UNITEDHEALTHCARE COMMUNITY PLAN OF LOUISIANA

Annual External Quality Review Technical Report

Review Period: July 1, 2013 – June 30, 2014

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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) require that state agencies contract with an External Quality Review Organization (EQRO) to conduct an annual external quality review (EQR) of the services provided by contracted Medicaid managed care organizations (MCOs). This EQR must include an analysis and evaluation of aggregated information on quality, timeliness and access to the health care services that an MCO furnishes to Medicaid recipients. Quality is defined in 42 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, 2013 – June 30, 2014.

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 2014 *Quality Compass*® 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 December 2014)	282,016

III. ENROLLMENT AND PROVIDER NETWORK

Enrollment

Medicaid Enrollment

As of December 2014, the Health Plan's Medicaid enrollment totaled 282,016, which represents 31% of Bayou Health's active members. Table 2 displays UHCCP's Medicaid population across the three (3) Geographic Service Areas (GSAs), as well as the statewide enrollment totals. Figure 1 displays Bayou Health's membership distribution across all Health Plans.

Table 2. Medicaid Enrollment as of December 2014[1]

UHCCP	2013	2014	% Change	2014 Statewide Total[2]
GSA A	72,212	80,018	10.81%	280,483
GSA B	105,169	117,081	11.33%	324,664
GSA C	77,787	84,917	9.17%	318,993
Total Enrollment	255,168	282,016	10.52%	924,140

Data Source: Report No. 125-A

[1] This report shows all active members in Bayou Health as of the end of the reporting month. Members who will be disenrolled at the end of the reporting month are included in this report. 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.

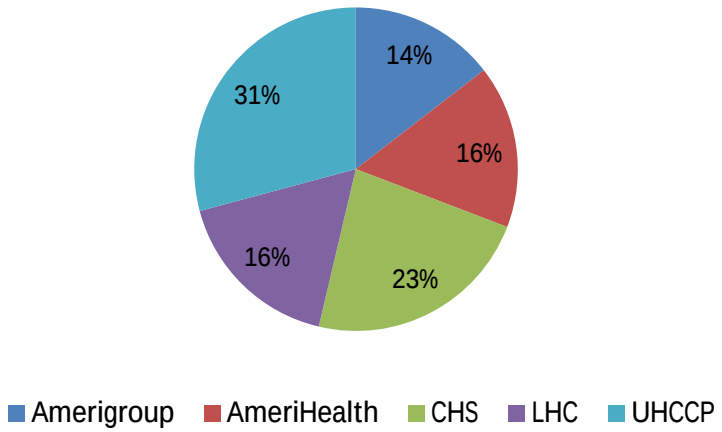
[2] Note: Total includes membership of all plans.

GSA A: New Orleans and North Shore

GSA B: Baton Rouge, Lafayette and Thibodaux

GSA C: Alexandria, Lake Charles, Monroe and Shreveport

Figure 1. Bayou Health Membership by Health Plan
as of December 2014



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 fourth quarter 2014.

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

Specialty	GSA A	GSA B	GSA C	MCO Statewide Unduplicated
Family Practice/General Medicine	278	328	466	699
Pediatrics	363	266	170	517
Nurse Practitioners	159	253	223	384
Internal Medicine	370	253	186	546
RHCS/FQHC[1]	104	234	202	124
OB/GYN[2]	37	19	7	41

Data source: Network Adequacy Review 2014 Q4

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

[1] Number of clinics, not practitioners.

[2] Accepts full PCP responsibility.

Status of Patient-Centered Medical Home (PCMH) Recognition

Patient-Centered Medical Home (PCMH) is a system of care led by a team of primary care providers who partner with the patient, the patient's family and the community to coordinate care in all settings, from specialists and hospitals to pharmacies, mental health programs, and home health agencies. The DHH requires that each Medicaid Health Plan promote and facilitate the capacity of primary care practices to function as patient-centered medical homes by using systematic, patient-centered and coordinated care management processes; and to receive National Committee on Quality Assurance (NCQA) Physician Practice Connections®-Patient Centered Medical Home (PPC®-PCMH) recognition or Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Primary Care Home (PCH) accreditation.

UHCCP's PCMH recognition as of June 2014 is displayed in Table 4.

Table 4. PCMH Recognition as of June 2014

Number of PCP Sites Contracted with MCO	Number of PCP Sites PCMH Certified or Accredited	Percentage of PCP Sites PCPMH Certified or Accredited
1,100	96[1]	8.7%

[1] Total includes providers who have achieved Level 1, Level 2 and Level 3 Recognition.

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".

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 #1: Reducing Emergency Department Visits

Indicator/Goal: 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 reduce the HEDIS® *Ambulatory Care – ED Visits* rate to at least the NCQA 2012 50th percentile, or 63.15/1,000.

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%.

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.

Opportunities for Improvement:
- It is unclear as to why the plan is not using the HEDIS® 2012 rate (reported in June 2013) as an interim measure. The first interim measurement period is reported to be the 2013 measurement year. The plan might want to consider also calculating the HEDIS® rate based on the subset of members that that they have directed interventions, i.e., asthma and sickle cell.
- As the project progresses and partnerships are established, the Health Plan should consider calculating HEDIS® performance at the hospital level.

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.

Opportunities for Improvement:
- Provider more clarification regarding interim rate and developing process measures in addition to the HEDIS® measure.

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). For the remaining two indicators, programming is still in progress; goals to be determined.

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.

Opportunities for Improvement:

- As the project progresses, the Health Plan might consider a hospital system as a possible partner, perhaps a hospital identified as an outlier.

Performance Measures: HEDIS® 2014 (Measurement Year 2013)

MCO-reported performance measures were validated as per HEDIS® 2014 Compliance Audit™ specifications developed by the National Committee for Quality Assurance (NCQA). The results of each MCO's HEDIS® 2014 Compliance Audit are summarized in its Final Audit Report (FAR).

The HEDIS® 2014 Final Audit Report (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 5 displays select HEDIS® Effectiveness of Care measure rates for Measurement Year 2013 (HEDIS® 2014) as compared to *Quality Compass*® 2014 national Medicaid benchmarks.

Table 5. HEDIS® Effectiveness of Care Measures – Measurement Year 2013 (HEDIS® 2014)

Measure	UHCCP HEDIS® 2014	*Quality Compass*® 2014 National Medicaid Benchmarks					
		National Average	P10	P25	P50	P75	P90
Adult BMI Assessment	64.72%	75.91%	64.35%	71.54%	78.78%	85.09%	90.82%
Antidepressant Medication Management - Acute Phase	50.21%	50.51%	41.87%	45.07%	49.67%	54.39%	60.86%
Antidepressant Medication Management - Continuation Phase	33.40%	35.18%	27.03%	29.90%	33.93%	38.25%	44.62%
Asthma Medication Ratio (5-64 Years)	60.00%	65.45%	53.29%	60.48%	66.37%	70.88%	76.23%
Breast Cancer Screening in Women	SS	57.90%	46.59%	51.21%	57.42%	65.12%	71.35%
Cervical Cancer Screening [1]	52.80%						
Childhood Immunization Status - Combination 3	67.40%	70.85%	58.70%	66.67%	72.33%	77.78%	80.86%
Chlamydia Screening in Women (16-24 Years)	53.66%	54.90%	41.19%	48.86%	54.97%	62.57%	67.19%
Comprehensive Diabetes Care - HbA1c Testing	77.62%	83.80%	77.55%	80.18%	83.87%	87.59%	91.73%
Comprehensive Diabetes Care - LDL-C Screening	69.10%	75.97%	66.87%	71.30%	76.87%	80.18%	83.71%
Controlling High Blood Pressure	45.74%	56.47%	43.07%	48.53%	56.20%	63.76%	69.79%
Cholesterol Management for Patients With Cardiovascular Conditions – LDL-C Control (<100 mg/dL)	25.35%	81.07%	74.57%	78.33%	81.45%	84.91%	87.84%
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	45.81%	46.35%	23.12%	37.17%	49.51%	57.55%	63.10%
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	32.59%	39.56%	21.77%	32.61%	41.09%	46.99%	53.03%
Lead Screening in Children	67.95%	66.46%	37.23%	58.39%	70.86%	80.83%	85.84%
Medication Management for People With Asthma Total - Medication Compliance 75% (5-64 Years)	31.12%	31.26%	20.07%	24.55%	30.19%	35.37%	43.08%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile	27.49%	56.92%	32.18%	41.85%	57.40%	73.72%	82.46%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	38.69%	58.70%	40.74%	50.00%	60.58%	69.21%	77.47%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity	26.03%	50.50%	33.77%	41.67%	51.16%	60.82%	69.76%

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 6 displays select HEDIS® Access to/Availability of Care measure rates for Measurement Year 2013 (HEDIS® 2014) as compared to *Quality Compass*® 2014 national Medicaid benchmarks.

Table 6. HEDIS® Access to/Availability of Care Measures – Measurement Year 2013 (HEDIS® 2014)

Measure	UHCCP HEDIS® 2014	*Quality Compass*® 2014 Benchmarks					
		National Average	P10	P25	P50	P75	P90
	Children and Adolescents' Access to PCPs						
12–24 Months	97.28%	96.14%	93.58%	95.92%	96.96%	97.86%	98.53%
25 Months–6 Years	87.82%	88.25%	82.16%	86.07%	89.08%	91.73%	93.58%
7–11 Years	86.92%	90.02%	83.57%	87.78%	91.15%	93.50%	95.19%
12–19 Years	85.09%	88.53%	81.57%	85.83%	89.98%	92.17%	94.42%
	Adults' Access to Preventive/Ambulatory Services						
20–44 Years	82.04%	80.71%	68.99%	78.34%	83.22%	86.21%	88.52%
45–64 Years	89.33%	87.34%	80.11%	85.88%	88.76%	90.99%	92.25%
65+ Years	78.31%	85.55%	73.24%	82.35%	88.40%	90.70%	92.61%
	Access to Other Services						
Timeliness of Prenatal Care	83.21%	81.93%	69.77%	77.80%	84.30%	89.62%	93.10%
Postpartum Care	54.99%	61.29%	48.37%	56.18%	62.84%	69.47%	74.03%

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 7 displays select HEDIS® Use of Services measure rates for Measurement Year 2013 (HEDIS® 2014) as compared to *Quality Compass*® 2014 national Medicaid benchmarks.

Table 7. Use of Services Measures – Measurement Year 2013 (HEDIS® 2014)

Measure	UHCCP HEDIS® 2014	*Quality Compass*® 2014 National Medicaid Benchmarks					
		National Average	P10	P25	P50	P75	P90
Adolescent Well-Care Visits	46.72%	50.03%	37.73%	41.70%	48.51%	59.21%	65.56%
Frequency of Ongoing Prenatal Care - ≥ 81%	73.48%	55.64%	21.74%	43.73%	60.10%	71.34%	78.37%
Well-Child Visits in the First 15 Months of Life 6+ Visits	58.39%	61.55%	45.50%	54.76%	62.86%	69.75%	76.92%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	63.59%	71.49%	60.18%	65.97%	71.76%	77.26%	82.69%

Member Satisfaction: Adult and Child CAHPS® 5.0H

In 2013, 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 8 and Table 9 show UHCCP's 2014 rates in comparison to the *Quality Compass*® 2014 national benchmarks.

Table 8. Adult CAHPS® 5.0H

Measure[1]	UHCCP		*Quality Compass*® 2014 Benchmarks					
	2013	2014	Average	P10	P25	P50	P75	P90
Getting Needed Care[2]	78.93%	76.84%	80.45%	74.70%	77.47%	80.90%	84.27%	85.59%
Getting Care Quickly[2]	78.70%	81.31%	81.00%	75.26%	78.39%	81.75%	83.75%	85.52%
How Well Doctors Communicate[2]	92.58%	88.46%	89.49%	86.17%	88.16%	89.76%	91.11%	92.42%
Customer Service[2]	88.94%	86.94%	86.51%	81.85%	84.45%	87.05%	88.64%	90.28%
Shared Decision Making[2]	50.13%	48.15%	51.20%	46.87%	49.07%	50.89%	53.69%	55.49%
Rating of All Health Care	70.53%	73.01%	71.26%	64.32%	68.54%	71.53%	74.06%	76.95%
Rating of Personal Doctor	76.13%	76.97%	78.75%	74.37%	76.45%	78.82%	80.97%	83.10%
Rating of Specialist	79.28%	79.87%	80.42%	75.89%	78.64%	80.61%	82.47%	85.31%
Rating of Health Plan	75.07%	77.08%	74.67%	66.57%	71.37%	75.52%	78.77%	81.49%

[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 9. Child CAHPS® 5.0H – General Population

Measure[1]	UHCCP		*Quality Compass*® 2014 Benchmarks					
	2013	2014	Average	P10	P25	P50	P75	P90
Getting Needed Care[2]	89.66%	90.71%	84.97%	79.05%	82.62%	85.44%	87.90%	90.71%
Getting Care Quickly[2]	92.19%	91.82%	89.46%	83.34%	87.67%	90.59%	92.45%	93.81%
How Well Doctors Communicate[2]	94.66%	95.30%	92.98%	89.71%	91.96%	93.25%	94.67%	95.61%
Customer Service[2]	88.21%	88.03%	87.89%	84.38%	85.98%	88.13%	89.91%	91.03%
Shared Decision Making[2]	57.37%	60.32%	54.65%	47.59%	51.79%	54.93%	58.26%	60.32%
Rating of All Health Care	80.81%	90.72%	84.70%	80.94%	82.63%	84.70%	86.65%	88.85%
Rating of Personal Doctor	88.46%	90.64%	87.63%	84.38%	85.89%	87.84%	89.43%	90.93%
Rating of Specialist	81.66%	92.66%	85.02%	80.69%	83.06%	85.01%	87.36%	89.50%
Rating of Health Plan	86.09%	92.16%	84.49%	78.63%	81.85%	84.83%	87.45%	88.66%

[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

This section of the report presents the results of the reviews by IPRO of UHCCP's compliance with regulatory standards and contract requirements for Contract Year 2014-2015. The information is derived from IPRO's conduct of the Readiness Review in January 2015.

UHCCP underwent a full readiness review of all the prepaid contract standards/elements contained as a result of the Plan's decision to shift from the shared-savings payment model to the prepaid payment model. The following domains were reviewed:

- § 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 10 displays the compliance determination categories used by IPRO during the 2014 Readiness Review.

Table 10. 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 Readiness Review follow. Table 11 displays the total number of requirements reviewed for each domain, as well as compliance determination counts for each domain. Table 12 displays descriptions of all standards/elements that were "Not Met".

Table 11. 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 12. Elements Requiring Corrective Action by Review Area

2014 Medicaid Managed Care Compliance 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 2014 HEDIS® Final Audit Report revealed no significant problems and the Health Plan was able to report all required Medicaid rates.
- In regard to the 2014-2015 Compliance Review, the Health Plan demonstrated strong performance, as requirements reviewed for ten (10) of the twelve (12) domains achieved "met" compliance determination.
- The Health Plan performed above the 75th percentile on the HEDIS® *Frequency of Ongoing Prenatal Care - ≥ 81%* measure.
- The Health Plan demonstrated strong performance in regard to child member satisfaction as indicated by meeting or exceeding the 75th percentile for the following Child CAHPS® General Population measures: *Getting Needed Care*, *How Well Doctors Communicate, Shared Decision Making, Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist* and *Rating of Health Plan.*

Opportunities for Improvement

- The Health Plan continues to demonstrate an opportunity for improvement in regard to its provider network as PCMH recognition remains low. (Note: PCMH recognition was an opportunity for improvement in the previous year's report.)
- In regard to the 2014-2015 Compliance Review, the Health Plan continues to demonstrate an opportunity for improvement in the Provider Network Requirements Domain as two (2) requirements were determined to be "not met". The Health Plan also demonstrates an opportunity for improvement in the Member Grievances & Appeals as one (1) requirement was determined to be "no met". (Note: Compliance with the Provider Network Requirements Domain was an opportunity for improvement in the previous year's report.)
- The Health Plan demonstrates an opportunity for improvement in regard to its overall HEDIS® performance. The following measures performed below the 50th percentile: *Adult BMI Assessment*, *Antidepressant Medication Management – Continuation Phase*, *Asthma Medication Ratio*, *Childhood Immunization Status – Combo 3*, *Chlamydia Screening in Women*, *Comprehensive Diabetes Care – HbA1c Testing*, *Comprehensive Diabetes Care – LDL-C Screening*, *Controlling High Blood Pressure*, *Cholesterol Management for Patients With Cardiovascular Conditions – LDL-C Control*, *Follow-up Care for Children Prescribed ADHD Medication – Continuation and Maintenance Phase*, *Follow-up Care for Children Prescribed ADHD Medication – Initiation Phase, Lead Screening in Children*, *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, Timeliness of Prenatal Care*, *Postpartum Care*, *Adolescent Well-Care Visits, Well-Child Visits in the First 15 Months of Life 6+ Visits* and *Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life*.

- In addition, the Health Plan demonstrates an opportunity for improvement in regard to access to care, as rates for age groups 25 Months-6 Years, 7-11 Years, 12-19 Years, 20-44 Years, and 65 Years +were below the 50th percentiles for the HEDIS® *Children and Adolescents Access to PCPs* and *Adults' Access to Preventive/Ambulatory Services* measures.
- 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, Rating of Personal Doctor* and *Rating of Specialist*. The Health Plan also performed below the 50th percentile for the a single Child CAHPS® General Population measure: *Customer Service*. (Note: Member satisfaction was an opportunity for improvement in the previous year's report.)

Recommendations

- 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.]*
- 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.]*
- 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.
- 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.
- 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.]*

Response to Previous Year's Recommendations

- 2012-2013 Recommendation: The Plan should report performance measures to the DHH that allow for the evaluation of the quality of, access to and timeliness of care, specifically, as it relates to its Medicaid population.

  Plan Response: Each year, UnitedHealthcare Community Plan of Louisiana (UHCCP) conducts an evaluation of its Quality Improvement (QI) Program to assess the overall effectiveness of the health plan's quality improvement processes. The evaluation reviews all aspects of the Program, emphasizing the Program's demonstrated improvements in the quality of care and service provided to members. The annual evaluation includes:
  - A summary of completed and ongoing QI activities that address quality and safety of clinical care and quality of service.
  - A review of the HEDIS® 2013 performance for dates of service in 2012.
  - A review of CAHPS® 2013 survey results.
  - A review of year over year performance to assess trends in performance in the quality and safety of clinical care and service. (Year over year performance is not available for HEDIS® measures as the plan was just initiated in 2012.)

- A quantitative and qualitative analysis of the results of all initiatives including identification of barriers to achieving goals.
- An evaluation of the overall effectiveness of the program including progress toward influencing safe clinical practices.

This document describes activities for the UHCCP Medicaid line of business.

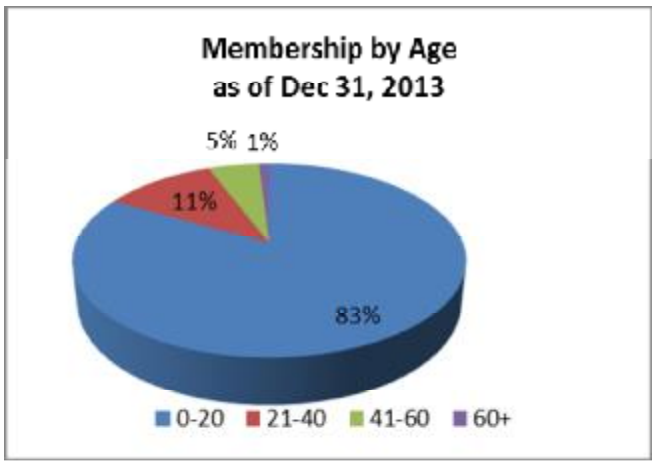
UHCCP uses the results of the annual evaluation to develop and prioritize activities included in the next year's QI Work Plan and to monitor previously identified issues. The Quality Management Committee (QMC) reviews and approves the annual evaluation and presents the annual evaluation to the Board of Directors. The final page of the annual evaluation documents the QMC approval and the Board of Directors review.

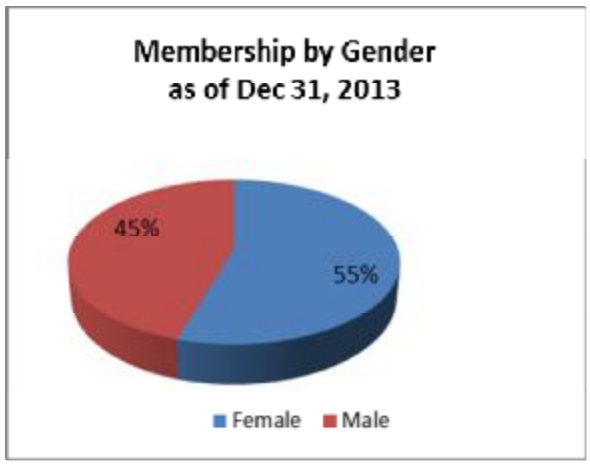
In order to fulfill the goals and objectives of the QI Program and effectively use resources, multiple activities were integrated throughout the health plan and UnitedHealth Group divisions. These included, but are not limited to, activities conducted with Health Services which included Disease and Case Management and Prevention; Provider Sales and Marketing; Compliance; Member Services; Clinical Services; Clinical Services Appeals (CSA) and the National Credentialing Center (NCC). In addition, the QI Program focused on high-volume, high-risk areas of care and service for its population. United Healthcare Community Plan is supported by the National Quality Management and Performance (QMP) shared service in conducting its QI program and associated activities.

United Healthcare Community Plan's QI Program demonstrated an inter-disciplinary approach to continuous QI activity, with support from the highest levels of management at the Plan. In addition, community physicians and other health care practitioners actively participated in the QI process. Following is a list of resources that supported QI Program activities:

- QMP staff including subject matter experts in the areas of QI program design, project management, accreditation, and data analysis and reporting worked with the health plan on an ongoing basis to achieve program goals and objectives
- National departments such as the National Credentialing Center and Community & State Appeals
- Health Services including Disease Management, Case Management, Pre-certification and Prevention
- UM including Medical Directors and Pharmacy
- Operations
- Provider Services
- Enrollment
- Compliance
- Marketing and Community Outreach

UHCCP membership as of December 31, 2013 was 257,746 Medicaid lives. The plan operated in all parishes in Louisiana.





The results for unaudited interim HEDIS® 2014 performance measures are analyzed below. These interim rates were calculated as of January 20, 2014, are not final, and may be understated. For all measures, claims are incomplete due to normal lag in submission and payment. For measures where NCQA allows a hybrid methodology for data collection, final rates may be significantly understated as this methodology allows for claims data to be augmented by chart review data.

State mandated non-HEDIS® measures will be reported for the first time for dates of service in 2014. UHCCP sets goals to increase the rates of HEDIS® performance measures based on NQMOC goals or State of Louisiana Department of Health and Hospitals (DHH) mandated performance goals, where applicable. Where available, rates are compared to the State benchmark rates from HEDIS® 2012. In the absence of State benchmarks, because this is the plan's inaugural year for reporting rates, trend data are not available.

HEDIS® 2013 rates for dates of service were calculated for purposes of monitoring performance, but are not reported here because the data represented only 11 months of enrollment for approximately one-third of the membership (GSA-A) during the period of transition to Bayou Health, the State's Medicaid managed care program. Bayou Health was phased in throughout the State by GSA over five months.

Preventive Health Activities

UHCCP is committed to providing programs that emphasize and encourage health, wellness and prevention, with a goal of improving performance annually. Through the year, performance rates are analyzed and targeted programs are developed and implemented.

This section of the document will provide an analysis of the plan's performance measure results.

Breast Cancer Screening for Women

Objective: Measure the effectiveness of interventions taken by the health plan to improve the breast cancer screening (BCS) rates for women aged 40-69.

Methodology: HEDIS® 2013 (administrative); NCQA significantly revised the specification for this measure for HEDIS® 2014, so to gauge improvement, unaudited interim rates for dates of service in 2013 were calculated using the specifications for HEDIS® 2013 to have measurement consistent with that used to calculate the State benchmark.

Results:

Measure	HEDIS® 2014 Goal (for Performance Improvement Project)	HEDIS® 2012 State Benchmark	Interim Unaudited Rate for Dates of Service in 2013 (as of 1/20/14)	Goal Met	State Benchmark Met
Breast Cancer Screening	61.81 (Percentile >= 50th)	42.65	46.55	No	Yes

Analysis/Limitations/Barriers: Based on the State's HEDIS® 2012 rate of 42.65 and breast cancer incidence and mortality rates in Louisiana, in 2012 UHCCP initiated a performance improvement project (PIP) to increase breast cancer screening rates. Initial results reflect improvement over the State benchmark.

For HEDIS® 2014 (dates of service 2013), NCQA lengthened the continuous enrollment requirement for this measure and changed the age range for the population from 40-69 to 50-74 to meet current evidence-based guidelines for care. Because of this, it is not possible to calculate a BCS rate using NCQA HEDIS® 2014 specifications. In addition, 2013 outreach efforts concentrated on the 40-69 age range to allow for measurement consistency for the PIP.

Actions and Interventions: Actions and interventions are described in the Performance Improvement Project section of this document.

Although monitoring and member outreach to improve BCS will continue in 2014, the PIP will be replaced by one on cervical cancer screening to take advantage of a shorter continuous enrollment period and a consistent NCQA specified population for inclusion in the denominator. This will allow for alignment between BCS outreach efforts and the NCQA specifications for the measure which are based upon evidence-based practice guidelines.

Cervical Cancer Screening for Women

Objective: Measure the effectiveness of interventions taken by the health plan to improve the cervical cancer screening rates for women.

Methodology: HEDIS® 2014 (hybrid)

Measure	HEDIS® 2014 Goal	Interim Unaudited Rate for HEDIS® 2014 (as of 1/20/14)	Goal Met
Cervical Cancer Screening	62.13 (HEDIS® 2012 State Benchmark)	49.19	Not as of 1/20/14, but claims will be augmented with chart review

Analysis/Limitations/Barriers:

- State benchmarks were calculated using a HEDIS®-like methodology that excluded members with third party liability in the denominator, which may have overstated what the rate would have been had the standard HEDIS® specifications been used.
- Through the Clinical Practice Consultant (CPC) program, a barrier that surfaced was the lack of coordination between primary care and gynecological care. Primary care practitioners (PCPs) assumed that the gynecologist was providing care which was not always the case.
- Through interaction with members and member advocacy groups, a second barrier is the lack of knowledge of the members about this important preventive screening and preventive healthcare in general.

Actions and Interventions:

- Continued CPC outreach and education to high-volume PCPs or to PCPs who are outliers in terms of cervical cancer screening in relationship to their peers. Education emphasizes that it is the PCP's responsibility either to perform cervical cancer screening or ensure that members see a gynecologist who does so. CPCs can also assist with identifying members with gaps in care to assist the PCPs with conducting their own outreach.
- Continued telephonic preventive health outreach calls to members with gaps in care.
- Continued yearly preventative health mailings.
- In 2014, a PIP for this measure will be initiated.

Chlamydia Screening in Women

Objective: Measure the effectiveness of interventions taken by the health plan to improve the Chlamydia screening rates for women 16-24 years.

Methodology: HEDIS® 2014 (admin)

Measure	HEDIS® 2014 Goal	Interim Unaudited Rate for HEDIS® 2014 (as of 1/20/14)	Goal Met
Chlamydia Screening	58.68 (HEDIS® 2012 State Benchmark)	51.32	Not as of 1/20/14

Analysis/Limitations/Barriers:

- Through the Clinical Practice Consultant (CPC) program, a barrier that surfaced was the lack of PCP knowledge about the availability of in-office screening kits and the lack of knowledge about Chlamydia screening being a part of preventative care. Secondarily, a lack of coordination between primary care and gynecological care was identified.
- Through interaction with members and member advocacy groups, a second barrier is the lack of knowledge of the members about this important preventive screening and preventive healthcare in general.
- UHCCP identified that institutional claims payment information from Molina, the fiduciary intermediary, did not include the Current Procedural Terminology (CPT) codes. This meant that any test conducted at a facility was not reflected in our HEDIS® rates, causing the rate reported above to be understated.
- UHCCP also identified that Chlamydia screenings conducted in Office of Public Health clinics may not have been billed to Medicaid, causing the rate reported above to be understated.

Actions and Interventions:

- Continued CPC outreach and education to high-volume PCPs or to PCPs who are outliers in terms of Chlamydia screening in relationship to their peers. Education emphasized that it is the PCP's responsibility to perform urine Chlamydia screens to all eligible populations. CPCs also assisted with identifying members with gaps in care to assist the PCPs with conducting their own outreach. These efforts will continue in 2014.
- An article about Chlamydia screening was included in the member newsletter in fall 2013.
- Continued telephonic preventive health outreach calls to members with gaps in care.
- Addition of a Louisiana-based Quality Outreach Coordinator to assist with targeted outreach calls to members with gaps in care.
- Molina has submitted institutional CPT codes for 2012 and 2013, and is working on submitting them to UHCCP as part of the standard claims payment information data feed.
- The Louisiana Department of Health and Hospitals is now facilitating data sharing between Bayou Health plans and the Office of Public Health.

Childhood Immunization Status

Objective: Measure the effectiveness of interventions taken by the health plan to improve the childhood immunization rates.

Methodology: HEDIS® 2014 (Hybrid)

Measure	HEDIS® 2014 Goal	Interim Unaudited Rate for HEDIS® 2014 (as of 1/20/14)	Goal Met
Childhood Immunization (Combo 3)	13.96 (HEDIS® 2012 State Benchmark)	65.78	Yes

Analysis/Limitations/Barriers:

- Because the health plan is relatively new, historical claims data for immunizations were not as robust as it might be for a more mature plan. One of the major barriers identified by the health plan was the lack of process for the health plan to participate in data sharing with the state immunization registry, LA LINKS.
- A second barrier was the lack of knowledge of the members about preventive healthcare in general.

Actions and Interventions:

- Obtained a one-time data file from LA LINKS with a promise for a second feed in spring 2014. A goal for 2014 is to increase the frequency of the data feeds. This will result in more actionable data for providers and the CPCs that support them to facilitate closing gaps in care. In addition, the health plan will be able to more accurately assess provider performance against their peers, to identify both best practice and opportunities for improvement.
- Included an article about well child care and immunizations in the summer 2013 member newsletter.
- Continued telephonic preventive health outreach calls to members with gaps in care.
- Addition of a Louisiana-based Quality Outreach Coordinator to assist with targeted outreach calls to members with gaps in care.
- Continued CPC outreach and education emphasizing strategies for closing gaps in care for immunizations.

Immunizations for Adolescents

Objective: Measure the effectiveness of interventions taken by the health plan to improve the adolescent immunization rates.

Methodology: HEDIS® 2014 (Hybrid)

Measure	HEDIS® 2014 Goal	Interim Unaudited Rate for HEDIS® 2014 (as of 1/20/14)	Goal Met
Immunizations for Adolescents (Combo 1)	68.25 (HEDIS® 2012 State Benchmark)	88.22	Yes

Analysis/Limitations/Barriers:

- UHCCP met its goal for this measure and exceeded the NCQA Quality Compass 90th percentile.
- Historically, the State EPSDT periodicity schedule indicated that adolescent well care was to be provided every two years as opposed to every year. The CPC program promoted annual visits for adolescents, which is one explanation for the improved performance.
- Because the health plan is relatively new, historical claims data for immunizations were not as robust as it might be for a more mature plan. One of the major barriers identified by the health plan was the lack of process for the health plan to participate in data sharing with the state immunization registry, LA LINKS.
- Another barrier is the lack of knowledge of the members about preventive healthcare in general.

Actions and Interventions:

- UHCCP adopted a periodicity scheduled aligned with the American Academy of Pediatrics (AAP) Bright Futures periodicity schedule that recommended annual visits as the standard of care. Through its involvement with the State Quality Committee, UHCCP successfully advocated for the State to change its EPSDT periodicity schedule to align with the AAP recommendations, which improved care not only for UHCCP members but for all Bayou Health and fee for service Medicaid recipients.
- Obtained a one-time data file from LA LINKS with a promise for a second feed in Spring 2014 with the same benefits as described in the Childhood Immunization Status measure above.
- Included an article about well child care and immunizations in the Summer 2013 member newsletter.
- Continued telephonic preventive health outreach calls to members with gaps in care.
- Addition of a Louisiana-based Quality Outreach Coordinator to assist with targeted outreach calls to members with gaps in care.
- Continued CPC outreach and education emphasizing strategies for closing gaps in care for immunizations.
- Developed and distributed a documentation sheet for provider use in medical records to improve documentation of provision of all HEDIS measures, including immunizations.
- Partnered with one provider to pilot a clinic day for well child visits and immunizations.

Prenatal Care and Postpartum Care

Objective: Measure the effectiveness of interventions taken by the health plan to improve prenatal and postpartum care.

Methodology: HEDIS® 2014 (Hybrid)

Measure	HEDIS® 2014 Goal	Interim Unaudited Rate for HEDIS® 2014 (as of 1/20/14)	Goal Met
Timeliness of Prenatal Care	68.91 (HEDIS® 2012 State Benchmark)	80.60	Yes
Frequency of Ongoing Prenatal (81%+)	64.65 (NCQA 25th Percentile)	63.15	Not as of 1/20/14, but claims will be augmented with chart review
Postpartum Care	53.14 (HEDIS® 2012 State Benchmark)	29.81	Not as of 1/20/14, but claims will be augmented with chart review

Analysis/Limitations/Barriers:

- One opportunity for improvement is to increase the number of pregnancies identified early enough to help women manage health risks. Women who enroll in Medicaid late in their pregnancies are not as likely to be positively impacted by care management as women who enroll early.
- Another opportunity is to collaborate with obstetric practitioners to facilitate early identification of high risk patients and simplify processes for communicating that information to UHCCP.
- Members are not always aware of recommended guidelines for prenatal and postpartum care.

Actions and Interventions:

- Continued member education about prenatal and postpartum care through the UHC Healthy First Steps maternal care management program.
- Collaboration with the State Performance Improvement Project Committee to develop an all health plan obstetric risk assessment form (OBRAF) to simplify processes for the provider community.
- Inclusion of articles about pregnancy in the summer and fall 2013 member newsletters.
- Continuation of Text4Baby messaging to pregnant women.
- Continued obstetric practitioner outreach by the UHCCP Maternal Management Coordinator to promote use of the new OBRAF.
- Initiation of a performance improvement project on decreasing elective deliveries at gestational ages of 37 and 38 weeks.
- In 2014, UHCCP will implement data feeds from Louisiana Vital Records as they are made available by the Department of Health and Hospitals. These data will assist with early identification of potential high risk pregnancies based on previous birth outcomes of individual expectant mothers.

Well-Child Visits in the 3rd, 4th, 5th and 6th year of life and Adolescent Well-Child Visits

Objective: Measure the effectiveness of interventions taken by the health plan to improve the well child visit rates for children ages 3-6 years and for adolescents ages 12-21 years.

Methodology: HEDIS® 2014 (Hybrid)

Measure	HEDIS® 2014 Goal	Interim Unaudited Rate for HEDIS® 2014 (as of 1/20/14)	Goal Met
Well-Child Visits (Ages 3 – 6 years)	35.45 (HEDIS® 2012 State Benchmark)	58.98	Yes
Adolescent Well-Child Visits	25.16 (HEDIS® 2012 State Benchmark)	43.51	Yes

Analysis/Limitations/Barriers:

- Through the Clinical Practice Consultant (CPC) program, UHCCP learned that well-child visits were required on the State EPSDT periodicity schedule every other year instead of every year as is specified in the HEDIS® measures. This difference in practice was a barrier toward improving the rates.
- Also through the CPC program, UHCCP learned that there were opportunities for improvement in medical record documentation practices that would demonstrate the care that providers were giving to members more accurately.
- Another barrier is the lack of knowledge of the members about preventive healthcare in general.

Actions and Interventions:

- UHCCP adopted a periodicity scheduled aligned with the American Academy of Pediatrics (AAP) Bright Futures periodicity schedule that recommended annual visits as the standard of care. Through its involvement with the State Quality Committee, UHCCP successfully advocated for the State to change its EPSDT periodicity schedule to align with the AAP recommendations, which improved care not only for UHCCP members but for all Bayou Health and fee for service Medicaid recipients.
- Developed and distributed a documentation sheet for provider use in medical records to improve documentation of provision of all HEDIS® measures, including immunizations.
- Continued Silverlink preventive health outreach calls to remind members of services for which they are due, and to assist with appointments as needed.
- Continued CPC outreach and education to high-volume PCPs, emphasizing EPSDT improvement strategies and accurate coding of well visits to maximize administrative data hits, and identifying members with gaps in care for provider outreach.
- Implemented incentive Sesame Street dolls to use on UHCCP clinic days with large providers to impact the Well-Child 3-6 measure.
- Included an article about well-child care and immunizations in the summer 2013 member newsletter.
- Added a Louisiana-based Quality Outreach Coordinator to assist with targeted outreach calls to members with gaps in care.
- Partnered with one provider to pilot a clinic day for well-child visits and immunizations.
- Implemented co-branded letter initiative with 8 practices.

Lead Screening in Children

Objective: Measure the effectiveness of interventions taken by the health plan to improve the blood lead screening rate for member's age 2 years.

Methodology: HEDIS® 2014 (Hybrid)

Measure	HEDIS® 2014 Goal	Interim Unaudited Rate for HEDIS® 2014 (as of 1/20/14)	Goal Met
Lead Screening in Children	57.52 (NCQA 25th Percentile)	67.23	Yes

Analysis/Limitations/Barriers:

- Providers were not always aware of the recommendations for lead screening.
- Lead screening samples are primarily sent out to Tamarac Medical for processing. Results were not always included in provider charts.

Actions and Interventions:

- Distributed an article about lead testing in a member newsletter.
- Continued CPC outreach to:
    - Remind providers to do blood lead screening as part of EPSDT visits.
    - Encourage PCPs to provide 24-month EPSDT and associated blood lead screen shortly before actual 2nd birthday if no test was performed at age 9 months-1 year.
    - Provide lists to PCPs identifying members with gaps in care.
- Acquired lab data feed from Tamarac, the major provider of lead screening in the State of Louisiana.

Chronic Health Care Management Activities

UHCCP is committed to providing programs that emphasize monitoring and control of chronic conditions to minimize complications and disease progression, with a goal of improved performance annually. Through the year, HEDIS® rates are analyzed and targeted programs developed and implemented. This section of the document will report on unaudited interim HEDIS® 2014 measures related to chronic health care management.

Comprehensive Diabetes Care

Objective: Measure the effectiveness of interventions taken by the health plan to improve comprehensive diabetes treatment.

Methodology: HEDIS® 2014 (Hybrid)

Measure	HEDIS® 2014 Goal (all HEDIS® 2012 State Benchmarks)	Interim Unaudited Rate for HEDIS® 2014 (as of 1/20/14)	Goal Met
Retinal Eye Exams for Diabetics	31.01	39.87	Yes
LDL-C Management in Diabetics<100	65.24	76.04	Yes
Nephropathy Monitoring	71.84	74.53	Yes
HbA1c Testing	71.63	73.55	Yes

Analysis/Limitations/Barriers:

- All State benchmarks given for Comprehensive Diabetes Care were exceeded.
- The principal barrier to improvement across the diabetic sub-measures is the high rate of members with diabetes who do not establish an ongoing relationship with a PCP for recommended monitoring and treatment.
- Vision services are managed by the Louisiana Department of Health and Hospitals. UHCCP had limited line of sight to claims which impeded the health plan's ability to identify where members were receiving eye care.
- Providers were not always aware of diabetes standards of care.

Actions and Interventions:

- Continued CPC outreach and education to high-volume PCPs, emphasizing improvement strategies and identification of members with gaps in care for provider outreach.
- Continued UHCCP efforts to encourage members with diabetes to establish a medical home with a PCP who will in turn provide routine monitoring.
- Disease management mailings to members with diabetes.
- In 2014, UHCCP will assess the feasibility of a quality improvement initiative to conduct outreach to identified vision providers to obtain evidence of a normal retinal exam within previous two years for members with diabetes.

Cardiovascular Care

Objective: Measure the effectiveness of interventions taken by the health plan to improve cardiovascular care and treatment.

Methodology: HEDIS® 2014 (Hybrid for LDL screening; administrative for Beta Blocker Treatment After Heart Attack)

Measure	HEDIS® 2014 Goal	Interim Unaudited Rate for HEDIS® 2014 (as of 1/20/14)	Goal Met
LDL-C Screening	73.23 (HEDIS® 2012 State Benchmark)	76.04	Yes
Persistence of Beta-Blocker Treatment After a Heart Attack	72.92 (NCQA 25th Percentile)	87.18	Yes (Note: n = 39)

Analysis/Limitations/Barriers

- Goals were met.

Actions and Interventions:

- Continued efforts to encourage adult members to establish a medical home with a PCP who will, in turn, provide routine monitoring and diet/exercise counseling and prescribe appropriate medication.
- Continued CPC emphasis on the importance of a problem list or other chart documentation that clearly identifies that a patient has hypertension and the duration of the diagnosis.

Chronic Obstructive Pulmonary Disease
Objective: Measure the effectiveness of interventions taken by the health plan to improve the diagnosis and treatment of members with chronic obstructive pulmonary disease (COPD).

Methodology: HEDIS® 2014 (administrative)

Measure	HEDIS® 2014 Goal	Interim Unaudited Rate for HEDIS® 2014 (as of 1/20/14)	Goal Met
Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	75.54 (NCQA 25th Percentile)	86.12	Yes
Pharmacotherapy Management of COPD Exacerbation - Corticosteroid	57.14 (NCQA 25th Percentile)	61.39	Yes

Analysis/Limitations/Barriers:
- Goals were met.

Actions and Interventions:
- Continued disease management/case management for members identified with COPD.
- Continued monitoring.

Follow-up Care for Children Prescribed ADHD Medication
Objective: Measure the effectiveness of interventions taken by the health plan to improve the rate of follow-up monitoring of pediatric members prescribed medication for ADHD.

Methodology: HEDIS® 2014 (administrative)

Measure	HEDIS® 2014 Goal	Interim Unaudited Rate for HEDIS® 2014 (as of 1/20/14)	Goal Met
Follow-up Care – Initiation Phase	31.83 (NCQA 25th Percentile)	32.40	Yes
Follow-up Care – Continuation and Maintenance Phase	34.75 (NCQA 25th Percentile)	45.44	Yes

Analysis/Limitations/Barriers:
- Goals were met.
- DHH has indicated that overprescribing of ADHD medications, particularly in white males, is a concern.

Actions and Interventions:
- In 2014, an action plan will be developed to address overprescribing of ADHD medications.

Coordination of Care - Medical
Objective: To assess coordination of health care between various sites of care.

Methodology: Site Audits, Provider Satisfaction Survey, Coordination of Care Survey.

Coordinating Postpartum Care after Hospital Delivery
Relevance and Methodology
According to the Centers for Disease Control, 99% of births take place in a hospital setting. After leaving the hospital, postpartum care is important part of the continuity of care needed by the mother and newborn child. Postpartum health care visits provide the opportunity for health care providers to assess and educate parents on important components of newborn care as well as manage identified risk factors. These visits help evaluate ongoing medical and psychosocial needs for the mother and child as well as establish an ongoing health home to address current and future needs. The American College of Obstetricians and Gynecologists recommends that the first postpartum visit should include a physical examination and an opportunity for the health care practitioner to answer parents' questions and give family planning guidance and counseling on nutrition. Many women experience some degree of emotional liability in the postpartum period making timely care and assessment critical for both the mother's and newborn's health. UHCCP assures continuity and coordination of care beyond delivery by encouraging members and providers to adhere to the recommended guidelines for postpartum care. The HEDIS measure, Postpartum Care, is used to monitor and improve performance. HEDIS® data is collected annually and is audited by NCQA-certified auditors.

Data and Analysis

HEDIS® Postpartum Care	The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery	Performance Goal (HEDIS® 2012 State Benchmark)	Goal Met
UHCCP	29.81 (as of 1/20/2014)	53.14	Not as of 1/20/14, but claims will be augmented with chart review
National	64.00		

Causal Analysis/Interventions

Barriers/Causal Analysis	Opportunities	Interventions
· Challenges to identify high risk members for outreach. · Lack of member awareness of the importance of consistent prenatal care and a postpartum visit. · Members who have had a C-section often think that their post-op visit is the same as their post-partum visit. · Member non-compliance with postpartum visit instruction. · Difficulty in obtaining current member phone numbers/contact information. · Delayed notification of delivery prevents early intervention for post-partum follow-up. · Conflicting priorities in post-partum period including infant care, pediatric well baby visits, and other child care. · Appointment availability may render post-partum visit outside of the required timeframe.	· Enhance member education regarding importance of prenatal care and postpartum visit. · Clarify the distinction for post C-section care to include both a post-op visit and a post-partum visit. · Improve early identification of high risk members for Case Management. · Collaboration between Community & State and Employer & Individual business segments to develop/share best practices. · Hospital contact information may be more accurate than home contact information.	· High Risk Pregnancy Case Management outreach to members with high risk conditions by RN case managers. · Text4Baby: educational program that provides messaging throughout pregnancy related to prenatal care, health education, mental health information etc., including postpartum messaging. · Pregnancy Care Guidelines are posted on the UHCCP provider website. · Healthy First Steps nurses initiate a live call to all level 2 and 3 members while they are still in the hospital and remind them of the importance of a postpartum. If unable to contact while in the hospital 3 additional attempts are made within 5 days. Scheduling assistance is offered. · Silverlink automated calls are made all to post- partum members which include a reminder to return to their OB/GYN 4-6 weeks post-partum visit. · New Mom welcome packets are sent to all members which include a reminder for postpartum visits.

Coordination of Care - Behavioral

Objective: To assess coordination of care between medical and behavioral health care.

Methodology:

- A plan based coordination of care project began in 2013 between the UHCCP Health Services Department and Magellan Behavioral Health (contractor for behavioral health services for the State of Louisiana).
- UHCCP and Magellan promote collaboration between behavioral health and medical care through various mechanisms, including the provision of a behavioral health consult to members who are receiving medical care while they are in an inpatient medical bed, particularly when they are receiving medical care for conditions likely to have co-morbid mental health concerns. UHCCP and Magellan also participate in joint rounds on a weekly basis.
- In 2013, a provider satisfaction survey was sent to UHCCP practitioners. This survey included two questions that involved behavioral health and medical care coordination. These questions asked about the timeliness of exchange of information and the adequacy of coordination of care. Providers were asked to rank their satisfaction level from zero (poor) to ten (excellent), or could choose the option to select "Don't Know." The results of the survey were placed into two categories. The first category is the top box category of 8 through 10, which represents the percentage of physicians who ranked the question with an 8, 9 or 10. The second is the top box category of 6 through 10.

Results:

- A total of 773 UHCCP members were referred for Magellan case management in the first three quarters of 2013. A total of 160 members (21%) were accepted by Magellan for behavioral health care in Q1-Q3, 2013.

2013 Medical-Behavioral Coordination Outcomes

Outreach Outcome	Q1 2013	Q2 2013	Q3 2013	Total	% of Referrals
Pending	0	1	50	51	6.6%
Invalid Referral	5	2	5	12	1.6%
Mailed Outreach Letter	1	1	0	2	0.3%
Member Transferred to Medical Unit	1	2	0	3	0.4%
Member Declined UBH Services	64	49	59	172	22.3%
Member Disenrolled	1	4	1	6	0.8%
Member Linked to Services	30	65	26	121	15.7%
Referred to Magellan	62	58	40	160	20.7%
Referred to Medical Partner	3	0	0	3	0.4%
Referred to FCA	0	0	1	1	0.1%
Unable to Reach Member	66	81	95	242	31.3%
Total Referrals	233	263	277	773	100.0%

2013 Physician Satisfaction Survey Results Reported in 2014

Survey Question	Top Box 8 through 10		Top Box 6 through 10	
	National	UHCCP	National	UHCCP
Please rate the timeliness of exchange of information/ communication/ reports from Behavioral Health Providers.	33	38	60	59
Please rate the adequacy of coordination of care from Behavioral Health Providers.	36	37	60	60

Analysis/Limitations/Barriers:

- Behavioral health practitioners may not have time to coordinate/communicate with enrollees' other treating practitioners/providers.
- Behavioral health (BH) is not provided by UHCCP necessitating coordination with a third party.

Actions and Interventions:

- Continue to collaborate with Magellan on an ongoing basis to monitor and improve the quality of care and service and the continuity of care for UHCCP members through three dedicated UHCCP Behavioral Health Liaisons. Clinical referrals identified as needing BH services are made from all UHC Medical Clinical teams to the Behavioral Health Liaisons. These Liaisons assess and refer appropriate members directly to Magellan Utilization Management and Case Management.
- UHCCP member newsletter article on depression and kids: summer 2013.
- Clinical practice guidelines for behavioral health available on the UHCCP provider web site.
- Article on the importance of coordinating care between Medical Health Care professionals and Behavioral Health practitioners was included in the summer 2013 Provider Newsletter.

Performance Improvement Projects (PIPs)

Increasing the Rate of Breast Cancer Screening (BCS)

UHCCP implemented a performance improvement project to increase the rate of breast cancer screening for women aged 40-69 in its population. This project is estimated to affect approximately 8,100 women. The research on screening is clear: regular mammography allows breast cancer to be detected earlier in the progression of the disease, which reduces mortality due to breast cancer.

Breast cancer screening rates were measured using HEDIS® data produced by an NCQA Software Certified HEDIS® vendor. Data for this measure are administrative only per HEDISâ technical specifications and are unaudited. No sampling was used. Statistical significance was not tested, but rather the rate was compared to the HEDIS® 2012 percentile rates to gauge improvement.

It was not possible to calculate a breast cancer screening rate for 2012 dates of service because of the HEDIS® specification of a two year continuous enrollment period. Therefore, the State provided HEDIS® 2012 rate was used as the baseline rate.

Measure	Baseline Rate (State HEDIS® 2012)	Interim Rate* Jan – Dec 2013 (unaudited)	Goal (NCQA 50th Percentile)	Goal Met?
Breast Cancer Screening (BCS)	42.64	46.55	52.40	No

*The interim rate reported is calculated monthly for the health plan to monitor progress toward the goal.

The denominator includes currently enrolled female members aged 40-69 who have the possibility of being continuously enrolled during the measurement year and the year prior to the measurement year as of December 31. The calculation uses the HEDIS® 2013 specification.

The baseline rate provided by the State was 42.64. For 2013 dates of service through December 26, 2013, reported as of January 2014, the unaudited BCS interim rate for UnitedHealthcare Community Plan was 46.55%. The goal of the 50th percentile has not been met at this time, but with three months claims lag still to be accounted for, the health plan has already exceeded the State's baseline rate.

Actions taken in 2013 included:

	Intervention	Date(s)	Notes about Deployment
A	Member Outreach · Data analysis showed pockets of gaps in care in New Orleans East, Metairie, and Kenner. More mammography facilities are available in Metairie and Kenner, so the Louisiana Quality Management Department conducted telephonic outreach to members in those areas. · Silverlink IVR outreach campaign	June 2013 Fall 2013	201 calls were attempted 9,961 members were called; 489 members chose a warm transfer to Member Services to assist with making an appointment.
B	Explore provider and community collaborative opportunities: · Provider outreach: Information on evidence-based guidelines for all preventative health HEDIS® measures was distributed. · Initiated co-branded letter initiative with 8 practices.	Fall 2013 Spring/ Summer 2013	409 packets distributed through Clinical Practice Program (nurses in the field providing education on the quality program, including performance measures).

For HEDIS® 2014 (dates of service 2013), NCQA lengthened the continuous enrollment requirement for this measure and changed the age range for the population from 40-69 to 50-74 to meet current evidence-based guidelines for care. Because of this, it is not possible to calculate a BCS rate for HEDIS® 2014.

Therefore, UHCCP has requested approval from the Louisiana Department of Health and Hospitals to discontinue this performance improvement project because the interim rate exceeded the State baseline rate and because measurement will be unstable for the next couple of years due to significant changes in the NCQA specifications. In 2014, UHCCP will replace this PIP with one for Increasing Cervical Cancer

Screening Rates while continuing to conduct outreach and education activities around breast cancer screening.

Reducing Emergency Department Visits

A performance improvement project for reducing ambulatory emergency department (ED) visits was initiated in 2012. At that time, QMC elected to focus on children with asthma, providing better management of the condition and in turn reducing ED visits. In 2013, while the improvement efforts on children with asthma continued, the focus broadened to all causes of ambulatory ED visits.

The PIP is designed to increase member outreach and asthma education for children under 21, and to increase provider outreach about asthma clinical practice guidelines for managing asthma. Both these efforts are aimed at reducing ambulatory care ER visits for children.

The population for the study has been changed to include not only children 1-19, but adults as well. The goal was to reduce the Ambulatory ER HEDIS® rate (AMB) to at least the HEDIS® 2012 50th percentile as defined in the fall 2012 Quality Compass®.

Actions taken in 2013 include:

	Intervention	*Date(s)*	*Notes about Deployment*
A	Continuation of asthma pilots with larger hospitals in New Orleans and Baton Rouge.	12/2012	See "Asthma Pilots" section below. 28 eligible UnitedHealthcare members were identified and referred to the HEAL program. 132 members with addresses in zip codes served by St. Elizabeth Hospital referred to their asthma management program.
B	Engagement of interns and residents in teaching environments. · Asthma Clinical Guidelines Training, including education on peak flow meters, nebulizers, medication, and asthma action plans, performed at Children's Hospital in New Orleans.	2/4/13	Over 30 primary care practitioners including residents, staff physicians, and nurse practitioners attended and earned CME credit.
C	Continue case management program of members who are high utilizers of the ER.		
	· Identification of top 1% of members with high ER visits and inpatient admissions for referral to case management.	Beginning 2/25/13; ongoing	

	Intervention	*Date(s)*	*Notes about Deployment*
	· Targeted sickle cell disease case management initiated.	6/2013	Data analysis revealed that sickle cell disease was one of the top five diagnoses for ED visits. In an effort to reduce low to mid-level ED visits, the top 100 sickle cell members were identified and members with 2-10 ED visits per quarter are targeted for case management (CM). CM engages the member, targets discussions regarding PCP visits and specialist evaluations. Behavioral Health referrals are given if needed.
D	ER Coach Pilot Program continued.	11/28/12 11/1/2013	Unique pilot plan in Louisiana in which UHC shares data with larger facilities across the state. Data include ER diagnosis, admit, and discharge information. Low level ER diagnoses are then routed to an ER Health Coach who attempts for 48 hours post ER visit to contact the member and discuss alternatives to ER visits, such as contacting the Nurseline, visiting the primary care provider, or going to an urgent care facility, if needed. The use of the ER is stressed as a source for emergency care only. In the period of January 1 – April 30, 2013, of 354 members identified, 78 (22%) were reached. ER Coach Pilot moved to a single hospital (Children's in New Orleans) to accommodate staffing constraints. More patients were available at Children's to gauge success of the specific intervention. If ER diversion is successful, then staff augmentation will be reviewed.
E	NurseLine	Ongoing	Nurseline is a 24/7 service available to members to assist with recommending appropriate levels of care. . In 2013, of 3,240 calls triaged by the Nurseline clinicians, 46% of the recommendations were

	Intervention	Date(s)	Notes about Deployment
			to contact a physician, 25% were to apply home care, and 8% were to proceed to an urgent care facility.

Asthma Pilots

In this section, outcomes of the collaborative pilots conducted with Our Lady of the Lake and the HEAL Project are reported. Through November 2013, 53 children were enrolled in intensive asthma case management programs. For each child, costs were compared for the period 6 months prior to enrollment in a program and for the period 6 months after enrollment in the program. These costs were then aggregated and classified into four categories: emergency room visits (ER), inpatient (IP) admissions, primary care practitioner (PCP) visits, and prescriptions (Rx). Overall, costs were lower post-enrollment versus pre-enrollment. IP costs were significantly lower and PCP visit and Rx costs were higher, which are all indicators of well managed patients with asthma. ER costs were a bit higher, which is not the desired outcome, so further analysis was conducted to understand the cause. Of the $5,566 of post-enrollment ER costs, over $3,200 were incurred by 2 children. Neither child had post enrollment PCP visits nor medication compliance.

These results were shared with DHH in December 2013 as a demonstration of the value of certified asthma educators. UHCCP asked DHH to consider certified asthma educators as a Medicaid benefit.

Asthma Pilot Costs (n = 53)

Time Period	ER	Inpatient	PCP Visits	Rx	Total (ER + IP + PCP + Rx)
Pre-Enrollment	4,724	34,474	6,593	33,398	79,188
Post-Enrollment	5,566	11,692	8,963	49,673	75,894
Differences Significant?	No	$p <= .10$	$p <= .05$	$p <= .01$	No

Measure	Baseline Rate (State HEDIS® 2012)	Interim Rate Jan – Dec 2013 (unaudited)	Goal	Goal Met?
Ambulatory Care – Emergency Department Visits per 1000 member months (AMB-a)	64.07	58.67	63.15	TBD

For the interim rate calculated above, the numerator was equal to the number of ambulatory emergency room visits (as defined in the HEDIS® 2012 Technical Specifications) in the period January – December 2013. This rate does not reflect full claims run out and so it is likely understated. The number of visits used was as reported in the UHC data warehouse as of January 27, 2014. The denominator consisted of the number of

member months per 1000 in the same timeframe. This is an unaudited, unofficial rate, used only as a proxy to ambulatory emergency department utilization in order to assess progress in reducing ambulatory ED visits. The standard HEDIS® methodology annualizes the member month data. Without any interim trend data, this number is difficult to assess at this time.

Decreasing Elective Deliveries Prior to 39 Weeks Gestational Age

In 2010, the Joint Commission established a new perinatal care core measure set that includes the number of elective deliveries (both vaginal and cesarean) performed at >= 37 and < 39 weeks of gestation completed. Elective inductions of labor and elective cesarean section deliveries <39 weeks are increasing despite the American Congress of Obstetricians and Gynecologists (ACOG) guidelines outlining criteria for medically indicated births earlier than 39 weeks gestational age. Non-medically indicated (elective) deliveries are either induced and/or done by scheduled cesarean section and indicate that physician decisions may, in part, be driving higher rates of early elective deliveries. In addition, it has been suggested that women may not have an accurate perception of the benefits of carrying a baby to term. The goal for this study is to decrease the number of elective deliveries at 37 and 38 weeks of gestation completed.

Multiple recent studies indicate that elective deliveries <39 weeks carry significant increased risk for the baby (odds ratios 2.0-3.0 compared to infants born between 39 and 41 weeks).

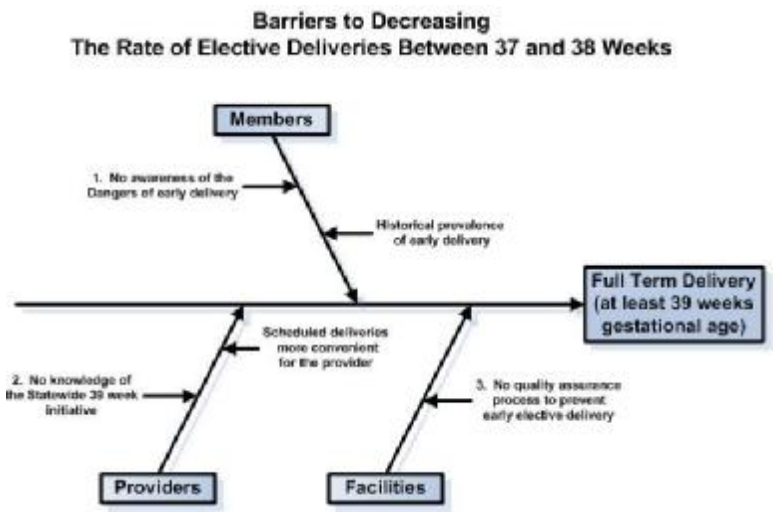
The risk is highest for scheduled pre-labor cesarean sections at 37 weeks gestation, but is significant for all subgroups examined. Even babies delivered at 38 4/7 to 38 6/7 weeks have higher risk of complications than those delivered after 39 weeks. Complications of elective deliveries between 37-39 weeks include increased Neonatal Intensive Care Unit (NICU) admissions, increased transient tachypnea of newborn, increased respiratory distress syndrome, increased ventilator support, increased suspected or proven sepsis, and increased newborn feeding problems or other transition issues. At the same time, there has been a significant fall in mean birth weights which has received almost no attention. Lower birth weights place infants at greater risk for mortality and are linked to some chronic conditions in adulthood.

This topic is especially relevant to the health plan's population. In Louisiana, 70% of all births are funded by Medicaid.

In summer 2013, the health plan initiated this performance improvement project and completed the following:

- Literature review on elective deliveries.
- Creation of an operational definition for elective deliveries grounded in the research and Joint Commission (JCAHO) standards.
- Specification of performance measures and reporting
    - Performance Indicator 1: The percentage of live singleton births with gestational age >= 37 weeks and < 39 weeks that were non-medically indicated (Baseline rate: 58.6%).
    - Performance Indicator 2: The percentage of live singleton births with gestational age >= 37 weeks and < 39 weeks that were non-medically indicated delivered by C-section (Baseline rate: to be determined).
    - Performance Indicator 3: The percentage of live singleton births with gestational age >= 37 weeks and < 39 weeks that were non-medically indicated resulting in a NICU admission (Baseline rate: to be determined).

January 2014, a barrier analysis was conducted as shown in the figure below.



The following interventions to address the barriers are slated for 2014:

	Interventions	*Barrier(s) Addressed*
A	Ensure Healthy First Steps (maternal management group) scripting for member outreach includes education on the State's 39 week initiative and the benefits of full term deliveries as opposed to early elective deliveries.	1
B	Develop and implement scripting for providers on the benefits of full term deliveries as opposed to early elective deliveries. This will be used as part of the provider outreach conducted by the EPSDT/Maternal Management Coordinator.	2
C	Include articles about the benefits of full term deliveries as opposed to early elective deliveries in member and provider newsletters.	1, 2
D	Ensure that Text4Baby scripting includes information about the benefits of full term deliveries as opposed to early elective deliveries.	1
E	Ascertain community partner knowledge of the 39 week initiative and engage their assistance. Specifically, attempt to engage with the Nurse Family Partnership and Healthy Start. Identify other potential partners.	1, 2, 3
F	Identify resources or develop education materials on the benefits of full term deliveries as opposed to early elective deliveries for use in School Based Health Centers. Distribute materials and/or resources to the health centers.	1, 2
G	Disseminate materials to primary care providers to share with members identified as pregnant.	1, 2
H	Identify facilities that are outliers with respect to gestational age at delivery and facilitate the development and implementation of improvement plans for improving adherence to the 39 week initiative.	3
I	Demonstrate birth outcomes of members who see providers who are participating with CenteringPregnancy[â] sites in Louisiana. Use information to promote best practices learned from the State pilot.	1, 2, 3
J	Create a proposal for billboard / bus shelter advertising about the benefits of full term deliveries as opposed to early elective deliveries.	1, 2, 3

This evaluation considered all aspects of the QI Program and evaluated the Program's overall effectiveness and progress towards goals. Identified barriers and selected opportunities for improvement for each area of clinical care and service described in the evaluation will be specifically addressed through actions in the 2014 QI Work Plan. The yearly planned activities for 2013 were completed and objectives were met as follows:

- Improvement in calculation of performance measures
  - Obtained data feed from immunization registry LA LINKS.
  - Partnered with lab providers to obtain lab data feeds.
- Review of provider and member satisfaction surveys
  - Provider satisfaction survey yielded a response rate and satisfaction ratings higher than UHC national averages.
  - Inaugural year of the Adult CAHPS Survey showed UHCCP met or exceeded the 75th percentile for accreditation scoring in 7 of the 8 ratings and composite scores, with 4 of 8 measures exceeding the 90th percentile for accreditation scoring.
  - Inaugural year of the Child CAHPS Survey showed UHCCP met or exceed the 75th percentile for accreditation scoring in all of the ratings and composite scores, with 6 of 8 measures exceeding the 90th percentile for accreditation scoring.
- PCP profile analysis
  - PCP profile analysis is being performed every quarter with appropriate referrals to case management. In addition, providers that have members that are high utilizers of ER services or have frequent hospitalizations and are not actively engaged in case management are notified of utilization and the need to encourage such patients to participate in UHCCP case management.
- Analysis to identify disparities in clinical care
  - UHCCP has chosen to focus on health care issues that disproportionately affect African Americans over other races, including breast and cervical cancer mortality, asthma management, and sickle cell disease.

Below are selected areas targeted for improvement in 2014:

- Achievement of NCQA Initial Survey accreditation
- Improvement in State incentive measures
- Improvement in communication of PCP profile analysis to high volume providers in order to assist practices with identifying opportunities for care for their patients
- Improvement in provider compliance with 24/7 access standards

UHCCP is committed to achieving the goals and objectives set forth in the QI Program Description and to effectively and efficiently using resources. Its QI staff will continue to work with divisions throughout the Health Plan, Quality Management & Performance, and UnitedHealth Group. We believe this integration of subject matter expertise and data-driven processes from both clinical and operational teams will promote continued improvement in the quality of care and service for our members.

§ 2012-2013 Recommendation: To improve member satisfaction, the Health Plan should conduct root cause analysis for CAHPS® measures performing below the 50th percentile and implement interventions to address these measures.

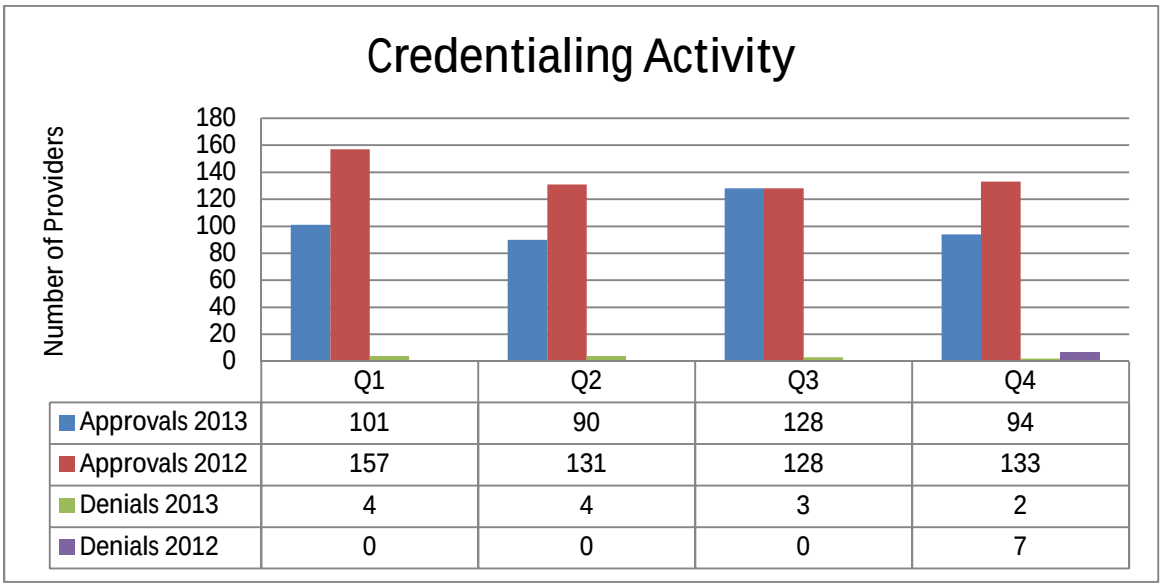
Plan Response: UnitedHealthcare has presented what it has in place to deliver quality health care, to ensure member safety and to improve member satisfaction.

Credentialing/Recredentialing

Objective:

- To ensure that members have access to quality primary care practitioners that have gone through a thorough credentialing process. UHCCP does not contract with specialists, facilities, or ancillary providers. Providers who are not primary care practitioners contract directly with the State of Louisiana's Department of Health and Hospitals.
- Improve practitioner satisfaction with the credentialing process.

Results: UHCCP credentialed 413 providers in 2013 and denied credentialing to 13 providers (.031% of applications).



	Q1	Q2	Q3	Q4
Approvals 2013	101	90	128	94
Approvals 2012	157	131	128	133
Denials 2013	4	4	3	2
Denials 2012	0	0	0	7

The reasons for denials were as follows: requested specialty, general practice, highest level of training internship, no hospital privileges, and non-responsiveness to request for additional information, exceeding malpractice threshold, and inability to verify credentials.

Analysis/Limitations/Barriers: No problems associated with the credentialing and re-credentialing of individual providers were identified.

Actions and Interventions:

- Continue current system of individual provider credentialing/recredentialing through NCC and oversight of NCC decisions by the PAC.
- In 2014, improve monitoring of credentialing/recredentialing turnaround times.

Delegation Oversight: Credentialing
Objective: To provide annual oversight of delegated credentialing entities.

Results: Delegated audits were completed for all entities and presented to QMC.

Delegated Entity	# PCPs In Group	Audit Date	Score	Expected Next Audit
Health Services of Northeast Louisiana	52	07/19/2013	100	7/2014
Louisiana State University Health Science Center	122	08/06/2013	98	8/2014
LSU Health Care Network - New Orleans	64	07/29/2013	95	7/2014
Ochsner	250	06/27/2013	98	6/2014
South Louisiana Medical Associates	18	02/19/2013	97	2/2014
Tulane University Medical Group	67	08/22/2013	100	8/2014
Willis Knighton Physician Network	201	06/24/2013	100	6/2014

Analysis/Limitations/Barriers:

- Delegated credentialing oversight for the Plan was performed by the UnitedHealthcare Network (UHN) Delegation Relations Department in 2013.

Actions and Interventions:

- Continue current process for delegated credentialing/recredentialing oversight by the UHN Delegation Relations Department and review of audit results by QMC. Delegated entities will have oversight audits completed annually.

Member Appeals/Grievances
Objective: To individually investigate all grievances with 95% being resolved within regulatory requirements. (Note that member appeals are handled only through State Fair Hearing as per State contract.)

Methodology: A grievance is defined as a general expression of dissatisfaction about the Plan or a practitioner or any matter other than an action, including but not limited to the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights.

All grievances were tracked, trended and reported through the QMC following the process approved by the committee. As dictated by policy, grievances related to quality of care were also reviewed by the PAC. Upon the recommendation of the committee, opportunities for improvement were suggested, plans developed and implemented, and outcomes evaluated.

Results:

Grievance Analysis							
Year	Average Members per Month	Member Months (MM)	# of Grievances	MM / 1000	Grievances / 1000	Percentage of Change Year over Year	Percent Resolved within Requirement
2012	184,455	2,029,009	88	2029	.043	N/A	100%
2013	249,616	2,995,397	281	2995	.094	219%	100%

** UHCCP* describes *a significant increase or decrease as greater than or less than 5%.*

Medicaid Grievances Received

	2012 (n=88)	2013 (n=281)
Primary Category		
Quality of Care Concerns	39	22
Access to Care Concerns	14	2
Service/ Attitude and Communication	33	39
Billing	1	217
Quality of Provider Office Sites	1	2*

*One office site visit was also a QOC issue, counted in both areas

Analysis/Limitations/Barriers:

- The number of grievances in 2013 was significantly higher than in 2012 due to improved data capture. See notes under "Actions and Interventions" below.
- 77% of grievances were in the Billing category, primarily related to providers balance billing members.
- All grievances were resolved within the State required timeframes.

Actions and Interventions:

- Based on the low number of member grievances per 1000, a workgroup was formed in summer 2013 to investigate the possibility of under-reporting of member grievances. The inquiry revealed that grievances resolved by the Member Services Call Center were not being reported to the Louisiana plan. In late December 2013, a revised report of all member grievances was supplied to UHCCP. UHCCP reconciled this with previous member grievance reports to check for duplication and ensure accuracy. In addition, the workgroup directed a quality improvement initiative to improve the accuracy of categorizing member calls, including the definition of what is to be classified as a member grievance. These concentrated efforts will result in improved data capture, categorization of grievances, and completeness in reporting.
- The grievances in the Billing category most often were triggered by a provider balance billing members for Medicaid services. To reduce the number of grievances in that category, Member Services sends educational materials to each provider who balance bills stating that members have no financial liability if members see a Medicaid provider and the service is a plan benefit. Provider Advocates have also been deployed and are assisting providers with correct coding, billing procedures, and billing issue resolution.
- Continue to track and trend.
- Operations and Quality are continuously working with Member Services to ensure all grievances are correctly categorized, received, resolved, and tracked.

- By policy, inter-rater reliability review is performed yearly for all non-physician reviewers of clinically closed cases. There were no non-physician clinically closed cases in 2013, so inter-rater reliability review was inapplicable.

Quality of Care
Objective: To track and investigate all quality of care (QOC) referrals reviewed by the Quality Management Department.

Methodology: As needed, suspected QOC issues may be referred to Quality Management by internal nurses and medical directors through CareOne, the UHCCP utilization and case management application. In addition, any staff member may refer a potential QOC issue to Quality Management for investigation as a possible QOC concern. Referrals are made on the basis of triggers such as a readmission for the same diagnosis within 7 days or a perceived delay in care.

QOC investigations may also be initiated through the member complaint process. QOC complaints are member-reported expressions of dissatisfaction that involve the quality of care or provider service received by the member. Both formal grievances and informal complaints are investigated, tracked, and reported in this category if they have a quality-of-care component.

All quality of care issues are leveled by a clinician according to the following definitions:
- Level 0 - There is no clinical issue found and there was no adverse member outcome. Issue could not be validated due to lack of information.
- Level 1 - An incident is found, but appears to have contributed no harm or damage to the member (damage may be physical or mental health or may have increased risk to health; such as an unneeded hospitalization).
- Level 2 - An incident is found and it appears to have contributed to a non-permanent harm or damage (the member fully recovered from the incident).
- Level 3 - An incident is found and it appears to have contributed to permanent harm or damage (not recoverable).

In 2012, policy dictated that an additional Level 4 for death of a member should be used. In 2013, Level 4 was omitted to simplify the leveling scale and align policy with process. Deaths are now assigned a Level 3. Level 0's and Level 1's may be assigned by the Chief Medical Officer's designee. A Registered Nurse assigned Level 0's and Level 1's with 100% over read by the Chief Medical Officer. The Medical Director assigned all Level 2's and 3's.

Results:

Quality of Care Investigations								
	Pended Cases from 2012	Received Cases in 2013	Total Cases	Level 0* Providers	Level 1* Providers	Level 2* Providers	Level 3* Providers	Pending 2013
Quality of Care Referrals	7	60	67	47	3	7	2	9

*QOC cases may involve several providers; therefore there may be more leveled providers than cases.

Analysis/Limitations/Barriers:

- In 2013, the UHCCP QI staff completed investigations of 56 potential QOC events with 9 pending cases at the end of 2013. Findings were reviewed with the Plan Chief Medical Officer for disposition. Twelve QOC issues were substantiated by the investigations. All Level 2-3 QOC cases were brought to the PAC for disposition. Three improvement action plans were prescribed by the PAC for providers with cases leveled a level 2 or 3.
- One corrective action plan was required in 2013 as a result of a quality of care issue, complaint or grievance.
- There were a total of 38 internal quality of care referrals with the remaining referrals with the remaining stemming from member grievances. These referrals trended down throughout the year, particularly from the utilization management staff.

Actions and Interventions:

- Re-education on quality of care triggers was provided in Q4 2013 to UHCCP utilization review staff, discharge planning staff, and case management staff.
- Due to the absence of significant volume or trends, no category of QOC issues was identified as needing corrective action.

Member Satisfaction

Objective: Measure the effectiveness of interventions taken by the health plan to improve member satisfaction.

Methodology: CAHPS® and complaint analysis

Results:

Adult CAHPS® 5.0H Survey Results	2013 Plan Rate	2013 UHC National Average (Medicaid)	Variance to UHC National Average	2013 NCQA Percentile
Ratings				
Rating of Personal Doctor	76.13%	79.36%	↓3.23%	75th
Rating of Specialist	79.28%	78.20%	↑1.08%	75th
Rating of All Healthcare	70.53%	71.04%	↓0.51%	90th
Rating of Health Plan	75.07%	72.88%	↑2.19%	75th
Composite Measures				
Getting Needed Care	78.93%	81.29%	↓2.36%	90th
Getting Care Quickly	78.70%	81.53%	↓2.83%	50th
How Well Doctors Communicate	92.58%	90.49%	↑2.09%	90th
Customer Service	88.94%	85.53%	↑3.41%	90th
Shared Decision Making	50.13%	Not Scored	Not Scored	Not Scored
Additional Content Areas				
Health Promotion and	69.50%	Not Scored	Not Scored	Not Scored

Adult CAHPS® 5.0H Survey Results	2013 Plan Rate	2013 UHC National Average (Medicaid)	Variance to UHC National Average	2013 NCQA Percentile
Education				
Coordination of Care	73.50%	Not Scored	Not Scored	Not Scored
Children with Chronic Conditions CAHPS® 5.0H Survey Results*	**2013 Plan Rate**	**2013 UHC National Average (Medicaid)**	**Variance to UHC National Average**	**2013 NCQA Percentile**
Ratings (General Population)				
Rating of Personal Doctor	88.31%	88.28%	↑0.03%	90th
Rating of Specialist Seen Most Often*	81.66%	85.91%	↓4.25%	90th
Rating of All Healthcare	80.77%	83.89%	↓3.12%	90th
Rating of Health Plan	83.25%	83.55%	↓0.3%	75th
Composite Measures (General Population)				
Getting Needed Care	89.69%	85.87%	↑3.79%	90th
Getting Care Quickly	91.01%	90.75%	↑0.26%	90th
How Well Doctors Communicate	94.91%	93.45%	↑1.46%	90th
Customer Service	85.68%	87.42%	↓1.74%	75th
Shared Decision Making	57.37%	Not Scored	Not Scored	Not Scored for accreditation
Additional Content Areas (General Population)				
Health Promotion and Education	73.70%	Not Scored	Not Scored	Not Scored for accreditation
Coordination of Care	78.79%	Not Scored	Not Scored	Not Scored for accreditation
Children with Chronic Conditions Measures (CCC Population)				
Access to Prescription Medicines	91.13%	91.38%	↓0.25%	Not Scored for accreditation
Access to Specialized Services	75.81%	76.73%	↓0.92%	Not Scored for accreditation
Getting Needed Information	92.34%	92.45%	↓0.11%	Not Scored for accreditation
Personal Doctor Who Knows Child	89.77%	90.48%	↓0.71%	Not Scored for accreditation
Coordination of Care for Children CCC	77.67%	75.87%	↑1.8%%	Not Scored for accreditation

Methodology for Deriving Improvement Strategies

UHCCP's CAHPS® vendor, Center for the Study of Services (CSS), conducted a key driver analysis which identifies the areas or dimensions of health plan performance that are closely related to the overall rating of the plan. The CSS Key Driver Model quantifies the contribution of each performance area to the overall rating. UHCCP results on each performance dimension are compared to the best score among all adult Medicaid plans surveyed by CSS in 2013, yielding a measure of available room for improvement in each area. The result is then weighted by the area's contribution to the overall Rating of Health Plan score. Opportunities for improvement are prioritized based on the expected impact on the overall score resulting from improved performance in each area.

Based on the key driver analysis, the health plan conducted a barrier analysis and developed an improvement intervention strategy to address the top key areas.

ADULT CAHPS®

Analysis/Limitations/Barriers and Interventions:

Composite/Rating Measure	Barrier	Intervention Strategy
Ø Rating of personal doctor	· The member is not connected to a medical home. · The member does not know who his/her assigned primary care provider is. · The member is not aware of the need to seek out preventative care.	· Continue patient centered medical home initiatives. · Engage in member engagement strategies that involve collaboration with the providers (e.g., co-branded letter and call initiatives, clinic days). · Consult with the Member Advisory Council(s) to identify barriers to seeking out preventative care.
Ø Getting urgent care as soon as needed	· The member is not connected to a medical home. · Lack of after-hours access.	· Continue patient centered medical home initiatives. · Continue initiatives around improving after-hours access. · Continue education around 24/7 NurseLine availability.

CHILD CAHPS®

Analysis/Limitations/Barriers and Interventions:

Composite/Rating Measure	Barrier	Improvement Strategy
Ø Rating of specialist seen most often	· The health plan only contracts with primary care physicians and uses the State Medicaid network for specialists. · The member is not connected to a medical home.	· Continue to provide thought leadership to the State on reimbursement policy and strategies with respect to specialists. · Continue patient centered

Composite/Rating Measure	Barrier	Improvement Strategy
		medical home initiatives.
Ø Customer Service Provided Needed Information/Help	· Call center does not always have access to the most current eligibility data. A member will call, but the data that the call center sees does not show the member as eligible yet. · Lack of specialists is a key driver of member complaints.	· Form a workgroup to look at the timing and loading of the eligibility file. · Further analyze the member surveys that members take at the end of calls to the call center to identify potential additional drivers of member dissatisfaction. · Engage in improvement strategy outlined under "Rating of specialist seen most often" measure in the line above.
Ø Does your child have a personal doctor?	· The member is not connected to a medical home. · The member does not know who his/her assigned primary care provider is. · The member is not aware of the need to seek out preventative care.	· Continue patient centered medical home initiatives. · Engage in member engagement strategies that involve collaboration with the providers (e.g., co-branded letter and call initiatives, clinic days). · Consult with the Member Advisory Council to identify barriers to seeking out preventative care.

Appointment Availability

Objective: To have 100% of PCPs meet the appointment standards. UHC monitors compliance with the following standards for appointment times within its PCP network:

- Emergency appointments are made immediately upon presentation at the service delivery site.
- Urgent care appointments are provided within twenty-four (24) hours.
- Non-urgent sick care within seventy-two (72) hours or sooner if medical condition(s) deteriorates into an urgent or emergency condition.
- Routine health assessment appointments (asymptomatic or history and physical) are available within three (6) weeks.

Methodology:

- CAHPS® data and member complaints regarding appointment availability and telephonic provider survey
- UHCCP engaged the services of McGahee & Associates, Inc. (M&A) to survey 258 high volume providers identified by UHCCP. M&A was responsible for determining each provider's earliest availability for each of the appointment types listed above. The survey was telephonic and results were self-reported by the provider or his/her office staff. M&A conducted outbound calls during regular business hours, beginning on October 21, 2013 and ending on November 19, 2013. Using the Call Script and Appointment Availability Audit Tool provided by UHC, M&A documented each provider's response to

survey questions. Providers were excluded from survey results if the phone number provided was invalid or if the provider's specialty is one that does not require compliance with appointment availability standards, such as an after-hours urgent care clinic.

Results:

- 91.6% of respondents on the Child CAHPS® survey and 82.23% of respondents on the Adult CAHPS® survey indicated that they usually/always got an appointment when they "needed care right away." 90.06% of child survey respondents and 80.39% of adult survey respondents indicated that they usually/always got a non-urgent appointment as soon as needed.
- The rate of member complaints data regarding appointment availability in 2013 was .0078 per 1000 member months.

2013 Appointment Availability Survey Results

Appointment Standard	Number of Compliant PCPs	Total Number of PCPs Surveyed	2013 Rate	2012 Rate	Change in Rate Year over Year
Timely Emergency Appointments	256	258	99%	98%	+1%
Timely Urgent Care Appointments	256	258	99%	99%	-
Timely Routine Appointments (Symptomatic)	240	258	93%	85%	+8%
Timely Routine Appointments (Asymptomatic)	248	258	96%	99%	-3%

Analysis/Limitations/Barriers:

- The rate of member complaints regarding appointment accessibility in 2013 is consistent with the rate in the previous year and is not excessive.
- CAHPS survey responses suggest that adult members experience more problems than child members in getting appointments.
- The telephonic provider survey indicated that compliance rates are consistent year over year, with the exception of timely routine appointments (symptomatic) which showed an 8% increase in 2013 over 2012.

Actions and Interventions:

- Appointment availability standards are published in the Provider Manual.
- The Provider Relations team and/or the Clinical Practice Consultants will provide education about appointment availability standards to non-compliant providers.

24/7 Accessibility
Objective: All PCPs will be accessible to their panel members 24 hours a day/7 days per week.

Methodology:
- CAHPS® survey
- PCPs are contacted at least every three years or a rotating basis to determine if members have the ability to reach their provider after normal office hours. Calls were placed by a vendor (McGahee & Associates) in 2013 to 125 of Plan PCP practices. Going forward, approximately 125 providers per quarter will be contacted. Providers who are non-compliant with 24/7 access standards are notified via mail, and then are resurveyed telephonically approximately 60 days after the date of the letter.

Results:
- Questions on the Adult CAHPS® survey about calls placed to a doctor or clinic after hours indicated that only 11.48% of respondents had done so. Of these respondents: 6.45% indicated that they "never" got the help they needed, while 51.61% responded that they "always" got the needed help.
- Results of the 2013 survey indicated that overall 61% of providers contacted were compliant with 24/7 access standards. 44 providers were non-compliant.

Analysis/Limitations/Barriers:
- Compliance with 24/7 access standards among surveyed providers improved year over year from 51% to 61%.
- The most common reason for a non-compliance score was that providers did not return calls within 30 minutes (66%). This is higher than last year's percentage of 36% which may indicate that PCPs are moving to having acceptable after-hours coverage messaging with delays in responding. Other reasons for non-compliance scores included providing no coverage (18%); having a message that directed patients to the emergency room (11%); and having no live person answer the phone when a first message directs patients to call a different number (4.5%).

Actions and Interventions:
- Continue to monitor PCP sites for 24/7 access quarterly.
- All non-compliant providers were notified of lack of compliance by certified mail, and will be re-surveyed telephonically approximately 60 days after the date of the letter.
- Employed Provider Advocate team and Clinical Practice Consultant team to educate providers on the 24/7 access standards.

In 2012-2013 year the after-hours access and appointment availability surveys were begun. These results were published in the 2013 QI Program Evaluation. In 2012 after hours access was also reported to DHH on the SQ217 report, QAPI Early Warning Systems Performance Measures. HEDIS® measures were included in the 2012 QI program evaluation with the caveat that they were not audited nor submitted to DHH.

Geographical Access
Objective: To determine if the network is adequate to meet the needs of our population.

Methodology: UHCCP defines Primary Care outlined in the Availability of Practitioners and Providers Policy (UHC.QMP.001). Primary Care Practitioners include those doctors practicing Internal Medicine, Family Practice, General Practice, and Pediatrics. Nurse Practitioners and Physician Assistants may be included when they are within the scope of credentialing and provide primary care as licensed independent practitioners. Other types of physicians may be considered as Primary Care as required by applicable state

law. Specialty Care and Behavioral Health Practitioners are carved out contractually by the State of Louisiana and, therefore, measurements of these types of practitioners are not in scope.

The availability of practitioners is measured by reviewing:

1. The ratio of primary care practitioners to members.
2. The geographic distribution of providers by specialty and location; metro, micro, rural, and counties with extreme access consideration (CEAC), based on the most recent CMS Medicare Advantage network adequacy criteria.
3. The cultural, ethnic, racial and linguistic needs of members. UHCCP may adjust the availability of its practitioners within the network, if necessary, to meet those needs. For example, language issues related to communicating with health care providers are evaluated as part of the cultural assessment. The demographic assessment also includes race.

The health plan's current performance is compared to the standards and any actions that will improve performance to meet standards are identified. The identified actions are presented to the SQIS for recommendations and approval.

Results:

Ratio of Primary Care Practitioners to Members

	Numeric Goal	Actual	Goal Met/Not Met
Primary Care Provider Type			
General Practice	1:1000	1: 394	Met
Internal Medicine	1:1000	1: 356	Met
Pediatrics	1:1000	1: 368	Met
Family Practice	1:1000	1: 280	Met

Analysis: All primary care provider categories exceeded the goal of one provider to one thousand members.

Geographic Availability

Primary Care	Metro Goal 1 in 10 miles		Micro Goal 1in 20 miles		Rural Goal 1 in 30 miles		CEAC* Goal 1 in 60 miles	
	Actual	Met/ Not Met	Actual	Met/ Not Met	Actual	Met/ Not Met	Actual	Met/ Not Met
Family Practice/ General Practice	98%	Met	100%	Met	100%	Met	100%	Met
Internal Medicine	95%	Met	99%	Met	98%	Met	100%	Met
Pediatrics	96%	Met	97%	Met	98%	Met	100%	Met
Total Adult PCP	99%	Met	100%	Met	100%	Met	100%	Met

** CEAC- Counties with Extreme Access Consideration*

Analysis: Goal is that 90% of the members will have access within specified mileage. All geographic areas exceeded their specified goals.

Opportunities/Interventions: All provider types met the numeric or geographical goals. UHCCP continuously seeks opportunities to improve its networks. UHCCP has identified Tangipahoa, St. Tammany, and Calcasieu

parishes as areas that have growth opportunities. UnitedHealth Networks is actively working to develop the network in these areas.

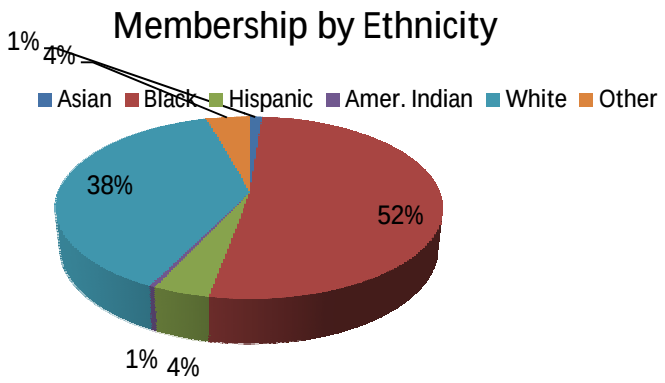
Cultural and Linguistic Needs of Members and Addressing Health Disparities

Objective: To ensure cultural and linguistically appropriate care and services for members.

- Analyze existence of significant health care disparities in clinical areas.
- Use practitioner and provider chart reviews and interviews to understand the differences in care provided and outcomes achieved.
- Identify and reduce a specific health care disparity.
- Provide information, training and tools to staff and practitioners to support culturally competent communication.

Race/Ethnicity	# Members*	% of Population
Asian	3,116	1.2%
Black	132,827	51.7%
Hispanic	10,323	4.0%
Amer. Indian	1,040	0.4%
White	98,636	38.4%
Other	11,000	4.3%
Total	256,942	100.0%

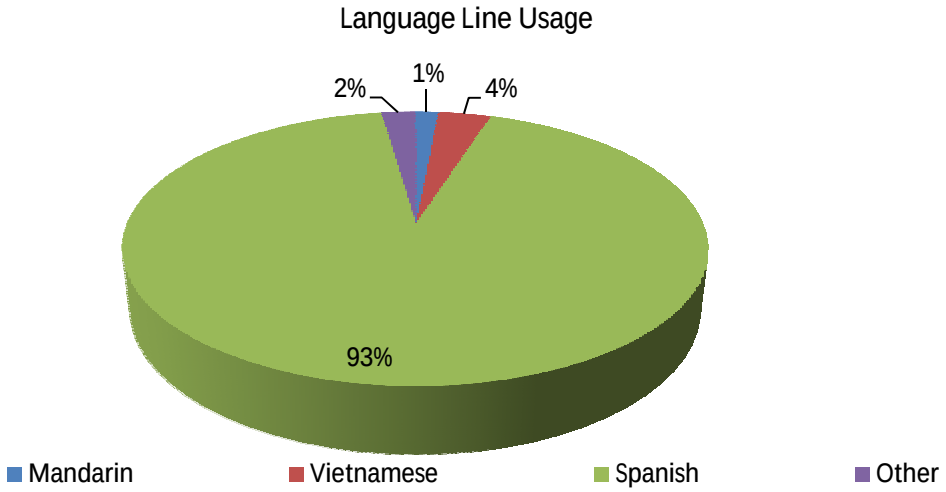
*as of 11/30/2013



Measure	Language
Percentage of Health Plan Practitioners (PCPs) who speak languages other than English	Spanish 8.06% French 2.49% Arabic 1.31% Vietnamese .74%

Language line usage was monitored quarterly by the SQIS. There were 1698 calls received in 2013, up from 477 in 2012. Spanish was by far the most common language requested, with Vietnamese being the next most frequently requested. A breakdown of languages requested in the period January – December 2013 is depicted in the pie chart below.

Top Languages Requested Through Language Line Services (Jan – Dec 2013)



The following CAHPS® 5.0H survey questions are measured annually for each UHC plan, based on the member's experience, in order to assess cultural and linguistically appropriateness of care and services.

CAHPS® Results

Adult Survey	2013	2013 Southeast Region Average
In the last 6 months, was it hard to find a personal doctor who speaks your language?	8.4%	11.2%
In the last 6 months, was it hard to find a personal doctor who knows your culture?	11.9%	13.1%

Child with Chronic Conditions Survey	2013	2013 Southeast Region Average
In the last 6 months, was it hard to find a personal doctor for your child who speaks your language?	7.7%	6.0%
In the last 6 months, was it hard to find a personal doctor for your child who knows your culture?	7.2%	6.5%

Analysis, Barriers, Limitations:

- There were 1,698 calls to the language line from January 1 – October 31, 2013. 93.6% of these calls were requested for Spanish language assistance with the next most popular language requested was Vietnamese at 3.3%.
- The plan looks at Louisiana census data to discern if there are any opportunities in the area of languages spoken. There is adequate diversity of provider languages as compared to Louisiana census data to serve the members who speak different languages.
- 2013 (Measurement Year 2012) was the inaugural year for UHCCP Child with Chronic Condition CAHPS® survey. There is no historical trend data to compare so the inaugural year was compared with the

Southeast region average. The UHCCP plan data for language and culture shows less satisfaction than the regional average.

- 2013 (Measurement Year 2012) was the inaugural year for UHCLA Adult CAHPS®. There is no historical trend data to compare so the inaugural year was compared with the Southeast region average. The UHCCP plan data for language and culture is better than the regional average.

Actions and Interventions:

- UHCCP provides language line services for its members through ATT for over 135 languages.
- UHCCP provides its materials in Spanish and Vietnamese for the two largest non-English speaking populations in the health plan.
- Practitioners who speak other languages are indicated in the provider search.
- UHCCP has already taken actions to address the specific needs of the African American population which represents over half of UHCCP's membership. UHCCP has chosen to focus on health care issues that disproportionately affect African Americans over other races, including breast and cervical cancer mortality, asthma management, and sickle cell disease. Though Louisiana ranks 40th in the United States in incidence of breast cancer, the State ranks 2nd highest in mortality from the disease. Likewise, African Americans are more likely to have asthma than their Caucasian counterparts. So UHCCP implemented targeted outreach to increase breast cancer screening, the most effective way to improve breast cancer mortality, and also tackled asthma management in initiatives ranging from provider education about treatment to engagement of schools in facilitating compliance with asthma action plans for children. In addition, UHCCP focused on identification of members with sickle cell disease and referral of those members to its case management program.

Access to Care

Objective: All members enrolled in UHCCP will have at least one preventive care or ambulatory visit with their PCP annually.

Methodology: HEDIS® 2014 (administrative)

Measure	HEDIS® 2014 Goal (All HEDIS® 2012 State Benchmarks)	Interim Unaudited Rate for HEDIS® 2014 (as of 1/20/14)	Goal Met
Children's Access to PCPs (Ages 12 to 24 Months)	97.05	97.23	Yes
Children's Access to PCPs (Ages 2 years to 6 Years)	87.85	87.55	Not as of 1/20/14
Children's Access to PCPs (Ages 7 years to 11 Years)	88.49	86.85	Not as of 1/20/14
Children's Access to PCPs (Ages 12-19 Years)	87.06	84.95	Not as of 1/20/14

Measure	HEDIS® 2014 Goal	Interim Unaudited Rate for HEDIS® 2014 (as of 1/20/14)	Goal Met
Adult Access (Ages 20 to 44 Years)	78.48 (NCQA 25th Percentile)	80.88	Yes
Adult Access (Ages 45 to 64 Years)	84.48 (NCQA 25th Percentile)	88.65	Yes
Adult Access (Ages 65+ Years)	78.47 (NCQA 25th Percentile)	75.90	Not as of 1/20/14
Adult Access (Total)	78.39 (HEDIS® 2012 State Benchmark)	83.59	Yes

Analysis/Limitations/Barriers:

- Through the Clinical Practice Consultant (CPC) program, a barrier that surfaced was the lack of coordination between primary care and gynecological care. Members qualifying for Medicaid only while pregnant often fail to see a PCP, instead receiving most of their care from their obstetricians.
- Another barrier is members who do not establish or maintain an ongoing relationship with a PCP.
- Members may also use hospital emergency departments rather than a PCP for non-emergent care.

Actions and Interventions:

- Continued efforts to encourage members to establish with a PCP through new member welcome calls, member newsletter articles, and Silverlink preventative health outreach calls.
- Continued CPC outreach and education to high-volume PCPs, emphasizing EPSDT, HEDIS® measure specifications, and identifying members with gaps in care.
- Partnered with one large PCP practice to provide a back-to-school clinic day.
- Instituted a co-branded letter and call campaign that included 8 practices with 13 providers touching over 3,500 members.
- Added a Quality Outreach Coordinator to make preventative health outreach calls to members with gaps in care.

Accessibility of Services

An annual evaluation of accessibility of services for UHCCP members was completed in 2013.

Adult CAHPS® 5.0H Survey Results*	2013 Plan Rate	2013 UHC National Average (Product)	Variance to National Average	2013 NCQA Percentile for Accreditation
Regular or Routine Care				
In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed? (Usually/Always)	75.17%	79.84%	↓4.67	<50th
Urgent/Emergent Care				
In the last 6 months, when you needed care right away, how often did you get care as soon as you needed? (Usually/Always)	82.23%	83.22%	↓.99%	<50th
After Hours Care*				
In the last 6 months, when you called a doctor's office or clinic after hours, how often did you get the help you wanted? (Usually/Always)	77.42%	67.12%	↑10.3%	No Data

*Insufficient denominator to report to NCQA

Child with CCC CAHPS 5.0H Survey Results*	2013 Plan Rate	2013 UHC National Average (Product)	Variance to National Average	2013 NCQA Percentile for Accreditation
Regular or Routine Care (chronic population)				
In the last 6 months, when you made an appointment for a check-up or routine care for your child at a doctor's office or clinic, how often did you get an appointment as soon as your child needed? (Usually/Always)	92.31%	92.38%	↓.06	90th
Urgent/Emergent Care (chronic population)				
In the last 6 months, when your child needed care right away, how often did your child get care as soon as he or she needed? (Usually/Always)	92.06%	94.08%	↓2.02%	90th
After Hours Care* (chronic population)				
In the last 6 months, when you called a doctor's office or clinic after hours, how often did you get the help you wanted for your child? (Usually/Always)	81.40%	84.39%	↓2.99%	No Data

*Insufficient denominator to report to NCQA

Analysis, Opportunities & Actions

The detailed data in all tables of this report were reviewed and analyzed. UHCCP demonstrated the strength of its network of practitioners and facilities by scoring above the NCQA average on six of the eight key measures in the 2013 CAHPS®, including Overall Rating of the Health Plan. On the Children with Chronic Conditions Measures survey, the health plan scored above the NCQA accreditation average on three of the five key measures. Using the key driver analysis UHCCP identified the below areas that had opportunities for improvement.

Adult CAHPS®: Analysis of adult access CAHPS® data reveals the Regular or Routine Care measure to be 75.17%, 4.67% below the national average of 79.84%, or less than the 10th percentile for the region. The Urgent/Emergent Care measure resulted in 82.23%, or .99% below the national average of 83.22, or less than the 10th percentile for the region. The After Hours Care measure was 77.42%, 10.3% above the National Average of 67.12%, but Louisiana's rate was the highest in the Southeast region.

Children with Chronic Conditions (CCC) CAHPS®: Analysis of CCC CAHPS® reveals the Regular or Routine Care measure to be 92.31%,slightly less (0.06%) less than the national average of 92.38 or the 50th percentile for the region. The Urgent/Emergent Care measure was 92.06, 2.02% less than the national average of 94.08, or the 25th percentile. The After Hours Care Measure was 81.40, 2.99% less than the national average of 84.39. The After Hours Care measure quartile was not scored due to an insufficient denominator to report to NCQA.

Barriers:

- As a shared savings plan as mandated by the State, UHCCP only contracts with primary care practitioners.
- Members are not always connected to a medical home.
- Members are not aware of recommended preventative care.

Actions and Interventions:

- Continue to provide thought leadership to the State on reimbursement policy and strategies with respect to specialists.
- Consult the Member Advisory Council to identify barriers to preventative care.
- Engage in member engagement strategies that involve collaboration with the providers (e.g., co-branded letter and call initiatives, clinic days).

Customer Service Accessibility

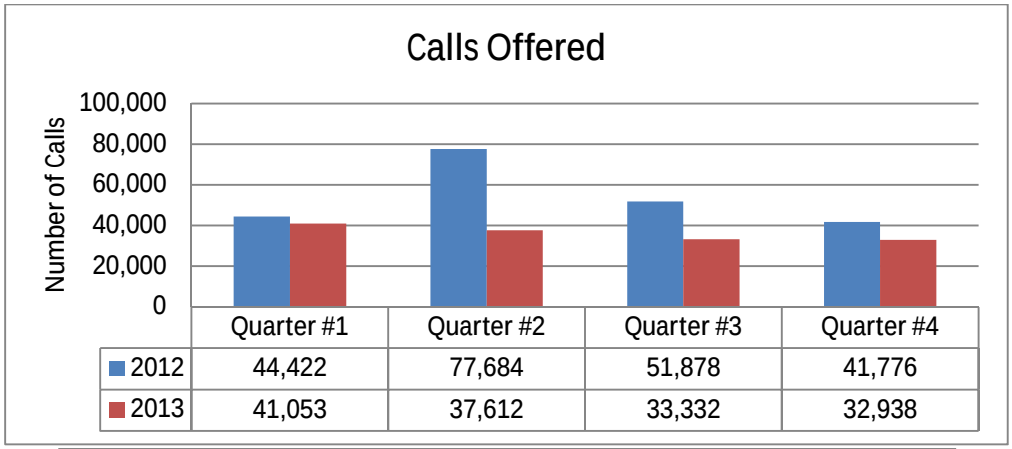
Objective: For the Member Services Call Center, to achieve:

- An average speed to answer (ASA) less than 30 seconds.
- A rate in excess of 90% for the percentage of calls answered within 30 seconds.
- An abandonment rate (ABA) of less than 5%.

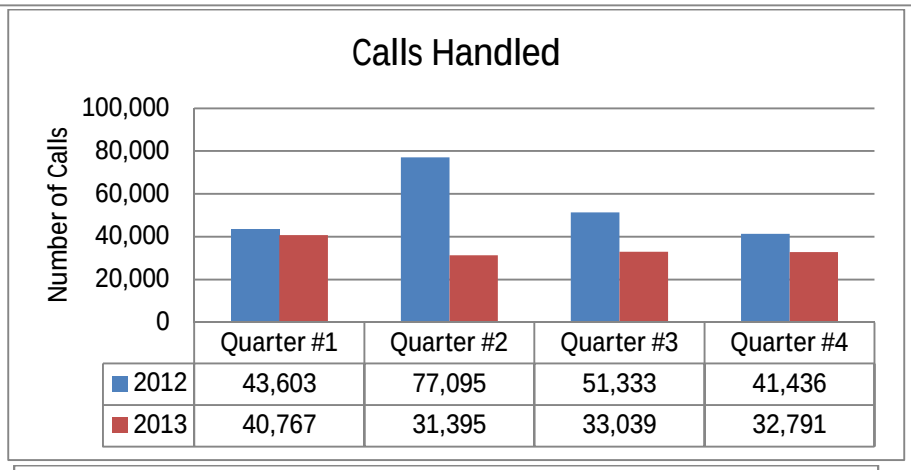
Methodology: Call Center metrics are reviewed monthly by the UHCCP Compliance Officer and are reported quarterly to the SQIS.

Results:

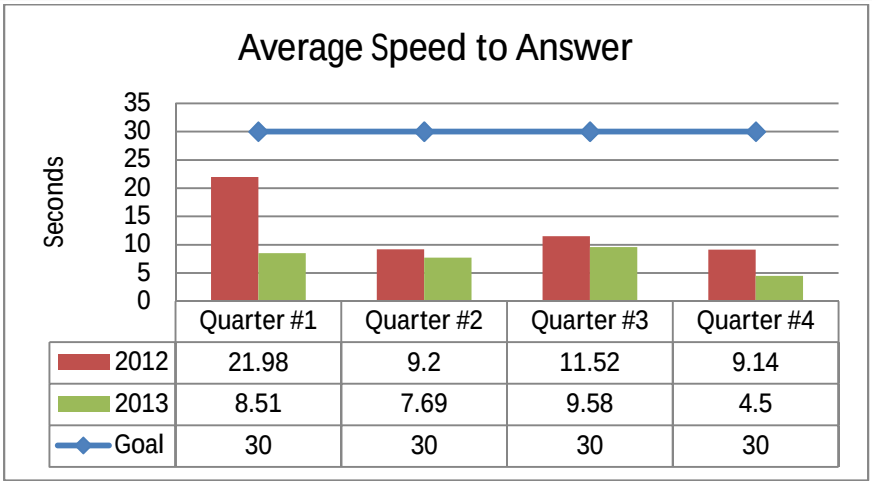
2012/2013 Member Call Center Statistics for Medicaid Members



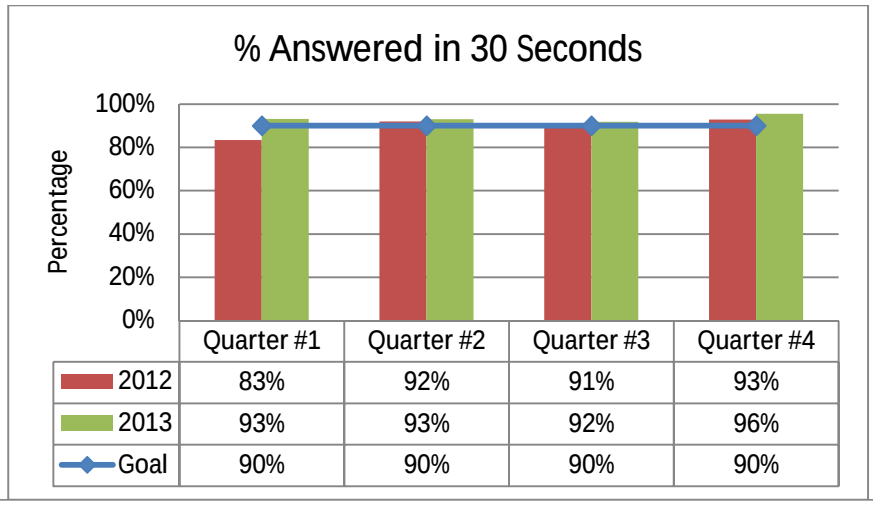
	Quarter #1	Quarter #2	Quarter #3	Quarter #4
2012	44,422	77,684	51,878	41,776
2013	41,053	37,612	33,332	32,938

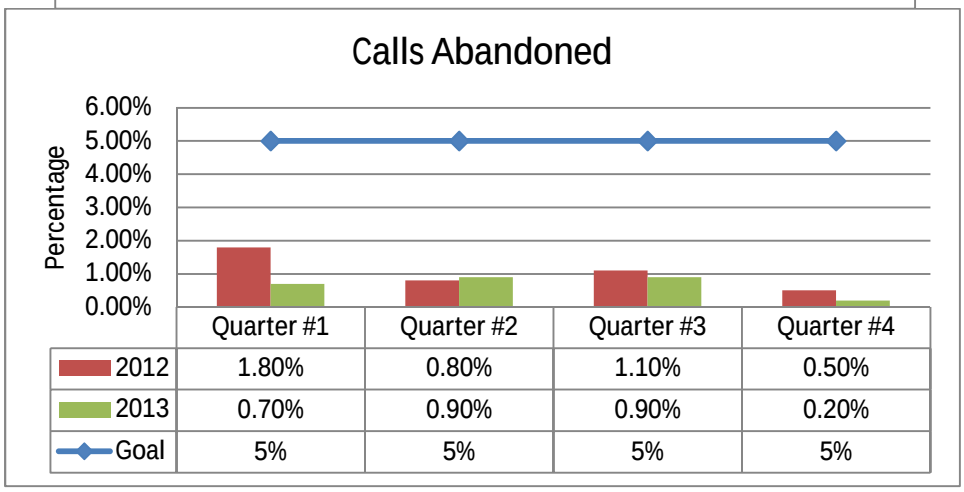


	Quarter #1	Quarter #2	Quarter #3	Quarter #4
2012	43,603	77,095	51,333	41,436
2013	40,767	31,395	33,039	32,791



	Quarter #1	Quarter #2	Quarter #3	Quarter #4
2012	21.98	9.2	11.52	9.14
2013	8.51	7.69	9.58	4.5
Goal	30	30	30	30





Analysis/Limitations/Barriers:
Year over year, there were more member calls handled and offered in 2012 versus 2013, with the largest number being in 2nd Quarter 2012. It is reasonable to expect that members would have called more frequently during the implementation of the plan versus during a more stable period. All goals for the Member Services Call Center were met or exceeded in 2013.

Actions and Interventions:
These metrics will continue to be tracked and trended.

Clinical Guidelines
Objective: To promote the use of evidence-based clinical guidelines to network providers.
In 2013, the guidelines listed in the table below were reviewed and approved by the PAC and the QMC. The provider network was informed via newsletters and mailings and was alerted about accessing the UHCCP web site, http://www.uhccommunityplan.com/health-professionals/la/clinical-practice-guidelines.html, for the entire guidelines.

Clinical Guidelines Reviewed

· Acute MI · Asthma · ADHD · Autism Spectrum Disorder · Bariatric Surgery · Bipolar disorder, depression, schizophrenia and substance abuse · Breast Pump · Cardiovascular disease · Cervical Cancer Screening · Cholesterol management	· Chemotherapy observation or inpatient hospitalization · Chronic stable angina · COPD · Depression/Major Depressive Disorder · Diabetes · Dietary Guidelines · Durable Medical Equipment, Supplies, Prosthetics and Orthotics · Heart failure · Hemophilia and von Willebrand Disease · HIV/AIDS · Neonatal hyperbilirubinemia · Hypertension	· Infertility · Inpatient Pediatric feeding programs · Oncology · Organ Transplantation · Physical Activity · Preventive Pediatric Health Care Screening · Propranolol Treatment for Infantile Hemangioma · Radiology · Maternity · Schizophrenia · Sickle cell disease · Spinal stenosis · Substance abuse disorders · Tobacco Use

Analysis/Limitations/Barriers:

- A barrier to active participation in the DM program is ensuring a reliable means to contact and communicate with members. Phone numbers are often times inaccurate or disconnected causing the case manager to be unable to reach the member.
- Adherence to several clinical practice guidelines that relate to disease management and preventative care are monitored using HEDIS® performance measures, including COPD, diabetes, hypertension, obesity prevention, and well child visits. All measures were below the HEDIS® 75th percentile.

Actions and Interventions:

- Encouraged members with chronic health problems to establish a medical home with a PCP who will provide holistic, coordinated care.
- Ensured availability of clinical practice guidelines on the Plan's website.
- Implemented an auto-dialer program where all new case management referrals' phone numbers on file are called. If the member answers, then he/she is connected with a live case manager.
- Continued to track and trend HEDIS® performance measures related to clinical practice guidelines.
- Continued CPC program and distribution of the Evidence-Based Guidelines Toolkits to providers.
- Promoted appropriate prenatal and postpartum care through the Healthy First Steps program.

Safety

Objective: To assess safety in the health care setting.

Methodology:

- Monitor for potential quality of care/adverse events, with appropriate corrective action as needed. (Adverse events include: medication error; surgical or clinical procedural error, complication or infection; unscheduled return to surgery; unexpected trauma occurring during treatment; unexpected death; unplanned readmission within 30 days).
- Corporate UHC Patient Safety program coordinates various programs across the organization.

Results:
Reports were reviewed and action plans developed through the PAC Committee. Quality of quality of care/adverse events investigations showed no remarkable trends. No quality of care issues were substantiated at the plan level; therefore, no corrective action was needed.

Actions and Interventions:
- Member newsletter articles about hurricane preparation and safety: summer 2013 continue quality of care referrals to the PAC as needed.

Member and Provider Health Education
Objective: To assess the educational materials offered to members and providers.

Methodology:
Review direct mailings, articles included in newsletters, and other forms of education to ensure that information is communicated in order to promote wellness, screenings, safety, and the latest clinical recommendations.

Activities:
- Launched a collaborative campaign ("Eat4Health") with 4-H targeting healthy eating.
- Member newsletter articles in 2013 included influenza vaccinations, asthma, what is an emergency, appointment wait times, generic drugs, case management, quality management, depression, heat related illness, hurricane preparedness, child/teen well care visits and immunizations, breast feeding, safety, whooping cough, member handbook, allergies and asthma, diabetes, lead testing, cold and flu season, preparing for doctor's visits, and Chlamydia screening.
- Targeted mailings for members with diabetes, asthma, COPD, cardiovascular disease, hypertension and pregnancy.
- Text4Baby messaging.
- Member access to NurseLine advice and patient education topics.
- New member outreach by phone and mail to encourage creation of a medical home.
- UHCCP website lists links for members to preventive health and immunization guidelines and behavioral health information.
- UHCCP website lists links for practitioners for clinical practice guidelines.
- UnitedHealthcareOnline.com offers a variety of clinical resources, tools and continuing education opportunities for practitioners.
- Provider newsletter articles in 2013 included admission notification, cultural competency, hurricane preparedness, afterhours access, generic drugs, utilization review, and members rights and responsibilities.
- HEDIS® training for PCP offices using the "Evidence-Based Quality Performance Guidelines" toolkit.

Analysis/Limitations/Barriers:
Effectiveness of member and provider health education materials can be assessed to some extent by the improvement in health outcomes. This is analyzed throughout this document in the presentation of HEDIS® performance measure results.

Actions and Interventions:
Continue to assess and monitor the effectiveness of health education tools as a part of the development of quality improvement initiatives.

Collaborative Projects:
Co-branded Member Outreach Initiative
UHCCP initiated a co-branded outreach campaign with 8 primary care practices with a total of 13 practitioners; the campaign included a combination of 6,924 letters and 2,824 automated reminder calls to members with opportunities for preventative care.

Clinic Day
UHCCP collaborated with one large provider practice to hold a clinic day in August 2013. The health plan conducted the outreach to the members assigned to the practice who had gaps in care and the practice opened up on a Saturday to see patients for well visits and immunizations.

Planning for 2014 Health Fair with East Baton Rouge Parish School Based Clinics
Health Centers in Schools integrates health programs and services, creating "medical homes" for all East Baton Rouge Parish public school students in Louisiana. In 2013, UHCCP was in the planning stages with the health center to hold a 2014 health fair at Broadmoor High School in Baton Rouge.

Asthma Management
One of UHCCP's performance improvement projects (PIPs) was Reducing Emergency Department Visits. Through this PIP, UHCCP had the opportunity to partner with several large hospital providers to implement an asthma action plan process in the hospital, refer the member to case management, and communicate the action plan to the member's primary care provider.
UHCCP partnered with two large tertiary facilities in GSA-B to identify the asthma pediatric population that was the highest utilizer of emergency and inpatient resources. UHCCP assisted this facility in implementing an asthma disease management program to include onsite and telephonic management. For more information about this PIP, see the Performance Improvement Projects section in this document.

JOIN for ME
In 2012, UHCCP partnered with Louisiana Alliance of Boys & Girls Clubs to launch a community-based pediatric obesity lifestyle intervention program, developed by UHG, to help reduce excess weight and improve health related quality of life in overweight and obese children in Orleans Parish. The JOIN for ME pilot was designed to provide affordable and accessible care in local communities. JOIN for ME focuses on helping children who struggle with extra weight, underscoring the importance of cultivating a healthier environment and healthier behaviors at home with the entire family. In 2013, the program continued at the Boys and Girls Club in New Orleans. A second location in St. Tammany Parish is projected to launch by mid-year 2014.

Patient Centered Medical Home (Accountable Care Communities Program)
The Accountable Care Communities program involves partnering with practices and helping them proactively manage high-risk patients using a web-based registry. Through the electronic registry, the practice team has access to information about care their members have received and can take on greater responsibility for continuous care. The goals of the program are to:
- Improve access to care by focusing on increasing same day appointment availability
- Reduce non-emergent use of the emergency room

- Reduce avoidable hospital admissions and readmissions
- Increasing focus on the management of high-risk patients

As of the end of 2013, eight practices were using the registry. The Chief Medical Officer has also been actively working with hospitals to provide daily emergency room and inpatient censuses to feed the web-based registry and to give data to our emergency room coaches for live member outreach. She has also engaged with the Louisiana Health Information Exchange (LAHIE) to supplement the registry data.

HEAL

United HealthCare partnered with Head-Off Environmental Asthma Louisiana (HEAL) program to refer asthmatics for targeted education from asthma educators.

Clinical Practice Consultant Program

The health plan has five clinical practice consultants engaged in educating primary care providers about the Healthcare Effectiveness and Information Data Set (HEDIS®). To improve HEDIS® rates, the plan has shared information about evidence based guidelines for care by distributing 409 Evidence Based Guidelines Toolkits to 221 practices. The consultants will continue to work with practices to proactively identify gaps in preventative and chronic care.

This evaluation considered all aspects of the QI Program and evaluated the Program's overall effectiveness and progress towards goals. Identified barriers and selected opportunities for improvement for each area of clinical care and service described in the evaluation will be specifically addressed through actions in the 2014 QI Work Plan. The yearly planned activities for 2013 were completed and objectives were met as follows:

- Improvement in calculation of performance measures
  - Obtained data feed from immunization registry LA LINKS.
  - Partnered with lab providers to obtain lab data feeds.
- Review of provider and member satisfaction surveys
  - Provider satisfaction survey yielded a response rate and satisfaction ratings higher than UHC national averages.
  - Inaugural year of the Adult CAHPS Survey showed UHCCP met or exceeded the 75th percentile for accreditation scoring in 7 of the 8 ratings and composite scores, with 4 of 8 measures exceeding the 90th percentile for accreditation scoring.
  - Inaugural year of the Child CAHPS Survey showed UHCCP met or exceed the 75th percentile for accreditation scoring in all of the ratings and composite scores, with 6 of 8 measures exceeding the 90th percentile for accreditation scoring.
- PCP profile analysis
  - PCP profile analysis is being performed every quarter with appropriate referrals to case management. In addition, providers that have members that are high utilizers of ER services or have frequent hospitalizations and are not actively engaged in case management are notified of utilization and the need to encourage such patients to participate in UHCCP case management.
- Analysis to identify disparities in clinical care
  - UHCCP has chosen to focus on health care issues that disproportionately affect African Americans over other races, including breast and cervical cancer mortality, asthma management, and sickle cell disease.

Below are selected areas targeted for improvement in 2014:

- Achievement of NCQA Initial Survey accreditation
- Improvement in State incentive measures
- Improvement in communication of PCP profile analysis to high volume providers in order to assist practices with identifying opportunities for care for their patients
- Improvement in provider compliance with 24/7 access standards

UHCCP is committed to achieving the goals and objectives set forth in the QI Program Description and to effectively and efficiently using resources. Its QI staff will continue to work with divisions throughout the Health Plan, Quality Management & Performance, and UnitedHealth Group. We believe this integration of subject matter expertise and data-driven processes from both clinical and operational teams will promote continued improvement in the quality of care and service for our members.

§ 2012-2013 Recommendation: The Plan should identify barriers preventing providers from earning PCMH recognition/accreditation and implement interventions to address these barriers.

Plan Response: The Louisiana ACC deployment is overseen by the local Health Plan, local ACC Transformation Consultants, and the national United Healthcare ACC team on a weekly, monthly and quarterly basis. Thereafter, the local Health Plan, local ACC Transformation Consultants, and the national United Healthcare ACC team will interact and monitor progress against individual practice ACC/NCQA metrics via the monthly JOC meetings.

PCMH recognition is an important milestone for a PCP practice. However, recognition alone does not assure the Triple Aim of improved individual health, improved population health, and lower per capita costs of care. To that end, UnitedHealthcare has launched its Patient Centered Medical Home model in Louisiana – a tiered approach to assist PCP practices to reach PCMH recognition and to launch our Accountable Care Communities (ACC) program. The core tenets of the ACC program are to:

- Improve access to the PCP
- Reduce avoidable ER visits
- Reduce avoidable hospitalization and readmission
- More closely manage the most fragile of each engaged PCP's patients

Over the past two years, UnitedHealthcare has deployed our ACC program across the state of Louisiana, to date partnering with 21 PCP practices. The ACC program now encompasses 65,000+ patients, over 200 providers, and more than 30 clinic locations. Statewide, we are already seeing results - a 14% reduction in Inpatient rates/1,000 and a 1.4% reduction in ER rates/1,000.

By following the tenets of our ACC program each practice is prepared for admission as an NCQA-certified practice since the ACC program closely follows the core aspects of the NCQA application and approval process. Presently, 9 ACC practices are NCQA certified encompassing over 150 individual providers. Each month we conduct Joint Operating Committee (JOC) meetings with the executive and clinical leadership of each ACC practice and note progress against ACC/NCQA metrics.

Through 2015, we anticipate expanding the Louisiana ACC program to an additional 109 PCP practices across all three GSA regions.

We expect to have 131 active ACC practices - all certified or working towards NCQA certification - by the end of 2015.

We are actively recruiting Transformation Consultants - who are physically located in the same communities as the ACC practices - to oversee the additional ACC practices through Q1 2015. We anticipate we will be engaging with and deploying the additional ACC practices through the remaining quarters of 2015.

§ 2012-2013 Recommendation: The Plan should continue to work to address contractual requirements related to Provider Network and Marketing & Member Education to ensure it achieves, at a minimum, "substantial" compliance during the next Annual Compliance Review.

Plan Response:

Appointment Availability
Objective: To have 100% of PCPs meet the appointment standards. UHC monitors compliance with the following standards for appointment times within its PCP network:

- Emergency appointments are made immediately upon presentation at the service delivery site.
- Urgent care appointments are provided within twenty-four (24) hours.
- Non-urgent sick care within seventy-two (72) hours or sooner if medical condition(s) deteriorates into an urgent or emergency condition.
- Routine health assessment appointments (asymptomatic or history and physical) are available within three (6) weeks.

Methodology:

- CAHPS® data and member complaints regarding appointment availability and telephonic provider survey.
- UHCCP engaged the services of McGahee & Associates, Inc. (M&A) to survey 258 high volume providers identified by UHCCP. M&A was responsible for determining each provider's earliest availability for each of the appointment types listed above. The survey was telephonic and results were self-reported by the provider or his/her office staff. M&A conducted outbound calls during regular business hours, beginning on October 21, 2013 and ending on November 19, 2013. Using the Call Script and Appointment Availability Audit Tool provided by UHC, M&A documented each provider's response to survey questions. Providers were excluded from survey results if the phone number provided was invalid or if the provider's specialty is one that does not require compliance with appointment availability standards, such as an after-hours urgent care clinic.

Results:

- 91.6% of respondents on the Child CAHPS® survey and 82.23% of respondents on the Adult CAHPS® survey indicated that they usually/always got an appointment when they "needed care right away." 90.06% of child survey respondents and 80.39% of adult survey respondents indicated that they usually/always got a non-urgent appointment as soon as needed.
- The rate of member complaints data regarding appointment availability in 2013 was .0078 per 1000 member months.

2013 Appointment Availability Survey Results

Appointment Standard	Number of Compliant PCPs	Total Number of PCPs Surveyed	2013 Rate	2012 Rate	Change in Rate Year over Year
Timely Emergency Appointments	256	258	99%	98%	+1%
Timely Urgent Care Appointments	256	258	99%	99%	-
Timely Routine Appointments (Symptomatic)	240	258	93%	85%	+8%
Timely Routine Appointments (Asymptomatic)	248	258	96%	99%	-3%

Analysis/Limitations/Barriers:

- The rate of member complaints regarding appointment accessibility in 2013 is consistent with the rate in the previous year and is not excessive.
- CAHPS® survey responses suggest that adult members experience more problems than child members in getting appointments.
- The telephonic provider survey indicated that compliance rates are consistent year over year, with the exception of timely routine appointments (symptomatic) which showed an 8% increase in 2013 over 2012.

Actions and Interventions:

- Appointment availability standards are published in the Provider Manual.
- The Provider Relations team and/or the Clinical Practice Consultants will provide education about appointment availability standards to non-compliant providers.

24/7 Accessibility

Objective: All PCPs will be accessible to their panel members 24 hours a day/7 days per week.

Methodology:

- CAHPS® survey
- PCPs are contacted at least every three years or a rotating basis to determine if members have the ability to reach their provider after normal office hours. Calls were placed by a vendor (McGahee & Associates) in 2013 to 125 of Plan PCP practices. Going forward, approximately 125 providers per quarter will be contacted. Providers who are non-compliant with 24/7 access standards are notified via mail, and then are resurveyed telephonically approximately 60 days after the date of the letter.

Results:

- Questions on the Adult CAHPS® survey about calls placed to a doctor or clinic after hours indicated that only 11.48% of respondents had done so. Of these respondents: 6.45% indicated that they “never” got the help they needed, while 51.61% responded that they “always” got the needed help.
- Results of the 2013 survey indicated that overall 61% of providers contacted were compliant with 24/7 access standards. 44 providers were non-compliant.

Analysis/Limitations/Barriers:

- Compliance with 24/7 access standards among surveyed providers improved year over year from 51% to 61%.
- The most common reason for a non-compliance score was that providers did not return calls within 30 minutes (66%). This is higher than last year's percentage of 36% which may indicate that PCPs are moving to having acceptable after-hours coverage messaging with delays in responding. Other reasons for non-compliance scores included providing no coverage (18%); having a message that directed patients to the emergency room (11%); and having no live person answer the phone when a first message directs patients to call a different number (4.5%).

Actions and Interventions:

- Continue to monitor PCP sites for 24/7 access quarterly.
- All non-compliant providers were notified of lack of compliance by certified mail, and will be re-surveyed telephonically approximately 60 days after the date of the letter.
- Employed Provider Advocate team and Clinical Practice Consultant team to educate providers on the 24/7 access standards.

Geographical Access

Objective: To determine if the network is adequate to meet the needs of our population.

Methodology: UHCCP defines Primary Care outlined in the Availability of Practitioners and Providers Policy (UHC.QMP.001). Primary Care Practitioners include those doctors practicing Internal Medicine, Family Practice, General Practice, and Pediatrics. Nurse Practitioners and Physician Assistants may be included when they are within the scope of credentialing and provide primary care as licensed independent practitioners. Other types of physicians may be considered as Primary Care as required by applicable state law. Specialty Care and Behavioral Health Practitioners are carved out contractually by the state of Louisiana and therefore measurements of these types of practitioners are not in scope.

The availability of practitioners is measured by reviewing:

1. The ratio of primary care practitioners to members;
2. The geographic distribution of providers by specialty and location; metro, micro, rural, and counties with extreme access consideration (CEAC), based on the most recent CMS Medicare Advantage network adequacy criteria.
3. The cultural, ethnic, racial and linguistic needs of members. UHCCP may adjust the availability of its practitioners within the network, if necessary, to meet those needs. For example, language issues related to communicating with health care providers are evaluated as part of the cultural assessment. The demographic assessment also includes race.

The Health Plan's current performance is compared to the standards and any actions that will improve performance to meet standards are identified. The identified actions are presented to the SQIS for recommendations and approval.

Results:

Ratio of Primary Care Practitioners to Members

	Numeric Goal	Actual	Goal Met/Not Met
Primary Care Provider Type			
General Practice	1:1000	1: 394	Met
Internal Medicine	1:1000	1: 356	Met
Pediatrics	1:1000	1: 368	Met
Family Practice	1:1000	1: 280	Met

Analysis: All primary care provider categories exceeded the goal of one provider to one thousand members.

Geographic Availability

Primary Care	Metro Goal 1 in 10 miles		Micro Goal 1in 20 miles		Rural Goal 1 in 30 miles		CEAC* Goal 1 in 60 miles	
	Actual	Met/ Not Met	Actual	Met/ Not Met	Actual	Met/ Not Met	Actual	Met/ Not Met
Family Practice/ General Practice	98%	Met	100%	Met	100%	Met	100%	Met
Internal Medicine	95%	Met	99%	Met	98%	Met	100%	Met
Pediatrics	96%	Met	97%	Met	98%	Met	100%	Met
Total Adult PCP	99%	Met	100%	Met	100%	Met	100%	Met

** CEAC- Counties with Extreme Access Consideration*

Analysis: Goal is that 90% of the members will have access within specified mileage. All geographic areas exceeded their specified goals.

Opportunities/Interventions:
All provider types met the numeric or geographical goals. UHCCP continuously seeks opportunities to improve its networks. UHCCP has identified Tangipahoa, St. Tammany, and Calcasieu parishes as areas that have growth opportunities. UnitedHealth Networks is actively working to develop the network in these areas.

Access to Care
Objective: All members enrolled in UHCCP will have at least one preventive care or ambulatory visit with their PCP annually.

Methodology: HEDIS® 2014 (administrative)

Measure	HEDIS® 2014 Goal (All HEDIS® 2012 State Benchmarks)	Interim Unaudited Rate for HEDIS® 2014 (as of 1/20/14)	Goal Met
Children's Access to PCPs (Ages 12 to 24 Months)	97.05	97.23	Yes
Children's Access to PCPs (Ages 2 years to 6 Years)	87.85	87.55	Not as of 1/20/14
Children's Access to PCPs (Ages 7 years to 11 Years)	88.49	86.85	Not as of 1/20/14
Children's Access to PCPs (Ages 12-19 Years)	87.06	84.95	Not as of 1/20/14

Measure	HEDIS® 2014 Goal	Interim Unaudited Rate for HEDIS® 2014 (as of 1/20/14)	Goal Met
Adult Access (Ages 20 to 44 Years)	78.48 (NCQA 25th Percentile)	80.88	Yes
Adult Access (Ages 45 to 64 Years)	84.48 (NCQA 25th Percentile)	88.65	Yes
Adult Access (Ages 65+ Years)	78.47 (NCQA 25th Percentile)	75.90	Not as of 1/20/14
Adult Access (Total)	78.39 (HEDIS® 2012 State Benchmark)	83.59	Yes

Analysis/Limitations/Barriers:

- Through the Clinical Practice Consultant (CPC) program, a barrier that surfaced was the lack of coordination between primary care and gynecological care. Members qualifying for Medicaid only while pregnant often fail to see a PCP, instead receiving most of their care from their obstetricians.
- Another barrier is members who do not establish or maintain an ongoing relationship with a PCP.
- Members may also use hospital emergency departments rather than a PCP for non-emergent care.

Actions and Interventions:

- Continued efforts to encourage members to establish with a PCP through new member welcome calls, member newsletter articles, and Silverlink preventative health outreach calls.
- Continued CPC outreach and education to high-volume PCPs, emphasizing EPSDT, HEDIS® measure specifications, and identifying members with gaps in care.
- Partnered with one large PCP practice to provide a back-to-school clinic day.
- Instituted a co-branded letter and call campaign that included 8 practices with 13 providers touching over 3,500 members.
- Added a Quality Outreach Coordinator to make preventative health outreach calls to members with gaps in care.

Accessibility of Services
An annual evaluation of accessibility of services for UHCCP members was completed in 2013.

Adult CAHPS® 5.0H Survey Results*	2013 Plan Rate	2013 UHC National Average (Product)	Variance to National Average	2013 NCQA Percentile for Accreditation
Regular or Routine Care				
In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed? (Usually/Always)	75.17%	79.84%	↓4.67	<50th
Urgent/Emergent Care				
In the last 6 months, when you needed care right away, how often did you get care as soon as you needed? (Usually/Always)	82.23%	83.22%	↓.99%	<50th
After Hours Care*				
In the last 6 months, when you called a doctor's office or clinic after hours, how often did you get the help you wanted? (Usually/Always)	77.42%	67.12%	↑10.3%	No Data

*Insufficient denominator to report to NCQA

Child with CCC CAHPS® 5.0H Survey Results*	2013 Plan Rate	2013 UHC National Average (Product)	Variance to National Average	2013 NCQA Percentile for Accreditation
Regular or Routine Care (chronic population)				
In the last 6 months, when you made an appointment for a check-up or routine care for your child at a doctor's office or clinic, how often did you get an appointment as soon as your child needed? (Usually/Always)	92.31%	92.38%	↓.06	90th
Urgent/Emergent Care (chronic population)				
In the last 6 months, when your child needed care right away, how often did your child get care as soon as he or she needed? (Usually/Always)	92.06%	94.08%	↓2.02%	90th
After Hours Care* (chronic population)				
In the last 6 months, when you called a doctor's office or clinic after hours, how often did you get the help you wanted for your child? (Usually/Always)	81.40%	84.39%	↓2.99%	No Data

*Insufficient denominator to report to NCQA

Analysis, Opportunities & Actions

The detailed data in all tables of this report were reviewed and analyzed. UHCCP demonstrated the strength of its network of practitioners and facilities by scoring above the NCQA average on six of the eight key measures in the 2013 CAHPS, including Overall Rating of the Health Plan. On the Children with Chronic Conditions Measures survey, the health plan scored above the NCQA accreditation average on three of the five key measures. Using the key driver analysis UHCCP identified the below areas that had opportunities for improvement.

Adult CAHPS: Analysis of adult access CAHPS® data reveals the Regular or Routine Care measure to be 75.17%, 4.67% below the national average of 79.84%, or less than the 10th percentile for the region. The Urgent/Emergent Care measure resulted in 82.23%, or .99% below the national average of 83.22, or less than the 10th percentile for the region. The After Hours Care measure was 77.42%, 10.3% above the National Average of 67.12%, but Louisiana's rate was the highest in the Southeast region.

Children with Chronic Conditions (CCC) CAHPS®: Analysis of CCC CAHPS® reveals the Regular or Routine Care measure to be 92.31%,slightly less (0.06%) less than the national average of 92.38 or the 50th percentile for the region. The Urgent/Emergent Care measure was 92.06, 2.02% less than the national average of 94.08, or the 25th percentile. The After Hours Care Measure was 81.40, 2.99% less than the national average of 84.39. The After Hours Care measure quartile was not scored due to an insufficient denominator to report to NCQA.

Barriers:

- As a shared savings plan as mandated by the State, UHCCP only contracts with primary care practitioners.
- Members are not always connected to a medical home.
- Members are not aware of recommended preventative care.

Actions and Interventions:

- Continue to provide thought leadership to the State on reimbursement policy and strategies with respect to specialists.
- Consult the Member Advisory Council to identify barriers to preventative care.
- Engage in member engagement strategies that involve collaboration with the providers (e.g., co-branded letter and call initiatives, clinic days).

Provider Satisfaction

Objective: Improve provider satisfaction.

Methodology: Survey providers annually.

UHCCP worked with UnitedHealthcare Network and Market Intelligence to develop and conduct a provider satisfaction survey to guide service improvements for our network providers. UHCCP health plans used fax methodology consisting of three waves of faxes to a sample of providers.

A sample of 1200 unique PCPs was randomly selected for this survey with a final response rate was 16.37%. The UHC national average response rate was 11.70%.

Provider Evaluation of Coordination of Care

Provider Satisfaction Survey				
Survey Response Rate	16.37%			
Adequacy of Coordination of Care	Top Box 8-10 *Goal = 50%*		Top Box 6-10 *Goal = 60%*	
Please rate the adequacy of coordination of care from:	2013	Goal Met?	2013	Goal Met?
Question 36: Behavioral Health Providers	*37*	*No*	*76*	*Yes*
Question 37: Specialists/Consulting Physicians	*50*	*Yes*	*76*	*Yes*
Question 38: Inpatient Hospitals	*59*	*Yes*	*77*	*Yes*
Question 39: Outpatient Treatment Centers/Surgery Centers	*51*	*Yes*	*76*	*Yes*
Question 40: Emergency Departments/Urgent Care Centers	*51*	*Yes*	*72*	*Yes*
Question 41: Home Health Agencies	*52*	*Yes*	*81*	*Yes*

Timeliness of Feedback	Top Box 8-10 *Goal = 50%*		Top Box 6-10 *Goal = 60%*	
Please rate the timeliness of exchange of information/communication/reports from the following:	2013	Goal Met?	2013	Goal Met?
Question 30: Behavioral Health Providers	*38*	*No*	*59*	*No*
Question 31: Specialist/Consulting Physicians	*48*	*No*	*77*	*Yes*
Question 32: Inpatient Hospitals	*59*	*Yes*	*81*	*Yes*
Question 33: Outpatient Treatment Centers/Surgery Centers	*53*	*Yes*	*78*	*Yes*
Question 34: Emergency Departments/Urgent Care Centers	*53*	*Yes*	*73*	*Yes*
Question 35: Home Health Agencies	*55*	*Yes*	*84*	*Yes*

Analysis, Limitations, Barriers:

- The UHCCP response rate was higher than the national average.
- Through the CPC program, UHCCP has learned that not all providers are focused on the exchange of information with other providers to ensure coordination and continuity of care.
- UHCCP does not contract with specialists, facilities, or ancillary providers.

Actions and Interventions:

- Continued education of members and providers on the importance of sharing patient information for coordination and continuity of care.
- Published a coordination of care article in the winter 2013 member newsletter that focused on the importance of informing practitioners about the care members are receiving from other practitioners.
- Published a coordination of care article in the summer 2013 provider newsletter on the importance of timely exchange of information. The article is to be published again in summer 2014.
- Continue to educate members and providers about UHCCP case management services that can assist members in coordinating care among providers.

Member and Provider Health Education

Objective: To assess the educational materials offered to members and providers.

Methodology: Review direct mailings, articles included in newsletters, and other forms of education to ensure that information is communicated in order to promote wellness, screenings, safety, and the latest clinical recommendations.

Activities:

- Launched a collaborative campaign ("Eat4Health") with 4-H targeting healthy eating.
- Member newsletter articles in 2013 included influenza vaccinations, asthma, what is an emergency, appointment wait times, generic drugs, case management, quality management, depression, heat related illness, hurricane preparedness, child/teen well care visits and immunizations, breast feeding, safety, whooping cough, member handbook, allergies and asthma, diabetes, lead testing, cold and flu season, preparing for doctor's visits, and Chlamydia screening.

- Targeted mailings for members with diabetes, asthma, COPD, cardiovascular disease, hypertension and pregnancy.
- Text4Baby messaging.
- Member access to NurseLine advice and patient education topics.
- New member outreach by phone and mail to encourage creation of a medical home.
- UHCCP website lists links for members to preventive health and immunization guidelines and behavioral health information.
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- UnitedHealthcareOnline.com offers a variety of clinical resources, tools and continuing education opportunities for practitioners.
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Analysis/Limitations/Barriers:
Effectiveness of member and provider health education materials can be assessed to some extent by the improvement in health outcomes. This is analyzed throughout this document in the presentation of HEDIS performance measure results.

Actions and Interventions:
Continue to assess and monitor the effectiveness of health education tools as a part of the development of quality improvement initiatives.

Co-branded Member Outreach Initiative
UHCCP initiated a co-branded outreach campaign with 8 primary care practices with a total of 13 practitioners; the campaign included a combination of 6,924 letters and 2,824 automated reminder calls to members with opportunities for preventative care.

Clinic Day
UHCCP collaborated with one large provider practice to hold a clinic day in August 2013. The health plan conducted the outreach to the members assigned to the practice who had gaps in care and the practice opened up on a Saturday to see patients for well visits and immunizations.

Planning for 2014 Health Fair with East Baton Rouge Parish School-Based Clinics
Health Centers in Schools integrates health programs and services, creating "medical homes" for all East Baton Rouge Parish public school students in Louisiana. In 2013, UHCCP was in the planning stages with the health center to hold a 2014 health fair at Broadmoor High School in Baton Rouge.

Asthma Management
One of UHCCP's performance improvement projects (PIPs) was Reducing Emergency Department Visits. Through this PIP, UHCCP had the opportunity to partner with several large hospital providers to implement an asthma action plan process in the hospital, refer the member to case management, and communicate the action plan to the member's primary care provider.

UHCCP partnered with two large tertiary facilities in GSA-B to identify the asthma pediatric population that was the highest utilizer of emergency and inpatient resources. UHCCP assisted this facility in implementing

an asthma disease management program to include onsite and telephonic management. For more information about this PIP, see the Performance Improvement Projects section in this document.

JOIN for ME

In 2012, UHCCP partnered with Louisiana Alliance of Boys & Girls Clubs to launch a community-based pediatric obesity lifestyle intervention program, developed by UHG, to help reduce excess weight and improve health related quality of life in overweight and obese children in Orleans Parish. The JOIN for ME pilot was designed to provide affordable and accessible care in local communities. JOIN for ME focuses on helping children who struggle with extra weight, underscoring the importance of cultivating a healthier environment and healthier behaviors at home with the entire family. In 2013, the program continued at the Boys and Girls Club in New Orleans. A second location in St. Tammany Parish is projected to launch by mid-year 2014.

Patient Centered Medical Home (Accountable Care Communities Program)

The Accountable Care Communities program involves partnering with practices and helping them proactively manage high-risk patients using a web-based registry. Through the electronic registry, the practice team has access to information about care their members have received and can take on greater responsibility for continuous care. The goals of the program are to:

- Improve access to care by focusing on increasing same day appointment availability
- Reduce non-emergent use of the emergency room
- Reduce avoidable hospital admissions and readmissions
- Increasing focus on the management of high-risk patients

As of the end of 2013, eight practices were using the registry. The Chief Medical Officer has also been actively working with hospitals to provide daily emergency room and inpatient censuses to feed the web-based registry and to give data to our emergency room coaches for live member outreach. She has also engaged with the Louisiana Health Information Exchange (LAHIE) to supplement the registry data.

HEAL

United HealthCare partnered with Head-Off Environmental Asthma Louisiana (HEAL) program to refer asthmatics for targeted education from asthma educators.

Clinical Practice Consultant Program

The health plan has five clinical practice consultants engaged in educating primary care providers about the Healthcare Effectiveness and Information Data Set (HEDIS®). To improve HEDIS® rates, the plan has shared information about evidence based guidelines for care by distributing 409 Evidence Based Guidelines Toolkits to 221 practices. The consultants will continue to work with practices to proactively identify gaps in preventative and chronic care.