Medicaid Managed Care Transparency Report 2017

Agency Response to La. Revised Statute 40:1253.2

Louisiana Department of Health

Bureau of Health Services Financing

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Introduction

This report is the sixth in a series produced by the Louisiana Department of Health (referenced as LDH or the Department) 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 health plans, and primary care case management (PCCM) known as shared savings plans. The state contracted with three prepaid and two shared savings plans, and individuals were given the option of choosing the plan that best met their needs. However, not all Medicaid services were available from health plans, and some health plan members continued to receive certain services under the fee-for-service program. In addition, many individuals covered by Medicaid were not eligible to enroll in and receive services from a health plan.

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 the managed care program:

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

Medicaid Expansion

On July 1, 2016, the state expanded eligibility for the Louisiana Medicaid program to include adults, ages 19 to 64 years old, with incomes at or below 138 percent of the federal poverty level. All members of the new adult expansion population were enrolled through a special open enrollment period in one of the five health plans as a full-benefit member. In addition, these members also received coverage for services under the adult denture program through the state’s DBPM. In State Fiscal Year 2017, 499,175 unduplicated members were enrolled through the expansion. In this transparency report, the expansion population is included in the reporting for full-benefit members. Additional information specific to the new adult expansion population can be found on the “Healthy Louisiana” home page at www.healthy.la.gov.

Transparency Report Measures and Data

This report includes 26 measures as outlined in La. Revised Statute 40:1253.2. It covers program operations for July 2016 through June 2017 (State Fiscal Year 2017), except the following measures which are reported on a calendar year basis per the contract between the Department and the managed care entities:

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

Information included in this report was collected from multiple sources. To the greatest extent possible, the data are extracted from state systems that routinely collect and maintain operational data on the Medicaid Managed Care Program. When unavailable from state sources, data were collected from the managed care entities or sourced from either routine reporting deliverables 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's contracted fiscal intermediary, 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 the MCOs and Dental Benefits Plan Manager.

As part of routine operations and as required by the Centers for Medicare and Medicaid Services (CMS), internal policies and procedures for collection of data were validated by the Department's contracted external quality review organization (EQRO), Island Peer Review Organization (IPRO), in 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. All five MCOs have obtained accreditation from NCQA.

In addition to standing operational quality assurances and EQRO reviews, the data included in this report were independently validated by Myers and Stauffer, an audit contractor of the Department. Myers and Stauffer reviewed for reasonability the data extraction code or process that the managed care entities or the Department used to generate data. For data originating from the MARS Data Warehouse or MMIS, Myers and Stauffer generated its own data from encounters or data extracts for each plan and compared its results to the results the Department produced. For data originating from the plans, Myers and Stauffer reviewed plan responses to a survey developed by Myers and Stauffer to document the process the plans used to generate the data, as well as policies and procedures in place to collect, track and report data. Where Myers and Stauffer found inconsistencies above or below the 10 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 2017, more than 1.6 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 provided 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 (MCO or health plans)

Managed care organizations, also called prepaid health plans in Louisiana, are risk-bearing entities that provide a wide array of Medicaid-covered benefits and services to enrolled members in exchange for a monthly capitation payment for each member. The plans contract directly with healthcare providers and manage all aspects of service delivery, including reimbursement of providers. The MCOs operate under the federal authority in Section 1932(a)(1) of the Social Security Act and 42 CFR Part 438. Participating Medicaid enrollees and covered benefits and services must be specified in Louisiana's CMS approved Medicaid State Plan.

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

A small number of individuals remained completely excluded from enrollment in an MCO and continued to receive services under fee-for-service. Medicaid populations excluded from enrollment in an MCO in State Fiscal Year 2017 were as follows:

- Individuals receiving limited Medicaid benefits or single service only;
- Individuals over age 21 residing in an intermediate care facility for the developmentally disabled (ICF/DD);
- Individuals enrolled in the Program for All-Inclusive Care for the Elderly (PACE);
- Medicare dual eligibles with incomes between 75 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 continued to be Medicaid fee-for-service and were not included in the managed care benefit package in State Fiscal Year 2017:

- 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 (DBPM or dental plan)

The state provided comprehensive dental services to Medicaid eligible children and adult dentures to full-benefit eligible adults through a single, 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 EPSDT program, and

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

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

1 CONTRACTED MANAGED CARE ENTITIES

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

For the State Fiscal Year 2017 reporting period, the Department contracted with five managed care organizations (MCOs) 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 managed care entities, State Fiscal Year 2017

Plan Name	Plan Type	Common Abbreviation
Aetna Better Health, Inc.	Managed Care Organization	ABH
Community Care Health Plan of Louisiana, Inc. (dba Amerigroup Louisiana)[1]	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
MCNA Insurance Company, Inc.	Dental Benefit Program Manager	MCNA

Source: Medicaid managed care contracts

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

2 MANAGED CARE EMPLOYEES

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

Health plan contracts required certain staff be domiciled in-state, such as chief executive officer, medical director, behavioral health medical director, maternal/child health coordinator, contract compliance officer, member management coordinator, provider services manager, program integrity officer, encounter data quality coordinator, case management staff, and fraud, waste and abuse investigators and others. For other positions, such as call center staff, plans had the option to staff locally or leverage parent company resources out of state. It is also important to note in 2017, the data collection report was revised to clarify the count of employees across all health plans must be reported based on full-time equivalency (FTE) to appropriately account for part-time or partial year employment and turnover. As such, the data may not be directly comparable to 2016 data; however, all health plans confirmed that they maintained or slightly increased the number of Louisiana-based employees in State Fiscal Year 2017.

Table 2.1 Total number and average salary for MCO employees based in Louisiana, State Fiscal Year 2017

	ABH	ACLA	AMG	LHCC	UHC
Total number of LA Employees	158.85	183.38	197.96	582.34	369.00
Average Salary	$62,156	$70,890	$75,342	$62,475	$59,152

Source: 017 Annual Report to LDH

The average annual salary weighted across all health plans was $63,728. 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 2017, MCNA reported 11.2 full-time equivalent in-state staff. The average annual salary for MCNA employees based in Louisiana was $71,006.

Table 2.2 Total number of Louisiana employees and average salary for Dental Benefit Program Manager, State Fiscal Year 2017

	MCNA Dental
Total number of LA employees	11.2
Average Salary	$71,006

Source: 017 Annual Report to LDH

3 PAYMENTS TO MANAGED CARE ORGANIZATIONS

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

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

In State Fiscal Year 2017, the Department paid a total of $6,488,579,668 to all five managed care organizations for all health plan members combined. The payments to each health plan were based on the number of members enrolled in one of two distinct member groups based on eligibility and coverage:

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

Total unduplicated enrollment in a Medicaid managed care plan for State Fiscal Year 2017 was 1,659,897. Total enrollment unduplicated within each group was 1,538,005 full-benefit members and 133,696 partial-benefit members (NOTE: members can switch between full-benefit and partial-benefit coverage during the year based on their eligibility status). Variation in the average PMPM rate reflects differences in enrollment mix and risk adjustment across health plans. Managed care organizations with a larger share of enrollment from higher cost eligibility groups had a higher average PMPM payment and vice-versa.

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

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

Table 3.1 Total payments and average PMPM for full-benefit members[2] by month, State Fiscal Year 2017

	ABH		ACLA		AMG		LHCC		UHC	
	Total Payments	Average PMPM	Total Payments	Average PMPM	Total Payments	Average PMPM	Total Payments	Average PMPM	Total Payments	Average PMPM
Jul-16	$31,430,380	$401.02	$91,227,183	$487.85	$91,507,569	$457.18	$186,501,777	$435.84	$164,741,693	$445.11
Aug-16	$16,469,116	203.45	$52,232,037	$275.98	$55,677,114	$272.66	$129,002,669	$297.55	$105,395,396	$279.65
Sep-16	$60,434,040	$735.62	$105,670,386	$555.28	$113,047,762	$547.40	$183,986,078	$420.72	$179,466,650	$469.94
Oct-16	$53,195,891	$634.59	$109,335,548	$570.51	$101,419,687	$486.90	$215,557,424	$489.02	$200,078,135	$516.94
Nov-16	$53,761,676	$622.44	$88,751,633	$457.70	$108,311,031	$510.03	$175,737,340	$393.64	$166,143,319	$423.31
Dec-16	$53,570,397	$601.03	$102,051,123	$522.85	$110,559,006	$512.37	$202,351,857	$445.91	$186,536,390	$466.80
Jan-17	$48,542,733	$529.77	$88,525,915	$449.15	$96,624,679	$441.65	$177,633,490	$387.48	$171,801,429	$424.10
Feb-17	$47,413,321	$514.55	$87,638,724	$444.56	$96,177,060	$438.34	$175,089,844	$380.57	$165,912,164	$407.58
Mar-17	$46,855,240	$503.40	$86,250,223	$437.06	$95,303,945	$432.48	$175,532,945	$380.06	$163,257,559	$398.57
Apr-17	$50,682,089	$542.63	$90,951,523	$462.42	$102,290,003	$464.43	$188,705,717	$408.83	$173,942,488	$423.97
May-17	$48,029,124	$510.81	$89,318,445	$454.10	$97,172,057	$440.06	$182,377,475	$394.55	$168,143,254	$408.21
Jun-17	$2,242,323	$23.80	$4,419,990	$22.53	$7,161,763	$32.44	$9,559,306	$20.68	$10,379,606	$25.15
Total	**$512,626,330**	**$483.93**	**$996,372,727**	**$427.92**	**$1,075,251,678**	**$418.76**	**$2,002,035,924**	**$370.33**	**$1,855,798,082**	**$389.48**

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

Notes - off-cycle payment adjustments to MCOs for full-benefit members, State Fiscal Year 2017:

- Jul-16 includes both Jul-16 PMPM payments and Jun-16 PMPM payments delayed due to budget constraints in SFY16.
- Aug-16 includes non-expansion PMPM payments only.
- Sep-16 includes Aug-16 expansion PMPM payment and Sep-16 PMPM payments for both expansion and non-expansion.
- Oct-16 includes Health Insurance Providers Fee paid as lump sum (LHCC, ACLA, UHC; +$78M total).
- Nov-16 includes Health Insurance Providers Fee paid as lump sum (AMG, Aetna, LHCC, UHC; +$21M total).
- Dec-16 includes lump sum Premium Tax adjustment (+$83M).
- Apr-17 includes partial recoupment of lump sum Premium Tax adjustment made in Dec-16 (AMG, ABH, and ACLA).
- May-17 includes partial recoupment of lump sum Premium Tax adjustment made in Dec-16 (ACLA and LHCC).
- Jun-17 PMPM payouts pushed to Jul-2017 due to budget constraints in SFY17. Includes partial recoupment of lump sum Premium Tax adjustment made in Dec-16 (UHC).

[2] Including the new adult expansion population

Table 3.2 Total payments and average PMPM for partial-benefit members by month, State Fiscal Year 2017

	ABH		ACLA		AMG		LHCC		UHC	
	Total Payments	Average PMPM	Total Payments	Average PMPM	Total Payments	Average PMPM	Total Payments	Average PMPM	Total Payments	Average PMPM
Jul-16	$642,447	$28.75	$630,142	$29.84	$649,837	$30.22	$738,582	$30.73	$777,188	$30.67
Aug-16	$834,008	$37.28	$807,104	$38.04	$847,459	$39.17	$968,525	$40.01	$1,026,816	$40.23
Sep-16	$752,995	$33.62	$728,705	$34.19	$765,140	$35.28	$874,446	$35.92	$927,075	$36.14
Oct-16	$792,002	$35.43	$756,820	$35.54	$800,818	$37.01	$897,226	$36.85	$963,458	$37.52
Nov-16	$811,495	$36.37	$772,239	$36.21	$813,440	$37.56	$936,268	$38.32	$989,341	$38.47
Dec-16	$783,614	$35.60	$770,774	$36.54	$796,682	$36.87	$913,645	$37.06	$963,648	$37.61
Jan-17	$781,667	$35.64	$765,014	$36.27	$797,612	$36.90	$938,964	$38.07	$986,290	$38.43
Feb-17	$813,902	$37.20	$790,346	$37.52	$836,072	$38.78	$957,442	$38.75	$1,011,663	$39.46
Mar-17	$778,215	$35.60	$753,111	$35.82	$790,767	$36.68	$903,734	$36.56	$958,125	$37.35
Apr-17	$833,318	$38.25	$806,437	$38.50	$846,759	$39.42	$967,725	$39.27	$1,025,967	$40.09
May-17	$764,103	$35.21	$739,454	$35.31	$776,427	$36.15	$887,345	$35.85	$940,750	$36.69
Jun-17	$57,991	$2.68	$56,120	$2.68	$58,926	$2.74	$67,344	$2.71	$71,397	$2.78
Total	**$8,645,757**	**$32.67**	**$8,376,266**	**$33.06**	**$8,779,939**	**$33.91**	**$10,051,247**	**$34.15**	**$10,641,719**	**$34.61**

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

Notes - off-cycle payment adjustments to MCOs for partial-benefit members, State Fiscal Year 2017:

- Jun-17 PMPM payouts pushed to Jul-2017 due to budget constraints in SFY17.

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., June enrollment paid for in July. Table 3.3 below shows the total payments the Department made to MCNA and the average PMPM for each month for State Fiscal Year 2017.

Table 3.3 Total payments and average PMPM for dental benefit program members by month, State Fiscal Year 2017

	MCNA Dental	
	Total Payments	**Average PMPM**
Jul-16	$13,521,451	$9.77
Aug-16	$13,610,265	$9.68
Sep-16	$13,720,670	$9.66
Oct-16	$13,829,238	$9.65
Nov-16	$13,908,235	$9.58
Dec-16	$18,241,591	$12.38
Jan-17	$13,889,623	$9.32
Feb-17	$13,955,315	$9.34
Mar-17	$13,968,864	$9.31
Apr-17	$13,857,411	$9.24
May-17	$13,888,066	$9.24
Jun-17	$167,037	$0.11
Total	**$156,557,766**	**$8.92**

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

Notes - off-cycle payment adjustments to MCNA for dental benefit program, State Fiscal Year 2017:

- Dec-16 Health Insurer's Provider Fee paid as lump sum (+$4.4M)
- Jun-17 Majority of PMPM payouts pushed to July 2017 due to budget constraints in SFY17

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. It should be noted, however, that the unduplicated totals in tables 4.1 and 4.2 below will not match the provider totals in Appendix I as providers can enroll as more than one provider type, taxonomy, and in more than one parish.

Per contract requirements, the health plans submitted a registry of all providers that have contracted with the health plan, as well as any provider who was not in-network but was paid for services as an out of network provider or under a single case agreement. As specified in the authorizing legislation, the data reported in sections 4, 5 and 6 of this report are for contracted providers to reflect the in-network capacity of each health plan. Based on LDH findings and data user recommendations for improving the utility of this data set, the methodology for compilation of network providers was refined to exclude out-of-state providers, unless they were located in a county directly bordering Louisiana. This resulted in an overall reduction in the size of some health plan networks as compared to 2016 reported totals; but is considered more reflective of local accessibility.

The registry as of June 30, 2017, was used to determine if a provider was contracted with an MCO at any point during State Fiscal Year 2017 based on contract begin and end dates rather than its status as of June 30, 2017. Contracted provider counts are presented in tables 4.1 and 4.2 below.

Table 4.1 Total unduplicated[3] count of contracted providers by health plan, State Fiscal Year 2017

	ABH	ACLA	AMG	LHCC	UHC
Total Contracted Providers[4]	10,351	21,267	19,615	23,533	22,257

Source: LDH MARS Data Warehouse, June 30, 2017 Provider Registry

Table 4.2 Total unduplicated[3]count of contracted providers in DBPM, State Fiscal Year 2017

	MCNA Dental
Total Contracted Providers[4]	1,464

Source: LDH MARS Data Warehouse, June 30, 2017 Provider Registry

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

[4] In state or border county only.

5 PRIMARY CARE SERVICE PROVIDERS

The total number of providers contracted to provide healthcare services for each managed care organization that provides primary care services and submitted at least one claim for payment for services rendered to an individual enrolled in the health plan delineated by provider type, provider taxonomy code and parish.

The methodology for identifying contracted providers of primary care services in accordance with statutory requirements was further refined for 2017 reporting to exclude out-of-state-providers, unless they are located in a county directly bordering Louisiana. The listing of contracted primary care providers (PCPs) for each health plan was then matched to the encounter file to determine those PCPs who submitted at least one claim for service during State Fiscal Year 2017. The corresponding claims were further limited to the following 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, these data are not directly comparable to data reported in 2016, but it is believed to more accurately reflect legislative intent.

Total unduplicated provider counts for 2017 are presented in table 5.1. Appendix II lists primary care providers with at least one claim by provider type, provider taxonomy and parish. It should be noted, however, that the unduplicated totals in table 5.1 below will not match the provider totals in Appendix II as PCPs can enroll as more than one provider type, under multiple taxonomies, and in more than one parish.

Table 5.1 Total unduplicated[5] contracted primary care providers with at least one claim, State Fiscal Year 2017

	ABH	ACLA	AMG	LHCC	UHC
Total Contracted PCPs	2,253	4,521	2,399	4,179	3,514
PCPs with at least one claim	1,509	2,511	1,948	2,508	2,302
Percent PCPs with at least one claim	67%	56%	81%	60%	66%

Source: MARS Data Warehouse, June 30, 2017 Provider Registry

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

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

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

Primary care providers that contracted with health plans had the option to close their panels, or stop accepting new patients, under certain circumstances such as ensuring quality of care for members. Each health plan had its own policy on which providers could close their panels and when a panel could be closed, how to inform the health plan when a panel is closed or reopened, and how closed panels were tracked. For example, a health plan may have capped physician panels at 2,500 patients so that appropriate care and time was given to each person during their appointment.

Data for the providers with a closed panel on June 30, 2017, were extracted by the Department from provider registry files maintained in the MARS data warehouse. Table 6.1 shows the number of primary care providers with a closed panel by health plan as of June 30, 2017. Additional data by provider type, taxonomy and parish can be found in Appendix III. The unduplicated totals in table 6.1 below do not necessarily equate to the provider totals in Appendix III as providers can enroll as more than one provider type, under multiple taxonomies, and in more than one parish.

Table 6.1 Unduplicated[6] contracted primary care providers with a closed panel, June 30, 2017

	ABH	ACLA	AMG	LHCC	UHC
PCPs with a Closed Panel	61	851	887	123	428

Source: MARS Data Warehouse: June 30, 2017 Provider Registry

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

7 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 (MLR) standard. Federal regulations and health plan contracts required that a minimum of 85 percent of payments made by the Department for Louisiana Medicaid members be used to reimburse providers for services or certain specified purposes related to quality improvement and health information technology costs.

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 summarize 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 2016, all five managed care organizations met the 85 percent minimum and were not required to pay any rebates.

The MLR data presented are based on the independent auditor's reports prepared by Myers and Stauffer for the Adjusted Medical Loss Ratio Rebate Calculation for each of the five prepaid health plans for the calendar year ending on December 31, 2016. The audited reports for 2016 are posted on the Medicaid website at http://ldh.louisiana.gov/index.cfm/page/2142.

Table 7.1 Medical Loss Ratios, Calendar Year 2016

	ABH	ACLA	AMG	LHCC	UHC
Adjusted Current YTD MLR Capitation Revenue	$251,138,445	$686,381,992	$658,669,591	$1,366,334,479	$1,168,764,237
Total Adjusted MLR Expense	$237,417,430	$636,988,498	$601,130,327	$1,243,584,811	$1,068,359,761
MLR Percentage Achieved	94.5%	92.8%	91.3%	91.0%	91.4%
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

This section provides data on 18 health outcome measures tracked by the Department that are responsive to the legislative request specified in R.S. 40:1253.2 and bulleted above. These measures are sourced from two nationally recognized standardized measurement sets:

- Prevention Quality Indicators (PQI™), which are maintained by the Agency for Healthcare Research and Quality (AHRQ); and

- Healthcare Effectiveness Data and Information Set (HEDIS®), which are maintained by the National Committee for Quality Assurance (NCQA).

PQI™ data are presented for three hospital admissions indicators, and HEDIS® data are presented for the 15 indicators for access to primary and preventive services and immunizations. These measures may not necessarily align with the incentivized or monitored quality metrics under the current MCO contracts, but are required for the purposes of this legislative report. MCOs were required to submit results for the prior calendar year operations at the end of the subsequent year; as such, Calendar Year 2016 measures were due by the end of 2017.

It should be noted that the expansion population is not included in the 2016 PQI™ and 2017 NCQA HEDIS® measures presented. As enrollment of the expansion population did not begin until July 1, 2016, this group did not meet the requirement for continuous enrollment throughout Calendar Year 2016. Interim measures of access and health outcomes specific to the expansion population can be found on the dashboard of the "Healthy Louisiana" home page at www.healthy.la.gov.

In aggregate, all 18 measures have improved under managed care compared to the 2011 pre-managed care baseline, as seen in tables 8.1 and 8.3. The breakdown of individual health plan data for Calendar Year 2016 operations (HEDIS® 2017) are reported in tables 8.2 and 8.4.

Table 8.1 provides aggregate trend data across all health plans on three rates of hospital admissions used nationally to track improvement, i.e. a reduction in preventable hospitalizations for acute and chronic conditions. For these three measures, a lower rate indicates better performance. While the 2016 rates for all three measures are still below the pre-managed care baseline, the admission rates for adult asthma and uncontrolled diabetes both increased from 2015 reported rates. Trending performance on these rates is used to guide the Department and health plans in planning targeted improvement efforts. For additional information on disease burden and MCO strategies to address them, see the *Diabetes and Obesity Action Report for the Healthy Louisiana Program* available on line at http://ldh.la.gov/assets/docs/BayouHealth/ACT210201742018.pdf.

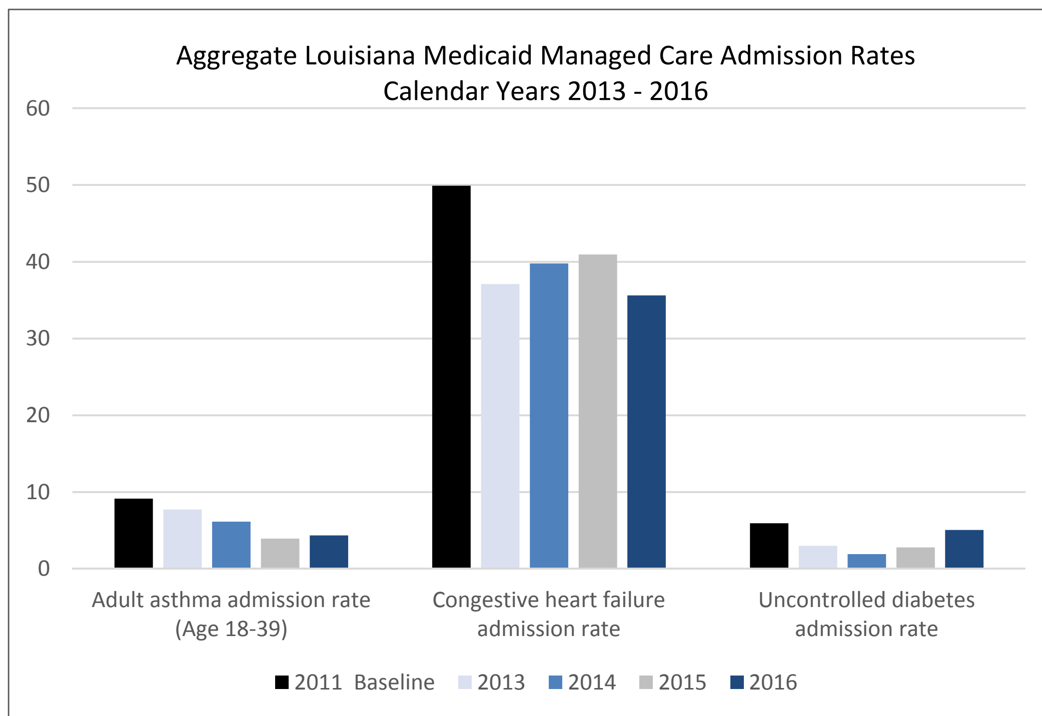
Table 8.1 Aggregate PQI™ health outcomes baseline and trend, Calendar Years 2013 – 2016

PQI™ Measures	2011 Baseline[7]	2013	2014	2015	2016
Younger Adult asthma admission rate (age 18-39)	9.14	7.73	6.14	3.95	4.35
Congestive heart failure admission rate (age 18 and above)	49.90	37.09	39.79	40.95	35.62
Uncontrolled diabetes admission rate (age 18 and above)	5.93	3.00	1.92	2.79	5.06

Source: 2016 AHRQ PQI™ compiled by ULM School of Pharmacy, Office of Outcomes Research. PQI™ Measures calculated and reported by Calendar Year.

Since Medicaid Inpatient PQI™ do not have national or regional benchmarks, figure 8.1 below provides a view of the trend for the three reported PQI™ measures by calendar year as compared to the pre-managed care baseline. For the three measures presented, a decrease in the admission rate indicates an improvement in health outcomes, while rate increases would indicate declining performance for these health outcomes.

Figure 8.1 Aggregate PQI™ Admission Rates Trends, Calendar Years 2013 - 2016



Source: 2016 AHRQ PQI™ data compiled by ULM School of Pharmacy, Office of Outcomes Research.

Calendar year 2016 data by individual health plan are presented in table 8.2. As consistent with the aggregate totals, all five health plans saw an increase in the rate of admissions for uncontrolled diabetes and a decrease in the heart failure admission rate in calendar year 2016 compared with the prior year. The asthma rate improved for two of the five health plans, AmeriHealth Caritas and Louisiana HealthCare Connections.

[7] Pre-Medicaid managed care baseline, Louisiana Medicaid fee for service operational year 2011.

8.2 Health outcome PQI™ measures by health plan, Calendar Year 2016

PQI™ Measures	ABH	ACLA	AMG	LHCC	UHC
Younger Adult asthma admission rate (age 18-39)	2.37	3.80	7.20	4.68	3.11
Congestive heart failure admission rate (age 18-64)	37.17	32.76	41.52	37.02	31.64
Uncontrolled diabetes admission rate (age 18-64)	3.72	4.28	4.99	6.76	4.17

Source: 2016 AHRQ PQI™ compiled by ULM School of Pharmacy, Office of Outcomes Research.

Table 8.3 presents aggregate HEDIS® trend data for key measures of access to primary and preventive care. In aggregate, Medicaid managed care plans continued to demonstrate improvement from the pre-managed care baseline. Ten of the twelve immunization rates improved in aggregate from HEDIS® 2016 (Calendar Year 2015 operations) to HEDIS® 2017 (Calendar Year 2016 operations). Immunization rates for rotavirus and influenza were the two exceptions, with slight rate decreases for the year.

Table 8.3 Aggregate HEDIS® outcome measures baseline and trend, HEDIS® 2014-2017

HEDIS® Measures	2012 Baseline[8]	2014	2015	2016	2017
Adult access to preventative/ ambulatory health services	78.35%	82.95%	82.13%	81.31%	84.45%
Breast cancer screening rate	42.15%	N/A[9]	53.63%	55.55%	55.84%
Well child visits in the 3rd, 4th, 5th and 6th years of life	35.45%	67.46%	63.74%	63.59%	65.68%
Childhood immunization rates					
DTaP	58.78%	68.30%	66.53%	73.87%	76.44%
IPV	72.97%	82.87%	82.41%	87.17%	90.03%
MMR	81.05%	86.15%	85.83%	87.60%	89.60%
HiB	77.98%	84.62%	83.40%	86.26%	88.81%
Hepatitis B	20.66%	75.60%	70.98%	87.44%	89.38%
VZV	81.25%	85.96%	85.71%	87.83%	89.39%
Pneumococcal conjugate	60.10%	69.49%	68.58%	75.09%	76.27%
Hepatitis A	35.30%	81.13%	81.28%	83.99%	86.04%
Rotavirus	49.96%	62.75%	58.65%	66.94%	65.80%
Influenza	27.86%	37.23%	38.21%	35.96%	32.37%
Combo 2[10]	15.02%	53.07%	54.94%	67.70%	72.12%
Combo 3[11]	13.73%	50.30%	52.54%	64.37%	68.08%

Sources: 2014 HEDIS®, 2015 HEDIS®, 2016 HEDIS®, 2017 HEDIS® | 2012 HEDIS® pre Medicaid managed care baseline provided by ULM School of Pharmacy, Office of Outcomes Research Note: HEDIS® data are reported in the year following the data collection period, i.e. HEDIS® 2017 is reporting data from Calendar Year 2016 operations.

[8] Pre-Medicaid managed care baseline, Louisiana Medicaid fee for service operational year 2011.

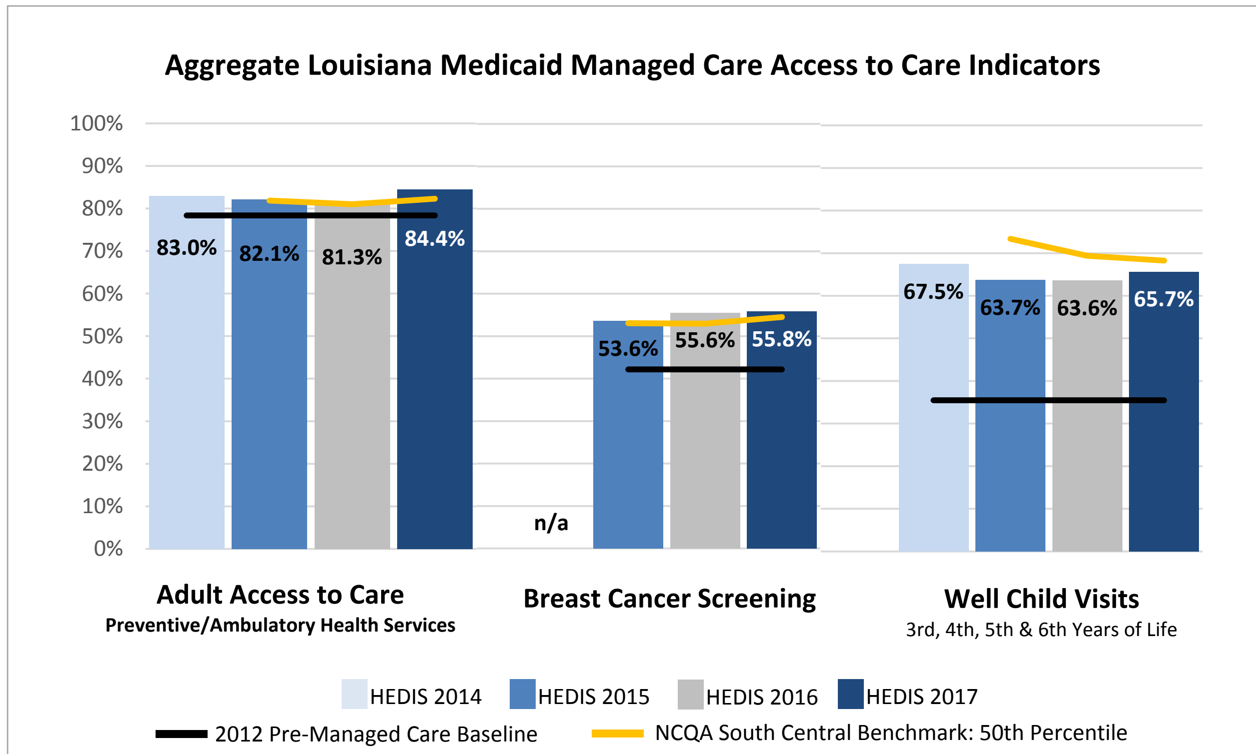
[9] Data limitation due to multi-year continuous enrollment criteria.

[10] Combo 2 - percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), and one chicken pox (VZV) vaccines by their second birthday.

[11] Combo 3 - percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV), and four pneumococcal conjugate (PCV) vaccines by their second birthday.

As part of its validation, the external quality review organization, IPRO, provided a comparison of Louisiana Medicaid HEDIS® measures to the NCQA Quality Compass South Central 50th percentile benchmark for Medicaid managed care published by NCQA. Figure 8.2 reflects this comparison, showing that Louisiana is slightly above the South Central median for adults' access to preventative/ambulatory health services, though we fall slightly below the benchmark for breast cancer screening and well child visits. In addition, Louisiana has improved significantly above the HEDIS® 2012 pre-managed care baseline for all three HEDIS® measures. For these access to care measures, an upward trend indicates improvement, while a downward trend or lower rate indicates a decline in performance.

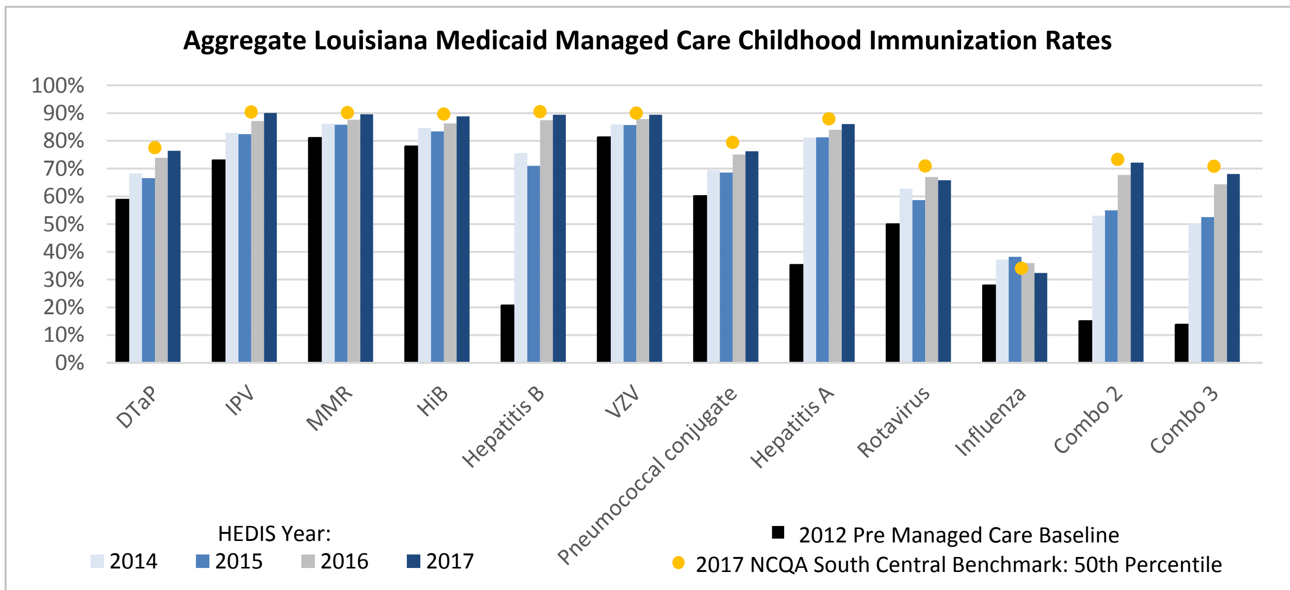
Figure 8.2 Louisiana Medicaid Managed Care Health Outcome Trends, HEDIS® 2014 - 2017



Source: 2017 HEDIS® (Jan 1-Dec 31, 2016 Measurement Year); Island Peer Review Organization (IPRO)

Figure 8.3 reflects a comparison of the aggregate health plan immunization rates by vaccine against the Quality Compass South Central 50th percentile benchmark, as published in the NCQA 2017 Quality Compass, and the 2012 pre-managed care immunization rate. 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 could be due to the heightened outreach and linkages to care through an enhanced provider network afforded by managed care.

Figure 8.3 Louisiana Medicaid managed care immunization rates, HEDIS® 2014 – 2017



Source: HEDIS® data compiled by ULM School of Pharmacy, Office of Outcomes Research

A comparison of individual plan HEDIS® 2017 rates are presented in table 8.4.

Table 8.4 Health outcomes by health plan, HEDIS® 2017

HEDIS® Measures	ABH	ACLA	AMG	LHCC	UHC
Adult access to preventative/ ambulatory health services	79.86%	84.38%	83.35%	84.40%	86.48%
Breast cancer screening rate	57.14%	58.05%	53.71%	57.25%	53.58%
Well child visits in the 3rd, 4th, 5th and 6th years of life	53.94%	62.76%	63.49%	66.13%	68.19%
Childhood immunization rates					
DTaP	53.24%	71.53%	75.00%	76.44%	80.78%
IPV	70.60%	86.62%	86.57%	90.14%	94.40%
MMR	73.61%	86.62%	88.66%	89.18%	92.94%
HiB	69.44%	85.64%	87.96%	87.98%	92.94%
Hepatitis B	68.98%	86.37%	89.35%	86.78%	95.38%
VZV	73.15%	87.83%	87.50%	89.66%	91.73%
Pneumococcal conjugate	54.40%	70.80%	75.93%	76.20%	80.29%
Hepatitis A	68.98%	83.21%	85.19%	86.78%	87.83%
Rotavirus	47.69%	58.15%	66.44%	62.50%	74.21%
Influenza	26.16%	33.33%	29.63%	31.97%	34.31%
Combo 2	50.00%	69.59%	67.82%	70.43%	79.08%
Combo 3	47.45%	65.21%	64.12%	67.31%	73.72%

Sources: 2017 HEDIS® (Jan 1-Dec 31, 2016 Measurement Year) provided by ULM School of Pharmacy, Office of Outcomes Research

Performance Measure Validation

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. § 438.330(b)(2). Validation of the health plans' 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 care furnished by the health plans.

9 MEMBER AND PROVIDER SATISFACTION SURVEYS

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

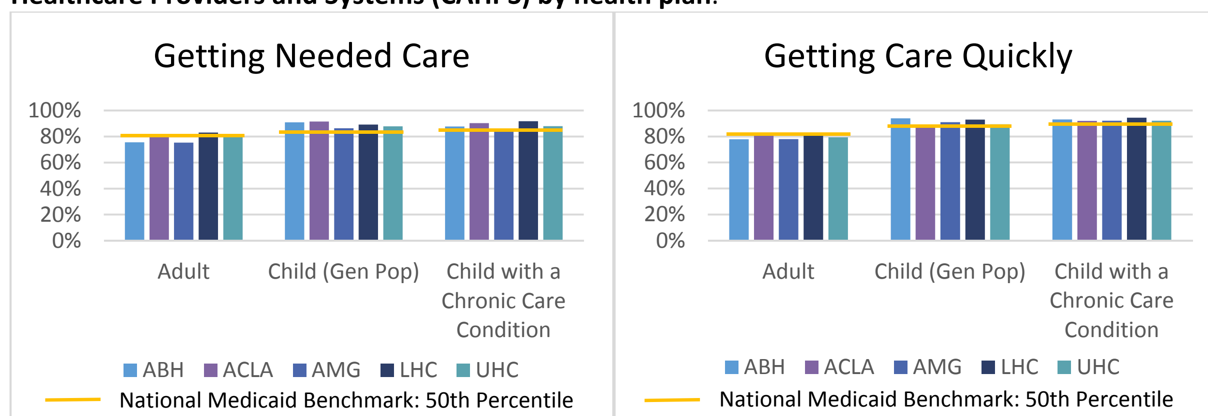
Member and provider satisfaction are measures of a patient's experience of care. Member satisfaction with their healthcare, which is considered an important component in managed care quality, can be defined as how members value and regard their care. The Department and health plans can use member and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

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

The Department required health plans to submit an annual member satisfaction survey report. In addition to reporting results to the Department, survey results were also collected by NCQA as part of its accreditation program and reviewed by the EQRO. As an example of the data available, a comparison of 2017 CAHPS survey results for two core measures on access to care and health plan satisfaction are presented in Figure 9.1 below. The full member survey reports for each health plan can be found in Appendix IV: Member Satisfaction Surveys.

Figure 9.1: Comparison of select access measure results from 2017 Consumer Assessment of Healthcare Providers and Systems (CAHPS) by health plan.



Source: EQR Health Plan Reports 2018 (http://new.dhh.louisiana.gov/index.cfm/page/2753)

Provider Satisfaction Survey

Unlike member satisfaction, there are no national standard survey instruments for a provider satisfaction assessment; however, each health plan is contractually required to conduct an annual assessment of providers to determine the level of satisfaction and identify areas for improvement. Each health plan is responsible for the development and implementation of a survey instrument that must cover key areas including provider enrollment, education and complaints; utilization management processes; claims processing and reimbursement; and, for primary care providers, availability of technical assistance in creating patient-centered medical homes. Per contract requirements, the Department approved both the survey instrument and methodology for each health plan. The Calendar Year 2016 provider satisfaction survey reports for each managed care entity are provided in Appendix V.

10 AUDITED FINANCIAL STATEMENTS

A copy of the annual audited financial statements for each managed care organization. The financial statements shall be those of the managed care organization operating in Louisiana and shall not be those financial statements of any parent or umbrella organization.

Financial statements are an important tool for financial oversight of Medicaid managed care entities. They provide critical information for assessing a company's financial condition, including but not limited to profitability and solvency. The Securities and Exchange Commission (SEC) requires that all publicly held entities must file audited annual financial statements. Third party auditors independently evaluated whether a company's financial statements were prepared in accordance with generally accepted accounting principles (GAAP) and presented a fair picture of the financial position and performance of the company.

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

The full financial statements for each plan can be found in Appendix VI. The statements are for Calendar Year 2016, which were reported during State Fiscal Year 2017.

11 SANCTIONS LEVIED BY THE DEPARTMENT

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

Actions or inactions by the Medicaid managed care entities that are subject to sanction by the Department are specified in 42 CFR §438.700, et seq., and delineated in the LDH Medicaid managed care contracts. In State Fiscal Year 2017, there were no sanctions levied against any of the Medicaid managed care entities.

In addition to sanctions, the Department may take other administrative actions, require corrective action, or impose monetary penalties for non-compliance issues that are not specifically subject to issuance of a sanction. Additional information on actions taken or penalties imposed is posted on the Department's website by contract period: http://new.dhh.louisiana.gov/index.cfm/page/1610.

12 DENTAL BENEFIT HEALTH OUTCOMES

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

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

MCNA EPSDT and Adult Denture Programs

The EPSDT (Early and Preventative Screenings, Diagnosis and Treatment) Dental Program is designated for enrollees under the age of 21. The EPSDT Dental Program, administered by MCNA, covers certain diagnostic, endodontic, periodontic, removable prosthodontic, maxillofacial prosthetic, oral and maxillofacial surgery, orthodontic, adjunctive general services, preventive, and maintenance and restoration services such as fillings, fluoride treatments, and cleanings. In State Fiscal Year 2017, MCNA covered 901,379 Medicaid enrollees under the age of 21. Of those, 422,601 members (46.9 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 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 95 percent of members who saw a dentist received oral prophylaxis services. At 20.7 percent and 10.5 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 Utilization rates for procedures performed on those patients under the age of 21 who saw a dentist through the Dental Benefit Program, State Fiscal Year 2017

	Total members received procedure	Rate of members who saw a dentist
Adult oral prophylaxis (12 -20 years of age)	118,312	28.00%
Child oral prophylaxis (under 12 years of age)	282,830	66.93%
Dental sealants	52,065	12.32%
Fluoride varnish	81,048	19.18%
Amalgam fillings	44,948	10.64%
Composite fillings	88,533	20.95%
Stainless steel crowns	36,496	8.64%
Extractions of primary teeth	33,062	7.82%
Extractions of permanent teeth	14,028	3.32%
Pulpotomies performed on primary teeth	17,529	4.15%
Root canals performed on permanent teeth	6,564	1.55%

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

MCNA Adult Denture Services

For Medicaid enrollees over the age of 21 that were eligible for full Medicaid benefits, the dental program was limited to denture services as outlined in the Medicaid State Plan. In State Fiscal Year 2017, MCNA covered 754,792 adult members for denture services, of which 12,604 (1.7 percent) saw a dentist for at least one denture service.

MCO Adult Dental Value Added Services

On February 1, 2015, as a value added benefit to adult full-benefit members[12], all five managed care organizations began offering a limited adult dental benefit beyond the state plan denture benefit covered by MCNA. In State Fiscal Year 2017, 90,538 or 13 percent of the 684,986 eligible adult members received at least one value added dental service through their managed care organization, up from 4 percent in 2016. Additional data on adult dental services by health plan are presented in tables 12.2 and 12.3.

Table 12.2 Eligibility and utilization data for dental benefits by health plan, State Fiscal Year 2017

	ABH	ACLA	AMG	LHCC	UHC	Total
Eligible Members (Full-benefit Adults age 21+)	80,131	106,866	117,636	185,542	194,811	684,986[8]
Number who saw a dentist	9,687	15,084	17,019	16,283	32,465	90,538
The percent of eligible patients that saw a dentist	12.09%	14.11%	14.47%	8.78%	16.66%	13.22%

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

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

Table 12.3 Utilization rates for most common procedures performed on those patients over the age of 21 who received a dental service through their managed care organization, State Fiscal Year 2017

		ABH	ACLA	AMG	LHCC[13]	UHC
Extraction of permanent teeth	Count	1,930	6,730	5,931		141,995
	Utilization	19.92%	44.62%	34.85%		46.19%
Adult oral prophylaxis	Count	3,769	5,687	6,596		12,110
	Utilization	38.91%	37.70%	38.76%		37.30%
Composite fillings	Count	1,895	2,740	3,221		7,299
	Utilization	19.56%	18.06%	18.93%		22.48%
Amalgam fillings	Count	461	744	890		1,853
	Utilization	4.76%	4.93%	5.23%		5.71%

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

[12] Includes full benefit members only, partial benefit members were not covered for value-added dental services.

[13] Breakdown of services by procedure code for value-added dental services was not available in LHCC encounter data at the time of this report. The system edits were put in place on November 1, 2017, to collect this information.

Medicaid Managed Care Enrollees

13 MEMBERS ENROLLED

The total number of unduplicated enrollees enrolled during the reporting period, and the monthly average of the number of members enrolled in each managed care organization delineated by eligibility category of the enrollees.

Out of the total 1,790,956 unduplicated individuals enrolled at some point in Louisiana Medicaid in State Fiscal Year 2017, 93 percent or 1,659,897 unduplicated individuals were enrolled in a health plan for one or more months during the year. The majority of health plan members received full-benefit coverage.

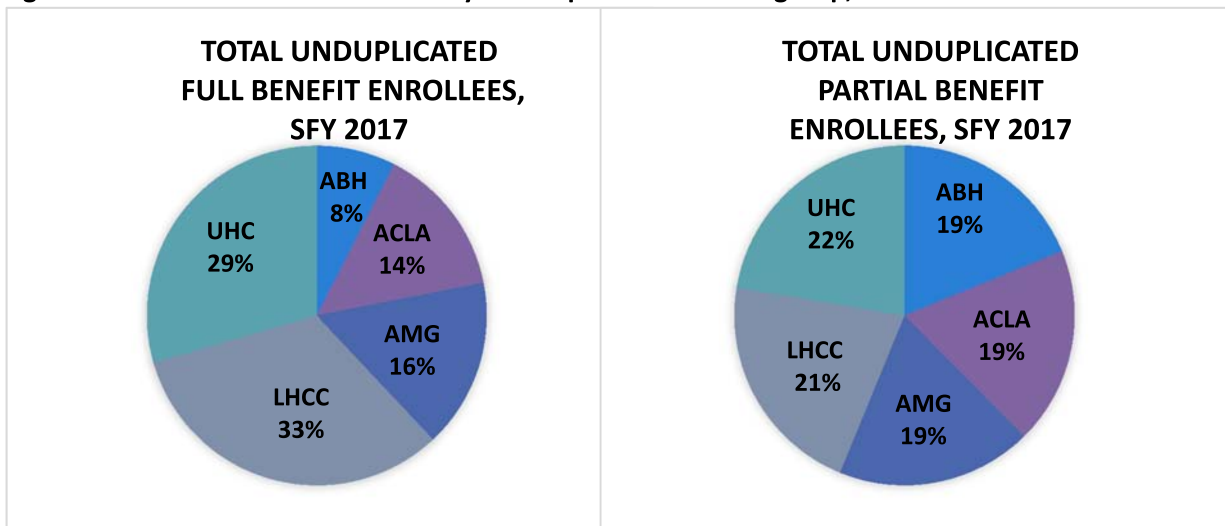
The distribution of total enrollees across health plans ranged from 9 percent in Aetna to 30 percent in Louisiana Healthcare Connections. Table 13.1 and Figure 13.1 below provide a breakdown of enrollment totals by health plan and benefits covered. This table represents unduplicated enrollment in each health plan throughout the year.

Table 13.1 Total enrollees by health plan and benefit group, State Fiscal Year 2017

	ABH	ACLA	AMG	LHCC	UHC	Total Unduplicated[14]
Full-benefit enrollees	119,418	228,880	255,608	517,264	467,960	1,538,005
Partial-benefit enrollees	25,624	24,598	25,341	29,192	30,490	133,696
Total enrollees unduplicated	143,460	251,494	278,916	543,478	495,527	1,659,897
Percent of total enrollees	8.6%	15.2%	16.8%	32.7%	29.9%	100%

Source: MARS Data Warehouse

Figure 13.1 Distribution of enrollees by health plan and benefit group, State Fiscal Year 2017



Source: MARS Data Warehouse

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

For purposes of health plan reimbursement, enrollees were assigned to one of the eligibility categories listed below in State Fiscal Year 2017:

- *Families and Children*: Children and teens under the age of 19 whose basis of Medicaid or LaCHIP eligibility was age, along with their parents or caregivers. This group also includes pregnant women whose primary basis of eligibility for Medicaid was pregnancy. Children with disabilities are not included in this group.
- *People with disabilities and Supplemental Security Income (SSI)-related seniors*: Individuals who were aged 65 and above as well as individuals of any age, including children, with disabilities.
- *Foster children*: Children who received 24-hour substitute care from someone other than a parent or guardian and for whom the Department of Children and Family Services (DCFS) has responsibility for placement and care.
- *Breast and Cervical Cancer (BCC)*: Uninsured women who have already been diagnosed by a Centers for Disease Control and Prevention (CDC)-approved screening entity with breast or cervical cancer or a precancerous condition and who were not otherwise eligible for Medicaid.
- *LaCHIP Affordable Plan (LAP):* Children and youth under the age of 19 with incomes between 217 and 255 percent of the federal poverty level (FPL). Families pay a monthly premium of $50.
- *Home and Community-Based Services (HCBS) Waiver*: Individuals who are elderly or have disabilities and receive waiver services to assist them in remaining in their homes and in the community.
- *Chisholm*: Louisiana Medicaid recipients under age 21 who are on the Developmental Disabilities Request for Services Registry.
- *New Adult Group (Expansion)*: All adults between the ages of 19 and 64 (including both parents and adults without dependent children) with incomes below 138 percent of FPL.

While figure 13.1 above presents unduplicated enrollees for the full twelve months during State Fiscal Year 2017, tables 13.1 and 13.2 below provide the average monthly number of enrollees for full-benefit and partial-benefit coverage respectively.

Table 13.1 Average number of full-benefit members enrolled each month delineated by eligibility category and health plan, State Fiscal Year 2017

	ABH	ACLA	AMG	LHCC	UHC
Families & Children	33,880	115,352	127,218	304,982	256,680
SSI	7,168	21,567	19,762	37,041	28,965
Foster Care	355	895	2,721	5,926	2,153
BCC	72	191	139	162	190
LAP	190	334	435	1,022	1,009
HCBS Waiver	99	236	233	446	432
Chisholm	131	287	325	825	592
New Adult Group/Expansion	46,380	55,172	63,141	100,106	107,044
All Categories	88,275	194,034	213,975	450,511	397,064

Source: MARS Data Warehouse

For the partial-benefit only population, the breakdown of average monthly membership for each health plan by eligibility category for State Fiscal Year 2017 is presented in table 13.2. The average monthly enrollment is lower than the total unduplicated count for the year presented in figure 13.1 because each month there were some members who lost eligibility, while others were newly enrolled.

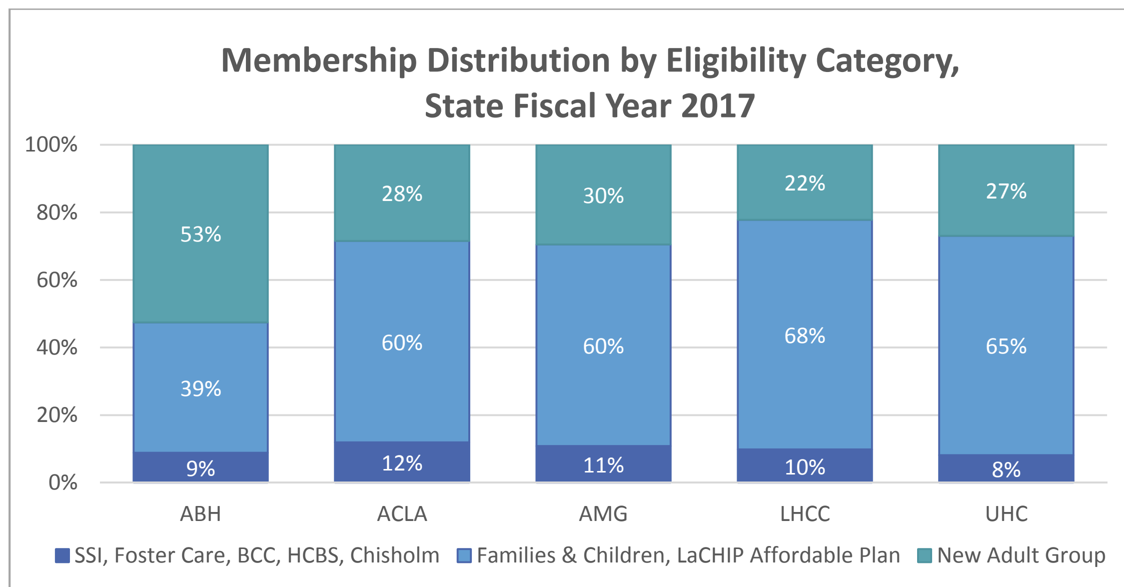
Table 13.2 Average number of Partial-benefit only members enrolled each month delineated by eligibility category and health plan, State Fiscal Year 2017

	ABH	ACLA	AMG	LHCC	UHC
Chisholm	627	692	772	1,079	1,041
Dual Eligibles	19,839	18,865	19,177	21,618	22,527
HCBS Waiver	991	989	997	1,163	1,298
Other[15]	593	569	632	668	755
All Categories	**22,050**	**21,115**	**21,578**	**24,529**	**25,620**

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 and the LaCHIP Affordable Plan eligibility categories are generally healthier and less costly per member as compared to the SSI, Foster Care, Breast & Cervical Cancer, Home & Community-Based Service and Chisholm groups. The distribution of members enrolled in each health plan by eligibility category and enrollment type is displayed in figure 13.2.

Figure 13.2 Full-benefit membership distribution by eligibility category, State Fiscal Year 2017



Source: MARS Data Warehouse

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

14 PROACTIVE CHOICE AND AUTO-ENROLLMENT

The number of members who proactively chose the managed care organization and the number of members who were auto-enrolled into each managed care organization delineated by managed care organization.

One of the goals of the Medicaid Managed Care Program is to engage members in selecting the health plan that best meets their needs. Factors that weigh in the decision include value added benefits that may be offered by a given plan and whether one's preferred providers participate in the plan's network. Health plan enrollment and disenrollment is managed by the Department's contracted enrollment broker, Maximus. As required by federal Medicaid regulations, the enrollment broker is independent and free from conflict of interest.

New Medicaid enrollees were given the opportunity to select a plan at the time of application. Members who did not choose a health plan were auto-assigned to the plan the enrollment broker determined to be the best fit for them, which was determined using information such as their prior enrollment in a health plan if that enrollment occurred within the previous 60 days, current providers, or whether family members were already enrolled in a plan.

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

Table 14.1 provides the individual plan and aggregate choice rates for State Fiscal Year 2017. All five health plans saw a significant increase in proactive choice rates, with the overall rate increasing from 37.6 percent in 2016 to 63.0 percent in 2017. There were no changes in the methodology for calculation of the choice rate. The increase is attributed to Medicaid expansion and heightened enrollment efforts, including the release of the Healthy Louisiana mobile enrollment app in August 2016. The Department continues to work with the enrollment broker and other stakeholders to inform and educate members about Medicaid managed care, available health plans and the process for selecting the plan of their choice.

Table 14.1 Proactive choice rates, State Fiscal Year 2017

	ABH	ACLA	AMG	LHCC	UHC	Total
Pro-active Choice Enrollments	23,028	23,705	37,733	74,355	87,751	**246,572**
Auto Enrollments	25,132	27,874	27,984	32,838	31,101	**144,929**
Total Enrollments	48,160	51,579	65,717	107,193	118,852	**391,501**
Choice rate	47.8%	46.0%	57.4%	69.4%	73.8%	**63.0%**

Source: Maximus Health Services

15 ENROLLEES WHO RECEIVED SERVICES

The total number of enrollees who received unduplicated Medicaid services from each managed care network, broken down by provider type, provider taxonomy code and place of service.

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

Table 15.1 shows the unduplicated counts and percent of members who received services in State Fiscal Year 2017. During this reporting period, 1,356,761 members received one or more Medicaid service(s) through their health plan for an overall rate of 81.7 percent across all plans. All five health plans demonstrated an increase in their individual rate from 2016. Rates for individual plans demonstrate variation across plans with a range of 68.4 percent (Aetna) to 85.3 percent (United HealthCare).

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

Table 15.1 Enrollees who received services, State Fiscal Year 2017

	ABH	ACLA	AMG	LHCC	UHC	Total Unduplicated
Unduplicated Count of Members	143,460	251,494	278,916	543,478	495,527	**1,659,897**[16]
Number Receiving One or More Services	98,066	204,328	221,000	452,912	422,581	**1,356,761**
Percent Receiving One or More Services	68.4%	81.2%	79.2%	83.3%	85.3%	**81.7%**

Source: MARS Data Warehouse

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

16 ENROLLEES WHO HAD A PRIMARY CARE VISIT

The total number and percentage of enrollees of each managed care organization who had at least one visit with their primary care provider during the reporting period.

Once a Medicaid recipient is assigned to a health plan, either by choice or by auto assignment, the health plan in turn links the member to their chosen primary care provider (PCP). These PCPs are providers who contracted with the health plan explicitly to provide primary care services and to serve as a medical home for their patients. Enrollees were contacted by their health plan to make a PCP selection. If no PCP selection was made within 10 days of enrollment into the health plan, enrollees were assigned one. The algorithm for auto assignment considers past history with a PCP or a family history with a PCP. The Department required each health plan to have a process through which members could request to change their PCP for cause.

The data in table 16.1 show the number and percentage of members who had at least one visit with a PCP to which they were linked during State Fiscal Year 2017. Though all members were linked to a PCP, they were not prohibited from seeking care from other providers. It is important to note that not included in this table is data on members who had a visit for primary care services rendered by a provider to which the member was not linked at the time. The data are reflective of legislative reporting specific to R.S. 40:1253.2, and as such, may exclude other primary care access points.

Table 16.1 Total number and percentage of enrollees of each managed care organization who had at least one visit with their primary care provider, State Fiscal Year 2017

	ABH	ACLA	AMG	LHCC	UHC
Unduplicated Full-benefit Members	119,418	228,880	255,608	517,264	467,960
Members with at least one PCP visit	22,950	74,846	87,392	182,282	153,893
Percentage	19.2%	32.7%	34.2%	35.2%	32.9%

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

17 HOSPITAL SERVICES PROVIDED

The following information concerning hospital services provided to Medicaid enrollees:

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

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

Table 17.1 lists the number of members receiving unduplicated outpatient emergency services for State Fiscal Year 2017. 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 at 396 per 1,000 total health plan members, and Aetna had the lowest rate of 369 per 1,000 health plan members, though no plan was a significant outlier. In aggregate, the rate across all health plans was 396.

Table 17.1 Number of members who received unduplicated outpatient emergency services, State Fiscal Year 2017

	ABH	ACLA	AMG	LHCC	UHC	Unduplicated Total
Members receiving unduplicated outpatient emergency services	44,045	88,758	101,200	201,226	180,472	609,050
Total Unduplicated Full-benefit Health Plan Members	119,418	228,880	255,608	517,264	467,960	1,538,005
Rate per 1,000 unduplicated health plan members	369	388	396	389	386	396

Source: MARS Data Warehouse

Table 17.2 lists the total inpatient Medicaid days for State Fiscal Year 2017. As with other data, wide variability is expected because of the distinct characteristics of each plan's membership.

Table 17.2 Number of total inpatient Medicaid days, State Fiscal Year 2017

	ABH	ACLA	AMG	LHCC	UHC	Unduplicated Total
Total Inpatient Medicaid Days	61,025	123,585	131,739	199,591	173,254	689,194
Rate per 1,000 unduplicated health plan members	511	540	515	386	370	448

Source: MARS Data Warehouse

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

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. Table 17.3 summarizes this data for 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.

The individual health plan rates for access to PCP either before or after an emergency room visit were over 75 percent for four of the plans, with Aetna's rate at 57 percent.

Table 17.3 Unduplicated members who saw a PCP[18] before or after a visit to the Emergency Room, State Fiscal Year 2017

	ABH	ACLA	AMG	LHCC	UHC	Unduplicated Total
12 months before outpatient emergency service	19,405	63,399	64,730	144,658	121,838	410,424
Percentage of total emergency service visits[19]	44.06%	71.43%	63.96%	71.89%	67.51%	67.39%
6 months after outpatient emergency service	20,416	60,374	62,791	135,297	116,509	391,374
Percentage of total emergency service visits	46.35%	68.02%	62.05%	67.24%	64.56%	64.26%

Source: MARS Data Warehouse

[18] 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.

[19] 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 plans' appeals to identify the extent to which they are valid and/or are in the actual control of the health plan. The health plans and the Department both looked for trends and used the reports to determine the need for operational changes and improvements.

Table 18.1 Appeals, state fair hearings and appeals overturned, State Fiscal Year 2017

	ABH	ACLA	AMG	LHCC	UHC	MCNA Dental
Total number of unduplicated members	143,460	251,494	278,916	543,478	495,527	1,659,897
Number of members who filed appeals	47	469	426	2,312	720	72
Number of members who accessed the State Fair Hearing process	18	17	33	47	46	10
Rate of members who filed an appeal (per 1000)	0.33	1.86	1.53	4.25	1.45	0.04
Total number of Appeals filed	48	521	435	2,586	760	72
Total number of appeals that reversed or otherwise resolved a decision in favor of the member[20]	10	188	76	948	266	17
Percent of appeals that reversed or otherwise resolved a decision in favor of the member	21%	36%	17%	37%	35%	24%

Source: 113 Monthly Appeal & State Fair Hearing Detail Workbook

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

[20] Includes an unduplicated count of all appeals that were overturned or partially overturned by the health plan, Division of Administrative Law, or LDH.

Healthcare Services Provided to Enrollees

To collect the data in this section, the Department defined emergency services as outpatient services provided in an emergency room, exclusive of the Emergency Medical Treatment and Labor Act (EMTALA) screening or urgent care, and professional services, specifically the evaluation and management of a patient, provided in an emergency room.[21] There were zero claims submitted to MCNA for emergency services since MCNA did not manage emergency services as defined for this report.

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

[21] Includes Claim Type 03 (outpatient services) with Revenue Codes 450, 451, and 981 and Claim Type 04 (Professional Services) with Procedure Codes 99281 through 99285.

19 CLAIMS SUBMITTED BY HEALTHCARE PROVIDERS

The total number of claims submitted by healthcare providers to each managed care organization. The total number shall also be delineated by claims for emergency services and claims for nonemergency services.

Health plans report claims data annually using the revised 177 reporting template developed by the Department, which captures unduplicated counts of claims received by each health plan. This report captures not only claims that are adjudicated (processed for payment or denial), but also captures rejected claim counts that are not reported in encounter submissions to the fiscal intermediary. The aggregate count of unduplicated claims submitted across all health plans and MCNA totaled 73,633,632 in State Fiscal Year 2017. The breakdown of unduplicated claim counts for State Fiscal Year 2017 is presented in table 19.1.

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

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

Table 19.1 Total claims by managed care plans for emergency and non-emergency services, State Fiscal Year 2017

	Rejected Claims	Emergency Services	Non-Emergency Services	Total
ABH	31	238,454	5,297,998	**5,536,483**
ACLA	216,404	412,782	10,293,050	**10,922,236**
AMG	2,430	309,762	11,325,872	**11,638,064**
LHCC	404,452	873,490	23,766,842	**25,044,784**
UHC	8,329	632,220	16,329,646	**16,970,195**
MCNA Dental	0	0	3,521,870	**3,521,870**
Total	631,646	2,466,708	70,535,278	**73,633,632**

Source: Report 177 Total and Out of Network Claims

20 DENIED CLAIMS

The total number of claims submitted by healthcare providers to each managed care organization which were adjusted [adjudicated] by the respective managed care organization and payment for services was denied. This item of the report shall include a delineation between emergency and nonemergency claim denials. Additionally, this item of the report shall include the number of denied claims for each managed care organization delineated by the standard set of Claim Adjustment Reason Codes published by the Washington Publishing Company.

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

Table 20.1 Total unduplicated denied claims, State Fiscal Year 2017

	Emergency Services	Non-Emergency Services	Total
ABH	16,382	1,157,620	**1,174,002**
ACLA	34,010	2,441,962	**2,475,972**
AMG	31,146	2,999,920	**3,031,066**
LHCC	37,215	4,212,513	**4,249,728**
UHC	91,453	3,696,467	**3,787,920**
MCNA Dental	0	378,096	**378,096**
Total	**210,206**	**14,886,578**	**15,096,784**

Source: 173 Denied Claims Report

Records for each denied claim must include a reason for the denial. The Department required plans to report these denials using claim adjustment reason codes (CARC) for medical and behavioral health claims and National Council for Prescription Drug Program (NCPDP) reject codes for pharmacy claims, which are both national standards. The number of CARC and NCPDP codes is greater than the unduplicated number of total denied claims as represented in table 20.1. The reason for this difference 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 CARC or NCPDP reject codes randomly and one is not primary in comparison to another.

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 2017

CARC	CARC Description	Emergency Claims[22]	Non-Emergency Claims	Total
197	Precertification/authorization/notification absent.	1,555	1,804,501	**1,806,056**
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	44,683	1,465,178	**1,509,861**
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	9,476	1,007,415	**1,016,891**
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.	10,156	825,994	**836,150**
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.	13,550	656,322	**669,872**
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	24,380	420,668	**445,048**
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.)	2,714	353,513	**356,227**
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	5,582	284,976	**290,558**
11	The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	786	256,801	**257,587**
29	The time limit for filing has expired.	8,438	235,364	**243,802**

Source: 173 Denied Claims Report

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

Table 20.3 shows the ten most frequently used NCPDP reject codes for emergency and non-emergency pharmacy claims. Pharmacy claims use a different national coding structure than is used for medical or behavioral health claims. For consistency with encounter data, the Department has utilized 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 2017

NCPDP Code	NCPDP Description	Emergency Claims[23]	Non-Emergency Claims	Total
79	Refill Too Soon	497	1,106,994	**1,107,491**
76	Plan Limitations Exceeded	6,651	1,072,182	**1,078,833**
75	Prior Authorization Required	1,432	887,704	**889,136**
70	Product/Service Not Covered	6,006	733,705	**739,711**
88	DUR Reject Error	3,481	443,763	**447,244**
MR	Product Not On Formulary	298	276,711	**277,009**
41	Submit Bill To Other Processor Or Primary Payer	2,399	249,879	**252,278**
85	Claim Not Processed	156	223,558	**223,714**
23	Missing or Invalid Ingredient Cost Submitted	6	214,175	**214,181**
69	Filled After Coverage Terminated	1,717	135,417	**137,134**

Source: 173 Denied Claims Report

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

21 CLEAN CLAIMS

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

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

Table 21.1 lists the total clean claims submitted to each health plan. This total includes claims that were paid, denied or otherwise adjudicated. Total clean claims for State Fiscal Year 2017 increased 90 percent over total clean claims submitted in 2016. Two significant factors impacting this increase include a thirty-four percent increase in total health plan enrollment, including Medicaid expansion, and a full 12 months of coverage for specialized behavioral health services as compared to 7 months in 2016.

Table 21.1 Total clean claims by health plan, State Fiscal Year 2017

ABH	ACLA	AMG	LHCC	UHC	MCNA	Total
3,443,813	10,774,110	7,075,787	18,659,937	13,407,290	832,927	**54,193,864**

Source: 221 Prompt Pay Report

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

Table 21.2 Percent of paid claims that were paid within 15 days, State Fiscal Year 2017

Provider Type	ABH	ACLA	AMG	LHCC	UHC	MCNA
Inpatient Hospital	79.00%	99.99%	96.27%	93.13%	99.13%	.
Outpatient Hospital	97.87%	100.00%	99.88%	99.48%	98.88%	.
Professional	97.45%	99.94%	99.78%	99.76%	99.91%	.
Rehab	98.54%	100.00%	99.64%	99.95%	99.96%	.
Home Health	86.71%	99.96%	99.76%	99.53%	99.08%	.
EMT(Transportation)	91.10%	100.00%	98.02%	99.11%	99.85%	.
NEMT & NEAT Transportation	99.56%	99.55%	99.39%	99.17%	99.60%	.
DME	94.63%	100.00%	99.29%	98.76%	99.69%	.
Pharmacy	99.43%	99.78%	97.53%	100.00%	96.94%	.
EPSDT Dental	.	.	.	.	.	99.91%
Adult Denture	.	.	.	.	.	99.79%

Source: 221 Prompt Pay Report

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

Table 21.3 Percent of paid claims that were paid within 30 days, State Fiscal Year 2017

Provider Type	ABH	ACLA	AMG	LHCC	UHC	MCNA
Inpatient Hospital	92.10%	100.00%	99.76%	98.03%	99.88%	.
Outpatient Hospital	99.44%	100.00%	99.96%	99.87%	99.28%	.
Professional	99.51%	100.00%	99.94%	99.94%	99.99%	.
Rehab	99.82%	100.00%	99.90%	100.00%	100.00%	.
Home Health	95.38%	99.96%	99.91%	99.88%	100.00%	.
EMT (Transportation)	97.79%	100.00%	98.78%	99.72%	100.00%	.
NEMT & NEAT (Transportation)	99.78%	99.79%	99.68%	99.75%	99.83%	.
DME	98.45%	100.00%	99.79%	99.68%	99.85%	.
Pharmacy	100.00%	100.00%	97.63%	100.00%	100.00%	.
EPSDT Dental	.	.	.	.	.	100.00%
Adult Denture	.	.	.	.	.	100.00%

Source: 221 Prompt Pay Report

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. It should be noted, however, that adjudicated date and paid date are not the same. It often occurs that a claim is adjudicated (paid or denied) and will not be paid until the next weekly check cycle. This information is reflective of the paid date as requested by the statutory reporting requirement.

Table 21.4 Average number of days to pay clean claims, State Fiscal Year 2017

Provider Type	ABH	ACLA	AMG	LHCC	UHC	MCNA
Inpatient Hospital	13.00	8.00	9.00	11.00	10.15	.
Outpatient Hospital	6.00	4.10	4.00	8.00	8.31	.
Professional	6.00	4.17	4.00	7.00	7.93	.
Rehab	6.00	4.60	5.00	7.00	7.95	.
Home Health	11.00	4.90	5.00	9.00	8.91	.
EMT (Transportation)	9.00	3.60	9.00	8.00	9.88	.
NEMT & NEAT (Transportation)	10.00	10.39	9.33	10.50	9.96	.
DME	8.00	5.40	5.00	8.00	8.69	.
Pharmacy	10.00	2.70	4.00	1.00	4.00	.
EPSDT Dental	.	.	.	.	.	7.00
Adult Denture	.	.	.	.	.	8.00

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

22 REGULAR AND EXPEDITED SERVICE REQUESTS PROCESSED

The total number and percentage of regular and expedited service authorization requests processed within the time frames specified by the contract for each managed care organization. In addition, the report shall contain the total number of regular and expedited service authorization requests which resulted in a denial for services for each managed care organization.

The health plans are required to reimburse for all medically necessary services. The determination of medical necessity by the plan is an important factor considered when a plan is evaluated for both overutilization and underutilization of services. Plans may require submission of clinical information for review and authorization of the service as a condition of payment. It is important in ensuring timely access to care that service authorization requests submitted by providers are acted on in a timely manner.

Health plan contracts with the Department stipulated that service authorizations must be processed within 14 calendar days of the request for authorization with at least 80 percent processed within two business days of receipt of needed documentation. If the situation warranted, the provider could request an expedited determination, in which case the request must be acted on within 72 hours or less, depending on the medical urgency. Per the Code of Federal Regulations, an extension of up to fourteen days could be granted if the member or the health plan justified a need for additional information and how the extension is in the member's best interest.

Contracted timeframes and compliance standards apply in aggregate for both medical and behavioral health service authorizations. Data for State Fiscal Year 2017 are presented in table 22.1. Variations in the number of authorizations processed by individual health plans can be attributed to plan policy, as well as membership size and complexity.

Table 22.1 Standard service authorizations processed, State Fiscal Year 2017

TIMEFRAME (COMPLIANCE STANDARD)		ABH	ACLA	AMG	LHCC	UHC
Processed within 2 business days from receipt of needed documentation (80%)	Number	17,013	72,539	23,592	155,346	82,540
	Percent	77.1%	91.8%	80.6%	92.7%	89.8%
Non-extended: Processed within 14 days of receipt of request for authorization (100%)	Number	21,168	78,820	104,187	146,603	71,201
	Percent	95.3%	99.6%	95.5%	99.1%	100.0%
Extended: Processed within 28 days[24] of receipt of request for authorization (100%)	Number	3,591	277	--[25]	19,526	20,500
	Percent	97.8%	100.0%	--[26]	98.5%	99.2%

Source: 188 Ad Hoc Annual Report, SFY 2017

[24] All authorizations for Durable Medical Equipment (DME) must be processed in 25 days or less.
[25] No extended authorizations reported.

Table 22.2 Expedited service authorizations processed, State Fiscal Year 2017

TIME FRAME (COMPLIANCE STANDARD)		ABH	ACLA	AMG	LHCC	UHC
Non-extended: Processed within 72 hours of receipt of request for authorization (100%)	**Number**	6,844	725	102	69	2,036
	Percent	83.6%	99.7%	100.0%	89.6%	100.0%
Extended: Processed within 14 days of receipt of request for authorization (100%)	**Number**	2,524	2	--[26]	18	46
	Percent	96.6%	100.0%	--[27]	100.0%	86.8%

Source: 188 Ad Hoc Annual Report, SFY 2017

The percent of prior authorizations that resulted in a denial of services are presented in table 22.4. Note that the counts presented are unduplicated denials based on the initial service authorization determination; some denials may have subsequently been reversed by the health plans upon reconsideration, appeal or through the state fair hearing process. See Section 18 of this report for additional information on appeals and state fair hearings.

Table 22.4 Percent of service authorizations denied, State Fiscal Year 2017

	ABH	ACLA	AMG	LHCC	UHC
Total service authorization processed	37,537	83,566	152,675	186,777	94,187
Number denied	2,821	10,966	9,968	14,487	9,829
Percent denied	7.52%	13.1%	6.5%	7.8%	10.4%

Source: 188 Ad Hoc Annual Report, SFY 2017

[26] No extended authorizations reported.

23 CLAIMS PAID TO OUT-OF-NETWORK PROVIDERS

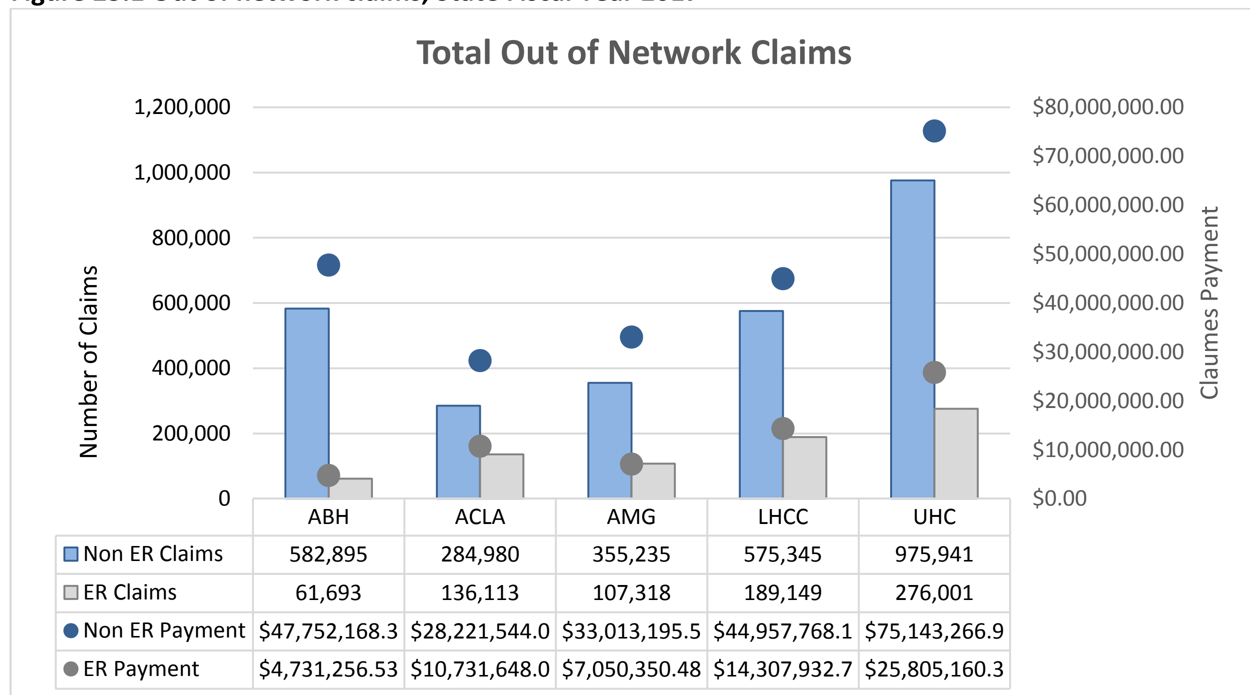
The total number and dollar value of all claims paid to out-of-network providers by claim type categorized by emergency services and nonemergency services for each managed care organization by parish.

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 time frame. The health plans may also make payments to non-network providers for care that was not classified as emergency services through single-case agreements or other arrangements.

The information in figure 23.1 reflects the number of claims and dollar value of payments by the health plans to non-network providers for both emergency services and non-emergency services. The data originate from submissions from the health plans on the standing annual report (report 177). 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, State Fiscal Year 2017



	ABH	ACLA	AMG	LHCC	UHC
Non ER Claims	582,895	284,980	355,235	575,345	975,941
ER Claims	61,693	136,113	107,318	189,149	276,001
Non ER Payment	$47,752,168.3	$28,221,544.0	$33,013,195.5	$44,957,768.1	$75,143,266.9
ER Payment	$4,731,256.53	$10,731,648.0	$7,050,350.48	$14,307,932.7	$25,805,160.3

Source: Report 177 Total and Out of Network Claims

24 PHARMACY BENEFITS

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

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

In State Fiscal Year 2017, all five health plans managed pharmacy benefits for members enrolled with full-benefits coverage. Partial-benefit only members continued to receive pharmacy benefits under fee-for-service Medicaid.

A managed care organization can self-administer its pharmacy benefits or subcontract with a pharmacy benefit manager. Table 24.1 identifies the pharmacy benefit manager for each managed care organization and whether the pharmacy benefit manager was a wholly-owned subsidiary or a contracted vendor during State Fiscal Year 2017.

Table 24.1 MCO pharmacy benefit managers, State Fiscal Year 2017

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

Source: MCO self-reported

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

Table 24.2 lists the unduplicated total number of pharmacy claims received by each health plan, as well as a breakdown of claims by the select categories requested. The variation in the data presented is reflective of the variation across health plans in implementing alternative approaches to managing pharmacy benefits, particularly in step-therapy and fail first protocols. When a drug was requested that required step therapy and fail first protocols, the recipient was required to try preferred product(s) before the requested drug would be approved. Each health plan had its own list of preferred drugs and drugs that required step therapy/fail first protocols. 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.

Table 24.2 Pharmacy claims comparison, State Fiscal Year 2017

		ABH	ACLA	AMG	LHCC	UHC
Total prescription claims	**#**	**1,717,387**	**3,162,449**	**3,879,867**	**6,582,557**	**6,002,028**
Subject to prior authorization	#	23,503	110,277	282,773	647,415	706,847
	%	1.37%	3.49%	7.29%	9.84%	11.78%
Denied	#	430,117	626,177	1,320,831	1,427,588	1,174,733
	%	25.04%	19.80%	34.04%	21.69%	19.57%
Subject to step therapy or fail first protocol	#	6,658	19,946	18,358	190,131	132,727
	%	0.39%	0.63%	0.47%	2.89%	2.21%

Source: Report RX055 - Pharmacy

25 MEDICAID DRUG REBATES

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

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

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

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, drug rebates, both federal and state supplemental, accrue directly to the state. For Medicaid enrollees in a full-risk managed care organization, only federal rebates accrue directly to the state. In Calendar Year 2016, the Department collected $211.1 million in federal rebates from managed care pharmacy utilization.

Since each Louisiana Medicaid managed care organization determines its own unique preferred drug list, supplemental rebates are not available to the state, but comparable negotiated discounts may be collected by the MCO. LDH requires plans to report rebates and discounts collected in quarterly financial reports (185 report). The Department's contracted actuaries considered the reported amounts when setting capitation rates for managed care organizations, and related reductions to capitation rates benefit the state indirectly. As a result, the managed care organizations remitted no drug rebates or manufacturer discounts directly to the Department.

Table 25.1 provides the amount of Medicaid drug rebates and manufacturer discounts collected and used as well as remitted to the Department during calendar year 2016, as reported by the managed care organizations in their quarterly financial reporting requirements.

Table 25.1 Total pharmacy rebates received, Calendar Year 2016

	Amount of Medicaid Drug Rebates and Manufacturer Discounts Collected and Used	Amount of Medicaid Drug Rebates and Manufacturer Discounts Collected and Remitted to the Department
ABH	$470,485	$0
ACLA	$5,058,000	$0
AMG	$3,269,690	$0
LHCC	$3,465,632	$0
UHC	$15,200,684	$0
Total	**$27,464,491**	**$0**

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

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

Table 25.2 Monthly pharmacy rebates received, Calendar Year 2016

	ABH[27]	ACLA	AMG	LHCC	UHC
January	-	352,000	249,197	182,598	1,081,298
February	93,086	363,000	159,258	180,863	1,118,676
March	-	361,000	220,793	199,978	1,204,563
April	-	356,000	250,847	176,054	1,201,809
May	131,893	339,000	193,154	147,441	1,148,076
June	-	275,000	199,061	480,354	1,052,137
July	-	333,000	269,550	276,771	1,109,957
August	148,550	426,000	332,458	380,579	1,417,560
September	-	426,000	453,670	361,901	1,344,145
October	-	364,000	235,195	343,890	1,413,054
November	96,956	716,000	344,476	339,519	1,552,889
December	-	747,000	362,031	395,684	1,556,520
2016 Total	**$470,485**	**$5,058,000**	**$3,269,690**	**$3,465,632**	**$15,200,684**

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

[27] ABH's PBM, CVS, remits rebates to ABH quarterly.

26 DENTAL PRIOR AUTHORIZATION REQUESTS

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

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

Louisiana Medicaid defines prior authorizations as "the process of determining medical necessity for specific services before they are rendered." In State Fiscal Year 2017, MCNA completed prior authorizations on a total of 321,092 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 the dental emergency benefits they cover.

Table 26.1 Number of prior authorization requests processed by DBPM by type of procedure, State Fiscal Year 2017

Type of Procedure	Children EPSDT (under 21 years)	Adult Denture (21 years & older)	Total Number of Prior Authorization Requests
Restorative	84,355	195	84,550
Oral & Maxillofacial Surgery	90,478	968	91,446
Adjunctive General Services	46,386	119	46,505
Endodontics	26,095	44	26,139
Removable Prosthodontics	859	32,360	33,219
Diagnostic	2,424	18,905	21,329
Preventive	12,490	16	12,506
Periodontics	3,827	49	3,876
Orthodontics	1,408	5	1,413
Fixed Prosthodontics	69	11	80
Maxillofacial Prosthetics	1	0	1
Implant Services	17	11	28
Total	**268,409**	**52,683**	**321,092**

Source: MCNA Report 188 Prior Authorization Summary Report - Annual Ad Hoc SFY2017

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 2 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 Times for responding to prior authorization requests by DBPM, State Fiscal Year 2017

Type of Procedure	Children EPSDT (under 21 years)		Adult Denture (21 years & older)	
	Average Time	Range of Times	Average Time	Range of Times
Oral & Maxillofacial Surgery	0.36	0-2 days	0.60	0-2 days
Adjunctive General Services	0.41	0-11 days	0.53	0-2 days
Restorative	0.41	0-7 days	0.81	0-2 days
Endodontics	0.36	0-2 days	0.70	0-2 days
Periodontics	0.38	0-2 days	0.59	0-2 days
Removable Prosthodontics	0.42	0-2 days	0.61	0-2 days
Diagnostic	0.91	0-2 days	0.59	0-2 days
Preventive	0.37	0-6 days	0.88	0-2 days
Orthodontics	0.50	0-2 days	0.60	0-1 days
Fixed Prosthodontics	0.35	0-2 days	0.45	0-1 days
Maxillofacial Prosthetics	1.00	0-1 days	0.00	0 days
Implant Services	0.24	0-1 days	0.82	0-1 days
Overall Average	**0.47**	**0-4 days**	**0.60**	**0-3 days**

Source: MCNA Report 188 Prior Authorization Summary Report - Annual Ad Hoc SFY2017

Of the 321,092 prior authorizations MCNA completed during State Fiscal Year 2017, 49,649 unduplicated authorizations were denied (15 percent). 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 (49,649) therefore, these items are reported independent of each other.

MCNA used a total of 32 unique denial reasons for prior authorizations. Table 26.3 includes the ten most frequently used authorization denial codes, which accounted for 41,546, or 83 percent of all denial reason codes applied. The most common denial reason, code 272, was due to a combination of services submitted on a request which cannot be performed by the same provider on the same date of service. Other common reasons were the lack of pre-operative x-rays, restoration not covered when the tooth has previously been restored or requests for services not covered under Departmental policy. All denials delineated by denial reason are included in Appendix XI.

In State Fiscal Year 2017, MCNA initially denied 44,513 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 21,036 or 47 percent of all denials after prior authorization was approved. All denials delineated by reason for denial are included in Appendix XI. It should be noted that the data reflect only initial denials and do not reflect if a claim was resubmitted and subsequently paid.

Table 26.3 Ten most prevalent reasons for authorization denial by DBPM, State Fiscal Year 2017

Authorization Denial Code	Code Description	Total
272	The combination of services submitted on this request for this member cannot be performed by the same provider on the same date of service.	11,768
252	This code requires pre-operative x-rays to be submitted with the claim for consideration. The procedure will be evaluated for medical necessity during the claim review.	6,764
18	There is no benefit for restorations when the tooth has previously been restored.	4,453
204	This is a non-covered service per the covered services outlined in your Provider Manual, Prosthodontic Service(s).	3,790
251	The attachment submitted is invalid, unreadable and/or contains no images. Please submit the attachments.	2,977
56	The Dental Director has advised that the x-rays received do not demonstrate the need for treatment submitted.	2,759
16	Upon review of the x-ray, the tooth appears to be missing.	2,519
269	This procedure can only be considered when reported and performed in conjunction with covered services.	2,373
169	The Plan will reimburse for either a full mouth x-ray series or a panoramic film, but not both, on the same date of service.	2,156
96	Procedure is only covered on permanent teeth. Primary teeth are not covered.	1,987
	TOTAL TOP TEN AUTHORIZATION DENIAL REASON CODES	**41,546**

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

Table 26.4 Ten most prevalent reasons for claim denial after prior authorization was approved by DBPM, State Fiscal Year 2017

CARC	Code Description	Total
252	Please provide the rationale for treatment and resubmit attached to this document for further review.	13,643
272	Alveoplasty is only covered when performed in conjunction with three or more adjacent extractions in a single quadrant.	11,578
169	Coverage has been provided for an alternate benefit.	4,287
204	This is a non-covered service per the covered services outlined in your provider manual. Endodontic service(s)	3,639
50	The dental director has advised there is no evidence of decay in the pulp chamber.	2,894
56	Coverage is limited to the more definitive treatment.	1,981
96	Treatment performed on teeth with poor or questionable prognosis is not covered.	1,221
251	Please resubmit the attachment in a readable format.	876
16	The procedure is approved; however, please submit the criteria for dental therapy under general anesthesia form (22 PT. FORM) for review of the request to treat the member under general anesthesia.	790
181	ADA code submitted is not a valid code with the American Dental Association. Resubmit with the correct ADA code.	739
	TOTAL TOP TEN CLAIM DENIAL REASON CODES	**41,648**

Source: Report 173 Denied Claims

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