Medicaid Managed Care Transparency Report 2020

Agency Response to La. Revised Statute 40:1253.2

Louisiana Department of Health

Bureau of Health Services Financing

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LOUISIANA DEPARTMENT OF HEALTH

Contents

Introduction

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

- improved care coordination with patient-centered medical homes for Medicaid enrollees;
- improved health outcomes and quality of care;
- increased emphasis on disease prevention and the early diagnosis and management of chronic conditions;
- improved access to Medicaid services;
- improved accountability with a decrease in fraud, abuse and wasteful spending; and
- a more financially stable Medicaid program.

Beginning in February of 2012, the original Medicaid Managed Care Program included two models of coordinated care networks: full-risk managed care organizations (MCOs) known as "prepaid health plans," and primary care case management (PCCM) known as "shared savings plans." The state contracted with three prepaid and two shared savings plans, and individuals were given the option of choosing the plan that best meet their needs. Not all Medicaid services were available from health plans, and some enrollees 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 by a single prepaid ambulatory health plan referred to as a "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.
- Non-emergency medical transportation and specialized behavioral health services were added on December 1, 2015 for enrollees not entitled to receive physical health services through a MCO.
- 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. This report covers program operations for July 2019 through June 2020 (State Fiscal Year 2020), 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

The State Fiscal Year 2020 presentation of this report has been updated to consolidate all data elements regarding the Dental Benefits Program into Sections 30 – 40.

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 (MSLC) 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 XIX and XX 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 2020, more than 1.74 million Louisiana Medicaid and Louisiana Children's Health Insurance Program (LaCHIP) enrollees received coverage for physical health, basic and specialized behavioral health services, and transportation services under the Medicaid Managed Care Program through one of five managed care organizations. The covered populations and services for each model of managed care are described below.

Managed Care Organizations (MCO)
Managed care organizations are risk-bearing entities that provide a wide array of Medicaid-covered benefits and services to enrollees in exchange for a monthly capitation payment for each member. The MCOs 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 MCO 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 2020 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 eligible recipients 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

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 2020 reporting period, the Department contracted with five MCOs to manage physical and behavioral healthcare services. 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 organizations, State Fiscal Year 2020

Plan Name	Plan Type	Common Abbreviation
Aetna Better Health, Inc.	Managed Care Organization	ABH
Community Care Health Plan of Louisiana, Inc. (dba Healthy Blue)	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

Source: Medicaid managed care contracts

In addition, the state provided coverage for comprehensive dental services to children and denture services to adults through a single DPBM as detailed in sections 30 - 41.

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 2020

	ABH	ACLA	HB	LHCC	UHC
Total number of LA employees (FTEs)	135.80	237.00	212.00	643.60	332.00
Average salary paid	$80,913	$64,476	$84,050	$64,281	$66,796

Source: 017 Annual Report to LDH

The average annual salary weighted across all health plans was $68,979. 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.

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 2020, the Department paid a total of $8,735,953,340 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 2020 was 1,749,276. Total enrollment unduplicated within each group was 1,602,130 full-benefit enrollees and 161,103 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[2] by month, State Fiscal Year 2020

	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-19	$54,985,241	$561.97	$90,914,293	$497.25	$122,067,544	$498.02	$187,170,009	$434.37	$188,815,916	$466.05
Aug-19	$57,174,318	$575.40	$94,469,907	$512.72	$125,859,540	$506.70	$195,623,226	$450.28	$196,662,436	$480.96
Sep-19	$57,171,331	$570.13	$95,241,629	$514.90	$126,032,860	$502.61	$196,773,324	$450.95	$196,716,949	$478.59
Oct-19	$70,891,287	$711.83	$114,730,823	$623.01	$153,401,877	$611.46	$240,470,584	$552.69	$239,228,400	$583.96
Nov-19	$58,211,522	$585.76	$95,262,032	$519.52	$127,916,337	$510.61	$191,819,837	$443.00	$198,152,226	$486.43
Dec-19	$56,462,749	$565.41	$93,828,204	$515.32	$127,854,168	$509.88	$199,740,298	$465.72	$195,088,984	$482.29
Jan-20	$58,496,091	$577.80	$95,728,291	$521.23	$130,156,904	$511.02	$197,300,275	$455.92	$198,152,548	$484.31
Feb-20	$64,317,697	$641.31	$105,793,921	$581.37	$143,387,245	$564.81	$218,597,277	$507.87	$219,286,552	$538.93
Mar-20	$74,087,891	$729.68	$123,328,793	$677.56	$166,659,278	$649.89	$247,871,160	$575.24	$256,071,234	$626.64
Apr-20	$68,434,056	$654.19	$105,687,529	$571.94	$149,581,209	$568.52	$223,146,237	$509.82	$223,294,716	$536.48
May-20	$62,525,342	$582.78	$98,938,229	$528.99	$140,524,220	$523.21	$204,497,273	$461.09	$210,708,711	$498.33
Jun-20	$65,252,356	$594.91	$101,203,508	$534.66	$145,157,007	$529.85	$211,002,126	$469.79	$216,949,623	$505.69
Total	**$748,009,881**	**$612.60**	**$1,215,127,158**	**$549.87**	**$1,658,598,190**	**$540.55**	**$2,514,011,626**	**$481.39**	**$2,539,128,293**	**$514.06**

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 2020:

- Sept ’19 includes $9M for the Managed Care Incentive Payment (MCIP) Program.
- Oct ’19 includes $111.2M for the MCIP Program and $199.8M for the Health Insurance Provider Fee (HIPF)
- Feb ’20 includes $64.4 for the MCIP Program.
- Mar ’20 includes $145M for the MCIP Program.
- Apr ’20 includes $58.9M for the MCIP Program.
- Jun ’20 includes $15.8M for the MCIP Program paid in July 20 (Fiscal Month 13).

[2] Including the adult expansion population

Table 3.2 Total payments and average PMPM for partial-benefit enrollees by month, State Fiscal Year 2020

	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-19	$698,153	$30.44	$689,143	$30.11	$759,588	$30.69	$909,069	$30.92	$949,821	$31.17
Aug-19	$963,401	$42.14	$970,755	$42.42	$1,077,916	$43.56	$1,293,678	$44.01	$1,353,340	$44.42
Sep-19	$876,264	$38.02	$890,350	$38.61	$984,617	$39.39	$1,171,055	$39.40	$1,212,409	$39.29
Oct-19	$777,540	$33.78	$805,681	$35.01	$892,747	$35.61	$1,057,808	$35.54	$1,122,605	$36.35
Nov-19	$967,475	$43.02	$964,499	$42.91	$1,082,946	$44.09	$1,303,314	$44.56	$1,343,803	$44.30
Dec-19	$859,107	$38.17	$883,432	$39.24	$994,916	$40.33	$1,188,503	$40.46	$1,243,384	$40.88
Jan-20	$932,457	$40.76	$965,676	$42.23	$1,065,606	$42.25	$1,261,575	$42.14	$1,314,358	$42.27
Feb-20	$20,175	$0.89	$20,847	$0.92	$35,554	$1.42	$38,178	$1.28	$38,895	$1.26
Mar-20	$1,630,814	$72.30	$1,656,202	$73.29	$1,863,022	$74.28	$2,239,735	$75.07	$2,311,963	$74.68
Apr-20	$891,211	$39.51	$909,341	$40.30	$1,032,365	$41.05	$1,202,842	$40.13	$1,259,186	$40.45
May-20	$867,157	$38.30	$856,280	$37.78	$985,484	$38.70	$1,185,946	$39.16	$1,229,190	$38.87
Jun-20	$812,608	$35.69	$831,880	$36.65	$974,042	$37.92	$1,159,712	$37.93	$1,198,572	$37.35
Total	**$10,296,362**	**$37.75**	**$10,444,085**	**$38.29**	**$11,748,805**	**$39.11**	**$14,011,415**	**$39.22**	**$14,577,526**	**$39.27**

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

Notes: off-cycle payment adjustments to MCOs for partial-benefit enrollees, State Fiscal Year 2020:

- Feb ’20 payments for January Date of Service (DOS) PMPMs postponed to March.
- Mar ’20 payments include payments for both February and January DOS PMPMs.

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 2020, a total of 51,311 providers were contracted by one or more of the five managed care plans to provide services to the Louisiana Medicaid managed care population. 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[3] count of contracted providers by health plan, State Fiscal Year 2020[4]

	ABH	ACLA	HB	LHCC	UHC	Total
Total Contracted Providers	18,641	31,323	29,778	39,252	17,363	51,311

Source: MARS Data Warehouse, June 26, 2020 Provider Registry

[3] 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 may be counted multiple times.

[4] 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 2020. 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 2020 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[5] contracted primary care providers with at least one claim, State Fiscal Year 2020[6]

	ABH	ACLA	HB	LHCC	UHC	Total
Total Contracted PCPs	2,025	3,928	3,166	5,134	2,367	8,885
PCPs with at least one claim	1,362	2,816	2,664	3,569	1,832	5,880
Percent with at least one claim	67.3%	71.7%	84.1%	69.5%	77.4%	66.2%

Source: MARS Data Warehouse, June 26, 2020 Provider Registry

[5] 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 may be counted multiple times

[6] 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 26, 2020. 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[7] contracted primary care providers with a closed panel, State Fiscal Year 2020[8]

	ABH	ACLA	HB	LHCC	UHC	Total
Total Contracted PCPs	2,025	3,928	3.166	5,134	2,367	8,885
PCPs with a Closed Panel	388	1,072	768	934	340	2,656
Percent with a Closed Panel	19.2%	27.3%	24.3%	18.2%	14.4%	29.9%

Source: MARS Data Warehouse: June 26, 2020 Provider Registry

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

[8]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, 2019. In Calendar Year 2019 all health plans met the 85% minimum ratio and no rebates to the Department were required. The audited reports for 2019 are posted on the Medicaid website at https://ldh.la.gov/index.cfm/page/2142.

Table 7.1 Medical loss ratios (MLR), Calendar Year 2019

	ABH	ACLA	HB	LHCC	UHC
Adjusted YTD MLR Capitation Revenue	$664,642,406	$1,093,255,780	$1,454,654,770	$2,259,514,823	$2,246,309,656
Total Adjusted MLR Expense	$635,225,298	$1,047,919,581	$1,364,371,850	$2,077,323,970	$2,088,673,352
MLR Percentage Achieved	95.6%	95.9%	93.8%	91.9%	93.0%
Dollar Amount of Rebate Required	$0	$0	$0	$0	$0

Source: Myers and Stauffer, LC (MSLC) Audited Medical Loss Ratio Reports

Table 7.2 Breakdown of total adjusted MLR, Calendar Year 2019

	ABH	ACLA	HB	LHCC	UHC
Patient Care	$628,334,442	$1,032,459,675	$1,345,993,330	$2,053,269,490	$2,045,233,308
Quality Improvement	$6,890,856	$12,773,875	$14,424,376	$24,054,480	$37,059,443
Information Technology	$0	$2,686,030	$3,954,143	$0	$6,380,601
Other[9]	$0	$0	$0	$0	$0
Total Adjusted MLR Expense	$635,225,298	$1,047,919,581	$1,364,371,850	$2,077,323,970	$2,088,673,352

Source: MSLC Audited Medical Loss Ratio Reports

[9] 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 https://ldh.la.gov/index.cfm/page/3936.

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 for 2019 – 2020 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 to have a license or certificate of authority issued by the Louisiana Department of Insurance (LDI) 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 2019, which were reported during State Fiscal Year 2020.

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 2020, 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.

Medicaid Managed Care Enrollees

12 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 1,883,015 unduplicated individuals enrolled in Louisiana Medicaid in State Fiscal Year 2020, 1,749,276 (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. A number of enrollees are enrolled in a health plan for partial benefits only, specifically covering non-emergency medical transportation and specialized behavioral health services. These enrollees receive their physical and acute care through fee-for-service.

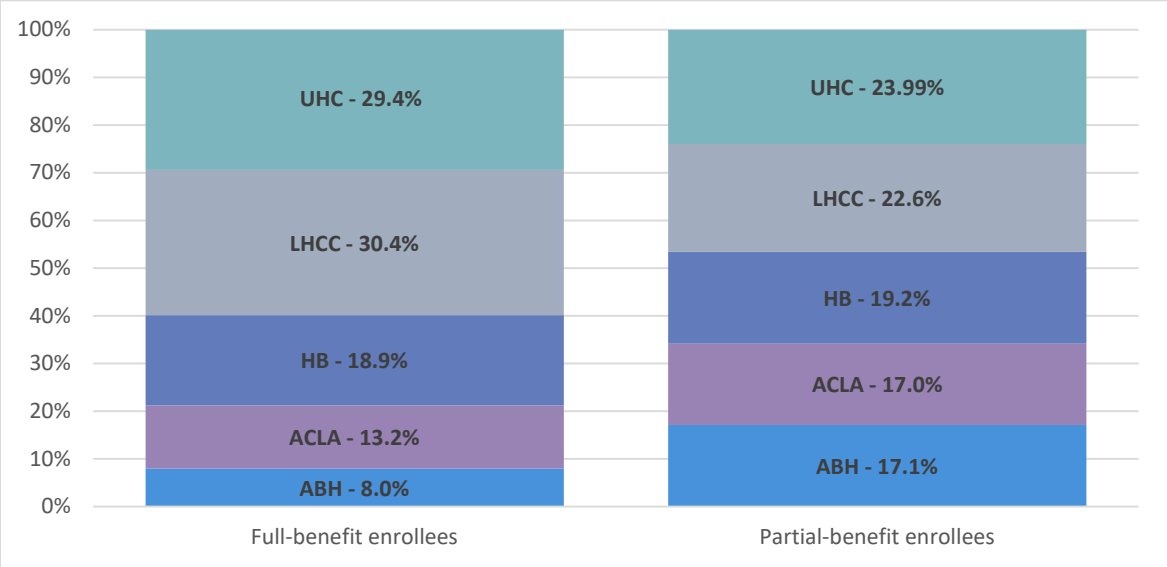
The distribution of total enrollees across health plans ranged from 9% in Aetna to 30% in Louisiana Healthcare Connections. Table 12.1 and Figure 12.1 below provide a breakdown of enrollment totals by health plan and benefits covered. This table represents unduplicated enrollment in each health plan throughout the year.

Table 12.1 Total enrollees by health plan and benefit group, State Fiscal Year 2020

	ABH	ACLA	HB	LHCC	UHC	Total Unduplicated[10]
Full-benefit enrollees	131,246	216,935	310,325	499,286	482,323	1,602,130
Partial-benefit enrollees	27,818	27,652	31,189	36,718	38,934	161,103
Total (unduplicated)	157,359	242,557	338,786	532,584	517,382	1,749,276
Percent of total	9.0%	13.9%	19.4%	30.4%	29.6%	100%

Source: MARS Data Warehouse

Figure 12.1 Distribution of enrollees by benefit group and health plan, State Fiscal Year 2020



Source: MARS Data Warehouse

[10] 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 2020:

- *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.
- *Institutions of Mental Health (IMD)*: Adults (age 21 and above) who enrolled in the 1115 SUD waiver providing IMD for 16 or more days within a calendar month for the purposes of Mental Health/SUD services. The waiver does not provide Medicaid eligibility – it only allows the service to be provided to those qualifying individuals were already Medicaid eligible.
- *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 12.1 presents unduplicated enrollees for the full twelve months during State Fiscal Year 2020, tables 12.2 and 12.3 below provide the average monthly number of enrollees by eligibility category for full-benefit and partial-benefit coverage respectively.

Table 12.2 Average number of full-benefit enrollees in each month delineated by eligibility category and health plan, State Fiscal Year 2020

	ABH	ACLA	HB	LHCC	UHC
SSI	9,005	20,327	22,258	35,850	31,879
Families & Children	41,991	99,531	131,661	262,820	236,321
Foster Care	347	716	3,800	6,690	1,852
BCC	31	57	70	88	81
LAP	135	193	319	585	670
HCBS Waiver	234	382	485	801	728
IMD	3	4	5	8	7
Chisholm	173	412	592	1,263	966
New Adult Group (Expansion)	49,828	62,580	96,399	127,153	139,109
All Categories	101,747	184,201	255,589	435,258	411,612

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 2020 is presented in table 12.3. The average monthly enrollment is lower than the total unduplicated count for the year presented in figure 12.1 because each month there were some members who lost eligibility, while others were newly enrolled.

Table 12.3 Average number of partial-benefit only members enrolled each month delineated by eligibility category and health plan, State Fiscal Year 2020

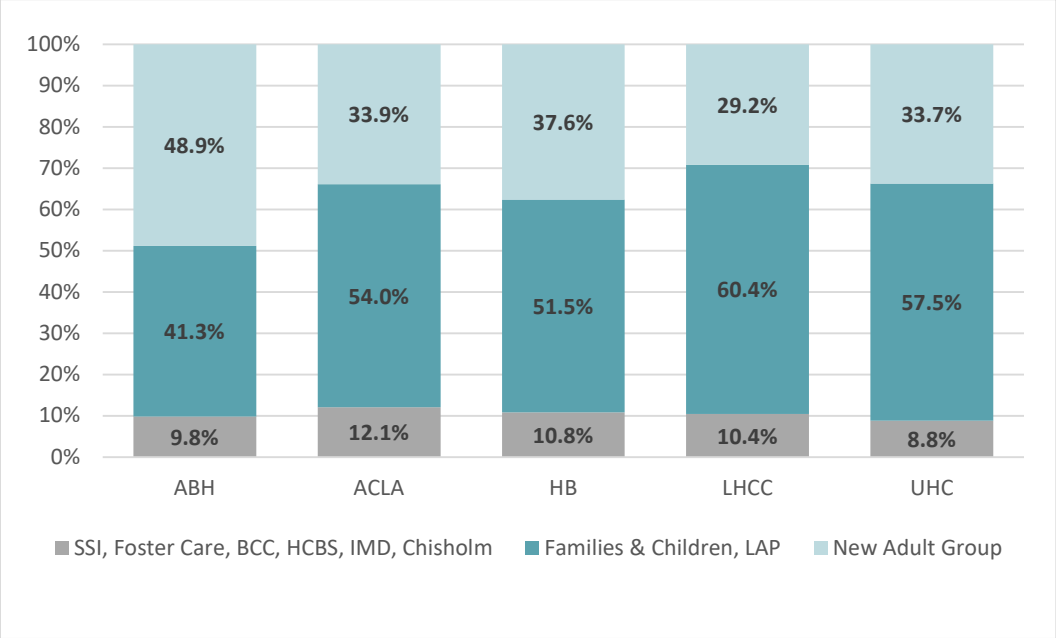
	ABH	ACLA	HB	LHCC	UHC
Chisholm	346	393	532	676	677
Dual Eligibles	21,013	20,928	22,829	27,136	28,036
HCBS Waiver	797	843	960	1,113	1,222
Other[11]	582	572	714	845	993
All Categories	22,737	22,735	25,034	29,770	30,928

Source: MARS Data Warehouse

[11]Includes individuals residing in nursing facilities (NF) or under the age of 21 residing in Intermediate Care Facility for the Developmentally Disabled (ICF/DD) and other eligibility categories excluded from full-benefit participation in Medicaid managed care.

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, IMD 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 12.2.

Figure 12.2 Membership distribution by eligibility category, State Fiscal Year 2020



Source: MARS Data Warehouse

13 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 13.1 provides the individual plan and aggregate choice rates for State Fiscal Year 2020. Proactive choice rates for all five health plans increased over 2019 rates with the overall rate increased from 65.0 percent in 2018 to 68.0 percent in 2020. 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 13.1 Proactive choice rates, State Fiscal Year 2020

	ABH	ACLA	HB	LHCC	UHC	Total
Pro-active Choice Enrollments	22,569	24,332	57,138	65,401	77,670	**247,110**
Auto Enrollments	19,399	21,433	22,976	27,411	25,727	**116,946**
Total Enrollments	41,968	45,765	80,114	92,812	103,397	**364,056**
Choice rate	53.8%	53.2%	71.3%	70.5%	75.1%	**67.9%**

Source: Maximus Health Services

14 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 14 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 14.1 shows the unduplicated counts and percent of members who received services in State Fiscal Year 2020. During this reporting period, 1,457,307 members received one or more Medicaid service through their health plan for an overall rate of 83% of members across all plans. Rates for individual plans demonstrate variation across plans with a range of 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 14.1 Enrollees who received services, State Fiscal Year 2020

	ABH	ACLA	HB	LHCC	UHC	Total Unduplicated[12]
Unduplicated Count of Enrollees	157,359	242,557	338,786	532,584	517,382	**1,749,276**
Number Receiving One or More Services	118,557	196,366	267,161	462,939	463,142	**1,457,307**
Percent Receiving One or More Services	75.3%	81.0%	78.9%	86.9%	89.5%	**83.3%**

Source: MARS Data Warehouse

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

15 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 15.1 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 2020. 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 15.1 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 2020

	ABH	ACLA	HB	LHCC	UHC
Unduplicated full-benefit enrollees	131,246	216,935	310,325	499,286	482,323
Enrollees with at least one PCP visit	21,875	65,404	93,797	134,219	120,917
Percentage	16.7%	30.1%	30.2%	26.9%	25.1%

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 are also compiled and presented in table 15.2. This expanded data demonstrates that 58% of all managed care enrollees did have at least one primary care visit with any PCP versus 27% receiving at least one visit with their specific PCP.

Table 15.2 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 2020

	ABH	ACLA	HB	LHCC	UHC
Unduplicated full-benefit enrollees	131,246	216,935	310,325	499,286	482,323
Enrollees with at least one PCP visit	42,572	129,798	170,998	354,384	242,553
Percentage	32.4%	59.8%	55.1%	71.0%	50.3%

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

16 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 16 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.[13]

Table 16.1 lists the number of members receiving unduplicated outpatient emergency services for State Fiscal Year 2020. For comparability across health plans, the rate per 1,000 total health plan members was calculated to account for variation in total member counts. Amerihealth Caritas of Louisiana had the highest rate of members receiving unduplicated outpatient emergency services at 361 per 1,000 members, and Aetna had the lowest rate of 338 per 1,000 members, though no plan was a significant outlier. In aggregate, the rate across all health plans was 361 per 1,000 total health plan members.

Table 16.1 Enrollees who received unduplicated outpatient emergency services, State Fiscal Year 2020

	ABH	ACLA	HB	LHCC	UHC	Total Unduplicated[14]
Enrollees receiving unduplicated outpatient emergency services	44,406	78,339	110,032	178,927	170,687	578,943
Total Unduplicated full-benefit enrollees	131,246	216,935	310,325	499,286	482,323	1,602,130
Rate per 1,000 unduplicated full-benefit enrollee	338	361	355	358	354	361

Source: MARS Data Warehouse

[13] 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 15 of this report.

[14] 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 16.2 lists the total inpatient Medicaid days for State Fiscal Year 2020. 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 2020 was 441 per 1,000 enrollees.

Table 16.2 Total inpatient Medicaid days, State Fiscal Year 2020

	ABH	ACLA	HB	LHCC	UHC	Total
Total Inpatient Medicaid Days	67,635	105,955	144,487	203,001	186,104	707,182
Rate per 1,000 full-benefit enrollees	515	488	466	407	386	441

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 16.3 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 16.3 Unduplicated enrollees who saw a PCP before or after a visit to the emergency room, State Fiscal Year 2020[15]

	ABH	ACLA	HB	LHCC	UHC	Total Unduplicated[16]
12 months before outpatient emergency service	21,471	58,942	74,362	146,644	106,636	406,040
Percentage of total emergency service visits[17]	48.4%	75.2%	67.6%	82.0%	62.5%	70.1%
6 months after outpatient emergency service	17,248	50,475	63,972	127,007	83,652	340,835
Percentage of total emergency service visits	38.8%	64.4%	58.1%	71.0%	49.0%	58.9%

Source: MARS Data Warehouse

[15] 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 15.1 of this report.

[16] 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.

[17] The percentage is calculated as the percent of total unduplicated members who received an outpatient emergency service as identified in table 16.1.

17 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 2,904 appeal and state fair hearing (SFH) determinations made in State Fiscal Year 2020, 42% of which resulted in a full or partial reversal in favor of the member.

Table 17.1 Appeals and state fair hearings, State Fiscal Year 2020

	ABH	ACLA	HB	LHCC	UHC
Total Members (unduplicated)	157,359	242,557	338,786	532,584	517,382
Members who filed an appeal	136	290	635	802	845
Members who accessed SFH	5	3	26	16	12
Total appeals filed at MCO level	142	323	664	997	881
Total appeals filed at SFH level	5	3	27	16	13
Total appeal & SFH determinations[18]	146	279	542	1,049	888
Total determinations fully or partially reversed in favor of the member	63	153	110	330	556
% of determinations fully or partially reversed in favor of the member	43.2%	54.8%	20.3%	31.5%	62.6%

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

[18]Total determinations include determinations made in State Fiscal Year 2020 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.[19]

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

[19] 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.

18 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 2020, the aggregate count of unduplicated claims submitted across all health plans totaled 87,238,899. The breakdown of unduplicated claim counts for State Fiscal Year 2020 is presented in table 18.1.

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 3% were for emergency services.

Claims that do not meet the specific data requirements or the basic format necessary will be rejected according to 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 right at one percent. Individual plan rejection rates are dependent upon a plan’s specific claims processing system and internal workflow.

Table 18.1 Total claims submitted, State Fiscal Year 2020

	Rejected Claims	Emergency Services	Non-Emergency Services	Total
ABH	14,427	232,531	8,412,937	**8,659,895**
ACLA	50,353	347,308	10,826,456	**11,224,117**
HB	19,537	382,401	15,300,549	**15,702,487**
LHCC	933,841	748,499	23,783,461	**25,465,801**
UHC	263,999	865,735	25,056,865	**26,186,599**
Total	**1,282,157**	**2,576,474**	**83,380,268**	**87,238,899**

Source: Report 177 Total and Out of Network Claims

19 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 19.1 below provides total unduplicated denied claims by health plan delineated by emergency and non-emergency services.

Table 19.1 Total unduplicated denied claims, State Fiscal Year 2020

	Emergency Services	Non-Emergency Services	Total
ABH	100,594	1,986,223	**2,086,817**
ACLA	15,711	1,969,007	**1,984,718**
HB	33,039	3,766,300	**3,799,339**
LHCC	34,578	4,425,231	**4,459,809**
UHC	42,754	3,829,660	**3,872,414**
Total	**226,676**	**15,976,421**	**16,203,097**

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 19.2 are greater than the unduplicated number of total denied claims presented in table 19.1. 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 19.2 shows the ten most frequently used CARC codes for emergency and non-emergency medical and behavioral health claims. The primary causes for denial were duplicate claims, 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. A breakout of all CARCs for denied claims for each health plan in numerical order is provided in Appendix VIII.

Table 19.2 Top claim adjustment reason codes (CARCs) for emergency and non-emergency services, State Fiscal Year 2020

CARC	CARC Description	Emergency Claims[20]	Non-Emergency Claims	Total
18	Exact duplicate claim/service	31,848	1,403,303	**1,435,151**
96	Non-covered charge(s)	7,768	1,234,914	**1,242,682**
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	8,015	856,623	**864,638**
16	Claim/service lacks information or has submission/billing error(s).	12,882	746,953	**759,835**
197	Precertification/authorization/notification/pre-treatment absent.	122	679,836	**679,958**
252	An attachment/other documentation is required to adjudicate this claim/service.	20,267	400,998	**421,265**
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	192	361,933	**362,125**
204	This service/equipment/drug is not covered under the patient's current benefit plan	6,006	332,149	**338,155**
133	The disposition of this service line is pending further review.	4,141	312,120	**316,261**
29	The time limit for filing has expired.	4,913	283,554	**288,467**

Source: 173 Denied Claims Report

Table 19.3 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 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.

[20] 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 19.3 Top NCPDP codes for denial of emergency and non-emergency pharmacy services, State Fiscal Year 2020

NCPDP Code	NCPDP Description	Emergency Claims[21]	Non-Emergency Claims	Total
79	Refill Too Soon	20,936	1,652,367	**1,673,303**
70	Product/Service Not Covered-Plan/Benefit Exclusion	8,107	1,127,859	**1,135,966**
88	Drug Utilization Review (DUR) Reject Error	3,048	1,065,958	**1,069,006**
75	Prior Authorization Required	21,795	1,039,721	**1,061,516**
76	Plan Limitations Exceeded	14,629	801,545	**816,174**
MR	Product Not On Formulary	5,510	358,641	**364,151**
69	Filled After Coverage Terminated	7,809	290,414	**298,223**
41	Submit Bill To Other Processor Or Primary Payer	725	294,936	**295,661**
7X	Days' Supply Exceeds Plan Limitation	2	285,641	**285,643**
39	Missing or Invalid (M/I) Diagnosis Code	4,059	223,944	**228,003**

Source: 173 Denied Claims Report

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

20 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 claim 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 20.1 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 20.1 Total clean claims, State Fiscal Year 2020

ABH	ACLA	HB	LHCC	UHC
5,464,566	9,216,044	12,052,833	20,136,560	16,941,102

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. Delineation of turnaround times by claim type is outlined in tables 20.2 and 20.3 below for illustrative purposes.

Table 20.2 Percent of paid clean claims that were paid within 15 days, State Fiscal Year 2020

Provider Type	ABH	ACLA	HB	LHCC	UHC
Inpatient Hospital	98.26%	99.95%	96.87%	99.27%	99.72%
Outpatient Hospital	99.10%	99.98%	97.82%	97.57%	99.50%
Professional	99.50%	99.89%	98.80%	99.59%	99.79%
Rehab	99.55%	100.00%	99.51%	99.30%	99.98%
Home Health	98.33%	100.00%	95.72%	99.87%	99.47%
Emergency Medical Transportation (EMT)	99.77%	99.99%	99.37%	99.81%	99.96%
NEMT & Nonemergency Ambulance Transportation (NEAT)	99.89%	100.00%	99.84%	99.86%	92.83%
Durable Medical Equipment (DME)	98.56%	99.94%	98.81%	99.73%	99.76%
Pharmacy	99.67%	100.00%	100.00%	100.00%	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 20.3 Percent of paid clean claims that were paid within 30 days, State Fiscal Year 2020

Provider Type	ABH	ACLA	HB	LHCC	UHC
Inpatient Hospital	99.64%	99.99%	99.06%	99.65%	99.92%
Outpatient Hospital	99.80%	100.00%	99.48%	99.33%	99.96%
Professional	99.81%	99.97%	99.58%	99.82%	99.97%
Rehab	99.76%	100.00%	99.88%	99.83%	100.00%
Home Health	99.60%	100.00%	98.80%	99.91%	100.00%
EMT (Transportation)	99.92%	99.99%	99.89%	99.93%	100.00%
NEMT & NEAT (Transportation)	99.99%	100.00%	96.83%	99.93%	98.92%
DME	99.72%	99.99%	99.62%	99.92%	99.99%
Pharmacy	100.00%	100.00%	100.00%	100.00%	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 20.4 Average number of days to pay clean claims, State Fiscal Year 2020

Provider Type	ABH	ACLA	HB	LHCC	UHC
Inpatient Hospital	7.00	10.79	10.58	8.75	8.79
Outpatient Hospital	5.00	3.72	8.25	8.61	7.94
Professional	11.90	7.88	5.39	7.64	7.78
Rehab	6.00	4.63	7.50	7.58	7.51
Home Health	7.00	4.92	10.00	8.23	11.41
EMT (Transportation)	5.00	4.17	7.67	7.40	8.01
NEMT & NEAT (Transportation)	15.90	6.42	11.00	10.89	13.36
DME	6.00	4.68	8.33	8.05	7.96
Pharmacy	10.90	7.51	1.00	10.85	10.41

Source: 221 Prompt Pay Report

21 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 2020 are presented in table 21.1. 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 21.1 Standard service authorizations processed, State Fiscal Year 2020

TIMEFRAME (COMPLIANCE STANDARD)		ABH	ACLA	HB	LHCC	UHC
Processed within 2 business days[22] from receipt of needed documentation (80%)	**Number**	70,441	53,689	156,189	192,650	124,187
	Percent	97.9%	74.2%	94.6%	97.9%	98.1%
Non-extended: Processed within 14 days of receipt of request for authorization (100%)	**Number**	71,933	71,897	164,633	166,561	126,515
	Percent	100.0%	99.9%	99.7%	99.8%	99.9%
Extended: Processed within 28 days[23] of receipt of request for authorization (100%)	**Number**	0	378	5	29,863	0
	Percent	--	100.0%	100.0%	99.9%	--

Source: 188 & 188BH Service Authorization - Quarterly Reports

At a rate of 74%, ACLA did not meet the overall contract compliance standard to process at least 80% of all standard prior authorizations within 2 business days. In cooperation with the Department, ACLA identified the underlying issues with turnaround times specifically for standard authorization for specialized behavioral health services and implemented a plan for correction. By the 4th quarter of State Fiscal Year 2020, ACLA had exceeded the 80% compliance rate with 93% of all standard authorizations processed within contract standards, 91% for specialized behavioral health authorizations and 95% for medical authorizations.

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

[23] 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 21.2 Expedited service authorizations processed, State Fiscal Year 2020

TIME FRAME (COMPLIANCE STANDARD)		ABH	ACLA	HB	LHCC	UHC
Non-extended: Processed within 72 hours of receipt of request for authorization (100%)	**Number**	1,097	1,639	9	120	2,335
	Percent	100.0%	100.0%	100.0%	100.0%	99.6%
Extended: Processed within 14 days of receipt of request for authorization (100%)	**Number**	0	20	0	54	0
	Percent	--	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 21.3. Note that the counts presented are unduplicated denials based on the *initial* service authorization determination.

Table 21.3 Percent of service authorizations denied, State Fiscal Year 2020

	ABH	ACLA	HB	LHCC	UHC
Total service authorizations processed	73,062	73,977	165,086	196,953	128,929
Number denied	8,272	12,385	14,420	3,653	10,015
Percent denied	11.3%	16.7%	8.7%	1.9%	7.8%

Source: 188 & 188BH Service Authorization - Quarterly Reports

Some denials may have subsequently been reversed by the health plans upon reconsideration, appeal or through the state fair hearing process. See Section 17 of this report for additional information on appeals and state fair hearings.

22 CLAIMS PAID TO OUT-OF-NETWORK PROVIDERS

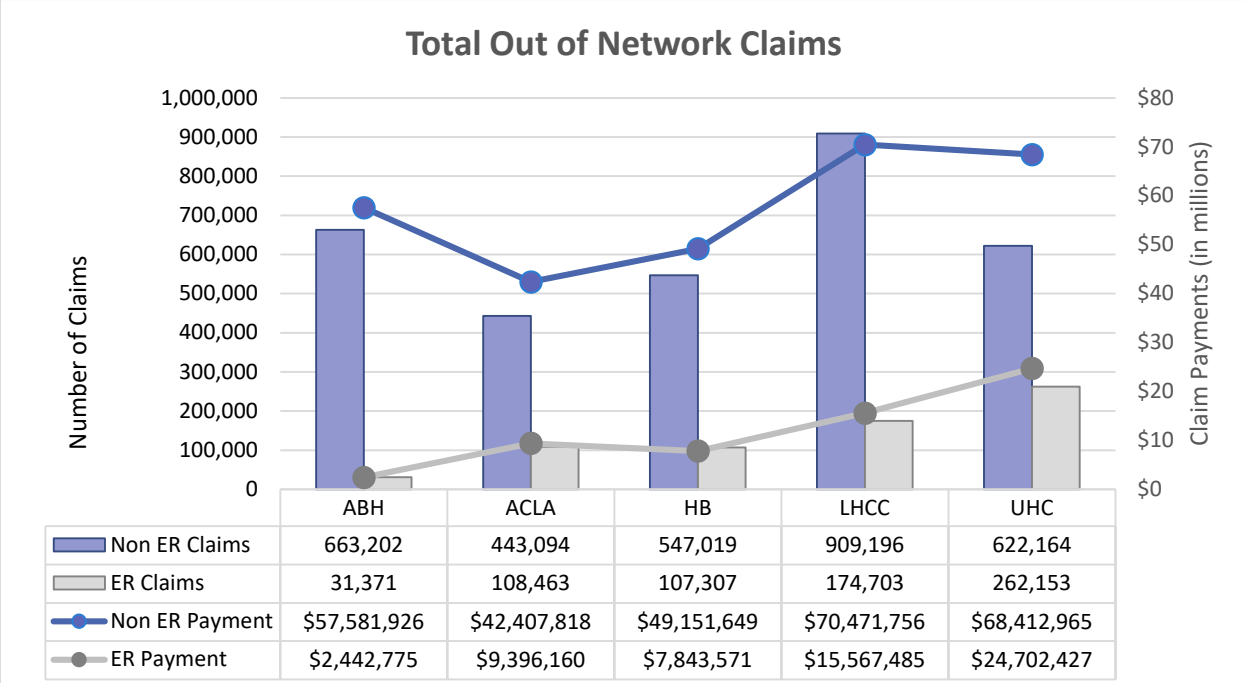
The total number and dollar value of all claims paid to out-of-network providers by claim type categorized by emergency services and nonemergency services for each managed care organization by parish.

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 22.1 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 22.1 Out of network claims, State Fiscal Year 2020



	ABH	ACLA	HB	LHCC	UHC
Non ER Claims	663,202	443,094	547,019	909,196	622,164
ER Claims	31,371	108,463	107,307	174,703	262,153
Non ER Payment	$57,581,926	$42,407,818	$49,151,649	$70,471,756	$68,412,965
ER Payment	$2,442,775	$9,396,160	$7,843,571	$15,567,485	$24,702,427

Source: Report 177 Total and Out of Network Claims

23 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 (IR) 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 2020, LDH received 470 requests for independent review of which 82 were deemed ineligible based on statutory requirement. Overall, 47% of the 388 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 23.1 provides a breakdown of total independent review requests received by claim type and status. Table 23.2 provides additional breakdown of independent review request by MCO.

Table 23.1 Requests for independent review submitted to LDH, State Fiscal Year 2020

	Behavioral Health	Hospital	Physician	Transportation	Total
Total requests received by LDH	**19**	**449**	**1**	**1**	**470**
Ineligible for independent review	11	71	0	**0**	82
Eligible for independent review	8	378	1	**1**	388
Settled by MCO & provider before IR decision	1	9	0	**0**	10
Fully overturned by IR	4	159	1	**1**	165
Partially overturned by IR	0	8	0	**0**	8
Upheld by IR	3	202	0	**0**	205
% of eligible cases settled, fully or partially overturned	62.5%	46.6%	100.0%	100.0%	47.2%

Source: LDH Independent Review Tracking System

Table 23.2 Independent review determinations by claim type and MCO, State Fiscal Year 2020

	ABH	ACLA	HB	LHCC	UHC
Total requests received – All claim types	**52**	**78**	**117**	**6**	**217**
Ineligible for independent review	18	15	7	1	41
Eligible for independent review	34	63	110	5	176
Settled by MCO & provider before IR decision	2	1	0	0	7
Fully overturned by IR	16	20	47	3	79
Partially overturned by IR	0	0	4	0	4
Upheld by IR	16	42	59	2	86
% of eligible cases settled, fully or partially overturned	52.9%	33.3%	46.4%	60.0%	51.1%
Total requests received – Behavioral Health	**10**	**1**	**3**	**2**	**3**
Ineligible for independent review	7	1	1	1	1
Eligible for independent review	3	0	2	1	2
Settled by MCO & provider before IR decision	1	0	0	0	0
Fully overturned by IR	1	0	1	1	1
Partially overturned by IR	0	0	0	0	0
Upheld by IR	1	0	1	0	1
% of eligible cases settled, fully or partially overturned	66.7%	--	50.0%	100.0%	50.0%
Total requests received – Hospital	**42**	**77**	**113**	**4**	**213**
Ineligible for independent review	11	14	6	0	40
Eligible for independent review	31	63	107	4	173
Settled by MCO & provider before IR decision	1	1	0	0	7
Fully overturned by IR	15	20	45	2	77
Partially overturned by IR	0	0	4	0	4
Upheld by IR	15	42	58	2	85
% of eligible cases settled, fully or partially overturned	51.6%	33.3%	45.8%	50.0%	50.9%

Source: LDH Independent Review Tracking System

(table continued)

Table 23.2 Independent review determinations by claim type and MCO, State Fiscal Year 2020

(continued)

	ABH	ACLA	HB	LHCC	UHC
Total requests received – Physician	**0**	**0**	**0**	**0**	**1**
Ineligible for independent review	0	0	0	0	0
Eligible for independent review	0	0	0	0	1
Settled by MCO & provider before IR decision	0	0	0	0	0
Fully overturned by IR	0	0	0	0	1
Partially overturned by IR	0	0	0	0	0
Upheld by IR	0	0	0	0	0
% of eligible cases settled, fully or partially overturned	--	--	--	--	100%
Total requests received – Transportation	**0**	**0**	**1**	**0**	**0**
Ineligible for independent review	0	0	0	0	0
Eligible for independent review	0	0	1	0	0
Settled by MCO & provider before IR decision	0	0	0	0	0
Fully overturned by IR	0	0	1	0	0
Partially overturned by IR	0	0	0	0	0
Upheld by IR	0	0	0	0	0
% of eligible cases settled, fully or partially overturned	--	--	100.0%	--	--

Source: LDH Independent Review Tracking System

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 2020, 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 is reflected in this 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 2020

		ABH	ACLA	HB	LHCC	UHC
Total prescription claims	#	**2,234,120**	**3,523,302**	**5,834,222**	**7,583,390**	**7,009,332**
Subject to prior authorization	#	121,140	73,356	435,494	516,817	128,658
	%	5.42%	2.08%	7.46%	6.82%	1.84%
Denied	#	531,975	782,102	1,361,710	1,871,409	1,431,903
	%	23.81%	22.20%	23.34%	24.68%	20.43%
Subject to step therapy or fail first protocol	#	96,790	32,267	40,213	95,354	53,180
	%	4.33%	0.92%	0.69%	1.26%	0.76%

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 2020[24]

	ABH	ACLA	HB	LHCC	UHC
Average response time (hours)	9.1	11.7	2.3	3.3	3.6
Response time range (hours)[25]	0.0 - 44.4	0.0 - 38.7	0.0 - 357.3	0.0 - 478.4	0.0 - 194.3

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 2020

	ABH	ACLA	HB	LHCC	UHC
Not Medically Appropriate	7,402	924	8,716	16,579	17,082
Not a Covered Benefit	789	971	151	1,162	916
Administrative - Lack of Information	0	10,191	5	1	111
Reduced Authorized	15	0	92	0	1,829
Other	1,183	0	7	640	0
Total Denials	9,389	12,086	8,971	18,382	19,938

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 2020

	ABH	ACLA	HB	LHCC	UHC
The number of claims denied after prior authorization was approved	25,539	20,153	39,364	61,969	54,183

Source: Report 173 Denied Claims - Pharmacy

[24]Includes all determinations: approved, denied, reduced, voided or withdrawn.
[25]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 2020 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 2020, 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 2020

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	IngenioRx	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 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 482 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. 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 2020 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. Monthly transaction fees data is provided in Appendix XII.

Table 25.2 Transaction fees paid by MCO to PBM, State Fiscal Year 2020

ABH	ACLA	HB	LHCC	UHC	Total
$1,151,860	$5,408,433	$2,609,965	$6,992,730	$9,642,885	$25,805,873

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. MCOs may still collect rebates if available on non-PDL items such as diabetic testing supplies. Since there is a 3 to 12-month delay between the date of service and the actual receipt of rebate payments, a portion of rebates received by the MCOs are for services provided prior to May 1, 2019. As the runout period comes to an end, the rebates received by the MCO/PBM will decline as they will be directly collected by the Department.

Table 25.3 details the total rebates received and retained by the PBM or MCO in State Fiscal Year 2020. Monthly rebate collections are available in Appendix XII. No rebates collected by the PBMs in State Fiscal Year 2020 were remitted to the Department.

Table 25.3 Rebates and discounts retained by the MCO or PBM, State Fiscal Year 2020

ABH	ACLA	HB	LHCC	UHC	Total
$2,183,884	$2,956,301	$2,737,468	$5,740,489	$7,062,543	$20,680,685

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 482 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 2020. Negative amounts are reflective of adjustments made to prior payments. Monthly data is available in Appendix XII.

Table 25.4 Amount retained by the PBM through spread pricing, State Fiscal Year 2020

ABH	ACLA	HB[26]	LHCC	UHC	Total
$0	$0	-$986	$0	$0	-$986

Source: 054 Pharmacy Benefit Management & Rebate monthly report

All other monies paid to the PBM and not reimbursed to pharmacies are captured in Table 25.5. Prior to the implementation of Act 482 limiting payments for pharmacy benefit management to a transaction fee basis, some MCOs used other payment methodologies that included administrative fees. 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 prior to May 1, 2019, included fees for administration items as footnoted below.

Table 25.5 Other monies retained by the PBM that are not reimbursed to pharmacists, SFY 2020

ABH	ACLA	HB[27]	LHCC	UHC	Total
$0	$0	$847	$0	$0	$847

Source: 054 Pharmacy Benefit Management & Rebate monthly report

[26] Spread pricing amounts reported by Healthy Blue are reflective of claims paid and adjustments made for services received prior to May 2019.

[27] Other monies reported by Healthy Blue are listed as fees for vaccine administration, member notification or contract transition, and coordination of benefits billed quarterly for services received prior to May 2019.

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 requirements 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 2020 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 of the annual Transparency Report are compiled using the same static eligibility and claims datasets pulled in December 2020 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 Appendix XIII.

26 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 2020, the unduplicated count of expansion enrollees enrolled in a health plan was 632,716. Table 26.1 provides a breakdown of enrollees by age and health plan for fiscal year 2020. Fiscal year totals are unduplicated and therefore will not equal the sum or counts by health or age cohort.

Table 26.1 Expansion enrollment by age cohort and MCO, State Fiscal Year 2020[28]

	ABH	ACLA	HB	LHCC	UHC	TOTAL
Ages 19 to 49	50,490	66,518	104,314	137,977	149,714	**496,828**
Ages 50 to 64	19,104	17,658	29,457	31,857	37,907	**132,915**
Ages 65+	465	423	579	712	822	**2,973**
Total	**70,059**	**84,599**	**134,350**	**170,546**	**188,443**	**632,716**

Source: Medicaid Data Warehouse

[28] Due to the dynamic nature of Medicaid enrollment and to provide for claims lag the dataset for this annual Transparency Report was extracted in December 2020, and will not necessarily match the data previously extracted and reported in the quarterly transparency reports.

27 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 27.1 presents the number of expansion enrollees in each MCO with earned income, employer based or self-employment, 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. Approximately 61% of the expansion population for State Fiscal Year 2020 had earned income.

Table 27.1 Unduplicated expansion enrollees with earned income by age cohort and MCO, State Fiscal Year 2020[29]

	ABH	ACLA	HB	LHCC	UHC	TOTAL
Ages 19 to 49	30,905	43,987	67,993	94,430	100,949	**330,058**
Ages 50 to 64	8,488	8,242	13,564	15,576	18,002	**62,190**
Total	**39,027**	**51,854**	**80,874**	**109,154**	**118,007**	**388,999**

Source: Medicaid Eligibility Data System

[29] Due to the dynamic nature of Medicaid enrollment and to provide for claims lag the dataset for this annual Transparency Report was extracted in December 2020, and will not necessarily match the data previously extracted and reported in the quarterly transparency reports

28 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 2020, the Department paid a total of $3,659,143,009 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 28.1 Total payments to MCOs for expansion population, State Fiscal Year 2020

ABH	ACLA	HB	LHCC	UHC
$386,337,312	$483,153,536	$748,496,743	$960,542,697	$1,080,612,721

Source: ISIS/CP-012 and Medicaid Data Warehouse

Table 28.2 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 28.2 Total payments for dental benefits for expansion population, State Fiscal Year 2020

	MCNA
SFY 20 Payments	$14,121,316

Source: ISIS/CP-012 and Medicaid Data Warehouse

29 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 2020 were $2,070,841,911 for the expansion population and $2,726,720,215 for the non-expansion population. This includes claims payments made to providers by the MCOs for these select services and does not include payments made under the fee-for-service program. Approximately 43% 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 29.1 and 29.2 on the following page provide the expenditures for the expansion population and the non-expansion population.

Table 29.1 Utilization and expenditures for specified services for expansion population enrolled in managed care, State Fiscal Year 2020[30]

EXPANSION		Age Cohort 0 to 18	Age Cohort 19 to 49	Age Cohort 50 to 64	Age Cohort 65+	Total
Emergency Department	Recipient	0	201,007	49,404	0	249,337
	Payment	$0	$73,642,865	$19,287,671	$0	$92,930,536
Hospital Inpatient	Recipient	0	40,316	13,303	0	53,534
	Payment	$0	$312,566,971	$159,713,558	$0	$472,280,530
Hospital Outpatient	Recipient	0	273,364	92,756	0	363,015
	Payment	$0	$230,411,450	$161,959,199	$0	$392,370,649
NEMT	Recipient	0	18,279	9,479	0	27,534
	Payment	$0	$9,681,703	$4,987,514	$0	$14,669,217
Pharmacy	Recipient	0	330,739	110,086	0	435,368
	Payment	$0	$509,740,499	$297,208,207	$0	$806,948,706
Physician	Recipient	0	323,362	102,225	0	421,856
	Payment	$0	$193,495,654	$98,146,618	$0	$291,642,272

Source: Medicaid Data Warehouse

Table 29.2 Utilization and expenditures for specified services for non-expansion population enrolled in managed care, State Fiscal Year 2020[30]

NON-EXPANSION		Age Cohort 0 to 18	Age Cohort 19 to 49	Age Cohort 50 to 64	Age Cohort 65+	Total
Emergency Department	Recipient	268,877	90,697	26,780	781	385,213
	Payment	$68,257,597	$37,622,382	$14,467,702	$294,806	$120,642,487
Hospital Inpatient	Recipient	46,374	35,869	9,312	455	91,865
	Payment	$366,968,695	$223,151,156	$137,770,148	$5,683,262	$733,573,261
Hospital Outpatient	Recipient	384,739	131,139	43,412	1,616	556,783
	Payment	$167,865,380	$142,083,330	$123,703,023	$3,361,333	$437,013,066
NEMT	Recipient	16,029	16,119	16,157	5,673	53,307
	Payment	$6,331,951	$11,332,496	$13,904,581	$4,981,365	$36,550,392
Pharmacy	Recipient	535,345	153,573	51,246	2,649	734,717
	Payment	$309,628,815	$320,754,085	$266,592,842	$5,094,371	$902,070,113
Physician	Recipient	606,762	152,232	47,741	2,200	802,473
	Payment	$308,452,141	$121,731,555	$64,634,666	$2,052,534	$496,870,896

Source: Medicaid Data Warehouse

[30] Due to the dynamic nature of Medicaid enrollment and to provide for claims lag the dataset for this annual Transparency Report was extracted in December 2020, and will not necessarily match the data previously extracted and reported in the quarterly transparency reports

Dental Benefits Program

Dental Benefit Program Manager (DBPM or dental plan)

On July 1, 2014, the state began providing comprehensive dental services to Medicaid eligible children and adult dentures to full-benefit eligible adults through a single prepaid ambulatory health plan (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. A PAHP provides services to enrollees under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use state plan payment rates. 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 Early and Periodic Screening, Diagnostic and Treatment (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 ICF/IIDs, and individuals who are 21 years of age and older that are certified as Qualified Medicare Beneficiary Only.

30 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 2020 reporting period, the Department contracted with a single vendor to operate its dental benefit program serving Medicaid enrollees.

Table 30.1 Name of contracted dental benefit program manager entity, State Fiscal Year 2020

Plan Name	Plan Type	Common Abbreviation
MCNA Insurance Company, Inc.	Dental Benefit Program Manager	MCNA

Source: Medicaid managed care contracts

31 MANAGED CARE EMPLOYEES – DENTAL PROGRAM

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

The Dental Benefit Program Manager is also required by the Department to maintain certain 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 2020, MCNA reported 8.6 full-time equivalent in-state staff. The average annual salary for MCNA employees based in Louisiana was $76,263.

Table 31.1 Total number of full-time equivalent (FTE) and average salary for MCNA employees based in Louisiana, State Fiscal Year 2020

	MCNA Dental
Total number of LA employees (FTEs)	8.6
Average salary paid	$76,263

Source: 017 Annual Report to LDH

32 PAYMENTS TO MANAGED CARE ORGANIZATIONS – DENTAL

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.

In State Fiscal Year 2020, the Department paid a total of $160,249,029 to MCNA for the administration of the Medicaid dental benefits management program. Capitation payments were determined with assistance from the Department's contracted actuary, Mercer, based on the number of Medicaid enrollees eligible for and enrolled in the dental program for the month and were paid in the month following enrollment, i.e., June enrollment was paid in July. Table 32.1 below shows the total payments the Department made to MCNA and the average PMPM for each month in State Fiscal Year 2020.

Table 32.1 Payments to MCNA for dental benefit program members by month, State Fiscal Year 2020

	MCNA	
	Total Payments	**Average PMPM**
Jul-19	$12,783,276	$8.51
Aug-19	$0	$0.00
Sep-19	$0	$0.00
Oct-19	$40,680,513	$26.78
Nov-19	$13,095,782	$8.67
Dec-19	$12,620,905	$8.39
Jan-20	$12,977,192	$8.54
Feb-20	$13,088,338	$8.67
Mar-20	$13,186,099	$8.71
Apr-2	$13,364,674	$8.66
May-20	$13,541,172	$8.65
Jun-20	$14,911,078	$9.38
Total	$160,249,029	$8.75

Source: ISIS and MARS Data Warehouse. 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 2020:

- Aug '19: No dental PMPMs paid pending approval of new contract.
- Sep '19: No dental PMPMs paid pending approval of new contract.
- Oct '19: Includes PMPMs for August, September, in addition to October

33 NUMBER OF HEALTHCARE PROVIDERS - DENTAL

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 covered dental services is an important goal of the Dental Benefit Program Manager. MCNA is required to maintain minimum ratios of contracted providers to enrollees for covered services. The Department conducts ongoing monitoring of the number of contracted providers and requires MCNA to submit quarterly geo-spatial analyses with provider locations.

Per contract requirements, MCNA submitted a registry of all providers that have contracted with the dental 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. The provider registry is maintained via weekly updates to the fiscal intermediary as needed.

There are a total of 1,806 dental providers contracted with MCNA to provide Medicaid covered dental services. Provider counts by provider type, taxonomy and parish are provided in Appendix XIV. It should be noted, however, that the unduplicated totals below will not match the provider totals in Appendix XIV as providers can enroll as more than one provider type, taxonomy, and in more than one parish.

Table 33.1 Total unduplicated[31] count of contracted providers in DBPM, State Fiscal Year 2020[32]

	MCNA Dental
Total Contracted Providers	1,806

Source: MARS Data Warehouse, June 26, 2020 Provider Registry

[31] 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 may be counted multiple times.

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

34 MEMBER AND PROVIDER SATISFACTION SURVEYS - DENTAL

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. MCNA monitors member satisfaction via their inbound call center. The results are summarized and reported to the Louisiana Department of Health on an annual basis. The full member and provider survey reports for SFY 2020 can be found in Appendix XV: Member and Provider Satisfaction Surveys.

35 AUDITED FINANCIAL STATEMENTS - DENTAL

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 the DBPM to have a license or certificate of authority issued by LDI to operate as Medicaid risk-bearing entities pursuant to Title 22:1016 of the Louisiana Revised Statutes.

The calendar year 2019 full financial statement for MCNA can be found in Appendix XVI.

36 BENEFIT HEALTH OUTCOMES - DENTAL

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 2020, MCNA covered 859,770 Medicaid enrollees under the age of 21. Of those, 377,040 members (43.9%) saw a dentist for at least one service.

Table 36.1 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, 94% received oral prophylaxis services. Composite fillings were the second most common procedure for this age group, received by 21% of members under the age of 21 who had a dental service.

Table 36.1 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 2020

Code Description	Total members receiving procedure	As a percent of members who saw a dentist
Oral prophylaxis (teeth cleaning)	352,896	93.6%
Composite fillings	77,458	20.5%
Fluoride varnish	72,827	19.3%
Dental Sealants	35,763	9.5%
Stainless steel crowns	30,535	8.1%
Extractions of primary teeth	28,932	7.7%
Amalgam fillings	27,334	7.2%
Pulpotomies performed on primary teeth	13,448	3.6%
Extractions of permanent teeth	12,508	3.3%
Root canals performed on permanent teeth	5,561	1.5%

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 2020, MCNA covered 906,007 unduplicated adult members for denture services, of which 10,543 (1.2%) 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 2020, 26% 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 36.2 and 36.3.

Table 36.2 Eligibility and utilization data for value added dental benefits by health plan, State Fiscal Year 2019

	ABH	ACLA	HB	LHCC	UHC	Total
Eligible Enrollees (Full-benefit Adults age 21+)[33]	82,220	105,504	159,132	200,750	221,469	**749,529**
Number who saw a dentist	10,107	11,747	22,487	25,848	32,983	**103,172**
The percent of eligible patients that saw a dentist	12.29%	11.13%	14.13%	12.88%	14.89%	**13.76%**

Source: MARS data warehouse

Teeth cleaning was the most common service received, followed by extraction of permanent teeth and fillings. Table 36.3 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 36.3 Utilization rates for value added dental services by health plan, State Fiscal Year 2020[34]

		ABH	ACLA	HB	LHCC	UHC
Adult oral prophylaxis	Count	4,472	4,550	9,685	8,920	14,420
	Utilization	44.25%	38.73%	43.07%	7.37%	43.72%
Extractions of permanent teeth	Count	3,591	4,493	8,638	8,222	10,957
	Utilization	35.53%	38.25%	38.41%	6.79%	33.22%
Composite fillings	Count	2,029	2,145	4,545	5,013	7,296
	Utilization	20.08%	18.26%	20.21%	4.14%	22.12%
Amalgam fillings	Count	252	264	592	732	918
	Utilization	2.49%	2.25%	2.63%	0.60%	2.78%

Source: MARS Data Warehouse

[33] Includes full benefit enrollees only, partial benefit enrollees were not covered for value-added dental services.
[34] The denominator for utilization rates by procedures is the unduplicated count of individuals who had at least 1 dental service.

37 MEMBERS THAT FILED APPEALS OR ACCESSED STATE FAIR HEARING PROCESS AND RESULTS - DENTAL

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.

Enrollees have the right to file appeals with both the DBPM and the state if they believe they have been unfairly denied benefits or access to services. Federal law requires the DBPM to administer a system for members to file appeals, and all states are required to review reports on both the frequency and nature of appeals filed as well as the steps DBPM 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 DBPM.

An appeal, which must be acted on within 30 days, is a request by a member to review one of the following actions that the DBPM 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 the DBPM to maintain records of appeals and submit them for state review. When reviewing the records, the Department analyzed the subjects of the appeals to identify the extent to which they are valid and/or are in the actual control of the health plan. In State Fiscal Year 2020, there were 48 determinations made under the dental program administered by MCNA with an overall 33% reversal rate.

Table 37.1 Appeals and state fair hearings, State Fiscal Year 2020

	MCNA
Total Members (unduplicated)	1,768,422
Members who filed an appeal	50
Members who accessed SFH	2
Total appeals filed at health plan level	50
Total appeals filed at SFH level	2
Total appeal & SFH determinations[35]	48
Total determinations fully or partially reversed in favor of the member	16
% of determinations fully or partially reversed in favor of the member	33.3%

Source: 113 Grievance, Appeal and Fair Hearing Report

[35]Total determinations may include determinations made in SFY 2020 for appeals received in a prior year.

38 CLAIMS SUBMITTED BY HEALTHCARE PROVIDERS - DENTAL

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.

MCNA report claims data annually using the revised 177 reporting template developed by the Department, which captures unduplicated counts of claims received by each managed care entity. 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 2020, there were 3,077,259 claims submitted to MCNA for dental services. The breakdown of unduplicated claim counts for State Fiscal Year 2020 is presented in table 38.1.

All claims accepted in the system for adjudication (determination of payment or denial) can be categorized as emergency or non-emergency.

Claims that do not meet the specific data requirements or the basic format necessary will be rejected according to CMS. “Rejected” claims are different from denied claims, as they are not adjudicated and are rejected before entering the 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.

Table 38.1 Total claims submitted, State Fiscal Year 2020

	Rejected Claims	Emergency Services	Non-Emergency Services	Total
MCNA	0	5,561	3,071,698	**3,077,259**

Source: Report 177 Total and Out of Network Claims

39 DENIED CLAIMS - DENTAL

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 [CARC] published by the Washington Publishing Company.

Table 39.1 below provides total unduplicated claims denied by MCNA delineated by emergency and non-emergency services. Table 39.1 provides a listing of the top ten reasons for claim denial which encompass 83% of all claim denials. The complete listing of all CARCs for denied claims for MCNA is provided in Appendix XVII.

Table 39.1 Total unduplicated denied claims, State Fiscal Year 2020

	Emergency Services	Non-Emergency Services	Total
MCNA	814	274,826	**275,640**

Table 39.2 Ten most prevalent reasons for claim denial by CARC, State Fiscal Year 2020[36]

CARC	Code Description	# Claims Denied	% of Claims Denied
169	Alternate benefit has been provided.	50,943	17%
18	Exact duplicate claim/service	44,039	15%
96	Non-covered charge(s).	35,887	12%
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period.	33,363	11%
6	The procedure/revenue code is inconsistent with the patient's age.	21,115	7%
252	An attachment/other documentation is required to adjudicate this claim/service.	14,656	5%
22	This care may be covered by another payer per coordination of benefits.	13,982	5%
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.	10,823	4%
16	Claim/service lacks information or has submission/billing error(s).	9,822	3%
169	Alternate benefit has been provided.	7,596	3%
Total	**TOTAL TOP TEN CLAIM DENIAL REASON CODES**	**242,226**	**83%**

Source: Report 173 Denied Claims

[36] Each claim denied may have multiple CARC codes therefore totals includes duplication.

40 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 contract defines 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.

In State Fiscal Year 2020, MCNA received a total of 2,098,604 clean claims. This total includes claims that were paid, denied or otherwise adjudicated based on the original claim submittal without the need for additional information. It does not include rejected claims, which do not meet the definition of a clean claim. Of the clean claims submitted 2,063,720 were paid. This total does not include other claims paid after additional information or verifications was received or the original claim was adjusted.

The DBPM is 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 DBPM 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. Delineation of turnaround times by claim type are provided in table 40.1.

Table 40.1 MCNA prompt pay performance for paid clean claims, State Fiscal Year 2020

	EPSDT Dental	Adult Denture	All Paid Clean Claims
Total Clean Claims Paid	2,058,543	5,177	2,063,720
Percent paid within 15 days	99.94%	100.00%	99.94%
Percent paid within 30 days	100.00%	100.00%	100.00%
Average number of days to pay clean claims	7.03	7.17	7.03

Source: 221 Prompt Pay Report

41 PRIOR AUTHORIZATION REQUESTS - DENTAL

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 2020, MCNA completed prior authorizations on a total of 164,585 requests. In alignment with a more expansive benefit for children, 82% of authorizations were for members under the age of 21. Table in table 41.1 provides a breakdown by age group and procedure code.

Table 41.1 Number of prior authorization requests processed by DBPM by type of procedure, State Fiscal Year 2020

Type of Procedure	Children EPSDT (under 21 years)	Adult Denture (21 years & older)	Total Number of Prior Authorization Requests
0100-0999 Diagnostic	1,464	8,513	9,977
1000-1999 Preventive	5,918	8	5,926
2000-2999 Restorative	35,731	117	35,848
3000-3999 Endodontics	12,675	49	12,724
4000-4999 Periodontics	1,299	13	1,312
5000-5899 Removable Prosthodontics	606	20,575	21,181
5900-5999 Maxillofacial Prosthodontics	6	1	7
6000-6199 Implant	13	1	14
6200-6999 Fixed	67	3	70
7000-7999 Oral/Maxillofacial surgery	43,448	239	43,687
8000-8999 Orthodontics	623	1	624
9000-9999 Adjunctive/other	32,997	83	33,080
Procedure code not specified	67	68	135
Total	**134,914**	**29,671**	**164,585**

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 41.2 provides the average and range of authorization processing times for both children and adults by type of procedure.

Table 41.2 Times for responding to prior authorization requests by DBPM, State Fiscal Year 2020

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	1.5	0 - 5	0.8	0 – 5
1000-1999 Preventive	1.2	0 - 5	0.8	0 – 2
2000-2999 Restorative	1.2	0 - 21	0.8	0 – 4
3000-3999 Endodontics	1.1	0 - 5	0.5	0 – 3
4000-4999 Periodontics	1.5	0 - 5	1.1	0 – 4
5000-5899 Removable	1.5	0 - 5	0.8	0 – 5
5900-5999 Maxillofacial	1.8	0 - 4	1.0	1 – 1
6000-6199 Implant	0.9	0 - 1	1.0	1 – 1
6200-6999 Fixed	1.6	0 - 4	0.0	0 – 0
7000-7999 Oral	1.3	0 - 10	1.1	0 – 9
8000-8999 Orthodontics	1.7	0 - 5	0.0	0 – 0
9000-9999 Adjunctive	1.4	0 - 21	1.3	0 – 4
Procedure code not specified	0.8	0 - 3	0.6	0 – 3
All prior authorizations	**1.3**	**0 - 21**	**0.8**	**0 – 9**

Source: MCNA Quarterly 188 Prior Authorization Reports

Prior Authorizations Denials

Of the 164,585 prior authorizations MCNA completed during State Fiscal Year 2020, 37,284 (22%) were denied. At 23%, the denial rate for children was slightly higher the adult denial rate of 19%.

There can be multiple denial reasons associated with each authorization request. As a result, the number of denied authorizations by denial reason code (61,853) is greater than the number unduplicated denied authorizations; therefore, these items are reported independent of each other. MCNA used a total of 34 unique reasons for denial of prior authorizations. Table 41.3 includes the ten most frequently used authorization denial codes, which accounted for 82% 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 XVIII.

Table 41.3 Ten most prevalent reasons for authorization denial by DBPM, State Fiscal Year 2020

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.	12,053	0	12,053
18	This request has been previously reported and an approval or denial was issued.	5,700	883	6,583
96	This procedure is considered non-covered in accordance with either the program benefits or the facility contract with MCNA.	4,566	1,373	5,939
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.	3,111	2,000	5,111
169	The clinical reviewer has recommended an alternate procedure/benefit.	4,698	69	4,767
252	Please submit x-ray(s) and narrative with this request.	3,518	362	3,880
50	The clinical reviewer has determined that the treatment is in excess of the member's needs.	3,474	22	3,496
16	Please submit a readable and most current bitewing and a periapical x-ray with endodontic requests.	3,330	154	3,484
49	This procedure is not covered in conjunction with the reported service(s).	2,751	205	2,956
269	This procedure can only be considered when reported and performed in conjunction with covered services.	2,414	0	2,414
TOTAL TOP TEN AUTHORIZATION DENIAL REASON CODES		**45,615**	**5,068**	**50,683**

Source: MCNA Quarterly 188 Prior Authorization Reports

Claims Denied After Prior Authorization Approved

In State Fiscal Year 2020, MCNA denied a total of 275,640 claims. Of these 16,696 (6%) were claims for services that had been previously prior authorized; however, the claim or documentation provided did not meet the criteria for payment. Table 41.4 includes the ten most frequently used 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 XVIII. It should be noted that the data reflect only initial denials and do not reflect if a claim was resubmitted and subsequently paid.

Table 41.4 Ten most prevalent reasons for claim denial after prior authorization was approved by DBPM, State Fiscal Year 2020

CARC	Code Description	Total
18	Exact duplicate claim/service	5,452
252	An attachment/other documentation is required to adjudicate this claim/service	2,620
16	Claim/service lacks information or has submission/billing error(s)	1,284
269	Anesthesia not covered for this service/procedure	1,111
22	This care may be covered by another payer per coordination of benefits	1,070
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment	942
272	Coverage/program guidelines were not met	699
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	549
96	Non-covered charge(s)	497
169	Alternate benefit has been provided	370
Total	**TOTAL TOP TEN CLAIM DENIAL REASON CODES**	**14,594**

Source: Report 173 Denied Claims

LIST OF APPENDICES