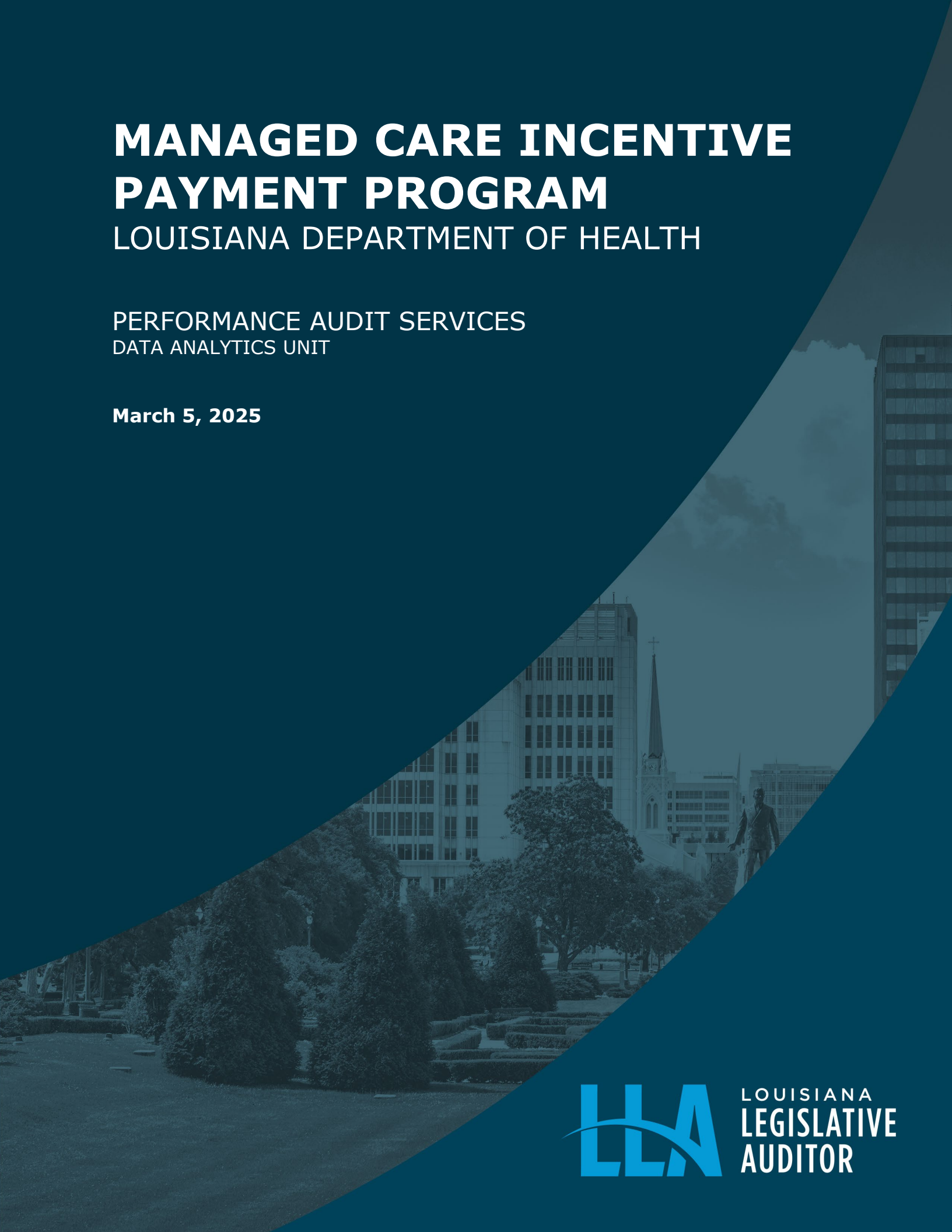
MANAGED CARE INCENTIVE PAYMENT PROGRAM

LOUISIANA DEPARTMENT OF HEALTH

PERFORMANCE AUDIT SERVICES
DATA ANALYTICS UNIT

March 5, 2025



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LOUISIANA LEGISLATIVE AUDITOR

MICHAEL J. "MIKE" WAGUESPACK, CPA
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March 5, 2025

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 evaluation of the Louisiana Department of Health's (LDH) design and oversight of the Medicaid Managed Care Incentive Payment (MCIP) Program which totaled $2.39 billion from September 2019 through March 2024.

Overall, we found that LDH's design and lack of oversight of the MCIP program led to the majority of MCIP program funds being paid for activities that do not have a direct, measurable result for how they improve access to healthcare, improve quality of care, or enhance the health of Medicaid beneficiaries.

Specifically, we found that LDH's design of the MCIP program allowed two separate Quality Networks comprised of different hospitals because competing hospitals did not want to operate as a single network. The networks – Louisiana Quality Network (LQN) and Quality and Outcome Improvement Network (QIN) – are referred to collectively as the Quality Networks.

LDH also required the Quality Networks to have different Approved Incentive Arrangements (AIAs) and milestones, resulting in hospitals in each network striving for different outcomes.

We found that LDH requests Intergovernmental Transfers (IGTs) to fund the MCIP program. Contracts between the Quality Networks and participating hospitals allow the Quality Networks to repay contributing entities for IGTs sent to LDH to fund the non-federal share of the MCIP program. LDH's process of using IGTs allowed LDH to obtain an additional $1.93 billion in federal Medicaid funds without using any state general fund dollars and without the risk that contributing entities would not be repaid for the funds used for IGTs.

LDH's design of the MCIP program prioritizes funding for non-milestone activities. Specifically, LDH paid $437.2 million (18.3%) of the $2.39 billion total MCIP program payments for reporting results timely, submitting annual reports, and holding annual meetings.

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Additionally, LDH paid $1.51 billion (63.3%) for non-measurable milestones and $440.2 million (18.4%) for achieving measurable milestones.

We also found that LDH does not monitor how MCIP program funds are used by the MCOs or the Quality Networks. Because of this lack of oversight, we reviewed the use of these funds and found that $1.08 billion (45.3%) of the $2.39 billion total MCIP funds paid by LDH were used for activities other than incentive payments to participating hospitals.

In addition, QIN's contract for management services may violate the Louisiana State Constitution because there is no documentation to support the actual services rendered.

We would like to express our appreciation to LDH, LQN, and QIN for their assistance during this project.

Respectfully submitted,

Michael J. "Mike" Waguespack, CPA
Legislative Auditor

MJW/aa

MCIP

Louisiana Legislative Auditor

Michael J. "Mike" Waguespack, CPA

Managed Care Incentive Payment Program
Louisiana Department of Health

March 2025

Audit Control #40230039

Introduction

We evaluated the Louisiana Department of Health's (LDH) design and oversight of the Medicaid Managed Care Incentive Payment (MCIP) program. We conducted this evaluation because the MCIP program, which is funded by both federal and non-federal funds, is LDH's most expensive incentive program related to improving the quality of healthcare in Louisiana. The MCIP program's total cost from September 2019 through March 2024 was approximately $2.39 billion, or five times more than LDH's managed care-based quality withhold incentive program.[1,2]

LDH's MCIP program is designed to provide incentive payments for quality reforms that increase access to health care, improve the quality of care, or enhance the health of patients and families the MCOs serve. LDH designed the program based on its evaluation of the Medicaid program and its Quality Strategy.

Louisiana has been named by America's Health Rankings[3] 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. Each state's 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 that are not within the control of LDH. Further, Louisiana was ranked 49th in 2019, the year the MCIP program began, and was most recently ranked 50th in 2023.

MCIP Program Creation. A federal regulation[4] revised in 2016 provided LDH with the ability to allow its Managed Care Organizations (MCOs)[5] to participate

[1] Under the quality withhold incentive program, LDH withholds 1.0% of each Managed Care Organization's (MCO) per-member per-month (PMPMs) payments for incentivized performance measures where the MCOs can earn the 1.0% withhold by meeting targets established by LDH or by improving their performance by 2.0% for each performance measure from one year to the next. LDH also has programs to withhold 0.5% of PMPMs for a value-based payment reimbursement program and to withhold 0.5% of PMPMs for a health equity strategies program.

[2] The quality withhold incentive program is discussed in detail in the previous LLA audit Oversight of Medicaid Quality Care.

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

[4] 42 Code of Federal Regulations (CFR) 438.6(b)(2)

[5] LDH pays a PMPM premium to six private insurance companies (prior to January 2023 LDH was contracted with five MCOs) to serve as MCOs to manage the care of Medicaid beneficiaries enrolled in their plans and to pay for their Medicaid services.

in incentive arrangements that provide payment of up to 5.0% above the approved annual capitation payments,[6] known as per-member per-month fees (PMPMs). These arrangements must be for a fixed period of time and specify activities, targets, performance measures, or quality-based outcomes that support program initiatives specified in LDH's federally-required[7] Quality Strategy. Pursuant to this regulation, LDH was required to involve the MCOs in the MCIP program and to design the program so that MCIP payments made by LDH would go to the MCOs. In February 2018, LDH began implementing the MCIP program by amending its MCO contracts to include the MCIP program as a voluntary incentive program. Following this amendment, the Louisiana Legislature requested through House Resolution 252 of the 2018 Regular Legislative Session[8] that LDH require all MCOs to participate in the MCIP program. In response to this request, LDH made MCO participation mandatory effective January 2020.

MCIP Program Entities and Roles. LDH designed the MCIP program to be included as part of the MCO's managed care contracts. The MCOs subcontracted with two separate hospital networks, the Louisiana Quality Network (LQN)[9] and the Quality and Outcome Improvement Network (QIN) (collectively referred to as the "Quality Networks"), to operate the MCIP program on their behalf. These Quality Networks were established to manage milestone activities and distribute MCIP funding received from the MCOs to the participating hospitals that conduct activities to achieve MCIP program goals. All six MCOs currently contract with both Quality Networks to assist in achieving the MCIP program goals. See Appendix C for a listing of LQN's 24 participating hospitals and QIN's 37 participating hospitals as of January 2024 according to LDH.

According to the MCOs, they have very little involvement with the MCIP program and primarily provide LDH with reports they receive from the Quality Networks and send MCIP funding they receive from LDH to the Quality Networks. This differs from statements made by LDH staff, who stated that the program is operated by the MCOs. However, it appears that the Quality Networks are the entities that actually oversee all services performed for the program, which they do with limited direct oversight from LDH or the MCOs. See Exhibit 1 for entities involved in the MCIP program and their roles.

[6] This allows PMPMs and incentive payments combined to total 105.0% of the approved annual capitation payments.
[7] 42 CFR 438.340. The Quality Strategy is LDH's written strategy created to assess and improve the quality of healthcare and services provided by MCOs for Medicaid beneficiaries.
[8] https://legis.la.gov/legis/ViewDocument.aspx?d=1099289
[9] Unlike QIN, LQN is not a legal entity. Due to this, LQN's contracts are between the MCOs, Louisiana State University Health Sciences Center New Orleans (LSUHSC), and the participating hospitals. As a result, any references to Quality Network contracts related to LQN in this report are referring to this contractual relationship.

Exhibit 1 MCIP Program Entities' Roles	
Entity	**Role**
LDH	State Medicaid agency that designed and oversees the administration of the MCIP program and approved the Approved Incentive Arrangements (AIAs) chosen by the Quality Networks and the milestones created by the Quality Networks that were consistent with LDH's Quality Strategy. LDH reviews achievement reports and supporting documentation submitted by the Quality Networks through the MCOs (on a quarterly and annual basis) to verify the reported milestone achievements. LDH has audit authority over all entities involved, which is provided within contracts between LDH and the MCOs, the MCOs and the Quality Networks, and the Quality Networks and the participating hospitals.
MCOs	Each MCO has the option to participate in the MCIP program and to determine which AIAs they participate in. The MCOs contract with third-party Quality Networks to operate MCIP.
Quality Networks (LQN and QIN)	Help develop the MCIP program, provide necessary resources, and assist in the program's operation and maintenance. Contract with hospitals to develop a network of providers aiming to achieve the AIA milestones. Collect documentation and submit results to the MCOs to support the achievement of milestones.
Contributing Entities	Transfer funding to LDH for use as non-federal share of MCIP payments. Includes Louisiana State University Health Sciences Center New Orleans (LSUHSC) for LQN and Southern Regional Medical Corporation (SRMC) and Hospital Service District #1 of Terrebonne Parish for QIN.
Participating Hospitals	Contract with/to participate in the Quality Networks to implement and conduct the work outlined in the AIAs. Submit information to the Quality Networks to support the achievement of milestones.
Source: Prepared by legislative auditor's staff using information from LDH and the Quality Networks.	

MCIP Milestones and Payments. MCOs receive incentive payments for annual AIA milestones achieved by each Quality Network. LDH designed the MCIP program so that each Quality Network has different AIAs and allowed each Quality Network to create their milestones with MCO input. LDH then approved these AIAs and milestones, which represent the areas of focus to increase access to health care, improve quality of care, and enhance the health of Medicaid beneficiaries. For example, one AIA is focused on improving breast cancer screening rates in Louisiana. An example of a milestone for this AIA is "to establish a multi-disciplinary cancer steering committee, including bylaws and membership." LDH, as the State Medicaid agency, has the sole authority to determine the achievement of milestones and the amount and timing of MCIP program payments. Although LDH did not develop the milestones, LDH did develop the criteria to evaluate the achievement of milestones for each Quality Network's AIAs. See Appendix D for a list of LQN's AIAs, milestones, and payments and Appendix E for a list of QIN's AIAs, milestones, and payments.

The objective of this evaluation was:

To evaluate LDH's design and oversight of the MCIP program.

Our results are summarized on pages 5 through 6 and discussed in detail throughout the remainder of the report. Appendix A-1 contains LDH's response, Appendix A-2 contains LQN's response, and Appendix A-3 contains QIN's response. Appendix B details our scope and methodology. Appendix C lists participating hospitals in each Quality Network as of January 2024, according to LDH. Appendix

D lists the AIAs, milestones, and payments for LQN, while Appendix E lists the AIAs, milestones, and payments for QIN. Appendix F shows the entire flow of MCIP funds to and from each entity involved in the MCIP program from September 2019 through June 2024. Appendix G shows the amounts paid by LQN to each participating hospital from April 2020 through June 2024, while Appendix H shows the amounts paid by QIN to each participating hospital from December 2019 through February 2024.

Objective: To evaluate LDH's design and oversight of the MCIP program.

Overall, we found that LDH's design and lack of oversight of the Managed Care Incentive Payment (MCIP) program led to the majority of MCIP program funds being paid for activities that do not have a direct, measurable result for how they improve access to healthcare, improve quality of care, or enhance the health of Medicaid beneficiaries. Specifically, we found the following:

- **LDH's design of the MCIP program allowed the use of two separate Quality Networks comprised of different hospitals because competing hospitals did not want to operate as a single network. LDH also required the Quality Networks to have different AIAs and milestones, resulting in hospitals in each network striving for different outcomes.** LDH approved different AIAs and milestones proposed by the two Quality Networks so their performance could not be compared, which would prevent disagreements regarding the amount of funding each network should receive.

- **LDH requests Intergovernmental Transfers (IGTs) for milestones achieved by the Quality Networks. Contracts between the Quality Networks and participating hospitals allow the Quality Networks to repay contributing entities for IGTs sent to LDH to fund the non-federal share of the MCIP program.** LDH's process of using IGTs allowed LDH to obtain an additional $1.93 billion in federal Medicaid funds without using any state general fund dollars and without the risk that contributing entities would not be repaid for the funds used for IGTs.

- **LDH's design of the MCIP program prioritizes funding for non-milestone activities. Specifically, LDH paid $437.2 million (18.3%) of the $2.39 billion total MCIP program payments for reporting results timely, submitting annual reports, and holding annual meetings. In addition, LDH paid $1.51 billion (63.3%) for non-measurable milestones and $440.2 million (18.4%) for achieving measurable milestones.** Increasing the dollars associated with measurable milestones that demonstrate improvement in the quality of services would help LDH meet the purpose of the MCIP program.

- **LDH does not monitor how MCIP program funds are used by the MCOs or the Quality Networks. Because of this lack of oversight, we reviewed the use of these funds and found that $1.08 billion (45.3%) of the $2.39 billion total MCIP funds paid**

by LDH were used for activities other than incentive payments to participating hospitals. In addition, QIN's contract for management services may violate the Louisiana State Constitution because there is no documentation to support the actual services rendered.

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

LDH's design of the MCIP program allowed the use of two separate Quality Networks comprised of different hospitals because competing hospitals did not want to operate as a single network. LDH also required the Quality Networks to have different AIAs and milestones, resulting in hospitals in each network striving for different outcomes.

The MCIP program is LDH's largest and most expensive incentive program related to improving the quality of healthcare in Louisiana. The MCIP program's total cost from September 2019 through March 2024 was approximately $2.39 billion.

Louisiana has two separate Quality Networks[10] due to competing hospital systems not wanting to operate as a single network. According to former LDH staff, Quality and Outcome Improvement Network (QIN) staff, and other stakeholders interviewed as part of this evaluation, consultants affiliated with QIN approached LDH with the idea of establishing the MCIP program in 2016. However, LDH declined to start the MCIP program at that time. In 2017, momentum built around establishing the MCIP program because of the additional federal funding the program could draw down for Louisiana, especially as the LSU Health Shreveport hospital was on the verge of closure due to mismanagement and financial insolvency. According to a former high-ranking LDH employee and QIN's consultants, who also represent the Ochsner Clinic Foundation (Ochsner), LDH created a plan to prevent the closure of the LSU Health

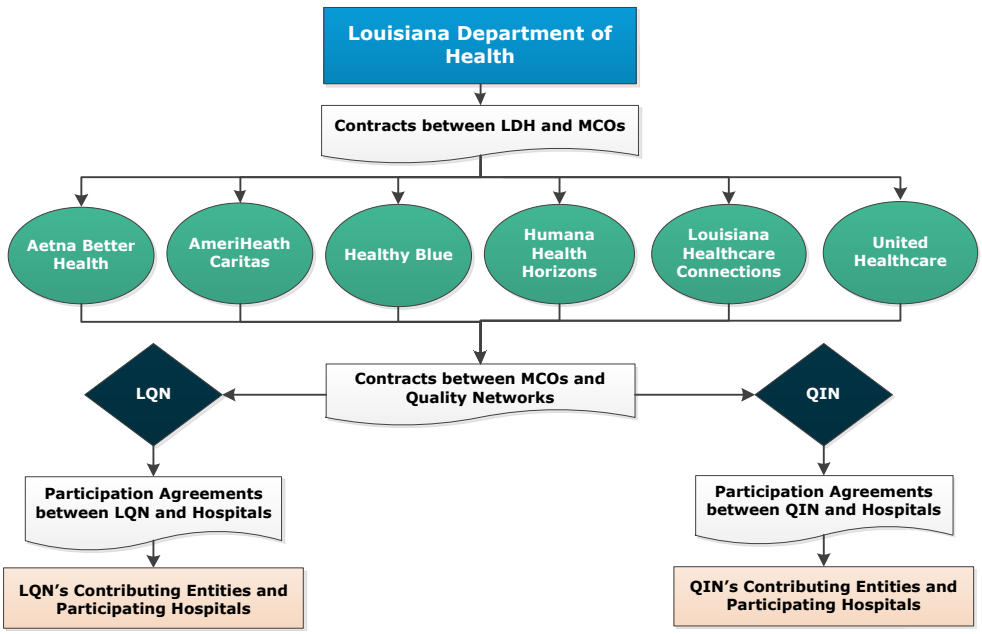
It is difficult to determine whether other states use more than one network because the Centers for Medicare and Medicaid Services (CMS) does not require states to submit amendments to their Medicaid plans in order to implement this type of incentive program. We contacted CMS to obtain a list of other states using similar incentive programs, but CMS stated that it does not maintain a list and does not know how states utilizing these types of programs structure them.

[10] Louisiana Quality Network (LQN) and the Quality and Outcome Improvement Network (QIN) (collectively referred to as the "Quality Networks").

Shreveport hospital through the use of MCIP funds.[11]

The initial plan for the MCIP program was for all hospitals willing to participate throughout the state to join a single network through QIN; however, competition between various hospitals prevented all hospitals from working together. Instead, the hospitals that did not want to join the QIN network combined to create a second network named the Louisiana Quality Network (LQN). QIN is administered by consultants hired by Ochsner and primarily consists of hospitals in the Ochsner Health System or hospitals that are managed by Ochsner. LQN's network is administered by LSUHSC New Orleans and is comprised primarily of Franciscan Missionaries of Our Lady Health System hospitals, Louisiana Children's Medical Center hospitals, and Willis-Knighton Health System hospitals. Exhibit 2 details the relationships between the various entities involved in LDH's MCIP program.

Exhibit 2
MCIP Program Entity Relationships



Source: Prepared by legislative auditor's staff using information from LDH, the MCOs, and the Quality Networks.

LDH designed the MCIP program so that each Quality Network has different AIAs and allowed each Quality Network to create their own milestones. As a result, hospitals in each Quality Network are striving for different outcomes, and each Quality Network's performance cannot be compared to the other. LDH had the Quality Networks choose different AIAs and allowed them to design their own milestones with MCO input, which LDH then

[11] In addition to the LSU Health Shreveport hospital receiving MCIP funding, Ochsner took over the management of the LSU Health Shreveport and LSU Health Monroe hospitals in 2018.

approved. For example, LQN has an AIA focusing on improving breast cancer screenings, but QIN does not. Conversely, QIN has an AIA focusing on improving outcomes for diabetic members, but LQN does not. According to a former high-ranking LDH employee and QIN's consultants, LDH chose to use different AIAs for each of the Quality Networks so their performance could not be compared. This former employee also stated that this was done to prevent disagreements regarding the payments each Quality Network should receive based on their performance, such as if one Quality Network improved their breast cancer screenings at a higher rate than the other one.

According to current MCO staff and staff from each Quality Network, they would prefer that the Quality Networks have the same AIAs so the entire state is striving for one goal and so their performance can be compared. Instead, hospitals in close proximity may be striving to achieve different AIAs and milestones depending on their Quality Network. For example, St. Francis Medical Center (in LQN) and Ochsner Monroe Medical Center (in QIN) are just over four miles apart in Monroe, Louisiana, but pursue different AIAs. Exhibit 3 shows the AIAs for each Quality Network. Appendix D lists the AIAs, milestones, and payments for LQN, while Appendix E lists them for QIN.

Exhibit 3
Quality Network AIAs

LQN	QIN
Address the Opioid Epidemic Through Multiple Care Settings	Emergency Department Utilization
Improve Breast Cancer Screening	Improve Lung Cancer Screening
Improve Maternal and Perinatal Outcomes	Improve Maternal Care
Improve Prevention, Screening, and Treatment of Childhood Obesity	Improve Outcomes for Diabetic Members
Improve Receipt of Global Developmental and Autism Screening in the First Three Years of Life	Improve Outcomes for Members with Hypertension
Promote Evidence Based Practice and Reduce Low Value Care through Network Graduate Medical Education/Continuing Medical Education Partnerships	Improve Tobacco Cessation
Reduce Inappropriate Emergency Department Utilization	Palliative and Hospice Care
Reduce Preventable Hospital Readmissions	Pediatric Primary Care Utilization

Source: Prepared by legislative auditor's staff using information from LDH and the Quality Networks.

Recommendation 1: LDH should evaluate the structure of its MCIP program and consider whether it should consolidate the AIAs to have a uniform plan for the MCIP program to improve the quality of care provided in Louisiana.

Summary of Management's Response: LDH agreed with this recommendation and stated that it has already evaluated the structure of the current MCIP program in order to align the program with the current

administration's goals and priorities. LDH will have uniform AIAs in order for both Quality Networks to focus on improving the same quality metrics and outcomes, which should improve the quality of care that Medicaid members receive and provide for a comparison of outcomes. See Appendix A-1 for LDH's full response.

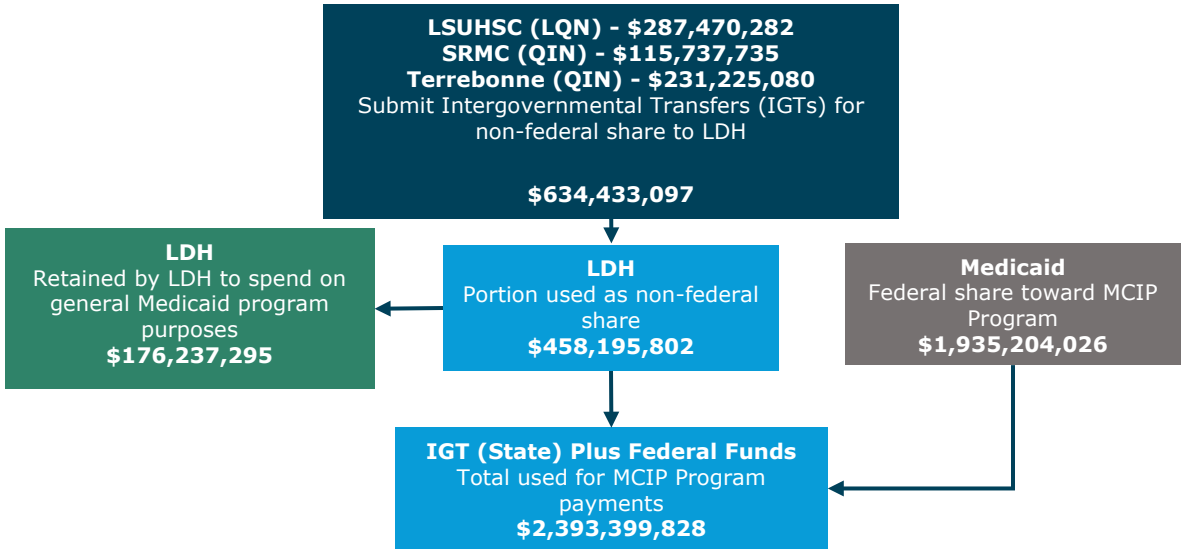
LDH requests IGTs for milestones achieved by the Quality Networks. Contracts between the Quality Networks and participating hospitals allow the Quality Networks to repay contributing entities for IGTs sent to LDH to fund the non-federal share of the MCIP program.

LDH receives federal Medicaid funding to pay for the MCIP program, but federal regulations[12] require LDH to contribute a portion (non-federal share)[13] to obtain this federal funding. Instead of using state general funds for the non-federal share, LDH uses intergovernmental transfers (IGTs)[14] received from LSUHSC (for LQN), Southern Regional Medical Corporation (SRMC)[15] (for QIN), and Hospital Service District #1 of Terrebonne Parish (Terrebonne) (for QIN) to fund the MCIP program's non-federal share.

The Quality Networks submit quarterly reports documenting the achievement of milestones for each AIA. In accordance with LDH policy, LDH reviews these reports and determines which milestones were met. LDH staff then calculate payments for each Quality Network's milestones and sends a request to each Quality Network for funding that must be provided to LDH for the non-federal share. The contributing entities for each Quality Network send the non-federal share to LDH via IGTs. LDH retains a portion of the IGTs to fund general Medicaid programs and uses the remaining IGT funds to obtain federal funds and pay the MCOs. Exhibit 4 details the flow of funds through this process. How these funds are then distributed will be discussed later in this report.

[12] 42 CFR 433.50 – 433.74
[13] According to CMS, the non-federal share is required by federal regulations so the state has a responsibility for ensuring that state and federal funds are properly used and to minimize possible fraud, waste, and abuse.
[14] IGTs are financial transfers between levels of government to support public spending.
[15] SRMC is a quasi-public entity incorporated by Terrebonne and managed by Ochsner.

Exhibit 4
MCIP IGTs and Sources of Funds
September 2019 through March 2024



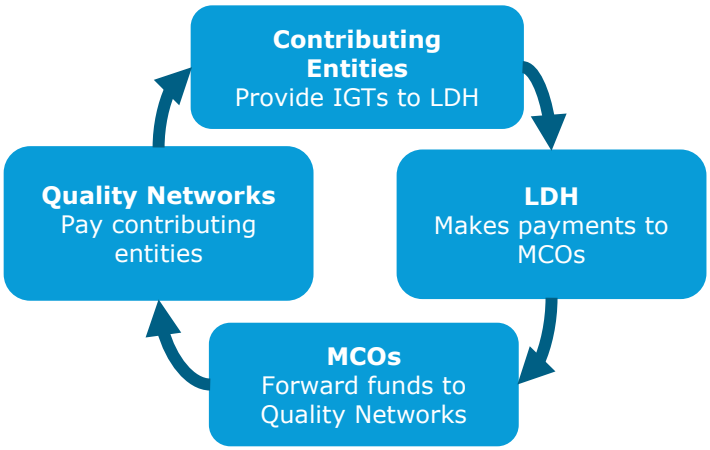
Source: Prepared by legislative auditor's staff using information from LDH, the MCOs, and the Quality Networks.

LDH requests IGTs for milestones achieved by the Quality Networks to fund the MCIP program. Contracts between the Quality Networks and participating hospitals allow the Quality Networks to repay contributing entities for IGTs sent to LDH to fund the non-federal share of the MCIP program. The United States Government Accountability Office (GAO) has found[16] that state governments finance their non-federal share of Medicaid expenditures in this manner. According to the GAO, states heavily rely on local government funds to finance payments such as those for the MCIP program. By doing this, states are able to shift the responsibility for financing a greater share of Medicaid payments to the Federal government. Contracts between the Quality Networks and participating hospitals allow the Quality Networks to repay the IGTs provided by the contributing entities for the non-federal share. According to each Quality Network's accounting records, the IGTs used to fund the non-federal share are ultimately returned to the contributing entities by the Quality Networks. Exhibit 5 details how IGTs are sent from and returned to the contributing entities.

[16] https://www.gao.gov/assets/gao-20-571r.pdf

LDH's process of using IGTs allowed LDH to obtain $1.93 billion in federal Medicaid funds without using any state general fund dollars and without the risk that contributing entities would not be repaid for the funds used for IGTs. Because the contributing entities receive funds from the Quality Networks that can be used to repay the funds used for their IGTs, they are able to provide their IGTs to LDH at no risk to their normal operations. The GAO states that oversight of the use of IGTs is important to ensure payments such as those in the MCIP program are made in an efficient and economical manner. However, LDH stated that it has not monitored how funds are used after it makes payment to the MCOs.

Exhibit 5
Flow of IGT Funds



Source: Prepared by legislative auditor's staff using information from LDH, the MCOs, and the Quality Networks.

LDH's design of the MCIP program prioritizes funding for non-milestone activities. Specifically, LDH paid $437.2 million (18.3%) of the $2.39 billion total MCIP program payments for reporting results timely, submitting annual reports, and holding annual meetings. In addition, LDH paid $1.51 billion (63.3%) for non-measurable milestones and $440.2 million (18.4%) for achieving measurable milestones.

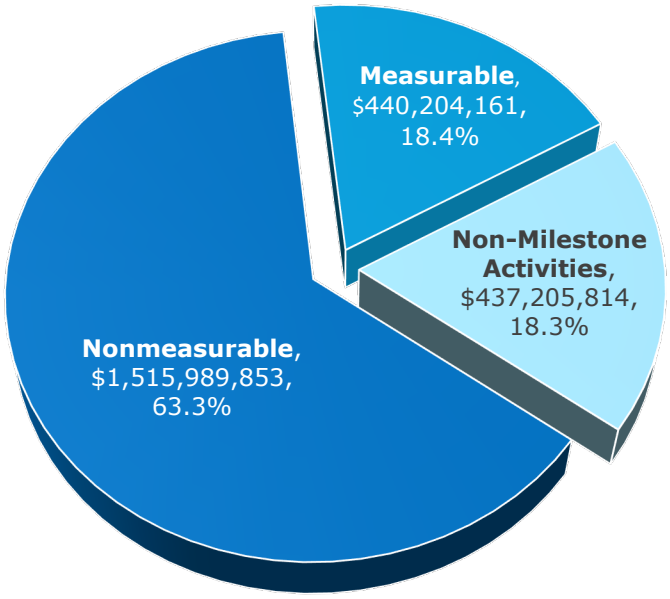
We reviewed AIA milestones and payments and found that LDH makes MCIP payments for non-milestone activities, such as holding annual meetings, which do not directly affect quality of care. We also found that, for most AIAs, LDH makes payments for two to three years prior to requiring any measurable quality outcome improvement to occur. LDH makes payments for activities and milestones in the three categories below, and Exhibit 6 shows the amount of payments in these categories.

- ***Non-milestone activities*** – this includes reporting results timely, submitting annual reports, and holding annual meetings.

- ***Non-measurable milestones*** – milestones where outcomes cannot be measured on a provider-specific basis, such as implementing a new protocol.

- ***Measurable milestones*** – milestones where outcomes can be measured on a provider-specific basis, such as enrollment of patients by a provider in a registry.

Exhibit 6
Categories of LDH MCIP Payments
September 2019 through March 2024



Source: Prepared by legislative auditor's staff using information from LDH and the Quality Networks .

LDH's design of the MCIP program places decreased importance on meeting milestones and prioritizes funding activities that do not directly affect quality. LDH paid approximately $437.2 million (18.3%) of the $2.39 billion total MCIP program payments from September 2019 through March 2024 for non-milestone activities that do not directly improve the quality of services for Medicaid beneficiaries. According to LDH's MCIP payment policy, LDH pays for non-milestone activities first and uses the remaining budgeted MCIP program funds to pay for the measurable and non-measurable milestones achieved in the program annually. Non-milestone activities include reporting results timely, submitting annual reports, and holding annual meetings. Per LDH policy, the percentage of MCIP funds dedicated to each of these AIAs increased from 12.0% in year one (4.0% for each of the three tasks) to 30.0% (10.0% for each of the three tasks) in years three through five, which increased the total amount earned for these activities over time. See Exhibit 7 for the amounts paid by LDH during calendar years 2019 through 2024.

Exhibit 7
MCIP Payments for Annual Meetings and Submitting Reports
Calendar Years 2019 through 2024

Calendar Year	LQN	QIN	Total
2019	$0	$13,413,790	**$13,413,790**
2020	41,285,323	33,592,408	**74,877,731**
2021	21,873,941	45,445,725	**67,319,666**
2022	56,201,984	52,785,490	**108,987,474**
2023	48,503,233	121,087,086	**169,590,319**
2024*	3,016,834	0	**3,016,834**
Total	**$170,881,315**	**$266,324,499**	**$437,205,814**

* This year is less than the other years because of the timing of our analysis.
Source: Prepared by legislative auditor's staff using information from LDH.

According to current LDH staff, they do not know why the MCIP program was designed to prioritize funding for non-milestone activities that do not directly improve the quality of services. However, a former high-ranking LDH employee stated that the MCIP program was designed this way so that LDH could immediately make a payment for QIN submitting an annual report, allowing QIN to provide the LSU Health Shreveport hospital with the funding required to continue operations.

Approximately $1.51 billion (63.3%) of the $2.39 billion total MCIP program payments made by LDH were for non-measurable milestones that are not directly associated with measurable quality outcomes. Quality Network staff stated that these non-measurable milestones indirectly contribute to measurable quality outcomes. LDH's MCIP program includes AIAs that are established for five-year periods, during which only the last two to three years generally have milestones that measure success in terms of outcomes resulting from services delivered to Medicaid beneficiaries. In the first two to three years of an AIA, payments are primarily made for administrative items such as developing plans and policies, creating flowcharts, distributing educational materials, holding award conferences, and establishing performance goals. For example, LDH paid $4,901,574 for the LQN milestone to "Hold [the] first EBP challenge Awards/Conference" for its Evidence-Based Practices AIA. LDH also paid $7,355,073 for the QIN milestone "Identify ideas to improve prenatal healthcare services for Healthy Louisiana enrollees ages 15-45" as part of its Maternal Care AIA.

We found that approximately $440.2 million (18.4%) of the $2.39 billion total MCIP payments made by LDH were for achieving measurable milestones that are directly associated with outcome-based quality improvements. This category of milestones represents the directly measurable results that the MCIP program is designed to achieve through its focus of increasing access to health care, improving quality of health care, and enhancing the health of Medicaid beneficiaries. For example, LDH paid $5,990,813 for the LQN milestone to "Measure changes in rates of process and outcome measures for Post-Hospitalization Protocol, as improvements made" as part of its Preventable Readmissions AIA. LDH also paid $5,463,985 for the QIN milestone "Increase [the]

percentage of members participating in activities designed to reduce members with BP poor control" as part of its Diabetes AIA. Increasing the dollars associated with measurable milestones that demonstrate improvement in the quality of services would help LDH meet the purpose of the MCIP program.

> **Recommendation 2:** LDH should re-evaluate its policy detailing the percentage of MCIP funds it pays for non-milestone activities that do not directly affect quality of care, such as reporting results timely and holding annual meetings.
>
> **Recommendation 3:** LDH should consider updating its milestones to place more emphasis on measurable results that document improvement in the direct quality of care received by Medicaid beneficiaries in each year, rather than the last two or three years of an AIA's five-year cycle.
>
> **Summary of Management's Response:** LDH agreed with these recommendations and stated that it has begun the re-evaluation of its MICP protocols and will no longer pay for non-milestone activities that do not directly affect quality of care. LDH will only incentivize measurable milestones, which will focus on LDH's priorities in each year of the AIAs. See Appendix A-1 for LDH's full response.

LDH does not monitor how MCIP program funds are used by the MCOs or the Quality Networks. Because of this lack of oversight, we reviewed the use of these funds and found that $1.08 billion (45.3%) of the $2.39 billion total MCIP funds paid by LDH were used for activities other than incentive payments to participating hospitals.

The GAO has highlighted the importance of good data on programs such as LDH's MCIP program to determine whether program payments are efficient and economical. However, LDH has not monitored how the MCOs or Quality Networks have used MCIP program funds despite having the authority to do so. Because of this, we obtained documentation from all six MCOs[17] and the Quality Networks[18] to identify the entities ultimately receiving MCIP funds.

As mentioned previously, between September 2019 and March 2024, LDH made MCIP program payments totaling $2.39 billion to the MCOs. We found that

[17] We obtained copies of contracts between the MCOs and Quality Networks and reports of all payments made by the MCOs to the Quality Networks.
[18] We obtained copies of contracts between the Quality Networks and participating hospitals, QIN's management agreement, and accounting reports documenting the receipt and expenditure of MCIP funds by the Quality Networks.

the MCOs retain 3.0% of all MCIP payments made by LDH as an administrative fee and pay the remaining MCIP funds (97.0%) to the Quality Networks. A portion of those funds are then paid by the Quality Networks to the participating hospitals as incentive payments for achieving milestones. From September 2019 through March 2024, the administrative fees retained by the six MCOs totaled $71,805,138. Exhibit 8 details the total administrative fees retained by each MCO during this timeframe.

Exhibit 8
Administrative Fees Retained by Each MCO
September 2019 through March 2024

MCO	Total
Aetna Better Health of Louisiana	$6,508,821
AmeriHealth Caritas of Louisiana	9,640,027
Healthy Blue	14,691,283
Humana Healthy Horizons in Louisiana*	199,524
Louisiana Healthcare Connections, Inc.	20,595,742
UnitedHealthcare of Louisiana, Inc.	20,169,741
Total	**$71,805,138**

* Began providing MCO services in January 2023.
Source: Prepared by legislative auditor's staff using information from LDH, the MCOs, and the Quality Networks.

Of the $2.32 billion received by the Quality Networks from the MCOs for the MCIP program, participating hospitals received incentive payments totaling $1.30 billion (56.3%) between December 2019 and June 2024. LQN paid $680.9 million (65.1%) of the $1.04 billion it received to 14 participating hospitals between April 2020 and June 2024. QIN paid $627.4 million (49.2%) of the $1.27 billion it received to 37 participating hospitals between December 2019 and February 2024.[19] According to hospital administrators for participating hospitals in QIN, the funds they received through the MCIP program allowed them to save lives, hire additional staff, and provide additional services. While the MCIP program is designed to increase access to health care, improve quality of care, and enhance the health of Medicaid beneficiaries by paying additional funds to hospitals, nearly half of these dollars do not appear to have been used for these purposes. This raises concerns about the efficiency and economy of the MCIP program as expressed by the GAO. More efficient and economic uses of funds could make additional funds available for these participating hospitals, instead of being spent in the ways detailed below.

For example, of the $1.01 billion retained by the Quality Networks for non-incentive payment purposes, $50.5 million (5.0%) was used to pay for administrative and management costs of the Quality Networks. The sections below detail how the $1.01 billion was used by each Quality Network. Exhibit 9 summarizes the amount of MCIP funds retained by the MCOs and how they were used by each Quality Network from September 2019 through June 2024. Appendix

[19] Based on the number of providers paid in each of the Quality Network's accounting records, the Quality Networks made payments to fewer hospitals than listed in their networks according to information LDH provided to LLA as of January 2024.

F shows the flow of MCIP funds to and from each entity involved in the MCIP program from September 2019 through June 2024. Appendix G details MCIP payments to hospitals for LQN from April 2020 through June 2024, while Appendix H details MCIP payments to hospitals for QIN from December 2019 through February 2024.

Exhibit 9
Use of MCIP Funds Paid by LDH
September 2019 through June 2024

Basis for Use of MCIP Funds	Use of LDH Payments (Pmts) for LQN	% of LQN Pmts	Use of LDH Pmts for QIN	% of QIN Pmts	Total Amount Paid	% of Total Pmts
MCO Administrative Fees	$32,348,999	3.0%	$39,456,139	3.0%	**$71,805,138**	**3.0%**
IGTs and Formation Costs Repaid to Contributing Entities	300,909,784*	27.9	463,530,000	35.3	**764,439,784**	**31.9**
Funds Held In Reserve or Bank Account	51,717,440	4.8	30,701	0.0	**51,748,141**	**2.2**
Administrative and Management Costs	12,281,253	1.1	38,270,884	2.9	**50,552,137**	**2.1**
Viability Payments to Ochsner and SRMC	-	-	138,000,001	10.5	**138,000,001**	**5.8**
"Other Costs" Paid to Ochsner	-	-	8,446,897	0.6	**8,446,897**	**0.4**
Incentive Payments to Participating Hospitals	680,990,128	63.2	627,417,602	47.7	**1,308,407,730**	**54.6**
Total	**$1,078,247,604**	**100.0%**	**$1,315,152,224**	**100.0%**	**$2,393,399,828**	**100.0%**

* Includes a $13,439,501 IGT for which LQN had not yet received the corresponding payment for as of June 30, 2024. This $13,439,501 IGT is not included in Exhibit 4 or Appendix F.
Source: Prepared by legislative auditor's staff using information from LDH and the Quality Networks.

LQN's Use of MCIP Funds. Our review of LQN's use of MCIP funds found that of the $1.04 billion in MCIP funds LQN received from the MCOs, $680.9 million (65.1%) was paid to participating hospitals. The remaining $364.9 million (34.9%) was used to do the following:

- repay the IGTs sent to LDH,
- pay for MCIP operating costs, and
- retained in a reserve account

LQN transferred $300.9 million[20] of MCIP funds to other LSUHSC accounts to repay the IGTs sent to LDH. As previously described, contributing entities in each Quality Network contribute IGTs for those milestones LDH confirms have been met to fund the non-federal share of the MCIP program. LSUHSC's contracts with participating hospitals allow for it to be paid for its continuing role as

[20] This amount includes a $13,439,501 IGT for which LQN had not yet received the corresponding payment for as of June 30, 2024. This $13,439,501 IGT is not included in Exhibit 4 or Appendix F.

the administrator of LQN. These transfers to other LSUHSC accounts are to repay the amount LSUHSC sent to LDH via IGTs for the non-federal share required to obtain the matching Federal Medicaid funds for the MCIP program. For example, LSUHSC contributed $300,909,784 in IGTs from February 2020 through February 2024 and were repaid funds from the MCIP payments they received from LDH through the MCOs.

LQN is administered by LSUHSC staff and pays for costs such as salaries directly from MCIP funds received. As stated in the previous section, LSUHSC's contracts with participating hospitals allow for it to be paid for its continuing role as the administrator of LQN. When requested, LQN provided the LLA with detailed expenditure reports documenting the use of all MCIP funds. According to LQN's accounting records, it used MCIP program funds totaling $12,281,253 for administrative costs from February 2020 through June 2024. These costs include items such as portions of employee salaries and fringe benefits, supplies, legal and consulting services, and data software.

LQN's contract with participating hospitals allows for it to retain a portion of MCIP funds it receives in a reserve account for future liabilities or recoupments associated with LQN. As of June 2024, the amount held in reserve totaled $51,717,440. According to LQN staff, it keeps these funds in reserve in case of any potential disallowances in the event that LDH or CMS would want to recover funds. LQN staff further stated that they are able to earn interest on these funds while held in reserve and that LQN releases these funds to hospitals after twelve months.

QIN's Use of MCIP Funds. Our review of QIN's use of MCIP funds found that of the $1.27 billion in MCIP funds QIN received from MCOs, $627.4 million (49.2%) was paid to participating hospitals. The remaining $648.2 million (50.8%) was used to do the following:

- pay management fees and other costs that may violate the Louisiana Constitution,
- repay IGTs sent to LDH and for costs incurred for the formation and development of QIN, and
- ensure the continued viability of participating hospitals

QIN's contract with each participating hospital allows QIN to set aside 40.0% to 55.0% of all MCIP payments received from the MCOs for its operating costs. QIN's operating costs include a flat-rate fee agreement with Ochsner to manage its MCIP program and the repayment of "other costs" to Ochsner by QIN. We requested invoices and documentation from QIN and Ochsner for these expenditures but were not provided with the requested information. Since QIN is a quasi-public entity, a flat-rate fee management contract and "other costs" paid without documentation to

support the expenditures may violate the Louisiana State Constitution.[21] The flat-rate fee is paid to Ochsner to reimburse costs incurred to manage QIN's MCIP program, including any amounts payable to special consultants that Ochsner contracts with for services pertaining to the MCIP program.[22] The "other costs" were also paid to Ochsner by QIN for costs pertaining to the MCIP program.

QIN's contract with Ochsner provides that QIN shall pay Ochsner a management fee totaling 3.0% of all payments QIN receives from MCOs as part of the MCIP program, which totaled $38,270,884 from December 2019 through February 2024. We asked QIN and Ochsner for documentation such as invoices supporting QIN's payments for management services provided by Ochsner. According to QIN's Assistant Executive Director, who is subcontracted by Ochsner to manage QIN's MCIP program, there is no documentation other than QIN's contract with Ochsner to support any of the $38,270,884 in management fees paid to Ochsner by QIN. Ochsner management also provided no documentation to support these expenditures but instead provided an eight-page narrative of activities performed to earn these management fees.

According to accounting records, QIN also paid $8,446,897 to Ochsner for "other costs." We requested documentation from QIN and Ochsner to support these payments. QIN's Assistant Executive Director provided $21,750 of invoices for "Website Maintenance" and stated that there was no other documentation to support the remaining $8,425,147 of payments to Ochsner. QIN staff also declined to state what these payments were for and instead referred the LLA to QIN's contracts with participating hospitals.[23] Ochsner management stated that the documentation supporting these costs is protected under attorney-client privilege.

QIN is a quasi-public agency[24] as defined by Louisiana State audit law,[25] and thus is required to report all revenues and expenditures of public funds to the LLA

[21] Louisiana State Constitution, Article 7, Section 14.
[22] According to QIN's agreement with Ochsner, special consultants include any attorney, accountant, financial consultant, reimbursement consultant, physician and nurse reviewer, corporate compliance consultant, planner, marketing consultant, personnel staffing consultant, or other consultant.
[23] The contract with participating hospitals states that these dollars are for any other reasonable costs necessary to meet its obligations to the various entities involved in the MCIP program.
[24] On May 7, 2013, Hospital Service District #1 of Terrebonne Parish (Terrebonne) incorporated Southern Regional Medical Corporation (SRMC) as part of Terrebonne, assuming responsibility for the operation of the Leonard J. Chabert Medical Center. In June 2018, SRMC established QIN as a non-profit entity. Terrebonne's Chief Executive Officer is the President of SRMC and is also the President and CEO of QIN. As a result of QIN being created by a quasi-public entity (SRMC) whose sole member is a governmental entity (Terrebonne), QIN is a quasi-public agency and thus is required to report all revenues and expenditures of public funds to the LLA in its annual financial statement report. Terrebonne includes SRMC and QIN in the consolidated financial statements that it submits to the LLA. According to Secretary of State incorporation documents, each of these entities were registered under the same address: 8166 Main Street, Houma, LA, 70360, which is Terrebonne's physical location. In essence, each of the entities is intermingled with one another and operate together in terms of the MCIP program.
[25] Louisiana Revised Statute (La. R.S.) 24:513(A)(1)(b)(iv) defines a quasi-public agency as "any not-for-profit organization that receives or expends any local or state assistance in any fiscal year."

in its annual financial statement report.[26] In addition, according to the Louisiana State Constitution,[27] funds of the state or any political subdivision shall not be donated to or for any person, association, or corporation, public or private. Therefore, a public entity can only pay for services that are actually rendered,[28] meaning that some method of substantiation must be provided to show the work that was actually performed to ensure the public entity receives services of at least equivalent value to the payments made to the service provider.[29] Because QIN is a political subdivision of Louisiana, it is required to document the time used and services received for the management fees and "other costs" paid to Ochsner. As a result of QIN's lack of maintaining documentation to support these expenditures, $46,696,031 of QIN's payments to Ochsner for management fees and "other costs" may be considered donations of public funds that violate the Louisiana State Constitution.

QIN's agreement with each participating hospital also allows QIN to use MCIP funds to repay contributing entities for the funds used as IGTs and in the formation of QIN. As previously described, contributing entities in each Quality Network contribute IGTs for those milestones LDH confirms have been met to fund the non-federal share of the MCIP program. According to the consultants hired by Ochsner to manage QIN, the majority of these operating costs are for "IGTs and costs required by the State to support low income services in North Louisiana. The remaining costs are the costs required to operate the network of providers participating in achievement of the AIAs." From December 2019 through February 2024, these payments from QIN to the contributing entities SRMC and Terrebonne totaled $463,530,000.

These payments to SRMC and Terrebonne are to repay the funds used for IGTs and to repay the costs incurred for the formation and development of QIN. We reviewed the IGTs sent to LDH by SRMC and Terrebonne and the non-incentive payments made to them by QIN and found that SRMC received $92,297,265 more than it contributed in IGTs, while Terrebonne received $24,269,920 more than it contributed in IGTs. These are additional funds received by these two contributing entities for providing the IGTs, which reduced the amount of funds available for the other participating hospitals in QIN. Exhibit 10 summarizes the IGTs sent by SRMC and Terrebonne to LDH and the amount received by each from QIN for non-incentive payments.

[26] La. R.S. 24:513(A)(3)
[27] Louisiana State Constitution, Article 7, Section 14.
[28] Louisiana Attorney General Opinion 06-0155
[29] Louisiana Attorney General Opinions 12-0080, 17-0171, and 20-0084

Exhibit 10
IGTs Paid to LDH and Payments from QIN for Non-Incentive Payments
September 2019 through June 2024

IGT Source and QIN Payee	IGT Amount Paid to LDH	Total Paid by QIN for Non-Incentive Payments	Amount Paid in Excess of IGT Payments	% of Excess of IGT Payments
SRMC	$115,737,735	$208,035,000	$92,297,265	79.2%
Terrebonne	231,225,080	255,495,000	24,269,920	20.8
Total	**$346,962,815**	**$463,530,000**	**$116,567,185**	**100.0%**

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

During the course of our review, we also found that Terrebonne entered into an agreement with Ochsner to manage SRMC.[30] Under this management agreement, Ochsner is paid management fees and retains any excess of revenues over expenses annually.[31] According to SRMC accounting records, Ochsner was paid a total of $273,010,822 in management service fees as part of this agreement from January 2019 through July 2024.

QIN's agreement with each participating hospital also allows QIN to set aside additional funds "to ensure the continued viability" of participating hospitals prior to making incentive payments to participating hospitals. These viability payments totaled approximately $138.0 million from December 2019 through February 2024. As mentioned previously, financial struggles at the LSU Health Shreveport hospital helped to build momentum for the MCIP program. QIN's agreement with each participating hospital contains a provision to set aside an agreed-upon amount to expand access to care and improve the healthcare delivery system in order to ensure the continued viability of participating hospitals, and specifically names the LSU Health Shreveport and LSU Health Monroe hospitals.

The amount actually set aside for viability payments varies from year to year. The initial $30,000,000 of these funds were paid between December 2019 and April 2020 to Ochsner, which manages the two LSU Health hospitals mentioned above. However, the remaining $108,000,001 was paid between May 2020 and February 2024 to SRMC, which is also managed by Ochsner and from which Ochsner receives a management fee and any excess of revenues over expenses annually. According to QIN's legal consultants hired by Ochsner, these viability payments were made to SRMC because it is a participating hospital that was adversely affected by Hurricane Ida, which made landfall on August 29, 2021. However, $32,800,000 of these payments were made by QIN to SRMC prior to this

[30] As part of Terrebonne assuming responsibility for the operation of the Leonard J. Chabert Medical Center, SRMC entered a management agreement with Chabert Operational Management Company, LLC (Chabert), which was incorporated by Ochsner, in June 2013. As a result of this management agreement, Ochsner manages SRMC and, according to Terrebonne employees, Ochsner handles SRMC's accounting.

[31] As part of this agreement, Ochsner also receives "reimbursement for purchased services incurred on behalf of the facilities."

date (between May 19, 2020, and August 13, 2021). During a subsequent meeting, QIN legal consultants hired by Ochsner said the funds from the viability payments made to SRMC were initially set aside for an unknown purpose, were ultimately determined to not be needed, and then were paid to Ochsner. We asked QIN, SRMC, and Ochsner for documentation supporting the use of all $138,000,001 of viability payments. According to QIN's Assistant Executive Director, there is no documentation to support any of the $138,000,001 of viability payments other than QIN's contracts with the participating hospitals. Ochsner management also provided no documentation to support the viability payments and also directed us to QIN's contracts with the participating hospitals.

Recommendation 4: LDH should consider amending its contracts with the MCOs to establish terms and conditions on how MCIP funds should be used.

Recommendation 5: LDH should regularly monitor the use of MCIP program funds to ensure they are being used efficiently and effectively.

Summary of Management's Response: LDH agreed with these recommendations and stated that it will amend its contracts with the MCOs in regards to the MCIP program to the extent allowed by federal law. LDH will monitor and review the use of MCIP program funds to ensure they are being spent in accordance with both federal and state law. See Appendix A-1 for LDH's full response.

APPENDIX A-1: LOUISIANA DEPARTMENT OF HEALTH'S RESPONSE

Jeff Landry
GOVERNOR

Michael Harrington, MBA, MA
SECRETARY

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

VIA E-MAIL ONLY

December 20, 2024

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

Report Number: 40230029

Re: Performance Audit Report on the Managed Care Incentive Payment Program

Dear Mr. Waguespack:

The Louisiana Department of Health (LDH) acknowledges receipt of correspondence from the Louisiana Legislative Auditor (LLA) dated November 15, 2024 regarding a performance audit report of the *Managed Care Incentive Payment Program*. LDH appreciates the opportunity to provide this response to your office's observations and recommendations.

As instructed by your email dated November 15, 2024, 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 1: LDH's design of the MCIP program allowed the use of two separate Quality Networks comprised of different hospitals because competing hospitals did not want to operate as single network. LDH also permitted the Quality Networks to have different AIAs and milestones, resulting in hospitals in each network striving for different outcomes.

Recommendation 1: LDH should evaluate the structure of its MCIP program and consider whether it should consolidate the AIAs to have a uniform plan for the MCIP program to improve the quality of care provided in Louisiana.

LDH Response: LDH agrees with this recommendation and has already evaluated the structure of the current MCIP program in order to align the program with the current administration's goals and priorities. 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.

Conclusion 2: LDH requests IGTs for milestones achieved by the Quality Networks. Contracts between the Quality Networks and participating hospitals allow the Quality Networks to repay the contributing entities for IGTs sent to LDH to fund the non-federal share of the MCIP program.

Conclusion 3: LDH's design of the MCIP program prioritizes funding for non-milestone activities. Specifically, LDH paid $437.2 million (18.3%) of the 2.39 billion total MCIP program payments for reporting results timely, submitting annual reports, and holding annual meetings. In addition, LDH paid $1.51 billion (63.3%) for non-measurable milestones and $440.2 million (18.4%) for achieving measurable milestones.

Recommendation 2: LDH should re-evaluate its policy detailing the percentage of MCIP funds it pays for non-milestone activities that do not directly affect quality of care, such as reporting results timely and holding annual meetings.

Recommendation 3: LDH should consider updating its milestones to place more emphasis on measurable results that document improvement in the direct quality of care received by Medicaid beneficiaries in each year, rather than only the last two or three years of an AIA's five year cycle.

LDH Response: LDH agrees with recommendation 2 and 3. LDH has begun the re-evaluation of its MCIP protocols and will no longer pay for non-milestone activities that do not directly affect quality of care. LDH will only incentivize measurable milestones which will focus on LDH's priorities in each year of the AIAs.

Conclusion 4: LDH does not monitor how MCIP program funds are used by the MCOs or the Quality Networks. Because of this lack of oversight, we reviewed the use of these funds and found that $1.08 billion (45.3%) of the $2.39 billion total MCIP funds paid by LDH were used for activities other than incentive payments to participating hospitals.

Recommendation 4: LDH should consider amending its contracts with the MCOs to establish terms and conditions on how MCIP funds should be used.

Recommendation 5: LDH should regularly monitor the use of MCIP program funds to ensure they are being used efficiently and effectively.

LDH Response: LDH will amend its contracts with the MCOs in regards to the MCIP program to the extent allowed by federal law. LDH will monitor and review the use of MCIP program funds to ensure they are being spent in accordance with both federal and state law.

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,

Signed by:
Michael Harrington
BAE5043244C645F...
Michael Harrington, MBA, MA
Secretary

Signed by:
Dr. Ralph Abraham
845BED979A47436...
Ralph L. Abraham, MD
Surgeon General

MH/ks

LOUISIANA LEGISLATIVE AUDITOR

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

Agency: Louisiana Department of Health

Audit Title: Managed Care Incentive Payment (MCIP) Program

Audit Report Number: 40230029

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: LDH's design of the MCIP program allowed the use of two separate Quality Networks comprised of different hospitals because competing hospitals did not want to operate as a single network. LDH also permitted the Quality Networks to have different AIAs and milestones, resulting in hospitals in each network striving for different outcomes.
Recommendation 1: LDH should evaluate the structure of its MCIP program and consider whether it should consolidate the AIAs to have a uniform plan for the MCIP program to improve the quality of care provided in Louisiana.
Does Agency Agree with Recommendation? [X] 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
LDH Response: LDH agrees with this recommendation and has already evaluated the structure of the current MCIP program in order to align the program with the current administration's goals and priorities. 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.

Conclusion 3: LDH's design of the MCIP program prioritizes funding for non-milestone activities. Specifically, LDH paid $437.2 million (18.3%) of the $2.39 billion total MCIP program payments for reporting results timely, submitting annual reports, and holding annual meetings. In addition, LDH paid $1.51 billion (63.3%) for non-measurable milestones and $440.2 million (18.4%) for achieving measurable milestones.
Recommendation 2: LDH should re-evaluate its policy detailing the percentage of MCIP funds it pays for non-milestone activities that do not directly affect quality of care, such as reporting results timely and holding annual meetings.
Does Agency Agree with Recommendation? [X] 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 3: LDH should consider updating its milestones to place more emphasis on measurable results that document improvement in the direct quality of care received by Medicaid beneficiaries in each year, rather than the last two or three years of an AIA's five-year cycle.
Does Agency Agree with Recommendation? [X] 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
LDH Response: LDH agrees with recommendation 2 and 3. LDH has begun the re-evaluation of its MCIP protocols and will no longer pay for non-milestone activities that do not directly affect quality of care. LDH will only incentivize measurable milestones which will focus on LDH's priorities in each year of the AIAs.

Conclusion 4: LDH does not monitor how MCIP program funds are used by the MCOs or the Quality Networks. Because of this lack of oversight, we reviewed the use of these funds and found that $1.08 billion (45.3%) of the $2.39 billion total MCIP funds paid by LDH were used for activities other than incentive payments to participating hospitals.
Recommendation 4: LDH should consider amending its contracts with the MCOs to establish terms and conditions on how MCIP funds should be used.
Does Agency Agree with Recommendation? [X] 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 5: LDH should regularly monitor the use of MCIP program funds to ensure they are being used efficiently and effectively.
Does Agency Agree with Recommendation? [X] 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
LDH Response: LDH will amend its contracts with the MCOs in regards to the MCIP program to the extent allowed by federal law. LDH will monitor and review the use of MCIP program funds to ensure they are being spent in accordance with both federal and state law.

APPENDIX A-2: LOUISIANA QUALITY NETWORK'S RESPONSE

December 9, 2024

Michael J. "Mike" Waguespack, Legislative Auditor
1600 North Third Street
Post Office Box 94397
Baton Rouge, Louisiana 70804-9397

Dear Mr. Waguespack:

Louisiana Quality Network (LQN) is a collaborative network of diverse hospitals across Louisiana, dedicated to improving the health outcomes of Medicaid beneficiaries. We are grateful for the opportunity to respond to your report on the Louisiana Department of Health's (LDH's) Managed Care Incentive Payment (MCIP) Program, and for the Louisiana Legislative Auditor's collaboration with us throughout the process.

LQN's collaborative framework empowers us to reach significant program milestones now and in the future by encouraging unprecedented cooperation aimed at improving health outcomes. Through LQN, healthcare professionals work together seamlessly, transcending hospital affiliations to share best practices, information, and innovative protocols. As evidenced in our recent progress report, "*Driving Results, Advancing Health in Louisiana by Improving Medicaid Care*," attached to this letter, our collective effort improves care efficiency and drives notable results, addressing low-value care and enhancing patient outcomes. Representing thousands of healthcare professionals, LQN fosters an environment where shared knowledge and resources lead to continuous improvement and empowered, efficient care delivery. The milestone framework the program established ensures steps are taken each quarter toward the end goal of improved outcomes. Team members across the various LQN hospitals spend hours each week working toward these shared goals and that work, in the last five years, produced significant results. The funding provided by the MCIP program has been critical in supporting increased access to care, community programming, quality initiatives, and weathering the unprecedented financial storm caused by the COVID-19 pandemic. More information on LQN's impact on health in Louisiana is available at www.laqualitynetwork.org.

While we agree that there are aspects of the program that can be improved from a policy perspective, the program design and implementation as it pertains to the LQN has been accomplished in good faith, in a compliant fashion, and has been integral to preserving and

improving access, quality and health equity in our state. We look forward to working with the legislature, LDH, and Louisiana's managed care organizations to make further improvements to this program to ensure optimal quality outcomes and to be good stewards of the resources provided. Below we highlight the areas where we believe the report is either misleading or erroneous.

Notable Clarifications

- *Non-Measurable Milestones:* The report implies that the program design was faulty because a portion of the incentive payments are for milestones that are not based on measurable results. This critique misunderstands the nature of quality improvement work, which involves intensive investment in infrastructure and improvement processes before measurable outcomes can be achieved.[1] The cornerstone of the MCIP program is the Approved Incentive Arrangements (AIAs), with each AIA focusing on a specific area of quality improvement and containing a number of milestones per year. The AIAs were designed to support significant and measurable improvement over a five-year period, with milestones carefully building upon each other towards achievement of the ultimate project goals. The fact that some of the milestones are process-related reflects the reality that the establishment of evidence-based processes is critical to achieving the quality goals. We object to any implication that only measurable outcomes directly contribute to quality improvement.

- *Milestone Payments:* The report does not provide adequate context for amounts paid for specific milestones that are highlighted in the report, suggesting that certain individual milestones are not worth the amount paid for them. The AIAs were each carefully and individually valued based on medical acuity, the size of the population and the expected cost savings. Once the value of the AIA was set, the total payment for the AIA was divided by the number of milestones for any given project year so that each milestone within the AIA is paid at the same level. Thus, the improvement work was valued at the aggregate level for the AIA per annum, not based on individual milestones. By failing to explain this methodology, the report may lead the reader to conclude that LDH overpaid for individual milestones without conveying the clinical care considerations and detail that went into valuing the AIAs as a whole.

[1] *See, e.g.,* CMS, Innovation Center Strategy Refresh, at 6 ("Significant infrastructure investments are often needed to participate in models, including electronic health record (EHR) enhancements, new staff, and data analytic support especially for safety net providers and those serving Medicaid beneficiaries."); Medicaid and CHIP Payment and Access Commission, Delivery System Reform Incentive Payment Programs, Issue Brief, April 2020 (noting that Medicaid delivery system reform incentive programs (DSRIPs) "tie disbursement of DSRIP funding to implementation of projects and achievement of specific milestones. Milestones can be process based (such as those related to project planning, implementation, and reporting), or outcomes based (such as improving health outcomes associated with the projects). Providers generally must meet more process milestones in the initial years of the program before transitioning to outcomes-based milestones in later years.")

- *LQN's Use of MCIP Payments:* Federal law does not dictate how providers or contractors "use" Medicaid payments once received in exchange for services provided or incentive milestones met. For example, Medicaid regulations permit providers to be paid in excess of their costs of providing services (as long as the payments are in line with applicable statutory or regulatory limits). That excess over cost may well be invested in other initiatives improving access and quality, but neither federal nor state law dictates how the excess must be used. As long as the provider rendered the services, or met the milestones for which it received the payment, the legal requirements are satisfied. Similarly, a public provider that funds the non-federal share of its Medicaid payments through intergovernmental transfers (IGTs) is inevitably going to receive Medicaid payments that effectively "repay" the cost of the IGT. That is not only permitted under federal law but protected.[2]

  The report's focus on LQN's "use" of MCIP payments, and the concern it expresses for the fact that the funds used for the IGTs were effectively replenished (or "repaid" in the language of the report) by the MCIP payments is therefore misplaced. The LQN earned the MCIP payments through achievement of the pre-approved milestones, and the distribution of the funding within the network was determined by negotiation in full compliance with federal and state law as neither dictated how the incentives payments were to be "used."[3]

  The LQN participants, including LSUHSC and the hospitals, contractually agreed to a distribution of the MCIP payments within the network, according to a formula that has remained consistent throughout the program's existence. The formula reflects LSUHSC's substantial role in the network's formation, operation and success, including responsibility for developing programs to assist the hospitals in achieving the milestones, leading all contracting efforts, providing continuing medical education for participants, providing human, technological and financial resources to support the network's operations and serving as the founding member, liaison, fiscal agent and administrator.

Moving Forward

[2] *See* Social Security Act, Sec. 1903(w)(6)(a) (prohibiting the Secretary of Health and Human Services from restricting states' use of funds derived from State or local taxes transferred from units of government as the nonfederal share of Medicaid expenditures *regardless of whether the unit of government is also a health care provider*.)

[3] In fact, the MCOs, in delegating to LQN their obligation to cooperate with any audits of the program, describe the oversight bodies' right to audit "any aspect of services and activities performed or determination of amounts payable under the MCO Medicaid Contract and this MCIP Agreement." The delegated audit right does not extend to how the participants use the funding once earned.

Although we disagree with several areas in the report, we stand ready to work collaboratively with LDH to improve the program moving forward. Such a process should seek to preserve what is working right about the program and the benefits to the State: fostering collaboration toward shared quality improvement goals, providing resources and support for struggling hospitals, particularly in rural areas where access is strained, aligning incentives across the health care system, and promoting best practices and evidence-based solutions that will enhance outcomes not just for Medicaid beneficiaries but for all Louisianans.

Thank you again for the opportunity to respond. On behalf of the Louisiana Quality Network and all its members, sincerely,

Ben Lousteau

Interim Vice Chancellor
Administration and Finance
Louisiana State University
Health Sciences Center -
New Orleans

Gregory C. Feirn

Chief Executive Officer
LCMC Health

E.J. Kuiper

President and Chief
Executive Officer,
Franciscan Missionaries of
Our Lady Health System

Michele K. Sutton, FACHE

President & CEO
North Oaks Health System

Mary Jane Ward

Senior VP-Finance CFO
Willis Knighton Health

Devon Hyde

President/CEO
Lake Charles Memorial
Health System

Greg Stock

Chief Executive Officer

Thibodaux Regional Health System

ATTACHMENT

[*Insert Summer 2024 "Driving Results" progress report]*

Louisiana Quality Network

LOUISIANA QUALITY NETWORK

Driving Results

Advancing Health in Louisiana by Improving Medicaid Care

SUMMER 2024

A Ripple Effect Across Louisiana

IT'S BEEN FIVE YEARS since our consortium of independent health systems, hospitals, and Managed Care Organizations joined together under the banner of Louisiana Quality Network (LQN) to improve the state's Medicaid Program. Over our first five years, we have made great strides, and we are proud to highlight some of our successes in this report.

We have accomplished much in our first five years and continue to build on this success. Through the process of improving care, we have discovered an unexpected benefit: **a ripple effect that has carried expertise, best practices, efficiencies, and the opportunity to improve healthcare outcomes across Louisiana -** not just for those within the Medicaid population.

LQN's collaborative structure enables us to achieve many impactful program milestones, both now and in the future:

Facilitating unprecedented collaboration. Through LQN, healthcare professionals work together and share best practices regardless of their hospital affiliation.

Improving care and driving results. LQN members share information, protocols, program ideas, technologies to create efficiencies, and improve low-value care and patient outcomes.

Empowering people. LQN represents thousands of healthcare professionals. Through LQN, their impact spreads far beyond the walls of their hospitals.

The programs and initiatives established by LQN are sustainable and replicable, meaning they will continue to deliver better healthcare outcomes and improved efficiencies for the benefit of all Louisianians.

Sincerely,

Ben Lousteau,
Interim Vice Chancellor
Administration and Finance,
Louisiana State University
Health Science Center
– New Orleans

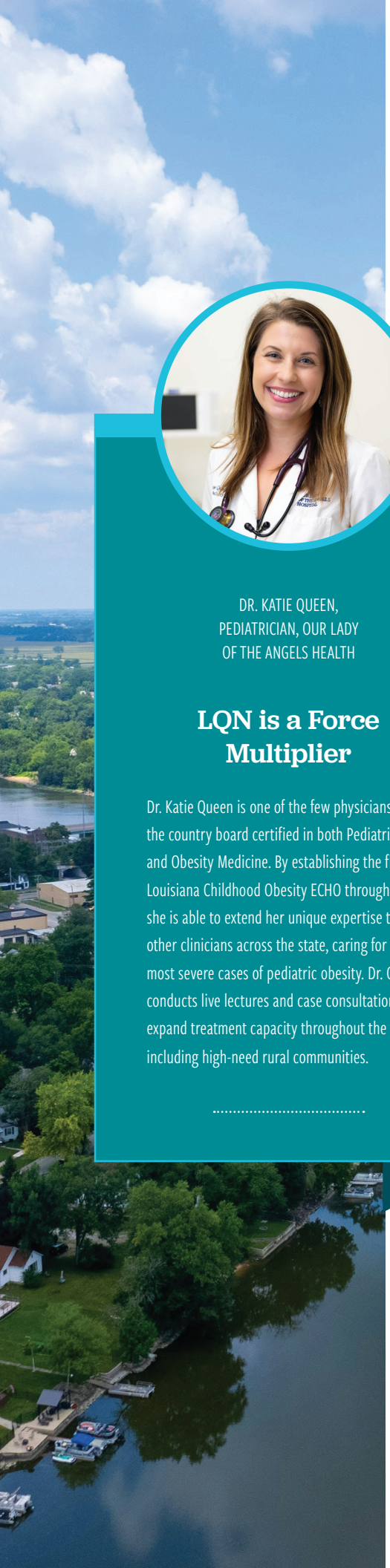
Gregory C. Feirn,
Chief Executive Officer,
LCMC Health

E.J. Kuiper
President and Chief
Executive Officer,
Franciscan Missionaries of
Our Lady Health System

Medicaid is Critical to Louisiana, America's Least Healthy State

Louisiana ranks among the least healthy states in the nation, and about 45% of the population is enrolled in Medicaid for their healthcare.[1]

[1] United Health Foundation. (2024). *Health Rankings: Louisiana*. America's Health Rankings. Retrieved from https://www.americashealthrankings.org/explore/states/la



DR. KATIE QUEEN,
PEDIATRICIAN, OUR LADY
OF THE ANGELS HEALTH

LQN is a Force Multiplier

Dr. Katie Queen is one of the few physicians in the country board certified in both Pediatrics and Obesity Medicine. By establishing the first Louisiana Childhood Obesity ECHO through LQN, she is able to extend her unique expertise to other clinicians across the state, caring for the most severe cases of pediatric obesity. Dr. Queen conducts live lectures and case consultations to expand treatment capacity throughout the state, including high-need rural communities.

Louisiana Quality Network: Improving Louisiana's Medicaid Program

Better Health Outcomes, Greater Efficiencies

Given Medicaid's importance to the health of Louisianans and the program's size and complexity, the Louisiana Department of Health (LDH) established the Managed Care Incentive Payment (MCIP) program in 2019 to improve health outcomes and create efficiencies within Medicaid.

The MCIP program allows Louisiana to leverage federal funding exclusively for providing incentives to hospitals and Managed Care Organizations, enabling them to cover the costs they invested in making improvements. By its very structure, the MCIP program is incentivizing sustainable, long-term Medicaid reforms to improve health and increase efficiencies.

LQN is a consortium of 11 healthcare systems (including a total of 26 individual hospitals) and six MCOs throughout Louisiana, administered by LSU Health Sciences Center – New Orleans, that came together to participate in the MCIP program. Collaboration of this kind is unprecedented in the state, allowing LQN to share best practices, better utilize technology and data, and improve healthcare for Medicaid patients across our network.

LQN's Journey to Healthcare Transformation

Taking on Louisiana's Greatest Healthcare Challenges

In LQN's inaugural year of 2019, LQN identified four program goals designed to address some of the most pressing health concerns and opportunities for cost savings within the Medicaid Program:

Goal #1 Reduce inappropriate emergency department utilization

2021-23 RESULT: **9.6% Decrease**

Goal #2 Reduce preventable hospital readmissions

2021-23 RESULT: **6.2% Decrease**

Goal #3 Promote evidence-based practice and reduce low-value care

2021-23 RESULT:

- **6%** **Decrease** in unnecessary lower back imaging
- **30%** **Decrease** in unnecessary antibiotic Rx for sinusitis

Goal #4 Improve maternal and perinatal outcomes

2021-23 RESULT:

- **100%** **LQN Hospitals** Earned Gift Designation
- **90%** **LQN Hospitals** Earned Birth Ready Designation

LQN has subsequently identified four additional goals to address additional chronic healthcare challenges for the benefit of Louisiana's Medicaid patients as well as the state's population at large:

Goal #5

Goal #6

2019 2020 2021 2022

Meeting Milestones: 100% Success

Each goal is backed by dozens of milestones that LQN members must achieve each year to qualify for the federal payments distributed through the Louisiana Department of Health. These milestones build on one another to improve Medicaid delivery in Louisiana.

By 2023, LQN was able to successfully achieve all 211 milestones established during the first five years of the program.

2023 marked the fifth and concluding year of this first set of goals, marked by measurable, significant achievements that will continue serving Louisiana for the long term.

But this was only a start.

Now in its sixth year, LQN is delivering on its promise and showing sustainable results toward the goal of a healthier Louisiana.

Improve breast cancer screening (2022-26)

SOLUTION PREVIEW: LQN is working to overcome the barriers to screening by expanding access to screening services, focusing on building awareness and education through social media campaigns, and amplifying community outreach and partnerships.

Increase Autism and developmental screening in the first three years of life (2022-26)

SOLUTION PREVIEW: LQN is working to educate parents and caregivers along with primary care providers on the importance of early developmental and emotional screening, evidence-based testing, and treatment methods.

Goal #7 — **Improve prevention, screening, and treatment of childhood obesity (2023-27)**

SOLUTION PREVIEW: Much of the initial work being carried out by LQN is to better understand how social determinants of health contribute to the childhood obesity crisis and what steps can be taken to help reverse this trend.

Goal #8 — **Address the opioid epidemic through multiple care settings (2023-27)**

SOLUTION PREVIEW: LQN is focused on breaking down the barriers to access treatment for Opioid Use Disorder by improving the coordination of care, building the capacity of healthcare providers on the front lines, and addressing the social determinants of health.

2023 2024 2025 2026 2027

Goal #1

Reduce Inappropriate Emergency Department Utilization

The Challenge

Because they may lack alternatives or awareness of them, Medicaid patients nationwide frequently utilize emergency departments (ED) for non-emergent conditions that could be better addressed by a primary care physician. This pattern puts considerable strain on busy emergency departments and unnecessarily increases the costs of care. Patients need to establish a medical home with a primary care provider to ensure they receive comprehensive, preventative, and well-coordinated care.

The Solution

Addressing this issue requires understanding its root causes, including social determinants of health. Over the last five years, LQN hospitals collaborated to identify barriers, gather data, explore best practices, and leverage community resources to provide alternatives to ED visits. LQN hospitals integrated systems and used data to target frequent ED visitors and provide personalized assistance. In many instances, Network members instituted patient navigation initiatives, including educational tools on the importance of primary care, assistance with appointment scheduling, transportation, and follow-up with patients to monitor and address additional barriers.

Results

LQN is Making Significant Cuts to Inappropriate ED Utilization

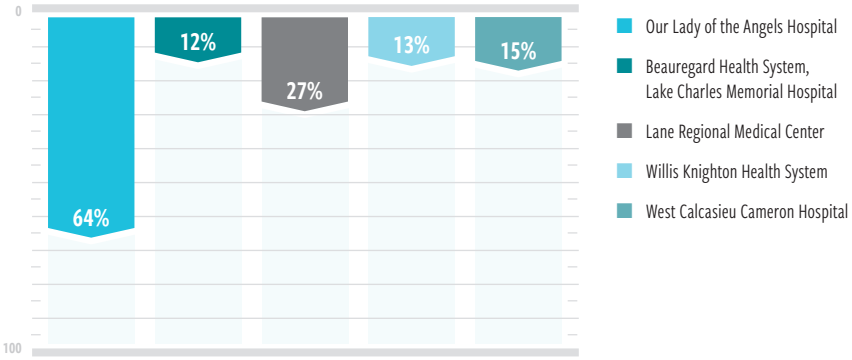
9.6%

Decrease 2021-2023

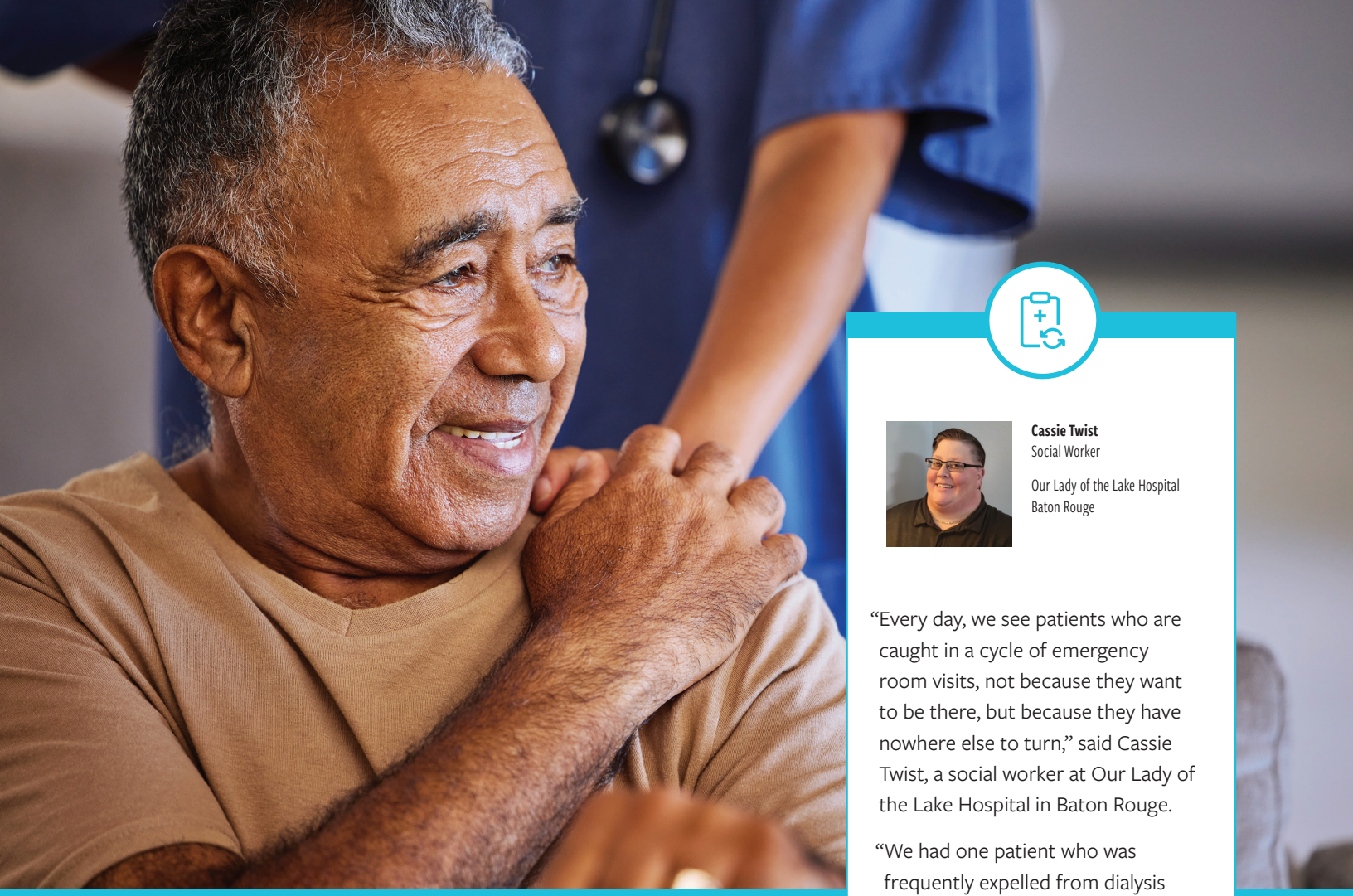
LQN's efforts directed some **3,000 patients** to more appropriate, cost-effective care over three years.

(Potentially preventable ED visits were categorized as non-trauma-related ED encounters at LQN facilities with a primary diagnosis that could be treated outside of the ED.)

Notable, Measured Success in LQN Hospitals



Decrease in Inappropriate ED Utilization from 2021 – 2023



Bridging the Gap: Addressing Social Determinants of Health

Social determinants of health greatly impact Medicaid patients' well-being and the program's efficiency and cost. Factors such as income levels, education gaps, housing instability, food insecurity, and transportation barriers can worsen health disparities and raise chronic illness rates.

By establishing alternative resources, coordinating local support resources, and improving communication with the patient community, LQN hospitals are directing patients to more appropriate care, both improving outcomes and lowering Medicaid costs.

Cassie Twist
Social Worker

Our Lady of the Lake Hospital
Baton Rouge

"Every day, we see patients who are caught in a cycle of emergency room visits, not because they want to be there, but because they have nowhere else to turn," said Cassie Twist, a social worker at Our Lady of the Lake Hospital in Baton Rouge.

"We had one patient who was frequently expelled from dialysis centers for aggressive behavior, had no permanent home, and did not have access to regular meals. As a result, he was frequently in the ED for treatment. I had more than 90 interactions with him."

"Through our holistic approach, we not only secured his medical care but also addressed his housing and nutritional needs. We even helped him find a home with a supportive environment and better access to dialysis treatment and primary care."

Months after settling into his new home, the patient reached out to Cassie to express his gratitude.

"His simple holiday greeting was a profound affirmation of our work, a reminder that when we treat the whole person, not just the symptoms, we can truly change lives."

Goal #2

Reduce Preventable Hospital Readmissions

The Challenge

More than 3.8 million adults in the U.S. are readmitted to the hospital within 30 days after being discharged, and Medicaid patients account for about 19% of these readmissions[2]. With an average cost of around $15,000 for each readmission, reducing the number of preventable hospital readmissions can lead to a dramatic reduction in Medicaid costs as well as a measurable improvement in patient outcomes, which is why LQN is focusing on the root causes: disengagement and non-compliance.

The Solution

Much like reducing preventable ED utilization, LQN members have focused on addressing the social determinants of health that are contributing to the number of preventable readmissions. Navigator services at LQN hospitals provide personalized support and guidance to patients as they transition from hospital care to home or other healthcare settings. These services typically involve a team of healthcare professionals, often including nurses, social workers, care coordinators, and patient advocates who work collaboratively through LQN to ensure that patients receive comprehensive support during their transition period. In many instances, this includes education on treatment plans, care coordination, medication management, follow-up care, and access to community resources, such as transportation and food.

Results

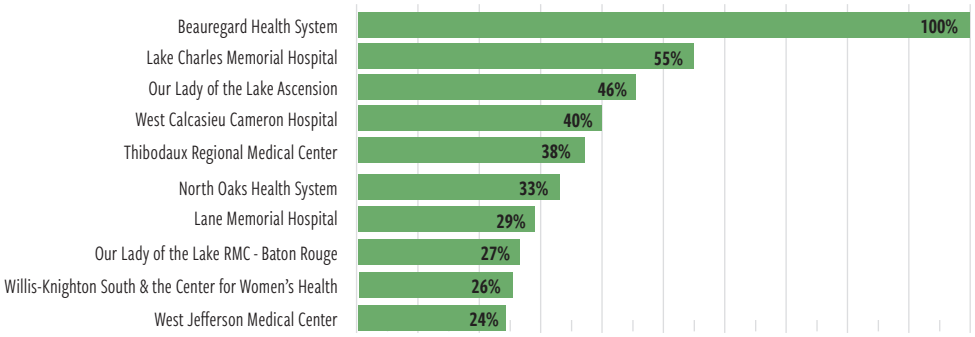
LQN is Reducing Readmissions Network-wide

6.2%

Decrease 2021-2023

(A readmission is counted if the patient returns to an LQN facility within 30 days of the previous inpatient discharge from a LQN facility.)

Notable, Measured Success in LQN Hospitals



Decrease in Preventable Readmissions from 2021 – 2023

[2] Agency for Healthcare Research and Quality. (2020). *Conditions with frequent readmissions by payer,* 2018 (HCUP Statistical Brief #278). Retrieved from https://hcup-us.ahrq.gov/reports/statbriefs/sb278-Conditions-Frequent-Readmissions-By-Payer-2018.jsp

Reducing Return Visits to the Hospital

One solution to reduce hospital readmissions is to give patients the tools they need to follow their treatment plans and make it easier to access the medications prescribed to them. LQN has promoted the innovative "Meds to Beds" program throughout its member hospitals to ensure patients have all their medications prior to discharge. By reducing or eliminating all the extra steps a patient may need to take to access prescribed medicines, Meds to Beds improves adherence to their prescribed treatment and reduces the risk of medical complications, which may lead to readmission.

Jason Lindsey of North Oaks Hospital's Case Management Department said "Many of these patients cannot access the medicines prescribed to them, either because they can't get to the pharmacy, are confused as to what they need to take, or don't want to spend more money on a new prescription, so they may just take the medicine they might already have at home."

The Meds to Beds program goes beyond just helping the patient. As Jason explains, getting the discharging teams to utilize the program is an important key to success. This includes simplifying the administrative process to get the right medicines directly to patients.

"By collaborating with nursing and pharmacy leaders, we've educated providers and developed streamlined processes, reducing the administrative burden and allowing healthcare professionals to focus more on patient care rather than paperwork."

These improvements have led to a significant reduction in readmissions, positively impacting patient health outcomes and enhancing the overall efficiency of healthcare delivery.

Goal #3

Promoting Evidence-Based Practices and Reducing Low-Value Care

The Challenge

"Evidence-Based Care" simply means the use of the best science and data to make the right medical care decisions. Promoting evidence-based practices is central to reducing expensive but low-value treatments or procedures, which in turn reduces inefficiencies and costs in the Medicaid delivery system. One example of "low-value" (and expensive) care is unnecessary imaging for lower back pain. Evidence shows these tests can be unnecessary and expose patients to harmful radiation. Another example is the prescribing of antibiotics to treat sinusitis. The overuse of antibiotics can lead to more resistant strains of bacteria, which can cause more severe infections, complications, longer hospital stays, and increased mortality.

The Solution

The beauty of LQN is in its ability to collect and share data so that prescribing physicians can make smarter decisions. In the case of addressing low-value care, a key to success has been in educating its healthcare providers and establishing protocols and technology solutions to help them choose better alternatives. For instance, in some of LQN's member hospitals, a system was put in place to automatically provide physicians with alternative options if they order a lower back scan.

Results

6%
Decrease 2021 - 2023
in unnecessary lower back imaging

30%
Decrease 2021 - 2023
in unnecessary antibiotic prescriptions for sinusitis

Hospitals Leading in Improvements

>40% improvement in reducing unnecessary lower back imaging

Hood Memorial Hospital	**100%**
Lallie Kemp Regional Medical Center	**88%**
LCMC Health	**64%**
North Oaks Health System	**47%**
Franciscan Missionaries of Our Lady Health System	**45%**
Beauregard Health System	**42%**

>50% improvement in reducing unnecessary antibiotic prescriptions for sinusitis

Thibodaux Regional Health System	**100%**
Lallie Kemp Regional Medical Center	**87%**
Hood Memorial Hospital	**83%**
North Oaks Health System	**61%**
Lake Charles Memorial Health System	**57%**

LQN Puts Theory into Practice, Cutting Costs and Eliminating Risks

Dr. Jeffrey Elder smiled down at the treatment plan. He realized at that moment that LQN's efforts to reduce Low-Value Care had become ingrained in practices at University Medical Center New Orleans. He was huddling with physicians about how to treat a patient with chronic sinusitis, and the conversation followed LQN's script to a tee. And it is a conversation happening at hospitals throughout Louisiana because of LQN, explained Dr. Elder.

"Everyone wants to eliminate low-value care in theory, but it takes a lot to get physicians to change their practice habits. LQN has put theory into practice. We created the structure to look at the data and educate frontline care providers. Now they're lowering risks to patients while lowering costs to Medicaid, not only at UMC but also at every hospital in the LQN."

Goal #4

Improving Maternal and Perinatal Outcomes

The Challenge

Louisiana has one of the highest infant mortality rates in the developed world and one of the worst maternal mortality rates in the nation. In addition there are alarming levels of preterm birth, low birth weight, and myriad postpartum conditions[3]. With six in ten births in Louisiana supported by Medicaid (the highest rate in the nation), LQN recognizes the necessity of improving the maternal and perinatal health care delivered by the program[4].

The Solution

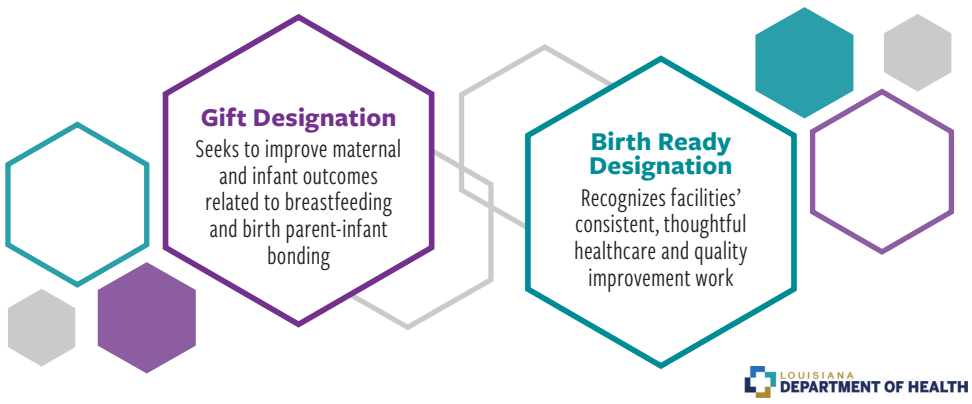
LQN is helping reverse Louisiana's worrisome maternal and perinatal trends by addressing the contributing factors (including hemorrhaging, cardiomyopathy, cardiovascular disease, and opioid use), sharing best practices, and taking advantage of existing programs with proven success rates. Chiefly, 100% of LQN members participating in this goal have earned The Gift designation: an evidence-based program administered by LDH to assist hospitals in improving the quality of their maternity services. Additionally, 90% of LQN hospitals earned LDH's Birth Ready designation for committing to practices that improve quality and outcomes for women giving birth. Other LQN efforts include developing models to improve care for high-risk pregnancies and enhance prenatal and postpartum care, reducing lengths of stay and readmissions, and connecting patients with education tools and community resources to help them stay healthy when they return home.

Results

Improving the Quality of Maternity Services

100%
LQN Hospitals
Earned *Gift* Designation

90%
LQN Hospitals
Earned *Birth Ready* or *Birth Ready +* Designation



[3] Times-Picayune. (2023). *Louisiana has an infant and maternal mortality crisis.* Retrieved from https://www.nola.com/news/healthcare_hospitals/louisiana-has-an-infant-and-maternal-mortality-crisis/article_cc00a6fe-2d66-11ee-a32e-cb4edc0ebcco.html

[4] March of Dimes. (n.d.). *Preterm birth rates - Louisiana.* Retrieved from https://www.marchofdimes.org/peristats/data?reg=99&top=11&stop=154&slev=4&obj=1&sreg=22

Extending the Expertise of Louisiana's Busiest Birthing Hospital

Woman's Hospital in Baton Rouge, an LQN member, holds a remarkable distinction as the top deliverer of babies in the state. Renowned for its commitment to maternal and infant health, the hospital serves as a beacon of excellence, championing better outcomes for mothers and newborns. Through LQN, Woman's Hospital shares invaluable wisdom, guidance, and tools to aid fellow network members in implementing stronger protocols and enhancing care standards.

Recognizing the power of communication, LQN emphasizes storytelling as a catalyst for change. Woman's Hospital experts share best practices and guide others through Grand Round Presentations and by helping to identify necessary improvements and training opportunities. These collaborative efforts exemplify the core values of LQN, fostering a culture of shared learning and continuous improvement to ensure that every mother and infant receives the highest quality of care.

Building on Success

Taking on Additional Challenges

As the original set of goals continues to improve outcomes across Louisiana, LQN has adopted four new goals to tackle even more of the state's toughest health challenges.

Goal #5

Improve Breast Cancer Screening (2022-2026)

The Challenge

Louisiana continues to have one of the highest breast cancer mortality rates in the nation, with Black women being disproportionately affected. Breast cancer screening is proven to reduce deaths, decrease the number of women diagnosed with late-stage cancer, and reduce health care spending. While advances have been made to improve access to breast cancer screening through Medicaid, a number of obstacles remain, most notably insufficient awareness of the importance of screening and how to access it.

The Solution

LQN is overcoming barriers to screening by expanding access to screening services, focusing on building awareness and education through social media campaigns, and amplifying community outreach and partnerships. LQN has also established metrics to better track progress and implemented enhanced tools to provide hospitals with access to better data.

LQN is planning a training series for providers over the next three years. These trainings will provide common patient cases for healthcare providers to study and learn how to improve communication with people from different backgrounds and, ultimately, increase the rate of screenings.

Goal #6

Increase Autism and Developmental Screenings (2022-2026)

The Challenge

One in six children in the U.S. has a developmental disability, affecting how they learn, play, speak, and behave[5]. For many children, developmental disabilities are not identified until *after* they start school, and nationally, only 17% of children under five with developmental needs receive services for them[6]. While signs of Autism Spectrum Disorder (ASD) can be detected as early as 18 months, many parents and caregivers are missing early diagnosis. This leads to critical delays in accessing effective treatment and support services - the kind of support that can lead to productive gains in development and reduce the need for services later in life.

The Solution

LQN is working to educate parents and caregivers along with primary care providers on the importance of early developmental and social-emotional screening, evidence-based testing, and treatment methods. These efforts include improving access to qualified health professionals who are experts at identifying and treating ASD and other developmental disorders.

[5] Centers for Disease Control and Prevention. (n.d.). *Developmental Disabilities.* Retrieved from https://www.cdc.gov/ncbddd/developmentaldisabilities/index.html

[6] American Academy of Pediatrics. (n.d.). *Developmental surveillance and screening patient care.* Retrieved from https://www.aap.org/en/patient-care/developmental-surveillance-and-screening-patient-care/

While still in the early stages, these new goals are already yielding results that will benefit all LQN hospitals and, of course, their patients.

Goal #7

Improve Prevention, Screening, and Treatment of Childhood Obesity (2023-2027)

The Challenge

Louisiana is one of seven states with childhood obesity rates higher than the national average[7]. Data clearly shows youth obesity leads to chronic and serious adult health issues, including diabetes, high cholesterol levels, hypertension, and liver disease, among others. Childhood obesity also contributes to other negative academic and socio-emotional consequences later in life. Because poverty is a contributor to poor diet, which, in turn, is a contributor to obesity, it is a particularly acute problem amongst the Medicaid patient population.

The Solution

Much of the initial work being carried out by LQN is to better understand how social determinants of health contribute to the childhood obesity crisis and what steps can be taken – not just by healthcare providers but also throughout the communities – to help to reverse this trend. In addition to resource guides for families, another promising LQN initiative being promoted across Louisiana hospitals is Project ECHO, a telementoring program that enables experts to share best practices and foster collaboration. Early indications suggest that patients who receive care from providers participating in the ECHO model have improved outcomes.

Goal #8

Address The Opioid Epidemic Through Multiple Care Settings (2023-2027)

The Challenge

Opioid use disorder (OUD) is a public health crisis in Louisiana. The state saw a 432% rise in opioid-related deaths between 2014 and 2021, and in some parishes, overdoses rank among the top three causes of death[8]. While misuse of opioids adversely affects people of all demographics and backgrounds, those in lower socio-economic categories (including those who qualify for Medicaid) are less likely to receive treatment that has been proven to reduce overdoses, withdrawal symptoms, and opioid cravings.

The Solution

LQN is focused on breaking down the barriers to access treatment for OUD by improving the coordination of care, building the capacity of healthcare providers on the front lines, and addressing the social determinants of health. To start, LQN aims to increase screenings to diagnose people with OUD whenever they receive healthcare, focusing on care settings such as community/outpatient care, emergency department/inpatient care, and substance-exposed mothers and babies. These initiatives allow Louisiana an opportunity to establish a baseline measurement of populations with OUD, to assess how many are receiving treatment, and ultimately, to provide treatment.

[7] State of Childhood Obesity. (n.d.). *Demographic data: Ages 10-17*. Retrieved from https:/stateofchildhoodobesity.org/demographic-data/ages-10-17/

[8] Louisiana Department of Health. (2021). 2021 *Annual Drug Death* Report. Retrieved from https://ldh.la.gov/assets/opioid/2021_Annual_Drug_Death_Report.pdf

Driving Results

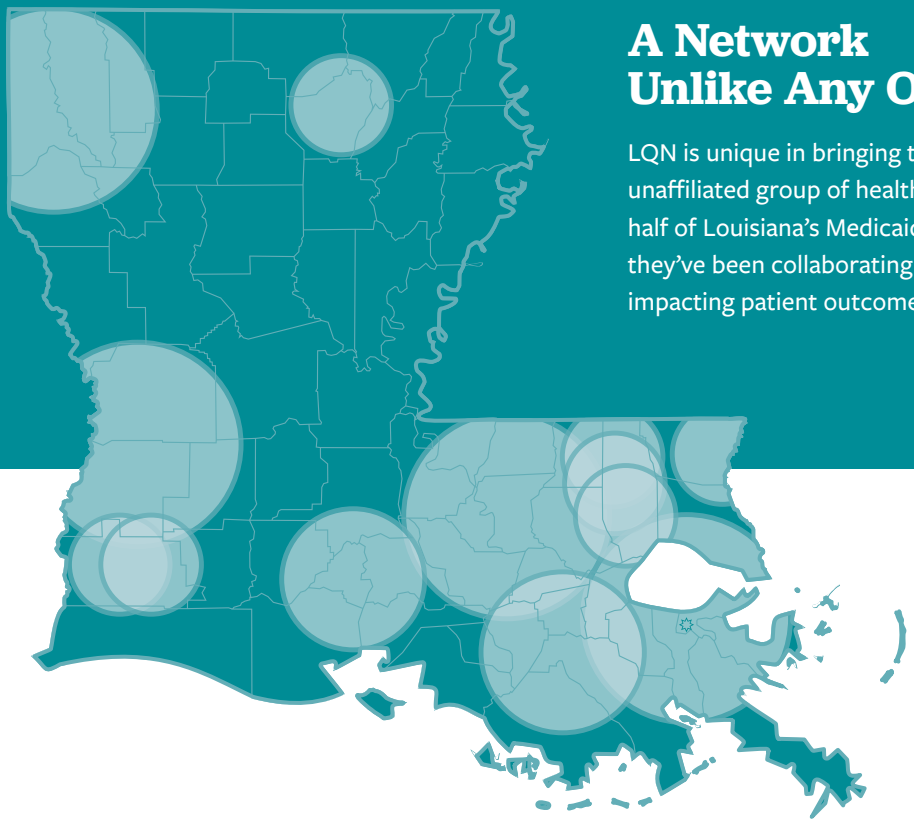
View a digital version of this report at **LAQualityNetwork.org**

Connecting Healthcare Systems Statewide

The LQN banner represents a consortium of 11 healthcare systems, totaling 26 hospitals, and six Managed Care Organizations (MCOs) across Louisiana that came together to participate in the Managed Care Incentive Payment (MCIP) Program, which provides federal funding exclusively for incentives to help states improve Medicaid healthcare and cost efficiency.

A Network Unlike Any Other

LQN is unique in bringing together a diverse, previously unaffiliated group of healthcare organizations that provide nearly half of Louisiana's Medicaid services. Since forming the network, they've been collaborating and sharing best practices, significantly impacting patient outcomes and cost-savings for the state.



Louisiana Quality Network

LQN MCIP PROGRAM ADMINISTRATOR

- **Louisiana State University Health Sciences Center – New Orleans**

LQN MEMBERSHIP

LQN is made up of 11 hospitals/systems:

1 **Beauregard Health System**

2 **Franciscan Missionaries of Our Lady Health System (FMOLHS)**
- Our Lady of the Lake Health
- Our Lady of the Lake Children's Health
- Our Lady of the Lake Ascension
- Our Lady of Lourdes Health
- Our Lady of Lourdes Women's and Children's Health Hospital
- Our Lady of the Angels Health Hospital
- St. Francis Health Medical Center

3 **Lake Charles Memorial Health System**

4 **Lallie Kemp Medical Center**

5 **Lane Regional Medical Center**

6 **LCMC Health**
- Children's Hospital
- New Orleans East Hospital
- Touro Infirmary
- University Medical Center
- East Jefferson General Hospital
- West Jefferson Medical Center

7 **North Oaks Health System**
- Hood Memorial Hospital

8 **Thibodaux Regional Health System**

9 **West Calcasieu Cameron Hospital**

10 **Willis Knighton Health System (WKHS)**
- Willis Knighton Medical Center
- Willis Knighton South & the Center for Women's Health
- Willis Knighton Bossier Health Center
- Willis Knighton Pierremont Health Center

11 **Woman's Hospital**

CONTRACTED MCOS WITH LQN

- **Aetna Better Health**
- **AmeriHealth Caritas Louisiana (ACLA)**
- **Healthy Blue Louisiana (HBL)**
- **Louisiana Healthcare Connections (LHCC)**
- **UnitedHealthcare (UHC)**
- **Humana Healthy Horizons – effective 2023**

APPENDIX A-3: QUALITY AND OUTCOME IMPROVEMENT NETWORK'S RESPONSE

QUALITY AND OUTCOME
IMPROVEMENT NETWORK, INC.

December 2, 2024

Michael J. Waguespack, CPA
Louisiana Legislative Auditor
1600 North Third Street
Baton Rouge, LA 70804-9397

Via Email: mwag@lla.la.gov

Re: Managed Care Incentive Payment ("MCIP") Program – Performance Audit Review, Audit Control # 40230039

Dear Mr. Waguespack:

The Quality and Outcome Improvement Network ("QIN") submits the following response to the Legislative Auditor's report regarding the MCIP program (the "Report"). QIN fully supports the shared goals of evaluating the program's design and providing more transparency into its operations, and QIN appreciates the Legislative Auditor's efforts in conducting its review. Nevertheless, QIN respectfully submits that the Report does not further these shared goals, because it omits critical information regarding the MCIP program, reflects a fundamental misunderstanding of applicable federal law, and includes many inaccuracies and conclusions not supported by evidence. Ultimately, the Report will likely result in misunderstandings by the Legislature and the public, both of which are inconsistent with the Report's goals.

The MCIP program represents a transformational investment to improve the health and wellbeing of the Medicaid population, based on a grassroots effort to impact patients' lives in a meaningful way and on an individual basis. The improvements in Medicaid member health, outcomes, and access created by the MCIP program are indisputable, and the program has fostered unprecedented coordination between the State, MCOs, and providers serving patients from every Parish in the State.

The Report does not make any finding that the MCIP program violated any federal law, contract, or accounting practice and fails to acknowledge that the program is approved by CMS *every year*. The Report simply raises concerns, without any citation to clinical or population health evidence, that the program should have been structured differently, the amount of funds paid for some activities in the program should have been lower, LDH could have selected different objectives, the ACOs could have formed and structured their networks differently, and LDH could have made the pathway to incentive payments more difficult. *The Report contains no analysis supporting its conclusion that changing the program would improve the impact of the MCIP program or improve the health of Louisiana's Medicaid population.* The Report instead omits the dramatic successes of the MCIP program in an arena of quality programs that have historically shown little-to-no success in improving outcomes for the Medicaid population.

QIN's primary concerns with the Report include:

- <u>The Report criticizes LDH's design of the MCIP program without acknowledging the reasons for this design and without providing the Legislature information regarding the program's successes.</u> The clearest indicator of the value in the MCIP program's current design is its success in driving calculable and meaningful improvements in health, access, and outcomes across the State. These improvements are more than just numbers – they mean fewer heart attacks, less kidney failure, fewer strokes, reduced ED use, and fewer early deaths. They also mean people in Louisiana are

healthier and more capable of contributing to society and improving their condition, driving cost savings at LDH for years to come. A performance audit should address the *performance* of the program, and the Report does not.

- The Report reflects a lack of understanding regarding the clinical steps necessary to actually improve health, access, and outcomes. Improving health and outcomes happens one patient at a time. Without any analysis, citation, or input from clinical or population health experts, the Report criticizes important MCIP program elements that drive current and future improvements and savings, including the collection of invaluable data on a member-level basis, collaboration and sharing of best practices between providers, enhancements to clinical protocols, coordination of MCO and provider actions, development of thousands of pages of analysis that led to specific plans to improve health and outcomes in Louisiana, and equipping of providers and patients with essential education and resources. The Report then incorrectly concludes that invaluable program efforts such as *ED navigation services, increasing preventative care and testing, providing at-home blood pressure cuffs to patients, and expansion of digital medicine services* "are not directly associated with measurable quality outcomes." Unlike other quality programs that only tie funding to improvement of outcomes, the MCIP program has succeeded in part *because* it requires MCOs and providers to work together to develop a plan, coordinate on implementation, and then act pursuant to that plan in each patient encounter.

- The Report omits information regarding the laws and contracts that govern the program, and instead relies on differing conclusions and viewpoints, which are inconsistent with the program's actual operations and likely to lead to misunderstandings. The Report implies the program was formed haphazardly. However, the MCIP program is established and operated through detailed guidelines and oversight. Specifically, the laws and contracts that govern the MCIP program provide a specific outline of the MCIP program's operation. The administration of the program is further described in a detailed LDH Protocol. The Report barely acknowledges these governing documents or the structure they create and does not contain a single finding that MCIP program participants violated any contract terms or the Protocol. Even after receiving contrary feedback, the Report persists in advancing a complete mischaracterization of the guiding federal laws for the program, incorrectly stating that this type of quality program was first authorized in 2016, incorrectly citing principles inapplicable to MCO incentive programs, mischaracterizing the source of public funds used to finance the program, and recommending that LDH take actions that are inconsistent with federal law.

- The Report incorrectly implies that QIN misspent half of the quality funds it received and criticizes the payment methodology negotiated between QIN's health systems (all sophisticated business entities). This internal network payment methodology has no impact on LDH's spending under the MCIP program and is outside LDH's control under federal law. The design of the QIN network is a fundamental component of its success, following lessons learned in the Medicare and commercial insurance worlds to ensure important collaboration, information sharing, and alignment of interests between diverse health care systems. It is not clear why an LDH performance audit criticizes this methodology, omits that all health systems involved support the methodology, and omits that the methodology is directly in line with other similar programs. The Report also does not acknowledge the tens of thousands of hours of critical work performed as a result of the methodology.

- The Report does not make clear that MCIP payments only account for 4.8% of LDH's payments to MCOs. The MCIP program, ***without any State General Funds***, has incentivized the six MCOs, two ACOs, and more than 60 health systems, including hospitals that provide almost 90% of Medicaid services in the State, to work together on 18 distinct quality programs across four years, investing more than 160,000 hours and 80 additional staff at QIN alone. The Report makes the MCIP payments appear dramatic by aggregating the payments across all of these providers,

projects, and years without providing this context or any reference to their federal and State character as "incentive payments."

- The Report questions whether payments from QIN to Ochsner are donations and therefore violate the Constitution. These payments are not donations under any reasonable definition of the word, due to the contracts between the parties, the work performed by Ochsner, and clear Louisiana law permitting contingent fee and cost reimbursement arrangements. Any suggestion that QIN's payments are unconstitutional is contrary to both the facts and established Louisiana law.

QIN respectfully disagrees with the Report's recommendations and urges the State to exercise caution before taking any action based on the Report. QIN is providing the following attachments in support of this request:

(A) Summary of MCIP program participants and their roles;

(B) Details of concerns with the Report; and

(C) Details of the work performed by QIN in support of the program's successes.

QIN remains committed to advancing the MCIP program in a manner that improves the health, access, and outcomes of Louisianians. Further, QIN will work with the LLA, LDH, and any other stakeholders to support any efforts that will make the program more effective and impactful. To the extent the State identifies more effective projects or performance measures to advance that goal in the future, QIN and its network of health systems support LDH adopting those suggestions. However, QIN firmly and respectfully opposes the Report's findings that are critical of a structure that has succeeded.

Sincerely yours,

Lane Sisung
Executive Director

Attachments

cc: Michael Harrington, Secretary, Louisiana Department of Health

Attachment A – Summary of Program Participants

The MCIP program includes many participants, some with multiple roles.

1) Louisiana Department of Health ("LDH"): LDH negotiates and executes an annual contract with each Medicaid managed care organization ("MCO"). This contract governs the overall Medicaid managed care program. Since 2019 these contracts have authorized the MCIP program as a mechanism for LDH to incentivize MCOs to pursue LDH-chosen quality goals that expand on the MCOs' other requirements in the agreement. The federal Centers for Medicare & Medicaid Services ("CMS") *reviews and approves each LDH-MCO contract every year.*

   Prior to launching the MCIP program, LDH also adopted a Protocol for the MCIP program, which details the establishment of the MCIP projects (called Approved Incentive Arrangements or "AIAs"), the MCOs' participation and reporting, LDH's disbursement of incentive payments to the MCOs, and the MCOs' milestone achievement and payment calculation. In addition to adopting the documents that govern the overall MCIP program, LDH oversees details of the MCIP program each year. Specifically, LDH:

   - Develops and releases a Quality Strategy for the Medicaid managed care program in Louisiana, which determines the areas of focus for all AIAs in the MCIP program.

   - Reviews input from MCOs and providers on potential AIA goals and milestones for each program year, finalizes the AIAs and milestones, determines the amount of incentive payment to tie to each milestone, and then approves and releases the AIAs to the MCOs.

   - Publishes guidelines each year identifying the specific targets and documentation required of the MCOs for each milestone's achievement.

   - Receives reports from the MCOs regarding the MCIP program's progress on a quarterly basis, evaluates each set of reports to identify which milestones the MCOs achieved, analyzes the MCOs' documentation to confirm the documentation evidences the MCOs' achievement of the milestone, and then notifies the MCOs of LDH's determination.

   - Monitors the MCIP program throughout the year, and on an annual basis determines which goals to continue incentivizing in the following year and whether any changes to the MCIP program will enhance the program's impact on the Medicaid population.

2) MCOs: The MCOs enter into contracts with LDH establishing their relationship in the MCIP program. Each MCO also reviews the AIAs it receives from LDH each year and subcontracts with two distinct network entities to assist the MCO in its achievement of distinct AIAs. Each network entity is an Accountable Care Organization ("ACO") that coordinates a distinct coalition of health systems to assist each MCO in its achievement of the AIAs.

   The ACOs submit documentation to each MCO reflecting the work the ACO complete on a quarterly basis. Each MCO works with the ACOs to address any MCO questions or comments regarding this quarterly documentation, and then upon the MCO's approval of the documentation, the MCO submits the documentation to LDH. Each MCO then works with LDH to address any questions or requests for changes/resubmission from LDH. Upon LDH's determination of the MCOs' achievement of milestones, each MCO receives an incentive payment from LDH.

   Contrary to statements in the Report, the MCOs also communicate with the ACOs on a routine basis outside of the quarterly reporting process and data review, including to: (1) provide guidance to the

ACO regarding the MCO's prioritization of subject matter areas for development of AIAs/milestones for the upcoming year; (2) participate in workshops and meetings with the ACO and health systems related to specific AIAs/milestones; (3) provide information to the ACO and health systems on resources available to Medicaid members that align with the work performed by the network in the AIA; (4) coordinate navigation efforts with the ACO and participating health systems; and (5) present information to the ACO and health systems in support of the MCIP program goals (including information on other MCO quality initiatives to further alignment across programs).

Separate from the MCIP program, but as a result of the coordination between the MCOs and health systems that results from the MCIP program, the MCOs analyze the data submitted by the ACO and use that information to better provide case management services for their enrollees.

3) Accountable Care Organization or "ACO": The ACOs contract with the MCOs to assist in achievement of MCIP quality milestones. An ACO "refers to a legal entity composed of a group of providers that assume responsibility (are accountable) to manage and coordinate care for a defined group of patients in an effective (high quality) and efficient (low cost) manner."[1] ACOs coordinate clinical efforts among participating health systems, facilitate the delivery of more effective and efficient care through increased care access, population management, care management, and education, and facilitate the ability to translate data to promote more effective care.[2] The ACO's efforts to coordinate its diverse network of health systems is essential to the success of the MCIP program in improving health and outcomes for the Medicaid population, as discussed in more detail in Attachment B. QIN only has visibility into its relationships with the MCOs, and QIN bases the information it provides in these Attachments, regarding MCO-ACO relationships, exclusively on QIN's relationships.

4) Quality and Outcome Improvement Network or "QIN": QIN is one of the two ACOs currently contracting with the MCOs related to the MCIP program. QIN was created by and is a component of the Hospital Service District No. 1 of the Parish of Terrebonne (the "District"). QIN has a contract with each MCO to lead, coordinate, and synthesize its network health systems' efforts to achieve quality milestones associated with specific AIAs. In return for QIN's services, each MCO agrees to pay QIN a portion of the funding the MCO receives under the MCIP program related to those AIAs.

   QIN successfully brought together a network of geographically diverse health systems, willing to work together collaboratively, providing services to individuals in every parish in the State, to assist the MCOs in achieving the quality milestones reflected in LDH's AIAs. QIN has a contract with each health system in its network. The contract requires the health system to use its administrative, financial, technological, population health, and clinical resources to assist in the MCOs' milestone achievement. These contracts also transparently identify the methodology QIN uses to pay each health system in QIN's network.

5) The District: The District owns and is responsible for the operations of two hospitals – Terrebonne General Health System ("TGHS") and Southern Regional Medical Corporation, dba Leonard J. Chabert Medical Center ("SRMC"). The District also owns QIN, and the District is responsible for the operation of QIN. Although these entities are described separately at times in the Report and herein, the three entities are controlled by the same Board of Commissioners and the same senior Leadership team. TGHS, SRMC, and QIN are each components of the District.

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1 Presentation by Dr. Neil Kirschner, American College of Physicians, "[ACO] 101 Brief Course".

2 *Id.*

Attachment B – Details of Concerns with the Report

CMS first authorized programs like the MCIP program, to incentive improvements in quality for the individuals covered by the Medicaid MCO program, in 2002 as part of Title 42, Section 438.6 of the Code of Federal Regulations. Unlike other quality programs that penalize MCOs or providers if they do not meet targets, through the MCIP program, the federal government and State utilize a small percentage of the State's overall payment to the MCOs to creatively incentivize the development, implementation, and success of quality initiatives. The MCIP program therefore provides the opportunity to use local public funds to draw additional federal funding, *which is not otherwise available to Louisiana*, to incentivize these quality initiatives for the most vulnerable citizens in Louisiana.

The Report omits discussion or analysis of the dramatic improvements in health, outcomes, and access that have resulted from the MCIP program design. Four critical components of the MCIP program enabled the program to begin effectuating long-lasting changes in the health of Louisiana's Medicaid population.

- LDH's milestones required MCOs and providers to first identify the causes of poor outcomes and develop solutions that work one patient at a time – successful solutions are more difficult to find for Medicaid members because of the additional barriers they face (e.g. transportation issues, inflexible work hours, less access to healthy foods, and other socioeconomic barriers).

- LDH's program design encouraged the providers that see Medicaid members to make meaningful investments that take time to show results by <u>both</u> supporting investments and incentivizing outcome improvements.

- The MCOs elected to use ACOs, a common tool utilized in the Medicare and commercial insurance worlds, to ensure collaboration, coordination, information sharing, and alignment of interests between diverse health care systems statewide.

- The MCIP program overcame a common hurdle to the success of quality programs, and used milestones to ensure that the data collected through the program was consistently and accurately reported.

The Report is critical of each of these components of the MCIP program, does not reflect sufficient analysis nor an understanding of their value, and contains no analysis supporting its conclusions that changing these components would improve the impact of the MCIP program on Louisiana's Medicaid population.

Although LDH's payments in the MCIP program appear dramatic when aggregated across six MCOs, two ACOs and more than 60 health systems representing tens of thousands of providers including hospitals (who provide almost 90% of the Medicaid services in the State), clinics, and clinicians, working on 18 distinct quality projects, the reality is that LDH only paid the MCOs an additional 4.8% of the total amount paid to the MCOs for insuring Louisiana's Medicaid population. The MCOs used 2.7% of this 4.8% to pay QIN and its network of health systems to assist in achieving these quality projects.

QIN's efforts required more than 160,000 hours from various levels of experts in clinical standards, case management, and population health and resulted in the investment of 80 Full Time Equivalents ("FTE") in additional staff serving the Medicaid population. In addition to these efforts, QIN's health systems trained thousands of providers, nurses, and staff members each year on best practices and project initiatives. The coordination of these efforts ensured that all health system staff members were working together to achieve the MCIP program goals.

The MCIP program has met, and continues to meet, the goals of the federal laws under which it operates, by developing innovative ways to truly impact population health, and by providing insight into future

methods for improving the quality of care for the entire Medicaid population, to ensure patients receive the right care at the right time and in the right setting.

Following are more details regarding: (1) the significant improvements in health, outcomes, and access and the transformational impact on delivering care to the Medicaid population that resulted from the MCIP program as designed; (2) the importance of incentivizing front-end investment, and coordination by an ACO in achieving these improvements; (3) the current source of local government and federal funding used to finance MCIP payments; (4) the federal laws and agreements that govern the MCIP program and inform its current design; and (5) the Louisiana constitutional concerns raised by the Report.

I. <u>The Report criticizes the design of the MCIP program without acknowledging the health outcomes and transformational impact on delivering care to the Medicaid population that resulted from that design.</u>

The MCIP program was designed to drive significant improvements in health outcomes for Medicaid patients, fully supporting LDH's commitment to quality care. As outlined in the sections below, the MCIP program has not only achieved, but continues to advance, this critical goal. The clearest indicator of the value in the MCIP program's current design is the program's success.

The Report expresses significant concerns regarding the MCIP program's design, without consideration of the MCIP program's successes, without regard to the MCIP program's compliance with federal law (as confirmed by CMS each year), without providing support from population health or clinical experts to substantiate the Report's concerns, and without recognition that the MCIP program, as currently designed, remains purposeful, impactful, and effective in fulfilling the program's mission.

The MCIP program's achievements include: (a) the improvements in Medicaid member health, outcomes, and access resulting from the MCIP program, (b) the meaningful activities undertaken by the health systems due to the MCIP program, and the long-term impact of these activities, and (c) the collaboration between and amongst MCOs, the health systems, and individual healthcare providers fostered by the program.

The Report does not discuss or analyze this information, nor does it reflect an understanding of the details surrounding quality efforts and their impact on patients. Instead, the Report concludes that invaluable efforts such as providing ED navigation services, increasing preventative care and testing, and improving analysis and data reporting "are not directly associated with measurable quality outcomes" and recommends that LDH consider "updating its milestones to place more emphasis on measurable results."[3]

A. The MCIP program accomplishes measurable health, outcome, and access improvements for the Medicaid population in Louisiana.

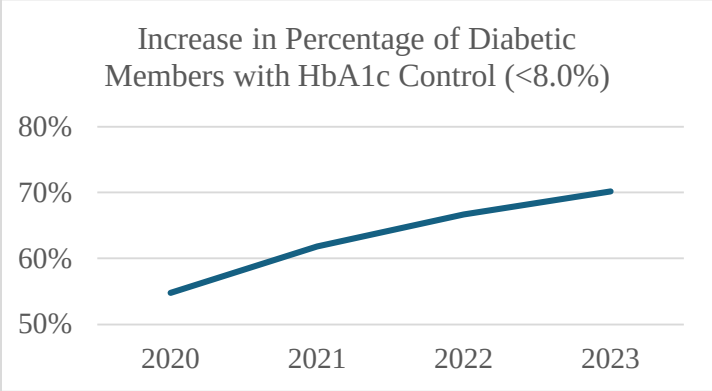
The MCIP program has proven successful in achieving dramatic improvements in the health and outcomes of Medicaid members, which improves the lives of these members and leads to lower costs for the State.

These improvements in health and outcomes are more than just numbers. They mean people in Louisiana are healthier and more capable of contributing to society and improving their condition. As examples, improvement in blood sugar management among patients with diabetes means fewer early deaths and fewer Louisiana residents facing amputation, heart problems, strokes, and kidney failure. Improving blood pressure control among patients means fewer heart attacks, fewer heart failures, and fewer strokes. Increased well-child visits leads to healthier children by identifying and addressing health issues earlier in the child's life, supporting healthier habits, and reducing ED use. All of these improvements separately lead to increased access – with Louisiana's shortages of health care professionals, every avoided health problem opens access for another patient in need. Finally, all of these improvements equate to current and future cost savings for the State and the federal government. Following are examples of how the MCIP program

[3] Report at 13 -14.

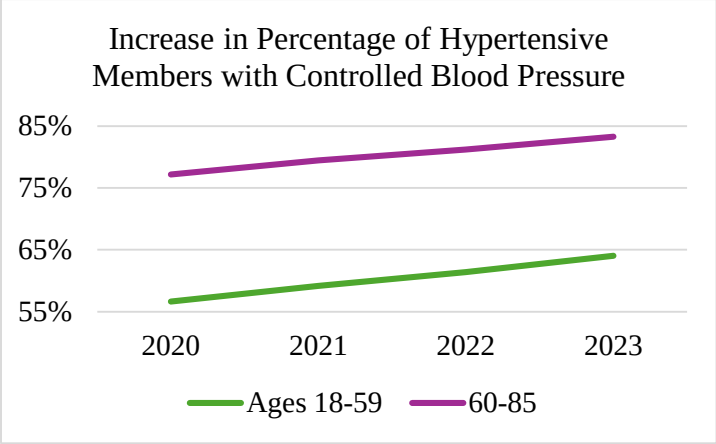
has improved healthcare outcomes and access across diverse patient populations, for the AIAs in which QIN is involved:

- A 28.1% improvement in diabetic blood sugar management with over 70% of the diabetic participants having a controlled A1c (which is in the 95th percentile nationally).



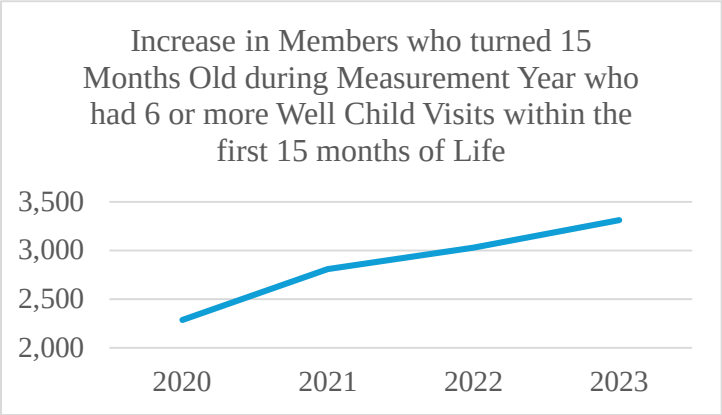
This chart reflects the consistent improvement, each year from 2020 to 2023, in the percentage of Medicaid diabetic patients tracked by the MCIP program who maintained control of their blood sugar levels.

- Consistent improvement in blood pressure control from 2020-2023 among Medicaid patients with hypertension:
    - Among those ages 18-59, blood pressure control improved from 56.64% to 64.07%, which is in the 75th percentile nationally, and among those ages 59-85, blood pressure control improved from 77.21% to 83.3%.



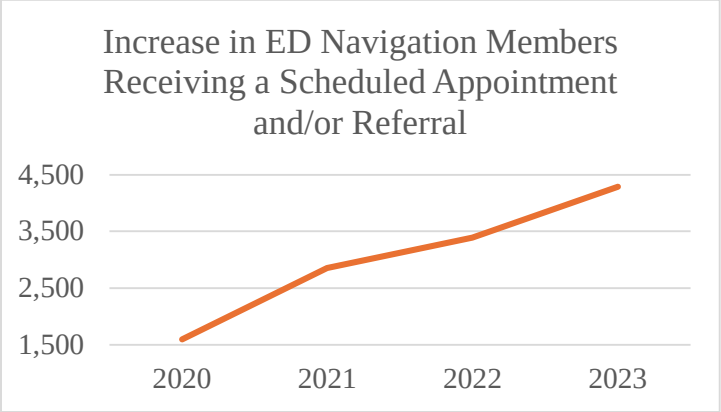
For both diabetes and hypertension, the year-over-year improvements presented in these charts exemplify the substantial investments made by the MCOs, ACO, and health systems. These outcomes are the result of comprehensive enhancements to clinical protocols, intensive training of care teams, and the implementation of new patient management processes. Each incremental gain in patient control underscores a commitment to rigorously refining treatment pathways, expanding patient education, and strengthening follow-up procedures, all of which have been made possible through strategic investments in both personnel and technology.

- Nearly 20% improvement in well-child visits, part of which is attributable to the health systems' efforts to facilitate school-based clinics, bringing care directly to the children and overcoming barriers including transportation issues.



Increased well-child visits will lead to long-term dividends in terms of healthier children and cost savings for the State, by identifying and addressing health issues earlier in the child's life, supporting healthier habits, and reducing these children's ED use.

- Consistent improvement in scheduling primary care and specialty care appointments/referrals for Medicaid enrollees who were frequently visiting a hospital ED for their care. QIN's health systems secured agreement from nearly 23,000 high-ED utilizers to join the MCIP ED navigation program by the end of 2023, with each individual affirmatively choosing to join the navigation program, agreeing to receive navigation services, meeting with a navigator, and providing contact information that enabled their continued navigation.



The MCIP program's ED navigation efforts lead to better outcomes, improved access, and cost savings for MCOs and LDH, through a meaningful reduction in avoidable ED visits from 2020 to 2023. Specifically, the rate of avoidable ED utilization at QIN's health systems decreased from 8.5% in 2020 to 7.34% in 2023. These figures are even more impressive due to the number of patients that did not go to the hospital or ED in 2020 because of the COVID pandemic.

This increase, as with the increase in well child-visits, underscores the commitment of the participating health systems to proactive and preventative care.

There are many other notable examples of the MCIP program's successes, for the AIAs in which QIN is involved, including: (1) increased rates of regular HbA1c testing among diabetic patients, which helps these patients manage their blood sugar control and directly results in improved health for this population; (2)

increased pediatric outreach related to enhanced awareness of body mass index ("BMI"), nutrition, and physical activity, fostering healthier habits from a young age; (3) educational initiatives for expectant mothers, contributing to a consistent decline in C-section rates and low birth weights; and (4) among frequent ED visitors, targeted education on outpatient care and appointment scheduling leading to more regular preventive care usage, reducing reliance on emergency services.

These improvements are significant, but especially so within the Medicaid population. Furthermore, the progress above is just the beginning. While the data presented reflects advancements over a 2-3 year period, QIN's efforts are structured to create lasting, sustainable changes that will continue to drive improvements and LDH cost savings well beyond the initial five-year AIA project timeline. Beyond the future cost savings from a healthier Medicaid population with better habits, expanding patient and provider engagement, and equipping Medicaid members with essential education and resources, will continue to drive further improvements in health and outcomes for years to come.

B. The MCIP program motivates health systems to identify and then implement initiatives above and beyond those required through the program.

The MCIP program's success is due in part to the design of the AIAs and LDH's inclusion of milestones that require MCOs to work with health systems to invest in infrastructure, change the manner in which providers relate to patients, and require activities that drive improvements in health and outcomes. This requires up-front investment in research and analysis to determine the specific reasons why Louisiana's Medicaid population underperforms on specific outcomes and to identify specific activities that will improve these outcomes. This then requires continuous investment in these activities on an individual patient basis.

Unlike other quality programs that only tie funding to improvement of outcomes, the MCIP program requires MCOs and providers to work together to develop a plan, coordinate on implementation of that plan, and then act pursuant to that plan in each patient encounter. These initiatives are reflected in detail in the thousands of pages of documents and reports the MCOs submitted to LDH in the MCIP program, which the Legislative Auditor received as part of its audit.

As an example, the ED navigation program required providers to assess each patient's individual reasons for frequent ED usage and work to address the patient's issues. Because this approach was uniquely tailored to each patient, providers witnessed firsthand the life-changing effect that successful navigation had on their patients. One story relates to a paraplegic Medicaid patient with 22 hospital admissions and 99 ED visits in the span of three years. Once ED navigators arranged reliable transportation for this patient, she was able to attend primary care and urology appointments on a regular basis and her hospital use decreased drastically. *The patient reported that MCIP changed her life and allowed her to care for herself again.* Another Medicaid patient frequented the ED for heart issues. When providers realized the patient's issues actually stemmed from anxiety, ED navigators scheduled a referral for the patient to receive anxiety treatment. *The patient told the navigator that MCIP allowed him to address the underlying causes of his condition, rather than just manage the symptoms.* The MCIP program is different from other quality programs because it focuses on improving outcomes for individual patients, not just reporting aggregate numbers. The MCIP program allows providers to put a face and an individual story to each patient, instead of looking at patients as another statistic.

There are countless similar stories of patients impacted by the MCIP program, including common stories of health systems and clinicians assisting patients to set up and attend primary care appointments, common stories of patients successfully avoiding subsequent ED visits, common stories of patients building relationships with their ED navigators and proactively reaching out to them for help in determining whether to seek care in the ED or through primary care services, and common stories of providers connecting patients with resources to address fragmented care, transportation issues, and other social and economic barriers to improving their health.

These gains are the direct result of focused investments in patient navigation services, expanded outreach initiatives, and enhanced scheduling infrastructures that facilitate timely access to care. By channeling resources into areas such as care coordination teams, streamlined appointment systems, and community education efforts, these health systems successfully improved patient engagement and adherence to recommended care schedules. This approach not only reduces unnecessary ED visits but also supports early developmental assessments and preventive care for young children, establishing a solid foundation for health outcomes that will positively influence patients and communities over the long term.

The MCIP program's design also emphasizes health system and patient engagement through prioritization of comprehensive patient education. The MCIP program's education efforts empower individuals with the knowledge and skills essential for managing their health effectively in the future. These are lifelong lessons that will continue to show benefit to the State, these patients, and to their families for decades to come. As one clinician phrased it, "MCIP teaches a person to fish, rather than handing them fish." Examples include educating patients regarding whether to seek urgent/primary care or the emergency room for medical issues, healthy lifestyle choices related to proper diet and exercise, tobacco cessation, and information on managing chronic illnesses.

Through the MCIP program, health systems build meaningful relationships with individual patients and helping them make appropriate medical decisions. Because of these meaningful relationships and the care that the systems have for their patients, they are motivated to go above and beyond to implement additional initiatives to further improve patient health. For example, health systems are also taking actions including:

- expanding access to services through flexible scheduling initiatives such as same day appointment availability and extended hours on nights and weekends,
- proactively monitoring Medicaid drug coverage to ensure drugs are covered and to promote increased medication adherence,
- tracking additional patient health data points through chronic disease registries,
- identifying and addressing social determinants of health that impact patients' wellbeing,
- providing or facilitating transportation to Medicaid patients to improve access,
- increasing availability of healthy food options in the community,
- assisting patients with completing Medicaid applications and addressing disenrollment issues,
- facilitating sleep studies to help understand the associated risk with high blood pressure,
- partnering with local community resources to address food insecurity issues,
- hiring specialty care and dental providers to expand access to services,
- developing a pulmonary rehabilitation program to assist individuals with chronic lung diseases, and
- providing at-home blood pressure cuffs to help hypertensive patients monitor blood pressure rates.

The at-home blood pressure cuff initiative is particularly notable. One clinician stated that prior to implementation of the MCIP program, practitioners would typically measure a patient's blood pressure 1-4 times per year. Now, through the remote blood pressure monitoring system, the clinician is able to monitor blood pressure 1-5 times per week.

Other examples of initiatives include mobile CT scans for lung cancer, community gardens to mitigate food insecurity and provide access to healthy foods, creating "New Mom" care packages that include resources like diapers, bottles, and other supplies for new mothers to utilize in effectively caring for their babies, developing innovative, diabetes-friendly recipes that incorporate traditional regional foods, offering healthier alternatives that respect and align with patients' cultural preferences and dietary practices, and hiring specialty physicians to supplement primary care clinic appointments for certain patients, guaranteeing that comprehensive services were available to those that needed them.

The MCIP program has also driven a transformative approach to chronic disease management that health systems built through allocating resources to specialized care teams, investing in monitoring systems, and establishing robust community outreach programs. Such investments not only drive sustainable

improvements in clinical outcomes but also set a new benchmark for quality care delivery, positioning these health systems as leaders in managing complex conditions and enhancing patient quality of life on a lasting scale.

C. The MCIP program enhances collaboration among all AIAs, participating health systems, and MCOs, ensuring that all stakeholders are consistently and systematically working toward the same goals.

The MCIP program promotes coordination across all AIA focus areas, as well as coordination between and amongst the participating health systems and MCOs. It is important that efforts to promote the AIAs align with each other and move Louisiana toward a common goal. Additionally, collaboration among MCOs and participating health systems is important because each of these stakeholders provides meaningful perspective and resources that are important to patient health in Louisiana.

In the words of one clinician, MCIP projects are synergistic, and "improvements [from one project] spill over into other areas." There are many examples of these synergies. The diabetes and hypertension AIAs are aligned because patients with diabetes typically struggle with hypertension as well. The MCIP program, and the collaboration the program's design fostered, resulted in the use of similar tactics to address both issues among patients. The maternal care and hypertension AIAs similarly reflected synergies. Remote blood pressure monitoring initiative in the hypertension AIA not only helped patients with high blood pressure, it also helped expectant mothers receive more information on their health throughout their pregnancy and monitor their health more effectively. As another example, health systems implemented an aspirin therapy course for pregnant women, designed to decrease the incidence of preeclampsia, a condition characterized by high blood pressure during pregnancy.

The MCIP program design also incentivizes the MCOs, ACOs, and diverse health systems to work together to improve the lives of Louisiana's Medicaid population. Achievement requires analysis, monitoring, and reporting.[4] One of the biggest struggles in implementing the MCIP program was tackling how to collect consistent data across participating health systems that operated on separate electronic health record systems. Like other ACOs, QIN worked with its network to develop, implement, monitor, and adjust consistent processes that ensured all participating health systems collected the same data points and reported on those data points in a standardized manner. This process took almost a full year at the outset of the program, with meetings on how to obtain and report the data within the confines of patient privacy and security, how to address cross-platform technology issues, and how to identify best practices for data collections.

The process continues now, as QIN works on an ongoing basis to ensure the consistency of its network's data. Now that the MCIP program is operational, the data compiled for the AIAs enables more robust data aggregation and intersectional analyses by demographic, such as race, ethnicity, geography, gender, and age. This helps identify gaps and allows providers to address disparities more accurately. QIN works with the participating health systems to coordinate analysis of the barriers and gaps leading to Louisiana's current health and outcome performance and to craft plans to overcome these barriers within the AIAs. Additionally,

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[4] See, e.g., Ellis, Lisa "Using Health Outcomes Research to Improve Quality of Care," Dec. 17, 2015, available at https://nam04.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.hsph.harvard.edu%2Fecpe%2Fusing-health-outcomes-research-to-improve-quality-of-care%2F&data=05%7C02%7Cbrinker%40gl-law.com%7Ca0bdc54277d24abc1edd08dcf75e5f86%7C6da2c7c82f884ff0ba87bc3888805377%7C1%7C0%7C6386572319 26929643%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C0%7C%7C%7C&sdata=n6GYwoGMWSuvlBiw1SNjAEj1g%2FqIDQEdGnCa%2BQRmcT8%3D&reserved=0 *("Healthcare professionals are increasingly turning to health outcomes research for the evidence-based guidance they need to improve care. Clinicians and executives use this information to assess and improve their business performance or for insight into the most effective treatment options to consider for diverse populations with a range of diagnoses."*).

a majority of the participating health systems in QIN established and utilize dashboards for ongoing monitoring of metrics to ensure they stay on track to reach LDH's goals.

The services the MCOs provide to LDH outside of the MCIP program also benefit from the collaboration fostered by the MCIP program. For example, the MCOs utilize the patient data from each AIA to identify and schedule interventions for at-risk patients, such as those with recurring high HbA1c results or those in need of ED navigation services, and to enhance the MCOs' case management services.

II. The Report criticizes the design of the QIN network, and inaccurately concludes the MCIP program therefore spent money inappropriately, without considering the importance of the QIN network's design to the program's successes.

Federal law prevents the State from directing how payments are negotiated once LDH makes an incentive payment to the MCOs for achieving LDH-set milestones. *Further, the amount of MCIP funding paid to participating health systems does not impact LDH's expenditures under the MCIP program*. It is therefore not clear why an audit of LDH's performance would include any discussion or criticism of the internal payment methodology negotiated between QIN and the sophisticated business entities (including large, multi-national corporations) that make up the QIN network. It is also unclear why the Report would recommend that LDH "consider amending its contracts with the MCOs to establish terms and conditions on how MCIP funds should be used" in light of the clear federal law on this issue.

The Report is nonetheless critical of the internal payment methodology agreed to by QIN and its participating health systems, because of the amount paid to the entities that coordinate the health systems' participation in the MCIP program. QIN disagrees with the Report's conclusions – the design of the QIN network represents a fundamental component of the MCIP program's success.

A. The Report concludes certain health system participants received excessive payments without acknowledging the significant investments made.

The Report appears to imply QIN spent half of the quality funds inappropriately, saying "QIN only paid $627.4 million (49.2%) of the $1.27 billion it received to 37 participating hospitals between December 2019 and February 2024" and incorrectly concluding that the remaining dollars were not used for the purposes of increasing access to health care, improving quality of care and enhancing the health of Medicaid beneficiaries.[5]

QIN does not "retain" funds as claimed in the Report. QIN is a wholly owned subsidiary of the District. QIN has no funds of its own, and everything QIN has belongs to the District. QIN is simply an operating subsidiary arm of the District. The District is also a health system that owns two participating hospitals – TGHS and SRMC. These two operating arms developed the ACO (under the direction of their owner, the District). By separating what is a single operating entity into separate components, the Report tries to characterize the funds as misappropriated. The terms ACO, TGHS, SRMC, and QIN are all terms for wholly owned components of the District. The District is all of them, and each of them is the District. Paying the hospitals owned by the District for developing, negotiating, and implementing the MCIP program is a critical component of the program's success. The fact that QIN is also owned by the District does not negate the payment from QIN to the District's hospitals.

QIN's contracts with the MCOs specify, "QIN is authorized to receive Coordination Payments from [MCO] all of which shall be distributed to Providers." Contrary to the Report, QIN satisfied this requirement – 100% of the payments received from the MCOs went to participating health systems. Nothing in the MCO-QIN contracts dictates the manner or amount in which QIN distributes payments to the participating health systems. QIN negotiated a contract with each participating health system, and these contracts also require

[5] Report at 15.

payment to participating health systems of 100% of the funding QIN receives under the MCIP program. QIN complied with all these contracts and paid all funds to its participating health systems.

B. The Report contends the MCIP program paid too much to the District for creating, investing in, and operating QIN.

Similar to other ACO's, QIN used about half its payments for the investment in creating the infrastructure, accepting the risk associated with serving as an ACO, and carrying on the day-to-day operations of the network related to its participation in the MCIP program.

QIN works with experts that research, identify, synthesize, educate, and explain the clinical and population health best practices needed to achieve improvements in health outcomes, technical staff that collect and synthesize the data from each participating health system, project managers that work to influence improvements, and program staff who compile the data and prepare the documents and reports for review and approval of the MCOs and LDH.

QIN also actively manages the coordination of all aspects of the AIAs to ensure consistent protocol development, uniform metric measurement, and synthesized data collection. This undertaking comprises different tasks throughout every stage of the AIAs, requiring up to 7,600 hours of consultant work per year. For example, some of this work includes:

- Formation of the network: Associated work included explaining the ACO to potential participants in the network, forming QIN as a component of the District, and negotiating agreements with each health system.
- Administration and coordination with LDH and MCOs: Related tasks include collaboration with LDH to design new AIAs, establishing criteria for annual milestones, soliciting MCO feedback on reporting submissions and focus areas for new AIAs, coordinating reporting submissions, and resolving issues identified by LDH in reporting submissions.
- Network maintenance and coordination: Associated work includes developing and administering a timeline for reporting deliverables, developing and maintaining standardized reporting templates, protocols, and milestone specifications for each AIA, facilitating ongoing engagement from participating health systems, and coordinating patient and provider education.
- Coordinating, creating, and completing milestone reporting**:** The related tasks include calculating QIN's baselines and performance rates to determine achievement of LDH's milestones.

More detail regarding the work provided by QIN and Ochsner is attached as Attachment C.

The Report does not relay the work underlying the amount paid to QIN as the ACO, fails to understand the impact of this work on the success of the MCIP program, and does not include any discussion regarding whether the amount paid to the District (the owner of two large participating health systems and the ACO) is also in line with other ACOs receive for using their funds to form, manage, and operate self-sustaining quality and coordination networks. Following is data on comparable ACOs and the amount dedicated to investments in infrastructure and design:

ACO (most recent year reported)	Payment to ACO (Investments in Infrastructure and Redesigned Care Processes/Resources)	Payment to Other ACO Participants
AHN Accountable Care Organization (2022)	74%	26%
Alabama Physician Network (APN), LLC (subsidiary of UAB Health System) 2022)	30%	70%

ACO (most recent year reported)	Payment to ACO (Investments in Infrastructure and Redesigned Care Processes/Resources)	Payment to Other ACO Participants
Ascension Care Management Health Partners Indianapolis (2022)	0%	100%
Baylor Quality Health Care Alliance (2022)	57.5%	42.5%
Baylor Scott and White Health (2022)	57.5%	42.5%
BJC HealthCare ACO (2021)	42%	58%
CareMax National Care Network (2021)	20%	80%
Coastal Carolina Quality Care (2022)	40.6%	59.4%
Delaware Valley ACO (2022)	32.5%	67.5%
Evolent Health (2022)	40%	60%
Kansas Clinical Improvement Collaborative (2020)	0%	100%
Louisiana Primary Care (2022)	70%	30%
Mass General Brigham ACO (2020)	5%	95%
Medical University of South Carolina (2020)	40%	60%
Memorial Hermann Healthcare System (2022)	35%	65%
Mission Health Partners (2021)	40%	60%
Northwest Florida Health Partners (2021)	50%	50%
Novant Health Accountable Care Organization (2022)	30%	70%
NYC Health and Hospitals ACO (2022)	42%	58%
Physician Quality Partners (2022)	30%	70%
Southeastern Health Partners Medicare ACO (2021)	25%	75%
SSM Health ACO (2022)	60%	40%
Stanford Medicine Partners (2022)	15%	84%
UC Irvine Health ACO (2020)	60%	40%
United Outstanding Physicians ACO (2019)	50%	50%
University Hospitals Coordinated Care (2022)	50%	50%
West Florida ACO (2022)	40%	60%

The amount paid to the District clearly represents reasonable and appropriate value for the tens of thousands of hours of work the District performed, the risk the District undertook in creating the network before knowing whether the MCIP program would succeed, and the District's investment in the MCIP program.

III. The Report reflects a misunderstanding of federal law surrounding IGTs and incorrectly describes the current IGT process.

The Report ignores or does not reference critical information regarding IGTs, which was previously provided to the Legislative Auditor, and instead incorrectly states in multiple separate contexts that the District is "repaid" its IGTs. It is unclear why the Report devotes several pages to a discussion of IGTs that

is likely to lead to confusion and misunderstanding, when the Report ultimately makes no recommendations to LDH related to IGTs.

The District receives payment from QIN for two roles. First, the District hospitals receive payment for investing to create, operate, and take the risk of being the ACO for the entire network. This is already addressed in Section II above. Second, the District's hospitals receive payment related to AIAs to incentivize the work performed to assist with achievement. Neither of these two payments are related to IGTs. These payments are required by the terms of the Network Provider Agreement in consideration of the investment and work performed by the District. Furthermore, the District always makes its IGTs before LDH makes an MCIP payment, consistent with CMS direction that no payment can be made until performance has been achieved. This flow of funds makes clear the District uses its public funds, not MCIP payments, as the source of all IGTs.

The Report ignores that *the amount the District receives (between 40% and 55% per the contract, plus a discretionary fund of $30 million per year) does not deviate based on whether and in what amount the District makes IGTs*, as explained in the contracts provided to the Legislative Auditor. The amount the District negotiated in these contracts was determined based on the work necessary to coordinate the network of participating health systems and is based on the market amount retained by ACOs generally.

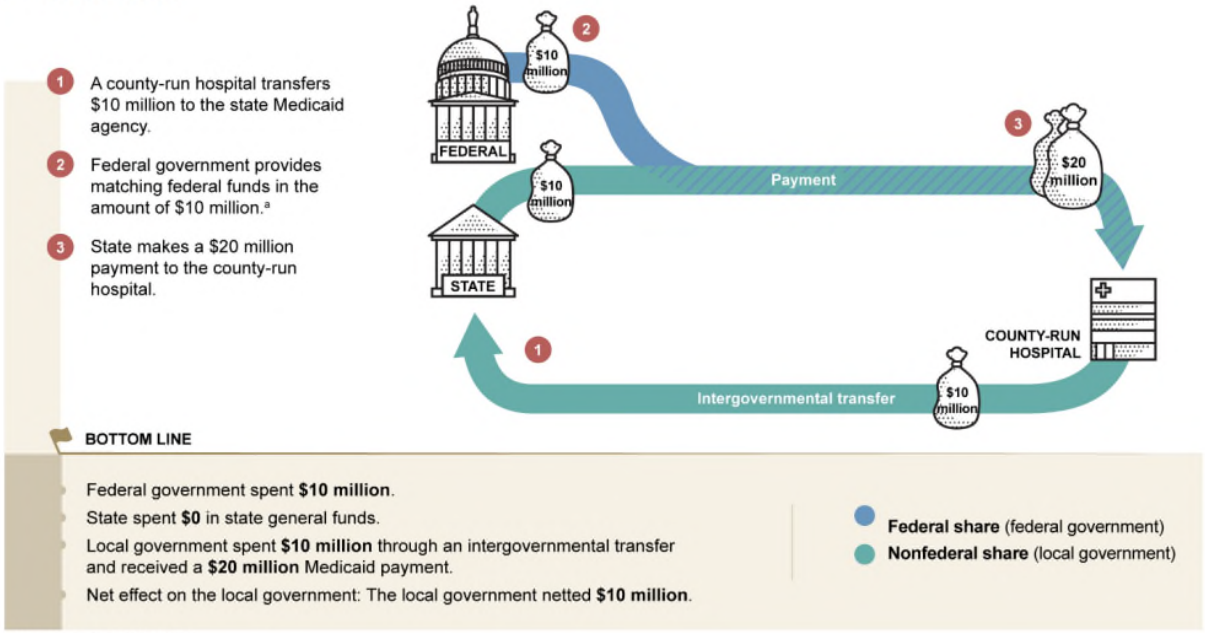
Under the MCIP program, both networks are State/local governmental entities willing to voluntarily transfer public funds to LDH as the State Medicaid agency through IGTs, in the event LDH did not receive State General Fund appropriations to finance the non-federal share of MCIP program. IGTs of public funds represent an eligible source of funding for the non-federal share of Medicaid payments explicitly authorized in federal law[6] *and protected by Congress*.[7]

In practice, the State of Louisiana has not contributed any State General Funds to the MCIP program. Therefore, whenever LDH determines payment is owed to the Medicaid MCOs under LDH's contracts with the MCOs, LDH requests that political subdivisions of the State transfer public funds to LDH to support the non-federal share of the payments. Since the inception of the program, the District, through its two operating hospitals TGHS and SRMC, transferred public funds (IGTs) for the non-federal share of the incentive payments to the MCOs. The funds LDH received as IGTs represent public funds eligible for federal match, in accordance with State and federal law. LDH subsequently used these IGTs to make MCIP program payments to the MCOs.

TGHS and SRMC also voluntarily transfer their public funds to support the General Medicaid program, which LDH uses to finance the non-federal share of other Medicaid payments. This IGT structure closely follows the structure of permissible IGTs outlined by the U.S. Government Accountability Office ("GAO"), in a 2020 report to Congress referenced by the Report, explaining that a state's non-Federal share may be paid entirely through an IGT "from local governmental entities such as providers owned or operated by local governments" through a process such as the following:

6 42 U.S.C. § 1396(a)(2). See also 42 C.F.R. § 433.51.
7 42 U.S.C. § 1396a(w)(6).

Figure 4: Example of a State Medicaid Payment Financed by an Intergovernmental Transfer and Federal Funds



Source: GAO. | GAO-20-571R

As the Medicaid and CHIP Payment and Access Commission ("MACPAC") similarly explained in a June 2024 report to Congress – "IGTs can be used to finance *payments for providers transferring the funding, to finance specific payments to other providers, or for overall Medicaid spending*."[8]

- Timing of IGTs – The timing of LDH requesting and receiving voluntary IGTs from other subdivisions of the State, in advance of the MCIP payments to the Medicaid MCOs, is intended to follow the approved practice nationwide. As the GAO explained in the same 2020 report to Congress – "[u]nder agency policy, CMS requires that IGTs occur *before* the state makes a Medicaid payment to the provider."[9]

- Source of IGT Funds – Congress, when issuing protections for IGTs in 1991 (these protections remain in place today), explicitly confirmed that "[a] hospital district may transfer or certify to the State Medicaid agency a portion of its revenues, which may be collected by the district's facilities as payment for services rendered, or through its special taxing authority."[10] This was most recently reiterated in the June 2024 report to Congress from MACPAC, which explained "[p]ublic providers, such as public hospitals, can derive the funds that they use for IGTs or CPEs from any public funds…" The source of IGTs provided by the District through TGHS and SRMC follows this guidance.

CMS has explained the IGT issue clearly, and last did so again in May 2024. IGTs from state and local governmental providers account for at least 10% of the non-federal share of Medicaid payments nationwide.[11] IGTs represent a permissible funding mechanism used by States across the country to finance Medicaid programs today including those used in Louisiana for the Hospital Directed Payment Program and MCIP programs.

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8 MACPAC, Improving the Transparency of Medicaid and CHIP Financing (June 2024) (*available at https://www.macpac.gov/wp-content/uploads/2024/06/MACPAC_June-2024-Chapter-1-Improving-the-Transparency-of-Medicaid-and-CHIP-Financing-1.pdf*).

9 GAO-20-571R (July 14, 2020) (*available at https://www.gao.gov/assets/gao-20-571r.pdf*) (emphasis added).

10 H.R. CONF. REP. 102-310, 1991 U.S.C.C.A.N. 1413, 1426 (Nov. 26, 1991).

11 89 Fed. Reg. 41002, 41073 (May 10, 2024).

IV. The Report does not acknowledge that the participants complied with every aspect of the rules and guidance LDH set forth and followed the terms of all contracts governing their actions.

The Report does not address the significant regulatory and contractual framework of the MCIP program. These strict and detailed program requirements are outlined in numerous government regulations, LDH protocols, and publicly available contracts. Despite the numerous findings contained in the Report, the Legislative Auditor does not suggest that QIN failed to comply with any MCIP program requirements. The following regulations and contracts govern the MCIP program:

Regulation/Contract	Description
42 C.F.R. § 438.6(b)	Federal regulation that allows states to enter into incentive arrangement contracts with Medicaid managed care plans up to 105 percent of the CMS-approved capitation rates. ***No findings in Report that the MCIP program deviates from this regulation.***
Contract Between LDH and MCOs	LDH's contract with the MCOs, which permits the MCOs to participate in MCO incentive arrangements with "one or more third parties" to assist in achievement of the incentive programs. Section 5.18.2 describes the activity third parties (i.e., QIN) are expected to perform. ***No findings in Report that QIN fails to perform any of the required activities.***
LDH Protocol for MCIP	Detailed guidelines issued by LDH confirm the approval of the MCIP program, requirements for MCO participation, MCO reporting, disbursement of incentive payments, and other program administrative matters. ***No findings in Report that MCOs have deviated from LDH protocol in any way.***
MCO-ACO Agreements	Contract between each MCO and QIN detailing QIN's specific performance obligations to assist with achievement of MCIP incentive achievement. The contract also provides specific obligations on MCOs, including payment of administrative fees and incentive awards. The agreement includes several exhibits listing participating health systems, specific project incentive values, and project descriptions and goals. ***No findings in Report that either MCOs or QIN failed to comply with these Agreements in any way.***
Accountable Care Network Participation Agreement	Contract between QIN and individual network health systems outlining QIN and network health systems' responsibilities to administer the MCIP incentive projects, validation of achievement, and payment of incentive awards. ***No findings in Report that QIN or network health systems failed to comply with these Agreements in any way.***

Far from the haphazard program the Report suggests, the MCIP program is established and operated through detailed guidance. The network of MCIP implementation documents provide specific regulatory requirements that clearly describe all parties' responsibilities and amount each party is paid to incentivize its role in improving health, access, and outcomes for Medicaid members. LDH, each of the MCOs, QIN, and the network health systems have complied with their regulatory and contractual obligations since the inception of the MCIP program. The Report does not contain a single finding suggesting otherwise.

At its core, rather than finding violation of the rules and regulations that govern the MCIP program, the Report finds that LDH could have structured the MCIP program differently, that LDH could have selected

different AIAs and milestones, that the ACOs could have formed and structured their networks differently, and that LDH could have made the pathway to incentive payments more difficult. These findings ignore one very important point – the dramatic successes of the MCIP program in an arena of quality programs that have historically shown little-to-no success in improving outcomes for the Medicaid population.

QIN remains committed to advancing the MCIP program in a manner that improves the health outcomes to Louisianians. To the extent the State identifies more effective projects or performance measures to advance that goal in the future, QIN and its network health systems support LDH adopting those suggestions. However, QIN firmly opposes the Report's findings that are critical of a structure that has succeeded.

V. The Report mischaracterizes the management agreement between QIN and Ochsner as a "flat-rate fee" management contract and misstates current law regarding the Louisiana Constitution.

The Report mischaracterizes the management agreement between QIN and Ochsner as a "flat-rate fee" contract despite the fact that QIN and Ochsner entered into a contingency fee arrangement. The 3% fee contained in the management agreement does not equate to a flat-fee, as the actual fee will vary depending on a multitude of factors. The Louisiana State Constitution, and Louisiana Attorney General Opinions, clearly permit public entities to enter into contingency fee arrangements.[12] Additionally, because of the very nature of contingency fee arrangements, it would be impossible to construe a fee arrangement as a prohibited donation within the meaning of the Louisiana Constitution, as the percentage fee only exists if there is an actual recovery. The Report's discussion of QIN's payments to Ochsner, and conclusion that QIN's "payments to Ochsner for management fees and 'other costs' may be considered donations of public funds that violate the Louisiana State Constitution," is contrary to both the facts and the established Louisiana law.

The Report correctly notes that QIN and Ochsner entered into arm's-length agreements that require QIN to pay Ochsner three percent (3%) of all payments QIN receives as part of the MICP program as well as reimbursement of out-of-pocket costs. The agreements enumerate specific performance obligations required of Ochsner, including:

(a) developing the network of health systems for purposes of achieving the AIA milestones,

(b) researching, developing, and educating the participating health systems on best practices designed to achieve the milestones and metrics required for network participation,

(c) assisting the participating health systems to implement the steps necessary to achieve the milestones,

(d) collecting information from the participating health systems, and organizing it in a coordinated manner, and

(e) preparing reports and other documentation for the MCOs validating the achievement of the milestones.

On a practical level, Ochsner's performance of its obligations under the agreements did not occur spontaneously or in a silo. QIN observes Ochsner's performance first-hand on an almost daily basis, and QIN has observed Ochsner's work day-to-day for more than five years, since before the first MCIP payment. Ochsner coordinates with QIN on a monthly, weekly, and in many cases daily basis to ensure the development of the AIAs remains on track and in compliance with the milestones set by LDH. QIN receives voluminous documentation of Ochsner's work, which shows the payments from QIN to Ochsner are not donations and that Ochsner's performance is commensurate with the scope of work in their agreements.

[12] *Town of Mamou v. Fontenot*, 756 So2d 719 (3rd Cir., Apr. 12, 2020); *see, also*, La. Atty. Gen. Op. Nos. 85-395, 86-118, 21-0135.

QIN also has significant direct and third-party validation that Ochsner is performing the services required under its agreements with QIN. Prior to QIN's receipt of each payment, Ochsner coordinates a set of data, documents, and reports evidencing achievement of MCIP program milestones by the participating health systems. QIN submits these documents to the MCOs for review and approval. Ochsner makes changes where needed based on questions or comments from the MCOs. After the MCOs submit the documentation to LDH, LDH reviews the documentation to confirm that the documentation evidences the work was performed and achievement of the associated quality milestones occurred.

Both the amount of the payments to Ochsner and the services performed by Ochsner are detailed in their agreement. These payments can be viewed as a contingent fee not tied to specific hours worked but rather to achievement of the contracted services to be performed. The agreements between QIN and Ochsner also require QIN to reimburse Ochsner for other costs, which represent actual out-of-pocket expenses. Most of those expenses were professional fees supported by materials that were not produced publicly because the materials included detailed narrative descriptions of deliberative processes and strategy, which is another reason why the contingency fee arrangement is important to the parties.[13] However, this does not make QIN's contractually-required payments to Ochsner a donation of QIN's public funds.

Ochsner's compliance with its obligations under the agreements meets the requirements for an expenditure of public funds, which includes legal authority to make the expenditure, the expenditure serves a public purpose, the expenditure is not gratuitous, and QIN has an objective and reasonable expectation of receiving something real and substantial in exchange for the expenditure.[14] QIN considered and complied with these factors. QIN also observed the performance of the personal services provided. It is clear the payments QIN makes to Ochsner do not represent a donation under any reasonable definition of that word.

However, in an effort to address the concerns raised in the Report, QIN is in the process of amending the Management Agreement with Ochsner to include additional specificity regarding the work and documentation required by Ochsner under the agreement.

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[13] See e.g., *Talley v. LA Dept of Trans. & Dev*., 361 So. 3d 1041, 1051 (Mar. 14, 2023); La. Code Evid. 506 (b)(c).

[14] *See* La. Atty. Gen. Op. No. 22-0061 (opining that, in light of *Cabela*, for an expenditure or transfer of public funds to be permissible under La. Const. art. VII, § 14(A), the public entity must have the legal authority to make the expenditure and show: 1) a public purpose for the use of funds that comports with the governmental purpose the entity is authorized to pursue; 2) the use, taken as a whole, does not appear gratuitous; and 3) the entity has a demonstrable, objective and reasonable expectation of receiving something real and substantial in exchange).

Attachment C – Details of Work Performed by ACO

Following is a non-exhaustive summary of the types of ACO work performed by QIN, directly and through its manager Ochsner, which has proven critical to the success of QIN and its network of health systems in achieving meaningful and measurable improvements in health, outcomes, and access for Louisiana's Medicaid population.

Formation of the Network:

- **Explaining the ACO to potential participants.** The ACO identified and met with interested health systems at the outset of the MCIP program, in order to develop a geographically diverse network capable of reaching all Medicaid members in the State. The ACO explained the proposed MCIP program to each health system, discussed the proposed roles and responsibilities of the parties, identified the changes expected at each health system as a result of the program, discussed the steps necessary to join the ACO network, and answered questions posed by each health system.

- **Forming QIN as a component of the District.** The ACO completed the internal, State, and federal approval processes necessary to form a new governmental non-profit corporation (QIN) to serve in the role as ACO for the MCOs related to the MCIP program.

- **Negotiating agreements with each health system.** The ACO developed and negotiated an agreement with each health system that joined the QIN network, identifying the role expected of each party and the amount QIN would pay each health system.

Administration and Coordination with LDH and MCOs:

- **Collaborate with LDH to design new AIAs.** The ACO analyzes Louisiana's Medicaid quality Strategy for the Medicaid managed care program to identify AIAs that are necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the Strategy. The ACO then coordinates with LDH on LDH's target areas within the Strategy and employs population health experience, clinical expertise, and experience with the Medicaid population to select AIAs to propose to the MCOs and LDH. The ACO analyze specific milestones that establish a plan for providers and MCOs to align in improving the outcomes associated with each AIA. The ACO consults with other health systems and MCOs to determine feasibility of implementation, submit proposed milestones to MCOs and LDH, address questions from LDH regarding milestones, and provide feedback to LDH regarding LDH's changes to the milestones. Upon LDH's finalization of the milestones for each AIA, the ACO disseminates the milestones to all health systems and then tracks each health system's decision regarding whether to participate in each AIA.

- **Coordinate with LDH to establish criteria for each milestone.** Once LDH releases the objective criteria LDH plans to use in order to determine whether the MCOs and network have achieved each milestone, the ACO analyzes the LDH milestone criteria based on population health and clinical experience and coordinate feedback to LDH from the network. Once LDH finalizes milestone criteria, the ACO disseminates the milestone criteria to all health systems and ensure a common understanding amongst health systems regarding LDH's requirements.

- **Solicit feedback from MCOs.** The ACO coordinates with the MCOs by soliciting feedback on the reporting submissions from the MCOs, soliciting the MCOs' participation in network discussions, and soliciting feedback from the MCOs regarding focus areas for new AIAs.

- **Coordinate submission of milestone documentation to MCOs, and from MCOs to LDH.** Once the network has completed documentation of achievement of a milestone within an AIA, the ACO prepares that documentation in the LDH-prescribed format, submit the information to the MCOs for review, tracks each MCO's submission of the reporting to LDH, assists MCOs in resolving submission issues, and confirms LDH receipt of the reporting from all MCOs.

- **Coordinate resolution of any LDH-identified issues in MCOs' reporting/achievement.** The ACO tracks LDH's review and decision on achievement for all MCO reporting related to the MCIP program. The ACO assists MCOs in addressing any LDH-identified issues, and in resubmitting documentation of reporting when necessary.

- **Coordinate payments from MCOs.** The ACO analyzes the agreements with each Medicaid MCO, and based on the terms of these agreements, prepares invoices to MCOs, tracks the payment status, and follows up as necessary to ensure payments are made accurately from the MCOs to the ACO.

- **Address contracts with the MCOs.** The ACO coordinates all contracts and amendments with the Medicaid MCOs.

- **Address contracts with the health systems and health system participation.** The ACO coordinates all contracts and amendments with the health systems. The ACO also negotiates requests from new health systems to join the network. The ACO also acts as a neutral party in addressing the internal workings of the network between and amongst the disparate health systems that make up the QIN network.

- **Board and executive leadership oversight.** The ACO provides Board and executive leadership oversight that includes governing the operation of QIN, preparing any required corporate and financial audit reporting, and responding to all third-party questions regarding the ACO.

Health System Maintenance and Coordination:

- **Develop and administer timeline and monitor and coordinate health system's adherence to timeline.** The ACO analyzes and identifies the underlying work steps necessary for the health systems to achieve each milestone selected by LDH for each MCIP program year. The ACO then analyzes the necessary timeline for completion of each work step in order to ensure timely achievement by the health systems and therefore the MCOs, creates the timeline reflecting deadlines and details for health systems' submissions and meetings, and disseminates this timeline to all health systems. The ACO then monitors the health systems' completion of the work steps, assists health systems that fail to meet deadlines, and updates the timeline as necessary throughout the year.

- **Develop and maintain data templates to capture information necessary for reporting outcomes.** For each AIA, the ACO creates one or more distinct data templates that are intended to ensure consistency in the health systems' reporting and ensure each health system captures all information necessary for each AIA's reporting. The ACO disseminates these data templates to all health systems, answers questions and incorporates feedback from health systems, and maintains a log that captures revisions made to the templates. The ACO also analyzes the templates on an ongoing basis to identify necessary revisions based on changes in milestones and milestone specifications, lessons learned through implementation of AIAs, and ongoing feedback received from health systems.

- **Develop and maintain protocols for health systems regarding data entry and maintenance.** For each AIA and the associated milestones, the ACO utilizes technical and clinical expertise to develop protocols to aid health systems in the implementation and day-to-day administration of the work required to achieve each AIA. The ACO disseminates these protocols to health systems, addresses questions from health systems, analyzes the protocols on an ongoing basis, and incorporates health system feedback and information learned from population health and clinical teams as needed.

- **Develop and maintain milestone specifications providing guidelines for reporting and calculating outcome performance.** The ACO uses experience in healthcare data reporting and analysis, as well as its clinical experience and analysis of HEDIS and other national quality measurement systems and electronic health records workflows, to develop specifications that provide health systems details on the baseline and performance calculations for each milestone. The ACO disseminates the milestone specifications, solicits and incorporates feedback from other health systems on changes, and then addresses ongoing questions with the goal of ensuring accuracy and consistency in data reporting across health systems.

- **Coordinate ongoing participation by health systems in AIAs.** The ACO facilitates and leads a monthly meeting of health systems, as part of which the ACO shares information regarding network progress towards milestone achievement, notifies health systems regarding upcoming deadlines, and shares questions raised by health systems related to recent project developments and solutions found. These meetings serve as a crucial platform for sharing performance data, discussing key metrics, and disseminating best practices across the network. The ACO also addresses health system questions that arise during these meetings. Following each meeting, the ACO prepares and distributes meeting minutes to ensure the health systems all receive the same information and to provide a resource for review of issues addressed during the monthly meetings. The ACO separately meets with health systems on a routine or as-needed basis, to address particular issues faced by those specific health systems and provide targeted support and tailored action plans. The ACO's coordination of health systems fosters collaboration and transparency and allows participants to better-address challenges and barriers.

- **Coordinate technical implementation meetings for AIAs.** The ACO uses its experience in data reporting and analytics to design and coordinate technical implementation meetings that ensure health systems are equipped to meet project objectives related to data reporting. These meetings also facilitate an environment in which health systems gain a comprehensive understanding of the intricacies and precise data submission requirements associated with each AIA, ask questions that facilitate learning and problem-solving by all health systems, and discuss anticipated challenges and potential solutions. The ACO documents the key points and outcomes of these meetings for all health systems.

- **Create and update Continuous Quality Improvement ("CQI") plans for each AIA.** The ACO analyzes and develops an overarching CQI framework specific to each AIA. This CQI plan details the efforts already undertaken, efforts in progress, and future goals as the AIA develops. The ACO then researches and prepares a report for each AIA that evaluates the outcomes and impact of the project to date and assesses how the project has affected the engagement, performance, and satisfaction of Louisiana's Medicaid members. The ACO secures feedback from health systems and updates the CQI plan for each AIA at least annually and to highlight unanticipated challenges, successful strategies, and best practices. Where appropriate, CQI reports also include strategies for improving and expanding the AIA, considering factors such as health systems resources and logistical requirements.

- **Facilitate network participation in CQI workshops.** CQI workshops are a crucial part of the quality enhancement process, designed to promote collaboration, knowledge sharing, and quality improvement among health systems. The ACO analyzes each AIA and the associated milestones, develops an agenda for each CQI workshop, schedules each CQI workshop, and coordinates health systems' participation in the CQI workshop. As AIAs progress, the ACO employs lessons learned in prior years and population health expertise to develop pre-workshop materials, create health systems panels, and craft discussion topics to enhance the workshops. After each CQI workshop, the ACO drafts a comprehensive summary that details the topics discussed for all health systems. Through the CQI workshop process for each project, each year the ACO actively facilitates knowledge-sharing across the network regarding successful workflows and best practices and helps health systems implement proven improvement strategies tailored to their needs. This collaborative approach fosters innovation and ensures that all health systems, regardless of size or affiliation, are equipped to improve patient outcomes and operationalize efficiencies in alignment with the MCIP program's goals.

- **Facilitate data training sessions for health systems.** The ACO develops and provides training sessions related to individual AIAs, explaining the data submission process and providing instructional guides for completing required data submissions. The ACO also facilitates discussion during the data training sessions regarding common data struggles and opportunities to improve data reporting. The ACO also maintains information on data collection challenges and, in the data training sessions for future periods, shares information with health systems regarding issues that were identified and corrections that need to take place moving forward.

- **Coordinate interim encounter-level data submissions, evaluate data, and provide feedback to health systems.** During the first year of each AIA, the ACO coordinates and receives interim encounter-level data submissions from each health system. The ACO then analyzes the data submitted by each health system, identifies errors to prevent flawed or inconsistent reporting in the final data submissions from health systems, works with health systems to implement corrections and troubleshoot data issues, and shares that information with all health systems to improve the data reported for each AIA. As part of the review, the ACO examines the data for any duplication or data not meeting LDH's standard of reporting (appropriate Medicaid IDs, missing data fields, etc.).

- **Coordinate provider education.** The ACO collaborates with health systems to develop educational presentations that each health system can use to provide education on AIA-specific topics, objectives, and guidelines. The ACO then develops documentation to track individual providers' attendance at educational sessions and certification documents to acknowledge providers' completion of trainings. The ACO coordinates and tracks health systems' submission of documentation that the education occurred on an ongoing basis.

- **Coordinate Medicaid member education.** The ACO works with health systems to develop materials used to educate Medicaid members. These educational resources impart crucial information and knowledge to members, ensuring they are well-informed, engaged, and empowered throughout the AIA. The creation of these materials involves collecting a diverse range of educational resources that health systems can utilize, and communicating with health systems to ensure educational materials are presented in a clear, concise, and accessible manner that adheres to LDH requirements and that is aligned across the network.

- **Prepare community resources.** Where called for by the AIA, the ACO develops lists of community resources that health systems can use or to which health systems may refer Medicaid members. These resources include information from community directories, government agencies,

non-profit organizations, healthcare providers, and community outreach programs. The ACO verifies the accuracy of the resources and creates user-friendly reference materials that include vital details, such as the resource's name, contact information, services offered, hours of operation, eligibility criteria, and any special requirements. The ACO maintains and updates these resource lists for the network.

- **Analyze and summarize root causes of poor outcomes and existing treatment gaps for Medicaid members.** As part of the development of strategies to improve outcomes for AIAs, the ACO researches statistical and scientific data, stakeholder feedback, and any other pertinent resources that shed light on the issues that represent the focus of the AIA. The ACO then identifies core reasons behind the issues or problems that are the subject of the AIA, be they systemic, provider-centered, or patient-centered. Finally, the ACO creates tailored reports for each AIA, identifying the unique set of challenges and their underlying causes, for use by the health systems, MCOs, and LDH. The reports are structured to provide insights into the problems and their context, with recommended next steps.

- **Create activities designed to address root causes of poor outcomes.** The ACO designs purposeful activities to address root causes of poor outcomes targeted by AIAs, and the ACO then assists health systems in their implementation of these activities. As part of this work, the ACO conducts a thorough review of any previously identified root cause analyses to gain a comprehensive understanding of the core issues leading to poor outcomes. Based on this analysis, the ACO identifies specific areas and aspects that require improvement or corrective actions and applies its clinical and population health expertise to formulate a set of activities designed to directly address all previously identified root causes. While developing the activities, the ACO considers the feasibility of implementing each activity and the effectiveness each activity would have in addressing root causes. The ACO also seeks health systems input through activity surveys, where health systems explain their perceptions on the pros and cons of each activity. Another crucial aspect in activity development is the assessment of the documentation necessary to evidence implementation. Once activities and their documentation are finalized, the ACO works with each health system to select one or more of the activities to implement. The ACO collaborates closely with health systems to facilitate the effective implementation of their selected activities. This collaboration often involves training, guidance, and providing necessary resources or tools. The ACO then assists health systems to report on implementation of activities.

- **Identify areas for health system and MCO collaboration, information that would be helpful to health systems and MCOs, and topics for network and MCO engagement throughout the year, culminating in an Annual Collaborative Meeting with all MCIP stakeholders, including health systems, MCOs, and guest speakers.** From the ACO's coordination of the network throughout the year, the ACO is able to identify areas for health system and MCO collaboration, information that would be helpful to health systems and MCOs, and topics for health system and MCO engagement. The ACO uses this information to structure an Annual Collaborative Meeting, which serves as a platform for knowledge exchange, collaboration, and engagement among health systems, MCOs, and LDH personnel when LDH attends. The ACO oversees the planning, development, organization, and success of this Annual Collaborative Meeting. The ACO collaborates with speakers to define the topics, content, and format of their presentations, ensuring alignment with the meeting's goals. After the meeting's conclusion, the ACO analyzes the information learned at the meeting and drafts a comprehensive summary that encapsulates the meeting's key highlights, discussions, and outcomes. The summary emphasizes how the event aligns with LDH objectives and highlights health systems' work in achieving project goals, areas for improvement, and goals for the future.

- **Prepare Annual Progress Report.** Throughout the year the ACO tracks and summarizes the achievements, activities, and developments of health systems to develop a statewide view of the network's achievements. The ACO obtains stakeholder feedback, tracks activities, and develops conclusions for reporting to LDH. The ACO then prepares an Annual Progress Report for the MCOs to submit to LDH, which includes details on the nature of health systems' actions, completion dates, achievements, challenges, lessons learned, and future objectives.

- **Maintain website with resources for health systems.** The ACO maintains a website for health systems that houses resources needed to participate in the program, as well as the reporting submitted to LDH for provider reference. The website is updated on a regular basis to include the most current and accurate materials.

- **Calculate and coordinate payments with health systems.** The ACO coordinates and communicates with health systems regarding their payments from the ACO on a quarterly basis.

- **Facilitate health systems coordination.** The ACO works throughout the year to coordinate information-sharing among health systems, participation in AIAs, and improvement of outcomes through achievement of the LDH-established milestones. Examples of these other coordination activities: (a) the ACO develops and administers online surveys to collect feedback from health systems on issues such as population review and activities designed to address project-specific root causes identified in reports; (b) the ACO corresponds with health systems to receive input, observations, and recommendations related to AIAs; and (c) the ACO actively engages with health systems during meetings and conference calls to address questions; and (d) the ACO uses its expertise and experience with the Medicaid population to share experiences and best practices targeted at assisting the network to improve outcomes.

Milestone Reporting:

- **Coordinate provider education reporting.** The ACO analyzes documentation submitted by each health system evidencing that all health systems educated members of their healthcare community on topics specific to each AIA. The ACO validates the accuracy of the information, provides feedback when a health system's submission is incomplete, and then consolidates materials into a unified format for reporting by the MCOs to LDH. This review process ensures that LDH receives clear and organized support of provider education efforts.

- **Coordinate reporting on health system education of Medicaid members.** The ACO analyzes member education materials submitted by each health system against LDH's pre-defined criteria and regulatory standards to ensure all health systems are providing aligned content to members consistent with LDH's standards. The ACO communicates with health systems to address any inconsistencies or deficiencies and to ensure that all health systems meet the Member education guidelines established by LDH. Following the ACO's review, the ACO consolidates all health systems' documentation for submission by the MCOs to LDH.

- **Analyze and complete year-end data submissions.** For all milestones that include encounter-level data, the ACO receives and conducts an in-depth review of each health system's data submissions. The ACO works with each health system to address any issues identified in their data submissions and to obtain updated data where necessary. Once the ACO finalizes all data submissions across an AIA, the ACO begins the consolidation process for analysis of performance calculations on a statewide basis. The ACO consolidates the data from all health systems, removes duplicate records where a single Medicaid member was treated at multiple health systems, and

conducts an in-depth review to prevent data errors. The ACO then prepares the consolidated data for submission by the MCOs to LDH.

- **Calculate network baseline and performance rates.** Once the ACO consolidates all health systems' data for a milestone, the ACO analyzes baseline and performance rates on a statewide basis for the network, using the milestone specifications provided by LDH. The ACO shares information with health systems on baseline and performance rates to inform the network on the achievement of each AIA. The ACO also conducts additional analysis when necessary to identify how the milestones are performing across different demographics, such as by race or tobacco use status. These additional analyses help the network identify necessary populations that require more assistance or focus from the health systems.

APPENDIX B: SCOPE AND METHODOLOGY

This report provides the results of our evaluation of the Louisiana Department of Health's (LDH) Managed Care Incentive Payment (MCIP) program. 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 September 2019 through June 2024. In some instances, our analyses included information before and after this scope. The objective of our evaluation was:

To evaluate LDH's design and oversight of the MCIP program.

To conduct this analysis, we performed the following steps:

- Researched relevant federal and state laws, rules, and regulations.
- Researched and reviewed relevant LDH policies, procedures, protocol documents, informational bulletins, Quality Strategy documents, and Managed Care Organization (MCO) contracts.
- Researched relevant Centers for Medicaid and Medicare Services (CMS) policies, procedures, data, and other documentation.
- Contacted CMS regarding its oversight of states utilizing incentive programs under 42 Code of Federal Regulations 438(b).
- Met with current and former LDH staff, MCO staff, and staff from the Louisiana Quality Network (LQN) and the Quality and Outcome Improvement Network (QIN) (collectively referred to as the "Quality Networks") to gain an understanding of the MCIP program, including each network's role in the program, why the program was started, and how the program increases quality of care for Medicaid beneficiaries.
- Obtained a listing of Approved Incentive Arrangements and milestones from LDH for each Quality Network.
- Obtained from QIN a list of measurable and non-measurable milestones and applied this methodology to LQN's milestones.
- Obtained and analyzed correspondence between LDH and the Quality Networks regarding the MCIP program.
- Obtained contracts between the LDH and the MCOs, the MCOs and the Quality Networks, the Quality Networks and the participating hospitals, and the MCOs and LQN's participating hospitals. Also obtained related contracts such as QIN's management agreement with Ochsner.
- Obtained and analyzed documents from LDH detailing amounts withheld and paid to MCOs for its MCIP program.

- Researched prior audit reports for contributing entities and participating hospitals.
- Obtained and reviewed the Quality Network's annual reports and documentation submitted to LDH to support meeting milestones.
- Researched other state's programs similar to Louisiana's MCIP program through contracts, other documents available online, and interviews.
- Analyzed MCIP program IGT and expenditure data from business objects, LDH, the MCOs, and the Quality Networks to determine which entities received funds and how much they received.
- Researched relationships between QIN, Southern Regional Medical Center, Terrebonne General Medical Center, Leonard J. Chabert Medical Center, and Hospital Service District #1 of Terrebonne Parish, including publicly available information and incorporation documents from the Louisiana Secretary of State.
- Met with representatives of LDH, LQN, QIN, and participating hospitals to discuss suggested edits for the report and to understand the impact of the MCIP program on participating hospitals.
- Provided our results to LDH and the Quality Networks to review and incorporated edits throughout the report.

APPENDIX C: PARTICIPATING HOSPITALS BY QUALITY NETWORK ACCORDING TO LDH AS OF JANUARY 2024

LQN	QIN
Beauregard Health System	Abbeville General Hospital
Franciscan Missionaries of Our Lady Health System – Our Lady of the Lake Children's Health	Allen Parish Community Healthcare
Franciscan Missionaries of Our Lady Health System – Our Lady of Lourdes Health	Baton Rouge General Medical Center
Franciscan Missionaries of Our Lady Health System – Our Lady of Lourdes Children's Health	CHRISTUS Coushatta Health Care Center
Franciscan Missionaries of Our Lady Health System – Our Lady of the Angels Health	CHRISTUS Health Shreveport-Bossier
Franciscan Missionaries of Our Lady Health System – Our Lady of the Lake Health	CHRISTUS Ochsner Lake Area Hospital
St. Francis Health	CHRISTUS Ochsner St. Patrick Hospital
LCMC Health – East Jefferson General Hospital	CHRISTUS St. Frances Cabrini Hospital
LCMC Health – Children's Hospital	Iberia Medical Center
LCMC Health – New Orleans East Hospital	North Caddo Medical Center
LCMC Health – Touro Infirmary	Ochsner Abrom Kaplan Memorial Hospital
LCMC Health – University Medical Center	Ochsner Acadia General Hospital
LCMC Health – West Jefferson Medical Center	Ochsner American Legion Hospital
North Oaks Health System – Hood Memorial Hospital	Ochsner Lafayette General
Lake Charles Memorial Hospital System	Ochsner LSU Health Monroe
Lallie Kemp Regional Medical Center	Ochsner LSU Health Shreveport
Lane Regional Medical Center	Ochsner Medical Center
Thibodaux Regional Health System	Ochsner Medical Center – Baton Rouge
West Calcasieu Cameron Hospital	Ochsner Medical Center – Kenner
Willis-Knighton Health System – Medical Center	Ochsner Medical Center – Northshore
Willis-Knighton Health System – South & the Center for Women's Health	Ochsner St. Anne General Hospital
Willis-Knighton Health System – Bossier Health Center	Ochsner St. Martin Hospital
Willis-Knighton Health System – Pierremont Health Center	Ochsner St. Mary
Woman's Hospital	Ochsner University Hospitals & Clinics
	Opelousas General
	Pointe Coupee General Hospital
	Rapides Regional Medical Center
	Savoy Medical Center
	Slidell Memorial Hospital
	Southern Regional Medical Corporation
	St. Bernard Parish Hospital
	St. Charles Parish Hospital
	St. Tammany Parish Hospital
	Terrebonne General Health System
	The General Hospital
	Tulane University Hospital and Clinic
	West Carroll Memorial Hospital

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

APPENDIX D: LQN's AIAs, MILESTONES, AND PAYMENTS FROM FEBRUARY 2020 THROUGH MARCH 2024

Milestone Number	AIA	Milestone Description*	Amount Paid for Milestone**
1.1	Reduce Inappropriate Emergency Department Utilization (ED Utilization)	Establish multidisciplinary steering committee (including bylaws and membership)	$3,663,099
1.2	ED Utilization	Educate stakeholders on 3M tool	3,663,099
1.3	ED Utilization	Engage stakeholders in validating the data products of the tool	3,663,099
1.4	ED Utilization	Identify top 10 most prevalent type of preventable ED visits	3,663,099
1.5	ED Utilization	Select 3 specific types of preventable ED visits to address (from top 10)	3,663,099
1.6	ED Utilization	Identify high utilizing ED members with documented method	3,663,099
1.7	ED Utilization	Identify gaps in care coordination and system navigation for high utilizing members - creating a documented driver diagram	3,663,099
1.8	ED Utilization	Conduct analysis of LQN participants health information technology capabilities and report on assessment findings	3,663,099
1.9	ED Utilization	Establish executed data sharing agreement with MCO's/LQN organizations for providers accounting for at least of 80% of LQN ED Volume (ED/ADT)	3,663,099
2.1	ED Utilization	Identify, assess and document effective efforts to reduce inappropriate ED utilization in other states	5,329,052
2.2	ED Utilization	Create document driver diagram on specific system issues that drive specified type of preventable ED visits with focus on: Primary Care, Specialty, Behavioral Health Access to Care; Social Determinants of Health, & Care Coordination	5,329,052
2.3	ED Utilization	Develop and document an actionable protocol to ameliorate key system issues	5,329,052
2.4	ED Utilization	Develop and document an ED Navigation protocol for identification and intervention with high utilizing patients at the point of care in the ED with focus on: Social Determinants of Health, members with behavioral health needs, care coordination	5,329,052
2.5	ED Utilization	Implement data sharing agreements with LQN providers	5,329,052
3.1	ED Utilization	Implement process measures as specified and developed in Year 2 for ameliorating key system issues (R/T removing barriers to care)	6,785,371
3.2	ED Utilization	Measure the impact of process measures as specified in the protocol on rates of selected preventable ED visits	6,785,371
3.3	ED Utilization	Implement ED Navigation protocol as outlined in Year 2	6,785,371

Milestone Number	AIA	Milestone Description*	Amount Paid for Milestone**
3.4	ED Utilization	Measure the impact of the ED navigation program on utilization among those identified as high utilizers as specified in the protocol process measures on rates of selected preventable ED visits	$6,785,371
3.5	ED Utilization	Identify opportunities to integrate shared data into routine clinical care (e.g., EMRs) and into the interventions described above	6,785,371
4.1	ED Utilization	Rapid cycle improvement activities on implemented protocol for barriers to care, specifying improvements made	5,786,580
4.2	ED Utilization	Continuous measurement of effect on specified preventable ED visits as interventions/improvements made in protocol	5,786,580
4.3	ED Utilization	Rapid cycle improvement activities on implemented protocol for ED Navigation protocol, specifying improvements made	5,786,580
4.4	ED Utilization	Continuous measurement of effect on changes in outcomes for high utilizing members as interventions/improvements made in protocol for ED navigation program	5,786,580
4.5	ED Utilization	Improvement on integration of shared data into care	5,786,580
4.6	ED Utilization	Enhanced communication with MCO's and other providers to identify and improve data sharing methods	5,786,580
5.1	ED Utilization	Continued quality improvement on preventable ED visits protocol	-
5.2	ED Utilization	Continued quality improvement on preventable ED navigation protocol	-
5.3	ED Utilization	Continuous improvement on integration of shared data	6,220,517
5.4	ED Utilization	Continuous communication with MCOs and other providers to identify and improve data sharing	6,220,517
1.1	Reduce Preventable Hospital Readmissions (Preventable Readmissions)	Establish multidisciplinary steering committee (including bylaws and membership)	3,833,476
1.2	Preventable Readmissions	Educate stakeholders on 3M tool	3,833,476
1.3	Preventable Readmissions	Engage stakeholders in validating the data products of the tool	3,833,476
1.4	Preventable Readmissions	Identify top 10 most common conditions associated with hospital readmission amount LA Medicaid members utilizing 3M tool	3,833,476
1.5	Preventable Readmissions	Target 3 specific conditions for hospital readmissions to address (from top 10)	3,833,476
1.6	Preventable Readmissions	Identify, assess and document effective efforts to improve transitions of care in other states	3,833,476
1.7	Preventable Readmissions	Identify and document transitions of care measures set to collect baseline data	3,833,476
2.1	Preventable Readmissions	Identify, assess and document effective efforts to reduce preventable hospital readmissions among priority population in other states	4,320,853
2.2	Preventable Readmissions	Identify and document specific drivers of readmission for the three selected conditions	4,320,853

Milestone Number	AIA	Milestone Description*	Amount Paid for Milestone**
2.3	Preventable Readmissions	Develop and document actionable protocol to intervene on key drivers of readmission, including process and outcome metrics	$4,320,853
2.4	Preventable Readmissions	Develop and document a protocol to improve specified components of transitions of care, including process and outcome metrics	4,320,853
2.5	Preventable Readmissions	Create a gap analysis report for primary care and specialty care access in all markets	4,320,853
2.6	Preventable Readmissions	Develop a protocol for improving post hospitalization access including: creating/updating directories for referrals for the ED or hospital case managers, creating/strengthen relationships with primary care providers and specialists, and develop methods to ensure timeliness of care	4,320,853
3.1	Preventable Readmissions	Implement the protocol as specified and developed in Year 2 for key drivers of readmissions	6,249,684
3.2	Preventable Readmissions	Measure the impact of process measures as specified in the protocol on rates of selected preventable targeted readmissions	6,249,684
3.3	Preventable Readmissions	Implement transitions of care protocol as outlined in Year 2	6,249,684
3.4	Preventable Readmissions	Measure the impact of the transitions of care protocol based on process and outcome measures	6,249,684
3.5	Preventable Readmissions	Implement the increased access protocol for post-hospitalization primary and specialty care	6,249,684
3.6	Preventable Readmissions	Measure the impact of the post-hospitalization access to care protocol based on process and outcome measures	6,249,684
4.1	Preventable Readmissions	Rapid cycle improvement activities on implemented protocol for reducing preventable readmissions	5,990,813
4.2	Preventable Readmissions	Continuous measurement on effectiveness of protocol on specified types of readmissions as interventions/improvements are made	5,990,813
4.3	Preventable Readmissions	Rapid cycle improvement activities for implemented protocol regarding transitions of care, specifying improvements made	5,990,813
4.4	Preventable Readmissions	Measure changes in rates of process and outcome measures for transitions of care protocol, as improvements made	5,990,813
4.5	Preventable Readmissions	Rapid cycle improvement activities for increasing post-hospitalization access to Primary and Specialty care, identify specific improvements made	5,990,813
4.6	Preventable Readmissions	Measure changes in rates of process and outcome measures for Post-Hospitalization Protocol, as improvements made	5,990,813
5.1	Preventable Readmissions	Continued quality improvement on preventable hospital readmissions protocol	5,041,043
5.2	Preventable Readmissions	Rapid cycle improvement activities for implemented protocol regarding transitions of care, specifying improvements made	5,041,043
5.3	Preventable Readmissions	Measure changes in rates of process and outcome measures for transitions of care protocol, as improvements made	-
5.4	Preventable Readmissions	Rapid cycle improvement activities for increasing post-hospitalization access to Primary and Specialty care, identify specific improvements made	5,041,043
5.5	Preventable Readmissions	Measure changes in rates of process and outcome measures for Post-Hospitalization Protocol, as improvements made	-

Milestone Number	AIA	Milestone Description*	Amount Paid for Milestone**
1.1	Promote Evidence Based Practice and Reduce Low Value Care through Network GME/CME Partnerships (Evidence-Based Practices)	Evaluate programs designed to impact low value care efforts in other states	$3,609,857
1.2	Evidence-Based Practices	Develop charter, membership and launch task force to lead Medicaid work laying foundation for multi-payer partnerships	3,609,857
1.3	Evidence-Based Practices	Partner with State to analyze Medicaid claims data to identify opportunities to reduce low value care including: Participate in data validation and review by multidisciplinary team, evaluate opportunities identified, develop detailed recommendations and outline plan for years 2-5 in selected opportunities to target in future years, establish targeted opportunity baselines to improve over in future, and establish framework for annual performance dashboard	3,609,857
1.4	Evidence-Based Practices	Develop indicator metric for target guidelines and establish data collection methodology for Target guideline metrics with MCOs	3,609,857
1.5	Evidence-Based Practices	Explore VBP pilot programs for identified target metrics	3,609,857
1.6	Evidence-Based Practices	Establish retrospective baseline compliance with Target Guidelines	3,609,857
1.7	Evidence-Based Practices	Establish Performance Improvement goals	3,609,857
1.8	Evidence-Based Practices	Socialize baselines performance across educational network (GME and Medical Staffs)	3,609,857
1.9	Evidence-Based Practices	Develop Educational Programs for Target Guideline A and B	3,609,857
1.10	Evidence-Based Practices	Develop indicator metrics and collection process for Target Guideline A and B	3,609,857
1.11	Evidence-Based Practices	Develop and distribute Patient Educational Materials to support initiative for Target Guideline A and B	3,596,777
1.12	Evidence-Based Practices	Assess baseline compliance across the network for Target Guideline A and B	3,609,857
2.1	Evidence-Based Practices	Implement quarterly topics for network promoted evidence based practice education	3,698,912
2.2	Evidence-Based Practices	Establish sponsorships for EBD Grand Rounds, conferences and similar GME offerings	3,698,912
2.3	Evidence-Based Practices	Investigate focused self-learning (web-based) offerings sponsored by member hospital's medical staffs	3,698,912
2.4	Evidence-Based Practices	Support resident engagement in RRC required PI research to focus on EBP program development and use of EMR embedded Clinical Decision Support for EBP at member organizations	3,698,912
2.5	Evidence-Based Practices	Establish performance improvement goals for Target Guidelines	3,698,912
2.6	Evidence-Based Practices	Implement clinical programs to reduce low value care in identified target areas (Pilot Programs with MCOs)	3,698,912

Milestone Number	AIA	Milestone Description*	Amount Paid for Milestone**
2.7	Evidence-Based Practices	Review Pilot Programs in Q4 of 2nd Year	$3,698,912
2.8	Evidence-Based Practices	Create focused GME/CME programs on Target Guidelines A and B	3,698,912
2.9	Evidence-Based Practices	Identify Faculty and Resident Champions for Target Guidelines A and B	3,698,912
2.10	Evidence-Based Practices	Implement clinical programs/pilots to reduce low value testing with improvement target for by end of year 3 for Target Guidelines A and B	3,698,912
2.11	Evidence-Based Practices	Evaluate and Implement EMR Clinical Decision Support tools to support clinical guidelines for Target Guidelines A and B	3,698,912
3.1	Evidence-Based Practices	Continue focused Educational Programs and CME, while focusing offerings on new guidelines and recognized opportunities for improvement	4,776,544
3.2	Evidence-Based Practices	Investigate focused self-learning (web-based) offerings sponsored by member hospital's medical staffs	4,776,544
3.3	Evidence-Based Practices	Announce EBP Challenge for Residency Programs	4,776,544
3.4	Evidence-Based Practices	Measure initial impact of education efforts	4,776,544
3.5	Evidence-Based Practices	Assess accuracy of indicator metrics by sample chart audits	4,776,544
3.6	Evidence-Based Practices	Set Targets for year 4 and 5	4,776,544
3.7	Evidence-Based Practices	Measure and socialize Year 2 results for Target Guidelines A and B	4,776,544
3.8	Evidence-Based Practices	Continued reassessment of data collection and reporting for Target Guidelines A and B	4,776,544
3.9	Evidence-Based Practices	Announce Challenge targets for Years 4 and 5 for Target Guidelines A and B	4,776,544
3.10	Evidence-Based Practices	Concentrate education efforts on low performing network members	4,776,544
4.1	Evidence-Based Practices	Continue focused Educational Programs and CME, while focusing offerings on new guidelines and recognized opportunities for improvement	4,901,574
4.2	Evidence-Based Practices	Implement focused self-learning (web-based) offerings sponsored by member hospital's medical staffs	4,901,574
4.3	Evidence-Based Practices	Hold 1st EBP Challenge Awards/Conference	4,901,574
4.4	Evidence-Based Practices	Reassess Target Guidelines and Compliance Goals	4,901,574
4.5	Evidence-Based Practices	Substitute new Target Guidelines if Compliance is greater than 90%	4,901,574
4.6	Evidence-Based Practices	Measure and Socialize Year 3 results for Target Guidelines A and B	4,901,574
4.7	Evidence-Based Practices	Continued reassessment of data collection and reporting for Target Guidelines A and B	4,901,574
4.8	Evidence-Based Practices	Concentrate education efforts on low performing network members	4,901,574
5.1	Evidence-Based Practices	Continue focused Educational Programs and CME, while focusing offerings on new guidelines and recognized opportunities for improvement	3,805,915
5.2	Evidence-Based Practices	Implement focused self-learning (web-based) offerings sponsored by member hospital's medical staffs	3,805,915

Milestone Number	AIA	Milestone Description*	Amount Paid for Milestone**
5.3	Evidence-Based Practices	Promote development of EMR embedded Clinical Decision Support for EBP at member organizations	$3,805,915
5.4	Evidence-Based Practices	Hold 2nd EBP Challenge Awards/Conference	3,805,915
5.5	Evidence-Based Practices	Reassess Target Guidelines and Compliance Goals	3,805,915
5.6	Evidence-Based Practices	Substitute new Target Guidelines if Compliance is greater than 90%	3,805,915
5.7	Evidence-Based Practices	Measure and Socialize Year 3 results for Target Guidelines A and B	3,805,915
5.8	Evidence-Based Practices	Continued reassessment of data collection and reporting for Target Guidelines A and B	3,805,915
5.9	Evidence-Based Practices	Concentrate education efforts on low performing network members	3,805,915
1.1	Improve Maternal and Perinatal Outcomes (Improve Maternal Outcomes)	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
1.2	Improve Maternal Outcomes	Develop a method to track risk stratification adherence and submission to MCIP/partnership with managed care plans	4,074,226
1.3	Improve Maternal Outcomes	Develop method to report completed gestational weeks at delivery for reporting and obtain baseline to support evaluation	4,089,041
1.4	Improve Maternal Outcomes	Conduct rapid evaluation of utility of risk stratification tool for identifying women at risk of preterm birth	4,074,226
1.5	Improve Maternal Outcomes	All hospitals sign on to Perinatal Quality Collaborative Reducing Maternal morbidity initiative	4,089,041
1.6	Improve Maternal Outcomes	Hospitals implement one change concept from each driver in collaborative driver diagram	4,089,041
1.7	Improve Maternal Outcomes	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
1.8	Improve Maternal Outcomes	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
1.9	Improve Maternal Outcomes	Develop process and outcomes measures and engagement process to assess coordination of care between obstetric and emergency settings	4,089,041
1.10	Improve Maternal Outcomes	Review and create a timeline for implementing the AIM bundle for reduction of low risk primary cesarean births	4,089,041
1.11	Improve Maternal Outcomes	Using the Baby-Friendly Ten Steps to Successful Breastfeeding as a guiding principle develop a breastfeeding policy	4,089,041
1.12	Improve Maternal Outcomes	Assess requirements for meeting The Gift Designation	4,089,041

Milestone Number	AIA	Milestone Description*	Amount Paid for Milestone**
2.1	Improve Maternal Outcomes	Pilot risk stratification tool in two-member hospitals using patient input to adjust implementation	$3,984,786
2.2	Improve Maternal Outcomes	Implement method for tracking provider compliance of performing risk stratification in pilot hospitals	3,984,786
2.3	Improve Maternal Outcomes	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
2.4	Improve Maternal Outcomes	Track results/make improvement	3,984,786
2.5	Improve Maternal Outcomes	Address barriers to improvement	3,984,786
2.6	Improve Maternal Outcomes	Implement method for reporting completed gestational weeks at delivery to support evaluation	3,984,786
2.7	Improve Maternal Outcomes	Stratify all process measures and outcome measures by race/ethnicity to support equity aim	3,984,786
2.8	Improve Maternal Outcomes	Integrate patient/family advisors into all improvement teams	3,935,960
2.9	Improve Maternal Outcomes	Address barriers to improvement and Sustain improvement	3,984,786
2.10	Improve Maternal Outcomes	Identify existing health information exchanges to leverage that enable coordination between emergency departments and prenatal care providers	3,984,786
2.11	Improve Maternal Outcomes	Engage system ED, OB, and prenatal providers around collaborative opportunities for improvement to reduce maternal morbidity	3,984,786
2.12	Improve Maternal Outcomes	Educate providers and nurses on AIM bundle components	3,984,786
2.13	Improve Maternal Outcomes	Begin to implement the AIM bundle components for TJC PC-02	3,984,786
2.14	Improve Maternal Outcomes	Implement breastfeeding policy	3,984,786
2.15	Improve Maternal Outcomes	Implement at least 3 Coeffective training and tools	3,984,786
3.1	Improve Maternal Outcomes	Implement risk stratification tool in all member hospitals	4,719,149
3.2	Improve Maternal Outcomes	Implement method for tracking compliance of risk stratification	4,719,149
3.3	Improve Maternal Outcomes	Implement referral to high risk pregnancy medical home or enhanced prenatal care delivery model for women with identified risks	4,719,149
3.4	Improve Maternal Outcomes	Monitor completed gestational weeks at delivery to support evaluation	4,719,149

Milestone Number	AIA	Milestone Description*	Amount Paid for Milestone**
3.5	Improve Maternal Outcomes	Conduct environmental scan and literature review regarding options for enhanced prenatal/postpartum care delivery & case management in partnership with managed care	$4,719,149
3.6	Improve Maternal Outcomes	Scale changes to level 1 and II facilities	4,719,149
3.7	Improve Maternal Outcomes	Establish baseline for process and outcomes measures assessing coordination of care between obstetric and emergency settings	4,719,149
3.8	Improve Maternal Outcomes	Pilot a health information exchange in one hospital system linking EDs to prenatal care	4,719,149
3.9	Improve Maternal Outcomes	Track results using collaboratively identified measures/make improvements	4,719,149
3.10	Improve Maternal Outcomes	Further implement change concepts in Collaborative change package to narrow disparities in severe maternal morbidity outcome	4,719,149
3.11	Improve Maternal Outcomes	Continue to implement AIM bundle for Cesarean rate for low-risk first birth women	4,719,149
3.12	Improve Maternal Outcomes	Monitor and address barriers to compliance for AIM Bundle	4,719,149
3.13	Improve Maternal Outcomes	Using The Gift Designation Data Collection Guide - Perform staff survey to at least 20% of staff or minimum of 10	4,719,149
3.14	Improve Maternal Outcomes	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
4.1	Improve Maternal Outcomes	Monitor and adjust risk stratification tools, referral and adherence to facility-based protocols for patients at risk for pre-term birth	4,452,263
4.2	Improve Maternal Outcomes	Monitor completed gestational weeks at delivery to support and maintain evaluation	4,452,263
4.3	Improve Maternal Outcomes	Sustain and scale changes from PQC change package	4,452,263
4.4	Improve Maternal Outcomes	Develop transfer and partnership agreements and protocols for timely transfer between level 1, 2, 3, and 4 obstetric facilities	4,452,263
4.5	Improve Maternal Outcomes	Implement all component components to the AIM bundles	4,452,263
4.6	Improve Maternal Outcomes	Monitor and address barriers to improvement for TJC PC-02	4,452,263
4.7	Improve Maternal Outcomes	Implement 4 QI activities to address barriers in reaching 80% on process measures on The Gift Survey and Mother Survey	4,452,263
4.8	Improve Maternal Outcomes	Attend at least 4 coaching calls for The Gift	4,452,263
4.9	Improve Maternal Outcomes	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

Milestone Number	AIA	Milestone Description*	Amount Paid for Milestone**
4.10	Improve Maternal Outcomes	Repeat Gift staff and mother surveys to assess for improvements	$4,452,263
5.1	Improve Maternal Outcomes	Monitor and sustain use of risk stratification tools, referral and adherence to facility-based protocols	3,594,974
5.2	Improve Maternal Outcomes	Monitor completed gestational weeks at delivery to support and maintain evaluation; assess impacts on preterm birth	3,594,974
5.3	Improve Maternal Outcomes	Sustain, scale, and study changes from PQC change package	3,594,974
5.4	Improve Maternal Outcomes	Support changes supporting agreements and coordination within and between birth facilities and health system emergency rooms	3,594,974
5.5	Improve Maternal Outcomes	Monitor and address barriers to improvement for TJC PC-02	-
5.6	Improve Maternal Outcomes	Repeat The Gift GMBS check-off tool (except for the purchase of formula, etc.)	3,594,974
5.7	Improve Maternal Outcomes	Implement 4 QI activities to address barriers in reaching or sustaining 80% of process measures on The Gift and Mother Surveys	3,594,974
5.8	Improve Maternal Outcomes	Repeat The Gift staff and mother surveys for improvements	-
1.1	Improve Breast Cancer Screening	Establish a LQN multidisciplinary cancer steering committee, including bylaws and membership.	6,613,857
1.2	Improve Breast Cancer Screening	Develop and document an approach for an annual breast cancer screening outreach campaign.	6,589,894
1.3	Improve Breast Cancer Screening	Identify, assess, and document effective efforts to enhance primary care clinic processes to improve cancer screening rates.	6,613,857
1.4	Improve Breast Cancer Screening	Identify, select and validate key performance indicators with a multidisciplinary team.	6,589,894
1.5	Improve Breast Cancer Screening	Create patient education materials on the importance of primary care sevices for preventative health.	6,613,857
1.6	Improve Breast Cancer Screening	Develop a plan to distribute patient education materials on the importance of primary care services for preventative health.	6,613,857
2.1	Improve Breast Cancer Screening	Collect baseline data on key performance indicators identified in Year 1 Milestone 4. Stratify, analyze and report baseline data for key performance indicators. Identify health disparities.	3,553,693
2.2	Improve Breast Cancer Screening	Implement approach for annual breast cancer screening outreach campaign.	3,553,693
2.3	Improve Breast Cancer Screening	Develop and document an approach to enhance primary care clinic processes to improve cancer screening based on findings from CY1 Milestone 3.	3,553,693
2.4	Improve Breast Cancer Screening	Develop and document an approach to enhance outreach to improve cancer screening rates among underserved populations and reduce identified disparities.	3,553,693

Milestone Number	AIA	Milestone Description*	Amount Paid for Milestone**
2.5	Improve Breast Cancer Screening	Develop training for primary care providers (PCP) on provider-patient communication for cancer screening adherence.	$3,553,693
2.6	Improve Breast Cancer Screening	Develop implementation and evaluation plan, including identifying key performance indicators, for PCP training on provider patient communication.	3,553,693
2.7	Improve Breast Cancer Screening	Establish performance improvement goals and set targets using baseline key performance indicator data and analysis of health disparities.	3,553,693
2.8	Improve Breast Cancer Screening	Implement plan to distribute patient education materials on the importance of primary care services for preventative health.	-
3.1	Improve Breast Cancer Screening	Report performance on selected key performance indicators and identify if performance improvement goals were achieved. Review and revise if necessary targets for improvement on the KPIs identified in Year 2 in consultation with MCO.	-
3.2	Improve Breast Cancer Screening	Conduct continuous quality improvement of annual cancer screening campaign. Identify impact of approach, lessons learned, opportunities for improvement, and key challenges associated the approach.	-
3.3	Improve Breast Cancer Screening	Implement approach to enhance a primary care clinic process to improve cancer screening rates.	-
3.4	Improve Breast Cancer Screening	Implement approach for enhanced outreach to improve cancer screening among underserved populations and reduce identified disparities.	-
3.5	Improve Breast Cancer Screening	Implement the PCP training on provider-patient communication.	-
3.6	Improve Breast Cancer Screening	Measure impact of the PCP training and establish performance improvement goals for year 4.	-
4.1	Improve Breast Cancer Screening	Report year 3 performance on selected key performance indicators and identify if performance improvement goals were achieved. Review and revise, if necessary, targets for improvement on the KPIs identified in Year 2 or Year 3 milestone 1, in consultation with MCO or set targets for Year 5 in consultaion with MCO.	-
4.2	Improve Breast Cancer Screening	Conduct continuous quality improvement of annual cancer screening campaign. Identify impact of approach, lessons learned, opportunities for improvement, and key challenges associated the approach.	-
4.3	Improve Breast Cancer Screening	Conduct continuous quality improvement of primary care clinic processes implemented in Year 3.	-
4.4	Improve Breast Cancer Screening	Conduct continuous quality improvement activies during year four for underserved populations.	-
4.5	Improve Breast Cancer Screening	Utilizing results of Milestone 3.6, incorporated training improvements and conduct training for PCPs on provider-patient communication.	-
4.6	Improve Breast Cancer Screening	Measure impact of the PCP training, identify barriers, and establish performance improvement goals for year 5.	-

Milestone Number	AIA	Milestone Description*	Amount Paid for Milestone**
5.1	Improve Breast Cancer Screening	Report performance on selected key performance indicators. Analyze trends and identify if performance improvement goals were achieved. If necessary based on findings of analysis, review and revise targets identified in milestone 4.1 in consultation with the MCOs.	-
5.2	Improve Breast Cancer Screening	Conduct continuous quality improvement of annual cancer screening campaign. Identify impact of approach, lessons learned, opportunities for improvement, and key challenges associated the approach.	-
5.3	Improve Breast Cancer Screening	Conduct continuous quality improvement of primary care clinic processes implemented in Year 4.	-
5.4	Improve Breast Cancer Screening	Conduct continuous quality improvement activies during year five for underserved populations.	-
5.5	Improve Breast Cancer Screening	Utilizing results of Milestone 4.6, incorporated training improvements and conduct training for PCPs on provider-patient communication.	-
5.6	Improve Breast Cancer Screening	Measure impact of the PCP training and identify opportunities to sustain improvements in patient-provider communication to adherence cancer screening adherence.	-
1.1	Improve Receipt of Global Developmental & Autism Screening in the First Three Years of Life (Improve Receipt of Global Developmental & Autism Screening)	Establish a LQN multidisciplinary developmental screening steering committee, including bylaws and membership.	$5,282,496
1.2	Improve Receipt of Global Developmental & Autism Screening	Create flow charts displaying the process of an office visit with developmental and/or autism screening with referral to an early intervention program.	5,263,357
1.3	Improve Receipt of Global Developmental & Autism Screening	Create driver diagrams on specific issues or barriers to conducting screenings using standardized tools and referring to early intervention programs with a focus on clinic processes, including plans for follow up	5,282,496
1.4	Improve Receipt of Global Developmental & Autism Screening	Develop key performance indicators and establish data collection methodology for metrics.	5,263,357

Milestone Number	AIA	Milestone Description*	Amount Paid for Milestone**
1.5	Improve Receipt of Global Developmental & Autism Screening	Distribute training for primary care providers on the signs and symptoms of autism spectrum disorders and common co-occurring conditions.	$5,282,496
1.6	Improve Receipt of Global Developmental & Autism Screening	Distribute educational materials to LQN facilities on Healthy LA billing and coding guidelines related to developmental and autism screening.	5,282,496
1.7	Improve Receipt of Global Developmental & Autism Screening	Develop and implement evaluation plan for provider training.	5,282,496
2.1	Improve Receipt of Global Developmental & Autism Screening	Collect annual baseline data (calendar year 2022) on KPIs identified in Year 1 Milestone 4. Stratify, analyze and report baseline data for key performance indicators. Identify health disparities.	3,948,547
2.2	Improve Receipt of Global Developmental & Autism Screening	Utilizing the flow chart created in CY1 Milestone 2 and driver diagram created in CY1 Milestone 3, develop a protocol to improve clinic processes to improve screening rates and/or referral/care coordination with early intervention programs.	3,948,547
2.3	Improve Receipt of Global Developmental & Autism Screening	Distribute evidence-based guardian/caregiver/parent education on the importance of developmental monitoring (celebrating your child's development, talking about your child's progress with doctors and childcare providers, learning what to expect next, and/or identifying any concerns early).	3,948,547
2.4	Improve Receipt of Global Developmental & Autism Screening	Develop and document a protocol to enhanced outreach and/or care coordination to reduce identified disparities.	3,948,547
2.5	Improve Receipt of Global Developmental & Autism Screening	Establish performance improvement goals and set targets using baseline key performance indicator data and analysis of health disparities.	3,948,547
2.6	Improve Receipt of Global Developmental & Autism Screening	Implement protocol to improve clinic processes.	3,948,547

Milestone Number	AIA	Milestone Description*	Amount Paid for Milestone**
2.7	Improve Receipt of Global Developmental & Autism Screening	Develop a protocol for record reviews for a subset of members who received developmental screening to ensure appropriate tools were used.	$3,948,547
2.8	Improve Receipt of Global Developmental & Autism Screening	Implement records review protocol. For identified concerns, create an action plan for improvement.	-
2.9	Improve Receipt of Global Developmental & Autism Screening	Implement protocol for enhanced outreach and/or care coordination to reduce identified disparities.	3,948,547
3.1	Improve Receipt of Global Developmental & Autism Screening	Report performance on selected key performance indicators and identify if performance improvement goals were achieved. Review and revise if necessary targets for improvement on the KPIs identified in Year 2 in consultation with MCOs.	-
3.2	Improve Receipt of Global Developmental & Autism Screening	Conduct continuous quality improvement of protocol to improve clinic processes implemented in Year 2. Identify impact of protocol, lessons learned, opportunities for improvement, and key challenges associated the protocol.	-
3.3	Improve Receipt of Global Developmental & Autism Screening	Conduct records reviews utilizing records review protocol. For identified concerns, create and implement an action plan for improvement.	-
3.4	Improve Receipt of Global Developmental & Autism Screening	Conduct continuous quality improvement activities to address health disparities.	-
4.1	Improve Receipt of Global Developmental & Autism Screening	Report year 3 performance on selected key performance indicators and identify if performance improvement goals were achieved. Review and revise, if necessary, targets for improvement on the KPIs identified in Year 2 or Year 3 milestone 1, in consultation with MCO or set targets for Year 5 in consultaion with MCO.	-
4.2	Improve Receipt of Global Developmental & Autism Screening	Conduct continuous quality improvement of protocol to improve clinic processes implemented. Identify impact of protocol, lessons learned, opportunities for improvement, and key challenges associated the protocol.	-

Milestone Number	AIA	Milestone Description*	Amount Paid for Milestone**
4.3	Improve Receipt of Global Developmental & Autism Screening	Conduct records reviews utilizing records review protocol. For identified concerns, create and implement an action plan for improvement.	-
4.4	Improve Receipt of Global Developmental & Autism Screening	Conduct continuous quality improvement activities to address health disparities.	-
5.1	Improve Receipt of Global Developmental & Autism Screening	Report year 4 performance on selected key performance indicators. Analyze trends and identify if performance improvement goals were achieved. If necessary based on findings of analysis, review and revise targets identified in milestone 4.1 in consultation with the MCOs.	-
5.2	Improve Receipt of Global Developmental & Autism Screening	Conduct continuous quality improvement of protocol to improve clinic processes implemented. Identify impact of protocol, lessons learned, opportunities for improvement, and key challenges associated the protocol.	-
5.3	Improve Receipt of Global Developmental & Autism Screening	Conduct records reviews utilizing protocol. For identified concerns, create and implement an action plan for improvement.	-
5.4	Improve Receipt of Global Developmental & Autism Screening	Conduct continuous quality improvement activities to address health disparities.	-
1.1	Improve prevention, screening, and treatment of Childhood Obesity	Establish a LQN multidisciplinary Childhood Obesity Steering Committee, including bylaws and membership.	$4,637,759
1.2	Improve prevention, screening, and treatment of Childhood Obesity	Identify LQN members to serve on LQN Childhood Obesity ECHO Hub Team including ECHO Lead/Facilitator, Program Support Staff, IT Support, and Subject Matter Experts. Define roles and responsibilities.	4,830,999
1.3	Improve prevention, screening, and treatment of Childhood Obesity	Create and distribute a network community resource guide for Louisiana Medicaid beneficiaries for services and programs related to nutrition, physical activity, behavioral modification, and/or weight management, including virtual care services as available.	-

Milestone Number	AIA	Milestone Description*	Amount Paid for Milestone**
1.4	Improve prevention, screening, and treatment of Childhood Obesity	Create driver diagrams on specific issues or barriers to obesity assessment and counseling for nutrition and physical activity for children covered under Louisiana Medicaid.	$4,830,999
1.5	Improve prevention, screening, and treatment of Childhood Obesity	Complete Project ECHO strategic planning documentation.	4,637,759
1.6	Improve prevention, screening, and treatment of Childhood Obesity	Selected Hub Team members complete the introductory ECHO training and observe an ECHO session to observe the All Teach, All Learn principle to support a successful implementation of LQN Childhood Obesity ECHO.	4,637,759
1.7	Improve prevention, screening, and treatment of Childhood Obesity	Identify, select, and validate key performance indicators with a multidisciplinary team.	-
2.1	Improve prevention, screening, and treatment of Childhood Obesity	Collect annual baseline data (calendar year 2023) on KPIs identified in Year 1 Milestone 9. Stratify, analyze, and report baseline data for key performance indicators. Identify health disparities.	-
2.2	Improve prevention, screening, and treatment of Childhood Obesity	Develop ECHO curriculum, case presentation, and recommendation forms. Develop and distribute LQN Childhood Obesity ECHO marketing materials.	-
2.3	Improve prevention, screening, and treatment of Childhood Obesity	Two LQN pilot organizations develop and document a protocol for community collaboration to address childhood obesity within school settings. Implement pilot protocol to improve access to care.	-
2.4	Improve prevention, screening, and treatment of Childhood Obesity	Develop and implement a LQN Clinical Pathway for the Assessment and Management of Childhood Obesity to provide a link between the best available evidence and clinical practice.	-
2.5	Improve prevention, screening, and treatment of Childhood Obesity	Develop and implement a protocol to improve obesity assessment and counseling for nutrition and physical activity in primary care clinic settings.	-

Milestone Number	AIA	Milestone Description*	Amount Paid for Milestone**
2.6	Improve prevention, screening, and treatment of Childhood Obesity	Launch LQN Childhood Obesity ECHO Program and host post-session debrief to inform continuous quality improvement efforts.	-
2.7	Improve prevention, screening, and treatment of Childhood Obesity	Establish performance improvement goals and set targets using baseline key performance indicator data and analysis of health disparities.	-
3.1	Improve prevention, screening, and treatment of Childhood Obesity	Report performance on selected key performance indicators and identify if performance improvement goals were achieved. Review and revise if necessary targets for improvement on the KPIs identified in Year 2.	-
3.2	Improve prevention, screening, and treatment of Childhood Obesity	Conduct continuous quality improvement of focused Childhood Obesity ECHO Program. Identify impact of program, lessons learned, opportunities for improvement, and key challenges associated with the protocol.	-
3.3	Improve prevention, screening, and treatment of Childhood Obesity	Conduct continuous quality improvement of pilot of childhood obesity protocol within school settings. Identify impact of protocol, lessons learned, opportunities for improvement, and key challenges associated with the protocol.	-
3.4	Improve prevention, screening, and treatment of Childhood Obesity	Conduct continuous quality improvement of the LQN Clinical Pathway for the Assessment and Management to provide a link between the best available evidence and clinical practice of Childhood Obesity. Identify impact of the clinical pathway, lessons learned, opportunities for improvement, and key challenges associated with the tool.	-
3.5	Improve prevention, screening, and treatment of Childhood Obesity	Conduct continuous quality improvement on protocol to improve obesity assessment and counseling for nutrition and physical activity. Identify impact of protocol, lessons learned, opportunities for improvement, and key challenges associated with the protocol.	-
4.1	Improve prevention, screening, and treatment of Childhood Obesity	Report year 3 performance on selected key performance indicators and identify if performance improvement goals were achieved. Review and revise if necessary targets for improvement on the KPIs identified in Year 2 or Year 3 Milestone 1 in consultation with MCOs.	-
4.2	Improve prevention, screening, and treatment of Childhood Obesity	Conduct continuous quality improvement of focused Childhood Obesity ECHO Program. Identify impact of program, lessons learned, opportunities for improvement, and key challenges associated with the protocol.	-

Milestone Number	AIA	Milestone Description*	Amount Paid for Milestone**
4.3	Improve prevention, screening, and treatment of Childhood Obesity	Conduct continuous quality improvement of pilot of childhood obesity protocol within school settings. Identify impact of protocol, lessons learned, opportunities for improvement, and key challenges associated with the protocol.	-
4.4	Improve prevention, screening, and treatment of Childhood Obesity	Conduct continuous quality improvement of the LQN Clinical Pathway for the Assessment and Management to provide a link between the best available evidence and clinical practice of Childhood Obesity. Identify impact of the clinical pathway, lessons learned, opportunities for improvement, and key challenges associated with the tool.	-
4.5	Improve prevention, screening, and treatment of Childhood Obesity	Conduct continuous quality improvement on protocol to improve obesity assessment and counseling for nutrition and physical activity. Identify impact of protocol, lessons learned, opportunities for improvement, and key challenges associated with the protocol.	-
4.6	Improve prevention, screening, and treatment of Childhood Obesity	Host a LQN Childhood Obesity Community Collaborative Summit to identify aligned goals in addressing health disparities with community partners and provide clinical education to providers.	-
5.1	Improve prevention, screening, and treatment of Childhood Obesity	Report year 4 performance on selected key performance indicators and identify if performance improvement goals were achieved. Review and revise if necessary targets for improvement on the KPIs identified in Year 2 or Year 4 Milestone 1 in consultation with MCOs.	-
5.2	Improve prevention, screening, and treatment of Childhood Obesity	Conduct continuous quality improvement of focused Childhood Obesity ECHO Program. Identify impact of program, lessons learned, opportunities for improvement, and key challenges associated with the protocol.	-
5.3	Improve prevention, screening, and treatment of Childhood Obesity	Conduct continuous quality improvement of pilot of childhood obesity protocol within school settings. Identify impact of protocol, lessons learned, opportunities for improvement, and key challenges associated with the protocol.	-
5.4	Improve prevention, screening, and treatment of Childhood Obesity	Conduct continuous quality improvement of the LQN Clinical Pathway for the Assessment and Management to provide a link between the best available evidence and clinical practice of Childhood Obesity. Identify impact of the clinical pathway, lessons learned, opportunities for improvement, and key challenges associated with the tool.	-
5.5	Improve prevention, screening, and treatment of Childhood Obesity	Conduct continuous quality improvement on protocol to improve obesity assessment and counseling for nutrition and physical activity. Identify impact of protocol, lessons learned, opportunities for improvement, and key challenges associated with the protocol.	-

Milestone Number	AIA	Milestone Description*	Amount Paid for Milestone**
1.1	Address the Opioid epidemic through multiple care settings	Establish a LQN multidisciplinary opioid epidemic steering committee, including bylaws and membership.	$4,518,842
1.2	Address the Opioid epidemic through multiple care settings	Conduct an assessment to evaluate and document current LQN interventions and areas of opportunity to improve community / outpatient care.	4,518,842
1.3	Address the Opioid epidemic through multiple care settings	Conduct an assessment to evaluate and document current LQN interventions and areas of opportunity to improve emergency department / inpatient care.	4,518,842
1.4	Address the Opioid epidemic through multiple care settings	Conduct an assessment to evaluate and document current LQN use of best practices and areas of opportunity to improve the quality of care for substance exposed mothers and newborns.	4,518,842
1.5	Address the Opioid epidemic through multiple care settings	Identify, assess, and document effective efforts in other states to enhance community / outpatient care, emergency department /inpatient care, and newborn care.	4,518,842
1.6	Address the Opioid epidemic through multiple care settings	Identify, select, and validate key performance indicators in all clinical pathways with a multidisciplinary team.	-
2.1	Address the Opioid epidemic through multiple care settings	Collect annual baseline data (calendar year 2023) on KPIs identified in Year 1 Milestone 6. Stratify, analyze, and report baseline data for key performance indicators.	-
2.2	Address the Opioid epidemic through multiple care settings	Develop and document a protocol to enhance the quality of community /outpatient care interventions based on findings from CY1 Milestone 2.	-
2.3	Address the Opioid epidemic through multiple care settings	Develop and document a protocol to enhance the quality of emergency department /inpatient care based on findings from CY1 Milestone 3.	-

Milestone Number	AIA	Milestone Description*	Amount Paid for Milestone**
2.4	Address the Opioid epidemic through multiple care settings	Develop and document a protocol to enhance the quality of care for substance exposed mothers and newborns based on CY1 Milestone 4.	-
2.5	Address the Opioid epidemic through multiple care settings	Implement protocol to enhance the quality of community /outpatient care interventions based on findings from CY1 Milestone 2.	-
2.6	Address the Opioid epidemic through multiple care settings	Implement protocol to enhance the quality of emergency department /inpatient care based on findings from CY1 Milestone 3.	-
2.7	Address the Opioid epidemic through multiple care settings	Implement protocol to enhance the quality of care for substance exposed mothers and newborns based on CY1 Milestone 4.	-
2.8	Address the Opioid epidemic through multiple care settings	Host focused Grand Rounds Educational Programs, while focusing offerings on recognized opportunities for improvement.	-
2.9	Address the Opioid epidemic through multiple care settings	Establish performance targets among each of the clinical pathways using baseline key performance indicator data submitted in milestone 2.1.	-
3.1	Address the Opioid epidemic through multiple care settings	Report performance on selected key performance indicators and identify if performance improvement goals were achieved in all clinical pathways. Review and revise if necessary targets for improvement on the KPIs identified in Year 2 in consultation with MCOs.	-
3.2	Address the Opioid epidemic through multiple care settings	Conduct continuous quality improvement on protocol to enhance the quality of community /outpatient care interventions based on findings from CY2 Milestone 2. Measure impact of approach, lessons learned, opportunities for improvement, and key challenges associated the approach.	-
3.3	Address the Opioid epidemic through multiple care settings	Conduct continuous quality improvement on protocol to enhance the quality of emergency department /inpatient care based on findings from CY2 Milestone 3. Measure impact of approach, lessons learned, opportunities for improvement, and key challenges associated the approach.	-

Milestone Number	AIA	Milestone Description*	Amount Paid for Milestone**
3.4	Address the Opioid epidemic through multiple care settings	Conduct continuous quality improvement of protocol to enhance the quality of care for substance exposed mothers and newborns based on CY2 Milestone 4. Measure impact of approach, lessons learned, opportunities for improvement, and key challenges associated the approach.	-
3.5	Address the Opioid epidemic through multiple care settings	Hold 1st Annual Louisiana Quality Network Opioid Epidemic Challenge Awards/Conference.	-
4.1	Address the Opioid epidemic through multiple care settings	Report performance on selected key performance indicators and identify if performance improvement goals were achieved in all clinical pathways. Review and revise if necessary targets for improvement on the KPIs identified in Year 3 in consultation with MCOs.	-
4.2	Address the Opioid epidemic through multiple care settings	Conduct continuous quality improvement on protocol to enhance the quality of community /outpatient care interventions based on findings from CY3 Milestone 2. Measure impact of approach, lessons learned, opportunities for improvement, and key challenges associated the approach.	-
4.3	Address the Opioid epidemic through multiple care settings	Conduct continuous quality improvement on protocol to enhance the quality of emergency department /inpatient care based on findings from CY3 Milestone 3. Measure impact of approach, lessons learned, opportunities for improvement, and key challenges associated the approach.	-
4.4	Address the Opioid epidemic through multiple care settings	Conduct continuous quality improvement of protocol to enhance the quality of care for substance exposed mothers and newborns based on CY3 Milestone 4. Measure impact of approach, lessons learned, opportunities for improvement, and key challenges associated the approach.	-
4.5	Address the Opioid epidemic through multiple care settings	Hold 2nd Annual Louisiana Quality Network Opioid Epidemic Challenge Awards/Conference.	-
5.1	Address the Opioid epidemic through multiple care settings	Report performance on selected key performance indicators and identify if performance improvement goals were achieved in all clinical pathways. Review and revise if necessary targets for improvement on the KPIs identified in Year 4 in consultation with MCOs.	-
5.2	Address the Opioid epidemic through multiple care settings	Conduct continuous quality improvement on protocol to enhance the quality of community /outpatient care interventions based on findings from CY4 Milestone 2. Measure impact of approach, lessons learned, opportunities for improvement, and key challenges associated the approach.	-

Milestone Number	AIA	Milestone Description*	Amount Paid for Milestone**
5.3	Address the Opioid epidemic through multiple care settings	Conduct continuous quality improvement on protocol to enhance the quality of emergency department /inpatient care based on findings from CY4 Milestone 3. Measure impact of approach, lessons learned, opportunities for improvement, and key challenges associated the approach.	-
5.4	Address the Opioid epidemic through multiple care settings	Conduct continuous quality improvement of protocol to enhance the quality of care for substance exposed mothers and newborns based on CY4 Milestone 4. Measure impact of approach, lessons learned, opportunities for improvement, and key challenges associated the approach.	-
5.5	Address the Opioid epidemic through multiple care settings	Hold 3rd Annual Louisiana Quality Network Opioid Epidemic Challenge Awards/Conference.	-
Total Paid			**$907,366,291**

* 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. Also, this amount does not include the portion of the payment made for non-milestone related activities.
Source: Prepared by legislative auditor's staff using information from LDH.

APPENDIX E: QIN's AIAs, MILESTONES, AND PAYMENTS FROM SEPTEMBER 2019 THROUGH DECEMBER 2024

Milestone Number	AIA	Milestone Description*	Amount Paid for Milestone**
1.1	Improve Outcomes for Diabetic Members (Diabetes)	Evaluate accuracy and effectiveness of registries in addressing treatment gaps and improving outcomes	$6,705,301
1.2	Diabetes	Identify root causes of HbA1c poor control	6,705,301
1.3	Diabetes	Identify root causes of BP poor control	6,705,301
1.4	Diabetes	Create registry	6,705,301
1.5	Diabetes	Meet with providers to address technical implementation issues	6,705,301
1.6	Diabetes	Create and disseminate protocols	6,705,301
1.7	Diabetes	Educate and train providers	6,705,301
1.8	Diabetes	Launch registry	6,705,301
2.1	Diabetes	Enroll members in registry	4,359,625
2.2	Diabetes	Study treatment gaps for diabetic patients	4,359,625
2.3	Diabetes	Review and modify registry data fields	4,359,625
2.4	Diabetes	Educate providers regarding registry use	4,359,625
2.5	Diabetes	Measure baseline for members enrolled in registry	4,359,625
2.6	Diabetes	Measure baseline for HbA1c tests	4,359,625
2.7	Diabetes	Measure baseline for registry members with HbA1c poor control	4,359,625
2.8	Diabetes	Measure baseline for registry members with BP poor control	4,359,625
2.9	Diabetes	Measure baseline for registry members with HbA1c control	4,359,625
2.10	Diabetes	Create action items to address root causes of HbA1c poor control	4,359,625
2.11	Diabetes	Create action items to address root causes of BP poor control	4,359,625
2.12	Diabetes	Create continuous quality improvement plan	4,359,625
3.1	Diabetes	Create action items to address treatment gaps	4,894,802
3.2	Diabetes	Implement activities designed to address treatment gaps	4,894,802
3.3	Diabetes	Measure baseline of activities designed to address treatment gaps	4,894,802
3.4	Diabetes	Implement activities designed to reduce members with HbA1c poor control and measure baseline for member participation	4,894,802
3.5	Diabetes	Implement activities designed to reduce members with BP poor control and measure baseline for member participation	4,894,802

Milestone Number	AIA	Milestone Description*	Amount Paid for Milestone**
3.6	Diabetes	Increase registry enrollment	$4,894,802
3.7	Diabetes	Increase HbA1c tests	4,894,802
3.8	Diabetes	Decrease HbA1c poor control	4,894,802
3.9	Diabetes	Decrease BP poor control	4,894,802
3.10	Diabetes	Increase HbA1c control	4,894,802
3.11	Diabetes	Conduct continuous quality improvement activities	4,894,802
3.12	Diabetes	Review and modify registry data fields	4,894,802
3.13	Diabetes	Continuous education of providers	4,894,802
4.1	Diabetes	Increase activities designed to address treatment gaps	5,463,985
4.2	Diabetes	Increase percentage of members participating in activities designed to reduce members with HbA1c poor control	-
4.3	Diabetes	Increase percentage of members participating in activities designed to reduce members with BP poor control	5,463,985
4.4	Diabetes	Increase registry enrollment	5,463,985
4.5	Diabetes	Increase HbA1c tests	5,463,985
4.6	Diabetes	Increase HbA1c control	5,463,985
4.7	Diabetes	Decrease HbA1c poor control	5,463,985
4.8	Diabetes	Decrease BP poor control	5,463,985
4.9	Diabetes	Conduct continuous quality improvement activities	5,463,985
5.1	Diabetes	Increase activities designed to address treatment gaps	4,757,690
5.2	Diabetes	Increase percentage of members participating in activities designed to reduce members with HbA1c poor control	-
5.3	Diabetes	Increase percentage of members participating in activities designed to reduce members with BP poor control	-
5.4	Diabetes	Increase registry enrollment	-
5.5	Diabetes	Increase HbA1c tests	-
5.6	Diabetes	Decrease HbA1c poor control	-
5.7	Diabetes	Decrease BP poor control	-
5.8	Diabetes	Increase HbA1c control	-
5.9	Diabetes	Conduct continuous quality improvement activities	4,757,690
1.1	Improve Outcomes for Members with Hypertension (Hypertension)	Evaluate accuracy and effectiveness of use of registries in addressing treatment gaps and improving outcomes	7,040,566
1.2	Hypertension	Identify root causes of BP poor control for members 18-59	7,040,566
1.3	Hypertension	Identify root causes of BP poor control for members 60-85	7,040,566
1.4	Hypertension	Create registry	7,040,566
1.5	Hypertension	Meet with network providers to address technical implementation issues	7,040,566

Milestone Number	AIA	Milestone Description*	Amount Paid for Milestone**
1.6	Hypertension	Create and disseminate protocols	$7,040,566
1.7	Hypertension	Conduct provider education	7,040,566
1.8	Hypertension	Launch registry	7,040,566
2.1	Hypertension	Enroll in registry MCO members ages 18-85 with hypertension at network providers.	4,535,771
2.2	Hypertension	Identify and study treatment gaps specific to patients enrolled in registries.	4,535,771
2.3	Hypertension	Create action items to address treatment gaps identified.	4,535,771
2.4	Hypertension	Review registry data fields and modify as needed to report on identified treatment gaps.	4,535,771
2.5	Hypertension	Continuous education of providers regarding use of registries and updates made to registries.	4,535,771
2.6	Hypertension	Measure baseline for members ages 18-85 with hypertension enrolled in the registry.	4,535,771
2.7	Hypertension	Measure baseline for members ages 18-59 with hypertension enrolled in the registry whose BP was adequately controlled (<140/90).	4,535,771
2.8	Hypertension	Measure baseline for members ages 18-59 with hypertension enrolled in the registry whose BP was adequately controlled (<150/90).	4,535,771
2.9	Hypertension	Create action items to address root causes of poor BP control for members ages 18-59 (>140/90).	4,535,771
2.10	Hypertension	Create action items to address root causes of poor BP control for members ages 60-85 (>150/90).	4,535,771
2.11	Hypertension	Create continuous quality improvement plan, including information identifying project impacts, registry modifications needed, lessons learned, opportunities to scale project to a broader population, and key challenges associated with expansion of project.	4,535,771
3.1	Hypertension	Implement action items designed to address treatment gaps	5,965,541
3.2	Hypertension	Implement activities designed to increase BP control for registry members and measure baseline for member participation	5,965,541
3.3	Hypertension	Increase members ages 18-85 enrolled in registry	5,965,541
3.4	Hypertension	Increase percentage of registry members ages 18-59 with adequate BP control	5,965,541
3.5	Hypertension	Increase percentage of registry members ages 60-85 with adequate BP control	5,965,541
3.6	Hypertension	Conduct continuous quality improvement activities	5,965,541
3.7	Hypertension	Review and modify registry	5,965,541
3.8	Hypertension	Continous education of providers	5,965,541
4.1	Hypertension	Increase member participation in activities designed to increase BP control for registry members	6,921,048
4.2	Hypertension	Increase members ages 18-85 enrolled in registry	6,921,048
4.3	Hypertension	Increase percentage of registry members ages 18-59 with adequate BP control	6,921,048
4.4	Hypertension	Increase percentage of registry members ages 60-85 with adequate BP control	6,921,048

Milestone Number	AIA	Milestone Description*	Amount Paid for Milestone**
4.5	Hypertension	Conduct continuous quality improvement activities	$6,921,048
5.1	Hypertension	Increase member participation in activities designed to increase BP control for registry members	-
5.2	Hypertension	Increase members ages 18-85 enrolled in registry	-
5.3	Hypertension	Increase percentage of registry members ages 18-59 with adequate BP control	-
5.4	Hypertension	Increase percentage of registry members ages 60-85 with adequate BP control	-
5.5	Hypertension	Conduct continuous quality improvement activities	6,026,408
1.1	Pediatric Primary Care Utilization (Pediatric Primary Care)	Identify gaps in preventative healthcare services for Louisiana Medicaid members ages 0-21 years based on the American Academy of Pediatrics ("AAP") recommendations for Preventative Pediatric Health Care	8,213,993
1.2	Pediatric Primary Care	Create and disseminate protocols to providers regarding preventative healthcare services	8,213,993
1.3	Pediatric Primary Care	Identify and test ideas to improve preventative healthcare services	8,213,993
1.4	Pediatric Primary Care	Identify and study root causes for insufficient preventative healthcare services	8,213,993
2.1	Pediatric Primary Care	Conduct provider training and education activities, and measure baseline percentage of network providers meeting protocol criteria	5,328,430
2.2	Pediatric Primary Care	Measure baseline for members who turned 15 months old during the measurement year and had six or more well-child visits during the first 15 months of life	5,328,430
2.3	Pediatric Primary Care	Measure baseline for members ages 3-6 years who had one or more well-child visits during the measurement year	5,328,430
2.4	Pediatric Primary Care	Measure baseline for members ages 12-21 years who had at least one comprehensive well-care visit during the measurement year	5,328,430
2.5	Pediatric Primary Care	Analyze methods to improve PCP visits consistent with AAP recommendations and revise protocols as needed	5,328,430
3.1	Pediatric Primary Care	Increase percentage of network providers meeting protocol criteria	6,131,250
3.2	Pediatric Primary Care	Increase members who turned 15 months old during the measurement year and had six or more well-child visits during the first 15 months of life	6,131,250
3.3	Pediatric Primary Care	Increase members ages 3-6 years who had one or more well-child visits during the measurement year	6,131,250
3.4	Pediatric Primary Care	Increase members ages 12-21 years who had at least one comprehensive well-care visit during the measurement year	6,131,250
3.5	Pediatric Primary Care	Measure baseline for members ages 3 -17 years that had an outpatient visit during the measurement year with evidence of BMI percentil documentation by age and gender, counseling for nutrition, and counseling for physical activity	6,131,250

Milestone Number	AIA	Milestone Description*	Amount Paid for Milestone**
3.6	Pediatric Primary Care	Conduct activities designed to improve PCP visits for members ages 0-21 years consistent with AAP recommendations and revise protocols as needed	$6,131,250
4.1	Pediatric Primary Care	Increase percentage of network providers meeting protocol criteria	5,615,763
4.2	Pediatric Primary Care	Increase members who turned 15 months old during the measurement year and had six or more well-child visits during the first 15 months of life	5,615,763
4.3	Pediatric Primary Care	Increase members ages 3-6 years who had one or more well-child visits during the measurement year	5,615,763
4.4	Pediatric Primary Care	Increase members ages 12-21 years who had at least one comprehensive well-care visit during the measurement year	5,615,763
4.5	Pediatric Primary Care	Increase members ages 3 -17 years that had an outpatient visit during the measurement year with evidence of BMI percentil documentation by age and gender, counseling for nutrition, and counseling for physical activity	5,615,763
4.6	Pediatric Primary Care	Conduct activities designed to improve PCP visits for members ages 0-21 years consistent with AAP recommendations and revise protocols as needed	5,615,763
5.1	Pediatric Primary Care	Increase percentage of network providers meeting protocol criteria	5,550,639
5.2	Pediatric Primary Care	Increase members who turned 15 months old during the measurement year and had six or more well-child visits during the first 15 months of life	-
5.3	Pediatric Primary Care	Increase members ages 3-6 years who had one or more well-child visits during the measurement year	-
5.4	Pediatric Primary Care	Increase members ages 12-21 years who had at least one comprehensive well-care visit during the measurement year	-
5.5	Pediatric Primary Care	Increase members ages 3 -17 years that had an outpatient visit during the measurement year with evidence of BMI percentil documentation by age and gender, counseling for nutrition, and counseling for physical activity	-
1.1	Emergency Department (ED) Utilization	Identify and study root causes of avoidable ED utilization in Louisiana Medicaid population	6,956,749
1.2	ED Utilization	Identify and study root causes for lack of annual ambulatory or preventative care visits	6,956,749
1.3	ED Utilization	Meet with network providers to establish ED navigation programs	6,956,749
1.4	ED Utilization	Identify and draft parameters for identifying high ED utilizers	6,956,749
1.5	ED Utilization	Create and disseminate protocols for navigation programs	6,956,749
1.6	ED Utilization	Document types of navigation services to be provided to members enrolled	6,956,749
1.7	ED Utilization	Conduct training and education of providers	6,956,749
1.8	ED Utilization	Launch ED navigation programs for high-ED utilizers	6,956,749
2.1	ED Utilization	Create action items to address root causes of inappropriate ED utilization	4,007,332

Milestone Number	AIA	Milestone Description*	Amount Paid for Milestone**
2.2	ED Utilization	Create action items to address root cause for lack of annual ambulatory or preventative care visits for members assigned to network physician providers	$4,007,332
2.3	ED Utilization	Enroll members in navigation programs	4,007,332
2.4	ED Utilization	Measure baseline for members enrolled in ED navigation programs receiving education regarding outpatient primary care options	4,007,332
2.5	ED Utilization	Document types of navigation services provided to members enrolled	4,007,332
2.6	ED Utilization	Measure baseline for members ages 20 or older receiving annual ambulatory or preventative care visits	4,007,332
2.7	ED Utilization	Measure baseline for number of members receiving an appointment reminder 24-48 hours before a scheduled appointment	4,007,332
2.8	ED Utilization	Measure baseline for number of scheduled appointments and/or referrals provided to members identified as high-ED utilizers	4,007,332
2.9	ED Utilization	Create continuous quality improvement plan	4,007,332
2.10	ED Utilization	Measure baseline for percentage of ambulatory care ED visits at network providers	4,007,332
2.11	ED Utilization	Continuous education of providers	4,007,332
3.1	ED Utilization	Implement activities designed to address inappropriate ED utilization and measure baseline of member participation	5,219,848
3.2	ED Utilization	Implement activities designed to address root cause for lack of annual ambulatory or preventative care visits for members assigned to network physician providers	5,219,848
3.3	ED Utilization	Increase members enrolled in navigation programs	5,219,848
3.4	ED Utilization	Increase number of members enrolled in ED navigation programs receiving education regarding outpatient primary care options	5,219,848
3.5	ED Utilization	Increase members ages 20 or older receiving annual ambulatory or preventative care visits	-
3.6	ED Utilization	Increase members receiving an appointment reminder 24-48 hours before a scheduled appointment	5,219,848
3.7	ED Utilization	Increase number of scheduled appointments and/or referrals provided to members identified as high-ED utilizers	5,219,848
3.8	ED Utilization	Conduct continuous quality improvement activities	-
3.9	ED Utilization	Decrease in percentage of ambulatory ED visits	5,219,848
3.10	ED Utilization	Continuous education of providers	5,219,848
4.1	ED Utilization	Increase members enrolled in navigation programs	5,008,653
4.2	ED Utilization	Increase number of members enrolled in ED navigation programs receiving education regarding outpatient primary care options	5,008,653

Milestone Number	AIA	Milestone Description*	Amount Paid for Milestone**
4.3	ED Utilization	Increase participation in activities designed to address avoidable ED utilization	$5,008,653
4.4	ED Utilization	Increase participation in activities designed to address lack of annual or preventative care visits	5,008,653
4.5	ED Utilization	Increase or maintenance of members receiving an appointment reminder 24-48 hours before a scheduled appointment	5,008,653
4.6	ED Utilization	Increase number of scheduled appointments and/or referrals provided to members identified as high-ED utilizers	5,008,653
4.7	ED Utilization	Decrease in percentage of ambulatory ED visits	5,008,653
4.8	ED Utilization	Conduct continuous quality improvement activities	5,008,653
5.1	ED Utilization	Increase members enrolled in navigation programs	-
5.2	ED Utilization	Increase number of members enrolled in ED navigation programs receiving education regarding outpatient primary care options	-
5.3	ED Utilization	Increase participation in activities designed to address avoidable ED utilization	-
5.4	ED Utilization	Increase participation in activities designed to address lack of annual ambulatory or preventative care visits	-
5.5	ED Utilization	Increase or maintenance of members receiving an appointment reminder 24-48 hours before a scheduled appointment	-
5.6	ED Utilization	Increase number of scheduled appointments and/or referrals provided to members identified as high-ED utilizers	-
5.7	ED Utilization	Decrease in percentage of ambulatory ED visits	-
5.8	ED Utilization	Conduct continuous quality improvement activities	4,361,216
1.1	Improve Maternal Care (Maternal Care)	Identify prenatal care treatment gaps specific to Healthy Louisiana enrollees ages 15-45.	7,355,073
1.2	Maternal Care	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
1.3	Maternal Care	Identify ideas to improve prenatal healthcare services for Healthy Louisiana enrollees ages 15-45	7,355,073
1.4	Maternal Care	Identify and study root causes for insufficient prenatal care for Healthy Louisiana enrollees ages 15-45.	7,355,073
2.1	Maternal Care	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
2.2	Maternal Care	Implement activities designed to address treatment gaps and root causes for insufficient prenatal care.	5,513,964

Milestone Number	AIA	Milestone Description*	Amount Paid for Milestone**
2.3	Maternal Care	Analyze methods to improve prenatal care visits for enrollees ages 15-45 and revise protocols as needed.	$5,513,964
2.4	Maternal Care	Measure baseline percentage of nulliparous enrollees with a term, singleton baby in a vertex position delivered by cesarean birth (C-section).	5,513,964
2.5	Maternal Care	Measure baseline percentage of enrollees with elective vaginal deliveries or elective cesarean sections at ≥37 and <39 weeks of gestation completed.	5,513,964
2.6	Maternal Care	Measure baseline percentage of enrollees with live births that weighed less than 2,500 grams.	5,513,964
2.7	Maternal Care	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
3.1	Maternal Care	Continue activities designed to address treatment gaps and root causes for insufficient prenatal care.	6,374,650
3.2	Maternal Care	Continue to analyze methods to improve prenatal healthcare services for enrollees ages 15-45 and revise protocols as needed.	6,374,650
3.3	Maternal Care	Decrease 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.	6,374,650
3.4	Maternal Care	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
3.5	Maternal Care	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
3.6	Maternal Care	Conduct continuous quality improvement activities during Year Three.	6,374,650
4.1	Maternal Care	Continue activities designed to address treatment gaps and root causes for insufficient prenatal care.	5,550,639
4.2	Maternal Care	Continue to analyze methods to improve prenatal visits for enrollees ages 15-45 and revise protocols as needed.	5,550,639
4.3	Maternal Care	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	Maternal Care	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	Maternal Care	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	Maternal Care	Conduct continuous quality improvement activities during Year Four.	5,550,639

Milestone Number	AIA	Milestone Description*	Amount Paid for Milestone**
5.1	Maternal Care	Continue activities designed to address treatment gaps and root causes for insufficient prenatal care.	-
5.2	Maternal Care	Continue to analyze methods to improve prenatal visits for enrollees ages 15-45 and revise protocols as needed.	-
5.3	Maternal Care	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.	-
5.4	Maternal Care	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	Maternal Care	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	Maternal Care	Conduct continuous quality improvement activities during Year Five.	-
1.1	Improve Tobacco Cessation	Identify and study root causes of tobacco use in the Medicaid population to identify opportunities to prevent use from starting.	$5,744,990
1.2	Improve Tobacco Cessation	Identify and study root causes of lack of tobacco cessation treatment in inpatient and ED settings.	5,744,990
1.3	Improve Tobacco Cessation	Create a reporting template with data fields necessary to assess members' tobacco use and tobacco cessation activities.	5,744,990
1.4	Improve Tobacco Cessation	Meet with network providers to address technical implementation issues.	5,744,990
1.5	Improve Tobacco Cessation	Create and disseminate protocols for network providers to use.	5,744,990
1.6	Improve Tobacco Cessation	Conduct education and training of network providers regarding tobacco cessation, including assessing tobacco use status of members and tobacco cessation counseling.	5,744,990
1.7	Improve Tobacco Cessation	Evaluate accuracy and effectiveness of tobacco cessation methods.	5,744,990
2.1	Improve Tobacco Cessation	Create action items designed to address root causes of tobacco use and to identify opportunities to prevent use from starting in the Medicaid population.	4,061,621
2.2	Improve Tobacco Cessation	Create action items designed to address root causes of lack of tobacco cessation treatment in inpatient and ED settings.	4,061,621
2.3	Improve Tobacco Cessation	Review reporting template and modify as needed.	4,061,621
2.4	Improve Tobacco Cessation	Review and revise protocols as needed.	4,061,621

Milestone Number	AIA	Milestone Description*	Amount Paid for Milestone**
2.5	Improve Tobacco Cessation	Continuous education and training of network providers regarding tobacco cessation, including assessing tobacco use status of members and tobacco cessation counseling.	$4,061,621
2.6	Improve Tobacco Cessation	Measure baseline for members whose smoking status is assessed in the ED.	-
2.7	Improve Tobacco Cessation	Measure baseline for members whose smoking status is assessed as inpatients.	-
2.8	Improve Tobacco Cessation	Identify and prepare summary of community providers that offer tobacco cessation treatment services to members, to which network providers could refer members.	4,061,621
2.9	Improve Tobacco Cessation	Create continuous quality improvement plan, including information identifying project impacts, reporting modifications needed, lessons learned, opportunities to scale project to a broader population, and key challenges.	4,061,621
3.1	Improve Tobacco Cessation	Implement activities designed to address root causes of tobacco use and to identify opportunities to prevent use from starting in the Medicaid population.	-
3.2	Improve Tobacco Cessation	Implement activities designed to address root causes of lack of tobacco cessation treatment in inpatient and ED settings.	-
3.3	Improve Tobacco Cessation	Review and revise protocols as needed.	-
3.4	Improve Tobacco Cessation	Increase members whose smoking status is assessed in the ED.	-
3.5	Improve Tobacco Cessation	Increase members whose smoking status is assessed as inpatients.	-
3.6	Improve Tobacco Cessation	Create action items to improve counseling and initiation of pharmacotherapy/NRT for smoking cessation in the ED.	-
3.7	Improve Tobacco Cessation	Measure baseline of members receiving ED counseling and initiation of pharmacotherapy/NRT for smoking cessation.	-
3.8	Improve Tobacco Cessation	Create action items to improve inpatient counseling and use of pharmacotherapy/ NRT for smoking cessation while hospitalized.	-
3.9	Improve Tobacco Cessation	Measure baseline for members receiving inpatient counseling and use of pharmacotherapy/NRT for smoking cessation while hospitalized.	-
3.10	Improve Tobacco Cessation	Update summary of community providers that offer tobacco cessation treatment services to members, to which network providers could refer members.	-
3.11	Improve Tobacco Cessation	Measure baseline for members receiving a referral to community providers that offer tobacco cessation treatment services at discharge from hospital.	-
3.12	Improve Tobacco Cessation	Measure baseline for members receiving a referral to community providers that offer tobacco cessation treatment services at discharge from the ED.	-

Milestone Number	AIA	Milestone Description*	Amount Paid for Milestone**
3.13	Improve Tobacco Cessation	Conduct continuous quality improvement activities during Year Three.	-
4.1	Improve Tobacco Cessation	Continue activities designed to address root causes of tobacco use and to identify opportunities to prevent use from starting in the Medicaid population.	-
4.2	Improve Tobacco Cessation	Continue activities designed to address root causes of lack of tobacco cessation treatment in inpatient and ED settings.	-
4.3	Improve Tobacco Cessation	Review reporting template and modify as needed.	-
4.4	Improve Tobacco Cessation	Additional increase in members whose smoking status is assessed in the ED.	-
4.5	Improve Tobacco Cessation	Additional increase in members whose smoking status is assessed as inpatients.	-
4.6	Improve Tobacco Cessation	Implement activities to improve counseling and initiation of pharmacotherapy/ NRT for smoking cessation in the ED.	-
4.7	Improve Tobacco Cessation	Increase members receiving ED counseling and initiation of pharmacotherapy/ NRT for smoking cessation.	-
4.8	Improve Tobacco Cessation	Implement activities to improve inpatient counseling and use of pharmacotherapy/ NRT for smoking cessation while hospitalized.	-
4.9	Improve Tobacco Cessation	Increase members receiving inpatient counseling and use of pharmacotherapy/ NRT for smoking cessation while hospitalized.	-
4.10	Improve Tobacco Cessation	Update summary of community providers that offer tobacco cessation treatment services to members, to which network providers could refer members.	-
4.11	Improve Tobacco Cessation	Increase members receiving a referral to community providers that offer tobacco cessation treatment services at discharge from the hospital.	-
4.12	Improve Tobacco Cessation	Increase members receiving a referral to community providers that offer tobacco cessation treatment services at discharge from the ED.	-
4.13	Improve Tobacco Cessation	Conduct continuous quality improvement activities during Year Four.	-
5.1	Improve Tobacco Cessation	Continue activities designed to address root causes of tobacco use and to identify opportunities to prevent use from starting in the Medicaid population.	-
5.2	Improve Tobacco Cessation	Continue activities designed to address root causes of lack of tobacco cessation treatment in inpatient and ED settings.	-
5.3	Improve Tobacco Cessation	Additional increase in members whose smoking status is assessed in the ED.	-
5.4	Improve Tobacco Cessation	Additional increase in members whose smoking status is assessed as inpatients.	-

Milestone Number	AIA	Milestone Description*	Amount Paid for Milestone**
5.5	Improve Tobacco Cessation	Continue activities to improve counseling and initiation of pharmacotherapy/NRT for smoking cessation in the ED.	-
5.6	Improve Tobacco Cessation	Additional increase in members receiving ED counseling and initiation of pharmacotherapy/NRT for smoking cessation.	-
5.7	Improve Tobacco Cessation	Continue activities to improve inpatient counseling and use of pharmacotherapy/NRT for smoking cessation while hospitalized.	-
5.8	Improve Tobacco Cessation	Additional increase in members receiving inpatient counseling and use of pharmacotherapy/NRT for smoking cessation while hospitalized.	-
5.9	Improve Tobacco Cessation	Update summary of community providers that offer tobacco cessation treatment services to members, to which network providers could refer members.	-
5.10	Improve Tobacco Cessation	Additional increase in members receiving a referral to community providers that offer tobacco cessation treatment services at discharge from the hospital.	-
5.11	Improve Tobacco Cessation	Additional increase in members receiving a referral to community providers that offer tobacco cessation treatment services at discharge from the ED.	-
5.12	Improve Tobacco Cessation	Conduct continuous quality improvement activities during Year Five.	-
1.1	Improve Lung Cancer Screening	Identify and study root causes of low lung cancer screening rates.	$5,984,365
1.2	Improve Lung Cancer Screening	Conduct education and training of network providers regarding low lung cancer screening rates.	5,984,365
1.3	Improve Lung Cancer Screening	Create materials to educate members (including but not limited to members who meet the criteria for low dose CT scans) regarding the importance of lifestyle decisions in cancer prevention, including tobacco use and other factors that could lead to increased risk of cancer.	5,984,365
1.4	Improve Lung Cancer Screening	Create materials to educate members who meet the criteria for low dose CT scans regarding the importance of lung cancer screening.	5,984,365
1.5	Improve Lung Cancer Screening	Research current recommendations for lung cancer screening.	5,984,365
1.6	Improve Lung Cancer Screening	Create a reporting template with data fields necessary to assess member eligibility for, and receipt of, lung cancer screening.	5,984,365
1.7	Improve Lung Cancer Screening	Meet with network providers to address technical implementation issues.	5,984,365
2.1	Improve Lung Cancer Screening	Create action items designed to address root causes of low lung cancer screening rates.	4,679,428
2.2	Improve Lung Cancer Screening	Continuous education and training of network providers regarding low lung cancer screening rates.	4,679,428

Milestone Number	AIA	Milestone Description*	Amount Paid for Milestone**
2.3	Improve Lung Cancer Screening	Continuous education of members (including but not limited to members who meet the criteria for low dose CT scans) regarding the importance of lifestyle decisions in cancer prevention, including tobacco use and other factors that could lead to increased risk of cancer.	$4,679,428
2.4	Improve Lung Cancer Screening	Continuous education of members who meet the criteria for low dose CT scans regarding the importance of lung cancer screening.	4,679,428
2.5	Improve Lung Cancer Screening	Create and disseminate protocols for network providers to use.	4,679,428
2.6	Improve Lung Cancer Screening	Measure baseline for members who met criteria for lung cancer screening and received a low-dose CT scan.	-
2.7	Improve Lung Cancer Screening	Assess ability of network providers to create lung cancer screening reminders in electronic medical records.	4,679,428
2.8	Improve Lung Cancer Screening	Create continuous quality improvement plan, including information identifying project impacts, reporting modifications needed, lessons learned, opportunities to scale project to a broader population, and key challenges.	4,679,428
3.1	Improve Lung Cancer Screening	Implement activities designed to address root causes of low lung cancer screening rates.	-
3.2	Improve Lung Cancer Screening	Review member education materials and update as necessary.	-
3.3	Improve Lung Cancer Screening	Continuous education of members (including but not limited to members who meet the criteria for low dose CT scans) regarding the importance of lifestyle decisions in cancer prevention, including tobacco use and other factors that could lead to increased risk of cancer.	-
3.4	Improve Lung Cancer Screening	Continuous education of members who meet the criteria for low dose CT scans regarding the importance of lung cancer screening.	-
3.5	Improve Lung Cancer Screening	Review reporting template and modify as needed.	-
3.6	Improve Lung Cancer Screening	Review and revise protocols as needed.	-
3.7	Improve Lung Cancer Screening	Increase members who met criteria for lung cancer screening and received a low-dose CT scan.	-
3.8	Improve Lung Cancer Screening	Conduct outreach to members that missed lung cancer screening appointments and reschedule appointments for those members.	-
3.9	Improve Lung Cancer Screening	Conduct continuous quality improvement activities during Year Three.	-
4.1	Improve Lung Cancer Screening	Continue activities designed to address root causes of low lung cancer screening rates.	-

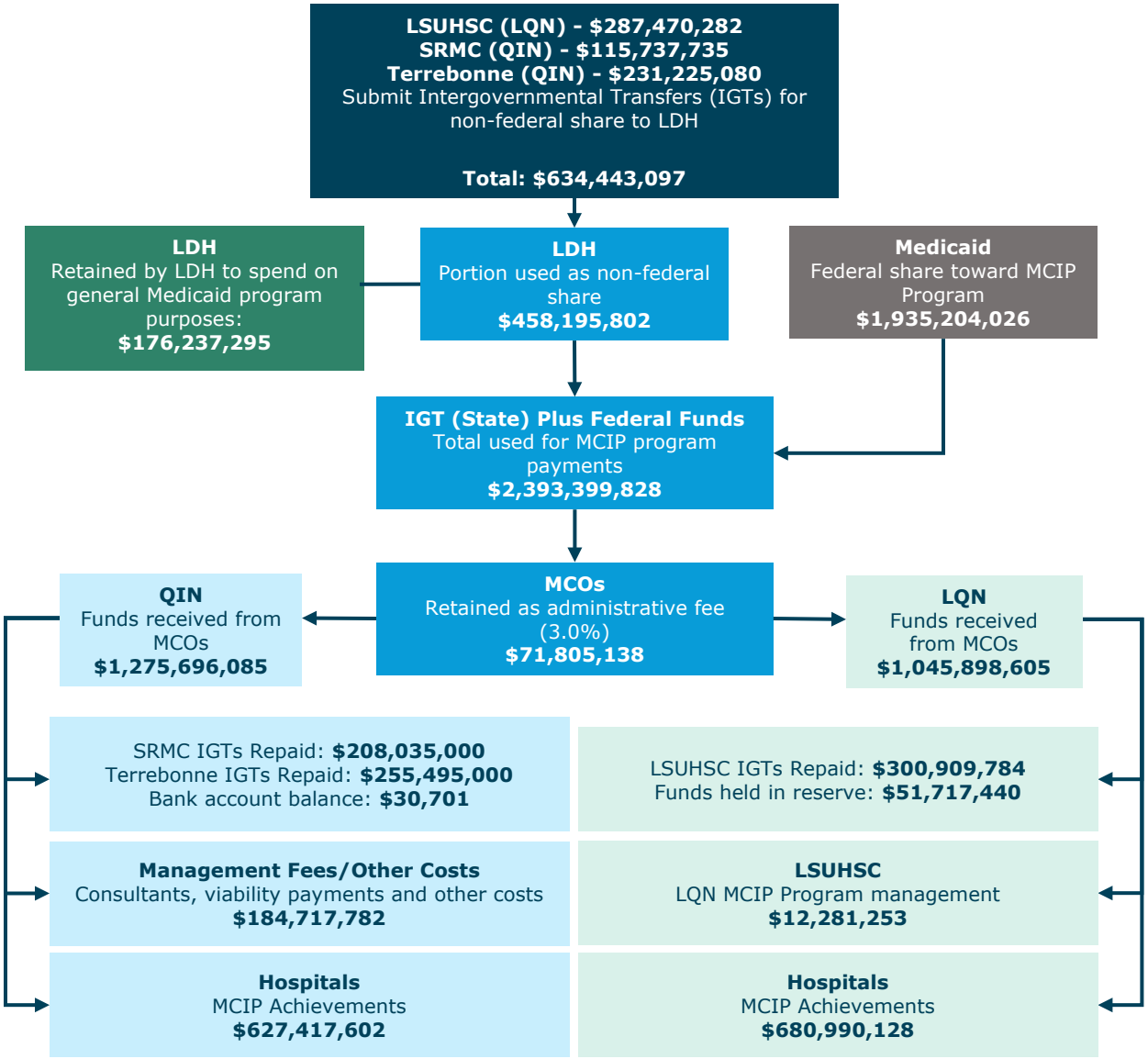
Milestone Number	AIA	Milestone Description*	Amount Paid for Milestone**
4.2	Improve Lung Cancer Screening	Continuous education of members (including but not limited to members who meet the criteria for low dose CT scans) regarding the importance of lifestyle decisions in cancer prevention, including tobacco use and other factors that could lead to increased risk of cancer.	-
4.3	Improve Lung Cancer Screening	Continuous education of members who meet the criteria for low dose CT scans regarding the importance of lung cancer screening.	-
4.4	Improve Lung Cancer Screening	Review reporting template and modify as needed.	-
4.5	Improve Lung Cancer Screening	Review and revise protocols as needed.	-
4.6	Improve Lung Cancer Screening	Additional increase in members who met criteria for lung cancer screening and received a low-dose CT scan.	-
4.7	Improve Lung Cancer Screening	Continue outreach to members that missed lung cancer screening appointments and reschedule appointments for those members.	-
4.8	Improve Lung Cancer Screening	Conduct continuous quality improvement activities during Year Four.	-
5.1	Improve Lung Cancer Screening	Continue activities designed to address root causes of low lung cancer screening rates.	-
5.2	Improve Lung Cancer Screening	Continuous education of members (including but not limited to members who meet the criteria for low dose CT scans) regarding the importance of lifestyle decisions in cancer prevention, including tobacco use and other factors that could lead to increased risk of cancer.	-
5.3	Improve Lung Cancer Screening	Continuous education of members who meet the criteria for low dose CT scans regarding the importance of lung cancer screening.	-
5.4	Improve Lung Cancer Screening	Additional increase in members who met criteria for lung cancer screening and received a low-dose CT scan.	-
5.5	Improve Lung Cancer Screening	Continue outreach to members that missed lung cancer screening appointments and reschedule appointments for those members.	-
5.6	Improve Lung Cancer Screening	Conduct continuous quality improvement activities during Year Five.	-
1.1	Palliative and Hospice Care	Identify and study root causes of insufficient pain management in palliative and hospice care.	$5,471,344
1.2	Palliative and Hospice Care	Identify and study root causes of inadequate hospice admission rates for terminal cancer patients.	5,471,344
1.3	Palliative and Hospice Care	Create a reporting template with data fields necessary to report Members' pain assessment, end-of-life preference, and receipt of palliative or hospice care consultation.	5,471,344
1.4	Palliative and Hospice Care	Conduct education and training of network providers regarding palliative and hospice care initiatives.	5,471,344

Milestone Number	AIA	Milestone Description*	Amount Paid for Milestone**
1.5	Palliative and Hospice Care	Create and disseminate protocol for network providers to use.	$5,471,344
1.6	Palliative and Hospice Care	Assess ability of network providers to create electronic health record notifications for Members eligible for palliative or hospice care.	5,471,344
1.7	Palliative and Hospice Care	Document conditions for which network providers currently consult palliative or hospice care.	5,471,344
1.8	Palliative and Hospice Care	Meet with network providers to address technical implementations issues.	5,471,344
2.1	Palliative and Hospice Care	Create action items designed to address root causes of insufficient pain management in palliative and hospice care.	-
2.2	Palliative and Hospice Care	Create action items designed to address root causes of inadequate hospice admission rates for terminal cancer patents.	-
2.3	Palliative and Hospice Care	Continuous education and training of network providers regarding palliative and hospice care initiatives.	-
2.4	Palliative and Hospice Care	Create materials to educate Members and their caregivers regarding end-of-life preferences.	-
2.5	Palliative and Hospice Care	Measure baseline of Members enrolled in palliative or hospice care who received a clinical assessment for pain.	-
2.6	Palliative and Hospice Care	Measure baseline of Members who died in the hospital who received a palliative or hospice care consultation.	-
2.7	Palliative and Hospice Care	Create continuous quality improvement plan, including information identifying project impacts, reporting modifications needed, lessons learned, opportunities to scale project to a broader population, and key challenges.	-
3.1	Palliative and Hospice Care	Implement activities designed to address root causes of insufficient pain management in palliative and hospice care.	-
3.2	Palliative and Hospice Care	Review reporting template and modify as needed.	-
3.3	Palliative and Hospice Care	Review and revise protocol as needed.	-
3.4	Palliative and Hospice Care	Conduct education of Members and their caregivers regarding end-of-life preferences.	-
3.5	Palliative and Hospice Care	Continuous education and training of network providers regarding palliative and hospice care initiatives.	-
3.6	Palliative and Hospice Care	Measure baseline of Members enrolled in palliative or hospice care who education regarding end-of-life preferences.	-
3.7	Palliative and Hospice Care	Increase in Members enrolled in palliative or hospice care who received a clinical assessment for pain.	-
3.8	Palliative and Hospice Care	Increase in Members who died in the hospital who received a palliative or hospice care consultation.	-
3.9	Palliative and Hospice Care	Conduct continuous quality improvement activities.	-

Milestone Number	AIA	Milestone Description*	Amount Paid for Milestone**
4.1	Palliative and Hospice Care	Continue activities designed to address root causes of insufficient pain management in palliative and hospice care.	-
4.2	Palliative and Hospice Care	Continue activities designed to address root causes of inadequate hospice admission rates for terminal cancer patients.	-
4.3	Palliative and Hospice Care	Continuous education of Members and their caregivers regarding end-of-life preferences.	-
4.4	Palliative and Hospice Care	Increase in Members enrolled in palliative or hospice care who received education regarding end-of-life preferences.	-
4.5	Palliative and Hospice Care	Additional increase in Members enrolled in palliative or hospice care who received a clinical assessment for pain.	-
4.6	Palliative and Hospice Care	Additional increase in Members who died in the hospital who received a palliative or hospice care consultation.	-
4.7	Palliative and Hospice Care	Conduct continuous quality improvement activities.	-
5.1	Palliative and Hospice Care	Continue activities designed to address root causes of insufficient pain Management in palliative and hospice care.	-
5.2	Palliative and Hospice Care	Continue activities designed to address root causes of inadequate hospice Admission rates for terminal cancer patients.	-
5.3	Palliative and Hospice Care	Continuous education of Members and their caregivers regarding end-of-life preferences.	-
5.4	Palliative and Hospice Care	Additional increase in Members enrolled in palliative or hospice care who received education regarding end-of-life preferences.	-
5.5	Palliative and Hospice Care	Additional increase in Members enrolled in palliative or hospice care who received a clinical assessment for pain.	-
5.6	Palliative and Hospice Care	Additional increase in Members who died in the hospital who received a palliative or hospice care consultation.	-
5.7	Palliative and Hospice Care	Conduct continuous quality improvement activities.	-
Total Paid			**$1,048,827,724**

* 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. Also, this amount does not include the portion of the payment made for non-milestone related activities.
Source: Prepared by legislative auditor's staff using information from LDH.

APPENDIX F: MCIP FLOW OF FUNDS FROM SEPTEMBER 2019 THROUGH JUNE 2024



Source: Prepared by legislative auditor's staff using information from LDH, the MCOs, and the Quality Networks.

APPENDIX G: LQN PAYMENTS TO HOSPITALS FROM APRIL 2020 THROUGH JUNE 2024

Hospital	Incentive Payments*
Beauregard Memorial Hospital	$8,394,231
East Jefferson General	9,134,811
Franciscan Missionaries of Our Lady Health System	207,099,333
Hood Memorial Hospital	2,476,541
Lake Charles Memorial Hospital	36,564,161
Lallie Kemp Regional Medical Center	5,739,811
Lane Regional Medical Center	7,447,908
Louisiana Children's Medical Center	249,749,431
New Orleans East Hospital	8,894,067
North Oaks Health System	26,852,711
Thibodaux Regional Medical Center	11,988,795
West Calcasieu Cameron	5,007,690
Willis-Knighton Medical Center	54,242,543
Woman's Hospital Foundation	47,398,095
Total Paid	**$680,990,128**

* In addition to the payments to hospitals, LSUHSC repaid IGTs totaling $300,909,784, held $51,717,440 in reserve, and used $12,281,255 for program management.
Source: Prepared by legislative auditor's staff using information from LQN.

APPENDIX H: QIN PAYMENTS TO HOSPITALS FROM DECEMBER 2019 THROUGH FEBRUARY 2024

Hospital	Incentive Payments	Non-Incentive Payments*	Total Payments**
Abbeville General Hospital	$13,329,975	-	$13,329,975
Allen Parish Hospital	9,458,151	-	9,458,151
Baton Rouge General Medical Center	18,459,967	-	18,459,967
CHRISTUS Coushatta Health Care Center	10,430,745	-	10,430,745
CHRISTUS Health Shreveport-Bossier	13,346,911	-	13,346,911
CHRISTUS Ochsner Lake Area Hospital	12,996,758	-	12,996,758
CHRISTUS Ochsner St. Patrick Hospital	13,128,456	-	13,128,456
CHRISTUS St. Frances Cabrini Hospital	23,055,999	-	23,055,999
Iberia Medical Center	16,111,244	-	16,111,244
North Caddo Medical Center	2,500,001	-	2,500,001
Ochsner Abrom Kaplan	9,707,960	-	9,707,960
Ochsner Acadia General	12,956,212	-	12,956,212
Ochsner American Legion Hospital	3,111,388	-	3,111,388
Ochsner Lafayette General	20,682,584	-	20,682,584
Ochsner LSU Health Monroe	28,131,866	-	28,131,866
Ochsner LSU Health Shreveport	45,645,974	-	45,645,974
Ochsner Medical Center	63,083,925	$76,717,781	139,801,706
Ochsner Medical Center - Baton Rouge	23,479,338	-	23,479,338
Ochsner Medical Center - Kenner	19,562,645	-	19,562,645
Ochsner Medical Center - Northshore	12,908,307	-	12,908,307
Ochsner St. Anne General Hospital	13,881,540	-	13,881,540
Ochsner St. Martin	10,953,220	-	10,953,220
Ochsner St. Mary Morgan City	9,694,769	-	9,694,769
Ochsner University Hospitals & Clinics	29,475,215	-	29,475,215
Opelousas General Hospital	15,817,141	-	15,817,141
Pointe Coupee General Hospital	10,008,850	-	10,008,850
Rapides Regional Medical Center	19,821,470	-	19,821,470
Savoy Medical Center	10,069,411	-	10,069,411
Slidell Memorial Hospital	20,653,222	-	20,653,222
SRMC - Leonard J. Chabert Medical Center***	30,032,655	316,035,001	346,067,656
St. Bernard Parish Hospital***	12,238,864	-	12,238,864
St. Charles Parish Hospital***	11,267,646	-	11,267,646
St. Tammany Parish Hospital	16,582,308	-	16,582,308
Terrebonne General Medical Center	14,730,910	255,495,000	270,225,910
The General - Baton Rouge	7,930,435	-	7,930,435
Tulane University (LCMC) Hospital/Clinics	20,836,375	-	20,836,375
West Carroll Health Systems	1,335,165	-	1,335,165
Total Paid	**$627,417,602**	**$648,247,782**	**$1,275,665,384**

* We added this column for QIN because of the additional way it paid hospitals unlike LQN.
** In addition to the payments to hospitals, QIN retained $30,701 in its bank account.
*** Under management agreements with these facilities, "Ochsner receives management fees and any excess of revenues over expenses generated by each of these facilities annually, as well as reimbursement of purchased services incurred on behalf of the facilities."
Source: Prepared by legislative auditor's staff using information from QIN.