MATERNAL HEALTH OUTCOMES

LOUISIANA DEPARTMENT OF HEALTH

PERFORMANCE AUDIT SERVICES
DATA ANALYTICS UNIT

March 12, 2025

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LOUISIANA LEGISLATIVE AUDITOR

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March 12, 2025

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

Dear President Henry and Speaker DeVillier:

This report provides the results of our evaluation of the Louisiana Department of Health's (LDH) efforts to improve maternal health outcomes.

Overall, we found an increase in the number of pregnant women in Louisiana who did not receive prenatal care as recommended, with pregnant Medicaid beneficiaries representing a disproportionate share of these women.

Based on Medicaid data and other research, possible barriers to receiving recommended care include a lack of obstetric providers in certain areas of the state, lack of Medicaid reimbursement for certain maternal health services, and potentially low provider reimbursement rates for birth-related costs.

Specifically, we found the percentage of all pregnant women in Louisiana who did not receive prenatal care in the first trimester, as recommended by best practices, increased from 22.5% in calendar year 2018 to 25.9% in calendar year 2023. Among pregnant Medicaid beneficiaries, 76.4% (63,182 of 82,726) did not have timely access to prenatal care, which was 18.6% higher than the national rate for pregnant Medicaid beneficiaries during calendar years 2018 through 2023.

We also found that Medicaid complaint data indicated issues with pregnant Medicaid beneficiaries not being able to access obstetric care. LDH Medicaid provider network adequacy reports and Medicaid data showed a lack of providers in certain areas of the state. According to LDH, low provider reimbursement rates contribute to these issues. We analyzed the network adequacy reports for Obstetrician Gynecologist (OBGYN) access and found that 163 (18.3%) of 893 OBGYN Medicaid providers listed on these reports had no claims for services from July 2023 through December 2023. Twenty-four (37.5%) of 64 parishes had no OBGYNs who provided services as of December 2023.

In addition, we found that LDH case management data indicated the managed care organizations (MCOs) identified and enrolled a low percentage of pregnant and postpartum Medicaid beneficiaries for case management services. We

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found the MCOs identified only 8,680 (26.4%) of 32,836 Medicaid beneficiaries who gave birth in calendar year 2023 for case management services during their pregnancy or up to three months postpartum. In addition, we found the MCOs were not completing case management assessments in a timely manner as required by their contracts and were not issued monetary penalties for these violations.

Statewide maternal health quality improvement programs include the Louisiana Perinatal Quality Collaborative's (LaPQC) Safe Birth Initiative and the Managed Care Incentive Payment (MCIP) program. While LaPQC's maternal health quality initiatives have led to improved outcomes, we found the MCIP program's maternal health initiatives were not always designed to achieve measurable outcomes and, in some instances, were duplicative of other LDH initiatives.

The MCIP program contributed $383.2 million for maternal health quality reform efforts between February 2020 and March 2024. However, the program paid for hospitals to develop and implement policies and protocols that, in some instances, were already in place.

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

We would like to express our appreciation to the Louisiana Department of Health for its assistance during this review.

Respectfully submitted,

Michael J. "Mike" Waguespack, CPA
Legislative Auditor

MJW/aa

MATERNALHEALTH

Louisiana Legislative Auditor

Michael J. "Mike" Waguespack, CPA

Maternal Health Outcomes
Louisiana Department of Health

March 2025 *Audit Control # 40230035*

Introduction

> **Maternal health** refers to the health of women during pregnancy, childbirth, and the postpartum period.

We evaluated the Louisiana Department of Health's (LDH) efforts to improve maternal health outcomes. In transitioning to a managed care model[1] utilizing managed care organizations (MCOs),[2] LDH sought to improve access to care, quality of care, health outcomes, and care coordination, as well as increase the emphasis on disease prevention and early diagnosis and management of chronic conditions. Federal regulations[3] require LDH to annually 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 and other initiatives focus, in part, on maternal health care.

We conducted this evaluation because previous LLA audits[4] identified Medicaid beneficiaries who received no Medicaid services while enrolled, including certain preventative screenings. In addition, Louisiana's maternal mortality rate has increased at a higher rate than that of the United States as a whole, with significant disparities by race, ethnicity, and socioeconomic status. According to the 2020 Louisiana Pregnancy-Associated Mortality Review report, 94.0% of all pregnancy-related deaths were deemed potentially preventable. According to the 2024 America's Health Rankings,[5] Louisiana ranks 48th nationally for the health of women across social and economic factors, physical environment, clinical care, behaviors,

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[1] LDH transitioned from a fee-for-service Medicaid program to managed care in 2012. 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.

[2] LDH pays a 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).

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

[4] LDH: Medicaid Residency Audit and Oversight of Medicaid Quality Care

[5] https://assets.americashealthrankings.org/app/uploads/ahr_2024hwc_comprehensivereport_final_web.pdf

and health outcomes.[6] Because of these factors, as well as the National Center for Health Statistics finding that 34,871 (63.5%) of 54,927 people who gave birth in Louisiana in 2023 were insured through Medicaid, we examined the impact of these issues for pregnant Medicaid beneficiaries.

LDH Responsibilities. While the MCOs are responsible for managing the care of Medicaid beneficiaries enrolled in their health plans to ensure they receive appropriate care, it is LDH's responsibility to oversee the MCOs. Multiple entities within LDH are involved in facilitating improvements in maternal health outcomes. The legislature and LDH have recently increased focus on and resources for maternal health issues through creating the Office of Women's Health and Community Health (OWHCH) in June 2022 and incentivizing MCOs and providers to improve maternal health care through the Managed Care Incentive Payment (MCIP) program beginning in 2020.[7] Exhibit 1 lists the LDH entities and their responsibilities related to maternal health outcomes.

Exhibit 1
LDH Entities Responsible for Maternal Health

Entity	Responsibilities
Office of Public Health (OPH)	The Office of Public Health is charged with protecting and promoting the health and wellness of all individuals and communities in Louisiana. One of the main initiatives in the Office of Public Health to address maternal outcomes is the Louisiana Perinatal Quality Collaborative (LaPQC). The LaPQC is a network of perinatal care providers, public health professionals and advocates who work to improve outcomes for women, infants and families through the implementation of evidence-based best practices that promote safe, equitable, and dignified patient-centered care.
OWHCH	Serves as a clearinghouse, coordinating agency, and resource center for women's health data and strategies.
Medicaid	Has teams tasked with overseeing the MCOs' provider networks and delivery of quality care and the MCIP program, which provides incentive payments to MCOs for achieving quality reforms in certain areas, including maternal health.

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

The objective of this review was:

To evaluate LDH's efforts to improve maternal health outcomes.

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 lists the parishes with no OBGYN providers based on the December 2023 network adequacy reports. Appendix D lists maternal health-related Approved Incentive Arrangements, milestones, and payments made as part of the MCIP program.

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[6] These health rankings serve as an indicator of the health of the state as a whole, not specifically of LDH's Medicaid program, and include factors such as physical environment, social, and economic factors outside of the control of LDH.

[7] LDH's design and oversight of the MCIP program was analyzed in a report issued in March 2025. See https://app2.lla.state.la.us/publicreports.nsf/0/bcd9d00e72853d6d86258c44006e1020/$file/00006f7eb.pdf?openelement&.7773098.

Objective: To evaluate LDH's efforts to improve maternal health outcomes.

Overall, we found an increase in pregnant women in Louisiana who did not receive prenatal care as recommended, with pregnant Medicaid beneficiaries representing a disproportionate share of women without prenatal care. Based on Medicaid data and other research, possible barriers to receiving recommended care include a lack of obstetric providers in certain areas of the state, lack of Medicaid reimbursement for certain maternal health services, and potentially low provider reimbursement rates for birth-related costs. Further, it appears that MCOs are only providing case management services, which we found increases the likelihood of receiving postpartum care, to a small percentage of pregnant Medicaid beneficiaries. LDH has certain maternal health initiatives that appear to be working successfully, but others are less clear. Specifically, we found the following:

- **According to Natality data,[8] the percentage of all pregnant women in Louisiana who did not receive prenatal care in the first trimester, as recommended by best practices, increased from 22.5% in calendar year 2018 to 25.9% in calendar year 2023. Medicaid beneficiaries represented a disproportionate share of women who did not receive timely care.** Louisiana's rate of untimely access to prenatal care for Medicaid beneficiaries was 76.4% (63,182 of 82,726), which was 18.6% higher than the national rate for pregnant Medicaid beneficiaries of 57.8% during calendar years 2018 through 2023.

- **Medicaid complaint data indicates issues with pregnant Medicaid beneficiaries not being able to access obstetric care. LDH Medicaid provider network adequacy reports and Medicaid data show a lack of providers in certain areas of the state. According to LDH, low provider reimbursement rates contribute to these issues.** We analyzed the network adequacy reports for Obstetrician Gynecologist (OBGYN) access and found that 163 (18.3%) of 893 OBGYN Medicaid providers listed on these reports had no claims for services from July 1, 2023, through December 31, 2023; and 24 (37.5%) of 64 parishes had no OBGYNs who provided services as of December 2023. LDH could improve health care access in rural areas by increasing access to services that best practices have shown improve health care, such as increasing access to certified nurse midwives. Research suggests Medicaid provider networks can be improved with higher reimbursement rates.

[8] As mandated by federal law, all birth certificates and other vital statistics data is collected and published in the National Vital Statistics System by the National Center for Health Statistics (NCHS) and the States. The natality dataset is based on information derived from birth certificates and includes statistics for all births occurring in the United States.

- **LDH case management data indicates that the MCOs identified and enrolled a low percentage of pregnant and postpartum Medicaid beneficiaries for case management services. Because pregnant women who received case management services obtained postpartum care at a higher rate, LDH should specify high-risk populations who potentially require case management services in MCO contracts, such as pregnant Medicaid beneficiaries.** We found that the MCOs identified only 8,680 (26.4%) of 32,836 Medicaid beneficiaries who gave birth in calendar year 2023 for case management services during their pregnancy or up to three months postpartum. In addition, we found that MCOs are not completing case management assessments timely as required by their contracts and were not issued monetary penalties for these violations.

- **Statewide maternal health quality improvement programs include the Louisiana Perinatal Quality Collaborative's (LaPQC) Safe Birth Initiative (SBI) and the Managed Care Incentive Payment (MCIP) program. While LaPQC's maternal health quality initiatives have led to improved outcomes, we found that the MCIP program's maternal health initiatives were not always designed to achieve measurable outcomes and, in some instances, were duplicative of other LDH initiatives.** The MCIP program contributed $383.2 million for maternal health quality reform efforts between February 2020 and March 2024. However, the MCIP program paid for hospitals to develop and implement policies and protocols that, in some instances, were already in place. For example, LDH paid $12,803,552 for three milestones related to developing and implementing a breastfeeding policy and assessing requirements for meeting The Gift designation, despite all 16 hospitals already having a breastfeeding policy in place and 15 (93.8%) of 16 hospitals already having The Gift designation.

This information is discussed in more detail on the pages that follow.

According to Natality data, the percentage of all pregnant women in Louisiana who did not receive prenatal care in the first trimester, as recommended by best practices, increased from 22.5% in calendar year 2018 to 25.9% in calendar year 2023. Medicaid beneficiaries represented a disproportionate share of women who did not receive timely care.

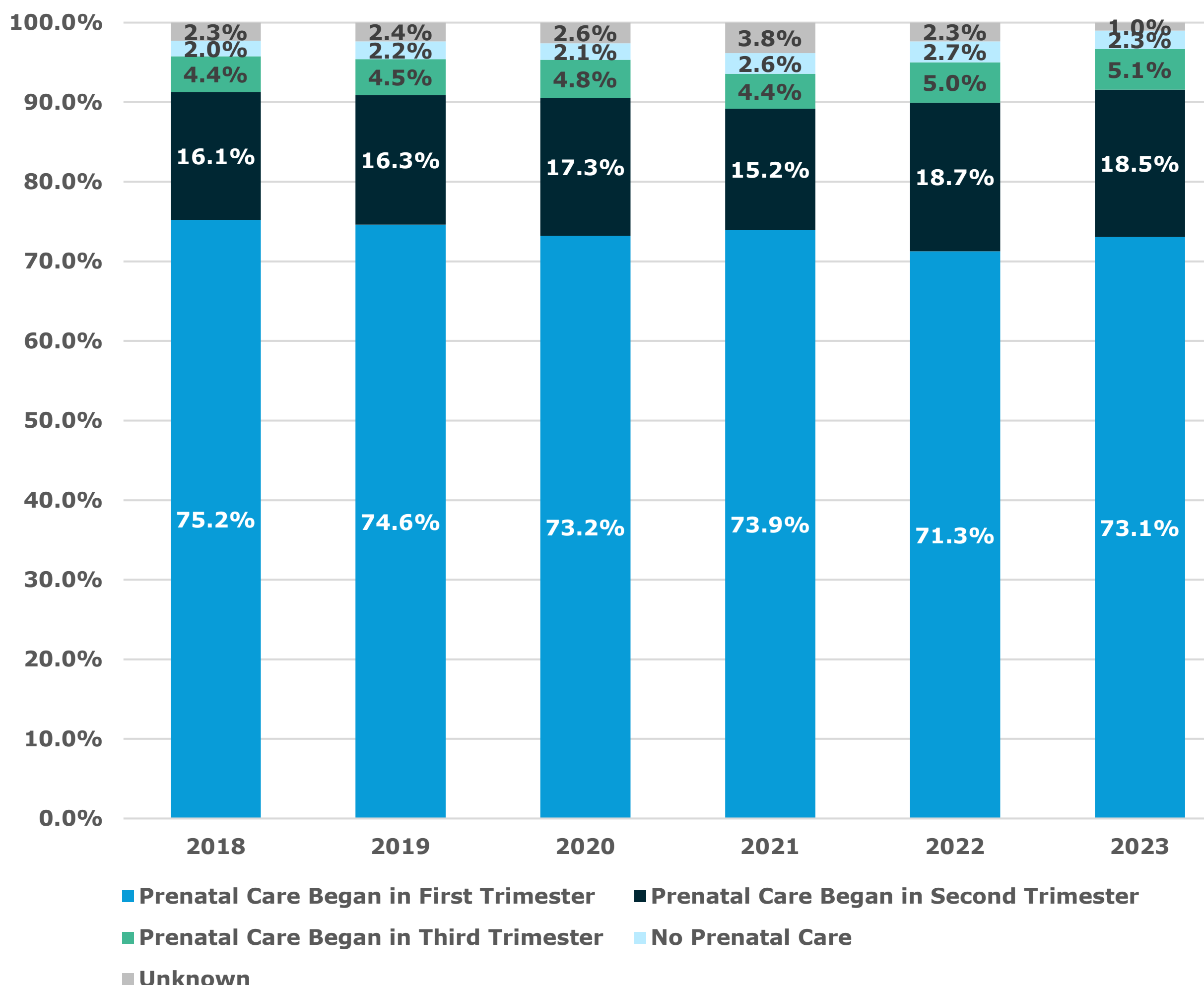
According to best practices, prenatal care access is considered timely if medical care is established in the first trimester.

Access to comprehensive, quality maternal healthcare services is important for improving health outcomes and achieving health equity for women in Louisiana. According to the United States Department of Health and Human Services (HHS), having good access to care means having health insurance and timely access to care. According to the Centers for Disease Control (CDC) and American College of Obstetricians and Gynecologists (ACOG), early and regular prenatal care can improve the likelihood of a healthy pregnancy and infant and set the stage for the long-term health and well-being of both mother and child. Prenatal care can prevent or minimize complications from pregnancy risks such as hypertension, anemia, infections, depression, and gestational diabetes. These complications can lead to preterm birth, low birth-weight babies, malnutrition, and death.

We found that the percentage of all pregnant women in Louisiana who did not receive prenatal care in the first trimester, as recommended by best practices, increased from 22.5% in calendar year 2018 to 25.9% in calendar year 2023, according to Natality data.[9] This represents pregnant women who did not receive prenatal care until the second trimester, the third trimester (considered late care), or at all. The percentage of pregnant women who received prenatal care untimely increased for each of these categories from calendar year 2018 through 2023. Exhibit 2 shows the timeliness of prenatal care for all Louisiana births in calendar years 2018 through 2023.

[9] As mandated by federal law, all birth certificates and other vital statistics data is collected and published in the National Vital Statistics System by the National Center for Health Statistics (NCHS) and the States. The natality dataset is based on information derived from birth certificates and includes statistics for all births occurring in the United States.

Exhibit 2
Timeliness of Prenatal Care for All Louisiana Births
Calendar Year 2018 through 2023

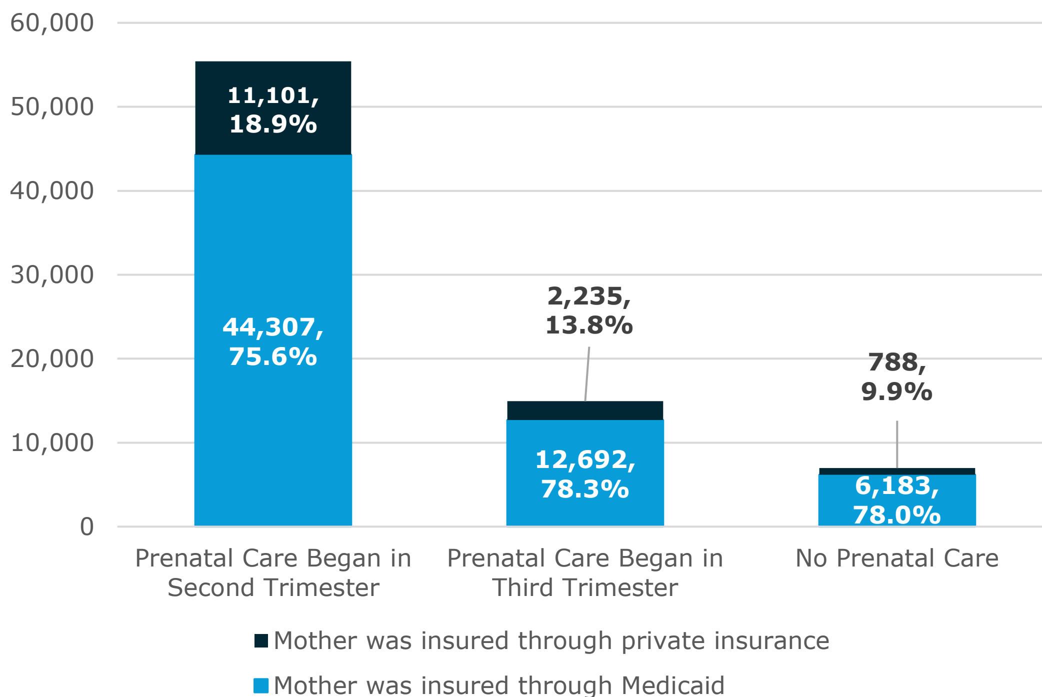


Source: Prepared by legislative auditor's staff using NCHS Natality data.

Louisiana's rate of Medicaid beneficiaries who did not receive prenatal care within the first trimester was 18.6% higher than the national rate for Medicaid beneficiaries during calendar years 2018 through 2023. Additionally, pregnant Medicaid beneficiaries represented a disproportionate share of pregnant women in Louisiana who received no prenatal care or prenatal care outside of recommended timelines. We analyzed Natality data and found that 76.4% (63,182 of 82,726) of pregnant women in Louisiana who did not receive maternal care until after their first trimester were insured through Medicaid from calendar years 2018 through 2023. This was 18.6% higher than the corresponding national rate for pregnant Medicaid beneficiaries of 57.8%. Pregnant Medicaid beneficiaries comprise 6,183 (78.0%) of 7,930 pregnant women in Louisiana who did not receive any prenatal care during pregnancy, despite only 61.6% of births in Louisiana being Medicaid births. In contrast, only 788 (9.9%) of 7,930 women who did not have prenatal care during

pregnancy were insured through private insurance. This highlights the need for LDH to ensure that the MCOs provide outreach to Medicaid beneficiaries to connect them with prenatal care. Exhibit 3 compares the number and percentage of women in Louisiana who were insured through Medicaid or through private insurance that had prenatal care beginning in the second or third trimester or no prenatal care.

Exhibit 3
Number and Percentage of Women in Louisiana Insured Through Medicaid vs. Private Insurance with Untimely Access to Prenatal Care
Calendar Years 2018 to 2023



Source: Prepared by legislative auditor's staff using National Center for Health Statistics Natality data.

Medicaid complaint data indicates issues with pregnant Medicaid beneficiaries not being able to access obstetric care. LDH Medicaid provider network adequacy reports and Medicaid data show a lack of providers in certain areas of the state. According to LDH, low provider reimbursement rates contribute to these issues.

Louisiana's Pregnancy Risk Assessment Monitoring System (PRAMS) is administered by LDH and the CDC and uses surveys mailed to a random sample of women in Louisiana who have recently given birth to collect information on their

experiences.[10] According to the 2019 Louisiana PRAMS Surveillance report,[11] the most commonly-reported barriers to receiving prenatal care as early as desired were: could not get an appointment when desired (43%), not knowing they were pregnant (37%), not having a Medicaid card (26%), and not having a doctor or insurance plan that would start prenatal care when they wanted it (23%).[12] LDH receives Medicaid beneficiary complaints from the MCOs, directly from Medicaid beneficiaries, or through other parties such as providers or legislators.

MCOs are required by their contracts to maintain an adequate network of providers to meet the needs of Medicaid beneficiaries. According to the March of Dimes, a maternity care desert is any parish without a hospital or birth center offering obstetric care and without any obstetric providers. A 2023 March of Dimes analysis[13] identified that 17 (26.6%) of 64 parishes in Louisiana were maternity care deserts, and 9 parishes (14.1%) had low access to care.[14] Having accurate provider directories and adequate provider networks are important because they inform beneficiaries of available healthcare providers in their area. Inaccurate provider data can create a barrier to care that prohibits beneficiaries from improving their health and makes it difficult for LDH to determine whether network adequacy requirements are being met.

> Maternity care desert: no hospitals providing obstetric care, no birth centers, no obstetricians, no certified nurse midwives and no family practice physicians
>
> Low access to care: less than two hospitals or birthing centers offering obstetric service and fewer than 60 obstetric providers per 10,000 births, and the proportion of women without health insurance was 10% or greater

We analyzed Medicaid complaint data and found that pregnant Medicaid beneficiaries experience issues with accessing care, such as finding providers and obtaining transportation to providers. A previous LLA audit[15] found that the majority of complaints made by Medicaid beneficiaries were related to a lack of quality care or a lack of access to care. Identifying the total number of complaints related to pregnant beneficiaries was challenging because LDH does not specifically track maternal health-related complaints. Capturing this information would allow LDH to know the total number of complaints received by pregnant beneficiaries and identify trends. LDH captures this information in a field for other populations, such as complaints related to behavioral health. We identified individual pregnant beneficiaries from our analysis of complaint data who were unable to find an in-network provider, especially in rural areas. For example, a beneficiary who was 21 weeks pregnant and living in a rural area was unable to

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[10] These questionnaires are mailed to approximately 200 women each month and may be completed online or returned via mail. Participation in the study is voluntary.
[11] https://partnersforfamilyhealth.org/wp-content/uploads/2023/07/PRAMS-2019-Surveillance-Report.pdf
[12] Survey respondents can check multiple options in this survey; therefore, these examples total more than 100.0%.
[13] https://www.marchofdimes.org/peristats/reports/louisiana/maternity-care-deserts
[14] Providers included in this analysis are obstetricians, certified nurse midwives, and family practice physicians.
[15] Oversight of Medicaid Quality Care

access care because the limited number of OBGYN providers in her area were not in her MCO's provider network.

We also identified complaints filed by pregnant beneficiaries who requested non-emergency medical transportation (NEMT), which MCOs are required to provide, to prenatal care appointments and did not receive it. For example, a beneficiary who was 30 weeks pregnant filed a complaint claiming that she missed several prenatal care appointments because scheduled transportation did not pick her up timely or at all. Her obstetrician notified her that they would stop seeing her due to the missed appointments. The beneficiary spoke to a supervisor at her NEMT provider to stress the importance of receiving transport to her next appointment, yet transportation failed to show up. These complaints indicate issues with the availability of maternal health providers and being able to get transportation to the providers that are available.

According to the LDH Secretary, "There's a very clear distinction between [Medicaid] coverage and access… having coverage under Medicaid does not mean that you [beneficiaries] have access [to services]."

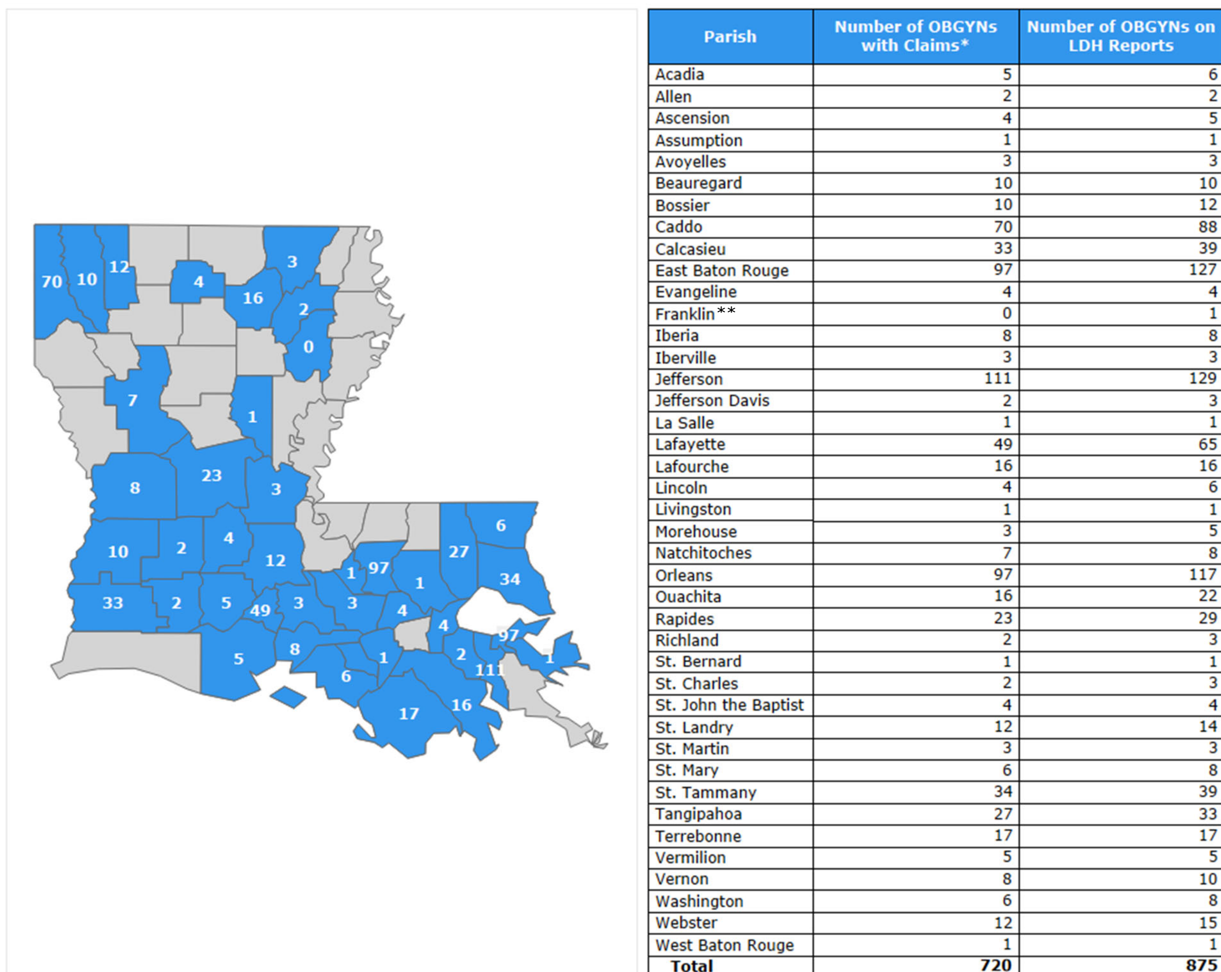
MCO provider network adequacy reports indicate gaps in OBGYN Medicaid providers in rural areas of the state. We also analyzed Medicaid data and found that provider networks are not as robust as network adequacy reports indicate. LDH's network adequacy reports provide a list of all current, in-network Medicaid providers. MCOs submit these reports to LDH semi-annually, and LDH determines whether MCOs are meeting provider network adequacy standards set in their contracts. These network adequacy standards seek to ensure that Medicaid beneficiaries, at a minimum, have equal access to qualified providers as the rest of the insured population. We reviewed the network adequacy reports for OBGYN access and found that 24 (37.5%) of 64 parishes had no OBGYNs who provided services as of December 2023.[16]

Our previous audit[17] found that MCO provider networks are not as robust as network adequacy reports indicate for a variety of reasons, such as MCOs including providers with no claims on the reports. 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. However, we analyzed the network adequacy reports referenced above for OBGYN access and found that 163 (18.3%) of 893 OBGYN Medicaid providers listed on network adequacy reports had no claims for services provided from July 1, 2023, through December 31, 2023. LDH began an initiative in March 2024 that requires MCOs to perform activities to ensure the accuracy of their provider networks reporting and directories.[18] This initiative was originally slated to last six months, but remained ongoing, as of February 2025. Exhibit 4 shows the number of OBGYNs by parish, including those parishes where

[16] Twenty-two (91.7%) of 24 parishes with no providers are rural parishes according to LDH.
[17] Oversight of Medicaid Quality Care
[18] Examples of these activities include requiring MCOs to identify providers with fewer than 25 services over a six-month period, which means the provider is inactive, according to LDH contracts. In addition, LDH is requiring the MCOs to confirm information such as provider types and addresses.

there are no OBGYNs with claims during this six-month period. Appendix C lists the parishes with no OBGYN providers based on the December 2023 network adequacy reports.

Exhibit 4
Number of OBGYN Providers With Claims by Parish
December 2023



Parish	Number of OBGYNs with Claims*	Number of OBGYNs on LDH Reports
Acadia	5	6
Allen	2	2
Ascension	4	5
Assumption	1	1
Avoyelles	3	3
Beauregard	10	10
Bossier	10	12
Caddo	70	88
Calcasieu	33	39
East Baton Rouge	97	127
Evangeline	4	4
Franklin**	0	1
Iberia	8	8
Iberville	3	3
Jefferson	111	129
Jefferson Davis	2	3
La Salle	1	1
Lafayette	49	65
Lafourche	16	16
Lincoln	4	6
Livingston	1	1
Morehouse	3	5
Natchitoches	7	8
Orleans	97	117
Ouachita	16	22
Rapides	23	29
Richland	2	3
St. Bernard	1	1
St. Charles	2	3
St. John the Baptist	4	4
St. Landry	12	14
St. Martin	3	3
St. Mary	6	8
St. Tammany	34	39
Tangipahoa	27	33
Terrebonne	17	17
Vermilion	5	5
Vernon	8	10
Washington	6	8
Webster	12	15
West Baton Rouge	1	1
Total	**720**	**875**

* Represents OBGYNs with claims in the Medicaid data from July 1, 2023, through December 31, 2023.
** Franklin Parish is included in this map because the one provider listed on Network Adequacy reports had zero claims during our scope.
Source: Prepared by legislative auditor's staff using network adequacy data provided by LDH and Medicaid claims data.

LDH could improve access in rural areas by increasing access to services that best practices have shown to improve health care. Specifically, the following services have been shown to improve health care:

- **Increasing Access to Certified Nurse Midwives (CNMs).** Midwifery care has been linked to improved quality of care and rapid

and sustained reductions in maternal and newborn mortality. However, Louisiana has the fourth-lowest rate of midwife-attended births in the nation. According to the Bureau of Family Health (BFH), to increase access to CNMs, the state must increase the number of midwives and address regulatory requirements that serve as barriers to practicing in Louisiana. As of May 2023, there were only 83 CNMs and Certified Midwives in Louisiana.[19] A February 2024 report released by Louisiana's Nursing Taskforce for Improving Maternal Mortality and Preterm Birth Rates in Louisiana (Nursing Taskforce) suggested providing increased funding through stipends and loan forgiveness to students training to be midwives or returning to the field to increase the number of CNMs in Louisiana. In addition, barriers prevent patient access, such as exclusion of CNMs as approved providers and hospital bylaws that prevent CNM's credentialing and employment. The Nursing Taskforce recommended ways to alleviate these barriers such as incentivizing CNM employment by creating tax credits for hospitals and physicians for integrating CNMs into their practice or system. Also, Louisiana is one of only 17 states in which scope of practice requirements mandate that CNMs and physicians enter into a collaborative practice agreement as a condition of licensure,[20] which is cited as a barrier preventing CNMs from providing reproductive health care, including obstetric care, in rural areas. Additionally, practicing CNMs are not currently included as a provider specialty in the Medicaid provider directory, so beneficiaries may be unaware of CNM providers in their area of residence.

- **Remote Monitoring.** The Health Resources and Services Administration and the American College of Obstetricians and Gynecologists (ACOG) recommend that state Medicaid agencies and private payers expand medically necessary remote monitoring of pregnant beneficiaries as a means to improve maternal and fetal outcomes, especially for women facing barriers with accessing prenatal care. Remote monitoring involves the use of digital devices to monitor a patient's health. According to LDH's MCO Manual, MCO coverage of remote patient monitoring for the management of hypertension and diabetes for pregnant Medicaid beneficiaries is optional. Legislation[21] passed in the 2024 Regular Legislative Session allows for remote monitoring coverage for certain conditions, but high-risk pregnancy, gestational diabetes, and hypertension were not listed as qualifying conditions for these services. According to LDH, only two (33.3%) of the six MCOs, Aetna and ACLA, currently offer remote monitoring coverage of pregnant beneficiaries in-lieu of face-to-face service. Further, LDH noted that current reimbursement requirements for

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[19] Louisiana ranked 37th nationally for the number of Certified Nurse Midwives and Certified Midwives.
[20] Thirty-one states and the District of Columbia license and regulate CNMs to independently practice and the remaining two states still require physician supervision of CNMs.
[21] Louisiana Revised Statute (La. R.S.) 40:1221.1 & 40:1227.1-8

remote monitoring, such as the number of required readings per month, are not feasible for women during pregnancy.

- **Group Prenatal Care.** Because of increasing health care costs, issues with healthcare provider availability, dissatisfaction with wait times, and minimal opportunity for education and support, other states started offering group prenatal care. A common model for this service involves a group of eight to 10 pregnant women meeting with a health care provider privately and with the group over 10 visits to discuss questions and concerns. Outcomes from implementing group prenatal care models include participants who have more knowledge about prenatal care, feel more prepared for labor and delivery, have lower rates of premature births and babies with higher birth weights, and are more likely to begin breastfeeding.[22] A 2021 survey[23] of states found that 12 states provide Medicaid reimbursement for group prenatal care, but Louisiana does not.

- **Perinatal Mental Health Screenings.** ACOG recommends that depression and anxiety screenings using evidence-based tools occur at the initial prenatal visit, later in pregnancy, and at postpartum visits. Legislation[24] was passed in the 2022 Regular Legislative Session requiring hospitals to educate women discharged following a pregnancy about perinatal mood and anxiety disorders. The legislation also recommends that providers conduct postpartum depression or related mental health screenings; however, because current law does not require providers to administer them at recommended intervals, they may not always be provided. As of April 2024, five states had legislation requiring perinatal mental health screenings. LDH stated a lack of perinatal mental health providers is a barrier to implementing this legislation.

- **Home Visiting.** LDH currently offers two home visiting services for parents who meet certain income requirements. The Nurse-Family Partnership pairs first time mothers with a registered nurse during their second or third trimester to help guide them through pregnancy and newborn care. Parents as Teachers (PAT) pairs families who are expecting a baby or have young children with parent educators who provide support, help families navigate services, and keep babies on track with their health and development. However, a 2023 study[25] by the Louisiana Policy Institute for Children found that current state-sponsored home visiting programs reached only approximately 6.0% of all births in the state in 2022. A task force was convened in August

[22] Committee Opinion developed by ACOG.
[23] Kaiser Family Fund survey of pregnancy-related service coverage, https://www.kff.org/report-section/medicaid-coverage-of-pregnancy-related-services-findings-from-a-2021-state-survey-report
[24] La. R.S. 40:1123.1-4
[25] Louisiana Home Visiting Capacity Study (October 2023), https://policyinstitutela.org/wp-content/uploads/2024/05/Louisiana-Home-Visiting-Capacity-Study-2023.pdf

2024 in response to legislation[26] to study the implementation and impact of Family Connects, a new postpartum newborn nurse home visiting model that is being implemented in the New Orleans region and other states.

According to LDH, low Medicaid provider reimbursement rates prevent maternal healthcare providers from accepting Medicaid beneficiaries. Research suggests Medicaid provider networks can be improved with higher reimbursement rates. The amount Louisiana Medicaid providers are paid is set by LDH. Low Medicaid reimbursement rates are often cited as a reason why providers choose not to accept Medicaid patients, resulting in Medicaid beneficiaries not having equal access to care. MCOs pay providers for maternal health services provided, including prenatal, delivery, and postpartum care. When a pregnant Medicaid beneficiary delivers a baby, the MCOs submit evidence of the delivery to LDH and are paid a "kick payment." This kick payment is a one-time payment to reimburse the MCOs for providing prenatal care, the delivery, and postpartum care, although only evidence of a delivery is required.

Because fee schedules for Medicaid services are set by each state, other states have passed legislation and created policies to increase Medicaid reimbursement rates. For example, Illinois now requires certain providers to bill Medicaid at the same rate they charge private-pay patients and patients covered by other third-party payers. New York has an enhanced Medicaid provider reimbursement rate for its maternal health-related services program that sets higher Medicaid provider reimbursement rates. ACOG states that Medicaid reimbursement rates are on average 82% of Medicare reimbursement rates. In an effort to move toward more equitable Medicaid provider reimbursement, Louisiana passed legislation[27] during the 2024 Regular Legislative Session to require LDH to develop a plan for increasing Medicaid reimbursement rates to equal Medicare reimbursement rates. According to LDH, this legislation will take up to two years to implement, and LDH is still working to finalize the changes.

Recommendation 1: LDH should add a field to beneficiary complaints that allows for analysis of population-specific concerns for beneficiaries, such as maternal health related concerns.

Summary of Management's Response: LDH agreed with this recommendation and stated that it currently reviews member complaints utilizing various reports. LDH further stated that it will review requirements to implement this change. See Appendix A for LDH's full response.

Recommendation 2: LDH should consider offering additional services and/or enhanced reimbursement to address issues with maternal health outcomes, such as providing reimbursement for group prenatal care, remote monitoring during pregnancy, postpartum home visiting services, and increasing provider reimbursement for birth related services.

[26] House Concurrent Resolution 113, https://legis.la.gov/legis/ViewDocument.aspx?d=1380355
[27] La. R.S. 40:460.76.1

Summary of Management's Response: LDH agreed with this recommendation and stated that as a result of the 2024 Regular Legislative Session, Senate Bill 190 requires LDH to review rates and propose a plan to increase provider reimbursement to 100% of Medicare rates. LDH stated that this plan has been submitted to the legislature and is subject to appropriation of funding. See Appendix A for LDH's full response.

Recommendation 3: LDH should consider updating the Medicaid provider directory to include CNMs as a provider specialty to potentially increase CNM beneficiary access.

Summary of Management's Response: LDH agreed with this recommendation and stated that CNMs are currently listed as a provider specialty in all MCO and FFS provider directories. See Appendix A for LDH's full response.

Matter for Legislative Consideration 1: The legislature may wish to consider enacting legislation that reviews and amends current collaborative practice agreements for Certified Nurse Midwives to allow for independent practice during certain phases of pregnancy.

Matter for Legislative Consideration 2: The legislature may wish to consider enacting legislation requiring providers to administer evidence-based mental health screenings at recommended intervals.

LDH case management data indicates that the MCOs identified and enrolled a low percentage of pregnant and postpartum Medicaid beneficiaries for case management services. Because pregnant women who received case management services obtained postpartum care at a higher rate, LDH should specify high-risk populations who potentially require case management services in MCO contracts, such as pregnant Medicaid beneficiaries.

LDH's MCO contracts require the MCOs to develop and offer a case management program in which they work with Medicaid beneficiaries who have chronic and complex medical conditions. Case management services help to ensure that beneficiaries receive appropriate and coordinated care by assisting beneficiaries with accessing medical, social, educational, and other support services. MCOs identify beneficiaries for case management outreach through beneficiary and provider referral, needs assessments, and claims data. Case managers conduct an initial assessment to determine interest and eligibility. Case managers also work with identified beneficiaries to develop a plan of care, which

establishes beneficiaries' needs, capacities, and priorities for case management, and assists the beneficiary in attaining these outcomes.

MCO contracts do not require the MCOs to conduct outreach for case management services for high-risk populations, such as pregnant Medicaid beneficiaries. We found that beneficiaries who received case management were more likely to have a postpartum visit. Despite research indicating the benefits of case management[28] and the results we identified in our analyses below, LDH's MCO contracts do not specify high-risk populations that require case management outreach, including pregnant beneficiaries or beneficiaries with high-risk pregnancies. As a result, MCOs are not obligated to offer case management services to beneficiaries who may benefit the most.

The MCOs are required to submit case management reports to LDH that provide information on both case management outreach and services provided. We analyzed case management reports against Medicaid data to identify whether receiving a plan of care appeared to increase the likelihood of postpartum visits. We identified 32,836 beneficiaries who gave birth in calendar year 2023 through Medicaid claims data.[29] We found that only 1,706 (5.2%) of these 32,836 beneficiaries had a plan of care during their pregnancy or up to three months postpartum. Further, only 1,174 (68.8%) of the 1,706 beneficiaries with a plan of care had a postpartum visit, while only 4,308 (13.8%) of 31,130 beneficiaries who did not have a plan of care had a postpartum care visit.

We found that the MCOs identified and provided case management services to a low percentage of pregnant and postpartum Medicaid beneficiaries. Since MCOs are not required to provide case management services to pregnant Medicaid beneficiaries, we analyzed case management reports and compared them to Medicaid data to determine how many pregnant beneficiaries who gave birth in calendar year 2023 received case management during their pregnancies or up to three months postpartum.[30] We found that the MCOs identified only 8,680 (26.4%) of 32,836 Medicaid beneficiaries who gave birth in calendar year 2023 for case management services during their pregnancy or up to three months postpartum.

While the overall objective of case management is to assist the patient in attaining outcomes identified in the plan of care, we found that only 1,706 (19.7%) of the 8,680 beneficiaries worked with a case manager to develop a plan of care during the pregnancy and postpartum period. This means that while the MCOs are identifying a small percentage of pregnant Medicaid beneficiaries for case management, an even smaller number are actually getting a plan of care. Exhibit 5 shows the number and percent of Medicaid beneficiaries who gave birth in calendar

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[28] Benefits of case management include positive patient outcomes, such as reduced hospital and emergency department use and healthcare costs.
[29] This does not include Humana, which was not an MCO for the entire scope of this analysis.
[30] We analyzed beneficiary case management up to three months after delivery because the postpartum period can last up to 12 weeks.

year 2023 and were identified and/or worked with a case manager to develop a plan of care during their pregnancies or up to three months postpartum.

Exhibit 5
Medicaid Beneficiaries Who Gave Birth in Calendar Year 2023 and Received Case Management Services by MCO

MCO*	Total Pregnant and Postpartum Beneficiaries Identified for Case Management	Total Pregnant and Postpartum Beneficiaries Receiving a Plan of Care	Total Pregnant Beneficiaries	Percent of Pregnant and Postpartum Beneficiaries Receiving a Plan of Care
Aetna Better Health of Louisiana	199	70	**2,845**	**2.5%**
AmeriHealth Caritas of Louisiana	951	526	**4,105**	**12.8%**
Healthy Blue	1,493	104	**7,483**	**1.4%**
Louisiana Healthcare Connections, Inc.	3,333	407	**10,452**	**3.9%**
United Healthcare of Louisiana, Inc.	2,704	599	**7,951**	**7.5%**
Total	**8,680**	**1,706**	**32,836**	**5.2%**

* Humana was excluded from this analysis because this analysis required case management report data prior to the start of their contract with LDH in 2023.
Source: Prepared by legislative auditor's staff using data provided by LDH.

We also found that MCOs are not completing case management assessments timely, as required by their contracts, and were not issued monetary penalties for these violations. While case management is not required for pregnant and postpartum Medicaid beneficiaries, LDH's contracts with the MCOs do require that MCOs complete case management assessments within 90 days of identification for 90.0% of enrollees they contact. However, we found that only 1,814 (20.9%) of the 8,680 beneficiaries identified were assessed within 90 days of identification. Further, we found that 6,795 (78.3%) were not assessed at all during their pregnancy or up to three months postpartum. The data field in the case management reports indicating why these beneficiaries were not assessed for case management was blank for 6,293 (92.6%) of 6,795 beneficiaries, meaning it is unclear why they were not assessed for case management services.[31] LDH reviewed MCO data from calendar year 2023 and issued Aetna, Healthy Blue, and Humana Notices of Action for failure to meet these case management requirements

[31] In the remaining 502 (7.4%) instances, pregnant and postpartum beneficiaries either declined prior to assessment, were unable to be reached, switched plans, or improved so that case management was no longer needed.

to assess Medicaid beneficiaries for case management services within 90 days of identification, but none were issued monetary penalties.

Recommendation 4: LDH should specify high-risk populations who potentially require case management services in MCO contracts, such as pregnant Medicaid beneficiaries.

Summary of Management's Response: LDH agreed with this recommendation and stated that the MCO contract defines pregnant high-risk individuals as a special health care needs population that shall be enrolled in case management. LDH stated that it is amending the current MCO contract to expand the definition of high-risk pregnancy and to allow more flexibility with case management to increase member participation. See Appendix A for LDH's full response.

Recommendation 5: LDH should continue to monitor case management outreach to pregnant beneficiaries to ensure MCO compliance.

Summary of Management's Response: LDH agreed with this recommendation and stated that it utilizes Report 039 to monitor compliance. See Appendix A for LDH's full response.

Recommendation 6: LDH should improve its oversight of care provided by the MCOs by analyzing Medicaid data over time to ensure MCOs identify and provide outreach to pregnant and postpartum beneficiaries who may benefit from case management services.

Summary of Management's Response: LDH agreed with this recommendation and stated that it currently has a robust monitoring plan that includes various activities. See Appendix A for LDH's full response.

Statewide maternal health quality improvement programs include the Louisiana Perinatal Quality Collaborative's (LaPQC) Safe Birth Initiative (SBI) and the Managed Care Incentive Payment (MCIP) program. While LaPQC's maternal health quality initiatives have led to improved outcomes, we found that the MCIP program's maternal health initiatives were not always designed to achieve measurable outcomes and, in some instances, were duplicative of other LDH initiatives.

The Louisiana Perinatal Quality Collaborative (LaPQC) was established in 2017 within LDH as an initiative of BFH to create a voluntary network of perinatal

care providers and professionals who work to improve outcomes for birthing persons, families, and newborns in Louisiana. LaPQC is an authorized activity of the Louisiana Commission on Perinatal Care and Prevention of Infant Mortality (Perinatal Commission). Although LDH and healthcare partners led initiatives prior to LaPQC's formation, LaPQC was the first formalized, long-term, statewide platform for organizing and supporting birth outcome improvement efforts. LaPQC has been instrumental in implementing nationally recommended Patient Safety Bundles in Louisiana, which are collections of actionable, evidence-informed best practices developed by the Alliance for Innovation on Maternal Health with multidisciplinary experts that can be adapted by facilities to address clinically specific conditions in pregnant and postpartum women to improve outcomes.

LDH also oversees initiatives to improve maternal health quality through the Managed Care Incentive Payment (MCIP) program. MCIP provides incentive payments to Medicaid MCOs and ultimately hospitals for achieving quality reforms in various focus areas to increase access to health care, improve the quality of care, and/or enhance the health of MCO enrollees. Improving maternal health outcomes is one of these focus areas.

Designation programs recognize birthing facilities that have implemented evidence-based best practices to improve maternal health outcomes.

LaPQC has implemented various initiatives and designation programs, which have led to improvement in maternal health outcomes. In August 2018, shortly after LaPQC's establishment, it began implementing its *Reducing Maternal Morbidity Initiative* (RMMI), with the objective to reduce Severe Maternal Morbidity (SMM)[32] by 20.0% among women giving birth who experience hemorrhage and/or severe hypertension by May 2020 and decrease the Black-white disparity in SMM among women giving birth who experience hemorrhage and hypertension in the same time period in alignment with AIM Patient Safety Bundle guidelines. Forty-one (78.8%) of 52 birthing facilities participated in the initiative. While LaPQC surpassed the goal of a 20.0% reduction in SMM among women experiencing hemorrhage at participating facilities, it did not meet the goal of a 20.0% reduction in SMM among women experiencing hypertension.[33] The RMMI initiative resulted in a significant increase in the number of persons receiving timely treatment of severe hypertension, risk assessments, and facilities routinely performing quantitative blood loss procedures.[34]

In January 2021, LaPQC launched the *Safe Births Initiative* (SBI), which continued to integrate nationally-recommended AIM Patient Safety Bundles focused on improving maternal hypertension and hemorrhage rates in Louisiana, and began implementing an AIM bundle for reducing Louisiana's low-risk first time Cesarean

[32] SMM events are the unexpected outcomes of labor and delivery that result in significant short or long-term consequences to a woman's health.
[33] SMM among women experiencing hemorrhage decreased by 34.8% from baseline to final measurement. SMM among women experiencing hypertension decreased by 11.6% from baseline to final measurement.
[34] Quantitative blood loss procedures measure blood loss through systemic means rather than through estimation.

(c-section) delivery rate. In addition, in January 2021, facilities participating in LaPQC became eligible to earn *Birth Ready* and *Birth Ready* + designations by meeting requirements for participation in collaborative learning, health equity and patient partnership, policies and procedures, structure measures and education, and outcome and process measures. As of February 2025, 18 facilities achieved *Birth Ready* + designations, and 13 facilities achieved *Birth Ready* designations.

By December 2022, participating facilities reduced the low-risk first time c-section delivery rate from 33.0% to 27.5%. In May 2023, LaPQC began implementing an AIM bundle to reduce obstetric sepsis. According to data provided by the BFH, the number of facilities participating in the SBI has steadily increased from 32 participating facilities in calendar year 2018 to 44 in calendar year 2024. Birthing facilities also have the opportunity to achieve a designation for participating in LaPQC's initiative to boost low breastfeeding rates, called The Gift. Although in existence since 2006 through LDH, The Gift was integrated into LaPQC in 2018. The Gift provides tools, training, and coaching to support Louisiana birthing facilities in implementing practices to improve breastfeeding outcomes and infant feeding rates. As of February 2025, 40 (87.0%) of 46 birthing hospitals have an active The Gift designation.

The MCIP program contributed $383.2 million to maternal health quality reform efforts between February 2020 and March 2024. However, the MCIP program paid for hospitals to develop and implement policies and protocols that, in some instances, were already in place. Also, the MCIP program does not emphasize improvements in patient outcomes in early years. We analyzed the MCIP program to understand how it would improve quality of care for Medicaid beneficiaries. We found that activities for some milestones (goals) were already required by LaPQC designation programs, such as The Gift, while others use existing policies or protocols of one hospital to "meet" the milestone. For example:

- LDH paid $12,803,552 for three milestones related to developing and implementing a breastfeeding policy and assessing requirements for meeting The Gift designation, despite all 16 hospitals already having a breastfeeding policy in place and 15 (93.8%) of 16 hospitals already having The Gift designation.

- Another milestone for which LDH paid $4,259,418 was for the submission of a risk-stratification tool developed and already in use by Woman's Hospital in Baton Rouge. In this instance, nothing new was created as part of this initiative.

- LDH approved two milestones and paid a total of $13,011,937 for milestones already part of LDH's Medicaid Quality Withhold program. One of these milestones was to "decrease in percentage of percentage of[35] nulliparous enrollees with a term, singleton baby in a vertex

[35] We did not correct any misspellings or grammatical issues in the milestone descriptions received from LDH.

position delivered by C-section, to a defined target set by LDH in consultation with MCO." However, LDH had already incentivized this measure directly with the MCOs and paid them $15,104,818. In essence, LDH paid for the same improvement twice.

According to BFH staff, they were not asked to assist in the development or review of these milestones despite being the lead LDH agency on family health. If they were, they could have informed LDH Medicaid Quality staff that some milestones were already implemented so MCIP program funding could be focused on developing new quality initiatives. See Appendix D for a listing of milestones related to maternal health care and the amounts LDH paid for those milestones as part of the MCIP program.

Recommendation 7: LDH should improve its oversight and approval process for MCIP Approved Incentive Arrangements (AIAs) to ensure that they are implementing new reforms that are linked to measurable improvements in patient outcomes.

Summary of Management's Response: LDH agreed with this recommendation and stated that it has already evaluated the structure and is making changes to the MCIP program. LDH stated that it will have uniform AIAs to focus on improving the same quality metrics and outcomes, which should improve the quality of care Medicaid members receive. See Appendix A for LDH's full response.

APPENDIX A: MANAGEMENT'S RESPONSE

Docusign Envelope ID: C24C249D-49F0-48C8-B7D8-1C5E1E768986

Jeff Landry
GOVERNOR

Michael Harrington, MBA, MA
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

VIA E-MAIL ONLY

February 28, 2025

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

Report Number: 40230035

Re: Performance Audit Report on the Maternal Health Outcomes

Dear Mr. Waguespack:

The Louisiana Department of Health (LDH) acknowledges receipt of correspondence from the Louisiana Legislative Auditor (LLA) dated February 14, 2025 regarding a performance audit report of the *Maternal Health Outcomes*. LDH appreciates the opportunity to provide this response to your office's observations and recommendations.

As instructed by your email dated February 14, 2025, attached is the completed checklist which includes LDH's written responses to each of the recommendations, and the improvement activities that LDH has developed and/or will develop to ensure that LDH addresses the potential limitations identified in the audit.

Conclusion 2: Medicaid complaint data indicates issues with pregnant Medicaid beneficiaries not being able to access obstetric care. LDH Medicaid provider network adequacy reports and Medicaid data show a lack of providers in certain areas of the state. Low provider reimbursement rates may contribute to these issues.

Recommendation 1: LDH should add a field to beneficiary complaints that allows for analysis of population specific concerns for beneficiaries, such as maternal health related concerns.

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LDH Response: LDH agrees with this recommendation. Currently, LDH reviews member complaints utilizing various reports. LDH will review requirements to implement this change.

Recommendation 2: LDH should consider offering additional services and/or enhanced reimbursement to address issues with maternal health outcomes, such as providing reimbursement for group prenatal care, remote monitoring during pregnancy, postpartum home visiting services, and increasing provider reimbursement for birth related services.

LDH Response: As a result of the 2024 Regular Legislative Session, SB 190 requires LDH to review rates and propose a plan to increase provider reimbursement to 100% of Medicare rates. This has been submitted to the legislature and is subject to appropriation of funding.

Recommendation 3: LDH should consider updating the Medicaid provider directory to include CNMs as a provider specialty to potentially increase CNM beneficiary access.

LDH Response: LDH agrees with this recommendation. CNMs are currently listed as a provider specialty in all MCO and FFS provider directories.

Conclusion 3: LDH case management data indicates that the MCOs identified and enrolled a low percentage of pregnant and postpartum Medicaid beneficiaries for case management services. Because pregnant women who received case management services obtained postpartum care at a higher rate, LDH should specify high-risk populations who potentially require case management services in MCO contracts, such as pregnant Medicaid beneficiaries.

Recommendation 4: LDH should specify high-risk populations who potentially require case management services in MCO contracts, such as pregnant Medicaid beneficiaries.

LDH Response: LDH agrees with this recommendation. The MCO contract defines pregnant high-risk individuals as a special health care needs population that shall be enrolled in case management. LDH is amending the current MCO contract to expand the definition of high-risk pregnancy and to allow more flexibility with case management to increase member participation.

Recommendation 5: LDH should continue to monitor case management outreach to pregnant beneficiaries to ensure MCO compliance.

LDH Response: LDH agrees with this recommendation and utilizes Report 039 to monitor compliance.

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Recommendation 6: LDH should improve its oversight of care provided by the MCOs by analyzing Medicaid data over time to ensure MCOs identify and provide outreach to pregnant and postpartum beneficiaries who may benefit from case management services.

LDH Response: LDH currently has a robust monitoring plan that includes review of multiple reports to ensure compliance of contract provisions, penalize non-compliance, participation in the MCO's quality/UM/CMO meetings, utilization of Medicaid's EQRO to also monitor compliance, creation and participation in ad hoc MCO workgroup meetings, and engage the MCOs on quality and payment delivery reforms.

Conclusion 4: Statewide maternal health quality improvement programs include the Louisiana Perinatal Quality Collaborative's (LaPQC) Safe Birth Initiative (SBI) and the Managed Care Incentive Payment (MCIP) program. While LaPQC's maternal health quality initiatives have led to improved outcomes, we found that the MCIP program's maternal health initiatives were not always designed to achieve measurable outcomes and, in some instances, were duplicative of other LDH initiatives.

Recommendation 7: LDH should improve its oversight and approval process for MCIP Approved Incentive Arrangements to ensure that they are implementing new reforms that are linked to measurable improvements in patient outcomes.

LDH Response: LDH agrees with this recommendation and has already evaluated the structure and is making changes to the current MCIP program LDH will have uniform AIAs in order for both Quality Networks to focus on improving the same quality metrics and outcomes. This change should improve the quality of care our Medicaid members receive on a greater scale and provide for comparison outcomes.

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, at (225) 342-7439 or via email at Kolynda.Parker@la.gov with any questions about this matter.

Sincerely,

Michael Harrington, MBA, MA
Secretary

Docusign Envelope ID: C24C249D-49F0-48C8-B7D8-1C5E1E768986

MICHAEL J. "MIKE" WAGUESPACK, CPA
LOUISIANA LEGISLATIVE AUDITOR

Agency: Louisiana Department of Health

Audit Title: Maternal Health Outcomes

Audit Report Number: 40230035

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 2: Medicaid complaint data indicates issues with pregnant Medicaid beneficiaries not being able to access obstetric care. LDH Medicaid provider network adequacy reports and Medicaid data show a lack of providers in certain areas of the state. Low provider reimbursement rates may contribute to these issues.
Recommendation 1: LDH should add a field to beneficiary complaints that allows for analysis of population specific for beneficiaries, such as maternal health related concerns. **LDH Response: LDH agrees with this recommendation. Currently, LDH reviews member complaints utilizing various reports. LDH will review requirements to implement this change.**
Does Agency Agree with Recommendation? ☒ Agree ☐ Disagree
Agency Contact Responsible for Recommendation:
Name/Title: Kolynda Parker
Address: 628 N. 4th Street
City, State, Zip: Baton Rouge, LA 70802
Phone Number: 225-342-7439
Email: Kolynda.parker@la.gov
Recommendation 2: LDH should consider offering additional services and/or enhanced reimbursement to address issues with maternal health outcomes, such as providing reimbursement for group prenatal care, remote monitoring during pregnancy, postpartum home visiting services, and increasing provider reimbursement for birth related services. **LDH Response: As a result of the 2024 Regular Legislative Session, SB 190 requires LDH to review rates and propose a plan to increase provider reimbursement to 100% of Medicare rates. This has been submitted to the legislature and is subject to appropriation of funding.**

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Conclusion 3: LDH case management data indicates that the MCOs identified and enrolled a low percentage of pregnant and postpartum Medicaid beneficiaries for case management services. Because pregnant women who received case management services obtained postpartum care at a higher rate, LDH should specify high-risk populations who potentially require case management services in MCO contracts, such as pregnant Medicaid beneficiaries.
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Recommendation 5: LDH should continue to monitor case management outreach to pregnant beneficiaries to ensure MCO compliance.

LDH Response: LDH agrees with this recommendation and utilizes Report 039 to monitor compliance.

Does Agency Agree with Recommendation? ☒Agree ☐ Disagree
Agency Contact Responsible for Recommendation:
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LDH Response: LDH currently has a robust monitoring plan that includes review of multiple reports to ensure compliance of contract provisions, penalize non-compliance, participation in the MCO's quality/UM/CMO meetings, utilization of Medicaid's EQRO to also monitor compliance, creation and participation in ad hoc MCO workgroup meetings, and engage the MCOs on quality and payment delivery reforms.

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Conclusion 4: Statewide maternal health quality improvement programs include the Louisiana Perinatal Quality Collaborative's (LaPQC) Safe Birth Initiative (SBI) and the Managed Care Incentive Payment (MCIP) program. While LaPQC's maternal health quality initiatives have led to improved outcomes, we found that the MCIP program's maternal health initiatives were not always designed to achieve measurable outcomes and, in some instances, were duplicative of other LDH initiatives.

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APPENDIX B: SCOPE AND METHODOLOGY

This report provides the results of our evaluation of the Louisiana Department of Health's (LDH) efforts to improve maternal health outcomes. We conducted this evaluation under the provisions of Title 24 of the Louisiana Revised Statutes of 1950, as amended. This evaluation covered the period of January 2018 through December 2024. In some instances, our analyses included information before and after this scope. The objective of our evaluation was:

To evaluate LDH's efforts to improve maternal health outcomes.

To conduct this analysis, we performed the following steps:

- Researched relevant federal and state laws, rules, and regulations.
- Researched relevant LDH policies, procedures, protocol documents, informational bulletins, Quality Strategy documents, Managed Care Organization (MCO) contracts, and the MCO manual.
- Met with LDH staff to gain an understanding of the various programs and initiatives LDH has to improve maternal health outcomes, including those from the Bureau of Family Health, the Office of Women's Health and Community Health, the Louisiana Perinatal Quality Collaborative (LaPQC), Medicaid, and the Program Operations and Compliance Section.
- Researched relevant best practices, studies, data, and other information from various entities, including a 2023 March of Dimes Analysis, the 2019 Louisiana's Pregnancy Risk Assessment Monitoring System (PRAMS) Surveillance report, a February 2024 report from the Nursing Taskforce for Improving Maternal Mortality and Preterm Birth Rates in Louisiana, information from the Health Resources and Services Administration, information from the American College of Obstetricians and Gynecologists, a 2021 Kaiser Family Fund survey, and a 2023 Louisiana Policy Institute for Children study.
- Obtained Medicaid data to identify whether pregnant Medicaid beneficiaries received prenatal or postpartum care.
- Used SQL, ACL, and Tableau to analyze Medicaid data.
- Obtained Natality data from the National Center for Health Statistics.
- Obtained complaint data from LDH to identify complaints related to pregnant Medicaid beneficiaries.

- Obtained network adequacy reports from LDH to identify potential gaps in OBGYN networks.

- Compared network adequacy reports to Medicaid data to identify OBGYN's listed as in an MCO(s) network but who actually provided no services.

- Researched various services that could improve maternal health care, including increasing access to certified midwives, remote monitoring, group prenatal care, perinatal mental health screenings, and home visiting.

- Researched reimbursement rates and fee schedules related to certain maternal health services.

- Obtained case management data from LDH to determine the number of pregnant Medicaid beneficiaries identified for and receiving case management services.

- Compared case management reports with Medicaid data to identify those pregnant Medicaid beneficiaries who did and did not receive case management services to identify discrepancies in receiving postpartum services.

- Obtained information related to various initiatives implemented by LDH, including the Reducing Morbidity Initiative, the Safe Births Initiative, Birth Ready and Birth Ready + designations, and The Gift.

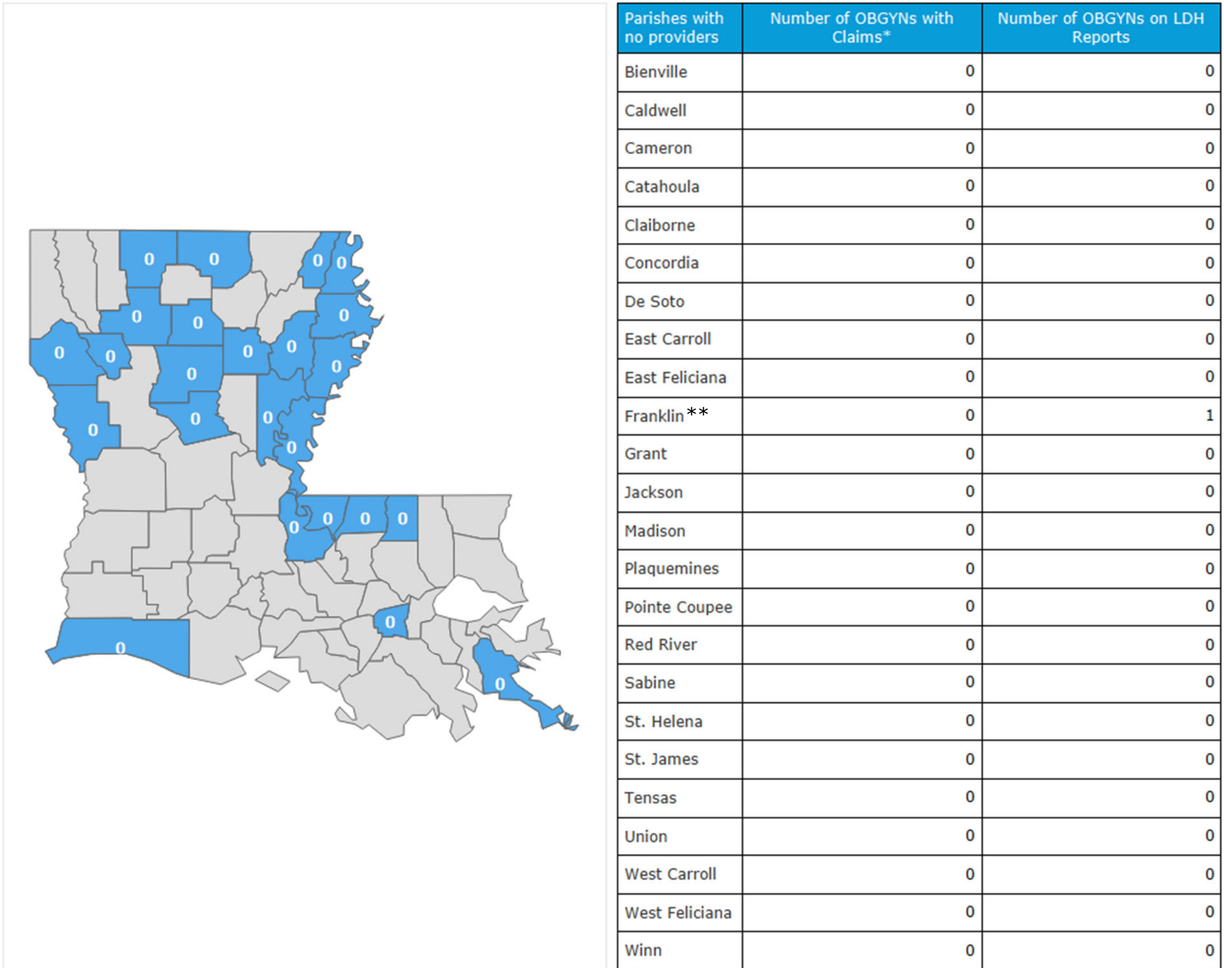
- Obtained a listing of Approved Incentive Arrangements and milestones from LDH for each Quality Network related to maternal health.

- Obtained documentation from LDH supporting whether the Quality Networks met milestones related to maternal health.

- Analyzed the Managed Care Incentive Payment program intergovernmental transfer (IGT) and expenditure data from business objects, LDH, the MCOs, and the Quality Networks to determine how much LDH paid for maternal health initiatives.

- Provided our results to LDH to review and incorporated edits throughout the report.

APPENDIX C: PARISHES WITHOUT OBGYN PROVIDERS AS OF DECEMBER 2023



Parishes with no providers	Number of OBGYNs with Claims*	Number of OBGYNs on LDH Reports
Bienville	0	0
Caldwell	0	0
Cameron	0	0
Catahoula	0	0
Claiborne	0	0
Concordia	0	0
De Soto	0	0
East Carroll	0	0
East Feliciana	0	0
Franklin**	0	1
Grant	0	0
Jackson	0	0
Madison	0	0
Plaquemines	0	0
Pointe Coupee	0	0
Red River	0	0
Sabine	0	0
St. Helena	0	0
St. James	0	0
Tensas	0	0
Union	0	0
West Carroll	0	0
West Feliciana	0	0
Winn	0	0

* Represents OBGYNs with claims in the Medicaid data from July 1, 2023, through December 31, 2023.
** Franklin Parish is included in this map because the one provider listed on Network Adequacy reports had zero claims during our scope.
Source: Prepared by legislative auditor's staff using network adequacy data provided by LDH and Medicaid claims data.

APPENDIX D: LOUISIANA QUALITY NETWORK (LQN) AND QUALITY AND OUTCOME IMPROVEMENT NETWORK (QIN) APPROVED INCENTIVE ARRANGEMENTS (AIAS), MILESTONES, AND PAYMENTS FROM FEBRUARY 2020 THROUGH MARCH 2024

Milestone Number	LQN Milestone Description*	Amount Paid for Milestone Achievement	Amount Paid for Non-Milestone Activities	Total Amount Paid for Milestone
1.1	Create risk stratification tool that includes at minimum the following: cervical length screening; history of previous preterm birth; presence of high risk factors for preeclampsia/hypertension; 5P's and/or social determinants of health screening	$4,089,041	$170,377	**$4,259,418**
1.2	Develop a method to track risk stratification adherence and submission to MCIP/partnership with managed care plans	4,074,226		**4,074,226**
1.3	Develop method to report completed gestational weeks at delivery for reporting and obtain baseline to support evaluation	4,089,041	170,377	**4,259,418**
1.4	Conduct rapid evaluation of utility of risk stratification tool for identifying women at risk of preterm birth	4,074,226		**4,074,226**
1.5	All hospitals sign on to Perinatal Quality Collaborative Reducing Maternal morbidity initiative	4,089,041	170,377	**4,259,418**
1.6	Hospitals implement one change concept from each driver in collaborative driver diagram	4,089,041	170,377	**4,259,418**
1.7	Each facility develops and iteratively edits facility aim statement and uploads data on collaborative measures focused on reduction of morbidity due to hemorrhage and hypertension	4,089,041	170,377	**4,259,418**
1.8	Develop, implement and tests of change focused on a protocol to treat patients with new onset severe hypertension two blood pressure taking 15 minutes apart (>/=160/110) within one hour	4,074,226		**4,074,226**
1.9	Develop process and outcomes measures and engagement process to assess coordination of care between obstetric and emergency settings	4,089,041	170,377	**4,259,418**

Milestone Number	LQN Milestone Description*	Amount Paid for Milestone Achievement	Amount Paid for Non-Milestone Activities	Total Amount Paid for Milestone
1.10	Review and create a timeline for implementing the AIM bundle for reduction of low risk primary cesarean births	$4,089,041	$170,377	**$4,259,418**
1.11	Using the Baby-Friendly Ten Steps to Successful Breastfeeding as a guiding principle develop a breastfeeding policy	4,089,041	170,377	**4,259,418**
1.12	Assess requirements for meeting The Gift Designation	4,089,041	170,377	**4,259,418**
2.1	Pilot risk stratification tool in two-member hospitals using patient input to adjust implementation	3,984,786	299,930	**4,284,716**
2.2	Implement method for tracking provider compliance of performing risk stratification in pilot hospitals	3,984,786	299,930	**4,284,716**
2.3	Conduct pilot implementation of an enhanced prenatal and postpartum care delivery model for women identified at high risk in partnership with evaluation partner and public health/managed care	3,984,786	299,930	**4,284,716**
2.4	Track results/make improvement	3,984,786	299,930	**4,284,716**
2.5	Address barriers to improvement	3,984,786	299,930	**4,284,716**
2.6	Implement method for reporting completed gestational weeks at delivery to support evaluation	3,984,786	299,930	**4,284,716**
2.7	Stratify all process measures and outcome measures by race/ethnicity to support equity aim	3,984,786	299,930	**4,284,716**
2.8	Integrate patient/family advisors into all improvement teams	3,935,960		**3,935,960**
2.9	Address barriers to improvement and Sustain improvement	3,984,786	299,930	**4,284,716**
2.10	Identify existing health information exchanges to leverage that enable coordination between emergency departments and prenatal care providers	3,984,786	299,930	**4,284,716**
2.11	Engage system ED, OB, and prenatal providers around collaborative opportunities for improvement to reduce maternal morbidity	3,984,786	299,930	**4,284,716**
2.12	Educate providers and nurses on AIM bundle components	3,984,786	299,930	**4,284,716**
2.13	Begin to implement the AIM bundle components for TJC PC-02	3,984,786	299,930	**4,284,716**
2.14	Implement breastfeeding policy	3,984,786	299,930	**4,284,716**

Milestone Number	LQN Milestone Description*	Amount Paid for Milestone Achievement	Amount Paid for Non-Milestone Activities	Total Amount Paid for Milestone
2.15	Implement at least 3 Coeffective training and tools	$3,984,786	$299,930	**$4,284,716**
3.1	Implement risk stratification tool in all member hospitals	4,719,149	248,376	**4,967,525**
3.2	Implement method for tracking compliance of risk stratification	4,719,149	248,376	**4,967,525**
3.3	Implement referral to high risk pregnancy medical home or enhanced prenatal care delivery model for women with identified risks	4,719,149	248,376	**4,967,525**
3.4	Monitor completed gestational weeks at delivery to support evaluation	4,719,149	248,376	**4,967,525**
3.5	Conduct environmental scan and literature review regarding options for enhanced prenatal/postpartum care delivery & case management in partnership with managed care	4,719,149	248,376	**4,967,525**
3.6	Scale changes to level 1 and II facilities	4,719,149	248,376	**4,967,525**
3.7	Establish baseline for process and outcomes measures assessing coordination of care between obstetric and emergency settings	4,719,149	248,376	**4,967,525**
3.8	Pilot a health information exchange in one hospital system linking EDs to prenatal care	4,719,149	248,376	**4,967,525**
3.9	Track results using collaboratively identified measures/make improvements	4,719,149	248,376	**4,967,525**
3.10	Further implement change concepts in Collaborative change package to narrow disparities in severe maternal morbidity outcome	4,719,149	248,376	**4,967,525**
3.11	Continue to implement AIM bundle for Cesarean rate for low-risk first birth women	4,719,149	248,376	**4,967,525**
3.12	Monitor and address barriers to compliance for AIM Bundle	4,719,149	248,376	**4,967,525**
3.13	Using The Gift Designation Data Collection Guide - Perform staff survey to at least 20% of staff or minimum of 10	4,719,149	248,376	**4,967,525**
3.14	Using The Gift Designation Data Collection Guide - Perform mother survey on 20% of deliveries a month to a maximum of 30 patients per month	4,719,149	248,376	**4,967,525**
4.1	Monitor and adjust risk stratification tools, referral and adherence to facility-based protocols for patients at risk for pre-term birth	4,452,263	-	**4,452,263**

Milestone Number	LQN Milestone Description*	Amount Paid for Milestone Achievement	Amount Paid for Non-Milestone Activities	Total Amount Paid for Milestone
4.2	Monitor completed gestational weeks at delivery to support and maintain evaluation	$4,452,263	-	**$4,452,263**
4.3	Sustain and scale changes from PQC change package	4,452,263	-	**4,452,263**
4.4	Develop transfer and partnership agreements and protocols for timely transfer between level 1, 2, 3, and 4 obstetric facilities	4,452,263	-	**4,452,263**
4.5	Implement all component components to the AIM bundles	4,452,263	-	**4,452,263**
4.6	Monitor and address barriers to improvement for TJC PC-02	4,452,263	-	**4,452,263**
4.7	Implement 4 QI activities to address barriers in reaching 80% on process measures on The Gift Survey and Mother Survey	4,452,263	-	**4,452,263**
4.8	Attend at least 4 coaching calls for The Gift	4,452,263	-	**4,452,263**
4.9	Develop and implement processes to address The Gift Guidelines for the Marketing of Breast-Milk Substitutes (GMBS) except for the purchase of formula, etc.	4,452,263	-	**4,452,263**
4.10	Repeat Gift staff and mother surveys to assess for improvements	4,452,263	-	**4,452,263**
5.1	Monitor and sustain use of risk stratification tools, referral and adherence to facility-based protocols	3,594,974	-	**3,594,974**
5.2	Monitor completed gestational weeks at delivery to support and maintain evaluation; assess impacts on preterm birth	3,594,974	-	**3,594,974**
5.3	Sustain, scale, and study changes from PQC change package	3,594,974	-	**3,594,974**
5.4	Support changes supporting agreements and coordination within and between birth facilities and health system emergency rooms	3,594,974	-	**3,594,974**
5.5	Monitor and address barriers to improvement for TJC PC-02	-	-	**3,594,974**
5.6	Repeat The Gift GMBS check-off tool (except for the purchase of formula, etc.)	3,594,974	-	**3,594,974**
5.7	Implement 4 QI activities to address barriers in reaching or sustaining 80% of process measures on The Gift and Mother Surveys	3,594,974	-	**3,594,974**

Milestone Number	LQN Milestone Description*	Amount Paid for Milestone Achievement	Amount Paid for Non-Milestone Activities	Total Amount Paid for Milestone
5.8	Repeat The Gift staff and mother surveys for improvements	-	-	-
Total Paid**		**$240,907,581**	**$9,209,680**	**$250,117,261**

* We did not correct any misspellings or grammatical issues in the milestone descriptions received from LDH.
** The sum of the individual rows does not equal the total due to rounding.
Source: Prepared by legislative auditor's staff using information from LDH.

Milestone Number	QIN Milestone Description*	Amount Paid for Milestone Achievement	Amount Paid for Non-Milestone Activities	Total Amount Paid for Milestone
1.1	Identify prenatal care treatment gaps specific to Healthy Louisiana enrollees ages 15-45.	$7,355,073	$306,461	**$7,661,534**
1.2	Create and disseminate protocols for network obstetricians/gynecologists ("OB/GYNs") regarding prenatal services for enrollees ages 15-45 and conduct training and education activities.	7,355,073	306,461	**7,661,534**
1.3	Identify ideas to improve prenatal healthcare services for Healthy Louisiana enrollees ages 15-45	7,355,073	306,461	**7,661,534**
1.4	Identify and study root causes for insufficient prenatal care for Healthy Louisiana enrollees ages 15-45.	7,355,073	306,461	**7,661,534**
2.1	Conduct ongoing training and education activities for network OB/GYNs regarding recommended prenatal care services for enrollees ages 15-45 and measure baseline percentage of network primary care providers ("PCPs") and OB/GYNs meeting protocol criteria.	5,513,964	415,030	**5,928,993**
2.2	Implement activities designed to address treatment gaps and root causes for insufficient prenatal care.	5,513,964	415,030	**5,928,993**
2.3	Analyze methods to improve prenatal care visits for enrollees ages 15-45 and revise protocols as needed.	5,513,964	415,030	**5,928,993**
2.4	Measure baseline percentage of nulliparous enrollees with a term, singleton baby in a vertex position delivered by cesarean birth (C-section).	5,513,964	415,030	**5,928,993**
2.5	Measure baseline percentage of enrollees with elective vaginal deliveries or elective cesarean sections at ≥37 and <39 weeks of gestation completed.	5,513,964	415,030	**5,928,993**
2.6	Measure baseline percentage of enrollees with live births that weighed less than 2,500 grams.	5,513,964	415,030	**5,928,993**
2.7	Create continuous quality improvement plan, including information identifying impact of incentive arrangement, lessons learned, opportunities to scale incentive arrangement to a broader population, and key challenges associated with expansion of incentive arrangement.	5,513,964	415,030	**5,928,993**
3.1	Continue activities designed to address treatment gaps and root causes for insufficient prenatal care.	6,374,650	708,294	**7,082,944**
3.2	Continue to analyze methods to improve prenatal healthcare services for enrollees ages 15-45 and revise protocols as needed.	6,374,650	708,294	**7,082,944**

Milestone Number	QIN Milestone Description*	Amount Paid for Milestone Achievement	Amount Paid for Non-Milestone Activities	Total Amount Paid for Milestone
3.3	Decrease percentage of nulliparous enrollees with a term, singleton baby in a vertex position delivered by cesarean birth (C-section), to a defined target set by LDH in consultation with MCO.	$6,374,650	$708,294	**$7,082,944**
3.4	Decrease percentage of enrollees with elective vaginal deliveries or elective cesarean sections at ≥37 and <39 weeks of gestation completed, to a defined target set by LDH in consultation with MCO.	6,374,650	708,294	**7,082,944**
3.5	Decrease percentage of enrollees with live births that weighed less than 2,500 grams, to a defined target set by LDH in consultation with MCO.	6,374,650	708,294	**7,082,944**
3.6	Conduct continuous quality improvement activities during Year Three.	6,374,650	708,294	**7,082,944**
4.1	Continue activities designed to address treatment gaps and root causes for insufficient prenatal care.	5,550,639	616,738	**6,167,376**
4.2	Continue to analyze methods to improve prenatal visits for enrollees ages 15-45 and revise protocols as needed.	5,550,639	616,738	**6,167,376**
4.3	Additional decrease in percentage of percentage of nulliparous enrollees with a term, singleton baby in a vertex position delivered by cesarean birth (C-section), to a defined target set by LDH in consultation with MCO.	-	-	**-**
4.4	Additional decrease in percentage of enrollees with elective vaginal deliveries or elective cesarean sections at ≥37 and <39 weeks of gestation completed, to a defined target set by LDH in consultation with MCO.	-	-	**-**
4.5	Additional decrease in percentage of enrollees with live births that weighed less than 2,500 grams, to a defined target set by LDH in consultation with MCO.	-	-	**-**
4.6	Conduct continuous quality improvement activities during Year Four.	5,550,639	616,738	**6,167,376**
5.1	Continue activities designed to address treatment gaps and root causes for insufficient prenatal care.	-	-	**-**
5.2	Continue to analyze methods to improve prenatal visits for enrollees ages 15-45 and revise protocols as needed.	-	-	**-**
5.3	Additional decrease in percentage of percentage of nulliparous enrollees with a term, singleton baby in a vertex position delivered by cesarean birth (C-section), to a defined target set by LDH in consultation with MCO.	-	-	**-**

Milestone Number	QIN Milestone Description*	Amount Paid for Milestone Achievement	Amount Paid for Non-Milestone Activities	Total Amount Paid for Milestone
5.4	Additional decrease in percentage of enrollees with elective vaginal deliveries or elective cesarean sections at ≥37 and <39 weeks of gestation completed, to a defined target set by LDH in consultation with MCO.	-	-	-
5.5	Additional decrease in percentage of enrollees with live births that weighed less than 2,500 grams, to a defined target set by LDH in consultation with MCO.	-	-	-
5.6	Conduct continuous quality improvement activities during Year Five.	-	-	-
Total Paid**		**$122,917,849**	**$10,231,031**	**$133,148,881**

* We did not correct any misspellings or grammatical issues in the milestone descriptions received from LDH.
** The sum of the individual rows does not equal the total due to rounding.
Source: Prepared by legislative auditor's staff using information from LDH.