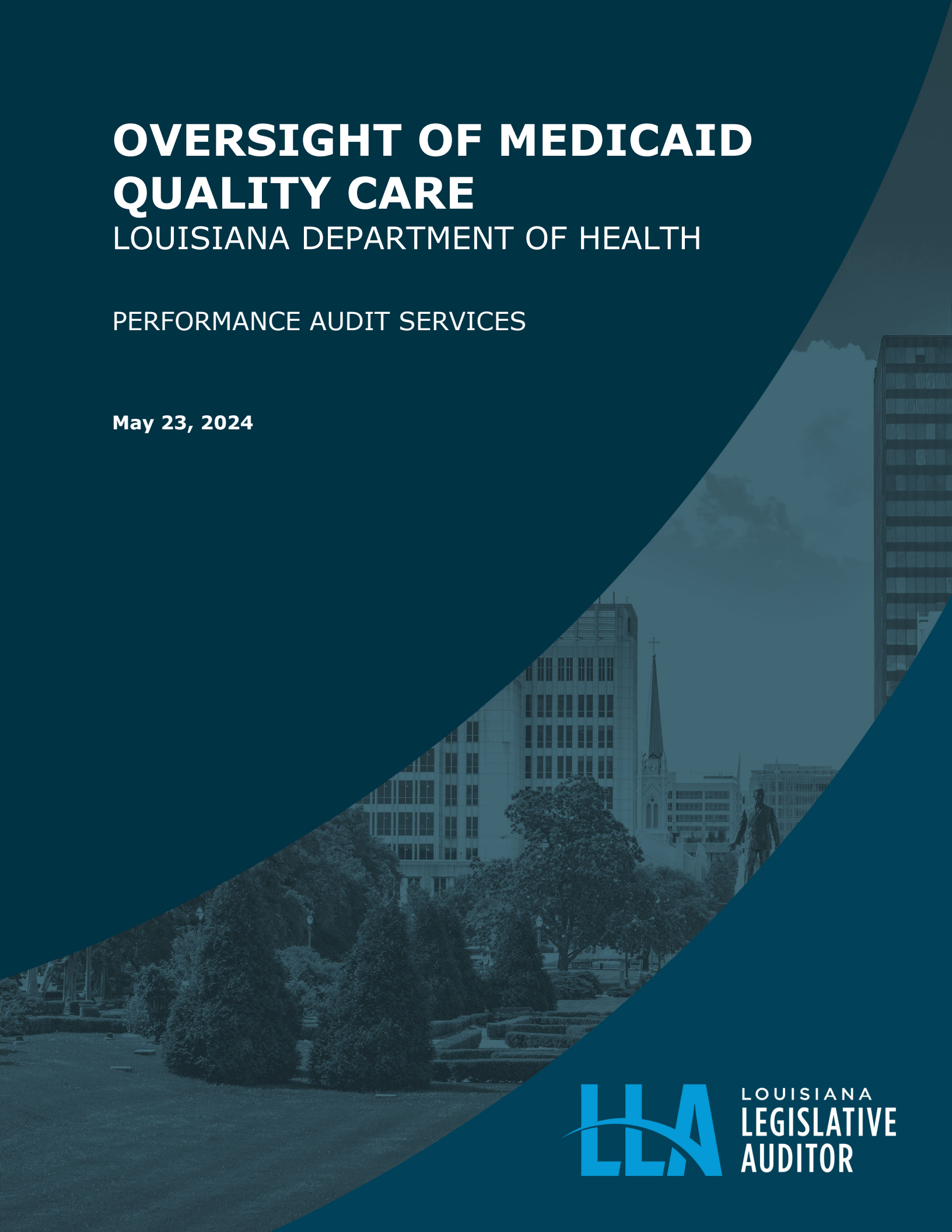
OVERSIGHT OF MEDICAID QUALITY CARE

LOUISIANA DEPARTMENT OF HEALTH

PERFORMANCE AUDIT SERVICES

May 23, 2024



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LOUISIANA LEGISLATIVE AUDITOR

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May 23, 2024

The Honorable J. Cameron Henry, Jr.
President of the Senate
The Honorable Phillip R. DeVillier,
Speaker of the House of Representatives

Dear Senator Henry and Representative DeVillier:

This report provides the results of our audit of the Louisiana Department of Health (LDH). The purpose of this audit was to evaluate LDH's oversight of Managed Care Organizations (MCOs) to ensure Medicaid beneficiaries are receiving quality care and necessary services.

We found that while LDH withholds 1.0% of per-member per-month fees as part of its quality withhold incentive program to encourage the MCOs to increase quality of care, LDH's design of the program allows the MCOs to receive these funds without improving performance. For example, of the $283.6 million withheld between calendar years 2018 and 2022, LDH paid the MCOs $32.2 million (11.4%) for instances when they met their performance target, but their performance still decreased from the prior year.

We also found that LDH does not use Medicaid data as part of its Quality Strategy to identify beneficiaries who have not received any services or who have not received services recommended based on demographics, such as their age or gender. In addition, LDH paid the MCOs $720.5 million to manage the care of 49,894 beneficiaries who appear to have been continuously enrolled in Medicaid for 13 to 60 months between January 2018 and December 2022 but received no services.

We found, too, that LDH does not have a consolidated database of beneficiary complaints that would allow for comprehensive tracking and trend analysis. Using available complaint data, we found that the majority of beneficiary complaints were related to a lack of quality care or a lack of access to care.

Additionally, we found that the MCO provider directories and networks were inaccurate and listed providers who did not provide Medicaid services. LDH's provider directory audits found an accuracy rate of 49.4% between May 2018 and February 2023, and we found that 33.2% of providers listed on network adequacy reports did not provide Medicaid services between July 2022 and December 2022.

The report contains our conclusions and recommendations. I hope this report will benefit you in your legislative decision-making process.

We would like to express our appreciation to LDH for its assistance during this audit.

Respectfully submitted,

Michael J. “Mike” Waguespack, CPA
Legislative Auditor

MJW/aa

LDHOVERSIGHTMCOS

Louisiana Legislative Auditor

Michael J. "Mike" Waguespack, CPA

Oversight of Medicaid Quality Care
Louisiana Department of Health

May 2024

Audit Control # 40230020

Introduction

We evaluated the Louisiana Department of Health's (LDH) oversight of Managed Care Organizations (MCOs)[1] to ensure that Medicaid beneficiaries are receiving quality care and necessary services. In transitioning to a managed care model,[2] LDH sought to improve access to care, quality of care and health outcomes, and care coordination and increased emphasis on disease prevention and early diagnosis and management of chronic conditions. Federal regulations[3] require LDH to implement a written quality strategy for assessing and improving the quality of healthcare and services provided by the MCOs for Medicaid beneficiaries.

LDH's Quality Strategy is guided by a Triple Aim that partners with beneficiaries, providers, and MCOs to achieve:

1. Better Care,
2. Better Health, and
3. Lower Costs.

We conducted this audit because a previous LLA audit identified Medicaid beneficiaries who received no Medicaid services and did not appear to reside in Louisiana while enrolled in Medicaid.[4] This included beneficiaries who were disabled, aged, and blind who may be at higher health risk if they do not receive needed services. Further, Louisiana has been named by America's Health Ranking[5] as one of the three least healthy states each year since 2011 despite its move to a managed care model in 2012 and the expansion of Medicaid coverage in 2016, which helped to decrease the share of the state's adult population without medical coverage by 59.1% between 2011 and 2021 (from 23.0% in 2011 to 9.4% in 2021) according to health insurance surveys sponsored by LDH.[6] This health ranking serves as an indicator of the health of the state as a whole, not specifically of LDH's Medicaid program, and includes factors such as physical environment, social, and economic factors not within the control of LDH.

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[1] LDH pays a per-member per-month (PMPM) premium to six private insurance companies (as of January 2023) to serve as MCOs to manage the care of Medicaid beneficiaries enrolled in their plans and pay for their Medicaid services. The six MCOs include Aetna Better Health Louisiana (Aetna); AmeriHealth Caritas of Louisiana (ACLA); Healthy Blue; Humana Healthy Horizons in Louisiana (Humana); Louisiana Healthcare Connections (LHC); and United Healthcare Community Plan (UHC).

[2] A managed care model is an arrangement for health care in which an organization acts as a gatekeeper or intermediary between the person seeking care and the physician.

[3] 42 Code of Federal Regulations (CFR) 438.340

[4] LDH: Medicaid Residency Audit

[5] https://www.americashealthrankings.org/

[6] 2011 Louisiana Health Insurance Survey; 2021 Louisiana Health Insurance Survey

Medicaid and Managed Care in Louisiana. LDH administers the Medicaid program to provide health and medical services for uninsured and medically-indigent citizens. LDH has implemented various changes to how it delivers Medicaid services to beneficiaries over the last 12 years. In February 2012, LDH transitioned from a fee-for-service (FFS) program, where LDH directly paid for services rendered by providers, to managed care. Under managed care, LDH pays MCOs a monthly fee/premium, referred to as a per-member per-month (PMPM) payment, to manage the health needs of the Medicaid population. MCOs then pay providers for services delivered to beneficiaries. However, LDH maintains responsibility for Medicaid functions such as monitoring the MCOs, determining Medicaid beneficiary eligibility, enrolling applicants into Medicaid programs, and ensuring beneficiaries receive quality healthcare.

From fiscal year 2012 through 2022, while changing the Medicaid delivery system to better coordinate care and deliver better outcomes, Louisiana's Medicaid enrollment and funding both increased, with the average annual cost per beneficiary increasing from $4,356 to $7,052. However, Louisiana's health ranking decreased from 49th to 50th during the same time. Exhibit 1 details by year the number of beneficiaries in relation to the state's population and information about the cost of Medicaid.

Exhibit 1
Fiscal Year Enrollment and Medicaid Payments to MCOs
Fiscal Year 2012 through 2022

Fiscal Year	Medicaid Program Enrollment	State Population Estimate (in Millions)	Estimated Population on Medicaid	Medicaid Payments to MCOs (in Millions)	Average Annual Cost per Beneficiary
2012	1,360,026	4,574,836	29.7%	$5,924,353,404	$4,356
2013	1,414,370	4,601,893	30.7%	6,176,836,372	$4,367
2014	1,417,304	4,625,470	30.6%	6,226,249,493	$4,393
2015	1,485,012	4,649,676	31.9%	6,764,255,713	$4,555
2016	1,602,954	4,670,724	34.3%	7,172,862,959	$4,475
2017	1,790,956	4,681,666	38.3%	9,810,237,936	$5,478
2018	1,856,480	4,684,333	39.6%	10,687,990,561	$5,757
2019	1,853,660	4,659,978	39.8%	11,416,847,816	$6,159
2020*	1,883,015	4,648,794	40.5%	12,046,130,387	$6,397
2021	1,953,276	4,645,318	42.0%	13,305,932,264	$6,812
2022**	2,057,869	4,624,047	44.5%	14,512,794,394	$7,052
Total				**$104,044,491,299**	

* The COVID-19 Public Health Emergency (PHE) was declared in March 2020 and led to an increase in the number of beneficiaries enrolled in Medicaid because federal regulations only allowed LDH to terminate a beneficiary's Medicaid coverage if they moved out-of-state, died, or requested closure.
** According to LDH's monthly Enrollment Analysis report, Medicaid program enrollment was 1,632,843 in March 2024. The large decrease is due to the Medicaid unwind that began on April 1, 2023, and allowed states to resume Medicaid eligibility determinations and to terminate the coverage for individuals who were no longer eligible for Medicaid following the end of the PHE.
Source: Prepared by legislative auditor's staff using information and Medicaid data from LDH, state population data from the United States Census Bureau, and health rankings from United Health Foundation's Health Rankings.

LDH Responsibilities for Medicaid Quality Improvement. Although the MCOs are responsible for managing the care of individual Medicaid beneficiaries, LDH is responsible for the oversight of Louisiana's Medicaid program and the MCOs to ensure the quality of services and to improve health outcomes. LDH's strategy for achieving this responsibility is its Medicaid Managed Care Quality Strategy (Quality Strategy). The Quality Strategy outlines how the managed care delivery system will accomplish three items, collectively referred to as the Triple Aim and individually as Aims: (1) Better Care, (2) Better Health, and (3) Lower Costs. Exhibit 2 details examples of goals and objectives for each of these Aims.

Exhibit 2
LDH Quality Strategy Triple Aim Goals and Objectives

Aim	Meaning	Goals	Example 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; improve coordination and transitions of care; facilitate patient-centered, whole-person care	Ensure timely and approximate access to primary and specialty care; integrate behavioral and physical health
Better Health	Improve the health of Louisianans through better prevention and treatment and proven interventions that address physical, behavioral, and social needs	Promote wellness and prevention; improve chronic disease management and control; partner with communities to improve population health and address health disparities	Ensure maternal safety and appropriate care during childbirth and postpartum; improve cancer screening; improve quality of mental health and substance use disorder care
Lower Costs	Demonstrate good stewardship of public resources by ensuring high value,* efficient care	Pay for value and incentivize innovation; minimize wasteful spending	Advance value-based payment arrangements and innovation; reduce low value care

* High-value services, as defined by the National Academy of Medicine, represent the "best care for the patient, with the optimal result for these circumstances, delivered at the right price." LDH's full September 2023 Quality Strategy is located at https://ldh.la.gov/assets/docs/MQI/MQIStrategy.pdf. We used the March 2023 Quality Strategy for our analyses.
Source: Prepared by legislative auditor's staff using LDH's Quality Strategy.

LDH primarily evaluates MCO quality of care through the use of patient outcome performance measures (57 in calendar year 2022), which MCOs are required to report to LDH annually. Many of these performance measures are required by the Center for Medicare and Medicaid Services (CMS) and include 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 calendar year.

LDH oversees the quality of care through various oversight activities, including analyzing performance measures on an annual basis to determine if the MCOs met targets or improved; receiving and managing beneficiary complaints to resolve issues; and conducting provider directory audits and reviewing network adequacy reports submitted by the MCOs to ensure they have an adequate provider

network with accurate provider information. These areas will be discussed throughout the report. The objective of this audit was:

To evaluate LDH's oversight of the MCOs' management of Medicaid beneficiary's care.

Our results are summarized on the next page and discussed in detail throughout the remainder of the report. Appendix A contains LDH's response, and Appendix B contains our scope and methodology. Appendix C shows statewide results for performance measures, both those that were incentivized and those that were not, for calendar years 2018 through 2022. Appendix D shows beneficiaries enrolled in Medicaid between 13 and 60 months but who received no services by age range, coverage type, MCO, and parish.

Objective: To evaluate LDH's oversight of the MCOs' management of Medicaid beneficiary's care.

Overall, we found the following:

- **While LDH withholds 1.0% of PMPMs to incentivize MCOs to increase quality of care, LDH's design of the quality withhold incentive program allows MCOs to receive these funds without improving performance. LDH could make improvements to strengthen its quality withhold incentive program.** For example, of the $283.6 million withheld from MCOs for the quality withhold incentive program between calendar years 2018 and 2022, LDH paid MCOs $32.2 million (11.4%) for incentivized measures where the MCOs met the target but performance decreased from the prior year.

- **LDH does not use Medicaid data as part of its Quality Strategy to identify beneficiaries who have not received any services or who have not received recommended services based on demographics, such as age and gender. We found that LDH paid the MCOs $720.5 million to manage the care of 49,894 beneficiaries who appear to have been continuously enrolled in Medicaid for 13 to 60 months between January 2018 and December 2022 but received no services**. In addition, we found that 64,882 (44.1%) of 147,177 female beneficiaries ages 45 through 73 enrolled in Medicaid in December 2022 did not receive any type of breast cancer screening between December 2018 and December 2022. Further, we found that 165,042 (65.0%) of 253,877 beneficiaries ages 45 through 74 enrolled in Medicaid in December 2022 did not receive any type of colorectal cancer screening between March 2018 and December 2022.

- **LDH does not have a consolidated database of beneficiary complaints that would allow for comprehensive tracking and trend analysis. Using available complaint data, we found that the majority of beneficiary complaints were related to a lack of quality care or a lack of access to care.** Examples of these complaints include 3,973 (26.6%) related to members missing appointments due to transportation-related problems, 608 (4.1%) related to a lack of access to care, and 397 (2.7%) related to an inability to find a provider within a reasonable distance or timeframe.

- **MCO provider directories and networks are inaccurate and contain providers who do not provide Medicaid services. LDH provider directory audits found an accuracy rate of 49.4% between May 2018 and February 2023, and we found that**

33.2% of providers listed on network adequacy reports did not provide Medicaid services between July 2022 and December 2022. We also found that 6,947 (21.4%) of the 32,512 unique providers were only listed as out-of-state providers and had no Louisiana addresses listed in the provider directories. Also, 6,711 (20.6%) were listed with multiple provider types, such as a provider being both an adult primary care provider and a pediatric primary care provider. This results in the appearance that there are more providers available than are actually accessible.

Our conclusions and recommendations are discussed in more detail in the sections below.

While LDH withholds 1.0% of PMPMs to incentivize MCOs to increase quality of care, LDH's design of the quality withhold incentive program allows MCOs to receive these funds without improving performance. LDH could make improvements to strengthen its quality withhold incentive program.

LDH uses various methods to incentivize MCOs to improve the quality of care provided to beneficiaries enrolled in Louisiana's Medicaid program. According to LDH staff, its "largest lever" for holding MCOs accountable in Louisiana's Medicaid program is its quality withhold incentive program. We specifically analyzed LDH's 1.0% quality withhold tied to the achievement of quality and health outcomes.[7] As part of this program, LDH requires MCOs to report annually on patient outcomes in specific performance measures so it can monitor the quality and health outcomes in the Medicaid program.[8] To increase performance in these measures, LDH added a requirement in its MCO contracts in February 2018 to incentivize the achievement of improved quality and health outcomes for certain performance measures.

This incentive includes withholding 1.0% (quality withhold) of all PMPMs paid during the year and then paying it to the MCOs for each incentivized measure[9] if they either (a) meet the target rate established by LDH **or** (b) improve by at least

[7] LDH withholds a total of 2.0% of PMPMs for quality programs. Our analysis of LDH's quality withhold incentive program focused solely on incentivized performance measures (1.0%), because MCOs are supposed to receive payment based on meeting targets established by LDH or by improving their performance from one year to the next. The value-based payments program is a reimbursement program (0.5%), and LDH's health equity strategies program was not implemented until January 2023 (0.5%).

[8] This is comprised of 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.

[9] Each incentivized measure is valued at the same amount.

two percentage points from the prior-year results. It is important for LDH to evaluate its quality withhold incentive program to ensure it is improving the health of beneficiaries enrolled in the Medicaid program and because of the substantial amount of funds associated with the quality withhold incentive program, which totaled $283.6 million between calendar years 2018 and 2022.[10]

Of the $283.6 million withheld from MCOs for the quality withhold incentive program between calendar years 2018 and 2022,[11] LDH paid MCOs $32.2 million (11.4%) for incentivized measures where the MCOs met the target but performance decreased from the prior year. As previously stated, LDH policy requires MCOs to meet either the target rate set by LDH[12] for each incentivized measure or improve their rate by at least two percentage points from the prior year. Therefore, if the target set by LDH for a measure is lower than the rate MCOs achieved during the previous year, MCO performance can decline and the MCO will still receive the quality withhold incentive payment as long as they meet the target set by LDH. For example, the 2022 target set by LDH for the performance measure Immunization Status for Adolescents Combo 2 was 36.74%. Although one MCO's score was 43.07% in 2021 and then decreased to 37.27% in 2022, the MCO was still paid for this performance measure in 2022 because the LDH target was met despite the MCO's declining performance. We found 30 instances during our scope where LDH paid MCOs quality withholds totaling $32,219,894 for incentivized measures where the MCOs met the target despite their performance decreasing from the prior year.

LDH does not impose penalties when performance declines on measures tied to quality withholds. We researched other states' quality withhold incentive programs and found that for the above example, some states would have penalized the MCO in addition to not paying the quality withhold amount. For example, Georgia and South Carolina impose penalties on MCOs whose incentive measure results decline from the prior year, and Georgia also fines MCOs $100,000 for each quality measure it fails to achieve.

LDH paid MCOs $50.9 million (18.0%) simply for reporting the results of certain incentivized measures[13] rather than requiring the actual improvement of performance. In addition, LDH suspended its quality withhold incentive program in calendar years 2020 and 2023.[14] LDH converts incentivized measures to report-only, instead of requiring MCOs to improve performance, when a change in the methodology for determining the rate

[10] LDH also uses a Managed Care Incentive Payment (MCIP) Program to incentivize MCOs to improve the quality of care received by Medicaid beneficiaries. Payments made to MCOs and their contracted networks totaled $2.3 billion during the time period September 2019 through December 2023. The MCIP Program will be discussed in a subsequent report.
[11] LDH suspended the quality withhold incentive program during calendar years 2020 and 2023.
[12] LDH sets the target rate based on the National Committee for Quality Assurance (NCQA) Quality Compass National 50th percentile rate, or better.
[13] This includes instances where MCOs were allowed to report prior calendar year results due to changes in the NCQA's rate calculation methodology for certain measures.
[14] LDH returned any funds initially withheld in these two years. Because of this, these amounts are not included in this report.

is made. For example, HEDIS technical specifications, such as the age range used for calculating the performance of colorectal cancer screenings, were changed between 2021 and 2022, which resulted in the colorectal cancer screening incentive measure being a report-only measure for 2022. The MCOs were paid a total of $7,511,266 for the colorectal screening performance measure for calendar year 2022 regardless of their performance since this measure was a report-only measure. In all instances where incentivized measures were converted to report-only, LDH paid MCOs quality withholds totaling $50,927,777 for simply reporting their results and not for the actual rate achieved for the measure. According to LDH, it does this to allow the MCOs 12 months to establish a baseline score for the methodology change.

Our research of other states' quality withhold incentive programs found that some states provide no payment or a significantly reduced payment for report-only measures. For example, Washington does not pay its MCOs for report-only measures, and Missouri pays a smaller amount for them when compared to its other measures. As mentioned previously, LDH's current practice for determining each incentivized measure's value is to divide the 1.0% quality withhold evenly between the incentivized measures and pay the MCOs the same amount for each achieved measure. LDH may be able to improve the effectiveness of its quality withhold incentive program by shifting the funds withheld for report-only measures to the remaining incentivized measures to ensure that MCOs are receiving payment for actual improved results.

In addition to paying MCOs for measures where performance declined and for report-only measures, LDH also suspended its quality withhold incentive program for calendar year 2020 due to the COVID-19 pandemic and calendar year 2023 as a result of the addition of a sixth MCO, which LDH stated disrupted beneficiary continuity of care. This means that the quality withhold incentive program, which LDH describes as its "largest lever" to ensure MCOs are providing quality care and improving their performance, was not used during these calendar years because of these circumstances.

LDH permanently withheld quality withholds totaling $70.8 million (24.9%) based on the MCOs failing to meet their target and improvement rates. This means that only $129.7 million (45.7%) of the quality withhold amounts for calendar years 2018 through 2022 was paid to the MCOs for actual improved performance compared to the prior year. Because of LDH's design of the program, the MCOs were paid $212,803,622 million as part of the quality withhold incentive program despite only earning $129,655,951 (60.9%) of that amount for actual improved performance. Overall, MCO results for performance measures, both those that were incentivized and those that were not, fluctuated throughout calendar years 2018 through 2022, and Appendix C shows the results for each performance measure during this timeframe.

Our research of other states' quality withhold incentive programs found opportunities for LDH to strengthen Louisiana's quality withhold incentive program. For example, we found that 10 (55.6%) of 18 states analyzed withheld more than

1.0% of PMPMs, ranging from 1.5% to 5.0% of PMPMs. In addition, two (11.1%) states withhold 1.0% in the first year an incentive measure is in place and up to 2.0% in subsequent years. Exhibit 3 summarizes the quality withhold amounts withheld and paid in the categories described in the previous sections of the report by MCO.

Exhibit 3
Quality Withhold Payments to MCOs and Permanently Withheld Funds
January 2018 through December 2022

MCO	Total 1.0% Quality Withhold	Amount Paid for Passing Measures and Improving Performance	Amount Paid for Passing Measures and Declining Performance	Amount Paid for Report-Only Measures	Total Withholds Paid to MCOs	Amount Permanently Withheld for Failed Measures
ACLA	$38,400,857	$19,483,092	$5,620,075	$8,304,791	$33,407,958	$4,992,899
Aetna	24,891,436	11,428,657	279,432	4,805,913	16,514,002	8,377,434
Healthy Blue	55,725,994	26,321,151	5,522,319	9,344,342	41,187,812	14,538,182
LHC	82,473,380	31,826,529	11,941,307	12,969,442	56,737,278	25,736,102
UHC	82,073,214	40,596,522	8,856,761	15,503,289	64,956,572	17,116,642
Total	**$283,564,881**	**$129,655,951**	**$32,219,894**	**$50,927,777**	**$212,803,622**	**$70,761,259**

Source: Prepared by legislative auditor's staff using information obtained from LDH.

Recommendation 1: LDH should evaluate the design of the quality withhold incentive program and implement strategies to further strengthen the program, which could include imposing penalties for declining performance on withhold measures, preventing or reducing payments to MCOs for report-only measures, preventing MCOs from receiving payment without demonstrating improvement on quality measures from the previous year, and increasing the PMPM withhold rate.

Summary of Management's Response: LDH agreed with this recommendation and stated that it is evaluating the design of the quality program withhold incentive and will implement strategies to further strengthen the program to be outcome driven. Appendix A contains LDH's full response.

LDH does not use Medicaid data as part of its Quality Strategy to identify beneficiaries who have not received any services or who have not received recommended services based on demographics, such as age and gender. We found that LDH paid the MCOs $720.5 million to manage the care of 49,894 beneficiaries who appear to have been continuously enrolled in Medicaid for 13 to 60 months between January 2018 and December 2022 but received no services.

LDH's MCO contracts require the MCOs to monitor and manage the care received by beneficiaries enrolled in Louisiana's Medicaid program, while LDH is supposed to monitor the MCOs for contract compliance. LDH currently relies on its External Quality Review Organization (EQRO) and Medicaid staff to review its Quality Strategy, including its Triple Aim, to assess its overall effectiveness to improve healthcare delivery, accessibility, and quality in the populations served by the MCOs. The EQRO does this through assessing the following: MCO performance to national benchmarks; health plan target and improvement objectives; performance improvement initiatives; and examining strengths and opportunities for improvement, as well as making recommendations.[15] However, neither LDH nor these reviews include an analysis of LDH's comprehensive Medicaid data, which includes all services provided to Medicaid beneficiaries under each MCO and could assist in determining whether the Triple Aim is being met. Analyzing this data could allow LDH to identify beneficiaries who have not received any services for extended periods of time or beneficiaries who qualify for recommended preventive services but have not received them.

The Aim "Better Care" is focused on making health care more person-centered, coordinated, and accessible so it occurs at the "right care, right time, right place."

The Aim "Lower Costs" is focused on minimizing wasteful spending.

We analyzed Medicaid data and identified 49,894 beneficiaries who appear to have been continuously enrolled in Medicaid for 13 to 60 months between January 2018 and December 2022 but received no services.[16] LDH paid the MCOs $720.5 million to manage these beneficiaries' care during this period.[17,18] Some of these Medicaid beneficiaries may not seek out Medicaid

[15] A copy of the April 2023 report, which reviewed the period of July 1, 2021, through June 30, 2022, can be found here: LDH EQRO Report - April 2023

[16] Of these, 28,557 (57.2%) beneficiaries were still enrolled during the month of June 2023.

[17] For the purposes of our analysis, we only included those individuals who were continuously enrolled for more than a 12-month period and received no services. There were additional Medicaid beneficiaries enrolled for less than 13 months and received no services.

[18] Of these, 1,867 (3.7%) beneficiaries were identified as possibly living out-of-state in the previous LLA audit LDH: Medicaid Residency.

services because they are healthy. For example, the age range with the highest cost of PMPMs identified in our analysis are those beneficiaries ages 26 through 35, accounting for 10,394 beneficiaries (20.8%) and $195.3 million (27.1%) in PMPMs. However, in other instances, it is unlikely that certain beneficiaries did not need any services. For example, there were 6,211 disabled, aged, or blind beneficiaries (12.4%) with $142.4 million (19.8%) in PMPMs paid on their behalf who received no services while enrolled in Medicaid during our audit scope.[19] In addition, 10,090 (20.2%) of these beneficiaries reside in a rural parish and may have difficulty obtaining services. We reviewed a targeted selection of beneficiary cases identified in this analysis and found that LDH often went years without receiving responses from beneficiaries when LDH attempted to contact them.

LDH may not be meeting its Aim of providing "Better Care" if beneficiaries, especially those likely to require more intensive services, are not receiving care. LDH may also not be meeting its Aim of "Lower Costs" by not attempting to identify beneficiaries who may no longer qualify for or need Medicaid coverage. By using Medicaid data to identify beneficiaries with no services, LDH could both ensure that MCOs are managing the care of their enrolled beneficiaries and identify those beneficiaries who should no longer be enrolled in Louisiana Medicaid. Exhibit 4 shows the length of time and cost of PMPMs associated with beneficiaries who received no services while enrolled in Medicaid, while Appendix D shows the number of beneficiaries and amount of PMPMs by age range, coverage type, MCO, and parish.

Exhibit 4
Number of Months Beneficiaries Received No Medicaid Services
January 2018 through December 2022

Range of Months	Number of Beneficiaries	PMPMs Paid
13 to 23 months	23,002	$163,105,556
24 to 35 months	9,021	113,323,704
36 to 47 months	4,540	76,369,957
48 to 59 months	2,771	58,785,863
60 months*	10,560	309,013,235
Total	**49,894**	**$720,598,315**

* Beneficiaries in this group represent those who were enrolled and received no services during the entire scope of our analysis.
Source: Prepared by legislative auditor's staff using Medicaid data.

According to LDH, it does not conduct routine analyses of Medicaid data to identify Medicaid beneficiaries who have not received any Medicaid services for extended periods of time. LDH further stated that it is the MCOs' responsibility to manage the care of beneficiaries and to identify those beneficiaries who have not received any services. However, we found that 48,664 (97.5%) of the beneficiaries identified in our analysis were enrolled with the same MCO during the period covered by our audit but received no services despite that continuity of care under a single MCO.

[19] There were 692 beneficiaries ages 26 through 35 included in this number.

According to MCOs we interviewed, they analyze claims data to identify beneficiaries who have not received services for certain periods of time and then conduct various outreach activities.[20] The MCOs also stated that they do not share the results of these analyses with LDH and consider this an eligibility issue that is LDH's responsibility. LDH stated that it has not requested these results. LDH could better accomplish its Aims of "Better Health" and "Lower Costs" by identifying beneficiaries who have been enrolled in Medicaid for extended periods of time without receiving services and determine the reason why they have not received any services. LDH could then either report this information to the MCOs to ensure they perform case management activities or remove beneficiaries from Medicaid if coverage is no longer needed.

LDH could improve its oversight of quality care provided by the MCOs by analyzing Medicaid data over time to identify individuals who qualify for recommended preventive services, such as breast or colorectal cancer screenings, but are not receiving them. According to the American Cancer Society's Guidelines for the Early Detection of Cancer (Guidelines),[21] cancer screenings are used to find cancer before a person has any symptoms and help to find and treat pre-cancers and cancers early before they have a chance to spread. LDH's Quality Strategy lists improving cancer screening as an objective to promote wellness and prevention under the Aim of "Better Health."

One of the Aims of LDH's Triple Aim outlined in its Quality Strategy is "Better Health", which LDH defines as improving the health of Louisianans through better prevention and treatment and proven interventions that address physical, behavioral, and social needs.

In some instances, it appears that Louisiana's Medicaid program is trending better than the national average. For example, Louisiana Medicaid's 2022 breast cancer screening (mammograms) rate of 55.8% was higher than the national screening rate of 52.2%.[22] Also, Louisiana's 2022 colorectal cancer screening rate of 58.6% was higher than the national screening rate of 55.0%.[23] However, even though Louisiana is reporting higher screening rates for these measures, there are still many Medicaid beneficiaries who are not receiving these recommended cancer screenings. According to LDH staff, LDH only focuses on the state's ranking as a whole and does not perform any analyses to identify individual Medicaid beneficiaries who are not receiving preventive cancer screenings over time because that is the MCO's responsibility. We found the following from our analyses of Medicaid data on breast cancer screenings and colorectal cancer screenings:

- *Breast Cancer Screenings* – Guidelines state that women ages 45 to 54 should receive mammograms every year, while women ages 55 and

[20] Outreach activities cited included phone calls, text messages, emails, and physical mailings.
[21] American Cancer Society Guidelines for the early detection of cancer
[22] According to NCQA 2022 data.
[23] According to Centers for Disease Control and Prevention data. NCQA did not report a national average rate for colorectal cancer screenings in 2022 for Medicaid beneficiaries.

older should receive mammograms every two years.[24] We analyzed Medicaid data for the population in the guidelines to identify female beneficiaries ages 45 through 73[25] who did not receive any type of breast cancer screening and found that 64,882[26] (44.1%) of 147,177 female beneficiaries enrolled in Medicaid in December 2022 did not receive any type of breast cancer screening between December 2018 and December 2022.

- *Colorectal Cancer Screenings* – Guidelines state that regular screening should start at age 45 and continue through age 75 for people at average risk[27] for colorectal cancer.[28] We analyzed Medicaid data for the population in the Guidelines to identify beneficiaries ages 45 through 74 who did not receive any type of colorectal cancer screening[29] and found that 165,042[30] (65.0%) of 253,877 beneficiaries enrolled in Medicaid in December 2022 did not receive any type of colorectal cancer screening between March 2018 through December 2022.

According to LDH staff, it does not analyze Medicaid data to identify beneficiaries who qualify for recommended services but are not receiving them. LDH staff instead stated that it is the responsibility of the MCOs to identify these beneficiaries. According to MCO staff we interviewed, they conduct these analyses but do not share the results with LDH because LDH has not requested them. LDH confirmed that it does not request this information from the MCOs despite being responsible for the oversight of the MCOs' management of beneficiary care and LDH's MCO contracts allowing LDH to request the results of these types of data analyses. By not analyzing Medicaid data to identify trends in those who receive services, such as preventive cancer screenings, LDH may not be fully meeting its Aim of providing "Better Health" to the state's Medicaid beneficiaries.

[24] Women 55 and older can continue to receive yearly screenings, and screenings should continue as long as a woman is in good health and is expected to live 10 more years or longer.
[25] The beneficiaries included in our analysis were between ages 45 and 73 on January 1, 2022, and had at least 24 months of continuous enrollment in Louisiana's Medicaid program.
[26] Of the beneficiaries identified in this analysis, 1,908 (2.9%) also appeared in the results of our analysis of beneficiaries who received no services while enrolled in Medicaid.
[27] People who are in good health and with a life expectancy of more than 10 years should continue regular screening. Average risk means people who do not have: a personal or family history of colorectal cancer, a personal history of certain types of polyps, a personal history of inflammatory bowel disease, a confirmed or suspected hereditary colorectal cancer syndrome, or a personal history of getting radiation to the abdomen or pelvic area to treat prior cancer.
[28] This includes any of the following tests: an annual fecal immunochemical (FIT) test; an annual fecal occult blood test; flexible sigmoidoscopy every five years; colonoscopy every 10 years; computed tomography colonography every five years; stool DNA test every three years.
[29] The beneficiaries included in our analysis were between ages 45 and 74 on January 1, 2022, and had at least 24 months of continuous enrollment in Louisiana's Medicaid program.
[30] Of the beneficiaries identified in this analysis, 4,902 (2.97%) also appeared in the results of our analysis of beneficiaries who received no services while enrolled in Medicaid.

Recommendation 2: LDH should conduct analyses of Medicaid data to identify beneficiaries who receive no services over certain periods of time to ensure they are still eligible for Medicaid.

Recommendation 3: LDH should conduct analyses of Medicaid data to identify beneficiaries who receive no services over certain periods of time to ensure MCOs conduct appropriate outreach activities.

Recommendation 4: LDH should conduct analyses of Medicaid data to identify groups of beneficiaries who should receive certain services, such as mammograms or colorectal screenings, but routinely do not, to ensure MCOs conduct appropriate outreach activities.

Summary of Management's Response: LDH agreed with these recommendations. LDH stated that a fundamental aspect of managed care is that you pay for both high utilizers of services and non-utilizers of services, and the managed care plans receive a set PMPM no matter if that individual utilizes many services or no services for that month. Appendix A contains LDH's full response.

LLA Additional Comments: These recommendations are aimed at ensuring that LDH uses Medicaid data as part of its Quality Strategy to monitor the MCOs so Medicaid members receive necessary services to create a healthier Medicaid population and/or identify those who no longer qualify for Medicaid. While LLA agrees with LDH's response regarding utilization, this response does not address LLA recommendations regarding identifying these individuals to ensure MCOs are conducting appropriate outreach activities and to determine if they are eligible for the Medicaid program.

LDH does not have a consolidated database of beneficiary complaints that would allow for comprehensive tracking and trend analysis. Using available complaint data, we found that the majority of beneficiary complaints were related to a lack of quality care or a lack of access to care.

MCO's are required to submit monthly reports to LDH documenting all complaints received from beneficiaries enrolled in their plan and the MCO's response to each complaint. LDH also receives complaints directly from beneficiaries through a customer service center, as well as from providers, legislators, and other parties, and stores these complaints in multiple locations based on LDH's ability to resolve the complaint when it was initially received and the method through which it was received. Comprehensively analyzing complaints is important because it would allow LDH to identify trends and determine whether

issues exist related to its Aims of "Better Care," which includes focusing on person-centered, coordinated, and accessible care, and "Better Health," which focuses on improving the health of beneficiaries.

While LDH receives and manages beneficiary complaints in various ways, it does not document the complaints in a consolidated database, which would allow LDH to monitor and analyze beneficiary complaints for trends and help to ensure its Triple Aim is being met. LDH receives complaints and manages them in different ways depending on how the complaint was originally received and, if the complaint was received by LDH customer services representatives (CSRs), whether they could resolve the complaint or if the complaint had to be escalated to LDH management. While LDH CSRs and management respond to and document these complaints individually, LDH does not compile complaints received through the various collection methods into a consolidated database to identify overall trends, such as the reasons for the complaints, issues with repeat complaints, or which MCOs tend to have a higher number of complaints. Further, each of the various methods LDH currently uses to receive complaints have weaknesses that further complicate any attempt to create a consolidated database. Exhibit 5 details the methods through which LDH receives complaints, a description of each type, and examples of the issues with each complaint collection method type individually and collectively.

Exhibit 5
Beneficiary Complaint Types

Type	Description	Issues
MCO Complaint Reports	Complaints received by the MCOs and reported to LDH on a monthly basis. Maintained in Excel files.	LDH does not compile each MCO's complaints into a single database for that MCO. In addition, LDH does not compile complaints from each MCO into a consolidated database. These complaints are not combined with the other complaint types.
CSR	Complaints received and resolved by CSR staff. Maintained in text-form case notes.	These complaints are only stored within each beneficiary's electronic case notes. These complaints are not compiled for analysis and are not combined with the other complaint types.
LDH Management	Complaints received by CSR staff that could not be resolved or complaints from other sources. Maintained in its own database.	These complaints do not consistently have a unique identifier assigned to each complaint, making it difficult to identify a true count of the number of unique complaints. These complaints are not combined with the other complaint types.

Source: Prepared by legislative auditor's staff using information from LDH.

We analyzed MCO beneficiary complaint reports and beneficiary complaints received by LDH management from January 2019 through December 2022 and found that the majority of complaints were related to a lack of quality care or lack of access to care. Because complaints handled by the CSRs are contained in each beneficiary's electronic case notes, we were unable to analyze those complaints. We did not combine complaints from the MCO complaint reports and LDH management because the categories of complaints in the MCO reports do not match the categories of complaints in the LDH reports.

Since LDH uses different categories to classify complaints received by MCOs and LDH, it is difficult to determine the types of issues Medicaid beneficiaries reported.

Using the individual monthly MCO complaint reports, we compiled a master database of 14,958 unique complaints submitted to the MCOs by beneficiaries between August 2019 and December 2022. Examples of these complaints include 3,973 (26.6%) related to members missing appointments due to transportation-related problems, 608 (4.1%) related to a lack of access to care, and 397 (2.7%) related to an inability to find a provider within a reasonable distance or timeframe. We also analyzed the complaint records[31] received by LDH management from January 2019 through December 2022 and found that 319 (20.0%) of the 1,596 complaint records were related to transportation-related issues and 274 (17.2%) were related to issues with benefits and services. However, because of the varying level of detail captured in LDH's complaint reports when compared to the complaints documented on the MCO complaint reports, we did not combine the two complaint databases in a single analysis.

Recommendation 5: LDH should create a database that captures complaints received and resolved by CSR staff.

Recommendation 6: LDH should ensure it captures similar types of information across MCO complaint reports, complaints submitted to CSRs, complaints submitted to LDH management, and any other sources from which LDH receives complaints to allow it to create a comprehensive database of all complaints.

Recommendation 7: Once LDH has ensured it captures similar types of information across the various ways it receives complaints, it should compile this information into a master database that contains all complaints and perform analyses to identify the areas with the highest level of concern for beneficiaries.

Summary of Management's Response: LDH disagreed with these recommendations and stated that current funding limits LDH from developing a comprehensive database. Appendix A contains LDH's full response.

LLA Additional Comments: Relatively low-cost options exist to implement these recommendations. LDH already compiles complaints received from MCOs and those resolved by LDH management into separate databases, which could be streamlined to ensure they collect the same type of information and then be combined with one another. CSR staff could enter complaints into an Excel file with the same type of information which could then be combined with the other two complaint methods.

[31] Of the 1,596 records we reviewed, 298 (18.7%) did not have a unique identifier for the complaint. Because of this, we are reporting these complaints as records instead of unique complaints.

MCO provider directories and networks are inaccurate and contain providers who do not provide Medicaid services. LDH provider directory audits found an accuracy rate of 49.4% between May 2018 and February 2023, and we found that 33.2% of providers listed on network adequacy reports did not provide Medicaid services between July 2022 and December 2022.

As mentioned previously, access to care was a common issue identified by our analysis of beneficiary complaints. LDH conducts provider directory audits and requires MCOs to submit semi-annual network adequacy reports to ensure MCOs have accurate and adequate provider networks. Provider directories are lists of in-network providers for health plans and include information such as the provider's phone number, physical address, and whether the provider is accepting new patients, and are an important tool for beneficiaries seeking providers. LDH requires the MCOs to maintain an accurate provider directory because inaccurate provider directories make it difficult for beneficiaries to locate providers and access care.

MCOs are also required to maintain an adequate network of providers to meet the needs of Medicaid beneficiaries. While federal rules require states to establish and enforce network adequacy standards for MCOs, each state has the flexibility to define and enforce those standards. LDH requires the MCOs to maintain a network of providers that ensures Medicaid beneficiaries, at a minimum, have equal access to qualified providers as the rest of the insured population. LDH can penalize MCOs for inaccurate provider directories and inadequate provider networks. Having accurate provider directories and adequate networks are important because they inform beneficiaries of how their healthcare needs will be met. Inaccurate provider data can create a barrier to care that prohibits beneficiaries from improving their health and calls into question whether network adequacy requirements are being met.

The Aim of "Better Care," in part, focuses on ensuring care is accessible for Medicaid members.

LDH conducted 70 provider directory audits of the MCOs between May 2018 and February 2023 and found the median accuracy of the directories was 49.4%. LDH penalized the MCOs over $2.7 million for issues identified in these audits. LDH conducts quarterly provider directory audits[32] to determine the accuracy of MCO provider directories. These audits verify the accuracy of provider information, such as addresses, telephone numbers, provider specialty, and whether the provider is currently accepting new patients. LDH can issue MCOs a $50,000 penalty if their provider directories do not achieve the minimum accuracy rate on quarterly provider directory audits. LDH required the MCOs to maintain a provider directory accuracy rate of at least 90.0% between February 2018 and March 2019 in order to avoid being penalized by LDH. However,

[32] The provider directory accuracy rate is calculated by LDH reviewing a sample of 125 providers.

the MCOs never achieved this accuracy rate, so LDH lowered the minimum required accuracy rate starting in April 2019. The minimum accuracy rate was changed to 75.0%, **or** 50.0% if the MCO had a 2.0% increase in accuracy from the previous quarter's audit. According to LDH, the rate was lowered to "…grant leniency to the MCOs while promoting gradual improvement…"; however, gradual improvement has not occurred.

LDH's provider directory audits have routinely found that MCO provider directories are inaccurate, as the median accuracy rate across 70 provider directory audits we reviewed was 49.4%, which is well below requirements. LDH penalized the MCOs $2,771,000 for not meeting the required accuracy rate between 2019 and 2022. LDH also assessed UHC a $225,000 penalty for failure to maintain an adequate network of pediatric surgeons. This is the only instance that we identified where LDH levied a penalty for network inadequacy separate from provider directory related penalties. Exhibit 6 shows provider directory audit results for each of the five MCOs over this time period.

Exhibit 6
LDH Provider Directory Audit Accuracy Rates
May 2018 through February 2023

MCO	Audits	Lowest Directory Accuracy Rate	Highest Directory Accuracy Rate	Median Directory Accuracy Rate	Monetary Penalties
ACLA	14	42.7%	74.4%	55.2%	$551,000
Aetna	14	29.1%	67.2%	39.2%	708,000
Healthy Blue	14	40.8%	61.6%	46.3%	555,000
LHC	14	35.8%	68.0%	56.0%	400,000
UHC	14	30.7%	67.2%	50.2%	557,000
Total	**70**	**29.1%**	**74.4%**	**49.4%**	**$2,771,000**

Source: Prepared by legislative auditor's staff using information from LDH.

While LDH requires MCOs to submit semi-annual network adequacy reports, LDH's review of this information is limited and could be expanded to identify adequacy issues. Further, LDH does not use Medicaid claims data to validate the information submitted by MCOs on network adequacy reports or to identify network adequacy issues. Our analyses found that MCO provider networks are not as robust as network adequacy reports indicate. LDH requires the MCOs to maintain an adequate network of providers that is sufficient to provide adequate access to Medicaid services. As mentioned previously, this is important to ensure Medicaid beneficiaries are able to locate and access care. LDH requires MCOs to submit reports semi-annually that document the adequacy of their provider networks,[33] and LDH reviews these reports for items such as providers being listed multiple times on the report. However, LDH staff

[33] MCOs are required to report behavioral health providers and non-behavioral health providers on separate reports. Behavioral Health Provider Network Detail Reports are submitted quarterly, while MCO network adequacy reports are submitted semi-annually. For the purposes of this report, only the semi-annual network adequacy reports were reviewed and analyzed.

stated that they do not analyze Medicaid data to validate information submitted by MCOs on their network adequacy reports.

We performed various tests of the MCOs' network adequacy reports and utilized Medicaid claims data to better understand Louisiana's Medicaid provider network. We combined each MCO's semi-annual provider network report covering the period July 1, 2022, through December 31, 2022, and identified 32,512 unique individual providers across the five MCOs. However, it appears there are far fewer providers available to actually provide services to Medicaid beneficiaries based on our analyses:

- ***Providers with no claims.*** We found that 10,790 (33.2%) of the 32,512 unique providers had no claims for services provided from July 1, 2022, through December 31, 2022.[34] Of these, 1,193 were reported by MCOs as servicing multiple regions of the state.[35] LDH's contracts with the MCOs require the MCOs to only report providers who are actively providing services to enrollees, which is defined as at least 25 claims within a six-month period for providers enrolled during that entire time. Our analysis is more conservative than the contract definition.

- ***Providers only listed as out-of-state.*** We found that 6,947 (21.4%) of the 32,512 unique providers were only listed as out-of-state providers and had no Louisiana addresses listed in the provider directories. The MCOs include out-of-state providers to satisfy federal law requirements for circumstances where a beneficiary may need to seek medical services in another state when there is a medical emergency, the beneficiary's health is endangered, services are more readily available in another state, or the provider is within a beneficiary's Trade Area[36] designated by LDH. Unless Medicaid beneficiaries need medical care for one of these reasons, these providers are not available to them.

- ***Providers listed as providing services in more than one region.*** We found that 980 (15.4%) of the 6,374 providers listed on the network adequacy reports as a provider in more than one region of the state did not provide services in at least one of their reported regions. This indicates that there may be fewer providers available for Medicaid beneficiaries in certain regions than listed on network adequacy reports, but these providers are not identified in the previous analysis because they did have claims in at least one region.

[34] Of these, 6,440 (59.7%) were in-state providers and 4,350 (40.3%) were out-of-state only providers.
[35] LDH divides the state into nine geographical regions, each of which contains between four and 12 parishes.
[36] Trade Areas are treated with the same criteria as an in-state provider. These counties directly touch Louisiana parish borders.

- ***Providers listed with multiple provider types.*** Although instructions state that MCOs are to only report each provider's primary provider type, we found that 6,711 (20.6%) of the 32,512 unique providers were listed with multiple provider types, such as a provider being both an adult primary care provider and a pediatric primary care provider. This results in the appearance that there are more providers available than are actually accessible.

- ***Providers counted more than one time per region and provider type.*** We found that two MCOs reported providers multiple times in a region when calculating the ratio to validate the network adequacy for each provider type. Overreporting the number of providers makes it appear that the MCO's network is bigger than it actually is. One MCO over-reported two providers, whereas the other MCO over-reported 3,621 providers.

According to LDH, it is aware of most of these issues. In March 2024, after meeting with LLA auditors regarding these issues, LDH began a six-month initiative that requires MCOs to perform activities to ensure the accuracy of their entire provider directories. For example, to determine whether providers are still providing Medicaid services, LDH is requiring the MCOs to identify providers who have provided less than 25 services over a six-month period, which, according to LDH's contracts with the MCOs, means the provider is not an active provider. In addition, LDH is requiring the MCOs to confirm information such as provider types and addresses. While this initiative should assist in creating more accurate provider networks and directories, LDH should also conduct this type of analysis on a routine basis to ensure it fulfills its role as the contract monitor over the MCOs. Because LDH does not routinely look for these types of issues, it has only issued one monetary penalty related to an inadequate network of providers based on a complaint by a provider,[37] despite the persistent issues found during provider directory audits and issues with the network adequacy reports described above. Without routinely looking for these types of issues, LDH is not able to fulfill its Aims of "Better Health" and "Better Care."

Recommendation 8: LDH should perform routine analyses of network adequacy reports to proactively review the accuracy of the reports.

Recommendation 9: LDH should analyze Medicaid data to help validate network adequacy reports submitted by MCOs, which could include identifying providers with no claims, providers with multiple provider types, etc.

Recommendation 10: Using the results from any network adequacy analyses, LDH should determine if any additional penalties are warranted.

[37] LDH penalized UHC in the amount of $225,000 for having an inadequate network of pediatric surgeons.

Summary of Management's Response: LDH agreed with these recommendations and stated that it is actively engaged in a network adequacy project that will span six months through September 2024 of provider directories and reporting that are effective for Medicaid beneficiaries. Appendix A contains LDH's full response.

APPENDIX A: MANAGEMENT'S RESPONSE

Jeff Landry
GOVERNOR

Ralph L. Abraham, M.D.
SECRETARY

State of Louisiana
Louisiana Department of Health
Bureau of Health Services Financing

VIA E-MAIL ONLY

May 16, 2024

Mr. Michael J. "Mike" Waguespack, CPA
Legislative Auditor
P. O. Box 94397
Baton Rouge, Louisiana 70804-9397

Re: Oversight of Medicaid Quality Care

Dear Mr. Waguespack:

The Louisiana Department of Health (LDH) acknowledges receipt of correspondence from the Louisiana Legislative Auditor (LLA) dated May 2, 2024 regarding a performance audit report titled Oversight of Medicaid Quality Care. LDH appreciates the opportunity to provide this response to your office's observations and conclusions.

Conclusion 1: While LDH withholds one percent of PMPMs to incentivize MCOs to increase quality of care, LDH's design of the quality withhold program allows MCOs to receive payment of these funds without improving quality of care. LDH could make improvements to strengthen its quality withhold incentive program.

Recommendation 1: LDH should evaluate the design of the quality withhold incentive program and implement strategies to further strengthen the program, which could include imposing penalties for declining performance on withhold measures, preventing or reducing payment to MCOs for report-only measures, preventing MCOs from receiving a payout without demonstrating improvement on quality measures from the previous year, and increasing the PMPM withhold rate.

LDH Response:

LDH is evaluating the design of the quality program withhold incentive and will implement strategies to further strengthen the program to be outcome driven.

Conclusion 2: LDH does not use Medicaid data as part of its Quality Strategy to identify beneficiaries who have not received any services or who have not received recommended services based on demographics, such as age and gender. We found that LDH paid the MCOs $720.5 million to manage the care of 49,894 beneficiaries who appear to have been continuously enrolled in Medicaid between 13 and 60 months between January 2018 through December 2022 but received no services.

Recommendation 2: LDH should conduct analyses of Medicaid data to identify beneficiaries who receive no services over certain periods of time to ensure they are still eligible for Medicaid.

Recommendation 3: LDH should conduct analyses of Medicaid data to identify beneficiaries who receive no services over certain periods of time to ensure MCOs conduct appropriate outreach activities.

Recommendation 4: LDH should conduct analyses of Medicaid data to identify groups of beneficiaries who should receive certain services, such as mammograms, but routinely do not, to ensure MCOs conduct appropriate outreach activities.

LDH Response:

A fundamental aspect of managed care is that you pay for both high utilizers of services and non-utilizers of services. The managed care plans receive a set PMPM no matter if that individual utilizes many services or no services for that month.

LDH Medicaid is contracted with Milliman to provide the federally required Medicaid Managed Care actuarial services. Part of Milliman's responsibility is to establish an actuarial sound rate which has to be approved by CMS. As part of the actuarial review, Milliman accounts for members who have not received services. As part of the development of the rates, Milliman must also look at the high utilizers of services. If Milliman did not factor in the non-utilizers of Medicaid services into the rate development, the PMPMs for the MCOs would actually be higher.

LDH agrees that it should complete an analysis of Medicaid data to identify groups of beneficiaries who should receive certain services, but routinely do not to ensure the MCOs conduct appropriate outreach activities.

Conclusion 3: LDH does not have a consolidated database beneficiary complaints that would allow for comprehensive tracking and trend analysis. Using available complaint data, we found that the majority of beneficiary complaints were related to a lack of quality care or a lack of access to care.

Recommendation 5: LDH should create a database that captures complaints received and resolved by CSR staff.

Recommendation 6*: LDH should ensure it captures similar types of information across MCO complaint reports, complaints submitted to CSRs, complaints submitted to LDH management, and any other sources from which LDH receives complaints to allow it to create a comprehensive database of all complaints.*

Recommendation 7: *Once LDH has ensured it captures similar types of information across the various ways it receives complaints, it should compile this information into a master database that contains all complaints and perform analyses to identify the areas with the highest level of concern for beneficiaries.*

LDH Response:

Current funding limits Medicaid from developing a comprehensive database. What we can do is track and implement plans to address access issues and quality of care.

Conclusion 4: MCO provider directories and networks are inaccurate and contain providers who do not provide Medicaid services. LDH provider directory audits found an accuracy rate of 49.4% between May 2018 and February 2023, and we found that 33.2% of providers listed on network adequacy reports did not provide Medicaid services between July 2022 and December 2022.

Recommendation 8: LDH should perform routine analyses of network adequacy reports to proactively review the accuracy of the reports.

Recommendation 9: LDH should analyze Medicaid data to help validate network adequacy reports submitted by MCOs, which could include identifying providers with no claims, providers with multiple provider types, etc.

Recommendation 10: Using the results from any network adequacy analyses, LDH should determine if any additional penalties are warranted.

LDH Response:

LDH agrees with this conclusion and is actively engaged in a Network Adequacy project that will span 6 months through September 2024 to provider directories and reporting that are effective for Medicaid recipients.

You may contact Kimberly Sullivan, Medicaid Director at (225) 219-7810 or via e-mail at Kimberly.Sullivan@la.gov or Kolynda Parker, Medicaid Deputy Director of Program Operations & Compliance at (225) 342-7439 or via email Kolynda.Parker@LA.GOVwith any questions about this matter.

Sincerely,

DocuSigned by:
Ralph Abraham
CF38B383F66F4AE...

Ralph L. Abraham, M.D.
Secretary

RA/ks

Agency: Louisiana Department of Health

Audit Title: Oversight of Medicaid Quality Care

Audit Report Number: 40230020

Instructions to Audited Agency: Please fill in the information below for each recommendation. A summary of your response for each recommendation will be included in the body of the report. The entire text of your response will be included as an appendix to the audit report.

Conclusion 1: While LDH withholds one percent of PMPMs to incentivize MCOs to increase quality of care, LDH's design of the quality withhold incentive program allows MCOs to receive these funds without improving performance. LDH could make improvements to strengthen its quality withhold incentive program.
Recommendation 1: LDH should evaluate the design of the quality withhold incentive program and implement strategies to further strengthen the program, which could include imposing penalties for declining performance on withhold measures, preventing or reducing payment to MCOs for report-only measures, preventing MCOs from receiving payment without demonstrating improvement on quality measures from the previous year, and increasing the PMPM withhold rate.
Does Agency Agree with Recommendation? [X] Agree [ ] Disagree
Agency Contact Responsible for Recommendation: Kolynda Parker
Name/Title: Medicaid Deputy Director of Program Operations & Compliance
Address: Bienville Building
City, State, Zip: Baton Rouge
Phone Number: 225 342 7439
Email: Kolynda.Parker@LA.GOV

Conclusion 2: LDH does not use Medicaid data as part of its Quality Strategy to identify beneficiaries who have not received any services or who have not received recommended services based on demographics, such as age and gender. We found that LDH paid the MCOs $720.5 million to manage the care of 49,894 beneficiaries who appear to have been continuously enrolled in Medicaid for 13 to 60 months between January 2018 and December 2022 but received no services.
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Conclusion 3: LDH does not have a consolidated database of beneficiary complaints that would allow for comprehensive tracking and trend analysis. Using available complaint data, we found that the majority of beneficiary complaints were related to a lack of quality care or a lack of access to care.
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Does Agency Agree with Recommendation? [ ] Agree [X] Disagree
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Recommendation 6: LDH should ensure it captures similar types of information across MCO complaint reports, complaints submitted to CSRs, complaints submitted to LDH management, and any other sources from which LDH receives complaints to allow it to create a comprehensive database of all complaints.
Does Agency Agree with Recommendation? [ ] Agree [X] Disagree
Agency Contact Responsible for Recommendation: Kolynda Parker
Name/Title: Medicaid Deputy Director of Program Operations & Compliance
Address: Bienville Building
City, State, Zip: Baton Rouge
Phone Number: 225 342 7439
Email: Kolynda.Parker@LA.GOV
Recommendation 7: Once LDH has ensured it captures similar types of information across the various ways it receives complaints, it should compile this information into a master database that contains all complaints and perform analyses to identify the areas with the highest level of concern for beneficiaries.
Does Agency Agree with Recommendation? [ ] Agree [X] Disagree
Agency Contact Responsible for Recommendation: Kolynda Parker
Name/Title: Medicaid Deputy Director of Program Operations & Compliance
Address: Bienville Building
City, State, Zip: Baton Rouge
Phone Number: 225 342 7439
Email: Kolynda.Parker@LA.GOV

Conclusion 4: MCO provider directories and networks are inaccurate and contain providers who do not provide Medicaid services. LDH provider directory audits found an accuracy rate of 49.4% between May 2018 and February 2023, and we found that 33.2% of providers listed on network adequacy reports did not provide Medicaid services between July 2022 and December 2022.
Recommendation 8: LDH should perform routine analyses of network adequacy reports to proactively review the accuracy of the reports.
Does Agency Agree with Recommendation? [X] Agree [ ] Disagree
Agency Contact Responsible for Recommendation: Kolynda Parker
Name/Title: Medicaid Deputy Director of Program Operations & Compliance
Address: Bienville Building
City, State, Zip: Baton Rouge
Phone Number: 225 342 7439
Email: Kolynda.Parker@LA.GOV
Recommendation 9: LDH should analyze Medicaid data to help validate network adequacy reports submitted by MCOs, which could include identifying providers with no claims, providers with multiple provider types, etc.
Does Agency Agree with Recommendation? [X] Agree [ ] Disagree
Agency Contact Responsible for Recommendation: Kolynda Parker
Name/Title: Medicaid Deputy Director of Program Operations & Compliance
Address: Bienville Building
City, State, Zip: Baton Rouge
Phone Number: 225 342 7439
Email: Kolynda.Parker@LA.GOV
Recommendation 10: Using the results from any network adequacy analyses, LDH should determine if any additional penalties are warranted.
Does Agency Agree with Recommendation? [X] Agree [ ] Disagree
Agency Contact Responsible for Recommendation: Kolynda Parker
Name/Title: Medicaid Deputy Director of Program Operations & Compliance
Address: Bienville Building
City, State, Zip: Baton Rouge
Phone Number: 225 342 7439
Email: Kolynda.Parker@LA.GOV

APPENDIX B: SCOPE AND METHODOLOGY

This report provides the results of our performance audit of the Louisiana Department of Health (LDH). We conducted this performance audit under the provisions of Title 24 of the Louisiana Revised Statutes of 1950, as amended. This audit covered the period of January 1, 2018, through December 31, 2022. In some instances, our analyses included information before and after this scope. Our audit objective was:

To evaluate LDH's oversight of the MCOs' management of Medicaid beneficiary's care.

We conducted this performance audit in accordance with generally-accepted *Government Auditing Standards* issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

We obtained an understanding of internal control that is significant to the audit objective and assessed the design and implementation of such internal control to the extent necessary to address our audit objective. We also obtained an understanding of legal provisions that are significant within the context of the audit objective, and we assessed the risk that illegal acts, including fraud, and violations of applicable contract, grant agreement, or other legal provisions could occur. Based on that risk assessment, we designed and performed procedures to provide reasonable assurance of detecting instances of noncompliance significant to those provisions.

To conduct this analysis, we performed the following steps:

- Researched relevant federal and state laws, rules, and regulations.
- Researched relevant LDH policies, procedures, informational bulletins, Quality Strategy documents, and Managed Care Organization (MCO) contracts.
- Researched relevant Centers for Medicaid and Medicare Services (CMS) and Centers for Disease Control and Prevention policies, procedures, data, and other documentation.
- Met with LDH staff to gain an understanding of the processes it uses to monitor MCOs and ensure quality services are provided to Medicaid beneficiaries.

- Met with MCO staff to gain an understanding of the processes they use to ensure beneficiaries have access to and receive quality Medicaid services, as well as the outreach they conduct when people are not receiving services.

- Obtained and analyzed documents from LDH detailing amounts withheld and paid to MCOs for its quality withhold incentive program.

- Researched other state's quality withhold incentive programs through contracts and other documents available online. States researched include Arizona, Delaware, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Massachusetts, Michigan, Mississippi, Missouri, New Hampshire, Ohio, South Carolina, Tennessee, Virginia, and Washington.

- Researched the American Cancer Society's guidelines regarding the frequency that certain individuals should receive breast cancer screenings and colorectal cancer screenings.

- Obtained Medicaid data from LDH, including claims and encounters and beneficiary eligibility information.

- Used SQL, ACL, and Excel to analyze Medicaid data to identify beneficiaries who received no services for certain periods of time and those who qualify for certain preventive cancer screenings but didn't receive them.

- Obtained procedure and diagnosis codes related to breast cancer screenings and colorectal cancer screenings from various sources such as CMS, the MCOs, and the AAPC, formerly known as the American Academy of Professional Coders.

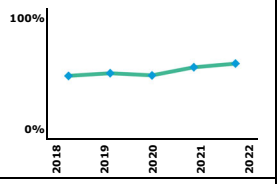
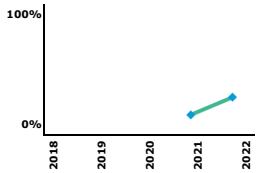
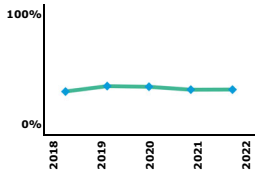
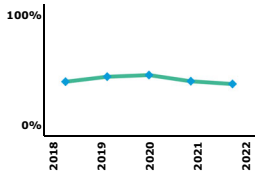
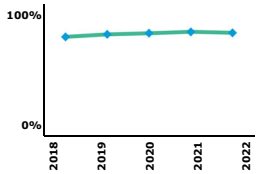
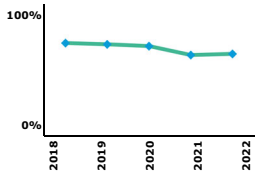
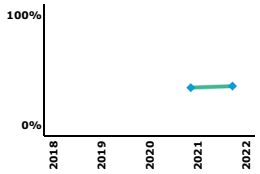
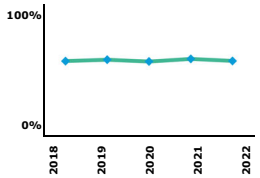
- Pulled a targeted selection of 21 beneficiary case files with the highest PMPM amounts paid to identify any communication between LDH and beneficiaries with no services.

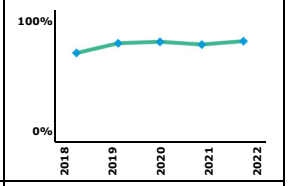
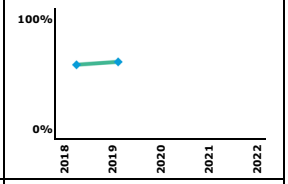
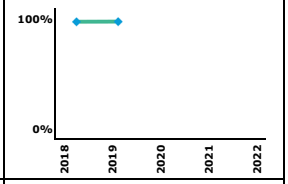
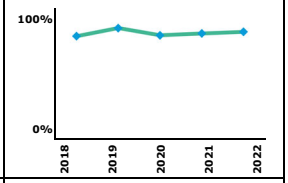
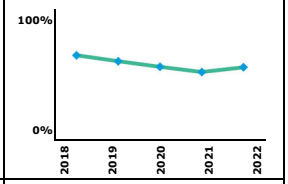
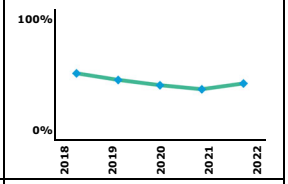
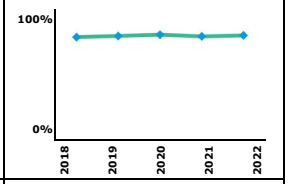
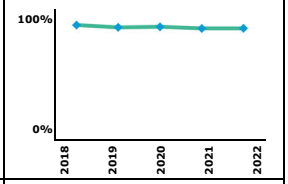
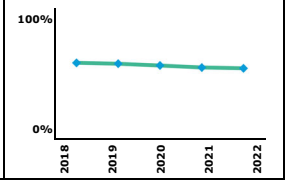
- Obtained complaint data from LDH for analysis. This included complaints received by MCOs and submitted to LDH and those handled by LDH management. Because complaints received by customer service representative staff are maintained in free text case notes, we were unable to include them in our analysis.

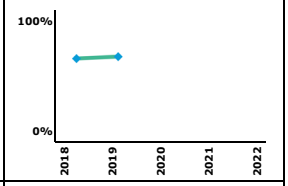
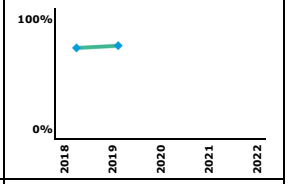
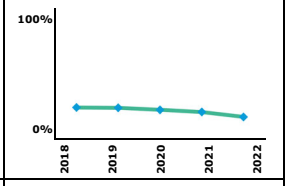
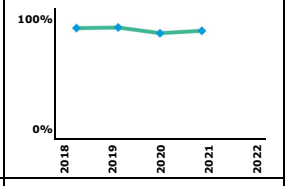
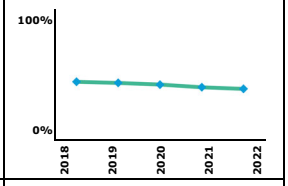
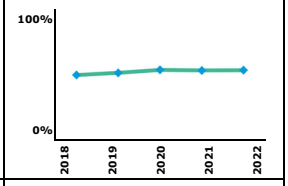
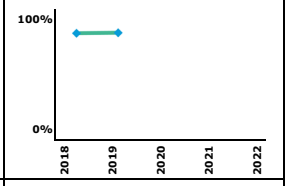
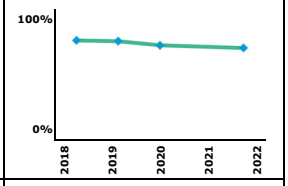
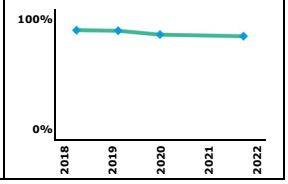
- Obtained LDH's compliance tracking log and provider directory audits to analyze MCO performance and LDH monetary penalties assessed as a result of these audits.

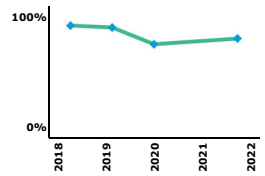
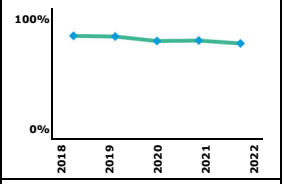
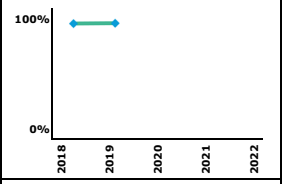
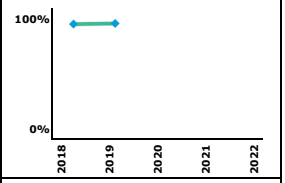
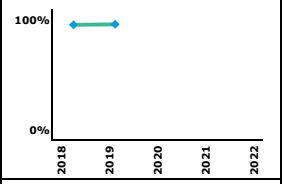
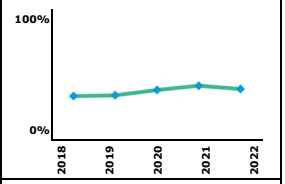
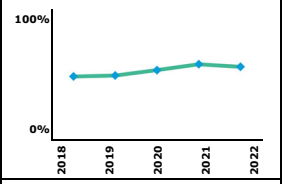
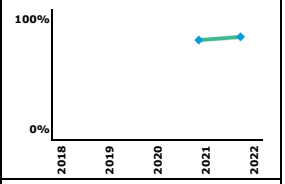
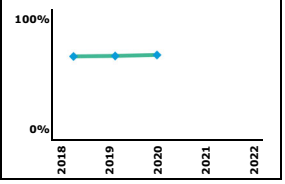
- Obtained MCO network adequacy reports for July 2022 through December 2022 and analyzed them for potential issues related to the adequacy of MCO networks.
- Analyzed Medicaid data to identify providers listed on MCO network adequacy reports to identify providers who provide no Medicaid services across the entire state and by region.
- Provided our results to LDH to review and incorporated edits throughout the report.

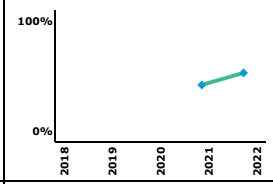
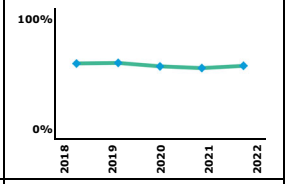
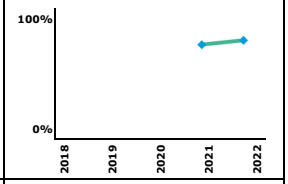
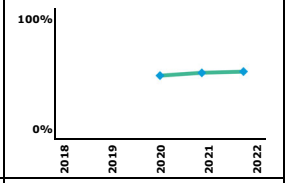
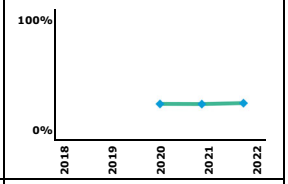
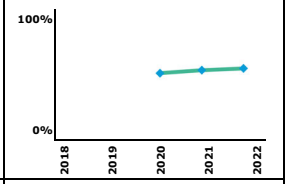
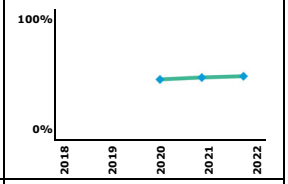
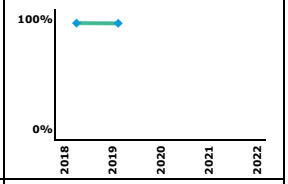
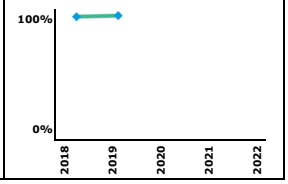
APPENDIX C: STATE MEDICAID RESULTS - TRACKED AND INCENTIVIZED QUALITY MEASURES CALENDAR YEARS 2018 THROUGH 2022

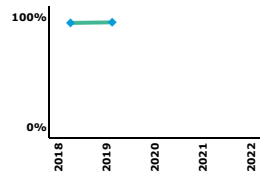
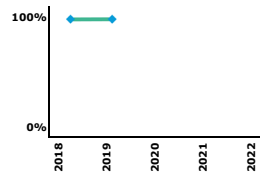
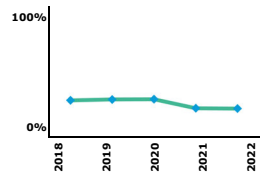
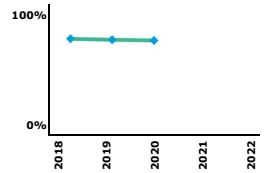
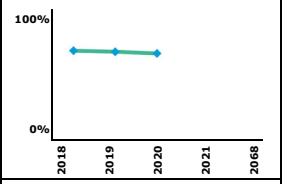
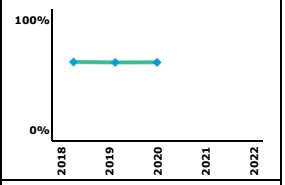
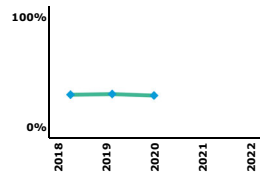
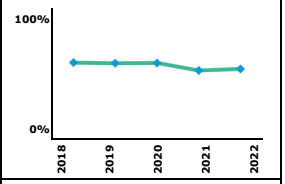
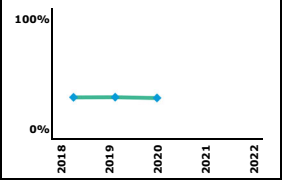
Measure	Number of Years Tracked	Number of Years Incentivized	Total Payments (2018-2022)	2018	2019	2020	2021	2022	Percentage Point Change	Trend
Measures in Percentage Form - Higher Numbers Indicate Better Performance										
Controlling High Blood Pressure	5	4	$ 20,348,822	47.88%	49.98%	48.24%	54.73%	57.62%	9.74%	
Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - Within 30 Days of Discharge	2	2	$ 15,104,818	-	-	-	13.74%	27.70%	13.96%	
Colorectal Cancer Screening	5	2	$ 14,418,250	32.23%	36.54%	36.06%	33.70%	33.81%	1.58%	
Immunization Status for Adolescents - Combination 2	5	2	$ 13,746,224	40.49%	44.44%	45.78%	40.86%	38.69%	-1.80%	
HIV Viral Load Suppression	5	2	$ 10,750,110	75.88%	77.85%	78.75%	79.80%	79.04%	3.16%	
Childhood Immunization Status - Combination 3	5	2	$ 10,716,624	70.99%	69.99%	68.61%	61.53%	62.44%	-8.55%	
Follow-up After Emergency Department Visit for Mental Illness - Within 30 Days of Discharge	2	2	$ 10,420,169	-	-	-	35.35%	36.52%	1.17%	
Cervical Cancer Screening	5	2	$ 9,139,623	56.41%	57.49%	56.11%	58.17%	56.53%	0.12%	

Measure	Number of Years Tracked	Number of Years Incentivized	Total Payments (2018-2022)	2018	2019	2020	2021	2022	Percentage Point Change	Trend
Prenatal and Postpartum Care - Postpartum Care	5	2	$ 7,603,716	67.63%	75.38%	76.50%	74.31%	77.00%	9.37%	
Adolescent Well Care Visits	2	2	$ 7,324,284	56.68%	58.97%	-	-	-	2.29%	
Comprehensive Diabetes Care - Medical Attention for Nephropathy	2	2	$ 6,585,804	90.85%	90.98%	-	-	-	0.13%	
Prenatal and Postpartum Care - Prenatal Care	5	2	$ 6,585,804	79.40%	85.85%	80.06%	81.56%	82.86%	3.46%	
Follow-up Care for Children Prescribed ADHD Medication - Continuation Phase	5	2	$ 6,082,139	65.01%	60.24%	55.84%	51.70%	55.44%	-9.57%	
Follow-up Care for Children Prescribed ADHD Medication - Initiation Phase	5	2	$ 6,082,139	50.65%	45.42%	41.24%	38.00%	42.65%	-8.00%	
CAHPS, Adult (Rating of Health Plan, 8+9+10)	5	2	$ 5,996,504	79.46%	80.34%	81.36%	80.04%	80.81%	1.35%	
CAHPS, Child (Rating of Health Plan-General Population, 8+9+10)	5	2	$ 5,996,504	89.01%	87.19%	87.65%	86.37%	86.41%	-2.60%	
Comprehensive Diabetes Care - Eye exams (Renamed Eye Exam for Patients with Diabetes in 2022)	5	2	$ 5,995,812	58.20%	57.52%	56.13%	54.48%	53.85%	-4.35%	

Measure	Number of Years Tracked	Number of Years Incentivized	Total Payments (2018-2022)	2018	2019	2020	2021	2022	Percentage Point Change	Trend
Well-Child Visits in the First 15 Months of Life 6+ visits	2	2	$ 5,562,743	63.22%	64.72%	-	-	-	1.50%	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Live	2	2	$ 4,544,831	70.05%	71.86%	-	-	-	1.81%	
Initiation of Injectable Progesterone for Preterm Birth Prevention	5	2	$ 3,955,532	22.76%	22.50%	20.89%	19.16%	15.28%	-7.48%	
Comprehensive Diabetes Care - HbA1c Testing	4	2	$ 3,507,613	85.78%	86.28%	81.74%	83.64%	-	-2.14%	
Follow-up After Hospitalization for Mental Illness - Within 30 Days of Discharge	5	4	$ 1,017,912	43.97%	43.04%	41.74%	39.60%	38.33%	-5.64%	
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	5	0	$ -	49.36%	51.03%	53.40%	52.96%	53.17%	3.81%	
Adult BMI Assessment	2	0	$ -	82.51%	82.90%	-	-	-	0.39%	
Adults Access to Preventative/Ambulatory Health Services - 20-44 years	4	0	$ -	76.81%	76.19%	72.93%	-	70.84%	-5.97%	
Adults Access to Preventative/Ambulatory Health Services - 45-65 years	4	0	$ -	84.95%	84.49%	81.45%	-	80.13%	-4.82%	

Measure	Number of Years Tracked	Number of Years Incentivized	Total Payments (2018-2022)	2018	2019	2020	2021	2022	Percentage Point Change	Trend
Adults Access to Preventative/Ambulatory Health Services - 65 years and older	4	0	$ -	86.24%	84.71%	71.37%	-	75.93%	-10.31%	
Adults Access to Preventative/Ambulatory Health Services - Total	5	0	$ -	79.61%	79.10%	75.53%	75.91%	73.65%	-5.96%	
Annual Monitoring for Patients on Persistent Medications - ACE Inhibitors / ARBs	2	0	$ -	89.44%	89.70%	-	-	-	0.26%	
Annual Monitoring for Patients on Persistent Medications - Diuretic	2	0	$ -	88.96%	89.47%	-	-	-	0.51%	
Annual Monitoring for Patients on Persistent Medications - Total	2	0	$ -	89.23%	89.60%	-	-	-	0.37%	
Antidepressant Medication Management - Effective Continuation Phase Treatement (6 months, 180 Days)	5	0	$ -	32.56%	33.25%	37.45%	40.82%	38.18%	5.62%	
Antidepressant Medication Management -Effective Acute Phase (12 weeks, 84 Days)	5	0	$ -	48.17%	48.98%	53.24%	57.91%	55.83%	7.66%	
Appropriate Treatment for Children with Upper Respiratory Infection	2	0	$ -	-	-	-	77.09%	79.64%	2.55%	
Asthma Medication Ratio - Total	3	0	$ -	64.08%	64.50%	65.24%	-	-	1.16%	

Measure	Number of Years Tracked	Number of Years Incentivized	Total Payments (2018-2022)	2018	2019	2020	2021	2022	Percentage Point Change	Trend
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	2	0	$ -	-	-	-	42.21%	51.85%	9.64%	
Breast Cancer Screening	5	0	$ -	57.70%	58.13%	55.43%	54.04%	55.83%	-1.87%	
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	2	0	$ -	-	-	-	72.67%	76.14%	3.47%	
Child and Adolescent Well-Care Visits - 12-17 years	3	0	$ -	-	-	48.08%	50.29%	51.26%	3.19%	
Child and Adolescent Well-Care Visits - 18-21 years	3	0	$ -	-	-	26.36%	26.26%	27.04%	0.68%	
Child and Adolescent Well-Care Visits - 3-11 years	3	0	$ -	-	-	50.80%	53.19%	54.57%	3.77%	
Child and Adolescent Well-Care Visits - Total	3	0	$ -	-	-	45.81%	47.32%	48.34%	2.53%	
Child and Adolescents' Access to Primary Care Practitioners - 12-19 Years	2	0	$ -	90.60%	90.38%	-	-	-	-0.22%	
Child and Adolescents' Access to Primary Care Practitioners - 12-24 Months	2	0	$ -	95.68%	96.51%	-	-	-	0.83%	

Measure	Number of Years Tracked	Number of Years Incentivized	Total Payments (2018-2022)	2018	2019	2020	2021	2022	Percentage Point Change	Trend
Child and Adolescents' Access to Primary Care Practitioners - 25 Months - 6 Years	2	0	$ -	88.36%	88.84%	-	-	-	0.48%	
Child and Adolescents' Access to Primary Care Practitioners - 7-11 Years	2	0	$ -	91.25%	91.27%	-	-	-	0.02%	
Childhood Immunization Status - Combination 10	5	0	$ -	26.84%	27.51%	27.69%	20.59%	20.30%	-6.54%	
Childhood Immunization Status - Combination 2	3	0	$ -	74.12%	73.38%	72.77%	-	-	-1.35%	
Childhood Immunization Status - Combination 4	3	0	$ -	68.61%	67.82%	66.45%	-	-	-2.16%	
Childhood Immunization Status - Combination 5	3	0	$ -	60.03%	59.67%	59.76%	-	-	-0.27%	
Childhood Immunization Status - Combination 6	3	0	$ -	31.33%	31.82%	30.68%	-	-	-0.65%	
Childhood Immunization Status - Combination 7	5	0	$ -	58.43%	57.89%	58.08%	52.12%	53.35%	-5.08%	
Childhood Immunization Status - Combination 8	3	0	$ -	30.76%	30.91%	30.26%	-	-	-0.50%	

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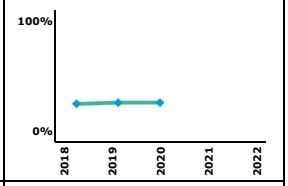
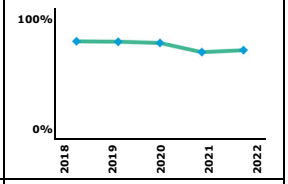
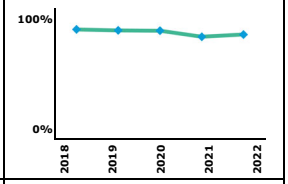
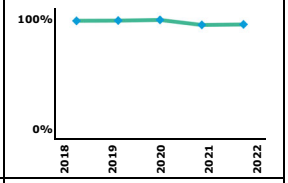
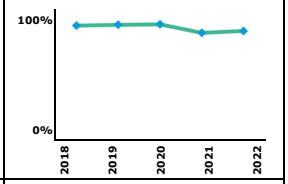
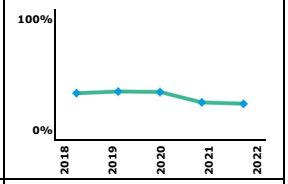
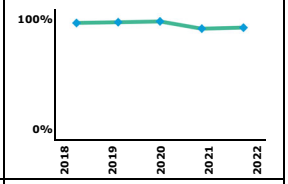
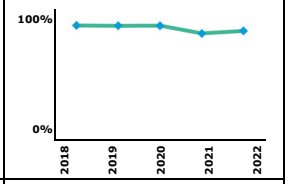
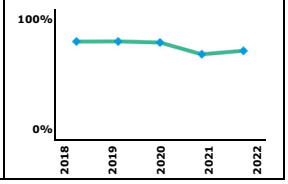
Childhood Immunization Status - Combination 9	3	0	$ -	27.19%	28.17%	28.17%	-	-	0.98%	
Childhood Immunization Status - Dtap	5	0	$ -	75.28%	74.99%	74.04%	66.71%	68.23%	-7.05%	
Childhood Immunization Status - Hepatitis A	5	0	$ -	84.73%	84.01%	83.76%	78.94%	80.70%	-4.03%	
Childhood Immunization Status - Hepatitis B	5	0	$ -	91.58%	91.81%	92.28%	88.31%	88.75%	-2.83%	
Childhood Immunization Status - HiB	5	0	$ -	88.56%	89.23%	89.61%	82.83%	84.33%	-4.23%	
Childhood Immunization Status - Influenza	5	0	$ -	34.86%	36.23%	35.81%	27.56%	26.49%	-8.37%	
Childhood Immunization Status - IPV	5	0	$ -	90.72%	91.25%	91.92%	86.13%	87.00%	-3.72%	
Childhood Immunization Status - MMR	5	0	$ -	88.74%	88.49%	88.55%	82.36%	84.34%	-4.40%	
Childhood Immunization Status - Pneumococcal conjugate	5	0	$ -	75.92%	75.97%	75.15%	65.85%	68.57%	-7.35%	

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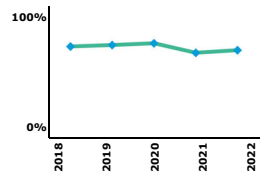
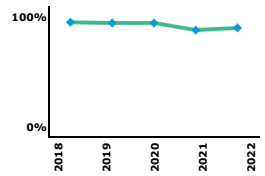
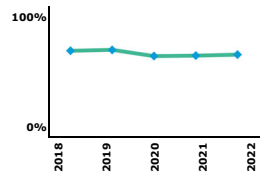
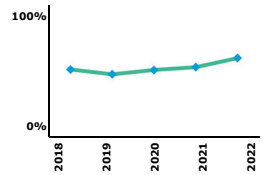
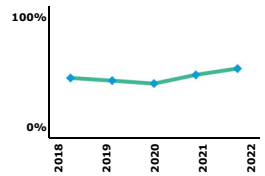
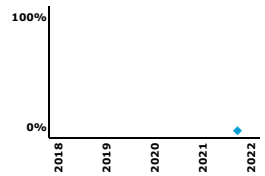
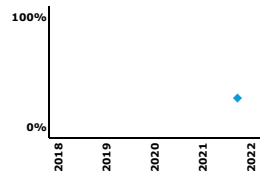
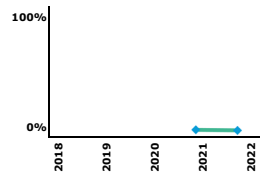
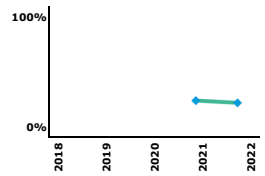
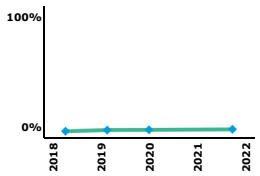
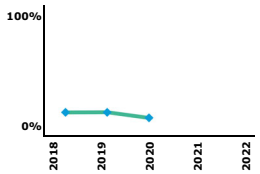
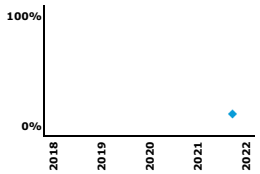
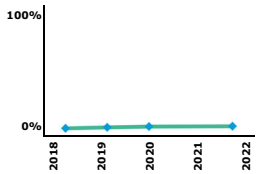
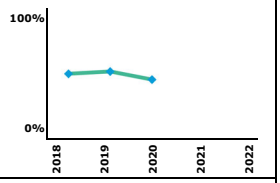
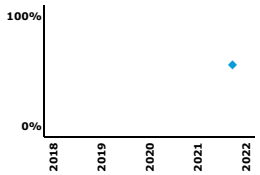
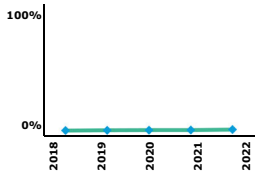
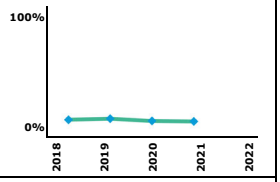
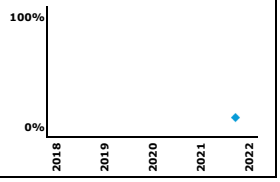
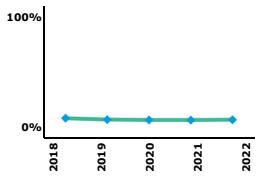
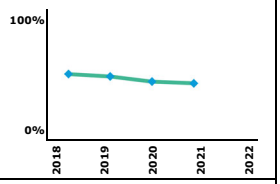
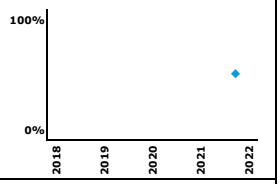
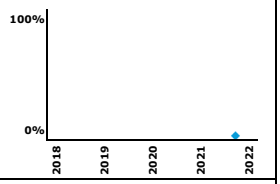
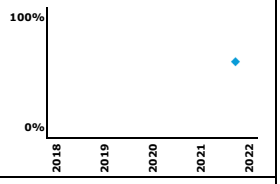
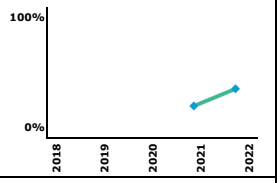
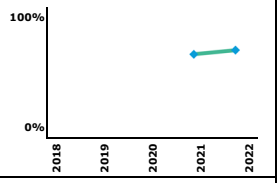
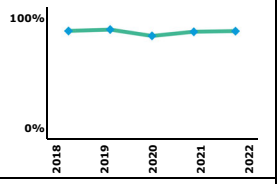
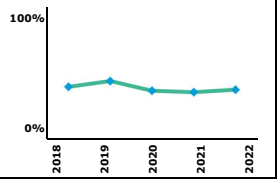
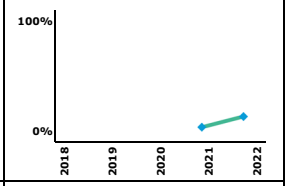
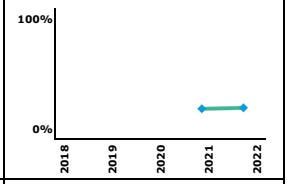
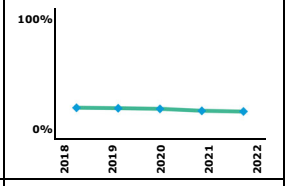
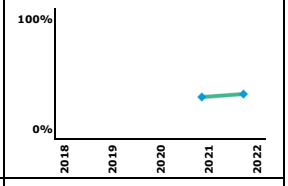
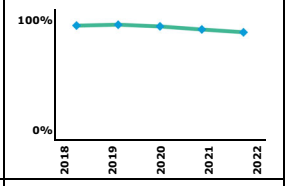
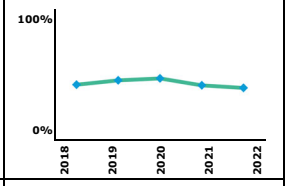
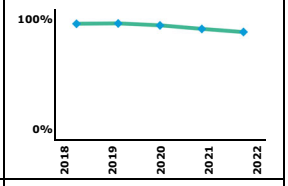
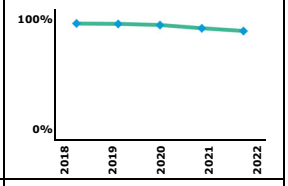
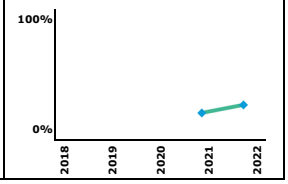
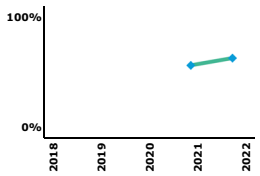
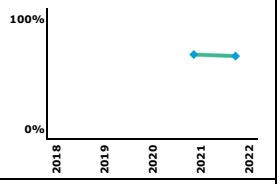
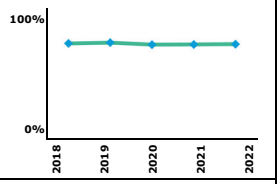
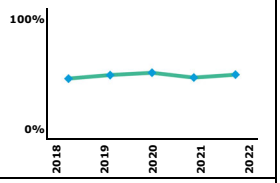
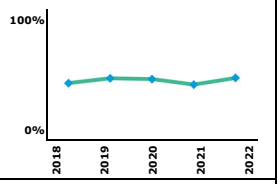
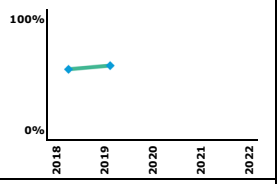
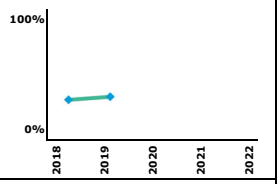
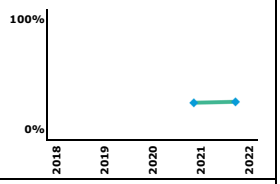
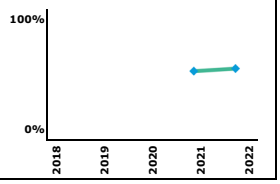
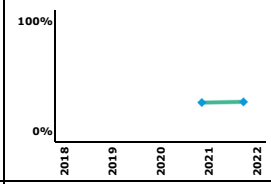
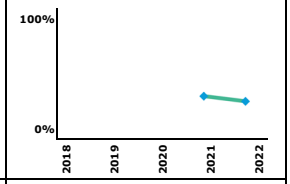
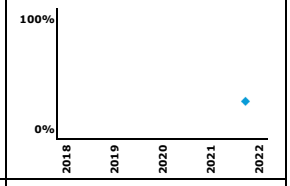
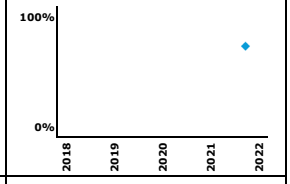
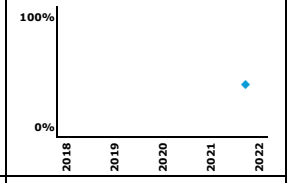
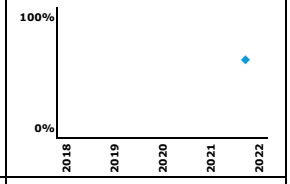
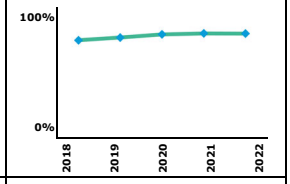
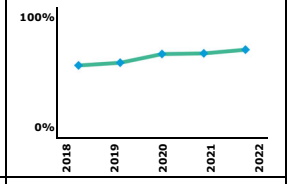
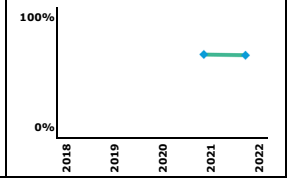
Childhood Immunization Status - Rotavirus	5	0	$ -	69.59%	70.76%	72.13%	64.61%	66.63%	-2.96%	
Childhood Immunization Status - VZV	5	0	$ -	88.84%	88.27%	88.27%	82.67%	84.35%	-4.49%	
Chlamydia Screening in Women - Total	5	0	$ -	66.19%	66.88%	61.98%	62.40%	63.13%	-3.06%	
Comprehensive Diabetes Care - BP Control (<140/90 mm Hg) (Renamed Blood Pressure Control for Patients with Diabetes in 2022)	5	0	$ -	50.93%	47.18%	50.56%	52.80%	59.93%	9.00%	
Comprehensive Diabetes Care - HbA1c Poor Control (<8.0%) (Renamed HbA1c Control for Patients with Diabetes - HbA1c Poor Control (<8.0%) in 2022)	5	0	$ -	45.04%	42.92%	40.62%	47.49%	52.48%	7.44%	
Contraceptive Care - All Women (ages 15-20), LARC[1]	1	0	$ -	-	-	-	-	2.71%	-	
Contraceptive Care - All Women (ages 15-20), most or moderately effective	1	0	$ -	-	-	-	-	28.67%	-	
Contraceptive Care - All Women (ages 21-44), LARC[1]	2	0	$ -	-	-	-	3.45%	3.00%	-0.45%	
Contraceptive Care - All Women (ages 21-44), most or moderately effective	2	0	$ -	-	-	-	26.61%	24.83%	-1.78%	

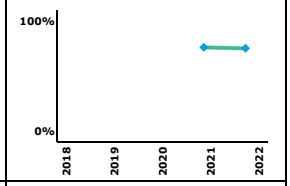
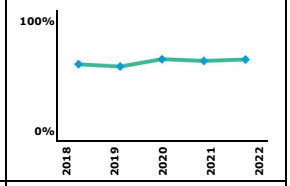
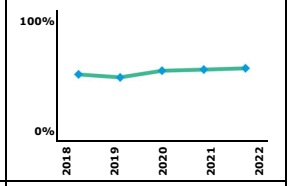
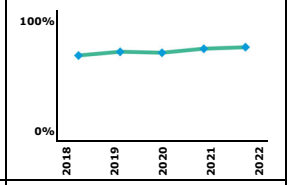
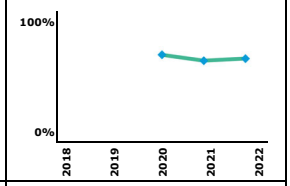
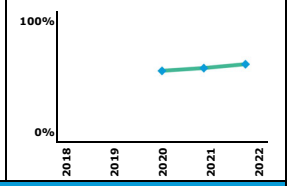
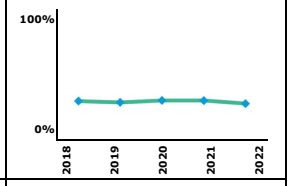
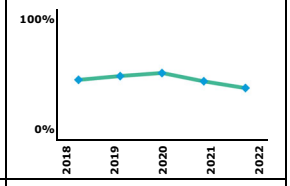
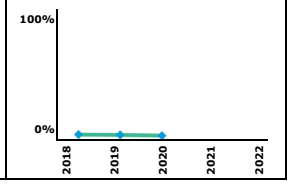
Measure	Number of Years Tracked	Number of Years Incentivized	Total Payments (2018-2022)	2018	2019	2020	2021	2022	Percentage Point Change	Trend
Contraceptive Care - Postpartum (ages 15-20), LARC, 3 days[1]	4	0	$ -	2.28%	3.23%	3.41%	-	3.82%	1.54%	
Contraceptive Care - Postpartum (ages 15-20), LARC, 60 days[1]	3	0	$ -	16.45%	16.54%	12.13%	-	-	-4.32%	
Contraceptive Care - Postpartum (ages 15-20), LARC, 90 days[1]	1	0	$ -	-	-	-	-	15.20%	-	
Contraceptive Care - Postpartum (ages 15-20), most or moderately effective, 3 days	4	0	$ -	3.81%	4.56%	5.21%	-	5.46%	1.65%	
Contraceptive Care - Postpartum (ages 15-20), most or moderately effective, 60 days	3	0	$ -	49.53%	51.32%	44.94%	-	-	-4.59%	
Contraceptive Care - Postpartum (ages 15-20), most or moderately effective, 90 days	1	0	$ -	-	-	-	-	54.56%	-	
Contraceptive Care - Postpartum (ages 21-44), LARC, 3 days[1]	5	0	$ -	2.02%	2.19%	2.36%	2.43%	2.77%	0.75%	
Contraceptive Care - Postpartum (ages 21-44), LARC, 60 days	4	0	$ -	11.42%	12.25%	10.43%	10.09%	-	-1.33%	
Contraceptive Care - Postpartum (ages 21-44), LARC, 90 days[1]	1	0	$ -	-	-	-	-	13.18%	-	

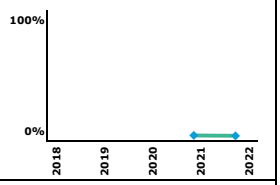
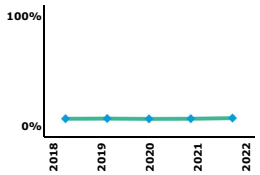
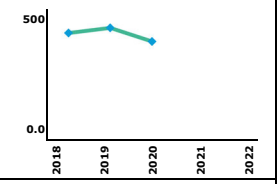
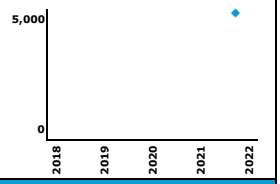
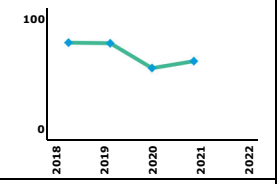
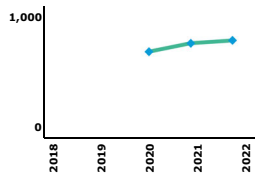
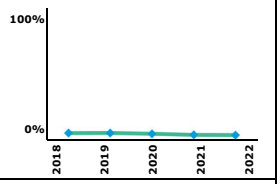
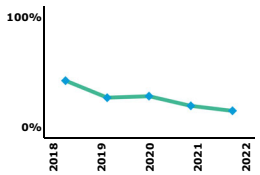
Measure	Number of Years Tracked	Number of Years Incentivized	Total Payments (2018-2022)	2018	2019	2020	2021	2022	Percentage Point Change	Trend
Contraceptive Care - Postpartum (ages 21-44), most or moderately effective, 3 days	5	0	$ -	12.61%	11.56%	11.19%	11.14%	11.40%	-1.21%	
Contraceptive Care - Postpartum (ages 21-44), most or moderately effective, 60 days	4	0	$ -	50.11%	48.21%	44.11%	42.71%	-	-7.40%	
Contraceptive Care - Postpartum (ages 21-44), most or moderately effective, 90 days	1	0	$ -	-	-	-	-	50.41%	-	
Depression Screening and Follow-Up for Adolescents and Adults - Depression Screening (Total)	1	0	$ -	-	-	-	-	1.00%	-	
Depression Screening and Follow-Up for Adolescents and Adults - Follow-up on Positive Screen (Total)	1	0	$ -	-	-	-	-	58.25%	-	
Developmental Screening in the First Three Years of Life	2	0	$ -	-	-	-	23.10%	36.83%	13.73%	
Diabetes Monitoring for People with Diabetes and Schizophrenia	2	0	$ -	-	-	-	64.25%	67.47%	3.22%	
Diabetes Screening for People with Schizophrenia or Bipolar who are using Antipsychotic Medications	5	0	$ -	82.88%	84.00%	79.00%	82.24%	82.78%	-0.10%	
Flu Vaccinations for Adults Ages 18 to 64	5	0	$ -	38.85%	43.36%	35.78%	34.61%	36.62%	-2.23%	

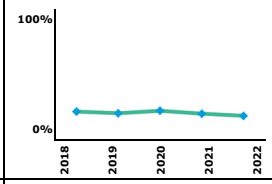
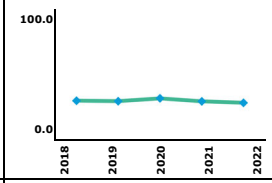
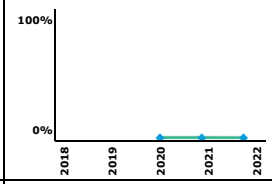
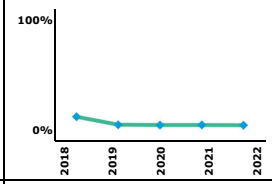
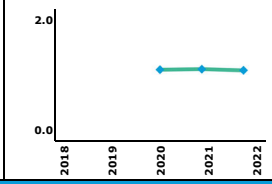
Measure	Number of Years Tracked	Number of Years Incentivized	Total Payments (2018-2022)	2018	2019	2020	2021	2022	Percentage Point Change	Trend
Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - Within 7 Days	2	0	$ -	-	-	-	8.64%	17.19%	8.54%	
Follow-up After Emergency Department Visit for Mental Illness - Within 7 Days of Discharge	2	0	$ -	-	-	-	21.69%	22.45%	0.76%	
Follow-up After Hospitalization for Mental Illness - Within 7 Days of Discharge	5	0	$ -	22.55%	22.15%	21.66%	20.12%	19.52%	-3.03%	
Hepatitis C Virus Screening	2	0	$ -	-	-	-	31.03%	33.41%	2.38%	
Immunization Status for Adolescents - Combination 1	5	0	$ -	88.58%	89.26%	87.96%	85.54%	83.26%	-5.32%	
Immunization Status for Adolescents - HPV	5	0	$ -	41.65%	45.09%	46.67%	41.17%	39.08%	-2.57%	
Immunization Status for Adolescents - Meningococcal	5	0	$ -	90.04%	90.33%	88.78%	85.98%	83.48%	-6.56%	
Immunization Status for Adolescents - Tdap/Td	5	0	$ -	90.23%	89.90%	89.06%	86.47%	84.30%	-5.93%	
Initiation and Engagement of Alcohol and Other Drug Abuse of Dependence Treatment - Engagement of AOD Treatment (Renamed Initiation and Engagement of SUD Treatment - Engagement of SUD Treatment in 2022)	2	0	$ -	-	-	-	19.23%	25.62%	6.39%	

Measure	Number of Years Tracked	Number of Years Incentivized	Total Payments (2018-2022)	2018	2019	2020	2021	2022	Percentage Point Change	Trend
Initiation and Engagement of Alcohol and Other Drug Abuse of Dependence Treatment - Initiation of AOD Treatment (Renamed Initiation and Engagement of SUD Treatment - Initiation of SUD Treatment in 2022)	2	0	$ -	-	-	-	54.64%	60.37%	5.73%	
Lead Screening in Children	2	0	$ -	-	-	-	64.78%	63.59%	-1.19%	
Medical Assistance with Smoking and Tobacco Use Cessation - Advising Smokers and Tobacco Users to Quit	5	0	$ -	73.61%	74.25%	72.68%	72.80%	73.05%	-0.56%	
Medical Assistance with Smoking and Tobacco Use Cessation - Discussing Cessation Medications	5	0	$ -	45.66%	48.52%	50.32%	46.55%	48.84%	3.18%	
Medical Assistance with Smoking and Tobacco Use Cessation - Discussing Cessation Strategies	5	0	$ -	42.85%	46.69%	46.05%	41.71%	47.04%	4.19%	
Medication Management for People with Asthma - Total - Medication Compliance 50%	2	0	$ -	53.85%	56.83%	-	-	-	2.98%	
Medication Management for People with Asthma - Total - Medication Compliance 75%	2	0	$ -	29.61%	32.06%	-	-	-	2.45%	
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing	2	0	$ -	-	-	-	27.30%	28.05%	0.75%	
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing	2	0	$ -	-	-	-	52.41%	54.46%	2.06%	

Measure	Number of Years Tracked	Number of Years Incentivized	Total Payments (2018-2022)	2018	2019	2020	2021	2022	Percentage Point Change	Trend
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing	2	0	$ -	-	-	-	28.23%	28.80%	0.56%	
Pharmacotherapy for Opiod Use Disorder	2	0	$ -	-	-	-	31.72%	27.67%	-4.05%	
Self-Reported Overall Health (Adult)	1	0	$ -	-	-	-	-	27.68%	-	
Self-Reported Overall Health (Child)	1	0	$ -	-	-	-	-	69.87%	-	
Self-Reported Overall Mental or Emotional Health (Adult)	1	0	$ -	-	-	-	-	39.42%	-	
Self-Reported Overall Mental or Emotional Health (Child)	1	0	$ -	-	-	-	-	59.82%	-	
Statin Therapy for Patients with Cardiovascular Disease - Received Statin Therapy: Total	5	0	$ -	75.32%	77.54%	80.00%	80.79%	80.66%	5.34%	
Statin Therapy for Patients with Cardiovascular Disease - Statin Adherence 80%: Total	5	0	$ -	55.34%	57.54%	64.45%	64.96%	67.86%	12.52%	
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	2	0	$ -	-	-	-	64.02%	63.46%	-0.56%	

Measure	Number of Years Tracked	Number of Years Incentivized	Total Payments (2018-2022)	2018	2019	2020	2021	2022	Percentage Point Change	Trend
Use of Imaging Studies for Low Back Pain	2	0	$ -	-	-	-	72.09%	71.31%	-0.78%	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children / Adolescents Body Mass Index Assessment for Children / Adolescents - Counseling for Nutrition	5	0	$ -	58.66%	56.89%	62.72%	61.35%	62.46%	3.80%	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children / Adolescents Body Mass Index Assessment for Children / Adolescents - Counseling for Physical Activity	5	0	$ -	50.62%	48.23%	53.57%	54.48%	55.47%	4.85%	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children / Adolescents Body Mass Index Assessment for Children / Adolescents - BMI Percentile Documentation	5	0	$ -	65.66%	68.57%	67.84%	70.97%	72.22%	6.56%	
Well-Child Visits in the First 30 Months of Life - 15 Months - 30 Months	3	0	$ -	-	-	66.98%	62.32%	63.95%	-3.02%	
Well-Child Visits in the First 30 Months of Life - First 15 Months	3	0	$ -	-	-	54.28%	56.41%	59.52%	5.24%	
Measures in Percentage Form - Lower Numbers Indicate Better Performance										
Low- Risk Cesarean Delivery (Cesarean Rate for Low-Risk First Birth Women)	5	2	$ 15,104,818	28.62%	27.58%	29.15%	29.05%	26.61%	-2.01%	
Comprehensive Diabetes Care - HbA1c Poor Control (>9.0%) (Renamed HbA1c Control for Patients with Diabetes - HbA1c Poor Control (>9.0%) in 2022)	5	2	$ 12,856,675	45.52%	48.47%	50.96%	44.32%	38.96%	-6.56%	
Elective Delivery	3	0	$ -	2.02%	1.73%	1.20%	-	-	-0.82%	

Measure	Number of Years Tracked	Number of Years Incentivized	Total Payments (2018-2022)	2018	2019	2020	2021	2022	Percentage Point Change	Trend
Non-recommended Cervical Screening in Adolescent Females	2	0	$ -	-	-	-	2.17%	1.81%	-0.36%	
Percentage of Low Birth Weight Births	5	0	$ -	12.09%	12.23%	11.98%	12.15%	12.62%	0.53%	
Measure	**Number of Years Tracked**	**Number of Years Incentivized**	**Total Payments (2018-2022)**	**2018**	**2019**	**2020**	**2021**	**2022**	**Rate Change**	**Trend**
Measures in Rate Form - Higher Numbers Indicate Better Performance										
Ambulatory Care Outpatient Visits/1000 Member Months	3	0	$ -	413.54	433.98	379.97	-	-	-33.57	
Ambulatory Care Outpatient Visits/1000 Member Years	1	0	$ -	-	-	-	-	4930.50	-	
Measures in Rate Form - Lower Numbers Indicate Better Performance										
Ambulatory Care Emergency Department Visits/1000 Member Months	4	1	$ 3,356,152	75.02	74.57	54.82	60.36	-	-14.66	
Ambulatory Care Emergency Department Visits/1000 Member Years[2]	1	0	$ -	-	-	657.89	724.31	746.42	88.53	
Asthma in Younger Adults Admission Rate	5	0	$ -	3.17	3.21	2.62	1.79	1.58	-1.59	
COPD and Asthma in Older Adults Admission Rate	5	0	$ -	42.47	28.92	30.14	22.48	18.52	-23.95	

Measure	Number of Years Tracked	Number of Years Incentivized	Total Payments (2018-2022)	2018	2019	2020	2021	2022	Rate Change	Trend
Diabetes Short Term Complications Admission Rate	5	0	$ -	20.30	18.98	20.92	18.55	16.94	-3.36	
Heart Failure Admission Rate	5	0	$ -	28.92	28.53	30.81	28.39	27.26	-1.66	
Plan All-Cause Readmissions - Expected Readmission Rate	3	0	$ -	-	-	9.59%	9.59%	9.57%	-0.02%	
Plan All-Cause Readmissions - Observed Readmission Rate	5	0	$ -	16.87%	10.50%	10.28%	10.35%	10.15%	-6.72%	
Plan All-Cause Readmissions - Observed-to-Expected Ratio	3	0	$ -	-	-	1.07	1.08	1.06	-0.01	

[1] LARC means long-acting reversible contraception.
[2] This measure was converted from a per 1,000 member months basis to a per 1,000 member years basis in 2022. The measures reported in 2021 and 2020 were converted by LDH from months to years, using results from the previous measure. As a result, there are three values reported for this measure, even though the measure was only required by LDH for one year.
Source: Prepared by legislative auditor staff using information from LDH

APPENDIX D: BENEFICIARIES WITH NO SERVICES BY AGE RANGE, COVERAGE TYPE, MCO, AND PARISH

Exhibit D.1 shows the results of our no services analysis by age range.

Exhibit D.1
No Services by Beneficiary Age Range
Calendar Years 2018 through 2022

Age Range	Unique Beneficiaries	PMPMs Paid
0-17	13,664	$89,232,989
18-20	3,089	26,912,884
21-25	5,124	87,682,499
26-35	10,394	195,384,618
36-45	6,801	127,604,235
46-55	4,189	83,130,509
56-65	3,954	91,324,877
Over 65	2,679	19,325,704
Total	**49,894**	**$720,598,315**

Source: Prepared by legislative auditor's staff using Medicaid data from LDH.

Exhibit D.2 shows the results of our no services analysis by coverage type, which denotes the primary reason the Medicaid beneficiary was eligible for Medicaid coverage.

Exhibit D.2
No Services by Coverage Type
Calendar Years 2018 through 2022

Coverage Type	Unique Beneficiaries	PMPMs Paid
Aged	2,705	$22,704,946
Blind	53	2,153,055
Disabled	3,453	117,543,070
Families and Children	15,145	91,855,085
Foster Care	199	4,675,256
Louisiana Health Insurance Premium Payment (LaHIPP) Program	32	109,347
Low-Income Families with Children (LIFC) Group	2,227	29,086,331
Other	68	1,178,678
Medicaid Expansion Adult Group	26,012	451,292,547
Total	**49,894**	**$720,598,315**

Source: Prepared by legislative auditor's staff using Medicaid data from LDH.

Exhibit D.3 shows the results of our no services analysis by MCO. This represents the most recent MCO for which the Medicaid beneficiary had coverage. For example, if a beneficiary was previously enrolled with Aetna but is currently enrolled with Healthy Blue, the beneficiary and all associated PMPMs are counted in the Healthy Blue row.

Exhibit D.3 No Services by MCO Calendar Years 2018 through 2022		
MCO	**Unique Beneficiaries**	**PMPMs Paid**
ACLA	7,944	$119,620,410
Aetna	7,586	102,601,778
Healthy Blue	10,420	148,609,133
LHC	12,457	175,714,575
United	12,751	174,052,419
Unique Total	**49,894***	**$720,598,315**

* There were 1,230 beneficiaries enrolled with two, three, or four MCOs during the period covered by our audit who received no services. This represents the unique total number of beneficiaries identified by our analysis.
Source: Prepared by legislative auditor's staff using Medicaid data from LDH.

Exhibit D.4 shows the results of our no services analysis by parish of residence, as well as whether that parish is considered a rural or urban parish. This represents the most recent parish for which the Medicaid beneficiary lived. For example, if a beneficiary previously lived in Ascension Parish but currently lives in Caddo Parish, the beneficiary and all associated PMPMs are counted in the Caddo Parish row.

Exhibit D.4 No Services by Parish Calendar Years 2018 through 2022			
Parish	**Rural or Urban**	**Unique Beneficiaries**	**PMPMs Paid**
ACADIA	Urban	497	$7,132,238
ALLEN	Rural	183	2,751,891
ASCENSION	Urban	811	11,296,451
ASSUMPTION	Rural	106	1,719,584
AVOYELLES	Rural	308	5,499,599
BEAUREGARD	Rural	401	6,010,634
BIENVILLE	Rural	145	2,267,720
BOSSIER	Urban	1,220	16,505,364
CADDO	Urban	3,218	47,110,376
CALCASIEU	Urban	2,288	30,504,169
CALDWELL	Rural	76	1,141,942
CAMERON	Rural	28	358,088
CATAHOULA	Rural	84	1,430,296
CLAIBORNE	Rural	134	2,201,889
CONCORDIA	Rural	230	3,764,032
DESOTO	Rural	237	3,635,374
EAST BATON ROUGE	Urban	4,031	58,554,315
EAST CARROLL	Rural	122	1,678,533
EAST FELICIANA	Rural	188	2,911,731
EVANGELINE	Rural	240	3,346,998
FRANKLIN	Rural	199	2,845,479
GRANT	Rural	156	1,940,231
IBERIA	Rural	694	10,073,481

Parish	Rural or Urban	Unique Beneficiaries	PMPMs Paid
IBERVILLE	Rural	220	3,358,529
JACKSON	Rural	98	1,300,817
JEFFERSON	Urban	5,211	73,379,381
JEFFERSON DAVIS	Rural	257	4,068,685
LAFAYETTE	Urban	2,308	30,055,579
LAFOURCHE	Urban	687	11,669,787
LASALLE	Rural	90	1,398,407
LINCOLN	Rural	531	8,443,519
LIVINGSTON	Urban	1,045	15,723,412
MADISON	Rural	162	2,414,417
MOREHOUSE	Rural	384	5,737,456
NATCHITOCHES	Rural	355	4,516,457
ORLEANS	Urban	6,044	94,549,145
OUACHITA	Urban	1,953	28,044,315
OUT-OF-STATE	Out-of-State	2,402	24,997,348
PLAQUEMINES	Urban	188	2,956,984
POINTE COUPEE	Rural	129	2,111,422
RAPIDES	Urban	1,233	18,981,187
RED RIVER	Rural	86	1,015,041
RICHLAND	Rural	209	2,904,218
SABINE	Rural	226	3,132,934
ST. BERNARD	Urban	466	7,128,691
ST. CHARLES	Urban	345	5,267,342
ST. HELENA	Rural	49	708,608
ST. JAMES	Urban	138	2,224,036
ST. JOHN THE BAPTIST	Urban	415	5,787,939
ST. LANDRY	Urban	912	13,284,309
ST. MARTIN	Urban	444	6,234,895
ST. MARY	Rural	540	8,760,166
ST. TAMMANY	Urban	2,089	29,512,976
TANGIPAHOA	Rural	1,231	19,926,956
TENSAS	Rural	57	986,917
TERREBONNE	Urban	1,180	16,835,401
UNION	Rural	250	3,454,841
VERMILION	Rural	427	5,507,078
VERNON	Rural	524	7,191,170
WASHINGTON	Rural	448	8,376,723
WEBSTER	Urban	454	6,686,717
WEST BATON ROUGE	Urban	225	3,141,890
WEST CARROLL	Rural	120	1,781,650
WEST FELICIANA	Rural	54	733,343
WINN	Rural	112	1,627,212
Total		**49,894**	**$720,598,315**

Source: Prepared by legislative auditor's staff using Medicaid data from LDH.