State of Louisiana Department of Health & Hospitals

Louisiana Healthcare Connections, Inc.
Annual External Quality Review Technical Report

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I. INTRODUCTION

The Centers for Medicare and Medicaid Services (CMS) requires 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 Louisiana Healthcare Connections (LHCC) for review period July 1, 2016 – June 30, 2017.

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*® 2017 South Central – All Lines of Business (LOB) (Excluding PPOs and 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 plan 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

Louisiana Healthcare Connections, Inc.	
Type of Organization	Health Maintenance Organization
Tax Status	For Profit
Year Operational	02/01/2012
Product Line(s)	Medicaid
Total Medicaid Enrollment (as of June 2017)	476,873

III. ENROLLMENT AND PROVIDER NETWORK

Enrollment

Medicaid Enrollment

As of June 2017, the MCO's Medicaid enrollment totaled 476,873, which represents 33% of Healthy Louisiana's active members. Table 2 displays LHCC's Medicaid enrollment for 2015 to 2017, as well as the 2017 statewide enrollment total. Figure 1 displays Healthy Louisiana's membership distribution across all Medicaid MCOs.

Table 2: Medicaid Enrollment as of June 2017

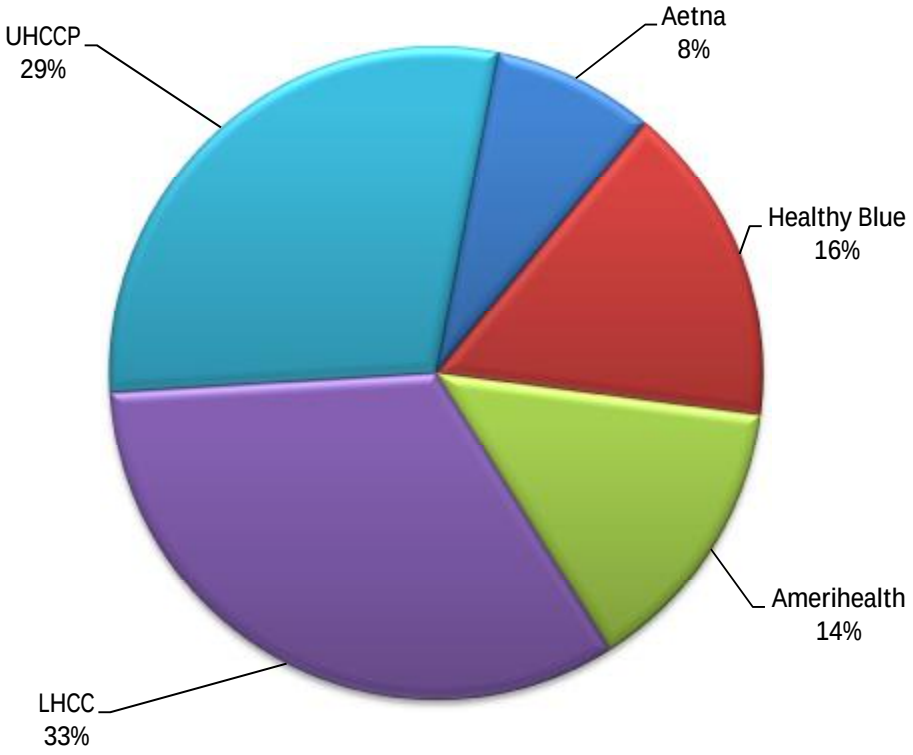
LHCC	June 2015	June 2016	June 2017	% Change	2017 Statewide Total[2]
Total Enrollment	355, 677	428,878	476,873	11%	1,464,516

Data Source: Report No. 125-A

[1] This report shows all active members in Healthy Louisiana as of the effective date above. Members who will be disenrolled at the end of the reporting month are not included. Enrollees who gain and lose eligibility during the reporting month are not included. Enrollees who opt out of Healthy Louisiana during the reporting month are not included.

[2] Note: The statewide total includes membership of all plans.

Figure 1. Healthy Louisiana Membership by MCO as of June 2017



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 LHCC's primary care providers, OB/GYNs and other physicians with primary care responsibilities within each geographic service area as of June 30, 2017.

Table 3: Primary Care & OB/GYN Counts by Geographic Service Area (GSA)

Specialty	LHCC			MCO Statewide Unduplicated
	GSA A	GSA B	GSA C	
Family Practice/General Medicine	192	207	273	641
Pediatrics	214	170	148	516
Nurse Practitioners	253	303	350	856
Internal Medicine[1]	215	139	128	463
RHC/FQHC	74	94	126	294
OB/GYN[1]	9	5	7	18

Data source: Network Adequacy Review 2017 Q2

Geographic Service Area: A: New Orleans and North Shore; B: Baton Rouge, Lafayette and Thibodaux; C: Alexandria, Lake Charles, Monroe and Shreveport

[1] Accepts full PCP responsibility.

Provider Network Accessibility

LHCC 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 26, 2017

Provider Type		Access Standard[1] X Provider(s) within X Miles	Percentage of Members for Whom Standard was Met
Family Practitioner	Urban	1 within 10 miles	95.9%
General Medicine	Urban	1 within 10 miles	51.7%
Internal Medicine	Urban	1 within 10 miles	90.6%
Pediatrician	Urban	1 within 10 miles	91.9%
Nurse Practitioner	Urban	1 within 10 miles	97.2%
OB/GYN	Urban	1 within 10 miles	69.5%
FQHC	Urban	1 within 10 miles	86.5%
RHC	Urban	1 within 10 miles	40.3%

[1] 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 LHCC 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 re-measurement are as follows:

- Initiation of injectable progesterone for preterm birth prevention: increase from 2.16% to 17.5%
- Use of most effective contraceptive methods: increase from 8.57% to 30%
- Chlamydia test during pregnancy: increase from 70.29% to 87%
- HIV test during pregnancy: increase from 62.56% to 85%
- Syphilis test during pregnancy: increase from 71.18% to 85%
- HEDIS® *Postpartum Care* measure: increase from 58.23% to 70%

Intervention Summary:

- Member:
  - Case Manager contacts member to complete Notice of Pregnancy (NOP) form. The members that completed the form receives a Start Smart Thermometer
  - Members in the high-risk registry will be contacted for enrollment in case management
  - Smart Start for Your Baby Program
  - Cent Account bonus money
- Provider:
  - Healthy Louisiana collaboration and proposed implementation of standard Healthy Louisiana-wide NOP communication from provider to MCO
  - $75 incentive for completed NOP forms submitted from providers
  - Implementation of high-risk registry communication from MCO to provider
  - Medicaid 101: Regional provider workshops conducted by LHCC educating providers on updated Medicaid coverage/benefits and misconceptions
- MCO:
  - Case Management communicates with members and providers to coordinate care
  - Complete timely outreach to identified high-risk pregnancy members for enrollment through use of high-risk pregnancy registry
  - Enhancement of care management programs to improve outreach to PIP eligible and at-risk members for engagement in care coordination

Results:

- From second quarter 2016 to first quarter 2017, the percentage of high-risk pregnant members who were enrolled in care management within 30 days of pregnancy notification and who had a plan of care collaboratively developed between the member and case manager increased from 19% to 27%.
- From second quarter 2016 to first quarter 2017, the percentage of high-risk pregnant members who were enrolled in care management within 60 days of pregnancy notification and who had a plan of care collaboratively developed between the member and case manager increased from 22% to 33%.
- From baseline to interim year, the percentage of women with a prior preterm birth who received injectable progesterone increased from 2% to 10%.
- From baseline to interim year, the percentage of pregnant women screened for Chlamydia increased from 70% to 84%, screened for HIV increased from 63% to 79%, and screened for syphilis increased from 71% to 83%.
- From baseline to interim year, the percentage of women with a postpartum visit increased from 58% to 65%.

Overall Credibility of Results: There are no validation findings that indicate that the credibility of the study is at risk.

Strengths: Elaboration of interventions as, with process measures integrated into the intervention table so that the PIP can be used by the MCO as a working document to monitor the progress of and/or barriers to interventions.

Opportunities for Improvement:

- Clarify how gap reports will be used to (1) identify members not in the annual performance indicator numerators, (2) interventions to outreach (a) members with care gaps and (b) their providers for care coordination and care management, (3) report corresponding quarterly intervention tracking (process) measure data, and (4) indicate revisions to interventions to address newly identified barriers in response to intervention tracking (process) measure trends that indicate lack of improvement.
- Report each intervention in the intervention table, with corresponding intervention tracking measure data in the intervention tracking (process) measure table. Number intervention tracking measures to align with the interventions they are monitoring.
- Consider a supplementary means other than the NOP to identify pregnant women among the high-risk subpopulation, for example, by conducting ongoing review of current claims data for prenatal-related claims among women with a prior preterm birth.

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 final re-measurement are as follows:

- Validated ADHD screening instrument: increase from 33.3% to 54.7%.
- ADHD screening in multiple settings: increase from 14.67% to 30.67%
- Assessment of other behavioral health conditions/symptoms: increase from 16% to 32.6%.
- Referral for evaluation of other behavioral health conditions: increase from 60.0% to 80.0%
- Referral to treat other behavioral health conditions: increase from 50.0% to 80.0%
- Primary care provider care coordination: increase from 38.67% to 60.7%
- MCO care coordination: increase from 5.33% to 60.7%
- MCO outreach with member contact: increase from 4% to 50.0%
- First line behavior therapy for children less than 6 years: increase from 0% to 50%
- 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 40.44% to 44.48%
- 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 53.83% to 59.21%
- 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 39.9% to 43.89%
- 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 will decrease from 46.2% to 40.0%

Intervention Summary:

- Provide face-to-face provider education for providers with high prescribing volume
- Provide clinical training to physical health and behavioral health providers on ADHD assessment
- Develop a plan of care for children with ADHD who are enrolled in case management

- Utilize Disease Management staff and systems to monitor effectiveness of care, e.g., improved Vanderbilt score
- Provide PCPs with list of behavioral health providers in their service area, e.g., providers with specialized training in Parent Child Interactive Therapy (PCIT), Child Parent Psychotherapy (CPP), Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) and Positive Parenting Program (PPP)

Results: Not yet available.

Strengths: The MCO includes enhance disease management intervention tracking measures as well as provider intervention tracking measures that both work towards ongoing monitoring of member and provider education.

Opportunities for Improvement:
- Utilize the provider survey findings that showed different barriers for pediatricians and family practice physicians to inform the development of at least one provider education intervention tailored to pediatricians and at least one provider intervention tailored to family practitioners, with corresponding intervention tracking (process) measures.
- The subpopulations with the greatest ADHD prevalence included children in foster care ages 6-12 and children in foster care ages 13-17. Indicate these susceptible subpopulations in the Barrier Analysis with corresponding interventions and intervention tracking (process) measures.
- Pending clinic hiring of licensed clinical social workers (LCSWs), indicate interim interventions to facilitate communication between LCSWs and PCPs.
- Identify the parishes with the greatest behavioral health (BH) provider shortages, as well as those parishes with the highest volume of ADHD cases. Utilized this information to target BH provider training.
- Indicate interventions that will be implemented to inform PCPs of BH providers who have received specialized training in evidenced-based practice.
- Collaborate with MCOs and LDH to distribute American Academy of Pediatrics (AAP) ADHD Toolkit to PCPs with pediatric patients.

Performance Measures: HEDIS® 2017 (Measurement Year 2016)

MCO-reported performance measures were validated as per HEDIS® 2017 Compliance Audit™ specifications developed by the National Committee for Quality Assurance (NCQA). The results of each MCO's HEDIS® 2017 Compliance Audit are summarized in its Final Audit Report (FAR).

The HEDIS® 2017 FAR prepared for LHCC by Attest Health Care Advisors indicates that the MCO demonstrated compliance with all areas of Information System Capabilities Assessment (ISCA) and all areas of measure determination required for successful HEDIS® reporting.

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® 2015, HEDIS® 2016 and HEDIS® 2017, Healthy Louisiana 2017 statewide averages and *Quality Compass*® 2017 South Central – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

Table 5: HEDIS® Effectiveness of Care Measures – 2015-2017

Measure	LHCC			QC 2017 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded	Healthy Louisiana 2017 Average
	HEDIS® 2015	HEDIS® 2016	HEDIS®2017		
Adult BMI Assessment	68.10%	69.05%	85.36%	50th	80.75%
Antidepressant Medication Management - Acute Phase	NR	NR	44.50%	25th	47.89%
Antidepressant Medication Management - Continuation Phase	NR	NR	28.17%	25th	33.04%
Asthma Medication Ratio (5-64 Years)	49.87%	46.89%	55.33%	10%	57.25%
Breast Cancer Screening in Women	54.10%	55.97%	57.25%	66.67th	55.84%
Cervical Cancer Screening	55.29%	54.86%	56.39%	33.33rd	59.01%
Childhood Immunization Status - Combination 3	55.48%	40.87%	67.31%	33.33rd	68.04%
Chlamydia Screening in Women (16-24 Years)	57.78%	61.78%	64.13%	95th	63.21%
Comprehensive Diabetes Care - HbA1c Testing	81.86%	79.72%	74.13%	10th	77.35%
Controlling High Blood Pressure	34.95%	42.24%	39.45%	10th	37.07%
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	44.20%	58.43%	53.83%	25th	56.60%
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	36.00%	47.45%	40.44%	25th	44.55%
Medication Management for People With Asthma Total - Medication Compliance 75% (5-64 Years)	19.73%	20.41%	19.94%	10th	24.10%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile	42.38%	50.48%	56.25%	25th	53.77%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	48.57%	43.27%	58.17%	25th	54.90%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity	37.86%	32.69%	44.23%	25th	41.10%

NR: Not reported

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® 2015, HEDIS® 2016 and HEDIS® 2017, Healthy Louisiana 2017 statewide averages and *Quality Compass*® 2017 South Central – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

Table 6: HEDIS® Access to/Availability of Care Measures – 2015-2017

Measure	LHCC			QC 2017 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded	Healthy Louisiana 2017 Average
	HEDIS® 2015	HEDIS® 2016	HEDIS®2017		
	Children and Adolescents' Access to PCPs				
12–24 Months	94.66%	95.71%	96.67%	50th	96.17%
25 Months–6 Years	84.01%	85.78%	87.97%	50th	87.64%
7–11 Years	85.58%	85.62%	89.29%	33.33rd	89.29%
12–19 Years	84.60%	85.16%	88.35%	33.33rd	88.47%
	Adults' Access to Preventive/Ambulatory Services				
20–44 Years	77.64%	77.00%	81.64%	66.67th	82.22%
45–64 Years	87.60%	86.54%	88.09%	50th	88.56%
65+ Years	74.29%	74.49%	87.57%	50th	87.23%
	Access to Other Services				
Timeliness of Prenatal Care	84.95%	78.04%	80.94%	33.33rd	80.77%
Postpartum Care	50.23%	58.23%	64.85%	66.67th	63.80%

HEDIS® Use of Services Measures

This section of the report explores utilization of LHCC'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® 2015, HEDIS® 2016 and HEDIS® 2017, Healthy Louisiana 2017 statewide averages and *Quality Compass*® 2017 South Central – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

Table 7: Use of Services Measures – 2015-2017

Measure	LHCC			QC 2017 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded	Healthy Louisiana 2017 Average
	HEDIS® 2015	HEDIS® 2016	HEDIS®2017		
Adolescent Well-Care Visit	50.24%	51.68%	52.64%	50th	54.70%
Ambulatory Care Emergency Department Visits/1000 Member Months[1]	74.04	67.39	67.62	33.33rd	73.88
Ambulatory Care Outpatient Visits/1000 Member Months	356.09	371.83	371.65	50th	400.17
Frequency of Ongoing Prenatal Care - ≥ 81%	56.11%	61.34%	64.60%	33.33rd	67.71%
Well-Child Visits in the First 15 Months of Life 6+ Visits	52.64%	52.19%	52.29%	10th	56.06%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	60.82%	66.59%	66.13%	33.33rd	65.68%

[1] A lower rate is desirable.

Member Satisfaction: Adult and Child CAHPS® 5.0H

In 2017, 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 LHCC by the NCQA-certified survey vendor, Morpace. 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 LHCC's CAHPS® rates for 2015, 2016 and 2017, 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 – 2015-2017

Measure[1]	LHCC			QC 2017 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded
	CAHPS® 2015	CAHPS® 2016	CAHPS® 2017	
Getting Needed Care	77.80%	79.10%	83.09%	50th
Getting Care Quickly	76.30%	76.90%	80.76%	25th
How Well Doctors Communicate	88.10%	90.40%	91.02%	33.33rd
Customer Service	88.80%	90.30%	93.14%	95th
Shared Decision Making[2]	73.20%	79.00%	73.23%	<10th
Rating of All Health Care	71.70%	75.90%	73.02%	10th
Rating of Personal Doctor	80.50%	84.80%	82.66%	50th
Rating of Specialist	77.90%	84.10%	87.59%	90th
Rating of Health Plan	78.80%	78.50%	77.20%	33.33rd

[1] 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".
[2] In 2015, NCQA revised measure specifications and response options.

Table 9: Child CAHPS® 5.0H General Population – 2015-2017

Measure[1]	LHCC			QC 2017 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded
	CAHPS® 2015	CAHPS® 2016	CAHPS® 2017	
Getting Needed Care	85.80%	92.30%	89.13%	66.67th
Getting Care Quickly	92.10%	93.60%	92.98%	75th
How Well Doctors Communicate	93.20%	93.60%	94.09%	66.67th
Customer Service	89.10%	89.60%	90.32%	50th
Shared Decision Making[2]	74.80%	76.60%	77.97%	25th
Rating of All Health Care	84.10%	87.60%	88.12%	33.33rd
Rating of Personal Doctor	87.50%	90.80%	88.42%	10th
Rating of Specialist	87.40%	SS	85.85%	10th
Rating of Health Plan	84.80%	88.50%	90.11%	66.67th

[1] 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".
[2] In 2015, NCQA revised measure specifications and response options.
SS: Small sample (less than 100 responses)

Table 10: Child CAHPS® 5.0H CCC Population – 2015-2017

Measure[1]	LHCC			QC 2017 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded
	CAHPS® 2015	CAHPS® 2016	CAHPS® 2017	
Getting Needed Care	88.70%	91.10%	91.75%	75th
Getting Care Quickly	92.10%	94.70%	94.49%	50th
How Well Doctors Communicate	92.80%	93.30%	95.25%	66.67th
Customer Service	89.20%	87.50%	93.91%	90th
Shared Decision Making[2]	82.30%	84.10%	83.85%	33.33rd
Rating of All Health Care	83.60%	87.90%	85.98%	33.33rd
Rating of Personal Doctor	86.10%	89.20%	90.06%	50th
Rating of Specialist	84.50%	88.00%	87.37%	33.33rd
Rating of Health Plan	82.40%	87.60%	89.82%	75th

[1] 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".
[2] In 2015, NCQA revised measure specifications and response options.

Health Disparities

For this year's technical report, 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.

LHCC reported that the following activities and interventions took place between 2016 and 2017 to identify and/or address disparities in health outcomes and/or health care among its Medicaid population:

In March 2016, an analysis was conducted to analyze health disparities. The data was examined and the HEDIS® Committee determined that the initiative they would focus on would be the post-partum measure. Interventions to reduce the disparity began in September 2016, and included targeted telephonic outreach in Spanish, birth notification outreach had a language column added, and assurance that CentAccount information goes out in Spanish. The results of these interventions were successful. By the end of the HEDIS year, the post-partum measure disparity between English speakers and Spanish speakers reduced to just 2.24% from 12.99% in August 2016.

Community Health Service Representatives are located in each region. These representatives are field personnel who provide health coaching as well as assistance with connecting members to needed services and/or case management. The placement of Community Health Service Representatives into the community is part of the LHCC Member Connections Maturity Model which was implemented in 2017. These representatives address both social and health needs of the members and partner with the Medical Management personnel. Current targeted focus areas are preventable readmissions coaching, community outreach, and ED frequent flyer coaching.

An assessment of the 2017 LHCC population, including member receiving supplemental security income (SSI) or Temporary Assistance for Needy Families (TANF), Medicaid expansion members and behavioral health members was completed in October 2017 by the LHCC Medical Management department. Data utilized for assessment of the entire member population includes information provided by the Centers for Medicare & Medicaid (CMS) and/or the state agency and included information such as age, gender, ethnicity, race, and/or primary language, and benefit category.

The MCO reported that the following interventions were implemented to address disparities in care and to improve the quality of care for members identified with high-risk characteristics:

- Integrated Care Management Model: Transitioned to the Integrated Care Management Model which focuses on member-centric care management with one care management point of contact and supporting integrated care management team.

- Community Health Representatives Program: Implementation of field personnel who provide health coaching as well as assistance with connecting members to needed services and/or case management. The placement of Community Health Service Representatives into the community is part of LHCC Member Connections Maturity Model. These representatives address both social and health needs of the members and partner with the Medical Management personnel. Current targeted focus areas are preventable readmissions coaching, community outreach and emergency department frequent flyer coaching.

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 late 2018-early 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 LHCC's compliance with contractual requirements during the period of September 1, 2015 through August 31, 2016.

The 2017 Compliance Audit included a comprehensive evaluation of LHCC'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 LHCC'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
Full	The MCO has met or exceeded the standard
Substantial	The MCO has met most of the requirements of the standard but has minor deficiencies.
Minimal	The MCO has met some of the requirements of the standard, but has significant deficiencies that require corrective action.
Not Met	The MCO has not met the standard.

Findings from LHCC'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

Audit Domain	Total Elements	Full	Substantial	Minimal	Not Met	Not Applicable	% Full
Benefits and Services	123	122	0	0	0	1	100%
Provider Network	163	157	6	0	0	0	96%
Utilization Management	92	90	1	0	0	1	99%
Eligibility, Enrollment and Disenrollment	13	13	0	0	0	0	100%
Marketing and Member Education	77	75	0	0	0	2	100%
Member Grievances and Appeals	62	61	1	0	0	0	98%
Quality Management	86	85	0	0	0	1	100%
Reporting	1	1	0	0	0	0	100%
Fraud Waste and Abuse	105	105	0	0	0	0	100%
Total	722	709	8	0	0	5	99%

It is IPRO's and the LDH's expectation that LHCC submit a corrective action plan for each of the 8 elements determined to be less than fully compliant along with a timeframe for completion. It should be noted that LHCC 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. Five (5) of the 8 elements rated less than fully complaint 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 LHCC.

VI. STRENGTHS, OPPORTUNITIES FOR IMPROVEMENT & RECOMMENDATIONS

This section summarizes the accessibility, timeliness and quality of services provided by LHCC 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) –
  - The 2017 HEDIS® Final Audit Report revealed no significant problems and the MCO was able to report all required Medicaid rates.
  - LHCC met or exceeded the 75th percentile for the following HEDIS® measure:
    - *Chlamydia Screening in Women (16-24 Years)*
- CAHPS® (Member Satisfaction) – LHCC met or exceeded the 75th percentile for the following CAHPS® measures:
  - Adult CAHPS®
    - *Customer Service*
    - *Rating of Specialist*
  - Child CAHPS® General Population
    - *Getting Care Quickly*
  - Child CAHPS® CCC Population
    - *Getting Needed Care*
    - *Customer Service*
    - *Rating of Health Plan*
- Compliance – The MCO achieved "full" compliance in six (6) of the nine (9) domains reviewed.

Opportunities for Improvement

- HEDIS® (Quality of Care) – LHCC demonstrates an opportunity for improvement in the following areas of care as performance was below the 50th percentile:
  - *Antidepressant Medication Management – Acute Phase*
  - *Antidepressant Medication Management – Continuation Phase*
  - *Asthma Medication Ratio (5-64 Years)*
  - *Cervical Cancer Screening*
  - *Childhood Immunization Status – Combination 3*
  - *Comprehensive Diabetes Care – HbA1c Testing*
  - *Controlling High Blood Pressure*
  - *Follow-up Care for Children Prescribed ADHD Medication – Continuation and Maintenance Phase*
  - *Follow-up Care for Children Prescribed ADHD Medication – Initiation Phase*
  - *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*
    - *7-11 Years*

        - *12-19 Years*
    - *Adults' Access to Preventive/Ambulatory Services*
        - *20-44 Years*
    - *Timeliness of Prenatal Care*
    - *Frequency of Ongoing Prenatal Care - ≥81%*
    - *Well-Child Visits in the First 15 Months of Life – 6+ Visits*
    - *Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life*
- § CAHPS® (Member Satisfaction) – LHCC demonstrates an opportunity for improvement in regard to member satisfaction. The MCO performed below the 50th percentile for the following measures:
    - Adult CAHPS®
        - *Getting Care Quickly*
        - *How Well Doctors Communicate*
        - *Shared Decision Making*
        - *Rating of All Health Care*
        - *Rating of Health Plan*
    - Child CAHPS® General Population
        - *Shared Decision Making*
        - *Rating of All Health Care*
        - *Rating of Personal Doctor*
        - *Rating of Specialist*
    - Child CAHPS® CCC Population
        - *Shared Decision Making*
        - *Rating of All Health Care*
        - *Rating of Specialist*

Recommendations

- § The MCO should continue to work to improve HEDIS® rates that perform below the 50th percentile. As most HEDIS® rates have trended upward, the MCO should continue the intervention strategy described in the MCO's response to the previous year's recommendation. However, for rates that have declined, the MCO should evaluate the effectiveness of related interventions and modified these interventions based on current root cause analyses. *[Repeated recommendation.]*
- § In regard to access to primary care, the MCO should continue with the improvement strategy outlined in its in response to the previous year's recommendation as access to primary care rates have trended upward for all age groups. The MCO should continue its root cause analysis on access to ambulatory care for the 7-11 and 12-19 years age groups and implement targeted interventions to address identified barriers. *[Repeated recommendation.]*
- § The MCO should continue to work to improve CAHPS® measures that perform below the 50th percentile. In addition to the improvement strategy described in the MCO's response to the previous year's recommendation, the MCO should consider the use of additional data sources to drive improvement initiatives. Additionally, correlations between CAHPS® scores and HEDIS® rates should be identified to maximize opportunities for improvement. *[Repeated recommendation.]*

Response to Previous Year's Recommendations

- § 2015-2016 Recommendation: The Health Plan should continue to work to improve HEDIS® rates that perform below the 50th percentile using the intervention strategy outline in the Plan's response to the previous year's recommendation coupled with a more targeted approach for rates for which improvement has not been achieved. *[Repeated recommendation.]*

MCO Response: HEDIS is monitored, evaluated and assessed in the HEDIS Steering Committee. The committee is composed of key members from each department within the plan. The committee reviews the detailed rates and trends month over month to formulate a course of action, monitor interventions and identify possible barriers to the interventions. A predictive model of the HEDIS measures has also been created to provide additional information and data to identify potential risks and changes in rates. The HEDIS team and Data Analytics team work together to analyze the monthly HEDIS rates specifically for any changes in the numerators and denominators. Any identified discrepancies are reported to the committee and addressed.

The following interventions were implemented to improve member care and close HEDIS gaps:

- HEDIS Steering Committee developed a strategic plan for improving LHCC's HEDIS measures
- A HEDIS Summit was presented to LHCC leadership and management team to communicate the strategic plan along with each department's role and responsibility related to improving overall HEDIS scores
- Partnered with U.S. Medical Management (USMM), to have providers who make home visits to evaluate members, assess their overall health needs, and complete any gaps in care noted in the member records
- Altegra and LHCC Health Care Coordinators conducted three way calls with members and providers to schedule appointments for members with care gaps
- Maintained HEDIS score cards for provider consultants and Patient Centered Medical Home to educate and inform providers of their quality metrics and how to improve their outcomes
- Health fair events were held to reach members who needed screenings and provide these services in convenient locations for our members
- Maintained a HEDIS call center with a primary focus of reaching out to members and providers to set up appointments, address PCP changes, OTC, Voinace (translators) and arrangement for transportation if necessary
- Enrolled members in corporate programs to send immunization reminders to all members in the age group meeting criteria for both well-child 3-6 and adolescent well-care
- Sent well-child birthday cards reminding members meeting age specific criteria for well-child 3-6 and adolescent well-care visits to see their PCPs for screenings
- Member Connections and Quality Improvement staff educated members and providers on CentAccount program and rewards
- Included articles in newsletters related to the screenings and appropriate care

- 2015-2016 Recommendation: Although there remains an opportunity for improvement in regard to access to care, the Health Plan should continue with the improvement strategy outlined in its in response to the previous year's recommendation as access to primary care rates have trended upward for all child and adolescent groups. The Health Plan should continue its root cause analysis on access to ambulatory care for the adult population and implement targeted interventions to address identified barriers. *[Repeated recommendation.]*

  MCO Response: In order to understand and assess lower than average access and barriers to primary care, LHCC completed an Emergency Department (ED) Diversion Review between January 1, 2015 & August 2, 2015. The study included members with three or more ED visits within a 90-day period and covered the time frame. Root-cause analysis revealed the following most common reasons for utilizing the ED instead of the primary care physician's office:
  - Life-threatening condition
  - Physician accessibility - outside of office hours
  - ED is member's preference for care

- Not actively seeing PCP
- Instructed by PCP during office hours
- Physician accessibility – unable to get appointment
- Multiple other reasons included no contracted urgent care center in area, ER encouraged return visit, and knowledge deficit

As a result of the 2015 ED Diversion Review and root cause analysis, LHCC implemented and has continued the following interventions and member-level outreach activities:

- Referrals to Care Management, Behavioral Health, and Disease Management resources
- Physician collaboration-assisting member with obtaining a PCP
- Physician collaboration-coordinating physician appointment
- Provided transportation resources
- Education on disease process, home care/self-management, medication regimen, and PCP/UCC/ED utilization
- Detailed reporting to the Provider Consultant team to address providers through education and discussion related to high ED utilization by the members in their care
- Educating members post-hospitalization on the importance of following up with their PCP
- Updating the provider appointment availability surveys to include the assessment of the 1st, 2nd, and 3rd appointment availability to better identify potential barriers for appointment access
- Utilizing a system of outreach targeting high risk members for assistance in the provision of home based primary care

It is expected that access to primary care metrics will increase and meet or exceed targets as a result of the interventions completed. The Plan will review all metrics and results for monitoring to determine effectiveness through the monthly conducted PIT meetings, where findings are reviewed and action items based on results are implemented.

- 2015-2016 Recommendation: While there remains an opportunity for improvement in regard to member satisfaction, the Health Plan should continue with the improvement strategy outlined in its response to the previous year's recommendation as most CAHPS® rates trended upward. However, for the scores that have declined, the Health Plan should modify its intervention strategy based on root cause analysis. *[Repeated recommendation.]*

  MCO Response: LHCC conducted a Member Satisfaction Analysis including member complaints/grievances and the Member Satisfaction Survey. Key findings indicated that the members' most common areas of dissatisfaction in member experience were in areas of Care Coordination by the Providers, Access to Care and Attitude and Service. The Member Satisfaction Survey reflects common areas of concern such as adults getting care quickly, child coordination of care, adult health promotion and education, and adult rating of specialists. The Coordination of Care by Providers is indicative of the members perception of their provider's understanding of the entire scope of services or specialties involved with their care. The Member Satisfaction Survey is supported by the analysis of the member grievances received in 2015 and 2016 which indicate specific subcategories containing member grievance expressions for access to care issues (involving "getting care quickly" and "getting needed care"). These grievances reflect the members' concerns related to the inability to obtain a requested service and barriers such as transportation and eligibility concerns. The member grievances in the category of Attitude and Services define many of the members' interpersonal experiences such as physician communication, health promotion, and care coordination concerns. These grievances also contain quality of service issues related to transportation.
  As a result, the following interventions/actions were implemented:

- LHCC staff educated members/provider with verbal telephone discussion, including contacts related to grievances, appeals, and problem resolution. All communication will contain appropriate information in layman's terms and provide appropriate contact numbers for further assistance, if needed. All available resources will be identified for the member or provider's review.
- LHCC staff educated the provider with each request for appeal of denied services. Educational opportunities will be identified with verbal (telephone) contact related to the appeal process and documents needed to meet medical necessity, including identification of any missing clinical documentation required.
- Customer Service Representatives conduct end-of-call surveys, requesting if the members' needs are being met. Results are entered into CRM for tracking and analysis.
- Broadened implementation of end-of-all surveys to all member-facing/touching departments.
- Performed member outreach to frequent callers based on bi-weekly report (call top 10-20 members listed as frequent callers) and assure that member's needs are met and satisfaction is noted.
- The MCO tracked and trended member grievances and dissected information into sub-categories to truly identify root cause of the grievances, identifying areas of need for specific and timely intervention. The MCO also increased interdepartmental communication in regard to resolving member grievances in a more efficient manner.
- The MCO assessed the sufficiency of providers who can assist with language barriers and translation needs.
- The MCO revised birthday mail cards, highlighting well visits which included what the "next steps" should be for the member related to well visits, and sent them out to the members.
- The MCO continues to offer assistance to PCP providers who are open to becoming PCMH certified. Assistance offered is with modifying or creating appropriate policies & procedures, effective member outreach & scheduling, effective usage of their Electronic Medical Records and allowing providers to utilize the MCO's status with NCQA for accreditation purposes.