AETNA BETTER HEALTH OF LOUISIANA

Annual External Quality Review Technical Report

Review Period: July 1, 2014 – June 30, 2015
April 2016

Prepared on Behalf of
The State of Louisiana
Department of Health & Hospitals

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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 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 State of Louisiana's Department of Health & Hospitals (DHH) contracted with IPRO to assess and report the impact of its Medicaid managed care program, the Bayou Health Program, and each of the participating Health Plans 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, 2014 – June 30, 2015.

The framework for IPRO's assessment is based on the guidelines and protocols established by CMS, as well as 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.

Please note: As Aetna began enrollment in February 2015, the Health Plan did not report HEDIS® or CAHPS® during this review period. The Health Plan will have these data available for inclusion in the next iteration of the Annual EQR Technical Report.

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 plan has opportunities for improvement, recommendations for improving the quality of the MCO's health care services are provided.

II. MCO CORPORATE PROFILE

Table 1. Corporate Profile

Aetna	
Type of Organization	Health Maintenance Organization (HMO)
Tax Status	For Profit
Year Operational	2015
Product Line(s)	Medicaid and LaCHIP
Total Medicaid Enrollment (as of June 2015)	26,100

III. ENROLLMENT AND PROVIDER NETWORK

Enrollment

Medicaid Enrollment

As of June 2015, the Health Plan's Medicaid enrollment totaled 26,100, which represents 3% of Bayou Health's active members. Table 2 displays Aetna's Medicaid enrollment, as well as the statewide enrollment total. Figure 1 displays Bayou Health's membership distribution across all Health Plans.

Table 2. Medicaid Enrollment as of June 2015[1]

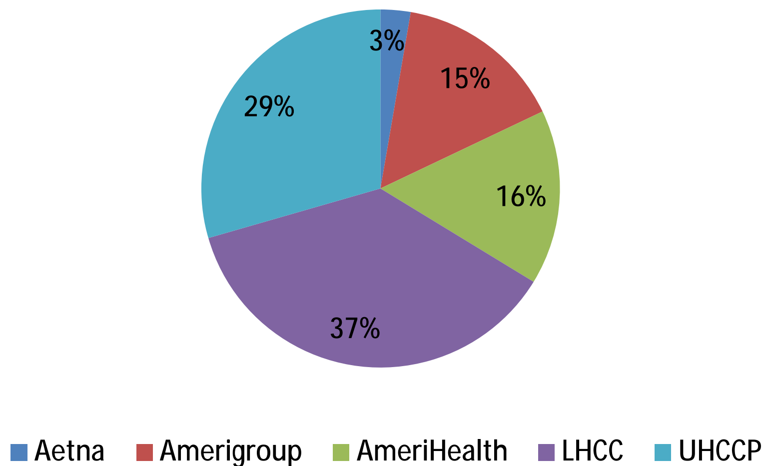
Aetna	June 2015	% Change	June 2015 Statewide Total[2]
Total Enrollment	26,100	-	965,955

Data Source: Report No. 125-A

[1] This report shows all active members in Bayou Health as of the effective date above. Members who will be disenrolled at the end of the reporting month are not included. Enrollees who gain and lose eligibility during the reporting month are not included. Enrollees who opt out of Bayou Health during the reporting month are not included.

[2] Note: Total includes membership of all plans.

Figure 1. Bayou Health Membership by Health Plan as of June 2015



Provider Network

Providers by Specialty

Table 3 shows the sum of primary care providers, other physicians with primary care responsibilities and OB/GYNs as of June 30, 2015.

Table 3. Primary Care & OB/GYN Counts by GSA

Specialty	GSA A	GSA B	GSA C	MCO Statewide Unduplicated
Family Practice/General Medicine	172	197	222	572
Pediatrics	168	151	106	401
Nurse Practitioners	110	278	224	574
Internal Medicine[1]	176	115	123	412
OB/GYN[1]	10	12	61	54
RHCS/FQHC	30	35	72	125

Data source: Network Adequacy Review 2015 Q2

GSA: Geographic Service Area: A: New Orleans and North Shore; B: Baton Rouge, Lafayette and Thibodaux; C: Alexandria, Lake Charles, Monroe and Shreveport

[1] Accepts full PCP responsibility.

Provider Network Accessibility

DHH requires that Medicaid provider networks include a sufficient number of primary care providers to ensure members have reasonable choice among providers. 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 January 27, 2016

Provider Type		Access Standard[1] X Provider(s) within X Miles	Percentage of Members for Whom Standard was Met
Family Practitioners and General Practitioners	Urban	1 within 20 miles	99.7%
	Rural	1 within 30 miles	99.1%
Internal Medicine	Urban	1 within 20 miles	98.0%
	Rural	1 within 30 miles	97.6%
Pediatricians	Urban	1 within 20 miles	97.1%
	Rural	1 within 30 miles	96.6%
Nurse Practitioners	Urban	1 within 20 miles	99.5%
	Rural	1 within 30 miles	98.9%
OB/GYN	Urban	1 within 20 miles	85.2%
	Rural	1 within 30 miles	59.0%
RHCS/FQHC	Urban	1 within 20 miles	51.3%
	Rural	1 within 30 miles	56.0%

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

IV. QUALITY INDICATORS

To measure quality of care provided by the Health Plans, 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®.

As Aetna began enrollment in February 2015, the Health Plan did not report HEDIS® or CAHPS®. Also, the Health Plan did not conduct PIPs during this review period. The Health Plan will have these data available for inclusion in the next iteration of the Annual EQR Technical Report.

V. COMPLIANCE MONITORING

Medicaid Compliance Review Findings for Contract Year 2014-2015

During this review period, IPRO conducted Readiness Reviews of the Bayou Health Medicaid MCOs. The purpose of the Readiness Reviews were to assess the MCOs operational capacity to participate in Medicaid managed care and begin enrollment in accordance with the newly-enforced state contract regulations for Medicaid managed care. The MCOs were required to demonstrate the ability to operate a program that meets the Department of Health and Hospitals' (DHH) requirements and were expected to clearly define and document the policies and procedures to support day-to-day business activities related to Louisiana Medicaid enrollees. Enrollment under the updated contract regulations began in February 2015.

The following domains were reviewed for the 2014-2015 Aetna Readiness Review:

§ 2.0: Scope of Work/Requirements
§ 4.0: Staff Requirements and Support Services
§ 6.0: Core Benefits & Services
§ 7.0: Provider Network Requirements
§ 8.0: Utilization Management
§ 10.0: Provider Services
§ 11.0: Eligibility, Enrollment & Disenrollment
§ 12.0a: Marketing
§ 12.0b: Member Education
§ 13.0: Member Grievances & Appeals
§ 14.0: Quality Management
§ 15.0 Fraud, Abuse and Waste Prevention

Table 11 displays the compliance determination categories used by IPRO during the 2014-2015 Readiness Review.

Table 5. 2014-2015 Readiness Review Determination Description

Determination	Definition
Met	Health plan has met or exceeded requirements.
Not Met	Health plan has not met most critical requirements, all or some non-critical requirements, and has significant deficiencies requiring corrective action.
N/A	Not applicable.

Findings from Aetna's 2014-2015 Readiness Review follow. Table 12 displays the total number of requirements reviewed for each domain, as well as compliance determination counts for each domain. Table 13 displays descriptions of all standards/elements that were "Not Met".

Table 6. Overall Compliance Determination by Domain

Domain	Total No. of Requirements Reviewed	Compliance Determination Totals		
		Met	Not Met	N/A
2.0 Scope of Work/Requirements	3	3	0	0
4.0 Staff Requirements and Support Services	4	4	0	0
6.0 Core Benefits & Services	100	100	0	0
7.0 Provider Network Requirements	167	167	0	0
8.0 Utilization Management	98	98	0	0
10.0 Provider Services	58	56	0	2
11.0 Eligibility, Enrollment & Disenrollment	26	26	0	0
12.0a Marketing	118	118	0	0
12.0b Member Education	133	131	0	2
13.0 Member Grievances & Appeals	67	67	0	0
14.0 Quality Management	65	65	0	0
15.0 Fraud, Abuse and Waste Prevention	110	109	0	1
TOTAL	949	944	0	5

Table 7. Elements Requiring Corrective Action by Review Area

2014-2015 Readiness Review – Elements Not Fully Met	
Domain	Description of Review Findings Not Fully Met
	All contract requirements fully met.

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 Plan'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

§ In regard to the 2014-2015 Readiness Review, the Health Plan demonstrated strong performance, as it was found to have "met" all requirements for the nine (9) domains reviewed.

Opportunities for Improvement

There were no opportunities for improvement identified for this reporting period.

Recommendations

- § The Plan should report performance measures to the DHH that allow for the evaluation of the quality of, access to and timeliness of care, specifically, as it relates to its Medicaid population.
- § The Plan should report performance measures to the DHH that allow for the evaluation of Medicaid member satisfaction.