



State of Louisiana Department of Health & Hospitals

AmeriHealth Caritas Louisiana  
Annual External Quality Review Technical Report

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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 AmeriHealth Caritas Louisiana (AmeriHealth) for review period July 1, 2016 – June 30, 2017.

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*® 2017 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 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

AmeriHealth Caritas Louisiana	
Type of Organization	Health Maintenance Organization
Tax Status	For Profit
Year Operational	02/01/2012
Product Line(s)	Medicaid, LaCHIP and Medicare
Total Medicaid Enrollment (as of June 2017)	211,763

### III. ENROLLMENT AND PROVIDER NETWORK

#### Enrollment

##### Medicaid Enrollment

As of June 2017, the MCO's Medicaid enrollment totaled 211,763, which represents 14% of Health Louisiana's active members. Table 2 displays AmeriHealth's Medicaid enrollment for 2015 to 2017, as well as the 2017 statewide enrollment totals. Figure 1 displays Healthy Louisiana's membership distribution across all Medicaid MCOs.

Table 2: Medicaid Enrollment as of June 2017<sup>1</sup>

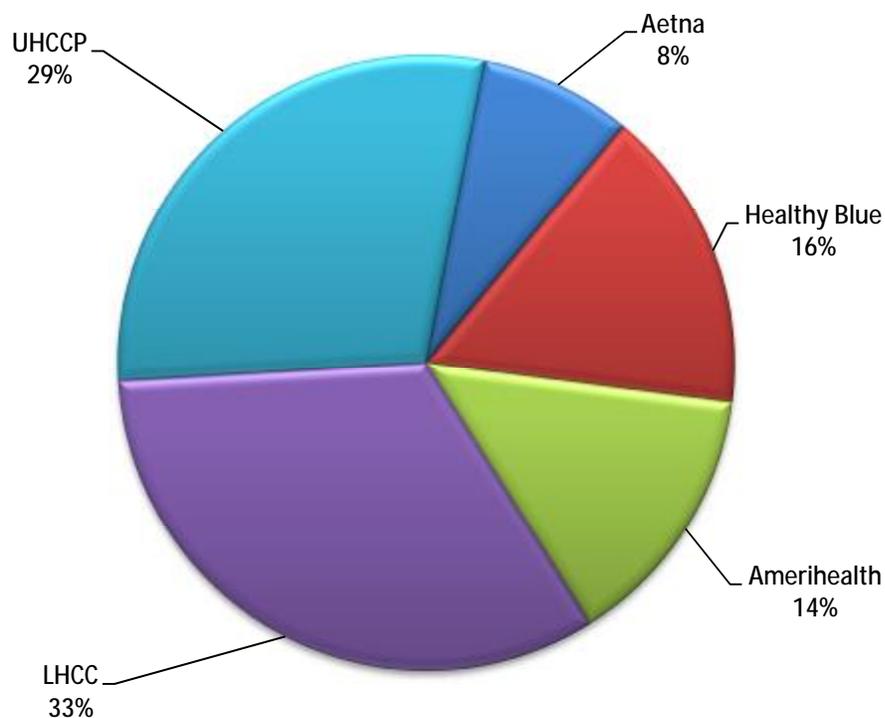
AmeriHealth	June 2015	June 2016	June 2017	% Change	2017 Statewide Total <sup>2</sup>
<b>Total Enrollment</b>	152,405	196,279	211,763	7.9%	1,464,516

Data Source: Report No. 125-A

<sup>1</sup>This report shows all active members in Healthy Louisiana 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 Healthy Louisiana during the reporting month are not included.

<sup>2</sup>Note: The statewide total includes membership of all plans.

Figure 1. Healthy Louisiana Membership by Health Plan as of June 2017



## 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 AmeriHealth's primary care providers, OB/GYNs and other physicians with primary care responsibilities within each geographic service area as of June 30, 2017.

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

Specialty	AmeriHealth			MCO Statewide Unduplicated
	GSA A	GSA B	GSA C	
Family Practice/General Medicine	602	460	532	753
Pediatrics	824	433	241	536
Nurse Practitioners	1034	924	780	896
Internal Medicine <sup>1</sup>	484	282	194	545
OB/GYN <sup>1</sup>	7	17	12	32
RHC/FQHC	152	153	167	241

Data source: Network Adequacy Review 2017 Q2

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

<sup>1</sup>Accepts full PCP responsibility.

### Provider Network Accessibility

AmeriHealth 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 07, 2017

Provider Type		Access Standard <sup>1</sup> X Provider(s) within X Miles	Percentage of Members for Whom Standard was Met
Family Practitioner and General Practitioner	Urban	1 within 10 miles	100%
	Rural	1 within 30 miles	100%
Internal Medicine	Urban	1 within 10 miles	100%
	Rural	1 within 30 miles	100%
Pediatrician	Urban	1 within 10 miles	100%
	Rural	1 within 30 miles	100%

<sup>1</sup>The Access Standard is measured in distance to member address.

## IV. QUALITY INDICATORS

To measure quality of care provided by the MCOs, the State prepares and reviews a number of reports on a variety of quality indicators. This section is a summary of findings from these reports, including Performance Improvement Projects (PIPs), as well as HEDIS® and CAHPS®.

### Performance Improvement Projects

Performance Improvement Projects (PIPs) engage MCO care and quality managers, providers and members as a team with the common goal of improving patient care. The MCO begins the PIP process by targeting improvement in annual baseline performance indicator rates. The next step is to identify barriers to quality of care, and to use barrier analysis findings to inform interventions designed to overcome the barriers to care. Interventions are implemented and monitored on an ongoing basis using quarterly intervention tracking measures. Declining quarterly intervention tracking measure rates signal the need to modify interventions and re-chart the PIP course. Improving intervention tracking measures are an indication of robust interventions.

Healthy Louisiana is in the process of conducting two Collaborative PIPs: (1) Improving Prenatal and Postpartum Care to Reduce the Risk of Preterm Birth and (2) Improving the Quality of Diagnosis, Management and Care Coordination for Children and Adolescents with Attention-Deficit Hyperactivity Disorder (ADHD). 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
  - § Implement the Notice of Pregnancy communication from provider to MCO
  - § Implement the High-Risk Registry communication from MCO to provider
  - § Conduct provider education for how to provide and bill for evidence-based care
  - § Develop and implement or revised care management programs to improve outreach to eligible and at-risk members for engagement in care coordination
  
- (2) Improving the Quality of Diagnosis, Management and Care Coordination for Children and Adolescents with ADHD
  - § Improve workforce capacity
  - § Conduct provider education for ADHD assessment and management consistent with clinical guidelines
  - § Expand PCP access to behavioral health consultation
  - § Develop and implement or revised care management programs to improve outreach to eligible and at-risk members for engagement in care coordination

Summaries of each of the PIPs conducted by AmeriHealth 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:

- § Initiation of injectable progesterone for preterm birth prevention: increase from 12.32% to 18%
- § Use of most effective contraceptive methods: increase from 15.37% to 18.37%
- § Chlamydia test during pregnancy: increase from 86% to 89%
- § HIV test during pregnancy: increase from 79.6% to 82.6%
- § Syphilis test during pregnancy: increase from 84.2% to 87.2%
- § HEDIS® *Postpartum Care* measure: increase from 64.65% to 69.5%

### Intervention Summary:

#### § Member:

- Gift card incentive for attending prenatal visits and postpartum visit
- Bright Start phone app
- High-risk member outreach
- Community education outreach
- Prepare for your doctor visit brochure

#### § Provider:

- Medicaid 101- AmeriHealth will develop provider toolkit account executives and/or Medical Director will schedule and distribute materials to targeted providers
- The Health Plan will post educational resources in the provider portal
- Notice of Pregnancy (NOP) implementation via provider toolkit, provider portal and fax blast, with Health Plan receipt of NOP form from provider via fax and information entered into Case Management tracking system
- Perinatal Quality Enhancement Program

#### § MCO:

- Enhanced Obstetric Care Management Engagement and Outreach Program (e.g., Bright Start phone application, high-risk member outreach, Logisticare transportation referrals)

### Results:

- § MCO educational outreach to OB providers showed a quarterly rate increase from less than 3% to 8.6%, and the quarterly rate of OB provider receipt of enhancement payments increased from 51% to 66%.
- § From first to last quarter 2016, the rate of high-risk member engagement in care management increased from 59% to 65%.
- § From first quarter 2016 to first quarter 2017, the percentage of women who had a postpartum visit with successful postpartum outreach calls increased from 48% to 63%.
- § From baseline to interim year, the rate of high-risk member receipt of injectable progesterone increased from 12% to 14%.
- § From baseline to interim year, the prenatal chlamydia screening rate increased from 86% to 97%, for HIV testing from 80% to 88%, and for syphilis testing from 84% to 94%.
- § From baseline to interim year, the rate for receipt of an FDA-approved method of contraception increased from 28% to 47%.

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

### Strengths:

§ The MCO elaborates on interventions, 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:

- § Clarify how gap reports will be used to (1) identify members not in the annual performance indicator numerators, (2) interventions to outreach (a) members with care gaps and (b) their providers for care coordination and care management, (3) report corresponding quarterly intervention tracking (process) measure data, and (4) indicate revisions to interventions to address newly identified barriers in response to intervention tracking (process) measure trends that indicate lack of improvement.
- § Incorporate all new and modified interventions into the intervention table, with corresponding intervention tracking measures and data in the intervention tracking measure table.
- § Identify new barriers by conducting drill down analyses of those intervention tracking measures that show stagnant or declining performance, and modify interventions in response.

### 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:

- § Validated ADHD screening instrument: increase from 18.33% to 37.9%
- § ADHD screening in multiple settings: increase from 16.67% to 35.5%
- § Assessment of other behavioral health conditions/symptoms: increase from 26.67% to 49%
- § Referral for evaluation of other behavioral health conditions: increase from 46.67% to 75%
- § Referral to treat other behavioral health conditions: increase from 40% to 69%
- § PCP care coordination: increase from 5% to 16%
- § MCO care coordination: increase from 3.39% to 40%
- § MCO outreach with member contact: increase from 16.67% to 40%
- § MCO outreach with member engagement: increase from 22.22% to 60%
- § First line behavioral therapy for children less than 6 years of age: increase from 3.33% to 43%
- § The percentage of members aged 6-12 years as of the index prescription start date (IPSD) with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day initiation phase: increase from 34.73% to 42.19%
- § 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 calls with a practitioner within 270 days after the initiation phase ended: increase from 45.15% to 52.47%

### Intervention Summary:

- § Provide behavior therapy trainings to providers (e.g., Positive Parenting Program, Trauma-focused Cognitive Behavioral Therapy, Parent Management Training)
- § Integrated healthcare management care coordination telephonic outreach to younger than six years old ADHD population; this population will also receive an educational letter
- § Rapid response care coordination telephonic outreach to 6-12 year old ADHD population
- § Outreach via ADHD educational letter to the 6-12 year old population, the letter also explains the plan's gift card program
- § Member incentive for follow-up visit for ADHD medication initiation. Members also receive an "I am Healthy" educational flyer with their gift card
- § ADHD member toolkit

§ Behavioral Health (BH) PCP Toolkit. The toolkit includes an overview, medication management suggestions, assessments, screening tools, resources, and follow up for each disorder

Results: Not yet available

Strengths: The MCO initiated robust interventions that included provider outreach for behavioral health, telephonic outreach to 6-12 year old ADHD population, and behavioral health consultations to primary care providers.

Opportunities for Improvement:

- § Conduct analysis of network adequacy and present findings regarding parishes lacking providers in the barrier analysis. Use those findings to inform targeted interventions, with corresponding intervention tracking (process) measures.
- § Collaborate with MCOs and LDH to distribute American Academy of Pediatrics (AAP) ADHD Toolkit to PCPs with pediatric patients.

## Performance Measures: HEDIS® 2017 (Measurement Year 2016)

MCO-reported performance measures were validated as per HEDIS® 2017 Compliance Audit™ specifications developed by the National Committee for Quality Assurance (NCQA). The results of each MCO's HEDIS® 2017 Compliance Audit are summarized in its Final Audit Report (FAR).

The HEDIS® 2017 FAR prepared for AmeriHealth by Healthcare Data Company, LLC indicates that the MCO demonstrated compliance with all areas of Information Systems and all areas of measure determination required for successful HEDIS® reporting.

### HEDIS® Effectiveness of Care Measures

HEDIS® Effectiveness of Care measures evaluate how well a MCO provides preventive screenings and care for members with acute and chronic illnesses. Table 5 displays MCO performance rates for select HEDIS® Effectiveness of Care measures for HEDIS® 2015, HEDIS® 2016, HEDIS® 2017, Healthy Louisiana 2017 statewide averages and *Quality Compass*® 2017 South Central – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

Table 5: HEDIS® Effectiveness of Care Measures – 2015-2017

Measure	AmeriHealth			QC 2017 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded	Healthy Louisiana 2017 Average
	HEDIS® 2015	HEDIS® 2016	HEDIS®2017		
Adult BMI Assessment	59.49%	85.17%	79.91%	25 <sup>th</sup>	80.75%
Antidepressant Medication Management - Acute Phase	47.22%	56.43%	53.62%	75 <sup>th</sup>	47.89%
Antidepressant Medication Management - Continuation Phase	32.72%	41.21%	39.34%	75 <sup>th</sup>	33.04%
Asthma Medication Ratio (5-64 Years)	54.56%	41.82%	44.57%	<10 <sup>th</sup>	57.25%
Breast Cancer Screening in Women	57.23%	57.97%	58.05%	75 <sup>th</sup>	55.84%
Cervical Cancer Screening	54.33%	57.18%	61.54%	50 <sup>th</sup>	59.01%
Childhood Immunization Status - Combination 3	47.92%	65.97%	65.21%	25 <sup>th</sup>	68.04%
Chlamydia Screening in Women (16-24 Years)	59.35%	62.40%	64.42%	95 <sup>th</sup>	63.21%
Comprehensive Diabetes Care - HbA1c Testing	83.51%	80.80%	86.86%	75 <sup>th</sup>	77.35%
Controlling High Blood Pressure	35.33%	38.00%	34.06%	<10 <sup>th</sup>	37.07%
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	40.66%	40.36%	45.15%	<10 <sup>th</sup>	56.60%
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	31.35%	31.00%	34.73%	10 <sup>th</sup>	44.55%
Medication Management for People With Asthma Total - Medication Compliance 75% (5-64 Years)	30.65%	32.97%	33.73%	75 <sup>th</sup>	24.10%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile	30.79%	47.69%	48.91%	10 <sup>th</sup>	53.77%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	39.58%	45.37%	46.72%	10 <sup>th</sup>	54.90%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity	25.93%	30.32%	35.28%	10 <sup>th</sup>	41.10%

### HEDIS® Access to/Availability of Care Measures

The HEDIS® Access to/Availability of Care measures examine the percentages of Medicaid children/adolescents, child-bearing women and adults who receive PCP/preventive care services, ambulatory care (adults only) or receive timely prenatal and postpartum services. Table 6 displays MCO rates for select HEDIS® Access to/Availability of Care measure rates for HEDIS® 2015, HEDIS® 2016, HEDIS® 2017, Healthy Louisiana 2017 statewide averages and *Quality Compass*® 2017 South Central – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

Table 6: HEDIS® Access to/Availability of Care Measures – 2015-2017

Measure	AmeriHealth			QC 2017 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded	Healthy Louisiana 2017 Average
	HEDIS® 2015	HEDIS® 2016	HEDIS® 2017		
<b>Children and Adolescents' Access to PCPs</b>					
12–24 Months	94.55%	96.10%	96.04%	33.33 <sup>rd</sup>	96.17%
25 Months–6 Years	84.06%	84.80%	86.92%	33.33 <sup>rd</sup>	87.64%
7–11 Years	86.28%	86.39%	87.88%	10 <sup>th</sup>	89.29%
12–19 Years	84.59%	85.72%	87.09%	33.33 <sup>rd</sup>	88.47%
<b>Adults' Access to Preventive/Ambulatory Services</b>					
20–44 Years	78.63%	79.27%	81.91%	75 <sup>th</sup>	82.22%
45–64 Years	87.27%	88.06%	88.93%	66.67 <sup>th</sup>	88.56%
65+ Years	72.22%	81.25%	77.34%	10 <sup>th</sup>	87.23%
<b>Access to Other Services</b>					
Timeliness of Prenatal Care	83.80%	83.49%	77.37%	25 <sup>th</sup>	80.77%
Postpartum Care	43.06%	64.65%	57.11%	25 <sup>th</sup>	63.80%

## HEDIS® Use of Services Measures

This section of the report explores utilization of AmeriHealth's services by examining selected HEDIS® Use of Services rates. Table 7 displays MCO rates for select HEDIS® Use of Services measure rates for HEDIS® 2015, HEDIS® 2016, HEDIS® 2017 Healthy Louisiana 2017 statewide averages and *Quality Compass*® 2017 South Central – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

Table 7: Use of Services Measures – 2015-2017

Measure	AmeriHealth			QC 2017 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded	Healthy Louisiana 2017 Average
	HEDIS® 2015	HEDIS® 2016	HEDIS®2017		
Adolescent Well-Care Visit	43.75%	55.79%	52.33%	50 <sup>th</sup>	54.70%
Ambulatory Care Emergency Department Visits/1000 Member Months <sup>1</sup>	76.23	78.38	81.68	90 <sup>th</sup>	73.88
Ambulatory Care Outpatient Visits/1000 Member Months	361.20	513.92	397.17	66.67 <sup>th</sup>	400.17
Frequency of Ongoing Prenatal Care - ≥ 81%	68.75%	76.51%	67.63%	50 <sup>th</sup>	67.71%
Well-Child Visits in the First 15 Months of Life 6+ Visits	49.77%	54.40%	59.71%	50 <sup>th</sup>	56.06%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	62.21%	59.31%	62.76%	10 <sup>th</sup>	65.68%

<sup>1</sup> A lower rate is desirable

## Member Satisfaction: Adult and Child CAHPS® 5.0H

In 2017, 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 AmeriHealth by the NCQA-certified survey vendor, Morpace. For purposes of reporting the Child Medicaid with CCC survey results, the results are divided into two groups: General Population and CCC Population. The General Population consists of all child members who were randomly selected for the CAHPS® 5.0H Child survey during sampling. The CCC Population consists of all children (either from the CAHPS® 5.0H Child survey sample or the CCC Supplemental Sample) who are identified as having a chronic condition, as defined by the member's responses to the CCC survey-based screening tool.

Table 8, Table 9 and Table 10 show AmeriHealth's CAHPS® rates for 2015, 2016 and 2017, as well as *Quality Compass*® 2017 South Central – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

Table 8: Adult CAHPS® 5.0H – 2015-2017

Measure <sup>1</sup>	AmeriHealth			QC 2017 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded
	CAHPS® 2015	CAHPS® 2016	CAHPS® 2017	
Getting Needed Care	79.77%	78.09%	81.89%	33.33 <sup>rd</sup>
Getting Care Quickly	81.57%	84.20%	81.52%	33.33 <sup>rd</sup>
How Well Doctors Communicate	87.47%	89.13%	89.86%	33.33 <sup>rd</sup>
Customer Service	89.10%	88.60%	88.15%	25 <sup>th</sup>
Shared Decision Making <sup>2</sup>	80.85%	73.85%	75.84%	10 <sup>th</sup>
Rating of All Health Care	66.54%	72.08%	69.92%	10 <sup>th</sup>
Rating of Personal Doctor	77.74%	77.59%	78.30%	10 <sup>th</sup>
Rating of Specialist	78.90%	84.00%	76.40%	<10 <sup>th</sup>
Rating of Health Plan	72.59%	77.27%	77.62%	33.33 <sup>rd</sup>

<sup>1</sup> 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".

<sup>2</sup> In 2016, NCQA revised measure specifications and response options.

Table 9: Child CAHPS® 5.0H General Population – 2015-2017

Measure <sup>1</sup>	AmeriHealth			QC 2017 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded
	CAHPS® 2015	CAHPS® 2016	CAHPS® 2017	
Getting Needed Care	92.56%	84.29%	91.55%	95 <sup>th</sup>
Getting Care Quickly	92.80%	92.97%	87.08%	10 <sup>th</sup>
How Well Doctors Communicate	95.62%	92.86%	94.60%	75 <sup>th</sup>
Customer Service	94.77%	88.22%	89.12%	33.33 <sup>rd</sup>
Shared Decision Making <sup>2</sup>	75.94%	69.35%	76.17%	10 <sup>th</sup>
Rating of All Health Care	87.07%	85.85%	87.44%	10 <sup>th</sup>
Rating of Personal Doctor	92.16%	86.59%	90.57%	66.67 <sup>th</sup>
Rating of Specialist	91.53%	81.13%	87.10%	25 <sup>th</sup>
Rating of Health Plan	85.66%	87.17%	89.04%	50 <sup>th</sup>

<sup>1</sup> 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”.

<sup>2</sup> In 2016, NCQA revised measure specifications and response options.

Table 10: Child CAHPS® 5.0H CCC Population – 2015-2017

Measure <sup>1</sup>	AmeriHealth			QC 2017 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded
	CAHPS® 2015	CAHPS® 2016	CAHPS® 2017	
Getting Needed Care	91.22%	86.10%	90.35%	50 <sup>th</sup>
Getting Care Quickly	94.62%	93.19%	91.96%	10 <sup>th</sup>
How Well Doctors Communicate	94.72%	93.35%	95.04%	50 <sup>th</sup>
Customer Service	91.42%	90.63%	85.85%	< 10 <sup>th</sup>
Shared Decision Making <sup>2</sup>	82.00%	85.76%	86.17%	75 <sup>th</sup>
Rating of All Health Care	86.28%	83.96%	88.84%	66.67 <sup>th</sup>
Rating of Personal Doctor	88.57%	86.27%	92.02%	90 <sup>th</sup>
Rating of Specialist	89.58%	80.49%	89.58%	75 <sup>th</sup>
Rating of Health Plan	79.84%	85.12%	88.58%	66.67 <sup>th</sup>

<sup>1</sup> 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”.

<sup>2</sup> In 2016, NCQA revised measure specifications and response options.

## 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.

AmeriHealth reported that the following interventions were implemented in 2016 through 2017 to identify and/or address disparities in health outcomes and/or health care among its Medicaid population:

- § Set a 2017 annual operating plan goal of enhancing the integration of social determinants in our population health relationship-centered care model.
- § Increased data collection on social determinants through the Health Risk Assessment and JIVA assessment.
- § Communicates social determinant data through the Medical Clinical Summary in JIVA.
- § Medical clinical summary with social determinants made available to providers through NaviNet.
- § Implemented Aunt Bertha, a platform that provides support to members who may be experiencing complex social issues such as food, health, housing, job training programs and more.
- § Provide transportation services through plan vendor.

## V. COMPLIANCE MONITORING

Please note that the last Compliance Audit for Louisiana took place in 2016 and the next audit is anticipated to take place in late 2018-early 2019.

### Medicaid Compliance Audit Findings for Contract Year 2016

In 2016, IPRO conducted the 2016 Compliance Audit on behalf of the LDH. Full compliance audits occur every three years, with partial audits occurring within the intervening years. The 2016 Compliance Audit was a full audit of AmeriHealth’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 AmeriHealth’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 AmeriHealth’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 AmeriHealth’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
Core Benefits and Services	123	112	10	1	0	0	91%
Provider Network	163	149	9	3	0	2	93%
Utilization Management	92	77	8	0	2	5	89%
Eligibility, Enrollment and Disenrollment	13	13	0	0	0	0	100%
Marketing and Member Education	77	73	2	0	0	2	97%
Member Grievances and Appeals	62	54	5	2	1	0	87%
Quality Management	86	79	5	0	0	2	94%
Reporting	1	1	0	0	0	0	100%
Fraud Waste and Abuse	105	104	1	0	0	0	99%
Total	722	662	40	6	3	11	93%

It is IPRO's and the LDH's expectation that AmeriHealth submit a corrective action plan for each of the 49 elements determined to be less than fully compliant along with a timeframe for completion. It should be noted that AmeriHealth 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. Twelve (12) of the 49 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 AmeriHealth.

## VI. STRENGTHS, OPPORTUNITIES FOR IMPROVEMENT & RECOMMENDATIONS

This section summarizes the accessibility, timeliness and quality of services provided by AmeriHealth 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) –

- The 2017 HEDIS® Final Audit Report revealed no significant problems and the MCO was able to report all required Medicaid rates.
- AmeriHealth met or exceeded the 75<sup>th</sup> percentile for the following HEDIS® measures:
  - *Antidepressant Medication Management – Acute Phase*
  - *Antidepressant Medication Management – Continuation Phase*
  - *Breast Cancer Screening in Women*
  - *Chlamydia Screening in Women (16-24 Years)*
  - *Comprehensive Diabetes Care – HbA1c Testing*
  - *Medication Management for People with Asthma Total – Medication Compliance 75% (5-64 Years)*
  - *Adults' Access to Preventive/Ambulatory Services*
    - *20-44 Years*

#### § CAHPS® (Member Satisfaction) – AmeriHealth met or exceeded the 75<sup>th</sup> percentile for the following CAHPS® measures:

- Child CAHPS® General Population
  - *Getting Needed Care*
  - *How Well Doctors Communicate*
- Child CAHPS® CCC Population
  - *Shared Decision Making*
  - *Rating of Personal Doctor*
  - *Rating of Specialist*

#### § Compliance – The MCO achieved “full” compliance in two (2) of the nine (9) domains reviewed.

### Opportunities for Improvement

#### § HEDIS® (Quality of Care) – AmeriHealth demonstrates an opportunity for improvement in the following areas of care as performance was below the 50<sup>th</sup> percentile:

- *Adult BMI Assessment*
- *Asthma Medication Ratio (5-64 Years)*
- *Childhood Immunization Status – Combination 3*
- *Controlling High Blood Pressure*
- *Follow-up Care for Children Prescribed ADHD Medication – Continuation and Maintenance Phase*
- *Follow-up Care for Children Prescribed ADHD Medication – Initiation Phase*
- *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*
    - *25 Months-6 Years*
    - *7-11 Years*
    - *12-19 Years*
  - *Adults' Access to Preventive/Ambulatory Services*
    - *65+ Years*
  - *Timeliness of Prenatal Care*
  - *Postpartum Care*
  - *Well-Child Visits in the 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup> and 6<sup>th</sup> Years of Life*
- § CAHPS® (Member Satisfaction) – AmeriHealth demonstrates an opportunity for improvement in regard to member satisfaction. The MCO performed below the 50<sup>th</sup> percentile for the following measures:
- **Adult CAHPS®**
    - *Getting Needed Care*
    - *Getting Care Quickly*
    - *How Well Doctors Communicate*
    - *Customer Service*
    - *Shared Decisions Making*
    - *Rating of All Health Care*
    - *Rating of Personal Doctor*
    - *Rating of Specialist*
    - *Rating of Health Plan*
  - **Child CAHPS® General Population**
    - *Getting Care Quickly*
    - *Customer Service*
    - *Shared Decision Making*
    - *Rating of All Health Care*
    - *Rating of Specialist*
  - **Child CAHPS® CCC Population**
    - *Getting Care Quickly*
    - *Customer Service*

## Recommendations

- § The MCO continues to demonstrate opportunities for improvement in regard to the quality of, access to and timeliness of care. The MCO should conduct root cause analysis for each HEDIS® measure performing below the 50<sup>th</sup> percentile and implement a multifaceted intervention strategy that targets members, providers and MCO operations. The effectiveness of implemented interventions should be monitored often and routinely, and should be modified as needed. *[Repeated recommendation.]*
- § In addition to monitoring provider compliance with appointment timeliness standards, the MCO should expand its monitoring to include other factors that may impede member access to care, such as access to provider information that is accurate and current, member access to primary care during non-traditional business hours, member access to transportation, etc. *[Repeated recommendation.]*
- § The MCO should continue to work to improve CAHPS® measures that perform below the 50<sup>th</sup> percentile. As CAHPS® assesses member satisfaction the internal CAHPS workgroup should expand its intervention strategy to include interventions that specifically address member concerns. Root cause analysis should be conducted to identify these concerns and to develop targeted interventions. Correlations between CAHPS® scores and HEDIS® rates should also be identified to maximize opportunities for improvement. *[Repeated recommendation.]*

## Response to Previous Year's Recommendations

§ 2015-2016 Recommendation: Although there remains an opportunity for improvement in regard to HEDIS® performance, the Health Plan should continue with the improvement strategy outlined in its response to the previous year's recommendation as most HEDIS® rates appear to be trending upward. However, for the rates that have declined, the Health Plan should modify its intervention strategy based on root cause analysis. *[Repeated recommendation.]*

Health Plan Response: AmeriHealth conducts weekly interdepartmental meetings to discuss high priority HEDIS® measures and facilitate collaboration between all departments. AmeriHealth monitors data using an interim HEDIS® report with month over month trending and benchmarking against Quality Compass. A root cause analysis is conducted for low performing measures and high performing measures that are trending downward. As a result of the ongoing analysis, member and provider interventions are adjusted or enhanced as needed.

AmeriHealth has continued to support and educate providers utilizing HEDIS® Summary Reports. Within these reports, providers are able to evaluate performance and identify non-compliant members for key measures. Provider "Wellness Days" have been established as a multi-functional approach to member engagement and to assist with gap closures for non-compliant members. AmeriHealth staff supports providers with member outreach efforts and participates in the coordination and implementation of these events.

Utilizing HEDIS® dashboards, top low performing providers are targeted for outreach on key measures. HEDIS® Coding Guidelines are provided to practices to assist with appropriate coding and education is provided when claims analysis indicates missed opportunities and enhancement payment impact.

AmeriHealth is continuously enhancing outreach materials and sources. The MCO is implementing two new member texting campaigns and a digital campaign that will focus on key measures. Numerous "On the Move" health fair events were held throughout the year where members were able to receive education and close care gaps. Member and provider newsletters include education around priority measures for improved health outcomes. Additionally, member incentives are offered for services relating to key measures.

To address high emergency department utilization rates, AmeriHealth has implemented numerous projects throughout the plan. An ED workgroup meets monthly to evaluate interventions and rate impact. A Top 150 ED Utilizer report and Top 150 ED Cost report are used for outreach by the Rapid Response Outreach Team and the Integrated Health Care Management Team. An ED Diversion Survey is conducted with high ED utilizers to collect data for a root analysis to determine the most common reasons for using the emergency department instead of accessing primary care services. Interventions will be developed and implemented based on the data analysis. Additionally, education material is mailed to high ED utilizers quarterly. To communicate ED utilization usage specific to a provider's panel, a weekly ED report was developed and pushed to NaviNet, where it can be conveniently accessed by the provider. AmeriHealth will continue to monitor ED utilization and intervention impact.

§ 2015-2016 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 and ambulatory care rates have trended upward for all age groups. *[Repeated recommendation.]*

Health Plan Response: AmeriHealth surveys providers on an annual basis to ensure member access for primary care services. The 2017 survey has been completed and the raw data is currently being analyzed. AmeriHealth will take the following action steps to ensure member access to care in the primary care setting:

#### Action Specifically Using Study Results

- § AmeriHealth uses the raw data file for the Appointment Availability research to identify non-compliant PCPs, specialists and behavioral health providers.
  - AmeriHealth will complete a second survey of the provider sites found to be non-compliant during the initial survey in an effort to validate survey or vendor results.
  - AmeriHealth will share survey results with non-compliant providers and discuss contractual requirements best practices moving forward. AmeriHealth may request that a corrective action plan be implemented. This will include standards that providers should meet in the communication (e.g., Urgent Care standard is to see a patient within 24 hours).
  - AmeriHealth will allow 30 to 60 days from date of provider education and will then re-survey the provider site, if found to be still non-compliant request for a corrective action plan will be implemented.
- § AmeriHealth considers which appointment types have the highest non-compliance rates.
  - Improve urgent care compliance: actions may include but not limited to the following - AmeriHealth will work with providers to implement same-day appointments for certain patient types, walk-in ability, leave appointment slots open daily, extend office hours, etc.
  - AmeriHealth is working to expand member access to urgent care centers.
  - Improve prenatal care compliance: AmeriHealth will work with providers to address urgent/sick care appointment needs such as an appointment needed early in the week, schedule routine prenatal care for late in the week.
  - AmeriHealth will ensure providers are aware of standards for Prenatal Care
- § AmeriHealth will identify compliant providers in the raw data file for the appointment availability research for 2017. Account Executive staff meets with these offices to identify best practices. Suggestions may include:
  - What was learned that could be shared with other practices who had higher compliance scores or as they are implementing corrective action plans?
  - What are panel sizes in these practices?
  - Do providers work in teams?
  - What tasks are delegated and to whom in order to manage a large number of members?
  - Does practice include physician extenders?
- § AmeriHealth will offer clinic education programs for physician offices to include:
  - Consider recommendations for adding mid-level providers to staffing mix to cover heavy volume times.
  - Develop Customer Service seminars for physicians' office staff.
    - o Discuss compliant protocols after hours (e.g., do not automatically send to ER; communicate to patient the expected call-back time from the provider. Etc.
    - o Encourage offices to have a means to reach a live party if using a recorded message and emergency instructions on recorded messages.
  - Discuss scheduling protocols (e.g., how to pinpoint urgent symptoms and how soon these patients need to be seen).
  - Best practices to manage challenges and improve efficiency within office (report learnings from meeting with offices that are compliant).

- § Through AmeriHealth’s Member Engagement and Member Outreach teams, AmeriHealth will educate members on appointment access and scheduling options to manage expectations and utilization. It is anticipated that with focused education and outreach efforts, primary care access will improve.
  - Offer effective care management services for chronically ill patients (e.g., case manager to go to member’s home after hospital visit to ensure care plan is followed).
  - Offer Peer Support Services by phone or face-to-face supports.
  - Offer Wellness days with partnering physician offices during routine and/or non-routine business hours.
  - Offer specialized care management through intensive telephonic/face-to-face to a targeted group of members with multiple medical and behavioral health challenges.
- § Educate members on appointment access and scheduling options to manage expectations and utilization.
  - What symptoms require doctor visit?
  - How long should member wait to go to doctor after developing symptoms?
  - What are potential options such as an appointment at a physician’s office or the use of an Urgent Care Center?

§ 2015-2016 Recommendation: The Health Plan should continue to work to improve CAHPS® measures that perform below the 50<sup>th</sup> percentile. The Health Plan should routinely monitor the effectiveness of the strategy described in its response to the previous year’s recommendation and modify it as needed to ensure continued improvement. *[Repeated recommendation.]*

Health Plan Response: AmeriHealth consistently works to improve CAHPS scores for both the adult and children surveys by identifying opportunities where the MCO performs below the NCQA 50<sup>th</sup> percentile. AmeriHealth continued its “CAHPS” workgroup of multi-disciplinary internal departments. The CAHPS® workgroup convened on a quarterly basis and evaluated ratings/composites not meeting goal and/or at risk as determined by the QI analysis of the annual survey results. Also reviewed were areas where enterprise-wide CAHPS® composite goals were not achieved, decline in satisfaction were of statistical significance, and/or declining trends in member satisfaction were detected. The workgroup performed a barrier analysis to identify opportunities specific to low-performing and/or at risk areas as noted in the QI annual results analysis.

CAHPS Work Plan Items include but are not limited to the following:

- § Continued Krewe of CAHPS Carnival “Mardi Gras” celebration for associates attending CAHPS training webinars to encourage associate engagement
- § Flyer is displayed within the office during the survey as well as distributed via email to all associates.
- § Focus on CAHPS within provider education trainings