Medicaid Managed Care Organization (MCO) Performance Report - 2017

Public Data compiled by

Kentucky Hospital Association

September 2018

Medicaid Managed Care Organization (MCO)

Performance Report - 2017

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 2017, there were five MCOs operating in all regions of the state and managing care for about 1.3 million Medicaid recipients.

- **Aetna Better Health of Kentucky (Aetna)**
- **Anthem Kentucky Managed Care Plan (Anthem)**
- **Humana Care Source (Humana)**
- **Passport Health Plan (Passport)**
- **Wellcare Health Insurance Company of Kentucky (Wellcare)**

In state fiscal year 2017, Wellcare had the highest average membership, followed by Passport, Aetna, Humana, and Anthem. All of the MCOs gained membership in 2017 except Aetna, which saw nearly a 23,000 reduction in enrollees.

	Avg Enrollment	Avg Enrollment		2017
	SFY 2016	SFY 2017	% Change	% of Total
Aetna	283,779	261,008	-8%	21%
Anthem	91,454	115,537	26%	9%
Humana	122,560	137,588	12%	11%
Passport	277,105	301,263	9%	24%
Wellcare	436,290	442,929	2%	35%
Total	1,211,188	1,258,325	4%	100%

This report provides comparative MCO performance on their medical loss ratios, utilization review denial rates, consumer ratings, corrective actions from the state, and prompt payment of hospital claims.

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 2017 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 2017. The data for Aetna, Anthem, 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 80 percent of Humana's total reported Medicaid premium revenue.

The calculation of Medical Loss Ratio, Administrative Loss Ratio, and Underwriting Ratio follows the methodology, definitions and data sources published by Milliman in "Medicaid managed care financial results for 2017."

Table 1: MCO Medical Loss Ratio

Kentucky Medicaid MCO Medical Loss Ratios and Profits, as of December 31, 2017

Annual 2017 DOI STATEMENT	Aetna Better Health	Anthem MCO	Humana	Passport	Wellcare	Total All
Medicaid - Kentucky			(all States)			
Total Revenue, Medicaid	$1,075,366,624	$658,940,312	$263,537,863	$1,897,000,830	$2,612,743,484	$6,507,589,113
Total Hospital and Medical Expenses Medicaid	$927,895,004	$558,070,876	$252,946,321	$1,705,056,248	$2,286,417,897	$5,730,386,346
Medical Loss Ratio	86.3%	84.7%	96.0%	89.9%	87.5%	88.1%
Estimated CMS Medical Loss Ratio	88.8%	87.2%	98.5%	92.4%	90.0%	90.6%
Claim Adjustment Expenses	$27,111,921	$31,397,235	$18,788,072	$202,057	$32,078,888	$109,578,173
General Administrative Expenses	$66,351,464	$29,393,550	$17,694,275	$176,834,110	$177,032,418	$467,305,817
Total Administrative Expense	$93,463,385	$60,790,785	$36,482,347	$177,036,167	$209,111,306	$576,883,990
Prorated Taxes and Fees	$10,603,442	$9,494,448	$760,956	$868,452	$26,244,110	$47,971,408
Administrative Loss Ratio (ALR) Net of Taxes and Fees	7.8%	7.9%	13.6%	9.3%	7.1%	8.2%
Net Underwriting Gain or (Loss): Medicaid	$54,008,235	$40,078,651	-$25,890,805	$14,908,415	$117,214,281	$200,318,777
Underwriting Ratio (Profit)	5.0%	6.1%	-9.8%	0.8%	4.5%	3.1%
Underwriting Ratio Net of Taxes & Fees	5.9%	7.4%	-9.6%	0.8%	5.4%	3.8%
Percent Profit > National Average of 3.2%	2.7%	4.2%	-12.8%	-2.4%	2.2%	
Credit for ALR Cost Efficiency	-0.8%	-0.7%			-1.5%	
Net Percent Profit >National Average	1.9%	3.5%			0.7%	
MCO Profit Above National Average	$20,578,358	$23,114,479	-	-	$18,021,856	$61,714,693

Taxes and Fees includes state and local insurance taxes, state premium taxes, regulatory authority licenses and fees and excludes payroll, real estate, and federal and state income taxes; prorated based on Medicaid claim and general administrative expense to total for all lines of business

CMS Medical Loss Ratio estimated by adding 2.5% to calculated medical loss ratio based on Milliman Report that CMS adjustment for quality improvement expenditures and removal of Medicaid taxes, licensing and regulatory fees from revenue generally results in an additional 2% to 3% increase in the CMS MLR.

Source: 2017 Annual Statement, pg. 7., Milliman definitions of MLR, Administrative Loss Ratio and Underwriting Ratio

Findings

- Kentucky MCOs reported $6.5 billion in capitation payments and $5.7 billion in payments for Medicaid enrollee health care services, for an 88% combined Medical Loss Ratio (MLR). While on an aggregate basis this compares favorably with the national average MLR for Medicaid plans (88.2%) , the MLR varied substantially among Kentucky's MCOs, ranging from 86% to 96%.
- **Humana and Passport had the highest medical loss ratios, with both exceeding 90 percent.** Wellcare had an 88% MLR, followed by Aetna and Anthem with an 86% MLR and an 85% MLR, respectively. This represents an increase for Aetna, which had a 76% MLR in 2016, while Anthem's MLR remained steady at 85% in 2016 and 2017.
- **The Department for Medicaid Services (DMS) contractually requires the MCOs to operate at a 90% MLR using the Centers for Medicare and Medicaid Services (CMS) methodology (which is different from how Milliman calculates the MLR).** The CMS method includes an adjustment for quality improvement expenditures and removes Medicaid taxes, licensing, and regulatory fees from revenue, which generally results in an additional 2% to 3% increase in the CMS MLR. To account for this difference, **Table 1** provides an estimated CMS MLR by adding 2.5% to each MCO's calculated MLR per the Milliman method, to provide a comparison as to whether the 90% MLR requirement was met. **Humana, Passport, and Wellcare met the 90% MLR requirement while Aetna and Anthem did not.**
- **The Kentucky MCOs collectively used about 8% of their capitation payments for administrative costs, but this ranged from 7.1% (Wellcare) to nearly 14% (Humana). Humana had the highest administrative loss ratio in both 2016 and 2017, and it remains substantially higher than the other plans as well as the national average of 8.6%.** The administrative loss ratio (ALR) is calculated net of state and federal taxes and fees, since those can vary greatly from state to state. Taxes and fees includes state and local insurance taxes, state premium taxes, regulatory authority licenses and excludes payroll, real estate, and federal and state income taxes. Since this information is reported for all lines of business, the amount was prorated based on the percentage of total claim adjustment and general administrative expense reported for Medicaid lines of business by the MCO. The ALR was calculated by excluding the prorated taxes and fees from total administrative expenses and total revenue.

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MCO Medicaid Financial Performance Findings - continued

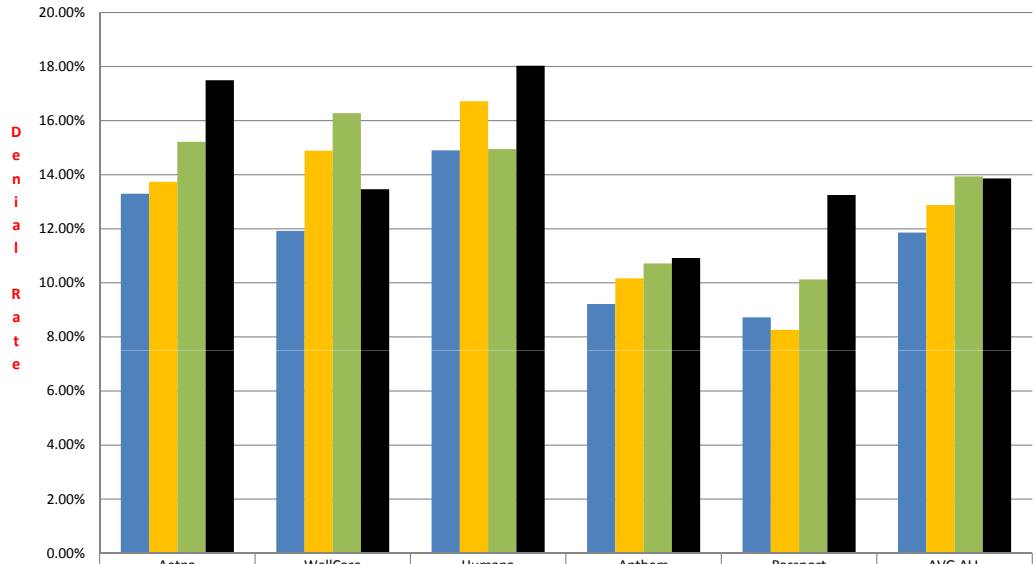
- The MCOs had a combined three percent (3%) profit margin, but this was due to one plan (Humana) experiencing a 10% loss and another (Passport) operating near break-even with a 1% margin. **Wellcare had a 4.5% margin, Aetna had a 5% margin, and Anthem had the highest profit margin of 6%.** The profitable Kentucky MCOs had a **combined profit of $226 million in 2017.**
- According to a May 2018 report issued by Milliman , the **national average MCO profit margin was 0.9% in 2017. However, when the impact of federal and state taxes and fees is removed, the national average margin was 3.2 percent** (100% - 88.2% MLR + 8.6% ALR net of taxes and fees).
- **Profit margins for Aetna, Anthem, and Wellcare were higher than 3.2% when their underwriting ratios were calculated without taxes and fees as part of administrative costs.** However, part of these higher profits were due to the MCOs having greater administrative cost efficiency when comparing their ALR net of taxes and fees to the national average of 8.6%. After giving credit for the percent below the national average ALR, these three MCOs still had a profit margin greater than the national average for all MCOs. **Anthem was the highest at 3.5% above the national average after adjusting for administrative efficiency, followed by Aetna at 1.9%, and then Wellcare at 0.7%.**
- **Taxpayers, which fund the Medicaid program, paid an estimated $62 million more in MCO profits in 2017 –to three MCOs - than if the profitable Kentucky MCOs had profit margins equal to the 2017 national average for Medicaid MCOs as reported by Milliman and after adjusting for taxes, fees, and administrative cost efficiencies.**

Medicaid Utilization Review Denial Rates

The chart below shows Medicaid prior authorization denial rates for the last four 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:

- Anthem had the lowest denial rate in SFY 2017, which is consistent with their general performance over the last four years.
- Passport's denial rate, which had historically been the lowest, jumped to 13.2% in SFY 2017 and was on par with Wellcare at 13.5%.
- Humana had the highest denial rate in SYF 2017 (18%) followed closely by Aetna at 17.5%. Humana and Aetna have consistently had the highest denial rates over the four year period, except in SFY 2016 when Wellcare was higher.
- Denial rates overall have risen almost two percent from SFY 2014 to SYF 2017 (11.86% to 13.9%), and for all MCOs except Anthem (whose rate has remained steady) and Wellcare (whose rate declined in SYF 2017).



	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%
SYF 2017	17.5%	13.5%	18.0%	10.9%	13.2%	13.9%

Source: *MCO Dashboard Reports, DMS*

Consumer Rating

The Department for Medicaid Services annually publishes MCO ratings on quality and access measures to assist Medicaid enrollees in the selection of an MCO. The measures were changed in 2018. Prior to 2018, plans were rated on seven preventive care measures, including childhood immunizations, well child visits, diabetes testing, smoking cessation, cervical screening and prenatal care. There were also seven measures which gauged members' experience with getting help when needed, including getting child and adult care quickly, customer service, and member satisfaction with the plan. In 2018, the specific preventive measures were eliminated, and all 22 of the measures are based on a member survey reflecting the member's perception of plan performance rated separately for adults and children. Members rate overall plan performance as well as ease of getting treatments and appointments, whether plan forms were easy to complete, and the member's perception of their personal physician. Each MCO was rated on a scale from one star, "much below average", to five stars, "excellent", with star ratings based on a comparison of NCQA national averages and information submitted by the MCOs.

Findings:

Highest Rated:

- Wellcare had the highest overall plan rating for adults with five stars.
- Humana and Passport each received four stars in the overall plan rating for adults.
- Both Passport and Wellcare were the highest rated plans for children, with each receiving four stars.

Lowest Rated:

- Aetna and Anthem were the lowest rated plans for adults, each receiving only two stars.
- Aetna was the worst rated plan for children, with only one star. Anthem and Humana followed with just two stars each in their overall plan rating for children.

Kentucky UNBRIDLED SPIRIT

2018 Guide to Choosing a Medicaid Health Plan

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

	AETNA	ANTHEM	HUMANA	PASSPORT	WELLCARE
	855-300-5528	855-690-7784	855-852-7005	800-578-0603	877-389-9457
ADULT MEASURES					
Rating of Health Plan	★★	★★	★★★★	★★★★	★★★★★
Got care as soon as needed when care was needed right away	★★★★★	★★★★★	★★★	★★★	★★★★★
Ease of getting care, tests, or treatment	★★★★	★★★	★★★★	★★★	★★★★★
Personal doctor explained things	★★	★★★	★★★★	★★	★★★★
Personal doctor listened carefully	★★★★★	★★★	★★★	★★★★★	★★★★
Personal doctor showed respect	★★★	★★★	★★	★★★	★★★
Personal doctor spent enough time	★★	★★★★	★★★★	★★★	★★★
Got appointment with specialist as soon as needed	★★	★★	★★★★★	★★★★	★★★★★
Customer service provided information or help	NA	★★	NA	★★★★★	★★
Customer service treated member with courtesy and respect	NA	★★★★	NA	★★★★★	★★★★
Health plan forms were easy to fill out	★★★★	★★★★	★★★★	★★★	★★★★★
CHILD MEASURES					
Rating of Health Plan	★	★★	★★	★★★★	★★★★
Got care as soon as needed when care was needed right away	★★★	★★★★	★★★★	★★★	★★★★★
Got check-up routine appointment as soon as needed	★★★★	★★★	★★★★	★★★★	★★★★★
Ease of getting care, tests, or treatment	★★★★★	★★★	★★★★	★★★★	★★★★★
Personal doctor explained things	★★	★★	★★	★★	★★★★★
Personal doctor listened carefully	★★★	★★	★★★★★	★	★★★★★
Personal doctor showed respect	★★★★	★★	★★★	★	★★★★★
Personal doctor spent enough time	★★★★★	★★★	★★★	★★	★★★★★
Got appointment with specialist as soon as needed	★★★★	★★★	NA	★★★★	★★★★★
Customer service provided information or help	★★★	★★★	NA	★★★	★★★★
Customer service treated member with courtesy and respect	★★★★★	★★	NA	★★★★★	★★★★★
Health plan forms were easy to fill out	★★★★★	★★★★	NA	★★★	★★★★★

Source: *DMS*

NA-the health plan did not receive a rating because there were less than 100 members that answered that question.
The Star Ratings are based on a comparison of NCQA (National Committee for Quality Assurance) national averages and information submitted by the health plans.

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.
- **Penalty –** DMS can impose a fine for various violations without requiring a Letter of Concern or a Correction Action Plan before fines are imposed. Such violations include failing to provide accurate encounter data on a timely basis and failing to respond timely to Department written requests.
- **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.

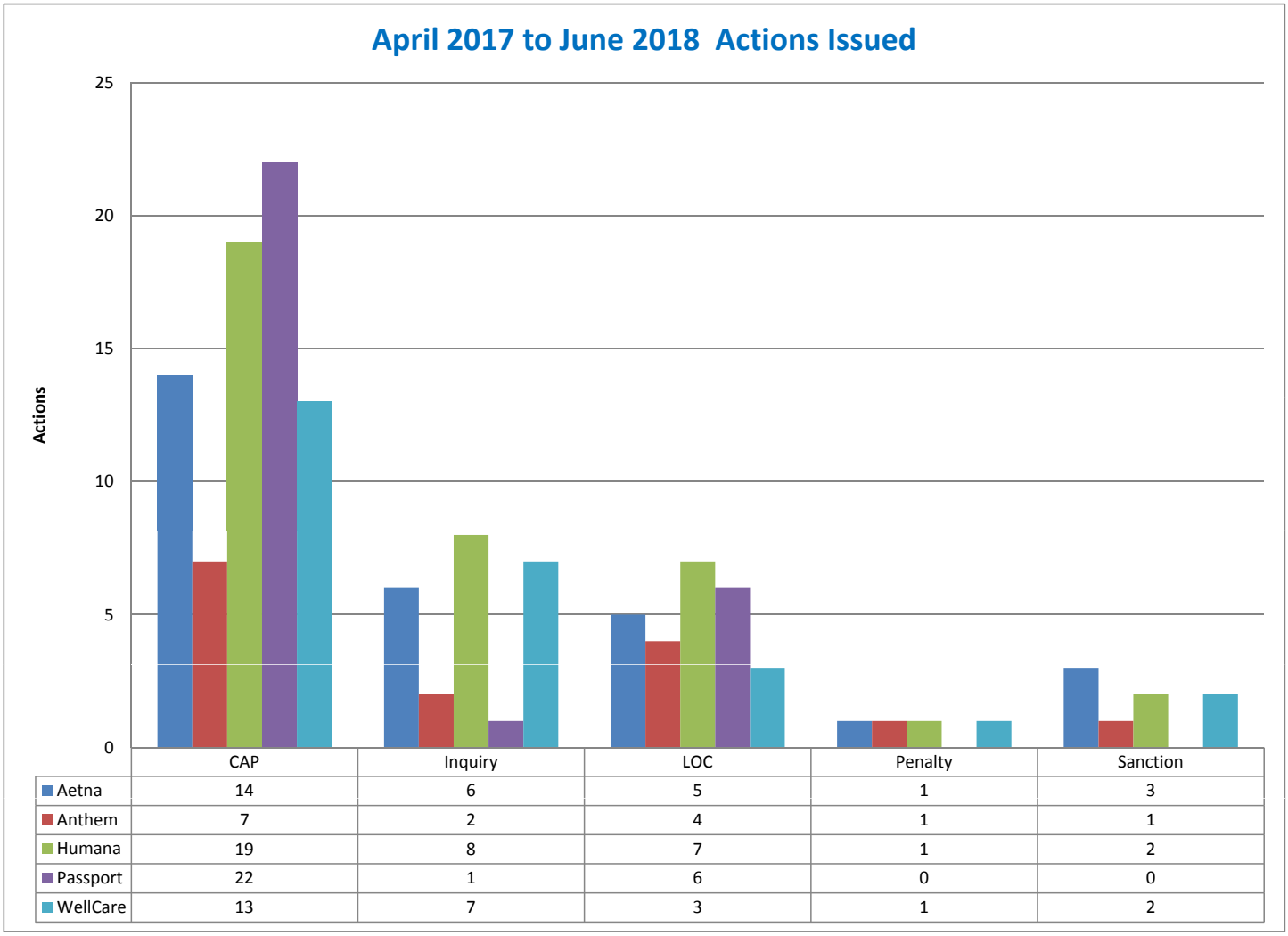
The following table shows the number of actions taken by the Department for Medicaid Services (DMS) against each MCO for the period March 2016 to April 2017 and from April 2017 to June 2018. This information was compiled from DMS data provided to the Kentucky Hospital Association pursuant to an open records request.

Findings:

- For the most current period, April 2017 – June 2018:
  - Passport was the only MCO without any penalties or sanctions
  - Aetna had the most sanctions
  - All of the MCOs, except Passport, received one penalty (penalty data was not provided to KHA in the prior period)
  - Humana and Passport had the highest number of Letters of Concern, and Passport had the highest number of Corrective Action Plans at 22, followed by Humana with 19.
  - Anthem had the lowest number of Corrective Action Plans at 7.
- There has been a significant reduction in the total number of Letters of Concern and Corrective Action Plans issued by DMS from April 2017 – June 2018 compared to the prior period; however, the number of sanctions has increased.

DMS Corrective Action by MCO

	Letters of Concern		Corrective Action Plan		Sanctions		Inquiry	Penalty
MCO	Mar 2016 - April 2017	April 2017 - June 2018	Mar 2016 - April 2017	April 2017 - June 2018	Mar 2016 - April 2017	April 2017 - June 2018	April 2017 - June 2018	April 2017 - June 2018
Aetna	22	5	50	14	1	3	6	1
Anthem	15	4	26	7	1	1	2	1
Humana	14	7	11	19	1	2	8	1
Passport	13	6	16	22	0	0	1	0
Wellcare	11	3	14	13	0	2	7	1
Total	75	25	117	75	3	8	24	4



	CAP	Inquiry	LOC	Penalty	Sanction
Aetna	14	6	5	1	3
Anthem	7	2	4	1	1
Humana	19	8	7	1	2
Passport	22	1	6	0	0
WellCare	13	7	3	1	2

Source: *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 fourth quarter of 2014 through the fourth quarter of 2017. 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:

- **Payment of Clean Claims in 30 Days:**
  - Over the three year period, Passport most consistently met the requirement to pay 90% of hospital clean claims within 30 days; however, their performance deteriorated in the third and fourth quarter of 2017 when a new claims processing system was implemented.
  - Aetna and Anthem had the worst performance over the three years, as neither plan reported meeting the 90% requirement for prompt payment in any quarter covered in this report.
  - In SFY 2017, Anthem's performance was the worst, with all quarters below 80%, followed by Aetna, with all quarters above 80% but below 90%. Wellcare only had one quarter above 90%, while Humana and Passport each had two quarters where the 90% metric was met.

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Prompt Payment of Hospital Claims - continued

- **Payment of 90% of Dollars Owed in 30 Days:**
  - Anthem has the best overall performance of paying at least 90% of dollars owed to hospitals in 30 days, as they reported achieving this in every quarter over the last three years.
  - Humana's performance was the worst over the three year period, as the plan's percentage of total dollars paid was below the 90% threshold except for five quarters in 2016 and early 2017.
  - In SYF 2017, only Anthem and Aetna were consistently above 90%. Each of the other MCOs met the 90% requirement only in two of the four quarters.

Payment of Hospital Claims by MCOs

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

MCO	Q4 2014	Q1 2015	Q2 2015	Q3 2015	Q4 2015	Q1 2016	Q2 2016	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 20
Aetna	88.36%	88.39%	87.87%	87.96%	86.34%	68.58%	79.67%	83.60%	87.25%	85%	87.94%	81.31%	83.87%
Anthem	81.42%	81.76%	79.33%	77.68%	78.58%	80.36%	75.06%	74.25%	77.36%	77.98%	77.23%	76.93%	77.14%
Humana	64.18%	83.63%	81.73%	77.64%	84.74%	76.60%	87.67%	94.90%	94.64%	93.74%	94.90%	89.22%	87.06%
Passport	84.01%	89.31%	76.61%	94.02%	94.10%	93.55%	93.12%	93.12%	92.02%	92.63%	91.76%	72.90%	83.55%
Wellcare	NR	87.51%	89.26%	89.78%	89.14%	90.49%	91.05%	90.98%	90.18%	90.43%	80.58%	83.39%	87.87%

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

MCO	Q4 2014	Q1 2015	Q2 2015	Q3 2015	Q4 2015	Q1 2016	Q2 2016	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017
Aetna	96.53%	97.46%	94.33%	97.62%	96.59%	77.35%	87.40%	86.78%	94.29%	94.88%	94.98%	90.22%	97.37%
Anthem	96.85%	96.21%	99.31%	99.42%	97.26%	99.66%	98.64%	98.80%	97.23%	98.82%	97.76%	98.39%	97.09%
Humana	69.55%	82.78%	86.51%	85.08%	82.66%	78.54%	90.70%	98.94%	98.40%	97.10%	97.87%	88.62%	86.46%
Passport	89.24%	90.70%	77.38%	97.14%	91.19%	98.92%	99.92%	99.92%	96.96%	96.82%	98.51%	86.35%	84%
Wellcare	NR	94.53%	96.11%	97.49%	88.83%	94.63%	97.12%	95.95%	95.11%	95.92%	85.67%	84.05%	90.89%

Source: *Kentucky Department of Insurance.*