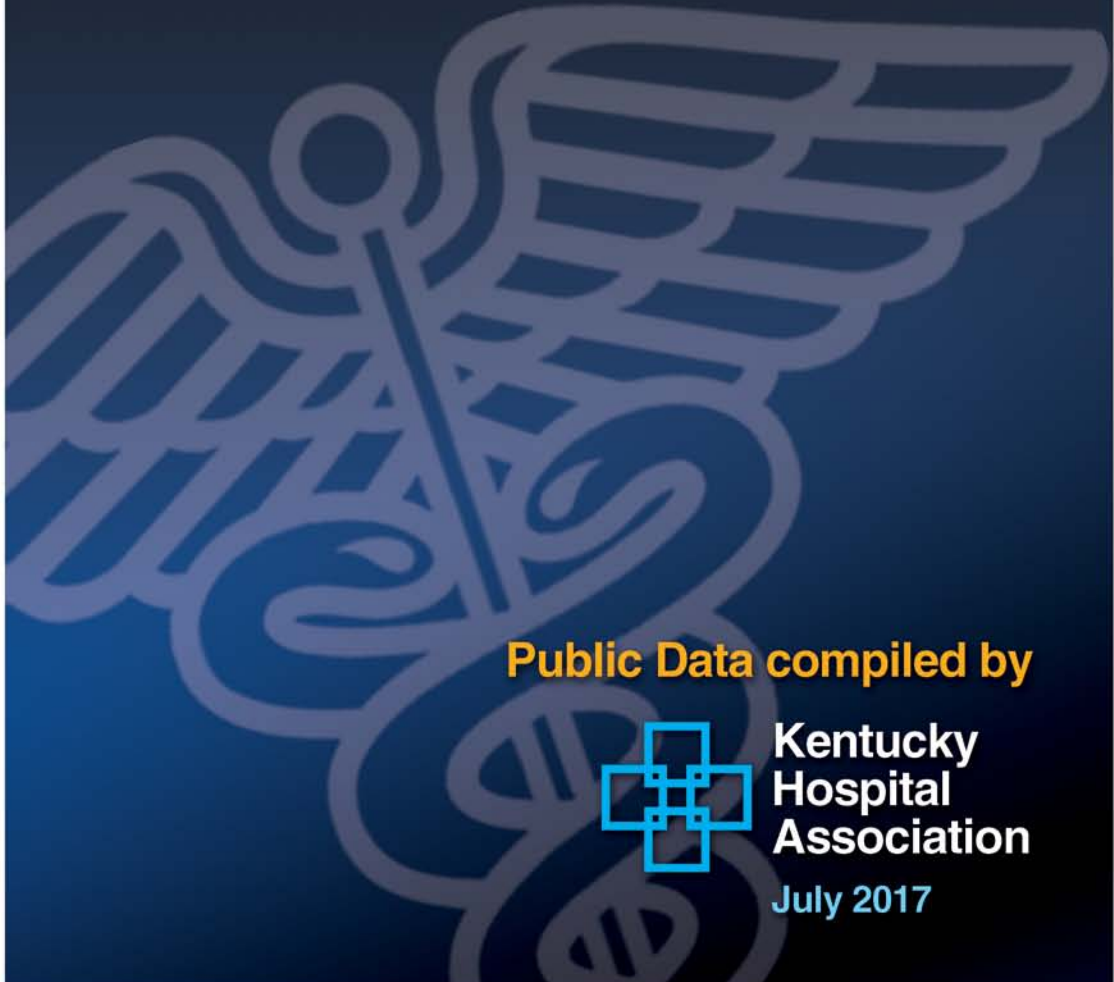
Medicaid Managed Care Organization (MCO) Performance Report - 2016



Public Data compiled by

Kentucky Hospital Association

July 2017

Medicaid Managed Care Organization (MCO)

Performance Report - 2016

Introduction

In November, 2011, Kentucky enrolled approximately ninety percent (90%) of the Medicaid population in managed care, through which Medicaid Managed Care Organizations (MCOs) are paid a fixed monthly capitated rate per enrollee and are at financial risk for recipient use and service expenditures. The MCOs are responsible for managing both physical and behavioral health services for their members. In 2016, there were five MCOs operating in all regions of the state and managing care for about 1.3 million Medicaid recipients.

This report provides comparative MCO performance on their medical loss ratios, utilization review denial rates, quality scores, corrective action citations from the state, and prompt payment of hospital claims. All data in this report has been compiled from public data sources.

MCO Medicaid Financial Performance

Because the MCOs are risk-bearing entities, they are required to be licensed by the Kentucky Department of Insurance (DOI) as an HMO or insurer and meet the applicable financial solvency requirements. As licensed insurers, the MCOs are also required to file an Annual Statement with the Department of Insurance which details assets, liabilities, revenue and expenses. The Annual Statement is a standard national reporting form such that data may be compared among reporting entities. As part of this filing, MCOs must report information on the number of members, premiums, and expenses for health care services for their total business and separately for business in the Commonwealth of Kentucky, broken down by Medicaid, individual, and group plans.

The information in **Table 1** was compiled from each MCO's 2016 Annual Statement filed with the Kentucky Department of Insurance. It compares Medicaid premium revenue (capitation payments from the state for Medicaid enrollees) with amounts incurred by the MCO for health care services for their Medicaid members. Using this data, a medical loss ratio can be calculated to determine the percent of premium revenue (capitation payments) used to pay for health care services to enrollees of the MCO. The report also calculates an Administrative Loss Ratio, as the percentage of revenue (capitation payments) used by the MCO to pay claims and for other administrative costs. The Net Underwriting Gain or Loss indicates whether the MCO made a profit or experienced a loss on its Medicaid business. The underwriting ratio expresses the profit or loss as a percentage of the MCO's revenue (capitation payments).

Table 1 presents Kentucky Medicaid premium revenue, expenses for health care services for Medicaid members, the medical loss ratio, administrative loss ratio, and underwriting ratio (profit or loss) for each MCO in 2016. The data for Aetna Better Health, Anthem MCO, Passport, and Wellcare reflect Kentucky Medicaid business, while the data for Humana covers their Medicaid business in multiple states of which Kentucky Medicaid premiums represent eleven percent of Humana's total reported Medicaid net premium income.

The calculation of Medical Loss Ratio, Administrative Loss Ratio, and Underwriting Ratio follows the methodology, definitions and data sources published by Milliman in "Medicaid risk-based managed care: Analysis of financial results for 2015."

Table 1: MCO Medical Loss Ratio

DMS Contract Requires 90%

Kentucky Medicaid MCO Medical Loss Ratios and Profits - as of December 31, 2016

Annual 2016 DOI STATEMENT	Aetna Better Health	Anthem MCO	Humana	Passport	Wellcare	Total All
Medicaid - Kentucky			(all States)			
Total Revenue, Medicaid	$1,062,881,977	$583,157,263	$294,289,038	$1,730,097,322	$2,590,509,181	$6,260,934,781
Total Hospital and Medical Expenses Medicaid	$803,276,717	$493,174,663	$280,167,162	$1,644,681,907	$2,253,369,566	$5,474,670,015
Increase in Reserves for Accident and Health Contracts	-	-	-	(1,280,459)	-	(1,280,459)
Medical Loss Ratio	76%	85%	95%	95%	87%	87%
Claim Adjustment Expenses	$25,774,574	$27,336,548	$20,522,283	$1,237,383	$30,192,146	$105,062,934
General Administrative Expenses	$70,380,388	$31,935,162	$22,734,406	$164,749,524	$236,046,288	$525,845,768
Administrative Loss Ratio	9.0%	10.2%	14.7%	9.6%	10.3%	10.1%
Net Underwriting Gain or (Loss): Medicaid	$163,450,298	$30,710,890	-$29,134,813	-$79,291,033	$70,901,181	$156,636,523
Underwriting Ratio (Profit)	15%	5%	-10%	-5%	3%	3%
Excess Profit (Actual -Profit at 2.6%)	$135,815,367	$15,548,801			$3,547,942	$154,912,110

Source: 2016 Annual Statement, pg. 7., Milliman definitions of MLR, Administrative Loss Ratio and Underwriting Ratio

Findings

- Kentucky MCOs reported $6.3 billion in capitation payments and $5.5 billion in payments for Medicaid enrollee health care services, for an 87% combined Medical Loss Ratio (MLR). However, the MLR varied substantially among MCOs, ranging from 78% to 95%.
- **MCO contracts with the Department for Medicaid Services require the MCOs to operate at a 90% MLR.** Both Humana and Passport had a 95% MLR, Anthem and Wellcare were close with an 85% and 87% MLR, respectively, but **Aetna Better Health was significantly below the requirement with a 76% MLR.**
- The Kentucky MCOs used about 10% of their capitation payments for administrative costs, but this ranged from 9% (Aetna Better Health) to nearly 15% (Humana).
- The MCOs had a combined three percent (3%) profit margin, but this was due to two plans (Humana and Passport) experiencing a loss. **Wellcare had a 3% margin, Anthem had a 5% margin, but Aetna Better Health had the highest profit margin of 15%.**
- According to a May 2016 report issued by Milliman , the national average Medicaid MCO profit margin was 2.6% in 2015. Each of Kentucky's MCOs reporting a gain had a margin higher than the 2015 national average MCO margin, and **one MCO's margin was nearly six times greater.**
- The profitable Kentucky MCOs had a **combined profit of $265 million** in 2016.
- **Taxpayers, which fund the Medicaid program, paid $155 million more in MCO profits in 2016 – primarily to one MCO - than if the profitable Kentucky MCOs had profit margins equal to the 2015 national average for Medicaid MCOs as reported by Milliman.**

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[1]Palmer, J., Pettit, C. (May 2016). Medicaid risk-based managed care: Analysis of financial results for 2015. Milliman.

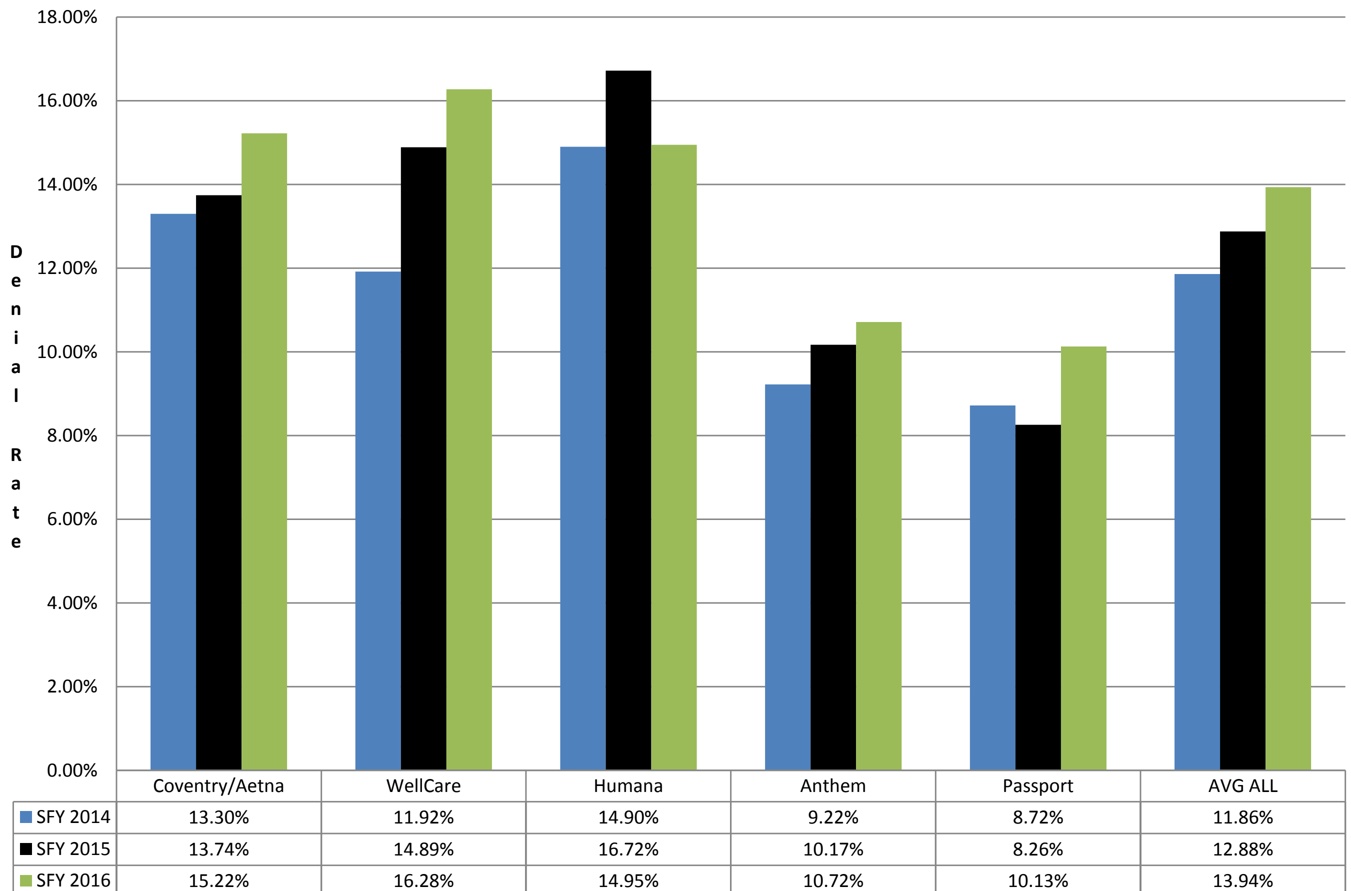
Medicaid Utilization Review Denial Rates

Table 2 shows Medicaid prior authorization denial rates for the last three state fiscal years by MCO. This reflects the number of preauthorization requests denied by the MCO for all services, exclusive of pharmacy, compiled from monthly MCO Dashboard reports published by the Department for Medicaid Services.

Findings

- For the last three years (SFY 2014-2016), Passport Health Plan has consistently had the lowest denial rate at about 9%, followed closely by Anthem with an average denial rate of 10%.
- Humana Care Source had the highest average denial rate from SFY 2014-2016 at 15.5%, followed by Wellcare at 14.4%, and then Coventry/Aetna Better Health at 14%.
- In state fiscal year 2016, however, Wellcare had the highest denial rate at 16.3%, followed by Aetna Better Health at 15.2%, and then Humana Care Source at 15%. Passport had the lowest denial rate at 10%, followed by Anthem at 11%.

Table 2: Medicaid Prior Authorization Denials by Medicaid MCO
(excludes pharmacy)



	Coventry/Aetna	WellCare	Humana	Anthem	Passport	AVG ALL
SFY 2014	13.30%	11.92%	14.90%	9.22%	8.72%	11.86%
SFY 2015	13.74%	14.89%	16.72%	10.17%	8.26%	12.88%
SFY 2016	15.22%	16.28%	14.95%	10.72%	10.13%	13.94%

Source: *MCO Dashboard Reports, DMS*

Quality Scores

The Department for Medicaid Services annually publishes MCO ratings on quality and access measures to assist Medicaid enrollees in the selection of an MCO. Each MCO was rated on a scale from **one star, "much below average"**, to **five stars, "excellent"**, on measures related to preventive care and getting help when needed.

Findings

- Passport Health Plan was again the highest rated MCO. In the 2017 ratings, Passport had three (3) five-star ratings and no one-star ratings.
- Anthem had the highest number of one-star ratings at seven (7), followed closely by Humana Care Source and Aetna which both had six (6) one-star ratings.

	Number of Five Stars "Excellent"	Number of One Stars "Much Below Average"
Passport	3	0
Wellcare	2	4
Aetna Better Health	1	6
Humana Care Source	0	6
Anthem	0	7

- When above average and below average ratings are combined, Passport Health Plan continues to be the highest rated plan. Aetna Better Health is the lowest rated plan both in terms of lacking above average scores and with the highest number of below average performance scores.

	Number of Excellent + Above Average Scores	Number of Below Average + Much Below Average Scores
Passport	**5**	6
Wellcare	4	5
Anthem	3	8
Humana Care Source	2	9
Aetna Better Health	1	**11**

2017 Guide to Choosing a Medicaid Health Plan

KEY – ★★★★★ Excellent ★★★★ Above Average ★★★ Average ★★ Below Average ★ Much Below Average

PREVENTIVE CARE

Health Plan	Childhood Immunizations	Well-Child Visits in the First 15 Months of Life	Well-Child Visits Ages 3 to 6	Diabetes Testing HbA1c	Tobacco Use Cessation	Cervical Screening	Prenatal Care
Aetna Better Health of Kentucky	★★	★★	★	★★	★	★	★★
Anthem BCBS Medicaid	★	★	★	★★★	★	★	★★
Humana - CareSource	★	★	★	★★★	★	★	★★
Passport Health Plan	★★★★★	★★★★	★★	★★	★★	★★	★★★
WellCare of Kentucky	★	★★	★	★★★	★★★	★	★★★

GETTING HELP WHEN NEEDED

Health Plan	Getting Child Care Quickly	Child Customer Service	Parent Overall Satisfaction with Child's Health Plan	21 and Under Dental Visits	Getting Adult Care Quickly	Adult Customer Service	Adult Overall Satisfaction with Health Plan
Aetna Better Health of Kentucky	★★★★★	★★★	★	★★★	★★	★	★
Anthem BCBS Medicaid	★★★★	★★★	★	★	★★★★	★★★★	★★★
Humana - CareSource	★★★	★★★	★	★★	★★★★	★★	★★★★
Passport Health Plan	★★	★★★	★★★★	★★	★★★	★★★★★	★★★★★
WellCare of Kentucky	★★★★★	★	★★★	★★★★	★★★★	★★★	★★★★★

Source: *DMS*

DMS Corrective Action by MCO

The contract between the Department for Medicaid Services (DMS) and the MCOs establishes progressive corrective actions to be taken when DMS finds that an MCO is violating their state contract.

- **Letter of Concern –** DMS sends a letter of concern in response to an MCO contract violation. An MCO must contact DMS in two business days and indicate how the concern will be addressed. If the MCO fails to respond, DMS proceeds with additional enforcement.
- **Corrective Action Plan (CAP) –** DMS notifies an MCO that a Corrective Action Plan is needed when they find the MCO is not in substantial compliance with a material provision in their state contract. The MCO receives a written deficiency and must submit a corrective action plan within ten days which includes a timeframe for resolution. The MCO's plan is subject to DMS approval. If an MCO fails to cure a default in accordance with a plan of correction, DMS may impose a variety of fines, depending on the nature of the deficiency. At the time that a written deficiency notice requiring a CAP is issued, DMS withholds 0.25% of monthly capitation for Type B and 0.5% for Type A deficiencies until the CAP is completed. A nonrefundable penalty of $10,000/Type B and $50,000/Type A infraction is also imposed. Type A deficiencies include contract violations relating to provider payment, network adequacy, appeals, and covered services. MCOs can receive fines for ignoring a CAP or failing to correct the deficiency.
- **Notice of Breach –** If an MCO fails to cure a deficiency under a CAP or it is determined they cannot cure the deficiency, DMS may suspend further enrollment in the MCO, suspend capitation payment, disenroll members, and appoint temporary management.
- **Termination for Default –** The Commonwealth may terminate the contract for nonperformance of the terms and conditions as well as for other reasons which include fiscal insolvency, failing to meet minimum standards of care, loss of their HMO license, providing fraudulent or intentionally misleading information to members, and failing to provide covered services to members.

The following table shows the number of Letters of Concern, Corrective Action Plans, Sanctions, and Cease and Desist Orders issued by the Department for Medicaid Services (DMS) to each MCO from March 1, 2016 through April 30, 2017. This information was compiled from DMS data provided to the Medicaid Advisory Council.

Findings:

- Aetna Better Health had the highest number and percentage of Letters of Concern and Corrective Action Plans of all MCOs.
  - Aetna received 22 Letters of Concern, representing 29% of the total issued.
  - Aetna received 50 deficiencies requiring a Corrective Action Plan, representing 43% of the total CAPs issued by DMS.
- Aetna Better Health, Anthem, and Humana Care Source also each were sanctioned, and Wellcare received one Cease and Desist Order.

DMS Corrective Action by MCO - March 1, 2016 – April 30, 2017

MCO	Letters of Concern (LOC)	% of Total LOCs	Corrective Action Plans	% of Total CAPs	Sanctions	Cease & Desist Orders
Aetna/Coventry	22	29%	50	43%	1	0
Anthem	15	20%	26	22%	1	0
Humana	14	19%	11	9%	1	0
Passport	13	17%	16	14%	0	0
Wellcare	11	15%	14	12%	0	1
Total	**75**		**117**		**3**	**1**

Sanctions: Humana – TPL issues, Aetna & Anthem – Failure to Cooperate
Cease & Desist: Failure to respond to DMS on Medical Necessity Criteria for Therapy
Source: Medicaid Advisory Council Reports. DMS

Prompt Payment of Hospital Claims

The Kentucky Prompt Pay Law applies to Medicaid MCOs. The law requires MCOs to pay the total amount of a clean claim at the provider's contracted rate within thirty (30) days of receipt by the MCO, unless the claim is denied or a portion is disputed, in which case, the MCO must pay the portion not in dispute. Also, at least 90% of the total dollar amount of the clean claims received that are not denied or contested must be paid within 30 days.

The following data was compiled from the prompt pay reports submitted by each of the Medicaid MCOs to the Department of Insurance from the third quarter of 2014 through the third quarter of 2016. This data illustrates the MCO's reported adherence to the payment of clean hospital claims within thirty days as well as the extent to which the MCOs report paying 90% of the total dollar value of the hospital clean claims within 30 days.

Findings:

- Over the two year period, Passport Health Plan had the highest self-reported consistency in achieving above 90% of hospital clean claims paid within 30 days.
- Humana Care Source had the worst performance with two quarters below 70% and two quarters below 80%, followed by Anthem with four quarters below 80%. Coventry Cares/Aetna Better Health also had one quarter below 70% and one quarter below 80%, and their performance deteriorated after the third quarter of 2015 which was when Coventry Cares transitioned to Aetna Better Health.
- Neither Aetna Better Health nor Anthem reported paying at least 90% of the hospital clean claims they received within 30 days in any quarter during the two year time period covered in this report.
- Most MCOs report that they pay 90% of the total dollar amount of hospital clean claims in 30 days, with the exception of Aetna Better Health and Humana Care Source. Care Source's percentage of total dollars paid was consistently well below the 90% required threshold until the second and third quarters of 2016. Aetna Better Health's compliance declined in 2016 which coincides with the transition of Coventry Cares to the Aetna Better Health claims payment system.

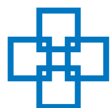
Payment of Hospital Claims by MCOs

Clean Claims Paid Promptly in 30 Days (Paid and not denied)

MCO	Q3 2014	Q4 2014	Q1 2015	Q2 2015	Q3 2015	Q4 2015	Q1 2016	Q2 2016	Q3 2016
Coventry/Aetna	84.36%	88.36%	88.39%	87.87%	87.96%	86.34%	68.58%	79.67%	83.60%
Anthem	85.48%	81.42%	81.76%	79.33%	77.68%	78.58%	80.36%	75.06%	74.25%
Humana Care Source	67.70%	64.18%	83.63%	81.73%	77.64%	84.74%	76.60%	87.67%	94.90%
Passport	92.74%	84.01%	89.31%	76.61%	94.02%	94.10%	93.55%	93.12%	93.12%
Wellcare	87.30%	No Report	87.51%	89.26%	89.78%	89.14%	90.49%	91.05%	90.98%

Percent of Dollars Owed to Hospitals Paid Promptly in 30 Days (90% Required)

MCO	Q3 2014	Q4 2014	Q1 2015	Q2 2015	Q3 2015	Q4 2015	Q1 2016	Q2 2016	Q3 2016
Coventry/Aetna	96.88%	96.53%	97.46%	94.33%	97.62%	96.59%	77.35%	87.40%	86.78%
Anthem	95.64%	96.85%	96.21%	99.31%	99.42%	97.26%	99.66%	98.64%	98.80%
Humana Care Source	70.23%	69.55%	82.78%	86.51%	85.08%	82.66%	78.54%	90.70%	98.94%
Passport	99.08%	89.24%	90.70%	77.38%	97.14%	91.19%	98.92%	99.92%	99.92%
Wellcare	93.05%	No Report	94.53%	96.11%	97.49%	88.83%	94.63%	97.12%	95.95%



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