State of Louisiana Department of Health

2022 Healthy Louisiana EQRO Compliance Audit
Aetna Better Health of Louisiana
Period of Review: January 1, 2021 – December 31, 2021

ISSUED NOVEMBER 2022

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FINAL

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Introduction and Audit Overview

Introduction

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

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

This report presents IPRO's findings of the 2022 annual compliance audit for Aetna Better Health of Louisiana (Aetna).

Audit Overview

The purpose of the audit was to assess Aetna's compliance with federal and state regulations regarding: access to care; structure and operations; grievance policies; provider network relations and network adequacy; quality measurement; fraud, waste and abuse; and utilization management (UM).

The audit included an evaluation of Aetna's policies, procedures, files, and other materials corresponding to the following 12 contractual domains:

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

The file review component assessed Aetna's implementation of policies and its operational compliance with regulations related to Grievance and Appeal Systems, Coordination and Continuity of Care (physical and behavioral health), Coverage and Authorization of Services-UM, Provider Selection, and Fraud Waste and Abuse.

Sample sizes for each file review type are presented in **Table 1**.

Table 1: File Review Sample Sizes

File Type	Sample Size
Appeals	20
Credentialing/Recredentialing	10
Member grievances	10
Utilization Management denials	10

The period of review was January 1, 2021 through December 31, 2021. All documents and case files reviewed were active during this time period.

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

Table 2: Review Determination Definitions

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

MCO: managed care organization.

The 2022 annual compliance audit consisted of three phases: 1) pre-onsite documentation review, 2) remote interviews, and 3) post-onsite report preparation.

For the purposes of this report the term "onsite" refers to a remote interview for this year.

Pre-onsite Documentation Review

To ensure a complete and meaningful assessment of Aetna's policies and procedures, IPRO prepared 12 review tools to reflect the areas for audit. These 12 tools were submitted to e LDH for approval at the outset of the audit process. The tools included the review elements drawn from the state and federal regulations. Based upon LDH's suggestions, some tools were revised and issued as final. These final tools were submitted to Aetna in advance of the remote audit.

Once LDH approved the methodology, IPRO sent Aetna a packet that included the review tools, along with a request for documentation and a guide to help Aetna staff understand the documentation that was required. The guide also included instructions for submitting the requested information using IPRO's secure File Transfer Protocol (FTP) site.

To facilitate the review process, IPRO provided Aetna with examples of documents that Aetna could furnish to validate its compliance with the regulations. Instructions regarding the file review component of the audit were also provided, along with a request for the universe of cases for each file review area under review. From the universe of cases, IPRO selected a sample for each area, which was reviewed remotely

Prior to the review, Aetna submitted written policies, procedures and other relevant documentation to support its adherence to state and federal requirements. Aetna was given a period of approximately 4 weeks to submit documentation to IPRO. To further assist MCO staff in understanding the requirements of the audit process, IPRO convened a conference call for all MCOs undergoing the review, with LDH staff in attendance. During the conference call, IPRO detailed the steps in the review process, the audit timeline, and answered any questions posed by Aetna staff.

After Aetna submitted the required documentation, a team of IPRO reviewers was convened to review Aetna's policies, procedures, and materials, and to assess Aetna's concordance with the state's contract requirements. This review was documented using audit tools IPRO developed to capture the review elements and record the findings. These review tools with IPRO's initial findings were used to guide the remote video interviews.

Post onsite Remote Preparation

The remote interviews were conducted between July 25 and August 3, 2022. Interviews discussed elements in each of the review tools that were considered less than fully compliant based upon initial review. Interviews were used to

further explore the written documentation and to allow Aetna to provide additional documentation, if available. Aetna staff were given two days from the close of the onsite review to provide any further documentation.

Post-Interview Report Preparation

Following the remote interviews, draft reports were prepared. These draft reports included an initial review determination for each element reviewed, and either evidence that Aetna was compliant with the standard or a rationale for why Aetna was not compliant and what evidence was lacking. For each element that was deemed not fully compliant, IPRO provided a recommendation for Aetna to consider in order for them to attain full compliance.

Each draft report underwent a second level of review by IPRO staff members who were not involved in the first level of review. Once completed, the draft reports were shared with LDH staff for review. Upon LDH approval, the draft reports were sent to Aetna with a request to provide responses for all elements that were determined to be less than fully compliant. Aetna was given nine days to respond to the issues noted on the draft reports.

After receiving Aetna's response, IPRO re-reviewed each element for which Aetna provided a response. As necessary, review scores were updated based on the response from Aetna.

Aetna 2022
Compliance Final Find

MCO Summary of Findings

Summary of Findings

Table 3 provides a summary of the audit results by audit domain. Detailed findings for each of the elements that were less than "fully compliant" follow within this section of the report.

Table 3: Audit Results by Domain

Audit Domain	Total Elements	Met	Partially Met	Not Met	N/A	Score[1]
Availability of Services	132	128	0	1	3	99.2%
Assurances of Adequate Capacity and Services	48	48	0	0	0	100%
Coordination and Continuity of Care	83	71	10	2	0	91.6%
Coverage and Authorization of Services – UM	65	63	2	0	0	98.5%
Provider Selection	24	22	1	0	1	97.8%
Enrollee Rights and Protection	107	97	5	5	0	92.1%
Grievance and Appeal Systems	71	70	0	0	1	100%
Subcontractual Relationships	8	8	0	0	0	100%
Practice Guidelines	27	27	0	0	0	100%
Health Information Services	8	8	0	0	0	100%
Quality Assessment and Performance Improvement	109	106	3	0	**0**	98.6%
Fraud Waste and Abuse	132	123	3	4	2	95.8%
Total	**814**	**771**	**24**	**12**	**7**	**97.0%**

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

UM: utilization management

As presented in **Table 3**, 814 elements were reviewed for compliance. Of the 814 elements, 771 were determined to fully meet the regulations, while 24 partially met the regulations, 12 did not met the regulations, and 7 were determined to be not applicable (N/A). Zero elements were deemed. The overall compliance score is 97%.

From each of the 12 detailed reports IPRO extracted those elements for which the requirement was found to be less than fully met. This information was compiled into a summary report to facilitate corrective action. **Table 4** presents this summary report and includes details about each element reviewed, the final review determination, Aetna's initial response, and, when possible, suggestions to achieve full compliance.

It is the expectation of LDH that MCOs submit a corrective action plan (CAP) for all elements determined to be less than fully compliant. LDH will officially request a CAP for any item it deems necessary.

Each of the 12 review tools and review determinations for each of the elements can be found in the ZIP file below.

Table 4: Deficient 2022 Audit Elements

LA Citation	State Contract Requirements	Plan Documentation	Review Determination	File Review Results	Comments	MCO Comments	Final Recommendations
CFR 438.206 Availability of services							
7.8.7 7.8.7.1	Prenatal Care Services The MCO shall assist all pregnant members in choosing a pediatrician, or other appropriate PCP, for the care of their newborn babies before the beginning of the last trimester of gestation. In the event that the pregnant member does not select a pediatrician, or other appropriate PCP, the MCO shall provide the member with a minimum of fourteen (14) calendar days after birth to select a PCP prior to assigning one.	**Aetna 7000.42 Prenatal Services**	Not Met		The policy provided addresses detailed pre-natal care and education for the pregnant member. It does not address the selection of a pediatrician or other appropriate PCP be the beginning of the last trimester. **Recommendation** ABHLA should add the required language to relevant policies.	ABH agrees with this finding; however we do have policy no. 4400.15 Enrollee Member Enrollment, pg. 4 (Newborn Section). We will update the Prenatal Services about updating and working with the mother on selecting a PCP. ABH utilizes the Weekly pregnancy report to outreach members to offer CM engagement and assist with obtaining providers for mother (if needed) and newborn when members reached.	
CFR 438.208 Coordination and Continuity of Care							
6.19.4.4	A person-centered integrated plan of care developed by the MCO care manager shall be completed within thirty (30) calendar days of provider treatment plan development that includes all medically necessary services including specialized behavioral health services and primary care services identified in the member's treatment plans (individualized treatment plans are developed by the provider(s)) and meet the requirements above.	Policy 7500.05 Integrated Care Management Amendment, pg. 15 ICM Program Description pg. 5 A-LA 7500.05 Integrated Care Management 2021, pg. 14	Partially Met	Of the 10 case management files reviewed, four (4) files met the requirement and six (6) files were not applicable. Of the 10 behavioral health case management files reviewed, one (1) file met the requirement, seven (7) files were not applicable, and two (2) files did not meet the requirement.	This requirement is addressed by the Integrated Care Management Policy on page 14. **Recommendation** Aetna should ensure that plans of care are developed for all eligible members.	ABH Agrees with the finding and will take or has taken the following action to ensure improvement. · Enhanced training to this requirement · Monthly audits of staff on element · CM managers review dashboard with staff on monthly 1:1's · Increased staffing over the last several months	

LA Citation	State Contract Requirements	Plan Documentation	Review Determination	File Review Results	Comments	MCO Comments	Final Recommendations
6.28.26.28.2.1	The MCO shall be responsible for ensuring:Member's health care needs and services/care are planned and coordinated through the MCO PCP and/or behavioral health provider;	Policy 7500.05 Integrated Care Management Amendment, pg. 2 A-LA 7500.05 Integrated Care Management 2021	Partially Met	Of the 10 case management files reviewed, five (5) files met the requirement, four (4) files were not applicable, and one (1) file did not meet the requirement. Of the 10 behavioral health case management files reviewed, four (4) files met the requirement, four (4) files were not applicable, and two (2) files did not meet the requirement.	This requirement is addressed by the Integrated Care Management Policy on page 26 .**Recommendation**Aetna should ensure establish communication with identified PCP/providers to ensure proper care coordination.	ABH Agrees with the finding and will take or has taken the following action to ensure improvement. · Updated/enhanced care plan letter to provider regarding sharing of information and seeking information. ·Sharing care plans with provider and will call providers if urgent need. · Enhance staff training · Monthly audits of staff on element	
6.28.2.3	Care coordination and referral activities, in person or telephonically depending on member's acuity, incorporate and identify appropriate methods of assessment and referral for members requiring both medical and behavioral health services. These activities must include scheduling assistance, monitoring and follow-up for member(s) requiring medical services and coordination for members requiring behavioral health services.	Policy 7500.05 Integrated Care Management Corporate Policy, pg. 21-23 ICM Program Description, pg. 24 A-LA 7500.05 Integrated Care Management 2021, pg. 19-22	Partially Met	Of the 10 case management files reviewed, seven (7) files met the requirement and three (3) were not applicable. Of the 10 behavioral health case management files reviewed, five (5) files met the requirement, four (4) files were not applicable, and one (1) file did not meet the requirement.	This requirement is addressed by the Integrated Care Management Policy on pages 20 through 23. **Recommendation** Aetna should ensure staff are properly trained to execute care coordination outreach activities.	ABH Agrees with the finding and will take or has taken the following action to ensure improvement. · Training of staff to this element. · Monthly audits of staff on element	

LA Citation	State Contract Requirements	Plan Documentation	Review Determination	File Review Results	Comments	MCO Comments	Final Recommendations
6.28.2.4	Patients with a condition that causes chronic pain and have five (5) or more ED visits in the most recent 12-month period for chief complaint of pain are contacted by the MCO for a pain management plan and this plan will be shared with the patients' PCP, the patient, and relevant ED staff	ICM Program Description pg. 9	Partially Met	Of the 10 case management files reviewed, one (1) file met the requirement and nine (9) files were not applicable.Of the 10 behavioral health case management files reviewed, all 10 files were not applicable.	This requirement is not addressed in the submitted policy and procedures. The member handbook describes an alternate pain management program for all members, consisting of three chiropractic visits and acupuncture services, but this is not a specialized pain management plan for the specific population described in this requirement. **Recommendation**Aetna should create a policy, procedure, or program description to address this requirement.	ABH Agrees with the finding and will take or has taken the following action to ensure improvement. · Create analytics report specific to this element for monthly list of identified membership. · Monthly list sent to outreach team to reach members. · Create desktop to address this element.	
6.30.2.3	Ensure each member is provided with information on how to contact the person designated to coordinate the services the member accesses;	Member Handbook, pg. 10 ICM Program Description pg. 11	Partially Met	Of the 10 case management files reviewed, all 10 files met the requirement. Of the 10 behavioral health case management files reviewed, seven (7) files met the requirement, one (1) file was not applicable, and two (2) files did not meet the requirement.	This requirement is partially addressed by the ICM Welcome Member Letter Template; however, a policy or procedure is still needed for full compliance. **Recommendation** Aetna should create a policy or procedure to address this requirement. Additionally, Aetna should ensure staff follow outreach protocols to members.	ABH agrees with the finding and will take or has taken the following action to ensure improvement. · Part of Supportive/Intensive Desk top procedure. · Member gets welcome letter with CM name on it to identify staff member working with member. · Monthly Audits of staff on this element	

LA Citation	State Contract Requirements	Plan Documentation	Review Determination	File Review Results	Comments	MCO Comments	Final Recommendations
6.30.2.11.2.	Care managers follow-up with members with a behavioral health related diagnosis within 72 hours following discharge.	7000.43 Coordination of Member Care pg. 5	Not Met	Of the 10 behavioral health case management files, one (1) file met the requirement and nine (9) files were not applicable.	The submitted policy and desktop procedure addresses discharges, but does not specify the diagnosis or timeframe stipulated in this requirement. **Recommendation** Aetna should create a policy, procedure, or program description to address this requirement.	ABH agrees with the finding and will take or has taken the following action to ensure improvement. · Check Updated 2022 desktop with BH timeframes. Currently states 24-48 hours for follow up · Monthly audits of staff on this element	
6.30.2.15	For the behavioral health population, provide aftercare planning for members prior to discharge from a 24-hour facility.	7200.07 Discharge Planning, pg. 3	Not Met		The Discharge Planning Policy is in regards to post-discharge care, which does not address this requirement (aftercare planning prior to discharge). Additionally, the Coordination of Member Care Policy references annual activities conducted to coordinate care, which does not address this requirement. **Recommendation** Aetna should create a policy, procedure, or program description to address this requirement.	ABH agrees with the finding and will take or has taken the following action to ensure improvement. · Create a desktop to address this element · Monthly audits of staff on this element	

LA Citation	State Contract Requirements	Plan Documentation	Review Determination	File Review Results	Comments	MCO Comments	Final Recommendations
6.19.4.1	The individualized treatment plans must be: 6.19.4.1 Developed by the member's primary care provider and/or other lead provider as appropriate, with member participation, and in consultation with any specialists caring for the member. For SHCN members, the treatment plan shall be submitted to the member's MCO no later than 30 days following the completion of the initial assessment or annual reassessment.	ICM Program Description pg. 24	Partially Met	Of the 10 case management files reviewed, two (2) files met the requirement, seven (7) files were not applicable, and one (1) file did not meet the requirement. Of the 10 behavioral health case management files reviewed, one (1) file met the requirement, seven (7) files were not applicable, and two (2) files did not meet the requirement.	This requirement is addressed by the Integrated Care Management Policy on page 23. **Recommendation** Aetna should collaborate with PCP/providers to obtain treatment plans for eligible members.	ABH agrees with the finding and will take or has taken the following action to ensure improvement. · Updated/enhanced care plan letter to provider regarding sharing of information and seeking information. ·Sharing care plans with provider and will call providers if urgent need. · Enhance staff training · Monthly audits of staff on element	
6.36.3	In any instance when the member presents to the network provider, including calling the MCO's toll-free number listed on the Member's ID card, and a member is in need of emergency behavioral health services, the MCO shall instruct the member to seek help from the nearest emergency medical provider. The MCO shall initiate follow-up with the member within forty-eight (48) hours for follow-up to establish that appropriate services were accessed.	Member handbook , pg. 41	Partially Met		This requirement is partially addressed in the member handbook and in the Supporting Members in Crisis Policy on pages 5 through 6; however, this documentation does not address the follow-up timeframe stipulated by the requirement. **Recommendation** Aetna should edit the policy to include all parts of the requirement.	ABH agrees with the finding and will take or has taken the following action to ensure improvement. · Modify the Supporting Members in Crisis Policy to include timeframe	

LA Citation	State Contract Requirements	Plan Documentation	Review Determination	File Review Results	Comments	MCO Comments	Final Recommendations
6.36.9.1.5	Develop capacity for enhanced rates or incentives to behavioral health clinics to employ a primary care provider (physician, physician's assistant, nurse practitioner, or nurse) part- or full-time in a psychiatric specialty setting to monitor the physical health of patients.	Provider contract	Partially Met		This requirement is partially addressed by the provider contract template; however, a policy or procedure is needed to demonstrate full compliance. During the post-onsite submission, Aetna provided a statement that said, "ABH does not provide Providers with internal Aetna policies. Therefore, the provider contract is ABH's preferred method of communicating of provider incentives or enhanced rates." However, an internal policy, procedure, or program description to instruct MCO staff to execute this requirement is needed, not a policy to the provider. **Recommendation** Aetna should create a policy, procedure, or program description to address this requirement.	ABH agrees with the finding.	

LA Citation	State Contract Requirements	Plan Documentation	Review Determination	File Review Results	Comments	MCO Comments	Final Recommendations
6.40.0	The MCO shall submit Case Management Program policies and procedures to LDH for approval within thirty (30) days from the date the Contract is signed by the MCO, annually and prior to any revisions. Case Management policies and procedures shall include, at a minimum, the following elements:	LA 1501.03	Partially Met		The Policy, Development, Revision, Execution, and Maintenance Policy addresses the internal process by which Aetna develops policies, but it does not include the external approval process detailed in this requirement. The Act 319 Policy Notice to LDH Process addresses the requirement; however, due to the document date, it cannot be accepted as part of this review. **Recommendation** Aetna should continue to implement the Act 319 Policy Notice to LDH Process to meet this requirement.	ABHLA agrees the recommendation and will continue to submit policies to the State for review per Act 319.	
6.42.4	The MCO shall submit Chronic Care Management Program policies and procedures to LDH for approval within thirty (30) days of signing the Contract, annually and previous to any revisions. The MCO shall develop and implement policies and procedures that:	1501.03 Policy	Partially Met		The Policy, Development, Revision, Execution, and Maintenance Policy addresses the internal process by which Aetna develops policies, but it does not include the external approval process detailed in this requirement. The Act 319 Policy Notice to LDH Process addresses the requirement; however, due to the document date, it cannot be accepted as part of this review. **Recommendation** Aetna should continue to implement the Act 319 Policy Notice to LDH Process to meet this requirement.	ABHLA acknowledges the recommendation and will continue to submit policies to the State for review per Act 319.	
CFR 438.210 Coverage and Authorization of Services-UM							

LA Citation	State Contract Requirements	Plan Documentation	Review Determination	File Review Results	Comments	MCO Comments	Final Recommendations
8.5.4.1.1.1	For service authorization approval for a non-emergency admission, procedure or service, the MCO shall notify the provider verbally or as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.	7200.05 Concurrent Review/Observation, p. 28	Partially Met	Nine (9) of 10 files met the requirements. Case 1 was marked as concurrent and urgent and appears it was received 3/19 but not decided until 3/22/2021.	This requirement is addressed in the Concurrent Review/Observation Care policy and procedure but only partially met as part of the file review. Case one (1) was concurrent urgent. **Recommendation** The entity should en+I73sure the file type is accurately captured and timeframes met.	ABH agrees with this the finding.	
8.5.2.1	In the event a provider indicates, or the MCO determines, that following the standard service authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours after receipt of the request for service.	7100.05 Prior Authorization, p. 28	Partially Met	Nine (9) of 10 files met the requirements. Case 1 was marked as concurrent and urgent and appears it was received 3/19 but not decided until 3/22/2021.	This requirement is addressed in the Prior Authorization policy and procedure but is partially addressed via the file review. Case one (1) was concurrent urgent. **Recommendation** The entity should ensure the file type is accurately captured and timeframes met.	ABH agrees with this the finding.	
CFR 438.214 Provider Selection							

LA Citation	State Contract Requirements	Plan Documentation	Review Determination	File Review Results	Comments	MCO Comments	Final Recommendations
7.6.3.27.14.1	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.	Aetna_LA 438.214_QM 54 Practitioner Credentialing Recredentialing FY2022 - Entire documentAetna_LA 438.214_A-QM 54 Practitioner Credentialing Recredentialing_Amendment FY2022 - Entire documentAetna_LA 438.214_QM 53 Credentialing Allied Health Practitioners FY2022 - Entire documentAetna_LA 438.214_QM 51 Assessment of Organizational Providers FY2022 - Entire document	Partially Met	Three (3) of five (5) initial credentialing files met the NCQA health plan accreditation standards. A date of written notification for two (2) credentialing files was not available resulting in IPRO being unable to determine whether the timeliness standard was met.Five (5) of five (5) re-credentialing files met the NCQA health plan accreditation standards	This requirement is addressed in Aetna's Practitioner Credentialing/Recredentialing Policy. **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.	ABH agrees with this finding. The unavailable files noted were credentialed prior to the centralization of data and implementation of our database that would allow us to verify date of notification vs. credentialing date. We now have in place both a database that notes the date the letter was sent but have recently updated the letter itself to indicate the date of credentialing as well as date of notification.	
CFR 438.224 Enrollee Rights and Protection							
12.9.2	All written materials must be clearly legible with a minimum font size of ten-point, preferably twelve-point, with the exception of Member ID cards, and or otherwise approved by LDH.	Policy A-LA 4500.20 Member Materials Standard - page 2	Not Met		This requirement is not addressed by the member materials policy. **Recommendation** The entity should update the member materials policy to include this requirement. (Noted by the entity in the MCO comments column.)	ABH agrees and has updated the policy. See uploads.	

LA Citation	State Contract Requirements	Plan Documentation	Review Determination	File Review Results	Comments	MCO Comments	Final Recommendations
12.9.4	If a person making a testimonial or endorsement for a MCO has a financial interest in the company, such fact must be disclosed in the marketing materials.		Not Met		This requirement is not addressed by any policy or procedure. **Recommendation** The entity should update the member materials policy to include this requirement. (Noted by the entity in the MCO comments column.)	ABH agrees and has updated Policies 4600.05 (Member Coms) & 4600.40 (Advertising). See uploads.	
12.9.5	All written materials must be in accordance with the LDH "Person First" Policy, Appendix NN.		Not Met		This requirement is not addressed by any policy or procedure. **Recommendation** The entity should update the member materials policy to include this requirement. (Noted by the entity in the MCO comments column.)	This information is not currently in the policy. Marketing will update the policy.ABH agrees and will update the policy.	
12.9.6	The quality of materials used for printed materials shall be, at a minimum, equal to the materials used for printed materials for the MCO's commercial plans if applicable.	N/A	Not Met		This requirement is not addressed by any policy or procedure. **Recommendation** The entity states that they have no commercial plans in Louisiana, however the state requirement belongs in a policy. The entity should update the member materials policy to include this requirement. (Noted by the entity in the MCO comments column.)	Aetna Better Health does not have any commericals plans. ABH agrees and has updated the policy, see attached.	

LA Citation	State Contract Requirements	Plan Documentation	Review Determination	File Review Results	Comments	MCO Comments	Final Recommendations
12.9.15	Except as indicated, the MCO may develop their own materials that adhere to requirements set forth in this document or use state developed model member notices. State developed model notices must be used for denial notices and lock-in notices.		Not Met		This requirement is not addressed by any policy or procedure. **Recommendation** The entity should update the member materials policy to include this requirement. (Noted by the entity in the MCO comments column.)	ABH agrees and has updated the policy. Please see policy no. 4600.05 in the uploads.	
12.19.4	Written materials must also be made available in alternative formats upon request of the potential member or member at no cost. Auxiliary aids and services must also be made available upon request of the potential member or member at no cost. Written materials must include taglines in the prevalent non-English languages in the state, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDY telephone number of the MCO's member/customer service unit. Large print means printed in a font size no smaller than 18 point.	Policy A-LA 4500.25 Interpreter and Translation Services - pages 3-5	Partially Met		This requirement is partially addressed by the Interpreter and Translation Services policy. **Recommendation**The MCO should add the provisions regarding TTY/DTY and font size to the policy.		
12.18.1	The MCO shall make a good faith effort to give written notice of a provider's termination to each member who received their primary care from, or was seen on a regular basis by the terminated provider. When timely notice from the provider is received, the notice to the member shall be provided within fifteen (15) calendar days of the receipt of the termination notice from the provider.	Policy A-LA 4500.12 Member Notice of Primary Care Practitioner (PCP) Termination - page 3	Partially Met		This requirement is partially addressed in the Member Notice of Primary Care Practitioner (PCP) / Practitioner Termination policy. **Recommendation** The entity should build the "within 15-day notice to member" into the policy.	ABH agrees and will update the policy.	

LA Citation	State Contract Requirements	Plan Documentation	Review Determination	File Review Results	Comments	MCO Comments	Final Recommendations
12.18.2	The MCO shall provide notice to a member or the parent/legal guardian and the involved state agency, as appropriate, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. The written notice shall be provided within seven (7) calendar days from the date the MCO becomes aware of such, if it is prior to the change occurring. Failure to provide notice prior to the dates of termination will be allowed when a provider becomes unable to care for members due to illness, a provider dies, the provider moves from the service area and fails to notify the MCO, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster. Under these circumstances, notice shall be issued immediately upon the MCO becoming aware of the circumstances.	Policy A-LA 4500.12 Member Notice of Primary Care Practitioner (PCP) Termination - page 4	Partially Met		This requirement is partially addressed in the Member Notice of Primary Care Practitioner (PCP) / Practitioner Termination policy. **Recommendation** The entity should build the "written notice within 7 calendar days from the date it becomes aware of a provider's unavailability" into the policy.	ABH agrees and will update the policy.	
12.14.4.3	Identification of any restrictions on the enrollee's freedom of choice among network providers; and	provider manual page 83	Partially Met		This requirement is partially addressed by the Provider Manual. **Recommendation**The entity should incorporate this requirement into a policy.	ABH agrees and will update the policy.	
12.14.4.4	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).	provider manual page 31	Partially Met		This requirement is partially addressed by the Provider Manual. **Recommendation** The entity should incorporate this requirement into a policy.	ABH agrees and will update the policy.	
CFR 438.330 Quality Assessment and Performance Improvement Program (QAPI)							
14.1.7	The MCO shall reduce underutilization of services in areas including, but not limited to HIV and Syphilis screening in pregnant women, use of long acting	Report 136 QAPI Program Description, Work Plan, Impact and Effectiveness of Program Evaluation - A (QAPI Program	Partially Met		This requirement is partially addressed in the Quality Assessment Performance Improvement 2022 Program	ABH agrees and Policy A-LA 7600.07 Pharmacy Prior Authorization was updated to reflect IRPO's	

LA Citation	State Contract Requirements	Plan Documentation	Review Determination	File Review Results	Comments	MCO Comments	Final Recommendations
	reversible contraceptives, appropriate pain management approaches in patients with sickle cell disease, and behavioral therapy for ADHD and other disorders for children under age 6.	Evaluation pg. 38, 41, 98)LARCS State Bulletin (entire document)			Description on page 6 and the Quality Assessment Performance Improvement Program Evaluation on page 38. In addition, the Quality Assessment Performance Improvement Program Evaluation 2021 recommends 2022 program changes to address sickle cell anemia on page 41, and in the Healthy Louisiana Billing and Ordering Guidance for Long Acting Reversible Contraceptives; however, documentation was lacking to support the requirement to address behavioral therapy as a first line treatment independent of pharmacotherapy for ADHD and other disorders for children under age 6 years. **Recommendation**The MCO should develop and implement a policy regarding behavioral therapy as a first line treatment independent of pharmacotherapy for children younger than 6 years of age. The MCO has responded that they will implement an ADHD work group to address behavioral therapies for ADHD and other disorders under age 6, was well as develop and implement policies and provider education programs.	recommendations.ABHLA also reinstated the ADHD task force to address behavioral therapies for ADHD and other disorders under age 6, was well as develop and implement policies and provider education programs. See uploads.	
14.1.8	The MCO shall reduce overutilization of services and medications through	Report 136 QAPI Program Description, Work Plan, Impact	Partially Met		This requirement is partially addressed in the Attention	ABH agrees and Policy A-LA 7600.07 Pharmacy Prior	

LA Citation	State Contract Requirements	Plan Documentation	Review Determination	File Review Results	Comments	MCO Comments	Final Recommendations
	policies such as, but not limited to, prior authorization for prescription of ADHD drugs to children younger than six years of age.	and Effectiveness of Program Evaluation - ACPG ADHDEPSDT PHM StrategyA-LA 7500.05 Integrated Care ManagementA-LA 7000.35 Practitioner and Member Over-Underutilization of ServicesA-LA 7600.07 Pharmacy Prior AuthorizationStimulants.and.Related.Agents.11152021 PDL (pg. 4)			Deficit Hyperactivity Disorder Medical Clinical Policy bulletin on page 2 which states, "Aetna considers pharmacotherapy and behavioral modification medically necessary for treatment of ADHD"; however, ABA as a first-line treatment for ADHD for children younger than 6 years of age independent of pharmacotherapy is not specifically addressed in the Attention Deficit/Hyperactivity disorder Medical Clinical Policy bulletin because this document states on page 6, "Psychotherapy is covered under Aetna mental health benefits if the member also exhibits anxiety and/or depression." **Recommendation**The MCO should develop and implement a policy regarding behavioral therapy as a first line treatment independent of pharmacotherapy for children younger than 6 years of age. The MCO has responded that they will implement an ADHD work group to address behavioral therapies for ADHD and other disorders under age 6, was well as develop and implement policies and provider education programs.	Authorization was updated to reflect IRPO's recommendations.ABHLA also reinstated the ADHD task force to address behavioral therapies for ADHD and other disorders under age 6, was well as develop and implement policies and provider education programs. See uploads.	

LA Citation	State Contract Requirements	Plan Documentation	Review Determination	File Review Results	Comments	MCO Comments	Final Recommendations
14.1.18	The MCO shall increase the alignment of assessment and treatment with best practice standards through policies including increasing the use of evidence- based behavioral therapies as the first-line treatment for ADHD for children younger than six years of age, and other methods to increase the alignment with best practices for ADHD care for all children and particularly for children under age six.	Report 136 QAPI Program Description and workplan355 Healthy Louisiana EBP ReportCPG ADHDA-LA 7500.05 Integrated Care ManagementA-LA 7000.35 Practitioner and Member Over-Underutilization of Serviceshttps://aetnet.aetna.com/mpa/cpb/400_499/0426.html	Partially Met		This requirement is partially addressed in the Quality Assessment Performance Improvement 2022 Program Description on page 6 and the Applied Behavioral Analysis (ABA) Provider Quality Monitoring Plan; however, ABA as a first-line treatment independent of pharmacotherapy for ADHD for children younger than 6 years of age is not specifically addressed in the Attention Deficit/Hyperactivity Disorder Medical Clinical Policy bulletin because this document states on page 6, "Psychotherapy is covered under Aetna mental health benefits if the member also exhibits anxiety and/or depression." **Recommendation**The MCO should develop and implement a policy regarding behavioral therapy as a first line treatment independent of pharmacotherapy for children younger than 6 years of age. The MCO has responded that they will implement an ADHD work group to address behavioral therapies for ADHD and other disorders under age 6, was well as develop and implement policies and provider education programs.	ABH agrees and Policy A-LA 7600.07 Pharmacy Prior Authorization was updated to reflect IRPO's recommendations.ABHLA also reinstated the ADHD task force to address behavioral therapies for ADHD and other disorders under age 6, was well as develop and implement policies and provider education programs. See uploads.	
CFR 438.608 Fraud Waste and Abuse							

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15.1.13	The MCO, as well as its subcontractors and providers, shall comply with all federal requirements (42 C.F.R. §1002) on exclusion and debarment screening. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as the result of this Contract shall screen their owners and employees against the federal exclusion databases (such as LEIE and System for Award Management). Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by the State and/or the MCO dependent upon the entity that identifies the payment of unallowable funds to excluded individuals.	3000.42 Excluded Individuals 20213000.42 Excluded IndividualsPolicy underwent review in 2022 and was updated to add more contract language. Including both versions.	Partially Met		This requirement is partially addressed in policy 3000.42 Excluded Individual. The screening of owners and employees against federal exclusion databases is included in both 2021 and 2022 versions of the policy. The refunding of funds made to excluded individuals is not included in the policy. **Recommendation**Aetna should include the refunding of funds made to excluded individuals in a policy.	ABH agrees this finding and will update relevant policies.	
15.2.6.16	• The MCO will require new employees to complete and attest to training modules within thirty (30) days of hire related to the following in accordance with federal and state laws: MCO Code of Conduct Training Privacy and Security – Health Insurance Portability and Accountability Act Fraud, waste, and abuse identification and reporting procedures Federal False Claims Act and employee whistleblower protections Procedures for timely consistent exchange of information and collaboration with LDH; Organizational chart including the Program Integrity Officer and full-time program integrity investigator(s); and Provisions that comply with 42 CFR §438.608 and 438.610 and all relevant state and federal laws, regulations, policies, procedures, and guidance (including CMS' Guidelines for Constructing a Compliance Program for Medicaid	Policy no. 3000.20, pg. 3 Code of Conduct, pg.24	Partially Met		This requirement is partially addressed in the CVS Health Code of Conduct and in policy A-LA 3000.20 Compliance Training and Education. The timeliness portion of this requirement, that the MCO will require new employees to complete and attest to training modules within thirty (30) days of hire is not included in documentation provided for review. **Recommendation** Aetna should include that the MCO will require new employees to complete and attest to training modules within thirty (30) days of hire in a policy.	ABH disagrees with this finding. The Code of Conduct submitted includes this item and this requirement is tracked internally. Also, Policy no. 3000.20 Compliance Training and Education Policy was updated . Policy CCIG-0025 also contains this information, but was not submitted in the initial materials. See uploads	No change in final determination. There is no reference to training within 30 days. Policy CCIG-0025 provided after the interview and no date when policy was updated.

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	Managed Care Organizations and Prepaid Networks) issued by Department, HHS, CMS, and the Office of Inspector General, including updates and amendments to these documents or any such standards established or adopted by the state of Louisiana or its Departments.						
15.4.1	Federal Financial Participation (FFP) is not available for services delivered by providers excluded by Medicare, Medicaid, or CHIP except for certain emergency services ; and	A-LA 3000.42 Excluded Individuals 2022, pg. 6	Not Met		The policy 3000.42 Excluded Individuals effective during the 2021 review period does not address this requirement. While it is addressed in policy 3000.42 Excluded Individuals 2022, the Revised date of this document is indicated as 04/12/2022, which is outside the review period. **Recommendation** No action is required by Aetna, as this issue was self-identified and added to the updated policy.	ABH agrees no further action is required.	

LA Citation	State Contract Requirements	Plan Documentation	Review Determination	File Review Results	Comments	MCO Comments	Final Recommendations
15.4.2	The MCO is responsible for the return to the State of any money paid for services provided by an excluded provider.	A-LA 3000.42 Excluded Individuals 2022, pg. 6	Not Met		The policy 3000.42 Excluded Individuals effective during the 2021 review period does not address this requirement. While it is addressed in policy 3000.42 Excluded Individuals 2022, the Revised date of this document is indicated as 04/12/2022, which is outside the review period. **Recommendation** No action is required by Aetna, as this issue was self-identified and added to the updated policy.	ABH agrees no further action is required.	
15.7.10	In the event LDH or its agent initiates a review on a network provider, a notification shall be sent to the MCO Special Investigation Unit (SIU) designee. The LDH notification of the intent to review shall include: provider name, NPI, city, and provider type, allegation or issue being reviewed, procedure codes or NDCs under review, date range for dates of service under review, and amount paid. The MCO shall have ten business days to indicate whether the claims were corrected or adjusted prior to the date of the notification from the Department. If the State does not receive a response from the MCO within ten business days, the State may proceed with its review.	DRAFT A-LA Aetna SIU Policy Dependence Statement This is not currently in ABHLA SIU policies, a draft version has been created to update at the next policy committee.	Not Met		This requirement is not addressed, as the Aetna SIU Policy Dependence Statement effective during the 2021 review period does not address this requirement. While it is addressed in DRAFT A-LA Aetna SIU Policy Dependence Statement, the Revised date of this document is indicated as 07/12/2022 , which is outside the review period. **Recommendation** No action is required by Aetna, as this issue was self-identified and added to the updated policy.	ABH agrees no further action is required.	

LA Citation	State Contract Requirements	Plan Documentation	Review Determination	File Review Results	Comments	MCO Comments	Final Recommendations
15.7.11	In the event the State or its agent investigates or audits a provider or member within the MCO's Network, the MCO shall comply with document and claims requests from the State within fourteen (14) calendar days of the request, unless another time period is agreed to by the MCO and State. Document requests do not include medical records that shall be obtained from the provider.	"002 MCD SIU OverviewCVS Health Healthcare Anti-Fraud Plan"	Partially Met		This requirement is partially addressed in policy 002 MCD SIU Overview. The timeliness portion of this requirement, where the MCO shall comply with document and claims requests from the State within fourteen (14) calendar days of the request is not included in documentation provided for review.Additionally, although this requirement is partially addressed in CVS Health Healthcare Anti-Fraud Plan, since the effective date is listed as 2/1/2022 which is outside the review period, it cannot be considered for compliance.Timeliness of responding to a request is not addressed in either document. **Recommendation**The entitiy should include that the MCO shall comply with document and claims requests from the State within fourteen (14) calendar days of the request, unless another time period is agreed to by the MCO and State in a policy.	ABH acknowledges this finding and has updated the SIU Depedence Policy to reflect to this change. See uploads.	

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7.6.2.3	The MCO shall not remit payment for services provided under this contract to providers located outside of the United States. The term “United States” means the fifty (50) states, the District of Columbia, and any U.S. territories.	A-LA Policy no. 6300.11, pg. 3	Not Met		Although this requirement is addressed in A-LA Policy no. 6300.11, the Revised date is indicated as 02/14/2022, which is not within the review period, and cannot be considered for review. **Recommendation** No action is required by Aetna, as this issue was self-identified and added to the updated policy.	ABH agrees no further action is required.	