

Medicaid Managed Care Program Oversight

Response to SR 194 of the 2025 Regular Session

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Introduction

The Louisiana Department of Health (LDH) is committed to improving health outcomes for Medicaid enrollees through a managed care delivery system that prioritizes quality, accountability, and value. Guided by the principles of the Triple Aim—better health, better care, and lower costs—LDH continuously refines its approach to oversight, performance measurement, and incentive design to ensure that Managed Care Organizations (MCOs) deliver high-quality, accessible, and equitable care.

This report outlines Louisiana Medicaid’s current and planned efforts to strengthen the effectiveness of its managed care program. It provides a comprehensive overview of ongoing quality improvement initiatives, oversight mechanisms, and performance-based payment strategies that align financial incentives with measurable improvements in enrollee health and system efficiency.

The following sections describe LDH’s strategies to:

- Monitor and improve key health outcomes;
- Strengthen oversight and accountability of MCO operations;
- Evaluate and optimize the number of contracted MCOs to balance competition, efficiency, and beneficiary choice; and
- Enhance the effectiveness of quality incentive programs, including the Managed Care Incentive Payment (MCIP) Program and quality withholds.
- Address beneficiaries who have been enrolled with an MCO, but have not received services in at least thirty months.

Together, these efforts demonstrate LDH’s ongoing commitment to achieving a high-performing, outcomes-driven Medicaid program that advances population health, promotes fiscal responsibility, and improves the quality of care for Louisiana’s Medicaid members.

Section 1 – Current efforts to improve healthcare outcomes

Louisiana’s Medicaid managed care program is responsible for providing high-quality, innovative, and cost-effective health care to Medicaid enrollees. Guided by the Triple Aim, the Louisiana Department of Health partners with enrollees, providers, and health plans to continue building a Medicaid managed care delivery system that improves the health of populations (better health), enhances the experience of care for individuals (better care) and effectively manages costs of care (lower costs). LDH utilizes various methods of improving health outcomes, including:

Subsection 1.1 – Monitoring and incentivizing Managed Care Organization (MCO) performance on health outcome measures

MCOs are required to report annually on quality performance measures on a range of subjects, such as chronic disease care, screening and prevention, and reducing low-value care. A core set of performance measures is incentivized through withholds. Currently, LDH withholds one percent of the MCO’s monthly capitation payments. Beginning in January of 2026, LDH will withhold three percent of the MCO’s monthly capitation payments for a quality withhold. Monthly capitation payments are a fixed, per-member, per-month fee that a LDH gives to MCOs in advance to cover the cost of healthcare services for Medicaid enrollees. The MCO receives this predictable payment regardless of how many times a patient uses services, creating an incentive for the organization to manage care efficiently and focus on preventive medicine to keep costs down. The MCOs can recoup the withheld portion of their capitation payments by meeting or exceeding performance targets set by LDH.

Subsection 1.2 - Performance Improvement Projects (PIPs)

MCOs must have an ongoing program of PIPs that focus on clinical and non-clinical areas. A PIP is intended to improve the care, services, or enrollee outcomes in a focused area of study. PIPs are designed to achieve, through ongoing cycles of enrollee input, planned intervention, and measurement, significant improvement on priority health outcomes sustained over time. LDH requires the MCOs to perform two PIPs, one additional behavioral health PIP, and up to two additional PIPs for a maximum of five per year. Current PIP topics include:

- Cervical cancer screening,
- HIV screening,
- Congenital syphilis screening,
- Fluoride varnish for pediatric members, and
- Behavioral health transitions in care (follow-ups).

Subsection 1.3 - Managed Care Incentive Payment (MCIP) Program:

The Managed Care Incentive Payment (MCIP) program is designed to incentivize the Medicaid Managed Care Organizations (MCOs) for achieving quality objectives that increase access to health care, improve the quality of care, and enhance the health of members the MCOs serve. The MCOs have chosen to contract with two networks of hospitals to assist in the achievement of these quality objectives. The MCIP program leverages federal regulations that allow state Medicaid Programs to include incentive arrangements in MCO contracts. An incentive arrangement is a payment mechanism under which an MCO may receive additional funds over and above the capitation rate in exchange for meeting specified targets. Incentive arrangements may provide for payments up to 5% above the approved capitation payments attributable to enrollees or services covered by the Approved Incentive Arrangements (AIA). Payments

are made when the MCOs, through the networks, achieve the specified activities, targets, performance measures, or quality-based outcomes identified in the AIA. Failure to achieve these activities, targets, performance measures, or quality-based outcomes reduces the amount of incentive payments.

Key performance indicators (KPIs) are established as performance measures. KPIs are directly tied to health outcomes and not administrative activities. KPIs for 2026 are focused on chronic disease, behavioral health, and maternal and infant health. The KPIs are as follows:

- Increase Narcan distribution in inpatient and emergency department settings
- Increase Hospital Bridge Program recognition participation
- Increase the administration of medications for opioid use disorder (MOUD) in hospital-based inpatient services
- Decrease all-cause readmissions
- Improve timeliness of cancer diagnosis and treatment through cancer navigation programs
- Improve the prevention of chronic disease through community-based healthy lifestyle interventions
- Improve optimal diabetes care in the outpatient setting
- Increase tobacco/vaping screening and intervention
- Decrease low-risk cesarean birth rates
- Decrease unexpected complications in term newborns
- Increase postpartum depression screening and follow-up
- Increase screening of all pregnant women for substance use disorder (SUD)
- Increase the rate of pregnant women with SUD receiving or being referred to recovery treatment services
- Improve timely treatment of hypertension among pregnant and postpartum women
- Increase the scheduling of postpartum blood pressure and symptoms check
- Increase the prescribing of low-dose aspirin for postpartum women at high-risk for preeclampsia
- Increase the use of cardiovascular Disease (CVD) risk assessments for pregnant and postpartum women

LDH oversees the program and ensures that incentive dollars are tied directly and solely to quality-related KPIs. LDH evaluates the program throughout the year, and MCOs submit an Annual Progress Report by July 31 of each year that details their preliminary performance and steps taken to implement the KPIs. LDH uses the Annual Progress Reports and quarterly performance data submissions to evaluate how the MCIP program is impacting the health of Medicaid members.

Subsection 1.4 - Annual external independent reviews

LDH's External Quality Review Organization (EQRO) performs an annual review of each MCO's performance related to quality, timeliness, and access to care furnished by each MCO. The resulting report includes recommendations for each MCO on how to improve their quality program.

Subsection 1.5 - Medicaid Managed Care Quality Strategy:

LDH maintains a Quality Strategy that establishes clear priority areas, goals, and objectives to drive improvements in care delivery and health outcomes, as well as metrics by which progress will be measured. It details priority interventions and the standards and mechanisms for holding MCOs accountable for desired outcomes. The state's contracted EQRO performs an annual evaluation of the Quality Strategy and provides recommendations on how to improve LDH's overall quality improvement program.

Section 2 – How the department intends to address oversight of the managed care organizations.

LDH has a federal responsibility under 42 C.F.R. Part 438 to provide robust oversight of contracted MCOs. Effective oversight ensures compliance with federal and state laws and rules, protects enrollees, and promotes quality care. Here are the key strategies Louisiana uses:

Subsection 2.1 – Strong Contract Design

1. **Clear, enforceable requirements:** Louisiana Medicaid's Managed Care contracts specify many robust requirements, including but not limited to, network adequacy, prior authorization timelines, quality metrics, grievance/appeals process and timeframes, and encounter data standards. If an MCO is non-compliant with contract requirements, LDH may apply administrative

actions or assess monetary penalties and intermediate sanctions to obtain the level of performance required for successful operation of the managed care program. LDH issued non-compliance actions to the MCOs are available [here](#).

2. **Value-based language:** Include performance incentives and withholds tied to quality outcomes, not just process measures. (see section 4)
3. **Transparency clauses:** MCOs are required to submit detailed reports on many metrics, including, but not limited to, finances, delivery of services, grievances and appeals, provider payments, and utilization management. A full list of MCO required reporting templates are available [here](#).

Subsection 2.2 – Data Collection & Validation

1. **Encounter Data Oversight:** Contracts require timely and complete submission of encounter data. Encounter data is information reported by MCOs that documents all healthcare services provided to their enrollees. This data includes details like patient diagnoses, treatments, procedures, and the services received, providing a comprehensive record of care delivered through the managed care system. Accurate encounter data is foundational for fiscal integrity, program accountability, and quality improvement within Medicaid managed care.
2. **Financial Monitoring:** Contracts require submission of and review medical loss ratios (MLRs) to ensure a least 85% the capitation payment is spent on medical claims. If an MCO's MLR falls below the state's 85% contractual requirement, the state requires the MCO to provide a refund. MCO MLR reports are available [here](#).

Subsection 2.3 – Independent Quality Monitoring

1. **External Quality Review Organization:** Federal law requires EQROs to conduct annual reviews of access, timeliness, and quality. Louisiana utilizes EQRO findings to guide corrective actions.
2. **Performance Improvement Projects:** MCOs are required to implement and report on PIPs targeting state health priorities.
3. **Standardized Measures:** Collect and compare Health Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), and other National Committee for Quality Assurance (NCQA) metrics across plans to benchmark performance.

Subsection 2.4 – Compliance & Accountability Tools

1. **Corrective Action Plans (CAPs):** Require MCOs with deficiencies to submit and follow CAPs with timelines.
2. **Sanctions & Withholds:** Impose financial penalties, withhold for quality metrics and enrollment freezes.
3. **Noncompliance Actions** – Failure to comply with the requirements and performance standards set forth in the MCO contracts may result in the assessment of a Monetary Penalty per incident and/or per calendar day of non-compliance. Determinations of non-compliance may be based on findings from a review of reports and deliverables, enrollee or provider complaints, or any other reliable source of information. Penalties are calculated and imposed based on the contract's table of monetary penalties. LDH issued noncompliance actions are available [here](#).

Subsection 2.5 – Beneficiary Protections

1. **Grievance & Appeal Tracking:** Monitor timeliness and outcomes of beneficiary complaints, appeals, and state fair hearings.
2. **Enrollee Satisfaction Surveys** – Annual enrollee CAHPS surveys are conducted and includes information such as obtaining needed care, getting care quickly, how well providers communicate, and MCO customer service.

Subsection 2.6 – Provider Network Oversight

1. **Credentialing Oversight:** Review MCO processes to ensure timely provider credentialing.
2. **Network Adequacy Reviews:** Validate provider directories through “secret shopper” calls, geo-mapping, provider to member ratios, and distance standards.
3. **Payment Monitoring:** Track timeliness and accuracy of provider payments to ensure network stability and meeting contract provider payment requirements.

Subsection 2.7 - Alignment with State Priorities

1. **Equity & Social Determinants of Health (SDOH):** Require reporting and interventions around disparities and social determinants of health.
2. **Care Coordination:** Evaluate how well MCOs perform case management requirements.
3. **Innovation:** Require MCOs to invest in value-based payment models with the providers.

Subsection 2.8 – Oversight to be considered

1. **Dashboards:** Use real-time dashboards for access, utilization, and complaints to identify red flags.
2. **Regular Audits:** Conduct desk reviews and onsite audits of claims, grievances, and provider networks.
3. **Stakeholder Engagement:** Hold regular public meetings, advisory committees, and provider and beneficiary listening sessions.

Section 3 – Number of Managed Care Organizations

When Louisiana Medicaid considers the appropriate number of MCOs to contract with, the state must weigh several policy, operational, and enrollee-focused factors:

Subsection 3.1 – Beneficiary Access & Choice

1. **Network Adequacy:** Ensuring enough MCOs to support a broad provider network across rural and urban areas.
2. **Geographic Distribution:** Multiple MCOs may be necessary to address regional differences in provider availability and enrollee needs.
3. **Consumer Choice:** CMS expects Medicaid enrollees to have at least two MCO options.

Subsection 3.2 – Administrative Efficiency & Oversight

1. **State Oversight Capacity:** More MCOs require additional monitoring, reporting, and contract management, which can stretch state resources.
2. **Consistency in Operations:** Fewer MCOs can make it easier to standardize policies (prior authorization, claims processing, provider credentialing).
3. **Administrative Burden for Providers:** Too many MCOs can create duplicative requirements, increasing provider dissatisfaction and potentially impacting network participation.

Subsection 3.3 – Market Competition & Performance

1. **Competitive Incentives:** Sufficient MCOs are needed to foster competition on quality, innovation, and efficiency. Too few can reduce accountability; too many can dilute market share and weaken financial stability.
2. **Plan Performance Variation:** Louisiana must consider whether multiple MCOs produce meaningful differences in quality or outcomes, or if performance is relatively uniform.

Subsection 3.4 – Financial Stability & Market Viability

1. **Enrollment Size per MCO:** Each MCO must have enough members to spread risk and remain financially viable.
2. **Market Consolidation Risks:** If enrollment is spread too thin, smaller MCOs may exit the market or underperform.
3. **State Budget Predictability:** Fewer MCOs may simplify capitation rate setting and risk adjustment.

Subsection 3.5 – Alignment with State Goals

1. **Policy Priorities:** MCOs help achieve goals like care coordination, health equity, value-based payment, and improved population health outcomes.
2. **Innovation Capacity:** Larger MCOs with more members may have stronger infrastructure for value-based care, analytics, and social determinant interventions.

Subsection 3.6 – Optimal Target Range

Louisiana must balance access and choice against administrative complexity and financial viability. Typically, states with Medicaid populations the size of Louisiana (around 1.5M enrollees) may contract with 3–5 MCOs, which allows competition and choice while keeping oversight manageable.

Peer State Comparison

State	Approx. Medicaid Enrollment	# of MCOs	MCO Names	Program Name	Key Features
Mississippi	~650,000	3	Magnolia Health, Molina Healthcare, TrueCare	MississippiCAN & CHIP	Limited to 3 vendors to simplify oversight and preserve statewide networks
Oklahoma	~1.3 million	3	Aetna Better Health, Humana Healthy Horizons, Oklahoma Complete Health	SoonerSelect (launched 2024)	New managed care rollout limited to 3 statewide plans to reduce fragmentation and ensure readiness.
West Virginia	~560,000	4	The Health Plan, Aetna Better Health, Unicare, Highmark Health Options	Mountain Health Trust	Four statewide plans; simplified procurement, uniform quality measures, centralized state oversight.
Iowa	~800,000	3	Amerigroup, Iowa Total Care, Molina Healthcare	IA Health Link	Initially had 4+ plans, reduced to 3 for stability and oversight after exit of smaller plans.
Tennessee	~1.7 million	3	Amerigroup, BlueCare Tennessee, UnitedHealthcare Community Plan	TennCare	Long-standing 3-plan structure with high performance metrics; state maintains tight contract control.

Section 4 – Improving the Effectiveness of Health Quality Measures Incentives Used by the Department and Managed Care Organizations

LDH continues to strengthen the alignment between Medicaid managed care payments and improved health outcomes. Through a combination of incentive payments, quality withholds, and value-based purchasing strategies, LDH seeks to reward MCOs for measurable improvements in quality, access, and efficiency.

This section outlines key components of LDH’s incentive structure: the Managed Care Incentive Payment (MCIP) Program, the Quality Withhold Program, and the Value-Based Payment (VBP) framework. Together, these initiatives advance LDH’s broader goals of improving maternal and infant health, chronic disease management, behavioral health outcomes, and access to care, while ensuring fiscal accountability and transparency in managed care operations.

Subsection 4.1 – Managed Care Incentive Payment (MCIP) Program

The MCOs are incentivized to improve their quality measure performance via the Managed Care Incentive Payment (MCIP) program and capitation withholds. Capitation withholds refer to a portion of the MCO's monthly capitation payment that LDH temporarily retains and makes contingent upon the MCO's performance on specified quality or administrative measures. The withheld amount can be earned back when the MCO meets or exceeds established performance targets. This approach is designed to incentivize continuous quality improvement and accountability in managed care delivery.

LDH continues to work to improve the effectiveness of the MCIP program. The following improvements were made in 2025:

- Incentive payments are now tied solely to the achievement of milestones.
- Approved incentive arrangements (AIAs) are designed to last five years. Only AIAs entering their fourth or fifth year in 2025 were continued into 2025, as the older AIAs are focused on incentivizing the improvement of key performance indicators (KPIs). All other AIAs were in the early phases of implementation and were therefore retired early.

The following improvements to the MCIP program are in the process of being implemented for 2026:

- New AIAs are being designed that exclusively incentivize the improvement of KPIs.
- Workgroups consisting of LDH and external stakeholders are collaborating to design these new AIAs and milestones related to maternal and infant health, chronic disease, behavioral health, and access to care.
- LDH will monitor the amount of the incentives retained by the MCOs and their third-party contractors.
- Other changes to the MCIP Protocol that improve the oversight and effectiveness of the program are being made.

Subsection 4.2 – Quality Withhold

LDH withholds one percent of the MCO's monthly capitated payment to incentivize performance of a core set of quality measures. The MCOs may earn back the withhold based on their performance on the measures relative to targets established by LDH. The effectiveness of these incentives is evaluated annually to determine if measures should be removed or added based on the MCOs' performance for that year. LDH and external stakeholder workgroups are currently collaborating to select the appropriate withhold measures for 2026, primarily related to maternal and infant health, chronic disease, behavioral health, and access to care. Effective January 1, 2026, the withhold portion of the MCO's monthly capitation payments is being increased from one percent to three percent, to better incentivize quality and health outcomes.

Section 5 – Medicaid Beneficiaries with No Services

The Louisiana Legislative Auditor (LLA) found that from 2018 to 2022, LDH paid more than \$720 million to Medicaid managed care organizations for nearly 50,000 beneficiaries who appeared to receive no services for 13–60 months. The audit concluded that LDH does not systematically use claims data to identify members with long gaps in care or missing preventive services. The auditor recommended that LDH implement regular data analyses, improve oversight of MCOs, and take steps to ensure beneficiaries are receiving needed services.

LDH agrees with the LLA’s recommendation and is committed to performing regular analyses of Medicaid data to identify beneficiaries who have not received any services for extended periods.

Subsection 5.1 – Recommendations and Actions

LDH is in the process of making changes to the Louisiana Medicaid Eligibility System so that anyone receiving Medicaid with no services for 30 or more months will be required to complete a standard eligibility renewal. This system update will be completed in February 2026.

LDH is also requiring the MCOs to conduct outreach to those identified beneficiaries with no services, and to report back on what outreach was done. To accomplish this, a new routine report is being developed that will require semi-annual identification of their members who have received no services for 30 or more months, conduct outreach, and submission of the report to LDH.

Lastly, the Department will conduct a semi-annual encounter data review to identify Medicaid beneficiaries who have received no services for 30 or more months, which will be compared to the MCO submissions.

Subsection 5.2 – Better Outcomes

By implementing the LLA's recommendations, LDH's intends to improve oversight of Medicaid and health outcomes by requiring MCOs to proactively reach out to members who may be:

- Missing preventive care
- Managing chronic conditions without treatment

Proactive identification and outreach creates opportunities to intervene early, leading to better long-term outcomes, which may lead to lower costs.

Subsection 5.3. More Efficient Use of Medicaid Funds

Removing or resolving cases where beneficiaries are enrolled but not using services will enable LDH to:

- Focus resources on people who genuinely need care
- Reduce overall spending or reinvest savings into benefit improvements or population health initiatives

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