State of Louisiana Department of Health

Louisiana Healthcare Connections

Annual External Quality Review Technical Report

Review Period: July 1, 2018 – June 30, 2019
Report Issued: April 2020

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List of Tables and Figures

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 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, 2018 – June 30, 2019.

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 2019 National – All Lines of Business ([LOBs] 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 MCO 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	
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 2019)	436,317

III. Enrollment and Provider Network

Enrollment

Medicaid Enrollment

As of June 2019, the MCO's Medicaid enrollment totaled 436,317, which represents 31% of Healthy Louisiana's active members. **Table 2** displays LHCC's Medicaid enrollment for 2017 to 2019, as well as the 2019 statewide enrollment totals.

Table 2: Medicaid Enrollment as of June 2019

LHCC[1]	June 2017	June 2018	June 2019	% Change	2019 Statewide Total[2]
Total enrollment	476,873	470,731	436,317	-7.3%	1,406,048

Data Source: Report No. 109-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 were 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] The statewide total includes membership of all plans.
LHCC: Louisiana Healthcare Connections.

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 June 30, 2019.

Table 3: Primary Care & Ob/Gyn Counts by LDH Region

	LHCC									MCO Statewide
	LDH Region									
Specialty	1	2	3	4	5	6	7	8	9	Unduplicated
Family Practice/ General Medicine	142	111	37	110	56	39	114	98	103	748
Pediatrics	162	77	27	59	32	23	79	21	73	537
Nurse Practitioners	172	203	102	172	86	130	86	207	169	1170
Internal Medicine	173	82	34	45	29	11	68	29	62	503
RHC/FQHC	75	43	32	36	20	42	39	58	40	385
Ob/gyn[1]	12	4	0	4	1	0	2	3	0	26

Data source: Network Adequacy Review Report 220 2019 Jan 1 – June 30.
1 Count includes only those that accept full PCP responsibilities
LDH: Louisiana Department of Health; 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; MCO: managed care organization; RHC/FQHC: Rural Health Clinic/ Federally Qualified Health Center

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 and time between providers and members can be assessed to determine whether members have access to care within a reasonable distance or time from their homes. MCO's are required to meet the distance and/or time standards set by LDH. **Tables 4 and 5** show the percentage of members for whom the distance and/or time standards were met respectively.

Table 4: GeoAccess Provider Network Accessibility (Distance) as of June 30, 2019

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	96.1%[2]
	Rural	1 within 30 miles	100%
Pediatric PCP	Urban	1 within 10 miles	96.6%
	Rural	1 within 30 miles	100%
Ob/gyn	Urban	1 within 15 miles	100%*
	Rural	1 within 30 miles	100%

Data Source: Network Adequacy Review Report 220 2019Jan 1 – June 30.
* Proportion rounded up
[1] The Access Standard is measured in distance to member address.
[2] LHCC reports that LHCC has contracted with all PCP's who are willing to service Medicaid members. LHCC has contracted with all available PCPs in certain parishes that are considered urban but have fewer than the adequate PCP distancing coverage required.
PCP: Primary Care Physician

Table 5: GeoAccess Provider Network Accessibility (Time) as of June 30, 2019

Provider Type		Access Standard[1] X Provider(s) within X Minutes	Percentage of Members for Whom Standard was Met
Adult PCP	Urban	1 in 20 minutes	98.0%
	Rural	1 in 60 minutes	100%
Pediatric PCP	Urban	1 in 20 minutes	98.2%
	Rural	1 in 60 minutes	100%
Ob/gyn	Urban	1 in 30 minutes	100%*
	Rural	1 in 60 minutes	99.0%

Data Source: Network Adequacy Review Report 220 2019Jan 1 – June 30.
* Proportion rounded up
[1] The Access Standard is measured in time to member address.
PCP: Primary Care Physician

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 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 and identifying drivers of improved evidence-based performance. 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 and/or monthly intervention tracking measures. Declining or stagnating intervention tracking measure rates signal the need to modify interventions and re-chart the PIP course. Positive intervention tracking measure trends are an indication of robust interventions.

During the period from July 1, 2018, through June 30, 2019, Healthy Louisiana was in the process of conducting three Collaborative PIPs: 1) Improving Prenatal and Postpartum Care to Reduce the Risk of Preterm Birth; a one-year extension after Final PIP report submitted on June 30, 2018, with PIP Extension reporting completed on June 30, 2019; 2) Improving the Quality of Diagnosis, Management and Care Coordination for Children and Adolescents with Attention-Deficit Hyperactivity Disorder (ADHD), with the Final PIP report submitted on June 30, 2019; and 3) Improving Rates for Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET), with First Quarter PIP Report for the Intervention Period beginning January 1, 2019, submitted on April 30, 2019. As a Collaborative, the five plans agreed upon the following intervention strategies for each PIP:

1. Improving Prenatal and Postpartum Care to Reduce the Risk of Preterm Birth
   A. Baseline to Final PIP Measurement Period (Retrospective Performance Indicator reporting): November 6, 2014–November 5, 2017
   - Implement the Notification 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

   B. Extension Measurement Period (Concurrent Monthly Intervention Tracking Measure [ITM] reporting at monthly ITM meetings): Beginning August 2018, for the measurement period beginning as early as March 2018 (depending upon MCO-specific data reporting) and extending through May 2019, the plans reported monthly on the same ITM to address each of the following corresponding interventions:
      1. Identify/ risk stratify pregnant women; ITM: The percentage of women with evidence of a previous preterm singleton birth (PPSB) event (24–36 weeks completed gestation) who are currently pregnant (denominator) and who had a comprehensive needs assessment ([CNA] e.g., for physical and behavioral health conditions, lack of social supports, substance abuse, hypertension/preeclampsia, etc.) with risk stratification completed (numerator).
      2. Conduct face-to-face care management; ITM: The percentage of women with evidence of a PPSB event (24–36 weeks completed gestation) who are currently pregnant (same denominator as ITM 1) who had a face-to-face encounter with patient navigator (consider for outlier practices) and/or care manager and/or community outreach worker and/or nurse in any setting (e.g., provider office, clinic, home; numerator).
      3. Conduct 17P-enhanced care coordination; ITM: The percentage of women with evidence of a PPSB event (24–36 weeks completed gestation) who are currently pregnant (denominator) and who were contacted via outreach with completed contact (telephonic or face-to-face) to provide education regarding risk for repeat PPSB and 17P treatment and to facilitate ob appointment (numerator).
      4. Provide contraception education/ reproductive plan; The percentage of women with evidence of a PPSB event (24–36 weeks completed gestation) who are currently pregnant (same as ITM 1 denominator) who were contacted during the third trimester for contraception education and completed a reproductive plan for postpartum period (numerator).

5. Notify providers of members at risk for preeclampsia; ITM: the percentage of pregnant women with a history of hypertension/ preeclampsia (denominator) whose provider received notification from the plan that the member is at risk for hypertension/preeclampsia (numerator).
6. Primary care/ Inter-conception referral; ITM: The percentage of women with a current preterm delivery (denominator) with postpartum outreach within six weeks of delivery for comprehensive education on chronic disease management, as indicated; pregnancy spacing and contraception planning; progesterone and ASA AND had an appointment with a PCP scheduled (numerator).

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; and
   - Develop and implement or revised care management programs to improve outreach to eligible and at-risk members for engagement in care coordination.

3. Improving Rates for Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)
   - Conduct provider training to expand the workforce for treatment initiation and follow-up (e.g., medication-assisted treatment guidelines, waiver training);
   - Partner with hospitals/emergency departments (EDs) to improve timely initiation and engagement in treatment (e.g., MCO liaisons, hospital initiatives, ED protocols);
   - Provide enhanced member care coordination (e.g., behavioral health integration, case management, improved communication between MCO utilization management and case management for earlier notification of hospitalization, improved discharge planning practices and support, such as recovery coaches); and
   - Other interventions as informed by the MCO's barrier analyses they will conduct as part of the PIP process.

Summaries of each of the PIPs conducted by Louisiana Healthcare Connections follow.

Improving Prenatal and Postpartum Care to Reduce the Risk of Preterm Birth

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

1. The percentage of women 15–45 years of age with evidence of a previous pre-term singleton birth event (< 37 weeks completed gestation) who received one or more progesterone injections between the 16th and 21st week of gestation (also as reported in the PTB incentive measure).
Baseline to final measurement goal: An improvement from the baseline 2.16% to 17.5% in the percentage of women 1545 years of age with evidence of a previous pre-term singleton birth event (< 37 weeks completed gestation) who received one or more progesterone injections between the 16th and 21st week of gestation.

2. The percentage of women aged 16 years and older who delivered a live birth and had at least one test for chlamydia during pregnancy.
Baseline to final measurement goal: An improvement from the baseline 70.29% to 87% in the percentage of women aged 16 years and older who delivered a live birth and had at least one test for chlamydia during pregnancy.

3. The percentage of women who delivered a live birth and had at least one test for human immunodeficiency virus (HIV) during pregnancy.
Baseline to final measurement goal: An improvement from the baseline 5.95% to 32% in the percentage of women who delivered a live birth and had at least one test for HIV during pregnancy.

4. The percentage of women who delivered a live birth and had at least one test for syphilis during pregnancy.

Baseline to final measurement goal: An improvement from the baseline 71.18% to 85% in the percentage of women who delivered a live birth and had at least one test for syphilis during pregnancy.

5. The percentage of postpartum women who:
a. Adopt use of a most effective Food and Drug Administration (FDA)-approved method of contraception (i.e., female sterilization or long-acting reversible contraception [LARC], such as contraceptive implants, or intrauterine devices of systems [IUD/IUS]).
Baseline to final measurement goal: Adopt use of a most effective FDA-approved method of contraception (i.e., female sterilization or LARC, such as contraceptive implants or intrauterine devices of systems [IUD/IUS]) from a baseline of 19.56% to 30%.

b. Adopt use of a moderately effective method of contraception (i.e., use of injectables, oral pills, patch, ring or diaphragm).
Baseline to final measurement goal: Adopt use of a moderately effective method of contraception (i.e., use of injectable, oral pills, patch, ring or diaphragm) from a baseline of 23.31% to 30%.

c. Adopt use of LARC during delivery hospitalization
Baseline to final measurement goal: Adopt use of a LARC during delivery hospitalization from a baseline of 1.90% to 30%.

d. Adopt use of LARC outpatient within 56 days postpartum
Baseline to final measurement goal: Adopt use of a LARC in an outpatient setting within 56 days postpartum from a baseline of 6.86% to 30%.

6. The percentage of women with a postpartum visit as per the HEDIS prenatal and postpartum care measure
Baseline to final measurement goal: An improvement in the percentage of women with a postpartum visit as per the HEDIS PPC postpartum measure per the baseline administrative rate of 45.96% to 55% and the baseline hybrid rate of 58.23% to 70%.

LHCC conducted the following interventions:

- **Interventions to address member barriers**: Enhanced case management services, notification of pregnancy
- **Interventions to address provider barriers**: Provider education, notification of pregnancy

Results and strengths from the final PIP report

- The original PIP 17P measure rate increased from 2.16% at baseline to 15.84% at final re-measurement (although this rate fell short of the target rate of 17.5%).
- The incentive 17P measure rate increased from 9.62% at interim phase (baseline not reported) to 18.05% at final phase, exceeding the 17.5% target rate.
- The chlamydia test rate increased from 70.29% at baseline to 85.71% at final re-measurement (just short of the 87% target rate).
- The HIV rate increased from 62.56% at baseline to 78.80% at interim, then declined to 75.83% at final re-measurement, which remained an increase from baseline (although short of the target rate of 85%).
- The syphilis test rate increased from 71.28% at baseline to 82.81% at interim, then declined to 77.67% at final-re-measurement, which remained an increase from baseline (although short of the target rate of 85%).
- The HEDIS PPC postpartum measure increased from 58.23% at baseline to 64.85% at interim, with a slight decline at final re-measurement to 63.42%, which remained an increase from baseline (although short of the 70% target rate).
- ITM: The NOP submission rate among the total number of deliveries was more than half, with increasing quarterly trends observed for member-, but not provider-, submitted NOP forms.

- ITM: The percentage of academic detailing visits completed by the medical director increased from Q1 2017 (3/20 = 15%) to Q4 2017 (22/22 = 100%).
- ITM: The percentage of ob/gyn visits completed by the provider network team with better ob/gyn resources material increased from 6.23% (24/385) in Q3 2017 to 90.64% (271/299) in Q4 2017.
- ITM: The percentage of PCP visits completed by the provider network team with preventive care incentives material increased from 10.41% in Q1 2017 to 19.77% in Q4 2017.
- ITM: The percentage of high-risk pregnant members who received CM outreach within 7 days of notification increased from 75% (231/308) in Q1 2017 to 96.60% (284/294) in Q4 2017.

Results/Strengths – Final ITM Workgroup ITM 3 Run Chart Presentation 6/20/19:

- The plan presented a run chart for ITM 3. An overall downward pattern was observed; however, no shifts or trends were observed for the ITM 3 monthly rate. The annual rate for 17P receipt increased from 2.32% in 2015 to 18.39% in 2018.

Opportunities for Improvement/ Next Steps Identified by LHCC:

- ITM 1: Adoption of new script to ensure that new pregnant members (high risk and all pregnant) receive information regarding all benefits and programs available to them and their baby in the initial contact – working towards improved success for successful contact.
- ITM 2: Process change. 100% telephonic outreach by CM with completion of care risk assessment. Members identified as high risk referred to be seen by nurse practitioner/ advance practice registered nurse home health agency for face-to-face meeting to establish and coordinate plan of care with physicians and care management team.
- ITM 3: Care management refers members to Optum weekly after phone contact attempts for 17P education. LHCC is collaborating with Optum to revamp the data reporting.
- ITM 4: Care management to contact all high-risk members during the third trimester of pregnancy for contraception education. Additional education will be mailed to all pregnant members during the third trimester to account for unsuccessful phone contact attempts by care management.
- ITM 5: During Q4 2018, LHCC implement fax blast process to notify providers when they are caring for an LHCC pregnant member with a history of preeclampsia. Further distribution of education material and new guidelines to providers.
- ITM 6: Care management outreach to the member within 7 days post-delivery to schedule postpartum visit. If unable to contact, additional attempts of successful contact will be made within the six weeks. Care management follow-up with member and physician post-appointment to assess if they completed the screening.

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

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

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

A. Hybrid Measures (Utilizing a Random, Stratified Sample of New ADHD Cases for Chart Review):

A1. ***Validated ADHD Screening Instrument***: The percentage of the eligible population sample whose PCP used a validated ADHD screening instrument.
Baseline to final measurement goal: The percentage of the eligible population sample whose PCP used a validated ADHD screening instrument will increase from 33.3% at baseline to 54.7% at final re-measurement.

A2. ***ADHD Screening in Multiple Settings***: The percentage of the eligible population sample whose PCP used a validated ADHD screening instrument completed by reporters across multiple settings (i.e., at home and school).
Baseline to final measurement goal: The percentage of the eligible population sample whose PCP used a validated ADHD screening instrument completed by reporters across multiple settings (i.e., at home and school) will increase from 14.67% to 30.67% at final re-measurement.

A3. ***Assessment of Other Behavioral Health Conditions/Symptoms***: The percentage of the eligible population sample whose PCP conducted a screening, evaluation, or utilized behavioral health consultation for at least one alternate cause of presenting symptoms and/or co-occurring conditions (e.g., oppositional-defiant disorder, conduct disorder, anxiety, depression, autism, learning/language disorders, substance use disorder, trauma exposure/toxic stress).
Baseline to final measurement goal: The percentage of the eligible population sample whose PCP conducted a screening, evaluation, or utilized behavioral health consultation for at least one alternate cause of presenting symptoms and/or co-occurring conditions (e.g., oppositional-defiant disorder, conduct disorder, anxiety, depression, autism, learning/language disorders, substance use disorder, trauma exposure/toxic stress) will increase from 16% to 32.6% at final re-measurement.

A4. ***Positive Findings of Other Behavioral Health Conditions***: The percentage of the eligible subpopulation sample with screening, evaluation, or utilization of behavioral health consultation whose PCP documented positive findings (i.e., positive screens or documented concerns for alternate causes of presenting symptoms and/or co-occurring conditions; goal setting not applicable).

A5a. ***Referral for Evaluation of Other Behavioral Health Conditions***: The percentage of the eligible subpopulation sample with positive findings regarding alternate causes/co-occurring conditions whose PCP documented a referral to a specialist behavioral health provider for evaluation and/or treatment of alternate causes of presenting symptoms and/or co-occurring conditions.
Baseline to final measurement goal: The percentage of the eligible subpopulation sample with positive findings regarding alternate causes/co-occurring conditions whose PCP documented a referral to a specialist behavioral health provider for evaluation and/or treatment of alternate causes of presenting symptoms and/or co-occurring conditions will increase from 60.0% to 80.0% at final re-measurement.

A5b. ***Referral to treat Other Behavioral Health Conditions***: The percentage of the eligible subpopulation sample referred to behavioral specialist for evaluation/treatment of alternate causes/co-occurring conditions whose PCP documented referral to a mental health rehabilitation provider (e.g., community psychiatric supportive treatment (CPST), psychosocial rehabilitation (PSR), Coordinated System of Care (CSoC) to treat alternate causes of presenting symptoms and/or co-occurring conditions.
Baseline to final measurement goal: The percentage of the eligible subpopulation sample referred to a behavioral specialist for evaluation/treatment of alternate causes/co-occurring conditions whose PCP documented referral to a mental health rehabilitation provider (e.g., CPST, PSR, CSOC) to treat alternate causes of presenting symptoms and/or co-occurring conditions will increase from 50.0% to 80.0% at final re-measurement.

A6. ***PCP Care Coordination***: The percentage of the eligible population sample who received PCP care coordination (e.g., provider notes regarding communication with a behavioral therapist, other specialist, the child's teacher, or health plan case manager regarding ADHD care coordination).
Baseline to final measurement goal: The percentage of the eligible population sample who received PCP care coordination (e.g., provider notes regarding communication with a behavioral therapist, other specialist, the child's teacher, or health plan case manager regarding ADHD care coordination) will increase from 38.67% to 60.7% at final re-measurement.

A7. ***MCO Care Coordination***: The percentage of the eligible population sample who received care coordination services from the health plan care coordinator.
Baseline to final measurement goal: The percentage of the eligible population sample who received care coordination services from the health plan care coordinator will increase from 5.33% to 60.7% at final re-measurement.

A8. ***MCO Outreach with Member Contact***: The percentage of the eligible population sample who were contacted via outreach by the health plan care coordinator.
Baseline to final measurement goal: The percentage of the eligible population sample who were contacted via outreach by the health plan care coordinator will increase from 4% to 50.0% at final re-measurement.

A9. ***MCO Outreach with Member Engagement***: The percentage of the members contacted via outreach who were engaged in care management.
Baseline to final measurement goal: The percentage of the members contacted via outreach who were engaged in care management will be maintained at 100% at final re-measurement.

A10. ***First-Line Behavior Therapy for Children < 6 years***: The percentage of the eligible population sample aged < 6 years who received evidence-based behavior therapy as first-line treatment for ADHD.
Baseline to final measurement goal: The percentage of the eligible population sample aged < 6 years who received evidence-based behavior therapy as first-line treatment for ADHD will increase from 0% to 50% at final re-measurement. For this measure, also report the counts for each of the three exclusion reasons.

B. Administrative Measures (Utilizing Encounter/Pharmacy Files):
HEDIS Administrative Measures:

B1a. ***Initiation Phase***: The percentage of members aged 6–12 years as of the 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.
Baseline to final measurement goal: The percentage of members aged 6–12 years as of the 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 will increase from 40.44% to 44.48% at final re-measurement.

B1b. ***Continuation and Maintenance (C&M) Phase***: The 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.
Baseline to final measurement goal: The 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 will increase from 53.83% to 59.21% at final re-measurement.

Non-HEDIS Administrative Measures:

B2a. ***BH Drugs with Behavioral Therapy*****:** Percentage of any ADHD cases, aged 0–20 years, stratified by age and foster care status, with documentation of behavioral health pharmacotherapy (e.g., ADHD medication, antipsychotics, and/or other psychotropics), <u>with</u> behavioral therapy.
Baseline to final measurement goal: Percentage of any ADHD cases, aged 0–20 years, stratified by age and foster care status, with documentation of behavioral health pharmacotherapy (e.g., ADHD medication, antipsychotics, and/or other psychotropics), <u>with</u> behavioral therapy will increase from 39.9% to 41.11% at final re-measurement.

B2b. ***BH Drugs <u>without</u> Behavioral Therapy***. Percentage of any ADHD cases, aged 0–20 years, stratified by age and foster care status, with documentation of behavioral health pharmacotherapy (e.g., ADHD medication, antipsychotics, and/or other psychotropics), <u>without</u> behavioral therapy.
Baseline to final measurement goal: Percentage of any ADHD cases, aged 0–20 years, stratified by age and foster care status, with documentation of behavioral health pharmacotherapy (e.g., ADHD medication, antipsychotics, and/or other psychotropics), <u>without</u> behavioral therapy will decrease from 46.2% to 40.0% at final re-measurement.

<u>LHCC conducted the following interventions</u> :

- <u>Interventions to address member barriers</u>: Enhanced case management program.
- <u>Interventions to address provider barriers</u>: Provider education, workforce capacity analysis, BH consultation to PCPs.

Results and strengths are summarized in the following:

- Indicator A1, Validated ADHD Screening instrument, increased from 33.33% at baseline to 72% at interim and exceeded the target rate of 54.63%. In response to IPRO's recommendation, the plan increased the target rate to 78.67%. However, at final report, the rate decreased from 72% to 62.66%, still above the initial target rate, but below the revised target rate; thus, improvement was not sustained.
- Indicator A2, ADHD Screeening in Multiple Settings, increased from 14.67% at baseline to 66.67% at interim and exceeded the target rate of 30.67%. In response to IPRO's recommendation, the plan increased the target rate to 78.67%. However, at final report, the rate decreased from 66.67% to 50.66%, still above the initial target rate, but below the revised target rate; thus, improvement was not sustained.
- Indicator A3, Assessment of Other Behavioral Health Conditions, increased from 16% at baseline to 24% at interim, then again to 46.66% at final re-measurement. The final rate exceeded the target rate of 32.60%; thus, improvement was sustained.
- Indicator A5a, Referral for Evaluation of Other Behavioral Health Conditions, increased from 60% at baseline to 78.94% at interim, then to 100% at final re-measurement and exceeded the target rate of 80.00%; thus, improvement was sustained.
- Indicator A5b, Referral to Treat Other Behavioral Health Conditions, increased from 50% to 89.47% and exceeded the target rate of 80%. In response to IPRO's recommendation, the plan increased the target rate to 85.00%. The final rate increased to 100% and again exceeded the target rate; thus, improvement was sustained.
- Indicator A6, PCP Care Coordination, increased from 38.67% at baseline to 64% at interim and exceeded the target rate of 60.70%. In response to IPRO's recommendation, the plan increased the target rate to 70.67%. The final rate increased to 90.66% and again exceeded the target rate; thus, improvement was sustained.
- Indicator A10, First-Line Behavioral Therapy for Children < 6 Years, increased from 0% to 43.33% and then the final rate declined to 33.33%. The target rate was not met; thus, improvement was not sustained.
- Indicator B1a, HEDIS ADHD Initiation, increased from 40.44% at baseline to 56.82% at interim and exceeded the target rate of 44.48%. However, the final rate declined to 49.81; therefore, although the final rate was above the target rate, improvement was not sustained.
- Indicator B1b, HEDIS ADHD Continuation, increased from 53.83% at baseline to 69.15% at interim and exceeded the target rate of 59.21%. However, the final rate declined to 65.82%; therefore, although the final rate was above the target rate, improvement was not sustained.
- Indicator B2b, BH Drug without Behavioral Therapy, decreased from 74.18% at baseline to 61.25% at interim, and decreased again to 59.58% at final re-measurement. Although improvement was sustained, the target rate of 40.00% was not achieved.
- ITM for providers completing LHCC-provided child-parent psychotherapy training: 35 of 35 providers completed training in Q2 2018, 35 of 35 in Q3 2018, and 31 of 35 in Q4 2018.
- ITM to monitor the percentages of foster children ages 4–5 with a new ADHD prescription who also have a claim for counseling was initiated in Q4 2018.
- ITM to monitor percentage of children in foster care (regardless of age) with a new ADHD prescription who also have a claim for counseling was initiated in Q4 2018.
- Next steps: The plan is offering nurse practitioners working with federally qualified health center training to become specialized in psychiatry.

Opportunities for Improvement:

- The plan added an ITM to monitor receipt of counseling by foster children with a new ADHD medication; however, this ITM does not address first-line behavioral therapy, and there was no new intervention indicated that was informed by a barrier analysis for this specific subpopulation.
- No new barrier analysis was conducted to inform tailoring and targeting of modified and enhanced interventions.
- There was a missed opportunity to conduct Plan-Do-Study-Act testing of a new intervention to engage children ages 4–5 diagnosed with ADHD in CM prior to ADHD medication prescription.
- The addition of new ITMs suggests that interventions were modified; however, it was not evident how barrier analysis informed modification of interventions key to address the behavioral therapy needs of children aged 4–5 years prior to ADHD prescription.

- There was a missed opportunity to modify care management interventions for enhanced CM to facilitated BH therapy as first-line therapy for children with ADHD who are aged 4–5 years.
- The missed opportunity indicated above includes a missed opportunity to monitor enhanced outreach for younger children to ensure receipt of BH therapy prior to, or instead of, ADHD pharmacotherapy.
- Plan attention is merited to consider impact on very young children, as described above in the interventions comments, as well as the overall weak performance of MCO CM performance indicators. Moreover, the poor performance of the MCO CM indicators merits more in-depth analysis and plans for action.
- More thorough analysis of barriers to CM is merited, particularly for very young children, with actions taken for next steps for improvement in CM for all children with ADHD, with particular focus on first-line BH therapy for very young children.

Overall Credibility of Results:

The validation findings generally indicate that the credibility of the PIP results is not at risk.

Improving Rates for Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)

Indicators, Baseline Rates and Goals: The indicators, baseline rates and corresponding target rates for performance improvement from baseline to final re-measurement are shown in **Table 6**.

Table 6: Indicators, Baseline Rates, and Goals for IET

Performance Indicator	Baseline Period	Final Goal/Target Rate
Indicator 1a.i. Initiation of AOD treatment: age 13–17 years, alcohol abuse or dependence diagnosis cohort	Numerator = 52 Denominator = 98 Rate = 53.06%	Target Rate:56.06 Rationale: 3 percentage points higher
Indicator 1a.ii. Initiation of AOD treatment: age 13–17 years, opioid abuse or dependence diagnosis cohort	Numerator = 17 Denominator = 18 Rate = 94.44%	Target Rate:97.44% Rationale: 3 percentage points higher
Indicator 1a.iii. Initiation of AOD treatment: age 13–17 years, other drug abuse or dependence diagnosis cohort	Numerator = 326 Denominator = 603 Rate = 54.06%	Target Rate: 57.06% Rationale: 3 percentage points higher
Indicator 1a.iv. Initiation of AOD treatment: age 13–17 years, total diagnosis cohort	Numerator = 350 Denominator = 659 Rate 53.11%	Target Rate: 56.11% Rationale: 3 percentage points higher
Indicator 1b.i. Initiation of AOD treatment: age 18+ years, alcohol abuse or dependence diagnosis cohort	Numerator = 1,527 Denominator = 3,526 Rate = 43.31%	Target Rate: 46.31% Rationale: 3 percentage points higher
Indicator 1b.ii. Initiation of AOD treatment: age 18+ years, opioid abuse or dependence diagnosis cohort	Numerator = 930 Denominator = 1,628 Rate = 57.13%	Target Rate: 58.67% Rationale: next highest NCQA Quality Compass percentile
Indicator 1b.iii. Initiation of AOD treatment: age 18+ years, other drug abuse or dependence diagnosis cohort	Numerator = 3,196 Denominator = 6,716 Rate = 47.59%	Target Rate: 50.59% Rationale: 3 percentage points higher
Indicator 1b.iv. Initiation of AOD treatment: age 18+ years, total diagnosis cohort	Numerator = 4,772 Denominator = 10,403 Rate = 45.87%	Target Rate:48.87% Rationale:3 percentage points higher
Indicator 1c.i. Initiation of AOD treatment: total age groups, alcohol abuse or dependence diagnosis cohort	Numerator = 1,579 Denominator = 3,624 Rate = 43.57%	Target Rate: 46.57% Rationale: 3 percentage points higher
Indicator 1c.ii.	Numerator = 947	Target Rate: 60.53%

Performance Indicator	Baseline Period	Final Goal/Target Rate
Initiation of AOD treatment: total age groups, opioid abuse or dependence diagnosis cohort	Denominator = 1,646 Rate = 57.53%	Rationale: 3 percentage points higher
Indicator 1c.iii. Initiation of AOD treatment: total age groups, other drug abuse or dependence diagnosis cohort	Numerator = 3,522 Denominator = 7,319 Rate = 48.12%	Target Rate:51.12% Rationale: 3 percentage points higher
Indicator 1c.iv. Initiation of AOD treatment: total age groups, total diagnosis cohort	Numerator = 5,122 Denominator = 11,062 Rate = 46.30%	Target Rate: 49.30% Rationale: 3 percentage points higher
Indicator 2a.i. Engagement of AOD treatment: age 13–17 years, alcohol abuse or dependence diagnosis cohort	Numerator = 29 Denominator = 98 Rate = 29.59%	Target Rate: 32.59% Rationale: 3 percentage points higher
Indicator 2a.ii. Engagement of AOD treatment: age 13–17 years, opioid abuse or dependence diagnosis cohort	Numerator = 11 Denominator = 18 Rate = 61.11%	Target Rate: 64.11% Rationale: 3 percentage points higher
Indicator 2a.iii. Engagement of AOD treatment: age 13–17 years, other drug abuse or dependence diagnosis cohort	Numerator = 190 Denominator = 603 Rate = 31.51%	Target Rate: 34.51% Rationale: 3 percentage points higher
Indicator 2a.iv. Engagement of AOD treatment: age 13–17 years, total diagnosis cohort	Numerator = 199 Denominator = 659 Rate = 30.20%	Target Rate: 33.20% Rationale: 3 percentage points higher
Indicator 2b.i. Engagement of AOD treatment: age 18+ years, alcohol abuse or dependence diagnosis cohort	Numerator = 339 Denominator = 3,526 Rate = 9.61%	Target Rate: 12.61% Rationale: 3 percentage points higher
Indicator 2b.ii. Engagement of AOD treatment: age 18+ years, opioid abuse or dependence diagnosis cohort	Numerator = 387 Denominator = 1,628 Rate = 23.77%	Target Rate: 26.77% Rationale: 3 percentage points higher
Indicator 2b.iii. Engagement of AOD treatment: age 18+ years, other drug abuse or dependence diagnosis cohort	Numerator = 899 Denominator = 6,716 Rate = 13.39%	Target Rate: 14.23% Rationale: next highest NCQA Quality Compass percentile
Indicator 2b.iv. Engagement of AOD treatment: age 18+ years, total diagnosis cohort	Numerator = 1,360 Denominator = 10,403 Rate = 13.07%	Target Rate: 15.57% Rationale: next highest NCQA Quality Compass percentile
Indicator 2c.i. Engagement of AOD treatment: total age groups, alcohol abuse or dependence diagnosis cohort	Numerator = 398 Denominator = 3,624 Rate = 10.15%	Target Rate: 12.65% Rationale: next highest NCQA Quality Compass percentile
Indicator 2c.ii. Engagement of AOD treatment: total age groups, opioid abuse or dependence diagnosis cohort	Numerator = 398 Denominator = 1,646 Rate = 24.18%	Target Rate: 27.18% Rationale: 3 percentage points higher
Indicator 2c.iii. Engagement of AOD treatment: total age groups, other drug abuse or dependence diagnosis cohort	Numerator = 1,089 Denominator = 7,319 Rate = 14.88%	Target Rate: 15.62% Rationale: next highest NCQA Quality Compass percentile
Indicator 2c.iv. Engagement of AOD treatment: total age groups, total diagnosis cohort	Numerator = 1,559 Denominator = 11,062 Rate = 14.09%	Target rate: 15.62% Rationale: next highest NCQA Quality Compass percentile

AOD: alcohol and other drug; NCQA: National Committee for Quality Assurance.

LHCC conducted the following interventions:

- **Interventions to address member barriers**: LHCC will be proactive in seeking out members who need this treatment rather than relying on member to reach out to us or their provider.
- **Interventions to address provider barriers**: Provider network to conduct outreach and educate providers about this certification and let them know of providers in their area that are certified in MAT.

Results/ Strengths:
- The plan identified proactive member and provider strategies for interventions to address general barriers.
- The plan specified an ITM to monitor education of PCPs regarding availability of MAT-trained providers.
- The plan specified an ITM to monitor member case management.

Opportunities for Improvement:
- There were no first quarter performance measure rates that met the target rate.
- Do primary care providers effectively screen for SUD, such as using SBIRT, TAPS, etc.? Once screened and an evaluation is indicated, do primary care and outpatient behavioral health providers know to whom to refer for a comprehensive SUD evaluation (ASAM six dimension) to determine the appropriate type/level of care?
- After screening, when indicated, are there sufficient licensed medical health professionals, as defined above, to evaluate members for placement at the appropriate type/level of care? Do the LMHPs have a list of all ASAM type/level referral options?
- Does the MCO have staff trained in SBIRT, TAPS, etc. to train PCPs in screening and ASAM six dimension patient placement criteria to educate LMHP SUD evaluators, and a listing of SUD providers at all covered ASAM levels of care easily available to all providers?

Overall Credibility of Results: Final PIP validation to be conducted upon IPRO receipt of the Final IET PIP Report due November 30, 2019.

Performance Measures: HEDIS 2019 (Measurement Year 2018)

MCO-reported performance measures were validated as per HEDIS 2019 Compliance Audit specifications developed by the NCQA. The results of each MCO's HEDIS 2019 Compliance Audit are summarized in its final audit report (FAR).

HEDIS Effectiveness of Care Measures

HEDIS Effectiveness of Care measures evaluate how well an MCO provides preventive screenings and care for members with acute and chronic illnesses. **Table 7** displays MCO performance rates for select HEDIS Effectiveness of Care measures for HEDIS 2017, HEDIS 2018, HEDIS 2019, Healthy Louisiana 2019 statewide averages, and Quality Compass 2019 National – All Lines of Business ([LOBs] Excluding PPOs and EPOs) Medicaid benchmarks.

Table 7: HEDIS Effectiveness of Care Measures – 2017–2019

Measure	LHCC			Quality Compass 2019 National – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded	Healthy Louisiana HEDIS 2019 Average
	HEDIS 2017	HEDIS 2018	HEDIS 2019		
Adult BMI Assessment	85.36%	80.37%	75.19%	10th	82.51%
Antidepressant Medication Management - Acute Phase	44.50%	49.13%	45.42%	10th	48.17%
Antidepressant Medication Management - Continuation Phase	28.17%	34.39%	29.30%	5th	32.56%
Asthma Medication Ratio (5-64 Years)	55.33%	66.59%	65.19%	50th	64.08%
Breast Cancer Screening in Women	57.25%	55.40%	59.50%	50th	57.70%
Cervical Cancer Screening	56.39%	49.14%	59.85%	33.33rd	56.41%
Childhood Immunization Status - Combination 3	67.31%	68.13%	72.02%	50th	70.99%
Chlamydia Screening in Women (16-24 Years)	64.13%	65.97%	67.11%	75th	66.19%
Comprehensive Diabetes Care - HbA1c Testing	74.13%	84.43%	84.91%	10th	85.78%
Controlling High Blood Pressure	39.45%	37.96%	41.61%	5th	47.88%
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	53.83%	69.15%	49.81%	66.67th	50.65%
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	40.44%	56.82%	65.82%	75th	65.01%
Medication Management for People With Asthma Total - Medication Compliance 75% (5-64 Years)	19.94%	29.83%	26.30%	10th	29.61%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile	56.25%	58.64%	62.04%	10th	65.66%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	58.17%	54.74%	53.53%	10th	58.66%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity	44.23%	43.80%	45.99%	10th	50.62%

HEDIS: Healthcare Effectiveness Data and Information Set; PPOs: Preferred Provider Organizations; EPOs: Exclusive Provider Organizations; BMI: body mass index; ADHD: attention deficit/hyperactivity disorder.

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 8** displays MCO rates for select HEDIS Access to/Availability of Care measure rates for HEDIS 2017 HEDIS 2018, HEDIS 2019, Healthy Louisiana 2019 statewide averages, and Quality Compass 2019 National – All Lines of Business ([LOBs] Excluding PPOs and EPOs) Medicaid benchmarks.

Table 8: HEDIS Access to/Availability of Care Measures – 2017–2019

Measure	LHCC			Quality Compass 2019 National – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded	Healthy Louisiana HEDIS 2019 Average
	HEDIS 2017	HEDIS 2018	HEDIS 2019		
Children and Adolescents' Access to PCPs					
12–24 Months	96.67%	96.81%	95.55%	33.33rd	95.68%
25 Months–6 Years	87.97%	89.08%	88.58%	50th	88.36%
7–11 Years	89.29%	90.88%	91.24%	50th	91.25%
12–19 Years	88.35%	90.15%	90.56%	50th	90.60%
Adults' Access to Preventive/Ambulatory Services					
20–44 Years	81.64%	77.57%	77.10%	33.33rd	76.81%
45–64 Years	88.09%	85.67%	85.07%	33.33rd	84.95%
65+ Years	87.57%	85.23%	74.96%	5th	86.24%
Access to Other Services					
Prenatal Care	80.94%	79.47%	75.67%	10th	79.40%
Postpartum Care	64.85%	63.42%	64.48%	33.33rd	67.63%

HEDIS: Healthcare Effectiveness Data and Information Set; PPOs: Preferred Provider Organizations; EPOs: Exclusive Provider Organizations.

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 9** displays MCO rates for select HEDIS Use of Services measure rates for HEDIS 2017, HEDIS 2018, HEDIS 2019, Healthy Louisiana 2019 statewide averages, and Quality Compass 2019 National – All Lines of Business ([LOBs] Excluding PPOs and EPOs) Medicaid benchmarks.

Table 9: Use of Services Measures – 2017–2019

Measure	LHCC			Quality Compass 2019 National – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded	Healthy Louisiana HEDIS 2019 Average
	HEDIS 2017	HEDIS 2018	HEDIS 2019		
Adolescent Well-Care Visit	52.64%	46.10%	53.04%	33.33rd	56.68%
Ambulatory Care Emergency Department Visits/1000 Member Months[1]	67.62	77.73	73.68	75th	75.02
Ambulatory Care Outpatient Visits/1000 Member Months	371.65	403.11	410.52	75th	413.54
Well-Child Visits in the First 15 Months of Life 6+ Visits	52.29%	58.54%	60.58%	25th	63.22%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	66.13%	67.92%	68.63%	25th	70.05%

1 A lower rate is desirable.
HEDIS: Healthcare Effectiveness Data and Information Set; PPOs: Preferred Provider Organizations; EPOs: Exclusive Provider Organizations.

Member Satisfaction: Adult and Child CAHPS 5.0H

In 2019, 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 LHCCC by the NCQA-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 10, **Table 11,** and **Table 12** show LHCC's CAHPS rates for 2017, 2018, and 2019, as well as Quality Compass 2019 National – All Lines of Business ([LOBs] Excluding PPOs and EPOs) Medicaid benchmarks.

Table 10: Adult CAHPS 5.0H – 2017–2019

Measure[1]	LHCC			QC 2019 National – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark
	CAHPS2017	CAHPS 2018	CAHPS2019	

Getting Needed Care	83.09%	83.71%	80.16%	10th
Getting Care Quickly	80.76%	83.15%	84.26%	66.67th
How Well Doctors Communicate	91.02%	91.35%	95.22%	90th
Customer Service	93.14%	90.50%	91.38%	75th
Shared Decision Making	73.23%	79.02%	78.77%	25th
Rating of All Health Care	73.02%	77.38%	78.65%	75th
Rating of Personal Doctor	82.66%	81.14%	85.92%	75th
Rating of Specialist	87.59%	86.44%	82.35%	33.33rd
Rating of Health Plan	77.20%	80.58%	80.63%	66.67th

[1] 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: Result is not reportable by NCQA due to insufficient denominator (less than 100 responses).
CAHPS: Consumer Assessment of Healthcare Providers and Systems; PPOs: Preferred Provider Organizations; EPOs: Exclusive Provider Organizations.

Table 11: Child CAHPS 5.0H General Population – 2017–2019

Measure[1]	LHCC			QC 2019 National – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded
	CAHPS 2017	CAHPS 2018	CAHPS 2019	
Getting Needed Care	89.13%	88.81%	85.70%	50th
Getting Care Quickly	92.98%	95.34%	91.89%	66.67th
How Well Doctors Communicate	94.09%	94.62%	95.70%	75th
Customer Service	90.32%	91.28%	90.68%	75th
Shared Decision Making	77.97%	81.73%	78.89%	33.33rd
Rating of All Health Care	88.12%	90.35%	89.90%	66.67th
Rating of Personal Doctor	88.42%	91.03%	91.03%	50th
Rating of Specialist	85.85%	88.79%	88.46%	50th
Rating of Health Plan	90.11%	89.06%	89.97%	75th

[1] 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: Result is not reportable by NCQA due to insufficient denominator (less than 100 responses).CAHPS: Consumer Assessment of Healthcare Providers and Systems; PPOs: Preferred Provider Organizations; EPOs: Exclusive Provider Organizations.

Table 12: Child CAHPS 5.0H CCC Population – 2017–2019

Measure[1]	LHCC			QC 2019 National – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded
	CAHPS 2017	CAHPS 2018	CAHPS 2019	
Getting Needed Care	91.75%	88.35%	88.49%	50th
Getting Care Quickly	94.49%	96.01%	96.65%	95th
How Well Doctors Communicate	95.25%	94.92%	96.23%	75th
Customer Service	93.91%	91.12%	88.46%	33.33rd
Shared Decision Making	83.85%	84.83%	81.88%	5th
Rating of All Health Care	85.98%	89.46%	88.47%	75th
Rating of Personal Doctor	90.06%	91.29%	92.39%	90th
Rating of Specialist	87.37%	86.36%	92.42%	90th
Rating of Health Plan	89.82%	88.57%	87.57%	75th

[1] 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: Result is not reportable by NCQA due to insufficient denominator (less than 100 responses).
CAHPS: Consumer Assessment of Healthcare Providers and Systems; PPOs: Preferred Provider Organizations; EPOs: Exclusive Provider Organizations; N/A: not applicable.

Health Disparities

For this year's technical report, the LA EQRO 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.

In the interest of report length only the MCO's response to question 5 detailing the interventions addressing disparities is reported here.

5. During 2018 and 2019, did the MCE conduct any studies or participate in any initiatives to do the following: Develop and/or implement interventions that aim to reduce or eliminate differences in health outcomes or health status and to improve the quality of care for MCE members identified with at-risk characteristics. If yes, describe impact of interventions.

MCO response: Louisiana Healthcare Connections' Case Management department developed an Emergency Department (ED) Diversion Program as a quality initiative to (1) identify members who were inappropriately utilizing the ED and (2) assess the root cause of why individual members utilized the ED instead of seeing their Primary Care Provider. Once the root cause was determined, a Care Manager assisted the member with relevant resources and appropriate education on where to go for care. Knowing how to utilize the correct level of care and manage their health care needs more appropriately improves the member's overall quality of care. Throughout 2019, Louisiana Healthcare Connections identified unique members from the SSI and Medicaid Expansion population who were enrolled in Case Management for ED over utilization. The average monthly baseline utilization of the group of members identified each quarter was 1,523 visits. By receiving assistance and education regarding ED utilization from the Care Managers, there were a total of 5,593 ED visits avoided in 2019.

In addition, Louisiana Healthcare Connections has implemented several new designed to address health disparities and eliminate differences in health outcomes. The initiatives are as follows:

a) Unite Us – a web-based platform that allows providers to network with and coordinate community services for members who have SDOH needs. This initiative is currently piloting in Region 4.
b) Quartet – a web-based platform that allows entities such as PCPs to engage/consult directly with Behavioral Health professionals such as Psychiatrists. This platform is particularly powerful in the effort to get behavioral health care to rural areas/regions. This initiative currently operates in Region 1, with talk of expanding to Region 2 soon.
c) "Hunger for Health" Food Insecurity Toolkits - In November 2018, Louisiana Healthcare Connections collaborated with Feeding Louisiana, the statewide food bank association, to develop food insecurity toolkits for providers. The toolkit included education for providers about food insecurity, instructed providers on how to use the Hunger Vital Sign™ two-question food insecurity screening to identify patients experiencing food insecurity and also included tear pads to refer patients to their local food bank. Toolkits were provided to all FQHCs and RHCs statewide and were also posted online for use by any provider. Our Provider Relations team continues to distribute toolkits to in-network providers and educate them about food insecurity and local resources.
d) The Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) performance improvement project (PIP) has been extended by LDH for at least another year. This PIP addresses a) the need to get more members into addiction treatment when needed, and b) the need to have more prescribers of medications like Buprenorphine, which aids in maintaining sobriety in people that are addicted to opiates/opioids.
e) Dental Benefit Enhancement - In February 2019, Louisiana Healthcare Connections responded to member feedback by enhancing our adult dental benefit, which is a value-added service. We partnered with Envolve Dental, a dental benefit manager, to bring new providers into our network and offer a benefit of $500 per member, per year.

Louisiana Healthcare Connections has also developed a Follow-up After Hospitalization (FUH) program which targets members who are high-risk and high-utilizers of the Emergency Department for education and support and aims to assist members who are discharging from IP psychiatric facilities with preliminary discharge planning.

Louisiana Healthcare Connections entered into agreements with two Intensive Outpatient Program (IOP) providers — Compass Health and Oceans Healthcare — which have facilities located across the state of Louisiana. In doing so, Louisiana Healthcare Connections was able to offer a step-down option from hospitalization to community for members who are discharging and offer facility discharge planners support with their plan of care for Louisiana Healthcare Connections members. Louisiana Healthcare Connections is the only Healthy Louisiana MCE that pays claims for IOP psychiatric treatment, as this service is not covered by traditional Medicaid. Louisiana Healthcare Connections is also able to assist with access to other levels of care available to members after their inpatient stay. The goal of the program is to ensure that the member attends their aftercare appointment within 7-30 days of discharge, thereby reducing re-hospitalization. Objectives of the program is as follows:

a) To ensure that members have appropriate psychiatric follow-up appointment after hospitalization.
b) To assist IP facilities with preliminary discharge planning for Louisiana Healthcare Connections members.
c) To assist members in removing barriers to access to care, and identify/ remove barriers to attending their aftercare appointments.

V. Compliance Monitoring

Medicaid Compliance Audit Findings for Contract Year 2019

IPRO conducted the 2019 Compliance Audit on behalf of the LDH. Full compliance audits occur every three years, with partial audits occurring within the intervening years. The 2019 annual compliance audit was a full audit of the MCO's compliance with contractual requirements during the period of April 1, 2018, through March 31, 2019.

The 2019 Compliance Audit included a comprehensive evaluation of LHCC's policies, procedures, files and other materials corresponding to the following nine domains:

- Eligibility and Enrollment
- Marketing and Member Education
- Member Grievances and Appeals
- Provider Network Requirements
- Utilization Management
- Quality Management
- Fraud, Waste and Abuse
- Core Benefits and Services
- Reporting

The file review component assessed the MCO's implementation of policies and its operational compliance with regulations related to complaints and grievances, member appeals, informal reconsiderations, care management (physical and behavioral health), utilization management, and provider credentialing and re-credentialing.

Specifically, file review consisted of the following six areas:

- Member Grievances
- Appeals
- Informal Reconsiderations
- Case Management (behavioral and physical health)
- Credential/Re-credentialing
- Utilization Management

Sample sizes for each file review type are presented in **Table 13**.

Table 13: File Review Sample Sizes

File Type	Sample Size
Member Grievances	15
Appeals	10

File Type	Sample Size
Informal Reconsiderations	5
Case Management (physical health)	10
Case Management(behavioral health)	10
Credential/Recredentialing	10
Utilization Management	10

The period of review was April 1, 2018, through March 31, 2019. All documents and case files reviewed were active during this time period.

For this audit, determinations of "full compliance," "substantial compliance," "minimal compliance," "non-compliance," and "Not Applicable" were used for each element under review. The definition of each of the review determinations is presented in **Table 14**.

Table 14: Review Determination Definitions

Review Determination	Definition
Full compliance	The MCO is compliant with the standard.
Substantial	The MCO is compliant with most of the requirements of the standard but has minor deficiencies.
Minimal	The MCO is compliant with some of the requirements of the standard, but has significant deficiencies that require corrective action.
Non-compliance	The MCO is not in compliance with the standard.
Not Applicable	The requirement was not applicable to the MCO.

Summary of Findings

Table 15 provides a summary of the audit results by audit domain. Detailed findings for each of the elements that were less than fully compliant follow the table.

Table 15: Audit Results by Audit Domain

Audit Domain	Total Elements	Full	Substantial	Minimal	Non-compliance	N/A	% Full[1]
Core Benefits and Services	115	113	2	0	0	0	98%
Provider Network Requirements	184	172	12	0	0	0	93%
Utilization Management	87	83	2	0	2	0	95%
Eligibility, Enrollment, and Disenrollment	13	13	0	0	0	0	100%
Marketing and Member Education	83	78	1	0	0	4	99%
Member Grievance and Appeals	65	61	4	0	0	0	94%
Quality Management	114	112	1	0	0	1	99%

Fraud, Abuse, and Waste Prevention	118	118	0	0	0	0	100%
Reporting	1	1	0	0	0	0	100%
TOTAL	780	751	22	0	2	5	97%

[1] N/As are not included in the calculation.
N/A: not applicable.

As presented in **Table 15**, 780 elements were reviewed for compliance. Of the 780, 751 were determined to fully meet the regulations, while 22 substantially met the regulations, and 2 were non-compliant. Five elements were deemed not applicable. The overall compliance score for LHCC was 97% elements in full compliance.

It is the expectation of both IPRO and the LDH that LHCC submit a corrective action plan for each of the 24 elements determined to be less than fully compliant, along with a timeframe for completion of the corrective action. Note that LHCC may have implemented corrective actions for some areas identified for improvement while the audit was in progress, but these corrective actions will still require a written response because they were made after the period of review. More than half of the issues noted related to LHCC's provider network adequacy and the MCO's ability to contract with providers in several specialty and sub-specialty areas–a problem prevalent in the Louisiana Medicaid Managed Care program. Though there were only four elements in the Utilization Management (UM) domain that did not achieve full compliance, two that related to concurrent utilization review were determined to be non-compliant and two that were substantially compliant related to UM file review issues. The MCO should ensure that their policies referencing concurrent utilization review are updated to reflect the contract requirement and that staff receive education in properly notifying providers regarding UM decisions and in the timing requirements of informal reconsiderations.

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 measures:
  - Chlamydia Screening in Women (16-24 Years)
  - Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase
  - Ambulatory Care Outpatient Visits/1000 Member Months

- **CAHPS (Member Satisfaction) –** LHCC met or exceeded the 75th percentile for the following CAHPS measures:
  - Adult population
    - How Well Doctors Communicate
    - Customer Service
    - Rating of All Health Care
    - Rating of Personal Doctor
  - Child General population
    - How Well Doctors Communicate
    - Customer Service
    - Rating of Health Plan
  - Child CCC population
    - Getting Care Quickly
    - How Well Doctors Communicate
    - Rating of All Health Care
    - Rating of Personal Doctor
    - Rating of Specialist
    - Rating of Health Plan

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
  - Antidepressant Medication Management - Acute Phase
  - Antidepressant Medication Management - Continuation Phase
  - Cervical Cancer Screening
  - Comprehensive Diabetes Care - HbA1c Testing
  - Controlling High Blood Pressure
  - Medication Management for People With Asthma Total - Medication Compliance 75% (5-64 Years)
  - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile
  - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition
  - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity
  - Children and Adolescents' Access to PCPs
    - 12–24 Months
  - Adults' Access to Preventive/Ambulatory Services
    - 20–44 Years

    - 45–64 Years
    - 65+ Years
  - Access to Other Services
    - Prenatal Care
    - Postpartum Care
  - Adolescent Well-Care Visit
  - Ambulatory Care Emergency Department Visits/1000 Member Months
  - 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 population
    - Getting Needed Care
    - Shared Decision Making
    - Rating of Specialist
  - Child general
    - Shared Decision Making
  - Child CCC population
    - Customer Service
    - Shared Decision Making

Recommendations

- Twenty (20) of 30 HEDIS measures fell below the 50th percentile; the MCO should continue to evaluate the effectiveness of their current interventions. The MCO had a prior recommendation to reevaluate the effectiveness of interventions due to poor performing HEDIS measures. These measures have not shown improvement over the reporting period.
    - The MCO should develop specific interventions to address the worst performing HEDIS measures:
      - Antidepressant Medication Management - Continuation Phase (<10th percentile)
      - Controlling High Blood Pressure
      - Adults' Access to Preventive/Ambulatory Services (65+ Years) (<10th percentile)

- The MCO should continue to work to improve CAHPS® scores that perform below the 50th percentile.
    - The MCO should develop specific interventions to address the worst performing CAHPS measure:
      - Child CCC population: Shared Decision Making (<10th percentile)

MCO's Response to Previous Recommendations (2019)

Recommendation: 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.

MCO Response: HEDIS measures and associated quality of care initiatives are closely monitored by the HEDIS Steering Committee, composed of key contributors from departments 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. The following initiatives are examples of the collaborative products of the HEDIS Steering Committee and LHCC as we strive for continued improvement of health outcomes and access to care.

- Two workgroups were formed from the HEDIS Steering Committee to better address barriers andto develop new strategies to move some of our more challenging HEDIS measures to the 50th percentile and beyond. The Behavioral Health workgroup concentrates on AMM, FUH, and SAA.The physical health workgroup specific measures of focus are SPD, CCS, and MMA.
- LHCC has implemented a HEDIS care gap tool, Interpreta, that allows stakeholders (including but not limited to providers and care managers), direct access to care gaps and HEDIS performance.This tool has positively impacted communication across the multidisciplinary team, providing timely information and allowing targeted intervention as needed.
- Provider incentives were aligned with HEDIS measures during 2019, promoting joint focus on clinical outcomes and improvement of quality scores. Provider engagement is supported through improved communication and collaboration, including direct access to PMPM reports andperformance dashboards each month via the secure provider portal. Providers who are not meeting the measures are identified and prioritized for on-site visits by the provider support staff.
- Measure performance remains closely monitored along with associated interventions completedand/or in progress to improve member care and close HEDIS gaps, including the following initiatives:
    - Implementation of automated messaging platforms to support outreach initiatives,specifically AMM and MMA measures identified for targeted intervention. A marketing initiative focusing on AMM education has also been added to support member engagement and compliance efforts.
    - Implementation of a digital care coordination platform, My Health Direct, is now fully operational and supporting gap closure efforts and appointment scheduling for members of participating providers who have chosen to sign up for this program.
    - Expanded collaboration between behavioral health and quality stakeholders to address FUH care gaps for members at risk of noncompliance and support access to follow upcare and continuation of treatment. An FUH pilot of a life coaching program was initiated in 2018, with continued expansion and development in 2019.
    - Targeted outreach for ADD was initiated by the BH team with ongoing monitoring ofcompliance and barrier identification for continued improvement. The 2018 ADHDPerformance Improvement Project with LDH further supported ongoing efforts to improvecompliance and HEDIS performance with multidisciplinary collaboration across plandepartments, including ADHD Coaching Program with Disease Management team.
        - Utilization of ADHD first fill report, in collaboration with Pharmacy and MedicalManagement BH team, to facilitate outreaches to members with newly filledprescriptions for ADHD related medication to offer education and support tomembers in ADD HEDIS Measure.
        - Additional efforts included collaboration with EPC vendor for identification ofmembers inappropriately prescribed medications in relation to ADHD for referral toCM and DM programs.
    - Development of In Lieu of Service Contracts with Oceans/Compass for IOP level of care.
    - Child Parent Psychotherapy initiative including trainings/certification for providers isongoing with continued monitoring since completion in 2018.
    - Behavioral Health Provider Trainings – offered in 2018 and continued into 2019

Recommendation: 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.

MCO Response: It is the goal for our ED Diversion Program to redirect members to appropriate levels of care to decrease inappropriate ED utilization through a specialized Integrated Care Team consisting of experienced RN Care Managers, Social Workers, LMHP Care Managers and Provider Relations. LHCCC provides a focus on access to care issues and resource education.

Interventions include:

- Linking the member to a PCP and assisting with appointment compliance, including provision ofeducation on transportation resources/availability, and transportation coordination assistance.Linking members to behavioral health community based services to prevent BH crises that maynecessitate an ED visit,
- Ongoing member education reinforcing the importance of receiving the appropriate care at theright time, and in the right setting. This is facilitated by the Care Management Model processflow which includes the following key elements:
    - Monitoring ED utilization trends and identification of members with 4 or more EDencounters within 12 months for targeted outreach and ER diversion opportunities.
    - Member identification, care review, and outreach; improving effectiveness of memberconnections with proactive review of care management needs, claims history, and caregaps for more effective outreach. Additionally, outreach attempts are varied by day andtime to optimize member contact, with "Unable to contact" letters mailed to memberswhen outreach attempts are exhausted and unsuccessful.
    - Care interventions facilitating appropriate levels of care for members, including (but notlimited to) resource management, community resources, and transportation.
    - Promoting self-management through education on care management, resources, andbenefits and service provisions that ultimately focus on self-care coordination
    - Health Coaching, including Disease Management programs which focus on disease specificcoaching to facilitate member self-management.

Through implementation of the above noted care management model and associated interventions, LHCCC has made successful gains towards the overall goal of reducing inappropriate ED utilization. Additional analysis of conducted by the Care Management department indicates the Medicaid Expansion population continue to seek ED resources, particularly after normal business hours when primary care provider offices are generally closed. In an effort to address these utilization patterns, the health plan implemented a PCP extended hours billing code with higher reimbursement to incentivize providers to offer extended hours to this population in an effort to reduce ED utilization which continued throughout 2018.

Behavioral Health (BH) Utilization Management (UM) initiatives have focused efforts towards robust discharge planning, including the successful completion of a Behavioral Health Intensive Outpatient Program (IOP) Pilot. Utilization Managers work closely with providers to ensure sound discharge plans are in place for member follow-up after an inpatient/residential stay. Outcomes for the BH pilot participants included a 13% reduction in readmission rates from the prior six month baseline, with continued declines in readmissions observed for populations in this program. An escalation team comprised of behavioral and physical health case managers work in collaboration with UM to navigate Provider barriers as needed, such as transportation, language, housing, and so on.

To summarize, the BH IOP program offers members an alternative level of care that is less restrictive in comparison to standard outpatient follow up or admission to a more restrictive inpatient psychiatric environment. Members enrolled in BH IOP will have a higher rate of CM engagement, facilitating a decrease in readmissions, ED utilization, improved follow up after hospitalization (and associated HEDIS rates), and overall cost savings. LHCCC began authorizing Mental Health IOP in 2018. This is not a Medicaid covered benefit.