State of Louisiana Department of Health

AmeriHealth Caritas Louisiana

Annual External Quality Review Technical Report

Review Period: July 1, 2018 – June 30, 2019

Report Issued: April 2020

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

I. Introduction 4

II. MCO Corporate Profile 5

III. Enrollment and Provider Network 6

Provider Network 6

IV. Quality Indicators 8

Performance Improvement Projects 8
Performance Measures: HEDIS 2019 (Measurement Year 2018) 18
Member Satisfaction: Adult and Child CAHPS 5.0H 22
Health Disparities 24

V. Compliance Monitoring 25

Medicaid Compliance Audit Findings for Contract Year 2019 25
Summary of findings 26

VI. Strengths, Opportunities for Improvement & Recommendations 28

Strengths 28
Opportunities for Improvement 28
Recommendations 29
MCO's Response to Previous Recommendations (2019) 29

List of Tables and Figures

Table 1: Corporate Profile....5
Table 2: Medicaid Enrollment as of June 2018....6
Table 3: Primary Care & Ob/Gyn Counts by LDH Region....6
Table 4: GeoAccess Provider Network Accessibility (Distance) as of June 30, 2019....7
Table 5: GeoAccess Provider Network Accessibility (Time) as of June 30, 2019....7
Table 6: Indicators, Baseline Rates, and Goals for IET....15
Table 7: HEDIS Effectiveness of Care Measures – 2017–2019....19
Table 8: HEDIS Access to/Availability of Care Measures – 2017-2019....20
Table 9: Use of Services Measures – 2017–2019....21
Table 10: Adult CAHPS 5.0H – 2017-2019....22
Table 11: Child CAHPS 5.0H General Population – 2017–2019....23
Table 12: Child CAHPS 5.0H CCC Population – 2017–2019....23
Table 13: File Review Sample Sizes....25
Table 14: Review Determination Definitions....26
Table 15: Audit Results by Audit Domain....27

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, 2018–June 30, 2019.

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* 2019 National – All Lines of Business ([LOBs] 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 Louisiana Children's Health Insurance Program (LaCHIP)
Total Medicaid Enrollment (as of June 2019)	194,944

III. Enrollment and Provider Network

Medicaid Enrollment

As of June 2019, the MCO's Medicaid enrollment totaled 194,944, which represents 13.9% of Healthy Louisiana's active members. Table 2 displays AmeriHealth's Medicaid enrollment for 2017 to 2019, as well as the 2019 statewide enrollment totals.

Table 1: Medicaid Enrollment as of June 2018

AmeriHealth[1]	June 2017	June 2018	June 2019	% Change 2018 to 2019	2019 Statewide Total[2]
Total enrollment	211,763	206,667	194,944	-5.7%	1,406,048

Data Source: Report No. 109-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] The statewide total includes membership of all plans.

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 June 30, 2019.

Table 2: 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	94	89	36	65	39	38	82	74	56	563
Pediatrics	146	64	24	53	15	16	68	10	60	441
Nurse Practitioners	116	140	68	97	52	95	79	162	122	894
Internal Medicine	129	67	26	30	14	14	45	24	29	378
RHC/FQHC	26	37	27	30	22	45	38	55	39	301
Ob/gyn[1]	2	7	0	2	2	1	2	1	0	17

Data source: Network Adequacy Review Report 20 2019 Q2.

[1] Count includes only those that accept full PCP responsibilities

LDH: Louisiana Department of Health; 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; MCO: managed care organization; RHC/FQHC: Rural Health Clinic/ Federally Qualified Health Center

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 and time between providers and members can be assessed to determine whether members have access to care within a reasonable distance or time from their homes. MCO's are required to meet the distance and/or time standards set by LDH. **Tables 4 and 5** show the percentage of members for whom the distance and/or time standards were met respectively.

Table 3: GeoAccess Provider Network Accessibility (Distance) as of June 30, 2019

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	98.2%
	Rural	1 within 30 miles	100%
Pediatric PCP	Urban	1 within 10 miles	98.6%
	Rural	1 within 30 miles	100%
Ob/gyn	Urban	1 within 15 miles	94.7%
	Rural	1 within 30 miles	96.4%

Data Source: Network Adequacy Review Report 220 2019 Jan 1 – June 30.
[1] The Access Standard is measured in distance to member address.
PCP: Primary Care Physician

Table 5: GeoAccess Provider Network Accessibility (Time) as of June 30, 2019

Provider Type		Access Standard[1] X Provider(s) within X Minutes	Percentage of Members for Whom Standard was Met
Adult PCP	Urban	1 in 20 minutes	99.9%
	Rural	1 in 60 minutes	100%
Pediatric PCP	Urban	1 in 20 minutes	99.9%
	Rural	1 in 60 minutes	100%
Ob/gyn	Urban	1 in 30 minutes	99.8%
	Rural	1 in 60 minutes	100%

Data Source: Network Adequacy Review Report 220 2019 Jan 1 – June 30.
[1] The Access Standard is measured in time to member address.
PCP: Primary Care Physician

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

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 and identifying drivers of improved evidence-based performance. 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 and/or monthly intervention tracking measures. Declining or stagnating intervention tracking measure rates signal the need to modify interventions and re-chart the PIP course. Positive intervention tracking measure trends are an indication of robust interventions.

During the period from July 1, 2018, through June 30, 2019, Healthy Louisiana was in the process of conducting three Collaborative PIPs: 1) Improving Prenatal and Postpartum Care to Reduce the Risk of Preterm Birth; a one-year extension after Final PIP report submitted on June 30, 2018, with PIP Extension reporting completed on June 30, 2019; 2) Improving the Quality of Diagnosis, Management and Care Coordination for Children and Adolescents with Attention-Deficit Hyperactivity Disorder (ADHD), with Final PIP report submitted on June 30, 2019; and 3) Improving Rates for Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET), with First Quarter PIP report for the Intervention Period beginning January 1, 2019, submitted on April 30, 2019. 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
   A. Baseline to Final PIP Measurement Period (Retrospective Performance Indicator reporting): November 6, 2014–November 5, 2017
      - Implement the Notification 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
   B. Extension Measurement Period (Concurrent Monthly Intervention Tracking Measure [ITM] reporting at monthly ITM meetings): Beginning August 2018, for the measurement period beginning as early as March 2018 (depending upon MCO-specific data reporting) and extending through May 2019, the plans reported monthly on the same intervention tracking measure (ITM) to address each of the following corresponding interventions:
      1. Identify/ risk stratify pregnant women; ITM: The percentage of women with evidence of a previous preterm singleton birth (PPSB) event (24–36 weeks completed gestation) who are currently pregnant (denominator) and who had a comprehensive needs assessment ([CNA] e.g., for physical and behavioral health conditions, lack of social supports, substance abuse, hypertension/preeclampsia, etc.) with risk stratification completed (numerator).
      2. Conduct face-to-face care management; ITM: The percentage of women with evidence of a PPSB event (24–36 weeks completed gestation) who are currently pregnant (same denominator as ITM 1) who had a face-to-face encounter with patient navigator (consider for outlier practices) and/or care manager and/or community outreach worker and/or nurse in any setting (e.g., provider office, clinic, home; numerator).
      3. Conduct 17P-enhanced care coordination; ITM: The percentage of women with evidence of a PPSB event (24–36 weeks completed gestation) who are currently pregnant (denominator) and who were contacted via outreach with completed contact (telephonic or face-to-face) to provide education regarding risk for repeat PPSB and 17P treatment and to facilitate OB appointment (numerator).
      4. Provide contraception education/ reproductive plan; ITM: The percentage of women with evidence of a PPSB event (24–36 weeks completed gestation) who are currently pregnant (same as ITM 1 denominator) who were contacted during the third trimester for contraception education and completed a reproductive plan for postpartum period (numerator).

5. Notify providers of members at risk for preeclampsia; ITM: the percentage of pregnant women with a history of hypertension/ preeclampsia (denominator) whose provider received notification from the plan that the member is at risk for hypertension/preeclampsia (numerator).
6. Primary care/ inter-conception referral; ITM: The percentage of women with a current preterm delivery (denominator) with postpartum outreach within six weeks of delivery for comprehensive education on chronic disease management, as indicated; pregnancy spacing and contraception planning; progesterone and ASA AND had an appointment with a PCP scheduled (numerator).

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; and
   - Develop and implement or revised care management programs to improve outreach to eligible and at-risk members for engagement in care coordination.

3. Improving Rates for Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)
   - Conduct provider training to expand the workforce for treatment initiation and follow-up (e.g., medication-assisted treatment guidelines, waiver training);
   - Partner with hospitals/EDs to improve timely initiation and engagement in treatment (e.g., MCO liaisons, hospital initiatives, ED protocols);
   - Provide enhanced member care coordination (e.g., behavioral health integration, case management, improved communication between MCO utilization management (UM) and case management (CM) for earlier notification of hospitalization, improved discharge planning practices and support, such as recovery coaches); and
   - Other interventions as informed by the MCO's barrier analyses they will conduct as part of the PIP process.

Summaries of each of the PIPs conducted by AmeriHealth Caritas 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 re-measurement are as follows:

- initiation of injectable progesterone for preterm birth prevention: increase from 12.32% to 18%;
- use of most effective contraceptive methods: increase from 15.37% to 18.37%;
- chlamydia test during pregnancy: increase from 86% to 89%;
- HIV test during pregnancy: increase from 79.6% to 82.6%;
- syphilis test during pregnancy: increase from 84.2% to 87.2%; and
- HEDIS Postpartum Care measure: increase from 64.65% to 69.5%.

Intervention Summary:

- Interventions to address member barriers: The plan continues to identify newly high-risk members and attempt to engage them in case management. The plan initiated a new intervention in 2017 and now monitors how many women are engaged in case management who delivered < 37 weeks gestation. The plan also updated the contraception outreach to members and now tracks how many members receive contraception who are engaged in case management or received a care coordination call. STD screenings are monitored, and the plan monitors members who are engaged in case management or received a care coordination call and received a STD screening. Postpartum outreach is monitored via outreach calls and having a successful visit as well as community education outreach to unable-to-contact members. The plan also developed a new process for identification of quality of care concerns with premature deliveries who qualified for 17P but did not receive it.
- Interventions to address provider barriers: AmeriHealth continues to offer the Perinatal Quality Enhancement Program (PQEP) to providers who participate and provide obstetrical care. Providers continue to fax in the Notification of Pregnancy (NOP) form; however, the Notice of Pregnancy provider incentive submission process has been changed to improve form collection and payment accuracy. Payments are now based on NOP forms submitted versus claims submitted. Account executives and/or medical directors continue to schedule and distribute materials to targeted providers (educational visits). Long acting reversible contraception guide is faxed to obstetric providers. Additionally, AmeriHealth's obstetric consultant conducts peer-to-peer provider outreach to targeted providers who are not utilizing 17P with eligible members.

Results/Strengths – Final PIP Report:

- 17P original PIP PM increased from 12.32% at baseline to 18.1% at final re-measurement, reaching the target rate of 18%.
- 17P incentive PM increased from 14.48% at baseline to 25.12% at final re-measurement, exceeding the target rate of 20%.
- The chlamydia test rate PM increased from 86% at baseline to 97% at final re-measurement, reaching the revised (upward) goal of 97%.
- The ITM rate for the proportion of high-risk pregnant members referred to CM and who were engaged in CM increased from 47.62% (150/315) to 79.03% (98/124) from Q1 2017 to Q4 2017.
- The ITM rate for members with a postpartum visit and who received a successful postpartum outreach call increased from 62.97% (398/632) to 81.75% (515/630) from Q1 2017 to Q4 2017.
- The plan implemented a new intervention to offer contraception information during the "pediatrician call," which takes place at the 28th week of pregnancy.
- The plan developed a new process for identification of quality of care concerns with premature deliveries, including a review of members who qualified for 17P but did not receive it.
- The plan implemented a new workflow for receiving and entering the NOP forms so that payments are now made based on forms received versus codes submitted.

Results/Strengths – Final ITM Workgroup ITM 3 Run Chart Presentation 6/20/19:

- AmeriHealth: Although no shifts (6 or more consecutive points all above or below the median) or trends (5 or more consecutive points all going up or down) were observed, the run chart showed an overall increasing monthly ITM 3 rate pattern, with notable increases after an enhanced early identification of pregnancy report was implemented in

July 2018, as well as after expanded UTC referrals to COS teams was initiated in December 2018. The annual rate for 17P receipt increased from 14.48% in 2015 to 24.08% in 2017.

Opportunities for Improvement/ Next Steps Identified by AmeriHealth:

- ITM 1: Improve stratified report and referral of high-risk members to community team.
- ITM 2: Expand dual role of case managers to increase access to face-to-face visits to other regions.
- ITM 3: Continue Community Outreach Teams referrals for women with a prior preterm birth.
- ITM 4: Continue prenatal assessments supplemented with interpregnancy assessments completed annually after delivery.
- ITM 5: Verify data and improve report for all pregnant members with a history of hypertension.
- ITM 6: Assist members with scheduling PCP appointment to facilitate primary care/ interconception care referral.

Overall Credibility of Results: There were no validation findings that indicate the credibility of the PIP results is at risk.

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.

A. Hybrid Measures (Utilizing a Random, Stratified Sample of New ADHD Cases for Chart Review):

A1. ***Validated ADHD Screening Instrument***: The percentage of the eligible population sample whose PCP used a validated ADHD screening instrument.
Baseline to final measurement goal: The percentage of the eligible population sample whose PCP used a validated ADHD screening instrument will increase 19.57%, from 18.33% at baseline to 37.9% at final re-measurement. The goal was set above the 95th confidence interval as the plan wants to encourage PCPs to utilize a validated ADHD screening instrument.

A2. ***ADHD Screening in Multiple Settings***: The percentage of the eligible population sample whose PCP used a validated ADHD screening instrument completed by reporters across multiple settings (i.e., at home and school).
Baseline to final measurement goal: The percentage of the eligible population sample whose PCP used a validated ADHD screening instrument completed by reporters across multiple settings (i.e., at home and school) will increase 18.83 %, from 16.67% at baseline to 35.5% at final re-measurement. The goal was set above the 95th confidence interval.

A3. ***Assessment of Other Behavioral Health Conditions/Symptoms***: The percentage of the eligible population sample whose PCP conducted a screening, evaluation, or utilized behavioral health consultation for at least one alternate cause of presenting symptoms and/or co-occurring conditions (e.g., oppositional-defiant disorder, conduct disorder, anxiety, depression, autism, learning/language disorders, substance use disorder, trauma exposure/toxic stress).
Baseline to final measurement goal: The percentage of the eligible population sample whose PCP conducted a screening, evaluation, or utilized behavioral health consultation for at least one alternate cause of presenting symptoms and/or co-occurring conditions (e.g., oppositional-defiant disorder, conduct disorder, anxiety, depression, autism, learning/language disorders, substance use disorder, trauma exposure/toxic stress) will increase 22.33% from 26.67% at baseline to 49.00% at final re-measurement. The goal was set above the 95th confidence interval.

A4. ***Positive Findings of Other Behavioral Health Conditions***: The percentage of the eligible subpopulation sample with screening, evaluation or utilization of behavioral health consultation whose PCP documented positive findings (i.e., positive screens or documented concerns for alternate causes of presenting symptoms and/or co-occurring conditions; goal setting not applicable).

A5a. ***Referral for Evaluation of Other Behavioral Health Conditions***: The percentage of the eligible subpopulation sample with positive findings regarding alternate causes/co-occurring conditions whose PCP documented a referral to a specialist behavioral health provider for evaluation and/or treatment of alternate causes of presenting symptoms and/or co-occurring conditions.
Baseline to final measurement goal: The percentage of the eligible subpopulation sample with positive findings regarding alternate causes/co-occurring conditions whose PCP documented a referral to a specialist behavioral health provider for evaluation and/or treatment of alternate causes of presenting symptoms and/or co-occurring conditions will increase 28.33%, from 46.67% at baseline to 75.00% at final re-measurement. The goal represents a bold aim, given the wide 95th confidence interval, which is attributable to a small sample size.

A5b. ***Referral to Treat Other Behavioral Health Conditions***: The percentage of the eligible subpopulation sample referred to behavioral specialist for evaluation/treatment of alternate causes/co-occurring conditions whose PCP documented referral to a mental health rehabilitation provider (e.g., community psychiatric support treatment, psychosocial rehabilitation, coordinated system of care to treat alternate causes of presenting symptoms and/or co-occurring conditions.
Baseline to final measurement goal: The percentage of the eligible subpopulation sample referred to behavioral specialist for evaluation/treatment of alternate causes/co-occurring conditions whose PCP documented referral to a

mental health rehabilitation provider (e.g., CPST, PSR, CsOC) to treat alternate causes of presenting symptoms and/or co-occurring conditions will increase 29%, from 40.00% at baseline to 69.00% at final re-measurement. The goal represents a bold aim, given the wide 95th confidence interval, which is attributable to a small sample size.

A6. ***PCP Care Coordination***: The percentage of the eligible population sample who received PCP care coordination (e.g., provider notes regarding communication with a behavioral therapist, other specialist, the child's teacher, or health plan case manager) regarding ADHD care coordination.
Baseline to final measurement goal: The percentage of the eligible population sample who received PCP care coordination (e.g., provider notes regarding communication with a behavioral therapist, other specialist, the child's teacher, or health plan case manager) regarding ADHD care coordination will increase 11%, from 5.00% at baseline to 16.00% at final re-measurement. The goal was set over the 95th confidence interval.

A7. ***MCO Care Coordination***: The percentage of the eligible population sample who received care coordination services from the health plan care coordinator.
Baseline to final measurement goal: The percentage of the eligible population sample who received care coordination services from the health plan care coordinator will increase 36.61%, from 3.39% at baseline to 40.00% at final re-measurement. The goal is aligned with our outreach target goal due to the plan's outreach interventions.

A8. ***MCO Outreach with Member Contact***: The percentage of the eligible population sample who were outreached by the health plan care coordinator.
Baseline to final measurement goal: The percentage of the eligible population sample contacted by the health plan care coordinator will increase 23.33%, from 16.67% at baseline to 40.00% at final re-measurement. The goal is based on a statistical and member population health perspective.

A9. ***MCO Outreach with Member Engagement***: The percentage of the members contacted who were engaged in care management.
Baseline to final measurement goal: The percentage of the members contacted who were engaged in care management will increase 37.78%, from 22.22% at baseline to 60.00% at final re-measurement. The goal is aligned with the plan's enhanced care management interventions.

A10. ***First-Line Behavior Therapy for Children < 6 years***: The percentage of the eligible population sample aged < 6 years who received evidence-based behavior therapy as first-line treatment for ADHD.
Baseline to final measurement goal: The percentage of the eligible population sample aged < 6 years who received evidence-based behavior therapy as first-line treatment for ADHD will increase 39.67%, from 3.33% at baseline to 43.00% at final re-measurement. Once interventions are initiated, the plan hopes to see significant changes and can possibly raise goal even higher.

B. Administrative Measures (Utilizing Encounter/Pharmacy Files):
HEDIS Administrative Measures:

B1a. ***Initiation Phase:*** The percentage of members aged 6–12 years as of the 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.
Baseline to final measurement goal: The percentage of members aged 6–12 years as of the 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 will increase 7.46%, from 34.73% at baseline to 42.19% at final re-measurement. This target rate is from the 25th to the 50th Quality Compass percentile.

B1b. ***Continuation and Maintenance (C&M) Phase:*** The percentage of members aged 6–12 years as of the IPSD with an ambulatory prescription 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 visits with a practitioner within 270 days (nine months) after the initiation phase ended.

Baseline to final measurement goal: The percentage of members aged 6–12 years as of the IPSD with an ambulatory prescription 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 visits with a practitioner within 270 days (nine months) after the initiation phase ended will increase 7.32%, from 45.15% at baseline to 52.47% at final re-measurement. This target rate is the 66.67th Quality Compass percentile.

Non-HEDIS Administrative Measures:

B2a. ***Behavioral Health (BH) Drugs with Behavioral Therapy:*** Percentage of any ADHD cases, aged 0–20 years, stratified by age and foster care status, with documentation of behavioral health pharmacotherapy (e.g., ADHD medication, antipsychotics, and/or other psychotropics), with behavioral therapy.
Baseline to final measurement goal: BH Drugs with Behavioral Therapy. Percentage of any ADHD cases, aged 0–20 years, stratified by age and foster care status, with documentation of behavioral health pharmacotherapy (e.g., ADHD medication, antipsychotics, and/or other psychotropics), with behavioral therapy will increase 2.4%, from 22.6% at baseline to 25% at final re-measurement. This target rate is above the upper 95% confidence interval.

B2b. ***BH Drugs without Behavioral Therapy:*** 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.
Baseline to final measurement goal: 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 will decrease 2.6%, from 57.6% at baseline to 55% at final re-measurement. This target rate is below the lower 95% confidence interval.

Intervention Summary:

- Interventions to address member barriers: The plan continues to work with members to increase recommended ADHD care. The Plan's IHCM team contacts members 6–12 and < 6 years of age to encourage appropriate follow-up with their provider and BH therapy, if ordered. The plan also distributes gift cards to the 6–12 years age group for follow-up visits. The MCO distributes educational letters to the 13–17 years old ADHD population. Outreach The plan contacts the 13–17 year old population diagnosed with ADHD, on BH drugs WITHOUT BH therapy, and who have a comorbidity. The goal of the outreach is to identify why members are not receiving BH therapy (identify barriers), also to identify their functional status because the member may not need therapy and also to identify if lack of BH providers is a barrier.
- Interventions to address provider barriers: The plan continues to work with providers to build a network of providers in all parishes of the state trained in evidence-based treatments for children 0–6 years (e.g., Child-Parent Psychotherapy [CPP] and Parent-Child Interaction Therapy [PCIT] and also provide behavior therapy training to providers (may include Positive Parenting Program [Triple P], Trauma-Focused Cognitive Behavioral Therapy [TF-CBT] and Parent Management Training [PMT]). The plan has sponsored Triple P training as well as hosted Preschool post traumatic stress disorder training for providers. The plan is working with providers to promote the American Academy of Pediatrics and PCP BH ADHD Toolkit. Provider network management is currently contacting the high-prescribing PCP providers to promote/educate the AAP ADHD toolkit. The Medical Neighborhood Initiative is evolving into Project Echo. "AmeriHealth is currently working on marketing this project to providers. The Medical Neighborhood initiative will be retired at this time and, once Project Echo is fully implemented, we will develop a process measure to support this initiative. The plan is also working to improve/enhance provider education for ADHD and also information on the Patient Health Questionnaire 9 initiative. AmeriHealth has developed an Integrated Health Care Screening Tool Flyer. This flyer explains what the Patient Health Questionnaire (PHQ) is and where it can be found on the plan's website. The flyer also explains that providers will be reimbursed for completing the screening and also how the screening should be billed. The plan's account executives will distribute the flyer when they make their provider visits.

Results/ Strengths:

- The rate for performance indicator A1, Validated ADHD Screening Instrument, increased from 18.33% at baseline to 22.22% at final re-measurement; however, improvement was not sustained due to the interim rate decrease to 16.67%, and the target rate of 37.9% was not met.
- The rate for performance indicator A7, MCO Care Coordination, increased from 3.39% at baseline to 9.09% at interim and to 22.22% at final re-measurement; thus, improvement was sustained; however, the target rate of 40% was not reached.
- The rate for performance indicator A8, MCO Outreach with Member Contact, increased from 16.67% at baseline to 18.18% at interim to 46.03% at final re-measurement and exceeded the target rate of 40%.
- The rate for performance indicator B1a, HEDIS ADD Measure: Initiation Phase, increased from 34.73% at baseline to 49.17% at final re-measurement and, although improvement was not sustained due to the final rate representing a decrease from the interim rate of 53.19%, the final rate did exceed the target rate of 42.19%.
- The rate for performance indicator B1b, HEDIS ADD Measure: Continuation Phase, increased from 45.15% at baseline to 64.98% at interim to 65.53% at final re-measurement; therefore, improvement was sustained. In addition, the final rate exceeded the target rate of 52.47%.
- The rate for Performance Indicator B2a, BH Drug with Behavioral Therapy, increased from 22.6% at baseline to 28.0% at interim to 29.3% at final re-measurement; therefore, improvement was sustained. In addition, the final rate exceeded the target rate of 25%.
- The rate for performance indicator B2b, BH Drug without Behavioral Therapy, showed sustained improvement with a decrease from a baseline rate of 57.6% to an interim rate of 48.8% to a final re-measurement rate of 48.6%, which fell below the target rate of 55% (lower rate represents better performance for this measure).
- The rate for the ITM for successful rapid response outreach calls to members ages 6–12 years increased from 25.9% in Q2 2017 2017 to 42.19% in Q2 2018.
- During each quarter of 2018, 100% of children < 6 years were mailed an educational letter; however, the denominators were small, ranging from 4 to -10 children. During all applicable quarters of 2018 (i.e., Q2–Q4), 100% of newly identified children with ADHD ages 13–17 years were mailed an educational letter; however, denominators for this subset of the population were small as well, ranging from 9 to 23 children.
- The plan implemented a care connector outreach intervention for children <6 years of age newly diagnosed with ADHD; however, contact rates during 2018 quarters declined from 83.3% (5 of 6) during Q3 to 12.5% (1 of 8) during Q4 2018.
- The plan has developed a PCP ADHD notification letter to inform PCPs when ADHD medication is prescribed by another physician, and includes guidelines for ADHD follow-up.

Opportunities for Improvement:

- Next steps address evidence-based practice (EBP) provider trainings for the 0–5 years age group while acknowledging the need to improve provider participation rates at provider trainings.
- Improve care connector outreach for children < 6 years of age newly diagnosed with ADHD.

Overall Credibility of Results: There were no validation findings that indicate the credibility of the PIP results is at risk.

Improving Rates for Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)

Indicators, Baseline Rates and Goals: The indicators, baseline rates and corresponding target rates for performance improvement from baseline to final re-measurement are shown in **Table 6**.

Table 6: Indicators, Baseline Rates, and Goals for IET

Submeasure	MY 2017 Rate	2018 QC	PIP Goal
Initiation for alcohol (13–17 years)	40.00%	50th	45.8% (2018 QC 75th percentile)
Engagement for alcohol (13–17 years)	16.00%	50th	21.22% (2018 QC 90th percentile)
Initiation for opioid (13–17 years)	83.33%		86.33% (No QC; 3% improvement)
Engagement for opioid (13–17 years)	33.33%		36.33% (No QC; 3% improvement)

Submeasure	MY 2017 Rate	2018 QC	PIP Goal
Initiation for other (13–17 years)	50.76%	50th	58.93% (2018 QC 90th percentile)
Engagement for other (13–17 years)	29.44%	90th	31.51% (2018 QC 95th percentile)
Initiation total (13–17 years)	49.32%	50th	56.67% (2018 QC 90th percentile)
Engagement total (13–17 years)	28.77%	90th	31.77% (3% improvement, above the 2018 QC 95th percentile)
Initiation for alcohol (18+ years)	41.35%	50th	44.76% (2018 QC 90th percentile)
Engagement for alcohol (18+ years)	10.09%	50th	13.41% (2018 QC 75th percentile)
Initiation for opioid (18+ years)	57.70%	75th	65.40% (2018 QC 90th percentile)
Engagement for opioid (18+ years)	23.16%	50th	31.52% (2018 QC 75th percentile)
Initiation for other (18+ years)	47.15%	50th	53.26% (2018 QC 90th percentile)
Engagement for other (18+ years)	12.69%	50th	17.91% (2018 QC 90th percentile)
Initiation total (18+ years)	45.15%	50th	50.49% (2018 QC 90th percentile)
Engagement total (18+ years)	12.93%	25th	17.61% (2018 QC 75th percentile)
Initiation for alcohol (all ages)	41.33%	50th	44.32% (2018 QC 75th percentile)
Engagement for alcohol (all ages)	10.16%	25th	13.51% (2018 QC 75th percentile)
Initiation for opioid (all ages)	57.85%	50th	65.22% (2018 QC 90th percentile)
Engagement for opioid (all ages)	23.22%	50th	31.47% (2018 QC 75th percentile)
Initiation for other (all ages)	47.33%	50th	52.70% (2018 QC 90th percentile)
Engagement for other (all ages)	13.53%	50th	18.42% (2018 QC 90th percentile)
Initiation total (all ages)	45.30%	50th	50.20% (2018 QC 90th percentile)
Engagement total (all ages)	13.50%	50th	17.73% (2018 QC 75th percentile)

MY: measurement year; QC: Quality Compass percentile; PIP: performance improvement project.

Intervention Summary:

- Interventions to address member barriers: AmeriHealth Caritas Louisiana developed robust interventions to address member barriers. New educational sessions were developed and conducted for internal associates on process flow and care coordination for IET members. To address member knowledge deficits, member education initiatives were implemented across various settings. Members are provided education and resources through integrated health care management (IHCM), community health navigators, and the Rapid Response Outreach Team (RROT). Additionally, IET education is provided during community events and at the AmeriHealth Caritas Wellness Centers. Based on the findings of the social determinant screenings, AmeriHealth Caritas designed action steps to support members in addressing their unmet social needs to improve health outcomes.
- AmeriHealth Caritas Louisiana has identified and targeted pilot practices to determine their willingness to participate in MAT and screening, brief intervention, and referral to treatment (SBIRT) trainings. The plan has partnered with American Society of Addiction Medicine (ASAM) for MAT training to expand primary care accessibility, as well as train OB, Emergency Room, FQHC, and urgent care providers. Additionally, the plan collaborates with providers on a continuous basis to encourage treatment and care of high-risk members such as pregnant members with adult-onset diabetes (AOD), and AOD members with high ER utilization and hospital admissions though provider outreach, education, and value-based contracting.

Results/ Strengths: Performance indicators that met or exceeded the target rate in the first quarter 2019 (reported April 2019) include the following:

- Indicator 1a.i. Initiation of AOD Treatment: age 13–17 years, alcohol abuse or dependence diagnosis cohort
- Indicator 1a.iii. Initiation of AOD Treatment: age 13–17 years, other drug abuse or dependence diagnosis cohort
- Indicator 1a.iv. Initiation of AOD Treatment: age 13–17 years, total diagnosis cohort
- Indicator 1b.i.Initiation of AOD Treatment: age 18+ years, alcohol abuse or dependence diagnosis cohort
- Indicator 1b.ii. Initiation of AOD Treatment: age 18+ years, opioid abuse or dependence diagnosis cohort
- Indicator 1b.iii. Initiation of AOD Treatment: age 18+ years, other drug abuse or dependence diagnosis cohort

- Indicator 1b.iv. Initiation of AOD Treatment: age 18+ years, total diagnosis cohort
- Indicator 1c.i. Initiation of AOD Treatment: Total age groups, alcohol abuse or dependence diagnosis cohort
- Indicator 1c.ii. Initiation of AOD Treatment: Total age groups, opioid abuse or dependence diagnosis cohort
- Indicator 1c.iii. Initiation of AOD Treatment: Total age groups, other drug abuse or dependence diagnosis cohort
- Indicator 1c.iv. Initiation of AOD Treatment: Total age groups, total diagnosis cohort

Opportunities for Improvement:
- Identify barriers to youth engagement and use barrier analysis findings to develop/ implement interventions.
- Enhance case management interventions to address engagement of serious mental illness subpopulation.

Overall Credibility of Results: Final PIP validation to be conducted upon IPRO receipt of the Final IET PIP Report due November 30th 2019.

Performance Measures: HEDIS 2019 (Measurement Year 2018)

MCO-reported performance measures were validated as per HEDIS 2019 Compliance Audit specifications developed by the National Committee for Quality Assurance (NCQA). The results of each MCO's HEDIS 2019 Compliance Audit are summarized in its Final Audit Report (FAR).

HEDIS Effectiveness of Care Measures

HEDIS Effectiveness of Care measures evaluate how well an MCO provides preventive screenings and care for members with acute and chronic illnesses. **Table 7** displays MCO performance rates for select HEDIS Effectiveness of Care measures for HEDIS 2017, HEDIS 2018, HEDIS 2019, Healthy Louisiana 2019 statewide averages, and Quality Compass 2019 National – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

Table 7: HEDIS Effectiveness of Care Measures – 2017–2019

Measure	AmeriHealth			Quality Compass 2019 National – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded	Healthy Louisiana HEDIS 2019 Average
	HEDIS 2017	HEDIS 2018	HEDIS 2019		
Adult BMI Assessment	79.91%	80.29%	87.04%	33.33rd	82.51%
Antidepressant Medication Management - Acute Phase	53.62%	78.30%	49.32%	25th	48.17%
Antidepressant Medication Management - Continuation Phase	39.34%	65.99%	34.28%	25th	32.56%
Asthma Medication Ratio (5-64 Years)	44.57%	56.15%	63.26%	33.33rd	64.08%
Breast Cancer Screening in Women	58.05%	58.88%	61.95%	50th	57.70%
Cervical Cancer Screening	61.54%	52.55%	56.34%	25th	56.41%
Childhood Immunization Status – Combination 3	65.21%	68.37%	65.45%	25th	70.99%
Chlamydia Screening in Women (16-24 Years)	64.42%	66.96%	66.90%	75th	66.19%
Comprehensive Diabetes Care - HbA1c Testing	86.86%	85.16%	88.08%	33.33rd	85.78%
Controlling High Blood Pressure	34.06%	30.17%	51.58%	10th	47.88%
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	45.15%	64.98%	49.17%	66.67th	50.65%
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	34.73%	53.19%	65.53%	75th	65.01%
Medication Management for People With Asthma Total - Medication Compliance 75% (5-64 Years)	33.73%	59.68%	34.20%	33.33rd	29.61%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile	48.91%	56.20%	75.18%	33.33rd	65.66%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	46.72%	51.58%	66.18%	33.33rd	58.66%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity	35.28%	43.07%	55.96%	25th	50.62%

HEDIS: Healthcare Effectiveness Data and Information Set; PPOs: Preferred Provider Organizations; EPOs: Exclusive Provider Organizations; BMI: body mass index; ADHD: attention deficit/hyperactivity disorder.

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 8** displays MCO rates for select HEDIS Access to/Availability of Care measure rates for HEDIS 2017, HEDIS 2018, HEDIS 2019, Healthy Louisiana 2019 statewide averages, and *Quality Compass* 2019 National – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

Table 8: HEDIS Access to/Availability of Care Measures – 2017-2019

Measure	AmeriHealth			Quality Compass 2019 National–All LOBs(Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded	Healthy Louisiana HEDIS 2019 Average
	HEDIS 2017	HEDIS 2018	HEDIS 2019		
Children and Adolescents' Access to PCPs					
12–24 Months	96.04%	96.14%	96.02%	50th	95.68%
25 Months–6 Years	86.92%	88.29%	88.27%	50th	88.36%
7–11 Years	87.88%	89.38%	90.75%	33.33rd	91.25%
12–19 Years	87.09%	88.77%	90.25%	50th	90.60%
Adults' Access to Preventive/Ambulatory Services					
20–44 Years	81.91%	75.57%	75.56%	33.33rd	76.81%
45–64 Years	88.93%	84.43%	84.54%	33.33rd	84.95%
65+ Years	77.34%	84.82%	85.96%	33.33rd	86.24%
Access to Other Services					
Prenatal Care	77.37%	72.21%	76.82%	10th	79.40%
Postpartum Care	57.11%	63.28%	66.15%	50th	67.63%

HEDIS: Healthcare Effectiveness Data and Information Set; PPOs: Preferred Provider Organizations; EPOs: Exclusive Provider Organizations.

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 9** displays MCO rates for select HEDIS Use of Services measure rates for HEDIS 2017, HEDIS 2018, HEDIS 2019, Healthy Louisiana 2019 statewide averages, and Quality Compass 2019 National – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

Table 9: Use of Services Measures – 2017–2019

Measure	AmeriHealth			Quality Compass 2019 National – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded	Healthy Louisiana HEDIS 2019 Average
	HEDIS 2017	HEDIS 2018	HEDIS 2019		
Adolescent Well-Care Visit	52.33%	50.73%	62.53%	66.67th	56.68%
Ambulatory Care Emergency Department Visits/1000 Member Months[1]	81.68	86.46	81.49	90th	75.02
Ambulatory Care Outpatient Visits/1000 Member Months	397.17	448.57	413.44	75th	413.54
Well-Child Visits in the First 15 Months of Life 6+ Visits	59.71%	56.91%	65.58%	33.33rd	63.22%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	62.76%	68.30%	71.39%	33.33rd	70.05%

[1] A lower rate is desirable.

HEDIS: Healthcare Effectiveness Data and Information Set; PPOs: Preferred Provider Organizations; EPOs: Exclusive Provider Organizations.

Member Satisfaction: Adult and Child CAHPS 5.0H

In 2019, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) 5.0H survey of adult Medicaid members and child Medicaid with chronic care conditions (CCCs) was conducted on behalf of AmeriHealth by the NCQA-certified survey vendor, SPH Analytics. 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 10, **Table 11,** and **Table 12** show AmeriHealth's CAHPS rates for 2017, 2018, and 2019, as well as Quality Compass 2019 National – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

Table 10: Adult CAHPS 5.0H – 2017-2019

Measure[1]	AmeriHealth			QC 2019 National – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded
	CAHPS 2017	CAHPS 2018	CAHPS 2019	
Getting Needed Care	81.89%	79.59%	82.77%	33.33rd
Getting Care Quickly	81.52%	80.36%	85.73%	75th
How Well Doctors Communicate	89.86%	92.19%	92.91%	50th
Customer Service	88.15%	90.87%	92.79%	90th
Shared Decision Making	75.84%	75.79%	81.18%	66.67th
Rating of All Health Care	69.92%	79.62%	72.14%	10th
Rating of Personal Doctor	78.30%	80.54%	83.08%	50th
Rating of Specialist	76.40%	83.80%	84.95%	66.67th
Rating of Health Plan	77.62%	75.86%	79.19%	50th

[1] 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."
Small sample: Result is not reportable by NCQA due to insufficient denominator (less than 100 responses).
CAHPS: Consumer Assessment of Healthcare Providers and Systems; PPOs: Preferred Provider Organizations; EPOs: Exclusive Provider Organizations.

Table 11: Child CAHPS 5.0H General Population – 2017–2019

Measure[1]	AmeriHealth			QC 2019National – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded
	CAHPS 2017	CAHPS 2018	CAHPS 2019	
Getting Needed Care	91.55%	93.26%	87.93%	66.67th
Getting Care Quickly	87.08%	92.60%	91.54%	50th
How Well Doctors Communicate	94.60%	95.06%	94.18%	50th
Customer Service	89.12%	92.10%	95.02%	95th
Shared Decision Making	76.17%	80.10%	73.22%	5th
Rating of All Health Care	87.44%	87.61%	87.21%	33.33rd
Rating of Personal Doctor	90.57%	88.40%	91.58%	66.67th
Rating of Specialist	87.10%	92.77%	91.04%	75th
Rating of Health Plan	89.04%	92.76%	88.89%	66.67th

[1] 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."
Small sample: Result is not reportable by NCQA due to insufficient denominator (less than 100 responses).CAHPS: Consumer Assessment of Healthcare Providers and Systems; PPOs: Preferred Provider Organizations; EPOs: Exclusive Provider Organizations.

Table 12: Child CAHPS 5.0H CCC Population – 2017–2019

Measure[1]	AmeriHealth			QC 2019National – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded
	CAHPS 2017	CAHPS 2018	CAHPS 2019	
Getting Needed Care	90.35%	90.35%	89.11%	66.67th
Getting Care Quickly	91.96%	91.24%	96.31%	95th
How Well Doctors Communicate	95.04%	95.33%	93.64%	10th
Customer Service	85.85%	94.47%	90.59%	75th
Shared Decision Making	86.17%	85.44%	81.43%	5th
Rating of All Health Care	88.84%	86.71%	86.24%	33.33rd
Rating of Personal Doctor	92.02%	89.42%	87.45%	10th
Rating of Specialist	89.58%	84.75%	84.38%	5th
Rating of Health Plan	88.58%	88.06%	86.22%	66.67th

[1] 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.
Small sample: Result is not reportable by NCQA due to insufficient denominator (less than 100 responses).
CAHPS: Consumer Assessment of Healthcare Providers and Systems; PPOs: Preferred Provider Organizations; EPOs: Exclusive Provider Organizations; N/A: not applicable.

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.

In the interest of report length only the MCO's response to question 5 detailing the interventions addressing disparities is reported here.

5. During 2018 and 2019, did the MCE conduct any studies or participate in any initiatives to do the following: Develop and/or implement interventions that aim to reduce or eliminate differences in health outcomes or health status and to improve the quality of care for MCE members identified with at-risk characteristics. If yes, describe impact of interventions.

MCO response: AmeriHealth develops and implements performance improvement projects (PIPs) guided by the monitoring of key performance indicators and quality activities, focusing on areas of concern or low performance, both clinical and service-related, identified through internal analysis and external recommendations. Internal performance targets, standards and external benchmarks are incorporated into internal key indicator monitoring and reporting to identify areas for additional analysis and, as necessary, implementation of performance improvement projects and corrective actions. Topics are chosen based on significance to the member population. Activities focus on improving rates for select HEDIS® measures integrated with health education programs, and completed on an annual basis. Interventions are based on the reporting year result, and the impact of the interventions is monitored in the subsequent year.

The following project(s) were targeted in 2019:

- Comprehensive Diabetes Care Intervention – Control Your Diabetes. Control Your Destiny.
- Focus: Improvement of HEDIS outcomes for African-American members in New Orleans and Shreveport, Louisiana.
- Goal: 2% improvement in HbA1c testing, retinal eye exams, and nephropathy screening for members in targeted ZIP codes.
- Interventions: Community and member-focused events where onsite exams were available.
- Outcome: All events executed as planned. AmeriHealth Caritas Louisiana's outcomes for Comprehensive Diabetes Care submeasures HbA1c testing and retinal eye exams have hit performance marks since 2017.

V. Compliance Monitoring

Medicaid Compliance Audit Findings for Contract Year 2019

IPRO conducted the 2019 Compliance Audit on behalf of the LDH. Full compliance audits occur every three years, with partial audits occurring within the intervening years. The 2019 annual compliance audit was a full audit of the MCO's compliance with contractual requirements during the period of April 1, 2018, through March 31, 2019.

The 2019 Compliance Audit included a comprehensive evaluation of AmeriHealth's policies, procedures, files and other materials corresponding to the following nine domains:

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

The file review component assessed the MCO's implementation of policies and its operational compliance with regulations related to complaints and grievances, member appeals, informal reconsiderations, care management (physical and behavioral health), utilization management, and provider credentialing and recredentialing.

Specifically, file review consisted of the following six areas:

1. Member Grievances
2. Appeals
3. Informal Reconsiderations
4. Case Management (behavioral and physical health)
5. Credential/Recredentialing
6. Utilization Management

Sample sizes for each file review type are presented in **Table 13**.

Table 13: File Review Sample Sizes

File Type	Sample Size
Member Grievances	15
Appeals	10
Informal Reconsiderations	5
Case Management (physical health)	10
Case Management(behavioral health)	10
Credential/Recredentialing	10
Utilization Management	10

For this audit, compliance determinations of "full," "substantial," "minimal," "non-compliance," and "not applicable" were used for each element under review. The definition of each of the review determinations is presented in **Table 14**.

Table 14: Review Determination Definitions

Review Determination	Definition
Full	The MCO is compliant with the standard.
Substantial	The MCO is compliant with most of the requirements of the standard but has minor deficiencies.
Minimal	The MCO is compliant with some of the requirements of the standard, but has significant deficiencies that require corrective action.
Non-compliance	The MCO is not in compliance with the standard.
Not applicable	The requirement was not applicable to the MCO.

MCO: managed care organization.

Summary of findings

Findings from AmeriHealth's 2019 Compliance Review follow. **Table 15** displays the total number of requirements reviewed for each domain, as well as compliance determination counts for each domain.

Table 15: Audit Results by Audit Domain

Audit Domain	Total Elements	Full	Substantial	Minimal	Non-compliance	N/A	% Full[1]
Core Benefits and Services	115	111	0	0	0	4	100%
Provider Network Requirements	184	163	15	5	0	1	89%
Utilization Management	87	87	0	0	0	0	100%
Eligibility, Enrollment, and Disenrollment	13	13	0	0	0	0	100%
Marketing and Member Education	83	80	2	0	0	1	98%
Member Grievance and Appeals	65	65	0	0	0	0	100%
Quality Management	114	113	1	0	0	0	99%
Fraud, Abuse, and Waste Prevention	118	116	0	0	0	2	100%
Reporting	1	1	0	0	0	0	100%
TOTAL	780	749	18	5	0	8	97%

[1] N/As are not included in the calculation.
NA: not applicable.

As presented in **Table 15**, 780 elements were reviewed for compliance. Of the 780, 749 were determined to fully meet the regulations, while 18 substantially met the regulations, 5 minimally met the regulations, and none were determined to be non-compliant. Eight (8) elements were determined to be not applicable. The overall compliance score for AmeriHealth was 97% elements in full compliance.

It is the expectation of both IPRO and the LDH that AmeriHealth submit a corrective action plan (CAP) for each of the 23 elements determined to be less than fully compliant, along with a timeframe for completion of the corrective action. Note that AmeriHealth may have implemented corrective actions for some of the areas identified for improvement while the audit was in progress, but these corrective actions will still require a written response because they were made after the period of review. The vast majority of the issues noted related to AmeriHealth's provider network adequacy (20 of the 23 elements rated less than fully compliant) and AmeriHealth's ability to contract with providers in several specialty and sub-specialty areas–a problem prevalent in the Louisiana Medicaid Managed Care program.

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:
  - Chlamydia Screening in Women (16–24 Years)
  - Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase
- **CAHPS (Member Satisfaction) –** AmeriHealth met or exceeded the 75th percentile for the following CAHPS measures:
  - Adult population
    - Customer Service
    - Getting Care Quickly
  - Child General population
    - Customer Service
    - Rating of Specialist
- Child CCC population
    - Getting Care Quickly
    - Customer Service

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
  - Antidepressant Medication Management - Acute Phase
  - Antidepressant Medication Management - Continuation Phase
  - Asthma Medication Ratio (5-64 Years)
  - Cervical Cancer Screening
  - Childhood Immunization Status – Combination 3
  - Comprehensive Diabetes Care - HbA1c Testing
  - Controlling High Blood Pressure
  - 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
  - Children and Adolescents' Access to PCPs
    - 7–11 Years
  - Adults' Access to Preventive/Ambulatory Services
    - 0–44 Years
    - 45–64 Years
    - 65+ Years
  - Access to Other Services
    - Prenatal Care
  - 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 population
    - Getting Needed Care
    - Rating of All Health Care
  - Child general
    - Shared Decision Making
    - Rating of All Health Care
  - Child CCC population
    - How Well Doctors Communicate
    - Shared Decision Making
    - Rating of All Health Care
    - Rating of Personal Doctor
    - Rating of Specialist

Recommendations

- Nineteen (19) of 30 HEDIS measures fell below the 50th percentile; the MCO should continue to evaluate the effectiveness of their current interventions. Low performing HEDIS measures have generally seen improvement from the prior year indicating some success of MCO interventions.

- The MCO should continue to work to improve CAHPS® scores that perform below the 50th percentile.
  - The MCO should develop specific interventions to address the worst performing CAHPS measures:
    - Child General population: Shared Decision Making (<10th percentile)
    - Child CCC population:
      - Shared Decision Making (<10th percentile)
      - Rating of Specialist (<10th percentile)

MCO's Response to Previous Recommendations (2019)

Recommendation: 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, because the MCO's performance for a variety of HEDIS measures has declined, routine monitoring of the effectiveness of the overall intervention strategy is recommended.

MCO's response: AmeriHealth Caritas Louisiana's quality improvement activities are aligned with the Triple Aim to ensure that our members receive high-quality, efficient care. As an organization, we promote a culture of quality through plan-wide quality activities and communications, all-employee trainings, and a "quality is everyone's job" mindset. We tailor our QM/QI activities to the needs of Louisiana's communities, providers, and members.

The plan continually strives to exceed the NCQA Quality Compass 50th percentile in HEDIS metrics and monitors rates to identify trends and opportunities for improvement. Month-over-month trending and benchmarking against Quality Compass are used to drive root cause analyses when areas for improvement are identified. The Plan-Do-Study-Act (PDSA) model is used to evaluate effectiveness of interventions and modifications are made, as needed.

The plan partners with providers to expand the focus on quality care and reduce low-value care. We acknowledge our providers as true partners in our quest for the delivery of quality care, and are leading delivery system and payment reform by investing in and supporting providers to improve quality and reduce costs. Our comprehensive provider support strategy is designed to give providers the training, technology, data, and alternative payment methods needed

to provide quality care. Provider dashboards are used to monitor provider performance and, through this analysis, practices are targeted for outreach. Our multidisciplinary team provides education, addresses needs, and dialogues with practices about opportunities for improvement based on performance report cards. Providers receive alerts on care gaps and are able to access detailed care gap reports. Additionally, resources are provided to assist practices in following evidenced-based practice guidelines and optimizing quality enhancement program payments.

Our bi-weekly Health Outcomes Workgroup provides a formal process to monitor and review plan-wide performance improvement initiatives for effectiveness, as well as to provide oversight of initiative implementation and rollout. The workgroup includes our CEO, CMO, COO, quality director, population health director, member services director, and provider supports director, among other key topic specific participants. The workgroup ensures that HEDIS performance objectives are adequately addressed and that health initiatives remain on task. Moreover, monthly interdepartmental workgroups are held with department subject matter experts to communicate barriers, modify/develop interventions, and evaluate intervention effectiveness.

At the end of each calendar year, AmeriHealth Caritas Louisiana conducts an evaluation of the QM/QI program. This evaluation is data-driven, and entails a comprehensive review and analysis of trends and outcomes for all clinical and service performance measures, performance improvement projects, and other studies and activities. Elements that are used in the evaluation of the effectiveness of specific improvement activities include whether they achieved statistically significant improvement, and/or whether they resulted in meeting the objectives for the initiative. Furthermore, this evaluation assesses the impact of the QM/QI program on health outcomes, experience, and per capita cost. Through this evaluation, AmeriHealth Caritas Louisiana identifies new and existing barriers and missed opportunities for improvement.

AmeriHealth Caritas Louisiana promotes wellness and prevention by engaging and empowering members to seek preventive care, complete age-appropriate screenings, and make healthy choices. We connect with members through numerous avenues such as face-to-face encounters, texting campaigns, telephonic outreach, social media, wellness days, mail reminders, and community events. Additionally, our community wellness centers host a variety of member- and community-focused activities to promote prevention and wellness. Our organization strives to improve management and control of chronic diseases by equipping members to effectively self-manage chronic conditions through tools, education, and care coordination. For example, telemonitoring platforms, mobile applications and remote monitoring are used to improve clinical outcomes and empower members to control the daily management of chronic diseases such as diabetes and hypertension. These tools, coupled with case management, increase the likelihood of positive changes in behavior and improve early detection of key clinical warnings.

AmeriHealth Caritas Louisiana is committed to improving the quality of mental health and substance use disorder (SUD) care. The plan has partnered with American Society of Addiction Medicine (ASAM) for Medication-Assisted-Training (MAT) training to expand primary care accessibility. The plan collaborates with providers on a continuous basis to encourage treatment and care of high-risk members. Our population health department works closely with this population to provide case management and ensure care coordination.

AmeriHealth Caritas Louisiana aims to improve coordination and transitions of care for members by ensuring appropriate follow-up care after ED visits and hospitalizations through effective care coordination and case management. Initiatives include expanding education, outreach, and referral programs to address barriers and improve coordination of care. Embedded discharge/transition case managers address member discharge needs and barriers; coordinates with UM and hospital staff; refer members to the next level of care; assist with post-hospital follow-up appointments, and link members to community resources. The plan's Care Extender Program is available for members identified with behavioral health diagnoses who have high ED utilization and/or inpatient readmissions. Admission, discharge and transfer (ADT) feeds are used to provide timely access to member utilization of hospitals for ER visits, which allows for notification to case managers and referrals to rapid response to quickly engage members as well as direct alerts to the provider portal. Additionally, numerous initiatives have been implemented to improve follow-up care for members after hospitalization for mental illness, such as peer support outreach while inpatient, community health navigator outreach post-discharge, and provider collaboration.

AmeriHealth Caritas Louisiana compares results of the data assessments to benchmarks, and conducts segmentation analysis by diagnosis, age, race and ethnicity, parishes where members reside, and provider/facility access and availability. These analyses help us better understand utilization patterns and barriers to receiving the right care, in the right place, at the right time. Examples of these barriers include lack of availability of needed services or access to appropriate care, or issues associated with specific social determinants of health. Our analyses also help detect potential areas to improve over- and underutilization rates and identify appropriate interventions to address deficiencies.

AmeriHealth Caritas Louisiana acknowledges that there has been a decline in a variety of the plan's HEDIS measures, and the outlined strategy supports how the organization monitors the effectiveness of the overall intervention strategy. The plan modifies the strategy as opportunities for improvement are identified.

Recommendation: 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.

MCO's response: AmeriHealth Caritas Louisiana will continue with the interventions outlined in the previous access improvement strategy. The plan added a presentation on the requirements for access and availability during the provider trainings in October and November 2019. The account executives are equipped with a flyer and PowerPoint deck to assist them with educating providers during site visits, with special attention to those providers who are non-compliant per the 2019 survey. The results of the 2019 survey are being used to educate providers who were non-compliant in 2018 and 2019 who may receive a corrective action plan. Account executives routinely communicate availability and accessibility standards, including appointment requirements for routine, urgent, emergent care, prenatal, and specialty behavioral health services. These requirements are also communicated via the provider handbook, provider portal, on-site presentations for newly credentialed providers, continuing education, and provider newsletters. We are using the results of the 2019 survey to educate providers on best practices and protocols to address root causes for deficiencies, such as insufficient staff or time constraints. We are also educating providers on what the requirements of after-hours voicemail or answering service and encouraging providers to direct enrollees to urgent care rather than the ED, when appropriate, and to communicate expected call-back time to enrollees. Urgent care centers serve as a bridge between enrollees' primary care physicians and needed care after hours and on weekends.

Recommendation: 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 analyses 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.

MCO's response: AmeriHealth 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. AmeriHealth continued its CAHPS workgroup of multidisciplinary internal departments.

The general population survey results reflect an overall decrease in scores: however, even with the decrease in component rates from the previous year, 6 of the 10 components goals were met at achieving the Quality Compass 50th Percentile. With N/A determinations obtained for 4 of the components (Shared decision making, How well doctors communicate, Customer service, and Rating of specialist), plans are to increase the sample size for future survey to ensure a sufficient sample size > 100.

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

- initiatives focused on internal health plan staff awareness;
- updating all member-facing end-of-call scripting and ensuring year-round CAHPS-centered initiatives are completed to help improve both member satisfaction as well as retention;
- analyze complaints received by customer service regarding inability to receive care;

- developing "leave behind" material for providers related to the clinical liaison role;
- incorporating informative articles into the plan's member newsletters; and
- continued focus on CAHPS in provider education trainings.

Recommendation: 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)?

MCO's response: AmeriHealth Caritas Louisiana used data-driven barrier analyses to determine key demographic and pertinent clinical subsets to address high-volume and high-risk members within the Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) Population.

Based on our data-driven barrier analyses, the plan identified 3% of our total population as having Alcohol or Other Drug (AOD) dependence. Forty-seven percent (47%) of the total eligible population is female and 53% is male. Although the population identifies more males, the female engagement rate is slightly lower. The male engagement rate is 15%, while the female engagement rate is 13%. Of the 47% female population, 3% are 13–17 years old and 97% are 18 years of age and over. Black and white females (91%) account for the majority of the eligible engagement population: 41% and 59%, respectively. Black females, 13–17 years old, had 9% total engagement while white females had 10%. Black females, 18 years of age and over, had 5% engagement and white females had 8% engagement. Females 18 years of age and over with AOD represent a larger population but lower engagement rate. Our subset populations with high-risk conditions and high utilization were identified as:

1. Pregnant Females with Alcohol or Other Drug Dependence/Substance Use Disorder (AOD/SUD): AOD/SUD during pregnancy is associated with an increased risk of adverse outcomes. It is imperative to identify pregnant members with AOD/SUD as early as possible to decrease the risks of obstetrical complications and birth defects. We identified 394 members who were either pregnant in the measure year or currently pregnant. Pregnant females constitute 13% of the eligible female population, which is equal to the total engagement rate for eligible females. Of the subset population, 33% are currently pregnant, which is more than the total engagement rate in the eligible female and male population.
2. Severe Mental Illness/Substance Use Disorder (SMI/SUD) Diagnosis: Schizophrenia, Bipolar Disorder and Major Depression: The plan identified 1,874 (29%) members with an SMI/SUD diagnosis: schizophrenia, bipolar disorder and major depression. Members in this high-risk population are also high utilizers that frequented the emergency department (ED) four or more times with at least two or more inpatient hospitalizations. Of those members, only 4% are actively engaged in case management. Members with SMI/SUD face an increased risk of having chronic medical conditions. Adults living with serious mental illness die, on average, 25 years earlier than others, largely due to treatable conditions.
3. AOD/SUD Members with ED and Inpatient Hospital Utilization: The plan identified 1,425 (22%) members as high utilizers with four or more ED visits and noted that only 8% are engaged in case management. Additionally, the plan identified 916 (14%) members as high utilizers with two or more inpatient hospitalizations and, of these, only 9% are engaged in case management. High utilization in members with AOD/SUD is often associated with homelessness, accessibility, and quality care.

Recommendation: Future PIPs: 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.

MCO's response: Using an Ishikawa fishbone diagram, AmeriHealth Caritas Louisiana conducted a root cause analysis to identify barriers and develop interventions to improve the HEDIS measure rates for Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET).

Barriers: According to the findings in the 2018 Behavioral Health Member Satisfaction survey, members being treated for alcohol and drug use are less likely to report that they are involved as much as they would like to be in their counseling and treatment. Members identified the inability to be involved in counseling and treatment due to social determinants of health. AmeriHealth Caritas Louisiana assesses member social determinants of health through a survey; however, the IET population is difficult to reach/locate during outreach attempts and has a low case management engagement rate. Providing education relative to treatment regimens and addressing social determinants of health is difficult due to the low contact rates. Subpopulations often face additional challenges in getting care. AOD/SUD during pregnancy is associated with an increased risk of adverse outcomes. Many providers are unwilling or reluctant to treat high-risk populations. Providers lack education relative to the treatment and engagement of the AOD population. The limited number of providers and resources available for behavioral health members was identified as an opportunity for improvement through provider feedback at the primary care level. The plan has limited trained staff and providers who have screening, brief intervention, and referral to treatment (SBIRT) and/or medication-assisted treatment (MAT) training. Lack of trained providers creates barriers for members and their access to care for behavioral health services. Additionally, providers reported challenges in attending trainings due to the length of the trainings and time out of office.

Interventions: AmeriHealth Caritas Louisiana developed robust interventions to address member barriers. New educational sessions were developed and conducted for internal associates on process flow and care coordination for IET members. To address member knowledge deficits, member education initiatives were implemented across various settings. Members are provided education and resources through integrated health care management (IHCM), community health navigators, and the rapid response outreach team (RROT). Additionally, IET education is provided during community events and at the AmeriHealth Caritas wellness centers. Based on the findings of the social determinant screenings, AmeriHealth Caritas designed action steps to support members in addressing their unmet social needs to improve health outcomes. The plan identified and targeted pilot practices to determine their willingness to participate in MAT and SBIRT trainings. The plan has partnered with American Society of Addiction Medicine (ASAM) for MAT training to expand primary care accessibility, as well as train OB, ER, FQHC, and urgent care providers. Additionally, the plan collaborates with providers on a continuous basis to encourage treatment and care of high-risk members, such as pregnant members with AOD, and AOD members with high ER utilization and hospital admissions, though provider outreach, education and value-based contracting.

Recommendation: Future PIPs – 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 analyses and use findings to modify interventions.

MCO's response: The plan developed numerous ITMs to inform effectiveness and drive modifications to interventions:

- Num: # of providers who complete MAT training/Denom: # of providers outreached
- Num: # of providers who complete SBIRT training/ Denom: # providers outreached
- Num: : # internal associates who received training on process flow and care coordination/Denom: Total number of internal associates/new hires within UM/CM/BH community navigators/Bright Start/Community Outreach
- Num: # members in a crisis who received resources/ Denom: # members who complete SDOH survey
- Num: # pregnant/AOD members who engage in treatment and case management (Cumulative based on IET Denominator)/ Denom: # pregnant/AOD members
- Num: AOD Pregnant members referred to case management (Cumulative based on IET denominator; removed if already in CM)/ # Denom: AOD pregnant members

- Num: AOD pregnant members referred to case management with a successful contact (Cumulative based on IET denominator; removed if already in CM)/Denom: #AOD pregnant members referred to CM
- Num: # of members with SMI/SUD that engage in case management (Cumulative based on IET denominator)/ Denom: # SMI/SUD members
- Num: # AOD SMI/SUD members referred to case management (Cumulative based on IET Denominator; Removed if already in CM)/ Denom: # AOD SMI/ SUD members
- Num: # AOD SMI/SUD members referred to case management with a successful contact (Cumulative based on IET denominator) / Denom: # AOD SMI/SUD members referred to case management
- Num: # AOD high ED utilizers engaged in case management (Cumulative based on IET denominator) / Denom:# AOD high ED utilizers
- Num: # AOD high ED utilizers referred to case management (Cumulative based on IET denominator); removed if already in CM / Denom: # AOD high ED utilizers
- Num: # AOD High ED utilizers referred to case management with a successful contact (Cumulative based on IET denominator) / Denom: # AOD high ED utilizers referred to case management

Recommendation: 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.

MCO's response: Through the course of the plan's PIPs, Plan-Do-Study-Act cycles are used as a tool to evaluate effectiveness of interventions and drive modifications and change. Additionally, IHI run charts are used to monitor how well processes are performing. Through data patterns, the plan determines if improvements are truly achieved. Successful processes are represented through flowcharts for visualization.