LOUISIANA DEPARTMENT OF HEALTH

2023 External Quality Review Compliance Review

for

Healthy Blue

December 2023

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

Introduction

In accordance with Title 42 of the Code of Federal Regulations (42 CFR) §438.358, the Louisiana Department of Health (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 managed care organization's (MCO's), prepaid ambulatory health plan's (PAHP's), or prepaid inpatient health plan's (PIHP'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, Health Services Advisory Group, Inc. (HSAG) is contracted to conduct the compliance review activity with each of the Healthy Louisiana MCOs, PAHPs, and the PIHP delivering services to members enrolled in the Louisiana Medicaid managed care program. When conducting the compliance review, 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 managed care entities (MCEs) to undergo periodic compliance reviews to ensure that an assessment is conducted to meet federal requirements. The 2023 compliance review, 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 compliance reviews. The compliance review focused on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific requirements. The compliance reviews for the Louisiana Medicaid managed care program consist of 14 program areas referred to as "standards." LDH requested that HSAG conduct a compliance review of all standards not yet reviewed during the three-year compliance review cycle for each MCO, PAHP, and PIHP. Table 1-1 outlines the division of standards reviewed in Year One (CY 2021) and Year Two (CY 2022).

[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—Compliance Review Standards

Standard	Associated Federal Citation[1]	Year One (CY 2021)			Year Two (CY 2022)		
		MCO	PAHP	PIHP	MCO	PAHP	PIHP
Standard I—Enrollment and Disenrollment	§438.56				✓	✓	✓
Standard II—Member Rights and Confidentiality	§438.100 §438.224	✓	✓	✓			
Standard III—Member Information	§438.10	✓	✓	✓			
Standard IV—Emergency and Poststabilization Services	§438.114	✓	NA				✓
Standard V—Adequate Capacity and Availability of Services	§438.206 §438.207	✓	✓	✓			
Standard VI—Coordination and Continuity of Care	§438.208	✓	✓	✓			
Standard VII—Coverage and Authorization of Services	§438.210	✓	✓	✓			
Standard VIII—Provider Selection	§438.214	✓	✓	✓			
Standard IX—Subcontractual Relationships and Delegation	§438.230	✓		✓		✓	
Standard X—Practice Guidelines	§438.236	✓	✓	✓			
Standard XI—Health Information Systems	§438.242	✓	✓	✓			
Standard XII—Quality Assessment and Performance Improvement	§438.330	✓	✓	✓			
Standard XIII—Grievance and Appeal Systems	§438.228	✓	✓	✓			
Standard XIV—Program Integrity	§438.608	✓	✓	✓			

[1] The compliance review 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).

Summary of Findings

Table 1-2 and Table 1-3 present an overview of the results of the 2023 compliance review for **Healthy Blue** (**HBL**). HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Section 2. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all standards. Refer to appendices B and C for a detailed description of the findings.

Table 1-2—Summary of Scores for the CY 2022 Compliance With Standards Review

Standard #	Standard Name	Total Elements	Number of Elements		Total Compliance Score
			M	*NM*	
I	Enrollment and Disenrollment	7	5	2	71.4%
	Total Compliance Score	**7**	**5**	**2**	**71.4%**

M=*Met*, ***NM***=*Not Met*

Total Elements: The total number of elements in each standard. This represents the denominator.

Total Compliance Score: 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.

Table 1-3—Summary of Scores for the CAP From the CY 2021 Review

	Total Elements in CAP	Number of Elements		Total Compliance Score From CAP
		M	*NM*	
Follow-Up on Corrective Action Plans (CAPs) From Prior Compliance Review	5	5	0	100%

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.

HBL received a performance score of 71.4 percent for Standard I—Enrollment and Disenrollment, which identified **HBL** has opportunities for improvement. Appendix A documents strengths and opportunities for improvement. Appendix B documents detailed findings, including recommendations for program enhancements.

HBL achieved compliance in five of five elements from the LDH-approved 2022 compliance review CAPs. Appendix B documents detailed findings of the review of the implementation of the **HBL**-approved 2022 compliance review CAPs.

Corrective Action Process

For any elements HSAG scored *Not Met*, **HBL** is required to submit a CAP to bring the element into compliance with the applicable standard(s). The process for submitting the CAP is described in Section 3.

2. Methodology

Activity Objectives

According to 42 CFR §438.358, a state or its EQRO must conduct a review within a three-year period to determine the MCEs' compliance with standards set forth in 42 CFR §438—Managed Care Subpart D, 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. To complete this requirement, HSAG, through its EQRO contract with LDH, performed compliance reviews of the five MCOs, two PAHPs, and one PIHP contracted with LDH to deliver services to Louisiana Medicaid managed care members.

The 2023 compliance review is the second year of the three-year cycle. The compliance review focused on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific requirements. LDH requested that HSAG conduct a compliance review of all standards not yet reviewed during the three-year compliance review cycle for each MCO, PIHP, and PAHP. Table 2-1 outlines the division of standards reviewed in Year One and Year Two.

Table 2-1—Compliance Review Standards

Standard	Associated Federal Citation[1]	Year One (CY 2021)			Year Two (CY 2022)		
		MCO	PAHP	PIHP	MCO	PAHP	PIHP
Standard I—Enrollment and Disenrollment	§438.56				✓	✓	✓
Standard II—Member Rights and Confidentiality	§438.100 §438.224	✓	✓	✓			
Standard III—Member Information	§438.10	✓	✓	✓			
Standard IV—Emergency and Poststabilization Services	§438.114	✓	NA				✓
Standard V—Adequate Capacity and Availability of Services	§438.206 §438.207	✓	✓	✓			
Standard VI—Coordination and Continuity of Care	§438.208	✓	✓	✓			
Standard VII—Coverage and Authorization of Services	§438.210	✓	✓	✓			
Standard VIII—Provider Selection	§438.214	✓	✓	✓			

Standard	Associated Federal Citation[1]	Year One (CY 2021)			Year Two (CY 2022)		
		MCO	PAHP	PIHP	MCO	PAHP	PIHP
Standard IX—Subcontractual Relationships and Delegation	§438.230	✓		✓		✓	
Standard X—Practice Guidelines	§438.236	✓	✓	✓			
Standard XI—Health Information Systems	§438.242	✓	✓	✓			
Standard XII—Quality Assessment and Performance Improvement	§438.330	✓	✓	✓			
Standard XIII—Grievance and Appeal Systems	§438.228	✓	✓	✓			
Standard XIV—Program Integrity	§438.608	✓	✓	✓			

[1] The compliance review 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).

This report presents the results of the 2023 compliance review, review period CY 2022 (January 1, 2022–December 31, 2022). LDH and the individual MCEs use the information and findings from the compliance reviews to:

- Evaluate the quality, timeliness, and accessibility of healthcare services furnished by the MCEs.
- Identify, implement, and monitor system interventions to improve quality.
- Evaluate current performance processes.
- Plan and initiate activities to sustain and enhance current performance processes.

Technical Methods of Data Collection and Analysis

Prior to beginning the compliance review, HSAG developed data collection tools, referred to as "compliance review tools," to document the review. The content in the tools was selected based on applicable federal and State regulations as they related to the scope of the review. The review processes used by HSAG to evaluate the MCEs' compliance were consistent with CMS EQR Protocol 3.

For each of the MCEs, HSAG's desk review consisted of the following activities.

Pre-Virtual Review Activities

- Collaborated with LDH to develop the scope of work, compliance review methodology, and compliance review tools.
- Prepared and forwarded to the MCE a detailed timeline, description of the compliance review process, pre-virtual review information packet, and a post-virtual review document tracker.
- Scheduled the virtual review with the MCE.
- Hosted a pre-virtual review preparation session with all MCEs.
- Generated a sample of cases for delegation file reviews.
- Conducted a desk review of supporting documentation the MCE submitted to HSAG.
- Followed up with the MCE, as needed, based on the results of HSAG's preliminary desk review.
- Developed an agenda for the virtual review interview sessions and provided the agenda to the MCE to facilitate preparation for HSAG's review.

Virtual Review Activities

- Conducted an opening conference, with introductions and a review of the agenda and logistics for HSAG's review activities.
- Interviewed MCE key program staff members.
- Conducted an information system (IS) review of the data systems that the MCE used in its operations, applicable to the standards under review.
- Conducted a closing conference during which HSAG reviewers summarized their preliminary findings, as appropriate.

Post-Virtual Review Activities

- Conducted a review of additional documentation submitted by the MCE.
- Documented findings and assigned each element a score (*Met* or *Not Met*) within the compliance review tool, as described in the Data Aggregation and Analysis section.
- Prepared an MCE-specific report and CAP template for the MCE to develop and submit its CAPs for each element that received a *Not Met* score.

Data Aggregation and Analysis

HSAG used scores of *Met* and *Not Met* to indicate the degree to which the MCE's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to an MCE during the period covered by HSAG's review. This scoring methodology is consistent with CMS EQR Protocol 3.

Met indicates full compliance defined as *all* of the following:

- All documentation listed under a regulatory provision, or component thereof, is present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.
- Documentation, staff responses, case file reviews, and IS reviews confirmed implementation of the requirement.

Not Met indicates noncompliance defined as *one or more* of the following:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interviews, but documentation is incomplete or inconsistent with practice.
- Documentation, staff responses, case file reviews, and IS reviews do not demonstrate adequate implementation of the requirement.
- No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.
- For those provisions with multiple components, key components of the provision could not be identified and any *Not Met* findings would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

From the scores that it assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each standard and an overall percentage-of-compliance score across the standards. HSAG calculated the total score for each standard by totaling the number of *Met* (1 point) elements and the number of *Not Met* (0 points) elements, then dividing the summed score by the total number of applicable elements for that standard.

HSAG determined the overall percentage-of-compliance score across all areas of review by following the same method used to calculate the scores for each standard (i.e., by summing the total values of the scores and dividing the result by the total number of applicable elements).

To draw conclusions about the quality, timeliness, and accessibility of care and services the MCE provided to members, HSAG aggregated and analyzed the data resulting from its desk and virtual review activities. The data that HSAG aggregated and analyzed included:

- Documented findings describing the MCE's progress in achieving compliance with State and federal requirements.
- Scores assigned to the MCE'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.

- Documented actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Not Met*.
- Documented recommendations for program enhancement, when applicable.

Description of Data Obtained

To assess the MCE's compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the MCE, including, but not limited to:

- Committee meeting agendas, minutes, and handouts.
- 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.

HSAG obtained additional information for the compliance review through interactions, discussions, and interviews with the MCE's key staff members. Table 2-2 lists the major data sources HSAG used to determine the MCE's performance in complying with requirements and the time period to which the data applied.

Table 2-2—Description of MCE Data Sources and Applicable Time Period

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during and after the site review	January 1, 2022–December 31, 2022
Information obtained through interviews	October 11, 2023
Information obtained from a review of a sample of delegated entity files	Listing of all delegates serving the Louisiana Medicaid managed care program at any time between January 1, 2022–December 31, 2022

3. Corrective Action Plan Process

HBL is required to submit to the HSAG SAFE site a CAP for all elements scored as *Not Met*. Appendix C contains the CAP template that HSAG prepared for **HBL** to use in preparing its plans of action to remediate any deficiencies identified during the 2023 compliance review. The CAP template lists each element for which HSAG assigned a score of *Not Met*, as well as the associated findings and required actions documented to bring **HBL** into full compliance with the deficient requirements. **HBL** must use this template to submit its CAP to bring any elements scored as *Not Met* into compliance with the applicable standard(s). **HBL**'s CAP must be submitted to the HSAG SAFE site **no later than 30 calendar days after receipt of the final report**.

The following criteria will be used by HSAG and LDH to evaluate the sufficiency of the CAP:

- The completeness of the CAP document in addressing each required action and assigning a responsible individual, a timeline/completion date, and specific plans of action/interventions that **HBL** will implement to bring the element into compliance.
- The degree to which the planned activities/interventions meet the intent of the requirement.
- The degree to which the planned interventions are anticipated to bring **HBL** into compliance with the requirement.
- The appropriateness of the timeline for correcting the deficiency.

Any CAPs that do not meet the preceding criteria will require resubmission by the MCO until approved by HSAG and LDH. Implementation of the CAP may begin once approval is received. LDH maintains ultimate authority for approving or disapproving any corrective action strategies proposed by **HBL** in its submitted CAP.

Appendix A. Conclusions and Recommendations

Standard I—Enrollment and Disenrollment

Strengths Related to Quality	
+	If LDH approved the MCO's member disenrollment request, the MCO gave the member written notice of the proposed disenrollment.

Strengths Related to Access and Timeliness	
+	The MCO implemented documented processes that focus on ensuring members are not disenrolled for any reason other than those stated in the LDH contract.

Opportunities for Improvement and Recommendations	
−	**Opportunities for Improvement:** The MCO did not consistently include all enrollment and disenrollment requirements in policies, procedures, or the member handbook. **Recommendations:** The MCO must update applicable policies, procedures, and the member handbook to consistently include all member enrollment and disenrollment federal and LDH contract requirements.
−	**Opportunities for Improvement:** The MCO's member handbook did not include all for cause and without cause member disenrollment rights. **Recommendations:** The MCO must update the member handbook to include all for cause and without cause member disenrollment rights.

Appendix B. 2023 Compliance With Standards Review Tool

This appendix includes the completed review tool that HSAG used to evaluate **HBL**'s performance and to document its findings; the scores it assigned associated with the findings; and, when applicable, the actions required to bring **HBL**'s performance into full compliance.

CY 2022 Compliance With Standards Review

Standard I—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the MCO**	**Score**
1. The MCO agrees to accept individuals enrolled into its MCO in the order in which they apply without restriction (unless authorized by the Department). *42 CFR §438.3(d)(1)* 2022 Contract Citations: 11.9.1 2023 Contract Citations: 2.3.12.1; 2.3.12.1.1; 2.3.12.1.2	• Member Handbook pg. 10-11 **Virtual Review Follow-Up Document Submission** • Member Handbook, pg. 87 • Member Rights and Responsibilities – LA, pg. 3 • Membership Load – Facets, pg. 1 • Non-Discrimination in Marketing Enrollment and Health Plan Operations, pgs. 1-4	☐ Met ☒ Not Met
HSAG Findings: The MCO's Healthy Blue Member Handbook: Integrated Health Services did not state the MCO agreed to accept individuals enrolled into its MCO in the order in which they apply without restriction (unless authorized by the Department). The MCO's Membership Loads—Facets policy stated that the Medicaid Enrollment and Billing Department will accept all eligible individuals, in the order in which they apply and without restriction. The MCO's Non-Discrimination in Marketing, Enrollment, and Health Plan Operations policy included the requirement in the Arkansas section of the policy, but the policy did not have a Louisiana section.		
Required Actions: The MCO must revise its member handbook to include language stating that the MCO agrees to accept individuals enrolled into its MCO in the order in which they apply without restriction (unless authorized by the Department). The MCO must update the Non-Discrimination in Marketing, Enrollment, and Health Plan Operations policy to state that the MCO agrees to accept individuals enrolled into its MCO in the order in which they apply without restriction (unless authorized by the Department) within the body of the policy or in a Louisiana-specific section.		
2. The MCO 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, race, color, national origin, sex, or disability.	• Disenrollment – LA policy pg. 2 • Member Handbook pg. 88 **Virtual Review Follow-Up Document Submission**	☒ Met ☐ Not Met

Standard I—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the MCO**	**Score**
42 CFR §438.3(d)(3-4) 2022 Contract Citations: 11.10.1.3 2023 Contract Citations: 2.3.12.1; 2.3.12.1.3	• Non-Discrimination in Marketing Enrollment and Health Plan Operations, pg. 1 • Screen Print • Membership Load – Facets, pg. 1 • Non-Discrimination Policy (in the Footer of the Member Website) • Member Rights and Responsibilities – LA, pg. 2	
3. The MCO 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 MCO's ability to furnish services to the member or to other members. *42 CFR §438.56(b)(2)* 2022 Contract Citations: 11.10.1.3; 11.11.4.1 2023 Contract Citations: 2.3.13.3.4	• Enrollment and Disenrollment Policy, Page 2	☒ Met ☐ Not Met
4. The MCO may initiate disenrollment of any member's participation in the MCO on one or more of the following grounds: • When the member ceases to be eligible for medical assistance under the State Plan as determined by the Department • Upon termination or expiration of the Contract	• Disenrollment – LA policy pgs. 3-4 • Member Handbook pg. 81-82	☒ Met ☐ Not Met

Standard I—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the MCO**	**Score**
• Death of the member • Confinement of the member in a facility or institution when confinement is not a covered service under the Contract *42 CFR §438.56(b)(1)* 2022 Contract Citations: 11.11.6.1; 11.11.6.2; 11.11.6.7 2023 Contract Citations: 2.3.12.3.2; 2.3.13.2		
5. The MCO shall not request disenrollment for reasons other than those stated in the Contract. In accordance with 42 CFR §438.56(b)(3), LDH shall ensure that the MCO is not requesting disenrollment for other reasons by reviewing and rendering decisions on all Disenrollment Request Forms submitted to the enrollment broker. *42 CFR §438.56(b)(3)* 2022 Contract Citations: 11.11.4.2 2023 Contract Citations: 2.3.13.3.5	• Enrollment and Disenrollment Policy, Page 2-3	☒ Met ☐ Not Met
6. If the Department approves the MCO's disenrollment request, the MCO gives the member written notice of the proposed disenrollment. *42 CFR §438.56(d)(5)* 2022 Contract Citations: 11.11.4.4; 11.11.4.8 2023 Contract Citations: 2.3.13.3.7	• Disenrollment – LA policy pgs. 4-5 • Member Handbook pg. 85 **Virtual Review Follow-Up Document Submission** • Member Handbook, pg. 2 • Member Appeals – Core Process pgs. 5, 9, and 12	☒ Met ☐ Not Met
7. The member may request disenrollment as follows: • For cause at any time, including: – The member has moved out of the MCO's service area;	• Disenrollment – LA policy pgs. 1-2 • Member Handbook pg. 81-82	☐ Met ☒ Not Met

Standard I—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the MCO**	**Score**
– The MCO does not (due to moral or religious objections) cover the service the member seeks; – The member needs related services to be performed at the same time, not all related services are available from the MCO's plan, and the member's primary care provider (or another provider) determines that receiving the services separately would subject the member to unnecessary risk; – Poor quality of care; – Lack of access, or lack of access to providers experienced in dealing with the member's specific needs; – The Contract between the MCO and LDH is terminated; – Lack of access to MCO covered services as determined by LDH; – The member's active specialized behavioral health provider ceases to contract with the MCO; or – Any other reason deemed to be valid by LDH and/or its agent. • Without cause at the following times: – During the disenrollment period offered to members at the start of the Contract – During the 90 days following the date of the member's initial enrollment with the MCO or during the 90 calendar days following the date the Enrollment Broker sends the member notice of that enrollment, whichever is later	**Virtual Review Follow-Up Document Submission** • Member Handbook, pgs. 81-82 • Disenrollment Policy pg. 2	

Standard I—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the MCO**	**Score**
– At least once every 12 months thereafter – Upon automatic reenrollment if temporary loss (90 calendar days) of eligibility has caused the member to miss the annual disenrollment opportunity – When the Department has imposed sanctions on the MCO (consistent with 42 CFR §438.702[a][4]) *42 CFR §438.56(c)-(d)(2)* 2022 Contract Citations: 11.11.3; 11.11.3.1; 11.11.3.2 2023 Contract Citations: 2.3.13.2		
HSAG Findings: The MCO's Healthy Blue Member Handbook: Integrated Health Services and the Disenrollment—LA policy did not include the correct federal citation (42 CFR §438.702[a][4]). The MCO's Disenrollment—LA policy did not include the requirement "lack of access within Healthy Blue to providers experienced in dealing with the member's specific needs."		
Required Actions: The MCO must update the Healthy Blue Member Handbook: Integrated Health Services and the Disenrollment—LA policy to include the correct federal citation (42 CFR §438.702[a][4]). The MCO's Disenrollment—LA policy must be updated to include the requirement "lack of access within Healthy Blue to providers experienced in dealing with the member's specific needs."		

Results for Standard I—Enrollment and Disenrollment							
Total	Met	=	5	X	1.0	=	5.0
	Not Met	=	2	X	0.0	=	0.0
Total Applicable		=	7	**Total Score**		=	5.0

Total Score ÷ Total Applicable	=	**71.4%**

CY 2021 Review CAP

Availability of Services CFR 438.206		
Requirement	**Evidence as Submitted by the MCO**	**Score**
1. The MCO shall comply with the provisions of 42 CFR §438.102(a)(1)(ii) concerning the integrity of professional advice to members, including interference with provider's advice to members and information disclosure requirements related to physician incentive plans. *42 CFR 438.206* Contract: 7.16.1.6	**2022 MCO Document Submission:** • Provider Manual P. 26 Sec 2.23 **2023 MCO Document Submission:** • Provider Manual_2022 Page 27 • Provider and Member Bill of Rights **Virtual Review Follow-Up Document Submission** • Bill of Rights policy - although finalized internally - has been submitted to the LDH for approval. • Initial Training of Provider on Plan's Product – LA policy, pg. 3	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*—This requirement was not found in any policies. This requirement is addressed in the Provider Manual.		
2022 Compliance Review Recommendation: Required language should be added to relevant policies.		
2022 MCO Comments: The health plan agrees with the assessment. Based on the recommendation, health plan will add the required information to the relevant policy.		
2023 CAP Review Findings: The MCO's Provider and Member Bill of Rights policy and procedure stated that HBL complies with the provisions of 42 CFR §438.102(a)(1)(ii) concerning the integrity of professional advice to members, including interference with providers' advice to members and information disclosure requirements related to physician incentive plans.		
2023 CAP Review Required Actions: None.		

Provider Selection: CFR 438.214		
Requirement	**Evidence as Submitted by the MCO**	**Score**
1. 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. *42 CFR 438.214* Contract: 7.6.3.2; 7.14.1	**2022 MCO Document Submission:** • 7.14.1_Cred Pol_4.0.1v8_011521_BH EDU Criteria_ Entire Policy • 7.14.1_Cred Pol_5v7_011521_Initial App_ Entire Policy • 7.14.1_Cred Pol_6v6_011521_Verification of Data Elements_Entire Policy • 7.14.1_Cred Pol_12v6_011521_Ongoing Sanction Monitoring_Entire Policy • 7.14.1_Cred Pol_9v8_011521_Recred_Entire Policy • 7.14.1_LA_State_Specific_Cred_Policy.2021v7_Page 1 • 7.14.1 _Cred Pol_2v10_011521_Provider Scope_Page 1 **2023 MCO Document Submission:** • Provider Selection CFR 438.214 **Virtual Review Follow-Up Document Submission** • TAT LA: Health Blue's TAT Monitoring Tool • Credentialing Initials Recred Desktop • Initial Cred Approval Letter Process Desktop	☒ Met ☐ Not Met

Provider Selection: CFR 438.214		
Requirement	**Evidence as Submitted by the MCO**	**Score**
	• 2 Internal desktops that support the credentialing Process initially submitted	
2022 Compliance Review Finding: *Partially Met*—Four (4) of five (5) initial credentialing files met the NCQA health plan accreditation standards. One (1) credentialing file failed to meet NCQA's provisional Timeliness Standard. Five (5) of five (5) re-credentialing files met the NCQA health plan accreditation standards This requirement is addressed in Healthy Blue's Additional State Specific Regulatory or Contractual Requirements for: Louisiana credentialing policy.		
2022 Compliance Review Recommendation: The entity should ensure that the organization's time frame for notifying applicants of initial credentialing decisions does not exceed 60 calendar days from the Credentialing Committee's decision.		
2022 MCO Comments: After researching, it was found that the letter was not mailed timely due to a technical issue. This issue has been addressed.		
2023 CAP Review Findings: The MCO's TAT LA Monitoring Tool showed, in all cases, that the credentialing process and notice to the provider were required to be completed within 60 days. In addition, the MCO's Anthem Provider Credentialing Approval Letter Procedure Document, Version No. 2.0, indicated that credentialing approval letters were to be sent out within five business days of the medical director's approval.		
2023 CAP Review Required Actions: None.		

Enrollee Rights and Protection: CFR 438.224		
Requirement	**Evidence as Submitted by the MCO**	**Score**
1. Identification of any restrictions on the enrollee's freedom of choice among network providers; and *42 CFR 438.224* Contract: 12.14.4.3	**2022 MCO Document Submission:** • 10 LA Medicaid Physical and BH Provider Directory 1221.pdf Page 9 **2023 MCO Document Submission:** • Enrollee Rights and Protection CFR 438.224 _ 1and2 _Pg. 17 **Virtual Review Follow-Up Document Submission** • Member Rights and Responsibilities – LA, pg. 2 • Enrollee Rights and Protection, pgs. 15-17 **Virtual Review Follow-Up Document Submission** • Member Rights and Responsibilities – LA, pg. 2. • Enrollee Rights and Protection, pgs. 15-17	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*—This requirement is partially addressed by the provider directories.		
2022 Compliance Review Recommendation: The entity should incorporate this requirement into a provider directory policy or a broader member materials policy.		
2022 MCO Comments: Health Plan agrees with the determination. Provider Directory Louisiana Update P&P will be updated to reflect these requirements - see attached draft, pages 12.		
2023 CAP Review Findings: The following language was found in the "Market-Specific State Requirements" section of the MCO's Member Rights and Responsibilities—LA policies and procedures: "In accordance with 42 CFR §438.10(h), the Provider Directory shall include, but not be limited to: Identification of any restrictions on the Enrollee's freedom of choice among Network Providers." The MCO's Provider Directory		

Enrollee Rights and Protection: CFR 438.224		
Requirement	**Evidence as Submitted by the MCO**	**Score**
policy included the requirement that the provider directory shall include identification of any restrictions on the enrollee's freedom of choice among network providers.		
2023 CAP Review Required Actions: None.		

Enrollee Rights and Protection: CFR 438.224		
Requirement	**Evidence as Submitted by the MCO**	**Score**
2. Identification of hours of operation including identification of providers with non-traditional hours (Before 8 a.m. or after 5 p.m. or any weekend hours). *42 CFR 438.224* Contract: 12.14.4.4	**2022 MCO Document Submission:** • 10 LA Medicaid Physical and BH Provider Directory 1221.pdf Page 18 • Provider Directories (P&)0. Page 2-3 **2023 MCO Document Submission:** • Enrollee Rights and Protection CFR 438.224 _ 1and2 _Pg. 17 **Virtual Review Follow-Up Document Submission** • Standards and Measures and Monitoring Appropriate Accessibility to Care – LA • Enrollee Rights and Protection, pgs. 15-17 • Provider Manual, pg. 16-17	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*—This requirement is partially addressed by the provider directories.		
2022 Compliance Review Recommendation: The entity should incorporate this requirement into a provider directory policy or a broader member materials policy.		
2022 MCO Comments: Provider Directory Louisiana Update P&P will be updated to reflect these requirements - see attached draft, pages 12 and 13.		
2023 CAP Review Findings: The following language was found in the MCO's Enrollee Rights and Protections policy and procedure in the "Market-Specific State Requirements" section: "In accordance with 42 CFR §438.10(h), the Provider Directory shall include, but not be limited to: Identification of hours of operation including identification of providers with non-traditional hours (before 8 a.m. or after 5 p.m., Central Time, or any weekend hours)." The MCO's Provider Directory policy included the identification of hours of operation requirement including identification of providers with nontraditional hours (before 8 a.m. or after 5 p.m., Central Time, or any weekend hours). The MCO's Standards and Measures and Monitoring Appropriate Accessibility to Care—LA policies and procedures included the requirement that the provider offer after-hours availability to patients who need medical advice. At a minimum, the primary care provider (PCP) office must		

Enrollee Rights and Protection: CFR 438.224		
Requirement	**Evidence as Submitted by the MCO**	**Score**
have a return call system staffed and monitored in order to assure members are connected to a designated medical practitioner within 30 minutes of the call. The policy also included vendor monitoring of standards for practitioner after-hours accessibility. The MCO's 2022 Provider Manual within the "PCP Onsite Availability" section stated that PCPs were strongly encouraged to offer after-hours office care in the evenings and on weekends. PCPs were encouraged to provide after-hours office care for two hours at least one day per week after 5 p.m. and four hours or longer on Saturdays.		
2023 CAP Review Required Actions: None.		

Grievance and Appeal System CFR 438.228		
Requirement	**Evidence as Submitted by the MCO**	**Score**
1. Reports of grievances and resolutions shall be submitted to DHH as specified in Section 13.4 and of this RFP. The MCO shall not modify the grievance procedure without the prior written approval of DHH. *42 CFR 438.228* Contract: 13.10.0	**2022 MCO Document Submission:** • None listed **2023 MCO Document Submission:** • Grievance and Appeal System CFR 438.228 pgs. 4-5 **Virtual Review Follow-Up Document Submission** • Member Complaints and Grievances – LA policy, pgs. 4 and 5 • Behavioral Health Member Appeals – Core Process shared	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*—This requirement is addressed in the case files; however, there is no policy for this requirement.		
2022 Compliance Review Recommendation: The entity should include this requirement to the Member Appeal policy or another policy or procedure.		
2022 MCO Comments: Agree with the IPRO findings		
2023 CAP Review Findings: The MCO submitted the Member Complaints and Grievances (Physical Health)—LA policy which stated that the health plan's grievance procedures and any changes thereto will be approved in writing by LDH prior to their implementation and will include, at a minimum, the requirements set forth in the Healthy Louisiana Contract. The policy also stated that the health plan shall report on grievances and appeals to LDH in a manner and format determined by LDH.		
2023 CAP Review Required Actions: None.		

Results for Follow-Up on 2022 Deficiencies Corrective Action Plans							
Total	Met	=	5	X	1.0	=	5.0
	Not Met	=	0	X	0.0	=	0.0
Total Applicable		=	5	**Total Score**		=	5.0

Total Score ÷ Total Applicable	=	**100%**

Appendix C. 2023 Corrective Action Plan Template

Standard I—Enrollment and Disenrollment			
Requirements—HSAG's Findings and MCE Required Corrective Actions			
Element 1: The MCO agrees to accept individuals enrolled into its MCO in the order in which they apply without restriction (unless authorized by the Department). *42 CFR §438.3(d)(1)* 2022 Contract Citations: 11.9.1 2023 Contract Citations: 2.3.12.1; 2.3.12.1.1; 2.3.12.1.2			
Findings: The MCO's Healthy Blue Member Handbook: Integrated Health Services did not state the MCO agreed to accept individuals enrolled into its MCO in the order in which they apply without restriction (unless authorized by the Department). The MCO's Membership Loads—Facets policy stated that the Medicaid Enrollment and Billing Department will accept all eligible individuals, in the order in which they apply and without restriction. The MCO's Non-Discrimination in Marketing, Enrollment, and Health Plan Operations policy included the requirement in the Arkansas section of the policy, but the policy did not have a Louisiana section.			
Required Actions: he MCO must revise its member handbook to include language stating that the MCO agrees to accept individuals enrolled into its MCO in the order in which they apply without restriction (unless authorized by the Department). The MCO must update the Non-Discrimination in Marketing, Enrollment, and Health Plan Operations policy to state that the MCO agrees to accept individuals enrolled into its MCO in the order in which they apply without restriction (unless authorized by the Department) within the body of the policy or in a Louisiana-specific section.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**
CAP Approval Status:			

Standard I—Enrollment and Disenrollment			
Requirements—HSAG's Findings and MCE Required Corrective Actions			
Element 7: The member may request disenrollment as follows: • For cause at any time, including: – The member has moved out of the MCO's service area; – The MCO does not (due to moral or religious objections) cover the service the member seeks; – The member needs related services to be performed at the same time, not all related services are available from the MCO's plan, and the member's primary care provider (or another provider) determines that receiving the services separately would subject the member to unnecessary risk; – Poor quality of care; – Lack of access, or lack of access to providers experienced in dealing with the member's specific needs; – The Contract between the MCO and LDH is terminated; – Lack of access to MCO covered services as determined by LDH; – The member's active specialized behavioral health provider ceases to contract with the MCO; or – Any other reason deemed to be valid by LDH and/or its agent. • Without cause at the following times: – During the disenrollment period offered to members at the start of the Contract – During the 90 days following the date of the member's initial enrollment with the MCO or during the 90 calendar days following the date the Enrollment Broker sends the member notice of that enrollment, whichever is later – At least once every 12 months thereafter – Upon automatic reenrollment if temporary loss (90 calendar days) of eligibility has caused the member to miss the annual disenrollment opportunity – When the Department has imposed sanctions on the MCO (consistent with 42 CFR §438.702[a][4]) *42 CFR §438.56(c)-(d)(2)* 2022 Contract Citations: 11.11.3; 11.11.3.1; 11.11.3.2 2023 Contract Citations: 2.3.13.2			
Findings: The MCO's Healthy Blue Member Handbook: Integrated Health Services and the Disenrollment—LA policy did not include the correct federal citation (42 CFR §438.702[a][4]). The MCO's Disenrollment—LA policy did not include the requirement "lack of access within Healthy Blue to providers experienced in dealing with the member's specific needs."			
Required Actions: The MCO must update the Healthy Blue Member Handbook: Integrated Health Services and the Disenrollment—LA policy to include the correct federal citation (42 CFR §438.702[a][4]). The MCO's Disenrollment—LA policy must be updated to include the requirement "lack of access within Healthy Blue to providers experienced in dealing with the member's specific needs."			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**
CAP Approval Status:			