LOUISIANA DEPARTMENT OF HEALTH

State Fiscal Year July 1, 2022–June 30, 2023

External Quality Review Technical Report

for

UnitedHealthcare Community

April 2024

HSAG HEALTH SERVICES ADVISORY GROUP

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Acknowledgments and Copyrights

1. Executive Summary

Introduction

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires states that contract with managed care organizations (MCOs), prepaid ambulatory health plans (PAHPs), and prepaid inpatient health plans (PIHPs) (collectively referred to as "managed care entities [MCEs]" in this report) for administering Medicaid and Children's Health Insurance Program (CHIP) programs to contract with a qualified external quality review organization (EQRO) to provide an independent external quality review (EQR) of the quality, timeliness, and accessibility of services provided by the contracted MCEs. Revisions to the regulations originally articulated in the BBA were released in the May 2016 Medicaid and CHIP Managed Care Regulations,[1-1] with further revisions released in November 2020.[1-2] The final rule is provided in Title 42 of the Code of Federal Regulations (42 CFR) Part 438 and cross-referenced in the CHIP regulations at 42 CFR Part 457. To comply with 42 CFR §438.358, the Louisiana Department of Health (LDH) has contracted with Health Services Advisory Group, Inc. (HSAG), a qualified EQRO.

The Louisiana Medicaid Managed Care Program

The day-to-day operations of the Louisiana Medicaid managed care program are the responsibility of the Bureau of Health Services Financing within LDH, with oversight of specialized behavioral health services, 1115 Substance Use Demonstration Waiver, and the Coordinated System of Care Waiver provided by the Office of Behavioral Health (OBH). In addition, the Bureau of Health Services Financing receives support from other LDH "program offices"—Office of Public Health (OPH), Office of Aging and Adult Services (OAAS), and Office for Citizens with Developmental Disabilities (OCDD). Louisiana Medicaid managed care provides services to over 1.8 million Louisianans, which is approximately 39 percent of the State's population.

The current MCE contracts are full-risk capitated Louisiana Medicaid managed care contracts. Under the authority of a 1915(b) waiver from the Centers for Medicare & Medicaid Services (CMS), LDH contracts with six Healthy Louisiana MCOs to provide physical and behavioral health care, including Humana Healthy Horizons, which started on January 1, 2023; and two dental PAHPs to provide dental services for Louisiana's Medicaid and CHIP members. Additionally, under the authority of a

[1-1] Centers for Medicare & Medicaid Services. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, May 6, 2016. Available at: https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered. Accessed on: Dec 14, 2023.

[1-2] Centers for Medicare & Medicaid Services. Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care, November 13, 2020. Available at: https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care. Accessed on: Dec 14, 2023.

1915(b)/1915(c) waiver from CMS, OBH contracts with a single behavioral health PIHP, Coordinated System of Care (CSoC), to help children with behavioral health challenges who are at risk for out-of-home placement. The MCEs contracted during state fiscal year (SFY) 2023 (July 1, 2022–June 30, 2023) are displayed in Table 1-1.

Table 1-1—Louisiana's Medicaid MCEs

MCE Name	Plan Type	Services Provided	Service Region	Acronym or Abbreviated Reference
Aetna Better Health	MCO	Behavioral and physical health	Statewide	ABH
AmeriHealth Caritas Louisiana	MCO	Behavioral and physical health	Statewide	ACLA
Healthy Blue	MCO	Behavioral and physical health	Statewide	HBL
Humana Healthy Horizons (new plan as of 01/01/2023)	MCO	Behavioral and physical health	Statewide	HUM
Louisiana Healthcare Connections	MCO	Behavioral and physical health	Statewide	LHCC
UnitedHealthcare Community	MCO	Behavioral and physical health	Statewide	UHC
DentaQuest USA Insurance Company (DentaQuest)	PAHP	Dental	Statewide	DQ
Managed Care North America	PAHP	Dental	Statewide	MCNA
Magellan of Louisiana	PIHP	Behavioral health services for children and youth with significant behavioral health challenges	Statewide	Magellan

Scope of External Quality Review

As set forth in 42 CFR §438.358, HSAG conducted all EQR-related activities in compliance with the CMS EQR Protocols released in February 2023.[1-3] For the SFY 2023 assessment, HSAG used findings from the mandatory and optional EQR activities to derive conclusions and make recommendations about

[1-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, February 2023*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 14, 2023.

the quality, timeliness, and accessibility of healthcare services provided by each MCE. Table 1-2 depicts the EQR activities conducted for each plan type.

Table 1-2—EQR Activities Conducted for Each Plan Type

EQR Activities	Description	CMS EQR Protocol	MCO	PAHP	PIHP
Performance Improvement Project (PIP) Validation	This activity verifies whether a PIP conducted by an MCE used sound methodology in its design, implementation, analysis, and reporting, and whether the PIP demonstrated significant improvement in performance.	Protocol 1. Validation of Performance Improvement Projects	✓	✓	✓
Performance Evaluation and Improvement	This activity assesses whether the performance measures calculated by an MCE are accurate based on the measure specifications and State reporting requirements.	Protocol 2. Validation of Performance Measures	✓	✓	✓
Compliance Reviews (CRs)	This activity determines the extent to which a Medicaid and CHIP MCE is in compliance with federal standards and associated state-specific requirements, when applicable.	Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations	✓	✓	✓
Network Adequacy and Availability Validation (NAV)	This activity assesses the extent to which an MCE has adequate provider networks in coverage areas to deliver healthcare services to its managed care members.	Protocol 4. Validation of Network Adequacy*	✓	✓	✓
Consumer Surveys: CAHPS-A and CAHPS-C	This activity reports the results of each MCO's CAHPS survey to HSAG for inclusion in this report.	Protocol 6. Administration or Validation of Quality of Care Surveys	✓	N/A	N/A
Behavioral Health Member Satisfaction Survey	This activity assesses adult members with a behavioral or mental health diagnosis and child members with a mental health diagnosis who have received behavioral health services and are enrolled in an MCO.	Protocol 6. Administration or Validation of Quality of Care Surveys	✓		
Case Management Performance Evaluation (CMPE)	This activity evaluates case management (CM) services to determine the number of individuals, the types of conditions, and the impact that CM	Protocol 9. Conducting Focus Studies of Health Care Quality	✓	N/A	N/A

EQR Activities	Description	CMS EQR Protocol	MCO	PAHP	PIHP
	services have on members receiving those services.				
Quality Rating System (QRS)	This activity evaluates and applies a rating to measure the quality of care and performance of the MCOs to provide information to help eligible members choose an MCO.	Protocol 10. Assist With Quality Rating of Medicaid and CHIP MCOs, PIHPs, and PAHPs	✓		

**Protocol 4. Validation of Network Adequacy* was released in February 2023; therefore, full implementation will occur with the 2024 NAV activities.

Report Purpose

To comply with federal healthcare regulations at 42 CFR Part 438, LDH contracts with HSAG to annually provide to CMS an assessment of the performance of the State's Medicaid and CHIP MCEs, as required at 42 CFR §438.364. This annual EQR technical report includes results of all EQR-related activities that the EQRO conducted with Louisiana Medicaid MCEs throughout SFY 2023. This EQR technical report is intended to help the Louisiana Medicaid managed care program:

- Identify areas for quality improvement (QI).
- Ensure alignment among an MCE's Quality Assessment and Performance Improvement (QAPI) requirements, the State's quality strategy, and the annual EQR activities.
- Purchase high-value care.
- Achieve a higher performance healthcare delivery system for Medicaid and CHIP beneficiaries.
- Improve the State's ability to oversee and manage the MCEs with which it contracts for services.
- Help the MCEs improve their performance with respect to the quality, timeliness, and accessibility of care.

Definitions

HSAG used the following definitions to evaluate and draw conclusions about the performance of each Louisiana Medicaid MCE in each of the domains of quality, timeliness, and access.

Quality	Timeliness	Access
as it pertains to the EQR, means the degree to which an MCO, PIHP, PAHP, or primary care case management (PCCM) entity (described in §438.310[c][2]) increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics; the provision of services that are consistent with current professional, evidence-based knowledge; and interventions for performance improvement.	as it pertains to EQR, is described by NCQA to meet the following criteria: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation." It further discusses the intent of this standard to minimize any disruption in the provision of healthcare. HSAG extends this definition to include other managed care provisions that impact services to members and that require a timely response from the MCO (e.g., processing expedited member appeals and providing timely follow-up care).	as it pertains to EQR, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (network adequacy standards) and §438.206 (availability of services). Under §438.206, availability of services means that each state must ensure that all services covered under the state plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs in a timely manner.

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. Federal Register Vol. 81 No. 18/Friday, May 6, 2016, Rules and Regulations, p. 27882. 42 CFR §438.320 Definitions; Medicaid Program; External Quality Review, Final Rule.
[2] National Committee for Quality Assurance. *2013 Standards and Guidelines for MBHOs and MCOs.*

Methodologies

Requirement 42 CFR §438.364(a)(1) describes the manner in which (1) the data from all activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed, and (2) conclusions were drawn as to the quality, timeliness, and accessibility of care furnished by each MCO.

Aggregating and Analyzing Statewide Data

HSAG follows a four-step process to aggregate and analyze data collected from all EQR activities and draw conclusions about the quality, timeliness, and accessibility of care furnished by each MCO, as well as the program overall. To produce Healthy Louisiana's MCO aggregate SFY 2023 EQR technical report, HSAG performed the following steps to analyze the data obtained and draw statewide conclusions about the quality, timeliness, and accessibility of care and services provided by the MCOs:

Step 1: HSAG analyzed the quantitative results obtained from each EQR activity for each MCO to identify strengths and weaknesses in each domain of quality, timeliness, and access to services furnished by the MCO for the EQR activity.

Step 2: From the information collected, HSAG identified common themes and the salient patterns that emerged across EQR activities for each domain and drew conclusions about overall quality, timeliness, and access to care and services furnished by the MCO.

Step 3: From the information collected, HSAG identified common themes and the salient patterns that emerged across all EQR activities related to strengths and opportunities for improvement in one or more of the domains of quality, timeliness, and access to care and services furnished by the MCO.

Step 4: HSAG identified any patterns and commonalities that exist across the program to draw conclusions about the quality, timeliness, and accessibility of care for the program.

Louisiana's Medicaid Managed Care Quality Strategy

In accordance with 42 CFR §438.340, LDH implemented a written quality strategy for assessing and improving the quality of healthcare and services furnished by the MCEs to Louisiana Medicaid managed care members under the Louisiana Medicaid managed care program. Louisiana's Medicaid Managed Care Quality Strategy (quality strategy) dated June 2022 is guided by the Triple Aim of the National Quality Strategy.

LDH's mission is to protect and promote health and to ensure access to medical, preventive, and rehabilitative services for citizens of the State of Louisiana. The Louisiana Medicaid managed care program is responsible for providing high-quality, innovative, and cost-effective healthcare to Medicaid members.

Goals and Objectives

The quality strategy identified goals and objectives that focus on process as well as achieving outcomes. The goals and supporting objectives are measurable and take into consideration the health status of all populations served by the Louisiana Medicaid managed care program.

The quality strategy identifies the following three aims and eight associated goals:

Better Care: Make healthcare more person-centered, coordinated, and accessible so it occurs at the "Right care, right time, right place."

Goal 1: Ensure access to care to meet enrollee needs

Goal 2: Improve coordination and transitions of care

Goal 3: Facilitate patient-centered, whole-person care

Healthier People, Healthier Communities: Improve the health of Louisianans through better prevention and treatment and proven interventions that address physical, behavioral, and social needs.

Goal 4: Promote wellness and prevention

Goal 5: Improve chronic disease management and control

Goal 6: Partner with communities to improve population health and address health disparities

Smarter Spending: Demonstrate good stewardship of public resources by ensuring high-value, efficient care.

Goal 7: Pay for value and incentivize innovation

Goal 8: Minimize wasteful spending

Quality Strategy Evaluation[1-4]

Strengths

LDH considers the quality strategy to be its roadmap for the future. Overall, the quality strategy represents an effective tool for measuring and improving the quality of Louisiana's Medicaid managed care services. The quality strategy promotes identification of creative initiatives to continually monitor, assess, and improve access to care, the quality of care and services, member satisfaction, and the timeliness of service delivery for Louisiana Medicaid managed care members. Additionally, LDH's initiatives tie to the quality strategy aims, goals, and objectives. The quality strategy strives to ensure members receive high-quality care that is safe, efficient, patient-centered, timely, value- and quality-based, data-driven, and equitable.

LDH conducts oversight of the MCEs in coordination with the quality strategy to promote accountability and transparency for improving health outcomes. The MCE should be committed to QI and its overall approach, and specific strategies will be used to advance the quality strategy and incentive-based quality measures.

Recommendations

HSAG's EQR results and guidance on actions assist LDH in evaluating the MCEs' performance and progress in achieving the goals of the program's quality strategy. These actions, if implemented, may assist LDH and the MCEs in achieving and exceeding goals. In addition to providing each MCE with specific guidance, HSAG offers LDH the following recommendations, which should positively impact the quality, timeliness, and accessibility of services provided to Medicaid members:

- HSAG recommends LDH consider a change in metric benchmarks so the MCEs can strive toward a consistent performance level. HSAG recommends LDH remove the target objectives and improvement objectives and establish benchmarks for all MCEs that align with nationally recognized quality measures (e.g., NCQA Quality Compass, CMS Adult and Child Core Sets) or the State's performance published in the CMS Annual State Measure Trends Snapshot, Chart Packs for the Child Core Set and Adult Core Set, or the State Profile pages on Medicaid.gov.

[1-4] Health Services Advisory Group, Inc. Medicaid Managed Care Quality Strategy Evaluation, Review Period: March 20, 2022–March 19, 2023, July 2023. Louisiana Department of Health. Available at: https://ldh.la.gov/assets/docs/MQI/Strategy/MQIStrategyEvaluation.pdf. Accessed on: Dec 12, 2023.

- HSAG recommends LDH consider using the measurement year (MY) 2023 reported rates in the 2024 quality strategy evaluation, which could include MY 2021 through MY 2023 results in order to include the most current data for evaluation.
- HSAG recommends LDH remove the duplicate objective, promote healthy development and wellness in children and adolescents.
- HSAG recommends LDH consider adding the objectives, improve overall health and promote reproductive health objectives, to the quality strategy.
- HSAG recommends LDH continue to collaborate with the MCOs to support adequate QI capacity, skills, and resources to support current and future PIPs. HSAG recommends LDH continue to meet regularly with the MCOs and share best practices for identifying QI goals, objectives, and interventions. Furthermore, LDH could consider incorporating a similar mechanism for the PAHPs to collaborate on current and future PIPs. HSAG also recommends LDH consider hosting a forum in which the MCEs could discuss programwide solutions to overcome barriers. These QI activities provide opportunities to improve population health by implementing best practices and addressing barriers and challenges.
- HSAG recommends LDH identify expectations for improvement targets over a three-year period. Current target improvements compare to the previous measurement year and do not consider the baseline measurement year.
- HSAG recommends the MCEs consider whether there are disparities within their populations that contributed to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. HSAG recommends the MCEs target QI interventions to reduce the identified disparities.
- HSAG recommends LDH consider working with the MCEs to share performance measure best practices and identify interdependencies across measures.
- HSAG recommends LDH consider a contract statement for all MCEs that the MCE's quality initiatives must be designed to help achieve the goals outlined in the quality strategy. Currently only the MCOs have this contract requirement.
- HSAG recommends LDH consider removing aim statements from the quality strategy. CMS defines "quality strategy goals" as SMART (specific, measurable, attainable, relevant, and time-bound), high-level managed care performance aims that provide direction for the State. CMS defines quality strategy (SMART) objectives as measurable steps toward meeting the State's goals that typically include quality measures.

Overview of External Quality Review Findings

This annual EQR technical report includes results of all EQR-related activities for UnitedHealthcare Community (UHC) conducted with Louisiana Medicaid managed care throughout SFY 2023.

Validation of Performance Improvement Projects

With the start of HSAG's EQRO contract with LDH in March 2023, HSAG initiated PIP validation training and technical assistance activities to assist LDH, UHC, and other MCOs in transitioning to HSAG's PIP validation process and methodology. UHC actively worked on PIPs throughout SFY 2023, and PIP validation activities were initiated. LDH required UHC to conduct PIPs on the following five state-mandated topics during SFY 2023:

- *Behavioral Health Transitions in Care*
- *Ensuring Access to the COVID-19 [coronavirus disease 2019] Vaccine Among Healthy Louisiana Enrollees*
- *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years*
- *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees*
- *Screening for HIV [human immunodeficiency virus] Infection*

At the time this report was drafted, HSAG's first validation cycle of UHC's PIPs was in progress and is scheduled to be completed in SFY 2024; therefore, final validation findings, including assessment of indicator results, interventions, strengths and opportunities, and recommendations will be reported in next year's annual EQR technical report.

Validation of Performance Measures

HSAG's validation of UHC's performance measures confirmed compliance with the standards of Title 42 CFR §438.330(a)(1). The results of the validation activity determined that UHC was compliant with the standards of Title 42 CFR §438.330(c)(2).

Information Systems Capabilities Assessment

Based on a review of the final audit reports (FARs) issued by UHC's certified HEDIS compliance auditor, HSAG found that UHC fully met the standard for all seven of the applicable NCQA HEDIS information systems (IS) standards.

HEDIS—Quality, Timeliness, and Access

HSAG's analysis was based on comparison of HEDIS measures/measure indicators to the MY 2022 NCQA national 50th percentile, which served as the benchmark. A total of 47 measures, comprising 89

measure indicators, were selected for analysis. Of the 89 measure indicators, 11 were not reported in Quality Compass and were therefore removed from the respective analyses due to lack of a benchmark.

Of the 78 HEDIS measures/measure indicators with an associated benchmark, UHC had 39 that performed greater than the NCQA national 50th percentile benchmark, and 39 that performed lower than the NCQA national 50th percentile benchmark. Detailed results are shown in Section 3—Validation of Performance Measures.

Assessment of Compliance With Medicaid Managed Care Regulations

In HSAG's CR, UHC received a compliance score of 85.7 percent for Standard I—Enrollment and Disenrollment, indicating that, overall, UHC has improvement to make in compliance with this standard.

HSAG also reviewed UHC's corrective action plans (CAPs) from the LDH-approved 2022 CR. UHC achieved compliance in 17 of 18 applicable elements from the 2022 CAPs, demonstrating positive improvements in implementing CAPs from 2022. UHC must implement the remaining approved CAPs for the one element for which compliance was not achieved.

Validation of Network Adequacy

HSAG's provider directory validation (PDV) indicated that, overall, the provider information maintained and provided by UHC was poor, which impacted access to care due to the inability of members to find a provider that delivered the requested services. Table 1-3 provides a summary of the findings from the study.

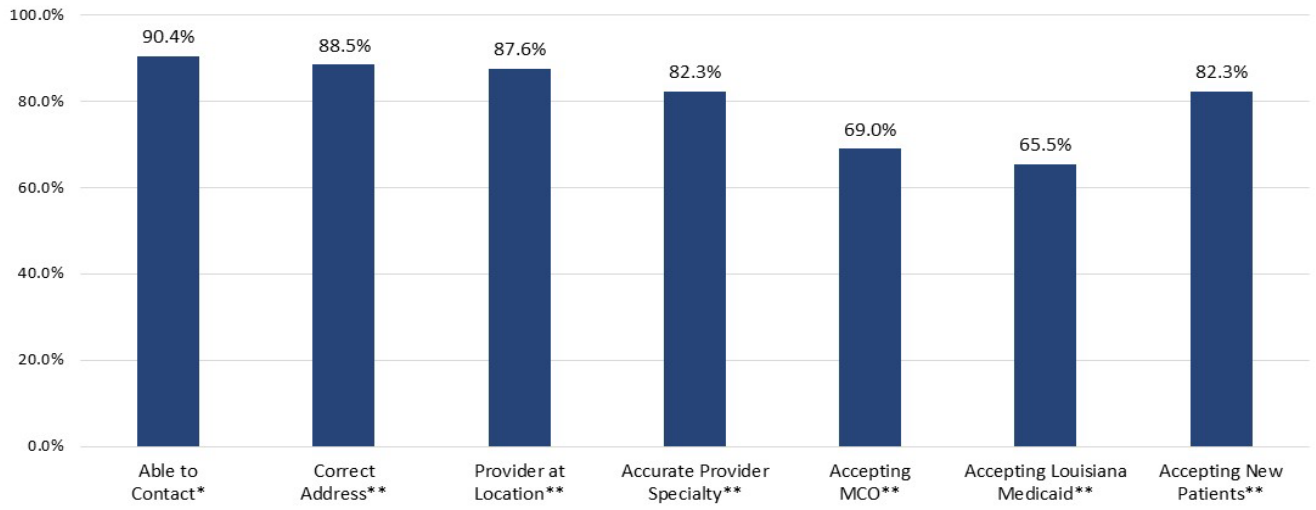
Table 1-3—Summary of Findings

Concerns	Findings
Acceptance of Louisiana Medicaid was inaccurate.	Overall, 65.5 percent of providers accepted Louisiana Medicaid.
Acceptance of the MCO was inaccurate.	Overall, 69.0 percent of providers accepted the requested MCO.
Provider's specialty in the provider directory was incorrect.	Overall, 82.3 percent of providers confirmed the specialty listed in the online provider directory was accurate.
Overall acceptance of new patients was low.	Overall, 82.3 percent of providers accepted new patients; however, only providers listed as accepting new patients in the online provider directory were selected for the PDV reviews.
Affiliation with the sampled provider was low.	Overall, 87.6 percent of the locations confirmed affiliation with the sampled provider.
Address information was incorrect.	Overall, 88.5 percent of respondents reported that UHC's provider directory reflected the correct address.

While the overall PDV response rate was relatively high at 90.4 percent, once contacted, the offices reported varying degrees of match rates for the online provider directory information. Accuracy of new patient acceptance, Louisiana Medicaid acceptance, and UHC acceptance exhibited the lowest match rates, with all indicators exhibiting a match rate below 90 percent.

Figure 1-1 presents the summary results for all sampled UHC providers.

Figure 1-1—Summary Results for All UHC Providers



*The denominator includes all sampled providers.
**The denominator includes cases reached.

UHC's weighted PDV compliance scores by specialty type ranged from 18.7 percent (behavioral health) to 66.7 percent (pediatrics).

Quarter 2 through Quarter 4 PDV and provider access survey results were not final at the time of reporting. Final results from these activities will be included in the SFY 2024 EQR technical report.

For geographic access (GeoAccess), UHC reported the percentage of members having access within required distance standards for 22 physical health provider types and 19 behavioral health provider types. Data were reported for a total of 44 physical health GeoAccess standards (All 22 of the physical health provider types were reported separately for the urban and rural populations) and 34 behavioral health GeoAccess standards (15 of the behavioral health provider types were reported separately for the urban and rural populations). For the entire SFY 2023, UHC met 15 of 44 physical health GeoAccess standards and two of 34 behavioral health GeoAccess standards.

Consumer Surveys: CAHPS-A and CAHPS-C

HSAG compared UHC's 2023 achievement scores to their corresponding 2022 achievement scores and the 2023 NCQA national averages to determine whether there were statistically significant differences.

Overall, UHC's 2023 achievement scores revealed strengths in the adult and general child population. For the adult population, results revealed achievement scores for *Rating of Personal Doctor* and *Getting Needed Care* were statistically significantly higher than the 2023 NCQA national averages. For the general child population, results revealed achievement scores for *Rating of All Health Care*, *Getting Needed Care*, and *How Well Doctors Communicate* were statistically significantly higher than the 2023 NCQA national averages.

Furthermore, opportunities for improvement were not identified for UHC's adult and general child populations, as UHC's 2023 achievement scores were neither statistically significantly lower in 2023 than 2022 nor statistically significantly lower than the 2023 NCQA national average on any measure.

Behavioral Health Member Satisfaction Survey

HSAG compared UHC's 2023 achievement scores to the 2023 Healthy Louisiana statewide average (SWA) to determine whether there were statistically significant differences. Overall, UHC's adult and child 2023 scores were not statistically significantly higher or lower than the Healthy Louisiana SWA; therefore, no strengths or opportunities for improvement were identified. However, several measures had less than 100 respondents. UHC should focus on increasing response rates to the behavioral health member satisfaction survey for its adult and child populations.

However, most of UHC's 2023 achievement scores were higher than the Healthy Louisiana SWA, though not statistically significantly higher.

Case Management Performance Evaluation

During SFY 2023, HSAG and LDH collaborated to determine the scope, methodology, data sources, and timing of the CMPE. HSAG will conduct the focus study in SFY 2024. Results, including conclusions, strengths, and opportunities for improvement, will be reported in the SFY 2024 EQR technical report.

Quality Rating System

Figure 1-2 displays the 2023 Health Plan Report Card, which presents the 2023 rating results for each MCO. The 2023 Health Plan Report Card shows that, for the Overall Rating, UHC received 3.5 stars. UHC received 4.0 stars for the Consumer Satisfaction composite, including 4.5 stars for the Satisfaction with Plan Services subcomposite, and 4.0 stars for both the Getting Care and Satisfaction with Plan Physicians subcomposites. Further, UHC also received 4.0 stars for the Cancer Screening, Diabetes, and Behavioral Health—Access, Monitoring, and Safety subcomposites. However, UHC received 2.0 stars for the Behavioral Health—Medication Adherence subcomposite, 1.5 stars for both the Respiratory and

Behavioral Health—Care Coordination subcomposites, and 1.0 star for the Risk-Adjusted Utilization subcomposite, demonstrating opportunities for improvement for UHC in these areas.

Figure 1-2—2023 Health Plan Report Card

Issued 09/2023

Healthy Louisiana

2023 HEALTH PLAN REPORT CARD

The ratings below compare the performance of Louisiana's Medicaid health plans. This report card shows the results of care in the areas of Consumer Satisfaction, Prevention, and Treatment, and can aid you and your family when deciding on a health plan.

PERFORMANCE KEY	Lowest	Low	Average	High	Highest	Insufficient Data
	★	★★	★★★	★★★★	★★★★★	—

	Aetna Better Health	AmeriHealth Caritas Louisiana	Healthy Blue	Humana Healthy Horizons	Louisiana Healthcare Connections	UnitedHealthcare Community Plan
Overall Rating	★★★½	★★★½	★★★½	*New	★★★	★★★½
CONSUMER SATISFACTION						
Overall Consumer Satisfaction	—	★★★★	★★★★	*New	★★★	★★★★
Getting care: How easily and quickly did members get appointments, preventive care, tests, and treatments?	—	★★★½	★★★½	*New	★★½	★★★★
Satisfaction with plan physicians: How happy are members with their primary care doctors?	★★★★★	★★★★	★★★★	*New	★★★½	★★★★
Satisfaction with plan services: How happy are members with their health plan and their overall care?	★★★½	★★★★	★★★★½	*New	★★★	★★★★½
PREVENTION						
Overall Prevention	★★	★★★	★★★	*New	★★½	★★★
Children/adolescent well-care: Do children and adolescents receive vaccines and weight assessments?	★½	★★½	★★½	*New	★★	★★½
Women's reproductive health: Do women receive care before and after their babies are born?	★★★	★★★	★★★	*New	★★½	★★★

Continued on next page...

Figure 1-2—2023 Health Plan Report Card (cont.)

	Aetna Better Health	AmeriHealth Caritas Louisiana	Healthy Blue	Humana Healthy Horizons	Louisiana Healthcare Connections	UnitedHealthcare Community Plan
Cancer screening: Do female members receive important cancer screenings?	★★★	★★★½	★★★	*New	★★★½	★★★★
Other preventive services: Do members receive important preventive services?	★★½	★★★½	★★★	*New	★★★	★★★
TREATMENT						
Overall Treatment	★★★	★★½	★★★	*New	★★½	★★★
Respiratory: Do people with respiratory issues get the services/treatments they need?	★★	★★	★★½	*New	★★½	★½
Diabetes: Do people with diabetes get the services/ treatments they need?	★★★½	★★★	★★★½	*New	★★	★★★★
Heart disease: Do people with heart disease get the services/ treatments they need?	★★★	★★★	★★	*New	★★½	★★★
Behavioral health—care coordination: Do people with behavioral health issues get the follow-up care they need?	★	★½	★½	*New	★½	★½
Behavioral health—medication adherence: Do people with behavioral health issues stay on prescribed medications?	★★★	★★½	★★	*New	★★★	★★
Behavioral health—access, monitoring, and safety: Do people on behavioral health medications receive the services/ monitoring they need?	★★★★	★★★	★★★½	*New	★★★	★★★★
Risk-adjusted utilization: Do members who are discharged from the hospital have unplanned readmissions within 30 days?	★★★	★★★	★★★	*New	★★★	★

This report card is reflective of data collected between January 2022 and December 2022.

**Due to Humana Healthy Horizons being a new plan in 2023, data are not available yet. Humana Healthy Horizons will be included in future health plan report cards.*

The categories and measures included in this report card are based on the 2023 National Committee for Quality Assurance (NCQA) Health Plan Ratings and LDH required measures lists. When feasible, categories and measures were kept consistent with the prior year's health plan report card, but some measures and categories were removed due to data availability. Any analysis, interpretation, and conclusions based on the data is solely that of the author. Anyone desiring to use or reproduce the materials must obtain approval from LDH.

2. Validation of Performance Improvement Projects

Results

SFY 2023 was the first year that HSAG was contracted as the EQRO for LDH. HSAG's EQRO contract with LDH was initiated in March 2023, and HSAG initiated PIP validation transition activities, training, and technical assistance activities the same month. During SFY 2023, HSAG worked with LDH to transition the MCOs to HSAG's PIP validation process and methodology. UHC actively worked on PIPs throughout SFY 2023, and HSAG initiated validation activities for UHC's PIPs. At the time this report was drafted, HSAG's first validation cycle of the UHC's PIPs was in progress; therefore, final validation findings, including assessment of indicator results, interventions, strengths and opportunities, and recommendations will be reported in next year's annual EQR technical report.

LDH required the MCOs, including UHC, to carry out PIPs to address five state-mandated topics during SFY 2023. Table 2-1 summarizes the PIP topics carried out by UHC in SFY 2023.

Table 2-1—SFY 2023 MCO PIP Topics and Targeted Age Groups

PIP Topic	Targeted Age Group
Behavioral Health Transitions in Care	• 6 years and older • 13 years and older
Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees	• 5–11 years • 12–15 years • 16 years and older
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	• 6 months–18 months • 19 months–2 years • 3–5 years
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	• 21–64 years
Screening for HIV Infection	• 13 years and older • 15–65 years

For each PIP topic, UHC collaborated on improvement strategies, meeting at least monthly with LDH and other MCOs, throughout the year. UHC also submitted updates on improvement strategies and interim indicator results for each PIP topic quarterly that were reviewed by HSAG and LDH. HSAG provided feedback and technical assistance on PIPs to LDH and UHC at group and one-on-one meetings throughout the contract year.

Table 2-2 summarizes key PIP validation milestones that occurred from March through June 2023, the end of SFY 2023.

Table 2-2—SFY 2023 MCO PIP Activities

PIP Activities and Milestones	Dates
HSAG provided training to LDH and the MCOs on HSAG's PIP validation process and templates	March–April 2023
Monthly collaborative PIP meeting with LDH, the MCOs, and HSAG	March 2023
Monthly collaborative PIP meeting with LDH, the MCOs, and HSAG	April 2023
The MCOs submitted Quarter 1 PIP updates	April 2023
Monthly collaborative PIP meeting with LDH, the MCOs, and HSAG	May 2023
Monthly collaborative PIP meeting with LDH, the MCOs, and HSAG	June 2023
The MCOs submitted PIP proposals to HSAG for initial review and feedback	June 2023

In SFY 2024, UHC will submit draft PIP reports for initial validation in January 2024 and the final PIP reports for final validation in March 2024. HSAG will complete the first annual validation cycle in April 2024.

Validation Results and Confidence Ratings

Table 2-3 summarizes UHC's PIP validation results and confidence ratings. The initial validation cycle for UHC's PIPs was in progress at the time this report was drafted; therefore, final validation ratings will be reported in next year's annual EQR technical report.

Table 2-3—PIP Validation Results and Confidence Ratings

PIP Topic	Validation Rating 1: PIP Demonstrated Adherence to Acceptable Methodology	Validation Rating 2: PIP Demonstrated Significant Improvement
Behavioral Health Transitions in Care	To be reported in SFY 2024	To be reported in SFY 2024
Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees	To be reported in SFY 2024	To be reported in SFY 2024
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	To be reported in SFY 2024	To be reported in SFY 2024
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	To be reported in SFY 2024	To be reported in SFY 2025
Screening for HIV Infection	To be reported in SFY 2024	To be reported in SFY 2025

Performance Indicator Results

UHC will report final calendar year (CY) 2023 indicator results in January through March 2024. HSAG will validate the performance indicator results in SFY 2024, and the final performance indicator results for each PIP topic will be included in next year's annual EQR technical report. Table 2-4 summarizes the measurement period that is being completed in CY 2023 and which results will be reported in SFY 2024.

Table 2-4—Measurement Periods in CY 2023 by PIP Topic

PIP Topic	Measurement Period in CY 2023
Behavioral Health Transitions in Care	Remeasurement 1
Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees	Remeasurement 1
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	Remeasurement 1
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	Baseline
Screening for HIV Infection	Baseline

Interventions

UHC will report final 2023 QI activities and interventions in January through March 2024. Table 2-5 includes barriers and interventions UHC initially reported early in the validation cycle initiated at the end of SFY 2023. UHC will report updated QI activities and interventions in SFY 2024, and HSAG will complete the assessment of UHC's QI activities and interventions when the validation cycle is completed in SFY 2024. An updated summary of UHC's interventions for each PIP topic will be included in next year's annual EQR technical report.

Table 2-5—Barriers and Interventions Reported by UHC for Each PIP Topic

PIP Topic	Barriers	Interventions
Behavioral Health Transitions in Care	• Lack of timely notification for hospital discharge • Difficult to engage enrollees in follow-up treatment	• None reported
Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees	• Lack of access to the COVID-19 vaccine • Challenges with reaching a large volume of eligible	• Targeted enrollee outreach to increase awareness on vaccine access and availability

PIP Topic	Barriers	Interventions
	members via CM outreach alone • Enrollees may not remember to obtain second dose of 2-dose vaccine series	• Distribution of eligible enrollee lists and vaccination site lists to primary care providers (PCPs) and facilitation of referrals as needed
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	• Lack of PCP training in varnish application	• Member outreach and education for dental provider appointment scheduling • Provider outreach and education using care gap report
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	• Lack of enrollee awareness of the importance of cervical cancer screening	• Member outreach for education on cervical cancer screening • Member education on transportation services through Medicaid
Screening for HIV Infection	• Lack of enrollee and provider knowledge on guidelines for HIV screening and on resources for obtaining screening	• Outreach for HIV screening education for all eligible members

MCO Strengths, Opportunities for Improvement, and Recommendations

HSAG will report statewide strengths, opportunities for improvement, and recommendations for UHC's PIPs in next year's annual EQR technical report, when HSAG has completed the first annual validation cycle for UHC's PIPs in SFY 2024.

Methodology

Objectives

The purpose of conducting PIPs is to achieve—through ongoing measurements and intervention—significant, sustained improvement in clinical or nonclinical areas. This structured method of assessing and improving MCO processes was designed to have favorable effects on health outcomes and member satisfaction.

The primary objective of PIP validation is to determine each MCO's compliance with requirements set forth in 42 CFR §438.240(b)(1), including:

- Measurement of performance using objective quality indicators.
- Implementation of systematic interventions to achieve improvement in performance.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

The goal of HSAG's PIP validation is to ensure that LDH and key stakeholders can have confidence that any reported improvement is related and can be reasonably linked to the QI strategies and activities the MCO conducted during the PIP. HSAG's scoring methodology evaluated whether the MCO executed a methodologically sound PIP.

Technical Methods of Data Collection

HSAG, as the State's EQRO, validated the PIPs through an independent review process. In its PIP evaluation and validation, HSAG used CMS' EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023 (CMS Protocol 1).[2-1]

HSAG's evaluation of each PIP includes two key components of the QI process:

1. HSAG evaluates the technical structure of the PIP to ensure that the MCO designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., PIP Aim statement, population, sampling techniques, performance indicator, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 15, 2023.

2. HSAG evaluates the implementation of the PIP. Once designed, a PIP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the MCO improves indicator results through implementation of effective processes (i.e., barrier analyses, interventions, and evaluation of results).

Description of Data Obtained

HSAG's methodology for PIP validation provided a consistent, structured process and a mechanism for providing the MCOs with specific feedback and recommendations. The MCOs used a standardized PIP Submission Form to document information on the PIP design, completed PIP activities, and performance indicator results. HSAG evaluated the documentation provided in the PIP Submission Form to conduct the annual validation.

How Data Were Aggregated and Analyzed

Using the PIP validation tool and standardized scoring, HSAG scored each PIP on a series of evaluation elements and scored each evaluation element within a given activity as *Met*, *Partially Met*, *Not Met*, *Not Applicable (NA)*, or *Not Assessed*. HSAG designated some of the evaluation elements pivotal to the PIP process as "critical elements." For a PIP to produce valid and reliable results, all critical elements needed to achieve a *Met* score. HSAG assigned each PIP an overall percentage score for all evaluation elements (including critical elements), calculated by dividing the total number of elements scored as *Met* by the sum of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculated a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*.

In alignment with CMS Protocol 1, HSAG assigned two PIP validation ratings, summarizing overall PIP performance. One validation rating reflected HSAG's confidence that the MCO adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. HSAG based this validation rating on the scores for applicable evaluation elements in steps 1 through 8 of the PIP validation tool. The second validation rating was only assigned for PIPs that have progressed to the Outcomes stage (Step 9) and reflected HSAG's confidence that the PIP's performance indicator results demonstrated evidence of significant improvement. The second validation rating is based on scores from Step 9 in the PIP validation tool. For each applicable validation rating, HSAG reported the percentage of applicable evaluation elements that received a *Met* score and the corresponding confidence level: *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*. The confidence level definitions for each validation rating are as follows:

1. **Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Steps 1 Through 8)**
   a. *High Confidence*: High confidence in reported PIP results. All critical evaluation elements were *Met*, and 90 percent to 100 percent of all evaluation elements were *Met* across all steps.

b. *Moderate Confidence*: Moderate confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 percent to 89 percent of all evaluation elements were *Met* across all steps.
c. *Low Confidence*: Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Partially Met*.
d. *No Confidence*: No confidence in reported PIP results. Across all steps, less than 65 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Not Met*.

2. Overall Confidence That the PIP Achieved Significant Improvement (Step 9)

a. *High Confidence*: All performance indicators demonstrated *statistically significant* improvement over the baseline.
b. *Moderate Confidence*: One of the three scenarios below occurred:
   i. All performance indicators demonstrated improvement over the baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over the baseline.
   ii. All performance indicators demonstrated improvement over the baseline, **and** none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
   iii. Some but not all performance indicators demonstrated improvement over baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over baseline.
c. *Low Confidence*: The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator **or** some but not all performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
d. *No Confidence*: The remeasurement methodology was not the same as the baseline methodology for all performance indicators or none of the performance indicators demonstrated improvement over the baseline.

HSAG analyzed the quantitative results obtained from the above PIP validation activities to identify strengths and weaknesses in each domain of quality, timeliness, and accessibility of services furnished by each MCO. HSAG then identified common themes and the salient patterns that emerged across the MCOs related to PIP validation or performance on the PIPs conducted.

How Conclusions Were Drawn

PIPs that accurately addressed CMS Protocol 1 requirements were determined to have high validity and reliability. Validity refers to the extent to which the data collected for a PIP measured its intent. Reliability refers to the extent to which an individual could reproduce the project results. For each completed PIP, HSAG assessed threats to the validity and reliability of PIP findings and determined whether a PIP was credible.

To draw conclusions about the quality, timeliness, and accessibility of care and services provided by the MCOs, HSAG assigned each PIP topic to one or more of these three domains. While the focus of an MCO's PIP may have been to improve performance related to healthcare quality, timeliness, or accessibility, PIP validation activities were designed to evaluate the validity and quality of the MCO's process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. In

addition, all PIP topics were assigned to other domains as appropriate. This assignment to domains is shown in Table 2-6.

Table 2-6—Assignment of PIPs to the Quality, Timeliness, and Access Domains

PIP Topic	Quality	Timeliness	Access
Behavioral Health Transitions in Care	✓	✓	✓
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	✓	✓	✓
Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees	✓		✓
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	✓	✓	✓
Screening for HIV Infection	✓	✓	✓

3. Validation of Performance Measures

Results

Information Systems Standards Review

The MCO's independent certified HEDIS compliance auditor determined that the rates reported by the MCO were calculated in accordance with NCQA's defined specifications and there were no data collection or reporting issues identified.

Based on a review of the FARs issued by UHC's independent certified HEDIS compliance auditor, HSAG found that UHC fully met the standard for all seven of the applicable NCQA IS standards.

UHC's compliance with each of the IS standards is outlined in Table 3-1.

Table 3-1—UHC Compliance With IS Standards—MY 2022

IS Standard	UHC
IS 1.0 Medical Services Data	Met
IS 2.0 Enrollment Data	Met
IS 3.0 Practitioner Data	Met
IS 4.0 Medical Record Review Processes	Met
IS 5.0 Supplemental Data	Met
IS 6.0 Data Preproduction Processing	Met
IS 7.0 Data Integration and Reporting	Met

Performance Measures

For SFY 2023, LDH required each contracted MCO to collect and report on 47 HEDIS measures, which includes 89 total measure indicators for HEDIS MY 2022 specified in the provider agreement. The measurement set includes 11 incentive measures. Table 3-2 displays the 89 measure indicators required by LDH. **Red** cells indicate that the measure fell below the NCQA national 50th percentile, **green** cells indicate that the measure was at or above the NCQA national 50th percentile.

Table 3-2 through Table 3-5 display a summary of UHC's HEDIS measure performance.

Table 3-2—UHC HEDIS Effectiveness of Care Measures—MY 2022

HEDIS Measure	UHC	SWA
Follow-Up After Hospitalization for Mental Illness		
Within 7 Days of Discharge	20.90%	19.52%
Within 30 Days of Discharge[I]	38.41%	38.33%
Follow-Up After Emergency Department Visit for Mental Illness		
Within 7 Days of Discharge	23.89%	22.45%
Within 30 Days of Discharge[I]	36.83%	36.52%
Follow-Up After Emergency Department Visit for Substance Use[B]		
Within 7 Days of Discharge	16.39%	17.19%
Within 30 Days of Discharge[I]	25.98%	27.70%
Plan All-Cause Readmissions*		
Observed Readmissions (Numerator/Denominator)	11.14%	10.15%
Expected Readmissions Rate	9.65%	9.57%
Observed-to-Expected (O/E) Ratio (Observed Readmissions/Expected Readmissions)	1.1540	1.0603
CAHPS Health Plan Survey 5.1H, Adult (Rating of Health Plan, 8+9+10)	82.05%	80.81%
CAHPS Health Plan Survey 5.1H, Child (Rating of Health Plan—General Population, 8+9+10)	89.86%	86.41%
Depression Screening and Follow-Up for Adolescents and Adults		
Depression Screening (Total)	0.58%	1.00%
Follow-Up on Positive Screen (Total)	72.73%	58.25%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	82.08%	82.78%
Diabetes Monitoring for People With Diabetes and Schizophrenia	68.64%	67.47%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	81.71%	76.14%
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
Blood Glucose Testing	55.99%	54.46%
Cholesterol Testing	30.63%	28.80%
Blood Glucose and Cholesterol Testing	29.76%	28.05%
Lead Screening in Children	65.45%	63.59%
Childhood Immunization Status		
Diphtheria, Tetanus, and Acellular Pertussis (DTaP)	67.88%	68.23%

HEDIS Measure	UHC	SWA
Polio Vaccine, Inactivated (IPV)	85.64%	87.00%
Measles, Mumps, and Rubella (MMR)	84.43%	84.34%
Haemophilus Influenzae Type B (HiB)	85.40%	84.33%
Hepatitis B	87.59%	88.75%
Varicella-Zoster Virus (VZV)	83.94%	84.35%
Pneumococcal Conjugate	69.83%	68.57%
Hepatitis A	80.78%	80.70%
Rotavirus	66.91%	66.63%
Influenza	23.60%	26.49%
Combination 3[I]	62.04%	62.44%
Combination 7	54.01%	53.35%
Combination 10	18.00%	20.30%
Immunization Status for Adolescents		
Meningococcal	84.67%	83.48%
Tetanus, Diphtheria, and Pertussis/Tetanus and Diphtheria (Tdap/Td)	85.89%	84.30%
Human Papillomavirus (HPV)	41.12%	39.08%
Combination 1	84.67%	83.26%
Combination 2[I]	40.39%	38.69%
Colorectal Cancer Screening[I]	34.48%	33.81%
Flu Vaccinations for Adults Ages 18 to 64	37.77%	36.62%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
Body Mass Index (BMI) Percentile Documentation	83.21%	72.22%
Counseling for Nutrition	68.86%	62.46%
Counseling for Physical Activity	60.10%	55.47%
HIV Viral Load Suppression[B,I]	77.60%	79.04%
Low-Risk Cesarean Delivery (Cesarean Rate for Low-Risk First Birth Women)[*,I]	26.47%	26.61%
Chlamydia Screening in Women		
Total	64.02%	63.13%
Breast Cancer Screening	57.11%	55.83%
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers to Quit	67.65%	73.05%

HEDIS Measure	UHC	SWA
Discussing Cessation Medications	48.00%	48.84%
Discussing Cessation Strategies	48.51%	47.04%
Controlling High Blood Pressure[I]	61.31%	57.62%
Statin Therapy for Patients With Cardiovascular Disease		
Received Statin Therapy—Total	80.50%	80.66%
Statin Adherence 80%—Total	63.81%	67.86%
Hemoglobin A1c Control for Patients With Diabetes		
Poor HbA1c Control (>9.0%)[,I]*	34.55%	38.96%
HbA1c Control (<8.0%)	57.91%	52.48%
Eye Exam for Patients With Diabetes	55.72%	53.85%
Blood Pressure Control for Patients With Diabetes (<140/90 mm Hg) (BPD)	67.15%	59.93%
Pharmacotherapy for Opioid Use Disorder	21.84%	27.67%
Initiation and Engagement of Substance Use Disorder (SUD) Treatment		
Initiation of SUD[B]	58.78%	60.37%
Engagement of SUD[B]	25.97%	25.62%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	67.86%	63.46%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	48.69%	53.17%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication		
Initiation Phase	44.13%	42.65%
Continuation and Maintenance Phase	58.40%	55.44%
Antidepressant Medication Management		
Effective Acute Phase Treatment	53.91%	55.83%
Effective Continuation Phase Treatment	35.51%	38.18%
Appropriate Treatment for Children With Upper Respiratory Infection	79.48%	79.64%
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	49.60%	51.85%
Use of Imaging Studies for Low Back Pain[B]	70.81%	71.31%
Non-Recommended Cervical Screening in Adolescent Females[*]	2.37%	1.81%
Cervical Cancer Screening[I]	61.07%	56.53%
Self-Reported Overall Health (Adult)	27.78%	27.63%
Adult—Very Good	18.69%	18.98%
Adult—Excellent	9.09%	8.65%

HEDIS Measure	UHC	SWA
Self-Reported Overall Health (Child-General)	71.02%	73.27%
Child General—Very Good	32.37%	36.17%
Child General—Excellent	38.65%	37.10%
Self-Reported Overall Health (Child-CCC)	61.48%	59.04%
Child CCC—Very Good	38.13%	36.64%
Child CCC—Excellent	23.35%	22.40%
Self-Reported Overall Mental or Emotional Health (Adult)	28.94%	38.64%
Adult—Very Good	13.20%	22.37%
Adult—Excellent	15.74%	16.27%
Self-Reported Overall Mental or Emotional Health (Child)	65.39%	65.65%
Child General—Very Good	28.37%	28.34%
Child General—Excellent	37.02%	37.31%
Self-Reported Overall Mental or Emotional Health (Child CCC)	42.74%	40.97%
Child CCC—Very Good	25.88%	24.08%
Child CCC—Excellent	16.86%	16.89%

[*] Indicates a lower rate is desirable.
[B] Indicates a break in trending between the most recent year and the prior year.
[I] Incentive Measure.
Green: ≥ NCQA national 50th percentile benchmark; red: < NCQA national 50th percentile benchmark.

Table 3-3—UHC HEDIS Access to/Availability of Care Measures—MY 2022

HEDIS Measure	UHC	SWA
Well-Child Visits in the First 30 Months of Life		
First 15 Months	62.07%	59.52%
15 Months–30 Months	66.66%	63.95%
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	73.82%	70.84%
45–64 Years	82.51%	80.13%
65 Years and Older	75.65%	75.93%
Total	76.47%	73.65%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care[C]	82.97%	82.86%
Postpartum Care[C]	77.37%	77.00%

[C] Indicates a caution in trending between the most recent year and the year prior.
Green: ≥ NCQA national 50th percentile benchmark; red: < NCQA national 50th percentile benchmark.

Table 3-4—UHC HEDIS Use of Services Measures—MY 2022

HEDIS Measure	UHC	SWA
Child and Adolescent Well-Care Visits		
3–11 Years	56.29%	54.57%
12–17 Years	52.84%	51.26%
18–21 Years	28.28%	27.04%
Total	49.99%	48.34%
Ambulatory Care		
Outpatient Visits/1,000 MM	5284.83	4,930.50
Emergency Department Visits/1,000 MM[*]	753.17	746.42

[*] Indicates a lower rate is desirable.
Green: ≥ NCQA national 50th percentile benchmark; red: < NCQA national 50th percentile benchmark.

Table 3-5—UHC HEDIS Measures Summary—MY 2022

Measure Status	UHC
≥ NCQA National 50th Percentile Benchmark	39
< NCQA National 50th Percentile Benchmark	39
NCQA National Benchmark Unavailable	11
Total	89

MCO Strengths, Opportunities for Improvement, and Recommendations

For UHC, the following strengths were identified:

- UHC's performance for the *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* measure ranked above the NCQA national 50th percentile benchmark and SWA. Lack of appropriate care for diabetes and cardiovascular disease for people with schizophrenia or bipolar disorder who use antipsychotic medications can lead to worsening health and death. Addressing these physical health needs is an important way to improve health, quality of life and economic outcomes downstream.[3-1] **[Quality]**

[3-1] National Committee for Quality Assurance. Diabetes and Cardiovascular Disease Screening and Monitoring for People With Schizophrenia or Bipolar Disorder (SSD, SMD, SMC). Available at: https://www.ncqa.org/hedis/measures/diabetes-and-cardiovascular-disease-screening-and-monitoring-for-people-with-schizophrenia-or-bipolar-disorder/. Accessed on: Jan 30, 2024.

- UHC's performance for the *Lead Screening in Children* measure ranked above the NCQA national 50th percentile benchmark and SWA. If not found early, exposure to lead and high blood lead levels can lead to irrevocable effects on a child's physical and mental health. Because children who are exposed to lead often have no obvious symptoms, lead poisoning often goes unrecognized. Screening for lead is an easy way to detect an abnormal blood lead level in children.[3-2] **[Quality]**
- UHC's performance for all *Immunization Status for Adolescents* measure indicators ranked above the NCQA national 50th percentile benchmark and SWA. Receiving recommended vaccinations is important because it is the best defense against vaccine-preventable diseases, which are serious diseases that can cause breathing difficulties, heart problems, nerve damage, pneumonia, seizures, cancer—and even death.[3-3] It is also notable that UHC was the only MCO to achieve this target benchmark for all five of the indicators included in this measure. **[Quality]**
- UHC's performance for the *Chlamydia Screening in Women* and *Breast Cancer Screening* measures both ranked above the NCQA national 50th percentile benchmarks and SWA. Screening for chlamydia is important, as approximately 75 percent of chlamydia infections in women are asymptomatic.[3-4] Screening for breast cancer can improve outcomes, as early detection reduces the risk of dying from breast cancer and can lead to a greater range of treatment options and lower healthcare costs.[3-5] **[Quality]**
- UHC's performance for the *Controlling High Blood Pressure* measure ranked above the NCQA national 50th percentile benchmark and SWA. Controlling high blood pressure is an important step in preventing heart attacks, stroke, and kidney disease, and in reducing the risk of developing other serious conditions. Healthcare providers and plans can help individuals manage their high blood pressure by prescribing medications and encouraging low-sodium diets, increased physical activity and smoking cessation.[3-6] **[Quality]**
- UHC's performance for the *Eye Exam for Patients With Diabetes* and *Blood Pressure Control for Patients With Diabetes (<140/90 mm Hg)* measures as well as for both *Hemoglobin A1c Control for Patients With Diabetes* measure indicators ranked above the NCQA national 50th percentile benchmark and SWA. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life. With support from healthcare providers, patients can manage their diabetes with self-care, taking medications as instructed, eating a healthy diet, being physically active and quitting smoking.[3-7] **[Quality]**

[3-2] National Committee for Quality Assurance. Follow-Up After Emergency Department Visit for Mental Illness (FUM). Available at: https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-mental-illness/. Accessed on: Jan 30, 2024.

[3-3] National Committee for Quality Assurance. Immunizations for Adolescents (IMA). Available at: https://www.ncqa.org/hedis/measures/immunizations-for-adolescents/. Accessed on: Jan 30, 2024.

[3-4] National Committee for Quality Assurance. Chlamydia Screening in Women (CHL). Available at: https://www.ncqa.org/hedis/measures/chlamydia-screening-in-women/. Accessed on: Jan 30, 2024.

[3-5] National Committee for Quality Assurance. Breast Cancer Screening (BCS, BCS-E). Available at: https://www.ncqa.org/hedis/measures/breast-cancer-screening/. Accessed on: Jan 30, 2024.

[3-6] National Committee for Quality Assurance. Controlling High Blood Pressure (CBP). Available at: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/. Accessed on: Jan 30, 2024.

[3-7] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Jan 30, 2024.

- UHC's performance for the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* measure ranked above the NCQA national 50th percentile benchmarks and SWA. Although antipsychotic medications may serve as effective treatment for a narrowly defined set of psychiatric disorders in children and adolescents, they are often prescribed for nonpsychotic conditions for which psychosocial interventions are considered first-line treatment. Safer, first-line psychosocial interventions may be underutilized, and children and adolescents may unnecessarily incur the risks associated with antipsychotic medications.[3-8] **[Quality]**
- UHC's performance for the *Cervical Cancer Screening* measure ranked above the NCQA national 50th percentile benchmarks and SWA. Cervical cancer was one of the most common causes of cancer death for American women; effective screening and early detection of cervical pre-cancers have led to a significant reduction in this death rate.[3-9] **[Quality and Access]**
- UHC's performance for the *Child and Adolescent Well-Care Visits* measure ranked above the NCQA national 50th percentile benchmarks and SWA for all four indicators. Well-care visits are important, particularly with children and adolescents, because they provide an opportunity for providers to influence health and development, providing a critical opportunity for screening and counseling.[3-10] **[Quality and Access]**

For UHC, the following opportunities for improvement were identified:

- UHC's performance for the *Follow-Up After Hospitalization for Mental Illness*, *Follow-Up After Emergency Department Visit for Mental Illness*, and *Follow-Up After Emergency Department Visit for Substance Use* measures ranked below the NCQA national 50th percentile benchmark for all indicators, with both the *Follow-Up After Emergency Department Visit for Substance Use* measure indicators falling below the SWA. The importance of providing follow-up care for these measures is critical to improving patient outcomes and decreasing the likelihood of re-hospitalization,[3-11] ensuring fewer repeat emergency department (ED) visits, improved physical and mental function, and increased compliance with follow-up instructions,[3-12] as well as a reduction in substance use, future ED use, hospital admissions and bed days,[3-13] respectively. **[Quality, Timeliness, and Access]**

3-8 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP). Available at: https://www.ncqa.org/hedis/measures/use-of-first-line-psychosocial-care-for-children-and-adolescents-on-anti-psychotics/. Accessed on: Jan 30, 2024.

3-9 National Committee for Quality Assurance. Cervical Cancer Screening (CCS). Available at: https://www.ncqa.org/hedis/measures/cervical-cancer-screening/. Accessed on: Jan 30, 2024.

3-10 National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Jan 30, 2024.

3-11 National Committee for Quality Assurance. Follow-Up After Hospitalization for Mental Illness (FUH). Available at: https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/. Accessed on: Jan 30, 2024.

3-12 National Committee for Quality Assurance. Follow-Up After Emergency Department Visit for Mental Illness (FUM). Available at: https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-mental-illness/. Accessed on: Jan 30, 2024.

3-13 National Committee for Quality Assurance. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA). Available at: https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-alcohol-and-other-drug-abuse-or-dependence/. Accessed on: Jan 30, 2024.

- UHC's performance for the *Pharmacotherapy for Opioid Use Disorder* measure ranked below the NCQA national 50th percentile benchmarks and SWA. Pharmacotherapy has been identified as a critical part of treatment for individuals with opioid use disorder (OUD). Encouraging pharmacotherapy is critical because individuals with OUD who engage in treatment with pharmacotherapy are less likely to exhibit withdrawal or craving symptoms and use illicit opioids, and are more likely to remain in treatment and engage in mental health therapy.[3-14] **[Quality]**
- UHC's performance for the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measure ranked below the NCQA national 50th percentile benchmarks and SWA. Schizophrenia is a chronic and disabling psychiatric disorder that requires ongoing treatment and monitoring. Medication non-adherence is common and a major concern in the treatment of schizophrenia. Using antipsychotic medications as prescribed reduces the risk of relapse or hospitalization.[3-15] **[Quality]**
- UHC's performance for both *Antidepressant Medication Management* measure indicators ranked below the NCQA national 50th percentile benchmarks and SWA. Effective medication treatment of major depression is important because it can improve a person's daily functioning and well-being and can reduce the risk of suicide.[3-16] **[Quality]**
- UHC's performance for the *Appropriate Treatment for Children With Upper Respiratory Infection* and *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measures both ranked below the NCQA national 50th percentile benchmark and SWA. The misuse of antibiotics can have adverse clinical outcomes, so ensuring the appropriate use of antibiotics for individuals will help them avoid harmful side-effects and possible resistance to antibiotics over time.[3-17,3-18] **[Quality]**
- UHC's performance for the *Use of Imaging Studies for Low Back Pain* measure ranked below the NCQA national 50th percentile benchmark and SWA. Unnecessary or routine imaging for low back pain is not associated with improved outcomes, and exposes patients to unnecessary harms such as radiation and further unnecessary treatment, so it is important to avoid imaging for patients when there is no indication of an underlying condition.[3-19] **[Quality]**
- UHC's performance for the *Non-Recommended Cervical Screening in Adolescent Females* measure ranked below the NCQA national 50th percentile benchmark and SWA. Cervical cancer screening can result in more harm than benefits for adolescent females. Adolescent females tend to have high

[3-14] National Committee for Quality Assurance. Pharmacotherapy for Opioid Use Disorder (POD). Available at: https://www.ncqa.org/hedis/measures/pharmacotherapy-for-opioid-use-disorder/. Accessed on: Jan 30, 2024.
[3-15] National Committee for Quality Assurance. Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA). Available at: https://www.ncqa.org/hedis/measures/adherence-to-antipsychotic-medications-for-individuals-with-schizophrenia/. Accessed on: Jan 30, 2024.
[3-16] National Committee for Quality Assurance. Antidepressant Medication Management (AMM). Available at: https://www.ncqa.org/hedis/measures/antidepressant-medication-management/. Accessed on: Jan 30, 2024.
[3-17] National Committee for Quality Assurance. Appropriate Treatment for Upper Respiratory Infection (URI). Available at: https://www.ncqa.org/hedis/measures/appropriate-treatment-for-upper-respiratory-infection/. Accessed on: Jan 30, 2024.
[3-18] National Committee for Quality Assurance. Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB). Available at: https://www.ncqa.org/hedis/measures/avoidance-of-antibiotic-treatment-for-acute-bronchitis-bronchiolitis/. Accessed on: Jan 30, 2024.
[3-19] National Committee for Quality Assurance. Use of Imaging Studies for Low Back Pain (LBP). Available at: https://www.ncqa.org/hedis/measures/use-of-imaging-studies-for-low-back-pain/. Accessed on: Jan 30, 2024.

rates of transient HPV infection and regressive cervical abnormalities. This may produce false-positive results and lead to unnecessary and potentially detrimental follow-up tests and treatment.[3-20] **[Quality]**

- UHC's performance for both *Prenatal and Postpartum Care* measure indicators ranked below the NCQA national 50th percentile benchmark and SWA. Timely and adequate prenatal and postpartum care can set the stage for the long-term health and well-being of new mothers and their infants.[3-21] **[Quality, Timeliness, and Access]**

For UHC, the following recommendations were identified:

- HSAG recommends that UHC focus its efforts on increasing timely follow-up care for members following discharge. UHC should also consider conducting a root cause analysis for the *Follow-Up After Hospitalization for Mental Illness*, *Follow-Up After Emergency Department Visit for Mental Illness*, and *Follow-Up After Emergency Department Visit for Substance Use* measures and implementing appropriate interventions to improve performance, such as providing patient and provider education or improving upon coordination of care following discharge. **[Quality, Timeliness, and Access]**
- HSAG recommends that UHC focus its efforts on increasing the use of pharmacotherapy for members with OUD. UHC should consider conducting a root cause analysis for the *Pharmacotherapy for Opioid Use Disorder* measure and implementing appropriate interventions to improve performance, such as patient and provider education. **[Quality]**
- HSAG recommends that UHC focus its efforts on increasing antipsychotic medication adherence for members with schizophrenia. UHC should consider conducting a root cause analysis for the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measure and implementing appropriate interventions to improve performance, such as patient education. **[Quality]**
- HSAG recommends that UHC focus its efforts on proper antidepressant medication management for members diagnosed with major depression. UHC should consider conducting a root cause analysis for the *Antidepressant Medication Management* measure and implementing appropriate interventions to improve performance, such as patient education and offering telehealth services. **[Quality]**
- HSAG recommends that UHC focus its efforts on appropriate treatment of respiratory conditions. UHC should also consider conducting a root cause analysis for the *Appropriate Treatment for Children With Upper Respiratory Infection* and *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measures and implementing appropriate interventions to improve performance, such as patient and provider education. **[Quality]**

[3-20] National Committee for Quality Assurance. Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS). Available at: https://www.ncqa.org/hedis/measures/non-recommended-cervical-cancer-screening-in-adolescent-females/. Accessed on: Jan 30, 2024.

[3-21] National Committee for Quality Assurance. Prenatal and Postpartum Care (PPC). Available at: https://www.ncqa.org/hedis/measures/prenatal-and-postpartum-care-ppc/. Accessed on: Jan 30, 2024.

- HSAG recommends that UHC focus its efforts on decreasing unnecessary imaging for low back pain. UHC should also consider conducting a root cause analysis for the *Use of Imaging Studies for Low Back Pain* measure and implementing appropriate interventions to improve performance, such as addressing provider behaviors, provider incentives, and addressing member expectation with education. **[Quality]**
- HSAG recommends that UHC focus its efforts on decreasing unnecessary screenings for cervical cancer among adolescent females. UHC should also consider conducting a root cause analysis for the *Non-Recommended Cervical Screening in Adolescent Females* measure and implementing appropriate interventions to improve performance, such as provider education. **[Quality]**
- HSAG recommends that UHC focus its efforts on increasing timely prenatal and postpartum care for members. UHC should also consider conducting a root cause analysis for the *Prenatal and Postpartum Care* measure and implementing appropriate interventions to improve performance, such as outreach campaigns, patient and provider education, and member incentives. **[Quality, Timeliness, and Access]**

Methodology

Objectives

In accordance with 42 CFR §438.330(c), states must require MCOs to submit performance measurement data as part of their QAPI programs. The validation of performance measures is one of the mandatory EQR activities that the state Medicaid agencies are required to perform according to the Medicaid managed care regulations.

The primary objectives of the performance measure validation (PMV) process were to:

1. Evaluate the accuracy of performance measure data collected by the MCO.
2. Determine the extent to which the specific performance measures calculated by the MCO (or on behalf of the MCO) followed the specifications established for each performance measure.
3. Identify overall strengths and areas for improvement in the performance measure calculation process.

Technical Methods of Data Collection

CMS' EQR *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity,* February 2023,[3-22] specifies that, in lieu of conducting a full on-site Information Systems Capabilities Assessment (ISCA), the EQRO may review an assessment of the MCO's IS conducted by another party. If an MCO is accredited by NCQA, the MCO will have received a full IS assessment as part of its annual HEDIS Compliance Audit by an NCQA HEDIS Compliance Audit licensed organization (LO). In this case, HSAG would request and review the MCO's NCQA HEDIS Record of Administration, Data Management, and Processes (Roadmap), FAR, and the data submission tool in lieu of conducting an on-site assessment.

The validation process is described separately for the HEDIS and non-HEDIS measures that the MCOs report.

HEDIS Measure Validation

The MCOs that report HEDIS measures to NCQA must undergo an audit of their data conducted by an NCQA HEDIS Compliance Audit LO. For these HEDIS measures, HSAG reviews the rates submitted on the NCQA reporting tool (Interactive Data Submission System [IDSS]), which is audited prior to submission, and the FAR, which is completed by the LO and describes the process used to produce the

[3-22] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 18, 2023.

measure rates and any problems that the MCOs experienced in the HEDIS process. Included in the FAR are the measures deemed *Not Reportable* due to biases in the calculation process.

HSAG used the results of the audit to report the results of each measure reported to LDH. Using information provided in the FAR and, if necessary, additional documentation (i.e., NCQA HEDIS Roadmap), HSAG prepared a report indicating the measure results for each of the MCOs that are required to report to LDH. Measures deemed *Not Reportable* were flagged. SWAs were computed, and NCQA Quality Compass benchmarks were provided as well. Results for the prior two years were provided for trending, when appropriate. Any issues in reporting any measure (e.g., medical record abstraction issues) were noted and, if LDH requested any other statistical analyses, the results were included in the report.

Non-HEDIS Measure Validation

For state-specific measures and standardized non-HEDIS measures (e.g., the Prevention Quality Indicators), University of Louisiana Monroe (ULM), contracted by LDH, conducted the audit. Measures that did not pass validation were deemed *Not Reportable*, and the reasons for this designation (e.g., unresolved source code issues) were noted. If LDH requested any other statistical analyses, the results were included in the report. ULM conducted the validation for non-HEDIS measures, and HSAG provided assistance when needed.

Description of Data Obtained

HSAG used the FAR and the MCO rates provided on the IDSS file as the primary data sources. The FAR included information on the MCOs' IS capabilities, findings for each measure, supplemental data validation results, medical record review validation results, results of any corrected programming logic (including corrections to numerators, denominators, or sampling used for final measure calculation), and opportunities for improvement. The FAR included final determinations of validity made by the auditor for each performance measure. The IDSS file detailed all rates that were submitted to NCQA and whether the auditor deemed them to be reportable. The IDSS file is "locked" by the auditor so that no changes can be made to the results.

How Data Were Aggregated and Analyzed

In accordance with the MY 2022 NCQA HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5, the LOs evaluated compliance with NCQA's IS standards. NCQA's IS standards detail the minimum requirements of an MCO's IS, as well as criteria that must be met for any manual processes used to report HEDIS information. For each HEDIS measure, the MCO was evaluated on how its rate compared to the NCQA Quality Compass MY 2022 national 50th percentile Medicaid HMO benchmark.

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of care and services that each MCO provided to members, HSAG evaluated the results for each performance measure and the MY 2022 performance levels based on comparison to the NCQA national 50th percentile benchmark percentile to identify strengths and weaknesses and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the MCO's Medicaid members.

To draw conclusions about the quality, timeliness, and accessibility of care provided by the Medicaid MCOs, HSAG assigned each of the components reviewed for PMV to one or more of three domains of care. This assignment to domains of care is depicted in Table 3-6. The measures marked *NA* are related to utilization of services.

Table 3-6—Assignment of Performance Measures to the Quality, Timeliness, and Access Domains

Performance Measure	Quality	Timeliness	Access
Childhood Immunization Status—DTaP, *IPV*, *MMR*, *HiB*, *Hepatitis B*, *VZV*, *Pneumococcal Conjugate, Hepatitis A*, *Rotavirus*, *Influenza*, *Combination 3*, *Combination 7*, and *Combination 10*	✓	N/A	✓
Immunization Status for Adolescents—Meningococcal, *Tdap/Td*, *HPV*, *Combination 1*, and *Combination 2*	✓		
Colorectal Cancer Screening	✓	N/A	N/A
Cervical Cancer Screening	✓		
Follow-Up After Hospitalization for Mental Illness—Within 7 Days of Discharge and *Within 30 Days of Discharge*	✓	✓	✓
Follow-Up After Emergency Department Visit for Mental Illness—Within 7 Days of Discharge and *Within 30 Days of Discharge*	✓	✓	✓
Follow-Up After Emergency Department Visit for Substance Use—Within 7 Days of Discharge and *Within 30 Days of Discharge*	✓	✓	✓
Hemoglobin A1c Control for Patients With Diabetes—Poor HbA1c Control (>9.0%) and *HbA1c Control (<8.0%)*	✓		
Controlling High Blood Pressure	✓	N/A	N/A
HIV Viral Load Suppression	✓		
Low-Risk Cesarean Delivery (Cesarean Rate for Low-Risk First Birth Women)	✓	N/A	N/A
Child and Adolescent Well-Care Visits—3–11 Years, *12–17 Years*, *18–21 Years*, and *Total*	✓		✓
Well-Child Visits in the First 30 Months of Life—First 15 Months and *15 Months–30 Months*	✓	N/A	✓

Performance Measure	Quality	Timeliness	Access
Adults' Access to Preventive/Ambulatory Health Services—20–44 Years, *45–64 Years*, *65 Years and Older*, and *Total*	✓		✓
Ambulatory Care—Outpatient Visits/1,000 MM and *Emergency Department Visits/1,000 MM*	NA	NA	NA
Plan All-Cause Readmissions—Observed Readmissions, *Expected Readmissions*, and *O/E Ratio*	✓		
CAHPS Health Plan Survey 5.1H, Child (Rating of Health Plan, 8+9+10)	✓		
CAHPS Health Plan Survey 5.1H, Child (Rating of Health Plan—General Population, 8+9+10)	✓		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	✓		
Diabetes Monitoring for People With Diabetes and Schizophrenia	✓		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	✓		
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing, *Cholesterol Testing*, and *Blood Glucose and Cholesterol Testing*	✓		
Prenatal and Postpartum Care—Timeliness of Prenatal Care and *Postpartum Care*	✓	✓	✓
Lead Screening in Children	✓		
Flu Vaccinations for Adults Ages 18 to 64	✓		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation, *Counseling for Nutrition*, and *Counseling for Physical Activity*	✓		
Chlamydia Screening in Women—Total	✓		
Breast Cancer Screening	✓		
Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*	✓		
Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total and *Statin Adherence 80%—Total*	✓		
Blood Pressure Control for Patients With Diabetes	✓		
Eye Exam for Patients With Diabetes	✓		
Pharmacotherapy for Opioid Use Disorder	✓		
Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD and *Engagement of SUD*	✓	✓	✓

Performance Measure	Quality	Timeliness	Access
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	✓	n/a	n/a
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	✓		
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase and *Continuation and Maintenance Phase*	✓	✓	✓
Antidepressant Medication Management—Effective Acute Phase Treatment and *Effective Continuation Phase Treatment*	✓		
Appropriate Treatment for Children With Upper Respiratory Infection	✓		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	✓		
Non-Recommended Cervical Screening in Adolescent Females	✓		
Depression Screening and Follow-Up for Adolescents and Adults	✓		
Self-Reported Overall Health (Adult)—Adult—Very Good and *Adult—Excellent*	✓		
Self-Reported Overall Health (Child General)—Child General—Very Good and *Child General—Excellent*	✓		
Self-Reported Overall Health (Child CCC)—Child CCC—Very Good and *Child CCC—Excellent*	✓		
Self-Reported Overall Mental or Emotional Health (Adult)—Adult—Very Good and *Adult—Excellent*	✓		
Self-Reported Overall Mental or Emotional Health (Child General)—Child General—Very Good and *Child General—Excellent*	✓		
Self-Reported Overall Mental or Emotional Health (Child CCC)—Child CCC—Very Good and *Child CCC—Excellent*	✓		
Use of Imaging Studies for Low Back Pain	✓		

4. Assessment of Compliance With Medicaid Managed Care Regulations

Results

In CY 2022, the first year of a new three-year review cycle, LDH's former EQRO conducted a CR covering a review period of CY 2021 and most of the federally required standards. In CY 2023, HSAG conducted a CR for Standard I—Enrollment and Disenrollment (this standard had not been included in the prior year's CR), thereby completing the required evaluation for the administrative and compliance process in a three-year period. LDH plans to use CY 2024 for remediation and to prepare for a new CR cycle. Table 4-1 presents an overview of the results for UHC.

Table 4-1—Summary of CR Scores for the Three-Year Review Period: CY 2021–CY 2023[1,2]

Standard Name	2021	2022	2023
Enrollment and Disenrollment		**85.7%**	
Member Rights and Confidentiality	99.5%		
Member Information			
Coverage and Authorization of Services	100%		
Emergency and Post-Stabilization Services			
Availability of Services	98.8%		
Assurances of Adequate Capacity and Services	100%		
Coordination and Continuity of Care	90.7%		
Provider Selection	97.8%		
Subcontractual Relationships and Delegation	100%		
Practice Guidelines	100%		
Health Information Systems	100%		
Quality Assessment and Performance Improvement Program	100%		
Grievance and Appeal Systems	100%		
Program Integrity	100%		

[1] Grey shading indicates the standard was not reviewed in the calendar year.

[2] Bold text indicates scores that were determined by HSAG. All other scores were determined by LDH's former EQRO. HSAG's scoring methodology included three levels: *Met*, *Not Met*, and *Not Applicable*.

During the 2023 CR, UHC received a compliance score of 85.7 percent for Standard I—Enrollment and Disenrollment, which identified UHC has opportunities for improvement. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed. For any elements HSAG scored *Not Met*, UHC is required to submit a CAP to bring the element into compliance with the applicable standard(s).

Follow-Up on Previous Compliance Review Findings

LDH contracted HSAG to assess the remediation UHC conducted as a result of the deficiencies identified in the prior year's CR (conducted by LDH's previous EQRO). UHC was issued a CAP and required to remediate each element as recommended by the previous EQRO. During this year's virtual partial compliance audit, HSAG reviewed the recommendations made by the previous EQRO and UHC's response. UHC submitted additional documentation or implemented policies and procedures to meet requirements. UHC also completed a response document to describe its remediation efforts for each element. HSAG then assessed all remediation elements to determine if compliance with requirements had been met and assigned a final score. Table 4-2 presents an overview of the results for UHC.

Table 4-2—Summary of Scores for the CAP From the CY 2021 Review

N/A	Total Elements in CAP	Number of Elements			Total Compliance Score From CAP
		M	*NM*	*NA*	
Follow-Up on CAPs From Prior CR	19	17	1	1	94.4%

M=*Met*, ***NM***=*Not Met*
Total Elements in CAP: The total number of elements within the CAP from the CY 2021 review. This represents the denominator.
Total Compliance Score From CAP: The overall percentages of the number of elements that received a score of *Met* (1 point) then dividing this total by the total number of elements.

UHC achieved compliance in 17 of 18 applicable elements from the LDH-approved 2022 CR CAPs. UHC must implement the remaining approved CAPs for the one element for which compliance was not achieved.

MCO Strengths, Opportunities for Improvement, and Recommendations

For UHC, the following strength was identified:

- UHC's policies and procedures ensured that UHC did not inappropriately request disenrollment of a member because of an adverse change in the member's health status, utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs. **[Quality and Access]**

For UHC, the following opportunity for improvement was identified:

- UHC's policies and procedures failed to include all requirements in Standard I—Enrollment and Disenrollment. **[Quality and Access]**

For UHC, the following required action and recommendation were identified:

- UHC must revise its policies and procedures to include all requirements in Standard I—Enrollment and Disenrollment as detailed in the CR report. **[Quality and Access]**

Methodology

Standards

Table 4-3 delineates the CR activities as well as the standards that were reviewed during the first two years of the three-year CR cycle. In addition, HSAG conducted a follow-up review of each MCO's implementation of CAPs from the CY 2021 CRs.

Table 4-3—Summary of CR Standards

Standard	Year One (CY 2021)			Year Two (CY 2022)		
	MCO	PAHP	PIHP	MCO	PAHP	PIHP
Standard I—Enrollment and Disenrollment				✓	✓	✓
Standard II—Member Rights and Confidentiality	✓	✓	✓			
Standard III—Member Information	✓	✓	✓			
Standard IV—Emergency and Poststabilization Services	✓	NA				✓
Standard V—Adequate Capacity and Availability of Services	✓	✓	✓			
Standard VI—Coordination and Continuity of Care	✓	✓	✓			
Standard VII—Coverage and Authorization of Services	✓	✓	✓			
Standard VIII—Provider Selection	✓	✓	✓			
Standard IX—Subcontractual Relationships and Delegation	✓		✓		✓	
Standard X—Practice Guidelines	✓	✓	✓			
Standard XI—Health Information Systems	✓	✓	✓			
Standard XII—Quality Assessment and Performance Improvement	✓	✓	✓			
Standard XIII—Grievance and Appeal Systems	✓	✓	✓			
Standard XIV—Program Integrity	✓	✓	✓			

HSAG divided the federal regulations into 14 standards consisting of related regulations and contract requirements. Table 4-4 describes the standards and associated regulations and requirements reviewed for each standard.

Table 4-4—Summary of CR Standards and Associated Regulations

Standard	Federal Requirements Included[1]	Standard	Federal Requirements Included
Standard I—Enrollment and Disenrollment	42 CFR §438.3(d) 42 CFR §438.56	Standard VIII—Provider Selection	42 CFR §438.12 42 CFR §438.102 42 CFR §438.106 42 CFR §438.214 42 CFR §438.602(b) 42 CFR §438.608 42 CFR §438.610
Standard II—Member Rights and Confidentiality	42 CFR §438.100 42 CFR §438.224 42 CFR §422.128	Standard IX—Subcontractual Relationships and Delegation	42 CFR §438.230
Standard III—Member Information	42 CFR §438.10	Standard X—Practice Guidelines	42 CFR §438.236
Standard IV—Emergency and Poststabilization Services	42 CFR §438.114	Standard XI—Health Information Systems	42 CFR §438.242
Standard V—Adequate Capacity and Availability of Services	42 CFR §438.206 42 CFR §438.207	Standard XII—Quality Assessment and Performance Improvement	42 CFR §438.330
Standard VI—Coordination and Continuity of Care	42 CFR §438.208	Standard XIII—Grievance and Appeal Systems	42 CFR §438.228 42 CFR §438.400– 42 CFR §438.424
Standard VII—Coverage and Authorization of Services	42 CFR §438.210 42 CFR §438.404	Standard XIV—Program Integrity	42 CFR §438.608

[1] The CR standards comprise a review of all requirements, known as "elements," under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard XIII—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).

Objectives

Private accreditation organizations, state licensing agencies, and state Medicaid agencies all recognize that having standards is only the first step in promoting safe and effective healthcare. Making sure that the standards are followed is the second step. The objective of each virtual review was to provide meaningful information to LDH and the MCOs regarding:

- The MCOs' compliance with federal managed care regulations and contract requirements in the standard areas reviewed.

- Strengths, opportunities for improvement, recommendations, or required actions to bring the MCOs into compliance with federal managed care regulations and contract requirements with the standard areas reviewed.
- The quality, timeliness, and access to care furnished by the MCOs, as addressed within the specific areas reviewed.
- Possible additional interventions recommended to improve the quality of the MCOs' care provided and services offered related to the areas reviewed.

Technical Methods of Data Collection

To assess the MCOs' compliance with regulations, HSAG conducted the five activities described in CMS' EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity,* February 2023.[4-1] Table 4-5 describes the five protocol activities and the specific tasks that HSAG performed to complete each activity.

Table 4-5—Protocol Activities Performed for Assessment of Compliance With Regulations

For this protocol activity,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Conducted before the review to assess compliance with federal managed care regulations and LDH contract requirements: • HSAG and LDH collaborated to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG developed and submitted CR tools, report templates, and agendas, and sent review dates to LDH for review and approval. • HSAG forwarded the CR tools and agendas to the MCOs. • HSAG scheduled the virtual reviews to facilitate preparation for the reviews.
Activity 2:	**Perform Preliminary Review**
	• HSAG conducted an MCO pre-virtual review preparation session to describe HSAG's processes and allow the MCOs the opportunity to ask questions about the review process and MCO expectations. • HSAG confirmed a primary MCO contact person for the review and assigned HSAG reviewers to participate. • During the MCO pre-virtual review preparation session, HSAG notified the MCOs of the request for desk review documents. HSAG delivered a desk review form, the CR tool, CAP implementation review tool, and a webinar review agenda via HSAG's Secure Access File Exchange (SAFE) site. The desk review request included

[4-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 18, 2023.

For this protocol activity,	HSAG completed the following activities:
	instructions for organizing and preparing the documents to be submitted. The MCO provided documentation for the desk review, as requested. • Examples of documents submitted for the desk review and CR consisted of the completed desk review form, the CR tool with the MCO's section completed, policies and procedures, staff training materials, reports, minutes of key committee meetings, and member and provider informational materials. • The HSAG review team reviewed all documentation submitted prior to the scheduled webinar and prepared a request for further documentation and an interview guide to use during the webinar.
Activity 3:	**Conduct MCO Virtual Review**
	• HSAG conducted an opening conference, with introductions and a review of the agenda and logistics for HSAG's virtual review activities. • During the review, HSAG met with groups of the MCO's key staff members to obtain a complete picture of the MCO's compliance with Medicaid and CHIP managed care regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the MCO's performance. • HSAG requested, collected, and reviewed additional documents, as needed. • HSAG conducted a closing conference during which HSAG reviewers summarized preliminary findings, as appropriate.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the 2023 LDH-approved CR Report Template to compile the findings and incorporate information from the CR activities. • HSAG analyzed the findings and calculated final scores based on LDH-approved scoring strategies. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to LDH**
	• HSAG populated and submitted the draft reports to LDH and the MCOs for review and comments. • HSAG incorporated the feedback, as applicable, and finalized the reports. • HSAG included a pre-populated CAP template in the final report for all requirements determined to be out of compliance with managed care regulations (i.e., received a score of *Not Met*). • HSAG distributed the final reports to the MCOs and LDH.

Description of Data Obtained

The following are examples of documents reviewed and sources of the data obtained:

- Committee meeting agendas, minutes, and reports
- Written policies and procedures
- Management/monitoring reports and audits
- Narrative and/or data reports across a broad range of performance and content areas
- Records for delegation
- Member and provider materials

How Data Were Aggregated and Analyzed

HSAG aggregated and analyzed the data resulting from the desk review, virtual interviews conducted with key MCO personnel, and any additional documents submitted as a result of the interviews. The data that HSAG aggregated and analyzed included the following:

- Documented findings describing the MCO's performance in complying with each standard requirement.
- Scores assigned to the MCO's performance for each requirement.
- The total percentage-of-compliance score calculated for each standard.
- The overall percentage-of-compliance score calculated across the standards.
- Documentation of the actions required to bring performance into compliance with the requirements for which HSAG assigned scores of *Not Met*.
- Recommendations for program enhancements.

Based on the results of the data aggregation and analysis, HSAG prepared and forwarded draft reports to LDH and to each MCO's staff members for their review and comment prior to issuing final reports.

HSAG analyzed the quantitative results obtained from the above compliance activity to identify strengths and weaknesses in each domain of quality, timeliness, and access to care furnished by each MCO. HSAG then identified common themes and the salient patterns that emerged across MCOs related to the compliance activity conducted.

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and access to care provided by the MCOs, HSAG assigned each of the components reviewed for assessment of compliance with regulations to one or more of those domains of care. Each standard may involve assessment of more than one domain of care due to the combination of individual requirements within each standard. HSAG then analyzed, to draw conclusions and make recommendations, the individual requirements within each standard that assessed

the quality, timeliness, or access to care and services provided by the MCOs. Table 4-6 depicts assignment of the standards to the domains of care.

Table 4-6—Assignment of CR Standards to the Quality, Timeliness, and Access Domains

CR Standard	Quality	Timeliness	Access
Standard I—Enrollment and Disenrollment	✓		✓
Standard II—Member Rights and Confidentiality			✓
Standard III—Member Information			✓
Standard IV—Emergency and Poststabilization Services		✓	✓
Standard V—Adequate Capacity and Availability of Services		✓	✓
Standard VI—Coordination and Continuity of Care	✓	✓	✓
Standard VII—Coverage and Authorization of Services		✓	✓
Standard VIII—Provider Selection	✓	✓	✓
Standard IX—Subcontractual Relationships and Delegation	✓		
Standard X—Practice Guidelines	✓		
Standard XI—Health Information Systems	✓		✓
Standard XII—Quality Assessment and Performance Improvement	✓		
Standard XIII—Grievance and Appeal Systems	✓	✓	✓
Standard XIV—Program Integrity	✓	✓	✓

Results

Provider Access Surveys

The provider access survey results were not final at the time of reporting. Provider access survey results will be included in the SFY 2024 EQR technical report. At the time of reporting, HSAG and LDH finalized the first semiannual provider access survey methodology, and HSAG conducted the survey telephone calls.

Provider Directory Accuracy

This section presents the results from the Quarter 1 PDV for all sampled UHC providers by specialty type. Quarter 2 through Quarter 4 PDV results were not final at the time of reporting and will be included in the SFY 2024 EQR technical report.

Table 5-1 illustrates the survey disposition and response rates for UHC by specialty type.

Table 5-1—Survey Dispositions and Response Rates for UHC by Specialty Type

Specialty Type	Sampled Cases	Respondents	Refusals*	Bad Phone Number**	Unable to Reach***	Response Rate
Total	**125**	**113**	**0**	**3**	**9**	**90.4%**
Internal Medicine/Family Medicine	25	21	0	1	3	84.0%
Pediatrics	25	25	0	0	0	100%
Obstetrics/Gynecology (OB/GYN)	25	22	0	1	2	88.0%
Specialists (any)	25	25	0	0	0	100%
Behavioral Health (any)	25	20	0	1	4	80.0%

* This includes offices that refused to participate, or the representative did not have enough information to answer the survey questions.
** This includes reaching a disconnected number, fax number, nonmedical facility, or billing office that was unable to transfer/provide corrected number.
*** This includes reaching a voicemail, busy signal, continuous ringing, and/or extended hold time after three attempts.

Table 5-2 illustrates the indicator match rates for UHC by specialty type.

Table 5-2—Indicator Match Rates for UHC by Specialty Type

Specialty Type	Correct Address		Provider at Location		Confirmed Specialty		Accepted MCO		Accepted Louisiana Medicaid		Accepted New Patients	
	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)
Total	**100**	**88.5%**	**99**	**87.6%**	**93**	**82.3%**	**78**	**69.0%**	**74**	**65.5%**	**93**	**82.3%**
Internal Medicine/Family Medicine	18	85.7%	19	90.5%	18	85.7%	15	71.4%	16	76.2%	17	81.0%
Pediatrics	25	100%	22	88.0%	20	80.0%	19	76.0%	18	72.0%	21	84.0%
OB/GYN	19	86.4%	19	86.4%	18	81.8%	15	68.2%	15	68.2%	17	77.3%
Specialists (any)	22	88.0%	22	88.0%	22	88.0%	21	84.0%	20	80.0%	22	88.0%
Behavioral Health (any)	16	80.0%	17	85.0%	15	75.0%	8	40.0%	5	25.0%	16	80.0%

Table 5-3 presents UHC's PDV weighted compliance scores by specialty type. Please see the network adequacy validation (NAV) Methodology for the weighted compliance score calculation criteria.

Table 5-3—PDV Weighted Compliance Scores by Specialty Type

Specialty Type	Total	Compliant[1]	Weighted Compliance Score
Total	**125**	**59**	**51.2%**
Internal Medicine/Family Medicine	25	13	56.0%
Pediatrics	25	16	66.7%
OB/GYN	25	9	42.7%
Specialists (any)	25	17	72.0%
Behavioral Health (any)	25	4	18.7%

[1]Compliant providers include providers in which all indicators match between the online provider directory and the information obtained during the survey call to the sampled location.

Table 5-4 presents UHC's reasons for noncompliance.

Table 5-4—Reasons for Noncompliance

Reason	Count	Rate (%)
Noncompliant providers	**66**	**52.8%**
Total reasons for noncompliance	**76**	**Not Applicable**
Provider does not participate with MCO or Louisiana Medicaid	27	21.6%
Provider is not at site	12	9.6%
Provider not accepting new patients	6	4.8%
Wrong telephone number	1	0.8%
No response/busy signal/disconnected telephone number (after three calls)	11	8.8%
Representative does not know	0	0.0%
Incorrect address reported	12	9.6%
Address (suite number) needs to be updated	1	0.8%
Wrong specialty reported	6	4.8%

GeoAccess Provider Network Accessibility

UHC's contract with LDH (effective dates January 1, 2023–December 31, 2025) requires UHC to comply with the following GeoAccess standards:

- Travel distance to adult primary care (family/general practice, internal medicine, Federally Qualified Health Center [FQHC], Rural Health Center [RHC], and pediatric primary care (pediatric practices, family/general practice, internal medicine, FQHC, RHC):
  - Urban—10 miles
  - Rural—30 miles
- Travel distance to acute inpatient hospitals
  - Urban—10 miles
  - Rural—30 miles
- Travel distance to ancillary care (laboratory and radiology):
  - Urban—20 miles
  - Rural—30 miles
- Travel distance to ancillary care (pharmacy and hemodialysis):
  - Urban—10 miles
  - Rural—30 miles

- Travel distance to specialty care (OB/GYN and psychiatrists):
  - Urban—15 miles
  - Rural—30 miles
- Travel distance to all other specialty care (except behavioral health care):
  - Urban—60 miles
  - Rural—60 miles
- Travel distance to licensed mental health specialists (advanced practice registered nurse [APRN], psychologist, licensed clinical social worker [LCSW]):
  - Urban—15 miles
  - Rural—30 miles
- Travel distance to pediatric psychiatric residential treatment facilities (PRTFs) (mental health and American Society of Addiction Medicine [ASAM]):
  - Urban—200 miles
  - Rural—200 miles
- Travel distance to ASAM levels of care (LOCs) (both urban and rural):
  - ASAM LOC 1 (adult and pediatric 1):
    - Urban—15 miles
    - Rural—30 miles
  - ASAM LOC 2.1 (adult and pediatric)
    - Urban—15 miles
    - Rural—30 miles
  - ASAM LOC 2 Withdrawal Management (WM) (adult and pediatric)—60 miles
  - ASAM LOC 3.1 (adult)—30 miles
  - ASAM LOC 3.1 (pediatric)—60 miles
  - ASAM LOC 3.2WM (adult and pediatric)—60 miles
  - ASAM LOC 3.3 (adult)—30 miles
  - ASAM LOC 3.5 (adult)—30 miles
  - ASAM LOC 3.5 (pediatric)—60 miles
  - ASAM LOC 3.7 (adult)—60 miles
  - ASAM LOC 3.7WM (adult)—60 miles
- Travel distance to psychiatric inpatient hospital services (free standing, distinct psychiatric unit):
  - Urban—90 miles
  - Rural—90 miles
- Travel distance to behavioral health rehabilitation services (legacy and non-legacy agency):
  - Urban—15 miles
  - Rural—30 miles

Table 5-5 presents the percentage of members UHC reported having access within the required distance standard for the reporting period of July 1, 2022, through June 30, 2023, for the physical health provider types depicted in Attachment F of UHC's contract with LDH.

Table 5-5—GeoAccess Results for UHC—Physical Health

Provider Type	Region	Standard	Reporting Period 07/01/22—12/31/22	Reporting Period 01/01/23—06/30/23
Adult Primary Care	Urban	10 miles/100%	98.7%	98.6%
	Rural	30 miles/100%	100%	100%
Pediatric Primary Care	Urban	10 miles/100%	99.0%	98.9%
	Rural	30 miles/100%	100%	100%
FQHCs	Urban	10 miles/100%	89.0%	89.1%
	Rural	30 miles/100%	99.8%	99.7%
RHCs	Urban	10 miles/100%	53.1%	56.3%
	Rural	30 miles/100%	100%	100%
Acute Inpatient Hospitals	Urban	10 miles/100%	90.2%	89.7%
	Rural	30 miles/100%	100%	100%
Ancillary Care—Laboratory	Urban	20 miles/100%	99.2%	99.2%
	Rural	30 miles/100%	100%	100%
Ancillary Care—Radiology	Urban	20 miles/100%	99.4%	98.9%
	Rural	30 miles/100%	100%	100%
Ancillary Care—Pharmacy	Urban	10 miles/100%	98.0%	97.7%
	Rural	30 miles/100%	100%	100%
Ancillary Care—Hemodialysis	Urban	10 miles/100%	89.9%	89.4%
	Rural	30 miles/100%	98.7%	98.8%
Specialty Care—OB/GYN	Urban	15 miles/100%	94.9%	95.2%
	Rural	30 miles/100%	94.8%	96.4%
Allergy/Immunology	Urban	60 miles/100%	99.7%	95.7%
	Rural	60 miles/100%	95.3%	88.3%
Cardiology	Urban	60 miles/100%	100%	100%
	Rural	60 miles/100%	100%	100%

Provider Type	Region	Standard	Reporting Period 07/01/22—12/31/22	Reporting Period 01/01/23—06/30/23
Dermatology	Urban	60 miles/100%	95.7%	97.3%
	Rural	60 miles/100%	89.0%	93.9%
Endocrinology and Metabolism	Urban	60 miles/100%	97.8%	97.0%
	Rural	60 miles/100%	96.0%	94.3%
Gastroenterology	Urban	60 miles/100%	100%	99.9%
	Rural	60 miles/100%	99.9%	99.9%
Hematology/Oncology	Urban	60 miles/100%	100%	99.9%
	Rural	60 miles/100%	100%	100%
Nephrology	Urban	60 miles/100%	100%	99.9%
	Rural	60 miles/100%	100%	100%
Neurology	Urban	60 miles/100%	100%	99.9%
	Rural	60 miles/100%	99.9%	99.9%
Ophthalmology	Urban	60 miles/100%	100%	99.9%
	Rural	60 miles/100%	100%	100%
Orthopedics	Urban	60 miles/100%	100%	100%
	Rural	60 miles/100%	100%	100%
Otorhinolaryngology/ Otolaryngology	Urban	60 miles/100%	100%	100%
	Rural	60 miles/100%	100%	99.5%
Urology	Urban	60 miles/100%	100%	99.9%
	Rural	60 miles/100%	99.2%	99.1%

Meets the required distance standards
Results of 99.0% or higher

Table 5-6 presents the percentage of members UHC reported having access within the required distance standard for the reporting period of July 1, 2022, through June 30, 2023, for the behavioral health provider types depicted in Attachment F of UHC's contract with LDH.

Table 5-6—GeoAccess Results for UHC—Behavioral Health

Provider Type	Region	Standard	Quarter 1 07/01/22—09/30/22	Quarter 2 10/01/22—12/31/22	Quarter 3 01/01/23—03/01/23	Quarter 4 04/01/23—06/30/23
Specialty Care—Psychiatrists	Urban	15 miles/100%	96.9%	96.9%	96.7%	96.5%
	Rural	30 miles/100%	99.9%	99.9%	99.9%	99.3%
Behavioral Health Specialists	Urban	15 miles/100%	99.3%	99.3%	99.2%	99.1%
	Rural	30 miles/100%	99.9%	99.9%	99.9%	99.9%
All Prescribers	Urban	15 miles/100%	98.8%	98.8%	98.7%	98.9%
	Rural	30 miles/100%	99.9%	99.9%	99.9%	99.7%
Pediatric PRTF	Urban or Rural	200 miles/100%	100%	100%	100%	100%
ASAM LOC 1	Urban	15 miles/100%	NR	NR	70.8%	95.1%
	Rural	30 miles/100%	NR	NR	38%	97.7%
ASAM LOC 2.1	Urban	15 miles/100%	NR	NR	89.4%	90.1%
	Rural	30 miles/100%	NR	NR	68.9%	78.2%
ASAM LOC 2WM	Urban	60 miles/100%	NR	NR	43.2%	67.0%
	Rural	60 miles/100%	NR	NR	11.8%	21.1%
ASAM LOC 3.1 Adult	Urban	30 miles/100%	NR	NR	80.9%	85.5%
	Rural	30 miles/100%	NR	NR	36.7%	36.9%
ASAM LOC 3.1 Pediatric/Adolescent	Urban or Rural	60 miles/100%	NR	NR	66.4%	92.9%
ASAM LOC 3.2WM Adult	Urban	60 miles/100%	NR	NR	70.2%	99.9%
	Rural	60 miles/100%	NR	NR	56.6%	97.0%
ASAM LOC 3.2WM Pediatric/Adolescent	Urban or Rural	60 miles/100%	NR	NR	56.3%	99.9%
ASAM LOC 3.3 Adult	Urban	30 miles/100%	62.0%	61.9%	59.8%	96.0%
	Rural	30 miles/100%	13.9%	13.8%	14.5%	69.4%

Provider Type	Region	Standard	Quarter 1 07/01/22—09/30/22	Quarter 2 10/01/22—12/31/22	Quarter 3 01/01/23—03/01/23	Quarter 4 04/01/23—06/30/23
ASAM LOC 3.5 Adult	Urban	30 miles/100%	87.6%	87.6%	87.8%	96.2%
	Rural	30 miles/100%	58.1%	58.2%	57.3%	72.5%
ASAM LOC 3.7 Adult	Urban	60 miles/100%	72.2%	72.2%	72.0%	99.9%
	Rural	60 miles/100%	74.6%	74.6%	75.1%	98.3%
ASAM LOC 3.7WM Adult	Urban	60 miles/100%	91.2%	91.2%	91.6%	99.9%
	Rural	60 miles/100%	80.6%	80.6%	81.2%	98.5%
ASAM LOC 3.5 Pediatric	Urban or Rural	60 miles/100%	77.5%	77.5%	98.4%	99.6%
Inpatient Psychiatric	Urban	90 miles/100%	100%	100%	99.9%	99.9%
	Rural	90 miles/100%	100%	100%	100%	100%
Medication-Assisted Treatment (MAT)	Urban	15 miles/100%	86.2%	86.2%	86.1%	88.2%
	Rural	30 miles/100%	89.1%	89.1%	89.1%	72.2%
Behavioral Health Rehabilitation	Urban	15 miles/100%	NR	NR	94.8%	95.9%
	Rural	30 miles/100%	NR	NR	98.8%	99.2%

Meets the required distance standards
Results of 99.0% or higher
NR—Not Reported; MCOs were not required to report these ASAM LOCs prior to January 2023.

UHC submitted network reports and gap analysis through the state fiscal year. UHC reported using industry registries to identify available ASAM providers to assist with recruiting efforts. For MAT services, UHC reported supporting online training to expand the provision of MAT services to contracted PCPs. For all ASAM LOCs, UHC reported working with providers to improve reporting of ASAM LOC capability. UHC also reported adding three provider organizations to its behavioral health network in SFY 2023, and initiating the contracting process with another provider.

MCO Strengths, Opportunities for Improvement, and Recommendations

For UHC, the following strengths were identified:

- The overall PDV response rate was 90.4 percent. A higher response rate correlates to correct provider data (i.e., telephone number accuracy) and improves a member's ability to contact provider locations when seeking care. **[Quality and Access]**
- UHC had a PDV match rate of 100 percent for the address indicator (i.e., accuracy of UHC's directory reflecting the correct address) for pediatrics. Correct address information is essential for members to locate providers when seeking care. **[Quality and Access]**
- UHC had a PDV match rate of 90.5 percent for the provider affiliation indicator for internal medicine/family medicine. Correct provider information is essential for members to locate providers when seeking care. **[Quality and Access]**
- For GeoAccess, UHC achieved a rate above 99 percent across both reporting periods for 17 of 22 physical health provider types reported separately for rural standards. **[Access]**
- UHC achieved a rate above 99 percent for at least one of the reporting periods for 13 of 22 physical health provider types reported separately for urban standards. **[Access]**
- For all four quarters, UHC achieved GeoAccess results above 99 percent for rural and urban behavioral health specialists, rural behavioral health prescribers, and urban and rural pediatric PRTF, and urban and rural inpatient psychiatric providers. **[Access]**

For UHC, the following opportunities for improvement were identified:

- Acceptance of Louisiana Medicaid had an overall match rate at 65.5 percent across all provider types in the PDV. **[Quality and Access]**
- Acceptance of the MCO had an overall match rate at 69.0 percent across all provider types in the PDV. **[Quality and Access]**
- Overall, 82.3 percent of providers confirmed the specialty listed in the online provider directory was accurate. **[Quality and Access]**
- Overall, 82.3 percent of providers confirmed they were accepting new patients; however, only providers listed as accepting new patients in the online provider directory were selected for the PDV reviews. **[Quality and Access]**
- Overall, 87.6 percent of the PDV locations confirmed affiliation with the sampled provider. **[Quality and Access]**
- Overall, 88.5 percent of PDV respondents confirmed UHC's online provider directory reflected the correct address. **[Quality and Access]**
- UHC demonstrated a shortage of FQHCs and RHCs in urban areas, with GeoAccess results below 90 percent. **[Quality and Access]**
- UHC did not meet any GeoAccess standards for any ASAM or MAT provider types. **[Quality and Access]**

For UHC, the following recommendations were identified:

- LDH should provide UHC with the case-level PDV data files (i.e., flat files) and a defined timeline by which it will address provider data deficiencies identified during the PDV reviews (e.g., provider specialty, MCO acceptance, and Louisiana Medicaid acceptance). **[Quality and Access]**
- In addition to updating provider directory information, UHC should conduct a root cause analysis to identify the nature of the data mismatches for PDV study indicators that scored below 90 percent. **[Quality and Access]**
- UHC should conduct an in-depth review of ASAM and MAT providers as GeoAccess standards were not met, with the goal of determining whether failure to meet the standard(s) resulted from a lack of providers or an inability to contract with providers in the geographic area. Analyses should evaluate the extent to which UHC has requested exemptions from LDH for provider types for which providers may not be available or willing to contract. **[Quality and Access]**
- UHC should evaluate whether offering additional telehealth services could increase compliance with GeoAccess standards. **[Quality and Access]**

Methodology

Objectives

The purpose of NAV activities is to evaluate the sufficiency of the provider network as reported by the MCO, ensure the sufficiency of the network to provide adequate access to all services covered under the contract for all members, and provide recommendations to address network deficiencies.

Technical Methods of Data Collection

In February 2023, CMS released updates to the CMS EQR protocols, including the newly developed NAV protocol. As established in the 2016 final rule, states must begin conducting the NAV activity at 42 CFR §438.358(b)(1)(iv) no later than one year from the issuance of CMS' EQR *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023 (CMS Protocol 4).[5-1] This means that by February 2024, HSAG will begin conducting NAV activities in accordance with CMS Protocol 4 and will report results in the EQR technical report due April 30, 2025.

Provider Directory Validation

To conduct the NAV analysis, HSAG utilized the MCOs' online provider directories to locate and extract provider data elements. Trained interviewers collected survey responses using a standardized script to validate survey indicators pertaining to provider data accuracy, such as telephone number, address, provider specialty, provider affiliation with the requested MCO, provider's acceptance of Medicaid, and accuracy of new patient acceptance.

Provider Access Survey

To conduct the NAV analysis, each MCO used the data request document prepared by HSAG to identify providers potentially eligible for survey inclusion, and to submit provider data files used to populate its online provider directory to HSAG. At a minimum, the data elements requested for each provider included: provider name, Medicaid identification (ID), National Provider Identification (NPI) number, provider specialty, physical (practice) address, telephone number, provider taxonomy code, and whether or not the provider accepted new patients.

Upon receipt of the data files, HSAG assessed the data to ensure alignment with the requested data file format, data field contents, and logical consistency between data elements. HSAG also assessed the distribution of provider specialty data values present in each MCO's data to determine which data values attributed to each provider domain.

[5-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 20, 2023.

GeoAccess Provider Network Accessibility Assessment

The MCO was required to submit network analysis reports, GeoAccess mapping and tables, network gap analysis reports, and development plans depicting interventions or activities designed to address identified gaps in the networks. The MCO used GeoAccess mapping software to calculate compliance with contractual distance standards for each required provider type. HSAG compared each MCO's GeoAccess compliance reporting to the contractual standards.

Description of Data Obtained

HSAG, with approval from LDH, conducted the following network adequacy monitoring tasks during CY 2023:

1. PDV, to validate the MCOs' online provider directories to ensure members have appropriate access to provider information. HSAG utilized the MCOs' online provider directories to locate and extract provider data elements required to conduct the survey component of the PDV activity.
2. Provider access survey, to determine the accuracy of the managed care network information supplied to Healthy Louisiana members using the MCOs' provider data files and to ensure that Louisiana provider networks are following the established LDH standard for office-hour appointments. HSAG utilized the MCOs' provider data files used to populate their online provider directories to conduct the survey component of the provider access survey activity.
3. HSAG assessed the GeoAccess Provider Network Accessibility reports and tables, and Gap Analysis reports submitted by each MCO to LDH.

How Data Were Aggregated and Analyzed

Provider Directory Validation

For each sampled case, HSAG compared the MCOs' provider directory values to the information obtained via the survey call for the following list of indicators. All items must match exactly, except for common United States Postal Service (USPS) standard abbreviations and naming conventions (e.g., E and East or 1st and First).

- Telephone number
- Address
- Office affiliation with the sampled provider
- Accuracy of provider specialty
- Provider affiliation with the requested MCO
- Provider's acceptance of Louisiana Medicaid
- Accuracy of new patient acceptance

HSAG used the following validation responses to assess each indicator:

- Yes, the information matched between the online provider directory and the survey call.
- No, the information did not match between the online provider directory and the survey call.

Using the results of the PDV, HSAG calculated a compliance score for each MCO. The criteria in Table 5-7 were used to calculate the weight of each noncompliance survey outcome.

Table 5-7—Noncompliance Reasons and Weighting

Noncompliance Reason	Weight
Provider does not participate with MCO or Louisiana Medicaid	3
Provider is not at site	3
Provider not accepting new patients	3
Wrong telephone number	3
No response/busy signal/disconnected telephone number (after three calls)	3
Representative does not know	3
Incorrect address reported	2
Address (suite number) needs to be updated	1
Wrong specialty reported	1
Refused to participate in survey	0

Table 5-8—Weighted Noncompliance Criteria

Weighted Noncompliance Scores	
Numerator	The numerator is the sum of all provider noncompliance scores for the MCO. Each provider record received a noncompliance score based upon the reasons for noncompliance in Table 5-7. If multiple noncompliance criteria are met, the noncompliance criterion with the largest weight was used.
Denominator	The denominator is the number of provider records multiplied by 3.

Weighted compliance score equation:

MCO's weighted compliance score = 1 – the weighted noncompliance score

Compliance: The MCOs were compliant if their weighted compliance score was ≥ 75 percent **or** have a weighted compliance score ≥ 50 percent **and** have improved by ≥ 2 percentage points from the previous quarter.

Provider Access Survey

Using a survey script approved by LDH, HSAG validated the following information pertaining to provider data accuracy:

- Telephone number
- Address
- Accuracy of provider specialty
- Provider affiliation with the requested MCO
- Provider's acceptance of Louisiana Medicaid
- Accuracy of new patient acceptance
- Sampled provider at location
- Appointment availability

Using the results of the survey, HSAG calculated a compliance score for each MCO. The criteria in Table 5-9 were used to calculate the weight of each noncompliance survey outcome.

Table 5-9—Noncompliance Reasons and Weighting

Noncompliance Reason	Weight
Provider does not participate with MCO or Louisiana Medicaid	3
Provider is not at site	3
Provider not accepting new patients	3
Wrong telephone number	3
No response/busy signal/disconnected telephone number (after three calls)	3
Representative does not know	3
Incorrect address reported	2
Address (suite number) needs to be updated	1
Wrong specialty reported	1
Refused to participate in survey	0

Table 5-10—Weighted Noncompliance Criteria

Weighted Noncompliance Scores	
Numerator	The numerator is the sum of all provider noncompliance scores for the MCO. Each provider record received a noncompliance score based upon the reasons for noncompliance in Table 5-9. If multiple noncompliance criteria are met, the noncompliance criterion with the largest weight was used.
Denominator	The denominator is the number of provider records multiplied by 3.

Weighted compliance score equation:

MCO's weighted compliance score = 1 – the weighted noncompliance score

Compliance: The MCOs were compliant if their weighted compliance score was ≥ 75 percent **or** have a weighted compliance score ≥ 50 percent **and** have improved by ≥ 2 percentage points from the previous quarter.

GeoAccess Provider Network Accessibility Assessment

HSAG used a standard reporting table to aggregate the GeoAccess mapping results for each provider type. HSAG determined whether the results for each provider type were compliant or noncompliant with the contract standards. HSAG then reviewed each MCO's reports to determine whether the MCO developed interventions to address network deficiencies.

How Conclusions Were Drawn

HSAG determined that results of network adequacy activities could provide information about MCO performance related to the quality, timeliness, and access domains of care. For example, HSAG determined that GeoAccess mapping not only provides insight into whether the access to specific providers is sufficient, but also that if network gaps exist, the quality of care a member receives may be impacted if care is received by nonqualified providers or not received at all. HSAG used analysis of the network data obtained to draw conclusions about Healthy Louisiana member access to particular provider networks (e.g., primary, specialty, or behavioral health care) in specified geographic regions. The data also allowed HSAG to draw conclusions regarding the quality of the MCOs' ability to track and monitor their respective provider networks.

To draw conclusions about the quality, timeliness, and accessibility of care provided by the Medicaid MCOs, HSAG assigned each of the components reviewed for NAV activities to one or more of three domains of care. This assignment to domains of care is depicted in Table 5-11.

Table 5-11—Assignment of NAV Activities to the Quality, Timeliness, and Access Domains

NAV Activity	Quality	Timeliness	Access
PDV	✓		✓
Provider Access Survey	✓	✓	✓
GeoAccess Provider Network Accessibility Assessment	✓		✓

Results

Table 6-1 presents UHC's 2022 and 2023 adult achievement scores.

Table 6-1—Adult Achievement Scores for UHC

Measure	2022	2023
Rating of Health Plan	81.51%	82.05%
Rating of All Health Care	NA	79.85%
Rating of Personal Doctor	86.24%	88.68% ↑
Rating of Specialist Seen Most Often	NA	NA
Getting Needed Care	NA	87.02% ↑
Getting Care Quickly	NA	80.74%
How Well Doctors Communicate	NA	93.98%
Customer Service	NA	NA

A minimum of 100 respondents is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of respondents are denoted as *Not Applicable (NA)*.
↑ *Indicates the 2023 score is statistically significantly higher than the 2023 NCQA national average.*
↓ *Indicates the 2023 score is statistically significantly lower than the 2023 NCQA national average.*
▲ *Indicates the 2023 score is statistically significantly higher than the 2022 score.*
▼ *Indicates the 2023 score is statistically significantly lower than the 2022 score.*

Table 6-2 presents UHC's 2022 and 2023 general child achievement scores.

Table 6-2—General Child Achievement Scores for UHC

Measure	2022	2023
Rating of Health Plan	90.19%	89.86%
Rating of All Health Care	91.54%	94.33% ↑
Rating of Personal Doctor	91.98%	91.79%
Rating of Specialist Seen Most Often	NA	NA
Getting Needed Care	NA	92.56% ↑
Getting Care Quickly	NA	88.03%
How Well Doctors Communicate	93.65%	97.49% ▲ ↑
Customer Service	NA	NA

A minimum of 100 respondents is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of respondents are denoted as *Not Applicable (NA)*.
↑ *Indicates the 2023 score is statistically significantly higher than the 2023 NCQA national average.*
↓ *Indicates the 2023 score is statistically significantly lower than the 2023 NCQA national average.*
▲ *Indicates the 2023 score is statistically significantly higher than the 2022 score.*
▼ *Indicates the 2023 score is statistically significantly lower than the 2022 score.*

MCO Strengths, Opportunities for Improvement, and Recommendations

For UHC, the following strengths were identified:

- For the adult population, UHC's achievement scores for *Rating of Personal Doctor* and *Getting Needed Care* were statistically significantly higher than the 2023 NCQA national averages. **[Quality and Access]**
- For the general child population, UHC's achievement scores for *Rating of All Health Care*, *Getting Needed Care*, and *How Well Doctors Communicate* were statistically significantly higher than the 2023 NCQA national averages. UHC's 2023 achievement score for *How Well Doctors Communicate* was statistically significantly higher in 2023 than in 2022. **[Quality and Access]**

For UHC, the following opportunities for improvement were identified:

- For the adult and general child populations, UHC's 2023 achievement scores were not statistically significantly lower than in 2022, and scores were not statistically significantly lower than the 2023 NCQA national average on any measure; therefore, no opportunities for improvement were identified.

For UHC, the following recommendation was identified:

- HSAG recommends UHC monitor the measures to ensure significant decreases in scores over time do not occur. **[Quality, Timeliness, and Access]**

Methodology

Objectives

The CAHPS activity assesses members' experiences with an MCO and its providers, and the quality of care they receive. The goal of the CAHPS surveys is to provide feedback that is actionable and will aid in improving members' overall experiences.

Technical Methods of Data Collection and Analysis

The MCOs accomplished the technical method of data collection by administering the CAHPS 5.1H Adult Medicaid Health Plan Survey to the adult Medicaid population, and the CAHPS 5.1H Child Medicaid Health Plan Survey (with the Children with Chronic Conditions [CCC] measurement set) to the child Medicaid population. The MCOs employed various methods of data collection used for the CAHPS surveys, such as mixed-mode (i.e., mailed surveys followed by telephone interviews of non-respondents) and mixed-mode and Internet protocol methodology (i.e., mailed surveys with an Internet link included on the cover letter followed by telephone interviews of non-respondents). In addition, some MCOs had an option for members to complete the survey in Spanish and Chinese. Adult members and parents/caretakers of child members completed the surveys from February through May 2023, following NCQA's data collection protocol.

The CAHPS 5.1H Medicaid Health Plan Surveys included a set of standardized items (40 items for the CAHPS 5.1H Adult Medicaid Health Plan Survey and 76 items for the CAHPS 5.1H Child Medicaid Health Plan Survey with CCC measurement set) that assessed members' experiences with care. The survey categorized questions into eight measures of experience. These measures included four global ratings and four composite measures.[6-1] The global ratings reflected patients' overall experiences with their personal doctor, specialist, MCO, and all healthcare. The composite measures were derived from sets of questions to address different aspects of care (e.g., *Getting Needed Care* and *How Well Doctors Communicate*).

For each of the four global ratings, HSAG calculated the percentage of respondents who chose a positive experience rating (a response value of 8, 9, or 10 on a scale of 0 to 10). For each of the four composite measures, HSAG calculated the percentage of respondents who chose a positive response. CAHPS composite measure response choices were "Never," "Sometimes," "Usually," or "Always." A positive response for the composite measures was a response of "Usually" or "Always."

[6-1] For this report, the 2023 Child Medicaid CAHPS results presented are based on the CAHPS survey results of the general child population only (i.e., results for children selected as part of the general child CAHPS sample). Therefore, results for the CAHPS survey measures evaluated through the CCC measurement set of questions (i.e., five CCC composite scores and items) and CCC population are not presented in this report.

For this report, HSAG included results for a CAHPS measure even when the NCQA minimum reporting threshold of 100 respondents was not met. Caution should be exercised when interpreting results for those measures with fewer than 100 respondents. HSAG used a cross (+) to denote CAHPS scores with fewer than 100 respondents. Additionally, for this report, HSAG compared the adult and general child Medicaid populations' survey findings to the 2023 NCQA CAHPS adult and general child Medicaid national averages.[6-2]

HSAG compared each measure rate to the 2023 NCQA national average and identified a statistically significant difference by using the confidence interval for each measure rate. Information provided below the figures discusses statistically significant differences between each measure rate's lower and upper confidence intervals and the 2023 NCQA national average.

Description of Data Obtained

The CAHPS survey asks adult members or parents/caretakers of child members to report on and to evaluate their/their child's experiences with healthcare. The survey covers topics important to members, such as the communication skills of providers and the accessibility of services. The MCOs contracted with a CAHPS vendor to administer the survey to adult members and parents/caretakers of child members. The CAHPS survey asks about members' experiences with their MCO during the last six months of the measurement period (i.e., July through December 2022).

The MCOs' CAHPS vendors administered the surveys from February to May 2023. The CAHPS survey response rate is the total number of completed surveys divided by all eligible members of the sample. A survey received a disposition code of "completed" if at least three of the designated five questions were completed.[6-3] Eligible members included the entire sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, were invalid (they did not meet the eligible population criteria), had a language barrier, or were mentally or physically incapacitated (adult Medicaid only). The survey also identified ineligible members during the process. The survey vendor recorded this information and provided it to HSAG in the data received.

How Data Were Aggregated and Analyzed

HSAG performed a trend analysis of the results in which the 2023 achievement scores were compared to their corresponding 2022 achievement scores to determine whether there were statistically significant differences. Statistically significant differences between the 2023 achievement scores and the 2022 achievement scores are noted with directional triangles. An MCO's score that performed statistically significantly higher in 2023 than 2022 is noted with a black upward (▲) triangle. An MCO's score that performed statistically significantly lower in 2023 than 2022 is noted with a black downward (▼)

6-2 National data were obtained from NCQA's 2023 Quality Compass.

6-3 A survey was assigned a disposition code of "completed" if at least three of the following five questions were completed for adult Medicaid: questions 3, 10, 19, 23, and 28. A survey was assigned a disposition code of "completed" if at least three of the following five questions were completed for child Medicaid: questions 3, 25, 40, 44, and 49.

triangle. An MCO that did not perform statistically significantly higher or lower between years is not denoted with a triangle.

Additionally, HSAG compared MCO scores to the NCQA national averages to determine if there were any statistically significant differences. An MCO that performed statistically significantly higher than the 2023 NCQA national average was denoted with a green upward (↑) arrow.[6-4] Conversely, an MCO that performed statistically significantly lower than the 2023 NCQA national average was denoted with a red downward (↓) arrow. An MCO that did not perform statistically significantly higher or lower than the 2023 NCQA national average was not denoted with an arrow.

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of care and services that each MCO provided to members, HSAG compared each MCO's 2023 survey results to the 2023 NCQA national averages to determine if there were any statistically significant differences. HSAG drew conclusions concerning quality of care, timeliness of care, and/or access to care by evaluating the questions included in each of the global ratings and composite measures presented in this report and relating the questions to the definitions of the three domains. This assignment to the domains is depicted in Table 6-3.

Table 6-3—Assignment of CAHPS Survey Measure Activities to the Quality, Timeliness, and Access Domains

CAHPS Survey Measure	Quality	Timeliness	Access
Rating of Health Plan	✓		
Rating of All Health Care	✓		
Rating of Personal Doctor	✓		
Rating of Specialist Seen Most Often	✓		
Getting Needed Care	✓		✓
Getting Care Quickly	✓	✓	
How Well Doctors Communicate	✓		
Customer Service	✓		

[6-4] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2023.* Washington, DC: NCQA, September 2023.

7. Behavioral Health Member Satisfaction Survey

Results

Table 7-1 presents the adult 2023 achievement scores for UHC and the Healthy Louisiana SWA.

Table 7-1—Adult Achievement Scores for UHC

Measure	2023	Healthy Louisiana SWA
Rating of Health Plan	60.16%	58.96%
How Well People Communicate	87.10%	90.06%
Cultural Competency	75.00%+	73.77%+
Helped by Counseling or Treatment	65.63%	67.65%
Treatment or Counseling Convenience	86.51%	86.70%
Getting Needed Treatment	73.60%	77.08%
Help Finding Counseling or Treatment	54.17%+	47.04%
Customer Service	70.00%+	67.14%+
Helped by Crisis Response Services	79.17%+	76.09%

Scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a measure, caution should be exercised when interpreting results.
↑ *Indicates the 2023 score is statistically significantly higher than the 2023 Healthy Louisiana SWA.*
↓ *Indicates the 2023 score is statistically significantly lower than the 2023 Healthy Louisiana SWA.*

Table 7-2 presents the child 2023 achievement scores for UHC and the Healthy Louisiana SWA.

Table 7-2—Child Achievement Scores for UHC

Measure	2023	Healthy Louisiana SWA
Rating of Health Plan	64.66%	62.67%
How Well People Communicate	92.59%	92.54%
Cultural Competency	100%+	97.85%+
Helped by Counseling or Treatment	56.90%	58.20%
Treatment or Counseling Convenience	89.66%	89.52%
Getting Needed Treatment	77.39%	77.36%
Help Finding Counseling or Treatment	35.00%+	41.85%+
Customer Service	58.82%+	61.54%+
Getting Professional Help	89.74%	88.83%
Help to Manage Condition	85.47%	85.94%

Scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a measure, caution should be exercised when interpreting results.
↑ *Indicates the 2023 score is statistically significantly higher than the 2023 Healthy Louisiana SWA.*
↓ *Indicates the 2023 score is statistically significantly lower than the 2023 Healthy Louisiana SWA.*
— *Indicates the MCO's score was not reported due to insufficient data.*

MCO Strengths, Opportunities for Improvement, and Recommendations

For UHC, the following strengths were identified:

- For the adult and child populations, UHC did not score statistically significantly higher than the 2023 Healthy Louisiana SWA on any measure; therefore, no strengths were identified.

For UHC, the following opportunities for improvement were identified:

- For the adult and child populations, UHC did not score statistically significantly lower than the 2023 Healthy Louisiana SWA on any measure; therefore, no opportunities for improvement were identified.

For UHC, the following recommendations were identified:

- HSAG recommends UHC monitor the measures to ensure significant decreases in scores over time do not occur. **[Quality, Timeliness, and Access]**
- HSAG recommends UHC focus on increasing response rates to the behavioral health member satisfaction survey for both populations so there are greater than 100 respondents for each measure. This can be achieved by educating and engaging all employees to increase their knowledge of surveys and providing awareness to members during the survey period. Additionally, member-facing teams, such as the customer service team, could consider asking members if they know about the behavioral health member satisfaction survey and, if they received the survey, what barriers may prevent them from responding to the survey. These questions can be asked during routine contacts with members or when members outreach to UHC. The information provided by these members could be shared with LDH to help identify solutions to address low response rates. **[Quality, Timeliness, and Access]**

Methodology

Objectives

The primary objective of this activity is to gather direct feedback from Healthy Louisiana adult members and parents/caretakers of child members who received behavioral health services regarding their experiences and the quality of the services they received. The survey covers topics that are important to members, such as the communication skills of people they saw for counseling or treatment and the accessibility of behavioral health services. This feedback will aid in improving overall experiences of adults and parents/caretakers of child members who receive behavioral health services.

Technical Methods of Data Collection and Analysis

To conduct the activity, HSAG, with support from LDH, developed and administered a custom behavioral health member satisfaction survey to the Healthy Louisiana MCO members. The survey was administered to adult members and parents/caretakers of child members identified as having three or more specified outpatient behavioral health encounters during the measurement period. All adult members and parents/caretakers of sampled child members completed the survey from July to September 2023.

The adult and child behavioral health member satisfaction survey included one global measure question, one composite measure, and 11 individual item measures. The global measure (also referred to as global rating) reflects overall member experience with the MCO. The composite measure is a set of questions grouped together to address a specific aspect of care (i.e., *How Well People Communicate)*. The individual item measures are individual questions that look at different areas of care (e.g., *Cultural Competency* or *Helped by Counseling or Treatment*).

For the global rating, HSAG calculated the percentage of respondents who chose a positive experience rating (i.e., a response of 9 or 10 on a scale of 0 to 10). For the composite measure, HSAG calculated the percentage of respondents who chose a positive response. The composite measure response choices were "Never," "Sometimes," "Usually," or "Always." A positive response for the composite measure was a response of "Usually" or "Always." For the individual item measures, HSAG calculated the percentage of respondents who chose a positive response (i.e., "Usually/Always," "Yes," "A lot," or "Not a problem").

For this report, HSAG included results for a measure even when there were less than 100 respondents. Caution should be exercised when interpreting results for those measures with fewer than 100 respondents. HSAG used a cross (+) to denote scores with fewer than 100 respondents.

Description of Data Obtained

The behavioral health member satisfaction survey asked adult members or parents/caretakers of child members to report on and to evaluate their/their child's experiences with behavioral health services. HSAG requested sample frame data files from each MCO that included the following information related to each member of the eligible population: name, gender, date of birth, mailing address, telephone number, primary language, race, and ethnicity. HSAG utilized information received in the sample frame data files to conduct the behavioral health member satisfaction survey.

How Data Were Aggregated and Analyzed

HSAG compared the MCO-specific results to the total MCO program average to determine if the results were significantly different. The total MCO program results were weighted based on the eligible population included in each MCO. An MCO that performed statistically significantly higher than the program average was denoted with an upward black (↑) arrow. Conversely, an MCO that performed statistically significantly lower than the program average was denoted with a downward black (↓) arrow. An MCO that did not perform statistically significantly different than the program average was not denoted with an arrow. Comparisons to national data could not be performed given the custom nature of the survey instruments administered.

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and access to care and services provided by the MCOs, HSAG assigned the measures evaluated in the behavioral health member satisfaction survey to one or more of these three domains. This assignment to domains is shown in Table 7-3.

Table 7-3—Assignment of Behavioral Health Member Satisfaction Survey Measures to the Quality, Timeliness, and Access Domains

Behavioral Health Member Satisfaction Survey Measure	Quality	Timeliness	Access
Rating of Health Plan	✓		
How Well People Communicate	✓		
Cultural Competency	✓		
Helped by Counseling or Treatment	✓		
Treatment or Counseling Convenience			✓
Getting Counseling or Treatment Quickly	✓	✓	
Getting Needed Treatment	✓		✓
Barriers to Counseling or Treatment	✓		✓
Help Finding Counseling or Treatment	✓		✓

Behavioral Health Member Satisfaction Survey Measure	Quality	Timeliness	Access
Customer Service	✓		
Crisis Response Services Used			✓
Receipt of Crisis Response Services			✓
Helped by Crisis Response Services	✓		
Getting Professional Help	✓		✓
Help to Manage Condition	✓		

8. Case Management Performance Evaluation

Introduction

States may direct their EQROs to conduct focus studies for QI, administrative, legislative, or other purposes. Focus studies may examine clinical or nonclinical aspects of care provided by MCOs and assess quality of care at a specific point in time. LDH contracted with HSAG to conduct a focused CMPE to evaluate the MCO's compliance with the CM provisions of its contract with LDH and determine the effectiveness of CM activities.

Activities Conducted During SFY 2023

During SFY 2023, HSAG and LDH collaborated to determine the scope, methodology, data sources, and timing of the CMPE. HSAG will conduct the focus study, which will commence in SFY 2024, in accordance with CMS EQR *Protocol 9. Conducting Focus Studies of Health Care Quality: An Optional EQR-Related Activity*, February 2023.[8-1]

At the time of this report, the CMPE had not been completed. Results, including conclusions, strengths, and opportunities for improvement, will be reported in the SFY 2024 EQR technical report.

Methodology

Objectives

LDH requires the Healthy Louisiana MCO reporting of data on CM services to determine the number of individuals, the types of conditions, and the impact that CM services have on enrollees receiving those services. LDH established CM requirements to ensure that the services provided to enrollees with special health care needs (SHCN) are consistent with professionally recognized standards of care. To assess MCO compliance with CM elements, LDH requested that HSAG evaluate the MCOs' compliance with the CM provisions of their contracts with LDH, including the rates of engagement in CM; the specific services offered to enrollees receiving CM; and the effectiveness of CM in terms of increasing the quality of care, increasing the receipt of necessary services, and reducing the receipt of potentially unnecessary services such as acute care.

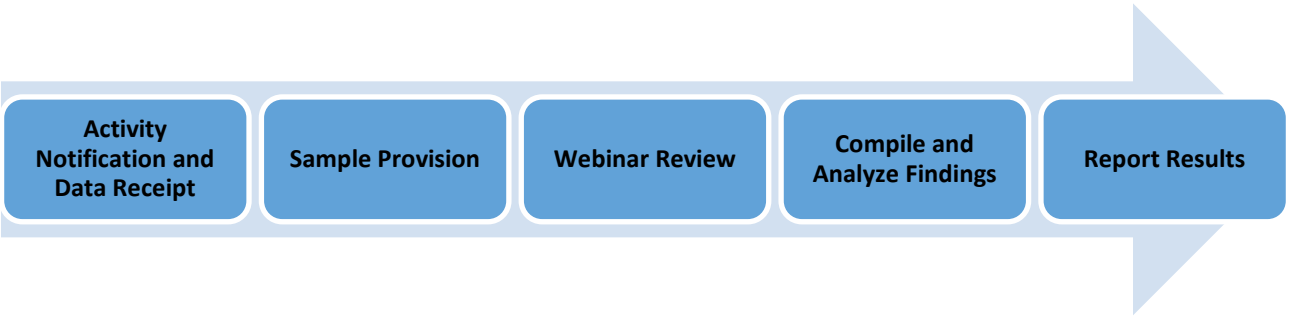
HSAG's CMPE review tool will comprehensively address the services and supports that are necessary to meet enrollees' needs. The tool will include elements for review of CM documentation and enrollee care

[8-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 9. Conducting Focus Studies of Health Care Quality: An Optional EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 19, 2023.

plans to ensure that they are consistent with a person-centered approach to care planning and service delivery and that outcomes are being achieved or progress is being made toward their achievement. The CMPE review tool will include MCO contract requirements, evaluation criteria of those requirements, and reviewer determinations of performance.

Review Process

HSAG's CM Review process will include five activities:



Activity 1: Activity Notification and Data Receipt

To initiate the CM Review, HSAG will conduct an activity notification webinar for the MCOs. During the webinar, HSAG will provide information about the activity and expectations for MCO participation, including provision of data. HSAG will request the LA PQ039 Case Management report from each MCO.

Table 8-1—Activity 1: Activity Notification and Data Receipt

For this step,	HSAG will…
Step 1:	**Notify the MCOs of the review.**
	HSAG will host a webinar to introduce the activity to the MCOs. The MCOs will be provided a timeline, review tools, and a question and answer (Q&A) document post-webinar. HSAG will provide assistance to all MCOs prior to the review, including clear instructions regarding the scope of the review, timeline and logistics of the webinar review, identification of expected review participants, and any other expectations or responsibilities.
Step 2:	**Receive data universes from the MCOs.**
	HSAG will review the data received from the MCOs for completeness.

Activity 2: Sample Provision

Upon receipt of each MCO's LA PQ039 Case Management report, HSAG will review the data to ensure completeness for sample selection. To be included in the sample, the enrollee must meet the following criteria:

- Have a classification of "SHCN-MED," "SHCN-BH," or "SHCN-BOTH." HSAG will identify these enrollees by the "reason identified for case management" field provided in the LA PQ039 Case Management report.
- Current CM span began on or before June 1, 2023. HSAG will identify these enrollees by the "date entered case management" field provided in the LA PQ039 Case Management report.
- Enrollees with a CM span of at least three months. HSAG will identify these enrollees by utilizing data from the "date entered case management" and "date exited case management" fields provided in the LA PQ039 Case Management report.

Enrollees who are identified by the MCOs for CM but not enrolled will be excluded from the sample. HSAG will exclude any enrollees identified in the "members identified, but not enrolled" field in the LA PQ039 Case Management report.

In future review years, HSAG will collaborate with LDH to determine any changes to the sampling criteria, including exclusions such as enrollees who were selected for the review the year prior.

Based on the inclusion criteria, HSAG will generate a random sample of 110 enrollees for each MCO, which includes a 10 percent oversample to account for exclusions or substitutions. HSAG will provide each MCO with its sample 10 business days prior to the webinar review. The MCO will be given five business days to provide HSAG with any requests for exclusions or substitutions. If the oversample is not large enough to obtain the necessary sample size, HSAG will select additional random samples to fulfill the sample size. The final sample of cases (100 total) will be confirmed with the MCO no later than three business days prior to the webinar review.

Table 8-2—Activity 2: Sample Provision

For this step,	HSAG will…
Step 1:	**Identify enrollees for inclusion in the sample.**
	HSAG will utilize the data provided in each MCO's LA PQ039 Case Management report.
Step 2:	**Provide the sample to the MCOs.**
	HSAG will provide the 100-enrollee sample and 10-enrollee oversample to each MCO 10 business days prior to the webinar review. The sample will be provided via HSAG's SAFE site.
Step 3:	**Finalize the sample.**
	The MCOs will provide HSAG with any requests for exclusions or substitutions to the sample within five business days of receipt of the sample file from HSAG. HSAG will provide the final sample of 100 enrollee cases to each MCO no later than three business days prior to the webinar.

Activity 3: Webinar Review

HSAG will collaborate with the MCOs to schedule and conduct webinar reviews with key MCO staff members to:

- Ensure understanding of terminology and documents used by the MCO to record CM activities.
- Review sampled cases to determine compliance with contractual requirements.

The webinar review consists of several key activities:

- Entrance Conference: HSAG will dedicate the first 15 minutes of each webinar to introduce the activity and the HSAG review team, and to provide key logistics of the review. HSAG will review documentation naming conventions with the MCO to ensure understanding of the information that will be displayed by the MCO and reviewed during the activity.
- Case Review: HSAG will conduct a review of each sample file. The MCO's CM representative(s) will navigate the MCO's CM system and respond to HSAG reviewers' questions. The review team will determine evidence of compliance with each of the scored elements on the CM Review tool. Concurrent interrater reliability will be conducted by the HSAG team lead to respond to questions from the review team in real time so that feedback can be provided to the MCO, and any discrepancies addressed, prior to the end of the review.
- Leadership Meeting (optional): HSAG will schedule a meeting with the MCO and LDH to discuss the progress of the review and provide preliminary findings. The meeting will also allow HSAG to confirm information that may be needed to complete the review of cases, and for the MCO to ensure understanding of LDH's expectations.
- Exit Conference: HSAG will schedule a 30-minute exit conference with the MCO and LDH. During the exit conference, HSAG will provide a high-level summary of the cases reviewed, preliminary findings, and recommendations to address opportunities for improvement.

Table 8-3—Activity 3: Webinar Review

For this step,	HSAG will…
Step 1:	**Provide the MCOs with webinar dates.**
	HSAG will provide the MCOs with their scheduled webinar dates. HSAG will consider MCO requests for alternative dates or accommodations.
Step 2:	**Identify the number and types of reviewers needed.**
	HSAG will assign review team members who are content area experts with in-depth knowledge of CM requirements who also have extensive experience and proven competency conducting case reviews. To ensure interrater reliability, HSAG reviewers are trained on the review methodology to ensure that the determinations for each element of the review are made in the same manner.

For this step,	HSAG will…
Step 3:	**Conduct the webinar review.**
	During the webinar, HSAG will set the tone, expectations, and objectives for the review. MCO staff members who participate in the webinar reviews will navigate their documentation systems, answer questions, and assist the HSAG review team in locating specific documentation. As a final step, HSAG will meet with MCO staff members and LDH to provide a high-level summary and next steps for receipt of findings.

Scoring Methodology

HSAG will use the CM Review tool to record the results of the case reviews. HSAG will use a two-point scoring methodology. Each requirement will be scored as *Met* or *Not Met* according to the criteria identified below. HSAG will also use a designation of *NA* if the requirement is not applicable to a record; *NA* findings will not be included in the two-point scoring methodology.

Met indicates full compliance defined as the following:

- All documentation listed under contract requirements was present in the case file.
- Cases reviewed met the scoring criteria assigned to each requirement.
- Cases reviewed had documentation that met "due diligence" criteria.

Not Met indicates noncompliance defined as either of the following:

- Cases reviewed did not meet the scoring criteria assigned to each requirement.
- Not all documentation was present.

Not Applicable (NA) indicates a requirement that will not be scored for compliance based on the criteria listed for the specific element in the Review Tool and Evaluation Criteria document.

HSAG will calculate the overall percentage-of-compliance score for each of the requirements. HSAG calculated the score for each requirement by adding the score from each case, indicating either a score of *Met* (value: 1 point) or *Not Met* (value: 0 points), and dividing the summed scores by the total number of applicable cases. Data analysis will also include aggregate performance by domain.

Reporting of Abuse, Neglect, or Exploitation (ANE)

If, during the review process, a reviewer identifies potential ANE of an enrollee, HSAG will report the concern to the MCO immediately upon identification and to LDH within 24 hours of identification. If the reviewer identifies a potential health, safety, or welfare concern that does not rise to the level of an ANE, HSAG will report the concern to the MCO and LDH at the identification of the concern and no later than the end of the webinar review.

Activity 4: Compile and Analyze Findings

Following the webinar review, HSAG will compile and analyze findings for each MCO. Findings will include performance by domain and each scored element. Additional data gathering information may be compiled to inform analysis and results (e.g., program information such as the total number of enrollees in CM during the lookback period).

Domain and Element Performance

Findings will be compiled into domains, which represent a set of elements related to a specific CM activity (e.g., assessment, care planning). Domain performance is calculated by aggregating the scores for each element in the domain and dividing by the total number of applicable cases. Domain performance scores provide a high-level result to inform analysis of opportunities for improvement.

Analysis of scored element performance allows for targeted review of individual elements that may impact overall domain performance. Individual element performance scores will be used to inform analysis of specific opportunities for improvement, especially when an element is performing at a lower rate than other elements in the domain.

Analysis of findings will include identification of opportunities for improvement.

Activity 5: Report Results

HSAG will develop a draft and final report of results and findings for each MCO. The report will describe the scores assigned for each requirement, assessment of the MCO's compliance by domain, and recommendations for improvement. Following LDH's approval of the draft report, HSAG will issue the final report to LDH and each MCO.

How Conclusions Were Drawn

Upon completion of the activity, HSAG will provide results for each MCO in three performance domains: Assessment, Care Planning, and Enrollee Interaction and Coordination of Services. Each domain includes scored elements, displayed in Table 8-4, which demonstrate each MCO's compliance with contractual requirements.

Table 8-4—Assignment of CMPE Measures to the Quality, Timeliness, and Access Domains

CMPE Measure	Quality	Timeliness	Access
The enrollee's initial health needs assessment was completed within 90 calendar days of enrollment.		✓	
The enrollee's initial comprehensive assessment was completed within 90 calendar days of identification of SHCN.		✓	

CMPE Measure	Quality	Timeliness	Access
A reassessment was completed in person quarterly with the enrollee.		✓	
A plan of care (POC) was developed within 30 calendar days of identification of risk stratification.		✓	
A POC was developed within 90 calendar days of identification of risk stratification.		✓	
The MCO developed and implemented a person-centered care plan reflective of the most recent assessment and included all enrollee goals, needs, and risks as well as the formal and informal supports responsible for assisting the enrollee with the POC.	✓		
The POC was updated per the enrollee's tier schedule.		✓	
The POC was updated when the enrollee's circumstances or needs changed significantly, or at the request of the enrollee, their parent or legal guardian, or a member of the multidisciplinary care team.	✓		
The MCO developed a multidisciplinary care team, including the case manager, enrollee and/or authorized representative, and members based on the enrollee's specific care needs and goals.	✓		✓
The multidisciplinary care team was convened at regular intervals required for the enrollee's tier level.		✓	
The case manager made valid timely contact, or due diligence is documented in the enrollee's record.		✓	
For enrollees demonstrating needs requiring coordination of services, the case manager coordinated needed care/services, actively linking the enrollee to providers; medical services; and residential, social, community, and other support services.	✓		✓

Results

The 2023 (CY 2022) QRS results for UHC are displayed in Table 9-1.

Table 9-1—2023 (CY 2022) QRS Results

Composites and Subcomposites	UHC
Overall Rating*	**3.5**
Consumer Satisfaction	**4.0**
Getting Care	4.0
Satisfaction with Plan Physicians	4.0
Satisfaction with Plan Services	4.5
Prevention	**3.0**
Children and Adolescent Well-Care	2.5
Women's Reproductive Health	3.0
Cancer Screening	4.0
Other Preventive Services	3.0
Treatment	**3.0**
Respiratory	1.5
Diabetes	4.0
Heart Disease	3.0
Behavioral Health—Care Coordination	1.5
Behavioral Health—Medication Adherence	2.0
Behavioral Health—Access, Monitoring, and Safety	4.0
Risk-Adjusted Utilization	1.0

**This rating includes all measures in the 2023 Health Plan Report Card as well as an Accreditation bonus for those MCOs that are NCQA Accredited.*
Insufficient Data indicates that the plan was missing most data for the composite or subcomposite.

UHC received an Overall Rating of 3.5 points, with 4.0 points for the Consumer Satisfaction composite, 3.0 points for the Prevention composite, and 3.0 points for the Treatment composite.

MCO Strengths, Opportunities for Improvement, and Recommendations

For UHC, the following strengths were identified:

- For the Consumer Satisfaction composite, UHC received 4.5 points for the Satisfaction with Plan Services subcomposite, 4.0 points for the Satisfaction with Plan Physicians subcomposite, and 4.0 points for the Getting Care subcomposite. These subcomposites are based on UHC member responses to CAHPS surveys questions, demonstrating UHC members are satisfied with their health plan, providers, and the care they receive. **[Quality]**
- For the Prevention composite, UHC received 4.0 points for the Cancer Screening subcomposite, demonstrating strength for UHC related to ensuring women receive breast and cervical cancer screenings. **[Quality and Access]**
- For the Treatment composite, UHC received 4.0 points for the Diabetes subcomposite, demonstrating strength for UHC related to diabetic care. UHC also received 4.0 points for the Behavioral Health—Access, Monitoring, and Safety subcomposite, demonstrating strength for UHC related to care for adults and children using antipsychotics, and children using ADHD medication. **[Quality, Access, and Timeliness]**

For UHC, the following opportunities for improvement were identified:

- For the Treatment composite, UHC received 2.0 points for the Behavioral Health—Medication Adherence subcomposite, demonstrating opportunities for UHC to ensure adherence to prescribed medications for mental illness and substance use. UHC received 1.5 points for the Respiratory subcomposite, demonstrating opportunities for UHC to ensure appropriate treatment of upper respiratory infections and acute bronchitis. UHC received 1.5 points for the Behavioral Health—Care Coordination subcomposite, demonstrating opportunities for UHC to ensure timely follow-up after hospitalizations and ED visits for mental illness. UHC also received 1.0 point for the Risk-Adjusted Utilization subcomposite, demonstrating opportunities for UHC to improve unplanned readmission rates.

UHC should reference the recommendations made in Section 3—Validation of Performance Measures and Section 6—Consumer Surveys: CAHPS-A and CAHPS-C as the 2023 Health Plan Report Card reflects HEDIS and CAHPS results.

Methodology

Objectives

HSAG was tasked with developing a QRS to evaluate the performance of the five Healthy Louisiana Medicaid MCOs (i.e., ABH, ACLA, HBL, LHCC, and UHC) relative to national benchmarks and assign ratings to each MCO in key areas. The 2023 Health Plan Report Card is targeted toward a consumer audience; therefore, it is user friendly, easy to read, and addresses areas of interest for consumers.

Technical Methods of Data Collection

HSAG received MY 2022 CAHPS member-level data files and HEDIS IDSS data files from LDH and the five MCOs. The *HEDIS MY 2022 Specifications for Survey Measures, Volume 3* was used to collect and report on the CAHPS measures. The *HEDIS MY 2022 Technical Specifications for Health Plans, Volume 2* was used to collect and report on the HEDIS measures.

Description of Data Obtained

HSAG received the final, auditor-locked HEDIS IDSS data files from each of the MCOs, as well as the CAHPS member-level data files and summary reports. HSAG also downloaded the 2022 (MY 2021) Quality Compass national Medicaid all lines of business (ALOB) benchmarks for this analysis.[9-1]

How Data Were Aggregated and Analyzed

Using the HEDIS and CAHPS measure results for each MCO, HSAG calculated MCO ratings in alignment with NCQA's 2023 Health Plan Ratings Methodology, where possible, for the following composites and subcomposites:[9-2]

- Overall
- Consumer Satisfaction
  - Getting Care
  - Satisfaction with Plan Physicians
  - Satisfaction with Plan Services

[9-1] 2022 (MY 2021) Quality Compass national Medicaid ALOB benchmarks were used since LDH requested a finalized report card by October 1, 2023, and 2023 (MY 2022) Quality Compass national Medicaid ALOB benchmarks were not available until September 29, 2023.

[9-2] National Committee for Quality Assurance. 2023 Health Plan Ratings Methodology. Available at: https://www.ncqa.org/wp-content/uploads/2022/12/2023-HPR-Methodology_12.14.2022.pdf. Accessed on: Dec 19, 2023.

- Prevention
  - Children and Adolescent Well-Care
  - Women's Reproductive Health
  - Cancer Screening
  - Other Preventive Services
- Treatment
  - Respiratory
  - Diabetes
  - Heart Disease
  - Behavioral Health—Care Coordination
  - Behavioral Health—Medication Adherence
  - Behavioral Health—Access, Monitoring, and Safety
  - Risk-Adjusted Utilization

For each measure included in the 2023 Health Plan Report Card, HSAG compared the raw, unweighted measure rates to the 2022 (MY 2021) Quality Compass national Medicaid ALOB percentiles and scored each measure as outlined in Table 9-2. For the *Plan All-Cause Readmissions* measure, HSAG followed NCQA's methodology for scoring risk-adjusted utilization measures.

Table 9-2—Measure Rate Scoring Descriptions

Score	MCO Measure Rate Performance Compared to National Benchmarks
5	The MCO's measure rate was at or above the national Medicaid ALOB 90th percentile.
4	The MCO's measure rate was at or between the national Medicaid ALOB 66.67th and 89.99th percentiles.
3	The MCO's measure rate was at or between the national Medicaid ALOB 33.33rd and 66.66th percentiles.
2	The MCO's measure rate was at or between the national Medicaid ALOB 10th and 33.32nd percentiles.
1	The MCO's measure rate was below the national Medicaid ALOB 10th percentile.

HSAG then multiplied the scores for each measure by the weights that align with NCQA's 2023 Health Plan Ratings. For each composite and subcomposite, HSAG calculated scores using the following equation:

$$Composite\ or\ Subcomposite\ Rating = \frac{\sum(Measure\ Rating * Measure\ Weight)}{\sum(Measure\ Weights)}$$

To calculate the Overall Rating, HSAG calculated a weighted average using the weighted measure-level scores previously calculated. HSAG also added 0.5 bonus points to scores for MCOs that were Accredited or had Provisional status, and 0.15 bonus points for MCOs that had Interim status. These bonus points were added to the Overall Rating before rounding to the nearest half-point.

For the Overall Rating and each composite/subcomposite rating, HSAG aligned with NCQA's rounding rules and awarded scores as outlined in Table 9-3.

Table 9-3—Scoring Rounding Rules

Rounded Score	5	4.5	4.0	3.5	3.0	2.5	2.0	1.5	1.0	0.5	0.0
Score Range	≥4.750	4.250–4.749	3.750–4.249	3.250–3.749	2.750–3.249	2.250–2.749	1.750–2.249	1.250–1.749	0.750–1.249	0.250–0.749	0.000–0.249

How Conclusions Were Drawn

For the 2023 Health Plan Report Card, HSAG displayed star ratings based on the final scores for each rating. Stars were partially shaded if the MCO received a half rating (e.g., a score of 3.5 was displayed as 3.5 stars).

10. MCO Strengths, Opportunities for Improvement, and Recommendations

HSAG used its analyses and evaluations of EQR activity findings from SFY 2023 to comprehensively assess UHC's performance in providing quality, timely, and accessible healthcare services to Louisiana's Medicaid and CHIP members. HSAG provides UHC's strengths, opportunities for improvement, and recommendations in Table 10-1 through Table 10-3.

Table 10-1—Strengths Related to Quality, Timeliness, and Access

Overall MCO Strengths	
Quality	• UHC demonstrated a strength in women's screenings, as performance for the *Chlamydia Screening in Women*, *Breast Cancer Screening*, *Cervical Cancer Screening* measures ranked at or above the NCQA national 50th percentile benchmark and SWA. This suggests women were receiving screenings which are important for prevention, improved outcomes, and reduction of complications. • UHC demonstrated strengths in monitoring patients with diabetes, as performance for the *Eye Exam for Patients With Diabetes* and *Blood Pressure Control for Patients With Diabetes (<140/90 mm Hg)* measures as well as for both *Hemoglobin A1c Control for Patients With Diabetes* measure indicators ranked above the NCQA national 50th percentile benchmark and SWA. • UHC's performance for the following measures ranked at or above the NCQA national 50th percentile benchmark and SWA: – *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* – *Controlling High Blood Pressure* – *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics*
Quality and Access	• UHC demonstrated strengths in delivering critical aspects of preventive care for children and adolescents. Performance for the *Lead Screening in Children*, *Immunization Status for Adolescents*, and *Child and Adolescent Well-Care Visits* measures ranked at or above the NCQA national 50th percentile benchmark and SWA. • Caregivers of UHC child members reported it was easy to get the care needed and that their child's doctor's communicated well. This was evidenced by *Getting Needed Care* and *How Well Doctors Communicate* results that were statistically significantly higher than the 2023 NCQA national averages. • Caregivers of UHC child members were satisfied with their child's healthcare, as evidenced by *Rating of All Health Care* results that were statistically significantly higher than the 2023 NCQA national averages. • UHC adults members reported satisfaction with their personal doctor ad well as being able to get the care needed, as evidenced by *Rating of Personal Doctor* and *Getting Needed Care* results that were statistically significantly higher than the 2023 NCQA national average.

Overall MCO Strengths	
	• In CR, UHC met requirements 3, 4, and 5 of Standard I—Enrollment and Disenrollment, including policies that ensured members were not disenrolled based on health status, utilization of services, diminished mental capacity, or uncooperative behavior.
Access	• UHC was the highest performing MCO for GeoAccess standards for physical health and behavioral health provider types in rural areas.

Table 10-2—Opportunities for Improvement Related to Quality, Timeliness, and Access

Overall MCO Opportunities for Improvement	
Quality, Timeliness, and Access	• UHC had challenges in following up and managing the care of members that accessed the hospital or ED for mental illness and substance abuse. UHC's performance for the *Follow-Up After Hospitalization for Mental Illness*, *Follow-Up After Emergency Department Visit for Mental Illness*, and *Follow-Up After Emergency Department Visit for Substance Use* measures ranked below the NCQA national 50th percentile benchmark for all indicators. The *Follow-Up After Hospitalization for Mental Illness* and *Follow-Up After Emergency Department Visit for Mental Illness* measure rates also fell below the SWA. • UHC's performance for both *Prenatal and Postpartum Care* measure indicators ranked below the NCQA national 50th percentile benchmark and SWA.
Quality	• UHC's can improve how members with upper respiratory infections and acute bronchitis are treated. UHC's performance for the *Appropriate Treatment for Children With Upper Respiratory Infection* and *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measures ranked below the NCQA national 50th percentile benchmark and SWA. • UHC's performance for the following measures ranked below the NCQA national 50th percentile benchmark and SWA: – *Pharmacotherapy for Opioid Use Disorder* – *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* – *Antidepressant Medication Management* – *Use of Imaging Studies for Low Back Pain* – *Non-Recommended Cervical Screening in Adolescent Females*
Access	• The results of several EQR activities indicate opportunities for UHC to improve access to care for its members. UHC demonstrated a shortage of FQHCs and RHCs in urban areas and did not meet any GeoAccess standards for any ASAM or MAT provider types. In addition, the provider directory information maintained and provided by UHC was poor.

Table 10-3—Recommendations

Overall MCO Recommendations	
Recommendation	**Associated Quality Strategy Goals to Target for Improvement**
UHC should conduct a root cause analysis for the *Follow-Up After Hospitalization for Mental Illness*, *Follow-Up After Emergency Department Visit for Mental Illness*, and *Follow-Up After Emergency Department Visit for Substance Use* measures and implement appropriate interventions to improve performance, such as providing patient and provider education and enhancing communication and collaboration with hospitals to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs.	Goal 1: Ensure access to care to meet enrollee needs Goal 2: Improve coordination and transitions of care Goal 3: Facilitate patient-centered, whole-person care
UHC should convene a focus group to conduct root cause analyses to determine barriers to members with upper respiratory infections and acute bronchitis receiving appropriate treatment. The focus group should include parent/guardian and provider participation as well as subject matter experts. The focus group should recommend evidenced-based interventions that address barriers. UHC should consider holistic and novel interventions that aim to increase preventive care rates rather than reiterating previous interventions focused on specific topics or short-term campaigns.	Goal 1: Ensure access to care to meet enrollee needs Goal 4: Promote wellness and prevention Goal 7: Pay for value and incentivize innovation
HSAG recommends that UHC focus its efforts on increasing timely prenatal and postpartum care for members. UHC should also consider conducting a root cause analysis for the *Prenatal and Postpartum Care* measure and implementing appropriate interventions to improve performance, such as outreach campaigns, patient and provider education, and member incentives.	Goal 1: Ensure access to care to meet enrollee needs Goal 2: Improve coordination and transitions of care Goal 3: Facilitate patient-centered, whole-person care
To improve access to care, UHC should adopt a programmatic approach to identify barriers to access across all aspects of Medicaid operations. A planwide taskforce should include provider network staff members, utilization management staff members, and other members as determined by UHC. The taskforce should include key community stakeholders to identify barriers/facilitators to members accessing preventive and follow-up care. UHC should consider multi-tiered approaches such as: • Reviewing provider office procedures for ensuring appointment availability standards. • Conducting "secret shopper" provider office surveys. • Evaluating member use of telehealth services to determine best practices or opportunities to improve access that may be reproduceable.	Goal 1: Ensure access to care to meet enrollee needs Goal 6: Partner with communities to improve population health and address health disparities

11. Follow-Up on Prior Year's Recommendations

Regulations at 42 CFR §438.364 require an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR §438.310[c][2]) has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR. LDH required each MCO to document the follow-up actions per activity that the MCO completed in response to SFY 2020–2021 recommendations. Table 11-1 through Table 11-7 contain a summary of the follow-up actions that UHC completed in response to the previous EQRO's SFY 2022 recommendations. Furthermore, HSAG assessed UHC's approach to addressing the recommendations. Please note that the responses in this section were provided by the plans and have not been edited or validated by HSAG.

EQRO's Scoring Assessment

HSAG developed a methodology and rating system for the degree to which each health plan addressed the prior year's EQR recommendations. In accordance with CMS guidance, HSAG used a three-point rating system. The health plan's response to each EQRO recommendation was rated as *High*, *Medium,* or *Low* according to the criteria below.

High indicates *all* of the following:

- The plan implemented new initiatives or revised current initiatives that were applicable to the recommendation.
- Performance improvement directly attributable to the initiative was noted *or* if performance did not improve, the plan identified barriers that were specific to the initiative.
- The plan included a viable strategy for continued improvement or overcoming identified barriers.

A rating of *high* is indicated by the following graphic:

Medium indicates one or more of the following:

- The plan continued previous initiatives that were applicable to the recommendation.
- Performance improvement was noted that may or may not be directly attributable to the initiative.
- If performance did not improve, the plan identified barriers that may or may not be specific to the initiative.
- The plan included a viable strategy for continued improvement or overcoming barriers.

A rating of *medium* is indicated by the following graphic:

Low indicates one or more the following:

- The plan did not implement an initiative or the initiative was not applicable to the recommendation.
- No performance improvement was noted *and* the plan did not identify barriers that were specific to the initiative.
- The plan's strategy for continued improvement or overcoming identified barriers was not specific or viable.

A rating of *low* is indicated by the following graphic:

Table 11-1—Follow-Up on Prior Year's Recommendations for PIPs

1. Prior Year Recommendations from the EQR Technical Report for Performance Improvement Projects:
Recommendations
None identified.

Table 11-2—Follow-Up on Prior Year's Recommendations for Performance Measures

2. Prior Year Recommendations from the EQR Technical Report for Performance Measures:
Recommendations
UHC should target interventions to improve rates for the measures that fell below the NCQA 50th percentile.
Response
Describe initiatives implemented based on recommendations: • The following behavioral health related Healthcare Effectiveness Data and Information Set® (HEDIS®) measures for Measurement Year 2022 did not meet the goal of the National Committee for Quality Assurance (NCQA) 50th percentile: Antidepressant Medication Management (AMM) Effective Acute Phase Treatment (EAPT) and Effective Continuation Phase Treatment (ECPT), (Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM), Follow-Up After Hospitalization (FUH)-7 and -30 day, Follow-Up After Emergency Department Visit for Mental Illness (FUM)-7 and -30 day, Pharmacotherapy for Opioid Use Disorder (POD), and Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA). The following interventions were implemented to increase the rates going forward. – Antidepressant Medication Management (AMM), Follow up After Hospitalization (FUH), Follow up After Emergency Department Visit for Mental Illness (FUM), Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA). Implemented an expanded high-needs behavioral health case

2. Prior Year Recommendations from the EQR Technical Report for Performance Measures:

management program for members with high utilization. The program includes outreach and care coordination by a Community Health Worker, Behavioral Health Advocate, and/or Peer Support staff depending on member needs. Face to face or telephonic follow up by the assigned staff occurs during or immediately after a mental health hospitalization or behavioral health related emergency department visit and assistance with and encouragement to attend timely follow up appointments is provided. Staff will also encourage medication compliance for all psychotropic medications. Provider training also occurred. Email blasts to Behavioral Health Providers on medication compliance for all psychotropic medications were completed. An on-demand webcast titled: "Depression and Follow-Up After Higher Levels of Care" is promoted to providers during in-person meetings, which review FUH and FUM requirements and medication compliance issues.

- Follow up after emergency department visit for substance use disorders (FUA), Follow up After Hospitalization (FUH), Follow up after Emergency Department Visit for Mental Illness (FUM): Financially incentivized behavioral health outpatient practices for kept appointments of attributed enrollees through an Integrated Behavioral Health Home model. A fax blast was sent to all contracted Primary Care Providers (PCPs) reviewing FUA, FUH, and FUM requirements and best practices. We continued monetary incentive and shared savings programs for behavioral health providers for closing gaps in these measures.
- Follow up after hospitalization (FUH): UHC implemented a monetary member incentive which includes an enhanced appointment reminder card provided to members at the time of discharge from a mental health admission.
- Follow up FUH, FUM: UHC implemented a follow up program for individuals discharging from an emergency department admission. Members are contacted via telephone and assistance with care coordination is offered. UHC continued a monetary incentive program for PCPs whose attributed members attend successful FUH or FUM appointments.
- Pharmacotherapy for Opioid Use Disorder (POD): Eleanor Health is contracted to provide outreach and care coordination to high utilizing members with substance use disorder diagnoses. Eleanor Health provides services such as care coordination and peer support, and may also provide treatment, including Medication for Opioid Use Disorders (MOUD). These services encourage members to remain adherent to their treatment plan and keep them connected to a prescribing provider. Provider education is also sent by an email blast for behavioral health providers, as well as, presented during in-person meetings, and provider performance on POD was reviewed with each provider during meetings with Clinical Practice Consultants.

- Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM). Provider education is featured through an email blast on best practices for treatment of children and adolescents, including metabolic monitoring. An on-demand webcast titled "Behavioral Health Treatment for Children and Adolescents" is promoted to providers during in-person meetings. Provider performance on APM is reviewed with each provider during meeting with Clinical Practice Consultants. Updated PCP Toolkit on providerexpress.com to include information on best practices for children and adolescents, including metabolic testing recommendations. Information on MOUD best practices, an on-demand webcast tilted "Substance-Use Disorders in Primary Care" is promoted to providers.
- Childhood Immunization Status-combo 10 (CIS Combo 3/Combo 10/); Immunizations for Adolescents-IMA-Tdap. Meningococcal: Immunizations for Adolescents- Meningococcal (IMA) Provider education is our top priority; however, member education is also required as parents control the vaccines children receive. Through our Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, we

2. Prior Year Recommendations from the EQR Technical Report for Performance Measures:

educate providers regarding the required vaccines via our toolkits and in-person provider visits by our clinical staff. Our unique gap closure program is utilized to work with providers to allow them the visibility to detect their members who need these vaccines along with the ability to outreach to the members to get them into the office to ensure their children are receiving needed care. Members are sent mailings to remind and encourage them to receive the vaccines, along with live-calling reminders/updates.

- Adults' Access to Preventive/Ambulatory Health Services (AAP): Education is shared with members via case management along with member mailings to remind them of the need for preventative visits. Providers are educated through provider toolkits along with our gap-closure reports, so providers are able to view who they need to encourage to come into the office to have their annual wellness exam.
- Timeliness of prenatal care: Prenatal and Postpartum Care timeliness of prenatal care (PPC). Provider/Member education remains a top priority. For our members, we offer electronic contact, Interactive Voice Response (IVR) calling, member mailings along with an interactive web option (app). Providers are educated via multiple methods including in-person education along with electronic information. We continue to strive to reach our providers to ensure our members are cared for according to the specifications.
- Well-Child Visits in the First 30 Months of Life (W30 – 15 to 30 months). Members receive live callings and are mailed letters monthly discussing the benefits of prevention. Our providers are educated in person and via electronic methods to ensure they remain aware of open gaps in care for the members on their panels. Members who are part of our case management programs are outreached as needed, to ensure barriers to care are alleviated, to assist the members to see their PCP timely. Our clinical provider facing staff outreaches to providers to share education and our Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program with those providers who care for our members.
- Counseling for Nutrition/Counseling for Physical Activity (WCC). Our EPSDT Program continues to evolve. Providers have access to the gap-reports which identifies members with special gaps in care. Through these means, our providers are aware of the need for accurate coding and documentation to meet these measures. We share EPSDT toolkits along with other forms of education with our providers throughout the year. Our members are outreached through the provider and also receive mailings to ensure they are aware of the need for wellness visits and to maintain the provider/member relationship.
- Lead Screening in Children (LSC). UHC has partnered with a 3rd party vendor program to provide in-home testing kits through targeted direct mailing to identified members. Members are contacted initially, educated on the importance of lead testing, and allowed to opt into receiving an at-home test kit via phone or text. Members receive reminder letters, reminder emails, and/or SMS to encourage members to return the test kits. The member and the PCP receive the lab results, and if abnormal results are identified, a nurse directly calls the member to encourage follow-up and continuity of care.
- Statin Therapy for Patients with Cardiovascular Disease (SPC). Providers are educated on the specifications required to address open gaps in care for members as well as the need to outreach to members to ensure they are being seen timely in their office. Members who have barriers to care are assisted through our case management teams to address issues with transportation, etc. We work closely with providers throughout the state in order to ensure members receive the needed care.
- Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS). Provider Education is our focus using PATH guides and Gynecology (GYN) toolkit that has references for PCPs on measure specifics and recommended screening guidelines.

2. Prior Year Recommendations from the EQR Technical Report for Performance Measures:
Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Prospective HEDIS® data for the most recent claims run, occurring on 11/3/2023, shows increases in the AMM-EAPT, APM, FUM-7 and -30, and SAA rates in comparison to the rates at the same time in 2022. AMM-ECPT, FUH-7 and -30, and POD rates for the claims run occurring 11/3/2023 are similar, though not improved, to those for the claims run occurring at the beginning of 11/2022. • Prospective HEDIS® data for the most recent claims run, occurring on 11/13/2023, shows increases in the AAP, CIS combo 10, IMA-Tdap, Immunization for Adolescents – Human Papillomavirus Vaccine, IMA-HPV, IMA- combo 1, Lead Screening for Children LSC, PPC-timeliness of prenatal care, SPC, W30- 15-30 months, WCC-Counseling for nutrition, and WCC-counseling for physical activity rates in comparison to the rates at the same time in 2022. CIS-combo 3, NCS, and IMA- Meningococcal rates for the claims run occurring 11/13/2023 are similar, though not improved, to those for the claims run occurring at the beginning of 11/2022. • We continue to identify barriers to care for our members throughout the state. Lack of awareness of the need to establish the PCP/Member relationship seems to be at the forefront of this issue. Fear and anxiety regarding vaccines after the pandemic continues to be an educational opportunity for both Providers and members. Primary care outside the traditional 9-5 time seems to be an opportunity for Providers to establish relationships with children due to parents work schedules. We have many different cultures within the state, and meeting members where they are on a cultural level is essential to the PCP gaining the trust of the member/parents.
Identify any barriers to implementing initiatives: • Reach rates for care coordination and case management programs may not be high due to outdated or inaccurate member phone numbers or addresses being on file. Enrollees may lack motivation or availability to attend follow up appointments. Some providers may not have availability to accept new patients or schedule a timely appointment for existing patients. There may be confusion between PCP and Behavioral Health Providers regarding whose responsibility it is to order metabolic testing. Providers are being educated on training materials and their location. • We continue to identify barriers to care for our members throughout the state. Lack of awareness of the need to establish the Primary Care Physician (PCP) /Member relationship seems to be at the forefront of this issue. Fear and anxiety regarding vaccines continues to be an educational opportunity for both providers and members. Primary care outside the traditional 9-5 time seems to be an opportunity for providers to accommodate members with children due to parent/guardian work schedules. We have many different cultures within the state, and meeting members where they are on a cultural level is essential to the Primary Care Physician gaining the trust of the member.
Identify strategy for continued improvement or overcoming identified barriers: • Case management efforts will continue. Staff is working to access admissions data faster and, therefore, be able to make contact, with the member while admitted. Increased face to face outreach could increase reach rates and enrollment. Various provider outreach methods are being explored to share training materials. Email blasts and posting online are emphasizing coordination of care. • Member education along with provider education is a top priority. We try to meet the members where they are through various events/outreaches throughout the state. We continue to identify providers based on need for assistance with gap-closure. Through our provider outreach, we share members needing care who are on their panels and who have open gaps. This information is also available on our provider portal for providers to access anytime.

2. Prior Year Recommendations from the EQR Technical Report for Performance Measures:
HSAG Assessment


Table 11-3—Follow-Up on Prior Year's Recommendations for Compliance With Medicaid Managed Care Regulations

3. Prior Year Recommendations from the EQR Technical Report for Compliance With Medicaid Managed Care Regulations:
As described in Section 4—Assessment of Compliance With Medicaid Managed Care Regulations, LDH contracted with HSAG to validate UHC's remediation of the deficiencies identified in the prior year's CR CAP. HSAG reviewed UHC's responses and the additional documentation they submitted to assess whether compliance had been reached. The details of this follow-up are included in Appendix B.

Table 11-4—Follow-Up on Prior Year's Recommendations for Network Adequacy

4. Prior Year Recommendations from the EQR Technical Report for Validation of Network Adequacy:
Recommendations
None identified.

Table 11-5—Follow-Up on Prior Year's Recommendations for CAHPS

5. Prior Year Recommendations from the EQR Technical Report for Validation of Quality of Care Surveys – CAHPS Member Experience Survey:
Recommendations
None identified.

Table 11-6—Follow-Up on Prior Year's Recommendations for the Behavioral Health Member Satisfaction Survey

6. Prior Year Recommendations from the EQR Technical Report for the Behavioral Health Member Satisfaction Survey:
Recommendations
None identified.

Table 11-7—Follow-Up on Prior Year's Recommendations for the Quality Rating System

7. Prior Year Recommendations from the EQR Technical Report for MCO Quality Ratings:
Recommendations
None identified.

Appendix A. MCO Health Equity Plan Summary

For the annual EQR technical report, LDH asked HSAG to summarize information from UHC's Health Equity Plan (HEP) submission from February 2023.

Health Equity Plan

HSAG reviewed UHC's HEP submitted February 2023. In the section titled "RFP Response Related to Proposed Health Equity Approach and Experience to Date," HSAG summarized and organized each MCO's response into the following topics, for comparison among MCOs—Stated Goals; Policies and Procedures; Staffing and Resources; Leveraging Data; Social Determinants of Health; and Community, Provider, and Member Engagement Initiatives. For the other sections of the HEP, HSAG organized the discussions in this report as each MCO presented the topics in its own HEP. Therefore, comparison across MCOs for the "Health Equity Plan Development Process," "Health Equity Action Plan by Focus Area," "Plan to Conduct Cultural Responsiveness and Implicit Bias Training," and "Stratify MCO Results on Attachment H Measures" sections of the HEP is not possible.

RFP Response Related to Health Equity Approaches and Experience

HSAG summarized and organized UHC's Request for Proposal (RFP) responses into a standard set of topics as follows:

Stated Goals

UHC reported the following programmatic goals in its HEP:

- Improve the quality of care and outcomes related to maternal and infant health.
- Increase understanding of the importance of cultural sensitivity and the role of implicit bias on maternal outcomes.
- Provide integrated care to decrease acute behavioral readmissions and increase community tenure for individuals with complex needs.
- Close gaps in care.
- Promote self-management of chronic conditions such as hypertension and diabetes.
- Address disparities in well child visits and vaccinations.
- Design and deploy targeted interventions to address social determinants of health (SDOH).

Policies and Procedures

UHC reported the following organizational policies and procedural program components:

- Commit to adopting systems and policies that promote health equity.
- Develop and implement wraparound services, which include transportation services, enhanced prenatal care, teen pregnancy and parenting programs, mommy and baby support groups, physical health screenings, mental health counseling, and targeted case management.
- Value-based payments and shared savings linked to provider performance on selected performance measures.

Staffing and Resources

UHC reported commitment to the following:

- Mandatory training for case management staff includes the importance of birth equity and the role UHC plays in meeting the needs of all individuals it serves, and the through their eyes cultural competency training.
- UHC hired a local health equity director to lead a cross-functional Health Equity Action Team. (HEAT) and establish a Diversity Inclusion and Racial Equity (DIRE) committee comprised of a diverse group of Louisiana staff, and to develop and implement UHC's Health Equity Plan.
- UHC has earned the NCQA's Multicultural Health Care Distinction.
- Workforce development designed for a more ethnically and linguistically diverse provider network.

Leveraging Data

UHC reported that it:

- Uses disparity analyses using stratified data and the validated Area Deprivation Index (ADI) to identify and address priority areas for designing interventions for subpopulations.
- Tracks severe maternal morbidity (SMM) by race and ethnicity.
- Uses documentation platforms to enhance data sharing between teams for interdisciplinary rounds, case management, and consultations.
- Leverages root cause analysis (RCA) and data analysis.
- Uses data analytics tools across all departments to design, implement, and evaluate coordinated initiatives to address enrollee disparities.
- Leverages data from UHC's SDOH registry.

Social Determinants of Health

UHC reported the following activities:

- Partnering with community-based organizations (CBOs) to address SDOH.
- Analyzing provider gap reports to target providers for education about community resources.
- Collecting SDOH data from internal and external sources, which include claims (International Classification of Diseases, 10th Revision [ICD-10] Z codes), enrollee health needs assessments (HNAs) conducted via enrollee touchpoints (e.g., enrollee services, care management, community healthcare worker outreach), as well as case management documentation tracked in UHC's care management platforms.
- Analyzing SDOH measures (e.g., percentage of people who are homeless/unhoused or food insecure) by region to identify patterns of social needs across enrollee populations by both community and region.
- Using geo-mapping tools through HealthView Analytics to integrate SDOH data (such as the percentage of members with SDOH markers) by ZIP Code.
- Using proactive and regular screening for social needs and closed-loop referral to needed resources.

Community, Provider, and Member Engagement Initiatives

UHC reported that it:

- Partners with CBOs such as the March of Dimes, Family Road of Greater Baton Rouge, and the New Orleans Breastfeeding Center to provide wraparound services and address SDOH and health disparities.
- Partners with behavioral health hospitals throughout the State to improve communication with inpatient staff, provide proactive identification of needs, increase opportunities to
- address member behavioral needs upon discharge, improve relationships with providers, and minimize silos of care, thereby decreasing readmission rates and maintaining members in the community.
- Provides training to providers on implicit and explicit bias.
- Incentivizes a partner practice and offers providers additional incentives for screening for sexual transmitted infections, as well as prenatal and postpartum care.
- Offers value-based payment models to incentivize improvements to reduce disparities.
- Supports a doula program offered in New Orleans and provides grant funding to provide doula support for women as well as lactation support for new mothers.
- Expanded community- and home-based support through use of community health workers (CHWs), peer supports, and doulas.
- Uses an Enrollee Advisory Committee and community-integration models to engage stakeholders in shared decision-making and co-creation of solutions.

Health Equity Plan Development Process

UHC reported completing the following steps and priorities for developing its HEP:

- Develop a community engagement approach, which consists of five key pillars:
  a. Explore—use of data and feedback to understand disparities and inequities.
  b. Engage—build trust, cultivate, and strengthen relationships, and engage in meaningful dialogue with the community.
  c. Understand—listen with humility to respect a community's unique culture, values, and priorities.
  d. Collaborate—shared decision-making to incorporate opportunities for feedback, create a spirit of collaboration, and create positive impact across communities.
  e. Sustain—focus on initiative and program capacity and sustainability.
- Using data to address homelessness and housing instability.
- Design and deploy strategies and targeted interventions to reduce disparities.
- Using feedback to identify and execute program improvements.
- Develop strategies to share provider performance data with providers in a timely, actionable manner.
- Develop approaches to meeting care management requirements.
- Determined the following key focus areas for addressing disparities:
  a. Building social awareness and understanding of adverse childhood events (ACEs)
  b. Mobilizing trauma-informed communities
  c. Training community service providers (doctors, nurses, educators, counselors) to become trauma-informed
  d. Building referral networks of treatment providers
  e. Empowering people with the skills and resources necessary to transform personal and professional lives.
- Develop and implement care management programs with the following core components:
  a. Member stratification—use a proprietary algorithm that identifies members who have high clinical risk and impactable conditions.
  b. Multi-disciplinary team—team to include CHWs, behavioral health specialists and registered nurses who leverage other internal experts (e.g., in pharmacy, and housing) as needed.
  c. Team-based care—each member of the team contributes expertise in addressing member needs, whether face-to-face with the member or in consultation with the team.
  d. Meaningful engagement—prioritizing member-centered care.
  e. Outcomes orientation—design key performance indicators (KPIs) around advancing health outcomes and changing utilization patterns of behavior.

f. Innovation integration—leverage innovative technology and capabilities to help promote advancement of member goals.
g. Provider and community engagement—reduce barriers, strengthen relationships and, where possible, align community and natural support systems to effectively continue supporting the member beyond closure of care management.

- The following additional organizational materials and processes to support members with specific needs such as SDOH or ACEs, and the providers who support them:
  a. Providing information in UHC's Behavioral Health Toolkit for Medical Providers.
  b. UHC medical directors facilitate provider education to help community providers identify ACEs during their engagement with enrollees.
  c. Medical directors, care management teams, and supporting staff receive ongoing specialized training on ACEs and trauma-informed care.
  d. Impact Pro—a predictive modeling tool that uses more than 300 clinical indicators to analyze demographics and claims from medical, behavioral, pharmacy, and SDOH indicators to determine risk level, and identify enrollees with gaps in care, high utilization, risk markers, and condition-specific triggering events.
- Added an additional primary care incentive measure for general SDOH screening.
- Develop and/or enhance the following health equity initiatives:
  a. March of Dimes partnership for maternal health
  b. Doula program
  c. Healthy First Steps case management program
  d. Babyscripts
  e. RACI and Genoa
  f. NorthStar
  g. Developmental Disabilities Toolkit
  h. Foster Care Toolkit
  i. MAT-ER program
  j. Devereaux
  k. Partial hospital program for children on Asperger's Syndrome
  l. Comprehensive medication management program
  m. Integrated case management program
  n. Hypertension task force
  o. Comprehensive diabetes care with FQHCs
  p. Catalyst
  q. Health equity and SDOH collaborative council

r. Respite
s. Resource centers
t. Enrollee Advisory Committee (EAC)

Health Equity Action Plan by Focus Area

Table A-1 describes UHC's focus areas, goals and objectives, strategies, activities planned, and participants needed to address each focus area:

Table A-1—Addressing Focus Areas

Focus Area	Goals	Objectives	Strategies	Activities	Participants
A. Maternal Health	• Prenatal • Postpartum	By December 2023: • Increase in prenatal care visits • Improve HEDIS prenatal measures (target is 85.89 percent) • Reduce C-sections • Reduce low birth weights • Improve provider/enrollee engagement • Increase postpartum visits • Improve HEDIS postpartum measures (target is 76.40 percent)	• Enrollee and provider incentives • Education	• Maternity-focused value-based purchasing (VBP) arrangements • OB gap closure program • Promote the March of Dimes Implicit Bias Training with OB Toolkit to OB providers • Enrollee incentives for completion of the Health Needs Assessment (HNA) and postpartum visits	• African-American women ages 21-44
B. Breast Cancer Screening	Mammograms – all types and methods including: • Screening • Diagnostic • Film • Digital • Digital breast tomosynthesis	• Increase the number of breast cancer screenings (target is 50.95 percent) by December 2023	• Community Plan-Primary Care Provider incentives (CP-PCPi)	• Review: – Medical records – Consultation reports – Diagnostic reports • Accept breast cancer screening or mastectomy codes as	• Adult women ages 50 to74

Focus Area	Goals	Objectives	Strategies	Activities	Participants
				supplemental data to reduce the need for chart review	
C. Colorectal Cancer Screening	• Colonoscopy • Flexible sigmoidoscopy • CT colonography	• Increase the number of colorectal screenings (target is 39.42 percent) by December 2023	• CP-PCPi • Provider and member outreach • Provider education – including toolkit; sharing of Centers for Disease Control and Prevention (CDC) to Colorectal Cancer Screening Continuing Education, and provider portal • Community events—educate the community on the importance of screenings • Adding information to Joint Operating Committees (JOCs)	• Medical record reviews • Consultation reports • Diagnostic reports • Health history and physical • Lab reports • Pathology reports • Focusing on Region 3	• All adults ages 45 to 75

Plan to Conduct Cultural Responsiveness and Implicit Bias Training

UHC reported the following activities designed to conduct cultural responsiveness and implicit bias training:

- Monthly trainings (available to all employees and staff) to address culture and diversity, including the following topics:
  - Implicit and explicit bias
  - Attitudes
  - Awareness
  - Skills
  - Acknowledge cultural differences
  - Understand our own individual culture
  - Engage in self-assessment
  - Acquire knew knowledge and skills around culture and diversity
  - Learn to view behavior within a cultural context
- Additional single training titled Achieving Cultural Competency
- Cultural competency and bias training during the new hire process and annually
- Additional trainings quarterly and on demand, which include:
  - Health Equity
  - Across the Sexual Orientation and Gender Identity Spectrum: A Call to Action
  - Addressing Maternal Mortality
  - Caring for the LGBTQ+ Community: An Introduction
  - Disparities in Social Determinants of Health (SDOH): What Can We Do?
  - Driving Health Equity Through Technology & Service Innovation
  - Healing Racial Trauma Through Somatic Anti-Racism Practices
  - Health Disparities in Obesity
  - Health Equity Foundations
  - Racial Trauma and Health Equity Across the Lifespan
  - Sensor-Based Electronic Monitoring for Asthma: A Randomized Controlled Trial
  - Social Inequities and Health and How to Effectively Address Them
- Created Louisiana-specific training materials, Louisiana Cultural and Geographic Training, and Tribal Education to further support the unique needs of Louisiana Medicaid members.
-
- All-Staff Town Hall meetings to provide a safe place for the team to offer individual experiences, thoughts, values, and practices.

- Assessed employee demographic data to identify geographical gaps in UHC's internal workforce; developed initiatives to remove or minimize the gaps.
- Ongoing policy of recruiting, educating, retaining, and promoting staff to foster and advance a diverse representation throughout the workforce.
- Face-to-face and online provider training (with continuing education units offered, when available) and distribution of materials, which may include:
  - Implicit Bias and Cultural Responsiveness
  - A Physician's Practical Guide to Culturally Competent Care handout
  - Awareness to Action: Dismantling Bias in Maternal and Infant Healthcare
  - Health Equity Foundations and Cultural Sensitivity trainings
  - LGBTQ+, Mental Health, and Unconscious Bias trainings

Stratify MCO Results on Attachment H Measures

For this section of the HEP, UHC did not provide stratified rates for the measures; however, UHC indicated that it plans to incorporate the Attachment H measures into its data analytics tools to stratify and analyze by age, gender, race/ethnicity, language, disability, and geography.

Appendix B. Compliance Review Remediation Follow-Up

Appendix B includes UHC's response to the CAP recommendations made by the previous EQRO for addressing deficiencies from the prior year's CR and HSAG's findings after reviewing UHC's responses and additional documentation. Please note that the responses in this section were provided by the plans and have not been edited by HSAG.

Recommendations
Requirement: *Working with MCO case managers to develop plans of care for members receiving case management services.* This requirement is not addressed in any submitted policy or procedures. This requirement is addressed in the Care Provider Manual. UHC should add the language to relevant policies.
Response
Describe initiatives implemented based on recommendations: UHC Clinical Division reviewed LA 002 Case Management (CM) Policy. The policy language was updated to reflect compliance as noted in LA 002 pages 9 and 11. Clinical division staff members were educated regarding the policy language update relevant to development of plans for member's receiving Case Management services. Staff was educated during monthly Clinical Employee Staff Meetings. The policy language was also reiterated during staff 1:1 session. A CM Management staff chart audit tool was developed and implemented with ongoing audits performed by the Management Team. In addition, the Network Development Plan was updated to include 1) Collaborate with case managers to develop plans of care for members receiving case management services 2) Participate with the case management team, as applicable and medically necessary. UHC provided 2022-2023 Specialized Behavioral Health Network Provider Development and Management Plan as part of the 2023 External Quality Review Compliance Review completed in October 2023 as supporting documentation for this requirement.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Case management staff complied with the development of Plans of Care for members' receiving CM services related to Policy LA 002. Plans of Care for members are patient-centered and individualized including member self-care management with Primary Care Provider involvement. Development included a standardized goal of sharing the Plan of Care with the Provider. The CM staff complied with adhering to the language added to the relevant policy. The Clinical Management Team will perform ongoing monitoring and surveillance using the Chart Audit Tool process and will meet with staff for reeducation and schedule coaching sessions as needed.
Identify any barriers to implementing initiatives: Unable to reach or losing contact with Member after development of the Plan of Care to effectively impact member involvement with self-care management.
Identify strategy for continued improvement or overcoming identified barriers: The strategies for overcoming identified barriers regarding losing contact with members and/or being unable to reach the members. We use the Admit Discharge and Transfer (ADT) feed for inpatient and emergency department admissions. This demographic information is also utilized to connect with members. We also contact the member's pharmacy and review prescription claims data and contact member's physician office to obtain and update the member's record with most current address, phone number and email address. This strategy was implemented, and staff was educated during staff meetings and incorporated in both staff annual education and new staff onboarding process. Our identified strategy is ongoing monitoring and surveillance which is incorporated into staff meetings, annual staff education and new staff onboarding. Management oversight with ongoing review for any improvement needs using chart auditing process.

HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement: *Participating in the MCO's case management team, as applicable and medically necessary.* This requirement is not addressed in any submitted policy or procedures. This requirement is addressed in the Care Provider Manual. UHC should add the language to relevant policies.
Response
Describe initiatives implemented based on recommendations: UHC Clinical Division reviewed LA 002 Case Management Policy specific to standards 2.7.8.2, 2.7.8.3, 2.7.8.4 regarding relevant policy language for Case Management Teams as being applicable and medically necessary. The policy language was updated to reflect compliance as noted in LA 002 pages 12 and 13 bullets 2,3,4 and 6. Clinical division staff members were educated regarding the policy language update. Staff was educated during monthly Clinical Employee Staff Meetings. The policy language was also reiterated during staff 1:1 session. In addition, the Network Development Plan was updated to include: 1) Collaborate with case managers to develop plans of care for members receiving case management services and 2) Participate with the case management team, as applicable and medically necessary. UHC provided 2022-2023 Specialized Behavioral Health Network Provider Development and Management Plan as part of the 2023 External Quality Review Compliance Review completed in October 2023 as supporting documentation for this requirement.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Staff have been educated during staff meetings on the additional policy statements/requirements. Case Management Leadership Team developed and implemented a Staff Chart Audit Tool which includes bullet points verifying narrative summarizing case management medical necessity.
Identify any barriers to implementing initiatives: No specific barriers identified; staff education will continue.
Identify strategy for continued improvement or overcoming identified barriers: Our identified strategy is developing the chart audit tool, educate staff regarding the audit tool and implementation of the use of the chart audit tool. The Clinical Leadership team has set aside time for 1-2 chart audits per month per staff member. Leadership has scheduled meetings with staff 1:1 to review audits. Leadership has ongoing monthly surveillance and monitoring of compliance of the chart audit reports. We have an ongoing review for any improvement needs in chart auditing process. Ongoing monitoring and surveillance for process is incorporated in both annual staff education and new hire onboarding. The CM staff complied with adhering to the language added to the relevant policy. Clinical Management Team will perform ongoing monitoring and surveillance using the Chart Audit Tool process. The Manager to meet with staff for reeducation and schedule coaching sessions as needed.
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement: *Conducting screens for common behavioral issues, including but not limited to depression, anxiety, trauma/adverse childhood experiences (ACEs), and substance use, to determine whether the member needs behavioral health services.* This requirement is not addressed in any submitted policy or procedures. This requirement is addressed in the Care Provider Manual. UHC should add the language to relevant policies.

Response
Describe initiatives implemented based on recommendations: The UHC Policy titled: Ambulatory Medical Record Review Process addresses this. The LA 002 Policy, section 3 states according to standard 2.7.1, United Healthcare Community and State Louisiana (UHC C&S LA) Health Plan has implemented a comprehensive care management program to support Enrollees of all ages, which is based on an individualized assessment of care needs (LA Core Assessment). UHC Louisiana uses the LDH required LA Core Assessment which is inclusive of the screening questions for common behavioral issues on questions 28 (anxiety and depression, Post Traumatic Stress Disorder, Substance Use Disorder, Severe Mental Illness or other Behavioral Health Diagnosis), 59 (PHQ2 and PHQ9), 61(Mental and Behavioral Health Counseling or Treatment) , 63 (as a child or adult ever experienced physical, psychological, intimate or sexualized abuse or neglect), 66 (use of street or illegal drugs or used a prescription medication for nonmedical reasons), 67, 68, 69 and 70 (Alcohol consumption/CAGE Assessment). The LA Core assessment is completed on every member enrolled in Case Management Services. Case Management staff completes a PHQ9 screening on each enrollment which is imbedded in the LA Core Assessment. Staff was educated during monthly Clinical Employee Staff Meetings. The policy language was also reiterated during staff 1:1 session. In addition, the Network Development Plan was updated to include: 1) Collaborate with case managers to develop plans of care for members receiving case management services and 2) Participate with case management team, as applicable and medically necessary. In addition, the Network Development Plan was changed to include Conducting screens for common behavioral issues, including but not limited to depression, anxiety, trauma/adverse childhood experiences (ACEs), and substance use, to determine whether the member needs behavioral health services. UHC provided 2022-2023 Specialized Behavioral Health Network Provider Development and Management Plan as part of the 2023 External Quality Review Compliance Review completed in October 2023 as supporting documentation for this requirement. In the section titled “Enhancing Detection of Behavioral Disorders in Primary Care Settings (all ages) (page 25 of 38).” We also provide our “Behavioral Health Toolkit for Medical Providers, featuring screening tools, checklists, best practices and Clinical Guidelines” which includes access/links to initial questionnaire assessments and screening tools for mental health and substance use disorders. Joint Operating Committee meetings with primary medical providers include information on the Behavioral Health Toolkit with this information.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The CM staff complied with adhering to the language added to the relevant policy. The Clinical Management team performs ongoing monitoring and surveillance using the Chart Audit Tool process. The Manager meets with staff for reeducation and schedule coaching sessions as needed**.**
Identify any barriers to implementing initiatives: No barriers noted at this time. Monitoring and education will be ongoing.
Identify strategy for continued improvement or overcoming identified barriers: Our identified strategy is ongoing monitoring and surveillance that is incorporated into staff meetings, annual staff education and new hire onboarding. Management oversight with ongoing review for any improvement needs using chart auditing process.
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement: *A person-centered integrated plan of care developed by the MCO care manager shall be completed within thirty (30) calendar days of provider treatment plan development that includes all medically necessary services including specialized behavioral health services and primary care services identified in the*

member's treatment plans (individualized treatment plans are developed by the provider(s)) and meet the requirements above.

Of the 10 case management files reviewed, nine (9) files met the requirement, and one (1) file was not applicable. Of the 10 behavioral health case management files reviewed, five (5) files met the requirement, and five (5) files were not applicable. This requirement is partially addressed by the Case Management Process Policy on pages 3 through 5 and the Chronic Illness Program Process on pages 5 and 7; these documents do not address the timeframe stipulated by the requirement. The Case Management Process, submitted after the on-site interview, also partially addresses the requirement, but due to the revision date, it cannot be accepted as part of this review. UHC should add the language to relevant policies.

Response

Describe initiatives implemented based on recommendations:

LA Case Management Process Policy LA 002 added language within Purpose and Scope to outline the process for establishing a consistent process for assessment and the development of an evidence based, person centered plan of care (POC) for individuals identified and enrolled in case management. The language relevant to this policy includes individualized treatment plans developed by the member's Primary Care Provider, the case management team and individualized Plan of Care developed with member participation, and in consultation with any specialists caring for the member, inclusive of Behavioral Health as applicable. Patient centered care plans will be completed within 30 calendar days of treatment plan development as medically necessary. CM staff outreach to PCP/providers and Behavioral health care providers (when applicable) using available avenues to include telephonic, email and use of Provider portal to obtain treatment plans for members. All staff were educated during monthly All Clinical Employee Staff Meetings. The policy language was also reiterated during staff 1:1 session.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

The Case Management staff complied with adhering to the language added to the relevant policy. The Clinical Management Team will perform ongoing monitoring and surveillance using the Chart Audit Tool process. The Manager will meet with staff for reeducation and schedule coaching sessions as needed.

Identify any barriers to implementing initiatives:

No barriers at this time. Education and monitoring of this process is ongoing.

Identify strategy for continued improvement or overcoming identified barriers:

Our identified strategy is ongoing monitoring and surveillance which is incorporated into staff meetings, annual staff education and new hire onboarding. Management oversight continues with ongoing reviews for any improvement needs using our chart auditing process. Continue and monitor staff compliance and improvement on audit findings

HSAG Assessment

The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.

Recommendations

Requirement: *The MCO shall be responsible for ensuring: Member's health care needs and services/care are planned and coordinated through the MCO PCP and/or behavioral health provider.*

Of the 10 case management files reviewed, three (3) files met the requirement, two (2) files were not applicable, and five (5) files did not meet the requirement. Of the 10 behavioral health case management files reviewed, eight (8) files met the requirement, and two (2) files were not applicable. This requirement is addressed by the Case Management Process on page 3. UHC should ensure that staff are outreaching to the PCP/providers to collaborate and coordinate care for members.

Response
Describe initiatives implemented based on recommendations: Clinical staff members were educated regarding the LA Case Management LA 002-policy language relevant to ensuring that member's health care needs and services are planned and coordinated through the MCO PCP and/or Behavioral Health provider. The policy language was also reiterated during staff 1:1 session. Staff was educated during monthly Clinical Employee Staff Meetings.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The CM staff complied with adhering to the language relevant to the policy. The Clinical Management team performs ongoing monitoring and surveillance using the Chart Audit Tool process. The Manager meets with staff for reeducation and schedule coaching sessions as needed.
Identify any barriers to implementing initiatives: No barriers at this time. Education and monitoring are ongoing.
Identify strategy for continued improvement or overcoming identified barriers: Our identified strategy is ongoing monitoring and surveillance that is incorporated into staff meetings, annual staff education and new hire onboarding. Management oversight continues with ongoing review for any improvement needs using chart auditing process.
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement: *Care managers follow-up with members with a behavioral health related diagnosis within 72 hours following discharge.* Of the 10 behavioral health case management files reviewed, four (4) files met the requirement, and six (6) files were not applicable. This requirement is partially addressed by the Coordination of Behavioral Healthcare Policy on page 2. The Coordination, Continuity, and Transition of Behavioral Health Care Addendum addresses the requirement; however, due to the document date, it cannot be accepted as part of this review. UHC should continue to implement the Coordination, Continuity, and Transition of Behavioral Health Care Addendum to meet this requirement.
Response
Describe initiatives implemented based on recommendations: UHC will continue to implement the Coordination, Continuity, and Transition of Behavioral Health Care Addendum and the C&S BH CCA Transitions of Care process to meet this requirement. UHC provided C&S BH CCA Transitions of Care process as part of the 2023 External Quality Review Compliance Review completed in October 2023 as supporting documentation for this requirement.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The Audit tool has been amended to address the PCP/BH communication as part of the routine audit/staff education.
Identify any barriers to implementing initiatives: No barriers at this time. Ongoing monitoring and education will be continued.
Identify strategy for continued improvement or overcoming identified barriers: Our identified strategy is that this will be incorporated in both annual staff education and new hire onboarding. We will continue monitoring results for staff compliance and improvement on audit findings
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.

Recommendations
Requirement: *Members approaching the end of medical necessity/continued stay for PRTF or TGH have concrete and proactive discharge plans in place, including linkage with aftercare providers to address the member's treatment needs in the member's next recommended level of care or living situation. Concrete and proactive discharge plans, including linkage with aftercare providers in the member's next LOC or living situation, should be in place thirty (30) calendar days prior to discharge from a PRTF or TGH. The MCO shall follow up and coordinate with the discharging PRTF or TGH, receiving provider(s), and the member/guardian to ensure that the member is contacted by and is receiving services from aftercare providers as per the member's discharge plan.* Of the 10 behavioral health case management files reviewed, one (1) file met the requirement and nine (9) files were not applicable. This requirement is partially addressed by the Coordination of Behavioral Healthcare Policy on page 2; this policy does not include the 30-day timeframe stated in the requirement. This requirement is addressed by the Coordination, Continuity, and Transition of Behavioral Health Care Addendum on pages 3 through 4; however, due to the document date, it cannot be accepted as part of this review. UHC should continue to implement the Coordination, Continuity, and Transition of Behavioral Health Care Addendum to meet this requirement.
Response
Describe initiatives implemented based on recommendations: UHC provided the Coordination, Continuity and Transition of Behavioral health Care Addendum Policy, the Louisiana (LA) Medicaid Psychiatric Residential Treatment Facilities (PRTF) Overview process and the Discharge Planning process as part of the 2023 External Quality Review Compliance Review completed in October 2023 as supporting documentation for this requirement. The Policy will undergo LDH approval and public posting. UHC will continue to implement the Louisiana (LA) Medicaid Psychiatric Residential Treatment Facilities (PRTF) Overview process and the Discharge Planning process to meet this requirement.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The Audit tool has been amended to address the PCP/BH communication as part of the routine audit/staff education.
Identify any barriers to implementing initiatives: No barriers at this time. Education and monitoring are ongoing.
Identify strategy for continued improvement or overcoming identified barriers: Our identified strategy is that this is incorporated in both annual staff education and new hire onboarding. We will continue monitoring results for staff compliance and improvement on audit findings.
HSAG Assessment
The documents submitted by the MCO did not address the recommendation from the 2022 CR, and the MCO was unable to demonstrate compliance during the virtual review. The MCO must address this recommendation to remediate the finding.
Recommendations
Requirement: *The individualized treatment plans must be: 6.19.4.1 Developed by the member's primary care provider and/or other lead provider as appropriate, with member participation, and in consultation with any specialists caring for the member. For SHCN members, the treatment plan shall be submitted to the member's MCO no later than 30 days following the completion of the initial assessment or annual reassessment.* Of the 10 case management files reviewed, one (1) file met the requirement, four (4) files were not applicable, and five (5) files did not meet the requirement. Of the 10 behavioral health case management files reviewed, seven (7) files were not applicable and two (2) files did not meet the requirement. This requirement is partially addressed by the Louisiana Care Management Process on page 3; this process does not address the timeframe

stipulated by the requirement. UHC should edit the process to include the entire requirement. Additionally, UHC should ensure that staff are outreaching PCP/providers properly in order to obtain treatment plans for members.

Response

Describe initiatives implemented based on recommendations:
UHC Clinical Division reviewed LA 002 Case Management Policy. The Policy language was updated to reflect compliance on pages 3 and 6. Clinical division staff members were educated regarding the policy language update relevant to development of plans of care for member' receiving Case Management services. Staff was educated during monthly Clinical Employee Staff Meetings. The policy language was also reiterated during staff 1:1 session. The Case Management staff chart audit tool was developed and implemented with ongoing audits performed by the Management team.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
The case management staff complied with adhering to the language added to the relevant policy. Clinical Management Team will perform ongoing monitoring and surveillance using the Chart Audit Tool process. The Manager will meet with staff for reeducation and schedule coaching sessions as needed.

Identify any barriers to implementing initiatives:
No barriers noted at this time. Education and monitoring are ongoing.

Identify strategy for continued improvement or overcoming identified barriers:
Our identified strategy is ongoing monitoring and surveillance. This information is incorporated into staff meetings, annual staff education and new hire onboarding. Management oversight will continue with ongoing reviews for any improvement needs using chart auditing process.

HSAG Assessment

The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.

Recommendations

Requirement: *In any instance when the member presents to the network provider, including calling the MCO's toll-free number listed on the Member's ID card, and a member is in need of emergency behavioral health services, the MCO shall instruct the member to seek help from the nearest emergency medical provider. The MCO shall initiate follow-up with the member within forty-eight (48) hours for follow-up to establish that appropriate services were accessed.*

This requirement is partially addressed by the Access Standards and Care Advocacy Center Hours of Operation Policy on pages 2 through 3; the policy does not address the follow-up portion of the requirement. The Utilization Management of Behavioral Health Benefits Addendum does not address the requirement. The Coordination, Continuity, and Transition of Behavioral Health Care Addendum addresses the requirement; however, due to the document date, it cannot be accepted as part of this review. UHC should continue to implement the Coordination, Continuity, and Transition of Behavioral Health Care Addendum to meet this requirement.

Response

Describe initiatives implemented based on recommendations:
UHC provided the Coordination, Continuity and Transition of Behavioral health Care Addendum Policy as part of the 2023 External Quality Review Compliance Review completed in October 2023 as supporting documentation for this requirement. UHC will continue to implement the Coordination, Continuity, and Transition of Behavioral Health Care Addendum to meet this requirement. UHC has a policy specifically stating that the MCO shall initiate follow-up with the member within forty-eight (48) hours for follow-up to

establish that appropriate services were accessed. Policy titled: Emergency Behavioral Health Services and follow-up.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Continue monitoring results for staff compliance and improvement on audit findings.
Identify any barriers to implementing initiatives: No barriers at this time. Education and monitoring are ongoing.
Identify strategy for continued improvement or overcoming identified barriers: Our identified strategy is that this will be incorporated in both annual staff education and new hire onboarding. We will continue monitoring results for staff compliance and improvement on audit findings.
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement: *The MCO shall include documentation in the member's medical record that attempts are made to engage the member's cooperation and permission to coordinate the member's over-all care plan with the member's behavioral health and primary care provider.* This requirement is partially addressed by the Community Care Activity Tracking document. The Coordination, Continuity, and Transition of Behavioral Health Care Addendum and the member handbook do not address the requirement. UHC should address this requirement in a policy and a process.
Response
Describe initiatives implemented based on recommendations: UHC Policy titled "Ambulatory Medical Record Review Process" addresses this. LA Case Management Policy LA 002 Page 10 Section I, #2 and #4 as stated in standard 2.7.5 regarding the Case Management Process. The policy language was updated to reflect compliance. Clinical division staff members were educated regarding the policy language update. Staff was educated during monthly Clinical Employee Staff Meetings, clinical email blasts and also reiterated during staff 1:1 session. UHC provided the Coordination, Continuity and Transition of Behavioral health Care Addendum Policy as part of the 2023 External Quality Review Compliance Review completed in October 2023 as supporting documentation for this requirement. UHC will continue to implement the Coordination, Continuity, and Transition of Behavioral Health Care Addendum to meet this requirement.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The Case Management staff complied with adhering to the language added to the relevant policy. The Clinical Management Team performs ongoing monitoring and surveillance using the Chart Audit Tool process. The Manager meets with staff for reeducation and schedule coaching sessions as needed.
Identify any barriers to implementing initiatives: No barriers at this time. Education and Monitoring are ongoing. .
Identify strategy for continued improvement or overcoming identified barriers: Our identified strategy is ongoing monitoring and surveillance. The results are incorporated into staff meetings, annual staff education and new hire onboarding. Management oversight and ongoing review for any improvement needs using the chart auditing process.
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.

Recommendations
Requirement: Develop capacity for enhanced rates or incentives to behavioral health clinics to employ a primary care provider (physician, physician's assistant, nurse practitioner, or nurse) part- or full-time in a psychiatric specialty setting to monitor the physical health of patients. This requirement is not addressed in any policy or procedure. During the review, UHC acknowledged that this is a requirement to develop and needs additional work. UHC should address this requirement in a policy and a process.
Response
Describe initiatives implemented based on recommendations: UHC provided the Integrated Health Home Template and BHPi Program Overview Dual Brand Flyer as part of the 2023 External Quality Review Compliance Review completed in October 2023 as supporting documentation for this requirement. UHC addresses this in the Physical and Behavioral Health Integration of Providers Policy.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Initiatives continuing as set in place in 2022/2023. To support efforts to develop capacity for enhanced rates/incentives. We also have a workgroup that is looking to work with mental health clinics to employ medical staff (currently there is one (1) mental health clinic that has medical staff employed).
Identify any barriers to implementing initiatives: We will continue to work and expand our provider network.
Identify strategy for continued improvement or overcoming identified barriers: UHC will continue efforts and strategies to expand our provider participation.
HSAG Assessment
During the virtual review, the MCO noted that this requirement is no longer included in the 2023 contract. HSAG reviewed this with LDH and recommended this requirement be scored as not applicable. LDH agreed with this update.
Recommendations
Requirement: *Distributing Release of Information forms as per 42 CFR §431.306, and provide training to MCO providers on its use.* This requirement is partially addressed by the Confidential Exchange of Information Form. The Coordination, Continuity, and Transition of Behavioral Health Care Addendum addresses the requirement; however, due to the document date, it cannot be accepted as part of this review. UHC should continue to implement the Coordination, Continuity, and Transition of Behavioral Health Care Addendum to meet this requirement.
Response
Describe initiatives implemented based on recommendations: This element has been included in the Clinical Operations – Behavioral Health Policy. Policy Title is "Coordination, Continuity, and Transition of Behavioral Health Care Addendum".
Identify any noted performance improvement as a result of initiatives implemented (if applicable): UHC continues to implement the Coordination, Continuity, and Transition of Behavioral Health Care Addendum UHC provided a supporting document UHC Authorization for Release of Health Information and an additional supporting document on Release of Information Request.
Identify any barriers to implementing initiatives: Forms are available on identified websites. Providers have ongoing education. We will continue education to make providers aware of the forms and where they are located on our websites.

Identify strategy for continued improvement or overcoming identified barriers: Provider facing teams will continue with support and education.
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement: *Developing capacity for enhanced rates or incentives for integrated care by providers.* This requirement Is partially addressed by the Provider Incentives Rates document. The Integration of Physical and Behavioral Health Through Whole Person Care Policy does not address the requirement. UHC should address this requirement in a policy and a process.
Response
Describe initiatives implemented based on recommendations: UHC provided the Integrated Health Home Template and BHPi Program Overview Dual Brand Flyer as part of the 2023 External Quality Review Compliance Review completed in October 2023 as supporting documentation for this requirement. UHC addresses this in the Physical and Behavioral Health Integration of Providers Policy.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Initiatives continuing as set in place in 2022/2023.
Identify any barriers to implementing initiatives: We will continue to work to expand our provider network.
Identify strategy for continued improvement or overcoming identified barriers: We will continue efforts and strategies to expand our provider participation.
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement: *Participating in regular collaborative meetings at least yearly or as needed, with LDH representatives for the purpose of coordination and communication.* This requirement is partially addressed by the 2022 LA IPRO EQRO Compliance Review Audit Narrative. The Integration of Physical and Behavioral Health Through Whole Person Care Policy does not address the requirement. UHC should address this requirement in a policy and a process.
Response
Describe initiatives implemented based on recommendations: UHC has updated the Policy – "Participate in LDH meetings as required" was updated 1/1/2023 and 10/2023.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): MCO leaders meet with the Louisiana Department of Health on an ongoing basis including regularly scheduled meetings and ad hoc meetings.
Identify any barriers to implementing initiatives: None at this time.
Identify strategy for continued improvement or overcoming identified barriers: Continue to meet and provide subject matter experts as appropriate.

HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement: *Procedures and criteria for making referrals to specialists and subspecialists.* This requirement is partially addressed by the provider handbook. UHC should address this requirement in a policy and a process.
Response
Describe initiatives implemented based on recommendations: UHC has addressed this requirement in a policy and process. LA Specialist Referral including the availability of specialists listed in the Provider Network Companion Guide with the ratio, distance, and appointment time requirements. We have established a process that Primary Care Providers can utilize to find specialists for their members. Providers can contact our Provider Services team during our standard business hours of 7:00am-7:00pm, chat via uhcprovider.com, or by emailing that team any time (24/7). Our Provider Services team responds with up to three (3) specialist options for the member in question, confirming that the specialists are available for appointments.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): We have received no complaints about our established process. If a PCP raises concerns about specialist availability, we share this process with them, and encourage utilization
Identify any barriers to implementing initiatives: (No barriers noted at this time.
Identify strategy for continued improvement or overcoming identified barriers: We have found this process serves not only the immediate need of a specific specialist for a specific enrollee, but also provides needed information to Primary Care Physicians regarding available specialists and assists in building relationships between Primary Care Providers & Specialist offices. This reduces the need for the same Primary Care Provider to make multiple contacts and expedites the timeline for an enrollee receiving the specialty care they need.
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement: *The MCO shall provide a Chronic Care Management Program (CCMP) for members diagnosed with the following chronic conditions: Asthma; Congestive heart failure; Diabetes; HIV; Hepatitis C; Obesity; and Sickle Cell Anemia, particularly diagnosed members who are high utilizers of ED and inpatient services.* This requirement is partially addressed by the UnitedHealthcare Community & State Care Management Program Description, the submitted toolkits, and the booklet educational materials; however, there was no documentation of hepatitis C included in the CCMP. UHC should develop a chronic care management program for hepatitis C.
Response
Describe initiatives implemented based on recommendations: UHC Clinical Division developed a Chronic Care Program for managing Hepatitis C. The 2023 Program document for the HCV Plan shows the scope of the Hepatitis C program. Staff education regarding the Hepatitis C program initiation was completed during clinical employee staff meetings and disseminated using

clinical email blasts. Member education is provided regarding the Hepatitis C program as deemed medically applicable. United Healthcare adhered to the LDH Hepatitis C PIP requirement.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The Clinical Management team performs ongoing monitoring and surveillance using the Chart Audit Tool process. The Manager will meet with staff for reeducation and schedule coaching sessions as needed.
Identify any barriers to implementing initiatives: No barriers noted at this time. Education and monitoring will continue.
Identify strategy for continued improvement or overcoming identified barriers: Our identified strategy is ongoing monitoring and surveillance. The results are incorporated into staff meetings, annual staff education and new hire onboarding. Management oversight will be ongoing. Review results for any improvement needs using the chart auditing process will be provided through education.
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement: *Include a written description of the stratification levels for each chronic condition, including member criteria and associated interventions.* This requirement is partially addressed by the UnitedHealthcare Community & State Care Management Program Description. UHC should add detail to the program description on the stratification levels for each chronic condition.
Response
Describe initiatives implemented based on recommendations: UHC Clinical Division reviewed the LA 002 Case Management Policy. The policy language was updated to reflect compliance. The Disease Management Program document was submitted. Clinical division staff members were educated regarding the policy language update relevant to risk stratification for member's receiving Case Management services. Staff was educated during monthly clinical employee staff meetings, clinical email blasts and employee 1:1 session.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The Clinical Management Team educates staff regarding member's risk stratification policy update and will reeducate staff as needed.
Identify any barriers to implementing initiatives: None at this time.
Identify strategy for continued improvement or overcoming identified barriers: Our identified strategy is ongoing monitoring and surveillance that is incorporated into staff meetings, annual staff education and new hire onboarding. We have ongoing management oversight with continuous review for any improvement needs.
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement: *The MCO shall establish and follow a documented process for credentialing and re-credentialing of network providers [42 CFR §438.12(a)(2).* *The MCO must have a written credentialing and re-credentialing process that complies with 42 CFR §438.12, §438.206, §438.214, §438.224, §438.230 and NCQA health plan Accreditation Standards for the review, credentialing and re-credentialing of licensed, independent providers and provider groups with whom it*

contracts or employs and with whom it does not contract but with whom it has an independent relationship. An independent relationship exists when the MCO selects and directs its members to see a specific provider or group of providers. These procedures shall be submitted to LDH within sixty (60) calendar days after contract amendment, when a change is made, and annually thereafter by contract year. Five (5) of five (5) initial credentialing files met the NCQA health plan accreditation standards. Four (4) of five (5) re-credentialing files met the NCQA health plan accreditation standards. One (1) recredentialing, file did not meet the timeliness standard (every 3 years). This requirement is addressed in UHC's Network Provider Management, Credentialing and Recredentialing Policy. The plan should conduct on-going internal reviews of credentialed provider records to ensure that providers are re-evaluated in a timely manner.
Response
Describe initiatives implemented based on recommendations: UHC will complete audits at specific periods to ensure compliance with recredentialing. In our current operations audit, we check them monthly. Credentialing, recredentialing, medical and behavioral are included.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): We are following the process established in 2022/2023 which supports monthly reviews.
Identify any barriers to implementing initiatives: None at this time.
Identify strategy for continued improvement or overcoming identified barriers: Continue monthly review of credentialing, and recredentialing, performance guarantee requirements.
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.
Recommendations
Requirement: *The MCO shall develop and maintain separate member handbooks that adhere to the requirements in 42 CFR §438.10 (g) and may use the state developed model member handbook for each of the covered populations as specified in section 3.3.3.).* This requirement is partially addressed by the member handbooks. UHC should incorporate the member handbook requirements into a member handbook policy or a broader written materials policy.
Response
Describe initiatives implemented based on recommendations: The UHC Health Plan reviewed its Marketing Enrollee Education Policy and Procedures against contract requirements and the EQR audit recommendations. The recommendations were implemented and incorporated into our "Marketing Enrollee Education Policy and Procedures" to meet requirements.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The Policy is in place.
Identify any barriers to implementing initiatives: None at this time.
Identify strategy for continued improvement or overcoming identified barriers: UHC Health Plan will continue to maintain separate member handbooks and ensure member handbook requirements are addressed in our policies.
HSAG Assessment
The MCO submitted revised policies and/or demonstrated compliance during the virtual review that evidenced implementation of the LDH-approved CAPs and compliance with the requirements.