Medicaid Managed Care Transparency Report 2019

Agency Response to La. Revised Statute 40:1253.2

Louisiana Department of Health

Bureau of Health Services Financing

July 2020

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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 meet 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.

Transparency Report Measures and Data

This report includes 31 areas of measurement outlined in La. Revised Statute 40:1253.2. New items for the SFY 2019 report added by Act 482 of the 2018 regular legislative session include data elements on pharmacy services in Sections 24 and 25 and four entirely new sections (28 – 31) on the Adult Expansion. It should be noted that the expansion population enrolled in managed care is included in the total MCO counts presented in sections 1 through 29 with Sections 30 through 31 being a subset of data specific to the expansion population as required by Act 482.

This report covers program operations for July 2018 through June 2019 (State Fiscal Year 2019), 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

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 Appendices IV and XVI for the survey instruments.

[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 2019, more than 1.72 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 and non-emergency medical transportation, 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 2019 were as follows:

- Individuals receiving limited Medicaid benefits or single service only;
- Individuals over age 21 residing in an intermediate care facility for individuals with intellectual disabilities (ICF/IID);
- 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 services continued to be provided only under the Medicaid fee-for-service program and were not included in the managed care benefit package in State Fiscal Year 2019:

- 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 individuals with intellectual disabilities (ICF/IID), 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 2019 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 contracted entity names and common abbreviations used in this report are detailed in table 1.1 in alphabetical order by plan type.

Table 1.1 Names of contracted managed care entities, State Fiscal Year 2019

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.

Table 2.1 Total number of full-time equivalent (FTE) and average salary for MCO employees based in Louisiana, State Fiscal Year 2019

	ABH	ACLA	HB	LHCC	UHC
Total number of LA employees (FTEs)	141.83	235.98	243.00	584,12	330.00
Average salary paid	$69,135	$60,403	$79,108	$64,081	$65,980

Source: 017 Annual Report to LDH

The average annual salary weighted across all health plans was $66,770. 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 2019, MCNA reported 11.6 full-time equivalent in-state staff. The average annual salary for MCNA employees based in Louisiana was $75,436.

Table 2.2 Total number of full-time equivalent (FTE) and average salary for MCNA employees based in Louisiana, State Fiscal Year 2019

	MCNA Dental
Total number of LA employees (FTEs)	11.6
Average salary paid	$75,436

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 2019, the Department paid a total of $7,903,544,877 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 2019 was 1,720,496. Total enrollment unduplicated within each group was 1,580,372 full-benefit enrollees and 152,723 partial-benefit enrollees (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 enrollees and 3.2 for partial-benefit enrollees. 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 enrollees[3] by month, State Fiscal Year 2019

	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-18	$48,292,540	$497.30	$97,092,445	$510.80	$112,994,591	$482.09	$208,905,940	$461.11	$194,640,359	$466.72
Aug-18	$49,859,497	$508.84	$88,350,924	$464.53	$109,638,571	$464.68	$186,394,735	$411.09	$181,298,304	$433.05
Sep-18	$49,935,656	$508.51	$87,701,033	$463.64	$105,734,698	$433.16	$185,463,510	$415.55	$178,460,075	$426.75
Oct-18	$50,454,621	$510.85	$88,226,338	$465.39	$109,537,610	$446.17	$185,696,640	$415.45	$180,705,801	$430.93
Nov-18	$50,871,621	$512.72	$87,534,201	$460.86	$112,417,569	$455.65	$181,674,554	$405.83	$178,000,604	$423.86
Dec-18	$70,557,685	$696.95	$118,810,642	$617.63	$141,499,207	$564.68	$244,538,333	$541.45	$243,525,781	$574.36
Jan-19	$53,311,757	$521.87	$89,282,792	$462.42	$116,856,105	$462.40	$184,722,084	$406.84	$187,099,296	$439.07
Feb-19	$52,302,310	$511.56	$87,245,766	$452.44	$112,871,991	$445.65	$181,883,172	$400.83	$180,305,824	$423.07
Mar-19	$53,793,293	$522.52	$90,497,172	$468.47	$120,180,253	$471.77	$188,898,720	$415.56	$194,211,883	$454.29
Apr-19	$56,051,416	$565.93	$92,321,944	$495.12	$124,408,497	$504.86	$193,037,072	$439.43	$200,346,716	$486.10
May-19	$56,357,994	$572.73	$93,503,200	$504.52	$123,117,172	$500.74	$194,479,814	$444.48	$196,963,390	$480.22
Jun-19	$58,886,904	$602.16	$97,788,118	$533.66	$127,855,242	$523.05	$202,745,993	$469.91	$203,334,960	$501.70
Total	**$650,675,295**	**$544.33**	**$1,118,354,575**	**$491.62**	**$1,417,111,505**	**$479.58**	**$2,338,440,567**	**$435.63**	**$2,318,892,993**	**$461.68**

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 enrollees, State Fiscal Year 2019:

- Dec-18 Includes $181M in Health Insurer Provider Fee (HIPF) payments to MCOs

[3] Including the adult expansion population

Table 3.2 Total payments and average PMPM for partial-benefit enrollees by month, State Fiscal Year 2019

	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-18	$806,849	$38.45	$815,062	$39.50	$886,926	$40.85	$1,083,639	$41.97	$1,123,236	$42.26
Aug-18	$755,177	$35.99	$768,310	$37.10	$835,370	$38.35	$1,010,994	$38.97	$1,035,289	$38.71
Sep-18	$824,778	$39.54	$808,601	$39.29	$868,826	$39.43	$1,048,888	$40.39	$1,052,556	$39.35
Oct-18	$788,819	$37.90	$792,931	$38.39	$859,117	$39.00	$1,040,693	$40.03	$1,089,067	$40.71
Nov-18	$621,483	$27.38	$628,375	$27.93	$693,507	$28.87	$824,501	$29.18	$865,120	$29.72
Dec-18	$803,983	$35.33	$800,372	$35.47	$881,241	$36.48	$1,044,436	$36.66	$1,099,532	$37.42
Jan-19	$761,692	$31.94	$801,191	$33.93	$835,647	$32.90	$1,039,119	$34.79	$1,081,814	$34.90
Feb-19	$914,970	$38.59	$927,997	$39.36	$1,043,239	$41.30	$1,199,996	$40.33	$1,254,877	$40.65
Mar-19	$748,255	$31.68	$760,621	$32.37	$808,088	$31.97	$985,419	$33.12	$1,006,759	$32.58
Apr-19	$715,088	$30.47	$730,902	$31.31	$784,445	$31.19	$936,997	$31.63	$977,534	$31.77
May-19	$1,075,428	$45.96	$1,098,981	$47.27	$1,205,532	$48.12	$1,427,981	$48.29	$1,499,067	$48.88
Jun-19	$1,523,176	$66.42	$1,555,021	$68.08	$1,710,002	$69.37	$1,996,969	$68.34	$2,105,457	$69.57
Total	**$10,339,698**	**$38.30**	**$10,488,364**	**$39.17**	**$11,411,940**	**$39.82**	**$13,639,632**	**$40.31**	**$14,190,308**	**$40.54**

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.

In State Fiscal Year 2019, the Department paid a total of $171,108,065 to MCNA for the administration of the Medicaid dental benefits management program. 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 in month following the month of enrollment, i.e., June enrollment was paid in July. Table 3.3 below shows the total payments the Department made to MCNA and the average PMPM for each month in State Fiscal Year 2019.

Table 3.3 Total payments and average PMPM for dental benefit program members by month, State Fiscal Year 2019

	MCNA Dental	
	Total Payments	**Average PMPM**
Jul-18	$13,914,384	$9.22
Aug-18	$13,968,735	$9.24
Sep-18	$14,039,282	$9.27
Oct-18	$14,102,989	$9.29
Nov-18	$14,052,674	$9.13
Dec-18	$18,685,843	$12.05
Jan-19	$14,196,807	$9.07
Feb-19	$14,262,537	$9.10
Mar-19	$14,274,799	$9.08
Apr-19	$13,413,875	$8.81
May-19	$13,662,281	$9.01
Jun-19	$13,533,859	$9.02
Total	**$172,108,065**	**$9.36**

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 2019:

- Dec-18 Includes $4.62M in Health Insurer Provider Fee (HIPF) payments to MCOs

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 conducts 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 receives 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 primary care providers with closed panels.

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.

In State Fiscal Year 2019, a total of 44,766 providers were contracted by one or more of the five managed care plans to provide services to the Louisiana Medicaid managed care population. In addition, 1,708 providers were contracted with MCNA to provide Medicaid covered dental services. Provider counts by plan, provider type, taxonomy and parish are provided in Appendix I. It should be noted, however, that the unduplicated totals 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.

Table 4.1 Total unduplicated[4] count of contracted providers by health plan, State Fiscal Year 2019[5]

	ABH	ACLA	HB	LHCC	UHC	Total
Total Contracted Providers	14,681	29,215	25,431	31,397	15,188	44,766

Source: MARS Data Warehouse, June 28, 2019 Provider Registry

Table 4.2 Total unduplicated[4] count of contracted providers in DBPM, State Fiscal Year 2019[5]

	MCNA Dental
Total Contracted Providers	1,708

Source: MARS Data Warehouse, June 28, 2019 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]Includes only providers with locations in Louisiana or within a border county.

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 2019. 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 2019 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[6] contracted primary care providers with at least one claim, State Fiscal Year 2019[7]

	ABH	ACLA	HB	LHCC	UHC	Total
Total Contracted PCPs	2,221	3,739	2,866	4,330	2,503	7,716
PCPs with at least one claim	1,539	2,682	2,448	2,561	1,954	4,701
Percent with at least one claim	69.3%	71.7%	85.4%	59.1%	78.1%	60.9%

Source: MARS Data Warehouse, June 28, 2019 Provider Registry

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

[6] 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

[7] Includes only providers with locations in Louisiana or within a border county.

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 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 28, 2019. 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[8] contracted primary care providers with a closed panel, State Fiscal Year 2019[9]

	ABH	ACLA	HB	LHCC	UHC	Total
Total Contracted PCPs	2,221	3,739	2,866	4,330	2,503	7,716
PCPs with a Closed Panel	389	1,091	700	166	354	2,192
Percent with a Closed Panel	17.5%	29.2%	24.4%	3.8%	14.1%	28.4%

Source: MARS Data Warehouse: June 28, 2019 Provider Registry

[8]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.
[9]Includes only providers with locations in Louisiana or within a border county.

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 health plans for the calendar year ending on December 31, 2018. In CY 2018 all health plans met the 85% minimum ratio and no rebates to the Department were required. The audited reports for 2018 are posted on the Medicaid website at http://ldh.la.gov/index.cfm/page/2142.

Table 7.1 Medical loss ratios (MLR), Calendar Year 2018

	ABH	ACLA	HB	LHCC	UHC
Adjusted YTD MLR Capitation Revenue	$583,073,658	$1,001,760,939	$1,239,964,082	$2,104,747,792	$2,040,200,454
Total Adjusted MLR Expense	$579,037,899	$962,046,021	$1,179,481,023	$1,925,497,627	$1,900,249,517
MLR Percentage Achieved	99.3%	96.0%	95.1%	91.5%	93.1%
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, Calendar Year 2018

	ABH	ACLA	HB	LHCC	UHC
Patient Care	$572,347,259	$947,725,423	$1,158,913,787	$1,903,586,963	$1,867,537,146
Quality Improvement	$6,690,640	$11,785,575	$16,512,553	$21,910,664	$27,371,479
Information Technology	$0	$2,338,866	$4,054,683	$0	$5,340,892
Other[10]	$0	$196,157	$0	$0	$0
Total Adjusted MLR Expense	$579,037,899	$962,046,021	$1,179,481,023	$1,925,497,627	$1,900,249,517

Source: MSLC Audited Medical Loss Ratio Reports

[10] External quality review related expenditures

8 External Quality Review

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

Additionally, the Department publishes a Medicaid Managed Care Quality Dashboard which provides a comparison of MCO HEDIS and non-HEDIS performance trends overtime and to relevant benchmarks. The dashboard is available online at https://qualitydashboard.ldh.la.gov/.

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. The full member survey reports for each health plan can be found in Appendix IV: Member Satisfaction Surveys.

Provider Satisfaction Survey

Unlike member satisfaction, there are currently 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. Because the individual survey methodologies vary meaningful comparison of results across health plans was limited.

To provide for comparability across health plans, the Department contracted with IPRO to develop and conduct a single standard annual survey of providers to replace the individual MCO surveys. The target population of the survey was comprised of providers currently in the network of at least one of the five MCOs serving Medicaid members in Louisiana. Primary Care Providers (PCPs), behavioral health providers, and physical health specialist physicians were surveyed. The first annual survey was conducted in the summer of 2018 collecting information in the following 11 domains:

- Descriptive information about the practice
- The provider enrollment process
- Education and Training
- Claims Processing
- Network Coordination/Case Management
- No-Show Appointments
- Customer Service/Provider Relations
- Utilization Management
- The Call Center
- Overall Satisfaction

A copy of the final report detailing the survey methodology and results can be found 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 2018, which were reported during State Fiscal Year 2019.

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 2019, 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 Dental 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 2019, MCNA covered 872,154 Medicaid enrollees under the age of 21. Of those, 421,526 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. Of members who saw a dentist 96% received oral prophylaxis services. Fillings were the second most common procedure for this age group, received by 30% of members under the age of 21 who had a dental service.

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 2019

CDT Code	Code Description	Total members received procedure	As a percent of members who saw a dentist
D1110, D1120	Oral prophylaxis (teeth cleaning)	404,319	95.9%
D1206	Fluoride varnish	82,288	19.5%
D1351	Dental sealants	44,543	10.6%
D21140-D2161	Amalgam fillings	35,909	8.5%
D2330–D2394	Composite fillings	90,286	21.4%
D2930–D2931, D2933-D2934	Stainless steel crowns	36,442	8.6%
D3220	Pulpotomies performed on primary teeth	16,378	3.9%
D3310–D3346	Root canals performed on permanent teeth	7,056	1.7%
D7111–D7250	Extractions of primary teeth	33,147	7.9%
D7111–D7250, D7280	Extractions of permanent teeth	15,642	3.7%

Source: MARS Data Warehouse

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 2019, MCNA covered 864,775 unduplicated adult members for denture services, of which 11,736 (1.4%) saw a dentist for at least one covered service.

MCO Adult Dental Value Added Services (VAS)
Beginning February 1, 2015, as a value added benefit to adult full-benefit enrollees, 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 2019, 23% of 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 2019

	ABH	ACLA	HB	LHCC	UHC	Total
Eligible Enrollees (Full-benefit Adults age 21+)[11]	79,963	104,613	142,073	192,809	211,558	**703,941**
Number who saw a dentist	11,774	15,505	24,870	70,565	40,214	**162,928**
The percent of eligible patients that saw a dentist	14.72%	14.82%	17.51%	36.60%	19.01%	**23.15%**

Source: MARS data warehouse

Teeth cleaning was the most common service received, followed by extraction of permanent teeth and fillings. Table 12.3 provides utilization rates by MCO for most the common procedures performed on those patients over the age of 21 who received a dental service provided as a value added service through their health plan.

Table 12.3 Utilization rates for MCO value added services dental benefits, State Fiscal Year 2019[12]

		ABH	ACLA	HB	LHCC[13]	UHC
Adult oral prophylaxis	Count	5,378	6,581	10,953	4,158	17,540
	Utilization	45.68%	42.44%	44.04%	5.89%	43.62%
Extractions of permanent teeth	Count	4,264	5,962	9,720	4,097	15,929
	Utilization	36.22%	38.45%	39.08%	5.81%	39.61%
Composite fillings	Count	2,509	2,963	5,162	2,302	9,360
	Utilization	21.31%	19.11%	20.76%	3.26%	23.28%
Amalgam fillings	Count	327	407	737	369	1,363
	Utilization	2.78%	2.62%	2.96%	0.52%	3.39%

Source: MARS Data Warehouse

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[11] Includes full benefit enrollees only, partial benefit enrollees were not covered for value-added dental services.
[12] The denominator for utilization rates by procedures is the unduplicated count of individuals who had at least 1 dental service.
[13] LHCC encounter data breakdown of services by procedure code for value-added dental services was not available prior to January 1, 2019.

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 1,853,660 unduplicated individuals enrolled in Louisiana Medicaid in State Fiscal Year 2019, 1,720,496 (93%) 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.

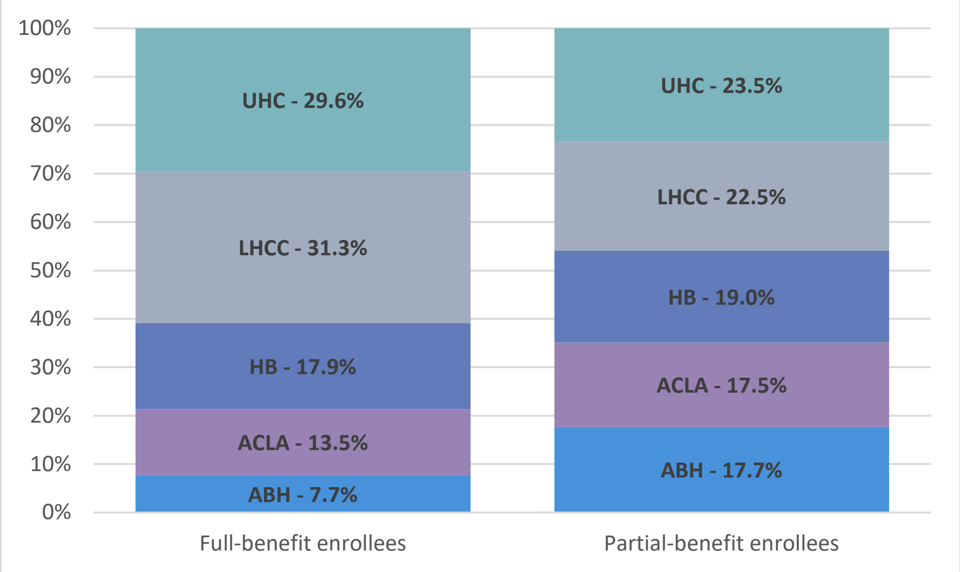
The distribution of total enrollees across health plans ranged from 9% in Aetna to 32% in Louisiana Healthcare Connections. Table 13.1 and Figure 13.1 below provide a breakdown of enrollment totals by health plan and benefits covered. This table represents unduplicated enrollment in each health plan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

Table 13.1 Total enrollees by health plan and benefit group, State Fiscal Year 2019

	ABH	ACLA	HB	LHCC	UHC	Total Unduplicated[14]
Full-benefit enrollees	127,195	222,539	293,439	513,633	485,712	1,580,372
Partial-benefit enrollees	27,337	27,013	29,347	34,780	36,298	152,723
Total (unduplicated)	153,036	247,668	320,536	545,191	518,594	1,720,496
Percent of total	8.9%	14.4%	18.6%	31.7%	30.1%	100%

Source: MARS Data Warehouse

Figure 13.1 Distribution of enrollees by benefit group and health plan, State Fiscal Year 2019



Source: MARS Data Warehouse

[14] 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 2019:

- *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 Office of Citizen's with 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 2019, 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 enrollees in each month delineated by eligibility category and health plan, State Fiscal Year 2019

	ABH	ACLA	HB	LHCC	UHC
SSI	7,629	19,640	20,238	34,279	29,079
Families & Children	39,049	102,879	129,082	274,767	243,201
Foster Care	321	752	3,508	6,455	1,875
BCC	38	100	88	93	105
LAP	185	347	440	959	1,028
HCBS Waiver	178	313	368	676	597
Chisholm	156	378	508	1,140	837
New Adult Group (Expansion)	51,949	65,128	91,906	128,987	141,858
All Categories	**99,504**	**189,538**	**246,136**	**447,355**	**418,580**

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 2019 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.

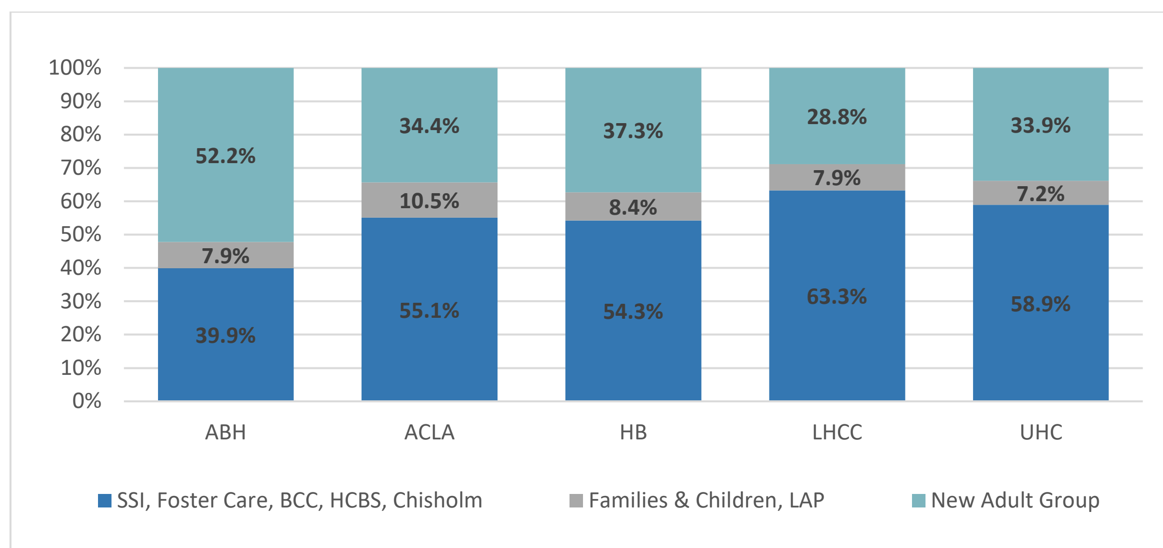
Table 13.3 Average number of partial-benefit only members enrolled each month delineated by eligibility category and health plan, State Fiscal Year 2019

	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[15]	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 Membership distribution by eligibility category, State Fiscal Year 2019



Source: MARS Data Warehouse

[15]Includes individuals residing in nursing facilities (NF) or under the age of 21 residing in intermediate care facilities for individuals with intellectual disabilities (ICF/IID) 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 2019. Proactive choice rates for all five health plans decreased from 2018 rates, with the overall rate decreasing from 71% in 2018 to 65% in 2019. There were no changes in the methodology for calculation of the choice rate. 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 2019

	ABH	ACLA	HB	LHCC	UHC	Total
Pro-active Choice Enrollments	13,783	15,758	32,515	41,049	47,645	**150,750**
Auto Enrollments	14,454	15,323	16,151	18,156	17,503	**81,587**
Total Enrollments	28,237	31,081	48,666	59,205	65,148	**232,337**
Choice rate	48.8%	50.7%	66.8%	69.3%	73.1%	**64.9%**

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 2019. During this reporting period, 1,463,129 members received one or more Medicaid service through their health plan for an overall rate of 85% of members across all plans. Rates for individual plans demonstrate variation across plans with a range of 75% (Aetna) to 90% (UnitedHealthcare).

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 2019

	ABH	ACLA	HB	LHCC	UHC	Total Unduplicated[16]
Unduplicated Count of Enrollees	153,036	247,668	320,536	545,191	518,594	**1,720,496**
Number Receiving One or More Services	115,414	206,383	260,934	475,146	467,805	**1,463,129**
Percent Receiving One or More Services	75.4%	83.3%	81.4%	87.2%	90.2%	**85.0%**

Source: MARS Data Warehouse

[16] 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 2019. 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 2019

	ABH	ACLA	HB	LHCC	UHC
Unduplicated full-benefit enrollees	127,195	222,539	293,439	513,633	485,712
Enrollees with at least one PCP visit	23,804	66,778	94,514	141,892	144,954
Percentage	18.7%	30.0%	32.2%	27.6%	29.8%

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 62% of all managed care enrollees did have at least one primary care visit with any PCP versus 30% receiving at least one visit with their specific PCP.

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 2019

	ABH	ACLA	HB	LHCC	UHC
Unduplicated full-benefit enrollees	127,195	222,539	293,439	513,633	485,712
Enrollees with at least one PCP visit	48,444	138,601	171,593	346,504	275,129
Percentage	38.1%	62.3%	58.5%	67.5%	56.6%

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

17 HOSPITAL SERVICES PROVIDED

The following information concerning hospital services provided to Medicaid enrollees:

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

The data in Section 17 show the number of members who received inpatient and outpatient emergency hospital services. Additionally, it shows the number of members who received emergency services within a year after having seen a primary care provider.[17]

Table 17.1 lists the number of members receiving unduplicated outpatient emergency services for State Fiscal Year 2019. 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 393 per 1,000 members, and Aetna had the lowest rate of 370 per 1,000 members, though no plan was a significant outlier. In aggregate, the rate across all health plans was 397 per 1,000 total health plan members.

Table 17.1 Enrollees who received unduplicated outpatient emergency services, State Fiscal Year 2019

	ABH	ACLA	HB	LHCC	UHC	Total Unduplicated[18]
Enrollees receiving unduplicated outpatient emergency services	47,083	86,698	115,211	198,153	185,840	**27,082**
Total Unduplicated full-benefit enrollees	127,195	222,539	293,439	513,633	485,712	**1,580,372**
Rate per 1,000 unduplicated full-benefit enrollee	370	390	393	386	383	**397**

Source: MARS Data Warehouse

[17] 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.

[18] 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 lists the total inpatient Medicaid days for State Fiscal Year 2019. 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 State Fiscal Year 2019 was 442 per 1,000 enrollees.

Table 17.2 Total inpatient Medicaid days, State Fiscal Year 2019

	ABH	ACLA	HB	LHCC	UHC	Total
Total Inpatient Medicaid Days	69,040	110,534	136,265	202,024	180,600	**698,463**
Rate per 1,000 full-benefit enrollees	448	497	464	393	372	**442**

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 enrollee counts and rates per total enrollees receiving outpatient emergency services are presented for comparability across health plans.

Table 17.3 Unduplicated enrollees who saw a PCP before or after a visit to the emergency room, State Fiscal Year 2019[19]

	ABH	ACLA	HB	LHCC	UHC	Total Unduplicated[20]
12 months before outpatient emergency service	23,583	65,127	79,901	149,843	123,334	**437,824**
Percentage of total emergency service visits[21]	50.1%	75.1%	69.4%	75.6%	66.4%	**69.8%**
6 months after outpatient emergency service	19,950	57,179	70,217	130,655	102,494	**377,362**
Percentage of total emergency service visits	42.4%	66.0%	60.9%	65.9%	55.2%	**60.2%**

Source: MARS Data Warehouse

[19] 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.

[20] 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.

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

18 Members 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.

Across all five health plans there were a total of 4,267 appeal and state fair hearing determinations made in state fiscal year 2019, 30% of which resulted in a full or partial reversal in favor of the member. There were an additional 129 determinations made under the dental program administered by MCNA with an overall 24% reversal rate.

Table 18.1 Appeals and state fair hearings, State Fiscal Year 2019

	ABH	ACLA	HB	LHCC	UHC	MCNA
Total Members(unduplicated)	153,036	247,668	320,536	545,191	518,594	1,736,929
Members who filed an appeal	206	514	812	1,354	869	112
Members who accessed SFH	1	8	23	24	14	9
Total appeals filed at MCO level	211	555	829	1,845	995	117
Total appeals filed at SFH level	1	8	23	24	14	9
Total appeal & SFH determinations[22]	212	474	706	1,843	1,032	129
Total determinations fully or partially reversed in favor of the member	61	199	130	505	393	31
% of determinations fully or partially reversed in favor of the member	28.8%	42.0%	18.4%	27.4%	38.1%	24.0%

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

[22]Total determinations include determinations made in SFY 2019 for appeals received in a prior year.

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.[23] 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.

[23] 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. In State Fiscal Year 2019, the aggregate count of unduplicated claims submitted across all health plans totaled 94,751,234 with an additional 3,417,627 submitted to MCNA for dental services. The breakdown of unduplicated claim counts for State Fiscal Year 2019 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 or MCNA, 3.1% 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 submitted, State Fiscal Year 2019

	Rejected Claims	Emergency Services	Non-Emergency Services	Total
ABH	12,576	381,564	7,990,549	**8,384,689**
ACLA	57,681	392,974	11,910,404	**12,361,059**
HB	10,562	367,206	16,794,813	**17,172,581**
LHCC	941,521	850,282	25,728,624	**27,520,427**
UHC	131,614	992,739	28,188,125	**29,312,478**
MCNA Dental	0	1,360	3,416,267	**3,417,627**
Total	**1,153,954**	**2,986,125**	**94,028,782**	**98,168,861**

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 2019

	Emergency Services	Non-Emergency Services	Total
ABH	21,267	1,984,957	**2,006,224**
ACLA	20,290	2,478,687	**2,498,977**
HB	29,848	3,997,607	**4,027,455**
LHCC	33,732	4,606,322	**4,640,054**
UHC	51,627	4,064,121	**4,115,748**
MCNA Dental	318	284,427	**284,745**
Total	**157,082**	**17,416,121**	**17,573,203**

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. Since each claim line can have more than one CARC or NCPDP reject code, the number of CARC and NCPDP codes presented in table 20.2 are greater than the unduplicated number of total denied claims presented in table 20.1. 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 2019

CARC	CARC Description	Emergency Claims[24]	Non-Emergency Claims	Total
18	Exact duplicate claim/service	37,106	1,473,275	**1,510,381**
197	Precertification/authorization/notification/pre-treatment absent.	349	1,454,412	**1,454,761**
96	Non-covered charge(s)	10,468	1,147,756	**1,158,224**
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	9,745	1,011,373	**1,021,118**
16	Claim/service lacks information or has submission/billing error(s).	10,002	965,288	**975,290**
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	148	565,866	**566,014**
252	An attachment/other documentation is required to adjudicate this claim/service.	22,364	462,079	**484,443**
133	The disposition of this service line is pending further review.	8,648	312,628	**321,276**
27	Expenses incurred after coverage terminated.	15,805	284,464	**300,269**
204	This service/equipment/drug is not covered under the patient's current benefit plan	6,210	277,862	**284,072**

Source: 173 Denied Claims Report

[24] 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 2019

NCPDP Code	NCPDP Description	Emergency Claims[25]	Non-Emergency Claims	Total
79	Refill Too Soon	123	1,600,360	**1,600,483**
76	Plan Limitations Exceeded	388	1,238,100	**1,238,488**
70	Product/Service Not Covered-Plan/Benefit Exclusion	1,030	1,189,751	**1,190,781**
88	DUR {drug utilization review} Reject Error	484	992,039	**992,523**
75	Prior Authorization Required	239	657,974	**658,213**
41	Submit Bill To Other Processor Or Primary Payer	410	302,106	**302,516**
69	Filled After Coverage Terminated	646	257,140	**257,786**
MR	Product Not On Formulary	-	223,715	**223,715**
39	M/I {missing/invalid}Diagnosis Code	1	197,927	**197,928**
65	Patient Is Not Covered	506	181,195	**181,701**

Source: 173 Denied Claims Report

[25] 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, State Fiscal Year 2019

ABH	ACLA	HB	LHCC	UHC	MCNA
5,738,845	9,820,403	11,985,793	21,441,627	19,654,141	2,691,103

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 2019

Provider Type	ABH	ACLA	HB	LHCC	UHC	MCNA
Inpatient Hospital	90.01%	99.97%	99.30%	97.85%	91.07%	
Outpatient Hospital	98.58%	99.98%	99.55%	99.19%	98.45%	
Professional	99.52%	99.92%	99.54%	99.42%	98.91%	
Rehab	99.85%	99.81%	99.64%	98.33%	99.55%	
Home Health	98.69%	100.00%	99.72%	95.05%	100.00%	
EMT(Transportation)	99.10%	100.00%	99.92%	98.19%	94.71%	
NEMT & NEAT Transportation	99.19%	99.93%	99.47%	99.25%	94.20%	
DME	97.12%	99.89%	99.79%	98.56%	97.66%	
Pharmacy	99.27%	100.00%	99.98%	100.00%	100.00%	
EPSDT Dental	.	.	.	.	.	100.00%
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 2019

Provider Type	ABH	ACLA	HB	LHCC	UHC	MCNA
Inpatient Hospital	96.27%	100.00%	100.00%	100.00%	98.53%	
Outpatient Hospital	99.68%	99.99%	100.00%	100.00%	99.81%	
Professional	99.88%	99.98%	100.00%	100.00%	99.79%	
Rehab	100.00%	99.81%	100.00%	100.00%	99.79%	
Home Health	99.53%	100.00%	100.00%	100.00%	100.00%	
EMT (Transportation)	99.75%	100.00%	100.00%	100.00%	99.30%	
NEMT & NEAT (Transportation)	99.51%	100.00%	100.00%	100.00%	99.47%	
DME	98.25%	99.90%	100.00%	100.00%	99.54%	
Pharmacy	100.00%	100.00%	100.00%	100.00%	100.00%	
EPSDT Dental	.	.	.	.	.	100.00%
Adult Denture	.	.	.	.	.	100.00%

Source: 221 Prompt Pay Report

It should be noted that adjudicated date and paid date may not be the same. It often occurs that a claim is adjudicated, i.e. the decision is made to pay or deny, but payment may not be issued until the next weekly check cycle. This information is reflective of the actual date of payment as requested by the statutory reporting requirement. All health plans paid the vast majority of provider types in within two weeks or less.

Table 21.4 Average number of days to pay clean claims, State Fiscal Year 2019

Provider Type	ABH	ACLA	HB	LHCC	UHC	MCNA
Inpatient Hospital	11.00	8.10	8.00	9.20	11.87	.
Outpatient Hospital	7.00	3.60	5.00	8.05	8.36	.
Professional	12.10	4.20	8.30	7.83	8.27	.
Rehab	6.00	4.90	6.00	8.39	7.89	.
Home Health	8.00	4.50	6.00	9.86	8.33	.
EMT (Transportation)	6.00	3.90	9.00	8.31	9.55	.
NEMT & NEAT (Transportation)	11.20	9.11	11.10	11.09	11.35	.
DME	8.00	4.40	6.00	8.39	8.88	.
Pharmacy	11.10	3.44	12.00	11.01	10.80	.
EPSDT Dental	.	.	.	.	.	6.83
Adult Denture	.	.	.	.	.	6.80

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 2019 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 2019

TIMEFRAME (COMPLIANCE STANDARD)		ABH	ACLA	HB	LHCC	UHC
Processed within 2 business days[26] from receipt of needed documentation (80%)	**Number**	65,125	66,189	148,495	236,487	154,601
	Percent	94.1%	87.2%	86.1%	95.9%	98.6%
Non-extended: Processed within 14 days of receipt of request for authorization (100%)	**Number**	69,109	77,122	177,531	162,540	157,206
	Percent	99.9%	100.0%	99.6%	99.8%	99.8%
Extended: Processed within 28 days[27] of receipt of request for authorization (100%)	**Number**	0	553	88	86,093	0
	Percent	--	100.0%	100.0%	99.7%	--

Source: 188 & 188BH Service Authorization - Quarterly Reports

[26] In five (5) calendar days for PSR, CPST, ACT, MST, FFT & Homebuilder services, per section 8.5.1.1 of the contract.

[27] 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 2019

TIME FRAME (COMPLIANCE STANDARD)		ABH	ACLA	HB	LHCC	UHC
Non-extended: Processed within 72 hours of receipt of request for authorization (100%)	Number	864	1,599	21	623	1,909
	Percent	99.2%	100.0%	100.0%	99.5%	99.4%
Extended: Processed within 14 days of receipt of request for authorization (100%)	Number	1	8	0	261	0
	Percent	100.0%	100.0%	--	100.0%	--

Source: 188 & 188BH Service Authorization - Quarterly Reports

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 2019

	ABH	ACLA	HB	LHCC	UHC
Total service authorizations processed	93,168	79,282	240,122	387,448	242,286
Number denied	2,841	13,757	15,466	7,896	7,205
Percent denied	3.0%	17.4%	6.4%	2.0%	3.0%

Source: 188 & 188BH Service Authorization - Quarterly Reports

23 CLAIMS PAID TO OUT-OF-NETWORK PROVIDERS

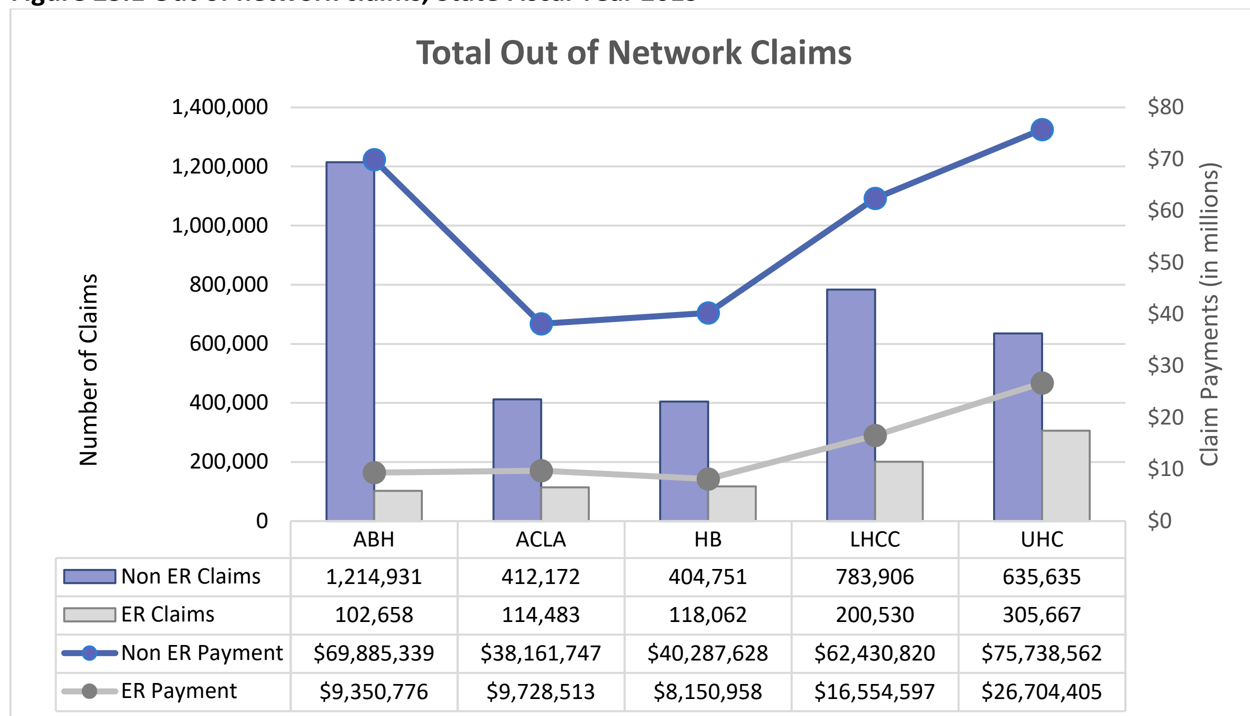
The total number and dollar value of all claims paid to out-of-network providers by claim type categorized by emergency services and nonemergency services for each managed care organization by parish.

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 2019



	ABH	ACLA	HB	LHCC	UHC
Non ER Claims	1,214,931	412,172	404,751	783,906	635,635
ER Claims	102,658	114,483	118,062	200,530	305,667
Non ER Payment	$69,885,339	$38,161,747	$40,287,628	$62,430,820	$75,738,562
ER Payment	$9,350,776	$9,728,513	$8,150,958	$16,554,597	$26,704,405

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
- 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 2019, all five health plans managed pharmacy benefits for members enrolled with full-benefits coverage. Partial-benefit only enrollees continued to receive pharmacy benefits under fee-for-service Medicaid. Per the contract with the Department, managed care organizations can self-administer pharmacy benefits or subcontract with a pharmacy benefit manager (PBM). The PBMs for each health plan are listed in table 25.1 of the next section Pharmacy Benefit Managers and Rebates.

Table 24.1 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. Through April 30, 2019, 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. Starting May 1, 2019, the Department implemented a single, statewide preferred drug list (PDL). The impact of the single PDL will be primarily reflected in the upcoming State Fiscal Year 2020 report. The monthly details for claims by reporting category are provided in Appendix X.

Table 24.1 Pharmacy claims comparison, State Fiscal Year 2019

		ABH	ACLA	HB	LHCC	UHC
Total prescription claims	#	2,219,711	3,568,974	5,029,738	7,533,572	7,375,715
Subject to prior authorization	#	136,831	92,157	391,432	217,842	174,693
	%	6.16%	2.58%	7.78%	2.89%	2.37%
Denied	#	479,955	839,288	1,493,373	1,715,780	1,490,571
	%	21.62%	23.52%	29.69%	22.78%	20.21%
Subject to step therapy or fail first protocol	#	94,859	28,698	94,859	80,006	88,936
	%	4.27%	0.80%	1.89%	1.06%	1.21%

Source: Report RX055 - Pharmacy

In 2018 Act 482 of the regular legislative session legislature amended La RS 40:1253.2 to require the reporting of additional data on prior authorizations for pharmacy services and related denied claims, including determination response times, authorization denials and claims with an approved prior authorization denied at claim adjudication. These items are presented in tables 24.2 through 24.4.

Per federal regulations and MCO contract requirements, MCO determination of prior authorization requests for non-emergency pharmacy services must be made within 24 hours of receipt of all necessary documentation. Table 24.2 provides the average and range of response times by health plan. The data presented includes all determinations, approved, denied, reduced, voided or withdrawn.

Table 24.2 Response times for pharmacy prior authorization requests, State Fiscal Year 2019[28]

	ABH	ACLA	HB	LHCC	UHC
Average response time (hours)	12.1	9.8	4.6	5.3	5.3
Response time range (hours)[29]	0.0 – 96.5	0.0 - 27.2	0.0 - 303.6	0.0 - 162.1	0.0 - 191.4

Source: Report RX055 - Pharmacy

For reporting purposes, health plans are required to categorize authorization denials into 1 of 5 standard categories specified by the Department. Table 24.3 provides total counts of denied authorizations by these specified categories.

Table 24.3 Pharmacy prior authorization requests denied, State Fiscal Year 2019

	ABH	ACLA	HB	LHCC	UHC
Not Medically Appropriate	5,275	5,399	11,339	17,928	29,236
Not a Covered Benefit	647	459	172	608	669
Administrative - Lack of Information	0	4,787	30	0	429
Reduced Authorized	182	0	249	0	2,044
Other	818	0	11	388	16
Total Denials	**6,922**	**10,645**	**11,801**	**18,924**	**32,394**

Source: Report RX055 - Pharmacy

For prescriptions that require a prior authorization, the PBM makes the determination to approve, reduce or deny the service based on the clinical information provided by the prescriber at the time of the request for authorization. However, it is possible and appropriate for claims for approved services to deny at time of payment; for example, if the plan limitations have been exceeded or the refill is too soon. Table 24.4 presents the count of claims with an approved authorization that denied at point of sale by the health plan. The complete listing of denied claims with an approved authorization by denial reason is presented in in Appendix XI.

Table 24.4 Pharmacy claims denied after prior authorization was approved, State Fiscal Year 2019

	ABH	ACLA	HB	LHCC	UHC
The number of claims denied after prior authorization was approved	25,699	31,599	39,541	63,741	4,226

Source: Report 173 Denied Claims - Pharmacy

[28]Includes all determinations: approved, denied, reduced, voided or withdrawn.
[29]Minimum response time of zero hours indicates a response time of less than 3 minutes.

25 PHARMACY BENEFIT MANAGERS AND DRUG REBATES

The Louisiana Department of Health shall submit quarterly reports (and annual summary) to the senate and house committees on health and welfare encompassing the following data regarding the Medicaid managed Care organizations' pharmacy benefit managers:

- The name of each pharmacy benefit manager, identified as contracted or owned by the Medicaid managed care organization.
- Whether the pharmacy benefit manager is a subsidiary of the parent company of the Medicaid managed care organization.
- The total dollar amount paid to the pharmacy benefit manager by the Medicaid managed care organization as a transaction fee for each processed claim.
- The total dollar amount of the Medicaid drug rebates and manufacturer discounts collected and retained by the Medicaid managed care organization and pharmacy benefit manager.
- The total dollar amount of the Medicaid drug rebates and manufacturer discounts collected by the Medicaid managed care organization and pharmacy benefit manager and remitted to the Louisiana Department of Health.
- The total dollar amount retained by the pharmacy benefit manage through spread pricing. For purposes of this Subparagraph, "spread pricing" means the actual amount paid as reimbursement to a pharmacist as compared to the amount the pharmacy benefit manager charged to and was reimbursed by the Medicaid managed care organization to identify the excess amount paid to the pharmacy benefit manager above what was paid to the pharmacist.
- Identification of any other monies retained by the pharmacy benefit manager not otherwise provided for in this Subsection that are not reimbursed to pharmacists.

As required by Act 482 of the 2018 regular legislative session, this section has been expanded to include additional data on each MCO's pharmacy benefits program as listed above. The legislation amended Louisiana Revised Statute 40:1253.2 to require quarterly reporting on the pharmacy benefit managers and rebates collected under managed care. The act further required an annual summary of quarterly reports be included in the annual transparency report. The summary data for state fiscal year 2019 are presented here in tables 25.1 through 25.5. The monthly data from each quarterly report is presented in Appendix XII.

Managed care organizations can self-administer their pharmacy benefits or subcontract with a pharmacy benefits manager (PBM). In state fiscal year 2019, each of the five health plans utilized a PBM to manage their pharmacy benefit. Table 25.1 identifies the PBM for each managed care organization and indicates the contractual/ownership relationship between the MCO and the PBM.

Table 25.1 Pharmacy benefit managers (PBM), State Fiscal Year 2019

MCO	PBM	MCO/PBM Relationship
ABH	CaremarkPCS Health	CVS Health Corporation is the ultimate owner of both Aetna (MCO) and Caremark (PBM). Aetna has an intercompany agreement with Caremark for PBM services.
ACLA	PerformRx	Both AmeriHealth Caritas Louisiana, Inc. and PerformRx are wholly-owned by AmeriHealth Caritas Health Plan. ACLA subcontracts with PerformRx for PBM services.
HB	Express Scripts (through 4/30/2019) IngenioRx (as of 5/1/2019)	Express Scripts was contracted to provide PBM services through 4/30/19. As of 5/1/2019 HB began using IngenioRx as their PBM. Healthy Blue is a joint venture between Blue Cross Blue Shield Louisiana and Amerigroup Partnership Plan, LLC. Anthem, Inc. is the ultimate parent company of Amerigroup and IngenioRx. IngenioRx provides PBM service to Healthy Blue under a master intercompany services agreement.
LHCC	Envolve Pharmacy Solutions	Centene Corporation is the parent company of Louisiana Healthcare Connections (LHCC) and Envolve Pharmacy Solutions (EPS). LHCC has a PBM contract with EPS..
UHC	OptumRx	UnitedHealth Group is the parent company of both OptumRx and UnitedHealthcare of Louisiana. UnitedHealthcare of Louisiana, has a contractual relationship with OptumRx for PBM Services.

Source: MCO self-reported

The data in this section was also impacted by Act 483 of the 2018 regular legislative session amending Louisiana Revised Statute 39:1648 to provide specific limitations on the payment for PBM services and collection of rebates. These limitations include:

1. limitation of payment for PBM contracts to a transaction fee per pharmacy claim processed to be set by the Department,
2. eliminated the use of spread pricing, and
3. prohibited MCO/PBM retainage of state supplemental rebates or credits.

These limitations were implemented by the Department through contract amendment with each of the MCOs with a compliance date of May 1, 2019; hence impacting the last two months of data for state fiscal year 2019. Prior to the implementation of the new contract requirements, the five MCOs used various combinations of payment methodologies for PBM services including but not limited to a per claim transaction fee. Table 25.2 provides a summary of transaction fees paid in State Fiscal Year 2019 by MCO.

Prior to May 1, 2019 transaction fees varied across MCOs. Post May 1, transaction fees were limited to the Department established maximum rate of $1.25 per processed claim. At that time ACLA switched from a per member per month reimbursement methodology to a transaction fee basis as such, annual transaction fees paid by ACLA for PBM services in SFY 2019 reflect only two months of payments to the PBM. Data for the other four plans reflect 12 months of transaction fees. Monthly transaction fees data is provided in Appendix XII.

Table 25.2 Transaction fees paid by MCO to PBM, State Fiscal Year 2019

ABH	ACLA	HB	LHCC	UHC	Total
$1,088,392	$958,333	$3,937,974	$12,648,326	$13,444,971	$32,077,996

Source: 054 Pharmacy Benefit Management & Rebate monthly report

May 1, 2019, was also the effective date of the single statewide preferred drug list (PDL) established by the Department. The implementation of a single PDL allows the state to directly collect all eligible state supplemental rebates and all but eliminates rebates that can be collected by the MCO/PBM for services after April 30, 2019. Since there is a 3 to 12-month delay between the date of service and the actual receipt of rebate payments, there will be a significant runout period where rebates received by the MCO/PBM will decline as prospectively these rebates will be directly collected by the Department. Items not included on the single PDL that may be eligible for collection of rebates by the PBM, such as diabetic testing supplies, will continue to be reported to the Department and included in the quarterly and annual transparency reports.

Table 25.3 details the total rebates received and retained by the PBM or MCO in State Fiscal Year 2019. Monthly rebate collections are available in Appendix XII. No rebates collected by the PBMs in State Fiscal Year 2019 were remitted to the Department.

Table 25.3 Rebates and discounts retained by the MCO or PBM, State Fiscal Year 2019

ABH	ACLA	HB	LHCC	UHC	Total
$3,210,547	$5,947,545	$8,398,795	$14,240,543	$21,468,258	$53,265,688

Source: 054 Pharmacy Benefit Management & Rebate monthly report

Spread pricing refers to the difference in the amount charged by the PBM and the amount paid to the pharmacist that is then retained by PBM for management of pharmacy benefits. Act 483 prohibited the continued use of spread pricing, which was implemented by the Department for services after April 30, 2019. Table 25.4 reflects total amounts retained by the PBM through spread pricing in State Fiscal Year 2019. Monthly data is available in Appendix XII.

Table 25.4 Amount retained by the PBM through spread pricing, State Fiscal Year 2019

ABH	ACLA	HB	LHCC	UHC	Total
$0	$0	$33,661,280	$0	$34,573,319	$68,234,599

Source: 054 Pharmacy Benefit Management & Rebate monthly report

All other monies paid to PBM and not reimbursed to pharmacies are captured in Table 25.6. Prior to the implementation of Act 483 limiting payments for pharmacy benefit management to a transaction fee basis, some MCOs used other payment methodologies that included administrative fees. Most notably, ACLA paid for contracted PBM services on a per member per month (PMPM) fee. For services beginning in May 1, 2019, they discontinued the PMPM fees and transitioned to the required per claim transaction fee. Other monies reported by Healthy Blue and UnitedHealthcare prior to May 1, 2019, included fees for administration items as footnoted below.

Table 25.6 Other monies retained by the PBM that are not reimbursed to pharmacists, SFY 2019

ABH	ACLA[30]	HB[31]	LHCC	UHC[32]	Total
$0	$4,442,216	$16,235	$0	$48,644	$4,507,096

Source: 054 Pharmacy Benefit Management & Rebate monthly report

[30] PBM services paid on an administrative PMPM fee basis.

[31] Amounts include fees for vaccine administration, Medicaid transition and coordination of benefits billed quarterly.

[32] Payment for PreCheckMyScript program, which links OptumRx claims adjudication program with prescribers' Electronic Health Record systems.

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.
- 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 2019, MCNA completed prior authorizations on a total of 210,800 requests. As shown in table 26.1, 79% of services requested were classified as adjunctive/other unclassified procedure codes. Of those procedures classified, the two most common types of procedures prior authorized were oral/maxillofacial surgery and restorative procedures, accounting 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 2019

Type of Procedure	Children EPSDT (under 21 years)	Adult Denture (21 years & older)	Total Number of Prior Authorization Requests
0100-0999 Diagnostic	319	3,729	4,048
1000-1999 Preventive	2,385	5	2,390
2000-2999 Restorative	12,662	47	12,709
3000-3999 Endodontics	4,820	20	4,840
4000-4999 Periodontics	488	7	495
5000-5899 Removable Prosthodontics	183	7,010	7,193
5900-5999 Maxillofacial Prosthodontics	1		1
6000-6199 Implant	5	1	6
6200-6999 Fixed	15		15
7000-7999 Oral/Maxillofacial surgery	13,117	87	13,204
8000-8999 Orthodontics	212	3	215
9000-9999 Adjunctive	134,654	31,030	165,684
Total	**168,861**	**41,939**	**210,800**

Source: MCNA Quarterly 188 Prior Authorization Reports

The Dental Benefit Program Manager contract specifies 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. 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 2019

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 - 5	1.8	0 - 5
1000-1999 Preventive	1.6	0 - 5	2.4	1 - 5
2000-2999 Restorative	1.5	0 - 5	1.0	0 - 4
3000-3999 Endodontics	1.2	0 - 5	0.6	0 - 2
4000-4999 Periodontics	2.1	0 - 5	2.1	1 - 5
5000-5899 Removable	2.0	0 - 5	1.8	0 - 5
5900-5999 Maxillofacial	4.0	4 - 4	-	-
6000-6199 Implant	2.4	2 - 4	4.0	4 - 4
6200-6999 Fixed	1.8	0 - 5	-	-
7000-7999 Oral	1.6	0 - 5	1.5	0 - 5
8000-8999 Orthodontics	2.1	0 - 5	1.3	1 - 2
9000-9999 Adjunctive	1.2	0 - 6	1.8	0 - 5
Overall Average	**1.3**	**0 - 6**	**1.8**	**0 - 5**

Source: MCNA Quarterly 188 Prior Authorization Reports

Of the 210,800 prior authorizations MCNA completed during State Fiscal Year 2019, 45,859 (22%) were denied. There can be multiple denial reasons associated with each authorization request. As a result, the number of denied authorizations by denial reason code (70,378) 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 85% of all denial reason codes applied. The most common denial reason listed was code 56, indicating that clinical review of the x-rays received did not demonstrate the need for treatment submitted. A complete count of authorization denials delineated by denial reason are included in Appendix XIII.

Table 26.3 Ten most prevalent reasons for authorization denial by DBPM, State Fiscal Year 2019

Authorization Denial Code	Code Description	EPDST	ADULT	Total
56	The dental director has advised that the x-rays received do not demonstrate the need for treatment submitted.	11,910	3	11,913
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.	7,327	2,855	10,182
96	This procedure is considered non-covered in accordance with either the program benefits or the facility contract with MCNA.	6,047	2,050	8,097
18	This request has been previously reported and an approval or denial was issued.	5,800	1,357	7,157
252	Please submit x-ray(s) and narrative with this request.	4,500	655	5,155
169	The clinical reviewer has recommended an alternate procedure/benefit.	4,591	69	4,660
16	Please submit a readable and most current bitewing and a periapical x-ray with endodontic requests.	3,318	205	3,523
50	The clinical reviewer has determined that the treatment is in excess of the member's needs.	3,395	20	3,415
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.	2,769	52	2,821
269	This procedure can only be considered when reported and performed in conjunction with covered services.	2,734	3	2,737
56	**TOTAL TOP TEN AUTHORIZATION DENIAL REASON CODES**	**52,391**	**7,269**	**59,660**

Source: MCNA Quarterly 188 Prior Authorization Reports

In State Fiscal Year 2019, MCNA denied a total of 284,745 claims. Of these 17,684 (6.2%) were claims that had been previously prior authorized. Table 26.4 includes the ten most frequently used Claims Adjustment Reason Codes (CARCS) used for claims denied when the prior authorization had been previously approved. These ten denial reasons accounted for 84% of all reasons for claim denial after prior authorization was approved. All denials delineated by reason for denial are included in Appendix XIII. 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 2019

CARC	Code Description	Total
18	Exact duplicate claim/service	5,518
252	An attachment/other documentation is required to adjudicate this claim/service.	3,128
16	Claim/service lacks information or has submission/billing error(s).	1,127
22	This care may be covered by another payer per coordination of benefits.	1,048
272	Coverage/program guidelines were not met.	955
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.	874
96	Non-covered charge(s)	744
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	717
181	Procedure code was invalid on the date of service.	452
169	Alternate benefit has been provided.	402
Total	**TOTAL TOP TEN CLAIM DENIAL REASON CODES**	**14,965**

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 payment, 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. 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.

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, the Department determines if the disputed claims are eligible for independent review based on the statutory requirements. If the claims are eligible, the Department 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.

In state fiscal year 2019, LDH received 95 requests for independent review of which 12 were deemed ineligible based on statutory requirement. Overall, 78% of the 83 eligible cases resulted in full or partial payment to the provider as a result of a completed independent review or MCO settlement prior to the review decision. Table 27.1 provides a breakdown of total independent review requests received by claim type and status. Table 27.2 provides additional breakdown of independent review request by MCO.

Table 27.1 Requests for independent review submitted to LDH, State Fiscal Year 2019

	Behavioral Health	Hospital	Skilled Nursing Facility	Total
Total requests received by LDH in SFY 2019	**20**	**74**	**1**	**95**
Ineligible for independent review	4	7	1	12
Eligible for independent review	16	67	0	83
Settled by MCO & provider before IR decision	2	8	0	10
Fully overturned by IR	10	41	0	51
Partially overturned by IR	1	3	0	4
Upheld by IR	3	15	0	18
% of eligible cases settled, fully or partially overturned	81.3%	77.6%	-	78.3%

Source: LDH Independent Review Tracking System

Table 27.2 Independent review determinations by claim type and MCO, State Fiscal Year 2019

	ABH	ACLA	HB	LHCC	UHC
Total requests received – All claim types[33]	**7**	**12**	**15**	**26**	**35**
Ineligible for independent review	2	1	3	1	5
Eligible for independent review	5	11	12	25	30
Settled by MCO & provider before IR decision	1	3	3	1	2
Fully overturned by IR	4	7	4	20	16
Partially overturned by IR	0	0	1	2	1
Upheld by IR	0	1	4	2	11
% of eligible cases settled, fully or partially overturned	100.0%	90.9%	66.7%	92.0%	63.3%
Total requests received – Behavioral Health	**0**	**5**	**3**	**9**	**3**
Ineligible for independent review	0	1	1	1	1
Eligible for independent review	0	4	2	8	2
Settled by MCO & provider before IR decision	0	1	0	1	0
Fully overturned by IR	0	3	1	4	2
Partially overturned by IR	0	0	0	1	0
Upheld by IR	0	0	1	2	0
% of eligible cases settled, fully or partially overturned	-	100.0%	50.0%	75.0%	100.0%
Total requests received – Hospital	**6**	**7**	**12**	**17**	**32**
Ineligible for independent review	1	0	2	0	4
Eligible for independent review	5	7	10	17	28
Settled by MCO & provider before IR decision	1	2	3	0	2
Fully overturned by IR	4	4	3	16	14
Partially overturned by IR	0	0	1	1	1
Upheld by IR	0	1	3	0	11
% of eligible cases settled, fully or partially overturned	100.0%	85.7%	70.0%	100.0%	60.7%

Source: LDH Independent Review Tracking System

[33] ABH totals for all claim types includes 1 request for review of a skilled nursing facility (SNF) adverse determination that did not meet eligibility requirements for independent review. Further breakdown by MCO and status is not provided for SNF as no cases were eligible for review.

Adult Expansion Population

Per Executive Order JBE 16-01 on July 1, 2016, Louisiana expanded Medicaid coverage under the Affordable Care Act to adults aged 19 through 64 under 138% of the Federal Poverty Level that do not meet other Medicaid categorical cases or are not eligible for or enrolled in Medicare. ACT 482 of the 2018 Regular Legislative Session requires the Department to submit a quarterly report containing requested Medicaid Managed Care program data on the adult expansion population and payments to the health plans. The quarterly reports submitted provide monthly data for the reporting period, as well as unduplicated year-to-date (YTD) totals for the 2019 state fiscal year. In addition to quarterly reporting the legislation requires annual and monthly data to be included in the transparency report.

Included in this section of the transparency report is the requested annual data as per ACT 482 on the adult expansion population. As part of the Medicaid Managed Care Transparency Report, this section includes only those expansion population counts and expenditures for individuals enrolled in a health plan for either full or partial benefits. The monthly and annual year-to-date totals presented in this section the annual Transparency Report are compiled using the same static eligibility and claims datasets pulled in October 2019 for compilation of the Medicaid Annual Report. Due to the dynamic nature of Medicaid enrollment and claims lag the updated data presented in this section may not match monthly or year to date totals presented in previously published quarterly transparency reports. Monthly totals for all data sets are provided in the appendix XIV.

28 EXPANSION ENROLLMENT BY AGE COHORT AND HEALTH PLAN

Medicaid expansion population data which shall include the following:

- Number of individuals enrolled in Medicaid for the reporting period who are eligible as part of the expansion population.
- Number of individuals in the expansion population age nineteen to forty-nine and number of individuals age fifty to sixty-four.
- Number of individuals in the expansion population in each age category assigned to a Medicaid managed care organization, identified by each individual managed care organization.

In State Fiscal Year 2019, the unduplicated count of expansion enrollees enrolled in a health plan was 605,269. Table 28.1 provides a breakdown of enrollees by age and health plan for fiscal year 2019 Fiscal year totals are unduplicated and therefore will not equal the sum or counts by health or age cohort.

Table 28.1 Expansion enrollment by age cohort and MCO, State Fiscal Year 2019[34]

	ABH	ACLA	HB	LHCC	UHC	TOTAL
Ages 19 to 49	50,247	66,496	94,742	135,084	146,174	476,772
Ages 50 to 64	20,147	18,979	27,850	33,694	38,805	135,115
Ages 65+	512	441	647	816	868	3,284
Total	**69,581**	**84,612**	**121,267**	**167,146**	**183,045**	**605,269**

Source: Medicaid Data Warehouse

[34] Due to the dynamic nature of Medicaid enrollment and to provide for claim lag the dataset for this annual Transparency Report was extracted in October 2019, and will not necessarily match the data previously extracted and reported in the quarterly transparency reports.

29 EXPANSION ENROLLEES WITH EARNED INCOME

Medicaid expansion population data which shall include the following: Number of individuals in the expansion population in each age category with earned income.

Table 29.1 presents the number of expansion enrollees in each MCO with earned income by age cohort. This analysis was not restricted to only able-bodied adults and therefore may include individuals with a disability or other persons identified by CMS guidance whose ability to work may be limited, such as students and individuals with complex medical conditions.

During the fiscal year, data was extracted from MEDS which was replaced in November of 2018 with the new eligibility system, LaMEDS (Louisiana Medicaid Eligibility Data System). Beginning with November 2018 reporting, income data was extracted from the new eligibility system, which provides for more discrete reporting and deduplication of individuals with earned income. Approximately 51% of the expansion population for State Fiscal Year 2019 reported earned income.

Table 29.1 Unduplicated expansion enrollees with earned income by age cohort and MCO, State Fiscal Year 2019[35]

	ABH	ACLA	HB	LHCC	UHC	TOTAL
Ages 19 to 49	23,788	34,723	49,689	73,049	79,184	258,528
Ages 50 to 64[36]	6,534	6,445	9,629	12,162	13,686	48,059
Total[x]	**30,234**	**41,055**	**59,151**	**84,967**	**92,605**	**305,707**

Source: Medicaid Eligibility Data System

[35] Due to the dynamic nature of Medicaid enrollment and to provide for claim lag the dataset for this annual Transparency Report was extracted in October 2019, and will not necessarily match the data previously extracted and reported in the quarterly transparency reports

30 EXPANSION PER MEMBER PER MONTH PAYMENTS

Medicaid expansion population data which shall include the following: the per-member per-month cost paid to each managed care organization to manage the care of the individuals in the expansion population assigned to their plan, identified by each individual managed care organization.

In State Fiscal Year 2019, the Department paid a total of $3,190,294,669 to all five managed care organizations to manage the care of individuals in the expansion population for medical, specialized behavioral health, pharmacy and transportation services.

Table 30.1 Total payments to MCOs for expansion population, State Fiscal Year 2019

ABH	ACLA	HB	LHCC	UHC
$360,588,421	$431,465,245	$610,909,657	$835,437,003	$951,894,342

Source: ISIS/CP-012 and Medicaid Data Warehouse

Table 30.2 below shows the total payments the Department made to MCNA to provide administration of dental benefits for the expansion population. Expansion enrollees aged 19 and 20 years are eligible for all Medicaid covered dental services. Enrollees 21 years of age and over are eligible for covered denture services only.

Table 30.2 Total payments for dental benefits for expansion population, State Fiscal Year 2019

	MCNA
SFY 19 Payments	$14,506,438

Source: ISIS/CP-012 and Medicaid Data Warehouse

31 MEDICAID EXPANSION POPULATION SERVICE UTILIZATION

Medicaid expansion population utilization data which shall include the following:

- Comparison of individuals age nineteen to forty-nine, age fifty to sixty-four, and those who are covered by Medicaid who are not part of the expansion population utilizing the following services.
    - Emergency Department
    - Prescription Drugs
    - Physician Services
    - Hospital Services
    - Nonemergency Medical Transportation
- Expenditures associated with each service for individuals in the expansion population age nineteen to forty-nine, age fifty to sixty-four, and those who are covered by Medicaid who are not part of the expansion population.

The information covered in this section provides a comparison of specified service utilization for the expansion population and the non-expansion population by age cohort.

The number of recipients who received services is unduplicated within each service category and reporting time period and, as a result, cannot be added to ascertain the total number of recipients who received services each month. The total MCO expenditures within the specified service categories in State Fiscal Year 2019 were $1,681,409,477 for the expansion population and $2,172,837,989 for the non-expansion population. This includes claim payments made to providers by the MCOs for these select services and does not include payments made under the fee-for-service program. Approximately 44% of total payments by the MCOs to providers for the selected category of service presented below are attributed to the utilization by the expansion population. Tables 31.1 and 31.2 on the following page provide the expenditures for the expansion population and the non-expansion population.

Table 31.1 Utilization and expenditures for specified services for expansion population enrolled In Managed Care, State Fiscal Year 2019[37]

EXPANSION		Age Cohort 0 to 18	Age Cohort 19 to 49	Age Cohort 50 to 64	Age Cohort 65+	Total
Emergency Department	Recipient	0	201,372	51,252	0	251,478
	Payment	$0	$63,834,945	$17,240,081	$0	$81,075,026
Hospital Inpatient	Recipient	0	40,392	13,342	0	53,262
	Payment	$0	$280,070,548	$143,981,105	$0	$424,051,653
Hospital Outpatient	Recipient	0	269,089	93,420	0	359,341
	Payment	$0	$187,539,706	$129,861,550	$0	$317,401,256
NEMT	Recipient	0	19,857	10,917	0	30,458
	Payment	$0	$6,249,753	$3,049,699	$0	$9,299,452
Pharmacy	Recipient	0	331,318	109,686	0	435,611
	Payment	$0	$365,646,397	$214,509,244	$0	$580,155,641
Physician	Recipient	0	325,920	105,054	0	426,768
	Payment	$0	$178,589,826	$90,836,622	$0	$269,426,449

Source: Medicaid Data Warehouse

Table 31.2 Utilization and expenditures for specified services for non-expansion population enrolled in Managed Care, State Fiscal Year 2019[37]

NON-EXPANSION		Age Cohort 0 to 18	Age Cohort 19 to 49	Age Cohort 50 to 64	Age Cohort 65+	Total
Emergency Department	Recipient	272,739	90,167	26,514	672	387,956
	Payment	$55,787,907	$31,606,264	$11,739,884	$231,253	$99,365,308
Hospital Inpatient	Recipient	45,143	33,450	9,063	319	87,835
	Payment	$322,764,862	$192,337,444	$123,149,765	$4,068,373	$642,320,444
Hospital Outpatient	Recipient	382,842	125,597	41,323	1,411	546,979
	Payment	$118,986,431	$98,818,476	$80,502,348	$2,016,467	$300,323,722
NEMT	Recipient	19,317	17,234	16,686	5,655	58,012
	Payment	$5,118,380	$5,478,860	$5,734,258	$1,663,995	$17,995,493
Pharmacy	Recipient	569,769	150,233	47,675	2,255	761,278
	Payment	$278,399,833	$224,137,321	$185,664,858	$3,421,302	$691,623,313
Physician	Recipient	627,961	149,146	45,396	1,820	817,217
	Payment	$264,482,066	$102,327,729	$52,836,848	$1,563,067	$421,209,709

Source: Medicaid Data Warehouse

[37] Due to the dynamic nature of Medicaid enrollment and to provide for claim lag the dataset for this annual Transparency Report was extracted in October 2019, and will not necessarily match the data previously extracted and reported in the quarterly transparency reports

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