



**State of Louisiana  
Department of Health & Hospitals**

**Healthy Blue (Previously Amerigroup)  
Annual External Quality Review Technical Report**

**Review Period: July 1, 2017 – June 30, 2018  
Report Issued: April 23, 2019**

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## TABLE OF CONTENTS

<b>I. INTRODUCTION .....</b>	<b>1</b>
<b>II. MCO CORPORATE PROFILE .....</b>	<b>2</b>
<b>III. ENROLLMENT AND PROVIDER NETWORK.....</b>	<b>3</b>
Enrollment.....	3
Provider Network .....	4
<b>IV. QUALITY INDICATORS .....</b>	<b>5</b>
Performance Improvement Projects.....	5
Member Satisfaction: Adult and Child CAHPS® 5.0H .....	13
Health Disparities .....	15
<b>V. COMPLIANCE MONITORING.....</b>	<b>17</b>
Medicaid Compliance Audit Findings for Contract Year 2016.....	17
<b>VI. STRENGTHS, OPPORTUNITIES FOR IMPROVEMENT &amp; RECOMMENDATIONS.....</b>	<b>19</b>
Strengths .....	19
Opportunities for Improvement.....	19
Recommendations.....	20
Response to Previous Year’s Recommendations .....	21

## LIST OF TABLES

Table 1: MCO Corporate Profile .....	2
Table 2: Medicaid Enrollment as of June 2017 <sup>1</sup> .....	3
Table 3: Primary Care & OB/GYN Counts by Geographic Service Area (GSA) .....	4
Table 4: GeoAccess Provider Network Accessibility – as of July 27, 2018 .....	4
Table 5: HEDIS® Effectiveness of Care Measures – 2016-2018.....	10
Table 6: HEDIS® Access to/Availability of Care Measures – 2016-2018.....	11
Table 7: Use of Services Measures – 2016-2018.....	12
Table 8: Adult CAHPS® 5.0H – 2016-2018 .....	13
Table 9: Child CAHPS® 5.0H General Population – 2016-2018.....	14
Table 10: Child CAHPS® 5.0H CCC Population – 2016-2018.....	14
Table 11: 2017 Compliance Audit Determination Definitions.....	17
Table 12: Audit Results by Audit Domain.....	18

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## I. INTRODUCTION

The Centers for Medicare and Medicaid Services (CMS) require that state agencies contract with an External Quality Review Organization (EQRO) to conduct an annual external quality review (EQR) of the services provided by contracted Medicaid managed care organizations (MCOs). This EQR must include an analysis and evaluation of aggregated information on quality, timeliness and access to the health care services that an MCO furnishes to Medicaid recipients. Quality is defined in 42 Code of Federal Regulations (CFR) 438.320 as *“the degree to which an MCO or PIHP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge”*.

In order to comply with these requirements, the Louisiana Department of Health (LDH) contracted with IPRO to assess and report the impact of its Medicaid managed care program, the Healthy Louisiana Program, and each of the participating MCOs on the accessibility, timeliness and quality of services. Specifically, this report provides IPRO’s independent evaluation of the services provided by Healthy Blue for review period July 1, 2017 – June 30, 2018.

The framework for IPRO’s assessment is based on the guidelines and protocols established by CMS, as well as Louisiana State requirements. IPRO’s assessment included an evaluation of the mandatory activities, which encompass: performance measure validation, Performance Improvement Project (PIP) validation and compliance audits. Results of the most current HEDIS® and CAHPS® surveys are presented and are evaluated in comparison to the NCQA’s *Quality Compass*® 2018 South Central – All Lines of Business (LOB) Excluding Preferred-Provider Organizations (PPOs) and Exclusive Provider Organizations (EPOs) Medicaid benchmarks.

Section VI provides an assessment of the MCO’s strengths and opportunities for improvement in the areas of accessibility, timeliness and quality of services. For areas in which the MCO has opportunities for improvement, recommendations for improving the quality of the MCO’s health care services are provided. To achieve full compliance with federal regulations, this section also includes an assessment of the degree to which the MCO has effectively addressed the recommendations for quality improvement made by IPRO in the previous year’s EQR report. The MCO was given the opportunity to describe current and proposed interventions that address areas of concern, as well as an opportunity to explain areas that the MCO did not feel were within its ability to improve. The response by the MCO is appended to this section of the report.

## II. MCO CORPORATE PROFILE

**Table 1: MCO Corporate Profile**

Healthy Blue	
Type of Organization	Health Maintenance Organization
Tax Status	For Profit
Year Operational	02/01/2012
Product Line(s)	Medicaid and LaCHIP
Total Medicaid Enrollment (as of June 2017)	248,050

### III. ENROLLMENT AND PROVIDER NETWORK

#### Enrollment

##### Medicaid Enrollment

As of June 2018, the MCO’s Medicaid enrollment totaled 248,050, which represents 17% of Healthy Louisiana’s active members. **Table 2** displays Healthy Blue’s Medicaid enrollment for 2016 to 2018, as well as the 2018 statewide enrollment total. **Figure 1** displays Health Louisiana’s membership distribution across all Medicaid MCOs.

**Table 2: Medicaid Enrollment as of June 2018<sup>1</sup>**

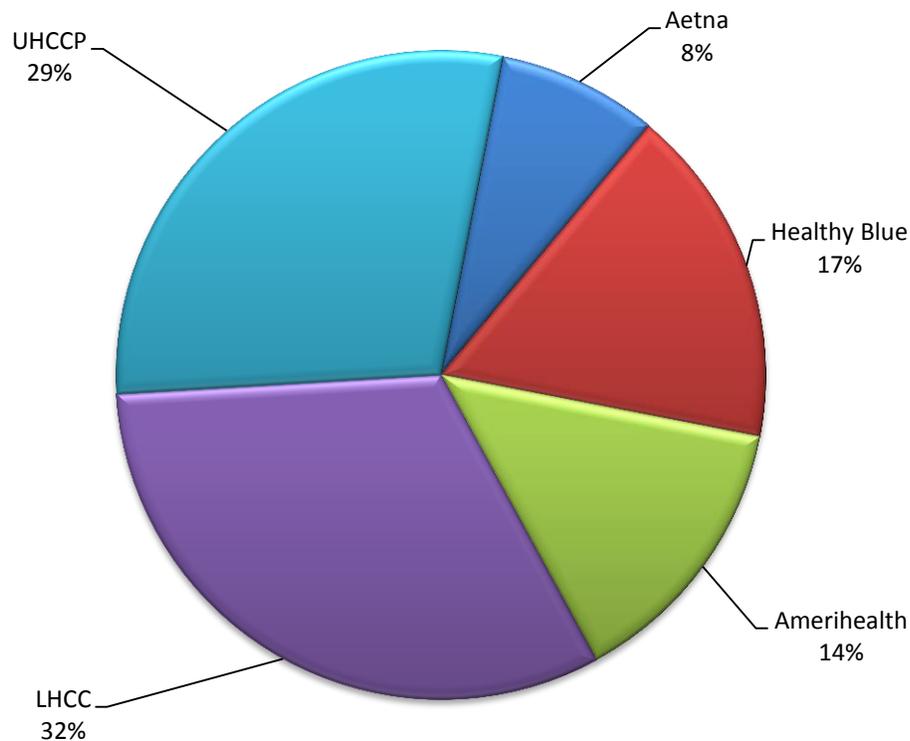
Healthy Blue	June 2016	June 2017	June 2018	% Change	June 2018 Statewide Total <sup>2</sup>
<b>Total Enrollment</b>	207,406	236,196	248,050	5.0%	1,473,685

Data Source: Report No. 125-A

<sup>1</sup>This report shows all active members in Healthy Louisiana as of the effective date above. Members to be disenrolled at the end of the reporting month are not included. Enrollees who gained and lost eligibility during the reporting month were not included. Enrollees who opted out of Healthy Louisiana during the reporting month were not included.

<sup>2</sup>Note: The statewide total includes membership of all Medicaid MCOs.

**Figure 1. Healthy Louisiana Membership by MCO as of June 2018**



## Provider Network

### Providers by Specialty

LDH requires each MCO to report on a quarterly basis the total number of network providers. **Table 3** shows the sum of Healthy Blue’s primary care providers, OB/GYNs and other physicians with primary care responsibilities within each LDH region as of March 7, 2018.

**Table 3: Primary Care & OB/GYN Counts by LDH Region**

Specialty	Healthy Blue									MCO Statewide Unduplicate d
	LDH Region									
	1	2	3	4	5	6	7	8	9	
Family Practice/ General Medicine	140	103	47	85	61	60	87	88	100	676
Pediatrics	199	107	41	89	26	39	76	40	106	630
Nurse Practitioners	149	161	98	112	61	113	90	183	136	917
Internal Medicine	192	76	44	46	29	17	37	30	63	491
RHC/FQHC <sup>1</sup>	46	31	27	27	15	29	34	42	34	285
OB/GYN	175	115	49	76	47	27	86	49	66	594

Data source: Network Adequacy Review 2018 Q2

LDH Region 1: New Orleans; Region 2: Baton Rouge; Region 3: Houma Thibodaux; Region 4: Lafayette; Region 5: Lake Charles; Region 6: Alexandria; Region 7: Shreveport; Region 8: West Monroe; Region 9: Hammond

<sup>1</sup>The FQHC/RHC mapping for miles and minutes are incorrect and will be corrected prior to quarter 3.

### Provider Network Accessibility

Healthy Blue monitors its provider network for accessibility and network capability using the GeoAccess software program. This program assigns geographic coordinates to addresses so that the distance between providers and members can be assessed to determine whether members have access to care within a reasonable distance from their homes. **Table 4** shows the percentage of members for whom geographic access standards were met.

**Table 4: GeoAccess Provider Network Accessibility – as of July 27, 2018**

Provider Type		Access Standard <sup>1</sup> X Provider(s) within X Miles	Percentage of Members for Whom Standard was Met
Adult PCP	Urban	1 within 10 miles	98.3%
	Rural	1 within 30 miles	100.0%
Adolescent PCP	Urban	1 within 10 miles	98.7%
	Rural	1 within 30 miles	100%
OB/GYN	Urban	1 within 15 miles	95.8%
	Rural	1 within 30 miles	95.4%

Data Source: Network Adequacy Review 2018 Q2

<sup>1</sup>The Access Standard is measured in distance to member address.

## IV. QUALITY INDICATORS

To measure quality of care provided by the MCOs, the State prepares and reviews a number of reports on a variety of quality indicators. This section is a summary of findings from these reports, including Performance Improvement Projects (PIPs), as well as HEDIS and CAHPS.

### Performance Improvement Projects

PIPs engage MCO care and quality managers, providers and members as a team with the common goal of improving patient care. The MCO begins the PIP process by targeting improvement in annual baseline performance indicator rates. The next step is to identify barriers to quality of care, and to use barrier analysis findings to inform interventions designed to overcome the barriers to care. Interventions are implemented and monitored on an ongoing basis using quarterly intervention tracking measures. Declining quarterly intervention tracking measure rates signal the need to modify interventions and re-chart the PIP course. Improving intervention tracking measures are an indication of robust interventions.

Healthy Louisiana is in the process of conducting two collaborative PIPs: (1) Improving Prenatal and Postpartum Care to Reduce the Risk of Preterm Birth and (2) Improving the Quality of Diagnosis, Management and Care Coordination for Children and Adolescents with Attention-Deficit Hyperactivity Disorder (ADHD). The five MCOs agreed upon the following intervention strategies for each PIP:

- (1) Improving Prenatal and Postpartum Care to Reduce the Risk of Preterm Birth
  - Implement the Notice of Pregnancy communication from provider to MCO
  - Implement the High-Risk Registry communication from MCO to provider
  - Conduct provider education for how to provide and bill for evidence-based care
  - Develop and implement or revised care management programs to improve outreach to eligible and at-risk members for engagement in care coordination
  
- (2) Improving the Quality of Diagnosis, Management and Care Coordination for Children and Adolescents with ADHD
  - Improve workforce capacity
  - Conduct provider education for ADHD assessment and management consistent with clinical guidelines
  - Expand PCP access to behavioral health consultation
  - Develop and implement or revised care management programs to improve outreach to eligible and at-risk members for engagement in care coordination

Summaries of each of the PIPs conducted by Healthy Blue follow.

## Improving Prenatal and Postpartum Care to Reduce the Risk of Preterm Birth

Indicators, Baseline Rates and Goals: The indicators, baseline rates and corresponding target rates for performance improvement from baseline to final measurement are as follows:

- Initiation of injectable progesterone for preterm birth prevention between the 16th and 24th week of gestation: increase from 18.60% to 19.40%
- Chlamydia test during pregnancy: increase from 52.40% to 65.00%
- HIV test during pregnancy: decrease from 31.70% to 27.20%
- Syphilis test during pregnancy: decrease from 44.50% to 28.60%
- Use of most effective contraceptive methods: decrease from 15.84% to 4.12%
- Use of moderately effective contraceptive methods: decrease from 34.20% to 10.60%
- Use of LARC during delivery hospitalization: decrease from 1.40% to 0.51%
- Use of LARC outpatient 56 days post-partum: decrease from 10.60% to .10%
- HEDIS *Postpartum Care* measure: increase from 61.97% to 65.21%

### Intervention Summary

- Provider
  - Send NOP fax blast to all OB/GYNs
  - Medicaid 101 Roadshow
  - OB Practice Consultant targeting providers with lowest LARC usage
- MCO:
  - Notification of high-risk pregnant members to providers
  - OB Practice Consultant to provide education to internal case management department on importance of engaging with high risk pregnant members
- Member:
  - Care Management Outreach and Engagement Program
  - Home visits for women who fall in the “difficult to reach population” to help educate them about alpha-hydroxyprogesterone caproate (17P) injection and postpartum health
  - Member Incentive Plan
  - LARC pregnancy packets distributed to high risk members.

### Results

- From first to fourth quarter 2017, the rate of NOP forms received from providers increased from 39% to 44%.
- From first to fourth quarter 2017, the percentage of pregnancy packets distributed increased from 10% to 56%
- From first to fourth quarter 2017, the percentage of women who received incentive payments for completing screenings for sexually transmitted diseases increased from 7% to 10%, and the percentage who received incentive payments for completing the postpartum visit increased from 8% to 14%.
- From interim to final measurement, the percentage of pregnant women who were screened for chlamydia increased from 58% to 65%.

Overall Credibility of Results: The validation findings generally indicate that the credibility of the PIP results is not at risk. Results must be interpreted with some caution due to the decrease of the 17P eligible population from baseline to final-re-measurement period.

Strengths: The use of 17-P had an improvement from baseline to final measurement due to the increase in education to members and providers.

### Opportunities for Improvement:

- LDH Managed Care Prematurity Prevention Improvement Project is seeking novel ways to engage providers in the fight against prematurity. As a next step, LDH has requested that each Healthy Louisiana Medical Director, together with each MCO's Prematurity Prevention Performance Improvement (PIP) quality team, and a volunteer physician representing the Medicaid Quality Maternity Care Subcommittee, meet with one provider practice to support quality improvement efforts at that practice. Based upon an analysis of opportunities to improve high risk member receipt of 17P, each PIP quality team has selected one provider to meet with on-site at their practice. At the provider site visit, each MCO team should complete the Practice Engagement Worksheet in collaboration with the practice providers to inform planning of further PDSA cycles and interventions.
- As part of ongoing PDSA efforts to improve early identification and outreach of members at risk for preterm birth and/or preeclampsia, MCOs should identify and address any outstanding care coordination and data integrity challenges. For example: clarification, communication and integration of data sources, collection methods, tasks, persons responsible, and timeframes are merited to ensure that members with a history of preterm birth, as well as those at risk for preeclampsia, are identified early for care management outreach, care coordination and engagement.
- The ITM workgroup should continue monitoring the Intervention Tracking Measures (ITMs) and, in response to issues revealed by the pattern analysis using the IHI Rules for Interpreting Charts, conduct barrier analysis to identify root causes, and use barrier analysis findings to inform modifications to interventions on an ongoing basis as part of the PDSA quality improvement process.

### **Improving the Quality of Diagnosis, Management and Care Coordination for Children and Adolescents with ADHD**

Indicators, Baseline Rates and Goals: The indicators, baseline rates and corresponding target rates for performance improvement from baseline to interim measurement are as follows:

- Validated ADHD screening instrument: increase from 22.70% to 46.67%
- ADHD screening in multiple settings: decrease from 28.00% to 17.33%
- Assessment of other behavioral health conditions/symptoms: increase from 57.30% to 57.33%
- Positive findings of other behavioral health conditions: increase from 57.30% to 60.00%
- Referral for evaluation of other behavioral health conditions: increase from 41.90% to 57.78%
- Referral to treat other behavioral health conditions: decrease from 41.90% to 22.22%
- Primary care provider care coordination: decrease from 29.30% to 26.67%
- MCO care coordination: decrease from 62.70% to 2.66%
- MCO outreach with member contact: decrease from 62.70% to 1.33%
- MCO outreach with member engagement: decrease from 66.00% to 0.00%
- First line behavior therapy for children less than 6 years: decrease from 81.00% to 11.36%
- Percentage of members aged 6-12 years as of the index prescription start date (IPSD) with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day initiation phase: increase from 47.42% to 48.70%
- Percentage of members aged 6-12 years as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days (nine months) after the initiation phase ended: increase from 60.21% to 62.95%
- Percentage of any ADHD cases, aged 0-20 years, stratified by age and foster care status, with documentation of behavioral health pharmacotherapy (ADHD medication, antipsychotic medication, and/or other psychotropic medication), with behavioral therapy: increase from 20.80% to 28.60%

- Percentage of any ADHD cases, aged 0-20 years, stratified by age and foster care status, with documentation of behavioral health pharmacotherapy (ADHD medication, antipsychotic medication, and/or other psychotropic medication), without behavioral therapy: increase from 35.75% to 43.88%
- Percentage of any ADHD cases, aged 0-5 years, stratified by age and foster care status, with documentation of behavioral health pharmacotherapy (ADHD medication, antipsychotics, and/or other psychotropics), without behavioral therapy: increase from 42.26% to 46.76%

#### Intervention Summary:

- Develop targeted provider and member outreach for children in foster care.
- Train PCPs on available behavioral health educational resources and online resources for assessment and treatment, tailored to the unique educational needs of pediatricians and family practitioners as identified by the ADHD provider survey findings.
- Expand access to in-person or telephonic case consultation to PCPs
- Quality Management outreach specialist to assist with scheduling 30-day follow-up appointment with members' prescribed ADHD medication.
- Educational letters mailed and faxed to the PCP's of members who were newly prescribed an ADHD medication.
- Connect families to non-pharmacologic interventions for a minimum of 6 months prior to initiating medication.

#### Results:

- The use of validated ADHD screening instrument results from baseline to interim improved by 23.97%. The interim rate has exceeded the target goal by 14.07%.
- BH Drug without Behavioral Therapy has increased from baseline to interim (inverted measure). The interim rate is 18.88 percentage points above the inverted goal.

Strengths: The MCO achieved improvement for some measures through provider and member education and outreach.

#### Opportunities for Improvement:

- Increase the proportion of PCPs who treat children who received the ADHD PCP TOOLKIT with MCO Provider Education on using the Vanderbilt Assessment for ADHD evaluation and diagnosis.
- Increase the proportion of targeted Evidence-Based Practice (EBP) Behavior Therapists Qualified to treat children <6 years of age diagnosed with ADHD who completed EBP training.
- Increase the proportion of PCPs who treat children who received behavioral provider referral list with MCO Provider Education on the EBP qualifications of behavioral providers on the referral list

## Performance Measures: HEDIS® 2018 (Measurement Year 2017)

MCO-reported performance measures were validated as per HEDIS 2018 Compliance Audit™ specifications developed by the National Committee for Quality Assurance (NCQA). The results of each MCO's HEDIS 2018 Compliance Audit are summarized in its Final Audit Report (FAR).

### HEDIS Effectiveness of Care Measures

HEDIS Effectiveness of Care measures evaluate how well a MCO provides preventive screenings and care for members with acute and chronic illnesses. **Table 5** displays MCO performance rates for select HEDIS Effectiveness of Care measures for HEDIS 2016, HEDIS 2017, and HEDIS 2018, Healthy Louisiana 2018 statewide averages and *Quality Compass* (QC) 2018 South Central – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

**Table 5: HEDIS® Effectiveness of Care Measures – 2016-2018**

Measure	Healthy Blue			QC 2018 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded	Healthy Louisiana 2018 Average
	HEDIS® 2016	HEDIS® 2017	HEDIS® 2018		
Adult BMI Assessment	77.67%	71.46%	81.75%	25 <sup>th</sup>	81.97%
Antidepressant Medication Management - Acute Phase	52.16%	43.51%	48.79%	33.33 <sup>rd</sup>	54.05%
Antidepressant Medication Management - Continuation Phase	36.87%	28.93%	34.11%	50 <sup>th</sup>	39.84%
Asthma Medication Ratio (5-64 Years)	55.54%	58.72%	61.66%	33.33 <sup>rd</sup>	63.75%
Breast Cancer Screening in Women	54.56%	53.71%	55.13%	66.67 <sup>th</sup>	56.03%
Cervical Cancer Screening	54.89%	58.91%	48.66%	10 <sup>th</sup>	51.61%
Childhood Immunization Status - Combination 3	71.53%	64.12%	64.72%	10 <sup>th</sup>	68.19%
Chlamydia Screening in Women (16-24 Years)	59.97%	63.22%	65.29%	90 <sup>th</sup>	65.78%
Comprehensive Diabetes Care - HbA1c Testing	77.86%	78.94%	84.67%	33.33 <sup>rd</sup>	84.21%
Controlling High Blood Pressure	41.22%	BR	32.36%	<10 <sup>th</sup>	37.71%
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	56.46%	60.21%	62.95%	50 <sup>th</sup>	67.89%
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	41.71%	47.42%	48.72%	50 <sup>th</sup>	54.53%
Medication Management for People With Asthma Total - Medication Compliance 75% (5-64 Years)	17.82%	23.13%	22.53%	25 <sup>th</sup>	32.76%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile	52.57%	38.43%	59.85%	10 <sup>th</sup>	62.35%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	36.21%	43.52%	47.20%	10 <sup>th</sup>	55.88%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity	32.48%	33.56%	37.71%	<10 <sup>th</sup>	45.10%

BR: Biased Rate

### HEDIS Access to/Availability of Care Measures

The HEDIS Access to/Availability of Care measures examine the percentages of Medicaid children/adolescents, child-bearing women and adults who receive PCP/preventive care services, ambulatory care (adults only) or receive timely prenatal and postpartum services. **Table 6** displays MCO rates for select HEDIS Access to/Availability of Care measure rates for HEDIS 2016, HEDIS 2017, HEDIS 2018, Healthy Louisiana 2018 statewide averages and *Quality Compass* 2018 South Central – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

**Table 6: HEDIS® Access to/Availability of Care Measures – 2016-2018**

Measure	Healthy Blue			QC 2018 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded	Healthy Louisiana 2018 Average
	HEDIS® 2016	HEDIS® 2017	HEDIS® 2018		
<b>Children and Adolescents' Access to PCPs</b>					
<b>12–24 Months</b>	94.30%	95.63%	96.09%	33.33 <sup>rd</sup>	96.43%
<b>25 Months–6 Years</b>	82.06%	85.15%	87.61%	33.33 <sup>rd</sup>	88.79%
<b>7–11 Years</b>	84.78%	86.12%	88.16%	10 <sup>th</sup>	90.61%
<b>12–19 Years</b>	83.26%	85.10%	87.36%	25 <sup>th</sup>	89.96%
<b>Adults' Access to Preventive/Ambulatory Services</b>					
<b>20–44 Years</b>	77.76%	81.33%	76.36%	25 <sup>th</sup>	76.75%
<b>45–64 Years</b>	86.09%	88.00%	84.74%	25 <sup>th</sup>	84.87%
<b>65+ Years</b>	79.43%	85.63%	79.31%	10 <sup>th</sup>	84.83%
<b>Access to Other Services</b>					
<b>Timeliness of Prenatal Care</b>	82.16%	77.89%	76.89%	25 <sup>th</sup>	78.40%
<b>Postpartum Care</b>	61.97%	65.11%	65.21%	50 <sup>th</sup>	64.04%

## HEDIS Use of Services Measures

This section of the report details utilization of Healthy Blue’s services by examining selected HEDIS Use of Services rates. **Table 7** displays MCO rates for select HEDIS Use of Services measure rates for HEDIS 2016, HEDIS 2017, HEDIS 2018, Healthy Louisiana 2018 statewide averages and *Quality Compass* 2018 South Central – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

**Table 7: Use of Services Measures – 2016-2018**

Measure	Healthy Blue			QC 2018 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded	Healthy Louisiana 2018 Average
	HEDIS® 2016	HEDIS® 2017	HEDIS® 2018		
Adolescent Well-Care Visit	41.20%	47.24%	51.09%	33.33 <sup>rd</sup>	54.18%
Ambulatory Care Emergency Department Visits/1000 Member Months <sup>1</sup>	78.69	78.65	84.74	90 <sup>th</sup>	81.09
Ambulatory Care Outpatient Visits/1000 Member Months	412.98	408.60	408.52	66.67 <sup>th</sup>	418.74
Frequency of Ongoing Prenatal Care - ≥ 81%	73.71%	66.09%	Retired <sup>2</sup>	Not Applicable	Retired <sup>2</sup>
Well-Child Visits in the First 15 Months of Life 6+ Visits	57.87%	58.49%	67.15%	66.67 <sup>th</sup>	64.11%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	54.40%	63.49%	68.13%	33.33 <sup>rd</sup>	68.06%

<sup>1</sup> A lower rate is desirable.

<sup>2</sup> NCQA retired this measure from HEDIS 2018.

## Member Satisfaction: Adult and Child CAHPS® 5.0H

In 2018, the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H survey of Adult Medicaid members and Child Medicaid with Chronic Care Conditions (CCC) was conducted on behalf of Healthy Blue by the NCQA-certified survey vendor, DSS Research. For purposes of reporting the Child Medicaid with CCC survey results, the results are divided into two groups: General Population and CCC Population. The General Population consists of all child members who were randomly selected for the CAHPS® 5.0H Child survey during sampling. The CCC Population consists of all children (either from the CAHPS® 5.0H Child survey sample or the CCC Supplemental Sample) who are identified as having a chronic condition, as defined by the member's responses to the CCC survey-based screening tool.

**Table 8, Table 9 and Table 10** show Healthy Blue's CAHPS® rates for 2016, 2017, and 2018 as well as *Quality Compass*® 2017 South Central – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

**Table 8: Adult CAHPS® 5.0H – 2016-2018**

Measure <sup>1</sup>	Healthy Blue			QC 2017 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded
	CAHPS® 2016	CAHPS® 2017	CAHPS® 2018	
Getting Needed Care	81.56%	75.35%	78.68%	10 <sup>th</sup>
Getting Care Quickly	83.46%	78.05%	77.68%	<10 <sup>th</sup>
How Well Doctors Communicate	87.57%	87.06%	89.55%	10 <sup>th</sup>
Customer Service	90.67%	92.56%	90.52%	50 <sup>th</sup>
Shared Decision Making <sup>2</sup>	80.38%	79.15%	80.23%	66.67 <sup>th</sup>
Rating of All Health Care	74.32%	73.50%	76.75%	50 <sup>th</sup>
Rating of Personal Doctor	79.26%	80.20%	80.74%	33.33 <sup>rd</sup>
Rating of Specialist	85.19%	73.33%	75.86%	<10 <sup>th</sup>
Rating of Health Plan	78.74%	75.43%	77.59%	33.33 <sup>rd</sup>

<sup>1</sup> Note: for "Rating of" measures, Medicaid rates are based on ratings of 8, 9 and 10; for measures that call for respondents to answer with "Always," "Usually," "Sometimes" or "Never" the Medicaid rate is based on responses of "Always" or "Usually".

<sup>2</sup> In 2016, NCQA revised measure specifications and response options.

**Table 9: Child CAHPS® 5.0H General Population – 2016-2018**

Measure <sup>1</sup>	Healthy Blue			QC 2018 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded
	CAHPS® 2016	CAHPS® 2017	CAHPS® 2018	
Getting Needed Care	84.40%	86.41%	84.03%	25 <sup>th</sup>
Getting Care Quickly	93.08%	91.00%	90.81%	50 <sup>th</sup>
How Well Doctors Communicate	93.26%	93.11%	92.61%	10 <sup>th</sup>
Customer Service	92.56%	90.15%	88.64%	33.33 <sup>rd</sup>
Shared Decision Making <sup>2</sup>	80.52%	78.83%	72.18%	10 <sup>th</sup>
Rating of All Health Care	85.39%	88.05%	87.50%	25 <sup>th</sup>
Rating of Personal Doctor	89.42%	90.34%	89.49%	33.33 <sup>rd</sup>
Rating of Specialist	86.90%	90.91%	87.64%	33.33 <sup>rd</sup>
Rating of Health Plan	82.70%	84.93%	87.72%	25 <sup>th</sup>

<sup>1</sup> Note: for “Rating of” measures, Medicaid rates are based on ratings of 8, 9 and 10; for measures that call for respondents to answer with “Always,” “Usually,” “Sometimes” or “Never” the Medicaid rate is based on responses of “Always” or “Usually”.

<sup>2</sup> In 2016, NCQA revised measure specifications and response options.

**Table 10: Child CAHPS® 5.0H CCC Population – 2016-2018**

Measure <sup>1</sup>	Healthy Blue			QC 2018 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded
	CAHPS® 2016	CAHPS® 2017	CAHPS® 2018	
Getting Needed Care	86.63%	86.20%	88.31%	25 <sup>th</sup>
Getting Care Quickly	90.79%	92.08%	94.04%	33.33 <sup>rd</sup>
How Well Doctors Communicate	92.79%	95.00%	93.11%	25 <sup>th</sup>
Customer Service	89.51%	90.60%	84.75%	<10 <sup>th</sup>
Shared Decision Making <sup>2</sup>	85.36%	85.79%	78.69%	<10 <sup>th</sup>
Rating of All Health Care	81.57%	85.37%	87.45%	50 <sup>th</sup>
Rating of Personal Doctor	86.45%	91.79%	91.24%	75 <sup>th</sup>
Rating of Specialist	83.59%	88.03%	96.00%	95 <sup>th</sup>
Rating of Health Plan	76.58%	84.31%	85.90%	33.33 <sup>rd</sup>

<sup>1</sup> Note: for “Rating of” measures, Medicaid rates are based on ratings of 8, 9 and 10; for measures that call for respondents to answer with “Always,” “Usually,” “Sometimes” or “Never” the Medicaid rate is based on responses of “Always” or “Usually”.

<sup>2</sup> In 2016, NCQA revised measure specifications and response options.

## Health Disparities

For this year's technical report, the IPRO evaluated MCOs with respect to their activities to identify and/or address gaps in health outcomes and/or health care among their Medicaid population according to at-risk characteristics such as race, ethnicity, gender, geography, etc. This information was obtained through surveying MCOs regarding the following activities:

- (1) Characterization, identification or analysis of the MCO's Medicaid population according to at-risk characteristics.
- (2) Identification of differences in health outcomes or health status that represent measurable gaps between the MCO's Medicaid population and other types of health care consumers.
- (3) Identification of gaps in quality of care for the MCO's Medicaid members and/or Medicaid subgroups.
- (4) Identification of determinants of gaps in health outcomes, health status, or quality of care for at-risk populations.
- (5) Development and/or implementation of interventions that aim to reduce or eliminate differences in health outcomes or health status and to improve the quality of care for MCO members with at-risk characteristics.

Healthy Blue reported that the following activities and interventions took place in 2017 through 2018 to identify and/or address disparities in health outcomes and/or health care among its Medicaid population:

Claims data was periodically and systematically reviewed to identify member-subgroups with at-risk characteristics. Four major strategies were implemented:

- Predictive modeling utilizing the MCO's Chronic Illness Intensity Index.
- Ranking members from the member's with the highest utilization costs to the lowest utilization cost by product type and then identifying statistical outliers for administrative case management review.
- Identifying and analyzing trends related to emergency room utilization and hospital rapid readmissions.
- Evidenced based literature reviews to identify national, state (Louisiana) and parish trends.

Based upon these strategies key findings related to health disparities included but were not limited to the following subgroups: neonates with high-risk post-partum conditions, high utilizers and rapid re-admitters of inpatient care and emergency room visits, members with clinical features identified through the MCO's Chronic Illness Intensity Index measures, and children who may be subject to over-prescribing for behavioral health issues, particularly included attention deficit hyperactive disorder (ADHD) youth under the age of 6.

Healthy Blue considered the five key areas of Social Determinants of Health (SDOH), Demographic and epidemiological statistics and specific HEDIS measures to identify at-risk members. Community-based healthcare and coordination of care programs were used to improve clinical and financial outcomes such as; Disease Management, Case Management and Demand Management. Healthy Blue implemented the use of health impact assessments to review needed proposed and existing social policies for their prospective impact on health.

Based upon these findings related to health disparities Healthy Blue developed the following specific interventions to improve the quality of care for members identified with at-risk characteristics:

- Tele health: a viable alternative to face-to face services for those who cannot be seen.
- Disease Management: initiatives utilize a "GIC" servicing model. Gaps in care (GIC) are defined as missed care opportunities (e.g. annual preventive screenings, routine labs and medication adherence) for chronic conditions based on data collection. Disease management can easily identify the number of gaps a member has and create care plans to address the gaps related to a member's condition.
- Complex Case Management: a member-centric approach that focuses on providing the tools and educational support necessary for members to effectively manage the member's healthcare needs.

Healthy Blue's Complex Case Managers specifically assess and address barriers that can limit a member's healthcare access and outcomes.

- Comprehensive clinical assessments: to assist the member with care plan development, which is intended to meet needs proactively, optimize care, and reduce the need for emergency and hospital healthcare services. Members are evaluated on an ongoing basis for gaps in care and changes in their health status.
- Navigation Program: provides behavioral health services for psychosocial rehabilitation services and Community Psychiatric Support and Treatment and patient stabilization for patients directed by the Amerigroup Behavioral Health department. Services rendered by a Navigator will be provided while the patient is inpatient if they are rapid re-admitters.
- 7-30 Day Follow-up Program: 7-30 day post behavioral health hospitalization is aimed at member engagement to increase member's attending this clinically significant follow up appointments.
- Collaborative Care Model: integrates physical and behavioral health services that can be implemented within a primary care-based Medicaid health home model, among other settings.
- Evidence based practices for 0-5 year olds with mental illness: ADHD PIP, ADHD AAP Toolkit and WebEx for providers, One TelMed - telemedicine Behavioral Health Network in place and the ADHD New Start Program.
- Community Respite Program: "Living Room Model" program that offers people in crisis an alternative to emergency departments.

## V. COMPLIANCE MONITORING

Please note that the most recent compliance audit for Louisiana took place in 2016, and the next audit is anticipated to take place in 2019.

### Medicaid Compliance Audit Findings for Contract Year 2016

In 2016, IPRO conducted the 2016 Compliance Audit on behalf of the LDH. Full compliance audits occur every three years, with partial audits occurring within the intervening years. The 2016 Compliance Audit was a full audit of Healthy Blue's compliance with contractual requirements during the period of September 1, 2015 through August 31, 2016.

The 2016 Compliance Audit included a comprehensive evaluation of Healthy Blue's policies, procedures, files and other materials corresponding to the following nine (9) domains:

- (1) Core Benefits and Services
- (2) Provider Network
- (3) Utilization Management
- (4) Eligibility, Enrollment and Disenrollment
- (5) Marketing and Member Education
- (6) Member Grievances and Appeals
- (7) Quality Management
- (8) Reporting
- (9) Fraud, Waste and Abuse

The file review component assessed Healthy Blue's implementation of policies and its operational compliance with regulations in the areas of appeals, behavioral health care management, case management, information reconsiderations, member grievances, provider credentialing and recredentialing, and utilization management denials.

For this audit, determinations of full compliance, substantial compliance, minimal compliance and compliance not met were used for each element under review. Definitions for these review determinations are presented in **Table 11**.

**Table 11: 2016 Compliance Audit Determination Definitions**

Determination	Definition
<b>Full</b>	The MCO has met or exceeded the standard
<b>Substantial</b>	The MCO has met most of the requirements of the standard but has minor deficiencies.
<b>Minimal</b>	The MCO has met some of the requirements of the standard, but has significant deficiencies that require corrective action.
<b>Not Met</b>	The MCO has not met the standard.

Findings from Healthy Blue's 2016 Compliance Review follow. **Table 12** displays the total number of requirements reviewed for each domain, as well as compliance determination counts for each domain.

**Table 12: Audit Results by Audit Domain**

<b>Audit Domain</b>	<b>Total Elements</b>	<b>Full</b>	<b>Substantial</b>	<b>Minimal</b>	<b>Not Met</b>	<b>Not Applicable</b>	<b>% Full</b>
<b>Core Benefits and Services</b>	123	121	2	0	0	0	98%
<b>Provider Network</b>	163	155	5	3	0	0	95%
<b>Utilization Management</b>	92	90	1	0	0	1	99%
<b>Eligibility, Enrollment and Disenrollment</b>	13	13	0	0	0	0	100%
<b>Marketing and Member Education</b>	77	76	0	0	0	1	100%
<b>Member Grievances and Appeals</b>	62	55	4	3	0	0	89%
<b>Quality Management</b>	86	85	0	0	0	1	100%
<b>Reporting</b>	1	1	0	0	0	0	100%
<b>Fraud Waste and Abuse</b>	105	104	1	0	0	0	99%
<b>Total</b>	<b>722</b>	<b>700</b>	<b>13</b>	<b>6</b>	<b>0</b>	<b>3</b>	<b>97%</b>

It is IPRO's and the LDH's expectation that Healthy Blue submit a corrective action plan for each of the 19 elements determined to be less than fully compliant along with a timeframe for completion. It should be noted that, in response to the compliance audit draft findings, Healthy Blue has implemented a corrective action for many of the areas identified for improvement in the report but the corrections were made after the audit was completed and were not applicable to the audit's review period. Eight (8) of the 19 elements rated less than fully compliant relate to network adequacy and the MCO's ability to contract with providers in several specialty and sub-specialty areas, a problem for all Medicaid MCOs in Louisiana that is not unique to Healthy Blue.

## VI. STRENGTHS, OPPORTUNITIES FOR IMPROVEMENT & RECOMMENDATIONS

This section summarizes the accessibility, timeliness and quality of services provided by Healthy Blue to Medicaid recipients based on data presented in the previous sections of this report. The MCO's strengths in each of these areas are noted, as well as opportunities for improvement. Recommendations for enhancing the quality of healthcare are also provided based on the opportunities for improvement noted.

### Strengths

- **HEDIS (Quality of Care)** – Healthy Blue met or exceeded the 75<sup>th</sup> percentile for the following HEDIS measure:
  - *Chlamydia Screening in Women (16-24 Years)*
- **CAHPS (Member Satisfaction)** – Healthy Blue met or exceeded the 75<sup>th</sup> percentile for the following CAHPS measures:
  - Child CAHPS CCC Population
    - *Rating of Personal Doctor*
    - *Rating of Specialist*
- **Compliance** – The MCO achieved “full” compliance in four (4) of the nine (9) domains reviewed.

### Opportunities for Improvement

- **HEDIS (Quality of Care)** – Healthy Blue demonstrates an opportunity for improvement in the following areas of care as it did not meet the 50<sup>th</sup> percentile for the following HEDIS measures:
  - *Adult BMI Assessment*
  - *Antidepressant Medication Management – Acute Phase*
  - *Asthma Medication Ratio (5-64 Years)*
  - *Cervical Cancer Screening*
  - *Childhood Immunization Status – Combination 3*
  - *Comprehensive Diabetes Care – HbA1c Testing*
  - *Controlling High Blood Pressure*
  - *Medication Management for People with Asthma Total – Medication Compliance 75%*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI Percentile*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Physical Activity*
  - *Children and Adolescents' Access to PCPs*
    - *12-24 Months*
    - *25 Months-6 Years*
    - *7-11 Years*
    - *12-19 Years*
  - *Adults' Access to Preventive/Ambulatory Services*
    - *20-44 Years*
    - *45-64 Years*
    - *65+ Years*
  - *Timeliness of Prenatal Care*
  - *Adolescent Well Care*
  - *Well-Child Visits in the 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup> and 6<sup>th</sup> Years of Life*

- **CAHPS® (Member Satisfaction)** – Healthy Blue demonstrates an opportunity for improvement in regard to member satisfaction. The MCO performed below the 50<sup>th</sup> percentile for the following measures:
  - Adult CAHPS®
    - *Getting Needed Care*
    - *Getting Care Quickly*
    - *How Well Doctors Communicate*
    - *Rating of Personal Doctor*
    - *Rating of Specialist*
    - *Rating of Health Plan*
  - Child CAHPS® General Population
    - *Getting Needed Care*
    - *How Well Doctors Communicate*
    - *Customer Service*
    - *Shared Decision Making*
    - *Rating of All Health Care*
    - *Rating of Personal Doctor*
    - *Rating of Specialist*
    - *Rating of Health Plan*
  - Child CAHPS® CCC Population
    - *Getting Needed Care*
    - *Getting Care Quickly*
    - *How Well Doctors Communicate*
    - *Customer Service*
    - *Shared Decision Making*
    - *Rating of Health Plan*

## Recommendations

- While the MCO's HEDIS performance continues to trend upward, overall performance continues to be poor suggesting that the quality strategy may be ineffective or insufficient. The new interventions and initiatives described in the MCO's response to the previous year's recommendation should be routinely monitored for effectiveness and modified as needed. The MCO should also seek opportunities to expand the reach of successful interventions.
- In regard to child, adolescent and adult access to primary care, the MCO should expand its approach to include interventions that specifically target member behavior and attitude towards seeking care. The MCO should consider the implementing incentive programs, transportation assistance, appointment scheduling assistance, PCP selection assistance and an education campaign around the importance of preventive care. The MCO's overall approach should be tied to the barriers identified in the CAHPS root cause analysis.
- Future PIPs:
  - Initiate data-driven barrier analyses upon receipt of each new PIP template. For example, analyze encounter data by stratifying baseline performance indicator measures by key demographic and pertinent clinical subsets in order to answer these two questions regarding high-volume and high-risk members:
    - High volume: among the PIP eligible population (e.g., members with substance use disorder {SUD} which demographic (e.g., age group, geographic area, race/ethnicity) subsets and which clinical subsets (e.g., Members with co-occurring serious mental illness {SMI} and members with chronic physical health conditions) comprise the highest caseload volumes?
    - High-risk: Among each subset grouping which demographic (e.g., race/ethnicity: black compared to white) and clinical subsets (e.g., with SMI compared to without SMI) are disproportionately lacking in recommended care (e.g., initiation and engagement in treatment for SUD)?

- Use barrier analysis findings to inform interventions that are targeted and tailored to susceptible subpopulations; however, do not restrict interventions to these subpopulations. Instead, conduct additional data driven barrier analyses (e.g., member and provider focus groups, early inpatient/emergency department admission notification process flow sheet analysis) and use these barrier analysis findings to inform a robust and feasible set of interventions that aim to more broadly reach the entire PIP eligible population.
- Focus on developing and utilizing ITMs to inform modifications to key interventions. For example, use ITMs to monitor the progress of enhanced care management interventions and, in response to stagnating or declining monthly or quarterly rates, conduct additional barrier/root cause analysis and use findings to modify interventions.
- Deploy quality improvement tools, such process flow charting, PDSA worksheets and IHI run charts, in order to test, evaluate and adapt interventions over the course of the PIP and beyond for ongoing quality improvement.

### Response to Previous Year's Recommendations

- **2016-2017 Recommendation:** The MCO continues to demonstrate opportunities for improvement in regard to the quality of, access to and timeliness of care. The MCO should continue to work to improve HEDIS measures that perform below the 50<sup>th</sup> percentile. The effectiveness of the overall strategy should be evaluated often and routinely, and modified as needed. *[Repeated recommendation.]*

#### MCO Response:

- The Health Plan continues to increase the scope of provider outreach year over year to promote education and provide the provider community with information to assist in care gap closure. The broadened scope included offering intense webinar trainings to providers and hosting provider summits. The plan has targeted the top 200 providers intensely to perform HEDIS education and gap in care reporting. This is an increase from the previous 75 provider targeted.
  - The Health Plan has also now aligned the Shared Savings program with the state pay for performance measures and collaborates closely in an integrated model with the Care Delivery Transformation Team to promote the shared savings program and alignment of quality measures with providers in the community.
  - The Health Plan continues to monitor for new contracting opportunities, identify to bring providers with rate disputes with incentive programs or alternative rates and monitor provider to member ratios for Adult PCP and encourage the use of nurse practitioners and physician assistants to panels to accommodate access to care.
  - Additionally, the Health Plan continues to explore opportunities with non-par providers and offer single case agreements to accommodate access to care.
  - Telemedicine was also implemented for Behavioral Health Services to expand on access to care along with contracting with a Behavioral Health Service Vendor to perform follow-up home/field visits for members recently discharged from a Behavioral Health facility. Plans to expand the Behavioral Health Telemedicine model to a Physical Health model are in progress.
- **2016-2017 Recommendation:** Although access to primary care rates for all age groups has trended upward, the MCO continues to demonstrate an opportunity for improvement. The MCO should identify a multitude of data sources, in addition to CAHPS, to support its intervention strategy. All interventions should target barriers that have been identified through thorough root cause analyses and should be continuously monitored for effectiveness. *[Repeated recommendation.]*

**MCO Response:**

- The Plan continuously monitors access to care and opportunities of improvement on a monthly basis via a monthly benchmark dashboard report. From this monitoring, the Plan develops sound strategies and interventions to assist in driving the performance outcomes.
  - The QM Department works collaboratively with all departments to collect data, analyze the data and assists in performing performance improvement sessions to drive initiatives throughout the plan. Interventions are tracked using an intervention tracking dashboard along with tracking of Performance Improvement Plan interventions.
  - The Health Plan has plans for 2019 to move to year round medical record data abstraction to assist in supplementing the data collection already being maintained year round. This will assist in supplementing the performance outcome rates and ensuring that data is captured collectively.
- **2016-2017 Recommendation:** The MCO should continue to work to improve CAHPS® measures that perform below the 50<sup>th</sup> percentile. In addition to the data analysis strategy described in the MCO's response to the previous year's recommendation, the MCO should develop specific interventions that target members' perceived issues with network providers and MCO operations. *[Repeated recommendation.]*

**MCO Response:**

- A root cause analysis of the 2018 CAHPS survey results was completed.
  - Based on our most recent CAHPS scores, the adult satisfaction data revealed that opportunities of improvement identified were related to access to care in regards to: getting Urgent Care, getting a specialist appointment, getting care/tests/treatment/doctor had scare appointments and received routine care. These opportunities identified were addressed in the above section related to access to care.
  - The Health Plan increased from 33<sup>rd</sup> percentile for Adult and Child for rating of the Health Plan (8, 9, & 10) to the 50<sup>th</sup> percentile (17 percentile change).
- The Health Plan is partnering with the Provider Relations Department to host large regional summits with providers and offering CME's and CEU's to providers for attending. The summits include education on opportunities of improvement identified. Trainings include: HEDIS Training, Patient Experience Training, Quality 101, PR 101 and additional discussions surrounding multiple departments in the Health Plan and how they can support the providers and their efforts to deliver quality patient care.
- The Health Plan sent out an educational fax blast to providers to encourage the "Importance of CAHPS and the member experience".
- Health Plan implemented a text messaging campaign to outreach members and alert them of gaps in care as well as educate them on diagnosis specific conditions. The Health Plan has seen much success in terms of engagement of members in the campaign thus far and anticipates that this will aid in driving access and timeliness of care. The text campaign will expand to including a real time member satisfaction survey in 2019 so the Health Plan can keep a real time pulse to gauge member satisfaction and leverage results to implement real time interventions.
- The Health Plan's call center has also developed and implemented a "post-call" satisfaction survey. The Health Plan continues to monitor results and identify opportunities for improvement.
- The Health Plan is re-structuring the member satisfaction work group for 2019 and utilizing the Agency for Health Care Research and Quality (AHRQ) resource strategies for improving patient experience as a foundation for driving improved strategy for 2019. Additionally, we will continue to track/trend member grievances related to satisfaction.