AMERIHEALTH CARITAS LOUISIANA

Annual External Quality Review Technical Report

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

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

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

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I. INTRODUCTION

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

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

The framework for IPRO's assessment is based on the guidelines and protocols established by CMS, as well as State requirements. IPRO's assessment included an evaluation of the mandatory activities, which encompass: performance measure validation, Performance Improvement Project (PIP) validation and compliance audits. Results of the most current HEDIS® and CAHPS® surveys are presented and are evaluated in comparison to the NCQA's 2014 *Quality Compass*® benchmarks.

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

II. MCO CORPORATE PROFILE

Table 1. Corporate Profile

AmeriHealth Caritas Louisiana	
Type of Organization	Health Maintenance Organization (HMO)
Tax Status	For Profit
Year Operational	02/01/2012
Product Line(s)	Medicaid, LaCHIP and Medicare
Total Medicaid Enrollment (as of December 2014)	145,581

III. ENROLLMENT AND PROVIDER NETWORK

Enrollment

Medicaid Enrollment

As of December 2014, the Health Plan's Medicaid enrollment totaled 145,581, which represents 16% of Bayou Health's active members. Table 2 displays AmeriHealth's Medicaid population across the three (3) Geographic Service Areas (GSAs), as well as the statewide enrollment totals. Figure 1 displays Bayou Health's membership distribution across all Health Plans.

Table 2. Medicaid Enrollment as of December 2014[1]

AmeriHealth Caritas Louisiana	2013	2014	% Change	2014 Statewide Total[2]
GSA A	37,109	38,337	3.31%	280,483
GSA B	53,582	53,349	-0.43%	324,664
GSA C	51,968	53,895	3.71%	318,993
Total Enrollment	142,659	145,581	2.05%	924,140

Data Source: Report No. 125-A

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

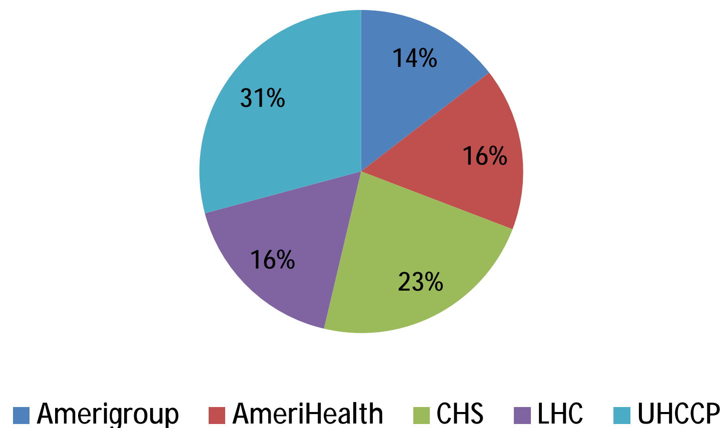
GSA A: New Orleans and North Shore

GSA B: Baton Rouge, Lafayette and Thibodaux

GSA C: Alexandria, Lake Charles, Monroe and Shreveport

[2] Note: Total includes membership of all plans.

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



Provider Network

Providers by Specialty

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

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

Specialty	GSA A	GSA B	GSA C	MCO Statewide Unduplicated
Family Practice/General Medicine	358	321	449	710
Pediatrics	367	234	210	491
Nurse Practitioners	403	535	563	698
Internal Medicine[1]	309	181	158	479
RHCS/FQHC	56	71	103	174
OB/GYN[1]	21	23	15	46

Data source: Network Adequacy Review 2014 Q4

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

[1] Accepts full PCP responsibility

Status of Patient-Centered Medical Home (PCMH) Recognition

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

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

Table 4. PCMH Recognition as of June 2014

Number of PCP Sites Contracted with MCO	Number of PCP Sites PCMH Certified or Accredited	Percentage of PCP Sites PCPMH Certified or Accredited
1,068	12[1]	1.1%

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

IV. QUALITY INDICATORS

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

Performance Improvement Projects

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

During this reporting period, each Health Plan was required to perform a minimum of two (2) State-approved PIPs. One (1) PIP was a common topic that all Health Plans addressed, and the second was selected by the Health Plan from a list of State-approved topics. The DHH-required common PIP was "Decreasing Emergency Room Utilization". The Health Plan-selected PIP was "Improving Women's Health – Cervical Cancer Screening Project".

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

State-Directed PIP: Decreasing Emergency Room Utilization

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

The Health Plan's goal for this PIP is to reduce the failure rate of inpatient and Emergency Room (ER) events for the following three key chronic conditions: diabetes, asthma, and cardiac disease by 3%.

Intervention Summary:

- Mailings of educational materials to members
- Telephonic outreach to members and assignment to CM, if warranted
- Home visits conducted by Community Education Department
- List of urgent care centers sent to members
- Provider fax blasts
- Utilization of ER utilization data for provider outreach to members with asthma, diabetes and cardiac disease

Results: The Health Plan's ER rate increased from baseline to interim measurement (3/14). ER visits for asthma increased, while ER visits for cardiovascular and diabetes care decreased.

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

Strengths:

- Strong rationale with nationwide and state performance cited.
- Interventions targeted toward both members and providers and designed to address noted barriers, which were identified via a Fishbone analysis. Interventions include providing members with case management and home visits, when warranted.
- A focus on members with chronic conditions: asthma, diabetes and cardiovascular disease.

Opportunities for Improvement:

- The Health Plan indicated that it would compile a list of urgent care centers, which would be posted online and distributed to members. It might be helpful to either send the list to PCPs as well or inform them that the list is posted online for them to share with members.
- It is unclear as to whether all three intervention groups will be receiving the educational materials that will be sent to the "Low Utilizers" (e.g., alternate ER services, assigned PCP). If not, it may be helpful for all groups to receive them.
- IPRO suggests adding targeted interventions to assist asthmatic members with high ER utilization with scheduling appointments. In addition, it is also suggested that the Health Plan conduct root-cause analysis to determine why asthmatic members have medication compliance issues.

Health Plan-Selected PIP: Improving Women's Health – Cervical Cancer Screening

Indicator(s)/Goals: The indicator for this PIP is the HEDIS® *Cervical Cancer Screening* measure - *the percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria:*

- *Women age 21-64 who had cervical cytology performed every 3 years.*
- *Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.*

The Health Plan's goal for this PIP is to increase cervical cancer screenings among eligible members by 5%.

Intervention Summary:

- Participate in health fairs for members
- Automatic reminder calls to eligible members due and past due for screenings
- Provide "on-hold" message regarding cervical cancer screening
- Member mailings
- Provider fax blasts

Results: The screening rate increased 4.15% from 38.99% at baseline to 40.61 at remeasurement. The interim rate is 49.81% which met the goal of increasing screenings by 5% from the 2012 baseline of 44.49%.

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

Strengths:

- Strong rationale with data specific to Louisiana reported, indicating the need to focus on cervical cancer screening in the state with adverse impact noted for specific racial/ethnic groups.
- Use of a standard measure to track performance (HEDIS® *Cervical Cancer Screening* measure).
- Interventions targeted to members and providers and linked to identified barriers.
- Several process measures developed to monitor specific interventions.
- Plan implemented a community intervention (i.e., health fairs).
- Limitations noted in interpreting the results to date.
- Plan has met its goal of improving cervical cancer screening rate by 5%.

Opportunities for Improvement:

- Upon submission of HEDIS® in 2014, the HEDIS® *Cervical Cancer Screening* rate should be incorporated into the project report.

Performance Measures: HEDIS® 2014 (Measurement Year 2013)

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

The HEDIS® 2014 Final Audit Report (FAR) prepared for AmeriHealth by HealthcareData Company indicates that the Health Plan demonstrated compliance with all areas of Information Systems and all areas of measure determination required for successful HEDIS® reporting.

HEDIS® Effectiveness of Care Measures

HEDIS® Effectiveness of Care measures evaluate how well a Health Plan provides preventive screenings and care for members with acute and chronic illnesses. Table 5 displays select HEDIS® Effectiveness of Care measure rates for Measurement Year 2013 (HEDIS® 2014) as compared to *Quality Compass*® 2014 national Medicaid benchmarks.

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

Measure	AmeriHealth HEDIS® 2014	*Quality Compass®* 2014 National Medicaid Benchmarks					
		National Average	P10	P25	P50	P75	P90
Adult BMI Assessment	10.11%	75.91%	64.35%	71.54%	78.78%	85.09%	90.82%
Antidepressant Medication Management - Acute Phase	41.87%	50.51%	41.87%	45.07%	49.67%	54.39%	60.86%
Antidepressant Medication Management - Continuation Phase	31.82%	35.18%	27.03%	29.90%	33.93%	38.25%	44.62%
Asthma Medication Ratio (5-64 Years)	54.20%	65.45%	53.29%	60.48%	66.37%	70.88%	76.23%
Breast Cancer Screening in Women	SS	57.90%	46.59%	51.21%	57.42%	65.12%	71.35%
Cervical Cancer Screening [1]	49.93%						
Childhood Immunization Status - Combination 3	40.73%	70.85%	58.70%	66.67%	72.33%	77.78%	80.86%
Chlamydia Screening in Women (16-24 Years)	55.84%	54.90%	41.19%	48.86%	54.97%	62.57%	67.19%
Comprehensive Diabetes Care - HbA1c Testing	79.87%	83.80%	77.55%	80.18%	83.87%	87.59%	91.73%
Comprehensive Diabetes Care - LDL-C Screening	73.96%	75.97%	66.87%	71.30%	76.87%	80.18%	83.71%
Controlling High Blood Pressure	0.00%	56.47%	43.07%	48.53%	56.20%	63.76%	69.79%
Cholesterol Management for Patients With Cardiovascular Conditions – LDL-C Control (<100 mg/dL)	6.02%	81.07%	74.57%	78.33%	81.45%	84.91%	87.84%
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	35.49%	46.35%	23.12%	37.17%	49.51%	57.55%	63.10%
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	31.85%	39.56%	21.77%	32.61%	41.09%	46.99%	53.03%
Lead Screening in Children	66.61%	66.46%	37.23%	58.39%	70.86%	80.83%	85.84%
Medication Management for People With Asthma Total - Medication Compliance 75% (5-64 Years)	31.53%	31.26%	20.07%	24.55%	30.19%	35.37%	43.08%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile	1.43%	56.92%	32.18%	41.85%	57.40%	73.72%	82.46%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	2.86%	58.70%	40.74%	50.00%	60.58%	69.21%	7747%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity	0.26%	50.50%	33.77%	41.67%	51.16%	60.82%	69.76%

SS: Sample Size too small to report (less than 30 members).
[1] Benchmarks were not available due to specification changes.

HEDIS® Access to/Availability of Care Measures

The HEDIS® Access to/Availability of Care measures examine the percentages of Medicaid children/adolescents, child-bearing women and adults who receive PCP/preventive care services, ambulatory care (adults only) or receive timely prenatal and postpartum services. Table 6 displays select HEDIS® Access to/Availability of Care measure rates for Measurement Year 2013 (HEDIS® 2014) as compared to *Quality Compass*® 2014 national Medicaid benchmarks.

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

Measure	AmeriHealth HEDIS® 2014	*Quality Compass*® 2014 Benchmarks					
		National Average	P10	P25	P50	P75	P90
	Children and Adolescents' Access to PCPs						
12–24 Months	94.77%	96.14%	93.58%	95.92%	96.96%	97.86%	98.53%
25 Months–6 Years	84.83%	88.25%	82.16%	86.07%	89.08%	91.73%	93.58%
7–11 Years	83.57%	90.02%	83.57%	87.78%	91.15%	93.50%	95.19%
12–19 Years	80.97%	88.53%	81.57%	85.83%	89.98%	92.17%	94.42%
	Adults' Access to Preventive/Ambulatory Services						
20–44 Years	80.18%	80.71%	68.99%	78.34%	83.22%	86.21%	88.52%
45–64 Years	87.86%	87.34%	80.11%	85.88%	88.76%	90.99%	92.25%
65+ Years	73.24%	85.55%	73.24%	82.35%	88.40%	90.70%	92.61%
	Access to Other Services						
Timeliness of Prenatal Care	77.83%	81.93%	69.77%	77.80%	84.30%	89.62%	93.10%
Postpartum Care	32.44%	61.29%	48.37%	56.18%	62.84%	69.47%	74.03%

HEDIS® Use of Services Measures

This section of the report explores utilization of AmeriHealth's services by examining selected HEDIS® Use of Services rates. Table 7 displays select HEDIS® Use of Services measure rates for Measurement Year 2013 (HEDIS® 2014) as compared to *Quality Compass*® 2014 national Medicaid benchmarks.

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

Measure	AmeriHealth HEDIS® 2014	*Quality Compass*® 2014 National Medicaid Benchmarks					
		National Average	P10	P25	P50	P75	P90
Adolescent Well-Care Visits	43.49%	50.03%	37.73%	41.70%	48.51%	59.21%	65.56%
Frequency of Ongoing Prenatal Care - ≥ 81%	57.75%	55.64%	21.74%	43.73%	60.10%	71.34%	78.37%
Well-Child Visits in the First 15 Months of Life 6+ Visits	36.92%	61.55%	45.50%	54.76%	62.86%	69.75%	76.92%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	57.17%	71.49%	60.18%	65.97%	71.76%	77.26%	82.69%

Member Satisfaction: Adult and Child CAHPS® 5.0H

In 2013, the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H survey of Adult Medicaid members and Child Medicaid with Chronic Care Conditions (CCC) was conducted on behalf of 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 2014 rates in comparison to the *Quality Compass*® 2014 national benchmarks.

Table 8. Adult CAHPS® 5.0H

Measure[1]	AmeriHealth		*Quality Compass*® 2014 Benchmarks					
	2013	2014	Average	P10	P25	P50	P75	P90
Getting Needed Care[2]	74.83%	77.00%	80.45%	74.70%	77.47%	80.90%	84.27%	85.59%
Getting Care Quickly[2]	77.48%	77.00%	81.00%	75.26%	78.39%	81.75%	83.75%	85.52%
How Well Doctors Communicate[2]	87.32%	86.00%	89.49%	86.17%	88.16%	89.76%	91.11%	92.42%
Customer Service[2]	87.08%	80.00%	86.51%	81.85%	84.45%	87.05%	88.64%	90.28%
Shared Decision Making[2]	52.32%	46.00%	51.20%	46.87%	49.07%	50.89%	53.69%	55.49%
Rating of All Health Care	67.83%	62.00%	71.26%	64.32%	68.54%	71.53%	74.06%	76.95%
Rating of Personal Doctor	75.43%	75.00%	78.75%	74.37%	76.45%	78.82%	80.97%	83.10%
Rating of Specialist	81.95%	81.00%	80.42%	75.89%	78.64%	80.61%	82.47%	85.31%
Rating of Health Plan	65.50%	63.00%	74.67%	66.57%	71.37%	75.52%	78.77%	81.49%

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

[2] These indicators are composite measures.

Table 9. Child CAHPS® 5.0H – General Population

Measure[1]	AmeriHealth		*Quality Compass®* 2014 Benchmarks					
	2013	2014	Average	P10	P25	P50	P75	P90
Getting Needed Care[2]	87.05%	86%	84.97%	79.05%	82.62%	85.44%	87.90%	90.71%
Getting Care Quickly[2]	92.88%	94%	89.46%	83.34%	87.67%	90.59%	92.45%	93.81%
How Well Doctors Communicate[2]	93.84%	94%	92.98%	89.71%	91.96%	93.25%	94.67%	95.61%
Customer Service[2]	88.51%	87%	87.89%	84.38%	85.98%	88.13%	89.91%	91.03%
Shared Decision Making[2]	52.00%	58%	54.65%	47.59%	51.79%	54.93%	58.26%	60.32%
Rating of All Health Care	83.19%	81%	84.70%	80.94%	82.63%	84.70%	86.65%	88.85%
Rating of Personal Doctor	87.50%	83%	87.63%	84.38%	85.89%	87.84%	89.43%	90.93%
Rating of Specialist	81.03%	87%	85.02%	80.69%	83.06%	85.01%	87.36%	89.50%
Rating of Health Plan	80.32%	73%	84.49%	78.63%	81.85%	84.83%	87.45%	88.66%

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

Table 10. Child CAHPS® 5.0H – CCC Population

Measure[1]	AmeriHealth		*Quality Compass®* 2014 Benchmarks					
	2013	2014	Average	P10	P25	P50	P75	P90
Getting Needed Care[2]	85.31%	87%	86.67%	82.49%	83.91%	86.94%	89.86%	90.78%
Getting Care Quickly[2]	91.68%	91%	92.72%	88.21%	91.88%	93.67%	94.41%	95.02%
How Well Doctors Communicate[2]	91.25%	93%	93.33%	89.85%	92.51%	93.75%	95.02%	95.83%
Customer Service[2]	92.23%	88%	88.63%	85.00%	86.76%	88.72%	91.13%	91.86%
Shared Decision Making[2]	56.00%	61%	61.27%	56.84%	59.10%	60.90%	63.93%	65.14%
Rating of All Health Care	75.62%	77%	83.33%	76.54%	82.63%	83.73%	85.47%	87.16%
Rating of Personal Doctor	83.55%	81%	86.50%	82.54%	85.24%	87.04%	88.28%	89.30%
Rating of Specialist	78.95%	90%	84.99%	78.80%	84.08%	85.71%	86.94%	88.05%
Rating of Health Plan	71.34%	68%	80.63%	72.35%	77.98%	80.99%	84.16%	86.15%

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

V. COMPLIANCE MONITORING

Medicaid Compliance Review Findings for Contract Year 2014-2015

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

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

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

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

Table 11. 2014 Annual Compliance Review Determination Description

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

Findings from AmeriHealth's 2014 Annual Compliance Review follow. Table 12 displays the total number of requirements reviewed for each domain, as well as compliance determination counts for each domain. Table 13 displays descriptions of all standards/elements that were "Not Met".

Table 12. Overall Compliance Determination by Domain

Domain	Total No. of Requirements Reviewed	Compliance Determination Totals		
		Met	Not Met	N/A
4.0 Staff Requirements and Support Services	4	4	0	0
6.0 Core Benefits & Services	100	100	0	0
7.0 Provider Network Requirements	167	164	2	1
10.0 Provider Services	58	56	0	2
11.0 Eligibility, Enrollment & Disenrollment	26	26	0	0
12.0a Marketing	117	116	0	1
12.0b Member Education	130	128	2	0
13.0 Member Grievances & Appeals	67	67	0	0
15.0 Fraud, Abuse, and Waste Prevention	114	114	0	0
TOTAL	783	775	4	4

Table 13. Elements Requiring Corrective Action by Review Area

2014 Medicaid Managed Care Compliance Review – Elements Not Fully Met (Review Year July 2013 – December 2014)	
Domain	Description of Review Findings Not Fully Met
7.0 Provider Network Requirements	§ The Plan did not provide Geo Access reports to demonstrate that their members have adequate access to pharmacies, such that travel distance does not exceed 10 miles and 30 miles in urban and rural parishes, respectively. § The documentation submitted for review did not address the requirement that MCOs may grant members' requests for a provider who is located beyond access standards; however, in such cases the MCO shall not be responsible for providing transportation for the member to access care from this provider.
12.0bMember Education	§ The Plan did not include the relevant information on the pharmacy-related ID card, that must include, at a minimum, the following data elements: o The name or identifying trademark of the MCO and the prescription benefit manager (see co-branding restrictions in 12.20.3); o The name and MCO member identification number of the recipient; o The telephone number that providers may call for: pharmacy benefit assistance, 24-hour member services and filing grievances, provider services and prior authorization, and reporting Medicaid Fraud (1-800-488-2917). § The Plan has chosen to include the prescription benefit information on the Bayou Health Plan card, but did not ensure that all members have a card that includes all necessary prescription benefit information.

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 Plan's strengths in each of these areas are noted, as well as opportunities for improvement. Recommendations for enhancing the quality of healthcare are also provided based on the opportunities for improvement noted.

Strengths

- The 2014 HEDIS® Final Audit Report revealed no significant problems and the Health Plan was able to report all required Medicaid rates.
- In regard to the 2014-2015 Compliance Review, the Health Plan demonstrated strong performance, as requirements reviewed for seven (7) of the nine (9) domains achieved "met" compliance determination.
- The Health Plan demonstrated strong performance on a single Child CAHPS® General Population measure: *Getting Care Quickly exceeding* the 90th percentile. The Health Plan also demonstrated strong performance on a single Child CAHPS® CCC Population measure: *Rating of Specialist* performing better than the 90th percentile.

Opportunities for Improvement

- The Health Plan continues to demonstrate an opportunity for improvement in regard to its provider network as PCMH recognition remains low. (Note: PCMH recognition was an opportunity for improvement in the previous year's report.)
- In regard to the 2014-2015 Compliance Review, the Health Plan continues to demonstrate an opportunity for improvement in the Provider Network Requirements Domain as two (2) requirements were determined to be "not met". The Health Plan also demonstrates an opportunity for improvement in the Member Education Domain as two (2) requirements were determined to be "not met". (Note: Compliance with the Provider Network Requirements Domain was an opportunity for improvement in the previous year's report.)
- The Health Plan demonstrates an opportunity for improvement in regard to its overall HEDIS® performance. The following measures performed below the 50th percentile: *Adult BMI Assessment*, *Antidepressant Medication Management – Acute Phase*, *Antidepressant Medication Management – Continuation Phase*, *Asthma Medication Ratio*, *Childhood Immunization Status – Combo 3*, *Comprehensive Diabetes Care – HbA1c Testing*, *Comprehensive Diabetes Care – LDL-C Screening*, *Controlling High Blood Pressure*, *Cholesterol Management for Patients With Cardiovascular Conditions – LDL-C Control*, *Follow-up Care for Children Prescribed ADHD Medication – Continuation and Maintenance Phase*, *Follow-up Care for Children Prescribed ADHD Medication – Initiation Phase, Lead Screening in Children*, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI Percentile*, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition*, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Physical Activity, Timeliness of Prenatal Care*, *Postpartum Care*, *Adolescent Well-Care Visits, Frequency of Ongoing Prenatal Care, Well-Child Visits in the First 15 Months of Life 6+ Visits* and *Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life.*
- In addition, the Health Plan demonstrates an opportunity for improvement in regard to access to care as rates for all age groups were below the 50th percentiles for the HEDIS® *Children and Adolescents Access to PCPs* and *Adults' Access to Preventive/Ambulatory Services* measures.

- The Health Plan continues to demonstrate an opportunity for improvement in regard to member satisfaction as it reported rates below the 50th percentile for several Adult CAHPS® measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Shared Decision Making*, *Rating of All Health Care*, *Rating of Personal Doctor* and *Rating of Health Plan*. The Health Plan also performed below the 50th percentile for the following Child CAHPS® General Population measures: *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor* and *Rating of Health Plan*, and for the following Child CAHPS® CCC Population measures*: Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor* and *Rating of Health Plan*. (Note: Member satisfaction was an opportunity for improvement in the previous year's report.)

Recommendations

- As the Health Plan has not demonstrated much progress with provider network PCMH recognition, the Health Plan should reevaluate its current approach and modify it as needed. *[Repeat recommendation.]*
- The Health Plan should continue to work to address Provider Network Requirements that did not meet contractual requirements, as well as Member Education Requirements that did not meet contractual requirements, to ensure it achieves "met" compliance during the next Compliance Review. *[Repeat recommendation.]*
- The Health Plan should conduct root cause analysis for all HEDIS® Effectiveness of Care and Use of Services measures that perform below the 50th percentile and develop interventions to address these barriers. The Health Plan should also routinely monitor HEDIS® performance to assess the effectiveness of its improvement strategy.
- As Health Plan members demonstrate lower than average access to primary care, a root cause analysis should be conducted to identify barriers to care for all age groups and to drive the development of targeted interventions that will address these barriers.
- Health Plan should continue to work to improve CAHPS® measures that perform below the 50th percentile. The Health Plan should also routinely assess the effectiveness of implemented interventions, starting with the interventions described in the Plan's response to the previous year's recommendation. *[Repeat recommendation.]*

Response to Previous Year's Recommendations

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

  Plan Response: In 2014, AmeriHealth Caritas Louisiana (ACLA) implemented surveys evaluating the quality of, access to and timeliness of care in 2014. The surveys were submitted to DHH / IPRO as part of the Readiness Review for the 2015 contract and deemed compliant with the requirements in Section 7 of the contract with DHH. Survey results are reported to ACLA's Quality of Service and QAPI Committees for analysis and intervention.

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

Plan Response: In 2014, ACLA conducted root cause analysis and implemented interventions to address CAHPS® measure with results below the 50th percentile. Examples of analysis and actions are as follows:

- Supplemental questions were added to the 2014 CAHPS survey to evaluate:
  - The parent/caregiver's/member's perception of how long it takes to see the physician.
  - Members' perception of appointment standards for routine/checkup visits, members' perception of getting care, tests, or treatment.
  - Member satisfaction with cultural and linguistic aspects of services provided.
  - Rating of specialist.
- Evaluation of pre-certification, authorization, and appeals processes was performed. ACLA also evaluates the manner in which the policies and procedures are delivered to the member, whether the delivery of the information is directly to the member or through the provider.
- Process developed to ensure both provider and member understand the reasons when care or treatment is denied.
- Access to Care Study was performed.
  - Seminar series developed for physicians' office staff to include telephonic skills as well as scheduling advice and obtaining feedback regarding member's interactions with ACLA.
  - Informative articles were incorporated into the Plan's Member Newsletters.
  - Health literacy and Cultural Competency brochures were also given to Providers.
  - A Health Outcomes and Satisfaction Summary will be completed annually to evaluate ACLA's progress.

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

  Plan Response: ACLA updated its PCMH Implementation Plan immediately upon receipt of the 2013 EQR Recommendations to include its PCMH reimbursement provisions. For the new contract period, ACLA also enhanced its reimbursement strategy to include PCMH recognition as an element of its Quality Enhancement Program, which incentivizes providers for meeting specified goals. Providers' progress in obtaining certification is tracked through the QEP.

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

  Plan Response: ACLA addressed the opportunities for improvement identified by IPRO during the PIP review process as follows:

  - All opportunities for PIP improvement identified by IPRO were accepted by ACLA. These recommendations were incorporated into the final PIP reports submitted to DHH.

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

  Plan Response: ACLA updated its non-compliant policies, procedures and processes immediately upon receipt of 2013 EQR Recommendations. Revised policies and refined processes were submitted to IPRO

at the conclusion of the review. Of note, all deficient 2013 standards were deemed compliant or N/A during the 2015 Readiness Review. Details are as follows:

- Core Benefits & Services
  - P&P UM905L updated to meet recommendations and resubmitted to IPRO in 2013.
- Provider Network Requirements
  - P&P NM303 updated to meet FQHC/RHC recommendations and resubmitted to IPRO in 2013.
  - Availability and accessibility surveys implemented as outlined in Response #1 above.
  - PCMH Implementation Plan updated as outlined in Response #3 above.
- Utilization Management
  - Provider Handbook updated to meet recommendations and resubmitted to IPRO in 2013.
  - Informal reconsideration and peer to peer review processes clarified and staff retrained on one day turnaround for peer to peer.
- Quality Management
  - QAPI Charter has been updated to reflect current membership composition.