



Louisiana's Medicaid Managed Care Quality Strategy

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Louisiana Medicaid
Quality Improvement and Population Health Section
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Louisiana Medicaid Managed Care Quality Strategy

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1 Introduction – Managed Care Goals, Objectives and Overview

1.1 History of Managed Care in Louisiana

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 (LDH) 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**).

More specifically, the Department's Medicaid managed care objectives include:

- advancing evidence-based practices, high-value care and service excellence;
- supporting innovation and a culture of continuous quality improvement (CQI) in Louisiana;
- ensuring enrollees ready access to care, including through innovative means such as medical homes and telehealth;
- improving enrollee health;
- decreasing fragmentation and increasing integration across providers and care settings, particularly for enrollees with behavioral health needs;
- using a population health approach, supported by health information technology, to advance health equity and address social determinants of health (SDOH);
- reducing complexity and administrative burden for providers and enrollees;
- aligning financial incentives and building shared capacity to improve health care quality through data and collaboration; and,
- minimizing wasteful spending, unnecessary utilization, and fraud.

Today, Louisiana Medicaid serves over 1.6 million Louisianans, approximately 35% percent of the state's population. Six (6) statewide Managed Care Organizations (MCOs), one (1) Behavioral Health Prepaid Inpatient Health Plan (PIHP) and two (2) Dental Prepaid Ambulatory Health Plan (PAHP) pay for healthcare services for more than 90 percent of the Louisiana Medicaid population, including more than 481,000 new adults since Medicaid expansion took effect in July 2016. These managed care entities (MCOs) pay for Medicaid benefits and services included in the Louisiana Medicaid state Plan, state statutes and administrative rules, Medicaid policy and procedure manuals. In addition, these MCOs also provide specified value-added Medicaid benefits and services. Accreditation information for Louisiana's MCOs, PIHPs, and PAHPs are posted to the Medicaid Quality Initiatives website and can be accessed at <https://ldh.la.gov/index.cfm/subhome/47>.

On February 1, 2012, the Louisiana Department of Health (LDH) transitioned nearly 900,000 Medicaid enrollees from the state's 45-year-old fee-for-service (FFS) program to a Medicaid managed care model. Rollout occurred in phases based upon designated geographic service areas, with the statewide rollout completed on June 1, 2012. In transitioning from fee-for-service to a Medicaid managed care model, Louisiana sought to:

- Improve access to care
- Improve care coordination

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- Increase emphasis on disease prevention and the early diagnosis and management of chronic conditions
- Improve health outcomes and quality of care
- Provide for a more financially stable Medicaid program

In December 2015, LDH integrated specialized behavioral health services into the managed care program in an effort to improve care coordination for enrollees and facilitate provision of whole-person health care. Louisiana also continues to administer the Coordinated System of Care (CSoc), a single behavioral health PIHP to help children with behavioral health challenges that are at risk for out of home placement. Wraparound support and other services are provided to assist children with staying in or returning to their home.

In 2021, LDH initiated procurement for its third-generation, full-risk Medicaid managed care contracts. The new third-generation, full-risk Medicaid managed care contracts with six (6) MCOs went into effect on January 1, 2023.

1.2 Quality Strategy Priority Areas, Goals, and Objectives

This Quality Strategy 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 articulates priority interventions, and details the standards and mechanisms for holding MCOs accountable for desired outcomes. The Quality Strategy is a roadmap by which LDH will use the managed care infrastructure to facilitate improvement in health and health care through programmatic interventions.

Guided by the four priority areas of the CMS National Quality Strategy – **Outcomes and Alignment, Equity and Engagement, Safety and Resiliency, and Interoperability and Scientific Advancement** – Louisiana’s Quality Strategy framework defines and drives the overall vision for advancing health outcomes and quality of care provided to Louisiana Medicaid enrollees. Described in Table 1, these priority areas link to Louisiana specific goals and objectives, intended to highlight key areas of quality focus for the Louisiana Medicaid managed care program.

Table 1: Louisiana Quality Strategy Priority Areas, Goals, and Objectives

Priority Areas	Goals	Objectives
Promote Aligned and Improved Health Outcomes	Improve quality and health outcomes across the care journey	Ensure timely and approximate access to primary and specialty care
		Ensure maternal safety and appropriate care during childbirth and postpartum
		Ensure patient safety
		Prevent prematurity and reduce infant mortality
		Promote oral health in children
		Improve immunization rates
		Prevent obesity and address physical activity and nutrition in children and adults
		Prevent prematurity and reduce infant mortality
		Improve cancer screening

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		Improve HIV and Hepatitis C virus infection screening
		Promote early initiation of palliative care to improve quality of life
		Promote healthy development and wellness in children and adolescents
		Improve hypertension, diabetes, and cardiovascular disease management and control
		Improve antibiotic stewardship
		Improve respiratory disease management and control
		Improve HIV control
		Improve quality of mental health and substance use disorder care
		Promote reproductive health
		Advance value-based payment arrangements and innovation
	Align and coordinate across programs and care settings	Ensure appropriate follow-up after emergency department visits and hospitalizations through effective care coordination and case management
		Ensure appropriate hospice onboarding and transitioning from palliative care to hospice
		Ensure members that are improving or stabilized in hospice are considered for discharge
Advance Equity and Engagement for All Individuals	Advance health equity and whole-person care	Integrate behavioral and physical health
		Stratify key quality measures by demographic data and narrow health disparities
		Advance specific interventions to address social determinants of health
		Improve overall health
	Engage individuals and communities to become partners in their care	Engage and partner with enrollees to improve enrollee experience and outcomes
Ensure Safe and Resilient Health Care Systems	Achieve zero preventable harm	Ensure that members have a mechanism to submit grievances for the state's review
	Enable a responsive and resilient health care	Monitor and resolve critical incidents reported to the state

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	system to improve quality	Reduce low value care
Accelerate Interoperability and Scientific Innovation	Accelerate and support the transition to a digital and data-driven health care system	Review data collection systems to ensure digital measurement and reporting is feasible
	Transform health care using science, analytics, and technology	Use quality performance data to evaluate the effectiveness of program interventions in improving health outcomes

Underpinning these priority areas, objectives and goals are a robust set of quality interventions/strategies and quality performance measures that MCOs are required to measure and report progress against, as described in Section 2, Driving Improvement and Monitoring Progress.

1.3 Quality Management Structure

The day-to-day operations of the Medicaid managed care program are the responsibility of the Bureau of Health Services Financing within LDH, with support from all LDH “program offices” – Office of Behavioral Health (OBH), Office of Public Health (OPH), Office of Aging and Adult Services (OAAS), Office for Citizens with Developmental Disabilities (OCDD), and Office of Women’s Health & Community Health (OWHCH). In addition, OBH has oversight of the Medicaid specialized behavioral health services (SBHS) and the Behavioral Health Coordinated System of Care (CSoC) contractor. The Medicaid Quality Improvement and Population Health Section, in collaboration with these program offices, the Medicaid Chief Medical Officer and Medicaid Executive Management Team, is responsible for the development, implementation and evaluation of the Medicaid Managed Care Quality Strategy.

The Louisiana Medicaid Advisory Committee (MAC) fulfills the role required by 42 CFR 431.12. The MAC provides focus and direction for Medicaid program quality activities that assure access and utilization of quality, evidence-based healthcare that is designed to meet the health needs of all Louisiana Medicaid and Children’s Health Insurance Program (CHIP) enrollees.

Members of the MAC and its subcommittees offer expertise and experience to recommend improvements to Medicaid that will serve to better meet the healthcare needs of recipients in a cost efficient manner. The MAC is interdisciplinary and includes representatives who are familiar with quality improvement and the medical needs of Medicaid enrollees.

The Beneficiary Advisory Council (BAC) fulfills the role required by 42 CFR 431.12. The BAC is comprised of individuals who are currently or have been Medicaid beneficiaries and individuals with direct experience supporting Medicaid beneficiaries, such as family members and paid or unpaid caregivers of those enrolled in Medicaid. The BAC advises LDH and the MAC regarding their experience with the Medicaid program on matters of concern related to policy development and matters related to the effective administration of the Medicaid program.

The BAC serves as the Home & Community Based Services (HCBS) Interested Parties Advisory Group (IPAG) required by 42 CFR 447.203.

2 DRIVING IMPROVEMENT AND MONITORING PROGRESS

2.1 Goals and Objectives for Continuous Quality Improvement

LDH is committed to a culture of Continuous Quality Improvement (CQI). We require MCOs to engage in and support CQI on clinical and administrative metrics, and work with providers and the Department to bring innovation to all aspects of health care. We expect MCOs to evaluate the effectiveness of program interventions and adjust continuously to optimally support whole-person centered care and improved health outcomes for enrollees.

2.2 MCO Performance Measures

Louisiana requires MCOs to report annually on patient outcome performance measures, including the Healthcare Effectiveness Data and Information Set (HEDIS®) quality metrics, CMS Adult and Child Core Set, Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators, Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, and state-specified quality measures. The state may add or remove performance measure reporting requirements prior to the start of a measurement year. Current MCO performance measure reporting requirements are described in Appendix A. All performance measures listed in Appendix A are listed on the Louisiana Medicaid Managed Care Quality Dashboard, which can be accessed at <http://qualitydashboard.ldh.la.gov/>.

Currently, one percent of each MCO's monthly capitated payment is withheld to incentivize a core set of quality and health outcomes (denoted in Appendix A with "\$\$"). The MCO may earn back the quality withhold for the measurement year based on its performance on incentive-based measures relative to targets as established by LDH. LDH aligns HEDIS benchmarks to NCQA Quality Compass Medicaid National 50th percentile. Targets for non-HEDIS incentive-based measures are equal to the best performance reported to LDH by any MCO for the prior measurement year. To earn back the full withhold amount associated with each incentive-based measure, MCO performance must either meet the target for that measure or improve by at least two points from the prior measurement year.

2.3 Performance Measures and Performance Improvement Projects (PIPs)

In accordance with 42 CFR 438.340 and 42 CFR § 438.330(d), 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. In addition to any CMS specified PIPs, LDH requires MCOs to perform two LDH-approved PIPs, a minimum of one additional LDH-approved behavioral-health PIP each contract year, and may require up to two additional projects for a maximum of five PIPs.

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-approved MCO, PIHP, and PAHP PIPs are listed below in Tables 2 and 3.

Annual PIP reports can be accessed at <https://ldh.la.gov/performance-improvement-projects>.

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Table 2: Medicaid MCO Performance Improvement Projects

2021-2023	Ensuring access to the COVID-19 vaccine among Healthy Louisiana vaccine-eligible enrollees	<p>Implement interventions to achieve the following objectives:</p> <ul style="list-style-type: none"> • Enrollee Interventions <ul style="list-style-type: none"> ○ Refer and facilitate making appointments for eligible enrollees engaged in case management to COVID-19 vaccination sites. ○ Refer and facilitate making appointments for eligible enrollees NOT engaged in case management to COVID-19 vaccination sites. ○ Educate and inform enrollees on vaccine merits, safety and accessibility with comprehensive and clear communication in accordance with the State of Louisiana communication plan for the COVID-19 vaccine [e.g., LDH COVID-19 website: Louisiana Coronavirus COVID-19 Department of Health State of Louisiana (la.gov)]. ○ Provide enrollees with second dose reminders for those overdue. • Provider Interventions <ul style="list-style-type: none"> ○ Distribute listings of COVID-19 vaccine-eligible enrollees, as well as listings of pharmacy vaccination sites and other LINK-enrolled providers, to PCPs. ○ Conduct training and education of providers, when necessary, using LINKS training videos and CDC/ACIP evidence-based guidance in collaboration with the Tri-Regional LINKS Outreach Coordinators. • Collaborate with state and local partners <ul style="list-style-type: none"> ○ Outreach to racial/ethnic minority enrollees. Utilize COVID-19 vaccination coverage reports generated in LINKS to track and monitor COVID-19 vaccination rates and to determine pockets of need (e.g., zip code and region level). Collaborate and coordinate with the Louisiana Department of Health Vaccination Strike Teams to vaccinate hard-to-reach target populations in Louisiana. ○ Collaborate with the Office of Public Health on vaccine education materials.
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2023-2025	Cervical Cancer Screening	<p>Implement interventions to achieve the following objectives:</p> <ul style="list-style-type: none"> Member Objective: Improve the HEDIS Cervical Cancer Screening performance indicator by developing and implementing interventions for the following eligible populations ages 21-64 years: <ul style="list-style-type: none"> Eligible population of women who are in case management. Eligible population of women who are not in case management and have at least one PCP or OB/GYN visit during the measurement year. Eligible population of women who are not in case management and have not had any PCP or OB/GYN visits during the measurement year. Interventions must address provider linkage. Disparity subpopulations identified using the Analysis of Disproportionate Over-Representation (cervical cancer prevalence) and Under-Representation (cervical cancer screening). Provider Objective: Improve the HEDIS Cervical Cancer Screening performance indicator by developing and implementing provider interventions (must include Gaps-In-Care Report and Provider Education).
2023-2025	HIV Screening	<p>Implement interventions to achieve the following objectives:</p> <ul style="list-style-type: none"> Member Objective: Improve the HIV screening rate by developing and implementing member interventions for the following eligible adolescent and adult with populations 1 through 3 screened during the measurement year, and the last eligible population ever screened: <ul style="list-style-type: none"> Pregnant persons or persons with encounters for labor and delivery Persons with past or present injection drug use Persons with contact with and (suspected) exposure to infections with a

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		<p>predominantly sexual mode of transmission or to human immunodeficiency virus or persons with high-risk heterosexual behavior, high-risk homosexual behavior, or high-risk bisexual behavior; This would also include persons diagnosed with infections with a predominantly sexual mode of transmission</p> <ul style="list-style-type: none"> ○ All others aged 15 to 65 years (without a current or past HIV diagnosis) ● Provider Objective: Improve the HIV screening rate for the total eligible population by implement provider interventions for PCP providers and OB/GYN/prenatal care providers
2024-2025	Addressing Congenital Syphilis through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees	<p>Implement member and provider interventions to in order to increase the percentage of members who delivered live births during the measurement period that were screened for syphilis at one or more of the following stages:</p> <ul style="list-style-type: none"> ○ At the first pregnancy examination ○ During 28 to 32 weeks of pregnancy ○ At delivery ○ During first trimester ○ During third trimester
2023-2025	Dental: Fluoride Varnish Application to Primary Teeth of All Enrollees Aged 6 Months through 5 Years by Primary Care Clinicians	<p>Implement interventions to:</p> <ul style="list-style-type: none"> ● Perform member outreach ● Perform provider education ● Prepare Member Fluoride Varnish Care Gap Report
2023-2025	Behavioral Health Transitions in Care	<p>Implement interventions to improve performance improvement of the following measures:</p> <ul style="list-style-type: none"> ● Follow-Up after Hospitalization for Mental Illness ● Follow-Up After Emergency Department Visit for Mental Illness ● Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

Table 3: Dental (PAHP) and CSoC (PIHP) Performance Improvement Projects

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2024-2025	Dental: Increase the percentage of EPSDT enrollees age 1-20 receiving at least 1 preventative dental service	<p>Use targeted interventions to increase the percentage of eligible Louisiana Medicaid enrollees who receive at least one preventative dental service during the measurement year by 2.5 percentage points over baseline performance. Dental Benefit Program Manager (DBPM) must select two or more of the following interventions:</p> <ul style="list-style-type: none"> • Assign enrollee to dental provider and inform them of their assigned provider and contact information • Sent monthly preventative care postcards to enrollees due for a preventive checkup • Care Connections team will use claims data (CPT procedure code D9986 – missed appointment) to conduct member outreach and provide education on the importance of keeping appointments, canceling with notice (when necessary), and will offer to reschedule the appointment. • Implement a Preventative Care Outbound Call Campaign to contact enrollees overdue for preventative care and provide oral health education and appointment scheduling assistance.
2024-2025	Dental: Increase the rate of children receiving an annual dental visit by their first birthday	<p>Use targeted interventions to increase the percentage of eligible Louisiana Medicaid enrollees who receive at least one dental service by their first birthday by 2.5 percentage points over baseline performance. Dental Benefit Program Manager (DBPM) must select two or more of the following interventions:</p> <ul style="list-style-type: none"> • Educational outreach to parent/guardian on importance of scheduling a dental visit no later than age of one. • Welcome call informing parent/guardian of dental benefits and importance of scheduling appointment • Baby's First Toothbrush Kit Mailing – At 10 months of age, enrollees will receive a baby toothbrush, oral health flyer and letter educating the parent/guardian regarding the importance of the child receiving their first dental checkup by the first birthday. • A postcard is sent to enrollees at nine months of age to educate parents/guardian on the importance of oral health and inform them that the first dental

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		visit should take place after the first tooth appears but no later than the child's first birthday.
2023-2025	CSoC: Increase the Effectiveness of Plans of Care in Addressing Actionable Clinical Needs of Youth Enrolled in CSoC	<p>CSoC enrollees are deemed at risk for or are currently in out-of-home placement and often have cross-system involvement (e.g., juvenile justice, child welfare, or special education). Services are administered using the Wraparound model, an intensive, structured, team-based care coordination process that prioritizes the preferences and perspectives of the youth and family throughout the design and implementation of the plan of care (POC).</p> <p>This project aims to improve the integration and incorporation of clinical interventions and evidence-based treatment (EBT) in addressing the actionable clinical needs of youth enrolled in CSoC. This will be measured through Plan of Care (POC) Reviews completed by the CSoC Contractor's Care Managers to monitor POC submissions to assess adherence to practice standards and verify that required program activities are completed. Specifically, Care Managers will review members' POCs to determine the extent to which member needs are linked to the assessment, evidence-based practices are considered to address member needs where appropriate, and strategies reflect member strengths and needs (and the effectiveness of strategies).</p>

2.3.1 PIP Processes

Each PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction, and must include the following elements:

- Measurement of performance using objective quality indicators
- Implementation of interventions to achieve improvement in the access to and quality of care
- Evaluation of the effectiveness of the interventions based on the performance measures designed using objective quality indicators
- Planning and initiation of activities for increasing or sustaining improvement

The MCOs, PAHPs, and PIHP must report the status and results of each PIP to LDH annually. The EQRO validates the annual submissions to ensure that the MCO, PAHP, or PIHP executed a methodologically sound PIP and that any reported improvement is related to and can be reasonably linked to the QI strategies and activities conducted during the PIP.

LDH facilitates regular PIP meetings with MCOs and other stakeholders to provide guidance and clinical leadership and allow for MCO collaboration.

2.4 Other Medicaid Quality Interventions

LDH has developed a series of interventions aligned closely with the Quality Strategy, designed to build an innovative, whole-person centered, well-coordinated system of care that addresses both medical and non-medical drivers of health. These interventions drive progress towards the Quality Strategy priority areas, goals, and objectives described in Section 1, Introduction – Managed Care Goals, Objectives and Overview. Progress against these priority areas, goals, and objectives, and the role of interventions in achieving those goals, will be assessed using the measures defined in Appendix A of this document.

2.4.1 MCO Withhold of Capitation Payments for Increasing Use of Value-Based Payments (VBP) and Improving Health Outcomes

Effective February 2018, Medicaid introduced a two percent (2%) withhold requirement into its MCO contracts to incentivize quality, health outcomes, and VBP. Effective January 2023, health equity was introduced as a third component of the two percent (2%) withhold.

- Half of the total withhold (i.e., 1%) is tied to the achievement of quality and health outcomes, specifically on MCOs' performance on the Medicaid managed care incentive-based quality measures identified in Appendix A.
- Half of the remaining total withhold amount (i.e., 0.5%) is linked to increasing the use of VBP. The MCO's VBP strategy must pertain to measurable outcomes that are meant to improve quality, reduce costs, and increase patient satisfaction. The VBP strategy placed emphasis on the establishment of provider payment arrangements designated as categories 3 and 4 and the evolution of providers along the APM model continuum (i.e. from less sophisticated to more advanced categories) with consideration of provider readiness to take on financial risk.
- The remaining withhold (i.e., 0.5%) is linked to MCO reporting and performance relative to the MCO's health equity strategies, including health equity deliverables such as the MCO's Health Equity Plan.

2.4.2 Managed Care Incentive Payment (MCIP) Program

Effective January 2019, the MCIP program is designed to provide incentive payments to Medicaid MCOs for achieving quality reforms that increase access to health care, improve the quality of care, and/or enhance the health of MCO enrollees. As of 2025, the current MCIP projects focus on the following:

- Improving lung and breast cancer screening rates
- Improving tobacco cessation
- Improving developmental and autism screening

2.4.3 Dental Incentive Payment Program (DIPP)

Effective January 2025, the DIPP is designed to provide value-based state directed payments to general and pediatric dentists practicing in dental clinics, Federally Qualified Health Centers, and Rural Health Clinics and who are participating in the Louisiana Medicaid dental program.

The DIPP aims to advance Louisiana's Medicaid managed care quality strategy goal of improving the quality of oral healthcare and enhancing the health of members the DBPMs serve. DIPP is expected to advance the quality goals of promoting wellness and prevention and ensuring access to care to meet enrollee needs.

2.4.4 Other LDH Department-Wide Quality Initiatives

Integral to this Quality Strategy and related priority areas, goals, and objectives are LDH-wide quality strategies and initiatives supported by the Medicaid managed care program, such as:

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- **Louisiana State Health Improvement Plan (SHIP):** The SHIP aims to improve behavioral health, community safety, maternal and child health, and chronic disease for all Louisianans. Priority areas were identified through the Louisiana State Health Assessment (SHA), a survey in which Louisianans were asked to give their insight on the health needs of the population. The SHIP is intended to spur nontraditional partnerships between local communities, state agency leaders, local health departments, businesses and various partners by identifying priorities, objectives and strategies to address Louisiana's most pressing health concerns.
- **Louisiana Perinatal Quality Collaborative:** a voluntary network of perinatal care providers, public health professionals and patient and community advocates who work to advance equity and improve outcomes for parents, families, and newborns in Louisiana, supported by LDH and authorized by the Louisiana Commission on Perinatal Care and Prevention of Infant Mortality.
- **Substance Use Disorder Strategy:** Through expanded federal grants from the Centers for Disease Control and Prevention and the Substance Abuse and Mental Health Services Administration, LDH will continue to work to expand access to opioid use disorder treatment in primary care settings, including the use of emergency department (ED) navigators and promoting Suboxone use in EDs
- **Hepatitis C Elimination Strategy:** LDH executed an innovative payment model for direct-acting antivirals in Medicaid with the goal of eliminating hepatitis C virus infection in Louisiana.
- **Louisiana Sickle Cell Disease Registry:** LDH is building a statewide public health monitoring system for Sickle Cell Disease. The aim of the Registry is to provide the public, healthcare providers and policy makers with summary information about people living in Louisiana with sickle cell disease, information about their health outcomes, comprehensive population estimates, and illustration of long-term trends in diagnosis, treatment and health care access.
- **Case Management and ED Diversion:** Interventions to increase ED diversion include case management for high ED utilizers, telehealth, remote patient monitoring, and an "opt-out" system for case management participation by members.

2.5 Annual External Independent Reviews

The MCOs' adherence to federal and state regulatory requirements and performance standards will be evaluated annually, in accordance with 42 CFR 438.340, by an independent EQRO. This will include a review of the services for timeliness, outcomes, and accessibility, using definitions contained in 42 CFR 438.320.

The scope of the annual EQR conducted by the state for MCOs, as outlined in 42 CFR 438.310(b), includes: a) criteria used to select entities to perform the reviews, b) specification of activities to be performed by the EQRO, c) the circumstances in which the EQR may use other accreditation review results and d) standards for availability of review results. The annual EQR will be conducted each calendar year, with the first EQR report including any months prior to the first full calendar year of operation.

The activities to be performed by the EQRO broadly include: measurement of quality and appropriateness of care and services; synthesis of results compared to the standards, and recommendations based on the findings. The EQRO will meet these obligations by utilizing the EQR protocols developed by CMS to perform the mandatory activities required of EQROs, as mentioned in 42 CFR 438.352 and 438.358, including data to be gathered, data sources, activities to ensure accuracy, validity and reliability of data, proposed data analysis and interpretation methods and documents and/or tools necessary to implement the protocol.

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The state ensures the EQRO has sufficient information for the review from the mandatory and optional EQR-related activities described in the regulation, as outlined in 42 CFR 438.350. This information will be obtained through methods consistent with established protocols, include the elements described in the EQR results section, and results will be made available, as specified in the regulation.

Requirements of MCOs include the following:

- The MCO shall provide all information requested by the EQRO and/or LDH including, but not limited to, information concerning timeliness of, and enrollee access to, benefits and services.
- The MCO shall cooperate with the EQRO during the review (including medical records review), which will be done at least one (1) time per calendar year.
- A description of the performance improvement goals, objectives, and activities developed and implemented in response to the EQRO findings will be included in the MCO's QAPI program. LDH may also require separate submission of an improvement plan specific to the findings of the EQRO.

If an MCO is deemed non-compliant during any aspect of the EQR process, a corrective action plan may be developed to address areas of noncompliance, including a timeline for achieving compliance. LDH provides ongoing monitoring of the corrective action plan.

If the EQRO indicates that the quality of care is not within acceptable limits set forth in the Contract, LDH may sanction the MCO in accordance with the provisions of the MCO contract and may suspend automatic assignment until the MCO attains a satisfactory level of quality of care as determined by the EQRO.

The EQRO produces, at least, the following information, as required in 42 CFR 438.364(a), without disclosing the identity of any patient, as mentioned in 42 CFR 438.364(c):

- A detailed technical report describing data aggregation and analysis and the conclusions (including an assessment of strengths and weaknesses) that were drawn as to the quality, timeliness, and access to care furnished by the MCO. For each activity conducted, the report does include objectives, technical methods of data collection and analysis, description of data obtained and conclusions drawn from the data;
- Recommendations for improving the quality of health care services furnished by the MCO; and,
- An assessment of the degree to which the MCO effectively addressed previous EQRO review recommendations.

EQR results and technical reports are reviewed by LDH. Ongoing EQR status reports and final technical and project reports are communicated through the Louisiana Medicaid Provider and Plan Resources, Reporting and Accountability website (<http://ldh.la.gov/index.cfm/page/1582>). Report results, including data and recommendations, are analyzed and used to identify opportunities for process and system improvements in LDH and MCO quality management programs, improvements to PIPs and Medicaid managed care quality performance measures, and determination of regulatory compliance of the MCOs.

LDH will provide copies of the EQRO results and reports, upon request, to interested parties through print or electronic media or alternative formats for persons with sensory impairments, as mentioned in 42 CFR 438.364(c). LDH will also provide copies of the EQRO results and reports to CMS. In addition, summary results and findings will be included in reports to the legislature and to the public, as appropriate.

2.6 Procedures for Identifying, Evaluating, and Reducing Health Disparities

2.6.1 Population Health and Community Considerations

LDH recognizes the differences and similarities of all of us that include, for example, individual characteristics (e.g., disability, age, education level, poverty status, rural/urban setting, race, ethnicity, and sexual orientation), values, beliefs, experiences and backgrounds. LDH also characterizes inclusion as creating a work environment in which all individuals are treated fairly and respectfully, have equal access to opportunities and resources, and can contribute fully to the work of our agency. This is inclusive of LDH also building its capacity to create, support and/or fund (i.e., via programming projects and contracts) efforts that do not discriminate against people, populations, and/or communities due to disability, age, education level, poverty status, rural/urban setting, race, ethnicity, and sexual orientation. LDH believes that reducing health disparities aid in more equitably achieving its mission – “...protect and promote health and to ensure access to medical, preventive and rehabilitative services for citizens of the State of Louisiana.”

2.6.2 Data Collection

In compliance with the requirements set forth in 42 CFR 438.340 (b)(6), and described in Section 2, Driving Improvement and Monitoring Progress, MCOs must report select measures outlined in Appendix A based on select strata such as race, ethnicity, biological sex, and rural/urban status.. This information is provided to MCOs upon enrollee enrollment and will be used by LDH to better understand disparities of care within and across MCOs.

The five racial categories for which data are gathered by the MCOs are: American Indian/Alaskan Native, Asian, Native Hawaiian/Pacific Islander, Black/African American and White. The two ethnic categories are: Hispanic or Latino and Non-Hispanic or Latino. When individuals do not self-identify their race and ethnicity, alternative system checks and follow-up with households are performed. If a racial and/or ethnic category cannot be obtained, the identification defaults to “Unknown.” Medicaid enrollees, who are a member of any federally recognized American Indian or Alaskan Native tribe, may voluntarily elect to enroll in the Medicaid managed care program.

During the Medicaid application process, the applicant may identify race, ethnicity, and primary spoken language. The data collected for race and language is processed through the Louisiana Medicaid Eligibility Determination System and downloaded nightly into the Medicaid Management Information System (MMIS). The applicant’s preferred language is also identified and forwarded to the MMIS. Because this is a voluntary disclosure, LDH relies on demographic updates to the eligibility system. Although this method does not collect 100 percent of the required data, there are data for a significant portion of Medicaid enrollees.

2.6.3 Communications with MCOs

LDH contracts with an Enrollment Broker that is responsible for Medicaid managed care program enrollment and disenrollment. Daily, the Enrollment Broker provides updates on those newly enrolled into the Medicaid managed care program. In addition, at specified times each month, the Enrollment Broker notifies each MCO regarding those that will be enrolled, re-enrolled or disenrolled to/from their MCO for the following month. The Enrollment Broker provides LDH a listing of current enrollees, via electronic media, on a monthly basis. MCOs, or their administrators, must be capable of uniquely identifying each enrollee across multiple systems within its span of control. To facilitate care delivery appropriate to client needs, the enrollment file includes race/ethnicity, primary language spoken, and

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selective health information. MCOs utilize this information to provide interpreter services and facilitate enrollee needs in the context of their cultural and language requirements.

MCOs are required to ensure that translation services are provided for written marketing and enrollee education materials for any language that is spoken as a primary language for four percent (4%) or more MCO enrollees or potential enrollees. The state requires that MCOs and any contractors have interpretation services for those who speak any language other than English. The Enrollment Broker will provide multi-lingual interpreters and enrollment material in other alternate formats (large print, and/or Braille) as needed.

2.6.4 Evaluating Health Disparities

LDH is committed to ensuring that improvements in health outcomes lead to equitable improvements in all groups. As a first step, LDH is requiring routine reporting of quality measures stratified by race/ethnicity as well as urban/rural status. LDH will support MCOs in including measures of health disparities in all quality improvement activities. Based on their results over time, LDH requires MCOs to develop and implement targeted interventions and/or other strategies to address identified disparities.

In addition, beginning in 2018, LDH's EQRO conducts a Health Disparities Survey of each MCO and includes the results in the Annual Technical Reports (ATR).

In 2020, LDH formed a Medicaid Health Equity Action Team to review Medicaid policy, procedures and processes to advance health equity initiatives and strategic goals.

Furthermore, LDH has strategies to address health disparities identified through data collection, data stratification, and analysis. Strategies include, but are not limited to leveraging managed care contracts to address disparities, health equity and SDOH; stratification of Medicaid performance measures; utilizing performance improvement projects to create targeted interventions for subpopulations experiencing health disparities; track and monitor improvements; publish quality measure data for public review; administer health disparities surveys to the MCOs to identify gaps in care; stakeholder engagement and collaboration with internal and external entities; implementing the LDH Health Equity Community Engagement Framework; and incentivizing MCO reporting and performance relative to the MCOs' health equity strategies.

2.7 Use of Sanctions

LDH may impose any or all sanctions, including requiring an MCO to take remedial action, imposing intermediate sanctions, and/or assessing liquidated damages due to non-compliance with contract requirements or applicable federal or state laws.

2.7.1 Acts or Failures to Act Subject to Intermediate Sanctions

Pursuant to 42 CFR §438.700, et seq., LDH may impose on the MCO intermediate sanctions if it determines that an MCO acts or fails to act as follows:

- Fails substantially to provide medically necessary services that the MCO is required to provide, under law or under the Contract, to an enrollee covered under the Contract;

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- Imposes on enrollees premiums or charges that are in excess of the premiums or charges permitted under the Louisiana Medicaid MCO Program;
- Acts to discriminate among enrollees on the basis of their health status or need for health care services; this includes termination of enrollment or refusal to reenroll an enrollee, except as permitted in Contract Section 2.3.13.3, or any practice that would reasonably be expected to discourage enrollment by recipients whose medical condition or history indicates probable need for substantial medical services.
- Misrepresents or falsifies information that it furnishes to CMS or to LDH;
- Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or a health care provider;
- Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 CFR §422.208 and §422.210;
- Distributes directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by LDH or that contain false or materially misleading information; or
- Violates any of the other applicable requirements of Section 1903(m), 1905(t)(3) or 1932 of the Social Security Act and any implementing regulations.

2.7.2 Other Misconduct Subject to Intermediate Sanctions

LDH also may impose sanctions against any MCO if it finds any of the following non-exclusive actions/occurrences:

- The MCO has failed to correct deficiencies in its delivery of service after having received written notice of these deficiencies from LDH;
- The MCO has been excluded from participation in Medicare because of fraudulent or abusive practices pursuant to Public Law 95-142;
- The MCO or any of its owners, officers or directors has been convicted of a criminal offense relating to performance of the Contract with LDH or of fraudulent billing practices or of negligent practice resulting in death or injury to the MCO's enrollee;
- The MCO has presented, or has caused to be presented, any false or fraudulent claim for services or has submitted or has caused to be submitted false information to be furnished to the state or the Secretary of the federal Department of Health and Human Services;
- The MCO has engaged in a practice of charging and accepting payment (in whole or part) from enrollees for services for which a PMPM payment was made by LDH;
- The MCO has rebated or accepted a fee or portion of fee or charge for a patient referral;
- The MCO has failed to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments;
- The MCO has failed to keep or make available for inspection, audit or copying, such records regarding payments claimed for providing services;
- The MCO has failed to furnish any information requested by LDH regarding payments for providing goods or services;
- The MCO has made, or caused to be made, any false statement or representation of a material fact to LDH or CMS in connection with the administration of the Contract;

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- The MCO has furnished goods or services to an enrollee which at the sole discretion of LDH, and based on competent medical judgment and evaluation are determined to be 1) insufficient for his or her needs, 2) harmful to the enrollee, or 3) of grossly inferior quality.

2.7.3 Sanction Types

The types of intermediate sanctions that LDH may impose on the MCO shall be in accordance with §1932 of the Social Security Act (42 U.S.C. §1396u-2) and 42 CFR §438.702-708 and may include any of the following:

- Civil monetary penalties in the amounts specified in 42 CFR §438.704
- Appointment of temporary management for an MCO as provided in 42 CFR §438.706;
- Granting enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to disenroll;
- Suspension of all new enrollments, including automatic assignment, after the effective date of the sanction;
- Suspension of payment for enrollees enrolled after the effective date of the sanction and until CMS or LDH is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur in accordance with 42 CFR §438.730; and
- Additional sanctions allowed under state statutes or regulations that address areas of noncompliance described above.

3 State Standards for Access and Clinical Policies and Guidelines

3.1 Provider Network Adequacy Standards and Availability of Services

Louisiana's MCO contracts include robust requirements to ensure that MCOs meet federal and state requirements and standards for adequate Medicaid enrollee access to covered services. All standards for network adequacy and availability of services are in accordance with the access and network adequacy standards set forth in the applicable federal regulations.

The following tables summarize provider network standards, as indicated in LDH's Medicaid MCO Contract Attachment F: Provider Network Standards, and other access performance standards.

Table 4: Provider Access and Distance Standards

Type ¹	Network Ratio ² (Provider: Member)	Rural Parishes ³ (miles)	Urban Parishes ³ (miles)
Primary Care⁴			
Adult ⁵ PCP (Family/General Practice; Internal Medicine; FQHC; RHC) ⁶	1:1,000	30	10
Pediatric ⁵ PCP (Pediatrics; Family/General Practice; Internal Medicine; FQHC; RHC) ⁶	1:1,000	30	10
Hospitals			
Acute Inpatient Hospitals		30	10
Ancillary			
Laboratory		30	20
Radiology		30	20
Pharmacy		30	10
Hemodialysis Centers		30	10
Home Health		60	60
Specialty Care			
OB/GYN ⁴	1:10,000	30	15
Allergy/Immunology	1:100,000	60	60
Cardiology	1:20,000	60	60
Dermatology	1:40,000	60	60
Endocrinology and Metabolism ⁷	1:25,000	60	60
Gastroenterology	1:30,000	60	60
Hematology/Oncology	1:80,000	60	60
Nephrology	1:50,000	60	60
Neurology ⁷	1:35,000	60	60
Ophthalmology	1:20,000	60	60
Orthopedics ⁷	1:15,000	60	60
Otorhinolaryngology/ Otolaryngology	1:30,000	60	60

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Type ¹	Network Ratio ² (Provider: Member)	Rural Parishes ³ (miles)	Urban Parishes ³ (miles)
Urology	1:30,000	60	60
Other Specialty Care		60	60

Type ¹	Rural Parishes ³ (miles)	Urban Parishes ³ (miles)
Psychiatrists	30	15
Specialty Care		
Physicians and LMHPs who specialize in pregnancy-related and postpartum depression or related mental health disorders and pregnancy-related	60	60
Physicians and LMHPs who specialize in pregnancy-related and postpartum substance use disorders	60	60
Other Specialty Care	60	60
Licensed Mental Health Specialists^{7,9}		
Advanced Practice Registered Nurse (Nurse Practitioners and Clinical Nurse Specialists with a behavioral health specialty)	30	15
Medical or Licensed Psychologist	30	15
Licensed Clinical Social Worker	30	15
Psychiatric Residential Treatment Facilities (PRTFs) (pediatric⁵)⁹		
Psychiatric Residential Treatment Facility	200	200
Psychiatric Residential Treatment Facility Addiction (ASAM Level 3.7)	200	200
Psychiatric Residential Treatment Facility Other Specialization	200	200
Substance Abuse and Alcohol Abuse Center - Outpatient		
ASAM Level 1	30	15
ASAM Level 2.1	30	15
ASAM Level 2WM	60	60
Substance Use Residential Treatment Facilities (adult⁵)		
ASAM Levels 3.1	30	30
ASAM Levels 3.3	30	30
ASAM Levels 3.5	30	30
ASAM Levels 3.2 –Withdrawal Management	60	60
ASAM Level 3.7	60	60
ASAM Level 3.7-Withdrawal Management	60	60
Substance Use Residential Treatment Facilities (pediatric⁵)		
ASAM Level 3.1	60	60
ASAM Level 3.2 Withdrawal Management	60	60
ASAM Level 3.5	60	60
Psychiatric Inpatient Hospital Services⁹		
Hospital, Free Standing Psychiatric Unit	90	90
Hospital, Distinct Part Psychiatric Unit	90	90
Behavioral Health Rehabilitation Services⁹		
Mental Health Rehabilitation Agency (Legacy MHR)	30	15

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Behavioral Health Rehab Provider Agency (Non-Legacy MHR)	30	15
¹ For the purposes of assessing Network Adequacy, the MCO shall consider only those Providers who are actively providing services to enrollees, which shall be defined as (1) physical health providers who have submitted at least twenty-five (25) claims in an office setting within the prior six (6) calendar months; (2) behavioral health providers who have submitted at least twenty-five (25) claims within the prior six (6) calendar months; or (3) any providers who were newly contracted within the prior six (6) calendar months, regardless of claim submissions.		
² The network ratio is a calculation of the MCO's Network Providers relative to the MCO's members.		
³ Unless otherwise specified in this Attachment, the Contractor must demonstrate that one hundred percent (100%) of applicable members (adult or pediatric) have access to Network Providers for the type of service specified within the identified distance standard from the Enrollee's residence, based on a driving route versus a straight line calculation.		
⁴ For purposes of assessing Network Adequacy for OB/GYN specialty services, access standards are established based on female members age 18 and over. The Contractor shall not include OB/GYN providers in its assessment of Network Adequacy for Primary Care Services.		
⁵ For purposes of reporting Network Adequacy for physical health services, adult is defined as an Enrollee age 18 and over and pediatric is defined as an Enrollee under age 18 and for behavioral health services, adult is defined as an Enrollee age 21 and over and pediatric is defined as an Enrollee under age 21.		
⁶ In order to be included in the calculation, the Provider must work as a PCP at least 24 hours per week. The MCO may use physician extenders to meet PCP network ratios and distance standards. Physician extenders include nurse practitioners and physician assistants linked to a physician group who provide Primary Care Services. For calculation of the network ratio, each physician extender is counted with a factor of 0.5 while physician PCPs are counted with a factor of 1.0.		
⁷ For these specialties, the travel distance standards shall be applied separately to the Contractor's adult and pediatric member populations and to specialists serving the applicable age group(s).		
⁸ The linkage ratio is a calculation of the MCO's network provider to his/her patients who are Louisiana Medicaid managed care enrollees, regardless of MCO. The linkage ratios specified are applicable to providers who work as PCPs at least 24 hours per week.		
⁹ Network standards are applied across the provider types listed collectively within the identified distance standard from the Enrollee's residence, based on a driving route versus a straight line calculation from the applicable members (adult or pediatric) residences.		

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Table 5: Provider Access and Timeliness Standards

Type of Visit/Admission/Appointment	Access/Timeliness Standard
Emergency care	24 hours, 7 days/week within 1 hour of request
Urgent non-emergency care	24 hours, 7 days/week within 24 hours of request,
Non-urgent sick primary care	72 hours
Non-urgent routine primary care	6 weeks
After hours, by phone	Answer by live person or call-back from a designated medical practitioner within 30 minutes
Ob/Gyn care for pregnant women	
1st Trimester	14 days
2nd Trimester	7 days
3rd Trimester	3 days
High risk pregnancy, any trimester	3 days
Family planning appointments	1 week
Specialist appointments	1 month
Scheduled appointments	Less than a 45 minute wait in office
Non-urgent routine behavioral health care	14 days
Urgent non-emergency behavioral health care	48 hours
Psychiatric inpatient hospital (emergency involuntary)	4 hours
Psychiatric inpatient hospital (involuntary)	24 hours
Psychiatric inpatient hospital (voluntary)	24 hours
ASAM Level 3.3, 3.5 & 3.7	10 business days
Residential withdrawal management	24 hours when medically necessary
Psychiatric Residential Treatment Facility (PRTF)	20 calendar days

Table 6: Dental Access to Care and Network Availability Standards

Network Capacity and Geographic Access Standards
<ul style="list-style-type: none"> The Primary Dental Provider (PDP) may practice in a solo or group practice or may practice in a clinic (i.e. Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC) or outpatient clinic). The Dental Benefit Program Manager (DBPM) shall contract with a sufficient number of PDPs needed to meet the geographic access, appointment, and wait time standards outlined in this contract. The DBPM shall provide access to dentists that offer extended office hours (before 8:00 a.m., after 4:30 p.m., and/or on Saturdays) at least one (1) day per week. Network providers must offer office hours at least equal to those offered by commercial dental insurance plans. If an enrollee requests a provider who is located beyond access standards, and the DBPM has an appropriate provider within the DBPM network who accepts new patients, it shall not be considered a violation of the access requirements for the DBPM to grant the enrollee's request. The DBPM shall not

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<p>submit encounters for travel outside of the access standards if an appropriate provider was available within the access standards.</p> <ul style="list-style-type: none"> The DBPM shall comply with the following maximum distance requirements, as determined by mapping software (e.g. MapQuest, Google Maps, ArcGIS). Requests for exceptions as a result of prevailing community standards must be submitted in writing to LDH for approval.
Distance to Primary Dental Services
<ul style="list-style-type: none"> Travel distance from enrollee's place of residence shall not exceed thirty (30) miles one-way for rural areas and ten (10) miles one way for urban areas.
Distance to Specialty Dental Services
<ul style="list-style-type: none"> Travel distance shall not exceed sixty (60) miles one-way from the enrollee's place of residence for at least seventy-five (75) percent of enrollees and shall not exceed seventy-five (75) miles one-way from the enrollee's place of residence for all enrollees. <ul style="list-style-type: none"> The DBPM shall ensure, at a minimum, the availability of the following specialists and other providers for enrollees under the age of twenty-one (21) years: <ul style="list-style-type: none"> Endodontists; Maxillofacial Surgeons; Oral Surgeons; Orthodontists; Pedodontists; Periodontists; Prosthodontists; and Special Needs Pedodontists.
Timely Access Standards
<ul style="list-style-type: none"> Urgent care services – within twenty-four (24) hours of a request for services that do not require prior authorization and within forty-eight (48) hours for a request for services that do require prior authorization; <ul style="list-style-type: none"> Primary Dental Care – within thirty (30) days; and Follow-up Dental Services – within thirty (30) days after assessment.

Table 7: Access Performance Standards

Access Performance Standards
Delivery Network
<p>Contracted network of appropriate providers (42 CFR 438.206(b)(1))</p> <p>Each MCO must meet the following requirements.</p> <ul style="list-style-type: none"> Maintains and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, each MCO must consider the anticipated Medicaid enrollment, the expected utilization of services, and take into consideration the characteristics and health care needs of specific, Medicaid populations enrolled. The MCO must also consider the numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services, the number of network providers who are not accepting new Medicaid patients, and the geographic location of providers and Medicaid enrollees. Distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, will be considered and whether the location provides physical access for Medicaid enrollees with disabilities.

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- The MCO networks must be comprised of hospitals, physicians and specialists in sufficient numbers to make available all covered services in a timely manner.
- The primary care network of the MCO must have at least 1 full time equivalent PCP for every 2,500 patients. Physicians with physician extenders (nurse practitioner/physician assistant, certified nurse midwife or OB/GYNs only) may increase the physician ration by 1,000 per extender. The maximum number of extenders shall not exceed two extenders per physician.
- The MCO shall ensure the availability of timely access to hospital care. Transport time will be usual and customary, not to exceed 30 miles, except in rural areas where distance may be greater. If greater, the standard shall be the community standard for accessing care. Exceptions must be justified, documented, and submitted to LDH for approval. The MCO shall include, at a minimum, access to the following:
 - One (1) hospital that provides emergency room services, inpatient, and outpatient care in each parish in the state, provided the parish has such a hospital (free standing psychiatric hospitals and distinct part psychiatric hospitals do not meet this requirement). The MCO must establish access to the following within their network of hospitals:
 - Level III Obstetrical services;
 - Level III Neonatal Intensive Care (NICU) services;
 - Pediatric services;
 - Trauma services;
 - Burn services; and
 - A Children's Hospital that meets the CMS definition in 42 C.F.R. §495.302 and §412.23(d).
 - Tertiary care is defined as health services provided by highly specialized providers, such as medical sub-specialists; these services frequently require complex technological and support facilities. The MCO shall provide tertiary care services including trauma centers, burn centers, level III (high-risk) nurseries, rehabilitation facilities, and medical sub-specialists twenty-four (24) hours per day. If the MCO does not have a full range of tertiary care services, the MCO shall have a process for providing such services including transfer protocols and arrangements with out-of-network providers.

Timely services for enrollees 438.3(q)(3)

- Each MCO must provide for arrangements with, or referrals to, sufficient numbers of physicians and other practitioners to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care.

Direct Access to Women's Health Specialist (42 CFR 438.206(b)(2))

- Provides female enrollees with direct access to women's health specialist within the network for covered care, necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.
- Contractors must ensure that the network procedures for accessing family planning services are convenient and easily comprehensible to enrollees.
- A women's health specialist may serve as a primary care provider.

Adequate and Timely Second Opinion (42 CFR 438.206(b)(3))

- Provides for a second opinion from a qualified health care professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.

Adequate and Timely Out-of-Network Providers (42 CFR 438.206(b)(4) & (b)(5))

- If the provider network is unable to provide necessary services, covered under the contract, to a particular enrollee, the MCO must adequately and timely cover these services out of network for the enrollee, for as long as the MCO provider network is unable to provide them.

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<ul style="list-style-type: none"> Requires out-of-network providers to coordinate with the MCO with respect to payment and ensures that cost to the enrollee is no greater than it would be if the services were furnished within the network.
Provider Credentialing as required in regulation (42 CFR 438.206(b)(6)) <ul style="list-style-type: none"> Demonstrates that its providers are credentialed as required by § 438.214
Timely Access (42 CFR 438.206(c)(1)(i-vi)) <ul style="list-style-type: none"> Each MCO must meet and require its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. Standards for access and timeliness are identified in the Provider Network Companion Guide. Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees. Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary. Establish mechanisms to ensure compliance by network providers, take corrective action if there is a failure to comply. Monitor network providers regularly to determine compliance Take corrective action if there is a failure to comply by a network provider.
Reasonable and Adequate Hours of Operation 438.3(q)(1) <ul style="list-style-type: none"> Each MCO must provide for reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment for emergency medical conditions.
Cultural Considerations (42 CFR 438.206(c)(2)) <ul style="list-style-type: none"> Each MCO participates in the state's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds. <ul style="list-style-type: none"> The MCO is required to have available interpretive services for all languages other than English upon request. The MCO will encourage and foster cultural competency in its employees.
Assurances of Adequate Capacity 438.207
Documentation and Assurances of Adequate Capacity and Services (42 CFR 438.207 (b), (c)) <ul style="list-style-type: none"> Each MCO must give assurances to the state and provide supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area and in accordance with the State's standards for access to care including § 438.68 and § 438.206(c)(1) <ul style="list-style-type: none"> <i>Nature of supporting documentation:</i> Each MCO must submit documentation to the state, in a format specified by the state to demonstrate that it complies with the requirements below. <ul style="list-style-type: none"> Offers an appropriate range of preventive, primary care, and specialty services that are adequate for the anticipated number of enrollees for the service area. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area. <i>Timing of documentation:</i> Each MCO must submit the required documentation, no less frequently than: <ul style="list-style-type: none"> at the time it enters into a contract with the state or at any time there has been a significant change (as defined by the state) in the MCO operations that would affect adequate capacity and services, including changes in Contractor services, benefits, geographic service area, payments or enrollment of a new population with the MCO.
Coordination and Continuity of Care 438.208

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Except as specified below, the State must ensure that through its contracts, each MCO complies with the requirements of this section.

- **Exception for MCOs that serve dually eligible enrollees.**

- For a MCO that serves enrollees who are also enrolled in and receive Medicare benefits from a Medicare+Choice plan, the state determines to what extent that a MCO must meet the primary care coordination, identification, assessment, and treatment planning provisions of this section.
- The state bases its determination on the services it requires the MCO to furnish to dually eligible enrollees.

- **Primary care and coordination of health care services for all MCO enrollees.**

Each MCO must implement procedures to deliver primary care to and coordinate health care services for all MCO enrollees. These procedures must meet state requirements and must do the following:

- Ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity designated as primarily responsible for coordinating the health care services furnished to the enrollee.
- Coordinate the services the MCO furnishes to the enrollee with the services the enrollee receives from any other MCO, PIHP, or PAHP, with services the enrollee receives in FFS; and with the services the enrollee receives from community and social support providers.
- Provide that the MCO makes a best effort to conduct an initial screening of each enrollee's needs, within 90 days of the effective date of enrollment for all new enrollees, including subsequent attempts if the initial attempt to contact the enrollee is unsuccessful.
- Share with the State or other MCOs serving the enrollee the results of any identification and assessment of that enrollee's needs to prevent duplication of those activities.
- Ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.

- **MCO contract §6.39 (Case Management)**

- The MCO shall maintain a case management program through a process which provides appropriate and medically-related services, social services, and basic and specialized behavioral health services that are identified, planned, obtained and monitored for identified members who are in the special healthcare needs (SHCN) population and identified members who have high risk or have unique, chronic, or complex needs.
- The process shall integrate the member's and case manager's review of the member's strengths and needs resulting in a mutually agreed upon appropriate plan that meets the medical, functional, social and behavioral health needs of the member.

- **Identification and Assessment (42 CFR 438.208(c)(1)(2))**

- Identification. The State must implement mechanisms to identify persons who need LTSS or persons with SHCN needs to MCO, as those persons are defined by the State. These identification mechanisms:
 - Must be specified in the State's quality strategy in § 438.340; and
 - May use State staff, the State's enrollment broker, or the State's MCOs.
- Assessment: Each MCO must implement mechanisms to comprehensively assess each Medicaid enrollee identified by the State (through the mechanism specified in paragraph (c)(1) of this section) and identified to the MCO by the State as LTSS or SHCN in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate providers or individuals meeting LTSS service coordination requirements of the State or the MCO as appropriate.

- **Mechanisms for Enrollees with SHCN or who need LTSS (42 CFR 438.208(c)(3))**

- Treatment/service plans: MCOs must produce a treatment or service plan meeting the criteria in paragraphs (c)(3)(i) through (v) of this section for enrollees who require LTSS and, if the State requires,

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must produce a treatment or service plan meeting the criteria in paragraphs (c)(3)(iii) through (v) of this section for enrollees with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring. The treatment or service plan must be:

- Developed by an individual meeting LTSS service coordination requirements with enrollee participation, and in consultation with any providers caring for the enrollee;
- (ii) Developed by a person trained in person-centered planning using a person-centered process and plan as defined in § 441.301(c)(1) and (2) of this chapter for LTSS treatment or service plans;
- (iii) Approved by the MCO, PIHP, or PAHP in a timely manner, if this approval is required by the MCO, PIHP, or PAHP;
- (iv) In accordance with any applicable State quality assurance and utilization review standards; and
- (v) Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the enrollee's circumstances or needs change significantly, or at the request of the enrollee per § 441.301(c)(3) of this chapter.

○ .

Mechanisms for Enrollees with SHCN: Direct Access to Specialists (42 CFR 438.208(c)(4))

- Direct access to specialists: For enrollees with SHCN determined through an assessment (consistent with § 438.208(c)(2)), to need a course of treatment or regular care monitoring, each MCO must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

Coverage and Authorization of Services §438.210

- The State must ensure through its contracts with each MCO complies with the requirements of this section.
 - Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer.
 - Require that the services identified in paragraph §438.210 (a)(1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS Medicaid, as set forth in § 440.230 and for enrollees under the age of 21, as set forth in subpart B of part 441.
- Provide that the MCO:
 - Must ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.
 - May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary.
- The MCO may place appropriate limits on a service based criteria applied under the State plan, such as medical necessity or for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose. The MCO must also specify what constitutes "medically necessary services" in a manner that:
 - is no more restrictive than that used in the State Medicaid program as indicated in State statutes and regulations, the State plan, and other state policy and procedures manuals; and
 - addresses the extent to which the MCO is responsible for covering services related to the following:
 - The prevention, diagnosis, and treatment of enrollee's disease, condition and/or disorder that results in health impairments and/or disability;

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- The ability to achieve age-appropriate growth and development
- The ability to attain, maintain, or regain functional capacity and
- The opportunity for an enrollee receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

Policies and Procedures for Authorization of Services (42 CFR 438.210(b)(1), (2), and (3))

- For the processing of requests for initial and continuing authorizations of services, each contract must require:
 - That the MCO and its subcontractors have in place, and follow, written policies and procedures.
 - That the MCO
 - Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and
 - Consult with the requesting provider when appropriate.
 - Authorize LTSS based on an enrollee's current needs assessment and consistent with the person-centered service plan.
 - That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs.

Notice of Adverse Action (42 CFR 438.210(c))

- Each contract must provide for the MCO to notify the requesting provider, and give the enrollee written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of §438.404, except that the notice to the provider need not be in writing. For Medicaid contracts with an applicable integrated plan, as defined in § 422.561, in lieu of the provisions in this paragraph governing notices of adverse benefit determinations, the provisions set forth in §§ 422.629 through 422.634 apply to determinations affecting dually eligible individuals who are also enrolled in a dual eligible special needs plan with exclusively aligned enrollment, as defined in § 422.2

Timeframe for decisions (42 CFR 438.210(d))(1), (2)&(e)

- Each MCO contract must provide for the following decisions and notices:
 - **Standard authorization decisions:** For standard authorization decisions, provide notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days, following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if:
 - The enrollee, or the provider, requests extension: or
 - The MCO justifies (to the state agency upon request) a need for additional information and the extent to which the extension is in the enrollee's interest.
 - **Expedited authorization decisions:** For cases in which a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service.

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- The MCO may extend the 72-hour time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.
- **Compensation for utilization management activities:** Each contract between the State and MCO must provide that, consistent with §§438.3(i), and §422.208 of this chapter, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.

Emergency and Post-Stabilization Care Service (42 CFR 438.114)

The MCOs will comply with the definitions used in this section:

- **Emergency medical condition** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:
 - Placing the health of the individual (or for pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
 - Serious impairment to bodily functions; or
 - Serious dysfunction of any bodily organ or part.
- **Emergency services** means covered inpatient and outpatient services that are:
 - Furnished by a provider that is qualified to furnish emergency services.
 - Needed to evaluate or stabilize an emergency medical condition.
- **Post-stabilization care services** means covered services, related to an emergency medical condition, that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or, under the circumstances described in paragraph (e) of this section, to improve or resolve the enrollee's condition.

Coverage and payment: MCOs are responsible for coverage and payment of emergency services and post-stabilization care services.

Coverage and payment: Emergency services.

(1) The entities identified in this section -

- Must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the MCO; and
- May not deny payment for treatment obtained under either of the following circumstances:
 - An enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in paragraphs (1), (2), and (3) of the definition of emergency medical condition in this section.
 - A representative of the MCO instructs the enrollee to seek emergency services.

Additional rules for emergency services.

(1) The MCOs may not -

- Limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms; and
- Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's primary care provider, MCO or applicable State entity of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services.

(2) An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

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(3) The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in paragraph (b) of this section as responsible for coverage and payment.

Coverage and payment: Post-stabilization care services. Post-stabilization care services are covered and paid for in accordance with provisions set forth in 42 CFR §422.113(c). In applying those provisions, reference to “MA organization” and “financially responsible” must be read as reference to the entities responsible for Medicaid payment, as specified in paragraph (b) of this section, and payment rules governed by Title XIX of the Act and the States.

(2) MA organization financial responsibility. The MA organization -

- Is financially responsible (consistent with § 422.214) for post-stabilization care services obtained within or outside the MA organization that are pre-approved by a plan provider or other MA organization representative;
- Is financially responsible for post-stabilization care services obtained within or outside the MA organization that are not pre-approved by a plan provider or other MA organization representative, but administered to maintain the enrollee's stabilized condition within 1 hour of a request to the MA organization for pre-approval of further post-stabilization care services;
- Is financially responsible for post-stabilization care services obtained within or outside the MA organization that are not pre-approved by a plan provider or other MA organization representative, but administered to maintain, improve, or resolve the enrollee's stabilized condition if –
 - The MA organization does not respond to a request for pre-approval within 1 hour;
 - The MA organization cannot be contacted; or
 - The MA organization representative and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultation. In this situation, the MA organization must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in § 422.113(c)(3) is met; and
- Must limit charges to enrollees for post-stabilization care services to an amount no greater than what the organization would charge the enrollee if he or she had obtained the services through the MA organization. For purposes of cost sharing, post-stabilization care services begin upon inpatient admission.

(3) End of MA organization's financial responsibility. The MA organization's financial responsibility for post-stabilization care services it has not pre-approved ends when -

- A plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care;
- A plan physician assumes responsibility for the enrollee's care through transfer;
- An MA organization representative and the treating physician reach an agreement concerning the enrollee's care; or
- The enrollee is discharged.

Applicability to PIHPs and PAHPs. To the extent that services required to treat an emergency medical condition fall within the scope of the services for which the *PIHP or PAHP* is responsible, the rules under this section apply.

3.2 Adoption & Dissemination of Evidence-Based Clinical Practice Guidelines

The application of evidence-based clinical practice guidelines has proven to reduce variation in treatment, resulting in improved quality. The MCO's development and use of evidence-based clinical practice guidelines for physical and behavioral health is expected and must be consistent with the requirements of 42 CFR 438.236:

- Are based on valid and reliable clinical evidence or a consensus of providers in the particular field;
- Consider the needs of enrollees;
- Are adopted in consultation with; and
- Are reviewed and updated periodically as appropriate.

LDH expects MCOs to coordinate the development of clinical practice guidelines with other MCOs and Louisiana Medicaid clinical leadership team through the process established to create provider manual updates, to avoid providers receiving conflicting practice guidelines.

MCOs must use clinical care standards and/or practice guidelines to objectively evaluate the care the MCO delivers or fails to deliver for targeted clinical conditions. These guidelines and/or clinical care standards must be formally adopted by the MCO's Quality Assessment and Performance Improvement (QAPI) Committee and disseminated to all affected providers and, upon request, to enrollees and potential enrollees. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply must be consistent with the guidelines. MCOs must monitor adherence to practice guidelines by medical record reviews and performance measure outcomes.

Examples of evidence-based practices guidelines plans are required to use are in the following categories:

- Federal guidelines (e.g., Agency for Healthcare Research and Quality evidence reviews and United States Preventive Service Taskforce recommendations)
- Specialty society guidelines (e.g., the Infectious Diseases Society of America/American Association for the Study of Liver Diseases Hepatitis C treatment guidelines)
- Other clinical practice guidelines produced by other organizations (e.g., Milliman Care Guidelines)

3.3 Transition of Care Policy

LDH monitors the development and maintenance of effective continuity of care activities to ensure a continuum of care approach to enrollees. MCOs are required to provide service authorization, referrals, coordination, and/or assistance in scheduling the covered services consistent with standards as defined in the Louisiana Medicaid State Plan and as specified in the terms of the MCO contract.

The MCO shall provide active assistance to enrollees when transitioning to another MCO or to Medicaid FFS. A receiving MCO is responsible for the provision of medically necessary services during the transition period that shall not exceed thirty (30) calendar days from the effective date of the enrollee's enrollment in the receiving MCO unless the enrollee has been identified as an individual with special health care needs. The MCO shall provide continuation/coordination of services for enrollees identified as having special health care needs up to ninety (90) calendar days or until the enrollee may be reasonably transferred without disruption, whichever is less. During the transition period, the receiving MCO shall be

responsible for notification to the new primary care provider of the enrollee's selection, initiation of the request of transfer for the enrollee's medical files, and arrangement of medically necessary services.

If an enrollee is to be transferred between MCOs but is hospitalized at the time, the transfer shall be effective for the date of enrollment into the receiving MCO; however, the relinquishing MCO is responsible for the enrollee's hospitalization until the enrollee is discharged. The receiving MCO is responsible for all other care.

The MCO shall not require service authorization for the continuation of medically necessary covered services of a new enrollee transitioning into the MCO, regardless of whether such services are provided by an in-network or out-of-network provider; however, the MCO may require prior authorization of services beyond thirty (30) calendar days. For the first thirty (30) calendar days of enrollment, the MCO is prohibited from denying prior authorization solely on the basis of the provider being an out-of-network provider.

3.4 Mechanisms Used to Identify Persons with Special Health Care Needs (SHCN)

An enrollee with SHCN is an individual of any age with a mental disability, physical disability, or other circumstance that places his or her health and ability to fully function in society at risk, and thus requires individualized health care requirements. Identification mechanisms should include:

- The MCO's use of historical claims data (if available) to identify enrollees who meet Medicaid managed care program eligibility criteria for SHCN. Enrollees with Special Health Care Needs is defined as individuals of any age with a behavioral health disability, physical disability, developmental disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized care approaches. Enrollees with Special Health Care Needs shall include any enrollees who:
 - have complex needs such as multiple chronic conditions, co-morbidities, and co-existing functional impairments;
 - are at high risk for admission/readmission to a hospital within the next six (6) months;
 - are at high risk of institutionalization;
 - have been diagnosed with a Serious Emotional Disturbance, a Severe and Persistent Mental Illness, or a Substance Use Disorder, or otherwise have significant behavioral health needs;
 - are homeless as defined in Section 330(h)(5)(A) of the Public Health Services Act and codified by the US Department of Health and Human Services in 42 U.S.C. 254(b);
 - are women with high-risk pregnancies (i.e., pregnancies that have one or more risk factors) or who have had an adverse pregnancy outcome during the pregnancy, including preterm birth of less than thirty-seven (37) weeks;
 - have been recently incarcerated and are transitioning out of custody;
 - are at high risk of inpatient admission or Emergency Department visits, including certain enrollees transitioning care across acute hospital, chronic disease and rehabilitation hospital or nursing facility setting;
 - are members of the Department of Justice (DOJ) Agreement Target Population;
 - are enrolled under the Act 421 Children's Medicaid Option; or
 - receive care from other state agency programs, including but not limited to programs through Office of Juvenile Justice (OJJ), Department of Children and Family Services (DCFS), or Office of Public Health (OPH).

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- The MCO must use claims data and other available data to identify enrollees who meet the SHCN criteria on at least a monthly basis.
- Primary care physicians can identify enrollees with SHCN at any time. An appropriate healthcare professional must conduct an assessment of those enrollees within 90 days of identification. If an assessment determines a course of treatment or regular care monitoring, referral for case management will be provided.
- Enrollees may also self-identify as SHCN to either the Enrollment Broker or the MCO.
- MCOs monitor and assess the appropriateness of care furnished to individuals with SHCN through various means including but not limited to evaluation of the quality assessment and performance improvement programs, comprehensive care management program reporting, care coordination, and use of the CAHPS Children with Chronic Conditions survey
- Louisiana implemented Act 421 enacted by the Louisiana Legislature effective January, 1, 2022. The program is titled the Act 421 Children’s Medicaid Option (“Act 421-CMO”). The Act 421-CMO extends Medicaid eligibility to children covered by § 1902(e)(3) of the Social Security Act, i.e., children age 18 and younger who meet institutional level of care (Nursing Facility, Hospital, Intermediate Care Facility for Individuals with Intellectual/Developmental Disabilities) and are in families with income that is too high to qualify for Medicaid, who could otherwise become Medicaid eligible if receiving extended care in an institutional setting.
 - The Demonstration option allows these children with disabilities to become Medicaid eligible based on their own resources in order to receive medical services in less-costly home-settings instead of an institution.
 - The 1115 demonstration waiver authority is to be used to provide coverage to eligible children but with a condition of coverage that families maintain pre-existing private major medical health insurance (obtained through employment or the private insurance market) unless the family demonstrates that maintaining private insurance would create a financial hardship for the family and meets good cause exception criteria.
 - The enrollment cap for 421-CMO is the number of children who can be served based on annual legislative appropriation. With the exception of children with dual coverage in Medicare and Medicaid, enrollment in managed care is required of all participants in order to control costs and enhance budget predictability.

3.5 Mechanism Used to Determine Disability Status of Members

LDH defines “disability status” as whether or not the individual qualified for Medicaid on the basis of disability. LDH uses the Supplemental Security Income (SSI) program’s definition of disability, which is an “inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.”

To determine an individual’s disability status, LDH uses the Social Security Administration’s SSI sequential evaluation process for assessing disability. The sequential evaluation process is a series of steps followed in a set order that evaluate whether or not the individual meets the above-mentioned definition of disability.

Data sources used to evaluate if an individual meets the definition of “disabled” using the SSI sequential evaluation process include financial information obtained from one or a combination of the State Wage

Information Collection Agency (SWICA), Internal Revenue Service (IRS), Social Security Administration (SSA), and state unemployment insurance; medical records to determine the individual's physical and/or mental condition severity and ability to perform work-related activities; social interview with the individual; and a residual functional capacity assessment if indicated by the sequential evaluation.

3.6 Non-Duplication Strategy

The CMS External Quality Review (EQR) regulations (42 CFR 438.360) allow for non-duplication of mandatory EQR activities at the state's discretion. These regulations permit use of information about an MCO obtained from a private accreditation review to be used in the annual EQR if certain conditions are met. These conditions include, but are not limited to, compliance with the standards established by a national accrediting organization when the organization's standards are comparable to the federal standards. For MCOs achieving accreditation, the LDH External Quality Review Organization (EQRO) can use the toolkits produced by the accrediting organizations and the MCO-specific accreditation reports/results to identify standards meeting federal and state regulatory requirements. The EQRO can then use the accrediting organization's results for those standards.

Should the state determine in the future that a private accreditation activity (e.g., National Committee on Quality Assurance [NCQA] accreditation) is comparable to any other EQR activities, the state will work with the EQRO to identify any areas in the NCQA accreditation program that may be redundant with the EQR review and deem these activities accordingly.

4 EVALUATING, UPDATING, AND DISSEMINATING THE QUALITY STRATEGY

4.1 Quality Strategy Development and Public Comment

The Quality Strategy reflects significant stakeholder input as well as thoughtful consideration of the quality priorities and issues that are most important in Louisiana. Through multiple, ongoing public stakeholder forums across the state and engagement with the Medical Care Advisory Committee, LDH specifies a set of measures that represent critical targets to improve the quality of care and health outcomes for Medicaid enrollees.

In 2017, in preparation for Louisiana’s transition to its VBP program, Medicaid conducted “A Deep Dive into Quality” through a series of public town hall meetings across the state. Led by Medicaid’s Chief Medical Officer and Chief Transformation Officer for Quality Improvement, LDH traveled to seven regions of the state to gain stakeholder input on quality measurement priorities that best reflect the needs and desired health outcomes of Medicaid enrollees. The results of this effort culminated in the prioritized set of MCO incentivized and monitored quality performance measures referenced in Section 2, Driving Improvement and Monitoring Progress, as ratified by the Medical Care Advisory Committee.

Later, in 2018, Medicaid conducted another series of public stakeholder events titled, “Paving the Way to a Healthier Louisiana: Advancing Medicaid Managed care,” to communicate its future vision for the Medicaid managed care program and gain stakeholder input on key managed care policies. These events laid the foundation for managed care policy priorities, including the Quality Strategy Priority Areas, Goals and Objectives, as described in Section 1, Managed Care Goals, Objectives and Overview.

In preparation for the changes to the Medicaid managed care program effective 2021, LDH updated its MCO quality performance measures (currently referenced in Section 2, Driving Improvement and Monitoring Progress) to best align with the priorities and objectives of the Louisiana Managed Care Quality Strategy and other LDH Department-wide priorities. LDH undertook a broad public stakeholder input process across major regions of the state in early 2019. As part of this effort, LDH worked in concert with the Medical Care Advisory Committee to reach consensus on the final set of performance measures.

In accordance with the state’s Tribal consultation policy, tribal notification was also made to request further input into the Quality Strategy. In parallel, prior to finalizing the Quality Strategy, LDH made the Quality Strategy available for public comment and incorporated edits as appropriate. LDH made the final Quality Strategy available on its website.

In revising the Quality Strategy, the state will make the document available for public comment before submission to CMS for review in accordance with 42 CFR 438.340(c).

4.2 Quality Strategy Review, Update, and Evaluation

The Quality Strategy will be reviewed and updated as needed, but no less than once every three years as required by the CMS Medicaid Managed Care Final Rule or when there is a significant change, defined as any change to the Quality Strategy that may reasonably be foreseen to materially affect the delivery or measurement of the quality of health care services. The Quality Strategy review includes an evaluation of the effectiveness of the quality strategy. Currently, the state’s EQRO conducts an in-depth, independent

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evaluation and produces an annual report on the implementation and effectiveness of the Quality Strategy. This evaluation can include feedback from both internal and external stakeholders. The Quality Strategy Evaluation report is published on LDH's website.

Updates to the Quality Strategy take into consideration recommendations provided by the state's EQRO. The 2023 and 2024 Quality Strategy Evaluation reports included the following recommendations:

Table 8: EQRO Quality Strategy Evaluation Recommendations & Associated Actions

Recommendation	State Action
The EQRO recommends that LDH consider removing the target objectives and improvement objectives and establish benchmarks for all managed care entities (MCEs) that align with nationally recognized quality measures.	LDH utilizes nationally standardized performance targets and will continue to use its existing method for identifying target and improvement objectives.
The EQRO recommends that LDH consider using the measurement year 2023 reported rates in the 2024 quality strategy evaluation.	LDH agrees to use the MY2023 reported rates in the 2024 quality strategy evaluation.
The EQRO recommends that LDH remove the duplicate objective "promote health development and wellness in children and adolescents."	LDH has updated the Quality Strategy to remove this duplicate objective.
The EQRO recommends LDH consider adding the objectives "improve overall health" and "promote reproductive health" because those objectives are included in Appendix A.	LDH has updated the Quality Strategy to include these two objectives.
The EQRO recommends that LDH continue to collaborate with the MCOs and meet regularly to support adequate QI capacity, skills, and resources to support current and future PIPs. The EQRO also recommends LDH consider incorporating a similar PIP collaboration process for the PAHPs. Lastly, the EQRO recommends that LDH consider hosting a forum in which the MCEs could discuss program wide solutions to overcome barriers.	LDH will continue to meet and collaborate with the MCOs related to PIPs. LDH agrees with the EQRO's recommendation to incorporate a similar PIP collaboration process for the PAHPs and the process is currently being developed. Lastly, LDH considers the monthly PIP meetings to be an avenue for discussing program wide solutions to overcome barriers.
The EQRO recommends that LDH identify expectations for improvement targets over a three-year period. Current target improvements compare to the previous measurement year and do not consider the baseline measurement year.	LDH monitors improvement over time using the Quality Dashboard. Improvements are compared between MCOs, the statewide average, and NCQA Quality Compass benchmarks.
The EQRO recommends that the MCEs consider whether there are disparities within their populations that contributed to lower performance in a stratified demographic and that the MCEs target QI interventions to reduce the identified disparities.	The MCOs document this process in their annual Health Equity Plans.
The EQRO recommends that LDH consider working with the MCEs to share performance	LDH currently work with the MCEs collaboratively during monthly and quarterly PIP

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measure best practices and identify interdependencies across measures.	meetings as well as quarterly MAC meetings. The MAC consist of MCE CMOs. Best practices are discussed frequently. In addition, LDH meets with the MCO CEOs and other support staff during quarterly business reviews to discuss recommendations and best practices.
HSAG recommends that LDH consider a contract statement for all MCEs that the MCE's quality initiatives must be designed to help achieve the goals outlined in the quality strategy. Currently only the MCOs have this contract requirement.	LDH plans to add a similar statement to the Dental contract. Quality is being revamped and expanded for Dental. LA Medicaid will also work with OBH to incorporate in the CSOC contracts.
The EQRO recommends that LDH consider removing AIM statements from the quality strategy. CMS defines "quality strategy goals" as SMART high-level managed care performance aims that provide direction for the State. CMS defines quality strategy (SMART) objectives as measurable steps toward meeting the State's goals that typically include quality measures.	LDH has updated the Quality Strategy to incorporate the CMS National Quality Strategy's priority areas and goals.
<p>To improve programwide performance in support of LDH's quality strategy goals, the EQRO recommends LDH identify a measure to align with the following objectives:</p> <ul style="list-style-type: none"> • Ensure appropriate hospice onboarding and transitioning from palliative care to hospice • Promote early initiation of palliative care to improve quality of life • Promote health development and wellness in children and adolescents • Advance specific interventions to address SDOH • Advance value-based payment arrangements and innovation • Ensure members who are improving or stabilized in hospice are considered for discharge 	LDH will review nationally standardized measures to ensure if inclusion is appropriate. LDH has alternative mechanism to monitor and track these objectives.
To target improvement in Goal #3, "Facilitate patient-centered, whole person care," the EQRO recommends LDH include performance measures for the PAHPs and PIHP in the quality strategy.	The PAHP performance measures are identified in the DBPM contract.
To target improvement in Goal #3, "Facilitate patient-centered, whole person care," the EQRO	LDH agrees and will work on implementing a collaborative PIP process for the PAHPs.

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recommends LDH continue to implement a PIP collaboration process for the PAHPs to collaborate on current and future PIPs.	
To improve programwide performance in support of LDH's quality strategy goals, the EQRO recommends that LDH continue to work with the MCEs during PIP and MAC meetings to discuss best practices for performance measures. During these discussions, LDH could focus on specific performance measures in the quality strategy that have not met improvement objectives and target objectives.	LDH agrees and has implemented this recommendation.
To improve MCO performance in Goal #6, "Partner with communities to improve population health and address health disparities," the EQRO recommends that LDH dedicate time in established meetings with the MCOs to discuss their health equity plans and the progress being made through quality interventions to reduce health disparities.	LDH agrees and has implemented this recommendation.
To improve programwide performance in support of LDH's quality strategy goals, the EQRO recommends that LDH update performance measures in the quality strategy to align with the requirements in the Performance Measure Submission Guide for the MCOs.	These recommended revisions have been made to the Quality Strategy.
To target improvement in Goal #1, "Ensure access to care to meet enrollee needs," the EQRO recommends LDH assess MCO failure to provide NEMT and have the MCOs implement interventions to improve provision of NEMT and ensure it is timely and accessible.	LDH agrees and has implemented this recommendation. It is handled by the Medicaid NEMT team.
To improve programwide performance in support of LDH's quality strategy goals, HSAG recommends LDH assess areas of noncompliance that resulted in an MCO receiving a notice of monetary penalty. This assessment should identify root causes for noncompliance and then work to identify appropriate interventions to eliminate noncompliance and improve performance.	LDH agrees and has implemented this recommendation. It is handled by the Medicaid Compliance team. Compliance actions are listed online.
<p>• HSAG recommends that LDH report rates for the following measures included in Appendix B of the quality strategy:</p> <ul style="list-style-type: none"> • Enrollment by Product Line • Language Diversity of Membership • Race/Ethnicity Diversity of Membership 	LDH agrees and has implemented this recommendation. MCOs are required to report their rates for these three measures.

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MCO quality performance measure results, stakeholder input on current issues and barriers to health care access and quality, and LDH strategic priorities all inform decisions regarding quality goals and measures. Measures are assessed to determine what, if any, updates should be made, including the addition and removal of measures and the selection of incentive-based measures. Criteria used to make decisions regarding measure recommendations includes:

- **Relevance:** Measures must be relevant to Medicaid enrollees
- **Scientific Soundness:** Measures must be based on evidence produced through research and evaluation, ideally at the national level
- **Feasibility:** Measures initially must meet at least one of three requirements:
 - Be retrievable through routinely collected administrative data
 - Be collected via survey of enrollees or their caretakers
 - Be collected via a medical record review

Additional considerations for decisions regarding quality measures and initiatives include technical aspects, such as whether:

- The measure has been in operation for a sufficient period of time to demonstrate effectiveness
- The measure has demonstrated success documented through tangible results
- The measure is consistent with current policy and evidence-based practice

APPENDIX A: Louisiana Medicaid MCO Performance Measures (Measurement Year 2025 and Subsequent Years)

Aims	Goals	Objectives	\$\$	Measures	Measure Description	Steward
Better Care. Make health care more person-centered, coordinated, and accessible so that enrollees get the right care at the right time in the right place.	Ensure access to care to meet enrollee needs	Ensure timely and approximate access to primary and specialty care		1. Child and Adolescent Well-Care Visits (WCV)	The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	NCQA
				2. Well-Child Visits in the First 30 Months of Life (W30)	The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported: 1. Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits. 2. Well-Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.	
				3. Antibiotic Utilization for Respiratory Conditions (AXR)	The percentage of episodes for members 3 months of age and older with a diagnosis of a respiratory condition that resulted in an antibiotic dispensing event.	
				4. Appropriate Testing for Pharyngitis (CWP)	The percentage of episodes for members 3 years and older where the member was diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode	
				5. Adult Access to Preventive/Ambulatory Services (AAP)	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: <ul style="list-style-type: none">• 20-44 years• 45-64 years• 65 years and older• Total	
				6. Acute Hospital Utilization	For members 18 years of age and older, the risk-adjusted ratio of observed-to-expected acute inpatient and observation stay discharging during the measurement year. Note: For Medicaid, report only members 18-64 years of age.	

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Aims	Goals	Objectives	\$\$	Measures	Measure Description	Steward
			\$\$	7. Follow-Up After Hospitalization for Mental Illness (FUH)	<p>The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported:</p> <ul style="list-style-type: none"> • \$\$: The percentage of discharges for which the member received follow-up within 30 days after discharge. • The percentage of discharges for which the member received follow-up within 7 days after discharge. 	
			\$\$	8. Follow-Up After Emergency Department Visit for Mental Illness (FUM)	<p>The percentage of emergency department (ED) visits for members 6 years of age and older with a diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported:</p> <ul style="list-style-type: none"> • \$\$: The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). • The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days). 	
			\$\$	9. Follow-Up After Emergency Department Visit for Substance Use (FUA)	<p>The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was a follow up. Two rates are reported:</p> <ul style="list-style-type: none"> • \$\$: The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). • The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days). 	
				10. Follow-Up After High Intensity Care for Substance Use Disorder (FUI)	<p>The percentage of acute inpatient hospitalizations, residential treatment or withdrawal management visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder. Two rates are reported:</p> <ol style="list-style-type: none"> 1. The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 30 days after the visit or discharge. 2. The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 7 days after the visit or discharge. 	

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Aims	Goals	Objectives	\$\$	Measures	Measure Description	Steward
	Facilitate patient-centered, whole person care	Engage and partner with enrollees to improve enrollee experience and outcomes		11. Plan All-Cause Readmissions (PCR)	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
				12. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H – Child Version (Medicaid) (CPC)	This measure provides information on parents’ experience with their child’s Medicaid organization.	
				13. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H, Adult Version (Medicaid) (CPA)	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.	
		Integrate behavioral and physical health		14. Children with Chronic Conditions (CCC)	This measure provides information on parents’ experience with their child’s Medicaid organization for the population of children with chronic conditions.	NCQA
				15. Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) <i>(Note: This is a pilot measure and LDH will work with the MCO on strategies to collect this information. This measure is not required for reporting).</i>	The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care. <ul style="list-style-type: none"> <i>Depression Screening.</i> The percentage of members who were screened for clinical depression using a standardized instrument. <i>Follow-Up on Positive Screen.</i> The percentage of members who received follow-up care within 30 days of screening positive for depression. 	
				16. Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	
				17. Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.	
				18. Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)	The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and cardiovascular disease, who had an LDL-C test during the measurement year.	
				19. Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)	The percentage of children and adolescents with ongoing antipsychotic medication use who had metabolic testing during the year	

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Aims	Goals	Objectives	\$\$	Measures	Measure Description	Steward
Healthier People, Healthier Communities. Improve the health of enrollees through evidence-based prevention and treatment interventions that address physical and behavioral health needs.	Promote wellness and prevention	Improve overall health		20. Self-Reported Overall Health (Adult and Child) <i>Note: This measure is from the CAHPS survey. Reporting will be dependent on availability and validity of data.</i>	The percentage of members reporting overall excellent or very good health.	AHRQ
				21. Self-Reported Overall Mental or Emotional Health (Adult and Child) <i>Note: This measure is from the CAHPS survey. Reporting will be dependent on availability and validity of data.</i>	The percentage of members reporting overall excellent or very good mental or emotional health.	
		Ensure maternal safety and appropriate care during childbirth and postpartum	\$\$	22. Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC)	The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.	NCQA
			\$\$	23. Low-Risk Cesarean Delivery	\$\$: 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). <i>Note: A lower rate indicates better performance.</i>	TJC
			\$\$	24. Prenatal and Postpartum Care: Postpartum Care (PPC)	The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year that had a postpartum visit on or between 7 and 84 days after delivery.	NCQA
		Reduce infant mortality		25. Percentage of Low Birthweight Births	Percentage of live births that weighed less than 2,500 grams in the state during the reporting period.	CDC/NCHS
		Promote healthy development and wellness in children and adolescents		26. Developmental Screening in the First Three Years of Life	The percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.	CMS
				27. Lead Screening in Children (LSC)	The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.	NCQA
		Promote oral health in children		28. Topical Fluoride for Children (TFC)	The percentage of members 1-4 years of age who received at least two fluoride varnish applications during the measurement year. Report two age stratifications and a total rate:	NCQA

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Aims	Goals	Objectives	\$\$	Measures	Measure Description	Steward
					<ul style="list-style-type: none"> 1-2 years 3-4 years Total 	
				29. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Assessment for Children/Adolescents (WCC)	<p>The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year.</p> <ul style="list-style-type: none"> BMI percentile documentation Counseling for nutrition Counseling for physical activity <p><i>* Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.</i></p>	
				30. Contraceptive Care – All Women Ages 15 - 20	The percentage of women ages 15-20 who are at risk of unintended pregnancy and were provided a most or moderately effective method of contraception or were provided a LARC. Two rates are reported.	
		Prevent obesity and address physical activity and nutrition in children and adults		31. Contraceptive Care – Postpartum Women Ages 15-20	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 90 days of delivery or were provided a LARC within 3 and 90 days of delivery. Four rates are reported.	NCQA
	Promote reproductive health			32. Contraceptive Care – All Women Ages 21–44	The percentage of women ages 21-44 who are at risk of unintended pregnancy and were provided a most or moderately effective method of contraception or were provided a LARC. Two rates are reported.	OPA
				33. Contraceptive Care – Postpartum Women Ages 21–44	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 90 days of delivery or were provided a LARC within 3 and 90 days of delivery. Four rates are reported.	
				34. Chlamydia Screening (CHL)	The percentage of women 16–24 years of age who were recommended for routine chlamydia screening, were identified as sexually active and had at least one test for chlamydia during the measurement year.	

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Aims	Goals	Objectives	\$\$	Measures	Measure Description	Steward
				35. Cervical Cancer Screening (CCS) – moving to ECDS only	<p>\$\$: The percentage of women 21–64 years of age who were recommended for routine cervical cancer screening who were screened for cervical cancer using any of the following criteria:</p> <ul style="list-style-type: none"> Members 21–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology performed within the last 3 years. Members 30–64 years of age who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years. Members 30–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years. 	
				36. Colorectal Cancer Screening (COL-E)	<p>\$\$: The percentage of members 45-75 years of age who had appropriate screening for colorectal cancer.</p>	NCQA
		Improve cancer screening	\$\$	37. Hepatitis C Virus Screening	<ul style="list-style-type: none"> Percentage of eligible individuals screened for hepatitis C virus infection. 	NCQA
			\$\$	38. Medical Assistance With Smoking and Tobacco Use Cessation (MSC)	<p>Assesses different facets of providing medical assistance with smoking and tobacco use cessation.</p> <p>MCOs will report three components (questions):</p> <ul style="list-style-type: none"> Advising Smokers and Tobacco Users to Quit Discussing Cessation Medications Discussing Cessation Strategies 	
		Improve hepatitis C virus infection screening		39. Controlling High Blood Pressure (CBP)	<p>\$\$: The percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.</p>	State
		Promote use of evidence-based tobacco cessation treatments		40. Diabetes Short-Term Complications Admission Rate 41.	<p>Number of discharges for diabetes short term complications per 100,000 member months per Medicaid enrollees age 18 and older.</p> <ul style="list-style-type: none"> <i>Note: A lower rate indicates better performance.</i> 	NCQA
	Improve chronic disease	Improve hypertension, diabetes, and cardiovascular	\$\$	42. Statin Therapy for Patients with Cardiovascular Disease (SPC)	<ul style="list-style-type: none"> 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 	NCQA

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Aims	Goals	Objectives	\$\$	Measures	Measure Description	Steward
	management and control	disease management and control			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 had statin adherence of at least 80% (who remained on a high or moderate-intensity statin medication for at least 80% of the treatment period.)	
				Heart Failure Admission Rate	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).	AHRQ
				43. Glycemic Status Assessment for Patients With Diabetes (GSD)	The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year: <ul style="list-style-type: none"> • Glycemic Status <8.0%. • Glycemic Status >9.0%. Note: Organizations must use the same data collection method (Administrative or Hybrid) to report these indicators <ul style="list-style-type: none"> • . 	NCQA
				44. Blood Pressure Control for Patients With Diabetes (BPD)	The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year	AHRQ
			\$\$	45. Eye Exam for Patients With Diabetes (EED)	The percentage of members 18–75 years of age with diabetes (types 1 and 2) who had a retinal eye exam	NCQA
				46. Asthma in Younger Adults Admission Rate	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. <i>Note: A lower rate indicates better performance.</i>	NCQA
				47. Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate	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	NCQA

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Aims	Goals	Objectives	\$\$	Measures	Measure Description	Steward
					(COPD) or asthma per 100,000 member months for Medicaid enrollees age 40 and older. <i>Note: A lower rate indicates better performance.</i>	
		Improve respiratory disease management and control		48. Asthma Medication Ratio	The percentage of members 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. Ages 5-64 as of December 31 of the measurement year. Report the following age stratifications and a total rate: <ul style="list-style-type: none"> • 5-11 years • 12-18 years • 19-50 years • 51-64 years • Total 	AHRQ
				49. HIV Viral Load Suppression	\$\$: Percentage of patients age 18 and older with a diagnosis of HIV with a HIV viral load less than 200.	
				50. Pharmacotherapy for Opioid Use Disorder (POD)	The percentage of new opioid use disorder (OUD) pharmacotherapy episodes that resulted in 180 or more covered treatment days among members 16 years <ul style="list-style-type: none"> • of age and older with a diagnosis of OUD 	NCQA
		Improve HIV control	\$\$	51. Initiation and Engagement of Substance Use Disorder Treatment (IET)	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following. <ul style="list-style-type: none"> • Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis. Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional AOD services or medication treatment within 34 days of the initiation visit.	HRSA
		Improve quality of mental health and		52. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	The percentage of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.	NCQA

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Aims	Goals	Objectives	\$\$	Measures	Measure Description	Steward
		substance use disorder care		53. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	<ul style="list-style-type: none"> The percentage of members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period. 	
				54. Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication (ADD-E)	<p>The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported.</p> <ul style="list-style-type: none"> Initiation Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase. <p>Continuation and Maintenance (C&M) Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for 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.</p>	
				55. Measures for stratified data: <ol style="list-style-type: none"> Pregnancy: Percentage of Low Birthweight Births, Contraceptive Care – Postpartum Women Ages 21–44, Prenatal and Postpartum Care (PPC), Low-Risk Cesarean Delivery (LRCD) Child: Well Child Visits in the First 30 Months of Life, Childhood Immunizations (Combo 3), Immunizations for Adolescents (Combo 2), Child and Adolescent Well-Care Visits (WCV) Adult: Colorectal Cancer Screening, HIV Viral Load Suppression, Cervical Cancer Screening 56. Behavioral Health: Follow-Up After Emergency Department Visit for Mental Illness (within 30 days), Follow-Up After Emergency Department Visit for Substance Use (within 30 days), Follow-Up After	*Refer to individual measures	

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Aims	Goals	Objectives	\$\$	Measures	Measure Description	Steward
				Hospitalization for Mental Illness (within 30 days), Initiation and Engagement of Substance Use Disorder Treatment (IET)		
				57. Enrollment by Product Line (ENP)	<ul style="list-style-type: none"> The total number of members enrolled in the product line, stratified by age. 	
	Improve population health and address health disparities	Stratify key quality measures by race/ethnicity, rural/urban status, and sex and narrow health disparities		58. Language Diversity of Membership (LDM)	An unduplicated count and percentage of members enrolled at any time during the measurement year by spoken language preferred for health care and preferred language for written materials.	Various
				59. Race/Ethnicity Diversity of Membership (RDM)	An unduplicated count and percentage of members enrolled any time during the measurement year, by race and ethnicity.	NCQA
				60. Appropriate Treatment for Children With Upper Respiratory Infection (URI)	The percentage of children 3 months–18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription.	
Smarter Spending. Advance high-value, efficient care.	Minimize wasteful spending	Reduce low value care		61. Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)	The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.	NCQA
				62. Use of Imaging Studies for Low Back Pain (LBP)	The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	