AMERIHEALTH CARITAS LOUISIANA

Annual External Quality Review Technical Report

Review Period: July 1, 2014 – June 30, 2015

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

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I. INTRODUCTION

The Centers for Medicare and Medicaid Services (CMS) requires that state agencies contract with an External Quality Review Organization (EQRO) to conduct an annual external quality review (EQR) of the services provided by contracted Medicaid managed care organizations (MCOs). This EQR must include an analysis and evaluation of aggregated information on quality, timeliness and access to the health care services that an MCO furnishes to Medicaid recipients. Quality is defined in 42 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, 2014 – June 30, 2015.

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 2015 *Quality Compass*® 2015 South Central – All Lines of Business (LOB) (Excluding PPOs) Medicaid benchmarks.

Section VI provides an assessment of the MCO's strengths and opportunities for improvement in the areas of accessibility, timeliness and quality of services. For areas in which the plan has opportunities for improvement, recommendations for improving the quality of the MCO's health care services are provided. To achieve full compliance with federal regulations, this section also includes an assessment of the degree to which the MCO has effectively addressed the recommendations for quality improvement made by 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 June 2015)	152,405

III. ENROLLMENT AND PROVIDER NETWORK

Enrollment

Medicaid Enrollment

As of June 2015, the Health Plan's Medicaid enrollment totaled 152,405, which represents 16% of Bayou Health's active members. Table 2 displays AmeriHealth's Medicaid enrollment for 2013 to 2015, as well as the 2015 statewide enrollment totals. Figure 1 displays Bayou Health's membership distribution across all Health Plans.

Table 2. Medicaid Enrollment as of June 2015[1]

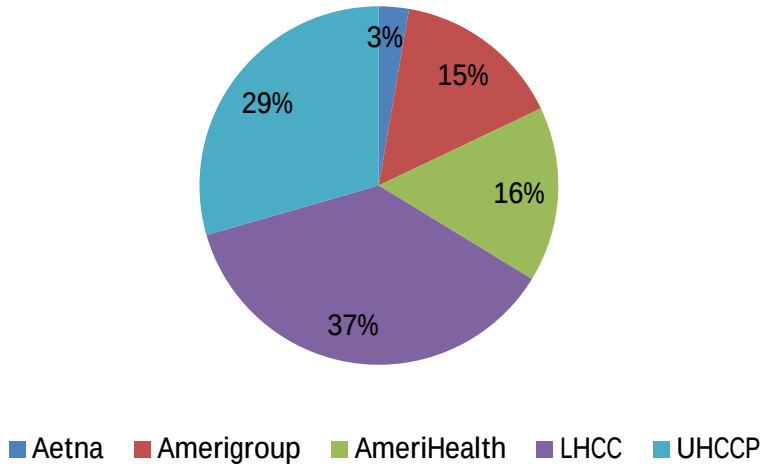
AmeriHealth Caritas Louisiana	June 2013	June 2014	June 2015	% Change	2015 Statewide Total[2]
Total Enrollment	147,421	141,963	152,405	7%	965,995

Data Source: Report No. 125-A

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

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

Figure 1. Bayou Health Membership by Health Plan as of June 2015



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 June 30, 2015.

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

Specialty	GSA A	GSA B	GSA C	MCO Statewide Unduplicated
Family Practice/General Medicine	377	359	461	730
Pediatrics	644	273	209	502
Nurse Practitioners	541	657	595	744
Internal Medicine[1]	329	202	156	494
OB/GYN[1]	9	23	15	34
RHC/FQHC	46	26	39	54

Data source: Network Adequacy Review 2015 Q2

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.

Provider Network Accessibility

DHH requires that Medicaid provider networks include a sufficient number of primary care providers to ensure members have reasonable choice among providers. 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 1/28/16

Provider Type		Access Standard[1] X Provider(s) within X Miles	Percentage of Members for Whom Standard was Met
Family Practitioners and General Practitioners	Urban	1 within 20 miles	99.8%
	Rural	1 within 30 miles	100.0%
Internal Medicine	Urban	1 within 20 miles	98.9%
	Rural	1 within 30 miles	97.5%
Pediatricians	Urban	1 within 20 miles	98.6%
	Rural	1 within 30 miles	99.6%

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

IV. QUALITY INDICATORS

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

Performance Improvement Projects

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

During this reporting period, each Health Plan was required to perform a minimum of two (2) State-approved PIPs. One (1) PIP was a common topic that all Health Plans addressed, and the second was selected by the Health Plan from a list of State-approved topics. The DHH-required common PIP was "Decreasing Emergency Room Utilization". The Health Plan-selected PIP was "Improving Women's Health – Cervical Cancer Screening Project". These PIPs were initiated in 2012 and were concluded in 2015.

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

State-Directed PIP: Emergency Department (ED) Visits

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 ED 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 Case Management, if warranted
- Home visits conducted by Community Education Department
- List of urgent care centers sent to members
- Provider fax blasts
- Utilization of ED utilization data for provider outreach to members with asthma, diabetes and cardiac disease

Results: The Health Plan's baseline ED rate of 75.97% increased to 76.85% for HEDIS® 2014 (Measurement Year 2013), then decreased to 76.23 for HEDIS® 2015 (Measurement Year 2014).

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.

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: Final report indicates baseline rate of 44.49%, interim rate of 49.93% and final rate of 54.33%; both interim and final rates exceed targeted rate increase of 5% (to 46.71%).

Overall Credibility of Results: Findings should be interpreted with caution until trending can be done with some consistent metric.

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%.

Performance Measures: HEDIS® 2015 (Measurement Year 2014)

MCO-reported performance measures were validated as per HEDIS® 2015 Compliance Audit™ specifications developed by the National Committee for Quality Assurance (NCQA). The results of each MCO's HEDIS® 2015 Compliance Audit are summarized in its Final Audit Report (FAR).

The HEDIS® 2015 Final Audit Report (FAR) prepared for AmeriHealth by HealthcareData Company, LLC 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 Health Plan performance rates for select HEDIS® Effectiveness of Care measures for HEDIS® 2014 and HEDIS® 2015, Bayou Health 2015 statewide averages and *Quality Compass*® 2015 South Central – All Lines of Business (LOB) (Excluding PPOs) Medicaid benchmarks.

Table 5. HEDIS® Effectiveness of Care Measures – 2014 and 2015

Measure	AmeriHealth		2015 Statewide Average	*Quality Compass*® 2015 South Central Regional Medicaid Benchmarks					
	HEDIS® 2014	HEDIS® 2015		Regional Average	P10	P25	P50	P75	P90
Adult BMI Assessment	10.11%	59.49%	68.69%	76.42%	66.91	71.32	78.37	86.81	89.35
Antidepressant Medication Management - Acute Phase	41.87%	47.22%	49.49%	50.30%	39.85	44.11	49.66	54.94	62.67
Antidepressant Medication Management - Continuation Phase	31.82%	32.72%	33.25%	34.71%	25.84	27.97	32.97	37.93	46.83
Asthma Medication Ratio (5-64 Years)	54.20%	54.56%	52.45%	61.07%	49.81	54.56	61.99	66.6	70.55
Breast Cancer Screening in Women	SS	57.23%	53.63%	54.52%	49.70	51.44	53.02	57.23	65.05
Cervical Cancer Screening [1]	49.93%	54.33%	56.31%	56.63%	45.39	50.56	57.18	64.32	69.15
Childhood Immunization Status - Combination 3	40.73%	47.92%	52.54%	70.66%	55.48	68.91	71.53	75.67	80.05
Chlamydia Screening in Women (16-24 Years)	55.84%	59.35%	58.14%	52.66%	45.27	49.32	51.79	57.24	59.35
Comprehensive Diabetes Care - HbA1c Testing	79.87%	83.51%	81.92%	82.84%	74.83	80.51	82.24	85.40	88.87
Controlling High Blood Pressure	0.00%	35.33%	38.52%	49.22%	35.33	41.19	50.30	56.17	60.46
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	35.49%	40.66%	52.62%	56.47%	44.20	51.17	57.68	63.79	69.62
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	31.85%	31.35%	40.58%	44.13%	32.09	38.79	44.45	51.10	55.79
Medication Management for People With Asthma Total - Medication Compliance 75% (5-64 Years)	31.53%	30.65%	25.21%	25.06%	16.02	19.14	23.47	30.48	36.67
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile	1.43%	30.79%	29.78%	54.62%	36.28	44.08	56.20	63.99	72.22
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	2.86%	39.58%	36.40%	55.85%	39.58	49.64	57.87	66.67	71.99
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity	0.26%	25.93%	26.14%	47.51%	30.07	40.39	47.20	62.73	63.81

SS: Sample Size too small to report (less than 30 members).

HEDIS® Access to/Availability of Care Measures

The HEDIS® Access to/Availability of Care measures examine the percentages of Medicaid children/adolescents, child-bearing women and adults who receive PCP/preventive care services, ambulatory care (adults only) or receive timely prenatal and postpartum services. Table 6 displays Health Plan rates for select HEDIS® Access to/Availability of Care measure rates for HEDIS® 2014 and HEDIS® 2015, Bayou Health 2015 statewide averages and *Quality Compass*® 2015 South Central – All Lines of Business (LOB) (Excluding PPOs) Medicaid benchmarks.

Table 6. HEDIS® Access to/Availability of Care Measures – 2014 and 2015

Measure	AmeriHealth		2015 Statewide Average	*Quality Compass*® 2015 South Central Regional Medicaid Benchmarks					
	HEDIS® 2014	HEDIS® 2015		Regional Average	P10	P25	P50	P75	P90
	Children and Adolescents' Access to PCPs								
12–24 Months	94.77%	94.55%	95.66%	96.03%	93.28	94.66	96.71	97.49	97.96
25 Months–6 Years	84.83%	84.06%	86.23%	89.08%	84.01	86.66	89.68	91.58	93.70
7–11 Years	83.57%	86.28%	88.18%	92.45%	86.28	89.66	94.00	94.75	96.30
12–19 Years	80.97%	84.59%	86.39%	90.37%	84.59	87.87	90.98	94.09	95.16
	Adults' Access to Preventive/Ambulatory Services								
20–44 Years	80.18%	78.63%	79.15%	79.30%	72.88	76.83	78.63	82.09	86.17
45–64 Years	87.86%	87.27%	87.80%	87.21%	83.52	86.49	87.93	90.34	92.00
65+ Years	73.24%	72.22%	77.11%	85.34%	74.64	83.13	86.39	89.44	92.27
	Access to Other Services								
Timeliness of Prenatal Care	77.83%	83.80%	85.41%	84.10%	70.57	83.80	87.10	88.54	91.00
Postpartum Care	32.44%	43.06%	46.72%	57.83%	47.45	51.41	59.12	64.48	68.86

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

Table 7. Use of Services Measures – 2014 and 2015

Measure	AmeriHealth		2015 Statewide Average	*Quality Compass*® 2015 South Central Regional Medicaid Benchmarks					
	HEDIS® 2014	HEDIS® 2015		Regional Average	P10	P25	P50	P75	P90
Adolescent Well-Care Visits	43.49%	43.75%	49.73%	53.59%	34.55	43.75	55.96	63.92	72.26
Frequency of Ongoing Prenatal Care - ≥ 81%	57.75%	68.75%	69.25%	61.86%	47.45	55.55	61.92	71.57	75.12
Well-Child Visits in the First 15 Months of Life 6+ Visits	36.92%	49.77%	55.22%	53.88%	40.23	48.60	53.12	61.30	67.88
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	57.17%	62.21%	63.74%	71.58%	59.75	64.10	73.36	78.76	82.73

Member Satisfaction: Adult and Child CAHPS® 5.0H

In 2014, 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 2013-2015, as well as *Quality Compass*® 2015 South Central – All Lines of Business (LOB) (Excluding PPOs) Medicaid benchmarks. The *Shared Decision Making* composite was modified and therefore not trendable.

Table 8. Adult CAHPS® 5.0H – 2013-2015

Measure[1]	AmeriHealth			*Quality Compass*® 2015 South Central Regional Medicaid Benchmarks					
	CAHPS® 2013	CAHPS® 2014	CAHPS® 2015	Regional Average	P10	P25	P50	P75	P90
Getting Needed Care[2]	74.83%	77.5%	79.77%	82.79%	79.28	80.31	83.24	84.68	85.41
Getting Care Quickly[2]	77.48%	76.6%	81.57%	81.60%	77.52	79.77	81.57	83.18	85.26
How Well Doctors Communicate[2]	87.32%	85.6%	87.47%	90.85%	87.66	89.05	91.09	92.34	93.12
Customer Service[2]	87.08%	79.6%	89.10%	88.42%	84.04	87.07	88.69	89.87	91.82
Shared Decision Making[2]			80.85%	77.06%	73.18	75.54	76.72	79.66	80.35
Rating of All Health Care	67.83%	62.2%	66.54%	73.90%	69.35	71.75	72.91	75.81	78.77
Rating of Personal Doctor	75.43%	74.8%	77.74%	80.56%	77.56	78.09	80.51	81.72	85.61
Rating of Specialist	81.95%	81.0%	78.90%	80.49%	73.58	77.94	80.98	83.75	86.63
Rating of Health Plan	65.50%	63.4%	72.59%	77.62%	72.80	74.81	78.14	80.44	80.92

[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 – 2013-2015

Measure[1]	AmeriHealth			*Quality Compass*® 2015 South Central Regional Medicaid Benchmarks					
	CAHPS® 2013	CAHPS® 2014	CAHPS® 2015	Regional Average	P10	P25	P50	P75	P90
Getting Needed Care[2]	87.05%	86.3%	92.56%	85.28%	78.75	82.86	86.07	88.25	89.42
Getting Care Quickly[2]	92.88%	93.9%	92.80%	89.68%	83.51	87.06	90.62	92.09	94.62
How Well Doctors Communicate[2]	93.84%	93.6%	95.62%	92.79%	89.75	91.06	93.32	94.03	95.62
Customer Service[2]	88.51%	87.4%	94.77%	89.36%	86.24	87.13	89.54	91.10	91.57
Shared Decision Making[2]			75.94%	75.82%	66.55	70.92	78.39	80.08	80.75
Rating of All Health Care	83.19%	81.1%	87.07%	85.73%	81.39	84.18	86.32	87.69	88.70
Rating of Personal Doctor	87.50%	82.8%	92.16%	88.47%	86.77	87.25	88.12	89.65	90.74
Rating of Specialist	81.03%	86.7%	91.53%	85.38%	81.67	83.90	85.34	86.71	87.88
Rating of Health Plan	80.32%	72.7%	85.66%	86.97%	81.85	84.86	86.40	89.72	92.35

[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 – 2013-2015

Measure[1]	AmeriHealth			*Quality Compass*® 2015 South Central Regional Medicaid Benchmarks					
	CAHPS® 2013	CAHPS® 2014	CAHPS® 2015	Regional Average	P10	P25	P50	P75	P90
Getting Needed Care[2]	85.31%	87.1%	91.22%	88.27%	86.14	87.28	88.64	88.79	90.68
Getting Care Quickly[2]	91.68%	91.4%	94.62%	93.96%	92.14	92.97	93.78	95.36	95.57
How Well Doctors Communicate[2]	91.25%	92.6%	94.72%	94.44%	92.81	93.71	94.50	95.29	95.73
Customer Service[2]	92.23%	88.3%	91.42%	89.02%	85.11	86.32	89.17	91.03	92.15
Shared Decision Making[2]			82.00%	83.46%	79.76	82.00	83.49	84.88	87.28
Rating of All Health Care	75.62%	76.5%	86.28%	84.89%	83.59	84.33	85.19	85.96	86.73
Rating of Personal Doctor	83.55%	81.1%	88.57%	87.96%	86.15	86.85	87.57	88.91	90.22
Rating of Specialist	78.95%	89.7%	89.58%	86.90%	83.48	84.46	87.67	88.94	89.63
Rating of Health Plan	71.34%	67.8%	79.84%	83.52%	79.84	81.97	82.99	85.44	87.17

[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

During this review period, IPRO conducted Readiness Reviews of the Bayou Health Medicaid MCOs. The purpose of the Readiness Reviews were to assess the MCOs operational capacity to participate in Medicaid managed care and begin enrollment in accordance with the newly-enforced state contract regulations for Medicaid managed care. The MCOs were required to demonstrate the ability to operate a program that meets the Department of Health and Hospitals' (DHH) requirements and were expected to clearly define and document the policies and procedures to support day-to-day business activities related to Louisiana Medicaid enrollees. Enrollment under the updated contract regulations began in February 2015.

The following domains were reviewed for the 2014-2015 AmeriHealth Readiness 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 2014-2015 Readiness Review.

Table 11. 2014-2015 Readiness 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 2014-2015 Readiness 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

2014-2015 Medicaid Managed Care Readiness Review – Elements Not Fully Met	
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.
12.0b Member 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 2015 HEDIS® Final Audit Report revealed no significant problems and the Health Plan was able to report all required Medicaid rates.
- The Health Plan met or exceeded the 75th percentile for the following HEDIS® measures: Breast *Cancer Screening in Women*, *Chlamydia Screening in Women (16-24 Years)* and *Medication Management for People With Asthma Total - Medication Compliance 75% (5-64 Years)*.
- The Health Plan demonstrated strong performance on a single Adult CAHPS® measure, exceeding the 90th percentile for *Shared Decision Making*. The Health Plan also demonstrated strong performance on several Child CAHPS® General Population measures, including: Getting *Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Rating of Personal Doctor* and *Rating of Specialist.* Additionally, the Health Plan exceeded the 75th percentile for the following Child CAHPS® CCC Population measures: *Getting Needed Care*, *Customer Service*, *Rating of All Health Care* and *Rating of Specialist*.

Opportunities for Improvement

- The Health Plan continues to demonstrate an opportunity for improvement in regard to its overall HEDIS® performance. The following measures performed below the 50th percentile: *Adult BMI Assessment*, *Antidepressant Medication Management – Acute Phase*, *Antidepressant Medication Management – Continuation Phase*, *Asthma Medication Ratio*, *Cervical Cancer Screening*, *Childhood Immunization Status – Combo 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, Timeliness of Prenatal Care*, *Postpartum Care*, *Postpartum Care*, *Adolescent Well-Care Visits, 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 continues to demonstrate an opportunity for improvement in regard to access to care as rates for all age groups were below the 50th percentiles for the HEDIS® *Children and Adolescents Access to PCPs*. Additionally, *Adults' Access to Preventive/Ambulatory Services* rates for the 45-64 years and 65+ years age groups were below the 50th percentiles.
- 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*, *How Well Doctors Communicate*, *Rating of All Health Care, Rating of Personal Doctor*, *Rating of Specialist* and *Rating of Health Plan*. The Health Plan also performed below the 50th percentile for the following Child CAHPS® General and CCC Populations measures: *Shared Decision Making* and *Rating of Health Plan.* (Note: Member satisfaction was an opportunity for improvement in the previous year's report.)

Recommendations

- Although there remains an opportunity for improvement in regard to HEDIS® performance, the Health Plan should continue with the improvement strategy outlined in its in response to the previous year's recommendation as most HEDIS® rates appear to be trending upward. The Health Plan should routinely monitor the effectiveness of this strategy and modify it as needed to ensure continued improvement. *[Repeat recommendation.]*
- As Health Plan members continue to demonstrate lower than average access to primary care, the Health Plan should assess the effectiveness of its current interventions and modify them as needed. The Health Plan should consider intensifying member-level education and outreach efforts. *[Repeat recommendation.]*
- The Health Plan should continue to work to improve CAHPS® measures that perform below the 50th percentile. The Health Plan should continue with the improvement strategy described in its response to the previous year's recommendation as rates are trending upward. The Health Plan should routinely monitor the effectiveness of this strategy and modify it as needed to ensure continued improvement. *[Repeat recommendation.]*

Response to Previous Year's Recommendations

- 2013-2014 Recommendation: 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.]*

  Health Plan Response: ACLA saw a significant increase in network practices achieving PCMH recognition in 2015; with 8% of network practices achieving recognition, impacting 15% of overall membership. This increase was attributed to the work that was done to ensure accurate reflection within provider practice data and the development of a field within ACLA's provider file system, FACETS to hold recognition information; as well as the electronic feed of PCMH provider information from NCQA to the FACETS system allowing for greater accuracy and reliability within data reporting.

  ACLA has spent considerable efforts in re-evaluating approach to PCMH recognition and identified core elements of a successful PCMH strategy is:
  - Incorporated as a critical element of other core strategies.
  - One component of the overall value based portfolio of strategies.
  - Includes integrated care management, behavioral health and dental health.
  - Includes payment transformation.

  ACLA is reinvigorating its current strategy to include the following Key Elements:
  - AmeriHealth Corporate and Plan Leadership Support
  - Medical Director Support and Plan Champions
  - Practice Support
    - Practice Coaching/Facilitation – at least one PCMH Champion/NCQA Certified Content Expert (CCE) per plan
    - Webinars and Regional PCMH specific collaboratives
  - Payment/Rewards Transformation
    - Reward for Achieving PCMH status
    - Reward for Sustaining PCMH status
    - Reward for outcomes/shared savings
  - Enterprise-Wide, as well as Market-Specific Team Approach

- Medical Directors
- Account Executives
- Quality Coach (Continuous Quality Improvement)
- Integrated Care Management
- Medical Economics

- Targeted Strategy for assisting rural practices and/or practices in underserved areas or with limited resources
- Ongoing Analysis of Impact:
  - Variation by market
  - Effectiveness of interventions
  - Best Practices and Lessons Learned
  - Opportunities for Data Sharing
  - Most effective model for integration of care management/care coordination activities between plan and PCMH

It is expected that by refining our approach and obtaining engagement from broader internal functional teams, ACLA can make strides in both clinic and member engagement.

§ 2013-2014 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.]*

Health Plan Response: As indicated in the pharmacy accessibility analysis, ACLA demonstrated that 97.9% of members have access to pharmacies within accessibility standards (within 10 miles and 30 miles in urban and rural parishes, respectively). (Managed Care Accessibility Analysis report attached)

ACLA provides members with open access to specialty services (including pharmacies); to ensure that members determined to need a course of treatment or regular care monitoring have access to a mechanism that allows direct access to a specialist as appropriate for members condition and identified needs. Members are always allowed to self-refer to the specialties of family planning.

To meet Member Education contractual requirements, ACLA has included all necessary prescription benefit information on the Bayou Health Plan card.

§ 2013-2014 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.

Health Plan Response: ACLA has conducted root cause analysis for HEDIS Effectiveness of Care and Use of Services measures that performed below the 50th percentile. The plan has implemented strong interventions to address barriers associated with these measures. To monitor the effectiveness of interventions and processes, ACLA tracks, trends and analyzes HEDIS metrics and Care Gap reports and conducts Program Evaluations, Health Outcomes Summaries, Quality Improvement Activities and Performance Improvement Projects. Data and information is shared with the Quality Assessment and Performance Improvement Committee for review and feedback. In addition to the measure intervention summary below, the plan has included detailed provider and member incentive tables offered throughout 2015.

To address care gaps for all measures, member care gaps are loaded into our internal information systems where it is visible to Care Management and Customer Service staff. When an ID number or name of a member with a Care Gap is entered into our care management or Customer Service system, a message either appears on the screen alerting staff to the member's Care Gaps or can be located in the care management system under the Care Gaps section. Each employee has a role-specific protocol to follow to address the care gap with the member. Practitioner/Provider offices also receive alerts on Care Gaps when they check eligibility through the ACLA Provider Portal. Primary Care Practitioners (PCP) can pull reports on their assigned members detailing Care Gaps and areas where the member's care is in compliance with clinical guidelines.

- *Timeliness of Prenatal Care*
- *Postpartum Care*
- *Frequency of Ongoing Prenatal Care*

Although AmeriHealth Caritas Louisiana continues to fall below the 50th percentile in key measures related to women's health, the plan has showed statistically significant improvement in the measures during measurement year 2014. To address poor results related to women's health measures, the plan implemented member incentives for prenatal well care and postpartum care. The plan's Bright Start Program encompasses a dedicated team of Care Managers and Care Connectors that outreach and engage pregnant members and linked providers. DVD and receiving blanket incentives were used for pregnant members that self identified.

In 2015, the plan implemented a Perinatal Quality Enhancement Program with a unique reimbursement system developed for participating obstetrics, midwife and family practice practitioners to deliver high quality, cost effective and timely care to pregnant members.

For members that are unable to be reached via telephonic outreach, Community Health Educators make additional effort to outreach members face to face. Member education material is distributed by this team at numerous events across the state. Information is available through welcome packets, the member web portal, and member newsletters. Transportation services are available for our members in need of transportation assistance.

- *Childhood Immunization Status*
- *Adolescent Well-Care*
- *Adolescent Well-Care Visits*
- *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*

For measures associated with well care services and immunizations, ACLA implemented member incentives targeting adolescents and children during 2015. Additionally, numerous provider incentives were offered through the Quality Enhancement Program and HEDIS Improvement Campaign. Provider telephonic outreach was conducted to practices with large noncompliant populations. Data on Members' EPSDT service status was distributed through the ACLA IHCM Information System, ACLA Member Service System and ACLA Provider Portal. ACLA's Provider Portal generates an alert for children missing EPSDT services at the time eligibility is checked. The alert identifies the missing/overdue service and can be printed for inclusion with the child's chart at the time of the PCP visit.

ACLA's Care Connectors make routine EPSDT phone calls to the parents/guardians of children under age 2 to remind them of EPSDT immunizations and screenings that are due in the next month and assist them to make an appointment with the child's PCP/Medical Home. During the phone call, the Care Connector reviews the EPSDT information for other members of the household and provides reminders and facilitates services for those children as well.

Birthday cards are mailed on an annual basis to the parent/guardian of members age one and older to wish the child a "Happy Birthday" and educate the parent/guardian on EPSDT services that are needed in conjunction with the birthday. In addition, each birthday card contains information on age-appropriate developmental milestones and safety tips, as well as important resource agencies and telephone numbers.

ACLA's IHCM information system and Member Service information system generate an alert for children missing EPSDT services when the child's ID number is entered into the system. This allows ACLA staff to address missing/overdue services with the parent/guardian when the parent/guardian contacts ACLA for any reason. ACLA includes information on the importance of EPSDT screening and immunizations and mechanisms to access care in new member materials, member and provider handbooks, newsletters, website articles and on-hold messaging. Additionally, ACLA included educational material and activities on EPSDT and other preventive health measures at numerous community events. Of note, a statistically significant improvement was noted in well-child and immunization measures during measurement year 2014.

- *Asthma Medication Ratio*
- *Medication Management for Members with Asthma*
- *Comprehensive Diabetes Care – HgbA1c Testing*
- *Comprehensive Diabetes Care – LDL-C Screening*
- *Controlling High Blood Pressure*
- *Cholesterol Management for Patients With Cardiovascular Conditions*
- *Adult BMI Assessment*
- *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*

The AmeriHealth Caritas Louisiana Community Care Management Team (CCMT), located in Baton Rouge, extends the traditional care management continuum by providing high-touch, face-to-face engagement for high-risk members, including those who have complex care needs, are difficult to engage through telephonic care management, access care primarily through emergency services or are frequently admitted to inpatient settings. Services are provided through a community-based team of a nurse, social worker and community health workers to help members navigate and increase their access to needed medical, behavioral health and social services. The team also supports the development of member self-management skills through encouragement and coaching for chronic disease management. In addition to improving the care and health outcomes of members, this community-based team provides valuable information for and coordination with other health plan staff and services, as well as other providers in the community.

2015 efforts to improve disease specific and prevention measures were initiated with Integrated Health Care Management. Every month, a report is completed to identify members at risk for targeted disease states. Member outreach and engagement is based on risk level stratification.

Asthma

Low Risk	High risk
· Welcome letter/educational material mailed to newly identified members · Focused educational mailings · Monitoring for medication adherence · Annual reminders for flu/pneumonia vaccine · Access to Rapid Response Unit · Access to 24/7 Nurse Line · Smoking Cessation Program referral · Integrated Care Management	In addition to low risk interventions, Integrated Care Management services, include: · Comprehensive Assessment · Individualized Care Plan focusing on priority Interventions (detailed below) · Outreach based according to level of intensity · Focused education, based on assessment including preventive measures, trigger identification/avoidance, worsening of symptoms and supportive measures · Monitoring of pharmaceutical medication · Utilization of Health risk assessments tools to monitor member outcomes · Provider contact and care plan collaboration · Identification, communication and intervention to resolve Gaps in Care · Connection to appropriate community resources and services · Provide high level supportive services and equipment

Diabetes

Low Risk	High Risk
· Welcome letter/educational material mailed to newly identified members · Focused educational Mailings · Monitoring for medication adherence · Monitoring for LDL and HgbA1C screening and results · Access to Rapid Response Unit · Access to 24/7 Nurse Line · Smoking Cessation Program · Complex Healthcare Management Assessment available upon request	In addition to low risk interventions, Complex Care Management services, including: · Comprehensive Assessment · Individualized Care Plan focusing on Priority Interventions (detailed below) · Frequent outreach based according to level of intensity · Focused education, based on assessment including preventive measures, worsening of symptoms and supportive measures · Monitoring of pharmaceutical medication · Utilization of Diabetes tools to monitor member outcomes · Provider contact and care plan collaboration · Provide high level supportive services and equipment · Outreach to members with HbA1C > 8.5% · Outreach to members with no HbA1C on file · Identification, communication and intervention to resolve Gaps in Care · Smoking cessation program · Connection to appropriate community resources and services

Cardiovascular

Interventions
· Welcome letter/educational material mailed to newly identified members · Focused prevention and condition related educational mailings · Annual reminders for flu/pneumonia vaccine · Monitoring for medication adherence · Access to Rapid Response Unit · Access to 24/7 Nurse Line · Referral to Smoking Cessation Program, as indicated · Complex Healthcare Management · Assessment available upon request

Adult Obesity

Low Risk	High Risk
· Welcome letter/describing obesity program and inviting member to call to talk to a CM for more information · Focused education mailings related to prevention of obesity, lifestyle changes, nutrition, and behavioral changes. · Complex Healthcare Management · Assessment available upon request · Access to Rapid Response Unit · Access to 24/7 Nurse Line	In addition to low risk interventions, Complex Care Management services, including: · Access to a multidisciplinary team consisting of a primary care provider, behavioral health provider and care manager · Focused education on preventing obesity, medical and behavior health risks associated with obesity · Assessment of family dynamics, cultural values and beliefs · Assessment of family history of diabetes and obesity · Collaborative goal setting · Frequent outreach based according to level of intensity · Individualized Care Plan focusing on Priority Goals and Interventions

Pediatric Obesity

Low Risk	High Risk
· Welcome letter/educational material · Focused education mailings related to prevention of obesity, lifestyle changes, nutrition, behavioral changes · Complex Care Management · Assessment available upon request · Access to Rapid Response Unit · Access to 24/7 Nurse Line	In addition to low risk interventions, Complex Care Management services, including: · Access to a multidisciplinary team consisting of a dietician, primary care provider, behavioral health provider and care manager · Focused education on preventing obesity, medical and behavior health risks associated with obesity · Monitoring BMI · Assessment of family dynamics, cultural values and beliefs · Assessment of family history of diabetes and obesity · Collaborative goal setting · Frequent outreach based according to level of intensity · Individualized Care Plan focusing on Priority Goals and Interventions · Monitoring of pharmaceutical medication · Identification, communication and intervention to resolve Gaps in Care, focusing on Well Child Visits · Connection to appropriate community resources and services

ACLA initiated a new program for obesity titled "Make Every Calorie Count". The program started in 2014 and continued through 2015 for adults and children. The program began with the adult and pediatric blue print and implementation of a health risk assessment tool. Training and education followed for the staff including development of educational material for staff and members such as brochures. Members are stratified utilizing the Obesity Blue prints. Members who meet the stratification criteria and engage in care management receive a welcome packet, tape measure, pedometer and calorie count journal.

These tools are used to promote self-management, motivation and are used as a teaching tool when the care manager engages with the member. Members are screened on initial assessment for BMI a subsequent health risk assessment is completed to reassess their BMI and weight management progress. An Individualized care plan is generated automatically from the completed assessment while at the same time the member's personal goals are addressed.

AmeriHealth Caritas Louisiana's Healthy Hoops community asthma event and Tackling Diabetes community event were both hosted during 2015. The events included member education, exercise and nutritional counseling, BMI assessments, blood pressure checks, targeted screenings and member incentives.

Additional member incentives and provider incentives were offered for HgbA1C testing, monitoring for nephropathy and retinal eye exams. Furthermore, Comprehensive Diabetes Care measures and Medication Management for People with Asthma are measures included in the ACLA's Quality Enhancement Program. Provider outreach was conducted to help identify noncompliant populations for Comprehensive Diabetes Care measures. A statistically significant increase was noted for HgbA1C testing during MY 2014.

- *Lead Screening in Children*
- *Breast Cancer Screenings*
- *Cervical Cancer Screenings*
- *Chlamydia Screenings in Women*

During 2015, preventative screening measures were addressed through a multitude of outreach efforts. Lead Screenings in Children, Breast Cancer Screenings, Cervical Cancer Screenings and Chlamydia Screenings in Women are part of the plan's Care Gap program. Lead Screenings in Children was also addressed through our Rapid Response Outreach Team. Chlamydia Screenings in Women is part of the plan's Provider Quality Enhancement Program. Other forms of outreach include member newsletters, on-hold messaging, sound-bites, web content and community outreach. Cervical Cancer Screenings and Chlamydia Screenings showed statistically significant increases during MY 2014.

- *Follow-up Care for Children Prescribed ADHD Medication- Initiation Phase*
- *Follow-up Care for Children Prescribed ADHD Medication-Continuation and Maintenance Phase*

2015 initiatives for Follow-Up Care for Children Prescribed ADHD Medication included numerous initiatives. Members that are started on a new ADHD medication receive a letter with follow up recommendations. Providers receive a letter as well identifying the member needing follow up and recommendations for follow up. A member incentive was implemented during 2015 for the Initiation Phase in addition to member outreach via the Rapid Reponses Outreach Team for Initiation and Continuation and Maintenance. I Am Healthy educational flyers and web content was developed for new initiatives. This measure is part of the Provider Quality Enhancement Program as well. Statistically significant improvement was noted in MY 2014 for the Continuation and Maintenance Phase.

- *Antidepressant Medication Management – Acute Phase*
- *Antidepressant Medication Management –Continuation Phase*

Antidepressant Medication Management was addressed through the plan's collaborative efforts with Magellan, on-going Behavioral Health Integration Rounds and the plan's Integrated Health Care Management (IHCM) medication management program. Effective December 1, 2015, ACLA's IHCM program enhanced integration of physical health, behavioral health and social-environmental aspects of the member's care into one comprehensive care plan with the carve in of Behavioral Health services.

§ 2013-2014 Recommendation: 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 Response: ACLA surveys providers on an annual basis to ensure member access for primary care services. 2015 Primary Care access and availability compliance for all individual measures was at 100% for all but two measures: Urgent Care and Prenatal Care (second trimester) with about two in ten PCP sites providing prenatal care.

ACLA does note that during the 2015 calendar year an adult access gap did present in the North Shore region of the state as a large multi-site federally qualified health clinic, Access Health, did lose multiple physicians; Access Health has since hired additional physicians to staff this location.

ACLA will take the following Action steps to ensure member access to care in the primary care setting:

- ACLA will use the raw data from the Appointment Availability annual survey to identify non-compliant PCPs and specialists.
- Account Executives will share survey results with non-compliant providers and request that a corrective action plan be implemented and Include standards that providers should meet in the communication (e.g., Urgent Care standard is to see patient within 24 hours).
- Account Executives will discuss with provider offices opportunities to implement same-day appointments for certain patient types, walk-in ability, leave appointment slots open daily, extend office hours, etc.
- Account Executives will discuss opportunities to improve Prenatal Care compliance:
    - Identify patterns in care in the office.
    - If more Urgent/Sick Care appointments are needed early in the week, schedule Routine Prenatal Care for late in the week.
- Account Executives will validate issues that may be impacting non-compliance such as:
    - What are panel sizes in these practices?
    - Do providers work in teams?
    - Does practice include physician extenders?
    - Consider recommendations for adding mid-level providers to staffing mix to cover heavy volume times.
- ACLA will implement clinic education programs and develop Customer Service seminars for physicians' office staff.
    - ACLA will 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 ACLA's Member Engagement and Member Outreach teams, ACLA 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.

§ 2013-2014 Recommendation: The 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.]*

Health Plan Response: ACLA continues to work on improving CAHPS scores for both the Adult and Children surveys by recognizing opportunities where the Plan performed below the NCQA 50th percentile. ACLA has developed a "CAHPS" workgroup which consist of multi-disciplinary internal

departments. The goal of the workgroup is to review and analyze the CAHPS results and identify barriers/opportunities as well as interventions for improving overall CAHPS scores. Examples of analysis and actions are as follows:

- The Plan continues to work with Network Management (NM) in regards to Access to Care.
    - NM will continue to offer provider education as it relates to appointment availability standards.
    - Primary Care Provider Groups and high volume Specialty Groups are surveyed to ensure compliance with Appointment Availability Standards, Non-compliant providers will receive additional education and placed on corrective action as needed.
    - Informative articles were incorporated into the Plan's Member Newsletters.
    - Work on developing on-hold messaging to educate members on appointment availability standards.

- The Plan worked with Network Management in regards to the 2015 Provider Satisfaction Survey to evaluate the services provided by practitioners. The Plan wanted to ensure that adequate services were available to the Plan's members. The survey found the following:
    - Specialist: The plan's 2015 Provider Satisfaction indicated that almost two-thirds of practitioners surveyed say that there are an adequate number of specialists in the network, which is significantly higher than in 2014.
    - Provider Training: More than eight in ten practitioners find Provider Training formats useful, which is significantly higher than 2014 ratings, while about the same proportion mentioned they would find similar webinars with the same type of information useful as well.

- After review of the 2014 CAHPS Adult survey, AmeriHealth Caritas Louisiana included supplemental questions on the 2015 CAHPS survey to cover the areas of Emergency Room (ER), Personal Doctor, Customer Service, Communication and Health Plan. Findings are listed below. The Plan will continue to review and analyze opportunities for supplemental questions.
    - When posing a question on emergency room, it was found 39% of respondents did not go to the emergency room to get care for themselves and 10% went to emergency room three or more times. It was also found that 66% of respondents used emergency room because they felt their illness was an emergency.
    - The supplemental question on Personal Doctor showed 61% of respondents said that their personal Doctor 'Never' used medical words they do not understand while 25% said 'Sometimes.'
    - 83% of respondents gave favorable responses (always and usually) that their Personal Doctor gives them easy information to understand instructions about what to do to take care of their illness or health condition.

- The plan developed an internal CAHPS Education and Awareness Campaign for all ACLA associates who have direct contact with members/providers. The program will be rolled out 2016 as a webinar training presentation that will include tips on improving members call satisfaction, communication skills and information about CAHPS.

- During ACLA's 2015 HEDIS Bonus Campaign, an after-hours incentive of $10 was offered to providers for providing after-hours care to AmeriHealth Caritas Louisiana members.