State of Louisiana
Department of Health & Hospitals

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

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

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

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I. INTRODUCTION

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

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

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

Section VI provides an assessment of the MCO's strengths and opportunities for improvement in the areas of accessibility, timeliness and quality of services. For areas in which the 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 2018)	470,731

III. ENROLLMENT AND PROVIDER NETWORK

Enrollment

Medicaid Enrollment

As of June 2018, the MCO's Medicaid enrollment totaled 470,731, which represents 32% of Healthy Louisiana's active members. **Table 2** displays LHCC's Medicaid enrollment for 2016 to 2018, as well as the 2018 statewide enrollment total. **Figure 1** displays Healthy Louisiana's membership distribution across all Medicaid MCOs.

Table 2: Medicaid Enrollment as of June 2018

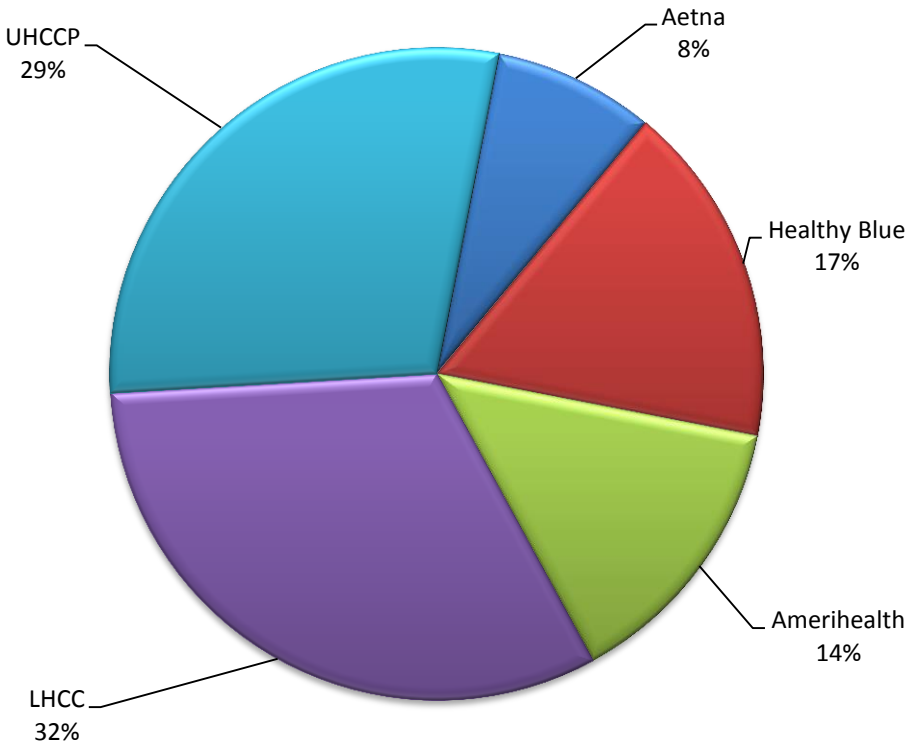
LHCC	June 2016	June 2017	June 2018	% Change	2018 Statewide Total[2]
Total Enrollment	428,878	476,873	470,731	1.3%	1,473,685

Data Source: Report No. 125-A

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

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

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



Provider Network

Providers by Specialty

LDH requires each MCO to report on a quarterly basis the total number of network providers. **Table 3** shows the sum of LHCC's primary care providers, OB/GYNs and other physicians with primary care responsibilities within each LDH region as of July 6, 2018.

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

Specialty	Louisiana Healthcare Connections LDH Region 1	2	3	4	5	6	7	8	9	MCO Statewide Unduplicated[1]
Family Practice/ General Medicine	223	149	67	161	86	75	181	156	138	688
Pediatrics	187	105	31	80	33	33	92	24	85	525
Nurse Practitioners	559	492	239	356	203	190	241	316	387	946
Internal Medicine	148	67	31	41	25	8	62	25	61	447
RHC/FQHC	70	37	30	31	16	37	39	54	39	217
OB/GYN	12	2	1	4	3	1	4	5	1	30

Data source: Network Adequacy Review 2018 Q2

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

[1]Provide an unduplicated count of contracted providers in the given Region that practice at a location in that region. For example, if Dr. Smith is registered within Region 1 and also practices in a location in Region 2, s/he would be counted in each of the Regions but only ONCE Statewide. Therefore, the total count under "Statewide Unduplicated" may be less than a total of the Regions.

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 August 14, 2018

Provider Type		Access Standard[1] X Provider(s) within X Miles	Percentage of Members for Whom Standard was Met
Adult PCP	Urban	1 within 10 miles	97.9%
	Rural	1 within 30 miles	100.0%
Pediatrician	Urban	1 within 10 miles	98.3%
	Rural	1 within 30 miles	100%
OB/GYN	Urban	1 within 15 miles	96.2%
	Rural	1 within 30 miles	95.9%

Data Source: Network Adequacy Review 2018 Q2

[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 measurement are as follows:

- Initiation of injectable progesterone for preterm birth prevention between the 16th and 24th week of gestation: increase from 13.60% to 18.05%
- Chlamydia test during pregnancy: increase from 70.29% to 85.71%
- HIV test during pregnancy: increase from 62.56% to 75.83%
- Syphilis test during pregnancy: increase from 71.28 to 77.67%
- Use of most effective contraceptive methods: increase from 8.57% to 9.57%
- Use of moderately effective contraceptive methods: decrease from 23.65% to 21.90%
- Use of long-acting reversible contraception (LARC) during delivery hospitalization: decrease from 1.90% to 1.55%
- Use of LARC outpatient within 56 days postpartum: increase from 6.86% to 8.02%
- HEDIS *Postpartum Care* measure: increase from 58.23% to 63.42%

Intervention Summary:

- Member:
  - Medicaid 101: Regional provider workshops conducted by LHCC educating providers on updated Medicaid coverage/benefits and misconceptions
- MCO:
  - Accurately identify high risk members with a history of preterm birth through use of High-Risk Pregnancy Registry.
  - Enhancement of case management services to improve engagement with high risk members.

Results:

- From fourth quarter 2016 to fourth quarter 2017, the percentage of OB/GYN visits completed by the Provider Network team with "Better OB/GYN Resources" material presented increased from 56.71% to 90.64%.
- From fourth quarter 2016 to fourth quarter 2017, the percentage of high-risk pregnant members that received Case Management outreach within 7 days of notification increased from 88.66% to 96.60%.
- From baseline to interim year, the percentage of pregnant women 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:

- The MCO had an increase in 17P utilization rates and exceeded the target rate of 17.5% in utilization in women between 16-24 weeks gestation.
- High NOP submissions coupled with an increase in case management engagement rates contributes to the plan being able to identify those women who are at high risk for a preterm birth which will result in more interventions being offered to prevent future preterm births.

Opportunities for Improvement:

- LDH Managed Care Prematurity Prevention Improvement Project is seeking novel ways to engage providers in the fight against prematurity. As a next step, LDH has requested that each Healthy Louisiana Medical Director, together with each MCO's Prematurity Prevention Performance Improvement (PIP) quality team,

and a volunteer physician representing the Medicaid Quality Maternity Care Subcommittee, meet with one provider practice to support quality improvement efforts at that practice. Based upon an analysis of opportunities to improve high risk member receipt of 17P (hydroxyprogesterone caproate injection), each PIP quality team has selected one provider to meet with on-site at their practice. At the provider site visit, each MCO team should complete the Practice Engagement Worksheet in collaboration with the practice providers to inform planning of further PDSA cycles and interventions.

- As part of ongoing PDSA efforts to improve early identification and outreach of members at risk for preterm birth and/or preeclampsia, MCOs should identify and address any outstanding care coordination and data integrity challenges. For example: clarification, communication and integration of data sources, collection methods, tasks, persons responsible, and timeframes are merited to ensure that members with a history of preterm birth, as well as those at risk for preeclampsia, are identified early for care management outreach, care coordination and engagement.
- The ITM workgroup should continue monitoring the Intervention Tracking Measures (ITMs) and, in response to issues revealed by the pattern analysis using the IHI Rules for Interpreting Charts, conduct barrier analysis to identify root causes, and use barrier analysis findings to inform modifications to interventions on an ongoing basis as part of the PDSA quality improvement process.

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

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

- Validated ADHD screening instrument: increase from 33.3% to 72.00%.
- ADHD screening in multiple settings: increase from 14.67% to 66.67%
- Assessment of other behavioral health conditions/symptoms: increase from 16.00% to 24.00%.
- Referral for evaluation of other behavioral health conditions: increase from 60.00% to 78.94%
- Referral to treat other behavioral health conditions: increase from 50.0% to 89.47%
- Primary care provider care coordination: increase from 38.67% to 64.00%
- MCO care coordination: decrease from 5.33% to 0.00%
- MCO outreach with member contact: decrease from 4.00% to 0.00%
- MCO outreach with member engagement: decrease from 100.00% to 0.00%
- First line behavior therapy for children less than 6 years: increase from 0.00% to 43.33%
- 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 56.82%
- 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 69.15%
- 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: decrease from 39.87% to 30.56%
- 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: decrease from 46.25% to 38.95%
- Percentage of any ADHD cases, aged 0-5 years, stratified by age and foster care status, with documentation of behavioral health pharmacotherapy (ADHD medication, antipsychotics, and/or other psychotropics), without behavioral therapy: decrease from 29.91% to 27.23%

Intervention Summary:

- Provide face-to-face provider education for providers with high prescribing volume
- Collaborate with providers to develop a plan of care for children with ADHD who are enrolled in case management

Results:

- LHC had a significant increase in referring members for outside behavioral services from Q1 to Q2 2017 in the 0-6 year old population. BH service referrals for 7-12 year olds remained constant at a rate between 50-60%, and for 13-18 year olds showed a decrease from Q1 to Q2 but has steadily increased over the last three quarters.
- Disease Management enrollment rates for all age groups averages around 80% of referrals made for the ADHD Disease Management program.

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:

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

Performance Measures: HEDIS® 2018 (Measurement Year 2017)

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

HEDIS® Effectiveness of Care Measures

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

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

Measure	LHCC			QC 2018 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded	Healthy Louisiana 2018 Average
	HEDIS® 2016	HEDIS®2017	HEDIS®2018		
Adult BMI Assessment	69.05%	85.36%	80.37%	10th	81.97%
Antidepressant Medication Management - Acute Phase	NR	44.50%	49.13%	50th	54.05%
Antidepressant Medication Management - Continuation Phase	NR	28.17%	34.39%	50th	39.84%
Asthma Medication Ratio (5-64 Years)	46.89%	55.33%	66.59%	50th	63.75%
Breast Cancer Screening in Women	55.97%	57.25%	55.40%	66.67th	56.03%
Cervical Cancer Screening	54.86%	56.39%	49.14%	10th	51.61%
Childhood Immunization Status - Combination 3	40.87%	67.31%	68.13%	25th	68.19%
Chlamydia Screening in Women (16-24 Years)	61.78%	64.13%	65.97%	95th	65.78%
Comprehensive Diabetes Care - HbA1c Testing	79.72%	74.13%	84.43%	33.33rd	84.21%
Controlling High Blood Pressure	42.24%	39.45%	37.96%	10th	37.71%
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	58.43%	53.83%	69.15%	75th	67.89%
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	47.45%	40.44%	56.82%	75th	54.53%
Medication Management for People With Asthma Total - Medication Compliance 75% (5-64 Years)	20.41%	19.94%	29.83%	50th	32.76%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile	50.48%	56.25%	58.64%	10th	62.35%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	43.27%	58.17%	54.74%	10th	55.88%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity	32.69%	44.23%	43.80%	10th	45.10%

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 2016, HEDIS 2017 and HEDIS 2018, Healthy Louisiana 2018 statewide averages and *Quality Compass* 2018 South Central – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

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

Measure	LHCC			QC 2018 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded	Healthy Louisiana 2018 Average
	HEDIS® 2016	HEDIS®2017	HEDIS®2018		
	Children and Adolescents' Access to PCPs				
12–24 Months	95.71%	96.67%	96.81%	50th	96.43%
25 Months–6 Years	85.78%	87.97%	89.08%	50th	88.79%
7–11 Years	85.62%	89.29%	90.88%	50th	90.61%
12–19 Years	85.16%	88.35%	90.15%	50th	89.96%
	Adults' Access to Preventive/Ambulatory Services				
20–44 Years	77.00%	81.64%	77.57%	33.33rd	76.75%
45–64 Years	86.54%	88.09%	85.67%	33.33rd	84.87%
65+ Years	74.49%	87.57%	85.23%	33.33rd	84.83%
	Access to Other Services				
Timeliness of Prenatal Care	78.04%	80.94%	79.47%	33.33rd	78.40%
Postpartum Care	58.23%	64.85%	63.42%	50th	64.04%

HEDIS® Use of Services Measures

This section of the report details 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 2016, HEDIS 2017 and HEDIS 2018, Healthy Louisiana 2018 statewide averages and *Quality Compass* 2018 South Central – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

Table 7: Use of Services Measures – 2016-2018

Measure	LHCC			QC 2018 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded	Healthy Louisiana 2018 Average
	HEDIS® 2016	HEDIS® 2017	HEDIS®2018		
Adolescent Well-Care Visit	51.68%	52.64%	46.10%	10th	54.18%
Ambulatory Care Emergency Department Visits/1000 Member Months[1]	67.39	67.62	77.73	75th	81.09
Ambulatory Care Outpatient Visits/1000 Member Months	371.83	371.65	403.11	50th	418.74
Frequency of Ongoing Prenatal Care - ≥ 81%	61.34%	64.60%	Retired[2]	Not Applicable	Retired[2]
Well-Child Visits in the First 15 Months of Life 6+ Visits	52.19%	52.29%	58.54%	25th	64.11%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	66.59%	66.13%	67.92%	25th	68.06%

[1] A lower rate is desirable.

[2] NCQA retired this measure from HEDIS 2018.

Member Satisfaction: Adult and Child CAHPS® 5.0H

In 2018, the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H survey of Adult Medicaid members and Child Medicaid with Chronic Care Conditions (CCC) was conducted on behalf of 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 2016, 2017 and 2018, as well as *Quality Compass*® 2018 South Central – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

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

Measure[1]	LHCC			QC 2018 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded
	CAHPS® 2016	CAHPS® 2017	CAHPS® 2018	
Getting Needed Care	79.10%	83.09%	83.71%	50th
Getting Care Quickly	76.90%	80.76%	83.15%	50th
How Well Doctors Communicate	90.40%	91.02%	91.35%	50th
Customer Service	90.30%	93.14%	90.50%	50th
Shared Decision Making	79.00%	73.23%	79.02%	33.33rd
Rating of All Health Care	75.90%	73.02%	77.38%	66.67th
Rating of Personal Doctor	84.80%	82.66%	81.14%	33.33rd
Rating of Specialist	84.10%	87.59%	86.44%	90th
Rating of Health Plan	78.50%	77.20%	80.58%	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".

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

Measure[1]	LHCC			QC 2018 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded
	CAHPS® 2016	CAHPS® 2017	CAHPS® 2018	
Getting Needed Care	92.30%	89.13%	88.81%	75th
Getting Care Quickly	93.60%	92.98%	95.34%	95th
How Well Doctors Communicate	93.60%	94.09%	94.62%	50th
Customer Service	89.60%	90.32%	91.28%	75th
Shared Decision Making	76.60%	77.97%	81.73%	90th
Rating of All Health Care	87.60%	88.12%	90.35%	75th
Rating of Personal Doctor	90.80%	88.42%	91.03%	66.67th
Rating of Specialist	Small Sample	85.85%	88.79%	50th
Rating of Health Plan	88.50%	90.11%	89.06%	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".

Small Sample: Small sample (less than 100 responses)

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

Measure[1]	LHCC			QC 2018 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded
	CAHPS® 2016	CAHPS® 2017	CAHPS® 2018	
Getting Needed Care	91.10%	91.75%	88.35%	33.33rd
Getting Care Quickly	94.70%	94.49%	96.01%	75th
How Well Doctors Communicate	93.30%	95.25%	94.92%	50th
Customer Service	87.50%	93.91%	91.12%	75th
Shared Decision Making	84.10%	83.85%	84.83%	50th
Rating of All Health Care	87.90%	85.98%	89.46%	90th
Rating of Personal Doctor	89.20%	90.06%	91.29%	75th
Rating of Specialist	88.00%	87.37%	86.36%	33.33rd
Rating of Health Plan	87.60%	89.82%	88.57%	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".

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 2017 and 2018 to identify and/or address disparities in health outcomes and/or health care among its Medicaid population:

LHCC conducted its third annual network assessment to determine changes from prior years as well as membership access to Culturally and Linguistically Appropriate Services (CLAS) and interventions that can be completed to improve member experience. The goal in each Parish is to have a sufficient number of language-specific Providers (at a rate at least roughly equivalent or close to the English-speaking population) to meet the needs of communities with higher Limited English Proficiency (LEP) populations. Some interventions that took place in 2018 as a result of the CLAS Network Assessment were:

- Educate Provider contracting team on gaps for any possible opportunities in recruitment.
- Re-educate Provider Consultants on availability of Cultural Competency brochures with language access information as well as laminated language identification sheets for visiting providers in these areas.
- Send members language-specific "I Speak" cards for doctor's office with letter that explains right to interpretation.

LHCC has implemented the use of blocked schedules with a My Health Direct tool that can focus language sensitive communication to members in practices that are participating. This tool will allow scheduling these language sensitive members more easily and increasing the compliance with member healthcare gaps.

LHCC has determined from a 2017 survey that 64% of members receive SNAP or WIC benefits and 23 % of members reported being 'hungry from lack of food. To address this food insecurity LHCC begun to implement an approach that focuses on community support, provider support, internal support and member support.

V. COMPLIANCE MONITORING

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

Medicaid Compliance Audit Findings for Contract Year 2016

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

The 2016 Compliance Audit included a comprehensive evaluation of 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 compliant relate to network adequacy and the MCO's ability to contract with providers in several specialty and sub-specialty areas, a problem for all Medicaid MCOs in Louisiana that is not unique to 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) –**
  - LHCC met or exceeded the 75th percentile for the following HEDIS measure:
    - *Chlamydia Screening in Women (16-24 Years)*
    - *Follow-Up Care for Children Prescribed ADHD Medication – Continuation and Maintenance Phase*
    - *Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase*
- **CAHPS (Member Satisfaction) –** LHCC met or exceeded the 75th percentile for the following CAHPS measures:
  - Adult CAHPS
    - *Rating of Specialist*
  - Child CAHPS General Population
    - *Getting Needed Care*
    - *Getting Care Quickly*
    - *Customer Service*
    - *Shared Decision Making*
    - *Rating of All Health Care*
  - Child CAHPS CCC Population
    - *Getting Care Quickly*
    - *Customer Service*
    - *Rating of All Health Care*
    - *Rating of Personal Doctor*
    - *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:
  - *Adult BMI Assessment*
  - *Cervical Cancer Screening*
  - *Childhood Immunization Status – Combination 3*
  - *Comprehensive Diabetes Care – HbA1c Testing*
  - *Controlling High Blood Pressure*
  - *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*
  - *Adults' Access to Preventive/Ambulatory Services*

        - *20-44 Years*
        - *45-64 Years*
        - *65+ Years*
    - *Timeliness of Prenatal Care*
    - *Adolescent Well-Care Visit*
    - *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®
        - *Shared Decision Making*
        - *Rating of Personal Doctor*
    - Child CAHPS® General Population
        - *Rating of Health Plan*
    - Child CAHPS® CCC Population
        - *Getting Needed Care*
        - *Rating of Specialist*

Recommendations

- In regard to HEDIS and the quality of care initiatives described in the MCO's response to the previous year's recommendation, the MCO should routinely monitor the effectiveness of these initiatives to ensure members have access to optimal health care and to improve health outcomes.
- As adult access to primary care has declined, it suggests that the improvement strategy outlined in the MCO's response to the previous year's recommendation needs modification. In addition to focusing on ED utilization, the MCO should address members who have zero contact with the health care system and attempt to engage these members through incentive programs and support with PCP selection, transportation and appointment scheduling. Furthermore, the improvement strategy should also be tied to the barriers identified through the MCO's CAHPS barrier analysis.

Response to Previous Year's Recommendations

- **2016-2017 Recommendation:** 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.]*

  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, the Quality Improvement Coordinators (QICs) and the 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 also addressed by the QICs as they work with their assigned departments.

  The following interventions were implemented or have continued from previous years to improve member care and close HEDIS gaps:

- HEDIS Steering Committee developed a strategic plan for improving LHCC's HEDIS measures.
- An annual HEDIS Summit is presented to LHCC's leadership and management team to communicate the strategic plan along with each department's role and responsibility related to improving overall HEDIS scores.
- Specific focus and attention have been placed on the new HEDIS measures selected by LDH to be initiated in MY 2018 in an effort to achieve set goals.
- Partnership with U.S. Medical Management (USMM) has continued, which allows providers to make home visits to evaluate members, assess their overall health needs, and complete any gaps in care noted in the member records.
- Maintained a HEDIS call center with a primary focus of reaching out to members and providers to set up appointments, address PCP changes, and make arrangements for transportation if necessary. The call center had use of Voiance to help with translation, if needed.
- Management has been evaluating the use of the My Health Direct system to increase outreach calls for gap closures with our members. We expect to initiate this new program in 2018.Maintained HEDIS score cards and developed Provider Profiles for provider consultants to share with providers to educate and inform them of their quality metrics and how to improve their outcomes.
- Refined our health fairs to align with our FQHCs which allowed us to hold more events to reach members who needed screenings and provide these services in convenient locations for our members.
- Enrolled members in corporate and local health plan 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
- Developed a new program with the Community Health Services department where the staff educated members and providers on our CentAccount program and rewards related to closing care gaps.
- Reviewed denied claims for Early and Periodic Screening, Diagnostic and Treatment and worked with Provider Consultants to resolve issues.
- Established a pilot for EPSDT to focus on closing care gaps for households with multiple siblings.
- Included articles in newsletters related to the screenings and appropriate care.

- **2016-2017 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.]*

  MCO Response: LHCC has continued with its strategy of assessing ED utilization. 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. LHCC has also started an analysis of the access to ambulatory care for the 7-11 and 12-19 years age group.

  As a result of the 2015 ED Diversion Review and root cause analysis, LHCC implemented and continues 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 (PC) 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 first, second and third 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.
- Reviewed denied claims for early and periodic screening, diagnostic and treatment and worked with PC team to resolve issues.
- Identified the five most non-compliant regions, providers and facilities for EPSDT. Worked with our PC team and our HCC outreach team to focus on these areas for gap closures for this specific age group.
- Established a pilot for EPSDT to focus on closing care gaps for households with multiple siblings to begin in 2018.

- **2016-2017 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.]*

  MCO Response: Based on the above recommendations, Louisiana Healthcare Connections has implemented the following action items to improve CAHPS scores moving forward.

  - Continue to host a quarterly Member Advisory Committee meeting to allow members to provide feedback to health plan staff and meet with various department representatives from within the health plan.
  - The Care Management department will be available to assist members as needed with scheduling appointments for care, treatment, and tests as well as locating and scheduling specialist appointments.
  - CM department will continue to include the following interventions with members who are enrolled in Care Management:
    - Assist members as needed with scheduling appointments for care, treatment, and tests and with locating and scheduling appointments with specialists.
    - Discuss with members ways to effectively communicate with their physicians.
    - Utilize Care Alerts in Impact Pro for promotion and education of healthy interventions and activities (ie: annual flu vaccine, mammograms, colorectal screenings, etc.)
    - Complete tobacco screening on all members and offer cessation measures for members who screen positive.
  - The Utilization Management department will revise the discharge planning process related to documentation and follow-up requirements for inpatient members to improve their access to outpatient care at the time of discharge.
  - Launch a Pilot Project to assist providers in finding nearby in-network specialists by providing an email mailbox for inquiries. Provider Services manages the inquiries to ensure that correct data is provided to Providers.

- The secret shopper program will continue to track providers' appointment availability. Education will be provided to providers who are not meeting required availability parameters, with re-auditing to track and trend effectiveness of education.
- Continue PCP on-site visits by a provider consultant at least annually to provide education, updates on policy/process changes, Provider Portal training, etc.
- The educational section of LHC's Facebook page and website for members (titled "Medicaid News") will be updated on a weekly basis to intermittently provide information on available services, encourage members to obtain preventative care, give tips on navigating the Medicaid healthcare system, and offer some general disease management education.
- Host health fairs throughout the year across the state to provide education and services to members in a convenient setting. Physicians are present to provide preventive care and close care gaps.
- Educate providers on pertinent topics via new provider orientation, intermittent provider workshops, provider newsletters, and ongoing Provider Portal updates on the LHC website. Topics of education include:
    - Cultural sensitivity
    - Effective communication with members
    - Shared decision making with members
    - Coordination of Care amongst providers
    - UM and PA processes for LHC
    - Available LHC Provider Resources
    - Current clinical standards
    - Care gap closure
    - HEDIS requirements
- Since grievance and appeals data validates the areas for improvement identified in the CAHPS surveys, grievance and appeals trends will be monitored to identify effectiveness of the above interventions, with targeted intervention as indicated.