POLICY AND PROCEDURE

DEPARTMENT: Quality	**DOCUMENT NAME:** Member Experience Analysis
PAGE: 1 of 5	**REPLACES DOCUMENT:**
EFFECTIVE DATE: 08/2020	**REVIEWED/REVISED:** 10/2020, 10/2022
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** LA.QI.06

SCOPE:
Louisiana Healthcare Connections ~~Medical Management~~Quality, Population Health and Clinical ~~Outcomes~~Operations, and Member Services departments.

PURPOSE:
To describe and outline the process for monitoring member experience with health plan services, including non-behavioral health and behavioral health services, and identifying potential areas for improvement.

POLICY:
The health plan conducts an annual assessment of member experience by evaluating member complaints/grievances and appeals, conducting the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey ~~or Qualified Health Plan (QHP) Enrollee Survey for the Marketplace/Exchange product,~~ and a behavioral health member experience survey. Input from the Member Advisory Committee may also be included, if applicable.

Following annual assessment of these data, the health plan identifies opportunities for improvement and sets priorities based on quantitative and qualitative/barrier analysis. The evaluation of the member experience and subsequent initiatives are reported annually to the Quality Committee, and makes the information available to members and providers, as needed or upon request.

PROCEDURE:

A. Annual Assessment of Member Complaints/Grievances and Appeals
    1. The health plan designee collects member complaints/grievances and member appeals by reason/category and reports results for each category, including calculating a rate per 1,000 members for each category and overall. All complaint/grievance and appeal data is aggregated; no sampling is used.
    2. Complaints/grievances and appeals specific to behavioral health services are collected, analyzed, and reported separately from other member complaint/grievance and appeals data.
    3. Complaint/grievance and appeal data may come from medical necessity and benefit appeals and other areas of member dissatisfaction.
    4. The health plan collects and reports complaints/grievances and appeals relating to the following major categories at minimum:
        - Quality of Care
        - Access
        - Attitude and Service
        - Billing and Financial Issues
        - Quality of Practitioner Office Site
    5. Data collection and the initial analysis may be conducted by but not limited to: the Member Services Designee, Appeals and Grievance Coordinator, Member Advocate,

Quality Designee, Member Advisory Committee, or Performance Improvement Team. A quantitative and qualitative analysis of the data collected is performed no less than annually.

6. Data collected must be sufficiently detailed (e.g. by the categories noted above at minimum, and by subcategories for each major category) to identify areas of dissatisfaction on which to act. Data collection involves accurately and consistently coded complaints/grievances and appeals, as well as trending of data over time. Data collected also includes Utilization Management coverage appeals and non-coverage appeals (i.e. appeals of complaints/grievances). A quantitative and qualitative analysis is completed on all data.
7. Complaints/grievances may also be aggregated by provider/provider group, by specialty area, or facility/location.

B. Annual Member Experience Survey

1. The CAHPS ~~and QHP~~ Enrollee surveys are conducted annually by an external National Committee for Quality Assurance (NCQA)-certified vendor. Louisiana Healthcare Connections confirm the survey vendor submitting CAHPS survey data on their behalf each year in the Health Organization Questionnaire (HOQ).
2. The CAHPS survey protocol utilizes the current Health Effectiveness Data and Information Set (HEDIS®). ~~The QHP Enrollee Survey questions align with CAHPS, specific Marketplace/Exchange population questions, and state and/or federal reporting standards.~~
3. The survey and collateral materials (e.g. member letters) are sent to the appropriate agency(s) for review and approval on an annual basis, per state and/or federal requirements.
4. Refer to LA.QI.06.01 CAHPS Work Process for regulatory survey requirements as defined by NCQA.
5. The data responses are reviewed to determine actionable information to improve quality and performance.

C. Behavioral Health Member Experience Survey

1. The behavioral health member experience survey is conducted annually by an external NCQA-certified vendor and/or a vendor designated by the state.~~.~~
2. Members included in the survey sample are those who have accessed behavioral health services through their health plan benefits.
3. Survey results obtained from the behavioral health survey allow the health plan to measure how well providers and the health plan are meeting member's expectations and needs.
4. Survey data can be used to improve the quality of mental health and substance abuse services, evaluate and monitor the quality of behavioral health organizations, and to hold providers accountable through public reports.

D. Analysis & Opportunities for Improvement

1. The health plan's Member Experience Committee ~~Performance Improvement Team~~ or other appropriate committee, identifies processes that may present barriers for improvement of member experience and completes final analysis of the findings.
    - The analysis includes a quantitative analysis of member complaint/grievance data and appeal data that incorporates aggregated results and trends over time. Complaints/grievances and appeals are analyzed for each of the five (5) categories mentioned above (Quality of Care, Access, Attitude and Service, Billing and Financial, and Quality of Practitioner Office Sites) at minimum. Additional categories or subcategories may also be included. Results are compared against a standard or goal.
    - CAHPS ~~and QHP~~ results for the applicable line of business are compared with benchmarks and thresholds published by NCQA, as available. Results are also compared to the health plan and/or state defined goals if different from NCQA. Due to survey questions changing between years, it may not be possible to include the same questions in subsequent annual data analysis.
    - Regional member experience survey data is utilized if available, as aggregate data may not provide sufficient information on what actions would be most effective for different geographic areas.
    - An analysis of complaints/grievance and appeals data by geographic region may also be completed, to ensure the collection of aggregate data does not obscure problems at individual locations.
    - Health plans may use other relevant surveys, such as disenrollment survey results, if the surveys identify opportunities for improvement.
2. The health plan conducts qualitative, i.e. root cause/barrier analysis, and identifies and prioritizes opportunities based on the analysis and significance to members.
3. For each opportunity identified, the health plan notes whether the opportunity was selected for improvement, prioritizes the actions planned or implemented, the date to be implemented and the relevant barriers.
4. Effectiveness of the interventions is measured at least annually. Evaluation of the effectiveness of the interventions is in measurable terms and includes initial and re-measurement against a goal and benchmark.
5. New or revised interventions or actions may be implemented based on the measurement results and will be included in subsequent annual assessment.

E. Communicating Results

1. The final member experience assessment results, proposed actions for improvement and subsequent improvement outcomes are reported at least annually to the health plan Quality Committee and included as part of the annual Quality Program Evaluation.
2. Members and providers may be notified of member experience results through newletters, website posting, etc. as needed or upon request.

REFERENCES:

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DEPARTMENT: Quality	**DOCUMENT NAME:** Member Experience Analysis
PAGE: 4 of 5	**REPLACES DOCUMENT:**
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Current NCQA Health Plan Accreditation Standards and Guidelines
NCQA HEDIS Volume 3 Specifications

ATTACHMENTS:

DEFINITIONS:
CAHPS®: Consumer Assessment of Healthcare Providers and Systems - a set of standardized surveys that measure patient satisfaction with the experience of care. CAHPS is sponsored by the Agency for Health Care Research and Quality (AHRQ).
HEDIS®: Healthcare Effectiveness Data and Information Set - a set of standardized performance measures designed to allow reliable comparison of the performance of managed health care plans.
HOQ: Healthcare Organization Questionnaire documents a health plan's validation and attestation of the HEDIS submissions, products, surveys, and vendors that the health plan is using for the upcoming HEDIS year.
~~Qualified Health Plan (QHP) Enrollee Survey: a satisfaction survey that assesses member experience with the Marketplace/Exchange health plans.~~
Qualitative Analysis: An examination of deficiencies or processes that may present barriers to improvement or cause failure to reach a stated goal. Also called a *causal, root cause* or *barrier* analysis. The analysis involves those responsible for the execution of the program.
Quantitative Analysis: A comparison of numeric results against a standard or benchmark, trended over time using charts, graphs or tables. Unless specified, tests of statistical significance are not required, but may be useful when analyzing trends.

REVISION LOG:	DATE
Converted corporate to local policy.	10/2020
Language added to align with corporate policy; removed reference to the QHP Marketplace survey; Updated Performance Improvement Team to Member Experience Committee; added definition of HOQ.	10/2022

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Archer is considered equivalent to a physical signature.

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