Medicaid Managed Care Transparency Report 2018

Agency Response to La. Revised Statute 40:1253.2

Louisiana Department of Health

Bureau of Health Services Financing

June 2019

LOUISIANA DEPARTMENT OF HEALTH

Contents

Introduction

This report is the seventh in a series produced by the Louisiana Department of Health (LDH or "the Department") to satisfy statutory reporting requirements intended to ensure the following outcomes are being achieved by Louisiana's Medicaid Managed Care Program (R.S. 40:1253.2):

- improved care coordination with patient-centered medical homes for Medicaid enrollees;
- 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.

Beginning in February of 2012, the original Medicaid Managed Care Program included two models of coordinated care networks: full-risk managed care organizations (MCOs) known as prepaid health plans, and primary care case management (PCCM) known as shared savings plans. The state contracted with three prepaid and two shared savings plans, and individuals were given the option of choosing the plan that best met their needs. However, not all Medicaid services were available from health plans, and some health plan members continued to receive certain services under the fee-for-service program. In addition, many individuals covered by Medicaid were not eligible to enroll in and receive services from a health plan.

LDH has progressively integrated services and populations into the Medicaid Managed Care Program. The following timeline includes major milestones in the growth of the managed care program:

- Pharmacy benefits were "carved-in" to the prepaid plan benefit package on November 1, 2012.
- Dental benefits have been provided to all Medicaid populations under a single Dental Benefits Program Manager (DBPM) since July 1, 2014.
- The delivery model was transitioned from three full-risk MCOs and two shared-savings PCCMs to five full-risk MCOs on February 1, 2015.
- Hospice benefits were added on February 1, 2015.
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) - Personal Care Services were added on February 1, 2015.
- Retroactive linkages to a Medicaid managed care plan were implemented on February 1, 2015.
- Specialized behavioral health benefits were added on December 1, 2015.
- Eligibility for Medicaid services was expanded to include the new adult population on July 1, 2016.

Medicaid Expansion

On July 1, 2016, the state expanded eligibility for the Louisiana Medicaid program to include adults ages 19 to 64 years old with incomes at or below 138% of the federal poverty level. In State Fiscal Year 2018, 587,912 unduplicated members were enrolled in a managed care plan through the expansion. In this transparency report, the expansion population is included in the reporting for full-benefit members. Additional information specific to the new adult expansion population can be found on the "LDH Medicaid Expansion Dashboard" at http://www.ldh.la.gov/HealthyLaDashboard/.

Transparency Report Measures and Data

This report includes 27 measures as outlined in La. Revised Statute 40:1253.2. It covers program operations for July 2017 through June 2018 (State Fiscal Year 2018), except for the following measures which are reported on a calendar year basis per the contract between the Department and the managed care entities:

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

Information included in this report was collected from multiple sources. To the greatest extent possible, the data are extracted from state systems that routinely collect and maintain operational data on the Medicaid Managed Care Program. When unavailable from state sources, data were collected from the managed care entities or sourced from either routine reporting deliverables[1] or ad hoc reports requested specifically for this purpose. The Medicaid Management Information System (MMIS) and the Management Administrative Reporting Subsystem (MARS Data Warehouse or MDW) are maintained by the Medicaid program's contracted fiscal intermediary, DXC Technologies (DXC), formerly Molina Healthcare. Detailed enrollee and provider information, as well as claims payment data for this report, were extracted from the MARS data warehouse. The state administrative system, called ISIS, maintained by the Office of Technology Services within the Division of Administration, was used to extract information on payments to the MCOs and Dental Benefits Plan Manager.

As part of routine operations and as required by the Centers for Medicare and Medicaid Services (CMS), 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 addition to standing operational quality assurances and EQRO reviews, the 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 managed care entities or the Department used to generate data. For data originating from the MARS Data Warehouse or MMIS, Myers and Stauffer generated its own data from encounters or data extracts for each plan and compared its results to the results the Department produced. For data originating from the 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% 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 XII for the survey instrument.

[1] Templates for routine reporting deliverables can be found at http://ldh.la.gov/index.cfm/page/1700.

Medicaid Managed Care

During State Fiscal Year 2018, more than 1.7 million Louisiana Medicaid and Louisiana Children's Health Insurance Program (LaCHIP) enrollees received coverage for physical health, basic and specialized behavioral health services under the Medicaid Managed Care Program through one of five managed care organizations contracted with the state. In addition, the state provided comprehensive dental services to children and denture services to adults through a single, prepaid ambulatory health plan (PAHP). The covered populations and services for each model of managed care are described below.

Managed Care Organizations (MCO or health plans)
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 healthcare providers and manage all aspects of service delivery, including reimbursement of providers. The MCOs operate under the federal authority in Section 1932(a)(1) of the Social Security Act and 42 CFR Part 438. Participating Medicaid enrollees and covered benefits and services are specified in Louisiana's CMS approved Medicaid State Plan.

With the integration of specialized behavioral health services in 2015, most individuals were mandatorily enrolled in an MCO for both physical and behavioral health services. Some individuals, primarily those in a home and community-based services waiver, nursing facility or intermediate care facility, were required to enroll in an MCO for behavioral health coverage, but were also given the option to receive physical health services through their health plan or continue to receive them through the Medicaid fee-for-service program (FFS).

A small number of individuals remained completely excluded from enrollment in an MCO and continued to receive services under FFS. Medicaid populations excluded from enrollment in an MCO in State Fiscal Year 2018 were as follows:

- Individuals receiving limited Medicaid benefits or single service only;
- Individuals over age 21 residing in an intermediate care facility for the developmentally disabled (ICF/DD);
- Individuals enrolled in the Program for All-Inclusive Care for the Elderly (PACE);
- Medicare dual eligibles with incomes between 75% and 135% of the federal poverty level (FPL) for whom Medicaid paid only the Medicare Part B monthly premium, and enrollees below 100% FPL with limited Medicare crossover payments where Medicaid is the secondary payer;
- Individuals with a limited period of eligibility; and
- Populations within specified programs including: Refugee Cash Assistance, Refugee Medical Assistance, Long-Term Care Co-Insurance, and Qualified Disabled Working Individuals.

Additionally, the following carved out services continued to be Medicaid fee-for-service and were not included in the managed care benefit package in State Fiscal Year 2018:

- Applied Behavior Analysis (carved into managed care in February 2018)
- Personal care services (21 and over)
- Long Term Care (LTC)/Nursing facility services
- Waiver services
- Early Steps
- Medicare Crossover Services

Dental Benefit Program Manager (DBPM or dental plan)

The state provided comprehensive dental services to Medicaid eligible children and adult dentures to full-benefit eligible adults through a single PAHP which operates under federal authority as provided in Sections 1902(a)(4) and 1932(a) (1)(A) of the Social Security Act, and 42 CFR Part 438. The majority of Medicaid covered individuals were mandatorily enrolled in the dental plan and received state plan covered services through the dental plan based on age category:

- **Medicaid Enrollees under the age of 21** – diagnostic, preventive, restorative, endodontic, periodontal, prosthodontics, maxillofacial prosthetics, oral and maxillofacial surgery, orthodontic and other screening and treatment services applicable under the EPSDT program, and

- **Adults 21 years of age and over** – dentures and related services were the only state plan covered dental services for adults.

The only populations excluded from the dental plan were individuals residing in Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), and individuals who are 21 years of age and older that are certified as Qualified Medicare Beneficiary Only.

1 CONTRACTED MANAGED CARE ENTITIES

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

For the State Fiscal Year 2018 reporting period, the Department contracted with five MCOs to manage physical and behavioral healthcare services. In addition, the Department contracted with a single vendor to operate its dental benefit program serving Medicaid enrollees. The names and common abbreviations of the health plans and the dental plan are in table 1.1 in alphabetical order by plan type.

Table 1.1 Names of contracted managed care entities, State Fiscal Year 2018

Plan Name	Plan Type	Common Abbreviation
Aetna Better Health, Inc.	Managed Care Organization	ABH
Community Care Health Plan of Louisiana, Inc. (dba Healthy Blue)[2]	Managed Care Organization	HB
Amerihealth Caritas Louisiana, Inc.	Managed Care Organization	ACLA
Louisiana Healthcare Connections, Inc.	Managed Care Organization	LHCC
UnitedHealthcare of Louisiana, Inc.	Managed Care Organization	UHC
MCNA Insurance Company, Inc.	Dental Benefit Program Manager	MCNA

Source: Medicaid managed care contracts

[2] As of 9/1/2017 Amerigroup Louisiana began operating as Healthy Blue.

2 MANAGED CARE EMPLOYEES

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

Health plan contracts required certain staff be domiciled in-state, such as chief executive officer, medical director, behavioral health medical director, maternal/child health coordinator, contract compliance officer, member management coordinator, provider services manager, program integrity officer, encounter data quality coordinator, case management staff, fraud, waste and abuse investigators and others. For other positions, such as call center staff, plans had the option to staff locally or leverage parent company resources out of state. All health plans maintained or slightly increased the number of Louisiana-based employees in State Fiscal Year 2018.

Table 2.1 Total number of full-time equivalent (FTE) and average salary for MCO employees based in Louisiana, State Fiscal Year 2018

	ABH	ACLA	HB	LHCC	UHC
Total number of LA employees (FTEs)	151.6	216.8	234.0	523.6	380.0
Average salary paid	$63,795	$72,009	$78,764	$64,291	$60,335

Source: 017 Annual Report to LDH

The average annual salary weighted across all health plans was $66,603. 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.

The Dental Benefit Program Manager is also required by the Department to maintain in-state staff. The positions that MCNA were required to domicile in Louisiana included the executive director, the dental director, and staff responsible for provider network development and management. For State Fiscal Year 2018, MCNA reported 10.7 full-time equivalent in-state staff. The average annual salary for MCNA employees based in Louisiana was $72,379.

Table 2.2 Total number of full-time equivalent (FTE) and average salary for MCNA employees based in Louisiana, State Fiscal Year 2018

	MCNA Dental
Total number of LA employees (FTEs)	10.7
Average salary paid	$72,379

Source: 017 Annual Report to LDH

3 PAYMENTS TO MANAGED CARE ORGANIZATIONS

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

In State Fiscal Year 2018, the Department paid a total of $7,604,832,262 to all five managed care organizations for all health plan members combined. The payments to each health plan were based on the number of members enrolled in one of two distinct member groups based on eligibility and coverage:

- Full-benefit: those who received all physical, behavioral health and transportation services through their health plan; and
- Partial-benefit: those who received only specialized behavioral health and non-emergency medical transportation (NEMT) through their health plan.

Total unduplicated enrollment in a Medicaid managed care plan for State Fiscal Year 2018 was 1,720,038. Total enrollment unduplicated within each group was 1,596,784 full-benefit members and 136,755 partial-benefit members (NOTE: members can switch between full-benefit and partial-benefit coverage during the year based on their eligibility status). 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.

The data on payments to the health plans for each member group are provided separately in tables 3.1 for full-benefit members and 3.2 for partial-benefit members. The average PMPMs for each plan were calculated as the total of all payments made to a plan in a given month divided by total membership for that plan in the same month.

PMPMs for enrollees are scheduled for payment to the plans retrospectively in the month following enrollment, e.g. PMPMs for June members are paid in July. However, as all payments are reported based on the actual date of payment, average monthly PMPMs varied as impacted by off-cycle payment adjustments including deferral of payments, lump sum payments and/or recoupments. The net effect of multiple adjustments in a single month can cause average PMPMs to appear significantly higher, lower or neutral for the month. See table notes for adjustments impacting each month's payment.

Table 3.1 Total payments and average PMPM for full-benefit members[3] by month, State Fiscal Year 2018

	ABH		ACLA		HB		LHCC		UHC	
	Total Payments	Average PMPM	Total Payments	Average PMPM	Total Payments	Average PMPM	Total Payments	Average PMPM	Total Payments	Average PMPM
Jul-17	$93,648,268	$996.28	$168,249,409	$860.98	$184,467,054	$836.83	$344,032,812	$745.39	$334,563,225	$810.45
Aug-17	$48,101,658	$507.74	$86,115,924	$440.25	$96,820,445	$437.12	$177,870,191	$384.56	$167,417,415	$403.60
Sep-17	$48,653,816	$514.14	$85,035,766	$437.60	$94,308,463	$426.71	$179,519,882	$390.15	$169,166,774	$409.46
Oct-17	$48,973,363	$522.31	$86,693,571	$449.95	$96,207,916	$431.68	$181,472,510	$393.34	$170,380,572	$410.40
Nov-17	$46,046,661	$482.86	$83,126,015	$429.67	$93,678,150	$416.30	$173,732,224	$375.88	$162,455,500	$389.61
Dec-17	$49,672,212	$515.89	$85,335,455	$440.56	$95,583,312	$421.69	$181,199,327	$392.27	$170,700,662	$408.79
Jan-18	$46,784,879	$484.91	$84,896,509	$438.85	$100,827,538	$442.38	$181,607,342	$393.25	$168,008,705	$402.08
Feb-18	$49,778,606	$513.96	$87,667,630	$454.11	$102,636,328	$448.08	$185,098,011	$400.95	$177,914,343	$425.03
Mar-18	$50,747,876	$522.78	$87,673,161	$454.62	$104,459,224	$453.24	$185,968,889	$403.26	$178,883,606	$426.55
Apr-18	$48,689,458	$501.08	$86,771,770	$451.51	$104,107,600	$449.45	$184,807,347	$402.59	$179,294,683	$427.62
May-18	$49,373,401	$508.24	$88,297,203	$461.22	$105,413,021	$453.68	$186,344,691	$407.35	$179,048,604	$427.64
Jun-18	$53,486,258	$550.87	$76,381,232	$400.96	$94,599,281	$405.54	$156,714,466	$345.08	$160,360,750	$384.09
Total	**$633,956,455**	**$550.98**	**$1,106,243,646**	**$477.10**	**$1,273,108,333**	**$467.68**	**$2,318,367,692**	**$419.62**	**$2,218,194,839**	**$443.48**

Source: ISIS and MARS Data Warehouse (MDW). Total payments are from the state accounting system, ISIS. MDW data used to calculate the distribution. Payments reported on a date of payment basis.

Notes - off-cycle payment adjustments to MCOs for full-benefit members, State Fiscal Year 2018:

- July-17 Includes Jul-17 PMPM payments and the majority of Jun-17 PMPM payments pushed due to budget constraints in SFY17.
- Jun-18 Includes all Expansion PMPM and majority of Non-Expansion PMPM payments; remaining Jun-18 PMPM payments pushed to Jul-18 due to budget constraints in SFY18.

[3] Including the adult expansion population

Table 3.2 Total payments and average PMPM for partial-benefit members by month, State Fiscal Year 2018

	ABH		ACLA		HB		LHCC		UHC	
	Total Payments	Average PMPM	Total Payments	Average PMPM	Total Payments	Average PMPM	Total Payments	Average PMPM	Total Payments	Average PMPM
Jul-17	$1,442,344	$66.37	$1,454,262	$69.32	$1,519,206	$69.96	$1,804,663	$72.16	$1,895,440	$72.73
Aug-17	$735,270	$33.90	$727,703	$34.68	$774,960	$35.66	$910,887	$36.28	$947,630	$36.27
Sep-17	$703,497	$32.53	$695,375	$33.19	$752,565	$34.67	$887,961	$35.32	$937,424	$35.85
Oct-17	$714,525	$33.29	$712,771	$34.15	$762,867	$35.17	$903,378	$35.45	$943,952	$35.96
Nov-17	$686,484	$32.02	$683,727	$32.80	$728,452	$33.51	$860,908	$33.60	$902,075	$34.24
Dec-17	$711,639	$33.29	$708,781	$34.10	$755,144	$34.81	$892,455	$34.83	$935,130	$35.47
Jan-18	$721,642	$33.83	$718,744	$34.64	$765,759	$35.35	$904,999	$35.27	$948,274	$35.96
Feb-18	$737,773	$34.71	$734,811	$35.51	$782,877	$36.18	$925,229	$36.12	$969,472	$36.76
Mar-18	$766,857	$36.22	$763,778	$36.92	$813,738	$37.68	$961,703	$37.50	$1,007,689	$38.27
Apr-18	$704,107	$33.33	$700,809	$34.02	$746,474	$34.66	$892,741	$34.84	$943,172	$35.82
May-18	$807,501	$38.41	$811,733	$39.45	$875,740	$40.70	$1,060,017	$41.34	$1,098,567	$41.71
Jun-18	$953,649	$45.48	$983,543	$47.91	$1,067,214	$49.59	$1,331,018	$52.02	$1,370,194	$51.93
Total	**$9,685,288**	**$37.80**	**$9,696,037**	**$38.90**	**$10,344,997**	**$39.83**	**$12,335,958**	**$40.35**	**$12,899,017**	**$40.89**

Source: ISIS and MARS Data Warehouse (MDW). Total payments are from the state accounting system, ISIS. MDW data used to calculate the distribution. Payments reported on a date of payment basis.

Notes - off-cycle payment adjustments to MCOs for partial-benefit members, State Fiscal Year 2018:

- July-17 Includes Jul-17 PMPM payments and the majority of Jun-17 PMPM payments pushed due to budget constraints in SFY17.

Capitation payments to MCNA for the dental benefit program were based on the number of Medicaid enrollees eligible for and enrolled in the dental program for the month and were paid during the month of enrollment, i.e., June enrollment paid for in July. Table 3.3 below shows the total payments the Department made to MCNA and the average PMPM for each month for State Fiscal Year 2018.

Table 3.3 Total payments and average PMPM for dental benefit program members by month, State Fiscal Year 2018

	MCNA Dental	
	Total Payments	**Average PMPM**
Jul-17	$27,604,192	$18.39
Aug-17	$13,866,846	$9.21
Sep-17	$13,844,797	$9.23
Oct-17	$13,869,100	$9.23
Nov-17	$13,854,412	$9.18
Dec-17	$13,760,969	$9.10
Jan-18	$13,760,582	$9.09
Feb-18	$13,831,357	$9.13
Mar-18	$13,807,923	$9.11
Apr-18	$13,685,176	$9.04
May-18	$13,688,775	$9.05
Jun-18	$13,664,164	$9.07
Total	$179,238,293	$9.90

Source: ISIS and MARS Data Warehouse (MDW). Total payments are from the state accounting system, ISIS. MDW data used to calculate the distribution. Payments reported on a date of payment basis.

Notes - off-cycle payment adjustments to MCNA for dental benefit program, State Fiscal Year 2018:

- Jul-17 Includes Jun-17 and Jul-17 payments.

4 NUMBER OF HEALTHCARE PROVIDERS

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

Timely access to necessary healthcare for Medicaid members is an important goal of the Medicaid Managed Care Program. Contracts with the health plans required them to maintain minimum ratios of contracted providers to enrollees for both primary care and specialty physicians. The Department conducted ongoing monitoring of the number of contracted providers in each health plan and required plans to submit geo-spatial analyses with provider locations. The Department received the total number of contracted providers for each health plan through weekly provider network registries submitted by the plans. It is important to note that the total number of healthcare providers contracting with a 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 health plan enrollees they will see, or have "closed their panels" to new plan members, in order to maintain access and quality of care to current clients. Section 6 includes data on providers with closed panels. Appendix I lists contracted providers by provider type, provider taxonomy, and parish. It should be noted, however, that the unduplicated totals in tables 4.1 and 4.2 below will not match the provider totals in Appendix I as providers can enroll as more than one provider type, taxonomy, and in more than one parish.

Per contract requirements, the health plans submitted a registry of all providers that have contracted with the health plan, as well as any provider who was not in-network but was paid for services as an out of network provider or under a single case agreement. As specified in the authorizing legislation, the data reported in sections 4, 5 and 6 of this report are for contracted providers to reflect the in-network capacity of each health plan. Based on LDH findings and data user recommendations for improving the utility of this data set, the methodology for compilation of network providers was refined in 2017 to exclude out-of-state providers, unless they were located in a county directly bordering Louisiana. This is considered more reflective of local accessibility and is consistent with 2017 reporting. Contracted provider counts are presented in tables 4.1 and 4.2 below.

Table 4.1 Total unduplicated[4] count of contracted providers by health plan, State Fiscal Year 2018

	ABH[5]	ACLA	HB	LHCC	UHC
Total Contracted Providers[6]	10,407	23,392	20,610	27,783	26,308

Source: LDH MARS Data Warehouse, June 29, 2018 Provider Registry

Table 4.2 Total unduplicated[3]count of contracted providers in DBPM, State Fiscal Year 2018

	MCNA Dental
Total Contracted Providers[6]	1,575

Source: LDH MARS Data Warehouse, June 29, 2018 Provider Registry

[4] Individual provider counts for each plan are unduplicated by National Provider Identifier (NPI) numbers; however, some provider groups or facilities (e.g. hospitals, labs) may have multiple NPIs for their multiple functions and therefore may be counted multiple times.

[5] Counts are reflective of data reported in the Provider Registry; however, it is noted that post 6/29/18 ABH discovered reporting errors resulting in an under reporting of their network providers.

[6] In state or border county only.

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.

Consistent with the methodology used to identify the total number of contracted providers in Section 4, the methodology for identifying contracted primary care providers was refined in 2017 to exclude out-of-state-providers, unless they are located in a county directly bordering Louisiana. The listing of contracted primary care providers (PCPs) for each health plan was then matched to the encounter file to determine those PCPs who submitted at least one claim for service during State Fiscal Year 2018. The corresponding claims were further limited to the following specialty types: 01-General Practice, 08-Family Practice, 37-Pediatrics, 41-Internal Medicine, 42-Federally Qualified Health Center, Clinic or Group Practice, 79-Nurse Practitioner, and 94 –Rural Health Clinic.

Total unduplicated provider counts for State Fiscal Year 2018 are presented in table 5.1. Appendix II lists primary care providers with at least one claim by provider type, provider taxonomy and parish. It should be noted, however, that the unduplicated totals in table 5.1 below will not match the provider totals in Appendix II as PCPs can enroll as more than one provider type, under multiple taxonomies, and in more than one parish.

Table 5.1 Total unduplicated[7] contracted primary care providers with at least one claim, State Fiscal Year 2018

	ABH[8,9]	ACLA	HB	LHCC	UHC
Total Contracted PCPs	1,966	3,759	2,186	4,223	2,905
PCPs with at least one claim	1,509	2,599	1,658	2,508	2,304
Percent PCPs with at least one claim	76.8%	69.1%	75.8%	59.4%	79.3%

Source: MARS Data Warehouse, June 29, 2018 Provider Registry

No data are reported for MCNA, as dental providers are not considered within the definition of primary care providers.

[7] Individual provider counts for each plan are unduplicated by National Provider Identifier numbers; however, some provider groups or clinics may have multiple National Provider Identifier numbers for their multiple functions and therefore may be counted multiple times

[8] Counts are reflective of data reported in the Provider Registry; however, it is noted that post 6/29/18 ABH discovered reporting errors resulting in an under reporting of their network providers.

[9] Counts are reflective of data reported in the Provider Registry; however, it is noted that post 6/29/18 ABH discovered reporting errors resulting in an under reporting of their network providers.

6 CONTRACTED PROVIDERS WITH A CLOSED PANEL

The total number of providers contracted to provide healthcare 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.

Based on recommendations from Myers and Stauffer, the methodology was modified beginning with the 2017 report to limit closed panel status to primary care providers only. This is consistent with currently available data and industry standards that only PCPs have defined panels. The Department continues to work with health plans, provider groups and other data users to improve the data available for monitoring health plan network accessibility.

Primary care providers that contracted with health plans had the option to close their panels, or stop accepting new patients, under certain circumstances such as ensuring quality of care for members. 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. For example, a health plan may have capped physician panels at 2,500 patients so that appropriate care and time was given to each person during their appointment.

Data for the providers with a closed panel on June 29, 2018, were extracted by the Department from provider registry files maintained in the MARS data warehouse. Table 6.1 shows the number of primary care providers with a closed panel by health plan as of June 29, 2018. Additional data by provider type, taxonomy and parish can be found in Appendix III. The unduplicated totals in table 6.1 below do not necessarily equate to the provider totals in Appendix III as providers can enroll as more than one provider type, under multiple taxonomies, and in more than one parish.

Table 6.1 Unduplicated[10] contracted primary care providers with a closed panel, June 30, 2017

	ABH[11,12]	ACLA	HB	LHCC	UHC
PCPs with a Closed Panel	61	990	507	182	555

Source: MARS Data Warehouse: June 29, 2018 Provider Registry

[10] Individual provider counts for each plan are unduplicated by National Provider Identifier numbers; however, some provider groups or clinics may have multiple National Provider Identifier numbers for their multiple functions and therefore may be counted multiple times.

[11] Counts are reflective of data reported in the Provider Registry; however, it is noted that post 6/29/18 ABH discovered reporting errors resulting in an under reporting of their network providers.

[12] Counts are reflective of data reported in the Provider Registry; however, it is noted that post 6/29/18 ABH discovered reporting errors resulting in an under reporting of their network providers.

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.

Federal regulations and health plan contracts required that a minimum of 85% of payments made by the Department for Louisiana Medicaid members be used to reimburse providers for services or certain specified purposes related to quality improvement and health information technology costs. This is known as the medical loss ratio (MLR).

Health plans are required to submit audited annual MLR reports summarizing how the plans spent their capitation payments, for each calendar year. The methodology established by the Department to calculate the annual MLR was adapted from the methodology CMS established for calculating MLR by commercial health plans. This methodology may differ from the methodology used by health plans in quarterly filings to the Department of Insurance and shareholders.

The MLR data presented are based on the independent auditor's reports prepared by Myers and Stauffer for the Adjusted Medical Loss Ratio Rebate Calculation for each of the five prepaid health plans for the calendar year ending on December 31, 2017, for the non-expansion population only. In CY 2017 all health plans met the 85% minimum ratio and no rebates to the Department were required. The audited reports for 2017 are posted on the Medicaid website at http://ldh.la.gov/index.cfm/page/2142.

Table 7.1 Medical loss ratios (MLR) non-expansion population, Calendar Year 2017

	ABH	ACLA	HB	LHCC	UHC
Adjusted YTD MLR Capitation Revenue	$227,628,995	$610,762,192	$663,767,580	$1,333,921,095	$1,144,339,182
Total Adjusted MLR Expense	$218,782,956	$569,626,666	$617,809,370	$1,213,152,260	$1,067,999,956
MLR Percentage Achieved	96.1%	93.3%	93.1%	90.9%	93.3%
Dollar Amount of Rebate Required	$0	$0	$0	$0	$0

Source: MSLC Audited Medical Loss Ratio Reports

Table 7.2 Breakdown of total adjusted MLR expense non-expansion population, Calendar Year 2017

	ABH	ACLA	HB	LHCC	UHC
Patient Care	$215,978,663	$559,311,463	$603,872,889	$1,201,836,536	$1,050,704,594
Quality Improvement	$2,804,293	$7,892,116	$11,148,592	$11,315,724	$14,139,326
Information Technology	$0	$2,303,874	$2,787,889	$0	$3,156,036
Other[13]	$0	$119,213	$0	$0	$0
Total Adjusted MLR Expense	$218,782,956	$569,626,666	$617,809,370	$1,213,152,260	$1,067,999,956

Source: MSLC Audited Medical Loss Ratio Reports

In a separate report, the MCO data for the initial expansion population MLR calculations was submitted in March of 2018 for the 18 months July 1, 2016 through December 31, 2017. Once Myers and Stauffer has completed its review, the audited reports will be available on the Medicaid website at http://ldh.la.gov/index.cfm/page/2142.

[13] External quality review related expenditures

8 EXTERNAL QUALITY REVIEW

A copy of the annual external quality review technical report produced pursuant to 42 DFR 438.364.

To provide for greater efficiency and consistency in reporting Medicaid managed care outcomes, Act 428 of the 2018 regular session of the Louisiana Legislature amended the reporting requirements of this report to provide the information on outcomes by reference to the external quality review technical reports.

CMS requires that state agencies contract with an External Quality Review Organization (EQRO) to conduct an annual external quality review (EQR) of the services provided by contracted Medicaid MCOs. This EQR must include an analysis and evaluation of aggregated information on quality, timeliness and access to the health care services that an MCO furnishes to Medicaid enrollees.

In order to comply with these requirements, the Department contracts with an EQRO to assess and report the impact of its Medicaid managed care program, the Healthy Louisiana Program, and each of the participating MCOs on the accessibility, timeliness and quality of services.

Among a variety of processes and measures reviewed by the EQRO, each annual report contains two years of data on 31 standard HEDIS® measures as compared to the Quality Compass® South Central Medicaid Benchmark and the most current Healthy Louisiana average.

The technical reports are available on line at http://www.ldh.la.gov/index.cfm/page/3176.

9 MEMBER AND PROVIDER SATISFACTION SURVEYS

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

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

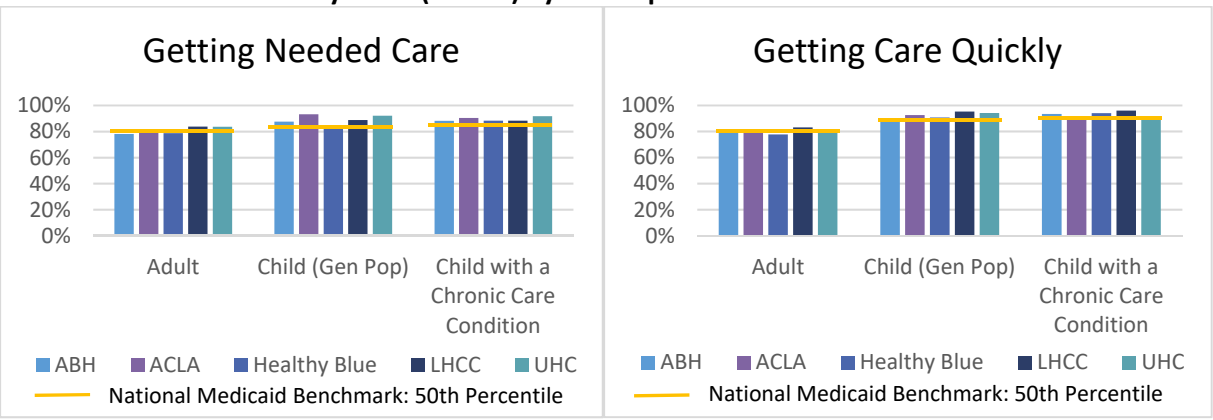
Member Satisfaction Survey

Member satisfaction surveys are questionnaires used to determine the 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, health plan contracts were precise concerning the following:

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

The Department required health plans to submit an annual member satisfaction survey report. In addition to reporting results to the Department, survey results were also collected by NCQA as part of its accreditation program and reviewed by the EQRO. As an example of the data available, a comparison of 2018 CAHPS survey results for two core measures on access to care and health plan satisfaction are presented in Figure 9.1 below. The full member survey reports for each health plan can be found in Appendix IV: Member Satisfaction Surveys.

Figure 9.1: Comparison of select access measure results from 2018 Consumer Assessment of Healthcare Providers and Systems (CAHPS) by health plan.



Source: 132 Member Satisfaction Surveys

Provider Satisfaction Survey

Unlike member satisfaction, there are no national standard survey instruments for a provider satisfaction assessment; however, each health plan is contractually required to conduct an annual assessment of providers to determine the level of satisfaction and identify areas for improvement. Each health plan is responsible for the development and implementation of a survey instrument that must cover key areas including provider enrollment, education and complaints; utilization management processes; claims processing and reimbursement; and, for primary care providers, availability of technical assistance in creating patient-centered medical homes. Per contract requirements, the Department approved both the survey instrument and methodology for each health plan. The Calendar Year 2017 provider satisfaction survey reports for each managed care entity are provided in Appendix V.

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.

Financial statements are an important tool for financial oversight of Medicaid managed care entities. They provide critical 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. Third party auditors independently evaluated whether a company's financial statements were prepared in accordance with generally accepted accounting principles (GAAP) and presented a fair picture of the financial position and performance of the company.

Further, the Department required Medicaid managed care entities (MCOs and DBPM) to have a license or certificate of authority issued by the Louisiana Department of Insurance (DOI) to operate as Medicaid risk-bearing entities pursuant to Title 22:1016 of the Louisiana Revised Statutes.

The full financial statements for each plan can be found in Appendix VI. The statements are for Calendar Year 2017, which were reported during State Fiscal Year 2018.

11 SANCTIONS LEVIED BY THE DEPARTMENT

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

Actions or inactions by the Medicaid managed care entities that are subject to sanction by the Department are specified in 42 CFR §438.700, et seq., and delineated in the LDH Medicaid managed care contracts. In State Fiscal Year 2018, there were no sanctions levied against any of the Medicaid managed care entities.

In addition to sanctions, the Department may take other administrative actions, require corrective action, or impose monetary penalties for non-compliance issues that are not specifically subject to issuance of a sanction. Additional information on actions taken or penalties imposed 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

MCNA EPSDT Program

The EPSDT Dental Program is designated for enrollees under the age of 21. The EPSDT Dental Program, administered by MCNA, covers certain diagnostic, endodontic, periodontic, removable prosthodontic, maxillofacial prosthetic, oral and maxillofacial surgery, orthodontic, adjunctive general services, preventive, and maintenance and restoration services such as fillings, fluoride treatments, and cleanings. In State Fiscal Year 2018, MCNA covered 896,209 Medicaid enrollees under the age of 21. Of those, 430,574 members (48%) saw a dentist for at least one service.

Table 12.1 shows the rates of utilization for members under the age of 21. Oral prophylaxis services, which is generally defined as the removal of deposits from the tooth surfaces (teeth cleaning), was the most common dental procedure received by members under the age of 21. Reported under two separate billing codes by age group, an aggregated 94% of members who saw a dentist received oral prophylaxis services. At 20.8% and 9.4% respectively, a combination of composite fillings and amalgam fillings made fillings the second most utilized dental service for members under the age of 21.

Table 12.1 Utilization rates for procedures performed on those patients under the age of 21 who saw a dentist through the Dental Benefit Program, State Fiscal Year 2018

	Total members received procedure	As a percent of members who saw a dentist
Adult oral prophylaxis (12 -20 years of age)	121,285	28.2%
Child oral prophylaxis (under 12 years of age)	283,104	65.8%
Dental sealants	47,445	11.0%
Fluoride varnish	84,938	19.7%
Amalgam fillings	40,524	9.4%
Composite fillings	89,408	20.8%
Stainless steel crowns	36,136	8.4%
Extractions of primary teeth	33,481	7.8%
Extractions of permanent teeth	15,451	3.6%
Pulpotomies performed on primary teeth	16,386	3.8%
Root canals performed on permanent teeth	6,987	1.6%

Source: MARS Data Warehouse, compiled by ULM School of Pharmacy, Office of Outcomes Research

MCNA Adult Denture Services

For Medicaid enrollees over the age of 21 that were eligible for full Medicaid benefits through either the FFS or MCO program, the dental benefit was limited to denture services as outlined in the Medicaid State Plan. In State Fiscal Year 2018, MCNA covered 829,196 adult members for denture services, of which 12,631 (1.5%) saw a dentist for at least one denture related service.

MCO Adult Dental Value Added Services (VAS)

On February 1, 2015, as a value added benefit to adult full-benefit members, all five managed care organizations began offering a limited adult dental benefit beyond the state plan denture benefit covered by MCNA. In State Fiscal Year 2018, 102,393 or 14% of the 723,025 eligible adult members received at least one value added dental service through their managed care organization. Additional data on adult dental services by health plan are presented in tables 12.2 and 12.3.

Table 12.2 Eligibility and utilization data for dental benefits by health plan, State Fiscal Year 2018

	ABH	ACLA	HB	LHCC	UHC	Total
Eligible Members (Full-benefit Adults age 21+)[14]	84,543	111,164	135,478	203,222	216,995	723,025
Number who saw a dentist	11,540	9,334	21,936	20,242	39,341	102,393
The percent of eligible patients that saw a dentist	13.65%	8.40%	16.19%	9.96%	18.13%	14.16%

Source: MARS data warehouse, compiled by ULM School of Pharmacy, Office of Outcomes Research

Extraction of permanent teeth was the most common service received, followed by teeth cleaning and fillings, table 12.3.

Table 12.3 Utilization rates for most common procedures performed on those patients over the age of 21 who received a dental service through their managed care organization, State Fiscal Year 2018

		ABH	ACLA	HB	LHCC[15]	UHC
Extraction of permanent teeth	Count	4,969	3,680	9,039		15,811
	Utilization	43.06%	39.43%	41.21%		40.19%
Adult oral prophylaxis	Count	4,489	3,522	9,318		17,002
	Utilization	38.90%	37.73%	42.48%		43.22%
Composite fillings	Count	2,349	1,611	4,394		8,825
	Utilization	20.36%	17.26%	20.03%		22.43%
Amalgam fillings	Count	460	436	866		1,799
	Utilization	3.99%	4.67%	3.95%		4.57%

Source: MARS Data Warehouse, compiled by ULM School of Pharmacy, Office of Outcomes Research

[14] Includes full benefit members only, partial benefit members were not covered for value-added dental services.
[15] Breakdown of services by procedure code for value-added dental services was not available in LHCC encounter data at the time of this report.

Medicaid Managed Care 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.

Out of the total 1,856,480 unduplicated individuals enrolled at some point in Louisiana Medicaid in State Fiscal Year 2018, 93% or 1,720,038 unduplicated individuals were enrolled in a health plan for one or more months during the year. The majority of health plan members received full-benefit coverage.

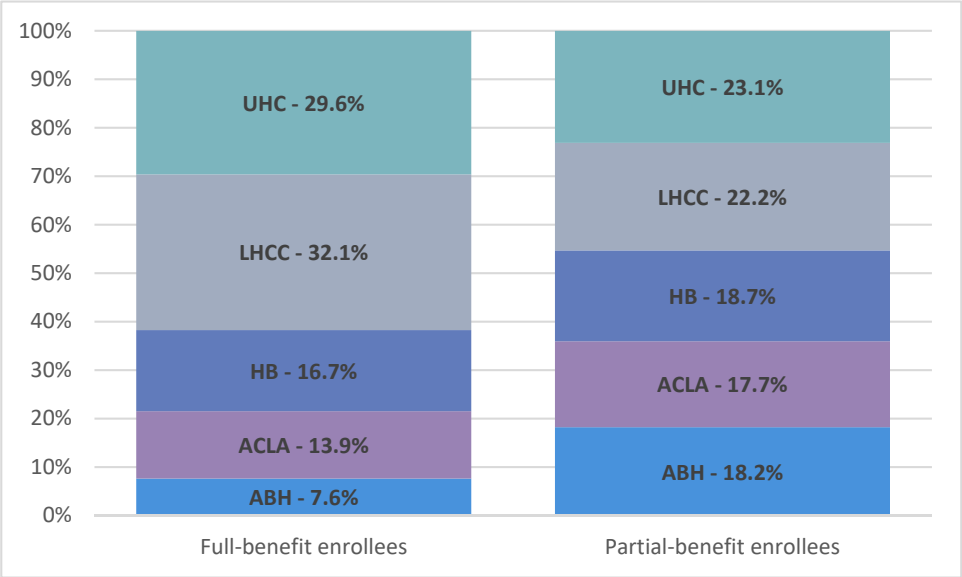
The distribution of total enrollees across health plans ranged from 9% in Aetna to 32% in Louisiana Healthcare Connections. Table 13.1 and Figure 13.1 below provide a breakdown of enrollment totals by health plan and benefits covered. This table represents unduplicated enrollment in each health plan throughout the year.

Table 13.1 Total enrollees by health plan and benefit group, State Fiscal Year 2018

	ABH	ACLA	HB	LHCC	UHC	Total Unduplicated[16]
Full-benefit enrollees	126,023	229,762	276,617	530,865	489,965	1,596,784
Partial-benefit enrollees	25,184	24,529	25,893	30,640	31,993	136,755
Total (unduplicated)	149,382	252,194	300,269	557,985	518,432	1,720,038
Percent of total	8.7%	14.7%	17.5%	32.4%	30.1%	100%

Source: MARS Data Warehouse

Figure 13.1 Distribution of enrollees by benefit group and health plan, State Fiscal Year 2018



Source: MARS Data Warehouse

[16] As individuals can be in more than one plan throughout the year, unduplicated count is less than the sum of individual plan enrollments.

For purposes of health plan reimbursement, enrollees were assigned to one of the eligibility categories listed below in State Fiscal Year 2018:

- *Families and Children*: Children and teens under the age of 19 whose basis of Medicaid or LaCHIP eligibility was age, along with their parents or caregivers. This group also includes pregnant women whose primary basis of eligibility for Medicaid was pregnancy. Children with disabilities are not included in this group.
- *People with disabilities and Supplemental Security Income (SSI)-related seniors*: Individuals who were aged 65 and above as well as individuals of any age, including children, with disabilities.
- *Foster children*: Children who received 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)*: 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 were not otherwise eligible for Medicaid.
- *LaCHIP Affordable Plan (LAP):* Children and youth under the age of 19 with incomes between 217 and 255% of the federal poverty level (FPL). Families pay a monthly premium of $50.
- *Home and Community-Based Services (HCBS) Waiver*: Individuals who are elderly or have disabilities and receive waiver services to assist them in remaining in their homes and in the community.
- *Chisholm*: Louisiana Medicaid enrollees under age 21 who are on the Developmental Disabilities Request for Services Registry.
- *New Adult Group (Expansion)*: All adults between the ages of 19 and 64 (including both parents and adults without dependent children) with incomes below 138% of FPL.

While figure 13.1 above presents unduplicated enrollees for the full twelve months during State Fiscal Year 2018, tables 13.2 and 13.3 below provide the average monthly number of enrollees for full-benefit and partial-benefit coverage respectively.

Table 13.2 Average number of full-benefit members enrolled each month delineated by eligibility category and health plan, State Fiscal Year 2018

	ABH	ACLA	HB	LHCC	UHC
Families & Children	35,716	107,035	124,246	290,838	248,996
SSI	7,027	20,264	19,274	36,010	28,655
Foster Care	365	872	2,842	6,073	2,125
BCC	50	131	93	114	138
LAP	189	369	472	1,068	1,095
HCBS Waiver	128	267	275	554	503
Chisholm	149	352	422	1,084	727
New Adult Group/Expansion	52,260	63,930	79,226	124,670	134,574
All Categories	95,883	193,222	226,850	460,412	416,814

Source: MARS Data Warehouse

For the partial-benefit only population, the breakdown of average monthly membership for each health plan by eligibility category for State Fiscal Year 2018 is presented in table 13.3. The average monthly enrollment is lower than the total unduplicated count for the year presented in figure 13.1 because each month there were some members who lost eligibility, while others were newly enrolled.

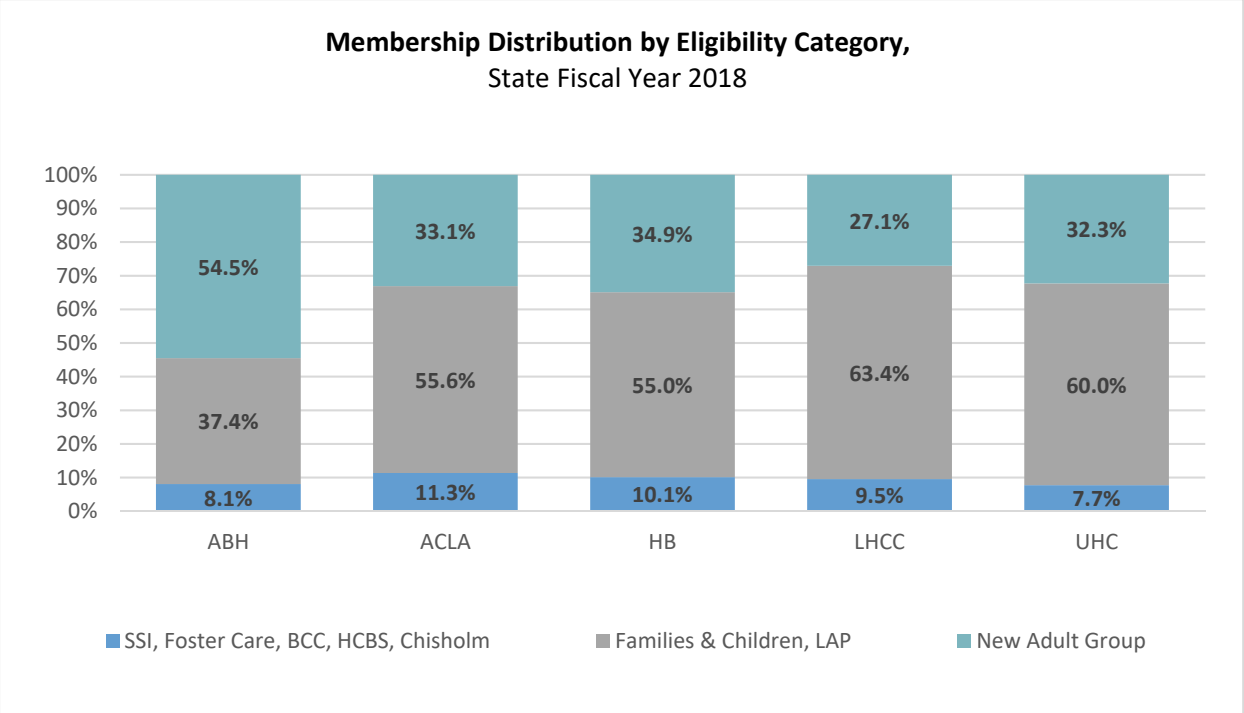
Table 13.3 Average number of partial-benefit only members enrolled each month delineated by eligibility category and health plan, State Fiscal Year 2018

	ABH	ACLA	HB	LHCC	UHC
Chisholm	489	582	684	960	928
Dual Eligibles	19,350	18,693	19,331	22,596	23,172
HCBS Waiver	900	904	943	1,110	1,218
Other[17]	611	591	687	814	968
All Categories	21,350	20,770	21,646	25,479	26,285

Source: MARS Data Warehouse

While the percent distribution for some eligibility categories was small in the number of members represented, the related cost of healthcare may be high due to the healthcare needs of the population. As an example, individuals in Family and Children and the LaCHIP Affordable Plan eligibility categories are generally healthier and less costly per member as compared to the SSI, Foster Care, Breast & Cervical Cancer, Home & Community-Based Service and Chisholm groups. Differences in percent distribution of total enrollment by member demographics are important factors when looking at the number and types of providers, services, utilization and costs for each health plan. The distribution of members enrolled in each health plan by eligibility category and enrollment type is displayed in figure 13.2.

Figure 13.2 Full-benefit membership distribution by eligibility category, State Fiscal Year 2018



Source: MARS Data Warehouse

[17]Includes individuals residing in nursing facilities (NF) or under the age of 21 residing in intermediate care facilities for people with developmental disabilities (ICF/DD) and other eligibility categories excluded from full-benefit participation in Medicaid managed care.

14 PROACTIVE 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 the Medicaid Managed Care Program is to engage members in selecting the health plan that best meets their needs. Factors that weigh in the decision include value added benefits that may be offered by a given plan and whether one's preferred providers participate in the plan's network. Health plan 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 were given the opportunity to select a plan at the time of application. Members who did not choose a health plan were auto-assigned to the plan the enrollment broker 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 previous 60 days, current providers, or whether family members were already enrolled in a plan.

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

Table 14.1 provides the individual plan and aggregate choice rates for State Fiscal Year 2018. Proactive choice rates for all five health plans increased over 2017 rates, with the overall rate increasing from 63% in 2017 to 71% in 2018. There were no changes in the methodology for calculation of the choice rate. The increase is attributed to Medicaid expansion and heightened enrollment efforts, including the release of the Healthy Louisiana mobile enrollment app in August 2016. The Department continues to work with the enrollment broker and other stakeholders to inform and educate members about Medicaid managed care, available health plans and the process for selecting the plan of their choice.

Table 14.1 Proactive choice rates, State Fiscal Year 2018

	ABH	ACLA	HB	LHCC	UHC	Total
Pro-active Choice Enrollments	18,316	20,993	43,053	58,718	68,147	209,227
Auto Enrollments	15,623	16,761	17,240	18,722	18,410	86,756
Total Enrollments	33,939	37,754	60,293	77,440	86,557	295,983
Choice rate	54.0%	55.6%	71.4%	75.8%	78.7%	70.7%

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 Medicaid Managed Care Program, the Department tracked utilization of core benefits and services, i.e., the extent to which enrollees used a health plan service in a specified period of time. Section 15 provides information on Medicaid services provided by each of the health plans. Data are inclusive of paid and denied claims but are reported by unduplicated members, not by claim count.

Table 15.1 shows the unduplicated counts and percent of members who received services in State Fiscal Year 2018. During this reporting period, 1,428,744 members received one or more Medicaid service(s) through their health plan for an overall rate of 83% of members across all plans. Rates for individual plans demonstrate variation across plans with a range of 73% (Aetna) to 86% (United HealthCare).

Appendix VII provides additional detail of members served by provider taxonomy, provider type, and place of service broken out by contract year. It should be noted that place of service is not a required field on all claims submissions.

Table 15.1 Enrollees who received services, State Fiscal Year 2018

	ABH	ACLA	HB	LHCC	UHC	Total Unduplicated[18]
Unduplicated Count of Members	149,382	252,194	300,269	557,985	518,432	1,720,038
Number Receiving One or More Services	109,008	206,435	241,444	471,741	446,552	1,428,744
Percent Receiving One or More Services	72.8%	81.8%	80.2%	84.5%	86.0%	83.1%

Source: MARS Data Warehouse

[18] Unduplicated totals by health plan cannot be summed as members can switch health plans throughout the year.

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 enrollee is assigned to a health plan, either by choice or by auto assignment, the health plan in turn links the member to a primary care provider (PCP). These PCPs are providers who contracted with the health plan explicitly to provide primary care services and to serve as a medical home for their patients. Enrollees were contacted by their health plan to make a PCP selection. If no PCP selection was made within 10 days of enrollment into the health plan, enrollees were assigned one. The algorithm for auto assignment considers past history with a PCP or a family history with a PCP. The Department required each health plan to have a process through which members could 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 a PCP to which they were linked during State Fiscal Year 2018. Though members are linked to a PCP, they are not prohibited from seeking care from other providers. It is important to note that not included in this table is data on members who had a visit for primary care services rendered by an individual provider to which the member was not linked at the time. The data are reflective of legislative reporting specific to R.S. 40:1253.2, and as such, may exclude other primary care access points.

Table 16.1 Total number and percentage of enrollees of each managed care organization who had at least one visit with their primary care provider, State Fiscal Year 2018

	ABH[19]	ACLA	HB	LHCC	UHC
Unduplicated Full-benefit Members	126,023	229,762	276,617	530,865	489,965
Members with at least one PCP visit	6,454	71,467	90,528	152,400	155,389
Percentage	5.1%	31.1%	32.7%	28.7%	31.7%

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

To provide additional information on access to primary care beyond a member's linked PCP, the counts of members who had at least one visit to any primary care provider were also compiled and presented in table 16.2. This expanded data demonstrates that 61% of all managed care enrollees did have at least one primary care visit in SFY 2018.

Table 16.2 Total number and percentage of enrollees of each managed care organization who had at least one visit with any primary care provider, State Fiscal Year 2018

	ABH[19]	ACLA	HB	LHCC	UHC
Unduplicated Full-benefit Members	126,023	229,762	276,617	530,865	489,965
Members with at least one PCP visit	45,114	143,922	115,223	355,153	296,844
Percentage	35.8%	62.6%	41.7%	66.9%	60.6%

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

[19]During the compilation of the Transparency Report, errors were identified in the ABH process for extracting data for submission of Provider Registry and PCP Linkage files to DXC resulting in an understatement of the number of members with at least one PCP visit in both tables 16.1 and 16.2.

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 emergency hospital services. Additionally, it shows the number of members who received emergency services within a year after having seen a primary care provider.[20]

Table 17.1 lists the number of members receiving unduplicated outpatient emergency services for State Fiscal Year 2018. For comparability across health plans, the rate per 1,000 total health plan members was calculated to account for variation in total member counts. Healthy Blue had the highest rate of members receiving unduplicated outpatient emergency services at 398 per 1,000 members, and Aetna had the lowest rate of 374 per 1,000 members, though no plan was a significant outlier. In aggregate, the rate across all health plans was 401 per 1,000 total health plan members

Table 17.1 Number of members who received unduplicated outpatient emergency services, State Fiscal Year 2018

	ABH	ACLA	HB	LHCC	UHC	Total Unduplicated[21]
Members receiving unduplicated outpatient emergency services	47,181	91,234	110,043	208,395	189,921	640,328
Total Unduplicated Full-benefit Health Plan Members	126,023	229,762	276,617	530,865	489,965	1,596,784
Rate per 1,000 unduplicated health plan members	374	397	398	393	388	401

Source: MARS Data Warehouse

Table 17.2 lists the total inpatient Medicaid days for State Fiscal Year 2018. As with other data, wide variability is expected because of the distinct characteristics of each plan's membership. In aggregate, the rate of total inpatient Medicaid days across all health plans for SFY 2018 was 434 per 1,000 members.

[20] In this section, a primary care provider is defined as any provider of primary care services, and is not necessarily the primary care provider the member is linked to as identified in Section 16 of this report.

[21] Totals by health plan cannot be summed as members can switch health plans throughout the year and may be counted in each health plan total but are only once in the unduplicated total.

Table 17.2 Number of total inpatient Medicaid days, State Fiscal Year 2018

	ABH	ACLA	HB	LHCC	UHC	Total Unduplicated[22]
Total Inpatient Medicaid Days	72,374	106,136	125,370	205,606	183,787	693,273
Rate per 1,000 unduplicated health plan members	574	462	453	387	375	434

Source: MARS Data Warehouse

In order to better understand the relationship between access to primary care and use of outpatient emergency services, the Department has expanded the data to not only look at the 12 month period prior to use of outpatient emergency services, but to also examine the six-month period after the use of outpatient emergency services. Table 17.3 summarizes this data for individual periods before and after receipt of emergency services. Both unduplicated member counts and rates per total members receiving outpatient emergency services are presented for comparability across health plans.

Table 17.3 Unduplicated members who saw a PCP[23] before or after a visit to the Emergency Room, State Fiscal Year 2018

	ABH	ACLA	HB	LHCC	UHC	Total Unduplicated[22]
12 months before outpatient emergency service	23,118	68,576	63,505	156,087	132,410	439,741
Percentage of total emergency service visits[24]	49.0%	75.2%	57.7%	74.9%	69.7%	68.7%
6 months after outpatient emergency service	20,090	61,310	53,536	136,536	112,540	380,636
Percentage of total emergency service visits	42.6%	67.2%	48.7%	65.5%	59.3%	59.4%

Source: MARS Data Warehouse

[22] Totals by health plan cannot be summed as members can switch between health plans throughout the year and may be counted in each health plan total but are only once in the unduplicated total.

[23] In this section, a primary care provider is defined as any provider of primary care services, and is not necessarily the primary care provider the member is linked to as identified in Section 16.1 of this report.

[24] The percentage is calculated as the percent of total unduplicated members who received an outpatient emergency service as identified in table 17.1.

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

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.

Health plan enrollees have the right to file appeals with both the health plan and 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 appeals filed as well as the steps health plans take to remedy such appeals. States must also provide an opportunity for a fair hearing to members whose appeal is either denied or not promptly acted upon by the health plan.

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, which is an expression of dissatisfaction about any matter other than one of the above actions.

As part of their quality strategy, states must require health plans to maintain records of appeals and submit them for state review. When reviewing the records, the Department analyzed the subjects of the plans' appeals to identify the extent to which they are valid and/or are in the actual control of the health plan. The health plans and the Department both looked for trends and used the reports to determine the need for operational changes and improvements.

Table 18.1 Appeals, state fair hearings and appeals overturned, State Fiscal Year 2018

	ABH	ACLA	HB	LHCC	UHC	MCNA Dental
Total number of unduplicated members	149,382	252,194	300,269	557,985	518,432	1,743,217
Number of members who filed appeals	79	437	442	1,876	861	81
Number of members who accessed the State Fair hearing process	8	20	29	51	23	3
Total number of Appeals filed	82	490	446	2,880	1,268	82
Rate of members who filed an appeal (per 1000)	0.53	1.73	1.50	3.36	1.66	0.05
Total number of appeals that reversed or otherwise resolved a decision in favor of the member[25]	31	182	84	621	366	17
Percent of appeals that reversed or otherwise resolved a decision in favor of the member	37.8%	37.1%	18.8%	21.6%	28.9%	20.7%

Source: 113 Monthly Appeal & State Fair Hearing Detail Workbook and Annual Summary Report

Variation in the rate of appeals across plans may be attributed to differences in plan interpretation of report definitions and timing of actions taken. The Department engaged the plans in a reporting improvement effort to increase the consistency of the data reported for monitoring service authorization timeframes, denials, and member appeals. As a result both the 113 Monthly Appeal & State Fair Hearing report and the 188 Service Authorizations reporting requirements are being revised to increase consistency and comparability on a prospective basis.

[25] Includes all appeals that were overturned or partially overturned by the health plan, Division of Administrative Law, or LDH. Because the timeframe for the full appeal process may span multiple years, it is possible for appeal reversals to be counted in multiple years.

Healthcare 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 the Emergency Medical Treatment and Labor Act (EMTALA) screening or urgent care, and professional services, specifically the evaluation and management of a patient, provided in an emergency room.[26] There were zero claims submitted to MCNA for emergency services since MCNA did not manage emergency services as defined for this report.

Non-emergency services are defined as all other claims that do not fit the definition of emergency services.

[26] 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.

19 CLAIMS SUBMITTED BY HEALTHCARE PROVIDERS

The total number of claims submitted by healthcare 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 report claims data annually using the revised 177 reporting template developed by the Department, which captures unduplicated counts of claims received by each health plan. This report captures not only claims that are adjudicated (processed for payment or denial), but also captures rejected claim counts that are not reported in encounter submissions to the fiscal intermediary. The aggregate count of unduplicated claims submitted across all health plans and MCNA totaled 90,704,065 in State Fiscal Year 2018. The breakdown of unduplicated claim counts for State Fiscal Year 2018 is presented in table 19.1.

All claims accepted in the system for adjudication (determination of payment or denial) can be categorized as emergency or non-emergency. Of total claims adjudicated by a health plan, less than 4% were for emergency services.

Claims that do not meet the specific data requirements or the basic format necessary will be rejected according to the CMS. “Rejected” claims are different from denied claims, as they are not adjudicated and are rejected before entering the health plan’s adjudication system. Reasons for rejection include Electronic Data Interchange (EDI) formatting issues on the transaction resulting in a system inability to read the claim or failure of the claim to meet basic HIPAA submission requirements. Since rejected claims are not processed through the health plans’ adjudication systems, services cannot be classified as emergency or non-emergency. The aggregate claim rejection rate across all health plans was just under one-half of one percent (0.5%). Individual plan rejection rates are dependent upon a plan’s specific claims processing system and internal workflow.

Table 19.1 Total claims by managed care plans for emergency and non-emergency services, State Fiscal Year 2018

	Rejected Claims	Emergency Services	Non-Emergency Services	Total
ABH	82	605,401	6,934,176	7,539,659
ACLA	58,556	423,859	12,113,315	12,595,730
HB	10,102	349,639	14,464,423	14,824,164
LHCC	276,891	888,666	25,241,461	26,407,018
UHC	29,921	1,023,601	24,784,337	25,837,859
MCNA Dental	0	0	3,499,635	3,499,635
Total	375,552	3,291,166	87,037,347	90,704,065

Source: Report 177 Total and Out of Network Claims

20 DENIED CLAIMS

The total number of claims submitted by healthcare providers to each managed care organization which were adjusted [adjudicated] 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.

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

Table 20.1 Total unduplicated denied claims, State Fiscal Year 2018

	Emergency Services	Non-Emergency Services	Total
ABH	14,679	1,642,563	1,657,242
ACLA	24,914	2,281,675	2,306,589
HB	32,227	3,027,439	3,059,666
LHCC	35,030	5,286,923	5,321,953
UHC	103,784	4,958,165	5,061,949
MCNA Dental	0	336,899	336,899
Total	210,634	17,533,664	17,744,298

Source: 173 Denied Claims Report

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) for medical and behavioral health claims and National Council for Prescription Drug Program (NCPDP) reject codes for pharmacy claims, which are both national standards. The number of CARC and NCPDP codes is greater than the unduplicated number of total denied claims presented in table 20.1 since each claim line can have more than one CARC or NCPDP reject code. In other words, a claim can be denied or adjusted for multiple reasons. As a claim cycles through the payment logic, the claims processing system applies all applicable CARC or NCPDP reject codes randomly, and one is not primary in comparison to another.

Table 20.2 shows the ten most frequently used CARC codes for emergency and non-emergency medical and behavioral health claims. The primary causes for denial were a lack of precertification or prior authorization, billing for non-covered services, the claim was lacking sufficient information to adjudicate or had submission/billing errors, and duplicate claims. A breakout of all CARCs for denied claims for each health plan in numerical order is provided in Appendix VIII.

Table 20.2 Top claim adjustment reason codes (CARCs) for emergency and non-emergency services, State Fiscal Year 2018

CARC	CARC Description	Emergency Claims[27]	Non-Emergency Claims	Total
197	Precertification/authorization/notification absent.	767	1,587,274	1,588,041
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	37,753	1,277,886	1,315,639
96	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.)	15,223	1,231,813	1,247,036
97	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.	12,125	1,110,409	1,122,534
16	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 Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	11,283	855,718	867,001
252	An attachment/other documentation is required to adjudicate this claim/service. 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).	24,206	494,964	519,170
29	The time limit for filing has expired.	8,883	353,191	362,074
256	Service not payable per managed care contract.	3,314	304,180	307,494
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	4,615	256,986	261,601
27	Expenses incurred after coverage terminated.	16,742	230,310	247,052

Source: 173 Denied Claims Report

[27] Emergency services are defined as claim type 03 with revenue codes 450, 459 or 981 (outpatient hospital) and claim type 04 with procedure codes 99281 through 99285 (professional).

Table 20.3 shows the ten most frequently used NCPDP reject codes for emergency and non-emergency pharmacy claims. Pharmacy claims use a different national coding structure than is used for medical or behavioral health claims. For consistency with encounter data, the Department has utilized the structure published by the National Council for Prescription Drug Programs (NCPDP) to monitor reasons for claims denials. The primary causes for denial stemmed from refilling too soon, billing for non-covered services, prior authorization lacking, or other coverage limitations.

Table 20.3 Top National Council for Prescription Drug Programs (NCPDP) codes for denial of emergency and non-emergency pharmacy services, State Fiscal Year 2018

NCPDP Code	NCPDP Description	Emergency Claims[28]	Non-Emergency Claims	Total
76	Plan Limitations Exceeded	9,604	1,467,597	1,477,201
79	Refill Too Soon	466	1,295,386	1,295,852
70	Product/Service Not covered	10,485	1,237,696	1,248,181
88	DUR Reject Error	7,091	981,851	988,942
41	Submit Bill to Other Processor or Primary Payer	3,181	646,629	649,810
75	Prior Authorization Required	1,307	566,063	567,370
19	Missing/Invalid Days Supply	136	362,083	362,219
69	Filled After Coverage Terminated	2,275	302,974	305,249
39	Missing/Invalid Diagnosis Code	25	234,357	234,382
MR	Product Not on Formulary	0	194,667	194,667

Source: 173 Denied Claims Report

[28] Emergency pharmaceutical services are defined as claim type 12 with a NCPDP field 418-DI value of 3.

21 CLEAN CLAIMS

The total number of claims submitted by the healthcare 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 healthcare providers delineated by provider type.

The managed care contracts define a clean claim 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 to each health plan. This total includes claims that were paid, denied or otherwise adjudicated. It does not include rejected claims, which do not meet the definition of a clean claim.

Table 21.1 Total clean claims by health plan, State Fiscal Year 2018

ABH	ACLA	HB	LHCC	UHC	MCNA	Total
4,161,437	12,279,121	14,091,918	26,353,112	25,508,916	2,768,743	82,394,504

Source: 221 Prompt Pay Report

Health plans are required by contract to pay 90% of all payable clean claims within 15 business days of the date of receipt and 99% within 30 calendar days of the date of receipt. The MCO must pay providers interest at 12% per annum of the amount payable, calculated daily, for the full period in which the clean claim remains unpaid beyond the 30-day claims processing deadline. This compliance measure is typically monitored in the aggregate for contract compliance; however, delineation of turnaround times by claim type is outlined in tables 21.2 and 21.3 below for illustrative purposes.

Table 21.2 Percent of paid clean claims that were paid within 15 days, State Fiscal Year 2018

Provider Type	ABH	ACLA	HB	LHCC	UHC	MCNA
Inpatient Hospital	87.64%	100.00%	97.22%	98.19%	99.27%	.
Outpatient Hospital	98.60%	100.00%	99.58%	99.11%	99.83%	.
Professional	98.20%	99.97%	99.49%	99.53%	98.96%	.
Rehab	99.53%	100.00%	99.34%	98.11%	99.80%	.
Home Health	93.41%	100.00%	99.44%	98.61%	100.00%	.
EMT(Transportation)	94.64%	100.00%	99.51%	97.89%	99.80%	.
NEMT & NEAT Transportation	99.30%	99.35%	99.94%	99.36%	99.87%	.
DME	95.55%	99.89%	98.48%	98.04%	99.73%	.
Pharmacy	99.38%	100.00%	99.81%	100.00%	100.00%	.
EPSDT Dental	.	.	.	.	.	99.89%
Adult Denture	.	.	.	.	.	100.00%

Source: 221 Prompt Pay Report

Inpatient, home health, and DME claims generally take longer to adjudicate when compared to other claim types due to the complexity, authorization requirements and need for manual review.

Table 21.3 Percent of paid clean claims that were paid within 30 days, State Fiscal Year 2018

Provider Type	ABH	ACLA	HB	LHCC	UHC	MCNA
Inpatient Hospital	92.64%	100.00%	99.67%	99.52%	99.75%	.
Outpatient Hospital	99.23%	100.00%	99.87%	99.75%	99.93%	.
Professional	99.14%	100.00%	99.80%	99.85%	99.80%	.
Rehab	99.86%	100.00%	99.71%	99.62%	99.84%	.
Home Health	95.47%	100.00%	99.90%	99.85%	100.00%	.
EMT (Transportation)	97.12%	100.00%	99.82%	99.01%	99.97%	.
NEMT & NEAT (Transportation)	99.93%	99.95%	100.00%	99.96%	99.99%	.
DME	97.82%	99.99%	99.46%	99.46%	99.93%	.
Pharmacy	100.00%	100.00%	99.91%	100.00%	100.00%	.
EPSDT Dental	.	.	.	.	.	100.00%
Adult Denture	.	.	.	.	.	100.00%

Source: 221 Prompt Pay Report

It should be noted, however, that adjudicated date and paid date are not the same. It often occurs that a claim is adjudicated (paid or denied) and will not be paid until the next weekly check cycle. This information is reflective of the paid date as requested by the statutory reporting requirement. All health plans paid the vast majority of provider types in approximately two weeks, with the average number of days being approximately one week (6 – 8 days) for most provider types.

Table 21.4 Average number of days to pay clean claims, State Fiscal Year 2018

Provider Type	ABH	ACLA	HB	LHCC	UHC	MCNA
Inpatient Hospital	10.00	9.20	10.00	10.00	9.45	.
Outpatient Hospital	6.00	4.50	5.00	9.00	8.13	.
Professional	6.40	4.08	4.15	8.10	8.33	.
Rehab	6.00	6.00	7.00	9.00	8.04	.
Home Health	9.00	4.70	7.00	10.00	8.54	.
EMT (Transportation)	7.00	3.80	13.00	9.00	9.05	.
NEMT & NEAT (Transportation)	9.72	10.15	3.30	10.70	8.91	.
DME	8.00	5.80	7.00	9.05	8.43	.
Pharmacy	11.00	2.57	1.00	1.00	1.00	.
EPSDT Dental	.	.	.	.	.	7.67
Adult Denture	.	.	.	.	.	7.66

Source: 221 Prompt Pay Report

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.

The 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 stipulated that service authorizations must be processed within 14 calendar days of the request for authorization, with at least 80% processed within two business days of receipt of needed documentation.

Contracted timeframes and compliance standards are applied in aggregate for both medical and behavioral health service authorizations. Data for State Fiscal Year 2018 are presented in table 22.1. Variations in the number of authorizations processed by individual health plans can be attributed to plan policy, as well as membership size and complexity.

Table 22.1 Standard service authorizations processed, State Fiscal Year 2018

TIMEFRAME (COMPLIANCE STANDARD)		ABH	ACLA	HB	LHCC	UHC
Processed within 2 business days from receipt of needed documentation (80%)	**Number**	24,994	72,733	116,357	180,765	96,097
	Percent	80.96%	93.45%	75.51%	96.03%	95.19%
Non-extended: Processed within 14 days of receipt of request for authorization (100%)	**Number**	30,341	77,780	148,659	161,005	99,900
	Percent	98.28%	100%	96.48%	99.46%	99.96%
Extended: Processed within 28 days[29] of receipt of request for authorization (100%)	**Number**	4,154	43	0	26,269	151
	Percent	99.93%	79.63%	--	99.67%	100%

Source: 188 Ad Hoc Annual Report, SFY 2018

[29] All authorizations for Durable Medical Equipment (DME) must be processed in 25 days or less.

If the situation warranted, the provider could request an expedited determination, in which case the request must be acted on within 72 hours or less, depending on the medical urgency. Per the Code of Federal Regulations, an extension of up to 14 days could be granted if the member or the health plan justified a need for additional information and how the extension is in the member's best interest.

Table 22.2 Expedited service authorizations processed, State Fiscal Year 2018

TIME FRAME (COMPLIANCE STANDARD)		ABH	ACLA	HB	LHCC	UHC
Non-extended: Processed within 72 hours of receipt of request for authorization (100%)	**Number**	713	909	0	120	1,777
	Percent	100.0%	100%	--	99.2%	100%
Extended: Processed within 14 days of receipt of request for authorization (100%)	**Number**	123	2	0	71	13
	Percent	91.79%	100%	--	100%	100.0%

Source: 188 Ad Hoc Annual Report, SFY 2018

The percent of prior authorizations that resulted in a denial of services are presented in table 22.3. Note that the counts presented are unduplicated denials based on the initial service authorization determination; some denials may have subsequently been reversed by the health plans upon reconsideration, appeal or through the state fair hearing process. See Section 18 of this report for additional information on appeals and state fair hearings.

Table 22.3 Percent of service authorizations denied, State Fiscal Year 2018

	ABH	ACLA	HB	LHCC	UHC
Total service authorization processed	36,287	78,745	154,090	114,480	102,777
Number denied	1,375	12,254	18,960	7,286	8,806
Percent denied	3.79%	15.56%	12.3%	6.4%	8.6%

Source: 188 Ad Hoc Annual Report, SFY 2018

23 CLAIMS PAID TO OUT-OF-NETWORK PROVIDERS

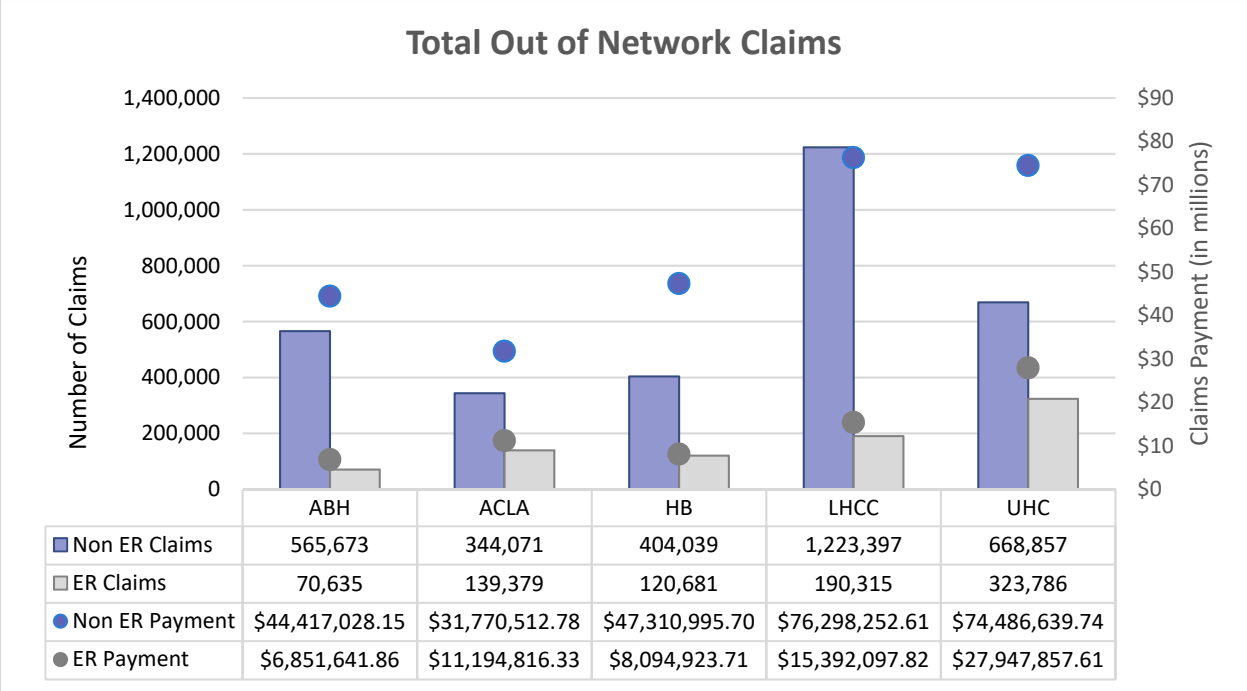
The total number and dollar value of all claims paid to out-of-network providers by claim type categorized by emergency services and nonemergency services for each managed care organization by parish.

LDH requires the health plans to pay both network and non-network providers for emergency services at least 100% of the Medicaid fee schedule that was in effect on the date of service. Prior authorization cannot be required, and payment cannot be contingent upon notification within a specific time frame. The health plans may also make payments to non-network providers for care that was not classified as emergency services through single-case agreements or other arrangements.

The information in figure 23.1 reflects the number of claims and dollar value of payments by the health plans to non-network providers for both emergency services and non-emergency services. The data originate from submissions from the health plans on the standing annual report (report 177).

Appendix IX shows out of network claims for all emergency and non-emergency services broken out by parish and claim type.

Figure 23.1 Out of network claims, State Fiscal Year 2018



	ABH	ACLA	HB	LHCC	UHC
Non ER Claims	565,673	344,071	404,039	1,223,397	668,857
ER Claims	70,635	139,379	120,681	190,315	323,786
Non ER Payment	$44,417,028.15	$31,770,512.78	$47,310,995.70	$76,298,252.61	$74,486,639.74
ER Payment	$6,851,641.86	$11,194,816.33	$8,094,923.71	$15,392,097.82	$27,947,857.61

Source: Report 177 Total and Out of Network Claims

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

In State Fiscal Year 2018, all five health plans managed pharmacy benefits for members enrolled with full-benefits coverage. Partial-benefit only members continued to receive pharmacy benefits under fee-for-service Medicaid.

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 during State Fiscal Year 2018.

Table 24.1 MCO pharmacy benefit managers, State Fiscal Year 2018

ABH	ACLA	HB	LHCC	UHC
CVS Caremark	PerformRx	Express Scripts	US Script	OptumRx
Contracted	Owned	Contracted	Owned	Owned

Source: MCO self-reported

Managed care organizations had flexibility in how to address appropriateness of medication therapy. Additionally, each pharmacy benefit manager had its own protocols for utilization management and decision making as to which drugs to include in its preferred drug list.

Table 24.2 lists the unduplicated total number of pharmacy claims received by each health plan, as well as a breakdown of claims by select categories. The variation in the data presented is reflective of the variation across health plans in implementing alternative approaches to managing pharmacy benefits, particularly in step therapy and fail first protocols. When a drug was requested that required step therapy and fail first protocols, the enrollee was required to try preferred product(s) before the requested drug would be approved. Each health plan had its own list of preferred drugs and drugs that required step therapy, fail first protocols, and/or prior authorization. The approach used, the drug selection, and the number of trials required before authorizing a non-preferred agent can vary significantly between plans. The monthly details for claims by reporting category are provided in Appendix X.

Table 24.2 Pharmacy claims comparison, State Fiscal Year 2018

		ABH	ACLA	HB	LHCC	UHC
Total prescription claims	#	2,213,970	3,428,295	4,204,097	7,378,927	7,149,011
Subject to prior authorization	#	99,739	119,932	306,042	322,137	689,947
	%	4.50%	3.50%	7.28%	4.37%	9.65%
Denied	#	575,370	725,316	1,191,637	1,663,791	1,418,751
	%	25.99%	21.16%	28.34%	22.55%	19.85%
Subject to step therapy or fail first protocol	#	82,017	20,513	22,172	142,304	144,351
	%	3.70%	0.60%	0.53%	1.93%	2.02%

Source: Report RX055 - Pharmacy

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 specifically to the managed care organizations, as the dental benefit program does not manage pharmacy benefits for its members. The MCOs submit this data on a calendar year basis in the quarterly financial reporting requirements (report 185).

In SFY 2018, MCOs, either directly or through their pharmacy benefit manager, negotiated 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, were generally exempt from prior authorization requirements.

For Medicaid enrollees in a fee-for-service delivery system, 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 Calendar Year 2017 the Department collected $442 million in federal rebates from managed care pharmacy utilization.

Since each Louisiana Medicaid MCO determined its own unique preferred drug list, supplemental rebates were not available to the state, but comparable negotiated discounts were collected by the MCO. On May 1, 2019, the department implemented a single Preferred Drug List (PDL); for services after this date, rebates for all members in managed care and FFS will be collected directly by LDH.LDH requires plans to report rebates and discounts collected in quarterly financial reports. The Department's contracted actuaries considered 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 remitted 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 2017, as reported by the managed care organizations in their quarterly financial reporting requirements.

Table 25.1 Total pharmacy rebates received, Calendar Year 2017

	Amount of Medicaid Drug Rebates and Manufacturer Discounts Collected and Used	Amount of Medicaid Drug Rebates and Manufacturer Discounts Collected and Remitted to the Department
ABH	$2,753,083	$0
ACLA	$5,673,471	$0
HB	$5,003,761	$0
LHCC	$11,578,619	$0
UHC	$20,723,497	$0
Total	$45,732,431	$0

Source: Report 185: Quarterly Financial Reporting Requirements (FRR)

Per the Department issued financial reporting guidelines, rebates are reported by MCOs on a cash basis, i.e. date received. The breakdown of rebates by month for each health plan are presented in table 25.2.

Table 25.2 Monthly pharmacy rebates received, Calendar Year 2017

	ABH	ACLA	HB	LHCC	UHC
January	$207,719	$398,401	$462,557	$1,047,283	$1,601,522
February	$198,835	$398,401	$391,990	$1,004,312	$1,510,732
March	$(70,569)	$398,401	$258,024	$1,023,466	$1,791,492
April	$141,370	$538,229	$310,538	$676,507	$1,620,973
May	$311,315	$538,229	$407,320	$725,623	$1,785,962
June	$0	$538,229	$492,242	$664,152	$1,647,008
July	$146,136	$547,776	$443,906	$1,171,662	$1,516,767
August	$146,136	$547,776	$522,777	$819,784	$1,765,286
September	$530,128	$547,776	$482,932	$795,284	$1,703,617
October	$210,984	$406,751	$414,541	$875,650	$1,978,781
November	$210,984	$406,751	$395,597	$863,065	$1,927,411
December	$720,043	$406,751	$421,337	$1,911,832	$1,873,946
2017 Total	$2,753,083	$5,673,471	$5,003,761	$11,578,619	$20,723,497

Source: Report 185: Quarterly Financial Reporting Requirements (FRR)

26 DENTAL 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.
- To 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.

In State Fiscal Year 2018, MCNA completed prior authorizations on a total of 207,194 requests. As shown in table 26.1, the two most common types of procedures prior authorized were oral/maxillofacial surgery and restorative procedures, which accounted for just under half of all prior authorizations. Oral/maxillofacial surgery included extractions, TMJ procedures, and other surgery on the mouth, jaws and face. Restorative services included tooth restorations, crowns and appliance removals, among others (these types of services are the most commonly performed, and thus the most commonly prior authorized).

No data are reported in this section for the five MCOs since none required prior authorization of their dental value-added services or dental emergency benefits.

Table 26.1 Number of prior authorization requests processed by DBPM by type of procedure, State Fiscal Year 2018

Type of Procedure	Children EPSDT (under 21 years)	Adult Denture (21 years & older)	Total Number of Prior Authorization Requests
0100-0999 Diagnostic	1,181	15,743	16,924
1000-1999 Preventive	9,179	9	9,188
2000-2999 Restorative	48,259	126	48,385
3000-3999 Endodontics	18,679	47	18,726
4000-4999 Periodontics	1841	24	1,865
5000-5899 Removable Prosthodontics	753	28,900	29,653
5900-5999 Maxillofacial Prosthodontics	1	1	2
6000-6199 Implant	15	6	21
6200-6999 Fixed	55	1	56
7000-7999 Oral/Maxillofacial surgery	51,719	302	52,021
8000-8999 Orthodontics	1,340	3	1,343
9000-9999 Adjunctive	28,914	96	29,010
Total	161,936	45,258	207,194

Source: MCNA Quarterly 188 Prior Authorization Reports

The Department included in the Dental Benefit Program Manager contract requirements for timely processing of prior authorization requests. For standard authorizations, 80% must be processed within 2 business days and 100% within 14 calendar days. For expedited authorizations, 100% must be processed no later than 72 hours after receipt. MCNA reported that all procedure types had an average prior authorization time of two days or less. Table 26.2 provides the average and range of authorization processing times for both children and adults by type of procedure.

Table 26.2 Times for responding to prior authorization requests by DBPM, State Fiscal Year 2018

Type of Procedure	Children EPSDT (under 21 years)		Adult Denture (21 years & older)	
	Average Time	Range of Times	Average Time	Range of Times
0100-0999 Diagnostic	2.1	0-6 days	2.0	0-9 days
1000-1999 Preventive	2.0	0-6 days	1.6	1-2 days
2000-2999 Restorative	1.6	0-6 days	1.4	0-4 days
3000-3999 Endodontics	1.3	0-6 days	1.3	0-4 days
4000-4999 Periodontics	2.2	0-6 days	1.8	0-4 days
5000-5899 Removable	2.1	0-6 days	1.9	0-9 days
5900-5999 Maxillofacial	3.0	3-3 days	4.0	4-4 days
6000-6199 Implant	2.4	1-4 days	1.0	0-2 days
6200-6999 Fixed	2.5	0-5 days	4.0	4-4 days
7000-7999 Oral	1.8	0-6 days	1.6	0-6 days
8000-8999 Orthodontics	1.7	0-6 days	3.0	1-4 days
9000-9999 Adjunctive	1.9	0-6 days	1.5	0-4 days
Overall Average	1.7	0-6 days	1.9	0-9 days

Source: MCNA Quarterly 188 Prior Authorization Reports

Of the 207,194 prior authorizations MCNA completed during State Fiscal Year 2018, 42,970 unduplicated authorizations were denied (21%). As with denied claims, there can be multiple denial reasons associated with each authorization request. As a result, the number of denied authorizations by denial reason code, 68,460, is greater than the number unduplicated denied authorizations; therefore, these items are reported independent of each other.

MCNA used a total of 37 unique reasons for denial of prior authorizations. Table 26.3 includes the ten most frequently used authorization denial codes, which accounted for 59,158, or 86% of all denial reason codes applied. The most common denial reason, code 272, was due to a combination of services submitted on a request which cannot be performed by the same provider on the same date of service. Other common reasons were the lack of pre-operative x-rays, restoration not covered when the tooth has previously been restored or requests for services not covered under Departmental policy.

Table 26.3 Ten most prevalent reasons for authorization denial by DBPM, State Fiscal Year 2018

Authorization Denial Code	Code Description	Total
272	No benefit is provided for this extraction of asymptomatic teeth which show no signs of infection; including but not limited to the removal of third molars. The member's condition does not meet MCNA's oral surgery guidelines.	14,920
18	This request has been previously reported and an approval or denial was issued.	7,989
252	Please submit x-ray(s) and narrative with this request.	6,919
56	The dental director has advised that the x-rays received do not demonstrate the need for treatment submitted.	6,021
96	This procedure is considered non-covered in accordance with either the program benefits or the facility contract with MCNA.	5,381
169	The clinical reviewer has recommended an alternate procedure/benefit.	5,293
251	The clinical reviewer has determined that the x-ray and/or photos submitted were not of diagnostic value. Please submit a diagnostic x-ray indicating the right and left sides and/or diagnostic quality photos.	4,037
50	The clinical reviewer has determined that the treatment is in excess of the member's needs.	3,128
16	Please submit a readable and most current bitewing and a periapical x-ray with endodontic requests.	2,872
269	This procedure can only be considered when reported and performed in conjunction with covered services.	2,598
	TOTAL TOP TEN AUTHORIZATION DENIAL REASON CODES	59,158

Source: MCNA Quarterly 188 Prior Authorization Reports

In State Fiscal Year 2018, MCNA denied a total of 336,899 claims. Of these 18,865 were claims that had been previously prior authorized. Table 26.4 includes the ten most frequently used Claims Adjustment Reason Codes, out of 49 total, used for claims denied when the prior authorization had been previously approved. These ten denial reasons accounted for 87% of all reasons for claim denial after prior authorization was approved. All denials delineated by reason for denial are included in Appendix XI. It should be noted that the data reflect only initial denials and do not reflect if a claim was resubmitted and subsequently paid.

Table 26.4 Ten most prevalent reasons for claim denial after prior authorization was approved by DBPM, State Fiscal Year 2018

CARC	Code Description	Total
18	Exact Duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	5,338
252	An attachment/other document is required to adjudicate this claim/service. 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).	3,715
B13	Previously Paid. Payment for this claim/service may have been provided in a previous payment.	1,542
22	This care may be covered by another payer per coordination of benefits.	1,258
272	Coverage/Program guidelines were not met.	1,176
16	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 Reason Code, or Remittance Advice Remark Code that is not an ALERT). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	949
49	This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	936
96	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 Service Payment Information REF), if present.	622
181	Procedure code was invalid on the date of service.	457
169	Alternate benefit has been provided.	402
	TOTAL TOP TEN CLAIM DENIAL REASON CODE (for claims denied after prior authorization approved)	16,395

Source: Report 173 Denied Claims

27 INDEPENDENT REVIEW

The total number of independent reviews conducted pursuant to R.S. 46:460.81 et seq., delineated by claim type for each managed care organization.

The total number and percentage of adverse determinations overturned as a result of an independent review conducted pursuant to R.S. 46:460.81 et seq., delineated by claim type for each managed care organization.

The independent review process was established by La. RS 46:460.81, et seq. to resolve claims disputes when a provider believes an MCO has partially or totally denied claims incorrectly. An MCO's failure to send a provider a remittance advice or other written or electronic notice either partially or totally denying a claim within 60 days of the MCO's receipt of the claim is considered a claim denial.

Effective Jan. 1, 2018 there is a $750 fee associated with an independent review request. If the independent reviewer decides in favor of the provider, the MCO is responsible for paying the fee. Conversely, if the independent reviewer finds in favor of the MCO, the provider is responsible for paying the fee.

LDH administers the independent review process but does not perform the independent review of the disputed claims. When a request for independent review is received, LDH determines if the disputed claims are eligible for independent review based on the statutory requirements. If the claims are eligible, LDH forwards the claims to a reviewer that is not a state employee or contractor and is independent of both the MCO and the provider. The decision of the independent reviewer is binding unless either party appeals the decision to a court having jurisdiction to review the independent reviewer's decision.

The independent review process is only one option a provider has to resolve claims payment disputes with an MCO. In lieu of requesting independent review, a provider may pursue any available legal or contractual remedy to resolve the dispute.

There were no requests for independent review in State Fiscal Year 2018.

LIST OF APPENDICES

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