Quality Companion Guide for Healthy Louisiana Managed Care Organizations

Prepared on Behalf of
State of Louisiana
Department of Health
February 2019
Table of Contents

Section 1: Introduction .............................................................................................................................................. 3
Section 2: Readiness Review ....................................................................................................................................... 5
Section 3: Annual Compliance Review .................................................................................................................... 8
Section 4: Performance Improvement Projects ....................................................................................................... 11
Section 5: Performance Measure Validation ........................................................................................................... 14
Section 6: MCO Annual Technical Report ................................................................................................................ 16
Section 7: Medical Loss Ratio Recommendations .................................................................................................. 18
Section 8: Focused Studies ......................................................................................................................................... 19
Section 9: Provider Satisfaction Surveys .................................................................................................................. 21
Section 10: Provider Directory Survey .................................................................................................................... 23
Appendix A: Performance Improvement Project Reporting Template ........................................................................ 24
Appendix B: Healthy Louisiana Medicaid Managed Care PIP Report Checklist ........................................................ 41
Appendix C: Required Performance Measures for 2019 Reporting .............................................................................. 44

List of Tables

Table 1: EQR-Related Activities ................................................................................................................................. 3
Table 2: Readiness Review Requirements ..................................................................................................................... 5
Table 3: Readiness Review Scoring Criteria ................................................................................................................ 6
Table 4: Readiness Review Timeline ........................................................................................................................... 7
Table 5: Compliance Review Scoring Criteria ........................................................................................................... 9
Table 6: Compliance Review Timeline ....................................................................................................................... 10
Table 7: Performance Improvement Projects ............................................................................................................ 11
Table 8: Timeline for the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment PIP ........... 13
Table 9: Performance Measure Validation Timeline .................................................................................................. 15
Table 10: Annual Technical Report Timeline ........................................................................................................... 17
Table 11: Provider Satisfaction Survey Timeline ...................................................................................................... 21

Healthcare Effectiveness Data and Information Set (HEDIS)® and Quality Compass® are registered trademarks of the National Committee for Quality Assurance (NCQA).
Section 1: Introduction

Quality Companion Guide Purpose

The Quality Companion Guide focuses on core quality improvement activities, assisting managed care organizations (MCOs) with Louisiana Department of Health (LDH) contract requirements and external quality review organization (EQRO) activities and processes. The timeframes provided for each activity may be modified at the discretion of LDH.

External Quality Review Regulations

Title 42 (Public Health) of the Federal Code of Regulations (FCR), Part 438 (Managed Care), Subpart E details Centers for Medicare and Medicaid Services (CMS) requirements for the conduct of annual external quality reviews (EQRs) of each MCO (https://www.ecfr.gov). Subpart E is broad in scope, addressing such topics as state responsibilities, protocols for conducting an EQR, qualifications of EQROs, state contract options, non-duplication of mandatory activities, exemption from EQR, and federal financial participation.

EQR-Related Activities

Section §438.358 specifies the mandatory and optional EQR-related activities (Table 1).

Table 1: EQR-Related Activities

<table>
<thead>
<tr>
<th>EQR-Related Activity</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Validation of performance improvement projects</td>
<td>Mandatory</td>
</tr>
<tr>
<td>Validation of performance measures</td>
<td>Mandatory</td>
</tr>
<tr>
<td>Review to determine plan compliance with structure and operations standards and quality assessment and performance improvement</td>
<td>Mandatory</td>
</tr>
<tr>
<td>Validation of network adequacy¹</td>
<td>Mandatory</td>
</tr>
<tr>
<td>Validation of encounter data</td>
<td>Optional</td>
</tr>
<tr>
<td>Administration or validation of consumer or provider surveys of quality of care</td>
<td>Optional</td>
</tr>
<tr>
<td>Calculation of performance measures</td>
<td>Optional</td>
</tr>
<tr>
<td>Conduct of performance improvement projects</td>
<td>Optional</td>
</tr>
<tr>
<td>Conduct of studies on quality that focus on a particular aspect of clinical or non-clinical services</td>
<td>Optional</td>
</tr>
<tr>
<td>Assist with the quality rating system¹</td>
<td>Optional</td>
</tr>
</tbody>
</table>

¹Pending issuance of new Centers for Medicare and Medicaid Services (CMS) protocols in 2018.

Although a single EQRO conducts the overall EQR, states may conduct individual EQR-related activities themselves or contract with other organizations to conduct EQR-related activities. If other entities conduct EQR-related activities, the state must provide the EQRO with the data generated from each of the EQR-related activities for analysis in the EQR.

CMS provides protocols for conducting each of the mandatory activities (https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html). States and EQROs are not required to use the CMS protocols in conducting EQR-related activities, but must use protocols that are consistent with the CMS protocols.

In addition to conducting the mandatory and optional activities listed in Table 1, the state may also direct the EQRO to provide technical assistance to MCOs to assist them in conducting these activities.

EQR Annual Reporting Requirements

Section §438.364 requires that all the mandatory and optional activities specified in §438.358 must be described in an annual detailed technical report, including information regarding the objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data. Also required is an assessment of strengths and weaknesses for each MCO, as well as recommendations for improvement and an assessment of whether each MCO has acted on recommendations for quality improvement made by the EQRO during the previous year’s EQR.
**Louisiana Medicaid Managed Care EQR Overview**

The Louisiana EQR contract with IPRO was extended in 2017. A brief description of each IPRO deliverable under this contract’s scope of work follows:

**Readiness reviews:** Develop a Louisiana-specific readiness review tool and methodology. Evaluate each MCO’s operational capacity to participate in Medicaid managed care (MMC) and begin enrollment. Determine if each MCO can demonstrate an accessible provider network within its service area and the ability to operate a program that will meet LDH requirements.

**Compliance reviews:** Develop a Louisiana-specific compliance review tool and methodology. Assess each MCO’s compliance with federal and state managed care regulations and with LDH contract requirements.

**Performance improvement project validation:** Present the performance improvement project (PIP) reporting method through a timeline and instructions, assess MCO methodology for conducting PIPs, evaluate overall validity and reliability of PIP study results, and evaluate the success of interventions to improve quality of care. Assist LDH staff in leading monthly PIP conference calls and meetings to monitor the progress of the state’s collaborative projects.

**Performance measure validation:** For the LDH-selected performance measures (PMs), present the measures and the reporting method through a timeline and instructions, evaluate data accuracy via data validation activities, calculate the results, and derive statewide averages, including national benchmarks.

**Technical report:** Produce annual technical reports that assess MCO performance, in compliance with the requirements of 42 CFR §438.364 and Louisiana specifications. Prepare a report for each MCO.

**Medical loss ratio recommendations:** Assess compliance with the MCO medical loss ratio (MLR) policy, review the activities that the MCOs assert are quality-related and make written recommendations as to whether the activities meet criteria to be classified as quality expenditures.

**The Quality Companion Guide:** Develop a written document to assist MCOs in carrying out quality improvement activities including background information on EQR regulations and the role of the EQRO and instructions and timelines related to readiness review, annual compliance review, PIP validation and PM validation. The Quality Companion Guide is updated annually.

**Focused studies:** At the discretion of LDH, design and conduct focused studies to evaluate the quality of clinical and/or nonclinical services at a point in time, as determined by the state. IPRO will collaborate with LDH to ensure alignment of study topics and objectives with state priorities, goals and initiatives.

**Provider surveys:** At the discretion of LDH, one statewide provider survey will be designed and implemented per year. Through provider surveys, LDH can evaluate the experience of specific types of providers in the MMC program, the effectiveness of certain managed care or Medicaid programs, and/or how satisfied Medicaid providers are with a particular aspect of an MCO’s performance.
Section 2: Readiness Review

It is not anticipated that LDH will request that IPRO conduct any readiness reviews for the mainstream MCOs during the 2019 contract year. This section describes the general process that is followed in Louisiana.

Process Overview

Readiness reviews evaluate Louisiana MCOs’ operational capacity to participate in MMC prior to enrolling members. Readiness reviews are conducted as close as possible in time to the commencement of enrollment. The MCOs are required to demonstrate the ability to operate a program that meets LDH requirements and are expected to clearly define and document the policies and procedures to support day-to-day business activities related to Louisiana Medicaid enrollees.

Task Description

As the Louisiana EQRO, IPRO readiness review activities focuses on policies, procedures and other documentation related to MCO operations including the following:

- operations activities in the contracted scope of work;
- provider contracting and credentialing;
- Member Services staff and provider training;
- coordination with state contractors and with the MCO’s subcontractors;
- member handbook;
- provider manual;
- provider directory;
- member identification card;
- member complaint and appeals processes;
- toll-free telephone systems and reporting capabilities for members and providers; and
- the Fraud and Abuse Compliance Plan.

The readiness reviews are conducted in three phases:
1. pre-onsite (desk review),
2. onsite, and
3. post-onsite (onsite follow-ups and reporting).

Methodology

Preparation of readiness review tools: IPRO prepares the readiness review tools for the LDH requirements listed in Table 2.

Table 2: Readiness Review Requirements

<table>
<thead>
<tr>
<th>LDH MCO Requirements</th>
<th>Domains Assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scope of work/requirements</td>
<td>Eligibility, enrollment and disenrollment</td>
</tr>
<tr>
<td>Staff requirements and support services</td>
<td>Member education</td>
</tr>
<tr>
<td>MCO reimbursement</td>
<td>Marketing</td>
</tr>
<tr>
<td>Core benefits and services</td>
<td>Member grievance and appeals</td>
</tr>
<tr>
<td>Provider network requirements</td>
<td>Quality management</td>
</tr>
<tr>
<td>Utilization management</td>
<td>Fraud, waste and abuse prevention</td>
</tr>
<tr>
<td>Provider services</td>
<td></td>
</tr>
</tbody>
</table>

LDH: Louisiana Department of Health; MCO: managed care organization.
**Scoring criteria:** Each LDH requirement is scored individually and on a three-point scale (Table 3).

<table>
<thead>
<tr>
<th>Review Determination</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Met (full compliance)</td>
<td>MCO has met or exceeded requirements.</td>
</tr>
<tr>
<td>Not met (non-compliance)</td>
<td>MCO has not met the requirements.</td>
</tr>
<tr>
<td>Not applicable</td>
<td>Requirement is not applicable.</td>
</tr>
</tbody>
</table>

Table 3: Readiness Review Scoring Criteria

MCO: managed care organization.

Some requirements may include a file review to verify compliance (e.g., provider contracts). File reviews are performed during the onsite visit.

**Schedule onsite reviews:** IPRO contacts each MCO to schedule the onsite reviews. Onsite reviews are conducted at the MCO offices.

**Training webinar/conference call:** Prior to the readiness reviews, IPRO conducts an orientation session for the MCOs to introduce the IPRO readiness review team and prepare the MCOs for the review. IPRO conducts a walk-through of the readiness review process and the review criteria, tools and documentation requirements. IPRO also presents the overall timeline for review activities and requirements for documentation submission and availability.

**Pre-onsite documentation:** IPRO prepares and submits a document submission guide, submission forms, and File Transfer Protocol (FTP) instructions to the MCOs.

**Desk Review**

During the desk review, each area is reviewed considering the supportive documentation submitted by the MCO. The desk review process is dependent on the MCO providing IPRO with all the appropriate documentation for each LDH requirement with the MCO’s original submission.

The review process includes one desk review. As deemed appropriate, IPRO may request additional information prior to the onsite; however, the MCO should prepare for only one document submission opportunity.

**Onsite Review**

Each onsite readiness review is completed in one day with additional teleconference time scheduled as necessary. The review begins with an opening conference during which IPRO presents an overview of the readiness review process and reviews the agenda for the visit. During the site visit, appropriate MCO managers and staff are interviewed in key areas, and relevant documentation is reviewed. The review concludes with a closing conference, during which IPRO provides feedback regarding preliminary findings.

**Reporting**

IPRO provides LDH with a readiness review report generally within two weeks of the onsite. At LDH’s discretion, IPRO distributes the MCO-specific findings to the respective MCOs. IPRO rates the MCO in each area as being “met” or “not met” (Table 3). Two categories of concern are identified: major areas of concern that the MCO must address prior to initiation of enrollment, and minor areas of concern that need to be corrected by a specific date, but do not have to be corrected prior to initiation of enrollment. It is the expectation that before MCOs begin operation, a “met” designation is required for each major area of concern.

LDH makes all final decisions regarding MCO operational readiness.
Timeline
The approximate readiness review timeline is outlined in Table 4.

Table 4: Readiness Review Timeline

<table>
<thead>
<tr>
<th>Readiness Review Task</th>
<th>Approximate Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPRO discusses with LDH the review methodology and obtains all necessary source documents.</td>
<td>Month one</td>
</tr>
<tr>
<td>IPRO conducts pre-onsite review (e.g., policies).</td>
<td>Month one</td>
</tr>
<tr>
<td>IPRO prepares and submits draft review methodology including review criteria, tools, crosswalk of standards eligible for deeming and pre-onsite correspondence to LDH for review and approval.</td>
<td>Month two</td>
</tr>
<tr>
<td>IPRO finalizes review methodology based upon LDH feedback.</td>
<td>Month three</td>
</tr>
<tr>
<td>IPRO conducts review process orientation for MCO.</td>
<td>Month four</td>
</tr>
<tr>
<td>IPRO conducts onsite review.</td>
<td>Month five</td>
</tr>
<tr>
<td>IPRO completes post-onsite review and issues a readiness review report to LDH.</td>
<td>Months six–seven</td>
</tr>
<tr>
<td>Readiness review findings are distributed to the MCOs.</td>
<td>Month eight</td>
</tr>
</tbody>
</table>

LDH: Louisiana Department of Health; MCO: managed care organization.
Section 3: Annual Compliance Review

It is expected that IPRO will conduct compliance reviews for the five Healthy Louisiana MCOs, as well as for MCNA Dental, during calendar year 2019. A compliance review is also anticipated for the Behavioral Health PAHP in 2019.

Process Overview

One of the mandatory activities for EQR is a review to determine an MCO’s compliance with state and federal standards that comply with federal regulations of § 438.358(b)(iii). This section includes standards related to Access; Structure and Operation; and Quality Assessment and Performance Improvement (QAPI). In addition, these standards reference two other related sections: Enrollee Rights (438.100) and Grievance Systems (Subpart F). At the discretion of LDH, the EQRO may review all standards annually.

The CMS EQR regulations (438.360) allow for non-duplication of mandatory activities at the state’s discretion. These regulations permit use of information about an MCO obtained from a private accreditation review, if certain conditions are met. These conditions include, but are not limited to, compliance with the standards established by the national accrediting organization, and that the organization’s standards are comparable to the federal standards. For MCOs achieving accreditation, IPRO uses the toolkits produced by the accrediting organizations and the MCO-specific accreditation reports/results to identify standards which have been found to meet the federal and state regulatory requirements and includes the accrediting organization’s results for those standards in the compliance review.

Task Description

The compliance review determines MCO compliance with LDH contract requirements and with state and federal regulations in accordance with the requirements of § 438.358(b)(iii). Each assessment includes a documentation review (desk audit), file review, MCO staff interviews, and, as appropriate, direct observation of key program areas. The assessment is completed in three phases:

1. phase one: pre-assessment activities (planning, preparation and desk audit);
2. phase two: onsite assessment activities; and
3. phase three: post-assessment activities (post-review follow-up and report preparation).

Methodology

Phase One: Pre-Assessment Activities

Preparation of assessment tools and worksheets: IPRO prepares the assessment tools and worksheets for each standard.

Each of the tools is structured the same and includes: federal requirements, related federal requirements, state-specific contract requirements/standards, suggested evidence (this column forms the basis of the pre-onsite documentation and case listing requests, and includes relevant documents and reports), reviewer comments (to document findings related to any requirements that are not fully compliant), and prior results and follow-up (pre-populated with the prior year’s findings for any requirements that were less than fully compliant. In addition, corrective actions taken by the MCO in response to the prior year’s findings are documented, so the reviewer can validate their implementation).

Some standards/requirements require file review. Worksheets for each type of file review that will be used by the IPRO reviewers to document their findings are created.

Scoring criteria: Each standard is rated as being in “full compliance,” “substantial compliance,” “minimal compliance,” or “non-compliance” (Table 5).
Table 5: Compliance Review Scoring Criteria

<table>
<thead>
<tr>
<th>Review Designation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full compliance</td>
<td>MCO has met or exceeded the standard.</td>
</tr>
<tr>
<td>Substantial compliance</td>
<td>MCO has met most of requirements of the standard but has minor deficiencies.</td>
</tr>
<tr>
<td>Minimal compliance</td>
<td>MCO has met some requirements of the standard, but has significant deficiencies requiring corrective action.</td>
</tr>
<tr>
<td>Non-compliance</td>
<td>MCO has not met the standard.</td>
</tr>
</tbody>
</table>

MCO: managed care organization.

Schedule onsite assessments: IPRO contacts each MCO to schedule the onsite assessments. Onsite assessments are conducted at the MCO offices.

Training webinar/conference call: IPRO provides a training session before the scheduled compliance reviews. The training includes a walkthrough of the assessment process, documentation requirements and timeline.

Introductory packet: IPRO prepares and submits an introductory packet to the MCOs including:
- confirmation of the dates for the assessment;
- a detailed site visit agenda;
- identification of the assessment team members;
- pre-onsite documentation request (all documents required for the compliance review will be requested); and
- request for listings of files eligible for review.

Select random and/or focused samples: Upon receipt of the eligible file lists from the MCOs, IPRO selects samples for review. MCOs are provided listings of the selected files via IPRO’s secure FTP site.

Review of pre-onsite documentation: Prior to the onsite assessment, IPRO reviews the pre-onsite documentation submitted by the MCOs and documents findings using the assessment tools. As deemed appropriate, IPRO may request additional information prior to the onsite interview session.

Phase Two: Onsite Assessment Activities

Opening conference: The onsite assessment begins with an opening conference, at which IPRO reviewers and MCO staff are introduced. During the opening, IPRO provides an overview of the purpose of and process for the review and onsite agenda. The opening conference may also allow for a brief presentation by the MCOs to highlight any corporate changes or new initiatives.

Onsite review: The onsite review is conducted in accordance with the onsite agenda previously shared with the MCO. The onsite agenda is tailored as necessary to accommodate MCO staff availability and/or the attendance of LDH staff. IPRO reviewers conduct the file reviews and face-to-face interviews with selected MCO staff members, to clarify and confirm findings. As appropriate, walkthroughs or demonstrations of work processes with key MCO staff are conducted.

Closing conference: The onsite review concludes with a closing conference, during which IPRO provides feedback regarding preliminary findings and presents the next steps in the review process.

Phase Three: Post-Assessment Activities

Preliminary findings: Upon completion of the onsite assessment, IPRO reviewers complete the assessment tools, and assign scoring designations to each standard/requirement. Preliminary findings are submitted to LDH for review.

Final findings: At LDH’s direction, IPRO distributes the MCO-specific findings to the respective MCOs.

QI action plan: A QI action plan is requested from MCOs for all areas that score minimal or non-compliance. A QI action plan form and submission instructions are provided. IPRO, in conjunction with LDH, reviews and approves the action plan or requests modifications. The action plan is validated during the next annual compliance review.
Timeline

The approximate compliance review timeline is outlined in Table 6.

**Table 6: Compliance Review Timeline**

<table>
<thead>
<tr>
<th>Compliance Review Task</th>
<th>Approximate Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPRO discusses with LDH the review methodology and obtains all necessary source documents.</td>
<td>Month one</td>
</tr>
<tr>
<td>IPRO prepares and submits draft review methodology including review criteria, tools, crosswalk of standards eligible for deeming and pre-onsite correspondence to LDH for review and approval.</td>
<td>Month two</td>
</tr>
<tr>
<td>IPRO finalizes review methodology based upon LDH feedback.</td>
<td>Month three</td>
</tr>
<tr>
<td>IPRO conducts review process orientation for MCO.</td>
<td>Month four</td>
</tr>
<tr>
<td>IPRO sends introductory communication and requests pre-onsite documentation including eligible file lists from MCO.</td>
<td>Month five</td>
</tr>
<tr>
<td>IPRO provides list of selected files to MCO.</td>
<td>Month six</td>
</tr>
<tr>
<td>IPRO reviews pre-onsite documentation as submitted by MCO.</td>
<td>Month seven</td>
</tr>
<tr>
<td>IPRO conducts onsite compliance review (opening conference, documentation review, interviews, observation, and closing conference).</td>
<td>Month eight</td>
</tr>
<tr>
<td>IPRO prepares and submits annual compliance review report to LDH.</td>
<td>Month nine</td>
</tr>
</tbody>
</table>

LDH: Louisiana Department of Health; MCO: managed care organization.
Section 4: Performance Improvement Projects

Process Overview
One of the mandatory activities for EQR is to review PIPs for methodological soundness of design, conduct and reporting to ensure meaningful improvement in care, and confidence in the reported improvements.

Task Description
PIPs promote MCO improvement in quality of care and outcomes for members. The CMS protocol for validating PIPs includes two mandatory activities:

- assessing the MCO’s methodology for conducting the PIP; and
- evaluating overall validity and reliability of PIP study results.

MCOs are required to conduct a minimum of two LDH-approved PIPs each year. 2018 collaborative PIP topics for the Healthy Louisiana MCOs are listed in Table 7.

Table 7: Performance Improvement Projects

<table>
<thead>
<tr>
<th>Contract Year</th>
<th>PIP Focus</th>
<th>PIP Report Due Dates</th>
<th>Target for Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015–2017 Extension Period: July 1, 2018–June 30, 2019</td>
<td>Prematurity - Reduce premature births to Medicaid-eligible women.</td>
<td>Monthly submission of Plan-Do-Study-Act (PDSA) worksheets and run charts for intervention tracking measures (ITMs) ITM worksheets updated and submitted as needed in response to modifications discussed at ITM meetings</td>
<td>Improve the initiation of progesterone between 16–24 weeks gestational age for the high-risk maternity Medicaid population from 16% to 30%. Reduce preterm births before 32 weeks of gestation by 10% in women who have experienced a prior preterm birth.</td>
</tr>
<tr>
<td>2016–2018</td>
<td>Attention-Deficit/Hyperactivity Disorder (ADHD) – Increase appropriate ADHD diagnosis and drug utilization.</td>
<td>Final PIP report due June 30, 2019</td>
<td>Reduce by 20% prescriptions among populations who are shown to have a high incidence of prescribing with a focus on the 0–6-year-old population.</td>
</tr>
<tr>
<td>2018–2019</td>
<td>Improving Rates for Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)</td>
<td>See Table 8.</td>
<td>To be determined by LDH</td>
</tr>
</tbody>
</table>

PIP: performance improvement project; LDH: Louisiana Department of Health.

Within three months of the execution of the contract and annually thereafter, the MCOs submit, in writing, a general and a detailed description of each PIP to IPRO on behalf of LDH for approval.

MCOs typically follow an approximate one-to-three year approach to collection of PIP baseline data and subsequent measurement of demonstrable improvement and measurement of sustained improvement. PIPs can be implemented early on as opposed to waiting for the MCOs to have a full year of service data.

With this approach, IPRO validates PIPs in a manner that emphasizes collaboration and the efficient and effective use of the resources expended by all parties directly participating in the processes. IPRO validates each MCO’s PIPs on an annual basis in compliance with CMS’s most current Validating Performance Improvement Projects Protocol.
Methodology

Preparation of validation methodology: IPRO prepares the validation methodology including an MCO PIP submission form, reviewer tools, and reporting formats that are compliant with the CMS protocol. To help the MCOs plan their PIPs, at the beginning of each cycle, IPRO provides submission requirements, timelines, and a submission form and instructions to standardize the submission process and facilitate comparisons among the MCOs.

Training webinar/conference call: To assure the MCOs understand PIP validation activities, prior to PIP validation and implementation IPRO conducts a training session. Topics for PIP training include:

- the PIP submission process,
- planning and implementing quality improvement strategies,
- measuring the effectiveness of interventions,
- conducting barrier analysis and developing interventions tailored to address these barriers,
- monitoring progress of interventions using intervention tracking measures (ITMs), and
- sustaining and spreading measured improvement.

Assessing MCO methodology for conducting PIPs: The MCOs are required to submit PIP methodology to IPRO for assessment. The MCOs are required to document all PIP activities on the MCO PIP Submission Form and to submit this completed form annually to IPRO. Detailed submission instructions/requirements and a timeline regarding expectations related to IPRO’s validation of the PIP are provided to all MCOs, including information that should be included in the various sections of the PIP form for each year of submission. The submission form addresses PIP elements, including topic, rationale, indicators, objectives, methodology, data sources and collection procedures, and interventions (see Appendix A).

Each PIP is evaluated against the following elements:

Demonstrable Improvement

- Project topic, type, focus area (review of the study question for comprehensiveness and expected goal/outcome)
- Topic relevance (review of the selected project topic for relevance of focus and for relevance to the MCO’s enrollment and the Medicaid population)
- Performance indicators (review of annual performance indicators which should be objective, measurable, clear and unambiguous and meaningful to the focus of the PIP)
- Baseline study design/analysis (review of data collection procedures to ensure complete and accurate data was collected)
- Baseline study population and baseline measurement/performance (review of the identified study population to ensure it is representative of the MCO’s enrollment and generalizable to the MCO’s total population; review of sampling methods, if sampling is used, for validity and proper technique)
- Interventions aimed at achieving demonstrable improvement (assessment of the improvement strategies for appropriateness and for overcoming barriers that have been identified)
- Demonstrable improvement (assessment of likelihood that reported improvement is “real” improvement)

Sustained Improvement

- Subsequent or modified interventions (review of ongoing, additional or modified interventions)
- Sustained improvement (assessment of whether the MCO achieved sustained improvement)
- Next steps (for each intervention, the MCO summarizes lessons learned, system-level changes made and/or planned, and outlines next steps for ongoing improvement beyond the PIP timeframe.)

IPRO evaluates each element against questions adapted from the CMS protocol. The first seven elements relate to the baseline and demonstrable improvement phases of the project. For assessment of sustained improvement, the first two elements pertain to sustaining improvement from the baseline measurement, and the last element relates to sustaining improvement beyond the PIP timeframe.
Reporting

Once PIPs undergo an initial review by IPRO, with additional input from LDH, IPRO communicates a written assessment to each MCO for each PIP. This assessment is structured to document the evaluation according to the sections on the PIP form. The review may include questions that require MCO clarification and concerns regarding an MCO’s potential achievement of compliance for the element(s) under review. IPRO coordinates conference calls with each MCO that receives the evaluation, as necessary, to discuss the review findings. After the written assessment is reviewed by the MCOs, they are given the opportunity to submit revised PIP documentation, when applicable.

In addition, for some PIPs, the MCOs are required to submit data analyses monthly/quarterly to LDH. For the Prematurity PIP extension year, the plans submit the ITM worksheet, PDSA worksheets and run charts, as indicated in Table 7. At the conclusion of each calendar year, the MCOs provide a written PIP report, as detailed in Appendix A. IPRO subsequently reviews each PIP and generates an evaluation report, which is detailed in Appendix B. This evaluation report is presented to LDH along with MCO-specific PIP validation findings and a report which summarizes annual PIP validation findings across the MCOs.

IPRO, in conjunction with LDH, holds regular teleconference calls with the MCOs to review the status of each PIP, report on intervention tracking measures, assess any barriers or need for change and to discuss the implementation strategy and timeline. In addition, IPRO facilitates an ITM workgroup that meets regularly for the Prematurity PIP extension period from July 1, 2018 to June 30, 2019.

New PIP Topic for 2018–2019

It is expected that the five Healthy Louisiana MCOs will embark on a new PIP topic for Office of Behavioral Health (OBH)/LDH framed around the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) measure. The aim of the PIP is to identify barriers and develop interventions to address the barriers observed with the goal to improve care provided to members with substance use disorders (SUDs; especially to improve follow-up care after members have been diagnosed with an SUD).

Timeline

The approximate PIP timeline is outlined in Table 8.

Table 8: Timeline for the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment PIP

<table>
<thead>
<tr>
<th>PIP Task</th>
<th>Approximate Timeline¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCOs submit PIP proposals with baseline data for 1/1/17–12/31/17 to LDH and LDH distributes to IPRO.</td>
<td>November 7, 2018</td>
</tr>
<tr>
<td>MCOs initiate interventions.</td>
<td>December 1, 2018</td>
</tr>
<tr>
<td>IPRO reviews PIP proposals, baseline data and target rates, holds conference calls with MCOs as needed and prepare PIP review reports.</td>
<td>November 8 – December 6, 2018</td>
</tr>
<tr>
<td>MCOs submit their first set of quarterly cumulative performance indicators and non-cumulative intervention tracking measures (ITMs) for the intervention period of 12/1/18–3/31/19.</td>
<td>April 30, 2019</td>
</tr>
<tr>
<td>MCOs submit their second set of quarterly cumulative performance indicators and non-cumulative ITMs for the intervention period of 4/1/19–6/30/19.</td>
<td>July 31, 2019</td>
</tr>
<tr>
<td>MCOs submit their third set of quarterly cumulative performance indicators and non-cumulative ITMs for intervention period of 7/1/19–9/30/19.</td>
<td>October 31, 2019</td>
</tr>
<tr>
<td>IPRO and LDH hold collaborative calls with the MCOs to obtain progress reports from the MCOs and address the MCOs’ issues and concerns.</td>
<td>Quarterly</td>
</tr>
<tr>
<td>MCOs will submit first drafts of final reports for interim (1/1/18–12/31/18) and final (1/1/19–6/30/19) measurement periods to LDH.</td>
<td>November 15, 2019</td>
</tr>
<tr>
<td>MCOs submit finalized final reports for interim (1/1/18–12/31/18) and final (1/1/19N6/30/19) measurement periods to LDH.</td>
<td>November 30, 2019</td>
</tr>
</tbody>
</table>

¹ PIP: performance improvement project; LDH: Louisiana Department of Health; MCO: managed care organization.
Section 5: Performance Measure Validation

Process Overview
LDH selected MCO quality PMs to assess access to care, effectiveness of care, and use of services.

The first performance measurement period for all MCOs was calendar year 2015. MCOs reported/will report PMs for the second year in 2016, the third year in 2017, and the fourth year in 2018. This approach affords several years of reporting and will allow for trending rates to help monitor progress and help identify priority areas in need of improvement.

One of the mandatory activities for EQR is validation of PMs to assess the accuracy and reliability of the PMs reported by the MCOs and to determine the extent to which they follow established measure technical specifications and are in accordance with the specifications in 42 CFR § 438.330(b).

The CMS protocols specify that in lieu of conducting a full onsite information systems (IS) assessment, the EQRO may review an assessment of the MCO’s IS conducted by another party. If an MCO is accredited by the National Committee for Quality Assurance (NCQA), the MCO will have received a full IS assessment as part of its annual Healthcare Effectiveness Data and Information Set (HEDIS®) audit by an NCQA-licensed audit organization. In this case, IPRO requests and reviews the MCO’s NCQA Roadmap, Final Audit Report (FAR) and the data submission tool in lieu of conducting an onsite assessment.

Task Description
The task of validating PMs assesses the MCOs’ processes for calculating PMs and whether the processes adhered to each measure’s specifications, and the accuracy of the PM rates as calculated and reported by the MCOs. Each assessment may include a documentation review, source code review, medical record validation and an assessment based on the reasonability of the information provided.

The validation follows a structure similar to HEDIS compliance audits, but focuses on process assessment and is fully compliant with the CMS EQRO Validating Performance Measures Protocol.

Note that for the state-specific PMs, an onsite visit is, in all likelihood, not necessary. Presently, IPRO assists the University of Louisiana – Monroe (ULM) in this activity with ULM conducting the source code analyses. If necessary, IPRO will conduct medical record review (MRR) to validate the MCO’s calculation of the measures. An onsite visit is usually only required when the MCO hasn’t undergone an NCQA-required HEDIS audit. The onsite methodology will be conducted only in those special circumstances when a formal validation that includes an onsite visit is required.

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

HEDIS Measure Validation Methodology
The MCOs that report HEDIS measures to NCQA must undergo an audit of their data conducted by a NCQA licensed HEDIS audit organization (LO). For these HEDIS measures, IPRO reviews the rates submitted on the NCQA reporting tool (Interactive Data Submission System [IDSS]), which is audited prior to submission, the FAR, which is completed by the LO and describes the process used to produce the 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. Other supporting documentation, such as the NCQA Roadmap is reviewed as well.

IPRO will use the results of the audit to report the results of each measure reported to LDH. Using information provided in the FAR and, if necessary in the NCQA Roadmap, IPRO will prepare a report indicating the measure results for each of the five MCOs that are required to report to LDH. Measures deemed “not reportable” will be flagged. Statewide averages will be computed and NCQA Quality Compass® benchmarks will be provided, as well. Any issues in reporting any measure will be noted (e.g., medical record abstraction issues) and should LDH request any other statistical analyses, these results will also be included in the report.
Non-HEDIS Measure Validation Methodology
For state-specific measures and standardized non-HEDIS measures (e.g., the Prevention Quality Indicators), IPRO will assist ULM in conducting the audit either by reviewing source code or, when necessary, conducting MRR validation. Measures which do not pass validation will be deemed “not reportable” and the reasons for this designation will be noted (e.g., problems in abstracting medical records accurately). Should LDH request any other statistical analyses, these results will also be included in the report. ULM conducts the validation for non-HEDIS measures and IPRO provides assistance when needed.

Timeline
The approximate PM timeline is outlined in Table 9.

Table 9: Performance Measure Validation Timeline

<table>
<thead>
<tr>
<th>PM Validation Task</th>
<th>Approximate Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCOs report HEDIS/PMs to NCQA via the IDSS or other reporting mechanism (for the state-specific measures).</td>
<td>June 17, 2019</td>
</tr>
<tr>
<td>MCOs submit the IDSS workbook, audit designation table and NCQA Roadmap to LDH via the IPRO FTP site.</td>
<td>June 17, 2019</td>
</tr>
<tr>
<td>MCOs submit HEDIS final audit reports to LDH via the IPRO FTP site.</td>
<td>July 5, 2019</td>
</tr>
<tr>
<td>MCOs submit non-HEDIS PMs to LDH via the IPRO FTP site.</td>
<td>August 5, 2019</td>
</tr>
<tr>
<td>CAHPS Adult and Child Survey with CCC. MCOs submit the de-identified .txt member-level files of CAHPS responses, following NCQA CAHPS file layout for file submission.</td>
<td>September 2, 2019</td>
</tr>
<tr>
<td>IPRO validates the PM rates via document review, source code review and medical record reviews, as necessary.</td>
<td>October 31, 2019</td>
</tr>
<tr>
<td>ULM, with IPRO’s assistance, validates the non-HEDIS PMs.</td>
<td>October 31, 2019</td>
</tr>
<tr>
<td>IPRO, in conjunction with LDH, compiles the MCOs’ HEDIS rates, including statewide averages and national/regional benchmarks.</td>
<td>October 31, 2019</td>
</tr>
</tbody>
</table>


MCO Performance Measures
MCOs are required to submit performance measures to LDH as described in Appendix C and can also be located in the Healthy Louisiana Performance Measure Submission Guide.

Incentive-based measures may affect MCO payments. These can be found in Appendix C, annotated with “$$.  

Section 6: MCO Annual Technical Report

MCO Annual Technical Report Content

The final rule of the Balanced Budget Act (BBA) of 1997 requires that state agencies contract with an EQRO to conduct an annual EQR of the services provided by contracted Medicaid MCOs. This EQR must include an analysis and evaluation of aggregated information on quality, timeliness and access to the health care services that an MCO furnishes to MMC recipients.

The EQR-related activities that must be included in detailed technical reports are:

- review to determine MCO compliance with structure and operations standards and the QAPI established by the state (42 CFR § 435.358 (b)(iii));
- validation of PIPs; and
- validation of MCO PMs.

For each contract year, IPRO produces technical reports that assess MCO performance, in compliance with the requirements of 42 CFR §438.364 and Louisiana specifications. IPRO prepares a report for each MCO and one statewide aggregate report which includes all MCOs. IPRO submits the MCO-specific reports to LDH within 30 days after completion of the annual review of each MCO.

IPRO works with LDH to identify the domains and data to be included in the MCO-specific technical reports and in the statewide aggregate technical report, and establish a production timeline.

The following information is included in the annual MCO technical reports as appropriate to the report type:

- objectives;
- a brief description of the technical methods of data collection and analysis, a review process overview, the scoring criteria, and the steps taken to prepare the reviewers and validate reviewer-completed instruments;
- follow-up activities since the preceding review;
- description of the data obtained, and the collection and analysis process;
- MCO-specific findings, including best practices;
- findings by each category of requirements;
- conclusions drawn from the data;
- trends in evaluation findings over the years that reviews have been completed;
- opportunities for improvement and recommendations;
- an assessment of each MCO’s strengths and weaknesses with respect to the quality, timeliness and access to health care services furnished to Medicaid recipients;
- methodologically appropriate, comparative information about all MCOs operating within Louisiana, as determined by LDH; and
- an assessment of the degree to which an MCO has effectively addressed the recommendations for quality improvement made by IPRO during the previous year’s EQR.

The technical reports are prepared in electronic format in accordance with all contract and LDH specifications.

MCO Technical Reports

As applicable, the MCO-specific technical reports provide the objectives for each key activity, the methods used to measure these objectives, and key findings and conclusions resulting from the data. The reports combine text, tables and graphs to best display each data set in a way that is easily understandable. If appropriate, IPRO conducts significance testing for each figure to provide a functional way to compare each MCO to statewide and/or national benchmarks, and includes multiple years for trending purposes.
The MCO-specific technical reports provide an assessment of the strengths and opportunities for improvement for each MCO relative to timeliness, access and quality of services delivered to members, and IPRO’s recommendations. MCO-specific technical reports include an assessment of the degree to which each MCO has effectively addressed the performance improvement recommendations made by IPRO during the previous year’s EQR.

**Timeline**

The approximate annual technical report timeline is outlined in Table 10.

**Table 10: Annual Technical Report Timeline**

<table>
<thead>
<tr>
<th>Annual Technical Report Task</th>
<th>Approximate Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPRO collects data from LDH/MCOs for inclusion in the technical report.</td>
<td>October to January of each contract year</td>
</tr>
<tr>
<td>IPRO submits draft of technical report to LDH for review.</td>
<td>Late February of each contract year (effective 2018)</td>
</tr>
<tr>
<td>IPRO prepares and submits final report to LDH based on LDH feedback.</td>
<td>Late March to early April of each contract year (effective 2018)</td>
</tr>
<tr>
<td>MCOs respond to IPRO recommendations.</td>
<td>December of each contract year</td>
</tr>
</tbody>
</table>

LDH: Louisiana Department of Health; MCO: managed care organization
Section 7: Medical Loss Ratio Recommendations

Process Overview
It is expected that this task will not be conducted in 2019. The process for conducting this task is outlined in this section.

At the request of LDH, IPRO will review each MCO’s MLR rebate calculation document to compare and ascertain alignment with the CFR for MLR. Specifically, IPRO will review each MCO’s MLR policy and calculation documents to ensure that the following regulated components are addressed:

2.3.4.1 Disclosure and Reporting: Sub Part A
- Reporting requirements related to premiums and expenditures
- Aggregate reporting
- Newer experience
- Premium revenue
- Reimbursement for clinical services provided to enrollees
- Activities that improve healthcare quality
- Expenditures related to health information technology (HIT) and meaningful use requirements
- Other non-claim costs
- Reporting of federal and state licensing and regulatory fees
- Reporting of federal and state taxes
- Allocation of expenses

2.3.4.2 Calculating and Providing the Rebate: Sub Part B
IPRO will review the MCO’s formula for calculating MLR to ensure that it is compliant and that the MCO’s policies for rebating payments (if the 85% MLR standard is not met) is also compliant. On an annual basis, IPRO will also conduct an MLR quality review of the reported MLR. Specifically, the activities and expenses will be reviewed to determine if they are quality-related.

Activities conducted to improve quality must be primarily designed to:
- improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline, and reduce health disparities among specified populations;
- prevent hospital re-admissions through a comprehensive hospital discharge program;
- improve patient safety, reduce medical errors and lower infection and mortality rates;
- implement, promote and increase wellness and healthy activities; or
- enhance the use of healthcare data to improve quality, transparency and outcomes, and support meaningful use of health information technology.

Primary quality activities are those associated with care management, disease management and wellness programs. These activities will comprise the focus of IPRO’s review. Primary activity examples include:
- arranging and managing care (e.g., primary care, specialty care, care transitions);
- medication and care compliance;
- programs to support shared decision making with patients, families, representatives;
- use of medical homes;
- comprehensive discharge planning;
- prospective medical and drug utilization review;
- wellness and health promotion activities (e.g., coaching and incentive programs for smoking, obesity); and
- certain HIT expenses (those associated with quality-related activities or activities that assist providers in the adoption and meaningful use of certified electronic health record technology and fees/subscriptions paid to the Louisiana Health Information Exchange [LaHIE]).
Section 8: Focused Studies

It is not expected that LDH will require IPRO to conduct a focused study in 2019. IPRO’s methodology for conducting focused studies is described in this section to familiarize MCOs with this type of study.

Process Overview

Focused studies assist LDH in evaluating the safety, quality, timeliness and efficiency of care provided to MCO enrollees, and ensure that care is patient-centered and equitable. Studies are designed and conducted in collaboration with LDH and in accordance with CMS’s most current EQR protocol for conducting focused studies of healthcare quality.

Task Description

IPRO will work with LDH to identify topics that are aligned with the state’s priorities and goals. In proposing topics, IPRO will consider clinical conditions and health service delivery issues that have the highest prevalence or incidence among Louisiana MCO members, the greatest potential for improving health outcomes and the overall potential impact on the Medicaid program.

For Louisiana, IPRO recommends conducting one focused study using administrative data supplied by the state or MCOs, and a second study using data abstracted using MRR.

Recent focused studies IPRO conducted include MRR studies to evaluate:

- prenatal and postpartum care;
- care for members with attention-deficit/hyperactivity disorder (ADHD);
- depression screening in primary care;
- discharge practices and risk factors for maternal postpartum hospital readmission and newborn hospital readmission;
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services;
- preventive services for children with special healthcare needs (CSHCN); and
- early childhood developmental surveillance and screening.

IPRO recently conducted focused studies using administrative data to evaluate:

- opioid prescribing patterns for MMC members with chronic pain;
- risk factors for non-receipt of medication assisted treatment (MAT) for MMC members with opioid use disorder;
- risk factors for non-receipt of hepatitis C treatment and hospitalization/emergency department (ED) visits for liver-related disease;
- non-traumatic dental ED visits as an indicator of unmet dental need;
- adverse delivery outcomes associated with prenatal smoking;
- utilization patterns of MMC members with co-occurring physical health (PH) and behavioral health (BH) conditions, diagnoses and other characteristics associated with ED utilization;
- diagnoses and characteristics associated with prenatal and postpartum hospital and ED utilization; and
- co-morbid conditions, behavioral risk factors and demographic factors associated with appropriate asthma medication.
- Also, MCO care management practices were evaluated against enrollment and medical record data using predictive modeling software.

IPRO also conducted survey studies to evaluate MCO members’ experience of care, such as postpartum members, members enrolled in Medicaid Managed Long-Term Care (MLTC), CSHCN, and members receiving Supplemental Security Income (SSI) who were recently transitioned to MMC. The focused study task has been used for the conduct of these surveys.
Methodology

As per the CMS protocol, focused studies will be conducted following these steps:

1. Select the study topic: In proposing topics, IPRO will consider clinical conditions and health service delivery issues that have the highest prevalence or incidence among Louisiana MCO members, the greatest potential for improving health outcomes and the overall potential impact on the Medicaid program. Examples of types of studies that could be considered include:
   - primary and preventative services,
   - chronic/acute conditions,
   - ambulatory care sensitive conditions,
   - continuity and care coordination, including care transitions,
   - co-occurring BH and PH conditions,
   - health service delivery issues,
   - access/utilization studies,
   - inappropriate treatments/management,
   - disparities including differences among demographic subsets, and
   - outcome studies.

2. Define the study questions
3. Select the study variable(s)
4. Study the whole population or use a representative sample
5. Use sound sampling methods
6. Reliably collect data
7. Analyze data and interpret study results
8. Report results to LDH

Once the study topic has been identified, IPRO submits a proposed study design to LDH that includes study topic, aim, study questions, indicators, eligible population and sampling strategy, data collection methodology and analysis methodology. Once the proposal is finalized, IPRO develops and submits a detailed data analysis plan (DAP) that will outline schemes for data analysis and reporting, including organization of indicators into domains, composite variables as applicable, groups for comparative analyses, other applicable analyses and statistical tests, and sample tables for presentation of data. Final study reports submitted to LDH include an executive summary, introduction, objectives, methods of data collection and analysis, results, discussion, limitations, conclusions and recommendations for improvement and issues requiring further study.
Section 9: Provider Satisfaction Surveys

Process Overview
Louisiana makes provision for the EQRO to design and implement one statewide provider survey per year. Through provider surveys, LDH can evaluate the experience of specific types of providers in the MMC program, the effectiveness of certain managed care or Medicaid programs, and/or how satisfied Medicaid providers are with a particular aspect of an MCO’s performance.

In 2018, IPRO developed the Healthy Louisiana Provider Satisfaction Survey for LDH. To develop survey items, IPRO incorporated the domains for inclusion identified by LDH, reviewed each of the five MCOs’ existing provider satisfaction surveys, and extracted common elements that reflected the domains identified by LDH. To ensure that the MCOs were aware of the survey, IPRO provided each MCO with the final provider survey instrument and informed them of the sampling protocol and survey administration timetable. IPRO also held a conference call at the outset of the project, with LDH input, to review the process and answer MCO staff questions.

The start date for the development of the provider survey was Spring 2018. IPRO, in consultation with LDH, designed a written survey to assess physicians’ experiences in interacting with a specific MCO and to obtain demographic information about the practice being surveyed. In addition to evaluating providers’ satisfaction and experience with the Healthy Louisiana Program, the survey assessed provider satisfaction with individual MCOs and also assessed potential differences among practice types.

To allow for a sufficient number of responses per MCO and to allow for meaningful comparisons among the five MCOs, a sample size of 1,200 providers per MCO was selected, stratified as 600 primary care providers (PCPs), 300 BH providers and 300 other specialists. To be eligible for selection, providers had to be currently contracted with at least one of the five Medicaid MCOs in the state. Providers were drawn from the MCOs’ most current provider databases. The survey mode consisted of a two-wave mailing. A cover letter was prepared by IPRO and signed by senior LDH staff stressing the importance of the survey and the need for provider input.

A final report will be issued in late November 2018.

Timeline
The approximate provider satisfaction survey timeline is outlined in Table 11.

Table 11: Provider Satisfaction Survey Timeline

<table>
<thead>
<tr>
<th>Provider Satisfaction Survey Task</th>
<th>Approximate Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPRO meets with LDH to discuss survey methodology, survey instrument, and mailing materials.</td>
<td>April 2018</td>
</tr>
<tr>
<td>IPRO develops study specifications and protocols, e.g., draft survey methodology, sampling, survey administration, instrument and materials.</td>
<td>May 2018</td>
</tr>
<tr>
<td>IPRO obtains and checks provider file.</td>
<td>May 2018</td>
</tr>
<tr>
<td>IPRO selects study sample and conducts field preparation including formatting, assembling, and printing mailing materials.</td>
<td>June 2018</td>
</tr>
<tr>
<td>IPRO sends first mailing of surveys to providers.</td>
<td>July 2018</td>
</tr>
<tr>
<td>IPRO sends second mailing of surveys to non-responders.</td>
<td>August 2018</td>
</tr>
<tr>
<td>IPRO conducts data analysis.</td>
<td>September 2018</td>
</tr>
<tr>
<td>IPRO prepares and submits final report to LDH.</td>
<td>November 2018</td>
</tr>
</tbody>
</table>
**Validation of MCO-Developed Provider Surveys**

Since IPRO developed and conducted a state-sponsored provider survey in 2018, it is not expected that IPRO will validate MCO-developed surveys in 2019. However, the approach IPRO follows is described in this section.

The process to validate the survey begins with a request to the MCO to provide IPRO with a hard copy version of the survey, accompanying instructions, the timeframe for survey administration and analysis, the sampling design and any policy and procedure document that describes the purpose of the survey and its intended usage.

IPRO employs a team, typically composed of two staff members, either psychometricians or staff experienced in survey design, to conduct the validation. The IPRO review entails a detailed evaluation of:

- the validity of the survey items in terms of whether they meet the stated objectives of the survey;
- the structure of the survey items and conformance to psychometrically-sound principles, (e.g., use of a Likert-type scale or semantic differential);
- the wording of the survey items to ensure clarity in reflecting the objective of the survey item (e.g., rewording of double-barreled items);
- the sampling design to ensure that the survey sample represents the population being surveyed (e.g., proportional or random sampling);
- the size of the survey sample frame to ensure that the response set is sufficiently large to draw meaningful conclusions;
- the survey protocol to ensure that:
  - the timeframe for surveying is adequate,
  - the mode of the survey is appropriate (e.g., mail, phone, or online), and
  - the time period for surveying is appropriate (e.g., post-contacting).

Once the evaluation is complete, IPRO prepares a report detailing the survey strengths and suggestions for improvements. This evaluation is shared with LDH for discussion, and then forwarded to the MCO for use in enhancing the survey and survey process.
Section 10: Provider Directory Survey

It is expected that IPRO will conduct a telephonic validation of the MCOs online provider directories in the fourth quarter of 2018.

Process Overview

The purpose of this activity is to validate information published in the Healthy Louisiana MCOs’ web-based Medicaid provider directories. Validation of MCO provider directories is performed to ensure MCOs have adequate provider networks and helps to ensure enrollees are being provided accurate information regarding the providers comprising the network. IPRO has multiple years of experience validating the accuracy of provider directories and proposing recommendations for improvement. IPRO is currently conducting this survey for at least two states on an annual basis. This activity is usually completed within a two-month timeframe.

Methodology

**Sampling process:** Using the MCO Medicaid provider web directories, IPRO selects 125 providers per MCO who meet the specialty and unrestricted panel (open to new Healthy Louisiana Medicaid patients) requirements. Individual providers or provider sites do not appear in the MCO sample more than once. IPRO makes a reasonable attempt to minimize the number of times a single provider is contacted across all MCOs.

**Survey protocol:** Survey calls take place Monday through Friday, 8:30 AM – 5:00 PM CST, excluding holidays; however, if there is any indication that a provider has alternative office hours, surveyors recall the provider during these alternative office hours. If an alternative telephone number for the named provider is obtained during the survey process, surveyors attempt to reach the provider using the alternative telephone number.

Surveyors introduce themselves as calling on behalf of LDH and confirm provider status. Call results are recorded using an IPRO-developed survey tool. Reporting options for non-compliance include:

- specialty other than what was identified in provider directory;
- closed panel for named MCO;
- non-participation with named MCO;
- provider no longer at site; and
- representative does not have enough information to answer the survey questions.

IPRO surveyors make up to three attempts to contact a live staff person at each provider office to complete the survey. For each call made, the surveyor documents the reason why no contact was made with a live staff member.

If an answering machine is reached on the first attempt, surveyors note the provider site’s office hours or alternate number and call back during the appropriate time.

**Reporting**

IPRO produces MCO- and state-level reports. At a minimum, the reports include:

- the description of the methodology,
- calculated rates,
- compliant provider details,
- non-compliant provider details, and
- resurveyed provider details, if applicable.

**Timeline**

It is expected that the initial provider directory survey will be conducted in the fourth quarter of 2018 with a report prepared by December 31, 2018.
Appendix A: Performance Improvement Project Reporting Template
Healthy Louisiana Performance Improvement Project (PIP)

MCO Name

PIP Title

Insert year of PIP initiation - Insert year of PIP final re-measurement

Project Phase: Choose an item

Submission Date: Click here to enter a date

Submission to: IPRO

State: Louisiana Department of Health
MCO Contact Information

1. **Principal MCO Contact Person**
   [PERSON RESPONSIBLE FOR COMPLETING THIS REPORT AND WHO CAN BE CONTACTED FOR QUESTIONS]
   
   Insert First and Last name
   Enter Title
   Enter Phone Number (direct line or indicate extension)
   Enter email address

2. **Additional Contact(s)**
   [PERSON(S) RESPONSIBLE IN THE EVENT THAT THE PRINCIPAL CONTACT PERSON IS UNAVAILABLE]
   
   Insert First and Last name
   Enter Title
   Enter Phone Number (direct line or indicate extension)
   Enter email address

   Insert First and Last name
   Enter Title
   Enter Phone Number (direct line or indicate extension)
   Enter email address

3. **External Collaborators (if applicable):** Click here to enter external collaborators involved in this
   PIP. If no external collaborators, enter N/A.

4. **For Final Reports Only: If Applicable, Summarize and Report All Changes in Methodology and/or Data Collection from Initial Proposal Submission:**
   Click here to enter text. Examples include: added new interventions, added a new survey, change in indicator definition or data collection, deviated from HEDIS specifications, reduced sample size(s). If no changes, enter N/A.
5. Attestation

Plan Name: Click here to enter text
Title of Project: Click here to enter text

Required signatures for PIP Proposal and PIP Final Report:
(1) Medical Director or Chief Medical Officer and (2) Quality Director or Vice President for Quality

The undersigned approve this PIP Proposal and assure involvement in the PIP throughout the course of the project.

Medical Director Signature
Printed Name

Quality Director Signature
Printed Name

IS Director Signature (when applicable)
Printed Name

CEO Signature
Printed Name

Healthcare Effectiveness and Information Data Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).
Abstract

The Abstract should be completed only for the Final Report submission. Should not exceed 2 pages.

Provide an abstract of the PIP highlighting the project topic and objectives, briefly describe the methodology and interventions, and summarize results and major conclusions of the project (refer to instructions in full report template or appendix).

Project Topic/Rationale/Aims
Title of Project: Click here to enter text.
Rationale for Project: Click here to enter text.
Project Aims: Click here to enter text.
Project Objectives: Click here to enter text.
Baseline Data: Click here to enter text.
Benchmark Data: Click here to enter text.
Goals for Improvement: Click here to enter text.

Methodology
Population: Click here to enter text.
Performance Indicators (numerators and denominators): Click here to enter text.
Sampling Method: Click here to enter text.
Baseline and Re-measurement Periods: Click here to enter text.
Data Collection Procedures: Click here to enter text.

Interventions
Barriers Identified: Click here to enter text.
Interventions: Click here to enter text.
Interventions’ Target Groups: Click here to enter text.
Interim Results from Plan Do Study Act (PDSA) Method: Click here to enter text. If PDSA Cycle was not used, enter N/A.

Results
Baseline Eligible Population: Click here to enter text.
Re-measurement Eligible Population: Click here to enter text.
Denominator, Numerator and Rates for Each Performance Indicator: Click here to enter text.

Conclusions
Indicate if Project Goals were met: Click here to enter text.
Interpretation of Major Project Findings: Click here to enter text.
Study Design Limitations: Click here to enter text.
Lessons Learned and Next Steps: Click here to enter text.
1. Project Topic/ Rationale and 2. Aim

Suggested length: 2 pages

1. Describe Project Topic and Rationale for Topic Selection

- Describe how PIP Topic addresses your member needs and why it is important to your members (e.g., disease prevalence stratified by demographic subgroups): Click here to enter text.
- Describe high-volume or high-risk conditions addressed: Click here to enter text.
- Describe current research support for topic (e.g., clinical guidelines/standards): Click here to enter text.
- Explain why there is opportunity for MCO improvement in this area (must include baseline and if available, statewide average/benchmarks): Click here to enter text.

2. Aim Statement, Objectives and Goals

**Aim Statement:**
An aim should be specific, measurable, and should answer the questions, How much improvement, to what, for whom, and by when?
“By (specify deadline) the MCO aims to (improve/increase/decrease) (specify indicator) for (specify eligible population).”

Example: By the end of 2018, the MCO aims to reduce the percentage of ED visits for asthma by 50% compared to 2016, among children 5-11 years of age who have an asthma diagnosis.

**Objective(s):**
“Implement [describe major intervention(s)] to improve [performance indicator] from baseline to final measurement.”

Example: Implement automatic pharmacy refills to improve the percent of members ages 5-11 years with asthma who were dispensed asthma controller medication from baseline to final measurement.

**Goal(s):**
Each performance indicator should have its own unique goal. Please copy and paste section below to list goals for each performance indicator.

| Baseline Rate | Benchmark Rate | PIP Goal Rate |

Using the information you entered above, complete following goal statements:

**Baseline to interim measurement goal:** Click here to enter baseline to interim measurement goal. Example:
Increase the percent of members 5-11 years old with an asthma controller medication prescription by 10 percentage points (from 56% to 66%) in order to meet the statewide average of 66% by December 2017.
Baseline to final measurement goal: Click here to enter baseline to final measurement goal. Example: Increase the percent of members 5-11 with an asthma controller medication prescription by 15 percentage points (from 56% to 71%) in order to exceed the statewide average of 66% by December 2018.

3. Methodology

Performance Indicators

Indicators should be measurable, objective, clearly defined, and correspond directly to the study aim. The timeframe should be indicated as the measurement year, i.e., the annual timeframe represented by the data, from the start date to the end date of each measurement year, as indicated in Section 4 (Timeline) below. If there is more than one indicator, copy the following headings for each one and complete the relevant information. Note: Meaningful, focused measurement is generally limited to 2-3 indicators.

Indicator #1 Data Source(s): Choose an item or manually enter if multiple sources
Click here to enter Indicator 1, Indicators, also known as Performance Measures, evaluate the outcome of the PIP, and thus the overall success of the project. They should be stated as “The percent of …..”
Ex: Percent of children ages 5-11 years with an asthma diagnosis who have an asthma controller medication prescription in measurement year (MY).

Eligible Population:
Describe members (by age/region/other demographic characteristics) for whom your PIP is designed to target and improve health outcomes.
Ex: If your PIP aim is to reduce ED asthma visits for children ages 5–11 years, the eligible population is all children ages 5-11 years with asthma diagnosis.

Exclusion Criteria:
Detail reasons why eligible members would not be included in this study.
Ex: Children ages 5-11 years with a known contraindication to asthma controller medications would be excluded from the eligible population.

HEDIS® Indicators: If using a HEDIS measure (e.g., MMA, which is provided as an example throughout this report template), specify the HEDIS® reporting year used and reference the HEDIS Volume 2 Technical Specifications (e.g., measure name(s)). It is not necessary to provide the entire specification. A summary of the indicator statement, and criteria for the eligible population, denominator, numerator, and any exclusions are sufficient. Describe any modifications being made to the HEDIS specification, e.g., change in age range.

Non-HEDIS Indicators: If not using a HEDIS measure or a modified HEDIS measure, clearly and concisely describe how the project indicator(s) will be measured. Be sure to include the measurement period, eligible population criteria, definitions for the numerator and denominator, and any exclusion criteria. Include all applicable diagnoses, procedure, pharmacy, provider type, place of service and other codes with narrative. If the state shared detailed measure specifications, the MCO can simply refer to those documents instead of providing all diagnoses, etc.

Changes: State whether the methodology for the interim and/or final remeasurement periods differs from the baseline methodology. Include the type of change, rationale for the change, and any bias that could affect the results.
Numerator Definition:
Detail members meeting the criteria or specifications for this indicator.
Ex: Number of children ages 5–11 years with a prescription filled during the MY for an asthma controller medication.

Denominator Definition:
Detail members for whom your PIP is designed to improve health outcomes (less exclusions).
Ex: Number of children ages 5-11 years with an asthma diagnosis excluding those with a known contraindication to asthma controller medications.

Data Collection and Analysis Procedures

Is the entire eligible population being targeted by PIP interventions? Click here to enter text. If sampling was used, please indicate “No” for this question, and proceed to following question.

If sampling was employed:
Describe sampling methodology: Click here to enter text. Identify if random sampling was used, stratified sampling, etc.
Sample Size and Justification: Click here to enter text.

Data Collection:
Describe who will collect the data (using staff titles and qualifications), and data collection tools used (abstraction tools, software, surveys, etc.). If a survey is used, indicate survey method (phone, mail, face-to-face), the number of surveys distributed and completed, and the follow-up attempts to increase response rate.

Validity and Reliability:
Describe efforts used to ensure data validity and reliability. For medical record abstraction, describe abstractor training, inter-rater reliability (IRR) testing, quality monitoring, and edits in the data entry tool. For surveys, address if the survey instrument has been validated. For administrative data, describe validation that has occurred, methods to address missing data and audits that have been conducted.

Data Analysis:
Explain the data analysis procedures and, if statistical testing is conducted, specify the procedures used. Describe the methods used to analyze data, whether measurements were compared to prior results or similar studies, and if results were compared among regions, provider sites, or other subsets or benchmarks.

Timeline
Report the baseline, interim and final measurement data collections periods below.

Baseline Measurement Period:
Start date: IPRO to pre-populate with date.
End date: IPRO to pre-populate with date.
Submission of Proposal Report Due: IPRO to pre-populate with date.

PIP Interventions (New or Enhanced) Initiated: Click here to enter a date.

Baseline Measurement Period:
Start date: IPRO to pre-populate with date.
End date: IPRO to pre-populate with date.

Interim Measurement Period:
Start date: IPRO to pre-populate with date.
End date: IPRO to pre-populate with date.

Submission of Interim Report Due: IPRO to pre-populate with date.

Final Measurement Period:
Start date: IPRO to pre-populate with date.
End date: IPRO to pre-populate with date.
Submission of Final Report Due: IPRO to pre-populate with date.
4. Barriers and 5. Interventions

This section describes the barriers identified and the related interventions planned to overcome those barriers in order to achieve improvement.

Populate the tables below with relevant information, based upon instructions in the footnotes.

Table of Barriers Identified and the Interventions Designed to Overcome Each Barrier.

<table>
<thead>
<tr>
<th>Description of Barrier</th>
<th>Method and Source of Barrier Identification</th>
<th>Number of Intervention</th>
<th>Description of Intervention Designed to Overcome Barrier</th>
<th>Intervention Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example 1: Automatic asthma controller refills not generated</td>
<td>Review of pharmacy procedures/claims</td>
<td>1</td>
<td>Pharmacy active asthma diagnosis flag to trigger automated refills as prescribed</td>
<td>Planned Start Date: Actual Start Date: Date Revised:</td>
</tr>
<tr>
<td>Example 2: Lack of CM outreach to parents of children with asthma</td>
<td>Review of member feedback in CM outreach logs</td>
<td>2</td>
<td>Stratify gap report for targeted CM outreach to members</td>
<td>Planned Start: Actual Start: Date Revised:</td>
</tr>
<tr>
<td>Click here to enter text.</td>
<td>Click here to enter text.</td>
<td>3</td>
<td>Click here to enter Intervention. Be sure to number accordingly (e.g., Intervention #1, #1a., #2, etc.).</td>
<td>Planned Start: Actual Start: Date Revised:</td>
</tr>
<tr>
<td>Click here to enter text.</td>
<td>Click here to enter text.</td>
<td>4</td>
<td>Click here to enter Intervention. Be sure to number accordingly (e.g., Intervention #1, #1a., #2, etc.).</td>
<td>Planned Start: Actual Start: Date Revised:</td>
</tr>
<tr>
<td>Click here to enter text.</td>
<td>Click here to enter text.</td>
<td>5</td>
<td>Click here to enter Intervention. Be sure to number accordingly (e.g., Intervention #1, #1a., #2, etc.).</td>
<td>Planned Start: Actual Start: Date Revised:</td>
</tr>
<tr>
<td>Click here to enter text.</td>
<td>Click here to enter text.</td>
<td>6</td>
<td>Click here to enter Intervention. Be sure to number accordingly (e.g., Intervention #1, #1a., #2, etc.).</td>
<td>Planned Start: Actual Start: Date Revised:</td>
</tr>
</tbody>
</table>

Barrier analysis should include analyses of both quantitative (e.g., performance indicator noncompliance rates stratified by demographic and clinical subgroups to identify susceptible subpopulations) and qualitative data (such as surveys, access and availability data or focus groups and interviews) and review of published literature where appropriate. Barriers, such as lack of member knowledge, insufficient number of providers in rural areas, lack of transportation, lack of standardized tools, and lack of adequate discharge planning should be distinguished from challenges the MCO confronted conducting the study and collecting data; these challenges should be described in the Limitations section (e.g., lack of resources / insufficient nurses for chart abstraction). Update the barrier analysis, as needed, to address stagnant or worsening rates for intervention tracking measures.

How the barrier was identified: Barriers should be based on data collected from sources that are both internal (e.g., QI committee brainstorming, analysis of claims data stratified by susceptible subpopulations) and external (discussion with providers); e.g., focus group, interview, survey, provider or member interviews, observation, literature review, etc.

Interventions should be developed to improve health plan and provider performance, as well as health outcomes among membership. Interventions should be likely to induce a permanent change rather than a short-term effect. They should be aligned with the study aims, objectives and indicators. Modifications to interventions are sometimes necessary; these modifications should be indicated in the table, with corresponding dates and the findings from the intervention tracking/process measure(s) that informed that modification.
Interventions should be timed for optimal impact, ideally and the end of or after baseline measurement period and early enough to allow time to impact the re-measurement results; an interval of at least 6 to 9 months is generally necessary to detect measurable impact of your interventions.

### Monitoring Table YEAR 1: Quarterly Reporting of Rates for Intervention Tracking Measures, with corresponding intervention numbers.

<table>
<thead>
<tr>
<th>Number of Intervention</th>
<th>Description of Intervention Tracking Measures</th>
<th>Q1 Enter year</th>
<th>Q2 Enter year</th>
<th>Q3 Enter year</th>
<th>Q4 Enter year</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Example: 1</strong></td>
<td>Percentage of children ages 5-11 years with asthma diagnosis with controller medication automatic refill &lt;br&gt; Num: # of children 5-11 with asthma diagnosis with automatic refill trigger &lt;br&gt; Denom: # children 5-11 with asthma diagnosis</td>
<td>Numerator: 100 Denominator: 1,500 Rate: 6.67%</td>
<td>Numerator: 250 Denominator: 1,520 Rate: 16.45%</td>
<td>Numerator: 500 Denominator: 1,600 Rate: 31.25%</td>
<td>Numerator: 750 Denominator: 1,650 Rate: 45.45%</td>
</tr>
<tr>
<td>2</td>
<td>Describe intervention tracking measure that corresponds to intervention #1 &lt;br&gt; Num: Enter description Denom: Enter description</td>
<td>Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom</td>
<td>Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom</td>
<td>Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom</td>
<td>Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom</td>
</tr>
<tr>
<td>3</td>
<td>Describe intervention tracking measure that corresponds to intervention #2 &lt;br&gt; Num: Enter description Denom: Enter description</td>
<td>Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom</td>
<td>Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom</td>
<td>Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom</td>
<td>Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom</td>
</tr>
<tr>
<td>4</td>
<td>Describe intervention tracking measure that corresponds to intervention #3 &lt;br&gt; Num: Enter description Denom: Enter description</td>
<td>Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom</td>
<td>Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom</td>
<td>Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom</td>
<td>Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom</td>
</tr>
<tr>
<td>5</td>
<td>Describe intervention tracking measure that corresponds to intervention #3 &lt;br&gt; Num: Enter description Denom: Enter description</td>
<td>Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom</td>
<td>Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom</td>
<td>Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom</td>
<td>Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom</td>
</tr>
<tr>
<td>6</td>
<td>Describe intervention tracking measure that corresponds to intervention #3 &lt;br&gt; Num: Enter description Denom: Enter description</td>
<td>Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom</td>
<td>Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom</td>
<td>Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom</td>
<td>Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom</td>
</tr>
</tbody>
</table>
### Intervention Tracking Measures

Intervention tracking measures are also known as process measures. These measures answer the questions: Are the parts/steps in the system performing as planned? Are we on track in our efforts to improve the system? If quarterly performance does not improve, conduct a barrier/root cause analysis and redesign the intervention to address the newly identified barrier.

### Monitoring Table YEAR 2: Quarterly Reporting of Rates for Intervention Tracking Measures, with corresponding intervention numbers.

<table>
<thead>
<tr>
<th>Number of Intervention</th>
<th>Description of Intervention Tracking Measures</th>
<th>Q1 Enter year</th>
<th>Q2 Enter year</th>
<th>Q3 Enter year</th>
<th>Q4 Enter year</th>
</tr>
</thead>
</table>
| **Example:** 1 | Percentage of children ages 5-11 years with asthma diagnosis with controller medication automatic refill | Numerator: 100  
Denominator: 1,500  
Rate: 6.67% | Numerator: 250  
Denominator: 1,520  
Rate: 16.45% | Numerator: 500  
Denominator: 1,600  
Rate: 31.25% | Numerator: 750  
Denominator: 1,650  
Rate: 45.45% |
| 2 | Describe intervention tracking measure that corresponds to intervention #1 | Numerator: Enter #  
Denominator: Enter #  
Rate: Enter results of num÷denom | Numerator: Enter #  
Denominator: Enter #  
Rate: Enter results of num÷denom | Numerator: Enter #  
Denominator: Enter #  
Rate: Enter results of num÷denom | Numerator: Enter #  
Denominator: Enter #  
Rate: Enter results of num÷denom |
| 3 | Describe intervention tracking measure that corresponds to intervention #2 | Numerator: Enter #  
Denominator: Enter #  
Rate: Enter results of num÷denom | Numerator: Enter #  
Denominator: Enter #  
Rate: Enter results of num÷denom | Numerator: Enter #  
Denominator: Enter #  
Rate: Enter results of num÷denom | Numerator: Enter #  
Denominator: Enter #  
Rate: Enter results of num÷denom |
| 4 | Describe intervention tracking measure that corresponds to intervention #3 | Numerator: Enter #  
Denominator: Enter #  
Rate: Enter results of num÷denom | Numerator: Enter #  
Denominator: Enter #  
Rate: Enter results of num÷denom | Numerator: Enter #  
Denominator: Enter #  
Rate: Enter results of num÷denom | Numerator: Enter #  
Denominator: Enter #  
Rate: Enter results of num÷denom |
<table>
<thead>
<tr>
<th>Number of Intervention</th>
<th>Description of Intervention Tracking Measures</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Describe intervention tracking measure that corresponds to intervention #3</td>
<td><strong>Numerator:</strong> Enter #</td>
<td><strong>Denominator:</strong> Enter #</td>
<td><strong>Rate:</strong> Enter results of num÷denom</td>
<td><strong>Numerator:</strong> Enter #</td>
</tr>
<tr>
<td>5</td>
<td>Num: Enter description Denom: Enter description</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Describe intervention tracking measure that corresponds to intervention #3</td>
<td><strong>Numerator:</strong> Enter #</td>
<td><strong>Denominator:</strong> Enter #</td>
<td><strong>Rate:</strong> Enter results of num÷denom</td>
<td><strong>Numerator:</strong> Enter #</td>
</tr>
<tr>
<td>6</td>
<td>Num: Enter description Denom: Enter description</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
6. Results

The results section should present project findings related to performance indicators. Indicate target rates and rationale, e.g., next Quality Compass percentile. Accompanying narrative should describe, but not interpret the results in this section.

OPTIONAL: Additional tables, graphs, and bar charts can be an effective means of displaying data that are unique to your PIP in a concise way for the reader. If you choose to present additional data, include only data that you used to inform barrier analysis, development and refinement of interventions, and/or analysis of PIP performance.

Results Table.

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Administrative (A) or Hybrid (H) Measure?</th>
<th>Baseline Period</th>
<th>Interim Period</th>
<th>Final Period</th>
<th>Final Goal/Target Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Eligible Population = Enter #</td>
<td>Eligible Population = Enter #</td>
<td>Eligible Population = Enter #</td>
<td>Target Rate:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Exclusions= Enter #</td>
<td>Exclusions= Enter #</td>
<td>Exclusions= Enter #</td>
<td>Rationale:</td>
</tr>
<tr>
<td>Indicator #1</td>
<td></td>
<td>If “H”, Sample size = Enter #</td>
<td>If “H”, Sample size = Enter #</td>
<td>If “H”, Sample size = Enter #</td>
<td></td>
</tr>
<tr>
<td>Enter indicator 1 here</td>
<td></td>
<td>Numerator = Enter #</td>
<td>Numerator = Enter #</td>
<td>Numerator = Enter #</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Denominator = Enter #</td>
<td>Denominator = Enter #</td>
<td>Denominator = Enter #</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rate = Enter %</td>
<td>Rate = Enter %</td>
<td>Rate = Enter %</td>
<td></td>
</tr>
<tr>
<td>Indicator #2</td>
<td></td>
<td>Eligible Population = Enter #</td>
<td>Eligible Population = Enter #</td>
<td>Eligible Population = Enter #</td>
<td>Target Rate:</td>
</tr>
<tr>
<td>Enter indicator 2 here</td>
<td></td>
<td>Exclusions= Enter #</td>
<td>Exclusions= Enter #</td>
<td>Exclusions= Enter #</td>
<td>Rationale:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If “H”, Sample size = Enter #</td>
<td>If “H”, Sample size = Enter #</td>
<td>If “H”, Sample size = Enter #</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Numerator = Enter #</td>
<td>Numerator = Enter #</td>
<td>Numerator = Enter #</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Denominator = Enter #</td>
<td>Denominator = Enter #</td>
<td>Denominator = Enter #</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rate = Enter %</td>
<td>Rate = Enter %</td>
<td>Rate = Enter %</td>
<td></td>
</tr>
<tr>
<td>Indicator #3</td>
<td></td>
<td>Eligible Population = Enter #</td>
<td>Eligible Population = Enter #</td>
<td>Eligible Population = Enter #</td>
<td>Target Rate:</td>
</tr>
<tr>
<td>Enter indicator 3 here</td>
<td></td>
<td>Exclusions= Enter #</td>
<td>Exclusions= Enter #</td>
<td>Exclusions= Enter #</td>
<td>Rationale:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If “H”, Sample size = Enter #</td>
<td>If “H”, Sample size = Enter #</td>
<td>If “H”, Sample size = Enter #</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Numerator = Enter #</td>
<td>Numerator = Enter #</td>
<td>Numerator = Enter #</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Denominator = Enter #</td>
<td>Denominator = Enter #</td>
<td>Denominator = Enter #</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rate = Enter %</td>
<td>Rate = Enter %</td>
<td>Rate = Enter %</td>
<td></td>
</tr>
</tbody>
</table>
7. Discussion

The discussion section is for explanation and interpretation of the results.

Discussion of Results

Interpret the performance indicator rates for each measurement period, i.e., describe whether rates improved or declined between baseline and interim, between interim and final and between baseline and final measurement periods: [Click here to enter text.]

Explain and interpret the extent to which improvement was or was not attributable to the interventions, by interpreting quarterly or monthly intervention tracking measure trends: [Click here to enter text.]

What factors were associated with success or failure? [Click here to enter text.]

Limitations

As in any population health study, there are study design limitations for a PIP. Address the limitations of your project design, i.e., challenges identified when conducting the PIP (e.g., difficulty locating Medicaid members, lack of resources, etc.)

- **Were there any factors that may pose a threat to the internal validity the findings?** [Click here to enter text.]
  
  **Definition and examples:** Internal validity means that the data measure what they were intended to measure, e.g., if the PIP data source did not capture all children 5-11 with an asthma diagnosis due to inaccurate ICD-10 coding for certain subsets of children with asthma, there is an internal validity problem.

- **Were there any threats to the external validity the findings?** [Click here to enter text.]
  
  **Definition and examples:** External validity describes the extent that findings can be applied or generalized to the larger/entire member population, e.g., a sample that was not randomly selected from the eligible population or that includes too many/too few members from a certain subpopulation (e.g., under-representation from a certain region).

- **Describe any data collection challenges.** [Click here to enter text.]
  
  **Definition and examples:** Data collection challenges include low survey response rates, low medical record retrieval rates, difficulty in retrieving claims data, or difficulty tracking case management interventions.

Member Participation

[Click here to describe the extent of member participation in the project, including topic selection, measurements, focus groups, interventions, etc.]

Describe methods utilized to solicit or encourage membership participation: [Click here to enter text.]
Dissemination of Findings

- Describe the methods used to make the findings available to members, providers, or other interested parties: Click here to enter text. Examples include member/provider newsletters, meetings/presentations and website postings.

8. Next Steps

In this final section, for each intervention, summarize lessons learned, system-level changes made and/or planned, and outline next steps for ongoing improvement beyond the PIP timeframe.

<table>
<thead>
<tr>
<th>Number of Intervention</th>
<th>Lessons Learned</th>
<th>System-level changes made and/or planned</th>
<th>Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix A

Optional PDSA (Plan-Do-Study-Act) Worksheet

Although the PDSA method is recommended by the Agency for Healthcare Research and Quality (AHRQ), it is not a requirement.

If the PDSA method was performed, use the AHRQ worksheet below to provide information regarding each PDSA component. Discuss any changes made to interventions and rationale for doing so. Intervention tracking measures that led to changes in your interventions should be presented here.

Plan

- We plan to test (intervention) from (start date) to (end date):
- We hope this produces/leads to: (indicate measurable goal here)
- Steps to execute: (what, by whom, when and where?)

Do

- What did you observe when your intervention(s) was implemented? What worked? What did not work? Problems? Unexpected observations?

Study

- What did you learn? Did you meet your measurement goal?

Act

- What did you conclude from this PDSA cycle (i.e., from the stated start and end date indicated above under Plan)? What interventions need modification? What is going to be adopted going forward?
Appendix B: Healthy Louisiana Medicaid Managed Care PIP Report Checklist
Healthy Louisiana Medicaid Managed Care PIP Report Checklist

Plan Name: Click here to enter Plan name  
PIP Topic: Click here to enter PIP topic  
PIP Phase: Choose an item.

| PIP Component and Subcomponents | MCO Check: Complete? | IPRO Review: M=Met  
PM=Partially Met  
NM=Not Met  
LDH Review: M=Met  
PM=Partially Met  
NM=Not Met |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ATTESTATION COMPLETE WITH SIGNATURES</td>
<td>Indicate: Y=yes N=no</td>
<td></td>
</tr>
</tbody>
</table>

1. Topic/ Rationale
   a. Impacts the maximum proportion of members that is feasible
   b. Potential for meaningful impact on member health, functional status or satisfaction
   c. Reflects high-volume or high risk-conditions
   d. Supported with MCO member data (baseline rates), e.g., disease prevalence

2. Aim
   a. Specifies Performance Indicators for improvement with corresponding goals
   b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark
   c. Objectives align aim and goals with interventions

3. Methodology
   a. Annual Performance Measures indicated
   b. Specifies numerator and denominator criteria
   c. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]
   d. Sampling method explained for each hybrid measure

4. Barrier Analysis, using one or more of the following:
   a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics
   b. Obtain direct member input from focus groups, quality meetings, surveys, and/or care management outreach
   c. Obtain direct provider input from focus groups, quality meetings, surveys, and/or care management outreach
   d. QI Process data ("5 Why’s", fishbone diagram)

5. Robust Interventions that are Measurable using Intervention Tracking Measures
   a. Informed by barrier analysis
   b. Actions that target member, provider and MCO
   c. New or enhanced, starting after baseline year
   d. With corresponding monthly or quarterly intervention tracking (process) measures, i.e., numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)

6. Results Table (Completed for Baseline, Interim and Final Re-Measurement Years)
   a. Table shows Performance Indicator rates, numerators and denominators
   b. Table shows target rates and rationale (e.g., next highest Quality Compass percentile)

7. Discussion (Final PIP Report)
   a. Interpretation of extent to which PIP is successful

8. Next Steps (Final PIP Report)
   a. Lessons Learned
   b. System-level changes made and/or planned
   c. Next steps for each intervention

1. “M”: addressed without the need for further elaboration; 2. “PM: partially addressed with the need for further elaboration; 3. “NM”: not addressed.
This second page is not included with the first page of the PIP Checklist sent to the plans, as it is initiated by the IPRO Reviewers once the plan has submitted their PIP Report.

IPRO Reviewers: Click here to enter name and contact info (email and phone)
Date Reviewed: Click here to enter a date

LDH Reviewers: Click here to enter name and contact info (email and phone)
Date Reviewed: Click here to enter a date

STRENGTHS: IPRO to summarize key strengths, for example:

- The barrier analysis stratified baseline performance measure data on hospital readmission rates by demographic (e.g., age groups, race/ethnicity, parish) and hospital subsets in order to identify susceptible subpopulations with the highest rates. The plan developed tailored interventions targeted to those member subpopulations.
- The plan distributes care gap reports to providers of members with care gaps (e.g., lack of HbA1c testing), and care coordinators follow up telephonically with providers and members to facilitate appointment scheduling and transportation.
- The Plan of Care (POC) intervention uses the validated Patient Activation Measure to assess the member’s readiness to self-manage care and engage the member in setting personal goals for health outcomes.
- In response to a decline in the Plan of Care (POC) intervention tracking measure from 1st to 2nd quarter of 2016, the plan conduct a root cause analysis, identified a language barrier, and modified the POC intervention to provide the member with a POC in his/her language.
- Care management engagement rates show quarterly improvement subsequent to modifying the POC intervention.
- The hospital readmission rate showed a decline from baseline to first re-measurement year.

IPRO/LDH Comments: (use black font for IPRO comments, red font for LDH comments)
For each subcomponent that is either “Partially Met” or “Not Met”, i.e., for all Review findings of “PM” or “NM”, reviewer should note 1) the subcomponent and 2) why it is not fully addressed or otherwise acceptable, and how the MCO can improve the PIP subcomponent.

Example:
2b. The MCO’s goal is only 2 percentage points above their current baseline rate. Given that interventions are designed to target members, MCO staff and providers, and the fact that the PIP is being conducted over a two year timeframe, the goal should be adjusted, and set to exceed the statewide average (or exceed Quality Compass, HEDIS, etc.).

For Final Report review ONLY, include following narrative:
Overall Credibility of Results
Select from one of the three options below and delete the others:
There were no validation findings which indicate that the credibility of the PIP results is at risk.

OR
The validation findings generally indicate that the credibility of the PIP results is not at risk. Results must be interpreted with some caution due to x. [State the concerns regarding study processes that put the conclusions at risk. Follow-up with any mitigating circumstances.]

OR
There are one or more validation findings that indicate a bias in the PIP results. [State the concerns regarding study processes that put the conclusions at risk.]
Appendix C: Required Performance Measures for 2019 Reporting
### 2019 Healthy Louisiana Performance Measures

<table>
<thead>
<tr>
<th>Identifier</th>
<th>Measure</th>
<th>Measure Description</th>
<th>Measure Steward</th>
<th>Federal Reporting Program</th>
<th>Target Population</th>
<th>Condition</th>
<th>Specification Source</th>
<th>2020 (2019 data measurement year) and Subsequent Years Target for Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTB $$</td>
<td>Initiation of Injectable Progesterone for Preterm Birth Prevention</td>
<td>The percentage of women 15-45 years of age with evidence of a previous preterm singleton birth event (24-36 weeks completed gestation) who received one or more progesterone injections between the 16th and 24th week of gestation for deliveries during the measurement year.</td>
<td>State</td>
<td>None</td>
<td>Children's and Maternal Health</td>
<td>Perinatal and Reproductive Health</td>
<td>Section V</td>
<td>2020 (2019 data measurement year) and Subsequent Years Target for Improvement</td>
</tr>
<tr>
<td>AWC $$</td>
<td>Adolescent Well Care Visit</td>
<td>The percentage of enrolled members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement year.</td>
<td>NCQA</td>
<td>CHIPRA</td>
<td>Children's Health</td>
<td>Utilization</td>
<td>HEDIS</td>
<td>NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year</td>
</tr>
<tr>
<td>ADD $$</td>
<td>Follow-up Care for Children Prescribed ADHD Medication-Initiation Phase</td>
<td>The percentage of children 6-12 years of age as of the index period start date with a newly prescribed ambulatory prescription dispensed for attention-deficit/hyperactivity disorder (ADHD) medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase.</td>
<td>NCQA</td>
<td>CHIPRA, MU2</td>
<td>Children's Health</td>
<td>Behavioral Health</td>
<td>HEDIS</td>
<td>NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year</td>
</tr>
<tr>
<td>ADD $$</td>
<td>Follow-up Care for Children Prescribed ADHD Medication-Continuation Phase</td>
<td>The percentage of children 6-12 years of age as of the index period start date with a newly prescribed ambulatory prescription dispensed for attention-deficit/hyperactivity disorder (ADHD) medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.</td>
<td>NCQA</td>
<td>CHIPRA, MU2</td>
<td>Children's Health</td>
<td>Behavioral Health</td>
<td>HEDIS</td>
<td>NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year</td>
</tr>
<tr>
<td>Identifier</td>
<td>Measure</td>
<td>Measure Description</td>
<td>Measure Steward</td>
<td>Federal Reporting Program</td>
<td>Target Population</td>
<td>Condition</td>
<td>Specification Source</td>
<td>2020 (2019 data measurement year) and Subsequent Years Target for Improvement</td>
</tr>
<tr>
<td>------------</td>
<td>-------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>-----------------</td>
<td>---------------------------</td>
<td>------------------</td>
<td>-----------</td>
<td>----------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>AMB-ED $$</td>
<td>Ambulatory Care- ED Visits</td>
<td>This measure summarizes utilization of ambulatory care ED Visits per 1,000 member months.</td>
<td>NCQA</td>
<td>CHIPRA</td>
<td>Population Health</td>
<td>Utilization</td>
<td>HEDIS</td>
<td>NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year</td>
</tr>
<tr>
<td>PPC $$</td>
<td>Prenatal and Postpartum Care - Timeliness of Prenatal Care</td>
<td>The percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment in the organization.</td>
<td>NCQA</td>
<td>MEDICAID ADULT</td>
<td>Maternal Health</td>
<td>Perinatal and Reproductive Health</td>
<td>HEDIS</td>
<td></td>
</tr>
<tr>
<td>PPC $$</td>
<td>Prenatal and Postpartum Care – Postpartum Care (PPC Numerator 2)</td>
<td>The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.</td>
<td>NCQA</td>
<td>MEDICAID ADULT</td>
<td>Maternal Health</td>
<td>Perinatal and Reproductive Health</td>
<td>HEDIS</td>
<td></td>
</tr>
<tr>
<td>FUH $$</td>
<td>Follow-Up After Hospitalization for Mental Illness - Within 30 days of discharge</td>
<td>The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner within 30 days of discharge.</td>
<td>NCQA</td>
<td>MEDICAID ADULT</td>
<td>Behavioral Health</td>
<td>Behavioral Health</td>
<td>HEDIS</td>
<td></td>
</tr>
<tr>
<td>Identifier</td>
<td>Measure</td>
<td>Measure Description</td>
<td>Measure Steward</td>
<td>Federal Reporting Program</td>
<td>Target Population</td>
<td>Condition</td>
<td>Specification Source</td>
<td>2020 (2019 data measurement year) and Subsequent Years Target for Improvement</td>
</tr>
<tr>
<td>------------</td>
<td>---------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------</td>
<td>--------------------------------------------------</td>
<td>---------------------------</td>
<td>----------------</td>
<td>-----------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>CBP $$</td>
<td>Controlling High Blood Pressure - Total</td>
<td>The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (&lt;140/90 mm Hg) during the measurement year.</td>
<td>NCQA</td>
<td>MEDICAID ADULT, MU2, CMS HEALTH HOMES</td>
<td>Chronic Disease</td>
<td>Cardiovascular Care</td>
<td>HEDIS</td>
<td>NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year</td>
</tr>
<tr>
<td>CDC $$</td>
<td>Comprehensive Diabetes Care - Hemoglobin A1c (HBA1c) testing</td>
<td>The percentage of members 18-75 years of age with diabetes (type 1 and type 2) with a Hemoglobin A1c (HbA1c) test.</td>
<td>NCQA</td>
<td>MEDICAID ADULT</td>
<td>Chronic Disease</td>
<td>Diabetes</td>
<td>HEDIS</td>
<td>NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year</td>
</tr>
<tr>
<td>CDC $$</td>
<td>Comprehensive Diabetes Care - Eye exam (retinal) performed</td>
<td>The percentage of members 18-75 years of age with diabetes (type 1 and type 2) with an eye exam (retinal) performed.</td>
<td>NCQA</td>
<td>MEDICAID ADULT</td>
<td>Chronic Disease</td>
<td>Diabetes</td>
<td>HEDIS</td>
<td>NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year</td>
</tr>
<tr>
<td>CDC $$</td>
<td>Comprehensive Diabetes Care - Medical attention for nephropathy</td>
<td>The percentage of members 18-75 years of age with diabetes (type 1 and type 2) with medical attention for nephropathy.</td>
<td>NCQA</td>
<td>CHIPRA</td>
<td>Chronic Disease</td>
<td>Diabetes</td>
<td>HEDIS</td>
<td>NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year</td>
</tr>
<tr>
<td>Identifier</td>
<td>Measure</td>
<td>Measure Description</td>
<td>Measure Steward</td>
<td>Federal Reporting Program</td>
<td>Target Population</td>
<td>Condition</td>
<td>Specification Source</td>
<td>2020 (2019 data measurement year) and Subsequent Years Target for Improvement</td>
</tr>
<tr>
<td>------------</td>
<td>---------</td>
<td>---------------------</td>
<td>----------------</td>
<td>---------------------------</td>
<td>-------------------</td>
<td>-----------</td>
<td>----------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>W15 $$</td>
<td>Well-Child Visits in the First 15 Months of Life - Six or more well-child visits.</td>
<td>The percentage of members who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life.</td>
<td>NCQA</td>
<td>CHIPRA</td>
<td>Children’s Health</td>
<td>Utilization</td>
<td>HEDIS</td>
<td>NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year</td>
</tr>
<tr>
<td>W34 $$</td>
<td>Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life</td>
<td>The percentage of members 3-6 years of age who had one or more well-child visits with a PCP during the measurement year.</td>
<td>NCQA</td>
<td>CHIPRA</td>
<td>Children’s Health</td>
<td>Utilization</td>
<td>HEDIS</td>
<td>NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year</td>
</tr>
<tr>
<td>CPA $$</td>
<td>CAHPS Health Plan Survey 5.0H, Adult (Rating of Health Plan, 8+9+10)</td>
<td>This measure provides information on the experiences of Medicaid members with the organization and gives a general indication of how well the organization meets members’ expectations.</td>
<td>NCQA</td>
<td>MEDICAID ADULT</td>
<td>Adult</td>
<td>Member Satisfaction</td>
<td>HEDIS</td>
<td>NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year</td>
</tr>
<tr>
<td>CPC $$</td>
<td>CAHPS Health Plan Survey 5.0H, Child (Rating of Health Plan-General Population, 8+9+10)</td>
<td>This measure provides information on parents’ experience with their child’s Medicaid organization.</td>
<td>NCQA</td>
<td>MEDICAID, CHIPRA</td>
<td>Child</td>
<td>Member Satisfaction</td>
<td>HEDIS</td>
<td>NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year</td>
</tr>
<tr>
<td>Identifier</td>
<td>Measure</td>
<td>Measure Description</td>
<td>Measure Steward</td>
<td>Federal Reporting Program</td>
<td>Target Population</td>
<td>Condition</td>
<td>Specification Source</td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>---------</td>
<td>---------------------</td>
<td>-----------------</td>
<td>---------------------------</td>
<td>-------------------</td>
<td>-----------</td>
<td>----------------------</td>
<td></td>
</tr>
<tr>
<td>CIS</td>
<td>Childhood Immunization Status</td>
<td>The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HIB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.</td>
<td>NCQA</td>
<td>CHIPRA, MU2</td>
<td>Children's Health</td>
<td>Prevention</td>
<td>HEDIS</td>
<td></td>
</tr>
<tr>
<td>IMA</td>
<td>Immunization Status for Adolescents</td>
<td>Percentage of adolescents that turned 13 years old during the measurement year and had specific vaccines by their 13th birthday. Report all individual vaccine numerators and combinations.</td>
<td>NCQA</td>
<td>CHIPRA</td>
<td>Children's Health</td>
<td>Prevention</td>
<td>HEDIS</td>
<td></td>
</tr>
<tr>
<td>WCC</td>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents</td>
<td>Percentage of children ages 3 to 17 that had an outpatient visit with a primary care practitioner (PCP) or obstetrical/gynecological (OB/GYN) practitioner and whose weight is classified based on body mass index percentile for age and gender. The percentage of children ages 3 to 17 that had an outpatient visit with a primary care practitioner (PCP) or obstetrical/gynecological (OB/GYN) practitioner, with evidence of: • BMI percentile documentation • Counseling for nutrition • Counseling for physical activity</td>
<td>NCQA</td>
<td>CHIPRA, MU2</td>
<td>Children's Health</td>
<td>Prevention</td>
<td>HEDIS</td>
<td></td>
</tr>
<tr>
<td>Identifier</td>
<td>Measure</td>
<td>Measure Description</td>
<td>Measure Steward</td>
<td>Federal Reporting Program</td>
<td>Target Population</td>
<td>Condition</td>
<td>Specification Source</td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>---------</td>
<td>---------------------</td>
<td>----------------</td>
<td>--------------------------</td>
<td>------------------</td>
<td>-----------</td>
<td>----------------------</td>
<td></td>
</tr>
<tr>
<td>SAA</td>
<td>Adherence to Antipsychotic Medications for Individuals with Schizophrenia</td>
<td>The measure calculates the percentage of individuals 19 years of age or greater as of the beginning of the measurement year with schizophrenia or schizoaffective disorder who are prescribed an antipsychotic medication, with adherence to the antipsychotic medication [defined as a Proportion of Days Covered (PDC)] of at least 0.8 during the measurement year (12 consecutive months).</td>
<td>NCQA</td>
<td>MEDICAID ADULT</td>
<td>Population Health</td>
<td>Behavioral Health</td>
<td>HEDIS</td>
<td></td>
</tr>
<tr>
<td>MPM</td>
<td>Annual Monitoring for Patients on Persistent Medications</td>
<td>The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. For each product line, report each of the two rates separately and as a total rate.</td>
<td>NCQA</td>
<td>MEDICAID ADULT</td>
<td>Chronic Disease</td>
<td>Prevention</td>
<td>HEDIS</td>
<td></td>
</tr>
<tr>
<td>ABA</td>
<td>Adult BMI Assessment</td>
<td>The percentage of members 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement or the year prior to the measurement year.</td>
<td>NCQA</td>
<td>MEDICAID ADULT, CMS HEALTH HOMES</td>
<td>Population Health</td>
<td>Prevention</td>
<td>HEDIS</td>
<td></td>
</tr>
<tr>
<td>AMM</td>
<td>Antidepressant Medication Management</td>
<td>The percentage of members 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported.</td>
<td>NCQA</td>
<td>MEDICAID ADULT, MU2</td>
<td>Population Health</td>
<td>Behavioral Health</td>
<td>HEDIS</td>
<td></td>
</tr>
<tr>
<td>Identifier</td>
<td>Measure</td>
<td>Measure Description</td>
<td>Measure Steward</td>
<td>Federal Reporting Program</td>
<td>Target Population</td>
<td>Condition</td>
<td>Specification Source</td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>---------</td>
<td>---------------------</td>
<td>-----------------</td>
<td>---------------------------</td>
<td>-------------------</td>
<td>-----------</td>
<td>----------------------</td>
<td></td>
</tr>
</tbody>
</table>
| CCS        | Cervical Cancer Screening | Percentage of women 21–64 years of age who were screened for cervical cancer:  
- Women 21-64 who had cervical cytology performed every 3 years  
- Women 30-64 who had cervical cytology/HPV co-testing performed every 5 years | NCQA | MEDICAID ADULT, MU2 | Population Health | Prevention | HEDIS |
| AMR        | Asthma Medication Ratio | The percentage of patients 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. | NCQA | MEDICAID | Population Health | Pulmonary/Critical Care | HEDIS |
| FVA        | Flu Vaccinations for Adults Ages 18 to 64 | The percentage of adults 18 years of age and older who self-report receiving an influenza vaccine within the measurement period. | NCQA | MEDICAID ADULT | Population Health | Prevention | HEDIS/CAHPS |
| MSC        | Medical Assistance With Smoking and Tobacco Use Cessation | Assesses different facets of providing medical assistance with smoking and tobacco use cessation.  
MCOs will report three components (questions):  
- Advising Smokers and Tobacco Users to Quit  
- Discussing Cessation Medications  
- Discussing Cessation Strategies | NCQA | MEDICAID ADULT | Population Health | Prevention | HEDIS/CAHPS |
<p>| MMA        | Medication Management for People with Asthma | The percentage of patients 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported. | NCQA | CHIPRA | Population Health | Pulmonary/Critical Care | HEDIS |</p>
<table>
<thead>
<tr>
<th>Identifier</th>
<th>Measure</th>
<th>Measure Description</th>
<th>Measure Steward</th>
<th>Federal Reporting Program</th>
<th>Target Population</th>
<th>Condition</th>
<th>Specification Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHL</td>
<td>CHL</td>
<td>Chlamydia Screening in Women</td>
<td>NCQA</td>
<td>CHIPRA, MEDICAID ADULT</td>
<td>Population Health, Maternal Health</td>
<td>Perinatal and Reproductive Health, Sexually Transmitted Infectious Diseases</td>
<td>HEDIS</td>
</tr>
<tr>
<td>BCS</td>
<td>BCS</td>
<td>Breast Cancer Screening</td>
<td>NCQA</td>
<td>MEDICAID ADULT, MU2</td>
<td>Senior Care</td>
<td>Prevention</td>
<td>HEDIS</td>
</tr>
<tr>
<td>CAP</td>
<td>CAP</td>
<td>Child and Adolescents’ Access to Primary Care Practitioners</td>
<td>NCQA</td>
<td>CHIPRA</td>
<td>Children’s Health</td>
<td>Access/ Availability of Care</td>
<td>HEDIS</td>
</tr>
<tr>
<td>COL</td>
<td>COL</td>
<td>Colorectal screening</td>
<td>NCQA</td>
<td>MEDICAID ADULT</td>
<td>Population Health</td>
<td>Prevention</td>
<td>HEDIS</td>
</tr>
<tr>
<td>SSD</td>
<td>SSD</td>
<td>Diabetes screening for people with Schizophrenia or Bipolar who are using Antipsychotic medications</td>
<td>NCQA</td>
<td>MEDICAID ADULT</td>
<td>Population Health</td>
<td>Behavioral Health</td>
<td>HEDIS</td>
</tr>
<tr>
<td>Identifier</td>
<td>Measure</td>
<td>Measure Description</td>
<td>Measure Steward</td>
<td>Federal Reporting Program</td>
<td>Target Population</td>
<td>Condition</td>
<td>Specification Source</td>
</tr>
<tr>
<td>------------</td>
<td>---------</td>
<td>---------------------</td>
<td>-----------------</td>
<td>--------------------------</td>
<td>-------------------</td>
<td>-------------------</td>
<td>---------------------</td>
</tr>
</tbody>
</table>
| SPC        | Statin Therapy for Patients with Cardiovascular Disease | • The percentage of males 21-75 years of age and females 40-75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and who received statin therapy (were dispensed at least one high or moderate-intensity statin medication during the measurement year.)
• The percentage of males 21-75 years of age and females 40-75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and who received statin medication for at least 80% of the treatment period.) | NCQA | MEDICAID ADULT | Population Health | Cardiovascular Care | HEDIS |
<p>| CDC        | Comprehensive Diabetes Care - HbA1c poor control (&gt;9.0%) | The percentage of members 18-75 years of age with diabetes (type 1 and type 2) with HbA1c poor control (&gt;9.0%). | NCQA | MEDICAID ADULT | Chronic Disease | Diabetes | HEDIS |
| CDC        | Comprehensive Diabetes Care - HbA1c control (&lt;8.0%) | The percentage of members 18-75 years of age with diabetes (type 1 and type 2) with HbA1c control (&lt;8.0%). | NCQA | MEDICAID ADULT | Chronic Disease | Diabetes | HEDIS |
| CDC        | Comprehensive Diabetes Care - BP control (&lt;140/90 mm Hg). | The percentage of members 18-75 years of age with diabetes (type 1 and type 2) with BP control (&lt;140/90 mm Hg). | NCQA | MEDICAID ADULT | Chronic Disease | Diabetes | HEDIS |
| PCR        | Plan All-Cause Readmissions | For members 18-64 years of age, the risk-adjusted rate of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days. | NCQA | MEDICAID ADULT | Population Health | All Cause Readmissions | HEDIS |</p>
<table>
<thead>
<tr>
<th>Identifier</th>
<th>Measure</th>
<th>Measure Description</th>
<th>Measure Steward</th>
<th>Federal Reporting Program</th>
<th>Target Population</th>
<th>Condition</th>
<th>Specification Source</th>
</tr>
</thead>
</table>
| AAP        | Adults’ Access to Preventive/Ambulatory Health Services | The percentage of members age 20 years and older who had an ambulatory or preventive care visit during the measurement year. Three age stratifications and a total rate are reported:  
- 20-44 years  
- 45-64 years  
- 65 years and older  
- Total | NCQA | MEDICAID ADULT | Population Health | Prevention | HEDIS |
| FUH        | Follow-Up After Hospitalization for Mental Illness - Within 7 days of discharge | The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner within 7 days of discharge. | NCQA | CHIPRA | Behavioral Health | Behavioral Health | HEDIS |
| AMB        | Ambulatory Care-Outpatient Visits | This measure summarizes utilization of ambulatory care Outpatient Visits per 1,000 member months. | NCQA | MEDICAID | Population Health | Utilization | HEDIS |

**PQI Measures**

<table>
<thead>
<tr>
<th>PQI01</th>
<th>Diabetes Short Term Complications Admission Rate</th>
<th>Number of discharges for diabetes short term complications per 100,000 member months per Medicaid enrollees age 18 and older.</th>
<th>AHRQ</th>
<th>MEDICAID ADULT</th>
<th>Chronic Disease</th>
<th>Diabetes</th>
<th>Section V</th>
</tr>
</thead>
<tbody>
<tr>
<td>PQI05</td>
<td>COPD and Asthma in Older Adults Admission Rate</td>
<td>This measure is used to assess the number of admissions for chronic obstructive pulmonary disease (COPD) per 100,000 population. The number of discharges for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 member months for Medicaid enrollees age 40 and older.</td>
<td>AHRQ</td>
<td>MEDICAID ADULT</td>
<td>Population Health</td>
<td>Pulmonary/Critical Care</td>
<td>Section V</td>
</tr>
<tr>
<td>Identifier</td>
<td>Measure</td>
<td>Measure Description</td>
<td>Measure Steward</td>
<td>Federal Reporting Program</td>
<td>Target Population</td>
<td>Condition</td>
<td>Specification Source</td>
</tr>
<tr>
<td>------------</td>
<td>---------</td>
<td>---------------------</td>
<td>-----------------</td>
<td>---------------------------</td>
<td>-------------------</td>
<td>-----------</td>
<td>----------------------</td>
</tr>
<tr>
<td>PQI08</td>
<td>Heart Failure Admission Rate</td>
<td>Percent of population with an admissions for heart failure (reported by Recipient Parish). The number of discharges for heart failure per 100,000 member months for Medicaid enrollees age 18 and older (reported by Recipient Parish).</td>
<td>AHRQ</td>
<td>MEDICAID ADULT</td>
<td>Chronic Disease</td>
<td>Cardiovascular Care</td>
<td>Section V</td>
</tr>
<tr>
<td>PQI15</td>
<td>Asthma in Younger Adults Admission Rate</td>
<td>Admissions for a principal diagnosis of asthma per 100,000 population, ages 18 to 39 years. Excludes admissions with an indication of cystic fibrosis or anomalies of the respiratory system, obstetric admissions, and transfers from other institutions. Number of discharges for asthma per 100,000 member months for Medicaid enrollees ages 18 to 39.</td>
<td>AHRQ</td>
<td>MEDICAID ADULT</td>
<td>Population Health</td>
<td>Pulmonary/Critical Care</td>
<td>Section V</td>
</tr>
</tbody>
</table>

### Vital Record Measures

<table>
<thead>
<tr>
<th>LBW</th>
<th>Percentage of low birth weight births</th>
<th>Percentage of live births that weighted less than 2,500 grams in the state during the reporting period.</th>
<th>CDC</th>
<th>CHIPRA, HRSA</th>
<th>Children's and Maternal Health</th>
<th>Perinatal and Reproductive Health</th>
<th>Section V</th>
</tr>
</thead>
<tbody>
<tr>
<td>NQF (PC-01)</td>
<td>Elective Delivery</td>
<td>This measure assesses patients with elective vaginal deliveries or elective cesarean sections at &gt;= 37 and &lt; 39 weeks of gestation completed</td>
<td>TJC</td>
<td>MEDICAID ADULT, MU2</td>
<td>Maternal Health</td>
<td>Perinatal and Reproductive Health</td>
<td>Section V</td>
</tr>
</tbody>
</table>

### CMS Measures

<table>
<thead>
<tr>
<th>HIV</th>
<th>HIV Viral Load Suppression</th>
<th>Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200.</th>
<th>HRSA HIV/AIDS Bureau</th>
<th>MEDICAID ADULT</th>
<th>Chronic Disease</th>
<th>HIV</th>
<th>Section V</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCP-CH</td>
<td>Contraceptive Care-Postpartum (ages 15-20)</td>
<td>The percentage of women ages 15-20 who had a live birth and were provided a most or moderately effective method of contraception within 3 and 60 days of delivery. Four rates are reported.</td>
<td>CMS</td>
<td>CHIPRA</td>
<td>Maternal Health</td>
<td>Perinatal and Reproductive Health</td>
<td>OPA</td>
</tr>
<tr>
<td>Identifier</td>
<td>Measure</td>
<td>Measure Description</td>
<td>Measure Steward</td>
<td>Federal Reporting Program</td>
<td>Target Population</td>
<td>Condition</td>
<td>Specification Source</td>
</tr>
<tr>
<td>------------</td>
<td>----------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------</td>
<td>---------------------------</td>
<td>---------------------------</td>
<td>-----------------------------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>CCP-AD</td>
<td>Contraceptive Care-Postpartum (ages 21-44)</td>
<td>The percentage of women ages 21-44 who had a live birth and were provided a most or moderately effective method of contraception within 3 and 60 days of delivery. Four rates are reported.</td>
<td>CMS</td>
<td>MEDICAID ADULT</td>
<td>Maternal Health</td>
<td>Perinatal and Reproductive Health</td>
<td>OPA</td>
</tr>
<tr>
<td>NSV</td>
<td>Cesarean Rate for Low-Risk First Birth Women</td>
<td>The percentage of cesareans in live births at or beyond 37.0 weeks gestation to women that are having their first delivery and are singleton (no twins or beyond) and are vertex presentation (no breech or transverse positions).</td>
<td>TJC</td>
<td>CHIPRA</td>
<td>Children’s and Maternal Health</td>
<td>Perinatal and Reproductive Health</td>
<td>Section V</td>
</tr>
</tbody>
</table>