State of Louisiana
Department of Health & Hospitals

Aetna Better Health of Louisiana
Annual External Quality Review Technical Report

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I. INTRODUCTION

The Centers for Medicare and Medicaid Services (CMS) require that state agencies contract with an External Quality Review Organization (EQRO) to conduct an annual external quality review (EQR) of the services provided by contracted Medicaid managed care organizations (MCOs). This EQR must include an analysis and evaluation of aggregated information on quality, timeliness and access to the health care services that an MCO furnishes to Medicaid recipients. Quality is defined in 42 Code of Federal Regulations (CFR) 438.320 as *"the degree to which an MCO or PIHP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge"*.

In order to comply with these requirements, the Louisiana Department of Health (LDH) contracted with IPRO to assess and report the impact of its Medicaid managed care program, the Healthy Louisiana Program, and each of the participating MCOs on the accessibility, timeliness and quality of services. Specifically, this report provides IPRO's independent evaluation of the services provided by Aetna Better Health of Louisiana (Aetna) for review period July 1, 2017 – June 30, 2018.

The framework for IPRO's assessment is based on the guidelines and protocols established by CMS, as well as Louisiana State requirements. IPRO's assessment included an evaluation of the mandatory activities, which encompass: performance measure validation, Performance Improvement Project (PIP) validation and compliance audits. Results of the most current HEDIS® and CAHPS® surveys are presented and are evaluated in comparison to the NCQA's *Quality Compass®* 2018 South Central – All Lines of Business (LOB) Excluding Preferred-Provider Organizations (PPOs) and Exclusive Provider Organizations (EPOs) Medicaid benchmarks.

Section VI provides an assessment of the MCO's strengths and opportunities for improvement in the areas of accessibility, timeliness and quality of services. For areas in which the MCO has opportunities for improvement, recommendations for improving the quality of the MCO's health care services are provided. To achieve full compliance with federal regulations, this section also includes an assessment of the degree to which the MCO has effectively addressed the recommendations for quality improvement made by IPRO in the previous year's EQR report. The MCO was given the opportunity to describe current and proposed interventions that address areas of concern, as well as an opportunity to explain areas that the MCO did not feel were within its ability to improve. The response by the MCO is appended to this section of the report.

II. MCO CORPORATE PROFILE

Table 1: MCO Corporate Profile

Aetna Better Health of Louisiana	
Type of Organization	Health Maintenance Organization
Tax Status	For Profit
Year Operational	2015
Product Line(s)	Medicaid and LaCHIP
Total Medicaid Enrollment (as of June 2018)	114,377

III. ENROLLMENT AND PROVIDER NETWORK

Enrollment

Medicaid Enrollment

As of June 2018, the MCO's Medicaid enrollment totaled 114,377, which represents 8% of Healthy Louisiana's active members. **Table 2** displays Aetna's Medicaid enrollment for 2016 to 2018, as well as the statewide enrollment total. **Figure 1** displays Healthy Louisiana's membership distribution across all Medicaid MCOs.

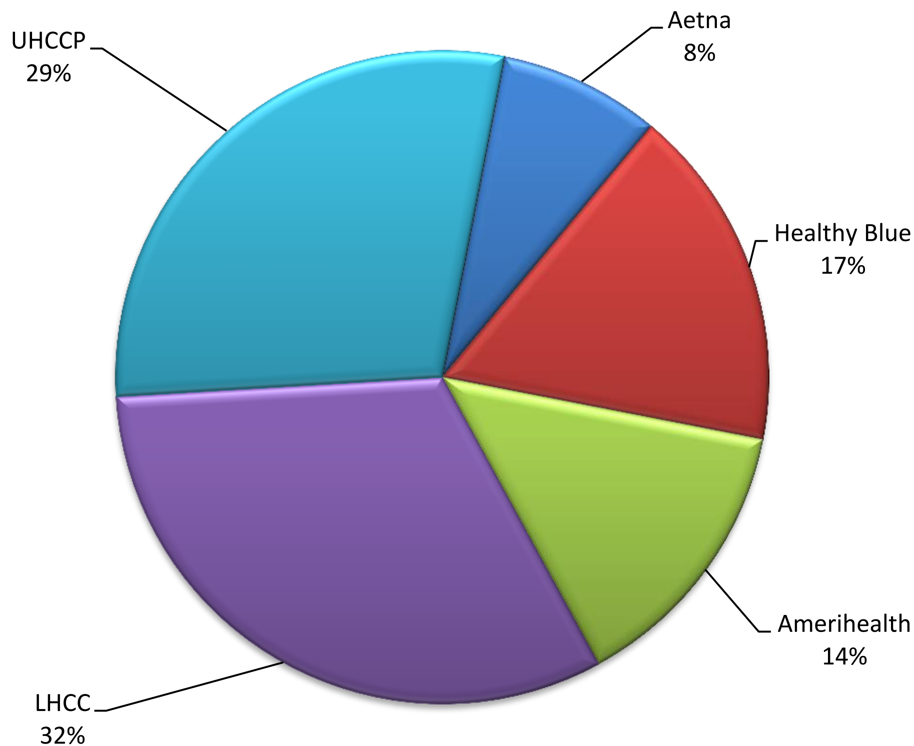
Table 2: Medicaid Enrollment as of June 2018[1]

Aetna	June 2016	June 2017	June 2018	% Change	June 2018 Statewide Total[2]
Total Enrollment	89,575	111,631	114,377	2.5%	1,473,685

Data Source: Report No. 125-A

[1] This report shows all active members in Healthy Louisiana as of the effective date above. Members to be disenrolled at the end of the reporting month are not included. Enrollees who gained and lost eligibility during the reporting month were not included. Enrollees who opted out of Healthy Louisiana during the reporting month were not included.

[2] Note: The statewide total includes membership of all Medicaid MCOs.



Provider Network

Providers by Specialty

LDH requires each MCO to report on a quarterly basis the total number of network providers. **Table 3** shows the sum of Aetna's primary care providers, OB/GYNs and other physicians with primary care responsibilities within each LDH region as of March 20, 2018.

Table 3: Primary Care & OB/GYN Counts by LDH Region

Specialty	Aetna Better Health LDH Region									MCO Statewide Unduplicated
	1	2	3	4	5	6	7	8	9	
Family Practice/ General Medicine	441	315	116	249	208	175	262	229	282	1670
Pediatrics	409	237	66	121	50	66	162	45	157	1052
Nurse Practitioners	661	563	244	343	225	264	364	272	406	2572
Internal Medicine	231	155	41	57	49	22	129	30	73	724
RHC/FQHC	18	5	2	11	5	21	23	17	2	89
OB/GYN[1]	14	5	2	11	7	1	34	4	5	76

Data source: Network Adequacy Review 2018 Q2

LDH Region 1: New Orleans; Region 2: Baton Rouge; Region 3: Houma Thibodaux; Region 4: Lafayette; Region 5: Lake Charles; Region 6: Alexandria; Region 7: Shreveport; Region 8: West Monroe; Region 9: Hammond

[1] Accepts full PCP responsibility.

Provider Network Accessibility

Aetna monitors its provider network for accessibility and network capability using the GeoAccess software program. This program assigns geographic coordinates to addresses so that the distance between providers and members can be assessed to determine whether members have access to care within a reasonable distance from their homes. **Table 4** shows the percentage of members for whom geographic access standards were met.

Table 4: GeoAccess Provider Network Accessibility as of July 25, 2018

Provider Type		Access Standard[1] X Provider(s) within X Miles	Percentage of Members for Whom Standard was Met
Adult PCP	Urban	1 within 10 miles	97.1%
	Rural	1 within 30 miles	100.0%
Pediatric PCP	Urban	1 within 10 miles	97.1%
	Rural	1 within 30 miles	100%
OB/GYN	Urban	1 within 15 miles	97.6%
	Rural	1 within 30 miles	95.2%

Data source: Network Adequacy Review 2018 Q2

[1] The Access Standard is measured in distance to member address.

IV. QUALITY INDICATORS

To measure quality of care provided by the MCOs, the State prepares and reviews a number of reports on a variety of quality indicators. This section is a summary of findings from these reports, including Performance Improvement Projects (PIPs), as well as HEDIS and CAHPS.

Performance Improvement Projects

PIPs engage MCO care and quality managers, providers and members as a team with the common goal of improving patient care. The MCO begins the PIP process by targeting improvement in annual baseline performance indicator rates. The next step is to identify barriers to quality of care, and to use barrier analysis findings to inform interventions designed to overcome the barriers to care. Interventions are implemented and monitored on an ongoing basis using quarterly intervention tracking measures. Declining quarterly intervention tracking measure rates signal the need to modify interventions and re-chart the PIP course. Improving intervention tracking measures are an indication of robust interventions.

Healthy Louisiana is in the process of conducting two collaborative PIPs: (1) Improving Prenatal and Postpartum Care to Reduce the Risk of Preterm Birth and (2) Improving the Quality of Diagnosis, Management and Care Coordination for Children and Adolescents with Attention-Deficit Hyperactivity Disorder (ADHD). The five MCOs agreed upon the following intervention strategies for each PIP:

(1) Improving Prenatal and Postpartum Care to Reduce the Risk of Preterm Birth
- Implement the Notice of Pregnancy communication from provider to MCO
- Implement the High-Risk Registry communication from MCO to provider
- Conduct provider education for how to provide and bill for evidence-based care
- Develop and implement or revised care management programs to improve outreach to eligible and at-risk members for engagement in care coordination

(2) Improving the Quality of Diagnosis, Management and Care Coordination for Children and Adolescents with ADHD
- Improve workforce capacity
- Conduct provider education for ADHD assessment and management consistent with clinical guidelines
- Expand PCP access to behavioral health consultation
- Develop and implement or revised care management programs to improve outreach to eligible and at-risk members for engagement in care coordination

Summaries of each of the PIPs conducted by Aetna follow.

Improving Prenatal and Postpartum Care to Reduce the Risk of Preterm Birth

Indicators, Baseline Rates and Goals: The indicators, baseline rates and corresponding target rates for performance improvement from baseline to final measurement are as follows:

- Initiation of injectable progesterone for preterm birth prevention between the 16th and 21st week of gestation: increase from 9.10% to 19.01%
- Chlamydia test during pregnancy: increase from 72.40% to 85.94%
- HIV test during pregnancy: increase from 70.33% to 79.68%
- Syphilis test during pregnancy: increase from 27.30% to 84.24%
- Use of most effective contraceptive methods: increase from 1.40% to 17.06%
- Use of moderately effective contraceptive methods: increase from 9.00% to 26.04%
- Use of long-acting reversible contraception (LARC) during delivery hospitalization: increase from 0.00% to 1.25%
- Use of LARC outpatient within 56 days postpartum: increase 6.30% to 8.48%
- HEDIS *Postpartum Care* measure: increase from 58.28% to 63.50%

Intervention Summary:

- Member:
  - Enrollment in care management for high-risk pregnant members and post-partum members.
  - Care Managers will provide resources for members enrolled into Nurse Family Program (NFP).
  - Promise Rewards Program to incentivize members to receive timely prenatal and postpartum care.
  - Community outreach events for members.
- Provider:
  - Implementation of notification of pregnancy (NOP) forms submitted by providers.
  - Communicate with providers by utilizing newsletter articles, meetings/focus groups, fax blasts, email notices, provider relations handouts and letters.
- MCO:
  - Contact high-risk pregnant members during the 3rd trimester for LARC education and post-partum care planning.
  - Create an Internal Pregnancy Registry using multiple data sources to pull accurate and up-to-date information on ABH pregnant members.
  - Care Management care coordination with Optum Home Health and providers administering 17P (hydroxyprogesterone caproate injection).

Results:

- The number of providers administering 17P showed a quarterly rate increase from .7% to 22%
- The quarterly rate of members who completed a post-partum office visit showed an increase from 14% to 42%.
- The quarterly rate of community outreach events related to maternal health increased from 11 to 26.
- The number of members enrolled in NFP increased from 36% to 50%.

Overall Credibility of Results: The validation findings generally indicate that the credibility of the PIP results is not at risk. Interpretations of improvement attributable to interventions must be interpreted with some caution due to lack of evidence of improvement in intervention tracking measures (ITMs).

Strengths: Improved reporting, more comprehensive claims data, change of staffing, educational programs for care management staff and, modification of forms and templates has improved MCO performance of measures related to reducing preterm births.

Opportunities for Improvement:

- LDH Managed Care Prematurity Prevention Improvement Project is seeking novel ways to engage providers in the fight against prematurity. As a next step, LDH has requested that each Healthy Louisiana Medical Director, together with each MCO's Prematurity Prevention Performance Improvement (PIP) quality team, and a volunteer physician representing the Medicaid Quality Maternity Care Subcommittee, meet with one provider practice to support quality improvement efforts at that practice. Based upon an analysis of opportunities to improve high-risk member receipt of 17P each PIP quality team has selected one provider to meet with on-site at their practice. At the provider site visit, each MCO team should complete the practice engagement worksheet in collaboration with the practice providers to inform planning of further PDSA cycles and interventions.
- As part of ongoing PDSA efforts to improve early identification and outreach of members at risk for preterm birth and/or preeclampsia, MCOs should identify and address any outstanding care coordination and data integrity challenges. For example: clarification, communication and integration of data sources, collection methods, tasks, persons responsible, and timeframes are merited to ensure that members with a history of preterm birth, as well as those at risk for preeclampsia, are identified early for care management outreach, care coordination and engagement.
- The ITM workgroup should continue monitoring the intervention tracking measures and, in response to issues revealed by the pattern analysis using the IHI Rules for Interpreting Charts, conduct barrier analysis to identify root causes, and use barrier analysis findings to inform modifications to interventions on an ongoing basis as part of the PDSA quality improvement process.

Improving the Quality of Diagnosis, Management and Care Coordination for Children with ADHD

Indicators, Baseline Rates and Goals: The indicators, baseline rates and corresponding target rates for performance improvement from baseline to interim measurement are as follows:

- Validated ADHD screening instrument: decrease from 45.45% to 20.00%
- ADHD screening in multiple settings: decrease from 27.27% to 20.00%
- Assessment of other behavioral health conditions/symptoms: decrease from 45.45% to 43.33%
- Positive findings of other behavioral health conditions: increase from 9.09% to 46.67%
- Referral for evaluation of other behavioral health conditions: increase from 0.00% to 32.14%
- Referral to treat other behavioral health conditions: increase from 0.00% to 35.71%
- PCP care coordination: increase from 9.09% to 15.00%
- MCO care coordination: increase from 0.00% to 11.67%
- MCO outreach with member contact: increase from 0.00% to 21.67%
- First line behavioral therapy for children less than 6 years of age: increase from 0.00% to 10.00%
- The percentage of members aged 6-12 years as of the index prescription start date (IPSD) with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day initiation phase: increase from 45.30% to 45.36%
- The percentage of members aged 6-12 years as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up calls with a practitioner within 270 days after the initiation phase ended: increase from 51.2% to 60.34%
- Percentage of any ADHD cases, aged 0-20 years, stratified by age and foster care status, with documentation of behavioral health pharmacotherapy (ADHD medication, antipsychotics, and/or other psychotropics), with behavioral therapy: increase from 29.40% to 34.40%
- Percentage of any ADHD cases, aged 0-20 years, stratified by age and foster care status, with documentation of behavioral health pharmacotherapy (ADHD medication, antipsychotics, and/or other psychotropics), without behavioral therapy: decrease from 56.90% to 55.19%

- Percentage of any ADHD cases, aged 0-5 years, stratified by age and foster care status, with documentation of behavioral health pharmacotherapy (ADHD medication, antipsychotics, and/or other psychotropics), without behavioral therapy: decrease from 52.86% to 39.18%

Intervention Summary:
- Utilize network adequacy reports to determine recruitment strategies by region
- Target provider education outreach efforts as informed by ADHD provider survey findings
- Support PCP offices by utilizing Aetna's Case Management to assist with coordination of behavioral health therapy, communicate with teachers and referral to resources
- Provide education and resources to PCP offices (face-to-face distribution of provider toolkit, member resource flyer, provider survey and ADHD awareness month)
- Refer patients less than six years of age to child-parent psychotherapy, and refer patients' parents to PMT/PCIT when indicated
- MCO to create reports to support ADHD interventions and measure process outcomes
- Case management initiates member care plans in collaboration with parents and providers
- Educate members on the Bright Futures teacher rating scale.

Results:
- During the second quarter of 2018, of the 209 children identified by case management as having a diagnosis or medication for ADHD, 138 (66.03%) were outreached by MCO care coordinators; and of the 138 outreached by MCO care coordinators, 24 (17.39%) children with ADHD had a successful contact (live communication).

Overall Credibility of Results: There are no validation findings that indicate that the credibility of the study is at risk.

Strengths:
- Interventions are robust in that they actively outreach to members and providers to provide education and coordination of care.
- ABHLA identified a prevalence of co-existing conditions for ADHD members, and some members identified with having more than one type of condition. From reviewing the findings, the MCO identified areas for improvement in outreach attempts for the care management program.

Opportunities for improvement:
- Increase the proportion of PCPs who treat children who received the ADHD PCP TOOLKIT with MCO Provider Education on using the Vanderbilt Assessment for ADHD evaluation and diagnosis.
- Increase the proportion of targeted Evidence-Based Practice (EBP) Behavior Therapists Qualified to treat children <6 years of age diagnosed with ADHD who completed EBP training.
- Increase the proportion of PCPs who treat children who received behavioral provider referral list with MCO Provider Education on the EBP qualifications of behavioral providers on the referral list

Performance Measures: HEDIS® 2018 (Measurement Year 2017)

MCO-reported performance measures were validated as per HEDIS 2018 Compliance Audit™ specifications developed by the National Committee for Quality Assurance (NCQA). The results of each MCO's HEDIS 2018 Compliance Audit are summarized in its Final Audit Report (FAR).

HEDIS Effectiveness of Care Measures

HEDIS Effectiveness of Care measures evaluate how well an MCO provides preventive screenings and care for members with acute and chronic illnesses. **Table 5** displays MCO performance rates for select HEDIS Effectiveness of Care measures for HEDIS 2016, HEDIS 2017 and HEDIS 2018, Healthy Louisiana 2018 statewide averages and *Quality Compass* 2018 South Central – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

Table 5: HEDIS® Effectiveness of Care Measures – 2016-2018

Measure	Aetna			QC 2018 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded	Healthy Louisiana 2018 Average
	HEDIS®2016	HEDIS®2017	HEDIS®2018		
Adult BMI Assessment	SS	72.22%	79.32%	10th	81.97%
Antidepressant Medication Management - Acute Phase	87.72%	81.63%	57.23%	90th	54.05%
Antidepressant Medication Management - Continuation Phase	84.21%	73.78%	44.60%	75th	39.84%
Asthma Medication Ratio (5-64 Years)	SS	52.25%	53.11%	<10th	63.75%
Breast Cancer Screening in Women	SS	57.14%	58.21%	75th	56.03%
Cervical Cancer Screening	30.77%	49.18%	44.28%	10th	51.61%
Childhood Immunization Status - Combination 3	42.86%	47.45%	65.21%	10th	68.19%
Chlamydia Screening in Women (16-24 Years)	62.73%	60.50%	64.96%	90th	65.78%
Comprehensive Diabetes Care - HbA1c Testing	79.47%	78.81%	84.67%	33.33rd	84.21%
Controlling High Blood Pressure	33.80%	25.17%	39.17%	10th	37.71%
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	SS	51.16%	60.34%	33.33rd	67.89%
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	SS	44.81%	45.36%	33.33rd	54.53%
Medication Management for People With Asthma Total - Medication Compliance 75% (5-64 Years)	SS	51.25%	30.36%	50th	32.76%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile	41.18%	42.59%	52.31%	<10th	62.35%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	39.53%	34.26%	49.39%	10th	55.88%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity	27.76%	23.61%	39.66%	10th	45.10%

SS: Sample size too small to report (less than 30 members) but included in the statewide average.

HEDIS® Access to/Availability of Care Measures

The HEDIS Access to/Availability of Care measures examine the percentages of Medicaid children/adolescents, child-bearing women and adults who receive PCP/preventive care services, ambulatory care (adults only) or receive timely prenatal and postpartum services. **Table 6** displays MCO rates for select HEDIS Access to/Availability of Care measure rates for HEDIS 2016 and HEDIS 2017, Healthy Louisiana 2017 statewide averages and *Quality Compass* 2017 South Central – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

Table 6: HEDIS® Access to/Availability of Care Measures – 2016-2018

Measure	Aetna			QC 2018 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded	Healthy Louisiana 2018 Statewide Average
	HEDIS®2016	HEDIS®2017	HEDIS®2018		
	Children and Adolescents' Access to PCPs				
12–24 Months	76.58%	92.45%	93.77%	10th	96.43%
25 Months–6 Years	68.04%	75.26%	81.27%	<10th	88.79%
7–11 Years	SS	76.22%	81.79%	<10th	90.61%
12–19 Years	SS	75.28%	81.46%	<10th	89.96%
	Adults' Access to Preventive/Ambulatory Services				
20–44 Years	68.22%	76.79%	67.79%	<10th	76.75%
45–64 Years	81.17%	85.76%	79.76%	<10th	84.87%
65+ Years	70.15%	77.57%	85.61%	33.33rd	84.83%
	Access to Other Services				
Timeliness of Prenatal Care	71.79%	75.70%	72.02%	10th	78.40%
Postpartum Care	58.28%	63.08%	63.50%	50th	64.04%

SS: Sample size too small to report (less than 30 members) but included in the statewide average.

HEDIS Use of Services Measures

This section of the report details utilization of Aetna's services by examining selected HEDIS Use of Services rates. **Table 7** displays MCO rates for select HEDIS Use of Services measure rates for HEDIS 2016, HEDIS 2017 and HEDIS 2018, Healthy Louisiana 2018 statewide averages and *Quality Compass* 2018 South Central – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

Table 7: Use of Services Measures – 2016-2018

Measure	Aetna			QC 2018 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded	Healthy Louisiana 2018 Average
	HEDIS®2016	HEDIS®2017	HEDIS®2018		
Adolescent Well-Care Visit	31.71%	42.82%	46.72%	10th	54.18%
Ambulatory Care Emergency Department Visits/1000 Member Months[1]	90.22	91.45	90.59	95th	81.09
Ambulatory Care Outpatient Visits/1000 Member Months	427.94	440.41	402.31	50th	418.74
Frequency of Ongoing Prenatal Care - ≥ 81%	63.17%	69.16%	Retired[2]	Not Applicable	Retired[2]
Well-Child Visits in the First 15 Months of Life 6+ Visits	SS	53.94%	63.99%	50th	64.11%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	41.94%	53.94%	59.12%	<10th	68.06%

[1] A lower rate is desirable.

SS: Sample size too small to report (less than 30 members) but included in the statewide average.

[2] NCQA retired this measure from HEDIS 2018.

Member Satisfaction: Adult and Child CAHPS® 5.0H

In 2018, the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H surveys of Adult Medicaid members and Child Medicaid with Chronic Care Conditions (CCC) was conducted on behalf of Aetna by the NCQA-certified survey vendor, Center for the Study of Service (CSS).

Table 8, Table 9 and Table 10 show Aetna's CAHPS® rates for 2016, 2017 and 2018, as well as *Quality Compass®* 2018 South Central – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

Table 8: Adult CAHPS® 5.0H – 2016-2018

Measure[1]	Aetna			QC 2018 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded
	CAHPS® 2016	CAHPS® 2017	CAHPS® 2018	
Getting Needed Care	79.72%	75.56%	78.06%	10th
Getting Care Quickly	81.09%	77.89%	78.87%	10th
How Well Doctors Communicate	87.25%	90.49%	93.08%	75th
Customer Service	83.18%	84.50%	Small Sample	Not Applicable
Shared Decision Making	80.17%	79.50%	78.27%	33.33rd
Rating of All Health Care	74.34%	69.88%	68.61%	<10th
Rating of Personal Doctor	77.11%	80.85%	83.00%	50th
Rating of Specialist	81.08%	79.81%	83.00%	50th
Rating of Health Plan	72.47%	72.19%	78.07%	50th

[1] Note: for "Rating of" measures, Medicaid rates are based on ratings of 8, 9 and 10; for measures that call for respondents to answer with "Always," "Usually," "Sometimes" or "Never" the Medicaid rate is based on responses of "Always" or "Usually".
Small Sample: Result is not reportable by NCQA due to insufficient denominator (less than 100 responses).

Table 9: Child CAHPS® 5.0H General Population – 2016-2018

Measure[1]	Aetna			QC 2018 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded
	CAHPS® 2016	CAHPS® 2017	CAHPS® 2018	
Getting Needed Care	86.14%	90.86%	87.52%	50th
Getting Care Quickly	88.97%	94.03%	89.59%	25th
How Well Doctors Communicate	94.78%	93.80%	94.65%	50th
Customer Service	Small Sample	88.33%	Small Sample	Not Applicable
Shared Decision Making[2]	Small Sample	Small Sample	Small Sample	Not Applicable
Rating of All Health Care	80.32%	89.20%	86.15%	10th
Rating of Personal Doctor	87.23%	90.37%	88.69%	25th
Rating of Specialist	Small Sample	Small Sample	Small Sample	Not Applicable
Rating of Health Plan	78.77%	85.96%	80.62%	<10th

[1] Note: for "Rating of" measures, Medicaid rates are based on ratings of 8, 9 and 10; for measures that call for respondents to answer with "Always," "Usually," "Sometimes" or "Never" the Medicaid rate is based on responses of "Always" or "Usually".
Small Sample: Result is not reportable by NCQA due to insufficient denominator (less than 100 responses).

Table 10: Child CAHPS® 5.0H CCC Population – 2016-2018

Measure[1]	Aetna			QC 2018 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded
	CAHPS® 2016	CAHPS® 2017	CAHPS® 2018	
Getting Needed Care	87.88%	87.69%	88.17%	10th
Getting Care Quickly	92.95%	93.11%	93.50%	25th
How Well Doctors Communicate	94.91%	93.57%	95.96%	75th
Customer Service	87.46%	88.79%	Small Sample	Not Applicable
Shared Decision Making	85.95%	84.52%	84.02%	33.33rd
Rating of All Health Care	82.76%	83.66%	87.46%	50th
Rating of Personal Doctor	89.12%	91.35%	91.30%	75th
Rating of Specialist	84.33%	86.81%	84.72%	10th
Rating of Health Plan	79.54%	81.10%	84.69%	25th

[1] Note: for "Rating of" measures, Medicaid rates are based on ratings of 8, 9 and 10; for measures that call for respondents to answer with "Always," "Usually," "Sometimes" or "Never" the Medicaid rate is based on responses of "Always" or "Usually".
Small Sample: Result is not reportable by NCQA due to insufficient denominator (less than 100 responses).
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Health Disparities

For this year's technical report, the LA EQRO evaluated MCOs with respect to their activities to identify and/or address gaps in health outcomes and/or health care among their Medicaid population according to at-risk characteristics such as race, ethnicity, gender, geography, etc. This information was obtained through surveying MCOs regarding the following activities:

(1) Characterization, identification or analysis of the MCO's Medicaid population according to at-risk characteristics.
(2) Identification of differences in health outcomes or health status that represent measurable gaps between the MCO's Medicaid population and other types of health care consumers.
(3) Identification of gaps in quality of care for the MCO's Medicaid members and/or Medicaid subgroups.
(4) Identification of determinants of gaps in health outcomes, health status, or quality of care for at-risk populations.
(5) Development and/or implementation of interventions that aim to reduce or eliminate differences in health outcomes or health status and to improve the quality of care for MCO members with at-risk characteristics.

Aetna reported that the following interventions were implemented in 2017 through 2018 to identify and/or address disparities in health outcomes and/or health care among its Medicaid population:

- Care management program
- Maternal child program
- Member incentives
- Community events
- Neonatal intensive care unit care management program
- Referrals to Nurse Family Partnership and Parents as Teachers
- Remote Patient Monitoring Program
- Care management collaboration with maternal, infant and early childhood home visiting program and a memorandum of understanding
- Care management and department of corrections population
- Integrating rounding process
- Member restriction program
- Emergency department utilization program
- Ready Responders Community Care Program
- Over the counter monthly benefit
- Notification of pregnancy
- Maternal Health Promise Program and Rewards: Text4baby program, case management, and member incentives
- 17P administration
- Lifeline smartphone
- Diabetes Program: Care4Life, case management, ongoing provider education, member and provider newsletters, targeted mailings, outreach calls, text messages and online self-management programs
- Performance improvement project focusing on pregnant mother who are either confirmed substance use disorder or have not been identified
- Opioid assessment which includes; provider training, partner with hospitals and emergency department, and enhanced member care coordination
- Improving detection, monitoring and treatment of our substance use disorder and alcohol and other drugs members
- Improve the quality of diagnosis, management and care for members diagnosed with bipolar or schizophrenia and who are at risk for Diabetes comorbidity

- Case management telephonic outreach to members newly diagnosed with ADHD
- Enrollment into Breakthrough, ABH's mental health counseling vendor
- Health care equity and community initiatives (community events)
- Population health assessments to assist staff to better understand the population and drives staff training for the coming year
- Case managers and other member facing staff gather and document Social Determinants of Health information on members
- HEDIS based performance improvement activities, integrated care management and other quality management initiatives
- Quality Management initiatives
- Health care equity initiatives
- Poverty simulation
- Cultural competency learning and performance

V. COMPLIANCE MONITORING

Please note that the most recent compliance audit for Louisiana took place in 2016, and the next audit is anticipated to take place in 2019.

Medicaid Compliance Audit Findings for Contract Year 2016

In 2016, IPRO conducted the 2016 Compliance Audit on behalf of the LDH. Full compliance audits occur every three (3) years, with partial audits occurring within the intervening years. The 2016 Compliance Audit was a full audit of Aetna's compliance with contractual requirements during the period of September 1, 2015 through August 31, 2016.

The 2016 Compliance Audit included a comprehensive evaluation of Aetna's policies, procedures, files and other materials corresponding to the following nine (9) domains:

(1) Core Benefits and Services
(2) Provider Network
(3) Utilization Management
(4) Eligibility, Enrollment and Disenrollment
(5) Marketing and Member Education
(6) Member Grievances and Appeals
(7) Quality Management
(8) Reporting
(9) Fraud, Waste and Abuse

The file review component assessed Aetna's implementation of policies and its operational compliance with regulations in the areas of appeals, behavioral health care management, case management, information reconsiderations, member grievances, provider credentialing and recredentialing, and utilization management denials.

For this audit, determinations of full compliance, substantial compliance, minimal compliance and compliance not met were used for each element under review. Definitions for these review determinations are presented in **Table 11.**

Table 11: 2016 Compliance Audit Determination Definitions

Determination	Definition
Full	The MCO has met or exceeded the standard
Substantial	The MCO has met most of the requirements of the standard but has minor deficiencies.
Minimal	The MCO has met some of the requirements of the standard, but has significant deficiencies that require corrective action.
Not Met	The MCO has not met the standard.

Findings from Aetna's 2016 Compliance Review follow. **Table 12** displays the total number of requirements reviewed for each domain, as well as compliance determination counts for each domain.

Table 12: Audit Results by Audit Domain

Audit Domain	Total Elements	Full	Substantial	Minimal	Not Met	Not Applicable	% Full
Core Benefits and Services	123	114	8	1	0	0	93%
Provider Network	163	145	16	1	1	0	89%
Utilization Management	92	39	52	0	0	1	43%
Eligibility, Enrollment and Disenrollment	13	12	1	0	0	0	92%
Marketing and Member Education	77	74	2	0	1	0	96%
Member Grievances and Appeals	62	52	10	0	0	0	84%
Quality Management	86	81	3	0	0	2	96%
Reporting	1	1	0	0	0	0	100%
Fraud Waste and Abuse	105	105	0	0	0	0	100%
Total	**722**	**623**	**92**	**2**	**2**	**3**	**87%**

It is IPRO's and the LDH's expectation that Aetna submit a corrective action plan for each of the 96 elements determined to be less than fully compliant along with a timeframe for completion. It should be noted that Aetna has implemented a corrective action for many of the areas identified for improvement in the report but the corrections were made after the audit was completed and were not applicable to the audit's review period. Eighteen (18) of the 96 elements rated less than fully compliant relate to network adequacy and the MCO's ability to contract with providers in several specialty and sub-specialty areas, a problem for all Medicaid MCOs in Louisiana that is not unique to Aetna**.**

VI. STRENGTHS, OPPORTUNITIES FOR IMPROVEMENT & RECOMMENDATIONS

This section summarizes the accessibility, timeliness and quality of services provided by Aetna to Medicaid recipients based on data presented in the previous sections of this report. The MCO's strengths in each of these areas are noted, as well as opportunities for improvement. Recommendations for enhancing the quality of healthcare are also provided based on the opportunities for improvement noted.

Strengths

- **HEDIS (Quality of Care) –**
  - Aetna met or exceeded the 75th percentile for the following HEDIS measures:
    - *Antidepressant Medication Management – Acute Phase*
    - *Antidepressant Medication Management – Continuation Phase*
    - *Breast Cancer Screening in Women*
    - *Chlamydia Screening in Women (16-24 Years)*
- **CAHPS® (Member Satisfaction) –** Aetna met or exceeded the 75th percentile for the following CAHPS measures:
  - Adult CAHPS
    - *How Well Doctors Communicate*
  - Child CAHPS CCC Population
    - *How Well Doctors Communicate*
    - *Rating of Personal Doctor*
- **Compliance –** According to the Medicaid Compliance Audit findings for contract year 2016, the health plan achieved "full" compliance in two (2) of the nine (9) domains reviewed.

Opportunities for Improvement

- **HEDIS (Quality of Care)** – Aetna demonstrates an opportunity for improvement in the following areas of care:
  - *Adult BMI Assessment*
  - *Cervical Cancer Screening*
  - *Childhood Immunization Status – Combination 3*
  - *Comprehensive Diabetes Care – HbA1c Testing*
  - *Controlling High Blood Pressure*
  - *Follow-up Care for Children Prescribed ADHD Medication – Continuation and Maintenance Phase*
  - *Follow-up Care for Children Prescribed ADHD Medication – Initiation Phase*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI Percentile*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Physical Activity*
  - *Children and Adolescents' Access to PCPs*
    - *12-24 Months*
    - *25 Months-6 Years*
    - *7-11 Years*
    - *12-19 Years*
  - *Adults' Access to Preventive/Ambulatory Services*
    - *20-44 Years*

- *45-64 Years*
    - *65+ Years*
  - *Timeliness of Prenatal Care*
  - *Adolescent Well Care*
  - *Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life*
- **CAHPS® (Member Satisfaction) –** Aetna demonstrates an opportunity for improvement in regard to member satisfaction. The MCO performed below the 50th percentile for the following measures:
  - Adult CAHPS®
    - *Getting Needed Care*
    - *Getting Care Quickly*
    - *Shared Decision Making*
    - *Rating of All Health Care*
  - Child CAHPS® General Population
    - *Getting Care Quickly*
    - *Rating of All Health Care*
    - *Rating of Personal Doctor*
    - *Rating of Health Plan*
  - Child CAHPS® CCC Population
    - *Getting Needed Care*
    - *Getting Care Quickly*
    - *Shared Decision Making*
    - *Rating of Specialist*
    - *Rating of Health Plan*

Recommendations

- The health plan should continue to work to improve all HEDIS measures that performed below the 50th percentile. The health plan should continue with its improvement strategy for the HEDIS rates that have trended upward and continue to closely monitor their performance. However, for the measures that trended downward, an updated root causes analysis should be performed to ensure that the appropriate barriers to care are being effectively addressed.
- Although identified as an opportunity for improvement, child and adolescent access to primary care has improved; therefore, it is recommended that the health plan continue with the initiatives described in its response to the previous year's recommendation while modifying its approach for improving access to primary care for adults.
- The MCO should continue improve member satisfaction. The MCO should develop interventions based on the identified barriers described in its response to the previous year's recommendation. Interventions should address member and provider needs, as well address deficiencies in the system that impeded access to care.
- Future PIPs:
  - Initiate data-driven barrier analyses upon receipt of each new PIP template. For example, analyze encounter data by stratifying baseline performance indicator measures by key demographic and pertinent clinical subsets in order to answer these two questions regarding high-volume and high-risk members:
    - High volume: among the PIP eligible population {e.g., members with substance use disorder {SUD} which demographic (e.g., age group, geographic area, race/ethnicity) subsets and which clinical subsets (e.g., Members with co-occurring serious mental illness {SMI} and members with chronic physical health conditions) comprise the highest caseload volumes?

- High-risk: Among each subset grouping which demographic (e.g., race/ethnicity: black compared to white) and clinical subsets (e.g., with SMI compared to without SMI) are disproportionately lacking in recommended care (e.g., initiation and engagement in treatment for SUD)?
- Use barrier analysis findings to inform interventions that are targeted and tailored to susceptible subpopulations; however, do not restrict interventions to these subpopulations. Instead, conduct additional data driven barrier analyses (e.g., member and provider focus groups, early inpatient/emergency department admission notification process flow sheet analysis) and use these barrier analysis findings to inform a robust and feasible set of interventions that aim to more broadly reach the entire PIP eligible population.
- Focus on developing and utilizing ITMs to inform modifications to key interventions. For example, use ITMs to monitor the progress of enhanced care management interventions and, in response to stagnating or declining monthly or quarterly rates, conduct additional barrier/root cause analysis and use findings to modify interventions.
- Deploy quality improvement tools, such as process flow charting, PDSA worksheets and IHI run charts, in order to test, evaluate and adapt interventions over the course of the PIP and beyond for ongoing quality improvement.

Response to Previous Year's Recommendations

- **2016-2017 Recommendation:** The MCO should continue to work to improve all HEDIS measures that performed below the 50th percentile. The MCO should continue with the quality improvement strategy outlined in its response to the previous year's recommendation as interventions were developed based on root cause analysis and include a multifaceted approach that addresses member, provider and operational barriers to care. The interventions should be monitored for effectiveness and modified as needed. *[Repeat recommendation.]*

  MCO Response: ABH-LA conducted a root cause / Ishikawa analysis to assess the barriers/challenges to meeting target goal for the following measures:
  - Ambulatory Care Emergency Department Visits/1000 Members
  - Follow-Up After Hospitalization for Mental Illness – Within 7 days of Discharge
  - Follow-Up After Hospitalization for Mental Illness – Within 30 days of Discharge
  - Timeliness of Prenatal Care
  - Comprehensive Diabetes Care – Eye exam (retinal) performed

- **2016-2017 Recommendation:** As access to primary care rates have trended upward, the MCO should continue with the interventions outlined in the MCO's response to the previous year's recommendation. Interventions should be monitored for effectiveness and modified as needed. The MCO should also leverage its corporate structure to identify best practices implemented by other Aetna Medicaid MCOs. *[Repeat recommendation.]*

  MCO Response: ABH-LA will continue to monitor the effectiveness of our interventions and modify them as needed. We will leverage our corporate structure to identify best practices and implemented by other Aetna Medicaid MCOs.

Measure Description	HEDIS 2016 - MY 2015	HEDIS 2017 - MY 2016	HEDIS 2018 - MY 2017	State Target Goal and/or NCQA 50th percentile	% State Target Goal	% Change 2015/2016	% Change 2016/2017	Met/ Not Met
Adolescent Well Care	31.71%	42.82%	46.72%	40.69%	6.03%	11.11%	3.90%	Met
Well Child 15 Months (6+ Visits)	N/A	53.94%	63.99%	62.06%	1.93%	N/A	10.05%	Met
Well Child 3-6 Years	41.94%	53.94%	59.12%	72.45%	-13.33%	12.00%	5.18%	Met

ABH-LA met and surpassed the State target goal for Adolescent Well-Care visits with a rating score of 46.72%, exceeding goal by 6.03%, with a change of 3.90% from the previous year. For Well-Child Visits in the 15 Months of life, with six or more well-child visits, we surpassed State target goal by 1.93%, and increased from the previous year by 10.05%. For Well-Child visits 3-6 years we did not meet State target goal by -13.33%, however we increased year-over-year, with an increase by 5.18% from the previous year.

The importance of educating our health care provides of the importance of annual member wellness visits impacts our entire population. Potentially life-saving preventive services and screenings can be ordered to help them live longer, healthier lives.

The issue also being that most patients see their primary care physician for a sick visit, and do not obtain the necessary preventive health care services to keep them healthy. Knowing this we must encourage and teach our doctors to complete the annual wellness exams when the patient presents at their office or clinic.

ABH-LA has implemented a more aggressive education and outreach program to our IPA Provider Groups and individual practitioners. All health plan departments have been trained on what to communicate, and increased focus on correct coding and improved member outreach.

ABH-LA interventions are focused on practitioner and member education, best practices, and service delivery.

Practitioner knowledge deficit

- Provider tip sheet and billing guide, ensuring correct documentation and codes utilized
- HEDIS luncheon with web streaming in 2018, with Provider HEDIS Handbook
- Health plan development of standardized annual wellness form based on age, growth and development with dissemination to the practitioner, coding of wellness visit embedded in form

Member Knowledge Deficit

- $25 Incentive birthday letters mailed monthly
- Monthly EPSDT letter mailings
- Member services and Wellness Coordinator outreach calls – live person
- Improved text messaging to all members

- Eliza telephone outreach phone calls to member and/or their legal guardians with use of Medical Director live voice for introduction has been effective
- Care management outreach to members who request a call back after the Eliza phone call
- Health fairs to promote improved health and wellness, including the Ted E. Bear initiative for Diabetes and weight control for children

<u>Transportation/Accessibility</u>

- We encourage members' use of Logisticare transportation services to Medical appointments
- Contracted with Rapid Responders to assist members in attending to their scheduled physician appointment
- Outreach by vendor of Nurse Practitioner and/or physician at home visits to close care gaps
- Establishment of mobile community wellness clinics for rural communities
- Establishment and coordination of completion of annual visits with schools, respective to location

To further increase our rating scores ABH-LA is outreaching to our IPA Providers Groups for submission of standard and non-standard supplemental data files, secondary to coding errors. The data files will be directly uploaded into our Inovalon NCQA accredited software. The intent is to capture missing claims and encounters. A report will be generated post upload.

ABH-LA has generated a gap in care list of our members enrolled in care management. Care managers are actively outreaching to those members to see their primary care physician and get the services needed to keep them healthy.

ABH-LA will monitor the effectiveness of our interventions monthly, throughout the measurement year using our auto-generated gap in care list. The same list is aggregated and provided to provider offices and IPA Provider Groups on a monthly basis, plus they are easily accessible on our provider portal. Based on our findings, additional initiatives and outreach will be conducted to ensure we meet and exceed target goal set.

- **2016-2017 Recommendation:** In regard to member satisfaction, the MCO should continue with its quality improvement strategy for improving Child CAHPS® as scores are trending upward; however, the effectiveness of the quality improvement strategy for Adult CAHPS® should be assessed and modified as most scores have declined. *[Repeat recommendation.]*

  MCO Response: ABH-LA conducted a root cause analysis to assess the barriers/challenges to meeting the target goal. When identifying opportunities for improvement, Aetna Better Health of Louisiana evaluates the problem that is attributed to the members' experience with the health care received and what can be done to address the problem. Possible reasons and barriers identified were:

  - Health plan culture and process changes – member may be new to Medicaid managed care.
  - Members may be rating health plan versus health care and providers.
  - Appointment accessibility expectations may not be in sync with the member's clinical needs.
  - Personal practitioners are sometimes limited in the amount of time they can spend with a patient.
  - Members may be in disagreement with the providers' decisions or plan of care.
  - Did not receive the care, tests or treatment the respondent though necessary and may be unclear if testing is related medications.
  - Members may not be informing their providers of other doctors they are seeing,
  - Providers may be reaching out to other providers and not receiving return information.
  - CAHPS results are retrospective not prospective.
  - Member and provider lack of understanding of health plan benefits.

Action Plan:

- Aetna Cares program for culture change implementation in 2019 to improve member experience in services provided.
- Improve member access to care with use of telemedicine options, CVS mini-clinics, and increased provider contracts
- Provider access audits by SPH conducted quarterly with education, corrective action plan, and follow-up assessment for issues found.
- Hiring additional quality staff for increased provider audits 2019 with improved process flow with building of MRR audit data platform.
- Onsite education and review of provider records for coordination of care to ensure doctors are communicating and developing care plan uniformly for their member.
- Website modification to improve enrollee access to member handbook, and benefits.