LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS

BAYOU HEALTH TRANSPARENCY REPORT

CALENDAR YEAR 2013

Department of Health and Hospitals

P.O. Box 629

Baton Rouge, LA 70821-0629

Phone: (225) 342-9500

Fax: (225) 342-5568

JANUARY 2015

Table of Contents

Preface....................i
1 Health Plans....................1
2 Healthcare Providers....................7
3 Members Enrolled....................9
4 PCPs Providing Continuous Phone Access....................12
5 Authorization Requests Processed....................14
6 Claims Paid to Providers....................17
7 Claims Denied....................19
8 Claims Paid to Non-Network Providers....................22
9 Plan Choice and Auto-Assignment....................25
10 Payments to Health Plans....................27
11 Medical Loss Ratios (MLRs) and Related Refunds....................29
12 Health Outcomes....................31
14 Member and Provider Satisfaction Surveys....................41
15 Audited Financial Statements....................44
16 Savings from Shared Savings Plans....................45
17 Sanctions Levied against Health Plans....................47
18 Grievances and Appeals....................49
19 Members Receiving Medicaid Services....................51
20 Members Receiving Outpatient Emergency Services....................54
21 Inpatient Medicaid Days....................55
22 Claims for Emergency Services....................56
23 Pharmacy Benefits....................57
24 LA Health Works Commission Survey....................58

Preface

Act 212 of the 2013 Regular Session of the Louisiana Legislature requires the Louisiana Department of Health and Hospitals (DHH) to submit annual reports concerning the Bayou Health program to the Legislature's Senate and House Committees on Health and Welfare. The following Bayou Health Transparency Report: Calendar Year (CY) 2013 is intended to provide all information outlined in Act 212 for the second annual report to the Legislature. This report presents information on the Bayou Health program during the 2013 calendar year[1].

Information and data for inclusion in this report were collected and provided by the contracted Bayou Health plans. The health plans' internal policies and procedures for collection of data were validated by DHH's contracted external quality review organization (EQRO), Island Peer Review Organization (IPRO), in conjunction with 2013 external quality reviews. An additional validation was performed by either the National Committee for Quality Assurance (NCQA) or the Utilization Review Accreditation Commission (URAC) as part of the contractually required health plan accreditation process.

Plans are contractually required to obtain accreditation from either NCQA or URAC for their Bayou Health plan serving Louisiana members. All Bayou Health plans have obtained accreditation from those national accrediting bodies NCQA or URAC, which are rigorous processes involving comprehensive reviews of the plans' policies, procedures and practices.

[1] Much of the data required for this report is extracted from health claims data. For health services provided during the year 1/1/13 – 12/31/13, claims can be initially submitted until the end of CY 2014. While the majority of Bayou Health claims were submitted for payment during the first 90 days after services were incurred (by 3/31/14), it is important to note that activity for claims received after 05/31/2014 are not reflected in this report.

Bayou Health Plan	Accrediting Body	Accreditation Date
Amerigroup	NCQA (New Health Plan)	September 2013
Amerihealth Caritas	NCQA (Interim Status)	December 2013
Community Health Solutions	URAC (Health Utilization Management) URAC (Case Management)	November 2012 November 2013
Louisiana Healthcare Connections	NCQA (Full Accreditation))	June 2014
UnitedHealthcare Community Plan	NCQA (Full Accreditation))	July 2014

Prior to Feb. 1, 2012, all plans completed an information systems capability assessment. The assessment specified the desired capabilities of the plans' information systems and evaluated the strength of a plan with respect to these capabilities. As recommended by the Centers for Medicare & Medicaid Services (CMS), the assessment assisted the State in assessing the extent to which plans' information systems are capable of producing valid encounter data, performance measures, and other data necessary to support quality assessment and improvement while managing the care delivered to its beneficiaries. DHH contracted with Mercer Government Consulting to complete these assessments in 2011. All five plans were found to be in full compliance with data processing, acquisition and reporting capabilities.

DHH began compiling data for Act 212 for calendar year 2013 on April 30, 2014. A workgroup was developed with health plan contacts, business/data analysts and Medicaid Quality Management staff. The project entailed weekly meetings for each Act 212 item included in this report to validate reporting requirements and data specifications. Part One was completed on June 3, 2014.

As further validation, DHH contracted with the auditing firm Myers and Stauffer LC (MSLC) to review the data collected by DHH. MSLC began reviewing the data on Aug. 8, 2014. Eligibility and most claims-related information reported here were derived by DHH staff, extracting data from the Medicaid Administrative Reporting

Subsystem (MARS) Data Warehouse. Other information in this report was collected through the Bayou Health reporting program. For these items, MSLC evaluated the completeness and accuracy of reports submitted by the plans. Furthermore, MSLC assessed the completeness and accuracy of encounter data submitted by prepaid plans to the State consistent with the procedures specified by CMS under *External Quality Review Protocol 4: Validation of Encounter Data Reported by the MCO*. The firm determined that 2013 encounter data submissions are substantially complete. It also identified discrete areas of concern and recommended corrective actions. All plans are on schedule to complete the recommended corrective actions prior to the end of the contract term in January 2015.

1 HEALTH PLANS

Bayou Health is the name of Louisiana's Medicaid managed-care delivery system through which more than one million Louisiana Medicaid and Louisiana Children's Health Insurance Program (LaCHIP) enrollees received physical health services for one or more months during CY2013. Initially implemented in February 2012, the Bayou Health Coordinated Care Networks (CCNs) Program is comprised of two Medicaid-managed care models as defined in federal Medicaid regulations: managed care organizations (MCO) and primary care case management (PCCM) entities. The five health plans were selected through a competitive procurement in 2011.

MCOs, also called prepaid plans in Louisiana, are risk-bearing entities that provide a wide array of Medicaid-covered benefits and services to enrolled members in exchange for a monthly capitation payment for each member. The plans contract directly with providers and manage all aspects of service delivery, including reimbursement of providers. The three MCO model Bayou Health plans, which operate statewide, are:

- Amerigroup Louisiana (AMG) (parent company Anthem, formerly WellPoint)
- AmeriHealth Caritas of Louisiana (AHC) (formerly LaCare)
- Louisiana Healthcare Connections (LHCC) (parent company Centene)

PCCM entities, also called shared savings plans in Louisiana, are paid a monthly management fee for each enrolled member in exchange for coordinating care for enrolled members. Shared savings plans only contract with primary care providers (PCPs). All other services that they coordinate are provided through the Louisiana Medicaid program's provider network. While the plan is responsible for service utilization, actual provider payments continue to be made by the Department. Shared savings plans are at limited risk for repaying a portion of the monthly management fee in the event savings benchmarks are not achieved. A portion of any savings realized as a result of improved coordination of care is "shared" with the entity. The two PCCM model Bayou Health plans, which operate statewide, are:

- Community Health Solutions (CHS) (owned by Louisiana Healthcare Connections as of 7/1/14)
- UnitedHealthcare Community Plan (UHC)

While shared savings plans are responsible for service utilization for most prepaid health plan core benefits and services, the legacy Medicaid program continued to authorize durable medical equipment, prosthetics, orthotics, and certain supplies (DMEPOS); pharmacy; and non-emergency medical transportation (NEMT) to members of these plans.

In addition to the Bayou Health MCOs and PCCMs, Louisiana provides specialized Medicaid behavioral health services through a single, prepaid inpatient health plan (PIHP) operated by Magellan and Medicaid dental services through a single, prepaid ambulatory health plan (PAHP) operated by Managed Care of North America (MCNA).

Participating Health Plans

- Amerigroup Louisiana (MCO)
- Amerihealth Caritas of Louisiana (MCO)
- Louisiana Healthcare Connections (MCO)
- Community Health Solutions (PCCM)
- UnitedHealthcare Community Plan (PCCM)

Medicaid Populations and Services in Bayou Health

The Bayou Health program operates under the federal authority in Section 1932(a)(1) of the Social Security Act. Participating Medicaid enrollees as well as included benefits and services must be specified in Louisiana's approved Medicaid State Plan. While most Medicaid enrollees are required to enroll in a Bayou Health plan, there are individuals who can voluntarily enroll. These individuals are referred to as optional enrollees. In addition, there are individuals that are excluded from enrolling in a Bayou Health plan.

In 2013, excluded Medicaid populations are as follows:

- persons residing in nursing facilities or a facility for persons with intellectual and/or developmental disabilities;
- persons receiving hospice services;
- children under 21 years of age who are listed on the New Opportunities Waiver Request for Services Registry (*Chisholm* class members);
- persons receiving services through the Program of All-Inclusive Care for the Elderly (PACE);
- persons who have a limited period of eligibility such as eligibility through the Spend-down Medically Needy Program or Emergency Services Only;
- Medicare dual eligibles including those who receive both Medicare and full Medicaid benefits;
- Medicare dual eligibles with incomes between 75 percent and 135 percent of the federal poverty level (FPL), for whom Medicaid pays only the Medicare Part B monthly premium, and enrollees below 100 percent FPL with limited Medicare crossover payments as the secondary payer;
- enrollees in the Louisiana Health Insurance Premium Payment (LaHIPP) Program;
- individuals receiving limited Medicaid benefits, including enrollees in the Greater New Orleans Community Health Connection (GNOCHC) and those who were enrolled in Take Charge Section 1115 Medicaid demonstration waivers[1]; and
- enrollees in Section 1915(c) home and community based (HCBS) waivers or children and youths under age 21 on the waiting list for an HCBS waiver.[2]

[1] Effective 7/1/14, most individuals eligible to receive services through the Take Charge demonstration waiver are now eligible to receive family planning-related services through Take Charge Plus, part of the CMS-approved state plan.
[2] Effective 7/1/14, individuals enrolled in an HCBS waiver, can "opt in" to Bayou Health.

Services excluded from Bayou Health core benefits and services in 2013 include:

- long term services and supports,
- personal care services[3],
- hospice[4],
- applied behavioral analysis (ABA),
- services provided through DHH's Early Steps Program,
- nursing facility services,
- targeted case management,
- individualized education program (IEP) services,
- school nursing, and
- dental and specialized behavioral health that are managed by other health plans.

Bayou Health Program Goals

DHH designed and implemented the Bayou Health program with the expectation that the managed care health services delivery model would achieve the following outcomes:

- improved coordination of care;
- patient-centered medical homes for Medicaid recipients;
- better health outcomes;
- increased quality of care as measured by metrics such as the Healthcare Effectiveness Data and Information Set (HEDIS®);
- greater emphasis on disease prevention and the management of chronic conditions;
- earlier diagnosis and treatment of acute and chronic illness;
- improved access to essential specialty services;
- outreach and education to promote healthy behaviors;
- increased personal responsibility and self-management;
- reduction in the rate of avoidable hospital stays and readmissions;

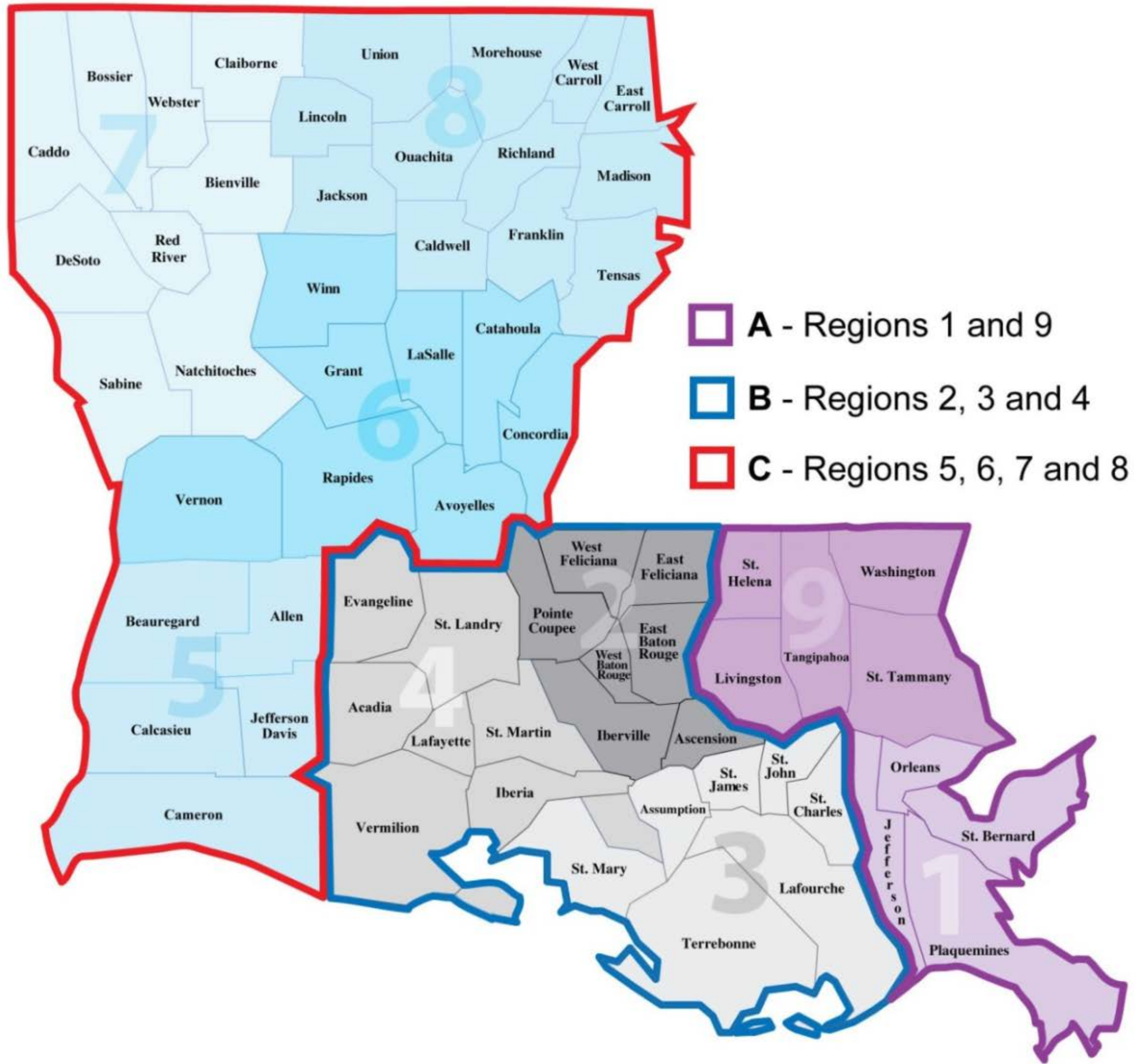
[3] Effective 2/1/15, personal care services for children and youths under age 21 will become a core benefit of Bayou Health plans.
[4] Effective 2/1/15, hospice will become a core benefit of Bayou Health plans.

- decrease in fraud, abuse, and wasteful spending;
- greater accountability for the dollars spent;
- a more financially sustainable system; and
- net savings to the State compared to the fee-for-service Medicaid delivery system.

Bayou Health Geographic Service Areas (GSAs)

Statewide implementation of Bayou Health in the first half of 2012 occurred over a four-month period and spanned three phases. Each phase was based on the geographical region of residence of enrollees. Notably, pre-Bayou Health Medicaid costs varied considerably among regions, and these variations are reflected in the capitation payments for enrollees in the prepaid plans.

Figure 1: Map of Geographic Service Areas (GSA)



2 Healthcare Providers

Timely access to necessary health care for Medicaid members is an important goal of the Bayou Health program. Contracts with the prepaid health plans require them to maintain minimum ratios of specialty physicians to enrollees, and both prepaid and shared savings plans must meet primary care provider (PCP) ratios. The Department conducts ongoing monitoring of the number of contracted providers in each health plan, and plans are required to submit geo-spatial analyses with provider locations. DHH receives the total number of contracted providers for each health plan through weekly provider network registries, which are reports submitted by the plans. Network development and areas for additional focus are standing topics for discussion at quarterly individual business reviews between DHH and the health plans. Since the inception of Bayou Health, DHH has held individual quarterly meetings with each health plan's leadership and DHH leadership in attendance for the purpose of reviewing overall performance and outcomes and to identify opportunities for improvement and any needed adjustments.

It is important to note that the total number of healthcare providers contracting with a Bayou Health plan cannot be used in isolation as an indicator of network adequacy and member access. Provider networks may consist of both in-state and out-of-state providers, and some contracted providers may limit the number of Bayou Health enrollees they will see or have closed their panels to new Bayou Health enrollees.

For more details on the network adequacy, please refer to:

Appendix I: Number of Healthcare Providers by Provider Type, Plan, Service Area and Entity Type

Appendix II: Number of Healthcare Providers by Provider Specialty, Plan, Service Area and Entity Type

Table 2: Total Number of Healthcare Providers by Service Area and Network

	Prepaid Plans			Shared Savings Plans	
Service Area	**AMG**	**AHC**	**LHCC**	**CHS**	**UHC**
GSA A	4,220	4,074	3,737	1,270	1,387
GSA B	3,566	4,065	3,914	1,606	1,609
GSA C	3,439	4,167	3,839	1,506	1,468
In-State	10,259	11,617	10,616	3,822	4,464
Out-of-State	6,735[1]	1,399	497	517	698
Total[2]	**16,797**	**12,925**	**10,992**	**4,339**	**5,162**

Source: Management and Administrative Reporting Subsystem (MARS) Data Warehouse

1. Amerigroup includes all national vendors in its network analysis. Beginning in 2015, AMG will adjust to exclude national vendors in its network analyses.
2. Duplicated totals (sum of parts may not equal total)

3 Members Enrolled

In 2013, Bayou Health enrolled over one million Medicaid recipients across the five health plans. UnitedHealthcare Community Plan of Louisiana had the most members enrolled with nearly 28 percent of all Bayou Health members. Community Health Solutions of Louisiana had the second-largest number of members with nearly 22 percent of all members. Together, these two shared savings plans accounted for 50 percent of all Bayou Health members. The remaining 50 percent were split across the three prepaid plans, with Louisiana Healthcare Connections, AmeriHealth Caritas of Louisiana, and Amerigroup Louisiana each enrolling 18, 17, and 15 percent of all members, respectively.

Figure 1: Enrollment Trends by Health Plan Linkage (dated 5/8/2014)

Differences in member demographics for each of the five health plans are important factors when looking at the number and types of providers, services, utilization and costs. The differences in demographics are reflected by the eligibility group to which an enrollee is assigned.

For purposes of health plan reimbursement, Bayou Health prepaid plan enrollees are assigned to one of the eligibility groups listed below.

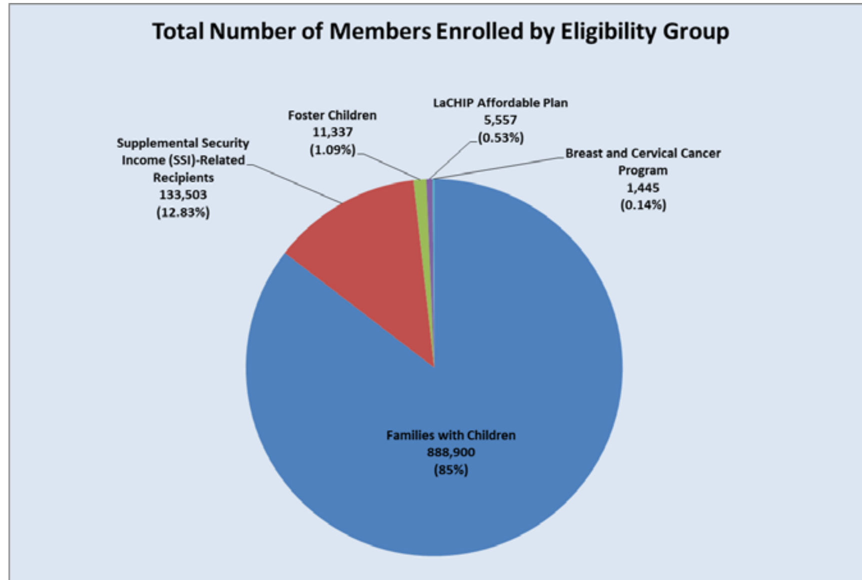
- Families and children – Includes children and teens under the age of 19 whose basis of Medicaid or LaCHIP eligibility is age (children with disabilities are not included in this group) and their parents or caregivers. Also includes pregnant women whose primary basis of eligibility for Medicaid is pregnancy.

- LaCHIP Affordable Plan enrollees – Includes children and youth under the age of 19 with incomes over the limit of 206 percent of the FPL for regular LaCHIP enrollment but with incomes lower than 256 percent of the FPL. Families pay a monthly premium of $50.
- Foster children – Children who receive 24-hour substitute care from someone other than a parent or guardian and for whom the Department of Children and Family Services (DCFS) has responsibility for placement and care.
- People with disabilities and Supplemental Security Income (SSI)-related seniors – Includes individuals who are aged 65 and above as well as individuals of any age, including children, with disabilities.
- Breast and cervical cancer – Includes uninsured women who have already been diagnosed by a Centers for Disease Control and Prevention (CDC)-approved screening entity with breast or cervical cancer or a precancerous condition and who are not otherwise eligible for Medicaid.

Shared savings plan enrollees are assigned to one of the following two eligibility groups for which the monthly management fee depends on the group designation of the enrollee:

- Parents and children whose basis of eligibility is not disability or pregnancy. Plans receive a management fee of $10.24 per-member per-month for enrollees in this group.
- Individuals with disabilities, including children, and pregnant women whose sole basis of eligibility is pregnancy. Plans receive a management fee of $15.74 per-member per-month for enrollees in this group.

Figure 2: Enrollment Trends by Category of Assistance (dated 5/8/2014)



When comparing the prepaid plans against each other and doing the same for the shared savings plans, it was noted that members from each eligibility group were distributed similarly between the plans. However, significant differences in membership structure were noted when plans were compared across plan models. The three prepaid plans had larger proportions of their membership consisting of Supplemental Security Income (SSI)-related recipients when compared to the shared savings plans. The percentage of total membership from this eligibility group ranged from 15 to 17 percent in the prepaid plans and 9 to 11 percent in the shared savings plans. Conversely, the shared savings plans had larger proportions of their total membership that were made up of recipients from the families and children group. This eligibility group made up 88 to 90 percent of total membership in the shared savings plans versus only 83 to 84 percent in the prepaid plans. The disproportionate share of families and children membership among the shared savings plans relative to the prepaid plans greatly affects utilization and outcomes measurement. The overall difference in the health status of the memberships of the different plans makes objective comparison difficult at best.

For more details on the number of members enrolled by plan, eligibility group and month, please refer to Appendix III: Number of Members Enrolled by Plan, Eligibility Group and Month.

4 PCPs Providing Continuous Phone Access

The Bayou Health program requires that contracted health plans arrange for each member to have a primary care provider (PCP) to assist in coordination of care. The PCP serves as the member's initial and most-important point of interaction with the health plan's provider network. A PCP must provide or arrange for the delivery of necessary medical services, including case management, in a timely manner. A PCP must give 24-hour access to members, and health plans are required to monitor their contracted providers for compliance and take corrective action when needed. Plans must also conduct an annual survey of 24-hour access compliance and maintain the results. Bayou Health contracts require tracking of the proportion of PCPs providing 24-hour access and stipulate that survey results must be kept on file and be readily available for review by DHH upon request. The Bayou Health contracts include actual examples of acceptable and unacceptable after-hours coverage.

Examples of acceptable PCP after-hours coverage are listed below.

- The PCP's office telephone is answered after-hours by an answering service that can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes.
- The PCP's office telephone is answered after normal business hours by a recording directing the member to call another number to reach the PCP or another provider designated by the PCP. Someone must be available to answer the designated provider's telephone. Another recording is not acceptable.
- The PCP's office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP or another designated medical practitioner who can return the call within 30 minutes.

Examples of unacceptable PCP after-hours coverage are listed below.

- the PCP's office telephone is only answered during office hours,
- the PCP's office telephone is answered after-hours by a recording that tells patients to leave a message,
- the PCP's office telephone is answered after-hours by a recording that directs patients to go to an emergency room for any services needed, or
- returning after-hours calls takes longer than 30 minutes.

Prior to issuance of DHH clarification to health plans regarding acceptable PCP after-hours coverage during the third quarter of CY 2013, some plans interpreted the requirement more narrowly, resulting in considerable variation. It should be noted that the majority of PCPs are enrolled in multiple Bayou Health plan networks and no plan's PCP network is exclusive to any single plan.

Table 4: Percentage of Primary Care Practices with Continuous Phone Access by Quarter and Plan

	Prepaid Plans			**Shared Savings Plans**	
Quarter	**AMG**	**AHC**	**LHCC**	**CHS**	**UHC**
Jan.-March	NR	NR	NR	NR	NR
April-June	82.0%	80.4%	36.1%	19.9%	51.4%
July-Sept.	70.0%	80.4%	35.6%	19.8%	51.0%
Oct.-Dec.	84.8%	55.2%	55.2%	61.4%	61.4%

Source: Bayou Health Report #217 (QAPI Early Warning System Performance Measures)
NR – Not reported

5 Authorization Requests Processed

Bayou Health plans are required to reimburse for all services that are medically necessary. The determination of medical necessity by the plan is an important factor considered when a plan is evaluated for both overutilization and underutilization of services. Plans may require submission of clinical information for review and authorization of the service as a condition of payment. It is important in insuring timely access to care that service authorization requests submitted by providers are acted on in a timely manner.

The Bayou Health contracts stipulate that service authorizations must be processed within 14 days unless an extension is requested by the provider to submit additional requested information. If the situation warrants it, the provider can request an expedited determination, in which case the request must be acted on within 72 hours or less, depending on the medical urgency. Contracts require that at least 95 percent of requests be processed within these timeframes.

The Department monitors timeliness of action on service authorizations through the review of monthly reports submitted by the health plans and analysis of member and provider complaints and grievances.

Table 5.1: Percentage of Regular Service Authorization Requests Processed by Plan

		Prepaid Plans			Shared Savings Plans	
	Contract Requirement	**AMG**	**AHC**	**LHCC**	**CHS**	**UHC**
Processed within 2 Business Days	80%	95.5%	92.6%	90.2%	95.1%	97.2%
Processed within 14 Calendar Days	95%	99.9%	98.2%	99.4%	99.4%	99.8%
Processed within 28 Calendar Days	100% unless extension requested by member	99.9%	99.6%	99.7%	99.9%	99.9%

Source: Bayou Health Report #188 (PA and Pre-Cert Summary)

Pursuant to the Consent Agreement in Dickson v. Fischer, which became an order of the federal district court for the Eastern District of Louisiana on June 3, 1981, the timeframe for processing requests for prior authorization of medical appliances, equipment and supplies is 25 days or within 24 hours in emergency cases. This agreement requires "[d]efendants and their successors and employees" to act (e.g., approve, deny, etc.) within 25 days or within 24 hours in emergency cases "on all . . . requests for prior approval of medical appliances, equipment and supplies on behalf of Medicaid recipients"; failure to do so constitutes automatic approval.

Table 5.2: Percentage of Medical Appliance, Equipment and Supplies Authorization Requests Processed by Plan within 25 Days

	Prepaid Plans			Shared Savings Plans	
	AMG	**AHC**	**LHCC**	**CHS**	**UHC**
Processed within 25 Calendar Days	99.8%	98.8%	99.5%	NA	NA

Source: Bayou Health Report #188 (PA and Pre-Cert Summary)

Table 5.3: Percentage of Expedited Service Authorization Requests Processed by Plan

	Prepaid Plans			Shared Savings Plans	
	AMG	**AHC**	**LHCC**	**CHS**	**UHC**
Processed within 72 Hours	99.8%	96.1%	99.6%	100%	97.1%

Source: Bayou Health Report #188 (PA and Pre-Cert Summary)

The figures presented in Tables 5.1 through 5.3 were submitted by the plans in Bayou Health Report #188. In order to validate the information reported by the health plans, Myers and Stauffer LC asked each plan how regular and expedited authorization requests are defined, how prior authorizations are monitored and tracked, how reports on prior authorizations are generated and to provide supporting documentation for the plan's response.

DHH began collecting additional prior authorization data from plans in October of 2014. DHH will perform an in-house analysis of this data for next year's report, including the number of prior authorization requests that were actually approved or denied, the total number of requests and the percentage of requests processed within the timelines.

6 Claims Paid to Providers

Timely processing of claims is important in order for Bayou Health plans to retain their network providers and to maintain cash flow for providers who deliver services to Bayou Health enrollees. Health plans are required to pay 90 percent of "clean claims" within 15 business days of receipt for each major provider type (physician, hospital, home health, DME, therapy, lab and X-ray) and 99 percent of such claims within 30 calendar days.

A clean claim is defined in the Bayou Health contract as a "claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a state's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, [SIC] or a claim under review for medical necessity." The following tables display information on the percentage of clean claims paid to providers and the average number of days to pay all claims. Table 6.1 lists the percentage of claims considered clean claims paid within 30 days by provider type for each managed care organization. While shared savings plans do not pay claims submitted by health care organizations, Tables 6.1 and 6.2 include data on the claims that were subsequently paid by the State's fiscal intermediary after the preprocessing.

Table 6.2 lists the average number of days to pay all claims by provider type for each health plan. All five health plans paid the large majority of provider types in approximately two weeks, with the average number of days being less than one week for many provider types. The variation among provider types indicated in the following tables are due in part to the complexity of cross-walking Legacy Medicaid provider types to the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12N standard. Provider type classifications used by the Legacy Medicaid fiscal intermediary are proprietary, and considerable work had to be performed to map them back to standard taxonomy in use by other health care organizations. All Health Insurance Portability and Accountability Act (HIPAA) -covered entities are required to be compliant with the ASC X12 version 5010. As health care vocabulary and terminology standards continue to evolve, DHH will continue to work to ensure health plan compliance to this standard and ensure provider directories are

accurate and complete. For example, all health plans are required to submit their full provider registries to DHH each week to ensure that the Department has the most current and accurate provider information available at any given time.

Table 6.1: Percentage of Clean Claims within 30 Days by Provider Type and Plan

		Prepaid Plans			Shared Plans	
Provider Type	**Benchmark**	**AMG**	**AHC**	**LHCC**	**CHS**	**UHC**
Ambulatory Health Care Facilities	99.00%	99.32%	99.99%	99.74%	99.22%	99.87%
Hospitals	99.00%	99.73%	100%	99.44%	99.04%	99.91%
Laboratories	99.00%	98.40%	99.99%	99.89%	99.78%	99.98%
Nursing Service Providers	99.00%	100%	99.99%	99.88%	99.23%	99.96%
Physician Assistants and Advanced Practice Nursing	99.00%	100%	99.90%	99.82%	98.98%	99.79%
Physicians	99.00%	99.95%	100%	99.74%	99.14%	100%
Pharmacies	99.00%	99.95%	99.99%	98.59%	NA	NA
Other Service Providers	99.00%	99.75%	99.95%	99.86%	99.12%	100%
Durable Medical Equipment, Prosthetics and Orthotics Suppliers	99.00%	97.81%	99.99%	99.73%	NA	NA
Transportation Services	99.00%	99.95%	99.92%	99.67%	NA	NA

Source: Management and Administrative Reporting Subsystem (MARS) Data Warehouse; HIPAA Taxonomy; Health Plans' Claims Adjudication Systems
NA – Not applicable

Table 6.2: Average Number of Days to Pay All Claims by Provider Type and Plan

	Prepaid Plans			Shared Savings Plans	
Provider Type	**AMG**	**AHC**	**LHCC**	**CHS**	**UHC**
Ambulatory Health Care Facilities	6	3	8	9	7
Hospitals	7	8	8	10	7
Laboratories	5	3	7	9	7
Nursing Service Providers	8	3	8	10	7
Physician Assistants and Advanced Practice Nursing	5	6	7	9	7
Physicians	5	3	7	10	7
Pharmacies	1	3	8	NA	NA
Other Service Providers	6	3	7	11	7
Durable Medical Equipment, Prosthetics and Orthotics Suppliers	19	10	9	NA	NA
Transportation Services	0	8	8	NA	NA

Source: Management and Administrative Reporting Subsystem (MARS) Data Warehouse; HIPAA Taxonomy
NA – Not applicable

7 CLAIMS DENIED

In designing the Bayou Health plans, DHH's contracted actuary, Mercer, identified certain types of claim denials by health plans that bear special scrutiny and ongoing monitoring to assure that claims are not being inappropriately denied. Those denial reasons are as follows:

- lack of medical necessity,
- prior authorization not on file,
- a primary payer must be billed first before Bayou Health is billed as a secondary payer,
- initial claim filing failed to occur before the deadline of 365 days after the date of service, or
- service not covered by Medicaid.

Records for each denied claim must include the reason for denial. The table below shows the number of claims that were denied in CY 2013 for one of the six reasons below.

- Denial Code 1 Medical Necessity
- Denial Code 2 PA (Prior Authorization) Not on File
- Denial Code 3 EOB (Explanation of Benefits) from Primary Payer Required
- Denial Code 4 Timely Filing Not Met
- Denial Code 5 Not a Covered Service
- Denial Code 6 Failure of Health Plan to Comply with Other Health Plan Administrative Function

For all but one health plan, the majority of claims were denied for failure to meet other health plan administrative requirements. This reason accounted for over 69 percent of claims denied among these six denial codes for each of these four health plans. For the remaining plan, Community Health Solutions of Louisiana, 69 percent of claims that were denied among these six denial codes were due to the claims not being for a qualified Louisiana Medicaid covered service. The second-most-common reason for denying claims for three out of the five health plans was that they did not

have prior authorization on file for services provided. This reason accounted for 11 to 18 percent of all claims denied in these six categories by Amerigroup Louisiana, AmeriHealth Caritas Louisiana and UnitedHealthcare Community Plan of Louisiana. It should be noted that the values for Community Health Solutions of Louisiana and UnitedHealthcare Community Plan of Louisiana only reflect claims returned to the provider during the pre-processing phase of the adjudication cycle. This is because the final adjudication of claims occurs with the Medicaid fiscal intermediary for plans in the shared model.

Table 7: Number of Claims Denied by Reason and Plan

	Prepaid Plans			**Shared Savings Plans**	
Reason	**AMG**	**AHC**	**LHCC**	**CHS**	**UHC**
Medical Necessity	1,493	10	53,708	22,237	20,501
PA (Prior Authorization) Not on File	132,906	209,221	96,232	13,565	42,845
EOB (Explanation of Benefits) from Primary Payer Required	71,155	46,569	61,536	NA	NA
Timely Filing Not Met	17,931	19,444	17,831	0	1,460
Not a Covered Service	88,960	13,185	149,226	118,759	16,449
Failure of Health Plan to Comply with Other Health Plan Administrative Function	843,890	845,879	843,451	17,940	182,917

Source: Bayou Health Report #173 (Prepaid Denied Claims)

The figures in Table 7 were submitted to DHH by the health plans as contractually required via Bayou Health Report 173. In order to validate the information reported, Myers and Stauffer LC asked plans to indicate if claims were denied through an auto-adjudication or a manual process, explain tracking and auditing procedures utilized and provide criteria for denial. Myers and Stauffer LC staff concluded that the procedures supporting the reported values appear reasonable for all three prepaid plans. As previously noted, the information systems capability assessment completed by each plan demonstrates high fidelity in each plan's claims adjudication system and data processing procedures.

8 Claims Paid to Non-Network Providers

Prepaid health plans are required to pay both network and non-network providers for emergency services at 100 percent of the Medicaid fee schedule that is in effect on the date of service. Prior authorization cannot be required and payment cannot be contingent on notification within a specific timeframe. The health plans may also make payments to non-network providers for care that is not classified as emergency services through single-case agreements and other arrangements.

The following information reflects the number of claims and dollar value of payments by prepaid health plans to non-network providers for both emergency services and non-emergency services. Table 8.1 provides the number of claims broken down by service area and claim type for each managed care organization under the prepaid plan model. The claim types are categorized by emergency and non-emergency services performed by facility (e.g., hospital) and professional provider types.

Table 8.1: Number of Claims Paid to Non-Network Providers by Claim Type, Service Area and Plan

Service Area	Claim Type	AMG	AHC	LHCC
GSA A	Emergency - Facility	11,327	5,968	10,851
GSA A	Emergency - Professional	16,228	17,962	21,891
GSA A	Non-Emergency - Facility	468	4,208	13,257
GSA A	Non-Emergency - Professional	21,595	48,952	49,978
GSA B	Emergency - Facility	10,363	7,935	2,745
GSA B	Emergency - Professional	33,590	36,399	18,074
GSA B	Non-Emergency - Facility	701	3,763	3,407
GSA B	Non-Emergency - Professional	34,909	50,430	41,610
GSA C	Emergency - Facility	20,892	3,347	906
GSA C	Emergency - Professional	32,491	38,341	22,964
GSA C	Non-Emergency - Facility	474	4,783	1,520
GSA C	Non-Emergency - Professional	37,081	29,866	56,089

Source: Management and Administrative Reporting Subsystem (MARS) Data Warehouse and Health Plans' Data Warehouses

Table 8.2: Value of Claims Paid to Non-Network Providers by Claim Type, Service Area and Plan

Service Area	Claim Type	AMG	AHC	LHCC
GSA A	Emergency - Facility	$1,850,858	$1,433,231	$1,224,791
GSA A	Emergency - Professional	$1,202,742	$1,373,862	$1,485,676
GSA A	Non-Emergency - Facility	$21,084	$5,984,792	$7,173,130
GSA A	Non-Emergency - Professional	$1,534,916	$3,859,949	$4,168,675
GSA B	Emergency - Facility	$970,418	$1,293,484	$377,129
GSA B	Emergency - Professional	$2,546,903	$2,748,976	$1,132,081
GSA B	Non-Emergency - Facility	$59,500	$5,220,402	$2,242,268
GSA B	Non-Emergency - Professional	$2,649,746	$6,238,246	$4,207,543
GSA C	Emergency - Facility	$2,021,970	$572,722	$152,720
GSA C	Emergency - Professional	$2,535,160	$2,916,656	$1,441,876
GSA C	Non-Emergency - Facility	$9,312	$2,911,027	$2,058,506
GSA C	Non-Emergency - Professional	$2,829,016	$3,704,976	$5,531,793

Source: Management and Administrative Reporting Subsystem (MARS) Data Warehouse and Health Plans Data Warehouse

The figures in Tables 8.1 and 8.2 originate from data submitted to DHH by the health plans. Myers and Stauffer LC asked the three prepaid plans to explain the assumptions and criteria used in reporting these data while attempting to validate these figures. MSLC found that certain emergency services included in DHH reporting requirements may have been excluded from the analysis. Specifically, hospital revenue codes 451, 452 and 456 were not included for all three prepaid plans. However, these three revenue codes have actually never been payable under the Louisiana Medicaid fee-for-service schedule. Therefore, their exclusion was appropriate.

9 PLAN CHOICE AND AUTO-ASSIGNMENT

One of the goals of Bayou Health is to engage members in selecting the Bayou Health plan that best meets their needs. Factors that weigh in the decision include additional benefits and services that may be offered by a given plan and whether one's preferred providers participate. Bayou Heath enrollment and disenrollment is managed by DHH's contracted enrollment broker, Maximus. As required by federal Medicaid regulations, the enrollment broker is independent and free from conflict of interest.

New Medicaid enrollees receive all benefits and services through the legacy Medicaid program pending their enrollment in a Bayou Health plan. Shortly after enrollment in Medicaid, members receive a choice letter with instructions on how to submit their choice of plan and notifying them of the availability of choice counseling. Members who do not choose a health plan within 30 days are auto-assigned to the plan determined to be the best fit for them using information such as their prior enrollment in a health plan if that enrollment occurred within the past 60 days or whether family members are already enrolled in in a plan.

Maximus provides monthly reports to the Department that indicate the number of self-selections as well as the number of auto-assignments by health plan. Following auto-assignment, a member has 90 days to change health plans for any reason. After the expiration of the 90 days, members must wait until the next annual open enrollment period to switch plans unless they can show good cause for doing so, for example a poor quality of care, to enroll in same plan as family members, or documented lack of access to needed services.

Table 9 provides the number of members who actively chose to enroll in each plan and the number of members who were auto-assigned to each plan in 2013. The proportion of members who chose their health plan ranges from 51 percent for Amerigroup Louisiana to 74 percent for UnitedHealthcare Community Plan of Louisiana. The two shared savings plans, Community Health Solutions of Louisiana and UnitedHealthcare Community Plan of Louisiana, had the two highest ratios of

self-selectors to auto-assigned members as well as the majority of all self-selectors across all plans (59 percent).

Table 9: Number of Members Who Chose Their Plan Versus Auto-Enrolled Members

	Prepaid Plans			**Shared Plans**	
	AMG	**AHC**	**LHCC**	**CHS**	**UHC**
Proactive Choice Enrollments	12,742	17,479	13,367	23,401	39,355
Auto Enrollments	12,480	12,581	11,511	13,431	13,645
Total Enrollments (2013)	**25,222**	**30,060**	**24,878**	**36,832**	**53,000**
Choice Rate	51%	58%	54%	64%	74%

Source: Maximus Health Services

10 Payments to Health Plans

Payments to Bayou Health plans are made monthly for services provided during that month. Both capitation payments and monthly management fees are determined with assistance from DHH's contracted actuary, Mercer. In addition to the monthly capitation payments, also called the per-member per-month (PMPM) payments, prepaid plans receive a supplemental, one-time, fixed payment referred to as a kick payment for each delivery billed by hospitals. This payment is intended to reimburse for the costs associated with newborns. The following factors are considered in determining the PMPM for a member and account for the differences in average PMPM:

- age,
- gender,
- geographic region of residence,
- eligibility group, and
- the plan's risk score.[1]

In calendar year 2013, over $1.4 billion was paid to the five Bayou Health plans. These payments represent 18.7 percent of all Louisiana Medicaid payments for health care services ($7,691,528,982 CY13). The remaining 72.3 percent of Medicaid expenditures represent payment to providers for services to members enrolled in the shared savings plans; Medicaid enrollees excluded from Bayou Health, such as individuals receiving long term supports and services; services excluded from Bayou Health; and supplemental payments to providers.

Nearly 96 percent of the $1.4 billion of Bayou Health payments went to the three prepaid plans, which are directly responsible for payment of enrollee claims. The remainder of the $1.4 billion, approximately $59 million, excluding shared savings payouts, was paid to the two entities operating plans under the shared savings model, which are directly responsible for only primary care case management and the pre-processing of enrollee claims.

---

[1] Payments are risk adjusted to account for significant differences in the acuity level of the plan's membership

On an average per-member per-month basis, the prepaid plans ranged from $246 to $276. Variation in the average PMPM rate reflects differences in enrollment mix and risk adjustment across health plans. The prepaid plans with a larger share of enrollment from higher cost eligibility groups will have a higher average per-member per-month payment, and vice-versa. Similarly, health plans with higher risk scores will also have higher average per-member per-month rates. Risk scores reflect the health status of total plan membership. A risk score of 1.0 reflects a membership of average health. A risk score of greater than 1.0 reflects a membership with greater health needs than the average. A risk score below 1.0 reflects a membership healthier than the average. Risk adjustment applies risk scores to a universal PMPM rate to compensate plans for the relative financial risk of their membership.

The two plans operating under the shared savings model each had average per-member per-month payments of approximately $11. This rate consistency reflects universal monthly care management fees for each enrolled member that are not risk-adjusted. More detailed figures, including monthly payments to health plans, can be found in Appendix IV: Total and Average per Member per Month Payment to Each Plan by Month.

Table 10: Total and Average per Member per Month Payment to Each Plan Based on Date of Payment

	Prepaid Plans			**Shared Plans**	
	AMG[1]	**AHC**[1]	**LHCC**[1]	**CHS**[2]	**UHC**[2]
Total Payments*	$417,750,578	$492,018,422	$462,759,259	$26,131,514	$32,960,967
Average PMPM Payment	$264.25	$276.65	$247.14	$11.00	$11.06

Source: Management and Administrative Reporting Subsystem (MARS) Data Warehouse
* Does not include enhanced Affordable Care Act (ACA) Enhanced Reimbursement for primary care at 100 percent of Medicare rate in CY 2013 for January through October due to delay in rate development and implementation.
1. Prepaid November 2013 includes manual check for ACA Reimbursement issued 11/12/2013
2. Does not include shared savings payouts

11 Medical Loss Ratios (MLRs) and Related Refunds

Bayou Health Plans that receive capitation payments to provide benefits and services to Louisiana Medicaid members are required to rebate a portion of the capitation payment to DHH in the event the plan does not meet the 85 percent medical loss ratio (MLR) standard. Bayou Health contracts require that a minimum of 85 percent of payments made by DHH for Louisiana Medicaid members be used to reimburse providers for services and certain specified purposes related to quality improvement and health information technology costs.

Health plans are required to submit annual medical loss ratio (MLR) reports, which are based on a calendar year, by June 1 of the following year that summarize how the capitation payments received from DHH were spent. The methodology established by DHH for calculation of the annual MLR reports is adapted from the CMS methodology established in 2011 for calculating MLR by commercial health plans. This methodology may differ from the methodology used by health plans in quarterly filings to the Department of Insurance and shareholders as well as the quarterly MLR Report submitted to DHH for financial analysis.

Because of the phase-in of Bayou Health in CY 2012, the first annual MLR reports were required from health plans for CY 2013. All were received prior to the June 1, 2014 deadline.

If a health plan does not meet the MLR requirement, it is required to pay a rebate to the Department of Health and Hospitals. In 2013, all three prepaid plans had MLRs above the 85 percent minimum requirement and did not pay any rebates. Louisiana Healthcare Connections had the lowest Medical Loss Ratio at 87 percent, and Amerigroup Louisiana had the highest at over 91 percent. For more detail, refer to Table 11 and the Medical Loss Ratio reports from each managed care organization in the appendices on the following page:

Appendix V: Amerigroup Louisiana Medical Loss Ratio Report

Appendix VI: AmeriHealth Caritas Louisiana Medical Loss Ratio Report

Appendix VII: Louisiana Healthcare Connections Medical Loss Ratio Report

Table 11: Medical Loss Ratios by Managed Care Organization

	AMG	**AHC**[1]	**LHCC**
Adjusted Current YTD MLR Capitation Revenue	$410,503,648	$749,618,771	$452,041,901
Total Adjusted MLR Expenses	$374,776,252	$680,825,137	$394,509,378
MLR Percentage Achieved	91.3%	90.8%	87.3%
Percentage below 85% Requirement	0%	0%	0%
Dollar Amount of Rebate Requirement	$0	$0	$0

Source: Bayou Health Report #019 (Medical Loss Ratio)
1. Figures for period beginning 2/1/2012 through 12/31/2013

As required by the Bayou Health Administrative Rule, the MLR reports are being independently audited, and the audited reports will be posted on the Medicaid website within 60 days of completion of the audit. Audit completion is expected on or about March 31, 2015.

12 Health Outcomes

The Bayou Health plan contracts require health plans to track 37 performance measures of quality of care and report results to the Department of Health and Hospitals. The measures include standardized measures from the following measurement sets:

- Healthcare Effectiveness Data and Information Set (HEDIS®), which are maintained by National Committee for Quality Assurance (NCQA);
- Prevention Quality Indicators (PQI), which are maintained by the Agency for Healthcare Research and Quality (AHRQ) and
- The Core Set of Children's Health Care Quality Measures from the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), which are maintained by the Center for Medicaid and CHIP Services (CMCS).

Many standardized performance measures require continuous enrollment in a health plan for a specified time period (either 12 months or 24 months), and the majority of information is extracted from claims that are often submitted several months or longer following the date of service. NCQA requires that HEDIS® performance measures to be audited prior to public reporting, and they are generally made available to the public in the fall for the previous calendar year. HEDIS® measures below represent performance in CY 2013, which is the first year of Bayou Health for which most HEDIS® measures could be calculated as any plan must have sufficient experience with the members before doing so.

The 37 quality measures on which Bayou Health plans report include the standardized performance measures required in the Act 212 Bayou Health Transparency Report.

Three of the measures for monitoring health care quality in Bayou Health are Prevention Quality Indicators (PQIs). PQIs are a set of measures established by the Agency for Healthcare Research & Quality (AHRQ) that can be used with hospital discharge data to measure the quality of care for "ambulatory care sensitive conditions."

The relevance of PQIs for Bayou Health is that good outpatient care for such conditions can potentially eliminate the need for hospitalization. Early intervention can also prevent complications or more severe manifestations of such diseases. Even though these indicators are based on hospital inpatient data, they provide insight into the availability of high-quality, community-based primary care. For example, the hospitalization of patients for complications associated with diabetes may be prevented if their conditions are adequately monitored or if they receive the patient education needed for appropriate self-management.

Some factors that can lead to hospitalization, such as poor environmental conditions or lack of patient adherence to treatment recommendations, are outside the direct control of the Bayou Health plans. However, the PQIs provide a good starting point for assessing the quality of the health services provided by the plans. They assist in identifying the impact of chronic care management programs for asthma, diabetes and congestive heart failure and how well patients avoid complications from a number of common conditions that would otherwise require hospitalization.

The AHRQ prevention quality indicators reported to the Department are below.

- Asthma in Younger Adults Admission Rate
- Congestive Heart Failure Admission Rate
- Diabetes Short-Term Complications Admission Rate

Twenty-seven of the Bayou Health performance measures are defined in the Healthcare Effectiveness Data and Information Set (HEDIS®). HEDIS® is a widely used set of performance measures maintained by the National Committee for Quality Assurance (NCQA). NCQA defines a performance measure as “a set of technical specifications that define how to calculate a ‘rate’ for some important indicator of quality.” HEDIS® was designed to allow for comparison of a health plan’s performance to other plans and to national or regional benchmarks. Although not originally intended for trending, HEDIS® results are increasingly used to track year-to-year performance and improvement.

HEDIS® data are collected from claims for hospitalizations, medical office visits and procedures, medical charts and surveys. Survey measures, such as member satisfaction, must be conducted by an NCQA-approved external survey organization.

Clinical measures use the administrative data collection methodology as specified by NCQA. Administrative data are electronic records of services, including claims and registration systems from hospitals, clinics, medical offices, pharmacies and labs.

NCQA HEDIS® measures reported to the Department are listed below.

- Adult Access to Primary/Preventive Care
- Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
- Childhood Immunization Status (Combination #3)
- Breast Cancer Screening Rate

Adult Access to Primary/Preventive Care is a measure of Access/Availability of Care. Well Child Visits is a measure of Utilization & Relative Resource Use. Childhood Immunization Status and Breast Cancer Screening Rate are measures of Effectiveness of Care. The immunization measure requires health plans to identify two-year-old children who have been enrolled for at least a year. The plans report the percentage of children who received specified immunizations. Plans may collect data for this measure by reviewing claims or automated immunization records, such as the Louisiana Immunization Network for Kids Statewide (LINKS) system maintained by the DHH Office of Public Health, but this method will not include immunizations received at Federally Qualified Health Centers (FQHCs), as they bill an all-inclusive encounter rate.

Plans are allowed to supplement claims data for the Childhood Immunization Status measure by selecting a random sample of the population and supplementing claims data with data from medical records, but they are not required to do so. When choosing this option, plans may identify additional immunizations and report more favorable and accurate rates. However, this hybrid method is more costly and time-consuming and requires nurses or other authorized personnel to review confidential medical records. It is important to note any differences in HEDIS® scores due to differing levels of investment by the plan in using hybrid methods.

Table 12 compares health outcomes across the five health plans. Health outcomes varied across plans but were not consistently better or worse for any particular plan. The younger-adult asthma admission rate was lowest in the UnitedHealthcare Community Plan of Louisiana, and both shared savings plans had the lowest

congestive heart failure admission rates. The plan with the highest percentage of adults with access to preventative or ambulatory health services was UnitedHealthcare Community Plan of Louisiana. AmeriHealth Caritas Louisiana had the highest breast cancer screening rate, and Community Health Solutions of Louisiana had the highest percentage of well child visits.

Table 12: Health Outcomes by Plan

	Prepaid Plans			Shared Plans	
	AMG	**AHC**	**LHCC**	**CHS**	**UHC**
Asthma In Younger Adults Admission Rate[1,2,3]	7.45	12.70	6.25	7.86	4.81
Congestive Heart Failure Admission Rate[1,2,4]	45.09	44.61	38.23	22.44	32.97
Diabetes Short-Term Complications Admission Rate[1,2,4]	25.36	17.05	21.90	15.96	15.59
Adult Access to Preventative / Ambulatory Health Services	81.5%	83.4%	82.9%	82.6%	86.1%
Breast Cancer Screening Rate[5]	51.2%	57.1%	52.4%	49.1%	51.9%
Well Child Visits[6]	45.3%	56.0%	53.0%	66.4%	57.1%

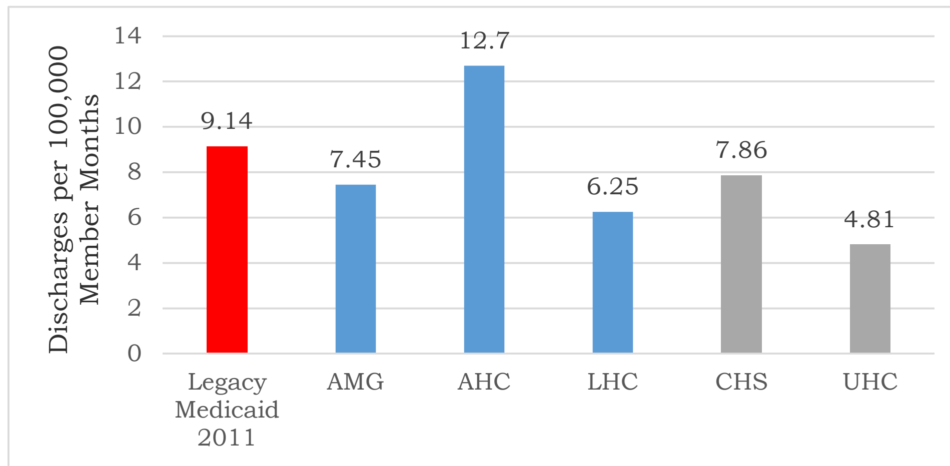
Source: 2014 HEDIS® (Jan 1-Dec 31, 2013 Measurement Year)

1. Rate per 100,000 Member Months
2. Differences in the lag time for the plans submitting encounter claims could impact the rates for 2013.
3. Age is greater or equal to 18 at beginning of year and less than or equal to 39 on 15th of each month.
4. Rate is reported for members ages 18 to 64.
5. The age range changed from 40-69 to 50-74 and the continuous enrollment criteria changed from the measurement year and the year prior to the measurement back to October 1 of two years prior.
6. Stricter PCP definition excludes claims where the servicing provider is not an identifiable PCP. This excludes clinic or group practices, KIDMED, Children's Choice Waiver, and FQHC/Regional Health Center (RHC) settings if PCP was not identified as servicing provider. This measure may be under-reported for Louisiana Medicaid as some PCP visits may be excluded due to group billing.

When comparing health outcomes across the five plans, it is important to note that the majority of members chose their own health plan. There is a potential that fewer healthy members systematically chose one plan or one model over another, i.e., prepaid versus shared savings. This possible selection bias should be taken into consideration when comparing the health outcomes of individual plans.

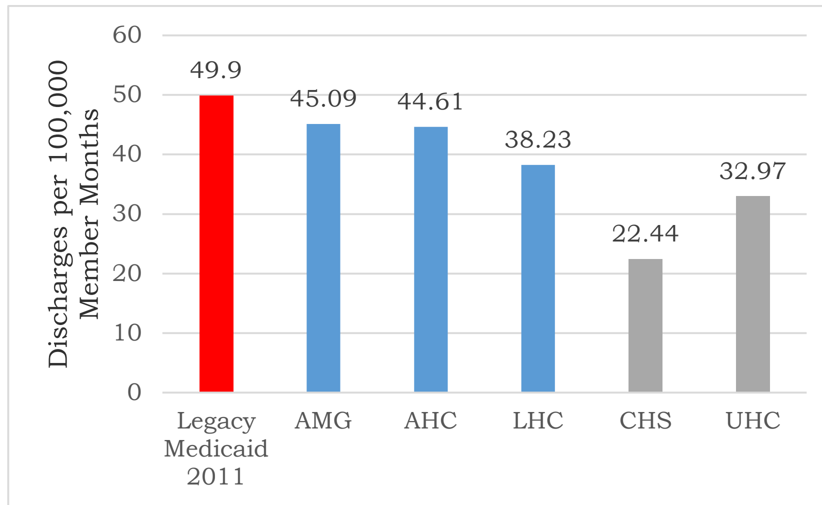
Figures 12.1 through 12.7 below provide a comparison of health outcomes in calendar year 2011 under Legacy Medicaid to outcomes in calendar year 2013 under each of the five Bayou Health plans. Asthma is a common and growing health issue for adults. Data from the National Health Interview Survey (NHIS), 2009 show that a total of 39,930,000 people ages 18 years and older in the U.S. reported an asthma diagnosis between 2008 and 2009. Asthma is one of the most common reasons for hospital admission and emergency room care. Nonetheless, it is widely accepted that most cases of asthma could be managed with proper ongoing therapy on an outpatient basis. The admission rates for asthma in younger adults (Figure 12.1) and congestive heart failure (Figure 12.2) have both decreased when comparing aggregate performance under Bayou Health in the 2013 measurement year to performance under Legacy Medicaid in the 2011 measurement year. Data for the prevention quality indicators were independently extracted from the claims and encounters by DHH. The technical specifications used in this calculation are based on the CMS Medicaid Adult Core Set.

Figure 12.1: Asthma in Younger Adults Admission Rate



Source: MARS Data Warehouse: Number of discharges for asthma per 100,000 member months for Medicaid enrollees age 39 and younger.

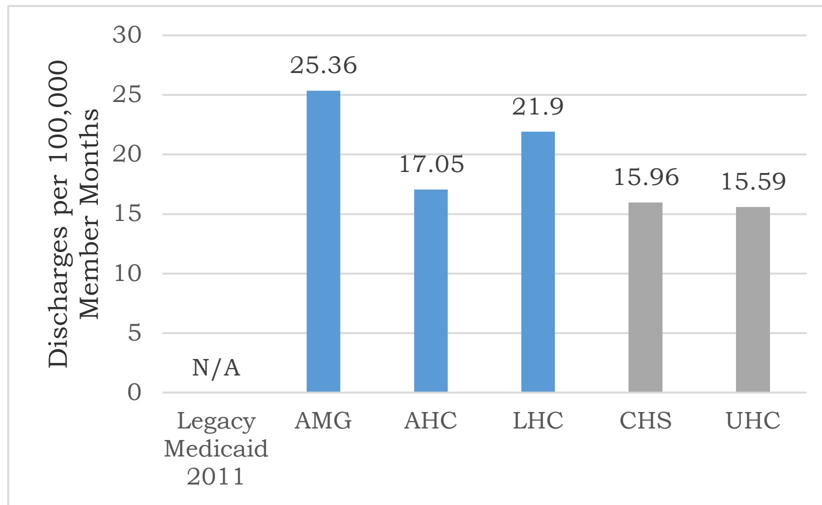
Figure 12.2: Congestive Heart Failure Admission Rate



Source: MARS Data Warehouse: Number of discharges for CHF per 100,000 member months for Medicaid enrollees age 18 and older.

The admission rate for short-term diabetes complications (Figure 12.3) measures the number of discharges for short-term complications of diabetes (ketoacidosis, hyperosmolarity or coma) per 100,000 member months for Medicaid enrollees age 18 and older. This measure is new to the CMS Adult Core Set of Health Care Quality measures. Therefore, no data were available from 2011. Higher admission rates attributed to the prepaid plans are indicative of their older membership with a higher prevalence of diabetes.

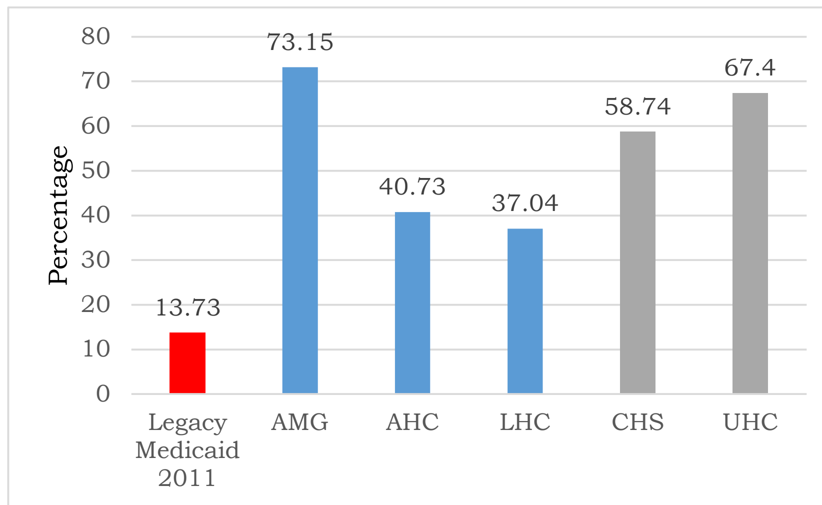
Figure 12.3: Diabetes Short-Term Complications Admission Rate



Source: MARS Data Warehouse: Number of discharges for diabetes short-term complications per 100,000 member months for Medicaid enrollees age 18 and older.

A key indicator of the continuity of primary care is whether children are up to date on their immunizations by age two. The CDC recommends the following immunizations by age two: four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three or four H influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines. The childhood immunization status (Figure 12.4) measure includes 10 rates for the individual vaccines and nine combination rates. The most common combination rate reported by states is "combination 3," which includes all of the vaccines except HepA, RV, and flu and requires at least two HiB vaccines by age two. As previously noted, electronic immunization data compiled by the Office of Public Health may be used to supplement claims data for this measure. The variability among reported results by plan suggests that some plans used supplemental immunization data while others relied on claims. Legacy Medicaid relied only on claims data for measurement year 2011.

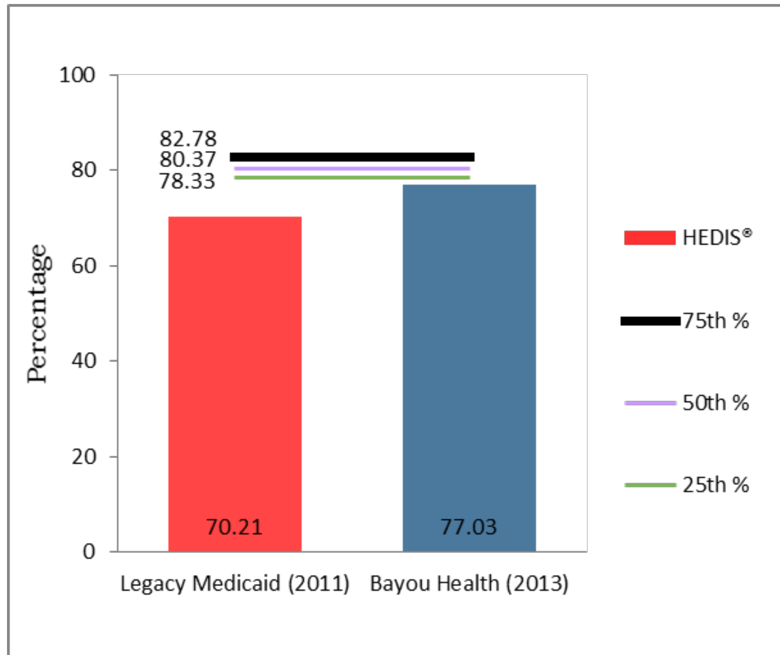
Figure 12.4: Childhood Immunization Status (Combination 3)



Source: 2012 and 2014 HEDIS®

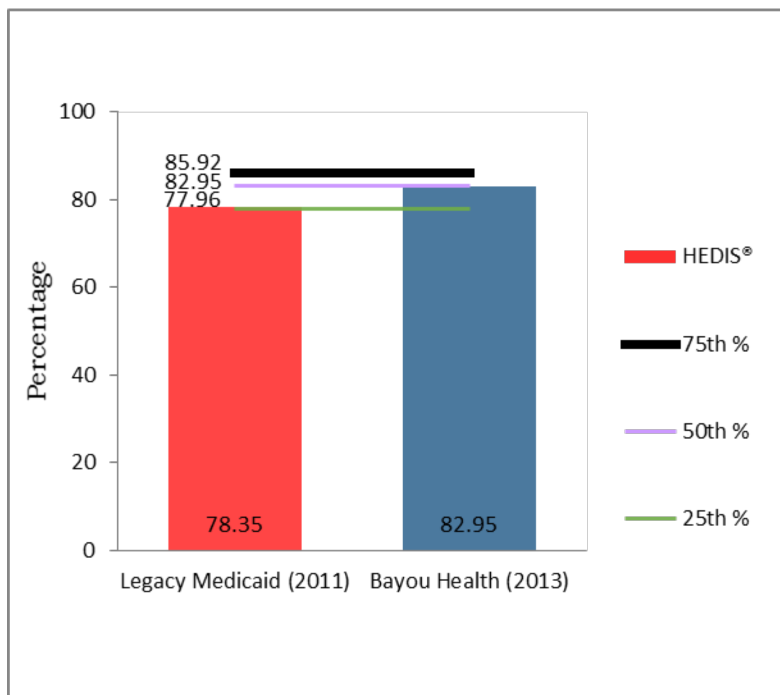
The three figures below show aggregate Bayou Health performance in the 2013 measurement year compared to 2011 performance in Legacy Medicaid. All of these measures are part of the Healthcare Effectiveness Data and Information Set (HEDIS®) and are frequently included in Medicaid managed care contracts for monitoring the quality of care provided to Medicaid enrollees receiving care through MCOs. In addition, these measures are calculated primarily using Medicaid administrative data and do not require medical record review. For comparative purposes the 25th, 50th, and 75th regional percentiles are included. The regional data presented below corresponds to the U.S. Census Southern Central region and pertains only to Medicaid HMO products reporting to the National Committee for Quality Assurance database. Data for the Breast Cancer Screening Rate of Bayou Health recipients could not be included in this year's report due to continuous eligibility requirements.

Figure 12.5: Comprehensive Diabetes Care (Hemoglobin A1c Testing)



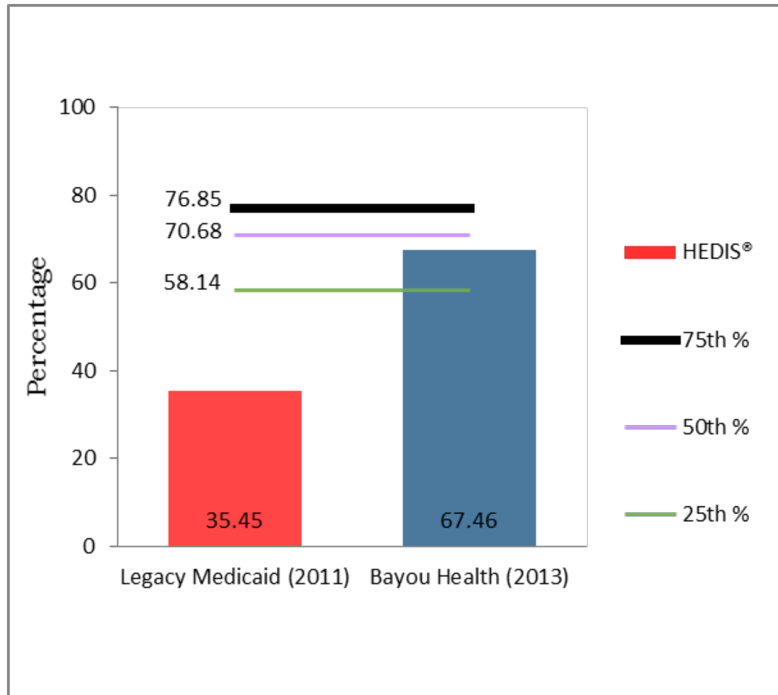
Source: 2012 and 2014 HEDIS®

Figure 12.6: Adults' Access to Preventive / Ambulatory Health Services



Source: 2012 and 2014 HEDIS®

Figure 12.7: Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life



Source: 2012 and 2014 HEDIS®

14 MEMBER AND PROVIDER SATISFACTION SURVEYS

Member and provider satisfaction are measures of a patient's experience of care. Member satisfaction with their health care, which is considered an important component in managed care quality, can be defined as how members value and regard their care. Member satisfaction data can be used by DHH as well as health plans to improve services.

Member satisfaction surveys are questionnaires that are used to determine overall level of satisfaction with the health plan and its providers. While an important tool in monitoring, a number of biases can affect the findings, such as non-response, the mode of administration, the timing of survey and the response format. To reduce bias and variation, Bayou Health contracts are precise in regard to the following:

- the survey instrument must be the most recent version of the Consumer Assessment of Healthcare Providers and Subsystems (CAHPS) at the time the survey is conducted;
- the survey on behalf of the Bayou Health plan must be administered by a vendor accredited by the National Committee for Quality Assurance (NCQA) to perform CAHPS surveys;
- separate surveys must be conducted and results reported for adults, children and children with chronic conditions; and
- topics included in survey must include getting needed care, getting care quickly, how well doctors communicate, health plan customer service and global ratings.

Health plans are required to submit an annual member satisfaction survey report within 120 days of January 31, which is the end of the plan year. Copies of each Bayou Health plan's survey for the plan year ending Jan. 31, 2014, are attached.

Bayou Health plans are required to conduct an annual survey of providers to determine the level of satisfaction and identify areas for improvement. The survey instrument, which must be approved by DHH along with the methodology, includes provider enrollment, education and complaints; utilization management processes;

claims processing and reimbursement; and, for PCPs, availability of technical assistance in creating patient-centered medical homes.

Copies of each health plan's member and provider satisfaction surveys are included in Appendices VIII through XXII of this report. In order to validate the information provided in these reports, Myers and Stauffer LC asked each health plan to explain the approach used to obtain the results. All five health plans use an independent, third-party NCQA-certified vendor to administer the CAHPS survey. CAHPS 5.0H measures of patient experience with health plans and providers are also collected by NCQA as part of its accreditation program.

Appendix VIII: Amerigroup Louisiana 2014 CAHPS Adult Medicaid Member Satisfaction Survey

Appendix IX: Amerigroup Louisiana 2014 CAHPS Child Medicaid with CCC Member Satisfaction Survey

Appendix X: AmeriHealth Caritas Louisiana 2014 CAHPS Adult Medicaid Member Satisfaction Survey

Appendix XI: AmeriHealth Caritas Louisiana 2014 CAHPS Child Medicaid with CCC Member Satisfaction Survey

Appendix XII: Louisiana Healthcare Connections 2014 Medicaid Adult CAHPS

Appendix XIII: Louisiana Healthcare Connections 2014 Medicaid Child with CCC CAHPS

Appendix XIV: Community Health Solutions of Louisiana 2014 CAHPS 5.0H Adult Medicaid Summary Report

Appendix XV: Community Health Solutions of Louisiana 2014 CAHPS 5.0H Child Medicaid with Chronic Conditions Report

Appendix XVI: UnitedHealthcare of Louisiana, Inc. 2014 HEDIS®/CAHPS Health Plan Survey Adult Medicaid Version

Appendix XVII: UnitedHealthcare of Louisiana, Inc. 2014 HEDIS®/CAHPS Health Plan Survey Child Medicaid with CCC Measure Version

Appendix XVIII: Amerigroup 2014 Provider Satisfaction Survey Report

Appendix XIX: AmeriHealth Caritas Louisiana 2014 Provider Satisfaction Survey Report

Appendix XX: Louisiana Healthcare Connections 2014 Provider Satisfaction Report

Appendix XXI: Community Health Solutions of Louisiana 2014 Provider Satisfaction Survey Report

Appendix XXII: UnitedHealthcare Community Plan 2014 Provider Satisfaction Survey Report

15 Audited Financial Statements

Financial statements are an important tool for financial oversight of Medicaid managed care entities. They provide important information for assessing a company's financial condition, including but not limited to profitability and solvency. The Securities and Exchange Commission (SEC) requires that all publicly held entities must file audited annual financial statements. Most Bayou Health plans are publicly held. Audits independently evaluate whether a company's financial statements are prepared in accordance with generally accepted accounting principles (GAAP) and present a fair picture of the financial position and performance of the company.

Further, prepaid Bayou Health plans are required have a license or certificate of authority issued by the Louisiana Department of Insurance (DOI) to operate as a Medicaid risk-bearing entity pursuant to Title 22:1016 of the Louisiana Revised Statutes.

Copies of each Health Plan's audited financial statements are included below:

Appendix XXIII: Amerigroup Louisiana, Inc. Audited Financial Statement

Appendix XXIV: AmeriHealth Caritas Louisiana Audited Financial Statement

Appendix XXV: Louisiana Healthcare Connections, Inc. Audited Financial Statement

Appendix XXVI: Community Health Solutions of Louisiana Plan Audited Financial Statement

Appendix XXVII: UnitedHealthcare of Louisiana, Inc. Audited Financial Statement

16 SAVINGS FROM SHARED SAVINGS PLANS

DHH contracted with Mercer Government Human Services Consulting to perform savings calculations for the Bayou Health shared savings plans. The shared savings plans are measured against a benchmark selected by DHH from a range of estimates developed by Mercer according to actuarial principles and guidelines. These benchmarks are intended to represent an unmanaged fee-for-service population experience and are based on historical fee-for-service experience prior to the implementation of Bayou Health. The benchmarks include adjustments for trends, program changes and fee schedule changes, and are also adjusted for acuity (risk scores). The shared savings plans are not at risk for the claims cost, which are paid by DHH, but are incentivized to manage care so that costs come in under these estimates. Shared savings plans are paid an enhanced primary care case management (ePCCM) fee upfront on a per-member basis. If costs exceed the benchmarks, shared-savings plans forfeit up to 50 percent of the ePCCM fees collected. Conversely, shared savings plans may earn up to 60 percent of any savings achieved by comparison to the benchmark. *(Note: More granular detail of the benchmark setting process is included in the benchmark development letters provided by Mercer to DHH with every benchmark issuance, including details on trends and program changes.)*

Mercer calculates the shared savings payments based on paid claims data and assumes that claims will continue to be submitted for six months following the date on which the service was actually provided. Analyzing claims prior to the six-month period allowable for payment would be premature and not identify all of the services that were received by members during the period being reviewed. These calculations use actual claims data and are compared to the benchmarks derived from the projected amount DHH would have spent in the absence of managed care for the same time period. Payments are made on an interim basis and later finalized. To date, only the interim savings payments have been determined for the first period (calendar year 2012). Mercer and DHH intend to make the final determination for the first period and the interim determination for the second period (calendar year 2013) by the end of state fiscal year 2015.

Based on the interim determination of the shared savings for the 2012 calendar year, the shared savings plans were eligible for $7,505,696 in savings payments. Seventy-five percent of that amount was distributed to the plans as shown below.

- December 4, 2013 - Payment of $4,519,202 made to Community Health Solutions
- April 8, 2014 - Payment of $1,110,070 made to UnitedHealthCare

The final determination for the first period and the interim determination for the second period (calendar year 2013) are in progress and should be completed by the end of SFY 15. The savings calculations are described in detail in a report included as Appendix XXVIII: Louisiana Shared Savings Program Interim Savings Determination for Program Year 1.

17 Sanctions Levied against Health Plans

To ensure the successful operation of the Bayou Health program, DHH monitors each plan and may apply administrative actions or monetary penalties if it is determined that a health plan is deficient or noncompliant with contract requirements. DHH's contracts with the health plans specify the factors that are to be considered when determining whether financial penalties should be assessed. DHH weighs each factor and applies the available penalties accordingly. As per Section 20.2.2 of Exhibit E in the Bayou Health contract, the following aspects are to be considered:

- the duration of the violation;
- whether the violation or one that is substantially similar has previously occurred;
- the CCN's history of compliance;
- the severity of the violation and whether it imposes an immediate threat to the health or safety of the Medicaid members; and
- the good faith exercised by the CCN in attempting to stay in compliance.

During calendar year 2013, three sanctions were levied against Bayou Health plans, two against AmeriHealth Caritas Louisiana and one against UnitedHealthcare Community Plan of Louisiana.

AmeriHealth Caritas Louisiana was assessed a $170,000 penalty on June 18, 2013 for noncompliance with the requirement to submit a monthly claim-level detail file of pharmacy encounters to DHH. The penalty was assessed according to the contract at $10,000 per day of noncompliance beginning March 4, 2013, and lasted for a period of 17 calendar days.

Again on July 16, 2013, AmeriHealth Caritas Louisiana was assessed a $240,000 penalty for failure to meet the requirement to submit 95 percent of its encounter data submissions at least monthly and no later than the 25th calendar day of the month following the month in which the claims were processed, approved or paid. The

penalty was assessed according to the contract at $10,000 per day of noncompliance beginning April 2, 2013, and lasted for a period of 24 calendar days.

In January 2013, DHH notified UnitedHealthcare Community Plan of Louisiana that it was taking action against the plan for failure to maintain an automated management information system for accepting provider claims, verifying eligibility, validating prior authorization, pre-processing claims and submitting claims data to DHH. UnitedHealthcare Community Plan of Louisiana submitted a plan of corrective action in February 2013 and was in full compliance by June 2013. A monetary penalty of $140,700 was paid by the plan in June 2013.

18 Grievances and Appeals

Bayou Health enrollees have the right to file grievances and appeals with both the health plan and with the State if they believe they have been unfairly denied benefits or access to services. Federal law requires MCOs to administer a system for members to file grievances and appeals, and all states are required to review MCO reports on both the frequency and nature of grievances filed as well as the steps MCOs take to remedy such grievances. States must also provide an opportunity for a fair hearing to members whose grievance or appeal is either denied or not promptly acted upon by the MCO.

An appeal, which must be acted on within 30 days, is a request by a member to review one of the following actions that a health plan has taken:

- denying or partially denying a requested service, including type or level of service;
- reducing, suspending or terminating a previously authorized service;
- denying, in whole or in part, payment for a service;
- failure to provide services in a timely manner (as defined by the State); and
- failure to act within 90 days on a grievance.

In contrast, a grievance means an expression of dissatisfaction about any matter other than one of the above actions. Examples of subjects for grievances include, but are not limited to, the quality of care or services provided; aspects of interpersonal relationships, such as rudeness of a provider or employee; or failure to respect the member's' rights. As stated above, the failure of a plan to act within 90 days of a member's grievance is an appealable action.

As part of their quality strategy, states must require health plans to maintain records of grievances and appeals and submit them for state review. In reviewing the records, DHH analyzes the subjects of the plan's grievances and appeals to identify the extent to which they are valid and/or are in the actual control of the health plan. For example, Community Health Solutions' reports indicate that the largest percentage of grievances by their members were related to the non-emergency medical transportation program, which was not in their purview and over which they had no

control. Health plans and DHH both look for trends and use the reports to determine the need for operational changes and improvements.

Table 18: Number of Members Who Filed a Grievance or Appeal and the Number of Members Who Accessed the State Fair Hearing Process

	AMG	**AHC**	**LHCC**	**CHS**	**UHC**
Grievances	604	639	167	716	188
Appeals	1,080	189	535	0	0
Appeals Reversed at Plan Level	132	70	424	NA	NA
Percentage of Appeals Reversed at Plan Level	12.2%	37.0%	79.3%	NA	NA
State Fair Hearing Process Accessed	14	16	10	14	18
Number of Appeals Reversed at State Level	0	0	0	0	1

Source: Bayou Health Report #'s114 & 117 (Grievance, Appeal and Fair Hearings)
NA – Not Applicable

The figures in Table 18 were submitted to DHH by the health plans in Bayou Health Reports 114 and 117. In order to validate the information reported by the health plans, Myers and Stauffer LC asked each plan to provide their definition of a grievance and an appeal. Additionally, each plan was asked to describe how grievances and appeals are tracked and what controls were in place to identify inaccuracies. MSLC found that the procedures indicated NCQA standards are followed for both grievances and appeals and that access to the State's fair hearing system comply with Federal Regulations at 42 CFR Part 438.

19 MEMBERS RECEIVING MEDICAID SERVICES

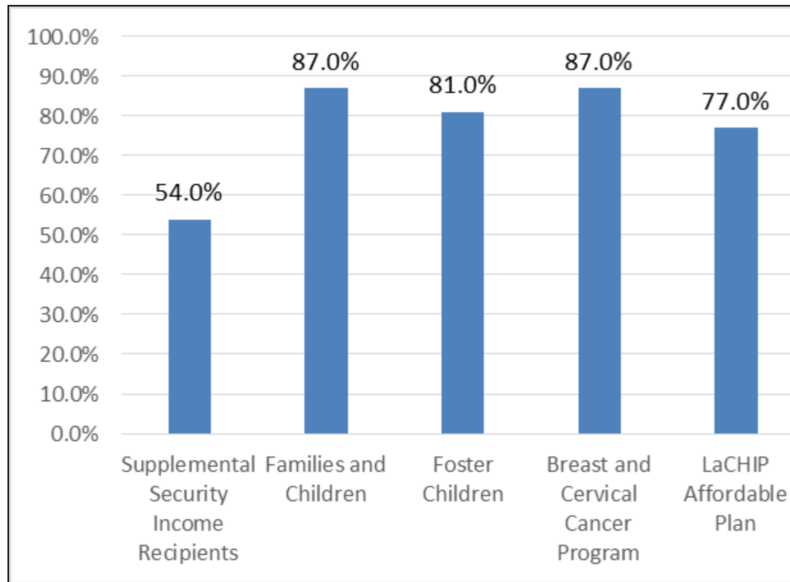
In monitoring the effectiveness and quality of the Bayou Health program, DHH tracks utilization of core benefits and services, i.e., the extent to which enrollees use a Bayou Health Medicaid service in a specified period, such as within a given month or year. Section 19 provides information on Medicaid services provided under Bayou Health. Table 19.1 shows unduplicated counts of the number of members receiving services by provider type and plan. Data are representative of paid and adjusted claims and exclude denied claims. In the prepaid plans, physicians and pharmacies were the two provider types from which members most frequently received services. Physicians were also the top providers under the shared savings model. The information presented in Tables 19.1 and 19.2 is based on plan membership. As the data show, members of a shared savings plan received pharmacy services, but it is important to note the services were delivered by Louisiana Medicaid fee-for-service program and were not under the purview of the shared savings plans.

Table 19.1: Number of Members Who Received Unduplicated Medicaid Services by Provider Type and Plan

Provider Type	AMG	AHC	LHCC	CHS	UHC
Ambulatory Health Care Facilities	43,714	28,648	24,283	20,897	24,657
Hospitals	87,061	96,138	99,386	119,158	165,093
Laboratories	37,089	42,584	49,592	63,388	77,513
Nursing Service Providers	12,854	14,015	13,023	28,476	34,725
Physician Assistants and Advanced Practice Nursing	37,502	53,622	52,237	84,259	82,121
Physicians	116,219	138,964	139,822	182,744	236,314
Pharmacies	113,871	131,184	129,933	174,885	223,269
Other Service Providers	68,526	75,511	86,643	117,600	149,475
Durable Medical Equipment, Prosthetics and Orthotics Suppliers	4,027	5,006	5,206	4,874	6,883
Transportation Services	10,762	14,528	14,838	12,086	16,699

Source: Management and Administrative Reporting Subsystem (MARS) Data Warehouse
NA – Not Applicable

Figure 3 Member Utilization by Eligibility Group



Source: Management and Administrative Reporting Subsystem (MARS) Data Warehouse

Figure 3 provides a summary of utilization by eligibility for Bayou Health enrollees derived by dividing the total number of members who received at least one service for which there is a paid record by the total number of enrollees. Specifically, paid claims included services paid through the fee-for-service program to reflect utilization of enrollees in a shared savings plan since such plans are responsible for coordinating services but are not responsible for payment.

Table 19.2 lists the number of members receiving services by the place of service. Across all plans, the largest number of members received services at doctors' offices. Hospital emergency rooms and outpatient hospitals were two other places where many members were receiving services.

Appendix XXIX provides the number of members receiving unduplicated Medicaid services by provider specialty[1] and plan. The largest number of members received Medicaid services from pediatricians. Other major specialties with large number of members receiving services included radiology, family practice and general practice. Appendix XXIX: Number of Members Who Received Unduplicated Medicaid Services by Provider Specialty and Plan

[1] Specialties are limited to the physician provider type.

Table 19.2: Number of Members Who Received Unduplicated Medicaid Services by Place of Service and Plan

Place of Service	AMG	AHC	LHCC	CHS	UHC
Ambulance - Air	57	68	75	0	1
Ambulance - Land	7,794	8,768	13,043	9	27
Ambulatory Surgical Center	759	1,179	1,144	2,219	2,483
Birthing Center	17	12	3	18	7
Comprehensive Inpatient Rehab Facility	130	125	133	66	92
Comprehensive Outpatient Rehab Facility	6	14	30	13	17
Emergency Room - Hospital	62,145	69,784	72,915	77,583	97,527
End-Stage Renal Disease Treatment Facility	277	125	123	40	152
FQHC	8,035	10,035	9,516	6,941	6,637
Home	6,120	6,495	7,887	275	384
Clinic	566	774	539	889	1,387
Laboratory	29,788	40,533	46,338	49,942	62,111
Inpatient Hospital	20,854	23,533	22,864	22,438	33,062
Mobile Unit	39	34	39	28	45
Nursing Facility	67	164	151	84	171
Office[2]	108,191	126,020	129,662	172,303	212,611
Other Place of Service	4,204	7,233	1,994	1,125	1,821
Outpatient Hospital	41,895	44,157	42,066	43,334	64,332
Rural Health Clinic	15,759	16,937	18,933	16,671	18,936
Skilled Nursing Facility	23	41	42	17	30
State or Local Public Health Clinic	14,949	12,718	15,411	22,733	21,566
Urgent Care Facility	2,191	7,511	3,485	2,422	15,856

Source: Management and Administrative Reporting Subsystem (MARS) Data Warehouse

[2] Location other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF) where the health professional routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis.

20 MEMBERS RECEIVING OUTPATIENT EMERGENCY SERVICES

Section 20 provides information on the number of members receiving outpatient emergency services under the prepaid plan model by hospital classifications defined in Act 212 of the 2013 Legislative Session. Table 20 lists the number of members receiving unduplicated outpatient emergency services by hospital class and plan. Data are representative of paid, adjusted and denied claims. The majority of outpatient emergency services were provided at private hospitals across all three plans. AmeriHealth Caritas Louisiana had the largest number of members receiving outpatient emergency services, while Amerigroup had the smallest number of members. As with other data, wide variability is expected because the characteristic of a plan's membership impacts this number.

Table 20: Number of Members Who Received Unduplicated Outpatient Emergency Services by Hospital Class and Plan

Hospital Class	AMG	AHC	LHCC
State	1,482	5,126	1,471
Public (non-state, non-rural)	10,159	14,521	10,476
Rural	13,046	18,564	14,371
Private	37,378	40,556	45,129
Other/Out of State	1,214	7,106	3,171
Total[1]	**63,279**	**85,873**	**74,618**

Source: Management and Administrative Reporting Subsystem (MARS) Data Warehouse

[1] Members with multiple claims may be counted more than once where different hospital classifications exist. However, members are counted only once within each hospital classification.

21 INPATIENT MEDICAID DAYS

Table 21 provides information on the number of total inpatient Medicaid days for each prepaid plan by hospital classifications as defined in Act 212 of the 2013 Legislative Session. The large majority, approximately 80 percent, of inpatient Medicaid days were at private hospitals. AmeriHealth Caritas had the largest number of inpatient Medicaid days while Amerigroup had the lowest.

Table 21: Number of Total Inpatient Medicaid Days[1] by Hospital Class and Plan

Hospital Class	**AMG**	**AHC**	**LHCC**
	Total Days	Total Days	Total Days
State	510	446	326
Public (non-state, non-rural)	9,810	14,309	7,510
Rural	3,512	3,830	3,356
Private	59,019	73,669	64,668
Other/Out of State	888	2,946	3,077
Total	**73,739**	**95,200**	**78,937**

Source: Management and Administrative Reporting Subsystem (MARS) Data Warehouse
Defined as the number of days Medicaid paid for the inpatient stay (denied days are not included).

22 CLAIMS FOR EMERGENCY SERVICES

Section 22 provides information on claims for emergency services provided under the Bayou Health prepaid model. Table 22.1 gives the number of claims for hospital emergency services that were paid and the number of claims denied. Table 22.2 gives the number of claims for professional emergency services that were paid and the number of claims denied. In general, there were slightly more claims for hospital emergency services than there were for professional emergency services, and the proportions of claims denied versus paid were similar for both hospital and professional emergency services. Comparing plans, AmeriHealth Caritas Louisiana denied the largest proportion of claims in both groups while Louisiana Healthcare Connections denied the smallest proportion. The proportion denied did not vary much across plans for professional emergency services. However, the proportion of hospital emergency services denied ranged from under 5 percent for Louisiana Healthcare Connections to nearly 16 percent for AmeriHealth Caritas Louisiana.

Table 22.1: Number of Claims for Hospital Emergency Services Paid or Denied by Plan

	AMG	**AHC**	**LHCC**
Paid	160,845	127,127	141,624
Denied	17,811	23,318	7,041

Source: Management and Administrative Reporting Subsystem (MARS) Data Warehouse

Table 22.2: Number of Claims for Professional Emergency Services Paid or Denied by Plan

	AMG	**AHC**	**LHCC**
Paid	126,361	131,019	137,312
Denied	11,941	14,095	11,137

Source: Management and Administrative Reporting Subsystem (MARS) Data Warehouse

23 PHARMACY BENEFITS

Section 23 provides information on claims for pharmacy benefits under the Bayou Health prepaid model. Table 23 lists the total number of claims received, paid and denied by health plan for the entire calendar year. It also gives the number of claims subject to prior authorization and the number of claims subject to step-therapy or fail first protocols.

Table 23: Total Claims for Pharmacy Benefits in Calendar Year by Plan

	AMG	AHC	LHCC
Unduplicated Claims Received	3,543,995	2,896,939	2,243,066
Unduplicated Claims Paid	2,061,987	1,922,693	1,721,403
Unduplicated Claims Denied	832,937	755,545	521,663
Claims Subject to Prior Authorization	66,106	204,743	135,076[1]
Claims Subject to Step-therapy or Fail First Protocols	582,965	13,958	NR[1]

Source: Bayou Health Report #055 (Pharmacy Report)
[1]LHC's Pharmacy Benefits Manager does not capture this information independently from those claims subject to prior authorization. Total for claims subject to prior authorization include those that require step therapy or fail first protocols.

Refer to Appendices XXX through XXXII for the number of total claims for pharmacy benefits by month.

Appendix XXX: Amerigroup Louisiana, Inc. 2013 Pharmacy Report

Appendix XXXI: AmeriHealth Caritas Louisiana 2013 Pharmacy Report

Appendix XXXII: Louisiana Healthcare Connections 2013 Pharmacy Report

24 LA Health Works Commission Survey

In 2013, the Louisiana Health Works Commission conducted a study, the Health Occupations Outlook, assessing the workforce impact of upcoming demographic and policy changes in the healthcare industry. The study combined analysis of existing research with original surveys of Louisiana healthcare employers and midlevel providers. Although these surveys were primarily designed to ascertain the impact of changes in the healthcare industry on the future supply and demand of labor for midlevel providers, it offers a unique and timely measure of Medicaid recipients' access to care through the new Bayou Health plans. In particular, the 2013 Health Occupations Outlook included questions about Bayou Health in a survey of Louisiana healthcare organizations that employ midlevel providers, e.g., physician assistants, nurse practitioners, certified registered nurse anesthetists, clinical nurse specialists and certified nurse midwives. These organizations account for approximately 30 percent of all healthcare organizations in the state.

The Health Works Commission survey asked healthcare organizations to indicate with which Bayou Health plans they were affiliated. Table 24.1 provides estimates from the survey of the percentage of all healthcare organizations employing midlevel providers that are in each Bayou Health plan. The estimates are similar across plans, ranging from 51 percent of organizations for Amerigroup Louisiana to 57 percent for UnitedHealthcare Community Plan of Louisiana.

Table 24.1: Percentage of Healthcare Organizations that Accept Each Type of Bayou Health Insurance

	AMG	**AHC**	**LHCC**	**CHS**	**UHC**
Organizations in Plan	51%	55%	52%	52%	57%

Source: Louisiana Health Works Commission 2013 Health Occupation Outlook
1. LA Healthcare Organizations employing midlevel providers only

More importantly, the survey asked healthcare organizations if they were currently accepting new Medicaid patients. Table 24.2 provides estimates from the survey of the percentage of healthcare organizations employing midlevel providers and belonging to a particular plan that were accepting new patients. The survey results show that the overwhelming majority, over 90 percent, of providers in each plan were accepting new Medicaid patients. Again, there was little variation in the estimates across the five Bayou Health plans.

Table 24.2: Percentage of Healthcare Organizations[1] Accepting New Patients by Plan

	AMG	**AHC**	**LHCC**	**CHS**	**UHC**
Organizations Accepting New Patients	94%	93%	93%	94%	92%

Source: Louisiana Health Works Commission 2013 Health Occupation Outlook; LSU Analysis

1. LA Healthcare Organizations employing midlevel providers only