LOUISIANA DEPARTMENT OF HEALTH

2023 External Quality Review Compliance Review

for

Aetna Better Health

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 the PIHP delivering services to members enrolled in the Louisiana Medicaid managed care program. When conducting the compliance review, HSAG adheres to the methodologies and guidelines established in CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity,* February 2023 (CMS EQR Protocol 3).[1-1]

Description of the External Quality Review Compliance Review

LDH requires its managed care entities (MCEs) to undergo periodic compliance reviews to ensure that an assessment is conducted to meet federal requirements. The 2023 compliance review, which comprises the calendar year (CY) 2022 review period (January 1, 2022−December 31, 2022), is the second year of the three-year cycle of compliance reviews. The compliance review focused on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific requirements. The compliance reviews for the Louisiana Medicaid managed care program consist of 14 program areas referred to as "standards." LDH requested that HSAG conduct a compliance review of all standards not yet reviewed during the three-year compliance review cycle for each MCO, PAHP, and PIHP. Table 1-1 outlines the division of standards reviewed in Year One (CY 2021) and Year Two (CY 2022).

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Aug 1, 2023.

Table 1-1—Compliance Review Standards

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

[1] The compliance review standards comprise a review of all requirements, known as "elements," under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard XIII—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).

Summary of Findings

Table 1-2 and Table 1-3 present an overview of the results of the 2023 compliance review for **Aetna Better Health** (**ABH**). 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	3	4	42.9%
	Total Compliance Score	**7**	**3**	**4**	**42.9%**

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

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

Total Compliance Score: The overall percentages of the number of elements that received a score of *Met* (1 point) then dividing this total by the total number of elements.

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

	Total Elements in CAP	Number of Elements		Total Compliance Score From CAP
		M	*NM*	
Follow-Up on Corrective Action Plans (CAPs) From Prior Compliance Review	36	34	2	94.4%

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

Total Elements in CAP: The total number of elements within the CAP from the CY 2021 review. This represents the denominator.

Total Compliance Score From CAP: The overall percentages of the number of elements that received a score of *Met* (1 point) then dividing this total by the total number of elements.

ABH received a compliance score of 42.9 percent for Standard I—Enrollment and Disenrollment, which identified **ABH** has opportunities for improvement. Appendix A documents strengths and opportunities for improvement. Appendix B documents detailed findings, including recommendations for program enhancements.

ABH achieved compliance in 34 of 36 elements from the LDH-approved 2022 compliance review CAPs. **ABH** must implement the remaining approved CAPs for the two elements for which compliance was not achieved. Appendix B documents detailed findings of the review of the implementation of the **ABH**-approved 2022 compliance review CAPs.

Corrective Action Process

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

2. Methodology

Activity Objectives

According to 42 CFR §438.358, a state or its EQRO must conduct a review within a three-year period to determine the MCEs' compliance with standards set forth in 42 CFR §438—Managed Care Subpart D, the disenrollment requirements and limitations described in §438.56, the enrollee rights requirements described in §438.100, the emergency and post-stabilization services requirements described in §438.114, and the quality assessment and performance improvement requirements described in §438.330. To complete this requirement, HSAG, through its EQRO contract with LDH, performed compliance reviews of the five MCOs, two PAHPs, and one PIHP contracted with LDH to deliver services to Louisiana Medicaid managed care members.

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

Table 2-1—Compliance Review Standards

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

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

[1] The compliance review standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard XIII—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).

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

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

Technical Methods of Data Collection and Analysis

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

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

Pre-Virtual Review Activities

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

Virtual Review Activities

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

Post-Virtual Review Activities

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

Data Aggregation and Analysis

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

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

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

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

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

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

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

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

- Documented findings describing the MCE's progress in achieving compliance with State and federal requirements.
- Scores assigned to the MCE's performance for each requirement.
- The total percentage-of-compliance score calculated for each standard.
- The overall percentage-of-compliance score calculated across the standards.

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

Description of Data Obtained

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

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- Management/monitoring reports and audits.
- Narrative and/or data reports across a broad range of performance and content areas.
- Records for delegation.
- Member and provider materials.

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

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

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during and after the site review	January 1, 2022–December 31, 2022
Information obtained through interviews	October 13, 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

ABH 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 **ABH** 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 **ABH** into full compliance with the deficient requirements. **ABH** must use this template to submit its CAP to bring any elements scored as *Not Met* into compliance with the applicable standard(s). **ABH**'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 **ABH** 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 **ABH** into compliance with the requirement.
- The appropriateness of the timeline for correcting the deficiency.

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

Appendix A. Conclusions and Recommendations

Standard I—Enrollment and Disenrollment

Strengths Related to Access and Timeliness	
+	The MCO's policies and procedures ensured that the MCO did not request disenrollment of a member because of an adverse change in the member's health status, utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs.

Opportunities for Improvement and Recommendations	
−	**Opportunities for Improvement:** The MCO's policies and procedures did not include the requirement that the MCO agrees to accept individuals enrolled into its MCO in the order in which they apply without restriction (unless authorized by the Department). **Recommendations:** The MCO must revise its policies and procedures to include language stating the MCO agrees to accept individuals enrolled into its MCO in the order in which they apply without restriction (unless authorized by the Department).
−	**Opportunities for Improvement:** The MCO's policies and procedures did not include the requirement that the MCO does not discriminate against individuals enrolled or use any policy or practice that has the effect of discriminating against individuals based on health status or need for healthcare services. **Recommendations:** The MCO must revise its policies and procedures to include language stating that the MCO does not discriminate against individuals enrolled or use any policy or practice that has the effect of discriminating against individuals based on health status or need for healthcare services.
−	**Opportunities for Improvement:** The MCO's Member Disenrollment/Disruptive Member Transfer policy stated that for disruptive member disenrollment, the MCO gives the member written notice of the proposed disenrollment. The MCO's policies and procedures did not include the requirement that for any approved disenrollment, the MCO gives the member written notice of the proposed disenrollment. In addition, the MCO's policies and procedures did not include all member disenrollment reasons with cause and without cause. **Recommendations:** The MCO must revise its policies and procedures to include language stating that if the Department approves the MCO's disenrollment, the MCO provides members written notice of the proposed disenrollment. The policies and procedures and the member handbook must also include all for cause and without cause reasons members may request disenrollment.

Appendix B. 2023 Compliance With Standards Review Tool

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

CY 2022 Compliance With Standards Review

Standard I—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the MCO**	**Score**
1. The MCO agrees to accept individuals enrolled into its MCO in the order in which they apply without restriction (unless authorized by the Department). *42 CFR §438.3(d)(1)* 2022 Contract Citations: 11.9.1 2023 Contract Citations: 2.3.12.1; 2.3.12.1.1; 2.3.12.1.2	• ABHLA accepts all membership sent on the La. Dept. of Health's 834 file. There is no information to screen member from this file, nor does the 834 file intake process consider any form or prescreening. Please find uploaded: • Element 1 - 2022 Desktop - Enrollment Manager (834 File Processing) • Element 1 - 2022 A-LA 3000.64 Compliance with Section 1557 of the PPACA • Element 1 - 2022 A-LA 4500.35 Member Rights and Responsibilities	☐ Met ☒ Not Met
HSAG Findings: The MCO's policies and procedures did not include the requirement that the MCO agrees to accept individuals enrolled into its MCO in the order in which they apply without restriction (unless authorized by the Department).		
Required Actions: The MCO must revise its policies and procedures to include language stating the MCO agrees to accept individuals enrolled into its MCO in the order in which they apply without restriction (unless authorized by the Department).		
2. The MCO does not discriminate against individuals enrolled or use any policy or practice that has the effect of discriminating against individuals, based on health status or need for healthcare services, race, color, national origin, sex, or disability. *42 CFR §438.3(d)(3-4)* 2022 Contract Citations: 11.10.1.3 2023 Contract Citations: 2.3.12.1; 2.3.12.1.3	• Please see Element 2 - 2022 A-LA 4500.35 Member Rights and Responsibilities, pgs. 2 - 3, and Element 2 - 2022- A-LA 4500.86 Member Disenrollment_Disruptive Member Transfer.	☐ Met ☒ Not Met

Standard I—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the MCO**	**Score**
HSAG Findings: The MCO's policies and procedures did not include the requirement that the MCO does not discriminate against individuals enrolled or use any policy or practice that has the effect of discriminating against individuals based on health status or need for healthcare services.		
Required Actions: The MCO must revise its policies and procedures to include language stating that the MCO does not discriminate against individuals enrolled or use any policy or practice that has the effect of discriminating against individuals based on health status or need for healthcare services.		
3. The MCO may not request disenrollment of a member because of an adverse change in the member's health status or because of the member's: • Utilization of medical services. • Diminished mental capacity. • Uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the MCO's ability to furnish services to the member or to other members. *42 CFR §438.56(b)(2)* 2022 Contract Citations: 11.10.1.3; 11.11.4.1 2023 Contract Citations: 2.3.13.3.4	• Please see Element 3- 2022- A-LA 4500.86 Member Disenrollment_Disruptive Member Transfer, pgs. 4-5.	☒ Met ☐ Not Met
4. The MCO may initiate disenrollment of any member's participation in the MCO on one or more of the following grounds: • When the member ceases to be eligible for medical assistance under the State Plan as determined by the Department • Upon termination or expiration of the Contract • Death of the member	• Please see Element 4 - 2022- A-LA 4500.86 Member Disenrollment_Disruptive Member Transfer, pgs. 4 & 7.	☒ Met ☐ Not Met

Standard I—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the MCO**	**Score**
• Confinement of the member in a facility or institution when confinement is not a covered service under the Contract *42 CFR §438.56(b)(1)* 2022 Contract Citations: 11.11.6.1; 11.11.6.2; 11.11.6.7 2023 Contract Citations: 2.3.12.3.2; 2.3.13.2		
5. The MCO shall not request disenrollment for reasons other than those stated in the Contract. In accordance with 42 CFR §438.56(b)(3), LDH shall ensure that the MCO is not requesting disenrollment for other reasons by reviewing and rendering decisions on all Disenrollment Request Forms submitted to the enrollment broker. *42 CFR §438.56(b)(3)* 2022 Contract Citations: 11.11.4.2 2023 Contract Citations: 2.3.13.3.5	• Please see Element 5 - 2022- A-LA 4500.86 Member Disenrollment_Disruptive Member Transfer.	☒ Met ☐ Not Met
6. If the Department approves the MCO's disenrollment request, the MCO gives the member written notice of the proposed disenrollment. *42 CFR §438.56(d)(5)* 2022 Contract Citations: 11.11.4.4; 11.11.4.8 2023 Contract Citations: 2.3.13.3.7	• Please see Element 6 - 2022- A-LA 4500.86 Member Disenrollment_Disruptive Member Transfer; • Element 6 – ABHLA Integrated Services Handbook, pgs. 18 & 76; and • Element 6 – A- LA 3100.70 Member Appeals. Pgs. 7 & 20	☐ Met ☒ Not Met
HSAG Findings: The MCO's Member Disenrollment/Disruptive Member Transfer policy stated that for disruptive member disenrollment, the MCO gives the member written notice of the proposed disenrollment. The MCO's policies and procedures did not include the requirement that for any approved disenrollment, the MCO gives the member written notice of the proposed disenrollment.		
Required Actions: The MCO must revise its policies and procedures to include language stating that if the Department approves the MCO's disenrollment, the MCO provides members written notice of the proposed disenrollment.		

Standard I—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the MCO**	**Score**
7. The member may request disenrollment as follows: • For cause at any time, including: – The member has moved out of the MCO's service area; – The MCO does not (due to moral or religious objections) cover the service the member seeks; – The member needs related services to be performed at the same time, not all related services are available from the MCO's plan, and the member's primary care provider (or another provider) determines that receiving the services separately would subject the member to unnecessary risk; – Poor quality of care; – Lack of access, or lack of access to providers experienced in dealing with the member's specific needs; – The Contract between the MCO and LDH is terminated; – Lack of access to MCO covered services as determined by LDH; – The member's active specialized behavioral health provider ceases to contract with the MCO; or – Any other reason deemed to be valid by LDH and/or its agent. • Without cause at the following times:	• Please see Element 7 - 2022- A-LA 4500.86 Member Disenrollment_Disruptive Member Transfer; and • Element 7 – ABHLA Integrated Services Handbook, pgs. 79-80	☐ Met ☒ Not Met

Standard I—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the MCO**	**Score**
– During the disenrollment period offered to members at the start of the Contract – During the 90 days following the date of the member's initial enrollment with the MCO or during the 90 calendar days following the date the Enrollment Broker sends the member notice of that enrollment, whichever is later – At least once every 12 months thereafter – Upon automatic reenrollment if temporary loss (90 calendar days) of eligibility has caused the member to miss the annual disenrollment opportunity – When the Department has imposed sanctions on the MCO (consistent with 42 CFR §438.702[a][4]) *42 CFR §438.56(c)-(d)(2)* 2022 Contract Citations: 11.11.3; 11.11.3.1; 11.11.3.2 2023 Contract Citations: 2.3.13.2		

HSAG Findings: The MCO's policies and procedures did not include the following requirements:

- Policy "With Cause" section:
  - The member's active specialized behavioral health provider ceases to contract with the MCO
  - Any other reason deemed to be valid by LDH and/or its agent
  - The contract between the MCO and LDH is terminated
- Policy "Without Cause" section:
  - When the Department has imposed sanctions on the MCO (consistent with 42 CFR §438.702[a][4])

HSAG also recommends that the language "Lack of providers experienced in dealing with health care needs" be clarified to state the "member's health care needs."

Standard I—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the MCO**	**Score**
The MCO's Member Handbook for Integrated Health Service did not include the following requirements: • Member handbook section titled "Good cause for disenrollment": – Lack of access, or lack of access to providers experienced in dealing with the member's specific needs – The member's active specialized behavioral health provider ceases to contract with the MCO • Member handbook section titled "Disenroll from Aetna Better Health of Louisiana": – When the Department has imposed sanctions on the MCO (consistent with 42 CFR §438.702[a][4])		
Required Actions: The MCO must revise the Member Disenrollment/Disruptive Member Transfer policy to include that the member may disenroll with cause for the following reasons: • The member's active specialized behavioral health provider ceases to contract with the MCO • Any other reason deemed to be valid by LDH and/or its agent • The contract between the MCO and LDH is terminated The MCO must also revise its policy to state that the member may disenroll without cause for the following reason: • When the Department has imposed sanctions on the MCO (consistent with 42 CFR §438.702[a][4]) The MCO must revise the member handbook to include that the member may disenroll with cause for the following reasons: • Lack of access, or lack of access to providers experienced in dealing with the member's specific needs • The member's active specialized behavioral health provider ceases to contract with the MCO The MCO must revise the member handbook to include that the member may disenroll without cause for the following reason: • When the Department has imposed sanctions on the MCO (consistent with 42 CFR §438.702[a][4])		

Results for Standard I—Enrollment and Disenrollment							
Total	Met	=	3	X	1.0	=	3.0
	Not Met	=	4	X	0.0	=	0.0
Total Applicable		=	7	**Total Score**		=	3.0

Total Score ÷ Total Applicable	=	**42.9%**

CY 2021 Review CAP

Availability of Services CFR 438.206		
Requirement	**Evidence as Submitted by the MCO**	**Score**
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. *42 CFR 438.206* Contract: 7.8.7; 7.8.7.*1*	**2022 MCO Document Submission:** • Aetna 7000.42 Prenatal Services **2023 MCO Document Submission:** • Policy no. 4400.15 Enrollee/Member Enrollment Policy	☒ Met ☐ Not Met
2022 Compliance Review Finding: *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.		
2022 Compliance Review Recommendation: ABH should add the required language to relevant policies.		
2022 MCO Comments: 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.		
2023 CAP Review Findings: The MCO's Enrollee/Member Enrollment policy, with a revision date of March 29, 2023, included that ABH shall assist all pregnant members in choosing a pediatrician, or other appropriate primary care provider (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, ABH shall provide the member with a minimum of 14 calendar days after birth to select a PCP prior to assigning one.		
2023 CAP Review Required Actions: None.		

Coordination and Continuity of Care: CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
1. 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. *42 CFR 438.208* Contract: 6.19.4.4	**2022 MCO Document Submission:** • Policy 7500.05 Integrated Care Management Amendment, pg. 15 • ICM Program Description pg. 5 • A-LA 7500.05 Integrated Care Management 2021, pg. 14 **2023 MCO Document Submission:** • Coordination and Continuity of Care CFR 438.208--Element No. 1----Person Centered--Part 1 of 2 and Part 2 of 2.	☒ Met ☐ Not Met
2022 Compliance Review Finding: *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.		
2022 Compliance Review Recommendation: Aetna should ensure that plans of care are developed for all eligible members.		
2022 MCO Comments: 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		
2023 CAP Review Findings: The MCO stated that ABH conducted monthly chart audits to ensure metrics were met. Within the audit tool, question 21 documented that the plan of care was completed within 30 days. These audit results were reviewed in ICM team meetings and with individual staff members through monthly one-on-one meetings. The MCO submitted examples of chart audit results and evidence of follow-up with case managers, when appropriate.		
2023 CAP Review Required Actions: None.		

Coordination and Continuity of Care: CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
2. 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. *42 CFR 438.208* Contract: 6.28.26.2; 8.2.1	**2022 MCO Document Submission:** • Policy 7500.05 Integrated Care Management Amendment, pg. 2 • A-LA 7500.05 Integrated Care Management 2021 **2023 MCO Document Submission:** • Coordination and Continuity of Care CFR 438.208--Element No. 2--Parts 1 & 2	☒ Met ☐ Not Met
2022 Compliance Review Finding: *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.		
2022 Compliance Review Recommendation: Aetna should ensure establish communication with identified PCP/providers to ensure proper care coordination.		
2022 MCO Comments: 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		
2023 CAP Review Findings: The MCO stated that ABH conducted monthly chart audits to ensure metrics were met. Within the audit tool, the following questions assessed evidence of ongoing communication with providers, practitioners, and care team participants (e.g., through phone calls, letters). • *Question 1:* Is there evidence of CM attempts to contact the member for initial contact after enrollment into Case Management, via multiple methods (i.e., phone, letter, PCP, contact, pharmacy, Google, etc.) and follows the business rules? • *Question 5:* Did follow up by the CM occur with the member as needed per CM's documentation?		

Coordination and Continuity of Care: CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
• *Question 23:* Were member referrals to resources facilitated and is there a follow-up process to determine whether members act on referrals? • *Question 31:* Is there evidence of care coordination, e.g., referrals made for needed services and information sharing with care team participants? The MCO also submitted examples of chart audit results and evidence of follow-up with case managers, when appropriate.		
2023 CAP Review Required Actions: None.		

Coordination and Continuity of Care: CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
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. *42 CFR 438.208* Contract: 6.28.2.3	**2022 MCO Document Submission:** • 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 **2023 MCO Document Submission:** • Coordination and Continuity of Care CFR 438.208--Element No. 3--Parts 1, 2, 3 and 4	☒ Met ☐ Not Met
2022 Compliance Review Finding: *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.		
2022 Compliance Review Recommendation: Aetna should ensure staff are properly trained to execute care coordination outreach activities.		
2022 MCO Comments: 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		
2023 CAP Review Findings: The MCO stated that ABH continued its efforts to ensure that members' health care needs were planned and coordinated through the members' PCP and/or behavioral health providers. The MCO implemented a new member welcome letter, and enhanced the care plan provider letter encouraging providers to send ABH their treatment plans to better coordinate member care. The MCO also stated that to assure staff members were following the MCO's standard operating procedures, ABH conducted monthly chart audits utilizing the ICM Standard File Audit Tool to ensure care management metrics were met. Audit results were reviewed in weekly ICM team meetings and in individual staff meetings. Question 30 of the ICM Standard File Audit Tool provided evidence of ongoing communication with providers, practitioners, and care team participants (e.g., through phone calls, letters) that included sharing of the member's individualized care plan. The 2022 updated ICM provider welcome letter was sent to the member's provider upon the member's enrollment in ICM. The		

Coordination and Continuity of Care: CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
enhanced care plan provider letter was sent to the provider regarding the sharing of information between the MCO integrated care management team and the provider. The MCO also submitted examples of chart audit results and evidence of follow-up with case managers, when appropriate. Additional documentation submitted addressed the recommendation from the 2022 compliance review of ensuring staff members are properly trained to execute care coordination outreach activities, including refresher training agendas and communications with case managers of required training.		
2023 CAP Review Required Actions: None.		

Coordination and Continuity of Care: CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
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. *42 CFR 438.208* Contract: 6.28.2.4	**2022 MCO Document Submission:** • ICM Program Description pg. 9 **2023 MCO Document Submission:** • Coordination and Continuity of Care CFR 438.208--Element No. 4--Parts 1 & 2	☒ Met ☐ Not Met
2022 Compliance Review Finding: *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.		
2022 Compliance Review Recommendation: Aetna should create a policy, procedure, or program description to address this requirement.		
2022 MCO Comments: 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.		
2023 CAP Review Findings: The MCO provided the desktop procedure for Identification of Candidates for Care Management that was revised on March 29, 2022. This procedure outlined that patients with a condition that caused chronic pain who also had five or more emergency department (ED) visits in the most recent 12-month period for a chief complaint of pain are identified in a monthly report. The MCO contacted the member for the development and implementation of a pain management plan. The plan was shared with the member's PCP, the patient, and relevant ED staff members.		
2023 CAP Review Required Actions: None.		

Coordination and Continuity of Care: CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
5. Ensure each member is provided with information on how to contact the person designated to coordinate the services the member accesses. *42 CFR 438.208* Contract: 6.30.2.3	**2022 MCO Document Submission:** • Member Handbook, pg. 10 • ICM Program Description pg. 11 **2023 MCO Document Submission:** • Coordination and Continuity of Care CFR 438.208--Element No. 5--Parts 1 through 3	☒ Met ☐ Not Met
2022 Compliance Review Finding: *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.		
2022 Compliance Review Recommendation: Aetna should create a policy or procedure to address this requirement. Additionally, Aetna should ensure staff follow outreach protocols to members.		
2022 MCO Comments: 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		
2023 CAP Review Findings: The MCO provided the Care Plan Development and Updating—Enhanced Version desktop procedure. The desktop procedure outlined that members were provided the ICM welcome letter in addition to their individualized care plan. Within the ICM welcome letter, the member was provided contact information to the designated person to coordinate care and services including name and contact number. ABH also provided the template of the ICM welcome letter. The MCO indicated that monthly chart audits were completed for each staff member. Audit findings were reviewed during ICM team meetings and in individual staff one-on-ones. The MCO also submitted examples of chart audit results and evidence of follow-up with case managers, when appropriate.		
2023 CAP Review Required Actions: None.		

Coordination and Continuity of Care: CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
6. Care managers follow-up with members with a behavioral health related diagnosis within 72 hours following discharge. *42 CFR 438.208* Contract: 6.30.2.11.2	**2022 MCO Document Submission:** • 7000.43 Coordination of Member Care pg. 5 **2023 MCO Document Submission:** • RAP 2.0 TOC desktop • Coordination and Continuity of Care CFR 438.208--Element No. 6--Parts 1 & 2	☒ Met ☐ Not Met
2022 Compliance Review Finding: *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.		
2022 Compliance Review Recommendation: Aetna should create a policy, procedure, or program description to address this requirement.		
2022 MCO Comments: 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		
2023 CAP Review Findings: The MCO submitted the Readmission Avoidance Program (RAP) 2.0 Program Desktop that was revised on April 5, 2023. The desktop procedure stated that care managers followed up within 72 hours post discharge with members that were inpatient and had a behavioral health-related diagnosis. The desktop procedure also included examples of applicable behavioral health diagnoses, which included: schizophrenia, delusional disorder, psychotic disorder, bipolar disorder, major depressive disorder, and generalized anxiety disorder. The desktop procedure included the requirement in both the 50 percent and higher and the 49.9 percent and lower RAP risk score categories.		
2023 CAP Review Required Actions: None.		

Coordination and Continuity of Care: CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
7. For the behavioral health population, provide aftercare planning for members prior to discharge from a 24-hour facility. *42 CFR 438.208* Contract: 6.30.2.15	**2022 MCO Document Submission:** • 7200.07 Discharge Planning, pg. 3 **2023 MCO Document Submission:** • Coordination and Continuity of Care CFR 438.208--Element No. 7--Parts 1 & 2	☒ Met ☐ Not Met
2022 Compliance Review Finding: *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.		
2022 Compliance Review Recommendation: Aetna should create a policy, procedure, or program description to address this requirement.		
2022 MCO Comments: 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		
2023 CAP Review Findings: The MCO submitted the Transitions Between Care Settings desktop procedure that was revised on August 24, 2022. The desktop procedure included that for members who were inpatient, including behavioral health and physical health diagnoses, the case management staff attempted phone outreach, prior to discharge, to assist members and to ensure a seamless transition between care settings, health plans, and providers.		
2023 CAP Review Required Actions: None.		

Coordination and Continuity of Care: CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
8. 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. *42 CFR 438.208* Contract: 6.19.4.1	**2022 MCO Document Submission:** • ICM Program Description pg. 24 **2023 MCO Document Submission:** • 2022 Updated ICM Provider welcome letter • Coordination and Continuity of Care CFR 438.208--Element No. 8--Parts 1 through 3	☒ Met ☐ Not Met
2022 Compliance Review Finding: *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.		
2022 Compliance Review Recommendation: Aetna should collaborate with PCP/providers to obtain treatment plans for eligible members.		
2022 MCO Comments: 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		
2023 CAP Review Findings: The MCO stated that ABH continued to collaborate with providers to obtain member treatment plans. The MCO updated the ICM provider welcome letter that was sent to the member's provider upon enrollment in ICM. In the letter, the MCO requested a copy of the member's treatment plan from the member's PCP or provider. The MCO also submitted the chart audit tool. Question 7 provided the MCO confirmation that the ICM provider welcome letter was audited. The MCO stated that it used the audit results for purposes of training in ICM team meetings and with individual staff members through monthly one-on-one meetings. The MCO also stated that it sends a newsletter blast to all providers to encourage increased efforts in sharing members' treatment plans with the MCO.		
2023 CAP Review Required Actions: None.		

Coordination and Continuity of Care: CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
9. 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. *42 CFR 438.208* Contract: 6.36.3	**2022 MCO Document Submission:** • Member handbook , pg. 41 **2023 MCO Document Submission:** • 7000.50 Supporting Members in Crisis • Coordination and Continuity of Care CFR 438.208--Element No. 9--Part 1, pg. 3	☒ Met ☐ Not Met
2022 Compliance Review Finding: *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.		
2022 Compliance Review Recommendation: Aetna should edit the policy to include all parts of the requirement.		
2022 MCO Comments: 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		
2023 CAP Review Findings: The MCO submitted policy 7000.50 Supporting Members in Crisis, which was revised on March 1, 2022. The policy stated that in any instance when a member presented to the network provider, including calling ABH's toll-free number listed on the member identification (ID) card, and a member was in need of emergency behavioral health services, ABH instructed the member to seek help from the nearest emergency medical provider. ABH conducted follow-up with the member within 48 hours to establish whether appropriate services were accessed.		
2023 CAP Review Required Actions: None.		

Coordination and Continuity of Care: CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
10. 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. *42 CFR 438.208* Contract: 6.36.9.1.5	**2022 MCO Document Submission:** • Provider contract **2023 MCO Document Submission:** • Coordination and Continuity of Care CFR 438.208--Element No. 10--Part 1	☐ Met ☒ Not Met
2022 Compliance Review Finding: *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.		
2022 Compliance Review Recommendation: Aetna should create a policy, procedure, or program description to address this requirement.		
2022 MCO Comments: ABH agrees with the finding.		
2023 CAP Review Findings: The MCO provided a narrative that was not identified as a policy, procedure, program description, or other operational document which stated, where applicable, that ABH will create a VBS agreement to include the option to negotiate an enhanced rate during initial contracting for providers that can offer part- or full-time PCP services (physician, physician's assistant, nurse practitioner, or nurse) in a psychiatric specialty setting to monitor the physical health of patients. In addition, for existing contracts, an amendment will be drawn to include the option to negotiate an enhanced rate for providers who can offer this service. The provision of such covered services to eligible members will be delivered in accordance with the terms and conditions set forth in the base agreement. The narrative also stated that the MCO's enhancements to compensation capacity will include highly utilized providers based on member visits and claims data. The contract updates will roll out June 30, 2023, to new and existing providers. The MCO did not submit a copy of the contract update or identify which providers received the amendment as evidence of implementation of this requirement.		
2023 CAP Review Required Actions: The MCO must submit a policy for developing the capacity for enhanced rates or incentives to behavioral health clinics to employ a part- or full-time PCP (physician, physician's assistant, nurse practitioner, or nurse) in a psychiatric specialty setting to monitor the physical health of patients. The MCO should submit the template and an example of the contract update for the enhanced rates or incentives to behavioral health clinics to employ a part- or full-time PCP in a psychiatric specialty setting to monitor the		

Coordination and Continuity of Care: CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
physical health of patients. The MCO must also submit a list or examples of the highly utilized providers (based on member visits and claims data) who received the amendment, or a timeline for when the contract amendment will be received by the providers.		

Coordination and Continuity of Care: CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
11. 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, *42 CFR 438.208* Contract: 6.40.0	**2022 MCO Document Submission:** • LA 1501.03 **2023 MCO Document Submission:** • Act 319 desktop • Coordination and Continuity of Care CFR 438.208--Element No. 11--Part 1	☒ Met ☐ Not Met
2022 Compliance Review Finding: *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.		
2022 Compliance Review Recommendation: Aetna should continue to implement the Act 319 Policy Notice to LDH Process to meet this requirement.		
2022 MCO Comments: ABH agrees the recommendation and will continue to submit policies to the State for review per Act 319.		
2023 CAP Review Findings: The MCO submitted the Act 319 Policy Notice to LDH Process desktop procedure with a revision date of July 22, 2022, which did not support that the MCO's CAP had been implemented. The desktop procedure included both the internal and external approval processes. Following the virtual review, the MCO resubmitted the desktop procedure updated on October 16, 2023, which included the steps to update policies and to submit to LDH for review annually.		
2023 CAP Review Required Actions: None.		

Coordination and Continuity of Care: CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
12. 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. *42 CFR 438.208* Contract: 6.42.4	**2022 MCO Document Submission:** • 1501.03 Policy **2023 MCO Document Submission:** • Act 319 desktop • Coordination and Continuity of Care CFR 438.208--Element No. 12--Part 1	☒ Met ☐ Not Met
2022 Compliance Review Finding: *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.		
2022 Compliance Review Recommendation: Aetna should continue to implement the Act 319 Policy Notice to LDH Process to meet this requirement.		
2022 MCO Comments: ABH acknowledges the recommendation and will continue to submit policies to the State for review per Act 319.		
2023 CAP Review Findings: The MCO submitted the Act 319 Policy Notice to LDH Process desktop procedure with a revision date of July 20, 2022. The desktop procedure included both the internal and external approval processes. It did not address the annual submission of the policies and procedures. The submission did not support that the MCO implemented the CAP. Following the virtual review, the MCO resubmitted the desktop procedure, which was updated by the MCO on October 16, 2023. The first paragraph of the desktop procedure stated that the scope included case management guidelines and chronic care management program policies.		
2023 CAP Review Required Actions: None.		

Coverage and Authorization of Services: CFR 438.210		
Requirement	**Evidence as Submitted by the MCO**	**Score**
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. *42 CFR 438.208* Contract: 8.5.4.1.1.1	**2022 MCO Document Submission:** • 7200.05 Concurrent Review/Observation, p. 28 **2023 MCO Document Submission:** • Coverage and Authorization of Services CFR 438.210--Element No. 1-- Parts 1 through 3	☒ Met ☐ Not Met
2022 Compliance Review Finding: *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.		
2022 Compliance Review Recommendation: The entity should ensure the file type is accurately captured and timeframes met.		
2022 MCO Comments: ABH agrees with this the finding.		
2023 CAP Review Findings: The MCO submitted a narrative of the implementation of the CAP, which included that the MCO immediately put in place a granular action plan with the following interventions to prevent errors moving forward: • Conduct team re-education series on all job aides, which must be followed • Actively log and monitor any authorization errors upon identification for review and discussion • Hold weekly LA Intake Manager/Supervisor meetings to address and review performance measures • Provide updated job aides to the intake team as changes occur • Ensure correct triaging of faxes to avoid any missed turnaround times (TATs) • Monitor compliance through audits The MCO submitted an example of a meeting notice for weekly LA-touchpoint meetings. The MCO also submitted an EQRO action plan that identified a problem in which a staff member received a fax that the staff member failed to attach correctly to the authorization on file. The action plan listed actions taken including re-education, educational sessions, one-on-one meetings, monitoring, and ensuring thorough review of		

Coverage and Authorization of Services: CFR 438.210		
Requirement	**Evidence as Submitted by the MCO**	**Score**
faxed documents to properly attach to correct authorizations. The stated goals included continuing to monitor closely and ensure that re-education is available to all staff members, and to decrease as many errors as possible to remain within the state compliance requirements effective immediately.		
2023 CAP Review Required Actions: None.		

Coverage and Authorization of Services: CFR 438.210		
Requirement	**Evidence as Submitted by the MCO**	**Score**
2. 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. *42 CFR 438.210* Contract: 8.5.2.1	**2022 MCO Document Submission:** • 7100.05 Prior Authorization, p. 28 **2023 MCO Document Submission:** • Coverage and Authorization of Services CFR 438.210--Element No. 2-- Parts 1 through 3	☒ Met ☐ Not Met
2022 Compliance Review Finding: *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.		
2022 Compliance Review Recommendation: The entity should ensure the file type is accurately captured and timeframes met.		
2022 MCO Comments: ABH agrees with this the finding.		
2023 CAP Review Findings: The MCO submitted a narrative of the implementation of the CAP, which included that the MCO immediately put in place a granular action plan with the following interventions to prevent errors moving forward: • Conduct team re-education series on all job aides, which must be followed • Actively log and monitor any authorization errors upon identification for review and discussion • Hold weekly LA Intake Manager/Supervisor meetings to address and review performance measures • Provide updated job aides to the intake team as changes occur • Ensure correct triaging of faxes to avoid any missed TATs • Monitor compliance through audits The MCO submitted an example of a meeting notice for weekly LA-touchpoint meetings. The MCO also submitted an EQRO action plan that identified a problem in which a staff member received a fax that the staff member failed to attach correctly to the authorization on file. The action plan listed actions taken including re-education, educational sessions, one-on-one meetings, monitoring, and ensuring thorough review of		

Coverage and Authorization of Services: CFR 438.210		
Requirement	**Evidence as Submitted by the MCO**	**Score**
faxed documents to properly attach to correct authorizations. The stated goals included continuing to monitor closely and ensure that re-education is available to all staff members, and to decrease as many errors as possible to remain within the state compliance requirements effective immediately.		
2023 CAP Review Required Actions: None.		

Provider Selection CFR 438.214		
Requirement	**Evidence as Submitted by the MCO**	**Score**
1. The MCO shall establish and follow a documented process for credentialing and re-credentialing of network providers [42 CFR §438.12(a)(2).The MCO must have a written credentialing and re-credentialing process that complies with 42 CFR §438.12, §438.206, §438.214, §438.224, §438.230 and NCQA health plan Accreditation Standards for the review, credentialing and re-credentialing of licensed, independent providers and provider groups with whom it contracts or employs and with whom it does not contract but with whom it has an independent relationship. An independent relationship exists when the MCO selects and directs its members to see a specific provider or group of providers. These procedures shall be submitted to LDH within sixty (60) calendar days after contract amendment, when a change is made, and annually thereafter by contract year. *42 CFR 438.214* Contract: 7.6.3.27.1.4.1	**2022 MCO Document Submission:** • Aetna_LA 438.214_QM 54 Practitioner Credentialing Recredentialing FY2022 - Entire document • Aetna_LA 438.214_A-QM 54 Practitioner Credentialing Recredentialing_Amendment FY2022 - Entire document • Aetna_LA 438.214_QM 53 Credentialing Allied Health Practitioners FY2022 - Entire document • Aetna_LA 438.214_QM 51 Assessment of Organizational Providers FY2022 - Entire document **2023 MCO Document Submission:** • QM 54 Practitioner Credentialing, Recredentialing • Provider Selection CFR 438.214--Element No. 1--Part 1 of 1	☒ Met ☐ Not Met
2022 Compliance Review Finding: *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.		
2022 Compliance Review Recommendation: The entity should ensure that the organization's time frame for notifying applicants of initial credentialing decisions does not exceed 60 calendar days from the Credentialing Committee's decision.		

Provider Selection CFR 438.214		
Requirement	**Evidence as Submitted by the MCO**	**Score**
2022 MCO Comments: 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.		
2023 CAP Review Findings: The MCO submitted the QM 54 Practitioner Credentialing, Recredentialing policy, which was updated on July 11, 2022. The policy contained a statement regarding the processing of all credentialing applications within a 60-day time period. The policy stated that LDH shall completely process credentialing applications from all types of provider types within 60 calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement.		
2023 CAP Review Required Actions: None.		

Enrollee Rights and Protections CFR 438.224		
Requirement	**Evidence as Submitted by the MCO**	**Score**
1. 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. *42 CFR 438.224* Contract: 12.9.2	**2022 MCO Document Submission:** • Policy A-LA 4500.20 Member Materials Standard - page 2 **2023 MCO Document Submission:** • Policy A-LA 4500.20 Member Materials Standard - page 2 • Enrollee Rights and Protections CFR 438.224--Element No. 1--Part 1	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Not Met*—This requirement is not addressed by the member materials policy.		
2022 Compliance Review Recommendation: The entity should update the member materials policy to include this requirement. (Noted by the entity in the MCO comments column.)		
2022 MCO Comments: ABH agrees and has updated the policy. See uploads.		
2023 CAP Review Findings: The MCO submitted the A-LA 4500.20 Member Materials Standard policy, which was revised on October 11, 2022, and included the requirements of this element, including that all written materials will be clearly legible with a minimum font size of 10 point, preferably 12 point, with the exception of member ID cards, or otherwise approved by LDH.		
2023 CAP Review Required Actions: None.		

Enrollee Rights and Protections CFR 438.224		
Requirement	**Evidence as Submitted by the MCO**	**Score**
2. 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. *42 CFR 438.224* Contract: 12.9.4	**2022 MCO Document Submission:** • No documents listed **2023 MCO Document Submission:** • Policies A-LA 4600.05 and 4600.40 • Enrollee Rights and Protections CFR 438.224--Element No. 2--Parts 1 & 2	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Not Met*—This requirement is not addressed by any policy or procedure.		
2022 Compliance Review Recommendation: The entity should update the member materials policy to include this requirement. (Noted by the entity in the MCO comments column.)		
2022 MCO Comments: ABH agrees and has updated Policies 4600.05 (Member Coms) & 4600.40 (Advertising). See uploads.		
2023 CAP Review Findings: The MCO submitted the Enrollee Rights and Protections policy and the 4600.06 policy, which were updated on October 11, 2022, and stated that if a person making a testimonial or endorsement for ABH has a financial interest in the company, such fact will be disclosed in the produced materials.		
2023 CAP Review Required Actions: None.		

Enrollee Rights and Protections CFR 438.224		
Requirement	**Evidence as Submitted by the MCO**	**Score**
3. All written materials must be in accordance with the LDH "Person First" Policy, Appendix NN. *42 CFR 438.224* Contract: 12.9.5	**2022 MCO Document Submission:** • No documents listed **2023 MCO Document Submission:** • Policy no. 4500.20 Member Materials Standards • Element no. 1--Provider Selection CFR 438.210--Part 1	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Not Met*—This requirement is not addressed by any policy or procedure.		
2022 Compliance Review Recommendation: The entity should update the member materials policy to include this requirement. (Noted by the entity in the MCO comments column.)		
2022 MCO Comments: This information is not currently in the policy. Marketing will update the policy. ABH agrees and will update the policy.		
2023 CAP Review Findings: The MCO submitted the Member Materials Standards policy that was updated on October 11, 2022. The policy included language that stated ABH will adopt the Department of Health and Hospitals' Person First Policy in all written and verbal communication with and regarding its members. In accordance with this policy, all references to members will consist of positive language that refers to the person first and then addresses traits or characteristics of the member. No member will be referred to in a manner that references any medical condition before his or her personhood (e.g., "a member with diabetes" as opposed to "a diabetic member"). When addressing diagnoses and conditions, negative words such as "suffer," "deficit," etc. will be avoided. When discussing members, emphasis will be placed on abilities rather than limitations. This same standard will be extended to the discussion of medical assistance devices.		
2023 Review Required Actions: None.		

Enrollee Rights and Protections CFR 438.224		
Requirement	**Evidence as Submitted by the MCO**	**Score**
4. 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. *42 CFR 438.224* Contract: 12.9.6	**2022 MCO Document Submission:** • No documents listed **2023 MCO Document Submission:** • Policy no. 4600.83 Print and Mailing • Provider Selection CFR 438.210--Element No. 2--12.9.6	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Not Met*—This requirement is not addressed by any policy or procedure.		
2022 Compliance Review 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.)		
2022 MCO Comments: Aetna Better Health does not have any commercial plans. ABH agrees and has updated the policy, see attached.		
2023 CAP Review Findings: The MCO submitted the Print and Mailing policy that was reviewed on October 11, 2022. The policy's Quality Control section included the requirement that the quality of materials used for printed materials will be, at a minimum, equal to the materials used for printed materials for any existing ABH commercial plans.		
2023 CAP Review Required Actions: None.		

Enrollee Rights and Protections CFR 438.224		
Requirement	**Evidence as Submitted by the MCO**	**Score**
5. 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. *42 CFR 438.224* Contract: 12.9.15	**2022 MCO Document Submission:** • No documents listed **2023 MCO Document Submission:** • Policy no. 4600.05 Member Communications • Provider Selection CFR 438.210--Element No. 3--12.9.15	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Not Met*—This requirement is not addressed by any policy or procedure.		
2022 Compliance Review Recommendation: The entity should update the member materials policy to include this requirement. (Noted by the entity in the MCO comments column.)		
2022 MCO Comments: ABH agrees and has updated the policy. Please see policy no. 4600.05 in the uploads.		
2023 CAP Review Findings: The MCO submitted the Member Communications policy that was updated on October 11, 2022. The policy contained the requirement that ABH will develop its own materials that adhere to requirements set forth by LDH or use state-developed model member notices. State-developed model notices will be used for denial notices and lock-in notices.		
2023 CAP Review Required Actions: None.		

Enrollee Rights and Protections CFR 438.224		
Requirement	**Evidence as Submitted by the MCO**	**Score**
6. 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. *42 CFR 438.224* Contract: 12.19.4	**2022 MCO Document Submission:** • Policy A-LA 4500.25 Interpreter and Translation Services - pages 3-5 **2023 MCO Document Submission:** • Policy no. 4500.25 Interpreter and Translation Services • Provider Selection—Element No. 4--CFR 438.210--12.19.4	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*—This requirement is partially addressed in the Member Notice of Primary Care Practitioner (PCP) / Practitioner Termination policy.		
2022 Compliance Review Recommendation: The MCO should add the provisions regarding TTY/DTY and font size to the policy.		
2022 MCO Comments: None.		
2023 CAP Review Findings: The MCO submitted the Interpreter and Translation Services policy that was revised on October 11, 2022. The policy included that written materials will also be made available in alternative formats upon request of the potential member or member at no cost. Auxiliary aids and services will also be made available upon request of the potential member or member at no cost. Written materials will 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 ABH's member service unit. Large print means printed in a font size no smaller than 18 point.		
2023 CAP Review Required Actions: None.		

Enrollee Rights and Protections CFR 438.224		
Requirement	**Evidence as Submitted by the MCO**	**Score**
7. 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. *42 CFR 438.224* Contract: 12.18.1	**2022 MCO Document Submission:** • Policy A-LA 4500.12 Member Notice of Primary Care Practitioner (PCP) Termination - page 3 **2023 MCO Document Submission:** • Policy no. A-LA 4500.12 Member Notice of Primary Care Practitioner (PCP) Termination - page 3 • Provider Selection CFR 438.210--Element No. 5--12.18.1	☐ Met ☒ Not Met
2022 Compliance Review Finding: *Partially Met*—This requirement is partially addressed in the Member Notice of Primary Care Practitioner (PCP) / Practitioner Termination policy.		
2022 Compliance Review Recommendation: The entity should build the "within 15-day notice to member" into the policy.		
2022 MCO Comments: ABH agrees and will update the policy.		
2023 CAP Review Findings: The MCO submitted the A-LA 4500.12 Member Notice of Primary Care Practitioner (PCP) Termination policy that was revised on March 21, 2023. The policy did not include the requirements of this element or the requirements in the MCO's CAP. Following the virtual review, the MCO stated that the plan would update the submitted A-LA 4500.12 Member Notice of Primary Care Practitioner (PCP) Termination policy to reflect the requirement.		
2023 CAP Review Required Actions: The MCO's policy must be updated to include the requirement that when timely notice from the provider is received, the notice to the member shall be provided within 15 calendar days of the receipt of the termination notice from the provider.		

Enrollee Rights and Protections CFR 438.224		
Requirement	**Evidence as Submitted by the MCO**	**Score**
8. 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. *42 CFR 438.224* Contract: 12.18.2	**2022 MCO Document Submission:** • Policy A-LA 4500.12 Member Notice of Primary Care Practitioner (PCP) Termination - page 4 **2023 MCO Document Submission:** • Policy no. A-LA 4500.12 Member Notice of Primary Care Practitioner (PCP) Termination - page 3 • Provider Selection CFR 438.210--Element No. 6--12.18.2	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*—This requirement is partially addressed in the Member Notice of Primary Care Practitioner (PCP) / Practitioner Termination policy.		
2022 Compliance Review 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.		
2022 MCO Comments: ABH agrees and will update the policy.		
2023 CAP Review Findings: The MCO submitted the A-LA 4500.12 Member Notice of Primary Care Practitioner (PCP) Termination policy that was revised on March 21, 2023. The policy included the requirements of this element, stating that ABH 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 calendar days from the date ABH 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, a provider moves from the service area and fails to notify the MCO, or when a		

Enrollee Rights and Protections CFR 438.224		
Requirement	**Evidence as Submitted by the MCO**	**Score**
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.		
2023 CAP Review Required Actions: None.		

Enrollee Rights and Protections CFR 438.224		
Requirement	**Evidence as Submitted by the MCO**	**Score**
9. Identification of any restrictions on the enrollee's freedom of choice among network providers; *42 CFR 438.224* Contract: 12.14.4.3	**2022 MCO Document Submission:** • Provider manual page 83 **2023 MCO Document Submission:** • Policy no. 6300.20 Provider Directory Updates, pg. 6 • Provider Selection CFR 438.210--Element No. 7--12.14.4.3	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*—This requirement is partially addressed by the Provider Manual.		
2022 Compliance Review Recommendation: The entity should incorporate this requirement into a policy.		
2022 MCO Comments: ABH agrees and will update the policy.		
2023 CAP Review Findings: The MCO submitted the Provider Directory Updates policy that was revised on April 5, 2023. Following the virtual review, the MCO stated that it would review and update the policy to correct the typographical errors.		
2023 CAP Review Required Actions: None.		

Enrollee Rights and Protections CFR 438.224		
Requirement	**Evidence as Submitted by the MCO**	**Score**
10. Identification of hours of operation including identification of providers with non-traditional hours (Before 8 a.m. or after 5 p.m. or any weekend hours). *42 CFR 438.224* Contract: 12.14.4.4	**2022 MCO Document Submission:** • Provider manual page 31 **2023 MCO Document Submission:** • Policy no. 6300.20 Provider Directory Updates, pg. 7 • Provider Selection CFR 438.210--Element No. 8--12.14.4.4	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*—This requirement is partially addressed by the Provider Manual.		
2022 Compliance Review Recommendation: The entity should incorporate this requirement into a policy.		
2022 MCO Comments: ABH agrees and will update the policy.		
2023 CAP Review Findings: The MCO submitted the Provider Directory Updates policy that was revised on April 5, 2023. The policy outlined the requirement that the following NCQA, CFR, and ABH state-specific information is included in the directories, including hours of operation. Following the virtual review, the MCO stated that it would add language to the policy that makes it clear the directory includes non-traditional hours (before 8 a.m. or after 5 p.m.) or any weekend hours.		
2023 CAP Review Required Actions: None.		

Quality Assessment and Performance Improvement Program (QAPI) CFR 438.330		
Requirement	**Evidence as Submitted by the MCO**	**Score**
1. 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 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. *42 CFR 438.330* Contract: 14.1.7	**2022 MCO Document Submission:** • Report 136 QAPI Program Description, Work Plan, Impact and Effectiveness of Program Evaluation - A (QAPI Program Evaluation pg. 38, 41, 98) • LARCS State Bulletin (entire document) **2023 MCO Document Submission:** • Quality Assessment and Performance Improvement Program (QAPI) CFR 438.330--Elements 1-3 • Pharmacy policy no. 7600.07 Pharmacy Prior Authorization	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*—This requirement is partially addressed in the Quality Assessment Performance Improvement 2022 Program 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.		
2022 Compliance Review 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.		
2022 MCO Comments: ABH agrees and Policy A-LA 7600.07 Pharmacy Prior Authorization was updated to reflect IRPO's recommendations.ABH 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.		

Quality Assessment and Performance Improvement Program (QAPI) CFR 438.330		
Requirement	**Evidence as Submitted by the MCO**	**Score**
2023 CAP Review Findings: The MCO submitted the Pharmacy Prior Authorization policy with a revision date of September 22, 2022, that included the following language: The ABH formulary/PDL indicates the medications available under a member's pharmacy benefit. PA requirements may include: • Specialty drugs. • Any medication not included on the formulary/PDL. • Any medication prescribed for a use that does not conform to ABH-established utilization practices. • Evidence-based behavioral therapies will be the first-line treatment for attention-deficit/hyperactivity disorder (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. Following the virtual review, the MCO submitted examples of provider education and training opportunities made available to providers.		
2023 CAP Review Required Actions: None.		

Quality Assessment and Performance Improvement Program (QAPI) CFR 438.330		
Requirement	**Evidence as Submitted by the MCO**	**Score**
2. The MCO shall reduce overutilization of services and medications through policies such as, but not limited to, prior authorization for prescription of ADHD drugs to children younger than six years of age. *42 CFR 438.330* Contract: 14.1.8	**2022 MCO Document Submission:** • Report 136 QAPI Program Description, Work Plan, Impact 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 Authorization Stimulants.and.Related.Agents.11152021 PDL (pg. 4) **2023 MCO Document Submission:** • Quality Assessment and Performance Improvement Program (QAPI) CFR 438.330--Elements 1-3 • Pharmacy policy no. 7600.07 Pharmacy Prior Authorization	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*— This requirement is partially addressed in the Attention 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."		
2022 Compliance Review 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.		

Quality Assessment and Performance Improvement Program (QAPI) CFR 438.330		
Requirement	**Evidence as Submitted by the MCO**	**Score**
2022 MCO Comments: ABH agrees and Policy A-LA 7600.07 Pharmacy Prior Authorization was updated to reflect IRPO's recommendations.ABH 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.		
2023 CAP Review Findings: The MCO submitted the Pharmacy Prior Authorization policy that was revised on September 22, 2022. The policy included the requirement that the ABH formulary/PDL indicated the medications available under a member's pharmacy benefit. PA requirements may include: • Specialty drugs. • Any medication not included on the formulary/PDL. • Any medication prescribed for a use that does not conform to ABH-established utilization practices. • Evidence-base behavioral therapies will be 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. The MCO also submitted monthly meeting minutes from the ADHD Workgroup. The meeting minutes stated that the ADHD Provider Toolkit was live on the ABH website. The MCO also submitted the ABH of LA Autism Member Tool Kit. Following the virtual review, the MCO submitted examples of provider education and training opportunities made available to providers.		
2023 CAP Review Required Actions: None.		

Quality Assessment and Performance Improvement Program (QAPI) CFR 438.330		
Requirement	**Evidence as Submitted by the MCO**	**Score**
3. 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. *42 CFR 438.330* Contract: 14.1.8	**2022 MCO Document Submission:** • Report 136 QAPI Program Description and workplan • 355 Healthy Louisiana EBP Report • CPG ADHDA-LA 7500.05 Integrated Care Management • A-LA 7000.35 Practitioner and Member Over-Underutilization of Services • https://aetnet.aetna.com/mpa/cpb/400_499/0426.html **2023 MCO Document Submission:** • Quality Assessment and Performance Improvement Program (QAPI) CFR 438.330--Elements 1-3 • Pharmacy policy no. 7600.07 Pharmacy Prior Authorization	☒ Met ☐ Not Met
2022 Compliance Review Finding: *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."		
2022 Compliance Review 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.		

Quality Assessment and Performance Improvement Program (QAPI) CFR 438.330		
Requirement	**Evidence as Submitted by the MCO**	**Score**
2022 MCO Comments: ABH agrees and Policy A-LA 7600.07 Pharmacy Prior Authorization was updated to reflect IRPO's recommendations.ABH 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.		
2023 CAP Review Findings: The MCO submitted the Pharmacy Prior Authorization policy with a revision date of September 22, 2022. The policy included that the ABH formulary/PDL indicated the medications available under a member's pharmacy benefit. PA requirements may include: • Specialty drugs. • Any medication not included on the formulary/PDL. • Any medication prescribed for a use that does not conform to ABH-established utilization practices. • Evidence-base behavioral therapies will be 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. The MCO also submitted monthly meeting minutes from the ADHD Workgroup. The meeting minutes stated that the ADHD Provider Toolkit was live on the ABH website. The MCO also submitted the ABH of LA Autism Member Tool Kit. Following the virtual review, the MCO submitted examples of provider education and training opportunities made available to providers.		
2023 CAP Review Required Actions: None.		

Fraud Waste and abuse CFR 438.608		
Requirement	**Evidence as Submitted by the MCO**	**Score**
1. 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. *42 CFR 438.608* Contract: 15.1.13	**2022 MCO Document Submission:** • 3000.42 Excluded Individuals 2021 • 3000.42 Excluded Individuals Policy underwent review in 2022 and was updated to add more contract language. Including both versions. **2023 MCO Document Submission:** • Policy no. 3000.42 Excluded Individuals, pgs. 5 & 6 • Fraud Waste and abuse CFR 438.608--Element no. 1--15.1.13	☒ Met ☐ Not Met
2022 Compliance Review Finding: *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.		
2022 Compliance Review Recommendation: Aetna should include the refunding of funds made to excluded individuals in a policy.		
2022 MCO Comments: ABH agrees this finding and will update relevant policies.		
2023 CAP Review Findings: The MCO submitted the Excluded Individuals policy, which stated that 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.		
2023 CAP Review Required Actions: None.		

Fraud Waste and abuse CFR 438.608		
Requirement	**Evidence as Submitted by the MCO**	**Score**
2. 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 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. *42 CFR 438.608* Contract: 15.2.6.16	**2022 MCO Document Submission:** • Policy no. 3000.20, pg. 3 • Code of Conduct, pg.24 **2023 MCO Document Submission:** • Policy no. 3000.20 Compliance Training and Education, pgs. 4 & 5 • Fraud Waste and abuse CFR 438.608--Element no. 2--15.2.6.16	☒ Met ☐ Not Met
2022 Compliance Review Finding: *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.		
2022 Compliance 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.		

Fraud Waste and abuse CFR 438.608		
Requirement	**Evidence as Submitted by the MCO**	**Score**
2022 MCO Comments: 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. EQRO Response: 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.		
2023 CAP Review Findings: The MCO submitted the Compliance Training and Education policy, which included that ABH will require new employees to complete and attest to training modules within 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 Managed Care Organizations and Prepaid Networks) issued by the 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.		
2023 CAP Review Required Actions: None.		

Fraud Waste and abuse CFR 438.608		
Requirement	**Evidence as Submitted by the MCO**	**Score**
3. Federal Financial Participation (FFP) is not available for services delivered by providers excluded by Medicare, Medicaid, or CHIP except for certain emergency services; and *42 CFR 438.608* Contract: 15.4.1	**2022 MCO Document Submission:** • A-LA 3000.42 Excluded Individuals 2022, pg. 6 **2023 MCO Document Submission:** • Policy no. 3000.42 Excluded Individuals, pg. 6 • Fraud Waste and abuse CFR 438.608--Element no. 3--15.4.1	☒ Met ☐ Not Met
2022 Compliance Review Finding: *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.		
2022 Compliance Review Recommendation: No action is required by Aetna, as this issue was self-identified and added to the updated policy.		
2022 MCO Comments: ABH agrees no further action is required.		
2023 CAP Review Findings: The MCO submitted the Excluded Individuals policy, which had a revision date of March 29, 2023. The policy stated that Federal Financial Participation (FFP) is not available for services delivered by providers excluded by Medicare, Medicaid, or Children's Health Insurance Program (CHIP) except for certain emergency services.		
2023 CAP Review Required Actions: None.		

Fraud Waste and abuse CFR 438.608		
Requirement	**Evidence as Submitted by the MCO**	**Score**
4. The MCO is responsible for the return to the State of any money paid for services provided by an excluded provider. *42 CFR 438.608* Contract: 15.4.2	**2022 MCO Document Submission:** • A-LA 3000.42 Excluded Individuals 2022, pg. 6 **2023 MCO Document Submission:** • Policy no. 3000.42 Excluded Individuals, pg. 6 • Fraud Waste and abuse CFR 438.608--Element no. 4--15.4.2	☒ Met ☐ Not Met
2022 Compliance Review Finding: *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.		
2022 Compliance Review Recommendation: No action is required by Aetna, as this issue was self-identified and added to the updated policy.		
2022 MCO Comments: ABH agrees no further action is required.		
2023 CAP Review Findings: The MCO submitted the Excluded Individuals policy, which had a revision date of March 29, 2023. The policy included that FFP is not available for services delivered by providers excluded by Medicare, Medicaid, or CHIP except for certain emergency services.		
2023 CAP Review Required Actions: None.		

Fraud Waste and abuse CFR 438.608		
Requirement	**Evidence as Submitted by the MCO**	**Score**
5. 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. *42 CFR 438.608* Contract: 15.7.10	**2022 MCO Document Submission:** • 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. **2023 MCO Document Submission:** • Policy no. 3000.42 Excluded Individuals, pg. 6 • Fraud Waste and abuse CFR 438.608--Element no. 5--15.7.10 Part 1 of 2 • Aetna SIU Policy Dependence • Fraud Waste and abuse CFR 438.608--Element no. 5--15.7.10 Part 2 of 2	☒ Met ☐ Not Met
2022 Compliance Review Finding: *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.		
2022 Compliance Review Recommendation: No action is required by Aetna, as this issue was self-identified and added to the updated policy.		
2022 MCO Comments: ABH agrees no further action is required.		
2023 CAP Review Findings: The MCO submitted the Excluded Individuals policy, which had a revision date of March 29, 2023. The policy included that in the event LDH or its agent initiates a review on a network provider, a notification shall be sent to ABH's Special Investigation Unit (SIU) designee. The LDH notification of the intent to review shall include: provider name, NPI, city, provider type, allegation or issue being reviewed, procedure codes or NDCs under review, date range for dates of service under review, and amount paid. ABH shall have 10 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 10 business days, the State may proceed with its review. The MCO also submitted the Aetna SIU Policy Dependence document, which included the following language:		

Fraud Waste and abuse CFR 438.608		
Requirement	**Evidence as Submitted by the MCO**	**Score**
In addition, the policy stated that in the event LDH or its agent initiates a review on a network provider, a notification shall be sent to the ABH SIU designee. The LDH notification of the intent to review shall include: provider name, NPI, city, 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 10 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 10 business days, the State may proceed with its review.		
2023 CAP Review Required Actions: None.		

Fraud Waste and abuse CFR 438.608		
Requirement	**Evidence as Submitted by the MCO**	**Score**
6. 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. *42 CFR 438.608* Contract: 15.7.11	**2022 MCO Document Submission:** • "002 MCD SIU OverviewCVS Health Healthcare Anti-Fraud Plan" **2023 MCO Document Submission:** • Aetna SIU Policy Dependence • Fraud Waste and abuse CFR 438.608--Element no. 6--15.7.11	☒ Met ☐ Not Met
2022 Compliance Review Finding: *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.		
2022 Compliance Review Recommendation: The entity 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.		
2022 MCO Comments: ABH acknowledges this finding and has updated the SIU Dependence Policy to reflect to this change. See uploads.		
2023 CAP Review Findings: The MCO submitted the Aetna SIU Policy Dependence document, which stated that SIU will respond to requests from LDH within 14 calendar days of the request, unless another time period is agreed to by the MCO and the State. Furthermore, SIU will coordinate the adjustment of claims and encounters when notified of a refund submitted directly to LDH.		
2023 CAP Review Required Actions: None.		

Fraud Waste and abuse CFR 438.608		
Requirement	**Evidence as Submitted by the MCO**	**Score**
7. 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. *42 CFR 438.608* Contract: 7.6.2.3	**2022 MCO Document Submission:** • A-LA Policy no. 6300.11, pg. 3 **2023 MCO Document Submission:** • Policy no. A-LA Policy no. 6300.11, pg. 3 Fraud, Waste, and Abuse CFR 438.608--Element no. 7--7.6.2.3	☒ Met ☐ Not Met
2022 Compliance Review Finding: *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.		
2022 Compliance Review Recommendation: No action is required by Aetna, as this issue was self-identified and added to the updated policy.		
2022 MCO Comments: ABH agrees no further action is required.		
2023 CAP Review Findings: The MCO submitted the Fraud, Waste, and Abuse policy, which included that ABH shall not remit payment for services provided under this contract to providers located outside of the United States. The term "United States" means the 50 states, the District of Columbia, and any United States territories.		
2023 CAP Review Required Actions: None.		

Results for Follow-Up on 2022 Deficiencies Corrective Action Plans							
Total	Met	=	34	X	1.0	=	34.0
	Not Met	=	2	X	0.0	=	0.0
Total Applicable		=	36	**Total Score**		=	34.0

Total Score ÷ Total Applicable	=	**94.4%**

Appendix C. 2023 Corrective Action Plan Template

Standard I—Enrollment and Disenrollment			
Requirements—HSAG's Findings and MCE Required Corrective Actions			
Element 1: The MCO agrees to accept individuals enrolled into its MCO in the order in which they apply without restriction (unless authorized by the Department). *42 CFR §438.3(d)(1)* 2022 Contract Citations: 11.9.1 2023 Contract Citations: 2.3.12.1; 2.3.12.1.1; 2.3.12.1.2			
HSAG Findings: The MCO's policies and procedures did not include the requirement that the MCO agrees to accept individuals enrolled into its MCO in the order in which they apply without restriction (unless authorized by the Department).			
Required Actions: The MCO must revise its policies and procedures to include language stating the MCO agrees to accept individuals enrolled into its MCO in the order in which they apply without restriction (unless authorized by the Department).			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**
CAP Approval Status:			

Standard I—Enrollment and Disenrollment			
Requirements—HSAG's Findings and MCE Required Corrective Actions			
Element 2: The MCO does not discriminate against individuals enrolled or use any policy or practice that has the effect of discriminating against individuals, based on health status or need for healthcare services, race, color, national origin, sex, or disability. *42 CFR §438.3(d)(3-4)* 2022 Contract Citations: 11.10.1.3 2023 Contract Citations: 2.3.12.1; 2.3.12.3			
HSAG Findings: The MCO's policies and procedures did not include the requirement that the MCO does not discriminate against individuals enrolled or use any policy or practice that has the effect of discriminating against individuals based on health status or need for healthcare services.			
Required Actions: The MCO must revise its policies and procedures to include language stating that the MCO does not discriminate against individuals enrolled or use any policy or practice that has the effect of discriminating against individuals based on health status or need for healthcare services.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**
CAP Approval Status:			

Standard I—Enrollment and Disenrollment			
Requirements—HSAG's Findings and MCE Required Corrective Actions			
Element 6: If the Department approves the MCO's disenrollment request, the MCO gives the member written notice of the proposed disenrollment. *42 CFR §438.56(d)(5)* 2022 Contract Citations: 11.11.4.4; 11.11.4.8 2023 Contract Citations: 2.3.13.3.7			
HSAG Findings: The MCO's Member Disenrollment/Disruptive Member Transfer policy stated that for disruptive member disenrollment, the MCO gives the member written notice of the proposed disenrollment. The MCO's policies and procedures did not include the requirement that for any approved disenrollment, the MCO gives the member written notice of the proposed disenrollment.			
Required Actions: The MCO must revise its policies and procedures to include language stating that if the Department approves the MCO's disenrollment, the MCO provides members written notice of the proposed disenrollment.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**
CAP Approval Status:			

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

Standard I—Enrollment and Disenrollment			
– The member's active specialized behavioral health provider ceases to contract with the MCO • Member handbook section titled "Disenroll from Aetna Better Health of Louisiana": • When the Department has imposed sanctions on the MCO (consistent with 42 CFR §438.702[a][4])			
Required Actions: The MCO must revise the Member Disenrollment/Disruptive Member Transfer policy to include that the member may disenroll with cause for the following reasons: • The member's active specialized behavioral health provider ceases to contract with the MCO • Any other reason deemed to be valid by LDH and/or its agent • The contract between the MCO and LDH is terminated The MCO must also revise its policy to state that the member may disenroll without cause for the following reason: • When the Department has imposed sanctions on the MCO (consistent with 42 CFR §438.702[a][4]) The MCO must revise the member handbook to include that the member may disenroll with cause for the following reasons: • Lack of access, or lack of access to providers experienced in dealing with the member's specific needs • The member's active specialized behavioral health provider ceases to contract with the MCO The MCO must revise the member handbook to include that the member may disenroll without cause for the following reason: • When the Department has imposed sanctions on the MCO (consistent with 42 CFR §438.702[a][4])			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**
CAP Approval Status:			