



LOUISIANA HEALTHCARE CONNECTIONS, INC. Annual External Quality Review Technical Report

Review Period: July 1, 2013 – June 30, 2014
April 2015

*Prepared on Behalf of
The State of Louisiana
Department of Health & Hospitals*

IPRO Corporate Headquarters
Managed Care Department
1979 Marcus Avenue
Lake Success, NY 11042-1002
phone: (516) 326-7767
fax: (516) 326-6177
www.ipro.org

TABLE OF CONTENTS

I. INTRODUCTION	1
II. MCO CORPORATE PROFILE.....	2
III. ENROLLMENT AND PROVIDER NETWORK.....	3
Enrollment	3
Provider Network	4
IV. QUALITY INDICATORS	5
Performance Improvement Projects	5
Performance Measures: HEDIS® 2014 (Measurement Year 2013)	8
Member Satisfaction: Adult and Child CAHPS® 5.0H	11
V. COMPLIANCE MONITORING.....	13
Medicaid Compliance Review Findings for Contract Year 2014-2015	13
VI. STRENGTHS, OPPORTUNITIES FOR IMPROVEMENT & RECOMMENDATIONS	16
Strengths.....	16
Opportunities for Improvement	16
Recommendations.....	17
Response to Previous Year’s Recommendations.....	17
VII. REFERENCES	ERROR! BOOKMARK NOT DEFINED.

LIST OF TABLES

Table 1. Corporate Profile	2
Table 2. Medicaid Enrollment as of December 2014.....	3
Table 3. Primary Care & OB/GYN Counts by GSA	4
Table 4. PCMH Recognition as of June 2014.....	4
Table 5. HEDIS® Effectiveness of Care Measures – Measurement Year 2013 (HEDIS® 2014).....	9
Table 6. HEDIS® Access to/Availability of Care Measures – Measurement Year 2013 (HEDIS® 2014).....	10
Table 7. Use of Services Measures – Measurement Year 2013 (HEDIS® 2014).....	10
Table 8. Adult CAHPS® 5.0H	11
Table 9. Child CAHPS® 5.0H – General Population	12
Table 10. Child CAHPS® 5.0H – CCC Population.....	12
Table 11. 2014 Annual Compliance Review Determination Description.....	13
Table 12. Overall Compliance Determination by Domain	14
Table 13. Elements Requiring Corrective Action by Review Area.....	15

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 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 State of Louisiana’s Department of Health & Hospitals (DHH) contracted with IPRO to assess and report the impact of its Medicaid managed care program, the Bayou Health Program, and each of the participating Health Plans on the accessibility, timeliness and quality of services. Specifically, this report provides IPRO’s independent evaluation of the services provided by Louisiana Healthcare Connections, Inc. (LHCC) for review period July 1, 2013 – June 30, 2014.

The framework for IPRO’s assessment is based on the guidelines and protocols established by CMS, as well as 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 2014 *Quality Compass*® 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 the LA EQRO 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. Corporate Profile

Louisiana Healthcare Connections, Inc.	
Type of Organization	Health Maintenance Organization (HMO)
Tax Status	For Profit
Year Operational	02/01/2012
Product Line(s)	Medicaid
Total Medicaid Enrollment (as of December 2014)	152,233

III. ENROLLMENT AND PROVIDER NETWORK

Enrollment

Medicaid Enrollment

As of December 2014, the Health Plan’s Medicaid enrollment totaled 152,233, which represents 16% of Bayou Health’s active members. Table 2 displays LHCC’s Medicaid population across the three (3) Geographic Service Areas (GSAs), as well as the statewide enrollment totals. Figure 1 displays Bayou Health’s membership distribution across all Health Plans.

Table 2. Medicaid Enrollment as of December 2014¹

LHCC	2013	2014	% Change	2014 Statewide Total ²
GSA A	48,224	49,120	1.86%	280,483
GSA B	47,224	47,780	1.18%	324,664
GSA C	54,586	55,333	1.37%	318,993
Total Enrollment	150,034	152,233	1.47%	924,140

Data Source: Report No. 125-A

¹This report shows all active members in Bayou Health as of the end of the reporting month. Members who will be disenrolled at the end of the reporting month are included in this report. Enrollees who gain and lose eligibility during the reporting month are not included. Enrollees who opt out of Bayou Health during the reporting month are not included.

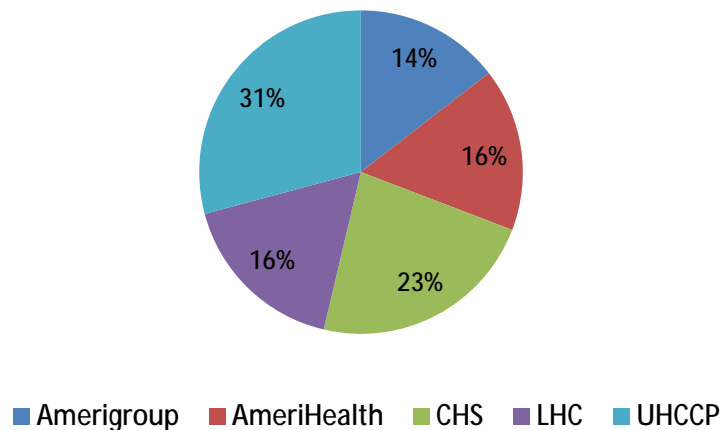
²Note: Total includes membership of all plans.

GSA A: New Orleans and North Shore

GSA B: Baton Rouge, Lafayette and Thibodaux

GSA C: Alexandria, Lake Charles, Monroe and Shreveport

Figure 1. Bayou Health Membership by Health Plan as of December 2014



Provider Network

Providers by Specialty

Table 3 shows the sum of primary care providers, other physicians with primary care responsibilities and OB/GYNs as of fourth quarter 2014.

Table 3. Primary Care & OB/GYN Counts by GSA

Specialty	GSA A	GSA B	GSA C	MCO Statewide Unduplicated
Family Practice/General Medicine	167	219	282	636
Pediatrics	191	196	157	503
Nurse Practitioners	177	216	259	608
Internal Medicine ¹	171	151	113	409
RHCS/FQHC	46	73	113	227
OB/GYN ¹	13	6	2	19

Data source: Network Adequacy Review 2014 Q4

GSA: 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

Status of Patient-Centered Medical Home (PCMH) Recognition

Patient-Centered Medical Home (PCMH) is a system of care led by a team of primary care providers who partner with the patient, the patient's family and the community to coordinate care in all settings, from specialists and hospitals to pharmacies, mental health programs, and home health agencies. The DHH requires that each Medicaid Health Plan promote and facilitate the capacity of primary care practices to function as patient-centered medical homes by using systematic, patient-centered and coordinated care management processes; and to receive National Committee on Quality Assurance (NCQA) Physician Practice Connections®-Patient Centered Medical Home (PPC®-PCMH) recognition or Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Primary Care Home (PCH) accreditation.

LHCC's PCMH recognition as of June 2014 is displayed in Table 4.

Table 4. PCMH Recognition as of June 2014

Number of PCP Sites Contracted with MCO	Number of PCP Sites PCMH Certified or Accredited	Percentage of PCP Sites PCPMH Certified or Accredited
927	79 ¹	8.5%

¹ Total includes providers who have achieved Level 1, Level 2 and Level 3 Recognition.

IV. QUALITY INDICATORS

To measure quality of care provided by the Health Plans, 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

A Performance Improvement Project (PIP) is intended to improve the care, services or member outcomes. DHH selects PIP topics to be performed by the Health Plans, and the Health Plans also select topics individually, that address specific areas of concern.

During this reporting period, each Health Plan was required to perform a minimum of two (2) State-approved PIPs. One (1) PIP was a common topic that all Health Plans addressed, and the second was selected by the Health Plan from a list of State-approved topics. The DHH-required common PIP was “Ambulatory Care Measure – ED Visit Category”. The Health Plan-selected PIP was and “Cervical Cancer Screening”.

In accordance with 42 CFR §438.358, IPRO conducted a review and validation of these PIPs using methods consistent with the CMS protocol for validating performance improvement projects. Summaries of each of the PIPs conducted by LHCC follow.

State-Directed PIP #1: Ambulatory Care – ED Visit Category

Indicator/Goal: The indicator for this PIP is the HEDIS® *Ambulatory Care – ED Visits* measure - the number of ED visits per 1000 member months that did not result in an inpatient stay during the measurement year.

The Health Plan's goal for this PIP is to meet or exceed the NCOA 2011 50th percentile of 65.65%.

Intervention Summary:

- § Increase providers that are certified as Medical Homes
- § Medical Management follow-up with members after discharge from the ED
- § Monetary payment to providers for after hours service
- § Member outreach on primary care and preventive service

Results: The Health Plan's baseline was the 74.89 (HEDIS® 2013). Preliminary reports for the end of 2013 show the Health Plan's ambulatory care-ED admissions as 74.04 (HEDIS® 2014), which is lower than the baseline.

Overall Credibility of Results: There were no validation findings that indicate that the credibility of the PIP results is at risk.

Strengths:

- § Literature review conducted with a strong rationale and nationwide and local performance cited.
- § Plan conducted a pilot study/ task force in preparation for the PIP.
- § Interventions targeted toward both members and providers and designed to address noted barriers. Interventions linked to Case Management, Pay for Performance and PCMH initiatives.
- § Focus on high utilizers.
- § A quantifiable and achievable goal was established.

Opportunities for Improvement:

- § As the project progresses, the Health Plan should try to assess which of its interventions are most successful in impacting the ED rate and which should be continued.

Health Plan-Selected PIP: Cervical Cancer Screening

Indicator/Goal: The indicator for this PIP is the HEDIS® *Cervical Cancer Screening* measure: *the percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer with no more than one gap in enrollment of up to 45 days during the measurement year.*

The Health Plan's goal for this PIP is to meet the NCQA 2011 Medicaid 50th percentile of 69.72%.

Intervention Summary:

- § Member compliant lists sent to providers
- § Provider profiling
- § Provider Pay for Performance for conducting cervical cancer screenings
- § Member and provider outreach calls
- § Encourage practices to become PCMH certified

Results: The Health Plan's cervical cancer screening rate as of May 2013 was 43.33%, up from 40.18% at baseline (March 2013) but below the NACQ benchmark.

Overall Credibility of Results: There were no validation findings that indicate that the credibility of the PIP results is at risk. The credibility of the findings has been maintained.

Strengths:

- § Strong rationale with historical data cited for the region.
- § Use of a standard measure to track performance (HEDIS® *Cervical Cancer Screening* measure).
- § Performance tracked monthly, which will allow for continual monitoring of interventions.
- § A multifaceted approach is planned with interventions focused on members and providers and linked to noted barriers.

Opportunities for Improvement:

- § Given the number of interventions that are being implemented, it would be helpful to design process measures to determine their effectiveness. Process measures will help the plan evaluate the effectiveness of the specific interventions. In this way, interventions which may not be working as planned can be modified or discarded.
- § The HEDIS® *Cervical Cancer Screening* measure has been revised for 2014 reporting. NCQA has determined that the measure is considered a first year measure in 2014. The Health Plan should note that its monthly tracking followed the administrative specifications and its 2014 audited rate to be report in June 2014 will follow the new specifications. For trending, the Health Plan can use the Step 1 rate, which corresponds to the specifications in 2013.
- § The Health Plan should consider promotion of HPV vaccination as part of your intervention strategy.
- § As the project progresses, the Health Plan may want to develop process measures to evaluate the effectiveness of its interventions.

Performance Measures: HEDIS® 2014 (Measurement Year 2013)

MCO-reported performance measures were validated as per HEDIS® 2014 Compliance Audit™ specifications developed by the National Committee for Quality Assurance (NCQA). The results of each MCO's HEDIS® 2014 Compliance Audit are summarized in its Final Audit Report (FAR).

The HEDIS® 2014 Final Audit Report (FAR) prepared for LHCC by Attest Health Care Advisors indicates that the Health Plan demonstrated compliance with all areas of Information Systems 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 Health Plan provides preventive screenings and care for members with acute and chronic illnesses. Table 5 displays select HEDIS® Effectiveness of Care measure rates for Measurement Year 2013 (HEDIS® 2014) as compared to *Quality Compass*® 2014 national Medicaid benchmarks.

Table 5. HEDIS® Effectiveness of Care Measures – Measurement Year 2013 (HEDIS® 2014)

Measure	LHCC HEDIS® 2014	Quality Compass® 2014 National Medicaid Benchmarks					
		National Average	P10	P25	P50	P75	P90
Adult BMI Assessment	54.06%	75.91%	64.35%	71.54%	78.78%	85.09%	90.82%
Antidepressant Medication Management - Acute Phase	NR	50.51%	41.87%	45.07%	49.67%	54.39%	60.86%
Antidepressant Medication Management - Continuation Phase	NR	35.18%	27.03%	29.90%	33.93%	38.25%	44.62%
Asthma Medication Ratio (5-64 Years)	58.93%	65.45%	53.29%	60.48%	66.37%	70.88%	76.23%
Breast Cancer Screening in Women	SS	57.90%	46.59%	51.21%	57.42%	65.12%	71.35%
Cervical Cancer Screening ¹	57.31%						
Childhood Immunization Status - Combination 3	37.04%	70.85%	58.70%	66.67%	72.33%	77.78%	80.86%
Chlamydia Screening in Women (16-24 Years)	56.83%	54.90%	41.19%	48.86%	54.97%	62.57%	67.19%
Comprehensive Diabetes Care - HbA1c Testing	73.51%	83.80%	77.55%	80.18%	83.87%	87.59%	91.73%
Comprehensive Diabetes Care - LDL-C Screening	67.99%	75.97%	66.87%	71.30%	76.87%	80.18%	83.71%
Controlling High Blood Pressure	37.39%	56.47%	43.07%	48.53%	56.20%	63.76%	69.79%
Cholesterol Management for Patients With Cardiovascular Conditions – LDL-C Control (<100 mg/dL)	NR	81.07%	74.57%	78.33%	81.45%	84.91%	87.84%
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	47.86%	46.35%	23.12%	37.17%	49.51%	57.55%	63.10%
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	41.81%	39.56%	21.77%	32.61%	41.09%	46.99%	53.03%
Lead Screening in Children	64.13%	66.46%	37.23%	58.39%	70.86%	80.83%	85.84%
Medication Management for People With Asthma Total - Medication Compliance 75% (5-64 Years)	19.11%	31.26%	20.07%	24.55%	30.19%	35.37%	43.08%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile	23.61%	56.92%	32.18%	41.85%	57.40%	73.72%	82.46%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	34.95%	58.70%	40.74%	50.00%	60.58%	69.21%	77.47%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity	24.07%	50.50%	33.77%	41.67%	51.16%	60.82%	69.76%

SS: Sample Size too small to report (less than 30 members).

NR: Not reported.

¹ Benchmarks were not available due to specification changes.

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 select HEDIS® Access to/Availability of Care measure rates for Measurement Year 2013 (HEDIS® 2014) as compared to *Quality Compass*® 2014 national Medicaid benchmarks.

Table 6. HEDIS® Access to/Availability of Care Measures – Measurement Year 2013 (HEDIS® 2014)

Measure	LHCC HEDIS® 2014	Quality Compass® 2014 Benchmarks					
		National Average	P10	P25	P50	P75	P90
Children and Adolescents' Access to PCPs							
12–24 Months	95.26%	96.14%	93.58%	95.92%	96.96%	97.86%	98.53%
25 Months–6 Years	84.12%	88.25%	82.16%	86.07%	89.08%	91.73%	93.58%
7–11 Years	84.69%	90.02%	83.57%	87.78%	91.15%	93.50%	95.19%
12–19 Years	84.02%	88.53%	81.57%	85.83%	89.98%	92.17%	94.42%
Adults' Access to Preventive/Ambulatory Services							
20–44 Years	79.28%	80.71%	68.99%	78.34%	83.22%	86.21%	88.52%
45–64 Years	87.95%	87.34%	80.11%	85.88%	88.76%	90.99%	92.25%
65+ Years	80.29%	85.55%	73.24%	82.35%	88.40%	90.70%	92.61%
Access to Other Services							
Timeliness of Prenatal Care	80.32%	81.93%	69.77%	77.80%	84.30%	89.62%	93.10%
Postpartum Care	41.44%	61.29%	48.37%	56.18%	62.84%	69.47%	74.03%

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 select HEDIS® Use of Services measure rates for Measurement Year 2013 (HEDIS® 2014) as compared to *Quality Compass*® 2014 national Medicaid benchmarks.

Table 7. Use of Services Measures – Measurement Year 2013 (HEDIS® 2014)

Measure	LHCC HEDIS® 2014	Quality Compass® 2014 National Medicaid Benchmarks					
		National Average	P10	P25	P50	P75	P90
Adolescent Well-Care Visits	39.12%	50.03%	37.73%	41.70%	48.51%	59.21%	65.56%
Frequency of Ongoing Prenatal Care - ≥ 81%	55.14%	55.64%	21.74%	43.73%	60.10%	71.34%	78.37%
Well-Child Visits in the First 15 Months of Life 6+ Visits	48.84%	61.55%	45.50%	54.76%	62.86%	69.75%	76.92%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	57.41%	71.49%	60.18%	65.97%	71.76%	77.26%	82.69%

Member Satisfaction: Adult and Child CAHPS® 5.0H

In 2013, 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, The Myers Group. 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 2014 rates in comparison to the *Quality Compass*® 2014 national benchmarks.

Table 8. Adult CAHPS® 5.0H

Measure ¹	LHCC		<i>Quality Compass</i> ® 2014 Benchmarks					
	2013	2014	Average	P10	P25	P50	P75	P90
Getting Needed Care ²	74.70%	73.00%	80.45%	74.70%	77.47%	80.90%	84.27%	85.59%
Getting Care Quickly ²	77.30%	78.70%	81.00%	75.26%	78.39%	81.75%	83.75%	85.52%
How Well Doctors Communicate ²	90.10%	91.20%	89.49%	86.17%	88.16%	89.76%	91.11%	92.42%
Customer Service ²	84.20%	88.00%	86.51%	81.85%	84.45%	87.05%	88.64%	90.28%
Shared Decision Making ²	46.30%	53.90%	51.20%	46.87%	49.07%	50.89%	53.69%	55.49%
Rating of All Health Care	68.80%	67.60%	71.26%	64.32%	68.54%	71.53%	74.06%	76.95%
Rating of Personal Doctor	80.30%	79.60%	78.75%	74.37%	76.45%	78.82%	80.97%	83.10%
Rating of Specialist	82.90%	87.10%	80.42%	75.89%	78.64%	80.61%	82.47%	85.31%
Rating of Health Plan	66.60%	67.90%	74.67%	66.57%	71.37%	75.52%	78.77%	81.49%

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 These indicators are composite measures.

Table 9. Child CAHPS® 5.0H – General Population

Measure ¹	LHCC		Quality Compass® 2014 Benchmarks					
	2013	2014	Average	P10	P25	P50	P75	P90
Getting Needed Care ²	81.20%	85.10%	84.97%	79.05%	82.62%	85.44%	87.90%	90.71%
Getting Care Quickly ²	90.30%	89.50%	89.46%	83.34%	87.67%	90.59%	92.45%	93.81%
How Well Doctors Communicate ²	92.90%	93.00%	92.98%	89.71%	91.96%	93.25%	94.67%	95.61%
Customer Service ²	84.90%	84.70%	87.89%	84.38%	85.98%	88.13%	89.91%	91.03%
Shared Decision Making ²	55.20%	57.50%	54.65%	47.59%	51.79%	54.93%	58.26%	60.32%
Rating of All Health Care	79.70%	80.80%	84.70%	80.94%	82.63%	84.70%	86.65%	88.85%
Rating of Personal Doctor	81.60%	86.90%	87.63%	84.38%	85.89%	87.84%	89.43%	90.93%
Rating of Specialist	67.60%	86.20%	85.02%	80.69%	83.06%	85.01%	87.36%	89.50%
Rating of Health Plan	59.20%	78.60%	84.49%	78.63%	81.85%	84.83%	87.45%	88.66%

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 These indicators are composite measures.

Table 10. Child CAHPS® 5.0H – CCC Population

Measure ¹	LHCC		Quality Compass® 2014 Benchmarks					
	2013	2014	Average	P10	P25	P50	P75	P90
Getting Needed Care ²	82.40%	82.80%	86.67%	82.49%	83.91%	86.94%	89.86%	90.78%
Getting Care Quickly ²	91.30%	91.40%	92.72%	88.21%	91.88%	93.67%	94.41%	95.02%
How Well Doctors Communicate ²	92.10%	92.10%	93.33%	89.85%	92.51%	93.75%	95.02%	95.83%
Customer Service ²	85.10%	86.80%	88.63%	85.00%	86.76%	88.72%	91.13%	91.86%
Shared Decision Making ²	61.50%	54.30%	61.27%	56.84%	59.10%	60.90%	63.93%	65.14%
Rating of All Health Care	79.30%	76.50%	83.33%	76.54%	82.63%	83.73%	85.47%	87.16%
Rating of Personal Doctor	84.20%	83.90%	86.50%	82.54%	85.24%	87.04%	88.28%	89.30%
Rating of Specialist	83.50%	84.10%	84.99%	78.80%	84.08%	85.71%	86.94%	88.05%
Rating of Health Plan	71.30%	72.10%	80.63%	72.35%	77.98%	80.99%	84.16%	86.15%

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 These indicators are composite measures.

V. COMPLIANCE MONITORING

Medicaid Compliance Review Findings for Contract Year 2014-2015

This section of the report presents the results of the reviews by IPRO of LHCC's compliance with regulatory standards and contract requirements for Contract Year 2014-2015. The information is derived from IPRO's conduct of the annual compliance review in January 2015 for the review period July 2013 through December 2014.

For LHCC, this year's review was a combination of an abbreviated compliance review of any standards/elements that were less than fully compliant the previous year, and a readiness review of new or updated standards/elements as a result of contract changes during the review period. The following domains were reviewed for the 2014 Annual Compliance Review:

- § 4.0: Staff Requirements and Support Services
- § 6.0: Core Benefits & Services
- § 7.0: Provider Network Requirements
- § 10.0: Provider Services
- § 11.0: Eligibility, Enrollment & Disenrollment
- § 12.0a: Marketing
- § 12.0b: Member Education
- § 13.0: Member Grievances & Appeals
- § 15.0: Fraud, Abuse, and Waste Prevention

Table 11 displays the compliance determination categories used by IPRO during the 2014 Annual Compliance Review.

Table 11. 2014 Annual Compliance Review Determination Description

Determination	Definition
Met	Health plan has met or exceeded requirements.
Not Met	Health plan has not met most critical requirements, all or some non-critical requirements, and has significant deficiencies requiring corrective action.
N/A	Not applicable.

Findings from LHCC's 2014 Annual 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 13 displays descriptions of all standards/elements that were "Not Met".

Table 12. Overall Compliance Determination by Domain

Domain	Total No. of Requirements Reviewed	Compliance Determination Totals		
		Met	Not Met	N/A
4.0 Staff Requirements and Support Services	4	4	0	0
6.0 Core Benefits & Services	100	100	0	0
7.0 Provider Network Requirements	167	165	0	1
10.0 Provider Services	58	56	0	2
11.0 Eligibility, Enrollment & Disenrollment	26	26	0	0
12.0a Marketing	118	118	0	0
12.0b Member Education	133	133	0	0
13.0 Member Grievances & Appeals	67	67	0	0
15.0 Fraud, Abuse, and Waste Prevention	110	110	0	0
TOTAL	783	779	0	3

Table 13. Elements Requiring Corrective Action by Review Area

2014 Medicaid Managed Care Compliance Review – Elements Not Fully Met (Review Year July 2013 – December 2014)	
Domain	Description of Review Findings Not Fully Met
	All contract requirements fully met.

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 Plan'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

- § The 2014 HEDIS® Final Audit Report revealed no significant problems and the Health Plan was able to report all required Medicaid rates.
- § In regard to the 2014-2015 Compliance Review, the Health Plan demonstrated strong performance, as it was found to have "met" all requirements for the nine (9) domains reviewed.
- § The Health Plan demonstrated strong performance on the following Adult CAHPS® measure: How Well Doctors Communicate, *Shared Decision Making* and *Rating of Specialist* meeting or exceeding the 75th percentile.

Opportunities for Improvement

- § The Health Plan continues to demonstrate an opportunity for improvement in regard to its provider network as PCMH recognition remains low. (Note: PCMH recognition was an opportunity for improvement in the previous year's report.)
- § The Health Plan demonstrates an opportunity for improvement in regard to its overall HEDIS® performance. The following measures performed below the 50th percentile: *Adult BMI Assessment, Asthma Medication Ratio, Childhood Immunization Status – Combo 3, Comprehensive Diabetes Care – HbA1c Testing, Comprehensive Diabetes Care – LDL-C Screening, Controlling High Blood Pressure, Cholesterol Management for Patients With Cardiovascular Conditions – LDL-C Control, Follow-up Care for Children Prescribed ADHD Medication – Continuation and Maintenance Phase, Lead Screening in Children, Medication Compliance 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, Timeliness of Prenatal Care, Postpartum Care, Adolescent Well-Care Visits, Frequency of Ongoing Prenatal Care, Well-Child Visits in the First 15 Months of Life 6+ Visits and Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life.*
- § In addition, the Health Plan demonstrates an opportunity for improvement in regard to access to care as rates for all age groups were below the 50th percentiles for the HEDIS® *Children and Adolescents Access to PCPs* and *Adults' Access to Preventive/Ambulatory Services* measures.
- § The Health Plan continues to demonstrate an opportunity for improvement in regard to member satisfaction as it reported rates below the 50th percentile for several Adult CAHPS® measures: *Getting Needed Care, Getting Care Quickly, Rating of All Health Care* and *Rating of Health Plan*. The Health Plan also performed below the 50th percentile for the following Child CAHPS® General Population measures: *Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, Rating of All Health Care, Rating of Personal Doctor* and *Rating of Health Plan*, and for the following Child CAHPS® CCC Population measures: *Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, Shared Decision Making, Rating of All Health Care, Rating of Personal Doctor, Rating*

of Specialist and Rating of Health Plan. (Note: Member satisfaction was an opportunity for improvement in the previous year's report.)

Recommendations

- § As the number of providers with PCMH recognition has increased, the Health Plan should continue its efforts described in the Plan's response to the previous year's recommendation. *[Repeat recommendation.]*
- § The Health Plan should conduct root cause analysis for all HEDIS® Effectiveness of Care and Use of Services measures that perform below the 50th percentile and develop interventions to address these barriers. The Health Plan should also routinely monitor HEDIS® performance to assess the effectiveness of its improvement strategy.
- § As Health Plan members demonstrate lower than average access to primary care, a root cause analysis should be conducted to identify barriers to care for all age groups and to drive the development of targeted interventions that will address these barriers.
- § The Health Plan should continue to work to improve CAHPS® measures that perform below the 50th percentile. The Health Plan should also routinely assess the effectiveness of implemented interventions, starting with the interventions described in the Plan's response to the previous year's recommendation. *[Repeat recommendation.]*

Response to Previous Year's Recommendations

- § 2012-2013 Recommendation: The Plan should report performance measures to the DHH that allow for the evaluation of the quality of, access to and timeliness of care, specifically, as it relates to its Medicaid population.

Plan Response: Louisiana Healthcare Connections (LHCCC) requires that all PCP and specialty physicians maintain sufficient access to facilities and personnel for all covered physician services. Quality metrics are monitored on an on-going basis to ensure that all members (Medicaid population) are receiving quality care in a timely manner. In 2013-2014, random access audits have been conducted on a quarterly basis, assessing telephonic and onsite services utilizing standard audit methodology. It is the expectation/goal that 90% of the surveyed/audited providers are compliant with standards. Results are monitored, tracked and trended. If minimum compliance is not met, the provider, network, or appropriate group will be asked to comply with a written Corrective Action Plan. Additionally, education and coaching are provided with necessary follow up. To ensure quality outcomes, the Quality Assessment Improvement Committee (QAPIC) analyzes the trended data and makes recommendations to address deficiencies related to member access and availability for providers who are not meeting their performance expectation.

- § 2012-2013 Recommendation: To improve member satisfaction, the Health Plan should conduct root cause analysis for CAHPS® measures performing below the 50th percentile and implement interventions to address these measures.

Plan Response: In 2013, LHCCC reviewed and analyzed the CAHPS member satisfaction survey conducted by The Meyers Group (TMG). The following is a list of opportunities for improvement for all composites noted as falling below the 50th percentile:

- Getting Needed Care
- Getting Care Quickly

- Rating of Healthcare
- Rating of Health Plan
- Rating of Specialists
- Customer Service Shared Decision Making
- Health Promotion & Education
- Coordination of Care
- Providing Needed Information
- Ease of Filling out Forms

The following is a summary of interventions that address the noted opportunities for improvement:

- Surveys have been conducted to measure after-hours accessibility of providers
- A process has been implemented to improve accessibility by monitoring provider compliance and educating providers to ensure that members are getting the care they need.
- The Plan will monitor provider access, availability and after-hours care to ensure members have adequate access to services.
- The Plan will track effectiveness of Centene Data Management System (CDMS) related to turnaround time and monitor the number of auto-generated authorizations impacting turnaround times as well.
- The Plan will monitor and track timely notification letters complete with rationale for denials.
- The Plan will track and monitor adequacy of specialists.
- The Plan changed the main phone number utilized for member outreach from an "800" number to a local extension to improve communications with our members.

It is the goal of LHCCC that the member satisfaction survey results align with the 2012 Quality Compass All Plan results. LHCCC conducts monthly meetings for updates and monitoring of noted interventions and action plans.

§ 2012-2013 Recommendation: The Plan should identify barriers preventing providers from earning PCMH recognition/accreditation and implement interventions to address these barriers.

Plan Response: LHCCC has reviewed the PCMH IP and has identified the following barriers for our PCPs:

- Lack of resources to complete the work needed for transformation.
- Lack of Knowledge about PCMH.
- PCPs state they feel DHH is forcing too much on them too soon (Bayou Health, Magellan and PCMH).

In an effort to address these barriers for our PCPs the PCMH staff has:

- LHCCC provided a \$1000.00 incentive for the PCPs who sign with LHCCC to become PCMHs.
- LHCCC provides a Medical Home Specialist to facilitate the PCMH recognition process with the PCP by email, teleconference and face-to-face.
- LHCCC has partnered with BizMed to provide a web based program for gathering policies and data for submission to NCQA.
- The LHCCC staff offers each provider three levels of document review. This process ensures accuracy and completion of forms and policies prior to the day of submission.

- Once PCPs have obtained their PCMH recognition, they qualify for participation in LHCCC's PCMH Innovation Payment Model.
- LHCCC will continue to sponsor their annual PCMH Summit. This event is focused on educating PCPs who have expressed an interest in becoming PCMH accredited as well as an opportunity for successful PCMH providers to share their challenges and best practices.
- LHCCC will continue to monitor the quality and performance metrics of PCMH accredited providers in comparison to non-PCMH providers. Metrics such as HEDIS®, after-hours access and appointment availability will be used in the comparison.

§ 2012-2013 Recommendation: The Plan should address the opportunities for improvement previously identified by the EQRO during the PIP review process to ensure that the creditability of the final results is not at risk.

Plan Response: The Plan utilizes NCQA's Quality Improvement Assessment Form for all health plan Performance Improvement Projects. When appropriate, the Performance Improvement Projects will be managed utilizing the Lean Six Sigma principles and an internal database for tracking. The Quality Analytics Department will validate the design to assure that the data utilized is accurate, reliable and developed according to accepted principles of scientific research and statistical analysis.

§ 2012-2013 Recommendation: The Plan should continue to work to address contractual requirements related to Core Benefits & Services, Provider Network Requirements, Utilization Management, Member Education and Member Grievances & Appeals to ensure it achieves, at a minimum, "substantial" compliance during the next Annual Compliance Review.

Plan Response: The Compliance Department will have processes in place for on-going monitoring of contract compliance across all departments of the health plan. Any areas of non-compliance will be addressed and referred to the Quality Department to facilitate a Performance Improvement Plan with the individual department. The metrics and progress of the action plan will be reported and monitored by the Performance Improvement Team.