AMERIGROUP LOUISIANA, INC.

Annual External Quality Review Technical Report

Review Period: July 1, 2014 – June 30, 2015
April 2016

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 Amerigroup Louisiana, Inc. (Amerigroup) 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

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 June 2015)	147,140

III. ENROLLMENT AND PROVIDER NETWORK

Enrollment

Medicaid Enrollment

As of June 2015, the Health Plan's Medicaid enrollment totaled 147,140, which represents 15% of Bayou Health's active members. Table 2 displays Amerigroup's Medicaid enrollment for 2013 to 2015, as well as the 2015 statewide enrollment total. Figure 1 displays Bayou Health's membership distribution across all Health Plans.

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

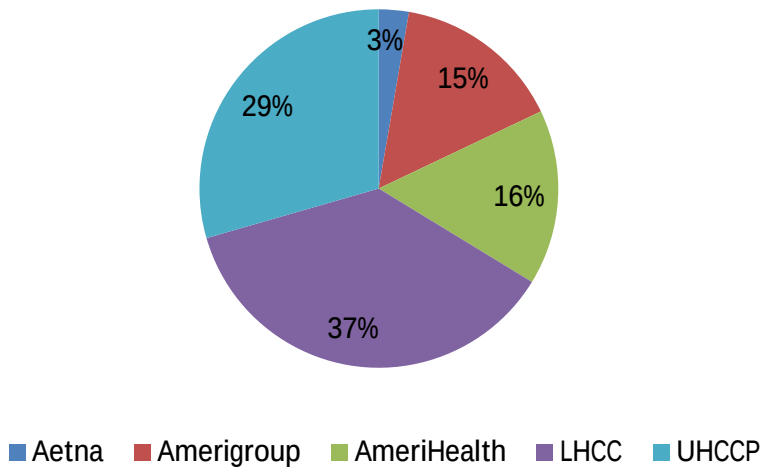
Amerigroup	June 2013	June 2014	June 2015	% Change	June 2015 Statewide Total[2]
Total Enrollment	131,044	127,501	147,140	15%	965,955

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	189	211	253	628
Pediatrics	247	216	164	572
Nurse Practitioners	156	223	254	596
Internal Medicine	235	158	99	477
RHC/FQHC	50	74	117	242
OB/GYN	206	212	173	550

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

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". 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 Amerigroup 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 be at or below the NCQA *Quality Compass*® Medicaid 2011 50th percentile of 69.72% 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 HEDIS® 2012 baseline rate was 78.01%. The HEDIS® 2014 rate final remeasurement rate was 78.61%, 8.57 points above the NCQA *Quality Compass*® 50th percentile. Frequent flyer utilization rates were also tracked and noted to be 47% of emergency department utilization.

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

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.

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: The HEDIS® 2013 baseline rate was 68.75%. The HEDIS 2014® final remeasurement rate was 75%.

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.

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. Progress continued with increase from the 2013 rate of 35.72% to 2014 rate of 42.58%.

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.

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 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 4 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 4. HEDIS® Effectiveness of Care Measures – 2014 and 2015

Measure	Amerigroup		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	71.00%	78.37%	68.69%	76.42%	66.91	71.32	78.37	86.81	89.35
Antidepressant Medication Management - Acute Phase	81.67%	50.64%	49.49%	50.30%	39.85	44.11	49.66	54.94	62.67
Antidepressant Medication Management - Continuation Phase	71.06%	33.21%	33.25%	34.71%	25.84	27.97	32.97	37.93	46.83
Asthma Medication Ratio (5-64 Years)	52.22%	49.16%	52.45%	61.07%	49.81	54.56	61.99	66.6	70.55
Breast Cancer Screening in Women	SS	52.98%	53.63%	54.52%	49.70	51.44	53.02	57.23	65.05
Cervical Cancer Screening	52.46%	54.57%	56.31%	56.63%	45.39	50.56	57.18	64.32	69.15
Childhood Immunization Status - Combination 3	73.15%	68.98%	52.54%	70.66%	55.48	68.91	71.53	75.67	80.05
Chlamydia Screening in Women (16-24 Years)	55.72%	58.24%	58.14%	52.66%	45.27	49.32	51.79	57.24	59.35
Comprehensive Diabetes Care - HbA1c Testing	76.81%	80.51%	81.92%	82.84%	74.83	80.51	82.24	85.40	88.87
Controlling High Blood Pressure	46.17%	40.84%	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	47.24%	56.71%	52.62%	56.47%	44.20	51.17	57.68	63.79	69.62
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	41.09%	44.61%	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)	57.91%	19.69%	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	35.65%	44.08%	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	43.29%	52.67%	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	22.45%	32.02%	26.14%	47.51%	30.07	40.39	47.20	62.73	63.81

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

Measure	Amerigroup		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	95.96%	94.74%	95.66%	96.03%	93.28	94.66	96.71	97.49	97.96
25 Months–6 Years	84.97%	83.80%	86.23%	89.08%	84.01	86.66	89.68	91.58	93.70
7–11 Years	83.44%	85.88%	88.18%	92.45%	86.28	89.66	94.00	94.75	96.30
12–19 Years	80.79%	83.92%	86.39%	90.37%	84.59	87.87	90.98	94.09	95.16
	Adults' Access to Preventive/Ambulatory Services								
20–44 Years	78.68%	78.11%	79.15%	79.30%	72.88	76.83	78.63	82.09	86.17
45–64 Years	87.48%	86.80%	87.80%	87.21%	83.52	86.49	87.93	90.34	92.00
65+ Years	81.63%	75.00%	77.11%	85.34%	74.64	83.13	86.39	89.44	92.27
	Access to Other Services								
Timeliness of Prenatal Care	86.77%	84.49%	85.41%	84.10%	70.57	83.80	87.10	88.54	91.00
Postpartum Care	56.38%	55.79%	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 Amerigroup's services by examining selected HEDIS® Use of Services rates. Table 6 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 6. Use of Services Measures – 2014 and 2015

Measure	Amerigroup		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 Visit	40.05%	43.75%	49.73%	53.59%	34.55	43.75	55.96	63.92	72.26
Frequency of Ongoing Prenatal Care - ≥ 81%	75.41%	71.53%	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	37.83%	50.00%	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	61.34%	64.81%	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 Amerigroup by the NCQA-certified survey vendor, DSS. 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 7, Table 8 and Table 9 show Amerigroup'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 7. Adult CAHPS® 5.0H – 2013-2015

Measure[1]	Amerigroup			*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]	76.00%	76.60%	82.44%	82.79%	79.28	80.31	83.24	84.68	85.41
Getting Care Quickly[2]	79.23%	80.98%	79.77%	81.60%	77.52	79.77	81.57	83.18	85.26
How Well Doctors Communicate[2]	85.08%	89.14%	87.66%	90.85%	87.66	89.05	91.09	92.34	93.12
Customer Service[2]			86.06%	88.42%	84.04	87.07	88.69	89.87	91.82
Shared Decision Making[2]	49.14%	54.75%	75.54%	77.06%	73.18	75.54	76.72	79.66	80.35
Rating of All Health Care	68.13%	69.52%	72.47%	73.90%	69.35	71.75	72.91	75.81	78.77
Rating of Personal Doctor	77.92%	80.45%	78.09%	80.56%	77.56	78.09	80.51	81.72	85.61
Rating of Specialist	82.65%	79.80%	83.52%	80.49%	73.58	77.94	80.98	83.75	86.63
Rating of Health Plan	71.71%	78.57%	76.49%	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 8. Child CAHPS® 5.0H General Population – 2013-2015

Measure[1]	Amerigroup			*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]	83.83%	86.13%	86.58%	85.28%	78.75	82.86	86.07	88.25	89.42
Getting Care Quickly[2]	89.50%	91.71%	91.77%	89.68%	83.51	87.06	90.62	92.09	94.62
How Well Doctors Communicate[2]	94.35%	92.35%	93.57%	92.79%	89.75	91.06	93.32	94.03	95.62
Customer Service[2]	87.40%	84.24%	93.76%	89.36%	86.24	87.13	89.54	91.10	91.57
Shared Decision Making[2]			79.52%	75.82%	66.55	70.92	78.39	80.08	80.75
Rating of All Health Care	84.23%	82.31%	88.70%	85.73%	81.39	84.18	86.32	87.69	88.70
Rating of Personal Doctor	90.05%	86.90%	89.11%	88.47%	86.77	87.25	88.12	89.65	90.74
Rating of Specialist	94.74%	85.29%	84.00%	85.38%	81.67	83.90	85.34	86.71	87.88
Rating of Health Plan	82.05%	78.44%	86.29%	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 9. Child CAHPS® 5.0H CCC Population – 2013-2015

Measure[1]	Amerigroup			*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]	82.77%	88.37%	88.82%	88.27%	86.14	87.28	88.64	88.79	90.68
Getting Care Quickly[2]	94.33%	93.77%	93.60%	93.96%	92.14	92.97	93.78	95.36	95.57
How Well Doctors Communicate[2]	95.27%	91.84%	92.15%	94.44%	92.81	93.71	94.50	95.29	95.73
Customer Service[2]	85.68%	89.00%	93.16%	89.02%	85.11	86.32	89.17	91.03	92.15
Shared Decision Making[2]			88.16%	83.46%	79.76	82.00	83.49	84.88	87.28
Rating of All Health Care	80.24%	83.51%	85.45%	84.89%	83.59	84.33	85.19	85.96	86.73
Rating of Personal Doctor	88.12%	85.24%	86.15%	87.96%	86.15	86.85	87.57	88.91	90.22
Rating of Specialist	88.00%	88.07%	86.73%	86.90%	83.48	84.46	87.67	88.94	89.63
Rating of Health Plan	76.08%	79.28%	83.00%	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 Amerigroup 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 10 displays the compliance determination categories used by IPRO during the 2014-2015 Readiness Review.

Table 10. 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 Amerigroup's 2014-2015 Readiness Review follow. Table 11 displays the total number of requirements reviewed for each domain, as well as compliance determination counts for each domain. Table 12 displays descriptions of all standards/elements that were "Not Met".

Table 11. 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 12. 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**
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.

2014-2015 Medicaid Managed Care Readiness Review – Elements Not Fully Met	
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 2015 HEDIS® Final Audit Report revealed no significant problems and the Health Plan was able to report all required Medicaid rates.
- The Health Plan exceeded the 75th percentile for the HEDIS® *Chlamydia Screening in Women* measure.
- The Health Plan met or exceeded the 90th percentile, demonstrating strong performance on the following Child CAHPS® General Population measures: *Customer Services* and *Rating of All Health Care*. The Health Plan also exceeded the 90th percentile for the following Child CAHPS® CCC Population measures: *Customer Service* and *Shared Decision Making*.

Opportunities for Improvement

- The Health Plan demonstrates an opportunity for improvement in regard to its overall HEDIS® performance. The following measures performed below the 50th percentile: Adolescent Well-Care Visit, Asthma Medication Ratio (5-64 Years), *Breast Cancer Screening*, Cervical Cancer Screening, Childhood Immunization Status – Combo 3, *Comprehensive Diabetes Care – HbA1c Testing*, *Controlling High Blood Pressure*, *Follow-up Care for Children Prescribed ADHD Medication – Continuation and Maintenance Phase*, Medication Management for People With Asthma Total – Medication Compliance 75% (5-64 Years), Postpartum Care, Timeliness of Prenatal Care, *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, 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.* (Note: HEDIS® performance was an opportunity for improvement in the previous year's report.)
- 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* and *Adults' Access to Preventive/Ambulatory Services* measures. (Note: Child and adult access rates were opportunities for improvement in the previous year's report.)
- The Health Plan continues to demonstrate an opportunity for improvement in regard to member satisfaction as it reported rates below the 50th percentile for most Adult CAHPS® measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Shared Decision Making*, *Rating of All Health Care, Rating of Personal Doctor* and *Rating of Health Plan*. The Health Plan also performed below the 50th percentile for a single Child CAHPS® General Population measure: *Rating of Specialist* and for the following Child CAHPS® CCC Population measures: *How Well Doctors Communicate*, *Rating of Personal Doctor* and *Rating of Specialist*. (Note: Member satisfaction was an opportunity for improvement in the previous year's report.)

Recommendations

- The Health Plan should continue to work to improve HEDIS® measures that perform below the 50th percentile. In addition to the activities described in the Health Plan's response to the previous year's recommendation, the Health Plan should enhance its quality improvement strategy to include member-level

interventions, such as education, incentives, reminders, assistance with making appointments, etc. *[Repeat recommendation.]*

- As Health Plan members continue to demonstrate lower than average access to primary care, the Health Plan should enhance its improvement strategy to include member-level interventions, and should routinely monitor the effectiveness of interventions described in the Health Plan's response to the previous year's recommendation and modify them as needed. *[Repeat 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.]*

Response to Previous Year's Recommendations

- 2013-2014 Recommendation: 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.]*

  Health Plan Response: The PCMH Implementation Plan submitted for the 2014 Readiness Review under Section 7.10 included the information on accreditation as recommended in the 2013 EQRO Final Report. This requirement was considered 'Met' by the IPRO reviewers.

  For the 2015 plan year the plan has gained momentum with practices involved in NCQA accreditation for PCMH. We currently have 6 active practices with 22 locations state wide engaged directly with dedicated staff working with them.

  Additionally, the plan has partnered with Louisiana Primary Care Association to encourage and facilitate PCMH preparation and recognition by these Louisiana Practices (ongoing). To further support PCMH adoptions the plan has implemented an incentive program that directly rewards practices a PMPM payment to achieve PCMH status, starting 1/1/2016. Amerigroup will continue reimbursing providers for 50% of the cost of accreditation when the provider achieves PCMH status (ongoing).

  The plan expects providers to continue engaging in the PCMH process, and to achieve accreditation. The plan will monitor the network through provider interaction with Provider Relations and Network Administration staff.

- 2013-2014 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.]*

  Health Plan Response: The CAP requested at the time of the 2014 Readiness Review outlined the steps taken to identify opportunities and accomplishments related to enhancing network adequacy. These included review of the network in all regions, as well as, an analysis of all Medicaid providers across the State for possible contracting opportunities. This information was provided to IPRO and was considered 'Met' by DHH as evident in their e-mail of 8/7/2015.

  Furthermore, the plan has created separate and distinct contracting teams apart from the Provider Relations staff focused on Behavioral Health and Physical Health contracting. We are engaged in a number of projects to support a robust network: (ongoing)

Projects to support a robust network:

- Roster Management with existing PAR providers (ongoing)
- Network comparisons with other Bayou Health plans and Commercial plans (2016)
- Expanded Urgent Care Network (complete)
- PCP Network expansion (ongoing)
- Insourcing DME and Infusions providers (complete)
- Expansion of the ASC Network and Free Standing Imaging Centers (2016)
- Inclusion of Hospice providers (complete)

Amerigroup expects to continue to grow our current robust network of providers and will monitor through our GeoAccess reports on a quarterly basis.

§ 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: Amerigroup conducts a root cause analysis monthly by reviewing all measures that fall below the 50th percentile. The health plan performs quarterly claims analysis for all administrative rates. The claims analysis identified provider mapping issues as HEDIS measures require specific provider specialties to perform certain services. Also, Amerigroup conducted an analysis of provider claim codes, pharmacy claim codes and member enrollment files for accuracy. The health plan has developed a HEDIS Provider Score Card with rates on key HEDIS measures. The score card identifies measures that are applicable to the providers' panel and specialty. It also contains the provider's individual and group HEDIS rates.

Amerigroup provides non-compliant member list to providers with 1000 or more Amerigroup members electronically. The non-compliant member list is reviewed with providers during the Provider Operational Development Team (POD) Meetings as well. Amerigroup conducted Provider Operational Development Team meetings in the 4th Quarter of 2015 with providers that had a high volume of non-compliant members on key HEDIS measures (i.e., Adolescent Well Care, Immunizations). The POD Team consisted of Quality Management Director, HEDIS Manager, Provider Relations Representative, Medical Director and PCMH Practice Consultant. Amerigroup Health Promotions staff was deployed to Provider Offices after the POD Team Meetings in an effort to assist with scheduling non-compliant members (HEDIS) into the provider scheduling system. Amerigroup will conduct POD Team meetings and provide member non-compliant outreach assistance to the TOP 75 low performing providers monthly beginning in 2nd Quarter 2016.

Amerigroup hired a HEDIS Manager (Certified in Coding and Risk Adjustment) in 3rd Quarter of 2015. The HEDIS Manager has conducted claims analysis for all providers and individual provider practices. HEDIS Manager has providers with technical assistance on denied claims and education on HEDIS specifications during POD Team meetings with providers. In addition, Amerigroup currently conducts bi-weekly Senior Leadership HEDIS meetings. The purpose of the meeting is to review all barriers, interdepartmental collaborations, and interventions by department in an effort to increase performance measures. All interventions are monitored monthly for effectiveness.

Amerigroup conducted Provider Operational Development Team meetings in 4th Quarter of 2015 to improve member compliance and provider performance on HEDIS measures. Our goal is to educate providers on

HEDIS specifications and provide member non-compliant outreach assistance to the TOP 75 low performing providers monthly in 2016. Our expected outcome for HEDIS 2017 is to improve these providers to the 50th percentile.

Amerigroup has implemented an interactive HEDIS Dashboard called Analytics Tool for HEDIS, Effectiveness and Monitoring Quality (ANTHEM^{Q}). The HEDIS Dashboard monitors Plan Performance, including 3-Year trend, quality compass benchmark achievement for HEDIS measures, competitor ranking, and programs implemented. Furthermore, it provides comprehensive quality performance status for the health plan that exemplifies the overall accreditation status and scores for NCQA ratings, retrospective view of additional conversion needed to achieve next threshold for HEDIS measures, and percentile movement by measure. ANTHEM^{Q} provides an interactive dashboard with display of list of current interventions, effectiveness rates, and potential additional conversions in an effort to monitor program effectiveness. Medicaid Value Based Purchasing incentive measures are compared month to month, current year to prior year and target rate. Finally, the population health assessment report in ANTHEM^{Q} provides member-level data through heat maps for the compliant and non-compliant members (rank ordered high to low) in each HEDIS measure.

§ 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: The Network Development Plan that was submitted with the Behavioral Health Readiness Review encompassing both physical and mental health addresses gaps and barriers in the network and their mitigation. This submission was considered 'Met' by DHH.

The plan understands that providers with high volume practices will migrate toward higher reimbursing plans. To address quality and access for Amerigroup members the plan has enhanced and expanded provider incentive programs:

- Increase in reimbursement for certain Primary Care, Preventative codes and procedures.
- Creation and utilization of OB & Maternal Quality Incentive programs with 30 participating practices.
- Provider Quality Incentive Program, our flagship program for practices with 1000 or more members. This is a gain sharing program focused on a 'HEDIS like' Quality matrix and delivery of efficient care.
- Provider Access and Quality Care Program is our latest incentive program focused on practices with at least 250 members. This program provides a Per Member Per Month payment based on afterhours access, 'HEDIS like' Quality measures, PCMH Accreditation and Non-Emergent Emergency room utilization.

Amerigroup expects to improve access to primary care and will monitor this through our member and provider surveys, and complaints and grievances process.

§ 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: Amerigroup has implemented various interventions to ensure improvement in member satisfaction with services rendered by the all departments in 2015 and 2016. Amerigroup added more providers to the Provider Network to increase access to medical care timely by members. Also, more

Urgent Care Centers were added to the Provider Network to increase after-hours access. The member newsletter was revised to include information on how to obtain needed care and how to access Urgent Care Centers. The member website is updated on a regular basis with the most recent provider directories to help members select providers as needed. Member Services Representative conducts telephone surveys with members after each call. The results of the surveys are analyzed and low ratings on the survey will elicit a call to the member in an effort to resolve the member's issue. Community Outreach and Health Promotion events such as health fairs, diaper drives, school supplies/book bag giveaway have increased member touch points for member satisfaction. Amerigroup has conducted outbound calls to assist non-compliant members in making appointments and coordinating transportation in 2015 and 2016. Member transportation complaints received by the health plan yielded the highest results of all complaints received. Therefore, Amerigroup obtained a new transportation vendor (South East Trans) effective December 1, 2015, due to the significant number of transportation related complaints by members.

CAHPS results do continue to improve in the area of "Getting Needed Care." The results for child general population "Getting Needed Care" for 2015 were reported at the 67th percentile compared to the 50th percentile for 2014 and greatly improved from 2013 which was at the 25th percentile. The Child with Chronic conditions population was reported at 75th percentile for 2015. Amerigroup significantly improved from 2014 which was at the 50th percentile and 25th percentile for 2013. The adult population for "Getting Needed Care" was reported at 50th percentile which is improved from 2014 at the 25th percentile and in 2013 was in the 10th percentile. Amerigroup Louisiana (Anthem Company) is ranked as number 1 out of all of the Anthem health plans in CAHPS results for 2015. Amerigroup Quality Management staff currently participates in the CAHPS Improvement Workgroup to obtain information on implementation of interventions for continuous improvement in member satisfaction.

Amerigroup conducts an analysis of the CAHPS results on a yearly basis. Member complaints are tracked and trended as needed for difficulties with getting needed care and members referred to Case Management as needed when members do find it difficult to get the care, tests or treatments they perceive they need. CAHPS results and member complaints data analysis are presented to the Amerigroup's Medical Advisory and Quality Management Committees for recommendations/approval.