State of Louisiana Department of Health

Medicaid Managed Care Quality Strategy Evaluation
Review Period: March 20, 2019 – March 19, 2020

FINAL

September 2020

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

Table of Contents

List of Tables

Introduction

This report is a comprehensive evaluation and progress summary of the Quality Strategy for Healthy Louisiana, the Louisiana Medicaid managed care program.

Authorizing legislation and regulation for state Medicaid managed care programs include the Social Security Act (Part 1915[1] and Part 1932(a)),[2] the Balanced Budget Act of 1997 (BBA)[3] and Title 42, Part 438 of the Code of Federal Regulations (CFR).[4] On May 6, 2016, the Centers for Medicare and Medicaid Services (CMS) published the Medicaid and Children's Health Insurance Program (CHIP) programs; Medicaid Managed Care, CHIP Delivered in Managed Care and Revisions Related to Third Party Liability Final Rule in the Federal Register.[5] The Final Rule modernized Medicaid managed care regulations to reflect changes in the usage of managed care delivery systems and sought to align Medicaid rules with those of other health insurance coverage programs, modernize how states purchase managed care for beneficiaries, and strengthen consumer experience and consumer protections.

According to federal regulations (42 CFR§438.340 et seq.),[6] all states that contract with a managed care organization (MCO) or prepaid inpatient health plan (PIHP) are required to have a written strategy for assessing and improving the quality of managed care services provided to Medicaid enrollees. Louisiana's Medicaid Managed Care Quality Strategy, dated March 2019, is guided by the Triple Aim of the National Quality Strategy.

This summary report details an evaluation of the Quality Strategy for Healthy Louisiana, Louisiana's Medicaid managed care program. To conduct this evaluation, Louisiana Medicaid contracted with IPRO, an external quality review organization. IPRO is a non-profit organization that works with government agencies, providers and patients to implement innovative programs that bring policy ideas to life. For 35 years IPRO has made creative use of clinical expertise, emerging technology and data solutions to make the healthcare system work better. IPRO holds contracts with federal, state and local government agencies, as well as private-sector clients, in more than 34 states and the District of Columbia. IPRO is an EQRO in 11 states. IPRO is headquartered in Lake Success, NY and also has offices in Albany, NY; Hamden, CT; Morrisville, NC; Hamilton, NJ; Beachwood, OH; and San Francisco, CA. IPRO conducted this evaluation between March 20, 2019 and March 19, 2020.

Medicaid Managed Care in Louisiana

On February 1, 2012, the Louisiana Department of Health (LDH) transitioned approximately 900,000 Medicaid enrollees from the state's fee-for-service (FFS) program to a managed care program. The rollout occurred in phases based on designated geographic service areas, resulting in a completed statewide rollout on June 1, 2012.

In 2014, a request for proposal (RFP) was issued for full-risk Medicaid managed care contracts, with a start date of February 1, 2015. The RFP provided for an initial 3-year contract term and the option to extend the contracts up to 24 months. Subsequently, the Louisiana Legislature approved a 23-month extension to these contracts, from February 1, 2018 through the contract expiration date of December 31, 2019. 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.

[1] Social Security Act, Section 1915: http://www.ssa.gov/OP_Home/ssact/title19/1915.htm (Accessed July 13, 2020).
[2] Social Security Act, Section 1932: http://www.ssa.gov/OP_Home/ssact/title19/1932.htm (Accessed July 13, 2020).
[3] Balanced Budget Act of 1997: http://www.govtrack.us/congress/bills/105/hr2015 (Accessed July 13, 2020).
[4] Electronic Code of Federal Regulations, 438 Managed Care: https://www.ecfr.gov/cgi-bin/text-idx?SID=8f10bd38d96ac3f7d64bdda24a553e1c&mc=true&node=pt42.4.438&rgn=div5 (Accessed July 13, 2020).
[5] Medicaid and CHIP Managed Care Final Rule, Federal Register, April 25, 2016: https://www.federalregister.gov/articles/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered (Accessed July 13, 2020).
[6] U.S. Government Publishing Office, Title 42 Public Health: https://www.govinfo.gov/app/details/CFR-2016-title42-vol4/CFR-2016-title42-vol4-sec438-340 (Accessed July 13, 2020).

Louisiana Medicaid currently serves nearly 1.7 million enrollees, approximately 35 percent of the state's population. There are five statewide MCOs: Aetna Better Health (ABH); AmeriHealth Caritas Louisiana (ACLA); Healthy Blue (HB); Louisiana Healthcare Connections (LHCC); and UnitedHealthcare Community Plan (UHC). There is also one Behavioral Health PIHP (Magellan of Louisiana CSoC Program [Magellan]), and, at the time of the evaluation, one Dental prepaid ambulatory health plan (PAHP; Managed Care of North America Dental [MCNA]). Healthy Louisiana covers more than 90 percent of Louisiana Medicaid members, including more than 481,000 new adults since Medicaid expansion took effect in July 2016. In addition to providing benefits as specified in the Medicaid State Plan, state statutes and administrative rules, and Medicaid policy and procedure manuals, these managed care entities (MCE) also provide case management services and certain value-added Medicaid benefits.

Table 1: List of Current Louisiana Medicaid MCOs by Enrollment

MCO Name	MCO Acronym	Enrollment June 2018	Enrollment June 2019
Aetna Better Health	ABH	114,377	112,513
AmeriHealth Caritas Louisiana	ACLA	206,667	194,944
Healthy Blue	HB	248,050	251,938
Louisiana Healthcare Connections	LHCC	470,731	436,317
UnitedHealthcare Community Plan	UHC	433,860	410,336
Total		1,473,685	1,406,048

Source: Louisiana Department of Health, Report No. 109-A: 1. This report shows all active members in Healthy Louisiana as of the effective date above. Members to be dis-enrolled at the end of the reporting month were not included. Enrollees who gained and lost eligibility during the reporting month were not included. Enrollees who opted out of Healthy Louisiana during the reporting month were not included. 2. The statewide total includes membership of all plans.
MCO: managed care organization.

Quality Strategy Goals

Louisiana's Quality Strategy is based on aims, goals, and objectives to promote improvement in health care delivery and outcomes, along with metrics by which progress can be measured. Aligned with the Institute of Healthcare Improvement (IHI)'s Triple Aim[7] and the aims and priorities selected by CMS for their national quality strategy, Louisiana's Quality Strategy seeks to promote person-centered care, provide incentives for the right outcomes, be sustainable, emphasize coordinated care and promote transparency of quality and cost information.

Posted on the LDH website, Louisiana's 2019 Quality Strategy identifies the following three aims:

Better Care: Make health care more person-centered, coordinated and accessible.

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

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

Responsibility for Quality Monitoring

Within LDH, the Bureau of Health Services Financing (BHSF) is responsible for the day-to-day operations of the MMC program, with support from other LDH program offices, including the Office of Behavioral Health (OBH), Office of Public Health (OPH), Office of Aging and Adult Services (OAAS), and the Office for Citizens with Developmental Disabilities (OCDD). The Medicaid Quality Improvement and Innovations Section, in collaboration with these program offices, the Medicaid Chief Medical Officer, and the Medicaid Executive Management Team, are responsible for the development, implementation and evaluation of the Medicaid Managed Care Quality Strategy.

[7] Institute for Healthcare Improvement (IHI): Triple Aim: http://www.ihi.org/Topics/TripleAim/Pages/Overview.aspx (Accessed July, 13, 2020).

The Louisiana Medicaid Quality Committee provides consultation on quality improvement activities to promote 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 enrollees. Members of the Medicaid Quality Committee and its subcommittees fulfill the role of the Medical Care Advisory Committee required by federal regulation (42 CFR 431.12). This committee is interdisciplinary and includes representatives who are familiar with quality improvement and the medical needs of Healthy Louisiana enrollees.

Evaluation Methodology

To evaluate Louisiana's 2019 Medicaid Managed Care Quality Strategy, a review of federal regulations was initially conducted to clearly define the requirements of the Quality Strategy and guide the evaluation methodology.

First, IPRO evaluated the core Healthy Louisiana performance results. This evaluation consisted of data analysis of measures identified in the Quality Strategy from the Healthcare Effectiveness Data and Information Set (HEDIS®), Consumer Assessment of Healthcare Providers and Systems (CAHPS®), Agency for Healthcare Research and Quality (AHRQ)'s Preventive Quality Indicators, Louisiana vital records, and CMS-developed measures. This analysis included comparisons of Louisiana HEDIS performance to national benchmarks using the Medicaid National Committee for Quality Assurance (NCQA) *Quality Compass*®.

Second, IPRO evaluated Louisiana Medicaid's Quality Monitoring activities. This evaluation consisted of a review of Louisiana Department of Health monitoring reports regarding enrollment, network adequacy, quality dashboard, program transparency, medical loss ratio (MLR) and diabetes and obesity reviews. LDH's approach to addressing health disparities and the use of sanctions were also reviewed. Further evaluation of the Quality Strategy consisted of a review of external quality review (EQR) report documents including compliance review results, validation reports for performance improvement projects (PIPs), performance measure results, and the Annual EQR Technical Reports.

Third, IPRO evaluated State-MCO-EQRO communications by reviewing on-line data sources. In addition to the LDH and external quality review monitoring reports, other website examples of data transparency such as MCO executed contracts and Informational Bulletins were reviewed.

Fourth, IPRO evaluated Louisiana Medicaid's strategies and interventions to promote quality improvement by reviewing MCO Performance Improvement Project reports, MCO withhold of capitation payments to increase the use of Value-Based Payment and improve health outcomes and the Louisiana Health Information Technology Roadmap.

Finally, based on key findings, IPRO prepared a summative analysis of program strengths, opportunities for improvement and recommendations.

Core Program Performance Results

LDH requires MCOs to report quality performance measures annually including the HEDIS quality metrics, CMS Adult and Children Core Set[8], AHRQ Prevention Quality Indicators, CAHPS[9] measures, and state-specified quality measures.

NCQA's *Quality Compass Medicaid* is derived from HEDIS data submitted to NCQA by Medicaid MCOs throughout the nation. Using these standardized measures as benchmarks allows states to make meaningful comparisons of their rates to the rates for all reporting MMC MCOs nationwide, and thus allows state policy creators to better identify program strengths and weaknesses and target areas most in need of improvement (**Table 2)**.

Table 2: HEDIS Rate Categories and NCQA Quality Compass National Percentiles

Rate Category	How the HEDIS 2019 Rate Compares to NCQA Quality Compass National Percentiles
< 25	Below the national Medicaid 25th percentile
> 25	At or above the national Medicaid 25th percentile but below the 50th percentile
> 50	At or above the national Medicaid 50th percentile but below the 75th percentile
> 75	At or above the national Medicaid 75th percentile but below the 90th percentile
> 90	At or above the national Medicaid 90th percentile
N/A	No national benchmarks available for this measure

HEDIS: Healthcare Effectiveness Data and Information Set; NCQA: National Committee for Quality Assurance; N/A: not applicable.

The following section of the evaluation presents an analysis of statewide performance metrics selected for the 2019 Quality Strategy and are categorized in three separate tables: Incentive-Based Measures; Non-Incentive HEDIS Measures; and non-HEDIS, State-Specific Measures. Change in rates between reporting years (RY) 2018 and 2019 are presented for all measures, and a benchmark comparison is also included in each table. For the HEDIS Incentive-Based measures **(Table 3)**, each measure rate is compared to a target benchmark rate derived from the NCQA *Quality Compass Medicaid®* [10] 50th percentile for the year prior to the measurement year (MY). All other HEDIS measures **(Table 4)** are compared to the HEDIS 2019 Medicaid *Quality Compass* percentile ranking. The benchmark selected for non-HEDIS measures **(Table 5)** is the best performance reported to LDH by any MCO for the prior MY.

For the 2019 Quality Strategy Core Measures that follow, there are several measures indicated where trending results should be viewed with caution, as per a NCQA memorandum dated March 2019. Specification changes in these measures for HEDIS 2019 may cause fluctuation in results when compared to the prior year. This memorandum further suggests that several HEDIS 2019 measures should not be trended with previous years due to significant changes in the measure specifications. One of these measures, Controlling High Blood Pressure (CBP), was included in the Quality Strategy list of Incentive Measures.

[8] CMS Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), Technical Specifications and Resource Manual for Federal Fiscal Year 2019 Reporting, February 2019; https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.htmlhttps://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html. CMS Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set), Technical Specifications and Resource Manual for Federal Fiscal Year 2019 Reporting, February 2019; https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2019-child-core-set.pdfhttps://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2019-child-core-set.pdf (Accessed July 13, 2020)

[9] Consumer Assessment of Healthcare Providers and Systems (CAHPS) provided by the Agency for Healthcare Research and Quality; http://www.ahrq.gov/cahps/index.html. (Accessed July 13, 2020).

[10] NCQA *Quality Compass®: Benchmark and Compare Quality Data*, available for purchase at: http://www.ncqa.org/HEDISQualityMeasurement/QualityMeasurementProducts/QualityCompass.aspxhttp://www.ncqa.org/HEDISQualityMeasurement/QualityMeasurementProducts/QualityCompass.aspx. (Accessed July 13, 2020).

Table 3: 2019 Healthy Louisiana Incentive Measures – Target and Improvement Objectives

Identifier	Measures	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentage Point Difference 2018–2019	Met Target Objective	Met Improve-ment Objective
Target Objective: HEDIS 2019 (MY 2018) rate meets or exceeds the Medicaid national 50th percentile rate for the year prior to the MY (2017 *Quality Compass*)						
Improvement Objective: Rate improved by 2.0 or more percentage points compared to prior year						
ADD	Follow-up Care for Children Prescribed ADHD Medication – Initiation Phase	54.53%	50.65%	-3.88	Yes	No
	Follow-up Care for Children Prescribed ADHD Medication – Continuation Phase	67.89%	65.01%	-2.88	Yes	No
AMB-ED	Ambulatory Care – ED Visits/1,000MM[1]	81.09	75.02	-6.07[1]	No	Yes
AWC	Adolescent Well Care Visit	54.18%	56.68%	2.50	Yes	Yes
CPA	CAHPS Adult Rating of Health Plan (8+9+10)[2]	78.56%	79.46%	0.90	Yes	No
CPC	CAHPS Child Rating of Health Plan (8+9+10)[2]	87.76%	89.01%	1.25	Yes	No
CBP	Controlling High Blood Pressure – Total[3]	37.71%	47.88%	10.17	No	Yes
CDC	Comprehensive Diabetes Care – HbA1c Testing	84.21%	85.78%	1.57	No	No
	Eye Exam (retinal) Performed	55.62%	58.20%	2.58	Yes	Yes
	Medical Attention for Nephropathy	91.48%	90.85%	-0.63	Yes	No
FUH	Follow-up after Hospitalization for Mental Illness – within 30 days of discharge	43.99%	43.97%	-0.02	No	No
PPC	Timeliness of Prenatal Care	78.40%	79.40%	1.00	No	No
	Postpartum Care	64.04%	67.63%	3.59	Yes	Yes
W15	Well-Child Visits in First 15 Months of Life – Six or more well-child visits	64.11%	63.22%	-0.89	Yes	No
W34	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	68.06%	70.05%	1.99	No	Yes
PTB	Initiation of Injectable Progesterone for Preterm Birth Prevention[4]	19.84%	22.76%	2.92	Yes	Yes
Total Number Meeting Objective[5]					10	7

[1] A lower rate indicates better performance.

[2] Statewide Rates were extracted from the NCQA *Quality Compass* Statewide Benchmarks: Average Rates.

[3] As per NCQA, HEDIS 2019 specifications for this measure significantly changed how this measure was calculated compared to prior years.

[4] This is a state-specific measure, not derived from CMS. This measure was calculated by LDH/University of Louisiana Monroe (ULM). The achievement target for this measure was designated by LDH in the 2019 Healthy Louisiana Performance Measures: Guide for MCO Reporting, 2019 Reporting Year.[5] Target Objective: HEDIS 2019 (MY 2018) rate meets or exceeds the Medicaid national 50th percentile rate for the year prior to the MY (2017 *Quality Compass*)

Improvement Objective: Rate improved by 2.0 or more percentage points compared to prior year

MY: measurement year; MM: member months; ED: emergency department.

Grey shaded cells indicate not applicable.

Table 4: HEDIS 2019 Non-Incentive Performance Measures –Trend and National Medicaid Benchmark Achieved

Identifier	Measures[1]	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentage Point Difference[2] 2018–2019	Met Improve-ment Objective[3]	HEDIS 2019 Percentile Achieved
Improvement Objective: HEDIS 2019 rate improved by 2.0 or more percentage points compared to HEDIS 2018						
AAP	Adults' Access to Preventive/Ambulatory Health Services: Total[2]	79.36%	79.61%	0.25	No	> 25th
AAP	AAP: 20–44 years[2]	76.75%	76.81%	0.06	No	> 25th
AAP	AAP: 45–64 years[2]	84.87%	84.95%	0.08	No	> 25th
AAP	AAP: 65+ years[2]	84.83%	86.24%	1.41	No	> 25th
ABA	Adult BMI Assessment[2]	81.97%	82.51%	0.54	No	< 25th
AMB	Ambulatory Care – Outpatient Visits Total ages[2]	418.74	413.54	-5.20	No	> 75th
AMM	Antidepressant Medication Management – Effective Acute Phase Treatment	54.05%	48.17%	-5.88	No	< 25th
AMM	Antidepressant Medication Management – Effective Continuation Phase Treatment	39.84%	32.56%	-7.28	No	< 25th
AMR	Asthma Medication Ratio – Total Rate[2]	63.75%	64.08%	0.33	No	> 50th
BCS	Breast Cancer Screening[2]	56.03%	57.70%	1.67	No	> 25th
CAP	Child and Adolescents' Access to Primary Care Practitioners: Children 12 – 24 mos.	96.43%	95.68%	-0.75	No	> 50th
CAP	Children 25 months – 6 years	88.79%	88.36%	-0.43	No	> 50th
CAP	Children 7-11 years	90.61%	91.25%	0.64	No	> 50th
CAP	Children 12-19 years	89.96%	90.60%	0.64	No	> 50th
CCS	Cervical Cancer Screening - Total	51.61%	56.41%	4.80	Yes	> 25th
CDC	HbA1c Poor Control (>9.0%)[1,2]	50.75%	45.52%	-5.23[1]	Yes	> 25th
CDC	HbA1c Control (<8.0%)[2]	41.36%	45.04%	3.68	Yes	> 25th
CDC	Blood Pressure Control (<140/90 mm Hg)[2]	44.20%	50.93%	6.73	Yes	< 25th
CHL	Chlamydia Screening in Women - Total	65.78%	66.19%	0.41	No	> 50th
CIS	Childhood Immunization Status – Diphtheria, Tetanus, and Acellular Pertussis (DTaP)	74.97%	75.28%	0.31	No	> 25th
CIS	Polio (IPV)	89.57%	90.72%	1.15	No	> 50th
CIS	Measles, Mumps and Rubella (MMR)[2]	88.26%	88.74%	0.48	No	> 50th
CIS	Haemophilus Influenza Type B (HiB)	87.12%	88.56%	1.44	No	> 90th
CIS	Hepatitis B (HepB)	91.27%	91.58%	0.31	No	> 50th
CIS	Chicken Pox (VZV)[2]	88.07%	88.84%	0.77	No	> 50th
CIS	Pneumococcal Conjugate (PCV)	74.66%	75.92%	1.26	No	> 25th
CIS	Hepatitis (HepA)[2]	84.05%	84.73%	0.68	No	> 50th
CIS	Rotavirus (RV)	69.44%	69.59%	0.15	No	> 25th
CIS	Influenza (flu)	33.88%	34.86%	0.98	No	< 25th
CIS	Combination 2[2]	72.41%	74.12%	1.71	No	> 50th
CIS	Combination 3[2]	68.19%	70.99%	2.80	Yes	> 50th
CIS	Combination 4[2]	65.07%	68.61%	3.54	Yes	> 50th
CIS	Combination 5[2]	58.79%	60.03%	1.24	No	> 25th
CIS	Combination 6[2]	29.44%	31.33%	1.89	No	< 25th
CIS	Combination 7[2]	56.81%	58.43%	1.62	No	> 25th
CIS	Combination 8[2]	28.53%	30.76%	2.23	Yes	< 25th
CIS	Combination 9[2]	26.41%	27.19%	0.78	No	< 25th
CIS	Combination 10[2]	25.71%	26.84%	1.13	No	< 25th
COL	Colorectal Screening	N/A	32.23%	N/A	N/A	N/A

Identifier	Measures[1]	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentage Point Difference[2] 2018–2019	Met Improve-ment Objective[3]	HEDIS 2019 Percentile Achieved
Improvement Objective: HEDIS 2019 rate improved by 2.0 or more percentage points compared to HEDIS 2018						
FUH	Follow-up after Hospitalization for Mental Illness within 7 days of discharge[2]	21.81%	22.55%	0.74	No	< 25th
FVA	Flu Vaccinations for Adults Ages 18 to 64	34.21%	38.85%	4.64	Yes	> 25th
IMA	Immunization Status for Adolescents: Meningococcal	88.91%	90.04%	1.13	No	> 75th
IMA	Tdap/Td	89.63%	90.23%	0.60	No	> 50th
IMA	HPV	42.95%	41.65%	-1.30	No	> 50th
IMA	Combination #1	87.96%	88.58%	0.62	No	> 75th
IMA	Combination #2	42.12%	40.49%	-1.63	No	> 75th
MMA	Medication Management for People with Asthma Total – Medication Compliance 50%[2]	56.80%	53.85%	-2.95	No	N/A
MMA	Medication Management for People with Asthma Total – Medication Compliance 75%[2]	32.76%	29.61%	-3.15	No	< 25th
MPM	Annual Monitoring for Patients on Persistent Medications – Total Rate	88.97%	89.23%	0.26	No	> 50th
MPM	ACE Inhibitors / ARBs	89.04%	89.44%	0.40	No	> 50th
MPM	Diuretic	88.88%	88.96%	0.08	No	> 50th
MSC	Medical Assistance with Smoking and Tobacco Use Cessation – Advising Smokers and Tobacco Users to Quit[2]	72.37%	73.61%	1.24	No	< 25th
MSC	Discussing Cessation Medications	45.42%	45.66%	0.24	No	< 25th
MSC	Discussing Cessation Strategies	41.33%	42.85%	1.52	No	> 25th
PCR	Plan All-Cause Readmissions – Observed Readmissions[2]	N/A	16.87%	N/A	N/A	N/A
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia[2]	50.01%	49.36%	-0.65	No	< 25th
SPC	Statin Therapy for Patients with Cardiovascular Disease – Received Statin Therapy Total[2]	75.41%	75.32%	-0.09	No	> 25th
SPC	Statin Adherence 80% Total[2]	61.04%	55.34%	-5.70	No	< 25th
SSD	Diabetes Screening for People with Schizophrenia or Bipolar who are using Antipsychotic Medications[2]	82.26%	82.88%	0.62	No	> 50th
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity – BMI Percentile[2]	62.35%	65.66%	3.31	Yes	< 25th
WCC	Counseling for Nutrition Total	55.88%	58.66%	2.78	Yes	< 25th
WCC	Counseling for Physical Activity Ages Total	45.10%	50.62%	5.52	Yes	< 25th

[1] A lower rate indicates better performance

[2] Trending should be viewed with caution, as per National Committee for Quality Assurance.

[3] Improvement Objective: HEDIS 2019 rate improved by 2.0 or more percentage points compared to HEDIS 2018

MY: measurement year; N/A: not applicable (no Medicaid *Quality Compass* benchmark).

Table 5: Non-HEDIS, State-Specific Performance Measures RY 2018–2019 – Target and Improvement Objectives

Identifier	Measures[1]	RY 2018 Rate	RY 2019 Rate[2]	Percentage Point Difference 2018–2019	Best MCO Rate for Prior MY	Met Target Objective[3]	Met Improve-ment Objective[3]
Target Objective: RY 2019 rate meets or exceeds the best performance reported to LDH by any MCO for the prior MY							
Improvement Objective: The RY 2019 rate improved by 2.0 or more percentage points compared to the prior MY							
CCP-CH	Contraceptive Care – Postpartum (ages 15–20), most or moderately effective, 3 days	3.21%	4.16%[2]	0.95	4.11%	Yes	No
CCP-CH	Contraceptive Care – Postpartum (ages 15–20), most or moderately effective, 60 days	50.07%	51.01%[2]	0.94	51.57%	No	No
CCP-CH	Contraceptive Care—Postpartum (ages 15–20), LARC 3 days	2.35%	2.40%[2]	0.05	3.03%	No	No
CCP-CH	Contraceptive Care—Postpartum (ages 15–20), LARC 60 days	15.04%	13.85%[2]	-1.19	18.01%	No	No
CCP-AD	Contraceptive Care—Postpartum (ages 21–44), most or moderately effective, 3 days	12.46%	13.10%[2]	0.64	13.39%	No	No
CCP-AD	Contraceptive Care—Postpartum (ages 21–44), most or moderately effective, 60 days	51.39%	51.84%[2]	0.45	52.12%	No	No
CCP-AD	Contraceptive Care—Postpartum (ages 21–44), LARC 3 days	1.90%	2.03%[2]	0.13	2.14%	No	No
CCP-AD	Contraceptive Care—Postpartum (ages 21–44), LARC 60 days	12.91%	11.97%[2]	-0.94	13.70%	No	No
HIV	HIV Viral Load Suppression	75.16%	75.59%[2]	0.43	79.88%	No	No
LBW	Percentage of Low Birth Weight Births[1]	12.15%	12.09%	-0.06[1]	10.03%	No	No
NQF PC-01	Elective Delivery[1]	1.19%	1.36%[2]	0.17[1]	0.71%	No	No
NSV	Cesarean Rate for Low-Risk First Birth Women[1]	28.61%	28.62%	0.01[1]	27.57%	No	No
PQI01	Diabetes Short Term Complications Admission Rate[1]	14.88	20.90[2]	6.02[1]	13.02	No	No
PQI05	COPD and Asthma in Older Adults Admission Rate[1]	54.50	45.39[2]	-9.11[1]	41.89	No	Yes
PQI08	Heart Failure Admission Rate[1]	30.87	32.12[2]	1.25[1]	22.92	No	No
PQI15	Asthma in Younger Adults Admission Rate[1]	4.09	3.15	-0.94[1]	2.14	No	No

[1] A lower rate indicates better performance

[2] University of Louisiana Monroe (ULM)-calculated rate appears where plan rates are not yet finalized.

[3] RY 2019 rate meets or exceeds the best performance reported to LDH by any MCO for the prior MY

Improvement Objective: The RY 2019 rate improved by 2.0 or more percentage points compared to the prior MY

RY: reporting year; MY: measurement year; LARC: long-acting reversible contraception.

Summary of Core Performance Measure Results

2019 Healthy Louisiana Incentive Measures

There were 16 Incentive Measures selected by LDH for 2019; these included measures of behavioral health, access to care, preventive care, chronic care, and consumer satisfaction. Fifteen of the measures were submitted by the Healthy Louisiana MCOs as part of their 2019 HEDIS and CAHPS submissions. There was also one state-specific measure, Initiation of Injectable Progesterone for Preterm Birth Prevention, which was calculated by LDH and the University of Louisiana Monroe (ULM).

Healthy Louisiana showed a high level of performance for achieving either the national benchmark target or the improvement objective or both. Ten of the 16 measures (63%) met or exceeded the national Medicaid 50th percentile target rate for the year prior to the MY. Seven measures (44%) improved by 2.0 or more percentage points between 2018 and 2019 reporting years. Statewide rates for four of the measures met both the national target and the improvement objective. Excluding the one measure, AMB – ED Visits/1,000 MM, where a lower rate indicates better performance, there were five measure rates (31%) that decreased slightly between HEDIS 2018 – HEDIS 2019; however, four of these measure rates still met or exceeded the national 50th percentile target (**Table 4**).

Based on this statewide rate analysis, opportunities for improvement are evident for three measures (19%) that failed to meet either the national target or the improvement objective:

- Comprehensive Diabetes Care – HbA1c Testing,
- Follow-up after Hospitalization for Mental Illness – Within 30 Days of Discharge, and
- Timeliness of Prenatal Care.

According to the validation report prepared by the EQRO entitled "2019 Healthy Louisiana HEDIS Performance Results and Analysis, January 2020," incentive-based measure results by MCO indicate a slightly different picture. There were seven HEDIS measures for which all MCOs met either one or both of the objectives. By MCO, ABH and LHCC each had four measure rates that did not meet either the improvement or the achievement target, while HB did not meet either objective for two measures; ACLA and UHC each only had one measure that did not meet either objective. Thus, each MCO has opportunities for improvement that may not exactly mirror those of the state. There were eight measures that had at least one MCO not meeting either objective. The most troublesome of the measures in this data set was Follow-up after Hospitalization for Mental Illness – Within 30 Days of Discharge, for which four MCOs did not meet the target nor the improvement objective, followed by CDC – HbA1c Testing, with two MCOs not meeting either objective. For the Timeliness of Prenatal Care measure, one MCO (UHC) met both objectives, three MCOs met the improvement objective only (ABH, ACLA and HB), and LHCC did not meet either objective.

HEDIS 2019 Non-Incentive Performance Measures

This measure set included a total of 62 statewide measure rates submitted by the Healthy Louisiana MCOs as part of their 2019 HEDIS and CAHPS submissions. The measures represented a range of HEDIS measures including effectiveness of care, access and availability, utilization, and consumer satisfaction. All but 2 of the 2019 measures (60 in total) could be compared to 2018 rates. There were 59 measures that could be compared to national benchmarks.

Of the 60 measures that could be trended, as many as 48 (80%) showed improvement; however, only 11 of the measures (18%) improved by at least 2.0 percentage points from the prior year. Of the 59 measures that could be compared to the 2019 NCQA *Quality Compass* benchmark rates, as many as 25 measures (42%) had rates at or above the national 50th percentile, including 4 measures with rates at or above the national 75th percentile but lower than the 90th percentile, and one measure (CIS: Haemophilus Influenza Type B [HiB]) with a statewide HEDIS 2019 rate above the national 90th percentile.

There were 10 measures (17%) that had decreasing rates of statewide performance between HEDIS 2018 and HEDIS 2019. Opportunities for improvement are also evident for 18 measures (31%) in this measure set, with rates below the national 25th percentile.

Non-HEDIS, State-Specific Measures: Preventive Quality Indicator Measures, Vital Records and CMS Measures

This measure set includes 16 state-specific measures that are submitted annually by all five Healthy Louisiana MCOs and included measures related to contraceptive care postpartum, low birth weight, elective and cesarean births, HIV viral load suppression, and AHRQ's Preventive Quality Indicators (PQIs). For 7 of the 16 measures, lower rates indicate better performance.

Ten (10) of the 16 measures (63%) showed improvement in measure rates between 2018 and 2019, including 3 measures where a lower rate indicates better performance. There was only one measure (PQI05: COPD and Asthma in Older Adults Admission Rate) that met the improvement object. The Quality Strategy indicated that the targets for these non-HEDIS measures should be equal to (or better than) the best Healthy Louisiana MCO performance in the prior measurement year. While the 2019 statewide average rates were close to many of the prior year's best MCO performance, there was only one measure (Contraceptive Care – Postpartum [ages 15–20], most or moderately effective, 3 days) that met the achievement target.

Opportunities for improvement should address two measures that decreased in rate from 2018 to 2019: Contraceptive Care-Postpartum (ages 15–20), LARC 60 days; and Contraceptive Care-Postpartum (21–44), LARC 60 days. In addition, for the measures where a lower rate indicates better performance, four measure rates increased. The PQI measures showed the largest gaps between the 2019 statewide averages and the target MCO performance from the prior year. LDH may want to explore what barriers the MCOs face in reducing the PQI rates and collaborate on ways to improve.

Quality Monitoring and Review

This section describes and assesses the quality monitoring and review activities of Louisiana Medicaid and Louisiana's EQRO.

Data Reporting Systems Review

Medicaid MCOs in Louisiana are required to maintain a management information system (MIS) to support all aspects of managed care operation, including member enrollment, encounter data, provider network data, quality performance data, as well as claims and surveillance utilization reports, to identify fraud and/or abuse by providers and members. MCOs verify the accuracy and timeliness of the information contained in their databases through edits and audits. They are expected to screen for data completeness, logic, and consistency. The Management Administrative Reporting Subsystem (MARS) is responsible for the day-to-day reporting operations for LDH Medicaid data.

Results of LDH data monitoring are posted on their website and include data from MCO-submitted reports for enrollment, provider network adequacy, member and provider satisfaction surveys, annual audited financial statements and quality performance. Of the data submitted to LDH, the EQRO is responsible for validating performance measure (PM) data and preparing Annual Technical Reports for each MCO as required by federal regulation 42 CFR§438.310(2).

Louisiana Department of Health Monitoring Reports

Enrollment Reports

Louisiana's five MCOs submit monthly enrollment data in several specified categories including number of transfers, plan changes, reasons for transfer, new enrollments and enrollment by parish, by plan and parish, by subprogram and subprogram without Medicaid expansion, and plan enrollment by means of enrollment. Data is presented from 2012 to early 2019. Enrollment shown in **Table 1**: List of Current Louisiana Medicaid MCOs by Enrollment was derived from enrollment Report 106-A.

Network Adequacy Review Report

Healthy Louisiana MCOs are required to meet standards set by LDH to ensure that members have access to providers within reasonable time (or distance) parameters. MCOs monitor their provider network for accessibility and network capacity by using the GeoAccess software program to assign geographic coordinates to addresses in order to calculate the distance between providers and members.

Current findings from the Network Adequacy Review Report 220 were published in the 2020 Annual External Quality Review Technical Report for data as of June 30, 2019 (for the period January 1, 2019 – June 30, 2019). All five MCOs reported 100% compliance with time and distance access standards to adult PCPs for members in rural areas. All five MCOs also met 100% compliance with time access standards to pediatric PCPs for members in rural areas, and four of the five MCOs met 100% compliance with distance access standards to pediatric PCPs for members in rural areas. Three of the five MCOs reported that 100% of members in rural areas met time access standards to OB/GYNs.

The percent of members in urban areas meeting the time and distance access standards to adult PCPs, pediatric PCPs and OB/GYNs was less than 100% for all five MCOs. Opportunities for improvement were particularly evidenced for four of the five MCOs for access to OB/GYNs by distance for members in both urban and rural areas.

Medicaid Managed Care Quality Dashboard

The LDH Medicaid Managed Care Dashboard was created to promote data transparency and health care accountability. Responsible for monitoring the performance of its five MMC MCOs, the BHSF presents both HEDIS and non-HEDIS quality metrics on the LDH website in the form of a Quality Dashboard. Seven domains of care are shown, including: behavioral health care for adults and children; care for children and adolescents; chronic disease care for adults; effective care in appropriate settings; experience of care for adults and children (CAHPS); preventive care for adults; and reproductive and pregnancy care. The user is able to select a category and view a list of measures. Further details such as the definition of the measure and a brief statement about why this measure is important are provided. A bar chart showing each MCO's rate for the measure, along with the statewide average rate and the national Medicaid *Quality Compass* 50th percentile rate, are provided. Below the bar chart is a trend chart showing each MCO and statewide rate over the most recent four years as well as the 2012 baseline rate for measures that were collected beginning in 2012.

The presentation of quality data in this dashboard format is user-friendly. It offers a quick and complete picture of how each MCO has performed for each measure over the past four years and shows how that performance compares to the statewide average and the national Medicaid 50th percentile.

Medicaid Managed Care Program Transparency Reports

LDH has prepared an annual transparency report from calendar year 2013 through state fiscal year (FY) 2018. Data in these reports is presented for each MCO, there is no aggregated statewide results presented. This report includes:

- Provider network summary data from the LDH MARS Data Warehouse, Provider Registry. Each MCO monitors its provider network for accessibility and network capability using a GeoAccess software program, which assigns geographic coordinates to physical addresses. This way, it can be determined whether members have access to care within a reasonable distance from their homes. MCOs are required to meet the distance and/or time standards set by LDH.
- Member and Provider satisfaction surveys. For member satisfaction, all MCOs used a certified NCQA survey vendor to conduct the CAHPS 5.0H Health Plan Survey for adult members. Provider Satisfaction surveys were also conducted by NCQA certified survey vendors for each of the MCOs; however, reporting of results varied by the individual vendors.
- Encounters and claims summary data submitted to the LDH MARS Data Warehouse, including: number of enrollees who received services by provider type, taxonomy and place of service; number of denied claims by claims adjustment reason (Denied Claims Report 173); total and out-of-network claims by place of service (Report 177); pharmacy claims submitted, paid, denied or subject to prior authorization; and dental program claims denied prior authorization.
- A survey form for Managed Care Organization (MCO)-Self Reported Items (Myers and Stauffer (MSLC) Survey).

Medical Loss Ratio (MLR) Reports

Each of these reports contains an independent auditor's review for the Adjusted Medical Loss Ratio (MLR) Rebate Calculation of the five prepaid MCOs each year. Reports from calendar year ending on December 31, 2012 through calendar year ending on December 31, 2018 are posted on the LDH website.

Diabetes and Obesity Report for Medicaid Managed Care Program, March 2019

The Diabetes and Obesity Report is prepared by the Bureau of Health Services Financing in response to ACT 210 of the 2013 State of Louisiana Legislative Session.[11] Annual versions of the report are available from January 2014 through March 2019.

The purpose of this report is to monitor incidence and prevalence of obesity and diabetes in Louisiana by examining costs, complications, and how LDH and the Medicaid MCOs have addressed obesity and diabetes in the populations they serve. Using data on prevalence, utilization, and costs submitted by each of the five Medicaid MCOs for measurement year 2017, this report also presents recommendations for improving the health of Louisianans who are at risk for developing obesity and diabetes. In response to Act 210, Louisiana Medicaid aggregated the data and information submitted by each of the MCOs to create the Diabetes and Obesity Action Report for the Healthy Louisiana Program.

Recommendations from LDH and the MCOs on ways to empower the community, promote self-management training and monitor health outcomes included the following:

- seek legislative appropriation of funds for a new Medicaid covered service to allow Medicaid recipients to receive nutritional consultations and services provided by registered dietitians;
- encourage the use of outpatient nutritional services provided by registered dietitians for all patients and all diagnoses, not just those diagnosed with diabetes and obesity;
- promote the use of diabetes self-management education (DSME) programs or incorporate elements of these programs into case management activities for patients diagnosed with diabetes; DSME programs have been associated with improved health outcomes for patients diagnosed with diabetes;
- implement reforms in the education system aimed at improving diabetes and obesity outcomes in Louisiana including:

[11] ACT 210 of the 2013 State of Louisiana Legislative Session: http://www.legis.la.gov/legis/ViewDocument.aspx?d=857223 .

- enforcing the Louisiana law (RS 17:17.1) that requires physical activity in schools, currently applicable to kindergarten through eighth-grade classes,
- expanding Louisiana's physical activity law to the high school system,
- adequately funding school systems to teach basic nutrition in the classroom at all schools and for all ages, and
- providing continuing education units (CEUs) to educators through subject matter experts (e.g. kinesiologists or exercise science experts) in order to increase their understanding about the methodology of correctly providing physical activity and nutritional education in the school setting.

External Quality Review Reports

2019 Healthy Louisiana HEDIS Performance Measure Results and Analysis, Final Report, January 2020

This report summarized the methods and findings of the analysis by Island Peer Review Organization (IPRO) of HEDIS 2019 data submitted by the five Louisiana MCOs serving Medicaid enrollees.

A total of 30 measures, comprising 69 numerators, were selected for analysis based on the Healthy Louisiana designated measure reporting list. The measures selected for reporting were the measures required by the LDH and appear in the Performance Measure Submission Guide for 2019 reporting. Using the 2019 HEDIS Interactive Data Submission System (IDSS) data, including audit designations and Final Audit Reports (FARs) from each of the five MCOs, IPRO verified the rates that were deemed reportable via the NCQA HEDIS audit protocol and FARs, and prepared an Excel file documenting each MCO's rates, the IPRO-computed statewide average (SWA), and last year's statewide averages. Finally, IPRO included comparisons of MCO rates to the NCQA's 2019 *Quality Compass* South Central 50th percentile and the National Medicaid *Quality Compass* 50th percentile, which served as the benchmarks.

Annual External Quality Review Technical Report, April 2020

The BBA requires state agencies that contract with Medicaid MCOs to prepare an annual external, independent review of quality outcomes, timeliness, and access to healthcare services. The 2020 External Quality Review Technical Reports, completed in April 2020 for review period July 1, 2018 through June 30, 2019, include results for each of the five Healthy Louisiana MCOs. The reports provide corporate profiles, enrollment, provider network data and GeoAccess accessibility, validation of PIPs, HEDIS quality performance data, CAHPS satisfaction data and results of compliance reviews. MCO strengths and opportunities for improvement are also outlined for each MCO. It is also required that each year's technical report include a section in which each MCO responds to recommendations listed for their MCO in the previous year's report. The Final Rule maintains the importance of the annual technical report and requires states to finalize and post the annual EQR report on their website by April 30 of each year. Louisiana MMC annual technical reports for 2013–2019 can be found on the LDH website.

Annual Compliance Reviews

Federal regulations require that every state with an MMC program conduct a full review of MCO compliance with state and federal regulations at least once every three years. To meet these federal requirements, LDH contracted with an EQRO to conduct the 2019 Compliance Audit on behalf of the LDH. In Louisiana, full compliance audits occur every three years, with partial audits occurring within the intervening years. The 2019 annual compliance audit was a full audit of each MCO's compliance with contractual requirements during the period of April 1, 2018 through March 31, 2019 and included the following domains: Core Benefits and Services; Provider Network Requirements; Utilization Management (UM); Eligibility, Enrollment and Disenrollment; Marketing and Member Education; Member Grievances and Appeals, Quality Management; Fraud, Abuse and Waste Prevention; and Reporting.

The file review component of the audit assessed the MCO's implementation of policies and its operational compliance with regulations related to complaints and grievances, member appeals, informal reconsiderations, care management (physical and behavioral health), utilization management, and provider credentialing and re-credentialing.

For each audit, determinations of full compliance, substantial compliance, minimal compliance, non-compliance or not applicable are used for each element under review. Each of the review determinations is defined as follows:

- **Full** – The MCO is compliant with the standard.
- **Substantial** – The MCO is compliant with most of the requirements of the standard, but has minor deficiencies.

- **Minimal** – The MCO is compliant with some of the requirements of the standard, but has significant deficiencies that require corrective action.
- **Non-compliance** – The MCO is not in compliance with the standard.
- **Not Applicable** – The requirement was not applicable to the MCO.

It is the expectation of both IPRO and the LDH that a corrective action plan (CAP) is submitted for each of the elements determined to be less than fully compliant. Further, if the EQRO indicates that the quality of care is not within acceptable limits according to the contract, then LDH may sanction the MCO by suspending automatic assignment of new enrollees to the MCO until a satisfactory level of care is determined by the EQRO.

Overall determinations from the 2019 audit of MCO compliance with state and federal regulations is shown in **Table 6**. The percent of elements achieving full compliance determination and the number of elements requiring a CAP is shown for each Medicaid MCO by domain category. A total of 780 elements were reviewed for each MCO; the number of elements rated N/A, which varied by MCO and domain, were removed when calculating percentages.

Table 6: Overall Final MCO Compliance Results by Audit Domain: Reviews Conducted in 2019

Audit Domain (# of elements)	ABH[1,2]		ACLA[1,2]		HB[1,2]		LHCC[1,2]		UHC[1,2]	
	% Full	CAPs	% Full	CAPs	% Full	CAPs	% Full	CAPs	% Full	CAPs
Core Benefits and Services (115)	100%	0	100%	0	97%	3	98%	2	93%	8
Provider Network Requirements (184)	85%	28	89%	20	91%	16	93%	12	91%	15
Utilization Management (87)	99%	1	100%	0	100%	0	95%	4	98%	2
Eligibility, Enrollment and Disenrollment (13)	46%	7	100%	0	85%	2	100%	0	85%	2
Marketing and Member Education (83)	76%	20	98%	2	99%	1	99%	1	96%	3
Member Grievances and Appeals (65)	95%	3	100%	0	89%	7	94%	4	100%	0
Quality Management (114)	96%	5	99%	1	97%	3	99%	1	100%	0
Fraud, Abuse and Waste Prevention (118)	100%	0	100%	0	75%	30	100%	0	98%	2
Reporting (1)	100%	0	100%	0	100%	0	100%	0	100%	0
Elements with Full Compliance & CAPs(%)[3]	714 (92%)	64 (8%)	749 (97%)	23 (3%)	713 (92%)	62 (8%)	751 (97%)	24 (3%)	741 (96%)	32 (4%)

[1] % Full: indicates the proportion of elements rated full compliance.

[2] CAPs: indicates the number of elements requiring corrective action plans.

[3] There were 780 elements reviewed for each MCO; the number of elements rated N/A were removed from the denominator for calculating percentages.

MCO: managed care organization; ABH: Aetna Better Health; ACLA: AmeriHealth Caritas Louisiana; HB: Healthy Blue; LHCC: Louisiana Healthcare Connections; UHC: UnitedHealthcare Community Plan; CAP: corrective action plan.

Compliance Results by Review Domain

Core Benefits and Services: The evaluation of this area included, but was not limited to, review of policies and procedures to ensure that required benefits were provided including behavioral health, emergency services, post stabilization, and special needs, as well as Early and Periodic Screening, Diagnostic and Treatment (EPSDT), eye care, and pharmacy benefits. This area also includes a review of care planning, care management, and transitions of care. Of the 115 total elements reviewed in this domain, two MCOs (ABH and ACLA) each had 100% full compliance determinations. There were a total of 13 CAPs required for this domain ranging from a high of 8 CAPs for UHC to a low of 2 CAPs for LHCC.

Provider Network Requirements: The evaluation of this area included, but was not limited to, review of policies and procedures for appointment availability, geographic access, monitoring and reporting on provider networks, provider credentialing and re-credentialing, enrollment of out-of-network providers, and the provider directory. Additionally, file review of credentialing and re-credentialing for PCPs and specialists was conducted. With 184 total elements reviewed for this domain, the percent of full compliance ranged from 93% full compliance for LHCC to 85% full compliance for ABH. While all MCOs had elements requiring CAPs for this domain, ABH had the most with 28 CAPs, followed by ACLA with 20 CAPs, HB with 16 CAPs, UHC with 15 CAPs, and LHCC with 12 CAPs. All five MCOs need to address issues raised in their compliance with provider network adequacy and conduct outreach to recruit providers, especially in key areas such as specialists and subspecialists, as this is a common problem in the Louisiana MMC program.

Utilization Management (UM): The evaluation of this area included, but was not limited to, review of UM policies and procedures, clinical practice guidelines, prior authorization, and over/under utilization reviews. Additionally, file review of adverse benefit determinations was conducted. ACLA and HB achieved 100% full compliance for this domain, while the other three MCOs also had high compliance, with 99% full compliance for ABH, 98% full compliance for UHC, and 95% full compliance for LHCC. With a total of 87 elements reviewed for this domain, there were only 7 CAPs required, including 4 for LHCC, 2 for UHC, and 1 for ABH. Though LHCC had only four elements in this domain that did not achieve full compliance, two of them, related to concurrent utilization review, were determined to be non-compliant, and two that were substantially compliant were related to UM file review issues. It was noted that the MCO should ensure that their policies referencing concurrent utilization review be updated to reflect the contract requirements and that staff receive education in properly notifying providers regarding UM decisions and in the timing requirements of informal reconsiderations.

Eligibility, Enrollment and Disenrollment: The evaluation of this area included, but was not limited to, review of policies and procedures for MCO enrollment and disenrollment. There were 13 elements reviewed in this domain, with the proportion of full compliance varying from a high of 100% full compliance for ACLA and LHCC, to a low of 46% full compliance for ABH. Eleven (11) CAPs were required overall: 7 CAPs from ABH; and 2 CAPs each from HB and UHC.

Marketing and Member Education: The evaluation of this area included, but was not limited to, review of policies and procedures related to marketing materials and activities, member informational materials, member handbook, and member services functions. With 83 elements reviewed for this domain, none of the MCOs achieved 100% full compliance. The level of full compliance ranged from 99% full compliance for HB and LHCC to 76% full compliance for ABH. ABH, with 20 of the 27 elements requiring a CAP for this domain, needs to direct improvement efforts in this area, especially to ensure that its member policies and procedures are up to date and reflect the state's regulations.

Member Grievances and Appeals: The evaluation of this area included, but was not limited to, the review of policies and procedures for processing member grievances and appeals, notice of action, and resolution and notification. Additionally, file review of member grievances and member appeals was conducted. Of the 65 elements reviewed in this domain, 2 MCOs (ACLA and UHC) each had 100% full compliance. For the other three MCOs, the proportion of full compliance ranged from 95% for ABH, to 89% for HB. With a total of 14 elements requiring a CAP, HB had 7 CAPs, followed by LHCC with 4 CAPs, and ABH with 3 CAPs.

Quality Management: The evaluation of this area included, but was not limited to, review of the MCO Quality Assessment and Performance Improvement (QAPI) Program, program description, QAPI Work Plan, QAPI Committee structure and function, accreditation, provider monitoring, PIPs, performance measure reporting, provider and member satisfaction surveys, and evidence-based practices. This domain, with 118 elements reviewed, had a high level of full compliance for all MCOs, including 100% full compliance for UHC, 99% full compliance for ACLA and LHCC, 97% full compliance for HB, and 96% full compliance for ABH. There were a total of 10 elements requiring a CAP; ABH had 5 elements requiring a CAP, followed by HB with 3 elements, and ACLA and LHCC each with 1 element.

Fraud, Abuse and Waste Prevention: The evaluation of this area included, but was not limited to, review of the policies and procedures related to provider fraud, waste, and abuse compliance, required disclosures, background checks, and prohibited affiliations. There were 3 MCOs (ABH, ACLA and LHCC) with 100% full compliance for the 118 elements reviewed in this domain, followed by UHC with 98% full compliance. HB only achieved 75% full compliance and had 30 elements requiring CAPs, including 15 elements that received a determination of minimally compliant. Significant attention is needed to ensure that HB improves compliance for this important regulatory area.

Reporting: The evaluation of this area included, but was not limited to, review of policies and procedures related to ownership disclosure and financial interest provisions, encounter data, financial reporting and health information system requirements. All five MCOs received 100% full compliance for the one element that was reviewed for this domain.

Overall determinations from the 2019 audit of PAHP and PIHP compliance with state and federal regulations are shown in **Table 7**.

Table 7: Overall Final PAHP and PIHP Compliance Results by Audit Domain: Reviews Conducted in 2019

Audit Domain	Magellan			MCNA Dental		
	# of Elements	% Full[1]	CAPs[2]	# of Elements	% Full[1]	CAPs[2]
Member Services	128	98%	3			
Provider Network Requirements	72	83%	12	103	98%	2
Care Management	44	100%	0			
Utilization Management	35	100%	0	79	100%	0
Provider Services	94	98%	2			
Enrollment	11	91%	1	17	100%	0
Grievance and Appeal System	76	93%	5	65	100%	0
Quality Management	65	99%	1	50	98%	1
Program Integrity	76	88%	8			
Audits, Records and Reports	1	100%	0	1	100%	0
Fraud, Waste and Abuse				96	100%	0
Provider Relations				45	100%	0
Member Education				78	100%	0
Total # of elements (% Full)[3]	602	560 (95%)	32(5%)	534	525 (99%)	3(1%)

[1] % Full: indicates the proportion of elements rated full compliance.
[2] CAPs: indicates the number of elements requiring corrective action plans.
[3] Total # of elements: the number of elements rated N/A were removed from the denominator for calculating percentages.
Grey shaded cells indicate domains that were not applicable to this MCE.
PAHP: prepaid ambulatory health plan; PIHP: prepaid inpatient health plan; MCNA: Managed Care of North America Dental; CAP: corrective action plan; MCE: managed care entity.

Both MCEs had full compliance audits in 2019 and both showed high overall compliance results. Ratings by domain for Magellan ranged from 83% full compliance for Provider Network Requirements, to 100% full compliance for three domains: Care Management; Utilization Management; and Audits, Records and Reports. The behavioral health MCE had 32 elements (5%) requiring CAPs. With 534 total elements reviewed, MCNA Dental had 7 out of the 9 domains rated 100% full compliance, while the remaining 2 domains each had 98% full compliance. MCNA Dental had only three elements requiring a CAP.

Evaluating Health Disparities

As stated in the Louisiana Quality Strategy, "LDH is committed to ensuring that improvements in health outcomes lead to equitable improvements in all groups." Accordingly, Section 2.6 of the Quality Strategy outlines procedures for identifying, evaluating, and reducing health disparities. Going forward, LDH has continued to implement the following strategies to address health disparities in the Healthy Louisiana population:

- Beginning January 1, 2020, LDH Medicaid will require MCOs to stratify performance metrics by race/ethnicity and urban/rural status.
- As a participant in CMS's Adult and Child Core Data Sets, LDH Medicaid is required to report to CMS on select performance measures for adult and child health. These measures are stratified by race, ethnicity, gender, geographic location (urban/rural), age, and disability (Supplemental Security Income [SSI]). The five racial categories for which data are collected 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. During the Medicaid application process, the applicant is asked to identify race, ethnicity, and primary language spoken. This data is processed through the Louisiana Medicaid Eligibility System and downloaded into the Medicaid Management Information System (MMIS). The applicant's preferred language is also identified and forwarded to the MMIS.

- All Medicaid managed care performance measure data can be accessed on the LDH website using the Quality Dashboard (https://qualitydashboard.ldh.la.gov/).
- In developing PIPs, MCOs are instructed to identify barriers that represent disparities (e.g. geographic, racial, behavioral health) and to implement interventions to address these barriers. PIP data results can be stratified by race, region, and MCO.
- A health disparities survey was first administered to the MCOs and reported in the 2016–2017 Annual Technical Report. The survey requests that the MCOs provide a description of actions being conducted to reduce disparities in health outcomes. Survey findings have been a part of Louisiana's Annual Technical Reports ever since. The current Annual Technical Reports for 2020 are available for each MCO on the LDH website (http://ldh.la.gov/index.cfm/page/3936).
- The EQRO has recently been tasked by LDH to design and conduct a behavioral health member satisfaction survey with the aim of producing a report that compares member satisfaction findings by MCO, and recommends actionable improvement for Healthy Louisiana overall. This report will interpret findings and identify demographic disparities in experience of care by age, sex, race/ethnicity, and MCO. Section III of the report will present a disparity analysis of the adult and child survey sample findings stratified by race/ethnicity, sex, primary language, disability status, and members with and without substance use disorder.
- In response to the 2019 Louisiana Senate Concurrent Resolution No. 70, sponsored by Senator Barrow, the LDH, Medicaid, and the Office of Public Health (OPH) are collaborating on a Community Health Worker (CHW) Workforce Committee to study and provide recommendations to the Secretary of the LDH related to supporting and expanding the community health worker workforce in Louisiana. According to the American Public Health Association (APHA), CHWs have helped to improve health outcomes, reduce costs of healthcare, and address social determinants of health by collaborating with healthcare, public health and social services systems.

Use of Sanctions

Louisiana's Quality Strategy outlines the state's use of 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 federal or state laws. Corrective Action Plans (CAPs) are often requested as a remedial action for MCOs with less than full compliance for elements reviewed in the annual Compliance Audit.

Healthy Louisiana MCOs must meet the requirements of their contract with LDH. If a contractor is deficient or non-compliant with contract requirements or federal or state laws, LDH may apply the following types of sanctions:

- Administrative actions and/or assess monetary penalties to obtain the level of performance required for successful operation of the Healthy Louisiana program;
- Appointment of temporary management for an MCO;
- Granting enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to dis-enroll;
- Suspension of all new enrollments, including automatic assignment;
- Suspension of payment for enrollees enrolled after the effective date of the sanction and until CMS or LDH is satisfied that the reason for the sanction no longer exists and is not likely to recur: and
- Additional sanctions allowed under state statutes or regulations that address the area of non-compliance.

Reports of administrative actions applied and/or monetary penalties assessed against each Healthy Louisiana MCO are posted on the LDH website from 2015 – 2019.[12] MCOs are notified by letter when there is a failed deliverable or non-compliance with contract requirements and are advised if a monetary penalty could or will be assessed. MCOs are allowed the opportunity to respond prior to a penalty being imposed. During CY 2019, the following issues resulted in receipt of a Notice of Action for potential sanction for two or more MCOs:

- Failure to provide accurate provider directory data;
- Failure to meet established benchmarks for quality improvement or performance measure outcomes;
- Claims reprocessing;

[12] LDH website link: http://ldh.la.gov/index.cfm/page/1610. (Accessed July 27, 2020).

- Prompt processing of claims;
- Standard resolution of appeals within specific timeframes; and
- Subcontractor performance.

Other notices of action directed to only one MCO regarded claims adjustments; marketing and member education materials review/free access to network pharmacies; UM program policies and procedures; drug utilization review; welcome calls and required deliverables submitted in a timely fashion.

State-MCO-EQRO Communications

Communication and collaboration are important in promoting effective quality monitoring and improvement. On a regular basis and sometimes ad hoc, communication between the state, MCOs, and the EQRO has evolved over time. IPRO communicates regularly with both LDH, and with each MCO by email and telephone, to gather information for EQR activities and to provide technical assistance. IPRO follows each PIP through to completion including conference calls with each MCO to discuss progress and problems and if needed, also conducts training for MCOs on PIP development and implementation.

LDH convenes meetings with the Medicaid Quality Committee and Medicaid Quality Subcommittees. The LDH website provides information regarding the Medicaid Quality Committee including upcoming events, meeting minutes and materials, links to resources and relevant reports, and a list of the committee and subcommittee members.

LDH effectively communicates with the MCOs, enrollees, and the public through a well-designed internet website which includes the following informational references:

- Informational Bulletins are posted on the Provider and Plan Resources webpage. Each bulletin is dated and identified by year and a sequential number. The purpose of the bulletin is to provide a centralized source of reference for new policies and/or procedures, and to clarify changes to current policies and procedures, thus offering a beneficial method of communicating this information with the MCOs and their provider network.
- Data transparency is evidenced by links on the website to the MCO executed contracts, quality performance measure reports, and MCO PIP reports. There is also a user-friendly, interactive Quality Dashboard that provides visual comparisons of MCO quality performance measure results.
- CMS required posting of the Louisiana Quality Strategy document, EQR annual technical reports, and current NCQA health plan accreditation status can also be found on the LDH website.

LDH contracts with an Enrollment Broker that is responsible for MMC enrollment and disenrollment activities. The Enrollment Broker provides daily updates on new enrollees and, at specified times each month, notifies each MCO on enrollments, re-enrollments, and dis-enrollments. MCOs use this information to maintain an enrollment file that includes race/ethnicity, primary language spoken, and selective health information, which assists the MCOs in determining what interpreter services are required in order to effectively communicate with enrollees.

Strategies and Interventions to Promote Quality Improvement

Louisiana's Quality Strategy includes several activities focused on quality improvement that are designed to build an innovative, well-coordinated system of care that addresses both medical and non-medical drivers of health such as PIPs, financial incentives, value-based payments (VBP), health information technology (HIT) and other LDH department-wide quality initiatives. This section discusses the current projects completed or ongoing in Louisiana.

Performance Improvement Projects

A protocol for conducting PIPs was developed by CMS[13] to assist MCOs in PIP design and implementation. Federal regulations require that all PIPs be validated according to guidelines specified by CMS. In Louisiana, the EQRO is responsible for validating all PIPs.

Each state's MMC program determines the number of PIPs required to be conducted each year. In Louisiana, MCOs are required to perform two LDH-approved PIPs and a minimum of one additional LDH-approved behavioral health PIP each contract year, and may require up to two additional projects for a total of five active PIPs. Behavioral Health Prepaid Inpatient Health Plan (PIHP) and the Dental Prepaid Ambulatory Health Plan (PAHP) also conduct PIPs that are validated by the EQRO.

The EQRO uses a systematic approach for validating MCO PIPs, including an EQRO and LDH review. The process begins with an EQRO and LDH review of the MCO's PIP proposal (topic rationale, aim, methodology, barrier analysis, planned interventions, and study indicators) using a PIP Report Checklist, created by IPRO. Each PIP component has a list of subcomponents which are rated as either Met, Partially Met, or Not Met. Specific comments are also included to further explain Partially Met and Not Met review determinations. IPRO's review of each PIP final report includes an analysis of indicator results compared to target rates, assessment of interventions to address barriers, PIP strengths and opportunities for improvement, and an overall determination of the credibility of the results.

In addition to baseline, interim and final reports, the MCOs also submit quarterly update reports. The Quarterly Update Report includes performance indicator results, interventions status, intervention tracking measures, and a discussion of barriers. The Prematurity PIP also included a PIP extension year during which the MCOs presented monthly Plan-Do-Study-Act (PDSA) updates. The hepatitis C virus (HCV) PIP entails monthly PDSA updates by the MCOs as well. The EQRO follows each PIP through to completion with conference calls with each MCO to discuss progress and problems. If needed, the EQRO also conducts training for MCOs on PIP development and implementation. Louisiana's statewide collaborative PIP model offers an opportunity for shared learning and an avenue to address the same message to all MMC providers and members. Individual MCO conference calls with the EQRO, quarterly update reports, and PDSA monthly presentations provide valuable insight on PIP progress, especially through the use of intervention tracking measures that can help quantify opportunities for improvement.

Table 8 lists the PIPs that are currently in process or completed in 2019.

[13] CMS has recently updated individual protocol documents and compiled them into one document, available on the CMS website: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf .

Table 8: Status of Healthy Louisiana Performance Improvement Projects

MCO	PIP Topic	PIP Period	Status
All MCOs	Improving Prenatal and Postpartum Care to Reduce the Risk of Preterm Birth	2015 – 2019	After the Final PIP, a one-year extension report was submitted on June 2018. MCOs presented monthly PDSA updates at the Prematurity PIP Intervention Tracking Measure (ITM) monthly meetings. The final PIP Extension PDSA status update was presented on June 20, 2019. Validation findings indicated that the credibility of the PIP results is not at risk for all MCOs.
All MCOs	Improving the Quality of Diagnosis, Management and Care Coordination for Children and Adolescents with Attention Deficit Hyperactivity Disorder (ADHD)	2015 – 2019	Final PIP report submitted in June 2019. Validation findings indicated that the credibility of the PIP results is not at risk for all MCOs.
All MCOs	Improving Rates for (1) Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) and (2) Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	2018 – 2020	Baseline measurement period for IET PIP: 1/1/2018 – 12/31/2018. PIP extension from 2019 to 2020 to include the FUA measure, as well as IET measure. Proposal/Baseline IET/FUA Report submitted February 2020. Final IET/FUA Report due 12/31/2020.
All MCOs	Improve Screening for Chronic Hepatitis C Virus (HCV) and Pharmaceutical Treatment Initiation	2019 – 2020	Baseline measurement period: 1/1/2019 – 12/31/2019. Revised Proposal/Baseline report was submitted March 2020. Final Report due 12/31/2020.
Dental (PAHP) and Behavioral Health (PIHP) Performance Improvement Projects			
MCNA Dental	Improving Enrollee Receipt of Oral Health Services	2016 – 2019	Baseline measurement period: 1/1/2015 – 12/31/2015; 3 re-measurement periods included an extension year from 1/1/2018 – 12/31/2018. The Final Extension PIP Report was submitted in April 2019. Validation findings indicated that the credibility of the PIP results is not at risk.
Behavioral Health: Magellan of Louisiana CSoC Program	Monitoring Hospitalization Follow-up Practices	2019 – 2020	The revised proposal was submitted on 7/30/2019, Proposal /Baseline Report submitted on 10/3/2019, and the First Interim Report submitted on 5/1/2020. Second Interim Report due 5/1/2021 and Final Report 5/1/2022.

MCO: managed care organization; PIP: performance improvement project; PDSA: Plan-Do-Study-Act; PAHP: prepaid ambulatory health plan; PIHP: prepaid inpatient health plan; MCNA: Managed Care of North America; CSoC: Coordinated System of Care.

Financial Incentives

Pay for Performance (P4P) incentive award programs have been implemented in states across the country as a means of improving quality performance. Some states have opted for a select set of measures while others include a much broader set of measures. State methodologies evaluate whether MCOs meet targeted goals, or improve year to year, or both. Several state methodologies also include penalties, such as failure to comply with submission requirements for reports or data or failure to meet benchmarks.

Managed Care Incentive Payment (MCIP) Program and Value-Based Payments

Beginning in 2018, LDH Medicaid introduced an MCO withhold of capitation payments to increase the use of VBP and improve health outcomes. MCO contracts required a two-percent (2%) withhold of capitation payments; half of the withhold was tied to achievement of quality and health outcome targets for a selected set of incentive-based quality measures, while the other half was linked to increasing MCOs' use of VBP. The MCO model contract sets the guidelines for earning back half or all of the VBP withhold amount based on the MCO maintaining or increasing its state fiscal year reported use of VBP consistent with the MCO's VBP Strategic Plan deliverables and its use of payment models described in the Learning Action Network (LAN) Alternative Payment Models Framework.

For the quality and health outcomes portion of the capitation withhold, 16 incentive-based measures were selected by LDH, including 15 measures submitted by the Healthy Louisiana MCOs as part of their 2019 HEDIS and CAHPS submissions, plus 1 non-HEDIS, state-specific measure, Initiation of Injectable Progesterone for Preterm Birth Prevention, which was calculated by LDH and ULM **(Table 3).** All incentive-based measures are equally weighted in terms of earning back the quality withhold. To earn back the full withhold amount associated with each incentive-based measure, the MCO must either meet the achievement target for that measure or show improvement in the measure rate by at least a 2.0 percentage point difference from the prior year's rate.

The EQRO validated HEDIS measure results for the 2019 reporting year in the report entitled "2019 Healthy Louisiana HEDIS Performance Measure Results and Analysis," which is available on the LDH website. For the incentive-based measures, the Medicaid MCOs performed well. ACLA and UHC met the target rate or improved by 2.0 percentage points for 14 of the 15 HEDIS incentive measures (93%), HB met the target rate or the improvement objective for 13 of these measures (87%), and ABH and LHCC met the target rate or improvement objective for 11 measures (73%). Although not connected to any withhold payments, the statewide average rate met the target rate or improvement objective for 12 of the 15 HEDIS measures (80%).

It is difficult to assess the impact of applying a financial incentive to improve quality of care as indicated by these incentive-based measures. By choosing a select set of measures, as opposed to using all reported measures, LDH can provide a more defined focus for MCO interventions that encourage provider behavior change leading to improvement of health outcomes. This incentive-based measure set is also comprehensive in that it addresses a concern for adult, child, and adolescent preventive care, ambulatory care, behavioral health, access to care and chronic conditions, as well as consumer satisfaction. It is important to use financial incentive strategies in the context of a broader quality improvement agenda, which LDH has in place. However, it is difficult to determine if the measure results would have occurred without the incentive, or if the incentives for selected measures result in disincentives for improvement of other measures.

Health Information Technology

LDH's long-term approach to HIT and health information exchange (HIE) began with the creation of the 2018–2021 Louisiana HIT Roadmap, prepared by Myers and Stauffer. The Roadmap includes suggested areas to advance the state's health IT infrastructure and related timelines, potential methods to promote information exchange among various data sources, and possible approaches for enhanced stakeholder involvement to support integrated service delivery and alternative payment models in order to produce measureable improvements in health and financial outcomes. The Roadmap is intended to be used as a resource for LDH and its stakeholders as they invest in health IT and data exchange models throughout the state.

During the development phase of the Health IT Roadmap plan, two statewide initiatives were proposed for 2019, including a statewide health information exchange summit and state stakeholder listening sessions, to better understand the needs of the stakeholder community. An LDH state agency discovery session with health-related state agency business and IT leaders and their staff was also planned to identify and prioritize activities and projects necessary for secure data exchange.

Other LDH Department-wide Quality Initiatives

The MMC program has benefitted from collaboration within the department in support of several on-going quality initiatives as follows:

- **Taking Aim at Cancer in Louisiana**: This statewide initiative was launched in May 2018 with a three-year grant from UnitedHealth Group to the Louisiana Cancer Consortium. The collaborative has successfully brought together payers, service providers, employers and advocates with an aim to improve cancer outcomes in Louisiana by expanding residents' access to cancer prevention, screening and standard of care treatment. Since the initial launch, the collaborative has worked to develop a coordinated strategy to improve cancer care and outcomes with a focus on colorectal cancer screening to reduce associated mortality and breast cancer treatment to improve outcomes and reduce treatment variation. At the end of the current three-year grant period, the collaborative will transfer the Taking Aim at Cancer initiative into a 501(c)(3) corporation in order to continue its efforts.

- **Louisiana Perinatal Quality Collaborative (LaPQC)**: This is an initiative of the Louisiana Commission on Perinatal Care and Prevention of Infant Mortality, a voluntary network of perinatal care providers, public health professionals and patient and community advocates supported by the LDH Office of Public Health, Bureau of Family Health. The goal of the collaborative is to transform systems so that evidence-based practices are followed for every family, every time at every birth facility. By participating in this collaborative, Louisiana hospitals are also benefitting from participation in a similar national effort, the Alliance for Innovation on Maternal Health, which has shown that best practices can result in real change for a state's maternal health outcomes. The collaborative's current focus is on improving maternal outcomes related to hemorrhage and hypertension and to reduce Louisiana's primary cesarean section rate through the *Safe Births (Reducing Maternal Morbidity) Initiative.*

- **Opioid Strategy:** Taking advantage of expanded federal grants from CDC and the Substance Abuse and Mental Health Services Administration (SAMHSA), LDH and the Office of Behavioral Health has continued to strive to expand access to opioid use disorder treatment in primary care settings. Activities of the Opioid Strategy include:
    - Passing of Act 88 of the Louisiana Legislature establishing the Advisory Council on Heroin and Opioid Prevention and Education (HOPE Council) to combat heroin and opioid use and abuse;
    - Expert Panel Recommendations to Address the Opioid Epidemic, 2018;
    - A three-day Opioid Action Summit held in early September 2019 that brought together healthcare providers, subject matter experts and addiction providers dedicated to addressing the opioid crisis; followed by LDH's release of Louisiana's Opioid Response Plan 2019; and The Louisiana Comprehensive Opioid Abuse Program Action Plan dated October 23, 2019;
    - Bureau of Health Informatics (BHI) in the Office of Public Health (OPH) supported these strategies by making data from multiple internal and external sources accessible through the Louisiana Opioid Data and Surveillance System tool;[14]
    - In July 2020, the ATLAS (Addiction Treatment Locator, Assessment and Standards) on-line platform was created to provide standardized information on the quality of treatment facilities in the state that could appropriately assist an individual who is seeking addiction treatment services.

- **Hepatitis C Elimination Strategy:** In efforts to eliminate hepatitis C, LDH continues to engage partners across the state to educate the public on the availability of a cure for hepatitis C; to outreach to high-risk populations for screenings; to connect people living with hepatitis C to care; and to expand provider capacity. In June 2019, LDH and the Louisiana Department of Corrections launched an innovative payment model as part of Louisiana's plan to eliminate hepatitis C. By partnering with Asegua Therapeutics LLC, this model allows the state to provide an unrestricted amount of the pharmaceutical company's direct-acting antiviral medication to treat patients who are on Medicaid or who receive care through the state's correction system.

[14] Louisiana Opioid Data and Surveillance System tool: https://lodss.ldh.la.gov/ (Accessed July 31, 2020).

•

Strengths, Opportunities for Improvement and Recommendations

The strengths and opportunities for improvement in Louisiana's MMC program are presented in this section as a culmination of this quality strategy evaluation summary.

Strengths

- Louisiana's Quality Strategy, entitled "Louisiana's Medicaid Managed Care Quality Strategy," was a major update and was approved by CMS on March 20, 2019.
- Aligned with IHI's Triple Aim[15] and the aims and priorities selected by CMS for their national quality strategy, Louisiana's Quality Strategy established three aims:
  - **Better Care**: Make healthcare more person-centered, coordinated and accessible.
  - **Healthier People, Healthier Communities**: Improve the health of Louisianans through better prevention and treatment and proven interventions that address physical, behavioral and social needs.
  - **Smarter Spending:** Demonstrate good stewardship of public resources by ensuring high-value, efficient care.
- LDH requires MCOs to annually report quality performance measures including HEDIS quality metrics, CMS Adult and Children Core Data Sets, AHRQ Prevention Quality Indicators, CAHPS consumer satisfaction, and several state-specified quality measures. All quality data is submitted annually by all five MCOs.
  - Louisiana Medicaid MCOs showed a high level of performance for achieving either the national benchmark target or the improvement objective or both for the 16 Incentive-Based measures selected by LDH. Ten (10) of the 16 measures (63%) met or exceeded the national Medicaid 50th percentile target rate for the year prior to the MY. Seven measures (44%) improved by 2.0 or more percentage points between 2018 and 2019 reporting years. Statewide rates for four of the measures met both the national target and the improvement objective.
  - Of the 60 non-incentive HEDIS measures that could be trended, 48 (80%) showed improvement; 11 (18%) of these measures improved by at least 2.0 percentage points from the prior year.
  - Of the 59 non-incentive HEDIS measures that could be compared to the 2019 NCQA *Quality Compass* benchmark rates, 25 measures (42%) had rates at or above the national 50th percentile.
  - For the state-specific measures submitted by the MCOs in 2019, 10 of the 16 measure rates (63%) showed improvement between 2018 and 2019, including three measures where a lower rate indicates better performance; one measure (PQI05: COPD and Asthma in Older Adults Admission Rate) improved by at least 2 percentage points.
- The 2019 annual compliance audit was a full audit of each of the five MCOs' compliance with contractual requirements during the period of April 1, 2018 through March 31, 2019. Overall results indicated a high level of full compliance, from HB with 92% of total elements reviewed achieving full compliance, to ACLA and LHCC each achieving 97% of total elements with full compliance.
- LDH has shown its commitment to ensuring that improvements in health outcomes lead to equitable improvements in all groups as it has integrated procedures for identifying, evaluating, and reducing health disparities throughout the Healthy Louisiana program.
- There is effective communication between the state, MCOs, and the EQRO as evidenced by regularly scheduled meetings and conference calls for EQR activities. LDH commendably communicates with the MCOs, enrollees and the public through a well-designed internet website.
- There is a structured and standardized approach in place for conducting and validating PIPs. In 2019, Louisiana MCOs submitted an extended year of data for the Improving Prenatal and Postpartum Care to Reduce the Risk of Preterm Birth PIP and a final PIP report for Improving the Quality of Diagnosis, Management and Care Coordination for Children and Adolescents with Attention Deficit Hyperactivity Disorder (ADHD). The EQRO validated all final PIPs.
- Healthy Louisiana has successfully integrated quality as a fundamental aspect of the managed care program by introducing an MCO withhold of capitation payments to increase the use of VBP and improve health outcomes.

[15] Institute for Healthcare Improvement (IHI): Triple Aim: http://www.ihi.org/Topics/TripleAim/Pages/Overview.aspx (Accessed July 13, 2020).

Opportunities for Improvement

- Opportunities for improvement are evident for three statewide incentive-based measures that failed to meet either the national target or the improvement objective:
  - Comprehensive Diabetes Care – HbA1c Testing;
  - Follow-up after Hospitalization for Mental Illness – Within 30 Days of Discharge; and
  - Timeliness of Prenatal Care.
- There were 10 non-incentive HEDIS measures (17%) that had decreasing rates of performance between HEDIS 2018 and HEDIS 2019.Opportunities for improvement are also evident for 18 measures (30%) with rates below the national 25th percentile in this measure set.
- Opportunities for improvement should address the following state-specific performance measures:
  - 15 of the 16 statewide average rates did not meet or exceed the target objective, and 15 of the 16 of the statewide rates did not meet the improvement objective.
  - Contraceptive Care-Postpartum (ages 15–20), LARC 60 days and Contraceptive Care-Postpartum (ages 21–44), LARC 60 days both decreased in rate from 2018 to 2019.
  - In addition, for the measures where a lower rate indicates better performance, four measure rates increased.
  - The PQI measures showed the largest gaps between the 2019 statewide averages and the target MCO performance from the prior year. LDH may want to learn more from the MCOs by exploring what barriers they are facing in reducing the PQI rates and collaborate on ways to improve.
- The following 2019 Compliance Review findings indicate opportunities for improvement:
  - All MCOs were required to prepare CAPs for elements that were not fully compliant, which included 64 elements for ABH, 62 elements for HB, 32 elements for UHC, 24 elements for LHCC, and 23 elements for ACLA.
  - For the five MCOs, a total of 91 CAPs were required for the Provider Network Requirement domain. The EQRO suggested that MCOs conduct outreach to recruit providers, especially in key areas such as specialists and subspecialists, as this is a common problem in the Louisiana Medicaid managed care program.

Recommendations

Overall, LDH is successfully implementing the 2019 Quality Strategy, but it is recommended that LDH, in collaboration with the EQRO and the MCOs, address the above listed opportunities for improvement and the following recommendations.

- While the statewide results of the incentivized measures demonstrated success in terms of the number of measures resulting in withhold payments returned to the MCOs, each of the MCOs has a different set of measures that present opportunities for their improvement. There were seven incentive-based measures where the MCOs met either the achievement target, or the improvement objective, or both, while there were eight measures that had at least one MCO not meeting either objective. Each MCO must examine their own results and determine how best to meet the objectives for the incentivized measure.
- For the non-incentive HEDIS measures and the state-specific measures, LDH should examine each of the measures that have statewide average rates that are not improving over time or that are below the desired benchmarks. To prioritize where improvement is most needed, LDH could start with the 18 HEDIS measure rates that were below the Medicaid *Quality Compass* 25th percentile for HEDIS 2019. Further analysis by MCO may indicate whether poor performance is mainly a problem with one or two MCOs, or if it is an issue for most MCOs. Conducting barrier analysis on the issues may suggest implementing interventions such as future PIPs or focused clinical studies.
- Compliance audit results indicated a need to further address provider network adequacy, which was identified by the reviewers as a common problem in the Louisiana Medicaid managed care program. LDH may want to consider methods of supporting the MCOs in their outreach to recruit providers, especially in key areas such as specialists and subspecialists in urban areas. It should also be noted that Network Adequacy Validation is now a mandatory EQR activity, but CMS has not yet published a protocol to support the activity. Once the protocol is created, states will have one year to begin implementation. In anticipation of this requirement, LDH could consider initiating validation activities such as regular provider directory validations and/or access and availability surveys to provide a basis for implementing the upcoming CMS protocol.