LOUISIANA DEPARTMENT OF HEALTH

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

# External Quality Review Technical Report

## for

## Louisiana Healthcare Connections

*March 2026*

HSAG HEALTH SERVICES ADVISORY GROUP

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# Acknowledgments and Copyrights

# 1. Executive Summary

## Introduction

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

## The Louisiana Medicaid Managed Care Program

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

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

[1] Centers for Medicare & Medicaid Services. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, May 6, 2016. Available at: https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered. Accessed on: Dec 29, 2025.

[2] Centers for Medicare & Medicaid Services. Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care, November 13, 2020. Available at: https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care. Accessed on: Dec 29, 2025.

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

**Table 1-1—Louisiana's Medicaid MCEs**

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

## Scope of External Quality Review

As set forth in 42 CFR §438.358, HSAG conducted all EQR-related activities in compliance with the *CMS EQR Protocols* released in February 2023.[3] For the SFY 2025 assessment, HSAG used findings from the mandatory and optional EQR activities to derive conclusions and make recommendations about the quality, timeliness, and accessibility of healthcare services provided by each MCE. Table 1-2 depicts the EQR activities conducted for each plan type.

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

| EQR Activities | Description | CMS EQR Protocol | MCO | PAHP | PIHP |
|---|---|---|---|---|---|
| Performance Improvement Project (PIP) Validation | This activity verifies whether a PIP conducted by an MCE used sound methodology in its design, implementation, analysis, and reporting, and whether the PIP demonstrated significant improvement in performance. | Protocol 1. Validation of Performance Improvement Projects | ✓ | ✓ | ✓ |
| Performance Evaluation and Improvement | This activity assesses whether the performance measures calculated by an MCE are accurate based on the measure specifications and State reporting requirements. | Protocol 2. Validation of Performance Measures | ✓ | ✓ | ✓ |
| Compliance Reviews (CRs) | This activity determines the extent to which a Medicaid and CHIP MCE is in compliance with federal standards and associated state-specific requirements, when applicable. | Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations | ✓ | ✓ | ✓ |
| Network Adequacy and Availability Validation (NAV) | The audit activity assesses the accuracy of the state-defined network adequacy indicators reported by the MCEs; evaluates the collection of provider data, reliability and validity of network adequacy data, methods used to assess network adequacy, and systems and processes used; and determines the overall phases of design, data collection, analysis, and interpretation of the network | Protocol 4. Validation of Network Adequacy | ✓ | ✓ | ✓ |

[3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, February 2023*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 29, 2025.

| EQR Activities | Description | CMS EQR Protocol | MCO | PAHP | PIHP |
|---|---|---|---|---|---|
| | adequacy indicators, as set forth by the State. Additionally, this activity evaluates the accuracy of provider directory information submitted by the MCOs and determines appointment availability information by conducting telephone surveys among a sample of providers. | | | | |
| Encounter Data Validation (EDV) | This activity validates the accuracy and completeness of encounter data submitted by an MCO. | Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan | ✓ | ✓ | ✓ |
| Consumer Surveys: CAHPS-A and CAHPS-C | This activity reports the results of each MCO's CAHPS survey to HSAG for inclusion in this report. | Protocol 6. Administration or Validation of Quality of Care Surveys | ✓ | | |
| CAHPS Dental Survey | This activity reports the results of each PAHP's CAHPS Dental Survey for inclusion in this report. | Protocol 6. Administration or Validation of Quality of Care Surveys | | ✓ | |
| Behavioral Health Member Satisfaction Survey | This activity assesses adult members with a behavioral or mental health diagnosis and child members with a mental health diagnosis who have received behavioral health services and are enrolled in an MCO. | Protocol 6. Administration or Validation of Quality of Care Surveys | ✓ | | |
| Case Management Performance Evaluation (CMPE) | This activity evaluates case management (CM) services to determine the number of individuals, the types of conditions, and the impact that CM services have on members receiving those services. | Protocol 9. Conducting Focus Studies of Health Care Quality | ✓ | | |
| Quality Rating System (QRS) | This activity evaluates and applies a rating to measure the quality of care and performance of the MCOs to provide information to help eligible members choose an MCO. | Protocol 10. Assist With Quality Rating of Medicaid and CHIP MCOs, PIHPs, and PAHPs | ✓ | | |

## Report Purpose

To comply with federal healthcare regulations at 42 CFR Part 438, LDH contracts with HSAG to annually provide to CMS an assessment of the performance of the State's Medicaid and CHIP MCEs, as required at 42 CFR §438.364. This annual EQR technical report includes results of all EQR-related activities that the EQRO conducted with Louisiana Medicaid MCEs throughout SFY 2025. This EQR technical report is intended to help the Louisiana Medicaid managed care program:

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

## Definitions

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

| Quality | Timeliness | Access |
|---|---|---|
| as it pertains to the EQR, means the degree to which an MCO, PIHP, PAHP, or primary care case management (PCCM) entity (described in §438.310[c][2]) increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics; the provision of services that are consistent with current professional, evidence-based knowledge; and interventions for performance improvement.[1] | as it pertains to EQR, is described by NCQA to meet the following criteria: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[2] It further discusses the intent of this standard to minimize any disruption in the provision of healthcare. HSAG extends this definition to include other managed care provisions that impact services to members and that require a timely response from the MCO (e.g., processing expedited member appeals and providing timely follow-up care). | as it pertains to EQR, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (network adequacy standards) and §438.206 (availability of services). Under §438.206, availability of services means that each state must ensure that all services covered under the state plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs in a timely manner.[1] |

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

# Methodologies

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

## *Aggregating and Analyzing Statewide Data*

HSAG follows a four-step process to aggregate and analyze data collected from all EQR activities and draw conclusions about the quality, timeliness, and accessibility of care furnished by each MCO, as well as the program overall. To produce Healthy Louisiana's MCO aggregate SFY 2025 EQR technical report, HSAG performed the following steps to analyze the data obtained and draw statewide conclusions about the quality, timeliness, and accessibility of care and services provided by the MCOs:

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

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

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

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

# Louisiana's Medicaid Managed Care Quality Strategy

In accordance with 42 CFR §438.340, LDH implemented a written quality strategy for assessing and improving the quality of healthcare and services furnished by the (MCEs to Louisiana Medicaid members under the Louisiana Medicaid managed care program). Louisiana's Medicaid Managed Care Quality Strategy (quality strategy) dated September 2023 is guided by the Triple Aim of the National Quality Strategy.

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

## Goals and Objectives

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

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

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

Goal 1: Ensure access to care to meet enrollee needs

Goal 2: Improve coordination and transitions of care

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

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

Goal 4: Promote wellness and prevention

Goal 5: Improve chronic disease management and control

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

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

Goal 7: Pay for value and incentivize innovation

Goal 8: Minimize wasteful spending

## Quality Strategy Evaluation[4]

### Strengths

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

[4] Health Services Advisory Group, Inc. Louisiana Department of Health. Medicaid Managed Care Quality Strategy Evaluation, Review Period: March 20, 2024–March 19, 2025, November 2025. Louisiana Department of Health. Available at: https://ldh.la.gov/assets/docs/MQI/LA_2025_QSE-Report_F1.pdf. Accessed on: Dec 29, 2025.

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

The EQRO has identified the following strengths:

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

## Recommendations

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

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

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

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

## Actions on External Quality Review Recommendations

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

**Table 1-3—EQRO Recommendations and LDH Actions**

| EQRO Recommendations for Review Period March 20, 2023–March 19, 2024 | LDH Actions |
|---|---|
| To improve programwide performance in support of LDH's quality strategy goals, HSAG recommended that LDH identify a measure to align with the following objectives:<br>• Ensure appropriate hospice onboarding and transitioning from palliative care to hospice.<br>• Promote early initiation of palliative care to improve quality of life.<br>• Promote health development and wellness in children and adolescents.<br>• Advance specific interventions to address social determinants of health (SDOH).<br>• Advance value-based payment arrangements and innovation.<br>• 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:<br>• *Enrollment by Product Line*<br>• *Language Diversity of Membership*<br>• *Race/Ethnicity Diversity of Membership* | MCOs are already required to report these measures. They are not included on the Medicaid Quality Dashboard because they are statistical in nature and not performance based. |

# Overview of External Quality Review Findings

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

## *Validation of Performance Improvement Projects*

LHCC 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 LHCC 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 LHCC's performance measures confirmed compliance with the standards of 42 CFR §438.330(a)(1). The results of the validation activity determined that LHCC 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 LHCC's certified HEDIS compliance auditor, HSAG found that LHCC fully met the standard for all four of the applicable NCQA HEDIS information systems (IS) standards.

### HEDIS—Quality, Timeliness, and Access

HSAG's analysis was based on comparison of HEDIS measures/measure indicators to the MY 2024 NCQA national 50th percentile, which served as the benchmark. A total of 44 measures, comprising 185 measure indicators, were selected for analysis. Of the 185 measure indicators, 29 were excluded from comparisons to NCQA national 50th percentile benchmarks: five indicators were excluded from the analysis because they were not reported in Quality Compass for MY 2024; 24 indicators were excluded from the analysis because their rates were not percentages and a percentage point difference could not be determined.

Of the 156 HEDIS measures/measure indicators with an associated benchmark, LHCC had 78 indicators that performed greater than the NCQA national 50th percentile benchmark, 49 that performed lower than the NCQA national 50th percentile benchmark, and one indicator that was not compared to the NCQA national 50th percentile benchmark because the reported rate was *Not Applicable (NA)* (i.e., small denominator). Detailed results are shown in Section 3—Validation of Performance Measures.

## *Assessment of Compliance With Medicaid Managed Care Regulations*

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

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

| Standard # | Standard Name | CY 2024 | MCO Average Results |
|---|---|---|---|
| I | Enrollment and Disenrollment Requirements and Limitations | 100% | 85% |
| II | Member Rights and Confidentiality | 100% | 99% |
| III | Member Information | 67% | 69% |
| IV | Emergency and Poststabilization Services | 100% | 99% |
| V | Adequate Capacity and Availability of Services | 60% | 52% |
| VI | Coordination and Continuity of Care | 92% | 85% |
| VII | Coverage and Authorization of Services | 100% | 93% |
| VIII | Provider Selection | 84% | 70% |
| IX | Subcontractual Relationships and Delegation | 67% | 64% |
| X | Practice Guidelines | 100% | 97% |
| XI | Health Information Systems | 100% | 96% |
| XII | Quality Assessment and Performance Improvement | 100% | 100% |
| XIII | Grievance and Appeal Systems | 100% | 90% |
| XIV | Program Integrity | 94% | 97% |
| **Total Compliance Score** | | **91%** | |

## *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 LHCC was inaccurate. Table 1-5 provides a summary of the aggregate Q1 and Q2 findings from the study.

**Table 1-5—Summary of PDV Findings**

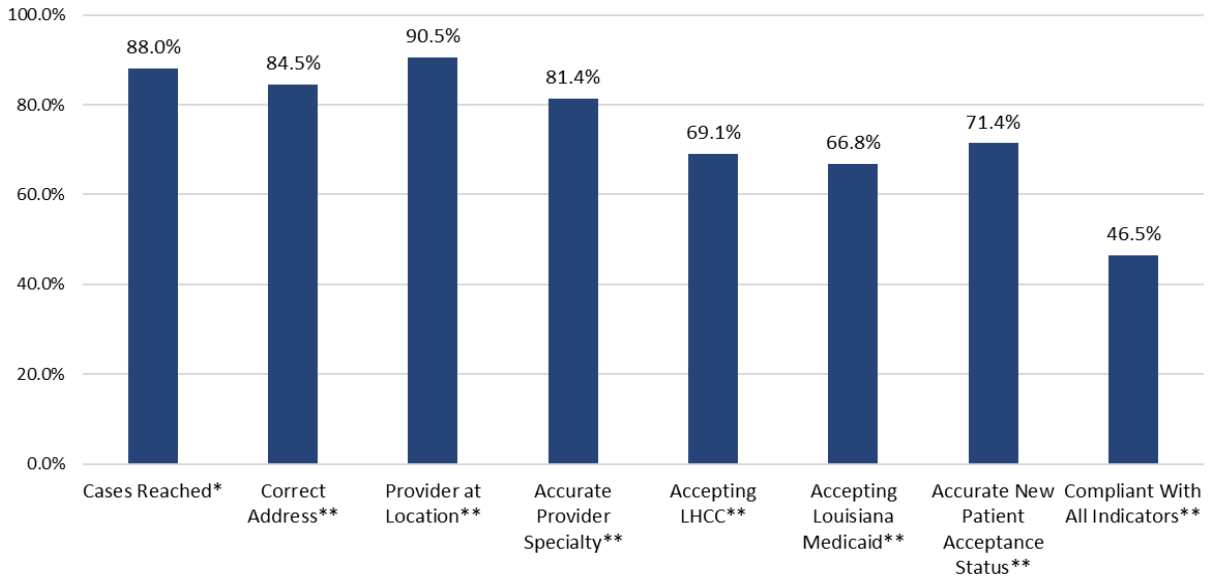
| Concerns | Findings |
|---|---|
| Acceptance of Louisiana Medicaid was low. | Overall, 66.8 percent of providers accepted Louisiana Medicaid. |
| Acceptance of LHCC was low. | Overall, 69.1 percent of providers accepted LHCC. |
| Specialty provider type was incorrect in the provider directory. | Overall, 81.4 percent of providers confirmed the specialty listed in the online provider directory was accurate. |
| Overall accuracy of the new patient acceptance status was low.[1] | Overall, 71.4 percent of providers confirmed the new patient acceptance status in the online provider directory was correct. |
| Address information was incorrect. | Overall, 84.5 percent of respondents reported that LHCC's provider directory reflected the correct address. |

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

While the overall PDV response rate was relatively high at 88.0 percent, once contacted, the offices reported varying degrees of match rates for the online provider directory information. Accuracy of the provider's new patient acceptance status, Louisiana Medicaid acceptance, and LHCC acceptance exhibited the lowest match rates.

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

**Figure 1-1—Summary Results for All Sampled LHCC Providers**




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

LHCC's aggregate Q1 and Q2 weighted PDV compliance scores by specialty provider type ranged from internal medicine/family medicine at 31.3 percent to obstetricians/gynecologists (OB/GYNs) at 54.7 percent.

## Provider Access Survey

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

**Table 1-6—Summary of Provider Access Survey Findings**

| Concerns | Findings |
|---|---|
| Affiliation with the sampled provider was low. | Overall, 58.0 percent of the locations confirmed affiliation with the sampled provider. |
| Acceptance of new patients was low. | Overall, 86.0 percent of providers accepted new patients; however, only providers listed as accepting new patients in the provider data were selected for the survey sample. |

| Concerns | Findings |
|---|---|
| Acceptance of Louisiana Medicaid was low. | Overall, 88.0 percent of providers accepted Louisiana Medicaid. |
| Acceptance of the MCO was low. | Overall, 88.0 percent of providers accepted the requested MCO. |

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

**Table 1-7—Provider Access Survey Call Outcomes**

| Specialty | Able to Contact[1] | Correct Address[2] | Offering Services[2] | Accepting MCO[2] | Accepting Medicaid[2] | Accepting New Patients[2] | Confirmed Provider[2] |
|---|---|---|---|---|---|---|---|
| Allergists | 66.7% | 95.0% | 85.0% | 85.0% | 85.0% | 85.0% | 50.0% |
| Dermatologists | 66.7% | 100% | 100% | 91.7% | 91.7% | 91.7% | 66.7% |
| Orthopedic Surgeons | 45.0% | 100% | 100% | 88.9% | 88.9% | 83.3% | 61.1% |
| **Total** | **56.8%** | **98.0%** | **94.0%** | **88.0%** | **88.0%** | **86.0%** | **58.0%** |

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

LHCC's weighted first provider access survey compliance scores by specialty provider type ranged from 27.5 percent (orthopedic surgeons) to 38.9 percent (allergists).

### NAV Audit

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

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

| Provider Type | Urbanicity |
|---|---|
| Adult Primary Care Provider (PCP) (Family/General Practice; Internal Medicine) | Rural |
| Pediatrics (Family/General Practice; Internal Medicine) | Rural |
| Federally Qualified Health Centers (FQHCs) | Rural |
| Rural Health Clinics (RHCs) | Rural |
| Pharmacy | Rural |
| Cardiology | Rural |
| Gastroenterology | Rural |

| Provider Type | Urbanicity |
|---|---|
| Orthopedics (Adult) | Rural |
| Orthopedics (Pediatric) | Rural |
| Physicians and licensed mental health practitioners (LMHPs) who specialize in pregnancy-related and postpartum depression or related mental health disorders | Urban |
| Behavioral Health Specialist (Advanced Practice Registered Nurse—Behavioral Health [APRN-BH] specialty, Licensed Psychologist, or Licensed Clinical Social Worker [LCSW]) | Rural |
| Psychiatric Residential Treatment Facilities (PRTFs) (Level 3.7 Withdrawal Management [WM]) and Other Specialization (Pediatric Under Age 21) | All |

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

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

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

| Type of Visit | Access/Timeliness Standard | Performance Goal | Compliance Rate |
|---|---|---|---|
| Emergency Care | 24 hours, 7 days/week within 1 hour of request | 90% | 87% |
| Urgent Non-Emergency Behavioral Health Care | 48 hours (2 calendar days) | 90% | 87% |
| Non-Urgent Routine Behavioral Health Care | 14 calendar days | 70% | 87% |

## *Encounter Data Validation*

### Information Systems Review

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

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

| IS Review | LHCC | | Note |
|---|---|---|---|
| Encounter Data Sources and Systems | — | | None. |
| Payment Structures | — | | None. |
| **Encounter Data Quality Monitoring** | | | |
| Processes for Encounters Collected by Subcontractors | X | | Weakness was for pharmacy encounters. |
| Quality Monitoring on Encounters Collected by Subcontractors | ✓ | X | Strengths were for dental and vision encounters. Weaknesses were for NEMT and pharmacy encounters. |
| Quality Monitoring on Encounters Collected by LHCC | X | | Weakness was for missing claim volume and timeliness checks. |
| % of Encounters Initially Rejected and Not Yet Accepted by LDH | ✓ | X | Strength was for pharmacy encounters. Weaknesses were for non-subcontractor professional and institutional encounters. |

## Administrative Profile

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

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

| Administrative Profile | Professional | Institutional | Dental | Pharmacy |
|---|---|---|---|---|
| **Encounter Data Completeness** | | | | |
| Monthly Encounter Volume per 1,000 MM | — | — | — | — |
| Monthly Payment Amount PMPM | — | — | — | — |
| TPL Payment Amount PMPM | — | — | — | — |
| % of Duplicate Encounters | ✓ | ✓ | X | ✓ |
| **Encounter Data Timeliness** | | | | |
| Lag Between MCO Payment Date and Received Date by LDH | — | X | X | ✓ |
| **Field-Level Completeness and Accuracy** | | | | |
| % Present | — | — | X | — |
| % Valid | X | X | ✓ | X |

| Administrative Profile | Professional | Institutional | Dental | Pharmacy |
|---|---|---|---|---|
| **Encounter Referential Integrity** | | | | |
| Encounter vs Enrollment | — | | | — |
| Medical/Dental vs Pharmacy Encounter | — | | | |
| Encounter vs Provider | — | | | X |
| **Encounter Data Logic** | | | | |
| % of Members Who Had an Encounter | — | — | — | — |
| Member Enrollment Continuity | — | — | — | — |

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

## Consumer Surveys: CAHPS-A and CAHPS-C

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

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

## Behavioral Health Member Satisfaction Survey

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

Overall, LHCC's 2025 child achievement score was statistically significantly lower than the 2024 achievement score for *Rating of Health Plan*. The rate for *Rating of Health Plan* could be improved by frequently including information about the ratings from the CAHPS survey in provider communications during the year. LHCC could include reminders about the importance of handling challenging patient encounters and emphasizing patient-centered communication for the MCO members.

## Case Management Performance Evaluation

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

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

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

## Quality Rating System

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

**Figure 1-2—2025 Health Plan Report Card**

Issued 07/2025

Healthy Louisiana

# 2025 HEALTH PLAN REPORT CARD

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

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

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

*Continued on next page...*

## Figure 1-2—2025 Health Plan Report Card (cont.)

| | Aetna Better Health | AmeriHealth Caritas Louisiana | Healthy Blue | Humana Healthy Horizons | Louisiana Healthcare Connections | UnitedHealthcare Community Plan |
|---|---|---|---|---|---|---|
| **Cancer screening:** Do members receive important cancer screenings? | ★★★½ | ★★★½ | ★★★ | ★ | ★★★★½ | ★★★½ |
| **Equity:** Do health plans collect race, ethnicity, and language information from their members? | ★★★½ | ★★★★★ | ★★★★★ | ★★★★★ | ★★★★★ | ★★★½ |
| **Other preventive services:** Do members receive important preventive services? | ★★★★ | ★★★★ | ★★★★ | ★★★★ | ★★★★ | ★★★★ |
| **TREATMENT** | | | | | | |
| **Overall Treatment** | ★★★½ | ★★★½ | ★★★ | ★★★ | ★★★½ | ★★★½ |
| **Respiratory:** Do people with respiratory issues get the services/treatments they need? | ★★½ | ★★½ | ★★★ | ★★★½ | ★★½ | ★★½ |
| **Diabetes:** Do people with diabetes get the services/ treatments they need? | ★★★★ | ★★★★½ | ★★★★ | ★★★★ | ★★★½ | ★★★★ |
| **Heart disease:** Do people with heart disease get the services/ treatments they need? | ★★★ | ★★★ | ★★ | ★★★ | ★★★★ | ★★★½ |
| **Behavioral health—care coordination:** Do people with behavioral health issues get the follow-up care they need? | ★★½ | ★★½ | ★★★ | ★★½ | ★★½ | ★★½ |
| **Behavioral health—medication adherence:** Do people with behavioral health issues stay on prescribed medications? | ★★★★ | ★★★ | ★★½ | ★★★½ | ★★★★ | ★★★★½ |
| **Behavioral health—access, monitoring, and safety:** Do people on behavioral health medications receive the services/ monitoring they need? | ★★★ | ★★★½ | ★★★★ | ★★★ | ★★★ | ★★★½ |

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

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

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

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

*The categories and measures included in this report card are based on the 2025 National Committee for Quality Assurance (NCQA) Health Plan Ratings and LDH required measures lists. When feasible, categories and measures were kept consistent with the prior year's health plan report card, but some measures and categories were removed due to data availability. The Risk-Adjusted Utilization category was removed because changes in the way the data were calculated and reported prevented comparisons to national data. Any analysis, interpretation, and conclusions based on the data is solely that of the author. Anyone desiring to use or reproduce the materials must obtain approval from LDH.*

# 2. Validation of Performance Improvement Projects

## Results

SFY 2025 (review period) was the third year that HSAG was contracted as the EQRO for LDH. LDH required the MCOs, including LHCC, 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 LHCC in SFY 2025.

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

| PIP Topic | Targeted Age Group |
|---|---|
| *Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees* | • No restrictions |
| *Behavioral Health Transitions of Care* | • 6 years and older<br>• 13 years and older |
| *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years* | • 6 months–18 months<br>• 19 months–2 years<br>• 3–5 years |
| *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees* | • 21–64 years |
| *Screening for HIV Infection* | • 13 years and older<br>• 15–65 years |

For each PIP topic, LHCC collaborated on improvement strategies, meeting at least quarterly with LDH and other MCOs, throughout the year. LHCC 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 LHCC at group and one-on-one meetings throughout the contract year.

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

**Table 2-2—SFY 2025 MCO PIP Activities**

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

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

## Validation Results and Confidence Ratings

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

**Table 2-3—SFY 2025 PIP Validation Results for LHCC**

| PIP Topic | Validation Rating 1 | | | Validation Rating 2 | | |
|---|---|---|---|---|---|---|
| | Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP | | | Overall Confidence That the PIP Achieved Significant Improvement | | |
| | Percentage Score of Evaluation Elements *Met*[1] | Percentage Score of Critical Elements *Met*[2] | Confidence Level[3] | Percentage Score of Evaluation Elements *Met*[1] | Percentage Score of Critical Elements *Met*[2] | Confidence Level[3] |
| *Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees* | 100% | 100% | *High Confidence* | *Not Assessed*[4] | | |
| *Behavioral Health Transitions of Care* | 100% | 100% | *High Confidence* | 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* |

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

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

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

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

## Performance Indicator Results

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

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

**Table 2-4—Performance Indicator Results for 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<br>D: 8,377 | 22.61% | —<br>— | — | —<br>— | — | *Not Assessed* |
| *Syphilis screening during weeks 28 to 32 of pregnancy.* | N: 2,575<br>D: 6,067 | 42.44% | —<br>— | — | —<br>— | — | *Not Assessed* |
| *Syphilis screening at delivery.** | N: 20<br>D: 8,384 | 0.24% | —<br>— | — | —<br>— | — | *Not Assessed* |
| *Syphilis screening at any time during pregnancy or at delivery.* | N: 7,555<br>D: 8,384 | 90.11% | —<br>— | — | —<br>— | — | *Not Assessed* |
| *Syphilis screening during the first trimester.* | N: 4,597<br>D: 5,700 | 80.65% | —<br>— | — | —<br>— | — | *Not Assessed* |
| *Syphilis screening during the first trimester for all live births.* | N: 4,599<br>D: 8,384 | 54.85% | —<br>— | — | —<br>— | — | *Not Assessed* |
| *Syphilis screening during the third trimester for all live births.* | N: 4,483<br>D: 8,384 | 53.47% | —<br>— | — | —<br>— | — | *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 LHCC's *Behavioral Health Transitions of Care* PIP.

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

| Performance Indicator | Baseline (01/01/2022 to 12/31/2022) | | Remeasurement 1 (01/01/2023 to 12/31/2023) | | Remeasurement 2 (01/01/2024 to 12/31/2024) | | Sustained Improvement |
|---|---|---|---|---|---|---|---|
| *Follow-Up After Hospitalization for Mental Illness (FUH)—Total, 7 Days* | N: 1,673<br>D: 9,156 | 18.27% | N: 1,717<br>D: 8,592 | 19.98%+ ▲ | N: 1,634<br>D: 7,724 | 21.15%+ ▲ | *Yes* |
| *Follow-Up After Hospitalization for Mental Illness (FUH)—Total, 30 Days* | N: 3,551<br>D: 9,156 | 38.78% | N: 3,444<br>D: 8,592 | 40.08%+ | N: 3,321<br>D: 7,724 | 43.00%+ ▲ | *Not Assessed* |
| *Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 7 Days* | N: 401<br>D: 1,804 | 22.23% | N: 349<br>D: 1,593 | 21.91% | N: 279<br>D: 1,318 | 21.17% | *Not Assessed* |
| *Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 30 Days* | N: 679<br>D: 1,804 | 37.64% | N: 598<br>D: 1,593 | 37.54% | N: 493<br>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<br>D: 2,912 | 15.87% | N: 309<br>D: 2,336 | 13.23% | N: 268<br>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<br>D: 2,912 | 26.06% | N: 509<br>D: 2,336 | 21.79% | N: 455<br>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 2-6 displays data for LHCC's *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years* PIP.

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

| Performance Indicator | Baseline (01/01/2022 to 12/31/2022) | | Remeasurement 1 (01/01/2023 to 12/31/2023) | | Remeasurement 2 (01/01/2024 to 12/31/2024) | | Sustained Improvement |
|---|---|---|---|---|---|---|---|
| *Fluoride varnish application by primary care provider (PCP) for children aged 6–18 months* | N: 1,612<br>D: 14,780 | 10.91% | N: 2,014<br>D: 15,383 | 13.09%+ ▲ | N: 1,716<br>D: 10,255 | 16.73%+ ▲ | *Yes* |
| *Fluoride varnish application by PCP for children aged 19 months–2 years* | N: 1,205<br>D: 19,605 | 6.15% | N: 1,448<br>D: 19,548 | 7.41%+ ▲ | N: 1,085<br>D: 10,623 | 10.21%+ ▲ | *Yes* |
| *Fluoride varnish application by PCP for children aged 3–5 years* | N: 858<br>D: 22,133 | 3.88% | N: 946<br>D: 22,215 | 4.26%+ ▲ | N: 574<br>D: 10,334 | 5.55%+▲ | *Yes* |
| *Fluoride varnish application by PCP for all children aged 6 months–5 years* | N: 3,675<br>D: 56,518 | 6.50% | N: 4,408<br>D: 57,146 | 7.71%+ ▲ | N: 3,375<br>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 2-7 displays data for LHCC's *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees* PIP.

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

| Performance Indicator | Baseline (01/01/2023 to 12/31/2023) | | Remeasurement 1 (01/01/2024 to 12/31/2024) | | Remeasurement 2 (01/01/2025 to 12/31/2025) | | Sustained Improvement |
|---|---|---|---|---|---|---|---|
| *The percentage of women aged 21–64 years who were screened for cervical cancer* | N: 46,964<br>D: 89,499 | 52.47% | N: 43,277<br>D: 75,051 | 57.66% +▲ | —<br>— | — | *Not Assessed* |

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

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

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

| Performance Indicator | Baseline (01/01/2023 to 12/31/2023) | | Remeasurement 1 (01/01/2024 to 12/31/2024) | | Remeasurement 2 (01/01/2025 to 12/31/2025) | | Sustained Improvement |
|---|---|---|---|---|---|---|---|
| *Persons screened for HIV during the measurement year among pregnant persons or persons with encounters for labor and delivery* | N: 10,679<br>D: 14,450 | 73.90% | N: 9,178<br>D: 12,701 | 72.26% | —<br>— | — | *Not Assessed* |
| *Persons screened for HIV during the measurement year among persons with past or present (injection) drug use* | N: 7,803<br>D: 26,295 | 29.67% | N: 6,621<br>D: 23,303 | 28.41% | —<br>— | — | *Not Assessed* |
| *Persons screened for HIV during the measurement year among persons with risk factors related to sexual mode of transmission* | N: 20,917<br>D: 51,895 | 40.31% | N: 17,970<br>D: 47,572 | 37.77% | —<br>— | — | *Not Assessed* |

| Performance Indicator | Baseline (01/01/2023 to 12/31/2023) | | Remeasurement 1 (01/01/2024 to 12/31/2024) | | Remeasurement 2 (01/01/2025 to 12/31/2025) | | Sustained Improvement |
|---|---|---|---|---|---|---|---|
| *Persons ever screened for HIV among all others aged 15 to 65 years without a diagnosis of HIV infection* | N: 42,423 | 25.93% | N: 36,894 | 28.13%+ ▲ | — | — | *Not Assessed* |
| | D: 163,580 | | D: 131,143 | | — | | |

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

## Interventions

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

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

| PIP Topic | Barriers | Interventions |
|---|---|---|
| *Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees* | • Lack of enrollee knowledge on importance of timely prenatal care<br>• Lack of provider strategies for addressing stigma regarding syphilis screening during pregnancy<br>• 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<br>• Provider education on methods for reducing the stigma of syphilis screening when delivering prenatal care<br>• 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 admission, discharge, transfer (ADT) feeds/applications<br>• Short time window between enrollee discharge and required follow-up visits to provide follow-up care support<br>• Lack of engagement from enrollees with substance use disorders (SUD) in follow-up care | • Enhanced hospital-to-MCO workflow for notification of hospital admissions, discharges, and transfers<br>• Linkage to aftercare with behavioral health providers prior to discharge from hospital<br>• Provide critical enrollee information to aftercare behavioral health providers within three days of enrollee's discharge through provider-friendly, automated processes |

| PIP Topic | Barriers | Interventions |
|---|---|---|
| *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years* | • Lack of PCP training in fluoride varnish application<br>• Lack of provider knowledge regarding fluoride varnish application recommendations and opportunities for reimbursement<br>• 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, American Academy of Pediatrics (AAP) guidelines on fluoride use to prevent dental caries, LDH bulletin regarding reimbursement and course requirements/link, and Well-Ahead Louisiana resources<br>• Provided PCPs with customized list of enrollees for whom fluoride varnish application was indicated<br>• 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<br>• 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<br>• Enhanced MCO enrollee outreach and education on cervical cancer screening via text messages<br>• 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<br>• 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<br>• 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 |

## MCO Strengths, Opportunities for Improvement, and Recommendations

For LHCC, the following strengths were identified:

- The MCO developed and carried out a methodologically sound design for all five PIPs that facilitated valid and reliable measurement of objective indicator performance over time. **[Quality]**
- The MCO conducted and reported accurate analyses and interpretation of performance indicator results for all five PIPs. **[Quality]**
- The MCO carried out interventions for all five PIPs that had the potential to address identified barriers and improve performance indicator results. **[Quality]**
- The MCO collected, analyzed, and reported intervention-specific effectiveness data to monitor the progress and impact of interventions throughout the most recent measurement period for all five PIPs. **[Quality]**
- For all four PIPs assessed for achieving significant improvement (*Behavioral Health Transitions of Care*, *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years*, *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees*, and *Screening for HIV Infection*), some of the MCO's reported performance indicator results demonstrated statistically significant improvement from baseline to the most recent remeasurement. **[Quality, Timeliness, and Access]**
- For two PIPs assessed for achieving significant improvement (*Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years* and *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees)*, all of the MCO's reported indicator results demonstrated statistically significant improvement from baseline to the most recent remeasurement. **[Quality, Timeliness, and Access]**

For LHCC, the following opportunity for improvement was identified:

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

For LHCC, the following recommendation was identified:

- To facilitate significant outcomes improvement for all PIPs, the MCO should review intervention evaluation results to determine if each intervention is having the desired impact and how interventions can be revised to increase effectiveness. The MCO should also revisit MCO-specific barrier analyses for each PIP to evaluate whether additional barriers need to be addressed by new or revised interventions to drive outcomes improvement. **[Quality, Timeliness, and Access]**

# Methodology

## Objectives

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

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

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

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

## Technical Methods of Data Collection

HSAG, as the State's EQRO, validated the PIPs through an independent review process. In its PIP evaluation and validation, HSAG used the CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 1).[5]

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

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

[5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 29, 2025.

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

## Description of Data Obtained

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

## How Data Were Aggregated and Analyzed

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

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

1. **Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Steps 1 Through 8)**
   - *High Confidence*: High confidence in reported PIP results. All critical evaluation elements were *Met*, and 90 percent to 100 percent of all evaluation elements were *Met* across all steps.
   - *Moderate Confidence*: Moderate confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 percent to 89 percent of all evaluation elements were *Met* across all steps.
   - *Low Confidence*: Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Partially Met*.
   - *No Confidence*: No confidence in reported PIP results. Across all steps, less than 65 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Not Met*.
2. **Overall Confidence That the PIP Achieved Significant Improvement (Step 9)**
   - *High Confidence*: All performance indicators demonstrated *statistically significant* improvement over the baseline.
   - *Moderate Confidence*: One of the three scenarios below occurred:
     - All performance indicators demonstrated improvement over the baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over the baseline.
     - All performance indicators demonstrated improvement over the baseline, **and** none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
     - Some but not all performance indicators demonstrated improvement over baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over baseline.
   - *Low Confidence*: The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator **or** some but not all performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
   - *No Confidence*: The remeasurement methodology was not the same as the baseline methodology for all performance indicators or none of the performance indicators demonstrated improvement over the baseline.

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

## How Conclusions Were Drawn

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

To draw conclusions about the quality, timeliness, and accessibility of care and services provided by the MCOs, HSAG assigned each PIP topic to one or more of these three domains. While the focus of an MCO's PIP may have been to improve performance related to healthcare quality, timeliness, or accessibility, PIP validation activities were designed to evaluate the validity and quality of the MCO's process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. In addition, all PIP topics were assigned to other domains as appropriate. This assignment to domains is shown in Table 2-10.

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

| PIP Topic | Quality | Timeliness | Access |
|---|---|---|---|
| *Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees* | ✓ | ✓ | ✓ |
| *Behavioral Health Transitions of Care* | ✓ | ✓ | ✓ |
| *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years* | ✓ | ✓ | ✓ |
| *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees* | ✓ | ✓ | ✓ |
| *Screening for HIV Infection* | ✓ | ✓ | ✓ |

# 3. Validation of Performance Measures

## Results

### *Information Systems Capabilities Assessment*

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

Based on a review of the FARs issued by LHCC's independent certified HEDIS compliance auditor, HSAG found that LHCC fully met the standard for all four of the applicable NCQA IS standards.

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

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

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

### *Performance Measures*

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

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

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

| HEDIS Measure | MY 2022 | MY 2023 | MY 2024 | SWA |
|---|---|---|---|---|
| ***Follow-Up After Hospitalization for Mental Illness*** | | | | |
| *Within 7 Days of Discharge—Total* | 18.74%^ | 20.70%^ | 22.14%^ | 22.05%^ |
| *Within 30 Days of Discharge[I]—Total* | 39.48%^ | 41.60%^ | 44.68%^ | 42.18%^ |
| ***Follow-Up After Emergency Department Visit for Mental Illness*** | | | | |
| *Within 7 Days of Discharge—Total* | 22.54%^ | 22.39%^ | 22.07%^ | 23.02%^ |
| *Within 30 Days of Discharge[I]—Total* | 37.76%^ | 38.24%^ | 38.49%^ | 38.77%^ |
| ***Follow-Up After Emergency Department Visit for Substance Use*** | | | | |
| *Within 7 Days of Discharge—Total* | 15.88%^ | 13.42%^ | 14.96%^ | 15.66%^ |
| *Within 30 Days of Discharge[I]—Total* | 26.05%^ | 21.89%^ | 25.19%^ | 25.41%^ |
| ***Follow-Up After High-Intensity Care for SUD*** | | | | |
| *Within 7 Days of Visit or Discharge—Total* | — | — | 56.29%+ | 59.23%+ |
| *Within 30 Days of Visit or Discharge—Total* | — | — | 66.99%+ | 70.77%+ |
| ***Plan All-Cause Readmissions[B]*** | | | | |
| *Observed Readmissions (Numerator/Denominator)** | 9.52% | 10.06% | 10.12% | 10.05% |
| *Expected Readmissions Rate* | 9.40% | 9.62% | 8.42% | 8.53% |
| *Observed-to-Expected (O/E) Ratio (Observed Readmissions/Expected Readmissions)[*]* | 1.0122^ | 1.0460^ | 1.2024^ | 1.1771^ |
| ***Depression Screening and Follow-Up for Adolescents and Adults—Electronic Clinical Data System (ECDS)*** | | | | |
| *Depression Screening—Total* | 0.00% | NR | 6.17%+ | 3.31%^ |
| *Follow-Up on Positive Screen—Total* | 0.00% | NR | 76.00%+ | 73.57%+ |
| ***Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*** | 82.52%+ | 83.89%+ | 84.90%+ | 85.11%+ |
| ***Diabetes Monitoring for People With Diabetes and Schizophrenia*** | 67.44%^ | 73.32%+ | 77.61%+ | 75.60%+ |
| ***Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia*** | 76.84%^ | 81.91%+ | 82.52%+ | 82.56%+ |
| ***Metabolic Monitoring for Children and Adolescents on Antipsychotics—ECDS*** | | | | |
| *Blood Glucose Testing—Total* | — | — | 52.85%^ | 53.68%^ |
| *Cholesterol Testing—Total* | — | — | 27.55%^ | 28.43%^ |
| *Blood Glucose and Cholesterol Testing—Total* | — | — | 26.51%^ | 27.26%^ |
| ***Lead Screening in Children*** | 61.64%^ | 68.13%+ | 72.75%+ | 70.87%+ |
| ***Colorectal Cancer Screening[I]—ECDS*** | — | — | 52.24%+ | 45.44%+ |

| HEDIS Measure | MY 2022 | MY 2023 | MY 2024 | SWA |
|---|---|---|---|---|
| ***Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*** | | | | |
| *Body Mass Index (BMI) Percentile Documentation—Total* | 60.58%^ | 81.51%^ | 89.29%+ | 86.26%+ |
| *Counseling for Nutrition—Total* | 57.18%^ | 70.56%^ | 69.34%^ | 70.74%^ |
| *Counseling for Physical Activity—Total* | 51.58%^ | 59.12%^ | 64.72%^ | 66.86%^ |
| ***HIV Viral Load Suppression[I]*** | 79.78% | 81.99% | 82.48% | 82.24% |
| ***Low-Risk Cesarean Delivery (Cesarean Rate for Low-Risk First Birth Women)[*,I]*** | 27.47% | 27.18% | 26.78% | 26.37% |
| ***Chlamydia Screening in Women*** | | | | |
| *Total* | 63.84%+ | 67.37%+ | 67.27%+ | 66.43%+ |
| ***Controlling High Blood Pressure[I]*** | 55.23%^ | 60.34%^ | 68.61%+ | 65.03%^ |
| ***Statin Therapy for Patients With Cardiovascular Disease*** | | | | |
| *Received Statin Therapy—Total* | 80.41%+ | 81.94%+ | 81.71%+ | 82.62%+ |
| *Statin Adherence 80%—Total* | 73.30%+ | 74.18%+ | 76.96%+ | 71.14%^ |
| ***Glycemic Status Assessment for Patients With Diabetes*** | | | | |
| *Glycemic Status >9.0%[*,I]* | 45.99%^ | 31.63%+ | 29.68%+ | 28.35%+ |
| *Glycemic Status <8.0%* | 44.77%^ | 61.56%+ | 63.02%+ | 64.86%+ |
| ***Eye Exam for Patients With Diabetes*** | 53.04%+ | 59.37%+ | 66.42%+ | 59.29%+ |
| ***Blood Pressure Control for Patients With Diabetes*** | 50.61%^ | 63.02%^ | 69.10%^ | 69.65%^ |
| ***Pharmacotherapy for Opioid Use Disorder*** | 34.90%+ | 34.11%+ | 40.31%+ | 34.64%+ |
| ***Initiation and Engagement of SUD Treatment*** | | | | |
| *Initiation of SUD Treatment—Total* | 55.86%+ | 49.81%+ | 54.87%+ | 59.26%+ |
| *Engagement of SUD Treatment—Total* | 21.55%+ | 15.87%+ | 24.60%+ | 27.37%+ |
| ***Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics*** | 60.10%^ | 61.74%+ | 61.91%^ | 64.29%+ |
| ***Adherence to Antipsychotic Medications for Individuals With Schizophrenia*** | 59.14%^ | 60.69%^ | 67.28%+ | 61.49%^ |
| ***Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—ECDS*** | | | | |
| *Initiation Phase* | — | — | 43.95%^ | 45.46%^ |
| *Continuation and Maintenance Phase* | — | — | 51.43%^ | 52.86%^ |
| ***Antidepressant Medication Management*** | | | | |
| *Effective Acute Phase Treatment* | 56.85%^ | 59.73%^ | 63.27%^ | 60.88%^ |
| *Effective Continuation Phase Treatment* | 39.76%^ | 42.60%^ | 48.13%+ | 45.44%^ |

| HEDIS Measure | MY 2022 | MY 2023 | MY 2024 | SWA |
|---|---|---|---|---|
| ***Appropriate Treatment for Children With Upper Respiratory Infection (URI)*** | 79.95%^ | 80.12%^ | 82.13%^ | 81.90%^ |
| ***Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*** | 52.58%^ | 51.12%^ | 52.74%^ | 52.98%^ |
| ***Use of Imaging Studies for Low Back Pain*** | 71.47%^ | 69.11%^ | 69.83%^ | 68.86%^ |
| ***Cervical Cancer Screening[I]*** | 56.69%^ | 58.64%+ | 65.21%+ | 57.33%^ |
| ***Asthma Medication Ratio*** | | | | |
| *5–11 Years* | — | 79.44%+ | 63.84%^ | 65.73%^ |
| *12–18 Years* | — | 74.41%+ | 64.37%^ | 63.52%^ |
| *19–50 Years* | — | 72.27%+ | 63.25%+ | 63.12%+ |
| *51–64 Years* | — | 69.43%+ | 66.28%+ | 65.14%+ |
| *Total* | — | 74.21%+ | 64.06%+ | 64.22%+ |
| ***Appropriate Testing for Pharyngitis*** | | | | |
| *3–17 Years* | — | — | 83.34%^ | 82.73%^ |
| *18–64 Years* | — | — | 80.72%+ | 78.29%+ |
| *65 Years and Older* | — | — | NA | 60.61%+ |
| *Total* | — | — | 82.62%^ | 81.44%^ |
| ***Topical Fluoride for Children*** | | | | |
| *1–2 Years* | — | 6.54% | 7.98% | 6.04% |
| *3–4 Years* | — | 10.52% | 12.13% | 7.59% |
| *Total* | — | 8.55% | 10.09% | 6.82% |

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

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

| HEDIS Measure | MY 2022 | MY 2023 | MY 2024 | SWA |
|---|---|---|---|---|
| ***Adults' Access to Preventive/Ambulatory Health Services*** | | | | |
| *20–44 Years* | 72.25%+ | 76.80%+ | 79.04%+ | 75.53%^ |
| *45–64 Years* | 81.11%+ | 84.67%+ | 86.51%+ | 83.48%+ |
| *65 Years and Older* | 78.18%^ | 82.46%+ | 82.48%^ | 77.97%^ |
| *Total* | 74.69%+ | 79.11%+ | 81.24%+ | 78.09%+ |

| HEDIS Measure | MY 2022 | MY 2023 | MY 2024 | SWA |
|---|---|---|---|---|
| ***Prenatal and Postpartum Care*** | | | | |
| *Timeliness of Prenatal Care* | 81.51%^ | 78.83%^ | 85.64%^ | 83.83%^ |
| *Postpartum Care* | 75.18%^ | 77.62%^ | 83.45%+ | 81.62%^ |

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

| HEDIS Measure | MY 2022 | MY 2023 | MY 2024 | SWA |
|---|---|---|---|---|
| ***Well-Child Visits in the First 30 Months of Life*** | | | | |
| *First 15 Months* | 58.57%+ | 63.17%+ | 65.77%+ | 64.83%+ |
| *15 Months–30 Months* | 63.41%^ | 70.49%+ | 72.32%+ | 72.42%+ |
| ***Child and Adolescent Well-Care Visits*** | | | | |
| *3–11 Years* | 55.24%^ | 59.98%+ | 61.60%^ | 60.45%^ |
| *12–17 Years* | 52.49%+ | 56.83%+ | 57.77%+ | 56.11%+ |
| *18–21 Years* | 27.83%+ | 32.59%+ | 34.78%+ | 32.68%+ |
| *Total* | 49.12%+ | 54.23%+ | 56.02%+ | 54.58%^ |
| ***Antibiotic Utilization for Respiratory Conditions*** | | | | |
| *3 Months–17 Years* | — | — | 34.44%+ | 34.05%+ |
| *18–64 Years* | — | — | 29.99%+ | 29.16%+ |
| *65 Years and Older* | — | — | 19.78%+ | 20.07%+ |
| *Total* | — | — | 32.94%+ | 32.26%+ |
| ***Enrollment by Product Line*** | | | | |
| *Less than 1 Year* | — | 11,905 | 11,144 | 37,522 |
| *1–4 Years* | — | 48,863 | 45,028 | 141,537 |
| *5–9 Years* | — | 61,390 | 59,027 | 182,737 |
| *10–14 Years* | — | 60,025 | 58,545 | 176,938 |
| *15–17 Years* | — | 35,848 | 35,569 | 109,211 |
| *18–19 Years* | — | 20,567 | 19,357 | 60,260 |
| *20–24 Years* | — | 41,722 | 34,416 | 111,685 |
| *25–29 Years* | — | 30,569 | 25,375 | 93,717 |
| *30–34 Years* | — | 29,615 | 24,377 | 92,906 |
| *35–39 Years* | — | 25,187 | 21,259 | 82,628 |
| *40–44 Years* | — | 22,294 | 18,424 | 72,625 |
| *45–49 Years* | — | 17,049 | 14,310 | 56,774 |

| HEDIS Measure | MY 2022 | MY 2023 | MY 2024 | SWA |
|---|---|---|---|---|
| *50–54 Years* | — | 14,789 | 11,873 | 48,838 |
| *55–59 Years* | — | 14,718 | 11,703 | 48,549 |
| *60–64 Years* | — | 13,907 | 11,493 | 48,032 |
| *65–69 Years* | — | 1,161 | 528 | 1,704 |
| *70–74 Years* | — | 170 | 145 | 620 |
| *75–79 Years* | — | 74 | 60 | 306 |
| *80–84 Years* | — | 48 | 38 | 200 |
| *85–89 Years* | — | NA | NA | 86 |
| *90 Years and Older* | — | NA | NA | 65 |
| *Unknown* | — | NA | NA | NA |
| *Total* | — | 449,932 | 402,700 | 1,366,940 |
| ***Language Diversity of Membership*** | | | | |
| *Spoken Language Preferred for Health Care—Health Plan* | — | 0.00%+ | 96.75%+ | 51.08%+ |
| *Spoken Language Preferred for Health Care—CMS/State* | — | 99.91%+ | 0.00%^ | 47.98%+ |
| *Spoken Language Preferred for Health Care—Other Third-Party* | — | 0.09%+ | 3.25%+ | 0.94%+ |
| *Preferred Language for Written Materials—Health Plan* | — | 0.00%+ | 96.75%+ | 51.25%+ |
| *Preferred Language for Written Materials—CMS/State* | — | 99.91%+ | 0.00%^ | 24.75%+ |
| *Preferred Language for Written Materials—Other Third-Party* | — | 0.09%+ | 3.25%+ | 24.00%+ |
| *Other Language Needs—Health Plan* | — | 0.00%+ | 96.75%+ | 46.39%+ |
| *Other Language Needs—CMS/State* | — | 99.91%+ | 0.00%+ | 20.61%+ |
| *Other Language Needs—Other Third-Party* | — | 0.09%^ | 3.25%+ | 33.00%+ |
| *Spoken Language Preferred for Health Care—Percent English* | — | 98.36%+ | 95.48%+ | 97.19%+ |
| *Spoken Language Preferred for Health Care—Percent Non-English* | — | 1.55%^ | 1.33%^ | 1.86%^ |
| *Spoken Language Preferred for Health Care—Percent Declined* | — | 0.00%+ | 0.00%+ | 0.00%+ |
| *Spoken Language Preferred for Health Care—Percent Unknown* | — | 0.09%^ | 3.18%+ | 0.95%^ |
| *Language Preferred for Written Materials—Percent English* | — | 98.36%+ | 95.48%+ | 65.15%^ |
| *Language Preferred for Written Materials—Percent Non-English* | — | 1.55%^ | 1.33%^ | 1.31%^ |

| HEDIS Measure | MY 2022 | MY 2023 | MY 2024 | SWA |
|---|---|---|---|---|
| *Language Preferred for Written Materials—Percent Declined* | — | 0.00%+ | 0.00%+ | 0.00%+ |
| *Language Preferred for Written Materials—Percent Unknown* | — | 0.09%^ | 3.18%^ | 33.54%+ |
| *Other Language Needs—Percent English* | — | 98.36%+ | 95.48%+ | 37.76%+ |
| *Other Language Needs—Percent Non-English* | — | 1.55%+ | 1.33%+ | 0.57%+ |
| *Other Language Needs—Percent Declined* | — | 0.00%+ | 0.00%+ | 0.00%+ |
| *Other Language Needs—Percent Unknown* | — | 0.09%^ | 3.18%^ | 61.67%^ |
| ***Race/Ethnicity Diversity of Membership*** | | | | |
| *Race—Health Plan* | — | 0.00%+ | 76.24%+ | 44.31%+ |
| *Race—CMS/State* | — | 88.86%+ | 10.79%^ | 41.33%^ |
| *Race—Other Direct* | — | 1.59%+ | 5.99%+ | 1.69%+ |
| *Race—Direct Total* | — | 90.44%+ | 93.02%+ | 87.33%+ |
| *Race—Indirect Total* | — | 0.00%+ | 0.00%+ | 1.14%+ |
| *Race—Unknown Total* | — | 9.56%^ | 6.98%^ | 11.53%^ |
| *Ethnicity—Health Plan* | — | 0.00%+ | 40.04%+ | 35.42%+ |
| *Ethnicity—CMS/State* | — | 2.16%^ | 7.58%^ | 36.27%+ |
| *Ethnicity—Other Direct* | — | 8.10%+ | 34.32%+ | 9.66%+ |
| *Ethnicity—Direct Total* | — | 10.26%^ | 81.95%^ | 81.35%^ |
| *Ethnicity—Indirect Total* | — | 26.82%+ | 9.93%+ | 4.26%+ |
| *Ethnicity—Unknown Total* | — | 62.92%+ | 8.12%^ | 14.39%+ |
| *Race: White—Ethnicity: Hispanic or Latino* | — | 1.05%^ | 1.78%^ | 3.01%+ |
| *Race: White—Ethnicity: Not Hispanic or Latino* | — | 14.83%^ | 36.54%+ | 32.21%+ |
| *Race: White—Ethnicity: Asked but No Answer* | — | 0.00%+ | 0.00%+ | 0.01%+ |
| *Race: White—Ethnicity: Unknown* | — | 21.57%+ | 0.14%^ | 2.86%+ |
| *Race: White—Ethnicity: Total* | — | 37.46%^ | 38.46%^ | 38.09%^ |
| *Race: Black or African American—Ethnicity: Hispanic or Latino* | — | 0.26%+ | 0.44%+ | 3.34%+ |
| *Race: Black or African American—Ethnicity: Not Hispanic or Latino* | — | 17.42%+ | 48.86%+ | 37.02%+ |
| *Race: Black or African American—Ethnicity: Asked but No Answer* | — | 0.00%+ | 0.00%+ | 0.00%+ |
| *Race: Black or African American—Ethnicity: Unknown* | — | 30.74%+ | 0.62%+ | 3.99%+ |
| *Race: Black or African American—Ethnicity: Total* | — | 48.41%+ | 49.92%+ | 44.36%+ |

| HEDIS Measure | MY 2022 | MY 2023 | MY 2024 | SWA |
|---|---|---|---|---|
| *Race: American Indian or Alaska Native—Ethnicity: Hispanic or Latino* | — | 0.04%+ | 0.07%+ | 0.09%+ |
| *Race: American Indian or Alaska Native—Ethnicity: Not Hispanic or Latino* | — | 0.24%+ | 0.40%+ | 0.47%+ |
| *Race: American Indian or Alaska Native—Ethnicity: Asked but No Answer* | — | 0.00%+ | 0.00%+ | 0.00%+ |
| *Race: American Indian or Alaska Native—Ethnicity: Unknown* | — | 0.40%+ | 0.27%+ | 0.21%+ |
| *Race: American Indian or Alaska Native—Ethnicity: Total* | — | 0.68%+ | 0.74%+ | 0.77%+ |
| *Race: Asian—Ethnicity: Hispanic or Latino* | — | 0.02%+ | 0.03%+ | 0.12%+ |
| *Race: Asian—Ethnicity: Not Hispanic or Latino* | — | 0.47%^ | 0.56%^ | 1.53%+ |
| *Race: Asian—Ethnicity: Asked but No Answer* | — | 0.00%+ | 0.00%+ | 0.00%+ |
| *Race: Asian—Ethnicity: Unknown* | — | 0.86%+ | 0.25%+ | 0.40%+ |
| *Race: Asian—Ethnicity: Total* | — | 1.35%^ | 0.84%^ | 2.04%+ |
| *Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Hispanic or Latino* | — | 0.00%+ | 0.01%^ | 0.01%^ |
| *Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Not Hispanic or Latino* | — | 0.00%^ | 0.01%^ | 0.02%^ |
| *Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Asked but No Answer* | — | 0.00%+ | 0.00%+ | 0.00%+ |
| *Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Unknown* | — | 0.01%+ | 0.01%+ | 0.01%+ |
| *Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Total* | — | 0.02%^ | 0.03%^ | 0.04%^ |
| *Race: Some Other Race—Ethnicity: Hispanic or Latino* | — | 0.38%+ | 0.50%+ | 0.53%+ |
| *Race: Some Other Race—Ethnicity: Not Hispanic or Latino* | — | 0.32%+ | 0.19%+ | 1.30%+ |
| *Race: Some Other Race—Ethnicity: Asked but No Answer* | — | 0.00%+ | 0.00%+ | 0.00%+ |
| *Race: Some Other Race—Ethnicity: Unknown* | — | 1.80%+ | 1.38%+ | 0.70%+ |
| *Race: Some Other Race—Ethnicity: Total* | — | 2.50%+ | 2.07%+ | 2.54%+ |
| *Race: Two or More Races—Ethnicity: Hispanic or Latino* | — | 0.00%+ | 0.18%+ | 0.27%+ |
| *Race: Two or More Races—Ethnicity: Not Hispanic or Latino* | — | 0.01%+ | 0.39%+ | 0.13%+ |
| *Race: Two or More Races—Ethnicity: Asked but No Answer* | — | 0.00%+ | 0.00%+ | 0.00%+ |

| HEDIS Measure | MY 2022 | MY 2023 | MY 2024 | SWA |
|---|---|---|---|---|
| *Race: Two or More Races—Ethnicity: Unknown* | — | 0.02%+ | 0.39%+ | 0.24%+ |
| *Race: Two or More Races—Ethnicity: Total* | — | 0.03%+ | 0.96%+ | 0.64%+ |
| *Race: Unknown—Ethnicity: Hispanic or Latino* | — | 0.62%^ | 0.93%^ | 0.99%^ |
| *Race: Unknown—Ethnicity: Not Hispanic or Latino* | — | 1.43%+ | 0.98%+ | 3.02%+ |
| *Race: Unknown—Ethnicity: Asked but No Answer* | — | 0.00%+ | 0.00%+ | 1.54%+ |
| *Race: Unknown—Ethnicity: Unknown* | — | 7.51%+ | 5.07%+ | 5.98%+ |
| *Race: Unknown—Ethnicity: Total* | — | 9.56%^ | 6.98%^ | 11.53%^ |
| *Race: Total—Ethnicity: Hispanic or Latino* | — | 2.37%^ | 3.94%^ | 8.36%^ |
| *Race: Total—Ethnicity: Not Hispanic or Latino* | — | 34.71%^ | 87.93%+ | 75.70%+ |
| *Race: Total—Ethnicity: Asked but No Answer* | — | 0.00%+ | 0.00%+ | 1.55%+ |
| *Race: Total—Ethnicity: Unknown* | — | 62.92%+ | 8.12%^ | 14.39%+ |
| *Race: Total—Ethnicity: Total* | — | 100.00%+ | 100.00%+ | 100.00%+ |
| *Race: Asked but No Answer—Ethnicity: Hispanic or Latino* | — | 0.00%+ | 0.00%+ | 0.00%+ |
| *Race: Asked but No Answer—Ethnicity: Not Hispanic or Latino* | — | 0.00%+ | 0.00%+ | 0.00%+ |
| *Race: Asked but No Answer—Ethnicity: Asked but No Answer* | — | 0.00%+ | 0.00%+ | 0.00%+ |
| *Race: Asked but No Answer—Ethnicity: Unknown* | — | 0.00%+ | 0.00%+ | 0.00%+ |
| *Race: Asked but No Answer—Ethnicity: Total* | — | 0.00%+ | 0.00%+ | 0.00%+ |

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

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

| Measure Status | MY 2022 | MY 2023 | MY 2024* |
|---|---|---|---|
| ≥ NCQA National 50th Percentile Benchmark | 28 | 190 | 100 |
| < NCQA National 50th Percentile Benchmark | 50 | 85 | 50 |
| NCQA National Benchmark Unavailable | 11 | 12 | 5 |
| **Total** | **89** | **287** | **155** |

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

## MCO Strengths, Opportunities for Improvement, and Recommendations

For LHCC, the following strengths were identified:

- LHCC's rates on the *Follow-Up After High-Intensity Care for SUD* measure indicators were above the NCQA national 50th percentile benchmark for MY 2024. These results suggest that LHCC was effective in coordinating with providers to ensure that adolescent and adult members diagnosed with SUD who were discharged from an inpatient setting or visited a residential treatment or withdrawal management center received timely and adequate follow-up care to manage their conditions. **[Quality, Timeliness, and Access]**
- LHCC's rates on the *Depression Screening and Follow-Up for Adolescents and Adults—ECDS* measure indicators were above the NCQA national 50th percentile benchmark for MY 2024. These results suggest that LHCC was effective in coordinating with providers to ensure adolescent and adult Medicaid members had timely follow-up care after a positive depression screen. **[Quality]**
- LHCC's rate on the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure was above the NCQA national 50th percentile benchmark for MY 2024. Additionally, LHCC's rate 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 LHCC was 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]**
- LHCC's rate 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 LHCC was effective in ensuring that adult members with cardiovascular disease and schizophrenia who are on antipsychotics had their cholesterol monitored to promote positive health outcomes. **[Quality]**
- LHCC's rate on the *Lead Screening in Children* measure was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that LHCC was effective in ensuring that children under 2 years of age were adequately receiving lead blood testing to ensure they maintained limited exposure to lead. **[Quality]**
- LHCC's rate on the *Colorectal Cancer Screening—ECDS* measure was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that LHCC was effective in ensuring that members 45 to 75 years of age had appropriate screening for colorectal cancer. **[Quality]**
- LHCC's rate on the *Chlamydia Screening in Women—Total* measure indicator was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that LHCC effectively coordinated with providers to facilitate annual follow-ups with and screening of sexually active members. **[Quality]**
- LHCC's rate on the *Controlling High Blood Pressure* measure was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that LHCC was effective in coordinating with providers to help members manage their blood pressure, reducing their risk for heart disease and stroke. **[Quality]**

- LHCC's rates on the *Statin Therapy for Patients With Cardiovascular Disease* measure indicators were above the NCQA national 50th percentile benchmark for MY 2024. These results suggest that LHCC effectively coordinated with providers to ensure that members with clinical atherosclerotic cardiovascular disease (ASCVD) received statin therapy to manage their condition, reducing the risk of adverse outcomes. **[Quality]**
- LHCC's rate on the *Eye Exam for Patients With Diabetes* measure was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that LHCC effectively coordinated with providers to ensure that adult members with diabetes received a retinal eye exam to screen for diabetic retinal disease. **[Quality]**
- LHCC's rate on the *Pharmacotherapy for Opioid Use Disorder* measure was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that LHCC effectively coordinated with providers to engage members with opioid use disorder in continuous treatment with pharmacotherapy, increasing the chance for positive outcomes. **[Quality]**
- LHCC's rates on the *Initiation and Engagement of SUD Treatment* measure indicators were above the NCQA national 50th percentile benchmark for MY 2024. These results suggest that LHCC 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]**
- LHCC's rate on the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measure was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that LHCC was effective in coordinating with providers to ensure that members with schizophrenia or schizoaffective disorder are dispensed and remain on an antipsychotic medication for at least 80 percent of their treatment period. **[Quality]**
- LHCC's rate on the *Cervical Cancer Screening* measure was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that LHCC effectively coordinated with providers to ensure that women ages 21 to 64 years received appropriate, early detection cancer screening. **[Quality]**
- LHCC's rates on the following *Adults' Access to Preventive/Ambulatory Health Services* measure indicators were above the NCQA national 50th percentile benchmark for MY 2024: *20–44 Years*, *45–64 Years*, and *Total*. These results suggest that LHCC effectively coordinated with PCPs to ensure that adult members were engaging in preventive or ambulatory visits to manage their health and avoid adverse outcomes. **[Quality and Access]**
- LHCC's rate on the *Prenatal and Postpartum Care—Postpartum Care* measure indicator was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that LHCC was effective in coordinating with providers to ensure that members receive timely and adequate postpartum care, in alignment with guidance provided by the AAP and the American College of Obstetricians and Gynecologists (ACOG). **[Quality, Timeliness, and Access]**
- LHCC's rates 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 LHCC 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]**

- LHCC's rates on *Antibiotic Utilization for Respiratory Condition* measure indicators were above the NCQA national 50th percentile benchmark for MY 2024. These results suggest that LHCC was effective in coordinating with providers to ensure that members diagnosed with a respiratory condition were not inappropriately dispensed an antibiotic. **[Quality]**

For LHCC, the following opportunities for improvement were identified:

- LHCC's rates on the *Follow-Up After Hospitalization for Mental Illness* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest that LHCC has room for improvement in its coordination with providers to ensure that members hospitalized for mental health issues receive adequate follow-up care after hospital discharge to reduce the risk of re-hospitalization. **[Quality, Timeliness, and Access]**
- LHCC's rates on the *Follow-Up After Emergency Department Visit for Mental Illness* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. Additionally, LHCC's rates on the *Follow-Up After Emergency Department Visit for Substance Use* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest that LHCC has room for improvement with properly managing the care of patients discharged after an ED visit for mental illness and for substance use, as they are vulnerable after release. **[Quality, Timeliness, and Access]**
- LHCC's rate 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 LHCC was effective with facilitating appropriate post-discharge planning and care coordination. **[Quality]**
- LHCC's rates on the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—ECDS* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest that LHCC has room for improvement in its coordination with providers to effectively monitor blood glucose and cholesterol in child and adolescent members on antipsychotics. **[Quality]**
- LHCC's rate on the *Blood Pressure Control for Patients With Diabetes* measure was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that LHCC has room for improvement in coordinating with providers to help adult members with diabetes adequately control their blood pressure. **[Quality]**
- LHCC's rate on the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* measure was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that LHCC has room for improvement in coordinating with providers to ensure the use of psychosocial care as first-line treatment for children and adolescents recently started on antipsychotic medications. **[Quality]**
- LHCC's rates on the *Follow-Up Care for Children Prescribed ADHD Medication—ECDS* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest that LHCC has room for improvement in coordinating with providers to initiate appropriate follow-up visits for children prescribed ADHD medication. **[Quality, Timeliness, and Access]**
- LHCC's rate on the *Appropriate Treatment for Children With URI* measure was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that LHCC has room for

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

- LHCC's rate on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that LHCC has room for improvement with ensuring that providers effectively prevent or minimize the prescribing of antibiotics for members with a diagnosis of bronchitis or bronchiolitis. **[Quality]**
- LHCC's rate on the *Use of Imaging Studies for Low Back Pain* measure was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that LHCC has room for improvement with ensuring that providers properly order imaging studies. **[Quality]**
- LHCC's rates on the following *Adults' Access to Preventive/Ambulatory Health Services* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024: *65 Years and Older*. These results suggest that LHCC has room for improvement in coordinating with PCPs to ensure that adult members are engaging in preventive or ambulatory visits to manage their health and avoid adverse outcomes. **[Quality and Access]**
- LHCC's rate on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that LHCC has room for improvement in coordinating with providers to ensure that members receive timely and adequate prenatal care, in alignment with guidance provided by the AAP and ACOG. **[Quality, Timeliness, and Access]**

For LHCC, 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 LHCC 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 LHCC. LHCC 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 LHCC work with providers to improve post-discharge planning and care coordination. **[Quality]**
- To improve performance on the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—ECDS* measure indicators, HSAG recommends that LHCC 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 *Blood Pressure Control for Patients With Diabetes* measure, HSAG recommends that LHCC work with providers to identify and address barriers to effective blood pressure management for diabetic members. HSAG also recommends that LHCC 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. LHCC 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 *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* measure, HSAG recommends that LHCC work with providers to identify and address barriers to the use of psychosocial care as the first-line treatment for members on antipsychotic medications. LHCC 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 *Follow-Up Care for Children Prescribed ADHD Medication—ECDS* measure indicators, HSAG recommends that LHCC work with providers to identify and address barriers to initial follow-up visits with children prescribed ADHD medication. LHCC could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions. **[Quality, Timeliness, and Access]**
- To improve performance on the *Appropriate Treatment for Children With URI* measure, HSAG recommends that LHCC work with providers to trial solutions to reduce antibiotic dispensing to treat URIs. LHCC 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 LHCC work with providers to trial solutions to reduce or prevent the prescribing of antibiotics for members with a diagnosis of bronchitis or bronchiolitis. LHCC 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 LHCC focus its efforts on decreasing unnecessary imaging for low back pain. HSAG also recommends that LHCC 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 *Adults' Access to Preventive/Ambulatory Health Services—65 Years and Older* measure indicators, HSAG recommends that LHCC work with PCPs to identify and address barriers to preventive or ambulatory visits for adult members. LHCC could also consider data analysis and stratification across key demographics (i.e., race, ethnicity, and ZIP Code) to identify disparities and implement targeted interventions, such as patient and provider education, outreach campaigns, and sending reminders. **[Quality and Access]**
- To improve performance on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator, HSAG recommends that LHCC work with providers to identify and address

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

# Methodology

## Objectives

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

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

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

## Technical Methods of Data Collection

The CMS EQR *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity,* February 2023,[6] specifies that, in lieu of conducting a full on-site Information Systems Capabilities Assessment (ISCA), the EQRO may review an assessment of the MCO's IS conducted by another party. If an MCO is accredited by NCQA, the MCO will have received a full IS assessment as part of its annual HEDIS Compliance Audit by an NCQA HEDIS Compliance Audit licensed organization (LO). In this case, HSAG would request and review the MCO's NCQA HEDIS Record of Administration, Data Management, and Processes (Roadmap), FAR, and the data submission tool in lieu of conducting an on-site assessment.

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

### HEDIS Measure Validation

The MCOs that report HEDIS measures to NCQA must undergo an audit of their data conducted by an NCQA HEDIS Compliance Audit LO. For these HEDIS measures, HSAG reviews the rates submitted on the NCQA reporting tool (Interactive Data Submission System [IDSS]), which is audited prior to submission, and the FAR, which is completed by the LO and describes the process used to produce the

[6] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 29, 2025.

measure rates and any problems that the MCOs experienced in the HEDIS process. Included in the FAR are the measures deemed *Not Reportable* due to biases in the calculation process.

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

### Non-HEDIS Measure Validation

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

## *Description of Data Obtained*

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

## *How Data Were Aggregated and Analyzed*

In accordance with the MY 2023 NCQA HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5, the LOs evaluated compliance with NCQA's IS standards. NCQA's IS standards detail the minimum requirements of an MCO's IS, as well as criteria that must be met for any manual processes used to report HEDIS information. For each HEDIS measure, the MCO was evaluated on how its rate compared to the NCQA Quality Compass MY 2024 national 50th percentile Medicaid health maintenance organization (HMO) benchmark.

## How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of care and services that each MCO provided to members, HSAG evaluated the results for each performance measure and the MY 2024 performance levels based on comparison to the NCQA national 50th percentile benchmark percentile to identify strengths and opportunities for improvement and determine whether each strength and opportunity for improvement impacted one or more of the domains of quality, timeliness, or access. Additionally, for each opportunity for improvement, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the MCO's Medicaid members.

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

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

| Performance Measure | Quality | Timeliness | Access |
|---|---|---|---|
| *Colorectal Cancer Screening—ECDS* | ✓ | | |
| *Cervical Cancer Screening* | ✓ | | |
| *Follow-Up After Hospitalization for Mental Illness—Within 7 Days of Discharge—Total* and *Within 30 Days of Discharge—Total* | ✓ | ✓ | ✓ |
| *Follow-Up After Emergency Department Visit for Mental Illness—Within 7 Days of Discharge—Total* and *Within 30 Days of Discharge—Total* | ✓ | ✓ | ✓ |
| *Follow-Up After Emergency Department Visit for Substance Use—Within 7 Days of Discharge—Total* and *Within 30 Days of Discharge—Total* | ✓ | ✓ | ✓ |
| *Follow-Up After High-Intensity Care for SUD—Within 7 Days of Visit or Discharge—Total* and *Within 30 Days of Visit or Discharge—Total* | ✓ | ✓ | ✓ |
| *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status >9.0%* and *Glycemic Status <8.0%* | ✓ | | |
| *Controlling High Blood Pressure* | ✓ | | |
| *HIV Viral Load Suppression* | ✓ | | |
| *Low-Risk Cesarean Delivery (Cesarean Rate for Low-Risk First Birth Women)* | ✓ | | |
| *Child and Adolescent Well-Care Visits—3–11 Years*, *12–17 Years*, *18–21 Years*, and *Total* | ✓ | | ✓ |
| *Well-Child Visits in the First 30 Months of Life—First 15 Months* and *15 Months–30 Months* | ✓ | | ✓ |

| Performance Measure | Quality | Timeliness | Access |
|---|---|---|---|
| *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years*, *45–64 Years*, *65 Years and Older*, and *Total* | ✓ | | ✓ |
| *Plan All-Cause Readmissions—Observed Readmissions (Numerator/Denominator)*, *Expected Readmissions*, and *O/E Ratio (Observed Readmissions/Expected Readmissions)* | ✓ | | |
| *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* | ✓ | | |
| *Diabetes Monitoring for People With Diabetes and Schizophrenia* | ✓ | | |
| *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* | ✓ | | |
| *Metabolic Monitoring for Children and Adolescents on Antipsychotics—ECDS—Blood Glucose Testing—Total*, *Cholesterol Testing—Total*, and *Blood Glucose and Cholesterol Testing—Total* | ✓ | | |
| *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* | ✓ | ✓ | ✓ |
| *Lead Screening in Children* | ✓ | | |
| *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total* | ✓ | | |
| *Chlamydia Screening in Women—Total* | ✓ | | |
| *Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total* and *Statin Adherence 80%—Total* | ✓ | | |
| *Blood Pressure Control for Patients With Diabetes* | ✓ | | |
| *Eye Exam for Patients With Diabetes* | ✓ | | |
| *Pharmacotherapy for Opioid Use Disorder* | ✓ | | |
| *Initiation and Engagement of SUD Treatment—Initiation of SUD—Total* and *Engagement of SUD—Total* | ✓ | ✓ | ✓ |
| *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* | ✓ | | |
| *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* | ✓ | | |
| *Follow-Up Care for Children Prescribed ADHD Medication—ECDS—Initiation Phase* and *Continuation and Maintenance Phase* | ✓ | ✓ | ✓ |
| *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* | ✓ | | |
| *Appropriate Treatment for Children With URI* | ✓ | | |

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

# 4. Assessment of Compliance With Medicaid Managed Care Regulations

## Results

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

**Table 4-1—Summary of Scores for Each Standard**

| Standard # | Standard Name | Total Elements | Total Applicable Elements | Number of Elements | | | Total Compliance Score |
|---|---|---|---|---|---|---|---|
| | | | | *M* | *NM* | *NA* | |
| I | Enrollment and Disenrollment Requirements and Limitations | 12 | 9 | 9 | 0 | 3 | 100% |
| II | Member Rights and Confidentiality | 24 | 24 | 24 | 0 | 0 | 100% |
| III | Member Information | 19 | 18 | 12 | 6 | 1 | 67% |
| IV | Emergency and Poststabilization Services | 13 | 13 | 13 | 0 | 0 | 100% |
| V | Adequate Capacity and Availability of Services | 15 | 15 | 9 | 6 | 0 | 60% |
| VI | Coordination and Continuity of Care | 12 | 12 | 11 | 1 | 0 | 92% |
| VII | Coverage and Authorization of Services | 23 | 21 | 21 | 0 | 2 | 100% |
| VIII | Provider Selection | 19 | 19 | 16 | 3 | 0 | 84% |
| IX | Subcontractual Relationships and Delegation | 6 | 6 | 4 | 2 | 0 | 67% |
| X | Practice Guidelines | 6 | 6 | 6 | 0 | 0 | 100% |
| XI | Health Information Systems | 9 | 9 | 9 | 0 | 0 | 100% |
| XII | Quality Assessment and Performance Improvement | 13 | 11 | 11 | 0 | 2 | 100% |
| XIII | Grievance and Appeal Systems | 38 | 37 | 37 | 0 | 1 | 100% |
| XIV | Program Integrity | 18 | 18 | 17 | 1 | 0 | 94% |
| **Total Compliance Score** | | **227** | **218** | **199** | **19** | **9** | **91%** |

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

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

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

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

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

For LHCC, the following strengths were identified:

- LHCC achieved a 100 percent compliance score for Standard I—Enrollment and Disenrollment Requirements and Limitations, demonstrating nondiscriminatory enrollment and contractually compliant disenrollment processes under LDH oversight. **[Quality and Access]**
- LHCC 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]**
- LHCC achieved a 100 percent compliance score for Standard IV—Emergency and Poststabilization Services, demonstrating that it had adequate processes in place to ensure access to, coverage of, and payment for emergency and poststabilization care. **[Quality, Timeliness, and Access]**
- LHCC achieved a 100 percent compliance score for Standard VII—Coverage and Authorization of Services, demonstrating consistent and clinically driven authorization and ABD notification processes within required authorization time frames as well as compliance with coverage definitions and medical necessity and utilization management standards. **[Quality, Timeliness, and Access]**
- LHCC 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]**
- LHCC achieved a 100 percent compliance score for XI—Health Information Systems, demonstrating effective data collection, validation, reporting, encounter submission, and interoperability aligned with federal and State requirements. **[Quality and Access]**
- LHCC achieved a 100 percent compliance score for Standard XII—Quality Assessment and Performance Improvement, demonstrating a robust QAPI program with effective governance, performance measurement, and under- and overutilization monitoring; LDH-approved PIPs; and timely reporting to LDH. **[Quality]**
- LHCC achieved a 100 percent compliance score for Standard XIII—Grievance and Appeal Systems, demonstrating a grievance and appeal system that is timely, well-documented, and fully aligned with federal and State requirements. **[Quality, Timeliness, and Access]**

For LHCC, the following opportunities for improvement were identified:

- LHCC did not ensure that its website provided all required information to members and potential members in a manner and format that may be easily understood and is readily accessible. **[Quality]**
- LHCC did not ensure it makes a good faith effort to give written notice of termination of a contracted provider, within required time frames, to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider, and the notice to the member must be provided. **[Quality, Timeliness, and Access]**
- LHCC did not ensure its member handbook included language that informed members of the availability of assistance in the filing for grievances, the member's rights under State law to accept or refuse behavioral health treatment, and information regarding specialized behavioral health services (SBHS). **[Quality]**
- LHCC's paper and electronic provider directory were missing required components. **[Quality and Access]**
- LHCC did not have a provider directory available on its website in a machine-readable file and format. **[Quality and Access]**
- LHCC's website did not include language informing the member that information that is available in electronic form is available in paper form without charge upon request and that the MCE provides it upon request within five business days. **[Quality]**
- LHCC was not monitoring its provider network to ensure adequate access to all services covered under the contract for all members, including those with physical disabilities. **[Quality]**
- LHCC did not ensure that its network includes sufficient family planning providers to ensure timely access to covered services. **[Quality]**
- LHCC did not meet and require its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. **[Quality and Access]**
- LHCC did not monitor whether its network providers offer office hours at least equal to those offered by commercial insurance plans. **[Quality and Access]**
- LHCC did not ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities. **[Quality and Access]**
- LHCC did not ensure it offers an appropriate range of preventive, primary care, specialty services, and long-term services and supports (LTSS) that is adequate for the anticipated number of members for the service area as well as maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. **[Quality and Access]**
- LHCC's CMPE file review demonstrated noncompliance with timely completion of the initial health needs assessment. **[Quality and Timeliness]**
- LHCC did not verify a history of professional liability claims that resulted in settlement or judgment paid on behalf of the practitioner within 180 calendar days of the credentialing decision. **[Quality and Timeliness]**

- LHCC did not verify the State sanctions, restrictions on licensure, and limitations of scope of practice within 180 days of the credentialing decision and verify in all states where the practitioner provides and/or provided care to members within the most recent five-year period available. **[Quality and Timeliness]**
- LHCC did not include evidence for credentialing and recredentialing of current malpractice providers coverage obtained through verification. **[Quality]**
- LHCC did not ensure that all its 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]**
- LHCC's written delegation agreements did not comply with the federal or State language, which is exacting. **[Quality]**
- LHCC did not issue notice of payment suspension that comports with federal regulations and retains the suspension in accordance with federal requirements. **[Quality]**

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

- LHCC must ensure that its website provides all required information to members and potential members in a manner and format that may be easily understood and is readily accessible. **[Quality]**
- LHCC must ensure it makes a good faith effort to give written notice of termination of a contracted provider, within required time frames, to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider, and the notice to the member must be provided. **[Quality, Timeliness, and Access]**
- LHCC must ensure its member handbook includes language that informs members of the availability of assistance in the filing for grievances, the member's rights under State law to accept or refuse behavioral health treatment, and information regarding SBHS. **[Quality]**
- LHCC must include required components in its paper and electronic provider directory. **[Quality and Access]**
- LHCC must have a provider directory available on its website in a machine-readable file and format as specified by the Secretary. **[Quality]**
- LHCC must inform members on the website that information provided electronically is available in paper form without charge upon request and provide it upon request within five business days. **[Quality]**
- LHCC must monitor, through the collection and analysis of data, its provider network to ensure adequate access to all services covered under the contract for all members, including those with physical disabilities. **[Quality and Access]**
- LHCC must monitor, and ensure through data analysis, that its network includes sufficient family planning providers to ensure timely access to covered services. **[Quality]**
- LHCC must meet and require its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. **[Quality and Access]**

- LHCC must monitor whether its network providers offer office hours at least equal to those offered by commercial insurance plans. **[Quality and Access]**
- LHCC must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities. **[Quality and Access]**
- LHCC 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 as well as maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. **[Quality and Access]**
- LHCC 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]**
- LHCC 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]**
- LHCC must verify the State sanctions, restrictions on licensure, and limitations of scope of practice within 180 days of the credentialing decision and verify in all states where the practitioner provides and/or provided care to members within the most recent five-year period available. **[Quality and Timeliness]**
- LHCC must include evidence for credentialing and recredentialing of current malpractice providers coverage obtained through verification. **[Quality]**
- LHCC must ensure that all its 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]**
- LHCC's written delegation agreements must comply with the federal or State language, which is exacting. **[Quality]**
- LHCC must issue notice of payment suspension that comports with federal regulations and retains the suspension in accordance with federal requirements. **[Quality]**

# 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 for CY 2021, CY 2022, CY 2023, and CY 2024.

**Table 4-2—CR Standards**

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

| Standard | CFR | CY 2021 | | | CY 2022 | | | CY 2023* | CY 2024 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | MCO | PAHP | PIHP | MCO | PAHP | PIHP | MCEs | MCO | PAHP | PIHP |
| Authorization of Services | | | | | | | | | | | |
| Standard VIII—Provider Selection | §438.214 | ✓ | ✓ | ✓ | | | | - | ✓ | ✓ | ✓ |
| Standard IX—Subcontractual Relationships and Delegation | §438.230 | ✓ | | ✓ | | ✓ | | - | ✓ | ✓ | ✓ |
| Standard X—Practice Guidelines | §438.236 | ✓ | ✓ | ✓ | | | | - | ✓ | ✓ | ✓ |
| Standard XI—Health Information Systems | §438.242 | ✓ | ✓ | ✓ | | | | - | ✓ | ✓ | ✓ |
| Standard XII—Quality Assessment and Performance Improvement | §438.330 | ✓ | ✓ | ✓ | | | | - | ✓ | ✓ | ✓ |
| Standard XIII—Grievance and Appeal Systems | §438.228 | ✓ | ✓ | ✓ | | | | - | ✓ | ✓ | ✓ |
| Standard XIV—Program Integrity | §438.608 | ✓ | ✓ | ✓ | | | | - | ✓ | ✓ | ✓ |

[1] The CR standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard XIII—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).
* No CR was conducted for CY 2023 for the Louisiana MCEs.

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

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

## Technical Methods of Data Collection

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

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

### Pre-Virtual Review Activities

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

### Virtual Review Activities

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

[7] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 29, 2025.

### Post-Virtual Review Activities

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

### Data Aggregation and Analysis

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

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

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

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

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

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

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

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

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

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

## Description of Data Obtained

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

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

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

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

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

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

## *How Data Were Aggregated and Analyzed*

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

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

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

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

## How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of care provided by the MCOs, HSAG assigned each of the components reviewed for assessment of compliance with regulations to one or more of those domains of care. Each standard may involve assessment of more than one domain of care due to the combination of individual requirements within each standard. HSAG then analyzed, to draw conclusions and make recommendations, the individual requirements within each standard that assessed the quality, timeliness, or accessibility of care and services provided by the MCOs. Table 4-4 depicts assignment of the standards to the domains of care.

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

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

# Results

## *Provider Directory Validation*

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

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

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

| Specialty Provider Type | Response Rate | | Correct Address | | Provider at Location | | Confirmed Specialty | | Accepted MCO | | Accepted Louisiana Medicaid | | Confirmed New Patient Acceptance Status[1] | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Count | Rate (%) | Count | Rate (%) | Count | Rate (%) | Count | Rate (%) | Count | Rate (%) | Count | Rate (%) | Count | Rate (%) |
| Internal Medicine/ Family Medicine | 49 | 98.0% | 42 | 85.7% | 46 | 93.9% | 40 | 81.6% | 24 | 49.0% | 24 | 49.0% | 31 | 63.3% |
| Pediatrics | 42 | 84.0% | 34 | 81.0% | 36 | 85.7% | 33 | 78.6% | 31 | 73.8% | 29 | 69.0% | 31 | 73.8% |
| OB/GYNs | 45 | 90.0% | 40 | 88.9% | 40 | 88.9% | 35 | 77.8% | 35 | 77.8% | 33 | 73.3% | 33 | 73.3% |
| Specialists (any) | 43 | 86.0% | 33 | 76.7% | 39 | 90.7% | 34 | 79.1% | 28 | 65.1% | 27 | 62.8% | 34 | 79.1% |
| Behavioral Health (any) | 41 | 82.0% | 37 | 90.2% | 38 | 92.7% | 37 | 90.2% | 34 | 82.9% | 34 | 82.9% | 28 | 68.3% |
| **Total** | **220** | **88.0%** | **186** | **84.5%** | **199** | **90.5%** | **179** | **81.4%** | **152** | **69.1%** | **147** | **66.8%** | **157** | **71.4%** |

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

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

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

| Specialty Provider Type | Total | Compliant[1] | Weighted Compliance Score |
|---|---|---|---|
| Internal Medicine/Family Medicine | 50 | 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% |
| **Total** | **250** | **103** | **46.5%** |

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

## *Provider Access Survey*

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

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

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

| Specialty Provider Type | Response Rate | | Correct Address | | Offered Requested Services | | Accepted MCO | | Accepted Louisiana Medicaid | | Accepted New Patients | | Provider at Location | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Count | Rate (%) | Count | Rate (%) | Count | Rate (%) | Count | Rate (%) | Count | Rate (%) | Count | Rate (%) | Count | Rate (%) |
| Allergists | 20 | 66.7% | 19 | 95.0% | 17 | 85.0% | 17 | 85.0% | 17 | 85.0% | 17 | 85.0% | 10 | 50.0% |
| Dermatologists | 12 | 66.7% | 12 | 100% | 12 | 100% | 11 | 91.7% | 11 | 91.7% | 11 | 91.7% | 8 | 66.7% |
| Orthopedic Surgeons | 18 | 45.0% | 18 | 100% | 18 | 100% | 16 | 88.9% | 16 | 88.9% | 15 | 83.3% | 11 | 61.1% |
| **Total** | **50** | **56.8%** | **49** | **98.0%** | **47** | **94.0%** | **44** | **88.0%** | **44** | **88.0%** | **43** | **86.0%** | **29** | **58.0%** |

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

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

| Appointment Type | Wait Time (in Days) | Percentage of Appointments Meeting Compliance Standard |
|---|---|---|
| Allergists | 6 | 100% |
| Dermatologists | 335 | 0.0% |
| Orthopedic Surgeons | 11 | 100% |

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

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

| Specialty Provider Type | Total Providers Surveyed | Compliant[1] | Weighted Compliance Score[2] |
|---|---|---|---|
| Allergists | 30 | 10 | 38.9% |
| Dermatologists | 18 | 8 | 44.4% |
| Orthopedic Surgeons | 40 | 11 | 27.5% |
| **Total** | **88** | **29** | **34.8%** |

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

## *NAV Audit*

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

### Network Adequacy Indicator-Specific Validation Ratings

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

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

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

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

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

## Access Standards

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

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

| Provider Type | Urbanicity | Percentage of Members With Access |
|---|---|---|
| Adult PCP (Family/General Practice; Internal Medicine) | Urban | 99.4% |
| | Rural | 100% ↑ |
| Pediatrics (Family/General Practice; Internal Medicine) | Urban | 99.5% |
| | Rural | 100% ↑ |
| FQHCs | Urban | 87.1% |
| | Rural | 100% ↑ |
| RHCs | Urban | 56.2% |
| | Rural | 100% ↑ |
| Acute Inpatient Hospitals | Urban | 85.5% |
| | Rural | 99.8% |
| Laboratory | Urban | 99.8% |
| | Rural | 99.8% |
| Radiology | Urban | 99.7% |
| | Rural | 99.8% |

[8] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 29, 2025.

| Provider Type | Urbanicity | Percentage of Members With Access |
|---|---|---|
| Pharmacy | Urban | 97.5% |
| | Rural | 100% ↑ |
| Hemodialysis Centers | Urban | 99.5% |
| | Rural | 99.9% |
| OB/GYNs (access only for adult female members ages 21 and over) | Urban | 93.6% |
| | Rural | 94.4% |
| Allergy/Immunology | Urban | 90.7% |
| | Rural | 92.4% |
| Cardiology | Urban | 99.9% |
| | Rural | 100% ↑ |
| Dermatology | Urban | 99.9% |
| | Rural | 92.9% |
| Endocrinology and Metabolism (Adult) | Urban | 97.3% |
| | Rural | 99.9% |
| Endocrinology and Metabolism (Pediatric) | Urban | 91.5% |
| | Rural | 99.9% |
| Gastroenterology | Urban | 99.9% |
| | Rural | 100% ↑ |
| Hematology/Oncology | Urban | 99.9% |
| | Rural | 99.9% |
| Nephrology | Urban | 99.9% |
| | Rural | 99.1% |
| Neurology (Adult) | Urban | 99.9% |
| | Rural | 97.8% |
| Neurology (Pediatric) | Urban | 99.9% |
| | Rural | 97.7% |
| Ophthalmology | Urban | 99.9% |
| | Rural | 99.9% |
| Orthopedics (Adult) | Urban | 99.9% |
| | Rural | 100% ↑ |
| Orthopedics (Pediatric) | Urban | 99.9% |
| | Rural | 100% ↑ |
| Otorhinolaryngology/Otolaryngology | Urban | 99.9% |
| | Rural | 99.8% |
| Urology | Urban | 99.9% |
| | Rural | 99.9% |

| Provider Type | Urbanicity | Percentage of Members With Access |
|---|---|---|
| Psychiatrists | Urban | 93.4% |
| | Rural | 97.2% |
| Physicians and LMHPs who specialize in pregnancy-related and postpartum depression or related mental health disorders | Urban | 100% ↑ |
| | Rural | 96.9% |
| Physicians and LMHPs who specialize in pregnancy-related and postpartum SUD | Urban | 86.9% |
| | Rural | 80.9% |
| Behavioral Health Specialist (APRN-BH specialty, Licensed Psychologist, or LCSW) | Urban | 99.9% |
| | Rural | 100% ↑ |
| PRTFs (Level 3.7 WM) and Other Specialization (Pediatric Under Age 21) | All | 100% ↑ |
| American Society of Addiction Medicine (ASAM) Level 1 | Urban | 91.5% |
| | Rural | 97.0% |
| ASAM Level 2.1 | Urban | 89.9% |
| | Rural | 92.8% |
| ASAM Level 2 WM | Urban | 86.0% |
| | Rural | 70.8% |
| ASAM Level 3.1 (Adult over age 21) | Urban | 84.5% |
| | Rural | 39.5% |
| ASAM Level 3.1 (Pediatric under age 21) | All | 89.7% |
| ASAM Level 3.2 WM (Adult over age 21) | Urban | 78.2% |
| | Rural | 57.0% |
| ASAM Level 3.2 WM (Pediatric under age 21) | All | 73.0% |
| ASAM Level 3.3 (Adult over age 21) | Urban | 67.2% |
| | Rural | 40.0% |
| ASAM Level 3.5 (Adult over age 21) | Urban | 94.6% |
| | Rural | 64.1% |
| ASAM Level 3.5 (Pediatric under age 21) | All | 99.4% |
| ASAM Level 3.7 (Adult over age 21) | Urban | 91.3% |
| | Rural | 92.8% |
| ASAM Level 3.7 WM (Adult over age 21) | Urban | 99.9% |
| | Rural | 96.3% |
| Inpatient Psychiatric Hospital (Free Standing Psychiatric Hospital; Distinct Part Psychiatric Unit) | Urban | 100% ↑ |
| | Rural | 100% ↑ |

| Provider Type | Urbanicity | Percentage of Members With Access |
|---|---|---|
| Mental Health Rehabilitation (MHR) Agency (Community Psychiatric Support and Treatment; Psychosocial Rehabilitation; and Crisis Intervention—MHR Agency [Legacy MHR], Behavioral Health Rehab Provider Agency [Non-Legacy MHR]; Mental Health Clinics) | Urban | 90.9% |
| | Rural | 96.7% |

## Provider-to-Member Ratios

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

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

| Provider Type | Indicator | Compliant |
|---|---|---|
| **Statewide Combined Ratio** | | |
| Combined Adult PCP Full-Time Equivalents (FTEs) (1:1,000 adult members) | 1.33% | Yes |
| Combined Pediatrics (1:1,000 child members) | 1.50% | Yes |

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

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

| Specialty Provider Type | Indicator | Statewide Ratio | Compliant |
|---|---|---|---|
| OB/GYNs | 1:10,000 | 0.13% | Yes |
| Allergy/Immunology | 1:100,000 | 0.01% | Yes |
| Cardiology | 1:20,000 | 0.09% | Yes |
| Dermatology | 1:40,000 | 0.03% | Yes |
| Endocrinology and Metabolism | 1:25,000 | 0.02% | Yes |
| Gastroenterology | 1:30,000 | 0.06% | Yes |
| Hematology/Oncology | 1:80,000 | 0.05% | Yes |
| Nephrology | 1:50,000 | 0.04% | Yes |
| Neurology | 1:35,000 | 0.07% | Yes |

| Specialty Provider Type | Indicator | Statewide Ratio | Compliant |
|---|---|---|---|
| Ophthalmology | 1:20,000 | 0.04% | Yes |
| Orthopedics | 1:15,000 | 0.07% | Yes |
| Otorhinolaryngology/Otolaryngology | 1:30,000 | 0.05% | Yes |
| Urology | 1:30,000 | 0.03% | Yes |

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

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

| Type of Visit | Access/Timeliness Standard | Performance Goal | Compliance Rate |
|---|---|---|---|
| Emergency Care | 24 hours, 7 days/week within 1 hour of request | 90% | 87% |
| Urgent Non-Emergency Behavioral Health Care | 48 hours (2 calendar days) | 90% | 87% |
| Non-Urgent Routine Behavioral Health Care | 14 calendar days | 70% | 87% |

## MCO Strengths, Opportunities for Improvement, and Recommendations

For LHCC, the following strengths were identified:

- Overall, 98.0 percent of respondents in the provider access survey confirmed the sampled address was correct. **[Quality and Access]**
- Overall, 94.0 percent of respondents in the provider access survey confirmed the location offered the requested services. **[Quality and Access]**
- Overall, 90.5 percent of the sampled locations in the PDV confirmed affiliation with the sampled provider. **[Quality and Access]**
- LHCC retained vendors H1 and Veda to provide additional oversight ensuring accuracy of provider directory data which contributed to ensuring accuracy of overall provider data. **[Quality]**
- LHCC worked proactively with providers across the state to increase access to care in healthcare provider shortage areas by conducting proactive outreach to increase behavioral health services and including over half of LHCC members in a value-based payment model. LHCC held virtual townhalls with every ASAM provider in the state and frequently contacted these providers to increase their level of service for members. **[Quality and Access]**

For LHCC, the following opportunities for improvement were identified:

- Acceptance of LHCC was inaccurate with 69.1 percent of providers in the PDV and 88.0 percent of locations in the provider access survey accepting LHCC. Additionally, 66.8 percent of providers in the PDV and 88.0 percent of locations in the provider access survey accepted Louisiana Medicaid. **[Quality and Access]**
- Overall, only 81.4 percent of providers in the PDV confirmed the specialty was accurate. Additionally, 85.0 percent of allergist locations in the provider access survey confirmed the specialty was accurate. **[Quality and Access]**
- Overall, acceptance of new patients was relatively low with 71.4 percent of providers in the PDV and 86.0 percent of locations in the provider access survey accepting new patients. **[Quality and Access]**
- Provider affiliation was relatively low with 58.0 percent of provider access survey locations confirming the sampled provider was at the location. **[Quality and Access]**
- Of the limited number of cases that offered an appointment, none of the dermatologist cases were within the wait time compliance standards. **[Timeliness and Access]**
- Compliance scores varied by survey type with overall compliance scores of 46.5 percent for the PDV and 34.8 percent for the provider access survey. **[Quality and Access]**
- Compliance scores also varied by provider type with internal medicine/family medicine having the lowest compliance score at 31.3 percent and OB/GYNs having the highest compliance score at 54.7 percent for the PDV. For the provider access survey, orthopedic surgeons exhibited the lowest compliance score at 27.5 percent, and dermatologists exhibited the highest compliance score at 44.4 percent. **[Quality and Access]**
- LHCC initially did not submit separate rural and urban maps for several specialties as required by LDH. **[Quality]**

For LHCC, the following recommendations were identified:

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

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

- LHCC should strengthen its review process before submitting network adequacy reporting to LDH to ensure that all applicable requirements have been followed. **[Quality]**

# Methodology

## Objectives

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

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

The objectives of the validation of network adequacy are to:

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

## Technical Methods of Data Collection

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

### Provider Directory Validation

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

### Provider Access Survey

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

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

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

### NAV Audit

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

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

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

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

## Description of Data Obtained

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

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

## How Data Were Aggregated and Analyzed

### Provider Directory Validation

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

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

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

HSAG used the following validation responses to assess each indicator:

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

Using the results of the PDV, HSAG calculated a compliance score for each MCO. The criteria in Table 5-11 were used to calculate the weight of each noncompliance survey outcome.

**Table 5-11—Noncompliance Reasons and Weighting**

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

**Table 5-12—Weighted Noncompliance Criteria**

| Weighted Noncompliance Scores | |
|---|---|
| Numerator | The numerator is the sum of all provider noncompliance scores for the MCO. Each provider record received a noncompliance score based upon the reasons for noncompliance in Table 5-11. If multiple noncompliance criteria were met, the noncompliance criterion with the largest weight was used. |
| Denominator | The denominator is the number of provider records multiplied by 3. |

Weighted compliance score equation:

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

Compliance: The MCOs were compliant if their weighted compliance score was ≥ 75.

## Provider Access Survey

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

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

Using the results of the survey, HSAG calculated a compliance score for each MCO. The criteria in Table 5-13 were used to calculate the weight of each noncompliance survey outcome.

**Table 5-13—Noncompliance Reasons and Weighting**

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

**Table 5-14—Weighted Noncompliance Criteria**

| Weighted Noncompliance Scores | |
|---|---|
| Numerator | The numerator is the sum of all provider noncompliance scores for the MCO. Each provider record received a noncompliance score based upon the reasons for noncompliance in Table 5-13. If multiple noncompliance criteria were met, the noncompliance criterion with the largest weight was used. |
| Denominator | The denominator is the number of provider records multiplied by 3. |

Weighted compliance score equation:

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

Compliance: The MCOs were compliant if their weighted compliance score was ≥ 75 percent.

### NAV Audit

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

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

## *How Conclusions Were Drawn*

### Provider Directory Validation/Provider Access Survey

HSAG determined that results of network adequacy activities could provide information about MCO performance related to the quality, timeliness, and access domains of care. HSAG used analysis of the network data obtained to draw conclusions about Healthy Louisiana member access to particular provider networks (e.g., primary, specialty, or behavioral health care) in specified geographic regions. The data also allowed HSAG to draw conclusions regarding the quality of the MCOs' ability to track and monitor their respective provider networks.

To draw conclusions about the quality, timeliness, and accessibility of care provided by the Medicaid MCOs, HSAG assigned each of the components reviewed for NAV activities to one or more of three domains of care. This assignment to domains of care is depicted in Table 5-15.

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

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

### NAV Audit

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

**Table 5-16—Validation Score Calculation**

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

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

**Table 5-17—Indicator-Level Validation Rating Categories**

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

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

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

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

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

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

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

## Results

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

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

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

**Table 6-1—EDV Results for LHCC**

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

| Analysis | Key Findings |
|---|---|
| Encounter Data Quality Monitoring | • LHCC stated that it had subcontractors for dental, NEMT, pharmacy, and vision encounters. For the encounters collected by these subcontractors, LHCC noted that it stored dental encounters; reviewed encounter data before submission to LDH for dental, NEMT, and vision encounters; did not modify the data before submission for NEMT, pharmacy, or vision encounters; and reviewed the encounters after submission to LDH for all encounter types.<br>• LHCC and/or its subcontractors noted that they performed claim volume, completeness and accuracy, timeliness, and reconciliation with financial reports checks on these encounters collected by subcontractors, except the claim volume and timeliness checks on NEMT and pharmacy, and completeness and accuracy checks on pharmacy encounters.<br>• For encounters collected by LHCC, LHCC noted that it performed completeness and accuracy, and reconciliation with financial reports checks.<br>• Based on LHCC's responses to the questionnaire, the percentage of encounters that were initially rejected and not yet accepted by LDH varied from 0.8 percent (pharmacy encounters) to 6.4 percent (non-subcontractor professional encounters). |
| **Administrative Profile** | |
| Encounter Data Completeness | • LHCC 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.<br>• LHCC had a rate of duplicate encounters of less than 1.0 percent for professional, institutional, and pharmacy encounter types. For dental encounters, LHCC had a relatively high rate (5.0 percent) of duplicate encounters. |
| Encounter Data Timeliness | • Within 60 days, LHCC submitted 91.4 percent of professional, 82.3 percent of institutional, 89.7 percent of dental, and 99.4 percent of pharmacy encounters to LDH after the payment date. |
| Field-Level Completeness and Accuracy | • All key data elements in LHCC's encounter data had a relatively high or reasonable rate of population (i.e., percent present) except for the Tooth Number, Tooth Surface, and Oral Cavity Code fields in LHCC's dental encounters.<br>• LHCC had all key data elements populated with at least 95.0 percent of valid values in dental encounters, while there was at least one data element with an accuracy rate below 95.0 percent for the other three encounter types. Refer to the opportunities for improvement section below for the list of data elements needing LHCC's attention. |

| Analysis | Key Findings |
|---|---|
| Encounter Referential Integrity | • No major concerns were noted for LHCC when evaluating the integrity between medical/dental/pharmacy encounters and member enrollment data, or between medical/dental encounters and pharmacy encounters.<br>• Of all identified provider NPIs in LHCC's submitted medical/dental and pharmacy encounters, only 91.2 percent and 79.5 percent were identified in the provider data, respectively. |
| Encounter Data Logic | • LHCC had 64.8 percent of members with both medical/dental and pharmacy encounters throughout the measurement year.<br>• LHCC had 75.2 percent of members who were continuously enrolled in the measurement year. |

## MCO Strengths, Opportunities for Improvement, and Recommendations

For LHCC, the following strengths were identified:

- LHCC and/or its dental and vision subcontractors noted that they performed claim volume, completeness and accuracy, timeliness, and reconciliation with financial reports checks on the corresponding encounters. **[Quality and Timeliness]**
- LHCC reported less than 1.0 percent of pharmacy encounters as initially rejected and not yet accepted. **[Quality]**
- LHCC had low duplicate rates for professional encounters (0.3 percent), institutional encounters (<0.1 percent), and pharmacy encounters (<0.1 percent). **[Quality]**
- LHCC submitted 99.4 percent of pharmacy encounters within 60 days from the payment date. **[Timeliness]**
- For dental encounters, LHCC had all key data elements populated with at least 95.0 percent of valid values. **[Quality]**

For LHCC, the following opportunities for improvement were identified:

- **Process and Quality Checks for Subcontractor Data**:
  - NEMT: Neither LHCC nor its subcontractor performed claim volume or timeliness checks on the NEMT encounters. **[Quality and Timeliness]**
  - Pharmacy: LHCC noted that it did not store its pharmacy subcontractor data nor review the data prior to submission to LDH. In addition, neither LHCC nor its subcontractor performed claim volume, completeness and accuracy, or timeliness checks on the pharmacy encounters. **[Quality and Timeliness]**
- LHCC did not report claim volume and timeliness checks on encounters collected by the MCE (i.e., non-subcontractor data). **[Quality and Timeliness]**

- LHCC had 6.4 percent of non-subcontractor professional encounters and 5.6 percent of institutional encounters classified as encounters initially rejected and not yet accepted by LDH. **[Quality]**
- LHCC had the second highest duplicate encounter rate (5.0 percent) among the MCEs with dental encounters. **[Quality]**
- LHCC only submitted 82.3 percent of institutional encounters and 89.7 percent of dental encounters within 60 days from the payment date. **[Timeliness]**
- The LDH-submitted data did not contain any values for the Tooth Number, Tooth Surface, and Oral Cavity Code fields for LHCC's dental encounters. **[Quality]**
- LHCC had the following data elements with less than 95.0 percent of valid values: **[Quality]**
  - Professional Encounters: *Referring Provider NPI* (94.2 percent)
  - Institutional: *Attending Provider Taxonomy Code* (92.1 percent)
  - Pharmacy: *Prescribing Provider NPI* (93.9 percent)
- For referential integrity, LHCC had a low percentage of providers in the pharmacy encounter file who were also in the provider file, at approximately 79.5 percent. **[Quality]**

For LHCC, the following recommendations were identified:

- LHCC should develop a comprehensive suite of encounter data quality monitoring reports to assess the accuracy, completeness, and timeliness of encounter data received from its NEMT and pharmacy subcontractors. **[Quality and Timeliness]**
- LHCC should build additional encounter data quality monitoring reports to evaluate encounter data completeness and timeliness for encounters collected by LHCC (i.e., non-subcontractor data). **[Quality and Timeliness]**
- LHCC should build a process with LDH to ensure that rejected non-subcontractor professional and institutional encounters will be submitted to LDH with correct information. **[Quality]**
- LHCC should review its system for identifying and handling duplicates for dental encounters. Identification and appropriate handling of duplicate encounters is crucial for accurate financial and actuarial calculations. **[Quality]**
- LHCC should monitor its encounter data submission to LDH to ensure institutional and dental encounters are submitted to LDH in a timely manner after payment. **[Timeliness]**
- For dental encounters, LHCC should work with LDH to decide whether LHCC should submit values (if any) for the Tooth Number, Tooth Surface, and Oral Cavity Code fields to LDH. **[Quality]**
- LHCC should investigate the root causes for data elements with less than 95.0 percent of valid values (i.e., those listed in the opportunities for improvement section) to improve accuracy. **[Quality]**
- LHCC should work with LDH to ensure both entities have an accurate and complete database of contracted providers for pharmacy encounters. **[Quality]**

# Methodology

## Objectives

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

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

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

## Technical Methods of Data Collection

### Information Systems Review

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

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

[9] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 29, 2025.

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

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

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

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

### Administrative Profile

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

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

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

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

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

### Metrics for Encounter Data Completeness

HSAG evaluated encounter data completeness through the following metrics:

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

### Metrics for Encounter Data Timeliness

HSAG evaluated encounter data timeliness through the following metrics:

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

## Metrics for Field-Level Completeness and Accuracy

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

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

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

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

| Key Data Elements | 837P Encounters | 837I Encounters | 837D Encounters | NCPDP Encounters | Criteria for Validity |
|---|---|---|---|---|---|
| Member ID[H] | ✓ | ✓ | ✓ | ✓ | • In member file<br>• Enrolled in a specific MCE on the date of service |
| Detail Service From Date[D] | ✓ | ✓ | ✓ | | • Detail Service From Date ≤ Detail Service To Date<br>• Detail Service From Date ≤ Paid Date |
| Detail Service To Date[D] | ✓ | ✓ | ✓ | | • Detail Service To Date ≥ Detail Service From Date<br>• 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<br>• Meets Luhn formula requirements |
| Rendering Provider NPI[H] | ✓ | | ✓ | | • In provider data when service occurred<br>• Meets Luhn check digit formula requirements |
| Attending Provider NPI[H] | | ✓ | | | • In provider data when service occurred<br>• Meets Luhn check digit formula requirements |
| Referring Provider NPI[H] | ✓ | ✓ | ✓ | | • In provider data when service occurred<br>• Meets Luhn check digit formula requirements |
| Prescribing Provider NPI | | | | ✓ | • In provider data when service occurred<br>• Meets Luhn check digit formula requirements |
| Rendering Provider Taxonomy Code[H] | ✓ | | ✓ | | • In standard taxonomy code set<br>• Matches the value in provider data |
| Attending Provider Taxonomy Code[H] | | ✓ | | | • In standard taxonomy code set<br>• Matches the value in provider data |

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

[10] Healthy Louisiana. Medicaid Managed Care Entities System Companion Guide, Version 1, June 18, 2025. Available at: https://ldh.la.gov/assets/medicaid/MCE_System_Companion_Guide/HLA_MCE_SCG_v.1.pdf. Accessed on: Dec 4, 2025.

| Key Data Elements | 837P Encounters | 837I Encounters | 837D Encounters | NCPDP Encounters | Criteria for Validity |
|---|---|---|---|---|---|
| Revenue Codes[D] | | ✓ | | | In national standard revenue code sets for the correct code year |
| Type of Bill Codes[H] | | ✓ | | | In national standard type of code set |
| 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<br>• 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<br>• 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<br>• 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<br>• 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<br>• Direction 2: Percentage of Providers in the Provider File Who Were Also in the Pharmacy Encounter File |

### Metrics for Encounter Data Logic

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

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

## *Description of Data Obtained*

### Information Systems Review

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

### Administrative Profile

Data obtained from LDH included:

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

## *How Data Were Aggregated and Analyzed*

### Information Systems Review

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

### Administrative Profile

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

## *How Conclusions Were Drawn*

### Information Systems Review

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

### Administrative Profile

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

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

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

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

## Results

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

**Table 7-1—Adult Achievement Scores**

| Measure | 2023 | 2024 | 2025 |
|---|---|---|---|
| *Rating of Health Plan* | 77.08% | 78.67% | 78.24% |
| *Rating of All Health Care* | 71.43% | 80.65% | 79.88% |
| *Rating of Personal Doctor* | 83.25% | 89.33% | 87.76% |
| *Rating of Specialist Seen Most Often* | NA | NA | 79.81% |
| *Getting Needed Care* | 75.06% | 84.25% | 86.15% |
| *Getting Care Quickly* | 85.07% | 83.35% | 81.38% |
| *How Well Doctors Communicate* | 92.80% | 93.78% | 95.25% |
| *Customer Service* | NA | NA | NA |

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

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

**Table 7-2—General Child Achievement Scores**

| Measure | 2023 | 2024 | 2025 |
|---|---|---|---|
| *Rating of Health Plan* | 86.26% | 90.40% | 84.36% |
| *Rating of All Health Care* | 87.69% | 89.26% | 88.34% |
| *Rating of Personal Doctor* | 89.38% | 91.08% | 90.05% |
| *Rating of Specialist Seen Most Often* | NA | NA | NA |
| *Getting Needed Care* | NA | NA | 90.79% ↑ |
| *Getting Care Quickly* | NA | NA | 90.77% ↑ |
| *How Well Doctors Communicate* | 95.21% | 93.18% | 95.49% |
| *Customer Service* | NA | NA | NA |

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

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

## MCO Strengths, Opportunities for Improvement, and Recommendations

For LHCC, the following strengths were identified:

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

For LHCC, the following opportunity for improvement was identified:

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

For LHCC, the following recommendation was identified:

- HSAG recommends that LHCC 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

The MCOs accomplished the technical method of data collection by administering the CAHPS 5.1H Adult Medicaid Health Plan Survey to the adult Medicaid population, and the CAHPS 5.1H Child Medicaid Health Plan Survey (with the Children with Chronic Conditions [CCC] measurement set) to the child Medicaid population. The MCOs employed various methods of data collection used for the CAHPS surveys, such as mixed-mode (i.e., mailed surveys followed by telephone interviews of nonrespondents) and mixed-mode and Internet protocol methodology (i.e., mailed surveys with an Internet link included on the cover letter followed by telephone interviews of nonrespondents). In addition, some MCOs had an option for members to complete the survey in Spanish and Chinese. Adult members and parents/caretakers of child members completed the surveys from February through May 2025, following NCQA's data collection protocol.

The CAHPS 5.1H Medicaid Health Plan Surveys included a set of standardized items (39 items for the CAHPS 5.1H Adult Medicaid Health Plan Survey and 76 items for the CAHPS 5.1H Child Medicaid Health Plan Survey with CCC measurement set) that assessed members' experiences with care. The survey categorized questions into eight measures of experience. These measures included four global ratings and four composite measures.[11] The global ratings reflected patients' overall experiences with their personal doctor, specialist, MCO, and all healthcare. The composite measures were derived from sets of questions to address different aspects of care (e.g., *Getting Needed Care* and *How Well Doctors Communicate*).

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

[11] For this report, the 2025 Child Medicaid CAHPS results presented are based on the CAHPS survey results of the general child population only (i.e., results for children selected as part of the general child CAHPS sample). Therefore, results for the CAHPS survey measures evaluated through the CCC measurement set of questions (i.e., five CCC composite scores and items) and CCC population are not presented in this report.

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

## Description of Data Obtained

The CAHPS survey asks adult members or parents/caretakers of child members to report on and to evaluate their/their child's experiences with healthcare. The survey covers topics important to members, such as the communication skills of providers and the accessibility of services. The MCOs contracted with a CAHPS vendor to administer the survey to adult members and parents/caretakers of child members. The CAHPS survey asks about members' experiences with their MCO during the last six months of the measurement period (i.e., July through December 2024).

The CAHPS survey response rate is the total number of completed surveys divided by all eligible members of the sample. A survey received a disposition code of "completed" if at least three of the designated five questions were completed.[13] Eligible members included the entire sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, did not meet the eligible population criteria, had a language barrier, or were mentally or physically incapacitated (adult Medicaid only). The survey also identified ineligible members during the process. The survey vendor recorded this information and provided it to HSAG in the data received.

## How Data Were Aggregated and Analyzed

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

Additionally, HSAG compared MCO scores to the NCQA national averages to determine if there were any statistically significant differences. An MCO that performed statistically significantly higher than the 2025 NCQA national average was denoted with a black upward arrow (↑).[14] Conversely, an MCO that performed statistically significantly lower than the 2025 NCQA national average was denoted with

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

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

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

a black downward arrow (↓). An MCO that did not perform statistically significantly higher or lower than the 2025 NCQA national average was not denoted with an arrow.

## How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of care and services that each MCO provided to members, HSAG compared each MCO's 2024 survey results to the 2025 NCQA national averages to determine if there were any statistically significant differences. HSAG drew conclusions concerning quality of care, timeliness of care, and/or access to care by evaluating the questions included in each of the global ratings and composite measures presented in this report and relating the questions to the definitions of the three domains. This assignment to the domains is depicted in Table 7-3.

**Table 7-3—Assignment of CAHPS Survey Measure Activities to the Quality, Timeliness, and Access Domains**

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

# 8. Behavioral Health Member Satisfaction Survey

## Results

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

**Table 8-1—Adult Achievement Scores for LHCC**

| Measure | 2023 | 2024 | 2025 | Healthy Louisiana SWA |
|---|---|---|---|---|
| *Rating of Health Plan* | 55.65% | 60.00% | 51.15% | 57.88% |
| *How Well People Communicate* | 91.35% | 90.43% | 90.04% | 91.16% |
| *Cultural Competency* | 66.67%+ | 83.33%+ | 73.33%+ | 86.01%+ |
| *Helped by Counseling or Treatment* | 68.55% | 71.81% | 64.93% | 70.38% |
| *Treatment or Counseling Convenience* | 86.29% | 87.25% | 85.82% | 88.13% |
| *Getting Needed Treatment* | 81.97% | 83.22% | 81.06% | 81.75% |
| *Help Finding Counseling or Treatment* | 37.50%+ | 57.14%+ | 53.33%+ | 50.82% |
| *Customer Service* | 64.29%+ | 72.41%+ | 57.69%+ | 70.81% |
| *Helped by Crisis Response Services* | 85.71%+ | 69.23%+ | 63.33%+ | 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 LHCC and the Healthy Louisiana SWA.

**Table 8-2—Child Achievement Scores for LHCC**

| Measure | 2023 | 2024 | 2025 | Healthy Louisiana SWA |
|---|---|---|---|---|
| *Rating of Health Plan* | 70.37%+ | 62.07%+ | 56.60%↓ | 63.63% |
| *How Well People Communicate* | 96.29%+ | 94.94%+ | 90.36% | 91.03% |
| *Cultural Competency* | 100.00%+ | 100.00%+ | 88.89%+ | 92.57%+ |
| *Helped by Counseling or Treatment* | 68.52%+ | 50.85%+ | 60.00% | 61.01% |
| *Treatment or Counseling Convenience* | 92.45%+ | 91.53%+ | 91.59% | 88.86% |
| *Getting Needed Treatment* | 84.91%+ | 74.58%+ | 76.42% | 78.93% |
| *Help Finding Counseling or Treatment* | 66.67%+ | 50.00%+ | 46.67%+ | 38.57%+ |
| *Customer Service* | 60.00%+ | 63.64%+ | 81.82%+ | 71.71%+ |
| *Getting Professional Help* | 90.57%+ | 86.44%+ | 86.67% | 87.75% |
| *Help to Manage Condition* | 94.23%+ | 93.10%+ | 84.11% | 83.38% |

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

↓ *Indicates the 2025 score is statistically significantly lower than the 2025 Healthy Louisiana SWA.*

## MCO Strengths, Opportunities for Improvement, and Recommendations

For LHCC, the following strength was identified:

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

For LHCC, the following opportunities for improvement were identified:

- For the adult population, LHCC's 2025 achievement scores were not statistically significantly lower than the 2024 achievement scores or Healthy Louisiana SWA for any measure; therefore, no substantial opportunities for improvement were identified. **[Quality, Timeliness, Access]**
- For the child population, LHCC's 2025 achievement score for *Rating of Health Plan* was statistically significantly lower than the 2025 Healthy Louisiana SWA. **[Quality]**

For LHCC, the following recommendation was identified:

- HSAG recommends that LHCC focus on improving members' overall experiences with their health plan by performing a root cause analysis, which could determine if there are any outliers within the data so that LHCC can identify the primary areas of focus and develop appropriate strategies to improve the performance. LHCC could include CAHPS results to providers and send reminders about the importance of handling challenging patient encounters. Additionally, LHCC should emphasize patient-centered communication for the MCO members. **[Quality]**

# Methodology

## Objectives

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

## Technical Methods of Data Collection

To conduct the activity, HSAG, with support from LDH, developed and administered a custom Behavioral Health Member Satisfaction Survey to the Healthy Louisiana MCO members. The survey was administered to adult members and parents/caretakers of child members identified as having three or more specified outpatient behavioral health encounters during the measurement period. All adult members and parents/caretakers of sampled child members completed the survey from June to August 2025.

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

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

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

## Description of Data Obtained

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

## How Data Were Aggregated and Analyzed

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

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

## How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of care and services provided by the MCOs, HSAG assigned the measures evaluated in the Behavioral Health Member Satisfaction Survey to one or more of these three domains. This assignment to domains is shown in Table 8-3.

**Table 8-3—Assignment of Behavioral Health Member Satisfaction Survey Measures to the Quality, Timeliness, and Access Domains**

| Behavioral Health Member Satisfaction Survey Measure | Quality | Timeliness | Access |
|---|---|---|---|
| *Rating of Health Plan* | ✓ | | |
| *How Well People Communicate* | ✓ | | |
| *Cultural Competency* | ✓ | | |

| Behavioral Health Member Satisfaction Survey Measure | Quality | Timeliness | Access |
|---|---|---|---|
| *Helped by Counseling or Treatment* | ✓ | | |
| *Treatment or Counseling Convenience* | | | ✓ |
| *Getting Counseling or Treatment Quickly* | ✓ | ✓ | |
| *Getting Needed Treatment* | ✓ | | ✓ |
| *Barriers to Counseling or Treatment* | ✓ | | ✓ |
| *Help Finding Counseling or Treatment* | ✓ | | ✓ |
| *Customer Service* | ✓ | | |
| *Crisis Response Services Used* | | | ✓ |
| *Receipt of Crisis Response Services* | | | ✓ |
| *Helped by Crisis Response Services* | ✓ | | |
| *Getting Professional Help* | ✓ | | ✓ |
| *Help to Manage Condition* | ✓ | | |

# 9. Case Management Performance Evaluation

## Results

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

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

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

## MCO Strengths, Opportunities for Improvement, and Recommendations

For LHCC, the following strength was identified:

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

For LHCC, the following opportunity for improvement was identified:

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

For LHCC, the following recommendation was identified:

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

# 10. Quality Rating System

## Results

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

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

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

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

LHCC earned an Overall Rating of 4.0 stars, with 4.5 stars for the Patient Experience composite, 4.0 stars for the Prevention and Equity composite, and 3.5 stars for the Treatment composite.

## MCO Strengths, Opportunities for Improvement, and Recommendations

For LHCC, the following strengths were identified:

- For the Patient Experience composite, LHCC earned 4.5 stars for the Getting Care, Satisfaction with Plan Physicians, and Satisfaction with Plan and Plan Services subcomposites. These subcomposites are based on LHCC member responses to CAHPS survey questions, demonstrating LHCC members are satisfied with their health plan and the services it provides, providers, and they get the care they need. **[Quality and Access]**
- For the Prevention and Equity composite, LHCC earned 5.0 stars for the Equity subcomposite, demonstrating strength for LHCC related to collecting language preferences and race/ethnicity information from their members. LHCC also earned 4.5 stars for the Cancer Screening subcomposite, demonstrating strength for LHCC related to providing cervical and colorectal cancer screenings. LHCC also earned 4.0 stars for the Children and Adolescent Well-Care and Other Preventive Services subcomposites, demonstrating strength for LHCC related to documenting BMI percentiles in children and providing chlamydia screenings for young women. **[Quality and Access]**
- For the Treatment composite, LHCC earned 4.0 stars for the Heart Disease and Behavioral Health—Medication Adherence subcomposites, demonstrating strength for LHCC related to ensuring that members with hypertension control their blood pressure and that members with cardiovascular disease remain on their statin medications and ensuring members with behavioral health issues stay on prescribed medications. **[Quality, Timeliness, and Access]**

For LHCC, the following opportunity for improvement was identified:

- For the Treatment composite, LHCC earned 2.5 stars for the Respiratory and Behavioral Health—Care Coordination subcomposites, demonstrating opportunities for improvement for LHCC related to antibiotic use for bronchitis/bronchiolitis and ensuring members receive timely follow up after hospitalizations and ED visits for behavioral health conditions. **[Quality, Timeliness, and Access]**

For LHCC, the following recommendation was identified:

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

# Methodology

## Objectives

HSAG was tasked with developing a QRS to evaluate the performance of the six Healthy Louisiana Medicaid MCOs (i.e., ABH, ACLA, HBL, HUM, LHCC, and UHC) relative to national benchmarks and assign ratings to each MCO in key areas. The 2025 Health Plan Report Card is targeted toward a consumer audience; therefore, it is user friendly, easy to read, and addresses areas of interest for consumers.

## Technical Methods of Data Collection

HSAG received MY 2024 CAHPS member-level data files and HEDIS IDSS data files from LDH and the six MCOs. The *HEDIS MY 2024 Specifications for Survey Measures, Volume 3* was used to collect and report on the CAHPS measures. The *HEDIS MY 2024 Technical Specifications for Health Plans, Volume 2* was used to collect and report on the HEDIS measures.

## Description of Data Obtained

HSAG received the final, auditor-locked HEDIS IDSS data files from each of the MCOs, as well as the CAHPS member-level data files and summary reports. HSAG also downloaded the 2024 (MY 2023) Quality Compass national Medicaid all lines of business (ALOB) benchmarks for this analysis.[15]

## How Data Were Aggregated and Analyzed

Using the HEDIS and CAHPS measure results for each MCO, HSAG calculated MCO ratings in alignment with NCQA's 2025 Health Plan Ratings Methodology, where possible, for the following composites and subcomposites:[16,17]

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

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

[16] NCQA. 2025 Health Plan Ratings Required HEDIS, CAHPs, and HOS Measures. Available at: https://wpcdn.ncqa.org/www-prod/2025-HPR-List-of-Required-Performance-Measures_April-2025-Update.pdf. Accessed on: Dec 29, 2025.

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

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

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

**Table 10-2—Measure Rate Scoring Descriptions**

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

HSAG then multiplied the scores for each measure by the weights that align with NCQA's 2024 Health Plan Ratings. For each composite and subcomposite, HSAG calculated scores using the following equation:

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

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

For the Overall Rating and each composite/subcomposite rating, HSAG aligned with NCQA's rounding rules and awarded scores as outlined in Table 10-3.

**Table 10-3—Scoring Rounding Rules**

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

## How Conclusions Were Drawn

For the 2025 Health Plan Report Card, HSAG displayed star ratings based on the final scores for each rating. Stars were partially shaded if the MCO received a half rating (e.g., a score of 3.5 was displayed as 3.5 stars).

# 11. MCO Strengths, Opportunities for Improvement, and Recommendations

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

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

| Overall MCO Strengths | |
|---|---|
| **PIP** | • For all four PIPs assessed for achieving significant improvement, some of LHCC's reported performance indicator results demonstrated statistically significant improvement from baseline to the most recent remeasurement. **[Quality, Timeliness, and Access]** |
| **PMV** | • LHCC's members received screenings for colorectal cancer, chlamydia, lead, and cervical cancer at rates above the NCQA national 50th percentile benchmark. **[Quality]**<br>• LHCC was effective in coordinating 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]** |
| **Compliance** | • LHCC scored 100 percent for eight standards in the CR, indicating that LHCC's policies and procedures were generally compliant with contract requirements and staff were generally knowledgeable about the requirements, policies, and procedures. **[Quality]** |
| **NAV** | • LHCC proactively worked with providers to increase access to care in healthcare provider shortage areas by conducting outreach to increase behavioral health services. **[Quality]** |
| **EDV** | • LHCC and its dental and vision subcontractors reported performing checks on claim volume, completeness, accuracy, timeliness, and reconciliation with financial reports for corresponding encounters. For dental encounters, all key data elements were populated with at least 95 percent valid values. **[Quality and Timeliness]** |
| **CAHPS and Behavioral Health Member Satisfaction Survey** | • For the general child CAHPS population, LHCC's 2025 CAHPS achievement scores were statistically significantly higher than the 2025 NCQA child national averages for two measures: *Getting Needed Care* and *Getting Care Quickly*. **[Quality, Timeliness, and Access]**<br>• For the Behavioral Health Member Satisfaction Survey, no notable strengths were identified. **[Quality]** |

| Overall MCO Strengths | |
|---|---|
| **CMPE** | • LHCC successfully completed remediation actions to address the CAP findings. **[Quality]** |

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

| Overall MCO Opportunities for Improvement | |
|---|---|
| **PIP** | • LHCC did not achieve significant improvement outcomes for all PIPs. **[Quality]** |
| **PMV** | • LHCC had room for improvement to ensure that members hospitalized or accessing the ED for mental illness and substance abuse receive adequate follow-up care. **[Quality, Timeliness, and Access]**<br>• LHCC had room for improvement in ensuring that providers effectively prevent or minimize the prescribing of antibiotics to children with URIs and adults with bronchitis or bronchiolitis. **[Quality]** |
| **Compliance** | • LHCC scored 67 percent for Standard IX—Subcontractual Relationships and Delegation, demonstrating the need to ensure that all contract or written arrangements include State and federal requirements. **[Quality]**<br>• LHCC scored 60 percent for Standard V—Adequate Capacity and Availability of Services, demonstrating the need to improve adequate access to all services. **[Quality]** |
| **NAV** | • Compliance scores varied by survey type with an overall score of 46.5 percent for the PDV and 34.8 percent for the provider access survey. **[Quality and Access]**<br>• Only 58 percent of surveyed locations verified that the sampled provider was affiliated with their site, indicating relatively low provider presence. **[Quality and Access]** |
| **EDV** | • LHCC had the second highest duplicate encounter rate (5.0 percent) among the MCEs with dental encounters. **[Quality]**<br>• LHCC submitted only 82.3 percent of institutional encounters and 89.7 percent of dental encounters within 60 days of the payment date. **[Quality and Timeliness]**<br>• LHCC had several 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 opportunities for improvement were identified. **[Quality]**<br>• For the child population in the Behavioral Health Member Satisfaction Survey, LHCC's 2025 achievement score for *Rating of Health Plan* was statistically significantly lower than the 2025 Healthy Louisiana SWA benchmark, indicating an opportunity to enhance member experience and satisfaction. **[Quality]** |
| **CMPE** | • LHCC demonstrated an opportunity for improvement with elements related to ongoing scheduled CM activities. **[Quality and Timeliness]** |

**Table 11-3—Recommendations**

| Overall MCO Recommendations | | |
|---|---|---|
| **EQR Activities** | **Recommendation** | **Associated Quality Strategy Goals to Target for Improvement** |
| **PIP** | • To facilitate significant outcomes improvement for all PIPs, LHCC should review intervention evaluation results to determine if each intervention is having the desired impact and how interventions can be revised to increase effectiveness. LHCC should also revisit specific barrier analyses for each PIP to evaluate whether additional barriers need to be addressed by new or revised interventions to drive outcomes improvement. **[Quality, Timeliness, and Access]** | Goal 4: Promote wellness and prevention |
| **PMV** | • LHCC 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 abuse. **[Quality, Timeliness, and Access]**<br>• LHCC should work with providers to prevent or reduce antibiotic dispensing to treat URIs in children and adults with bronchitis or bronchiolitis. **[Quality]** | Goal 2: Improve coordination and transitions of care<br>Goal 3: Facilitate patient-centered, whole-person care<br>Goal 4: Promote wellness and prevention |
| **Compliance** | • LHCC must ensure that all contracts or written arrangements include State and federal requirements. **[Quality]**<br>• LHCC must monitor its provider network to ensure adequate access to all services. **[Quality]**<br>• LHCC must complete its CAP to resolve all *Not Met* findings from the CR. **[Quality, Timeliness, and Access]** | Goal 1: Ensure access to care to meet enrollee needs<br>Goal 2: Improve coordination and transitions of care<br>Goal 3: Facilitate patient-centered, whole-person care<br>Goal 4: Promote wellness and prevention<br>Goal 7: Pay for value and incentivize innovation |
| **NAV** | • LHCC should conduct outreach to its providers to ensure the providers and/or their offices routinely submit up-to-date information on all pertinent provider indicators. **[Quality]** | Goal 1: Ensure access to care to meet enrollee needs |
| **EDV** | • LHCC should review its system for identifying and handling duplicates for | Goal 7: Pay for value and incentivize innovation |

| Overall MCO Recommendations | | |
|---|---|---|
| | dental encounters. Identification and appropriate handling of duplicate encounters is crucial for accurate financial and actuarial calculations. **[Quality]**<br>• LHCC should monitor its encounter data submission to LDH to ensure institutional and dental encounters are submitted to LDH in a timely manner after payment. **[Timeliness]**<br>• LHCC should investigate the root causes for data elements with less than 95.0 percent of valid values (i.e., those listed in the opportunities for improvement section) to improve accuracy. **[Quality]** | Goal 8: Minimize wasteful spending |
| **CAHPS and Behavioral Health Member Satisfaction Survey** | • LHCC should monitor the CAHPS measures to ensure significant decreases in scores over time do not occur. **[Quality, Timeliness, and Access]**<br>• For the Behavioral Health Member Satisfaction Survey, LHCC should focus on improving members' overall experiences with their health plan by performing a root cause analysis, which could determine if there are any outliers within the data so that LHCC can identify the primary areas of focus and develop appropriate strategies to improve the performance. **[Quality, Timeliness, and Access]** | Goal 3: Facilitate patient-centered, whole-person care |
| **CMPE** | • LHCC should continue the efforts documented in its CAP responses to ensure compliance with contractual CM requirements. **[Quality and Timeliness]** | Goal 2: Improve coordination and transitions of care |

# 12. Follow-Up on Prior Year's Recommendations

Regulations at 42 CFR §438.364 require an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR §438.310[c][2]) has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR. LDH required each MCO to document the follow-up actions per activity that the MCO completed in response to SFY 2023–2024 recommendations. Table 12-1 through Table 12-9 contain a summary of the follow-up actions that LHCC completed in response to the EQRO's SFY 2024 recommendations. Furthermore, HSAG assessed LHCC's approach to addressing the recommendations. Please note that the responses in this section were provided by the plans and have not been edited or validated by HSAG.

## EQRO's Scoring Assessment

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

*High* indicates *all* of the following:

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

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


*Medium* indicates one or more of the following:

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

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

*Low* indicates one or more the following:

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

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


**Table 12-1—Follow-Up on Prior Year's Recommendations for PIPs**

| Recommendation |
|---|
| To facilitate significant outcomes improvement for all PIPs, HSAG recommended that LHCC review intervention evaluation results to determine whether each intervention is having the desired impact and how interventions can be revised to increase effectiveness. LHCC should also revisit MCO-specific barrier analyses for each PIP to evaluate whether additional barriers need to be addressed through new or revised interventions to drive outcomes improvement. |
| ***Response*** |
| **Describe initiatives implemented based on recommendations:**<br>As part of ongoing Performance Improvement Project (PIP) efforts, LHCC monitors intervention outcomes and assesses barriers to success. Intervention results are collected and evaluated monthly to determine effectiveness and to proactively address previously identified - as well as emerging - barriers as they are identified. As a result of this ongoing review and analysis, the following initiatives were implemented and/or expanded upon:<br>• Ongoing cross-functional, multi-disciplinary collaboration to review performance indicator rates, intervention success, barriers to success, and identification of new interventions.<br>• Enhanced email outreach included personalized messaging to identify care opportunities and provider (PCP) contact information.<br>• Automated messaging campaigns—such as emails, mailers, and digital outreach—were deployed to support specific PIP performance measures.<br>• Member and provider incentive programs were evaluated to align with PIP goals and Louisiana Department of Health (LDH) priorities.<br>• Social media platforms were also utilized to extend health messaging and increase visibility.<br>• Community engagement through participation in and sponsorship of conferences and local events provided broader outreach and feedback opportunities.<br>• Provider education offered through webinars and educational materials updated to address new or existing barriers as identified.<br>• Provider partnerships targeting PIPs topics evaluated for effectiveness and expanded when possible to address larger subpopulations and geographical service area. |

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

As a result of MY2024 PIP efforts, the following performance indicators demonstrated statistically significant improvement:

- Follow-Up After Hospitalization for Mental Illness (FUH) - Total, 7 days improved from Baseline (18.27%) to Remeasurement Period 2 (21.15%), an increase of 2.88 percentage points
- Follow-Up After Hospitalization for Mental Illness (FUH) - Total, 30 days improved from Baseline (38.78%) to Remeasurement Period 2 (43.00%), an increase of 4.21 percentage points
- Cervical Cancer Screening (CCS) improved from Baseline (52.47%) to Remeasurement Period 1 (57.66%), an increase of 5.19 percentage points
- Fluoride varnish (members 6 months-18 months) improved from Baseline (10.91%) to Remeasurement Period 2 (16.73%), an increase of 5.83 percentage points
- Fluoride varnish (members 19 months – 2 years) improved from Baseline (6.15%) to Remeasurement Period 2 (10.21%), an increase of 4.07 percentage points
- Fluoride varnish (members 3-5 years) improved from Baseline (3.88%) to Remeasurement Period 2 (5.55%), an increase of 1.68 percentage points
- Fluoride varnish (members 6 months-5 years) improved from Baseline (6.50%) to Remeasurement Period 2 (10.81%), an increase of 4.31 percentage points
- HIV Screening (**Persons ever screened for HIV among all others aged 15 to 65 years)** improved from Baseline (25.93%) to Remeasurement Period 1 rate (28.13%), an increase of 2.20 percentage points

The following performance indicators demonstrated a statistically significant decrease:

- HIV Screening of pregnant persons or persons with encounters for labor and delivery declined from Baseline (73.90%) to Remeasurement Period 1 (72.26%), a decrease of 1.64 percentage points
- HIV Screening of persons with past or present (injection) drug use declined from Baseline (29.67%) to Remeasurement Period 1 (28.41%), a decrease of 1.26 percentage points
- HIV Screening of persons with risk factors related to sexual mode of transmission declined from Baseline (40.31%) to Remeasurement Period 1 (37.77%), a decrease of 2.53 percentage points

The following performance indicators did not demonstrate a statistically significant decrease:

- Follow-Up After Emergency Department Visit for Mental Illness (FUM) - Total, 7 days declined from Baseline (22.23%) to Remeasurement Period 2 (21.17%), a decrease of 1.06 percentage points
- Follow-Up After Emergency Department Visit for Mental Illness (FUM) - Total, 30 days declined from Baseline (37.64%) to Remeasurement Period 2 (37.41%), a decrease of 0.23 percentage points
- Follow-Up After Emergency Department Visit for Substance Use (FUA) – Total, 7 days declined from Baseline (15.87%) to Remeasurement Period 2 (14.40%), a decrease of 1.47 percentage points
- Follow-Up After Emergency Department Visit for Mental Illness (FUM) - Total, 30 days declined from Baseline (26.06%) to Remeasurement Period 2 (24.45%), a decrease of 1.61 percentage points

**Identify any barriers to implementing initiatives:**

Barriers to implementation and impact of interventions include:

- Successful member telephone outreach continues to challenge the health plan and providers due to inconsistent telephone services and inaccurate contact information available across providers in the care continuum.
- Additional Social Determinants of Health (SDoH), i.e., transportation, housing insecurity, also contribute to lower member utilization of health care benefits and services.
- Provider coding practices that do not align with PIP performance indicator methodology affect health plan data aggregation.

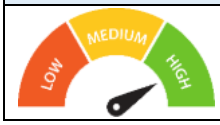
| |
|---|
| • Provider utilization of ADT platforms impact timely notification of IP/ED visits and subsequent follow-care. |
| **Identify strategy for continued improvement or overcoming identified barriers:**<br>Continue to utilize data and feedback loops to identify opportunities for new or revised interventions to impact outcome health outcomes targeted through PIPs. |
| ***HSAG Assessment*** |
|  |

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

| Recommendation |
|---|
| HSAG recommended that LHCC evaluate performance measures with rates below the NCQA national 50th percentile. |
| ***Response*** |
| **Describe initiatives implemented based on recommendations:**<br>As a result of ongoing review and analysis of performance measures below the NCQA national 50th percentile, and HSAG recommendations the following initiatives were implemented and/or expanded upon:<br>• Enhanced member outreach messaging using personalized and tailored content.<br>• Revised provider incentives to include incentives for completion of SDOH assessments and BMI measurements.<br>• Direct member calls to assist with follow up appointments and medication refills to support continuation of ADHD medication.<br>• Increased efforts to expand EHR connectivity across provider network to improve capture of electronic measures such as APM- E and ADD-E.<br>• Established provider partnership offering Digital Medicine programs to assist members with effective diabetes and blood pressure management.<br>• Doula pilot initiative to augment routine prenatal care and postnatal health care.<br>• Expansion of targeted provider partnerships to expand primary care resources and care coordination.<br>• Increased community presence through Community Health Workers and participating in community events, prioritizing areas with identified disparity populations.<br>• Targeted outreach to low performing providers to assist with education, member gaps, tips for compliance, and proper coding guidelines.<br>• Per the direction of LDH, altered immunization messaging to recommend members discuss considerations for vaccination with their healthcare provider. |
| **Identify any noted performance improvement as a result of initiatives implemented (if applicable):**<br>LHCC met thresholds for the NCQA 50th percentile in 2024, with improvements noted year over year in the following HEDIS measures:<br>• CIS (Dtap) rate 75.91%, a 5.46% increase over prior year<br>• CIS (Pneumococcal Conjugate) rate 74.21%, a 4.69% increase over prior year<br>• CIS (Rotavirus) rate 70.8%, a 7.19% increase over prior year<br>• CIS (Combo 3) rate 69.83%, a 6.03% increase over prior year |

- CIS (Combo 7) rate 59.12%, a 6.67% increase over prior year
- WCC (BMI) rate 89.29%, a 7.78% increase over prior year
- CBP rate 68.61%, a 8.27% increase over prior year
- SAA rate 67.28%, a 6.59% increase over prior year
- AMM (Continuation) rate 48.13%, a 5.53% increase over prior year
- PPC (Postpartum) rate 83.45%, a 5.83% increase over prior year

Although thresholds for NCQA 50th percentile were not met in 2024, improvement was noted year over year for the following HEDIS measures:

- APM-E (Glucose) rate 52.85%, a 0.49% increase over prior year
- APM-E (Cholesterol) rate 27.55%, a 1.62% increase over prior year
- APM-E (Total) rate 26.51%, a 1.65% increase over prior year
- WCC (Physical Activity) rate 64.72%, a 5.6% increase over prior year
- BPD rate 69.1%, a 6.08% increase over prior year
- ADD-E (Continuation) rate 51.43%, rate unchanged from the prior year
- AMM (Acute) rate 63.27%, a 3.54% increase over prior year
- URI rate 82.13%, a 2.01% increase over prior year
- AAB rate 52.74%, a 1.62% increase over prior year
- PPC (Timeliness) rate 85.64%, a 6.81% increase over prior year

For 2024, HEDIS rates declined year over year for the following measures:

- CIS (Influenza) rate 19.46%, a 1.0% decrease from prior year
- CIS (Combo 10) rate 14.76%, a 0.85% decrease from prior year
- WCC (Nutrition) rate 69.34%, a 1.22% decrease from prior year
- ADD-E (Initiation) rate 43.95%, a 0.26% decrease from prior year

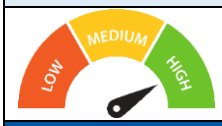
**Identify any barriers to implementing initiatives:**

Barriers to implementation and impact of interventions include:

- Per LDH direction as of February of 2025, all vaccine promotion events were cancelled.
- As of August of 2025, immunization measures were removed from MCO quality performance measure reporting and withhold incentives.
- Parental vaccine hesitancy contributing to low levels of vaccine coverage.
- Successful member telephone outreach due to inconsistent telephone services and inaccurate member demographics.
- Member challenges attending scheduled appointments (i.e., transportation, employment, childcare, etc.).
- Provider coding/billing practices; i.e., not submitting appropriate billing codes to accurately capture gap closures.
- Provider willingness to partner on EHR access, health information exchange participation, and opportunities to expand supplemental data feeds.

**Identify strategy for continued improvement or overcoming identified barriers:**

- Reassess member and provider incentives to align with LDH priorities and measures below the NCQA 50th percentile.
- Continue monthly Performance Improvement Committee meetings to review rates, identify trends, follow up on interventions, and develop new interventions.
- Continue with targeted provider education on performance measures, member care gaps, and clinical practice guidelines.
- Continue to expand electronic health record (EHR) connectivity and supplemental data sources.

| ***HSAG Assessment*** |
|---|
|  |
| **Recommendation** |
| To improve performance on *the Follow-Up After Hospitalization for Mental Illness—Within 7 Days of Discharge and Within 30 Days of Discharge, Follow-Up After Emergency Department Visit for Mental Illness—Within 7 Days of Discharge and Within 30 Days of Discharge, and Follow-Up After Emergency Department Visit for Substance Use—Within 7 Days of Discharge and Within 30 Days of Discharge* measure indicators, HSAG recommended that the MCOs work with providers to identify barriers to timely follow-up care and trial solutions to improve coordination of care following discharge among providers and between providers and the MCOs. |
| ***Response*** |
| **Describe initiatives implemented based on recommendations:**<br>Annual evaluation of intervention effectiveness and a root cause analysis of newly identified or persistent barriers are conducted in alignment with our state Performance Improvement Project (PIP) initiatives. Based on the insights gained from this ongoing review and analysis, the following initiatives were implemented or expanded:<br>• Expansion of strategic provider partnership delivering follow-up care and access to BH services through a home-based model (i.e., Upward Health) across additional regions in the state.<br>• Enhanced email outreach messaging using personalized and tailored content to increase engagement following discharge and support member communication preferences.<br>• Dedicated personnel, including member outreach and Behavioral Health Care Management staff, are engaged to perform targeted outreach and facilitate a warm handoff for subsequent follow-up assessment.<br>• Ongoing collaboration to expand ADT connectivity with BH providers/facilities to supplement BH inpatient prior authorizations and support discharge notifications.<br>• Education with BH facilities and emergency department to encourage participation in ADT/Health Information Exchange applications.<br>• Collaboration with ACT teams to support increased knowledge of local hospital workflows and processes to support discharge planning and follow-up after hospitalization or emergency department visit.<br>• Continuation of year-round provider outreach/education (PCP/ED departments/BH providers) related to IP/ED discharge reports and gap closure alerts available through secure provider portal; education regarding updates HEDIS measures (FUH/FUM/FUA) year over year to support understanding and adherence. |
| **Identify any noted performance improvement as a result of initiatives implemented (if applicable):**<br>Although thresholds for NCQA 50th percentile were not met for behavioral follow-up care measures, the following trends were observed:<br>• Rates for follow-up after hospitalization and emergency department visits for mental illness showed improvement:<br>  • FUH (7d) rate 22.14%, a 1.44% improvement over prior year<br>  • FUH (30d) rate 44.68%, a 3.08% improvement over prior year<br>  • FUA (7d) rate 14.96%, a 1.54% improvement over prior year<br>  • FUA (30d) rate 25.19%, a 3.30% improvement over prior year<br>  • FUM (30d) rate 38.49%, a 0.48% improvement over prior year<br>• Rate for 7-day follow-up after emergency department visits for mental illness declined year over year: |

- FUM (7d) rate 22.07%, a 0.32% decline over prior year

**Identify any barriers to implementing initiatives:**

- Successful member outreach to provide education and follow up appointment scheduling is impacted by access to consistent telephone services, inaccurate contact information available to providers in the care continuum, and other Social Determinants of Health (SDoH), i.e., transportation, housing insecurity, that also influence member utilization of health care benefits and services.
- Provider engagement in follow-up care is impacted by ongoing provider community abrasion, perceived inadequate reimbursements via LA Medicaid fee schedule, and limited provider staffing resources; provider documentation/coding practices also impede identification of BH IP/ED visits and follow-up needs.
- Provider participation in and utilization of ADT platforms impact timely identification of IP/ED visits and member engagement for follow-up; limited ADT system identification of BH visits impacts customized member outreach for follow-up.

**Identify strategy for continued improvement or overcoming identified barriers:**

Ongoing review of intervention effectiveness and barrier analysis annually, and:

- Expansion of provider partnership utilizing multi-disciplinary home-based care model to address larger subpopulation and geographical service area.
- Exploring potential IT enhancements and emerging artificial intelligence (AI) trends that may expand ADT identification of BH IP visits
- Provider-focused education webinars and the revision of educational materials to address updates to HEDIS measures and new barriers.
- Continued evaluation and alignment of member and provider incentive programs to support engagement with follow-up after discharge.
- Enhanced member email strategy to increase engagement through the use of personalized content and imagery.

***HSAG Assessment***


**Recommendation**

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

***Response***

**Describe initiatives implemented based on recommendations:**

- Behavioral Health ACT Integration:
  - The UM and CM teams launched a proactive Assertive Community Treatment (ACT) engagement protocol targeting members admitted for behavioral health inpatient care.
    - Upon admission, the ACT team is immediately notified to initiate discharge planning and ensure continuity of care.
    - Feedback from ACT partners has been overwhelmingly positive, citing improved coordination and member outcomes.
    - This pilot has since evolved into a standard practice, ensuring seamless transitions from admission through discharge.
- High-Risk Readmission Escalation:

    - The Physical Health UM team now flags members with elevated readmission risk for weekly High-Intensity Care Coordination (ICC) rounds.
    - These interdisciplinary discussions drive targeted discharge planning and result in real-time TOC referrals, enhancing visibility and accountability across care teams.
- Transition of Care (TOC) Team Activation:
    - A dedicated TOC management team was formally established in 2023 to streamline post-discharge outreach and ensure timely follow-up care.
- Vendor-Partnered Outreach Expansion:
    - The BH UM team leverages an external case management partner (e.g., Upward Health) to conduct intensive outreach for members requiring complex, high-touch interventions.

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

- For MY 2024, the rate for *Plan All-Cause Readmissions—O/E Ratio* measure declined 1.2%, a 0.15% decrease from prior year.
- ACT Pilot Outcomes:
    - Launched on 08/13/2025, the ACT pilot is currently under evaluation.
        - Early qualitative feedback indicates improved discharge coordination; quantitative ROI and health analytics are forthcoming.
- TOC Outreach Optimization:
    - Since its 2023 implementation, the TOC outreach process has been refined to prioritize members based on diagnosis and readmission frequency, resulting in more efficient and impactful interventions.
- CM Referral Targeting:
    - Enhanced referral workflows now prioritize members with frequent readmissions, enabling earlier engagement and reducing avoidable hospitalizations.

**Identify any barriers to implementing initiatives:**

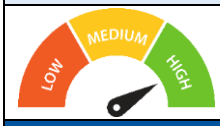
- Member Contact Challenges:
    - Outreach is often hindered by disconnected or outdated phone numbers, lack of voicemail responses, and frequent changes in contact information.
        - All unsuccessful attempts are documented.
- Housing Instability:
    - A significant portion of the population faces homelessness, complicating discharge planning due to lack of shelter, transportation, and access to medications or follow-up care.
- High Comorbidity Burden:
    - The region experiences a high prevalence of co-occurring chronic conditions (e.g., hypertension, diabetes, COPD, mental illness), which complicates care coordination and recovery.

**Identify strategy for continued improvement or overcoming identified barriers:**

- Enhanced Provider Collaboration:
    - Strengthening coordination with members' PCPs and psychiatrists to obtain updated contact information and reinforce care continuity.
- Single-Provider Care Model:
    - Promoting a centralized care approach where one provider oversees all aspects of a member's care to reduce fragmentation.
- Peer Liaison Home Visits:
    - Deploying a dedicated peer liaison to conduct home visits for members with frequent readmissions due to medication non-compliance or missed appointments.
- Peer Support Integration:

- Peer support specialists work alongside clinical teams to ensure members receive timely behavioral health and social support services.
- Multi-Channel Outreach:
  - ATC letters mailed to members' last known addresses.
  - Pharmacy-based outreach to obtain alternative contact information when direct member contact fails.

***HSAG Assessment***




**Recommendation**

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

***Response***

**Describe initiatives implemented based on recommendations:**
LHCC analysis indicated opportunity for enhanced provider education and support to decrease the incidence of members receiving unnecessary imaging for low back pain. Initiatives implemented include:

- Collaboration with Medical Directors, finance & and 3rd party vendor medical reviewers (managing non-emergent outpatient radiology testing authorizations) on peer reviews, outlier trends, and any quality-of-care concerns.
- Education on evidenced based recommendations and available clinical practice guidelines for diagnosis and treatment of low back pain added to provider joint operating committee (JOC) meetings.

**Identify any noted performance improvement as a result of initiatives implemented (if applicable):** For MY2024, a slight improvement was noted: Low Back Pain (LBP) rate 69.83%, a 0.72% improvement over prior year.

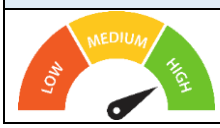
**Identify any barriers to implementing initiatives:**
Barriers to implementation and impact of interventions include:

- Retrospective performance measures pose a challenge to address proactively vs member-targeted open 'care gap' approach.
- Treatment practices may be influenced by members' insistence of imaging vs conservative therapy measures for pain management; limited health literacy surrounding risks related to radiation exposure and unnecessary treatment.
- Failure of providers to use appropriate exclusion codes when applicable.

**Identify strategy for continued improvement or overcoming identified barriers:**

- Review of clinical practice guidelines on treatment of low back pain to ensure current provider resources.
- Development of provider educational material including a Low Back Pain Toolkit.
- Offer a peer led provider Webinar on best practice and clinical guidelines with emphasis on conservative measures such as first-line treatment for low back pain.

***HSAG Assessment***



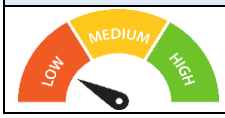
| Recommendation |
|---|
| To improve performance on the *Non-Recommended Cervical Screening in Adolescent Females* measure, HSAG recommended that the MCOs work with providers to trial solutions to reduce or avoid unnecessary cervical cancer screenings for adolescent females. |
| ***Response*** |
| **Describe initiatives implemented based on recommendations:** For MY2024, NCQA retired the Non-Recommended Cervical Screening in Adolescent Females (NCS) HEDIS measure citing, "*Recent HEDIS performance data indicate very little room for improvement at the health plan level*". *HEDIS MY 2024: What's New, What's Changed, What's Retired* |
| **Identify any noted performance improvement as a result of initiatives implemented (if applicable):** MY2024 results not available. Measure retired by NCQA per *HEDIS Measurement Year 2024 Volume 2: Technical Specifications for Health Plans page 4.* |
| **Identify any barriers to implementing initiatives:** N/A |
| **Identify strategy for continued improvement or overcoming identified barriers:** N/A |
| ***HSAG Assessment*** |
|   |

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

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

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

| Recommendation |
|---|
| HSAG recommended that LDH provide LHCC with the case-level PDV and provider access survey data files (i.e., flat files) and a defined timeline by which LHCC will address provider data deficiencies identified during the PDV reviews and/or provider access survey (e.g., provider specialty, MCO acceptance, and Louisiana Medicaid acceptance). |
| ***Response*** |
| **Describe initiatives implemented based on recommendations:**<br>• In alignment with HSAG's recommendation, LHCC resumed its LDH directory audit work process following LDH's reintroduction of case-level PDV survey data files in Q1 2025. LDH provided a defined timeline for addressing deficiencies, which was communicated in their email notice to LHCC.<br>• In response, LHCC reactivated its established workflow for reviewing PDV data, conducting provider outreach, collecting attestations and rosters, and confirming provider participation and specialty accuracy. We also resumed corrective actions for any data confirmed to be inaccurate. |

- To further strengthen our audit readiness, LHCC rewrote its entire LDH directory audit work process prior to the resumption of the 2025 audits. This updated process ensures alignment with LDH expectations and supports timely resolution of identified deficiencies.

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

- As a result of LHCC's updated LDH directory audit work process, we were able to more efficiently and accurately analyze the PDV data, identify discrepancies, conduct targeted outreach, and complete necessary corrections. The revised workflow positioned us to respond quickly and thoroughly to LDH's audit requirements.
- By aligning our methodology and calculations with those used by HSAG, LHCC was able to precisely determine expected scores across all five audited provider categories and calculate our overall weighted compliance score. This enabled us to present a detailed, data-supported analysis that offered an alternative perspective to the initial audit results.
- Our internal analysis showed that LHCC exceeded the 75% compliance threshold in four out of five provider categories, with an overall weighted compliance score of 80.5%. Following our submission of this analysis, LDH reviewed our response and revised our final audit score to 88.09%.

**Identify any barriers to implementing initiatives:**

- While LHCC has implemented a robust audit work process, we have identified potential barriers that may be contributing to inaccurate scoring.
- Based on our outreach and internal analysis, we suspect that certain survey questions may be misinterpreted by providers. For example, the failure reason "Provider does not participate with MCO or Louisiana Medicaid" was cited 30 times, yet our review found that 23 of those providers were, in fact, compliant. This suggests that the phrasing of the question may lead to unintended misclassification.
- Additionally, we observed discrepancies in how provider specialties are reported. Providers often use titles that do not align with the state-defined specialties outlined in the system companion guide. If these titles are interpreted literally, without cross-referencing the guide, it may result in scoring deductions despite the provider being compliant.
- These findings are based on LHCC's internal validation efforts and outreach feedback. While not yet verified by HSAG, they represent meaningful barriers that could impact the accuracy of future audits if not addressed.

**Identify strategy for continued improvement or overcoming identified barriers:**

- LHCC's strategy for continued improvement centers on maintaining the updated LDH directory audit work process implemented in preparation for the 2025 audits. This process has proven effective in enabling timely analysis, outreach, and corrections, and will remain the foundation of our audit response efforts.
- Although no additional changes have been made specifically in response to HSAG's recommendations prior year, LHCC has implemented several internal improvements to how we review and validate provider data. These enhancements were part of our broader audit readiness efforts and not directly tied to HSAG's guidance. That said, LHCC will continue to monitor provider responses and scoring trends—particularly around MCO/Medicaid participation and specialty classification—to identify potential areas of misinterpretation. While these issues have not been formally confirmed by HSAG, our internal analysis suggests they may be contributing to scoring discrepancies.
- Lastly, we will use future audit cycles to validate these findings further and, if necessary, collaborate with LDH to clarify survey language and specialty mapping guidance. Our goal is to ensure that providers understand the questions accurately and that their responses reflect true compliance, thereby supporting continued improvement in audit outcomes.

| *HSAG Assessment* |
|---|
| An HSAG auditor assessment of the MCO's intervention was not required, as no prior recommendation had been issued. |
| **Recommendations** |
| HSAG recommended that LHCC conduct a root cause analysis to identify the nature of the data mismatches for PDV and provider access survey study indicators that scored below 90 percent. |
| *Response* |
| **Describe initiatives implemented based on recommendations:**<br>• LHCC incorporated deeper internal review steps into our updated LDH directory audit work process. These steps included enhanced validation of provider responses, closer examination of scoring discrepancies, and outreach to providers to better understand potential causes of mismatches.<br>• Additionally, LHCC completed a root cause analysis to assess the nature of the scoring discrepancies and to identify if any patterns emerged. Through this approach, we examined provider responses, outreach outcomes, and scoring patterns.<br>• Our analysis suggests that the nature of the data mismatches may not stem from systemic data issues within LHCC, but rather from how providers interpret certain survey questions and how their specialty titles are recorded. |
| **Identify any noted performance improvement as a result of initiatives implemented (if applicable):**<br>• The improvements made to our audit work process allowed LHCC to more accurately identify and address scoring discrepancies. This contributed to a significant increase in our audit performance, culminating in a final score of 88.09% for Q1 2025—well above the 75% threshold and the highest score ever achieved.<br>• Our internal review and outreach efforts helped us better understand the nature of mismatches and supported our ability to present an alternative perspective to the initial audit results with data-backed evidence. |
| **Identify any barriers to implementing initiatives:**<br>• The primary barrier to conducting a formal root cause analysis is the lack of clear evidence that systemic data issues exist within LHCC's provider directory. Our internal data has consistently shown high accuracy, and the Q1 2025 audit score of 88.09% reinforces this.<br>• Additionally, the small percentage of mismatches appears to be linked to delays in receiving updated information from providers and potential misinterpretation of survey questions—the latter of which is difficult to isolate and confirm without direct validation from HSAG. |
| **Identify strategy for continued improvement or overcoming identified barriers:**<br>• LHCC will continue to rely on its updated audit work process, which includes enhanced internal review and provider outreach. This process has proven effective in identifying and resolving discrepancies and will remain our primary strategy moving forward.<br>• We will also continue monitoring provider response patterns and scoring trends to identify any recurring issues. If future audits reveal consistent mismatches, LHCC will revisit the need for a formal root cause analysis and consider engaging LDH or HSAG for clarification on survey interpretation and specialty classification standards. |
| *HSAG Assessment* |
|  |

| Recommendations |
|---|
| HSAG recommended that LHCC consider conducting a review of the offices' eligibility verification requirements to ensure these barriers do not unduly burden members' ability to access care. |
| ***Response*** |
| **Describe initiatives implemented based on recommendations:** LHCC partners closely with in-network providers to uphold appointment accessibility standards outlined in the Network Companion Guide, Attachment F. In alignment with these standards, LHCC conducts secret shopper audits and complaint analysis reviews to identify opportunities for improvement. To support providers, LHCC proactively delivers education on appointment accessibility requirements and shares branded materials to increase awareness particularly among scheduling personnel and centers. This guidance is reinforced through New Provider Orientation (within 30 days of network activation), Provider Manual training, and ongoing in-person visits throughout the year. Additionally, LHCC encourages providers to leverage platforms that best fit their workflows to minimize administrative burden. Upon receipt of LDH audit data, LHCC can implement more targeted outreach to collaborate with providers and address identified areas for improvement. |
| **Identify any noted performance improvement as a result of initiatives implemented (if applicable):** N/A |
| **Identify any barriers to implementing initiatives:** In some instances, frequent staffing changes among the providers scheduling centers, front desk personnel, and after-hours vendors create challenges in maintaining consistent understanding of appointment accessibility standards and eligibility verification processes across provider office staff. |
| **Identify strategy for continued improvement or overcoming identified barriers:** LHCC will continue to strengthen provider education initiatives, ensuring clarity and consistency in compliance requirements. Ongoing monitoring through secret shopper audits and active provider engagement will be leveraged to identify improvement opportunities and reinforce standards. Additionally, refresher training will be integrated into regular provider touchpoints, including quarterly check-ins and in-person visits, to maintain alignment and understanding across all staff levels. |
| ***HSAG Assessment*** |
|  |

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

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

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

| Recommendation |
|---|
| HSAG recommended that LHCC focus on increasing response rates to the CAHPS survey for all populations so there are greater than 100 respondents for each measure. |
| ***Response*** |
| **Describe initiatives implemented based on recommendations:**<br>Initiatives intended to increase response rates to the 2025 CAHPS survey included: |

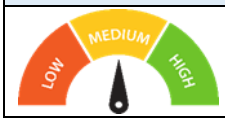
| Recommendation |
|---|
| • Oversampling by 50% for both Adult and Child surveys.<br>• Member Survey Awareness Campaign to highlight upcoming surveys and encourage participation with communication via email, website, and social media platforms.<br>• Education during provider JOCs to include encouraging member participation in member experience surveys. |
| **Identify any noted performance improvement as a result of initiatives implemented (if applicable):**<br>For 2025, an improvement was noted in CAHPS response rates for both the adult and child surveys as follows:<br>• Adult survey response rate 12.7%, 1.3 percentage point increase over prior year<br>• Child survey response rate 10.2%, a 1.1 percentage point increase over prior year<br>• Adult survey with 81% of composite measure with over 100 respondents, a 9% increase over prior year<br>• Child survey with 70% of composite measures with over 100 respondents, a 20% increase over prior year |
| **Identify any barriers to implementing initiatives:**<br>Barriers to implementation and impact of interventions include:<br>• Unsuccessful member engagement related to potential survey fatigue affecting response rates. |
| **Identify strategy for continued improvement or overcoming identified barriers:**<br>• Continue with oversampling to achieve over 100 respondents per composite/measure for both populations.<br>• Continue with Member Experience workplan to include increasing employee knowledge of CAHPS, using customer service techniques, and providing awareness to members and provider during the survey period. |
| ***HSAG Assessment*** |
|  |

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

| Recommendation |
|---|
| HSAG recommended that LHCC focus on increasing response rates to the behavioral health member satisfaction survey for all populations so there are greater than 100 respondents for each measure. |
| ***Response*** |
| **Describe initiatives implemented based on recommendations:**<br>Initiatives intended to increase response rates to the 2025 BH Member Survey included:<br>• Analysis of sample population logic to ensure identification of all members meeting inclusion criteria. This, along with expanded specialty codes for 2025, resulted in a year over year increase in overall sample size for both the adult and child populations.<br>• Member Survey Awareness Campaign to highlight upcoming surveys and encourage participation with communication via email, website, and social media platforms. |
| **Identify any noted performance improvement as a result of initiatives implemented (if applicable):**<br>The latest response rates from 2025 BH member survey conducted by LDH/HSAG are not currently available to evaluate the effectiveness of implemented initiatives. |
| **Identify any barriers to implementing initiatives:**<br>Barriers to implementation and impact of interventions include: |

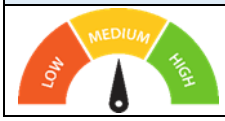
| Recommendation |
| --- |
| • Unsuccessful member engagement related to potential survey fatigue affecting response rates. |
| **Identify strategy for continued improvement or overcoming identified barriers:**<br>• Continue to monitor sample population logic and changes in reference codes to ensure identification of all members meeting survey inclusion criteria.<br>• Continue with Member Experience workplan to include increasing employee knowledge of CAHPS, using customer service techniques, and providing awareness to members and provider during the survey period. |
| ***HSAG Assessment*** |
|  |

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

| Recommendation |
| --- |
| None identified. |

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

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

# Appendix A. MCO Health Equity Plan Summary

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

## Health Equity Plan

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

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

# Development and Implementation of Focus Areas

## Overview

Louisiana HealthCare Connections (LHCC) has commenced the year with a determined focus on maintaining the progress achieved in the first year towards providing equitable care for our members. While we have observed continued growth and advancement, we have also encountered certain barriers and challenges that we continue to monitor and evaluate for mediation opportunities and will continue to meet our goals for December 2025.

Reflecting on a year of dedicated efforts, we continue last year's health equity approach are "fidelity" and "leveraging." Our primary emphasis remains on evaluating the processes of existing programs and services and internally applying our health equity initiatives. Summarized within our efforts and accomplishments thus far, highlighting our dedication to advancing health equity and promoting the holistic well-being of our enrollees, particularly those experiencing significant health disparities.

## Focus Area (A): Training

**A1.1 Health Equity Training for LHCC Staff –** Building on the progress made in year one, LHCC has continued to make substantial advancements toward our objectives of educating staff on health disparities among vulnerable populations. In the first two quarters of 2025, we expanded our Health Equity training initiatives by introducing complimentary training programs for legacy employees. This complements the mandatory completion of this training for all newly hired staff and includes updates to the Centene-hosted Cultural Competency training as well as the revised Social Determinants of Health (SDOH) training. Specific updates to the SDOH training emphasize the updated definitions of determinants versus drivers and their impact on the overall member experience.

While we have had a slow start to trainings this year, we are being thoughtful in our roll-out, while remaining responsive to federal and state mandates around health equity education. We do however still plan to hit our overall training goal for the year by years end. Furthermore, we continue to offer an expanded set of trainings to LHCC providers, covering topics such as Cultural Competency and trauma-informed care within the clinical setting, facilitated by our internal Centene Institute, as detailed in Table A3. A significant portion of our 2025 yearly training courses is scheduled for rollout in quarters 3 and 4.

**A1.2 Cultural Responsiveness and Implicit Bias Training** – As previously communicated, LHCC introduced annual cultural responsiveness and implicit bias training for both LHCC staff and Network Providers. In 2025 we plan to maintain the previously established methods of implementation, having implemented two intervention opportunities: during provider re-credentialing and annual compliance training. These training sessions are hosted through our Centene University platform as well as through our unique partnership with Trusted Provider Network (TPN). For LHCC Staff – we are confident that we will maintain our progress of achieving 95% participation among eligible staff and providers by December 2025. For detailed training records from January to May 2025, please refer to tables A1 and A2.

Through the MCO collaborative partnership with TPN, we continue to streamline training content and reporting, reducing completion attestation burdens for providers across multiple MCOs through a "no wrong door" approach. Continuing best practices established in 2024, the MCO's continue to meet in roundtable format to discuss modifications in approach and marketing of the "Advancing Wellness Together" training course to our provider networks. Meeting monthly, we review collective best practices, provider feedback, barriers to implementation and identify next steps. In addition to utilizing our medical directors as health

equity Champions to share the importance and availability of the Cultural Competency Trainings. Since the start of the partnership, LHCC has had 603 providers voluntarily register to complete the training. Figure A1 provides a breakdown of module offerings and statistics. Specific to this year, the MCO's will host two collaborative trainings, expanding on previous health equity training offerings.

**A1.3 Childhood Adversity and Trauma** – As previously highlighted, our strategy of conducting annual training for existing staff and providing onboarding sessions for new hires has resulted in the comprehensive training of most of our frontline staff on the critical aspects of Trauma-Informed Care. This includes understanding the profound effects of adverse childhood experiences on enrollees' interactions with the healthcare system. Detailed breakdowns of completed training from Q1 through Q2 of 2025 can be found in tables A1 and A2. We continue to outreach state resource programs to better understand additional opportunities for our Case management and Community Health Workers to receive full ACE certification. In collaboration with our community innovations team, we will be hosting an all day intensive on trauma informed care and how to embed best practices within our current community-based work.

### Focus Area (B): Social Determinants of Health

**B1.1 Community Resource List** –Over the past year and a half, we have achieved significant strides in operationalizing the LHCC-curated FindHelp portal. We have enhanced its functionality to allow separate assessment of its usage by the public and by our staff, enabling us to evaluate the impact of offering a searchable database of support services and community resources for enrollees. Enrollee-facing team members continue to be trained with fidelity on how to assess enrollee needs and input them into FindHelp to generate a list of relevant resources within their communities. In 2025, we introduced custom forms within the portal to capture key member data and track engagement more effectively. These forms are designed to streamline the data collection process, ensuring that all necessary information is gathered to provide comprehensive support to our enrollees. The custom forms also facilitate better tracking of the closed loop referral process, allowing us to monitor referral outcomes more accurately and improve our overall referral rates. Within the first two quarters of this year, 143 identifiable unique enrollees have utilized the service with another 1,676 anonymous users, requesting a total of 735 referrals in Q1 and 1,014 thus far in Q2, covering various needs like housing, food insecurity, new mother support, sober living arrangements, transportation for life events, and financial assistance. We are reinforcing the importance of reporting outcomes for these referrals, implementing closed loop referral improvements such as reducing double data-entry across tracking systems and having Findhelp serve as the source of truth. We are on target to maintain our achievement of 100% utilization of FindHelp by enrollee-facing staff, consistently reviewing new functionalities on the platform that will further aid in identifying and addressing enrollees' social determinants of health needs. For a summary of the most frequently requested services, refer to Table B1.

**B1.2 Sharing SDoH Needs with Network Providers** –During the first quarter and the beginning of the second quarter, our primary focus has been on refining our collection of Social Determinants of Health (SDoH) data from various systems. These systems include case management, call center data, and provider-level claims data. Our objective is to enhance the depth and relevance of our understanding of the health disparities experienced by our enrollees. By utilizing the Find Help tool and our updated Health Needs Assessment (HNA), we engage with our enrollees at two key interaction points to identify their needs. We ensure that all information gathered through any method is accessible to all team members interfacing with an enrollee.

Additionally, through our established Health Equity data universe/dashboard, we can assess the overall "NEST" scores of our members in relation to their communities by zip code, county, and region. The NEST score also helps us determine if our current data collection effectively measures social vulnerability.

Furthermore, we monitor completed assessments, and the number of referrals generated, while assessing our efficiency in closing the loop on these referrals. Looking ahead to December 2025, LHCC plans to onboard key community partners to Findhelp for seamless communication across programs on service level needs while linking with our TruCare Cloud case management platform. This integration aims to reduce the burden on providers and care managers in assessing and monitoring enrollees' SDoH needs for care plan development/integration, as well as improve communication with outside vendors/community organizations regarding member referrals. Additionally, we have created new resource cards with prioritized resources by geographic location for our case management and community health worker teams.

**B1.3 Reimbursing Network Providers -** Over the past two quarters, we have made significant progress in implementing our comprehensive data report that analyzes the intersection of Social Determinants of Health (SDoH) vulnerabilities identified in Health Needs Assessments (HNAs), resource assessments, and our proprietary tools. This report aids us in identifying potential gaps in preventive care services. One notable enhancement is the capability to compare health equity metrics of our value-based payment (VBP) providers with other primary care providers in our network. This comparison demonstrates that with appropriate management and support, there are opportunities for cost savings across the Emergency Department (ED) and inpatient settings. Although there has been limited sustained difference when comparing VBP to non-VBP providers, we are actively evaluating any potential barriers. Furthermore, we can now assess utilization metrics relative to access points across our network and collaborate effectively with community partners to address identified gaps. We are dedicated to using this data to pinpoint areas of greatest need and seek input from our Provider Advisory Council (PAC) for further refinement. At each PAC meeting, we now include a Health Equity corner where we update our provider champions on opportunities to enhance member experience or positively impact provider burden. Our objective remains to improve the integration of our provider network with our case management and community engagement teams.

Looking ahead, we continue to anticipate utilizing the state-developed dashboard to inform our strategic planning, particularly regarding standardized Z code usage reimbursements for our providers. We have also developed our own internal dashboard to investigate usage and opportunities to identify new or enhanced resources for our members based on the needs identified. These services are made available to our provider network through FindHelp.

**B1.4 Identifying SDoH needs for enrollees –** At the close of 2023, LHCC established official policies to enhance our resource assessment methods, aiming to better inform the services provided to enrollees and explore new potential partnerships. During quarters one and two of 2025, we have gathered referral assessment data from 1,749 enrollees. The primary areas of identified Social Determinants of Health (SDoH) needs include assistance with doula services, food insecurity, mental health support, housing, and transportation.

Our ongoing efforts include refining the referral process, and we are progressing well towards our overarching objective of developing, implementing, and leveraging data to effectively address enrollees' SDoH needs. As part of this strategy, we have integrated elements such as our Impact Pro score to assess social vulnerability across various care pathways. In doing so we were able to identify our top five areas of vulnerability for our membership, region specific to better tailor our programming and outreach throughout the year. This has

pushed us to develop a newly tailored health coaching program, re-training key community health workers across the state on how to better move our members toward health promoting behaviors. What we have learned is that Hypertension, Diabetes and cardiovascular health are of top priority, having more disparate affects in regions 1 and 9 (Table B3). We are continuing to work towards developing a searchable partner database that will help share more readily accessible information on the health of these partners when examined through an equity lens. This approach ensures that we not only meet but exceed the goals outlined for 2025.

### Focus Area (C): Community Approach

**C1.1 Neighborhood Health Equity (HE) Project –** The LHCC Community Innovations team has made significant progress in establishing relationships and partnerships with community entities statewide to better understand and meet the needs of our members and their surrounding communities. These efforts have improved collaboration with SWLA, reinforcing our position as a key resource and facilitator in identifying necessary resources and services in Lake Charles and Lafayette. Initially planned under HE 2023, the development of LHCC-specific Health Equity Neighborhoods has evolved leveraging existing coalitions and stakeholder groups that serve as forums for resource sharing, discussion of community concerns, and best practices. By aligning with these established coalitions and stakeholder groups, the aim is to optimize resource allocation for greater community impact. This collaborative approach improves the ability to assess health equity and identifies strategic opportunities for intervention. We have exemplified this through our equitable partnership programs, working with the universities to provide community supports through collaborative programing. Of note is our upcoming Super Saturday event with Delgado – City Park campus. Capitalizing on the opportunity of registration, we are inviting students and community members to bring their families out to engage around being healthy and whole. Delgado nursing students will provide on site screenings, the Fire Department and Police department will join to promote disaster preparedness, and DePaul Health Clinic will provide on site mental health supports. In addition to this work, we are also exploring ways to support Delgado's Single Stop center which provides additional SDOH supports to students in need. Due to funding cuts – they are in need of additional supports to keep the center staffed; therefore, we are exploring ways to stretch the dollar and ensure the sustainability of the center overall.

Through two active years of monitoring, we have noted no concerns of equitable distribution of redetermination and enrollee redistribution on access to appropriate care and services, however we continue to monitor passively internally.

**C1.2 Community Engagement Activities –** Throughout the year, LHCC has continued to host various community events and coalition meetings to continue to advance our health equity agenda, prioritizing active partnerships and improved outcomes. Events have included a community service effort at the Northshore Foodbank, an ACES presentation on trauma-informed care at North Oaks Medical Center, and a coalition meeting in Region 4 focused on healthy living and community resources. Events continue to be hosted equally across the state with intention of ensuring equitable access to programming and support services regardless of location. Our top 4 regions for programming thus far include regions 9 (53 partnered events), region 6 (41 events), region 2 (27 events) and region 8 (26 events). We continue to hold monthly Healthy Initiative coalition

meetings in each parish of region 6, uniting regional partners, local officials, and volunteers to address community needs. We continue to think creatively in our approach, utilizing school meetings with parents and teachers to explore Medicaid, Marketplace coverage, and health planning for the new year, while collaborative meetings with Bethlehem Baptist Church and other stakeholders are paving the way for future initiatives in region 9.

Educational programs include United Way NELA's *Read.Learn.Success* for literacy enhancement and presentations emphasizing positive role models. Workforce exploration events help guide students' career decisions, and CRC is part of the pre-K school system advisory council. Health-focused events feature resource fairs, maternal health summits, prenatal and post-partum education, breastfeeding support, mental health, and childhood obesity prevention. Planning collaborations involve Louisiana Healthcare Connections and OneBreathe.

Program of note includes "No One Eats Alone" Day in collaboration with Bricolage Academy in New Orleans, Oak Park Elementary in Lake Charles, Centene Foundation and the Beyond Differences organization. The goal of the program was to highlight the negative impacts of social isolation on overall health of students through peer-to-peer programming promoting connection and self-esteem in schools.

**C1.3 Community Wellness Centers -** LHCC is actively shaping the development of our Community Wellness Centers (CWCs) to tailor programming specifically for our enrollees and the broader community. Currently operational in Covington and Lafayette, these centers are pivotal venues for hosting scheduled events such as our member appreciation and advisory council meetings. They also offer enrollees the opportunity to meet with case managers to assess SDoH vulnerabilities and connect them with necessary resources. Community wellness across Louisiana has been advanced through a wide range of inclusive, culturally relevant events and initiatives designed to meet people where they are and connect them with the resources they need to thrive. From local health fairs, maternal health summits, and resource distributions to physical activity-based events like kite festivals and obstacle courses, wellness efforts have touched every age group and community. Programs such as *Well Women* events have empowered women statewide to prioritize their mental, physical, and emotional health, while events like community baby showers, autism awareness fairs, pediatric heart walks, and NICU family reunions have supported specific populations with tailored outreach. Youth wellness has been promoted through school-based mental health days, afterschool programs teaching healthy eating and social skills, and family-focused days filled with games, STEM activities, and nutrition demos. By providing preventive care services, behavioral health support, education, screenings, and engagement opportunities, these initiatives have helped reduce disparities and build a more connected, health-conscious Louisiana. Supported by organizations like Louisiana Healthcare Connections (LHCC), local leaders, and grassroots partners, community wellness efforts continue to foster healthier lifestyles, improve access to care, and strengthen the overall wellbeing of individuals and families across the state.

**C1.4 Community Partnership Expansion –** As previously shared, Louisiana Healthcare Connections has established a 1.5+ million-dollar program to eliminate health disparities and support pathways towards a more inclusive, representative healthcare system through workforce development. The "Equity in Health and Care initiative" includes community colleges and youth programs in both north and south Louisiana, focusing on diversity and inclusion in the healthcare workforce, as well as economic, and social determinants of health (SDOH). In the first two years, we established allied health scholarship programs with Bossier Parish Community College as well as Delgado Community college and begun exploring the creation of a Data Science

summer enrichment course for incoming first-year students as well as a research fellowship for staff. In year two we expanded this approach, strategically transitioning previous sponsored relationships into workforce and pipeline development initiatives. The core tenants of our program are as follows:

- Make scholarships available to the public with focus on providing opportunity to those with financial barriers especially those enrolled in Medicaid.
- LHCC members, employees seeking professional development and employees of in-network providers seeking to advance their skills are to receive preferential consideration.
- Develop a plan to recruit and market the partnership/program via community events, direct to member/student communication, university open houses, etc.
- Monitor and track student success as well as direct and in-direct impacts of the program.
- Identify and partner to provide resources for SDOH needs of students and community via on-site campus resource centers.

Summarized below are our efforts to date with each partner.

Bossier Parish community College:
In the first two years of implementation over 300 applications were received, of which 106 were qualified applicants. In year two, we have reached more members enrolled with LHCC Medicaid or another MCO. In total, 50 scholarships have been awarded to students across the allied health programs. Additional funds were allotted to cover the scholar's exam fees to ensure sustainability and continued progress, as well as course materials/supplies to support program sustainability. Just in the fall semester alone we have seen requests for scholarships double in 2025! With increased engagement we are exploring expansion to the Natchitoches Parish and Sabine Valley campuses.

To further demonstrate our commitment to workforce development we also hold a seat on BPCC Community impact board as well as the BPCC Foundation board.

Delgado Community College:

LHCC provides scholarships for allied health programming at Delgado which includes but is not limited to the Certified Nursing Assistance (CNA) program, Community Health Worker (CHW) Certification program as well as the Certified Clinical Medical Assistant (CCMA) program. The partnership began in late 2023 and the scholarships were administered at the start of the Spring 2024 Semester. To date, 35 students have been awarded scholarships. In addition to their program certifications, they are also covered to receive a certificate in Basic Life Support. Below are excerpts from students that have received scholarships at Delgado.

Within year three, we will also expand scholarship offerings to include Medical Billing and Coding Program as well as employ creative approaches to reach young parents in college as well as single parent households through their Single Stop Moms program. Unique to our partnership with Delgado, we are able to host community programming at the City Park Campus as well as the River Parishes campus expanding our reach and working to center the partnerships as community wellness hubs. In September 2024, we will work with Delgado to co-host a Super Saturday registration and health fair, mobilizing the allied health professional programs to deliver onsite services such as health screenings by the Nursing program. Additionally, we are pulling in additional community partners to provide a web of holistic services to both the LHCC and Delgado communities respectively.

Xavier University:

Different from the other University partners, we officially launched the research fellowship and pipeline programming with Xavier University in the latter half of Q2 2024. Within the first quarter we established application criteria and identified prioritized areas of focus. Applications were reviewed internally and awarded in Q3 of 2024. Under the leadership of Dr. Chamika Hawkins- Taylor, we currently offer 4 fellowships for faculty and student paired research teams in the amount of $16,250 each. The purpose of the research fellowships is to support the forward progress of research studies that examine the impacts of social drivers on the health of Louisianans. Specifically, the proposed studies must touch on one of LHCC's identified areas of concern which includes maternal health, the foster care landscape, Syphilis, and SDOH in Medicaid. Current fellowship research topics include but are not limited to; breast cancer and environmental stress, diabetes education and prevention within the New Orleans Hospitality Industry Workforce, as well as pharmacy led patient education on diabetes and hypertension during pregnancy.

In addition to the fellowships, LHCC funded the first Data Science and Informatics track within the Summer Start Institute (SSI) Program. This is a residential 5-week long intensive course that will expose incoming Xavier Freshman to majors and career tracks available to them and bridge content gaps to ensure they are prepared for success in their first year. The program will cover five key areas: (1) health outcomes, (2) education and equity education, (3) population health, (4) policy and advocacy, and (5) community health. This past summer, with the team at Xavier, we funded and informed the creation of the for underserved incoming first-year student. The program was able to sponsor 20 participants who end the summer with 2 college credits. The program was able to sponsor 20 participants who end the summer with 2 college credits.

We are also exploring additional partnerships with nursing programs across the state to support workforce advancement in addition to overall development. When planning for community engagement activities with these partners we are also creating apprenticeship opportunities for students to actively learn through community outreach, education and engagement. These sustained, cross-sector collaborations have expanded the reach and effectiveness of services, enhanced trust among community members, and built a stronger foundation for long-term public health improvements across the state.

## Focus Area (D): Inequities in Care

**D1.1 Improve Pregnancy and Birth Outcomes Addressing Inequities Experienced by Black Enrollees –**

LHCC continues to remain responsive to the needs of our members and communities through the changing political landscape and expectations around race, ethnicity and its intersection with health needs. Regardless of Race, Louisiana birthing individuals continue to face resounding disparities in care due to factors outside of their genetic make-up. With this in mind, LHCC is committed to providing equitable access to care and resources for all birthing individuals across the state. Our programs and resources continue to address gaps throughout the maternal health journey, more recently with a focus on post-partum care as well as recognizing the importance of individualized care teams that may or may not include a doula. Of note are two of our pilot programs that as of January 2025 have moved into full implementation across the state.

The Maternal Child Health Post-partum program, designed to increase postpartum engagement and care for birthing individuals, has successfully outreached our members at a 35% success rate and increased referrals for high-risk mitigation to case management. Since expansion Region six appears to be the most engaged/demonstrated need for post-partum care services and supports. While close to 80% have confirmed post partum appointments, confirmed attendance has not been as successful. Bi-weekly meetings are held to

discuss progress of this program and opportunities for improvement. To monitor and evaluate the effectiveness of these efforts, we developed a Power BI dashboard for tracking purposes (Figure D1). The dashboard allows us to peer into the finer details of the program and identify opportunities for improvement. For instance, we noticed that of those outreached, birthing individuals who delivered via cesarian section were more likely to confuse their wound care appointment as a post-partum visit and therefore less likely to attend the true postpartum follow-up appointment. In response to this our Clinical team developed educational materials to share with members and clarify this step in the member journey.

In addition to this we continue to monitor and evaluate our efforts with Mary's Hands to expand doula workforce opportunities and in turn, the availability of doula services to our membership. Initially started Quarter 4 of 2024 sponsoring the training of 19 doulas in the Lafayette, New Orleans, Baton Rouge and Covington areas. This funding also supports 12 previously trained doulas and planning for next training in Bossier/Shreveport area with our University partner BPCC. Overall, since the start of the program, MHN has received 59 applications from LHCC Members. Of those 25 have been actively engaged in care and services. Within the first four months of implementation, we worked with Mary's Hands to optimize overall referral process to include FindHelp. A half day interdisciplinary meeting was held to review successes to date as well as opportunities for growth and further optimization. We will formally evaluate initial program outcomes in July with an emphasis on assessing opportunity to combine the LHCC post-partum program with doula efforts. The next doula training will take place in September at Baton Rouge General.

**D1.2 Enrollee & Family Feedback to Identify & Execute Program Improvements –** We are continuing to approach the sourcing of feedback from enrollees and their families with a critical and creative mindset. Our strategy includes stratifying data at all levels by race, ethnicity, geographic region, gender, disability, and other disparities to identify gaps and areas for improvement in both programming and partnerships. Through the Health Equity Universe, we can assess these trends in real time, allowing us to be targeted in our response to member's needs. As previously shared, to enhance our impact, we have shifted our approach to leverage the unique platforms of established community coalitions. This shift has resulted in a significant increase in our presence, with more members attending events on average also increasing opportunities for direct impact. This expanded reach has enabled us to gather more extensive anecdotal and formal feedback from both plan enrollees and the broader community, thus we have established the **Member Feedback Project**— a comprehensive initiative under the Health Equity team at Louisiana Healthcare Connections. It is designed to centralize, track, and act on member feedback to improve program planning and service delivery. The core goal of the Member Feedback Project is to establish a **plan-wide process** for collecting, categorizing, and responding to member feedback. This initiative aims to:

- Improve existing programs and processes.
- Identify opportunities for new initiatives.
- Ensure feedback is actionable and leads to measurable improvements

Thus far a shared platform has been developed to house all member feedback, ensuring transparency and accessibility across all departments. Feedback is defined as "suggestions that can directly inform improvements in services, workflows, or member engagement strategies". Monthly check-ins and quarterly touchpoints are scheduled to ensure feedback is consistently logged, addressed and reported to the Health Equity Improvement Committee as well as considered during strategic planning sessions.

Moving forward, we will continue to utilize the data shared in section E1.2 to guide our efforts and address identified gaps. These achievements affirm that we are on track to successfully meet the goals outlined by December 2024, positioning us well for continued progress in advancing health equity across our member base and communities.

**D1.3 Decrease Disparities for Children & Adolescents –** We maintain our commitment to identifying valuable partners in meeting the needs of our adolescent members. From expanded foster care services to increased behavioral supports for autistic youth as well as partnerships with organizations like "Beyond Differences" – LHCC is committed to addressing key disparities affecting our membership. This collaboration includes coordinating with Head Start and Early Childhood Centers to conduct dental screenings and provide fluoride varnish treatments. Additionally we have bolstered our focus on Childhood obesity and as a result have held physical acidity focused events with six partner schools in the first half of the year.

Within our own staff, we have expanded our training initiatives focused on childhood trauma and adversity. These trainings aim to enhance understanding of how environmental factors and non-healthcare behaviors impact overall development. Specifically, this quarter we will host multiple in person half day training for front line staff with Shavon Chavis of Louisiana coalition of Domestic Violence on trauma informed care, how to properly assess for and address it. These efforts underscore our commitment to proactive healthcare strategies and enhancing outcomes for our enrollees, particularly in addressing childhood health needs and developmental influences.

**D1.4 Improve Well-Child Visits and Vaccination Rates**

We are well on our way to meeting our year-end goal of increasing compliance rates by 2%, as shown in Table D1. For 2024, we plan to identify key factors influencing compliance and non-compliance. Using Social Vulnerability Index data and insights from community partners, we aim to uncover more influences on children's outcomes. We host community events, providing childcare to keep adults engaged. These efforts enhance the member experience and foster valuable feedback. This year, we focus on the Foster Care Community with appreciation and educational events for caregivers and foster children. Our updated Foster Care dashboard helps understand this population's needs by tracking race, ethnicity, and location, although working with a notably smaller pool of members after the redistribution led by the State. By collaborating with community partners and school networks, we address vaccination and well-child visit inequities. Our year-end report will detail progress and expansion of these initiatives, reflecting our dedication to improving compliance rates and addressing disparities.

**D1.5 Improve Preventive Dental Services –** The deployment of mobile dental services has continued effectively, despite changes to the ILOS. Since dental services are only provided for pediatric members, the number of eligible and served members has decreased. In quarter 1, 125 FV were completed, including 42 LHCC members. A separate resource list specific to dental services has been created to ensure all dental resources for adult members are known and shared widely among the membership. Case managers and community health workers have been trained on the preferred resources for members. The main services targeted through outreach efforts include oral health screenings/cleanings and fluoride varnishing. Moving into the second half of the year, there will be further examination of the intersection of dental service needs, compliance rates, and SDoH factors to identify additional areas for intervention. The goal remains to achieve a 10% increase in oral screenings and a 0.5% increase in FVs by the end of the year which we expect to meet.

## Focus Area (E): Quality Improvement

**E1.1 Advancing health equity and enrollee outcomes through the use of CHW (Community Health Workers) and peer support specialists -** Our Community Health Workers (CHWs) play a crucial role in ensuring that our enrollees have equitable access to services, resources, and programs tailored to their needs. We have successfully trained our CHWs in Adverse Childhood Experiences (ACEs) education, marking the first step in establishing our internal train-the-trainer model. Upon completing their certifications in collaboration with OPH (Office of Public Health), our CHWs will be equipped to train staff, providers, and various community partners, fostering a trauma-informed system of care. Currently, ACE Certification Courses are not offered frequently throughout the year, making it increasingly difficult to offer this opportunity to more team members. We are hoping to work with the Office of Public Health to better understand how to get more of our CHWs trained. To continuously improve our programming and support services, we regularly convene Enrollee and Community Health Advisory meetings to gather feedback and measure satisfaction with our CHWs and peer support specialists. While we aim to expand our peer specialist team to support community engagement events and partner activities, current resource constraints prevent immediate expansion. In collaboration with PHCO (Population Health and Clinical Operations), our health equity team is exploring innovative approaches to overcome these challenges.

**E1.2 RELD (Race, Ethnicity, Language & Disability) and geographic data –** Through close collaboration with our data analytics team, we continue to optimize the LHCC Health Equity Universe reporting Dashboard. This dashboard is designed to provide detailed insights into the demographic breakdown of our enrollees, emphasizing our focus on Race, Ethnicity, Spoken Language, Region, Geography Type (rural vs. urban), as well as Zip Code and Parish filters. The implementation of this dashboard marked a crucial step in centralizing our data sources and establishing a unified source of truth. This advancement enables us to conduct more thorough analyses of disparity data and identify intersections among various demographic factors. By leveraging these improvements, we are better positioned to address health disparities effectively and enhance the overall quality of care for our enrollees. In year three we have optimized the dashboard to utilize real-time updates with optimized visuals to provide a clearer snapshot of the data without any manual input. Summarized below is a snapshot of our membership to date. Images of the newest iteration will be included in our Final Mid-year report.

**Enrollees:**

As shown in a static snapshot of our dashboard, our total number of Active enrollees at the time of this reporting was 389,362. Our plan enrollees are comprised of 48.7% African American, 35.3% White, 0.59% Asian, 0.63% American Indian or Alaskan Native and 0.01% Native Hawaiian or other Pacific Islander. Of those 389K enrollees, 4.4% Identify as Hispanic or Latino. Approximately5.93 % of enrollees' race remains unknown. 1323_____of our enrollees that provided no race detail identify as Hispanic (5.87___%). 28.5% of enrollees reside in Rural area vs. 70% residing in Urban areas [~1.7% unreported].

**Parish - Our top Parishes by number of active enrollees are:**

1. East Baton Rouge (8.01%)
2. Calcasieu (7.12%)
3. Jefferson (6.53%)

4. Orleans (6.38%)
5. Tangipahoa (5.54%)
6. Lafayette (5.20%)
7. Caddo (4.96%)
8. Ouachita (4.77%)
9. St. Tammany (3.82%)
10. Rapides (3.28%)

**Through further investigation we also see that the top 4-enrollee-dense zip codes for the top three parishes are…**

a. East Baton Rouge (8.01%)
    a. 70805 (3,983; 1.02%)
    b. 70816 (2,891; 0.74%)
    c. 70802 (2,689; 0.69%)
b. Calcasieu (7.12%)
    a. 70601 (5,651; 1.45%)
    b. 70607 (4,359; 1.12%)
    c. 70663 (3,918; 1.01%)
c. Jefferson (6.53%)
    a. 70072 (4,070; 1.05%)
    b. 70058 (3,275; 0.84%)
    c. 70056 (3,110; 0.80%)
d. Orleans (6.38%)
    a. 70126 (3,123; 0.80%)
    b. 70117 (2,888; 0.74%)
    c. 70127 (2,417; 0.62%)

We use this data to create feedback reports for each functional area providing up to date and real-time trend analysis, highlighting any potential areas for further evaluation or intervention. For example, our community Innovations team uses this data to inform where it's best to host specific events. By drilling down zip-codes on the foster care dashboard, we best identified where to host our foster care member appreciation event. As previously mentioned in our previous reports, Plan-Do-Study-Act (PDSA) and root cause analysis processes are used to remediate any noted areas for optimization.

To address the inclusion of disability data in our assessment of disparities across programs and services we are collaborating with our community partner, Split Second Foundation, and founder Mark Raymond Jr. to inform the best way to assess impact and thoughtfully interpret LHCC's limited disability data. We will also be working with Split Second to identify additional stakeholders within the community that can help inform the establishment of best practices around the colle4ction of this data moving forward. In Q1, we participated in a wheelchair washday where we connected with community members and gleaned feedback from them on ways LHCC can support our less-abled individuals.

## Cultural Responsiveness and Implicit Bias Training

**E1.3 CLAS (Cultural and Linguistic Appropriate Services) -** LHCC continues its steadfast commitment to addressing the cultural and linguistic needs of its enrollees and the broader community. Tables A1-3 document various training courses completed by providers and LHCC staff aimed at enhancing CLAS (Culturally and Linguistically Appropriate Services) to better meet the needs of our enrollees. Throughout quarter one and into Q2, we have conducted training sessions covering topics such as Cultural Competency, the impact of language on enrollees' experiences, and the intersection of Social Determinants of Health with mental health needs.

In Q1of 2025, LHCC's call center received 1,524 voice language utilization calls. A significant majority, 96%, requested Spanish language assistance, with smaller numbers requesting Vietnamese and Arabic support. One of the biggest impacts to LSA's metrics is their misalignment with contractual expectations, specifically if a health plan sends in a last minute's request (anything w/in 24hr of the appointment for spoken language and 48hr for ASL) and LSA (Language Service Associates) is not able to provide. LSA was placed on Notice to Cure to improve metrics for face-to-face and over-the-phone metrics. LSA has since remediated both channels. Aligning with expectations has dramatically improved LSA's scoring. These misses in face-to-face translation services were reflected in members reported grievances, however the issues were properly addressed with the provider and members affected.

Through LHCC Health Equity Committee meetings, we have collaboratively established a formal process for collecting enrollee feedback on CLAS standards. This structured approach allows us to incorporate valuable feedback into our programs and services effectively. Furthermore, efforts with our community advisory committee have solidified the identification of bilingual staff. We have identified five staff members who have passed the Bilingual Spanish/English Proficiency test, with three currently serving in enrollee-facing roles. As of Q2 one has left LHCC. These individuals can provide ad-hoc translation services when needed, offering continuity and support in communication efforts.

These initiatives underscore LHCC's ongoing commitment to enhancing cultural competency, improving language access, and ensuring that our services are responsive to the diverse needs of our enrollees and communities.

**Tables:**

**Table A1. Provider and Legacy LHCC Staff Health Equity trainings completed in Q1 – Q2 (April) 2025**

| Training Title | Audience | Number of Attendees | Length of Training | Training Format |
|---|---|---|---|---|
| Provider Cultural Competency: Connecting Across Barriers and Language Identification Tool | Provider/ Provider Staff | 15 | Varies | Live - Provider Visits |
| Provider Cultural Competency: Connecting Across Barriers and Language Identification Tool | Provider/ Provider Staff | 51 | Varies | Live -Provider Orientation |
| TPN Hosted: Advancing Wellness Together | Provider/ Provider Staff | 603 | 2.5 hours | Live/On Demand |
| | | | | |
| Culturally and Linguistically Appropriate Services (CLAS) | LHCC Staff | *To be assigned in Q3* | 1 hour | eLearning |
| LA Cultural Humility: Building Upon the Foundation of Cultural Competency | Provider/ Provider Staff | 36 | 2.5 hours | Live |
| Centene: Cultural Humility & Health Equity | LHCC Staff | *To be assigned in Q3 2025* | 30 min | eLearning |
| Impacting Social Drivers and Determinants of Health in Healthcare | LHCC Staff | 433/438 (99%) | 30 min | eLearning |

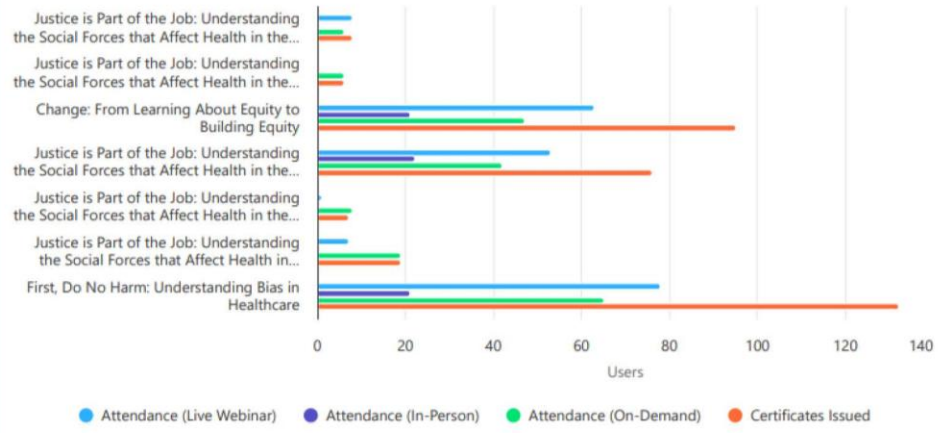
**Table A2. New Hire Trainings Assigned Q1 – May Q2 2025**

| Trainings | Quarter 1 *(LHCC new hires completed/assigned)* | Quarter 2 *(LHCC new hires completed/assigned as of May)* | Quarter 3 *(LHCC new hires completed/assigned)* | Quarter 4 *(LHCC new hires completed/assigned)* |
|---|---|---|---|---|
| Culturally and Linguistically Appropriate Services (CLAS) | 19/23 (82%) | 4/6 (67%& | | |
| Centene: Cultural Humility & Health Equity | 24/28 (86%) | 8/10 (80%) | | |
| Trauma Informed Care (with ACEs) - Live | 21/25 (84%) | 4/10 (40%) | | |
| Impacting Social Drivers and Determinants of Health in Healthcare | - | - | | |

**Table A3. Additional Provider Trainings hosted in Q1 - May Q2 2025 with CEUs**

| Provider training Topics | Total # of Attendees |
|---|---|
| Adverse Childhood Experiences - The Study and Beyond | *29* |
| Ethics for Mental Health Professionals | *3* |
| LA-Person Centered Planning The 4Ps | *14* |
| Lesbian Gay Bisexual Transgender Queer Questioning Intersex Asexual Ally | *11* |
| Poverty Competency | *4* |
| Resiliency and Recovery | *6* |
| Trauma Informed Care - Trauma Across the Life Span | *17* |

**Figure A1. MCO Collaborative – Advancing Wellness Together Session breakdown for LHCC Providers**




*This graph shows the breakdown of the three sessions offered within the Advancing Wellness Together Training along with attendance records by virtual, in person or on demand and resulted in an earned credit of completion.*

| Table B1. Most frequently offered Support Services in response to SDoH needs indicated through FindHelp – Top 20 (Q1- Q2 2025) | | | |
|---|---|---|---|
| **Organization Name** | **Program Type** | **Number of Enrollee Interactions** | **Number of Connections** |
| Mary's Hands Network | Doula Services | 154 | 93 |
| Louisiana Housing Corporation (LHC) | Low Income Home Energy Assistance Program (LIHEAP) | 345 | 84 |
| Lasagna Love | Once a Month Volunteer Prepared Meal Delivery | 50 | 56 |
| mRelief | SNAP (Food Stamps) Assistance | 40 | 46 |
| Catholic Charities of North Louisiana | Emergency Rent and Utilities Assistance | 97 | 38 |
| AirTalk Wireless | Lifeline Program - FREE Data, Unlimited Talk & Text Monthly Phone Service | 36 | 36 |
| Vital Options International (VOI) | Selma Schimmel Vital Grant | 39 | 33 |
| Free Formula Exchange | Formula Assistance | 36 | 33 |
| Southwest Louisiana Electric Membership Corporation (SLEMCO) | Utility Assistance Program | 21 | 31 |
| Our Daily Bread Food Bank | Food Assistance | 21 | 30 |
| Louisiana Department of Children and Family Services (DCFS) | Louisiana Supplemental Nutrition Assistance Program (SNAP) | 34 | 28 |
| Louisiana Dental Center | Dental Services | 33 | 27 |
| Operation Homefront | Critical Financial Assistance | 31 | 26 |
| Blue Runner Foods | Blue Runner Foods | 77 | 25 |
| Catholic Charities of Acadiana (CCA) | Lafayette Emergency Assistance Program (LEAP) | 22 | 23 |
| Stand Up Wireless | StandUp Lifeline Wireless | 22 | 23 |
| The Salvation Army of NWLA (Shreveport) | Gas and Rent Financial Assistance | 36 | 22 |
| Quad-Area Community Action Agency | EF&S Program | 47 | 21 |
| Patient Advocate Foundation (PAF) | Begin Again Foundation Financial Aid Fund | 33 | 21 |
| Calcasieu Parish Police Jury's Human Services Department | Low Income Home Energy Assistance Program (LIHEAP) | 19 | 21 |

| Table B2. Community Engagement Activities July – December 2024 | | | | | | |
|---|---|---|---|---|---|---|
| **Name of Event** | **Event Date** | **Parish** | **Region** | **City** | **Partner Organization** | **Event Description** |
| Northshore Foodbank Truck Deliver/ Food Pick Up | 1/6/2025 | St. Tammany Parish | 9 | Covington | Sarah Herndon / Northshore Food Bank | Holiday Volunteer Food Pick Up and Delivery. |
| ACES Presentation Intro to Trauma - Informed Care Module | 1/7/2025 | Tangipahoa Parish | 9 | Hammond | Jason Fontenelle / North Oaks Medical Center | ACES Presentation for North Oaks Medical Center on Intro to Trauma Informed Care. |
| Healthy Acadia Alliance Monthly Meeting | 1/7/2025 | Acadiana | 4 | Lafayette | Healthy Acadia Alliance | A coalition meeting to discuss healthy living and resources in region 4 community. |
| Vernon Parish Healthy Initiatives Coalition | 1/7/2025 | Vernon | 6 | Leesville | Vernon Healthy Initiatives Coalition | Region 6 hosts a collective of Healthy Initiatives coalitions that meet once a month in each parish of this region. Each meeting brings together regional partners, local governing entities, and community-based partners/volunteers who come together to help assist one another in the needs of the community. |
| Regina Coeli Parent Meeting / New Year Health Day | 1/8/2025 | Tangipahoa Parish | 9 | Robert | Greta Williams | Event / Meeting with Parents and Teachers on Medicaid / Market Place/ Health for the New Year |
| Morehouse Parish Healthy Communities Coalition | 1/8/2025 | Morehouse | 8 | Bastrop, LA | LSUAg | Healthy Communities Coalition Meeting |
| United Way RLS Reading Day | 1/8/2025 | Ouachita Parish | 8 | Monroe, LA | United Way of Northeast Louisiana | Read.Learn.Success is a United Way NELA community initiative aimed at helping 2nd and 3rd graders improve their reading and writing skills. This initiative partners trained volunteers with students in 20 local schools to enhance their literacy skills. |
| St. Martin RSN Advisory Council Meeting | 1/9/2025 | St. Martin | 4 | St. Martin | St. Martin Parish School Board | CRC is a member on the advisory council concerning the pre-k school system. |
| Community Meeting | 1/10/2025 | Orleans | 1 | New Orleans | LACHON | Monthly community meeting for vendors to share resources/upcoming events. |
| St. Tammany Commission on Families Board of Directors and Coalition Meeting | 1/14/2025 | St. Tammany Parish | 9 | Mandeville | Liz Garland / St. Tammany Commission on Families | Meeting organized with social organizations, vendors, community leaders to plan and discuss future events for local and surrounding communities . |
| Healthcare/Behavioral Health Workgroup Meeting | 1/14/2025 | Terrebonne | 3 | Gary, la. | Sherri Whitmore | Community meeting to share resources. |
| Grant Parish Healthy Initiatives Coalition Zoom Meeting | 1/14/2025 | Grant | 6 | Colfax | Louisiana Healthcare Connections | Grant Parish Healthy Initiatives Coalition Monthly Community Discussion Meeting |
| Beyond the Bell Appreciation Day | 1/15/2025 | Lafourche | 3 | Thibodaux | Heather Bonit | A luncheon to show appreciation for a 10-year milestone of serving the community. |
| Winn Healthy Initiatives Coalition | 1/15/2025 | Winn | 6 | Winnfield, LA | Winn Healthy Initiatives Coalition | Winn Healthy Initiatives Coalition Community Monthly Meeting |
| Shatter The Silence | 1/15/2025 | Orleans | 1 | New Orleans | Pat Davis | An eye-opening event featuring expert speaker regarding human trafficking. |
| Rapides Healthy Initiative Coalition | 1/16/2025 | Rapides | 6 | Alexandria, LA | Rapides HIC | Rapides Healthy Initiative Coalition Community Meeting |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Collaborative Meeting Bethlehem Baptist Church** | 1/16/2025 | Livingston Parish | 9 | Albany | Anna Peeler / Bethlehem Baptist Church | Collaborative Meeting with Bethlehem Baptist Church to plan future events for Livingston Parishes in Region 9. |
| **LaSalle Parish Parent Expo.** | 1/16/2025 | LaSalle | 6 | Jena, LA | Stephanie Francis LaSalle Parish Media Center, Homeless Liaison | ***This is a family event where we offer resources to help families.*** |
| **Union Parish Community Outreach Meeting** | 1/17/2025 | Union | 8 | Farmerville, LA | Union Parish Community Outreach | Union Parish Community Outreach Monthly meeting |
| **TRACC / Tangipahoa Reshaping Attitudes for Community Change Coalition Meeting** | 1/17/2025 | Tangipahoa Parish | 9 | Hammond | Taylor Addison / TRACC | Meeting organized with social organizations, vendors, community leaders to plan and discuss future events for local and surrounding communities |
| **NWLA Re-entry Coaltion** | 1/21/2025 | Bossier City | 7 | Shreveport | NWLA Re-entry Coalition | A coalition that assist people who have been incarcerated and needs assistance to re-enter in the community. |
| **Big Brother Big Sister Zoom meeting** | 1/22/2025 | Orleans | 1 | New Orleans | Big Brother Big Sister | Virtual partner summit. |
| **Network of Women NOW Empowered Hygiene Event** | 1/23/2025 | East Baton Rouge Parish | 2 | Baton Rouge | Network of Women Now | Wellness and Health event that aims to inspire teens to take ownership of their personal hygiene and practice healthy habits. There will be vendors, community leaders, resources and social organizations with educational material and health screenings. |
| **Maternal Health Summit** | 1/24/2025 | Rapides | 6 | Alexandria | CenLA Healthy Start Program | Maternal Health Summit is open to providers, partners, and individuals who aim to improve maternal health in Region 6. An engaging day of education and networking with Central Louisiana's leading healthcare professionals. Together, let's focus on supporting maternal health in our community. |
| **Abraham's Tent** | 1/27/2025 | Calcasieu | 5 | Lake Charles | Abraham's Tent | CRC volunteer serving food and packaging non-perishable items for the community. |
| **Washington Parish Community Coalition** | 1/28/2025 | Washington Parish | 9 | Bogalusa | Rhonda Gunnell/ Washington Parish Community Coalition | Meeting organized with social organizations, vendors, community leaders to plan and discuss future events for local and surrounding communities |
| **LaSalle Parish's HIC Meeting** | 1/28/2025 | LaSalle | 6 | Jena | LaSalle HIC | Monthly LaSalle HIC |
| **Healing Hearts Health Resource Fair** | 2/1/2025 | Tangipahoa Parish | 9 | Hammond | Delta Sigma Theta Sorority / Tangipahoa African American Heritage Museum | Health and Resource Fair with Screenings, Community Leaders, Social Organizations, resources for local and surrounding communities. |
| **T.A.S.T.E Community Volunteer** | 2/3/2025 | Avoyelles | 6 | Marksville | Saint John Church | Assist with Community Feeding |
| **Burgers After the Bell Appreciation Luncheon** | 2/4/2025 | Lafourche | 3 | Thibodaux | Heather Benoit | A appreciation luncheon for collaborations that give ongoing support to the program |
| **Vernon Healthy Initiatives Coalition Meeting** | 2/4/2025 | Vernon | 6 | Leesville | Vernon Parish HIC | *Vernon Parish Healthy Initiatives Coalition* Monthly Meeting |
| **One Breathe Coalition Meeting** | 2/4/2025 | East Baton Rouge | 2 | Baton Rouge | Louisiana Healthcare Connections | Collaboration Meeting between Louisiana Healthcare Connections and OneBreathe to plan future events for 2025. |
| **Covington Regina Coeli Head Start School Male Involvement Event** | 2/5/2025 | ST. Tammany Parish | N/A | Covington | Wendy Burton / Covington Regina Coeli Head Start School | Presentation / Meeting with students / children and their Father's on the Importance of being involved in your child's life. (ROLE MODEL) |
| **Salute to Service** | 2/5/2025 | Orleans | 1 | New Orleans | Centene Corp, Pro Football Hall of Fame, Big Brother Big Sister | A planning meeting to finalize plans for Salute to Service. |
| **DC Reeve Student Career Fair** | 2/7/2025 | Tangipahoa | 9 | Ponchatoula | DC Reeves | Students are encouraged to visit each partner represented to find out more about their occupation to help determine their course of a career |
| **Doula Networking Night** | 2/7/2025 | East Baton Rouge | 2 | Baton Rouge | Mary Hands Network | Education onbreastfeeding support, common challenges, and how to help moms.This is a great opportunity to unwind, share experiences, and learn from each other. |
| **Village Of Sicily Island Celebrating Black Health and Wellness** | 2/8/2025 | Catahoula Parish | 6 | Sicily Island | Michelle Brown | Health and Wellness Paying tribute to all African American healthcare workers. |
| **Northshore Food Bank Food Boxes for Families / Volunteer Work** | 2/10/2025 | St. Tammany Parish | 9 | Covington | Sarah Herndon / Northshore Food Bank | Volunteer Work |
| **Family and Child Welfare Workgroup** | 2/10/2025 | Terrebonne | 3 | Houma | Goodwill Ind. | Meeting to share resources and plan upcoming community events for region 3. |
| **TRACC Community Events Committee** | 2/10/2025 | Tangipahoa Parish | 9 | Hammond | Tangipahoa Reshaping Attitudes for Community Change | Meeting organized with social organizations, vendors, community leaders to plan and discuss future events for local and surrounding communities . |
| **Membership Meeting** | 2/10/2025 | West Feliciana | 2 | Saint Francisville | Happi LLanders | Membership Meeting |
| **St. Tammany Commission on Families Board of Directors and Coalition Meeting** | 2/11/2025 | ST. Tammany Parish | 9 | Mandeville | Liz Garland / St. Tammany Commission on Families | Meeting organized with social organizations, vendors, community leaders to plan and discuss future events for local and surrounding communities . |
| **North Central LA Coalition Monthly Meeting** | 2/11/2025 | Natchitoches | 7 | Natchitoches | NCLA Coalition | A coalition meeting with different partnerships that serves the community to provide resources, education and all types of information to assist whatever they may need. |
| **Training: High Functioning Depression In African American Women** | 2/11/2025 | Grant | 6 | Colfax | Region 6 Healthy Initiatives Coalitions | A Community Training on High Functioning Depression in African American Women offer by Central Louisiana Human Service District partnering with Region 6 Healthy initiatives |
| **No One Eats Alone** | 2/12/2025 | Calcasieu | 5 | Lake Charles | Evelyn Foster | No One Eats Alone program to combat social isolation. Program is being lead by Centene Corp., in partnership w/ Community Innovations, Government Affairs and the D.E.I. council. |
| **Morehouse Parish Coalition Meeting** | 2/12/2025 | Morehouse | 8 | Bastrop | LSUAg Center | Morehouse Parish Coalition Meeting February 2025 |
| **Ambetter MAG Meeting** | 2/13/2025 | East Baton Rouge | 2 | Baton Rouge | Ambetter | Ambetter MAG meeting sets an environment to hear from members and receive feedback on what is working well and what opportunities we have. CI will be present to discuss and answer questions regarding Medicaid. |

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| **Ambetter MAG Meeting** | 2/13/2025 | East Baton Rouge Parish | 2 | Baton Rouge | Patrika Cassie / Ambetter | MAG Ambetter Meeting with Community Leaders, Social Organizations and Resources comming together to plan future events for local and surrounding communities |
| **Central Tangipahoa Head Start School Winter Celebration Resource Event** | 2/13/2025 | Tangipahoa Parish | 9 | Independence | Carolyn Winebrener/ Central Tangipahoa Head Start School | Winter Celebration / Resource Event for students, families, local community members and surrounding communities. |
| **PARD (Ponchatoula Area Recreation District) Community Valentine's Social** | 2/14/2025 | Tangipahoa Parish | 9 | Ponchatoula | Christa Stewart / PARD | Health and Wellness Community Social with resource agencies, social organizations, community leaders for local community and surrounding communities . |
| **No One Eats Alone** | 2/14/2025 | Orleans | 1 | New Orleans, La. | Evelyn Foster | No One Eats Alone program to combat social isolation. Program is being lead by Centene Corp., in partnership with Community Innovations, Government Affairs and the D.E.I. council. |
| **Walk with a Purpose** | 2/15/2025 | Calcasieu | 5 | Lake Charles | Zeta Phi Beta Sorority, Inc, SWLA Center for Health Services | A pediatric heart awareness walk benefit event to support the Pediatric Cardiology of SWLA. |
| **JiggAerobics: Geo Prep Baker** | 2/17/2025 | East Baton Rouge | 2 | Baker | LHCC | Childhood obesity initiative promoting healthy habits, physical activity and more. |
| **Livingston Council on Aging and Meal Site Presentation on Cold Weather Safety** | 2/18/2025 | Livingston Parish | 9 | Denham Springs | Sheri Gill / Livingston Council on Aging | Volunteer Presentation on Cold Weather Safety |
| **Avoyelles Community and Youth Coalition Meeting** | 2/18/2025 | Avoyelles | 6 | Marksville | Avoyelles Community and Youth Coalition | Monthly ACYC Coalition meeting |
| **St. Tammany Parish School Board Krewe Du Kidz Resource Fair for Parents** | 2/18/2025 | St. Tammany Parish | 9 | Mandeville | Shelly Morris / St. Tammany Parish Public School System | Health and Resource event with screening, social organizations, community leaders, activities for Parents / Guardians, families and community members . |
| **Celebrating Our VIPs** | 2/19/2025 | Calcasieu | 5 | Lake Charles | Calcasieu Parish School Board | A "Partners in Education" brunch to celebrate all the very important community partners that offer support to the schools in region 5. |
| **Northeast Louisiana Recovery Coalition Meeting** | 2/19/2025 | Ouachita Parish | 8 | Monroe | Northeast Louisiana Recovery Coalition | NELRC Monthly Meeting |
| **Community Baby Shower** | 2/19/2025 | St. Landry | 4 | Eunice | St. Landry-Evangeline & Save the Children Head Start | A community baby shower to educate the community on the maternal child health discussions to help prenatal and post-partum mothers and their babies.<br><br>In-kind donations: baby car seat and gift baskets. |
| **Greater Baton Rouge Community Consortium** | 2/20/2025 | East Baton Rouge Parish | 2 | Baton Rouge | Levyette Matthews / Family Road of Greater Baton Rouge | Collaborative meeting with resource agencies, social organizations, community leaders to plan future events for the local and surrounding communities . |
| **Alidore Ambassadors** | 2/20/2025 | Lafourche | 3 | Raceland, La. | Heather Benoit | Community meeting various collaborations to share community resources. |
| **Cenla Vaping Town Hall** | 2/20/2025 | Rapides | 6 | Alexandria | Tobacco-Free Living | Central Louisiana Vaping Town hall |

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| Kiwanis Club of Livingston Parish | 2/20/2025 | Livingston Parish | 9 | Denham Springs | Larry Davis / Kiwanis Club of Livingston Parish | Collaborative Meeting with Community Leaders, Resource agencies, social organizations to come together to plan future events for the local community and surrounding communities. |
| JiggAerobics: Opelousas High School | 2/20/2025 | Opelousas | 4 | Opelousas | Jiggaerobics / LHCC | Childhood obesity initiative promoting healthy habits physical activity and more. |
| Union Parish Community Meeting | 2/21/2025 | Union | 8 | Marion | Union Parish Community Outreach | Union Parish Community Outreach Team Meeting |
| JiggAerobics: Carencro High School | 2/21/2025 | Acadiana | 4 | Lafayette | LHCC | Childhood obesity initiative promoting healthy habits, physical activity and more. |
| TRACC / Tangipahoa Reshaping Attitudes for Community Change | 2/21/2025 | Tangipahoa Parish | 9 | Hammond | Taylor Addison / TRACC / Tangipahoa Reshaping Attitudes for Community Change | Meeting organized with social organizations, vendors, community leaders to plan and discuss future events for local and surrounding communities . |
| Mardi Gras In the Zone Event / Hammond Mardi Gras Parade | 2/21/2025 | Tangipahoa Parish | 9 | Hammond | Taylor Addison / TRACC and Southeastern Louisiana University | Mardi Gras Event with education, resources, games, screening for families, local community and surrounding community members. |
| JiggAerobics Robinson Elementary | 2/24/2025 | Ouachita | 8 | Monroe | LHCC | Childhood obesity initiative promoting healthy habits, physical activity and more. |
| Washington Parish Coalition Meeting | 2/25/2025 | Washington Parish | 9 | Bogalusa | Rhonda Gunnell / Washington Parish Coalition | Meeting organized with social organizations, vendors, community leaders to plan and discuss future events for local and surrounding communities . |
| LA40BY2030 | 2/25/2025 | Concordia | 6 | Vidalia | Louisiana Health Equity | A tour that brings together community members, state and local officials, community-based organizations, providers, health professionals, and more to foster meaningful dialogue and gather valuable insights about health and healthcare in your area. |
| JiggAerobics Richwood Middle | 2/25/2025 | Ouachita | 8 | Monroe | LHCC | Childhood obesity initiative promoting healthy habits, physical activity and more. |
| Service Members, Veterans and Their Families Community Resource Fair | 2/26/2025 | East Baton Rouge Parish | 2 | Baton Rouge | Letosha Kelly / East Baton Rouge Library | Free Event with education, resources for current military members, veterans, their families, local community and surrounding community members. |
| JiggAerobics: Crawford Elementary School | 2/26/2025 | Arcadia | 7 | Arcadia | JiggAerobics / LHCC | Childhood obesity initiative promoting healthy habits physical activity and more. |
| Network of Women Now/ Empowered Hygiene for Boys | 2/26/2025 | East Baton Rouge Parish | 2 | Baton Rouge | Dedra Mollimore / Network of Women Now | Wellness and Health event that aims to inspire teens (boys) to take ownership of their personal hygiene and practice healthy habits. There will be vendors, community leaders, resources and social organizations with educational material and health screenings. |
| CAN Meeting | 2/27/2025 | Orleans | 1 | Harvey | Crescent Family Services | Community meeting for vendors to share community resources. |
| 225 Fest | 3/1/2025 | East Baton Rouge | 2 | Baton Rouge | 225 FEST | Community celebration of Baton Rouge culture, emerged from the annual 225Day, a social media phenomenon that celebrated the food, music, memes, and memories associated with the iconic Baton Rouge area code, 225. |

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| Community Baby Shower | 3/5/2025 | Calcasieu | 5 | Lake Charles | Zeta Phi Beta Sorority, Inc | A community baby shower to offer resources for expectant mothers. |
| United Way READ.LEARN.SUCCEED. | 3/5/2025 | Ouachita Parish | 8 | Monroe | United Way | United way Read Learn Succeed Program to assist Elementary students with reading and understanding. |
| Catahoula Parish Healthy Initiatives Coalition Meeting | 3/6/2025 | LaSalle | 6 | Harrisonburg | Catahoula Parish Healthy Initiatives Coalition | Coalition Monthly meeting and Training on Healing Through Faith: Integrating Spiritualityin Addiction Recovery<br><br>Postponed 2/27.. New Date is 3/6. |
| MAC Meeting | 3/6/2025 | N/A | N/A | N/A | Louisiana Healthcare Connections | Member Advisory Council (MAC) meetings are designed to capture member feedback, questions, and concerns. |
| Cenla KidzFest 2025 | 3/8/2025 | Rapides | 6 | Alexandria | Junior League of Alexandria | The Junior League of Alexandria hosts this annual event to make lifestyle education enjoyable for kids and their parents. Kids are invited to visit booths that focus on health, safety, and life skills. While all booths offer valuable advice and education, some provide an exciting opportunity to win prizes and giveaways. |
| Goodwill Meeting | 3/10/2025 | Terrebonne | 3 | Gray, La. | Sherri Whilmore | Meeting for venders to share community resources. |
| Region 8 Community Outreach Team Meeting | 3/10/2025 | Ouachita | 8 | Monroe | Region 8 Community Outreach Team | Region 8 Community Meeting |
| St. Tammany Commission on Families Board of Directors and Coalition Meeting | 3/11/2025 | St. Tammany Parish | 9 | Mandeville | Liz Garland / St. Tammany Commission on Families | Meeting organized with social organizations, vendors, community leaders to plan and discuss future events for local and surrounding communities . |
| NCLA Reentry Coalition Meeting | 3/11/2025 | Natchitoches | 7 | Via Zoom | Goodwill NLA | Coalition meeting to discuss the community needs and resources that different partners can offer. |
| 2nd Annual Iberia Parish Schools Parental Resource Fair | 3/11/2025 | Iberia Parish | 4 | New Iberia | Gifting Move Grace Project, Inc | A resource fair to educate and support the Iberia parish families in transition/homelessness. |
| Grant Parish Healthy Initiatives Coalition | 3/11/2025 | Grant | 6 | 71417 | Grant Parish Healthy Initiatives Coalition | Grant Parish Healthy Initiatives Coalition Monthly meeting |
| Choices Coordinated Care Solutions Training (Hosted by LHCC) | 3/12/2025 | St. Tammany Parish | 9 | Covington | Linda Cuccia / Choices Coordinated Care Solutions | LHCC is hosting Choices Coordinated Care Solutions for a Training at The Community Wellness Center in Covington, LA. |
| West Feliciana Prevention Coalition Meeting | 3/12/2025 | West Feliciana Parish | 2 | St. Francisville | Hazel Knighten / West Feliciana Prevention Coalition | Meeting organized with social organizations, vendors, community leaders to plan and discuss future events for local and surrounding communities . |
| Infant Empowerment | 3/12/2025 | Orleans | 1 | New Orleans, La. | Stephenie Marshall | Education regarding the pump act, food insecurity and maternal mental health. A featured panel will provide action items designed to help advocate for Women's overall health. |
| Richwood Health & Resource Fair | 3/12/2025 | Ouachita | 8 | Richwood | Town of Richwood | Health and Resource Fair for the town of Richwood |
| LaPRI 1ST Quarter 2025 Coalition Meeting | 3/13/2025 | Rapides | 6 | Alexandria | LaPRI Louisiana Prisoner Reentry Initiative | Louisiana Prisoner Reentry Initiative first Quarterly in Person Meeting |
| Faith House Shelter Shower | 3/14/2025 | Avoyelles | 6 | Mansura | Faith House domestic violence crisis center | Faith House is preparing to open our CENLA shelter. Community partners are asked to assist with stocking and collecting essential supplies. This will be a donation Drop-Off shower from 0900-1500. |
| 2025 Healthy You at the Zoo | 3/15/2025 | Rapides | 6 | Alexandria | LSUAG Center | The Alexandria Zoo and the LSU AgCenter are teaming up again for our 3rd annual "Healthy You at the Zoo" health fair. Invited as ahealth and wellness exhibitor to provide resources for our CENLA clients |
| NAUW Health & Resource Fair | 3/15/2025 | Acadiana | 4 | Lafayette | National Association of University Women, Inc | An annual health and resource fair to promote and conduct educational activities designed to provide community outreach services. |
| Black Family Wellness Expo | 3/15/2025 | Orleans | 1 | New Orleans | Tanzel Montgomery | An Expo to display Black Family Wellness and resources to the community |
| NWLA Reentry Coalition | 3/18/2025 | Bossier City | 7 | Shreveport | Goodwill Industries of North Louisiana | A reentry coalition meeting discuss resources and partnership events held within the area to assist the community. |
| Sickle Cell Support Group | 3/18/2025 | Rapides | 6 | Alexandria | Sickle Cell Resource Foundation | Sickle Cell Support group where sickle cell warriors will learn about Gene Therapy as well as LHCC benefits. |
| 2025 SWLA Leadership Breakfast | 3/20/2025 | Calcasieu | 5 | Lake Charles | American Cancer Society | Annual American Cancer Society leadership breakfast to spotlight recent successes from the community champions and fundraisers, celebrates cancer survivors and caregivers, share the mission impact of the ACS in region 5. |
| Annual Region 9 LHCC Community Baby Shower | 3/20/2025 | Livingston Parish | 9 | Albany | Louisiana Healthcare Connections | Annual LHCC Region 9 Community Baby Shower with vendors, resource agencies, social organizations and Bethlehem Baptist Church with education, information , food, drink for local community and surrounding community members. |
| Get Down with the Low Down" Education Event | 3/21/2025 | Rapides | 6 | Pineville, LA | Timmy's Toys | Education event for familiesabout child related experiences of developmental milestones, feeding issues or reflux, teething vs. illness |
| TRACC/ Tangipahoa Reshaping Attitudes for Community Change Coalition | 3/21/2025 | Tangipahoa Parish | 9 | Hammond | Taylor Addison / TRACC | Meeting organized with social organizations, vendors, community leaders to plan and discuss future events for local and surrounding communities. |
| Well- Ahead Louisiana Public Health and Community Wellness Fair | 3/22/2025 | East Baton Rouge Parish | 2 | Baton Rouge | Keshia Roberson / Well-Ahead and Southern University | Health and Wellness Event with Community Leaders, resource agencies, social organizations with information and education for local / surrounding community members. |
| "One Stop Pop up Shop" Bridging Health & Community Together | 3/22/2025 | St. Martinville | 4 | St. Martinville | Delta Sigma Theta Sorority, Inc | A community health fair, featuring a One Stop Shop where health fair meets community resources to better serve the community. |
| Let's Talk About Resources | 3/22/2025 | New Iberia | 4 | New Iberia | Community Youth & Media | A health fair that meets community resources to better serve our community for housing information, mental & behavioral health, medical information, insurance and justice bus. |
| T.A.S.T.E. | 3/24/2025 | Avoyelles | 6 | Marksville | TASTE | Volunteer to assist with serving food to the community |

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| **Washington Parish Coalition Meeting** | 3/25/2025 | Washington Parish | 9 | Bogalusa | Cheryl Burton / Washington Parish Coalition | Meeting organized with social organizations, vendors, community leaders to plan and discuss future events for local and surrounding communities . |
| **Northshore Technical Community College Health Awareness Event** | 3/25/2025 | Washington Parish | 9 | Bogalusa | Remy Williams / Northshore Technical Community College | Health Awareness Event for Northshore Technical Community College students, teachers and community members with social organizations, resources and local community vendors with education and information . |
| **Northeast Louisiana Recovery Meeting** | 3/25/2025 | Ouachita Parish | 8 | Monroe | Northeast Louisiana Recovery | Northeast Louisiana Recovery Meeting |
| **Lake Charles Foster Care Appreciation** | 3/25/2025 | Calcasieu | 5 | Lake Charles | Louisiana Health Care Connections | A event to show appreciation to the families that foster children in region 5. |
| **Livingston Council on Aging and Meal Site Health Tips Presentation** | 3/26/2025 | Livingston Parish | 9 | Denham Springs | Sheri Gill / Livingston on Council on Aging and Meal Site | Volunteer Work / Presentation |
| **Jefferson Davis Coalition Meeting** | 3/26/2025 | Jefferson Davis | 5 | N/A | Jeff Davis Parish Prevention Coalition | A coalition meeting to discuss underage drinking/vaping and bring awareness in the Jeff Davis parish community. |
| **TRACC/ Tangipahoa Reshaping Attitudes for Community Change Teen Life Maze Event** | 3/27/2025 | Tangipahoa Parish | 9 | Ponchatoula | Taylor Addison / TRACC and PARD | Health and Wellness Event with resources, education, social organizations for students in the grades 9th-12th in 9 high schools across Tangipahoa Parish . |
| **MAM Meeting Travel** | 3/27/2025 | East Baton Rouge | 2 | Baton | Louisiana Healthcare Connections | MAM's are intended to increase member engagement. This event allows us to let members know how much we appreciate them, collect member feedback, and connect members with community resources. |
| **ARCH Monthly Meeting** | 3/27/2025 | Acadiana | 4 | Online | Acadiana Regional Coalition on Homelessness and Housing- ARCH | A coalition meeting to discuss the needs and resources for the Lafayette Parish homeless children/youth education program and how education is the key to overcoming and preventing the cycle of homelessness in families. |
| **Northeast Delta HSA Summit** | 3/27/2025 | Ouachita | 8 | Monroe | HSA Northeast Delta Human Service Aurthority | Health and Wellness Summit |
| **RSN Meeting/Advisory Council** | 3/27/2025 | St. Martin Parish | 4 | Breaux Bridge | St. Martin Parish Federal Program | A planning meeting to discuss the growth of St. Martin Parish school system. |
| **Abraham's Tent** | 3/28/2025 | Calcasieu | 5 | Lake Charles | Louisiana Health Care Connections | Serve the community lunch or assist with organizing food & clothes. |
| **Kite Fest** | 3/29/2025 | East Baton Rouge | 2 | Baton Rouge | Gardere Initiative | Kite festival and LHCC will oversee an obstacle course to promote physical activities |
| **Twin Fest** | 3/29/2025 | Terrebonne | 3 | Houma, La. | Sherri Whitmore | 2nd annual festival for twins and multi-births. The festival offers community resources, activities and health screenings. |
| **First True Love World Outreach Ministries Spring Fest Event** | 3/29/2025 | Tangipahoa Parish | 9 | Ponchatoula | Pam White / LHCC/ First True Love Outreach Ministries | Community Event hosted by Community Church leaders, social organizations, recourse agencies for the local and surrounding communities. |
| **Healthy Acadia Alliance** | 4/1/2025 | Acadiana | 4 | Zoom | Healthy Acadia Alliance | Coalition Meeting to discuss events and information concerning the Acadiana area. |

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| **Alidore Coalition Meet** | 4/2/2025 | Lafourche | 3 | Raceland, La | Alidore Amb. | Community organizations sharing resources and discussing upcoming events. |
| **Faith House Grand Opening Celebration, Maison De La Paix** | 4/2/2025 | Avoyelles | 6 | Mansura | Faith House | Faith House Grand Opening Celebration, Maison De La Paix. |
| **Resource Fair** | 4/3/2025 | St. Landry | 4 | Opelousas | Opelousas Housing Authority | A resource fair that the community need to create a stable life. |
| **Concordia Healthy Initiatives Coalition Meeting** | 4/3/2025 | Concordia | 6 | Vidalia, | Concordia HIC | Healthy Initiatives Coalition Meeting |
| **Bricolage Parent Meeting** | 4/3/2025 | Orleans | 1 | New Orleans, La. | D. Rhinehardt | Parent meeting where new Principal will be introduced. |
| **Spring Extraveganza** | 4/4/2025 | Terrebonne | 3 | Houma | Sherry Whitmore | A Spring time celebration for elementary school Kids. Activities include reading time, arts and crafts and an Easter Egg Hunt. |
| **2025 Healthy You at the Zoo** | 4/5/2025 | Rapides | 6 | Alexandria | LSUAG Center | The Alexandria Zoo and the LSU AgCenter are teaming up again for our 3rd annual "Healthy You at the Zoo" health fair. Invited as ahealth and wellness exhibitor to provide resources for our CENLA clients |
| **19th Annual Health & Resource Fair** | 4/5/2025 | St. Landry | 4 | Opelousas | Opelousas General Health System | The 19th annual health & resource fair with health screenings and a Easter egg hunt for the children that live within the community. |
| **5th Annual Walk Around the Block for Autism 5K/ Community Expo** | 4/5/2025 | Ouachita | 8 | Monroe | Wanda's Abundance Grace, Hampco Inc, Senator Jackson-Andrews | %K Fun Run/Walk and Community Expo to bring the community together to celebrate children and adults with disabilities, special abilities and special needs. |
| **City of Hammond Recreation Department Easter Egg Hunt and Resource Fair** | 4/5/2025 | Tangipahoa Parish | 9 | Hammond | City of Hammond Recreation Department / Betty Lee | Resource Fair/ event with community leaders, resource agencies, social organizations, information and education for local and surrounding communities. |
| **Twin Fest** | 4/6/2025 | Terrebonne | 3 | Houma, La. | Sherri Whitmore | 2nd annual festival for twins and multi-births. The festival offers community resources, activities and health screenings. |
| **Northshore Food Bank Truck Food Pick and Delivery** | 4/7/2025 | St. Tammany Parish | 9 | Covington | Sarah Herndon / Northshore Food Bank | Volunteer Work / Food Truck pick up and delivery |
| **St. Tammany Commission on Families Board of Directors and Coalition Meeting** | 4/8/2025 | St. Tammany Parish | 9 | Mandeville | Elizabeth Garland / St. Tammany Commission on Families | Collaborative Meeting with vendors, social organizations resource agencies to plan future events for the local and surrounding communities of St. Tammany Parish. |
| **Grant Parish Healthy Initiatives Coalition** | 4/8/2025 | Grant | 6 | Colfax | Grant Parish Healthy Initiatives Coalition | Grant Parish Healthy Initiatives Coalition Monthy Meeting |
| **SCARF Board Of Directors Meeting & Planning of Rosia Run/Walk Committee Meeting** | 4/8/2025 | Rapides | 6 | Alexandria | SCARF of Alexandria | Monthly Board Meeting and Planning Meeting for upcoming Annual Rosia's Walk/Run |
| **Regina Coeli Child Development Center Community Connections Event** | 4/9/2025 | St. Tammany Parish | 9 | Lacombe | Shanna Bickham / Regina Coeli Child Development Center | Resource event with community leaders, resource agencies, social organizations, information and education for local and surrounding communities. |
| **Read Learn Succeed Ending Celebration** | 4/9/2025 | Ouachita | 8 | Monroe | United Way | RLS Ending Celebration for Volunteers and Students.Volunteers will enjoy a few minutes of conversation with their student(s) and work on a small poster project with their student |

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| **Rapides Parish School District – Transformation Zone** | 4/10/2025 | Rapides | 6 | Alexandria | Rapides Parish School District's Transformation Zone in partnership with the Better Together Community Health Connections Group | Volunteer at School at an event that targets Mental Health and Behavioral Risk students. Students Kindergarten through 2nd grade students will have a day of fun, physician activities and social engagement. |
| **Ward 3 Health Fair (MLK Community Center)** | 4/10/2025 | Calcasieu | 5 | Lake Charles | LC Ward 3 Recreation Center | A community health fair to offer health screenings, blood pressure, food truck and juice truck. |
| **Union Parish Community Outreach Meeting** | 4/11/2025 | Union | 8 | Farmerville | Union Parish Outreach Team | Union Parish Outreach Community Team Meeting |
| **Ponchatoula Strawberry Festival** | 4/11/2025 | Tangipahoa Parish | 9 | Ponchatoula | Tanzel Montgomery / LHCC | Festival with screening, community leaders, education, social organizations and resource agencies for local and surrounding communities . |
| **Strawberry Festival** | 4/12/2025 | Tangipahoa | 9 | Ponchatoula | Strawberry Festival | Festival with screening, community leaders, education, social organizations and resource agencies for local and surrounding communities. |
| **Easter Egg Hunt & Ladybug Release** | 4/12/2025 | Caddo | 7 | Shreveport | American Rose Society | The 23rd annual Easter egg hunt and ladybug release is a community-wide event. |
| **Region 8 Community Outreach Meeting** | 4/14/2025 | Ouachita | 8 | Monroe | Region 8 Community Outreach | Region 8 Outreach Team Meeting which brings together a collaboration of community partners to discuss events, community topics and resources. |
| **CATT/Partnership for Healthier SWLA** | 4/15/2025 | Calcasieu | 5 | Lake Charles | Community Action & Advisory Team/Partnership for Healthier SWLA | A meeting to align our focus on using data-driven strategies and community engagement to drive impactful public health interventions across Allen, Beauregard, Cameron, Jefferson Davis and Calcasieu Parish. |
| **NWLA Reentry Coalition Meeting** | 4/15/2025 | Caddo | 7 | Shreveport | Goodwill Industries | Coalition meeting to discuss issues or resources concerning the community. |
| **Foster Care Appreciation Meeting** | 4/15/2025 | Lafourche | 3 | Thibodaux, la | Heather Benoit | A meeting to prepare for an event to show appreciation to foster parents. |
| **SWAG Career Fair** | 4/16/2025 | Tangipahoa | 9 | Amite | Tangipahoa Parish School Board | This is a career and health fair for students with disabilities. |
| **Tangipahoa Parish School Systems Career Day for Students** | 4/16/2025 | Tangipahoa Parish | 9 | Amite | Tangipahoa Parishes School Systems | Event designed by The Tangipahoa Parish School Systems to give back to the community, students graduating and preparing for the next step in life. |
| **Collaborative Meeting / Walk Thru for LHCC Care-A-Van Event** | 4/16/2025 | Tangipahoa Parish | 9 | Hammond | Tanzel Montgomery / LHCC and Hammond Recreation Deaprtment | Collaborative meeting with LHCC and Hammond Recreational Department on planning future event for Care- A- Van hosted by LHCC. |
| **CenLa Healthy Start Consortium & Region 6 Community Advisory & Action Team Meeting** | 4/16/2025 | Rapides | 6 | Alexandria | Consortium Coordinator | CenLa Healthy Start Consortium and the Region 6 Community Advisory & Action Team (CAAT) will host a meeting.Both teams are passionate about improving infant, child, and maternal mortality rates in Region 6, and we are thrilled to combine our resources to better serve individuals and families in our region. |

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| Jeff Davis Parish Prevention Coalition Meeting | 4/16/2025 | Via Teams | 5 | Lake Charles | Jeff Davis Parish Prevention Coalition | A coaliton meeting to discuss underage alcohol and smoking in the community. |
| West Feliciana High School Career Day and Resource Fair | 4/17/2025 | West Feliciana Parish | 2 | St. Francisville | Hazel Knighten / West Feliciana Parish Prevention and Coalition | Health and Wellness event with community leaders, resource agencies, social organizations, screenings, information and education for local and surrounding communities. |
| 2025 LaPri Second Chance Job and Resource Fair | 4/17/2025 | Rapides | 6 | Alexandria | LaPri | This event is geared towards second-chance candidates, but open to all job seekers and those looking to connect with valuable community resources.<br><br>Employers from manufacturing, technology, healthcare, and education<br>☑ Community service providers offering valuable resources<br>☑ Networking and career opportunities that can make a real difference |
| West Feliciana Head Start School - End of School Bash | 4/17/2025 | West Feliciana | 2 | St. Francisville | Cynthia Whitaker / West Feliciana Parish Head Start | End of the Year Resource Fair for students, families, teachers, community members and surrounding community members. |
| Boys & Girls Club After School Enrichment | 4/17/2025 | Calcasieu | 5 | Lake Charles | Cheniere Energy Club of Boys & Girls Clubs of Acadiana | After school program to discuss healthy eating and social skills with kids ages 6-12. |
| Bobby 'Blue" Hines Memorial Easter Egg Hunt in Collaboration with Grant HIC Resource Fair | 4/18/2025 | Grant | 6 | Colfax | Bobby 'Blue" Hines Memorial Easter Egg Hunt in Collaboration with Grant HIC Resource Fair | Community 25 year Easter Egg Hunt and Resource Fair bringing the community and resources together |
| St. Gabriel Community Center Easter Extravaganza | 4/19/2025 | St. Gabriel Parish | 2 | St. Gabriel | Detra Ingram / St. Gabriel Community Center | Health and Wellness event with community leaders, resource agencies, social organizations, information and education for local and surrounding communities. |
| Adult Easter Egg Hunt | 4/19/2025 | Calcasieu | 5 | Lake Charles | Brite ABA Therapy | An adult Easter egg hunt for the community. CRC will be a vendor. |
| Easter Seals and Florida Parishes Services Training LHCC / CWC | 4/21/2025 | St. Tammany Parish | 9 | Covington | Jason Fontenelle/ LHCC | Easter Seals and Florida Parishes Services Training hosted by LHCC at the Covington Wellness Center . |
| Washington Parish Human Services Coalition | 4/22/2025 | Washington Parish | 9 | Bogalusa | Cheryl Bruton / Washington Parish Human Services Coalition | Collaborative Meeting with vendors, social organizations resource agencies to plan future events for the local and surrounding communities of Washington Parish. |
| LaSalle Parish Healthy Initiatives Coalition Meeting | 4/22/2025 | LaSalle | 6 | Jena | LaSalle Parish Healthy Initiatives Coalition | LaSalle Parish Healthy Initiatives Coalition Meeting |
| Washington Parish Human Services Coalition | 4/22/2025 | Washington Parish | 9 | Bogalusa | Cheryl Bruton / Washington Parish Human Services Coalition | Collaborative Meeting with vendors, social organizations resource agencies to plan future events for the local and surrounding communities of Washington Parish. |
| LaSalle Parish Healthy Initiatives Coalition Meeting | 4/22/2025 | LaSalle | 6 | Jena | LaSalle Parish Healthy Initiatives Coalition | LaSalle Parish Healthy Initiatives Coalition Meeting |
| Maternal Health Focus Group | 4/23/2025 | Rapides | 6 | Alexandria | Louisiana Department of Health | Review Needs Assessment Data and give feedback. Assist in identifying barriers to care gaps in services and solution and connect with moms, maternal health partners and professionals. |
| BPCC Health & Resource Fair | 4/24/2025 | Bossier City | 7 | Bossier City | Bossier Community College | A community college health &resource fair to educate the student body concerning their health as well as resources that they may need. |
| Southern University Counseling Center Paws and Relax Event | 4/24/2025 | East Baton Rouge Parish | 2 | Baton Rouge | Stephenne Calhoun / Southern University | Wellness Event for students designed to help de-stress and recharge as they prepare for final exams with, resource agencies, social organizations with information and education . |
| Catahoula Parish Healthy Initiatives Coalition Meeting | 4/24/2025 | Catahoula | 6 | Harrisonburg | Catahoula Parish HIC | ***Catahoula Parish*** Healthy Initiatives Coalition monthly meeting for community partners and the community to collaborate on specific ideas and events |
| Family Sports Day | 4/25/2025 | Orleans | 1 | New Orleans, La. | We Play Training Grounds | A fun active event for kids under 5. |
| NAMI LA in Caddo Parish "Get Connected 2025 Mental Health Fair" | 4/25/2025 | Caddo | 7 | Shreveport | NAMI LA | A health fair to educate the community about being connected concerning your mental health. |
| Sickle Cell Anemia Support Group Meeting | 4/25/2025 | Acadiana | 4 | Lafayette | Sickle Cell Anemia | A sickle cell anemia support group meeting in region 4.<br><br>Meeting was cancelled b/c the president was sick. |
| Rosia's Walk and Health Fair 2025 | 4/26/2025 | Rapides | 6 | Alexandria, | SCARF | This event brings our community together to support individuals living with sickle cell anemia. |
| MANage Your Health | 4/26/2025 | West Baton Rouge | 2 | Baton Rouge | Pamela White | men wellness event with panelists and keynote speakers with community partners |
| Special Needs Expo 2025 | 4/26/2025 | St. Tammany Parish | 9 | Lacombe | St. Tammany Coroner's Office / Chris Knoblauch | Health and Wellness event with community leaders, resource agencies, social organizations, screenings, information and education for local and surrounding communities. |
| Caregiving Can Be Wild & Wonderful | 4/26/2025 | Acadiana | 4 | Lafayette | Christian Life | Appreciation event for the foster care parents and kids in region 4. |
| Jags Day on the Bluff | 4/27/2025 | West Baton Rouge | 2 | Baton Rouge | Taylor Debourg - Southern Athletics | Jags Day on the Bluff consists of children age 5-12 particupating in activities such as volleyball, basketball, football and more. |
| Northshore Food Bank Food Truck Pick up and Delivery | 4/28/2025 | St. Tammany Parish | 9 | Covington | Sarah Herndon / Northshore Food Bank | Volunteer Work / Food Truck Pick up and Delivery |
| Goodwill Bag Stuffing Volunteer | 4/28/2025 | Terrebonne | 3 | Gray, La. | Goodwill | A bag staffing for hope at every doorstep, a community invite focus on mental health. |
| Livingston Council on Aging and Meal Site Healthy Tips Presentation | 4/29/2025 | Livingston Parish | 9 | Denham Springs | Sheri Gill / Livingston Council on Aging and Meal Site | Volunteer Work |
| The Oasis by New Day Grand Opening | 4/29/2025 | Acadiana | 4 | Lafayette | The Oasis | A grand opening facility that will host personal care services for the community. |

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| **VACCINES Let's talk about them!** | 4/29/2025 | Calcasieu | 5 | Lake Charles | SWLA AHEC | A focus group to discuss why parents or primary care givers who don't vaccine their kids of 2 years & under. |
| **Strive New Orleans** | 4/30/2025 | Orleans | 1 | New Orleans, La. | Strive New Orleans | Inaugural Employer Advisory Committee Meeting. |
| **In April We Wear Blue for Autism Awareness Event** | 4/30/2025 | Tangipahoa Parish | 9 | Independence | Cutting The Pattern Project | Local Health and Wellness Event with Vendors, local leaders, social organizations and Resource Agencies to support Autism Awareness for local and surrounding communities . |
| **Behavioral Health Day** | 5/1/2025 | East Baton Rouge Parish | 2 | Baton Rouge | Andrea Dubiel / Louisiana Mental Health Association | Health and Wellness Event with community leaders, vendors, social organizations and resources to educate and support local and surrounding communities. |
| **Concordia Healthy Initiatives Coalition Meeting** | 5/1/2025 | Concordia | 6 | Vidalia | Concordia HIC | Concordia Healthy Initiatives Coalition Monthly Meeting |
| **National Day of Prayer and Community Resource Event** | 5/1/2025 | Tangipahoa Parish | 9 | Hammond | Pam White / Empowering Kingdom Growth Church | Community Resource Event with Resource Agencies, social organizations, community leaders with information, education for local and surrounding communities. |
| **MAC Meeting** | 5/1/2025 | N/A | N/A | N/A | Louisiana Healthcare Connections | Member Advisory Council (MAC) meetings are designed to provide information about plan benefits, capture feedback, questions, and concerns. |
| **Woodland Park Magnet School Color Run** | 5/2/2025 | Tangipahoa | 9 | Hammond | Woodland Park Magnet School | Color run for students K-3 to promote physical activities for childhood obesity |
| **Crawfish King Cook-off** | 5/2/2025 | East Baton Rouge | 2 | Baton Rouge | Big Buddy | LHCC in partnership with Big Buddy for aThe Crawfish King Cook-off Fundraiser. A team crawfish boil competition held in downtown Baton Rouge.It's a popular event where companies compete for the title of "Crawfish King" and involves over 13,000 pounds of crawfish. |
| **Southern University Nursing School Free Baby Shower Event** | 5/2/2025 | East Baton Rouge Parish | 2 | Baton Rouge | Iva Painia / Southern University Nursing School | Community Free Baby Shower Event hosted by Community leaders, social organizations, resources agencies and Southern University for the local and surrounding communities. |
| **Foster Care Appreciation** | 5/3/2025 | Livongston | 9 | Denham Springs | Pamela White | foster care event to promote awareness and resources for foster families. |
| **Children's Miracle Network Hospitals Family Day & NICU Reunion** | 5/3/2025 | Calcasieu | 5 | Lake Charles | Christus Health Southwestern Louisiana Foundation | A family fun day recognizing the NICU babies from any hospital in the area. The event will have the families and former NICU kids come to have fun with the nurses and doctors that they encounter during their hospital stay. |
| **Sickle Cell Gene Therapy Support Group Phase II** | 5/6/2025 | Rapides | 6 | Pineville | SCARF-Alexandria | SCARF Support Group Session for Warriors on Gene Therapy Education thru Vertex, Session II |
| **SU AG Health Fair** | 5/7/2025 | Morehouse | 8 | Bastrop | SU Ag | SU Ag will present a Health and Wellness event with screenings, Physical Activities, Education, etc. Community Partners are invited to share resources. |
| **Geaux Baby and Me** | 5/10/2025 | St. Charles | 3 | St. Rose | Louisiana Healthcare Connections | Baby Shower to education and provide resources for Medicaid Members. |
| **Family and Child Welfare Workgroup** | 5/12/2025 | Terrebonne | 3 | Gray, la | Sherri Whitmore | Workgroup meeting to discuss family and child welfare and resources. |

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| Region 8 Community Meeting | 5/12/2025 | Ouachita | 8 | Monroe | Region 8 Community Outreach Team | Monthly Community Outreach Team Meeting |
| Food Bank of Northeast Louisiana Senior Volunteer | 5/12/2025 | Ouachita | 8 | Monroe | Food Bank of Northeast Louisiana | Volunteering at Food Bank of Northeast Louisiana for Prepping boxes for Senior Program distribution. |
| St. Tammany Commission on Families 2nd Annual Mental Health and Wellness Fair | 5/13/2025 | St. Tammany | 9 | Mandeville | Elizabeth Garland / St. Tammany Commission on Families | Health and Wellness event with community leaders, resource agencies, social organizations, screenings, information and education for local and surrounding communities. |
| North-Central LA Re-entry Coalition | 5/13/2025 | Natchitoches | 7 | Natchitoches | Goodwill NLA | A coalition meeting to discuss different resources and events that are being held in the community and how we can serve the city. |
| Healthcare Behavioral Workgroup | 5/13/2025 | Terrebonne | 3 | Gray, la | Goodwill | Meeting to discuss resources for community member regarding behavioral health. |
| Ouachita Healthy Communities Monthly Meeting | 5/13/2025 | Ouachita | 8 | West Monroe | LSUAg Center of Monroe | Healthy Communities Coalition May 2025 Board Meeting to discuss up coming Summer projects and Collaborative Events . |
| MAM Meeting Travel | 5/13/2025 | Lafouche | 3 | Shriver | LHCC MAM | MAM is designed collect feedback from members and thank them for choosing LHCC. |
| Talent Show | 5/14/2025 | Orleans | 1 | New Orleans, La. | Bricolage School | End of the year talent show for the kids. |
| Open Health Mental Health Fair | 5/14/2025 | East Baton Rouge | 2 | Baton Rouge | Open Health Clinic | Mental Health Fair hosted by Open Health Clinic of Baton Rouge with vendors, social organizations, resources and health screening for the local and surrounding communities. |
| Rapides Healthy Initiative Coalition Meeting | 5/15/2025 | Rapides | 6 | Alexandria | Rapides Healthy Initiative Coalition | Rapides Healthy Initiative Coalition Monthly Meeting |
| Parent Meeting | 5/15/2025 | St. Mary | 3 | Baldwin, la | Families helping Families | Meeting with parents to discuss community resources. |
| Power U | 5/16/2025 | Orleans | 1 | New Orleans | Kati LeBreton | community event for women's health and empowerment. |
| Geaux Baby & Me Community Baby Shower - Region 7 | 5/17/2025 | Caddo | 7 | Shreveport | Louisiana Health Care Connections | A community baby shower to educate and inform moms in region 7. |
| Avoyelles Community & Youth Coalition Meeting | 5/20/2025 | Avoyelles | 6 | Marksville | ACYC | Avoyelles Community & Youth Coalition Monthly Meeting with community partners |
| Veterans Breakfast City of Hammond Recreation Department | 5/22/2025 | Tangipahoa Parish | 9 | Hammond | Betty Lee / City of Hammond Recreation Deaprtment | Volunteer Work |
| Geaux Baby And Me Region 8 Baby Shower | 5/22/2025 | Ouachita | 8 | Monroe | LHCC | GBAM Region 8 Baby Shower #1. LHCC & Ouachita Health unit collaborative baby shower brining together community resources for expected parents and their family. |
| Bawcomville Bash | 5/23/2025 | Ouachita Parish | 8 | West Monroe, LA | Northeast Delta Human Service Authority | Organizations from all across NELA, sharing life-saving information and resources with those in need. In conjunction with the festival, we will host a drive to collect adult bicycles, safety vests, tire repair kits and other bike safety items for residents who are in need of transportation. |
| Parent Cafe | 5/23/2025 | Terrebonne | 3 | Houma | Start Corporation/Lindsay Davis | A wellness parent support event that grant the participants an opportunity to connect with other parents and learn from similar experiences. |
| Sickle Cell Anemia Support Group Meeting | 5/23/2025 | Acadiana | 4 | Lafayette | Sickle Cell Anemia | A sickle cell anemia support group meeting in region 4. |
| Tiger Activity Day | 5/24/2025 | Catahoula Parish | 6 | Sicily Island | First Baptist Outreach Ministries | Community Day of physical fun. Providing games, Healthy Food Demonstration, STEM activities, Heath Tips for the entire family. |
| Love Doves Ministry Mental Health Seminar | 5/24/2025 | Bossier City | 7 | Bossier City | Sunflower's Missionary Baptist Church | A health seminar to discuss mental health and resources within the community. |
| Methodist Foster Movie premier | 5/25/2025 | Tangipahoa | 9 | Ponchatoula | First United Methodist Foster | There was a movie premier of the Sound of Hope. The community was invited to attend and get resources from community partners. |
| Washington Parish Human Services Coalition Meeting | 5/27/2025 | Washington Parish | 9 | Bogalusa | Cheryl Bruton / Washington Parish Human Services Coalition | Collaborative Meeting with vendors, social organizations resource agencies to plan future events for the local and surrounding communities of Washington Parish. |
| Livingston Council on Aging and Meal Site Healthy Tips Presentation | 5/29/2025 | Livingston Parish | 9 | Denham Springs | Sherri Gills / Livingston Council on Aging and Meal Site | Volunteer Work |
| Overdose Response Recognition Event | 5/29/2025 | Franklin | 8 | Winnsboro | LDH Public Health | Event geared to building a healthier, safer community through awarenessand prevention of opioid overdose and tobacco use. LEARN TO SAVE LIVES: Overdose response training, including recognizingsymptoms and administering naloxone, is crucial. Learn how to combat stigma andempower yourself to act in emergencies. We'll also address the serious health risksof tobacco use, a leading cause of cancer, heart disease, and respiratory problems. |
| Greater Baton Rouge Child Health Consortium | 5/30/2025 | East Baton Rouge Parish | 2 | Baton Rouge | Levyette Matthews / Family Road for Greater Baton Rouge | Collaborative Meeting with vendors, social organizations resource agencies to plan future events for the local and surrounding communities of East Baton Rouge Parish. |
| Red Table Talk "A Community Conversation" | 5/30/2025 | Ouachita | 8 | West Monroe | The Children's Coalition | A community conversation to network with Community members, Learn about available support services and gain awareness of community resources. |
| Surviving the Journey Planning Committee Meeting | 5/30/2025 | Ouachita | 8 | Monroe | Northeast Louisiana Recovery Coalition | Surviving the Journey Planning Committee Meeting to discuss upcoming Event |
| Love Impact Coalition | 5/31/2025 | East Baton Rouge | 2 | Baton Rouge | Marketing Team | Love Impact Coalition is a health and wellness event offering free dental, medical and vision to the residents of Baton Rouge. |

## Stratify MCO Results on Attachment H Measures

| Table D1. Stratification of HEDIS Measures by Race, Ethnicity and Geographical Region highlighting potential Inequities in care | | | | | |
|---|---|---|---|---|---|
| | Category | Eligible Population | Numerator Final | MY 2025 Rate* | MY 2024 Rate |
| Childhood Immunization Status (Combo 3) | **Total** | **9,330** | **5,953** | **57.80%** | **63.80%** |
| | **Race** | | | | |
| | White | 2,446 | 1,548 | | 63.29% |
| | Black or African American | 3,902 | 2,420 | | 62.02% |
| | American Indian and Alaska Native | 21 | 10 | | 47.62% |
| | Asian | 74 | 51 | | 68.92% |
| | Native Hawaiian or Other Pacific Islander | 3 | 1 | | 33.33% |
| | Some Other Race | 650 | 476 | | 73.23% |
| | Two or More Races | 1 | 1 | | 100.00% |
| | Asked but No Answer | 0 | 0 | | 0.00% |
| | Unknown | 2,233 | 1,446 | | 64.76% |
| | **Ethnicity** | | | | |
| | Hispanic or Latino | 190 | 149 | | 78.42% |
| | Not Hispanic or Latino | 0 | 0 | | 0.00% |
| | Declined Ethnicity | 1,430 | 1,004 | | 70.21% |
| | Unknown Ethnicity | 7,710 | 4,800 | | 62.26% |
| | **Geography** | | | | |
| | Rural | 2,808 | 1,732 | | 61.68% |
| | Urban | 3513 | 1903 | | 64.91% |
| | Unknown | 98 | 51 | | 52.04% |
| Immunization Status for Adolescents (Combo 2) | **Total** | **9,119** | **3,545** | **35.1%** | **38.87%** |
| | **Race** | | | | |
| | White | 3,716 | 1,218 | | 32.78% |
| | Black or African American | 4,708 | 2,019 | | 42.88% |
| | American Indian and Alaska Native | 65 | 16 | | 24.62% |
| | Asian | 118 | 55 | | 46.61% |
| | Native Hawaiian or Other Pacific Islander | 1 | 1 | | 100.00% |
| | Some Other Race | 85 | 42 | | 49.41% |
| | Two or More Races | 0 | 0 | | 0.00% |
| | Asked but No Answer | 0 | 0 | | 0.00% |
| | Unknown | 426 | 194 | | 45.54% |
| | **Ethnicity** | | | | |
| | Hispanic or Latino | 476 | 220 | | 46.22% |
| | Not Hispanic or Latino | 2,258 | 901 | | 39.90% |
| | Declined Ethnicity | 0 | 0 | | 0.00% |
| | Unknown Ethnicity | 6,385 | 2,424 | | 37.96% |
| | **Geography** | | | | |
| | Rural | 2,840 | 941 | | 33.13% |
| | Urban | 6,179 | 2,587 | | 41.87% |
| | Unknown | 100 | 17 | | 17.00% |
| | **Total** | **8,186** | **5,171** | **56.20%** | **63.17%** |

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| Well-Child Visits in the First 30 Months of Life: First 15 Months | **Race** | | | | |
| | White | 2,090 | 1,351 | | 64.64% |
| | Black or African American | 3,281 | 1,994 | | 60.77% |
| | American Indian and Alaska Native | 15 | 11 | | 73.33% |
| | Asian | 69 | 47 | | 68.12% |
| | Native Hawaiian or Other Pacific Islander | 8 | 7 | | 87.50% |
| | Some Other Race | 586 | 422 | | 72.01% |
| | Two or More Races | 2 | 1 | | 50.00% |
| | Asked but No Answer | 0 | 0 | | 0.00% |
| | Unknown | 2,135 | 1,338 | | 62.67% |
| | **Ethnicity** | | | | |
| | Hispanic or Latino | 160 | 131 | | 81.88% |
| | Not Hispanic or Latino | 1,071 | 730 | | 68.16% |
| | Declined Ethnicity | 0 | 0 | | 0.00% |
| | Unknown Ethnicity | 6,955 | 4,310 | | 61.97% |
| | **Geography** | | | | |
| | Rural | 2,570 | 1,596 | | 62.10% |
| | Urban | 5,527 | 3,528 | | 63.83% |
| | Unknown | 89 | 47 | | 52.81% |
| Well-Child Visits in the First 30 Months of Life: 15 Months - 30 Months | **Total** | **8,932** | **6,296** | **69.61%** | **70.49%** |
| | **Race** | | | | |
| | White | 2,306 | 1,637 | | 70.99% |
| | Black or African American | 3,701 | 2,592 | | 70.04% |
| | American Indian and Alaska Native | 30 | 22 | | 73.33% |
| | Asian | 86 | 66 | | 76.74% |
| | Native Hawaiian or Other Pacific Islander | 7 | 4 | | 57.14% |
| | Some Other Race | 593 | 472 | | 79.60% |
| | Two or More Races | 2 | 2 | | 100.00% |
| | Asked but No Answer | 0 | 0 | | 0.00% |
| | Unknown | 2,207 | 1,501 | | 68.01% |
| | **Ethnicity** | | | | |
| | Hispanic or Latino | 182 | 161 | | 88.46% |
| | Not Hispanic or Latino | 1,422 | 1,115 | | 78.41% |
| | Declined Ethnicity | 1 | 1 | | 100.00% |
| | Unknown Ethnicity | 7,327 | 5,019 | | 68.50% |
| | **Geography** | | | | |
| | Rural | 2,848 | 1,884 | | 66.15% |
| | Urban | 5,999 | 4,359 | | 72.66% |
| | Unknown | 85 | 53 | | 62.35% |
| Colorectal Cancer Screening | **Total** | **38,473** | **17,036** | **50.29%** | **44.28%** |
| | **Race** | | | | |
| | White | 16,888 | 7,323 | | 43.36% |
| | Black or African American | 17,071 | 7,810 | | 45.75% |
| | American Indian and Alaska Native | 240 | 111 | | 46.25% |
| | Asian | 707 | 341 | | 48.23% |

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|---|---|---|---|---|---|
| | Native Hawaiian or Other Pacific Islander | 3 | 1 | | 33.33% |
| | Some Other Race | 749 | 336 | | 44.86% |
| | Two or More Races | 30 | 19 | | 63.33% |
| | Asked but No Answer | 0 | 0 | | 0.00% |
| | Unknown | 2,785 | 1,095 | | 39.32% |
| | **Ethnicity** | | | | |
| | Hispanic or Latino | 1,641 | 760 | | 46.31% |
| | Not Hispanic or Latino | 29,935 | 12,723 | | 42.50% |
| | Declined Ethnicity | 2 | 1 | | 50.00% |
| | Unknown Ethnicity | 6,895 | 3,552 | | 51.52% |
| | **Geography** | | | | |
| | Rural | 12,450 | 5,338 | | 42.88% |
| | Urban | 25,769 | 11,618 | | 45.09% |
| | Unknown | 254 | 80 | | 31.50% |
| **Cervical Cancer Screening** | **Total** | **411** | **224** | **56.32%** | **54.50%** |
| | **Race** | | | | |
| | White | 166 | 81 | | 48.80% |
| | Black or African American | 208 | 125 | | 60.10% |
| | American Indian and Alaska Native | 1 | 0 | | 0.00% |
| | Asian | 5 | 2 | | 40.00% |
| | Native Hawaiian or Other Pacific Islander | 0 | 0 | | 0.00% |
| | Some Other Race | 6 | 4 | | 66.67% |
| | Two or More Races | 0 | 0 | | 0.00% |
| | Asked but No Answer | 0 | 0 | | 0.00% |
| | Unknown | 25 | 12 | | 48.00% |
| | **Ethnicity** | | | | |
| | Hispanic or Latino | 15 | 9 | | 60.00% |
| | Not Hispanic or Latino | 267 | 166 | | 62.17% |
| | Declined Ethnicity | 0 | 0 | | 0.00% |
| | Unknown Ethnicity | 129 | 49 | | 37.98% |
| | **Geography** | | | | |
| | Rural | 113 | 53 | | 46.90% |
| | Urban | 295 | 169 | | 57.29% |
| | Unknown | 3 | 2 | | 66.67% |
| **Follow-Up After Hospitalization for Mental Illness (Within 30 Days)** | **Total** | **8,216** | **3,418** | **43.91%** | **41.60%** |
| | **Race** | | | | |
| | White | 3,990 | 1,797 | | 45.04% |
| | Black or African American | 3,689 | 1,407 | | 38.14% |
| | American Indian and Alaska Native | 80 | 25 | | 31.25% |
| | Asian | 40 | 24 | | 60.00% |
| | Native Hawaiian or Other Pacific Islander | 1 | 1 | | 100.00% |
| | Some Other Race | 119 | 50 | | 42.02% |
| | Two or More Races | 4 | 2 | | 50.00% |
| | Asked but No Answer | 0 | 0 | | 0.00% |
| | Unknown | 293 | 112 | | 38.23% |

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|---|---|---|---|---|---|
| | **Ethnicity** | | | | |
| | Hispanic or Latino | 251 | 129 | | 51.39% |
| | Not Hispanic or Latino | 0 | 0 | | 0.00% |
| | Declined Ethnicity | 4,431 | 1,812 | | 40.89% |
| | Unknown Ethnicity | 3,534 | 1,477 | | 41.79% |
| | **Geography** | | | | |
| | Rural | 2,156 | 940 | | 43.60% |
| | Urban | 5,965 | 2,449 | | 41.06% |
| | Unknown | 95 | 29 | | 30.53% |
| **Follow-Up After Emergency Department Visit for Mental Illness (Within 30 Days)** | **Total** | **1,514** | **579** | **39.71%** | **38.24%** |
| | **Race** | | | | |
| | White | 607 | 255 | | 42.01% |
| | Black or African American | 806 | 281 | | 34.86% |
| | American Indian and Alaska Native | 9 | 4 | | 44.44% |
| | Asian | 5 | 3 | | 60.00% |
| | Native Hawaiian or Other Pacific Islander | 0 | 0 | | 0.00% |
| | Some Other Race | 26 | 11 | | 42.31% |
| | Two or More Races | 2 | 1 | | 50.00% |
| | Asked but No Answer | 0 | 0 | | 0.00% |
| | Unknown | 59 | 24 | | 40.68% |
| | **Ethnicity** | | | | |
| | Hispanic or Latino | 37 | 15 | | 40.54% |
| | Not Hispanic or Latino | 0 | 0 | | 0.00% |
| | Declined Ethnicity | 750 | 271 | | 36.13% |
| | Unknown Ethnicity | 727 | 293 | | 40.30% |
| | **Geography** | | | | |
| | Rural | 378 | 150 | | 39.68% |
| | Urban | 1,117 | 424 | | 37.96% |
| | Unknown | 19 | 5 | | 26.32% |
| **Follow-Up After Emergency Department Visit for Substance Use (Within 30 Days)** | **Total** | **2,302** | **504** | **27.48%** | **21.89%** |
| | **Race** | | | | |
| | White | 1,035 | 266 | | 25.70% |
| | Black or African American | 1,075 | 197 | | 18.33% |
| | American Indian and Alaska Native | 25 | 7 | | 28.00% |
| | Asian | 14 | 3 | | 21.43% |
| | Native Hawaiian or Other Pacific Islander | 0 | 0 | | 0.00% |
| | Some Other Race | 34 | 5 | | 14.71% |
| | Two or More Races | 1 | 0 | | 0.00% |
| | Asked but No Answer | 0 | 0 | | 0.00% |
| | Unknown | 118 | 26 | | 22.03% |
| | **Ethnicity** | | | | |
| | Hispanic or Latino | 66 | 11 | | 16.67% |
| | Not Hispanic or Latino | 1,449 | 309 | | 21.33% |
| | Declined Ethnicity | 0 | 0 | | 0.00% |
| | Unknown Ethnicity | 787 | 184 | | 23.38% |

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|---|---|---|---|---|---|
| | **Geography** | | | | |
| | Rural | 601 | 122 | | 20.30% |
| | Urban | 1,671 | 376 | | 22.50% |
| | Unknown | 30 | 6 | | 20.00% |
| **HIV Viral Load Suppression** | **Total** | **1,523** | **254** | **83.69%** | **16.68%** |
| | **Race** | | | | |
| | White | 285 | 49 | | 17.19% |
| | Black or African American | 1,116 | 175 | | 15.68% |
| | American Indian and Alaska Native | 6 | 1 | | 16.67% |
| | Asian | 2 | 0 | | 0.00% |
| | Native Hawaiian or Other Pacific Islander | 0 | 0 | | 0.00% |
| | Some Other Race | 0 | 0 | | 0.00% |
| | Two or More Races | 0 | 0 | | 0.00% |
| | Asked but No Answer | 114 | 29 | | 25.44% |
| | Unknown | 0 | 0 | | 0.00% |
| | **Ethnicity** | | | | |
| | Hispanic or Latino | 55 | 44 | | 80.00% |
| | Not Hispanic or Latino | 1,466 | 1,223 | | 83.42% |
| | Declined Ethnicity | 0 | 0 | | 0.00% |
| | Unknown Ethnicity | 2 | 2 | | 100.00% |
| | **Geography** | | | | |
| | Rural | 1,243 | 1,048 | | 84.31% |
| | Urban | 268 | 211 | | 78.73% |
| | Unknown | 12 | 10 | | 83.33% |
| **Percentage of Low Birth Weight Births** | **Total** | **6,928** | **965** | **13.76%** | **13.93%** |
| | **Race** | | | | |
| | White | 2,659 | 253 | | 9.51% |
| | Black or African American | 3,745 | 654 | | 17.46% |
| | American Indian and Alaska Native | 65 | 9 | | 13.85% |
| | Asian | 57 | 4 | | 7.02% |
| | Native Hawaiian or Other Pacific Islander | 2 | 0 | | 0.00% |
| | Some Other Race | 0 | 0 | | 0.00% |
| | Two or More Races | 0 | 0 | | 0.00% |
| | Asked but No Answer | 398 | 45 | | 11.31% |
| | Unknown | 2 | 0 | | 0.00% |
| | **Ethnicity** | | | | |
| | Hispanic or Latino | 369 | 35 | | 9.49% |
| | Not Hispanic or Latino | 6,456 | 913 | | 14.14% |
| | Declined Ethnicity | | 0 | | 0.00% |
| | Unknown Ethnicity | 101 | 17 | | 16.83% |
| | **Geography** | | | | |
| | Rural | 4,650 | 694 | | 14.92% |
| | Urban | 2,173 | 256 | | 11.78% |
| | Unknown | 105 | 15 | | 14.29% |
| | **Total** | **4,848** | **481** | **10.88%** | **9.92%** |

| | | | | | |
|---|---|---|---|---|---|
| Contraceptive Care - Postpartum (ages 21–44), most or moderately effective, 3 day rate | **Race** | | | | |
| | White | 1,888 | 184 | | 9.75% |
| | Black or African American | 2,601 | 262 | | 10.07% |
| | American Indian and Alaska Native | 47 | 2 | | 4.26% |
| | Asian | 42 | 5 | | 11.90% |
| | Native Hawaiian or Other Pacific Islander | 0 | 0 | | 0.00% |
| | Some Other Race | 0 | 0 | | 0.00% |
| | Two or More Races | 0 | 0 | | 0.00% |
| | Asked but No Answer | 270 | 28 | | 10.37% |
| | Unknown | 0 | 0 | | 0.00% |
| | **Ethnicity** | | | | |
| | Hispanic or Latino | 263 | 28 | | 10.65% |
| | Not Hispanic or Latino | 4,558 | 453 | | 9.94% |
| | Declined Ethnicity | | 0 | | 0.00% |
| | Unknown Ethnicity | 108 | 0 | | 0.00% |
| | **Geography** | | | | |
| | Rural | 3,188 | 329 | | 10.32% |
| | Urban | 1,580 | 142 | | 8.99% |
| | Unknown | 80 | 10 | | 12.50% |
| Contraceptive Care - Postpartum (ages 21–44), most or moderately effective, 90 day rate | **Total** | **4,848** | **1,875** | **47.24%** | **38.68%** |
| | **Race** | | | | |
| | White | 1,888 | 747 | | 39.57% |
| | Black or African American | 2,601 | 993 | | 38.18% |
| | American Indian and Alaska Native | 47 | 12 | | 25.53% |
| | Asian | 42 | 17 | | 40.48% |
| | Native Hawaiian or Other Pacific Islander | 0 | 0 | | 0.00% |
| | Some Other Race | 0 | 0 | | 0.00% |
| | Two or More Races | 0 | 0 | | 0.00% |
| | Asked but No Answer | 270 | 106 | | 39.26% |
| | Unknown | 0 | 0 | | 0.00% |
| | **Ethnicity** | | | | |
| | Hispanic or Latino | 263 | 115 | | 43.73% |
| | Not Hispanic or Latino | 4,558 | 1,753 | | 38.46% |
| | Declined Ethnicity | | 0 | | 0.00% |
| | Unknown Ethnicity | 108 | 7 | | 6.48% |
| | **Geography** | | | | |
| | Rural | 3,188 | 329 | | 10.32% |
| | Urban | 1,580 | 142 | | 8.99% |
| | Unknown | 80 | 10 | | 12.50% |
| Contraceptive Care - Postpartum (ages 21–44), LARC 3 day rate | **Total** | **4,848** | **94** | **1.5%** | **1.94%** |
| | **Race** | | | | |
| | White | 1,888 | 66 | | 3.50% |
| | Black or African American | 2,601 | 0 | | 0.00% |
| | American Indian and Alaska Native | 47 | 1 | | 2.13% |
| | Asian | 42 | 0 | | 0.00% |

| | | | | | |
|---|---|---|---|---|---|
| | Native Hawaiian or Other Pacific Islander | 0 | 0 | | 0.00% |
| | Some Other Race | 0 | 0 | | 0.00% |
| | Two or More Races | 0 | 0 | | 0.00% |
| | Asked but No Answer | 270 | 7 | | 2.59% |
| | Unknown | 0 | 0 | | 0.00% |
| | **Ethnicity** | | | | |
| | Hispanic or Latino | 263 | 7 | | 2.66% |
| | Not Hispanic or Latino | 4,558 | 87 | | 1.91% |
| | Declined Ethnicity | | 0 | | 0.00% |
| | Unknown Ethnicity | 108 | 0 | | 0.00% |
| | **Geography** | | | | |
| | Rural | 3,188 | 1,222 | | 38.33% |
| | Urban | 1,580 | 617 | | 39.05% |
| | Unknown | 80 | 36 | | 45.00% |
| **Contraceptive Care - Postpartum (ages 21–44), LARC 90 day rate** | **Total** | **4,848** | **429** | **11.42%** | **8.85%** |
| | **Race** | | | | |
| | White | 1,888 | 157 | | 8.32% |
| | Black or African American | 2,601 | 231 | | 8.88% |
| | American Indian and Alaska Native | 47 | 4 | | 8.51% |
| | Asian | 42 | 5 | | 11.90% |
| | Native Hawaiian or Other Pacific Islander | 0 | 0 | | 0.00% |
| | Some Other Race | 0 | 0 | | 0.00% |
| | Two or More Races | 0 | 0 | | 0.00% |
| | Asked but No Answer | 270 | 32 | | 11.85% |
| | Unknown | 0 | 0 | | 0.00% |
| | **Ethnicity** | | | | |
| | Hispanic or Latino | 263 | 34 | | 12.93% |
| | Not Hispanic or Latino | 4,558 | 392 | | 8.60% |
| | Declined Ethnicity | | 0 | | 0.00% |
| | Unknown Ethnicity | 108 | 3 | | 2.78% |
| | **Geography** | | | | |
| | Rural | 3,188 | 83 | | 2.60% |
| | Urban | 1,580 | 10 | | 0.63% |
| | Unknown | 80 | 1 | | 1.25% |

*MY 2025 Stratification updates were not complete at the time of preliminary reporting but will be added to final Mid year report.

**Figure D1. Maternal Health Postpartum Pilot to Program Dashboard 2025**