Louisiana's Medicaid Managed Care Quality Strategy

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Louisiana Medicaid

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LOUISIANA DEPARTMENT OF HEALTH

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1 Introduction – Managed Care Goals, Objectives and Overview

1.1 History of Managed Care in Louisiana

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

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

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

Today, Louisiana Medicaid serves nearly 1.7 million Louisianans, approximately 35 percent of the state's population. Five (5) statewide Managed Care Organizations (MCOs), one (1) Behavioral Health Prepaid Inpatient Health Plan (PIHP) and one (1) Dental Prepaid Ambulatory Health Plan (PAHP) pay for healthcare services for more than 90 percent of the Louisiana Medicaid population, including more than 481,000 new adults since Medicaid expansion took effect in July 2016. These managed care entities (MCEs) pay for Medicaid benefits and services included in the Louisiana Medicaid state Plan, state statutes and administrative rules, Medicaid policy and procedure manuals. In addition, these MCEs also provide specified value-added Medicaid benefits and services.

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

- Improve access to care
- Improve care coordination
- Increase emphasis on disease prevention and the early diagnosis and management of chronic conditions

- Improve health outcomes and quality of care
- Provide for a more financially stable Medicaid program

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

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

In 2019, LDH has initiated procurement for its third-generation, full-risk Medicaid managed care contracts, with an operational start date of January 1, 2020.

1.2 Quality Strategy Aims, Goals, and Objectives

This Quality Strategy establishes clear aims, goals, and objectives to drive improvements in care delivery and health outcomes as well as metrics by which progress will be measured. It articulates priority interventions, and details the standards and mechanisms for holding MCEs accountable for desired outcomes. The Quality Strategy is a roadmap by which LDH will use the managed care infrastructure to facilitate improvement in health and health care through programmatic interventions.

Guided by the Triple Aim and the broad aims of the National Quality Strategy – **Better Care, Healthy People, Healthy Communities, and Affordable Care –** Louisiana's Quality Strategy framework defines and drives the overall vision for advancing health outcomes and quality of care provided to Louisiana Medicaid enrollees. Described in Table 1, these broad aims link to Louisiana specific goals and objectives, intended to highlight key areas of quality focus for the Louisiana Medicaid managed care program.

Table 1: Louisiana Quality Strategy Aims, Goals, and Objectives

Aims	Goals	Objectives
Better Care. Make health care more person-centered, coordinated, and accessible so it occurs at the "Right care, right time, right place."	Ensure access to care to meet enrollee needs	Ensure timely and approximate access to primary and specialty care
	Improve coordination and transitions of care	Ensure appropriate follow-up after emergency department visits and hospitalizations through effective care coordination and case management
	Facilitate patient-centered, whole-person care	Engage and partner with enrollees to improve enrollee experience and outcomes
		Integrate behavioral and physical health

Aims	Goals	Objectives
Healthier People, Healthier Communities. Improve the health of Louisianans through better prevention and treatment and proven interventions that address physical, behavioral, and social needs.	Promote wellness and prevention	Ensure maternal safety and appropriate care during childbirth and postpartum
		Prevent prematurity and reduce infant mortality
		Promote healthy development and wellness in children and adolescents
		Promote oral health in children
		Improve immunization rates
		Prevent obesity and address physical activity and nutrition in children and adults
		Prevent prematurity and reduce infant mortality
		Improve cancer screening
		Improve HIV and Hepatitis C virus infection screening
		Promote healthy development and wellness in children and adolescents
		Promote use of evidence-based tobacco cessation treatments
	Improve chronic disease management and control	Improve hypertension, diabetes, and cardiovascular disease management and control
		Improve respiratory disease management and control
		Improve HIV control
		Improve quality of mental health and substance use disorder care
	Partner with communities to improve population health and address health disparities	Stratify key quality measures by race/ethnicity and rural/urban status and narrow health disparities
		Advance specific interventions to address social determinants of health
Smarter Spending. Demonstrate good stewardship of public resources by ensuring high-value*, efficient care.	Pay for value and incentivize innovation	Advance value-based payment arrangements and innovation
	Minimize wasteful spending	Reduce low value care*

*High value services, as defined by the Institute of Medicine, represent the "best care for the patient, with the optimal result for the circumstances, delivered at the right price." Low-value services represent care that does not meet these criteria.

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

1.3 Quality Management Structure

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

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

Members of the Medicaid Quality Committee and its subcommittees provide advisory insight to the Medicaid program. This committee provides recommendations for the delivery of high quality care. It is interdisciplinary and includes representatives who are familiar with quality improvement and the medical needs of Medicaid enrollees.

2 DRIVING IMPROVEMENT AND MONITORING PROGRESS

2.1 Goals and Objectives for Continuous Quality Improvement

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

2.2 MCO Performance Measures

Louisiana requires MCOs to report annually on patient outcome performance measures, including the Healthcare Effectiveness Data and Information Set (HEDIS®) quality metrics, CMS Adult and Children Core Set, Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators, Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, and state-specified quality measures. The state may add or remove performance measure reporting requirements prior to the start of a measurement year. Current MCO performance measure reporting requirements are described in Appendix A.

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

2.3 Performance Measures and Performance Improvement Projects (PIPs)

In accordance with 42 CFR 438.340, MCEs must have an ongoing program of PIPs that focus on clinical and non-clinical areas. A PIP is intended to improve the care, services or enrollee outcomes in a focused area of study. In addition to any CMS specified PIPs, LDH requires MCOs to perform two LDH-approved PIPs, a minimum of one additional LDH-approved behavioral-health PIP each contract year, and may require up to two additional projects for a maximum of five PIPs.

PIPs are designed to achieve, through ongoing cycles of enrollee input, planned intervention, and measurement, significant improvement on priority health outcomes sustained over time.

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

Table 2: Medicaid MCO Performance Improvement Projects

Contract Year(s)	PIP Focus	Target for Improvement
2015-2019	**Prematurity -** Reduce premature births to Medicaid-enrolled women	• Improve the initiation of progesterone between 16–24 weeks gestational age for the high-risk maternity Medicaid population from 16% to 30%. • Reduce preterm births before 32 weeks of gestation by 10% in women who have experienced a prior preterm birth.
2015-2019	**Attention Deficit and Hyperactivity Disorder (ADHD)** – Increase appropriate ADHD diagnosis and drug utilization	• Reduce by 20% prescriptions among populations who are shown to have a high incidence of prescribing with a focus on the 0-6 population.
2018-2019	**Improve Rates for Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)**	• Implement interventions to achieve the following objectives: o Conduct provider training to expand the workforce for treatment initiation and follow-up; o Partner with hospitals/emergency departments (EDs) to improve timely initiation and engagement in treatment; o Provide enhanced enrollee care coordination; and, o Other interventions as informed by the MCOs' barrier analyses conducted as part of the PIP process. • Target to be determined by LDH using MCO HEDIS IET 2018 rates as reported to NCQA.

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

Contract Year(s)	PIP Focus	Target for Improvement
2016-2018	**Dental: Improving Enrollee Receipt of Oral Health Services**	2 percentage point annual improvement for each of the following performance indicators: • Any dental service, ages 1-20 • Dental preventive visits, ages 1-2. • Dental sealants, ages 6-9
2016-2018	**CSOC: Monitoring Best Practices in Wraparound**	Implement indicators that monitor best practices in wraparound in order to have an ongoing mechanism to track fidelity to the model. Indicators included the following: • Indicator 1: A minimum of one Child and Family Team (CFT) per month. Goal: 85%. • Indicator 2: Team Composition, Natural/Informal Support Participation in the CFT. Goal: 60%.

2.3.1 PIP Topics and Processes

Each PIP must be completed in a reasonable time period so as to generally allow information on the success of PIPs in the aggregate to produce new information regarding quality of care every year. Quality improvement project topics should:

- Include aims that are expressed as a Specific, Measureable, Actionable, Realistic, and Time-bound (SMART)
- Connect to the specific health outcomes prioritized in the LDH Quality Strategy
- Use key driver diagrams (or other cause-and-effect diagrams) to show the theory of improvement or how the interventions being tested are thought to impact the project goal (SMART aim)
- Incorporate enrollee voice and concerns into topic choice and/or theory of improvement
- Use clear descriptions of methods used to identify key drivers, associated interventions, and prioritization of interventions (e.g., process mapping, Pareto analyses, root cause analyses, Failure Mode & Effects Analysis, Gemba walk)
- Reflect examples of intervention tests (PDSAs) and lessons learned
- Use objective quality indicators to measure performance including: whether the measure is a process measure, an outcome measure, or balancing measure, data source(s) for the measure, the intervention or driver to which the measure is linked, the frequency of measurement, the frequency of review of longitudinal (time series) measurement data, stratification of key data by race and other demographic factors to assess for disparities, and, mention of methods used to draw conclusions from the data (e.g., identification of special cause or the degree of variance in processes)
- Use longitudinal (trended) depictions (run charts, control charts, line graphs) of the MCO's improvement project outcomes over time with annotation of intervention periods and special cause identification
- Include results and lessons learned from performance and quality improvement projects and describe how these are communicated within and across the organization, as well as integrated into the overall MCO QAPI program
- Define processes or procedures that have been or will be put in place to sustain and spread successful interventions

LDH facilitates regular PIP meetings with MCEs to provide guidance and clinical leadership, and allow for MCE collaboration. The EQRO validates MCE PIPs and related performance measures each year and produces a report, reviewed and approved by LDH prior to release to MCEs, which summarizes the PIP results and findings for each MCE and recommendations for improvement.

2.4 Other Medicaid Quality Interventions

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

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

Effective February 2018, Medicaid introduced a two percent (2%) withhold requirement into its MCO contracts to incentivize quality, health outcomes, and VBP:

- Half of the withhold is tied to the achievement of quality and health outcomes, specifically an MCOs' performance on the Medicaid managed care incentive-based quality measures identified in Appendix A.
- The other half is linked to the increasing use of VBP to improve quality and health outcomes. MCOs are required to increase provider payments by ten percent (10%) over initial baselines. All MCO VBP arrangements with providers must include at least one of the incentive-based quality measures.

2.4.2 Managed Care Incentive Payment (MCIP) Program

Effective January 2019, the MCIP program is designed to provide incentive payments to Medicaid MCOs for achieving quality reforms that increase access to health care, improve the quality of care, and/or enhance the health of MCO enrollees. Current quality reforms focus on increasing enrollees' access to primary health care, improving health outcomes for pregnant women, newborns, and enrollees with chronic conditions, as well as reducing inefficiencies and costs by reducing unnecessary utilization, promoting evidence-based practices, and reducing low-value care.

2.4.3 Health Information Technology (HIT)

LDH's approach to the long-term sustainability of its current and future HIT and health information exchange (HIE) statewide infrastructure began with the creation of its 2018 - 2021 Louisiana HIT Roadmap. The Roadmap provides a foundational framework to achieve ubiquitous, interoperable health care data sharing among participants throughout the broader Louisiana health care community. The Department's current focus is on several statewide events in 2019 to understand the needs of the stakeholder community as they relate to HIE.

2.4.4 Other LDH Department-Wide Quality Initiatives

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

- **Taking Aim at Cancer in Louisiana**: a statewide initiative that brings together leaders across sectors in healthcare, business, government, community, advocacy, philanthropy and other sectors to work toward the common goal of improving cancer outcomes in Louisiana. **Louisiana Perinatal Quality Collaborative**: a voluntary network of perinatal care providers, public health professionals and patient and community advocates who work to advance equity and improve outcomes for parents, families, and newborns in Louisiana, supported by LDH and authorized by the Louisiana Commission on Perinatal Care and Prevention of Infant Mortality.
- **Opioid Strategy**: Through expanded federal grants from the Centers for Disease Control and Prevention and the Substance Abuse and Mental Health Services Administration, LDH will continue to work to expand access to opioid use disorder treatment in primary care settings.
- **Hepatitis C Elimination Strategy**: LDH is pursuing an innovative drug pricing model for direct-acting antivirals in Medicaid with the goal of treating 10,000 people by 2020.

2.5 Annual External Independent Reviews

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

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

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

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

Requirements of MCEs include the following:

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

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

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

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

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

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

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

2.6 Procedures for Identifying, Evaluating, and Reducing Health Disparities

2.6.1 Data Collection

In compliance with the requirements set forth in 42 CFR 438.340 (b)(6), and described in Section 3, Driving Improvement and Monitoring Progress, MCOs must report select measures outlined in Appendix A based on select strata such as age, race, ethnicity, sex, primary language, and disability status, where feasible. This information is provided to MCOs upon enrollee enrollment, and will be used by LDH to better understand disparities of care within and across MCOs.

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

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

2.6.2 Communications with MCOs

LDH contracts with an Enrollment Broker that is responsible for Medicaid managed care program enrollment and disenrollment. Daily, the Enrollment Broker provides updates on those newly enrolled into the Medicaid managed care program. In addition, at specified times each month, the Enrollment Broker notifies each MCO regarding those that will be enrolled, re-enrolled or disenrolled to/from their MCO for the following month. The Enrollment Broker provides LDH a listing of current enrollees, via

electronic media, on a monthly basis. MCOs, or their administrators, must be capable of uniquely identifying each enrollee across multiple systems within its span of control. To facilitate care delivery appropriate to client needs, the enrollment file includes race/ethnicity, primary language spoken, and selective health information. MCOs utilize this information to provide interpreter services and facilitate enrollee needs in the context of their cultural and language requirements.

MCOs are required to ensure that translation services are provided for written marketing and enrollee education materials for any language that is spoken as a primary language for 200 or more MCO enrollees within the geographic service area. The state requires that MCOs and any contractors have interpretation services for those who speak any language other than English. The Enrollment Broker will provide multi-lingual interpreters and enrollment material in other alternate formats (large print, and/or Braille) as needed.

2.6.3 Evaluating Health Disparities

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

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

2.7 Use of Sanctions

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

2.7.1 Acts or Failures to Act Subject to Intermediate Sanctions

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

- Fails substantially to provide medically necessary services that the MCO is required to provide, under law or under the Contract, to an enrollee covered under the Contract;
- Imposes on enrollees premiums or charges that are in excess of the premiums or charges permitted under the Louisiana Medicaid MCO Program;
- Acts to discriminate among enrollees on the basis of their health status or need for health care services; this includes termination of enrollment or refusal to reenroll an enrollee, except as permitted in RFP Section 11.12.2 or any practice that would reasonably be expected to discourage enrollment by recipients whose medical condition or history indicates probable need for substantial medical services.
- Misrepresents or falsifies information that it furnishes to CMS or to LDH;
- Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or a health care provider;

- Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 CFR §422.208 and §422.210;
- Distributes directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by LDH or that contain false or materially misleading information; or
- Violates any of the other applicable requirements of Section 1903(m), 1905(t)(3) or 1932 of the Social Security Act and any implementing regulations.

2.7.2 Other Misconduct Subject to Intermediate Sanctions

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

- The MCO has failed to correct deficiencies in its delivery of service after having received written notice of these deficiencies from LDH;
- The MCO has been excluded from participation in Medicare because of fraudulent or abusive practices pursuant to Public Law 95-142;
- The MCO or any of its owners, officers or directors has been convicted of a criminal offense relating to performance of the Contract with LDH or of fraudulent billing practices or of negligent practice resulting in death or injury to the MCO's enrollee;
- The MCO has presented, or has caused to be presented, any false or fraudulent claim for services or has submitted or has caused to be submitted false information to be furnished to the state or the Secretary of the federal Department of Health and Human Services;
- The MCO has engaged in a practice of charging and accepting payment (in whole or part) from enrollees for services for which a PMPM payment was made by LDH;
- The MCO has rebated or accepted a fee or portion of fee or charge for a patient referral;
- The MCO has failed to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments;
- The MCO has failed to keep or make available for inspection, audit or copying, such records regarding payments claimed for providing services;
- The MCO has failed to furnish any information requested by LDH regarding payments for providing goods or services;
- The MCO has made, or caused to be made, any false statement or representation of a material fact to LDH or CMS in connection with the administration of the Contract;
- The MCO has furnished goods or services to an enrollee which at the sole discretion of LDH, and based on competent medical judgment and evaluation are determined to be 1) insufficient for his or her needs, 2) harmful to the enrollee, or 3) of grossly inferior quality.

2.7.3 Sanction Types

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

- Civil monetary penalties in the amounts specified in 42 CFR §438.704
- Appointment of temporary management for an MCO as provided in 42 CFR §438.706;

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

3 State Standards for Access and Clinical Policies and Guidelines

3.1 Provider Network Adequacy Standards and Availability of Services

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

The following tables summarize provider network standards, as indicated in LDH's MCO Provider Network Companion Guide, and other access performance standards.

Table 4: Provider Network Geographic and Capacity Standards

Type	Ratio (Provider: Enrollee)	Rural Parishes		Urban Parishes		Notes
		miles[2]	minutes[2]	miles[2]	minutes[2]	
Primary Care[1]						
Adult PCP access (for enrollees 21 and over) [3]						
Family/General Practice; Internal Medicine; FQHCs; RHCs; Non-Physician Provider: Nurse practitioners, certified nurse mid-wives, and physician assistants linked to a physician group who provide primary care services to adults.	Physicians: 1:2,500 adult enrollees Non-Physician Provider: 1:1,000 adult enrollees	30	60	10	20	PCP mileage and time network standards are applied across these provider types collectively. Only include physicians that have agreed to accept full PCP requirements.
Pediatric PCP access (for enrollees under age 21)[3]						
Pediatrics; Family/General Practice; Internal Medicine; FQHCs; RHCs; Non-Physician Provider: Nurse practitioners, certified nurse midwives, and physician assistants linked to a physician group who provide primary care services to pediatric patients.	Physicians: 1:2,500 pediatric enrollees Non-Physician Provider: 1:1,000 pediatric enrollees	30	60	10	20	PCP mileage and time network standards are applied across these provider types collectively. Only include physicians that have agreed to accept full PCP requirements.
Hospitals						
Acute Inpatient Hospitals		30	60	10	20	

Type	Ratio (Provider: Enrollee)	Rural Parishes		Urban Parishes		Notes
		miles[2]	minutes[2]	miles[2]	minutes[2]	
Ancillary						
Laboratory		30	60	20	40	
Radiology		30	60	20	40	
Pharmacy		30	60	10	20	
Hemodialysis centers		30	60	10	20	
Dental - Pediatric[3]		30	60	10	20	
Specialty Care						
OB/GYN [1]		30	60	15	30	
Allergy/Immunology	1:100,000	Travel distance does not exceed 60 miles for at least 75% of enrollees and 90 minutes for 100% of enrollees		Travel distance does not exceed 60 miles for at least 75% of enrollees and 90 miles for 100% of enrollees		
Cardiology	1:20,000					
Dermatology	1:40,000					
Endocrinology and Metabolism	1:25,000					
Gastroenterology	1:30,000					
Hematology/Oncology	1:80,000					
Nephrology	1:50,000					
Neurology	1:35,000					
Ophthalmology	1:20,000					
Orthopedics	1:15,000					
Otorhinolaryngology/ Otolaryngology	1:30,000					
Urology	1:30,000					
Behavioral Health						
Psychiatrists						
Psychiatrists		30	60	15	30	
Behavioral Health Specialists (adult)						
Advanced Practice Registered Nurse (Behavioral Health Specialty; Nurse Practitioner		30	60	15	30	Behavioral Health specialist network adequacy standards are applied across

Type	Ratio (Provider: Enrollee)	Rural Parishes		Urban Parishes		Notes
		miles^2	minutes^2	miles^2	minutes^2	
or Clinical Nurse Specialist); or						these provider types collectively as compared to residences of adult enrollees
Medical or Licensed Psychologist; or						
Licensed Clinical Social Worker						
Behavioral Health Specialists (pediatric)						
Advanced Practice Registered Nurse (Behavioral Health Specialty; Nurse Practitioner or Clinical Nurse Specialist); or		30	60	15	30	Behavioral Health specialist network adequacy standards are applied across these provider types collectively as compared to residences of pediatric enrollees
Medical or Licensed Psychologist; or						
Licensed Clinical Social Worker						
Psychiatric Residential Treatment Facilities (PRTFs) (pediatric)						
Psychiatric Residential Treatment Facility		Travel distance to a PRTF shall not exceed 200 miles or 3.5 hours from the enrollee's residence				PRTF network standards are applied across these provider types collectively as compared to residences of all pediatric enrollees
Psychiatric Residential Treatment Facility Addiction (ASAM Level 3.7)						
Psychiatric Residential Treatment Facility Other Specialization						
Substance Use Residential Treatment Facilities - Adult Population						
ASAM Levels 3.3/ 3.5		30	60	30	60	
ASAM Level 3.7		60	90	60	90	
ASAM Level 3.7-WM		60	90	60	90	
Substance Use Residential Treatment Facilities - Adolescent Population						
ASAM Level 3.5		60	90	60	90	
Psychiatric Inpatient Hospital Services						
Hospital, Free Standing Psychiatric Unit		90	90	90	90	Psych inpatient network standards are applied across these provider types collectively as compared to residences for all enrollees
Hospital, Distinct Part Psychiatric Unit						

Type	Ratio (Provider: Enrollee)	Rural Parishes		Urban Parishes		Notes
		miles[2]	minutes[2]	miles[2]	minutes[2]	
[1] For purposes of assessing network adequacy for OB/GYN specialty services, access standards are established based on female enrollees age 21 and over. The MCO shall not include OB/GYN providers in its assessment of network adequacy for primary care.						
[2] Unless otherwise specified, MCO must demonstrate that 100% of applicable enrollees (adult or pediatric) have access to network providers for the type of service specified within the identified miles or minutes standard from the enrollee's residence.						
[3] For purposes of reporting network adequacy for both physical and behavioral health services, adult is defined as enrollees age 21 and over, pediatric is defined as enrollees under age 21.						

Table 5: Provider Network Appointment Availability Standards

Provider/Facility Type	Standard	Monitoring
Emergencies and Urgent Care		
Emergency Care	24 hours, 7 days/week within 1 hour of request	CAHPS Survey, Complaint Analysis
Urgent Non-emergency Care	24 hours, 7 days/week within 24 hours of request	
Primary Care		
Non-Urgent Sick	72 hours	CAHPS Survey, Complaint Analysis
Non-Urgent Routine	6 weeks	
After Hours, by phone	Answer by live person or call-back from a designated medical practitioner within 30 minutes	Survey, Complaint Analysis
Prenatal Visits		
1st Trimester	14 days	CAHPS Survey, Complaint Analysis
2nd Trimester	7 days	
3rd Trimester	3 days	
High risk pregnancy, any trimester	3 days	
Specialty Care		
Specialist Appointment	1 month	Complaint Analysis, Mystery Shopper, EQRO Survey
Waiting Room Time		
Scheduled Appointments	<45 minutes	Complaint Analysis
Accepting New Patients		
The practitioner office is open to new patients	Provider is listed in directory and/or registry file as open	EQRO Survey, Mystery Shopper, Complaint Analysis
Specialized Behavioral Health Providers		
Non-Urgent Routine	14 days	

Provider/Facility Type	Standard	Monitoring
Urgent Non-emergency Care	48 hours	Mystery Shopper, Complaint Analysis
Psychiatric Inpatient Hospital (emergency involuntary)	4 hours	Complaint Analysis
Psychiatric Inpatient Hospital (involuntary)	24 hours	
Psychiatric Inpatient Hospital (voluntary)	24 hours	
ASAM Level 3.3, 3.5 & 3.7	10 business days	
Withdrawal Management	24 when medically necessary	
Psychiatric Residential Treatment Facility (PRTF)	20 calendar days	

Table 6: Dental Access to Care and Network Availability Standards

Network Capacity and Geographic Access Standards
• The Primary Dental Provider (PDP) may practice in a solo or group practice or may practice in a clinic (i.e. Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC) or outpatient clinic). The Dental Benefit Program Manager (DBPM) shall provide at least one (1) full time equivalent (FTE) PDP per five thousand (5,000) enrollees. LDH defines a full-time PDP as a provider that provides dental care services for a minimum of thirty-two (32) hours per week of practice time. The DBPM shall provide access to dentists that offer extended office hours (before 8:00 a.m., after 4:30 p.m., and/or on Saturdays) at least one (1) day per week. • The DBPM shall provide access to dentists that offer extended office hours (before 8:00 a.m., after 4:30 p.m., and/or on Saturdays) at least one (1) day per week. • Network providers must offer office hours at least equal to those offered by commercial dental insurance plans. • If an enrollee requests a provider who is located beyond access standards, and the DBPM has an appropriate provider within the DBPM network who accepts new patients, it shall not be considered a violation of the access requirements for the DBPM to grant the enrollee's request. The DBPM shall not submit encounters for travel outside of the access standards if an appropriate provider was available within the access standards. • The DBPM shall comply with the following maximum distance requirements, as determined by mapping software (e.g. MapQuest, Google Maps, ArcGIS). Requests for exceptions as a result of prevailing community standards must be submitted in writing to LDH for approval.
Distance to Primary Dental Services
• Travel distance from enrollee's place of residence shall not exceed thirty (30) miles or sixty (60) minutes one-way for rural areas and ten (10) miles or twenty (20) minutes for urban areas.
Distance to Specialty Dental Services
• Travel distance shall not exceed sixty (60) miles one-way from the enrollee's place of residence for at least seventy-five (75) percent of enrollees and shall not exceed ninety (90) minutes one-way from the enrollee's place of residence for all enrollees. ▪ The DBPM shall ensure, at a minimum, the availability of the following specialists and other providers for enrollees under the age of twenty-one (21) years:

▪ Endodontists; ▪ Maxillofacial Surgeons; ▪ Oral Surgeons; ▪ Orthodontists; ▪ Pedodontists; ▪ Periodontists; ▪ Prosthodontists; and ▪ Special Needs Pedodontists.
Timely Access Standards
• Urgent care services – within twenty-four (24) hours of a request for services that do not require prior authorization and within forty-eight (48) hours for a request for services that do require prior authorization; ▪ Primary Dental Care – within thirty (30) days; and ▪ Follow-up Dental Services – within thirty (30) days after assessment.

Table 7: Access Performance Standards

Access Performance Standards
Delivery Network
Contracted network of appropriate providers (42 CFR 438.206(b)(1)) Each MCO must meet the following requirements. • Maintains and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, each MCO must consider the anticipated Medicaid enrollment, the expected utilization of services, and take into consideration the characteristics and health care needs of specific, Medicaid populations enrolled. The MCO must also consider the numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services, the number of network providers who are not accepting new Medicaid patients, and the geographic location of providers and Medicaid enrollees. Distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, will be considered and whether the location provides physical access for Medicaid enrollees with disabilities. • The networks must be comprised of hospitals, physicians and specialists in sufficient numbers to make available all covered services in a timely manner. • The primary care network must have at least 1 full time equivalent PCP for every 2,500 patients. Physicians with physician extenders (nurse practitioner/physician assistant, certified nurse midwife or OB/GYNs only) may increase the physician ration by 1,000 per extender. The maximum number of extenders shall not exceed two extenders per physician. • The MCO shall ensure the availability of timely access to hospital care. Transport time will be usual and customary, not to exceed 30 miles, except in rural areas where distance may be greater. If greater, the standard shall be the community standard for accessing care. Exceptions must be justified, documented, and submitted to LDH for approval. The MCO shall include, at a minimum, access to the following: o One (1) hospital that provides emergency room services, inpatient, and outpatient care in each parish in the state, provided the parish has such a hospital (free standing psychiatric hospitals and distinct part psychiatric hospitals do not meet this requirement). The MCO must establish access to the following within their network of hospitals: ▪ Level III Obstetrical services; ▪ Level III Neonatal Intensive Care (NICU) services;

Access Performance Standards
▪ Pediatric services; ▪ Trauma services; ▪ Burn services; and ▪ A Children's Hospital that meets the CMS definition in 42 C.F.R. §495.302 and §412.23(d). o Tertiary care is defined as health services provided by highly specialized providers, such as medical sub-specialists; these services frequently require complex technological and support facilities. The MCO shall provide tertiary care services including trauma centers, burn centers, level III (high-risk) nurseries, rehabilitation facilities, and medical sub-specialists twenty-four (24) hours per day. If the MCO does not have a full range of tertiary care services, the MCO shall have a process for providing such services including transfer protocols and arrangements with out-of-network providers. **Timely services for enrollees 438.6(k)(3)** • Each MCO must provide for arrangements with, or referrals to, sufficient numbers of physicians and other practitioners to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care.
Direct Access to Women's Health Specialist (42 CFR 438.206(b)(2) • Provides female enrollees with direct access to women's health specialist within the network for covered care, necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist. • Contractors must ensure that the network procedures for accessing family planning services are convenient and easily comprehensible to enrollees. • A women's health specialist may serve as a primary care provider.
Adequate and Timely Second Opinion (42 CFR 438.206(b)(3)) • Provides for a second opinion from a qualified health care professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.
Adequate and Timely Out-of-Network Providers (42 CFR 438.206(b)(4) & (b)(5)) • If the network is unable to provide necessary medical services, covered under the contract, to a particular enrollee, the MCO must adequately and timely cover these services out of network for the enrollee, for as long as the MCO is unable to provide them. • Requires out-of-network providers to coordinate with the MCO with respect to payment and ensures that cost to the enrollee is no greater than it would be if the services were furnished within the network.
Provider Credentialing as required in regulation (42 CFR 438.206(b)(6)) • Demonstrates that its providers are credentialed as required by § 438.214
Timely Access (42 CFR 438.206(c)(1)(i-vi)) • Each MCO must meet and require its providers to meet state standards for timely access to care and services, taking into account the urgency of the need for services. Standards for access and timeliness are identified in the chart at the beginning of the standards section. • Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees. • Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary. • Establish mechanisms to ensure compliance by providers, monitor providers regularly in order to determine compliance, and take corrective action if there is a failure to comply. **Reasonable and Adequate Hours of Operation 438.6(k)(1)**

Access Performance Standards

- Each MCO must provide for reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment for emergency medical conditions.

Cultural Considerations (42 CFR 438.206(c)(2))

- Each MCO participates in the state's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.
  - The MCO is required to have available interpretive services for all languages other than English upon request.
  - The MCO will encourage and foster cultural competency in its employees.

Assurances of Adequate Capacity 438.207

Documentation and Assurances of Adequate Capacity and Services (42 CFR 438.207 (b), (c))

- Each MCO must give assurances to the state and provide supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area and in accordance with the state's standards for access to care.
  - *Nature of supporting documentation:* Each MCO must submit documentation to the state, in a format specified by the state to demonstrate that it complies with the requirements below.
    - Offers an appropriate range of preventive, primary care, and specialty services that are adequate for the anticipated number of enrollees for the service area.
    - Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.
  - *Timing of documentation:* Each MCO must submit the required documentation, no less frequently than:
    - at the time it enters into a contract with the state or at any time there has been a significant change (as defined by the state) in the MCO operations that would affect adequate capacity and services, including changes in Contractor services, benefits, geographic service area, payments or enrollment of a new population with the MCO.

Coordination and Continuity of Care 438.208

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

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

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

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

- Ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity designated as primarily responsible for coordinating the health care services furnished to the enrollee.
- Coordinate the services the MCO furnishes to the enrollee with the services the enrollee receives from any other MCO, PIHP, or PAHP.

Access Performance Standards

- Share with other MCOs, PIHPs, and PAHPs serving the enrollee with SHCN the results of its identification and assessment of the enrollee's needs to prevent duplication of those activities.
- Ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.

MCO contract §6.33 and MCO contract §7.1.6

The MCO must maintain a case management program. The MCO will ensure case managers initiate and maintain an enrollee care/treatment plan that includes:

- A thorough initial assessment including all domains of care with periodic updates, including enrollee strengths and barriers to care
- Short and long term goals that are developed in collaboration with the enrollee
- Periodic assessment of goal achievement and development of new goals
- Identification and documentation of coordination of care opportunities with all providers involved in the enrollee's care

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

- Identification. The state must implement mechanisms to identify persons with SHCN to MCOs, as those persons are defined by the state. These identification mechanisms:
    - Must be specified in the state's QI strategy in § 438.202; and
    - May use state staff, the state's enrollment broker, or the state's MCOs.
- Assessment: Each MCO must implement mechanisms to assess each Medicaid enrollee identified by the state (through the mechanism specified in paragraph (c)(1) of this section) and identified to the MCO by the state as having SHCN in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals.

Mechanisms for Enrollees with SHCN: Development of Treatment Plans (42 CFR 438.208(c)(3))

- Treatment plans: If the state requires MCOs to produce a treatment plan for enrollees with SHCN who are determined through assessment to need a course of treatment or regular care monitoring, the treatment plan must be—
    - Developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee;
    - Approved by the MCO in a timely manner, if this approval is required by the MCO; and
    - In accord with any applicable state QA and utilization review standards.

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

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

Coverage and Authorization of Services 438.210

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

- **Exception for MCOs that serve dually eligible enrollees.**
    - For a MCO that serves enrollees who are also enrolled in and receive Medicare benefits from a Medicare+Choice plan, the state determines to what extent that an MCO must meet the primary care coordination, identification, assessment, and treatment planning provisions of this section.

Access Performance Standards
○ The state bases its determination on the services it requires the MCO to furnish to dually eligible enrollees. • MCOs are required to provide for all medically necessary and appropriate Medicaid covered services, consistent with FFS Medicaid, in sufficient amount, scope, and duration to achieve the purpose of the service(s) and, may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the enrollee. • The MCO may place appropriate limits on a service based criteria applied under the state plan, such as medical necessity or for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose. The MCO must also specify what constitutes "medically necessary services" in a manner that: ○ is no more restrictive than that used in the state Medicaid program as indicated in state statutes and regulations, the state plan, and other state policy and procedures manuals; and ○ addresses the extent to which the MCO is responsible for covering services related to the following: ▪ The prevention, diagnosis, and treatment of health impairments, ▪ The ability to achieve age-appropriate growth and development, and ▪ The ability to attain, maintain, or regain functional capacity.
Policies and Procedures for Authorization of Services (42 CFR 438.210(b)(1), (2), and (3)) • For the processing of requests for initial and continuing authorizations of services, each contract must require: ○ That the MCO and its subcontractors have in place, and follow, written policies and procedures. ○ That the MCO ▪ Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and ▪ Consult with the requesting provider when appropriate. • That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.
Notice of Adverse Action (42 CFR 438.210(c)) • Each contract must provide for the MCO to notify the requesting provider, and give the enrollee written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of §438.404, except that the notice to the provider need not be in writing.
Timeframe for decisions (42 CFR 438.210(d))(1), (2)&(e) • Each MCO contract must provide for the following decisions and notices: ○ *Standard authorization decisions*: For standard authorization decisions, provide notice as expeditiously as the enrollee's health condition requires and within state-established timeframes that may not exceed 14 calendar days, following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if: ▪ The enrollee, of the provider, requests extension: or ▪ The MCO justifies (to the state agency upon request) a need for additional information and the extent to which the extension is in the enrollee's interest. ○ *Expedited authorization decisions:* For cases in which a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision

Access Performance Standards
and provide notice as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service. o The MCO may extend the 3 working days' time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO justifies (to the state agency upon request) a need for additional information and how the extension is in the enrollee's interest. • Compensation for utilization management activities: Each contract must provide that, consistent with §438.6(h), and §422.208 of this chapter, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.
Emergency and Post–Stabilization Care Service (42 CFR 438.114) The MCOs will comply with the definitions used in this section: • *Emergency medical condition* means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: o Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; o Serious impairment to bodily functions; or o Serious dysfunction of any bodily organ or part. • *Emergency services* means covered inpatient or outpatient services that are: o Furnished by a provider qualified to furnish emergency services. o Needed to evaluate or stabilize an emergency medical condition. • *Post-stabilization care services* means covered services, related to an emergency medical condition, that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or, under the circumstances described in paragraph (e) of this section, to improve or resolve the enrollee's condition. • The MCO must cover Post Stabilization services without requiring authorization, and regardless of whether the enrollee obtains the services within or outside the Contractor's provider network if any of the following circumstances exist: o The Post Stabilization Services were pre-approved by the Contractor; o The Post Stabilization Services were not pre-approved by the Contractor because the Contractor did not respond to the Provider's request for these Post stabilization services within one (1) hour of the request; o The Post stabilization services were not pre-approved by the Contractor because the Contractor could not be reached by the provider to request pre-approval for these post stabilization services; or o The Contractor's representative and the treating physician cannot reach an agreement concerning the enrollee's care and a Contracting physician is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a plan physician while the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in 42 CFR 422.113 (C) (3) is met. • The MCO may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. • The MCO may not refuse to cover emergency services based on the ER provider, hospital, or fiscal agent not notifying the enrollee's primary care provider, MCO, or applicable state entity of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services. • An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

Access Performance Standards
• The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities responsible for coverage and payment.

3.2 Adoption & Dissemination of Evidence-Based Clinical Practice Guidelines

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

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

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

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

3.3 Transition of Care Policy

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

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

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

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

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

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

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

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

- The MCO must identify enrollees with SHCN within 90 days of receiving the enrollee's historical claims data.

- Primary care physicians can identify enrollees with SHCN at any time. An appropriate healthcare professional must conduct an assessment of those enrollees within 90 days of identification. If an assessment determines a course of treatment or regular care monitoring, referral for case management will be provided.
- Enrollees may also self-identify as SHCN to either the Enrollment Broker or the MCO.
- MCOs monitor and assess the appropriateness of care furnished to individuals with SHCN through various means including but not limited to evaluation of the quality assessment and performance improvement programs, comprehensive care management program reporting, care coordination, and use of the CAHPS Children with Chronic Conditions survey.

3.5 Non-Duplication Strategy

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

Currently, there are no EQR activities for which the state has exercised the option described in this section. However, should the state determine in the future that a private accreditation activity (e.g., National Committee on Quality Assurance [NCQA] accreditation) is comparable to EQR activities, the state would work with the EQRO to identify any areas in the NCQA accreditation program that may be redundant with the EQR review and deem these activities accordingly.

4 EVALUATING, UPDATING, AND DISSEMINATING THE QUALITY STRATEGY

4.1 Quality Strategy Development and Public Comment

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

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

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

In preparation for the future Medicaid managed care program effective 2020, LDH is preparing to update its MCO quality performance measures (currently referenced in Section 2, Driving Improvement and Monitoring Progress) to best align with the priorities and objectives of the Louisiana Managed Care Quality Strategy and other LDH Department-wide priorities. LDH undertook a broad public stakeholder input process across major regions of the state in early 2019. As part of this effort, LDH is working in concert with the Medicaid Quality Committee to reach consensus on the final set of performance measures.

In accordance with the state's Tribal consultation policy, tribal notification was also made to request further input into the Quality Strategy. In parallel, prior to finalizing the Quality Strategy, LDH will make the Quality Strategy available for public comment and will incorporate edits as appropriate and submit the document to CMS for feedback prior to adopting it as final. LDH will make the final Quality Strategy available on its website.

4.2 Quality Strategy Review, Update, and Evaluation

The Quality Strategy will be reviewed and updated as needed, but no less than once every three years as required by the CMS Medicaid Managed Care Final Rule or when there is a significant change, defined as any change to the Quality Strategy that may reasonably be foreseen to materially affect the delivery or measurement of the quality of health care services. The Quality Strategy review includes an evaluation of the effectiveness of the quality strategy. Currently, this reporting requirement is satisfied by means of the state's annual EQR technical report. However, in the future, LDH will consider this review and evaluation through a separate, annual report on the implementation and effectiveness of the quality strategy to be

conducted by the state's EQRO. This evaluation can include feedback from both internal and external stakeholders.

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

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

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

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

APPENDIX A: Louisiana Medicaid MCO Performance Measures (2020 HEDIS Reporting Year /2019 Measurement Year)

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source	2020 (2019 data measurement year) and Subsequent Years Target for Improvement
PTB $$	Initiation of Injectable Progesterone for Preterm Birth Prevention	The percentage of women 15-45 years of age with evidence of a previous preterm singleton birth event (24-36 weeks completed gestation) who received one or more progesterone injections between the 16th and 24th week of gestation for deliveries during the measurement year.	STATE	None	Children's and Maternal Health	Perinatal and Reproductive Health	Section V	24.08
AWC $$	Adolescent Well Care Visit	The percentage of enrolled enrollees 12-21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement year.	NCQA	CHIPRA	Children's Health	Utilization	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year
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	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source	2020 (2019 data measurement year) and Subsequent Years Target for Improvement
ADD $$	Follow-up Care for Children Prescribed ADHD Medication-Continuation Phase	The percentage of children 6-12 years of age as of the index period start date with a newly prescribed ambulatory prescription dispensed for attention-deficit /hyperactivity disorder (ADHD) medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.	NCQA	CHIPRA, MU2	Children's Health	Behavioral Health	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year
AMB-ED $$	Ambulatory Care-ED Visits	This measure summarizes utilization of ambulatory care ED Visits per 1,000 enrollee months.	NCQA	CHIPRA	Population Health	Utilization	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year
PPC $$	Prenatal and Postpartum Care - Timeliness of Prenatal Care	The percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year that received a prenatal care visit as a enrollee of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment in the organization.	NCQA	MEDICAID ADULT	Maternal Health	Perinatal and Reproductive Health	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source	2020 (2019 data measurement year) and Subsequent Years Target for Improvement
PPC $$	Prenatal and Postpartum Care – Postpartum Care (PPC Numerator 2)	The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	NCQA	MEDICAID ADULT	Maternal Health	Perinatal and Reproductive Health	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year
FUH $$	Follow-Up After Hospitalization for Mental Illness - Within 30 days of discharge	The percentage of discharges for enrollees 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	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year
CBP $$	Controlling High Blood Pressure - Total	• The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.	NCQA	MEDICAID ADULT, MU2, CMS HEALTH HOMES	Chronic Disease	Cardiovascular Care	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year
CDC $$	Comprehensive Diabetes Care - Hemoglobin A1c (HBA1c) testing	The percentage of enrollees 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	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source	2020 (2019 data measurement year) and Subsequent Years Target for Improvement
CDC $$	Comprehensive Diabetes Care - Eye exam (retinal) performed	The percentage of enrollees 18-75 years of age with diabetes (type 1 and type 2) with an eye exam (retinal) performed.	NCQA	MEDICAID ADULT	Chronic Disease	Diabetes	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year
CDC $$	Comprehensive Diabetes Care - Medical attention for nephropathy	The percentage of enrollees 18-75 years of age with diabetes (type 1 and type 2) with medical attention for nephropathy.	NCQA	CHIPRA	Chronic Disease	Diabetes	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year
W15 $$	Well-Child Visits in the First 15 Months of Life - Six or more well-child visits.	The percentage of enrollees who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life.	NCQA	CHIPRA	Children's Health	Utilization	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source	2020 (2019 data measurement year) and Subsequent Years Target for Improvement
W34 $$	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	The percentage of enrollees 3-6 years of age who had one or more well-child visits with a PCP during the measurement year.	NCQA	CHIPRA	Children's Health	Utilization	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year
CPA $$	CAHPS Health Plan Survey 5.0H, Adult (Rating of Health Plan, 8+9+10)	This measure provides information on the experiences of Medicaid enrollees with the organization and gives a general indication of how well the organization meets enrollees' expectations.	NCQA	MEDICAID ADULT	Adult	Enrollee Satisfaction	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year
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	Enrollee Satisfaction	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source
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

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	Percentage of children ages 3 to 17 that had an outpatient visit with a primary care practitioner (PCP) or obstetrical/ gynecological (OB/GYN) practitioner and whose weight is classified based on body mass index percentile for age and gender. The percentage of children ages 3 to 17 that had an outpatient visit with a primary care practitioner (PCP) or obstetrical/ gynecological (OB/GYN) practitioner, with evidence of: • BMI percentile documentation • Counseling for nutrition • Counseling for physical activity	NCQA	CHIPRA, MU2	Children's Health	Prevention	HEDIS
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	The measure calculates the percentage of individuals 19 years of age or greater as of the beginning of the measurement year with schizophrenia or schizoaffective disorder who are prescribed an antipsychotic medication, with adherence to the antipsychotic medication [defined as a Proportion of Days Covered (PDC)] of at least 0.8 during the measurement year (12 consecutive months).	NCQA	MEDICAID ADULT	Population Health	Behavioral Health	HEDIS
MPM	Annual Monitoring for Patients on Persistent Medications	The percentage of enrollees 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. For each product line, report each of the two rates separately and as a total rate.	NCQA	MEDICAID ADULT	Chronic Disease	Prevention	HEDIS

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source
ABA	Adult BMI Assessment	The percentage of enrollees 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement or the year prior to the measurement year.	NCQA	MEDICAID ADULT, CMS HEALTH HOMES	Population Health	Prevention	HEDIS
AMM	Antidepressant Medication Management	The percentage of enrollees 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
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

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source
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
MMA	Medication Management for People with Asthma	The percentage of patients 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported.	NCQA	CHIPRA	Population Health	Pulmonary/ Critical Care	HEDIS
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

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source
CAP	Child and Adolescents' Access to Primary Care Practitioners	Percentage of children ages 12 months – 19 years who had a visit with a PCP. The MCO reports four separate percentages: • Children 12-24 months and 25 months – 6 years who had a visit with a PCP in the measurement year • Children 7-11 years and adolescents 12-19 years who had a visit with a PCP in the measurement year or the year prior to the measurement year.	NCQA	CHIPRA	Children's Health	Access/ Availability of Care	HEDIS
COL	Colorectal screening	The percentage of enrollees 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 enrollees 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

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source
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
CDC	Comprehensive Diabetes Care - HbA1c poor control (>9.0%)	The percentage of enrollees 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 enrollees 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 enrollees 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

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source
PCR	Plan All-Cause Readmissions	For enrollees 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 enrollees age 20 years and older who had an ambulatory or preventive care visit during the measurement year. Three age stratifications and a total rate are reported: • 20-44 years • 45-64 years • 65 years and older • Total	NCQA	MEDICAID ADULT	Population Health	Prevention	HEDIS
FUH	Follow-Up After Hospitalization for Mental Illness - Within 7 days of discharge	The percentage of discharges for enrollees 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner within 7 days of discharge.	NCQA	CHIPRA	Behavioral Health	Behavioral Health	HEDIS
AMB	Ambulatory Care-Outpatient Visits	This measure summarizes utilization of ambulatory care Outpatient Visits per 1,000 enrollee months.	NCQA	MEDICAID	Population Health	Utilization	HEDIS
PQI Measures							

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source
PQI01	Diabetes Short Term Complications Admission Rate	Number of discharges for diabetes short term complications per 100,000 enrollee 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 discharges for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 enrollee months for Medicaid enrollees age 40 and older.	AHRQ	MEDICAID ADULT	Population Health	Pulmonary/ Critical Care	Section V
PQI08	Heart Failure Admission Rate	Percent of population with an admissions for heart failure (reported by Recipient Parish). The number of discharges for heart failure per 100,000 enrollee 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 discharges for asthma per 100,000 enrollee months for Medicaid enrollees ages 18 to 39.	AHRQ	MEDICAID ADULT	Population Health	Pulmonary/ Critical Care	Section V
Vital Record Measures							
LBW	Percentage of low birth weight births	Percentage of live births that weighted 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

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source
NQF (PC-01)	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
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
NSV	Cesarean Rate for Low-Risk First Birth Women	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