UNITEDHEALTHCARE COMMUNITY PLAN OF LOUISIANA

Annual External Quality Review Technical Report

Review Period: July 1, 2014 – June 30, 2015
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Prepared on Behalf of
The State of Louisiana
Department of Health & Hospitals

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I. INTRODUCTION

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

In order to comply with these requirements, the State of Louisiana's Department of Health & Hospitals (DHH) contracted with IPRO to assess and report the impact of its Medicaid managed care program, the Bayou Health Program, and each of the participating Health Plans on the accessibility, timeliness and quality of services. Specifically, this report provides IPRO's independent evaluation of the services provided by UnitedHealthcare Community Plan of Louisiana, Inc. (UHCCP) for review period July 1, 2014 – June 30, 2015.

The framework for IPRO's assessment is based on the guidelines and protocols established by CMS, as well as State requirements. IPRO's assessment included an evaluation of the mandatory activities, which encompass: performance measure validation, Performance Improvement Project (PIP) validation and compliance audits. Results of the most current HEDIS® and CAHPS® surveys are presented and are evaluated in comparison to the NCQA's 2015 *Quality Compass*® 2015 South Central – All Lines of Business (LOB) (Excluding PPOs) Medicaid benchmarks.

Section VI provides an assessment of the MCO's strengths and opportunities for improvement in the areas of accessibility, timeliness and quality of services. For areas in which the plan has opportunities for improvement, recommendations for improving the quality of the MCO's health care services are provided. To achieve full compliance with federal regulations, this section also includes an assessment of the degree to which the MCO has effectively addressed the recommendations for quality improvement made by the LA EQRO in the previous year's EQR report. The MCO was given the opportunity to describe current and proposed interventions that address areas of concern, as well as an opportunity to explain areas that the MCO did not feel were within its ability to improve. The response by the MCO is appended to this section of the report.

II. MCO CORPORATE PROFILE

Table 1. Corporate Profile

UnitedHealthcare Community Plan of Louisiana, Inc.	
Type of Organization	Health Maintenance Organization (HMO)
Tax Status	For Profit
Year Operational	02/01/2012
Product Line(s)	Medicaid and LaCHIP
Total Medicaid Enrollment (as of June 2015)	284,633

III. ENROLLMENT AND PROVIDER NETWORK

Enrollment

Medicaid Enrollment

As of June 2015, the Health Plan's Medicaid enrollment totaled 284,633, which represents 29% of Bayou Health's active members. Table 2 displays UHCCP's Medicaid enrollment for 2013 to 2015, as well as the 2015 statewide enrollment total. Figure 1 displays Bayou Health's membership distribution across all Health Plans.

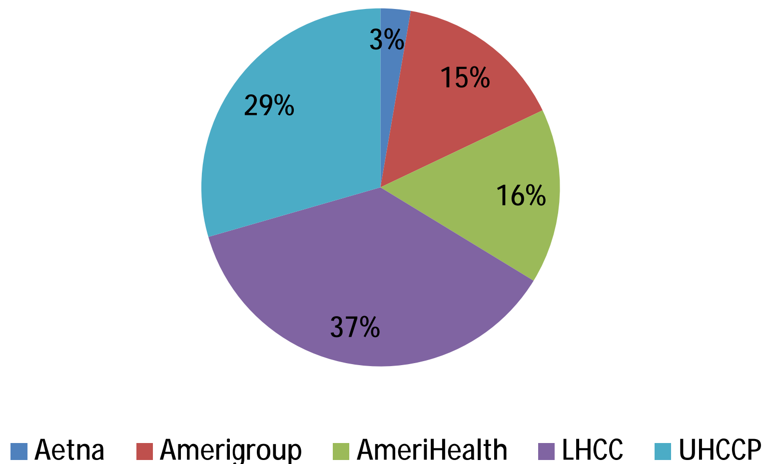
Table 2. Medicaid Enrollment as of June 2015[1]

UHCCP	June 2013	June 2014	June 2015	% Change	2015 Statewide Total[2]
Total Enrollment	256,516	274,239	284,633	4%	965,955

Data Source: Report No. 125-A

[1] This report shows all active members in Bayou Health as of the effective date above. Members who will be disenrolled at the end of the reporting month are not included. Enrollees who gain and lose eligibility during the reporting month are not included. Enrollees who opt out of Bayou Health during the reporting month are not included.

[2] Note: Total includes membership of all plans.



Provider Network

Providers by Specialty

Table 3 shows the sum of primary care providers, other physicians with primary care responsibilities and OB/GYNs as of June 30, 2015.

Table 3. Primary Care & OB/GYN Counts by GSA

Specialty	GSA A	GSA B	GSA C	MCO Statewide Unduplicated
Family Practice/General Medicine	583	537	1064	948
Pediatrics	650	403	358	663
Nurse Practitioners	459	551	540	619
Internal Medicine[1]	754	467	466	786
OB/GYN[1]	148	106	95	195
RHC/FQHC	62	83	145	135

Data source: Network Adequacy Review 2015 Q2

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

[1] Accepts full PCP responsibility.

IV. QUALITY INDICATORS

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

Performance Improvement Projects

A Performance Improvement Project (PIP) is intended to improve the care, services or member outcomes. DHH selects PIP topics to be performed by the Health Plans, and the Health Plans also select topics individually, that address specific areas of concern.

During this reporting period, each Health Plan was required to perform a minimum of two (2) State-approved PIPs. One (1) PIP was a common topic that all Health Plans addressed, and the second was selected by the Health Plan from a list of State-approved topics. The DHH-required common PIP was "Reducing Emergency Department Visits". The Health Plan-selected PIPs were "Increasing the Rate of Breast Cancer Screening" and "Reducing Non-Medically Indicated (Elective) Deliveries Before 39 Weeks Gestational Age". These PIPs were initiated in 2012 and were concluded in 2015.

In accordance with 42 CFR §438.358, IPRO conducted a review and validation of these PIPs using methods consistent with the CMS protocol for validating performance improvement projects. Summaries of each of the PIPs conducted by UHCCP follow.

State-Directed PIP: Emergency Department (ED) Visits

Indicator(s)/Goals: The indicator for this PIP is the HEDIS® *Ambulatory Care – ED Visits* measure - the number of ED visits per 1000 member months that did not result in an inpatient stay during the measurement year.

The Health Plan's goal for this PIP is to be at or below the NCQA *Quality Compass®* Medicaid 2012 50th percentile of 63.15% for the HEDIS® *Ambulatory Care: ED Visits* measure.

Intervention Summary:

- Dissemination of asthma management guidelines to high volume providers
- Asthma pilot project partnering with larger hospitals
- Ensure asthma clinical guidelines are posted on the provider portal
- Engage interns and residents about asthma management and appropriate use of the ED
- Continue case management for high utilizers
- Case management asthma education materials for members
- Discuss prior authorization requirements for nebulizers and provision of peak flow meters
- Educate members on Smoking Cessation Hotline
- Explore use of "A is for Asthma" education materials
- ER Coach pilot
- 24/7 Nurseline
- Target members with sickle cell for case management

Results: Using the HEDIS® *Ambulatory Care – ED Visits* measure, the Jan-May 2013 partial (non-audited) interim rate of 58.67% is lower than the 2012 baseline rate of 64.07% reported by the State and is also lower than the Health Plan's goal of 63.15%. The Health Plan's unaudited 2013 measurement year rate is 58.67. The targeted HEDIS® ambulatory care emergency department visits rate was met and showed a statistically significant improvement in performance; however, it is not clear whether the comparison is between the baseline and final re-measurement rate or between the interim and final re-measurement rate. In addition, the procedures state that statistical significance testing will not be used.

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

Strengths:

- Strong rationale with data specific to Louisiana reported, indicating the need to focus on reducing ED usage. Focus on members with asthma was expanded to include all members.
- Use of a standard measure to track performance.
- A quantifiable and achievable goal (HEDIS® 50th percentile) was established.
- Strong interventions in development, including interventions targeted to all members and members with asthma and sickle cell.
- We support the plan's decision to expand the study to include all ED visits, not just asthma. However, many of the interventions are asthma focused and may not effect improvement in the total ED rate.

Health Plan-Selected PIP #1: Increasing the Rate of Breast Cancer Screening

Indicator/Goal: The indicator for this PIP is the HEDIS® *Breast Cancer Screening Rate: total number of enrolled female members aged 40 - 69 as of December 2013 who had a mammogram during the measurement period.*

The Health Plan's goal for this PIP is to increase the BCS rate to at least the HEDIS® 2011 50th percentile, or 52.4%.

Intervention Summary:

§ Use of a vendor, Silverlink, for member outreach
§ Identify mobile mammography resources
§ Preventive care scripts
§ Explore provider and community collaborative opportunities

Results: Using the HEDIS® *Breast Cancer Screening* measure, the baseline rate reported by the state is 42.64%. The Health Plan's reported, non-audited, 2013 rate is 46.55%, which exceeded the State's baseline rate but remains below the project goal of 52.4% (HEDIS® 2012 50th percentile).

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

Strengths:

§ Strong rationale with data specific to Louisiana reported, indicating the need to focus on breast cancer screening. Mortality is higher than national norms.
§ Use of a standard measure to track performance.
§ A quantifiable and achievable goad (HEDIS® 50th percentile) was established.
§ Strong interventions planned and in progress, including interventions targeted to members, providers and the community. Interventions are linked to a barrier analysis and address education, access and alert providers to those in need of services.

Health Plan-Selected PIP #2: Reducing Non-Medically Indicated (Elective) Deliveries Before 39 Weeks Gestational Age

Indicator(s)/Goals: The indicators for this PIP are as follows:

- The percentage of live singleton births with gestational age >= 37 weeks and < 39 weeks that were non-medically indicated.
- The percentage of live singleton births with gestational age >= 37 weeks and < 39 weeks that were non-medically indicated delivered by C-section.
- The percentage of live singleton births with gestational age >= 37 weeks and < 39 weeks that were non-medically indicated resulting in a NICU admission.

The Health Plan's goal for this PIP is to decrease the number of elective deliveries to <39 weeks.

Intervention Summary:

- Ensure Healthy First Steps (Maternal Management Group) scripting for member outreach
- Develop and implement scripting for providers on the benefits of full term deliveries
- Articles about the benefits of full term deliveries in member and provider newsletters
- Engage with the Nurse Family Partnership and Healthy Start, and identify other potential partners
- Identify and distribute to School Based Health Centers resources and education materials on the benefits of full term deliveries
- Disseminate materials to primary care providers to share with members identified as pregnant
- Identify facilities that are outliers with respect to gestational age at delivery and facilitate the development and implementation of improvement plans
- Demonstrate birth outcomes of members who see providers who are participating with Centering Pregnancy sites in Louisiana. Use information to promote best practices learned from the State pilot
- Create a proposal for billboard/bus shelter advertising about the benefits of full term deliveries

Results: Baseline rate (Jan. – June 2013): Percent of live singleton births with gestational age >= 37 weeks and < 39 weeks that were non-medically indicated = 58.6 (Indicator #1). The rates for non-medically indicated induced early deliveries, non-medically indicated C-section early deliveries and non-medically indicated induced early deliveries resulting in NICU admission declined from baseline to re-measurement and, although not statistically significant, met the targeted goals.

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

Strengths:

- Strong project rationale, including both national and state rationale for study.
- Performance measures relevant to study aim and developed specifically for this project.
- Barrier analysis conducted and interventions developed based on findings.

Performance Measures: HEDIS® 2015 (Measurement Year 2014)

MCO-reported performance measures were validated as per HEDIS® 2015 Compliance Audit™ specifications developed by the National Committee for Quality Assurance (NCQA). The results of each MCO's HEDIS® 2015 Compliance Audit are summarized in its Final Audit Report (FAR).

The HEDIS® 2015 FAR prepared for UHCCP by Attest Health Care Advisors indicates that the Health Plan demonstrated compliance with all areas of Information Systems and all areas of measure determination required for successful HEDIS® reporting.

HEDIS® Effectiveness of Care Measures

HEDIS® Effectiveness of Care measures evaluate how well a Health Plan provides preventive screenings and care for members with acute and chronic illnesses. Table 4 displays Health Plan performance rates for select HEDIS® Effectiveness of Care measures for HEDIS® 2014 and HEDIS® 2015, Bayou Health 2015 statewide averages and *Quality Compass*® 2015 South Central – All Lines of Business (LOB) (Excluding PPOs) Medicaid benchmarks.

Table 4. HEDIS® Effectiveness of Care Measures – 2014 and 2015

Measure	UHCCP		2015 Statewide Average	*Quality Compass*® 2015 South Central Regional Medicaid Benchmarks					
	HEDIS® 2014	HEDIS® 2015		Regional Average	P10	P25	P50	P75	P90
Adult BMI Assessment	64.72%	71.32%	68.69%	76.42%	66.91	71.32	78.37	86.81	89.35
Antidepressant Medication Management - Acute Phase	50.21%	50.51%	49.49%	50.30%	39.85	44.11	49.66	54.94	62.67
Antidepressant Medication Management - Continuation Phase	33.40%	33.66%	33.25%	34.71%	25.84	27.97	32.97	37.93	46.83
Asthma Medication Ratio (5-64 Years)	60.00%	53.88%	52.45%	61.07%	49.81	54.56	61.99	66.6	70.55
Breast Cancer Screening in Women	SS	52.93%	53.63%	54.52%	49.70	51.44	53.02	57.23	65.05
Cervical Cancer Screening [1]	52.80%	61.95%	56.31%	56.63%	45.39	50.56	57.18	64.32	69.15
Childhood Immunization Status - Combination 3	67.40%	71.53%	52.54%	70.66%	55.48	68.91	71.53	75.67	80.05
Chlamydia Screening in Women (16-24 Years)	53.66%	56.12%	58.14%	52.66%	45.27	49.32	51.79	57.24	59.35
Comprehensive Diabetes Care - HbA1c Testing	77.62%	80.54%	81.92%	82.84%	74.83	80.51	82.24	85.40	88.87
Controlling High Blood Pressure	45.74%	43.55%	38.52%	49.22%	35.33	41.19	50.30	56.17	60.46
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	45.81%	54.87%	52.62%	56.47%	44.20	51.17	57.68	63.79	69.62
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	32.59%	41.78%	40.58%	44.13%	32.09	38.79	44.45	51.10	55.79
Medication Management for People With Asthma Total - Medication Compliance 75% (5-64 Years)	31.12%	26.98%	25.21%	25.06%	16.02	19.14	23.47	30.48	36.67
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile	27.49%	41.36%	29.78%	54.62%	36.28	44.08	56.20	63.99	72.22
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	38.69%	53.04%	36.40%	55.85%	39.58	49.64	57.87	66.67	71.99
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity	26.03%	41.61%	26.14%	47.51%	30.07	40.39	47.20	62.73	63.81

SS: Sample Size too small to report (less than 30 members).

[1] Benchmarks were not available due to specification changes.

HEDIS® Access to/Availability of Care Measures

The HEDIS® Access to/Availability of Care measures examine the percentages of Medicaid children/adolescents, child-bearing women and adults who receive PCP/preventive care services, ambulatory care (adults only) or receive timely prenatal and postpartum services. Table 5 displays Health Plan rates for select HEDIS® Access to/Availability of Care measure rates for HEDIS® 2014 and HEDIS® 2015, Bayou Health 2015 statewide averages and *Quality Compass®* 2015 South Central – All Lines of Business (LOB) (Excluding PPOs) Medicaid benchmarks.

Table 5. HEDIS® Access to/Availability of Care Measures – 2014 and 2015

Measure	UHCCP HEDIS® 2014	UHCCP HEDIS® 2015	2015 Statewide Average	*Quality Compass®* 2015 South Central Regional Medicaid Benchmarks					
				Regional Average	P10	P25	P50	P75	P90
	Children and Adolescents' Access to PCPs								
12–24 Months	97.28%	96.34%	95.66%	96.03%	93.28	94.66	96.71	97.49	97.96
25 Months–6 Years	87.82%	87.19%	86.23%	89.08%	84.01	86.66	89.68	91.58	93.70
7–11 Years	86.92%	89.34%	88.18%	92.45%	86.28	89.66	94.00	94.75	96.30
12–19 Years	85.09%	87.68%	86.39%	90.37%	84.59	87.87	90.98	94.09	95.16
	Adults' Access to Preventive/Ambulatory Services								
20–44 Years	82.04%	81.59%	79.15%	79.30%	72.88	76.83	78.63	82.09	86.17
45–64 Years	89.33%	89.85%	87.80%	87.21%	83.52	86.49	87.93	90.34	92.00
65+ Years	78.31%	85.19%	77.11%	85.34%	74.64	83.13	86.39	89.44	92.27
	Access to Other Services								
Timeliness of Prenatal Care	83.21%	90.71%	85.41%	84.10%	70.57	83.80	87.10	88.54	91.00
Postpartum Care	54.99%	55.01%	46.72%	57.83%	47.45	51.41	59.12	64.48	68.86

HEDIS® Use of Services Measures

This section of the report explores utilization of UHCCP's services by examining selected HEDIS® Use of Services rates. Table 6 displays Health Plan rates for select HEDIS® Use of Services measure rates for HEDIS® 2014 and HEDIS® 2015, Bayou Health 2015 statewide averages and *Quality Compass*® 2015 South Central – All Lines of Business (LOB) (Excluding PPOs) Medicaid benchmarks.

Table 6. Use of Services Measures – 2014 and 2015

Measure	UHCCP		2015 Statewide Average	*Quality Compass*® 2015 National Medicaid Benchmarks					
	HEDIS® 2014	HEDIS® 2015		Regional Average	P10	P25	P50	P75	P90
Adolescent Well-Care Visit	46.72%	55.96%	49.73%	53.59%	34.55	43.75	55.96	63.92	72.26
Frequency of Ongoing Prenatal Care - ≥ 81%	73.48%	78.24%	69.25%	61.86%	47.45	55.55	61.92	71.57	75.12
Well-Child Visits in the First 15 Months of Life 6+ Visits	58.39%	65.34%	55.22%	53.88%	40.23	48.60	53.12	61.30	67.88
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	63.59%	63.40%	63.74%	71.58%	59.75	64.10	73.36	78.76	82.73

Member Satisfaction: Adult and Child CAHPS® 5.0H

In 2014, the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H survey of Adult Medicaid members and Child Medicaid members was conducted on behalf of UHCCP by the NCQA-certified survey vendor, The Center for the Study of Services.

Table 7 and Table 8 show UHCCP's CAHPS® rates for 2013-2015, as well as *Quality Compass*® 2015 South Central – All Lines of Business (LOB) (Excluding PPOs) Medicaid benchmarks. The *Shared Decision Making* composite was modified and therefore not trendable.

Table 7. Adult CAHPS® 5.0H – 2013-2015

Measure[1]	UHCCP			*Quality Compass*® 2015 South Central Regional Medicaid Benchmarks					
	CAHPS® 2013	CAHPS® 2014	CAHPS® 2015	Regional Average	P10	P25	P50	P75	P90
Getting Needed Care[2]	78.93%	76.84%	80.31%	82.79%	79.28	80.31	83.24	84.68	85.41
Getting Care Quickly[2]	78.70%	81.31%	80.50%	81.60%	77.52	79.77	81.57	83.18	85.26
How Well Doctors Communicate[2]	92.58%	88.46%	90.65%	90.85%	87.66	89.05	91.09	92.34	93.12
Customer Service[2]	88.94%	86.94%	87.35%	88.42%	84.04	87.07	88.69	89.87	91.82
Shared Decision Making[2]			74.71%	77.06%	73.18	75.54	76.72	79.66	80.35
Rating of All Health Care	70.53%	73.01%	73.52%	73.90%	69.35	71.75	72.91	75.81	78.77
Rating of Personal Doctor	76.13%	76.97%	80.61%	80.56%	77.56	78.09	80.51	81.72	85.61
Rating of Specialist	79.28%	79.87%	84.62%	80.49%	73.58	77.94	80.98	83.75	86.63
Rating of Health Plan	75.07%	77.08%	77.49%	77.62%	72.80	74.81	78.14	80.44	80.92

[1] Note: for "Rating of" measures, Medicaid rates are based on ratings of 8, 9 and 10; for measures that call for respondents to answer with "Always," "Usually," "Sometimes" or "Never" the Medicaid rate is based on responses of "Always" or "Usually".
[2] These indicators are composite measures.

Table 8. Child CAHPS® 5.0H General Population – 2013-2015

Measure[1]	UHCCP			*Quality Compass®* 2015 South Central Regional Medicaid Benchmarks					
	CAHPS® 2013	CAHPS® 2014	CAHPS® 2015	Regional Average	P10	P25	P50	P75	P90
Getting Needed Care[2]	89.66%	90.71%	86.24%	85.28%	78.75	82.86	86.07	88.25	89.42
Getting Care Quickly[2]	92.19%	91.82%	94.62%	89.68%	83.51	87.06	90.62	92.09	94.62
How Well Doctors Communicate[2]	94.66%	95.30%	93.75%	92.79%	89.75	91.06	93.32	94.03	95.62
Customer Service[2]	88.21%	88.03%	87.67%	89.36%	86.24	87.13	89.54	91.10	91.57
Shared Decision Making[2]			78.04%	75.82%	66.55	70.92	78.39	80.08	80.75
Rating of All Health Care	80.81%	90.72%	88.08%	85.73%	81.39	84.18	86.32	87.69	88.70
Rating of Personal Doctor	88.46%	90.64%	89.23%	88.47%	86.77	87.25	88.12	89.65	90.74
Rating of Specialist	81.66%	92.66%	88.37%	85.38%	81.67	83.90	85.34	86.71	87.88
Rating of Health Plan	86.09%	92.16%	86.14%	86.97%	81.85	84.86	86.40	89.72	92.35

[1] Note: for "Rating of" measures, Medicaid rates are based on ratings of 8, 9 and 10; for measures that call for respondents to answer with "Always," "Usually," "Sometimes" or "Never" the Medicaid rate is based on responses of "Always" or "Usually".
[2] These indicators are composite measures.

V. COMPLIANCE MONITORING

Medicaid Readiness Review Findings for Contract Year 2014-2015

During this review period, IPRO conducted Readiness Reviews of the Bayou Health Medicaid MCOs. The purpose of the Readiness Reviews were to assess the MCOs operational capacity to participate in Medicaid managed care and begin enrollment in accordance with the newly-enforced state contract regulations for Medicaid managed care. The MCOs were required to demonstrate the ability to operate a program that meets the Department of Health and Hospitals' (DHH) requirements and were expected to clearly define and document the policies and procedures to support day-to-day business activities related to Louisiana Medicaid enrollees. Enrollment under the updated contract regulations began in February 2015.

The following domains were reviewed for the 2014-2015 Aetna Readiness Review:

- 2.0 Scope of Work/Requirements
- 4.0 Staff Requirements and Support Services
- 6.0 Core Benefits & Services
- 7.0 Provider Network Requirements
- 8.0 Utilization Management
- 10.0 Provider Services
- 11.0 Eligibility, Enrollment & Disenrollment
- 12.0a Marketing
- 12.0b Member Education
- 13.0 Member Grievances & Appeals
- 14.0 Quality Management
- 15.0 Fraud, Abuse and Waste Prevention

Table 9 displays the compliance determination categories used by IPRO during the 2014-2015 Readiness Review.

Table 9. 2014 Readiness Review Determination Description

Determination	Definition
Met	Health plan has met or exceeded requirements.
Not Met	Health plan has not met most critical requirements, all or some non-critical requirements, and has significant deficiencies requiring corrective action.
N/A	Not applicable.

Findings from UHCCP's 2014-2015 Readiness Review follow. Table 10 displays the total number of requirements reviewed for each domain, as well as compliance determination counts for each domain. Table 11 displays descriptions of all standards/elements that were "Not Met".

Table 10. Overall Compliance Determination by Domain

Domain	Total No. of Requirements Reviewed	Compliance Determination Totals		
		Met	Not Met	N/A
2.0 Scope of Work/Requirements	3	3	0	0
4.0 Staff Requirements and Support Services	4	4	0	0
6.0 Core Benefits & Services	100	100	0	0
7.0 Provider Network Requirements	167	162	5	0
8.0 Utilization Management	98	98	0	0
10.0 Provider Services	58	58	0	0
11.0 Eligibility, Enrollment & Disenrollment	26	26	0	0
12.0a Marketing	118	118	0	0
12.0b Member Education	133	131	0	2
13.0 Member Grievances & Appeals	67	66	1	0
14.0 Quality Management	65	63	0	2
15.0 Fraud, Abuse and Waste Prevention	110	108	0	2
TOTAL	949	937	6	6

Table 11. Elements Requiring Corrective Action by Review Area

2014-2015 Medicaid Managed Care Readiness Review – Elements Not Fully Met	
Domain	**Description of Review Findings Not Fully Met**
7.0 Provider Network Requirements	§ According to the Geo Access report, deficiencies exist in most counties with regard to member access to the following specialists to which the plan (for most parishes) has provided no remedy - either by subcontracting the service or by requesting an exception from DHH: o Allergy/Immunology o Colon and Rectal Surgery o Dermatology o Dialysis o Endocrin and Metabolism o Neuro Surgery o Neurology o Pediatric Allergist o Pediatric Cardiology o Pediatric Critical Care Medicine o Pediatric Emergency Medicine o Pediatric Endocrinology o Pediatric Gastroenterology o Pediatric Hematology/Oncology o Pediatric Infectious Disease o Pediatric Nephrology o Pediatric Pulmonology o Pediatric Rheumatology o Pediatric Surgery o Plastic Surgery o Rheumatology o Thoracic Surgery § Deficiencies were also noted in travel distance for members living in urban parishes (exceeding 20 miles) whereby 3% of all urban members do not have access to 1 provider in 20 miles. § Geo Access reports for pharmacies were not submitted for review by the Plan, therefore, adequate access for members could not be assessed. This area was not addressed in the gap narrative. § Geo Access reports for hemodialysis centers were not submitted for review by the Plan, therefore, adequate access for members could not be assessed. This area was not addressed in the gap narrative. § The contract requirement which states that the MCO shall notify the Fiscal Intermediary by close of business the next business day of a PCP's termination was not addressed in any policy document.
13.0 Member Grievances & Appeals	§ The documentation submitted for review did not address the required 5-day timeframe related to member fraud.

VI. STRENGTHS, OPPORTUNITIES FOR IMPROVEMENT & RECOMMENDATIONS

This section summarizes the accessibility, timeliness and quality of services provided by UHCCP to Medicaid recipients based on data presented in the previous sections of this report. The Plan's strengths in each of these areas are noted, as well as opportunities for improvement. Recommendations for enhancing the quality of healthcare are also provided based on the opportunities for improvement noted.

Strengths

- The 2015 HEDIS® Final Audit Report revealed no significant problems and the Health Plan was able to report all required Medicaid rates.
- The Health Plan performed above the 75th percentile on the following HEDIS® measures: *Timeliness of Prenatal Care*, *Frequency of Ongoing Prenatal Care - ≥ 81%* and *Well-Child Visits in the First 15 Months of Life 6+ Visits*.
- The Health Plan performed well in regard to some areas of member satisfaction. The Health Plan exceeded the 75th percentile for the Adult CAHPS® *Rating of Specialist* measure, and exceeded the 75th percentile for the following Child CAHPS® measures: *Getting Care Quickly*, *Rating of All Health Care* and *Rating of Specialist*.

Opportunities for Improvement

- The Health Plan continues to demonstrate an opportunity for improvement in regard to its overall HEDIS® performance. The following measures performed below the 50th percentile: *Adult BMI Assessment*, *Asthma Medication Ratio*, *Breast Cancer Screening*, *Comprehensive Diabetes Care – HbA1c Testing*, *Controlling High Blood Pressure*, *Follow-up Care for Children Prescribed ADHD Medication – Continuation and Maintenance Phase*, *Follow-up Care for Children Prescribed ADHD Medication – Initiation Phase, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI Percentile*, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition*, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Physical Activity*, *Postpartum Care* and *Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life*.
- In addition, the Health Plan continues to demonstrate an opportunity for improvement in regard to access to care as rates for all age groups were below the 50th percentiles for the HEDIS® *Children and Adolescents Access to PCPs*. Additionally, *Adults' Access to Preventive/Ambulatory Services* rates for the 65+ years age group was also below the 50th percentile.
- The Health Plan continues to demonstrate an opportunity for improvement in regard to member satisfaction as it reported rates below the 50th percentile for several Adult CAHPS® measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Shared Decision Making* and *Rating of Health Plan*. The Health Plan also performed below the 50th percentile for following Child CAHPS® General Population measures: *Customer Service*, *Shared Decision Makin* and *Rating of Health Plan*. (Note: Member satisfaction was an opportunity for improvement in the previous year's report.)

Recommendations

- The Health Plan should continue to work to improve HEDIS® measures that perform below the 50th percentile. Specifically, the Health Plan should continue with the improvement strategy outlined in its *2014 Quality Improvement Program Evaluation* as it includes a variety of provider, member and Health Plan initiatives. The effectiveness of the improvement strategy should routinely be assessed and modified as needed. *[Repeat recommendation.]*

- As Health Plan members continue to demonstrate lower than average access to primary care, the Health Plan should assess the effectiveness of its current interventions and modify them as needed. The Health Plan should consider intensifying member-level education and outreach efforts. *[Repeat recommendation.]*
- The Health Plan should continue to work to improve CAHPS® rates that perform below the 50th percentile. Specifically, the Health Plan should continue to address associated barriers identified in its *2014 Quality Improvement Program Evaluation* and modify initiatives as needed. *[Repeat recommendation.]*

Response to Previous Year's Recommendations

- 2013-2014 Recommendation: As the Health Plan has not demonstrated much progress with provider network PCMH recognition, the Health Plan should reevaluate its current approach and modify it as needed. *[Repeat recommendation.]*

  Plan Response: Since 2013 the Health Plan has embraced the concept of Accountable Care Communities (ACC) – United Healthcare's branded Accountable Care Organization (ACO) program for the Bayou Health membership – as its mechanism to achieve the goals of PCMH recognition. Indeed, the ACC program is a patient-centered ACO with the added goals of the Triple Aim - improved individual health, improved population health, and lower per capita costs of care. This direction has been reinforced by research and literature including a recent article in Medical economics ("ACO or PCMH"; February 2016).

  The ACC program embraces the five core principles of PCMH: Comprehensive Care through a team-based approach; Patient-centered Care oriented to the whole person; Coordinated Care with an emphasis on care transitions; Accessible PCP Services, and; a focus on Quality. In addition the program embraces technology enablers to provide actionable data to the PCP, mentorship, training and continuous process improvement of patient-centric interactions, and an opportunity for the PCP to reap incentives when they meet the programmatic goals via a Value Based Contract (VBC).

  In order to prepare and guide PCP practices towards not only PCMH certification, if they so desire, and meeting the goals of the Triple Aim, the ACC program hinge on five key tenets:

  - The reduction of avoidable ER visits;
  - The reduction of avoidable inpatient admissions and the reduction of readmissions;
  - Identification and high touch focus on the most fragile members of a PCP's practice based on propensity to be admitted in the next 90 days;
  - Improvement in access to care and ready appointment availability for the membership, and;
  - Adherence to meeting HEDIS and other quality metrics.

  To accomplish these goals the ACC program deploys several technology tools. Real-time access to data by the PCP is key to help improve the health of our members at the individual and population level, and to reduce our members total costs of care. We have deployed our innovative Population Registry tool to all ACC PCP practices which brings up to 2 years of claims based data to the fingertips of providers, provides member-specific evidence-based gaps in care to each practice-attributed patient panel, and risk stratifies practice population. In addition, we have begun deployment of an additional technology tool, UHC Transitions, which augments the admission/discharge/ transfer (ADT) data from local hospitals and LaHIE presently enjoyed within the Population Registry. One key benefit of UHC Transitions is its notification to the PCP upon admission to the hospital – allowing real-time intervention and collaboration of the PCP with the hospital admitting staff. Additionally, we continue to enjoy ADT feeds directly from several partner Louisiana hospitals across all three GSA regions and are actively working with the FMOL system for ADT access for all their

facilities. On average, we load 1,000+ Emergency Room and Inpatient events into the Population Registry on a monthly basis.

We also provide support to assist each PCP practice in their transformation to achieve the goals as a partner within our ACC program (e.g. education, training, information technology tools, and the provision of data relevant to patient clinical care management) via a dedicated Transformation Consultant.

The Consultant works directly with leadership of assigned physician practices to support practice transformation from a reactive model of patient care to a proactive Medical Home, analyzing practice population data to effectively measure, monitor and manage care of patients, and to present results and outcomes to practice and Plan executive leadership. These Consultants are located within the communities in which their assigned practices are located and we presently enjoy sixteen (16) ACC Consultant staff located in communities such as Shreveport, Baton Rouge, Lafayette, St. Charles and New Orleans.

The ACC program in Louisiana is now entering its fourth year. The past year, in particular, has seen an increased commitment to expand our interventions and programmatic footprint. Through 2015 UnitedHealthcare has continued to deploy our ACC program across an additional 100 PCP practices and now partners with 122 PCP practices across the state. As of January 1st, 2016 the ACC program impacts the lives of over 158,000 Bayou Health members.

Goals of this program continue to reinforce the direction the model is taking showing double- digit decreases in Inpatient Rates per 1,000 and substantial impact in Emergency Room Rates per 1,000. Through the remainder of 2016 we intend to continue to engage with the launched ACC practices to seek increasing positive quality and financial results.

§ 2013-2014 Recommendation: The Health Plan should continue to work to address Provider Network Requirements that did not meet contractual requirements, as well as Member Grievance & Appeals Requirements that did not meet contractual requirements, to ensure it achieves "met" compliance during the next Compliance Review. *[Repeat recommendation.]*

Plan Response: The plan conducts an annual evaluation of its programs and initiative. Barrier analysis and interventions are also reviewed and opportunities are identified for the next year. In 2013-2014 United was a shared savings plan and we did not address appeals directly, these operations were conducted by State. See the *2014 Quality Improvement Program Evaluation*, Member Grievances & Appeals, pages 73-74.

§ 2013-2014 Recommendation: The Health Plan should conduct root cause analysis for all HEDIS® Effectiveness of Care and Use of Services measures that perform below the 50th percentile and develop interventions to address these barriers. The Health Plan should also routinely monitor HEDIS® performance to assess the effectiveness of its current improvement strategy.

Plan Response: The plan conducted Barrier Analysis and Intervention on HEDIS results. See the *2014 Quality Improvement Program Evaluation*, HEDIS, pages 8-18.

§ 2013-2014 Recommendation: As Health Plan members demonstrate lower than average access to primary care, a root cause analysis should be conducted to identify barriers to care for all age groups and to drive the development of targeted interventions that will address these barriers.

Plan Response: The plan reviewed several elements that addresses access to care for our membership. Geo Access/CAHPS/QOC/Grievances & Appeals/ Access & Availability survey. See the *2014 Quality Improvement Program Evaluation,* Access/Availability/After Hours, pages 74-86 and 90- 96

- 2013-2014 Recommendation: The Health Plan should continue to work to improve member satisfaction, specifically, among its adult population. The Health Plan should also assess the effectiveness of its current approach and modify it as needed, perhaps by drawing upon successful interventions for its child population. *[Repeat recommendation.]*

  Plan Response: The plan conduct analysis Barrier Analysis/and interventions based on review of CAHPS/QOC/ Grievances & Appeals. See the *2014 Quality Improvement Program Evaluation,* CAHPS/QOC, pages 18-20, 27-31 and 71-74.