0.00%+	0.00%+	0.00%+	0.00%+	34.32%+	0.00%+	9.66%+
Ethnicity—Direct Total	72.75%+	50.33%^	92.20%+	50.03%^	10.26%^	97.02%+	60.32%^	71.91%^	60.15%^	99.60%+	64.42%^	81.95%^	86.18%+	81.35%^
Ethnicity—Indirect Total	0.00%+	0.00%+	7.61%+	0.00%+	26.82%+	0.00%+	8.74%+	14.73%+	0.00%+	0.35%+	0.00%+	9.93%+	0.00%+	4.26%+
Ethnicity—Unknown Total	27.25%+	49.67%+	0.19%^	49.97%+	62.92%+	2.98%^	30.93%+	13.36%+	39.85%+	0.04%^	35.58%+	8.12%^	13.82%+	14.39%+
Race: White—Ethnicity: Hispanic or Latino	0.00%^	4.05%+	0.23%^	0.00%^	1.05%^	0.00%^	0.81%^	10.22%+	6.12%+	0.09%^	0.00%^	1.78%^	3.63%+	3.01%+
Race: White—Ethnicity: Not Hispanic or Latino	27.02%+	14.51%^	41.96%+	32.62%+	14.83%^	37.91%+	28.15%+	27.17%+	15.77%^	42.15%+	32.30%+	36.54%+	28.63%+	32.21%+
Race: White—Ethnicity: Asked but No Answer	0.00%+	0.17%+	0.02%+	0.00%+	0.00%+	0.00%+	0.02%+	0.00%+	0.00%+	0.02%+	0.00%+	0.00%+	0.00%+	0.01%+
Race: White—Ethnicity: Unknown	0.00%^	16.51%+	0.05%^	0.45%^	21.57%+	0.00%^	7.88%+	2.44%+	13.13%+	0.00%^	0.11%^	0.14%^	4.86%+	2.86%+
Race: White—Ethnicity: Total	27.02%^	35.24%^	42.27%^	33.07%^	37.46%^	37.91%^	36.87%^	39.83%^	35.02%^	42.27%^	32.41%^	38.46%^	37.12%^	38.09%^
Race: Black or African American—Ethnicity: Hispanic or Latino	0.00%^	4.94%+	0.07%^	0.00%^	0.26%+	0.00%^	0.67%+	12.72%+	7.87%+	0.02%^	0.00%^	0.44%+	4.90%+	3.34%+
Race: Black or African American—Ethnicity: Not Hispanic or Latino	31.94%+	21.23%+	44.01%+	0.01%^	17.42%+	29.32%+	25.38%+	29.26%+	23.85%+	46.44%+	15.05%+	48.86%+	32.91%+	37.02%+
Race: Black or African American—Ethnicity: Asked but No Answer	0.00%+	0.22%+	0.01%+	0.00%+	0.00%+	0.00%+	0.03%+	0.00%+	0.00%+	0.01%+	0.00%+	0.00%+	0.00%+	0.00%+

HEDIS Measure	MY 2023							MY 2024						
	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Race: Black or African American—Ethnicity: Unknown	0.14%^	22.96%+	0.03%^	0.71%+	30.74%+	0.00%^	11.17%+	3.55%+	18.01%+	0.01%^	0.18%^	0.62%+	6.33%+	3.99%+
Race: Black or African American—Ethnicity: Total	32.08%+	49.35%+	44.12%+	0.72%^	48.41%+	29.32%+	37.26%+	45.53%+	49.73%+	46.49%+	15.23%^	49.92%+	44.14%+	44.36%+
Race: American Indian or Alaska Native—Ethnicity: Hispanic or Latino	0.00%^	0.12%+	0.01%^	0.00%^	0.04%+	0.00%^	0.03%+	0.31%+	0.18%+	0.00%^	0.00%^	0.07%+	0.09%+	0.09%+
Race: American Indian or Alaska Native—Ethnicity: Not Hispanic or Latino	0.55%+	0.30%+	0.75%+	0.00%^	0.24%+	0.80%+	0.48%+	0.36%+	0.36%+	0.78%+	0.00%^	0.40%+	0.59%+	0.47%+
Race: American Indian or Alaska Native—Ethnicity: Asked but No Answer	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+
Race: American Indian or Alaska Native—Ethnicity: Unknown	0.00%^	0.35%+	0.00%^	0.63%+	0.40%+	0.00%^	0.21%+	0.23%+	0.24%+	0.00%^	0.61%+	0.27%+	0.15%+	0.21%+
Race: American Indian or Alaska Native—Ethnicity: Total	0.55%+	0.78%+	0.76%+	0.63%+	0.68%+	0.80%+	0.72%+	0.90%+	0.78%+	0.78%+	0.61%+	0.74%+	0.82%+	0.77%+
Race: Asian—Ethnicity: Hispanic or Latino	0.00%^	0.15%+	0.07%+	0.00%^	0.02%+	0.00%^	0.04%+	0.63%+	0.23%+	0.00%^	0.00%^	0.03%+	0.09%+	0.12%+
Race: Asian—Ethnicity: Not Hispanic or Latino	0.00%^	0.46%^	5.96%+	0.00%^	0.47%^	1.10%^	1.58%+	1.03%^	0.50%^	4.99%+	0.00%^	0.56%^	1.13%^	1.53%+
Race: Asian—Ethnicity: Asked but No Answer	0.00%+	0.01%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+
Race: Asian—Ethnicity: Unknown	6.61%+	0.77%+	0.00%^	1.14%+	0.86%+	0.00%^	1.02%+	0.32%+	0.64%+	0.00%^	1.56%+	0.25%+	0.35%+	0.40%+
Race: Asian—Ethnicity: Total	6.61%+	1.38%^	6.03%+	1.14%^	1.35%^	1.10%^	2.64%+	1.98%+	1.37%^	5.00%+	1.56%^	0.84%^	1.58%^	2.04%+
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Hispanic or Latino	0.00%+	0.02%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.02%+	0.05%+	0.00%^	0.00%^	0.01%^	0.00%^	0.01%^

HEDIS Measure	MY 2023							MY 2024						
	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Not Hispanic or Latino	0.00%^	0.03%+	0.02%+	0.00%^	0.00%^	0.01%^	0.01%^	0.01%^	0.03%^	0.04%^	0.00%^	0.01%^	0.01%^	0.02%^
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Asked but No Answer	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Unknown	0.03%+	0.03%+	0.00%+	0.01%+	0.01%+	0.00%+	0.01%+	0.01%+	0.03%+	0.00%+	0.02%+	0.01%+	0.00%+	0.01%+
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Total	0.03%^	0.08%^	0.02%^	0.01%^	0.02%^	0.01%^	0.02%^	0.04%^	0.11%^	0.04%^	0.02%^	0.03%^	0.02%^	0.04%^
Race: Some Other Race—Ethnicity: Hispanic or Latino	0.00%^	0.00%^	0.22%+	0.00%^	0.38%+	0.00%^	0.15%+	2.05%+	0.00%^	0.05%^	0.00%^	0.50%+	0.80%+	0.53%+
Race: Some Other Race—Ethnicity: Not Hispanic or Latino	0.00%^	0.00%^	3.10%+	0.00%^	0.32%+	0.00%^	0.68%+	0.56%+	0.00%^	3.91%+	0.00%^	0.19%+	1.94%+	1.30%+
Race: Some Other Race—Ethnicity: Asked but No Answer	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+
Race: Some Other Race—Ethnicity: Unknown	0.11%+	0.00%^	0.01%^	0.00%^	1.80%+	2.98%+	1.19%+	1.11%+	0.00%^	0.00%^	0.00%^	1.38%+	0.91%+	0.70%+
Race: Some Other Race—Ethnicity: Total	0.11%^	0.00%^	3.33%+	0.00%^	2.50%+	2.98%+	2.02%+	3.72%+	0.00%^	3.97%+	0.00%^	2.07%+	3.64%+	2.54%+
Race: Two or More Races—Ethnicity: Hispanic or Latino	0.00%+	1.21%+	0.00%+	0.00%+	0.00%+	0.00%+	0.14%+	0.00%+	1.96%+	0.00%+	0.00%+	0.18%+	0.00%+	0.27%+
Race: Two or More Races—Ethnicity: Not Hispanic or Latino	0.00%+	0.14%+	0.00%+	0.00%+	0.01%+	0.00%+	0.02%+	0.00%+	0.17%+	0.00%+	0.00%+	0.39%+	0.00%+	0.13%+

HEDIS Measure	MY 2023							MY 2024						
	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Race: Two or More Races—Ethnicity: Asked but No Answer	0.00%+	0.01%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+
Race: Two or More Races—Ethnicity: Unknown	0.00%+	1.34%+	0.00%+	0.00%+	0.02%+	0.00%+	0.16%+	0.00%+	1.19%+	0.00%+	0.00%+	0.39%+	0.00%+	0.24%+
Race: Two or More Races—Ethnicity: Total	0.00%+	2.70%+	0.00%+	0.00%+	0.03%+	0.00%+	0.33%+	0.00%+	3.33%+	0.00%+	0.00%+	0.96%+	0.00%+	0.64%+
Race: Unknown—Ethnicity: Hispanic or Latino	1.63%^	2.04%+	0.35%^	0.02%^	0.62%^	0.87%^	0.83%^	2.30%^	2.54%^	0.09%^	0.01%^	0.93%^	0.92%^	0.99%^
Race: Unknown—Ethnicity: Not Hispanic or Latino	0.46%+	0.68%+	3.03%+	0.00%^	1.43%+	27.01%+	7.38%+	0.01%^	0.51%+	1.33%+	0.00%^	0.98%+	10.55%+	3.02%+
Race: Unknown—Ethnicity: Asked but No Answer	11.14%+	0.04%+	0.00%+	17.39%+	0.00%+	0.00%+	2.65%+	0.00%+	0.00%+	0.00%+	17.05%+	0.00%+	0.00%+	1.54%+
Race: Unknown—Ethnicity: Unknown	20.37%+	7.72%+	0.09%^	47.02%+	7.51%+	0.00%^	9.27%+	5.69%+	6.61%+	0.03%^	33.10%+	5.07%+	1.22%^	5.98%+
Race: Unknown—Ethnicity: Total	33.61%+	10.48%^	3.47%^	64.43%+	9.56%^	27.88%+	20.14%+	8.00%^	9.66%^	1.45%^	50.16%+	6.98%^	12.69%^	11.53%^
Race: Total—Ethnicity: Hispanic or Latino	1.63%^	12.53%+	0.94%^	0.02%^	2.37%^	0.87%^	2.67%^	28.24%+	18.95%+	0.27%^	0.01%^	3.94%^	10.43%^	8.36%^
Race: Total—Ethnicity: Not Hispanic or Latino	59.97%+	37.35%^	98.83%+	32.63%^	34.71%^	96.15%+	63.68%+	58.40%^	41.19%^	99.65%+	47.36%^	87.93%+	75.75%+	75.70%+
Race: Total—Ethnicity: Asked but No Answer	11.14%+	0.45%+	0.04%+	17.39%+	0.00%+	0.00%+	2.71%+	0.00%+	0.00%+	0.04%+	17.05%+	0.00%+	0.00%+	1.55%+
Race: Total—Ethnicity: Unknown	27.25%+	49.67%+	0.19%^	49.97%+	62.92%+	2.98%^	30.93%+	13.36%+	39.85%+	0.04%^	35.58%+	8.12%^	13.82%+	14.39%+
Race: Total—Ethnicity: Total	100.00%+	100.00%+	100.00%+	100.00%+	100.00%+	100.00%+	100.00%+	100.00%+	100.00%+	100.00%+	100.00%+	100.00%+	100.00%+	100.00%+
Race: Asked but No Answer—Ethnicity: Hispanic or Latino	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+
Race: Asked but No Answer—Ethnicity: Not Hispanic or Latino	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+

HEDIS Measure	MY 2023							MY 2024						
	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Race: Asked but No Answer—Ethnicity: Asked but No Answer	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+
Race: Asked but No Answer—Ethnicity: Unknown	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+
Race: Asked but No Answer—Ethnicity: Total	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+	0.00%+

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, *NQ* indicates that the MCO was not required to report the measure, and *R* indicates the measure was retired.

— is presented for measures that NCQA retired for MY 2024 and were not reported by the MCOs.

Caution is recommended when comparing HUM's MY 2023 rates to the LDH target rates or other MCOs' rates due to HUM's limited period as an MCO in Louisiana.

Statewide MCO Strengths, Opportunities for Improvement, and Recommendations

For the MCOs statewide, the following strengths were identified:

- The Health Louisiana SWAs 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 the MCOs were 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]**
- The Healthy Louisiana SWA on the *Depression Screening and Follow-Up for Adolescents and Adults—ECDS—Follow-Up on Positive Screen—Total* measure indicator was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that the MCOs were effective in coordinating with providers to ensure adolescent and adult Medicaid members are properly screened for depression, enabling timely follow-up care. **[Quality]**
- The Healthy Louisiana SWA 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. Additionally, the Healthy Louisiana SWA on the *Diabetes Monitoring for People With Diabetes and Schizophrenia* measure was above the NCQA national 50th percentile benchmark for MY 2024. These results suggest that the MCOs were effective in ensuring that adult members on antipsychotics were screened for diabetes and had their diabetes monitored, resulting in positive health outcomes for this population. **[Quality]**
- The Healthy Louisiana SWA on the *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* measure was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that the MCOs were effective in ensuring that adult members with cardiovascular disease and schizophrenia had their cholesterol monitored to promote positive health outcomes. **[Quality]**
- The Healthy Louisiana SWA on the *Lead Screening in Children* measure was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that the MCOs were effective in ensuring that children under 2 years of age were adequately receiving lead blood testing to ensure they maintained limited exposure to lead. **[Quality]**
- The Healthy Louisiana SWA on the *Colorectal Cancer Screening—ECDS* measure was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that the MCOs were effective in ensuring that members 45 to 75 years of age had appropriate screening for colorectal cancer. **[Quality]**
- The Healthy Louisiana SWA on the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total* measure indicator was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that the MCOs were 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]**

- The Healthy Louisiana SWA on the *Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total* measure indicator was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that the MCOs were effective in coordinating with providers to ensure that members with clinical atherosclerotic cardiovascular disease (ASCVD) receive statin therapy to manage their condition, reducing the risk of adverse outcomes. **[Quality]**
- The Healthy Louisiana SWA on the *Chlamydia Screening in Women—Total* measure indicator was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that the MCOs effectively coordinated with providers to facilitate annual follow-ups with and screening of sexually active members. **[Quality]**
- The Healthy Louisiana SWAs 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 the MCOs were effective in coordinating with providers to help members control their blood sugar levels, reducing the risk of complications. **[Quality]**
- The Healthy Louisiana SWA on the *Eye Exam for Patients With Diabetes* measure was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that the MCOs were effective in coordinating with providers to ensure that adult members with diabetes receive a retinal eye exam to screen for diabetic retinal disease. **[Quality]**
- The Healthy Louisiana SWA on the *Pharmacotherapy for Opioid Use Disorder* measure was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that the MCOs were effective in coordinating with providers to engage members with opioid use disorder in continuous treatment with pharmacotherapy, increasing the chance for positive outcomes. **[Quality]**
- The Healthy Louisiana SWAs 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 the MCOs 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]**
- The Healthy Louisiana SWA 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 the MCOs 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]**
- The Healthy Louisiana SWAs on the following *Asthma Medication Ratio* measure indicators were above the NCQA national 50th percentile benchmark for MY 2024: *19–50 Years*, *51–64 Years*, and *Total*. These results suggest that the MCOs effectively coordinated with providers to help adolescent and adult members with persistent asthma manage this treatable condition. **[Quality]**
- The Healthy Louisiana SWAs on the *Appropriate Testing for Pharyngitis—18–64 Years* and *65 Years and Older* measure indicators were above the NCQA national 50th percentile benchmark for MY 2024. These results suggest that the MCOs were 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]**

- The Healthy Louisiana SWAs on the *Adults' Access to Preventive/Ambulatory Health Services—45–64 Years* and *Total* measure indicators were above the NCQA national 50th percentile benchmark for MY 2024. These results suggest that the MCOs were effective in coordinating with PCPs to ensure that older members were engaging in preventive or ambulatory visits to manage their health and avoid adverse outcomes. **[Quality and Access]**
- The Healthy Louisiana SWAs on the *Well-Child Visits in the First 30 Months of Life* measure indicators were above the NCQA national 50th percentile benchmark for MY 2024. These results suggest that the MCOs effectively coordinated with PCPs to ensure that children were seen within the first 30 months of life to assess and influence members' early development. **[Quality and Access]**
- The Healthy Louisiana SWAs on the *Child and Adolescent Well-Care Visits—12–17 Years* and *18–21 Years* measure indicators were above the NCQA national 50th percentile benchmark for MY 2024. These results suggest that the MCOs effectively coordinated with providers to ensure that adolescent members received appropriate well-care visits to provide screening and counseling. **[Quality and Access]**
- The Healthy Louisiana SWAs on the *Antibiotic Utilization for Respiratory Conditions* measure indicators were above the NCQA national 50th percentile benchmark for MY 2024. These results suggest that the MCOs were effective in coordinating with providers to ensure that members diagnosed with a respiratory condition were not inappropriately dispensed an antibiotic. **[Quality]**

For the MCOs statewide, the following opportunities for improvement were identified:

- The Healthy Louisiana SWAs 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 the MCOs have room for improvement in their 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]**
- The Healthy Louisiana SWAs 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, the Healthy Louisiana SWAs 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 the MCOs have 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]**
- The Healthy Louisiana SWA on the *Plan All-Cause Readmissions—O/E Ratio* measure indicator was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that the MCOs have room for improvement with facilitating appropriate post-discharge planning and care coordination. **[Quality]**
- The Healthy Louisiana SWAs 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 the MCOs have room for improvement in their coordination with providers to effectively monitor blood glucose and cholesterol in child and adolescent members on antipsychotics. **[Quality]**

- The Healthy Louisiana SWA 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 the MCOs have 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]**
- The Healthy Louisiana SWAs on the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* and *Counseling for Physical Activity—Total* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest that the MCOs have room for improvement in coordinating with providers to ensure that child and adolescent members are having their weight and BMI monitored, and are receiving appropriate counseling to reduce the risk for obesity and prevent adverse health outcomes. **[Quality]**
- The Healthy Louisiana SWA on the *Controlling High Blood Pressure* measure was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that the MCOs have room for improvement in coordinating with providers to help members manage their blood pressure, reducing their risk for heart disease and stroke. **[Quality]**
- The Healthy Louisiana SWA on the *Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total* measure indicator was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that the MCOs have room for improvement in coordinating with providers to ensure that members with ASCVD adhere to statin therapy to effectively manage their condition. **[Quality]**
- The Healthy Louisiana SWA 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 the MCOs have room for improvement in coordinating with providers to help adult members with diabetes adequately control their blood pressure. **[Quality]**
- The Healthy Louisiana SWA 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 the MCOs have room for improvement in coordinating with providers to ensure that members with schizophrenia or schizoaffective disorder were dispensed and remain on an antipsychotic medication for at least 80 percent of their treatment period. **[Quality]**
- The Healthy Louisiana SWAs 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 the MCOs have room for improvement in coordinating with providers to ensure that children prescribed ADHD medication participate in continuous follow-up visits with a practitioner with prescribing authority to properly manage their prescriptions. **[Quality, Timeliness, and Access]**
- The Healthy Louisiana SWAs on the *Antidepressant Medication Management* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest that the MCOs have room for improvement in coordinating with providers to treat adult members

diagnosed with major depression with antidepressant medication and help members remain on antidepressant medication for at least 84 days (Acute Phase) through 180 days (Continuation Phase). **[Quality]**

- The Healthy Louisiana SWA on the *Appropriate Treatment for Children With URI* measure was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that the MCOs have room for improvement with ensuring that a diagnosis of URI does not result in an antibiotic dispensing event for members. **[Quality]**
- The Healthy Louisiana SWA on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that the MCOs have room for improvement with ensuring that providers effectively prevent or minimize the prescribing of antibiotics for members with a diagnosis of bronchitis or bronchiolitis. **[Quality]**
- The Healthy Louisiana SWA 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 the MCOs have room for improvement with ensuring that providers properly order imaging studies. **[Quality]**
- The Healthy Louisiana SWA on the *Cervical Cancer Screening* measure was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that the MCOs have room for improvement in coordinating with providers to ensure that women ages 21 to 64 years received appropriate, early detection cancer screening. **[Quality]**
- The Healthy Louisiana SWAs on the *Asthma Medication Ratio—5–11 Years* and *12–18 Years* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest that the MCOs have room for improvement in coordinating with providers to help child members with persistent asthma manage this treatable condition. **[Quality]**
- The Healthy Louisiana SWAs on the *Appropriate Testing for Pharyngitis—3–17 Years* and *Total* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest that the MCOs have room for improvement in coordinating with providers to ensure that child members diagnosed with pharyngitis receive a group A streptococcus test to aid in minimizing use of antibiotics. **[Quality]**
- The Healthy Louisiana SWAs on the *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years* and *65 Years and Older* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest that the MCOs have 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]**
- The Healthy Louisiana SWAs on the *Prenatal and Postpartum Care* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest that the MCOs have room for improvement in coordinating with providers to ensure that members receive timely and adequate prenatal and postpartum care, in alignment with guidance provided by the AAP and the American College of Obstetricians and Gynecologists. **[Quality, Timeliness, and Access]**
- The Healthy Louisiana SWAs on the *Child and Adolescent Well-Care Visits—3–11 Years* and *Total* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest that the MCOs have room for improvement in coordinating with providers to ensure

that child members receive appropriate well-care visits to provide screening and counseling. **[Quality and Access]**

For the MCOs statewide, 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 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. The MCOs 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 *Plan All-Cause Readmissions—O/E Ratio* measure indicator, HSAG recommends that the MCOs work with providers to improve post-discharge planning and care coordination. **[Quality]**
- To improve performance on the *Depression Screening and Follow-Up for Adolescents and Adults—ECDS—Depression Screening—Total* measure indicator, HSAG recommends that the MCOs work with providers to identify and address barriers to follow-up care for members who are positively screened for depression. The MCOs 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 follow-up care for members screened for depression. **[Quality]**
- To improve performance on the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—ECDS* measure indicators, HSAG recommends that the MCOs 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 *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* and *Counseling for Physical Activity—Total* measure indicators, HSAG recommends that the MCOs 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. The MCOs 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 the MCOs work with providers to identify and address barriers to effective blood pressure management in members. The MCOs 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, the MCOs 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—Statin Adherence 80%—Total* measure indicator, HSAG recommends that the MCOs work with providers to identify and address barriers to statin therapy adherence among members with ASCVD. The MCOs 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 medication adherence. **[Quality]**
- To improve performance on the *Blood Pressure Control for Patients With Diabetes* measure, HSAG recommends that the MCOs work with providers to identify and address barriers to effective blood pressure management for diabetic members. HSAG also recommends that the MCOs 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. The MCOs 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 the MCOs 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. The MCOs 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 the MCOs work with providers to identify and address barriers to initial follow-up visits with children prescribed ADHD medication. The MCOs could also consider data analysis and stratification across key demographics race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions. **[Quality, Timeliness, and Access]**
- To improve performance on the *Antidepressant Medication Management* measure indicators, HSAG recommends that the MCOs work with providers to identify and address barriers to prescribing antidepressant medication to adult members with major depression and helping members remain on antidepressant medication for the appropriate amount of time. The MCOs 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 education and offering telehealth services. **[Quality]**
- To improve performance on the *Appropriate Treatment for Children With URI* measure, HSAG recommends that the MCOs work with providers to trial solutions to reduce antibiotic dispensing to treat URIs. The MCOs could also work with providers to review noncompliant claims to ensure

there were no additional diagnoses during the appointment that justified the prescription of an antibiotic. **[Quality]**

- To improve performance on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure, HSAG recommends that the MCOs work with providers to trial solutions to reduce or prevent the prescribing of antibiotics for members with a diagnosis of bronchitis or bronchiolitis. The MCOs 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 the MCOs focus its efforts on decreasing unnecessary imaging for low back pain. HSAG also recommends that the MCOs 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 the MCOs work with providers to identify and address barriers to cervical cancer screening for women ages 21 to 64 years old. The MCOs 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 *Asthma Medication Ratio—5–11 Years* and *12–18 Years* measure indicators, HSAG recommends that the MCOs work with providers to identify and address challenges with access to asthma medication or medication adherence in child members with persistent asthma. The MCOs could also consider expanding on existing strategies that focus on disease and chronic condition management, evaluating and expanding current and/or new member outreach and engagement initiatives, and offering provider education and engagement opportunities such as webinars and newsletters on best practices in asthma management. Additionally, the MCOs could 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 *Appropriate Testing for Pharyngitis—3–17 Years* and *Total* measure indicators, HSAG recommends that the MCOs 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. The MCOs 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—20–44 Years* and *65 Years and Older* measure indicators, HSAG recommends that the MCOs work with PCPs to identify and address barriers to preventive or ambulatory visits for adult members. The MCOs 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 the MCOs work with providers to identify and address barriers to timely and

adequate prenatal and postpartum care. HSAG recommends that the MCOs consider implementing interventions such as offering provider education and engagement opportunities, including educational webinars and newsletters on postpartum health services, and piloting a member incentives program designed to encourage engagement in timely prenatal and postpartum care services. **[Quality, Timeliness, and Access]**

- To improve performance on the *Child and Adolescent Well-Care Visits—3–11 Years* and *Total* measure indicators, HSAG recommends that the MCOs work with providers to identify and address barriers to well-care visits for child members. The MCOs could also consider data analysis and stratification across key demographics (i.e., race, ethnicity, age, and ZIP Code) to identify disparities and implement targeted interventions, such as patient and provider education, outreach campaigns, sending reminders, and incentives for members upon completion of the well-care visits. **[Quality and Access]**

Methodology

Objectives

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

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

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

Technical Methods of Data Collection

The CMS EQR *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity,* February 2023 (CMS EQR Protocol 2),[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 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 IDSS, which is audited prior to submission, and the FAR, which is completed by the LO and describes the process used to produce the measure rates and any problems that

[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: Jan 15, 2026.

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, MRRV 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 2024 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 2024 performance levels based on comparison to the NCQA national 50th percentile benchmark 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 3-10. The measures marked *NA* are related to utilization of services.

Table 3-10—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*	✓		✓
Adults' Access to Preventive/Ambulatory Health Services—20–44 Years, *45–64 Years*, *65 Years and Older*, and *Total*	✓		✓

Performance Measure	Quality	Timeliness	Access
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	✓		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	✓		

Performance Measure	Quality	Timeliness	Access
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

Aggregate Results

Table 4-1 presents the results of the 2025 CR, review period CY 2024 (January 1, 2024–December 31, 2024) for each MCO, along with the MCO average results, for each standard.

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

Standard #	Standard Name	ABH	ACLA	HBL	HUM	LHCC	UHC	MCO Average Results
I	Enrollment and Disenrollment Requirements and Limitations	100%	100%	100%	33%	100%	78%	85%
II	Member Rights and Confidentiality	100%	96%	96%	100%	100%	100%	99%
III	Member Information	67%	67%	67%	72%	67%	72%	69%
IV	Emergency and Poststabilization Services	100%	100%	92%	100%	100%	100%	99%
V	Adequate Capacity and Availability of Services	71%	64%	57%	43%	60%	14%	52%
VI	Coordination and Continuity of Care	92%	83%	83%	83%	92%	75%	85%
VII	Coverage and Authorization of Services	100%	100%	100%	95%	100%	62%	93%
VIII	Provider Selection	32%	79%	89%	68%	84%	63%	70%
IX	Subcontractual Relationships and Delegation	50%	67%	50%	67%	67%	83%	64%
X	Practice Guidelines	100%	100%	100%	100%	100%	83%	97%
XI	Health Information Systems	100%	100%	100%	100%	100%	78%	96%
XII	Quality Assessment and Performance Improvement	100%	100%	100%	100%	100%	100%	100%
XIII	Grievance and Appeal Systems	97%	86%	86%	84%	100%	84%	90%
XIV	Program Integrity	100%	100%	100%	100%	94%	89%	97%
Total Compliance Score		**87%**	**88%**	**89%**	**83%**	**91%**	**77%**	

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

For the MCOs statewide, the following strengths were identified:

- All MCOs 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]**
- All but one MCO achieved a 100 percent compliance score for Standard IV—Emergency and Poststabilization Services, demonstrating that the MCOs had adequate processes in place to ensure access to, coverage of, and payment for emergency and poststabilization care. **[Quality, Timeliness, and Access]**
- All but one MCO 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]**
- All but one MCO achieved a 100 percent compliance score for Standard XI—Health Information Systems, demonstrating effective data collection, validation, reporting, encounter submission, and interoperability aligned with federal and State requirements. **[Quality and Access]**
- All MCOs achieved a 100 percent compliance score for Standard XII—Quality Assessment and Performance Improvement, demonstrating robust QAPI programs with effective governance, performance measurement, and under- and overutilization monitoring; LDH-approved PIPs; and timely reporting to LDH. **[Quality]**

For the MCOs statewide, the following opportunities for improvement were identified:

- Three MCOs did not establish an organization-wide approach to ensuring member rights. **[Quality]**
- Three MCOs did not ensure that all required information for members and potential members is provided in a manner and format that may be easily understood and is readily accessible by members and potential members. **[Quality]**
- The written materials critical to obtaining services of four MCOs did not meet criteria related to taglines and request for auxiliary aids and services at no cost. **[Quality and Access]**
- Four MCOs did not make a good faith effort to give written notice, within required time frames, to members regarding termination of contracted a provider to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. **[Quality and Timeliness]**
- Five of the six MCOs did not include all required elements in the member handbook. **[Quality]**
- Four MCOs did not include the required information in the provider directory. **[Quality and Access]**

- All MCOs' websites 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 the MCOs provide it upon request within five business days. **[Quality and Timeliness]**
- All MCOs failed to monitor their provider networks 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]**
- Four MCOs did not demonstrate that their provider networks include sufficient family planning providers to ensure timely access to covered services. **[Quality and Access]**
- No MCOs required network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. **[Quality, Timeliness, and Access]**
- Five MCOs 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]**
- No MCOs ensured that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities. **[Quality and Access]**
- All MCOs failed to offer 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 and 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 and Access]**
- The MCOs' CMPE file reviews demonstrated noncompliance with timely completion of the initial health needs assessment. **[Quality and Timeliness]**
- Three MCOs' CMPE file reviews demonstrated noncompliance with completion of timely in-person reassessments for Tier 2 and Tier 3 enrollees. **[Quality and Timeliness]**
- For credentialing and recredentialing, three MCOs did not verify compliance with primary source verification (PSV) requirements specifically related to verification time frames and required documentation elements. **[Quality and Timeliness]**
- The initial credentialing case files or policies for four MCOs did not verify compliance with PSV requirements or verification of State sanctions, restrictions on licensure, and limitations on scope of practice, as required. **[Quality and Timeliness]**
- Three MCOs did not ensure the application and attestation for credentialing and recredentialing included all requirements. **[Quality]**
- The credentialing and recredentialing file review demonstrated that three MCOs did not verify that the MCOs confirmed the provider is in good standing with State and federal regulatory bodies. **[Quality]**
- The credentialing and recredentialing file review demonstrated that five MCOs did not confirm that providers were reviewed and approved by an accrediting body or that the MCOs conducted an on-site quality assessment if the provider was not accredited. **[Quality]**

- No MCOs ensured that all contracts or written arrangements comply—and that all delegates agreed to comply—with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions, and rules, policies, procedures, manuals, the State Plan, and Waivers. **[Quality]**
- Five MCOs failed to include required provisions ensuring federal and State audit access to all delegate records, systems, and facilities—including downstream entities—for up to 10 years after contract termination. **[Quality and Timeliness]**
- Three MCOs failed to demonstrate that if the grievance resolution time frame is extended not at the request of the member, they make reasonable efforts to give the member prompt oral and written notice. **[Quality and Timeliness]**

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

- The MCOs must demonstrate a multi-departmental approach to training and the monitoring of member interactions to ensure member rights. **[Quality]**
- Three MCOs must ensure that all required information for members and potential members is provided in a manner and format that may be easily understood and is readily accessible by members and potential members. **[Quality]**
- The MCOs must ensure written materials that are critical to obtaining services, including at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices, are available in the prevalent non-English languages in their service areas. **[Quality and Access]**
- The MCOs must make a good faith effort to give written notice, within required time frames, of termination of a contracted provider to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. **[Quality and Timeliness]**
- The MCOs must include all required language in the member handbook. **[Quality and Access]**
- The MCOs must include the required components in the provider directory. **[Quality]**
- The MCOs must inform members on their websites that information provided electronically is available in paper form without charge upon request and provide it upon request within five business days. **[Quality and Timeliness]**
- The MCOs must monitor, through the collection and analysis of data, their provider network to ensure access to all services for all members, including those with limited English proficiency or physical or mental disabilities. **[Quality and Access]**
- The MCOs must demonstrate that their provider networks include sufficient family planning providers to ensure timely access to covered services. **[Quality and Access]**
- The MCOs must meet and require their network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. **[Quality, Timeliness, and Access]**

- The MCOs must ensure that their 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]**
- The MCOs must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities. **[Quality and Access]**
- The MCOs must offer an appropriate range of preventive, primary care, specialty services, and LTSS that is adequate for the anticipated number of members for the service area and 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 and Access]**
- The MCOs 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]**
- The MCOs 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]**
- The MCOs must 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 and Timeliness]**
- For credentialing and recredentialing, the MCOs must verify the State sanctions, restrictions on licensure, and limitations of scope of practice within 180 days of the credentialing decision. Additionally, the MCOs must verify all states where the practitioner provides and/or provided care to members within the most recent five-year period available. **[Quality and Timeliness]**
- For credentialing and recredentialing, the MCOs must revise policies and any other applicable documents to include language that states the application and attestation include current malpractice insurance coverage, and a current and signed attestation confirming the correctness and completeness of the application. Furthermore, credentialing files must include evidence of current malpractice coverage obtained through verification. **[Quality]**
- For credentialing and recredentialing, the MCOs must confirm that a provider is in good standing with State and federal regulatory bodies. **[Quality]**
- For credentialing and recredentialing, the MCOs must confirm that a provider has been reviewed and approved by an accrediting body; if the provider is not accredited, the MCOs must conduct an on-site quality assessment. Furthermore, the MCOs must have a process for ensuring that the provider credentials its practitioners. **[Quality]**
- The MCOs must ensure that all contracts or written arrangements comply—and that all delegates agree to comply—with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions, and rules, policies, procedures, manuals, the State Plan, and Waivers. **[Quality]**
- The MCOs must ensure all subcontractor agreements include full federal and State audit rights—covering all records, systems, premises, and downstream entities, including fraud-related audits—with access maintained for at least 10 years. **[Quality and Timeliness]**

- Three MCOs must demonstrate that if the grievance resolution time frame is extended not at the request of the member, they make a reasonable efforts to give the member prompt oral and written notice. **[Quality and Timeliness]**

Methodology

Activity 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 in 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 and Analysis

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.

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.

[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: Jan 15, 2026.

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	✓	✓	✓

5. Validation of Network Adequacy

Aggregate Results

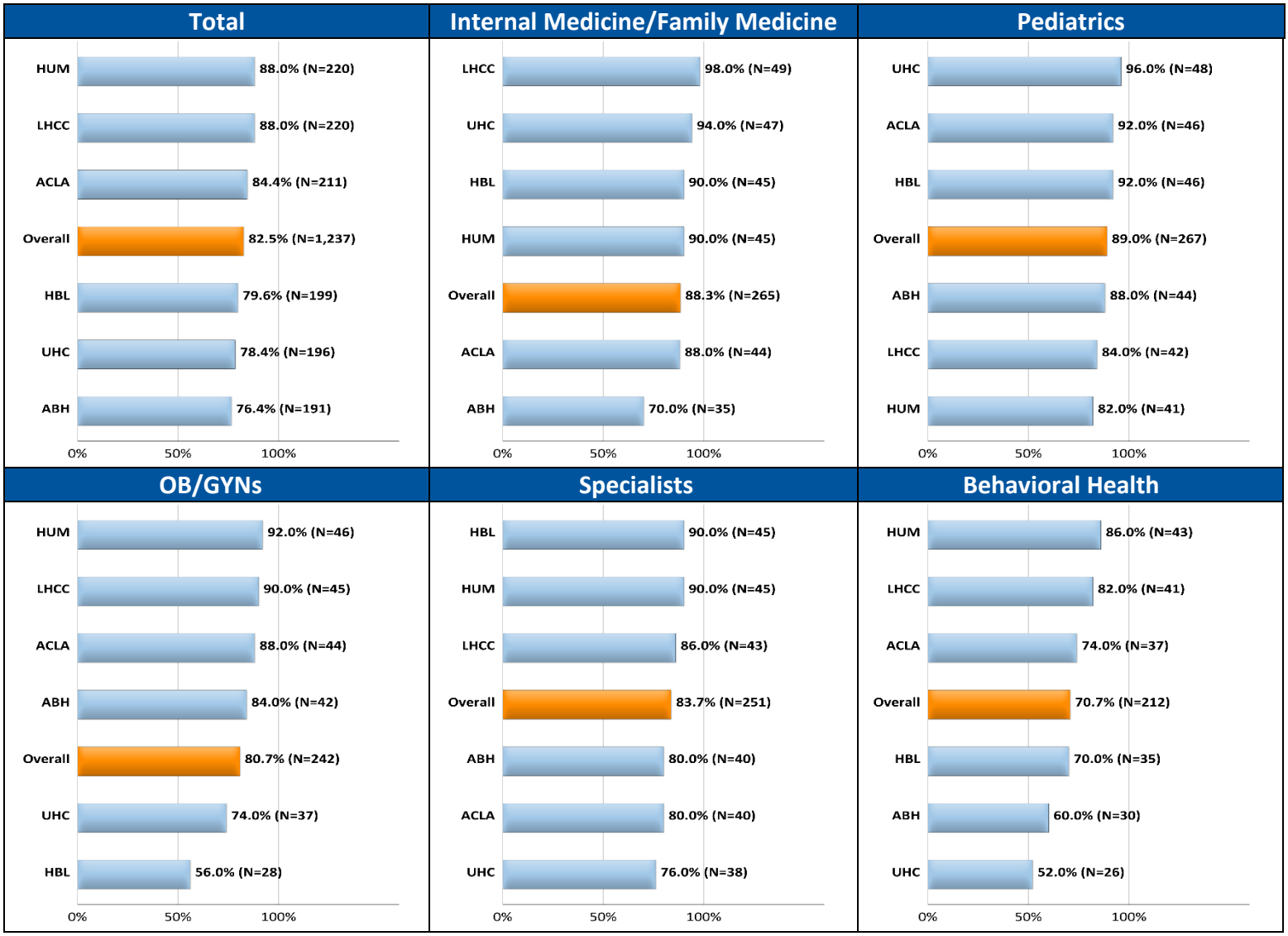
Provider Directory Validation

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 providers by MCO and specialty provider type.

Response Rate

Figure 5-1 illustrates the survey disposition and response rates by MCO and specialty provider type.

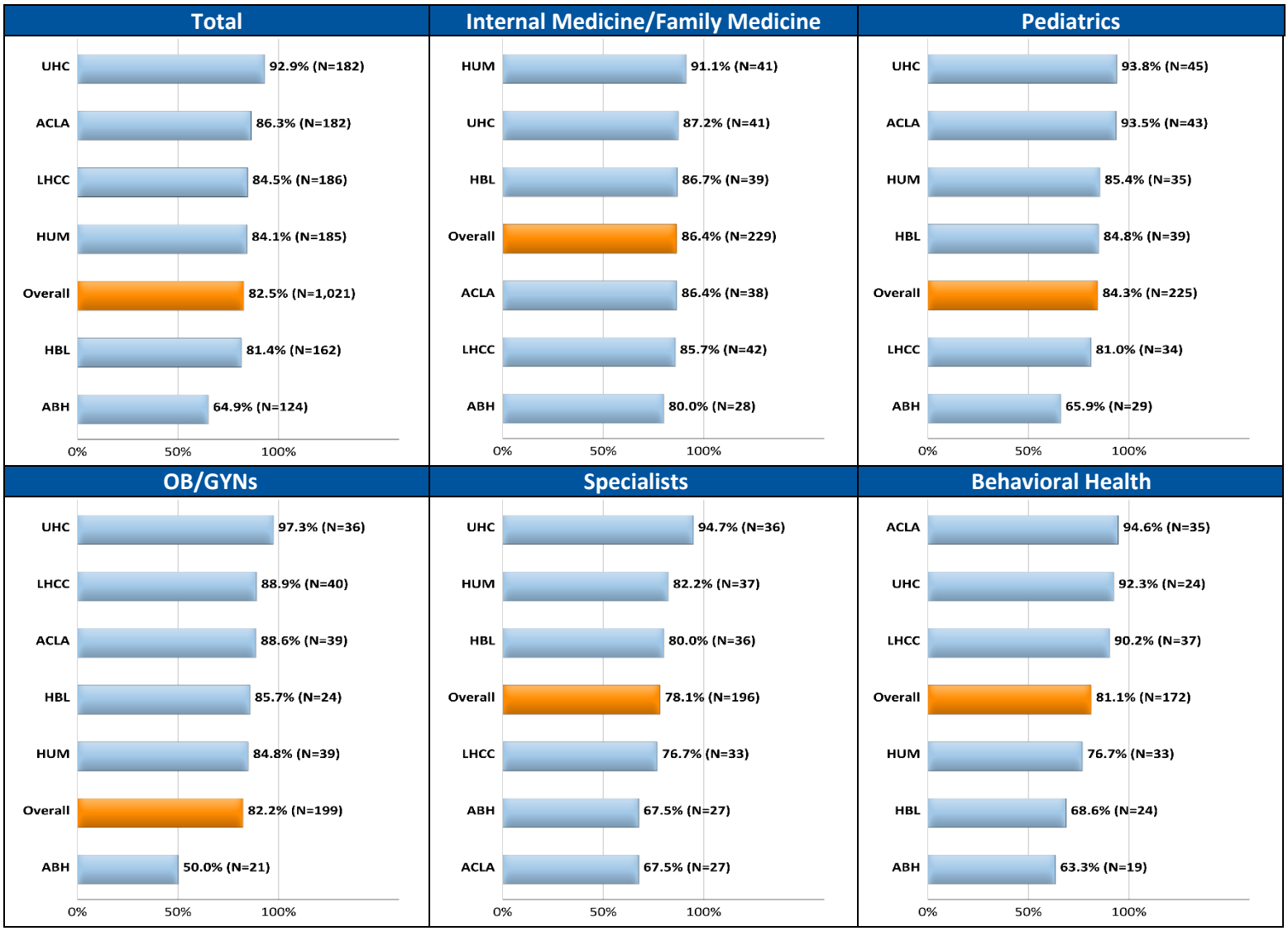
Figure 5-1—PDV Response Rates by MCO and Specialty Provider Type



Correct Address

Figure 5-2 displays the percentage of cases in which the survey respondent reported that the MCOs' provider directories reflected the correct address.

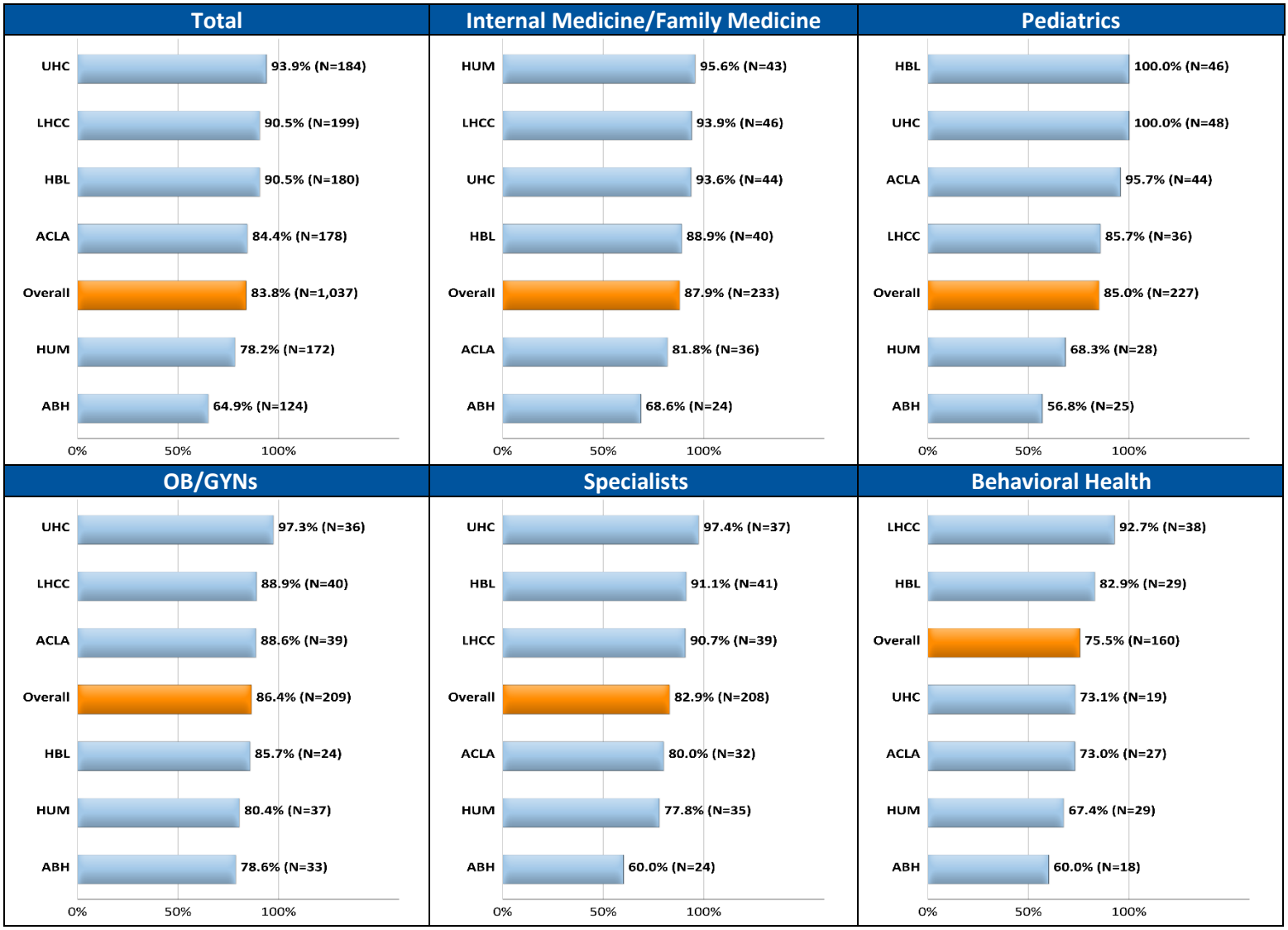
Figure 5-2—Respondents With the Correct Address



Provider at Correct Location

Figure 5-3 displays the percentage of cases in which the survey respondent confirmed that the sampled provider was at the location.

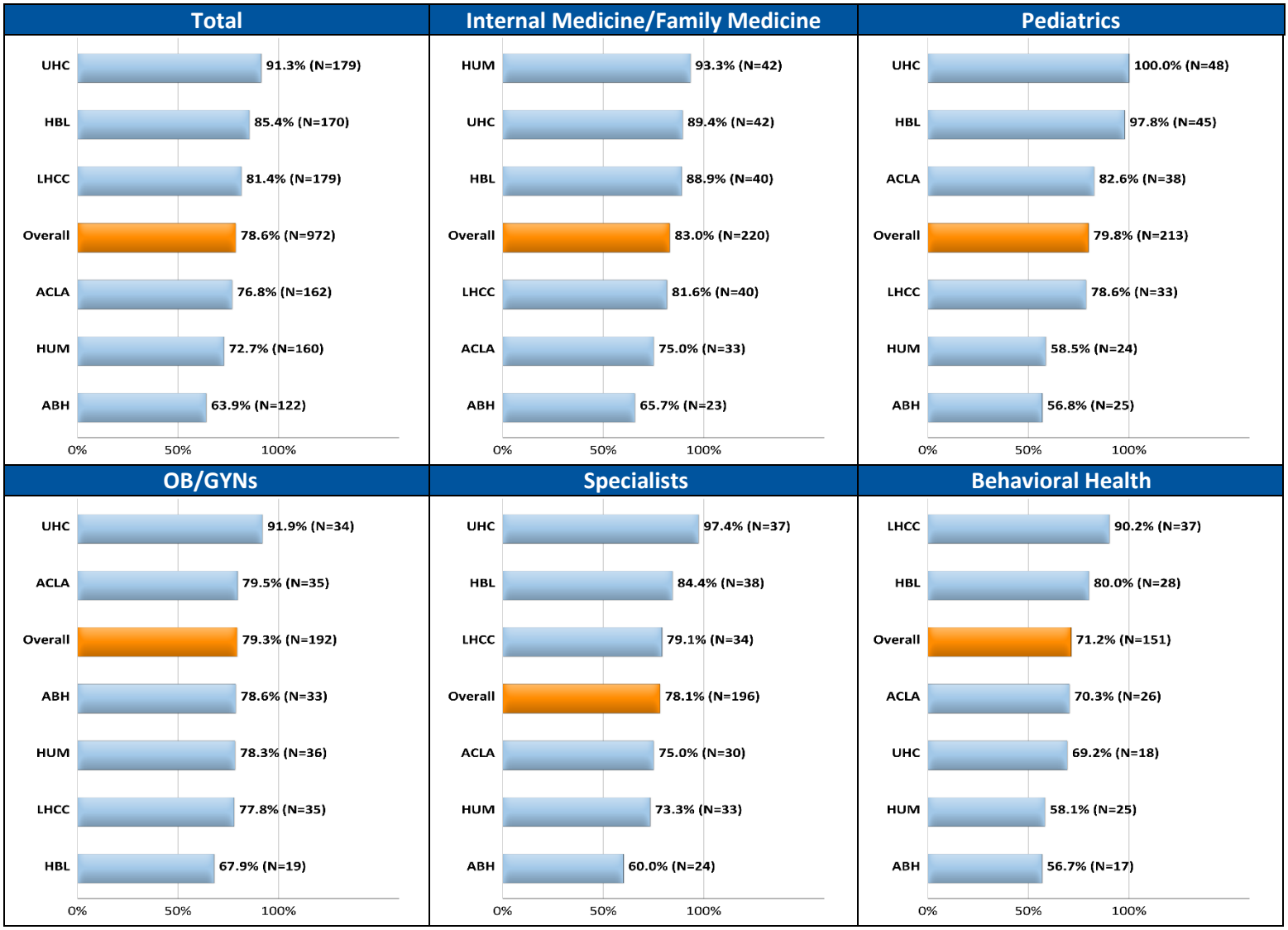
Figure 5-3—Respondents That Confirmed Sampled Provider at Correct Location



Specialty Provider Type

Figure 5-4 displays the percentage of cases in which the survey respondent confirmed that the sampled provider was the specialty provider type indicated in the MCOs' provider directories.

Figure 5-4—Respondents That Confirmed Specialty Provider Type



Acceptance Rates

Figure 5-5 through Figure 5-7 display the percentage of cases in which the survey respondent confirmed the provider accepted the requested MCO, Louisiana Medicaid, and confirmed new patient acceptance status, respectively.

Figure 5-5—Respondents That Confirmed the Provider Accepted the MCO

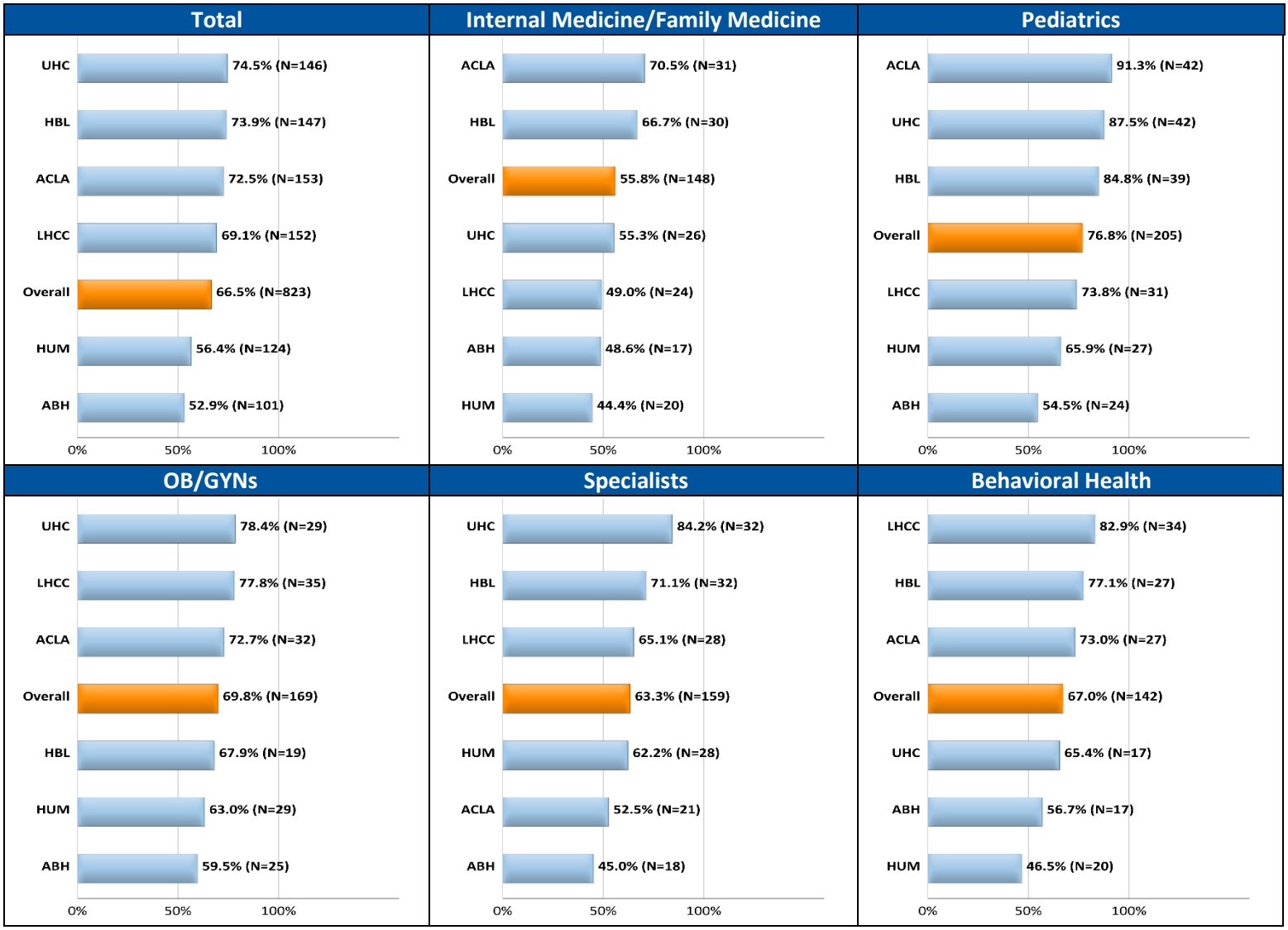


Figure 5-6—Respondents That Confirmed the Provider Accepted Louisiana Medicaid

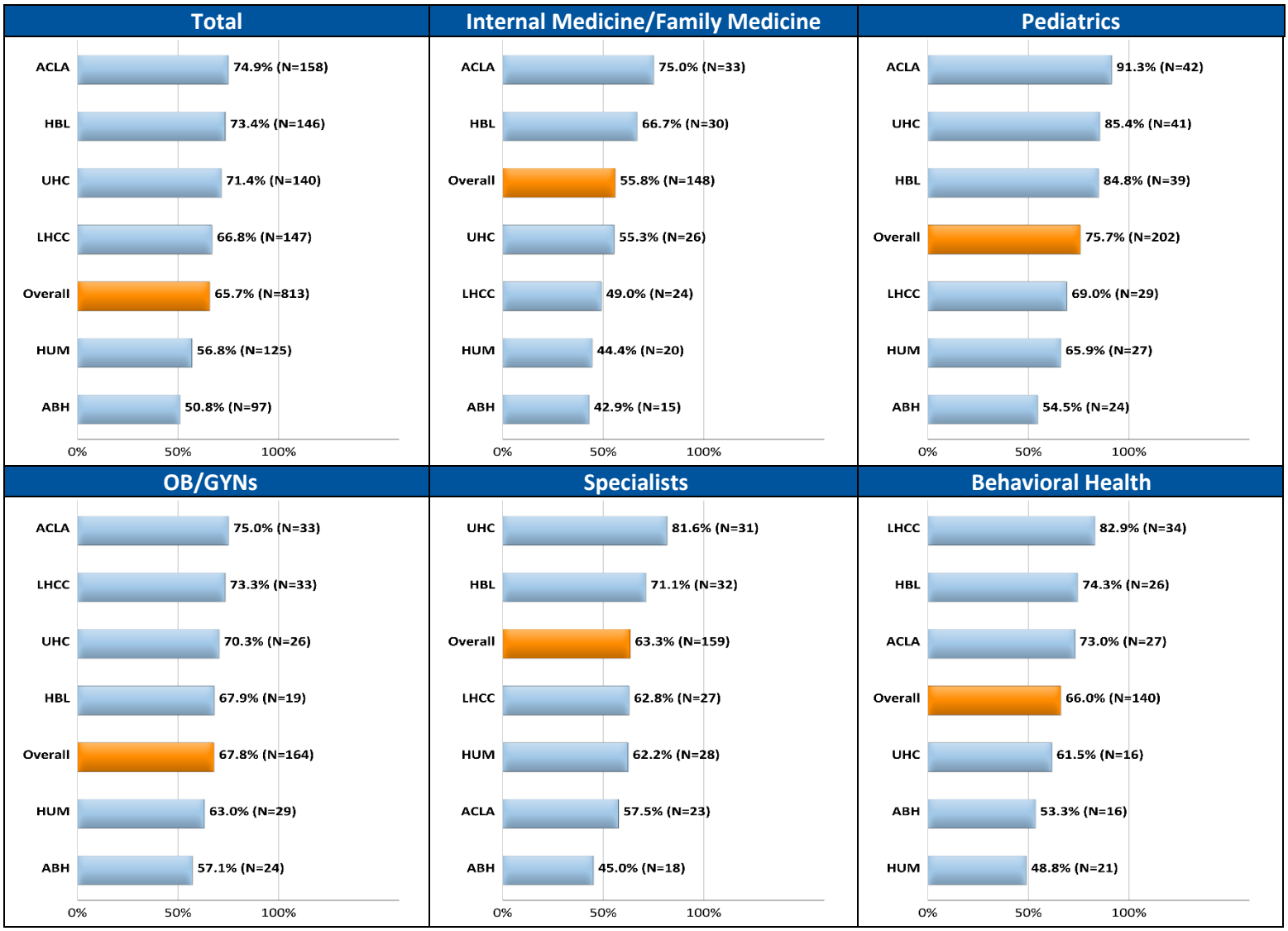
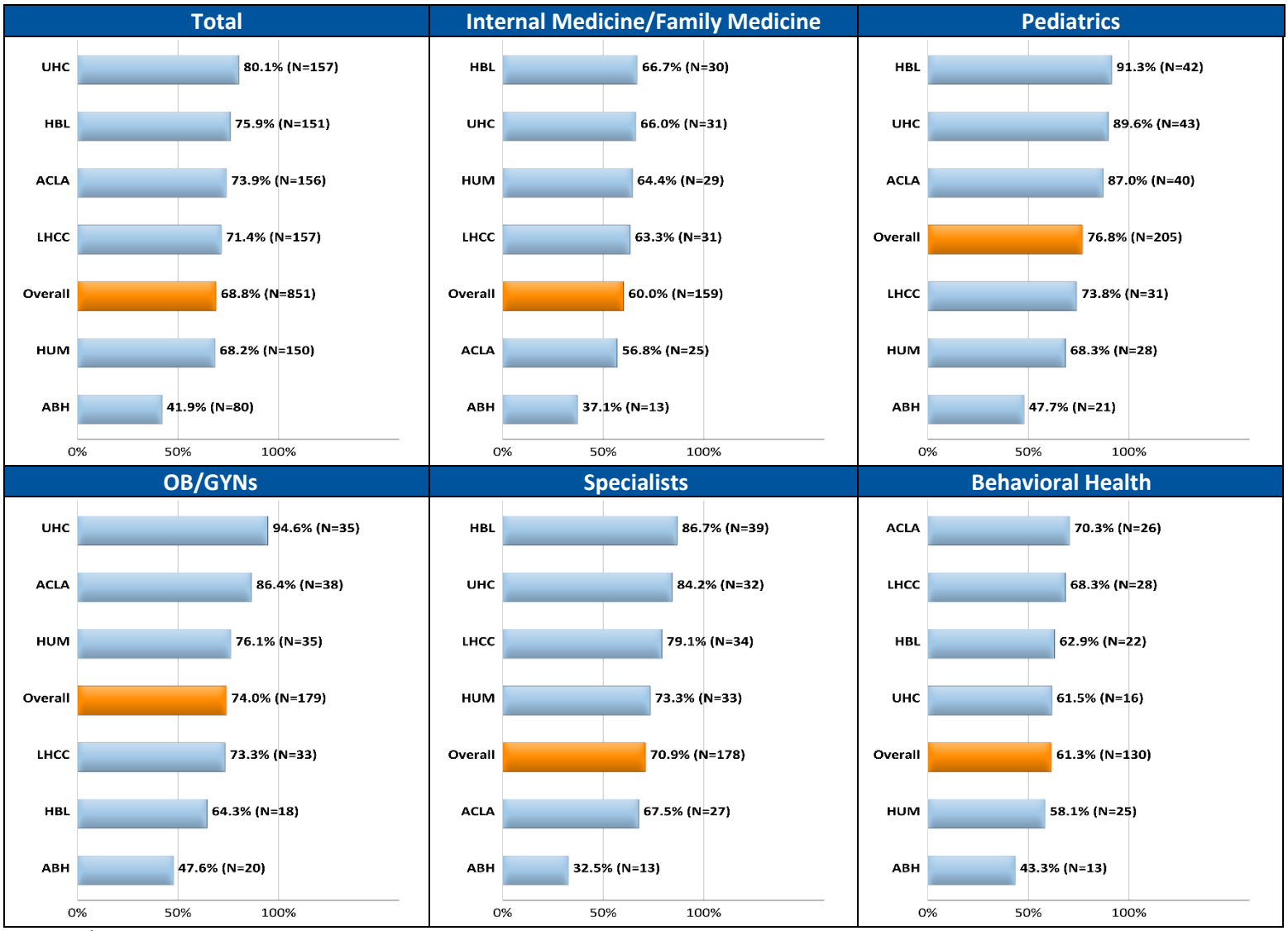


Figure 5-7—Respondents That Confirmed the Provider Accepted New Patients[1]



[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.

Compliance Scores

Table 5-1 and Table 5-2 present the PDV weighted compliance scores by specialty provider type and MCO, respectively.

Table 5-1—PDV Weighted Compliance Scores by Specialty Provider Type

Specialty Provider Type	Total	Compliant[1]	Weighted Compliance Score
Internal Medicine/Family Medicine	300	97	35.1%
Pediatrics	300	155	58.2%
OB/GYNs	300	116	44.4%
Specialists (any)	300	111	42.7%
Behavioral Health (any)	300	91	34.8%
Overall	**1,500**	**570**	**43.0%**

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

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

Specialty Provider Type	Total	Compliant[1]	Weighted Compliance Score
ABH	**250**	**43**	**23.1%**
Internal Medicine/Family Medicine	50	10	22.7%
Pediatrics	50	13	32.7%
OB/GYNs	50	7	22.7%
Specialists (any)	50	7	19.3%
Behavioral Health (any)	50	6	18.0%
ACLA	**250**	**116**	**52.3%**
Internal Medicine/Family Medicine	50	20	44.0%
Pediatrics	50	34	76.0%
OB/GYNs	50	25	57.3%
Specialists (any)	50	13	34.0%
Behavioral Health (any)	50	24	50.0%
HBL	**250**	**97**	**44.5%**
Internal Medicine/Family Medicine	50	20	43.3%
Pediatrics	50	30	66.0%
OB/GYNs	50	11	27.3%
Specialists (any)	50	23	54.0%

Specialty Provider Type	Total	Compliant[1]	Weighted Compliance Score
Behavioral Health (any)	50	13	32.0%
HUM	**250**	**90**	**41.1%**
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%
LHCC	**250**	**103**	**46.5%**
Internal Medicine/Family Medicine	50	14	31.3%
Pediatrics	50	22	52.0%
OB/GYNs	50	24	54.7%
Specialists (any)	50	20	45.3%
Behavioral Health (any)	50	23	49.3%
UHC	**250**	**121**	**50.8%**
Internal Medicine/Family Medicine	50	18	38.7%
Pediatrics	50	35	72.7%
OB/GYNs	50	26	54.0%
Specialists (any)	50	28	58.0%
Behavioral Health (any)	50	14	30.7%
Overall	**1,500**	**570**	**43.0%**

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

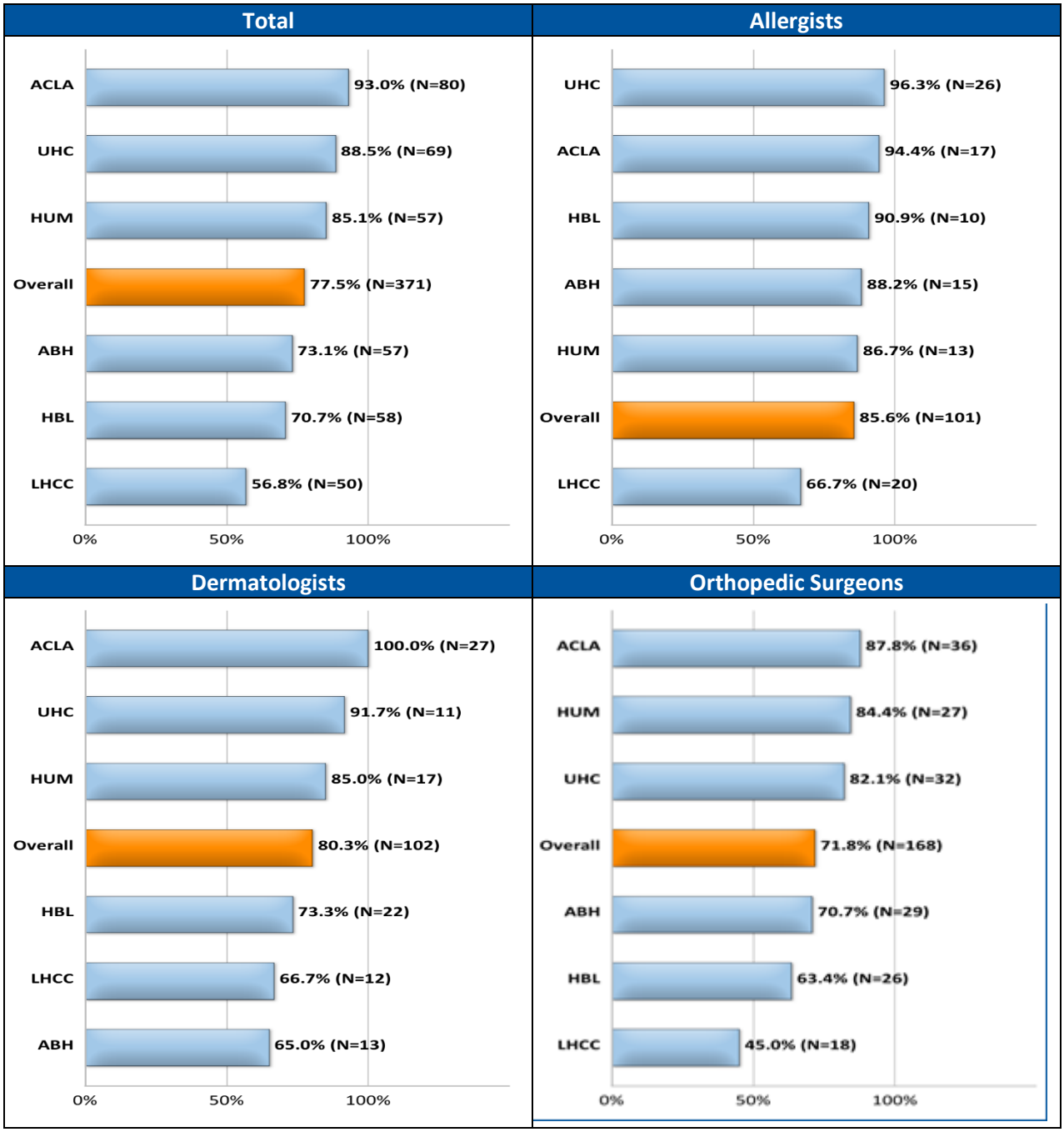
Provider Access Surveys

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.

Response Rate

Figure 5-8 illustrates the provider access survey response rates by MCO and specialty provider type.

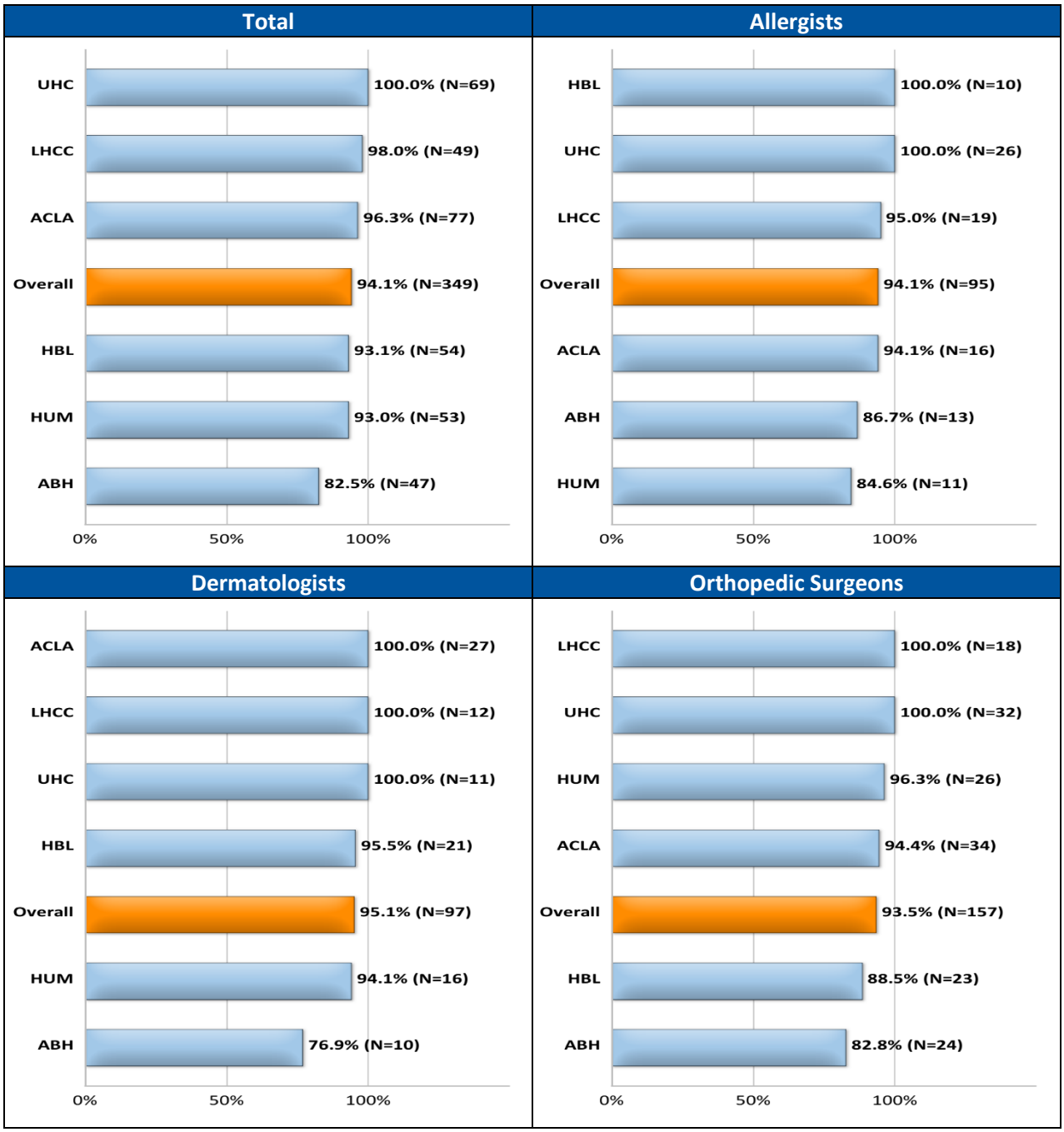
Figure 5-8—Provider Access Survey Response Rates by MCO and Specialty Provider Type



Correct Address

Figure 5-9 displays the percentage of cases in which the provider access survey respondent reported that the MCOs' provider data reflected the correct address.

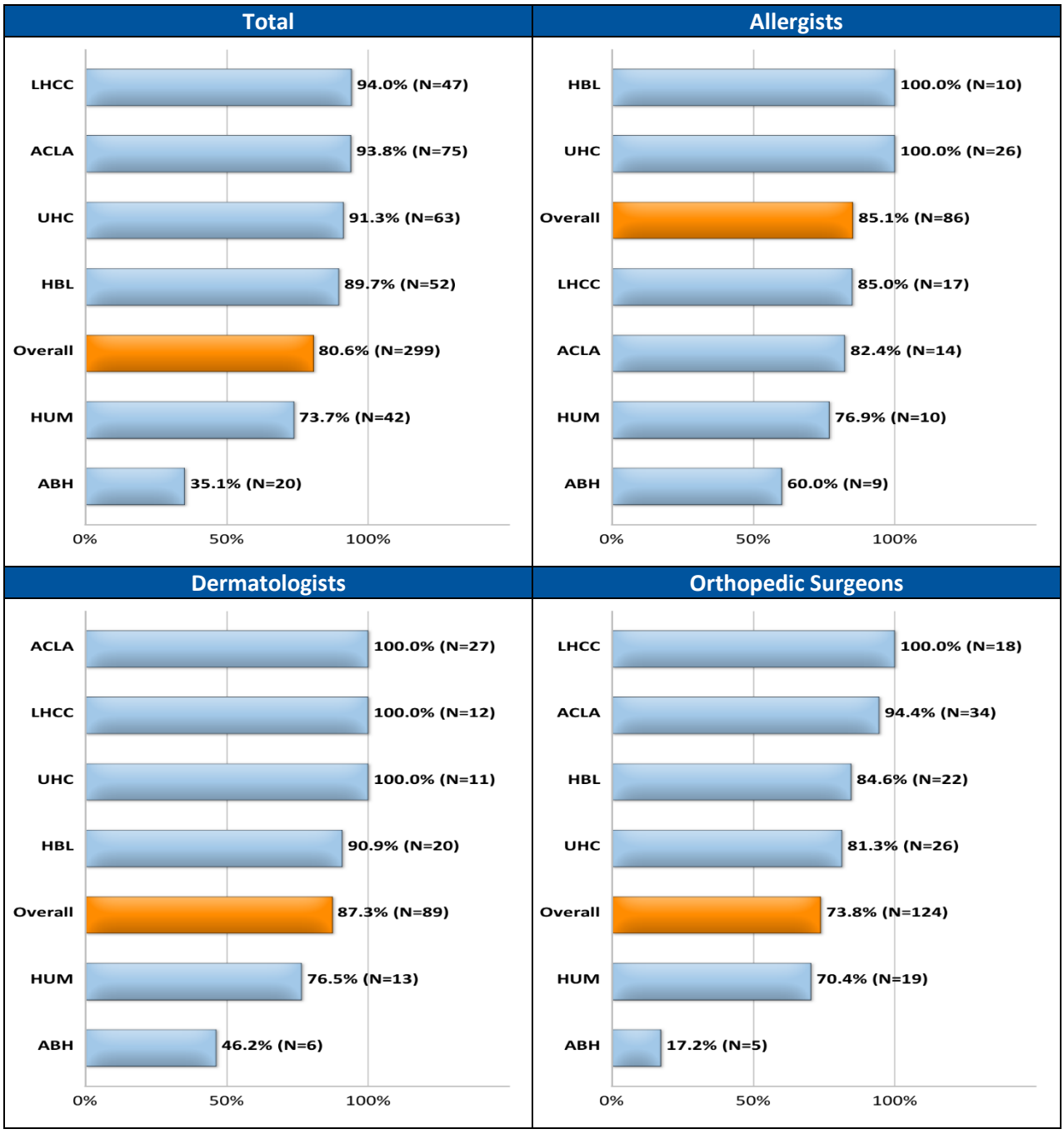
Figure 5-9—Provider Access Survey Respondents With the Correct Address



Offered Requested Services

Figure 5-10 displays the percentage of cases in which the provider access survey respondent confirmed that the sampled location offered the requested services.

Figure 5-10—Provider Access Survey Locations That Offered the Requested Services



Acceptance Rates

Figure 5-11 through Figure 5-13 display the percentage of cases in which the provider access survey respondent confirmed the location accepted the requested MCO, Louisiana Medicaid, and new patients, respectively.

Figure 5-11—Provider Access Survey Respondents That Confirmed the Location Accepted the MCO

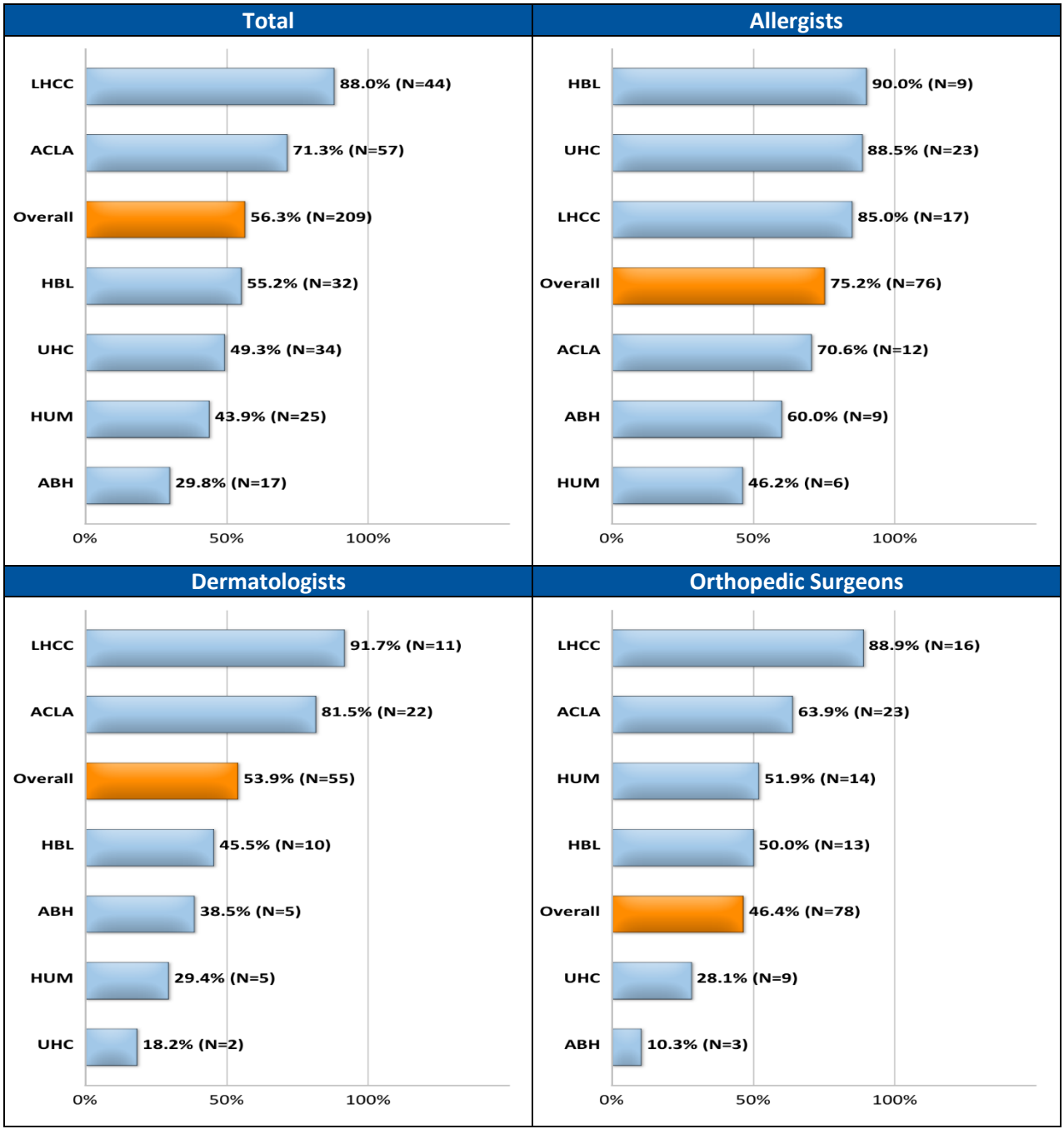


Figure 5-12—Provider Access Survey Respondents That Confirmed the Location Accepted Louisiana Medicaid

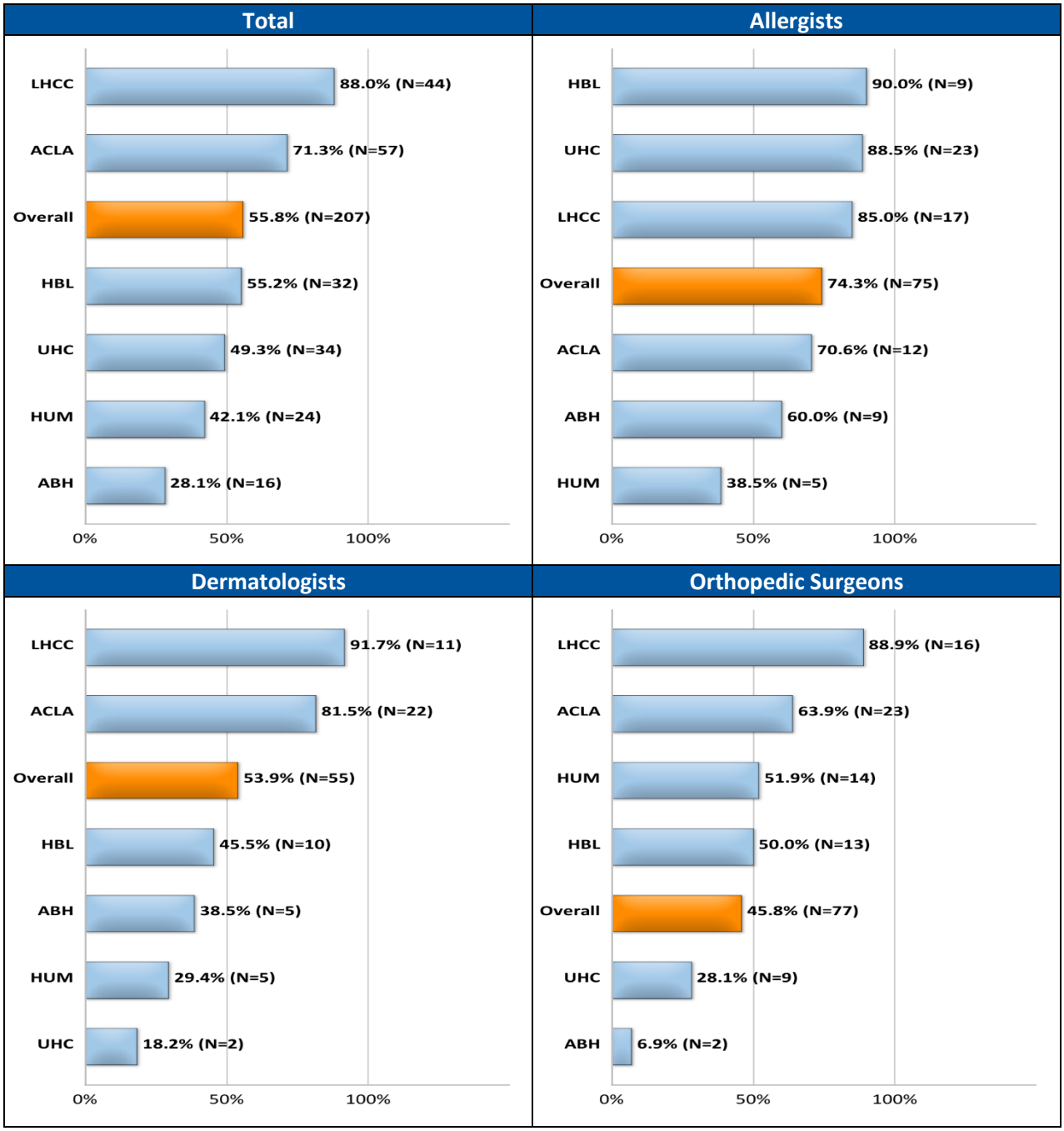
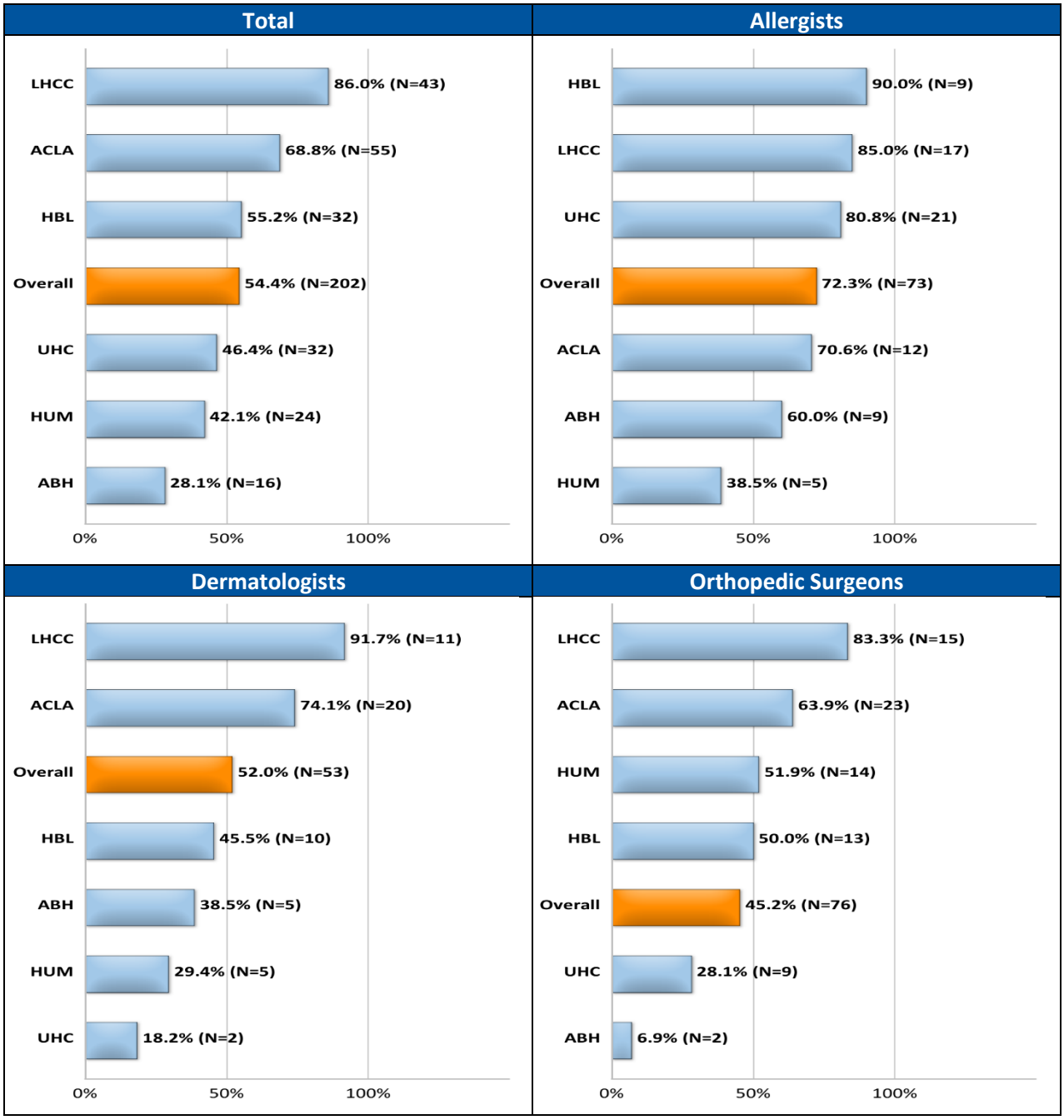


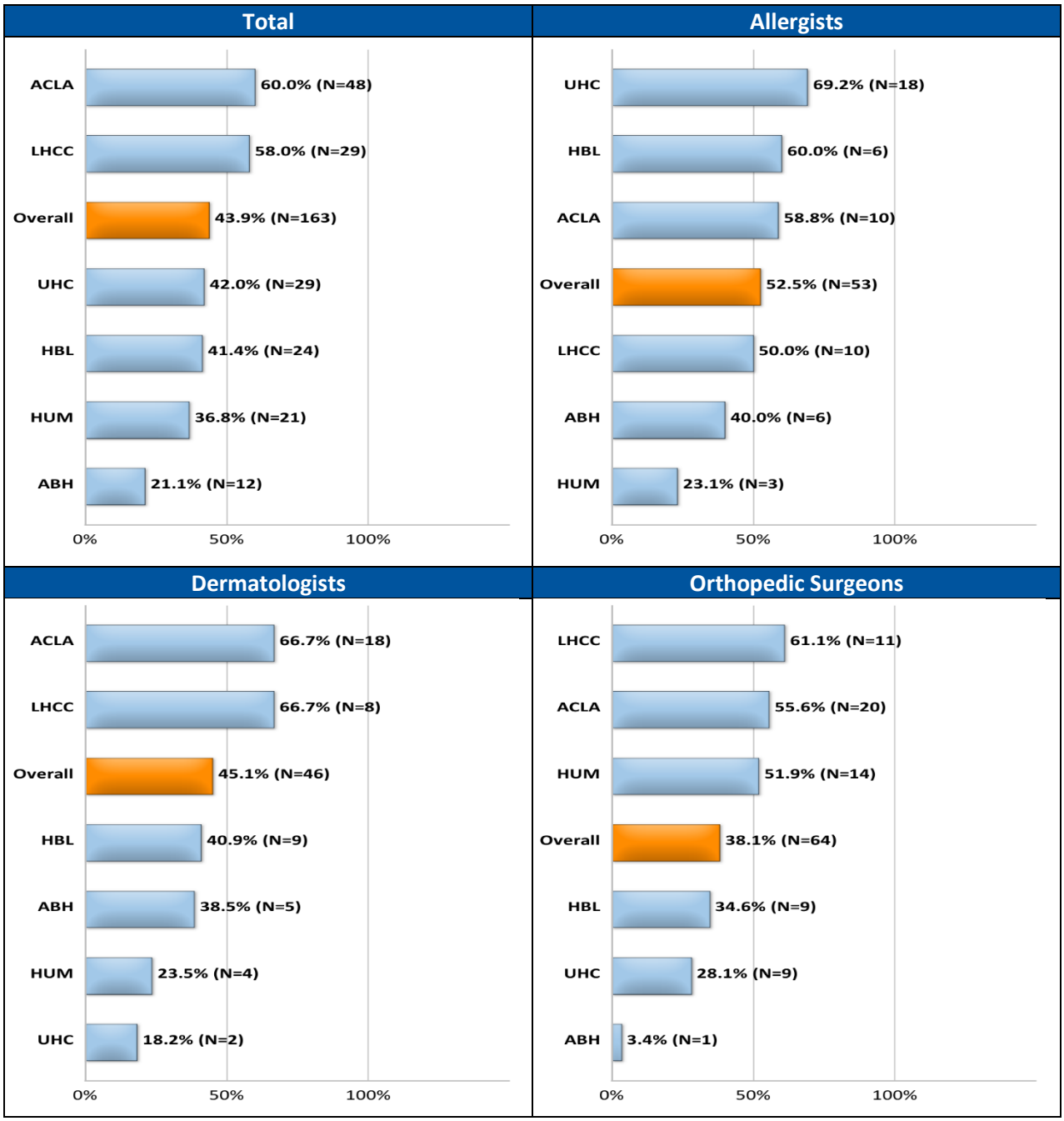
Figure 5-13—Provider Access Survey Respondents That Confirmed the Location Accepted New Patients



Provider at Correct Location

Figure 5-14 displays the percentage of cases in which the provider access survey respondent confirmed that the sampled provider was at the location.

Figure 5-14—Provider Access Survey Respondents That Confirmed Sampled Provider at Location



Wait Times

Figure 5-15 displays the average wait times for new patient appointments.

Figure 5-15—Provider Access Survey Average New Patient Wait Times

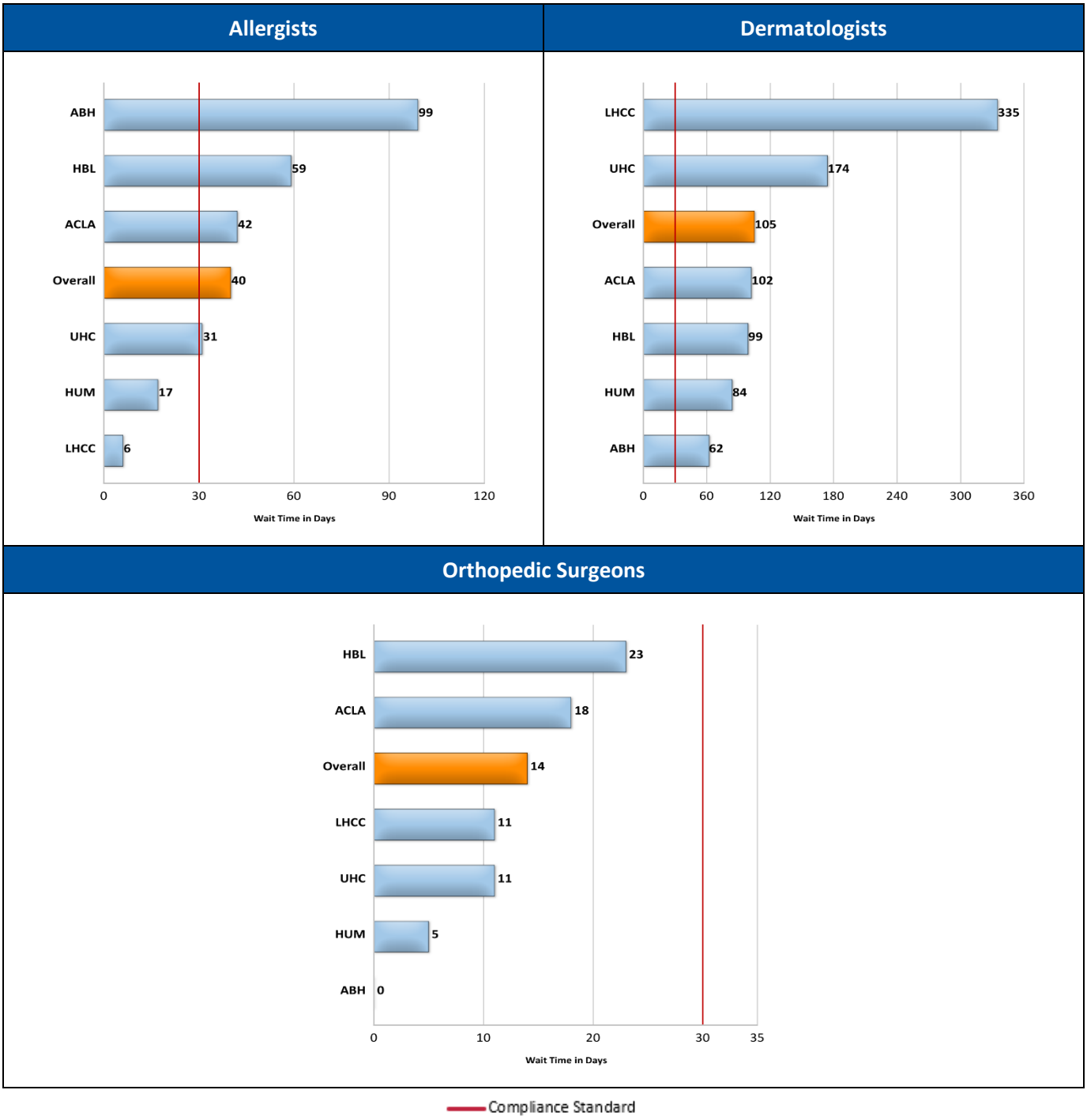


Figure 5-16 displays the percentage of cases within the appointment availability compliance standards for new patient appointments of one month (i.e., 30 calendar days) for non-urgent specialty care appointments.

Figure 5-16—Appointments Meeting Compliance Standards

Compliance Scores

Table 5-3 and Table 5-4 present the provider access survey weighted compliance scores by specialty provider type and MCO, respectively.

Table 5-3—Provider Access Survey Weighted Compliance Scores by Specialty Provider Type

Specialty Provider Type	Total Number of Providers Surveyed	Compliant[1]	Weighted Compliance Score[2]
Allergists	118	52	51.4%
Dermatologists	127	46	41.7%
Orthopedic Surgeons	234	64	38.3%
Overall	**479**	**162**	**42.4%**

[1] Compliant providers include providers for which all indicators match between the MCO provider data 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 5-10 and Table 5-11 of the Methodology section were used to calculate the weight of each noncompliance survey outcome.

Table 5-4—Provider Access Survey Weighted Compliance Scores by MCO

MCO	Total Number of Providers Surveyed	Compliant[1]	Weighted Compliance Score[2]
ABH	**78**	**11**	**42.3%**
Allergists	17	5	52.9%
Dermatologists	20	5	43.3%
Orthopedic Surgeons	41	1	37.4%
ACLA	**86**	**48**	**58.5%**
Allergists	18	10	64.8%
Dermatologists	27	18	66.7%
Orthopedic Surgeons	41	20	50.4%
HBL	**82**	**24**	**32.5%**
Allergists	11	6	54.5%
Dermatologists	30	9	33.3%
Orthopedic Surgeons	41	9	26.0%

MCO	Total Number of Providers Surveyed	Compliant[1]	Weighted Compliance Score[2]
HUM	**67**	**21**	**44.3%**
Allergists	15	3	28.9%
Dermatologists	20	4	31.7%
Orthopedic Surgeons	32	14	59.4%
LHCC	**88**	**29**	**34.8%**
Allergists	30	10	38.9%
Dermatologists	18	8	44.4%
Orthopedic Surgeons	40	11	27.5%
UHC	**78**	**29**	**42.3%**
Allergists	27	18	66.7%
Dermatologists	12	2	16.7%
Orthopedic Surgeons	39	9	33.3%
Overall	**479**	**162**	**42.4%**

[1] Compliant providers include providers for which all indicators match between the MCO provider data 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 5-10 and Table 5-11 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.

HSAG conducted the SFY 2025 validation of network adequacy indicators in accordance with the CMS EQR *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 4)[8] activities, confirming the MCOs' 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 MCOs and LDH's network adequacy monitoring efforts.

Based on the results of a completed ISCA combined with a virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the MCOs' interpretation of data was accurate. HSAG determined validation ratings for

[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: Jan 15, 2026.

each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each MCO according to Table 5-5.

Table 5-5—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*

HSAG assessed the MCOs' submitted distance report results and noted that for several provider types, there was a notable difference between one or two MCOs and the remaining MCOs for reported percentage of member access. Table 5-6 lists the MCO or MCOs that had at least a 25-point difference in member access, by provider type and urbanicity, as compared to the next closest MCO's member access.

Table 5-6—MCOs With a 25-Point or Greater Deficit of Member Access Compared to the Next Highest MCO's Level of Member Access, by Provider Type and Urbanicity

Provider Type	Urbanicity	MCO and Member Access Percent	Next Highest MCO and Percentage of Member Access
Laboratory	Rural	ABH (44.4%)	HUM (86.8%)
Pharmacy	Urban	HUM (18.9%)	HBL (95.7%)
	Rural	HUM (50.8%)	HBL (99.9%)
Hemodialysis Centers	Urban	HBL (0.0%)	ABH (89.5%)
	Rural	HBL (5.1%)	ABH (95.2%)
Endocrinology and Metabolism (Pediatric)	Rural	UHC (65.6%)	ABH (99.1%)
Neurology (Pediatric)	Urban	UHC (0.0%)	ABH, ACLA, HUM, LHCC (99.9%)
	Rural	UHC (0.0%)	LHCC (97.7%)
Physicians and LMHPs who specialize in pregnancy-related and postpartum SUD	Urban	HBL (8.2%)	ACLA (79.5%)
	Rural	ACLA (34.6%) HBL (13.1%)	LHCC (80.9%)
ASAM Level 1	Urban	HBL (53.6%)	HUM (88.5%)
	Rural	HBL (8.7%) HUM (45.5%)	ACLA (92.8%)

Provider Type	Urbanicity	MCO and Member Access Percent	Next Highest MCO and Percentage of Member Access
ASAM Level 2.1	Urban	HBL (45.9%)	ACLA (86.6%)
	Rural	HBL (3.3%) HUM (45.1%)	ACLA (81.8%)
ASAM Level 2 WM	Urban	HBL (0.0%)	ACLA (75.8%)
	Rural	HBL (0.0%) HUM (3.2%)	UHC (69.3%)
ASAM Level 3.1 (Pediatric under age 21)	All	HBL (35.7%)	UHC (80.5%)
ASAM Level 3.2 WM (Adult over age 21)	Urban	HBL (38.8%)	UHC (65.7%)
ASAM Level 3.5 (Pediatric under age 21)	All	HBL (12.5%)	HUM (95.7%)
ASAM Level 3.7 (Adult over age 21)	Rural	HBL (69.2%) HUM (72.9%)	LHCC (92.8%)
ASAM Level 3.7 WM (Adult over age 21)	Urban	HBL (65.8%)	ABH (94.1%)
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)	Rural	HBL (45.2%)	ABH (94.7%)

HSAG assessed the appointment timeliness standards and determined that for the three behavioral health indicators reported to LDH through the LA 359 report template, one MCO, ABH, met all three of the required compliance rates for the three timeliness standards, and one MCO, ACLA, met none.

Table 5-7 displays each behavioral provider health access and timeliness standard by indicator by visit type, and the MCOs that met the specific indicator.

Table 5-7—MCOs That Met Behavioral Health Provider Access and Timeliness Goals, by Standard

Type of Visit	Access/Timeliness Standard	MCOs That Met Compliance Goal
Emergency Care	24 hours, 7 days/week within 1 hour of request	ABH, HUM

Type of Visit	Access/Timeliness Standard	MCOs That Met Compliance Goal
Urgent Non-Emergency Behavioral Health Care	48 hours (2 calendar days)	ABH
Non-Urgent Routine Behavioral Health Care	14 calendar days	ABH, HBL, LHCC, UHC

Statewide MCO Strengths, Opportunities for Improvement, and Recommendations

For the MCOs statewide, the following strengths were identified:

- Overall, 94.1 percent of the provider access survey respondents indicated the sampled address was correct. **[Quality, Timeliness, and Access]**
- Of the limited cases that offered an appointment date in the provider access survey, 92.3 percent of orthopedic surgeon cases offered an appointment within the compliance standard. **[Quality, Timeliness, and Access]**
- No strengths were identified in the PDV, as all indicators had match rates below 90 percent. **[Quality and Access]**
- Overall, the MCEs had well-defined processes and procedures in place to ensure efficient and accurate collection of member and provider data to support network adequacy calculation and reporting. **[Quality, Timeliness, and Access]**
- Network adequacy remained robust for many provider types across the MCEs, demonstrating high member access rates. **[Quality, Timeliness, and Access]**

For the MCOs statewide, the following opportunities for improvement were identified:

- Acceptance of the MCO was low with 66.5 percent of providers in the PDV and 56.3 percent of locations in the provider access survey accepting the requested MCO. Additionally, 65.7 percent of providers in the PDV and 55.8 percent of locations in the provider access survey accepted Louisiana Medicaid. **[Quality and Access]**
- Overall, only 78.6 percent of providers in the PDV and 80.6 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 68.8 percent of providers in the PDV and 54.4 percent of locations in the provider access survey accepting new patients. **[Quality and Access]**
- Provider affiliation varied by survey type with 83.8 percent of PDV locations and 43.9 percent of provider access survey locations confirming the sampled provider was at the location. **[Quality and Access]**

- Overall, only 22.4 percent of the provider access survey locations offered an appointment. Of the cases offered an appointment date, 56.7 percent of allergy cases and 44.4 percent of dermatology cases were within the wait time compliance standards. **[Quality, Timeliness, and Access]**
- Compliance scores varied by MCO and survey type with overall compliance scores of 43.0 percent for the PDV and 42.4 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 34.8 percent and pediatrics having the highest compliance score at 58.2 percent for the PDV. For the provider access survey, orthopedic surgeons exhibited the lowest compliance score at 38.3 percent, and allergists exhibited the highest compliance score at 51.4 percent. **[Quality and Access]**
- For several provider types, member access percentages for one or two MCOs were notably lower than those reported by the remaining MCOs. **[Quality, Access, and Timeliness]**
- For emergency behavioral health care within one hour of request, four of the six MCOs did not meet the LDH-established compliance requirements, and for urgent non-emergency behavioral health care within 48 hours, five of the six MCOs did not meet the LDH-established compliance requirements. **[Quality, Timeliness, and Access]**

For the MCOs statewide, the following recommendations were identified:

- LDH should provide each MCO with the case-level data files (i.e., flat files) and a defined timeline by which each MCO will address provider data deficiencies identified during PDV reviews and/or the provider access survey (e.g., incorrect or disconnected telephone numbers, lack of MCO and Louisiana Medicaid acceptance, and/or provider information that does not correspond to the sampled location). **[Quality and Access]**
- In addition to updating provider information, each MCO 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]**
- The MCOs should conduct outreach to their 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 MCOs to confirm office outreach and confirmation of provider information. **[Quality, Timeliness, and Access]**
- LDH and the MCOs 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. **[Quality, Timeliness, and Access]**
- In coordination with ongoing outreach and network management activities, LDH could request the MCOs review provider office procedures for ensuring appointment availability standards are being met, address questions or reeducate providers and office staff members on LDH standards, and incorporate appointment availability standards into educational materials. The MCOs should provide LDH with copies of any training or educational materials. **[Quality, Timeliness, and Access]**

- LDH should continue to monitor the MCOs' compliance with existing State standards for appointment availability. Additionally, LDH should evaluate whether additional access standards or access assessments are needed to address gaps in provider availability. **[Quality, Timeliness, and Access]**
- LDH could consider requesting that each MCO supply copies of its documentation regarding the MCO's processes for monitoring and evaluating members' ability to access care, including both geographic access and timely access to care. **[Quality, Timeliness, and Access]**
- LDH and the MCOs could collaborate to identify existing barriers contributing to gaps in provider networks where it appears the gaps may not be as severe for other MCOs; and develop a Strategic, Measurable, Attainable, Realistic, and Timebound (SMART) plan to address and close these gaps. **[Quality, Timeliness, and Access]**
- The MCOs should work with behavioral health providers to identify barriers to care and what steps may be taken to assist in improving access for members to address these more acute needs timely. **[Quality, Timeliness, and Access]**

Methodology

Objectives

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

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

The objectives of the validation of network adequacy are to:

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

Technical Methods of Data Collection

In February 2023, CMS released updates to the CMS EQR protocols, including the newly developed NAV protocol. As established in the 2016 final rule, states must begin conducting the NAV activity at 42 CFR §438.358(b)(1)(iv) no later than one year from the issuance of the CMS EQR Protocol 4. Therefore, in February 2024, HSAG began conducting NAV activities in accordance with the CMS EQR Protocol 4 and will report results in the EQR technical report due April 30, 2025.

Provider Directory Validation

HSAG conducted PDV reviews from January through April 2025. To conduct the NAV analysis, HSAG utilized the MCOs' online provider directories to locate and extract provider data elements. Trained interviewers collected survey responses using a standardized script to validate survey indicators pertaining to provider data accuracy, such as telephone number, address, specialty provider type, provider affiliation with the requested MCO, provider's acceptance of Medicaid, and accuracy of new patient acceptance status.

Provider Access Survey

HSAG conducted the first provider access survey from April to May 2025. To conduct the NAV analysis, each MCO used the data request document prepared by HSAG to identify providers potentially

eligible for survey inclusion, and to submit provider data files used to populate its online provider directory to HSAG. At a minimum, the data elements requested for each provider included: provider name, Medicaid identification (ID), National Provider Identifier (NPI) number, specialty provider type, physical (practice) address, telephone number, provider taxonomy code, and whether the provider accepted new patients.

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

NAV Audit

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

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

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

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

Description of Data Obtained

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

1. PDV, to validate the MCOs' online provider directories to ensure members have appropriate access to provider information. HSAG utilized the MCOs' online provider directories to locate and extract provider data elements required to conduct the survey component of the PDV activity.
2. Provider access survey, to determine the accuracy of the managed care network information supplied to Healthy Louisiana members using the MCOs' provider data files and to ensure that Louisiana provider networks are following the established LDH standard for office-hour appointments. HSAG utilized the MCOs' provider data files used to populate their online provider directories to conduct the survey component of the provider access survey activity.
3. HSAG prepared a document request packet that was submitted to each MCO outlining the activities conducted during the validation process. The document request packet included a request for documentation to support HSAG's ability to assess each MCO's IS and processes, network adequacy indicator methodology, and accuracy of network adequacy reporting at the indicator level. Documents requested included an ISCAT, a timetable for completion, and instructions for submission. HSAG worked with the MCOs to identify all data sources informing calculation and reporting at the network adequacy indicator level. HSAG obtained the following data and documentation from the MCOs to conduct the NAV audits:
   - IS data from the ISCAT
   - Network adequacy logic for calculation of network adequacy indicators
   - Network adequacy data files
   - Network adequacy monitoring data
   - Supporting documentation, including policies and procedures, data dictionaries, system flow diagrams, system log files, and data collection process descriptions

How Data Were Aggregated and Analyzed

Provider Directory Validation

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

- Telephone number
- Address
- Office affiliation with the sampled provider
- Accuracy of specialty provider type

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

HSAG used the following validation responses to assess each indicator:

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

Using the results of the PDV, HSAG calculated a compliance score for each MCO. The criteria in Table 5-8 were used to calculate the weight of each noncompliance survey outcome.

Table 5-8—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 5-9—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 5-8. 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.

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 5-10 were used to calculate the weight of each noncompliance survey outcome.

Table 5-10—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 5-11—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 5-10. 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 5-12.

Table 5-12—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 5-13.

Table 5-13—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 5-14 and assigned by HSAG once HSAG has calculated the validation score for each indicator.

Table 5-14—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 5-15.

Table 5-15—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

Aggregate Results

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

Table 6-1—EDV Results for MCOs

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• All MCOs 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. • All MCOs reported methods to identify duplicate claims. • All MCOs were responsible for the collection and maintenance of the provider information. In addition, all MCOs integrated the Medicaid member enrollment files into their systems for claim processing.
Payment Structures	• All MCOs reported a wide range of pricing methodologies that varied by encounter type and subcontractors. • All MCOs collected and verified TPL information, processed payment based on TPL information, and submitted TPL information to LDH via the encounter data.
Encounter Data Quality Monitoring	• All MCOs noted that they had subcontractors for NEMT and pharmacy encounters, while five (ABH, HBL, HUM, LHCC, and

Analysis	Key Findings
	UHC) of the six MCOs had dental and vision subcontractors, and HBL also noted a palliative care subcontractor. The list below shows a few key findings regarding whether the MCOs stored, reviewed, or modified encounters before submitting them to LDH, and reviewed them after submission to LDH. – HUM noted that it did not store its dental subcontractor data, while LHCC noted it did not store the data for its NEMT, pharmacy, or vision subcontractors. Additionally, UHC did not store data for its pharmacy subcontractor. – LHCC is the only MCO that modified the data prior to submission to LDH, and the modification is only for its dental subcontractor. – HBL noted it did not review its pharmacy subcontractor data either before or after submission, while HUM did not review its dental subcontractor data either before or after submission. • For encounters collected by subcontractors, the MCOs and their subcontractors noted that they generally performed at least one listed data quality check (i.e., claim volume, completeness and accuracy, timeliness, and reconciliation with financial reports). However, the types of checks varied by MCO and type of subcontractor, as shown by the list below: – Neither HUM nor the HUM subcontractors acknowledged using claim volume and/or timeliness checks for any of the subcontractors' data. – ABH and ACLA and/or their subcontractors noted they have completeness, accuracy, as well as timeliness checks for all types of encounters from their subcontractors. – ABH, ACLA, LHCC, and UHC and/or their subcontractors noted they used reconciliation with financial reports as a data check for all types of encounters from their subcontractors. • For encounters collected by the MCOs, all MCOs noted that they performed completeness and accuracy and reconciliation with financial reports checks, while the claim volume and timeliness checks varied by MCO. • Based on the MCOs' responses to the questionnaire, the pharmacy encounters generally had the lowest percentage of encounters initially rejected and not yet accepted by LDH, with a range of 0.3 percent (ABH and ACLA) to 0.8 percent (HBL, HUM, LHCC, and UHC). The relatively high rejection rates varied by MCO and encounter type, as shown by the list below: – HBL had the highest rejection rates for non-subcontractor professional encounters at 11.2 percent.

Analysis	Key Findings
	– HUM had the highest rejection rates for both NEMT and vision encounters at 7.3 percent and 8.9 percent, respectively.
Administrative Profile	
Encounter Data Completeness	• All MCOs generally displayed consistent encounter volume per 1,000 MM, payment amount PMPM, and TPL payment amount PMPM for professional, institutional, dental, and pharmacy encounters throughout the measurement year. • The aggregate percentages of duplicate encounters across all MCOs were less than 1.0 percent for professional, institutional, and pharmacy encounters, while the aggregated MCO duplicate rate for dental encounters was 3.4 percent.
Encounter Data Timeliness	• Professional encounters: Within 60 days, two MCOs (ACLA and UHC) submitted at least 98.0 percent of encounters to LDH after the payment date, while two MCOs (HBL and HUM) submitted less than 78.0 percent of encounters to LDH after the payment date. • Institutional encounters: Within 60 days, no MCOs submitted at least 98.0 percent of encounters to LDH after the payment date, while three MCOs (HBL, HUM, and LHCC) submitted less than 83.0 percent of encounters to LDH after the payment date. • Dental encounters: Within 60 days, two MCOs (ABH and UHC) submitted at least 98.0 percent of encounters to LDH after the payment date, while HUM submitted 11.1 percent of encounters to LDH after the payment date. • Pharmacy encounters: Within 60 days, four MCOs (ABH, ACLA, LHCC, and UHC) submitted at least 99.0 percent of encounters to LDH after the payment date. Additionally, within 60 days, all six MCOs submitted at least 90.8 percent of encounters to LDH after the payment date.
Field-Level Completeness and Accuracy	• The key data elements in the professional, institutional, and pharmacy encounters had a relatively high or reasonable rate of population (i.e., percent of present) for all MCOs. Among the dental encounters, the key data elements were reasonably populated, except for ABH and HUM, which did not contain any values for the Oral Cavity Code field, as well as LHCC, which did not contain any values for the Tooth Number, Tooth Surface, and Oral Cavity Code fields. • For all four encounter types, the MCOs had many of the key data elements populated with at least 95.0 percent of valid values. The data element that was most populated with less than 95.0 percent of valid values was the NDC field in the professional encounters. Refer to the opportunities for improvement section below for the data elements needing the MCOs' attention.

Analysis	Key Findings
Encounter Referential Integrity	• No major concerns were noted for the MCOs when evaluating the integrity between medical/dental/pharmacy encounters and member enrollment data or between medical/dental encounters and pharmacy encounters. • Among the MCOs, 85.4 percent (ABH) to 94.3 percent (ACLA) of identified providers in the medical/dental encounters were found in the provider file. Similarly, 67.0 percent (HBL) to 96.2 percent (UHC) of identified providers found in the pharmacy encounters were found in the provider file.
Encounter Data Logic	• Among the six MCOs, HUM had the lowest percentage of members (17.3 percent) with both a medical/dental encounter and a pharmacy encounter. This is because pharmacy services were carved out for HUM until October 28, 2023. During the carve out period, pharmacy claims for linked members were referred to FFS. Of the remaining MCOs, about 53.6 to 64.8 percent of members had both medical/dental and pharmacy encounters throughout the measurement year. • For the MCOs, 50.1 percent (HUM) to 75.2 percent (LHCC) of LDH Medicaid members were continuously enrolled throughout the measurement year.

Statewide MCO Strengths, Opportunities for Improvement, and Recommendations

For the MCOs statewide, the following strengths were identified:

- For the encounters collected by all subcontractors, two MCOs (ABH and ACLA) noted that they stored and reviewed these encounter data before submission to LDH, did not modify the data before submission, and reviewed the encounters after submission to LDH. In addition, these two MCOs and/or all of their subcontractors noted that they performed at least three types of checks among the four checks including claim volume, completeness and accuracy, timeliness, and reconciliation with financial reports checks on the corresponding encounters. **[Quality and Timeliness]**
- For the encounters collected by the MCOs, two MCOs (HUM and UHC) noted that they performed claim volume, completeness and accuracy, timeliness, and reconciliation with financial reports checks on encounters. **[Quality and Timeliness]**
- All MCOs reported less than 1.0 percent of pharmacy encounters as initially rejected and not yet accepted. **[Quality]**
- All MCOs had a rate of duplicate encounters of less than 1.0 percent for professional, institutional, and pharmacy encounters. **[Quality]**

- Two MCOs (ACLA and UHC) submitted at least 98.2 percent of professional encounters within 60 days from the payment date, while two MCOs (ABH and UHC) submitted at least 98.2 percent of dental encounters within 60 days from the payment date. In addition, four MCOs (ABH, ACLA, LHCC, and UHC) submitted at least 99.4 percent of pharmacy encounters within 60 days from the payment dates. **[Timeliness]**
- For institutional encounters, four MCOs (ABH, ACLA, HBL, and HUM) had all key data elements populated with at least 95.0 percent of valid values. For dental encounters, the two MCOs with the same strength were LHCC and UHC, while the two MCOs for the pharmacy encounters were ACLA and UHC. **[Quality]**
- For referential integrity, UHC had the highest rate of providers in the pharmacy encounter file that were also in the provider file at approximately 96.2 percent. **[Quality]**

For the MCOs statewide, the following opportunities for improvement were identified:

- Four MCOs (HBL, HUM, LHCC, and UHC) reported that neither the MCOs nor their subcontractors performed sufficient quality checks on the encounters collected by their subcontractors. **[Quality and Timeliness]**
- Two MCOs (ACLA and LHCC) did not report performing claim volume and timeliness checks on encounters collected by the MCO (i.e., non-subcontractor data). **[Quality and Timeliness]**
- Among the six MCOs, five (ABH, HBL, HUM, LHCC, and UHC) showed high (i.e., greater than 5.0 percent) rejection rates for encounters initially rejected and not yet accepted by LDH for at least one encounter type. **[Quality]**
- ACLA had no dental encounters with dates of service in 2023 in LDH's data warehouse. **[Quality]**
- For dental encounters, HBL and LHCC had high duplicate encounter rates at 5.5 percent and 5.0 percent, respectively. **[Quality]**
- Among the six MCOs, three MCOs (HBL, HUM, and LHCC) had relatively low submission rates (i.e., less than 90.0 percent) for encounters submitted to LDH within 60 days from the MCO payment date for at least one encounter type. **[Timeliness]**
- For dental encounters, the LDH-submitted data did not contain any values for the Oral Cavity Code field for three MCOs (ABH, HUM, and LHCC), as well as the Tooth Number and Tooth Surface fields for LHCC. **[Quality]**
- All MCOs had one or more data elements with less than 95.0 percent of valid values. **[Quality]**
- For referential integrity, five MCOs (ABH, ACLA, HBL, HUM, and LHCC) showed a relatively low percentage of providers in the pharmacy encounter file who were also in the provider file. For providers in the medical/dental encounter file who were also in the provider file, two MCOs (ABH and HBL) showed relatively low percentages. **[Quality]**

For the MCOs statewide, the following recommendations were identified:

- Four MCOs (HBL, HUM, LHCC, and UHC) should develop a comprehensive suite of encounter data quality monitoring reports to assess the accuracy, completeness, and timeliness of encounter data received from their subcontractors. **[Quality and Timeliness]**
- Two MCOs (ACLA and LHCC) should develop a comprehensive suite of encounter data quality monitoring reports to assess the accuracy, completeness, and timeliness of encounter data collected by the MCO (i.e., non-subcontractor data). **[Quality and Timeliness]**
- Five MCOs (ABH, HBL, HUM, LHCC, and UHC) should build processes with their subcontractors noted below and LDH to ensure that rejected encounters will be submitted to LDH with correct information: **[Quality]**
  - ABH's vision encounters
  - HBL's non-subcontractor professional encounters
  - HUM's NEMT and vision encounters
  - LHCC's non-subcontractor professional and institutional encounters
  - UHC's institutional encounters
- ACLA should work with LDH to determine whether ACLA had dental encounters with dates of service in 2023 that should be submitted to LDH. **[Quality]**
- Two MCOs (HBL and LHCC) should review their systems for identifying and handling duplicates for dental encounters. Identification and appropriate handling of duplicate encounters is crucial for accurate financial and actuarial calculations. **[Quality]**
- Three MCOs (HBL, HUM, and LHCC) should monitor their encounter data submissions to ensure all encounters are submitted to LDH in a timely manner after payment. **[Timeliness]**
- For dental encounters, three MCOs (ABH, HUM, and LHCC) should work with LDH to decide whether they should submit values (if any) for the three noted fields (i.e., the Oral Cavity Code field for all three MCOs, and the Tooth Number and Tooth Surface fields for LHCC) to LDH. **[Quality]**
- All MCOs 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 of the MCO-specific annual technical report) to improve accuracy. **[Quality]**
- Each of the five MCOs (ABH, ACLA, HBL, HUM, and LHCC) should work with LDH to ensure both entities have an accurate and complete database of contracted providers for pharmacy encounters. In addition, two MCOs (ABH and HBL) should work with LDH to ensure both entities have an accurate and complete database of contracted providers for medical/dental encounters. **[Quality]**

Methodology

Objective

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: Jan 15, 2026.

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

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

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

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

Administrative Profile

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

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

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

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

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

Metrics for Encounter Data Completeness

HSAG evaluated encounter data completeness through the following metrics:

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

Metrics for Encounter Data Timeliness

HSAG evaluated encounter data timeliness through the following metrics:

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

Metrics for Field-Level Completeness and Accuracy

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

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

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

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

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

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

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

[10] Healthy Louisiana. Medicaid Managed Care Entities System Companion Guide, Version 1, June 18, 2025. Available at: https://ldh.la.gov/assets/medicaid/MCE_System_Companion_Guide/HLA_MCE_SCG_v.1.pdf. Accessed on: Jan 15, 2026.

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
National Drug Codes (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

Aggregate Results

Table 7-1 presents the 2023, 2024, and 2025 adult achievement scores for the Healthy Louisiana SWA.[11]

Table 7-1—Adult Achievement Scores for the Healthy Louisiana SWA

Measure	2023	2024	2025
Rating of Health Plan	80.38%	77.66%	79.60%
Rating of All Health Care	76.24%	79.68%	80.31% ↑
Rating of Personal Doctor	85.60%	86.61%	86.75%
Rating of Specialist Seen Most Often	82.46%	85.65%	84.91%
Getting Needed Care	80.47%	83.35%	84.21%
Getting Care Quickly	82.54%	82.56%	83.27%
How Well Doctors Communicate	93.11%	94.59%	94.50%
Customer Service	92.14%	90.22%	89.25%

↑ *Indicates the 2025 score is statistically significantly higher than the 2025 NCQA national average.*

Table 7-2 presents the 2023, 2024, and 2025 general child achievement scores for the Healthy Louisiana SWA.

Table 7-2—General Child Achievement Scores for the Healthy Louisiana SWA

Measure	2023	2024	2025
Rating of Health Plan	86.74%	88.48%	86.51%
Rating of All Health Care	89.15%	89.95%	88.75%
Rating of Personal Doctor	90.72%	91.73%	91.38%
Rating of Specialist Seen Most Often	85.95%	87.54%	88.68%
Getting Needed Care	89.06%	84.66%	88.22% ↑
Getting Care Quickly	89.34%	89.88%	88.85% ↑
How Well Doctors Communicate	95.46%	94.06%	94.96%
Customer Service	88.47%	88.09%	90.66%

↑ *Indicates the 2025 score is statistically significantly higher than the 2025 NCQA national average.*

[11] HUM started providing coverage to child and adult Medicaid beneficiaries throughout Louisiana starting January 1, 2023. Therefore, caution should be exercised when comparing the 2023 rates to 2025, as the 2023 rates include five MCOs and the 2025 rates include six MCOs.

Statewide MCO Strengths, Opportunities for Improvement, and Recommendations

For the MCOs statewide, the following strengths were identified:

- For the adult population, the Healthy Louisiana SWA's 2025 achievement score was statistically significantly higher than the 2025 NCQA adult Medicaid national average for one measure, *Rating of All Health Care*. **[Quality]**
- For the general child population, the Healthy Louisiana SWA's 2025 achievement scores were statistically significantly higher than the 2025 NCQA child Medicaid national averages for two measures: *Getting Needed Care* and *Getting Care Quickly*. **[Quality, Timeliness, and Access]**

For the MCOs statewide, the following opportunity for improvement was identified:

- For the adult and general child populations, the Healthy Louisiana SWA'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]**

For the MCOs statewide, the following recommendation was identified:

- HSAG recommends that the MCOs monitor the measures to ensure significant decreases in scores over time do not occur. **[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 and Analysis

The MCOs accomplished the technical method of data collection by administering the CAHPS 5.1H Adult Medicaid Health Plan Survey to the adult Medicaid population, and the CAHPS 5.1H Child Medicaid Health Plan Survey (with the Children with Chronic Conditions [CCC] measurement set) to the child Medicaid population. The MCOs employed various methods of data collection used for the CAHPS surveys, such as mixed-mode (i.e., mailed surveys followed by telephone interviews of 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.[12] 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."

[12] 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.[13]

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.[14] 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 (↑).[15] Conversely, an MCO that performed statistically significantly lower than the 2025 NCQA national average was denoted with

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

[14] 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.

[15] 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

Aggregate Results

Table 8-1 presents the 2023, 2024, and 2025 adult achievement scores for the Healthy Louisiana SWA.[16]

Table 8-1—Adult Statewide Results for the Healthy Louisiana SWA

Measure	2023	2024	2025
Rating of Health Plan	58.96%	56.43%	57.88%
How Well People Communicate	90.06%	92.65%	91.16%
Cultural Competency	73.77%+	82.85%+	86.01%+
Helped by Counseling or Treatment	67.65%	69.38%	70.38%
Treatment or Counseling Convenience	86.70%	88.46%	88.13%
Getting Needed Treatment	77.08%	81.83%	81.75%
Help Finding Counseling or Treatment	47.04%	52.90%	50.82%
Customer Service	67.14%+	71.32%	70.81%
Helped by Crisis Response Services	76.09%	75.17%	72.26%

Scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a measure, caution should be exercised when interpreting results.

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

Table 8-2—Child Statewide Results for the Healthy Louisiana SWA

Measure	2023	2024	2025
Rating of Health Plan	62.67%	65.18%	63.63%
How Well People Communicate	92.54%	90.74%	91.03%
Cultural Competency	97.85%+	90.17%+	92.57%+
Helped by Counseling or Treatment	58.20%	56.92%	61.01%
Treatment or Counseling Convenience	89.52%	86.12%	88.86%
Getting Needed Treatment	77.36%	77.13%	78.93%
Help Finding Counseling or Treatment	41.85%+	46.93%+	38.57%+
Customer Service	61.54%+	59.54%+	71.71%+
Getting Professional Help	88.83%	85.72%	87.75%
Help to Manage Condition	85.94%	83.70%	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.

[16] HUM started providing coverage to child and adult Medicaid beneficiaries throughout Louisiana starting January 1, 2023. Therefore, caution should be exercised when comparing the 2023 rates to 2025, as the 2023 rates include five MCOs and the 2025 rates include six MCOs.

Statewide MCO Strengths, Opportunities for Improvement, and Recommendations

For the MCOs statewide, the following strength was identified:

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

For the MCOs statewide, the following opportunity for improvement was identified:

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

For the MCOs statewide, the following recommendation was identified:

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

Methodology

Objectives

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

Technical Methods of Data Collection and Analysis

To conduct the activity, HSAG, with support from LDH, developed and administered a custom Behavioral Health Member Satisfaction Survey to the Healthy Louisiana MCO members. The survey was administered to adult members and parents/caretakers of child members identified as having three or more specified outpatient behavioral health encounters during the measurement period. All adult members and parents/caretakers of sampled child members completed the survey from 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 (i.e., Health Louisiana SWA) 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 (↓) 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

Aggregate Results

During SFY 2025, HSAG conducted a review of the MCOs' 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 MCOs successfully completed remediation actions to address the CAP findings, and the CAPs were closed in October 2024.

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

Statewide MCO Strengths, Opportunities for Improvement, and Recommendations

For the MCOs statewide, the following strength was identified:

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

For the MCOs statewide, the following opportunity for improvement was identified:

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

For the MCOs statewide, the following recommendation was identified:

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

10. Quality Rating System

Aggregate Results

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

Table 10-1—2025 (CY 2024) QRS Results

Composites and Subcomposites	ABH	ACLA	HBL	HUM	LHCC	UHC
Overall Rating*	**4.0**	**4.0**	**4.0**	**3.5**	**4.0**	**4.0**
Patient Experience	**3.5**	**4.0**	**4.0**	**4.0**	**4.5**	**3.5**
Getting Care	3.0	3.5	4.0	Insufficient Data	4.5	Insufficient Data
Satisfaction with Plan Physicians	4.0	5.0	4.5	4.0	4.5	3.5
Satisfaction with Plan and Plan Services	4.0	4.5	4.0	4.0	4.5	4.0
Prevention and Equity	**3.0**	**3.5**	**3.5**	**3.0**	**4.0**	**3.5**
Children and Adolescent Well-Care	3.0	3.0	3.0	4.0	4.0	4.0
Women's Reproductive Health	2.0	2.5	3.0	2.5	3.5	3.5
Cancer Screening	3.5	3.5	3.0	1.0	4.5	3.5
Equity	3.5	5.0	5.0	5.0	5.0	3.5
Other Preventive Services	4.0	4.0	4.0	4.0	4.0	4.0
Treatment	**3.5**	**3.5**	**3.0**	**3.0**	**3.5**	**3.5**
Respiratory	2.5	2.5	3.0	3.5	2.5	2.5
Diabetes	4.0	4.5	4.0	4.0	3.5	4.0
Heart Disease	3.0	3.0	2.0	3.0	4.0	3.5
Behavioral Health—Care Coordination	2.5	2.5	3.0	2.5	2.5	2.5
Behavioral Health—Medication Adherence	4.0	3.0	2.5	3.5	4.0	4.5
Behavioral Health—Access, Monitoring, and Safety	3.0	3.5	4.0	3.0	3.0	3.5
Reduce Low Value Care	3.0	3.0	3.0	2.0	3.0	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 MCO 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.

For the Overall Rating, five of the six MCOs (ABH, ACLA, HBL, LHCC, and UHC) earned 4.0 stars, while HUM earned 3.5 stars. Performance was highest within the Patient Experience composite, with most MCOs earning 4.0 stars or more. Performance was lowest within the Treatment composite, with no MCOs earning a rating higher than 3.5 stars.

Statewide MCO Strengths, Opportunities for Improvement, and Recommendations

For the MCOs statewide, the following strengths were identified:

- For the Patient Experience composite, all six of the MCOs earned a rating of 4.0 stars or more for the Satisfaction With Plan and Plan Services subcomposite, and UHC was the only MCO that earned a rating lower than 4.0 stars for the Satisfaction with Plan Physicians subcomposite. **[Quality, Timeliness, and Access]**
- For the Prevention and Equity composite, four of the six MCOs (ACLA, HBL, HUM, and LHCC) earned 5.0 stars for the Equity subcomposite, which assesses whether the MCOs collect language and racial/ethnic data from their members. Additionally, all six MCOs earned 4.0 stars related to the Other Preventive Services subcomposite, which assesses how often young women are screened for chlamydia. Of note, LHCC is the only MCO that earned 4.0 stars for the Prevention and Equity composite overall and was the only MCO that earned more than 4.0 stars for the Cancer Screening subcomposite, with a rating of 4.5 stars. **[Quality and Access]**
- For the Treatment composite, all six MCOs earned a rating of 3.5 stars or higher for the Diabetes subcomposite, with only LHCC earning a rating below 4.0 stars. For the Behavioral Health—Medication Adherence subcomposite, three of the six MCOs (ABH, LHCC, and UHC) earned a rating of 4.0 stars or higher, demonstrating strength for these MCOs related to ensuring members with depression and opioid use disorder stay on prescribed medications. **[Quality, Timeliness, and Access]**

For the MCOs statewide, the following opportunities for improvement were identified:

- For the Prevention and Equity composite, ABH and HUM were the lowest performing MCOs. Of note, ABH earned a rating of 2.0 stars for the Women's Reproductive Health subcomposite, and HUM earned a rating of 1.0 star for the Cancer Screening subcomposite. Specifically for the Women's Reproductive Health subcomposite, three of the six MCOs (ABH, ACLA, and HUM) earned ratings of 2.5 stars or lower, demonstrating opportunities for improvement for these MCOs related to women receiving prenatal and postpartum care. **[Quality and Access]**
- For the Treatment composite, HBL and HUM were the lowest performing MCOs. Of note, HBL earned a rating of 2.0 stars for the Heart Disease subcomposite, while HUM and UHC earned 2.0 stars for the Reduce Low Value Care subcomposite. Additionally, five of the six MCOs (ABH, ACLA, HUM, LHCC, and UHC) earned a rating of 2.5 stars for the Behavioral Health—Care Coordination subcomposite, demonstrating opportunities for improvement for these MCOs related to ensuring members receive timely follow up after hospitalizations and ED visits for behavioral health

conditions. Four of the six MCOs (ABH, ACLA, LHCC, and UHC) earned 2.5 stars for the Respiratory subcomposite, demonstrating opportunities for improvement for these MCOs related to antibiotic use for bronchitis/bronchiolitis. **[Quality, Timeliness, and Access]**

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.[17]

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.[18,19]

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

[17] 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.

[18] 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: Jan 15, 2026.

[19] 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.

  - Satisfaction with Plan and Plan Services
- 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 2025 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 Aggregate Strengths, Opportunities for Improvement, and Recommendations

HSAG used its analyses and evaluations of EQR activity findings from SFY 2025 to comprehensively assess the MCOs' performance in providing quality, timely, and accessible healthcare services to Louisiana's Medicaid and CHIP members. HSAG provides the MCOs' aggregate 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	• The MCOs participated in regular collaborative meetings with LDH, facilitated by HSAG, to share lessons learned, explore effective improvement strategies, learn new approaches to QI, and explore solutions to barriers related to the five statewide PIP topics. **[Quality]** • The MCOs carried out interventions for the PIPs that had the potential to address identified barriers and improve performance indicator results, and collected, analyzed, and reported intervention-specific effectiveness data to monitor the progress and impact of interventions throughout the most recent measurement period for the PIPs. **[Quality]** • For the *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees* PIP, all MCOs' reported performance indicator results demonstrated statistically significant improvement at Remeasurement 1 compared to baseline results. **[Quality, Timeliness, and Access]**
PMV	• The MCOs demonstrated effective coordination with providers to engage members with opioid use disorder in continuous treatment with pharmacotherapy, initiate treatment for members with a new SUD episode, and engage these members in subsequent SUD services or medications. **[Quality, Timeliness, and Access]** • The MCOs' members received screenings for chlamydia at rates above the NCQA national 50th percentile benchmark. **[Quality]** • Most MCO's members received recommended well-child visits in their first 30 months of life. **[Quality, Timeliness, and Access]**
Compliance	• All MCOs achieved a compliance score for Standard II—Member Rights and Confidentiality of 96 percent or better, demonstrating appropriate member rights protections, privacy practices, and confidentiality controls consistent with regulatory and contractual requirements. **[Quality and Access]** • All but one MCO achieved a 100 percent compliance score for Standard IV—Emergency and Poststabilization Services, demonstrating that the MCOs had adequate processes in place to ensure access to, coverage of, and payment for emergency and poststabilization care. **[Quality, Timeliness, and Access]**

Overall MCO Strengths	
	• All but one MCO achieved a 100 percent compliance score for Standard X—Practice Guidelines, demonstrating that the MCOs used evidence-based adoption, annual review, provider involvement, LDH approval, broad dissemination, and consistent application in clinical and operational processes. **[Quality and Access]** • All but one MCO achieved a 100 percent compliance score for Standard XI—Health Information Systems, demonstrating that the MCOs' health information systems had effective data collection, validation, reporting, encounter submission, and interoperability aligned with federal and State requirements. **[Quality and Access]** • All MCOs achieved a 100 percent compliance score for Standard XII—Quality Assessment and Performance Improvement, demonstrating that the MCOs had robust QAPI programs with effective governance, performance measurement, and under- and overutilization monitoring; LDH-approved PIPs; and timely reporting to the LDH. **[Quality]**
NAV	• Overall, 94.1 percent of the provider access survey respondents indicated the sampled address was correct. **[Quality and Access]**
CMPE	• The MCOs successfully completed remediation actions to address the CAP findings. **[Quality]**
CAHPS and Behavioral Health Member Satisfaction Survey	• For the adult population, the Healthy Louisiana SWA's CAHPS 2025 achievement score was statistically significantly higher than the 2025 NCQA adult Medicaid national average for one measure, *Rating of All Health Care*. **[Quality]** • For the general child population, the Healthy Louisiana SWA's CAHPS 2025 achievement scores were statistically significantly higher than the 2025 NCQA child Medicaid national averages for two measures: *Getting Needed Care* and *Getting Care Quickly*. **[Quality, Timeliness, and Access]** • For the Behavioral Health Member Satisfaction Survey, no substantial strengths were identified. **[Quality, Timeliness, and Access]**

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

Overall MCO Opportunities for Improvement	
PIP	• For three of the four PIP topics assessed for achieving significant improvement (*Behavioral Health Transitions of Care*, *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years*, and *Screening for HIV Infection*), not all of the MCOs' reported indicator results demonstrated statistically significant improvement from baseline to the most recent remeasurement. **[Quality, Timeliness, and Access]**
PMV	• The MCOs 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]**

Overall MCO Opportunities for Improvement	
	• The MCOs had room for improvement in ensuring that providers effectively prevent or minimize the prescribing of antibiotics to children with URIs and adults with bronchitis or bronchiolitis. **[Quality]** • The MCOs had room for improvement in coordinating with providers to ensure that members receive timely and adequate prenatal and postpartum care. **[Quality, Timeliness, and Access]**
Compliance	• The MCOs' average CR results demonstrated low compliance with Standard III—Member Information (69 percent). **[Quality and Access]** • The MCOs' average CR results demonstrated low compliance with Standard V—Adequate Capacity and Availability of Services (52 percent). **[Quality, Timeliness, and Access]** • The MCOs' average CR results demonstrated low compliance with Standard VIII—Provider Selection (70 percent). **[Quality, Timeliness, and Access]** • The MCOs' average CR results demonstrated low compliance with Standard IX—Subcontractual Relationships and Delegation (64 percent). **[Quality and Access]**
NAV	• The PDV revealed low acceptance of the MCO (66.5 percent), low acceptance of Louisiana Medicaid (65.7 percent), inaccurate specialty provider types, low acceptance of new patients, and inaccurate provider affiliations with listed location. **[Quality and Access]** • The provider access survey revealed low acceptance of the MCO (56.3 percent), low acceptance of Louisiana Medicaid (55.8 percent), inaccurate specialty provider types, low acceptance of new patients, and inaccurate provider affiliations with listed location. **[Quality and Access]**
EDV	• Four MCOs (HBL, HUM, LHCC, and UHC) reported that neither the MCOs nor their subcontractors performed sufficient quality checks on the encounters collected by their subcontractors. **[Quality and Timeliness]** • Five MCOs showed high rejection rates for encounters initially rejected and not yet accepted by LDH for at least one encounter type. **[Quality]** • All MCOs had one or more data elements with less than 95.0 percent of valid values. **[Quality]**
CAHPS and Behavioral Health Member Satisfaction Survey	• For the adult and general child CAHPS populations, no substantial weaknesses were identified. **[Quality, Timeliness, and Access]** • For the Behavioral Health Member Satisfaction Survey, no substantial weaknesses were identified. **[Quality, Timeliness, and Access]**
CMPE	• The MCOs demonstrated an opportunity for improvement with elements related to ongoing scheduled CM activities**. [Quality]**

Table 11-3—Recommendations

Overall MCO Recommendations		
EQR Activity	**Recommendation**	**Associated Quality Strategy Goals to Target for Improvement**
PIP	• To facilitate significant outcomes improvement for all PIPs, the MCOs should review intervention evaluation results to determine if each intervention is having the desired impact and how interventions can be revised to increase effectiveness. Each 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]**	Goal 4: Promote wellness and prevention
PMV	• The MCOs 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]** • The MCOs should work with providers to prevent or reduce antibiotic dispensing to treat URIs in children and adults with bronchitis or bronchiolitis. **[Quality]** • The MCOs should work with providers to identify and address barriers to timely and adequate prenatal and postpartum care. **[Quality, Timeliness, and Access]**	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 Goal 4: Promote wellness and prevention Goal 6: Partner with communities to improve population health and address health disparities
Compliance	• The MCOs must consult their CR results and develop corrective actions related to *Not Met* findings. **[Quality, Timeliness, and Access]**	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 Goal 4: Promote wellness and prevention Goal 5: Improve chronic disease management and control

Overall MCO Recommendations		
EQR Activity	**Recommendation**	**Associated Quality Strategy Goals to Target for Improvement**
		Goal 6: Partner with communities to improve population health and address health disparities Goal 7: Pay for value and incentivize innovation Goal 8: Minimize wasteful spending
NAV	• The MCOs should work with LDH to obtain case-level data files and define a timeline to address provider data deficiencies. **[Quality and Access]** • Each MCO 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]** • The MCOs should conduct outreach to their providers to ensure the providers and/or their offices routinely submit up-to-date information on all pertinent provider indicators. **[Quality and Access]**	Goal 1: Ensure access to care to meet enrollee needs
CAHPS and Behavioral Health Member Satisfaction Survey	• The MCOs should monitor the CAHPS and Behavioral Health Member Satisfaction Survey measures to ensure significant decreases in scores over time do not occur. **[Quality]**	Goal 1: Ensure access to care to meet enrollee needs Goal 3: Facilitate patient-centered, whole-person care
CMPE	• The MCOs should continue the efforts documented in their CAP responses to ensure compliance with contractual requirements. **[Quality]**	Goal 2: Improve coordination and transitions of care
EDV	• The MCOs should develop a comprehensive suite of encounter data quality monitoring reports to assess the accuracy, completeness, and timeliness of encounter data received from their subcontractors. **[Quality and Timeliness]** • The MCOs should build processes with their subcontractors noted below and LDH to ensure that rejected	Goal 7: Pay for value and incentivize innovation Goal 8: Minimize wasteful spending

Overall MCO Recommendations		
EQR Activity	**Recommendation**	**Associated Quality Strategy Goals to Target for Improvement**
	encounters will be submitted to LDH with correct information. **[Quality]** • The MCOs should investigate the root causes for data elements with less than 95.0 percent of valid values to improve accuracy. **[Quality]**	

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 QI 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. Each MCO's response is included in the SFY 2025 EQR technical report produced for each MCO. Please reference the MCO-specific reports to review MCO responses to prior EQR recommendations and HSAG's assessment of their responses.

Appendix A. MCO Health Equity Plan Summaries

For the annual EQR technical report, LDH asked HSAG to summarize information from each MCO's HEP submissions from July 2025. Each MCO's response is included in the SFY 2025 EQR technical report produced for each MCO. Please reference the MCO-specific reports to review MCO responses.