Medicaid Managed Care Transparency Report

Agency Response to La. Revised Statute 40:1253.2

Louisiana Department of Health

Bureau of Health Services Financing

June 30, 2017

LOUISIANA DEPARTMENT OF HEALTH

Contents

Introduction

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

- improved care coordination with patient-centered medical homes for Medicaid recipients;
- 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 plans and primary care case management (PCCM) known as shared savings plans. The state contracted with three prepaid and two shared savings plans, and individuals were given the option of choosing the plan that best met their needs. However, not all Medicaid services were available from health plans, and some health plan members continued to receive certain services under the fee-for-service program. In addition, many individuals covered by Medicaid were not eligible to enroll in and receive services from a health plan.

The program has continued to evolve with each year of operation. LDH has progressively integrated services and populations into the Medicaid Managed Care Program. The following timeline includes major milestones in the growth of our managed care program:

- Pharmacy benefits were “carved-in” to the prepaid plan benefit package on November 1, 2012.
- Dental benefits have been provided to all Medicaid populations under a single Dental Benefits Program Manager (DBPM) since July 1, 2014.
- The delivery model was transitioned from three risk-bearing MCOs and two shared-savings PCCMs to five risk-bearing MCOs on February 1, 2015.
- Hospice benefits were added on February 1, 2015.
- EPSDT PCS benefits were added on February 1, 2015.
- Retroactive linkages to Healthy Louisiana were implemented on February 1, 2015.
- Specialized behavioral health benefits were added on December 1, 2015.

The ability to “opt-out” of physical health services was eliminated as of December 1, 2015, for the following populations: children under age 19 with a disability or special healthcare need, children in foster care, and Native Americans/Alaskan Natives. The populations became mandatory participants in Healthy Louisiana. Prior to December 1, 2015, all specialized behavioral health services were provided through the managed care program as a carve out service under the Louisiana Behavioral Health Partnership operated by Magellan.

To facilitate the integration of SBH services, members already enrolled in a health plan began to receive their specialized behavioral health services through their existing plan. For other individuals, eligible for specialized behavioral health services but not currently enrolled in managed care, a special open enrollment period was held in the fall of 2015 to give them an opportunity to choose their own plan for behavioral health service continuation. For ease of access and coordination, all non-emergency transportation services (NEMT) for this partial benefits group are also provided by their chosen health

plan. The partial benefits group continues to receive all physical health and long-term care services through fee-for-service Medicaid. It is also worth noting that while there was much planning and outreach for Medicaid expansion during this reporting period, the effective eligibility date for the expansion population began on July 1, 2016, and are therefore not covered in this reporting period. Medicaid expansion will be addressed in the State Fiscal Year 2017 report.

This report includes 26 measures as outlined in La. Revised Statute 40:1253.2. It covers program operations for July 2015 through June 2016 (State Fiscal Year 2016), except the following measures which are reported on a calendar year basis per the contract between the Department and the health plans:

Section 7 – Medical Loss Ratio
Section 8 – Health Outcomes
Section 9 – Member and Provider Satisfaction Surveys
Section 10 – Audited Financial Statements
Section 25 – Medicaid Drug Rebates

Information included in this report was collected from multiple sources. To the greatest extent possible, the data is extracted from state systems which routinely collect and maintain operational data on the Medicaid Managed Care Program. When unavailable from state sources, data were collected from the health plans, sourced from either routine reporting deliverables or ad hoc reports requested specifically for this purpose. The Medicaid Management Information System (MMIS) and the Management Administrative Reporting Subsystem (MARS Data Warehouse) are maintained by the Medicaid program contracted fiscal intermediary, which in State Fiscal Year (SFY) 2016 was Molina Healthcare. Detailed recipient 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 health plans.

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 conjunction with their annual external quality reviews. Additionally, plans are contractually required to obtain accreditation from the National Committee for Quality Assurance (NCQA) for their Medicaid health plan serving Louisiana members. NCQA accreditation involves a rigorous process involving comprehensive reviews of the plans' policies, procedures and practices. For State Fiscal Year 2016, four of the health plans had obtained accreditation from NCQA. Aetna as a new plan was in the process of applying for accreditation.

In addition to standing operational quality assurances and EQRO reviews, the data included in this report was 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 health plans or the Department used to generate data. For data originating from the MARS Data Warehouse or the MMIS, Myers and Stauffer generated its own data from encounters or data extracts for each health plan and compared its results to the results the Department produced. For data originating from the health plans, Myers and Stauffer reviewed plan responses to a survey developed by Myers and Stauffer to document the process the plans used to generate the data, as well as policies and procedures in place to collect, track and report data. Where Myers and Stauffer found inconsistencies above or below the 10 percent variance threshold established by the Department, they made recommendations to the Department and/or the health plan to improve the method used to collect data. See Appendix XII for the survey instrument.

Medicaid Managed Care

During State Fiscal Year 2016, more than a million Louisiana Medicaid and Louisiana Children's Health Insurance Program (LaCHIP) enrollees received physical health, basic and specialized behavioral services under the Medicaid Managed Care Program through one of five managed care organizations contracted with the state. In addition, the state provides comprehensive dental services to Medicaid eligible children and adult dentures through a single, prepaid ambulatory health plan (PAHP). The covered populations and services for each model of managed care are described below.

Managed Care Organizations (Health Plans)
Managed care organizations, also called prepaid health plans in Louisiana, are risk-bearing entities that provide a wide array of Medicaid-covered benefits and services to enrolled members in exchange for a monthly capitation payment for each member. The plans contract directly with healthcare providers and manage all aspects of service delivery, including reimbursement of providers. The health plans 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 must be specified in Louisiana's approved Medicaid State Plan.

With the integration of specialized behavioral health services, most individuals were mandatorily enrolled in a health plan for both physical and behavioral health services. Some individuals, primarily those in a home and community-based waiver program, were required to enroll in a health plan for behavioral health coverage, but were also given the option to receive physical health services through their health plan or continue to receive them through the Medicaid fee-for-service program. A small number of individuals remained excluded from enrollment in a health plan and continued to receive services under fee-for-service. Medicaid populations excluded from enrollment in a health plan in State Fiscal Year 2016 after behavioral health integration were as follows:

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

Additionally, the following carved out services will continue to be Medicaid fee-for-service and were not included in the managed care benefit package:

- Applied Behavior Analysis
- ICF/DD Services
- Personal care services (21 and over)
- Long Term Care (LTC)/Nursing facility services
- Waiver services
- Early Steps
- Medicare Crossover Services

Dental Benefit Program Manager (Dental Plan)
The state provided comprehensive dental services to Medicaid eligible children and adult dentures 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. 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 Recipients 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 Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), and individuals who are 21 years of age and older that are certified as Qualified Medicare Beneficiary Only.

1 CONTRACTED MANAGED CARE PLANS

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

For the State Fiscal Year 2016 reporting period, the Department contracted with five managed care organizations to manage physical and behavioral healthcare services. In addition, the Department contracted with a single vendor to operate its dental benefit program serving all Medicaid recipients. The names and common abbreviations of the health plans and the dental plan are in Table 1.1 in alphabetical order by plan type.

Table 1.1: Names of contracted health plans, State Fiscal Year 2016

Plan Name	Plan Type	Common Abbreviation
Aetna Better Health	Managed Care Organization	AETNA
Amerigroup Louisiana, Inc.	Managed Care Organization	AMG
Amerihealth Caritas Louisiana, Inc.	Managed Care Organization	ACLA
Louisiana Healthcare Connections, Inc.	Managed Care Organization	LHCC
UnitedHealthcare of Louisiana, Inc.	Managed Care Organization	UHC
Managed Care of North America, Inc.	Dental Benefit Program Manager	MCNA

Source: Health plan contracts

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 high-level 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; and fraud, waste and abuse investigators and others. For other positions, plans had the option to staff locally or leverage parent company resources out of state, such as call center staff. It is also important to note that the data included was for all staff who worked for the health plan within the year and not necessarily the number of positions dedicated to the health plan. Therefore, if there was turnover in a given position during the year, both employees (the former and the new one) were included in the count.

Table 2.1: Total number of Louisiana employees and average salary, State Fiscal Year 2016

	AETNA	AMG	ACLA	LHCC	UHC
Total number of LA Employees	152	161	205	574	343
Average Salary	$62,067	$71,659	$66,810	$62,397	$58,500

Source: Revised P015 SFY 16 Report to LDH

In 2016, each of the five health plans increased the total number of Louisiana-based employees, with a total increase from 921 local employees in 2015 to 1,435 local employees in 2016. This represents a 56 percent aggregate increase in the number of Louisiana-based employees across all plans. The increase in staffing for individual plans ranged from 25 percent at Aetna to 83 percent at UnitedHealthcare. The increases across plans are largely attributed to the increase staffing to support the inclusion of specialized behavioral health services.

The weighted average annual salary of Louisiana-based employees in 2016, was $63,100, a two percent increase from the 2015 average salary of $62,147. Aetna and Amerigroup both reported slight decreases in average salaries of 5 percent and 9 percent respectively. The three other plans each reported increases ranging from 5 to 6 percent. Variances in the average salary across plans largely reflect the mix of positions located in state. Some plans have a larger share of lower salary positions in state, such as call center staff, whereas others have a larger share of higher salary positions in state, such as clinical staff performing prior authorization functions.

The Dental Benefit Program Manager is also required by the Department to maintain in-state staff. The positions that Managed Care of North America, Inc. (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 2016, MCNA reported 8.4 fulltime equivalent local staff with an average salary of $53,276, shown in Table 2.2. In addition to the required local staff, MCNA reported that contracted clinical reviewers and member and provider relations staff were also domiciled in Louisiana. In comparison to data reported for 2015, this reflects a 24 percentage decrease in direct MCNA local staffing and a 15 percent reduction in the average salary. These decreases were attributed to a stabilization of operations post implementation and an increase in locally contracted staff. MCNA continues to meet contractual staffing requirements.

Table 2.2: Total number of Louisiana employees and average salary for Dental Benefit Program Manager, State Fiscal Year 2016

	MCNA Dental
Total number of LA employees	8.4
Average Salary	$53,276

Source: Revised P015 SFY 16 Report to LDH

3 PAYMENTS TO MANAGED CARE ORGANIZATIONS

The amount of the total payments and average per member per month (PMPM) payment paid by the state to each managed care organization delineated monthly.

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

Beginning on December 1, 2015, with the integration of specialized behavioral health services there were two distinct member groups:

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

In State Fiscal Year 2016, the Department paid a total of $3,799,247,076 to all five managed care organizations for all member groups combined. Total unduplicated enrollment was 1,127,092 full benefit members and 122,286 behavioral health only members. The average PMPM payments to individual plans ranged from $281.47 to $535.02 for full benefit members and $20.48 to $25.49 for behavioral health & NEMT only members. 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.

Similarly, health plans with higher risk scores had higher average PMPM rates. Risk scores reflect the health status of total plan membership. A risk score of 1.0 reflects a membership of average health. A risk score of greater than one reflects a membership that is sicker than the average. A risk score of less than one reflects a membership that is healthier than the average. Risk adjustment applies risk scores to a universal PMPM rate to compensate plans for the relative financial risk of their membership.

The data on payments to the health plans for each member group are provided separately in tables 3.1 and 3.2.

Table 3.1: Total payments and average PMPM by plan for full benefit members, State Fiscal Year 2016

	AETNA		AMG		ACLA		LHCC		UHC	
	Total Payments	Average PMPM	Total Payments	Average PMPM	Total Payments	Average PMPM	Total Payments	Average PMPM	Total Payments	Average PMPM
Jul-15	$15,901,784	$462.76	$48,160,931	$319.29	$50,726,740	$326.56	$95,221,511	$263.80	$80,755,877	$278.08
Aug-15	$21,438,763	$590.58	$50,208,880	$331.37	$52,122,037	$335.70	$96,798,773	$268.06	$82,019,479	$280.58
Sep-15	$20,352,757	$543.51	$51,150,203	$335.50	$53,357,996	$342.72	$99,196,613	$274.32	$84,440,353	$286.96
Oct-15	$16,477,577	$430.13	$48,504,218	$317.05	$49,745,600	$319.52	$93,540,242	$258.29	$81,579,949	$275.95
Nov-15	$21,700,433	$557.58	$54,922,742	$359.08	$55,019,359	$354.67	$103,224,766	$285.65	$90,706,370	$306.56
Dec-15	$21,820,200	$537.47	$52,606,947	$342.91	$56,248,143	$367.89	$104,679,582	$289.35	$92,224,841	$310.19
Jan-16	$40,718,550	$993.18	$100,232,672	$649.68	$100,881,688	$666.93	$196,470,639	$542.21	$169,241,820	$571.73
Feb-16	$8,376,834	$204.92	$19,339,012	$125.55	$19,320,731	$129.00	$36,807,894	$101.80	$31,793,127	$107.70
Mar-16	$25,115,107	$615.20	$59,104,991	$384.46	$59,058,086	$397.55	$119,464,625	$331.22	$104,332,108	$353.93
Apr-16	$23,683,498	$583.90	$57,850,673	$377.34	$56,646,834	$384.45	$114,848,023	$320.08	$99,589,427	$338.87
May-16	$21,667,145	$537.70	$59,812,491	$392.78	$59,203,134	$406.77	$115,486,833	$324.51	$101,243,546	$346.39
Jun-16	$14,176,910	$350.51	$22,654,078	$149.20	$16,000,471	$110.77	$40,996,274	$115.65	$41,734,391	$142.94
Total	**$251,429,559**	**$535.02**	**$624,547,840**	**$340.61**	**$628,330,819**	**$345.82**	**$1,216,735,775**	**$281.47**	**$1,059,661,290**	**$300.19**

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

The average PMPM is calculated as the total of all payments made to an MCO in a given month divided by total membership for that MCO in the same month. This calculation is therefore impacted by off-cycle payment adjustments (such as lump sum estimated payments or recoupments). Variation in the averages among the MCOs is also a result of the unique "member mix" of each MCO – that is, by the distribution of enrollees between eligibility categories that are reimbursed at different rates, dependent on the health risk of that eligibility group. As such, this average does not necessarily correlate to the composite risk-adjusted capitation rate payment in effect for that MCO for a given month. Off-cycle payment adjustments for State Fiscal Year 2016 include:

1. January 2016 – Lump Sum payout ($271.36M) for December PMPMs due to delay in receiving risk-adjusted rates; recouped in February
2. February 2016 – Recoupment of lump sum payout ($-271.36M) for Dec PMPMs
3. Majority of PMPM payouts pushed to July 2016 due to budget constraints

Table 3.2: Total payments and average PMPM by plan for partial benefit: behavioral health & NEMT only members, State Fiscal Year 2016

	AETNA		AMG		ACLA		LHCC		UHC	
	Total Payments	Average PMPM	Total Payments	Average PMPM	Total Payments	Average PMPM	Total Payments	Average PMPM	Total Payments	Average PMPM
Jan-16	$470,542	$20.82	$451,436	$21.03	$437,496	$20.75	$491,175	$20.82	$535,824	$21.38
Feb-16	$115,720	$5.14	$381,130	$17.77	$383,140	$18.13	$837,397	$35.45	$679,423	$27.10
Mar-16	$675,981	$30.06	$656,665	$30.59	$625,303	$29.55	$730,815	$30.85	$778,906	$31.02
Apr-16	$683,645	$30.54	$632,312	$29.56	$585,425	$27.80	$736,670	$31.16	$819,406	$32.70
May-16	$653,894	$29.28	$653,176	$30.53	$614,399	$29.21	$723,497	$30.46	$779,533	$31.07
Jun-16	$638,618	$28.66	$652,892	$30.48	$611,919	$29.07	$723,601	$30.40	$781,854	$31.13
Total	**$3,238,400**	**$20.48**	**$3,427,611**	**$22.73**	**$3,257,682**	**$21.96**	**$4,243,154**	**$25.49**	**$4,374,946**	**$24.79**

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

Capitation payments to MCNA for the dental benefit program were based on the number of Medicaid recipients eligible for and enrolled in the dental program for the month and were paid during the month of enrollment, i.e., July enrollment paid for in July. Table 3.3 below shows the total payments the Department made to MCNA and the average PMPM for each month for State Fiscal Year 2016.

Table 3.3: Total payments and average PMPM based on date of payment for dental benefit program, State Fiscal Year 2016

	MCNA Dental	
	Total Payments	Average PMPM
July-15	$11,421,309	$10.28
Aug-15	$14,528,058	$13.03
Sep-15	$12,914,066	$11.52
Oct-15	$13,070,737	$11.62
Nov-15	$13,139,377	$11.69
Dec-15	$13,007,286	$11.59
Jan-16	$15,258,620	$13.62
Feb-16	$12,918,117	$11.56
Mar-16	$12,967,320	$11.63
Apr-16	$12,892,793	$11.61
May-16	$12,807,452	$11.60
Jun-16	$12,713,922	$11.55
Total	**$157,639,057**	**$11.78**

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

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 received the total number of contracted providers for each health plan through weekly provider network registries submitted by the plans. It is important to note that the total number of healthcare providers contracting with a health plan cannot be used in isolation as an indicator of network adequacy and member access. Provider networks may consist of both in-state and out-of-state providers, and some contracted providers may limit the number of health plan enrollees they will see or have closed their panels to new plan members in order to maintain access and quality of care to current clients. Section 6 includes data on providers with closed panels. Appendix I lists contracted providers by provider type, provider taxonomy, and parish.

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 contract providers. The provider registry data were updated on a regular weekly cycle. Currently, the MARS data warehouse does not maintain historical information on the provider registry and reflects only the most current status of all providers for a given point in time. For the purposes of the 2016 Transparency Report, data on provider network status as of June 29, 2016, is presented in Table 4.1 below.

Table 4.1: Total unduplicated[1] count of contracted providers by health plan, State Fiscal Year 2016

	AETNA	AMG	ACLA	LHCC	UHC
Total Contracted Providers	27,041	15,866	18,245	21,420	41,636

Source: LDH MARS Data Warehouse, June 29, 2016 Provider Registry

Overall, the number of contracted providers for each health plan increased at least 22 percent from last year's reporting. The majority of the increase was attributed to the addition of behavioral health providers beginning in December of 2015. In general the network size for each plan was reflective of the membership size; however, a few differences in the reporting of data across plans was noted. Both Aetna and UnitedHealthcare reported a significantly higher percentage of out of state contracted providers, 62 percent and 34 percent respectively, as compared to a range of 3 to 9 percent for the other three plans. The large majority of Aetna's out of state providers were pharmacies, while UnitedHealthcare's out of state providers were dispersed across several provider types. The larger scale of out of state providers for Aetna and UnitedHealthcare are contracted through the health plan's national network. Also noted, at the time of the provider registry extract (June 2016), Amerihealth Caritas did not report any pharmacies in its registry; however, Amerihealth Caritas independently reported 2,631 pharmacies contracted in-

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

network during State Fiscal Year 2016 on the Myers and Stauffer survey and has since corrected its registry. The department is working with the health plans to correct errors and increase the consistency in data reported across health plans.

State Fiscal Year 2016 was the second year of operation of the dental benefit program. MCNA reported 1,130 contracted providers reflecting a 13 percent increase from 2015.

Table 4.2 Total unduplicated[1] count of contracted providers in dental benefit program, State Fiscal Year 2016

	MCNA Dental
Total Contracted Providers	1,130

Source: LDH MARS Data Warehouse, June 29, 2016 Provider Registry

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.

Based on recommendations from Myers and Stauffer, the methodology for identifying contracted providers of primary care services in accordance with statutory requirements was refined for 2016 reporting to reflect services delivered by health plan designated primary care providers (PCP) in the provider registry. The listing of contracted 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 2016. The corresponding claims were further limited to those specialty types: 01-General Practice, 08-Family Practice, 16-OB/GYN, 37-Pediatrics, 41-Internal Medicine, 42-Federally Qualified Health Center, Clinic or Group Practice, 79-Nurse Practitioner, and 94 –Rural Health Clinic. Due to the change in methodology, this data is not directly comparable to data reported in 2015, but it is believed to more accurately reflect legislative intent. This methodology will be further enhanced with improved verification and consistency in the data reported across health plans.

Total unduplicated provider counts for 2016 are presented in Table 5.1. Appendix II lists primary care providers with at least one claim by provider type, provider taxonomy and parish.

Table 5.1: Total unduplicated[2] contracted primary care providers with at least one claim, State Fiscal Year 2016

	AETNA	AMG	ACLA	LHCC	UHC
PCPs with one claim	1,568	1,555	4,620	3,150	2,500

Source: MARS Data Warehouse, June 29, 2016 Provider Registry

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

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

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.

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 3,000 patients so that appropriate care and time was given to each person during their appointment.

Table 6.1 shows the number of providers with a closed panel by health plan for State Fiscal Year 2016. Data for the providers with a closed panel were extracted by the department from provider registry files maintained in the MARS data warehouse. As noted, there were differences in how each health plan reported closed panels in the registry according to their internal policies, accounting for variation in closed panels reported across plans. It does not mean the data are wrong according to current contract requirements, but for some plans it may understate the actual number of physicians and specialists who are not accepting new patients. For example, Amerihealth Caritas and UnitedHealthcare report panel status for all provider types. Aetna and Louisiana Healthcare Connections report panel status for primary care providers only, and Amerigroup reported panel status for primary care and non-emergency transportation providers. Additional data by provider type, taxonomy and parish can be found in Appendix III.

Table 6.1: Unduplicated[3] Contracted providers with a closed panel, State Fiscal Year 2016

	AETNA	AMG	ACLA	LHCC	UHC
Closed Panels	653	1,727[4]	4,660	106	30,489

Source: MARS Data Warehouse: June 29, 2016 Provider Registry

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

[4] Amerigroup recognized that non-emergent medical transportation (NEMT) providers are listed as a closed panel in its system where they should be listed as having a no panel status. This is being corrected currently, but will not have an impact until the FY17 transparency report data pull. At the time of this submission, AMG registry contained 1,049 NEMT providers with closed panels.

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.

Health plans that received capitation payments to provide benefits and services to Louisiana Medicaid members were required to rebate a portion of the capitation payment to the Department in the event the plan did not meet the 85-percent medical loss ratio standard. Plan contracts required that a minimum of 85 percent of payments made by the Department for Louisiana Medicaid members was used to reimburse providers for services or for certain specified purposes related to quality improvement and health information technology costs.

Health plans are required to submit audited annual medical loss ratio reports, which are based on a calendar year, by June 1 of the following year that summarized how the plans spent their capitation payments. The methodology established by the Department to calculate the annual medical loss ratio was adapted from the methodology CMS established in 2011 for calculating medical loss ratio 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.

If a health plan did not meet the 85 percent minimum requirement, it was required to pay the Department a rebate. In Calendar Year (CY) 2015, all five managed care organizations met the 85-percent minimum and were not required to pay any rebates. Louisiana Healthcare Connections had the lowest medical loss ratio at 86.8 percent. Aetna had the highest at 97.1 percent, which was driven by a smaller member population with high inpatient and outpatient medical expenses. Louisiana Healthcare Connections explained that its MLR is in part due to its lower PMPM (as indicated in Section 3), and therefore aligned with the risk scoring of its member population which had a very high percentage of children, who are typically healthier and less costly. For more detail, refer to Table 7.1.

Data and analysis are based on draft reports provided by Myers and Stauffer following its examination of calendar year (CY) 2015 MLR rebate calculation data reported by the health plans. Final reports are expected to be delivered to LDH in late June of 2017. As required by the Managed Care Administrative Rule, the MLR reports are independently audited, and the audited reports are posted on the Medicaid website at http://ldh.louisiana.gov/index.cfm/page/2142 as they are received and validated each year.

Table 7.1: Medical Loss Ratios, Calendar Year 2015

	AETNA	AMG	ACLA	LHCC	UHC
Adjusted Current YTD MLR Capitation Revenue	$177,132,930	$585,449,389	$603,562,887	$1,107,421,482	$901,378,349
Total Adjusted MLR Expense	$172,041,333	$534,713,858	$542,888,310	$961,029,166	$786,414,909
MLR Percentage Achieved	97.1%	91.3%	89.9%	86.8%	87.2%
Dollar Amount of Rebate Required	$0	$0	$0	$0	$0

Source: MSLC Audited Medical Loss Ratio Reports

8 HEALTH OUTCOMES

A comparison of health outcomes, which includes but is not limited to the following, among each managed care organization:

- Adult asthma admission rate
- Congestive heart failure admission rate
- Uncontrolled diabetes admission rate
- Adult access to preventative/ambulatory health services
- Breast cancer screening rate
- Well child visits
- Childhood immunization rates

Health plans were required to track 37 performance measures of quality of care and report results to the Department. These included standardized measures from the following measurement sets:

- Healthcare Effectiveness Data and Information Set (HEDIS®), which are maintained by National Committee for Quality Assurance (NCQA);
- Prevention Quality Indicators (PQI), which are maintained by the Agency for Healthcare Research and Quality (AHRQ); and
- The Core Set of Children's Health Care Quality Measures from the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), which are maintained by the Center for Medicaid and CHIP Services (CMCS).

Results for the prior calendar year were due to the Department at the end of the subsequent year; as such, Calendar Year 2015 measures were due by the end of 2016. Of the six outcomes measures and the twelve childhood immunization rates reported as required by the legislation, in aggregate, all measures have improved under managed care compared to the fee-for-service baseline from 2011. Additionally, eleven of the twelve immunization rates improved in aggregate from Calendar Year 2014 to Calendar Year 2015 with the exception of influenza; however, only two of the six performance metrics, specifically the adult asthma admission rate and the breast cancer screening rate, have improved from the prior year as evidenced in Table 8.1 below.

Table 8.1: Aggregate outcome measures baseline and trend, Calendar Years 2013 – 2015

	CY 2011 Baseline Medicaid FFS	CY 2013 Aggregate Rate all Health Plans	CY 2014 Aggregate Rate all Health Plans	CY 2015 Aggregate Rate all Health Plans
Adult asthma admission rate (Age 18-39)	9.14[5]	7.73	6.14	3.95
Congestive heart failure admission rate	49.9[8]	37.09	39.79	40.95
Uncontrolled diabetes admission rate	5.93[8]	3.00	1.92	2.79
Adult access to preventative/ ambulatory health services	78.35%	82.95%	82.13%	81.31%
Breast cancer screening rate	42.65%	N/A	53.63%	55.55%
Well child visits in the 3rd, 4th, 5th and 6th years of life	35.45%	67.46%	63.74%	63.59%

[5] 2011 PQIs were recalculated to match current specifications (per 100,000 member months)

Childhood immunization rates				
DTaP	58.78%	68.30%	66.53%	73.87%
IPV	72.97%	82.87%	82.41%	87.17%
MMR	81.05%	86.15%	85.83%	87.60%
HiB	77.98%	84.62%	83.40%	86.26%
Hepatitis B	20.66%	75.60%	70.98%	87.44%
VZV	81.25%	85.96%	85.71%	87.83%
Pneumococcal conjugate	60.10%	69.49%	68.58%	75.09%
Hepatitis A	35.30%	81.13%	81.28%	83.99%
Rotavirus	49.96%	62.75%	58.65%	66.94%
Influenza	27.86%	37.23%	38.21%	35.96%
Combo 2	15.02%	53.07%	54.94%	67.70%
Combo 3	13.73%	50.30%	52.54%	64.37%

Sources: 2014 HEDIS®, 2015 HEDIS®, 2016 HEDIS® | 2011 Baseline & 2015 AHRQ PQI™ provided by ULM School of Pharmacy, Office of Outcomes Research

Table 8.2 shows the summary of health outcomes from Calendar Year 2015 operations by health plan. Excluding immunization rates, for the three prepaid health plans, Amerigroup, Amerihealth Caritas, and Louisiana Healthcare Connections, progress in health plan performance in the outcomes measures was indicated between CY2014 and CY2015 in three of the six reported measures including asthma in younger adults admission rate, heart failure admission rate, and breast cancer screening rate. The adult access to preventative/ambulatory health services rate decreased for Amerihealth Caritas, while the well child visit rate decreased for Louisiana Healthcare Connections. The uncontrolled diabetes admission rate increased for all three health plans in Calendar Year 2015 compared with the prior year. For childhood immunizations, Amerihealth Caritas improved in all measures, Amerigroup improved in all rates except Hepatitis A and B, while Louisiana Healthcare Connections' rates dropped in all immunizations except Rotavirus.

In 2015, LHCC added the members from Community Health Solutions, a former shared savings model plan would which impacted their scores. Additionally, UnitedHealthcare was converted from a shared savings plan to a prepaid plan in Calendar Year 2015 and so had much of the necessary infrastructure in place for measuring performance outcomes; however, due to changes in the overall management and provider network structure of the health plan, the data are not comparable across calendar years. As a new health plan, Calendar Year 2015 was Aetna's first reporting year, which consisted of only eleven rather than a full twelve months. Due to its newness and shorter reporting year, Aetna reported its first eligible year results for Calendar Year 2015 lower than each of the other four plans in each immunization status other than Hepatitis B and Combo 3 in which LHCC was lower on both measures. Aetna also had a lower asthma admission rate and uncontrolled diabetes admission rate compared to the other four plans; however, this is likely attributable to its lower membership. It should be noted that Aetna has N/A indicated on its results for the breast cancer screening rate because this HEDIS measure requires measurement back two years and so was not reportable in Calendar Year 2015.

Table 8.2: Health outcomes by health plan, Calendar Year 2015

	AETNA	AMG	ACLA	LHCC	UHC
Asthma In Younger Adults Admissions Rate[6,7]	0.99	2.37	4.65	4.08	4.95
Heart Failure Admission Rate [4, 8]	50.47	46.81	38.16	39.00	39.35
Uncontrolled Diabetes Admission Rate [4,5]	0.63	2.82	3.00	3.36	2.35
Adult Access to Preventative/ Ambulatory Health Services	73.32%	80.51%	82.37%	80.00%	83.66%
Breast Cancer Screening[9]	N/A	54.56%	57.97%	55.97%	53.37%
Well Child Visits	41.94%	54.40%	59.31%	66.59%	66.15%
Childhood Immunization Rates:					
Diphtheria, pertussis, and tetanus (DTaP)	47.62%	77.78%	72.92%	61.54%	78.35%
Polio Vaccine (IPV)	69.05%	92.13%	86.57%	77.16%	90.02%
Measles, mumps, and rubella (MMR)	61.90%	90.05%	86.11%	80.53%	90.51%
Haemophilus influenzae type B (HiB)	66.67%	89.81%	85.65%	75.48%	90.02%
Hepatitis B	69.05%	92.82%	86.81%	64.66%	95.86%
Varicella zoster virus (VZV)	64.29%	88.66%	86.11%	81.25%	91.24%
Pneumococcal Conjugate	54.76%	77.78%	74.54%	61.78%	80.29%
Hepatitis A	69.05%	84.03%	81.71%	74.28%	89.29%
Rotavirus	50.00%	71.99%	65.51%	56.97%	70.07%
Influenza	16.67%	38.19%	33.56%	28.61%	39.42%
Combo 2	42.86%	74.77%	68.52%	45.91%	74.45%
Combo 3	42.86%	71.53%	65.97%	40.87%	71.53%

Sources: 2016 HEDIS® (Jan 1-Dec 31, 2015 Measurement Year) | 2015 AHRQ PQI™ provided by ULM School of Pharmacy, Office of Outcomes Research

The Island Peer Review Organization (IPRO) validated all performance measures by following CMS's most current "validating performance measures" protocol. The validation of performance measures was conducted on a calendar year basis and results are published in the annual technical report in compliance with the requirements set forth in 42 C.F.R. § 438.240(b)(2). Validation of the health plan's quality assessment and performance improvement program included: (1) Review of the data management processes of the Medicaid managed care plan; (2) Algorithmic compliance (the translation of captured data into actual statistics) with specifications defined by the Department; and (3) Verification of performance measures to confirm that the reported results were based on accurate source information. The technical report also described the manner in which the data from the validation of performance measures were aggregated and analyzed and conclusions were drawn as to the quality, timeliness and access to the care furnished by the health plans.

As part of its validation, IPRO also provided a comparison of the three Louisiana Medicaid HEDIS measures to the average of other states in CMS's South Central Region according to the Quality Compass published by the National Committee for Quality Assurance (NCQA).[10] Figure 8.3 below reflects this comparison showing that Louisiana is slightly above the South Central median for breast cancer screenings and adult

[6]Rate per 100,000 Member Months

[7] Age is greater or equal to 18 at beginning of year and less than or equal to 39 on 15th of each month.

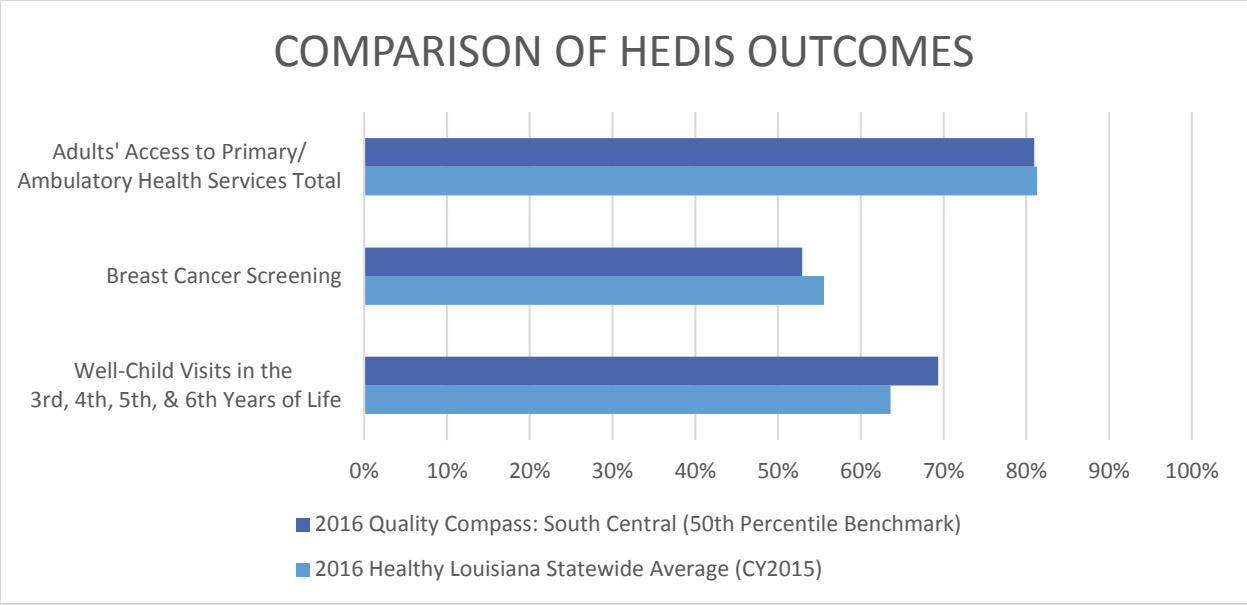
[8] Age: 18+ as of the 15 day of eligible month for the denominator; 18+ as of the date of admission for the numerator.

[9] The age range is 50-74 and the continuous enrollment is measured back to October 1 of two years prior.

[10] The CMS South Central Region comprises Arkansas, Louisiana, New Mexico, Oklahoma, and Texas

access to primary and ambulatory services, though we fall slightly below the benchmark for well child visits.

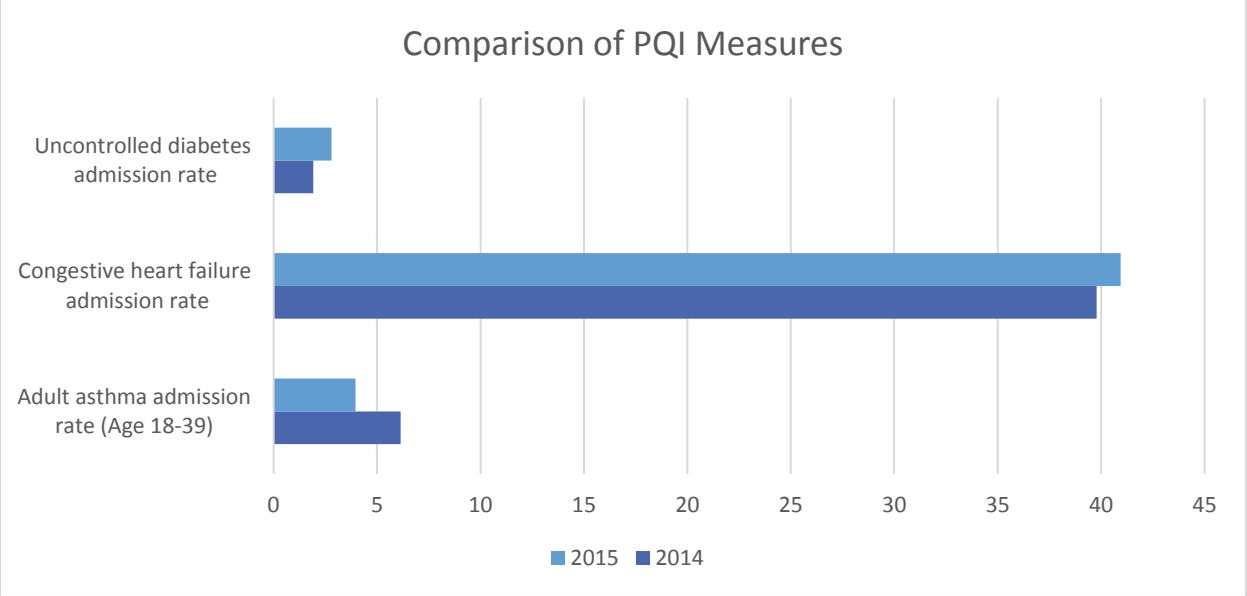
Figure 8.3: Aggregate comparison of Louisiana HEDIS measures to NCQA Quality Compass, (Calendar Year 2015 data reported in 2016)



Source: 2016 HEDIS® (Jan 1-Dec 31, 2015 Measurement Year); Island Peer Review Organization (IPRO)

Since Medicaid Inpatient Prevention Quality Indicators (PQI) are not nationally or regionally benchmarked by CMS in the same way it collects and ranks HEDIS measures, Figure 8.4 below provides a comparison of the three reported PQI measures by calendar year.

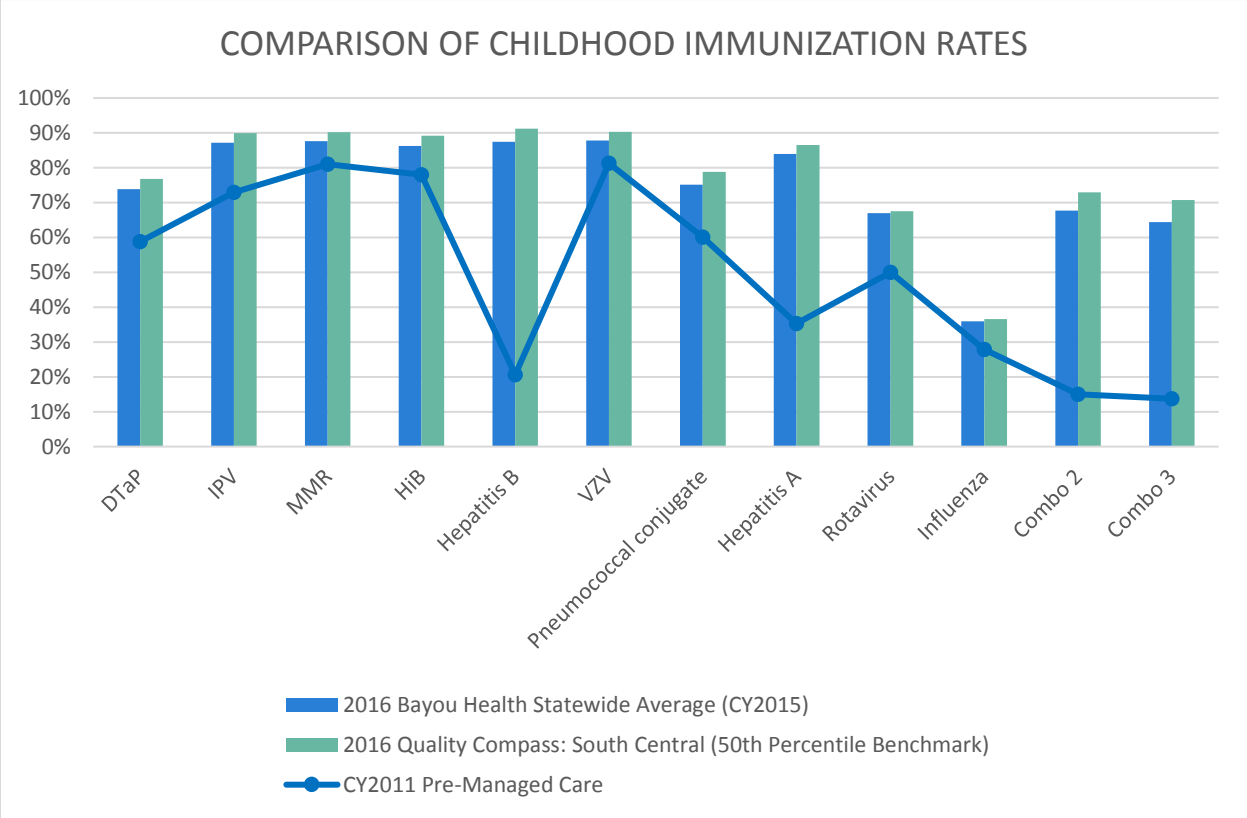
Figure 8.4: Aggregate comparison of PQI measures between Calendar Year 2014 and Calendar Year 2015



Source: 2015 AHRQ PQI™ provided by ULM School of Pharmacy, Office of Outcomes Research

Figure 8.5 reflects a comparison of the aggregate health plan immunization rates by vaccine against the South Central regional average as published in the 2016 Quality Compass by NCQA and immunization rate outcomes pre-managed care in 2011. In general, childhood immunization rates have continued to show steady improvement under Medicaid managed care, especially with regard to Hepatitis A & B and Combo 2 & 3 vaccines, which on average have improved approximately 54 percentage points due to the heightened outreach and linkages to care through an enhanced provider network afforded by managed care.

Figure 8.5: Comparison of Louisiana immunization rates to NCQA Quality Compass Benchmark (Calendar Year 2015 data reported in 2016)



Source: 2016 HEDIS® (Jan 1-Dec 31, 2015 Measurement Year); Island Peer Review Organization (IPRO)

9 MEMBER AND PROVIDER SATISFACTION SURVEYS

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

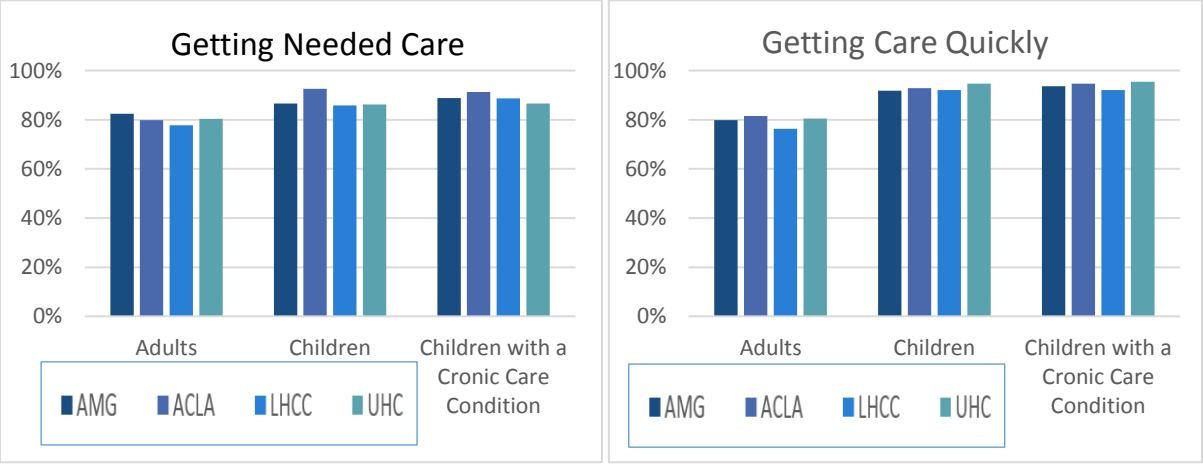
Member and provider satisfaction are measures of a patient's experience of care. Member satisfaction with their healthcare, which is considered an important component in managed care quality, can be defined as how members value and regard their care. The Department and health plans can use member and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

Member satisfaction 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 in regard to 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 on behalf of the health plans 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 within 120 days of the end of the contract year. With the start of the new managed care contract period beginning February 1, 2015, Aetna Better Health was a newly contracted health plan and not required to submit a 2015 CAHPS 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 annually by the EQRO. As an example of the data available, a comparison of 2015 CAHPS survey results for two core measures on access to care are presented in Figure 9.1 below. The full member survey reports for each health plan can be found in Appendix IV: Member Satisfaction Surveys.

Figure 9.1: Comparison of select access measure results from 2015 Consumer Assessment of Healthcare Providers and Systems (CAHPS) by health plan.



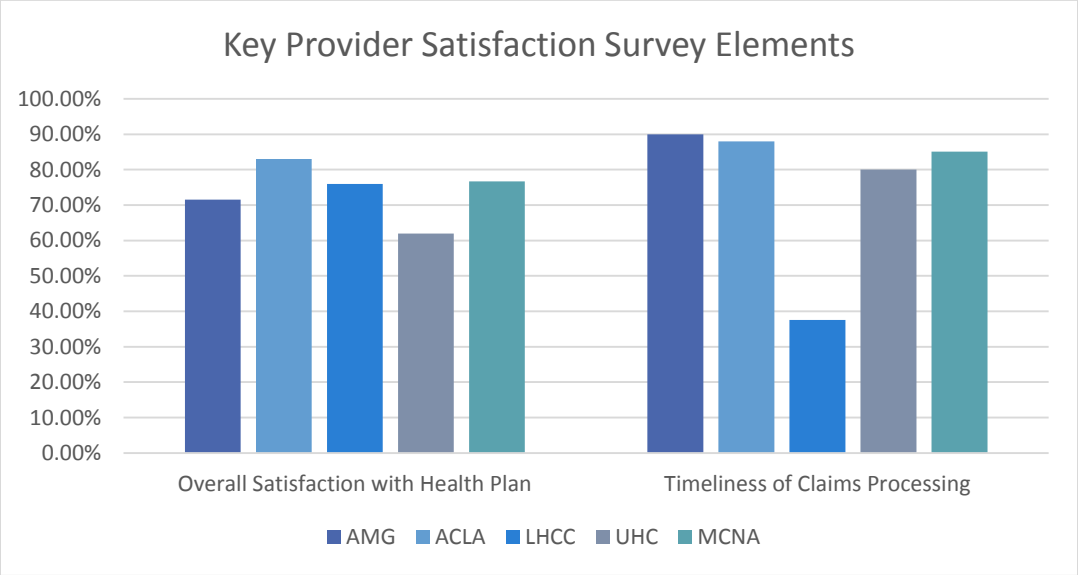
Source: EQR Health Plan Reports 2017 prepared by IPRO (http://new.dhh.louisiana.gov/index.cfm/page/2753)

Provider Satisfaction Survey

Unlike CAHPS, there are no national standard survey instruments for 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 as specified in the contract 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, both the survey instrument and methodology for each health plan were approved by the department prior to implementation. Figure 9.2 below compares two key satisfaction elements across health plans including overall satisfaction with the health plan and timeliness of claims processing.

It should be noted, however, that provider perception is not indicative of actual plan performance. Of particular note, Louisiana Healthcare Connections has met all claims processing turnaround time contractual requirements as outlined in Section 21 of this report.

Figure 9.2: Key provider satisfaction survey elements, Calendar Year 2015



Source: 133 Provider Satisfaction Survey Report

With the start of the new managed care contract period beginning February 1, 2015, Aetna Better Health was a newly contracted health plan and not required to submit a Calendar Year 2015 provider satisfaction survey as there was not a full year of data for the report.

See Appendix V for the Calendar Year 2015 provider satisfaction surveys for Amerigroup, Amerihealth Caritas, Louisiana Healthcare Connections, UnitedHealthcare, and MCNA.

10AUDITED 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 important 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 managed care organizations to have a license or certificate of authority issued by the Louisiana Department of Insurance (DOI) to operate as Medicaid risk-bearing entities pursuant to Title 22:1016 of the Louisiana Revised Statutes.

The full financial statements for each health plan can be found in Appendix VI. The statements are for Calendar Year 2015 which were reported during State Fiscal Year 2016.

11SANCTIONS LEVIED BY THE DEPARTMENT

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

There were no sanctions levied by the Department against any of the health plans during State Fiscal Year 2016.

More detailed information on levied sanctions is posted on the Department's website by contract period: http://ldh.louisiana.gov/index.cfm/page/1610.

12 DENTAL BENEFIT HEALTH OUTCOMES

For managed care organizations that administer dental benefits, a comparison of oral health outcomes that includes but is not limited to the percentage of eligible patients that saw a dentist in that fiscal year as well as the following rates of procedures performed on those who saw a dentist:

- Adult oral prophylaxis
- Child oral prophylaxis
- Dental sealants
- Fluoride varnish
- Amalgam fillings
- Composite fillings
- Stainless steel crowns
- Extractions of primary teeth
- Extractions of permanent teeth
- Pulpotomies performed on primary teeth
- Root canals performed on permanent teeth

For Medicaid enrollees under the age of 21, the dental program covers preventive, maintenance and restoration services such as fillings, fluoride treatments, and cleanings. In State Fiscal Year 2016, MCNA covered 876,531 Medicaid members under the age of 21. Of those, 409,748 members (46.8 percent) saw a dentist for at least one service.

For Medicaid enrollees over the age of 21 that were eligible for full Medicaid benefits, the dental program was limited to denture services included in the Medicaid State Plan. In State Fiscal Year 2016, MCNA covered 376,553 adult members for denture services, of which 6,334 (1.7 percent) saw a dentist for at least one service.

Table 12.1 shows the rates of utilization for members under the age of 21. Oral prophylaxis services, which is generally defined as is the removal of deposits from the tooth surfaces (teeth cleaning), was the most common dental procedure received by members under the age of 21. Reported under two separate billing codes by age group, an aggregated 94.6 percent of members who saw a dentist received oral prophylaxis services. At 20.2 percent and 12.3 percent respectively, a combination of composite fillings and amalgam fillings made fillings the second most utilized dental service for members under the age of 21.

Table 12.1: The rates of procedures performed on those patients under the age of 21 who saw a dentist through the Dental Benefit Program, State Fiscal Year 2016

	Total members received procedure	Rate of members who saw a dentist
Child oral prophylaxis (under 12 years of age)	278,080	67.9%
Adult oral prophylaxis (12 years & over)	109,540	26.7%
Composite fillings	82,585	20.2%
Fluoride varnish	77,053	18.8%
Amalgam fillings	50,360	12.3%
Dental sealants	43,794	10.7%
Stainless steel crowns	35,780	8.7%
Extractions of primary teeth	32,685	8.0%
Pulpotomies performed on primary teeth	17,349	4.2%
Extractions of permanent teeth	11,470	2.8%
Root canals performed on permanent teeth	5,975	1.5%

Source: MCNA Data Warehouse

Since MCNA only covers denture services for adults, on February 1, 2015, as a value added benefit to members, all five managed care organizations began offering a limited dental benefit. Value added services included adult dental services not covered under the Medicaid State Plan in addition to required emergency dental procedures. In State Fiscal Year 2016, 22,301 or 4 percent of eligible adult members received at least one dental service through their managed care organization, and 5,809 received other, emergency related dental services (1 percent). Extraction of permanent teeth was the most common service received, followed by teeth cleaning and fillings. Additional data on adult dental services are presented in Tables 12.2 and 12.3 by health plan.

Table 12.2: Eligibility and utilization data for dental benefits by managed care organization, State Fiscal Year 2016

	AETNA	AMG	ACLA	LHCC	UHC	Total
Eligible Members (Full Benefit Adults age 21+)	52,768	103,977	108,879	151,969	133,863	**551,456**
Number who saw a dentist	1,528	3,923	5,515	4,474	7,261	**22,701**
The percent of eligible patients that saw a dentist	2.9%	3.8%	5.1%	2.9%	5.4%	**4.1%**

Source: MARS data warehouse

Table 12.3: The rates of most common procedures performed on those patients over the age of 21 who received a dental service through their managed care organization, State Fiscal Year 2016

		AETNA	AMG	ACLA	LHCC	UHC
Extractions of permanent teeth	Count	0	958	2,129	0	2,826
	Utilization Rate	0.0%	24.4%	38.6%	0.0%	38.9%
Adult oral prophylaxis	Count	669	1,560	1,955	661	2,566
	Utilization Rate	43.8%	39.8%	35.4%	14.6%	35.3%
Composite fillings	Count	209	527	911	94	1,502
	Utilization Rate	13.7%	13.4%	16.5%	2.1%	20.7%
Amalgam fillings	Count	54	173	293	34	495
	Utilization Rate	3.5%	4.4%	5.3%	0.8%	6.8%

Source: MARS Data Warehouse

Health Plan Enrollees

13MEMBERS 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.

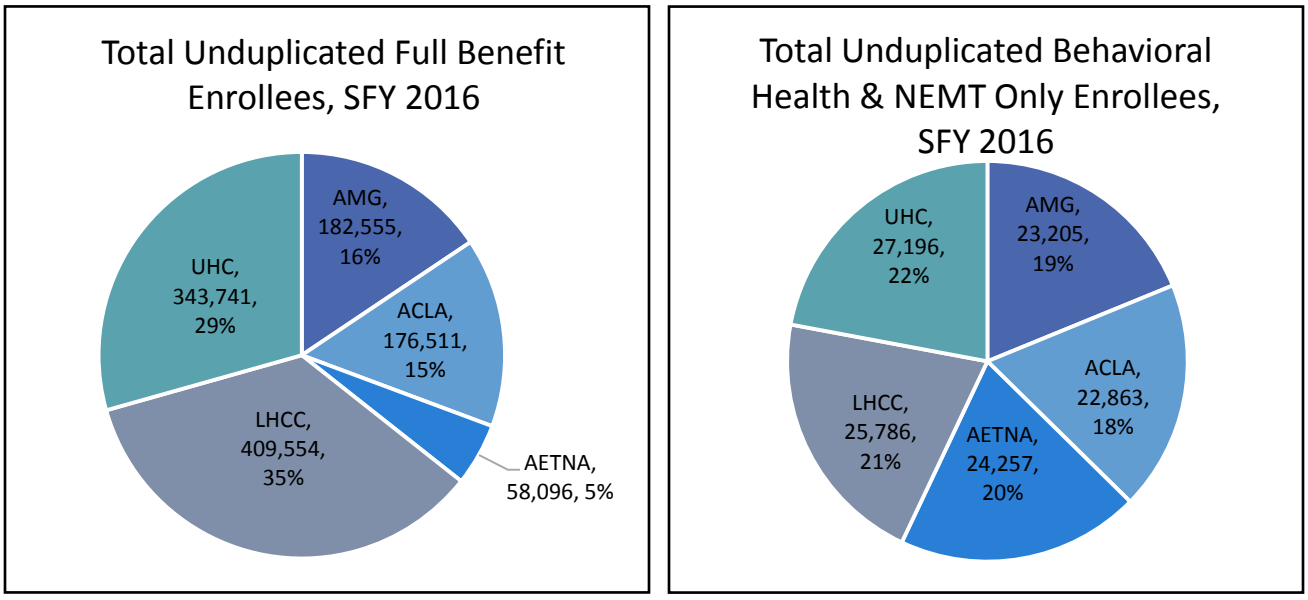
In State Fiscal Year 2016, the department enrolled 1,249,378 Medicaid recipients in a health plan. Ninety percent or 1,127,092 unduplicated recipients were enrolled for full benefits and 10 percent or 122,286 were enrolled with partial benefits including specialized behavioral health and non-emergency transportation (NEMT) services only. The distribution of total enrollees across health plans ranged from 6 percent in Aetna to 34 percent in Louisiana Healthcare Connections. Upon integration of specialized behavioral health services effective December 2015, partial benefit enrollees for specialized behavioral health and non-emergency transportation services only were auto-assigned via a more even distribution across plans. Table 13.1 and Figure 13.2 below provide a breakdown of enrollment totals by health plan and benefits covered.

Table 13.1: Total unduplicated enrollees by health plan and benefit group, State Fiscal Year 2016

	AETNA	AMG	ACLA	LHCC	UHC
Full Benefit Enrollees	58,096	182,555	176,511	409,554	343,741
Behavioral Health & NEMT Only Enrollees	24,257	23,205	22,863	25,786	27,196

Source: MARS Data Warehouse

Figure 13.2: Total enrollees by health plan, State Fiscal Year 2016[11]



Source: MARS Data Warehouse

For purposes of health plan reimbursement, enrollees were assigned to one of the eligibility categories listed below in State Fiscal Year 2016.

- *Families and Children*: Includes children and teens under the age of 19 whose basis of Medicaid or LaCHIP eligibility was age (children with disabilities are not included in this group) and their

[11] Due to changes in eligibility,

parents or caregivers. Also includes pregnant women whose primary basis of eligibility for Medicaid was pregnancy.

- *People with disabilities and Supplemental Security Income (SSI)-related seniors*: Includes 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)*: Includes 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.
- *Home and Community-Based Services (HCBS) Waiver*: Included individuals who are elderly or have disabilities and receive waiver services to assist them in remaining in their homes and in the community.
- *Chisholm*: All current and future recipients of Medicaid in the state of Louisiana under age 21 who are now or will in the future be placed on the Developmental Disabilities Request for Services Registry.

The breakdown of the average number of Medicaid enrollees by eligibility category for State Fiscal Year 2016 for Full Benefit members is provided in Table 13.3. For the full benefit population, the majority of members across all plans were enrolled in the Families and Children category, ranging from a low of 78.9 percent of Aetna's population and a high of 88.6 percent for UnitedHealthcare. Supplemental Security Income (SSI) members were a distant second accounting for an average of 11.8 percent of members across all plans. The remaining eligibility categories combined accounted for 2.3% or less of each plan's total membership.

Table 13.3: Average number of full benefit members enrolled each month delineated by eligibility category and health plan, State Fiscal Year 2016.

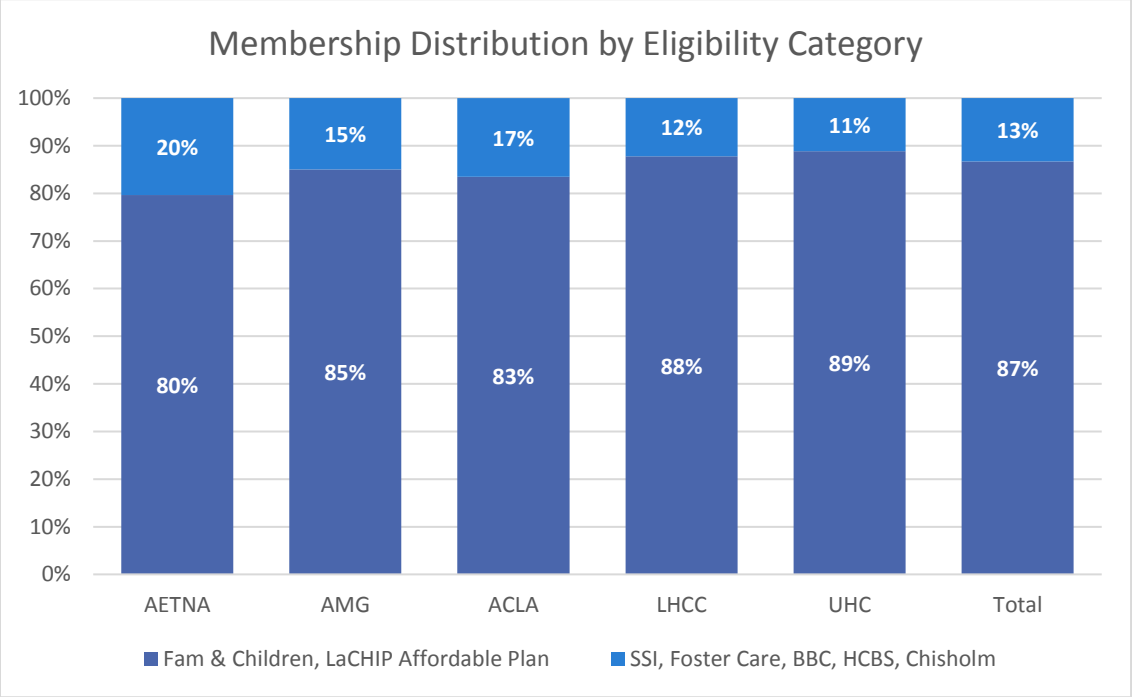
	AETNA	AMG	ACLA	LHCC	UHC	Total
Families & Children	30,914	129,466	126,039	315,132	260,651	**862,202**
SSI	7,335	20,248	23,086	37,926	29,026	**117,620**
Foster Care	373	2,035	1,240	5,107	2,678	**11,433**
BCC	97	232	308	278	273	**1,188**
LAP	275	422	362	1,005	817	**2,881**
HCBS Waiver	73	196	200	328	358	**1,155**
Chisholm	95	204	177	456	361	**1,293**
All Categories	**39,162**	**152,803**	**151,411**	**360,232**	**294,164**	**997,772**

Source: MARS Data Warehouse

While the percent distribution for some eligibility categories was small in the number of members represented, they may have significant differences in the relative health and related cost of healthcare. These differences in percent distribution of total enrollment by member demographics for each of the five health plans are important factors when looking at the number and types of providers, services, utilization and costs. The differences in demographics across plans were reflected by the eligibility group to which an enrollee was assigned. As an example, individuals in Family and Children, LaCHIP Affordable Plan (LAP) eligibility categories are generally healthier and less costly per member as compared to the SSI, Foster Care, Breast & Cervical Cancer, Home & Community-Based Service and Chisholm groups. Based on proportion distribution of full benefit members for State Fiscal Year 2016, Aetna had the highest variation

in membership by eligibility category. The Distribution of members enrolled in each health plan by eligibility category and enrollment type is displayed in Figure 13.3.

Figure 13.3: Full benefit membership distribution by eligibility category, State Fiscal Year 2016



Source: MCNA Data Warehouse

For the behavioral health and NEMT only population, the breakdown of membership for each health plan by eligibility category for State Fiscal Year 2016 is in Table 13.4.

Table 13.4: Average number of behavioral health & NEMT only members enrolled each month delineated by eligibility category and health plan, State Fiscal Year 2016.

	AETNA	AMG	ACLA	LHCC	UHC	Total
Chisholm	295	340	314	468	445	**1,861**
Dual Eligibles	8,306	7,858	7,789	8,635	9,122	**41,709**
HCBS Waiver	447	437	441	498	566	**2,389**
Other[12]	4,130	3,934	3,820	4,272	4,575	**20,731**
All Categories	**13,177**	**12,569**	**12,363**	**13,873**	**14,708**	**66,690**

Source: MARS Data Warehouse

[12] Specialized Behavioral Health and Non-Emergency Transportation Services were integrated 12/1/15. For December 2015 and January 2016, members were all put in "Other" category for rate setting purposes. Effective 2/1/15, they were grouped into Chisholm, Dual Eligibles, HCBS Waiver, and Other.

14PROACTIVE 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 indicate 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 can show good cause for doing so, for example, poor quality of care, to enroll in the same plan as family members, or documented lack of access to needed services.

Table 14.1 provides the individual plan and aggregate choice rates for State Fiscal Year 2016. Aetna and AmeriHealth Caritas have the lowest choice rates, both just under 25 percent. With a choice rate of 50 percent, UnitedHealthcare's rate remained the highest. The aggregate choice rate across all plans for 2016 was 37.6 percent, down from a rate of 53.7 percent in State Fiscal Year 2015. The 2016 choice rate may have been impacted by the large influx of new members associated with the December 1, 2015, integration of specialized behavioral health services. 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 a plan of their choice.

Table 14.1: Proactive choice rates, State Fiscal Year 2016

	AETNA	AMG	ACLA	LHCC	UHC	Total
Pro-active Choice Enrollments	18,516	31,481	18,986	53,893	67,790	**190,666**
Auto Enrollments	59,158	57,917	57,479	74,507	67,789	**316,850**
Total Enrollments	77,674	89,398	76,465	128,400	135,579	**507,516**
Choice rate	23.80%	35.20%	24.80%	42.00%	50.00%	**37.60%**

Source: Maximus Health Services

15ENROLLEES 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, such as within a given month or year. Section 15 provides information on Medicaid services provided by each of the health plans. Data are inclusive of paid and denied claims but are reported by unduplicated members, not by claim count.

Table 15.1 shows unduplicated counts and percent of members who received services by health plan in State Fiscal Year 2016. As is typical of any health insurance plan, Medicaid or commercial, some percentage of enrolled recipients do not need or access services. During this reporting period, 1,015,722 members received one or more Medicaid service(s) through their health plan for an overall rate of 90.1 percent across all plans. This is an increase of 3.9 percentage points over the 2015 rate of 86.2 percent. All five health plans demonstrated an increase in their individual rate for 2016. Amerihealth Caritas had the highest percentage of members receiving one or more services at a rate of 92.4 percent. Rates for individual plans demonstrate variation across plans with a range of 88.2 percent (Aetna) to 92.4 percent (Amerihealth Caritas). While still having the lowest rate (88.1 percent) of members receiving one or more services, Aetna demonstrated the largest improvement of a 27.8 percentage point increase over their 2015 rate of 60.3 percent. Data are representative of all claims, approved and denied.

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, however, that place of service is not a required field on all claims submissions.

Table 15.1: Enrollees who received services, State Fiscal Year 2016

	AETNA	AMG	ACLA	LHCC	UHC	Total
Unduplicated Count of Members	58,121	182,573	176,526	409,569	343,752	**1,127,161**
Number Receiving One or More Services	51,213	162,089	163,051	361,419	316,069	**1,015,722**
Percent Receiving One or More Services	88.1%	88.8%	92.4%	88.2%	92%	**90.1%**

Source: MARS Data Warehouse

16ENROLLEES 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 recipient was assigned to a health plan, either by choice or by auto assignment, the health plan assigned them to a primary care provider (PCP). These were 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 selection. If no PCP selection was made within 10 days of enrollment into the health plan, enrollees were assigned one. The algorithm for auto assignment considers past history with a PCP or a family history with a PCP. The Department required each health plan to have a process through which members could request to change their PCP for cause.

The data in Table 16.1 show the number and percentage of members who had at least one visit with the PCP to which they were linked during State Fiscal Year 2016. Though all members were linked to a PCP, they were not prohibited from seeking care from other providers. Not included in this table is data on members who had a visit with a provider for primary care services to which the member was not linked at the time.

The percentage of enrollees with a primary care provider visit increased for all health plans in State Fiscal Year 2016 over 2015 rates. The data shows a variation of 23.7 percentage points between UnitedHealthcare, which had the highest percentage of members who had a visit with their linked PCP and the plan with the lowest, Aetna.

Table 16.1: The 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 2016

	AETNA	AMG	ACLA	LHCC	UHC
Recipients with at least one PCP visit	11,590	68,490	68,251	169,360	150,076
Percentage	19.94%	37.51%	38.66%	41.35%	43.66%

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

17HOSPITAL SERVICES PROVIDED

The following information concerning hospital services provided to Medicaid enrollees:

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

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

Table 17.1 lists the number of members receiving unduplicated outpatient emergency services for State Fiscal Year 2016. For comparability across health plans, the rate per 1,000 total health plan members was calculated to account for variation in total member counts. Amerigroup had the highest rate of members receiving unduplicated outpatient emergency services, 372 per 1,000 total health plan members and Aetna had the lowest rate of 339 per 1,000 health plan members, though no plan was a significant outlier.

Table 17.1: The number of members who received unduplicated outpatient emergency services, State Fiscal Year 2016

	AETNA	AMG	ACLA	LHCC	UHC	Unduplicated Total
Members receiving unduplicated out-patient emergency services	19,669	67,912	64,998	148,407	121,275	**416,737**
Total Unduplicated Full Benefit Health Plan Members	58,096	182,555	176,511	409,554	343,741	**1,170,457**
Rate per 1,000 unduplicated health plan members	339	372	368	362	353	**356**

Source: MARS Data Warehouse

Table 17.2 lists the total inpatient Medicaid days for State Fiscal Year 2016. As with other data, wide variability is expected because the characteristics of a plan's membership impact this number. Louisiana Healthcare Connections had the most inpatient days. In its review of the data, Myers & Stauffer found that this is likely attributable to data indicators that the reported inpatient days could be overstated due to duplicate hospital encounters.

Table 17.2: The number of total inpatient Medicaid days, State Fiscal Year 2016

	AETNA	AMG	ACLA	LHCC	UHC	Unduplicated Total
Total Inpatient Medicaid Days	33,701	83,799	82,554	135,207	68,365	**403,626**

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 look at primary care access for the 6 month period following receipt of an outpatient emergency service. Table 17.3 summarizes this data for the individual periods pre and post receipt of emergency services, as well as, the combined period of 12 months prior

to and 6 months post receipt. Both unduplicated member counts and rates per total members receiving outpatient emergency services are presented for comparability across health plans.

Of the 416,737 health plan members who received outpatient emergency services during State Fiscal Year 2016, 86 percent had at least one visit to a primary care provider within one year prior to their emergency room visit, 81 percent had a visit to a primary care provider within 6 months after and 94 percent had a primary care visit either 12 months prior to the emergency service, 6 months post emergency service, or both. As expected, the total volume of members who received outpatient emergency services for individual plans was consistent with the magnitude of their total plan membership. The individual health plan rates for access to PCP either before or after an emergency room visit were approximately 94 percent for four of the plans, with Aetna's rate slightly lagging at 89.4 percent.

Table 17.3: Unduplicated members who saw a PCP[13] before or after a visit to the Emergency Room, State Fiscal Year 2016

	AETNA	AMG	ACLA	LHCC	UHC	Unduplicated Total
12 months before outpatient emergency service	14,471	58,308	56,117	129,913	106,080	360,219
Percentage of total emergency service visits[14]	73.6%	85.9%	86.3%	87.5%	87.5%	86.4%
6 months after outpatient emergency service	15,778	55,411	52,928	120,670	98,629	338,839
Percentage of total emergency service visits	80.2%	81.6%	81.4%	81.3%	81.4%	81.3%
12 months before or 6 months after outpatient emergency service (unduplicated)	17,578	63,526	60,688	139,310	114,513	390,289
Percentage of total emergency service visits	89.4%	93.5%	93.4%	93.9%	94.4%	93.7%

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 16 of this report.

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

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

The number of members, delineated by each managed care organization who filed an appeal, the number of members who accessed the state fair hearing process, and the total number and percentage of appeals that reversed or otherwise resolved a decision in favor of the member. For purposes of this subparagraph, "appeal" means a request for review of an action.

Health plan enrollees have the right to file appeals with both the health plan and with 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. In reviewing the records, the Department analyzed the subjects of the plan's appeals to identify the extent to which they are valid and/or are in the actual control of the health plan. Health plans and the Department both looked for trends and used the reports to determine the need for operational changes and improvements.

Table 18.1: Appeals, state fair hearings and appeals overturned, State Fiscal Year 2016

	AETNA	AMG	ACLA	LHCC	UHC	MCNA Dental
Total number of appeals	29	194	504	1540	956	90
Number of members who filed appeals	26	183	452	1349	878	90
Rate of members who filed appeals per 1,000 unduplicated health plan members	0.45	1.00	2.56	3.29	2.55	0.08
Appeals overturned at the health plan level	8	34	178	742	215	12
Percentage of appeals reversed (overturned)	27%	18%	35%	48%	22%	13%
Number of members who accessed State Fair Hearings	0	28	18	25	20	9
Number of reversals at State Fair Hearing	0	0	0	0	0	0

Source: Health Plan Report 114 and Dental Plan Report 114 ad hoc

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 EMTALA screening or urgent care, and professional services, specifically the evaluation and management of a patient, provided in an emergency room.[15] Non-emergency services are defined as all other claims that do not fit the definition of emergency services.

19CLAIMS 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 reported claims data using a new annual reporting template developed by the Department (report 177), which captures all claims meeting the contractual definition of a clean or not clean claim and also included rejected claim counts. Data are inclusive of paid and denied claims.

Note that no claims are reported by MCNA for emergency services because MCNA does not manage emergency services. Emergent dental services are addressed in hospital emergency departments, and as such, covered by the managed care organizations. Also, as a new health plan beginning February 1, 2015, Aetna had fewer claims likely due to its lower enrollment.

Table 19.1 shows data on total claims the health plans received during State Fiscal Year 2016. The emergency services and non-emergency services claims were ultimately paid or denied, however, rejected claims are reported separately. Rejected claims are different from denied claims as they are not adjudicated, but are rejected before entering the health plans' system for reasons such as Electronic Data Interchange (EDI) formatting issues on the transaction and the system cannot read the claim or failure of the claim to meet basic HIPAA submission requirements. Since rejected claims are not processed through the health plans' systems, whether a service is coded as emergency or non-emergency cannot be ascertained. UHC reports that it very rarely rejects claims as its claims processing system, combined with internal workflows, allows it to enter and deny a claim even if the member is not a UHC member or the claim is lacking required fields as opposed to rejecting.

Table 19.1 Total claims processed by health plans for emergency and non-emergency services, State Fiscal Year 2016

	Emergency Services	Non-Emergency Services	Rejected Claims	Total
AETNA	111,309	1,668,437	950	1,780,696
AMG	219,910	8,047,771	7,067	8,274,748
ACLA	1,164,211	7,173,202	564,147	8,901,560
LHCC	625,949	15,781,653	1,163,983	17,571,585
UHC	508,253	7,709,963	0	8,218,216
MCNA Dental	0	3,427,326	33,470	3,460,796
Total	**2,629,632**	**43,808,352**	**1,769,617**	**48,207,601**

Source: 177 annual report (new standing report)

[15] 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.

20DENIED CLAIMS

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

Records for each denied claim must include a reason for the denial. The Department required plans to report these denials using claim adjustment reason codes (CARC) for medical and behavioral health claims and National Council for Prescription Drug Program (NCPDP) reject codes for pharmacy claims, which are both national standards. The number of CARC and NCPDP codes is greater than the unduplicated number of total denied claims as represented in Table 20.1. The reason for this discrepancy is that each individual claim line that is denied often has multiple associated CARC or NCPDP reject codes. In other words, a claim can be denied or adjusted for multiple reasons. As it cycles through the payment logic, the claims processing system applies all applicable CARCs or NCPDP reject codes randomly and one is not primary in comparison to another. As such, these two components are reported independent of each other.

Table 20.1 below provides total unduplicated denied clean claims by health plan divided by emergency and non-emergency services. There were zero claims submitted to MCNA for emergency services since MCNA did not manage emergency services as defined for this report.

Table 20.1: Total denied clean claims by health plan, State Fiscal Year 2016

	Emergency Services	Non-Emergency Services	Total
AETNA	11,696	725,697	**737,393**
AMG	23,462	2,098,627	**2,122,089**
ACLA	35,314	1,763,949	**1,799,263**
LHCC	29,301	2,802,295	**2,831,596**
UHC	53,934	2,352,716	**2,406,650**
MCNA Dental	--	410,818	**410,818**
Total	**153,707**	**10,154,102**	**10,307,809**

Source: Health Plans' Data Warehouses

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

Table 20.2: Top claim adjustment reason codes (CARCs) for emergency and non-emergency services, State Fiscal Year 2016

CARC	CARC Description	Emergency Claims[16]	Non-Emergency Claims	Total
197	Precertification/authorization/notification absent.	891	1,457,849	**1,458,740**

[16] 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).

18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	41,551	1,142,074	**1,183,625**
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.).	8,762	715,937	**724,699**
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	9,037	562,935	**571,972**
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	13,178	526,102	**539,280**
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	15,704	251,477	**267,181**
A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	2,920	244,335	**247,255**
150	Payer deems the information submitted does not support this level of service.	1,881	188,355	**190,236**
4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	283	168,043	**168,326**
8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	12	151,129	**151,141**

Source: 173 Denied Claims Report (Health Plans' Data Warehouses)

In reviewing the denial reasons above, the Department found that CARC 96 was used by all five of the managed care organizations but was not utilized by the dental health plan. Some examples of associated Remittance Advice Remark Codes (RARCs) to explain the cause for denial using CARC 95 are: 1) this drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement; 2) it's a statutorily excluded service(s); 3) separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed; 4) services for newborns must be billed separately; 5) service not payable with other service rendered on same date; 6) patient ineligible for this service; 7) procedure code bill is not correct/valid for the services billed or the

date of service billed; 8) Not covered when performed with, or subsequent to, a non-covered service, and others.

CARC A1 was primarily used by Louisiana Healthcare Connections with a smaller number of denied claims also from Amerihealth Caritas for the following non-exclusive reasons:

- Missing/incomplete/invalid HCPCS
- Missing/incomplete/invalid/deactivated/withdrawn National Drug Code (NDC)
- Missing/incomplete/invalid procedure code(s)
- Missing/incomplete/invalid admitting diagnosis
- Global code in invalid per state guidelines
- Invalid provider type or category of service
- Mom and baby charges should be billed separately
- The provider must update license information with the payer

Though CARC 150 did not require an associated remark code for further explanation, the chief health plans utilizing this code were UnitedHealthcare and Louisiana Healthcare Connections. When asked about usage of this CARC, UnitedHealthcare explained that typical examples included obstetrics ultrasounds when the supporting documentation does not meet medical necessity requirements or Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) claims denying the T1015 all-inclusive visit code as a duplicate because an FQHC/RHC claim has already been received and paid for the same member/same date of service. Louisiana Healthcare Connections further explained that for its plan, the particular adjudication status reason code mapped to this CARC code is used by the compliance coding department to designate that the claim has been denied after review of the patient's claim history.

Table 20.3 shows the ten most frequently used NCPDP reject codes for emergency and non-emergency pharmacy claims. Unlike medical or behavioral health claims, pharmacy claims use their own national coding structure. For consistency with encounter data, the department has utilized this structure published by the National Council for Prescription Drug Programs (NCPDP) in monitoring reasons for claims denials. The primary causes for denials stemmed from refilling too soon, non-covered service, prior authorization lacking, or other coverage limitations.

Table 20.3: Top National Council for Prescription Drug Programs (NCPDP) codes for denial of emergency and non-emergency pharmacy services, State Fiscal Year 2016

NCPDP Code	NCPDP Description	Emergency Claims[17]	Non-Emergency Claims	Total
79	Refill Too Soon	497	675,719	**676,216**
76	Plan Limitations Exceeded	1,263	650,728	**651,991**
70	Product/Service Not Covered – Plan/Benefit Exclusion	3,603	462,385	**465,988**
75	Prior Authorization Required	968	463,588	**464,556**
88	Drug Utilization Review (DUR) Reject Error	1,142	295,844	**296,986**
MR	Product Not On Formulary	612	188,095	**188,707**
41	Submit Bill To Other Processor Or Primary Payer	1,181	130,494	**131,675**
85	Claim Not Processed	3	124,005	**124,008**
65	Patient Is Not Covered	973	113,854	**114,827**
69	Filled After Coverage Terminated	1,358	91,037	**92,395**

Source: 173 Denied Claims Report (Health Plans' Data Warehouses)

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

The Department found that NCPDP reject code 85 was primarily used by Louisiana Healthcare Connections, which reserves it for clinical edits. It primarily comes up on teratogenic drugs, which can be overridden with a confirmation that a member is (a) not pregnant or (b) if physician approves drug for use during pregnancy. Extra caution is used by Louisiana Healthcare Connections with regard to these drugs since they are agents or contain factors that cause malformation of an embryo.

21CLEAN CLAIMS

The total number of claims submitted by the healthcare providers to each managed care organization which meets the definition of a clean claim as it is defined in the contract executed between the state and the managed care organization, and the percentage of those clean claims that each of the managed care plans has paid for each provider type within fifteen calendar days and within thirty calendar days. In addition, the report shall include the average number of days for each managed care organization to pay all claims of healthcare providers delineated by provider type.

The managed care contracts define a clean claim as a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a state's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Table 21.1 lists the total clean claims submitted for each health plan. There is a significant uptick in the number of claims when compared to last year's report, likely attributable to stabilization and a better understanding of claims processing changes for the health plans and providers after initial ramp-up ended with the new managed care contract implemented in State Fiscal Year 2015. Below in Tables 21.2 through 21.4 are the percentage of clean claims paid within 15 and 30 days, and average number of days to pay all claims by provider type for each health plan. The variation among provider types is due in part to the complexity of cross-walking fee-for-service legacy Medicaid provider types to the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12N standard, which regulates and establishes standards for claims filing. Provider type classifications used by Louisiana Medicaid are unique to its fiscal intermediary, and considerable work had to be performed to map them back to standard taxonomy codes in use by other healthcare organizations in the United States. All Health Insurance Portability and Accountability Act (HIPAA)-covered entities are required to be compliant with the ASC X12 version 5010, which only requires reporting of taxonomy on claims if a provider has multiple taxonomies associated with their National Provider Identifier on file. As healthcare terminology standards continue to evolve, the Department will continue to work to ensure health plan compliance to this standard and ensure provider directories are accurate and complete.

Table 21.1: Total clean claims by health plan, State Fiscal Year 2016

AETNA	AMG	ACLA	LHCC	UHC	MCNA	*Total*
1,291,900	4,615,505	4,759,362	8,831,354	8,105,337	830,472	**28,586,938**

Source: 221 Prompt Pay Report (Health Plans' Data Warehouses)

Health plans are required by contract to adjudicate ninety percent (90%) of all clean claims within fifteen (15) business days of the date of receipt and ninety-nine percent (99%) of all clean claims within thirty (30) calendar days of the date of receipt. Claims are reported at the header/claim level as opposed to line level for this reporting element and contract compliance. As such, it will differ from Sections 19 which primarily counts claims at the claim line level with the exception of institutional claims. The MCO must pay providers interest at 12% per annum, calculated daily for the full period in which the clean claim remains unadjudicated beyond the 30-day claims processing deadline. This compliance measure is typically monitored in the aggregate; however, delineation of turnaround times by claim type is outlined in Tables 21.2 and 21.3 below for illustrative purposes.

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

in particular continues to be an outlier for prompt pay turnaround times. Services that require authorizations can cause delays in claim adjudication if not referenced or billed properly.

Table 21.2: Percent of submitted claims paid within 15 days, State Fiscal Year 2016

Provider Type	AETNA	AMG	ACLA	LHCC	UHC	MCNA
Inpatient Hospital	87.48%	96.50%	99.94%	93.83%	98.05%	N/A
Outpatient Hospital	98.29%	99.38%	99.99%	99.61%	99.57%	N/A
Professional	98.06%	99.52%	99.08%	99.42%	99.59%	N/A
Rehab	97.42%	98.32%	99.98%	99.23%	98.73%	N/A
Home Health	93.33%	95.55%	100.00%	92.37%	99.53%	N/A
EMT (Transportation)	96.14%	99.43%	99.99%	99.17%	99.76%	N/A
NEMT & NEAT (Transportation)	99.54%	99.72%	99.59%	99.34%	99.55%	N/A
DME	93.70%	93.14%	99.95%	99.48%	99.08%	N/A
Pharmacy	99.14%	99.71%	99.60%	100.00%	100.00%	N/A
EPSDT Dental	N/A	N/A	N/A	N/A	N/A	100.00%
Adult Denture	N/A	N/A	N/A	N/A	N/A	100.00%

Source: 221 Prompt Pay Report (Health Plans' Data Warehouses)

Table 21.3: Percent of submitted claims paid within 30 days, State Fiscal Year 2016

Provider Type	AETNA	AMG	ACLA	LHCC	UHC	MCNA
Inpatient Hospital	93.64%	99.55%	99.98%	98.69%	99.82%	N/A
Outpatient Hospital	99.44%	99.74%	100.00%	99.89%	99.98%	N/A
Professional	99.15%	99.82%	100.00%	99.85%	99.98%	N/A
Rehab	99.23%	99.56%	99.98%	99.84%	99.73%	N/A
Home Health	97.25%	97.73%	100.00%	95.58%	100.00%	N/A
EMT (Transportation)	98.50%	99.79%	100.00%	99.68%	99.97%	N/A
NEMT & NEAT (Transportation)	99.90%	99.93%	99.87%	99.63%	99.84%	N/A
DME	96.82%	96.29%	99.99%	99.55%	99.93%	N/A
Pharmacy	100.00%	99.85%	99.75%	100.00%	100.00%	N/A
EPSDT Dental	N/A	N/A	N/A	N/A	N/A	100.00%
Adult Denture	N/A	N/A	N/A	N/A	N/A	100.00%

Source: 221 Prompt Pay Report (Health Plans' Data Warehouses)

All health plans paid the vast majority of provider types in approximately two weeks, with the average number of days being approximately one week (6 – 8 days) for most provider types.

Table 21.4: Average Days to Adjudicate Claims, State Fiscal Year 2016

Provider Type	AETNA	AMG	ACLA	LHCC	UHC	MCNA
Inpatient Hospital	13	9	12.1	11	9.8	N/A
Outpatient Hospital	7	4	4.5	7	8.2	N/A
Professional	7	4	4.5	7	8.1	N/A
Rehab	8	6	6.8	8	8.7	N/A
Home Health	11	7	5.8	10	8.5	N/A
EMT (Transportation)	9	8	3.7	7	9.4	N/A
NEMT & NEAT (Transportation)	8	10	10.3	10.6	10.5	N/A
DME	10	7	8.1	8	8.9	N/A
Pharmacy	11	1.2	2.6	1	0	N/A
EPSDT Dental	N/A	N/A	N/A	N/A	N/A	7.4
Adult Denture	N/A	N/A	N/A	N/A	N/A	8.2

Source: 221 Prompt Pay Report (Health Plans' Data Warehouses)

22REGULAR 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 with at least 80 percent processed within two business days. 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, though an extension of up to fourteen days could be granted if the member or if the health plan justified a need for additional information and how the extension is in the member's best interest. With behavioral health integration into the managed care organization covered service array on Dec. 1, 2015, behavioral health authorizations became subject to the same compliance standard. Additionally, section 6.38.4.4 and the penalty provisions of the contract required 95 percent of adult mental health rehabilitation authorizations be completed within 5 business days following assessment or recertification. However, reporting of behavioral health service authorizations did not start until quarter two of 2016 since continuity of care provisions ensured that all existing authorizations carried over from the previous behavioral health contractor continued for 90 days post-integration or longer.

Tables 22.1 and 22.2 show the number and percentage of regular, expedited and adult Mental Health Rehabilitation (MHR) service authorizations processed within the time frames included in the contract. The tables are divided into medical and behavioral health benefits. For purposes of this report, legislative intent is interpreted to focus on prior authorizations. Therefore, reported behavioral health authorizations include Psychiatric Residential Treatment Facility (PRTF) authorizations but exclude concurrent review and post-authorizations. Health plans have a lot of discretion over which services require prior authorization, which accounts for the wide variation in the number of authorizations across plans. For example, UnitedHealthcare does not require authorization for MHR services.

Table 22.1 Medical service authorizations processed July 2015 – June 2016

		AETNA	AMG	ACLA	LHCC	UHC
Regular Processed within 2 Business Days	**Number**	9,304	61,610	15,860	40,990	47,355
	Percent	71%	85%	86%	81%	88%
Regular Processed within 14 Business Days	**Number**	12,225	72,061	18,380	50,290	53,588
	Percent	94%	100%	100%	100%	99%
Expedited Processed within 72 Hours	**Number**	323	48	373	66	2,363
	Percent	73%	100%	100%	100%	99%
Expedited Processed within 14 Day Extension Period	**Number**	418	0	3	3	154
	Percent	95%	--	100%	100%	100%

Sources: MSLC Survey

Amerihealth Caritas made a decision to extend the continuity of care timeframe through April 2016. As such, a higher proportion of authorizations were processed in a short timeframe within the last 2 months

of State Fiscal Year 2016. Also, for adult MHR authorizations, Amerihealth Caritas indicates that while they reported the percentage based on the date a provider assessment was completed there was often lag time between that date and submission to the MCO. Amerihealth Caritas was able to ensure a significantly higher rate of processing within 5 days from the time of receipt of request of the assessment by the plan. UnitedHealthcare's behavioral health authorization numbers are lower than the other health plans because it only required prior authorization for crisis intervention, Assertive Community Treatment, Substance Abuse Intensive Outpatient (IOP) treatment, and Psychiatric and Substance Use Residential services. It did not require prior authorization for Multi-Systemic Therapy, Functional Family Therapy or Home Builders services.

Table 22.2 Behavioral health service authorizations processed post-integration from January 2016 – June 2016

		AETNA	AMG	ACLA	LHCC	UHC
Regular Processed within 2 Business Days	**Number**	60	16,087	12,518	69,745	2,350
	Percent	56%	56%	51%	91%	90%
Regular Processed within 14 Business Days	**Number**	100	28,885	23,885	75,186	2,561
	Percent	94%	100%	97%	98%	98%
Expedited Processed within 72 Hours	**Number**	0	1	5	227	4
	Percent	0%	100%	100%	100%	100%
Expedited Processed within 14 Day Extension Period	**Number**	0	1	1	6	0
	Percent	--	100%	100%	100%	--
Adult Mental Health Rehabilitation Processed within 5 business days following completion of assessment/recertification	**Number**	190	10,223	786	7,677	N/A
	Percent	100%	93%	29%	87%	N/A

Source: MSLC Survey

Table 22.3 shows the percent of prior authorizations that resulted in a denial of services. It should be noted that over a third of UnitedHealthcare's denials are for laboratory services. Since UnitedHealthcare requires prior authorization for all non-emergent out-of-network services, the majority of requests to utilize out-of-network and/or out-of-state lab services are denied, with providers being redirected to in-network labs.

Table 22.3: Percent of service authorizations that resulted in denial July 2015 – June 2016

	AETNA	AMG	ACLA	LHCC	UHC
Denied service authorizations	4.4%	4.1%	8.8%	4.2%	16.2%

Source: MSLC Survey

23CLAIMS PAID TO OUT-OF-NETWORK PROVIDERS

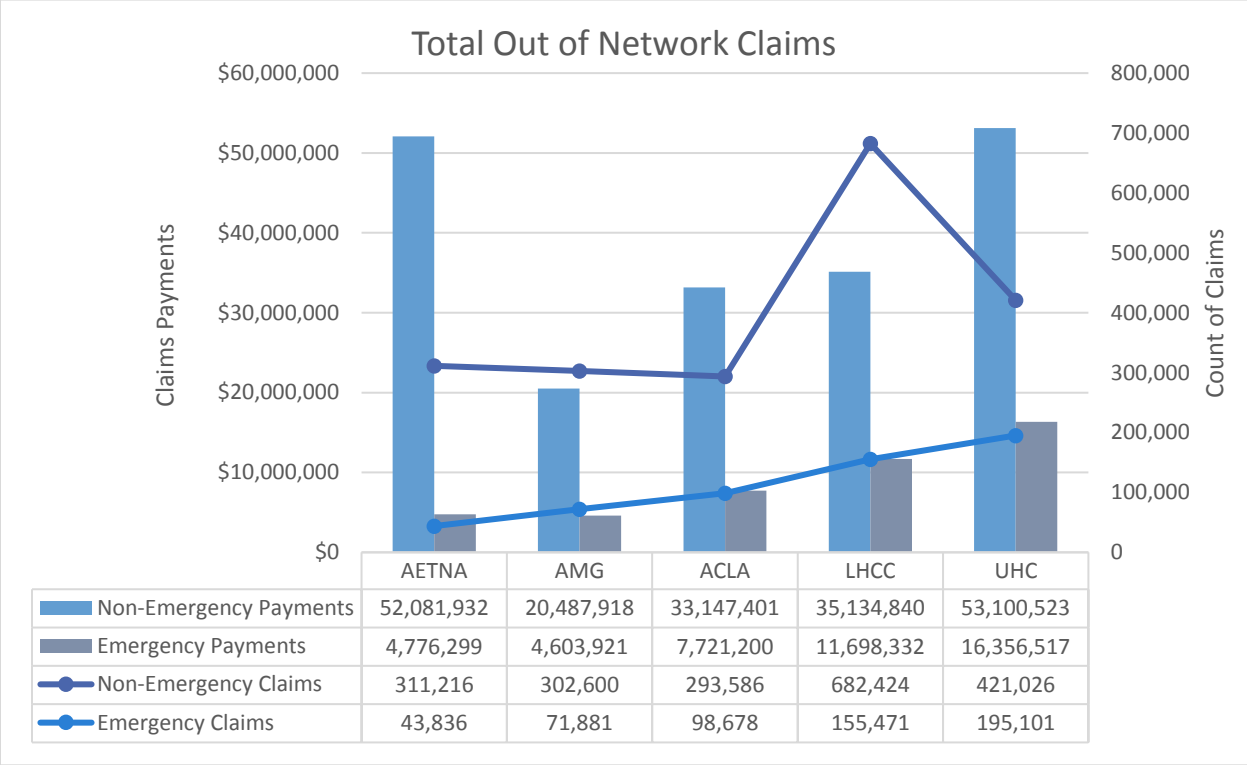
The total number and dollar value of all claims paid to out-of-network providers by claim type categorized by emergency services and nonemergency services for each managed care organization by parish.

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

The following information in Figure 23.1 reflects the number of claims and dollar value of payments by the health plans to non-network providers for both emergency services and non-emergency services. The data originate from submissions from the health plans on the new annual standing report (report 177). The Department continues to work with Myers and Stauffer to identify methods of cross-walking provider registry network data with encounters for future reporting.

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

Figure 23.1: Out of network claims for State Fiscal Year 2016



	AETNA	AMG	ACLA	LHCC	UHC
Non-Emergency Payments	52,081,932	20,487,918	33,147,401	35,134,840	53,100,523
Emergency Payments	4,776,299	4,603,921	7,721,200	11,698,332	16,356,517
Non-Emergency Claims	311,216	302,600	293,586	682,424	421,026
Emergency Claims	43,836	71,881	98,678	155,471	195,101

Source: 177 annual report (new standing report)

24PHARMACY BENEFITS

The following information concerning pharmacy benefits delineated by each managed care organization and by month:

- Total number of prescription claims
- Total number of prescription claims subject to prior authorization
- Total number of prescription claims denied
- Total number of prescription claims subject to step therapy of fail first protocols

In State Fiscal Year 2016, all five health plans managed pharmacy benefits for all members enrolled with full benefits coverage. Behavioral Health and NEMT only members continued to receive pharmacy benefits under fee-for-service Medicaid.

A managed care organization can self-administer its pharmacy benefits or subcontract with a pharmacy benefit manager. Table 24.1 identifies the pharmacy benefit manager for each managed care organization and whether the pharmacy benefit manager was a wholly-owned subsidiary or a contracted vendor during State Fiscal Year 2016.

Table 24.1: MCO pharmacy benefit managers, State Fiscal Year 2016

AETNA	AMG	ACLA	LHCC	UHC
CVS Caremark	Express Scripts	PerformRx	US Script	OptumRx
Contracted	Contracted	Owned	Owned	Owned

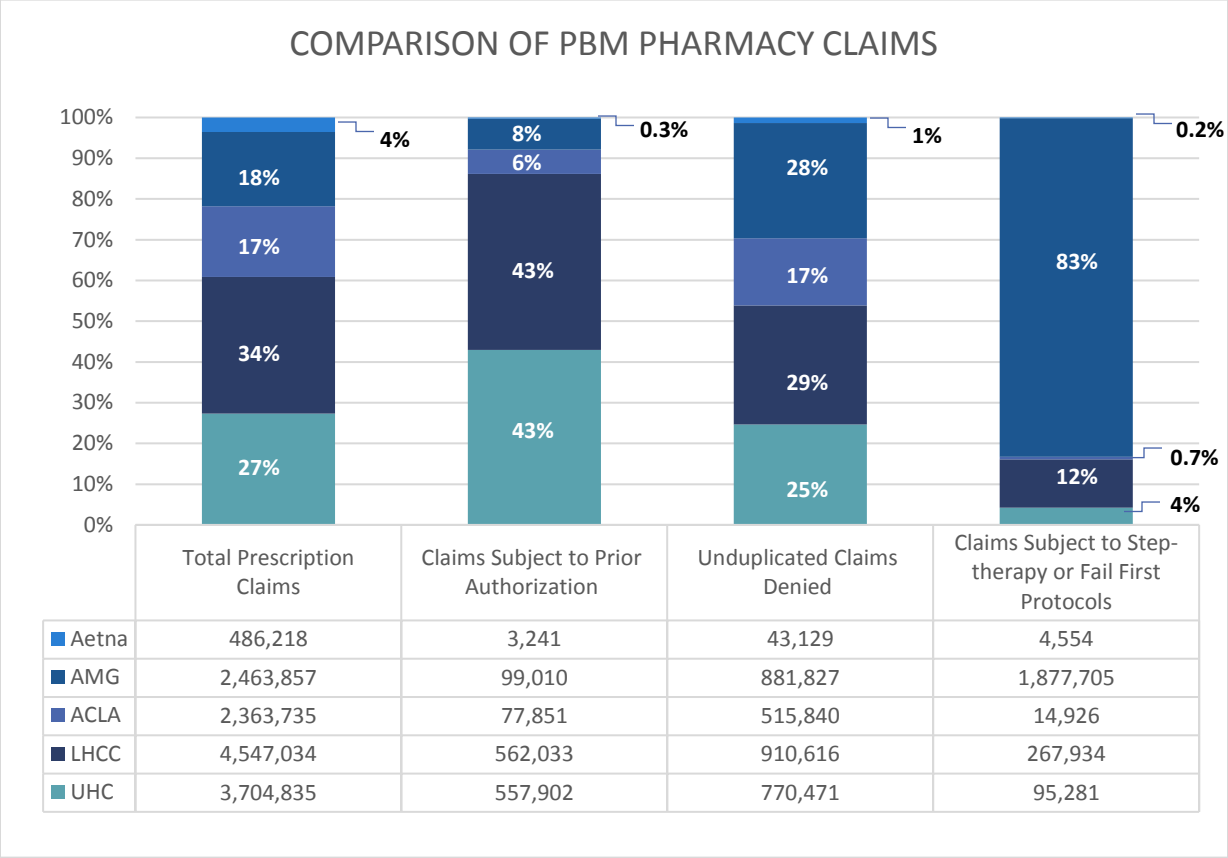
Source: MCO self-reported

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

Figure 24.1 lists the unduplicated total number of claims received by each health plan, as well as, a breakdown of claims by the select categories requested. The graph displays the distribution of each category across health plans for comparison. 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 requires step therapy and fail first protocols, the recipient was required to try preferred product(s) before the drug requested would be approved. Each health plan had its own list of preferred drugs and drugs that required step therapy/fail first protocols. The approach used, the drug selection, and the number of trials required before authorizing a non-preferred agent can vary significantly between plans. The monthly details for claims by reporting category are provided in Appendix X.

This measure only applies to the managed care organizations as the dental benefit program does not manage pharmacy benefits for its members.

Figure 24.1: Pharmacy claims comparison, State Fiscal Year 2016



	Total Prescription Claims	Claims Subject to Prior Authorization	Unduplicated Claims Denied	Claims Subject to Step-therapy or Fail First Protocols
Aetna	486,218	3,241	43,129	4,554
AMG	2,463,857	99,010	881,827	1,877,705
ACLA	2,363,735	77,851	515,840	14,926
LHCC	4,547,034	562,033	910,616	267,934
UHC	3,704,835	557,902	770,471	95,281

Source: Monthly RX055 Pharmacy Report

25MEDICAID DRUG REBATES

The report shall include the following information concerning Medicaid drug rebates and manufacturer discounts delineated by each managed care organization and the prescription benefit manager contracted or owned by the managed care organization and by month:

- Total dollar amount of the Medicaid drug rebates and manufacturer discounts collected and used.
- Total dollar amount of Medicaid drug rebates and manufacturer discounts collected and remitted to the Department of Health and Hospitals.

This measure applies specifically to the managed care organizations as the dental benefit program does not manage pharmacy benefits for its members. The managed care organizations submit this data on a calendar year basis in the quarterly financial reporting requirements (report 185). However, because the quarterly financial reporting requirements are not audited through independent review, the Department is planning to contractually address discrepancies between the Annual Audited Financial Statements and the quarterly 185 report and ensure the necessary rebate reporting requirements are incorporated into the Annual Audited Financial Statements. See Section 10 of the report for additional information regarding the Annual Audited Financial Statements.

Managed care organizations, either directly or through their pharmacy benefit manager, negotiate agreements with drug manufacturers to collect rebates or discounts on the cost of drugs provided to their members. These agreements provide a financial incentive to health plans to prefer certain drugs over others in meeting their members' pharmacy needs. Preferred drugs, included on a plan's preferred drug list, were generally exempt from prior authorization requirements.

For Medicaid enrollees in a fee-for-service delivery system, manufacturer discounts and drug rebates (both federal and state supplemental) accrue directly to the state. For Medicaid enrollees in a full-risk managed care organization, only federal rebates accrue directly to the state. In Louisiana, since managed care organizations determine their own unique preferred drug list, supplemental rebates are not available to the state; however, in Calendar Year 2015, the Department collected $211.1 million in federal rebates as a result of the managed care pharmacy program.

Managed care organizations reported to the Department through routine quarterly and audited annual financial reporting the amount of rebates and discounts collected from manufacturers. Rather than require health plans to remit rebates and discounts collected to the Department, the Department's contracted actuaries considered the reported amounts from the quarterly financial reporting requirements (185 report) when setting capitation rates for managed care organizations, and related reductions to capitation rates benefit the state indirectly. As a result, the managed care organizations remitted no drug rebates or manufacturer discounts directly to the Department.

Table 25.1 provides the amount of Medicaid drug rebates and manufacturer discounts collected and used as well as remitted to the Department during Calendar Year 2015, as reported by managed care organizations in their quarterly financial reporting requirements for that year. Table 25.2 shows the monthly breakdown.

Table 25.1: Total pharmacy rebates, Calendar Year 2015

	Amount of Medicaid Drug Rebates and Manufacturer Discounts Collected and Used	Amount of Medicaid Drug Rebates and Manufacturer Discounts Collected and Remitted to the Department
AETNA	$5,191	$0
AMG	$2,267,903	$0
ACLA	$4,125,000	$0
LHCC	$2,715,199	$0
UHC	$11,295,495	$0
Total	**$20,408,788**	**$0**

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

Aetna's amount is net of rebates and an Over the Counter (OTC) offset of $17,551.52 for reimbursing Navarro (now owned by CVS) based on actual utilization as per original 2015 185 reporting instructions for definition re: Global/Subcapitation Payments and Pharmacy Rebates. This offset resulted in negative line item reporting on the 185 report for several of the months during Calendar Year 2015. Total rebates for Aetna, exclusive of OTC the sub-payment, were $22,741.62.

Table 25.2: Monthly pharmacy rebates, Calendar Year 2015

	AETNA	AMG	ACLA	LHCC	UHC
January	$0	$74,513	$350,000	$58,900	$0
February	$8,801	$64,035	$376,000	$134,083	$672,101
March	$13,826	$36,573	$376,000	$144,885	$787,143
April	$(553)	$138,465	$359,000	$119,220	$997,031
May	$(537)	$136,722	$323,000	$243,154	$950,626
June	$(1,334)	$211,869	$335,000	$379,010	$979,533
July	$(1,753)	$316,679	$349,000	$159,199	$1,036,860
August	$(2,961)	$234,787	$348,000	$166,600	$1,209,683
September	$(3,228)	$386,678	$115,000	$158,607	$1,149,343
October	$(3,939)	$275,637	$332,000	$195,648	$1,162,482
November	$(3,131)	$215,501	$405,000	$149,327	$1,154,577
December	$0	$176,444	$457,000	$806,565	$1,196,116
2015 Total	**$5,191**	**$2,267,903**	**$4,125,000**	**$2,715,199**	**$11,295,495**

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

26DENTAL PRIOR AUTHORIZATION REQUESTS

For managed care organizations that administer dental benefits, the following information concerning prior authorization requests, delineated by type of procedure:

- The number of prior authorization requests.
- The average and range of times for responding to prior authorization requests.
- The number of prior authorization requests denied, delineated by the reasons for denial.
- The number of claims denied after prior authorization was approved, delineated by the reasons for denial.

MCNA, which is the Louisiana Medicaid Dental Benefit Program Manager, defines prior authorizations as the prior review of a service by a qualified health professional to authorize, partially deny, or deny the payment of a service, including a service requested by a member. In State Fiscal Year 2016, MCNA completed prior authorizations on a total of 261,038 requests. As shown in Table 26.1, the two most common types of procedures prior authorized were oral/maxillofacial surgery and restorative procedures, which accounted for over half of all prior authorizations. Oral/maxillofacial surgery included extractions, TMJ procedures and other surgery on the mouth, jaws and face. Restorative services included tooth restorations, crowns and appliance removals, among others (these types of services are the most commonly performed, and thus the most commonly prior authorized). Unlike the dental benefit program, the managed care organizations do not require prior authorization of their dental value-added services or of the dental emergency benefits they cover.

Table 26.1: The number of prior authorization requests by type of procedure, State Fiscal Year 2016

Type of Procedure	Children (under 21 years)	Adult Denture (21 years & older)	Total Number of Prior Authorization Requests
Restorative	78,363	128	**78,491**
Oral & Maxillofacial Surgery	77,471	591	**78,062**
Adjunctive General Services	34,781	46	**34,827**
Endodontics	24,671	33	**24,704**
Removable Prosthodontics	765	15,607	**16,372**
Diagnostic	3,317	8,532	**11,849**
Preventive	11,962	5	**11,967**
Periodontics	3,529	30	**3,559**
Orthodontics	1,051	0	**1,051**
Fixed Prosthodontics	111	4	**115**
Maxillofacial Prosthetics	17	0	**17**
Implant Services	14	10	**24**
Total	**236,052**	**24,986**	**261,038**

Source: Report 188 – Prior authorization summary

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

Table 26.2: The overall average and range of times for responding to prior authorization requests, State Fiscal Year 2016

Type of Procedure	Children (under 21 years)		Adult Denture (21 years & older)	
	Average Time	Range of Times	Average Time	Range of Times
Oral & Maxillofacial Surgery	1.7	0-6 days	1.0	0-4 days
Adjunctive General Services	1.6	0-6 days	0.8	0-4 days
Restorative	1.7	0-6 days	0.8	0-4 days
Endodontics	1.3	0-14 days	0.8	0-3 days
Periodontics	1.7	0-6 days	1.0	0-24 days
Removable Prosthodontics	2.0	0-6 days	1.0	0-24 days
Diagnostic	1.7	0-6 days	1.4	0-4 days
Preventive	1.8	0-6 days	0.8	0-5 days
Orthodontics	1.5	0-6 days	0	0 days
Fixed Prosthodontics	1.6	0-5 days	0.3	0-1 days
Maxillofacial Prosthetics	1.2	1-5 days	0	0 days
Implant Services	2.0	0-4 days	2.0	0-3 days
Overall Average	**1.6**	**0-14 days**	**1.0**	**0-24 days**

Source: Report 188 – Prior authorization summary

Of the 261,038 prior authorizations MCNA completed during State Fiscal Year 2016, 29,967 unduplicated authorizations were denied (13%). As with denied claims, there can be multiple denial reasons associated with each authorization request and as a result, the number of denied reason codes (58,040) will be greater than the number unduplicated denied authorizations (20,967); therefore, these items are reported independent of each other.

MCNA used a total of 113 unique denial reasons for prior authorizations. Table 26.3 includes the ten most frequently used authorization denial codes which accounted for 43,431, or 75 percent of all denial reason codes applied. The most common denial reason, Code 535, was due to a lack of benefit coverage when medical necessity not met for oral surgery/extraction. Other common reasons were for duplicate requests, services that were either not covered or were limited, MCNA determined that either the procedure did not meet clinical criteria, or that the supporting documentation did not meet the company's guidelines. All denials delineated by denial reason are included in Appendix XI.

Table 26.3: Ten most prevalent reasons for authorization denial, State Fiscal Year 2016

Authorization Denial Code	Code Description	Total
535	No benefit is provided for the extraction of asymptomatic teeth which show no signs of infection; including but not limited to the removal of the third molars. The member's condition does not meet MCNA's oral surgery guidelines.	10,206
2	This request has been previously reported and an approval or denial was issued.	7,911
400	Clinical criteria were not met.	4,779
17	This a non-covered service per the covered services outlined in your provider manual.	4,644
48	Please submit x-rays and narrative with request.	3,395

321	The clinical reviewer has determined that the treatment is in excess of the member's needs.	**3,039**
120	The clinical reviewer has recommended an alternate procedure/benefit	**3,005**
150	The Dental Director has advised that the x-rays received do not demonstrate the need for treatment submitted.	**2,926**
111	The clinical reviewer has determined that the x-ray and/or photos submitted were not of diagnostic value. Please submit a diagnostic x-ray indicating the right and left sides and/or diagnostic quality photos.	**1,877**
121	This procedure can only be considered when reported and performed in conjunction with covered services.	**1,649**
TOTAL		**43,431**

Source: MCNA 188 Prior Authorization Summary Report – Ad Hoc SFY 2016

In State Fiscal Year 2016, MCNA denied 21,201 claims that had been previously prior authorized. Table 26.4 includes the ten most frequently used Claims Adjustment Reason Codes (out of 53 total CARCs) for denied claims when the prior authorization had been previously approved. These ten denial reasons accounted for 18,629, or 88 percent of all denials after prior authorization was approved. The most commonly used denial reason is Code 18, "Exact duplicate claim/service." All denials delineated by reasons for denial are included in Appendix XI.

Table 26.4: Ten most prevalent reasons for claim denial after prior authorization was approved, State Fiscal Year 2016

CARC	Code Description	Total
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	**5,734**
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**4,591**
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	**2,603**
	CARC not provided[18]	**2,022**
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	**1,486**
169	Alternate benefit has been provided.	**820**
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	**460**
164	Attachment/other documentation referenced on the claim was not received in a timely fashion.	**355**
46	This (these) service(s) is (are) not covered.	**311**
17	Requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	**247**
TOTAL		**18,629**

Source: MCNA 173 Denied Claims Report – Ad Hoc SFY 2016

[18] CARCs were not required on denied claims in SFY 2016.

LIST OF APPENDICES