State of Louisiana
Department of Health & Hospitals

AmeriHealth Caritas Louisiana
Annual External Quality Review Technical Report

Review Period: July 1, 2017 – June 30, 2018
Report Issued: April 23, 2019

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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 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 Healthy Louisiana Program, and each of the participating Health Plans on the accessibility, timeliness and quality of services. Specifically, this report provides IPRO's independent evaluation of the services provided by AmeriHealth Caritas Louisiana (AmeriHealth) for review period July 1, 2017 – June 30, 2018.

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*® 2018 South Central – All Lines of Business (LOB) [Excluding Preferred-Provider Organizations (PPOs) and Exclusive Provider Organizations (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 MCO 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

AmeriHealth Caritas Louisiana	
Type of Organization	Health Maintenance Organization
Tax Status	For Profit
Year Operational	02/01/2012
Product Line(s)	Medicaid and LaCHIP
Total Medicaid Enrollment (as of June 2018)	206,667

III. ENROLLMENT AND PROVIDER NETWORK

Enrollment

Medicaid Enrollment

As of June 2018, the MCO's Medicaid enrollment totaled 206,667, which represents 14% of Healthy Louisiana's active members. **Table 2** displays AmeriHealth's Medicaid enrollment for 2016 to 2018, as well as the 2018 statewide enrollment totals. **Figure 1** displays Healthy Louisiana's membership distribution across all Medicaid MCOs.

Table 2: Medicaid Enrollment as of June 2018[1]

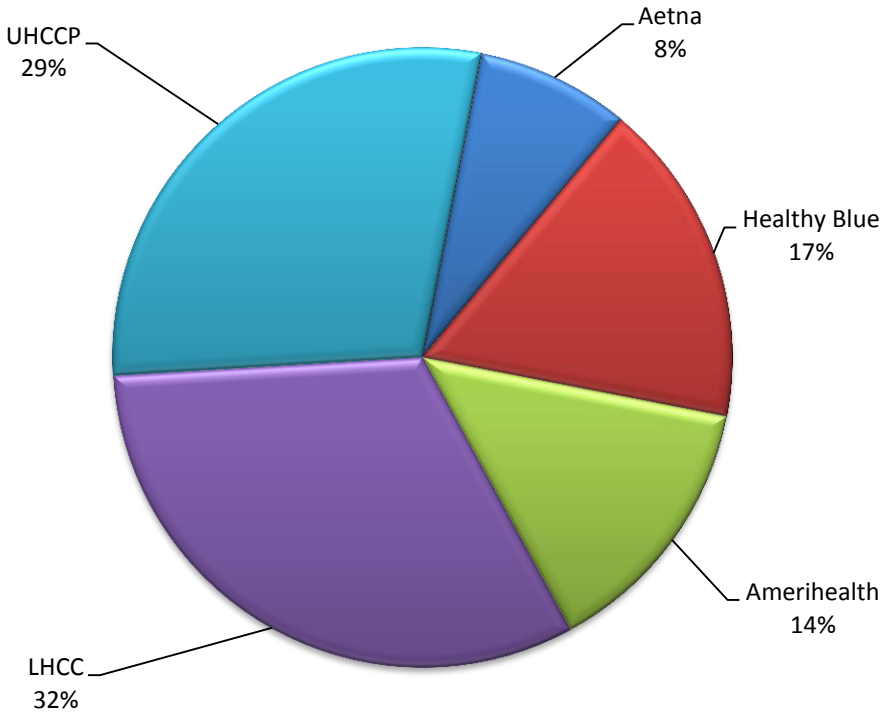
AmeriHealth	June 2016	June 2017	June 2018	% Change	2018 Statewide Total[2]
Total Enrollment	196,279	211,763	206,667	2.4%	1,473,685

Data Source: Report No. 125-A

[1] This report shows all active members in Healthy Louisiana as of the effective date above. Members to be disenrolled at the end of the reporting month were not included. Enrollees who gained and lost eligibility during the reporting month were not included. Enrollees who opted out of Healthy Louisiana during the reporting month were not included.

[2] Note: The statewide total includes membership of all plans.

Figure 1. Healthy Louisiana Membership by Health Plan as of June 2018



Provider Network

Providers by Specialty

LDH requires each MCO to report on a quarterly basis the total number of network providers. **Table 3** shows the sum of AmeriHealth's primary care providers, OB/GYNs and other physicians with primary care responsibilities within each LDH region as of March 20, 2018.

Table 3: Primary Care & OB/GYN Counts by LDH Region

Specialty	AmeriHealth Caritas Louisiana LDH Region 1	2	3	4	5	6	7	8	9	MCO Statewide Unduplicated
Family Practice/ General Medicine	147	130	55	98	64	65	117	102	98	793
Pediatrics	199	112	66	70	11	31	90	18	88	537
Nurse Practitioners	161	192	117	110	67	124	88	177	176	962
Internal Medicine	166	89	41	46	29	29	69	27	63	526
RHC/FQHC	24	40	27	30	18	40	38	47	36	273
OB/GYN[1]	3	7	1	4	4	1	6	5	1	30

Data source: Network Adequacy Review 2018 Q2

LDH Region 1: New Orleans; Region 2: Baton Rouge; Region 3: Houma Thibodaux; Region 4: Lafayette; Region 5: Lake Charles; Region 6: Alexandria; Region 7: Shreveport; Region 8: West Monroe; Region 9: Hammond

Provider Network Accessibility

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

Table 4: GeoAccess Provider Network Accessibility – as of July 13, 2018

Provider Type		Access Standard[1] X Provider(s) within X Miles	Percentage of Members for Whom Standard was Met
Adult PCP	Urban	1 within 10 miles	98.6%
	Rural	1 within 30 miles	100%
Pediatric PCP	Urban	1 within 10 miles	94.1%
	Rural	1 within 30 miles	100%
OB/GYN	Urban	1 within 15 miles	93.1%
	Rural	1 within 30 miles	96.7%

Data Source: Network Adequacy Review 2018 Q2

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

IV. QUALITY INDICATORS

To measure quality of care provided by the MCOs, 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

Performance Improvement Projects (PIPs) engage MCO care and quality managers, providers and members as a team with the common goal of improving patient care. The MCO begins the PIP process by targeting improvement in annual baseline performance indicator rates. The next step is to identify barriers to quality of care, and to use barrier analysis findings to inform interventions designed to overcome the barriers to care. Interventions are implemented and monitored on an ongoing basis using quarterly intervention tracking measures. Declining quarterly intervention tracking measure rates signal the need to modify interventions and re-chart the PIP course. Improving intervention tracking measures are an indication of robust interventions.

Healthy Louisiana is in the process of conducting two Collaborative PIPs: (1) Improving Prenatal and Postpartum Care to Reduce the Risk of Preterm Birth and (2) Improving the Quality of Diagnosis, Management and Care Coordination for Children and Adolescents with Attention-Deficit Hyperactivity Disorder (ADHD). As a Collaborative, the five plans agreed upon the following intervention strategies for each PIP:

(1) Improving Prenatal and Postpartum Care to Reduce the Risk of Preterm Birth
- Implement the Notice of Pregnancy communication from provider to MCO
- Implement the High-Risk Registry communication from MCO to provider
- Conduct provider education for how to provide and bill for evidence-based care
- Develop and implement or revised care management programs to improve outreach to eligible and at-risk members for engagement in care coordination

(2) Improving the Quality of Diagnosis, Management and Care Coordination for Children and Adolescents with ADHD
- Improve workforce capacity
- Conduct provider education for ADHD assessment and management consistent with clinical guidelines
- Expand PCP access to behavioral health consultation
- Develop and implement or revised care management programs to improve outreach to eligible and at-risk members for engagement in care coordination

Summaries of each of the PIPs conducted by AmeriHealth follow.

Improving Prenatal and Postpartum Care to Reduce the Risk of Preterm Birth

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

- Initiation of injectable progesterone for preterm birth prevention between the 16th and 24th week of gestation: increase from 14.48% to 25.12%
- Chlamydia test during pregnancy: increase from 86.00% to 97.00%
- HIV test during pregnancy: increase from 79.60% to 80.30%
- Syphilis test during pregnancy: increase from 84.20% to 84.80%
- Use of most effective contraceptive methods: decrease from 15.37% to 7.20%
- Use of moderately effective contraceptive methods: increase from 12.20% to 34.40%
- Use of long-acting reversible contraception (LARC) during delivery hospitalization: decrease from 1.20 % to 0.30%
- Use of LARC outpatient within 56 days postpartum: decrease from 6.00% to 3.80%
- HEDIS *Postpartum Care* measure: decrease from 64.65% to 63.28%

Intervention Summary:

- Member:
  - Keys to your care program
  - Bright Start phone app
  - High-risk member outreach
  - Community education outreach
  - Prepare for your doctor visit brochure
- Provider:
  - AmeriHealth will develop provider toolkit to educate and provide resources to targeted providers
  - The Health Plan will post educational resources in the provider portal
  - Notice of Pregnancy (NOP) implementation via provider toolkit, provider portal and fax blast, with Health Plan receipt of NOP form from provider via fax and information entered into Case Management tracking system
  - Perinatal Quality Enhancement Program
- MCO:
  - Enhanced Obstetric Care Management Engagement and Outreach Program (e.g., Bright Start phone application, high-risk member outreach, targeted mailings, improvement of post-partum care management)

Results:

- The total number of members with Bright Start increased from 25 to 26.
- From first to last quarter 2017, the total number of newly identified high risk pregnant members engaged in Case Management increased from 55% to 83%.
- From interim to final measurement, the rate of high-risk member receipt of injectable progesterone increased from 14% to 18%.
- The total number of successful post-partum outreach calls increased from 47% to 54%.

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

Strengths:

- Member engagement with Case Management demonstrated an increase in all four quarters in 2017.

Opportunities for Improvement:

- LDH Managed Care Prematurity Prevention Improvement Project is seeking novel ways to engage providers in the fight against prematurity. As a next step, LDH has requested that each Healthy Louisiana Medical Director, together with each MCO's Prematurity Prevention Performance Improvement (PIP) quality team, and a volunteer physician representing the Medicaid Quality Maternity Care Subcommittee, meet with one provider practice to support quality improvement efforts at that practice. Based upon an analysis of opportunities to improve high risk member receipt of 17P (hydroxyprogesterone caproate injection), each PIP quality team has selected one provider to meet with on-site at their practice. At the provider site visit, each MCO team should complete the Practice Engagement Worksheet in collaboration with the practice providers to inform planning of further PDSA cycles and interventions.
- As part of ongoing PDSA efforts to improve early identification and outreach of members at risk for preterm birth and/or preeclampsia, MCOs should identify and address any outstanding care coordination and data integrity challenges. For example: clarification, communication and integration of data sources, collection methods, tasks, persons responsible, and timeframes are merited to ensure that members with a history of preterm birth, as well as those at risk for preeclampsia, are identified early for care management outreach, care coordination and engagement.
- The ITM workgroup should continue monitoring the Intervention Tracking Measures (ITMs) and, in response to issues revealed by the pattern analysis using the IHI Rules for Interpreting Charts, conduct barrier analysis to identify root causes, and use barrier analysis findings to inform modifications to interventions on an ongoing basis as part of the PDSA quality improvement process.

Improving the Quality of Diagnosis, Management and Care Coordination for Children with ADHD

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

- Validated ADHD screening instrument: decrease from 18.33% to 16.67%
- ADHD screening in multiple settings: decrease from 16.67% to 12.12%
- Assessment of other behavioral health conditions/symptoms: increase from 26.67% to 27.27%
- Positive findings of other behavioral health conditions: increased from 93.75% to 94.44%
- Referral for evaluation of other behavioral health conditions: increase from 46.67% to 52.94%
- Referral to treat other behavioral health conditions: decrease from 40.00% to 11.76%
- PCP care coordination: increase from 5.00% to 36.36%
- MCO care coordination: increase from 3.39% to 9.09%
- MCO outreach with member contact: increase from 16.67% to 18.18%
- MCO outreach with member engagement: increase from 22.22% to 33.33%
- First line behavioral therapy for children less than 6 years of age: decrease from 3.33% to 0.00%
- The percentage of members aged 6-12 years as of the index prescription start date (IPSD) with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day initiation phase: increase from 34.73% to 53.19%
- The percentage of members aged 6-12 years as of the IPSD with an ambulatory pr**e**scription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up calls with a practitioner within 270 days after the initiation phase ended: increase from 45.15% to 64.98%
- Percentage of any ADHD cases, aged 0-20 years, stratified by age and foster care status, with documentation of behavioral health pharmacotherapy (ADHD medication, antipsychotics, and/or other psychotropics), with behavioral therapy: increase from 22.60% to 28.00%
- Percentage of any ADHD cases, aged 0-20 years, stratified by age and foster care status, with documentation of behavioral health pharmacotherapy (ADHD medication, antipsychotics, and/or other psychotropics), without behavioral therapy: decrease from 57.60% to 48.80%

- Percentage of any ADHD cases, aged 0-5 years, stratified by age and foster care status, with documentation of behavioral health pharmacotherapy (ADHD medication, antipsychotics, and/or other psychotropics), without behavioral therapy: increase from 16.64% to 16.82%

Intervention Summary:

- Provide behavior therapy trainings to providers (e.g., Positive Parenting Program, Trauma-focused Cognitive Behavioral Therapy, and Parent Management Training). ACLA sponsored Preschool PTSD training for providers.
- Provider incentives for completion of PHQ9 and Healthy Living evaluation
- Enhanced Case Management; telephonic outreach to members starting ADHD medication and/or diagnosed with ADHD, Member Initiation Phase gift card incentive and distribution of an educational letter.
- ACLA collaborating with Healthy Blue and Aetna to sponsor additional trainings for providers.
- Outreach via ADHD educational letter to the 6-12 year old population and their PCPs
- Behavioral Health (BH) PCP Toolkit. The toolkit includes an overview, medication management suggestions, assessments, screening tools, resources, and follow up for each disorder
- AAP ADHD Toolkit which includes AAP guidelines, screening tools, guidelines and resources for referrals

Results:

- During the fourth quarter of 2017; 784 children were identified by case management as having a new diagnosis or medication for ADHD. 309 (39%) of these members received a Rapid Response outreach call.
- During 2017, the rate of members that were compliant for 30 day follow up visits increased from 67.3% to 85.9%.

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

Strengths: The MCO initiated robust interventions that included provider outreach, provider educational trainings and telephonic outreach to 6-12 year old ADHD population.

Opportunities for Improvement:

- Increase the proportion of PCPs who treat children who received the ADHD PCP toolkit with MCO provider education on using the Vanderbilt Assessment for ADHD evaluation and diagnosis.
- Increase the proportion of targeted Evidence-Based Practice (EBP) Behavior Therapists Qualified to treat children <6 years of age diagnosed with ADHD who completed EBP training.
- Increase the proportion of PCPs who treat children who received behavioral provider referral list with MCO provider education on the EBP qualifications of behavioral providers on the referral list

Performance Measures: HEDIS® 2018 (Measurement Year 2017)

MCO-reported performance measures were validated as per HEDIS 2018 Compliance Audit™ specifications developed by the National Committee for Quality Assurance (NCQA). The results of each MCO's HEDIS 2018 Compliance Audit are summarized in its Final Audit Report (FAR).

HEDIS Effectiveness of Care Measures

HEDIS Effectiveness of Care measures evaluate how well a MCO provides preventive screenings and care for members with acute and chronic illnesses. **Table 5** displays MCO performance rates for select HEDIS Effectiveness of Care measures for HEDIS 2016, HEDIS 2017, HEDIS 2018, Healthy Louisiana 2018 statewide averages and *Quality Compass* 2018 South Central – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

Table 5: HEDIS® Effectiveness of Care Measures – 2016-2018

Measure	AmeriHealth			QC 2018 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded	Healthy Louisiana 2018 Average
	HEDIS® 2016	HEDIS® 2017	HEDIS®2018		
Adult BMI Assessment	85.17%	79.91%	80.29%	10th	81.97%
Antidepressant Medication Management - Acute Phase	56.43%	53.62%	78.30%	95th	54.05%
Antidepressant Medication Management - Continuation Phase	41.21%	39.34%	65.99%	95th	39.84%
Asthma Medication Ratio (5-64 Years)	41.82%	44.57%	56.15%	10th	63.75%
Breast Cancer Screening in Women	57.97%	58.05%	58.88%	90th	56.03%
Cervical Cancer Screening	57.18%	61.54%	52.55%	33.33rd	51.61%
Childhood Immunization Status - Combination 3	65.97%	65.21%	68.37%	33.33rd	68.19%
Chlamydia Screening in Women (16-24 Years)	62.40%	64.42%	66.96%	95th	65.78%
Comprehensive Diabetes Care - HbA1c Testing	80.80%	86.86%	85.16%	50th	84.21%
Controlling High Blood Pressure	38.00%	34.06%	30.17%	<10th	37.71%
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	40.36%	45.15%	64.98%	50th	67.89%
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	31.00%	34.73%	53.19%	66.67th	54.53%
Medication Management for People With Asthma Total - Medication Compliance 75% (5-64 Years)	32.97%	33.73%	59.68%	95th	32.76%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile	47.69%	48.91%	56.20%	10th	62.35%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	45.37%	46.72%	51.58%	10th	55.88%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity	30.32%	35.28%	43.07%	10th	45.10%

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 MCO rates for select HEDIS Access to/Availability of Care measure rates for HEDIS 2016 HEDIS 2017, HEDIS 2018, Healthy Louisiana 2018 statewide averages and *Quality Compass* 2018 South Central – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

Table 6: HEDIS® Access to/Availability of Care Measures – 2016-2018

Measure	AmeriHealth			QC 2018 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded	Healthy Louisiana 2018 Average
	HEDIS® 2016	HEDIS® 2017	HEDIS®2018		
	Children and Adolescents' Access to PCPs				
12–24 Months	96.10%	96.04%	96.14%	33.33th	96.43%
25 Months–6 Years	84.80%	86.92%	88.29%	50th	88.79%
7–11 Years	86.39%	87.88%	89.38%	25th	90.61%
12–19 Years	85.72%	87.09%	88.77%	50th	89.96%
	Adults' Access to Preventive/Ambulatory Services				
20–44 Years	79.27%	81.91%	75.57%	25th	76.75%
45–64 Years	88.06%	88.93%	84.43%	25th	84.87%
65+ Years	81.25%	77.34%	84.82%	33.33rd	84.83%
	Access to Other Services				
Timeliness of Prenatal Care	83.49%	77.37%	72.21%	10th	78.40%
Postpartum Care	64.65%	57.11%	63.28%	33.33rd	64.04%

HEDIS® Use of Services Measures

This section of the report details utilization of AmeriHealth's services by examining selected HEDIS Use of Services rates. **Table 7** displays MCO rates for select HEDIS Use of Services measure rates for HEDIS 2016, HEDIS 2017, HEDIS 2018 Healthy Louisiana 2018 statewide averages and *Quality Compass*®2018 South Central – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

Table 7: Use of Services Measures – 2016-2018

Measure	AmeriHealth			QC 2018 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded	Healthy Louisiana 2018 Average
	HEDIS® 2016	HEDIS® 2017	HEDIS®2018		
Adolescent Well-Care Visit	55.79%	52.33%	50.73%	33.33rd	54.18%
Ambulatory Care Emergency Department Visits/1000 Member Months[1]	78.38	81.68	86.46	90th	81.09
Ambulatory Care Outpatient Visits/1000 Member Months	513.92	397.17	448.57	90th	418.74
Frequency of Ongoing Prenatal Care - ≥ 81%	76.51%	67.63%	Retired[2]	Not Applicable	Retired[2]
Well-Child Visits in the First 15 Months of Life 6+ Visits	54.40%	59.71%	56.91%	10th	64.11%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	59.31%	62.76%	68.30%	33.33rd	68.06%

[1] A lower rate is desirable

[2] NCQA retired this measure from HEDIS 2018.

Member Satisfaction: Adult and Child CAHPS® 5.0H

In 2018, the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H survey of Adult Medicaid members and Child Medicaid with Chronic Care Conditions (CCC) was conducted on behalf of AmeriHealth by the NCQA-certified survey vendor, Morpace. For purposes of reporting the Child Medicaid with CCC survey results, the results are divided into two groups: General Population and CCC Population. The General Population consists of all child members who were randomly selected for the CAHPS® 5.0H Child survey during sampling. The CCC Population consists of all children (either from the CAHPS® 5.0H Child survey sample or the CCC Supplemental Sample) who are identified as having a chronic condition, as defined by the member's responses to the CCC survey-based screening tool.

Table 8, **Table 9** and **Table 10** show AmeriHealth's CAHPS® rates for 2016, 2017 and 2018, as well as *Quality Compass*® 2018 South Central – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

Table 8: Adult CAHPS® 5.0H – 2016-2018

Measure[1]	AmeriHealth			QC 2018 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded
	CAHPS® 2016	CAHPS® 2017	CAHPS® 2018	
Getting Needed Care	78.09%	81.89%	79.59%	25th
Getting Care Quickly	84.20%	81.52%	80.36%	10th
How Well Doctors Communicate	89.13%	89.86%	92.19%	50th
Customer Service	88.60%	88.15%	90.87%	75th
Shared Decision Making[2]	73.85%	75.84%	75.79%	10th
Rating of All Health Care	72.08%	69.92%	79.62%	95th
Rating of Personal Doctor	77.59%	78.30%	80.54%	33.33rd
Rating of Specialist	84.00%	76.40%	83.80%	66.67th
Rating of Health Plan	77.27%	77.62%	75.86%	33.33rd

[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 2016, NCQA revised measure specifications and response options.

Table 9: Child CAHPS® 5.0H General Population – 2016-2018

Measure[1]	AmeriHealth			QC 2018 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded
	CAHPS® 2016	CAHPS® 2017	CAHPS® 2018	
Getting Needed Care	84.29%	91.55%	93.26%	95th
Getting Care Quickly	92.97%	87.08%	92.60%	66.67th
How Well Doctors Communicate	92.86%	94.60%	95.06%	75th
Customer Service	88.22%	89.12%	92.10%	90th
Shared Decision Making[2]	69.35%	76.17%	80.10%	75th
Rating of All Health Care	85.85%	87.44%	87.61%	33.33rd
Rating of Personal Doctor	86.59%	90.57%	88.40%	10th
Rating of Specialist	81.13%	87.10%	92.77%	75th
Rating of Health Plan	87.17%	89.04%	92.76%	95th

[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 2016, NCQA revised measure specifications and response options.

Table 10: Child CAHPS® 5.0H CCC Population – 2016-2018

Measure[1]	AmeriHealth			QC 2018 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded
	CAHPS® 2016	CAHPS® 2017	CAHPS® 2018	
Getting Needed Care	86.10%	90.35%	90.35%	66.67th
Getting Care Quickly	93.19%	91.96%	91.24%	10th
How Well Doctors Communicate	93.35%	95.04%	95.33%	50th
Customer Service	90.63%	85.85%	94.47%	95th
Shared Decision Making[2]	85.76%	86.17%	85.44%	50th
Rating of All Health Care	83.96%	88.84%	86.71%	33.33rd
Rating of Personal Doctor	86.27%	92.02%	89.42%	50th
Rating of Specialist	80.49%	89.58%	84.75%	25th
Rating of Health Plan	85.12%	88.58%	88.06%	50th

[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 2016, NCQA revised measure specifications and response options.

Health Disparities

For this year's technical report, the LA EQRO evaluated MCOs with respect to their activities to identify and/or address gaps in health outcomes and/or health care among their Medicaid population according to at-risk characteristics such as race, ethnicity, gender, geography, etc. This information was obtained through surveying MCOs regarding the following activities:

(1) Characterization, identification or analysis of the MCO's Medicaid population according to at-risk characteristics.
(2) Identification of differences in health outcomes or health status that represent measurable gaps between the MCO's Medicaid population and other types of health care consumers.
(3) Identification of gaps in quality of care for the MCO's Medicaid members and/or Medicaid subgroups.
(4) Identification of determinants of gaps in health outcomes, health status, or quality of care for at-risk populations.
(5) Development and/or implementation of interventions that aim to reduce or eliminate differences in health outcomes or health status and to improve the quality of care for MCO members with at-risk characteristics.

AmeriHealth reported that the following interventions were implemented in 2017 through 2018 to identify and/or address disparities in health outcomes and/or health care among its Medicaid population:

- Conducted an annual comparison of 2017 Healthcare Effectiveness Data and Information Set (HEDIS) compliance rates based on race and language. Also, compared 2017 HEDIS rates to NCQA's 2017 national benchmark averages. Specific interventions were then recommended to improve outcomes of the lowest or underperforming groups.

- An examination of the ZIP codes surrounding the ACLA Community Wellness Center in Shreveport revealed specific determinates of gaps in outcomes in that area. In an effort to address the high rate of diagnosed diabetes as well as the HEDIS rates of members in the area, ACLA developed and implemented the intervention *Control Your Diabetes. Control Your Destiny*.

- The *Control Your Diabetes. Control Your Destiny.* program is designed to impact behaviors of members living with diabetes through ongoing efforts to: improve HEDIS measures, educate members, empower members to take control of their lives, modify attitudes and behaviors and recruit and maintain member participation in healthy activities. The program features two annual large scale events:
    - Diabetes Destination Walk-Health & Wellness Expo: to create an urgent sense of awareness about diabetes and serves as motivation to exercise while having fun.
    - Diamond Chef Member Cooking Competition: encourage members to be creative when preparing food while maintaining ingredient standards that support overall health.

V. COMPLIANCE MONITORING

Please note that the most recent compliance audit for Louisiana took place in 2016, and the next audit is anticipated to take place in 2019.

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 AmeriHealth's compliance with contractual requirements during the period of September 1, 2015 through August 31, 2016.

The 2016 Compliance Audit included a comprehensive evaluation of AmeriHealth'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 AmeriHealth'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 AmeriHealth'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	112	10	1	0	0	91%
Provider Network	163	149	9	3	0	2	93%
Utilization Management	92	77	8	0	2	5	89%
Eligibility, Enrollment and Disenrollment	13	13	0	0	0	0	100%
Marketing and Member Education	77	73	2	0	0	2	97%
Member Grievances and Appeals	62	54	5	2	1	0	87%
Quality Management	86	79	5	0	0	2	94%
Reporting	1	1	0	0	0	0	100%
Fraud Waste and Abuse	105	104	1	0	0	0	99%
Total	**722**	**662**	**40**	**6**	**3**	**11**	**93%**

It is IPRO's and the LDH's expectation that AmeriHealth submit a corrective action plan for each of the 49 elements determined to be less than fully compliant along with a timeframe for completion. It should be noted that AmeriHealth 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. Twelve (12) of the 49 elements rated less than fully compliant 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 AmeriHealth.

VI. STRENGTHS, OPPORTUNITIES FOR IMPROVEMENT & RECOMMENDATIONS

This section summarizes the accessibility, timeliness and quality of services provided by AmeriHealth to Medicaid recipients based on data presented in the previous sections of this report. The MCO'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

- **HEDIS (Quality of Care) –**
  - AmeriHealth met or exceeded the 75th percentile for the following HEDIS measures:
    - *Antidepressant Medication Management – Acute Phase*
    - *Antidepressant Medication Management – Continuation Phase*
    - *Breast Cancer Screening in Women*
    - *Chlamydia Screening in Women (16-24 Years)*
    - *Medication Management for People with Asthma Total – Medication Compliance 75% (5-64 Years)*
- **CAHPS (Member Satisfaction) –** AmeriHealth met or exceeded the 75th percentile for the following CAHPS measures:
  - Adult CAHPS
    - *Customer Service*
    - *Rating of All Health Care*
  - Child CAHPS General Population
    - *Getting Needed Care*
    - *How Well Doctors Communicate*
    - *Customer Service*
    - *Shared Decision Making*
    - *Rating of Specialist*
    - *Rating of Health Plan*
  - Child CAHPS CCC Population
    - *Customer Service*
- **Compliance –** The MCO achieved "full" compliance in two (2) of the nine (9) domains reviewed.

Opportunities for Improvement

- **HEDIS® (Quality of Care)** – AmeriHealth demonstrates an opportunity for improvement in the following areas of care as performance was below the 50th percentile:
  - *Adult BMI Assessment*
  - *Asthma Medication Ratio (5-64 Years)*
  - *Cervical Cancer Screening*
  - *Childhood Immunization Status – Combination 3*
  - *Controlling High Blood Pressure*
  - *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*
  - *Children and Adolescents' Access to PCPs*

    - *12-24 Months*
    - *7-11 Years*
  - *Adults' Access to Preventive/Ambulatory Services*
    - *20-44 Years*
    - *45-64 Years*
    - *65+ Years*
  - *Timeliness of Prenatal Care*
  - *Postpartum Care*
  - *Adolescent Well-Care Visit*
  - *Well-Child Visits in the First 15 Months of Life 6+ Visits*
  - *Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life*
- **CAHPS® (Member Satisfaction) –** AmeriHealth demonstrates an opportunity for improvement in regard to member satisfaction. The MCO performed below the 50th percentile for the following measures:
  - Adult CAHPS®
    - *Getting Needed Care*
    - *Getting Care Quickly*
    - *Shared Decision Making*
    - *Rating of Personal Doctor*
    - *Rating of Health Plan*
  - Child CAHPS® General Population
    - *Rating of All Health Care*
    - *Rating of Personal Doctor*
  - Child CAHPS® CCC Population
    - *Getting Care Quickly*
    - *Rating of All Health Care*
    - *Rating of Specialist*

Recommendations

- The MCO should evaluate the effectiveness of the interventions implemented to address poor performing HEDIS measures. In its response to the previous year's recommendation, the MCO describes an intervention strategy that is broad and multifaceted. However, as the MCO's performance for a variety of HEDIS measures has declined, routine monitoring of the effectiveness of the overall intervention strategy recommended.
- Despite the improvement in access to primary care rates for children and adolescents, there remains an opportunity for improvement in regard to adult access to primary care. The MCO should continue with the interventions outlined in the MCO's response to the previous year's recommendation. Interventions should be monitored for effectiveness and modified as needed.
- The MCO should continue to work to improve CAHPS® scores that perform below the 50th percentile. The internal CAHPS workgroup should continue to conduct root cause analysis to identify opportunities specific to low-performing and/or at-risk areas. Correlations between CAHPS scores and HEDIS rates should also be identified to maximize opportunities for improvement.
- Future PIPs:
  - Initiate data-driven barrier analyses upon receipt of each new PIP template. For example, analyze encounter data by stratifying baseline performance indicator measures by key demographic and pertinent clinical subsets in order to answer these two questions regarding high-volume and high-risk members:
    - High-volume: among the PIP eligible population {e.g., members with substance use disorder {SUD} which demographic (e.g., age group, geographic area, race/ethnicity) subsets and which

clinical subsets (e.g., Members with co-occurring serious mental illness {SMI} and members with chronic physical health conditions) comprise the highest caseload volumes?
    - High-risk: Among each subset grouping which demographic (e.g., race/ethnicity: black compared to white) and clinical subsets (e.g., with SMI compared to without SMI) are disproportionately lacking in recommended care (e.g., initiation and engagement in treatment for SUD)?
- Use barrier analysis findings to inform interventions that are targeted and tailored to susceptible subpopulations; however, do not restrict interventions to these subpopulations. Instead, conduct additional data driven barrier analyses (e.g., member and provider focus groups, early inpatient/emergency department admission notification process flow sheet analysis) and use these barrier analysis findings to inform a robust and feasible set of interventions that aim to more broadly reach the entire PIP eligible population.
- Focus on developing and utilizing ITMs to inform modifications to key interventions. For example, use ITMs to monitor the progress of enhanced care management interventions and, in response to stagnating or declining monthly or quarterly rates, conduct additional barrier/root cause analysis and use findings to modify interventions.
- Deploy quality improvement tools, such process flow charting, PDSA worksheets and IHI run charts, in order to test, evaluate and adapt interventions over the course of the PIP and beyond for ongoing quality improvement.

Response to Previous Year's Recommendations

- **2016-2017 Recommendation:** The MCO continues to demonstrate opportunities for improvement in regard to the quality of, access to and timeliness of care. The MCO should conduct root cause analysis for each HEDIS measure performing below the 50th percentile and implement a multifaceted intervention strategy that targets members, providers and MCO operations. The effectiveness of implemented interventions should be monitored often and routinely, and should be modified as needed. *[Repeated recommendation.]*

  Health Plan Response: ACLA continually strives to improve the quality of care and services delivered to our members. ACLA endeavors to exceed the 50th percentile in HEDIS metrics and monitors rates throughout the year to identify opportunities for improvement. ACLA conducted a root cause analysis for HEDIS® measures that performed below the 50th percentile and developed a strategy to improve performance and member health outcomes.

  As part of the improvement strategy and to build upon monthly interdepartmental meetings, ACLA initiated weekly strategic meetings with the executive leadership team in order to discuss HEDIS measures, health outcomes and areas identified as opportunities for improvement. On a monthly basis, ACLA monitors HEDIS measures through interim HEDIS reports. Month-over-month trending and benchmarking against Quality Compass is monitored and drives root cause analyses when areas for improvement are identified. As a result of the ongoing analysis, member and provider interventions are adjusted or enhanced, as needed.

  ACLA utilizes provider dashboards to monitor performance and identify practices for outreach. Through our multi-disciplinary team approach, provider outreach is conducted by a specialized team that works with providers on all levels. During these visits, report cards are shared and opportunities for improvement are discussed. Additionally, resources are provided to assist practices in following evidenced-based practice guidelines and optimizing quality enhancement program payments.

  To ensure members are identified when out of compliance with standards of care, processes have been established and implemented as ongoing procedures to alert staff of member gaps in care. Additionally, initiatives are implemented throughout the year to facilitate gap closures and improved health outcomes. Each member-facing employee has a role-specific protocol to follow to address the care gap with the

member. Practitioner/Provider offices also receive alerts on care gaps and are able to access detailed reports detailing care gaps.

Additional improvement strategy initiatives include:

- Implementation of a new user-friendly member reward system that includes a reloaded card that allows for a prompt reward to quickly reinforce healthy behavior
- Updated member incentives to align with LDH priorities
- Wellness day event expansion to improve member engagement and assist practices with gap closures
- HEDIS texting campaign to alert members of needed services around wellness, maternity, and chronic disease
- Telephonic member outreach to targeted populations
- Member mailings to targeted populations
- Urgent care center expansion
- School-based health center collaboration
- Collaboration with community-based partners to utilize mobile units for screenings
- Grand opening of two community wellness centers that provide residents with important resources, such as diabetes classes, healthy cooking demonstrations, fitness classes and nutritional workshops
- Enhanced member mobile application
- Strengthened Member Advisory Council forum
- Implemented member surveys as a mechanism to obtain member feedback
- Identification and recognition of provider champions to drive initiatives
- Regional and individual HEDIS Provider Trainings
- Enhanced case management to include face-to-face outreach
- Implementation of telemedicine for chronic disease management
- Utilization of peer support team to assist members with obtaining physical and behavioral health services
- Restructure of the Quality Enhancement Program and Value-Based Contracting to align with state priority measures
- Enhanced provider incentives
- Expansion of non-standard supplemental data collection
- Facilitation of provider electronic data exchanges

ACLA continually monitors initiatives and routinely obtains stakeholder feedback to determine effectiveness and alignment with the strategy of the state and plan. Initiatives are modified as needed.

- **2016-2017 Recommendation:** In addition to monitoring provider compliance with appointment timeliness standards, the MCO should expand its monitoring to include other factors that may impede member access to care, such as access to provider information that is accurate and current, member access to primary care during non-traditional business hours, member access to transportation, etc. *[Repeated recommendation.]*

  Health Plan Response:

  - ACLA developed a web-based response tool that is displayed within ACLA's provider directory to allow members, potential members, or any member of the public to directly notify the plan when they identify provider directory information that is inaccurate. ACLA guarantees that the plan will investigate these reports and modify directories accordingly and in a timely manner.
  - ACLA investigates reports of inaccuracies and modifies directories (such as by removing providers no longer in the network) in accordance with their findings within no more than 30 days.

- ACLA conducts regular validation audits on all of the providers in each specialty in its directory twice a year to assess the accuracy of information, such as: 1) whether their contact information is correct, 2) whether they are really in the plan's network, 3) whether they are taking new patients. If the directory lists which languages other than English providers speak, ACLA assesses the accuracy of this information; and, if any of the information listed in the directory is found to be inaccurate based on the findings of the audit, the directory is updated within no longer than one month of the date in which the inaccuracy is noted.

- In addition to its bi-annual validation audit, ACLA utilizes a vendor to sample a significant volume of providers in each specialty in its directory throughout the year to validate the accuracy of information and provide findings. If found to be inaccurate based on the findings of the audit, the directory is updated within no longer than one month of the date in which the inaccuracy is noted.

- ACLA contacts providers listed as in-network who have not submitted claims within the past 18 months to determine whether the providers still intend to participate in the network. ACLA proactively removes the provider from the directory until ACLA makes contact with the provider. Based on the providers' responses, ACLA updates the directory accordingly.
- ACLA uses the raw data file from the annual Appointment Availability and Access research to identify non-compliant PCPs, specialists and behavioral health providers.
    - ACLA will complete a second survey of the provider sites found to be non-compliant during the initial survey in an effort to validate survey or vendor results.
    - ACLA will share survey results with non-compliant providers and discuss contractual requirements best practices moving forward. ACLA may request that a corrective action plan be implemented. This will include standards that providers should meet in the communication (e.g., Urgent Care standard is to see a patient within 24 hours).
    - ACLA will allow 30 to 60 days from date of provider education and will then re-survey the provider site. If found to be still non-compliant, a corrective action plan will be implemented.

- ACLA considers which appointment types have the highest non-compliance rates.
    - Improve Urgent Care compliance: actions may include but are not limited to the following: ACLA will work with providers to implement same-day appointments for certain patient types, walk-in ability, leave appointment slots open daily, extend office hours, etc.
    - ACLA is working to expand member access to urgent care centers (UCC). This includes but is not limited to expanding UCCs in the ACLA network, increasing communications to members and providers of availability by using various modalities. Modalities include searchable tools for members such as the ACLA website and phone apps.
    - Improve prenatal care compliance: ACLA will work with providers to address urgent/sick care appointment needs such as an appointment need early in the week, schedule routine prenatal care for late in the week.
    - ACLA will ensure providers are aware of standards for prenatal care by sending provider notifications and notices in provider newsletter.
- ACLA identifies compliant providers in the raw data file for the appointment availability research for 2018. Account executive staff meets with these offices to identify best practices. Suggestions may include:
    - What was learned that could be shared with other practices who had higher compliance scores or as they are implementing corrective action plans?
    - What are panel sizes in these practices?
    - Do providers work in teams?

- What tasks are delegated and to whom in order to manage a large number of members?
- Does practice include physician extenders?

- ACLA offers clinic education programs for physician offices to include:
  - Recommendations for adding mid-level providers to staffing mix to cover heavy volume times.
  - Develop customer service seminars for physicians' office staff.
    - Discuss compliant protocols after hours (e.g., do not automatically send to ER voice messaging; communicate to patient the expected call-back time from the provider, etc.).
    - Encourage offices to have a means to reach a live party if using a recorded message and emergency instructions on recorded messages.
  - Discuss scheduling protocols (e.g., how to pinpoint urgent symptoms and how soon these patients need to be seen).
  - Best practices to manage challenges and improve efficiency within office (report learnings from meeting with offices that are compliant).
- Through ACLA's Member Engagement and Member Outreach teams, ACLA educates members on appointment access and scheduling options to manage expectations and utilization. It is anticipated that with ongoing focused education and outreach efforts, primary care access will improve.
  - Offer effective care management services for chronically ill patients (e.g., case manager to go to member's home after hospital visit to ensure care plan is followed).
  - Offer Peer Support Services by phone or face-to-face supports.
  - Offer wellness days with partnering physician offices during routine and/or non-routine business hours, including weekends along with activities and transportation assistance.
  - Offer specialized care management through intensive telephonic/face-to-face interactions to a targeted group of members with multiple medical and behavioral health challenges.
- Educate members on appointment access and scheduling options to manage expectations and utilization.
  - What symptoms require doctor visit?
  - How long should a member wait to go to doctor after developing symptoms?
  - What are potential options such as an appointment at a physician's office or the use of an urgent care center?

- **2016-2017 Recommendation:** The MCO should continue to work to improve CAHPS® measures that perform below the 50th percentile. As CAHPS® assesses member satisfaction the internal CAHPS workgroup should expand its intervention strategy to include interventions that specifically address member concerns. Root cause analysis should be conducted to identify these concerns and to develop targeted interventions. Correlations between CAHPS® scores and HEDIS® rates should also be identified to maximize opportunities for improvement. *[Repeated recommendation.]*

  Health Plan Response: ACLA consistently works to improve CAHPS scores for both the Adult and Children surveys by identifying opportunities where the Plan performs below the NCQA 50th percentile. ACLA continued its "CAHPS" workgroup of multi-disciplinary internal departments.

  The general population survey results reflected an overall improvement in scores, as 7 of the 8 composites/ratings showed an increase in percentage from the prior year. In addition, goals were met, achieving the Quality Compass 50th Percentile, except for one: Getting Care Quickly.

  CAHPS Work Plan Items include but are not limited to the following:

- Continued with CAHPS trainings for all associates
- Implemented a call center associate training with a focus on Getting Care Quickly
- Analyze complaints received by Customer Service regarding inability to receive care
- Created “Ask me about CAHPS” buttons for all member and provider facing teams to wear during outreach
- Incorporated informative articles into the Plan’s member newsletters
- Continued focus on CAHPS within provider education trainings