MCIP Annual Progress Report

2023

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Managed Care Incentive Payment Program

2023 Annual Progress Report

I. INTRODUCTION

The Louisiana Department of Health ("LDH") implemented the Medicaid Managed Care Incentive Payment ("MCIP") Program in January 2019. Through the MCIP Program, LDH, as part of its contracts with each Louisiana Medicaid Managed Care Organization, authorizes additional payments to any Medicaid Managed Care Organizations that participate in the incentive arrangements established by LDH in accordance with 42 C.F.R. § 438.6(b) ("Approved Incentive Arrangements" or "projects"). Any Medicaid Managed Care Organization participating in an Approved Incentive Arrangement must agree to implement the initiative for all eligible Medicaid patients ("Members").

Through the MCIP Program, LDH provides incentive payments to Medicaid Managed Care Organizations for achieving quality reforms that increase access to health care, improve the quality of care, and/or enhance Members' health.[1] The quality reforms focus on increasing Members' access to primary and maternal health care services, improving health outcomes for enrollees with chronic conditions, as well as reducing inefficiencies and costs by reducing unnecessary utilization, promoting evidence-based practices, and reducing low-value care. The MCIP Program aligns with LDH's most recent Medicaid Managed Care Quality Strategy dated March 2023 (the "Quality Strategy"), which seeks to advance health outcomes and quality of care provided to Members.[2]

All five of the Medicaid Managed Care Organizations contracted with LDH at the onset of the MCIP Program chose to participate in the MCIP Program in each of the seven MCIP Approved Incentive Arrangements. In 2023, another Medicaid Managed Care Organization, Humana Healthy Horizons, contracted with LDH to begin providing services and elected to participate in the MCIP Program for any projects implemented on or after January 1, 2023. Each of these six Medicaid Managed Care Organizations contracted with the Quality and Outcome Improvement Network, an extensive network of physicians, mid-level providers, clinics, and hospitals that is capable of reaching Members across the State ("ACO"), to assist the Medicaid Managed Care Organizations related to their participation in the MCIP Program (the Medicaid Managed Care Organizations and the ACO are collectively referred to as the "MCO").

LDH's MCIP Program Protocol (the "MCIP Protocol") outlines MCO participation and reporting requirements for the program. Section VI.B.2 of the MCIP Protocol requires the MCO to submit a coordinated annual progress report to LDH outlining MCIP Program activities through June 30 of each year. In fulfillment of this requirement, the progress report provided below covers the MCO's activities from July 1, 2022 through June 30, 2023 (activities conducted since the 2022 Annual Progress Report).

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[1] Medicaid Managed Care Quality Incentive Program, LA. DEP'T OF HEALTH, https://ldh.la.gov/assets/docs/LegisReports/HR252RS201812.pdf (December 1, 2018), at 1.

[2] Bureau of Health Servs. Financing, Louisiana's Medicaid Managed Care Quality Strategy, https://ldh.la.gov/assets/docs/MQI/MQIStrategy.pdf (March 2023) (hereafter Quality Strategy).

There are currently seven projects implemented through the MCIP Program. The pilot projects, implemented in 2019, include:

- Improve Outcomes for Diabetic Members (the "Diabetes Project"),
- Improve Outcomes for Members with Hypertension (the "Hypertension Project"),
- Improve Health for Members Ages 21 or Younger (the "Pediatric Project"), and
- Reduce Avoidable Emergency Department ("ED") Utilization for Members Ages 20 or Older (the "ED Project").

One additional project, Improve Maternal Care (the "Maternal Care Project"), was implemented in 2020.

Two additional projects were implemented in 2022:

- Improve Tobacco Cessation (the "Tobacco Cessation Project") and
- Improve Lung Cancer Screening ("the "Lung Cancer Project").

LDH implemented one additional project in 2023, Improve Palliative and Hospice Care (the "Palliative Care Project"). The 2022 and 2023 milestones for each project are listed in Appendix A.

II. ACTIVITIES SINCE 2022 ANNUAL PROGRESS REPORT

A. EXPANSION OF NETWORK

The MCO relies on its Network Providers to successfully implement and achieve clinical outcome goals for each of the projects. To ensure that the Network Providers reach a broad base of Medicaid patients in the State of Louisiana, the MCO continuously works to ensure that all interested hospitals are included in the network. The MCO is pleased to note that in 2023, it expanded its network to incorporate one additional hospital, West Carroll Memorial Hospital. A list of the current Network Providers is included as Appendix B.

B. DEVELOPMENT OF NEW APPROVED INCENTIVE ARRANGEMENT

The MCIP Program is designed to impact all Medicaid members throughout the State. In order to ensure that the MCIP Program is as impactful as possible, each year the MCO develops and proposes new incentive arrangements to LDH for consideration in the MCIP Program. For 2023, the MCO proposed an incentive arrangement aimed at improving palliative and hospice care (the "Palliative Care Project"). To develop this project, the MCO evaluated the Quality Strategy to identify goals and objectives that the MCIP Program could complement. For example, the Quality Strategy indicates that LDH would like to prioritize engagement with Medicaid members in order to improve their experience and outcomes. The MCO hopes to achieve this objective through the Palliative Care Project. The milestones for this project aim to improve Member engagement by providing clinical assessments for pain, educating Members on end-of-life preferences, and providing palliative and hospice care consultations to Members. LDH approved the Palliative Care Project for 2023

implementation. The MCO hopes to continue expanding the MCIP Program in the future in order to broaden its impact on the Medicaid population in Louisiana.

C. 2022 ANNUAL COLLABORATIVE MEETING

The MCO was pleased to be able to hold the 2022 Annual Collaborative Meeting in-person in 2022, the first time an Annual Collaborative Meeting has been held in-person since 2019. The meeting was held on September 22, 2022 in New Orleans, Louisiana. All of the Medicaid Managed Care Organizations and Network Providers participated in the meeting. During the meeting, the Network Providers delivered collaborative presentations related to integration and coordination of the projects, overarching MCIP benefits to the Medicaid population that are not necessarily captured through the project milestones, improving provider and patient engagement, the role of digital medicine in improving MCIP outcomes, and innovative MCIP solutions to problems encountered throughout the course of the MCIP Program. The Medicaid Managed Care Organizations provided presentations on various topics, including insights into tobacco utilization trends for targeted cessation initiatives, complex care management teams as effective tools for engagement, the use of MCIP data to supplement case management programs and address social determinants of health ("SDOH") for Members, Medicaid behavioral health resources available to Members, and updates on their integrated collaborative care programs.[3]

D. MONTHLY GROUP DISCUSSIONS

The MCO holds monthly group discussions with the Network Providers to discuss frequently asked questions, upcoming reporting deadlines, solutions to problems encountered by Network Providers related to administration of the projects, and any other issues that the Network Providers would like to discuss. The MCO initially implemented monthly group discussions in February 2020, to help Network Providers troubleshoot technical issues during the first year that the Network Providers started collecting patient-level data. However, the Network Providers indicated that the group discussions provided valuable insight and collaboration opportunities. Therefore, the MCO decided to continue this practice through 2023. As the MCIP Program continues, the Network Providers are becoming more informed regarding the Healthy Louisiana Medicaid program and the benefits available to Members. For example, during one of the group discussions, one Network Provider gave a presentation outlining the over-the-counter benefits available to Members. Many of the Network Providers found this to be helpful in coordinating care for Members, specifically through the ED Project. Appendix C includes a summary of each group discussion held since the 2022 Annual Progress Report.

E. IDENTIFICATION OF BARRIERS TO CARE

The Medicaid population in Louisiana encounters several barriers to care when accessing health services, and these barriers evolve and change as the healthcare landscape changes. Throughout the duration of the MCIP Program, the MCO has continuously worked to identify

[3] For more information regarding the presentations at the Annual MCIP Meeting, please refer to the 2022 Annual Meeting Minutes submitted to LDH.

these barriers to care in order to more effectively address them. The MCO identifies these barriers through research and through soliciting Network Provider feedback in surveys or continuous quality improvement ("CQI") workshops.[4] Below is a summary of the barriers to care the MCO identified as currently affecting Members:

- Transportation issues. Lack of transportation can cause a Member to miss primary or specialty care appointments. Although Medicaid Managed Care Organizations provide transportation services, Members indicate that the transportation provided is sometimes unreliable or inconvenient. For example, one Network Provider indicated that its Member would be dropped off for an appointment at 8 a.m. and would have to wait until 5 p.m. to be picked up from the office, essentially wasting an entire workday on one clinic appointment. This creates a problem for Members that must obtain childcare in order to attend an appointment or for Members that cannot miss work hours.
- Lack of knowledge regarding available Medicaid benefits. Members lack knowledge on the resources available to them through the Louisiana Medicaid program. For example, some Medicaid Managed Care Organizations provide incentives, such as gift cards, that encourage Members to attend routine preventative care visits.
- Lack of available specialty care providers. This barrier particularly affects Members residing in rural areas. Members sometimes have to travel over four hours to see specialty care providers that accept Medicaid. Network Providers cited the following specialties as the most challenging: dentistry, ophthalmology, podiatry, and endocrinology.
- SDOH. Network Providers believe that SDOH issues present a significant barrier to care for Members. Some of the most prominent issues identified by Network Providers include food insecurity, inadequate housing, and financial instability.

F. STEPS TAKEN TO OVERCOME BARRIERS TO CARE

Since the MCIP Program's implementation in 2019, the MCO has continuously worked to overcome barriers for Members. Below is an outline of some of the initiatives the MCO has implemented to overcome these barriers.

(1) Continuous Review and Modification of Project Resources

For each project, the MCO creates two documents: (1) milestone specifications and (2) a project protocol. The milestone specifications outline the eligibility requirements for Members monitored through each of the projects and describe how the performance rates are calculated for each of the outcome milestones. The project protocols outline administration of each project, including the applicable data collection process and data maintenance requirements. On an ongoing basis, the MCO reviews these resources to identify necessary modifications to improve the project, outcomes for Members, or to align with updated guidance from LDH and the Centers for Medicare and Medicaid Services ("CMS"). Additionally, the MCO encourages Network Provider feedback regarding these resources and

[4] More information regarding the CQI workshops is addressed in the individual project sections below.

incorporates suggested changes as appropriate to ensure resources robustly and accurately cover all aspects of the MCIP Program.

(2) Medicaid Managed Care Organization Initiatives

The Medicaid Managed Care Organizations independently implement initiatives that are complementary to the MCIP Program and projects. Below is a summary of these initiatives:

- Pilot ED Navigation Program. One of the Medicaid Managed Care Organizations partnered with a Network Provider to pilot an ED navigation program focusing on Members needing behavioral healthcare services.
- Member Incentives. Some of the Medicaid Managed Care Organizations offer incentives to Members to reward certain behaviors. For example, Aetna Better Health of Louisiana ("Aetna") offers financial incentives for Members that complete medication adherence. This initiative was started to increase the rate of prescriptions getting filled, since Aetna noticed a low rate of prescriptions being filled for Members.
- Remote Support Services. The Medicaid Managed Care Organizations indicated that remote support services are available for Members. For example, Aetna provides mental and physical health services through a third-party vendor, which includes a phone application that Members can download in order to access mental and physical health services, as well as community resources for these issues. Members that utilize this service have access to telephone service 24 hours a day and can also text through the application to speak with a team member regarding loneliness or depression issues.
- In-home Appointments. One of the Medicaid Managed Care Organizations indicated that it provides in-home appointments to Members, as necessary. This initiative is instrumental in helping address transportation issues affecting Members.
- Engaging Community Providers to Provide Necessary Services. Medicaid Managed Care Organizations are finding creative ways to engage the community in taking care of Member health. For example, Aetna implemented a community initiative to teach community barbers to conduct blood pressure ("BP") readings, so that barbers can conduct BP readings on customers and provide education regarding the importance of healthy BP readings.
- Utilization of MCIP Data to Identify Members for Care Coordination. The Medicaid Managed Care Organizations utilize the data included in the MCIP reporting submissions to identify Members in need of care coordination services and additional care. For example, Healthy Blue of Louisiana ("Healthy Blue") maintains a "Gap in Care" list of Members that are in need of follow-up and monitoring of chronic disease conditions. Healthy Blue reviews the MCIP data reports to identify additional Members to include on the list.

(3) Independent Network Provider Initiatives

Throughout the duration of the MCIP Program, the Network Providers have implemented independent initiatives that provide additional resources for Members. Below is a summary of some of the independent Network Provider initiatives that Network Providers have implemented:

- Assistance with Completing Social Security and Medicaid Applications. One of the Network Providers assists Members in completing social security applications, as part of its ED navigation program. This Network Provider indicated that many Members suffer from financial insecurity. These Members benefit from receiving social security funding to help with the cost of healthy food and stable housing. Another Network Provider assists Members in obtaining services to help with completing and submitting Medicaid applications.
- Comprehensive Services Provided at Primary Care Visits. Because many Members struggle with transportation issues, some Network Providers have implemented processes to ensure that services provided during a Member's primary care visit are as comprehensive as possible, thereby reducing the number of clinic visits for which a Member needs to obtain transportation. Another Network Provider enlisted specialty physicians to come to its clinics on a monthly basis, so that the Member can receive specialty and primary care services in the same location without having to obtain separate transportation services.
- Facilitating School-Based Clinics. To increase the number of well-child visits, some Network Providers implemented school-based clinics. This process helps address transportation issues for Members, breaking down one of the obstacles that Members face when attempting to access primary care. Network Providers report significant increases in the number of children seen for primary care visits through this initiative.
- Increased Appointment Reminders. Some Network Providers indicated that appointment reminders have shown improvement in no-show rates, so these Network Providers decided to send *two* appointment reminders to Members, instead of one. One of the appointment reminders is sent to the Member a week prior to the appointment and the second reminder is sent to the Member one day prior to the appointment.
- Implemented SDOH Outreach Teams. Due to the pervasive impact of SDOH issues on Member health, one Network Provider implemented an SDOH outreach team in order to assist patients in addressing SDOH issues.
- Monitoring Medicaid Drug Coverage. Because many Members experience financial insecurity, one Network Provider implemented a prior authorization process that analyzes changes in Medicaid drug coverage on a monthly basis. The Network Provider shares its results with its providers and pharmacies, so that providers can be aware of Medicaid coverage when prescribing medications to Members and to reduce the number of medications prescribed to Members that are not covered by Medicaid.
- Partnerships with Community Resources. Many Network Providers partner with local community resources to help address food insecurity for Members. For example, the Network Providers partner with local food banks, resources that provide food boxes, and other resources that accept food stamps or offer discounted groceries. Other Network Providers focused their partnership efforts on transportation services. One Network Provider partnered with the Council on Aging to provide transportation services to Members. Additionally, Network Providers work with their local communities to provide education at local community events.

- Food Garden. To promote healthier eating and address food insecurity, one Network Provider developed a community garden to grow healthy food options for its patients, including Members. This Network Provider hosts educational seminars on a monthly basis to teach patients the skills needed to plant, maintain, and harvest crops from a garden.
- Mobile Screening Programs. One Network Provider started a mobile screening program to make it easier for Members to receive screening services, thereby eliminating the need for Members to obtain transportation services.
- Employing Additional Providers. One Network Provider identified a need in its community for dental providers that served Members. To address this need, this Network Provider hired an onsite dentist.
- Community Baby Showers. To ensure that expectant mothers in the community are prepared for the birth of their child, many Network Providers facilitate or participate in community baby showers that are designed to equip pregnant Members with the skills and tools they will need as new mothers.

These initiatives are important because they are tailored to each Network Provider's specific community. The MCO encourages Network Providers to implement these initiatives and share ideas for new initiatives with other Network Providers.

G. INTEGRATION OF KNOWLEDGE GAINED

Through the MCIP Program, the MCO utilizes knowledge gained through the various projects and leverages this information to provide the best results possible for Members. This section describes the various actions the MCO has taken since the 2022 Annual Progress Report to improve the MCIP Program and outcomes for all Louisiana healthcare patients.

(1) Coordination among MCIP Projects

As the MCIP Program expands and evolves, the MCO works to identify overlaps and opportunities for coordination among the MCIP projects. For example, the Network Providers can utilize information gathered through the Diabetes Project, the Hypertension Project, or the ED Navigation Project to determine whether a Member is a tobacco user in need of a tobacco cessation intervention through the Tobacco Cessation Project. In prior years, Network Providers identified an opportunity to utilize information gathered through the ED Directory to identify mothers in need of prenatal care services through the Maternal Care Project and Network Providers continue to conduct these efforts. Additionally, the Network Providers indicated that navigation through the ED Navigation Project has been instrumental in helping diabetic patients find a primary medical home and better manage their conditions. As the MCIP Program continues to expand and encompasses additional target populations, the Network Providers are increasingly able to identify opportunities for coordination. The MCO continuously evaluates methods to further coordinate Network Provider efforts and initiatives among the projects.

(2) Incorporation of MCIP Initiatives into Network Provider Processes for All Patients

The Network Providers have worked tirelessly throughout the last four years to improve the MCIP Program and outcomes for Members. Because of this effort, the Network Providers identified MCIP Program initiatives that would be beneficial to their patient population as a whole and expanded those initiatives to include all patient populations, including patients with commercial insurance or who lack insurance coverage altogether. For example, some Network Providers indicated that the MCIP Program initiatives incentivize Network Providers to improve collection of inaccurate data, particularly in areas of patient demographics. These Network Providers now utilize the same improved recordkeeping practices for all patients. Other Network Providers identified community partners that provide resources that could aid in MCIP projects and offered these resources to their entire patient population. For example, one Network Provider partnered with the Louisiana Tobacco Control Initiative to start a tobacco cessation resource program for its entire patient population. The MCO is pleased to report that the Network Providers are finding the MCIP initiatives to be useful to improve the health of all Louisianans. Additionally, providing these services to all patients helps to ensure that Members who lose Medicaid coverage or obtain commercial coverage continue to have access to these valuable resources.

H. AREAS IDENTIFIED FOR IMPROVEMENT

While the MCIP Program has seen many successes throughout the past four years, the MCO acknowledges that there is still room for improvement. Below is a summary of the areas identified for improvement, based on the MCO's research, insights from the Medicaid Managed Care Organizations, and Network Provider feedback:

- Member education regarding available Medicaid benefits;
- Accurate contact information for Members;
- Breast cancer/colon screening/mammography;
- Automation of electronic health record ("EHR") functions;
- Consolidating EHR capabilities among separate Network Provider facilities to identify gaps in care;
- Member engagement;
- Physician engagement; and
- Focus on nutrition and body mass index ("BMI").

The MCO plans to continue working with Network Providers to develop ways to address these issues in the future.

I. 2022 MCIP PROGRAM ACHIEVEMENTS

The MCO is proud of its accomplishments achieved through the MCIP Program in 2022. In 2022, the MCO achieved 47 of the 48 milestones attributable to 2022 by end of the calendar year. The MCO identified several additional achievements, including improving health equity, addressing care barriers, participating in initiatives to increase community

engagement, and making healthcare more accessible to Members. These additional achievements are outlined in Appendix D.

For the projects implemented prior to 2022, the milestones build upon the MCIP Program milestones over the previous three years to improve performance rates for outcome milestones, conduct CQI activities, and increase Member participation in activities designed to address treatment gaps and root causes of poor outcomes. To report on these milestones, the MCO calculated performance rates for each of its outcome-based measures and helped network providers create documentation sufficient to evidence achievement for each of the remaining milestones. To facilitate this process, the MCO conducted monthly group discussions to ensure that Network Providers were adequately capturing the data needed to calculate performance rates and worked with Network Providers throughout the year to ensure that all data submissions were accurate and complete.

For the projects implemented in 2022, the milestones focused on developing the infrastructure necessary to conduct a successful project. The milestones include identifying and studying root causes of poor outcomes, conducting provider education, creating educational materials for members, developing reporting templates and protocols, and meeting with network providers to address technical implementation issues. More information on the MCO's work to complete these milestones is included below.

III. SUMMARY OF MCIP APPROVED INCENTIVE ARRANGEMENTS

A. IMPROVE OUTCOMES FOR DIABETIC MEMBERS

Through this Project, the MCO aims to identify and track diabetic Members and their health, coordinate each Member's healthcare needs, and educate and assist Members to manage their diabetes and improve their outcomes. This project aligns with the Quality Strategy, which includes an objective to improve diabetes disease management and control.[5] This project also complements LDH's efforts to bolster diabetes screening initiatives throughout the state, as outlined in more detail in LDH's Fiscal Year ("FY") 2023 Business Plan (hereafter referred to as "LDH's Business Plan").[6]

(1) 2022 Diabetes Project Achievements

Since the 2022 Annual Progress Report, the MCO reported its performance for the remaining 2022 milestones, including the following:

4.1 Increase activities to address treatment gaps.
4.2 Increase percentage of registry member participation in activities designed to reduce diabetic members with hemoglobin A1c ("HbA1c") poor control.
4.3 Increase percentage of registry member participation in activities designed to reduce diabetic members with poor BP control.

[5] *See* the Quality Strategy, supra note 2, at 3.
[6] LA. DEP'T OF HEALTH, LDH Business Plan FY2023 10, https://ldh.la.gov/assets/bp/2023/LDH-BP-FY23.pdf (last visited July 21, 2023).

4.4 Additional increase in number of diabetic members ages 18-75 enrolled in the registry.
4.5 Additional increase in number of HbA1c tests for members enrolled in the registry.
4.6 Additional increase in percentage of members enrolled in the registry with HbA1c control (<8.0%).
4.7 Additional decrease in percentage of members enrolled in the registry with HbA1c poor control (>9.0%).
4.8 Additional decrease in percentage of members enrolled in the registry with poor BP control (>140/90).

The MCO was pleased with its 2022 performance. The MCO fully achieved each of the milestones listed above, with the exception of Milestone 4.2 related to Member participation in activities designed to reduce HbA1c poor control. However, for all outcome measures, the MCO performed better than the baseline rates and exceeded LDH's goals.

The MCO is particularly pleased with its performance regarding Hba1c poor control rate as related to the statewide and national Medicaid rates. For example, the Louisiana statewide Medicaid rate for HbA1c poor control in federal fiscal year ("FFY") 2020 was 48.5%, nearly half.[7] The nationwide average for HbA1c poor control among Medicaid patients is 42.3%.[8] The MCO's reported rate for CY2022 was only 21.01% for members enrolled in the diabetes registry, which is a significantly lower rate than the statewide average. This indicates that the Diabetes Project initiatives are helping reduce poor HbA1c control.

The MCO performed better than the nationwide averages for HbA1c control as well. The MCO's rate for HbA1c control in CY2022 was 66.69%. Nationwide among Medicaid patients, the rate for HbA1c control in 2021 was significantly lower at 48.3%.[9]

Overall, the MCO is pleased with these results. However, the MCO recognizes that there is room for improvement regarding member participation in activities. To ensure that its performance improves in CY2023, the MCO is working with Network Providers to select and conduct activities that facilitate increased Member participation.

(2) 2023 Diabetes Project Status

LDH approved nine milestones in 2023, which include further improvement over baselines and CQI activities. To date, the MCO reported achievement of one milestone to conduct CQI activities. To achieve this milestone, each of the Network Providers participated in a CQI workshop designed to discuss (1) CQI activities conducted throughout the year, (2) effectiveness of the CQI activities, and (3) barriers and potential areas for improvement. The Network Providers formed three discussion panels that outlined different topics related to the Diabetes Project. After the CQI workshop, the MCO updated its Diabetes CQI plan to

[7] *Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%): Ages 18 to 75*: MEDICAID.GOV, https://www.medicaid.gov/state-overviews/scorecard/comprehensive-diabetes-care/index.html (last visited on July 13, 2023).
[8] *Comprehensive Diabetes Care (CDC),* NAT'L COMM. FOR QUALITY ASSURANCE, https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/ (last visited July 13, 2023).
[9] *Id.*

address activities completed and made any necessary changes to the plan to account for Network Provider feedback.[10]

The MCO is actively working to complete Milestone 5.1 to increase the activities designed to address treatment gaps. Each Network Provider has selected an additional activity to implement and is working to achieve this goal. The MCO plans to report this milestone for achievement by September 30, 2023.

The MCO is planning to achieve and report on the remaining seven milestones after the completion of CY2023. These remaining milestones require the MCO to compile CY2023 data and assess performance rates using the entire year's data. The MCO is hopeful that it will continue to achieve the outcome milestones for this project.

In addition to continuing efforts to improve Member outcomes, the MCO is actively considering proposing continuation of this project in 2024. When the project was initially implemented, the MCO and LDH anticipated the project would perform over five years. Now that the developmental stage of this project is complete, the MCO will evaluate the project to determine whether there is additional room for outcome improvement and whether Members would benefit from continuation of the project. The MCO plans to work with LDH to determine what the next steps are for the Diabetes Project.

B. IMPROVE OUTCOMES FOR MEMBERS WITH HYPERTENSION

The Hypertension Project was designed to improve health outcomes for Members with high blood pressure ("BP"). To do so, the MCO works to assist patients with improving their BP levels. This project aligns with the Quality Strategy, which includes an objective to improve hypertension disease management and control.[11] This project also complements LDH's efforts to bolster BP screening initiatives throughout the state.[12]

(1) 2022 Hypertension Project Achievements

Since the 2022 Annual Progress Report, the MCO reported its performance for the remaining 2022 milestones, including the following:

4.1 Increase in percentage of registry members participating in activities designed to increase adequate BP control.
4.2 Additional increase in number of members ages 18-85 with hypertension enrolled in a registry.
4.3 Additional increase in percentage of members enrolled in the registry whose BP was adequately controlled (<140/90 ages 18-59).
4.4 Additional increase in percentage of members enrolled in the registry whose BP was adequately controlled (<150/90 ages 60-85).

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[10] For more information regarding the MCO's completion of this milestone, please refer to the support for Milestone 5.5.
[11] *See* the Quality Strategy, *supra note 2,* at 3.
[12] LDH Business Plan, *supra note 6*, at page 15.

The MCO was pleased to report that it improved upon its CY2021 performance for each of these milestones. However, the MCO was only able to meet partial achievement of LDH's milestone goals for Milestones 4.1, 4.3 and 4.4. The MCO recognizes that it has room for improvement regarding these milestones and is hopeful that it will be able to improve its performance in 2023 to fully achieve these milestones.

Although the MCO did not fully achieve its milestones for the BP control, the MCO's performance is better than the statewide Medicaid rates for BP control. For example, the Louisiana statewide Medicaid rate for BP control in FFY 2020 was 50%.[13] The MCO's reported rate for CY2022 was higher for both age ranges reported. Over 61% of Members ages 18-59 enrolled in the hypertension registry had BP control in CY2022. The rate for Members ages 60-85 enrolled in the hypertension registry was significantly higher at 81.24%. This indicates that the Hypertension Project initiatives are helping Members control BP.

(2) 2023 Hypertension Project Status

LDH approved five milestones in the Hypertension Project for 2023. The milestones include further improvement over baselines and CQI activities. The MCO reported achievement of one milestone to date, the milestone requiring the MCOs to conduct CQI activities. To achieve this milestone, each of the Network Providers participated in a CQI workshop in May 2023. During the workshop, the Network Providers discussed project improvements, difficulties encountered throughout the project, and project achievements. After the CQI workshop, the MCO revised its Hypertension CQI plan to address activities completed and future planned activities.

The MCO is planning to achieve and report on the remaining four milestones after the completion of CY2023. These remaining milestones require the MCO to compile CY2023 data and assess performance rates using the entire year's data. The MCO is hopeful that it can improve upon last year's performance rates to achieve LDH's milestones.

In addition to the activities outlined above, the MCO is evaluating whether to propose continuation of this project past 2023. To do so, the MCO is analyzing further opportunities for improvement in health outcomes for Members with hypertension. The MCO plans to work with LDH to determine what the next steps are for the Hypertension Project.

C. IMPROVE HEALTH FOR MEMBERS AGES 21 OR YOUNGER THROUGH INCREASED PRIMARY CARE

The Pediatric Project focuses on improving the health of pediatric Members by identifying and addressing gaps in preventative healthcare services and improving primary care services. The Quality Strategy includes an objective to promote healthy development and

[13] *Controlling High Blood Pressure: Ages 18 to 85*: MEDICAID.GOV, https://www.medicaid.gov/state-overviews/scorecard/controlling-high-blood-pressure/index.htmll (last visited on July 16, 2023).

wellness in children, which aligns with the goal of this project.[14] This project is aligned with LDH's initiatives to improve health outcomes in childhood.[15]

(1) 2022 Pediatric Project Achievements

Since the 2022 Annual Progress Report, the MCO reported its performance for all six 2022 milestones, including the following:

- 4.1 Additional increase in percentage of Network Providers meeting protocol criteria.
- 4.2 Additional increase in members who turned 15 months old during the measurement year who had six or more well-child visits with a network PCP during the first 15 months of life.
- 4.3 Additional increase in members ages 3-6 years who had one or more well-child visits during the measurement year with a network PCP.
- 4.4 Additional increase in members ages 12-21 years who had at least one comprehensive well-care visit during the measurement year with a network PCP or OB/GYN practitioner.
- 4.5 Increase in members ages 3-17 years that had an outpatient visit with a network PCP or OB/GYN practitioner during the measurement year, with evidence of: (1) BMI percentile documentation by age and gender; (2) counseling for nutrition; or (3) counseling for physical activity.
- 4.6 Continue to conduct activities designed to improve PCP visits for members ages 0-21 years consistent with AAP recommendations and revise protocols as needed.

The MCO was excited to report that it fully achieved each of the six milestones for 2023. The MCO reported achievement of Milestone 4.6 by September 30, 2023. The remaining five milestones required data from the entirety of CY2023 and were reported in the December 31, 2023 reporting submission.

(2) 2023 Pediatric Project Status

LDH approved five milestones in 2023 for the Pediatric Project. The milestones focus on increasing the number of Network Providers meeting protocol criteria and further improvement over baselines for outcomes. The MCO is planning to achieve all milestones for this project and will report them in the September 2023 or December 2023 reporting submissions.

D. REDUCE AVOIDABLE ED UTILIZATION FOR MEMBERS AGES 20 AND OLDER

Through this project, the MCO is working to improve the health of Members who overutilize the ED by improving care coordination for these Members, referring Members to more appropriate healthcare settings and helping them establish medical homes, and assisting Members with scheduling and attending visits with primary care professionals ("PCPs") to

[14] *See* the Quality Strategy, *supra note 2,* at 3.
[15] LDH Business Plan, *supra note 6*, at page 10.

address ambulatory care issues. This Project aligns with the Quality Strategy objective to ensure appropriate follow-up after ED visits through effective care coordination.[16]

(1) 2022 ED Project Achievements

Since the 2022 Annual Progress Report, the MCO reported its performance for the remaining 2022 milestones, including the following:

4.1 Additional increase in number of members enrolled in ED navigation programs.
4.2 Additional increase in number of members enrolled in ED navigation programs at network providers receiving education regarding outpatient primary care options.
4.3 Increase participation in activities designed to address avoidable ED utilization for members enrolled in ED navigation programs.
4.4 Increase participation in activities designed to address lack of annual or preventative care visits for members enrolled in ED navigation programs.
4.5 Increase or maintenance of percentage of members ages 20 and older who are enrolled in the ED navigation programs that received at least one appointment reminder 24-48 hours before a scheduled appointment.
4.6 Additional increase in number of scheduled appointments and/or referrals provided to members enrolled in the ED navigation programs.
4.7 Additional decrease in percentage of ambulatory ED visits at network hospital providers for members ages 20 and older.

The MCO was pleased to report that it fully achieved six of these seven milestones. For Milestone 4.7 to decrease ambulatory ED visits, the MCO improved its rate from the CY2020-baseline and its CY2021 performance rate. However, it did not fully achieve the goal established by LDH for CY2022. The MCO recognizes this opportunity for improvement and hopes to improve upon its performance in CY2023.

In addition to the quantitative data collected for this project, the MCO is also pleased to note that the majority of the Network Providers believe that the ED Navigation Project has been the most effective MCIP project in improving health outcomes for Members. This is because the ED Navigation Project interconnects with target populations from each of the other projects. During CQI workshops and in survey feedback, Network Providers are eager to share individual success stories from the Members enrolled in the ED navigation programs, which focus on improvement in quality of life, reductions in ED visits, and better chronic care management. Network Providers believe that these individual success stories help improve provider engagement.

(2) 2023 ED Project Status

LDH approved eight milestones for CY2023 related to this project. The 2023 milestones for this project focus on further improvement over baselines for outcomes, increasing the number

[16] *See* the Quality Strategy at 3.

of Members participating in activities designed to address root causes of ED overutilization, and conducting CQI activities.

The MCO has reported one milestone for achievement so far, Milestone 5.8 requiring the MCO to conduct CQI activities in 2023. To complete this milestone, the MCO conducted a CQI workshop in April 2023 with the Network Providers to discuss activities conducted, overall ED Project goals, areas of improvement, the project's effectiveness and project impacts, overcoming barriers to care, streamlining internal Network Provider processes, and enhancing coordination among MCOs and Network Providers. Each of the Network Providers participated in panel discussions for each of these topics.[17]

The remaining seven milestones require the entirety of CY2023 data, so the MCO will report these after the CY is complete. In the meantime, the MCO is working to evaluate ways to better navigate Members and improve its ambulatory ED visit rate.

In addition to the activities described above, the MCO also creates resources for the Network Providers to use when navigating patients to appropriate levels of care. For example, at the onset of the ED Project, the MCO created a summary of the available community resources serving Members, including urgent care centers, behavioral health and substance abuse services, food banks, senior care services, and transportation services. The resource summary is organized by parish, making is easier for Network Providers to locate resources specific to their communities. In early 2023, the MCO reviewed this summary, researched to ensure that the resources were still available and identified additional community resources, and updated the summary as necessary.

When the ED project was implemented in 2019, LDH and the MCO anticipated that the project would yield improved outcomes over a five-year timeframe. However, because the Network Providers have seen immense success through this project, and because of the potential for additional improvement among Members, the MCO is considering proposing continuation of this project in 2024.

E. IMPROVE MATERNAL CARE

The maternal care project was designed to improve the health of mothers and babies enrolled in the Louisiana Medicaid program, through identifying and addressing prenatal care treatment gaps and improving prenatal healthcare services. This project aligns with the Quality Strategy objective to ensure maternal safety and appropriate care during childbirth, prevent prematurity, and reduce infant mortality.[18] This project also complements LDH's overall efforts to improve health outcomes in pregnancy and childhood, which are outlined in more detail in LDH's Business Plan.[19]

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[17] For more information on the CQI activities conducted in 2023, please refer to the Milestone 5.8 report submitted to LDH.
[18] *See* the Quality Strategy at 3.
[19] LDH's Business Plan, *supra note 6*, at 10.

(1) 2022 Maternal Care Project Achievements

Since the 2022 Annual Progress Report, the MCO submitted reporting for the following milestones:

3.1 Continue activities designed to address treatment gaps and root causes for insufficient prenatal care.
3.3 Decrease percentage of nulliparous enrollees with a term, singleton baby in a vertex position delivered by cesarean birth (C-section).
3.4 Decrease percentage of enrollees with elective vaginal deliveries or elective cesarean sections at ≥37 and <39 weeks of gestation completed.
3.6 Decrease percentage of enrollees with live births that weighed less than 2,500 grams.

The MCO fully achieved Milestone 3.1 and partially achieved the remaining milestones. Although the MCO's performance rates for the outcome milestones fell short of LDH's goals, the MCO was pleased to discover that its performance rates had improved over the baseline goals and over CY2021 performance rates. The MCO recognizes that it is difficult to effectuate meaningful change on birth outcomes and is optimistic that its efforts through the project will continue to have positive impacts on Maternal Care Project outcomes.

(2) 2023 Maternal Care Project Status

LDH approved six milestones for the Maternal Care Project in 2023. To date, the MCO has reported achievement of two of these milestones, including the following:

4.2 Continue to analyze methods to improve prenatal healthcare services for enrollees ages 15-45 and revise protocols as needed.
4.3 Conduct CQI activities.

For Milestone 4.2, the MCO requested feedback from Network Providers regarding improvement policies and implementation challenges to date for the methods adopted to improve prenatal healthcare services for Members. The MCO also asked Network Providers to evaluate the effectiveness of the methods implemented. Next, the MCO reviewed the Network's performance on milestone achievement to determine overall effectiveness of these methods on maternal care outcomes. The MCO also reviewed and revised the project's protocol.[20]

For Milestone 4.3, the MCO compiled a report outlining the CQI activities completed in 2023. For this milestone, the MCO updated the CQI plan, measured the 2022 performance, analyzed milestone achievement and reporting to LDH, modified reporting template data fields, revised milestone specifications and project protocol, and conducted a CQI workshop in May 2023 to facilitate collaboration among Network Providers.[21]

[20] For more information on the MCO's achievement of this milestone, please refer to the Milestone 4.2 report submitted to LDH.
[21] For more information, please refer to the Milestone 4.3 report submitted to LDH.

The MCO will report the remaining four milestones for achievement after CY2023 ends. These milestones rely on patient data from the entirety of CY2023. The MCO is hopeful that its CY2023 performance will be an improvement from CY2022 rates.

F. IMPROVE TOBACCO CESSATION

This project was implemented on January 1, 2022. Similar to the existing projects, the MCO evaluated the Quality Strategy to develop the milestones for this project. One of LDH's objectives listed in the Quality Strategy is to promote the use of evidence-based tobacco cessation treatments.[22] This project aligns with this objective because its milestones are designed to promote medical assistance with smoking and tobacco use cessation through the initiation and use of pharmacotherapy and nicotine replacement therapy ("NRT"). This project also aligns with LDH's Business Plan, which highlights the state's focus on tobacco cessation programs and goals to increase coverage for tobacco cessation counseling for Medicaid enrollees.[23]

(1) 2022 Tobacco Cessation Project Achievements

After the 2022 Annual Progress Report, the MCO reported its final 2022 milestone for achievement, meeting with Network Providers to address technical implementation issues. This milestone is particularly important in the first year of a project because Network Providers are starting to develop processes to implement the project's goals, and it is important to ensure that the Network Providers have the resources and support necessary to do so. The MCO held the technical implementation meeting on July 19, 2022. During the meeting, the MCO gave an overview of the project, addressed questions, and solicited feedback from the Network Providers. After the meeting, the MCO circulated meeting materials, including minutes and the presentation slides, to the Network Providers.[24]

(2) 2023 Tobacco Cessation Project Status

LDH established nine milestones for the Tobacco Cessation Project in 2023. Most notably, CY2023 is when the Network Providers start collecting patient level data for this project in order to report baselines at the end of the year. While working through the technical issues related to data collection, the MCO also reported achievement on the following seven milestones:

2.1 Create action items designed to address root causes of tobacco use and to identify opportunities to prevent use from starting in the Medicaid population.
2.2 Create action items designed to address root causes of lack of tobacco cessation treatment in inpatient and ED settings.
2.3 Review reporting template and modify as needed.
2.4 Review and revise protocols as needed.

[22] *See* the Quality Strategy at 3.
[23] LDH's Business Plan is located online at https://ldh.la.gov/assets/bp/2023/LDH-BP-FY23.pdf.
[24] For more information regarding the technical implementation meeting, please refer to the Milestone 1.4 report submitted to LDH.

2.5 Continuous education and training of network providers regarding tobacco cessation, including assessing tobacco use status of members and tobacco cessation counseling.

2.8 Identify and prepare summary of community providers that offer tobacco cessation treatment services to members, to which network providers could refer members.

2.9 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.

Each of these milestones helps build a foundation for the project, so the MCO can capture data related to tobacco use status, counseling and initiation of pharmacotherapy/NRT, and referrals to community providers that offer tobacco cessation treatment services.

The MCO plans to report the remaining two milestones after the end of CY2023. These milestones require the MCO to measure baselines for tobacco status assessed in the ED and for inpatients. The MCO is currently working with Network Providers to ensure that they are able to capture the data necessary to calculate and report these baselines.

G. IMPROVE LUNG CANCER SCREENING

This project was implemented on January 1, 2022. This project aligns with the Quality Strategy objective to "improve cancer screening" among Members.[25] Through this project, the MCO plans to increase lung cancer screening rates, educate Members on the importance of low dose computerized tomography ("CT") scans and the importance of lifestyle decisions in cancer prevention, implement activities designed to address root causes of lung cancer screening rates, conduct CQI activities, and conduct outreach to Members that missed lung cancer screening appointments and reschedule appointments for those members.

(1) 2022 Lung Cancer Project Achievements

Subsequent to submission of the 2022 Annual Progress Report, the MCO completed the remaining three milestones for this project. The milestones include the following:

1.3 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.

1.4 Create materials to educate members who meet the criteria for low dose CT scans regarding the importance of lung cancer screening.

1.7 Meet with network providers to address technical implementation issues.

To complete the Member education milestones, the MCO worked with the Network Providers to create the materials necessary to educate Members. Each Network Provider created their own materials specific to their Member population.[26]

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[25] *See* the Quality Strategy at 3.

[26] For more information, please see the Milestone 1.3 and 1.4 reports submitted to LDH.

To complete Milestone 1.7, the MCO conducted a technical implementation meeting on July 19, 2022. During the meeting, the MCO and Network Providers discussed the project milestones, Network Provider responsibilities, the lung cancer screening template, project implementation issues, and the milestone specifications outlining performance calculations for the project's milestones. After the meeting, the MCO circulated the presentation materials and meeting minutes.[27]

(2) 2023 Lung Cancer Project Status

LDH established eight milestones for the Lung Cancer Screening Project in 2023. To date, the MCO has reported achievement for seven of these milestones, which are listed below:

2.1 Create action items designed to address root causes of low lung cancer screening rates.
2.2 Continuous education and training of Network Providers regarding low lung cancer screening rates.
2.3 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.
2.4 Continuous education of members who meet the criteria for low dose CT scans regarding the importance of lung cancer screening.
2.5 Create and disseminate protocols for Network Providers to use.
2.7 Assess ability of network providers to create lung cancer screening reminders in electronic medical records.
2.8 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.

Each of these milestones is important in building a foundation for this project so that the MCO can report lung cancer screenings. The MCO plans to report the CY2023 baseline for this rate after the end of the year. The MCO is actively working with Network Providers to address any data issues regarding this baseline data.

H. IMPROVE PALLIATIVE AND HOSPICE CARE

The Palliative Care Project is the newest MCIP project, implemented on January 1, 2023. The aims of this project are to: (1) increase palliative and hospice care consultations among Members who died in the hospital; and (2) increase clinical pain assessments and education regarding end-of-life preferences for Members enrolled in palliative or hospice care.

LDH approved eight milestones in 2023 for this project. The milestones are designed to provide a foundation for the project by preparing Network Providers with the tools necessary to achieve the project goals established by LDH. The milestones include identifying and studying root causes, creating a reporting template and protocol, conducting education and

[27] For more information, please see the Milestone 1.7 report submitted to LDH.

training of Network Providers, holding a technical implementation meeting, documenting conditions for which Network Providers currently consult palliative or hospice care, and assessing the ability of Network Providers to create EHR notifications for Members eligible for palliative or hospice care. The MCO is working to achieve these milestones and is on track to complete each of these by the end of CY2023.

IV. PLANNING AHEAD AND NEXT STEPS

During 2022, the MCO worked collaboratively with LDH to develop the 2023 milestones for each of the seven projects and the new project implemented on January 1, 2023. LDH has a five-year initial plan for each of the projects, but federal regulations require the milestones to be approved annually. Consistent with its efforts in previous years, the MCO reviewed the five-year plans for each of the projects to determine whether any revisions should be made to improve the projects moving forward. After this review, the MCO recommended that LDH revise several milestones to ensure consistency with the LDH-approved 2022 milestone language.

The MCO worked with Network Providers to prepare for the anticipated 2023 activities necessary to achieve each of the milestones. To do so, the MCO created a Network Provider timeline of proposed 2023 milestones to facilitate the completion of each of the milestones. The Network Provider timeline assists the Network Providers in providing a roadmap for upcoming deadlines so that the Network Providers can appropriately prepare. The timeline also gives Network Providers the opportunity to ask questions about upcoming requirements before the deadlines and to identify any data collection issues. The MCO also reviewed resources, such as milestone specifications and protocols, for all projects to determine whether revisions should be made based on the project's development and evolution. The MCO maintains a website for the Network Providers with all of these resources, along with copies of the reporting submissions to LDH, group discussion summaries, CQI presentations, and other MCIP documentation. The website is updated on a continuous basis to ensure that the Network Providers have access to the most up-to-date materials.

The MCO is analyzing additional focus areas for new MCIP projects. To complete this analysis, the MCO is researching CMS' guidance, the Quality Strategy, Network Provider feedback, treatment gaps in Louisiana, and LDH's current initiatives. The MCO is planning to complete this research and develop proposed projects for implementation in 2024.

V. CONCLUSION

The MCO is proud of its continued improvement and impact through the MCIP Program. The MCO achieved or partially achieved 47 of the 48 milestones attributable to 2023. In addition to the milestone achievements, the MCO is proud of its qualitative accomplishments, such as the individual Member success stories, increased coordination among Network Providers and MCOs, increased patient engagement, and independent initiatives pursued by Network Providers and MCOs. The MCO continues to work to ensure that the Network Providers are on track to report the remaining 2023 milestones in the last half of the year. The MCO looks

forward to working with LDH and the Network Providers to achieve these milestones, finalize and work toward new milestones in 2024, and developing new projects for implementation in 2024 to expand the impact of the MCIP Program on Members.

APPENDIX A – 2022 AND 2023 MCIP MILESTONES

2022 MILESTONES

Improve Outcomes for Diabetic Members

4.1 Increase activities designed to address treatment gaps.
4.2 Increase in percentage of registry members that are participating in activities designed to reduce HBA1c poor control, to a defined target set by LDH in consultation with MCO.
4.3 Increase in percentage of registry members that are participating in activities designed to reduce poor BP control, to a defined target set by LDH in consultation with MCO.
4.4 Additional increase in number of diabetic members ages 18-75 enrolled in the registry to a defined target set by LDH in consultation with MCO.
4.5 Additional increase in number of HbA1c tests for members enrolled in the registry to a defined target set by LDH in consultation with MCO.
4.6 Additional decrease in percentage of members enrolled in the registry with HbA1c control (<8.0%) to a defined target set by LDH in consultation with MCO.
4.7 Additional decrease in percentage of members enrolled in the registry with HbA1c poor control (>9.0%) to a defined target set by LDH in consultation with MCO.
4.8 Additional increase in percentage of members enrolled in the registry with poor BP control (>140/90) to a defined target set by LDH in consultation with MCO.
4.9 Conduct continuous quality improvement activities during Year Four.

Improve Outcomes for Members with Hypertension

4.1 Increase in percentage of registry members participating in activities designed to increase adequate BP control to a define target set by LDH in consultation with MCO.
4.2 Additional increase in number of members ages 18-85 with hypertension enrolled in the registry, to a defined target set by LDH in consultation with MCO.
4.3 Additional increase in percentage of members enrolled in the registry whose BP was adequately controlled (<140/90 ages 18-59), to a defined target set by LDH in consultation with MCO.
4.4 Additional increase in percentage members enrolled in the registry whose BP was adequately controlled (<150/90 ages 60-85), to a defined target set by LDH in consultation with MCO.
4.5 Conduct continuous quality improvement activities during Year Four.

Improve Member Health for Members Ages 21 Years or Younger Through Increased Primary Care Utilization

4.1 Additional increase in percentage of Network Providers meeting protocol criteria.
4.2 Additional increase in members who turned 15 months old during the measurement year who had six or more well-child visits with a network PCP during the first 15 months of life to a defined target set by LDH in consultation with MCO.

4.3 Addition increase in members ages 3-6 years who had one or more well-child visits during the measurement year with a network PCP to a defined target set by LDH in consultation with MCO.

4.4 Additional increase in members ages 12-21 years who had at least one comprehensive well- care visit during the measurement year with a network PCP or OB/GYN practitioner to a defined target set by LDH in consultation with MCO.

4.5 Increase in members ages 3-17 years that had an outpatient visit with a PCP or OB/GYN practitioner during the measurement year, with evidence of: (1) BMI percentile documentation by age and gender; (2) counseling for nutrition; or (3) counseling for physical activity to a defined target set by LDH in consultation with MCO.

4.6 Continue to conduct activities designed to improve PCP visits for members ages 0-21 years consistent with AAP recommendations and revise protocols as needed.

Reduce Avoidable Emergency Department (ED) Utilization for Members Ages 20 and Older

4.1 Additional increase in number of members ages 20 and older enrolled in ED navigation programs at hospital network providers, to a defined target set by LDH in consultation with MCO.

4.2 Additional increase in number of members in ED navigation programs at network providers receiving education regarding outpatient primary care options, to a defined target set by LDH in consultation with MCO.

4.3 Increase participation in activities designed to address avoidable ED utilization for members enrolled in ED navigation programs.

4.4 Increase participation in activities designed to address lack of annual or preventative care visits for members enrolled in ED navigation programs.

4.5 Increase or maintenance of percentage of members ages 20 and older who are enrolled in ED navigation programs that received at least one appointment reminder 24-48 hours before a scheduled appointment.

4.6 Additional increase in number of scheduled appointments and/or referrals provided to members enrolled in the ED navigation programs, to a defined target set by LDH in consultation with MCO.

4.7 Additional decrease in percentage of ambulatory ED visits at network hospital providers for members ages 20 and older, to a defined target set by LDH in consultation with MCO.

4.8 Conduct continuous quality improvement activities during Year Four.

Improve Maternal Care

3.1 Continue activities designed to address treatment gaps and root causes for insufficient prenatal care.

3.2 Continue to analyze methods to improve prenatal healthcare services for enrollees ages 15-45 and revise protocols as needed.

3.3 Decrease percentage of nulliparous enrollees with a term, singleton baby in a vertex position delivered by cesarean birth (C-section), to a defined target set by LDH in consultation with MCO.

3.4 Decrease percentage of enrollees with elective vaginal deliveries or elective cesarean sections at $\geq$37 and <39 weeks of gestation completed, to a defined target set by LDH in consultation with MCO.
3.5 Decrease percentage of enrollees with live births that weighed less than 2,500 grams, to a defined target set by LDH in consultation with MCO.
3.6 Conduct continuous quality improvement activities during Year Three.

Improve Tobacco Cessation

1.1 Identify and study root causes of tobacco use in the Medicaid population to identify opportunities to prevent use from starting.
1.2 Identify and study root causes of lack of tobacco cessation treatment in inpatient and ED settings.
1.3 Create a reporting template with data fields necessary to assess members' tobacco use and tobacco cessation activities.
1.4 Meet with network providers to address technical implementation issues.
1.5 Create and disseminate protocols for network providers to use.
1.6 Conduct education and training of network providers regarding tobacco cessation, including assessing tobacco use status of members and tobacco cessation counseling.
1.7 Evaluate accuracy and effectiveness of tobacco cessation methods.

Improve Lung Cancer Screening

1.1 Identify and study root causes of low lung cancer screening rates.
1.2 Conduct education and training of network providers regarding low lung cancer screening rates.
1.3 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.
1.4 Create materials to educate members who meet the criteria for low dose CT scans regarding the importance of lung cancer screening.
1.5 Research current recommendations for lung cancer screening.
1.6 Create a reporting template with data fields necessary to assess member eligibility for, and receipt of, lung cancer screening.
1.7 Meet with network providers to address technical implementation issues.

2023 MILESTONES

Improve Outcomes for Diabetic Members

5.1 Additional increase in activities designed to address treatment gaps.
5.2 Additional increase in registry members that are participating in activities designed to reduce HbA1c poor control, to a defined target set by LDH in consultation with MCO.
5.3 Additional increase in registry members that are participating in activities designed to reduce diabetic members with poor BP control, to a defined target set by LDH in consultation with MCO.
5.4 Additional increase in number of diabetic members ages 18-75 enrolled in the registry to a defined target set by LDH in consultation with MCO.
5.5 Additional increase in number of HbA1c tests for members enrolled in the registry to a defined target set by LDH in consultation with MCO.
5.6 Additional decrease in percentage of members enrolled in the registry with HbA1c poor control (>9.0%) to a defined target set by LDH in consultation with MCO.
5.7 Additional decrease in percentage of members enrolled in the registry with poor BP control (>140/90) to a defined target set by LDH in consultation with MCO.
5.8 Additional increase in percentage of members enrolled in the registry with HbA1c control (<8.0%) to a defined target set by LDH in consultation with MCO.
5.9 Conduct continuous quality improvement activities during Year Five.

Improve Outcomes for Members with Hypertension

5.1 Additional increase in registry members that are participating in activities designed to increase adequate BP control to a define target set by LDH in consultation with MCO.
5.2 Additional increase in number of members ages 18-85 with hypertension enrolled in the registry to a defined target set by LDH in consultation with MCO.
5.3 Additional increase in percentage of members enrolled in the registry whose BP was adequately controlled (<140/90 ages 18-59), to a defined target set by LDH in consultation with MCO.
5.4 Additional increase in percentage members enrolled in the registry whose BP was adequately controlled (<150/90 ages 60-85), to a defined target set by LDH in consultation with MCO.
5.5 Conduct continuous quality improvement activities during Year Five.

Improve Member Health for Members Ages 21 Years or Younger Through Increased Primary Care Utilization

5.1 Additional increase in percentage of Network Providers meeting protocol criteria.
5.2 Additional increase in members who turned 15 months old during the measurement year who had six or more well-child visits with a network PCP during the first 15 months of life to a defined target set by LDH in consultation with MCO.
5.3 Additional increase in members ages 3-6 years who had one or more well-child visits during the measurement year with a network PCP to a defined target set by LDH in consultation with MCO.

5.4 Additional increase in members ages 12-21 years who had at least one comprehensive well- care visit during the measurement year with a network PCP or OB/GYN practitioner to a defined target set by LDH in consultation with MCO.

5.5 Additional increase in members ages 3-17 years that had an outpatient visit with a PCP or OB/GYN practitioner during the measurement year, with evidence of: (1) BMI percentile documentation by age and gender; (2) counseling for nutrition; or (3) counseling for physical activity to a defined target set by LDH in consultation with MCO.

Reduce Avoidable Emergency Department (ED) Utilization for Members Ages 20 and Older

5.1 Additional increase in number of members ages 20 and older enrolled in ED navigation programs at network providers, to a defined target set by LDH in consultation with MCO.

5.2 Additional increase in number of members in ED navigation programs at network providers receiving education regarding outpatient primary care options, to a defined target set by LDH in consultation with MCO.

5.3 Increase participation in activities designed to address avoidable ED utilization for members enrolled in ED navigation programs.

5.4 Increase participation in activities designed to address lack of annual ambulatory or preventative care visits for members enrolled in ED navigation programs.

5.5 Increase or maintenance of percentage of members ages 20 or older enrolled in ED navigation programs that received at least one appointment reminder 24-48 hours before a scheduled appointment.

5.6 Additional increase in number of scheduled appointments and/or referrals provided to members enrolled in the ED navigation programs, to a defined target set by LDH in consultation with MCO.

5.7 Additional decrease in percentage of ambulatory ED visits at network hospital providers for members ages 20 and older, to a defined target set by LDH in consultation with MCO.

5.8 Conduct continuous quality improvement activities during Year Five.

Improve Maternal Care

4.1 Continue activities designed to address treatment gaps and root causes for insufficient prenatal care.

4.2 Continue to analyze methods to improve prenatal healthcare services for enrollees ages 15-45 and revise protocols as needed.

4.3 Additional decrease percentage of nulliparous enrollees with a term, singleton baby in a vertex position delivered by cesarean birth (C- section), to a defined target set by LDH in consultation with MCO.

4.4 Additional 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.

4.5 Additional 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.

4.6 Conduct continuous quality improvement activities during Year Four.

Improve Tobacco Cessation

2.1 Create action items designed to address root causes of tobacco use and to identify opportunities to prevent use from starting in the Medicaid population.
2.2 Create action items designed to address root causes of lack of tobacco cessation treatment in inpatient and ED settings.
2.3 Review reporting template and modify as needed.
2.4 Review and revise protocols as needed.
2.5 Continuous education and training of network providers regarding tobacco cessation, including assessing tobacco use status of members and tobacco cessation counseling.
2.6 Measure baseline for members whose tobacco status is assessed in the ED.
2.7 Measure baseline for members whose tobacco status is assessed as inpatients.
2.8 Identify and prepare summary of community providers that offer tobacco cessation treatment services to members, to which network providers could refer members.
2.9 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.

Improve Lung Cancer Screening

2.1 Create action items designed to address root causes of low lung cancer screening rates.
2.2 Continuous education and training of network providers regarding low lung cancer screening rates.
2.3 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.
2.4 Continuous education of members who meet the criteria for low dose CT scans regarding the importance of lung cancer screening.
2.5 Create and disseminate protocols for network providers to use.
2.6 Measure baseline for members who met criteria for lung cancer screening and received a low-dose CT scan.
2.7 Assess ability of network providers to create lung cancer screening reminders in electronic medical records.
2.8 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.

Palliative and Hospice Care

1.1 Identify and study root causes of insufficient pain management in palliative and hospice care.
1.2 Identify and study root causes of inadequate hospice admission rates for terminal cancer patients.
1.3 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.
1.4 Conduct education and training of network providers regarding palliative and hospice care initiatives.

1.5 Create and disseminate protocol for network providers to use.
1.6 Assess ability of network providers to create electronic health record notifications for Members eligible for palliative or hospice care.
1.7 Document conditions for which network providers currently consult palliative or hospice care.
1.8 Meet with network providers to address technical implementations issues.

APPENDIX B – LIST OF NETWORK PROVIDERS

Abbeville General Hospital
Allen Parish Community Healthcare
Baton Rouge General Medical Center
CHRISTUS Coushatta Health Care Center
CHRISTUS Health Shreveport-Bossier
CHRISTUS Ochsner Lake Area Hospital
CHRISTUS Ochsner St. Patrick Hospital
CHRISTUS St. Frances Cabrini Hospital
Iberia Medical Center
North Caddo Medical Center
Ochsner Abrom Kaplan Memorial Hospital
Ochsner Acadia General Hospital
Ochsner American Legion
Ochsner Lafayette General
Ochsner LSU Health Monroe
Ochsner LSU Health Shreveport
Ochsner Medical Center
Ochsner Medical Center - Kenner
Ochsner Medical Center - North Shore
Ochsner Medical Center - Baton Rouge
Ochsner St. Anne General Hospital
Ochsner St. Martin Hospital
Ochsner St. Mary
Ochsner University Hospital and 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

APPENDIX C – GROUP DISCUSSION SUMMARIES

(1) July 2022 Group Discussion

During this group discussion, the MCO discussed the nine milestones achieved and reported to LDH in the previous month and thanked Network Providers for their hard work. The MCO reminded attendees of the forthcoming technical implementation meetings for the newly implemented Lung Cancer Screening and Tobacco Cessation projects. In alignment with the Network's goal to increase the number of Network Provider sites complying with the Pediatric Protocol, the MCO requested that Network Providers submit one Pediatric Protocol compliance questionnaire per Network Provider site with a copy of policies and procedures. The MCO outlined the upcoming requirements for submitting supporting documentation for activity implementation and continuation of activities and reminded Network Providers to redact any protected health information from their submissions. The MCO answered Network Provider questions related to upcoming Lung Cancer Screening deadlines for creating educational materials for members. The meeting concluded with the MCO discussing the time and location of the 2022 annual meeting.

(2) August 2022 Group Discussion

During the call, the MCO summarized the technical implementation meetings held for the Tobacco Cessation and Lung Cancer Screening projects in the prior month and advised Network Providers on the availability of revised milestone specifications, protocols, and data templates that address issues raised during the technical implementation meetings. The MCO requested Network Providers who had yet to appoint a Tobacco Cessation Administrator to oversee the implementation of the project to advise the MCO of their selection. The MCO also reminded Network Providers of the deadlines for submitting supporting documentation for activity implementation/activity continuation and deadlines for submitting Lung Cancer Screening educational materials for Members.

(3) September 2022 Group Discussion

The MCO began the discussion by reminding Network Providers that the annual meeting would be held in New Orleans later in the month and that at least one representative from each Network Provider must attend. Next, the discussion continued with the MCO describing the Maternal Care template trainings that were recently scheduled. The Maternal Care template was updated to add a new column for "Patients in Spontaneous Labor." This change aligns with the milestone specifications related to reducing elective deliveries and ensures that only elective deliveries are included in the numerator of data analysis. The discussion concluded with the MCO answering Network Provider questions regarding a list of LDH approved nicotine replacement therapies ("NRTs") for Medicaid. LDH maintains a list of approved NRTs online.

(4) October 2022 Group Discussion

The group discussion began with the MCO thanking Network Providers for attending the annual meeting, which had an attendance rate of 100%, including all Medicaid Managed Care Organizations and Network Providers. The MCO reminded Network Providers of the

upcoming Maternal Care template trainings and how changes to the template allow the reporting to distinguish patients who came to the hospital in labor from those who were induced. The MCO reminded Network Providers that it will begin collecting data in 2023 for lung cancer screening member education. The MCO advised Network Providers it would share updates as further information regarding data collection became available.

(5) November 2022 Group Discussion

During this call, the MCO outlined the Maternal Care template training scheduled for later in the month. The MCO also updated the data submission guidelines for ED, Maternal Care, and Pediatric data for 2022, to include any revisions to the project resources. The MCO answered Network Provider questions related to any changes and reminded those in attendance that CY2022 data submissions were due on January 16, 2023. The discussion concluded with the MCO answering Network Provider questions related to initiating pharmacotherapy for tobacco cessation in the ED.

(6) December 2022 Group Discussion

Given this meeting's proximity to the end of CY2022, the discussion focused on upcoming data submission requirements, including the process for submission and tips for correctly completing the templates. The MCO also advised Network Providers regarding the CY2023 activity options for the Diabetes, Hypertension, ED, Pediatrics, and Maternal Care projects. The MCO discussed the new CY2023 Network Provider timeline, outlining upcoming Network Provider deadlines. Finally, the MCO discussed the possibility of LDH implementing a new project effective January 1, 2023.

(7) January 2023 Group Discussion

During this call, the MCO reminded Network Providers of upcoming data submission deadlines for the Diabetes, Hypertension, ED, Maternal Care, and Pediatric projects. The MCO addressed changes to the distribution of group discussion summaries, which will be available exclusively on the LAMCIP website moving forward. The MCO also explained that a new Medicaid Managed Care Organization, Humana, started participating in the MCIP Program effective January 1, 2023. Network Providers were additionally reminded to include all patients with any indicia of Medicaid in the data templates, if the Members met all other eligibility requirements for inclusion. The MCO addressed Network Provider questions regarding error messages related to deliveries from young mothers and inclusion in the data template for the Pediatric Project. Next, the MCO detailed changes made to the CY2023 Network Provider timeline. The MCO concluded the meeting by reviewing upcoming deadlines.

(8) February 2023 Group Discussion

Prior to the February group discussion, the MCO distributed consolidated surveys relating to the Tobacco Cessation, Lung Cancer Screening, and Maternal Care projects. The MCO reminded Network Providers to complete the surveys on or before the requested due dates for each. The MCO also detailed the status of the data submissions from Network Providers, with over 75% of templates finalized. The MCO answered questions from the Network

Providers regarding the submission of member education materials for the LCS Project milestones for member education. Finally, the MCO shared changes made to the Tobacco Cessation template which corrected a software error and clarified that encounters for members eighteen years or older should be included in the template.

(9) March 2023 Group Discussion

Prior to the meeting, the MCO finalized the calculations of Network achievement using Network Provider data submissions. During the meeting, the MCO shared the achievements of the Network reflected in the CY2022 data submissions. The MCO detailed achievement for each project and highlighted milestones that were fully achieved as well as partial achievement in certain milestones. Overall, nineteen out of twenty-five milestones were fully achieved. The meeting concluded with the MCO reminding Network Providers of upcoming survey response deadlines and ED CQI workshop speaker submission requirements.

(10) April 2023 Group Discussion

The group discussion began with the MCO overviewing the revisions made to the 2023 Network Provider timeline, which has been abbreviated to increase readability and amended to allow additional preparation time for the Hypertension CQI workshop. The MCO then reminded Network Providers of upcoming deadlines related to CQI workshops and documentation for LCS and Tobacco Cessation provider education. Network Providers received emails detailing their specific CY2022 performance rates prior to the group discussion. The MCO ended the meeting by discussing the opportunity for Network Providers to submit optional feedback regarding the Tobacco Cessation reporting template.

(11) May 2023 Group Discussion

During this group discussion, the MCO shared upcoming deadlines with Network Providers, including provider education requirements related to Pediatrics, LCS, and Tobacco Cessation. The bulk of the remainder of the March discussion was led by Ms. Meridith at Ochsner, who detailed available over-the-counter benefits available from different Medicaid Managed Care organizations in Louisiana. For example, Aetna members receive a five-dollar gift card if they receive a flu shot. Network Providers expressed gratitude for Ms. Meridith's presentation and plan to advise Members of available over-the-counter benefits more often. The MCO ended the discussion by inviting other Network Provider personnel to present at future group discussions.

(12) June 2023 Group Discussion

The MCO began the group discussion by sharing with Network Providers that LDH approved a new project for 2023. The new project focuses on palliative and hospice care and the MCO has started working to develop milestone specifications, a reporting template, and other project materials. To aid the MCO in developing project plans for the new Palliative Care Project, the MCO will distribute consolidated surveys to Network Providers in the upcoming weeks. The MCO also advised Network Providers that Humana will begin participating in

projects beginning with the Palliative Care project. The discussion concluded with the MCO sharing details regarding the annual meeting.

APPENDIX D – SUMMARY OF MCIP ACCOMPLISHMENTS

2022 SUMMARY

Medicaid Incentive Payment Program

Achievements and Positive Outcomes

Quality and Outcome Improvement Network ("QIN")

Beginning in 2019, the Louisiana Department of Health ("LDH") coordinates a **comprehensive, multi-year plan for improving the health of its Medicaid population and thereby lowering costs**. Improvements are achieved through QIN, a coalition of Medicaid MCOs and participating providers working together to advance network goals and ameliorate treatment gaps within the Louisiana Medicaid population.

QIN has enjoyed notable successes in several project areas that support program initiatives in LDH's Medicaid Managed Care Quality Strategy, including:

REDUCING AVOIDABLE ED UTILIZATION	143%	increase in the number of Medicaid participants receiving one-on-one navigation services (including help scheduling primary care visits, appointment reminders, and education) from 2020 to 2022.
IMPROVING OUTCOMES FOR DIABETIC MEMBERS	67%	of Medicaid participants controlled their diabetes, almost double the number of participants in 2020 and 20% more than the national average.
IMPROVING OUTCOMES FOR MEMBERS WITH HYPERTENSION	69%	of Medicaid participants controlled their hypertension (high blood pressure), 10% more than the national average.
IMPROVING PEDIATRIC PRIMARY CARE	32%	increase in the number of child and adolescent Medicaid participants receiving an annual well-child or well-care visit from 2020 to 2022.

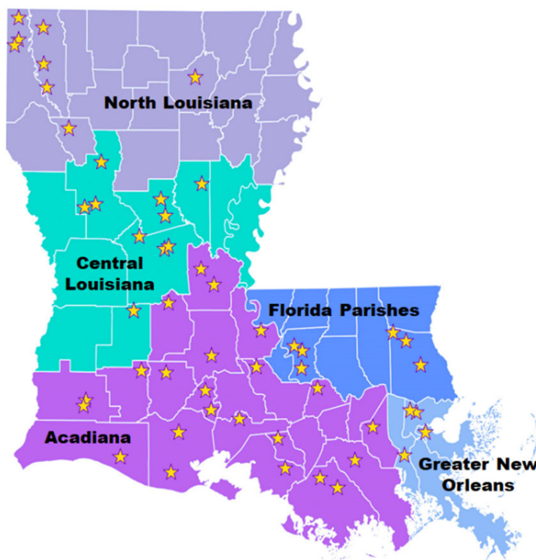
These successes are due to significant expansion and improvement in the resources and services that QIN network providers offer to Medicaid participants as a direct result of this and other LDH initiatives that incentivize providers to treat Medicaid participants. QIN's work includes:

- **Improving Health Equity**: navigators and social workers connect patients to services offered by MCOs (including case management with face-to-face encounters) and organizations within their communities, providing much needed resources to Medicaid participants.
- **Addressing Care Barriers**: network providers coordinate care across the board and ensure that staff is engaged in closing treatment gaps, providing integrated care for Louisiana's Medicaid population. This team-based approach fosters improved provider engagement and development of chronic care management programs.
- **Engaging the Community**: ongoing conversations between clinicians, social service providers, non-profits, and community leaders result in effective solutions to overcome care barriers. For example, analyzing food insecurity and how staff can help Medicaid participants.
- **Bringing Care to Patients**: with efforts like including diabetes testing, monitoring, and education in health fairs, QIN is making healthcare more accessible to Medicaid participants in all Louisiana communities.

Quality and Outcome Improvement Network Service Providers

Acadiana

- Abbeville General Hospital
- Abbeville General Hospital Clinic
- Abbeville General Hospital Pediatric Care Clinic
- Abram Kaplan Memorial Hospital
- Abrom Kaplan Family Medicine
- Acadia General
- Avoyelles Charter School-Based Health Center
- Avoyelles High School-Based Health Center
- Basile Rural Health Clinic
- Bryan Sibley, MD, APMC
- Chabert Hospital
- CHRISTUS Lake Area Hospital
- CHRISTUS St. Patrick Hospital
- Combre-Fondel Elementary School-Based Health Center
- Elton Rural Health
- Erath/Delcambre Clinic
- Iberia Medical Center
- Iberia Medical Center – North Family Practice 2 Clinic
- Iberia Medical Center – North Family Practice 3 Clinic
- Iberia Medical Center – Phys Internal Medicine
- Iberia Medical Center – Phys North Family Practice 1 Clinic
- Iberia Medical Center – Phys OB/GYN Clinic
- Innis Community Health Center
- Jeanerette Rural Health Clinic
- Jennings American Legion Hospital Eunice Family Medicine
- Jennings American Legion Hospital Family Medicine
- Jennings American Legion Hospital Lake Arthur Family Medicine
- Lafayette Community Health Clinic
- Lafayette General Medical Center
- Lafayette General Orthopedics
- Lake Charles Clinics
- Livonia Community Health Center
- Livonia School-Based Health Center
- Mamou Family Care
- Maringouin Community Health Center
- Maurice Community Care Clinic
- Molo Middle School-Based Health Center
- New Roads Community Health Center
- Ochsner Acadia General Health Center
- Ochsner St. Mary Clinics
- Ochsner St. Mary Hospital
- Ochsner Urgent Care Clinics
- Opelousas General – Main
- Opelousas General – South
- Pointe Coupee Central High School-Based Health Center
- Pointe Coupee General Hospital
- Savoy Family Care
- Savoy Medical Center
- South Cameron School-Based Health Center
- St. Anne Clinics
- St. Anne Hospital
- St. Charles Parish Hospital
- St. Martin Acute
- St. Martin Community Health Clinic
- Terrebone Clinics
- Terrebone General Medical Center
- University Hospital and Clinics – Ambulatory Clinics
- University Hospital and Clinics – Pediatrics
- University Hospital and Clinics – University Hospital
- Ville Platte Rural Clinic
- Washington-Marion School-Based Health Center
- Women's Health of Vermillion



Central Louisiana

- Allen Parish Hospital
- Allen Parish Hospital Rural Health Clinic
- Buckeye School-Based Health Center
- CHRISTUS Cabrini Community Clinic
- CHRISTUS Cabrini Hospital
- CHRISTUS Community Clinic – Alexandria
- CHRISTUS Community Clinic – Pineville
- CHRISTUS Community Health Clinic – Boyce
- CHRISTUS Family Medicine Center – Pineville
- CHRISTUS Primary Care Versailles
- Family Medicine Center – Alexandria
- Family Medicine Center – Pineville
- Glenmora School-Based Health Center
- Grant School-Based Health Center
- Jena High School-Based Health Center
- Jena Jr. High School-Based Health Center
- Lakeview School-Based Health Center
- Lessie Moore School-Based Health Center
- Marthaville School-Based Health Center
- Natchitoches Central School-Based Health Center
- Northwood School-Based Health Center
- Pineville Jr. High School-Based Health Center
- Pollock School-Based Health Center
- Provencal School-Based Health Center
- Rapides Cardiology and Vascular Clinic
- Rapides Coliseum Boulevard
- Rapides North Boulevard
- Rapides Regional Medical Center
- Tioga High School-Based Health Center
- Tioga Jr. High School-Based Health Center

Florida Parishes

- Baton Rouge Clinics
- Baton Rouge General Medical Center
- Northshore Clinics
- Northshore Hospital
- Ochsner Health Center – Bluebonnet South
- Ochsner Health Center for Children – Goodwood
- Ochsner Community Health – Brees Family Center (Howell Blvd.)
- Ochsner Medical Center Baton Rouge
- Ochsner Urgent Care Clinics
- Slidell Memorial Clinics
- Slidell Memorial Hospital
- St. Tammany Clinics
- St. Tammany Hospital
- St. Tammany Physicians Network
- Start Community Health Center Covington
- Start Community Health Center Mandeville
- The General Hospital

Greater New Orleans

- Baptist Clinics
- Jefferson Highway Clinics
- Jefferson Highway Hospital
- Kenner Clinics
- Kenner Hospital
- Lakeview Cardiology Associates
- Lakeview Regional – Northshore
- Lakeview Regional – Slidell
- Lakeview Regional Medical Center
- Ochsner Community Health – Brees Family Center (Bullard Ave.)
- Ochsner Medical Center
- Ochsner Urgent Care Clinics
- St. Bernard Parish Hospital
- Tulane – Downtown
- Tulane – Lakeside
- Tulane Institute of Sports Medicine
- Tulane LaSalle Multispecialty Clinic
- Tulane Multispecialty Clinic Metairie
- Tulane University Hospital & Clinic
- Tulane Uptown Clinic
- West Bank Hospital
- Westbank Clinics

North Louisiana

- Benton Clinic
- Benton Medical
- CHRISTUS Coushatta Health Care
- CHRISTUS Coushatta Ringgold Rural Health Clinic
- CHRISTUS Coushatta Rural Health Clinic
- CHRISTUS Highland
- CHRISTUS Primary Care Associates Shreveport-Bossier
- CHRISTUS Primary Care Partners
- CHRISTUS Primary Care Shreveport
- CHRISTUS Primary Care South Bossier
- Monroe Clinics
- Monroe Hospital
- North Caddo Medical Center
- Plain Dealing Clinic
- Primary Care Associates
- Shreveport Clinics
- Shreveport Hospital
- Vivian Clinic

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