State of Louisiana
Department of Health

Quality Companion Guide for Healthy Louisiana Managed Care Organizations

FINAL

May 2021

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Section 1: Introduction

Quality Companion Guide Purpose

The Quality Companion Guide (the Guide) focuses on core Quality Improvement (QI) activities to assist managed care entities (MCEs) with Louisiana Department of Health (LDH) contract requirements and external quality review organization (EQRO) activities and processes. The Guide is updated annually and timeframes provided for each activity may be modified at the discretion of LDH.

External Quality Review Regulations

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

EQR-Related Activities

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

Table 1: EQR-Related Activities

EQR-Related Activity	Type
Validation of performance improvement projects	Mandatory
Validation of performance measures	Mandatory
Review to determine plan compliance with structure and operations standards and quality assessment and performance improvement	Mandatory
Preparation of MCEs' annual technical reports	Mandatory
Validation of network adequacy: Provider Directory Survey Provider Access Survey	Mandatory
Administration or validation of provider satisfaction surveys	Optional
Calculation of performance measures	Optional
Conduct of performance improvement projects	Optional
Conduct of studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time	Optional
Development of a quality rating system (QRS)	Optional
Behavioral health member survey	Optional
Evaluation of Louisiana's quality strategy	Optional
CAHPS dashboard and summary report	Optional
Technical Assistance	Optional

EQR: external quality review; QRS: quality rating system; CAHPS: Consumer Assessment of healthcare Providers and Systems.

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

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

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

EQR Annual Reporting Requirements

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

Louisiana Medicaid Managed Care EQR Overview

A brief description of each IPRO deliverable under this contract's scope of work follows:

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

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

Performance improvement project validation: Present the performance improvement project (PIP) reporting method through a timeline and instructions, assess MCE/PAHP methodology for conducting PIPs, evaluate overall validity and reliability of PIP study results, and evaluate the success of interventions to improve quality of care. Assist LDH staff in leading PIP status conference calls and meetings to monitor the progress of the state's collaborative projects. Two rapid cycle PIPs are being undertaken by the MCEs in 2021. One behavioral health PIP is focused on the Healthcare Effectiveness Data and Information Set (HEDIS®) Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) measure, whose goal is to improve care provided to members with substance use disorders (SUDs). The second PIP topic is intended to improve hepatitis C virus (HCV) screening and treatment. A detailed description of each of these PIPs is described in more detail in **Section 4** of this Guide.

Performance measure validation: For the LDH-selected performance measures (PMs), evaluate the calculation process and the reporting method, evaluate data accuracy via data validation activities, report the results for each MCE, and derive statewide averages, present regional and national benchmarks, and compare the results.

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

The Quality Companion Guide: Develop a written document to assist MCEs in carrying out QI activities including background information on EQR regulations and the role of the EQRO and instructions and timelines related to readiness review, annual compliance review, PIP validation, PM validation, and other EQR activities. The Quality Companion Guide is updated annually. The annual Quality Companion Guide was last completed in April 2020.

Provider surveys: LDH requires provider surveys to be done by MCEs and submit to LDH. IPRO will not conduct provider surveys this year.

Validation of network adequacy: Two types of telephone surveys will be conducted to help assess the MCEs' network adequacy. A provider directory audit will be conducted quarterly to assess the accuracy of the information contained in the MCEs' online provider directories. A second survey will be conducted that will assess the MCEs' network providers' ability to meet the state's appointment availability standards. This survey will follow the "secret shopper" methodology, where phone interviewers will role-play as Medicaid members and will attempt to make an appointment with a provider in the MCEs' network. The timeframe for this survey will be determined.

The Quality Rating System (QRS): An MMC QRS developed by CMS will be adopted by the state. The QRS will be used to evaluate and apply a rating to measure the quality of care provided by the MCEs. The CMS framework, methodology, and performance measures that align with the Louisiana quality strategy will be utilized.
Behavioral health member survey: An annual statewide member survey will be developed and administered annually to evaluate members' experience and satisfaction with the services they are receiving from the MCEs' behavioral health (BH) network providers. Findings of this survey will be used to help evaluate access to and quality of BH care in the state and compare performance across MCEs.

Evaluation of Louisiana's quality strategy: Annually, a comprehensive assessment of the state's Medicaid managed care quality strategy, developed as per Federal Regulation 42 CFR 438, Subpart E, will be conducted and posted on the LDH website. The evaluation will analyze state reports, measurement results, and other documents and procedures to evaluate the state's success in meeting the goals of the quality strategy.

Consumer Assessment of Healthcare Provider and Systems (CAHPS) dashboard and summary report: LDH requires each of the state's MCEs to report CAHPS as part of the annual HEDIS submission. A CAHPS data dashboard and summary report will be developed to help LDH monitor the MMC program.

Focus Study: The conduct of a focus study is an optional activity. At the discretion of LDH, IPRO will design and conduct focus studies to evaluate the quality of clinical and/or nonclinical services on a topic of high priority for the state. IPRO will collaborate with LDH to ensure alignment of study topics and objectives with the state's Quality Strategy and its goals and initiatives. A focus study is not under consideration for the 2021 time period.

Technical Assistance: IPRO, at the State's direction, provide technical guidance to groups of MCOs, PIHPs, PAHPs, or PCCM entities (described in § 438.310(c)(2)) to assist them in conducting activities related to the mandatory and optional activities described in this section that provide information for the EQR and the resulting EQR technical report. As an example, during 2021, IPRO will assist LDH in helping the MCEs conduct their behavioral provider monitoring program.

Section 2: Readiness Review

It is not anticipated that LDH will request that IPRO conduct any readiness reviews for the mainstream MCEs during the 2020–2021 contract year. Readiness reviews are being conducted in late 2021 for two dental PAHPs. This section describes the general process that is followed in Louisiana.

Process Overview

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

Task Description

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

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

The readiness reviews are conducted in three phases:

1. pre-onsite (desk review),
2. onsite/remote meetings, and
3. post-onsite (onsite follow-ups and reporting).

Methodology

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

Table 2: Readiness Review Requirements

LDH MCE Requirements	Domains Assessed
Scope of work/requirements	Eligibility, enrollment and disenrollment
Staff requirements and support services	Member education
MCE reimbursement	Marketing
Core benefits and services	Member grievance and appeals
Provider network requirements	Quality management
Utilization management	Fraud, waste and abuse prevention
Provider services	

LDH: Louisiana Department of Health; MCE: managed care entity.

Scoring criteria: Each LDH requirement is scored individually and on a three-point scale (**Table 3**).

Table 3: Readiness Review Scoring Criteria

Review Determination	Description
Ready (full compliance)	MCE has met or exceeded requirements.
Not ready (non-compliance)	MCE has not met the requirements.
Not applicable	Requirement is not applicable.

MCE: managed care entity.

Schedule onsite/remote reviews: IPRO contacts each MCE to schedule the onsite or remote reviews. Onsite reviews are conducted at the MCE local offices. Remote reviews are conducted via video conferences.

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

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

Desk Review

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

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

Onsite/Remote Review

Each onsite/remote readiness review is completed in 1–2 days with additional teleconference time scheduled as necessary. The review begins with an opening conference during which IPRO presents an overview of the readiness review process and reviews the agenda for the visit. During the site visit, appropriate MCE managers and staff are interviewed in key areas, and relevant documentation is reviewed. The review concludes with a closing conference, during which IPRO provides feedback regarding preliminary findings.

Reporting

IPRO provides LDH with a readiness review report generally within 2 weeks of the onsite/remote meeting. At LDH's discretion, IPRO distributes the MCE-specific findings to the respective MCEs. IPRO rates the MCE in each area as being "ready" or "not ready" (**Table 3**). Two categories of concern are identified: major areas of concern that the MCE must address prior to initiation of enrollment, and minor areas of concern that need to be corrected by a specific date, but do not have to be corrected prior to initiation of enrollment. It is the expectation that before MCEs begin operation, a "ready" designation is required for each critical area of concern.

LDH makes all final decisions regarding MCE operational readiness.

Timeline

The approximate readiness review timeline is outlined in **Table 4**.

Table 4: Readiness Review Timeline

Readiness Review Task	Approximate Timeline
IPRO discusses with LDH the review methodology and obtains all necessary source documents.	Month 1
IPRO conducts pre-onsite/remote review (e.g., policies and contract materials).	Month 1
IPRO prepares and submits draft review methodology including review criteria, tools, crosswalk of standards eligible for deeming, and pre-onsite correspondence to LDH for review and approval.	Month 2
IPRO finalizes review methodology based upon LDH feedback.	Month 3
IPRO conducts review process orientation for MCE.	Month 4
IPRO conducts onsite/remote review.	Month 5
IPRO completes post-onsite/remote review and issues a readiness review report to LDH.	Months 6–7
Readiness review findings are distributed to the MCEs.	Month 8

LDH: Louisiana Department of Health; MCE: managed care entity.

Section 3: Annual Compliance Review

A targeted case management review for the five Healthy Louisiana MCEs will be conducted in 2021. It is expected that IPRO will conduct full compliance reviews for the five Healthy Louisiana MCEs, as well as for MCNA Dental, DentaQuest and Magellan Health during calendar year 2022. The reviews will focus on elements with which MCEs were found to be less than fully compliant in 2020 in addition to any new contractual requirements in effect since conducting of the compliance review in 2021.

Process Overview

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

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

Task Description

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

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

Methodology

Phase One: Pre-assessment Activities

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

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

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

Scoring criteria: Each standard is rated as being in "full compliance," "substantial compliance," "minimal compliance," or "non-compliance" (**Table 5**).

Table 5: Compliance Review Scoring Criteria

Review Designation	Description
Full compliance	MCE has met or exceeded the standard.
Substantial compliance	MCE has met most of requirements of the standard, but has minor deficiencies.
Minimal compliance	MCE has met some requirements of the standard, but has significant deficiencies requiring corrective action.
Non-compliance	MCE has not met the standard.

MCE: managed care entity.

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

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

Introductory packet: IPRO prepares and submits an introductory packet to the MCEs including:

- confirmation of the dates for the assessment;
- a detailed site visit agenda;
- identification of the assessment team members;
- pre-onsite documentation request (all documents required for the compliance review will be requested); and
- request for listings of files eligible for review.

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

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

Phase Two: Onsite/Remote Assessment Activities

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

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

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

Phase Three: Post-assessment Activities

Preliminary findings: Upon completion of the onsite/remote assessment, IPRO reviewers complete the assessment tools and assign scoring designations to each standard/requirement. Preliminary findings are submitted to LDH for review, after which they are sent to the MCEs to provide them with an opportunity to provide additional documentation to address the compliance issue.

Final findings: At LDH's direction, IPRO distributes the MCE-specific findings to the respective MCEs.

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

Timeline

The approximate compliance review timeline is outlined in **Table 6**.

Table 6: Compliance Review Timeline

Compliance Review Task	Approximate Timeline
IPRO discusses with LDH the review methodology and obtains all necessary source documents.	March 2021
IPRO prepares and submits draft review methodology including review criteria, tools, crosswalk of standards eligible for deeming, and pre-onsite correspondence to LDH for review and approval.	March 2021
IPRO finalizes review methodology based upon LDH feedback.	April 2021
IPRO conducts review process orientation for MCE.	May 2021
IPRO sends introductory communication and requests pre-onsite documentation including eligible file lists from MCE.	May 2021
IPRO provides list of selected files to MCE.	June 2021
IPRO reviews pre-onsite documentation, as submitted by MCE.	June 2021
IPRO conducts onsite/remote compliance review (opening conference, documentation review, interviews, observation, and closing conference).	July/August 2021
IPRO prepares and submits annual compliance review report to LDH.	October 2021

LDH: Louisiana Department of Health; MCE: managed care entity.

Section 4: Performance Improvement Projects

Process Overview

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

Task Description

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

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

MCEs are required to conduct a minimum of two LDH-approved PIPs each year. For 2021, the MCEs will be conducting three PIPs.

Within 3 months of the execution of the contract and annually thereafter, the MCEs submit, in writing, a general and a detailed description of each PIP to IPRO on behalf of LDH for approval.

MCEs typically follow an approximate 1- to 3-year approach to collection of PIP baseline data and subsequent measurement of demonstrable improvement and measurement of sustained improvement. PIPs can be implemented early on as opposed to waiting for the MCEs to have a full year of service data.

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

Methodology

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

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

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

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

Each PIP is evaluated against the following elements:

Demonstrable Improvement

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

Sustained Improvement

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

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

Reporting

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

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

IPRO, in conjunction with LDH, holds regular teleconference calls with the MCEs to review the status of each PIP, report on intervention tracking measures, assess any barriers or need for change, and discuss the implementation strategy and timeline. In addition, IPRO facilitates an ITM workgroup that meets regularly for the Prematurity PIP extension period from July 1, 2019, to June 30, 2020.

PIP Topics for 2020–2021

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment PIP: In 2019, the five Healthy Louisiana MCEs initiated a second PIP collaborative for the Office of Behavioral Health (OBH)/LDH framed around the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) measure. The aim of the PIP is to identify barriers and develop interventions to address the barriers observed with the goal to improve care provided to members with substance use disorders (SUDs), especially to improve follow-up care after members have been diagnosed with an SUD. In 2020, the aim was expanded to include performance improvement of the Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) measure and, in 2021, the aim was further expanded to include performance improvement of the Pharmacotherapy for Opioid Use Disorder (POD) measure. This PIP follows the collaborative model. The PIP is scheduled to be completed in December 31, 2021, with the issuance of the MCEs' final reports.

HCV Screening PIP: The PIP to Improve Screening for Chronic Hepatitis C Virus (HCV) and Pharmaceutical Treatment Initiation was initiated in 2020. Member interventions include member outreach, education and referral to providers for HCV screening and treatment, as indicated. Provider interventions include provider education on evidence-based recommendations and availability of HCV specialty providers. This PIP follows the collaborative model. The PIP is scheduled to be completed in December 31, 2021, with the issuance of the MCEs' final reports.

Developmental Screening PIP: In 2021, the LDH aims to increase the percentage of children screened for risk of developmental, behavioral and social delays using a standardized global developmental screening tool in the 12 months preceding or on their first, second or third birthday.

The five Healthy Louisiana MCEs are focusing on 1) Conduct provider education on standardized global developmental screening tools, Healthy Louisiana billing & coding guideline, and early intervention programs. 2) Develop member gap reports, stratify by provider and distribute to providers. 3) Conduct parent education on importance of developmental screening. Conduct enhanced care coordination outreach/education to parents of members on gap report. 4) Conduct a Quarter 1 through Quarter 3 2021 PCP chart review of a) random sample of 30 charts in the Indicator 1 denominator with CPT Code 96110 to validate whether the tools in Table 4a were utilized for global developmental screening b) random sample of 30 eligible population charts in the Indicator 1 denominator without CPT Code 96110 to discern whether the tools in Table 4a were utilized for global developmental screening at the child's 9-month, 18 month or 30 month visit. 5) Collaborate with early intervention programs (EIP) and coordinate with providers to facilitate referrals from providers to EIP. This PIP follows the collaborative model. The PIP is scheduled to be completed in December 31, 2021, with the issuance of the MCEs' final reports.

COVID-19 Vaccine PIP: In 2021, LDH will initiate a PIP to ensure access to the COVID-19 vaccine among Healthy Louisiana vaccine-eligible enrollees. Performance indicators include receipt of at least one dose of the COVID-19 vaccine, and receipt of the complete vaccine course, overall and stratified by race/ethnicity. Member interventions include COVID-19 vaccine education, referral and facilitation of appointment scheduling for eligible enrollees, both in case management and not in case management, to COVID-19 vaccination sites. Provider interventions include the distribution of listings of COVID-19 vaccine-eligible enrollees, as well as listings of vaccination sites and other LINK-enrolled providers, to PCPs. The MCEs will collaborate with state and local partners to outreach to racial/ethnic minority enrollees. This PIP follows the collaborative model. The Baseline Report is due from the MCEs on April 5, 2021 and the Final Report is due on December 31, 2021.

Dental PIP: In 2021, MCNA Dental and DentaQuest will initiate a PIP to improve dental sealant receipt on permanent first molars. Improvement will be measured using the CMS Child Core Set performance indicator, as specified by the Dental Quality Alliance. The PIP Proposal/Baseline Report is due from MCNA Dental and DentaQuest by May 3, 2021.

Behavioral Health PIP (CSoC) Magellan Health: In 2020, initiated a PIP to improve the rates for the Follow-up After Hospitalization for Mental Illness (FUH) performance measure among the Coordinated System of Care (CSoC) population enrolled in Magellan of Louisiana. Interventions include the utilization of PST services to increase engagement with families while the youth is hospitalized, and the conduct of a crisis CFT by wraparound facilitators during the inpatient

hospitalization or no later than three business days following discharge. Magellan of Louisiana's 2nd Interim report is due on May 1, 2021 and the Final Report is due on May 1, 2022.

Timeline

The approximate timelines for the IET, HCV, Developmental Screening, COVID-19 Vaccine, Dental and the CSoC PIPs are outlined in **Tables 7**, **8**, **9, 10**, **11** and **12** respectively.

Table 7: Timeline for the Alcohol and Other Drug Dependence Treatment PIP

PIP Task[1]	Approximate Timeline
MCEs initiate interventions	February 2021
MCEs submit 1st quarterly status reports for intervention period of 1/1/21–3/31/21	April 30, 2021
MCEs submit 2nd quarterly status reports for intervention period of 4/1/21–6/30/21	July 31, 2021
MCEs submit 3rd quarterly status reports for intervention period of 7/1/21–9/30/21	October 31, 2021
MCEs submit IET/FUA/POD draft reports with CY 2021 data	December 10, 2021
MCEs IET/FUA/POD final reports with CY 2021 data	December 31, 2021

[1] PIPs: Improving Rates for (1) Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (EIT) and (2) Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA); (3) Pharmacotherapy for Opioid Use Disorder (POD).
PIP: performance improvement project; MCE: managed care entity; IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment; FUA: Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence; POD: Pharmacotherapy for Opioid Use Disorder; CY: calendar year.

Table 8: Timeline for the Chronic Hepatitis C Virus PIP

PIP Task[1]	Approximate Timeline
MCEs submit PIP proposals on the topic of HCV	February 2021
IPRO reviews PIP proposals, baseline data, and target rates; holds conference calls with MCEs as needed; and prepares PIP review reports	February 2021
MCEs initiate interventions	February 2021
MCEs submit their first set of quarterly cumulative performance indicators and non-cumulative intervention tracking measures (ITMs) for the intervention period of 2/1/20–3/31/21	April 30, 2021
MCEs submit their second set of quarterly cumulative performance indicators and non-cumulative ITMs for the intervention period of 4/1/20–6/31/21	July 31, 2021
MCEs submit their third set of quarterly cumulative performance indicators and non-cumulative ITMs for intervention period of 7/1/20–9/30/21	October 31, 2021
IPRO and LDH hold collaborative calls with the MCEs to obtain progress reports from the MCEs and address the MCEs' issues and concerns	Quarterly
MCEs will submit first drafts of final reports for interim (1/1/21–12/31/21) measurement period to LDH	December 10, 2021
MCEs submit finalized final reports for interim (1/1/21–12/31/21) measurement period to LDH	December 31, 2021

[1] Improve Screening for Chronic Hepatitis C Virus (HCV) and Pharmaceutical Treatment Initiation Performance Improvement Project.
HCV: Chronic hepatitis C virus; PIP: performance improvement project; MCE: managed care entity; ITM: intervention tracking measure; LDH: Louisiana Department of Health.

Table 9: Timeline for the Developmental Screening PIP

PIP Task	Approximate Timeline
MCEs submit PIP developmental screening proposal/baseline report for measurement period of 1/1/20–12/31/20	January 29, 2021
MCEs initiate PIP new or enhanced interventions for interim/final measurement period of 1/1/21–12/31/21	February 1, 2021
MCEs submit 1st quarterly status report for intervention period of 1/1/21–-3/31/21	April 30, 2021
MCEs submit 2nd quarterly status report for intervention period of 4/1/21–6/30/21	July 31, 2021
MCEs submit 3rd quarterly status report for intervention period of 7/1/21–9/30/21 and chart review findings for the period of 1/1/21–9/30/21	October 31, 2021
MCEs submit first drafts of final reports	December 10, 2021
MCEs submit finalized final reports	December 31, 2021

PIP: performance improvement project; MCE: managed care entity.

Table 10: Timeline for the COVID-19 Vaccine PIP

PIP Task	Approximate Timeline
Baseline Measurement Period: COVID-19 Vaccine Report as of 4/1/2021	
Submission of Baseline Report	5/7/2021
Submission of Final Report	December 31, 2021

COVID-19: 2019 novel coronavirus; PIP: performance improvement project.

Table 11: Timeline for the Dental PIP

PIP Task	Approximate Timeline
Baseline Measurement Period of 1/1/20-12/31/21	January 31, 2021
Submission of Proposal/Baseline Report	May 3, 2021
PIP Interventions (New or Enhanced) Initiated	May 3, 2022
Interim Measurement Period of 1/1/2021-12/31/2021	January 31, 2022
Submission of Interim Report	March 3, 2022
Final Measurement Period of 1/1/2022-12/31/2022	January 31, 2023
Submission of Final Report	March 3, 2023

PIP: performance improvement project.

Table 12: Timeline for the CSoC PIP

PIP Task	Approximate Timeline
Baseline Measurement Period of 1/1/18-12/31/18	January 31, 2019
Submission of Proposal Report	April 5, 2019
PIP Interventions (New or Enhanced) Initiated	July 1, 2019
Updated Baseline Measurement Period (use this to increase target rates if these baseline rates are more favorable) 1/1/19-6/30/19	July 31, 2019
Submission of Baseline Report with Barrier Analysis, Interventions and Intervention Tracking Measures (ITMs), with PDSA for first intervention and corresponding ITM	July 31, 2019
Re-Measurement Period 1 of 7/1/19-12/31/19	January 31, 2020
Submission of First Interim Report (that includes Re-Measurement Period 1)	May 1, 2020
Re-Measurement Period 2 of 1/1/20-12/31/20	January 31, 2021
Submission of Second Interim Report (that includes Re-Measurement Periods 1 & 2)	May 1, 2021
Final Measurement Period of 1/1/21-12/31/21	January 31, 2022
Submission of Final Report	May 1, 2022

CSoC: coordinated system of care; PIP: performance improvement project.

Section 5: Performance Measure Validation

Process Overview

LDH requires MCEs and PAHPs to report selected HEDIS and other standard and state-specific PMs to assess access to care, effectiveness and quality of care, and use of services.

The first performance measurement period for all MCEs was calendar year 2015. MCEs will continue to report PMs annually during the contract period beginning in 2021 (for measurement year 2020). This approach affords several years of reporting and will allow for trending rates to help monitor progress and identify priority areas in need of improvement.

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

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

Task Description

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

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

Note that for the non-HEDIS and state-specific PMs, an onsite visit is, in all likelihood, not necessary. Presently, IPRO assists the University of Louisiana Monroe (ULM) in this activity, with ULM conducting the source code analyses and the validation itself. If necessary, IPRO can assist ULM by conducting medical record review (MRR) for any measure ULM and LDH deem necessary to validate the MCE's calculation of these measures. An onsite visit is usually only required when the MCE has not undergone an NCQA-required HEDIS audit. The onsite methodology will be conducted only in those special circumstances when a formal validation that includes an onsite visit is required.

Methodology

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

HEDIS Measure Validation Methodology

The MCEs that report HEDIS measures to NCQA must undergo an audit of their data conducted by a NCQA-licensed HEDIS audit organization (LO). For these HEDIS measures, IPRO reviews the rates submitted on the NCQA reporting tool (Interactive Data Submission System [IDSS]), which is audited prior to submission, and the FAR, which is completed by the LO and describes the process used to produce the measure rates and any problems that the MCEs experienced in the HEDIS process. Included in the FAR are the measures deemed "not reportable" due to biases in the calculation process. Other supporting documentation, such as the NCQA Roadmap, is reviewed as well.

IPRO will use the results of the audit to report the results of each measure reported to LDH. Using information provided in the FAR and, if necessary, in the NCQA Roadmap, IPRO will prepare a report indicating the measure results for each of the MCEs that are required to report to LDH. Measures deemed "not reportable" will be flagged. Statewide averages will be computed and NCQA Quality Compass® benchmarks will be provided as well. Results for the prior 2 years will be

provided for trending purposes. Any issues in reporting any measure (e.g., medical record abstraction issues) will be noted and, should LDH request any other statistical analyses, these results will also be included in the report.

Non-HEDIS Measure Validation Methodology

For state-specific measures and standardized non-HEDIS measures (e.g., the Prevention Quality Indicators), IPRO may assist ULM in conducting the audit, either by reviewing source code or, when necessary, conducting MRR validation. Measures that do not pass validation will be deemed "not reportable" and the reasons for this designation (e.g., problems in abstracting medical records accurately) will be noted. Should LDH request any other statistical analyses, these results will also be included in the report. ULM conducts the validation for non-HEDIS measures, and IPRO provides assistance when needed.

Timeline

The approximate PM timeline for reporting year 2021 is outlined in **Table 13**.

Table 13: Performance Measure Validation Timeline

PM Validation Task	Approximate Timeline
MCEs report HEDIS/PMs to NCQA via the IDSS or other reporting mechanism (for the state-specific measures)	June 15, 2021
MCEs submit the IDSS workbook, audit designation table, and NCQA Roadmap to LDH via the IPRO FTP site	June 15, 2021
MCEs submit HEDIS Final Audit Reports (FARs) to LDH via the IPRO FTP site	July 16, 2021
MCEs submit non-HEDIS PMs to LDH via the IPRO FTP site	August 3, 2021
CAHPS Adult and Child Survey with CCC: MCEs submit the de-identified .txt member-level files of CAHPS responses, following NCQA CAHPS file layout for file submission	September 3, 2021
IPRO validates the PM rates via document review, source code review, and medical record re-reviews, as necessary	September 17, 2021
ULM, with IPRO's assistance, validates the non-HEDIS PMs	September 28, 2021
IPRO, in conjunction with LDH, compiles the MCEs' HEDIS rates, including 2 years of prior performance, statewide averages, and national/regional Quality Compass benchmarks	November 15, 2021

PM: performance measure; MCE: managed care entity; HEDIS: Healthcare Effectiveness Data and Information Set; NCQA: National Committee for Quality Assurance; IDSS: Interactive Data Submission System; LDH: Louisiana Department of Health; FAR: final audit report; FTP: File Transfer Protocol; CAHPS: Consumer Assessment of Healthcare Providers and Systems; CCC: Children with Chronic Conditions; ULM: University of Louisiana Monroe.

MCE Performance Measures

MCEs are required to submit the performance measures to LDH, as described in **Appendix C.** These measures can also be located in the Healthy Louisiana Performance Measure Submission Guide.

Incentive-based measures may affect MCE payments. These can be found in **Appendix C,** annotated with "$$."

Section 6: MCE Annual Technical Report

MCE Annual Technical Report Content

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

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

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

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

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

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

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

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

MCE Technical Reports

As applicable, the MCE-specific technical reports provide the objectives for each key activity, the methods used to measure these objectives, and key findings and conclusions resulting from the data. The reports combine text, tables, and graphs to best display each data set in a way that is easily understandable. If appropriate, IPRO conducts significance testing for each figure to provide a functional way to compare each MCE to statewide and/or national benchmarks, and includes multiple years for trending purposes.

The MCE-specific technical reports provide an assessment of the strengths and opportunities for improvement for each MCE relative to timeliness, access and quality of services delivered to members, and IPRO's recommendations. MCE-specific technical reports include an assessment of the degree to which each MCE has effectively addressed the performance improvement recommendations made by IPRO during the previous year's EQR.

Timeline

The approximate annual technical report timeline is outlined in **Table 14**.

Table 14: Annual Technical Report Timeline

Annual Technical Report Task	Approximate Timeline
IPRO collects data from LDH/MCEs for inclusion in the technical report	October to January of each contract year
IPRO submits draft of technical report to LDH for review	Late February of each contract year
IPRO prepares and submits final report to LDH based on LDH feedback	Late March to early April of each contract year
MCEs respond to IPRO recommendations	December of each contract year

LDH: Louisiana Department of Health; MCE: managed care entity.

Section 7: Other Provider Surveys

Provider Directory Survey

It is expected that IPRO will conduct a telephonic validation of the MCEs' online provider directories quarterly in 2021.

Process Overview

The purpose of this activity is to validate information published in the Healthy Louisiana MCEs' web-based Medicaid provider directories. Validation of MCE provider directories is performed to ensure MCEs have adequate provider networks and helps to ensure enrollees are being provided accurate information regarding the providers composing the network. This activity is usually completed within a 2-month timeframe.

Methodology

Sampling process: Using the MCE Medicaid provider web directories, IPRO selects 125 providers per MCE who meet the specialty requirement and who have unrestricted panels (open to new Healthy Louisiana Medicaid patients). IPRO makes every reasonable attempt to minimize the number of times a single provider is contacted across all MCEs, so individual providers or provider sites do not appear in the MCE sample more than once.

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

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

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

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

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

Reporting

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

- the description of the methodology;
- calculated rates, using the CMS scoring protocol;
- compliant provider details;
- non-compliant provider details; and
- resurveyed provider details, if applicable.

Timeline

It is expected that the next iteration of the provider directory survey will be conducted in the first quarter of 2021 with a report prepared by April 30, 2021.

Provider Access Survey

It is expected that IPRO will conduct two telephonic provider access surveys in 2021.

Process Overview

The purpose of this survey is to assess the MCEs' network providers have the capability to meet the state's appointment and availability standards and to ensure that the MCEs are following Medicaid participation standards for access and availability. This activity is usually completed within a 6-month timeframe.

Methodology

Sampling process: IPRO will use the most current provider network and member enrollment data available, as provided by the MCEs, to select a random sample of providers from each MCE for the survey. The final sample size will be determined using valid sampling methodology based on power analysis and approved by LDH. The sample size will include an oversample to account for provider exclusions (such as providers who terminated). Before proceeding, IPRO will verify that only the desired provider types (e.g., PCPs, particular specialty) are included in the sample.

Survey protocol: The survey will follow the "secret shopper" methodology. IPRO's surveyors will be trained to conduct the surveys, role-playing as Medicaid members, and will be given a guide specifying the protocol and script for all calls, including instructions on handling various outcomes. Following training, the surveyors, posing as MMC recipients, will call the selected providers during business hours seeking an appointment using one of our scripted scenarios developed by our clinical staff and approved by LDH. Scenarios are designed to correspond with the appointment types and standards in the state contract and inform the surveyed provider of the type of appointment that should be given to the caller (e.g., non-symptomatic, non-urgent symptomatic, etc.) Calls will be randomly monitored for quality purposes.

Reporting

Provider compliance will be determined based on the number of days between the date of the survey call and the appointment date. If the appointment meets the contract standard, it will be considered a pass. If it does not meet the standard, it will be considered a fail. Availability rates will be calculated for each MCE, based on a summary of each of their network providers' individual results, and stratified, for example, by provider type.

A preliminary report will be drafted in consultation with LDH that will include a summary of the results and a listing of provider sites and phone numbers by result. The MCEs will be given a period of time, usually 1 week to 10 business days, to review the results and advise IPRO of any status changes for any provider for whom appointments could not be made because, for example, the provider no longer participates with the MCE or is not accepting new MCE patients.

Based on the MCE's response to the preliminary report, provider sites can either be recalled for an appointment or excluded from the sample. Exclusions will be replaced by provider sites in the oversample. IPRO will issue final reports to the MCEs and LDH in a format approved by LDH. MCEs that do not achieve the target pass rate may be required to submit a plan to correct deficiencies.

IPRO will prepare the final reports for LDH and each MCE. The reports will include:

- a brief narrative summary of findings;
- description of the methodology;
- statewide and MCE results by region, including the number of providers contacted by appointment type and in total, and the percent of providers scheduled by appointment type and in total;
- list of providers excluded from the sample and reasons for exclusion;
- an analysis of failures by call type;
- listing of providers found to be in compliance; and
- list of providers found to be non-compliant and reasons.

Timeline

It is expected that the first provider access survey will begin in the first quarter of 2021. A detailed timeline follows in **Table 15**.

Table 15: Provider Access Survey Timeline

Provider Access Survey Task	Approximate Timeline
IPRO develops survey protocols, scripts and data collection tools	January 2021
IPRO receives provider directory files from MCEs	March 2021
IPRO selects random sample of MCEs' providers for survey	March 2021
IPRO conducts telephone survey pilot	March 2021
IPRO begins conducting telephone surveys for all MCEs	March 2021
IPRO prepares draft survey reports	June 2021
IPRO prepares draft call disposition reports for LDH review	June 2021
IPRO finalizes call disposition reports	July 2021

MCE: managed care entity; LDH: Louisiana Department of Health.

Section 8: Development of a Quality Rating System

Purpose of the Quality Rating System Initiative

The purpose of this activity is for IPRO to assist LDH in adopting an MMC QRS developed by CMS to evaluate and apply a rating to measure the quality of care provided by Louisiana Medicaid MCEs. LDH will utilize the CMS framework, methodology, and identified performance measures in accordance with 42 CFR §438.334 that align with the summary indicators of the qualified health plan QRS developed per 45 CFR §156.1120.

Background

In April 2016, CMS released the first major overhaul of managed care regulations for Medicaid and the Children's Health Insurance Program (CHIP). The rule added a new requirement for states contracting with comprehensive, risk-based Medicaid MCOs, PAHPs or PIHPs to implement a Medicaid QRS. The CMS methodology is expected to largely align with the Exchange Qualified Health Plan (QHP) Quality Rating System. Medicaid quality ratings will also include a defined core set of performance measures largely drawn from the CMS Scorecard, including adult and child core set measures. States also have the flexibility to adopt an alternative quality rating methodology, contingent on yielding substantially comparable results, to the extent feasible, to enable meaningful comparison across states. This flexibility presents an opportunity for states to design a more robust Medicaid QRS that includes performance measures addressing unique state quality priorities such as vulnerable populations and BH.

Scope of Work

To accomplish this task, IPRO will partner with NCQA, a private, not-for-profit organization and a leader in quality oversight and improvement initiatives at all levels of the healthcare system, for development and implementation of the QRS.

To meet the state's needs, the NCQA/IPRO team, in conjunction with LDH, will follow the CMS QRS methodology, but will also include performance measures of unique importance to Louisiana (e.g., Initiation of Injectable Progesterone for Preterm Birth Prevention).

Once CMS guidance, specifications, and protocols are issued, and as directed by LDH, IPRO will conduct the following:

- establish a work plan for producing Louisiana Medicaid QRS; the work plan will take into account existing and new CMS guidelines and capitalize on innovative approaches used by other state Medicaid programs and the healthcare industry;
- support data collection from MCEs; IPRO's FTP site will be utilized for the transfer of data from and to the MCEs, as necessary;
- produce reference materials, including documentation on items such as score calculation and data sources; conducted annually, as directed by LDH;
- develop and maintain Louisiana Medicaid QRS methodology documents, revised annually in collaboration with LDH;
- integrate new measures, as requested by LDH; as CMS and industry measurement sets evolve, new measures will be recommended for inclusion into the QRS;
- modify/enhance QRS to ensure that QRS aligns with LDH's changing business requirements, such as branding, changes in federal regulations, and contract revisions and changes to report card measure specifications, such as HEDIS and Consumer Assessment of Healthcare Providers and Systems (CAHPS®), as directed by LDH;
- modify/enhance QRS tools, as required, to ensure that they align with LDH's changing business requirements; and
- educate MCEs and any LDH staff on reading, interpreting, and using QRS within a performance improvement strategy.

QRS Display

The QRS will be clear, salient, and meaningful and will be used to drive quality of care. Traditionally, health plan quality ratings display stars, symbols, or descriptive categories. One option may be to use a five-star rating approach to align with prominent national ratings such as the CMS Exchange QHP Quality Ratings, Medicare Advantage Star Ratings, and NCQA Health Insurance Ratings. Alternatively, measures may be reported in descriptive categories (e.g., exceeds, meets, does not meet) to convey meaningful thresholds. LDH will approve the final decision regarding mode of presentation.

Timeframe

It is expected that the first QRS will be prepared in late 2021 after health plans report HEDIS in June 2021. Work on designing the QRS template and selecting metrics to report may begin earlier in 2021 using 2020 data.

Section 9: CAHPS Dashboards and Summary Reports

Currently, IPRO collects and aggregates CAHPS survey results from each of the MCEs and prepares a statewide CAHPS report, which LDH submits to CMS as part of its reporting requirements. This process will continue in the 3-year period beginning in 2021. In addition, IPRO will build upon this work to trend the results and to conduct root cause analyses to prompt QI initiatives in response to the CAHPS results.

To accomplish this new task, IPRO will be partnering with DataStat, a NCQA-licensed CAHPS survey vendor that conducts CAHPS for health plans nationally, as well as for state agencies. DataStat is experienced in producing CAHPS data analysis reports tailored to state needs.

In a typical CAHPS report produced by DataStat, results are presented in a format that is optimized for use in practical decision making to allow states and health plans to identify key opportunities for improving member experience. Member responses to survey questions will be summarized as achievement scores. Responses that indicate a positive experience are labeled as achievements, and an achievement score is computed as the proportion of responses qualifying as achievements.

Specifically, these reports are designed to:

- assist states and health plans in identifying strengths and weaknesses in the quality of care and services provided to Medicaid members;
- provide health plans with a way to assess where resources can best be allocated to repair weaknesses; and
- show health plans what effect their efforts to improve have had over time.

IPRO can use these reports and the various cross-tabulation analyses that DataStat produces and integrate them into dashboards and other tools for LDH to monitor results over time and help identify root causes. Quality Compass CAHPS benchmarks can also be used to assess MCE performance and to point to areas where improvement is required. DataStat can also calculate NCQA three-point means and prepare reports comparing Children with Chronic Conditions (CCC) survey results with the non-CCC survey results.

Section 10: Behavioral Health Member Survey

Purpose

The purpose of this activity is to develop, administer, and analyze a survey of members of both the mainstream MCEs and the BH PAHP, Magellan, who have received BH services in a prior to be determined timeframe. Findings will be used to assess member satisfaction with these services and used to promote change when improvement is warranted.

Background

Currently, LDH requires that the MCEs administer the CAHPS Experience of Care and Health Outcomes (ECHO) Survey, which is appropriate for patients with a range of BH service needs. However, the survey items and results have not been sufficiently specific to highlight particular programs and services in need of improvement. Also, response rates and the timing of the survey administration differ by MCE.

To help LDH pinpoint areas of concern, IPRO will be tasked with developing a concise survey targeted to specific areas and services of concern. Items must provide findings that can be used to compare performance among MCEs and are actionable when concerns are identified.

Scope of Work

IPRO will consult existing surveys that MCEs in Louisiana may have conducted (in addition to the ECHO) and also conduct a landscape review of similar surveys in use nationwide. IPRO will develop survey items according to sound psychometric principles and ensure that they are crafted to evaluate the specific domains under review that will be determined in consultation with LDH.

The sampling protocol and survey mode will be determined with LDH input. The samples will be drawn from a sample frame consisting of members from each MCE who have been receiving BH service for a length of time to be determined. Samples size will be sufficiently large to produce a respondent pool that will allow for meaningful interpretation of findings and to allow for comparison among the MCEs. It is expected that the survey mode will consist of a two- to three-wave mail survey, with the possibility of a web-based administration.

Timeframe

The timeframe for conducting the BH member survey is presented in **Table 16**.

Table 16: Behavioral Health Member Survey Timeline

Behavioral Health Survey Task	Approximate Timeline
IPRO met with LDH to discuss survey methodology, survey instrument, and mailing materials	October 2020
IPRO develops study specifications and protocols (e.g., draft survey methodology, sampling, survey administration), instrument, and materials	January 2021
IPRO obtains member universe file	February 2021
IPRO selects study sample and conducts field preparation including formatting, assembling, and printing mailing materials	February 2021
IPRO sends first mailing of surveys to providers	March 2021
IPRO sends second mailing of surveys to non-respondents	May 2021
IPRO conducts data analysis	August 2021
IPRO prepares and submits final report to LDH	November 2021

LDH: Louisiana Department of Health.

Section 11: Evaluation of Louisiana's Quality Strategy

Purpose

Each contract year, IPRO will assist LDH in developing a comprehensive evaluation of the state's MMC Quality Strategy. States must develop and communicate a quality strategy in accordance with Federal Regulation 42 CFR 438, Subpart E. Louisiana's stated quality strategy is posted on LDH's website and is guided by the Triple Aim® and broad aims of the AHRQ National Quality Strategy (better care, healthy people/healthy communities, and affordable care) and establishes clear aims, goals, and objectives to drive improvements in care delivery and outcomes and establish metrics by which progress will be measured. These metrics will be evaluated and analyzed by IPRO to assess whether the stated quality strategy's goals are being met. In addition, the evaluation will include a review of LDH's quality strategy, monitoring mechanisms, and both the MCEs' and LDH's reports and statistics.

Scope of Work

The evaluation will be based on an analysis of findings and results from EQR activities, as well as Louisiana Medicaid program reports and documents. In addition, any recent priorities in Louisiana's MMC program will be discussed, including a description of program monitoring responsibilities and the state's evaluation methodology. Interviews with key stakeholders may be conducted, if warranted.

The methodology will include:

- defining the components to be reviewed (e.g., aims and objectives);
- identifying quantitative and qualitative data sources (e.g., measures, LDH and EQRO reports);
- developing data collection tools such as interview scripts, if necessary;
- developing data analysis program tools (e.g., trending reports, statewide average calculations);
- identifying key interviewees and LDH staff, as necessary,
- conducting in-depth interviews;
- developing comparative data (e.g., benchmarking, year-to-year comparisons);
- compiling and analyzing data;
- developing a draft report; and
- finalizing and submitting the report to LDH.

Timeframe

The timeframe for conducting the evaluation and preparing a report evaluating the progress of the quality strategy will start in May 2021.

Section 12: Focus Studies

Focus studies are an optional activity. IPRO's methodology for conducting focused studies is described in this section to familiarize MCOs with this type of study.

Process Overview

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

Task Description

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

For Louisiana, IPRO recommends conducting one focused study using administrative data supplied by the state or MCOs.

Recent focused studies IPRO conducted included studies to evaluate:

- Potentially preventable hospitalizations and ED visits;
- Social determinants of health;
- Diabetes management;
- Colorectal cancer screening;
- COVID hospitalizations: risk factors and disparities;

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

Methodology

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

1. Select the study topic: In proposing topics, IPRO will consider clinical conditions and health service delivery issues that have the highest prevalence or incidence among Louisiana MCO members, the greatest potential for improving health outcomes and the overall potential impact on the Medicaid program. Examples of types of studies that could be considered include:
    - primary and preventative services,
    - chronic/acute conditions,
    - ambulatory care sensitive conditions,
    - continuity and care coordination, including care transitions,
    - co-occurring BH and PH conditions,
    - health service delivery issues,
    - access/utilization studies,
    - inappropriate treatments/management,
    - disparities including differences among demographic subsets, and
    - outcome studies.
2. Define the study questions
3. Select the study variable(s)
4. Study the whole population or use a representative sample
5. Use sound sampling methods
6. Reliably collect data
7. Analyze data and interpret study results
8. Report results to LDH

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

Section 13: Technical Assistance

IPRO provides technical guidance to groups of MCOs, PIHPs, PAHPs, or PCCM entities (described in § 438.310(c)(2)) to assist them in conducting activities related to the mandatory and optional activities described in this section that provide information for the EQR and the resulting EQR technical report.

Recent technical assistance IPRO conducted included:

- Behavioral Health Provider Monitoring tool and policy review;
- CSoC Performance Measure Validation;
- HEDIS Supplemental Hybrid calculations;
- LA Independent Assessment;
- Medicaid Reimbursement Focus Study;
- Performance Measure Submission Guide ;

Health Plan Performance Improvement Project (PIP)

PIP Implementation Period:

Project Phase: Choose an item

Submission Dates:

	Proposal	Baseline	Interim	Final
Version 1				
Version 2				

MCO Contact Information

1. Principal MCO Contact Person

[PERSON RESPONSIBLE FOR COMPLETING THIS REPORT AND WHO CAN BE CONTACTED FOR QUESTIONS]

First and last name:

Title:

Phone number:

Email:

2. Additional Contact(s)

[PERSON(S) RESPONSIBLE IN THE EVENT THAT THE PRINCIPAL CONTACT PERSON IS UNAVAILABLE]

First and last name:

Title:

Phone number:

Email:

First and last name:

Title:

Phone number:

Email:

3. External Collaborators (if applicable):

Attestation

Plan Name:

Title of Project:

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

Medical Director signature: _____

First and last name:

Date:

CEO signature: _____

First and last name:

Date:

Quality Director signature: _____

First and last name:

Date:

IS Director signature (if applicable): _____

First and last name:

Date:

For Interim and Final Reports Only: Report all changes in methodology and/or data collection from initial proposal submission in the table below.

[EXAMPLES INCLUDE: ADDED NEW INTERVENTIONS, ADDED A NEW SURVEY, CHANGE IN INDICATOR DEFINITION OR DATA COLLECTION, DEVIATED FROM HEDIS® SPECIFICATIONS, REDUCED SAMPLE SIZE(S)]

Table 1: Updates to PIP

Change	Date of change	Area of change	Brief Description of change
Change 1		☐ Project Topic ☐ Methodology ☐ Barrier Analysis / Intervention ☐ Other	
Change 2		☐ Project Topic ☐ Methodology ☐ Barrier Analysis / Intervention ☐ Other	
Change 3		☐ Project Topic ☐ Methodology ☐ Barrier Analysis / Intervention ☐ Other	
Change 4		☐ Project Topic ☐ Methodology ☐ Barrier Analysis / Intervention ☐ Other	

Abstract

For Final Report submission only. Do not exceed 1 page.

Provide a high-level summary of the PIP, including the project topic and rationale (include baseline and benchmark data), objectives, description of the methodology and interventions, results and major conclusions of the project, and next steps.

To be completed upon Proposal submission. Do not exceed 2 pages.

Describe Project Topic and Rationale for Topic Selection

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

Aims, Objectives and Goals

Aims and Objective(s)

- **Describe the major interventions that the health plan will implement, in order to positively affect member health outcomes or experiences of care:**
  The following sentence structure is encouraged:
  "Implement [describe major interventions] to improve [cite performance indicator(s)] from baseline to final measurement."

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

Table 2: Goals

Indicators	Baseline Rate[1] Measurement Period:	Target Rate[2]	Rationale for Target Rate[3]
Indicator 1:	N: D: R:	R:	
Indicator 2:	N: D: R:	R:	
Indicator 3:	N: D: R:	R:	
Indicator 4:	N: D: R:	R:	

[1] Baseline rate: the MCO-specific rate that reflects the year prior to when PIP interventions are initiated.

[2] Upon interim evaluation of target rates, consideration should be given to improving the target rate, if it has been met or exceeded at that time.

[3] Indicate the source of the final goal (e.g., NCQA Quality Compass) and/or the method used to establish the target rate (e.g., 95% confidence interval).

To be completed upon Proposal submission.

Performance Indicators[1]

Table 3: Performance Indicators

Indicator	Description	Data Source	Eligible Population	Exclusion Criteria	Numerator	Denominator
Example Indicator	*Percent of children ages 5-11 years with an asthma diagnosis who have an asthma controller medication prescription in measurement year.*	*Administrative claims data*	*Children ages 5-11 years with asthma diagnosis.*	*Children ages 5-11 years with a known contraindication to asthma controller medications.*	*Number of children ages 5–11 years with a prescription filled during the MY for an asthma controller medication.*	*Number of children ages 5-11 years with an asthma diagnosis excluding those with a known contraindication to asthma controller medications.*
Indicator 1						
Indicator 2						
Indicator 3						
Indicator 4						

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

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

Data Collection and Analysis Procedures

Is the entire eligible population being targeted by PIP interventions? If not, why?

Sampling Procedures

If sampling was employed (for targeting interventions, medical record review, or survey distribution, for instance), the sampling methodology should consider the required sample size, specify the true (or estimated) frequency of the event, the confidence level to be used, and the margin of error that will be acceptable.

- **Describe sampling methodology:**

Data Collection

Describe who will collect the performance indicator and intervention tracking measure data (using staff titles and qualifications), when they will perform collection, and data collection tools used (abstraction tools, software, surveys, etc.). If a survey is used, indicate survey method (phone, mail, face-to-face), the number of surveys distributed and completed, and the follow-up attempts to increase response rate.

- **Describe data collection:**

Validity and Reliability

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

- **Describe validity and reliability:**

Data Analysis

*Explain the data analysis procedures and, if statistical testing is conducted, specify the procedures used (note that hypothesis testing should only be used to test significant differences between **independent** samples; for instance, differences between health outcomes among sub-populations within the baseline period is appropriate).Describe the methods that will be used to analyze data, whether measurements will be compared to prior results or similar studies, and if results will be compared among regions, provider sites, or other subsets or benchmarks. Indicate when data analysis will be performed (monthly, quarterly, etc.).*

Describe how plan will interpret improvement relative to goal.

Describe how the plan will monitor intervention tracking measures (ITMs) for ongoing quality improvement (e.g., stagnating or worsening quarterly ITM trends will trigger barrier/root cause analysis, with findings used to inform modifications to interventions).

- **Describe data analysis procedures:**
- **Describe how plan will interpret improvement relative to goal:**
- **Describe how plan will monitor ITMs for ongoing QI:**

(Tentative) PIP Timeline

Report the baseline, interim and final measurement data collections periods below.
Baseline Measurement Period:
Start date: 1/1/2020

End date: 12/31/2020

Submission of Proposal/Baseline Report Due: 5/3/2021

PIP Interventions (New or Enhanced) Initiated: 5/3/2021

Interim Measurement Period:
Start date: 1/1/2021
End date: 12/31/2021

Submission of Interim Report Due: 3/3/2022

Final Measurement Period:
Start date: 1/1/2022
End date: 12/31/2022

Submission of Final Report Due: 3/3/2023

To be completed upon Proposal submission (to be updated for baseline, interim and final reports).

Table 4: Alignment of Barriers, Interventions and Tracking Measures

			Year 1				Year 2			
	Barrier: *Automatic asthma controller refills not generated* ***Method of barrier identification:*** *Review of pharmacy procedures/claims*		***Q1***	***Q2***	***Q3***	***Q4***	***Q1***	***Q2***	***Q3***	***Q4***
EXAMPLE	***Intervention to address barrier:*** *1. Pharmacy active asthma diagnosis flag to trigger automated refills as prescribed* ***Planned Start Date:*** *Jan 1, 2019* ***Actual Start Date****: Feb 1, 2019* ***End date (if applicable):*** *N/A*	***Intervention tracking measure 1a:*** *Percentage of children ages 5-11years with asthma diagnosis with controller medication automatic refill* ***N:*** *# of children 5-11 with asthma diagnosis with automatic refill trigger* ***D:*** *# of children 5-11 with asthma diagnosis*	*N: 105* *D: 580* *R: 18.1%*	*N:* *D:* *R:*	*N:* *D:* *R:*	*N:* *D:* *R:*	*N:* *D:* *R:*	*N:* *D:* *R:*	*N:* *D:* *R:*	*N:* *D:* *R:*
Barrier 1: **Method of barrier identification:**			**Year 1** **Q1**	**Q2**	**Q3**	**Q4**	**Year 2** **Q1**	**Q2**	**Q3**	**Q4**
Intervention to address barrier: 1. **Planned Start Date:** **Actual Start Date**: **End Date (if applicable):**	**Intervention tracking measure 1a:** **N:** **D:**		N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:
	Intervention tracking measure 1b: **N:** **D:**		N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Intervention to address barrier: 2. **Planned Start Date:** **Actual Start Date**:	**Intervention tracking measure 2a:** **N:** **D:**		N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:

End Date (if applicable):	**Intervention tracking measure 2b:** **N:** **D:**	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Barrier 2: **Method of barrier identification:**		**Year 1**				**Year 2**			
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Intervention to address barrier: 3. **Planned Start Date:** **Actual Start Date**:	**Intervention tracking measure 3a:** **N:** **D:**	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:
End Date (if applicable):	**Intervention tracking measure 3b:** **N:** **D:**	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Intervention to address barrier: 4. **Planned Start Date:** **Actual Start Date**:	**Intervention tracking measure 4a:** **N:** **D:**	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:
End Date (if applicable):	**Intervention tracking measure 4b:** **N:** **D:**	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Barrier 3: **Method of barrier identification:**		**Year 1**				**Year 2**			
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Intervention to address barrier: 5. **Planned Start Date:** **Actual Start Date**:	**Intervention tracking measure 5a:** **N:** **D:**	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:
End Date (if applicable):	**Intervention tracking measure 5b:** **N:** **D:**	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:

Intervention to address barrier: 6. **Planned Start Date:** **Actual Start Date**:	**Intervention tracking measure 6a:** **N:** **D:**	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:
End Date (if applicable):	**Intervention tracking measure 6b:** **N:** **D:**	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Barrier 4: **Method of barrier identification:**		**Year 1**				**Year 2**			
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Intervention to address barrier: 7. **Planned Start Date:** **Actual Start Date**:	**Intervention tracking measure 7a:** **N:** **D:**	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:
End Date (if applicable):	**Intervention tracking measure 7b:** **N:** **D:**	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Intervention to address barrier: 8. **Planned Start Date:** **Actual Start Date**:	**Intervention tracking measure 8a:** **N:** **D:**	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:
End Date (if applicable):	**Intervention tracking measure 8b:** **N:** **D:**	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:

Results

To be completed upon Baseline, Interim and Final Report submissions. The results section should present project findings related to performance indicators. ***Do not*** interpret the results in this section.

Table 5: Results

Indicator	Baseline Period Measure period:	Interim Period Measure period:	Final Period Measure period:	Target Rate[1]
Indicator 1:	N: D: R:	N: D: R:	N: D: R:	Rate:
Indicator 2:	N: D: R:	N: D: R:	N: D: R:	Rate:
Indicator 3:	N: D: R:	N: D: R:	N: D: R:	Rate:
Indicator 4:	N: D: R:	N: D: R:	N: D: R:	Rate:

[1] Upon interim evaluation of target rates, consideration should be given to improving the target rate, if it has been met or exceeded at that time.

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

In the results section, the narrative to accompany each table and/or chart should be descriptive in nature. Describe the most important results, simplify the results, and highlight patterns or relationships that are meaningful from a population health perspective. ***Do not*** interpret the results in terms of performance improvement in this section.

To be completed upon Interim and Final Report submissions. The discussion section is for explanation and interpretation of the results. In the Final Report Discussion, revise the Interim Discussion so that the Final Discussion Section represents one comprehensive and integrated interpretation of results, rather than a separate add-on to the Interim discussion.

Discussion of Results

- **Interpret the performance indicator rates for each measurement period,** i.e., describe whether rates improved or declined between baseline and interim, between interim and final and between baseline and final measurement periods.

- **Explain and interpret the results by reviewing the degree to which objectives and goals were achieved.** Use your ITM data to support your interpretations**.**

- **What factors were associated with success or failure?** For example, in response to stagnating or declining ITM rates, describe any findings from the barrier analysis triggered by lack of intervention progress, and how those findings were used to inform modifications to interventions.

Limitations

As in any population health study, there are study design limitations for a PIP. Address the limitations of your project design, i.e., challenges identified when conducting the PIP (e.g., accuracy of administrative measures that are specified using diagnosis or procedure codes are limited to the extent that providers and coders enter the correct codes; accuracy of hybrid measures specified using chart review findings are limited to the extent that documentation addresses all services provided).

- **Were there any factors that may pose a threat to the internal validity the findings?**
  Definition and examples: internal validity means that the data are measuring what they were intended to measure. For instance, if the PIP data source was meant to capture all children 5-11 years of age with an asthma diagnosis, but instead the PIP data source omitted some children due to inaccurate ICD-10 coding, there is an internal validity problem.

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

- **Describe any data collection challenges.**
  Definition and examples: data collection challenges include low survey response rates, low medical record retrieval rates, difficulty in retrieving claims data, or difficulty tracking case management interventions.

Next Steps

This section is completed for the Final Report. For each intervention, summarize lessons learned, system-level changes made and/or planned, and outline next steps for ongoing improvement beyond the PIP timeframe.

Table 6: Next Steps

Description of Intervention	Lessons Learned	System-Level Changes Made and/or Planned	Next Steps

References

Include a list of references for any sources of information used to formulate the project.

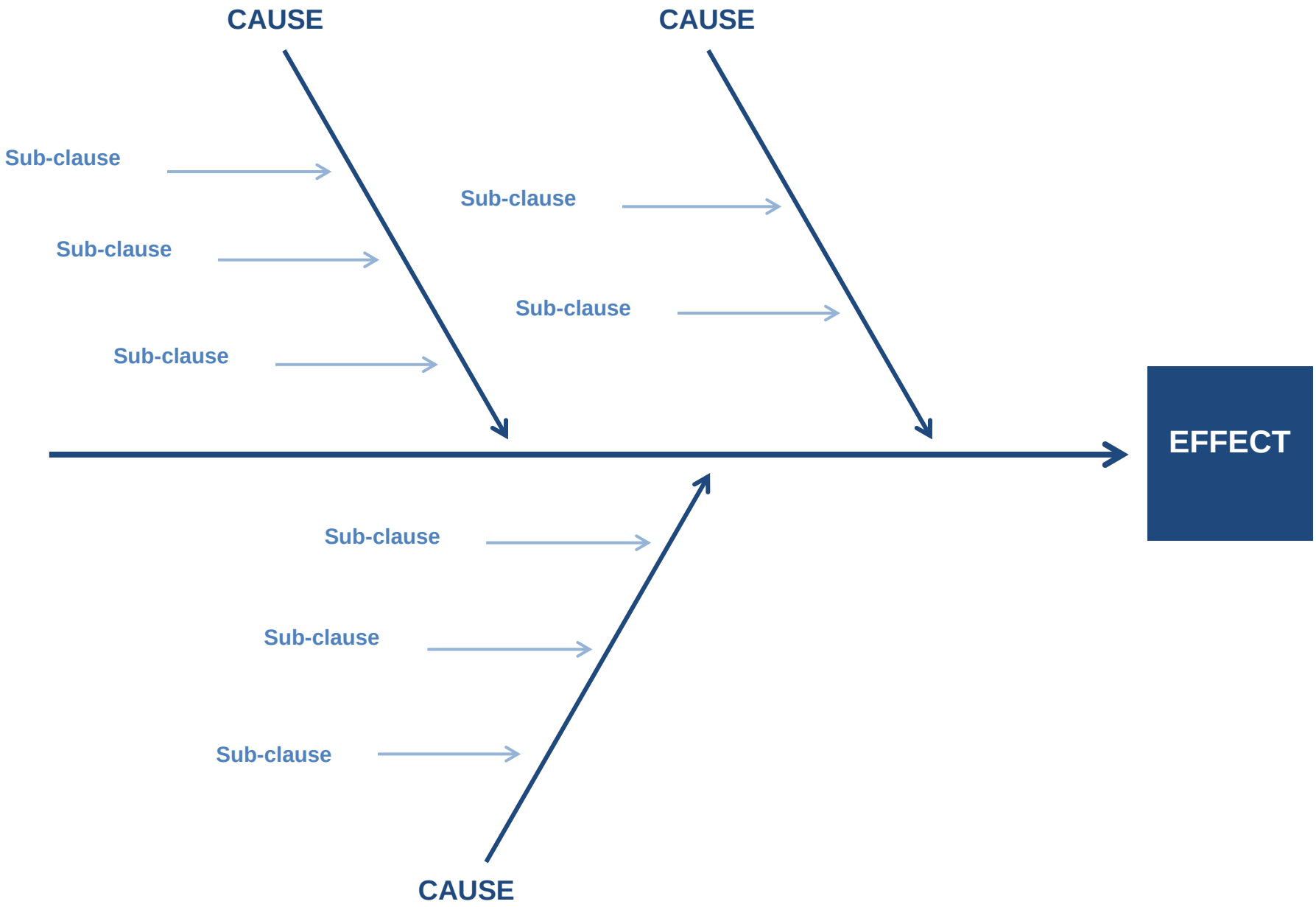
Glossary of PIP Terms

Table 7: PIP Terms

PIP Term	Also Known as…	Purpose	Definition
Aim	• Purpose	To state what the MCO is trying to accomplish by implementing their PIP.	An aim clearly articulates the goal or objective of the work being performed for the PIP. It describes the desired outcome. The Aim answers the questions "How much improvement, to what, for whom, and by when?"
Barrier	• Obstacle • Hurdle • Road block	To inform meaningful and specific intervention development addressing members, providers, and MCO staff.	Barriers are obstacles that need to be overcome in order for the MCO to be successful in reaching the PIP Aim or target goals. The root cause (s) of barriers should be identified so that interventions can be developed to overcome these barriers and produce improvement for members/providers/MCOs. A barrier analysis should include analyses of both quantitative (e.g., MCO claims data) and qualitative (such as surveys, access and availability data or focus groups and interviews) data as well as a review of published literature where appropriate to root out the issues preventing implementation of interventions.
Baseline rate	• Starting point	To evaluate the MCO's performance in the year prior to implementation of the PIP.	The baseline rate refers to the rate of performance of a given indicator in the year prior to PIP implementation. The baseline rate must be measured for the period before PIP interventions begin.
Benchmark rate	• Standard • Gauge	To establish a comparison standard against which the MCO can evaluate its own performance.	The benchmark rate refers to a standard that the MCO aims to meet or exceed during the PIP period. For example, this rate can be obtained from the statewide average, or Quality Compass.
Goal	• Target • Aspiration	To establish a desired level of performance.	A goal is a measurable target that is realistic relative to baseline performance, yet ambitious, and that is directly tied to the PIP aim and objectives.
Intervention tracking measure	• Process Measure	To gauge the effectiveness of interventions (on a quarterly or monthly basis).	Intervention tracking measures are monthly or quarterly measures of the success of, or barriers to, each intervention, and are used to show where changes in PIP interventions might be necessary to improve success rates on an ongoing basis.

PIP Term	Also Known as…	Purpose	Definition
Limitation	• Challenges • Constraints • Problems	To reveal challenges faced by the MCO, and the MCO's ability to conduct a valid PIP.	Limitations are challenges encountered by the MCO when conducting the PIP that might impact the validity of results. Examples include difficulty collecting/ analyzing data, or lack of resources / insufficient nurses for chart abstraction.
Performance indicator	• Indicator • Performance Measure (terminology used in HEDIS) • Outcome measure	To measure or gauge health care performance improvement (on a yearly basis).	Performance indicators evaluate the success of a PIP annually. They are a valid and measurable gauge, for example, of improvement in health care status, delivery processes, or access.
Objective	• Intention	To state how the MCO intends to accomplish their aim.	Objectives describe the intervention approaches the MCO plans to implement in order to reach its goal(s).

Appendix A: Fishbone (Cause and Effect) Diagram



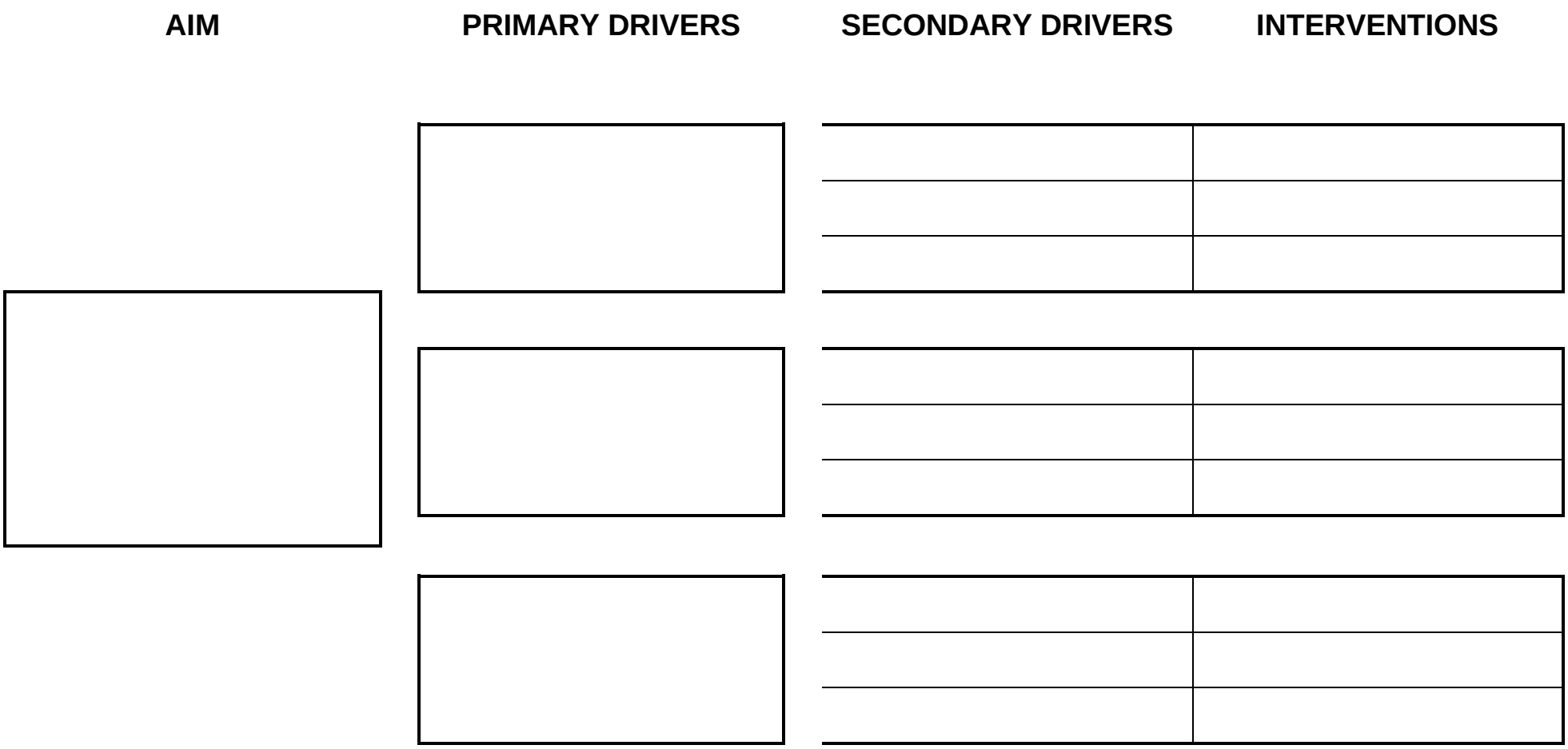
Appendix B: Priority Matrix

Which of the Root Causes Are...	Very Important	Less Important
Very Feasible to Address		
Less Feasible to Address		

Appendix C: Strengths, Weaknesses, Opportunities, and Threats (SWOT) Diagram

	Positives	Negatives
INTERNAL ***under your control***	***build on*** **STRENGTHS** ***Examples:***	***minimize*** **WEAKNESSES** ***Examples:***
EXTERNAL ***not under your control, but can impact your work***	***pursue*** **OPPORTUNITIES** ***Examples:***	***protect from*** **THREATS** ***Examples:***

Appendix D: Driver Diagram



Appendix E: Plan-Do-Study-Act Worksheet

	Pilot Testing	Measurement #1	Measurement #2
Intervention #1:			
Plan: Document the plan for conducting the intervention.	•	•	•
Do: Document implementation of the intervention.	•	•	•
Study: Document what you learned from the study of your work to this point, including impact on secondary drivers.	•	•	•
Act: Document how you will improve the plan for the subsequent phase of your work based on the study and analysis of the intervention.	•	•	•
Intervention #2:			
Plan: Document the plan for conducting the intervention.	•	•	•
Do: Document implementation of the intervention.	•	•	•
Study: Document what you learned from the study of your work to this point, including impact on secondary drivers.	•	•	•
Act: Document how you will improve the plan for the subsequent phase of your work based on the study and analysis of the intervention.	•	•	•

Appendix B: Healthy Louisiana Medicaid Managed Care PIP Report Checklist

Healthy Louisiana Medicaid Managed Care PIP Report Checklist **Date Submitted by MCO:**

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

PIP Component and Subcomponents	**MCO Check:** Complete? Indicate: Y=yes N=no	**IPRO Review:** M=Met[1]; PM=Partially Met[2]; NM=Not Met[3]	**LDH Review**: M=Met[1]; PM=Partially Met[2]; NM=Not Met[3]
ATTESTATION COMPLETE WITH SIGNATURES			
1. Topic/ Rationale			
a. Impacts the maximum proportion of members that is feasible			
b. Potential for meaningful impact on member health, functional status or satisfaction			
c. Reflects high-volume or high risk-conditions			
d. Supported with MCO member data (baseline rates), e.g., disease prevalence			
2. Aim			
a. Specifies Performance Indicators for improvement with corresponding goals			
b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark			
c. Objectives align aim and goals with interventions			
3. Methodology			
a. Annual Performance Measures indicated			
b. Specifies numerator and denominator criteria			
c. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]			
d. Sampling method explained for each hybrid measure			
4. Barrier Analysis, using one or more of following:			
a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics			
b. Obtain direct member input from focus groups, quality meetings, surveys, and/or care management outreach			
c. Obtain direct provider input from focus groups, quality meetings, surveys, and/or care management outreach			
d. QI Process data ("5 Why's", fishbone diagram)			
5. Robust Interventions that are Measurable using Intervention Tracking Measures			
a. Informed by barrier analysis			
b. Actions that target member, provider and MCO			
c. New or enhanced, starting after baseline year			
d. With corresponding monthly or quarterly intervention tracking (process) measures, i.e., numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)			
6. Results Table (Completed for Baseline, Interim and Final Re-Measurement Years)			
a. Table shows Performance Indicator rates, numerators and denominators			
b. Table shows target rates and rationale (e.g., next highest Quality Compass percentile)			
7. Discussion (Final PIP Report)			
a. Interpretation of extent to which PIP is successful			
8. Next Steps (Final PIP Report)			
a. Lessons Learned			
b. System-level changes made and/or planned			
c. Next steps for each intervention			

1. "M": addressed without the need for further elaboration; 2. "PM: partially addressed with the need for further elaboration; 3. "NM": not addressed.

This second page is not included with the first page of the PIP Checklist sent to the plans, as it is initiated by the IPRO Reviewers once the plan has submitted their PIP Report.

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

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

STRENGTHS: IPRO to summarize key strengths, for example:

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

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

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

For Final Report review ONLY, include following narrative:

Overall Credibility of Results

Select from one of the three options below and delete the others:
There were no validation findings which indicate that the credibility of the PIP results is at risk.

OR

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

OR

There are one or more validation findings that indicate a bias in the PIP results. ***[State the concerns regarding study processes that put the conclusions at risk.]***

Appendix C: Required Performance Measures for Reporting Year 2021 (Measurement Year 2020)

Measurement Year 2020 Performance Measures							
Identifier	**Measure**	**Measure Description**	**Measure Steward**	**Federal Reporting Program**	**Target Population**	**Condition**	**Specification Source**
Incentive Measures							
PTB $$	Initiation of Injectable Progesterone for Preterm Birth Prevention	The percentage of women 15–45 years of age with evidence of a previous preterm singleton birth event (24–36 weeks completed gestation) who received one or more progesterone injections between the 16th and 24th week of gestation for deliveries during the measurement year.	State	None	Children's and Maternal Health	Perinatal and Reproductive Health	Section V
WCV $$	Child and Adolescent Well-Care Visits	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	CHIPRA	Children's Health	Utilization	HEDIS
ADD $$	Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	The percentage of children 6–12 years of age as of the index period start date with a newly prescribed ambulatory prescription dispensed for attention-deficit/hyperactivity disorder (ADHD) medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase.	NCQA	CHIPRA, MU2	Children's Health	Behavioral Health	HEDIS

Measurement Year 2020 Performance Measures							
Identifier	**Measure**	**Measure Description**	**Measure Steward**	**Federal Reporting Program**	**Target Population**	**Condition**	**Specification Source**
ADD $$	Follow-Up Care for Children Prescribed ADHD Medication—Continuation Phase	The percentage of children 6–12 years of age as of the index period start date with a newly prescribed ambulatory prescription dispensed for attention-deficit/hyperactivity disorder (ADHD) medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.	NCQA	CHIPRA, MU2	Children's Health	Behavioral Health	HEDIS
PPC $$	Prenatal and Postpartum Care—Timeliness of Prenatal Care	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	Medicaid Adult	Maternal Health	Perinatal and Reproductive Health	HEDIS
PPC $$	Prenatal and Postpartum Care—Postpartum Care	The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year that had a postpartum visit on or between 7 and 84 days after delivery.	NCQA	Medicaid Adult	Maternal Health	Perinatal and Reproductive Health	HEDIS
FUH $$	Follow-Up After Hospitalization for Mental Illness—Within 30 days of discharge	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner within 30 days of discharge.	NCQA	Medicaid Adult	Behavioral Health	Behavioral Health	HEDIS

Measurement Year 2020 Performance Measures							
Identifier	**Measure**	**Measure Description**	**Measure Steward**	**Federal Reporting Program**	**Target Population**	**Condition**	**Specification Source**
CBP $$	Controlling High Blood Pressure—Total	The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (< 140/90 mm Hg) during the measurement year.	NCQA	Medicaid Adult, MU2, CMS Health Homes	Chronic Disease	Cardiovascular Care	HEDIS
CDC $$	Comprehensive Diabetes Care—Hemoglobin A1c (HBA1c) testing	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) with a Hemoglobin A1c (HbA1c) test.	NCQA	Medicaid Adult	Chronic Disease	Diabetes	HEDIS
CDC $$	Comprehensive Diabetes Care—Eye exam (retinal) performed	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) with an eye exam (retinal) performed.	NCQA	Medicaid Adult	Chronic Disease	Diabetes	HEDIS
W30 $$	Well-Child Visits in the First 30 Months of Life	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.	NCQA	CHIPRA	Children's Health	Utilization	HEDIS
CPA $$	CAHPS Health Plan Survey 5.0H, Adult (Rating of Health Plan, 8+9+10)	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.	NCQA	Medicaid Adult	Adult	Member Satisfaction	HEDIS

Measurement Year 2020 Performance Measures							
Identifier	**Measure**	**Measure Description**	**Measure Steward**	**Federal Reporting Program**	**Target Population**	**Condition**	**Specification Source**
CPC $$	CAHPS Health Plan Survey 5.0H, Child (Rating of Health Plan—General Population, 8+9+10)	This measure provides information on parents' experience with their child's Medicaid organization.	NCQA	Medicaid, CHIPRA	Child	Member Satisfaction	HEDIS
HEDIS Measures							
CIS	Childhood Immunization Status	The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.	NCQA	CHIPRA, MU2	Children's Health	Prevention	HEDIS
IMA	Immunization Status for Adolescents	Percentage of adolescents that turned 13 years old during the measurement year and had specific vaccines by their 13th birthday. Report all individual vaccine numerators and combinations.	NCQA	CHIPRA	Children's Health	Prevention	HEDIS

Measurement Year 2020 Performance Measures							
Identifier	**Measure**	**Measure Description**	**Measure Steward**	**Federal Reporting Program**	**Target Population**	**Condition**	**Specification Source**
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents: Body Mass Index Assessment for Children/ Adolescents	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. • BMI percentile documentation • Counseling for nutrition • Counseling for physical activity	NCQA	CHIPRA, MU2	Children's Health	Prevention	HEDIS
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	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.	NCQA	Medicaid Adult	Population Health	Behavioral Health	HEDIS
AMM	Antidepressant Medication Management	The percentage of members 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported.	NCQA	Medicaid Adult, MU2	Population Health	Behavioral Health	HEDIS
CCS	Cervical Cancer Screening	Percentage of women 21–64 years of age who were screened for cervical cancer: • Women 21–64 who had cervical cytology performed every 3 years • Women 30–64 who had cervical cytology/HPV co-testing performed every 5 years	NCQA	Medicaid Adult, MU2	Population Health	Prevention	HEDIS

Measurement Year 2020 Performance Measures							
Identifier	**Measure**	**Measure Description**	**Measure Steward**	**Federal Reporting Program**	**Target Population**	**Condition**	**Specification Source**
AMR	Asthma Medication Ratio	The percentage of patients 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	NCQA	Medicaid	Population Health	Pulmonary/ Critical Care	HEDIS
FVA	Flu Vaccinations for Adults Ages 18 to 64	The percentage of adults 18 years of age and older who self-report receiving an influenza vaccine within the measurement period.	NCQA	Medicaid Adult	Population Health	Prevention	HEDIS/CAHPS
MSC	Medical Assistance With Smoking and Tobacco Use Cessation	Assesses different facets of providing medical assistance with smoking and tobacco use cessation. MCOs will report three components (questions): • Advising Smokers and Tobacco Users to Quit • Discussing Cessation Medications • Discussing Cessation Strategies	NCQA	Medicaid Adult	Population Health	Prevention	HEDIS/CAHPS
CHL	Chlamydia Screening in Women	The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	NCQA	CHIPRA, Medicaid Adult	Population Health, Maternal Health	Perinatal and Reproductive Health, Sexually Transmitted Infectious Diseases	HEDIS
BCS	Breast Cancer Screening	Percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	NCQA	Medicaid Adult, MU2	Senior Care	Prevention	HEDIS

Measurement Year 2020 Performance Measures							
Identifier	**Measure**	**Measure Description**	**Measure Steward**	**Federal Reporting Program**	**Target Population**	**Condition**	**Specification Source**
COL	Colorectal Screening	The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.	NCQA	Medicaid Adult	Population Health	Prevention	HEDIS
SSD	Diabetes Screening for People with Schizophrenia or Bipolar who are Using Antipsychotic Medications	The percentage of members 18–64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	NCQA	Medicaid Adult	Population Health	Behavioral Health	HEDIS
SPC	Statin Therapy for Patients with Cardiovascular Disease	• The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and who received statin therapy (were dispensed at least one high- or moderate-intensity statin medication during the measurement year). • The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and who 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).	NCQA	Medicaid Adult	Population Health	Cardiovascular Care	HEDIS

Measurement Year 2020 Performance Measures							
Identifier	**Measure**	**Measure Description**	**Measure Steward**	**Federal Reporting Program**	**Target Population**	**Condition**	**Specification Source**
CDC	Comprehensive Diabetes Care—HbA1c poor control (> 9.0%)	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) with HbA1c poor control (> 9.0%).	NCQA	Medicaid Adult	Chronic Disease	Diabetes	HEDIS
CDC	Comprehensive Diabetes Care—HbA1c control (< 8.0%)	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) with HbA1c control (< 8.0%).	NCQA	Medicaid Adult	Chronic Disease	Diabetes	HEDIS
CDC	Comprehensive Diabetes Care—BP control (< 140/90 mm Hg).	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) with BP control (< 140/90 mm Hg).	NCQA	Medicaid Adult	Chronic Disease	Diabetes	HEDIS
PCR	Plan All-Cause Readmissions	For members 18–64 years of age, the risk-adjusted rate of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.	NCQA	Medicaid Adult	Population Health	All-Cause Readmissions	HEDIS
AAP	Adults' Access to Preventive/ Ambulatory Health Services	The percentage of members age 20 years and older who had an ambulatory or preventive care visit during the measurement year. Three age stratifications and a total rate are reported: • 20–44 years • 45–64 years • 65 years and older • Total	NCQA	Medicaid Adult	Population Health	Prevention	HEDIS

Measurement Year 2020 Performance Measures							
Identifier	**Measure**	**Measure Description**	**Measure Steward**	**Federal Reporting Program**	**Target Population**	**Condition**	**Specification Source**
FUH	Follow-Up After Hospitalization for Mental Illness—Within 7 days of discharge	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner within 7 days of discharge.	NCQA	CHIPRA	Behavioral Health	Behavioral Health	HEDIS
AMB-ED	Ambulatory Care–ED Visits	This measure summarizes utilization of ambulatory care ED visits per 1,000 member months.	NCQA	Medicaid	Population Health	Utilization	HEDIS
AMB	Ambulatory Care—Outpatient Visits	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner within 7 days of discharge.	NCQA	Medicaid	Population Health	Utilization	HEDIS
PQI Measures							
PQI01	Diabetes Short-Term Complications Admission Rate	Number of admissions for diabetes short-term complications per 100,000 member months per Medicaid enrollees age 18 and older.	AHRQ	Medicaid Adult	Chronic Disease	Diabetes	Section V
PQI05	COPD and 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 admissions for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 member months for Medicaid enrollees age 40 and older.	AHRQ	Medicaid Adult	Population Health	Pulmonary/ Critical Care	Section V

Measurement Year 2020 Performance Measures							
Identifier	**Measure**	**Measure Description**	**Measure Steward**	**Federal Reporting Program**	**Target Population**	**Condition**	**Specification Source**
PQI08	Heart Failure Admission Rate	Percentage of population with an admission for heart failure (reported by recipient parish). The number of admissions for heart failure per 100,000 member months for Medicaid enrollees age 18 and older (reported by recipient parish).	AHRQ	Medicaid Adult	Chronic Disease	Cardiovascular Care	Section V
PQI15	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 admissions for asthma per 100,000 member months for Medicaid enrollees ages 18 to 39.	AHRQ	Medicaid Adult	Population Health	Pulmonary/ Critical Care	Section V
Vital Record Measures							
LBW-CH	Percentage of low birth weight births	Percentage of live births that weighed less than 2,500 grams in the state during the reporting period.	CDC	CHIPRA, HRSA	Children's and Maternal Health	Perinatal and Reproductive Health	Section V
PC01	Elective Delivery	This measure assesses patients with elective vaginal deliveries or elective cesarean sections at > = 37 and < 39 weeks of gestation completed	TJC	Medicaid Adult, MU2	Maternal Health	Perinatal and Reproductive Health	Section V
CMS Measures							
HIV	HIV Viral Load Suppression	Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200.	HRSA HIV/AIDS Bureau	Medicaid Adult	Chronic Disease	HIV	Section V
CCP-CH	Contraceptive Care—Postpartum (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 60 days of delivery. Four rates are reported.	CMS	CHIPRA	Maternal Health	Perinatal and Reproductive Health	OPA

Measurement Year 2020 Performance Measures							
Identifier	**Measure**	**Measure Description**	**Measure Steward**	**Federal Reporting Program**	**Target Population**	**Condition**	**Specification Source**
CCP-AD	Contraceptive Care—Postpartum (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 60 days of delivery. Four rates are reported.	CMS	Medicaid Adult	Maternal Health	Perinatal and Reproductive Health	OPA
LRCD-CH (formerly PC02 (NSV))	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).	TJC	CHIPRA	Children's and Maternal Health	Perinatal and Reproductive Health	Section V