LOUISIANA DEPARTMENT OF HEALTH

2023 External Quality Review Compliance Review

for

Managed Care North America

December 2023

HSAG HEALTH SERVICES ADVISORY GROUP

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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 PIHPs 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 presents an overview of the results of the 2023 compliance review for **Managed Care North America** (**MCNA**). 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	6	1	85.7%
IX	Subcontractual Relationships and Delegation	6	5	1	83.3%
	Total Compliance Score	**13**	**11**	**2**	**84.6%**

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.

MCNA received performance scores below 90 percent for Standard I—Enrollment and Disenrollment and Standard IX—Subcontractual Relationships and Delegation, which identified opportunities for improvement. Appendix A documents strengths and opportunities for improvement. Appendix B documents detailed findings, including recommendations for program enhancements.

Corrective Action Process

For any elements HSAG scored *Not Met*, **MCNA** is required to submit a corrective action plan (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 LDS 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 a review of delegation records.
- 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).

HSAG conducted file reviews of the MCE's records for delegation to verify that the MCE had put into practice what the MCE had documented in its policies. HSAG selected 10 records for delegation from the full universe of records provided by the MCE. The file reviews were not intended to be a statistically significant representation of all the MCE's files. Rather, the file reviews highlighted instances in which practices described in policy were not followed by MCE staff members. Based on the results of the file reviews, the MCE must determine whether any area found to be out of compliance was the result of an anomaly or if a more serious breach in policy occurred. Findings from the file reviews were documented within the applicable standard and element in the compliance review tool.

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 4, 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

MCNA 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 **MCNA** 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 **MCNA** into full compliance with the deficient requirements. **MCNA** must use this template to submit its CAP to bring any elements scored as *Not Met* into compliance with the applicable standard(s). **MCNA**'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 **MCNA** 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 **MCNA** 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 PAHP 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 **MCNA** in its submitted CAP.

Appendix A. Conclusions and Recommendations

Standard I—Enrollment and Disenrollment

Strengths Related to Access and Timeliness	
+	The PAHP demonstrated implementation in its policies and procedures that it did not discriminate against or request disenrollment because of a change in a member's health status, utilization of medical services, diminished mental capacity, uncooperative or disruptive behavior; or based on a need for healthcare services, race, color, national origin, sex, or disability.

Opportunities for Improvement and Recommendations	
−	**Opportunities for Improvement:** The PAHP's enrollment and disenrollment policies and procedures did not include all required member for cause and without cause reasons to request disenrollment. **Recommendations:** The PAHP must revise its policy to include the following language related to member requests for disenrollment without cause at the following times: • During the 90 days following the date of the member's initial enrollment • Upon automatic reenrollment if temporary loss of eligibility has caused the member to miss the annual disenrollment opportunity • When the Department has imposed sanctions on the PAHP (consistent with 42 CFR §438.702[a][4])

Standard IX—Subcontractual Relationships and Delegation

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

Strengths Related to Access and Timeliness	
+	The PAHP had implemented policies and procedures to evaluate the prospective subcontractor's qualifications and ability to perform the delegated activities prior to executing the subcontract. The PAHP implemented processes to monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule.

Opportunities for Improvement and Recommendations	
–	**Opportunities for Improvement:** The PAHP did not include all required elements in its subcontractor and delegated agreements. **Recommendations:** The PAHP must update the FiServ subcontractor/delegation agreement to contain the requirements in this element. The subcontractor/delegation agreements must include: • The State, CMS, the United States Department of Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the PAHP's contract with the State. • The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems related to Medicaid members. • The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

Appendix B. 2023 Compliance With Standards Review Tool

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

CY 2022 Compliance With Standards Review

Standard I—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the PAHP**	**Score**
1. The PAHP agrees to accept individuals enrolled into its PAHP in the order in which they apply without restriction (unless authorized by the Department). *42 CFR §438.3(d)(1)* 2022 Contract Citation: 2.3.4.1.2	• 11.300LA Enrollment File Processing, page 2, paragraph 1.	☒ Met ☐ Not Met
2. The PAHP 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. *42 CFR §438.3(d)(3-4)* 2022 Contract Citation: 2.3.4.1.3	• 11.300LA Enrollment File Processing, page 2, paragraph 3. **Virtual Review Follow-Up Documents** • Policy 1.106 Non-Discriminatory Practices • Master Dental Provider Agreement • LA Provider Orientation Slideshow 08_08_2023	☒ Met ☐ Not Met
3. The PAHP 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 PAHP's ability to furnish services to the member or to other members. *42 CFR §438.56(b)(2)* 2022 Contract Citation: 2.3.7.3.4	• 11.404LA Involuntary Disenrollment, page 1, 3rd paragraph.	☒ Met ☐ Not Met

Standard I—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the PAHP**	**Score**
4. The PAHP may initiate disenrollment of any member's participation in the PAHP 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 • 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 Citation: 2.3.7.3	• 11.403LA Disenrollment, Page 1, 2nd paragraph **Virtual Review Follow-Up Documents** • Policy 1.106 Non-Discriminatory Practices	☒ Met ☐ Not Met
5. The PAHP 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 PAHP 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: 2.3.7.3.2; 2.3.7.3.5	• 11.404LA Involuntary Disenrollment, Page 2, paragraph 2	☒ Met ☐ Not Met
6. If the Department approves the PAHP's disenrollment request, the PAHP gives the member written notice of the proposed disenrollment and notifies the member of his or her right to submit a request for a State Fair Hearing. *42 CFR §438.56(d)(5)* C2022 Contract Citation: 2.3.7.3.7	• 11.404LA Involuntary Disenrollment, Page 2, 1st paragraph	☒ Met ☐ Not Met

Standard I—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the PAHP**	**Score**
7. The member may request disenrollment as follows: • For cause at any time, including: – The member has moved out of the PAHP's service area; – The PAHP 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 PAHP'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; or – Lack of access, or lack of access to providers experienced in dealing with the member's specific needs. • Without cause at the following times: – During the 90 days following the date of the member's initial enrollment – At least once every 12 months thereafter – Upon automatic reenrollment if temporary loss of eligibility has caused the member to miss the annual disenrollment opportunity – When the Department has imposed sanctions on the PAHP (consistent with 42 CFR §438.702[a][4]) *42 CFR §438.56(c)-(d)(2)* 2022 Contract Citation: 2.3.7.2.1	• 11.403LA Disenrollment, Page 1, 3rd paragraph **Virtual Review Follow-Up Documents** • Policy 11.403MIC Disenrollment Process • Member Handbook	☐ Met ☒ Not Met

Standard I—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the PAHP**	**Score**
HSAG Findings: The PAHP submitted the disenrollment policy as evidence of compliance with the requirements of this element. The policy did not include language related to a member's request for disenrollment without cause at the following times: • During the 90 days following the date of the member's initial enrollment • At least once every 12 months thereafter • Upon automatic reenrollment if temporary loss of eligibility has caused the member to miss the annual disenrollment opportunity • When the Department has imposed sanctions on the PAHP (consistent with 42 CFR §438.702[a][4])		
Required Actions: The PAHP must revise its policy to include the following language related to member requests for disenrollment without cause at the following times: • During the 90 days following the date of the member's initial enrollment • At least once every 12 months thereafter • Upon automatic reenrollment if temporary loss of eligibility has caused the member to miss the annual disenrollment opportunity • When the Department has imposed sanctions on the PAHP (consistent with 42 CFR §438.702[a][4])		

Results for Standard I—Enrollment and Disenrollment						
Total	Met	6	X	1.0	=	6.0
	Not Met	1	X	0.0	=	0.0
Total Applicable		7	**Total Score**		=	6.0

Total Score ÷ Total Applicable	=	**85.7%**

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the PAHP**	**Score**
1. Notwithstanding any relationship(s) with any subcontractor, the PAHP maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State. *42 CFR §438.230(b)(1)* 2022 Contract Citations: 13 (Terms and Conditions); 2.15.6	• 1.200MIC Contracting and Oversight of Subcontractors, Page 1, 1st paragraph **Virtual Review Follow-Up Additional Documentation:** • 119 MCNA 2022 Q3 119 MCNA 2022 Q3 • LA Q3 2022 QIC - Departmental Analyses_10.24.2022_Final • 2022 LA EPSDT_Adult Denture_Adult Waiver Program KPI Dashboard • Contractual Reports Used in Oversight • Subcontractual Monitoring Calendar • DASA and Amendments Requirement Crosswalk	☒ Met ☐ Not Met
2. All contracts or written arrangements between the PAHP and any subcontractor specify: • The delegated activities or obligations and related reporting responsibilities. • That the subcontractor agrees to perform the delegated activities and reporting responsibilities. • Provision for revocation of the delegation of activities or obligation, or specify other remedies in instances wherein the State or PAHP determines that the subcontractor has not performed satisfactorily. *42 CFR §438.230(b)(2); (c)(1)* 2022 Contract Citation: 2.15.6.3	• 1.200MIC Contracting and Oversight of Subcontractors, Page 1,1st paragraph to page 2 (top) **Virtual Review Follow-Up Additional Documentation:** • DASA and Amendments Requirement Crosswalk • Second Amendment to Louisiana DASA 9-15-20: • pages 1-2 • page 3 • Section 7; Page 6, item (b)	☒ Met ☐ Not Met

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the PAHP**	**Score**
3. The PAHP's written agreement with any subcontractor includes: • The subcontractor's agreement to comply with all applicable Medicaid laws and regulations, including applicable subregulatory guidance and contract provisions. *42 CFR §438.230(c)(2)* 2022 Contract Citations: 2.12.1.1	• 1.200MIC Contracting and Oversight of Subcontractors, Page 1, 1st paragraph **Virtual Review Follow-Up Additional Documentation:** • DASA and Amendments Requirement Crosswalk • Second Amendment to Louisiana DASA 9-15-20: pages 1-2, 3	☒ Met ☐ Not Met
4. The written agreement with the subcontractor includes: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the PAHP's contract with the State. • The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems related to Medicaid members. • The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. • If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar	• 1.200MIC Contracting and Oversight of Subcontractors, Page 3, 3rd Paragraph "Access to Records". • Dental Admin Services Agreement - MCNA - MCNA Insurance – Page 11 • First Amend to Dental Agreement MCNA Dental Plans - MCNA Insurance • Second Amendment to Louisiana DASA 09-15-20 • DASA Conforming Amendment 08.22 • Amendment_Fiserve-MCNA_Audit FINAL **Virtual Review Follow-Up Additional Documentation:** • DASA and Amendments Requirement Crosswalk • DASA Conforming Amendment 8/2022, page 1	☐ Met ☒ Not Met

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the PAHP**	**Score**
risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. *42 CFR §438.230(c)(3)* 2022 Contract Citations: 2.12.1.3; 2.12.1.4; 2.15.11.1		
HSAG Findings: The PAHP's MIC Contracting and Oversight of Subcontractors policy and the DASA Conforming Amendment included the requirements of this element. The PAHP did not include the requirements in the First Amendment to the Dental Agreement MCNA Dental Plans; Second Amendment to Louisiana DASA; or the sample agreement, the FiServ amendment.		
Required Actions: The PAHP must update the FiServ subcontractor/delegation agreement to contain the requirements in this element. The subcontractor/delegation agreements must include: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the PAHP's contract with the State. • The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems related to Medicaid members. • The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. •		
5. Prior to executing a subcontract, the PAHP must evaluate the prospective subcontractor's qualifications and ability to perform the activities to be delegated. 2022 Contract Citation: 2.15.6.2	• 1.200MIC Contracting and Oversight of Subcontractors, Page 2, 3rd paragraph, 1st bullet	☒ Met ☐ Not Met
6. The PAHP shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards. The PAHP shall identify deficiencies or areas for improvement and take corrective action. 2022 Contract Citation: 2.15.6.4; 2.15.6.5	• 1.200MIC Contracting and Oversight of Subcontractors, Page 2, 3rd Paragraph, bullets 2 and 3 **Virtual Review Follow-Up Additional Documentation:**	☒ Met ☐ Not Met

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the PAHP**	**Score**
	• 119 MCNA 2022 Q3 119 MCNA 2022 Q3 • LA Q3 2022 QIC - Departmental Analyses_10.24.2022_Final • 2022 LA EPSDT_Adult Denture_Adult Waiver Program KPI Dashboard • Contractual Reports Used in Oversight • Subcontractual Monitoring Calendar • MCNA Action Plan	

Results for Standard IX—Subcontractual Relationships and Delegation							
Total	Met	=	5	X	1.0	=	5.0
	Not Met	=	1	X	0.0	=	0.0
Total Applicable		=	6	**Total Score**		=	5.0

Total Score ÷ Total Applicable	=	**83.3%**

Appendix C. 2023 Corrective Action Plan Template

Standard I—Enrollment and Disenrollment
Requirements—HSAG's Findings and PAHP 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 PAHP's service area; – The PAHP 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 PAHP'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; or – Lack of access, or lack of access to providers experienced in dealing with the member's specific needs. • Without cause at the following times: – During the 90 days following the date of the member's initial enrollment – At least once every 12 months thereafter – Upon automatic reenrollment if temporary loss of eligibility has caused the member to miss the annual disenrollment opportunity – When the Department has imposed sanctions on the PAHP (consistent with 42 CFR §438.702[a][4]) *42 CFR §438.56(c)-(d)(2)* 2022 Contract Citation: 2.3.7.2.1
Findings: The PAHP submitted the disenrollment policy as evidence of compliance with the requirements of this element. The policy did not include language related to a member's request for disenrollment without cause at the following times: • During the 90 days following the date of the member's initial enrollment • At least once every 12 months thereafter • Upon automatic reenrollment if temporary loss of eligibility has caused the member to miss the annual disenrollment opportunity • When the Department has imposed sanctions on the PAHP (consistent with 42 CFR §438.702[a][4])
Required Actions: The PAHP must revise its policy to include the following language related to member requests for disenrollment without cause at the following times: • During the 90 days following the date of the member's initial enrollment • At least once every 12 months thereafter • Upon automatic reenrollment if temporary loss of eligibility has caused the member to miss the annual disenrollment opportunity • When the Department has imposed sanctions on the PAHP (consistent with 42 CFR §438.702[a][4])

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date

CAP Approval Status:

Standard IX—Subcontractual Relationships and Delegation			
Requirements—HSAG's Findings and PAHP Required Corrective Actions			
Element 4: The written agreement with the subcontractor includes: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the PAHP's contract with the State. • The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems related to Medicaid members. • The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. • If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. *42 CFR §438.230(c)(3)* 2022 Contract Citations: 2.12.1.3; 2.12.1.4; 2.15.11.1			
Findings: The PAHP's MIC Contracting and Oversight of Subcontractors policy and the DASA Conforming Amendment included the requirements of this element. The PAHP did not include the requirements in the First Amendment to the Dental Agreement MCNA Dental Plans; Second Amendment to Louisiana DASA; or the sample agreement, the FiServ amendment.			
Required Actions: The PAHP must update the FiServ subcontractor/delegation agreement to contain the requirements in this element. The subcontractor/delegation agreements must include: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the PAHP's contract with the State. • The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems related to Medicaid members. • The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. • If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**
CAP Approval Status:			