State of Louisiana Department of Health

2022 Healthy Louisiana EQRO Compliance Audit: Executive Summary

Period of Review: January 1, 2021 – December 31, 2021

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FINAL

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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) has contracted with IPRO, an EQRO, to conduct annual compliance audits every 3 years. The 2022 annual compliance audit was a full audit of the MCO's compliance with contractual requirements during the period of January 1, 2021 through December 31, 2021.

This report presents IPRO's findings of the 2022 annual compliance audit for the five MCOs in operation during the review period: Aetna Better Health of Louisiana (Aetna), AmeriHealth Caritas of Louisiana (ACLA), Healthy Blue of Louisiana (HBL), Louisiana Health Care Connections (LHCC), and United Healthcare (UHC).

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 2022 compliance audit was a full audit. The audit included an evaluation of the MCOs policies, procedures, files, and other materials corresponding to the following 12 domains:

	CFR	Domain
1.	438.206	Availability of Services
2.	438.207	Assurances of Adequate Capacity and Services
3.	438.208	Coordination and Continuity of Care
4.	438.210	Coverage and Authorization of Services – UM
5.	438.214	Provider Selection
6.	438.224	Enrollee Rights and Protection
7.	438.228	Grievance and Appeal Systems
8.	438.230	Subcontractual Relationships
9.	438.236	Practice Guidelines
10.	438.242	Health Information Services
11.	438.330	Quality Assessment and Performance Improvement Program (QAPI)
12.	438.608	Fraud, Waste and Abuse

To assess the MCOs' implementation of the policies and their operational compliance, file reviews were conducted via video interviews in the following areas: grievance and appeal systems, coverage and authorization of services, care coordination, and provider selection (credentialing/recredentialing).

For this audit, determinations of "met," "partially met," and "not met" were used for each element under review. A not applicable (N/A) was used if the requirement was not applicable to the MCO. The definition of each of the review determinations is presented in **Table 1**.

Table 1: Review Determination Definitions

Review Determination	Definition
Met	The MCO is compliant with the standard.
Partially Met	The MCO is compliant with most of the requirements of the standard, but has minor deficiencies.
Not Met	The MCO is not in compliance with the standard.
Not applicable	The requirement was not applicable to the MCO.

MCO: managed care organization.

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 12 review domains for the five MCOs' compliance score. There is very little variation between MCOs. The MCOs have done a good job complying with LDH contractual requirements.

Table 2: MCO Performance by Review Domain MCO Average Performance

Review Domain[1]	Aetna	ACLA	HBL	LHCC	UHC	MCO Average
Availability of Services	99.2%	95.0%	99.6%	100.0%	98.8%	98.5%
Assurances of Adequate Capacity and Services	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Coordination and Continuity of Care	91.6%	95.2%	100.0%	91.0%	90.7%	93.7%
Coverage and Authorization of Services – UM	98.5%	99.2%	100.0%	99.2%	100.0%	99.4%
Provider Selection	97.8%	100.0%	97.8%	100.0%	97.8%	98.7%
Enrollee Rights and Protection	93.0%	99.1%	99.1%	99.1%	99.5%	97.9%
Grievance and Appeal Systems	100.0%	100.0%	99.3%	100.0%	100.0%	99.9%
Subcontractual Relationships	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Practice Guidelines	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Health Information Services	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Quality Assessment and Performance Improvement	98.6%	98.6%	100.0%	100.0%	100.0%	99.4%
Fraud, Waste and Abuse	95.8%	100.0%	100.0%	94.6%	100.0%	98.1%
Total	97.0%	98.3%	99.7%	98.0%	98.8%	98.4%

[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.
UM: utilization management

As seen in **Table 2**, the average total compliance rate among all MCOs was 98.4%. Healthy Blue had the highest total compliance rate at 99.7%, while Aetna had the lowest at 97.0%. Across the 12 domains, there were four MCOs that achieved 100% compliance, while the rest ranged from 93.7% (Coordination and Continuity of Care) to 99.9% (Grievance and Appeal Systems).

The domains with the lowest performance; Coordination and Continuity of Care (93.7%), Enrollee Rights and Protection (97.9%), and Availability of Services (98.5%) each had three MCOs performing at less than 100%.

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.

MCO Corrective Action and Next Steps

It is the expectation of LDH that MCOs submit a corrective action plan for elements determined to be less than fully compliant. LDH will contact each MCO with specific corrective action plans.

Appendix A: Summary Table of Audit Results

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

Table 3: ACLA Audit Results by Audit Domain

Audit Domain	Total Elements	Met	Partially Met	Not Met	N/A	Score[1]
Availability of Services	132	116	13	0	3	95.0%
Assurances of Adequate Capacity and Services	48	48	0	0	0	100.0%
Coordination and Continuity of Care	83	78	2	3	0	95.2%
Coverage and Authorization of Services – UM	65	64	1	0	0	99.2%
Provider Selection	24	23	0	0	1	100.0%
Enrollee Rights and Protection	107	105	2	0	0	99.1%
Grievance and Appeal Systems	71	70	0	0	1	100.0%
Subcontractual Relationships	8	8	0	0	0	100.0%
Practice Guidelines	27	27	0	0	0	100.0%
Health Information Services	8	8	0	0	0	100.0%
Quality Assessment and Performance Improvement	109	107	1	1	0	98.6%
Fraud, Waste and Abuse	132	130	0	0	2	100.0%
Total	814	784	19	4	7	98.3%

[1] Each met element receives 1 point, each partially met element receives 1/2 point, and each not met element receives zero points. N/A elements are removed from the denominator. Score is equal to the sum of all points earned/applicable elements.
UM: utilization management

Table 4: Aetna Audit Results by Audit Domain

Audit Domain	Total Elements	Met	Partially Met	Not Met	N/A	Score[1]
Availability of Services	132	128	0	1	3	99.2%
Assurances of Adequate Capacity and Services	48	48	0	0	0	100.0%
Coordination and Continuity of Care	83	71	10	2	0	91.6%
Coverage and Authorization of Services – UM	65	63	2	0	0	98.5%
Provider Selection	24	22	1	0	1	97.8%
Enrollee Rights and Protection	107	97	5	5	0	93.0%
Grievance and Appeal Systems	71	70	0	0	1	100.0%
Subcontractual Relationships	8	8	0	0	0	100.0%
Practice Guidelines	27	27	0	0	0	100.0%
Health Information Services	8	8	0	0	0	100.0%
Quality Assessment and Performance Improvement	109	106	3	0	0	98.6%
Fraud, Waste and Abuse	132	123	3	4	2	95.8%
Total	814	771	24	12	7	97.0%

[1] Each met element receives 1 point, each partially met element receives 1/2 point, and each not met element receives zero points. N/A elements are removed from the denominator. Score is equal to the sum of all points earned/applicable elements.
UM: utilization management

Table 5: Healthy Blue Audit Results by Audit Domain

Audit Domain	Total Elements	Met	Partially Met	Not Met	N/A	Score[1]
Availability of Services	132	128	1	0	3	99.6%
Assurances of Adequate Capacity and Services	48	48	0	0	0	100.0%
Coordination and Continuity of Care	83	83	0	0	0	100.0%
Coverage and Authorization of Services – UM	65	65	0	0	0	100.0%
Provider Selection	24	22	1	0	1	97.8%
Enrollee Rights and Protection	107	105	2	0	0	99.1%
Grievance and Appeal Systems	71	69	1	0	1	99.3%
Subcontractual Relationships	8	8	0	0	0	100.0%
Practice Guidelines	27	27	0	0	0	100.0%
Health Information Services	8	8	0	0	0	100.0%
Quality Assessment and Performance Improvement	109	109	0	0	0	100.0%
Fraud, Waste and Abuse	132	130	0	0	2	100.0%
Total	814	802	5	0	7	99.7%

[1] Each met element receives 1 point, each partially met element receives 1/2 point, and each not met element receives zero points. N/A elements are removed from the denominator. Score is equal to the sum of all points earned/applicable elements.
UM: utilization management

Table 6: LHCC Audit Results by Audit Domain

Audit Domain	Total Elements	Met	Partially Met	Not Met	N/A	Score[1]
Availability of Services	132	129	0	0	3	100.0%
Assurances of Adequate Capacity and Services	48	48	0	0	0	100.0%
Coordination and Continuity of Care	83	69	13	1	0	91.0%
Coverage and Authorization of Services – UM	65	64	1	0	0	99.2%
Provider Selection	24	23	0	0	1	100.0%
Enrollee Rights and Protection	107	105	2	0	0	99.1%
Grievance and Appeal Systems	71	70	0	0	1	100.0%
Subcontractual Relationships	8	8	0	0	0	100.0%
Practice Guidelines	27	27	0	0	0	100.0%
Health Information Services	8	8	0	0	0	100.0%
Quality Assessment and Performance Improvement	109	109	0	0	0	100.0%
Fraud, Waste and Abuse	132	123	0	7	2	94.6%
Total	814	783	16	8	7	98.0%

[1] Each met element receives 1 point, each partially met element receives 1/2 point, and each not met element receives zero points. N/A elements are removed from the denominator. Score is equal to the sum of all points earned/applicable elements.
UM: utilization management

Table 7: UHC Audit Results by Audit Domain

Audit Domain	Total Elements	Met	Partially Met	Not Met	N/A	Score[1]
Availability of Services	132	126	3	0	3	98.8%
Assurances of Adequate Capacity and Services	48	48	0	0	0	100.0%
Coordination and Continuity of Care	83	67	13	1	2	90.7%
Coverage and Authorization of Services – UM	65	65	0	0	0	100.0%
Provider Selection	24	22	1	0	1	97.8%
Enrollee Rights and Protection	107	106	1	0	0	99.5%
Grievance and Appeal Systems	71	70	0	0	1	100.0%
Subcontractual Relationships	8	8	0	0	0	100.0%
Practice Guidelines	27	27	0	0	0	100.0%
Health Information Services	8	8	0	0	0	100.0%
Quality Assessment and Performance Improvement	109	109	0	0	0	100.0%
Fraud, Waste and Abuse	132	130	0	0	2	100.0%
Total	814	786	18	1	9	98.8%

[1] Each met element receives 1 point, each partially met element receives 1/2 point, and each not met element receives zero points. N/A elements are removed from the denominator. Score is equal to the sum of all points earned/applicable elements.
UM: utilization management