Aetna Better Health

Value Based Solutions Overview

Louisiana Association of Rural Health Clinics

Patti Gardner

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Month Year

Agenda

- About Aetna Better Health of Louisiana
- Aetna' s VBS Program Overview
  - Provider Collaboration
  - Value-Based Solutions Alternative Payment Models
  - Aetna's VBS Programs
  - Contracting Alternatives
- VBS Next Steps/Follow Ups
- Questions & Answers

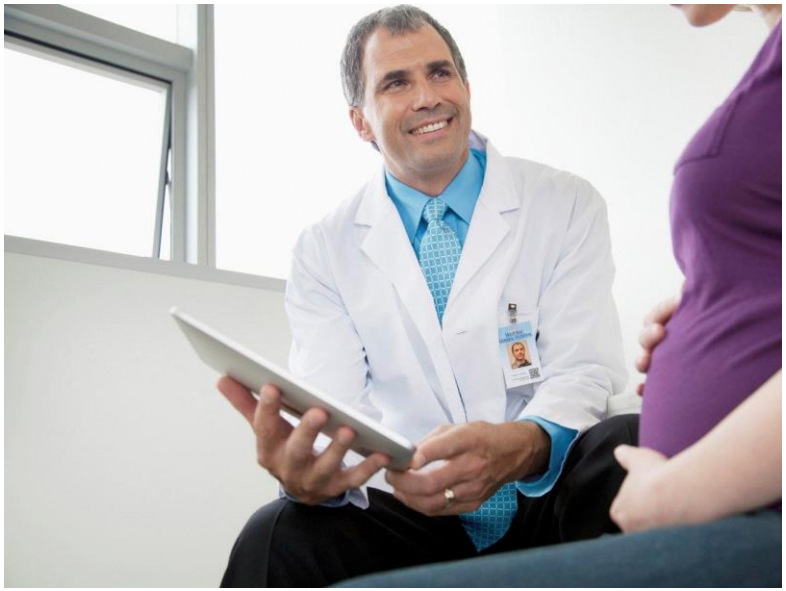
Aetna Better Health of Louisiana

- Currently 1 of 5 MCOs managing the Medicaid population
- Beginning 1/1/23 6 MCOs
- ABHLA – Contract began 2/1/15
- Membership Growth
  - 40,000 2/1/15
  - 60,000 12/1/15 – Specialized Behavioral Health
  - 85,000 7/1/16 – ACA Medicaid Expansion
  - 120,000 12/31/19
  - 159,000 Current
- Aetna VBS contracts cover 88% of PCPs and over 60% of Medical Spend – Leads MCOs
- Highest COVID vaccination rate of our members
- Only plan to increase star ratings in 2021 – tied for first

Provider Collaboration

Aetna Better Health's approach to provider collaboration includes a portfolio of Value-Based Programs that support clinical and financial success and aim to achieve key objectives:

- Improved quality of care and outcomes
- Increased access to care
- Reduced medical costs
- Growth of Aetna membership



Programs are selected for providers based on:

- Practice size and specialties
- Membership panel and population
- Level of understanding and engagement
- Clinical and technological capabilities

Provider Collaboration

Support providers in their transition from pay-for-volume to pay-for-value by improving access, quality, and affordability in the healthcare ecosystem.

Performance-Based Reimbursement

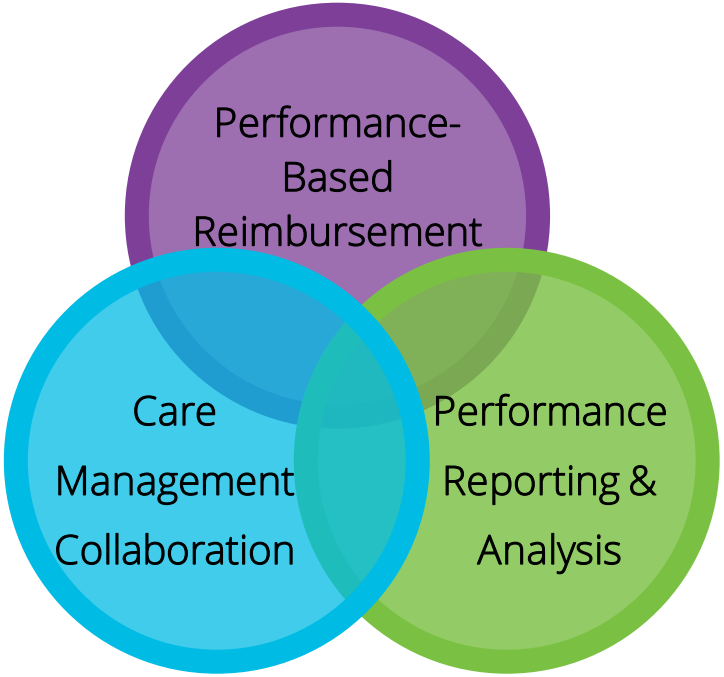
Providers are eligible for incentives tied to both clinical and financial outcomes. Incentive payments are based on performance of selected metrics and targets designed to reduce avoidable utilization and deliver improved care.

Care Management Collaboration

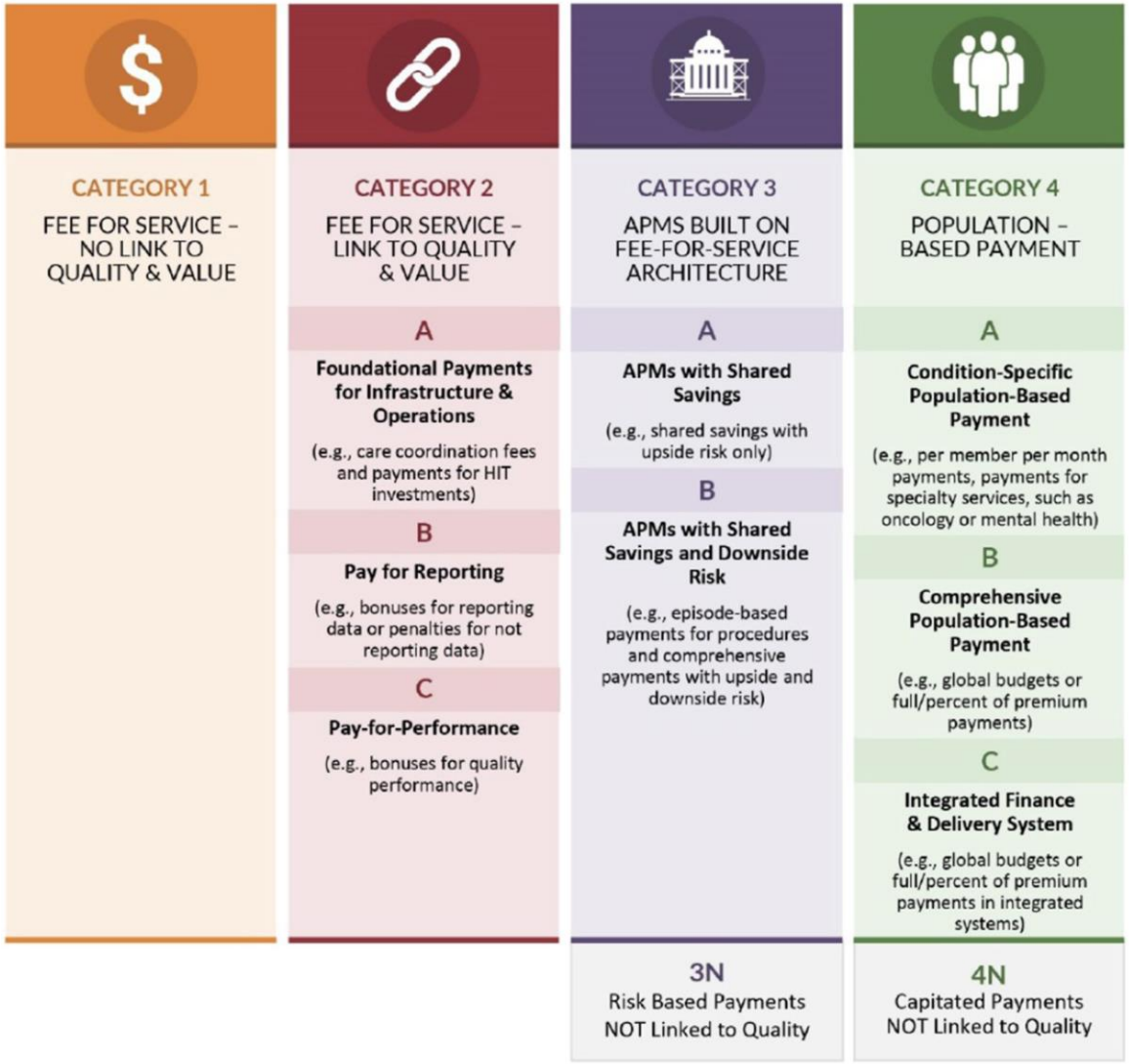
Care management support is provided through the use of technology, tools and locally-based clinical resources to assist providers in coordinating care for members.

Performance Reporting & Analysis

Reporting & analysis is available to support providers in understanding their performance and identifying key gaps and areas of opportunity to achieve success.



Alternative Payment Models Framework



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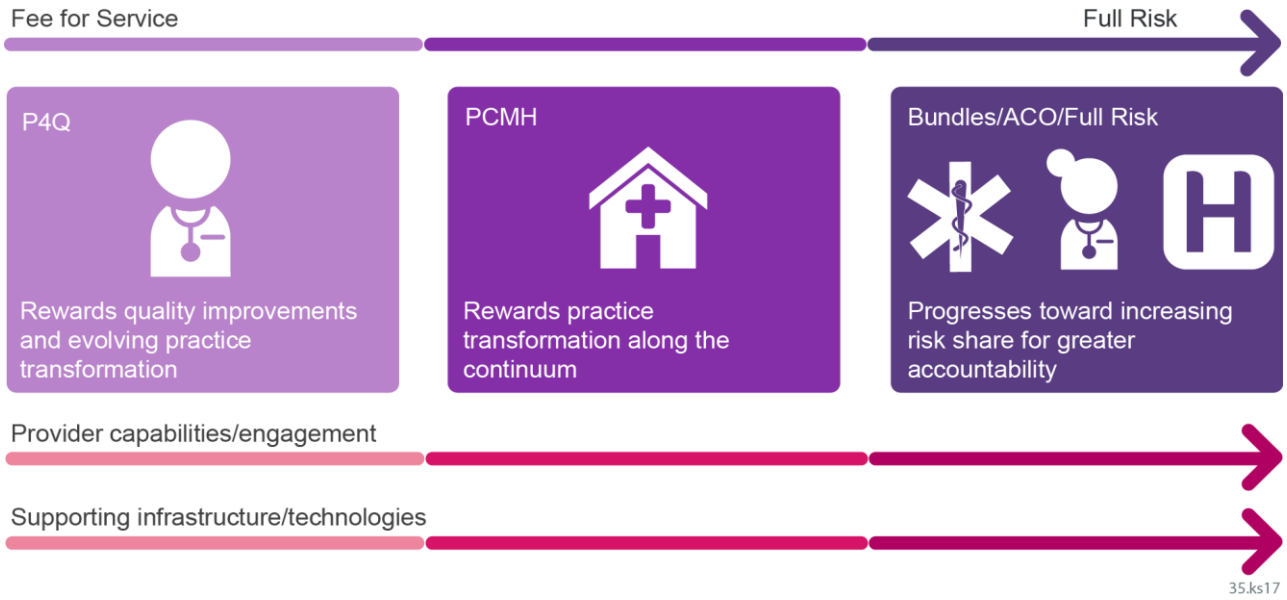
Aetna Medicaid VBS Programs



Innovative Non Traditional VBS Programs

Over 30+ non-traditional providers in the pipeline

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P4Q Program Structure

P4Q

Provider Eligibility	• Group practices with 50+ Aetna members may be eligible as long as not participating in another value-based arrangement for ABH-LA • Must maintain “open” panel
Performance Measurement	• 5-10 measures selected based on State metrics • Performance based on administrative data provided to Aetna • Provider must have a minimum of 10 members in the measure denominator to be eligible for incentive payment on that measure.
Payment Model	• Annual bonus payment for successfully meeting quality targets • Payment based on State incentives • HEDIS Target: 50th percentile of HEDIS National Medicaid/Medicare or 2% improvement over prior year performance of metric
Data & Reporting	• Aetna provides a monthly VBS Quality Report to all participating providers • Aetna's standardized, centralized, and actionable reports include gaps in care to allow providers to monitor their care and develop strategy • Available to providers 24/7 in Tableau through the Medicaid Web Portal (moving to Availity 4th quarter 2022
Collaboration Process	• Quarterly outreach to assess program success • Annual determination of provider readiness to move to next level

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PCMH Program Structure

PCMH

Provider Eligibility	• Group practices with 300+ assigned members may be eligible • Plan and Value Based Team may partner with practices who show a commitment to providing exceptional care in order to assess and enhance capabilities • Aetna may use assessment tool to help determine providers' ability to succeed under PCMH program • Requires a contract amendment
Performance Measurement	• Utilization metrics, (e.g. readmission rate, ED visit rate, annual visit rate), cost and quality metrics used to monitor provider performance • Targets established in recognition of baseline rates and market dynamics • Consistent success required for participation in program
Payment Model	• Monthly care coordination fee based on assigned membership • Variable rate based on HEDIS quality/utilization measure performance
Data & Reporting	• VBS KPI and FIN Reports: provide practice, individual practitioner & member-level monthly look into cost, quality and utilization with trends, analytics, member risk scoring, gaps in care.
Collaboration Process	• Outreach on a quarterly basis as needed • Provider Plan Collaboration Team to meet as needed to best help provider care for assigned members

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Shared Savings Program Structure

Shared Savings

Provider Eligibility	• All practices with 1000+ assigned Aetna members may be eligible • Practices/systems with requisite infrastructure and competency identified at the Plan level • Requires contract amendment
Performance Measurement	• MBR and quality/utilization metrics tracked through the year • Metrics and targets matched to population, market dynamics and historic performance; must be able to capture data
Payment Model	• MBR Target Developed based on historic performance or Plan level performance • MBR savings shared dependent on achieving quality and utilization metric targets
Data & Reporting	• VBS KPI and FIN Reports: Aetna provides practice & member-level view into cost, quality and utilization with trending, analytics, member risk scoring, and gaps in care • Quarterly financial reporting includes revenue and expense performance, including IBNR. • Aetna maintains channels for data transfer to and from providers
Collaboration Process	• Outreach on a monthly basis as needed to assist provider • Provider Plan Collaboration Team to meet quarterly as needed to develop strategy

VBS Reporting

PCMH

Group name

Measure	Submeasure	NUM	DENOM	Rate	Target	Addt'l Needed to Hit Target
AAP	Total	139	191	72.77%	85.09%	24
AWC		15	36	41.67%	61.99%	8
CAP	Members 12 to 19 Years of Age	23	28	82.14%	92.05%	3
CAP	Members 12 to 24 Months of Age	5	6	83.33%	97.03%	1
CAP	Members 25 Months to 6 Years of Age	33	37	89.19%	90.47%	1
CAP	Members 7 to 11 Years of Age	21	22	95.45%	93.04%	0
CCS		65	111	58.56%	65.96%	9
CDC	HBA1C Testing	21	27	77.78%	55.47%	0

HEDIS Quality Baseline Data – YTD 2018 thru 10/31/18-data run 1/14/9

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Next Steps

- Review of Aetna Better Health Value Based Solutions Program Addendum
- Collaboration on selection of contract measures which most effectively deliver exceptional-quality, impactful care to members
- Execute agreement
- Kick-off meeting with engagement staff and plan/provider leadership to discuss how to best collaborate over the measurement year to achieve program success

Questions