AMERIGROUP LOUISIANA, INC.

Annual External Quality Review Technical Report

Review Period: July 1, 2013 – June 30, 2014
April 2015

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) 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 Amerigroup Louisiana, Inc. (Amerigroup) 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

Amerigroup	
Type of Organization	Health Maintenance Organization (HMO)
Tax Status	For Profit
Year Operational	02/01/2012
Product Line(s)	Medicaid and LaCHIP
Total Medicaid Enrollment (as of December 2014)	132,509

III. ENROLLMENT AND PROVIDER NETWORK

Enrollment

Medicaid Enrollment

As of December 2014, the Health Plan's Medicaid enrollment totaled 132,509, which represents 14% of Bayou Health's active members. Table 2 displays Amerigroup'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]

Amerigroup	2013	2014	% Change	2014 Statewide Total[2]
GSA A	42,585	45,231	6.21%	280,483
GSA B	40,547	41,599	2.59%	324,664
GSA C	43,793	45,679	4.31%	318,993
Total Enrollment	126,925	132,509	4.40%	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.

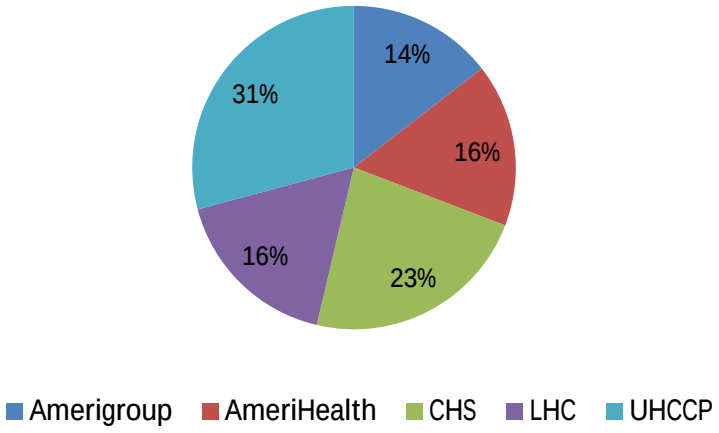
[2] Note: Total includes membership of all plans.

GSA A: New Orleans and North Shore

GSA B: Baton Rouge, Lafayette and Thibodaux

GSA C: Alexandria, Lake Charles, Monroe and Shreveport

Figure 1. Bayou Health Membership by Health Plan as of December 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	188	208	244	620
Pediatrics	252	207	163	561
Nurse Practitioners	152	207	243	566
Internal Medicine[1]	233	157	97	475
RHCS/FQHC	44	70	108	222
OB/GYN[1]	205	205	166	537

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.

Amerigroup'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
1,261	75[1]	5.9%

[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 "Emergency Department Visits". The Health Plan-selected PIPs were "Childhood Immunization – Combo 2" and "Cervical Cancer Screenings".

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 Amerigroup follow.

State-Directed PIP #1: Emergency Department 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 be at or below the NCQA *Quality Compass*® Medicaid 2011 50th percentile for the HEDIS® *Ambulatory Care: ED Visits* measure.

Intervention Summary:

- Development of state-approved letter to flag facility ED leadership
- Locate and contract with additional urgent care centers
- Updated profiling tools to identify members with high utilization for providers
- Quarterly ED reports for providers
- Case management for "frequent flyers"
- ED "frequent flyer" reports disseminated monthly
- Updated provider letters regarding targeted members
- Outreach to high volume hospital ED CM staff
- Presentations to religious/school leaders
- Develop posters for provider offices
- Calls to members using Eliza scripts
- Encourage adherence to PCMH goals
- Case Manager Call campaign
- Care Managers assigned to specific high volume ERs
- Targeted mailings to members
- Strategic partnerships with Urgent Care Centers and after hour clinics and offices
- Monthly medication adherence letters
- Deploying Outreach Specialist for telephonic outreach to unable to contact members

Results: The partial year December 2013 rate was 71.84, 8.57 points above the NCQA benchmark. Frequent flyer utilization rates were also tracked and noted to be 47% of emergency department utilization.

Overall Credibility of Results: This validation suggests that the findings of the interim PIP report should be interpreted with caution since the calculation and findings associated with the ER rate that was presented require a re-examination to ensure accuracy.

Strengths:

- Strong rationale with data specific to Louisiana reported, indicating the need to focus on reducing ER utilization.
- The plan expanded the study to include its special needs population. (The population was added on 7/1/12)
- Several interventions focusing on members, providers and facilities. Member interventions are particularly strong with a focus on high utilizers, enrollment into case management and adding urgent care centers to the network should all help to reduce utilization.
- Interventions also outreach to the community, i.e., churches.

Opportunities for Improvement:

- Upon submission of HEDIS® in 2014, the ER rate should be incorporated into the project report.

Health Plan-Selected PIP #1: Childhood Immunization – Combo 2

Indicator(s)/Goals: The indicator for this PIP is the HEDIS® *Childhood Immunization Status - Combo 2* - identifying those eligible members who have received appropriate immunizations on or before their second birthday.

The Health Plan's goal for this PIP is to be at or above the HEDIS® 50th percentile in NCQA Medicaid QC 2011.

Intervention Summary:

- Provider education
- Assessment feedback Incentives-Exchange (AIX) for providers
- Promote, recruit, and train providers to participate in LINKS
- Health Promotion/EPSTD toolkit for providers
- Patient reminder calls
- Access to immunization
- GeoAccess reports
- Member outreach through health fairs, education programs…
- Missed opportunity reports for providers/provider reports in advance of due date
- Immunization schedule to be included in new member packets
- Develop/distribute report cards

Results: Using the HEDIS® *Childhood Immunization Status - Combo 2* rate, baseline (12/31/12) was 31.25, below the national 50th percentile. Rates were tracked monthly. Steady monthly increases were observed in the rate through June 2013.

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 childhood immunizations.
- Use of a standard measure to track performance (HEDIS® *Childhood Immunization – Combo 2*).
- Interventions targeted to members and providers, and linked to identified barriers.
- Interventions target key sectors of the healthcare sector: the plan, provider, and community levels.
- Encouraging and using LINKS.
- A quantifiable and achievable goal was established.

Opportunities for Improvement:

- Upon submission of HEDIS® in 2014, the *Childhood Immunization Status - Combo 2* rate should be incorporated into the project report.

Health Plan-Selected PIP #2: Cervical Cancer Screenings

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 received one or more Pap tests to screen for cervical cancer with no more than one gap in enrollment of up to 45 days during the measurement year*.

The Health Plan's goal for this PIP is to meet or exceed the *Quality Compass*® 2013 Medicaid 50th percentile.

Intervention Summary:

- Quick reference tool for providers
- Education regarding acceptable medical records and documentation
- Create provider Ameritip regarding performance and statistics on CCS
- Encourage timely submission of claims
- Outreach and assistance to non-compliant members
- Highlight cervical cancer screening as part of the PCMH initiative

Results: Using the HEDIS® *Cervical Cancer Screening* measure, baseline (12/31/12) was 42.53%, below the national 50th percentile. Rates were tracked monthly and steady progress observed, helped by improved data collection. Steady progress continued in 2013 with rates increasing from 35.72% (7/13) to 41.54% (12/13). December 2013 rate was 28.18% below project goal.

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.
- Use of a standard measure to track performance, which is tracked monthly
- A quantifiable and achievable goal was established.

Opportunities for Improvement:

- Upon submission of HEDIS® in 2014, the *Cervical Cancer Screening* rate should be incorporated into the project report to assess whether the project goals have been met.

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 Amerigroup by Attest Health Care Advisors 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	Amerigroup HEDIS® 2014	*Quality Compass*® 2014 National Medicaid Benchmarks					
		National Average	P10	P25	P50	P75	P90
Adult BMI Assessment	71.00%	75.91%	64.35%	71.54%	78.78%	85.09%	90.82%
Antidepressant Medication Management - Acute Phase	81.67%	50.51%	41.87%	45.07%	49.67%	54.39%	60.86%
Antidepressant Medication Management - Continuation Phase	71.06%	35.18%	27.03%	29.90%	33.93%	38.25%	44.62%
Asthma Medication Ratio (5-64 Years)	52.22%	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]	52.46%						
Childhood Immunization Status - Combination 3	73.15%	70.85%	58.70%	66.67%	72.33%	77.78%	80.86%
Chlamydia Screening in Women (16-24 Years)	55.72%	54.90%	41.19%	48.86%	54.97%	62.57%	67.19%
Comprehensive Diabetes Care - HbA1c Testing	76.81%	83.80%	77.55%	80.18%	83.87%	87.59%	91.73%
Comprehensive Diabetes Care - LDL-C Screening	72.60%	75.97%	66.87%	71.30%	76.87%	80.18%	83.71%
Controlling High Blood Pressure	46.17%	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)	5.24%	81.07%	74.57%	78.33%	81.45%	84.91%	87.84%
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	47.24%	46.35%	23.12%	37.17%	49.51%	57.55%	63.10%
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	41.09%	39.56%	21.77%	32.61%	41.09%	46.99%	53.03%
Lead Screening in Children	67.82%	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)	57.91%	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	35.65%	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	43.29%	58.70%	40.74%	50.00%	60.58%	69.21%	77.47%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity	22.45%	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	Amerigroup HEDIS® 2014	*Quality Compass*® 2014 Benchmarks					
		National Average	P10	P25	P50	P75	P90
	Children and Adolescents' Access to PCPs						
12–24 Months	95.96%	96.14%	93.58%	95.92%	96.96%	97.86%	98.53%
25 Months–6 Years	84.97%	88.25%	82.16%	86.07%	89.08%	91.73%	93.58%
7–11 Years	83.44%	90.02%	83.57%	87.78%	91.15%	93.50%	95.19%
12–19 Years	80.79%	88.53%	81.57%	85.83%	89.98%	92.17%	94.42%
	Adults' Access to Preventive/Ambulatory Services						
20–44 Years	78.68%	80.71%	68.99%	78.34%	83.22%	86.21%	88.52%
45–64 Years	87.48%	87.34%	80.11%	85.88%	88.76%	90.99%	92.25%
65+ Years	81.63%	85.55%	73.24%	82.35%	88.40%	90.70%	92.61%
	Access to Other Services						
Timeliness of Prenatal Care	86.77%	81.93%	69.77%	77.80%	84.30%	89.62%	93.10%
Postpartum Care	56.38%	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 Amerigroup'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	Amerigroup HEDIS® 2014	*Quality Compass*® 2014 National Medicaid Benchmarks					
		National Average	P10	P25	P50	P75	P90
Adolescent Well-Care Visits	40.05%	50.03%	37.73%	41.70%	48.51%	59.21%	65.56%
Frequency of Ongoing Prenatal Care - ≥ 81%	75.41%	55.64%	21.74%	43.73%	60.10%	71.34%	78.37%
Well-Child Visits in the First 15 Months of Life 6+ Visits	37.83%	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	61.34%	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 Amerigroup 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 Amerigroup's 2014 rates as compared to *Quality Compass*® 2014 national Medicaid benchmarks.

Table 8. Adult CAHPS® 5.0H

Measure[1]	Amerigroup		*Quality Compass*® 2014 Benchmarks					
	2013	2014	Average	P10	P25	P50	P75	P90
Getting Needed Care[2]	76.00%	76.60%	80.45%	74.70%	77.47%	80.90%	84.27%	85.59%
Getting Care Quickly[2]	79.23%	80.98%	81.00%	75.26%	78.39%	81.75%	83.75%	85.52%
How Well Doctors Communicate[2]	85.08%	89.14%	89.49%	86.17%	88.16%	89.76%	91.11%	92.42%
Customer Service[2]	85.70%	82.22%	86.51%	81.85%	84.45%	87.05%	88.64%	90.28%
Shared Decision Making[2]	49.14%	54.75%	51.20%	46.87%	49.07%	50.89%	53.69%	55.49%
Rating of All Health Care	68.13%	69.52%	71.26%	64.32%	68.54%	71.53%	74.06%	76.95%
Rating of Personal Doctor	77.92%	80.45%	78.75%	74.37%	76.45%	78.82%	80.97%	83.10%
Rating of Specialist	82.65%	79.80%	80.42%	75.89%	78.64%	80.61%	82.47%	85.31%
Rating of Health Plan	71.71%	78.57%	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]	Amerigroup		*Quality Compass*® 2014 Benchmarks					
	2013	2014	Average	P10	P25	P50	P75	P90
Getting Needed Care[2]	83.83%	86.13%	84.97%	79.05%	82.62%	85.44%	87.90%	90.71%
Getting Care Quickly[2]	89.50%	91.71%	89.46%	83.34%	87.67%	90.59%	92.45%	93.81%
How Well Doctors Communicate[2]	94.35%	92.35%	92.98%	89.71%	91.96%	93.25%	94.67%	95.61%
Customer Service[2]	87.40%	84.24%	87.89%	84.38%	85.98%	88.13%	89.91%	91.03%
Shared Decision Making[2]	60.95%	48.74%	54.65%	47.59%	51.79%	54.93%	58.26%	60.32%
Rating of All Health Care	84.23%	82.31%	84.70%	80.94%	82.63%	84.70%	86.65%	88.85%
Rating of Personal Doctor	90.05%	86.90%	87.63%	84.38%	85.89%	87.84%	89.43%	90.93%
Rating of Specialist	94.74%	85.29%	85.02%	80.69%	83.06%	85.01%	87.36%	89.50%
Rating of Health Plan	82.05%	78.44%	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]	Amerigroup		*Quality Compass*® 2014 Benchmarks					
	2013	2014	Average	P10	P25	P50	P75	P90
Getting Needed Care[2]	82.77%	88.37%	86.67%	82.49%	83.91%	86.94%	89.86%	90.78%
Getting Care Quickly[2]	94.33%	93.77%	92.72%	88.21%	91.88%	93.67%	94.41%	95.02%
How Well Doctors Communicate[2]	95.27%	91.84%	93.33%	89.85%	92.51%	93.75%	95.02%	95.83%
Customer Service[2]	85.68%	89.00%	88.63%	85.00%	86.76%	88.72%	91.13%	91.86%
Shared Decision Making[2]	82.68%	56.68%	61.27%	56.84%	59.10%	60.90%	63.93%	65.14%
Rating of All Health Care	80.24%	83.51%	83.33%	76.54%	82.63%	83.73%	85.47%	87.16%
Rating of Personal Doctor	88.12%	85.24%	86.50%	82.54%	85.24%	87.04%	88.28%	89.30%
Rating of Specialist	88.00%	88.07%	84.99%	78.80%	84.08%	85.71%	86.94%	88.05%
Rating of Health Plan	76.08%	79.28%	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 Amerigroup'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 Amerigroup, 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 Amerigroup'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	3	1	0
6.0 Core Benefits & Services	100	99	0	1
7.0 Provider Network Requirements	167	156	11	0
10.0 Provider Services	58	56	0	2
11.0 Eligibility, Enrollment & Disenrollment	26	26	0	0
12.0a Marketing	117	117	0	0
12.0b Member Education	132	129	0	3
13.0 Member Grievances & Appeals	67	67	0	0
15.0 Fraud, Abuse, and Waste Prevention	110	108	0	2
TOTAL	781	761	12	8

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**
4.0 Staff Requirements and Support Services	§ The Plan submitted a statement that they did not meet the requirement that the MCO shall provide DHH with a list of any marketing training dates, time and location, at least fourteen (14) calendar days prior to the actual date of training dates in 2014.
7.0 Provider Network Requirements	§ Deficiencies in appointment availability were noted in the appointment availability data for Q3 2014 that was submitted for review. The Plan failed to submit evidence of a CAP for the deficiencies noted in the report. § Deficiencies were found regarding member access to pharmacies within the 10m requirement in urban parishes, and the Plan did not provide a gap analysis or a CAP to address these deficiencies. § The Plan failed to submit Geo Access reporting on hemodialysis centers. § Deficiencies were observed in the Geo Access reporting thereby rendering that the network has an insufficient number of providers and facilities to meet minimum ratio requirements and allow adequate access for members. § Since the Plan had noted deficiencies in their Geo Access reports, as well as in their appointment availability data, the Plan failed to demonstrate they maintain a provider network of physician specialists that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical needs of its members (adults and children) without excessive travel requirements. Any deficiencies observed need to be addressed with a CAP or an analysis. § The Plan failed to meet the requirement that they shall provide a pharmacy network that complies with DHH requirements but, at a minimum, includes only licensed and registered pharmacies that conform to the Louisiana Board of Pharmacy rules concerning the records to be maintained by a pharmacy. § The documentation submitted for review did not address the requirement that no MCO may prohibit any pharmacy or pharmacist participating in the Medicaid program from contracting as a network provider provided the pharmacy or pharmacist is licensed and in good standing with the Louisiana State Board of Pharmacy and accepts the terms and conditions of the contract offered to them by the MCO. § The Plan did not provide sufficient evidence that their web-based pharmacy directory includes the following information, at a minimum, as per the contract requirement: o Names, locations and telephone numbers. o Any non-English languages spoken. o Identification of hours of operation, including identification of providers that are open 24-hours per day. o Identification of pharmacies that provide vaccine services. o Identification of pharmacies that provide delivery services.

2014 Medicaid Managed Care Compliance Review – Elements Not Fully Met (Review Year July 2013 – December 2014)	
Domain	Description of Review Findings Not Fully Met
	§ The Plan did not provide sufficient evidence that they are compliant with regard to the timeframe for updating the hardcopy and online versions of the directory. § The documentation provided did not address the requirement that the network audit program include random audits to determine provider compliance with program policies. § The documentation provided did not address the contract requirement that MCOs and PBMs receive active agreement from pharmacy providers to participate in the MCO's pharmacy network, even if the pharmacy provider has an existing relationship with the MCO's PBM, i.e. that if a pharmacy provider is already contracted with an MCO's PBM for other coverage products, notification alone will not be sufficient for that pharmacy provider to be considered part of the PBM's Medicaid network.

VI. STRENGTHS, OPPORTUNITIES FOR IMPROVEMENT & RECOMMENDATIONS

This section summarizes the accessibility, timeliness and quality of services provided by Amerigroup 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 exceeded the 90th percentile for the HEDIS® *Antidepressant Medication Management Acute Phase* and *Continuation Phase* measures.
- The Health Plan exceeded the 90th percentile for the HEDIS® *Medication Management for People With Asthma – Medication Compliance 75%* measure.
- The Health Plan exceeded the 75th percentile for the HEDIS® *Frequency of Ongoing Prenatal Care* measure.
- The Health Plan demonstrated strong performance on a single Adult CAHPS® measure: *Shared Decision Making* exceeding the 75th 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 eleven (11) 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*, *Asthma Medication Ratio*, *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*, *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, 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 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*, *Rating of All Health Care* and *Rating of Specialist*. The Health Plan also performed below the 50th percentile for the following Child CAHPS® General Population measures: *How Well Doctors Communicate, Customer Service, Shared Decision Making, Rating of All Health Care, Rating of Personal Doctor* and *Rating of Health Plan,* and for the following Child CAHPS® CCC Population measures: *How Well Doctors Communicate*, *Shared Decision Making, 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 number of providers with PCMH recognition has increased, the Health Plan should continue its efforts described in the Plan's response to the previous year's recommendation. *[Repeat recommendation.]*
- The Health Plan should continue to work to address Provider Network Requirements that did not meet contractual requirements to ensure it achieves "met" compliance determination 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.
- 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.]*

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: Amerigroup is contracted with a third party, Morpace. Morpace completes a quarterly After Hours Survey to a predetermined selection of Primary Care Physicians. This survey verifies that providers are following standards to assure access to care for our members within DHH standards.

  Morpace provides Amerigroup with verbatim results for review and validation. After the results are validated by the health plan Morpace prepares and submits a final report to the health plan. Additionally, Morpace prepares and submits letters and corrective action forms to the health plan for all providers that fail the survey.

  The health plan Provider Relations team then contacts each provider that failed the survey and conducts an onsite face to face visit. The survey results are reviewed with the provider and Amerigroup utilizes this opportunity to educate, assist in removing barriers and facilitating an improved provider understanding of

why their practice failed the survey. The Provider Representative then assists the provider in completing the required corrective action plan.

All corrective action plans will be scanned and documented in Salesforce, the CRM Tool used by the Provider Relations team. Morpace also includes all providers that failed the survey in the following quarter's survey.

If a provider continues to fail the survey the provider relations representative will work with the provider to become compliant. After collecting one (1) calendar years data, the health plan management team will meet to review outliers that consistently fail to meet standards and determine the next course of action.
Morpace also completes an annual Appointment Availability Survey on behalf of Amerigroup. Random selections of providers are chosen to participate in this survey.

The survey is conducted regarding six different types of appointments:

1.) Urgent Care
2.) Symptomatic Acute (Sick) Care
3.) Routine Care
4.) Prenatal Care
5.) Emergent Care
6.) Hospital discharge follow-up

Morpace submits the verbatim results to the health plan for review and validation. Amerigroup then follows the protocol outlined above for non-compliant providers.

§ 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:
CAHPS® survey used was 5.0 Member Satisfaction Survey for reporting year 2013
2013 Adult CAHPS® Composite Scores noted below the 50th percentile

- Getting Care Quickly = 25th percentile
- How Well Doctors Communicate = 10th percentile
- Getting Needed Care = 25th percentile

Overall Ratings

- Health Care (% 8, 9, and 10) = 25th percentile
- Health Plan (% 8, 9, and 10) = 25th percentile

2013 Child CAHPS® Composite Scores noted below the 50th percentile

- All were over the 50th percentile

Overall Ratings

- Health Plan (% 8, 9, and 10) = 25th percentile

2013 Child with CCC Composite Scores noted below the 50th percentile

- Access to prescription Medicine = 10th percentile
- Access to specialized services = 10th percentile

Overall Ratings

- Health Care (% 8, 9, and 10) = 10th percentile
- Health Plan (% 8, 9, and 10) = 10th percentile

Initial Root Cause Investigation and Data Reviewed:

- Claim Data for Primary / Specialist Physician Services & Practice volumes
- Grievance Report Data
- Geo Access Report
- Morpace Access Survey

Strategies/Interventions:

- Onsite visits for targeted providers to review member access
- Onsite visits to targeted primary care physicians & collaborative meetings to understand specialty access / referral needs.
- Developed and held Regional Provider Engagement Sessions to improve processes based on provider feedback
- Provider Compensation Incentives developed & awarded for quality & utilization improvements
- Developed member educational material to assist with enhancing communication between patients and providers
- Corporate & local health plan workgroups developed to target low scores based on CAHPS survey and implement further initiatives to drive improvement
- Implemented a Physician Outreach & Development team with the goal to enhance access, improve collaboration, communication and drive quality within our provider network
    - Launched the end of 2nd Quarter 2014
    - Team of clinical quality associates, health promotion & provider relations representatives
    - Regional visits to key high volume / practices
    - Providers / Office Staff educated on key health plan / provider initiatives, utilization & case management, quality reports including HEDIS measurements, missed opportunity reports, emergency room utilization as well as providing orientation to overall member access / timeliness of care standards.
- Collaborated and enhanced efforts to ensure members received the right care, at the right place and time (RCPT) through our call campaign with goal of improving emergency room utilization and alignment / access to primary care.
    - Program consists of Eliza telephonic calls and dedicated CM outreach to members with a high ER triage score & those members with 3 or greater ER visits.
    - Members are educated on appropriate ER use and re-directed / aligned with their PCP
- Implemented customer service survey rating our associate in their ability to manage the call & how the customer was assisted in getting help / information.
    - Launched in 4th Quarter 2014
- Educated case management (CM) staff on HEDIS gap's in care, incorporated identified gaps into the CM workflow in April of 2014 to ensure education / communication to engaged members on what gaps were present & assist the member in seeing their primary care physician to obtain needed services.
- Additionally, our clinical support tool, Member 360°SM, which launched in the 4th quarter of 2014 combines member data and information from various sources into a single record to provide a holistic picture of the member's utilization, care management services and gaps in care. Member 360°SM includes such information as member health risk assessments, care plans, longitudinal

member health records, and clinical data all designed to help improve member communication during CM interactions, Inpatient Utilization Management (UM) discharge planning as well as facilitating HP physician to provider communications during peer to peers.

- An extension of the tool described above is called Patient 360 & launched in 1/2015. Through Patient 360 providers can see the member record via the Amerigroup provider portal giving them simple, easy-to-access data and information to assist them in engaging the member in their health and well-being. This view will enable any provider who is treating our members to see the full picture, including care plans and assessment information, enhancing their ability to reduce duplication and improve their quality of care. The physician view will enable them to understand from a population health perspective, how their Amerigroup members are doing, and more importantly, give them information that helps them achieve better results. Our platform will support providers in achieving the quality incentives defined in the Amerigroup quality programs. For example, providers will be able to search for their Amerigroup members with diabetes to view their most recent HbA1c test results. The tool will take the providers to the next level by delivering much more than data; instead it gives them information that is synthesized and displayed in a succinct view to create obvious, actionable items right in front of them.

Monitoring / Oversight going forward in 2015:

- Comprehensive overview & work plan development based on Annual Morpace Member Satisfaction Survey.
- Continued trending & state reporting of Grievances. Incorporating results / outliers into actionable QM activities for process / member satisfaction improvement.
- Developing a monthly grievance committee to address trends & strategize on initiatives for improvement
- Continue to monitor the GEO Access reports for any gaps and fill these gaps if noted.

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

Plan Response:

- The primary barrier to achieving PCMH recognition from a physician practice perspective is available practice resources. To achieve PCMH recognition, administrative and clinical procedures must be refined, or created and executed within the practice through education and technological enhancements.
- While practices eagerly embrace quality improvement and are eager to enhance the "patient experience", they lack the available resources to implement requirements set forth under the PCMH criteria.
- Amerigroup Louisiana, through its experience in working with practices, has noted a differentiating element in working with FQHCs. These FQHCs more often have access to dedicated resources that can accomplish PCMH objectives and see resources as less of a challenge / barrier to achieving PCMH recognition.
- Based on an assessment of the aforementioned barriers, Amerigroup Louisiana has hired and trained a dedicated resource person with PCMH consulting responsibility. This resource provides relief to the practice in the PCMH endeavor and offers the practice current research, best practices and project coordination.

- Amerigroup Louisiana's dedicated PCMH consultant is actively achieving results in the Louisiana provider community and simultaneously assists a number of practices throughout the state on an ongoing basis.
- Amerigroup Louisiana expects to increase the number of practices throughout Louisiana that has met PCMH standards and achieved recognition. Goal is to have 20% of contracted PCP sites to be recognized as NCQA accredited as a PCMH.
- Amerigroup Louisiana tracks outreach to the provider community. The Amerigroup PCMH consultant logs contact attempts where an effort has been made to discuss PCMH with the practice as well as attempts to provide the practice with an introductory overview of the PCHM concept and how Amerigroup can be of assistance. Additionally, Amerigroup monitors and tracks the practices that are actively engaged in utilizing Amerigroup resources to achieve PCMH recognition and monitors the progress that has been made in working with these practices.

§ 2012-2013 Recommendation: The Plan should continue to work to address Provider Network Requirements that did not meet contractual requirements to ensure it achieves, at a minimum, "substantial" compliance during the next Annual Compliance Review.

Plan Response: An exhaustive review of all of the recommendations provided by IPRO was completed in early 2014. Each recommendation was tracked using our online compliance tracking tool which identifies each Section and Heading of the IPRO audit tool, the section of the DHH contract language, EQRO review determination, EQRO comments, Amerigroup response/action plan, evidence Amerigroup prepared in response, business owner, required action steps and status. All contractual requirements below a "substantial" rating were addressed and the action plan to address those items was completed by beginning of 3rd Q 2014. Geo Access Reports and efforts for closing any gaps identified will be monitored quarterly.