DEPARTMENT OF HEALTH AND HOSPITALS

BAYOU HEALTH TRANSPARENCY REPORT

REPORT PREPARED IN RESPONSE TO ACT 212 OF THE 2013 REGULAR SESSION

JANUARY 2014

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EXECUTIVE SUMMARY

On February 1, 2012, DHH launched the single-largest transformation of the delivery of health care services in Louisiana Medicaid history when it transitioned nearly 900,000 Medicaid and LaCHIP enrollees from the state's 45-year old legacy, fee-for-service program to a managed health care delivery system for acute care services, known as Bayou Health.

A core component of reorganizing Louisiana's Medicaid acute care delivery system was an expansion and realignment of the state's capacity to monitor health plan operations, system performance and member health outcomes. Through a variety of tools – from provider and CAHPS (Consumer Assessment of Healthcare Providers and Systems) surveys to more than 50 monthly, quarterly and annual reports, Bayou Health is tracking and assessing each Health Plan's performance, as well as, the outcomes of Bayou Health as a whole.

Act 212 of the 2013 Legislative Session reinforces this high level of transparency in reporting, ensuring Medicaid managed care operates in the most efficient and sustainable method possible. The Act calls for 24 separate reports on Health Plan performance, many compared to pre-Bayou Health Medicaid data.

This report outlines responses to the request made by the legislature in Act 212 relative to Bayou Health management and performance. The measures included in this report are used to ensure the following outcomes are achieved:

1. Improved care coordination with patient-centered medical homes for Medicaid recipients.
2. Improved health outcomes and quality of care as measured by metric, such as the Healthcare Effectiveness Data and Information Set (HEDIS).
3. Increase emphasis on disease prevention and the early diagnosis and management of chronic conditions.
4. Improved access to Medicaid services.
5. Improved accountability with a decrease in fraud, abuse, and wasteful spending.
6. A more financially sustainable Medicaid program.

HISTORY OF BAYOU HEALTH IMPLEMENTATION

In 2012, DHH launched a complete overhaul of its legacy Medicaid system for delivery of acute care services resulting in the State's first managed care system for more than 900,000 residents enrolled in Medicaid. Before the system transformation began, the Department invested considerable time and resources in researching national best practices in Medicaid managed care during the development of Bayou Health, reaching out to more than two dozen states with active managed care programs. Through in-depth conversations and on-site visits, DHH identified and developed two separate Medicaid managed care models – which are called "Prepaid" and "Shared Savings" models in Louisiana – to best suit the immediate needs of Louisiana's Medicaid and LaCHIP enrollees. The federal authority for both models is a Section 1932(a)(1) State Plan Amendment (SPA).

The Prepaid Health Plan model provides for a traditional, risk-bearing Managed Care Organization (MCO). Prepaid Health Plans must establish networks of providers to cover the full range of Medicaid services, including primary, secondary and hospital care. Providers are not required to be participating Louisiana Medicaid providers to participate. The Health Plan receives a monthly capitation fee for each member enrolled to provide core benefits and services, with utilization management and claims payment handled directly by the Plan. Three entities operate as Prepaid Plans in Bayou Health: Amerigroup, AmeriHealth Caritas (formerly known as LaCare) and Louisiana Healthcare Connections (parent company Centene).

The Shared Savings Plan model provides for an enhanced Primary Care Case Management (PCCM) organization, which incorporates many of the features historically associated with an MCO, such as utilization management. A Shared Savings Plan's provider network consists of primary care physicians (PCPs) only, and all providers must also be enrolled in Louisiana Medicaid. The Shared Savings Plan is expected to coordinate specialty care and hospital care with providers enrolled in the Medicaid provider network. The Plan receives a monthly fee for each enrolled member $10.24 for children and healthy adults; $15.74 for pregnant women and members with disabilities – to provide enhanced management services, with the opportunity to share in any savings to the State that result from the improved coordination of care. While the Shared Savings Health Plans "pre-processes" claims, the state continues final processing and pays provider claims through its fiscal intermediary. Two entities operate as Shared Savings Plans in Bayou Health: Community Health Solutions of Louisiana and UnitedHealthcare Community Plan of Louisiana.

Both Prepaid and Shared Savings models began a phased-in implementation simultaneously in February 2012, with eligible members choosing between the two model types and the five Health Plans.

PROGRESS AND ACCOUNTABILITY

Already, DHH has seen a cost savings over what the state would have spent in absence of managed care. To ensure this progress continues and that Bayou Health enrollees are receiving high quality service and appropriate care, DHH actively monitors and tracks Health Plan performance, with additional ongoing reports, including enrollment information, grievance and appeals, claim denials, prompt payment performance and emergency room usage being posted to www.MakingMedicaidBetter.com at regular intervals. These are available under the "Reporting and Accountability" tab.

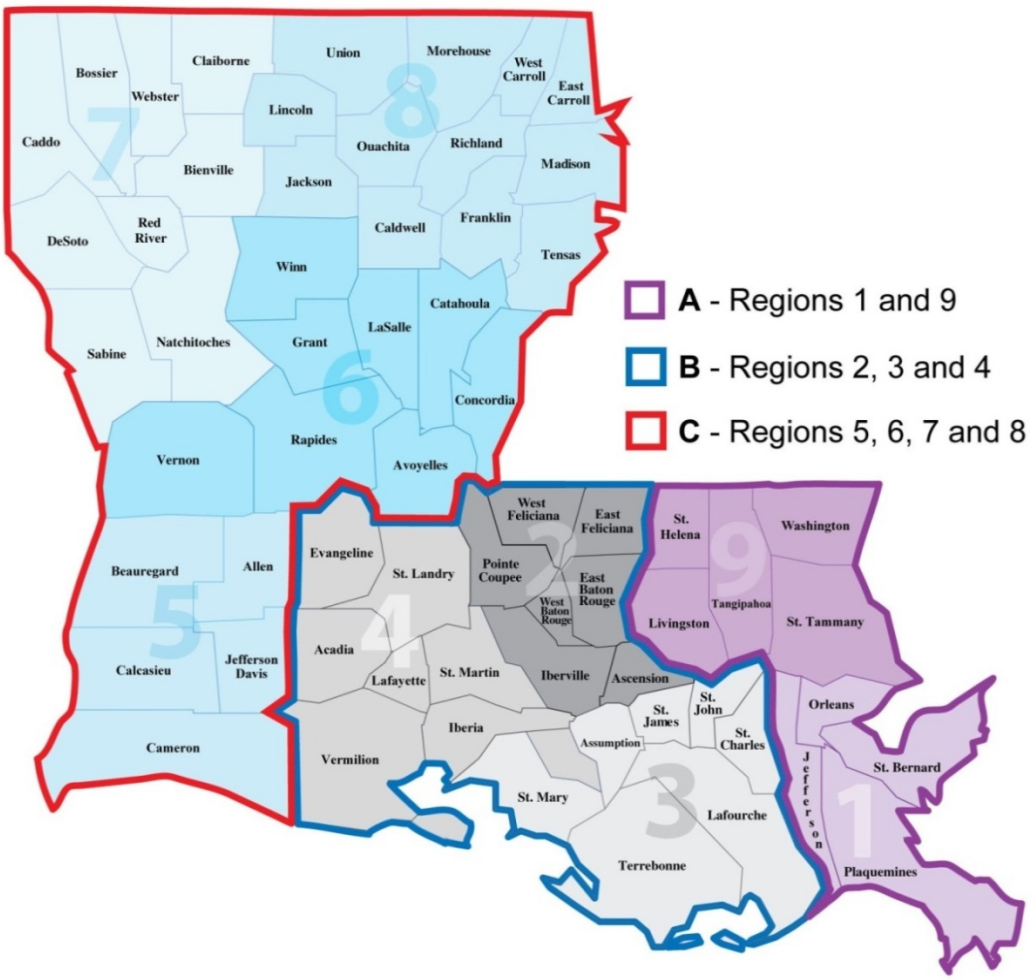
Bayou Health empowers Medicaid recipients to choose a Health Plan to fit their needs from a group of five different plans. DHH has observed marked improvements in the quality of care delivered under Bayou Health. Over the course of the first year of implementation of the Bayou Health program, there were numerous noteworthy accomplishments, including:

- Across the board, the average length of an adult's inpatient hospital stay has decreased from more than four days under legacy Medicaid to less than three under Bayou Health, which represents a reduction of thousands of hours spent in hospital rooms and a cost savings for the state;
- Claims data indicates a significant reduction in statewide neonatal intensive care unit (NICU) days paid by Medicaid, meaning more babies were carried full-term.
- The overall collective physician oversight for enrollees increased more than five-fold and new care management resources were offered to recipients.
- More than 25,000 individuals received case management to help them better manage their chronic or high-risk health conditions.
- Health Plans provided support for more than 63,000 members in their efforts to quit smoking, lose weight, gain access to dental and vision services and to purchase medical essentials such as prescription medications, health-related items for newborns and more.
- Health plans are providing ongoing assistance to at least 111 practices in attaining Patient Centered Medical Home (PCMH) certification.
- The Bayou Health Plans were recently subject to an External Quality Review (EQR) by an independent External Quality Review Organization. The initial review revealed that the health plans were at 98 percent full and substantial compliance across more than 4,000 collective state and federal regulations during the period of February 2012 through June 2013.

This report highlights specific data sets and program components requested by the Louisiana Legislature during the 2013 Louisiana Legislative Session outlined in Act 212. Components are described and summaries are provided in the sections contained within the text of this report; data relevant to the specific requests is also included in an addendum called the Act 212 Report Data Book. A full list of sources is included in the bibliography at the end of this document. In some cases the data is self-reported from the health plans, and in these cases the Department has worked diligently to ensure consistency in how data is captured and reported, though some discrepancies may still exist. For future reports, the Department is working to streamline how information is reported back from the health plans to the program and is exploring the option of contracting with on outside auditing firm to review and verify this self-reported information.

SECTION 1: COORDINATED CARE NETWORK NAME AND SERVICE AREA

Coordinated Care Networks	Geographic Service Area
Amerigroup Louisiana, Inc. (AMG)	Statewide (GSA A, B and C)
AmeriHealth Caritas Louisiana (AHC)	Statewide (GSA A, B and C)
Louisiana Healthcare Connections (LHC)	Statewide (GSA A, B and C)
Community Health Solutions of Louisiana (CHS)	Statewide (GSA A, B and C)
UnitedHealthcare Community Plan of Louisiana, Inc. (UHC)	Statewide (GSA A, B and C)



SECTION 2: TOTAL PROVIDERS BY HEALTH PLAN, GSA AND SPECIALTY

Included in the attached Act 212 Report Data Book is a full accounting of all providers for Bayou Health in each geographic service area (GSA) and specialty. These figures are unduplicated counts of providers currently registered with at least one Bayou Health prepaid plan. The 2011 figures used for comparison were actively enrolled in fee-for-service Medicaid from January 2011 through December 2012. In most areas, the number of available providers increased from the previous 2011 fee-for-service Medicaid program.

Total Specialty Providers by Geographic Service Area

Geographic Service Area	**Total Enrolled Bayou Health Providers**	**Total Enrolled Medicaid Providers in 2011**
A	6,580	5,506
B	4,923	3,891
C	4,823	3,970

Total Provider Types by Geographic Service Area

Geographic Service Area	**Total Enrolled Bayou Health Providers**	**Total Enrolled Medicaid Providers in 2011**
A	7,189	6,924
B	6,828	6,890
C	6,693	6,384

SECTION 3: TOTAL AND MONTHLY AVERAGE NUMBER OF MEMBERS ENROLLED IN EACH NETWORK BY ELIGIBILITY GROUP

The Bayou Health Plans, on average, had 885,649 members total each month in FY2013 , including more than 114,000 individuals receiving Medicaid because they also receive federal Supplemental Security Income, more than 760,000 families and children, approximately 8,000 children in foster care, more than 1,000 women in the Breast and Cervical Cancer program, and more than 3,000 children enrolled in the LaCHIP Affordable Plan. Totals for each plan for each month as well as overall figures are included in the Act 212 Report Data Book addendum.

Plan	SFY13 Average Monthly Enrollment
Amerigroup	137,831
Louisiana Healthcare Connections	165,583
AmeriHealth Caritas (LaCare)	153,898
Community Health Solutions	193,829
United Healthcare	236,509
Total	**885,649**

SECTION 4: CONTINUOUS PHONE ACCESS PROVIDED BY PCPS

Providers enrolled with Bayou Health Plans are required to provide after-hours coverage for their Bayou Health patients. To fulfill the requirement, a Primary Care Provider (PCP) must either utilize an after-hours answering service that can directly contact the PCP, provide an alternate PCP's number on a recording at the primary PCPs office, or transfer any after-hours calls to another location where it will be handled by a live person. All options must ensure the patient is connected with a PCP within 30 minutes of the call. Unmonitored answering machine messages that ask the patient to leave a message or refer the patient to the Emergency Room are not acceptable. The aggregate compliance rate across all plans was 63 percent, well below the intended target of 95 percent, which caused the Department to review this metric and make necessary technical amendments to Bayou Health contracts to clarify what DHH considers to be "continuous" monitoring and also to contract with a third party to verify access to all PCPs. An updated methodology for Community Health Solutions revealed that the compliance rate increased dramatically from nearly 20 percent to more than 61 percent, which will increase the overall compliance rate, but not up to the target.

The Department is making technical amendments to the Bayou Health contracts to clarify the allowable protocols for after-hours coverage, such that PCP offices that have "monitored" telephone answering machines or voice mail that is forwarded to a monitored call back system will no longer be counted as noncompliant. In 2014, the Department will contract with a single entity to complete the verification of PCP access. In addition to these survey method modifications, the health plans and the Department will be reaching out to primary care providers to increase access and compliance.

Health Plan	2013[1] Number of Primary Care Providers with Verified After Hours Coverage	2013[1] Number of Primary Care Providers Surveyed by Health Plan	2013[1] Percent of Health Plans Surveyed Primary Care Providers with Verified After Hours Coverage
Amerigroup	248	301	82.00%
AmeriHealth Caritas Louisiana	607	755	80.40%
Louisiana Healthcare Connections	66	183	36.07%
Community Health Solutions	62	312	19.87%[2]
UnitedHealthcare Community Plan	246	479	51.36%

[1] Data surveyed April – June 2013.
[2] Changes in methodology were made in the second quarter to address difficulties experienced with data collection of the initial report. The updated methodology demonstrated an increased rate of providers in compliance at 61%. Targeted outreach has been initiated and will continue for network providers not in compliance with this contractual responsibility.

SECTION 5: PERCENTAGE OF REGULAR AND EXPEDITED SERVICE AUTHORIZATION REQUESTS

Health plans processed prior-service authorizations very quickly across all quarters of the reporting period; they are required to have prior-authorization staff available for emergencies 24/7. Of the 133,046 prior-authorization requests, 89 percent were determined within two business days. After 28 business days 98 percent of requests had received determinations from the health plans. For expedited requests, 94 percent of the 4,070 submitted were approved within 72 hours.

Comparable data for prior authorization rates before the implementation of Bayou Health is not available. All five health plans have consistently exceeded the contracted requirement that 80 percent of standard authorizations are processed within 2 days. For the completion of expedited authorizations within 72 hours, significant and continued progress has been made each quarter since initial implementation of Bayou Health. DHH will continue to work with the health plans and providers to identify areas of improvement.

The set of data for this section is available in the attached Act 212 Report Data Book.

Plan	**Total Requests for Prior Authorization**	% of Prior Authorization Requests Processed within 2 Business Days	% of Prior Authorization Requests Processed within 28 Business Days	**Total Expedited Prior Authorization Requests**	% of Expedited Prior Authorization Requests Completed within 72 Hours
Amerigroup	38,711	93%	100%	3,188	99%
AmeriHealth Caritas Louisiana	14,576	87%	96%	208	85%
Louisiana Healthcare Connections	29,775	85%	99%	272	98%
Community Health Solutions	9,419	90%	100%	17	97%
UnitedHealthcare Community Plan	40,565	89%	98%	385	90%
Total	133,046	89%	99%	4,070	97%

SECTION 6: PERCENTAGE OF CLEAN CLAIMS PAID FOR PROVIDERS AND AVERAGE NUMBER OF DAYS TO PAY

The average number of days taken to pay all claims excluding the pre-processing timeline for all Bayou Health plans for the reporting period was seven days, fewer than the nine days taken pre-Bayou Health. Two of the Prepaid Bayou Health Plans have twice weekly (rather than once weekly) checkwrites.

The overall percentage of clean claims paid by the prepaid health plans to providers within established timeframe of 99% within 30 calendar days was nearly 100 percent for the reporting period – 99.7 percent. The transition to Bayou Health has maintained the high percentage of clean claims paid within 30 days by Medicaid prior to the implementation of Bayou Health.

A full breakdown of the claims paid by each plan per quarter of the year is available in the attached Act 212 Report Data Book.

Bayou Health Plan	**% of Clean Claims Paid within 30 Calendar Days**	**Average Number of Days to Pay All Claims**
Amerigroup	99.5%	5
AmeriHealth Caritas Louisiana	99.9%	6
Louisiana Healthcare Connections	99.6%	10
Total	**99.7%**	**7**
Pre-Bayou Health	99.6%	9

SECTION 7: NUMBER OF CLAIMS DENIED OR REDUCED BY EACH COORDINATED CARE NETWORK BY REASON

The Bayou Health plans denied 4,184,176 claims in 2012. In the year prior to the implementation of Bayou Health, the legacy Medicaid program denied 20,955,404 claims. While the differential is largely tied to the fact that Pre-Bayou Health claims denial information includes some services and populations that were carved out of Bayou Health, the Health Plans offer more robust provider education and technical assistance to help providers with administrative requirements like claims processing than the legacy Medicaid has traditionally provided.

The most commonly noted reason for denying a claim was missing pre-authorization for the filed claim. Other reasons cited for denying claims were that the documents did not support medical necessity, that a member had other insurance on file that needed to be billed first, that the claim was submitted after the timely filing deadline and a failure to meet other health plan administrative requirements. .In order to address these issues, the health plans are required to offer provider education and technical assistance, which was not a requirement under the legacy Medicaid program. There were also claims denied under an "all other" category, which included terminations, duplicate claims or charges that did not match the claims.

Attached in the Act 212 Report Data Book is a full breakdown of the number of denied claims and their associated reasons for denial per health plan. Because of carve outs, an exact comparison to claims data after the implementation is not possible.

Plan	Total Number of Denied Claims[1]
Amerigroup	1,212,616
AmeriHealth Caritas Louisiana	1,235,448
Louisiana Healthcare Connections	1,338,542
Community Health Solutions	164,634
UnitedHealthcare Community Plan	232,936
Pre-Bayou Health	20,955,404

[1] For the shared-savings plans (Community Health Solutions and UnitedHealthcare Community Plan) these totals reflect only claims denied by the plans during pre-processing.

SECTION 8: NUMBER AND DOLLAR VALUE OF CLAIMS PAID TO NON-NETWORK PROVIDERS BY TYPE

A key Bayou Health objective has been to ensure adequate access to appropriate care in the appropriate setting. All health plans are required to provide emergency services without requiring prior authorization and to reimburse for treatment of emergency medical conditions at 100 percent of the Medicaid rate regardless of whether the provider is in or out of the health plan's network. There were more than 565,000 total provider claims for emergency services paid to non-network providers totaling more than $61 million. It is important to remember that pre-paid plans are paid a fixed rate by the state which is not impacted by the level of non-network claims. Any expenses tied to non-network providers are born by individual health plans, not the state.

The full data sheet for Section 8 is contained within the attached Act 212 Report Data Book.

Plan	Number of Emergency Claims Paid to Non-Network Providers	Expenditures for Emergency Claims Paid to Non-Network Providers	Number of Non-Emergency Claims Paid to Non-Network Providers	Expenditures for Non-Emergency Claims Paid to Non-Network Providers
Amerigroup	93,064	$6,437,188	30,640	$1,173,444
AmeriHealth Caritas Louisiana	107,132	$10,003,293	127,406	$10,098,416
Louisiana Healthcare Connections	20,745	$1,840,065	257,665	$31,564,910
Total	**200,941**	**$18,280,546**	**415,711**	**$42,836,770**

SECTION 9: NUMBER OF MEMBERS WHO CHOSE THEIR NETWORK VERSUS AUTO-ENROLLED MEMBERS

Medicaid and LaCHIP enrollees who are Bayou Health eligible, both the mandatory and voluntary groups, may select a health plan when they first become eligible, during Bayou Health's annual open enrollment period, or at any other time if they have good cause to change plans. Some Medicaid recipients are allowed under federal rules to remain in the Legacy Medicaid program.

If members do not select a plan, they are automatically enrolled in a Bayou Health plan using an algorithm that takes into account family relationships and prior provider relationships. More individuals self-selected the UnitedHealthcare Community Plan than any other.

Members are only counted once in this report, even if they moved to more than one health plan during the year. The final proactive enrollment is the one that was counted.

Newly eligible Bayou Health members are provided an enrollment packet from the state's enrollment broker, Maximus. The packet includes a brochure with a breakdown of value-added services provided by each health plan. Enrollees can select a health plan a number of ways—by web, phone, and mail (using the postage-paid envelope) or in person at any Medicaid office or Application Center. During open enrollment, all current enrollees receive a notice from the enrollment broker regarding open enrollment and their option to select a new health plan.

Plan Name	**Proactive Choice Enrollments**	**Auto Enrollments**
Amerigroup	52,309	107,746
AmeriHealth Caritas	69,727	109,513
Louisiana Healthcare Connections	75,727	111,004
Community Health Solutions	108,838	122,078
UnitedHealthcare Community Plan	165,552	123,401
Legacy Medicaid	2,548	0
Totals	**474,701**	**573,742**

SECTION 10: TOTAL PAYMENTS AND AVERAGE PER MEMBER PER MONTH (PMPM) FOR EACH COORDINATED CARE NETWORK

A breakdown, by health plan, of the average monthly member enrollment across State Fiscal Year 2013 with total payments for the full year as well as monthly per member per month (PMPM) payments is included in the attached Act 212 Report Data Book.

Prepaid Bayou Health Plans have a higher actuarially determined PMPM because they are at full-risk to cover all state plan benefits and management required by the contract. The PMPM is also risk-adjusted, which accounts for variations in health risks among members.

The PMPM of the Shared Savings Plans (CHS and UHC) is a management fee paid for care coordination, utilization management and claims pre-processing. Shared plans do not pay claims; provider payments for services to a shared savings plan member are paid by DHH.

Bayou Health Plan Name	**Average Monthly Enrollment**	**Total Annual Payments to Plan**	**Average PMPM**
Amerigroup	137,831	$383,206,166	$232.38
AmeriHealth Caritas	158,898	$442,754,611	$240.08
Louisiana Healthcare Connections	163,583	$428,754,611	$219.00
Community Health Solutions	193,829	$25,716,638	$11.06
UnitedHealthcare Community Plan	236,509	$31,698,137	$11.17

SECTION 11: MEDICAL LOSS RATIOS FOR COORDINATED CARE NETWORKS AND RELATED REFUNDS

Bayou Health plans are required as part of their contracts to track their Medical Loss Ratio (MLR), which is defined as the percentage of the Per Member Per Month (PMPM) payments received by the health plans from DHH used to pay medical claims from providers, and approved quality improvements and IT costs. The MLR shall not be less than 85 percent. If the MLR falls below 85 percent, the health plans will be required to repay the difference to the Department.

The Medical Loss Ratio (MLR) Report used to determine whether a refund is due to DHH is due from pre-paid Health Plans no later than June 1, 2014. Federal regulations promulgated under Section 1001 of PPACA for determining the amount of premiums spent on health care define the MLR Reporting Year as a calendar year and require that more than 50% of a commercial health plan's membership must be enrolled for 12 consecutive months prior to the calculation of any MLR rebate. The MLR calculations for purposes of determining the percentage of premiums spent directly on Bayou Health members health care services use the same procedures.

Plan Name	**2012 Adjusted MLR**
Amerigroup	97.9%
AmeriHealth Caritas	97.2%
Louisiana Healthcare Connections	96.2%

In the interim, three separate data sheets in the attached Act 212 Report Data Book in which preliminary MLR specifics for the three applicable pre-paid plans are detailed.

SECTIONS 12 & 13: COMPARISON OF HEALTH OUTCOMES BETWEEN HEALTH PLANS AND TO MEDICIAD PRIOR TO BAYOU HEALTH

Health outcomes data requested in Section 12 of Act 212 for Bayou Health is not yet available; the outcomes specified are measures included in the national standards called Healthcare Effectiveness Data and Information Sets (HEDIS); these performance indicators were developed by the National Committee for Quality Assurance (NCQA) to help health care purchasers understand the value of health care purchases and measure plan performance. HEDIS data is reported by calendar year, must be established from claims tracked for a full calendar year, collected, allowing three months for claims to be received after the end of the year and certified. As Bayou Health was not implemented for the full calendar year of 2012, HEDIS data for 2012 could not be established. Data is currently being collected and closely monitored for calendar year 2013. It will be certified and made available in early summer 2014 as well as included in the next annual report required under Act 212.

Baseline data for pre-Bayou Health implementation as requested in Section 13 is available for SFY2011. These figures establish the starting point against which the performance of the Bayou Health plans will be measured. The pre-Bayou Health baseline performance measures are included in the chart below.

Legacy Medicaid Quality Measures[1]	**Actual Performance**	**Total to Which Measure Applies**	**Number of Hospital Admissions Per 100,000 Medicaid Members**
Adult Asthma Admission Rate (per 100,000)	261	275,879	94.61
CHF Admission Rate (per 100,000)	1,859	398,033	467.05
Uncontrolled Diabetes Admission Rate (per 100,000)	233	398,033	58.54
Adults' Access to Preventive/Ambulatory Health Services (Total)	162,921	205,615	79.24
Breast Cancer Screening (Total)	13,502	31,654	42.65
Well -Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (Total)	101,143	154,758	65.36
Childhood Immunization Status (Combination #3)	5,568	39,874	13.96

[1]Quality Measures for SFY11 for the Medicaid fee-for-service Program.

SECTION 14: MEMBER AND PROVIDER SATISFACTION SURVEYS FOR EACH BAYOU HEALTH PLAN

Member and provider surveys are contract requirements for each of the health plans to assess the quality and appropriateness of care to members, as well as provider satisfaction. Each health plan conducted separate surveys for adults, children and for providers.

Adult Member Satisfaction Composite Measures	Amerigroup	Amerihealth Caritas	Community Health Solutions	Louisiana Healthcare Connections	United Healthcare
Getting Care Quickly	79%	77%	82%	77%	79%
Shared Decision Making	49%	52%	50%	46%	50%
How Well Doctors Communicate	85%	87%	89%	90%	93%
Getting Needed Care	76%	75%	79%	75%	79%
Customer Service	86%	87%	82%	84%	89%

Children Member Satisfaction Composite Measures	Amerigroup	Amerihealth Caritas	Community Health Solutions	Louisiana Healthcare Connections	United Healthcare
Getting Care Quickly	89%	93%	91%	90%	92%
Shared Decision Making	61%	52%	57%	55%	57%
How Well Doctors Communicate	94%	94%	93%	93%	95%
Getting Needed Care	84%	87%	87%	81%	90%
Customer Service	87%	89%	88%	85%	88%

For purposes of reporting the CAHPS results in HEDIS (Healthcare Effectiveness Data and Information Set) and for scoring for health plan accreditation, the National Committee for Quality Assurance (NCQA) uses five composite measures.

The provider surveys for each health plan are included in the attached Act 212 Report Data Book.

SECTION 15: ANNUAL AUDITED FINANCIAL STATEMENTS FOR COORDINATED CARE NETWORKS

Included in the attached Act 212 Report Data Book are the annual audited financial statements for each of the five Bayou Health plans as provided to the Department.

SECTION 16: TOTAL SAVINGS TO THE STATE FOR EACH SHARED-SAVINGS COORDINATED CARE NETWORK

Shared savings for the shared-savings health plans are assessed by DHH's actuary through the comparison of actual expenditures during the measurement period for a Plan's members, compared to the actuarially established benchmark of what DHH would have paid for that care, in the absence of managed care. Beginning in Year 2, the plans' receipt of their share of any achieved savings will be contingent on their meeting five key performance measures. They will be eligible to receive 20 percent of their portion of the total savings (up to 60 percent of the total savings) for each one of the five performance measures. The state portion of the shared savings achieved by Community Health Solutions and United Healthcare Community Plan for the period ending 12/31/12 was slightly more than $5 million.

Shared Savings Plan Name	Below Benchmark for Period Ending 12/31/12 (Preliminary Reconciliation)	State of Louisiana Share of Savings for Period Ending 12/31/12
Community Health Solutions of America	$10,042,670	$4,017,068
United Healthcare of Louisiana, Inc.	$2,466,823	$986,729
Totals	$12,509,493	$5,003,797

SECTION 17: NARRATIVE OF SANCTIONS LEVIED BY DHH AGAINST A COORDINATED CARE NETWORK

The Department of Health and Hospitals may apply administrative actions or assess monetary penalties to obtain the level of performance required for successful operation of the Bayou Health program. If DHH determines that a health plan's quality performance is not acceptable, it will require the health plan to submit a corrective action plan. If that corrective action plan is not fulfilled within the specified time, DHH sanctions the health plan in accordance with the provisions set forth in the plan's contract and may immediately terminate all new enrollment activities and automatic assignments to the health plan in question. Monetary sanctions are utilized to provide DHH a means for obtaining the services and level of performance required for successful operation of the plan's contract.

Below is a list of sanctions DHH levied against Bayou Health Plans for being deficient or non-compliant with contract requirements:

1. **AmeriHealth Caritas Louisiana (formerly LaCare) was assessed a $170,000 monetary penalty on June 18, 2013 due to non-compliance with pharmacy encounter claims submissions**. Section 17.6.2.1 of Exhibit E states: The Health Plan shall submit a monthly claim level detail file of pharmacy encounters to DHH which includes individual claim level detail information on each pharmacy claim dispensed to a Medicaid patient, including but not limited to the total number of metric units, dosage form, strength and package size, as well as the Nation Drug Code of each covered outpatient drug dispensed to Medicaid enrollees. This monthly submission must comply with Section 17.5.4 requirements. The monetary penalty of $170,000, equal to $10,000 per day, for 17 calendar days of noncompliance, was assessed in accordance with section 20.2.3 of Exhibit E of the contract.

2. **AmeriHealth Caritas Louisiana (formerly LaCare) was assessed a $240,000 monetary penalty on July 16, 2013 due to noncompliance with encounter data submissions**. Section 17.5.4.12 states: For encounter data submissions, the CCN shall submit 95 percent of its encounter data at least monthly due no

later 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 ($0.00) and encounters in which the CCN has a capitation arrangement with a provider. The CCN CEO or CFO shall attest to the truthfulness, accuracy and completeness of all encounter data submitted. The monetary penalty of $240,000, equal to $10,000 per day for 24 calendar days of noncompliance, was assessed in accordance with section 20.2.3 of Exhibit E of the contract.

3. **United Healthcare Community Plan was assessed a $140,700 monetary penalty on June 18, 2013 due to noncompliance with pre-processed claims data submissions**. Section 13 of Exhibit E of the contract states: The CCN shall maintain an automated Management Information System, which accepts provider claims, verifies eligibility, validates prior authorization, pre-processes and submits claims data to DHH's fiscal intermediary that complies with DHH and federal reporting requirements. The monetary penalty of $140,700 for noncompliance beginning February 27, 2013 through April 27, 2013 was assessed in accordance with section 4.9 of Exhibit E of the contract.

During this reporting period, Amerigroup, Community Health Solutions and Louisiana Healthcare Connections were not assessed any monetary penalties for being deficient or non-compliant with contract requirements.

SECTION 18: GRIEVANCES, APPEALS, STATE FAIR HEARINGS BY NUMBER OF MEMBERS PER COORDINATED CARE NETWORK INCLUDING REVERSALS

Grievance and appeals processes are important components of ensuring a healthy system within the provision of services provided by the health plans. The internal appeals and grievances processes vary between health plans and the variation in numbers should not necessarily be taken as an indication of problems.

It is important to note that shared-savings plans do not have an internal appeals process for addressing the next step after a grievance. Instead, a grievance would next go to a state fair hearing with the Division of Administrative Law who then makes recommendations to the Secretary of DHH as to whether services must be provided. The Secretary of DHH has final authority over what services shall be provided after the recommendation has been made by the Division of Administrative Law. To date, no ruling has been overturned at a state fair hearing indicating that, where utilized, the internal review process is serving its function.

A breakdown of the number of members by Health Plan who filed a grievance or appeal and the number of members who accessed the state fair hearing process are included in the charts in the attached Act 212 Report Data Book. Also included are the number and percentage of grievances or appeals that were reversed or otherwise resolved a decision in favor of the member.

SECTIONS 19-23: DATA REGARDING TYPES OF SERVICES PROVIDED, LOCATIONS, TYPES OF CARE AND PRESCRIPTION BENEFITS

Act 212 requested various data sheets outlining in-depth data to outline types of services provided, where those services were provided and prescription benefits for Bayou Health members. Each set of data is provided in the attached Act 212 Report Data Book by section. In summary, the section components are listed below.

- Section 19: Number of members who received unduplicated Medicaid services from each Health Plan, broken down by provider type, specialty and place of service.

- Section 20: Number of members who received unduplicated outpatient emergency services, broken down by Health Plan and aggregated by the following hospital classifications, including state, non-state rural, rural and private.

- Section 21: Number of total inpatient Medicaid days broken down by Health Plan and aggregated by the following classifications, including state, public non-state non-rural, rural and private.

- Section 22: Number of claims for emergency services, broken out by Health Plan, whether the claim was paid or denied and by provider type, as well as comparable metrics for claims for emergency services that were processed by the Medicaid fiscal intermediary for the period prior to the date of services initially being provided under Bayou Health.

- Section 23: Information for pharmacy benefits broken down by each Health Plan and by month, including total number of prescription claims, total number of prescription claims subject to prior authorization, total number of prescription claims denied, and total number of prescription claims subject to step-therapy or fail-first protocols.

SECTION 24: ANY OTHER METRIC OR MEASURE THAT THE DEPARTMENT OF HEALTH AND HOSPITALS DEEMS APPROPRIATE FOR INCLUSION IN THE REPORT

Although data for Section 12 was not available in this first iteration of the report requested under Act 212, other health outcomes data reported by the health plans to DHH is available, including:

- Specialist visits for adults and children,

- Pre-term births,

- Low birth weight,

- Very low birth weight, and

- C-Sections data.

This outcomes data reveals positive progress in outcomes such as the reduction in the rate of pre-term births. This improvement seen through Bayou Health reporting information is key to a larger initiative engaged in by the Department of Health and Hospitals, hospitals across the state, the Louisiana Hospital Association and the March of Dimes. Measurable improvement in health outcomes that are critical to improving the long-term health prospects for Louisiana's children is an example of the ability of Bayou Health to partner with hospitals and programs at DHH to effect change in patient care.

CONCLUSION

Bayou Health is still a young iteration of the state's revamped Medicaid system for acute care service delivery, one that aims to transform patient care and dramatically improve health outcomes for the Medicaid population. The program marked one year of statewide enrollment in June 2013, and December 2013 marked the beginning of the second round of open enrollment for members since the program's implementation. These early indicators are positive signs that the overhaul was a positive change for the state's patients, hospitals and taxpayers.

DHH has high expectations for improvements in quality and health outcomes, and data available in the coming year – including the first HEDIS numbers in summer 2014 – will continue to provide measurement of the program's performance.

Acknowledgments

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BIBLIOGRAPHY

The majority of Act 212 reporting was collected through ad-hoc report requests of the Bayou Health Plans. Where possible, independent analysis of claims and encounters data was conducted by Medicaid Data Analysts in response to ACT 212 requirements. The primary data source used for this analysis was the Management and Administrative Reporting Subsystem (MARS) Data Warehouse maintained and supported by the state's Fiscal Intermediary, Molina.

Provider data was collected from the Bayou Health Provider Registry, submitted by the Bayou Health Plans reflecting contracted providers.

Enrollment data was collected from an ad-hoc reporting request made to the Bayou Health Enrollment Broker, Maximus, to fulfill report parameters of Act 212.

The following monthly, quarterly and annual reports, submitted by the Bayou Health Plans in keeping with contract deliverables, were utilized for Act 212 response:

- Report #113 – Grievance, Appeal and State Fair Hearing Report
- Report #114 – Grievance, Appeal and State Fair Hearing Report (Prepaid)
- Report #116 – Shared Savings Grievance Appeals SFH Summary
- Report #117– Grievance, Appeal and State Fair Hearing Report (Shared Savings)
- Report #132 – Annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for adults and children, following national CAHPS guidance <https://cahps.ahrq.gov/>
- Report #173 – Prepaid Denied Claims Report
- Report #188 – Prior Authorization and Pre-Cert Summary Report
- Report #217 – Early Warning Systems Report