Medicaid Managed Care Transparency Report 2021

Agency Response to La. Revised Statute 40:1253.2

Louisiana Department of Health

Bureau of Health Services Financing

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LOUISIANA DEPARTMENT OF HEALTH

Contents

Introduction

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

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

Beginning in February 2012, the original Medicaid managed care program included two models of coordinated care networks: a full-risk, managed care organization (MCO) model delivered by "prepaid health plans" and a primary care case management (PCCM) model delivered by "shared savings plans." The state contracted with three prepaid and two shared savings health plans, and individuals were given the option of choosing the plan that best met their needs. Not all Medicaid services were available from health plans, and some enrollees continued to receive certain services under the fee-for-service program. In addition, some populations covered by Medicaid were not eligible to enroll in and receive services from a health plan. LDH has progressively integrated services and populations into the Medicaid managed care program. The following timeline includes major milestones in the growth of the managed care program:

- Pharmacy benefits were "carved-in" to the prepaid plan benefit package on November 1, 2012.
- The provision of dental benefits to all Medicaid populations was contracted to a single prepaid ambulatory health plan referred to as a "dental benefits program manager" (DBPM) beginning July 1, 2014.
- The delivery model transitioned from three full-risk MCOs and two shared-savings PCCM models to five full-risk MCOs on February 1, 2015.
- Hospice benefits were added on February 1, 2015.
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) – Personal Care Services were added on February 1, 2015.
- Retroactive linkages to a Medicaid managed care plan were implemented on February 1, 2015.
- Specialized behavioral health benefits were added on December 1, 2015.
- Non-emergency medical transportation and specialized behavioral health services were added on December 1, 2015 for enrollees not entitled to receive physical health services through an MCO.
- Eligibility for Medicaid services expanded to include the new adult population on July 1, 2016.
- Effective January 1, 2021, the DBPM program expanded to include a second contracted dental plan.
- Effective January 1, 2021, coverage of dental services for individuals with intellectual disabilities (ICF/IID) moved from the fee-for-service program to coverage through one of the two DBPMs.

Transparency Report Measures and Data

This report includes 31 areas of measurement outlined in La. Revised Statute 40:1253.2 and covers program operations for State Fiscal Year (SFY) 2021. All measures are reported for the SFY, July 1, 2020 through June 30, 2021, except for the following that 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, and

Section 10 – Audited Financial Statements.

Beginning with the SFY 2020 report the format was updated to consolidate all data elements regarding the Dental Benefits Program into Sections 30 – 41.

Information included in this report was collected from multiple sources. To the greatest extent possible, the data were extracted from state systems that routinely collect and maintain operational data on the Medicaid managed care program. When unavailable from state sources, data were collected from the managed care entities or sourced from either routine reporting deliverables[1] or ad hoc reports requested specifically for this purpose. The Medicaid Management Information System (MMIS) and the Management Administrative Reporting Subsystem (MARS Data Warehouse or MDW) are maintained by the Medicaid program's contracted fiscal intermediary, Gainwell. Detailed enrollee and provider information, as well as claims payment data for this report, was 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 DBPMs.

As part of routine operations and as required by the Centers for Medicare and Medicaid Services (CMS), internal policies and procedures for collection of data were validated by the Department's contracted External Quality Review Organization (EQRO), Island Peer Review Organization (IPRO).

In addition to standing operational quality assurances and EQRO reviews, the data included in this report were independently validated by Myers and Stauffer, an audit contractor of the Department. Myers and Stauffer reviewed for reasonability the data extraction code or process that the managed care entities or the Department used to generate data. For data originating from the MARS Data Warehouse, Myers and Stauffer directly aggregated data from encounters or data extracts for each plan and compared its results to the results the Department produced. For data originating from the plans, Myers and Stauffer (MSLC) reviewed plan responses to a survey developed by Myers and Stauffer to document the process the plans used to generate the data as well as policies and procedures in place to collect, track and report data. Where Myers and Stauffer found inconsistencies above or below the 10% variance threshold established by the Department, it made recommendations to the Department or the health plan to improve the method used to collect data. See Appendices XVIII and XIX for the survey instruments.

[1] Templates for routine reporting deliverables can be found at http://ldh.la.gov/index.cfm/page/1700.

Medicaid Managed Care

During State Fiscal Year 2021, more than 1.82 million Louisiana Medicaid and Louisiana Children's Health Insurance Program (LaCHIP) enrollees received coverage for physical health, basic and specialized behavioral health services, or transportation services under the Medicaid managed care program through one of five managed care organizations.

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

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

A small number of individuals remained completely excluded from enrollment in an MCO and continued to receive services under FFS. Medicaid populations excluded from enrollment in an MCO in State Fiscal Year 2021 included:

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

Additionally, the following services continued to be provided only under the Medicaid fee-for-service program and were not included in the managed care benefit package in State Fiscal Year 2021:

- Personal care services (21 and over)
- Long term care (LTC)/nursing facility services
- Waiver services
- Early Steps
- Medicare crossover services

1 CONTRACTED MANAGED CARE ENTITIES

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

For the State Fiscal Year 2021 reporting period, the Department contracted with five MCOs to manage physical and behavioral healthcare services. The contracted entity names and common abbreviations used in this report are detailed in Table 1.1 in alphabetical order.

Table 1.1 Contracted managed care organizations, State Fiscal Year 2021

Plan Name	Plan Type	Common Abbreviation
Aetna Better Health, Inc.	Managed Care Organization	ABH
Community Care Health Plan of Louisiana, Inc. (dba Healthy Blue)	Managed Care Organization	HB
AmeriHealth Caritas Louisiana, Inc.	Managed Care Organization	ACLA
Louisiana Healthcare Connections, Inc.	Managed Care Organization	LHCC
UnitedHealthcare of Louisiana, Inc.	Managed Care Organization	UHC

Source: Medicaid managed care contracts

In addition, the state provided coverage for comprehensive dental services to children and denture services to adults through two dental benefit program managers as detailed in sections 30 – 41 of this report.

2 MANAGED CARE EMPLOYEES

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

Health plan contracts required certain staff be domiciled in-state, such as chief executive officer; medical director; behavioral health medical director; maternal/child health coordinator; contract compliance officer; member management coordinator; provider services manager; program integrity officer; encounter data quality coordinator; case management staff; fraud, waste and abuse investigators; and others. For other positions, such as call center staff, plans had the option to staff locally or leverage parent company resources out of state.

Table 2.1 Total number of full-time equivalent (FTE) and average salary for MCO employees based in Louisiana, State Fiscal Year 2021

	ABH	ACLA	HB	LHCC	UHC
Total number of LA employees (FTEs)	128.53	227.60	191.00	664.52	376.40
Average salary paid	$75,329	$80,198	$92,291	$74,471	$73,843

Source: 017 Annual Report to LDH

The average annual salary weighted across all health plans was $77,356. Variances in the average salary across plans largely reflect the mix of positions located in the state. Some plans have a larger share of lower salary positions in state, such as call center staff, whereas others have a larger share of higher salary positions in state, such as clinical staff performing prior authorization functions.

3 PAYMENTS TO MANAGED CARE ORGANIZATIONS

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

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

In State Fiscal Year 2021, the Department paid a total of $10,123,704,892[2] 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 2021 was 1,823,493. Total enrollment unduplicated within each group was 1,675,472 full-benefit enrollees and 163,222 partial-benefit enrollees (NOTE: members can switch between full-benefit and partial-benefit coverage during the year based on their eligibility status). Variation in the average PMPM rate reflects differences in enrollment mix and risk adjustment across health plans. Managed care organizations with a larger share of enrollment from higher cost eligibility groups had a higher average PMPM payment and vice-versa.

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

PMPMs for enrollees are scheduled for payment to the plans retrospectively in the month following enrollment, e.g. PMPMs for June members are paid in July. However, as all payments are reported based on the actual date of payment, average monthly PMPMs varied as impacted by off-cycle payment adjustments including deferral of payments, lump sum payments 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.

[2] The payments to the MCOs is net of $3,354,340 in monetary penalties assessed against the MCOs in SFY 2021 which reduces the amount actually paid to the MCOs as reported in the Monthly Medicaid Forecast and the Medicaid Annual Report.

Table 3.1 Total payments and average PMPM for full-benefit enrollees[3] by month, State Fiscal Year 2021

	ABH		ACLA		HB		LHCC		UHC	
	Total Payments	Average PMPM	Total Payments	Average PMPM	Total Payments	Average PMPM	Total Payments	Average PMPM	Total Payments	Average PMPM
Jul-20	$65,191,828	$581.27	$100,457,002	$524.14	$146,329,638	$523.70	$209,212,470	$459.64	$217,151,019	$498.42
Aug-20	$67,904,991	$594.67	$103,562,376	$535.65	$150,226,426	$528.67	$215,316,226	467.95	$221,772,632	$502.97
Sep-20	$68,444,884	$589.86	$104,833,378	$537.70	$150,155,232	$520.95	$215,797,116	$464.63	$222,190,206	$498.60
Oct-20	$93,548,809	$795.73	$146,323,799	$744.86	$214,768,113	$735.88	$313,033,750	$668.76	$316,551,500	$703.93
Nov-20	$71,659,163	$599.33	$104,281,557	$525.69	$156,299,903	$527.59	$220,615,430	$466.81	$224,627,455	$494.98
Dec-20	$69,338,240	$568.88	$107,499,641	$536.20	$159,751,363	$531.53	$221,285,460	$464.03	$230,429,649	$502.70
Jan-21	$76,161,948	$625.74	$115,147,773	$578.32	$174,038,262	$567.61	$242,996,220	$501.72	$248,128,885	$541.85
Feb-21	$82,904,292	$675.67	$115,939,981	$579.71	$174,040,956	$563.05	$247,974,149	$509.13	$251,525,760	$546.06
Mar-21	$72,562,796	$586.33	$105,268,971	$523.33	$159,386,038	$511.02	$220,036,329	$448.98	$228,006,225	$491.82
Apr-21	$72,110,857	$578.04	$104,712,735	$518.35	$157,492,840	$501.59	$219,045,221	$444.89	$225,565,979	$484.39
May-21	$71,428,898	$569.06	$105,658,311	$520.77	$157,910,670	$499.56	$220,012,639	$445.04	$226,567,396	$484.31
Jun-21	$99,667,566	$789.13	$146,002,181	$717.54	$226,438,116	$711.90	$312,294,732	$629.66	$318,779,265	$678.77
Total	**$910,924,271**	**$629.48**	**$1,359,687,704**	**$570.19**	**$2,026,837,559**	**$560.25**	**$2,857,619,742**	**$497.60**	**$2,931,295,971**	**$535.73**

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

Notes: off-cycle payment adjustments to MCOs for full-benefit enrollees, State Fiscal Year 2021:

- Jul 2020: Includes $15.8 million for the Managed Care Incentive Program (MCIP).
- Aug 2020: PMPM payments made via lump sum pending approval of 7/1/20 rates.
- Sep 2020: PMPM payments made via lump sum pending approval of 7/1/20 rates. Includes $26 million MCIP.
- Oct 2020: Includes $85.4 million MCIP and $199.8 million for Health Insurance Provider Fee (HIPF) payments.
- Dec 2020: Includes $10 million for Hep C Corridor payouts for ACLA, UHC, and HB.
- Jan 2021: Includes $73 million MCIP.
- Feb 2021: Payments made via lump sum pending approval of 1/1/21 rates. Includes $6.4 million for Hep C Corridor payouts for LHCC and ABH and $54.8 million MCIP.
- Mar 2021, April 2021, and May 2021: Payments made via lump sum pending approval of 1/1/21 rates.
- Jun 2021: Payments made via lump sum pending approval of 1/1/21 rates. Includes $182.4 million MCIP and $134.3 million for lump sum maternity kick payments.

[3] Including the adult expansion population

Table 3.2 Total payments and average PMPM for partial-benefit enrollees by month, State Fiscal Year 2021[4]

	ABH		ACLA		HB		LHCC		UHC	
	Total Payments	Average PMPM	Total Payments	Average PMPM	Total Payments	Average PMPM	Total Payments	Average PMPM	Total Payments	Average PMPM
Jul-20	$848,597	$36.74	$854,441	$37.21	$985,381	$37.60	$1,171,209	$37.62	$1,217,345	$37.04
Aug-20	$14,588	$0.63	$14,738	$0.64	$17,091	$0.65	$20,363	$0.65	$21,250	$0.64
Sep-20	$863,589	$36.85	$872,453	$37.30	$1,011,785	$37.46	$1,205,491	$37.69	$1,258,000	$37.14
Oct-20	$1,734,033	$73.44	$1,756,394	$74.49	$2,029,137	$74.37	$2,407,663	$74.42	$2,535,572	$73.95
Nov-20	$875,545	$36.90	$882,082	$37.22	$1,030,232	$37.39	$1,223,953	$37.47	$1,278,681	$36.95
Dec-20	$880,225	$36.90	$898,859	$37.77	$1,042,029	$37.54	$1,245,265	$37.73	$1,299,514	$37.21
Jan-21	$888,355	$37.13	$891,073	$37.59	$1,036,168	$36.72	$1,242,430	$37.14	$1,288,482	$36.41
Feb-21	$60,729	$2.57	$61,352	$2.62	$71,150	$2.55	$84,772	$2.57	$88,465	$2.54
Mar-21	$11,721	$0.49	$11,841	$0.50	$13,732	$0.49	$16,361	$0.49	$17,074	$0.48
Apr-21	$8,766	$0.39	$8,856	$0.40	$10,270	$0.39	$12,236	$0.39	$12,769	$0.39
May-21	$664	$0.03	$671	$0.03	$778	$0.03	$928	$0.03	$968	$0.03
Jun-21	$584	$0.03	$590	$0.03	$685	$0.03	$816	$0.03	$851	$0.03
Total	**$6,187,396**	**$21.84**	**$6,253,351**	**$22.15**	**$7,248,439**	**$22.10**	**$8,631,486**	**$22.19**	**$9,018,972**	**$21.90**

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

Notes: off-cycle payment adjustments to MCOs for partial-benefit enrollees, State Fiscal Year 2021:

- Aug 2020 and for Feb-Jun 2021, PMPM payments were made via lump sum payments that did NOT include allocations for partial benefit enrollees.

[4] Because of the small number of partial benefit enrollees and the retroactive nature of some of the payments, large variations from month to month may occur.

4 NUMBER OF HEALTHCARE PROVIDERS

The total number of healthcare providers contracted to provide healthcare services for each managed care organization delineated by provider type, provider taxonomy code and parish.

Timely access to necessary healthcare for Medicaid members is an important goal of the Medicaid managed care program. Contracts with the health plans required them to maintain minimum ratios of contracted providers to enrollees for both primary care and specialty physicians. The Department conducts ongoing monitoring of the number of contracted providers in each health plan and required plans to submit geo-spatial analyses with provider locations. The Department receives the total number of contracted providers for each health plan through weekly provider network registries submitted by the plans. It is important to note that the total number of healthcare providers contracting with a health plan cannot be used in isolation as an indicator of network adequacy and member access. Provider networks may consist of both in-state and out-of-state providers, and some contracted providers may limit the number of health plan enrollees they will see, or have "closed their panels" to new plan members, in order to maintain access and quality of care to current clients. Section 6 includes data on primary care providers with closed panels.

Per contract requirements, the health plans submitted a registry of all providers that have contracted with the health plan as well as any provider who was not in-network but was paid for services as an out-of-network provider or under a single-case agreement. As specified in the authorizing legislation, the data reported in Sections 4, 5 and 6 of this report are for contracted providers to reflect the in-network capacity of each health plan. Based on LDH findings and data user recommendations for improving the utility of this data set, the methodology for compilation of network providers was refined in 2017 to exclude out-of-state providers, unless they were located in a county directly bordering Louisiana. This is considered more reflective of local accessibility and is consistent with 2017 reporting.

In State Fiscal Year 2021, one or more of the five managed care plans contracted 55,619 providers to provide services to the Louisiana Medicaid managed care population. Provider counts by plan, provider type, taxonomy and parish are provided in Appendix I. It should be noted, however, that the unduplicated totals below will not match the provider totals in Appendix I as providers can enroll as more than one provider type, taxonomy, and in more than one parish.

Table 4.1 Total unduplicated[5] count of contracted providers by health plan, State Fiscal Year 2021[6]

	ABH	ACLA	HB	LHCC	UHC	Total
Total Contracted Providers	19,734	32,943	33,402	38,597	22,216	55,619

Source: MARS Data Warehouse, June 25, 2021 Provider Registry

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

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

5 PRIMARY CARE SERVICE PROVIDERS

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

Consistent with the methodology used to identify the total number of contracted providers in Section 4, the methodology for identifying contracted primary care providers was refined in 2017 to exclude out-of-state-providers, unless they are located in a county directly bordering Louisiana. The listing of contracted primary care providers (PCPs) for each health plan was then matched to the encounter file to determine those PCPs who submitted at least one claim for service during State Fiscal Year 2021. The corresponding claims were further limited to the following specialty types: 01-General Practice, 08-Family Practice, 37-Pediatrics, 41-Internal Medicine, 42-Federally Qualified Health Center, Clinic or Group Practice, 79-Nurse Practitioner and 94-Rural Health Clinic.

Total unduplicated provider counts for State Fiscal Year 2021 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 contracted primary care providers with at least one claim, State Fiscal Year 2021[7,8]

	ABH	ACLA	HB	LHCC[9]	UHC	Total
Total Contracted PCPs	2,012	4,194	3,494	2,859	2,166	7,814
PCPs with at least one claim	1,362	3,137	2,871	1,856	1,741	5,296
Percent with at least one claim	67.7%	74.8%	82.2%	64.9%	80.4%	67.8%

Source: MARS Data Warehouse, June 25, 2021 Provider Registry

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

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

[9] LHCC indicated they are aware of issues with their June 2021 provider registry and have corrected the issue going forward.

6 CONTRACTED PROVIDERS WITH A CLOSED PANEL

The total number of providers contracted to provide healthcare services for each managed care organization that has a closed panel for any portion of the reporting period delineated by provider type, provider taxonomy code and parish.

Based on recommendations from Myers and Stauffer, the methodology was modified beginning with the 2017 report to limit closed panel status to primary care providers only. This is consistent with currently available data and industry standards that only PCPs have defined panels. The Department continues to work with health plans, provider groups and other data users to improve the data available for monitoring health plan network accessibility.

PCPs 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.

The Department extracted data for the providers with a closed panel from provider registry files maintained in the MARS data warehouse. Table 6.1 shows the number of PCPs with a closed panel by health plan as of June 25, 2021. 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 Total contracted primary care providers with a closed panel, State Fiscal Year 2021[10,11]

	ABH	ACLA	HB	LHCC[12]	UHC	Total
Total Contracted PCPs	2,012	4,194	3,494	2,859	2,166	7,814
PCPs with a Closed Panel	383	1,106	857	265	277	2,381
Percent with a Closed Panel	19.0%	26.4%	24.5%	9.3%	12.8%	30.5%

Source: MARS Data Warehouse: June 25, 2021 Provider Registry

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

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

[12] LHCC indicated they are aware of issues with their June 2021 provider registry and have corrected the issue going forward.

7 MEDICAL LOSS RATIO

The medical loss ratio of each managed care organization and the amount of any refund to the state for failure to maintain the required medical loss ratio.

Federal regulations and health plan contracts required that a minimum of 85% of payments made by the Department for Louisiana Medicaid members be used to reimburse providers for services or certain specified purposes related to quality improvement and health information technology costs. This is known as the medical loss ratio (MLR).

Health plans are required to submit audited annual MLR reports summarizing how the plans spent their capitation payments, for each calendar year. The Department established methodology for calculating the annual MLR by adapting it from CMS's methodology for calculating MLR by commercial health plans. This methodology may differ from the methodology used by health plans in quarterly filings to the Department of Insurance and shareholders.

The MLR data presented are based on the independent auditor's reports prepared by Myers and Stauffer for the Adjusted Medical Loss Ratio Rebate Calculation for each of the five health plans for the calendar year ending on December 31, 2020. In Calendar Year 2020, all health plans met the 85% minimum ratio and no rebates to the Department were required. The audited reports for 2020 are posted on the Medicaid website at https://ldh.la.gov/index.cfm/page/2142.

Table 7.1 Medical loss ratios (MLR), Calendar Year 2020

	ABH	ACLA	HB	LHCC	UHC
Adjusted YTD MLR Capitation Revenue	$770,201,943	$1,193,792,336	$1,727,325,060	$2,472,088,036	$2,506,313,988
Total Adjusted MLR Expense	$706,013,697	$1,101,523,267	$1,560,581,870	$2,272,282,737	$2,309,292,957
MLR Percentage Achieved	91.7%	92.3%	90.3%	91.9%	92.1%
Dollar Amount of Rebate Required	$0	$0	$0	$0	$0

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

Table 7.2 Breakdown of total adjusted MLR, Calendar Year 2020

	ABH	ACLA	HB	LHCC	UHC
Patient Care	$698,802,224	$1,085,535,339	$1,546,652,758	$2,232,583,557	$2,271,214,321
Quality Improvement	$7,211,473	$13,443,430	$10,167,756	$32,955,956	$32,226,759
Information Technology	$0	$2,544,498	$3,761,356	$6,743,225	$5,851,877
Other[13]	$0	$0	$0	$0	$0
Total Adjusted MLR Expense	$706,013,697	$1,101,523,267	$1,560,581,870	$2,272,282,738	$2,309,292,957

Source: MSLC Audited Medical Loss Ratio Reports

[13] External quality review related expenditures

8 EXTERNAL QUALITY REVIEW

A copy of the annual external quality review technical report produced pursuant to 42 CFR 438.364.

To provide for greater efficiency and consistency in reporting Medicaid managed care outcomes, Act 428 of the 2018 regular session of the Louisiana Legislature amended the reporting requirements of this report to provide the information on outcomes by reference to the external quality review technical reports.

CMS requires that state agencies contract with an External Quality Review Organization (EQRO) to conduct an annual external quality review (EQR) of the services provided by contracted Medicaid MCOs. This EQR must include an analysis and evaluation of aggregated information on quality, timeliness and access to the health care services that an MCO furnishes to Medicaid enrollees.

In order to comply with these requirements, the Department contracts with an EQRO to assess and report the impact of its Medicaid managed care program, the Healthy Louisiana Program and each of the participating MCOs on the accessibility, timeliness and quality of services.

Among a variety of processes and measures reviewed by the EQRO, each annual report contains two years of data on 31 standard HEDIS® measures as compared to the Quality Compass® South Central Medicaid Benchmark and the most current Healthy Louisiana average. The technical reports are available on line at https://ldh.la.gov/index.cfm/page/4175.

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

9 MEMBER AND PROVIDER SATISFACTION SURVEYS

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

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

Member Satisfaction Survey

Member satisfaction surveys are questionnaires used to determine the overall level of satisfaction with the health plan and its providers. While an important tool in monitoring, a number of biases can affect the findings, such as non-response, the mode of administration, the timing of survey and the response format. To reduce bias and variation, health plan contracts were precise concerning the following:

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

The Department required health plans to submit an annual member satisfaction survey report. Furthermore, NCQA also collected survey results NCQA as part of its accreditation program and reviewed by the EQRO. The full member survey reports for each health plan can be found in Appendix IV: Member Satisfaction Surveys.

Provider Satisfaction Survey

Unlike member satisfaction, there are currently no national standard survey instruments for a provider satisfaction assessment; however, each health plan is contractually required to conduct an annual assessment of providers to determine the level of satisfaction and identify areas for improvement. Per contract requirements, the MCO shall submit an annual Provider Satisfaction Survey report that summaries the survey methods and findings, including raw data in the format provided by LDH, and provide analysis of opportunities for improvement. The annual provider survey provides insight to access of overall satisfaction as well as satisfaction with the following functions:

- Access to linguistic assistance;
- Provider enrollment;
- Provider communication;
- Provider education and trainings;
- Resolution to provider complaints/disputes;
- Claims processing;
- Claims reimbursement;
- Network/coordination of care; and utilization management processes.

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

To enhance the individual MCO surveys and to provide for comparability across the health plans, in 2018 the Department contracted with IPRO to develop and conduct a single standard annual survey of providers. The target population of the survey included providers currently in the network of at least one of the five MCOs serving the Medicaid members in Louisiana. The first annual survey was conducted in the summer of 2018 and was published in the SFY 2019 Annual Transparency Report. The second survey was conducted in 2019/2020 and was published in the SFY 2020 Annual Transparency Report. In regards to the 2019/2020 survey conducted, the Department is aware of the low response rate as noted in the IPRO report as likely attributable to the increased clinical demands on providers to the coronavirus pandemic. The Department is examining the options for obtaining a system wide survey in the future.

10 AUDITED FINANCIAL STATEMENTS

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

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

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

The full financial statements for each plan can be found in Appendix V. The statements are for Calendar Year 2020, which were reported during State Fiscal Year 2021.

11 SANCTIONS LEVIED BY THE DEPARTMENT

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

Actions or inactions by the Medicaid managed care entities that are subject to sanction by the Department are specified in 42 CFR §438.700, et seq., and delineated in the LDH Medicaid managed care contracts. In State Fiscal Year 2021, 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, https://ldh.la.gov/index.cfm/page/1610.

Medicaid Managed Care Enrollees

12 MEMBERS ENROLLED

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

Out of the total 1,953,276 unduplicated individuals enrolled in Louisiana Medicaid in State Fiscal Year 2021, 1,823,493 (93%) unduplicated individuals were enrolled in a health plan for one or more months during the year. The majority of health plan members received full-benefit coverage. A number of enrollees are enrolled in a health plan for partial benefits only, specifically covering non-emergency medical transportation and specialized behavioral health services. These enrollees receive their physical and acute care through fee for service.

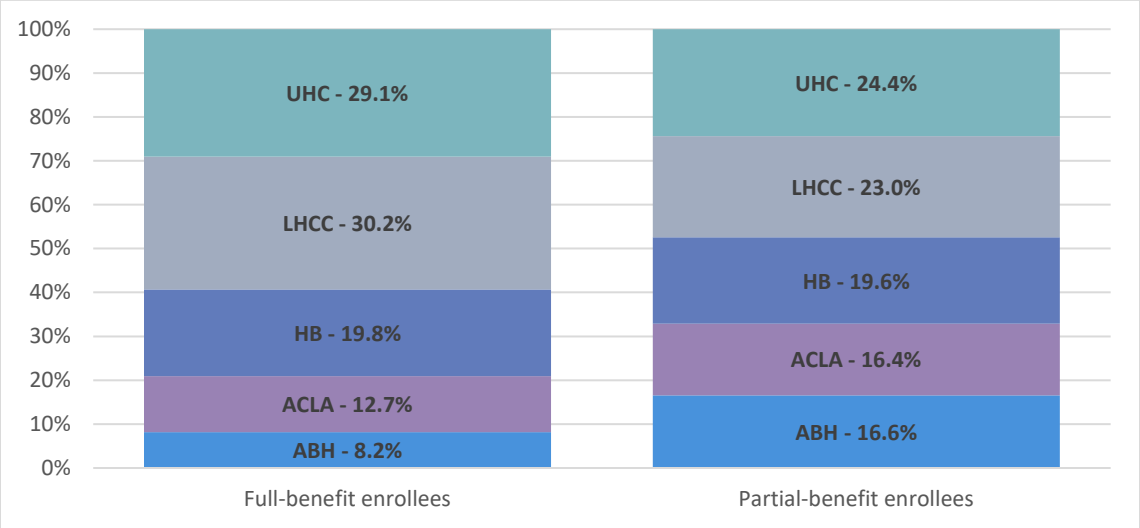
The distribution of total enrollees across health plans ranged from 9.2% in Aetna to 30.5% in Louisiana Healthcare Connections. Table 12.1 and Figure 12.1 below provide a breakdown of enrollment totals by health plan and benefits covered. This table represents unduplicated enrollment in each health plan throughout the year.

Table 12.1 Total enrollees by health plan and benefit group, State Fiscal Year 2021

	ABH	ACLA	HB	LHCC	UHC	Total Unduplicated[14]
Full-benefit enrollees	141,411	220,147	341,522	522,619	502,043	1,675,472
Partial-benefit enrollees	27,367	27,032	32,439	38,063	40,330	163,222
Total (unduplicated)	166,923	245,172	370,849	556,966	538,178	1,823,493
Percent of total	9.2%	13.4%	20.3%	30.5%	29.5%	100%

Source: MARS Data Warehouse

Figure 12.1 Distribution of enrollees by benefit group and health plan, State Fiscal Year 2021



Source: MARS Data Warehouse

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

For purposes of health plan reimbursement, enrollees were assigned to one of the eligibility categories listed below in State Fiscal Year 2021:

- *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 65 and above as well as individuals of any age, including children, with disabilities.

- *Foster children*: Children who received 24-hour substitute care from someone other than a parent or guardian and for whom the Department of Children and Family Services (DCFS) has responsibility for placement and care.

- *Breast and Cervical Cancer (BCC)*: Uninsured women who have already been diagnosed by a Centers for Disease Control and Prevention (CDC)-approved screening entity with breast or cervical cancer or a precancerous condition and who were not otherwise eligible for Medicaid.

- *LaCHIP Affordable Plan (LAP):* Children and youth under the age of 19 with incomes between 217% and 255% of the federal poverty level (FPL). Families pay a monthly premium of $50.

- *Home and Community-Based Services (HCBS) Waiver*: Individuals who are elderly or have disabilities and receive waiver services to assist them in remaining in their homes and in the community.

- *Institutions of Mental Health (IMD)*: Adults (age 21 and above) who enrolled in the 1115 SUD waiver providing IMD for 16 or more days within a calendar month for the purposes of Mental Health/SUD services. The waiver does not provide Medicaid eligibility – it only allows the service to be provided to those qualifying individuals were already Medicaid eligible.

- *Chisholm*: Louisiana Medicaid enrollees under age 21 who are on the Office of Citizens with Developmental Disabilities Request for Services Registry.

- *New Adult Group (Expansion)*: All adults between the ages of 19 and 64 (including both parents and adults without dependent children) with incomes below 138% of FPL.

While figure 12.1 presents unduplicated enrollees for the full 12 months during State Fiscal Year 2021, tables 12.2 and 12.3 below provide the average monthly number of enrollees by eligibility category for full-benefit and partial-benefit coverage respectively.

Table 12.2 Average number of full-benefit enrollees in each month delineated by eligibility category and health plan, State Fiscal Year 2021

	ABH	ACLA	HB	LHCC	UHC
SSI	10,872	21,478	25,853	39,625	36,396
Families & Children	47,486	102,383	144,582	273,398	245,897
Foster Care	364	692	4,158	7,055	1,840
BCC	33	53	73	92	77
LAP	165	186	383	606	664
HCBS Waiver	262	408	575	898	824
IMD	5	7	7	9	8
Chisholm	208	428	680	1,405	1,044
New Adult Group (Expansion)	61,118	73,026	125,046	155,374	169,039
All Categories	120,511	198,658	301,354	478,455	455,784

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 2021 is presented in table 12.3. The average monthly enrollment is lower than the total unduplicated count for the year presented in figure 12.1 because each month there were some members who lost eligibility, while others were newly enrolled.

Table 12.3 Average number of partial-benefit only members enrolled each month delineated by eligibility category and health plan, State Fiscal Year 2021

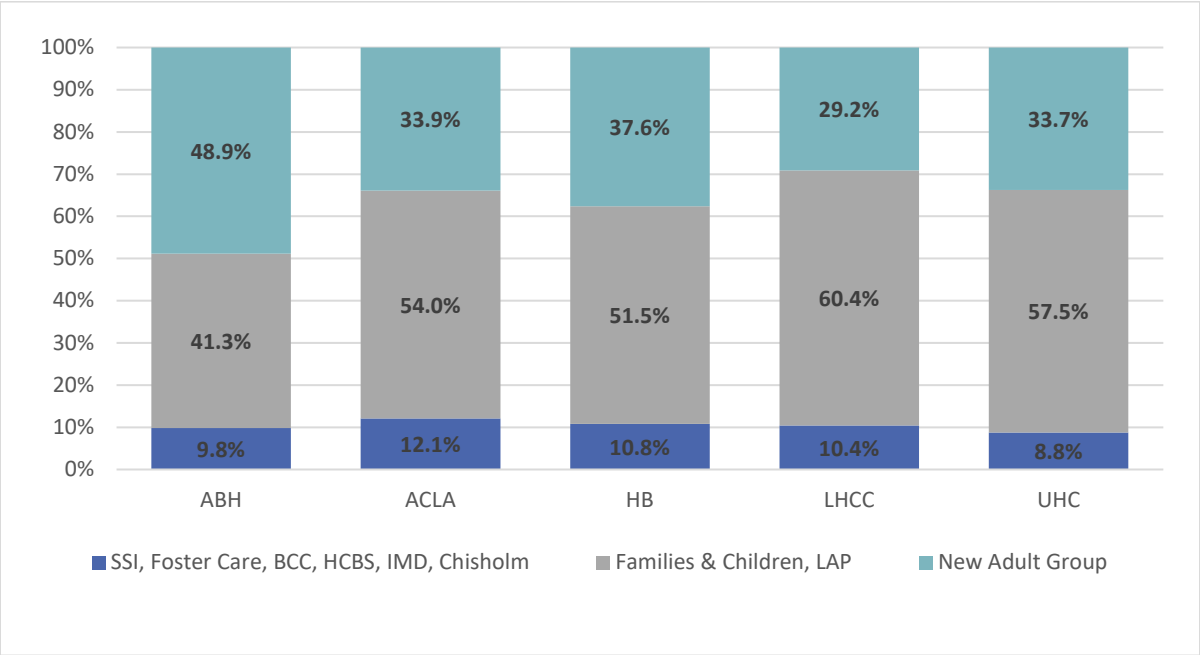
	ABH	ACLA	HB	LHCC	UHC
Chisholm	290	330	473	594	581
Dual Eligibles	21,704	21,555	25,049	29,712	31,280
HCBS Waiver	752	767	923	1,061	1,146
Other[15]	520	520	718	846	978
All Categories	23,266	23,171	27,163	32,212	33,984

Source: MARS Data Warehouse

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

While the percent distribution for some eligibility categories was small in the number of members represented, the related cost of healthcare may be high due to the healthcare needs of the population. As an example, individuals in Family and Children and the LaCHIP Affordable Plan eligibility categories are generally healthier and less costly per member as compared to the SSI, Foster Care, Breast & Cervical Cancer, and Home & Community-Based Service, IMD and Chisholm groups. Differences in percent distribution of total enrollment by member demographics are important factors when looking at the number and types of providers, services, utilization and costs for each health plan. The distribution of members enrolled in each health plan by eligibility category and enrollment type is displayed in figure 12.2.

Figure 12.2 Membership distribution by eligibility category, State Fiscal Year 2021



Source: MARS Data Warehouse

13 PROACTIVE CHOICE AND AUTO-ENROLLMENT

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

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

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

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

Table 13.1 provides the individual plan and aggregate choice rates for State Fiscal Year 2021. There were no changes in the methodology for calculation of the choice rate. In aggregate, the proactive choice rate held constant at 68% for SFYs 2020 and 2021. The rate varies by plan. The Department continues to work with the enrollment broker and other stakeholders to inform and educate members about Medicaid Managed Care, available health plans and the process for selecting the plan of their choice.

Table 13.1 Proactive choice rates, State Fiscal Year 2021

	ABH	ACLA	HB	LHCC	UHC	Total
Pro-active Choice Enrollments	16,736	15,443	40,804	44,336	51,151	**168,470**
Auto Enrollments	14,011	15,003	15,830	17,832	17,118	**79,794**
Total Enrollments	30,747	30,446	56,634	62,168	68,269	**248,264**
Choice rate	54.4%	50.7%	72.1%	71.3%	74.9%	**67.9**

Source: Maximus Health Services

14 ENROLLEES WHO RECEIVED SERVICES

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

In monitoring the effectiveness and quality of the Medicaid managed care program, the Department tracked utilization of core benefits and services, i.e., the extent to which enrollees used a health plan service in a specified period of time. Section 14 provides information on Medicaid services provided by each of the health plans. Data are inclusive of paid and denied claims but are reported by unduplicated members, not by claim count.

Table 14.1 shows the unduplicated counts and percent of members who received services in State Fiscal Year 2021. During this reporting period, 1,530,703 members received one or more Medicaid service through their health plan for an overall rate of 84% of members across all plans. Rates for individual plans demonstrate variation across plans with a range of 78% (Aetna) to 89% (UnitedHealthcare).

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

Table 14.1 Enrollees who received services, State Fiscal Year 2021

	ABH	ACLA	HB	LHCC	UHC	Total Unduplicated[16]
Unduplicated Count of Enrollees	166,923	245,172	370,849	556,966	538,178	1,823,493
Number Receiving One or More Services	130,832	204,264	302,279	479,317	479,021	1,530,703
Percent Receiving One or More Services	78.4%	83.3%	81.5%	86.1%	89.0%	83.9%

Source: MARS Data Warehouse

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

15 ENROLLEES WHO HAD A PRIMARY CARE VISIT

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

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

The data in table 15.1 show the number and percentage of members who had at least one visit with a PCP to which they were linked during State Fiscal Year 2021. Though members are linked to a PCP, they are not prohibited from seeking care from other providers. It is important to note that not included in this table is data on members who had a visit for primary care services rendered by an individual provider to which the member was not linked at the time. The data are reflective of legislative reporting specific to R.S. 40:1253.2, and as such, may exclude other primary care access points.

Table 15.1 Total number and percentage of enrollees of each managed care organization who had at least one visit with their primary care provider, State Fiscal Year 2021

	ABH	ACLA	HB	LHCC	UHC	TOTAL[17]
Unduplicated full-benefit enrollees	141,411	220,147	341,522	522,619	502,043	1,675,472
Enrollees with at least one PCP visit	20,711	64,294	96,747	143,125	108,311	435,571
Percentage	14.6%	29.2%	28.3%	27.4%	21.6%	26.0%

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

To provide additional information on access to primary care beyond a member's linked PCP, the counts of members who had at least one visit to any primary care provider are also compiled and presented in table 15.2. This expanded data demonstrates that 51% of all managed care enrollees did have at least one primary care visit with any PCP versus 26% receiving at least one visit with their specific PCP.

Table 15.2 Total number and percentage of enrollees of each managed care organization who had at least one visit with any primary care provider, State Fiscal Year 2021

	ABH	ACLA	HB	LHCC	UHC	TOTAL[17]
Unduplicated full-benefit enrollees	141,411	220,147	341,522	522,619	502,043	1,675,472
Enrollees with at least one PCP visit	44,158	135,292	193,724	241,304	243,326	848,100
Percentage	31.2%	61.5%	56.7%	46.2%	48.5%	50.6 %

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

[17] Totals by health plan cannot be summed as members can switch health plans throughout the year and may be counted in each health plan total but are only once in the unduplicated total.

16 HOSPITAL SERVICES PROVIDED

The following information concerning hospital services provided to Medicaid enrollees:

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

The data in Section 16 show the number of members who received inpatient and outpatient emergency hospital services. Additionally, it shows the number of members who received emergency services within a year after having seen a primary care provider.[18]

Table 16.1 lists the number of members receiving unduplicated outpatient emergency services for State Fiscal Year 2021. For comparability across health plans, the rate per 1,000 total health plan members was calculated to account for variation in total member counts. Amerihealth Caritas of Louisiana had the highest rate of members receiving unduplicated outpatient emergency services at 325 per 1,000 members, and Aetna had the lowest rate of 315 per 1,000 members, though no plan was a significant outlier. In total, the rate across all health plans was 328 per 1,000 total health plan members.

Table 16.1 Enrollees who received unduplicated outpatient emergency services, State Fiscal Year 2021

	ABH	ACLA	HB	LHCC	UHC	Total[19]
Enrollees receiving unduplicated outpatient emergency services	44,606	71,550	109,405	167,295	160,861	549,135
Total Unduplicated full-benefit enrollees	141,411	220,147	341,522	522,619	502,043	1,675,472
Rate per 1,000 unduplicated full-benefit enrollee	315	325	320	320	320	328

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 15 of this report.

[19] Totals by health plan cannot be summed as members can switch health plans throughout the year and may be counted in each health plan total but are only once in the unduplicated total.

Table 16.2 lists the total inpatient Medicaid days for State Fiscal Year 2021. As with other data, variability is expected because of the distinct characteristics of each plan's membership. The rate of total inpatient Medicaid days across all health plans for State Fiscal Year 2021 was 469 per 1,000 enrollees.

Table 16.2 Total inpatient Medicaid days, State Fiscal Year 2021

	ABH	ACLA	HB	LHCC	UHC	Total
Total Inpatient Medicaid Days	74,455	108,127	159,353	220,901	223,388	786,224
Rate per 1,000 full-benefit enrollees	527	491	467	423	445	469

Source: MARS Data Warehouse

In order to better understand the relationship between access to primary care and use of outpatient emergency services, the Department has expanded the data to not only look at the 12-month period prior to use of outpatient emergency services, but to also examine the six-month period after the use of outpatient emergency services. Table 16.3 summarizes this data for individual periods before and after receipt of emergency services. Both unduplicated enrollee counts and rates per total enrollees receiving outpatient emergency services are presented for comparability across health plans.

Table 16.3 Unduplicated enrollees who saw a PCP before or after a visit to the emergency room, State Fiscal Year 2021[20]

	ABH	ACLA	HB	LHCC	UHC	Total[21]
12 months before outpatient emergency service	19,154	52,229	71,363	69,827	88,078	298,162
Percentage of total emergency service visits[22]	42.9%	73.0%	65.2%	41.7%	54.8%	54.3%
6 months after outpatient emergency service	16,567	48,065	65,783	58,783	76,220	263,447
Percentage of total emergency service visits	37.1%	67.2%	60.1%	35.1%	47.4%	48.0%

Source: MARS Data Warehouse

[20] In this section, a primary care provider is defined as any provider of primary care services, and is not necessarily the primary care provider the member is linked to as identified in Section 15.1 of this report.
[21] Totals by health plan cannot be summed as members can switch between health plans throughout the year and may be counted in each health plan total but are only once in the unduplicated total.
[22] The percentage is calculated as the percent of total unduplicated members who received an outpatient emergency service as identified in table 16.1.

17 MEMBERS THAT FILED APPEALS OR ACCESSED STATE FAIR HEARING PROCESS AND RESULTS

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

Health plan enrollees have the right to file appeals with both the health plan and the state if they believe they have been unfairly denied benefits or access to services. Federal law requires health plans to administer a system for members to file appeals, and all states are required to review health plan reports on both the frequency and nature of appeals filed as well as the steps health plans take to remedy such appeals. States must also provide an opportunity for a fair hearing to members whose appeal is either denied or not promptly acted upon by the health plan.

An appeal, which must be acted on within 30 days, is a request by a member to review one of the following actions that a health plan has taken:

- Denying or partially denying a requested service, including type or level of service;
- Reducing, suspending or terminating a previously authorized service;
- Denying, in whole or in part, payment for a service;
- Failure to provide services in a timely manner (as defined by the state); and
- Failure to act within 90 days on a grievance, which is an expression of dissatisfaction about any matter other than one of the above actions.

As part of their quality strategy, states must require health plans to maintain records of appeals and submit them for state review. When reviewing the records, the Department analyzed the subjects of the plans' appeals to identify the extent to which they are valid or are in the actual control of the health plan. The health plans and the Department both looked for trends and used the reports to determine the need for operational changes and improvements.

Across all five health plans there were a total of 4,173 appeal and state fair hearing (SFH) determinations made in State Fiscal Year 2021, 41% of which resulted in a full or partial reversal in favor of the member.

Table 17.1 Appeals and state fair hearings, State Fiscal Year 2021

	ABH	ACLA	HB	LHCC	UHC
Total Members (unduplicated)	166,923	245,172	370,849	556,966	538,178
Members who filed an appeal	384	242	818	1,255	1,347
Members who accessed SFH	4	5	32	26	14
Total appeals filed at MCO level	435	252	565	1,609	1,347
Total appeals filed at SFH level	4	5	36	28	14
Total appeal & SFH determinations[23]	422	260	580	1,570	1,341
Total determinations fully or partially reversed in favor of the member	115	122	115	458	908
% of determinations fully or partially reversed in favor of the member	27.3%	46.9%	19.8%	29.2%	67.7%

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

[23]Total determinations include determinations made in State Fiscal Year 2021 for appeals received in a prior year.

Healthcare Services Provided to Enrollees

To collect the data in this section, the Department defined emergency services as outpatient services provided in an emergency room, exclusive of the Emergency Medical Treatment and Labor Act (EMTALA) screening or urgent care, and professional services, specifically the evaluation and management of a patient, provided in an emergency room.[24]

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

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

18 CLAIMS SUBMITTED BY HEALTHCARE PROVIDERS

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

Health plans report claims data annually using the revised 177 reporting template developed by the Department, which captures unduplicated counts of claims received by each health plan. This report captures not only claims that are adjudicated (processed for payment or denial), but also rejected claim counts that are not reported in encounter submissions to the fiscal intermediary. In State Fiscal Year 2021, the aggregate count of unduplicated claims submitted across all health plans totaled 93,875,902. The breakdown of unduplicated claim counts for State Fiscal Year 2021 is presented in table 18.1.

All claims accepted in the system for adjudication (determination of payment or denial) can be categorized as emergency or non-emergency. Of total claims adjudicated by a health plan, 2% were for emergency services.

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

Table 18.1 Total claims submitted, State Fiscal Year 2021

	Rejected Claims	Emergency Services	Non-Emergency Services	Total
ABH	8,519	235,558	9,325,889	9,569,966
ACLA	80,952	292,502	11,176,540	11,549,994
HB	9,190	347,795	17,112,782	17,469,767
LHCC	801,745	660,931	25,590,586	27,053,262
UHC	377,056	757,565	27,098,292	28,232,913
Total	1,277,462	2,294,351	90,304,089	93,875,902

Source: Report 177 Total and Out of Network Claims

19 DENIED CLAIMS

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

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

Table 19.1 Total unduplicated denied claims, State Fiscal Year 2021

	Emergency Services	Non-Emergency Services	Total
ABH	16,051	2,454,603	2,470,654
ACLA[25]	13,495	2,070,446	2,083,941
HB	26,108	4,204,709	4,230,817
LHCC	32,854	4,986,161	5,019,015
UHC	40,425	4,373,231	4,413,656
Total	128,933	18,089,150	18,218,083

Source: 173 Denied Claims Report

Records for each denied claim must include a reason for the denial. The Department required plans to report these denials using claim adjustment reason codes (CARC) for medical and behavioral health claims and National Council for Prescription Drug Program (NCPDP) reject codes for pharmacy claims, which are both national standards. Since each claim line can have more than one CARC or NCPDP reject code, the number of CARC and NCPDP codes presented in table 19.2 are greater than the unduplicated number of total denied claims presented in table 19.1. In other words, a claim can be denied or adjusted for multiple reasons. As a claim cycles through the payment logic, the claims processing system applies all applicable CARC or NCPDP reject codes randomly, and one is not primary in comparison to another.

[25] For SFY 2021, ACLA only reported original denied claims. Issue has been address with ACLA and going forward and corrections will be done for SFY 2022 reporting period going forward.

Table 19.2 shows the ten most frequently used CARC codes for emergency and non-emergency medical and behavioral health claims. The primary causes for denial were duplicate claims, non-covered charge(s), claim/service lacks information, the benefits for this service is included in the payment/allowance for another service and precertification/authorization is absent. A breakout of all CARCs for denied claims for each health plan in numerical order is provided in Appendix VII.

Table 19.2 Top claim adjustment reason codes (CARCs) for emergency and non-emergency services, State Fiscal Year 2021

CARC	CARC Description	Emergency Claims[26]	Non-Emergency Claims	Total
18	Exact duplicate claim/service	26,757	1,383,934	**1,410,691**
96	Non-covered charge(s).	8,570	1,373,270	**1,381,840**
16	Claim/service lacks information or has submission/ billing error(s).	16,263	978,670	**994,933**
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	7,478	925,308	**932,786**
197	Precertification/authorization/notification/pre-treatment absent.	156	633,656	**633,812**
252	An attachment/other documentation is required to adjudicate this claim/service.	16,824	447,127	**463,951**
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	549	423,966	**424,515**
204	This service/equipment/drug is not covered under the patient's current benefit plan	5,828	393,536	**399,364**
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	109	383,313	**383,422**
133	The disposition of this service line is pending further review.	4,712	366,270	**370,982**

Source: 173 Denied Claims Report

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

Table 19.3 shows the ten most frequently used NCPDP reject codes for emergency and non-emergency pharmacy claims. Pharmacy claims use a different national coding structure than is used for medical or behavioral health claims. For consistency with encounter data, the Department has utilized the structure published by NCPDP to monitor reasons for claims denials. The primary causes for denial stemmed from refilling too soon, DUR reject error, product/service not covered, or prior authorization required.

Table 19.3 Top NCPDP codes for denial of emergency and non-emergency pharmacy services, State Fiscal Year 2021

NCPDP Code	NCPDP Description	Emergency Claims[27]	Non-Emergency Claims	Total
79	Refill Too Soon	192	2,001,070	2,001,262
88	DUR Reject Error	191	1,480,013	1,480,204
70	Product/Service Not Covered – Plan/Benefit Exclusion	61	1,179,847	1,179,908
75	Prior Authorization Required	254	1,056,976	1,057,230
76	Plan Limitations Exceeded	807	993,394	994,201
41	Submit Bill To Other Processor Or Primary Payer	51	372,165	372,216
39	M/I Diagnosis Code	8	349,234	349,242
MR	Product Not On Formulary	30	240,078	240,108
7X	Days Supply Exceeds Plan Limitation	1	197,660	197,661
69	Filled After Coverage Terminated	5	158,719	158,724

Source: 173 Denied Claims Report

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

20 CLEAN CLAIMS

The total number of claims submitted by the healthcare providers to each managed care organization which meets the definition of a clean claim as it is defined in the contract executed between the state and the managed care organization, and the percentage of those clean claims that each of the managed care plans has paid for each provider type within 15 calendar days and within 30 calendar days. In addition, the report shall include the average number of days for each managed care organization to pay all claims of healthcare providers delineated by provider type.

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

Table 20.1 lists the total clean claims submitted to each health plan. This total includes claims that were paid, denied or otherwise adjudicated. It does not include rejected claims, or which otherwise do not meet the definition of a clean claim.

Table 20.1 Clean claims Submitted, State Fiscal Year 2021

	ABH	ACLA	HB	LHCC	UHC
Total Clean Claims	5,810,192	9,413,743	13,877,902	21,178,561	17,428,289

Source: 221 Prompt Pay Report

Health plans are required by contract to pay 90% of all payable clean claims within 15 business days of the date of receipt and 99% within 30 calendar days of the date of receipt. The MCO must pay providers interest at 12% per annum of the amount payable, calculated daily, for the full period in which the clean claim remains unpaid beyond the 30-day claims processing deadline. Delineation of turnaround times by claim type is outlined in tables 20.2 and 20.3 below for illustrative purposes.

Table 20.2 Percent of paid clean claims that were paid within 15 business days, State Fiscal Year 2021

Provider Type	ABH	ACLA	HB	LHCC	UHC
Inpatient Hospital	95.51%	97.70%	94.75%	98.92%	98.87%
Outpatient Hospital	98.67%	99.73%	96.91%	99.62%	98.89%
Professional	98.71%	99.91%	98.33%	99.82%	99.77%
Rehab	98.78%	99.94%	98.57%	99.82%	99.98%
Home Health	97.24%	99.89%	97.91%	99.94%	99.73%
Emergency Medical Transportation (EMT)	99.51%	99.97%	92.91%	99.90%	98.49%
NEMT & Nonemergency Ambulance Transportation (NEAT)	98.97%	99.90%	100.00%	99.68%	93.21%
Durable Medical Equipment (DME)	91.44%	99.92%	96.61%	99.59%	99.87%
Pharmacy	99.99%	100.00%	100.00%	100.00%	100.00%

Source: 221 Prompt Pay Report

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

Table 20.3 Percent of paid clean claims that were paid within 30 days, State Fiscal Year 2021

Provider Type	ABH	ACLA	HB	LHCC	UHC
Inpatient Hospital	98.41%	100.00%	99.33%	99.84%	99.73%
Outpatient Hospital	99.68%	100.00%	99.44%	99.94%	99.78%
Professional	99.45%	100.00%	99.80%	99.97%	99.94%
Rehab	99.73%	100.00%	99.77%	99.97%	99.98%
Home Health	99.85%	100.00%	99.25%	99.95%	100.00%
EMT (Transportation)	99.88%	100.00%	99.29%	99.99%	99.93%
NEMT & NEAT (Transportation)	99.94%	100.00%	100.00%	99.85%	95.15%
DME	95.52%	100.00%	99.72%	99.94%	99.98%
Pharmacy	100.00%	100.00%	100.00%	100.00%	100.00%

Source: 221 Prompt Pay Report

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

Table 20.4 Average number of days to pay clean claims, State Fiscal Year 2021

Provider Type	ABH	ACLA	HB	LHCC	UHC
Inpatient Hospital	8.30	16.10	10.40	8.60	9.80
Outpatient Hospital	5.80	4.70	8.60	7.60	8.10
Professional	13.90	9.10	7.80	7.40	7.40
Rehab	5.70	6.50	8.30	7.00	7.10
Home Health	8.30	6.60	10.20	7.50	14.80
EMT (Transportation)	5.30	5.60	10.70	7.40	8.20
NEMT & NEAT (Transportation)	9.50	6.60	12.00	11.40	18.90
DME	9.60	6.70	8.30	7.80	7.40
Pharmacy	10.90	7.80	1.00	10.90	10.50

Source: 221 Prompt Pay Report

21 REGULAR AND EXPEDITED SERVICE REQUESTS PROCESSED

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

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

Health plan contracts with the Department stipulated that service authorizations must be processed within 14 calendar days of the request for authorization, with at least 80% processed within two business days of receipt of needed documentation.

Contracted timeframes and compliance standards are applied in total for both medical and behavioral health service authorizations. Data for State Fiscal Year 2021 are presented in table 21.1. Variations in the number of authorizations processed by individual health plans can be attributed to plan policy, as well as membership size and complexity.

Table 21.1 Standard service authorizations processed, State Fiscal Year 2021

TIMEFRAME (COMPLIANCE STANDARD)	ABH	ACLA	HB	LHCC	UHC
Processed within 2 business days[28] from receipt of needed documentation (80%)	88,418	52,677	187,320	226,469	143,557
	98.1%	75.6%	92.4%	96.5%	97.1%
Non-extended: Processed within 14 days of receipt of request for authorization (100%)	90,033	69,321	201,906	222,124	148,182
	100.0%	99.7%	99.6%	99.9%	99.9%
Extended: Processed within 28 days[29] of receipt of request for authorization (100%)	31	93	0	12,349	0
	100.0%	100.0%	--	99.9%	--

Source: 188 & 188BH Service Authorization - Quarterly Reports

At a rate of 76%, ACLA did not meet the overall contract compliance standard to process at least 80% of all standard prior authorizations within two business days. In cooperation with the Department, ACLA identified the underlying issues with turnaround times specifically for standard authorization for specialized behavioral health services and implemented a plan for correction.

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

[29] All authorizations for Durable Medical Equipment (DME) must be processed in 25 days or less.

If the situation warranted, the provider could request an expedited determination, in which case the request must be acted on within 72 hours or less, depending on the medical urgency. Per the Code of Federal Regulations, an extension of up to 14 days could be granted if the member or the health plan justified a need for additional information and how the extension is in the member's best interest.

Table 21.2 Expedited service authorizations processed, State Fiscal Year 2021

TIME FRAME (COMPLIANCE STANDARD)	ABH	ACLA	HB	LHCC	UHC
Non-extended: Processed within 72 hours of receipt of request for authorization (100%)	1,592	1,613	0	89	4,051
	99.9%	98.8%	--	100.0%	98.9%
Extended: Processed within 14 days of receipt of request for authorization (100%)	0	2	0	12	0
	--	100.0%	--	85.7%	--

Source: 188 & 188BH Service Authorization - Quarterly Reports

At a rate of 86%, LHCC did not meet the overall contract compliance standard to process expedited authorizations within the extended 14 days allowed. LHCC identified the underlying issues with turnaround times for expedited authorizations and implemented a plan for correction.

The percent of prior authorizations that resulted in a denial of services are presented in table 21.3. Note that the counts presented are unduplicated denials based on the *initial* service authorization determination.

Table 21.3 Service authorizations denied, State Fiscal Year 2021

	ABH	ACLA	HB	LHCC	UHC
Total service authorizations processed	91,685	71,273	202,638	234,712	152,377
Number denied	6,956	10,687	15,862	3,686	9,529
Percent denied	7.6%	15.0%	7.8%	1.6%	6.3%

Source: 188 & 188BH Service Authorization - Quarterly Reports

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

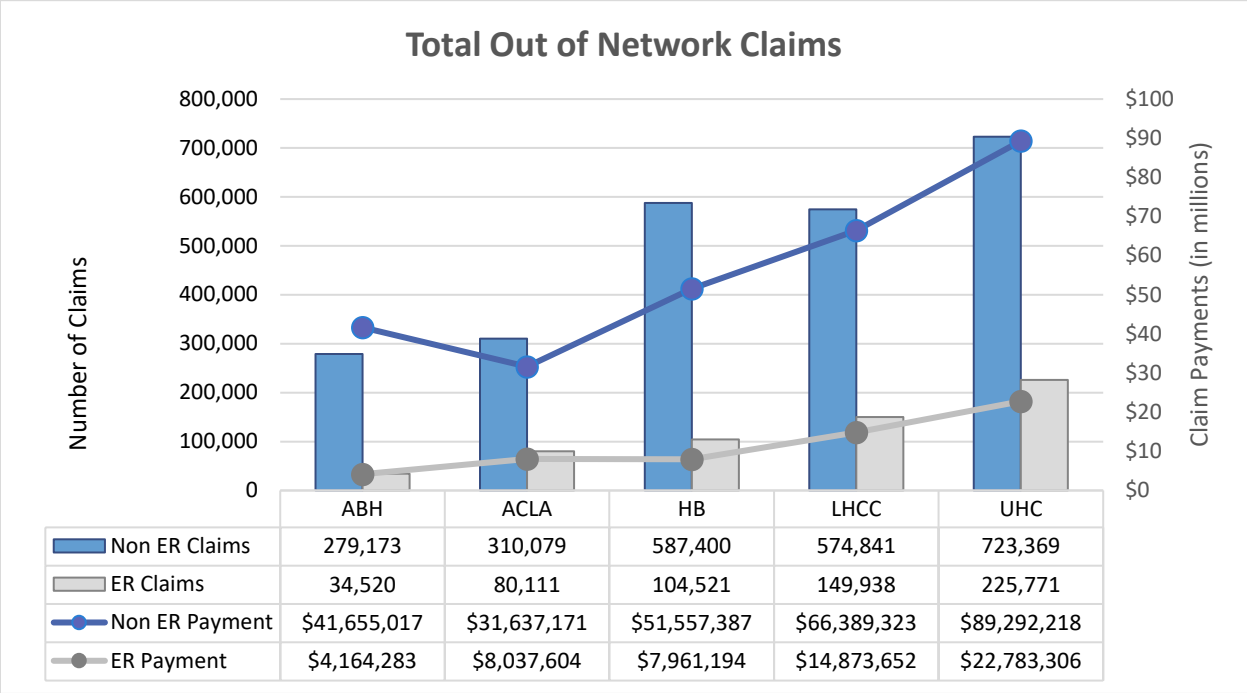
22 CLAIMS PAID TO OUT-OF-NETWORK PROVIDERS

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

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

The information in figure 22.1 reflects the number of claims and dollar value of payments by the health plans to non-network providers for both emergency services and non-emergency services. The data originate from submissions from the health plans on the standing annual report (report 177). Appendix VIII shows out of network claims for all emergency and non-emergency services broken out by parish and claim type.

Figure 22.1 Out of network claims, State Fiscal Year 2021



	ABH	ACLA	HB	LHCC	UHC
Non ER Claims	279,173	310,079	587,400	574,841	723,369
ER Claims	34,520	80,111	104,521	149,938	225,771
Non ER Payment	$41,655,017	$31,637,171	$51,557,387	$66,389,323	$89,292,218
ER Payment	$4,164,283	$8,037,604	$7,961,194	$14,873,652	$22,783,306

Source: Report 177 Total and Out of Network Claims

23 INDEPENDENT REVIEW

The total number of independent reviews conducted pursuant to R.S. 46:460.81 et seq., delineated by claim type for each managed care organization.

The total number and percentage of adverse determinations overturned as a result of an independent review conducted pursuant to R.S. 46:460.81 et seq., delineated by claim type for each managed care organization.

The independent review (IR) process was established by La. RS 46:460.81, et seq. to resolve claims disputes when a provider believes an MCO has partially or totally denied claims incorrectly. An MCO's failure to send a provider payment, a remittance advice or other written or electronic notice either partially or totally denying a claim within 60 days of the MCO's receipt of the claim is considered a claim denial. The IR process is only one option a provider has to resolve claims payment disputes with an MCO. In lieu of requesting independent review, a provider may pursue any available legal or contractual remedy to resolve the dispute.

LDH administers the IR process, but does not perform the IR of the disputed claims. When the Department receives a request for IR, it determines if the disputed claims are eligible for IR based on the statutory requirements. If the claims are eligible, the Department forwards the claims to a reviewer that is not a state employee or contractor and is independent of both the MCO and the provider. The independent reviewer's decision is binding unless either party appeals the decision to a court having jurisdiction to review the independent reviewer's decision.

In State Fiscal Year 2021, LDH received 65 requests for independent review of which 35 were deemed ineligible based on statutory requirement. Overall, 73% of the 30 eligible cases resulted in full or partial payment to the provider as a result of a completed independent review or MCO settlement prior to the review decision. Table 23.1 provides a breakdown of total independent review requests received by claim type and status. Table 23.2 provides additional breakdown of IR request by MCO.

Table 23.1 Requests for independent review submitted to LDH, State Fiscal Year 2021

	Behavioral Health	Hospital	Physician	Transportation	Total
Total requests received by LDH	13	49	0	3	65
Ineligible for independent review	6	26	0	3	35
Eligible for independent review	7	23	0	0	30
Settled by MCO & provider before IR decision	0	6	0	0	6
Fully overturned by IR	4	11	0	0	15
Partially overturned by IR	0	1	0	0	1
Upheld by IR	3	5	0	0	8
% of eligible cases settled, fully or partially overturned	57.1%	78.3%	n/a	n/a	73.3%

Source: LDH Independent Review Tracking System

Table 23.2 Independent review determinations by claim type and MCO, State Fiscal Year 2021

	ABH	ACLA	HB	LHCC	UHC
Total requests received – All claim types	25	12	16	7	5
Ineligible for independent review	16	6	4	5	4
Eligible for independent review	9	6	12	2	1
Settled by MCO & provider before IR decision	0	0	5	0	1
Fully overturned by IR	7	2	4	2	0
Partially overturned by IR	0	1	0	0	0
Upheld by IR	2	3	3	0	0
% of eligible cases settled, fully or partially overturned	77.8%	50.0%	75.0%	100.0%	100.0%
Total requests received – Behavioral Health	4	5	2	2	0
Ineligible for independent review	3	3	0	0	0
Eligible for independent review	1	2	2	2	0
Settled by MCO & provider before IR decision	0	0	0	0	0
Fully overturned by IR	1	0	1	2	0
Partially overturned by IR	0	0	0	0	0
Upheld by IR	0	2	1	0	0
% of eligible cases settled, fully or partially overturned	100.0%	0.0%	50.0%	100.0%	n/a
Total requests received – Hospital	18	7	14	5	5
Ineligible for independent review	10	3	4	5	4
Eligible for independent review	8	4	10	0	1
Settled by MCO & provider before IR decision	0	0	5	0	1
Fully overturned by IR	6	2	8	0	0
Partially overturned by IR	0	1	0	0	0
Upheld by IR	2	1	2	0	0
% of eligible cases settled, fully or partially overturned	75.0%	75.0%	130.0%	N/A	100.0%

Source: LDH Independent Review Tracking System

(table continued)

Table 23.2 Independent review determinations by claim type and MCO, State Fiscal Year 2021

(continued)

	ABH	ACLA	HB	LHCC	UHC
Total requests received – Physician	0	0	0	0	0
Ineligible for independent review	0	0	0	0	0
Eligible for independent review	0	0	0	0	0
Settled by MCO & provider before IR decision	0	0	0	0	0
Fully overturned by IR	0	0	0	0	0
Partially overturned by IR	0	0	0	0	0
Upheld by IR	0	0	0	0	0
% of eligible cases settled, fully or partially overturned	n/a	n/a	n/a	n/a	n/a
Total requests received – Transportation	3	0	0	0	0
Ineligible for independent review	3	0	0	0	0
Eligible for independent review	0	0	0	0	0
Settled by MCO & provider before IR decision	0	0	0	0	0
Fully overturned by IR	0	0	0	0	0
Partially overturned by IR	0	0	0	0	0
Upheld by IR	0	0	0	0	0
% of eligible cases settled, fully or partially overturned	n/a	n/a	n/a	n/a	n/a

Source: LDH Independent Review Tracking System

24 PHARMACY BENEFITS

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

- Total number of prescription claims
- Total number of prescription claims subject to prior authorization
- Total number of prescription claims denied
- Total number of prescription claims subject to step therapy of fail first protocols
- The average and range of times for responding to prior authorization requests.
- The number of prior authorization requests denied, delineated by the reasons for denial.
- The number of claims denied after prior authorization was approved, delineated by the reasons for denial.

In State Fiscal Year 2021, all five health plans managed pharmacy benefits for members enrolled with full-benefits coverage. Partial-benefit only enrollees continued to receive pharmacy benefits under fee-for-service Medicaid. Per the contract with the Department, managed care organizations can self-administer pharmacy benefits or subcontract with a pharmacy benefit manager (PBM). The PBMs for each health plan are listed in table 25.1 of the next section Pharmacy Benefit Managers and Rebates.

Table 24.1 lists the unduplicated total number of pharmacy claims received by each health plan, as well as a breakdown of claims by select categories. The variation in the data presented is reflective of the variation across health plans in implementing alternative approaches to managing pharmacy benefits, particularly in step therapy and fail first protocols. When a drug was requested that required step therapy and fail first protocols, the enrollee was required to try preferred product(s) before the requested drug would be approved. Through April 30, 2019, each health plan had its own list of preferred drugs and drugs that required step therapy, fail first protocols or prior authorization. The approach used, the drug selection, and the number of trials required before authorizing a non-preferred agent can vary significantly between plans. Starting May 1, 2019, the Department implemented a single, statewide preferred drug list (PDL). The impact of the single PDL is reflected in this Fiscal Year 2021 report. The monthly details for claims by reporting category are provided in Appendix IX.

Table 24.1 Pharmacy claims comparison, State Fiscal Year 2021

		ABH	ACLA	HB	LHCC	UHC
Total prescription claims	#	2,365,405	3,465,489	6,586,047	8,024,952	7,488,635
Subject to prior authorization	#	735,106	82,119	505,907	557,992	138,239
	%	31.08%	2.37%	7.68%	6.95%	1.85%
Denied	#	580,160	828,971	1,619,034	2,065,813	1,692,876
	%	24.53%	23.92%	24.58%	25.74%	22.61%
Subject to step therapy or fail first protocol	#	21,116	37,395	56,199	118,797	48,403
	%	0.89%	1.08%	0.85%	1.48%	0.65%

Source: Report RX055 - Pharmacy

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

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

Table 24.2 Response times for pharmacy prior authorization requests, State Fiscal Year 2021[30]

	ABH	ACLA	HB	LHCC	UHC
Average response time (hours)	14.8	8.4	2.6	4.2	4.2
Response time range (hours)[31]	0.0 - 43.3	0.0 - 24	0.0 - 341	0.0 - 119.7	0.0 - 70.6

Source: Report RX055 - Pharmacy

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

Table 24.3 Pharmacy prior authorization requests denied, State Fiscal Year 2021

	ABH	ACLA	HB	LHCC	UHC
Not Medically Appropriate	8,839	1,103	12,334	17,570	16,781
Not a Covered Benefit	2,047	872	611	468	1,216
Administrative - Lack of Information	0	10,483	2	2	993
Reduced Authorized	5	0	338	0	1,860
Other	1,004	0	7	1,084	0
Total Denials	11,895	12,458	13,292	19,124	20,850

Source: Report RX055 - Pharmacy

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

Table 24.4 Pharmacy claims denied after prior authorization was approved, State Fiscal Year 2021

	ABH	ACLA	HB	LHCC	UHC
The number of claims denied after prior authorization was approved	22,544	22,594	47,769	66,303	8,400

Source: Report 173 Denied Claims - Pharmacy

[30]Includes all determinations: approved, denied, reduced, voided or withdrawn.

[31]Minimum response time of zero hours indicates a response time of less than three minutes.

25 PHARMACY BENEFIT MANAGERS AND DRUG REBATES

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

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

As required by Act 482 of the 2018 Regular Legislative Session, this section has been expanded to include additional data on each MCO's pharmacy benefits program as listed above. The legislation amended Louisiana Revised Statute 40:1253.2 to require quarterly reporting on the pharmacy benefit managers and rebates collected under managed care. The act further required an annual summary of quarterly reports be included in the annual transparency report. The summary data for State Fiscal Year 2021 are presented here in tables 25.1 through 25.5. The monthly data from each quarterly report is presented in Appendix XI.

Managed care organizations can self-administer their pharmacy benefits or subcontract with a pharmacy benefits manager (PBM). In State Fiscal Year 2021, each of the five health plans utilized a PBM to manage their pharmacy benefit. Table 25.1 identifies the PBM for each managed care organization and indicates the contractual/ownership relationship between the MCO and the PBM.

Table 25.1 Pharmacy benefit managers (PBM), State Fiscal Year 2021

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

Source: MCO self-reported

The data in this section was also impacted by Act 482 of the 2018 Regular Legislative Session amending Louisiana Revised Statute 39:1648 to provide specific limitations on the payment for PBM services and collection of rebates. These limitations include:

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

The Department implemented these limitations through contract amendment with each of the MCOs with a compliance date of May 1, 2019. Prior to the implementation of the new contract requirements, the five MCOs used various combinations of payment methodologies for PBM services including but not limited to a per claim transaction fee. Table 25.2 provides a summary of transaction fees paid in State Fiscal Year 2021 by MCO.

Prior to May 1, 2019, transaction fees varied across MCOs. Post May 1, transaction fees were limited to the Department established maximum rate of $1.25 per processed claim. Monthly transaction fees data is provided in Appendix XI.

Table 25.2 Transaction fees paid by MCO to PBM, State Fiscal Year 2021

ABH	ACLA	HB	LHCC	UHC	Total
$1,479,910	$6,093,622	$4,186,238	$7,318,674	$11,552,866	$30,631,310

Source: 054 Pharmacy Benefit Management & Rebate monthly report

May 1, 2019, was also the effective date of the single statewide preferred drug list (PDL) established by the Department. The implementation of a single PDL allows the state to directly collect all eligible state supplemental rebates. MCOs may still collect rebates if available on non-PDL items such as diabetic testing supplies. Since there is a three to 12-month delay between the date of service and the actual receipt of rebate payments, a portion of rebates received by the MCOs are for services provided prior to May 1, 2019. As the runout period comes to an end, the rebates received by the MCO/PBM will decline as they will be directly collected by the Department.

Table 25.3 details the total rebates received and retained by the PBM or MCO in State Fiscal Year 2021. Monthly rebate collections are available in Appendix XI. No rebates collected by the PBMs in State Fiscal Year 2021 were remitted to the Department.

Table 25.3 Rebates and discounts retained by the MCO or PBM, State Fiscal Year 2021

ABH	ACLA	HB	LHCC	UHC	Total
$1,075,133	$1,309,291	$629,208	$261,924	$3,060,952	$6,336,508

Source: 054 Pharmacy Benefit Management & Rebate monthly report

Spread pricing refers to the difference in the amount charged by the PBM and the amount paid to the pharmacist that is then retained by PBM for management of pharmacy benefits. Act 482 prohibited the continued use of spread pricing, which was implemented by the Department for services after April 30, 2019. Table 25.4 reflects total amounts retained by the PBM through spread pricing in State Fiscal Year 2021. Monthly data is available in Appendix XI.

Table 25.4 Amount retained by the PBM through spread pricing, State Fiscal Year 2021

ABH	ACLA	HB	LHCC	UHC	Total
$0	$0	$0	$0	$0	$0

Source: 054 Pharmacy Benefit Management & Rebate monthly report

All other monies paid to the PBM and not reimbursed to pharmacies are captured in Table 25.5. Prior to the implementation of Act 482 limiting payments for pharmacy benefit management to a transaction fee basis, some MCOs used other payment methodologies that included administrative fees. For services beginning in May 1, 2019, they discontinued the PMPM fees and transitioned to the required per claim transaction fee.

Table 25.5 Other monies retained by the PBM that are not reimbursed to pharmacists, SFY 2021

ABH	ACLA	HB	LHCC	UHC	Total
$0	$0	$0	$0	$0	$0

Source: 054 Pharmacy Benefit Management & Rebate monthly report

Adult Expansion Population

Per Executive Order JBE 16-01 on July 1, 2016, Louisiana expanded Medicaid coverage under the Affordable Care Act to adults aged 19 through 64 under 138% of the Federal Poverty Level that do not meet other Medicaid categorical requirements or are not eligible for or enrolled in Medicare. Act 482 of the 2018 Regular Legislative Session requires the Department to submit a quarterly report containing requested Medicaid managed care program data on the adult expansion population and payments to the health plans. The quarterly reports submitted provide monthly data for the reporting period, as well as unduplicated year-to-date (YTD) totals for the 2021 State Fiscal Year. In addition to quarterly reporting the legislation requires annual and monthly data to be included in the transparency report.

Included in this section of the transparency report is the requested annual data as per Act 482 on the adult expansion population. As part of the Medicaid Managed Care Transparency Report, this section includes only those expansion population counts and expenditures for individuals enrolled in a health plan for either full or partial benefits. The monthly and annual year-to-date totals presented in this section of the annual Transparency Report are compiled using the same static eligibility and claims datasets pulled in December 2021 for compilation of the Medicaid Annual Report. Due to the dynamic nature of Medicaid enrollment and claims lag, the updated data presented in this section may not match monthly or year to date totals presented in previously published quarterly transparency reports. Monthly totals for all data sets are provided in Appendix XII.

26 EXPANSION ENROLLMENT BY AGE COHORT AND HEALTH PLAN

Medicaid expansion population data which shall include the following:

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

In State Fiscal Year 2021, the unduplicated count of expansion enrollees enrolled in a health plan was 694,824. Table 26.1 provides a breakdown of enrollees by age and health plan for state fiscal year 2021. Fiscal year totals are unduplicated and therefore will not equal the sum or counts by health or age cohort.

Table 26.1 Expansion enrollment by age cohort and MCO, State Fiscal Year 2021[32]

	ABH	ACLA	HB	LHCC	UHC	TOTAL
Ages 19 to 49	55,592	70,463	120,553	154,088	163,114	545,321
Ages 50 to 64	20,698	18,473	33,843	35,330	41,604	144,913
Ages 65+	683	613	993	1,057	1,294	4,590
Total	**76,973**	**89,549**	**155,389**	**190,475**	**206,012**	**694,824**

Source: Medicaid Data Warehouse

[32] Due to the dynamic nature of Medicaid enrollment and to provide for claims lag the dataset for this annual Transparency Report was extracted in December 2021, and will not necessarily match the data previously extracted and reported in the quarterly transparency reports.

27 EXPANSION ENROLLEES WITH EARNED INCOME

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

Table 27.1 presents the number of expansion enrollees in each MCO with earned income, employer based or self-employment, by age cohort. This analysis was not restricted to only able-bodied adults and therefore may include individuals with a disability or other persons identified by CMS guidance whose ability to work may be limited, such as students and individuals with complex medical conditions. Approximately 59% of the expansion population for State Fiscal Year 2021 had earned income.

Table 27.1 Unduplicated expansion enrollees with earned income by age cohort and MCO, State Fiscal Year 2021[33]

	ABH	ACLA	HB	LHCC	UHC	TOTAL
Ages 19 to 49	32,367	44,682	74,888	100,441	104,557	346,954
Ages 50 to 64	8,593	8,044	14,408	15,911	18,330	63,421
Total	**40,554**	**52,278**	**88,485**	**115,375**	**121,737**	**406,566**

Source: Medicaid Eligibility Data System

[33] Due to the dynamic nature of Medicaid enrollment and to provide for claims lag the dataset for this annual Transparency Report was extracted in December 2021, and will not necessarily match the data previously extracted and reported in the quarterly transparency reports

28 EXPANSION PER MEMBER PER MONTH PAYMENTS

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

In State Fiscal Year 2021, the Department paid $4,517,336,037 to all five managed care organizations to manage the care of individuals in the expansion population for medical, specialized behavioral health, pharmacy and transportation services.

Table 28.1 Total payments to MCOs for expansion population, State Fiscal Year 2021

ABH	ACLA	HB	LHCC	UHC
$544,329,139	$559,269,304	$974,810,372	$1,100,243,177	$1,338,684,045

Source: ISIS/CP-012 and Medicaid Data Warehouse

Table 28.2 below shows the total payments the Department made to DentaQuest and MCNA to provide administration of dental benefits for the expansion population. Total payments made to the Dental Benefit Program Managers (DBPM) were $27,125,591. Expansion enrollees 19 and 20-years-old are eligible for all Medicaid covered dental services. Enrollees 21 years and older are eligible for covered denture services only.

Table 28.2 Total payments for dental benefits for expansion population, State Fiscal Year 2021

	DentaQuest	MCNA
SFY 21 Payments	$6,127,702	$20,997,889

Source: ISIS/CP-012 and Medicaid Data Warehouse

29 MEDICAID EXPANSION POPULATION SERVICE UTILIZATION

Medicaid expansion population utilization data which shall include the following:

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

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

The number of recipients who received services is unduplicated within each service category and reporting time period and, as a result, cannot be added to ascertain the total number of recipients who received services each month. The total MCO expenditures within the specified service categories in State Fiscal Year 2021 were $2,545,145,588 for the expansion population and $2,906,270,715 for the non-expansion population. This includes claims payments made to providers by the MCOs for these select services and does not include payments made under the fee-for-service program. Approximately 47% of total payments by the MCOs to providers for the selected category of service presented below are attributed to the utilization by the expansion population. Tables 29.1 and 29.2 on the following page provide the expenditures for the expansion population and the non-expansion population.

Table 29.1 Utilization and expenditures for specified services for expansion population enrolled in managed care, State Fiscal Year 2021[34]

EXPANSION		Age Cohort 0 to 18	Age Cohort 19 to 49	Age Cohort 50 to 64	Age Cohort 65+	Total
Emergency Department	Recipient	0	210,615	49,739	0	259,276
	Payment	$0	$87,286,136	$20,985,567	$0	$108,271,704
Hospital Inpatient	Recipient	0	46,206	14,646	0	60,737
	Payment	$0	$355,758,882	$179,024,065	$0	$534,782,947
Hospital Outpatient	Recipient	0	313,857	104,386	0	414,411
	Payment	$0	$305,568,078	$195,309,367	$0	$500,877,445
NEMT	Recipient	0	13,672	6,907	0	20,470
	Payment	$0	$8,498,087	$4,457,714	$0	$12,955,800
Pharmacy	Recipient	0	379,748	121,791	0	496,133
	Payment	$0	$646,186,738	$363,148,178	$0	$1,009,334,916
Physician	Recipient	0	372,332	113,176	0	481,170
	Payment	$0	$254,103,242	$124,819,535	$0	$378,922,777

Source: Medicaid Data Warehouse

Table 29.2 Utilization and expenditures for specified services for non-expansion population enrolled in managed care, State Fiscal Year 2021[34]

NON-EXPANSION		Age Cohort 0 to 18	Age Cohort 19 to 49	Age Cohort 50 to 64	Age Cohort 65+	Total
Emergency Department	Recipient	209,057	87,675	27,641	836	322,278
	Payment	$57,097,318	$41,569,701	$15,964,032	$354,747	$114,985,798
Hospital Inpatient	Recipient	49,705	35,221	10,107	495	95,331
	Payment	$344,535,377	$227,827,374	$155,123,010	$7,331,186	$734,816,947
Hospital Outpatient	Recipient	354,106	137,534	48,325	1,894	534,917
	Payment	$180,539,106	$166,234,169	$143,050,697	$4,433,369	$494,257,341
NEMT	Recipient	8,182	12,295	12,981	4,565	37,448
	Payment	$3,456,883	$10,663,939	$14,006,137	$4,653,763	$32,780,722
Pharmacy	Recipient	486,992	160,016	55,097	2,968	693,303
	Payment	$320,938,778	$385,787,979	$298,776,483	$6,933,093	$1,012,436,333
Physician	Recipient	584,033	159,139	51,798	2,328	786,964
	Payment	$301,082,314	$135,185,666	$78,033,660	$2,691,933	$516,993,573

Source: Medicaid Data Warehouse

[34] Due to the dynamic nature of Medicaid enrollment and to provide for claims lag the dataset for this annual Transparency Report was extracted in December 2021, and will not necessarily match the data previously extracted and reported in the quarterly transparency reports

Dental Benefits Program

Dental Benefit Program Managers (DBPM or dental plan)

On July 1, 2014, the state began providing comprehensive dental services to Medicaid eligible children and adult dentures to full-benefit eligible adults through a single prepaid ambulatory health plan (PAHP), which operates under federal authority as provided in Sections 1902(a)(4) and 1932(a) (1)(A) of the Social Security Act, and 42 CFR Part 438. Effective January 1, 2021, coverage of dental services for individuals with intellectual disabilities (ICF/IID) moved from the fee for service program to coverage through on of the two DBPMs. The two DBPMs to provide dental services are identified in Section 30. A PAHP provides services to enrollees under contract with the state, and on the basis of capitation payments, or other payment arrangements that do not use state plan payment rates. The majority of Medicaid covered individuals were mandatorily enrolled in the dental plan and received state plan covered services through the dental plan based on age category:

- **EPSDT Dental Program:** Medicaid enrollees under the age of 21 are eligible for diagnostic, preventive, restorative, endodontic, periodontal, prosthodontics, maxillofacial prosthetics, oral and maxillofacial surgery, orthodontic and other screening and treatment services applicable under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, and

- **Adult Dentures:** Medicaid enrollees 21 years or older are eligible for dentures and related services.

The following groups are excluded from the two dental plans:

- Qualified Medicare Beneficiary (QMB) only;
- Specified Low-Income Medicare Beneficiary (SLMB);
- Qualified Individual (QI 1);
- Long Term Care (LTC) Co-Insurance;
- Program of All-Inclusive Care for the Elderly (PACE);
- Take Charge Plus;
- Illegal/Ineligible Aliens Emergency Services;
- Louisiana Behavioral Health Partnership (LBHP);
- Tuberculosis (TB); and
- Qualified Disabled Working Individual (QDWI).

30 CONTRACTED MANAGED CARE ENTITIES – DENTAL PROGRAM

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

For the State Fiscal Year 2021 reporting period, the Department contracted with two vendors to operate its dental benefit program serving Medicaid enrollees. Effective January 1, 2021, coverage of dental services for individuals with intellectual disabilities (ICF/IID) moved from the fee-for-service program to coverage through one of the two DBPMs.

Table 30.1 Name of contracted dental benefit program manager entity, State Fiscal Year 2021

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

Source: Medicaid managed care contracts

31 MANAGED CARE EMPLOYEES – DENTAL PROGRAM

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

The Department requires the Dental Benefit Program Managers to maintain certain in-state staff. The positions are 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 2021, DentaQuest reported seven full-time equivalent in-state staff and MCNA reported 6.6 full-time equivalent in-state staff. The average annual salary for both DentaQuest and MCNA employees based in Louisiana was $81,667.

Table 31.1 Total number of full-time equivalent (FTE) and average salary for MCNA employees based in Louisiana, State Fiscal Year 2021

	DentaQuest	MCNA
Total number of LA employees (FTEs)	7	6.6
Average salary paid	$85,000	$78,133

Source: 017 Annual Report to LDH

32 PAYMENTS TO MANAGED CARE ORGANIZATIONS – DENTAL

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

In State Fiscal Year 2021, the Department paid $289,655,666 to the DBPMs for the administration of the Medicaid dental benefits management program. Capitation payments were determined with assistance from the Department's contracted actuary, Mercer, based on the number of Medicaid enrollees eligible for and enrolled in the dental program for the month and were paid in the month following enrollment, i.e., June enrollment was paid in July. Table 32.1 below shows the total payments the Department made to the DBPMs and the average PMPM for each month in State Fiscal Year 2021.

Table 32.1 Payments to DBPMs for dental benefit program members by month, State Fiscal Year 2021

	DentaQuest		MCNA	
	Total Payments	**Average PMPM**	**Total Payments**	**Average PMPM**
Jul-20	$0	$0.00	$17,308,295	$10.75
Aug-20	$0	$0.00	$35,328,912	$21.71
Sep-20	$0	$0.00	$47,534,489	$28.91
Oct-20	$0	$0.00	$29,291,301	$17.81
Nov-20	$0	$0.00	$16,366,874	$9.85
Dec-20	$0	$0.00	$20,423,131	$12.30
Jan-21	$10,090,874	$11.69	$9,880,725	$11.53
Feb-21	$10,306,166	$11.89	$10,271,983	$11.89
Mar-21	$10,303,993	$11.82	$10,321,903	$11.86
Apr-21	$10,323,707	$11.86	$10,403,124	$11.95
May-21	$10,341,345	$11.82	$10,448,127	$11.96
Jun-21	$10,351,546	$11.77	$10,359,172	$11.83
Total	**$61,717,630**	**$11.81**	**$227,938,036**	**$14.36**

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

Notes: off-cycle payment adjustments for the dental benefit program managers, State Fiscal Year 2021:

- Jul 2020: PMPM Payments made via lump sum using 7/1/19 rates pending approval of 7/1/20 rates. Includes $2.6 million in adjustments for Sep- Dec 2019 PMPMs.
- Aug 2020: PMPM Payments made via lump sum using 1/1/20 rates pending approval of 7/1/20 rates. Includes $12.8 million in adjustments for Jan and Feb 2020 PMPMs using 1/1/20 rates.
- Sep 2020: PMPM Payments made via lump sum using 1/1/20 rates pending approval of 7/1/20 rates. Includes $25.7 million in adjustments for Mar-Jun 2020 PMPMs using 1/1/20 rates.
- Oct 2020: Includes $4.8 million adjustment for Jul 2020 using 7/1/20 rates and $4.5 million for Health Insurance Provider Fee (HIPF) payments.
- Nov 2020: Includes -$3.7 million in adjustments for Aug and Sep 2020 PMPMs at the 7/1/20 rates.
- Jan – Jun 2021: Payments made via lump sum estimates (using 7/1/20 rates) pending approval of 1/1/21 rates.

33 NUMBER OF HEALTHCARE PROVIDERS - DENTAL

The total number of healthcare providers contracted to provide healthcare services for each managed care organization delineated by provider type, provider taxonomy code and parish.

Timely access to covered dental services is an important goal of the Dental Benefit Program Managers (DBPM). The DBPMs are required to maintain minimum ratios of contracted providers to enrollees for covered services. The Department conducts ongoing monitoring of the number of contracted providers and requires the dental plans to submit quarterly geo-spatial analyses with provider locations.

Per contract requirements, the DBPMs submitted a registry of all providers that have contracted with the dental plans as well as any provider who was not in-network but was paid for services as an out of network provider or under a single case agreement. The provider registry is maintained via weekly updates to the fiscal intermediary as needed.

There are 996 dental providers contracted with DentaQuest and 1,843 dental providers contracted with MCNA to provide Medicaid covered dental services. Provider counts by provider type, taxonomy and parish are provided in Appendix XIII. It should be noted, however, that the unduplicated totals below will not match the provider totals in Appendix XIII as providers can enroll as more than one provider type, taxonomy, and in more than one parish.

Table 33.1 Total unduplicated[35] count of contracted providers in DBPM, State Fiscal Year 2021[36]

	DentaQuest	MCNA
Total Contracted Providers	996	1,843

Source: MARS Data Warehouse, June 25, 2021 Provider Registry

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

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

34 MEMBER AND PROVIDER SATISFACTION SURVEYS - DENTAL

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

Member and provider satisfaction are measures of a patient's experience of care. Member satisfaction with their healthcare, which is considered an important component in managed care quality, can be defined as how members value and regard their care. The new contracts require the member satisfaction survey to be completed 120 days after the first of the year on a calendar year basis. DentaQuest will not have the member or provider satisfaction survey for SFY 2021 as it is based on calendar year 2020. MCNA monitors member satisfaction via their inbound call center. The results are summarized and reported to the Louisiana Department of Health on an annual basis. The full member and provider survey reports for SFY 2021 can be found in Appendix XIV MCNA Member Satisfaction Surveys and Provider Satisfaction Surveys.

35 AUDITED FINANCIAL STATEMENTS - DENTAL

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

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

Further, the Department required the DBPMs to have a license or certificate of authority issued by LDI to operate as Medicaid risk-bearing entities pursuant to Title 22:1016 of the Louisiana Revised Statutes. The calendar year 2020 full financial statement for MCNA can be found in Appendix XV. Due to the contract effective date, January1, 2021 there was no CY 2020 financial statement for DentaQuest.

36 BENEFIT HEALTH OUTCOMES - DENTAL

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

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

EPSDT Dental Program

The EPSDT Dental Program is designated for enrollees under the age of 21. Dental benefits, administered by DQ and MCNA for the EPSDT Dental Program, 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 SFY 2021, DentaQuest covered 437,380 Medicaid enrollees under the age of 21. Of those, 29.2% saw a dentist for at least one service. Being that the DentaQuest contract began January 1, 2021, many of DentaQuest members were previously enrolled with MCNA and may have received services in the first six months of SFY 2021 through MCNA. MCNA covered 839,383 Medicaid enrollees under the age of 21. Of those, 37.9% saw a dentist for at least one service. A total of 869,750 unduplicated individuals under the age of 21 were enrolled in one or both of the Dental Benefit Management Plans (DBMP). Of these, 372,264 (43%) received at least one dental service.

Table 36.1 EPSDT Members who saw a dentist, State Fiscal Year 2021[37]

	DentaQuest	MCNA	Total
Total EPSDT members (under age 21)	437,380	839,383	869,750
Number who saw a dentist	127,760	318,188	372,264
Percent of members that saw a dentist	29.2%	37.9%	42.8%

Source: MARS Data Warehouse

Table 36.2 shows member utilization by service for individuals under the age of 21. Oral prophylaxis services, which is generally defined as the removal of deposits from the tooth surfaces (teeth cleaning), was the most common dental procedure received by members under the age of 21. Of members who saw a dentist, 94% received oral prophylaxis services. Composite fillings were the second most common procedure for this age group, received by 22% of members under the age of 21 who had a dental service.

[37] Totals by DBMP cannot be summed as members can switch health plans throughout the year and may be counted in each health plan total but are only once in the unduplicated total.

Table 36.2 Utilization by service for members under the age of 21, State Fiscal Year 2021[38]

Code Description	DentaQuest		MCNA		TOTAL	
	Members	%	Members	%	Members	%
Oral prophylaxis (teeth cleaning)	112,020	87.7%	292,829	92.0%	348,457	93.6%
Composite fillings	21,133	16.5%	63,779	20.0%	81,565	21.9%
Fluoride varnish	22,584	17.7%	59,010	18.5%	71,951	19.3%
Dental sealants	10,197	8.0%	30,393	9.6%	39,890	10.7%
Stainless steel crowns	8,272	6.5%	25,119	7.9%	32,472	8.7%
Extractions of primary teeth	7,735	6.1%	24,090	7.6%	31,172	8.4%
Amalgam fillings	6,319	4.9%	19,687	6.2%	24,929	6.7%
Pulpotomies performed on primary teeth	3,639	2.8%	11,644	3.7%	15,040	4.0%
Extractions of permanent teeth	2,358	1.8%	9,993	3.1%	12,254	3.3%
Root canals performed on permanent teeth	1,283	1.0%	4,262	1.3%	5,477	1.5%

Source: MARS Data Warehouse

Adult Denture Services

For Medicaid enrollees over the age of 21 that were eligible for full Medicaid benefits through either the FFS or MCO program, the dental benefit coverage through the DPMP was limited to denture services as outlined in the Medicaid State Plan. In aggregate for SFY 2021, 959,058 unduplicated adult members were enrolled in a DPMP for denture services, of which 26,283 (2.7%) saw a dentist for at least one covered service. Utilization by DBMP is provided in table 36.3.

Table 36.3 Adult members who saw a dentist, State Fiscal Year 2021[39]

	DentaQuest	MCNA	Total
Total adult members (age 21 and over)	475,976	903,637	959,058
Number who saw a dentist	16,162	10,445	26,283
Percent of members that saw a dentist	3.4%	1.2%	2.7%

Source: MARS Data Warehouse

In addition to the limited denture benefit provided by the DBMPs, the five managed care organizations provided their full benefit adult members a limited scope of expanded benefit for other services such as teeth cleaning, fillings and tooth extraction as a value added services (VAS). Data for VAS Dental services are provided in the next section.

[38] Counts are the number of members who received one or more service by category. The rate is expressed as a percent of total members who saw a dentist.

[39] Totals by DBMP cannot be summed as members can switch health plans throughout the year and may be counted in each health plan total but are only once in the unduplicated total.

MCO Adult Dental Value Added Services (VAS)

Beginning February 1, 2015, as a value added benefit to adult full-benefit enrollees, all five managed care organizations began offering a limited adult dental benefit beyond the state plan denture benefit covered by the two DBPMs. In State Fiscal Year 2021, 14% of eligible adult members received at least one value added dental service through their managed care organization. Additional data on adult dental services by health plan are presented in tables 36.4 and 36.5.

Table 36.4 Eligibility and utilization data for value added dental benefits by health plan, State Fiscal Year 2021

	ABH	ACLA	HB	LHCC	UHC	Total
Eligible Enrollees (Full-benefit Adults age 21+)[40]	89,694	109,707	181,599	221,408	239,225	811,166
Number who saw a dentist	12,079	15,457	28,861	31,981	32,540	120,918
The percent of eligible patients that saw a dentist	13.47%	14.09%	15.89%	14.44%	13.60%	14.91%

Source: MARS data warehouse

Teeth cleaning was the most common service received, followed by extraction of permanent teeth and fillings. Table 36.5 provides utilization rates by MCO for most the common procedures performed on those patients over the age of 21 who received a dental service provided as a value added service through their health plan.

Table 36.5 Utilization rates for value added dental services by health plan, State Fiscal Year 2021[41]

		ABH	ACLA	HB	LHCC	UHC
Adult oral prophylaxis	Count	5,507	6,179	13,030	12,340	14,070
	Utilization	45.59%	39.98%	45.15%	38.59%	43.24%
Extractions of permanent teeth	Count	3,982	5,825	9,891	9,298	11,556
	Utilization	32.97%	37.69%	34.27%	29.07%	35.51%
Composite fillings	Count	2,466	3,045	6,353	7,145	7,565
	Utilization	20.42%	19.70%	22.01%	22.34%	23.25%
Amalgam fillings	Count	232	288	587	734	833
	Utilization	1.92%	1.86%	2.03%	2.30%	2.56%

Source: MARS Data Warehouse

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

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

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

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

An appeal, which must be acted on within 30 days, is a request by a member to review one of the following actions that the DBPMs has taken:

- Denying or partially denying a requested service, including type or level of service;
- Reducing, suspending or terminating a previously authorized service;
- Denying, in whole or in part, payment for a service;
- Failure to provide services in a timely manner (as defined by the state); and
- Failure to act within 90 days on a grievance, which is an expression of dissatisfaction about any matter other than one of the above actions.

As part of their quality strategy, states must require the DBPMs to maintain records of appeals and submit them for state review. When reviewing the records, the Department analyzed the subjects of the appeals to identify the extent to which they are valid or are in the actual control of the health plan. In State Fiscal Year 2021, there were 535 determinations made under the dental program administered by both DBPMs with an overall 36% reversal rate.

Table 37.1 Appeals and state fair hearings, State Fiscal Year 2021

	DentaQuest	MCNA
Total Members (unduplicated)	913,356	1,743,020
Members who filed an appeal	458	71
Members who accessed SFH	2	4
Total appeals filed at DBPM level	473	71
Total appeals filed at SFH level	2	4
Total appeal & SFH determinations[42]	457	78
Total determinations fully or partially reversed in favor of the member	176	16
% of determinations fully or partially reversed in favor of the member	38.5%	20.5%

Source: 113 Grievance, Appeal and Fair Hearing Report

[42]Total determinations may include determinations made in SFY 2021 for appeals received in a prior year.

38 CLAIMS SUBMITTED BY HEALTHCARE PROVIDERS - DENTAL

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

DBPMs report claims data annually using the revised 177 reporting template developed by the Department, which captures unduplicated counts of claims received by each managed care entity. This report captures not only claims that are adjudicated (processed for payment or denial), but also the rejected claim counts that are not reported in encounter submissions to the fiscal intermediary. In State Fiscal Year 2021, there were 3,320,009 claims submitted to both DQ and MCNA for dental services. The breakdown of unduplicated claim counts for State Fiscal Year 2021 is presented in table 38.1.

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

Claims that do not meet the specific data requirements or the basic format necessary will be rejected according to CMS. "Rejected" claims are different from denied claims, as they are not adjudicated and are rejected before entering the plan's adjudication system. Reasons for rejection include Electronic Data Interchange (EDI) formatting issues on the transaction resulting in a system inability to read the claim or failure of the claim to meet basic HIPAA submission requirements. Since rejected claims are not processed through the health plans' adjudication systems, services cannot be classified as emergency or non-emergency.

Table 38.1 Total claims submitted, State Fiscal Year 2021

	Rejected Claims[43]	Emergency Services	Non-Emergency Services	Total
DentaQuest	0	0	698,532	698,532
MCNA	0	8,027	2,613,450	2,621,477
Total	0	8,027	3,311,982	3,320,009

Source: Report 177 Total and Out of Network Claims

[43] DentaQuest and MCNA do not reject claims. All claims are processed for adjudication to either pay or deny.

39 DENIED CLAIMS - DENTAL

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

Table 39.1 below provides total unduplicated claims denied by the DBPMs delineated by emergency and non-emergency services. Table 39.2 provides a listing of the top ten reasons for claim denial which encompass 83% of all claim denials. The complete listing of all CARCs for denied claims for both DentaQuest and MCNA is provided in Appendix XVI.

Table 39.1 Total unduplicated denied claims, State Fiscal Year 2021

	Emergency Services	Non-Emergency Services	Total
DentaQuest	0	47,609	47,609
MCNA	972	354,142	355,114

Source: Report 173 Denied Claims

Table 39.2 Ten most prevalent reasons for claim denial by CARC, State Fiscal Year 2021[44]

CARC	Code Description	# Claims Denied	% of Claims Denied
96	Non-covered charge(s).	93,487	22%
18	Exact duplicate claim/service	60,734	14%
169	Alternate benefit has been provided.	53,482	13%
27	Expenses incurred after coverage terminated.	43,024	10%
204	This service/equipment/drug is not covered under the patient's current benefit plan	20,775	5%
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period.	20,022	5%
6	The procedure/revenue code is inconsistent with the patient's age.	19,028	4%
22	This care may be covered by another payer per coordination of benefits.	14,362	3%
252	An attachment/other documentation is required to adjudicate this claim/service.	13,519	3%
119	Benefit maximum for this time period has been reached.	10,543	2%
Total	**TOTAL TOP TEN CLAIM DENIAL REASON CODES**	**348,976**	**83%**

Source: Report 173 Denied Claims

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

40 CLEAN CLAIMS

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

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

In State Fiscal Year 2021, there were 2,366,753 clean claims submitted to both DBPMs. This total includes claims that were paid, denied or otherwise adjudicated based on the original claim submittal without the need for additional information. It does not include rejected claims, which do not meet the definition of a clean claim. Of the clean claims submitted 2,247,816 were paid. This total does not include other claims paid after additional information or verifications was received or the original claim was adjusted.

Table 40.1 Clean claims, State Fiscal Year 2021

	DentaQuest	MCNA	Total
Total clean claims submitted	**698,539**	1,668,214	2,366,753
Clean claims paid	642,809	1,605,007	2,247,816

Source: 221 Prompt Pay Report

The DBPMs are required by contract to pay 90% of all payable clean claims within 15 business days of the date of receipt and 99% within 30 calendar days of the date of receipt. The DBPMs 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.

Table 40.2 Prompt pay performance for paid clean claims, State Fiscal Year 2021

	Paid within 15 business days		Paid within 30 calendar days	
	DentaQuest	MCNA	DentaQuest	MCNA
EPSDT Dental	100.00%	99.25%	100.00%	99.96%
Adult Denture	100.00%	96.79%	100.00%	100.00%

Source: 221 Prompt Pay Report

Table 40.3 Average number of days to pay clean claims, State Fiscal Year 2021

	DentaQuest	MCNA
EPSDT Dental	7.50	7.60
Adult Denture	6.30	9.80

Source: 221 Prompt Pay Report

41 PRIOR AUTHORIZATION REQUESTS - DENTAL

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

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

In State Fiscal Year 2021, the DPBMs completed prior authorizations on a total of 208,228 requests. In alignment with a more expansive benefit for children, 79% of authorizations were for members under the age of 21. Tables 41.1 and 41.2 provide a breakdown by age group and procedure code.

Table 41.1 Number of prior authorization requests processed by DBPMs by type of procedure, State Fiscal Year 2021

Type of Procedure	EPSDT (under 21)			Adult Denture (21 and over)		
	DentaQuest	MCNA	Total	DentaQuest	MCNA	Total
0100-0999 Diagnostic	521	1,472	1,993	1,714	7,495	9209
1000-1999 Preventive	1,475	4,589	6,064	14	23	37
2000-2999 Restorative	14,802	27,699	42,501	370	423	793
3000-3999 Endodontics	4,738	9,840	14,578	51	159	210
4000-4999 Periodontics	746	1,224	1,970	209	67	276
5000-5899Removable	121	454	575	8,245	19,638	27883
5900-5999 Maxillofacial	1	2	3	1	1	2
6000-6199 Implant	13	11	24	19	4	23
6200-6999 Fixed	25	50	75	38	0	38
7000-7999 Oral	17,430	36,185	53,615	4,099	1,662	5761
8000-8999 Orthodontics	146	450	596	0	3	3
9000-9999 Adjunctive/other	13,175	28,366	41,541	108	342	450
Procedure code not specified	3	0	3	5	0	5
Total	**53,196**	**110,342**	**163,538**	**14,873**	**29,817**	**44,690**

Source: MCNA Quarterly 188 Prior Authorization Reports

The Dental Benefit Program Managers contract specifies requirements for timely processing of prior authorization requests. For standard authorizations, 80% must be processed within two business days and 100% within 14 calendar days. For expedited authorizations, 100% must be processed no later than 72 hours after receipt. Tables 41.2 provides the average and range of authorization processing times for both children and adults by type of procedure.

Table 41.2 EPSDT prior authorization response times, State Fiscal Year 2021

Type of Procedure	DentaQuest		MCNA	
	Average Time	Range of Times	Average Time	Range of Times
0100-0999 Diagnostic	1.1	0 - 12	1.0	0 - 6
1000-1999 Preventive	0.7	0 - 12	0.8	0 - 31
2000-2999 Restorative	1.5	0 - 12	0.9	0 - 45
3000-3999 Endodontics	1.8	0 - 11	0.7	0 - 45
4000-4999 Periodontics	2.4	0 - 5	1.1	0 - 6
5000-5899 Removable	2.1	0 - 5	1.0	0 - 4
5900-5999 Maxillofacial	4.0	4 - 4	2.0	0 - 4
6000-6199 Implant	2.8	1 - 4	0.9	0 - 3
6200-6999 Fixed	3.0	2 - 4	1.1	0 - 5
7000-7999 Oral	2.0	0 - 14	0.8	0 - 45
8000-8999 Orthodontics	1.5	0 - 10	2.1	0 - 5
9000-9999 Adjunctive	2.0	0 - 14	1.0	0 - 45
Code not specified	1.3	0 - 4	-	-
All prior authorizations	**1.8**	**0 - 14**	**0.9**	**0 - 45**

Source: MCNA Quarterly 188 Prior Authorization Reports

Table 41.3 Adult Denture prior authorization response times, State Fiscal Year 2021

Type of Procedure	DentaQuest		MCNA	
	Average Time	Range of Times	Average Time	Range of Times
0100-0999 Diagnostic	2.1	0 - 7	0.5	0 - 4
1000-1999 Preventive	0.6	0 - 2	0.4	0 - 1
2000-2999 Restorative	0.7	0 - 5	0.6	0 - 5
3000-3999 Endodontics	0.8	0 - 5	0.5	0 - 4
4000-4999 Periodontics	0.5	0 - 5	0.7	0 - 4
5000-5899 Removable	2.1	0 - 13	0.5	0 - 5
5900-5999 Maxillofacial	0.0	0 - 0	1.0	1 - 1
6000-6199 Implant	0.3	0 - 4	0.3	0 - 1
6200-6999 Fixed	0.3	0 - 2	0.0	-
7000-7999Oral	2.1	0 - 6	0.4	0 - 5
8000-8999 Orthodontics	0.0	-	1.7	0 - 4
9000-9999 Adjunctive	1.0	0 - 4	0.6	0 - 4
Code not specified	2.8	1 - 4	-	-
All prior authorizations	**2.0**	**0 - 13**	**0.5**	**0 - 5**

Source: MCNA Quarterly 188 Prior Authorization Reports

Prior Authorizations Denials

Of the 208,228 prior authorizations the DBPMs completed during State Fiscal Year 2021, 49,998 (24%) were denied. At 25%, the denial rate for children was slightly higher the adult denial rate of 21%. There can be multiple denial reasons associated with each authorization request. As a result, the number of denied authorizations by denial reason code for both dental plans (62,797) is greater than the number unduplicated denied authorizations. DentaQuest used 167 unique reasons for denial of prior authorization. MCNA used 80 unique reasons for denial of prior authorizations. Tables 41.4 and 41.5 provide the ten most frequently used authorization denial codes for DentaQuest and MCNA respectively. A complete count of authorization denials delineated by denial reason are included in Appendix XVII.

Table 41.4 Ten most prevalent reasons for authorization denial by DentaQuest State Fiscal Year 2021

Denial Code	Code Description	EPDST	ADULT	Total
3931	Per Dental Director review, removal of impacted tooth is denied. There is no sign of infection, pain beyond normal eruption, or that the tooth is in a position that will not let it break through the gum on its own.	4,512	1	4,513
3430	We have approved the amount of anesthesia that is normally needed to safely complete the services requested. Based on Dental Director review, the additional time requested is not medically necessary.	1,762	0	1,762
3307	Anesthetic services are only covered when the associated services are approved.	1,701	0	1,701
2040	Service is not covered. Please refer to your Office Reference Manual for definition of covered teeth/quad/arch, patient ages, and procedure codes.	2	1,151	1,153
3447	Sedation is only covered when the patient needs a lot of dental work done on the same day, four or more teeth pulled, or the patient is nervous about their treatment and a different drug has been tried and failed to help the patient relax during treatment.	695	0	695
3445	Per Dental Director review, the x-rays do not show the need for bone removal or sectioning of the tooth. This is needed for teeth that have formed abnormal or multiple roots or teeth with 75% of the clinical crown destroyed by decay. A less severe extraction code would be considered.	219	357	576
3799	Per Dental Director review, periodontal scaling and root planning is denied due to no evidence of significant bone loss.	419	0	419
4186	Per Dental Director review, removal of impacted tooth is denied due to incomplete root development.	368	0	368
2099	Services provided by an Out-of- Network or Non-contracted provider are not provided under this benefit program.	255	77	332
3782	Per Dental Director review, the x-rays do not support the code requested. A less severe extraction code would be considered. Please review the ADA code you requested and resubmit with the appropriate ADA code.	327	1	328
TOTAL TOP TEN		10,260	1,587	11,847

Table 41.5 Ten most prevalent reasons for authorization denial by MCNA State Fiscal Year 2021

Denial Code	Code Description	EPDST	ADULT	Total
56	The dental director has advised that the X-rays received do not demonstrate the need for treatment submitted.	6,154	0	6,154
18	This request has been previously reported and an approval or denial was issued.	3,837	566	4,403
96	This procedure is considered non-covered in accordance with either the program benefits or the facility contract with MCNA.	2,143	1,197	3,340
169	The clinical reviewer has recommended an alternate procedure/benefit.	2,969	16	2,985
272	Clinical criteria were not met.	1,506	1,434	2,940
50	The clinical reviewer has determined that the treatment is in excess of the member's needs.	2,472	15	2,487
49	Please submit x-ray(s) and narrative with this request.	1,827	172	1,999
252	Please submit a treatment plan.	1,709	224	1,933
31	The subscriber is not currently active in the program.	1,410	317	1,727
16	Please submit the patient chart notes. Chart notes should include the date of service, services rendered, necessary details to service and the name of the rendering provider. The provider name should be in a legible format.	1,364	156	1,520
TOTAL TOP TEN		25,391	4,097	29,488

Source: Quarterly 188 Prior Authorization Reports

Claims Denied After Prior Authorization Approved

In State Fiscal Year 2021, both dental plans denied a total of 402,723 claims. Of these, 12,400 were claims for services that had been previously prior authorized; however, the claim or documentation provided did not meet the criteria for payment. Table 41.4 and 41.5 includes the ten most frequently used CARCs used for claims denied when the prior authorization had been previously approved. DentaQuest indicates reflects only three reasons for claim denied after prior authorization was approved. All denials delineated by reason for denial are included in Appendix XVII. It should be noted that the data reflect only initial denials and do not reflect if a claim was resubmitted and subsequently paid.

Table 41.6 Ten most prevalent reasons for claim denial after prior authorization was approved by DentaQuest, State Fiscal Year 2021

CARC	Code Description	Total
22	This care may be covered by another payer per coordination of benefits.	16
31	Patient cannot be identified as our insured.	77
197	Precertification/authorization/notification/pre-treatment absent.	4
Total	**TOTAL TOP TEN CLAIM DENIAL REASON CODES**	27

Source: Report 173 Denied Claims

Table 41.7 Ten most prevalent reasons for claim denial after prior authorization was approved by MCNA, State Fiscal Year 2021

CARC	Code Description	Total
18	Exact duplicate claim/service.	3,280
252	An attachment/other documentation is required to adjudicate this claim/service.	2,768
22	This care may be covered by another payer per coordination of benefits.	877
272	Coverage/program guidelines were not met.	670
27	Expenses incurred after coverage terminated.	577
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	528
96	Non-covered charge(s).	494
16	Claim/service lacks information or has submission/billing error(s).	436
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	360
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.	289
Total	**TOTAL TOP TEN CLAIM DENIAL REASON CODES**	10,279

Source: Report 173 Denied Claims

LIST OF APPENDICES