AMERIGROUP LOUISIANA, INC.

Annual External Quality Review Technical Report

Review Period: July 1, 2015 – June 30, 2016
April 2017

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

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

TABLE OF CONTENTS

LIST OF TABLES

I. INTRODUCTION

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

In order to comply with these requirements, the Louisiana Department of Health (LDH) contracted with IPRO to assess and report the impact of its Medicaid managed care program, the Bayou Health Program, and each of the participating Health Plans on the accessibility, timeliness and quality of services. Specifically, this report provides IPRO's independent evaluation of the services provided by Amerigroup Louisiana, Inc. (Amerigroup) for review period July 1, 2015 – June 30, 2016.

The framework for IPRO's assessment is based on the guidelines and protocols established by CMS, as well as Louisiana State requirements. IPRO's assessment included an evaluation of the mandatory activities, which encompass: performance measure validation, Performance Improvement Project (PIP) validation and compliance audits. Results of the most current HEDIS® and CAHPS® surveys are presented and are evaluated in comparison to the NCQA's *Quality Compass*® 2016 South Central – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

Section VI provides an assessment of the MCO's strengths and opportunities for improvement in the areas of accessibility, timeliness and quality of services. For areas in which the 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 IPRO in the previous year's EQR report. The MCO was given the opportunity to describe current and proposed interventions that address areas of concern, as well as an opportunity to explain areas that the MCO did not feel were within its ability to improve. The response by the MCO is appended to this section of the report.

II. MCO CORPORATE PROFILE

Table 1: Corporate Profile

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 2016)	207,406

III. ENROLLMENT AND PROVIDER NETWORK

Enrollment

Medicaid Enrollment

As of June 2016, the Health Plan's Medicaid enrollment totaled 207,406, which represents 16% of Bayou Health's active members. Table 2 displays Amerigroup's Medicaid enrollment for 2014 to 2016, as well as the 2016 statewide enrollment total. Figure 1 displays Bayou Health's membership distribution across all Health Plans.

Table 2: Medicaid Enrollment as of June 2016[1]

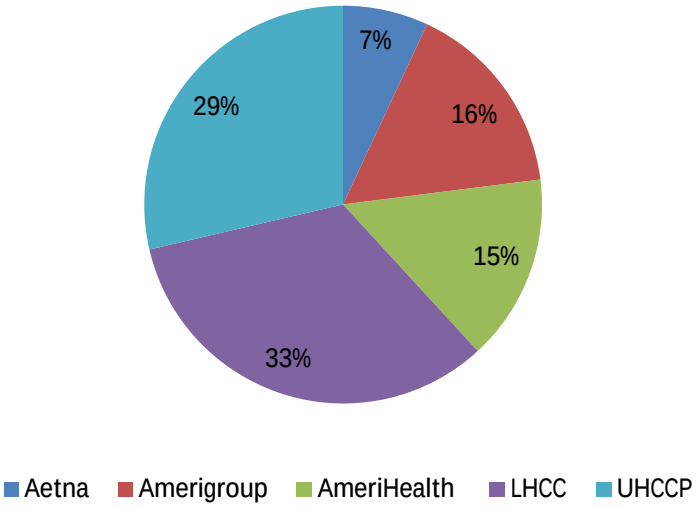
Amerigroup	June 2014	June 2015	June 2016	% Change	June 2016 Statewide Total[2]
Total Enrollment	127,501	147,140	207,406	34%	1,292,032

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: The statewide total includes membership of all plans.

Figure 1. Bayou Health Membership by Health Plan as of June 2016



Provider Network

Providers by Specialty

The LDH requires each MCO to report on a quarterly basis the total number of network providers. Table 3 shows the sum of Amerigroup's primary care providers, OB/GYNs and other physicians with primary care responsibilities within each geographic service area as of June 30, 2016.

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

Specialty	Amerigroup			MCO Statewide Unduplicated
	GSA A	GSA B	GSA C	
Family Practice/General Medicine	201	217	256	648
Pediatrics	254	211	169	582
Nurse Practitioners	198	246	285	678
Internal Medicine	245	164	105	496
RHC/FQHC	60	78	124	263
OB/GYN	226	218	171	567

Data source: Network Adequacy Review 2016 Q2

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

Provider Network Accessibility

Amerigroup monitors its provider network for accessibility and network capability using the GeoAccess software program. This program assigns geographic coordinates to addresses so that the distance between providers and members can be assessed to determine whether members have access to care within a reasonable distance from their homes. Table 4 shows the percentage of members for whom geographic access standards were met.

Table 4: GeoAccess Provider Network Accessibility – as of July 13, 2016

Provider Type		Access Standard[1] X Provider(s) within X Miles	Percentage of Members for Whom Standard was Met
Family Practitioners/ General Medicine	Urban	1 within 10 miles	96.6%
	Rural	1 within 30 miles	100.0%
Internal Medicine	Urban	1 within 10 miles	91.3%
	Rural	1 within 30 miles	99.0%
Pediatricians	Urban	1 within 10 miles	93.7%
	Rural	1 within 30 miles	99.9%
Nurse Practitioners	Urban	1 within 10 miles	96.6%
	Rural	1 within 30 miles	100.0%
OB/GYN	Urban	1 within 10 miles	84.9%
	Rural	1 within 30 miles	97.6%
FQHC	Urban	1 within 10 miles	77.8%
	Rural	1 within 30 miles	96.9%
RHC	Urban	1 within 10 miles	22.8%
	Rural	1 within 30 miles	94.7%

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

IV. QUALITY INDICATORS

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

Performance Improvement Projects

A Performance Improvement Project (PIP) is intended to improve the care, services or member outcomes. The LDH selects PIP topics that address specific areas of concern to the Medicaid population in the state and the projects are conducted by the Health Plans in a collaborative, facilitated by the LDH, the University of Louisiana Monroe and IPRO. All Health Plans are required to use the same basic methodology and report the same metrics so that the LDH will be able to aggregate results and report them statewide.

During this reporting period, each Health Plan was required to perform two (2) State-approved collaborative PIPs: Reducing Premature Births and the Identification and Treatment of Adolescents with ADHD.

In accordance with 42 CFR 438.358, IPRO conducted a review and validation of the Reducing Premature Birth PIP using methods consistent with the CMS protocol for validating performance improvement projects. The identification and Treatment of ADHD PIP was introduced in reporting year 2016 during which the Health Plans submitted their proposals but did not yet report any findings. Validation of this PIP will occur in 2017.

Summaries of each of the PIPs conducted by Amerigroup follow.

State-Directed Collaborative PIP: Reducing Premature Births

Indicators, Baseline Rates and Goals: The indicators, baseline rates and corresponding target rates for performance improvement from baseline to final re-measurement are as follows:

- Initiation of injectable progesterone for preterm birth prevention: increase from 17.5% to 20%
- Use of most effective contraceptive methods: increase from 34.2% to 44%
- Chlamydia test during pregnancy: increase from 52.4% to 60%
- HIV test during pregnancy: increase from 31.7% to 42-50%
- Syphilis test during pregnancy: increase from 44.5% to 54-64%
- HEDIS® *Postpartum Care* measure: increase from 61.97% to 62.13%

Intervention Summary:

Provider:

- Notice of Pregnancy (NOP) form
- Send NOP fax blast to all OB/GYNs
- Medicaid 101 Roadshow

MCO:

- Notification of high-risk pregnant members to providers

Member:

- Care Management Outreach and Engagement Program
- Home visits for unable to reach women (17P and postpartum)

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

Strengths:

- Reports baseline results, and include process measures with the potential to monitor the progress of interventions.

Opportunities for Improvement:

- Monitor, report and interpret monthly or quarterly trends/patterns for intervention tracking (process) measures in order to identify what is working, what is not working, and why, e.g., barriers.
- Refine interventions to address identified barriers.

State-Directed Collaborative PIP: Treatment of Adolescents with ADHD

This PIP aims to improve the quality of care received by children with ADHD by implementing a robust set of health plan, member, and community and provider interventions to improve rates of evaluation, diagnosis, management and treatment of ADHD consistent with clinical practice guidelines recommendations. Hybrid performance measures based upon a random sample of children will be used to assess diagnosis, evaluation and care coordination in accordance with guidelines recommendations. Administrative measures based upon the population newly prescribed ADHD medication will be used to assess compliance with medication monitoring standards in accordance with the HEDIS® measure, *Follow-Up Care for Children Prescribed ADHD Medication (ADD)*. In addition, encounter and pharmacy data will be used to assess receipt of behavioral therapy for children with ADHD who are on psychotropic medication.

Intervention Summary:

- Develop the provider network by recruiting trained providers or training new providers trained in Evidence-Based Practice (EBP) Practices
- Link children younger than six years of age to EBP therapists
- MCOs and the LDH collaborate to produce and distribute a PCP toolkit
- MCOs and the LDH collaborate to develop strategy to expand access to in-person or telephonic case consultation to PCPs
- Enhance Case Management to facilitate behavioral health referrals; to foster care plan collaboration among care managers, PCPs behavioral therapists, teachers, parents and children; and to increase PCP practice utilization of on-site care coordination and/or MCO care coordination

Results: Not yet available.

Performance Measures: HEDIS® 2016 (Measurement Year 2015)

MCO-reported performance measures were validated as per HEDIS® 2016 Compliance Audit™ specifications developed by the National Committee for Quality Assurance (NCQA). The results of each MCO's HEDIS® 2016 Compliance Audit are summarized in its Final Audit Report (FAR).

The HEDIS® 2016 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 Health Plan performance rates for select HEDIS® Effectiveness of Care measures for HEDIS® 2014, HEDIS® 2015 and HEDIS® 2016, Bayou Health 2016 statewide averages and *Quality Compass*® (QC) 2016 South Central – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

Table 5: HEDIS® Effectiveness of Care Measures – 2014-2016

Measure	Amerigroup			QC 2016 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded	2016 Statewide Average
	HEDIS® 2014	HEDIS® 2015	HEDIS®2016		
Adult BMI Assessment	71.00%	78.37%	77.67%	33.33rd	75.92%
Antidepressant Medication Management - Acute Phase	81.67%	50.64%	52.16%	50th	53.52%
Antidepressant Medication Management - Continuation Phase	71.06%	33.21%	36.87%	50th	38.09%
Asthma Medication Ratio (5-64 Years)	52.22%	49.16%	55.54%	10th	54.09%
Breast Cancer Screening in Women	SS	52.98%	54.56%	50th	55.55%
Cervical Cancer Screening	52.46%	54.57%	54.89%	50th	57.08%
Childhood Immunization Status - Combination 3	73.15%	68.98%	71.53%	50th	64.37%
Chlamydia Screening in Women (16-24 Years)	55.72%	58.24%	59.97%	75th	60.98%
Comprehensive Diabetes Care - HbA1c Testing	76.81%	80.51%	77.86%	<10th	80.01%
Controlling High Blood Pressure	46.17%	40.84%	41.22%	25th	40.96%
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	47.24%	56.71%	56.46%	33.33rd	55.69%
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	41.09%	44.61%	41.71%	25th	43.71%
Medication Management for People With Asthma Total - Medication Compliance 75% (5-64 Years)	57.91%	19.69%	17.82%	10th	24.73%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile	35.65%	44.08%	52.57%	33.33rd	46.06%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	43.29%	52.67%	36.21%	10th	45.36%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity	22.45%	32.02%	32.48%	10th	31.83%

SS: Sample size too small to report (less than 30 members) but included in the statewide average).

HEDIS® Access to/Availability of Care Measures

The HEDIS® Access to/Availability of Care measures examine the percentages of Medicaid children/adolescents, child-bearing women and adults who receive PCP/preventive care services, ambulatory care (adults only) or receive timely prenatal and postpartum services. Table 6 displays Health Plan rates for select HEDIS® Access to/Availability of Care measure rates for HEDIS® 2014, HEDIS® 2015 and HEDIS® 2016, Bayou Health 2016 statewide averages and *Quality Compass*® 2016 South Central – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

Table 6: HEDIS® Access to/Availability of Care Measures – 2014-2016

Measure	Amerigroup			QC 2016 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded	2016 Statewide Average
	HEDIS® 2014	HEDIS® 2015	HEDIS®2016		
	Children and Adolescents' Access to PCPs				
12–24 Months	95.96%	94.74%	94.30%	33.33rd	95.45%
25 Months–6 Years	84.97%	83.80%	82.06%	10th	85.49%
7–11 Years	83.44%	85.88%	84.78%	<10th	87.17%
12–19 Years	80.79%	83.92%	83.26%	<10th	86.14%
	Adults' Access to Preventive/Ambulatory Services				
20–44 Years	78.68%	78.11%	77.76%	33.33rd	78.48%
45–64 Years	87.48%	86.80%	86.09%	33.33rd	87.30%
65+ Years	81.63%	75.00%	79.43%	25th	77.92%
	Access to Other Services				
Timeliness of Prenatal Care	86.77%	84.49%	82.16%	50th	80.05%
Postpartum Care	56.38%	55.79%	61.97%	50th	60.19%

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 Health Plan rates for select HEDIS® Use of Services measure rates for HEDIS® 2014, HEDIS® 2015 and HEDIS® 2016, Bayou Health 2016 statewide averages and *Quality Compass*® 2016 South Central – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

Table 7: Use of Services Measures – 2014-2016

Measure	Amerigroup			QC 2016 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded	2016 Statewide Average
	HEDIS® 2014	HEDIS® 2015	HEDIS®2016		
Adolescent Well-Care Visit	40.05%	43.75%	41.20%	10th	51.51%
Ambulatory Care Emergency Department Visits/1000 Member Months[1]	78.61	78.21	78.69	75th	71.60
Ambulatory Care Outpatient Visits/1000 Member Months	405.56	394.16	412.98	75th	413.62
Frequency of Ongoing Prenatal Care - ≥ 81%	75.41%	71.53%	73.71%	75th	68.71%
Well-Child Visits in the First 15 Months of Life 6+ Visits	37.83%	50.00%	57.87%	66.67th	57.48%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	61.34%	64.81%	54.40%	<10th	63.59%

[1] A lower rate is desirable.

Member Satisfaction: Adult and Child CAHPS® 5.0H

In 2016, 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 Research. 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 CAHPS® rates for 2014, 2015 and 2016, as well as *Quality Compass*® 2016 South Central – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

Table 8: Adult CAHPS® 5.0H – 2014-2016

Measure[1]	Amerigroup			QC 2016 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded
	CAHPS® 2014	CAHPS® 2015	CAHPS® 2016	
Getting Needed Care	76.60%	82.44%	81.56%	50th
Getting Care Quickly	80.98%	79.77%	83.46%	75th
How Well Doctors Communicate	89.14%	87.66%	87.57%	<10th
Customer Service	82.22%	86.06%	90.67%	75th
Shared Decision Making[2]		75.54%	80.38%	50th
Rating of All Health Care	69.52%	72.47%	74.32%	50th
Rating of Personal Doctor	80.45%	78.09%	79.26%	33.33rd
Rating of Specialist	79.80%	83.52%	85.19%	90th
Rating of Health Plan	78.57%	76.49%	78.74%	66.67th

[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] In 2015, NCQA revised measure specifications and response options.

Table 9: Child CAHPS® 5.0H General Population – 2014-2016

Measure[1]	Amerigroup			QC 2016 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded
	CAHPS® 2014	CAHPS® 2015	CAHPS® 2016	
Getting Needed Care	86.13%	86.58%	84.40%	50th
Getting Care Quickly	91.71%	91.77%	93.08%	75th
How Well Doctors Communicate	92.35%	93.57%	93.26%	50th
Customer Service	84.24%	93.76%	92.56%	90th
Shared Decision Making[2]		79.52%	80.52%	66.67th
Rating of All Health Care	82.31%	88.70%	85.39%	33.33rd
Rating of Personal Doctor	86.90%	89.11%	89.42%	50th
Rating of Specialist	85.29%	84.00%	86.90%	50th
Rating of Health Plan	78.44%	86.29%	82.70%	25th

[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] In 2015, NCQA revised measure specifications and response options.

Table 10: Child CAHPS® 5.0H CCC Population – 2014-2016

Measure[1]	Amerigroup			QC 2016 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded
	CAHPS® 2014	CAHPS® 2015	CAHPS® 2016	
Getting Needed Care	88.37%	88.82%	86.63%	33.33rd
Getting Care Quickly	93.77%	93.60%	90.79%	25th
How Well Doctors Communicate	91.84%	92.15%	92.79%	10th
Customer Service	89.00%	93.16%	89.51%	50th
Shared Decision Making[2]		88.16%	85.36%	50th
Rating of All Health Care	83.51%	85.45%	81.57%	10th
Rating of Personal Doctor	85.24%	86.15%	86.45%	10th
Rating of Specialist	88.07%	86.73%	83.59%	10th
Rating of Health Plan	79.28%	83.00%	76.58%	10th

[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] In 2015, NCQA revised measure specifications and response options.

V. COMPLIANCE MONITORING

Medicaid Compliance Audit Findings for Contract Year 2016

In 2016, IPRO conducted the 2016 Compliance Audit on behalf of the LDH. Full compliance audits occur every three years, with partial audits occurring within the intervening years. The 2016 Compliance Audit was a full audit of Amerigroup's compliance with contractual requirements during the period of September 1, 2015 through August 31, 2016.

The 2017 Compliance Audit included a comprehensive evaluation of Amerigroup's policies, procedures, files and other materials corresponding to the following nine (9) domains:

1. Core Benefits and Services
2. Provider Network
3. Utilization Management
4. Eligibility, Enrollment and Disenrollment
5. Marketing and Member Education
6. Member Grievances and Appeals
7. Quality Management
8. Reporting
9. Fraud, Waste and Abuse

The file review component assessed Amerigroup's implementation of policies and its operational compliance with regulations in the areas of appeals, behavioral health care management, case management, information reconsiderations, member grievances, provider credentialing and recredentialing, and utilization management denials.

For this audit, determinations of full compliance, substantial compliance, minimal compliance and compliance not met were used for each element under review. Definitions for these review determinations are presented in Table 11.

Table 11: 2016 Compliance Audit Determination Definitions

Determination	Definition
Full	The MCO has met or exceeded the standard
Substantial	The MCO has met most of the requirements of the standard but has minor deficiencies.
Minimal	The MCO has met some of the requirements of the standard, but has significant deficiencies that require corrective action.
Not Met	The MCO has not met the standard.

Findings from Amerigroup's 2016 Compliance Review follow. Table 12 displays the total number of requirements reviewed for each domain, as well as compliance determination counts for each domain.

Table 12: Audit Results by Audit Domain

Audit Domain	Total Elements	Full	Substantial	Minimal	Not Met	Not Applicable	% Full
Core Benefits and Services	123	121	2	0	0	0	98%
Provider Network	163	155	5	3	0	0	95%
Utilization Management	92	90	1	0	0	1	99%
Eligibility, Enrollment and Disenrollment	13	13	0	0	0	0	100%
Marketing and Member Education	77	76	0	0	0	1	100%
Member Grievances and Appeals	62	55	4	3	0	0	89%
Quality Management	86	85	0	0	0	1	100%
Reporting	1	1	0	0	0	0	100%
Fraud Waste and Abuse	105	104	1	0	0	0	99%
Total	722	700	13	6	0	3	97%

It is IPRO's and the LDH's expectation that Amerigroup submit a corrective action plan for each of the 19 elements determined to be less than fully compliant along with a timeframe for completion. It should be noted that, in response to the compliance audit draft findings, Amerigroup has implemented a corrective action for many of the areas identified for improvement in the report but the corrections were made after the audit was completed and were not applicable to the audit's review period. Eight (8) of the 19 elements rated less than fully complaint relate to network adequacy and the MCO's ability to contract with providers in several specialty and sub-specialty areas, a problem for all Medicaid MCOs in Louisiana that is not unique to Amerigroup.

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 2016 HEDIS® Final Audit Report revealed no significant problems and the Health Plan was able to report all required Medicaid rates.
- The Health Plan met or exceeded the 75th percentile for the HEDIS® *Chlamydia Screening in Women* measure and the HEDIS® *Frequency of Ongoing Prenatal Care* measure.
- The Health Plan met or exceeded the 75th percentile, demonstrating strong performance on the following Adult CAHPS® Population measures: *Getting Care Quickly*, *Customer Services* and *Rating of Specialist*. The Health Plan also met or exceeded the 75th percentile for the following Child CAHPS® General Population measures: *Getting Care Quickly* and *Customer Service*.
- In regard to the 2016 Compliance Review, the Health Plan demonstrated strong performance in four (4) of the nine (9) domains, as it achieved "full" compliance for elements reviewed in these domains.

Opportunities for Improvement

- The Health Plan continues to demonstrate an opportunity for improvement in regard to its overall HEDIS® performance. The following measures performed below the 50th percentile: *Adult BMI Assessment*, *Asthma Medication Ratio (5-64 Years)*, *Comprehensive Diabetes Care – HbA1c Testing*, *Controlling High Blood Pressure*, *Follow-up Care for Children Prescribed ADHD Medication – Continuation and Maintenance Phase*, *Follow-up Care for Children Prescribed ADHD Medication –Initiation Phase*, *Medication Management for People With Asthma Total – Medication Compliance 75% (5-64 Years)*, *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, Adolescent Well-Care Visit* 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: *How Well Doctors Communicate* and *Rating of Personal Doctor*. The Health Plan also performed below the 50th percentile for a single Child CAHPS® General Population measure: *Rating of All Health Care* and Rating *of Health Plan* and for the following Child CAHPS® CCC Population measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of Personal Doctor*, *Rating of Specialist* and *Rating of Health Plan*. (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 expand its provider intervention strategy to include all network

providers, not only those who are considered high-volume. The effectiveness of the overall strategy should be evaluated routinely and modified as needed. *[Repeated recommendation.]*

- As Health Plan members continue to demonstrate lower than average access to primary care, it is important that the Health Plan conduct root cause analysis to identify barriers to care that may not be directly related to network size and address these barriers using a multi-tiered approach that considers members, providers and Health Plan operations. *[Repeated recommendation.]*
- The Health Plan should continue to work to improve CAHPS® measures that perform below the 50th percentile by continuing the intervention strategy described in the Plan's response to the previous year's recommendation. The effectiveness of each intervention should be monitored and modified as needed. *[Repeated recommendation.]*

Response to Previous Year's Recommendations

- 2014-2015 Recommendation: 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.]*

  Health Plan Response: Amerigroup continues to track and trend all measures that fall below the 50th percentile and conducts a root cause analysis of those measures on a monthly basis. The health plan has continued its efforts to educate and assist providers by producing the HEDIS Provider Score Card with rates and key HEDIS measures embedded. The Report Card is reviewed with the provider for collaborative initiatives developed to address areas of needed improvement. One of the many supportive means provided by the health plan to assist the providers would be the production of the Non-Complaint Member list for the providers that had a high volume of non-compliant members in key HEDIS measures (i.e., Adolescent Well Care, immunizations). This list of members is reviewed with the provider during the Provider Operational Development (POD) Team meetings. This POD Team consists of the Quality Management Director, HEDIS Manager, Provider Relations Representative, Medical Director and PCMH Practice Consultant. Amerigroup's Health Promotions staff has also been assigned the task of providing outreach assistance for non-compliant members which includes conducting in office "Clinic Days" to address members with high "No-Show" rates.

  The HEDIS Program Manager continues to conduct claims analysis for all providers and individual provider practices to provide technical assistance on correct coding, missing opportunities and education to the provider on HEDIS specifications during POD meetings. Monthly Senior Leadership Meetings, allow for the continuous communication of barriers, interdepartmental collaborations, and interventions by departments in an effort to increase performance measures. Effectiveness of interventions and initiatives is monitored monthly and reported out to senior leadership in several different internal meeting platforms.

  The Provider Operational Development team meetings, that provide education for our providers on HEDIS specifications and member non-compliant rates, continues to address the needs of the TOP 75 low performing providers with an effort to improve these providers to the 50th percentile.

  The health plan continues the use of the HEDIS Dashboard, "Analytics Tool for HEDIS, Effectiveness and Monitoring Quality, to track and trend Plan Performance, quality compass benchmark achievement for HEDIS measures, competitor ranking and all implemented programs. This dashboard also reflects the comprehensive status of the health plan related to overall accreditation status and scores for NCQA ratings, conversions needed to achieve next threshold for measures and movement by measure.

This tool allows the health plan to monitor effectiveness of strategic initiatives in place for each measure.

§ 2014-2015 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.]*

Health Plan Response: The health plan has enrolled 11 provider groups in the Provider Quality Incentive Program (PQIP), and 7 provider groups in the Provider Access and Quality Care program (PAQCP) with a total of 72,353 members. PQIP is a shared savings program with a quality component for providers with over 1,000 members. PAQCP is a program using a system of quality and access measures and pay-for-performance principles; the program seeks to encourage efficient, preventive and cost-effective health care practices. Eligible primary care physicians (PCPs) who meet certain eligibility requirements and quality/access targets can receive additional payments.

Amerigroup will continue to grow these incentive programs with a goal of 50% of membership being assigned to a provider in Value-Based programs by 2018. Monitoring of these programs is an ongoing process with quarterly reporting updates. Providers are evaluated annually for inclusion in the Value Based programs, based on panel status, good standing, and membership. In addition we have 47 groups in the OBGYN incentive programs and have all PCPs eligible for the PCP incentive program.

In addition, member and provider surveys are conducted to address any network adequacy issues, including after hour access.

Provider Relations works with Quality to outreach providers when Quality has identified them as having member access issues. Provider Relations encourages providers to reach out to these members and to document all attempts. Provider Relations also engages Quality's outreach programs on behalf of the PCP, when a PCP requests plan assistance.

Efforts to resolve all issues, as well as, access to care can be found in detail in the next bullet. These efforts are monitored by reviewing the Non-Compliant Member Listing to determine if outreach was successful in regards to member interventions.

§ 2014-2015 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 continues to address and ensure the continuous efforts towards member satisfaction improvement. This is a plan wide effort, touching all departments from Provider Network to Member Services. There have been several new, as well as several improved upon, initiatives that address member satisfaction. The health plan continues to track and trend grievances, to identify areas of concern for our members that need process improvement measures taken and Provider Relations enhancements, education and outreach. The member newsletter is a tool that is used to address trending concerns that members have expressed and have found to be identified as a member educational opportunity. Our Member Services Representatives conduct telephone surveys to convey this valuable information to the Health Plan as well. Amerigroup's Health Promotions Department continues its efforts developing member education tools, hosting member educational sessions throughout the state, sending Urgent Care Fliers, identifying member's PCP and closest urgent care facility, as well as, disseminating

educational information related to “Getting Needed Care and Getting Care Quickly”. The Adult Population for “Getting Needed Care” was reported at the 50th percentile for 2016, which has not changed from 2015, but does remain above the national average.

The Health Promotions team also performs Member Outreach calls to Non-Compliant members in an effort to engage the member in incentive programs as well as assisting high risk members with support services information. These actions aid the member to easily identify and connect with such services provided by the Health Plan.

These strategic initiatives have been put in place to address the area of “Child--Getting Needed Care”, as this area decreased from the 67th percentile in 2015 to the 33rd percentile in 2016. The Health Plan is currently performing above the National average at 80.4% and will continue working with our corporate team, members and providers to improve CAHPS measures.