AmeriHealth Caritas
VIP Care Plus

2018 Quality Report

AmeriHealth Caritas VIP Care Plus (Medicare-Medicaid Plan) has a Quality Assessment and Performance Improvement (QAPI) program to monitor the quality of services our members receive. In partnership with our network providers, we aim to make sure health care and services our members receive are:

- High quality
- Safe
- Appropriate
- Efficient
- Effective

Our mission is to help people get care, stay well, and build healthy communities by creating programs to serve our members who have special health care needs. AmeriHealth Caritas VIP Care Plus remains committed to a seamless member experience with access to high quality, coordinated and culturally competent clinical care and services across the care continuum, to decrease the burden of disease and improve health outcomes.

We review our QAPI program every year to evaluate how we are doing. This review includes analysis of whether the quality of health care and services for our members has improved as a result of the QAPI program activities and interventions. It provides the foundation to identify goals for the following year.

Below is a summary of the evaluation of the 2018 QAPI program for AmeriHealth Caritas VIP Care Plus. The evaluation identified both successes and continuing opportunities for improvement within the Plan's strategies and interventions.

Key Metrics Summary

As a critical element of the QAPI program, Plan leadership identifies performance and quality metrics within multiple departments and/or functional areas, benchmarks, and corresponding data sources and tracking mechanisms. The continuous improvement methodology of Plan-Do-Study-Act (PDSA) is applied to develop or revise action plans when benchmarks are not met.

Improve Access to Essential Services – Partially met

1. Adults' Access to Preventive/Ambulatory Health Services
    - Rate improved 2% from CY2017, did not meet benchmark.
2. PCP Network Adequacy: Minimal Time and Distance
3. High Volume Specialists Network Adequacy: Minimal Time and Distance
4. Medicare Provider Network: Network will meet CMS MMP Network Standards
    - All network measures met 100% benchmark.

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Improve Coordination of Care – Not met

1. Percent of members with documented discussions of care goals in the care plan.
    - Rate improved 28% CY2017, did not meet benchmark.
2. Percent of new members with an assessment completed within 90 calendar days of enrollment.
    - Rate improved 12% from CY2017, did not meet benchmark.
3. Percent of members with an annual reassessment.
    - Rate improved 28%, did not meet benchmark.
4. Percent of members with a care plan completed within 90 days of enrollment.
    - Rate decreased 7% from CY2017, did not meet benchmark.

Improve Seamless Transitions of Care – Partially met

1. Percent of members who had follow up with a mental health practitioner within 30 days of discharge after hospitalization for mental illness.
    - Rate improved 7.5% from CY2017, did not meet benchmark.
2. Percent of members discharged from a hospital stay who were readmitted within 30 days.
    - Met benchmark of Observed/Expected (O/E) ratio less than 1.0.
3. Care Transition Record: Percent of members discharged from an inpatient facility for whom a transition record was transmitted timely to the next provider of care.
    - Met benchmark of timely submission of report and required narrative.
4. Percent of members with a follow up visit within 30 days of hospital discharge.
    - Rate improved 12% from CY2017, exceeded benchmark.
5. Percent of members reassessed within 3 business days following inpatient discharge.
    - Rate improved 61% CY2017, exceeded benchmark.
6. Number of members who transitioned from long term care to community setting
    - Final result of 9 members exceeded benchmark of 8.

Improve Access to Preventive Health Services – Partially met

1. Percent of members who report having received a flu shot prior to flu season.
    - Rate unchanged from CY2017, did not meet benchmark.
2. Medication review all members.
    - Rate 100%, exceeded benchmark.

Improve Health Outcomes – Not met

1. Percent of members who fill their diabetes medication prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.
    - Rate decreased 3% from CY2017, did not meet benchmark.
2. Percent of members who fill their cholesterol medication prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.
    - Rate decreased 3% from CY2017, did not meet benchmark.
3. Percent of members who fill their blood pressure medication prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.
    - Rate increased 3% increase from CY2017, did not meet benchmark.

Improve Appropriate Utilization of Services – Partially met

1. Emergency department visits for ambulatory care sensitive conditions
    - Rate improved by 7% from CY2017, did not meet benchmark.
2. Ambulatory care sensitive hospital admissions (lower rate is better)
    - Rate increased 56% from CY2017, did not meet benchmark.
3. Nursing Facility Diversion
    - Rate decreased 10% from CY2017, did not meet benchmark.
4. Monitor appropriateness of the medical necessity determinations for utilization management.
    - Final rate 95.5% exceeded benchmark of 90%.

Healthcare Effectiveness Data and Information Set (HEDIS®)

HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

HEDIS® is a set of measures used in the healthcare industry to provide information on performance related to care and service. HEDIS data is evaluated year-over-year to identify trends, patterns and variances. The data is obtained through claims and review of medical records. We thank our network providers and their staff for assistance in providing requested medical record documentation to support HEDIS reporting.

The following is noted for CY2018 results in comparison to CY2017 for measures significant to our Plan population:

Staying Healthy Measures

- Breast Cancer Screening: Rate remained consistent at 47%
- Colorectal Cancer Screening: Rate improved 5%
    - The Plan offers an in-home testing option, which contributed to the increased rate.

Managing Chronic (Long-Term) Conditions Measures

Behavioral Health

- Follow-Up after Hospitalization for Mental Illness: Rate improved 7.5%
- Antidepressant Medication Management, Continuation Phase: Rate improved 9%

Cardiovascular

- Controlling Blood Pressure: Rate improved 3%

Diabetes

- HgbA1c Testing: Rate improved 0.5%
- Eye Exam: Rate improved 4%
- Medical Attention for Nephropathy: Rate remained consistent at 90%

Care of Older Adults

- Functional Status Assessment: Rate improved 6%
- Medication Review: Rate improved 4%
- Pain Assessment: Rate decreased 5%

Consumer Assessment of Health Plans and Systems (CAHPS®) Survey
CAHPS is a program of the Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services.

The CAHPS® Survey contains standardized questions that ask members to evaluate their experiences with a wide range of health care services received within the last six months.

Comparison of CY2018 results to CY2017:

- Health Plan Customer Service: 3% improvement
- Getting Needed Prescription Drugs: 3% improvement
- Care Coordination from Doctor's Office: 2% improvement
- Getting Needed Care remained consistent at 80%
- Getting Appointment and Care Quickly remained consistent at 76%
- Rating of Health Care Quality remained consistent at 84%
- Rating of Drug Plan remained consistent at 86%

Chronic Care Improvement Program (CCIP)
Completed final review for the Centers for Medicare and Medicaid Services (CMS) for the three-year Chronic Care Improvement Program that focused on Reducing Cardiovascular Disease. Rate of adherence for cholesterol (statin) medications was 75%, meeting the CCIP goal.

Quality Improvement Project (QIP)
The Plan completed three-year project "Reducing Avoidable Hospitalizations". Improvement was noted in all metrics: Readmission rate decreased 3%; transition of care program intervention rate increased 3%; and rate of follow up with primary care provider after discharge increased 13%.

Clinical Practice Guidelines
The Plan has adopted clinical practice guidelines for use in guiding the treatment of our members with the goal of reducing unnecessary variations in care. The clinical practice guidelines represent current professional standards, supported by scientific evidence and research. The guidelines are intended to inform, not replace, a practitioner's clinical judgment.

The Plan monitors practitioner use of clinical practice guidelines through analysis of HEDIS and other metric performance rates in addition to gaps in care. The guidelines are available at http://www.amerihealthcaritasvipcareplus.com/provider/resources/clinical/guidelines.aspx

Provider Collaboration Improvement
We implemented a monthly Provider Performance Report and HEDIS non-compliant member list for Review by every primary care provider. The Provider Performance Report includes several HEDIS/Medicare Stars measures and indicates the provider's current rates based on their member population.