BAYOU HEALTH TRANSPARENCY REPORT

STATE FISCAL YEAR 2014

LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS
P.O. BOX 629
BATON ROUGE, LA 70821-0629
PHONE: (225) 342-9500
FAX: (225) 342-5568

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Introduction

This report is the third in a series produced by the Louisiana Department of Health to satisfy statutory reporting requirements intended to ensure the following outcomes are being achieved by Medicaid managed care programs:

- improved care coordination with patient-centered medical homes for Medicaid recipients;
- improved health outcomes and quality of care;
- increased emphasis on disease prevention and the early diagnosis and management of chronic conditions;
- improved access to Medicaid services;
- improved accountability with a decrease in fraud, abuse and wasteful spending; and
- a more financially stable Medicaid program.

The first and second reports included 23 measures as outlined in Act 212 of the 2013 Regular Legislative Session. The first report, submitted to the Legislature on January 2, 2014, covered July 2012 through June 2013 (State Fiscal Year 2013). The second report, submitted to the Legislature on December 31, 2014, covered January 2013 through December 2013 (Calendar Year 2013). The Department shifted the reporting periods, from State Fiscal Year (SFY) in the first report to Calendar Year (CY) in the second report, duplicating six months of the first report (January 2013 through June 2013). The shift in reporting periods provided for complete claims data given Act 212's requirement of annual transparency report submission by January 1 and Medicaid's timely filing policy which allows providers 365 days from the date of service to file a claim for payment.

Act 158 of the 2015 Regular Legislative Session modified reporting requirements for the transparency report, adding three new measures and clarifying the reporting period. This third report includes 26 measures, and it covers July 2013 through June 2014 (State Fiscal Year 2014), duplicating six months of the second report (July through December 2013). All measures are reported on a fiscal year basis, except the following measures which are reported on a calendar year basis per the contract between the Department and the health plans:

- Section 7 – Medical Loss Ratio
- Section 8 – Health Outcomes
- Section 9 – Member and Provider Satisfaction Surveys
- Section 10 – Audited Financial Statements
- Section 25 – Medicaid Drug Rebates

Act 158 provides sufficient time for complete claims reporting for a state fiscal year by shifting the due date for report submission from January 1 to June 30.

This report covers the original contracting period for the Medicaid managed care program (beginning February 1, 2012) which includes physical and basic behavioral health services provided by both full-risk managed care organizations, called prepaid health plans and referred to in this document as managed care organizations (MCOs), and plans serving as primary care case management (PCCM) entities, referred to as shared savings health plans.

Information included in this report was collected from multiple sources. The Medicaid Management Information System (MMIS) and the Management Administrative Reporting Subsystem (MARS Data Warehouse) are maintained by the Medicaid program's contracted fiscal intermediary, which in State Fiscal Year 2014 was Molina Healthcare. The MMIS contains detailed recipient and provider information and the MARS Data Warehouse contains claims payment information. The state

administrative system, called ISIS, is maintained by the Office of Technology Services within the Division of Administration and contains information on payments to health plans.

The provider registry is maintained by Molina and contains information submitted by the health plans or their contracted providers. The provider registry is updated weekly with new information overwritten onto older information, which limits the utility of the data to point-in-time information.

To the greatest extent possible, the data originate from state systems rather than the health plans. Where unavailable from state sources, data were collected from the health plans, sourced from either routine reporting deliverables or ad hoc reports requested specifically for this purpose.

Data included in this report were independently validated by Myers and Stauffer, an audit contractor of the Department. Myers and Stauffer reviewed for reasonability the data extraction code or process that the health plans or the Department used to generate data. For data originating from the MARS Data Warehouse or the MMIS, Myers and Stauffer generated its own data for each health plan and compared its results to the results the Department produced. For data originating from the health plans, Myers and Stauffer reviewed plan responses to a survey developed by Myers and Stauffer to document the process the plans used to generate the data, as well as policies and procedures in place to collect, track and report data. Where Myers and Stauffer found inconsistencies above or below the 10 percent variance threshold established by the Department, they made recommendations to the Department and/or the health plan to improve the method used to collect data. See Appendix 14.IX for the survey instrument. To ensure maximum reliability, subject matter experts within the Department and Myers and Stauffer also reviewed the data. In some cases, the health plans also reviewed data pulled on their plans by the Department for reasonability.

In addition, health plans' internal policies and procedures for collection of data were validated by the Department's contracted external quality review organization (EQRO), Island Peer Review Organization (IPRO), in conjunction with annual 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 these national accrediting bodies, which are rigorous processes involving comprehensive reviews of the plans' policies, procedures and practices.

Health Plans

During State Fiscal Year 2014, more than one million Louisiana Medicaid and Louisiana Children's Health Insurance Program (LaCHIP) enrollees received physical and basic behavioral health services through a managed care delivery system known as Bayou Health.

During State Fiscal Year 2014, Bayou Health contracts were comprised of two Medicaid managed care models as defined in federal regulations: managed care organizations (MCOs) and primary care case management entities (PCCM). Managed care organizations, also called prepaid health 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 operated statewide, were:

- 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 health plans in Louisiana, are paid a monthly management fee for each enrolled member in exchange for coordinating care for enrolled members. Shared savings health 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 health plans were 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 was "shared" with the entity. The two PCCM model Bayou Health plans, which operated statewide, were:

- Community Health Solutions (CHS)
- UnitedHealthcare Community Plan (UHC)

While shared savings health plans were responsible for service utilization for most Medicaid core benefits and services, the fee-for-service 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.

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 enrollee populations, 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. Certain health services are also excluded from Bayou Health core benefits and services.

In State Fiscal Year 2014, excluded Medicaid populations were 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; and
- enrollees in Section 1915(c) home and community based (HCBS) waivers or children and youth under age 21 on the waiting list for an HCBS waiver.

Services excluded from Bayou Health core benefits and services in State Fiscal Year 2014 include:

- long term services and supports;
- personal care services;
- hospice;
- applied behavioral analysis (ABA);
- services provided through the Department's Early Steps Program;
- nursing facility services;
- targeted case management;
- individualized education program (IEP) services;
- school nursing;
- dental; and
- specialized behavioral health[1].

[1] Louisiana provided specialized Medicaid behavioral health services through a single, prepaid inpatient health plan (PIHP) operated by Magellan.

1 HEALTH PLANS

The name of each managed care organization that has contracted with the Department of Health and Hospitals to provide health care services to Medicaid enrollees.

In State Fiscal Year 2014, the Department contracted with five companies to manage and provide health care services to the majority of Medicaid enrollees in Louisiana. Three were contracted as managed care organizations, or prepaid health plans, and two were contracted as shared savings health plans. The names and common abbreviations of the five Bayou Health plans are in Table 1.1 in alphabetical order by plan type:

Table 1.1: Names of health plans

Health Plan Name	Plan Type	Common Abbreviation
Amerigroup Louisiana, Inc.	Managed Care Organization	AMG
Amerihealth Caritas Louisiana, Inc. (Formerly AmeriHealth Mercy of Louisiana, a/k/a, LaCare)	Managed Care Organization	ACLA
Louisiana Healthcare Connections, Inc.	Managed Care Organization	LHCC
Community Health Solutions of America, Inc.	Shared Savings	CHS
UnitedHealthcare of Louisiana Inc.	Shared Savings	UHC

Source: Health plan contracts

2 HEALTH PLAN EMPLOYEES

The total number of employees employed by each managed care organization), based in Louisiana, and the average salary paid to those employees.

Managed care organizations and shared savings health plans have different contract requirements for Louisiana-based staff. However, both models require certain high level staff be domiciled in-state, such as the chief executive officer, medical director, maternal/child health coordinator, contract compliance officer, member management coordinator, provider services manager and others. For other positions, plans have the choice to staff locally or leverage parent company resources out of state, such as call center staff.

The health plans submitted the information in Table 2.1 in response to a survey the Department sent to all plans. The survey requested the position or title, salary, and percent of time allocated to the Louisiana contract for all Bayou Health staff domiciled in Louisiana. Using the information submitted, the Department calculated the total number of employees and average salary for four of the five plans. UnitedHealthcare provided only the list of position titles and the total average salary along with an attestation that the information was correct.

Variation among health plans exists in both number of employees and average salary of Louisiana-based employees. The plan type accounts for much of the difference, for example, shared savings health plans did not pay claims or have claims processing staff. However, there is also variation within the plan types. Variances in the average salary across plans largely reflect the mix of positions located in state. Some plans have a larger share of lower salary positions in state, such as call center staff, whereas others have a larger share of higher salary positions in state, such as clinical staff performing prior authorization functions. Illustrating these variances are the following examples. Louisiana Healthcare Connections has roughly twice the local staff of the other two managed care organizations. Louisiana Healthcare Connections employed 17 Louisiana-based member service representatives with an average salary of about $27,000, which neither of the other managed care organizations reported as in-state staff. This difference both increases the total number of staff domiciled in the state and reduces the average salary. The reason for the disparity in salary between the two shared savings health plans is harder to identify as specific salary information was not provided for UnitedHealthcare. However, UnitedHealthcare reported 12 local high-risk case managers on staff in addition to the nurse case managers. Similar positions were not reported as Louisiana-based staff by Community Health Solutions.

Table 2.1: Total number of Louisiana employees and average salary

	AMG	ACLA	LHCC	CHS	UHC
Total number of LA-Based Employees	113	116	228	41	72
Average Salary	$78,365.55	$61,231.01	$58,622.94	$66,951.81	$79,281.38

Source: MSLC Survey Results

3 PAYMENTS TO HEALTH PLANS

The amount of the total payments and average per member per month (PMPM) payment paid by the state to each managed care organization, delineated monthly.

Capitation payments and monthly care management fees are determined with assistance from the Department's contracted actuary, Mercer. In addition to the monthly capitation payments, also called per member per month (PMPM) payments, managed care organizations receive a supplemental, one-time, fixed payment referred to as a maternity kick payment for each delivery billed by hospitals. This payment is for the costs associated with newborns. Factors such as age, gender, geographic region of residence, eligibility group, and the plan's risk score are considered in determining the PMPM for a member and account for the differences in average PMPM.

Payments to the Bayou Health plans are made monthly for enrollment during the month of enrollment, e.g., payment for February enrollment was made in mid-February. In State Fiscal Year 2014, the Department paid $1,434,485,782 to the five Bayou Health plans. Over 95 percent of the $1.4 billion of Bayou Health payments went to the three managed care organizations, which are directly responsible for payment of enrollee claims. The remaining $66,798,786 was paid to the two entities operating plans under the shared savings model; the shared plans are directly responsible for primary care case management but not payment of enrollee claims.

As shown in Table 3.1, average PMPM payments to the managed care organizations ranged from $252.95 to $284.04. Variation in the average PMPM rate reflects differences in enrollment mix and risk adjustment across health plans. Managed care organizations with a larger share of enrollment from higher cost eligibility groups had a higher average PMPM payment, and vice-versa. Similarly, health plans with higher risk scores also had higher average PMPM 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 sicker than the average. A risk score of less than 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 health care needs of their membership. The two plans operating under the shared savings model each had average PMPM payments of $11.41 and $12.81. This rate reflected a universal monthly care management fee for each enrolled member that was not risk-adjusted.

More detailed figures, including monthly payments to health plans, can be found in Tables 3.2 and 3.3.

Table 3.1: Total payments and average PMPM for each plan

	AMG	ACLA	LHCC	CHS	UHC
Total Payments	$419,196,878	$490,185,277	$458,304,841	$31,176,010	$35,622,776
Average PMPM Payment	$ 272.54	$ 284.04	$ 252.95	$12.81	$11.41

Source: Unduplicated member counts came from the MARS Data Warehouse and total payments are from the state accounting system, ISIS.

Table 3.2: Managed care organization monthly total payments and average PMPM for each plan based on date of payment

	Total Payments	Average PMPM	Total Payments	Average PMPM	Total Payments	Average PMPM
	AMG		ACLA		LHCC	
July-13	$ 48,437,217	$ 374.88	$ 56,413,914	$ 388.46	$ 53,377,012	$ 348.36
Aug-13	$ 32,574,555	$ 252.36	$ 38,373,654	$ 263.97	$ 36,464,074	$ 238.28

Sep-13	$ 33,069,882	$ 256.10	$ 38,329,611	$ 263.70	$ 36,108,039	$ 236.54
Oct-13	$ 34,299,865	$ 264.96	$ 40,253,365	$ 276.26	$ 36,825,830	$ 241.03
Nov-13	$ 41,842,592	$ 324.81	$ 47,244,912	$ 324.75	$ 45,837,499	$ 301.10
Dec-13	$ 33,325,033	$ 258.66	$ 39,802,672	$ 274.17	$ 37,246,367	$ 244.91
Jan-14	$ 34,090,529	$ 267.62	$ 40,405,300	$ 282.19	$ 36,582,683	$ 243.13
Feb-14	$ 31,728,933	$ 249.45	$ 37,511,442	$ 262.90	$ 35,312,999	$ 236.22
Mar-14	$ 33,173,797	$ 259.90	$ 39,197,926	$ 274.57	$ 36,072,859	$ 241.14
Apr-14	$ 31,997,509	$ 252.75	$ 37,999,584	$ 269.43	$ 34,629,437	$ 233.28
May-14	$ 32,544,254	$ 254.92	$ 37,287,892	$ 262.74	$ 34,641,760	$ 231.98
Jun-14	$ 32,112,712	$ 252.63	$ 37,365,004	$ 263.43	$ 35,206,282	$ 237.02
Total	**$ 419,196,878**	**$ 272.54**	**$ 490,185,277**	**$ 284.04**	**$ 458,304,841**	**$ 252.95**

Sources: Unduplicated member counts came from the MARS Data Warehouse and total payments are from the state accounting system, ISIS. Payments are reported on a date of payment basis

Payments and average PMPMs were atypically high in July 2013 as they included both full payment for July enrollment and partial payment for June enrollment deferred from State Fiscal Year 2013 due to budgeting constraints. Payments and average PMPMs in November of 2013 were atypically high as they included a lump sum payment to the health plans for the enhanced rates for primary care providers required by the Affordable Care Act in Calendar Years 2013 and 2014. Pursuant to the Affordable Care Act (ACA), state Medicaid agencies are required to reimburse primary care physicians with a specialty designation of family medicine, general internal medicine or pediatric medicine at parity with Medicare for specified Evaluation and Management (E&M) and Vaccine Administration services. The increased minimum payment level applies to specified primary care services and to services rendered by these provider types paid by Medicaid managed care plans that are contracted by states to provide primary care services. The lump sum payment was for the difference between the Medicaid rate and the enhanced ACA primary care provider rate from January through October 2013. The enhanced rate was included in capitation rates on a prospective basis in November 2013.

Table 3.3: Shared savings health plan monthly total payments and average PMPM for each plan based on date of payment

	Total Payments	**Average PMPM**	**Total Payments**	**Average PMPM**
	CHS		**UHC**	
July-13	$ 2,193,536	$ 10.96	$ 2,807,262	$ 11.08
Aug-13	$ 2,192,828	$ 10.94	$ 2,811,550	$ 11.04
Sep-13	$ 2,197,511	$ 10.94	$ 2,825,158	$ 11.06
Oct-13	$ 2,213,076	$ 10.98	$ 2,847,944	$ 11.09
Nov-13	$ 2,205,676	$ 10.95	$ 2,843,811	$ 11.06
Dec-13	$ 6,727,720	$ 33.33	$ 2,846,549	$ 11.05
Jan-14	$ 2,200,372	$ 10.94	$ 2,829,249	$ 11.04
Feb-14	$ 2,218,348	$ 10.95	$ 2,861,745	$ 11.00
Mar-14	$ 2,239,379	$ 11.02	$ 2,894,762	$ 11.09
Apr-14	$ 2,239,000	$ 10.93	$ 4,058,378	$ 15.22
May-14	$ 2,259,551	$ 10.96	$ 2,973,040	$ 11.06
Jun-14	$ 2,289,014	$ 10.95	$ 3,023,329	$ 11.07
Total	**$ 31,176,010**	**$ 12.81**	**$ 35,622,776**	**$ 11.41**

Source: Unduplicated member counts came from the MARS Data Warehouse and total payments are from the state accounting system, ISIS. Payments are reported on a date of payment basis

In Table 3.3, payments and the average PMPM are atypically high for Community Health Solutions in December of 2013 and for UnitedHealthcare in April of 2014 due to the payout of the interim savings amount determined for year one of the contract period. Shared savings payments were based on determinations made by the Department's actuary, specifically, whether the actual cost of care for a shared savings health plan's membership was more or less than the fee-for-service cost estimated by the actuaries. Determinations are made on an interim and final basis for each year of the three year contract term. Determinations are made more than a year after the close of the reporting period to allow sufficient time for all applicable claims to be filed by service providers. Community Health Solutions received $4,519,201 in December 2013, and UnitedHealthcare received $1,110,070 in April 2014.

4 HEALTH CARE PROVIDERS

The total number of health care providers contracted to provide health care services for each managed care organization delineated by provider type, provider taxonomy code and parish.

Timely access to necessary health care for Medicaid members is an important goal of the Bayou Health program. Contracts with the health plans require them to maintain minimum ratios of specialty physicians to enrollees, and both plan types must meet primary care provider (PCP) ratios. The Department conducts ongoing monitoring of the number of contracted providers in each health plan, and requires plans to submit geo-spatial analyses with provider locations. The Department receives the total number of contracted providers for each health plan through weekly provider network registries submitted by the plans. Network development and areas for additional focus are standing topics for discussion at quarterly business reviews between the Department and the health plans. Since the inception of Bayou Health, the Department has held quarterly meetings with each health plan's individual leadership 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 health care 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. Section 6 includes data on providers with closed panels.

The data in Table 4.1 are unduplicated by National Provider Identifier numbers. Some provider groups or facilities (e.g. hospitals, labs) may have multiple National Provider Identifier numbers for their multiple functions and therefore may be counted multiple times.

Appendix 14.I lists contracted providers by provider type, provider taxonomy and parish.

Table 4.1: Total contracted providers in each health plan

	AMG	ACLA	LHCC	CHS	UHC
Total Contracted Providers	11,630	13,380	12,220	2,434	4,783

Source: MSLC Survey Results

5 PRIMARY CARE SERVICE PROVIDERS

The total number of providers contracted to provide healthcare services for each managed care organization that provides primary care services and submitted at least one claim for payment for services rendered to an individual enrolled in the health plan delineated by provider type, provider taxonomy code and parish.

For this section, primary care providers are defined as any contracted provider that submitted at least one claim for payment for services using specific procedure codes identified as a primary care service. These services included regular office visits with new or established patients and comprehensive preventive evaluations for both new and established patients (i.e., CPT codes 99201-99215 and 99381-99397).

The data in Table 5.1 is unduplicated by National Provider Identifier numbers. Some provider groups or facilities (e.g. hospitals, labs) may have multiple National Provider Identifier numbers for their multiple functions and therefore may be counted multiple times.

Table 5.1 shows the number of providers specifically contracted by the health plans to provide primary care that had at least one claim during State Fiscal Year 2014.

Appendix 14.II lists primary care providers with at least one claim by provider type, provider taxonomy and parish.

Table 5.1: Total contracted primary care providers with at least one claim

	AMG	ACLA	LHCC	CHS	UHC
PCPs with one claim	4,932	6,237	4,693	754	1,378

Source: MSLC Survey Results

6 CONTRACTED PROVIDERS WITH A CLOSED PANEL

The total number of providers contracted to provide health care services for each managed care organization that has a closed panel for any portion of the reporting period delineated by provider type, provider taxonomy code and parish.

Providers that contracted with health plans had the option to close their panels, or stop accepting new patients, under certain circumstances. Each health plan had its own policy on which providers could close their panels and when a panel could be closed, how to inform the health plan when a panel is closed or reopened, and how closed panels were tracked. Additionally, each health plan had its own policy for closing network provider panels to ensure quality of care for members. For example, a managed care organization may cap physician panels at 3,000 clients so that appropriate care and time is given to each person during their appointment.

Table 6.1 shows the number of providers each plan reported with a closed panel in State Fiscal Year 2014. The health plans counted the providers with a closed panel differently, which accounts for the wide variation in closed panels reported across plans. For example, whereas Amerihealth Caritas and Louisiana Healthcare Connections reported only on the panel status of their primary care physicians, Amerigroup reported a closed panel inclusive of specialists as well.

The data in Table 6.1 are unduplicated by National Provider Identifier numbers. Some provider groups or facilities (e.g. hospitals, labs) may have multiple National Provider Identifier numbers for their multiple functions and therefore may be counted multiple times.

See Appendix 14.III for the data delineated by provider type, provider taxonomy code and parish.

Table 6.1: Contracted providers with a closed panel

	AMG	ACLA	LHCC	CHS	UHC
Providers with Closed Panel	693	124	90	110	470

Source: MSLC Survey Results

7 MEDICAL LOSS RATIO

The medical loss ratio of each managed care organization and the amount of any refund to the state for failure to maintain the required medical loss ratio.

Per the Department's contract with the health plans, medical loss ratios are reported on a calendar year basis. MLRs applicable to the State Fiscal Year 2014 transparency report are for Calendar Year 2013. Calendar year 2013 medical loss ratio reports were included in the transparency report submitted to the Louisiana Legislature in January 2015, which is excerpted below for reference. Note that appendices included are numbered in accordance with the January 2015 report and are not in sequential order.

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 the Department in the event the plan does not meet the 85-percent medical loss ratio (MLRs) standard. Bayou Health contracts require that a minimum of 85 percent of payments made by the Department 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 reports, which are based on a calendar year, by June 1 of the following year that summarize how the plans spent their capitation payments. The methodology established by the Department to calculate the annual medical loss ratio is adapted from the methodology the Centers for Medicare and Medicaid Services (CMS) established in 2011 for calculating medical loss ratio 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 85 percent minimum requirement, it is required to pay the Department a rebate. In Calendar Year 2013, all three managed care organizations met the 85-percent minimum and were not required to pay any rebates. Louisiana Healthcare Connections had the lowest medical loss ratio at 87 percent, and Amerigroup Louisiana had the highe st at over 91 percent. For more detail, refer to Table 7.1 and the medical loss ratio reports from each managed care organization in the appendices listed below.

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 7.1: Medical Loss Ratios by Managed Care Organization

	AMG	ACLA	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)

As required by the Bayou Health Administrative Rule, the MLR reports are independently audited, and the audited reports are posted on the Medicaid website within 60 days of completion of the audit. Audit completion is expected on or about March 31, 2015.[2]

[2] This audit was completed timely and data is available as of the published date of this document at http://ldh.louisiana.gov/index.cfm/page/2142.

8 HEALTH OUTCOMES

A comparison of health outcomes, which includes but is not limited to the following, among each managed care organization:

- Adult asthma admission rate
- Congestive heart failure admission rate
- Uncontrolled diabetes admission rate
- Adult access to preventative/ambulatory health services
- Breast cancer screening rate
- Well child visits
- Childhood immunization rates

Health plans are required to track 37 performance measures on quality of care and report results to the Department. Results for the prior calendar year are due to the Department at the end of the subsequent year. As such, Calendar Year 2013 measures are due by the end of 2014. Calendar year 2013 results were included in the transparency report submitted to the legislature in January 2015 and are excerpted below.

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

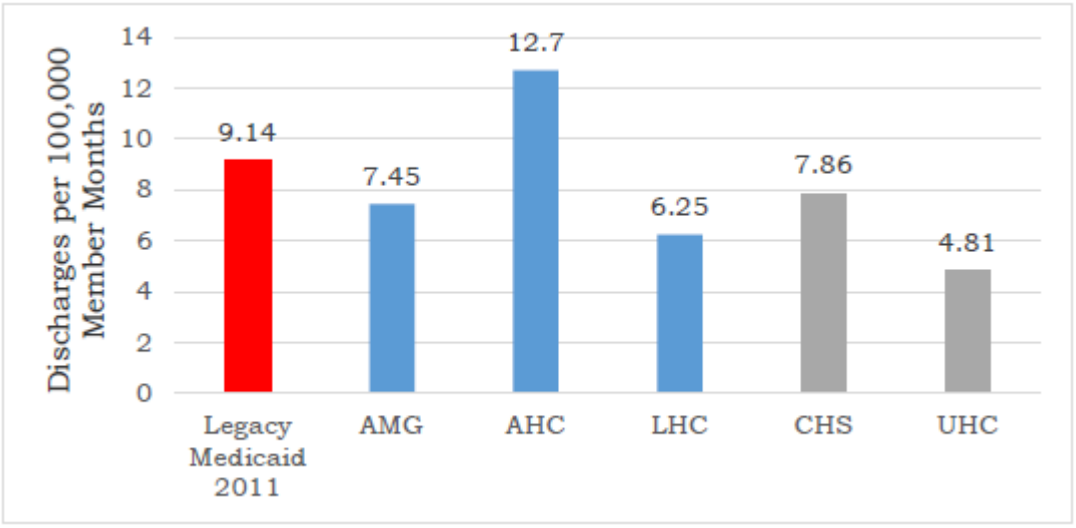
	Prepaid Plans			**Shared Plans**	
	AMG	**AHC**	**LHCC**	**CHS**	**UHC**
Asthma In Younger Adults Admission Rate[1,2,3]	7.45	12.70	6.25	7.86	4.81
Congestive Heart Failure Admission Rate[1,2,4]	45.09	44.61	38.23	22.44	32.97
Diabetes Short-Term Complications Admission Rate[1,2,4]	25.36	17.05	21.90	15.96	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.

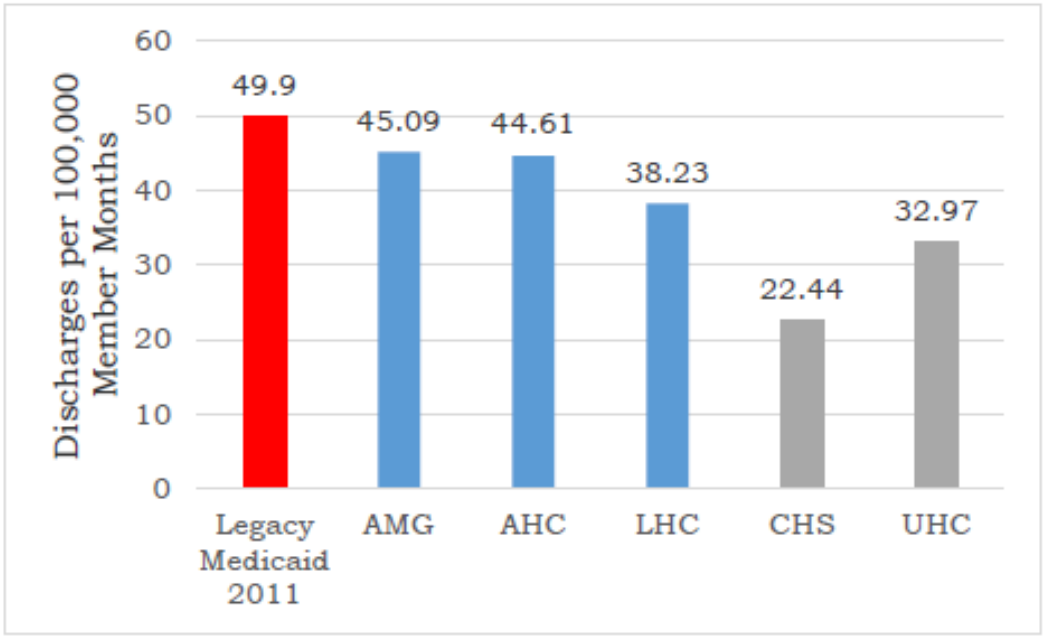
Figures 12.1 through 12.7 below provide a comparison of health outcomes in calendar year 2011 under Legacy Medicaid to outcomes in calendar year 2013 under each of the five Bayou Health plans. Asthma is a common and growing health issue for adults. Data from the National Health Interview Survey (NHIS), 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.

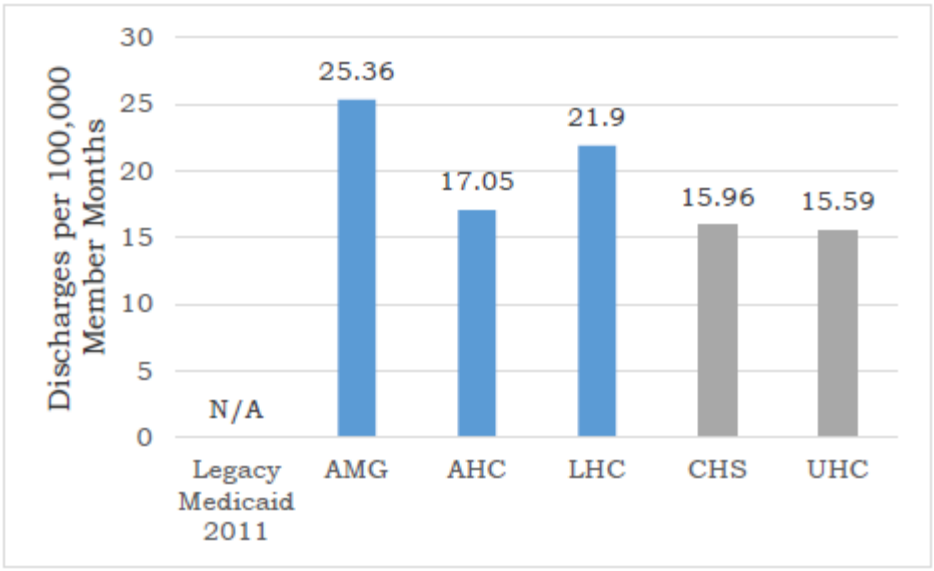
Figure 12.2: Congestive Heart Failure Admission Rate



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.

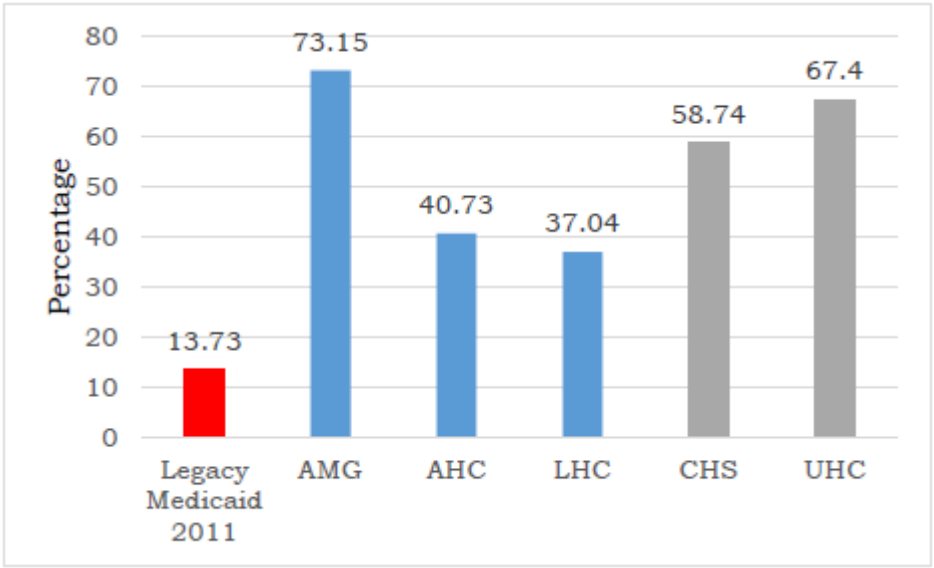
Figure 12.3: Diabetes Short-Term Complications Admission Rate



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.

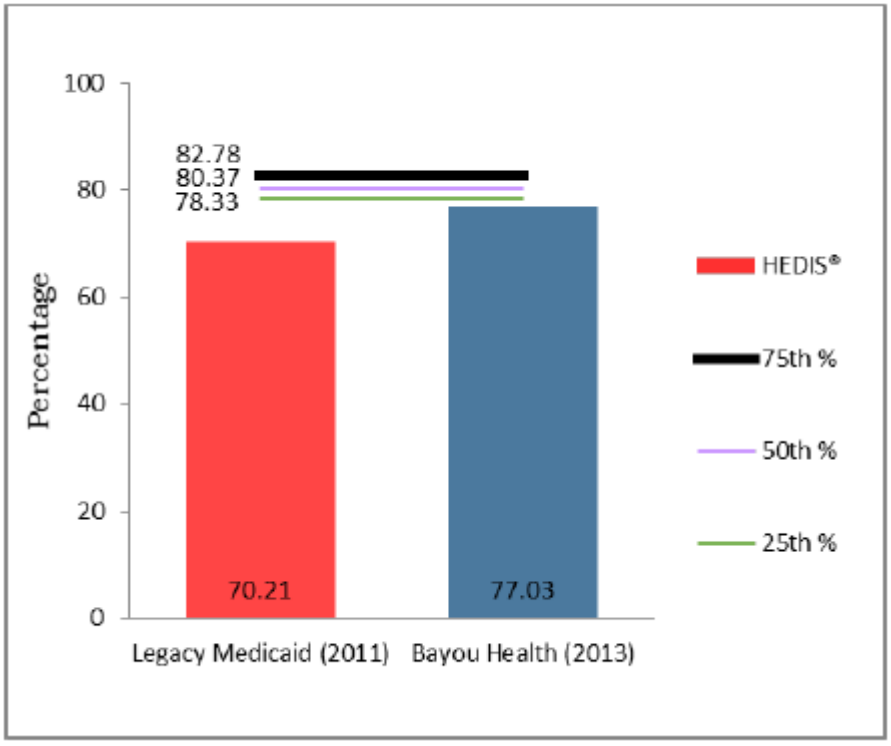
Figure 12.4: Childhood Immunization Status (Combination 3)



Source: 2012 and 2014 HEDIS®

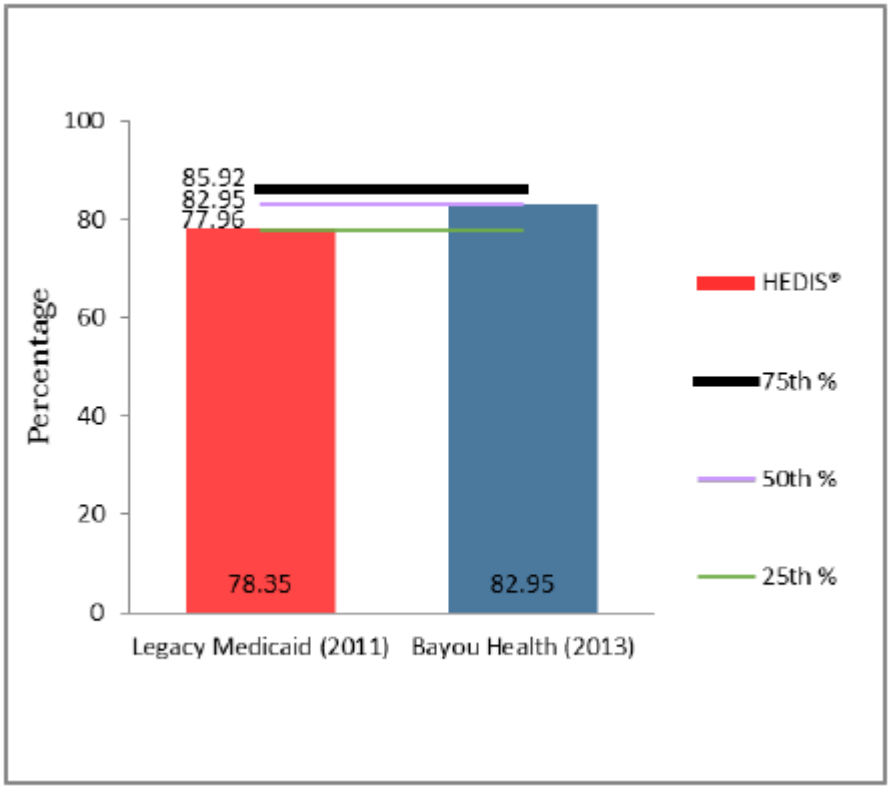
The three figures below show aggregate Bayou Health performance in the 2013 measurement year compared to 2011 performance in Legacy Medicaid. All of these measures are part of the Healthcare Effectiveness Data and Information Set (HEDIS®) and are frequently included in Medicaid managed care contracts 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)



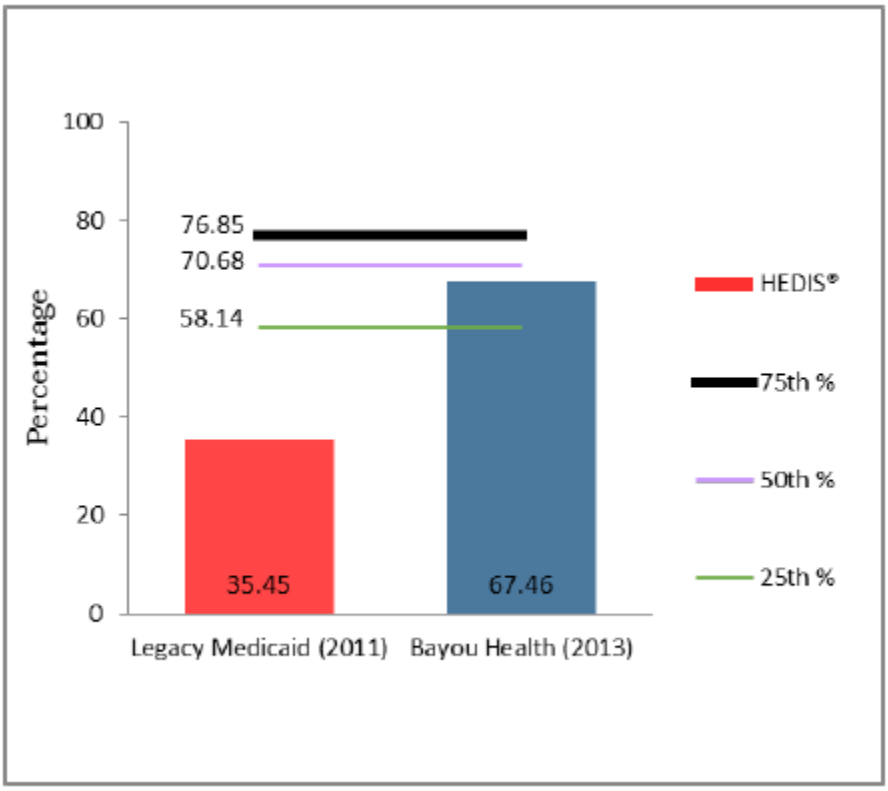
Source: 2012 and 2014 HEDIS®

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®

9 MEMBER AND PROVIDER SATISFACTION SURVEYS

A copy of the member and provider satisfaction survey reports for each managed care organization.

Because satisfaction surveys are conducted as per contract requirements on a calendar year basis, the data correlating to State Fiscal Year 2014 is from surveys conducted during Calendar Year 2013. This section is excerpted from the transparency report submitted to the Legislature in January 2015, as the information included remains the most recent. Note that appendices included below are numbered in accordance with the January 2015 report and are not in sequential order.

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

10 AUDITED FINANCIAL STATEMENTS

A copy of the annual audited financial statements for each managed care organization. The financial statements shall be those of the managed care organization operating in Louisiana and shall not be those financial statements of any parent or umbrella organization.

This section is excerpted from the transparency report submitted to the Louisiana Legislature in January 2015, as audited financial statements for Calendar Year 2013 were reported during State Fiscal Year 2014. Note that appendices included below are numbered in accordance with the January 2015 report and are not in sequential order.

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 to 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.

11 SANCTIONS LEVIED AGAINST HEALTH PLANS

A brief factual narrative of any sanctions levied by the Department of Health and Hospitals against a managed care organization.

During State Fiscal Year 2014, the Department assessed one penalty to Amerihealth Caritas (formerly LaCare) in the amount of $240,000 ($10,000 per day for 24 days). Note that though the infraction and notice of penalty occurred in State Fiscal Year 2013, the monetary penalty was paid in State Fiscal Year 2014.

On January 17, 2013, the Department sent a notice to LaCare that they were noncompliant with section 17.5.4.12 of the contract. The requirement was to submit 95 percent of encounter data monthly by the 25th calendar day of the month following the month in which they were processed and approved/paid, including encounters reflecting a zero-dollar amount, and encounters in which the health plan has a capitation arrangement with a provider. The Department granted an extension to LaCare to submit 93 percent of its encounter data by at least March 1, 2013, and to submit 95 percent of its encounter data by April 1, 2013, to meet contractual obligations.

From April 2, 2013, through April 25, 2013, the Department found LaCare to be out of compliance with the extension. The penalty for noncompliance, per section 20.2.3 of Exhibit E of the contract, was a sanction of $10,000 per calendar day for each day the information was late or incomplete, deficient, and/or inaccurate until the information was submitted and accepted by the Department as complete and accurate with no deficiencies. On June 18, 2013, the Department assessed a $240,000 penalty for the 24 days LaCare was out of compliance. The Department withheld the money from the monthly check-write on July 16, 2014.

More detailed information on this sanction is posted on the Department's website: http://new.dhh.louisiana.gov/index.cfm/page/1610.

12 DENTAL BENEFIT HEALTH OUTCOMES

For managed care organizations that administer dental benefits, a comparison of oral health outcomes that includes but is not limited to the percentage of eligible patients that saw a dentist in that fiscal year as well as the following rates of procedures performed on those who saw a dentist:

- Adult oral prophylaxis
- Child oral prophylaxis
- Dental sealants
- Fluoride varnish
- Amalgam fillings
- Composite fillings
- Stainless steel crowns
- Extractions of primary teeth
- Extractions of permanent teeth
- Pulpotomies performed on primary teeth
- Root canals performed on permanent teeth

This section does not apply to this transparency report as the dental benefit management program began service provision on July 1, 2014. The first dental benefit health outcomes will be included in the State Fiscal Year 2015 transparency report covering the period of July 1, 2014, through June 30, 2015.

Health Plan Enrollees

13 MEMBERS ENROLLED

The total number of unduplicated enrollees enrolled during the reporting period, and the monthly average of the number of members enrolled in each managed care organization delineated by eligibility category of the enrollees.

In State Fiscal Year 2014, the Department enrolled 885,820 Medicaid recipients across the five Bayou Health plans. Shown in Chart 13.1, UnitedHealthcare Community Plan of Louisiana had the largest membership with 29 percent of all Bayou Health enrollees. Community Health Solutions of Louisiana had the second-largest membership with nearly 23 percent of all Bayou Health enrollees. Together, these two shared savings health plans accounted for 52 percent of all Bayou Health enrollees. The remaining 48 percent was divided across the three managed care organizations, with Louisiana Healthcare Connections, AmeriHealth Caritas of Louisiana, and Amerigroup Louisiana each enrolling 17 percent, 16 percent and 15 percent of total Bayou Health membership, respectively.

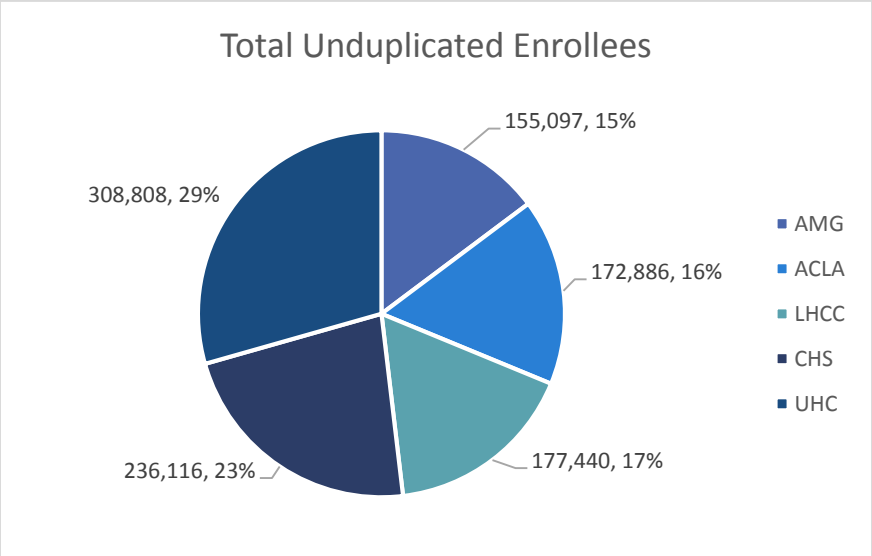
When comparing managed care organizations and shared savings health plans, it was noted that the mix of members by eligibility group were similar across plans of the same type. However, significant differences in membership mix were noted when comparing managed care organizations to shared savings health plans. The three managed care organizations had larger proportions of their membership consisting of Supplemental Security Income (SSI)-related recipients when compared to the shared savings health plans. The percentage of total membership from this eligibility group ranged from 15 percent to 17 percent in the managed care organizations and 9 percent to 11 percent in the shared savings health plans. Conversely, the shared savings health plans had larger proportions of their total membership consisting of recipients from the Families and Children eligibility group. This eligibility group made up 88 percent to 90 percent of total membership in the shared savings health plans versus only 83 percent to 84 percent in the managed care organizations. The disproportionate share of Families and Children membership among the shared savings health plans relative to the managed care organizations greatly affects utilization and outcomes measurement.

Table 13.1 Total unduplicated enrollees

	AMG	ACLA	LHCC	CHS	UHC
Enrollees	155,097	172,886	177,440	236,116	308,808

Source: MARS Data Warehouse

Chart 13.1: Total unduplicated enrollees



Source: MARS Data Warehouse

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 reimbursement, Bayou Health managed care organization 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.
- *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.
- *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.
- *Breast and Cervical Cancer (BCC)*: 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.
- *LaCHIP Affordable Plan enrollees*: Includes children and youth under the age of 19 with incomes between 200 and 250 percent of the Federal Poverty Level (FPL) for regular LaCHIP enrollment in 2013. With the implementation of the Affordance Care Act, income eligibility for LaCHIP Affordable Plan enrollees changed to be between 217 and 255 percent of the FPL starting in 2014 due to Modified Adjusted Gross Income (MAGI) conversions and a 5 percent disregard. Families pay a monthly premium of $50.

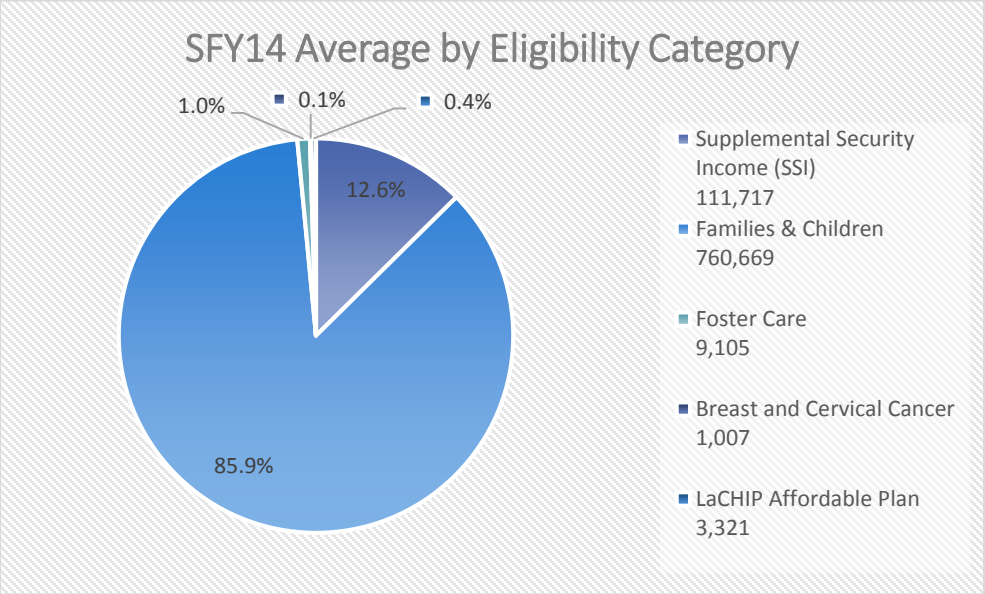
Shared savings health plan enrollees are assigned to one of the following two eligibility groups to which the monthly management fee corresponds:

- 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 and pregnant women whose sole basis of eligibility is pregnancy including children. Plans receive a management fee of $15.74 per-member per-month for enrollees in this group.

Chart 13.2 shows the breakdown of Medicaid enrollees by eligibility category. The majority of members are enrolled in the Families and Children category. SSI members are a distant second. The Foster Care, Breast and Cervical Cancer, and LaCHIP Affordable Plan eligibility categories contain the fewest members.

Chart 13.2: Average enrollees by eligibility category



Source: MARS Data Warehouse

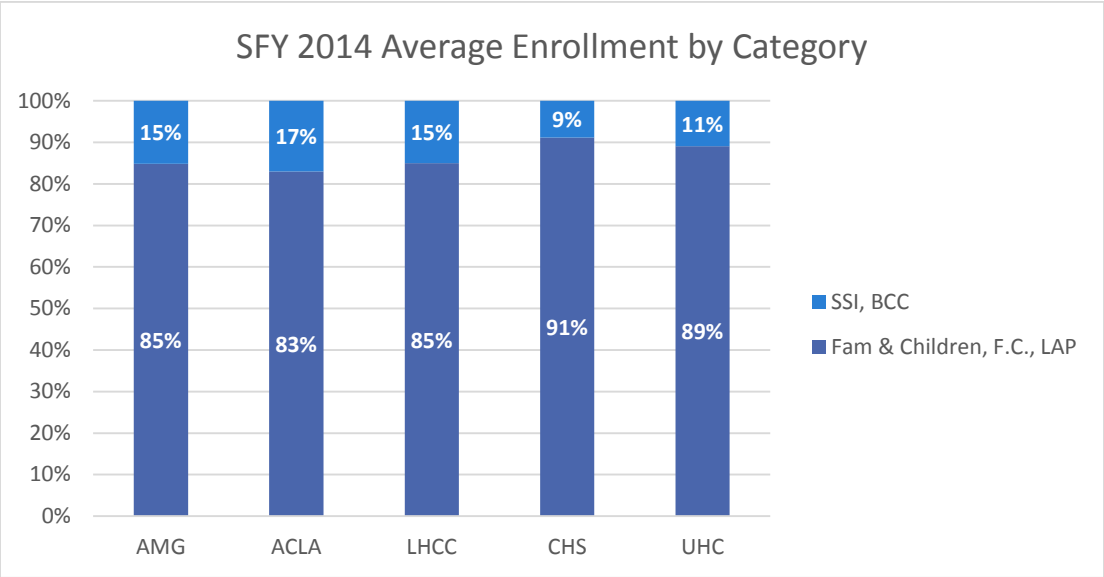
Table 13.2 and Chart 13.3 show the distribution of members enrolled in each health plan by eligibility category.

Table 13.2: Monthly average of the number of members enrolled in each health plan delineated by eligibility category

	AMG	ACLA	LHCC	CHS	UHC	Total
SSI	19,197	24,083	22,471	17,765	28,201	**111,717**
Families & Children	107,179	117,908	126,403	181,518	227,662	**760,669**
Foster Care	1,220	1,161	1,507	2,538	2,678	**9,105**
BCC	201	304	174	99	228	**1,007**
LAP	373	350	433	851	1,315	**3,321**
Total Sum	**128,171**	**143,807**	**150,987**	**202,772**	**260,084**	**885,820**

Source: MARS Data Warehouse

Chart 13.3: Average enrollment by eligibility category



Source: MARS Data Warehouse

14 PLAN CHOICE AND AUTO-ENROLLMENT

The number of members who proactively chose the managed care organization and the number of members who were auto-enrolled into each managed care organization delineated by managed care organization.

One of the goals of Bayou Health is to engage members in selecting the 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 in the plan's network. Bayou Heath enrollment and disenrollment is managed by the Department'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, fee-for-service 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, current providers, or whether family members are already enrolled 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 have to wait until the next annual open enrollment period to switch plans unless they can show good cause for doing so, for example, poor quality of care, to enroll in same plan as family members, or documented lack of access to needed services.

Table 14.1 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. The proportion of members who chose their health plan ranges from 52 percent for Louisiana Healthcare Connections to 74 percent for UnitedHealthcare. The two shared savings health plans, Community Health Solutions of Louisiana and UnitedHealthcare, had the two highest ratios of self-selections to auto-assigned members as well as the majority of all self-selections across all plans (62 percent).

Table 14.1: Proactive choice rates

	AMG	ACLA	LHCC	CHS	UHC	Total
Pro-Active Choice Enrollments	12,819	14,012	11,697	20,479	35,229	**94,236**
Auto Enrollments	11,188	11,238	10,840	12,112	12,524	**57,902**
Total Enrollments	24,007	25,250	22,537	32,591	47,753	**152,138**
Choice Rate	53%	55%	52%	63%	74%	62%

Source: Maximus Health Services

15 ENROLLEES WHO RECEIVED SERVICES

The total number of enrollees who received unduplicated Medicaid services from each managed care network, broken down by provider type, provider taxonomy code and place of service.

In monitoring the effectiveness and quality of the Bayou Health program, the Department 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 15 provides information on Medicaid services provided under Bayou Health. Data are inclusive of paid and denied claims but are reported by unduplicated members, not by claim count.

Table 15.1 shows unduplicated counts and percent of members receiving one or more services by plan. In State Fiscal Year 2014, 875,209 unduplicated members received one or more Medicaid service through their health plan, for an overall rate of 86.3 percent across all health plans. Of the health plans, Amerihealth Caritas had the highest percentage of members receiving one or more services. Rates for individual plans demonstrate minimal variation across plans with a range of 84.7 percent (Amerigroup) to 88.1 percent (Amerihealth Caritas). Data are inclusive of all claims, approved and denied.

Appendix 14.IV provides additional detail of members served by provider taxonomy, provider type, and place of service.

Table 15.1: Enrollees who received services

	AMG	ACLA	LHCC	CHS	UHC	Unduplicated Total
Unduplicated Members	155,097	172,886	177,440	236,116	308,808	**1,013,870**
Members Receiving One or More Services	131,381	152,232	151,124	201,597	264,609	**875,209**
Percent Receiving One or More Services	84.7%	88.1%	85.2%	85.4%	85.7%	**86.3%**

Source: MARS Data Warehouse

16 ENROLLEES WHO HAD A PRIMARY CARE VISIT

The total number and percentage of enrollees of each managed care organization who had at least one visit with their primary care provider during the reporting period.

Once a Medicaid recipient is assigned to a health plan, either by choice or by auto assignment, the health plan assigns them to a primary care provider (PCP). These are providers who contract with the health plan explicitly to provide primary care services and to serve as a medical home for their patients. Enrollees are contacted by their health plan to make a selection. If no selection is made within 10 days of enrollment into the health plan, they are assigned one. The algorithm for auto assignment considers past history with a PCP or a family history with a PCP. The Department requires each health plan to have a process through which members can request to change their PCP for cause.

The data in Table 16.1 show the number and percentage of members who had at least one visit with the PCP to which they were linked during State Fiscal Year 2014. Though all members were linked to a PCP, they are not prohibited from seeking care from another provider. Not included in this table is data on members who had a visit with a provider for primary care services to which the member was not linked at the time.

There is variation of over 12 percentage points between UnitedHealthcare, which had the highest percentage of members who had a visit with their linked PCP and the plan with the lowest, Community Health Solutions. However, the data in section 15 show less variation in overall access of health care services.

Table 16.1 Total number and percentage of enrollees of each health plan who had at least one visit with their PCP

	AMG	ACLA	LHCC	CHS	UHC
Recipients with at Least One PCP Visit	60,247	70,961	66,929	78,110	141,857
Percentage	38.85%	41.05%	37.72%	33.08%	45.94%

Source: MARS Data Warehouse (Primary Care Provider Linkage table, Bayou Health Eligibility File, Encounter Data)

17 HOSPITAL SERVICES PROVIDED

The following information concerning hospital services provided to Medicaid enrollees:

- The number of members who received unduplicated outpatient emergency services, delineated by managed care organization.
- The number of total inpatient Medicaid days delineated by managed care organization.
- The total number of unduplicated members who received outpatient emergency services and had at least one visit to a primary care provider within the past year of receiving the outpatient emergency services.

The data in Section 17 show the number of members who received inpatient and outpatient hospital services. Additionally, it shows the number of members who received emergency services within a year after having seen their primary care provider. Across the board, the shared savings health plans had a higher volume of hospital services than the managed care organizations. This is primarily due to the larger memberships in the shared savings health plans compared to the managed care organizations.

For the shared savings health plans, the hospital services are consistent with the member disparity, i.e., UnitedHealthcare had a larger membership and higher number of members receiving outpatient emergency services, more inpatient days, and more members that saw a PCP within a year after their outpatient emergency room service. As shown in Table 17.1 and 17.3 respectively, Louisiana Healthcare Connections was the managed care organization with the highest number of members who received outpatient emergency services as well as the most members who had at least one visit to a PCP within a year after their outpatient emergency service. However, Table 17.2 shows Amerihealth Caritas had the largest number of inpatient Medicaid days.

Table 17.1: The number of members who received unduplicated outpatient emergency services

	AMG	ACLA	LHCC	CHS	UHC	Total
Members	70,951	78,788	83,413	101,289	133,946	**468,387**

Source: MARS Data Warehouse

Table 17.2: The number of total inpatient Medicaid days

	AMG	ACLA	LHCC	CHS	UHC	Total
Total Inpatient Medicaid Days	64,297	82,661	75,621	95,507	134,118	**452,204**

Source: MARS Data Warehouse

Table 17.3: The total number of unduplicated members who received outpatient emergency services and had at least one visit to a primary care provider within the past year of receiving the outpatient emergency services.

	AMG	ACLA	LHCC	CHS	UHC	Total
Members	63,437	70,636	74,553	92,340	121,523	**422,489**

Source: MARS Data Warehouse

18 ENROLLEES THAT FILED APPEALS OR ACCESSED STATE FAIR HEARING PROCESS AND RESULT

The number of members, delineated by each managed care organization who filed an appeal, the number of members who accessed the state fair hearing process, and the total number and percentage of appeals that reversed or otherwise resolved a decision in favor of the member. For purposes of this subparagraph, "appeal" means a request for review of an action.

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 health plans to administer a system for members to file appeals, and all states are required to review health plan reports on both the frequency and nature of grievances and appeals filed as well as the steps health plans take to remedy such grievances and appeals. 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 managed care organization. In contrast to managed care organizations, shared savings health plans were required to log appeals and forward them directly to the Division of Administrative Law for a state fair hearing rather than adjudicate appeals internally. As such, all shared savings plan appeals are counted solely as state fair hearings in Table 18.1 below.

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, the Department 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 the Department both look for trends and use the reports to determine the need for operational changes and improvements.

Table 18.1: Appeals, state fair hearings and appeals overturned

	AMG	ACLA	LHCC	CHS	UHC
Appeals	634	183	722[3]	N/A	N/A
Appeals Reversed at the Plan Level	86	53	493	N/A	N/A
Appeals Reversed at the Plan Level - Percentage	14%	29%	68%	N/A	N/A
State Fair Hearings Accessed	2	13	12	17	34
Number of Appeals Reversed at State Fair Hearing	0	0	0	0	0
Percentage of Appeals Reversed at State Fair Hearing	0%	0%	0%	0%	0%

Source: Bayou Health Reports 114 and 117

[3] LHCC's data includes pharmacy appeals. The overturns were also reflective of lack of documentation submitted by the provider with the initial utilization management review.

Health Care Services Provided to Enrollees

To collect the data in this section, the Department defined emergency services as outpatient services provided in an emergency room, exclusive of EMTALA screening or urgent care, and professional services, specifically the evaluation and management of a patient, provided in an emergency room.[4] Non-emergency services are defined as all other claims that do not fit the definition of emergency services above.

19 CLAIMS SUBMITTED BY HEALTH CARE PROVIDERS

The total number of claims submitted by health care providers to each managed care organization. The total number shall also be delineated by claims for emergency services and claims for nonemergency services.

Health plans reported claims data using a reporting template developed by the Department. The template cross walked Louisiana Medicaid provider type codes to national taxonomy codes in an effort to standardize claims data reporting. Louisiana Medicaid provider type codes are unique to its fiscal intermediary contractor, Molina. Taxonomy codes are standardized for all providers in the United States.

Table 19.1 shows data on total claims the health plans received during State Fiscal Year 2014 delineated between emergency and non-emergency services. These claims were ultimately paid or denied, however, the data does not include rejected claims. Rejected claims are different from denied claims as they are not adjudicated, but are rejected before entering the health plans' systems for reasons such as Electronic Data Interchange (EDI) formatting issues on the transaction, the system cannot read the claim, or systems limitations. Since rejected claims are not processed through the health plans' systems, whether a service is coded as emergency or non-emergency cannot be ascertained.

Table 19.1 Total claims processed by health plans for emergency and non-emergency services

	Emergency Services	Non-Emergency Services	Total
AMG	315,919	3,653,275	3,969,194
ACLA	230,667	5,594,916	5,825,583
LHCC[5]	254,103	4,297,535	4,551,638
CHS	364,719	5,852,641	6,217,360
UHC	450,072	8,903,345	9,353,417
Total	**1,615,480**	**28,301,712**	**29,917,192**

Source: Health Plans' Data Warehouses

[4] Includes Claim Type 03 (outpatient services) with Revenue Codes 450, 451, and 981 and Claim Type 04 (Professional Services) with Procedure Codes 99281 through 99285.

[5] LHCC total claim count is at the claim header level and the clean claim count is at the service line level. Therefore, the clean claim count may appear higher than the total claim count.

20 DENIED CLAIMS

The total number of claims submitted by health care providers to each managed care organization which were adjusted by the respective managed care organization and payment for services was denied. This item of the report shall include a delineation between emergency and nonemergency claim denials. Additionally, this item of the report shall include the number of denied claims for each managed care organization delineated by the standard set of Claim Adjustment Reason Codes published by the Washington Publishing Company.

Certain types of claim denials by health plans bear special scrutiny and ongoing monitoring to assure that claims are not being inappropriately denied, including:

- 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 is not covered by Medicaid.

Records for each denied claim must include a reason for the denial. The Department required plans to report these denials using claim adjustment reason codes (CARC), which are national standards. The number of claim adjustment reason codes is greater than the unduplicated number of total denied clean claims as represented in Table 20.1. The reason for this discrepancy is that each individual claim line that is denied often has multiple associated claim adjustment reason codes. In other words, a claim can be denied or adjusted for multiple reasons. As it cycles through the payment logic, the claims processing system applies all applicable CARCs randomly and one is not primary in comparison to another. As such, these two components are reported independent of each other.

Table 20.1 below provides total unduplicated denied clean claims by health plan divided by emergency and non-emergency services.

Table 20.1: Total denied clean claims by health plan

	AMG	ACLA	LHCC	CHS	UHC	Total
Emergency Services	28,000	25,520	12,367	25,875	60,129	**151,891**
Non-Emergency Services	614,763	1,359,524	466,505	995,985	1,932,072	**5,368,849**

Source: Health Plans' Data Warehouses

Table 20.2 shows the ten most frequently used claim adjustment codes for emergency and non-emergency claims. The primary causes for adjustments or denials stemmed from a lack of information on the claim submission that was needed for adjudication, submission/billing errors and duplicate claims.

A breakout of all claim adjustment reason codes for denied claims for each health plan in numerical order is provided in Appendix 14.V.

Table 20.2: Top claim adjustment reason codes (CARCs) for emergency and non-emergency services

	Emergency Claims	Non-Emergency Claims	Total
Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject)	41,717	1,014,863	**1,056,580**
Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO); Start: 01/01/1995 | Last Modified: 06/02/2013	22,403	781,150	**803,553**
Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 S)	7,759	500,901	**508,660**
The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; Start: 01/01/1995 | Last Modified: 09/20/2009	3	415,012	**415,015**
The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	8,201	315,666	**323,867**
Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	649	271,487	**272,136**
Charges are covered under a capitation agreement/managed care plan.; Start: 01/01/1995 | Last Modified: 09/30/2007	16,008	254,506	**270,514**
Benefit maximum for this time period or occurrence has been reached.; Start: 01/01/1995 | Last Modified: 02/29/2004	608	259,839	**260,447**
Precertification/authorization/notification absent.; Start: 10/31/2006 | Last Modified: 09/30/2007	21	211,510	**211,531**
Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability) This change effective 11/1/2015: Charge exceeds fee schedule/maximum allowable or contracted/legislated	791	198,548	**199,339**

Source: Health Plans' Data Warehouses

21 CLEAN CLAIMS

The total number of claims submitted by the health care providers to each managed care organization which meets the definition of a clean claim as it is defined in the contract executed between the state and the managed care organization, and the percentage of those clean claims that each of the managed care plans has paid for each provider type within fifteen calendar days and within thirty calendar days. In addition, the report shall include the average number of days for each managed care organization to pay all claims of health care providers delineated by provider type.

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, or a claim under review for medical necessity.

Table 21.1 lists the total clean claims submitted for each health plan. While shared savings plans do not pay claims submitted by health care providers, Table 21.1 includes claims that were subsequently paid by the state's fiscal intermediary after preprocessing conducted by the shared savings plan.

Appendix 14.VI lists total clean claims, percentage of claims paid within 15 and 30 days, and average number of days to pay all claims by provider type for each health plan. All five health plans paid the vast 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 is due in part to the complexity of cross-walking fee-for-service Legacy Medicaid provider types to the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12N standard, which regulates and establishes standards for claims filing. Provider type classifications used by Louisiana Medicaid are unique to its fiscal intermediary, and considerable work had to be performed to map them back to standard taxonomy codes in use by other health care organizations in the United States. All Health Insurance Portability and Accountability Act (HIPAA)-covered entities are required to be compliant with the ASC X12 version 5010, which only requires reporting of taxonomy on claims if a provider has multiple taxonomies associated with their National Provider Identifier on file. As healthcare terminology standards continue to evolve, the Department will continue to work to ensure health plan compliance to this standard and ensure provider directories are accurate and complete.

Table 21.1: Total clean claims by health plan

	AMG	ACLA	LHCC	CHS	UHC	Total
Total Clean Claims	3,645,126	5,825,583	4,760,222	5,123,063	9,353,417	**28,707,411**

Source: Health Plans' Data Warehouses

22 REGULAR AND EXPEDITED SERVICE REQUESTS PROCESSED

The total number and percentage of regular and expedited service authorization requests processed within the time frames specified by the contract for each managed care organization. In addition, the report shall contain the total number of regular and expedited service authorization requests which resulted in a denial for services for each managed care organization.

Bayou Health plans are required to reimburse for all medically necessary services. 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 ensuring timely access to care that service authorization requests submitted by providers are acted on in a timely manner.

Health plan contracts with the Department 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, 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 grievances. 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.

The figures presented in Tables 22.1 and 22.2 were submitted by the plans in the monthly Bayou Health Report #188 and reflect the number and percentage of regular, expedited and durable medical equipment (DME) service authorizations processed in accordance with timeframes as established in the Bayou Health contract. In order to validate the information reported by the health plans, Myers and Stauffer asked each plan how regular and expedited authorization requests are defined, how prior authorizations are monitored and tracked, and how reports on prior authorizations are generated. Myers and Stauffer also requested each plan provide supporting documentation for its response.

Table 22.1 Service authorizations processed

		AMG	ACLA	LHCC	CHS	UHC
Regular Processed within 2 Business Days	**Number**	38,997	16,545	18,674	22,532	29,438
	Percent	97.70%	87.50%	92.30%	96.10%	91.40%
Regular Processed within 14 Business Days	**Number**	39,821	18,794	20,307	23,432	2,023
	Percent	99.80%	99.30%	99.20%	99.90%	97.60%
Regular Processed within 28 Business Days	**Number**	39,880	18,894	20,356	23,458	644
	Percent	100.00%	99.80%	99.50%	100.00%	99.60%
Expedited Processed within 72 Hours	**Number**	21	101	122	27	1,179
	Percent	99.98%	99.02%	100.00%	100.00%	97.05%
DME Processed within 25 Business Days	**Number**	5,872	3,981	20,350	19	N/A
	Percent	99.80%	99.60%	99.50%	99.60%	N/A

Sources: Percentages from Bayou Health Report #188. Total numbers from MSLC Survey

Table 22.2 shows the percent of prior authorizations that resulted in a denial of services. The two shared savings health plans had fewer denials than the managed care organizations. As is mentioned above, the shared savings health plans also reported fewer authorizations in general.

Table 22.2: Percent of prior authorizations that resulted in denial

	AMG	ACLA	LHCC	CHS	UHC
Denied Prior Authorizations	7.26%	8.84%	7.78%	4.10%	5.70%

Source: MSLC Survey Results

23 CLAIMS PAID TO OUT-OF-NETWORK PROVIDERS

The total number and dollar value of all claims paid to out-of-network providers by claim type categorized by emergency services and nonemergency services for each managed care organization by parish.

This measure applies to the managed care organizations only as they are required to maintain their own provider networks and pay their own claims. It does not apply to shared savings health plans whose networks are limited to Medicaid-enrolled providers and provider claims are paid by the Department.

The Department requires managed care organizations to pay both network and non-network providers for emergency services at or above 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 managed care organizations 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 in tables 23.1 and 23.2 reflects the number of claims and dollar value of payments by the managed care organizations to non-network providers for both emergency services and non-emergency services. The data originate from submissions from the managed care organizations on the claims reporting template developed by the Department. Myers and Stauffer asked the plans to explain the assumptions and criteria used in reporting these data while attempting to validate these figures. Myers and Stauffer found that certain emergency services included in the Department's reporting requirements may have been excluded from the analysis. Specifically, hospital revenue codes 451, 452 and 456 were not included for any managed care organization. However, these three revenue codes have never been payable under the Louisiana Medicaid fee-for-service schedule, making their exclusion appropriate.

Appendix 14.VII shows out of network claims for all emergency and non-emergency services broken out by parish.

Table 23.1: Out of network claims for emergency services

	AMG	ACLA	LHCC
Total Claims	119,827	88,152	70,205
Total Amount	$9,279,121	$7,026,394	$8,727,504

Source: MCO Data Warehouses

Table 23.2: Out of network claims for non-emergency services

	AMG	ACLA	LHCC
Total Claims	156,682	315,749	152,792
Total Amount	$13,363,001	$27,647,688	$25,700,739

Source: MCO Data Warehouses

24 PHARMACY BENEFITS

The following information concerning pharmacy benefits delineated by each managed care organization and by month:

- Total number of prescription claims
- Total number of prescription claims subject to prior authorization
- Total number of prescription claims denied
- Total number of prescription claims subject to step therapy of fail first protocols

This measure applies to managed care organizations which are required to manage pharmacy benefits for their members. It does not apply to shared savings health plans for which the pharmacy benefit was managed by the Department.

A managed care organization can self-administer its pharmacy benefits or subcontract with a pharmacy benefit manager. Table 24.1 identifies the pharmacy benefit manager for each managed care organization and whether the pharmacy benefit manager was a wholly-owned subsidiary or a contracted vendor.

Table 24.1: MCO pharmacy benefit managers

	AMG	ACLA	LHCC
PBM	CVS Caremark	PerformRx	US Script
Relationship	Contracted	Owned	Owned

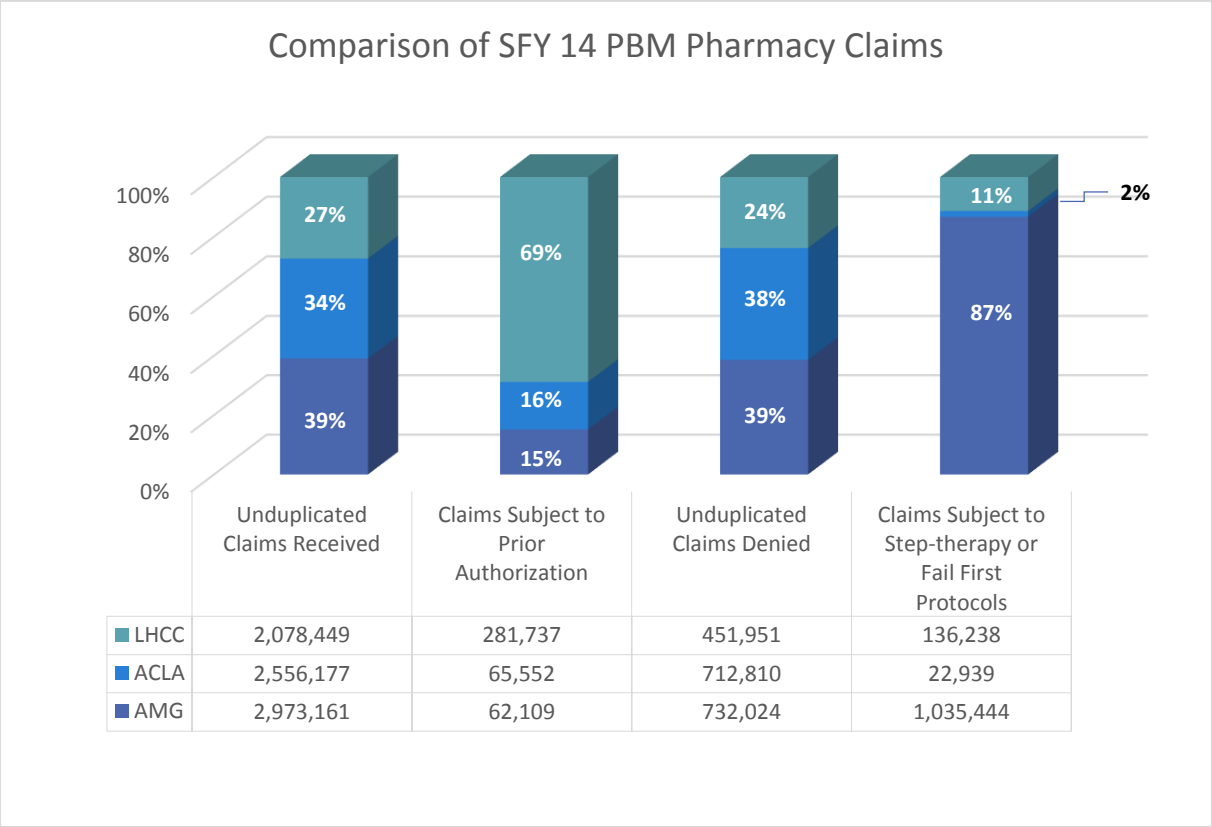
Source: MCO self-reported

Managed care organizations have flexibility in how to address appropriateness of medication therapy. Additionally, each pharmacy benefit manager has its own protocols for utilization management and decision making as to which drugs to include in its preferred drug list. A preferred drug list is a list of preferred brand name and generic drugs that are most cost-effective and do not require prior authorization. There are drugs assigned for each therapeutic drug class.

Variation in claims data reflected in the chart below is due to the ability of the managed care organizations to take alternative approaches to managing pharmacy benefits. As a result, the data from each plan vary significantly, particularly in the categories of claims denied, claims subject to prior authorization, and claims subject to step therapy or fail first protocols.

Chart 24.1 shows the unduplicated total number of pharmacy claims received by managed care organization for State Fiscal Year 2014. It also gives the number of claims denied, claims subject to prior authorization and the number of claims subject to step-therapy or fail first protocols. A breakout of the monthly claims data is provided in Appendix 14.VIII.

Chart 24.1 Pharmacy benefits comparison



	Unduplicated Claims Received	Claims Subject to Prior Authorization	Unduplicated Claims Denied	Claims Subject to Step-therapy or Fail First Protocols
LHCC	2,078,449	281,737	451,951	136,238
ACLA	2,556,177	65,552	712,810	22,939
AMG	2,973,161	62,109	732,024	1,035,444

Source: Monthly RX055 Pharmacy Report

25 MEDICAID DRUG REBATES

The report shall include the following information concerning Medicaid drug rebates and manufacturer discounts delineated by each managed care organization and the prescription benefit manager contracted or owned by the managed care organization and by month:

- Total dollar amount of the Medicaid drug rebates and manufacturer discounts collected and used.
- Total dollar amount of Medicaid drug rebates and manufacturer discounts collected and remitted to the Department of Health and Hospitals.

This measure applies to managed care organizations which are required to manage pharmacy benefits for its members. It does not apply to shared savings health plans for which the pharmacy benefit was managed by the Department. The managed care organizations submit this data on a calendar year basis in the audited annual financial report.

Managed care organizations, either directly or through their pharmacy benefit manager, negotiate agreements with drug manufacturers to collect rebates or discounts on the cost of drugs provided to their members. These agreements provide a financial incentive to health plans to prefer certain drugs over others in meeting their members' pharmacy needs. Preferred drugs, included on a plan's preferred drug list, are exempt from prior authorization requirements.

For Medicaid enrollees in a fee-for-service delivery system, manufacturer discounts and drug rebates (both federal and state supplemental) accrue directly to the state. For Medicaid enrollees in a full-risk managed care organization, only federal rebates accrue directly to the state. In Louisiana, since managed care organizations determine their own unique preferred drug list, supplemental rebates are not available to the state.

Each managed care organization also negotiates drug rebates differently. For Amerihealth Caritas, rebates were earned per manufacturer agreement specific to a given drug and each contract was unique. The rebates were a fixed amount per unit, with the amount based on dispensed quantity and performance (market share tiered), etc. Amerigroup negotiated a per script rebate minimum guarantee with its pharmacy benefit manager and 100 percent of rebates were passed through to Amerigroup. Louisiana Healthcare Connections used Caremark as their rebate aggregator. Caremark provided a flat amount without claim details to the pharmacy benefit manager (US Script) and US Script passed those rebates back to Louisiana Healthcare Connections.

Managed care organizations report to the Department through routine quarterly and audited annual financial reporting the amount of rebates and discounts collected from manufacturers. Rather than require health plans to remit rebates and discounts collected to the Department, the Department's contracted actuaries consider the reported amounts when setting capitation rates for managed care organizations, and related reductions to capitation rates benefit the state indirectly. As a result, the managed care organizations remit no drug rebates or manufacturer discounts directly to the Department.

Table 25.1 provides the amount of Medicaid drug rebates and manufacturer discounts collected and used as well as remitted to the Department during Calendar Year 2013, as reported by managed care organizations in their audited annual financial statement for that year. Table 25.2 shows the monthly breakdown.

Table 25.1: Pharmacy rebates in Calendar Year 2013

	AMG	ACLA	LHCC	Total
Amount of Medicaid Drug Rebates and Manufacturer Discounts Collected and Used	$1,127,533	$3,363,000	$622,419	**$5,112,952**
Amount of Medicaid Drug Rebates and Manufacturer Discounts Collected and Remitted to DHH	$0	$0	$0	**$0**

Source: Audited Annual Financial Report

Table 25.2: Monthly pharmacy rebates in Calendar Year 2013

	AMG	ACLA	LHCC
July-13	$0	$264,000	$24,914
Aug-13	$0	$61,000	$34,073
Sep-13	$0	$62,000	$26,920
Oct-13	$66,842	$230,000	$47,877
Nov-13	$70,344	$327,000	$100,739
Dec-13	$387,481	$326,000	$38,025
Jan-14	$47,823	$263,000	$67,261
Feb-14	$90,709	$253,000	$89,735
Mar-14	$75,729	$253,000	$61,571
Apr-14	$96,222	$266,000	$40,703
May-14	$76,665	$448,000	$53,688
Jun-14	$215,718	$610,000	$36,913
TOTAL REBATES	**$1,127,533**	**$3,363,000**	**$622,419**

Source: Audited Annual Financial Report

Dental Benefit Managed Care Organizations

26 PRIOR AUTHORIZATION REQUESTS

For managed care organizations that administer dental benefits, the following information concerning prior authorization requests, delineated by type of procedure:

- The number of prior authorization requests.
- The average and range of times for responding to prior authorization requests.
- The number of prior authorization requests denied, delineated by the reasons for denial.
- The number of claims denied after prior authorization was approved, delineated by the reasons for denial.

This measure does not apply to State Fiscal Year 2014 as the dental benefit management program began service provision on July 1, 2014.

List of Appendices