



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

Review Period: July 1, 2015 – June 30, 2016
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*Prepared on Behalf of
The State of Louisiana
Department of Health & Hospitals*

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I. INTRODUCTION

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

In order to comply with these requirements, the Louisiana Department of Health (LDH) contracted with IPRO to assess and report the impact of its Medicaid managed care program, the 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 (LHCC) for review period July 1, 2015 – June 30, 2016.

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*® 2016 South Central – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

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

II. MCO CORPORATE PROFILE

Table 1: 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 June 2016)	428,878

III. ENROLLMENT AND PROVIDER NETWORK

Enrollment

Medicaid Enrollment

As of June 2016, the Health Plan’s Medicaid enrollment totaled 428,878, which represents 33% of Bayou Health’s active members. Table 2 displays LHCC’s Medicaid enrollment for 2014 to 2016, as well as the 2016 statewide enrollment total. Figure 1 displays Bayou Health’s membership distribution across all Health Plans.

Table 2: Medicaid Enrollment as of June 2016

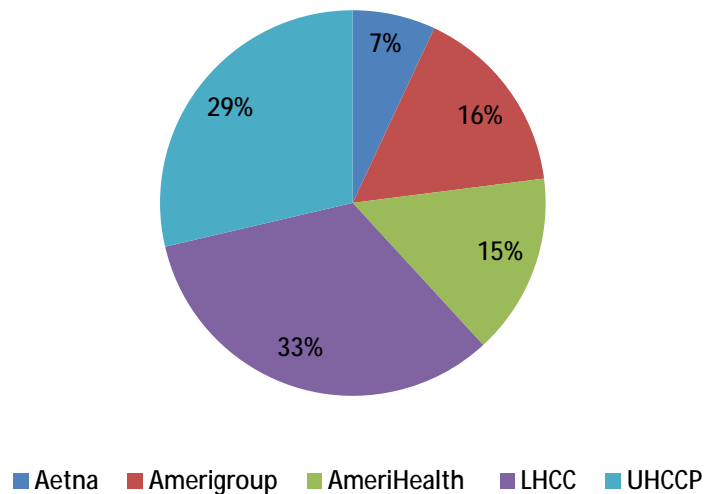
LHCC	June 2014	June 2015	June 2016	% Change	2016 Statewide Total ²
Total Enrollment	148,710	355,677	428,878	19%	1,292,032

Data Source: Report No. 125-A

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

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

Figure 1. Bayou Health Membership by Health Plan as of June 2016



Provider Network

Providers by Specialty

The LDH requires each MCO to report on a quarterly basis the total number of network providers. Table 3 shows the sum of LHCC's primary care providers, OB/GYNs and other physicians with primary care responsibilities within each geographic service area as of June 30, 2016.

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

Specialty	LHCC			MCO Statewide Unduplicated
	GSA A	GSA B	GSA C	
Family Practice/General Medicine	193	204	259	627
Pediatrics	215	169	146	504
Nurse Practitioners	202	237	274	654
Internal Medicine ¹	204	136	96	419
RHC/FQHC	65	88	123	276
OB/GYN ¹	9	6	5	19

Data source: Network Adequacy Review 2015 Q2

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

¹ Accepts full PCP responsibility.

Provider Network Accessibility

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

Table 4: GeoAccess Provider Network Accessibility – as of July 21, 2016

Provider Type		Access Standard ¹ X Provider(s) within X Miles	Percentage of Members for Whom Standard was Met
Family Practitioners	Urban	1 within 10 miles	96.4%
General Medicine	Urban	1 within 10 miles	44.3%
Internal Medicine	Urban	1 within 10 miles	90.7%
Pediatricians	Urban	1 within 10 miles	90.6%
Nurse Practitioners	Urban	1 within 10 miles	96.5%
OB/GYN	Urban	1 within 10 miles	65.5%
FQHC	Urban	1 within 10 miles	85.1%
RHC	Urban	1 within 10 miles	40.7%

¹ The Access Standard is measured in distance to member address.

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”. These PIPs were initiated in 2012 and were concluded in 2015.

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 Collaborative PIP: Reducing Premature Births

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

- § Initiation of injectable progesterone for preterm birth prevention: increase from 2.16% to 17.5%
- § Use of most effective contraceptive methods: increase from 19.56% to 30%
- § Chlamydia test during pregnancy: increase from 70.29% to 87%
- § HIV test during pregnancy: increase from 5.95% to 32%
- § Syphilis test during pregnancy: increase from 71.18% to 85%
- § HEDIS® *Postpartum Care* measure: increase from 58.23% to 70%

Intervention Summary:

Members:

- § Case Manager contacts member to complete Notice of Pregnancy (NOP) form. Completed form member receives Start Smart Thermometer
- § Members in the high risk registry will be contacted for enrollment in case management
- § Smart Start for Your Baby Program
- § CentAccount bonus money

Providers:

- § Bayou Health Plan collaboration and proposed implementation of standard Bayou Health-wide NOP communication from provider to plan
- § \$75 incentive for completed NOP forms submitted from providers
- § Implementation of High-Risk Registry communication from plan to provider
- § Medicaid 101 - Regional Provider workshops conducted by LHCC educating providers on updated Medicaid coverage/benefits and misconceptions

Health Plan:

- § Case Management communicates with members and providers to coordinate care
- § Complete timely outreach to identified high-risk pregnancy members for enrollment through use of High Risk Pregnancy Registry
- § Enhancement of care management programs to improve outreach to PIP eligible and at-risk members for engagement in care coordination

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

Strengths:

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

Opportunities for Improvement:

- § Monitor, report and interpret monthly/quarterly trends/patterns for intervention tracking (process) measures in order to identify what is working, what is not working, and why, e.g., barriers.
- § Refine interventions to address identified barriers.

State-Directed Collaborative PIP: Treatment of Adolescents with ADHD

This PIP aims to improve the quality of care received by children with ADHD by implementing a robust set of health plan, member, and community and provider interventions to improve rates of evaluation, diagnosis, management and treatment of ADHD consistent with clinical practice guidelines recommendations. Hybrid performance measures based upon a random sample of children will be used to assess diagnosis, evaluation and care coordination in accordance with guidelines recommendations. Administrative measures based upon the population newly prescribed ADHD medication will be used to assess compliance with medication monitoring standards in accordance with the HEDIS® measure, *Follow-Up Care for Children Prescribed ADHD Medication (ADD)*. In addition, encounter and pharmacy data will be used to assess receipt of behavioral therapy for children with ADHD who are on psychotropic medication.

Intervention Summary:

- § Develop the provider network by recruiting trained providers or training new providers trained in Evidence-Based Practice (EBP) Practices
- § Link children younger than six years of age to EBP therapists
- § MCOs and the LDH collaborate to produce and distribute a PCP toolkit
- § MCOs and the LDH collaborate to develop strategy to expand access to in-person or telephonic case consultation to PCPs
- § Enhance Case Management to facilitate behavioral health referrals; to foster care plan collaboration among care managers, PCPs behavioral therapists, teachers, parents and children; and to increase PCP practice utilization of on-site care coordination and/or MCO care coordination

Results: Not yet available.

Performance Measures: HEDIS® 2016 (Measurement Year 2015)

MCO-reported performance measures were validated as per HEDIS® 2016 Compliance Audit™ specifications developed by the National Committee for Quality Assurance (NCQA). The results of each MCO's HEDIS® 2016 Compliance Audit are summarized in its Final Audit Report (FAR).

The HEDIS® 2016 FAR prepared for LHCC by Attest Health Care Advisors indicates that the Health Plan demonstrated compliance with all areas of Information Systems (IS) and all areas of measure determination required for successful HEDIS® reporting. Areas of concern were noted for IS Standard 4.2 *Retrieval and abstraction of data from medical records is reliably and accurately performed.*

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 Health Plan performance rates for select HEDIS® Effectiveness of Care measures for HEDIS® 2014, HEDIS® 2015 and HEDIS® 2016, Bayou Health 2016 statewide averages and *Quality Compass*® 2016 South Central – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

Table 5: HEDIS® Effectiveness of Care Measures – 2014-2016

Measure	LHCC			QC 2016 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded	2016 Statewide Average
	HEDIS® 2014	HEDIS® 2015	HEDIS®2016		
Adult BMI Assessment	54.06%	68.10%	69.05%	10 th	75.92%
Antidepressant Medication Management - Acute Phase	NR	NR	NR	-	53.52%
Antidepressant Medication Management - Continuation Phase	NR	NR	NR	-	38.09%
Asthma Medication Ratio (5-64 Years)	58.93%	49.87%	46.89%	<10%	54.09%
Breast Cancer Screening in Women	SS	54.10%	55.97%	75 th	55.55%
Cervical Cancer Screening	57.31%	55.29%	54.86%	33.33 th	57.08%
Childhood Immunization Status - Combination 3	37.04%	55.48%	40.87%	<10%	64.37%
Chlamydia Screening in Women (16-24 Years)	56.83%	57.78%	61.78%	75 th	60.98%
Comprehensive Diabetes Care - HbA1c Testing	73.51%	81.86%	79.72%	10 th	80.01%
Controlling High Blood Pressure	37.39%	34.95%	42.24%	33.33 th	40.96%
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	47.86%	44.20%	58.43%	33.33 th	55.69%
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	41.81%	36.00%	47.45%	50 th	43.71%
Medication Management for People With Asthma Total - Medication Compliance 75% (5-64 Years)	19.11%	19.73%	20.41%	25 th	24.73%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile	23.61%	42.38%	50.48%	33.33 th	46.06%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	34.95%	48.57%	43.27%	10 th	45.36%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity	24.07%	37.86%	32.69%	25 th	31.83%

SS: Sample size too small to report (less than 30 members) but included in the statewide average).

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 Health Plan rates for select HEDIS® Access to/Availability of Care measure rates for HEDIS® 2014, HEDIS® 2015 and HEDIS® 2016, Bayou Health 2016 statewide averages and *Quality Compass*® 2016 South Central – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

Table 6: HEDIS® Access to/Availability of Care Measures – 2014-2016

Measure	LHCC			QC 2016 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded	2016 Statewide Average
	HEDIS® 2014	HEDIS® 2015	HEDIS®2016		
Children and Adolescents' Access to PCPs					
12–24 Months	95.26%	94.66%	95.71%	33.33 th	95.45%
25 Months–6 Years	84.12%	84.01%	85.78%	33.33 th	85.49%
7–11 Years	84.69%	85.58%	85.62%	10 th	87.17%
12–19 Years	84.02%	84.60%	85.16%	10 th	86.14%
Adults' Access to Preventive/Ambulatory Services					
20–44 Years	79.28%	77.64%	77.00%	33.33 th	78.48%
45–64 Years	87.95%	87.60%	86.54%	33.33 th	87.30%
65+ Years	80.29%	74.29%	74.49%	10 th	77.92%
Access to Other Services					
Timeliness of Prenatal Care	80.32%	84.95%	78.04%	25 th	80.05%
Postpartum Care	41.44%	50.23%	58.23%	33.33 th	60.19%

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 Health Plan rates for select HEDIS® Use of Services measure rates for HEDIS® 2014, HEDIS® 2015 and HEDIS® 2016, Bayou Health 2016 statewide averages and *Quality Compass*® 2016 South Central – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

Table 7: Use of Services Measures – 2014-2016

Measure	LHCC			QC 2016 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded	2016 Statewide Average
	HEDIS® 2014	HEDIS® 2015	HEDIS® 2016		
Adolescent Well-Care Visit	39.12%	50.24%	51.68%	33.33 th	51.51%
Ambulatory Care Emergency Department Visits/1000 Member Months ¹	74.73	74.04	67.39	33.33 th	71.60
Ambulatory Care Outpatient Visits/1000 Member Months	366.37	356.09	371.83	33.33 th	413.62
Frequency of Ongoing Prenatal Care - ≥ 81%	55.14%	56.11%	61.34%	33.33 th	68.71%
Well-Child Visits in the First 15 Months of Life 6+ Visits	48.84%	52.64%	52.19%	33.33 th	57.48%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	57.41%	60.82%	66.59%	33.33 th	63.59%

¹ A lower rate is desirable.

Member Satisfaction: Adult and Child CAHPS® 5.0H

In 2016, 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 NCOA-certified survey vendor, SPH Analytics. 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 2014, 2015 and 2016, as well as *Quality Compass*® 2016 South Central – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

Table 8: Adult CAHPS® 5.0H – 2014-2016

Measure ¹	LHCC			QC 2016 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded
	CAHPS® 2014	CAHPS® 2015	CAHPS® 2016	
Getting Needed Care	73.00%	77.80%	79.10%	25 th
Getting Care Quickly	78.70%	76.30%	76.90%	10 th
How Well Doctors Communicate	91.20%	88.10%	90.40%	33.33 th
Customer Service	88.00%	88.80%	90.30%	75 th
Shared Decision Making ²		73.20%	79.00%	33.33 th
Rating of All Health Care	67.60%	71.70%	75.90%	66.67 th
Rating of Personal Doctor	79.60%	80.50%	84.80%	90 th
Rating of Specialist	87.10%	77.90%	84.10%	75 th
Rating of Health Plan	67.90%	78.80%	78.50%	66.67 th

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

² In 2015, NCOA revised measure specifications and response options.

Table 9: Child CAHPS® 5.0H General Population – 2014-2016

Measure ¹	LHCC			QC 2016 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded
	CAHPS® 2014	CAHPS® 2015	CAHPS® 2016	
Getting Needed Care	85.10%	85.80%	92.30%	95 th
Getting Care Quickly	89.50%	92.10%	93.60%	90 th
How Well Doctors Communicate	93.00%	93.20%	93.60%	50 th
Customer Service	84.70%	89.10%	89.60%	66.67 th
Shared Decision Making ²		74.80%	76.60%	25 th
Rating of All Health Care	80.80%	84.10%	87.60%	66.67 th
Rating of Personal Doctor	86.90%	87.50%	90.80%	75 ^h
Rating of Specialist	86.20%	87.40%	SS	-
Rating of Health Plan	78.60%	84.80%	88.50%	75 th

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

² In 2015, NCQA revised measure specifications and response options.

SS: Small sample (less than 100 responses).

Table 10: Child CAHPS® 5.0H CCC Population – 2014-2016

Measure ¹	LHCC			QC 2016 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded
	CAHPS® 2014	CAHPS® 2015	CAHPS® 2016	
Getting Needed Care	82.80%	88.70%	91.10%	95 th
Getting Care Quickly	91.40%	92.10%	94.70%	75 th
How Well Doctors Communicate	92.10%	92.80%	93.30%	25 th
Customer Service	86.80%	89.20%	87.50%	25 th
Shared Decision Making ²		82.30%	84.10%	25 th
Rating of All Health Care	76.50%	83.60%	87.90%	90 th
Rating of Personal Doctor	83.90%	86.10%	89.20%	66.67 th
Rating of Specialist	84.10%	84.50%	88.00%	75 th
Rating of Health Plan	72.10%	82.40%	87.60%	90 th

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

² In 2015, NCQA revised measure specifications and response options.

V. COMPLIANCE MONITORING

Medicaid Compliance Audit Findings for Contract Year 2016

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

The 2017 Compliance Audit included a comprehensive evaluation of LHCC's policies, procedures, files and other materials corresponding to the following nine (9) domains:

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

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

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

Table 11: 2016 Compliance Audit Determination Definitions

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

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

Table 12: Audit Results by Audit Domain

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

It is IPRO's and the LDH's expectation that LHCC submit a corrective action plan for each of the 8 elements determined to be less than fully compliant along with a timeframe for completion. It should be noted that LHCC has implemented a corrective action for many of the areas identified for improvement in the report but the corrections were made after the audit was completed and were not applicable to the audit's review period. Five (5) of the 8 elements rated less than fully complaint relate to network adequacy and the MCO's ability to contract with providers in several specialty and sub-specialty areas, a problem for all Medicaid MCOs in Louisiana that is not unique to LHCC.

VI. STRENGTHS, OPPORTUNITIES FOR IMPROVEMENT & RECOMMENDATIONS

This section summarizes the accessibility, timeliness and quality of services provided by LHCC to Medicaid recipients based on data presented in the previous sections of this report. The 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 Health Plan met the 75th percentile for the following HEDIS® measures: *Breast Cancer Screening in Women* and *Chlamydia Testing in Women*.
- § The Health Plan met or exceeded the 75th percentile, demonstrating strong performance on the following Adult CAHPS® Population measures: *Customer Services*, *Rating of Personal Doctor* and *Rating of Specialist*. The Health Plan also met or exceeded the 75th percentile for the following Child CAHPS® General Population measures: *Getting Needed Care*, *Getting Care Quickly*, *Rating of Personal Doctor* and *Rating of Health Plan* and following Child CAHPS® CCC Population measures: *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health Care*, *Rating of Specialist* and *Rating of Health Plan*.
- § In regard to the 2016 Compliance Review, the Health Plan demonstrated strong performance in six (6) of the nine (9) domains, as it achieved "full" compliance for elements reviewed in these domains.

Opportunities for Improvement

- § The Health Plan continues to demonstrate an opportunity for improvement in regard to its overall HEDIS performance. The following measures performed below the 50th percentiles: *Adult BMI Assessment*, *Asthma Medication Ratio*, *Cervical Cancer Screening*, *Childhood Immunization Status – Combo 3*, *Comprehensive Diabetes Care – HbA1c Testing*, *Controlling High Blood Pressure*, *Follow-up Care for Children Prescribed ADHD Medication – Continuation and Maintenance Phase*, *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*. (Note: HEDIS® performance was an opportunity for improvement in the previous year's report.)
- § The Health Plan continues to demonstrate 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. (Note: Child and adult access rates were opportunities for improvement in the previous year's report.)
- § 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*, *How Well Doctors Communicate* and *Shared Decision Making*. The Health Plan also performed below the 50th percentile for the following Child CAHPS® General Population measure: *Shared Decision Making* and for the following Child CAHPS® CCC Population measures: *How Well Doctors Communicate*, *Customer Service* and *Shared Decision Making*. (Note: Member satisfaction was an opportunity for improvement in the previous year's report.)

Recommendations

- § The Health Plan should continue to work to improve HEDIS® rates that perform below the 50th percentile using the intervention strategy outline in the Plan's response to the previous year's recommendation

coupled with a more targeted approach for rates for which improvement has not been achieved. *[Repeated recommendation.]*

- § Although there remains an opportunity for improvement in regard to access to care, the Health Plan should continue with the improvement strategy outlined in its response to the previous year's recommendation as access to primary care rates have trended upward for all child and adolescent groups. The Health Plan should continue its root cause analysis on access to ambulatory care for the adult population and implement targeted interventions to address identified barriers. *[Repeated recommendation.]*
- § While there remains an opportunity for improvement in regard to member satisfaction, the Health Plan should continue with the improvement strategy outlined in its response to the previous year's recommendation as most CAHPS® rates trended upward. However, for the scores that have declined, the Health Plan should modify its intervention strategy based on root cause analysis. *[Repeated recommendation.]*

Response to Previous Year's Recommendations

- § 2014-2015 Recommendation: The Health Plan should intensify its HEDIS® improvement strategy by incorporating targeted interventions specifically for members who do not access care and for providers who missed opportunities to provide appropriate care. The Health Plan should continue to routinely monitor HEDIS® performance to assess the effectiveness of its improvement strategy. *[Repeat recommendation.]*

Health Plan 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 actions, interventions and identify possible barriers to the interventions. A predictive model of the HEDIS measures has also been created to provide additional information and data to identify potential risks and changes in rates. The HEDIS team and Data Analytics work together to analyze the monthly HEDIS rates specifically for any changes in the numerators and denominators. Any identified discrepancies are reported to the committee and addressed.

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

- § HEDIS Steering Committee developed a Strategic Plan for improving LHCC's HEDIS measures
- § A HEDIS Summit was presented to LHCC leadership and management team to communicate the strategic plan along with each department's role and responsibility related to improving overall HEDIS scores
- § Partnered with USMM, providers who make home visits to evaluate members, assess their overall health needs, and complete any gaps in care noted in the member records
- § Altegra and LHCC Health Care Coordinators conducted three way calls with member and providers to schedule appointments for members with care gaps
- § Maintained HEDIS score cards for provider consultants and PCMH to educate and inform providers of their quality metrics and how to improve their outcomes
- § Health fair events were held to reach members who needed screenings and provide these services in convenient locations for their members
- § Maintained HEDIS call center with a primary focus of reaching out to members and providers to set up appointments, addressed PCPs changes, OTC, Voinace (Translators) and arrangement for transportation if necessary
- § Enrolled members in corporate programs to send immunization reminders to ALL members in the age group meeting criteria for both well-child 3-6 and adolescent well-care
- § Sent well-child birthday cards reminding members meeting age specific criteria for well-child 3-6 and adolescent well-care visits to see their PCPs for screenings

- § Members Connections and Quality Improvement staff educated members and providers on CentAccount program and rewards
 - § Reviewed denied claims for EPSDT screenings and worked with Provider Consultants to resolve issues
 - § Included articles in newsletters related to the screenings and appropriate care
- § 2014-2015 Recommendation: As Health Plan members continue to demonstrate lower than average access to primary care, a more detailed and thorough root cause analysis should be conducted to identify barriers to care. Additionally, the Health Plan should consider the development of intense member-level outreach activities, specifically for members who do not access primary care and members who visited the ER for office-based services. *[Repeat recommendation.]*

Health Plan Response: In order to understand and assess lower than average access and barriers to primary care, LHCC completed an Emergency Department Diversion Review. The study included members with three or more ED visits within a 90 day period and covered the time frame January 1, 2015 – August 2, 2015. 6,141 members were identified. A total of 3,415 outreach calls were made, resulting in 411 successful calls. Root cause analysis for these 411 calls reveals the following most common reasons for utilizing the ED instead of the primary care physician's office:

- § Life-threatening condition (78 responses)
- § Physician accessibility - outside of office hours (45 responses)
- § ED is member's preference for care (41 responses)
- § Not actively seeing PCP (33 responses)
- § Instructed by PC DURING office hours (27 responses)
- § Physician accessibility – unable to get appointment (27 responses)
- § Multiple other reasons included no contracted urgent care center in area, ER encouraged return visit, and knowledge deficit

As a result of the 2015 ED Diversion review and root cause analysis, LHCC implemented 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

To further address the access to primary care gap, LHCC completed, and continues to provide, the following activities:

- § Detailed reporting to the Provider Consultants 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 Primary Care Physician (PCP)
- § Updating the provider appointment availability surveys to include the assessment of the 1st, 2nd, and 3rd appointment availability to better identify potential barriers for appointment access
- § Utilizing a system of outreach targeting high risk members for assistance in the provision of home based primary care

It is expected that access to primary care metrics will increase and meet or exceed targets as a result of the interventions completed. The Plan will review all metrics and results for monitoring to determine

effectiveness through the monthly conducted PIT meetings, where findings are reviewed and action items based on results are implemented.

- § 2014-2015 Recommendation: The Health Plan should continue to work to improve CAHPS® measures that perform below the 50th percentile. The Health Plan should analyze member grievances and member services complaints to identify potential barriers to care and implement initiatives to address these barriers. *[Repeat recommendation.]*

Health Plan Response: LHCC conducted a Member Satisfaction Analysis including Member complaints/grievances and the Member Satisfaction Survey. Key findings indicated that the member's most common areas of dissatisfaction in Member experience were in areas of Access to Care and Attitude and Service. The Member Satisfaction Survey reflects common areas of concern such as adults getting care quickly, child coordination of care, adult health promotion and education, and adult rating of specialists. The Member Satisfaction Survey is supported by the analysis of the member grievances received in 2015 which indicate specific subcategories containing member grievance expressions for access to care issues (involving "getting care quickly" and "getting needed care"). These grievances reflect the member's concerns related to the inability to obtain a requested service and barriers such as transportation and eligibility concerns. The member grievances in the Category of Attitude and Services define many of the member's interpersonal experiences such as physician communication, health promotion, and care coordination concerns. These grievances also contain quality of service issues related to transportation.

As a result, the following interventions/actions were implemented:

- § LHCC Staff educated member/provider with verbal telephone discussion, including contacts related to grievances, appeals, and problem resolution. All communication will contain appropriate information in layman's terms and provide appropriate contact numbers for further assistance, if needed. All available resources will be identified for the member or provider's review.
- § LHCC staff educated the provider with each request for appeal of denied services. Educational opportunities will be identified with verbal (telephone) contact related to the appeal process and documents needed to meet medical necessity, including identification of any missing clinical documentation required.
- § Customer Service Representatives conduct end of call surveys, requesting if the members' needs are being met. Results are entered into CRM for tracking and analysis.
- § Broadened implementation of End of Call Surveys to all member-facing/touching departments.
- § Performed member outreach to frequent callers based on bi-weekly report (call top 10-20 members listed as frequent callers) and assure that member's needs are met and satisfaction is noted.
- § The Plan tracked and trended member grievances, and dissected information into sub-categories to truly identify root cause of the grievances, identifying areas of need for specific and timely intervention. The Plan also increased interdepartmental communication in regard to resolving member grievances in a more efficient manner.
- § The Plan assessed the sufficiency of providers who can assist with language barriers and translation needs.

The Plan revised birthday mail cards, highlighting well visits which included what the "next steps" should be for the member related to well visits, and sent them out to the members.