LOUISIANA DEPARTMENT OF HEALTH

2023 External Quality Review
Compliance Review

Compliance Review Aggregate Report

December 2023

HSAG HEALTH SERVICES ADVISORY GROUP

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MCE Names

Health Services Advisory Group, Inc. (HSAG) evaluated for the 2023 compliance review (CR) the performance of the Louisiana Department of Health (LDH) Healthy Louisiana managed care organizations (MCOs); prepaid ambulatory health plans (PAHPs); and a prepaid inpatient health plan (PIHP), which is also referred to as a Coordinated System of Care (CSoC) plan. The plans are collectively referred to as "managed care entities (MCEs)." The table below lists the contracted MCEs included in the 2023 CR.

Louisiana's MCEs	Plan	Acronym or Abbreviated Reference
AmeriHealth Caritas Louisiana	MCO	ACLA
Aetna Better Health	MCO	ABH
Healthy Blue	MCO	HBL
Humana Healthy Horizons*	MCO	HUM
Louisiana Healthcare Connections	MCO	LHCC
UnitedHealthcare Community	MCO	UHC
DentaQuest USA Insurance Company (DentaQuest)	PAHP	DQ
Managed Care North America	PAHP	MCNA
Magellan of Louisiana	PIHP	Magellan

**Humana Healthy Horizons' contract was effective January 1, 2023, and therefore was not included in the 2023 CR.*

1. Executive Summary

Introduction

In accordance with Title 42 of the Code of Federal Regulations (42 CFR) §438.358, LDH or an external quality review organization (EQRO) may perform the mandatory and optional external quality review (EQR) activities, and the data from these activities must be used for the annual EQR and technical report described in 42 CFR §438.350 and §438.364. One of the four mandatory activities required by the Centers for Medicare & Medicaid Services (CMS) is:

- A review, conducted within the previous three-year period, to determine the MCO's, PIHP's, or PAHP's compliance with the standards set forth in Subpart D of this part (42 CFR §438), the disenrollment requirements and limitations described in §438.56, the enrollee rights requirements described in §438.100, the emergency and post-stabilization services requirements described in §438.114, and the quality assessment and performance improvement requirements described in §438.330.

As LDH's EQRO, HSAG is contracted to conduct the CR activity with each of the MCOs, PAHPs, and PIHPs delivering services to members enrolled in the Louisiana Medicaid managed care program. When conducting the CR, HSAG adheres to the methodologies and guidelines established in CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 3).[1-1]

Description of the External Quality Review Compliance Review

LDH requires its MCEs to undergo periodic CRs to ensure that an assessment is conducted to meet federal requirements. The 2023 CR, which comprises the calendar year (CY) 2022 review period (January 1, 2022−December 31, 2022), is the second year of the three-year cycle of CRs. The CR focused on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific requirements. LDH requested that HSAG conduct a CR of all standards not yet reviewed during the three-year CR cycle for each MCO, PAHP, and PIHP. In addition, HSAG conducted a follow-up review of each MCE's implementation of corrective action plans (CAPs) from the 2022 CRs.

Between September 2023 and October 2023, HSAG performed a virtual review of each MCE to assess compliance with the Louisiana Medicaid managed care regulations and with State contract requirements. Table 1-1 displays the MCEs contracted with the Louisiana Medicaid managed care program and the standards reviewed during the 2023 CRs.

[1-1] 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: Aug 1, 2023.

Table 1-1—MCEs and Standards Reviewed

Standard	MCO					PAHP		PIHP
	ACLA	ABH	HBL	LHCC	UHC	DQ	MCNA	Magellan
Standard I—Enrollment and Disenrollment (§438.56)	✓	✓	✓	✓	✓	✓	✓	✓
Standard IX—Subcontractual Relationships and Delegation (§438.230)						✓	✓	
Standard IV—Emergency and Poststabilization Services (§438.114)								✓

HSAG developed a review strategy and compliance monitoring tool based on these standards to review each MCE's performance. HSAG assigned each requirement in the compliance monitoring tool a score of *Met* or *Not Met*, and assigned required actions to any requirement receiving a score of *Not Met*. If a requirement was not applicable during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. The following table presents the definition of each of the review determinations.

Score	Definition
Met	***Met*** indicates full compliance.
Not Met	***Not Met*** indicates noncompliance.
Not Applicable	***NA*** indicates not applicable

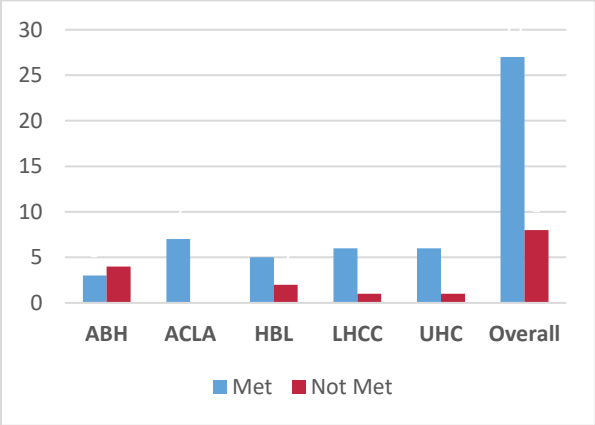
LDH also requested a follow-up review of each MCE's implementation of CAPs resulting from the 2022 CRs to evaluate whether the MCEs resolved the areas of noncompliance.

This report documents the aggregated results of the MCEs' virtual CRs to provide a statewide perspective of the MCEs' operations and progress toward achieving Louisiana Medicaid managed care program goals. This report also includes an overall summary of the CR results and includes a comparison of MCE performance based on aggregated scores of compliance with federal and State managed care requirements. This report includes HSAG's conclusions of MCE strengths and opportunities for improvement, and overall observations, recommendations, and required actions related to overall trends.

Summary of Compliance With Managed Care Regulations

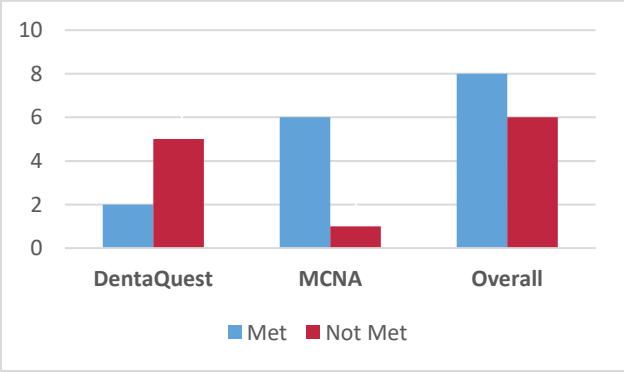
The following figures present an overview of the aggregate results of the MCEs' 2023 CRs. CR scores for individual standards are included in each MCE's CR report along with details regarding strengths, opportunities for improvement, and required actions based on noncompliance with regulations.

Summary of Scores—MCO 2023 Compliance With Standards Review

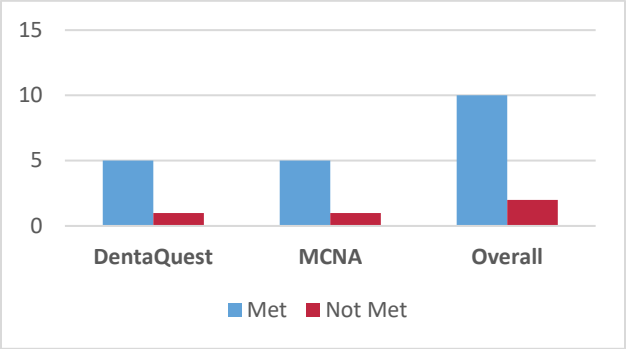


Overall, the MCO scores for Standard I—Enrollment and Disenrollment, reviewed in 2023, were moderately high, ranging from 42.9 percent (**ABH**) to 100 percent (**ACLA**) compliance, demonstrating a broad understanding of the enrollment and disenrollment regulations. The MCOs met all requirements for three elements (3, 4, and 5) including policies that ensured members were not disenrolled based on health status, utilization of services, diminished mental capacity, or uncooperative behavior.

Summary of Scores—PAHP 2023 Compliance With Standards Reviews

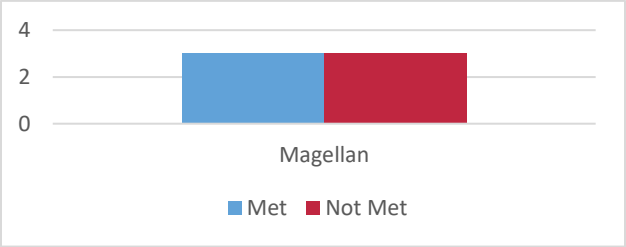


PAHP scores for Standard I—Enrollment and Disenrollment, reviewed in 2023, ranged from 28.6 percent (**DQ**) to 85.7 percent (**MCNA**) compliance, demonstrating opportunities for improvement. Overall, the PAHPs met eight elements and did not meet six elements.

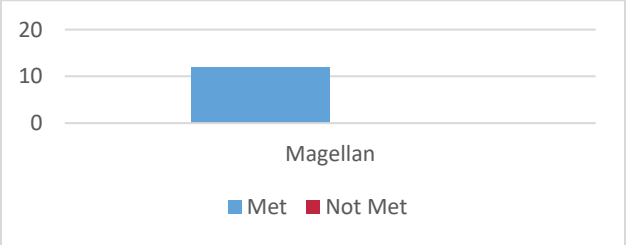


Both PAHPs scored 83.3 percent in Standard IX—Subcontractual Relationships and Delegation. Overall, the PAHPs met 10 elements and did not meet two elements. Results demonstrate that the PAHPs maintained responsibility for the performance of all LDH contract requirements and verified the subcontractors' and delegated entities' ability to perform the requirements that were included in their contract with the PAHP.

Summary of Scores—PIHP 2023 Compliance With Standards Review



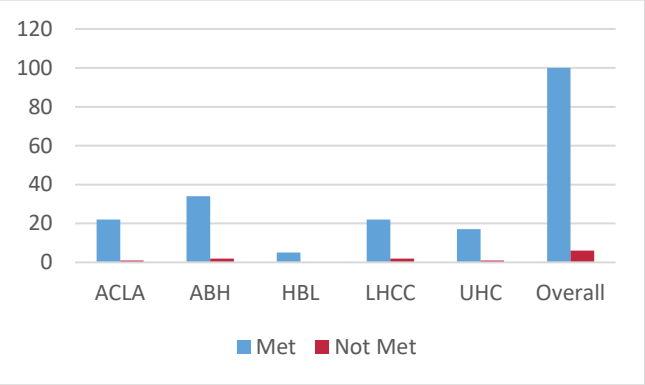
Of the standards reviewed during 2023, Magellan scored 50.0 percent in Standard I—Enrollment and Disenrollment. Overall, **Magellan** met three elements and did not meet three elements, demonstrating that the PIHP did not request disenrollment of members other than for reasons allowed in its contract with LDH, and had processes to provide written notice to members disenrolled from the PIHP.



The PIHP scored 100 percent in Standard IV—Emergency and Poststabilization Services. Overall, **Magellan** met all elements , demonstrating that the PIHP had appropriate policies and procedures for ensuring coverage of emergency and poststabilization services.

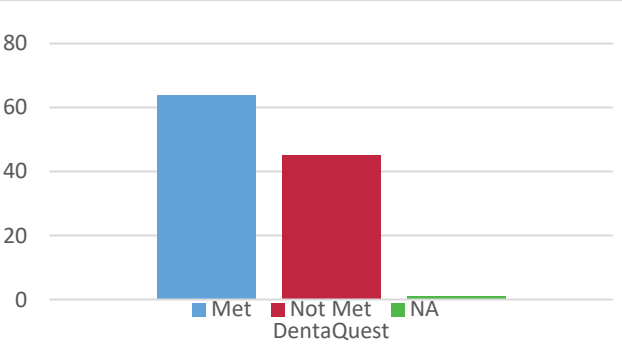
HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed in the follow-up on CAPs based on a standardized scoring methodology. In addition, HSAG assigned an aggregate percentage-of-compliance score across all standards. The following figures present an overview of the aggregate results of the follow-up on CAPs from the 2022 CRs. CR scores for individual standards included in the follow-up on the 2022 CRs are included in each MCE's CR report along with details regarding strengths, opportunities for improvement, and required actions based on noncompliance with regulations.

Summary of Scores—CAP From the MCO 2022 Reviews



Overall, the MCOs closed 100 of 106 CAPs from the 2022 CRs, demonstrating implementation of the LDH-approved CAPs and compliance with the regulations.

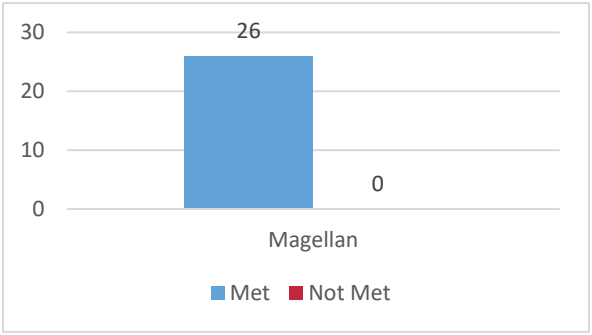
Summary of Scores—CAP From the PAHP 2022 Review



Overall, **DQ** closed 65 of 109 CAPs from the 2022 CRs, demonstrating compliance with the regulations. However, the PAHP did not implement the LDH-approved CAPs for 45 *Not Met* elements from the 2022 CR.

Note: MCNA did not have any required CAPs from the 2022 CR.

Summary of Scores—CAP From the PIHP 2022 Review



Overall, the PIHP closed 26 of 26 CAPs from the 2022 CR, demonstrating implementation of the LDH-approved CAPs and compliance with the regulations.

3. Conclusions and Recommendations

MCOs

Strengths Related to Quality	
+	Overall, the MCOs demonstrated that member disenrollment was not requested as a result of an adverse change in a member's health status, utilization of services, or diminished mental capacity.

Strengths Related to Access and Timeliness	
+	Overall, the MCOs implemented documented processes that focused on ensuring members were not disenrolled for any reason other than those stated in the LDH contract.

Opportunities for Improvement and Recommendations	
−	**Opportunities for Improvement:** Overall, the MCOs did not consistently include all member for cause and without cause reasons to disenroll in MCO policies, procedures, manuals, or handbooks. **Recommendations:** HSAG recommends that the MCOs review and update, as appropriate, policies, procedures, manuals, and handbooks to consistently include all member for cause and without cause reasons for disenrollment.

PAHPs

Strengths Related to Quality	
+	The PAHPs maintained ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of their contract with LDH in contracts with subcontractors and delegated entities.

Strengths Related to Access and Timeliness	
+	The PAHPs' policies and procedures demonstrated that the PAHPs do not discriminate against individuals based on health status or the need for healthcare services, race, color, national origin, sex, or disability.

Opportunities for Improvement and Recommendations	
−	**Opportunities for Improvement:** The PAHPs' policies and procedures demonstrated an opportunity for improvement. One PAHP did not include language about accepting individuals enrolled into the PAHP in the order in which they apply without restriction (unless authorized by the Department). The other PAHP did not include all with cause and without cause reasons for disenrollment in policies and procedures. **Recommendations:** HSAG recommends that the PAHPs review and update policies and procedures to ensure enrollment and disenrollment requirements are consistently included in policies and procedures.

Opportunities for Improvement and Recommendations	
−	**Opportunities for Improvement:** The PAHPs did not include all federal and State contract requirements in their subcontractor and delegated entity agreements. **Recommendations:** HSAG recommends that the PAHPs update their subcontractor and delegated entity agreements to include all federal and State requirements.

PIHP

Strengths Related to Quality	
+	The PIHP coordinated emergency services and inpatient discharges with the member's MCO, including coordinating follow-up behavioral health visits and, when needed, placement in a behavioral health inpatient or community setting.
+	The PIHP had a documented policy that ensures the PIHP works with providers to pay for services and ensures members who receive emergency services are not held liable for those services and any subsequent screening and treatment needed to diagnose the condition or stabilize the patient.

Strengths Related to Access and Timeliness	
+	The PIHP did not place any limits on what constitutes an emergency service and coordinated screening and treatment within 10 calendar days of presentation for emergency services.

Opportunities for Improvement and Recommendations	
−	**Opportunities for Improvement:** The PIHP's document submissions did not demonstrate that the PIHP agreed to accept individuals enrolled into its PIHP in the order in which they apply without restriction (unless authorized by the Department). **Recommendations:** The PIHP must include in a policy or procedure language stating the PIHP agrees to accept individuals enrolled into its PIHP in the order in which they apply without restriction (unless authorized by the Department).
−	**Opportunities for Improvement:** The PIHP did not demonstrate in policies, procedures, or other document submissions that the PIHP does not discriminate against individuals based on health status or need for healthcare services. **Recommendations:** The PIHP must submit a policy or procedure that demonstrates that the PIHP does not discriminate against individuals enrolled or use any policy or practice that has the effect of discriminating against individuals, based on health status or need for healthcare services. The PIHP must update the Coordinated System of Care Member Handbook to include in the list that they do not discriminate based on an individual's health status and the member's need for healthcare services.
−	**Opportunities for Improvement:** The PIHP's policies and procedures did not demonstrate that the PIHP does not request disenrollment of a member because of an adverse change in a member's health status or because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the PIHP's ability to furnish services to the member or to other members).

Opportunities for Improvement and Recommendations	
	Recommendations: The PIHP must include in a policy or procedure that the PIHP may not request disenrollment of a member because of an adverse change in the member's health status or because of the member's: • Utilization of medical services. • Diminished mental capacity. • Uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the PIHP's ability to furnish services to the member or to other members).