Act 158 Report MCO Survey

Louisiana Department of Health (LDH)
Louisiana Medicaid Managed Care Program
Act 158 Transparency Report
Survey for Managed Care Organization (MCO)-Self Reported Items

State Fiscal Year 2019
July 1, 2018 - June 30, 2019

Responses should be based on *State Fiscal Year 2019 (July 1, 2018 - June 30, 2019)*, unless otherwise noted.

Report Reference Number	LDH Internal Item Number	Task	Questions	MCO Response
1b	2	The total number of employees employed by each Managed Care Organization (MCO) which is based in Louisiana and the ***average*** salary paid of those employees.	What is the total number of employees who reside in LA?	
			Please complete the template on tab 1b (2).	
2f	18	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.*	***Please complete the template on tab 2f (18).***	
			Note: Amounts reported should agree with the sum of the monthly amounts reported to LDH on the 113 Appeal and SFH Report Annual Report for SFY 2019. A reconciliation and explanation of any discrepancies, if applicable, should be included with your survey response.	
3d	22	The total number and percentage of regular and expedited service authorization requests processed within the time frame 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.	***Please complete the template on tab 3d (22).***	
			Note: Amounts reported should agree with the sum of the quarterly amounts reported to LDH on the 188 quarterly Service Authorizations Report for the quarters ending September 2018, December 2018, March 2019 and June 2019. A reconciliation and explanation of any discrepancies, if applicable, should be included with your survey response.	
3e	23	The total number and dollar value of all claims paid to out-of-network providers by claim type categorized by emergency services and non-emergency services for each managed care organization by parish.	Please describe how out-of-network claims were determined. **Please include code** used to define out-of-network claims and determine results (annual Report 177, Total and Out of Network Claims).	
3f	24	The following information concerning pharmacy benefits delineated by each managed care organization: - Total number of prescription claims - Total number of prescription claims subject to prior authorization - Total number of prescriptions claims denied - Total number of prescription claims subject to step therapy or fail first protocols. - The average and range of times for responding to prior authorization requests. - The number of prior authorization requests denied, delineated by the reasons for denial. - The number of claims denied after prior authorization was approved, delineated by the reasons for denial.	What is the total number of prescription claims for SFY19?	
			What is the total number of prescription claims subject to a prior authorization (PA) for SFY19?	
			What is the total number of prescription claims denied for SFY19?	
			What is the total number of prescription claims subject to step therapy or fail first protocols for SFY19?	
			What is the average and range of times for responding to prior authorization requests for SFY19?	
			What is the number of prior authorization requests denied, delineated by the reasons for denial for SFY19?	
			What is the number of claims denied after prior authorization was approved, delineated by the reasons for denial for SFY19?	
			Note: Amounts reported should agree with the sum of the monthly amounts reported to LDH on the Rx055 monthly Pharmacy Report for the months ending July 2018 through June 2019. A reconciliation and explanation of any discrepancies, if applicable, should be included with your survey response.	
			What is the total dollar amount of Medicaid drug rebates and manufacturer discounts collected (received) by the PBM in SFY19?	
			What is the total dollar amount of Medicaid drug rebates and manufacturer discounts retained (kept) by the PBM in SFY19?	

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Report Reference Number	LDH Internal Item Number	Task	Questions	MCO Response
3g	25	Medicaid Drug rebates and manufacture discounts delineated by each managed care organization and the prescription benefit manager contracted or owned by the managed care organization by month.	What is the total dollar amount of Medicaid drug rebates and manufacturer discounts remitted (disbursed) by the PBM to the MCO in SFY19?	
			What is the total dollar amount paid to the PBM by the MCO as a transaction fee for each processed claim in SFY19?	
			What is the total dollar amount retained (kept) by the PBM through spread pricing in SFY19?	
			What is the total dollar amount of all the other monies paid to the PBM in SFY19?	
			What is the total dollar amount of Medicaid drug rebates and manufacturer remitted to the Louisiana Department of Health?	
			Note: Amounts reported should agree with the sum of the monthly amounts reported to LDH on the Rx054 monthly Pharmacy Benefits Management Report for the months ending July 2018 through June 2019. A reconciliation and explanation of any discrepancies, if applicable, should be included with your survey response.	
4	26	For Managed Care Organizations (MCO) that administer dental benefits, the following concerning prior authorization requests, delineated by type of procedure (***this includes any MCO dental services, value added and other dental services***): - The number of prior authorization requests - The average and range of times for responding to prior authorization requests - The number of prior authorization requests denied, delineated by the reasons for denial - The number of claims denied after prior authorization was approved, delineated by the reasons for denial	Does the MCO or MCO subcontractor require prior authorization for (**any**) dental services? If yes, please answer the questions below.	
			What is the number of prior authorization requests for SFY19?	
			What is the average amount of time for responding to prior authorization requests for SFY19?	
			What is the longest amount of turnaround time for responding to prior authorization requests for SFY19?	
			What is the shortest amount of turnaround time for responding to prior authorization requests for SFY19?	
			What is the number of prior authorization requests denied, delineated by the reason for denial for SFY19?	
			What is the number of claims denied after prior authorization was approved, delineated by the reasons for denial for SFY19?	
			Please complete the template on tab 4 (26).	
5	27	- The total number of independent reviews conducted pursuant to R.S. 46:460.81 et seq., delineated by claim type for each managed care organization. - The total number and percentage of adverse determinations overturned as a result of an independent review conducted pursuant to R.S. 46:460.81 et seq., delineated by claim type for each managed care organization.	What is the total number of independent reviews conducted pursuant to R.S. 46:460.81 et seq., delineated by claim type?	
			What is the total number and percentage of adverse determinations overturned as a result of the independent review, delineated by claim type?	
			Note: Amounts reported should agree with the sum of the monthly amounts reported to LDH on the 182 monthly Provider Complaint & Appeal Summary Report for the months ending July 2018 through June 2019. A reconciliation and explanation of any discrepancies, if applicable, should be included with your survey response.	

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Please provide the following information for all **Louisiana-based MCO employees or contracted staff (FTE of actual filled positions)** for Reporting Period SFY19 (July 1, 2018 - June 30, 2019) and **calculate the average salary** as indicated in column D.

Position/Title	Indicate if the position is a MCO employee or contracted staff	Salary	FTE	Average Salary (Salary x FTE)
Total:				

* Information should agree with **Report 17.**

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Please complete the template below, reporting the number of appeals filed, the number of appeals that accessed the state fair hearing process and the number of appeals that were reversed, overturned or otherwise resolved in favor of the member. For purposes of this template, "appeal" means a request for review of an action.

The MCO should only complete the white empty cells. The yellow highlighted cells are formula driven.

Appeals and State Fair Hearings	MCO Count	
	Member Count *(Unduplicated)*	Case Number Count
Total number of appeals filed in SFY19		
Total number of appeals that **accessed the state fair hearing process** in SFY19		
Total number of appeals with a determination[1] in SFY 2019		
Appeal Determinations		
Total number of appeals at the MCO level in SFY19		
Number of appeals **fully reversed or otherwise resolved in favor of the member at the MCO level**		
Number of appeals **partially reversed or otherwise resolved in favor of the member at the MCO level**		
Total number of appeals reversed or otherwise resolved in favor of the member at the MCO level (Line 18 + Line 19)	**0**	**0**
Number of appeals **fully upheld** at the MCO level		
Total Number of appeals FULLY UPHELD by the MCO that went to State Fair Hearing (Do not include appeals partially overturned or partially upheld by MCO)		
Number of appeals reversed by the MCO after State Fair Hearing requested		
Number of appeals **fully overturned at the State Fair Hearing in favor of the member**		
Number of appeals **partially overturned at the State Fair hearing in favor of the member**		
Total number of appeals overturned or otherwise resolved in favor of the member at the State Fair Hearing level (Line 23 + Line 24 + Line 25)	**0**	**0**
Number of appeals **fully upheld** at the State Fair Hearing		
Total Appeals		
Total number of **appeals** overturned or otherwise resolved a decision in favor of the member in SFY19 (Line 20 + Line 26)	0	0
Percent of **appeals** that overturned or otherwise resolved a decision in favor of the member in SFY19 (Line 29 / Line 15)	#DIV/0!	#DIV/0!

Note: Amounts reported should agree with the sum of the monthly amounts reported to LDH on the Report 113 monthly Grievance, Appeal and State Fair Hearing Report for the months ending July 2018 through June 2019. A reconciliation and explanation of any discrepancies, if applicable, should be included with your survey response.

[1]**Definitions of Determination**
Denied: Appeal requests that are found to be unacceptable for timeliness, coverage or appropriate filing, as determined by the Division of Administrative Law
Order Terminating Adjudication: A decision by the DAL that exhausts the appeal process within the Department of Health and Hospitals
Overturned: A decision at the State Fair Hearing level which reverses the health plan's decision in favor of the member
Reversed: A decision at the health plan level to approve a denied request prior to a State Fair Hearing being scheduled by the Division of Administrative Law.
Upheld: A decision at the State Fair Hearing level which confirms the health plan's denial of the member's request
Withdrawal: A written decision made by the appellant to terminate the appeals process

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MYERS AND STAUFFER LC CERTIFIED PUBLIC ACCOUNTANTS

Standard Service Authorizations

Standard (Regular) Service Authorizations	Medical		Behavioral Health		Total	
	Count	Percentage	Count	Percentage	Count	Percentage
Total Standard (Regular) Pending Authorizations (end of SFY2019)						
Total New Standard (Regular) Authorizations Requested (received during current reporting period)						
Total New Standard (Regular) Authorization Requests Withdrawn or Voided Prior to expiration						
Total Standard (Regular) Authorizations Approved						
Total Standard (Regular) Authorizations Denied or Partially Denied						
Standard (Regular) Authorization Determinations made within **2 business days (5 calendar days for CPST and PSR)** of obtaining appropriate medical information						

Standard (Regular) Service Authorizations Processing Timeframes - NOT EXTENDED	Medical		Behavioral Health		Total	
	Count	Percentage	Count	Percentage	Count	Percentage
Total Completed Standard Authorizations within **14 calendar days****						
Total Expired standard service authorizations						
Total Not Expired Standard Authorizations						

Note:
*** ***Completed in 14 Calendar Days*** *- regular standard service authorization determinations completed during the reporting period that were within 14 calendar days from the receipt of the request for authorization. Do not include any standard authorizations that had a request for an extended deadline for determination.* ***(It should include any standard authorization that were also included in the count of completed within 2 days, as long as they were not extended)***

Expired *- regular standard service authorization where the MCO did not make a determination within 14 day of receipt of the request. Do not include any standard authorizations that had a request for an extended deadline for determination.*

Not Expired *- regular standard service authorization where the MCO did not make a determination this reporting period, and the 14 day timeline for determination has not expired, i.e. they are still pending at the end of the reporting period. Do not include any standard authorizations that had a request for an extended deadline for determination.*

Standard (Regular) Service Authorizations Processing Timeframes - EXTENDED	Medical		Behavioral Health		Total	
	Count	Percentage	Count	Percentage	Count	Percentage
Total Completed Standard Authorizations within **28 calendar days (25 days for DME)****						
Total Expired standard service authorizations						
Total Not Expired Standard Authorizations						

Note:
*****Completed in 28 Calendar Days*** *- standard service authorization determinations that had deadlines for determination extended in accordance with RS 42 §438.210 (d) that were completed within the timeframe of the extension, not to exceed a total of 28 days from the date of receipt of the original request for authorization. (It should include any standard authorization that were also included in the count of completed within 2 days if they were extended)*

Expired *- Extended standard service authorization where the MCO did not make a determination within 14 day of receipt of the request. Do not include any standard authorizations that had a request for an extended deadline for determination.*

Not Expired *- Extended standard service authorization where the MCO did not make a determination this reporting period, and the 14 day timeline for determination has not expired.*

Standard Service Authorizations

Standard (Regular) Service Authorizations	Medical	Behavioral Health	Total

Expedited Service Authorizations

Expedited Service Authorizations	Medical		Behavioral Health		Total	
	Count	Percentage	Count	Percentage	Count	Percentage
Total Expedited Pending Authorizations (end of SFY2019)						
Total Expedited Authorizations Requested (received during current reporting period)						
Total Expedited Authorization Requests Withdrawn or Voided Prior to expiration						
Total Expedited Authorizations Approved						
Total Expedited Authorizations Denied or Partially Denied						

Expedited Service Authorizations Processing Timeframes - NOT EXTENDED	Medical		Behavioral Health		Total	
	Count	Percentage	Count	Percentage	Count	Percentage
Total Completed Expedited Authorizations **within 72 Hours****						
Total Expired Expedited service authorizations						
Total Not Expired Expedited Authorizations						

Note:
*****Completed within 72 hours*** *- expedited service authorization determinations completed during the reporting period that were made within 72 hours from the receipt of the request for authorization. Do not include any authorizations that had a request for an extended deadline for determination.*

Expired *- expedited service authorization where the MCO did not make a determination within 72 hours of receipt of the request. Do not include any standard authorizations that had a request for an extended deadline for determination.*

Not Expired *- expedited service authorization where the MCO did not make a determination this reporting period, and the 72 hour timeframe for determination has not expired. Do not include any standard authorizations that had a request for an extended deadline for determination.*

Expedited Service Authorizations Processing Timeframes - EXTENDED	Medical		Behavioral Health		Total	
	Count	Percentage	Count	Percentage	Count	Percentage
Total Completed Expedited Authorizations **within 14 Days****						
Total Expired Expedited service authorizations						
Total Not Expired Expedited Authorizations						

Note:
*****Completed in 14 Days*** *- expedited authorization determinations that had deadlines for determination extended in accordance with RS 42 §438.210(d) that were completed within the timeframe of the extension, not to exceed a total of 17 days from the date of receipt of the original request for authorization.*

Expired *- expedited service authorization where the MCO did not make a determination within the extension deadline.*

Not Expired *- expedited service authorization where the MCO did not make a determination this reporting period, and the deadline for determination has not expired.*

Total (All) Prior Authorizations Summary	Medical		Behavioral Health		Total	
	Count	Percentage	Count	Percentage	Count	Percentage
Total Authorizations (Prior Authorizations, PA) Requested						
Total PA Pending (end of SFY2019)						
Total PA Approved						
Total PA Denied						

Note: *Counts should reconcile with reported numbers above*

Standard Service Authorizations

Standard (Regular) Service Authorizations	Medical	Behavioral Health	Total

Note: Amounts reported should agree with the sum of the quarterly amounts reported to LDH on the 188 quarterly Service Authorizations Report for the quarters ending September 2018, December 2018, March 2019 and June 2019. A reconciliation and explanation of any discrepancies, if applicable, should be included with your survey response.

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Note: All counts should reflect line/detail/service level counts

Prior Authorizations	Total		Diagnostic D0100 - D0999	
	Valued-added Dental Services	Other Dental Services	Valued-added Dental Services	Other Dental Services
Total number of prior authorization requests for SFY19				
Total number of prior authorization requests **DENIED**,				
delineated by reasons for denial **(See Tab Line 11 Reasons for Denial)**				
Total number of claims denied AFTER prior authorization approval,				
delineated by reasons for denial **(See Tab Line 13 Reasons for Denial)**				
What is the average time for responding to prior authorization requests?				
What is the range of times for responding to prior authorization requests?				

Prior Authorizations	Preventive D1000 - D1999		Restorative D2000 - D2999	
	Valued-added Dental Services	Other Dental Services	Valued-added Dental Services	Other Dental Services
Total number of prior authorization requests for SFY19				
Total number of prior authorization requests **DENIED**,				
delineated by reasons for denial **(See Tab Line 11 Reasons for Denial)**				
Total number of claims denied AFTER prior authorization approval,				
delineated by reasons for denial **(See Tab Line 13 Reasons for Denial)**				
What is the average time for responding to prior authorization requests?				
What is the range of times for responding to prior authorization requests?				

Prior Authorizations	Endodontics D3000 - D3999		Periodontics D4000 - D4999	
	Valued-added Dental Services	Other Dental Services	Valued-added Dental Services	Other Dental Services
Total number of prior authorization requests for SFY19				
Total number of prior authorization requests **DENIED**,				
delineated by reasons for denial **(See Tab Line 11 Reasons for Denial)**				
Total number of claims denied AFTER prior authorization approval,				
delineated by reasons for denial **(See Tab Line 13 Reasons for Denial)**				
What is the average time for responding to prior authorization requests?				
What is the range of times for responding to prior authorization requests?				

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Prior Authorizations	Removable Prosthodontics D5000 - D5899		Maxillofacial Prosthetics D5900 - D5999	
	Valued-added Dental Services	Other Dental Services	Valued-added Dental Services	Other Dental Services
Total number of prior authorization requests for SFY19				
Total number of prior authorization requests **DENIED**,				
delineated by reasons for denial **(See Tab Line 11 Reasons for Denial)**				
Total number of claims denied AFTER prior authorization approval,				
delineated by reasons for denial **(See Tab Line 13 Reasons for Denial)**				
What is the average time for responding to prior authorization requests?				
What is the range of times for responding to prior authorization requests?				

Prior Authorizations	Implant Services D6000 - D6199		Fixed Prosthodontics D6200 - D6999	
	Valued-added Dental Services	Other Dental Services	Valued-added Dental Services	Other Dental Services
Total number of prior authorization requests for SFY19				
Total number of prior authorization requests **DENIED**,				
delineated by reasons for denial **(See Tab Line 11 Reasons for Denial)**				
Total number of claims denied AFTER prior authorization approval,				
delineated by reasons for denial **(See Tab Line 13 Reasons for Denial)**				
What is the average time for responding to prior authorization requests?				
What is the range of times for responding to prior authorization requests?				

Prior Authorizations	Oral & Maxillofacial Surgery D7000 - D7999		Orthodontics D8000 - D8999	
	Valued-added Dental Services	Other Dental Services	Valued-added Dental Services	Other Dental Services
Total number of prior authorization requests for SFY19				
Total number of prior authorization requests **DENIED**,				
delineated by reasons for denial **(See Tab Line 11 Reasons for Denial)**				
Total number of claims denied AFTER prior authorization approval,				
delineated by reasons for denial **(See Tab Line 13 Reasons for Denial)**				
What is the average time for responding to prior authorization requests?				
What is the range of times for responding to prior authorization requests?				

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Prior Authorizations	Adjunctive General Services D9000 - D9999	
	Valued-added Dental Services	Other Dental Services
Total number of prior authorization requests for SFY19		
Total number of prior authorization requests **DENIED**,		
delineated by reasons for denial **(See Tab Line 11 Reasons for Denial)**		
Total number of claims denied AFTER prior authorization approval,		
delineated by reasons for denial **(See Tab Line 13 Reasons for Denial)**		
What is the average time for responding to prior authorization requests?		
What is the range of times for responding to prior authorization requests?		

How are prior authorizations defined?

How are prior authorizations tracked?

What are the policies and procedures for prior authorizations?