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

External Quality Review Technical Report

for UnitedHealthcare Community

March 2026

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1. Executive Summary

Introduction

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

The Louisiana Medicaid Managed Care Program

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

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

[1] Centers for Medicare & Medicaid Services. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, May 6, 2016. Available at: https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered. Accessed on: Dec 30, 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 30, 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 30, 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 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]	**Timeliness** 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).	**Access** 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 30, 2025.

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

The EQRO has identified the following strengths:

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

Recommendations

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

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

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

Actions on External Quality Review Recommendations

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

Table 1-3—EQRO Recommendations and LDH Actions

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

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

Overview of External Quality Review Findings

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

Validation of Performance Improvement Projects

UHC 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 UHC 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 UHC's performance measures confirmed compliance with the standards of 42 CFR §438.330(a)(1). The results of the validation activity determined that UHC 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 UHC's certified HEDIS compliance auditor, HSAG found that UHC 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, UHC had 63 indicators that performed greater than the NCQA national 50th percentile benchmark, 55 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	78%	85%
II	Member Rights and Confidentiality	100%	99%
III	Member Information	72%	69%
IV	Emergency and Poststabilization Services	100%	99%
V	Adequate Capacity and Availability of Services	14%	52%
VI	Coordination and Continuity of Care	75%	85%
VII	Coverage and Authorization of Services	62%	93%
VIII	Provider Selection	63%	70%
IX	Subcontractual Relationships and Delegation	83%	64%
X	Practice Guidelines	83%	97%
XI	Health Information Systems	78%	96%
XII	Quality Assessment and Performance Improvement	100%	100%
XIII	Grievance and Appeal Systems	84%	90%
XIV	Program Integrity	89%	97%
Total Compliance Score		**77%**	

Validation of Network Adequacy

Provider Directory Validation

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

Table 1-5—Summary of PDV Findings

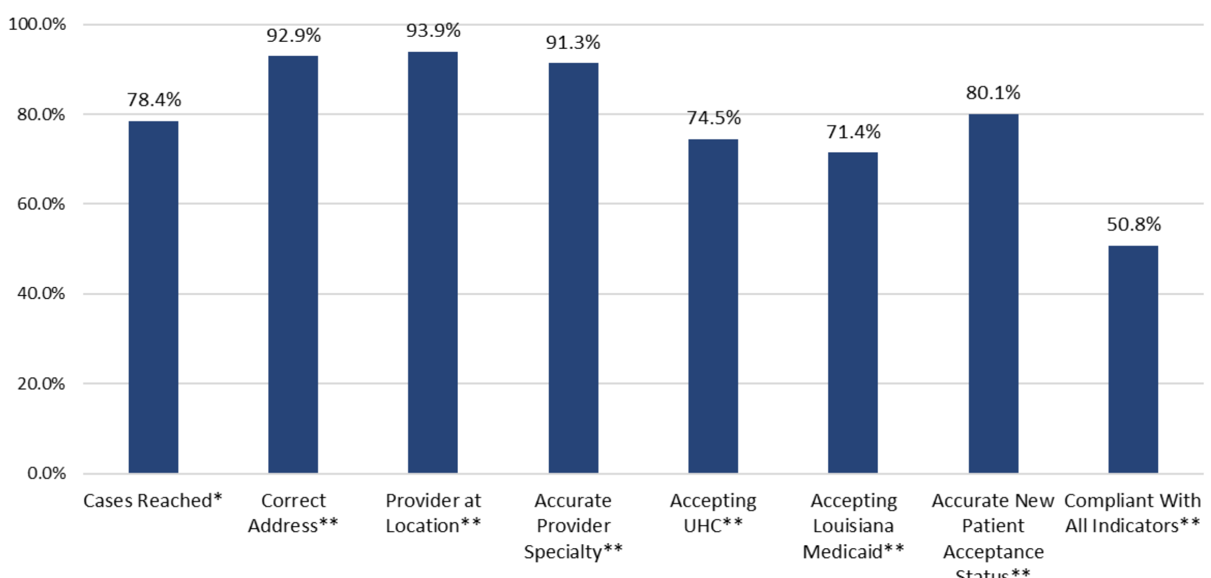
Concerns	Findings
Acceptance of Louisiana Medicaid was low.	Overall, 71.4 percent of providers accepted Louisiana Medicaid.
Acceptance of UHC was low.	Overall, 74.5 percent of providers accepted UHC.
Overall accuracy of the new patient acceptance status was low.[1]	Overall, 80.1 percent of providers confirmed the new patient acceptance status in the online provider directory was correct.

[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 78.4 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 UHC acceptance exhibited the lowest match rates.

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

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



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

UHC's aggregate Q1 and Q2 weighted PDV compliance scores by specialty provider type ranged from 30.7 percent for behavioral health to 72.7 percent for pediatrics.

Provider Access Survey

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

Table 1-6—Summary of Provider Access Survey Findings

Concerns	Findings
Affiliation with the sampled provider was low.	Overall, 42.0 percent of the locations confirmed affiliation with the sampled provider.
Acceptance of new patients was low.	Overall, 46.4 percent of providers accepted new patients; however, only providers listed as accepting new patients in the provider data were selected for the survey sample.
Acceptance of Louisiana Medicaid was low.	Overall, 49.3 percent of providers accepted Louisiana Medicaid.
Acceptance of the MCO was low.	Overall, 49.3 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	96.3%	100%	100%	88.5%	88.5%	80.8%	69.2%
Dermatologists	91.7%	100%	100%	18.2%	18.2%	18.2%	18.2%
Orthopedic Surgeons	82.1%	100%	81.3%	28.1%	28.1%	28.1%	28.1%
Total	**88.5%**	**100%**	**91.3%**	**49.3%**	**49.3%**	**46.4%**	**42.0%**

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

UHC's weighted first provider access survey compliance scores by specialty provider type ranged from 16.7 percent (dermatologists) to 66.7 percent (allergists).

NAV Audit

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

Table 1-8—UHC 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
Radiology	Rural
Pharmacy	Rural
Cardiology	All
Gastroenterology	Urban
Hematology/Oncology	All
Nephrology	Urban
Neurology (Adult)	All
Ophthalmology	All

Provider Type	Urbanicity
Orthopedics (Adult)	All
Otorhinolaryngology/Otolaryngology	Urban
Urology	Urban
Physicians and licensed mental health practitioners (LMHPs) who specialize in pregnancy-related and postpartum depression or related mental health disorders	Rural
Physicians and LMHPs who specialize in pregnancy-related and postpartum substance use disorders (SUD)	Rural
Psychiatric Residential Treatment Facilities (PRTFs) (Level 3.7 Withdrawal Management [WM]) and Other Specialization (Pediatric Under Age 21)	All

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

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

Table 1-9—UHC 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%	89%
Non-Urgent Routine Behavioral Health Care	14 calendar days	70%	95%

Encounter Data Validation

Information Systems Review

The IS review provides self-reported qualitative information from UHC 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.

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

IS Review	UHC		Note
Encounter Data Sources and Systems	—		None.
Payment Structures	—		None.
Encounter Data Quality Monitoring			
Processes for Encounters Collected by Subcontractors	✓	X	Strengths were for NEMT and vision encounters. Weakness was for pharmacy encounters.
Quality Monitoring on Encounters Collected by Subcontractors	✓	X	Strengths were for dental, NEMT, and vision encounters. Weakness was for pharmacy encounters.
Quality Monitoring on Encounters Collected by UHC	✓		Strength included all four types of data quality checks.
% of Encounters Initially Rejected and Not Yet Accepted by LDH	✓	X	Strengths were for pharmacy, NEMT, and vision encounters. Weakness was for institutional encounters.

Administrative Profile

The administrative profile analyzes LDH's encounter data, for UHC, 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.

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

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

<table>
<tr><th>Administrative Profile</th><th>Professional</th><th>Institutional</th><th>Dental</th><th>Pharmacy</th></tr>
<tr><td colspan="5">Encounter Referential Integrity</td></tr>
<tr><td>Encounter vs Enrollment</td><td colspan="3">—</td><td>—</td></tr>
<tr><td>Medical/Dental vs Pharmacy Encounter</td><td colspan="4">—</td></tr>
<tr><td>Encounter vs Provider</td><td colspan="3">—</td><td>✓</td></tr>
<tr><td colspan="5">Encounter Data Logic</td></tr>
<tr><td>% of Members Who Had an Encounter</td><td>—</td><td>—</td><td>—</td><td>—</td></tr>
<tr><td>Member Enrollment Continuity</td><td>—</td><td>—</td><td>—</td><td>—</td></tr>
</table>

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

Consumer Surveys: CAHPS-A and CAHPS-C

HSAG compared UHC'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, UHC's 2025 general child achievement score was statistically significantly higher than the 2025 NCQA national average for *How Well Doctors Communicate*.

Behavioral Health Member Satisfaction Survey

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

Overall, UHC's 2025 adult and child achievement scores were not statistically significantly higher or lower than the 2024 achievement scores or Healthy Louisiana SWA; therefore, no strengths or opportunities for improvement were identified.

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 UHC earned 4.0 stars for the Overall Rating. Additionally, UHC earned 4.5 stars for the Behavioral Health—Medication Adherence subcomposite and 4.0 stars for the Satisfaction with Plan and Plan Services, Children and Adolescent Well-Care, Other Preventive Services, and Diabetes subcomposites, demonstrating strength for UHC in these areas. However, UHC earned 2.5 stars for the Respiratory and Behavioral Health—Care Coordination subcomposites and 2.0 stars for the Reduce Low Value Care subcomposite, demonstrating opportunities for improvement for UHC in these areas.

Figure 1-2—2025 Health Plan Report Card

Issued 07/2025

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 UHC, 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 UHC in SFY 2025.

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

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

For each PIP topic, UHC collaborated on improvement strategies, meeting at least quarterly with LDH and other MCOs, throughout the year. UHC 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 UHC 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, UHC 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 UHC's final PIP validation results and confidence ratings delivered by HSAG in April 2025.

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

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	83%	88%	*Low Confidence*	*Not Assessed*[4]		
Behavioral Health Transitions of Care	100%	100%	*High Confidence*	33%	100%	*Low Confidence*
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	100%	100%	*High Confidence*	67%	100%	*Moderate 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 UHC'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 UHC's *Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees* PIP

Performance Indicator	Baseline (01/01/2024 to 12/31/2024)		Remeasurement 1 (01/01/2025 to 12/31/2025)		Remeasurement 2 (01/01/2026 to 12/31/2026)		Sustained Improvement
Syphilis screening during the first pregnancy examination.	N: 805 D: 3,895	20.67%	— —	—	— —	—	*Not Assessed*
Syphilis screening during weeks 28 to 32 of pregnancy.	N: 34 D: 63	53.97%	— —	—	— —	—	*Not Assessed*
*Syphilis screening at delivery.**	N: 7 D: 4,786	0.15%^	— —	—	— —	—	*Not Assessed*
Syphilis screening at any time during pregnancy or at delivery.	N: 3,318 D: 4,786	69.33%	— —	—	— —	—	*Not Assessed*
Syphilis screening during the first trimester.	N: 1,776 D: 3,422	51.90%	— —	—	— —	—	*Not Assessed*
Syphilis screening during the first trimester for all live births.	N: 2,107 D: 4,786	44.02%	— —	—	— —	—	*Not Assessed*
Syphilis screening during the third trimester for all live births.	N: 1,491 D: 5,199	28.68%	— —	—	— —	—	*Not Assessed*

N–Numerator D–Denominator

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

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

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

Table 2-5 displays data for UHC'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: 1,595 D: 7,632	20.90%	N: 1,432 D: 7,065	20.27%	N: 1,311 D: 6,230	21.04%+	*Not Assessed*
Follow-Up After Hospitalization for Mental Illness (FUH)—Total, 30 Days	N: 2,931 D: 7,632	38.40%	N: 2,619 D: 7,065	37.07%	N: 2,464 D: 6,230	39.55%+	*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 7 Days	N: 351 D: 1,469	23.89%	N: 268 D: 1,322	20.27%	N: 239 D: 991	24.12%+	*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 30 Days	N: 541 D: 1,469	36.83%	N: 429 D: 1,322	32.45%	N: 383 D: 991	38.65%+	*Not Assessed*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 7 Days	N: 495 D: 3,021	16.39%	N: 308 D: 2,198	14.01%	N: 244 D: 1,576	15.48%	*Not Assessed*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 30 Days	N: 785 D: 3,021	25.98%	N: 482 D: 2,198	21.93%	N: 382 D: 1,576	25.24%	*Not Assessed*

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

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

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 UHC'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: 28,000	20.40%	N: 46,556	42.11%+ ▲	—	—	*Not Assessed*
	D: 137,209		D: 110,555		—		

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 UHC'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: 9,192	64.90%*	N: 8,849	65.90%* +	—	—	*Not Assessed*
	D: 14,163		D: 13,428		—		
Persons screened for HIV during the measurement year among persons with past or present (injection) drug use	N: 6,494	34.74%*	N: 6,077	34.04%*	—	—	*Not Assessed*
	D: 18,691		D: 17,854		—		
Persons screened for HIV during the measurement year among persons with risk factors related to sexual mode of transmission	N: 14,067	60.66%*	N: 12,180	59.33%*	—	—	*Not Assessed*
	D: 23,190		D: 20,529		—		

<table>
<tr><th>Performance Indicator</th><th colspan="2">Baseline (01/01/2023 to 12/31/2023)</th><th colspan="2">Remeasurement 1 (01/01/2024 to 12/31/2024)</th><th colspan="2">Remeasurement 2 (01/01/2025 to 12/31/2025)</th><th>Sustained Improvement</th></tr>
<tr><td rowspan="2">Persons ever screened for HIV among all others aged 15 to 65 years without a diagnosis of HIV infection</td><td>N: 90,225</td><td rowspan="2">99.15%*</td><td>N: 100,095</td><td rowspan="2">99.37%* +▲</td><td>—</td><td rowspan="2">—</td><td rowspan="2">Not Assessed</td></tr>
<tr><td>D: 90,998</td><td>D: 100,728</td><td>—</td></tr>
</table>

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

Interventions

Table 2-9 summarizes UHC'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	• Potential provider knowledge deficits regarding congenital syphilis screening recommendations and infection rates • Lack of timely prenatal care	• Provider education on methods for reducing the stigma of syphilis screening when delivering prenatal care • Provider outreach/education on recommended timing of syphilis screening during pregnancy (first prenatal visit, early third trimester, and at delivery) • Enrollee outreach/education on importance of early pregnancy awareness/notification • Enrollee incentive for obtaining prenatal care during pregnancy
Behavioral Health Transitions of Care	• Lack of timely notification for hospital discharge • Difficult to engage enrollees in follow-up treatment	• Enhanced hospital-to-MCO workflow for notification of hospital and ED admissions, discharges, and transfers through analyzing ADT feeds

PIP Topic	Barriers	Interventions
		• Linked enrollees to aftercare with behavioral health providers prior to discharge from hospital or ED • Outreach and assistance in securing follow-up appointments for enrollees after ED discharge for mental health or SUD diagnoses
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	• Lack of PCP training in fluoride varnish application	• Provider education on the availability and use of care gap reports to identify enrollees due for fluoride varnish application • Targeted outreach calls for enrollee groups with fluoride varnish application disparities (enrollees residing in Region 1, Native American/Indian enrollees, Alaskan Native enrollees, Native Hawaiian or Pacific Islander enrollees, and enrollees in foster care)
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	• Lack of enrollee awareness of guidelines for cervical cancer screening • Lack of provider awareness of cervical cancer screening guidelines and reporting requirements	• Educational outreach to all enrollees, and for enrollee subgroups with identified disparities, to provide education on cervical cancer screening and Medicaid transportation benefits • Distribution of provider education materials and toolkit on cervical cancer screening
Screening for HIV Infection	• Lack of enrollee and provider knowledge on guidelines for HIV screening and on resources for obtaining screening	• Provided enhanced CM outreach for HIV screening education for all eligible pregnant enrollees in CM • Provided enhanced CM outreach for HIV screening education to all eligible enrollees 15–65 years of age in CM

MCO Strengths, Opportunities for Improvement, and Recommendations

For UHC, 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 carried out interventions for all five PIPs that had the potential to address identified barriers and improve performance indicator results. **[Quality]**
- The MCO collected, analyzed, and reported intervention-specific effectiveness data to monitor the progress and impact of interventions throughout the most recent measurement period for all five PIPs. **[Quality]**
- The MCO collected, analyzed, and reported intervention-specific effectiveness data to monitor the progress and impact of interventions throughout the most recent measurement period for all five PIPs. **[Quality]**
- For all four PIPs assessed for achieving significant improvement (*Behavioral Health Transitions of Care*, *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years*, *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees*, and *Screening for HIV Infection*), some of the MCO's reported performance indicator results demonstrated statistically significant improvement from baseline to the most recent remeasurement. **[Quality, Timeliness, and Access]**
- For one PIP assessed for achieving significant improvement (*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 UHC, the following opportunity for improvement was identified:

- For two PIPs (*Behavioral Health Transitions of Care* and *Screening for HIV Infection*) assessed for achieving significant improvement, 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 UHC, 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 30, 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	✓	✓	✓

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

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

Table 3-1—UHC 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 UHC'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—UHC HEDIS Effectiveness of Care Performance Measures—MY 2022, MY 2023, and MY 2024 Comparison

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
Follow-Up After Hospitalization for Mental Illness				
Within 7 Days of Discharge—Total	20.90%^	20.73%^	21.54%^	22.05%^
Within 30 Days of Discharge[I]—Total	38.41%^	39.16%^	40.86%^	42.18%^
Follow-Up After Emergency Department Visit for Mental Illness				
Within 7 Days of Discharge—Total	23.89%^	22.84%^	26.01%^	23.02%^
Within 30 Days of Discharge[I]—Total	36.83%^	37.68%^	41.84%^	38.77%^
Follow-Up After Emergency Department Visit for Substance Use				
Within 7 Days of Discharge—Total	16.39%^	14.40%^	15.49%^	15.66%^
Within 30 Days of Discharge[I]—Total	25.98%^	22.92%^	24.54%^	25.41%^
Follow-Up After High-Intensity Care for SUD				
Within 7 Days of Visit or Discharge—Total	—	—	57.49%+	59.23%+
Within 30 Days of Visit or Discharge—Total	—	—	71.21%+	70.77%+
Plan All-Cause Readmissions[B]				
*Observed Readmissions (Numerator/Denominator)**	11.14%	10.37%	10.98%	10.05%
Expected Readmissions Rate	9.65%	10.00%	8.67%	8.53%
*Observed-to-Expected (O/E) Ratio (Observed Readmissions/Expected Readmissions)**	1.1540^	1.0376^	1.2661^	1.1771^
Depression Screening and Follow-Up for Adolescents and Adults—Electronic Clinical Data System (ECDS)				
Depression Screening—Total	0.58%	0.85%^	2.33%^	3.31%^
Follow-Up on Positive Screen—Total	72.73%	74.14%+	57.75%^	73.57%+
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	82.08%+	83.96%+	84.63%+	85.11%+
Diabetes Monitoring for People With Diabetes and Schizophrenia	68.64%^	72.74%+	75.08%+	75.60%+
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	81.71%+	82.43%+	83.75%+	82.56%+
Metabolic Monitoring for Children and Adolescents on Antipsychotics—ECDS				
Blood Glucose Testing—Total	—	—	54.29%^	53.68%^
Cholesterol Testing—Total	—	—	28.75%^	28.43%^
Blood Glucose and Cholesterol Testing—Total	—	—	27.65%^	27.26%^
Lead Screening in Children	65.45%+	64.24%+	70.80%+	70.87%+
Colorectal Cancer Screening[I]—ECDS	—	—	45.01%+	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	83.21%+	83.21%+	87.10%+	86.26%+
Counseling for Nutrition—Total	68.86%^	58.39%^	72.26%^	70.74%^
Counseling for Physical Activity—Total	60.10%^	50.85%^	68.13%^	66.86%^
HIV Viral Load Suppression[I]	77.60%	82.05%	81.68%	82.24%
Low-Risk Cesarean Delivery (Cesarean Rate for Low-Risk First Birth Women)[*,I]	26.47%	26.41%	26.41%	26.37%
Chlamydia Screening in Women				
Total	64.02%+	65.49%+	65.98%+	66.43%+
Controlling High Blood Pressure[I]	61.31%+	61.80%^	63.26%^	65.03%^
Statin Therapy for Patients With Cardiovascular Disease				
Received Statin Therapy—Total	80.50%+	82.82%+	83.65%+	82.62%+
Statin Adherence 80%—Total	63.81%^	61.52%^	77.51%+	71.14%^
Glycemic Status Assessment for Patients With Diabetes				
Glycemic Status >9.0%[*,I]	34.55%+	23.60%+	26.03%+	28.35%+
Glycemic Status <8.0%	57.91%+	70.07%+	65.94%+	64.86%+
Eye Exam for Patients With Diabetes	55.72%+	54.74%+	55.47%^	59.29%+
Blood Pressure Control for Patients With Diabetes	67.15%+	70.07%+	71.29%^	69.65%^
Pharmacotherapy for Opioid Use Disorder	21.84%^	21.85%^	39.07%+	34.64%+
Initiation and Engagement of SUD Treatment				
Initiation of SUD Treatment—Total	58.78%+	60.16%+	59.09%+	59.26%+
Engagement of SUD Treatment—Total	25.97%+	28.17%+	28.06%+	27.37%+
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	67.86%+	65.02%+	68.20%+	64.29%+
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	48.69%^	51.27%^	68.84%+	61.49%^
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—ECDS				
Initiation Phase	—	—	45.53%^	45.46%^
Continuation and Maintenance Phase	—	—	51.07%^	52.86%^
Antidepressant Medication Management				
Effective Acute Phase Treatment	53.91%^	55.90%^	63.69%^	60.88%^
Effective Continuation Phase Treatment	35.51%^	36.41%^	49.73%+	45.44%^

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
Appropriate Treatment for Children With Upper Respiratory Infection (URI)	79.48%^	80.14%^	80.78%^	81.90%^
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	49.60%^	48.99%^	49.50%^	52.98%^
Use of Imaging Studies for Low Back Pain	70.81%^	69.60%^	67.72%^	68.86%^
Cervical Cancer Screening[I]	61.07%+	56.45%^	58.15%+	57.33%^
Asthma Medication Ratio				
5–11 Years	—	68.99%^	66.67%^	65.73%^
12–18 Years	—	59.53%^	58.33%^	63.52%^
19–50 Years	—	56.98%^	55.25%^	63.12%+
51–64 Years	—	55.61%^	55.65%^	65.14%+
Total	—	60.16%^	59.27%^	64.22%+
Appropriate Testing for Pharyngitis				
3–17 Years	—	—	84.64%^	82.73%^
18–64 Years	—	—	79.78%+	78.29%+
65 Years and Older	—	—	NA	60.61%+
Total	—	—	83.29%^	81.44%^
Topical Fluoride for Children				
1–2 Years	—	2.24%	2.75%	6.04%
3–4 Years	—	0.93%	0.95%	7.59%
Total	—	1.56%	1.82%	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—UHC 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	73.82%+	75.53%+	79.57%+	75.53%^
45–64 Years	82.51%+	84.90%+	87.10%+	83.48%+
65 Years and Older	75.65%^	74.54%^	79.16%^	77.97%^
Total	76.47%+	78.57%+	82.10%+	78.09%+

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	82.97%^	87.59%+	87.10%+	83.83%^
Postpartum Care	77.37%^	77.37%^	80.78%^	81.62%^

Table 3-4—UHC 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	62.07%+	66.33%+	66.68%+	64.83%+
15 Months–30 Months	66.66%^	69.64%+	74.35%+	72.42%+
Child and Adolescent Well-Care Visits				
3–11 Years	56.29%+	59.98%+	62.36%+	60.45%^
12–17 Years	52.84%+	56.83%+	58.55%+	56.11%+
18–21 Years	28.28%+	32.59%+	33.65%+	32.68%+
Total	49.99%+	54.23%+	56.46%+	54.58%^
Antibiotic Utilization for Respiratory Conditions				
3 Months–17 Years	—	—	35.01%+	34.05%+
18–64 Years	—	—	30.09%+	29.16%+
65 Years and Older	—	—	21.28%+	20.07%+
Total	—	—	33.24%+	32.26%+
Enrollment by Product Line				
Less than 1 Year	—	8,498	7,909	37,522
1–4 Years	—	35,729	31,545	141,537
5–9 Years	—	48,063	44,102	182,737
10–14 Years	—	48,805	45,869	176,938
15–17 Years	—	29,427	28,315	109,211
18–19 Years	—	16,987	15,306	60,260
20–24 Years	—	32,834	25,096	111,685
25–29 Years	—	24,721	18,877	93,717
30–34 Years	—	25,021	19,168	92,906
35–39 Years	—	22,937	17,777	82,628
40–44 Years	—	21,081	16,312	72,625
45–49 Years	—	16,300	12,782	56,774

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
50–54 Years	—	14,740	11,362	48,838
55–59 Years	—	14,428	11,161	48,549
60–64 Years	—	13,567	11,089	48,032
65–69 Years	—	507	331	1,704
70–74 Years	—	174	159	620
75–79 Years	—	90	79	306
80–84 Years	—	55	46	200
85–89 Years	—	NA	NA	86
90 Years and Older	—	NA	NA	65
Unknown	—	NA	NA	NA
Total	—	374,001	317,318	1,366,940
Language Diversity of Membership				
Spoken Language Preferred for Health Care—Health Plan	—	0.00%+	0.00%^	51.08%+
Spoken Language Preferred for Health Care—CMS/State	—	100.00%+	100.00%+	47.98%+
Spoken Language Preferred for Health Care—Other Third-Party	—	0.00%+	0.00%+	0.94%+
Preferred Language for Written Materials—Health Plan	—	0.00%+	0.00%^	51.25%+
Preferred Language for Written Materials—CMS/State	—	0.00%^	0.00%^	24.75%+
Preferred Language for Written Materials—Other Third-Party	—	100.00%+	100.00%+	24.00%+
Other Language Needs—Health Plan	—	0.00%+	0.00%^	46.39%+
Other Language Needs—CMS/State	—	0.00%+	0.00%+	20.61%+
Other Language Needs—Other Third-Party	—	100.00%+	100.00%+	33.00%+
Spoken Language Preferred for Health Care—Percent English	—	98.24%+	98.35%+	97.19%+
Spoken Language Preferred for Health Care—Percent Non-English	—	1.76%^	1.65%^	1.86%^
Spoken Language Preferred for Health Care—Percent Declined	—	0.00%+	0.00%+	0.00%+
Spoken Language Preferred for Health Care—Percent Unknown	—	0.00%^	0.00%^	0.95%^
Language Preferred for Written Materials—Percent English	—	0.00%^	0.00%^	65.15%^
Language Preferred for Written Materials—Percent Non-English	—	0.00%^	0.00%^	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	—	100.00%+	100.00%+	33.54%+
Other Language Needs—Percent English	—	0.00%+	0.00%+	37.76%+
Other Language Needs—Percent Non-English	—	0.00%+	0.00%+	0.57%+
Other Language Needs—Percent Declined	—	0.00%+	0.00%+	0.00%+
Other Language Needs—Percent Unknown	—	100.00%+	100.00%+	61.67%^
Race/Ethnicity Diversity of Membership				
Race—Health Plan	—	0.00%+	0.00%^	44.31%+
Race—CMS/State	—	72.12%+	87.31%+	41.33%^
Race—Other Direct	—	0.00%+	0.00%+	1.69%+
Race—Direct Total	—	72.12%^	87.31%+	87.33%+
Race—Indirect Total	—	0.00%+	0.00%+	1.14%+
Race—Unknown Total	—	27.88%+	12.69%^	11.53%^
Ethnicity—Health Plan	—	0.00%+	0.00%^	35.42%+
Ethnicity—CMS/State	—	97.02%+	86.18%+	36.27%+
Ethnicity—Other Direct	—	0.00%+	0.00%+	9.66%+
Ethnicity—Direct Total	—	97.02%+	86.18%+	81.35%^
Ethnicity—Indirect Total	—	0.00%+	0.00%+	4.26%+
Ethnicity—Unknown Total	—	2.98%^	13.82%+	14.39%+
Race: White—Ethnicity: Hispanic or Latino	—	0.00%^	3.63%+	3.01%+
Race: White—Ethnicity: Not Hispanic or Latino	—	37.91%+	28.63%+	32.21%+
Race: White—Ethnicity: Asked but No Answer	—	0.00%+	0.00%+	0.01%+
Race: White—Ethnicity: Unknown	—	0.00%^	4.86%+	2.86%+
Race: White—Ethnicity: Total	—	37.91%^	37.12%^	38.09%^
Race: Black or African American—Ethnicity: Hispanic or Latino	—	0.00%^	4.90%+	3.34%+
Race: Black or African American—Ethnicity: Not Hispanic or Latino	—	29.32%+	32.91%+	37.02%+
Race: Black or African American—Ethnicity: Asked but No Answer	—	0.00%+	0.00%+	0.00%+
Race: Black or African American—Ethnicity: Unknown	—	0.00%^	6.33%+	3.99%+
Race: Black or African American—Ethnicity: Total	—	29.32%+	44.14%+	44.36%+

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
Race: American Indian or Alaska Native—Ethnicity: Hispanic or Latino	—	0.00%^	0.09%+	0.09%+
Race: American Indian or Alaska Native—Ethnicity: Not Hispanic or Latino	—	0.80%+	0.59%+	0.47%+
Race: American Indian or Alaska Native—Ethnicity: Asked but No Answer	—	0.00%+	0.00%+	0.00%+
Race: American Indian or Alaska Native—Ethnicity: Unknown	—	0.00%^	0.15%+	0.21%+
Race: American Indian or Alaska Native—Ethnicity: Total	—	0.80%+	0.82%+	0.77%+
Race: Asian—Ethnicity: Hispanic or Latino	—	0.00%^	0.09%+	0.12%+
Race: Asian—Ethnicity: Not Hispanic or Latino	—	1.10%^	1.13%^	1.53%+
Race: Asian—Ethnicity: Asked but No Answer	—	0.00%+	0.00%+	0.00%+
Race: Asian—Ethnicity: Unknown	—	0.00%^	0.35%+	0.40%+
Race: Asian—Ethnicity: Total	—	1.10%^	1.58%^	2.04%+
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Hispanic or Latino	—	0.00%+	0.00%^	0.01%^
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Not Hispanic or Latino	—	0.01%^	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	—	0.00%+	0.00%+	0.01%+
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Total	—	0.01%^	0.02%^	0.04%^
Race: Some Other Race—Ethnicity: Hispanic or Latino	—	0.00%^	0.80%+	0.53%+
Race: Some Other Race—Ethnicity: Not Hispanic or Latino	—	0.00%^	1.94%+	1.30%+
Race: Some Other Race—Ethnicity: Asked but No Answer	—	0.00%+	0.00%+	0.00%+
Race: Some Other Race—Ethnicity: Unknown	—	2.98%+	0.91%+	0.70%+
Race: Some Other Race—Ethnicity: Total	—	2.98%+	3.64%+	2.54%+
Race: Two or More Races—Ethnicity: Hispanic or Latino	—	0.00%+	0.00%+	0.27%+
Race: Two or More Races—Ethnicity: Not Hispanic or Latino	—	0.00%+	0.00%+	0.13%+
Race: Two or More Races—Ethnicity: Asked but No Answer	—	0.00%+	0.00%+	0.00%+

HEDIS Measure	MY 2022	MY 2023	MY 2024	SWA
Race: Two or More Races—Ethnicity: Unknown	—	0.00%+	0.00%+	0.24%+
Race: Two or More Races—Ethnicity: Total	—	0.00%+	0.00%+	0.64%+
Race: Unknown—Ethnicity: Hispanic or Latino	—	0.87%^	0.92%^	0.99%^
Race: Unknown—Ethnicity: Not Hispanic or Latino	—	27.01%+	10.55%+	3.02%+
Race: Unknown—Ethnicity: Asked but No Answer	—	0.00%+	0.00%+	1.54%+
Race: Unknown—Ethnicity: Unknown	—	0.00%^	1.22%^	5.98%+
Race: Unknown—Ethnicity: Total	—	27.88%+	12.69%^	11.53%^
Race: Total—Ethnicity: Hispanic or Latino	—	0.87%^	10.43%^	8.36%^
Race: Total—Ethnicity: Not Hispanic or Latino	—	96.15%+	75.75%+	75.70%+
Race: Total—Ethnicity: Asked but No Answer	—	0.00%+	0.00%+	1.55%+
Race: Total—Ethnicity: Unknown	—	2.98%^	13.82%+	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—UHC 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	39	117	95
< NCQA National 50th Percentile Benchmark	39	67	55
NCQA National Benchmark Unavailable	11	12	5
Total	**89**	**196**	**155**

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

- UHC'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 UHC 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]**
- UHC'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, UHC'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 UHC 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]**
- UHC'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 UHC was effective in ensuring that adult members with cardiovascular disease and schizophrenia had their cholesterol monitored to promote positive health outcomes. **[Quality]**
- UHC's rate on the *Lead Screening in Children* measure was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that UHC 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]**
- UHC's rate on the *Colorectal Cancer Screening—ECDS* measure was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that UHC was effective in ensuring that members 45 to 75 years of age had appropriate screening for colorectal cancer. **[Quality]**
- UHC's rate on the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total* measure indicator was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that UHC was effective in coordinating with providers to ensure that child and adolescent members are having their weight and BMI monitored to reduce the risk for obesity and prevent adverse health outcomes. **[Quality]**
- UHC'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 UHC effectively coordinated with providers to facilitate annual follow-ups with and screening of sexually active members. **[Quality]**
- UHC'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 UHC effectively coordinated with providers to ensure that members with clinical atherosclerotic

cardiovascular disease (ASCVD) received statin therapy and adhered to the therapy to manage their condition, reducing the risk of adverse outcomes. **[Quality]**

- UHC's rates on the *Glycemic Status Assessment for Patients With Diabetes* measure indicators were above the NCQA national 50th percentile benchmark for MY 2024. These results suggest that UHC was effective in coordinating with providers to help members control their blood sugar levels, reducing the risk of complications. **[Quality]**
- UHC'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 UHC was effective in coordinating with providers to engage members with opioid use disorder (OUD) in continuous treatment with pharmacotherapy, increasing the chance for positive outcomes. **[Quality]**
- UHC'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 UHC 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]**
- UHC's rate on the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* measure was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that UHC effectively coordinated with providers to ensure the use of psychosocial care as first-line treatment for children and adolescents recently started on antipsychotic medications. **[Quality]**
- UHC'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 UHC was effective in coordinating with providers to ensure that members with schizophrenia or schizoaffective disorder were dispensed and remain on an antipsychotic medication for at least 80 percent of their treatment period. **[Quality]**
- UHC's rate on the *Cervical Cancer Screening* measure was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that UHC was effective in coordinating with providers to ensure that women ages 21 to 64 years received appropriate, early detection cancer screening. **[Quality]**
- UHC's rate on the *Appropriate Testing for Pharyngitis—18–64 Years* measure indicator was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that UHC was effective in coordinating with providers to ensure that adult members diagnosed with pharyngitis receive a group A streptococcus test to aid in minimizing use of antibiotics. **[Quality]**
- UHC's rates on the *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years*, *45–64 Years*, and *Total* measure indicators were above the NCQA national 50th percentile benchmark for MY 2024. These results suggest that UHC was effective 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]**
- UHC's rate on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator was above the NCQA national 50th percentile benchmark for MY 2024. This result suggests that UHC effectively coordinated with providers to ensure that members receive timely and adequate

prenatal care, in alignment with guidance provided by the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG). **[Quality, Timeliness, and Access]**

- UHC'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 UHC 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]**
- UHC's rates on the *Child and Adolescent Well-Care Visits* measure indicators were above the NCQA national 50th percentile benchmark for MY 2024. These results suggest that UHC effectively coordinated with providers to ensure that adolescent members received appropriate well-care visits to provide screening and counseling. **[Quality and Access]**
- UHC's rates on the *Antibiotic Utilization for Respiratory Conditions* measure indicators were above the NCQA national 50th percentile benchmark for MY 2024. These results suggest that UHC was effective in coordinating with providers to ensure that members diagnosed with a respiratory condition were not inappropriately dispensed an antibiotic. **[Quality]**

For UHC, the following opportunities for improvement were identified:

- UHC'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 UHC 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]**
- UHC'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, UHC'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 UHC 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]**
- UHC'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 UHC has room for improvement with facilitating appropriate post-discharge planning and care coordination. **[Quality]**
- UHC's rates on the *Depression Screening and Follow-Up for Adolescents and Adults—ECDS* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest that UHC has room for improvement in coordinating with providers to ensure adolescent and adult Medicaid members are properly screened for depression, enabling timely follow-up care. **[Quality]**
- UHC'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 UHC has room for improvement in its coordination with providers to effectively monitor blood glucose and cholesterol in child and adolescent members on antipsychotics. **[Quality]**

- UHC's rates on the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* and *Counseling for Physical Activity—Total* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest that UHC has room for improvement in coordinating with providers to ensure that child and adolescent members are receiving appropriate counseling to reduce the risk for obesity and prevent adverse health outcomes. **[Quality]**
- UHC's rate on the *Controlling High Blood Pressure* measure was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that UHC has room for improvement in coordinating with providers to help members manage their blood pressure, reducing their risk for heart disease and stroke. **[Quality]**
- UHC's rate on the *Eye Exam for Patients With Diabetes* measure was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that UHC has room for improvement in coordinating with providers to ensure that adult members with diabetes receive a retinal eye exam to screen for diabetic retinal disease. **[Quality]**
- UHC'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 UHC has room for improvement in coordinating with providers to help adult members with diabetes adequately control their blood pressure. **[Quality]**
- UHC'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 UHC has room for improvement in coordinating with providers to ensure that children prescribed ADHD medication participate in continuous follow-up visits with a practitioner with prescribing authority to properly manage their prescription. **[Quality, Timeliness, and Access]**
- UHC'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 UHC has room for improvement with ensuring that a diagnosis of URI does not result in an antibiotic dispensing event for members. **[Quality]**
- UHC'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 UHC 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]**
- UHC'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 UHC has room for improvement with ensuring that providers properly order imaging studies. **[Quality]**
- UHC's rates on the *Asthma Medication Ratio* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest that UHC has room for improvement in coordinating with providers to help members with persistent asthma manage this treatable condition. **[Quality]**

- UHC's rates on the *Appropriate Testing for Pharyngitis—3–17 Years* and *Total* measure indicators were below the NCQA national 50th percentile benchmark for MY 2024. These results suggest that UHC has room for improvement in coordinating with providers to ensure that child and adolescent members diagnosed with pharyngitis receive a group A streptococcus test to aid in minimizing use of antibiotics. **[Quality]**
- UHC's rate on the *Adults' Access to Preventive/Ambulatory Health Services—65 Years and Older* measure indicator was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that UHC has room for improvement in coordinating with PCPs to ensure that older members are engaging in preventive or ambulatory visits to manage their health and avoid adverse outcomes. **[Quality and Access]**
- UHC's rate on the *Prenatal and Postpartum Care—Postpartum Care* measure indicator was below the NCQA national 50th percentile benchmark for MY 2024. This result suggests that UHC has room for improvement in coordinating with providers to ensure that members receive timely and adequate postpartum care, in alignment with guidance provided by the AAP and ACOG. **[Quality, Timeliness, and Access]**

For UHC, 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 UHC 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 UHC. UHC 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 UHC work with providers to improve post-discharge planning and care coordination. **[Quality]**
- To improve performance on the *Depression Screening and Follow-Up for Adolescents and Adults—ECDS* measure indicators, HSAG recommends that UHC work with providers to identify and address barriers to depression screening for members. UHC could consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions to improve screening for depression and enable timely follow-up care. **[Quality]**
- To improve performance on the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—ECDS* measure indicators, HSAG recommends that UHC work with providers to identify root causes and trial interventions to ensure that children and adolescents with ongoing antipsychotic medication use have appropriate metabolic testing completed annually to appropriately manage their conditions. **[Quality]**

- To improve performance on the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators, HSAG recommends that UHC work with PCPs to identify and address barriers to primary care visits for children and adolescents in need of weight assessment and education on healthy habits. UHC could also consider data analysis and stratification across key demographics (i.e., race, ethnicity, age, and ZIP Code) to identify disparities and implement targeted interventions, such as patient and provider education, outreach campaigns, and sending reminders. **[Quality]**
- To improve performance on the *Controlling High Blood Pressure* measure, HSAG recommends that UHC work with providers to identify and address barriers to effective blood pressure management in members. UHC could also consider expanding on existing strategies that focus on disease and chronic condition management, which may include providing at-home devices, such as blood pressure monitoring devices, to hypertensive members; evaluating and expanding current and/or new member outreach and engagement initiatives; and offering provider education and engagement opportunities such as webinars and newsletters on hypertension management best practices. Additionally, UHC could consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions. **[Quality]**
- To improve performance on the *Eye Exam for Patients With Diabetes* measure, HSAG recommends that UHC work with providers to identify root causes and trial interventions to encourage members with diabetes to get screened for diabetic retinal disease. UHC could also consider expanding on existing strategies that focus on disease and chronic condition management, and evaluating and expanding current and/or new member outreach and engagement initiatives. **[Quality]**
- To improve performance on the *Blood Pressure Control for Patients With Diabetes* measure, HSAG recommends that UHC work with providers to identify and address barriers to effective blood pressure management for diabetic members. HSAG also recommends that UHC 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. UHC 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 UHC work with providers to identify and address barriers to initial follow-up visits with children prescribed ADHD medication. UHC 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 UHC work with providers to trial solutions to reduce antibiotic dispensing to treat URI. UHC 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 UHC work with providers to trial solutions to reduce or prevent the prescribing of antibiotics for members with a diagnosis of bronchitis or bronchiolitis. UHC 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 UHC focus its efforts on decreasing unnecessary imaging for low back pain. HSAG also recommends that UHC 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 *Asthma Medication Ratio* measure indicators, HSAG recommends that UHC work with providers to identify and address barriers to asthma management for members with persistent asthma. UHC 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 to improve asthma management, such as provide education on the importance of well-managed asthma, controller medications, and data collection on medication prescriptions. **[Quality]**
- To improve performance on the *Appropriate Testing for Pharyngitis—3–17 Years* and *Total* measure indicators, HSAG recommends that UHC work with providers to trial solutions to ensure that child and adolescent members diagnosed with pharyngitis are administered a group A streptococcus test to prevent the inappropriate prescribing of antibiotics. UHC could also consider data analysis and stratification across key demographics such as race, ethnicity, and ZIP Code to identify disparities and implement targeted interventions. **[Quality]**
- To improve performance on the *Adults' Access to Preventive/Ambulatory Health Services—65 Years and Older* measure indicator, HSAG recommends that UHC work with PCPs to identify and address barriers to preventive or ambulatory visits for adult members. UHC could also consider data analysis and stratification across key demographics (i.e., race, ethnicity, age, and ZIP Code) to identify disparities and implement targeted interventions, such as patient and provider education, outreach campaigns, and sending reminders. **[Quality and Access]**
- To improve performance on the *Prenatal and Postpartum Care—Postpartum Care* measure indicator, HSAG recommends that UHC work with providers to identify and address barriers to timely and adequate postpartum care. HSAG recommends that UHC consider implementing interventions such as offering provider education and engagement opportunities, including educational webinars and newsletters on postpartum health services, and piloting a member incentives program designed to encourage engagement in timely postpartum 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 30, 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 UHC. 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	7	2	3	78%
II	Member Rights and Confidentiality	24	24	24	0	0	100%
III	Member Information	19	18	13	5	1	72%
IV	Emergency and Poststabilization Services	13	13	13	0	0	100%
V	Adequate Capacity and Availability of Services	15	14	2	12	1	14%
VI	Coordination and Continuity of Care	12	12	9	3	0	75%
VII	Coverage and Authorization of Services	23	21	13	8	2	62%
VIII	Provider Selection	19	19	12	7	0	63%
IX	Subcontractual Relationships and Delegation	6	6	5	1	0	83%
X	Practice Guidelines	6	6	5	1	0	83%
XI	Health Information Systems	9	9	7	2	0	78%
XII	Quality Assessment and Performance Improvement	13	11	11	0	2	100%
XIII	Grievance and Appeal Systems	38	37	31	6	1	84%
XIV	Program Integrity	18	18	16	2	0	89%
Total Compliance Score		**227**	**217**	**168**	**49**	**10**	**77%**

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 UHC, the following strengths were identified:

- UHC 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]**
- UHC 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]**
- UHC 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]**

For UHC, the following opportunities for improvement were identified:

- UHC did not ensure its policies included all requirements should a member wish to disenroll. **[Quality]**
- UHC did not ensure it provides a 30-day written notice of the proposed disenrollment and notifies the member of his or her right to submit a request for a State fair hearing (SFH). **[Quality]**
- UHC 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]**
- UHC did not include a tagline on all written materials that are critical to obtaining services in the prevalent non-English languages and in a conspicuously visible font size explaining the availability of written translation or oral interpretation to understand the information provided. **[Quality]**
- UHC did not include in the member handbook that written translation is available in other prevalent languages. **[Quality]**
- UHC did not include components in its member handbook regarding information about specialized behavioral health services (SBHS). **[Quality]**
- UHC'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]**
- UHC's CR demonstrated low compliance with Standard V—Adequate Capacity and Availability of Services (14 percent). **[Quality and Access]**
- UHC's CMPE file review demonstrated noncompliance with timely completion of the initial health needs assessment. **[Quality and Timeliness]**

- UHC did not conduct an in-person quarterly reassessment and annual reassessment of each member's needs as required by assessed tier level, including subsequent attempts if the initial attempt to contact the member is unsuccessful. **[Quality]**
- UHC's CR demonstrated low compliance with Standard VII—Coverage and Authorization of Services (62 percent). **[Quality]**
- UHC's CR demonstrated low compliance with Standard VIII—Provider Selection (63 percent). **[Quality and Access]**
- UHC did not ensure that all its contracts or written arrangements—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]**
- UHC did not implement a process to adopt practice guidelines that are adopted in consultation with network providers through its established process. **[Quality]**
- UHC did not meet compliance with federal and State regulations that mandate a process for ensuring provider-submitted data are accurate and complete, nor verify the timeliness of reported data, screen for completeness, or collect data in standardized formats. **[Quality]**
- UHC did not comply with sections of the Affordable Care Act to ensure its claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements. **[Quality]**
- UHC did not provide evidence that it extends the time frame for resolving grievances by up to 14 calendar days if the member requests the extension or if there is need for additional information and how the delay is in the member's interest. **[Quality]**
- UHC did not acknowledge each appeal in writing within five business days of receipt of each appeal, unless the enrollee requests an expedited resolution. **[Quality and Timeliness]**
- UHC did not include in its policies for SFHs the requirement to provide the enrollee and his or her authorized representative with the enrollee's record, including the opportunity before and during the appeal or SFH process for the enrollee or an authorized representative to examine the record. **[Quality]**
- UHC's policy did not include that in the case of an expedited appeal denial, the MCE shall provide oral notice to the enrollee by close of business on the day of resolution and written notice to the enrollee within two calendar days of the disposition. **[Quality and Timeliness]**
- UHC's member handbook did not include components that inform members that the MCE includes parties to the appeal and SFH such as the member and his or her representative, the legal representative of a deceased member's estate, and the MCE. **[Quality]**
- UHC did not submit an attestation to LDH that it is certified for coordinating the efforts to obtain the information for the submission from the appropriate data sources. **[Quality]**
- UHC did not provide documentation that indicates that it terminates a network provider immediately upon notification from LDH that the network provider cannot be enrolled, or at the expiration of the

120-day period without enrollment of the provider, and notifies affected members. **[Quality and Access]**

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

- UHC must ensure its policies include all requirements should a member wish to disenroll. **[Quality]**
- UHC must ensure it provides a 30-day written notice of the proposed disenrollment and notifies the member of his or her right to submit a request for an SFH. **[Quality]**
- UHC must ensure its website is provided in a manner and format that may be easily understood and is readily accessible by members and potential members. **[Quality]**
- UHC must ensure written materials that are critical to obtaining services are available in the prevalent non-English languages in its service areas and comply with criteria related to taglines and requesting auxiliary aids and services at no cost. **[Quality]**
- UHC must include in its member handbook that UHC can provide translated printed materials if the member speaks a language other than English. **[Quality]**
- UHC must include components in its member handbook regarding information toward SBHS. **[Quality]**
- UHC must inform members on its website that information provided electronically is available in paper form without charge upon request and provide it upon request within five business days. **[Quality]**
- UHC must review compliance with Standard V—Adequate Capacity and Availability of Services. **[Quality and Access]**
- UHC 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]**
- UHC must conduct an in-person quarterly reassessment and annual reassessment of each member's needs as required by assessed tier level, including subsequent attempts if the initial attempt to contact the member is unsuccessful. **[Quality]**
- UHC must review compliance with Standard VII—Coverage and Authorization of Services. **[Quality]**
- UHC must review compliance with Standard VIII—Provider Selection. **[Quality and Access]**
- UHC must ensure that all its contracts or written arrangements comply—and that all delegates agree to comply—with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions and rules, policies, procedures, manuals, the State Plan, and Waivers. **[Quality]**
- UHC must implement a process to adopt practice guidelines that are adopted in consultation with network providers through its established process, the Provider Advisory Committee. **[Quality]**
- UHC must meet compliance with federal and State regulations that mandate a process for ensuring provider-submitted data are accurate and complete, as well as for verifying the timeliness of reported data, screening for completeness, and collecting data in standardized formats. **[Quality]**

- UHC must comply with all sections of the Affordable Care Act to ensure its claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements. **[Quality]**
- UHC must ensure it extends the time frame for resolving grievances by up to 14 calendar days if the member requests the extension or if there is need for additional information and how the delay is in the member's interest. **[Quality]**
- UHC must acknowledge each appeal in writing within five business days of receipt of each appeal unless the enrollee requests an expedited resolution. **[Quality and Timeliness]**
- UHC must include in its policies for SFHs the requirement that, upon request, UHC shall provide the enrollee and his or her authorized representative with the enrollee's record, including all medical records and any other documents and records considered or relied upon by UHC regarding an appeal or SFH, including the opportunity before and during the appeal or SFH process for the enrollee or an authorized representative to examine the record. **[Quality]**
- UHC's policy must include that in the case of an expedited appeal denial, the MCE shall provide oral notice to the enrollee by close of business on the day of resolution and written notice to the enrollee within two calendar days of the disposition. **[Quality and Timeliness]**
- UHC's member handbook must include components that inform members that the MCE includes parties to the appeal and SFH such as the member and his or her representative, the legal representative of a deceased member's estate, and the MCE. **[Quality]**
- UHC must submit the attestation to LDH that it is certified for coordinating the efforts to obtain the information for the submission from the appropriate data sources. **[Quality]**
- UHC must provide documentation that indicates that it terminates a network provider immediately upon notification from LDH that the network provider cannot be enrolled, or at the expiration of the 120-day period without enrollment of the provider, and notifies affected members. **[Quality and Access]**

Methodology

Objectives

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

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

Table 4-2—CR Standards

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

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

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

* No CR was conducted for CY 2023 for the Louisiana MCEs.

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

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

Technical Methods of Data Collection

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

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

Pre-Virtual Review Activities

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

Virtual Review Activities

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

[7] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 30, 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 UHC providers by specialty provider type.

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

Table 5-1—Response Rate and Indicator Match Rates for UHC 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	47	94.0%	41	87.2%	44	93.6%	42	89.4%	26	55.3%	26	55.3%	31	66.0%
Pediatrics	48	96.0%	45	93.8%	48	100.0%	48	100.0%	42	87.5%	41	85.4%	43	89.6%
Obstetricians/ Gynecologists (OB/GYNs)	37	74.0%	36	97.3%	36	97.3%	34	91.9%	29	78.4%	26	70.3%	35	94.6%
Specialists (any)	38	76.0%	36	94.7%	37	97.4%	37	97.4%	32	84.2%	31	81.6%	32	84.2%
Behavioral Health (any)	26	52.0%	24	92.3%	19	73.1%	18	69.2%	17	65.4%	16	61.5%	16	61.5%
Total	**196**	**78.4%**	**182**	**92.9%**	**184**	**93.9%**	**179**	**91.3%**	**146**	**74.5%**	**140**	**71.4%**	**157**	**80.1%**

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

Table 5-2 presents UHC'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[2]
Internal Medicine/Family Medicine	50	18	38.7%
Pediatrics	50	35	72.7%
OB/GYNs	50	26	54.0%
Specialists (any)	50	28	58.0%
Behavioral Health (any)	50	14	30.7%
Total	**250**	**121**	**50.8%**

[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.

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 UHC by specialty provider type.

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

	Response Rate		Correct Address		Offered Requested Services		Accepted MCO		Accepted Louisiana Medicaid		Accepted New Patients		Provider at Location	
Specialty Provider Type	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)
Allergists	26	96.3%	26	100%	26	100%	23	88.5%	23	88.5%	21	80.8%	18	69.2%
Dermatologists	11	91.7%	11	100%	11	100%	2	18.2%	2	18.2%	2	18.2%	2	18.2%
Orthopedic Surgeons	32	82.1%	32	100%	26	81.3%	9	28.1%	9	28.1%	9	28.1%	9	28.1%
Total	**69**	**88.5%**	**69**	**100%**	**63**	**91.3%**	**34**	**49.3%**	**34**	**49.3%**	**32**	**46.4%**	**29**	**42.0%**

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

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

Appointment Type	Wait Time (in Days)	Percentage of Appointments Meeting Compliance Standard
Allergists	31	60.0%
Dermatologists	174	0.0%
Orthopedic Surgeons	11	100%

Table 5-5 presents UHC'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	27	18	66.7%
Dermatologists	12	2	16.7%
Orthopedic Surgeons	39	9	33.3%
Total	**78**	**29**	**42.3%**

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

[2] The compliance scores in this section represent the weighted compliance score for each MCO and specialty and are not a calculation of the compliant providers divided by the total. The criteria in Table 5-11 and Table 5-12 of the Methodology section were used to calculate the weight of each noncompliance survey outcome.

NAV Audit

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

Network Adequacy Indicator-Specific Validation Ratings

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

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

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

Access Standards

Table 5-7 contains the percentage of members UHC 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—UHC Distance Requirements Met by Percentage of Members With Access by Provider Type and Urbanicity

Provider Type	Urbanicity	Percentage of Members With Access
Adult PCP (Family/General Practice; Internal Medicine)	Urban	98.7%
	Rural	100% ↑
Pediatrics (Family/General Practice; Internal Medicine)	Urban	99.0%
	Rural	100% ↑
FQHCs	Urban	89.9%
	Rural	100% ↑
RHCs	Urban	46.1%
	Rural	100% ↑
Acute Inpatient Hospitals	Urban	90.9%
	Rural	99.9%
Laboratory	Urban	99.5%
	Rural	99.9%

[8] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 30, 2025.

Provider Type	Urbanicity	Percentage of Members With Access
Radiology	Urban	99.5%
	Rural	100% ↑
Pharmacy	Urban	97.7%
	Rural	100% ↑
Hemodialysis Centers	Urban	89.5%
	Rural	98.8%
OB/GYNs (access only for adult female members ages 21 and over)	Urban	93.8%
	Rural	95.9%
Allergy/Immunology	Urban	99.7%
	Rural	97.2%
Cardiology	Urban	100% ↑
	Rural	100% ↑
Dermatology	Urban	97.8%
	Rural	94.3%
Endocrinology and Metabolism (Adult)	Urban	99.2%
	Rural	98.6%
Endocrinology and Metabolism (Pediatric)	Urban	88.3%
	Rural	65.6%
Gastroenterology	Urban	100% ↑
	Rural	99.9%
Hematology/Oncology	Urban	100% ↑
	Rural	100% ↑
Nephrology	Urban	100% ↑
	Rural	99.9%
Neurology (Adult)	Urban	100% ↑
	Rural	100% ↑
Neurology (Pediatric)	Urban	0.0%
	Rural	0.0%
Ophthalmology	Urban	100% ↑
	Rural	100% ↑
Orthopedics (Adult)	Urban	100% ↑
	Rural	100% ↑
Orthopedics (Pediatric)	Urban	99.8%
	Rural	96.4%
Otorhinolaryngology/Otolaryngology	Urban	100% ↑
	Rural	99.6%

Provider Type	Urbanicity	Percentage of Members With Access
Urology	Urban	100% ↑
	Rural	99.3%
Psychiatrists	Urban	96.6%
	Rural	99.6%
Physicians and LMHPs who specialize in pregnancy-related and postpartum depression or related mental health disorders	Urban	99.9%
	Rural	100% ↑
Physicians and LMHPs who specialize in pregnancy-related and postpartum SUD	Urban	99.9%
	Rural	100% ↑
Behavioral Health Specialist (Advanced Practice Registered Nurse—Behavioral Health [APRN-BH] specialty, Licensed Psychologist, or Licensed Clinical Social Worker [LCSW])	Urban	99.1%
	Rural	99.9%
PRTFs (Level 3.7 WM) and Other Specialization (Pediatric Under Age 21)	All	100% ↑
American Society of Addiction Medicine (ASAM) Level 1	Urban	94.6%
	Rural	98.7%
ASAM Level 2.1	Urban	92.3%
	Rural	92.9%
ASAM Level 2 WM	Urban	77.1%
	Rural	69.3%
ASAM Level 3.1 (Adult over age 21)	Urban	74.1%
	Rural	35.6%
ASAM Level 3.1 (Pediatric under age 21)	All	80.5%
ASAM Level 3.2 WM (Adult over age 21)	Urban	65.7%
	Rural	52.4%
ASAM Level 3.2 WM (Pediatric under age 21)	All	90.6%
ASAM Level 3.3 (Adult over age 21)	Urban	76.7%
	Rural	37.8%
ASAM Level 3.5 (Adult over age 21)	Urban	92.2%
	Rural	76.3%
ASAM Level 3.5 (Pediatric under age 21)	All	99.9%
ASAM Level 3.7 (Adult over age 21)	Urban	96.6%
	Rural	95.8%
ASAM Level 3.7 WM (Adult over age 21)	Urban	96.1%
	Rural	97.9%

Provider Type	Urbanicity	Percentage of Members With Access
Inpatient Psychiatric Hospital (Free Standing Psychiatric Hospital; Distinct Part Psychiatric Unit)	Urban	100% ↑
	Rural	100% ↑
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	96.0%
	Rural	99.7%

Provider-to-Member Ratios

HSAG assessed UHC'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 UHC'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—UHC 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)	1.99%	Yes
Combined Pediatrics (1:1,000 child members)	1.75%	Yes

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

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

Specialty Provider Type	Indicator	Statewide Ratio	Compliant
OB/GYNs	1:10,000	0.16%	Yes
Allergy/Immunology	1:100,000	0.01%	Yes
Cardiology	1:20,000	0.12%	Yes
Dermatology	1:40,000	0.03%	Yes
Endocrinology and Metabolism	1:25,000	0.02%	Yes
Gastroenterology	1:30,000	0.05%	Yes
Hematology/Oncology	1:80,000	0.06%	Yes

Specialty Provider Type	Indicator	Statewide Ratio	Compliant
Nephrology	1:50,000	0.05%	Yes
Neurology	1:35,000	0.07%	Yes
Ophthalmology	1:20,000	0.07%	Yes
Orthopedics	1:15,000	0.09%	Yes
Otorhinolaryngology/Otolaryngology	1:30,000	0.06%	Yes
Urology	1:30,000	0.04%	Yes

HSAG assessed UHC's results for behavioral health providers to determine the accessibility and availability of appointments and determined that UHC 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—UHC 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%	89%
Non-Urgent Routine Behavioral Health Care	14 calendar days	70%	95%

MCO Strengths, Opportunities for Improvement, and Recommendations

For UHC, the following strengths were identified:

- Overall, 100 percent of respondents in the provider access survey confirmed the sampled address was correct. **[Quality and Access]**
- Overall, 91.3 percent of respondents in the provider access survey confirmed the location offered the requested services. **[Quality and Access]**
- Overall, 93.9 percent of respondents in the PDV confirmed the provider was affiliated with the location. **[Quality and Access]**
- Within the PDV, 92.9 percent of the locations reached confirmed the sampled address was correct. **[Quality and Access]**
- Overall, 91.3 percent of respondents in the PDV confirmed the specialty was accurate. **[Quality and Access]**

- UHC maintained a robust process to keep provider data up to date and accurate through its quarterly attestation reminders to providers and data accuracy review by the Quality Assurance (QA) team and Audit team, credentialing process, and monthly monitoring of the multiple sanction/exclusion lists. **[Quality and Timeliness]**

For UHC, the following opportunities for improvement were identified:

- Acceptance of UHC was inaccurate with 74.5 percent of providers in the PDV and 49.3 percent of locations in the provider access survey accepting UHC. Additionally, 71.4 percent of providers in the PDV and 49.3 percent of locations in the provider access survey accepted Louisiana Medicaid. **[Quality and Access]**
- Overall, only 69.2 percent of behavioral health providers in the PDV confirmed the specialty was accurate. Additionally, 81.3 percent of orthopedic surgeon locations in the provider access survey confirmed the specialty was accurate. **[Quality and Access]**
- Overall, acceptance of new patients was relatively low with 80.1 percent of providers in the PDV and 46.4 percent of locations in the provider access survey accepting new patients. **[Quality and Access]**
- Provider affiliation varied by survey type with 73.1 percent of behavioral health PDV locations and 42.0 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, 60.0 percent of allergist cases and 0.0 percent of dermatologist cases were within the wait time compliance standards. **[Timeliness and Access]**
- Compliance scores varied by survey type with overall compliance scores of 50.8 percent for the PDV and 42.3 percent for the provider access survey. **[Quality and Access]**
- Compliance scores also varied by provider type with behavioral health having the lowest compliance score at 30.7 percent and pediatrics having the highest compliance score at 72.7 percent for the PDV. For the provider access survey, dermatologists exhibited the lowest compliance score at 16.7 percent, and allergists exhibited the highest compliance score at 66.7 percent. **[Quality and Access]**
- UHC generated GeoAccess tables and maps in preparation of the semiannual LA 220 report; however, three specialty provider types (i.e., Endocrinology/Metabolism, Neurology, and Orthopedics) were not calculated in accordance with LA requirements to report adult and pediatric access separately. **[Quality]**

For UHC, the following recommendations were identified:

- LDH should provide UHC with the case-level PDV and provider access survey data files (i.e., flat files) and a defined timeline by which UHC will address provider data deficiencies identified during the PDV reviews and/or provider access survey. **[Quality and Access]**
- In addition to updating provider information, UHC 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]**

- UHC 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]**
- UHC 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 UHC to confirm office outreach and confirmation of provider information. **[Quality and Access]**
- UHC should work with LDH to ensure clear understanding of the expectations for separating adult and pediatric populations for Endocrinology/Metabolism, Neurology, and Orthopedics in future reporting. **[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 UHC completed the LDH-approved questionnaire supplied by HSAG through the Universal Survey Tool (UST). HSAG identified follow-up questions based on UHC's original questionnaire responses, and UHC responded to these specific questions. To support its questionnaire responses, UHC submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from UHC 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 UHC.

Table 6-1—EDV Results for UHC

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• UHC 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. • UHC reported methods to identify duplicate claims. • UHC and its subcontractors were responsible for the collection and maintenance of the provider information. In addition, UHC and its subcontractors integrated the Medicaid member enrollment files into their systems for claim processing.
Payment Structures	• UHC reported a wide range of pricing methodologies that varied by encounter type and subcontractors. • UHC collected and verified TPL information, processed payment based on TPL information, and submitted TPL information to LDH via the encounter data.
Encounter Data Quality Monitoring	• UHC stated that it had subcontractors for dental, NEMT, pharmacy, and vision encounters. For the encounters collected by

Analysis	Key Findings
	these subcontractors, UHC noted that it stored and reviewed the encounter data except for pharmacy encounters. In addition, UHC did not modify the data prior to submission. Finally, UHC noted it did review the data before submission to LDH except for dental encounters. • For encounters collected by subcontractors, UHC and/or its subcontractors noted that they performed claim volume, completeness and accuracy, timeliness, and reconciliation with financial reports checks on dental, NEMT, and vision encounters. However, for pharmacy encounters, UHC and/or its subcontractor only performed reconciliation with financial reports checks. • For encounters collected by UHC, UHC noted that it performed claim volume, completeness and accuracy, timeliness, and reconciliation with financial reports checks. • Based on UHC'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 and NEMT encounters) to 6.3 percent (institutional encounters).
Administrative Profile	
Encounter Data Completeness	• UHC 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. • UHC had a rate of duplicate encounters of less than 1.0 percent for each of the four encounter types listed above.
Encounter Data Timeliness	• Within 60 days, UHC submitted 99.0 percent of professional, 91.9 percent of institutional, 99.1 percent of dental, and 99.7 percent of pharmacy encounters to LDH after the payment date.
Field-Level Completeness and Accuracy	• All key data elements in UHC's encounter data had a relatively high or reasonable rate of population (i.e., percent present). • UHC had all key data elements populated with at least 95.0 percent of valid values in dental and pharmacy encounters while there was at least one data element with an accuracy rate below 95.0 percent for the other two encounter types. Refer to the opportunities for improvement section below for the list of data elements needing UHC's attention.
Encounter Referential Integrity	• No major concerns were noted for UHC when evaluating the integrity between medical/dental/pharmacy encounters and member enrollment data, or between medical/dental encounters and pharmacy encounters.

Analysis	Key Findings
	• Of all identified provider NPIs in UHC's submitted medical/dental and pharmacy encounters, only 91.5 percent and 96.2 percent were identified in the provider data, respectively.
Encounter Data Logic	• UHC had 61.0 percent of members with both medical/dental and pharmacy encounters throughout the measurement year. • UHC had 72.2 percent of members who were continuously enrolled in the measurement year.

MCO Strengths, Opportunities for Improvement, and Recommendations

For UHC, the following strengths were identified:

- For NEMT and vision encounters collected by its subcontractors, UHC noted that it stored and reviewed encounter data before submission to LDH, did not modify the data before submission, and reviewed the encounters after submission to LDH. In addition, UHC and/or its dental, NEMT, and vision subcontractors noted that they performed claim volume, completeness and accuracy, timeliness, and reconciliation with financial reports checks on the corresponding encounters. **[Quality and Timeliness]**
- For the encounters collected by UHC, it noted that it performed claim volume, completeness and accuracy, timeliness, and reconciliation with financial reports checks on encounters. **[Quality and Timeliness]**
- UHC reported less than 1.0 percent of pharmacy encounters as initially rejected and not yet accepted. **[Quality]**
- UHC had a rate of duplicate encounters of less than 1.0 percent for each encounter type. **[Quality]**
- UHC submitted 99.0 percent of professional encounters, 99.1 percent of dental encounters, and 99.7 percent of pharmacy encounters within 60 days from the payment date. **[Timeliness]**
- For dental and pharmacy encounters, UHC had all key data elements populated with at least 95.0 percent of valid values. **[Quality]**
- For referential integrity, UHC had the highest rate of providers in the pharmacy encounter file who were also in the provider file at approximately 96.2 percent. **[Quality]**

For UHC, the following opportunities for improvement were identified:

- UHC noted that it did not store its pharmacy subcontractor data or review the data prior to submission to LDH. In addition, neither UHC nor its pharmacy subcontractor performed claim volume, completeness and accuracy, or timeliness checks on the pharmacy encounters. **[Quality and Timeliness]**
- Among the six MCOs, UHC had the highest percentage of institutional encounters initially rejected and not yet accepted by LDH at 6.3 percent. **[Quality]**

- UHC had the following data elements with less than 95.0 percent of valid values: **[Quality]**
  - Professional Encounters: *National Drug Codes (NDCs)* (94.8 percent)
  - Institutional: *Billing Provider NPI* (93.8 percent) and *Attending Provider Taxonomy Code* (75.6 percent)

For UHC, the following recommendations were identified:

- UHC should develop a comprehensive suite of encounter data quality monitoring reports to assess the accuracy, completeness, and timeliness of encounter data received from its pharmacy subcontractor. **[Quality and Timeliness]**
- UHC should build a process with LDH to ensure that rejected institutional encounters will be submitted to LDH with correct information. **[Quality]**
- UHC 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]**

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 30, 2025.

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

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

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

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

Administrative Profile

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

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

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

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

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

Metrics for Encounter Data Completeness

HSAG evaluated encounter data completeness through the following metrics:

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

Metrics for Encounter Data Timeliness

HSAG evaluated encounter data timeliness through the following metrics:

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

Metrics for Field-Level Completeness and Accuracy

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

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

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

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

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

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

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

[10] Healthy Louisiana. Medicaid Managed Care Entities System Companion Guide, Version 1, June 18, 2025. Available at: https://ldh.la.gov/assets/medicaid/MCE_System_Companion_Guide/HLA_MCE_SCG_v.1.pdf. Accessed on: Dec 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 • Direction 2: Percentage of Members in the Enrollment File With a Medical/Dental Encounter

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

Metrics for Encounter Data Logic

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

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

Description of Data Obtained

Information Systems Review

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

Administrative Profile

Data obtained from LDH included:

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

How Data Were Aggregated and Analyzed

Information Systems Review

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

Administrative Profile

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

How Conclusions Were Drawn

Information Systems Review

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

Administrative Profile

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

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

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

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

Results

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

Table 7-1—Adult Achievement Scores

Measure	2023	2024	2025
Rating of Health Plan	82.05%	82.95%	76.69%
Rating of All Health Care	79.85%	85.84%	80.70%
Rating of Personal Doctor	88.68%	90.00%	82.98%
Rating of Specialist Seen Most Often	NA	NA	NA
Getting Needed Care	87.02%	NA	NA
Getting Care Quickly	80.74%	NA	NA
How Well Doctors Communicate	93.98%	96.02%	92.82%
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 UHC's 2023, 2024, and 2025 general child achievement scores.

Table 7-2—General Child Achievement Scores

Measure	2023	2024	2025
Rating of Health Plan	89.86%	91.02%	85.95%
Rating of All Health Care	94.33%	91.74%	87.69%
Rating of Personal Doctor	91.79%	92.00%	91.30%
Rating of Specialist Seen Most Often	NA	NA	NA
Getting Needed Care	92.56%	NA	NA
Getting Care Quickly	88.03%	NA	NA
How Well Doctors Communicate	97.49%	94.07%	96.69% ↑
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 UHC, the following strengths were identified:

- For the adult population, UHC'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, UHC's 2025 achievement score was statistically significantly higher than the 2025 NCQA child national average for one measure, *How Well Doctors Communicate*. **[Quality]**

For UHC, the following opportunity for improvement was identified:

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

For UHC, the following recommendation was identified:

- HSAG recommends that UHC continues to focus on increasing response rates to the CAHPS survey for the adult and general child populations so there are greater than 100 respondents for each measure. **[Quality, Timeliness, and Access]**

Methodology

Objectives

The CAHPS activity assesses adult members' and parents'/caretakers' of child members experiences with an MCO and the quality of care that they/their children receive. The goal of the CAHPS surveys is to provide feedback that is actionable and will aid in improving members' overall experiences.

Technical Methods of Data Collection

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

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

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

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[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	✓		

Results

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

Table 8-1—Adult Achievement Scores for UHC

Measure	2023	2024	2025	Healthy Louisiana SWA
Rating of Health Plan	60.16%	59.38%+	63.91%	57.88%
How Well People Communicate	87.10%	93.55%	91.69%	91.16%
Cultural Competency	75.00%+	77.78%+	93.75%+	86.01%+
Helped by Counseling or Treatment	65.63%	68.00%	75.37%	70.38%
Treatment or Counseling Convenience	86.51%	88.89%+	88.72%	88.13%
Getting Needed Treatment	73.60%	82.00%	85.38%	81.75%
Help Finding Counseling or Treatment	54.17%+	45.00%+	38.89%+	50.82%
Customer Service	70.00%+	68.75%+	85.00%+	70.81%
Helped by Crisis Response Services	79.17%+	77.78%+	70.83%+	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 UHC and the Healthy Louisiana SWA.

Table 8-2—Child Achievement Scores for UHC

Measure	2023	2024	2025	Healthy Louisiana SWA
Rating of Health Plan	64.66%	66.67%	69.17%	63.63%
How Well People Communicate	92.59%	89.71%	91.29%	91.03%
Cultural Competency	100.00%+	87.50%+	100.00%+	92.57%+
Helped by Counseling or Treatment	56.90%	56.69%	61.19%	61.01%
Treatment or Counseling Convenience	89.66%	85.83%	86.47%	88.86%
Getting Needed Treatment	77.39%	76.98%	81.06%	78.93%
Help Finding Counseling or Treatment	35.00%+	46.67%+	33.33%+	38.57%+
Customer Service	58.82%+	57.14%+	65.00%+	71.71%+
Getting Professional Help	89.74%	84.92%	89.47%	87.75%
Help to Manage Condition	85.47%	81.25%	83.33%	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.

MCO Strengths, Opportunities for Improvement, and Recommendations

For UHC, the following strength was identified:

- For the adult and child populations, UHC'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 UHC, the following opportunity for improvement was identified:

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

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

Methodology

Objectives

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

Technical Methods of Data Collection

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 UHC, the following strength was identified:

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

For UHC, the following opportunity for improvement was identified:

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

For UHC, 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 UHC are displayed in Table 10-1.

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

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

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

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

MCO Strengths, Opportunities for Improvement, and Recommendations

For UHC, the following strengths were identified:

- For the Patient Experience composite, UHC earned 4.0 stars for the Satisfaction with Plan and Plan Services subcomposite. This subcomposite is based on UHC member responses to CAHPS survey questions, demonstrating UHC members are satisfied with their health plan and the services it provides. **[Quality]**
- For the Prevention and Equity composite, UHC earned 4.0 stars for the Children and Adolescent Well-Care and Other Preventive Services subcomposites, demonstrating strength for UHC related to documenting BMI percentiles in children and providing chlamydia screenings for young women. **[Quality and Access]**
- For the Treatment composite, UHC earned 4.5 stars and 4.0 stars for the Behavioral Health—Medication Adherence and Diabetes subcomposites, respectively, demonstrating strength for UHC related to ensuring members with depression and opioid use disorder stay on prescribed medications and to diabetic care. **[Quality, Timeliness, and Access]**

For UHC, the following opportunities for improvement were identified:

- For the Treatment composite, UHC earned 2.5 stars for the Respiratory and Behavioral Health—Care Coordination subcomposites, demonstrating opportunities for improvement for UHC related to antibiotic use for bronchitis/bronchiolitis and ensuring members receive timely follow up after hospitalizations and ED visits for behavioral health conditions. UHC also earned 2.0 stars for the Reduce Low Value Care subcomposite, demonstrating opportunities for improvement for UHC related to ensuring members with low back pain do not receive unnecessary imaging tests. **[Quality, Timeliness, and Access]**

For UHC, 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

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[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 30, 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 UHC's performance in providing quality, timely, and accessible healthcare services to Louisiana's Medicaid and CHIP members. HSAG provides UHC'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 UHC's reported performance indicator results demonstrated statistically significant improvement from baseline to the most recent remeasurement. **[Quality, Timeliness, and Access]**
PMV	• UHC's members received screenings for colorectal cancer, chlamydia, lead, and cervical cancer at rates above the NCQA national 50th percentile benchmark. **[Quality]** • UHC 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, engage these members in subsequent SUD services or medications, and follow up with members after high-intensity SUD treatment. **[Quality, Timeliness, and Access]**
Compliance	• UHC scored 100 percent for three standards in the CR, indicating that UHC's policies and procedures were generally compliant with contract requirements and staff were generally knowledgeable about the requirements, policies, and procedures. **[Quality]**
NAV	• UHC maintained a robust process for ensuring provider data accuracy through quarterly attestation reminders, QA and Audit team reviews, credentialing activities, and monthly monitoring of multiple sanction/exclusion lists. **[Quality]**
EDV	• UHC demonstrated strong encounter data quality and timeliness, reporting less than 1 percent of pharmacy encounters as initially rejected; submitting over 99 percent of professional, dental, and pharmacy encounters within 60 days of payment; and achieving at least 95 percent validity for key data elements in dental and pharmacy encounters. **[Quality]**
CAHPS and Behavioral Health Member Satisfaction Survey	• For the general child CAHPS population, UHC's 2025 CAHPS achievement score was statistically significantly higher than the 2025 NCQA child national average for one measure, *How Well Doctors Communicate*. **[Quality]** • For UHC's Behavioral Health Member Satisfaction Survey achievement scores, no notable strengths were identified. **[Quality]**
CMPE	• UHC 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	• UHC did not achieve significant improvement outcomes for all PIPs. **[Quality]**
PMV	• UHC 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]** • UHC 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	• UHC's CR demonstrated low compliance with Standard V—Adequate Capacity and Availability of Services (14 percent). **[Quality and Access]** • UHC's CR demonstrated low compliance with Standard VII—Coverage and Authorization of Services (62 percent). **[Quality]** • UHC's CR demonstrated low compliance with Standard VIII—Provider Selection (63 percent). **[Quality and Access]**
NAV	• UHC maintained a robust provider data accuracy process through quarterly attestations, QA team and Audit team reviews, credentialing, and sanction list monitoring; however, survey results revealed gaps in provider acceptance and affiliation, with only 74.5 percent of providers and 49.3 percent of locations accepting UHC, and affiliation confirmation varying significantly by survey type. **[Quality]** • Despite strong data accuracy controls, specialty provider types and compliance verification showed room for improvement, as only 69.2 percent of behavioral health providers confirmed accurate specialty information and overall compliance scores remained low (50.8 percent for PDV and 42.3 percent for provider access survey), highlighting opportunities to strengthen quality and access measures. **[Quality]**
EDV	• UHC noted that it did not store its pharmacy subcontractor data or review the data prior to submission to LDH. In addition, neither UHC nor its pharmacy subcontractor performed claim volume, completeness and accuracy, or timeliness checks on the pharmacy encounters. **[Quality]** • Among the six MCOs, UHC had the highest percentage of institutional encounters initially rejected and not yet accepted by LDH at 6.3 percent. **[Quality]** • UHC had three data elements with less than 95.0 percent of valid values. **[Quality]**
CAHPS and Behavioral Health Member Satisfaction Survey	• For UHC's 2025 CAHPS achievement scores, no notable opportunities for improvement were identified. **[Quality]** • For UHC's 2025 Behavioral Health Member Satisfaction Survey achievement scores, no notable opportunities for improvement were identified. **[Quality]**
CMPE	• UHC demonstrated an opportunity for improvement with elements related to ongoing scheduled CM activities. **[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, UHC should review intervention evaluation results to determine if each intervention is having the desired impact and how interventions can be revised to increase effectiveness. UHC should also revisit barrier analyses for each PIP to evaluate whether additional barriers need to be addressed by new or revised interventions to drive outcomes improvement. **[Quality]**	Goal 4: Promote wellness and prevention
PMV	• UHC 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]** • UHC should work with providers to prevent or reduce antibiotic dispensing to treat URIs in children and adults with bronchitis or bronchiolitis. **[Quality]**	Goal 3: Facilitate patient-centered, whole-person care
Compliance	• UHC's CR must demonstrate compliance with Standard V—Adequate Capacity and Availability of Services (14 percent). **[Quality and Access]** • UHC must demonstrate compliance with Standard VII—Coverage and Authorization of Services (62 percent). **[Quality]** • UHC must demonstrate compliance with Standard VIII—Provider Selection (63 percent). **[Quality and Access]** • UHC 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 Goal 3: Facilitate patient-centered, whole-person care Goal 4: Promote wellness and prevention Goal 7: Pay for value and incentivize innovation
NAV	• UHC should strengthen provider outreach to ensure offices consistently submit accurate, up-to-date information on key indicators (e.g., active providers, contact	Goal 2: Improve coordination and transitions of care

Overall MCO Recommendations		
	details, new patient acceptance). LDH should work with UHC to establish defined timelines and monitoring procedures, such as provider portals or data submission checks, to verify outreach and data accuracy. **[Quality and Access]**	
EDV	• UHC should develop a comprehensive suite of encounter data quality monitoring reports to assess the accuracy, completeness, and timeliness of encounter data received from its pharmacy subcontractor. **[Quality]** • UHC should build a process with LDH to ensure that rejected institutional encounters will be submitted to LDH with correct information. **[Quality]** • UHC 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 7: Pay for value and incentivize innovation Goal 8: Minimize wasteful spending
CAHPS and Behavioral Health Member Satisfaction Survey	• UHC should focus on increasing response rates to the CAHPS survey for its adult and general child populations and the Behavioral Health Member Satisfaction Survey so there are greater than 100 respondents for each measure by educating and engaging all employees to increase their knowledge of the surveys, using customer service techniques, oversampling, and continuing to provide awareness to members and providers during the survey period. **[Quality, Timeliness, and Access]**	Goal 3: Facilitate patient-centered, whole-person care
CMPE	• UHC should continue the efforts documented in its CAP responses to ensure compliance with contractual requirements. **[Quality]**	Goal 2: Improve coordination and transitions of care

12. Follow-Up on Prior Year's Recommendations

Regulations at 42 CFR §438.364 require an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR §438.310[c][2]) has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR. LDH required each MCO to document the follow-up actions per activity that the MCO completed in response to SFY 2023–2024 recommendations. Table 12-1 through Table 12-9 contain a summary of the follow-up actions that UHC completed in response to the EQRO's SFY 2024 recommendations. Furthermore, HSAG assessed UHC'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 UHC review intervention evaluation results to determine whether each intervention is having the desired impact and how interventions can be revised to increase effectiveness. UHC 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 outcome improvement.
Response
Describe initiatives implemented based on recommendations: In response to the recommendations, UnitedHealthcare Louisiana plan (UHCLA) has implemented targeted interventions across its Performance Improvement Projects (PIPs) to enhance rates and address identified barriers. Some of these initiatives include: • Development of educational toolkits • Conducted boots on the ground, statewide in person member education events and provider outreach • Provider and Member incentives • Data driven outreach to identified and target eligible members • Case management partnership
Identify any noted performance improvement as a result of initiatives implemented (if applicable): All PIPs have demonstrated quarter-over-quarter increases in rates. Notable success occurred when providers were educated on strategies for non-traditional care settings (e.g., urgent care, EDs) and when incentives were introduced.
Identify any barriers to implementing initiatives: Identified barriers include member challenges, provider challenges, and operational challenges. Member challenges included such things as missed appointments, incorrect demographics, and lack of awareness of screening importance. Provider challenges included reluctance to additional testing, limited knowledge of codes, and exclusions. Operational challenges included delays to outreach with the recent changes to TCPA laws.

Identify strategy for continued improvement or overcoming identified barriers:

Strategies for Continued Improvement:

UHCLA has identified multiple strategies for continued improvement and continual solutions to target identified barriers. Some of these include:

- Ongoing provider education and toolkit distribution tailored to LDH regions.
- Ongoing stakeholder feedback
- Expanded outreach via phone, events, and multiple communication channels to address demographic inaccuracies.
- Collaboration with Ryan White organizations and reinforcement of opt-out HIV screening legislation.
- Continued incentives and engagement efforts to sustain screening rate improvements.

HSAG Assessment

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

Recommendation

HSAG recommended that UHC evaluate performance measures with rates below the NCQA national 50th percentile.

Response

Describe initiatives implemented based on recommendations:

UHCLA monitors all performance measures and prioritizes improvement efforts for any metric falling below the NCQA national 50th percentile. UHC applies a continuous quality improvement approach, reviewing trends, identifying root causes, and implementing targeted interventions. UHCLA's goal is to not only meet national benchmarks but to continually elevate performance year-over-year to support better outcomes for our members.

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

The performance measures listed below reflect final annual rates for each reporting year and their corresponding NCQA Quality Compass 50th percentile benchmarks. Measures highlighted in green indicate achievement of or surpassing the 50th percentile for that year. Notably, several measures demonstrate consistent year-over-year improvement.

Measure	Final Rates MY2022	NC QA Quality Compass 50/% MY202	Final Rates MY2023	NCQA Quality Compass 50/% MY2023	Final rates MY2024	NCQA Quality Compass 50/% MY2024
CBP	61.31	59.85	61.8	64.48	63.26	67.88
FUH	38.41	59.42	39.16	59.85	40.86	62.08
FUA	25.98	21.24	22.92	36.18	24.54	39.1
FUM	36.83	54.51	37.68	53.82	41.84	57.13
PPC-Pre	82.97	77.37	87.59	84.55	87.1	86.37
PPC- Post	77.37	85.4	77.37	80.23	80.78	82.48

Identify any barriers to implementing initiatives:

Several operational and systemic factors have presented challenges in fully implementing quality improvement initiatives. Common barriers include:

- Limited provider engagement due to competing practice priorities
- Inconsistent documentation or coding practices that impact data accuracy
- Delays in receiving claims or encounter data
- Ability to reach members for case management and other UHC programs due to:
    - Incorrect member contact information
    - Members are unresponsive for phone calls, voice mail, and home visits
- Members have reported challenges with attending follow-up appointments or obtaining medications, such as:
    - Childcare concerns
    - Transportation issues, including the short timeframe to schedule Medicaid transportation when attending a 7-day follow-up
    - Work obligations

Identify strategy for continued improvement or overcoming identified barriers:
To support continued improvement and address identified barriers, UHCLA has implemented a multi-layered strategy grounded in targeted provider engagement, enhanced data integrity, and member-centered outreach. UHCLA continues to expand provider education through focused training, real-time performance feedback, and collaborative coaching to improve adherence to evidence-based guidelines.

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:
Based off the recommendations from HSAG, UHCLA has worked to identify barriers to timely follow-up care and has worked with providers to improve coordination of care following discharge between inpatient and outpatient providers and between providers and UHCLA. Some initiatives to address these barriers are the creation, implementation and expansion of High Needs Engagement and Support Program, expansion of the care coordination for behavioral health emergency department discharges, and the creation of value-based incentive for providers and also a member follow up incentive. Additionally, quarterly meetings have been set up with high utilizing inpatient facilities to discuss improvement of follow up rates and create solutions to emergent barriers.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
Recent data indicates that our rates for these measures have shown improvement compared to the previous reporting year.

Measure	MY2025 Rate as of 11/2025	Percent Increase
FUA-7 day	20.72%	5.30%
FUA-30 day	29.96%	5.97%
FUH-7 day	28.09%	8.41%
FUH-30 day	49.49%	13.48%
FUM-7 day	26.00%	2.34%
FUM-30 day	42.45%	5.92%

Identify any barriers to implementing initiatives:
To drive sustained improvement, UHC continually assesses barriers. Some identified barriers to implementing initiatives are:

- Members seeking services at Emergency Departments and Inpatient facilities that could be addressed in an outpatient setting.
- Emergency Departments are tasked with having to triage and stabilize the needs of members that are exhibiting urgent/emergent needs and are currently not set up to schedule follow-up appointments prior to discharge.
- Members can find it difficult to engage in routine behavioral and/or substance services.
- Members may have difficulty understanding discharge plans.

Identify strategy for continued improvement or overcoming identified barriers:
The previously noted interventions implemented in 2025 will be continued. Additionally, UHC is in the process of developing additional interventions for 2026.

- A list of office based and virtual outpatient behavioral health providers who have confirmed that they have 7-day FUH, FUM, and FUA follow up appointment availability is being compiled and will be provided to inpatient behavioral health facilities and emergency departments
- Set a list of mental health in lieu of service providers for intensive outpatient
- UHC is attempting to work with facilities who are not participating in the Health Information Exchange to enroll
- UHC is working with LDH and ACT providers to identify a billing process which more accurately captures the date of follow up/date the FUH gap was closed
- Stabilization and expansion of in-person inpatient wellness coordinators
- Working with transportation vendor to address transportation barriers
- Continuous provider education and outreach.

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:
Initiatives implemented to address the *Plan All-Cause Readmissions—O/E Ratio* measure include a coordinated set of initiatives focused on strengthening post-discharge transitions and continuity of care. Our clinical and population health teams conduct targeted outreach to members at discharge, and our population health consultants conduct outreach and education to providers to ensure sharing of best practices related to early identification of avoidable complications, appointment availability, and medication reconciliation. We continue to expand partnerships with key hospital systems and work towards creating strong relationships.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
Although the O/E ratio increased slightly from MY2023 to MY2024, performance remains well below 1.0, indicating that observed readmissions continue to occur at significantly lower rates than expected. The marginal increase highlights ongoing opportunities for refinement in our transitions-of-care processes.

C&S Accreditation Measure	MY2023	MY2024
Plan All-Cause Readmissions—O/E Ratio	0.059636441	0.061466007

Identify any barriers to implementing initiatives:
Noted barriers around implementing initiatives to target this measure relate to limited visibility into hospital discharge data as well as member engagement challenges.

Identify strategy for continued improvement or overcoming identified barriers:
UHCLA will continue to strengthen its readmission reduction approach by expanding our partnerships with hospital systems and community providers.

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: To improve performance on the *Use of Imaging Studies for Low Back Pain* measure, UHCLA has implemented targeted interventions aimed at reducing unnecessary imaging and addressing identified barriers. These efforts include enhancing provider

education through both in-person and virtual training sessions. Population Health Consultants continue to reinforce current PATH guidelines, ensuring clinicians have access to evidence-based practices. In addition, outreach has been expanded to promote appropriate utilization and strengthen adherence to national standards.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
Our rates have demonstrated consistent year-over-year improvement reflecting the effectiveness of collaborative efforts with providers.

C&S Accreditation Measure	MY 2022	MY2023	MY2024
Use of Imaging Studies for Low Back Pain (inverted rate)	70.81	69.6	67.72

Identify any barriers to implementing initiatives:
Not all providers are familiar with evidence-based recommendations and are reluctant for low back pain management without imaging.

Identify strategy for continued improvement or overcoming identified barriers:
UHCLA strategy for continued improvement to overcome identified barriers includes an approach that includes the whole care continuum from provider to member. Population Health Consultants continue to provide education and support to PCPs and are actively expanding outreach to providers across the state. To strengthen engagement, we are developing strategies to ensure communication and education for all providers to continue addressing gaps in care.

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:
To improve performance on the *Non-Recommended Cervical Screening in Adolescent Females* measure, UHCLA provides provider education with clear clinical decision pathways which includes age-appropriate guidance for testing. Additionally, members are educated with targeted health-literate educational materials.

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

Identify any barriers to implementing initiatives:
Identified barriers to implementing initiatives include:

- Difficulty with changing ingrained practice patterns
- Not all providers have EHRs that allow clinical decision supports
- Multiple competing clinical priorities
- Lack of standardized adolescent visit workflows

Identify strategy for continued improvement or overcoming identified barriers: UHCLA will continue to strengthen its efforts to reduce non-recommended cervical cancer screening in adolescent members by expanding provider support, reinforcing evidence-based practice across clinical settings utilizing codes that are universal over LOB to facilitate ease in coding and understanding the most up to date guidelines.
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 UHC with the case-level PDV and provider access survey data files (i.e., flat files) and a defined timeline by which UHC 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: UHCLA conducted a root cause analysis to address data deficiencies identified during the Provider Data Validation (PDV) reviews and provider access surveys. Errors were categorized based on the responsible party - provider, UHCLA, or the regulator. Provider-related issues were typically straightforward, such as outdated or missing information. UHCLA-related errors involved instances where updates were received but not accurately entered into the system. Regulator-related discrepancies included cases where fax numbers were mistakenly used from directories instead of valid phone numbers.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): UHCLA provided targeted education and feedback to selected providers emphasizing the importance of maintaining accurate and up-to-date demographic information through the Council for Affordable Quality Healthcare (CAQH) or direct submission to UnitedHealthcare. Providers were also educated on their contractual obligations with UHC, including the requirement to submit timely updates. Additionally, UHC coordinated with the regulator to ensure that valid contact information, specifically phone numbers rather than fax numbers, is selected and used for provider records.
Identify any barriers to implementing initiatives: Provider/office not available – closed or relocated without telling UHCLA.
Identify strategy for continued improvement or overcoming identified barriers: Automated directory suppression of providers with -0- claims during a 6-month period. Provider education, possible incentive for regular, valid attestation resulting in provider "passing"

HSAG Assessment

Recommendation

HSAG recommended that UHC 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:
UHCLA implemented a multi-pronged approach to address data mismatches identified in the Provider Data Validation (PDV) and provider access survey indicators. This included:

- Provider Education: Delivered targeted training emphasizing the importance of maintaining accurate demographic data and provided guidance on using UHC's online tools for data updates.
- Contractual Compliance: Educated providers on their contractual obligations with UHC, including the potential consequences of failing to maintain current information.
- Regulator Collaboration: Provided feedback to the regulator requesting thorough documentation of identified deficiencies and coordinated efforts to ensure valid contact information—specifically phone numbers rather than fax numbers—is selected for provider records.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
UHCLA met contract requirements for improvement for Q1 2025 audit, hopefully for Q2 as well.

Identify any barriers to implementing initiatives:
Several challenges have impacted the implementation of initiatives. First, there are limited incentives for providers to consistently maintain and update their demographic data, particularly when it comes to removing outdated information. Additionally, timing discrepancies have created a "moving target" scenario, errors identified during regulator surveys are sometimes corrected before UHCLA can verify and remediate them, complicating the validation process.

Identify strategy for continued improvement or overcoming identified barriers:
UHCLA is exploring the implementation of financial incentives for providers who successfully meet criteria during "secret shopper" audits, as a means to encourage accurate and timely data maintenance. Additionally, UHCLA continues to monitor provider addresses that have not been used in claims submissions over the past 6 to 12 months. These addresses are proactively reviewed for validity, and remediation efforts are initiated as needed to ensure the accuracy of provider directories.

HSAG Assessment

An HSAG auditor assessment of the MCO's intervention was not required, as no prior recommendation had been issued.

Recommendation

HSAG recommended that UHC 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:
We have a similar concern with claim denials for eligibility – we've found claims are sent to us instead of to the member's valid MCO for the DOS, needlessly increasing our denial rate and ultimately delaying the provider's reimbursement. The claims concern along with yours has resulted in eligibility verification being

added to general training materials shared during provider office visits. We also monitor (weekly) providers/groups with high eligibility denials and target them for specific education. Note that our state is also planning to post an online webinar provider offices can access to learn how to interpret their MEVS eligibility system (Providers can look up a member and find the assigned MCO for the DOS, without going into the eligibility systems for 6 different MCOs.)
Identify any noted performance improvement as a result of initiatives implemented (if applicable): None to date, but we continue to monitor.
Identify any barriers to implementing initiatives: Provider resistance to process changes.
Identify strategy for continued improvement or overcoming identified barriers: Emphasize the claims payment component of eligibility verification – let the financial impact help prioritize the issue.
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 UHC 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: UnitedHealthcare Community Plan of Louisiana has implemented several initiatives to improve CAHPS survey response rates across all populations. These initiatives include integration on QR codes in the initial, follow-up, and reminder letters, making it easier for members to access the online version of the survey. Additionally, in 2025, UHCLA oversampled both Adult and Child CAHPS surveys by 20%. For 2026, we are planning to increase oversampling to: Adult CCC-Medicaid Population – 80% and CCC-CHIP Population – 50%. UHC is also exploring outreach strategies such as email, text, and mailed letters to inform members ahead of time that they may receive a survey between March and May, encouraging participation to improve member experience feedback.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): While the QR code and oversampling strategies are relatively recent, early indicators suggest improved accessibility and engagement. However, proactive member communications have not yet shown a significant impact on final response counts based on historical data from other UHC plans.
Identify any barriers to implementing initiatives: Identified barriers for implementing these initiatives include difficulties with member contact information and engagement challenges. Historically, UHC has not had enough valid email addresses to fully leverage the email

Recommendation
optional protocols for CAHPS. Despite outreach efforts, member engagement remains inconsistent, particularly among our hard-to-reach populations.
Identify strategy for continued improvement or overcoming identified barriers: UHC's strategy for continued improvement and overcoming identified barriers include enhancements to improve the accuracy and completeness of member contact information to enable broader use of digital outreach methods. Continued refinement of communication strategies, including culturally and linguistically appropriate messaging, to better resonate with diverse member populations. Ongoing monitoring of response rates and effectiveness will guide adjustments to our approach for future survey cycles.
HSAG Assessment

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

Recommendation
None identified.

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

Recommendation
None identified.

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

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

Appendix A. MCO Health Equity Plan Summary

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

Health Equity Plan

HSAG reviewed UHC'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

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

A1 Goal (1): Pre-natal	
Participants (briefly describe):	African American and Hispanic/Latino women ages 21-44.
Strategy:	African American and Hispanic/Latino women ages 21–44 remain our priority population, as both groups face unique challenges and systemic barriers that contribute to inequitable maternal health outcomes.
Activity:	UnitedHealthcare Community Plan of Louisiana (UHCLA) continues to prioritize African American and Hispanic/Latino women ages 21–44 in its prenatal care initiatives, recognizing the persistent disparities these populations face in maternal health outcomes. African American women remain our primary focus, and in 2024, we expanded our efforts to include Hispanic/Latino women to address their unique barriers to care. Our strategy integrates enrollee and provider incentives with targeted education to drive engagement and improve outcomes. In 2025, we significantly increased the value of member incentives, raising the reward significantly. This enhancement was designed to promote early and sustained engagement in prenatal care. As of June 2025, eligible members received incentives for completing Health Needs Assessments (HNAs) and attending prenatal visits. Our provider engagement strategy includes maternity-focused Value-Based Payment (VBP) arrangements, such as the CP-PCPi and APM 2c programs, which reward OB practices for timely pregnancy notifications and closing care gaps aligned with HEDIS® prenatal measures. In 2024, UHCLA achieved an 87.10% gap closure rate for Timeliness of Prenatal Care, surpassing the target of 84.23%. These programs were expanded to include Hispanic/Latino women under the HEPi incentive structure, reinforcing our commitment to health equity. As of June 11, 2025, 78.87% of members are engaged in prenatal care, reflecting strong progress toward our 2025

<table>
<tr><td></td><td colspan="3">target of 84.55%. While earlier year-over-year comparisons are still being evaluated, this mid-year engagement rate indicates positive momentum.

To support providers, we hosted multiple Joint Operating Committees (JOCs) and clinical meetings since January 2025, offering platforms for education, performance evaluation, and peer learning. In Quarter 2, we are launching two workshops with free continue education credits that will focus on cultural competency and the impact of historical and contemporary policies on social determinants of health (SDOH). These sessions aim to equip providers with ethical, culturally responsive strategies to improve care delivery. We also expanded access to Trusted Provider Network (TPN) trainings, adding two new sessions in 2025 in collaboration with other managed care organizations to reduce provider burden. The OB Provider Toolkit continues to be a vital resource, now enhanced with Patient-Centered Outcomes Research (PCOR) and best practices to help providers close care gaps and improve outcomes.

Member education remains a cornerstone of our strategy. We actively promote the BabyScript app, which supports trimester tracking, prenatal education, and access to rewards. In partnership with maternal and child health organizations, we cohost prenatal and parenting classes that cover maternal health, infant care, breastfeeding, and safety. Participants are also connected to community resources such as WIC and Healthy Start and are educated on their UnitedHealthcare benefits and rewards.

Despite these successes, provider time constraints due to clinic hours and patient volume remain a challenge. To address this, we offer flexible, accessible training formats, including on-demand modules via TPN, in-person Lunch & Learns, and integration into provider meetings and JOCs. These efforts aim to reduce training burden while maintaining high engagement.

Overall, the program is demonstrating measurable impact, particularly in improving full-term birth rates and increasing early prenatal engagement. Quality incentives and HEPi structures remain in place to support both pre- and postnatal care for African American and Hispanic/Latino women. We are committed to refining, expanding, and evaluating our strategies to ensure sustained progress and improved maternal and infant health outcomes across Louisiana. Results will continue to be reported year-over-year through 2025 to track growth, impact, and opportunities for further improvement.</td></tr>
<tr><td>Measurable Objective:</td><td>Prenatal Care – timeliness of Prenatal Care

Measures MY2016 = 85.54%; MY2017 = 82.24%; MY2018 = 85.16%; MY2019 = 88.32%; MY2020 = 79.56%; MY2021 = 82.24%; MY2022= 82.97% (Hybrid); MY2023= 87.59%; MY 2024= 87.10%

Improve HEDIS® prenatal measures</td><td>Milestones to be Completed by June 2025</td><td>Increase in Prenatal Care visits

Improve HEDIS® prenatal measures

Reduce c-sections

Reduce low birth weights</td></tr>
</table>

	Reduce c-sections Reduce low birth weights Improve provider/enrollee engagement Review Member Gap In Care Report (PCOR) to (a) check for improvement in measures and (b) measure outcomes of those providers who complete relevant cultural competency, implicit bias, or equity related trainings verses those who did not.		Improve provider/enrollee engagement **Target is 84.55%** As this program expands into CY2025, results will be reported in 2026. As of claims date **6/11/2025**, **78.87%** of members were engaged in prenatal care. We will continue to expand and refine our initiatives and strategies to address disparities, inequities, and other barriers that impact the prenatal care for women of color with results reported YOY through 2025.
A1 Goal (2): Post-Partum			
Participants (briefly describe):	African American and Hispanic/Latino women ages 21-44.		
Strategy:	Enrollee and Provider incentives and education. Recognizing the significant disparities faced by African American women ages 21-44, they remain our priority population. In 2024, we respectfully expanded our focus to also prioritize Hispanic or Latino women ages 21-44, acknowledging the unique challenges and disparities they encounter.		
Activity:	UnitedHealthcare Community Plan of Louisiana (UHCLA) continues to prioritize maternal health equity, with a focused commitment to improving outcomes for African American and Hispanic/Latino women ages 21–44. African American women remain the primary focus due to persistent disparities in maternal morbidity and mortality. In 2025, UHCLA strengthened its postpartum care strategy by significantly increasing member incentives to promote early and sustained engagement in prenatal and postpartum care. Eligible members received rewards for completing Health Needs Assessments (HNAs) and attending prenatal visits—part of a broader initiative to reduce barriers and promote maternal wellness. UHCLA also maintains a strong commitment to provider engagement through value-based payment (VBP) models. The OB Gap Closure Program (APM 2c) offers quarterly incentive payments to qualifying OB practices for closing care gaps related to HEDIS® postpartum measures. Additional incentives are provided through CP-PCPi and HEPi programs, with a specific focus on African American and Hispanic/Latino women. To support providers in identifying and addressing care gaps, UHCLA supplies up-to-date Patient-Centered Outcomes Research (PCOR) data and the 2025 UHC PATH guides. Between January and June 2025, providers participated in structured clinical meetings and Joint Operating Committees (JOCs),		

	which served as platforms for peer learning, performance evaluation, and strategic planning. These sessions emphasized best practices in breast cancer screening and facilitated data-driven discussions to improve care delivery. Refinements made in 2024 positioned UHCLA to achieve an 80.78% postpartum care (PPC) gap closure rate—surpassing the 2024 target of 80.23% by 0.55 percentage points. In 2025, as of June, 64.32% of eligible enrollees have completed their postpartum visit within 84 days of delivery. While this reflects an upward trend, it remains approximately 15.91 percentage points below the 2025 target of 80.23%. This gap underscores the continued need for refined strategies to improve postpartum visit rates within the critical 7–84-day window and throughout the 12-month postpartum period. In response, UHCLA has expanded outreach and education through multiple modalities, including case management, digital communications, and targeted engagement campaigns. Postpartum value-added benefits were also enhanced in 2025 to further support members during the postpartum period. Additionally, UHCLA's maternal case management team launched a 12-month postpartum program to address maternal mortality, postpartum depression, and other critical issues affecting mothers and infants during the first year after delivery. These robust efforts are expected to drive continued improvement, and UHCLA remains confident in its ability to meet or exceed its 2025 target. To allow for full implementation and impact, the milestone date for achieving the PPC target has been extended from June 30 to December 31, 2025. **Provider Education and Capacity Building** Provider education remains a cornerstone of UHCLA's maternal health equity strategy. In Q2 2025, two continuing education workshops were launched, focusing on cultural competency and the impact of historical and contemporary policies on social determinants of health (SDOH). These sessions are designed to equip providers with ethical, culturally responsive strategies to improve care delivery. UHCLA also expanded access to Trusted Provider Network (TPN) trainings, adding two new sessions in collaboration with other managed care organizations to reduce provider burden. The OB Provider Toolkit was updated with PCOR data and best practices to support care gap closure and improve outcomes. **Addressing Barriers to Provider Engagement** Recognizing that provider time constraints remain a significant barrier—due to clinic hours and patient volume—UHCLA has implemented flexible training formats. These include on-demand TPN modules, in-person Lunch & Learns, and integration of training into provider meetings and JOCs. These efforts are designed to maintain high levels of provider engagement while minimizing disruption to clinical workflows.		
Measurable Objective:	Timeliness of Post-Partum Care. Measures MY2016 = 64.84%; MY2017 = 64.48%; MY2018 = 71.53%; MY2019 = 78.59%; MY2020 = 79.32%; MY2021 = 76.64%; MY2022 = 77.37% (Hybrid);	**Milestones to be Completed by December 2025**	Increase Post-Partum visits Improve HEDIS® post-partum measures **Target is 80.23%**

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<td>MY2023= 77.37% (Hybrid); MY2024= 80.78% (Hybrid)

Increase Post-Partum Care visits

Percentage of women who had a live birth that had a postpartum visit on or between 7–84 days after delivery.

Review Member Gap In Care Report (PCOR) to (a) check for improvement in measures and (b) measure outcomes of those providers who complete relevant cultural competency, implicit bias, or equity related trainings verses those who did not.</td>
<td></td>
<td>In CY2025, we will continue to educate our members and providers to ensure the members receive needed postpartum care. As of claims date 6/11/2025, 64.32% of members were engaged in prenatal care.

As UHC continue to expand and refine the program to address disparities, inequities, and needs into 2025, results will be reported in 2026.</td>
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<tr>
<td colspan="4">A1 Goal (3): Women's Health: Breast Cancer Screening and Cervical Cancer Screening</td>
</tr>
<tr>
<td>Participants (briefly describe):</td>
<td colspan="3">The participant populations for breast and cervical cancer screenings are determined based on age-specific criteria aligned with current best practices from the American Cancer Society, other relevant clinical associations, state eligibility requirements, and guidance from qualified subject matter experts.

• Breast Cancer Screening Participants:
In 2025, the HEDIS® measure for breast cancer screening expanded the eligible age range to include women ages 40–74. In alignment with these updated guidelines, UnitedHealthcare Community Plan of Louisiana (UHCLA) also expanded its eligible population for this focus area. This adjustment supports earlier detection, enables timely intervention, and helps address disparities and barriers to care at an earlier stage—particularly among populations historically underserved in preventive health.

• Cervical Cancer Screening Participants:
The eligible population for cervical cancer screening remains adult women ages 21–64. There have been no changes to the participant criteria for this measure at this time.</td>
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<tr>
<td>Strategy:</td>
<td colspan="3">Overall Women's Health Initiative
UnitedHealthcare Community Plan of Louisiana (UHCLA) remains committed to advancing women's health by increasing breast and cervical cancer screening rates through a comprehensive, equity-focused strategy. Our goal is to ensure more women—particularly those from historically underserved populations—have access to timely, preventive screenings that support early detection and improved health outcomes.

To make a more significant impact, UHCLA has extended its milestone date from June 30, 2025, to December 31, 2025, allowing for the full implementation of refined strategies and outreach efforts.

Data-Driven Provider Support and Engagement
To address care inequities, UHCLA equips providers statewide with current Patient-Centered Outcomes Research (PCOR) data and the 2025 UHC PATH guides to help identify and close care gaps. Since January 2025, providers have been supported through structured clinical meetings</td>
</tr>
</table>

<table>
<tr><td></td><td>and Joint Operating Committees (JOCs), which serve as strategic platforms for education, peer learning, and performance evaluation. These sessions have emphasized best practices in breast and cervical cancer screenings and facilitated data-driven discussions to align on targeted improvement strategies.

Clinical Transformation Managers (CTMs) have also presented focused slide content during monthly clinical meetings and JOCs, reinforcing key metrics and strategies related to women's health.

Tools and Resources for Providers
Providers are equipped with a comprehensive GYN Toolkit, which includes:
HEDIS® measure specifications for breast and cervical cancer screenings
Updated coding guidance to support gap closure
CDC educational materials
Access to the provider portal for real-time data
This toolkit is reviewed annually and shared directly with providers by UHCLA staff to ensure alignment with the most current clinical guidelines.

Integrated Strategies to Drive Engagement
UHCLA's approach integrates provider and member incentives with targeted education, outreach events, and community-based activities. Eligible members receive incentives for completing breast and cervical cancer screenings, promoting early detection and sustained engagement in preventive care.

These initiatives help providers identify eligible members and encourage timely screenings, ensuring more women receive appropriate care.

Breast Cancer Screening Highlights
Provider Incentive Program: Community Plan (CP-PCPi) value-based payment model
Performance: As of June 11, 2025, 54.42% of eligible enrollees have closed their breast cancer screening gap, exceeding the target of 52.68% by 1.74 percentage points
Community Collaboration: UHCLA partnered with Southern University in Shreveport (SUSLA) to support breast cancer awareness and screening events
Cervical Cancer Screening Highlights
Provider Incentive Program: CP-PCPi
Outreach and Education:
Provider and member outreach campaigns
Distribution of educational materials via the CDC and provider portal
Community events to raise awareness about the importance of cervical cancer screenings
Inclusion of cervical cancer screening updates in JOCs and clinical meetings</td></tr>
<tr><td>Activity:</td><td>Women's Health Initiative: Education, Outreach, and Progress

UnitedHealthcare Community Plan of Louisiana (UHCLA) continues to advance its Women's Health Initiative through a multi-faceted approach that integrates member and provider education, outreach, and support to increase access to vital breast and cervical cancer screenings. Our strategy includes the development and distribution of comprehensive toolkits, leveraging community partnerships, and utilizing data-driven outreach to close care gaps.

To support providers, UHCLA created and annually updates a GYN Toolkit that includes:</td></tr>
</table>

	HEDIS® measure specifications for breast and cervical cancer screenings CPT codes for gap closure Family planning resources A schedule of recommended services for Well-Woman Care Education on exclusions and coding guidance This toolkit is reviewed with providers by UHC staff and supplemented with CDC educational materials and access to the provider portal. Providers also receive Patient-Centered Outcomes Research (PCOR) reports to help identify members with care gaps. Additionally, medical record reviews—including consultation and diagnostic reports—are used to validate screenings, and certain breast cancer screening or mastectomy codes are accepted as supplemental data, reducing the need for manual chart reviews. UHCLA uses gap-in-care reporting to conduct targeted outreach to enrollees missing breast or cervical cancer screenings. Outreach efforts include education, assistance with scheduling appointments, navigation support for barriers such as transportation, and promotion of member incentives and community resources. **Activities, Achievements, and Progress** ***Breast Cancer Screenings*** No changes to the eligible population are anticipated at this time. UHCLA continues to participate in community events and share educational materials to raise awareness and promote access to screenings. Provider teams actively identify members with care gaps using PCOR data. As of June 2025, 54.42% of eligible enrollees have completed their breast cancer screenings—exceeding the target rate of 52.68%—demonstrating the effectiveness of our strategies. We continue to refine our efforts to further increase engagement, dismantle barriers, and improve Louisiana's health rankings in women's preventive care. ***Cervical Cancer Screenings*** In 2024, UHCLA implemented several strategies to improve cervical cancer screening rates, including: Provider incentives (CP-PCPi) Member and provider outreach Provider education through toolkits and CDC resources Community events and inclusion of screening updates in JOCs As of June 2025, 50.14% of eligible enrollees have completed their cervical cancer screenings. While this reflects steady progress, it remains below the 2025 target of 57.18%, indicating a need to increase screenings by approximately 7 percentage points. To address this gap, UHCLA launched a state-approved member incentive on January 1, 2025, and expanded educational efforts across multiple platforms. Informational pages on the incentive were created, and the GYN Toolkit was updated to include CCS-specific HEDIS® guidance and exclusions. UHC staff continue to attend member events statewide to provide education on cervical cancer screening and other women's health topics. Barriers and Mitigation Strategies A significant barrier to cervical cancer screening is confusion among eligible women regarding the frequency of Pap smears, due to evolving clinical guidelines. This has led to delays or missed screenings. To address this, UHCLA is enhancing educational outreach and encouraging

	more informed conversations between enrollees and their providers to clarify screening schedules and emphasize the importance of timely preventive care.		
Measurable Objective:	**Breast Cancer Screenings:** Measures MY2016 = 53.58%; MY2017 = 54.34%; MY2018 = 53.83%; MY2019 = 54.57%; MY2020 = 55.02%; MY2021 = 53.25%; MY2022 = 57.11%; MY2023= 62.42%; MY2024=60.80% **Cervical Cancer Screenings:** Measures MY20222= 61.07%; MY2023= 56.45%; MY2024= 55.85% Mammograms - all types and methods including screening, diagnostic, film, digital or digital breast tomosynthesis Routine cervical cancer screenings	**Milestones to be Completed by December 2025**	Improving women's health by increasing the number of breast cancer and cervical cancer screenings YOY through 2025. Increase the number of breast cancer screenings UHCLA continues to monitor progress. Based on claims through 6/11/2025, **54.42%** of eligible enrollees have gap closure for breast cancer screenings. **Targets:** **BCS: 52.68%** **CCS: 57.18%** For 2025, as of claims date **6/11/2025,** **50.14%** of eligible enrollees have gap closure for cervical cancer screenings. As this program expands into CY2025, these results will be reported in 2026.
A1 Goal (4): Colorectal Cancer Screening			
Participants (briefly describe):	All adults 45 years to 75.		

<table>
<tr><td>Strategy:</td><td>
Provider incentive (CP-PCPi) - UHCLA monitors reporting on Preventative Health focused Value Based Payment (VBP) arrangements for providers.
Provider and Enrollee outreach. UHCLA has been actively educating providers and enrollees throughout the state, about the importance of COL through efforts in all CM programing outreach, work with LDH's Process Improvement Project (PIP) and Taking Aim at Cancer (TACL).
UHCLA continuously update our COL Toolkit for providers and staff that is distributed during outreach meetings, including our scheduled Joint Operating Committees (JOCs).
In 2024, our target goal of 35.17% with eligible enrollee completing colorectal screenings for gap closure was 45.00%. this was highly due to a set of robust strategies and activities. In 2025, we have implemented additional innovative strategies inclusive of partnerships and access to more screening options. Since January, we've implemented the following strategies:

Successful launch of a partnership with Exact Sciences to distribute Cologuard kits directly to members identified as being in the gap.
Continued coordination with our partners in TACL, a state-based cancer screening and tracking partnership.
Utilization of Community Health Workers to reach members in need of screening.

As of June 11, 2025, the implementation of these innovative and robust strategies have yielded the following results : with a target goal of 38. 07%, data shows that 42.41% of eligible enrollees completed a colorectal screening and closed this gap. this is evident that past and current strategies continue to produce favorable outcomes and shows a % over our 2025 target goal.
<u>Activities, Achievements, and Progress:</u>
To further support providers in identifying eligible members and promoting cancer screenings, UnitedHealthcare Community Plan of Louisiana (UHCLA) has distributed current Patient-Centered Outcomes Research (PCOR) data and the 2025 UHC PATH guides to providers across the state. Since January 2025, providers have been engaged through structured clinical meetings and Joint Operating Committees (JOCs), which serve as strategic forums for education, performance review, and collaborative planning. These sessions have facilitated meaningful discussions to evaluate screening performance, identify care gaps, and align on targeted strategies to improve breast and cervical cancer screening rates.
Barriers:
Based on insights from subject matter experts and field experience, rural areas across Louisiana continue to face a lack of easily accessible facilities capable of performing colonoscopies. This geographic barrier significantly limits screening options for residents in underserved communities. Additionally, there remains a persistent lag in colorectal cancer screening participation among male enrollees, often due to stigma, fear of invasive procedures, and limited awareness of screening alternatives.
Medical Record Review and Documentation Standards
To support accurate reporting and reduce administrative burden, UHCLA accepts supplemental data for colorectal cancer screenings, including:

Consultation and diagnostic reports
Health history and physicals
Lab and pathology reports

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<tr><td></td><td colspan="3">For colonoscopies, documentation must indicate the type of screening or confirm that the scope advanced beyond the splenic flexure. For flexible sigmoidoscopies, records must show that the scope advanced into the sigmoid colon or specify the type of screening performed.

Strategic Activities and Innovations (Since January 2025)
UHCLA has launched several robust strategies to improve colorectal cancer screening rates and address persistent barriers:
At-Home Screening Access: Partnered with a vendor to distribute Cologuard® kits, allowing members to complete screenings at home and return samples via prepaid mail courier services.
Community-Based Collaboration: Continued coordination with the TACL (Tumor and Cancer Linkage) program, a state-based cancer screening and tracking partnership.
Community Health Worker Outreach: Leveraged Community Health Workers to conduct targeted outreach and education, significantly increasing reach and impact, particularly in underserved areas.
Grant-Funded Access Expansion: Supported Mary Bird Perkins Cancer Center's statewide efforts through grant funding, increasing access to colorectal screenings in their service areas. These services are available to all community members, regardless of insurance or Medicaid status, helping to improve Louisiana's health rankings and expand access for UHCLA enrollees facing provider-related barriers.
Progress and Impact
The combination of longstanding efforts since 2023 and the implementation of innovative strategies in 2025 has led to a measurable increase in gap closure rates among eligible members. UHCLA has consistently exceeded its colorectal cancer screening targets year over year since 2023 and successfully met its 2024 milestones. These efforts continue to demonstrate the potential to save lives and improve both state and county health rankings.
In 2025, UHCLA expanded provider incentives under the HEPi program to include the Hispanic/Latino population, further supporting equity in screening access and outcomes.

Looking Ahead
UHCLA remains focused on populations and communities with historically low colorectal cancer screening rates, particularly in rural areas. In 2025, eligible individuals in these regions will have increased access to point-of-care screenings. Our continued goal is to promote a healthier Louisiana by improving access, reducing disparities, and ultimately saving lives through early detection and preventive care.</td></tr>
<tr><td>Activity:</td><td colspan="3"></td></tr>
<tr><td>Measurable Objective:</td><td>Colonoscopy

Flexible sigmoidoscopy

CT colonography</td><td>Milestones to be Completed by December 2024</td><td>Increase the number of colorectal screenings

Target is 38.07%

As of June 11, 2025, 42.41%, of members were engaged in Colorectal Cancer screenings.</td></tr>
<tr><td></td><td></td><td></td><td>As this program expands into CY2025, final/official HEDIS results will be reported in 2026.</td></tr>
</table>

Cultural Responsiveness and Implicit Bias Training

3. **Cultural Responsiveness and Implicit Bias Training.**[1] Please describe:
   a. Staff and provider trainings conducted (e.g., training components, number and type of attendees, length of training and format) between January and June 2025
      i. *Provider*
         1. Using Ethics to Dismantle Cultural Encapsulation for Healthcare Professionals, 528 Attendees attended live webinar, January 2025- June 2025
         2. Intellectual and Developmental Disabilities (IDD) and Co-occurring Behavioral Health Needs, 73 Attendees attended On Demand, January 2025- June 2025
         3. Advancing Wellness Together, 11 Attendees attended On Demand, January 2025- June 2025
      ii. *Staff*
         1. Maternity Health Awareness: Black Maternal Health, Virtual, January 2025, 99 Attendees
         2. African American History, Culture, and Heritage, Virtual, February 2025, 100 Attendees
         3. Understanding Autism: Supporting Families with Compassion purpose, and Cultural Competency, Virtual, March 2025, 97 Attendees
         4. Women's History Month, Virtual, March 2025, 87 Attendees
         5. Health Equity and DEI Topics, Virtual, April 2025, 80 Attendees
         6. The Six Tripple Eight Movie Discussion, Virtual, May 2025, 81 Attendees
         7. Mental Health Awareness, Self-care, and Mindfulness, June 2025, 104 Attendees

   b. Additional training expected to be conducted by December 2025
   Additional staff and provider training sessions are scheduled through December 2025, with several topics and dates currently under development. These trainings will be designed to align with our Health Equity Plan and will adhere to Section 2.2.2.7.2 of our contractual obligations. Specifically, we will ensure that all staff—particularly those who interact directly with Enrollees or providers—receive both initial and ongoing training that includes:
   - An overview of contractual, state, and federal requirements relevant to their specific job functions
   - Comprehensive education on health equity and the social determinants of health (SDOH), extending beyond the standard Culturally and Linguistically Appropriate Services (CLAS) requirements
   - Guidance on the appropriate identification and handling of quality-of-care concerns

[1] See Section 2.2.2.7.2 The Contractor shall provide initial and ongoing staff training that includes an overview of contractual, state and federal requirements specific to individual job functions. The Contractor shall ensure that all staff members having contact with Enrollees or providers receive initial and ongoing training on health equity and social determinants of health, beyond Culturally and Linguistically Appropriate Services (CLAS) requirements and with regard to the appropriate identification and handling of quality of care concerns.

Training topics will be strategically selected to support these goals and will include but is not limited to:

- Understanding and Applying the Social Determinants of Health
- The Policy Roots of Health Inequities: Understanding Social Determinants of Health, June 23, 2025
- Asian and Pacific Islander Heritage, Date TBD
- Hispanic Heritage Month, September 2025
- Native American Heritage Month, November 2025

To ensure accessibility, these trainings will be offered in multiple formats—including virtual, in-person sessions, and on-demand modules—allowing participants to participate in ways that best suit their schedules and learning preferences.

We are also committed to fostering a culture of continuous improvement. Feedback from participants will be actively solicited and used to refine our training strategies, identify emerging needs, and expand future learning opportunities. This approach ensures that our workforce remains well-equipped to deliver equitable, high-quality care to all individuals we serve.

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

While no formal provider feedback has been received in 2025 to date, we have proactively adapted our training approach based on prior input and observed challenges, particularly regarding providers' scheduling limitations, such as time constraints and panel size. In response, we have expanded our training delivery formats to include flexible and accessible options such as lunch-and-learn sessions, live webinars, in-person events, and virtual modules. These modalities are designed to accommodate varying schedules and maximize participation.

In contrast, staff engagement has been robust in 2025, with frequent and constructive feedback shared through open discussions and interactive sessions. Based on this input, we have implemented several enhancements to our training offerings. These include continuing presentations that explore historical and cultural significance, incorporating movie and book discussion formats, and introducing a broader range of suggested topics focused on personal and professional growth. Additionally, staff have expressed interest in leading training sessions themselves, and we actively encourage and support this peer-led model to foster ownership and shared learning.

These ongoing adjustments reflect our commitment to responsive, inclusive, and evolving training strategies that meet the diverse needs of both staff and providers.

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

Yes, the MCO is on track to meet the training goals outlined in its Health Equity Plan. Training efforts to date have been aligned with the plan's objectives, including providing comprehensive education on health equity, social determinants of health, and culturally responsive care, in accordance with contractual, state, and federal requirements.

While we are making steady progress, we remain mindful of persistent barriers—particularly those affecting provider participation. Time constraints and scheduling challenges continue to limit provider availability for training sessions. In response, we have expanded our training formats to include flexible

options such as live webinars, virtual sessions, lunch-and-learns, and on-demand modules to better accommodate provider schedules.

We will continue to monitor participation trends and solicit feedback to further refine our approach, ensuring that all staff and providers have equitable access to meaningful and impactful training opportunities.

Stratify MCO Results on Attachment H Measures

4. **Stratified Results on Select Attachment H Measures (Measure #55)**
   a. *Legacy MCOs*—Please summarize the baseline information for the measures in Attachment H (Measure #55) below, including any stratifications of data from CY 2024 where available.

   Please note that finalized mid-year data percentage rates for the below measures will not be available until mid-August as these measures are tracked and reported by ULM. I will provide the updated data as soon as it is received and reviewed.
   - *Low Birthweight Births*
   - *Contraceptive Care – Postpartum (effective 3-day and 90-day, LARC 3-day and 90-day rates)*
   - *Low-Risk Cesarean Delivery*
   - *HIV Viral Load Suppression*

      i. **<u>Pregnancy:</u>** Percentage of Low Birthweight Births, Contraceptive Care – Postpartum Women Ages 21–44, Prenatal and Postpartum Care (PPC), Low-Risk Cesarean Delivery (LRCD)

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate
Percentage of Low Birthweight Births	Total					#DIV/0!
	Race					
	White					#DIV/0!
	Black or African American					#DIV/0!
	American Indian and Alaska Native					#DIV/0!
	Asian					#DIV/0!
	Native Hawaiian or Other Pacific Islander					#DIV/0!
	Some Other Race					#DIV/0!
	Two or More Races					#DIV/0!
	Asked but No Answer					#DIV/0!
	Unknown					#DIV/0!
	Ethnicity					
	Hispanic or Latino					#DIV/0!
	Not Hispanic or Latino					#DIV/0!
	Declined Ethnicity					#DIV/0!
	Unknown Ethnicity					#DIV/0!
	Sex					
	Male					#DIV/0!
	Female					#DIV/0!
	Unknown					#DIV/0!
	Geography					
	Rural					#DIV/0!
	Urban					#DIV/0!
	Unknown					#DIV/0!
Validation Check	Total Race	0	0	0	0	
	Total Ethnicity	0	0	0	0	
	Total Sex	0	0	0	0	
	Total Geography	0	0	0	0	

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate
Contraceptive Care - Postpartum Women (ages 21–44), most or moderately effective, 3 day rate	Total					#DIV/0!
	Race					
	White					#DIV/0!
	Black or African American					#DIV/0!
	American Indian and Alaska Native					#DIV/0!
	Asian					#DIV/0!
	Native Hawaiian or Other Pacific Islander					#DIV/0!
	Some Other Race					#DIV/0!
	Two or More Races					#DIV/0!
	Asked but No Answer					#DIV/0!
	Unknown					#DIV/0!
	Ethnicity					
	Hispanic or Latino					#DIV/0!
	Not Hispanic or Latino					#DIV/0!
	Declined Ethnicity					#DIV/0!
	Unknown Ethnicity					#DIV/0!
	Geography					
	Rural					#DIV/0!
	Urban					#DIV/0!
	Unknown					#DIV/0!
Validation Check	Total Race	0	0	0	0	
	Total Ethnicity	0	0	0	0	
	Total Geography	0	0	0	0	

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate
Contraceptive Care - Postpartum Women (ages 21–44), most or moderately effective, 90 day rate	Total					#DIV/0!
	Race					
	White					#DIV/0!
	Black or African American					#DIV/0!
	American Indian and Alaska Native					#DIV/0!
	Asian					#DIV/0!
	Native Hawaiian or Other Pacific Islander					#DIV/0!
	Some Other Race					#DIV/0!
	Two or More Races					#DIV/0!
	Asked but No Answer					#DIV/0!
	Unknown					#DIV/0!
	Ethnicity					
	Hispanic or Latino					#DIV/0!
	Not Hispanic or Latino					#DIV/0!
	Declined Ethnicity					#DIV/0!
	Unknown Ethnicity					#DIV/0!
	Geography					
	Rural					#DIV/0!
	Urban					#DIV/0!
	Unknown					#DIV/0!
Validation Check	Total Race	0	0	0	0	
	Total Ethnicity	0	0	0	0	
	Total Geography	0	0	0	0	

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate
Contraceptive Care - Postpartum Women (ages 21–44), LARC 3 day rate	Total					#DIV/0!
	Race					
	White					#DIV/0!
	Black or African American					#DIV/0!
	American Indian and Alaska Native					#DIV/0!
	Asian					#DIV/0!
	Native Hawaiian or Other Pacific Islander					#DIV/0!
	Some Other Race					#DIV/0!
	Two or More Races					#DIV/0!
	Asked but No Answer					#DIV/0!
	Unknown					#DIV/0!
	Ethnicity					
	Hispanic or Latino					#DIV/0!
	Not Hispanic or Latino					#DIV/0!
	Declined Ethnicity					#DIV/0!
	Unknown Ethnicity					#DIV/0!
	Geography					
	Rural					#DIV/0!
	Urban					#DIV/0!
	Unknown					#DIV/0!
Validation Check	Total Race	0	0	0	0	
	Total Ethnicity	0	0	0	0	
	Total Geography	0	0	0	0	

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate
Contraceptive Care - Postpartum Women (ages 21–44), LARC 90 day rate	Total					#DIV/0!
	Race					
	White					#DIV/0!
	Black or African American					#DIV/0!
	American Indian and Alaska Native					#DIV/0!
	Asian					#DIV/0!
	Native Hawaiian or Other Pacific Islander					#DIV/0!
	Some Other Race					#DIV/0!
	Two or More Races					#DIV/0!
	Asked but No Answer					#DIV/0!
	Unknown					#DIV/0!
	Ethnicity					
	Hispanic or Latino					#DIV/0!
	Not Hispanic or Latino					#DIV/0!
	Declined Ethnicity					#DIV/0!
	Unknown Ethnicity					#DIV/0!
	Geography					
	Rural					#DIV/0!
	Urban					#DIV/0!
	Unknown					#DIV/0!
Validation Check	Total Race	0	0	0	0	
	Total Ethnicity	0	0	0	0	
	Total Geography	0	0	0	0	

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator by Medical Records	Numerator By Supplemental	Rate
Prenatal and Postpartum Care: Timeliness of Prenatal Care	Total	5,739	411	344	13	1	87.10%
	Race						
	White	2,274	178	147	7	0	86.52%
	Black or African American	2,844	192	161	4	1	86.46%
	American Indian and Alaska Native	71	3	3	0	0	100.00%
	Asian	65	9	8	0	0	88.89%
	Native Hawaiian or Other Pacific Islander	2	0	0	0	0	#DIV/0!
	Some Other Race	115	5	4	1	0	100.00%
	Two or More Races	0	0	0	0	0	#DIV/0!
	Asked but No Answer	0	0	0	0	0	#DIV/0!
	Unknown	368	24	21	1	0	91.67%
	Ethnicity						
	Hispanic or Latino	701	40	31	2	0	82.50%
	Not Hispanic or Latino	4,163	299	261	9	0	90.30%
	Declined Ethnicity	0	0	0	0	0	#DIV/0!
	Unknown Ethnicity	875	72	52	2	1	76.39%
	Sex						
	Male	0	0	0	0	0	#DIV/0!
	Female	5,739	411	344	13	1	87.10%
	Unknown	0	0	0	0	0	#DIV/0!
	Geography						
	Rural	1,417	106	87	4	0	85.85%
	Urban	4,290	304	256	9	1	87.50%
	Unknown	32	1	1	0	0	100.00%
Validation Check	Total Race	5,739	411	344	13	1	
	Total Ethnicity	5,739	411	344	13	1	
	Total Sex	5,739	411	344	13	1	
	Total Geography	5,739	411	344	13	1	

	Category	Eligible Population	Denominator	Numerator By Admin		Numerator By Supplemental	Rate
Prenatal and Postpartum Care: Postpartum Care	Total	5,739	411	313	12	7	80.78%
	Race						
	White	2,274	178	135	8	4	82.58%
	Black or African American	2,844	192	141	4	2	76.56%
	American Indian and Alaska Native	71	3	2	0	0	66.67%
	Asian	65	9	9	0	0	100.00%
	Native Hawaiian or Other Pacific Islander	2	0	0	0	0	#DIV/0!
	Some Other Race	115	5	4	0	0	80.00%
	Two or More Races	0	0	0	0	0	#DIV/0!
	Asked but No Answer	0	0	0	0	0	#DIV/0!
	Unknown	368	24	22	0	1	95.83%
	Ethnicity						
	Hispanic or Latino	701	40	31	1	0	80.00%
	Not Hispanic or Latino	4,163	299	224	8	7	79.93%
	Declined Ethnicity	0	0	0	0	0	#DIV/0!
	Unknown Ethnicity	875	72	58	3	0	84.72%
	Sex						
	Male	0	0	0	0	0	#DIV/0!
	Female	5,739	411	313	12	7	80.78%
	Unknown	0	0	0	0	0	#DIV/0!
	Geography						
	Rural	1,417	106	76	4	3	78.30%
	Urban	4,290	304	237	8	4	81.91%
	Unknown	32	1	0	0	0	0.00%
Validation Check	Total Race	5,739	411	313	12	7	
	Total Ethnicity	5,739	411	313	12	7	
	Total Sex	5,739	411	313	12	7	
	Total Geography	5,739	411	313	12	7	

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate
Low-Risk Cesarean Delivery	Total					#DIV/0!
	Race					
	White					#DIV/0!
	Black or African American					#DIV/0!
	American Indian and Alaska Native					#DIV/0!
	Asian					#DIV/0!
	Native Hawaiian or Other Pacific Islander					#DIV/0!
	Some Other Race					#DIV/0!
	Two or More Races					#DIV/0!
	Asked but No Answer					#DIV/0!
	Unknown					#DIV/0!
	Ethnicity					
	Hispanic or Latino					#DIV/0!
	Not Hispanic or Latino					#DIV/0!
	Declined Ethnicity					#DIV/0!
	Unknown Ethnicity					#DIV/0!
	Geography					
	Rural					#DIV/0!
	Urban					#DIV/0!
	Unknown					#DIV/0!
Validation Check	Total Race	0	0	0	0	
	Total Ethnicity	0	0	0	0	
	Total Geography	0	0	0	0	

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

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate
Well-Child Visits in the First 30 Months of Life: First 15 Months	Total	6,281	6,281	4,136	52	66.68%
	Race					
	White	1,240	1,240	832	12	68.06%
	Black or African American	2,101	2,101	1,331	20	64.30%
	American Indian and Alaska Native	15	15	10	0	66.67%
	Asian	54	54	40	0	74.07%
	Native Hawaiian or Other Pacific Islander	4	4	3	0	75.00%
	Some Other Race	607	607	387	5	64.58%
	Two or More Races	0	0	0	0	#DIV/0!
	Asked but No Answer	0	0	0	0	#DIV/0!
	Unknown	2,260	2,260	1,533	15	68.50%
	Ethnicity					
	Hispanic or Latino	104	104	64	2	63.46%
	Not Hispanic or Latino	5,623	5,623	3,772	40	67.79%
	Declined Ethnicity	0	0	0	0	#DIV/0!
	Unknown Ethnicity	554	554	300	10	55.96%
	Sex					
	Male	3,201	3,201	2,124	25	67.14%
	Female	3,080	3,080	2,012	27	66.20%
	Unknown	0	0	0	0	#DIV/0!
	Geography					
	Rural	1,381	1,381	858	7	62.64%
	Urban	4,875	4,875	3,266	45	67.92%
	Unknown	25	25	12	0	48.00%
Validation Check	Total Race	6,281	6,281	4,136	52	
	Total Ethnicity	6,281	6,281	4,136	52	
	Total Sex	6,281	6,281	4,136	52	
	Total Geography	6,281	6,281	4,136	52	

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate
Well-Child Visits in the First 30 Months of Life: 15 Months - 30 Months	Total	6,313	6,313	4,557	137	74.35%
	Race					
	White	1,479	1,479	1,063	32	74.04%
	Black or African American	2,264	2,264	1,580	41	71.60%
	American Indian and Alaska Native	19	19	12	0	63.16%
	Asian	55	55	41	2	78.18%
	Native Hawaiian or Other Pacific Islander	6	6	4	0	66.67%
	Some Other Race	660	660	550	13	85.30%
	Two or More Races	0	0	0	0	#DIV/0!
	Asked but No Answer	0	0	0	0	#DIV/0!
	Unknown	1,830	1,830	1,307	49	74.10%
	Ethnicity					
	Hispanic or Latino	143	143	98	6	72.73%
	Not Hispanic or Latino	5,399	5,399	3,962	120	75.61%
	Declined Ethnicity	0	0	0	0	#DIV/0!
	Unknown Ethnicity	771	771	497	11	65.89%
	Sex					
	Male	3,225	3,225	2,329	65	74.23%
	Female	3,088	3,088	2,228	72	74.48%
	Unknown	0	0	0	0	#DIV/0!
	Geography					
	Rural	1,508	1,508	988	39	68.10%
	Urban	4,777	4,777	3,548	97	76.30%
	Unknown	28	28	21	1	78.57%
Validation Check	Total Race	6,313	6,313	4,557	137	
	Total Ethnicity	6,313	6,313	4,557	137	
	Total Sex	6,313	6,313	4,557	137	
	Total Geography	6,313	6,313	4,557	137	

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate
Child and Adolescent Well-Care Visits	Total	144,934	144,934	81,148	675	56.46%
	Race					
	White	51,057	51,057	26,904	261	53.21%
	Black or African American	69,136	69,136	38,017	293	55.41%
	American Indian and Alaska Native	1,101	1,101	578	10	53.41%
	Asian	2,271	2,271	1,356	11	60.19%
	Native Hawaiian or Other Pacific Islander	19	19	14	0	73.68%
	Some Other Race	5,221	5,221	3,670	28	70.83%
	Two or More Races	0	0	0	0	#DIV/0!
	Asked but No Answer	0	0	0	0	#DIV/0!
	Unknown	16,129	16,129	10,609	72	66.22%
	Ethnicity					
	Hispanic or Latino	13,849	13,849	7,320	94	53.53%
	Not Hispanic or Latino	107,724	107,724	61,205	456	57.24%
	Declined Ethnicity	0	0	0	0	#DIV/0!
	Unknown Ethnicity	23,361	23,361	12,623	125	54.57%
	Sex					
	Male	72,933	72,933	40,298	331	55.71%
	Female	72,001	72,001	40,850	344	57.21%
	Unknown	0	0	0	0	#DIV/0!
	Geography					
	Rural	33,525	33,525	16,924	99	50.78%
	Urban	110,003	110,003	64,188	575	58.87%
	Unknown	1406	1406	36	1	2.63%
Validation Check	Total Race	144,934	144,934	81,148	675	
	Total Ethnicity	144,934	144,934	81,148	675	
	Total Sex	144,934	144,934	81,148	675	
	Total Geography	144,934	144,934	81,148	675	

iii. **Adult**: Colorectal Cancer Screening, HIV Viral Load Suppression, Cervical Cancer Screening

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Medical Records	Numerator By Supplemental	Rate
Colorectal Cancer Screening (ECDS)	Total	31,862	31,222	8,947	0	5,105	45.01%
	Race						
	White	14,383	14,108	3,986	0	2,263	44.29%
	Black or African American	12,437	12,161	3,645	0	1,923	45.79%
	American Indian and Alaska Native	261	254	65	0	49	44.88%
	Asian	775	761	225	0	161	50.72%
	Native Hawaiian or Other Pacific Islander	2	2	0	0	0	0.00%
	Some Other Race	886	855	231	0	141	43.51%
	Two or More Races	0	0	0	0	0	#DIV/0!
	Asked but No Answer	0	0	0	0	0	#DIV/0!
	Unknown	3,118	3,081	795	0	568	44.24%
	Ethnicity						
	Hispanic or Latino	4,949	4,787	1,434	0	740	45.41%
	Not Hispanic or Latino	24,429	23,992	6,848	0	3,951	45.01%
	Declined Ethnicity	0	0	0	0	0	#DIV/0!
	Unknown Ethnicity	2,484	2,443	665	0	414	44.17%
	Sex						
	Male	12,363	12,084	2,904	0	1,746	38.48%
	Female	19,499	19,138	6,043	0	3,359	49.13%
	Unknown	0	0	0	0	0	#DIV/0!
	Geography						
	Rural	8,475	8,318	2,463	0	1,019	41.86%
	Urban	23,369	22,886	6,481	0	4,086	46.17%
	Unknown	18	18	3	0	0	16.67%
Validation Check	Total Race	31,862	31,222	8,947	0	5,105	
	Total Ethnicity	31,862	31,222	8,947	0	5,105	
	Total Sex	31,862	31,222	8,947	0	5,105	
	Total Geography	31,862	31,222	8,947	0	5,105	

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate
HIV Viral Load Suppression	Total					#DIV/0!
	Race					
	White					#DIV/0!
	Black or African American					#DIV/0!
	American Indian and Alaska Native					#DIV/0!
	Asian					#DIV/0!
	Native Hawaiian or Other Pacific Islander					#DIV/0!
	Some Other Race					#DIV/0!
	Two or More Races					#DIV/0!
	Asked but No Answer					#DIV/0!
	Unknown					#DIV/0!
	Ethnicity					
	Hispanic or Latino					#DIV/0!
	Not Hispanic or Latino					#DIV/0!
	Declined Ethnicity					#DIV/0!
	Unknown Ethnicity					#DIV/0!
	Sex					
	Male					#DIV/0!
	Female					#DIV/0!
	Unknown					#DIV/0!
	Geography					
	Rural					#DIV/0!
	Urban					#DIV/0!
	Unknown					#DIV/0!
Validation Check	Total Race	0	0	0	0	
	Total Ethnicity	0	0	0	0	
	Total Sex	0	0	0	0	
	Total Geography	0	0	0	0	

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Medical Records	Numerator By Supplemental	Rate
Cervical Cancer Screening	Total	56,493	411	224	11	4	58.15%
	Race						
	White	24,779	183	89	2	1	50.27%
	Black or African American	25,531	182	107	8	3	64.84%
	American Indian and Alaska Native	586	2	2	0	0	100.00%
	Asian	1,041	11	8	0	0	72.73%
	Native Hawaiian or Other Pacific Islander	4	0	0	0	0	#DIV/0!
	Some Other Race	944	5	3	0	0	60.00%
	Two or More Races	0	0	0	0	0	#DIV/0!
	Asked but No Answer	0	0	0	0	0	#DIV/0!
	Unknown	3,608	28	15	1	0	57.14%
	Ethnicity						
	Hispanic or Latino	6,707	40	19	3	0	55.00%
	Not Hispanic or Latino	43,414	331	181	7	4	58.01%
	Declined Ethnicity	0	0	0	0	0	#DIV/0!
	Unknown Ethnicity	6,372	40	24	1	0	62.50%
	Geography						
	Rural	14,340	92	47	1	1	53.26%
	Urban	42,112	319	177	10	3	59.56%
	Unknown	41	0	0	0	0	#DIV/0!
Validation Check	Total Race	56,493	411	224	11	4	
	Total Ethnicity	56,493	411	224	11	4	
	Total Geography	56,493	411	224	11	4	

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

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate
Follow-Up After Emergency Department Visit for Mental Illness (Within 30 Days)	Total	1,011	1,011	387	36	41.84%
	Race					
	White	407	407	176	16	47.17%
	Black or African American	515	515	184	18	39.22%
	American Indian and Alaska Native	6	6	3	1	66.67%
	Asian	4	4	2	0	50.00%
	Native Hawaiian or Other Pacific Islander	0	0	0	0	#DIV/0!
	Some Other Race	23	23	7	0	30.43%
	Two or More Races	0	0	0	0	#DIV/0!
	Asked but No Answer	0	0	0	0	#DIV/0!
	Unknown	56	56	15	1	28.57%
	Ethnicity					
	Hispanic or Latino	195	195	76	9	43.59%
	Not Hispanic or Latino	679	679	257	18	40.50%
	Declined Ethnicity	0	0	0	0	#DIV/0!
	Unknown Ethnicity	137	137	54	9	45.99%
	Sex					
	Male	498	498	184	20	40.96%
	Female	513	513	203	16	42.69%
	Unknown	0	0	0	0	#DIV/0!
	Geography					
	Rural	196	196	76	8	42.86%
	Urban	787	787	308	28	42.69%
	Unknown	28	28	3	0	10.71%
Validation Check	Total Race	1,011	1,011	387	36	
	Total Ethnicity	1,011	1,011	387	36	
	Total Sex	1,011	1,011	387	36	
	Total Geography	1,011	1,011	387	36	

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate
Follow-Up After Emergency Department Visit for Substance Use (Within 30 Days)	Total	1,569	1,569	381	4	24.54%
	Race					
	White	767	767	218	3	28.81%
	Black or African American	662	662	128	0	19.34%
	American Indian and Alaska Native	12	12	5	0	41.67%
	Asian	4	4	2	0	50.00%
	Native Hawaiian or Other Pacific Islander	0	0	0	0	#DIV/0!
	Some Other Race	25	25	6	0	24.00%
	Two or More Races	0	0	0	0	#DIV/0!
	Asked but No Answer	0	0	0	0	#DIV/0!
	Unknown	99	99	22	1	23.23%
	Ethnicity					
	Hispanic or Latino	247	247	55	0	22.27%
	Not Hispanic or Latino	1,183	1,183	296	4	25.36%
	Declined Ethnicity	0	0	0	0	#DIV/0!
	Unknown Ethnicity	139	139	30	0	21.58%
	Sex					
	Male	919	919	213	3	23.50%
	Female	650	650	168	1	26.00%
	Unknown	0	0	0	0	#DIV/0!
	Geography					
	Rural	343	343	78	3	23.62%
	Urban	1,199	1,199	301	1	25.19%
	Unknown	27	27	2	0	7.41%
Validation Check	Total Race	1,569	1,569	381	4	
	Total Ethnicity	1,569	1,569	381	4	
	Total Sex	1,569	1,569	381	4	
	Total Geography	1,569	1,569	381	4	

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate
Initiation and Engagement of Substance Use Disorder Treatment: Initiation of SUD Treatment	Total	9,543	9,543	5,580	59	59.09%
	Race					
	White	4,879	4,879	3,028	31	62.70%
	Black or African American	3,788	3,788	2,019	19	53.80%
	American Indian and Alaska Native	111	111	64	1	58.56%
	Asian	20	20	7	1	40.00%
	Native Hawaiian or Other Pacific Islander	0	0	0	0	#DIV/0!
	Some Other Race	176	176	102	2	59.09%
	Two or More Races	0	0	0	0	#DIV/0!
	Asked but No Answer	0	0	0	0	#DIV/0!
	Unknown	569	569	360	5	64.15%
	Ethnicity					
	Hispanic or Latino	1,408	1,408	820	9	58.88%
	Not Hispanic or Latino	7,193	7,193	4,228	43	59.38%
	Declined Ethnicity	0	0	0	0	#DIV/0!
	Unknown Ethnicity	942	942	532	7	57.22%
	Sex					
	Male	5,076	5,076	3,183	22	63.14%
	Female	4,467	4,467	2,397	37	54.49%
	Unknown	0	0	0	0	#DIV/0!
	Geography					
	Rural	2,406	2,406	1,397	20	58.89%
	Urban	7,005	7,005	4,152	39	59.83%
	Unknown	132	132	31	0	23.48%
Validation Check	Total Race	9,543	9,543	5,580	59	
	Total Ethnicity	9,543	9,543	5,580	59	
	Total Sex	9,543	9,543	5,580	59	
	Total Geography	9,543	9,543	5,580	59	

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate
Initiation and Engagement of Substance Use Disorder Treatment: Engagement of SUD Treatment	Total	9,543	9,543	2,668	10	28.06%
	Race					
	White	4,879	4,879	1,626	5	33.43%
	Black or African American	3,788	3,788	784	3	20.78%
	American Indian and Alaska Native	111	111	28	1	26.13%
	Asian	20	20	2	1	15.00%
	Native Hawaiian or Other Pacific Islander	0	0	0	0	#DIV/0!
	Some Other Race	176	176	33	0	18.75%
	Two or More Races	0	0	0	0	#DIV/0!
	Asked but No Answer	0	0	0	0	#DIV/0!
	Unknown	569	569	195	0	34.27%
	Ethnicity					
	Hispanic or Latino	1,408	1,408	350	2	25.00%
	Not Hispanic or Latino	7,193	7,193	2,050	7	28.60%
	Declined Ethnicity	0	0	0	0	#DIV/0!
	Unknown Ethnicity	942	942	268	1	28.56%
	Sex					
	Male	5,076	5,076	1,658	8	32.82%
	Female	4,467	4,467	1,010	2	22.66%
	Unknown	0	0	0	0	#DIV/0!
	Geography					
	Rural	2,406	2,406	731	5	30.59%
	Urban	7,005	7,005	1,924	5	27.54%
	Unknown	132	132	13	0	9.85%
Validation Check	Total Race	9,543	9,543	2,668	10	
	Total Ethnicity	9,543	9,543	2,668	10	
	Total Sex	9,543	9,543	2,668	10	
	Total Geography	9,543	9,543	2,668	10	

	Category	Eligible Population	Denominator	Numerator By Admin	Numerator By Supplemental	Rate
Follow-Up After Hospitalization for Mental Illness (Within 30 Days)	Total	6,101	6,101	2,298	195	40.86%
	Race					
	White	2,959	2,959	1,161	110	42.95%
	Black or African American	2,581	2,581	939	64	38.86%
	American Indian and Alaska Native	56	56	25	6	55.36%
	Asian	38	38	18	1	50.00%
	Native Hawaiian or Other Pacific Islander	0	0	0	0	#DIV/0!
	Some Other Race	136	136	50	3	38.97%
	Two or More Races	0	0	0	0	#DIV/0!
	Asked but No Answer	0	0	0	0	#DIV/0!
	Unknown	331	331	105	11	35.05%
	Ethnicity					
	Hispanic or Latino	1,193	1,193	476	28	42.25%
	Not Hispanic or Latino	4,181	4,181	1,562	136	40.61%
	Declined Ethnicity	0	0	0	0	#DIV/0!
	Unknown Ethnicity	727	727	260	31	40.03%
	Sex					
	Male	3,099	3,099	1,053	90	36.88%
	Female	3,002	3,002	1,245	105	44.97%
	Unknown	0	0	0	0	#DIV/0!
	Geography					
	Rural	1,426	1,426	503	50	38.78%
	Urban	4,566	4,566	1,757	145	41.66%
	Unknown	109	109	38	0	34.86%
Validation Check	Total Race	6,101	6,101	2,298	195	
	Total Ethnicity	6,101	6,101	2,298	195	
	Total Sex	6,101	6,101	2,298	195	
	Total Geography	6,101	6,101	2,298	195	

b. ***All MCOs – Please summarize your activities and data collection efforts to stratify and report results for Attachment H measures (Measure #55) for CY 2025 performance.***

We adhere to national protocols established by UnitedHealthcare. To promote health equity and improve health outcomes, our organization employs a comprehensive strategy involving various activities and data collection efforts. Our health plan focuses on the measures included in Attachment H, particularly Objective #58, which stratifies data for health equity purposes. We incentivize key preventive measures, such as colorectal cancer screening, cervical cancer screening, follow-up after emergency department visits for mental illness, and follow-up after hospitalization for mental illness.

In our commitment to health equity, we offer additional incentives to close care gaps for our Black/African American and Hispanic/Latino enrollees in areas like colorectal cancer screening, cervical cancer screening, timely prenatal care, and postpartum care.

Strong provider partnerships are crucial for achieving success with our HEDIS® results. We educate providers through our clinical staff, providing them with the knowledge and tools needed to effectively close care gaps. We distribute condition-specific toolkits and comprehensive provider guides through our Provider Portal.

Data collection is managed internally by our clinical quality teams, who collaborate regularly with providers. During the annual HEDIS® season, these teams reach out to providers to obtain the necessary records, ensuring a successful data collection process. The results are then compiled by our national partners and reported to LDH following validation.

These protocols guide our efforts in stratifying HEDIS results as required, enabling us to effectively report on our performance for CY 2025.

c. ***Non-legacy MCOs – If the MCO cannot provide stratified results on one or more measures in #55 listed above for MY24, please describe challenges in providing stratified data for each measure.***

Not applicable (N/A)

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

Other Comments and Observations on Health Equity Progress (January 1 – June 13, 2025)

Since the submission of the MCO 3.0 Health Equity Plan, UnitedHealthcare has demonstrated measurable progress in advancing health equity through a comprehensive, community-driven approach. Our efforts have focused on authentic engagement, cross-sector collaboration, and addressing disparities and social determinants of health (SDOH) in alignment with our strategic priorities.

Community Engagement and Collaborative Impact

We continue to lead the Health Equity and Social Determinants of Health Collaborative, a statewide initiative that brings together stakeholders, community partners, and state agencies to identify and address community-driven priorities. This inclusive platform fosters authentic dialogue and co-designed solutions that directly impact the well-being of the populations we serve.

Between January and June 2025, we hosted two quarterly collaborative meetings with over 100 total participants:

- Quarter 1 (Baton Rouge, 49 hybrid attendees): Focused on food insecurity and food as medicine, including maternal health and access to WIC and other nutrition resources.
- Quarter 2 (Shreveport, 50 hybrid attendees): Centered on maternal health, including doula access, maternal mental health, and resource navigation for maternal and infant well-being.

We also conducted Stakeholder Community Conversations across Regions 1, 2, 4, and 9, with participation from stakeholders representing Regions 1, 2, 4, 6, 7, 8, and 9. These sessions have been instrumental in surfacing regional needs and informing our equity strategies.

Adverse Childhood Experiences (ACEs): Trauma-Informed Education and Capacity Building

We expanded trauma-informed education for community partners, delivering Adverse Childhood Experiences (ACEs) training to 67 participants across three sessions. Participants included staff from the Department of Children and Family Services (DCFS) and TCA Head Start programs, with additional trainings scheduled for the remainder of the year.

Topics included:

- Parent-Child Relationship and Healing Spaces
- The Brain Architecture Game
- Introduction to Trauma-Informed Care
- Resilience Film Screening and Discussion

Health Equity Performance Metrics and Impact

UnitedHealthcare is making a significant impact in closing care gaps and improving preventive health outcomes across Louisiana. As of June 11, 2025, we have already surpassed key screening targets for the year—just halfway through the reporting period:

- Breast Cancer Screening (BCS): As of June 11, 2025, UnitedHealthcare achieved a 54.42% gap closure rate, surpassing the target of 52.68% by 1.74 percentage points.
- Cervical Cancer Screening (CCS): The gap closure rate reached 50.14%, exceeding the target of 38.07% by a significant margin of 12.07 percentage points.
- Colorectal Cancer Screening: Member engagement stands at 42.41%. While no formal target has been specified, this figure reflects a positive upward trend in preventive screening participation.

These early successes reflect the effectiveness of our targeted outreach, culturally responsive education, and community-based strategies. More importantly, they contribute to shifting Louisiana's health rankings in key preventive care areas—demonstrating that strategic, equity-focused interventions can drive measurable improvements in population health.