Report Highlights

Department of Health and Hospitals CommunityCARE Program

January 2002

Louisiana Legislative Auditor

Daniel G. Kyle, Ph.D., CPA,CFE

Legislative Auditor

The Department of Health and Hospitals (DHH) oversees Louisiana's only Medicaid managed care program, CommunityCARE. The CommunityCARE program was established in 20 rural parishes to provide more efficient and cost-effective services to Medicaid recipients. The program is also to provide recipients with increased access and quality of care. The overall program goal is to reduce health care costs by encouraging more appropriate use of health services.

In state fiscal year 2000, DHH estimated that CommunityCARE served approximately 75,000 recipients at a cost of $115.4 million. DHH's CommunityCARE staff of three oversee a private contractor, Birch & Davis Health Management Corporation. Birch & Davis administers the daily operations of the program. In calendar year 2000, the contract cost plus DHH's administrative expenses were approximately $1.5 million.

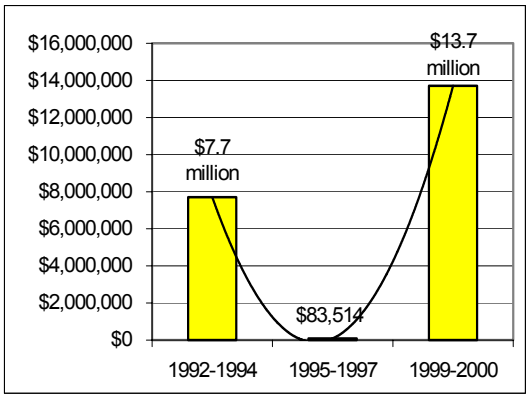
Audit Results

- DHH has not established a formal process to monitor the Birch & Davis contract.
- DHH's monitoring efforts have little impact on ensuring provider compliance or appropriateness of patient treatment.
- DHH estimates show fluctuating savings in the CommunityCARE Program.
- The CommunityCARE staff do not monitor for unnecessary utilization of health services.
- CommunityCARE seems to have reduced the use for emergency room doctor services for Temporary Assistance to Needy Family (TANF) recipients in calendar year 2000.

COST SAVINGS AND APPROPRIATE USE OF SERVICES

What We Found

- DHH estimates show inconsistent savings. The chart below shows that DHH estimates the CommunityCARE program saved $7.7 million from 1992 to 1994, $83,514 from 1995 to 1997, and $13.7 million from 1999 to 2000.



- Baseline methodology used by DHH may inflate DHH's savings projections.

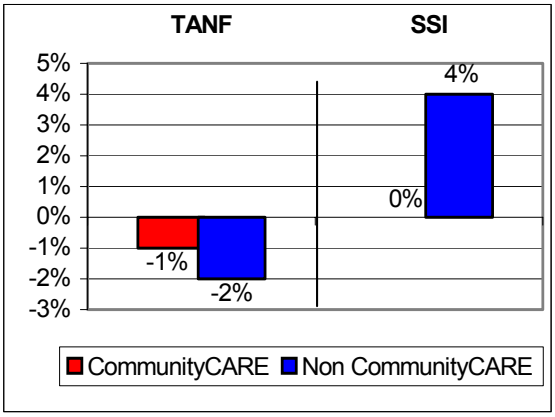
- CommunityCARE's statewide expansion may save money, but the amount is indeterminable because of the following factors:

  - Potential cuts and/or reinstatements of covered Medicaid services
  - Future increases/decreases in the monthly management fee and the Medicaid reimbursement rates paid to providers
  - Increase in number of eligibles (including Louisiana Children's Health Insurance Program eligibles)
  - Increases/decreases in the number of participating providers

- The CommunityCARE staff does not monitor for unnecessary utilization of services.

  - DHH does not use its monthly utilization reports to monitor providers for potential over-utilization.
  - In ten months of calendar year 2000, 107 providers exhibited 216 instances where the number of services they provided exceeded the overall average number of services per hundred patients.

- Health services utilization patterns for TANF and Supplemental Security Income (SSI) populations differ. For TANF recipients, the average decrease in services utilization in CommunityCARE parishes for calendar year 1998 to 2000 was 1%. The average decrease in Non CommunityCARE parishes for the same time period was 2%. For the SSI population, the health care services utilization in CommunityCARE parishes for calendar year 1998 to 2000 stayed constant, while Non CommunityCARE parishes increased 4% in the same time period.



- CommunityCARE seems to have a reduced use of emergency room services in calendar year 2000 for its TANF recipients.

Recommendations

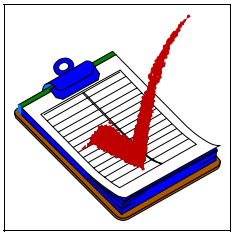
✓ Instead of an average number of services per patient, DHH should set a utilization standard to measure providers against. DHH should also require that providers give explanations when services exceed this standard.

✓ DHH should ensure that the baseline methodology for calculating cost savings considers the differences between rural and urban parishes.

MONITORING

What We Found

➲ DHH does not follow an established process to monitor the Birch & Davis contract.



- ♦ DHH does not review monthly reports sent by its contractor or ensure that reports are received timely.
- ♦ The contract requires penalties when the contractor fails to achieve performance standards outlined in the contract. However, because of a lack of monitoring and oversight by DHH staff, there is no way to be sure that work was performed when promised or that penalties have been assessed, if necessary.

➲ DHH's monitoring efforts have little impact on ensuring provider compliance.

- ♦ In a review of 296 monitoring visits done in calendar years 1999 and 2000, we found that 62% of providers had documentation compliance deficiencies of some type.

After two consecutive years of monitoring and educational efforts by Birch & Davis, 48% of these providers continued to demonstrate the same or similar problems.

- ♦ Of the 296 monitoring visits, 165 required a plan of corrective action by the provider to correct deficiencies. Upon a validation visit by Birch & Davis, 55% of the providers continued to have the same deficiencies as noted in the prior annual monitoring visit.

➲ Birch & Davis' monitoring of providers does not ensure appropriateness of patient treatment.

- ♦ Both DHH and Birch & Davis report that they do not check for the appropriateness of treatment as called for in the Health Care Financing Administration (HCFA) waiver renewal. Instead, they only check for documentation in provider files.

Recommendations

✓ DHH should establish a formal method to ensure that Birch & Davis' annual monitoring and validation visits are conducted as contracted. In addition, DHH should ensure that all contract and waiver requirements are met.

✓ DHH should clearly define and begin monitoring the appropriateness of treatment outcomes and referrals as called for in the waiver.

✓ DHH should re-evaluate the value of the monitoring activities currently conducted by the contractor to determine how the process could be made more beneficial for recipient care.

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STATE OF LOUISIANA
LEGISLATIVE AUDITOR

Department of Health and Hospitals
CommunityCARE Program

January 2002

Performance Audit

Daniel G. Kyle, Ph.D., CPA, CFE
Legislative Auditor

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Department of Health and Hospitals
CommunityCARE Program

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Performance Audit
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State of Louisiana

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January 23, 2002

The Honorable John J. Hainkel, Jr.,
President of the Senate
The Honorable Charles W. DeWitt,
Speaker of the House of Representatives

Dear Senator Hainkel and Representative DeWitt:

This report gives the results of our performance audit of the Department of Health and Hospitals' CommunityCARE program. The audit was conducted under the provisions of Title 24 of the Louisiana Revised Statutes of 1950, as amended.

This performance audit report contains our findings, conclusions, and recommendations. Appendix C contains the department's response. I hope this report will benefit you in your legislative decision-making process.

Sincerely,

Daniel G. Kyle, CPA, CFE
Legislative Auditor

DGK/ss

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Office of Legislative Auditor

Performance Audit
Department of Health and Hospitals - CommunityCARE Program

Executive Summary

The Department of Health and Hospitals (DHH) oversees Louisiana's only Medicaid managed care program, CommunityCARE. In state fiscal year 2000, DHH estimated that CommunityCARE served 75,000 recipients at a cost of $115.4 million. A private contractor, Birch & Davis Health Management Corporation, administers the daily operations of the program. The contractor administers recipient outreach/enrollment/linkage, annual monitoring of providers and data compilation/report generation. In calendar year 2000, the contract amount plus DHH administrative expenses cost approximately $1.5 million.

This performance audit reviews the annual monitoring of providers, projected cost-savings and the quality/appropriate use of services provided through the CommunityCARE program vs. traditional Medicaid services. The results are as follows:

Cost Savings: *(See pages 8 through 11 of the report.)*

- Flawed methodology shows fluctuating and potentially inflated cost savings.
  - DHH estimates show fluctuating savings.
  - Baseline methodology may inflate savings projections.
- CommunityCARE expansion should save money, but the amount is indeterminable.

Appropriate Use of Services: *(See pages 11 through 15 of the report.)*

- CommunityCARE staff do not monitor for unnecessary utilization of services.
- Utilization data for TANF and SSI populations differ.
- CommunityCARE seems to reduce emergency room services in calendar year 2000.

Monitoring: *(See pages 17 through 21 of the report.)*

- DHH has an informal process to monitor the Birch & Davis contract.
- Birch & Davis' annual monitoring has little impact on ensuring provider compliance.
- Birch & Davis' annual monitoring of providers does not ensure appropriateness of patient treatment.

Daniel G. Kyle, Ph.D., CPA, CFE, Legislative Auditor
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Introduction

Audit Initiation and Objectives

Louisiana Revised Statute (R.S.) 24:513(D)(2) directs the Legislative Auditor to conduct performance audits, program evaluations, and other studies to enable the legislature and its committees to evaluate the efficiency, effectiveness, and operations of state programs. The National State Auditors Association (NSAA) is currently conducting a national audit on Medicaid managed care. However, the NSAA audit focuses on capitated, full-risk managed care arrangements and Louisiana does not currently have this type of arrangement. Therefore, we conducted a performance audit of Louisiana's primary care case management (PCCM) arrangement called CommunityCARE, which is administered by the Department of Health and Hospitals (DHH). The audit scope and methodology are described in Appendix A. The audit objectives are as follows:

1. **Is CommunityCARE meeting its goals of cost savings and appropriate use of health care services?**
   - Has the program saved the state money?
   - Has the program resulted in more appropriate use of health care services?
2. **Do DHH's monitoring efforts ensure that the CommunityCARE waiver requirements are met?**
   - Does DHH's monitoring of the Birch & Davis contract ensure that Birch & Davis is meeting its work plan obligations?
   - Does Birch & Davis' monitoring of providers ensure that providers adhere to CommunityCARE waiver requirements?

Medicaid Managed Care

Medicaid is a jointly funded, federal-state health insurance program for certain low-income needy people. In 1999, the Health Care Financing Administration (HCFA) reported that Medicaid covered approximately 42 million Americans at a cost of $154.3 billion. Medicaid recipients include children, the aged and/or disabled, and people who are eligible for medical assistance because of low income.

Over the last decade, rising costs of health care have created a need for state Medicaid agencies to shift from traditional Medicaid systems to some type of managed care system. According to the DHH's 1998-99 Annual Report on the state's Medicaid program, managed care is the coordination of health care for maximum benefit and to avoid duplication, unnecessary or dangerous combinations of care. The Kaiser Commission on Medicaid (an independent organization that studies and reports on health care issues) states that managed care is designed to reduce health care costs by eliminating inappropriate and unnecessary services and relying more heavily on primary care and coordination of care.

Two of the most prevalent types of managed care are defined as follows:

1. **Managed Care Organizations (MCO) (risk-based plans) -** An MCO is an entity that has entered into a risk contract with a state Medicaid agency to provide a specified package of benefits to Medicaid enrollees in exchange for a monthly payment on behalf of each enrollee.

2. **Primary Care Case Management (PCCM) (fee for service/case management) -** A PCCM is a type of arrangement where one entity contracts with providers who serve as primary care physicians (PCPs). These PCPs act as gatekeepers approving and monitoring services. The contractor pays the providers a monthly management fee in addition to the regular fee-for-service.

Medicaid Managed Care in Louisiana

Louisiana's Medicaid managed care program CommunityCARE, authorized by Title XIX, Section 1915(b) of the federal Social Security Act, currently operates in 20 rural parishes.[1] Under this section of the federal law, state Medicaid agencies may obtain waivers that allow them to implement a primary care case management system. This PCCM can limit freedom of choice of providers and also limit the areas where the program is implemented.

Exhibit 1 on page 5 highlights those parishes with CommunityCARE. CommunityCARE links certain Medicaid recipients to a PCP. The target populations of the program are Medicaid recipients who receive Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI) benefits. These populations include the following:

- **TANF-related** includes low-income adults and children who are eligible for medical assistance based on specific income thresholds (excludes foster children or children receiving adoption assistance as well as Office of Youth Development clients).

- **SSI-related** includes low income elderly, blind and other people with disabilities (excludes residents of nursing facilities and long-term institutions, recipients 65 years and older, Medicare Part A & B beneficiaries, and Medically Needy Recipients).

According to data from DHH, the department established the CommunityCARE program to provide efficient and cost-effective services to Medicaid recipients as well as to provide recipients with increased access and quality of care.[2] The overall program goal is to reduce health care costs by encouraging more appropriate use of health services. Other goals of the program include the following:

[1] In August 2001 (after our fieldwork ended), CommunityCARE expanded to seven additional parishes.
[2] According to the Office of Primary Care and Rural Health, Louisiana was ranked the most unhealthy state in America in 1998. A major explanation for Louisiana's poor health status is the lack of access to routine and preventive care.

- Provide a "medical home" for Medicaid recipients
- Strengthen the patient/physician relationship
- Promote the educational preventive aspects of health care (PCP provides ongoing education to recipients.)
- Promote the responsibility of the recipient to use health care resources appropriately (Recipient must call his/her PCP before going to any other physician, clinic, or hospital.)
- Support use of quality health care within the recipient's community

DHH estimates that in state fiscal year 2000 the program served approximately 75,000 recipients at a cost of $115.4 million. According to the *2001 Louisiana Health Report Card*, CommunityCARE has 142 enrolled providers employing a total of 238 physicians. Appendix B lists the number of primary care physicians by parish. DHH pays CommunityCARE providers a management fee of $3 per recipient per month, in addition to the normal Medicaid fee for service, to manage recipients' health care.

Three full-time DHH employees oversee the CommunityCARE program. However, most of the program is administered by a health care management contractor, Birch & Davis, with whom DHH has a three-year $4.2 million contract (1999-2001). In state fiscal year 2000, the contract amount was approximately $1.5 million, but according to the waiver application, the department paid $1,308,332. Birch & Davis oversees the following activities:

1. Recipient outreach and linkage to PCPs
   - Notify and assign new eligible recipients
   - Maintain a toll-free hotline for complaints, PCP selection and changes, and other information
2. Administration
   - Maintain recipient eligibility and provider files
3. Monitoring
   - Certify new providers
   - Evaluate the 24-hour accessibility of providers
   - Conduct annual monitoring visits to determine compliance
   - Conduct consumer satisfaction surveys
4. Data compilation and report generation

In addition, Birch & Davis contracts with DHH's fiscal intermediary, Unisys, who is responsible for the Medicaid Management Information System (MMIS). MMIS is the claims processing system for Medicaid provider billing. Unisys generates various CommunityCARE reports for DHH and the contractor to review and analyze.

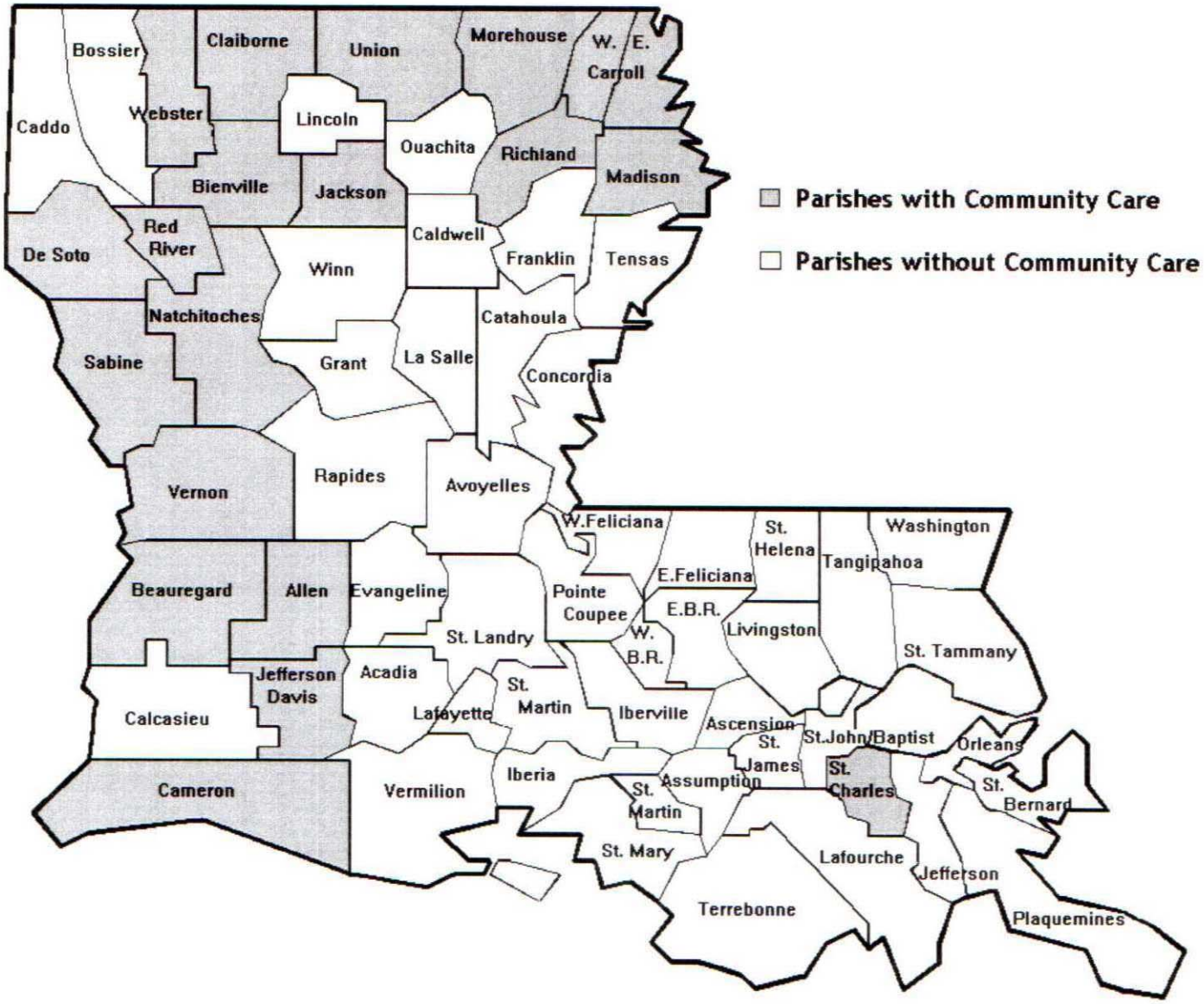
Issue for Further Study

One issue came to our attention that we did not pursue because the issue was outside the scope of the audit.

Referral system allows non-unique referral numbers to be used. When a PCP refers a client to a specialist, a referral number must be included, which is the same as the PCP's Medicaid provider number, to be reimbursed for services. However, the referral number is not unique for each referral. The current system could result in specialists using referral numbers repeatedly for services that the PCP did not refer or for services that were not provided.

Exhibit 1

CommunityCARE Parishes in Louisiana
January 2001



Source: Prepared by legislative auditor's staff from maps in the Louisiana Office of Primary Care and Rural Health publication, *Louisiana Health Report Card*.

Cost Savings and Appropriate Use of Health Care Services

Is CommunityCARE meeting its goals of cost savings and appropriate use of health care services?

It appears that the CommunityCARE program has met its goal of cost savings. However, the methodology used by DHH in the first waiver period may have inflated the cost savings projections. Although estimates show overall cost savings for the CommunityCARE program, those savings have been inconsistent through the first three waiver periods. Furthermore, although the CommunityCARE expansion statewide may save money, an exact amount cannot be determined because of many variables.

We could not determine with certainty whether DHH met its goal of ensuring appropriate use of health care services. The department does not use its utilization information, which shows how frequently recipients use services, to monitor providers. By monitoring and controlling these patterns, DHH could better guide the CommunityCARE program toward its goal of ensuring appropriate use of health care services as well as keeping costs down. Our review of DHH claims data gives inconsistent results on decreasing utilization rates for services over a three-year period. However, for the TANF population during year 2000, our analysis shows CommunityCARE recipients used emergency room doctors less often for routine medical care for two of three diagnoses than non-CommunityCARE recipients.

Recommendation 1: Instead of an average number of services per patient, DHH should set utilization standards against which providers are measured. DHH should also require that providers give explanations when services exceed this standard.

> **Management's Response:** **The department partially agrees.** The department recognizes the limitations with the current utilization reports and plans to develop a protocol to enhance the report. Consideration must be given to the provider's case mix and the need for adjusting for the severity of illness of enrollees.

Recommendation 2: DHH should ensure that the methodology for calculating cost savings considers the differences between rural and urban parishes.

> **Management's Response:** **The department disagrees.** The department will use a federally designed methodology that compares each parish's performance under fee-for-service prior to implementation of CommunityCARE. Each parish is essentially compared to itself.

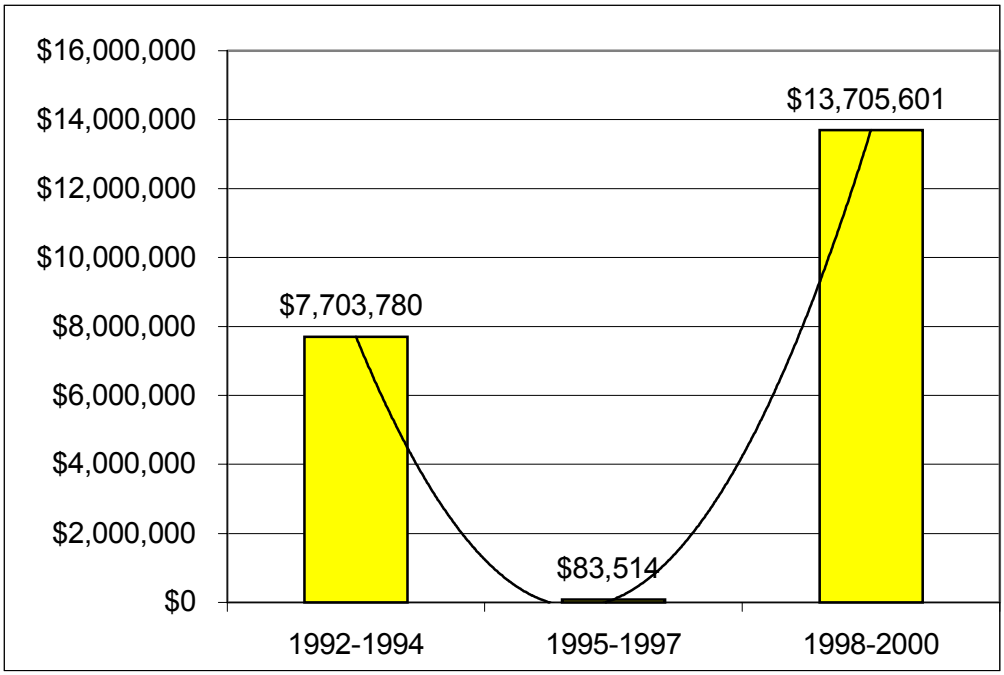
Cost Savings

DHH Estimates Show Fluctuating Savings

Since the CommunityCARE program's inception in 1992, DHH has estimated approximate cost savings of $21 million. However, the savings have fluctuated through the years as shown in Exhibit 2 below. In the first waiver period (1992-1994), DHH estimated the cost savings to be $7,703,780. In the second waiver period (1995-1997), DHH estimated the cost savings to be $83,514. In the third waiver period (1998-2000), DHH reported actual savings of $13,705,601.

Exhibit 2

DHH's Cost Savings Estimates for the CommunityCARE Program From 1992 to 2000



Note: Because the HCFA waiver renewal is a long process, HCFA commonly grants extensions to DHH. It is because of these extensions that DHH's estimated cost savings do not show any estimates for 1998. Also, parts of 1994, 1995, and 1997 were not included in any waiver period because they had an extension at that time. Consequently, a cost savings estimate would not have been calculated during those times.
Source: Prepared by legislative auditor's staff using cost savings data obtained from DHH.

HCFA requires that DHH report actual cost savings from the previous two years and estimates the cost savings for the next two years in order to renew the waiver every two to three

years. DHH's staff prepare the cost savings section of the waiver renewal using data obtained from DHH's fiscal intermediary, Unisys.

According to DHH's staff, there are many reasons for the inconsistent cost savings' estimates. DHH had to adjust HCFA's formula for estimating cost savings to fit its PCCM program. HCFA designed the formula to fit a different type of managed care program. According to DHH's staff since it was DHH's first time with this baseline methodology, the savings appeared reasonable at the time. However, the savings estimate may have actually been overstated.

The original methodology used historic costs and growth rates to project future costs. Because in 1992 Louisiana did not have any previous waiver program data to work with, DHH on advice from HCFA compared its proposed waiver program with another state's PCCM program (Kentucky's KenPac). DHH made the assumption that enough similarities existed between the two state programs to expect similar cost reductions to occur. However, there is no assurance that the rate of enrollment and the cost savings in the two original parishes (Claiborne and Red River) is representative of the rate of enrollment and cost savings that occurred in the parishes added later.

Furthermore, DHH officials state that this methodology will be used again when the program is implemented statewide. DHH must be sure that the 20 original baseline parishes' collective growth rate is comparable to the other 44 new parishes before making any projections.

For the second waiver, DHH used a different methodology. According to DHH's Research and Development staff, this new methodology gave a more accurate picture of the cost savings. The department was now comparing parishes with CommunityCARE to parishes with similar characteristics without CommunityCARE. In addition, the contract with Birch & Davis for the management of the CommunityCARE program also took effect in the second waiver period, which increased administrative costs and thus caused a reduction in savings. According to DHH staff, the initial Birch & Davis contract was very expensive because of start-up costs, which greatly diminished the cost savings of the program.

For the third waiver, DHH had gained experience with its new methodology and was able to get a better estimate of program costs. The cost of the Birch & Davis contract and the management fee also decreased. Together, these changes led to a much higher projected cost savings for the third waiver period.

Higher than achievable savings estimates could lead to potential budget shortfalls for DHH. In addition, the methodology that DHH used to develop savings estimates could also cause the CommunityCARE program to appear more or less cost efficient than it actually is.

CommunityCARE Expansion May Save Money, but the Amount Cannot Be Determined

We attempted to estimate the savings of the statewide expansion of the CommunityCARE program as compared to regular Medicaid services. However, a firm estimate cannot be determined because of many factors such as:

- Potential cuts and/or reinstatements of covered Medicaid services
- Incentives to enroll CommunityCARE providers may be necessary
- Future increases in the Medicaid reimbursement rates to providers
- Initial adjustment periods may be necessary before utilization patterns become similar to those in CommunityCARE parishes
- The increasing number of eligibles that the program will have to serve with the expansion, in addition to the LaCHIP children and parents who will be eligible for the CommunityCARE program
- A potential increase, decrease, or re-structuring in the current $3 per patient monthly management fee paid to each provider
- A change in the number of providers participating in the CommunityCARE program
- The effect of expansion into urban areas is unknown as the program has been restricted to rural areas

According to HCFA's waiver renewal form, DHH must report the cost savings of the CommunityCARE program two years in retrospect for each waiver renewal. The department must also project the difference between the total costs with the waiver and without the waiver two years into the future, which are the estimated cost savings of the program. Based on assumptions that the department is making, the state should save money with the statewide expansion of the CommunityCARE program by reducing unnecessary emergency room visits, frequent changes in doctors, and unnecessary testing.

We found that other states with similar programs also estimate cost savings. Exhibit 3 shows Louisiana's CommunityCARE program's and three other southern states' programs' enrollment, management fees, and estimated cost savings.

Exhibit 3

Enrollment, Fees, and Estimated Cost Savings for PCCM Programs in Certain Southern States

State	Area Covered	Enrollment	Management Fee Per Patient	Estimated Cost Savings	Waiver Period
Louisiana	20 Rural Parishes	75,000	$3	$13.7 million	June 29, 1998, to June 28, 2000
Kentucky	Statewide	242,000	$4-$5	N/A*	N/A
Arkansas	Statewide	192,000	$3	$153 million	Nov. 1, 1996, to Oct. 31, 1998
Georgia	Statewide	680,000	$3	$391 million	Dec. 15, 2000, to Dec. 14, 2002

*Since the KenPAC program only recently added the SSI population, Kentucky was unable to provide any cost savings data.

Source: Prepared by legislative auditor's staff using information currently available on the HCFA's Web site and through telephone interviews with Kentucky, Arkansas, and Georgia state officials.

Overall, Louisiana currently has a smaller PCCM program (20 parishes) than the three other states, which implemented their programs statewide. The management fees are the same as Louisiana in Arkansas and Georgia; however, Kentucky uses a sliding scale for the management fee based on provider performance.

Utilization of Health Care Services

CommunityCARE Staff Do Not Monitor for Unnecessary Utilization of Services

CommunityCARE staff do not use monthly utilization reports to monitor providers for potential overutilization of health care services. DHH sends utilization reports every month to all providers who have over 100 recipients assigned to their care or linkages. The utilization reports show the average number of times that each patient linked to the provider used various medical services in a month. For example, emergency room visits, laboratory services, pharmacy services, and physician office visits are all types of services that would be shown on utilization reports. Any services provided that are significantly above a calculated overall per-patient average are flagged as cases of potential overutilization. We found that for 107 CommunityCARE providers in ten months in calendar year 2000, there were 216 instances where the average number of services provided per hundred patients was significantly above the overall average for that service. However, CommunityCARE staff perform only limited follow-up on whether these cases actually involve overutilization.

According to CommunityCARE staff, the primary purpose of these reports is to allow the providers to see how they compare to their peers. However, DHH does not consult with or require an explanation from providers who show service levels significantly above the overall average.

Unlike Louisiana, both Arkansas and Georgia have public contractors that produce and review provider utilization reports as a method of monitoring the utilization of providers. In Arkansas, the utilization reports are given directly to the state medical director and a peer panel. The providers are questioned and attempts are made to educate them on better health care delivery methods, such as the use of generic prescription medications instead of name brand prescriptions. Georgia's Institute for Health Administration also takes an active role in reviewing the utilization reports. Officials there reported managing a program that highlights all providers with utilization problems. They resolve the issues by consulting with each provider and taking further actions, if necessary.

While the CommunityCARE staff do not actively track or monitor utilization patterns of providers, DHH's Surveillance and Utilization Review System (SURS) performs ongoing utilization reviews of all Medicaid providers. SURS will open cases on providers who show up on exception reports or who have complaints against them. However, SURS does not evaluate whether recipients are using health care services in the manner envisioned by CommunityCARE. In 1999 and 2000, SURS opened cases on approximately 60% of CommunityCARE providers. However, SURS reviewed these cases using its standard criteria rather than having criteria that are specific to CommunityCARE. For example, SURS could add checks for proper use of specialists and referrals.

Utilization Data for TANF and SSI Populations Differ

Although there have been some decreases in utilization of services for CommunityCARE parishes, the results differ between the TANF and SSI populations. An overall goal of managed care and the CommunityCARE program is to reduce costs by encouraging more appropriate use of health care services. Unnecessary services are intended to decrease with the presence of the CommunityCARE program in the 20 assigned parishes.

We reviewed DHH utilization data for calendar years 1998 through 2000, which compared units of service in CommunityCARE parishes to non-CommunityCARE parishes. We expected to see that the number of units of services per category[3] used by the eligible CommunityCARE recipients was less than that used by non-CommunityCARE Medicaid recipients.

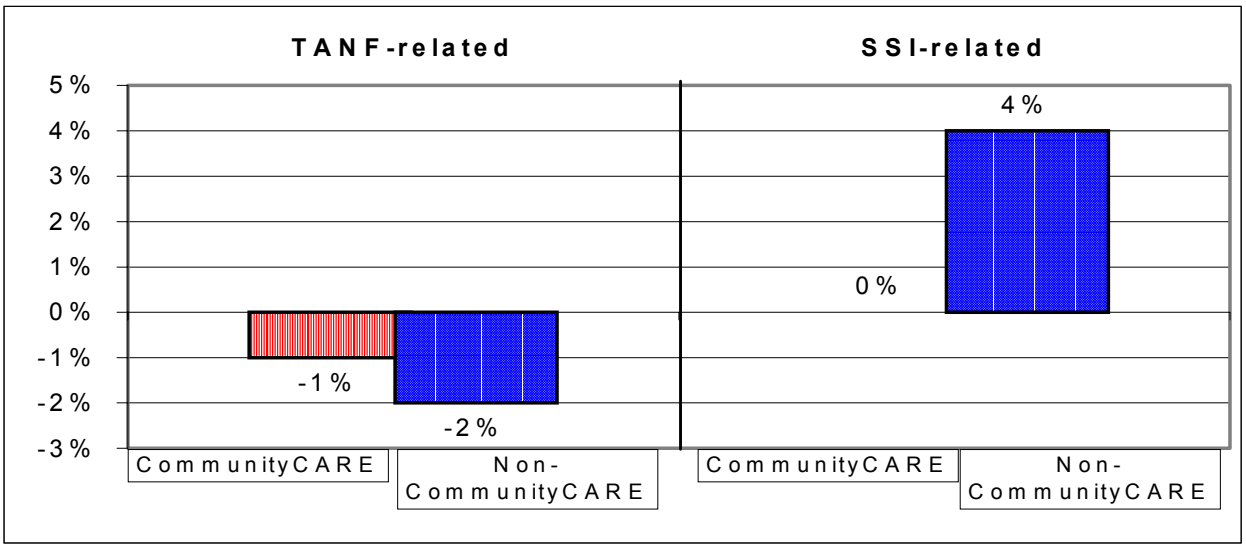
We found that, in the TANF-related population, the average decrease in utilization for all medical service categories in CommunityCARE parishes was 1%, while the overall decrease for non-CommunityCARE parishes was 2%. Although the percentage decreases are close, the non-CommunityCARE parishes' utilization actually decreased more than the parishes who had the

[3] DHH measures utilization in five primary service categories. They are physician services, outpatient hospital services, lab/x-ray services, pharmacy services and inpatient hospital services.

program. In the SSI population, as Exhibit 4 shows, the utilization in all service categories stayed the same in CommunityCARE parishes while service utilization increased 4% for the non-CommunityCARE parishes. Therefore, the cost of providing services to the non-CommunityCARE SSI population may also be higher.

Exhibit 4

Average Change in Use for All Service Categories
Calendar Years 1998 through 2000



Source: Prepared by legislative auditor's staff using cost savings data obtained from DHH's Division of Research and Development.

DHH utilization data show different utilization patterns between the TANF and SSI populations. CommunityCARE does not seem to have a significant impact on reducing utilization and, consequently, the cost of services for the TANF population. However, utilization and costs for the SSI population were constant in the CommunityCARE parishes while they increased in the non-CommunityCARE parishes (regular Medicaid population). Furthermore, the Kaiser Commission reported that in 1998, adults and children in low-income families (TANF) made up nearly three-fourths of Medicaid beneficiaries, but they accounted for only 25% of Medicaid spending. The elderly and disabled (SSI) made up slightly more than one-fourth of Medicaid beneficiaries, but they accounted for a majority (67%) of spending because of their intensive use of acute and long-term care services. In terms of saving the state money, the CommunityCARE program seems more beneficial with SSI recipients.

CommunityCARE Seemed to Reduce Use for Emergency Room Doctor Services in Calendar Year 2000

We sampled Medicaid paid claims for 1,000 TANF recipients in calendar year 2000 for three common diagnoses (upper respiratory infection, urinary tract infection, and bronchitis). Recipients in CommunityCARE parishes appeared to have a lower number of emergency room doctor visits for the treatment of two of the three diagnoses compared to recipients in non-CommunityCARE parishes. The results are as follows:

Upper Respiratory Infection

- CommunityCARE recipients sought treatment from emergency room doctors 7.46% of the time.
- Non-CommunityCARE recipients sought treatment from emergency room doctors 10.53% of the time.

Bronchitis

- CommunityCARE recipients sought treatment from emergency room doctors 6.15% of the time.
- Non-CommunityCARE recipients sought treatment from emergency room doctors 14.49% of the time.

Urinary Tract Infection

- CommunityCARE recipients sought treatment from emergency room doctors 5.56% of the time.
- Non-CommunityCARE recipients sought treatment from emergency room doctors 3.85% of the time.

Exhibit 5 shows the difference in emergency room usage between CommunityCARE recipients and non-CommunityCARE recipients for the three diagnoses analyzed. We used the basis "days of service" because multiple claims could be submitted for the same "day of service" for one recipient but cover only one encounter with a physician. For example, a recipient could visit his/her PCP and, during this visit, the recipient could receive multiple services related to the office visit. In Exhibit 5, hospital emergency room visits can generate many charges but be for only one visit on one day. Thus, we used the basis of "days of service" to show the number of days that an emergency room doctor charge was generated for a recipient in our sample.

According to the results shown in Exhibit 5, the CommunityCARE program appears to have helped reduce emergency room doctor use in calendar year 2000 for TANF recipients diagnosed with upper respiratory infection and bronchitis. However, non-CommunityCARE TANF recipients diagnosed with urinary tract infection actually used emergency room doctors less than CommunityCARE TANF recipients. Therefore, it appears that the CommunityCARE program was successful in limiting its TANF recipients' use of emergency room doctors for two of the three diagnoses that we sampled in calendar year 2000. Continued success in limiting unnecessary emergency room usage of the CommunityCARE recipients may lead to lower program costs in the future.

Exhibit 5

Emergency Room Doctor Use, by Diagnosis
For Calendar Year 2000

	CommunityCARE			Non-CommunityCARE		
Diagnosis	Days of Service	Days of Service Using ER Doctors	% ER Use	Days of Service	Days of Service Using ER Doctors	% ER Use
Upper Respiratory Infection	335	25	**7.46%**	304	32	**10.53%**
Bronchitis	65	4	**6.15%**	69	10	**14.49%**
Urinary Tract Infection	54	3	**5.56%**	52	2	**3.85%**

Source: Prepared by legislative auditor's staff using Medicaid paid claims data obtained from Unisys for calendar year 2000.

Monitoring Efforts

Does DHH's monitoring efforts ensure that CommunityCARE program requirements are met?

DHH seems to be ensuring that most CommunityCARE program requirements are met. However, DHH does not have a formal monitoring process to review and verify data in reports from Birch & Davis. Consequently, DHH cannot be sure that the contractor is meeting all requirements in its contract agreement. Without a monitoring process, DHH may not have collected penalties that could have been withheld from the contractor.

In addition, Birch & Davis' monitoring efforts on behalf of DHH do not appear to have significant impact on ensuring that providers comply with program requirements. The annual provider monitoring visits focus primarily on documentation compliance. Yet, we found that providers continue to have similar problems for two consecutive years.

Furthermore, provider monitoring does not address whether medical treatment and referrals are necessary as required by federal waiver guidelines. Therefore, DHH's monitoring efforts do not fully ensure that patients are receiving appropriate care.

Recommendation 3: DHH should establish a formal process to monitor Birch & Davis' annual monitoring and validation visits to ensure that all contract and waiver requirements are met.

> **Management's Response: The department partially agrees.** The department recognizes that going from a small program of 43,000 enrollees to a statewide program of more than 500,000 enrollees would require more formal accountability processes. The department says it is developing a database to formalize its review of the Birch & Davis contract.

Recommendation 4: DHH should clearly define and begin monitoring the appropriateness of treatment and referrals.

> **Management's Response: The department partially agrees.** The department states that PCCM programs use the primary care physician as the health care decision-maker. It is not the purpose of CommunityCARE to supplant the medical judgment of the PCP. The pending statewide expansion incorporates a number of quality indicators based on nationally recognized standards for disease management.

Recommendation 5: DHH should evaluate the value of the monitoring activities currently conducted by the contractor to determine how the process could be more beneficial to recipient care.

> **Management's Response: The department agrees.** The department states that it has begun to incorporate additional monitoring and to establish quality indicators based on nationally recognized standards for disease management. On-site monitoring will continue to check to see if providers are adhering to administrative procedures, clinical guidelines, and appropriate corrective actions when compliance problems are found.

DHH Has Not Established a Formal Process to Monitor the Birch & Davis Contract

DHH does not review or verify data in reports produced by its contractor or ensure that the reports are received timely. DHH contracts with Birch & Davis to do actual site visits to monitor the physicians who provide services in the CommunityCARE program. As a state agency contracting with a private corporation, DHH has the responsibility to monitor Birch & Davis' performance and to ensure that contract requirements are met. The CommunityCARE program manager said they do not follow any particular method to monitor the contract or verify the dates and contents of the reports received from Birch & Davis. She also said this deficiency exists because they do not have the time or adequate staff to perform thorough monitoring.

According to its contract with Birch & Davis, DHH is required to review the monthly reports Birch & Davis generates to document compliance with the contractual work plan agreement. In addition, the contract requires DHH to assess liquidated damages in order to assure the timely completion of contractual duties. For example, the contract requires that DHH assess $50 per day per report for late submission of reports. DHH receives 11 standard reports from Birch & Davis. In addition, DHH receives certification, annual, and validation visit reports each month. However, the CommunityCARE program manager was not aware of which reports are received on a monthly basis. In addition, DHH does not have a system to record the dates reports are received. Without this information, DHH cannot hold the contractor to the dates that reports are due.

The contract also requires that DHH assess $500 per day when monitoring activities are not conducted timely. DHH officials initially reported that they were not sure how to determine if all monitoring visits have been conducted in a given year and that they do not routinely check. The program manager later stated that they *can* tell this information through the reports sent from the contractor; however, we had already noted the lack of awareness of the reports received.

Since DHH is not aware of the receipt of reports each month or if the monitoring activities have occurred timely, they are also not aware if liquidated damages could have been assessed. As a result, the department may not have collected penalties that could have been withheld from payments to the contractor. Yet, the department has little assurance that the contractor provided services as required. However, we found no evidence that the department missed the opportunity to assess liquidated damages for the period we examined.

DHH's Monitoring Efforts Have Little Impact on Ensuring Provider Compliance

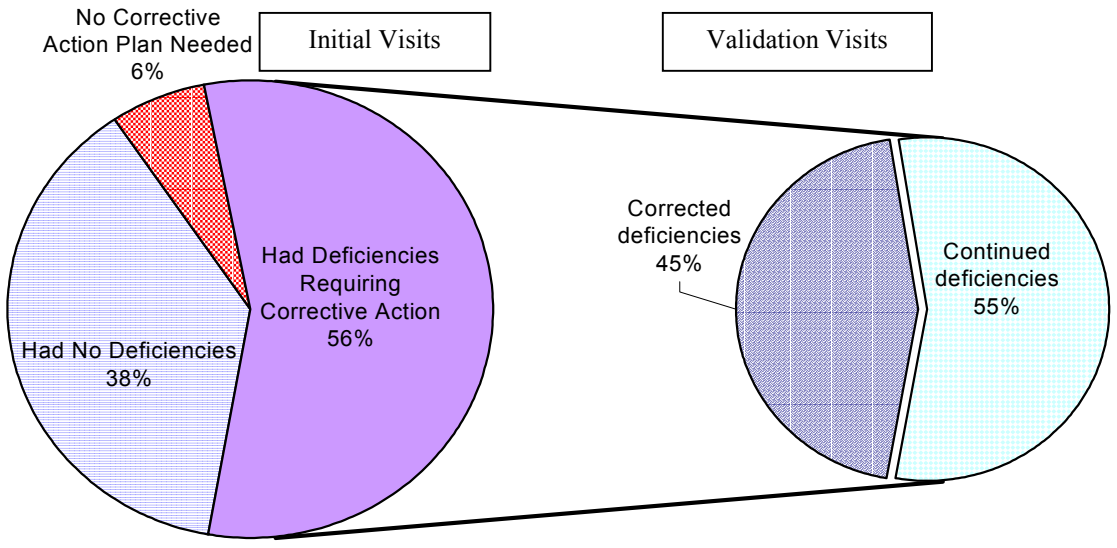
Despite the monitoring efforts of DHH and its contractor, Birch & Davis, CommunityCARE providers tend to have the same or similar problems over time. The waiver requires DHH to have a system to periodically review CommunityCARE providers. DHH reported that the annual monitoring visits done by Birch & Davis fulfill these monitoring requirements.

We attended two routine site visits with Birch & Davis monitors of CommunityCARE providers and found that Birch & Davis focuses on reviewing documentation of services provided. The most common deficiency found was in the area of medical history documentation. For example, this deficiency is noted when the provider fails to write the patient's family and surgical history, menstrual history, or obstetrical history in the medical record.

Our review of files for 296 monitoring visits done in 1999 and 2000 by Birch & Davis on behalf of DHH showed that 184 (62%) providers had some type of documentation compliance deficiency. Of the 184 providers with deficiencies, 165 had to submit a corrective action plan detailing how they would correct the problems. Once the corrective action plan is approved, Birch & Davis conducts a follow-up or "validation visit" to ensure all identified deficiencies were corrected. Exhibit 6 below shows that of the 165 providers requiring validation visits, 91 (55%) continued to have similar types of deficiencies.

Exhibit 6

Comparison of Outcomes of Initial and Validation Visits
Calendar Years 1999 and 2000



Source: Prepared by legislative auditor's staff using the results of our file review at Birch & Davis.

We also reviewed providers that were monitored *consecutively* in 1999 and 2000. Of the 118 providers monitored in both years, we found that almost half (57 or 48%) continued to demonstrate the same or similar problems after two years of monitoring and educational efforts by Birch & Davis. The high rate of repeated problems shows that the monitoring efforts do not have a significant impact on ensuring provider compliance.

DHH may not actually hold providers accountable for the deficiencies because DHH wants to keep satisfied providers in the program. The deficiencies identified by monitoring are generally minor such as the doctor failing to record the menstrual history of the patient. However, DHH is spending time and money to monitor providers in areas that may not affect patient care and that do not aid DHH in meeting its program goals outlined earlier. Furthermore, monitoring only for documentation compliance after the fact does not significantly impact quality or appropriateness of care. The current process may even discourage some providers from participating in the CommunityCARE program.

DHH's Monitoring of Providers Does Not Ensure Appropriateness of Patient Treatment

Both DHH and Birch & Davis reported that they do not check for appropriateness of treatment stating, "we cannot tell doctors how to practice medicine." However, in the 1997-1999 waiver renewal, DHH proposed to perform a ". . . review of the medical records in conjunction with claims history by nurses during the site monitoring visits, *including examination of referrals and appropriate follow-up for diagnoses identified in medical records/history."* However, we saw no evidence of monitoring for appropriateness of treatment during the site visits attended by the audit team.

The waiver requires that DHH explain how it will monitor providers for appropriateness of patient care, including the following aspects:

- Appropriateness of treatment with diagnosis
- Appropriateness of treatment with outcomes
- Appropriateness of referrals

Birch & Davis employs nurses to conduct annual monitoring visits. These nurses primarily check providers for compliance with documentation requirements. During these visits, the nurse reviews administrative procedures and medical documentation such as medical history, proof of immunization, and documentation to support paid claims. However, the nurses do not review medical records to ensure that the services/treatments received were appropriate for the patient.

The CommunityCARE program manager at DHH reported that Birch & Davis does not actually follow up on diagnoses, outcomes or referrals but simply checks for the documentation. DHH's Surveillance and Utilization Review System (SURS) Unit checks for appropriateness of treatment. DHH further states in the waiver document that ". . . edits in the claims processing system also check for diagnosis validity in conjunction with procedure code billed." According to DHH/SURS officials, SURS meets this part of the appropriateness requirements because there are flags established in the claims payment system. For example, if a claim is submitted for a pregnancy test on a male patient, the system would flag it to be further investigated. However, neither SURS nor CommunityCARE staff ensure that provider referrals are appropriate based on diagnoses. Determining whether services are appropriate is important in ensuring that CommunityCARE providers are not providing unnecessary services. Furthermore, since the monitoring process focuses on documentation compliance rather than appropriateness of treatment and referrals, DHH's current monitoring efforts add limited value to patient care.

Appendix A

Audit Scope and Methodology

Appendix A: Scope and Methodology

This performance audit was conducted under the provisions of Title 24 of the Louisiana Revised Statutes of 1950, as amended. We followed the applicable generally accepted government auditing standards as promulgated by the Comptroller General of the United States. Work on this audit began in January 2001 and ended in September 2001.

Scope

The National State Auditors Association (NSAA) is conducting a national joint audit on Medicaid managed care. We originally planned to participate in the audit. However, the NSAA audit focuses on capitated, full-risk managed care arrangements and Louisiana does not have any of these types of arrangements. Therefore, we opted to focus on the only type of Medicaid managed care that Louisiana currently has--a primary care case management (PCCM) arrangement called CommunityCARE. This audit covers all years since the implementation of the CommunityCARE program, focusing specifically on calendar years 1999 and 2000.

Methodology

To gain an understanding of Medicaid managed care and the CommunityCARE program, we completed the following procedures:

- Reviewed information on Medicaid Managed Care, Rural Health Care, other Southern Legislative Conference States Medicaid programs, and the CommunityCARE program
- Reviewed federal and state laws and regulations on Medicaid
- Reviewed other states audit reports on Medicaid, as well as audit reports by the Financial and Compliance Division of the Office of the Legislative Auditor
- Reviewed 1997 and 2000 1915(b) waiver renewal proposals submitted to HCFA by DHH
- Contacted legislative staff regarding any legislative concerns
- Reviewed the MMIS (Medicaid Management Information Systems) system and its controls
- Interviewed DHH, CommunityCARE, SURS, and Birch & Davis officials

To determine whether DHH and Birch & Davis' monitoring efforts ensure that certain program requirements are met:

- Reviewed Birch & Davis' most recent Request for Proposal, contract, and work plan
- Obtained and reviewed one year of Birch & Davis' monthly reports used by DHH to monitor Birch & Davis
- Accompanied Birch & Davis' nurses on two site visits to observe Birch & Davis' monitoring of providers
- Reviewed all Birch & Davis' provider files for monitoring visits conducted in calendar year 1999 and 2000
- Contacted other states with PCCM programs to determine their monitoring efforts for their programs

To determine if CommunityCARE is meeting its goals of cost savings and appropriate utilization of health services:

- Analyzed DHH's methodology for the three waiver periods
- Prepared estimates of cost expenditures and savings figures for the expansion of CommunityCARE statewide
- Used special audit software to generate three samples of 1,000 CommunityCARE and Non-CommunityCARE TANF recipients who were diagnosed with upper respiratory infection, urinary tract infection, and bronchitis, then analyzed emergency room doctor usage by each group
- Used monthly utilization review reports to identify those providers who are considered to have potentially over-utilized services
- Contacted other states with PCCM programs to determine their methodology used to determine cost effectiveness and how they dealt with problems of potential over-utilization

Other Work Performed

We performed other procedures that we considered necessary to address the audit objectives. These other procedures included data collection, interviews, analyses, and comparisons.

Appendix B

Number of Primary Care Physicians, by Parish and Specialty As of January 2001

Appendix B: Number of Primary Care Physicians, by Parish and Specialty As of January 2001

Parish	Family Practice	General Practice	Infectious Disease	Internal Medicine	Obstetrics & Gynecology	Pediatrics	Total
Acadia	14	4	0	6	3	4	**31**
Allen	5	1	0	4	0	3	**13**
Ascension	12	6	0	12	0	3	**33**
Assumption	5	2	0	0	0	0	**7**
Avoyelles	7	5	0	3	0	0	**15**
Beauregard	7	1	0	4	3	1	**16**
Bienville	1	0	0	1	0	0	**2**
Bossier	20	2	0	29	8	10	**69**
Caddo	75	9	2	231	55	81	**453**
Calcasieu	55	8	0	71	28	24	**186**
Caldwell	3	1	0	3	0	0	**7**
Cameron	1	0	0	1	0	0	**2**
Catahoula	2	1	0	2	0	0	**5**
Claiborne	9	1	0	1	0	1	**12**
Concordia	4	2	0	5	2	0	**13**
DeSoto	1	3	0	1	1	1	**7**
East Baton Rouge	91	46	1	209	91	97	**535**
East Carroll	2	1	0	3	0	1	**7**
East Feliciana	4	8	0	1	1	0	**14**
Evangeline	4	8	0	10	4	3	**29**
Franklin	3	0	0	1	0	1	**5**
Grant	2	1	0	0	1	0	**4**
Iberia	18	10	0	13	8	11	**60**
Iberville	8	2	0	8	1	3	**22**
Jackson	1	0	0	4	0	1	**6**
Jefferson	59	28	5	364	109	129	**694**

Parish	Family Practice	General Practice	Infectious Disease	Internal Medicine	Obstetrics & Gynecology	Pediatrics	Total
Jefferson Davis	3	5	0	8	3	2	**21**
Lafayette	39	20	0	99	42	39	**239**
Lafourche	24	9	0	22	11	7	**73**
LaSalle	2	2	0	3	0	0	**7**
Lincoln	7	2	0	11	3	4	**27**
Livingston	8	1	0	0	0	1	**10**
Madison	0	2	0	1	0	1	**4**
Morehouse	7	5	0	6	3	2	**23**
Natchitoches	6	4	0	9	4	6	**29**
Orleans	66	30	3	449	116	206	**870**
Ouachita	43	17	1	80	23	35	**199**
Plaquemines	2	2	0	2	0	0	**6**
Pointe Coupee	9	3	0	2	1	0	**15**
Rapides	43	3	0	69	20	28	**163**
Red River	1	1	0	1	0	1	**4**
Richland	7	2	0	4	2	0	**15**
Sabine	4	2	0	5	0	1	**12**
St. Bernard	1	3	0	17	3	4	**28**
St. Charles	4	1	0	4	1	5	**15**
St. Helena	3	2	0	0	0	0	**5**
St. James	6	1	0	3	1	2	**13**
St. John	6	1	0	8	4	3	**22**
St. Landry	22	8	0	20	11	13	**74**
St. Martin	6	1	0	1	0	0	**8**
St. Mary	13	2	0	7	7	4	**33**
St. Tammany	34	13	1	127	35	54	**264**
Tangipahoa	21	5	0	23	9	11	**69**
Tensas	0	2	0	0	0	0	**2**
Terrebonne	9	8	0	31	15	15	**78**

Parish	Family Practice	General Practice	Infectious Disease	Internal Medicine	Obstetrics & Gynecology	Pediatrics	Total
Union	1	3	0	4	0	0	**8**
Vermilion	5	5	0	5	2	5	**22**
Vernon	2	3	0	10	1	2	**18**
Washington	11	8	0	10	2	3	**34**
Webster	10	4	0	5	3	2	**24**
West Baton Rouge	3	0	0	1	0	1	**5**
West Carroll	1	1	0	3	0	1	**6**
West Feliciana	3	2	0	3	0	1	**9**
Winn	2	3	0	2	0	1	**8**
Total for CommunityCARE Parishes							**244***
Grand Total	847	336	13	2,042	637	834	**4,709**

Represents CommunityCARE parishes

*There are a total of 244 providers in the CommunityCARE parishes. A total of 238 (98%) of those providers are participating in the CommunityCARE program.

Source: Prepared by legislative auditor's staff using data from the Louisiana Board of Medical Examiners as of January 2001.

Appendix C

Department of Health and Hospitals' Response

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

M. J. "Mike" Foster, Jr.
GOVERNOR

LOUISIANA
Department of HEALTH and HOSPITALS

David W. Hood
SECRETARY

January 10, 2002

Daniel G. Kyle, Legislative Auditor
Office of Legislative Auditor
P.O. Box 94397
Baton Rouge, Louisiana 70804-9397

Dear Mr. Kyle:

Attached is the response of the Department of Health and Hospitals to the second draft of the report on the performance audit of for the CommunityCARE program by your staff. I appreciate the additional time provided for our response. We understand that the document has not yet been released to the public and therefore wish to respectfully request that the report acknowledge the many significant changes that have been made in this program in response to the Department's "Blue*Print* for Health" which includes the expansion of CommunityCARE statewise. Many of these changes have been noted in our responses to the formal recommendations and were also made to your staff at a meeting held on December 13, 2001 to discuss the first draft.

First and foremost, we wish to point out that the Department had recognized that changes in the administration of the program needed to be made in order to accommodate the transition from a very small program in 20 rural parishes to all parishes statewide. These have been undertaken as planning was begun to expand CommunityCARE statewide. Thus, we find it extremely important to reflect this in the report. In many instances, the audited program bears little resemblance to the statewide program proposed in our currently pending waiver application for implementation over the next two years. Many significant changes have been made as a result of input from advisory groups and providers to accommodate the transition to urban areas, as well as the increased scope of the program.

I am also concerned that despite the lack of findings of any wrong-doing, unfulfilled contract requirements, fraud or other such negative results, the somewhat negative tone of the report is such that the persons for whom the report is intended, and others who may subsequently read the report, may be influenced to consider the program to be less worthwhile than is actually the case. It appears that there may have been an underlying misconception that PCCM programs exert as much influence over medical providers as do health maintenance organizations or prepaid health plans. CommunityCARE is a simple primary care case management (PCCM) program that assures access to a "medical home" where Medicaid recipients can receive consistent care and does not provide all the controls on medical practice that capitated managed care provides and for which it has been rightly been criticized. This "medical home" concept is considered critical to the Department's plan to improve health outcomes in Louisiana. This "medical home" is essential to ensuring access to

primary care and appropriate utilization of health care resources and thereby containing costs. I am also concerned that current efforts to vigorously promote participation of medical practitioners in CommunityCARE and the acceptance by recipients will be hampered by the negative tone of this report.

I appreciate the efforts of your staff in the performance of this audit, and will ensure that initiatives already underway that respond to the recommendations will be successfully achieved.

Sincerely,

for David W. Hood
Secretary

DWH/HR/wp

Attachments

cc: Charles Castille
Ben Bearden

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"AN EQUAL OPPORTUNITY EMPLOYER"

Appendix C

Department of Health and Hospitals' Response

The Department of Health and Hospitals has examined the performance audit of the CommunityCARE program. However, we find it important to point out that prior to the audit, the Department began initiating many changes to the program to accommodate transitioning from a very small program in 20 rural parishes to all parishes statewide. This began with amendment of the current waiver to include our first urban parish of Calcasieu, to be followed by the remaining parishes in Region 3 (Houma/Thibodaux). We have recently submitted a new waiver application for approval for the remainder of the state. In many instances, the audited program bears little resemblance to the statewide program proposed in our currently pending waiver application for implementation over the next two years. Many significant changes have been made as a result of input from advisory groups to accommodate the transition to urban areas, as well as the increased scope of the program.

Although no instances of wrong-doing, improper conduct, unfulfilled contract stipulations, errors, fraud, or other negative results were found, the unnecessarily negative tone of the report is such that the persons for whom the report is intended, and others who may subsequently become acquainted with the content, may be influenced to consider the program to be less worthwhile than is actually the case.

Response to the findings is in two parts: 1) a listing of in-depth responses for the more critical incorrect, misleading, or negative statements, with observations as to why the statements are irregular, and 2) short response to the formal recommendations for incorporation into the report body.

Attachment I. **Listing of DHH Responses**

Page/Location	Legis. Audit Rpt. Language	DHH Response
Introduction, page 1 Medicaid Managed Care 1st paragraph, last sentence	Medicaid recipients include....."people who are eligible to receive federally assisted income maintenance payments".	Receipt of AFDC as an eligibility criteria for medical assistance was 'de-linked' under Welfare Reform legislation and replaced by qualification based on having income under certain percentages of the federal poverty level. Thus, the last sentence should read: "Medicaid recipients include children, the aged and/or disabled and people who are eligible for medical assistance due to low income."
Page 2, Medicaid Managed Care in Louisiana, 1st paragraph	"currently operates in 20 rural parishes"	CommunityCARE currently operates in 27 parishes. Language should be modified to reflect that during the covered audit period, Medicaid operated in 20 rural parishes. However, in August 2001, expansion occurred into Calcasieu Parish and then continued in Assumption, Lafourche, St. James, St. John, St. Mary, and Terrebonne parishes in September 2001.
Page 4, Issue for Further Study	"There is one issue that came to our attention that we did not pursue because the issue was outside the scope of the audit." ".....a referral number must be included, in addition to the PCP's Medicaid provider number, to be reimbursed for services. However, the referral number is not unique for each referral.....DHH management has identified this as a problem in an earlier waiver and has stated that they	We feel it is improper to cite an issue as not having been implemented when it is acknowledged as outside the scope of the audit. Inappropriate use of referral numbers is a component of the monitoring and utilization process as well as Surveillance and Utilization Review System (SURS) functions. Our current Program Integrity post-payment review system identifies those potentially fraudulent practices. The auditors apparently misunderstood our explanation of the process in stating that there is a referral number in addition to the referring physician's provider number. In practice, a PCP refers patients using the

Page/Location	Legis. Audit Rpt. Language	DHH Response
Page 4, Issue for Further Study	will begin changing the referral numbers quarterly. However, this change had not been implemented."	PCP's Medicaid provider number, which is unique for the PCP. During the last waiver period, a number of system enhancements were selected for the Region III HMO pilot and Enhanced CommunityCARE implementation. Because these programs were never implemented and the system enhancements were not done, the proposed quarterly referral number project was abandoned and is not part of the currently approved waiver.
Page 7, Is CommunityCARE meeting its goals of cost savings and appropriate use of healthcare services? 2nd paragraph	"We could not determine with certainty whether DHH met its goal of ensuring appropriate use of healthcare services."	The federal oversight agency has consistently approved the state's waiver application and renewals since inception of the program in 1992. Federal oversight has included on-site visits and review of independent assessments of the program's functioning. The program has consistently met the requirements for this type of program. In addition to federal oversight, the DHH CommunityCARE staff randomly review the utilization reports to identify both over- and under-utilization patterns. However, total numbers of patient services used is dependent on a number of factors other than physician misconduct, such as diagnoses, acuity, age, and number of patients. During the audit period, ensuring appropriate use of healthcare services has never been defined as reviewing the PCP's treatment practices. It has, rather, concentrated on appropriate use of emergency room and specialty services, and encouraging preventive services to avoid costly acute treatment. Appropriate use of services is accomplished in CommunityCARE by such measures as removing the patient's ability to self-refer to unnecessary services, and by savings engendered by eliminating duplicate laboratory tests, x-rays, and prescriptions.

Page/Location	Legis. Audit Rpt. Language	DHH Response
Page 11, CommunityCARE Staff Do Not Monitor for Unnecessary Utilization of Services (selected statements)	"CommunityCARE staff does not use monthly utilization reports to monitor providers for potential overutilization of healthcare services...CommunityCARE staff perform only limited follow-up on whether these cases actually involve overutilization...DHH does not consult with or require an explanation from providers who show service levels significantly above the overall average."	Monthly utilization reports are produced to allow CommunityCARE providers to compare the utilization patterns of their patients with those of other CommunityCARE providers. The two states cited in the report as having public contractors that produce and review provider utilization reports to monitor utilization have state-wide PCCM programs. Those states use that method of examining physician practices, rather than the state-specific safeguards against overutilization that have been developed in Louisiana to apply to all providers. Because of the limited area covered by CommunityCARE it has not been appropriate use of staff time to specifically monitor utilization in a different manner than that applied to all Medicaid providers. Additionally, in most instances, nationally recognized standards of disease management have only recently been established and accepted. The proposed statewide waiver will incorporate quality indicators based on these standards. Educational efforts regarding standards have been issued to providers and recipients under Medicaid's Pharmacy Benefits Management system and indicators will be established in conjunction with future educational efforts contractually required to be issued under the Unisys contract. Louisiana monitors provider billing and aberrant practice patterns for all providers, not just those in CommunityCARE parishes. For instance, many services require prior authorization, and claims must pass a number of edits prior to payment. As cited in the report, SURS statistical exception criteria apply to CommunityCARE physicians as well as to others. In addition to the safeguards against fraud and abuse

Page/Location	Legis. Audit Rpt. Language	DHH Response
Page 11, CommunityCARE Staff Do Not Monitor for Unnecessary Utilization of Services (selected statements)		that exist for all providers, CommunityCARE physicians are also reviewed randomly by CommunityCARE staff for both over- and under-utilization of healthcare services. Although there have been occasions when staff examined claims histories and met with providers for explanations, those functions are normally performed by SURS. DHH has requested additional staff to increase monitoring efforts by CommunityCARE staff. Additional monitoring is provided by several professional committees, such as the Drug Utilization Review (DUR) Board which meets quarterly to establish statewide drug utilization standards. Regional DUR boards meet monthly reviewing retrospective recipient drug utilization patterns to identify aberrant prescribing patterns and making referrals to Program Integrity for further investigation, when warranted. Act 395 of the 2001 Regular Legislative Session required the Department to develop peer-based prescribing and dispensing practice patterns and a process to promote such practice patterns. When fully implemented, this process will review the prescribing patterns for all Medicaid Physicians including PCPs. The DHH Primary Care Advisory Care Council represents physicians actively participating in CommunityCARE or rendering primary care. The subcommittee on CommunityCARE reviews CommunityCARE policies and makes recommendations to the Department regarding enhancements to that program.

Page/Location	Legis. Audit Rpt. Language	DHH Response
Page 12, Utilization Data for TANF and SSI Populations Differ	"Although there have been some decreases in utilization for services for CommunityCARE parishes, the results differ between the TANF and SSI populations...CommunityCARE does not seem to have a significant impact on reducing utilization, and, consequently, the cost of services for the TANF population."	TANF-related populations are predominantly children, and SSI-related populations are predominantly disabled adults. Utilization patterns for these groups differ significantly with TANF-related populations utilizing a lesser level of services under fee-for-service. In addition, as standards of care for children require much preventive care to ensure that conditions are identified and treated early, and that preventive measures such as immunizations are provided timely, utilization of physicians can frequently increase for children. Opportunities for reduction of costlier services such as inpatient hospital are more limited because fewer of these services are utilized. For disabled persons, having a "medical home" provides care more efficiently by eliminating duplication, contraindicated medications, and managing care rather than reacting to emergencies. The purpose of CommunityCARE is to provide a "medical home" where Medicaid recipients will receive their medical care. CommunityCARE is designed to make appropriate medical care more available and thus improve health outcomes, and to do so in a cost-effective manner. Concentrating on utilization alone is meaningless in terms of evaluation of this program. The Department believes our demonstrated over-all cost effectiveness more accurately portrays our programs's success.

Page/Location	Legis. Audit Rpt. Language	DHH Response
Page 14, CommunityCARE Seemed to Reduce Use for Emergency Room Doctor Services in Calendar Year 2000	"Continued success in limiting unnecessary emergency room usage of the CommunityCARE recipients may lead to lower program costs in the future."	While the Department agrees that CommunityCARE reduced the use of emergency room services in calendar year 2000, it should be noted that more recent federal Medicaid managed care regulations implemented the "prudent layperson" standard and required elimination of the three-visit limit for emergency room visits for adult CommunityCARE enrollees. The three-visit limit still exists for non-CommunityCARE Medicaid eligibles. Removing this limit will reduce the savings previously realized.
Page 17, Does DHH's monitoring efforts ensure that CommunityCARE program requirements are met?	"...DHH cannot be sure that the contractor is meeting all requirements in its contract agreement...monitoring efforts on behalf of DHH do not appear to have significant impact on ensuring that providers comply with program requirements...DHH's monitoring efforts do not fully ensure that patients are receiving appropriate care."	A synopsis of the contract requirements is found on pages 3 and 4 of the performance audit. The auditors have misunderstood the contract requirements, assuming that the contractor is to monitor the type of care provided by physicians. Such is not the case, as nationally recognized standards for disease management have only recently been widely available. This has been recognized and will be addressed through quality indicators and focused studies under the new waiver. Additionally, recognized standards for children regarding immunizations and well-child screenings have been monitored through the EPSDT program.
Page 18, DHH Has Not Established a Formal Process to Monitor the Birch & Davis Contract	"DHH does not review or verify data in reports produced by its contractor or ensure that the reports are received timely...the department has little assurance that the contractor provided services as required. However, we found no evidence that the department missed the opportunity to assess liquidated damages for the period we examined."	Logic for reports hade been previously verified and procedures for submission of reports had been in place for some time, in addition to weekly meetings. Contractor was previously assessed damages in a prior contract period and had taken steps to ensure that such errors did not occur again. The auditors' acknowledgment that no opportunities to assess damages during the audit period were identified attests to this. Staff previously did not have a formal check-off instrument to ensure that reports were received timely, but developed such a procedure to become effective with implementation of the new waiver beginning in

Page/Location	Legis. Audit Rpt. Language	DHH Response
Page 18, DHH Has Not Established a Formal Process to Monitor the Birch & Davis Contract		March, 2002. This tool was developed because the program is growing and will require more formal procedures as the number of recipients affected grows. We strongly feel that the title and substance of this section should reflect the most significant finding: that there were no missed opportunities to assess liquidated damages under the contract.
Page 19, DHH's Monitoring Efforts Have Little Impact on Ensuring Provider Compliance	"The waiver requires DHH to have a system to periodically review CommunityCARE providers. DHH reported that the annual monitoring visits done by Birch & Davis fulfill these monitoring requirements." "DHH may not actually hold providers accountable for the deficiencies because DHH wants to keep satisfied providers in the program. The deficiencies identified by monitoring are generally minor such as the doctor failing to record the menstrual history of the patient." "However, DHH is spending time and money to monitor providers in areas that may not affect patient care and that do not aid DHH in meeting its program goals outlined earlier."	The State's current waiver renewal does not include monitoring the appropriateness of treatment and referrals but does assure the federal oversight agency that the state has developed a proposed quality improvement strategy, a copy of which is attached to this response. The Department holds all providers accountable. According to the audit report, monitoring efforts identified **minor** deficiencies. We contend that with annual monitoring, minor deficiencies do not become major findings. Auditors also acknowledged the lack of impact of these deficiencies on patient care. As indicated in the audit report, our overall goal is to reduce healthcare costs by encouraging more appropriate use of health services. Although our monitoring plan is being modified to incorporate additional quality of care indicators, we believe our current monitoring strategy assists in reaching this goal.

Page/Location	Legis. Audit Rpt. Language	DHH Response
Page 19, DHH's Monitoring Efforts Have Little Impact on Ensuring Provider Compliance	"The current process may even discourage some providers from participating in the CommunityCARE program."	The Department does not agree that the current process discourages providers from participating in the CommunityCARE program. However, more radical and punitive monitoring may influence a provider's participation more negatively.
Page 21, DHH's Monitoring of Providers Does Not Ensure Appropriateness of Patient Treatment	"...we saw no evidence of monitoring for appropriateness of treatment...the nurses do not review medical records to ensure that the services/treatments received were appropriate for the patient...Determining whether services are appropriate is important in ensuring that CommunityCARE providers are not providing unnecessary services."	Unlike capitated managed care provided by managed care organizations, PCCM programs utilize the PCP as the decision-maker for health care decisions. In Louisiana this is supplemented by the implementation of many managed care functions such as prior authorization for services and certification for inpatient services applicable to both CommunityCARE and fee-for-service. Appropriateness of treatment is largely an educational effort as noted by the two states cited as examples by the auditors. It is not the purpose of CommunityCARE monitoring to supplant the medical judgement of the PCP's treatment decisions. Regulations do not currently exist to permit retroactive denial of claims for reasons other than fraud and abuse. Ensuring that unnecessary services are not provided is accomplished by requiring PCP referral for specialty services, lab and x-ray work, etc. as well as SURS review. DHH is also determining the feasibility under HIPAA of sharing more information with PCPs in regard to non-PCP services received by enrollees so that any referrals not made might be identified.
	"...review of the medical records in conjunction with claims history by nurses during the site monitoring visits..."	This language indicates that a nurse's review of the PCP's medical records ensures that all services provided by someone other than the PCP has a corresponding referral in the PCP's patient chart.

Page/Location	Legis. Audit Rpt. Language	DHH Response
Page 21, DHH's Monitoring of Providers Does Not Ensure Appropriateness of Patient Treatment	"...including examination of referrals and appropriate follow-up for diagnoses identified in medical records/history."	This phrase implies that appropriate lab work, x-rays or other diagnostic testing was ordered and appropriate follow-up (i.e. whether or not results were received, documented, and followed-up with the patient) was done. The intent of the CommunityCARE program via the waiver process is to provide a medical home for Medicaid recipients in a cost-effective manner by reducing duplication of services and over-utilization of the emergency room while at the same time ensuring that quality of care and access to services is no less for CommunityCARE enrollees than for recipients who are not in the CommunityCARE program. With regard to appropriateness of outcomes, our proposed Quality Assessment and Performance Improvement Plan, filed with our pending waiver application, contains quality indicators that are outcome based. A copy is attached (Attachment 3). Likewise, the Department has several tools to measure appropriateness of referrals. One is our customer satisfaction survey which for the year 2000 indicates that 28% of the respondents were referred for specialty care by their PCP, and 90% of those had no difficulty with the referral process. Also, the Department maintains a grievance system for the enrollee through the toll-free CommunityCARE Recipient hotline. Our experience indicates that any problem with referrals would surface in the grievance process, but has not.

II. DHH's Short Response to Recommendations

Recommendation 1: Instead of an average number of services per patient, DHH should set utilization standards against which providers are measured. DHH should also require that providers give explanations when services exceed this standard.

MANAGEMENTS RESPONSE: Partially Agree

During the audit period, standards were set in regard to EPSDT services for children. In addition, as a management instrument and on a monthly basis, the Utilization Report was transmitted to providers identifying paid claims for six specific service categories based on the average utilization per month, per 100 enrollees linked to the provider. The purpose is to allow the PCP to compare individual practice patterns with that of the peer group. Limitations had been recognized and DHH is proceeding with plans included in the current contract with ACS to develop a protocol to enhance this report. Consideration must be given to the provider's case mix and the need for adjusting for severity of illness of enrollees. These are to be included in the development of the enhanced utilization review protocol.

DHH's proposed Quality Management Plan included as part of the currently pending waiver application will evaluate performance against several quality indicators based on nationally recognized standards for disease management such as diabetes or asthma.

RECOMMENDATION 2: DHH should ensure that the methodology for calculating cost savings considers the differences between rural and urban parishes.

MANAGEMENTS RESPONSE: Disagree

Only rural parishes were enrolled in CommunityCARE during the time period for the performance audit. Participating rural parishes were compared to comparable rural parishes in accordance with a methodology approved by CMS. In transitioning to a statewide program, the methodology has been changed to track the federally designed 'baseline methodology' utilized by most PCCM programs which compares performance prior to implementation of the PCCM program under fee-for-service trended to the applicable time period in which the PCCM program was in place, as compared to utilization with the PCCM program. Thus, each parish is essentially compared to itself, so differences do not need to be accounted for in calculating cost savings.

RECOMMENDATION 3: DHH should establish a formal method to monitor Birch & Davis' annual monitoring and validation visits to ensure that all contract and waiver requirements are met.

MANAGEMENT'S RESPONSE: Partially Agree

In the past the CommunityCARE program was a very small program and informal monitoring and review of the contractor's responsibilities provided a guarantee of efficiency as evidenced by the

auditors' acknowledgment that no opportunities to assess damages during the audit period were identified. Logic for reports had been previously verified and procedures for submission of reports had been in place for some time, in addition to weekly meetings. Contractor was previously assessed damages in a prior contract period and had taken steps to ensure that such errors did not occur again. It had been recognized by DHH that going from a small program of 43,000 enrollees to a statewide program of more than 500,00 enrollees would require more formal accountability processes. Therefore, DHH has developed a database to enhance and formalize the review of the contractor's performance. The initial design is currently under review and the database is anticipated to be in place in the near future.

RECOMMENDATION 4: DHH should clearly define and begin monitoring the appropriateness of treatment and referrals.

MANAGEMENT'S RESPONSE: Partially Disagree

Unlike capitated managed care provided by managed care organizations, PCCM programs utilize the PCP as the decision-maker for health care decisions. In Louisiana this is supplemented by the implementation of many managed care functions such as prior authorization for services and certification for inpatient services applicable to both CommunityCARE and fee-for-service. Appropriateness of treatment is largely an educational effort as noted by the two states cited as examples by the auditors. It is not the purpose of CommunityCARE monitoring to supplant the medical judgement of the PCPs' treatment decisions. Emphasis was placed on increasing accessibility to primary care and to continuity of care. Appropriateness of care is a function of continuity of care as more appropriate care is provided when the PCP has an established relationship with the patient and is familiar with her health history and status. This continuity also has been recognized as key to improving health outcomes.

Regulations do not currently exist to permit retroactive denial of claims for reasons other than fraud and abuse. Additionally, other tools were used to evaluate care in regard to EPSDT standards for preventive services to children, enrollee satisfaction with referrals for care, as well as a lack of grievances regarding referrals. The currently pending waiver for statewide expansion incorporates a number of quality indicators based on nationally recognized standards for disease management. These standards have only recently become widely available and accepted. As clearly shown in our proposed Quality Assessment and Performance Improvement Plan (Attachment 3), quality indicators are outcome based.

Additionally, Louisiana Medicaid established numerous professional committees having oversight of various Medicaid programs. The following list identifies specific areas of review.

Quarterly, the Drug Utilization Review (DUR) Board meets establishing statewide drug utilization standards. Regional DUR boards meet monthly reviewing retrospective recipient drug utilization patterns. During these reviews, aberrant prescribing patterns may be identified and, when indicated, referrals can be made to Program Integrity for further investigation.

Act 395 of the 2001 Regular Legislative Session required the Department to develop peer-based prescribing and dispensing practice patterns and a process to promote such practice patterns. When fully implemented, this process will review the prescribing patterns of all Medicaid physicians.

The DHH Primary Care Advisory Council represents physicians actively participating in CommunityCARE or rendering primary care. The subcommittee on CommunityCARE reviews CommunityCARE policies and makes recommendations to the Department regarding enhancements to that program. A number of these were incorporated for the statewide expansion waiver.

RECOMMENDATION 5: DHH should evaluate the value of the monitoring activities currently conducted by the contractor to determine how the process could be more beneficial to recipient care.

MANAGEMENT'S RESPONSE: **Agree**

DHH had already initiated action to incorporate additional monitoring and establishment of quality indicators based on nationally recognized standards for disease management into the currently pending waiver for statewide expansion. The current contract provides for the contractor to develop an ongoing system that provides a monitoring function through continual assessment of the quality of care being delivered against the quality measurement standards. The on-site monitoring will include adherence to administrative procedures and clinical guidelines and appropriate corrective action where compliance problems are found.

Outline of
Quality Assessment and Performance Improvement Plan

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Outline of
Quality Assessment and Performance Improvement Plan

1. INTRODUCTION

Housed in the Department of Health and Hospitals (DHH), the Bureau of Health Services Financing (BHSF)—in its capacity as Louisiana's single State Medicaid agency—exercises overall executive responsibility for the health services furnished to CommunityCARE's diverse population. Ongoing daily responsibility for CommunityCARE is lodged with the BHSF's Office of the CommunityCARE program. To fulfill this responsibility and concurrently meet federal and State requirements for quality assurance and improvement, the Program Manager:

- Develops and implements standards, policies, and procedures that promote adequate access to high quality, medically necessary care
- Measures, monitors, and evaluates the quality of care provided
- Recommends ways to sustain or continuously improve the quality of care
- Implements adopted recommendations and subsequently analyzes the efficacy of new or revised policies

In accordance with federal guidelines, CommunityCARE has established a Quality Assessment and Performance Improvement (QAPI) program to monitor, evaluate and improve the quality of care provided to CommunityCARE enrollees. A multi-disciplinary committee oversees the QAPI program. CommunityCARE's Program Manager chairs the committee, which includes as members DHH's Medical Director, administrative and clinical personnel, and representatives of key stakeholder groups. At least annually, the committee evaluates the effectiveness of the QAPI program and updates its policies and procedures, as circumstances warrant.

In general, the QAPI program is divided into two major components—namely, research and operations. BHSF's Office of Research and Development plans and conducts studies and analyses of CommunityCARE's clinical and financial impacts. The ACS/Birch & Davis Health Management Corporation administers various aspects of the CommunityCare program (e.g., enrollee outreach, provider enrollment and technical assistance, and provider monitoring) has established a department of quality assessment performance and improvement to evaluate, assure, and improve the quality of care.

1. Scope and Purpose. This plan explains how CommunityCARE's QAPI program monitors, measures, assures, and improves the quality of care provided to its enrollees. The plan is divided into six major sections, which explain the methods, tools, and procedures to

monitor, measure, assure and improve quality in a systematic and coordinated manner. The sections are:

- Performance Measures
- Enrollee Satisfaction Surveys
- Provider Satisfaction Surveys
- Quality Improvement Projects
- Focused Studies
- Provider Support and Monitoring Activities

Findings from ongoing data collection and analysis will be used to identify new, or revise existing, performance measures, as well as determine and sequence the focused studies and quality improvement projects that the program conducts. In addition, the QAPI plan will also be updated periodically to incorporate new federal and State initiatives, and keep abreast of developments in the rapidly advancing art of quality assurance and improvement.

CommunityCARE's QAPI plan is anchored in the federal standards and guidelines that comprise the corresponding domain of the Quality Improvement System for Managed Care (QSMIC). The Centers for Medicare & Medicaid Services (CMS)—formerly the Health Care Financing Administration—developed QSMIC in the late 1990s to spell out various requirements that health maintenance organizations and other managed care organizations must meet in caring for Medicare and Medicaid enrollees.

For Medicare, QISMC is the equivalent of a program manual that specifies requirements for quality measurement and improvement and the delivery of health care and enrollee services. For Medicaid, QISMC is a voluntary tool that provides guidelines the States can use at their discretion to meet federal requirements for quality measurement and improvement and the delivery of health care and enrollee services. Furthermore, all QISMC standards do not apply to PCCMs, and in the case QISMC's QAPI requirements, PCCM programs cannot exert as much influence over their providers, as can health maintenance organizations and prepaid health plans.

2. PERFORMANCE MEASURES

A comprehensive set of performance measures is used to monitor, evaluate, and improve the quality of care provided to CommunityCARE enrollees. Taken together, the measures enable the Program Manager to determine whether (1) CommunityCARE complies with standards for preventive care and chronic or other specific health conditions, (2) CommunityCARE assures adequate access to medically necessary services, and (3) enrollees and providers are satisfied with the program.

The performance measures will also serve as sentinel indicators of clinical or non-clinical events that may warrant further investigation, perhaps as a focused study and eventually as a quality improvement project. The measures will also help to identify participating providers who may need additional support services to comply with CommunityCARE's requirements or fulfill their contractual obligations

The performance measures will be based on the national data collection and reporting instrument that CMS recommends for Medicaid managed care contracting—that is, the Health Plan Employer Data and Information Set (HEDIS). The selected HEDIS measures will be supplemented by several other widely utilized HEDIS-related measures that furnish information about services that CommunityCARE enrollees receive and patient outcomes. Both sets of measures will be tabulated by enrollee age, gender, and/or other demographic characteristics. In certain instances, parish-specific or regional tabulations are compared, and enrollees may be differentiated by the date their parish first became eligible for CommunityCARE. In all cases, the individual enrollee's privacy and confidentiality are maintained.

Performance measures for the CommunityCARE population will be compared with (1) benchmarks for comparable Medicaid recipients receiving traditional fee-for-service health care, and (2) targets established before a measurement period begins. Furthermore, as available data permit, performance measures for CommunityCARE enrollees with chronic conditions (e.g., asthma and diabetes) or other special health care needs will be reported separately from the same measures for other CommunityCARE enrollees.

HEDIS and HEDIS-related performance measures will be calculated primarily from information extracted from claims data for the Louisiana Medicaid and LAChip program and medical record reviews conducted by ACS/BDHMC nurses. Statistically valid methods are used to determine sample size and select the specific medical records from which information will be extracted.

2a. HEDIS Measures

Developed by the National Committee for Quality Assurance (NCQA), many HEDIS performance measures have been designed specifically for Medicaid populations. Below is a list of the Medicaid HEDIS measures that are currently used to monitor, evaluate, and improve the health care provided to CommunityCARE enrollees. The measures are sorted into the following four major categories:

I. Effectiveness of Care
- Childhood Immunization Status
- Adolescent Immunization Status
- Breast Cancer Screening
- Cervical Cancer Screening
- Use of Appropriate Medications for People With Asthma

II. Access/Availability of Care
- Children's Access to Primary Care Practitioners
- Adults' Access to Preventive/Ambulatory Health Services
- Prenatal and Postpartum Care
- Annual Dental Visit
- Availability of Language Interpretation Services

III. Use of Services
- Frequency of Ongoing Prenatal Care
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life
- Adolescent Well-Care Visits
- Frequency of Selected Surgical Procedures
- Acute Hospital Inpatient Discharges and Days—Total and maternity
- Maternity Care—Discharge and Length of Stay
- Cesarean Section Rate
- Number of Newborns
- Ambulatory Care
- Emergency Department Visits
- Ambulatory Surgery/Procedures
- Outpatient Drug Utilization

IV. Satisfaction with the Experience of Care
- CAHPS adult survey (see Section 3.0)
- CAHPS child survey (see Section 3.0)

Exhibit 1 defines the measures in the first three categories and identifies their data sources and the frequency of availability. In general, measures based on claims data are produced quarterly as compared with annually for measures derived from medical record reviews and monthly for measures based on enrollment and provider files.

Appendix A defines each of the preceding measures, using NCQA criteria for HEDIS 2002 as a starting point. **Appendix A** also lists the ICD-9-CM and HCPCS codes that identify the services covered by each measure, identifies persons excluded from the measures, and provides examples of how to calculate the measures. The appendix also contains examples of the tables and charts used to display and analyze the findings.

2.b HEDIS Related Measures

Below is a list of HEDIS-related measures that will be used to monitor enrollee access to primary and dental care, develop profiles of participating primary care providers, and help assess the utilization and quality of hospital inpatient care. The profiles will also be used to help highlight providers who may need additional support services or are not meeting their contractual obligations.

I. Provider Capacity/ Enrollee Access
- Number of participating PCPs, physician specialists, and dentists
- Geographic comparisons of PCPs and enrollees using GEONetworks software
- Number of PCPs not accepting new CommunityCARE enrollees
- PCP turnover rate

II. Profiles of Primary Care Providers (100 or more enrollees)
- Number and demographics of CommunityCARE enrollees
- Number of acute hospital inpatient discharges
- Number of office visits
- Number of emergency department visits
- Number of EPSDT screenings
- Number of referrals to physician specialists
- Ten highest-volume prescriptions
- Adverse drug-to-drug interactions
- Number of unserved members
- Number of disenrollees by reason
- Number of written complaints and grievances

III. Acute Hospital Inpatient Use
- Number of discharges with short stays (1 or 2 days)
- Number of discharges with long stays (30+ days)
- Number of readmissions within 7 days of discharge

IV. Acute Hospital Inpatient Care
- Mortality Rates
  --All procedures
  --Stillborns
  --Death within 28 days of birth
- Potentially Avoidable Hospital Admissions/Outcomes
  --Urinary tract infection after major surgery
  --Low birth weight
  --Very low birth weight
  --Pediatric admissions
  --Pneumonia and influenza admissions

Most of the preceding measures will be derived from claims data, enrollment files, and provider participation files. Acute hospital inpatient outcomes are quality indicators that the Agency for Health Care Policy and Research (AHCPR) recommends as a starting point to identify inpatient services that may warrant in-depth study.

Appendix B defines the numerator and denominator for each of the preceding measures, identifies the data sources, and presents examples of the calculations. **Appendix B** also lists the ICD-9-CM and HCPCS codes that identify the services covered by each measure, specifies the data sources and the measure's periodicity, and provides examples of how to calculate the measures. The appendix also contains examples of the tables and charts used to display and analyze the findings.

2.c Benchmarks

Performance measures for CommunityCARE's enrollees will be compared with benchmarks for comparable populations. The benchmarks may represent recent performance levels for comparable populations or targeted performance levels. Potential sources of both types of benchmarks include:

- Medicaid and CHIP data for Louisiana, neighboring states, and the nation
- NCQA's Quality Compass database
- Centers for Disease Control and Prevention—Vital and Health Statistics
- AHCPR—Medical Expenditure Panel Survey
- U.S. Healthy People 2010 Initiative
- HRSA survey data for children with special health needs
- EQRO studies

Comparisons may detect overutilization, underutilization, access barriers, or other clinical or non-clinical events that warrant improvement. They may also help establish priorities for focused studies and quality improvement projects. Comparisons by race may suggest policy initiatives to reduce any observed clinical health care disparities for minority populations or improve the provision of culturally and linguistically appropriate services.

Appendix C lists the types and examples of information that is currently available from the aforesaid sources. It also contains their telephone numbers and web site addresses.

3. ENROLLEE SATISFACTION SURVEY

The latest version—presently Version 2.0—of the Consumer Assessment of Health Plans (CAHPS) questionnaire will be used to assess enrollee satisfaction with CommunityCARE, including the perceived accessibility of covered services, the quality of care provided, and general use of health services. Developed by the Agency for Health Care Policy and Research (AHCPR), CAHPS is widely used by States, employers, and other purchasers of health care to evaluate health plans. Many of the questions resemble those on the Member Satisfaction Survey that NCQA requires managed care organizations to conduct for accreditation purposes.

3.a Adult and Child Surveys—AHCPR has developed a separate CAHPS "core" questionnaire for Medicaid adults and children; both are available in English and Spanish. The child questionnaire contains 51 questions, slightly more than the 46 questions on the child survey, which is completed by the child's parent or sponsor.

Exhibit 2 identifies the topic areas and summarizes the subject matter for the core CAHPS survey for Medicaid adults. The Office of CommunityCARE will supplement the core questions with other questions that incorporate "optional" CAHPS supplemental questions. **Exhibit 3** lists the optional items and indicates whether AHCPR recommends their use and whether they apply to Medicaid adults or Medicaid children. In addition, certain other questions will be asked that reflect special features of the CommunityCARE program, such as Hotline accessibility.

ACS/BDHMC will administer the CAPHS survey by mail to a statistically valid sample of CommunityCARE enrollees. A second mailing will be made to enrollees who do not respond to the first mailing within 30 days. Follow-up telephone calls will be made to enrollees who do not respond to the mail questionnaires. In all cases, individual enrollee privacy and confidentiality are safeguarded in accordance with State and federal law.

Survey responses will be entered into a relational (e.g., Access) database. Summarized findings will be shared with participating providers and are used to design provider education programs. Key findings will be displayed in a report card that resembles those adopted by other states and commercial managed care plans. Furthermore, in conjunction with the PCP Profile measures in Section 2.b, the findings will be used to help determine whether participating providers might need additional support services, or may not otherwise be fulfilling certain contractual obligations.

As circumstances permit, survey findings will be compared with the corresponding HEDIS performance measures and CommunityCARE's Recipient Complaint Tracking System. Significant differences or inconsistencies will be flagged and researched. Survey findings for CommunityCARE will be compared with findings from similar surveys conducted by other Medicaid agencies. Information for the latter may be obtained from the National CAHPS Benchmarking Database.

Appendix D contains a copy of the CAHPS core questionnaires for Medicaid adults and children, and a copy of the adult and child supplemental questions. This appendix also explains how sampled enrollees are selected, mail and telephone follow-up are conducted, and the responses are tabulated. **Appendix D** also contains examples of the tables and charts that are used to display and analyze the data.

4. PROVIDER SATISFACTION SURVEY

ACS/BDHMC will administer a survey to a statistically valid sample of primary care providers to assess their overall satisfaction with CommunityCARE and their perceptions of the quality of care that the program offers. Developed by the Office of CommunityCARE, The survey will resemble surveys that other State Medicaid managed care programs and commercial health plans have conducted. The survey will be administered annually by mail. A second mailing will be made to providers who do not respond to the first mailing within 30 days. Follow-up telephone calls will be made to providers who do not respond to the mail questionnaires. Safeguards are in place to protect individual provider privacy and confidentiality in accordance with State and federal law.

4.a Question Topics—The survey will include questions about the accessibility of the CommunityCARE nurse and hotline, as well as CommunityCARE education provider education programs, the responsiveness of CommunityCARE's provider relations representatives, and specific CommunityCARE policies and procedures. Other questions will resemble those asked of CommunityCARE members, such as frequency of missed appointments and waiting time for routine appointments.

Survey responses will be entered into a relational (e.g., Access) database in order to quickly tabulate and analyze the responses in myriad ways. Summarized findings will be shared with participating providers are used to design provider education programs. The findings may help to flag circumstances that require policy or operational changes to the CommunityCARE program.

Certain summarized information will be presented in a provider report card that the Department prepares annually. This information will be merged with information gathered from other sources, such as the enrollee satisfaction survey, recipient hotline, utilization reports, and provider site visit reports.

Appendix E contains a copy of the latest provider satisfaction survey, as well examples of the tables and charts that are used to display the findings. **Appendix E** also explains how the sample is selected and the measures are calculated. It also contains a copy of the latest provider report card.

5. QUALITY IMPROVEMENT PROJECTS

CommunityCARE will conduct quality improvement projects that rely on ongoing data analysis and planned interventions to achieve demonstrable and sustained improvements in significant clinical and non-clinical aspects of the services furnished to CommunityCARE's enrollees. Improvements are expected to have positive effects on enrollee health status and satisfaction with the program.

The CommunityCARE program will initiate one quality improvement project during each of the waiver period. One project will be initiated during each of the contract's three years. Data availability and the rollout schedule will largely determine when a project begins and the enrollees who are included in the study.

Quality improvement projects are designed in ways that mirror the fact that CommunityCARE is a primary care case management program, which means that it can exert less influence over the providers who diagnose and treat its enrollees than can the typical health maintenance organization. Less influence, in turn, constrains CommunityCARE's ability to implement policies to improve the quality of health care.

5.a Focus Areas. Consistent with QISMC requirements, the quality improvement projects will be designed to improve the quality of care provided for the treatment of specific medical conditions. Projects may involve interventions at the program level, provider level, or patient level. Over the waiver period, the projects will address most of the following clinical and non-clinical areas:

1. Clinical Areas
   --Primary, secondary, and/or tertiary prevention of acute conditions
   --Primary, secondary, and/or tertiary prevention of chronic conditions
   --Care of acute conditions
   --Care of chronic conditions
   --High-volume services
   --High-risk services
   --Continuity and coordination of care

2. Non-clinical Areas
   --Availability, accessibility, and cultural competency of services
   --Interpersonal aspects of care
   --Appeals, grievances, and other complaints

Areas not addressed during the waiver period will be co future will be the subject matter of future quality improvement projects.

5.b Questions and Issues—The questions and issues that a project addresses will be stated clearly in insure that they are well understood by the researchers and other participants. The questions will be in writing to ensure that their interpretation does not

change as time passes. The questions involve identifying and remedying deficiencies in care or services, such as inadequate adequacy to preventive medical or dental care.

5.c Quality Indicators—One or more quality indicators will be used to monitor and evaluate performance over time. The indicators will be objective, clearly defined, and based on current clinical knowledge or health services research. Preference is given to indicators that are generally used within the public health community or managed care industry. As circumstances permit, the indicators will be outcome measures—that is, they will reflect changes in health status, functional status, or enrollee satisfaction—or they will be valid proxies for outcome measures. Absent outcome measures, process measures will serve as proxies if strong evidence exists that the processes being measured are meaningfully associated with patient outcomes.

5.d Data Collection and Analysis—Random, valid, and unbiased samples of at-risk CommunityCARE enrollees will be selected to insure that the findings can be generalized. The sample may be statewide, regional, or provider-specific, depending on the circumstances and project. Sample size will depend on an event's prevalence/incidence, which may not be known the first time that a project is conducted. If unknown, valid statistical procedures will be used to determine sample size for alternative confidence levels, taking into account possible need for replacement records.

Standardized measures will be used to document treatment processes and patient outcomes. The measures typically will be based on information extracted from medical records, paid claims and special surveys. Data collection instruments with accompanying glossaries will unambiguously specify the data required to compute numerators, denominators, and quality indicators. The accuracy, timeliness, completeness, and logic of the data must be assessed. In the case of information from medical records, steps will be taken to ensure that the data are uniformly extracted and documented.

Data collection instruments will be field-tested for accuracy, completeness, and clarity. All data collectors will complete a special training course and must demonstrate proficiency for the tasks at hand. This includes a thorough understanding of the data collection instrument and privacy requirements.

5.e Performance Targets—QISMC provides managed care organizations with a two-year grace period during which quality improvement projects are not required to achieve demonstrable improvement. However, CommunityCARE expects to show improvement earlier, depending on start-up constraints and other rollout issues. Minimum performance targets will be established prospectively. If performance is disappointing, appropriate remedial interventions are designed and implemented, with follow-up to gauge their effectiveness.

5.f Specific Projects—Quality Improvement Projects will be identified through continuous data collection and analysis, taking into account the incidence and prevalence of a medical condition among or need for a service by CommunityCARE enrollees. Participating providers and enrollees will have an opportunity to participate in the

selection and prioritization of the projects. The projects will aim to attain the greatest practical benefit for CommunityCARE enrollees.

One quality improvement project will be initiated during each of the waiver contract's three years. The projects will be selected based on national priorities established by CMS coupled with findings of ongoing data collection and analysis of CommunityCARE enrollees. The Office of CommunityCARE will establish minimum improvement levels prospectively, taking into account data availability and the program's rollout schedule. Each project will span at least a year of experience for a defined set of CommunityCARE enrollees.

Below is a high level summary of several quality improvement projects that are being considered for adoption during the waiver contract. Data availability and ongoing data analysis will determine the projects that are implemented and their prioritization. Also identified are each project's two primary focus areas.

- Prenatal Care, Outcomes, and Postpartum Care. This study would document and analyze relationships between gestational age and the timing of the first prenatal visit, the adequacy of prenatal care, mother and newborn outcomes, and whether the mother had a postpartum visit within three and six weeks after delivery. Adequacy of care would be based on evidence-based standards governing the provision and documentation of prenatal and postpartum care. Focus areas: Primary, secondary, and/or tertiary prevention of acute conditions and high-volume services.

- Comprehensive Diabetes Care—This project would analyze the extent to which continuously enrolled CommunityCARE members with diabetes who were 18 through 64 years of age and had each of the following recommended services: hemoglobin A1c (HbA1c) tested, HbA1c poorly controlled (>9.5%), biennial lipid profile, lipids controlled (LDL<130 mg/dl), biennial dilated eye exam, a screening for kidney disease, and a foot examination. This project also would assess whether primary care providers document educational efforts and referrals for retinal examinations. Focus Areas: Primary, secondary, and/or tertiary prevention of chronic conditions and care of chronic conditions.

- Breast Cancer Screening—This study would document and analyze the proportion of CommunityCARE women age 52 through 69 years who were continuously enrolled during the measurement year and who had a mammogram who had a mammogram during the measurement year or the year prior to the measurement year. The project would also determine the incidence of breast cancer in the screened enrollees. Focus areas: Primary, secondary, and/or tertiary prevention of chronic conditions and high-volume services.

- Cervical Cancer Screening—This study would document and analyze the proportion of CommunityCARE women age 21 through 64 years who were continuously enrolled during the measurement year and who had a mammogram one or more Pap tests during the measurement year or the two years prior to the measurement year.

The project would also determine the incidence of cervical cancer in the screened population. Focus areas: Primary, secondary, and/or tertiary prevention of chronic conditions and high-volume services.

- Use of Appropriate Medications for People with Asthma—This project would document and examine the extent to which CommunityCARE members ages 5 through 56 years with persistent asthma are being prescribed and receive five classes of medications acceptable as primary therapy for long-term control of asthma. The classes are: inhaled corticosteroids, cromolyn sodium and nedocromil, leukotriene modifiers, methylxanthines, or long-acting inhaled beta-2 agonists. The project study would also document asthma severity, peak flow rates, and educational interventions for proper asthma management. Observed use rates would be compared with evidence-based practice guidelines for treatment of asthma. Focus areas: Care of chronic conditions, and continuity and coordination of care.

5.g Project Attributes—For each quality improvement project, **Appendix E** explains in detail the particulars of the following attributes:

- Project's relevance and importance—discusses the prevalence of the medical condition among the CommunityCARE population and the likelihood that early detection or improved quality can reduce its incidence.

- At-risk population and covered services—identifies the number and characteristics of the CommunityCARE population to be studied and the services that are to be provided at scheduled times

- Key research questions—specifies and explains the questions that the project will use as the designed to investigate and answer.

- Evidence-based practice guidelines—identifies the guidelines that will serve as the standard against which actual care will be compared

- Quality indicators—the measures that will be used to measure quality and improvements in quality associated with planned interventions.

- Baseline values for the indicators and corresponding performance targets—identifies the initial and targeted numerical values for the quality indicators.

- Sampling methods—explains the methods to determine sample size and select a statistically valid random sample of enrollees intended to yield statistically generalizable results.

- Data elements, data sources, and validation techniques—identifies the data elements to calculate the quality indicators, the sources of the data, and steps to validate the accuracy and completeness of the data.

- Data collection instruments—describes and illustrates the forms that will be used to collect the data that will be answer the calculate the quality indicators and answer the research questions

- Data analysis plan—explains the statistical methods that will be used to analyze the data and illustrates the tables and graphs that will be used to display the findings.

- Recommended system interventions—specifies alternative policies and procedures to improve performance and discusses the advantages and disadvantages of competing approaches.

- Corrective action plan and follow-up evaluation—describes the planned interventions to enhance quality and subsequent steps to determine their effectiveness.

Appendix E also explains how the quality indicators will be calculated and contains some of the tables and charts that will be used to display and analyze the findings. The projects' expected start and completion dates are shown, along with the deliverables and their due dates.

6. FOCUSED STUDIES

Focused studies resemble quality improvement projects, with the most notable exception being that the studies are *not required* to achieve demonstrable and sustained improvements in the quality of care. Instead, focused studies document and evaluate clinical and non-clinical aspects of the health care services with an eye toward flagging areas where quality can be improved. In certain instances, a focused study may suggest specific quality improvement projects, as well as corrective action plans to enhance quality in specific ways, with follow-up to assess their efficacy.

Focused studies are conducted like quality improvement projects. Standardized process and outcome measures are used to quantify and assess performance, although focused studies are more likely to include subjective measures than are quality improvement projects. Focused studies assess quality and performance in light of the clinical and non-clinical areas in Section 5.1 and attributes in Section 5.7. The findings will be compared with baseline values for comparable populations, and may be used to formulate performance targets for the future. Depending on the circumstances, a target may be higher or lower than a corresponding baseline value. In cases where performance is disappointing or can be enhanced meaningfully, appropriate interventions are crafted and implemented, with follow-up to gauge their effectiveness.

6.a Specific Studies—One focused study will be initiated during each of the waiver contract's three years. The design of the studies will reflect the fact that CommunityCARE is a primary care case management program and therefore can exert much less influence on provider practice patterns than can capitated managed care programs. The studies will be grounded in national priorities established by CMS and findings from ongoing data collection and analysis.

The studies will be selected and sequenced to attain the greatest practical benefit for CommunityCARE enrollees. Data availability and the CommunityCARE rollout schedule will largely determine when a study begins, as well as the enrollees who qualify for the study. The findings will be used to identify areas needing improvement and implement continuous quality improvement (CQI) activities that would be expected to enhance health outcomes.

Below is a high level summary of several focused studies that are being considered for adoption during the waiver contract. Data availability and ongoing data analysis will determine the projects that are implemented and their prioritization. Also identified are each project's two primary focus areas. Each focused study will span at least a year of experience for a defined set of CommunityCARE enrollees. Ideally, focused studies will be completed within nine months after startup.

- Child Immunization and EPSDT Services. Building on the Government Performance and Results Act (GPRA) Immunization Study conducted in 1998, this project would analyze the extent to which continuously enrolled children received immunizations, medical checkups, and screenings (medical, lead, dental,

and vision) during the first 24 months of life. Adequacy of care would be evaluated using evidence-based standards governing the type, timing, and periodicity of vaccinations, checkups and screenings. The Clinic Assessment Software Application developed by the National Immunization Program would be the medical record abstraction instrument. Focus areas: Primary, secondary, and/or tertiary prevention of acute conditions and continuity and coordination of care.

- Dental Screens and Referrals—Data from the "Child Immunization and EPSDT Services" study would be analyzed to determine the extent to which CommunityCARE children received referred dental care and dentists were available to serve these children. The study would also review the adequacy of the systems and processes that link general health and dental providers; facilitate the referral of children to dental providers for required diagnostic, preventive and treatment services; assist children and their families in scheduling and attending dental appointments; and PCP follow-up to assure that referred dental screens were furnished. Focus areas: Care of acute conditions and availability, accessibility, and cultural competency of services.

- Lead Screens and Referrals—Information from the "Child Immunization and EPSDT Services" study would be analyzed to determine the extent to which CommunityCARE children received referred lead poisoning tests. The study would also gather and analyze information on the timeliness of the tests and test findings. Additionally, the study would assess PCP compliance with documentation, follow-up, and other CommunityCARE lead-screening policies. Focus areas: Primary, secondary, and/or tertiary prevention of acute conditions and continuity and coordination of care.

- Children with Special Health Care Needs—Building on the CAHPS module for children with special needs and the FACCT initiative, this study would survey a statistically valid sample of CommunityCARE children with chronic conditions and other special health care needs to determine their experience with CommunityCARE, including primary care, referrals, provider responsiveness. This study also would assess the processes that CommunityCARE employs to enroll, identify, and reach out to these children; and examine processes to coordinate with other providers, State/local agencies, community agencies, disease management entities, case managers, and advocacy groups. As available data permit, these children's utilization patterns would be compared with those of other CommunityCARE children. Focus areas: Care of chronic conditions, and continuity and coordination of care.

Appendix F identifies the covered population, quality indicators, sampling methods, data sources, data elements, validation techniques, and performance measures for each focused study. **Appendix F** also explains how to calculate the measures and contains examples of some of the forms, tables, and graphs that will be used to gather information and display and analyze the findings. The studies' expected start and completion dates are also shown.

7. PROVIDER SUPPORT AND MONITORING ACTIVITIES

CommunityCARE relies on state-of-the-art provider monitoring activities to fortify and supplement its other efforts to track, measure, assure, and continuously improve the quality of care. These activities are classified under the following three major categories:

- Certification and Compliance
- On-site Visits
- Stakeholder Involvement

The activities covered by each of these areas are explained below.

7.a Certification and Monitoring

Comply with CommunityCARE policies and procedures
24-hour accessibility
Provider profiling
UR management

7.b On-site Visits

Program Support—Certification—training and experience of PCPs
Credentialing and Recredentialing
Six-Month Conditional Site Visit
Annual Monitoring Site Visit

7.c Stakeholder Involvement

Surveys
Provider training programs
Feedback
Newsletters

Exhibit 1

Definition of Selected HEDIS Performance Measures

I. Effectiveness of Care

Childhood Immunization Status—The percentage of enrolled children who turned two years old during the measurement year, who were continuously enrolled for 12 months immediately preceding their second birthday, who were identified as having four DTP/DTaP, three IPV/OPV, one MMR, two H influenza type b, three hepatitis B, and one chicken pox vaccine by the time period specified and the member's second birthday. Two separate combination rates will also be calculated.

Adolescent Immunization Status—The percentage of enrolled adolescents who turned 13 years old during the measurement year, were continuously enrolled for 12 months immediately prior to their 13th birthday and who were identified as having had a second dose of MMR, three hepatitis B, and one VZV by the member's 13th birthday. Two separate combination rates will also be calculated.

Breast Cancer Screening—The percentage of women age 50 through 69 years who were continuously enrolled during the measurement year, and who had a mammogram during the measurement year or the year prior to the measurement year.

--Number of Breast Cancer Screens
--Number of CommunityCARE Women Receiving Breast Cancer Screens
--Screens per 1,000 Women Members
--Percent of CommunityCARE Women Receiving Breast Cancer Screens

Cervical Cancer Screening—The percentage of women age 18 through 64 years who were continuously enrolled during the measurement year and the two years prior to the measurement year and who received one or more Pap tests during the measurement year or the two years prior to the measurement year. The measures are:

--Number of Cervical Cancer Screens
--Number of CommunityCARE Women Receiving Cervical Cancer Screens
--Screens per 1,000 Women Members
--Percent of CommunityCARE Women Receiving Cervical Cancer Screens

Use of Appropriate Medications by People With Asthma—The percentage of members ages 5 through 56 years with persistent asthma who are continuously enrolled during the measurement year and the year prior to measurement and who have been prescribed certain medications acceptable as primary therapy for long-term control of asthma. The measures are:

--Number of Members Prescribed the Medications

--Percent of Members Prescribed the Medications

II. Access/Availability of Care

Children's Access to Primary Care Practitioners—The percentage of enrollees ages 12 months through 24 months, 25 months through 6 years, and 7 years through 11 years who had a visit with a primary care practitioner during the measurement year.

--Number of PCP Visits
--Number of CommunityCARE Members Receiving Primary Care
--Visits per 1,000 Child Members
--Percent of Child Members Receiving Preventive/Ambulatory Care

Adults' Access to Preventive/Ambulatory Health Services—The percentage of enrollees age 20 through 44, 45 through 64, and 65 years and older who had an ambulatory or preventive care visit during the measurement year.

--Number of Preventive/Ambulatory Visits
--Number of CommunityCARE Members Receiving Preventive/Ambulatory Care
--Visits per 1,000 Adult Members
--Percent of Adult Members Receiving Preventive/Ambulatory Care

Prenatal and Postpartum Care—The percentage of sampled women who received a prenatal care visit as a CommunityCARE member in the first trimester OR within 42 days of enrollment in CommunityCARE. The percentage of sampled women who had a postpartum visit on or between 21 days and 56 days after delivery. The measures are:

--Number of Women Who Received Timely Prenatal Visit
--Percent of Women Who Received Timely Prenatal Visit
--Number of Women Who Received Timely Postpartum Visit
--Percent of Women Who Received Timely Postpartum Visit

Annual Dental Visit—The percentage of enrolled members age 4 through 21 who were continuously enrolled during the measurement year and who had at least one dental visit during the measurement year. The measures are:

--Number of Dental Visits
--Number of CommunityCARE Recipients Receiving Dental Care
--Dental Visits per 1,000 Members
--Percent of Members Receiving Dental Care

Availability of Language Interpretation Services—Part A: The number of PCPs and member services staff who provide services to CommunityCARE members and speak languages other than English. Part B: All non-staff arrangements through which a PCP

secured interpreter services during the measurement year, regardless of whether the service was utilized. The measures of

--Number of PCPs
--Number of Members Served by These PCPs
--Percent of all Members Served by these PCPs

III. Use of Services

Frequency of Ongoing Prenatal Care—The percentage of pregnant women who received less than 21 percent, 21 percent through 40 percent, 41 percent through 60 percent, 61 percent though 80 percent, or 81+ percent of the expected number of prenatal visits, adjusted for gestational age and the month the member enrolled in CommunityCARE. The measures are:

--Number of Women Who Received Timely Care
--Percent of Women Who Received Timely Care
--Actual Number of Prenatal Visits (Live Newborns)
--Ration of Actual to Expected Visits

Well-Child Visits in the First 15 Months of Life—The percentage of enrolled persons who turned 15 months old during the measurement year, who were continuously enrolled from 31 days of age, and who received either zero, one, two, three, four, five, or six or more well-child visits with a primary care practitioner during their first 15 months of life.

--Number of Well-Child Visits
--Number of Infant CommunityCARE Members Receiving Primary Care
--Visits per 1,000 Child Members
--Percent of Child Members Receiving Preventive/Ambulatory Care

Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life—The percentage of members who were three, four, five, or six years old during the measurement year, who were continuously enrolled during the measurement year, and who received either one or more well-child visits with a primary care practitioner during the measurement year.

--Number of Well-Child Visits
--Number of Child CommunityCARE Members Receiving Primary Care
--Visits per 1,000 Child Members
--Percent of Child Members Receiving Preventive/Ambulatory Care

Adolescent Well-Care Visits—The percentage of enrolled members who were age 12 through 21 years during the measurement year, who were continuously enrolled during the measurement year, and who had at least one comprehensive well-care visit with a primary care practitioner or OB/GYN practitioner during the measurement year.

--Number of Well-Care Visits
--Number of Adolescent CommunityCARE Members Receiving Primary Care
--Visits per 1,000 Adolescent Members
--Percent of Adolescent Members Receiving Preventive/Ambulatory Care

Frequency of Selected Surgical Procedures—The total number of selected procedures and the number per 1,000 members are reported by member age and gender. The procedures are: myringotomy, tonsillectomy, dilation and curettage, hysterectomy (abdominal), hysterectomy (vaginal), cholecystectomy (open), cholecystectomy (closed), and prostatectomy. The measures for each selected procedure are:

--Total procedures
--Procedures per 1,000 members

Acute Hospital Inpatient Discharges and Days—The number of CommunityCARE enrollees discharged from a short-stay hospital during the measurement year and the number of days they were hospitalized. The number of member months must also be reported. Excluded from the measure are nonacute care, mental health and chemical dependency, and newborn care. In other words, the measure covers medicine, surgery, and maternity only. (Newborns are included if admitted after discharge after birth.) The data are tabulated separately for these three areas and by member age. The measures are:

--Total discharges
--Total patients
--Total days
--Total member months
--Average length of stay
--Discharges per 1,000 members
--Days per 1,000 members
--Patients per discharge

Maternity Care—Discharges and Length of Stay. The number of CommunityCARE female members who were discharged from a short-stay hospital during the measurement year for maternity care and had live births. The number of days they were hospitalized and number of member months must also be reported. Data are reported separately for total deliveries, vaginal deliveries, and Cesarean section deliveries separately and by age of mother. The measures are:

--Total discharges
--Total days
--Total member months
--Average length of stay
--Discharges per 1,000 members
--Days per 1,000 members
--C section rate = Cesarean deliveries/Total deliveries

Number of Newborns—The number of CommunityCARE newborns delivered in an inpatient setting or a birthing center. This includes live newborns and stillborns. The measures are:

--Total newborns
--Live newborns
--Stillborns
--Stillborns/Total newborns

Ambulatory Care—The number of evaluation and management visits that CommunityCARE members received during the measurement year by member age. Member months must be calculated. The measures are:

--Total visits
--Visits per 1,000 members

Emergency Department Visits—The number of emergency department visits that CommunityCARE members received during the measurement year by member age. Member months must be calculated. The measures are:

--Total visits
--Visits per 1,000 members

Ambulatory Surgery/Procedures—The number of procedures that CommunityCARE members received during the measurement year by member age. Member months must be calculated. The measures are:

--Total procedures
--Procedures per 1,000 members

Outpatient Drug Utilization—The number of outpatient drug prescriptions that CommunityCARE enrollees received during the measurement year. Each refill is counted as a separate prescription. The number of member months must be reported separately. Utilization is reported by age of enrollee.

--Total number of prescriptions
--Number of CommunityCARE members who received prescriptions
--Average number of prescriptions
--Prescriptions per 1,000 members