2020 Healthy Louisiana EQRO Compliance Audit: Executive Summary

Period of Review: April 1, 2019 – March 31, 2020

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Introduction

The Balanced Budget Act of 1997 established that state agencies contracting with Medicaid managed care organizations (MCOs) provide for an annual external, independent review of the quality outcomes, timeliness of, and access to the services included in the contract between the state agency and the MCO. Subpart E – External Quality Review of 42 Code of Federal Regulations (CFR) sets forth the requirements for annual external quality review (EQR) of contracted MCOs. Further, CFR 438.350 requires states to contract with an external quality review organization (EQRO) to perform an annual EQR for each contracted MCO. States must further ensure that the EQRO has sufficient information to carry out the EQR; that the information be obtained from EQR-related activities; and that the information provided to the EQRO be obtained through methods consistent with the protocols established by the Centers for Medicaid and Medicare Services (CMS).

To meet these federal requirements, the Louisiana Department of Health (LDH) contracted with IPRO, an EQRO, to conduct annual compliance audits every three years, followed by partial audits in the intervening years. The 2020 annual compliance audit was a partial audit of MCO compliance with contractual requirements during the period of April 1, 2019, through March 31, 2020.

This report presents IPRO's findings of the 2020 annual compliance audit for the five MCOs in operation during the review period: Aetna Better Health of Louisiana, AmeriHealth Caritas of Louisiana, Healthy Blue of Louisiana, Louisiana Health Care Connections, and United Healthcare.

Compliance Audit Objectives

The purpose of the audit was to assess the five Louisiana MCOs' compliance with federal and state regulations regarding access to care; member services; structure and operations; grievance and appeals policies and procedures; provider network relations and network adequacy; quality measurement; fraud, waste and abuse; and utilization management.

The 2020 compliance audit was a partial audit. Only requirements that were not fully compliant in the prior audit were reviewed. The audit included an evaluation of the MCOs policies, procedures, files, and other materials corresponding to the following nine domains:

1. Eligibility and Enrollment
2. Marketing and Member Education
3. Member Grievances and Appeals
4. Provider Network Requirements
5. Utilization Management
6. Quality Management
7. Fraud, Waste and Abuse
8. Core Benefits and Services
9. Reporting

To assess the MCOs' implementation of the policies and their operational compliance, file reviews were conducted via video interviews in the following areas: appeals, grievances and informal reconsiderations, care management, utilization management denials, and provider credentialing/recredentialing.

For this audit, determinations of "full compliance," "substantial compliance," "minimal compliance," "non-compliance", and "not applicable" were used for each element under review. The definition of each of the review determinations is presented in **Table 1**.

Table 1: Review Determination Definitions

Review Determination	Definition
Full	The MCO is compliant with the standard.
Substantial	The MCO is compliant with most of the requirements of the standard, but has minor deficiencies.
Minimal	The MCO is compliant with some of the requirements of the standard, but has significant deficiencies that require corrective action.
Non-compliance	The MCO is not in compliance with the standard.
Not applicable	The requirement was not applicable to the MCO.

More detail about the conduct of the audit can be found in the individual MCO compliance review findings report.

Statewide Summary of MCO Performance

Summary of Findings

Table 2 presents each of the five MCOs' performance in ranked order by domain of review. For this partial compliance review, the table displays the percentage of elements that have improved to fully compliant since the prior review. It does not show the total percentage of fully compliant elements for each MCO by domain. The MCO average represents the average percentage of elements that have improved to fully compliant across the five MCOs. The total is the average percentage across review domains. The MCO(s) score that showed the greatest improvement in each domain is highlighted in green while the MCO with the least improvement is highlighted in red.

Please note this is a partial review. This table excludes full items from the prior review. Total compliance for each tool (including full items from prior year) will be higher for domains scoring less than 100%. Additionally, some items were new requirements for this review which may have impacted overall percentages

Table 2: MCO Performance in Ranked Order by Review Domain

Review Domain[1]	Aetna	ACLA	Healthy Blue	LHCC	UHC	MCO Average
Reporting	0%	100%	N/A	N/A	100%	67%
Core Benefits and Services	83%	83%	100%	88%	54%	82%
Utilization Management	100%	N/A	N/A	75%	100%	92%
Quality Management	100%	100%	100%	100%	N/A	100%
Member Grievances and Appeals	100%	N/A	100%	75%	N/A	92%
Fraud Waste and Abuse	N/A	N/A	100%	N/A	100%	100%
Marketing/Member Education	40%	100%	100%	100%	100%	88%
Provider Network	31%	48%	47%	23%	44%	39%
Eligibility, Enrollment and Disenrollment	0%	N/A	100%	N/A	100%	67%
Total	**43%**	**61%**	**87%**	**58%**	**61%**	**62%**

[1]The MCO(s) score that was the highest in each domain is highlighted in green while the score of the lowest performing MCO(s) are highlighted in red.
Aetna: Aetna Better Health of Louisiana; ACLA: AmeriHealth Caritas of Louisiana; Healthy Blue: Healthy Blue of Louisiana; LHCC: Louisiana Health Care Connections; UHC: United Healthcare.
N/A: Tool was not reviewed for the MCO during this partial compliance review

The MCO with the highest total percentage of requirements that improved to fully compliant across review domains was Healthy Blue at 87%. Healthy Blue was nearly fully compliant on all domains, with the exception of Provider Network at 47%. The MCO with the lowest total percentage of requirements that improved to fully compliant was Aetna at 43%; Aetna did not improve at all in the Reporting and Eligibility, Enrollment, and Disenrollment domains.

Full compliance for the Provider Network requirements remains the most difficult domain for the MCOs. MCO average improvement for this domain was the lowest at 39%. After this partial review, 100% of Quality Management requirements are fully compliant across the state.

Several requirements in the Provider Network domain were not fully met by any MCOs. As seen in **Table 2,** the requirements that were not fully met by any MCOs are related to network adequacy standards. Access to and availability of providers serving the Medicaid population, especially in several specialty and subspecialty areas in rural regions of the state, has been an ongoing issue since the inception of the Medicaid Managed Care Program in 2012 (**Table 3**). As found in the prior compliance review, a limiting factor is the lack of providers in several parishes for MCOs to outreach.

A summary table of audit results for each MCO by domain is reported in **Appendix A**. This appendix displays tables found in the individual MCO compliance reports.

Table 3: Requirements Not Met by Any MCO

Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)
Provider Network	
7.3.1 7.3.1.1 7.3.1.2	Primary Care Providers .1 Travel distance for members living in rural parishes shall not exceed 30 miles; and .2 Travel distance for members living in urban parishes shall not exceed 10 miles
7.3.2 7.3.2.1 7.3.2.2	Acute Inpatient Hospitals .1Travel distance for members living in rural parishes shall not exceed 30 miles; if no hospital is available within 30 miles of a member's residence, the MCO may request, in writing, an exception to this requirement. .2 Travel distance for members living in urban parishes shall not exceed 10 miles.
7.3.4 7.3.4.1 7.3.4.2	Lab and Radiology Services .1Travel distance shall not exceed 20 miles in urban parishes; and .2Travel distance shall not exceed 30 miles for rural parishes.
7.3.5 7.3.5.1 7.3.5.2	Pharmacies .1Travel distance shall not exceed 10 miles in urban parishes; and .2Travel distance shall not exceed 30 miles in rural parishes.
7.3.6 7.3.6.1 7.3.6.2	Hemodialysis Centers .1Travel distance shall not exceed 10 miles in urban areas; and .2 Travel distance shall not exceed 30 miles in rural areas.

MCO Corrective Action and Next Steps

It is the expectation of LDH that MCOs submit a corrective action plan for new elements determined to be less than fully compliant.

Appendix A: Summary Table of Audit Results

Appendix A includes audit results for each MCO by domain. These tables duplicate tables found in the individual MCO compliance reports.

ACLA

Table 1: Audit Results by Audit Domain

Audit Domain	Total Elements	Full	Substantial	Minimal	Non-compliance	N/A	% Full[1]
Marketing and Member Education	2	2	0	0	0	0	100%
Provider Network Requirements	21	10	10	1	0	0	48%
Quality Management	1	1	0	0	0	0	100%
Core Benefits and Services	6	5	1	0	0	0	83%
Reporting	1	1	0	0	0	0	100%
Total	**31**	**19**	**11**	**1**	**0**	**0**	**61%**

[1] N/As are not included in the calculation.

Aetna

Table 2: Audit Results by Audit Domain

Audit Domain	Total Elements	Full	Substantial	Minimal	Non-compliance	N/A	% Full[1]
Eligibility and Enrollment	7	0	7	0	0	0	0%
Marketing and Member Education	20	8	5	7	0	0	40%
Member Grievances and Appeals	3	3	0	0	0	0	100%
Provider Network Requirements	29	9	14	6	0	0	31%
Utilization Management	1	1	0	0	0	0	100%
Quality Management	5	5	0	0	0	0	100%
Core Benefits and Services	6	5	1	0	0	0	83%
Reporting	1	0	1	0	0	0	0%
Total	**72**	**31**	**30**	**11**	**0**	**0**	**43%**

[1] N/As are not included in the calculation.

Healthy Blue

Table 3: Audit Results by Audit Domain

Audit Domain	Total Elements	Full	Substantial	Minimal	Non-compliance	N/A	% Full[1]
Eligibility and Enrollment	2	2	0	0	0	0	100%
Marketing and Member Education	1	1	0	0	0	0	100%
Member Grievances and Appeals	7	7	0	0	0	0	100%
Provider Network Requirements	17	8	9	0	0	0	47%
Quality Management	3	3	0	0	0	0	100%
Fraud, Waste and Abuse	30	30	0	0	0	0	100%
Core Benefits and Services	9	9	0	0	0	0	100%
Total	**69**	**60**	**9**	**0**	**0**	**0**	**87%**

[1] N/As are not included in the calculation.

LHCC

Table 4: Audit Results by Audit Domain

Audit Domain	Total Elements	Full	Substantial	Minimal	Non-compliance	N/A	% Full[1]
Marketing and Member Education	1	1	0	0	0	0	100%
Member Grievances and Appeals	4	3	1	0	0	0	75%
Provider Network Requirements	13	3	10	0	0	0	23%
Utilization Management	4	3	1	0	0	0	75%
Quality Management	1	1	0	0	0	0	100%
Core Benefits and Services	8	7	1	0	0	0	88%
Total	**31**	**18**	**13**	**0**	**0**	**0**	**58%**

[1] N/As are not included in the calculation.

UHC

Table 5: Audit Results by Audit Domain

Audit Domain	Total Elements	Full	Substantial	Minimal	Non-compliance	N/A	% Full[1]
Eligibility and Enrollment	2	2	0	0	0	0	100%
Marketing and Member Education	3	3	0	0	0	0	100%
Provider Network Requirements	18	8	10	0	0	0	44%
Utilization Management	2	2	0	0	0	0	100%
Fraud, Waste and Abuse	2	2	0	0	0	0	100%
Core Benefits and Services	13	7	6	0	0	0	54%
Reporting	1	1	0	0	0	0	100%
Total	**41**	**25**	**16**	**0**	**0**	**0**	**61%**

[1] N/As are not included in the calculation.