

Medicaid Managed Care Transparency Report 2023

Agency Response to La. Revised Statute 40:1253.2

Louisiana Department of Health

Bureau of Health Services Financing

August 2025



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Introduction

This report is the tenth in a series of annual reports 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). The program focuses on achieving the following outcomes:

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

The program initially included two coordinated care models: 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.” Over time, LDH integrated services and populations into the managed care program, achieving significant milestones along the way. The most significant change in the MCO program for SFY 2023 was the re-procurement of MCO contractors, expanding the number of MCOs from five to six, effective January 1, 2023. The populations and services in Managed Care remained relatively unchanged.

In SFY 2014, Louisiana Medicaid initiated a new managed care program to contract for the management of state plan and EPSDT-covered dental services for children’s and adult dentures through a single contracted Dental Benefits Plan Manager (DBPM). In SFY 2021, this program expanded from one to two contracted DBPMs. In SFY 2023, the populations and services covered were expanded to include comprehensive dental services for adults with developmental or intellectual disabilities who were also enrolled in a Waiver Program or residing in an Intermediate Care Facility (ICF).¹

Transparency Report Measures and Data

This annual transparency report includes 46 areas of measurement outlined in Louisiana Revised Statute 40:1253.2 and covers program operations for state fiscal year (SFY) 2023. All measures are reported for the SFY 2023, July 1, 2022, through June 30, 2023, unless otherwise indicated. The first twenty-nine sections of this report cover operations and outcomes for Managed Care Organizations, specifically health plans. Sections 30 through 46 cover Dental Benefit Management Plan (DBMP) operations and outcomes.

The 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 deliverables² 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, were extracted from the MARS Data Warehouse. The state administrative system, LaGOV Enterprise Resource Planning System – Finance

¹ Act 450 of the 2021 Regular Session and Act 366 of the 2022 Regular Session: R.S. 40:1250.31 and 1250.32

² Templates for routine reporting deliverables can be found at <https://ldh.la.gov/medicaid/mco-resources>.

Module (LaGOV), 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), the Department's internal policies and procedures for data collection 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 the data extraction code or process used by the managed care entities or the Department for reasonability. For data originating from the MARS Data Warehouse, Myers and Stauffer directly aggregated data from encounters or data extracts for each plan and compared the results to those produced by the Department. For data originating from the plans, Myers and Stauffer (MSLC) reviewed plan responses to a survey developed by Myers and Stauffer to document the processes the plans used to generate the data, as well as the policies and procedures in place to collect, track, and report data. Where Myers and Stauffer found inconsistencies above or below the 10% variance threshold established by the Department, they made recommendations to the Department or the health plan to improve the method used to collect data. See [Appendix XIX](#) and [Appendix XX](#) for the survey instruments.

Medicaid Managed Care Organizations

During state fiscal year (SFY) 2023, more than 1.9 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 six 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 provider reimbursement. The MCOs operate under federal authority, as outlined 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 (FFS) program.

A small number of individuals remained excluded entirely from enrollment in an MCO and continued to receive services under FFS. Medicaid populations excluded from enrollment in an MCO in SFY 2023 included:

- Individuals over age 21 residing in an ICF/IID;
- Individuals enrolled in the Program for All-Inclusive Care for the Elderly (PACE);
- Populations within specified programs, including Refugee Cash Assistance, Refugee Medical Assistance, Long-Term Care Co-Insurance, Take Charge Plus, and Qualified Disabled Working Individuals;
- 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; and
- Individuals with a limited period of eligibility.

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 SFY 2023:

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

1 CONTRACTED MANAGED CARE ORGANIZATIONS

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

For the first six months of SFY 2023 (July – December 2022), five MCOs were contracted with LDH to manage physical and behavioral healthcare services. Effective January 1, 2023, the state began a new three-year contract for all continuing MCOs and added Humana as the sixth health plan. All data presented in this report for Humana is for the six months of operations, January 1 – June 30, 2023.

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 2023

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

Source: Medicaid managed care contracts

The state also contracted for the managed care of covered dental services through two dental benefit program managers (DBPMs) as detailed in sections 30 through 46 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 require certain staff to be domiciled in-state, such as the 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. 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 2023

	ABH	ACLA	HBL	HHH	LHCC	UHC
Total number of LA employees (FTEs)	214	209	208	327	587	375
Average salary paid	\$71,027	\$81,175	\$81,508	\$73,073	\$81,273	\$93,820

Source: Annual 017 Staffing Report

The average annual salary, weighted across all health plans, was \$81,202. 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 the state, such as call center staff, whereas others have a larger share of higher salary positions in the 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 SFY2023, the Department paid a total of \$13,601,585,324³ to the six contracted MCOs 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 SFY2023 was 1,985,845. Total enrollment, unduplicated within each group, was 1,835,261 full-benefit enrollees and 165,763 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 the 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 vary as impacted by off-cycle payment adjustments, including deferrals 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.

³ The payments to the MCOs is net of monetary penalties and adjustments assessed against the MCOs in SFY 2023 and may not equal payments to MCOs as reported in the Monthly Medicaid Forecast and the Medicaid Annual Report.

Table 3.1 Payments to MCOs for full-benefit enrollees by month, State Fiscal Year 2023

	ABH		ACLA		HBL	
	Total Payments	Average PMPM	Total Payments	Average PMPM	Total Payments	Average PMPM
Jul-22	\$76,649,752	\$564.35	\$109,738,202	\$521.81	\$178,243,872	\$520.30
Aug-22	\$80,415,319	\$587.82	\$115,908,907	\$548.91	\$188,814,076	\$548.02
Sep-22	\$78,063,411	\$567.70	\$112,489,068	\$531.21	\$182,992,183	\$529.32
Oct-22	\$140,300,133	\$1,014.19	\$204,301,845	\$960.64	\$325,612,381	\$937.46
Nov-22	\$75,487,426	\$539.77	\$105,668,697	\$489.22	\$179,145,463	\$513.86
Dec-22	\$153,540,606	\$1,088.49	\$230,037,721	\$1,045.08	\$360,615,591	\$1,030.94
Jan-23	\$78,825,341	\$528.92	\$118,860,194	\$535.15	\$184,436,081	\$574.41
Feb-23	\$76,642,052	\$508.55	\$111,127,954	\$512.60	\$175,300,871	\$539.77
Mar-23	\$153,338,086	\$1,005.87	\$214,475,233	\$999.60	\$336,678,926	\$1,031.40
Apr-23	\$83,994,162	\$542.97	\$111,682,830	\$526.86	\$183,747,540	\$560.28
May-23	\$86,624,265	\$556.88	\$109,592,622	\$517.36	\$180,474,375	\$549.06
Jun-23	\$146,932,405	\$942.33	\$197,467,394	\$939.22	\$325,839,091	\$993.97
Total	\$1,230,812,958	\$704.24	\$1,741,350,667	\$677.69	\$2,801,900,449	\$694.34
	HHH		LHCC		UHC	
	Total Payments	Average PMPM	Total Payments	Average PMPM	Total Payments	Average PMPM
Jul-22	\$0	\$0.00	\$243,737,670	\$466.80	\$242,105,521	\$494.88
Aug-22	\$0	\$0.00	\$257,623,031	\$491.38	\$259,211,560	\$527.68
Sep-22	\$0	\$0.00	\$251,841,315	\$479.00	\$252,176,034	\$512.02
Oct-22	\$0	\$0.00	\$452,069,648	\$857.75	\$453,758,320	\$919.56
Nov-22	\$0	\$0.00	\$240,515,330	\$455.10	\$245,030,903	\$495.47
Dec-22	\$0	\$0.00	\$502,900,948	\$949.05	\$495,834,188	\$1,000.11
Jan-23	\$0	\$0.00	\$254,686,501	\$529.33	\$252,586,651	\$590.53
Feb-23	\$46,506,035	\$347.61	\$240,868,386	\$495.77	\$237,189,903	\$548.95
Mar-23	\$42,647,969	\$320.34	\$440,857,609	\$901.00	\$416,546,544	\$960.46
Apr-23	\$45,484,725	\$342.29	\$235,116,871	\$477.49	\$223,755,564	\$515.19
May-23	\$48,160,299	\$356.62	\$247,071,967	\$500.75	\$221,967,083	\$510.31
Jun-23	\$50,078,685	\$366.07	\$436,989,893	\$886.59	\$418,996,100	\$964.52
Total	\$232,877,713	\$287.21	\$3,804,279,169	\$624.41	\$3,719,158,370	\$669.64

Source: LaGov and MARS Data Warehouse (MDW)

Notes - off-cycle payment adjustments for the managed care organization, state fiscal year 2023:

- Aug 2022 July Date of Service (DOS) PMPMs paid via lump sum pending approval of 7/1/22 rates.
- Sep 2022 Aug DOS PMPMs paid via lump sum pending approval of 7/1/22 rates.
- Oct 2022 Includes \$668.6 million in Directed Payments (Q1) and \$48.3 million in Managed Care Incentive Program (MCIP) payments.
- Nov 2022 Jul and Aug DOS PMPMs processed in MMIS and lump sum payments recouped. Includes \$96.8 million in MCIP payments.
- Dec 2022 Includes \$668.6 million in Directed Payments (Q2), \$110.9 million in MCIP payments, and \$0.8 million in COVID Vaccine Admin.
- Jan 2023 Includes \$26.3 million in MCIP payments. No capitation payment for Humana, as payments are made one month in arrears.
- Feb 2023 Jan DOS PMPMs paid via lump sum pending approval of 1/1/23 rates.
- Mar 2023 Jan DOS PMPMs process in MMIS and lump sum recouped. Includes \$668.6 million in Directed Payments (Q3), \$59.1 million in MCIP, and \$1 million in COVID Vaccine Admin.
- Jun 2023 Includes \$663.7 million in Directed Payments and \$22.1 million in Managed Care Incentive Program (MCIP).

Table 3.2 Payments to MCOs for partial-benefit enrollees by month, State Fiscal Year 2023⁴

	ABH		ACLA		HBL	
	Total Payments	Average PMPM	Total Payments	Average PMPM	Total Payments	Average PMPM
Jul-22	\$928,796	\$41.53	\$941,207	\$42.27	\$1,170,316	\$42.75
Aug-22	\$13,217	\$0.59	\$12,837	\$0.57	\$18,332	\$0.67
Sep-22	\$9,701	\$0.43	\$8,287	\$0.37	\$12,104	\$0.44
Oct-22	\$921,520	\$40.44	\$930,455	\$40.76	\$1,180,234	\$42.71
Nov-22	\$2,782,117	\$120.79	\$2,762,581	\$119.96	\$3,497,165	\$126.11
Dec-22	\$934,190	\$40.27	\$999,283	\$42.93	\$1,189,213	\$42.94
Jan-23	\$913,440	\$39.50	\$975,136	\$42.59	\$1,162,720	\$41.85
Feb-23	\$674,801	\$29.30	\$317,914	\$13.99	\$467,993	\$16.88
Mar-23	\$1,886,547	\$82.29	\$1,902,860	\$84.26	\$2,355,960	\$84.84
Apr-23	\$972,182	\$42.50	\$933,907	\$41.61	\$1,172,397	\$42.27
May-23	\$966,196	\$42.39	\$936,755	\$41.93	\$1,159,791	\$41.83
Jun-23	\$614,089	\$27.25	\$626,819	\$28.40	\$752,613	\$27.48
Total	\$11,616,795	\$42.45	\$11,348,040	\$41.79	\$14,138,838	\$42.64
	HHH		LHCC		UHC	
	Total Payments	Average PMPM	Total Payments	Average PMPM	Total Payments	Average PMPM
Jul-22	\$0	\$0.00	\$1,405,873	\$43.53	\$1,456,997	\$42.84
Aug-22	\$0	\$0.00	\$20,230	\$0.63	\$28,092	\$0.83
Sep-22	\$0	\$0.00	\$13,842	\$0.43	\$26,909	\$0.79
Oct-22	\$0	\$0.00	\$1,384,993	\$42.54	\$1,419,466	\$41.40
Nov-22	\$0	\$0.00	\$4,139,347	\$126.98	\$4,258,902	\$123.66
Dec-22	\$0	\$0.00	\$1,377,189	\$42.27	\$1,437,875	\$41.78
Jan-23	\$0	\$0.00	\$1,361,284	\$41.68	\$1,408,685	\$40.47
Feb-23	\$0	\$0.00	\$186,495	\$5.72	\$209,146	\$6.01
Mar-23	\$255,736	\$53.05	\$2,792,157	\$85.75	\$2,888,420	\$82.95
Apr-23	\$160,988	\$29.42	\$1,391,005	\$42.74	\$1,420,959	\$40.78
May-23	\$197,898	\$32.54	\$1,399,001	\$43.08	\$1,444,137	\$41.47
Jun-23	\$164,985	\$24.56	\$913,184	\$28.39	\$938,527	\$27.31
Total	\$779,607	\$25.29	\$16,384,600	\$42.03	\$16,938,117	\$40.94

Source: LaGOV and MARS Data Warehouse (MDW).

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 requires plans to submit geospatial 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. 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 for 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 prior years’ reporting.

In SFY 2023, one or more of the six managed care plans contracted 65,332 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, under multiple taxonomies and in more than one parish.

Table 4.1 Total unduplicated⁵ count of contracted providers by health plan, State Fiscal Year 2023⁶

	ABH	ACLA	HBL	HHH	LHCC	UHC	Total
Total Contracted Providers	22,457	37,469	35,959	25,052	42,258	33,212	65,332

Source: MARS Data Warehouse, June 23, 2023 Provider Registry

⁵Individual 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 its multiple functions and may be counted multiple times.

⁶Includes 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 encounter files to determine those PCPs who submitted at least one claim for service during SFY 2023. 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 SFY 2023 are presented in Table 5.1. [Appendix II](#) lists primary care providers, categorized by provider type, provider taxonomy, and parish, with at least one claim. It should be noted, however, that the unduplicated totals in Table 5.1 below may 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 2023^{7,8}

	ABH	ACLA	HBL	HHH	LHCC	UHC	Total
Total Contracted PCPs	2,079	4,759	4,236	4,496	4,023	2,127	9,494
PCPs with at least one claim	1,361	3,574	3,393	2,617	3,074	1,603	5,998
Percent with at least one claim	65.5%	75.1%	80.1%	58.2%	76.4%	75.4%	63.2%

Source: MARS Data Warehouse, June 23, 2023, Provider Registry

⁷Individual 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. Total is a count of unique NPIs across all plans.

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

6 CONTRACTED PROVIDERS WITH A CLOSED PANEL

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

Based on recommendations from Myers and Stauffer, the methodology was modified beginning with the 2017 report to limit closed panel status to primary care providers only. This is consistent with currently available data and industry standards, which indicate 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 the quality of care for members. Each health plan sets a plan-specific policy on which providers can close their panels, when a panel can be closed, how to inform the health plan when a panel is closed or reopened, and how closed panels are tracked.

The Department extracted data for the providers with a closed panel from provider registry files submitted by each MCO. Table 6.1 displays the number of primary care physicians (PCPs) with a closed panel by health plan as of June 23, 2023. Additional data, organized by provider type, taxonomy, and parish, can be found in [Appendix III](#). The unduplicated totals in Table 6.1 below do not necessarily align with the provider totals in Appendix III, as providers can enroll in 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 2023^{9,10}

	ABH	ACLA	HBL	HHH	LHCC	UHC	Total
Total Contracted PCPs	2,079	4,759	4,236	4,496	4,023	2,127	9,494
PCPs with a Closed Panel	404	776	1,066	540	1,417	296	3,407
Percent with a Closed Panel	19.4%	16.3%	25.2%	12.0%	35.2%	13.9%	35.9%

Source: MARS Data Warehouse: June 23, 2023 Provider Registry

⁹Individual 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 its multiple functions and may be counted multiple times. Total is a count of unique NPIs across all plans.

¹⁰Includes only providers with locations in Louisiana or within a border county.

7 MEDICAL LOSS RATIO

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

Federal regulations and health plan contracts require that a minimum of 85% of payments made to MCOs 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 a 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, 2022. In calendar year 2022, all health plans met the 85% minimum ratio, and no rebates to the Department were required. The audited reports for 2022 are posted on the Medicaid website at <https://ldh.la.gov/page/2142>.

Table 7.1 Medical loss ratios (MLR), Calendar Year 2022¹¹

	Adjusted YTD MLR Capitation Revenue	Total Adjusted MLR Expense	MLR Percentage	Rebate Required
ABH	\$1,053,481,725	\$988,480,434	93.8%	\$0
ACLA	\$1,527,908,209	\$1,403,659,095	91.9%	\$0
HBL	\$2,478,158,976	\$2,334,509,212	94.2%	\$0
LHCC	\$3,420,121,953	\$3,274,520,849	95.7%	\$0
UHC	\$3,371,608,277	\$3,175,800,937	94.2%	\$0

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

Table 7.2 Breakdown of total adjusted MLR, Calendar Year 2022¹¹

	Patient Care	Quality Improvement	Information Technology	Other	Total Adjusted MLR Expense
ABH	\$975,894,239	\$12,586,195	\$0	\$0	\$988,480,434
ACLA	\$1,387,994,250	\$11,909,243	\$3,755,603	\$0	\$1,403,659,096
HB	\$2,318,295,169	\$13,979,474	\$2,234,568	\$0	\$2,334,509,211
LHCC	\$3,235,519,966	\$35,537,147	\$3,463,737	\$0	\$3,274,520,850
UHC	\$3,129,587,013	\$35,820,930	\$10,392,994	\$0	\$3,175,800,937

Source: MSLC Audited Medical Loss Ratio Reports

¹¹Includes expansion and non-expansion populations

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 the quality, timeliness, and access to healthcare services that an MCO provides to Medicaid enrollees.

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 the various processes and measures reviewed by the EQRO, each annual report includes 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 online at <https://ldh.la.gov/resources/EQR>.

Additionally, the Department publishes a Medicaid Managed Care Quality Dashboard, which provides a comparison of MCO HEDIS and non-HEDIS performance trends over time 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, considered an important component of managed care quality, can be defined as the extent to which members value and regard their care. The Department and health plans can utilize member and provider satisfaction data to enhance their 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, some biases can affect the findings, including non-response bias, mode of administration, survey timing and 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 were getting needed care, receiving care quickly, the quality of doctor communication, health plan customer service, and global ratings.

The Department requires health plans to submit an annual member satisfaction survey report. Furthermore, NCQA also collected survey results 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: MCO Satisfaction Surveys](#).

Provider Satisfaction Survey

Unlike member satisfaction, there are currently no national standard survey instruments for assessing provider satisfaction; 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 summarizes the survey methods and findings, including raw data in the format provided by LDH, and provides an analysis of opportunities for improvement. The annual provider survey provides insight into access of overall satisfaction, as well as satisfaction with the following functions:

- Access to linguistic assistance;
- Provider enrollment;
- Provider communication;
- Provider education and training;
- 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 are available in [Appendix IV: MCO Satisfaction Surveys](#).

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 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 representation of the company's financial position and performance.

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

The full financial statements for each plan are available in [Appendix V](#). These statements cover the calendar year 2022, which was reported during the state fiscal year 2023.

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 SFY 2023, no sanctions were 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 noncompliance issues that are not specifically subject to the issuance of a sanction. Additional information on actions taken or penalties imposed is available on the Department's website at <https://ldh.la.gov/Sanctions>.

Managed Care Organization 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 2,136,072 unduplicated individuals enrolled in Louisiana Medicaid in SFY2023, 1,985,845 (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. Some enrollees are enrolled in a health plan for partial benefits only, specifically covering nonemergency medical transportation and specialized behavioral health services. These enrollees receive their physical and acute care through fee for service.

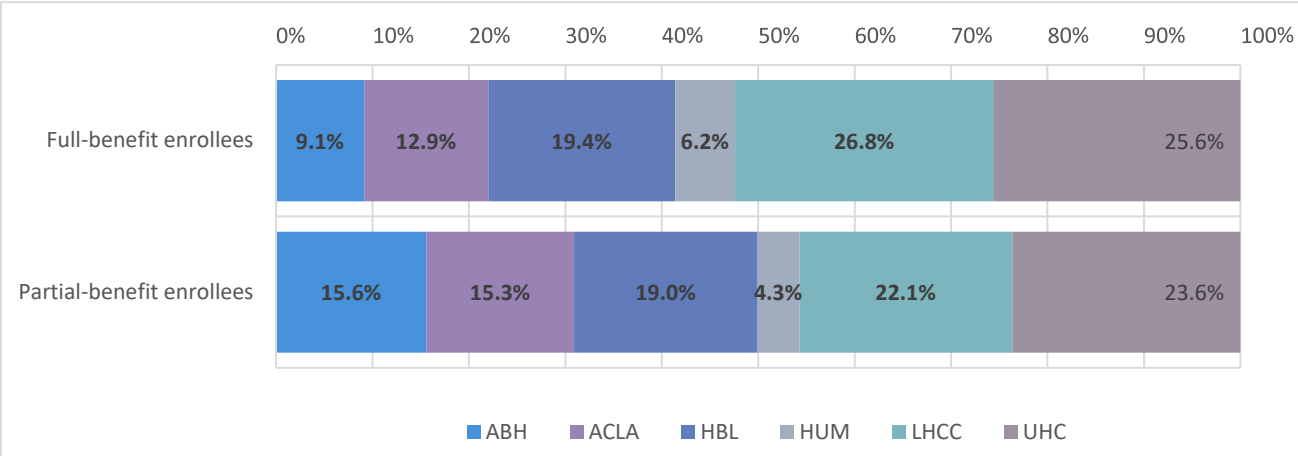
The distribution of total enrollees across health plans ranged from 9.5% in Aetna to 26.6% in Louisiana Healthcare Connections. Table 12.1 and Figure 12.1 below provide a breakdown of enrollment totals by health plan and benefit group. This table represents unduplicated enrollment in each health plan throughout the year.

Table 12.1 Total enrollees by health plan and benefit group, State Fiscal Year 2023

	ABH	ACLA	HBL	HHH	LHCC	UHC	Total ¹²
Full-benefit enrollees	233,432	329,314	495,794	158,125	686,444	653,745	1,835,261
Partial-benefit enrollees	26,469	25,982	32,245	7,380	37,509	40,113	165,763
Total (unduplicated)	258,251	353,456	524,875	165,309	720,451	689,961	1,985,845
Percent of total	9.5%	13.0%	19.4%	6.1%	26.6%	25.4%	100%

Source: MARS Data Warehouse

Figure 12.1 Distribution of enrollees by benefit group and health plan, State Fiscal Year 2023



Source: MARS Data Warehouse

¹² 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 SFY 2023:

- *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 is pregnancy. Children with disabilities are not included in this group.
- *People with disabilities and Supplemental Security Income (SSI) 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 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 Mental Health/SUD services. The waiver does not provide Medicaid eligibility – it only allows the service to be provided to those qualifying individuals who 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.
- *Adult Expansion*: Adults between the ages of 19 and 64 (including both parents and adults without dependent children) with household incomes below 138% of FPL, not otherwise qualified for Medicaid or Medicare.
- *Act 421 Children’s Medicaid Option (Act 421-CMO)*: Certain children under 19 years of age who qualify as an individual with a disability under Section 1614(a) of the Social Security Act, even if their parents earn too much money to qualify for Medicaid.

While Figure 12.1 presents unduplicated enrollees for the full 12 months during SFY 2023, 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 full-benefit enrollees each month by eligibility category, State Fiscal Year 2023

	ABH	ACLA	HBL	HHH	LHCC	UHC
Families and Children	58,514	105,545	145,609	74,062	271,022	235,320
SSI	9,123	16,520	21,897	5,080	31,839	28,946
Foster Care	447	666	5,013	143	7,969	1,750
BCC	27	46	73	10	81	97
LAP	146	190	348	213	434	450
HCBS Waiver	376	492	797	33	1,226	1,115
IMD	4	5	8	2	6	6
Chisholm	317	551	946	61	1,782	1,317
Adult Expansion	76,538	90,039	161,230	55,465	193,169	193,588
Act 421 - CMO	151	71	355	71	185	231
Total – All Categories	145,644	214,126	336,276	135,139	507,713	462,821

Source: MARS Data Warehouse

For the partial-benefit-only population, the breakdown of average monthly membership by health plan and eligibility category for state fiscal year 2023 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 some members lost eligibility, while others were newly enrolled.

Table 12.3 Average partial-benefit enrollees each month by eligibility category, State Fiscal Year 2023

	ABH	ACLA	HBL	HHH	LHCC	UHC
Chisholm	192	223	367	8	452	416
HCBS Waiver	658	661	871	27	958	1,033
Dual Eligibles	21,487	21,275	25,641	5,055	30,173	32,073
Other¹³	465	471	755	49	905	958
Total - All Categories	22,802	22,629	27,633	5,138	32,488	34,480

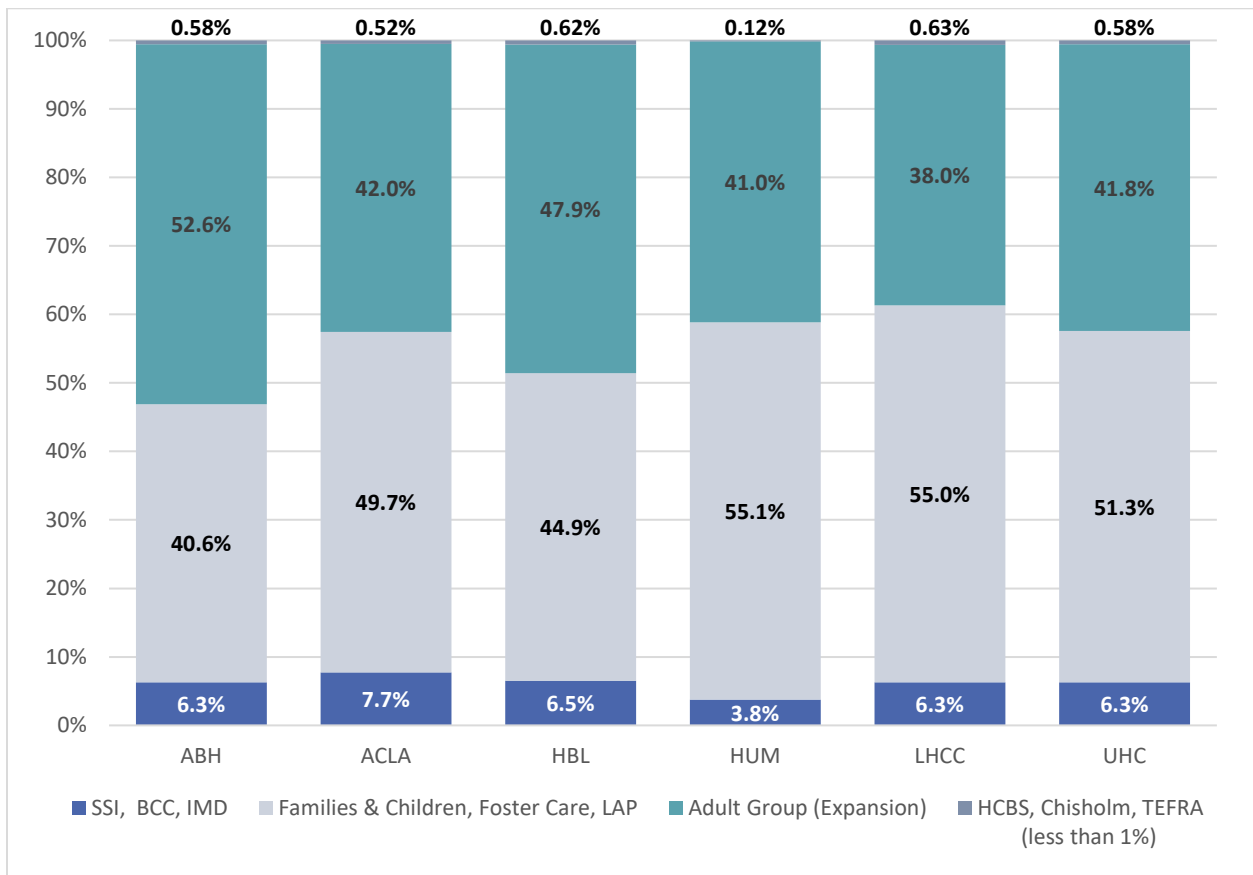
Source: MARS Data Warehouse

While the percent distribution for some eligibility categories was small in terms of the number of members represented, the related healthcare costs of healthcare may be high due to the healthcare

¹³Includes 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.

needs of the population. As an example, individuals in the Family and Children and the LaCHIP Affordable Plan eligibility categories are generally healthier and less costly per member compared to the SSI, Foster Care, Breast and Cervical Cancer, Home and Community-Based Services, IMD, and Chisholm groups. Differences in the percent distribution of total enrollment by member demographics are important factors when examining the number and types of providers, services, utilization, and costs for each health plan. The distribution of full-benefit members enrolled in each health plan by eligibility category and enrollment type is displayed in Figure 12.2.

Figure 12.2 Full benefit membership distribution by eligibility category, State Fiscal Year 2023



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 influence the decision include the value-added benefits offered by a given plan and whether one’s preferred providers participate in the plan’s network. Health plan enrollment and disenrollment are 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. Through the enrollment broker, members can self-select their health plan when initially enrolled in Medicaid and once annually thereafter during open enrollment.

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, current providers, or whether family members were already enrolled in a plan.

Existing Medicaid members can change their health plan during the specified open enrollment period. The open enrollment period in SFY 2023 was from October 15, 2022, to November 30, 2022. Changes made during this period took effect January 1, 2023. If a member did not make a change, they kept their current health plan. Open Enrollment is the only time, outside of the initial enrollment period, that Medicaid enrollees can change health plans without a qualifying reason.

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

Table 13.1 provides the individual plan and aggregate choice rates for SFY 2023. There were no changes in the methodology used for calculating the choice rate. In aggregate, the proactive choice rate held constant at just under 51% for SFY 2023. 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 2023

	ABH	ACLA	HBL	HHH	LHCC	UHC	Total
Pro-active Choice Enrollments	9,896	5,544	17,379	1,725	17,022	19,299	70,865
Auto Enrollments	7,060	14,823	7,944	22,158	9,224	7,587	68,796
Total Enrollments	16,956	20,367	25,323	23,883	26,246	26,886	139,661
Choice rate	58.36%	27.22%	68.63%	7.22%	64.86%	71.8%	50.7%

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, specifically, the extent to which enrollees utilized a health plan service within a specified period. 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 SFY 2023. During this reporting period, 1,656,407 members received one or more Medicaid services through their health plan, resulting in an overall rate of 83.41% of members across all plans. Rates for individual plans demonstrate variation across plans with a range of 51% (Humana) to 80% (Louisiana Healthcare Connections).

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

Table 14.1 Enrollees who received services, State Fiscal Year 2023

	ABH	ACLA	HBL	HHH	LHCC	UHC	Total ¹⁴
Unduplicated count of enrollees	258,251	353,456	524,875	165,309	720,451	689,961	1,985,845
# Receiving 1 or more services	185,244	261,236	391,580	84,829	579,573	554,863	1,656,407
% Receiving 1 or more services	71.73%	73.91%	74.60%	51.32%	80.45%	80.42%	83.41%

Source: MARS Data Warehouse

¹⁴ 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 have 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 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 shows the number and percentage of members who had at least one visit with a PCP to which they were linked during SFY 2023. Though members are linked to a PCP, they are not prohibited from seeking care from other providers. It is important to note that this table does not include 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 reflect legislative reporting specific to R.S. 40:1253.2 and, as such, may exclude other primary care access points.

Table 15.1 Enrollees who had at least one visit with their primary care provider, State Fiscal Year 2023

	ABH	ACLA	HBL	HHH	LHCC	UHC	Total ¹⁵
Full-benefit enrollees	233,432	329,314	495,794	158,125	686,444	653,745	1,835,261
With at least 1 PCP visit	23,645	61,960	101,421	6,211	135,311	111,698	420,115
Percentage	10.13%	18.81%	20.46%	3.93%	19.71%	17.09%	22.89%

Source: MARS Data Warehouse

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 54% of all managed care enrollees had at least one primary care visit with any PCP versus 23% who received at least one visit with their specific PCP.

Table 15.2 Enrollees who had at least one visit with any primary care provider, State Fiscal Year 2023

	ABH	ACLA	HBL	HHH	LHCC	UHC	TOTAL ¹⁵
Full-benefit enrollees	233,432	329,314	495,794	158,125	686,444	653,745	1,835,261
With at least 1 PCP visit	56,155	165,545	229,755	40,609	372,037	237,815	994,147
Percentage	24.06%	50.27%	46.34%	25.68%	54.20%	36.38%	54.17%

Source: MARS Data Warehouse

¹⁵ 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.

Table 16.1 lists the number of members receiving unduplicated outpatient emergency services for SFY 2023. For comparability across health plans, the rate per 1,000 total health plan members was calculated to account for variation in total member counts. Louisiana Healthcare Connections had the highest rate of members receiving unduplicated outpatient emergency services, at 296 per 1,000 members, while Humana had the lowest rate, at 148 per 1,000 members; however, no plan was a significant outlier. In total, the rate across all health plans was 352 per 1,000 total health plan members.

Table 16.1 Enrollees who received outpatient emergency services, State Fiscal Year 2023

	ABH	ACLA	HBL	HHH	LHCC	UHC	Total ¹⁶
Enrollees Receiving outpatient emergency services	59,289	86,915	132,702	23,335	203,217	184,367	646,541
Total full-benefit enrollees	233,432	329,314	495,794	158,125	686,444	653,745	1,835,261
Rate per 1,000 full-benefit enrollees	254	264	268	148	296	282	352

Source: MARS Data Warehouse

Table 16.2 lists the total number of inpatient Medicaid days for SFY 2023. 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 SFYr 2023 was 394 per 1,000 enrollees.

Table 16.2 Total inpatient Medicaid days, State Fiscal Year 2023

	ABH	ACLA	HBL	HHH	LHCC	UHC	Total ¹⁷
Total Inpatient Medicaid Days	66,877	98,663	145,589	15,045	211,340	185,173	722,687
Rate per 1,000 full-benefit enrollees	286	300	294	95	308	283	394

Source: MARS Data Warehouse

¹⁶ 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.

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.

To better understand the relationship between access to primary care and the use of outpatient emergency services, the Department has expanded the data to examine not only the 12 months preceding the use of outpatient emergency services, but also the six months following its use. Table 16.3 summarizes the data for individual periods before and after receiving 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 Enrollees who saw a PCP before or after an emergency room visit, State Fiscal Year 2023¹⁸

		ABH	ACLA	HBL	HHH	LHCC	UHC	Total ¹⁹
12 months before outpatient emergency service²⁰	#	28,690	65,728	91,659	13,160	148,552	139,429	462,303
	%	48.4%	75.6%	69.1%	56.4%	73.1%	75.6%	71.5%
6 months after the outpatient emergency service²⁰	#	22,171	56,613	78,601	10,702	127,084	121,741	398,767
	%	37.4%	65.1%	59.2%	45.9%	62.5%	66.0%	61.7%
12 months before or 6 months after outpatient emergency service²⁰	#	34,400	72,617	102,879	16,069	163,403	153,159	511,298
	%	58.0%	83.5%	77.5%	68.9%	80.4%	83.1%	79.1%

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 15.1 of this report.

¹⁹ 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.

²⁰ 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

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 the 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 its quality strategy, each state 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 determine the extent to which they are valid and are actually under the control of the health plan. The health plans and the Department both sought trends and utilized the reports to identify the need for operational changes and improvements.

Across all six health plans, a total of 7,065 appeals and state fair hearing (SFH) determinations were made in state fiscal year 2023, 37.9% 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 2023

	ABH	ACLA	HBL	HHH	LHCC	UHC
Total Members (unduplicated)	258,251	353,456	524,875	165,309	720,451	689,961
Members who filed an appeal	495	568	2,074	11	2,054	1,743
Members who accessed SFH	9	3	37	0	42	23
Total appeals filed at the MCO level	367	609	1,435	16	2,638	1,870
Total appeals filed at the SFH level	11	3	39	0	43	23
Total appeal and SFH determinations²¹	390	585	1,482	13	2,662	1,933
Total determinations fully or partially reversed in favor of the member	142	226	226	4	992	1,089
% of determinations fully or partially reversed in favor of the member	36.4%	38.6%	15.2%	30.8%	37.3%	56.3%

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

²¹Total determinations may include determinations made in SFY 2023 for appeals received in a prior year.

Healthcare Services Provided to Enrollees

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 SFY 2023, the aggregate count of claims submitted to all health plans totaled 115,360,127. The breakdown of claim counts for SFY 2023 is presented in Table 18.1.

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 the system’s 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 nonemergency. The aggregate claim rejection rate across all health plans was right at one percent. Individual plan rejection rates depend on a plan’s specific claims processing system and internal workflow.

All claims accepted in the system for adjudication (i.e., determination of payment or denial) can be categorized as either emergency or nonemergency. Of the total claims adjudicated by a health plan, 5% were for emergency services. For this report, the Department defined emergency services as outpatient services provided in an emergency room, excluding 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 setting.²² Nonemergency services are defined as all claims that do not fall under the definition of emergency services.

Table 18.1 Total claims submitted, State Fiscal Year 2023

	Total Claims Submitted	Rejected	Emergency Services ²²	Non-Emergency Services
ABH	11,435,348	0	325,251	11,110,097
ACLA	14,750,517	54,840	400,163	14,350,354
HBL	21,404,569	2,453	2,535,691	18,868,878
HHH	1,495,133	0	77,468	1,417,665
LHCC	32,738,796	886,431	971,788	31,767,008
UHC	33,535,764	221,213	1,013,363	32,522,401
Total	115,360,127	1,164,937	5,323,724	110,036,403

Source: Report 177 Total and Out-of-Network Claims

²² Includes Claim Type 03 (outpatient services) with Revenue Codes 450, 451, and 981 and Claim Type 04 (Professional Services) with Procedure Codes 99281 through 99285.

19 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 nonemergency services.

Table 19.1 Total unduplicated denied claims, State Fiscal Year 2023

	Emergency Services	NonEmergency Services	Total
ABH	30,044	2,136,785	2,166,829
ACLA	39,329	3,084,314	3,123,643
HBL	123,253	2,860,495	2,983,748
HHH	11,667	428,795	440,462
LHCC	66,814	6,301,911	6,368,725
UHC	78,792	6,992,945	7,071,737
Total	349,899	21,805,245	22,155,144

Source: 177 Total Claims Summary 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, as well as the National Council for Prescription Drug Program (NCPDP) reject codes for pharmacy claims, both of which are national standards. Since each claim line can have more than one CARC or NCPDP reject code, the number of CARC and NCPDP codes will be greater than the unduplicated number of total denied claims presented in Table 19.1. In other words, a claim can be denied or adjusted for multiple reasons. As a claim cycles through the payment logic, the claims processing system applies all applicable CARC or NCPDP reject codes randomly, and one is not primary in comparison to another.

Table 19.2 shows the ten most frequently used CARC codes for emergency and nonemergency medical and behavioral health claims. The primary causes for denial were duplicate claims, noncovered charges, claim/service lacking information, the benefits for this service are included in the payment/allowance for another service, and precertification/authorization is absent. A breakout of all CARCs for denied claims, listed in numerical order by health plan, is provided in [Appendix VII](#).

Table 19.2 Top ten claim adjustment reason codes (CARCs), State Fiscal Year 2023

CARC	CARC Description	Emergency Claims ²³	Non-Emergency Claims	Total
16	Claim/service lacks information or has submission/billing error(s).	41,587	1,803,720	1,845,307
96	Non-covered charge(s).	19,340	1,431,494	1,450,834
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	29,566	1,199,654	1,229,220
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	8,500	906,613	915,113
252	An attachment/other documentation is required to adjudicate this claim/service.	44,694	840,227	884,921
147	Provider contracted/negotiated rate expired or is not on file.	689	687,010	687,699
197	Precertification/authorization/notification/pre-treatment absent.	565	649,240	649,805
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	12,366	571,841	584,207
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	23,634	512,554	536,188
256	Service is not payable under the managed care contract.	2,272	511,705	513,977

Source: 173 Denied Claims Report

²³ 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 utilize a distinct national coding structure compared to 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.

Table 19.3 Top Ten NCPDP codes for denial of pharmacy services, State Fiscal Year 2023

NCPDP Code	NCPDP Description	Emergency Claims²⁴	Non-Emergency Claims	Total
79	Refill Too Soon	37	2,309,112	2,309,149
88	DUR Reject Error	39	1,892,243	1,892,282
76	Plan Limitations Exceeded	466	1,410,826	1,411,292
70	Product/Service Not Covered – Plan/Benefit Exclusion	15	1,121,193	1,121,208
75	Prior Authorization Required(may be used when drug formulary status is set as prior authorization required)	284	941,959	942,243
39	M/I Diagnosis Code	188	819,295	819,483
41	Submit Bill To Other Processor Or Primary Payer	2	529,098	529,100
69	Filled After Coverage Terminated	4	332,696	332,700
MR	Product Not On Formulary	1	309,776	309,777
7X	Days Supply Exceeds Plan Limitation	3	263,331	263,334

Source: 173 Denied Claims Report

²⁴ 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 one that can be processed without requiring additional information from the service provider or a third party. It includes a claim with errors originating in a state’s claim system. It does not include claims from providers who are under investigation for fraud or abuse or claims 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 those that do not meet the definition of a clean claim.

Table 20.1 Clean Claims Submitted, State Fiscal Year 2023

	ABH	ACLA	HBL	HHH	LHCC	UHC
Total Submitted	9,352,599	12,756,912	21,264,273	1,194,476	30,595,274	27,575,194
Paid	7,310,785	10,606,957	16,319,775	907,942	24,722,724	22,482,721
Denied	2,041,814	2,149,955	4,944,498	286,534	5,872,550	5,092,473

Source: 221 Prompt Pay Report

For the first six months of the SFY 2023 (July 1, 2022 – December 31, 2022) health plans were required by contract to pay 90% of all payable clean claims within 15 “business” days of the date of receipt of the claim. Beginning January 1, 2023, the 15 “business” day requirement was changed to 15 “calendar” days. The percentages reported in Table 20.2 reflect total contract compliance, based on the criteria in effect for each month’s reporting.

In addition, health plans are required to pay 99% of all clean claims within 30 calendar days of the date of receipt (Table 20.2). For any clean claim not paid within 30 days, the plan 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.

It is worth noting that the 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 reflects the actual payment date as required by statutory reporting requirements.

Table 20.2 Percent of paid clean claims that were paid within 15 days²⁵, State Fiscal Year 2023

	ABH	ACLA	HBL	HHH	LHCC	UHC
Inpatient Hospital	98.39%	94.22%	54.80%	99.45%	96.13%	99.61%
Outpatient Hospital	98.93%	93.95%	92.08%	99.94%	99.66%	99.92%
Professional	99.40%	97.15%	94.52%	99.87%	99.72%	98.14%
Rehabilitation	99.70%	n/a	93.29%	100.00%	n/a	88.72%
Home Health	97.96%	91.87%	73.02%	100.00%	99.74%	99.82%
Ambulance (Emergency and NonEmergency)	97.50%	97.56%	67.79%	94.04%	98.84%	99.73%
NonEmergency Medical Transportation	79.94%	99.95%	79.16%	90.34%	93.18%	98.70%
Durable Medical Equipment (DME)	98.71%	88.44%	85.99%	99.49%	99.13%	99.84%
Dental Adult (value-added service)	100.00%	n/a.	100.00%	100.00%	99.45%	98.84%
Pharmacy	99.98%	100.00%	99.87%	n/a	100.00%	100.00%
Total - All Claim Types	98.90%	97.09%	94.81%	99.69%	99.62%	99.16%

Source: 221 Prompt Pay Report

Table 20.3 Percent of paid clean claims that were paid within 30 calendar days, State Fiscal Year 2023

CLAIM TYPE	ABH	ACLA	HBL	HHH	LHCC	UHC
Inpatient Hospital	99.48%	99.99%	83.52%	99.98%	99.37%	99.94%
Outpatient Hospital	99.51%	100.00%	98.03%	100.00%	99.93%	99.97%
Professional	99.72%	99.98%	98.24%	99.99%	99.93%	99.93%
Rehabilitation	100.00%	.	98.16%	100.00%	.	99.92%
Home Health	98.98%	100.00%	94.11%	100.00%	99.99%	99.99%
Ambulance (EMT and NEAT)	99.61%	99.94%	92.87%	100.00%	99.83%	99.84%
NonEmergency Medical Transportation	99.74%	100.00%	100.00%	100.00%	99.95%	99.96%
Durable Medical Equipment (DME)	99.15%	99.96%	96.16%	100.00%	99.73%	99.89%
Dental Adult (VAS)	100.00%	n/a	100.00%	100.00%	100.00%	100.00%
Pharmacy	100.00%	100.00%	100.00%	n/a	100.00%	100.00%
Total - All Claim Types	99.74%	99.99%	98.62%	99.99%	99.94%	99.96%

Source: 221 Prompt Pay Report

²⁵ For the first six months (July - Dec 2022) the contract requirement specified 15 “business” days; effective January 1, 2023 the new contract changed compliance to 15 “calendar” days. The percentages reported are total contract compliance based on the criteria in effect for each month’s reporting.

On average, health plans took longer to issue payments for Inpatient, nonemergency medical transportation (NEMT), and pharmacy claims compared to other claim types; however, all health plans paid the vast majority of clean claims for all provider types within two weeks or less.

Table 20.4 Average number of days to pay clean claims, State Fiscal Year 2023

CLAIM TYPE	ABH	ACLA	HBL	HHH	LHCC	UHC
Inpatient Hospital	7.2	10.1	18.4	3.0	9.1	9.5
Outpatient Hospital	5.7	6.4	8.1	3.9	7.4	5.8
Professional	6.1	6.4	7.2	4.7	7.3	7.1
Rehabilitation	5.3	n/a	7.6	4.8	n/a	5.6
Home Health	8.1	7.5	11.4	2.3	7.3	8.6
Ambulance (EMT and NEAT)	7.8	6.8	15.3	5.7	7.9	6.6
NonEmergency Medical Transportation	15.7	8.3	15.5	11.8	11.9	12.3
Durable Medical Equipment (DME)	6.9	8.8	8.9	4.8	7.5	5.9
Dental Adult (VAS)	3.1	n/a	3.4	4.2	4.9	6.4
Pharmacy	10.9	7.2	11.0	n/a	10.9	11.3
Total - All Claim Types	7.7	7.0	8.7	4.5	8.3	8.2

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.

Federal regulations and health plan contracts stipulate that standard service authorizations must be processed within 14 calendar days of receiving the service request. 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. The contract sets additional limits on the number of hours or days the plan has to make a determination after receipt of needed documentation.

Contracted timeframes and compliance standards are applied in total for both medical and behavioral health service authorizations. Data for SFY 2023 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 2023

TIMEFRAME (COMPLIANCE STANDARD)		ABH	ACLA	HBL	LHCC	UHC
Non-Extended: Processed within 14 days of receipt of request for authorization	#	100,669	84,200	224,246	14,166	181,345
	%	100.0%	100.0%	99.9%	100.0%	99.8%
Extended: Processed within 28 days of receipt of request for authorization	#	0	0	0	0	15,786
	%	--	--	--	--	99.7%
Processed within the contract timeframe from receipt of needed documentation	#	112,560	93,137	250,841	14,045	263,553
	%	99.2%	93.7%	98.0%	99.1%	99.1%

Source: 188 & 188BH Service Authorization - Quarterly Reports

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. An extension of up to 14 days could be granted if the member or the health plan justifies a need for additional information and demonstrates that the extension is in the member’s best interest. The number of expedited service authorizations processed for SFY 2023 and timeframe compliance by a health plan is provided in Table 21.2.

Table 21.2 Expedited service authorizations processed, State Fiscal Year 2023

TIME FRAME (COMPLIANCE STANDARD)		ABH	ACLA	HBL	HHH	LHCC	UHC
Non-extended: Processed within 72 hours of receipt of request for authorization (100%)	#	2,069	1,480	0	58	386	3,529
	%	99.7%	99.6%	--	100.0%	99.2%	99.7%
Extended: Processed within 14 days of receipt of request for authorization (100%)	#	0	0	0	0	106	0
	%	--	--	--	--	100.0%	--

Source: 188 & 188BH Service Authorization - Quarterly Reports

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

Table 21.3 Service authorizations denied, State Fiscal Year 2023

	ABH	ACLA	HBL	HHH	LHCC	UHC
Total service authorizations	110,038	96,715	247,445	14,224	254,764	183,271
Number denied	14,059	11,529	18,462	275	24,883	8,820
Percent denied	12.8%	11.9%	7.5%	1.9%	9.8%	4.8%

Source: 188 & 188BH Service Authorization - Quarterly Reports

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

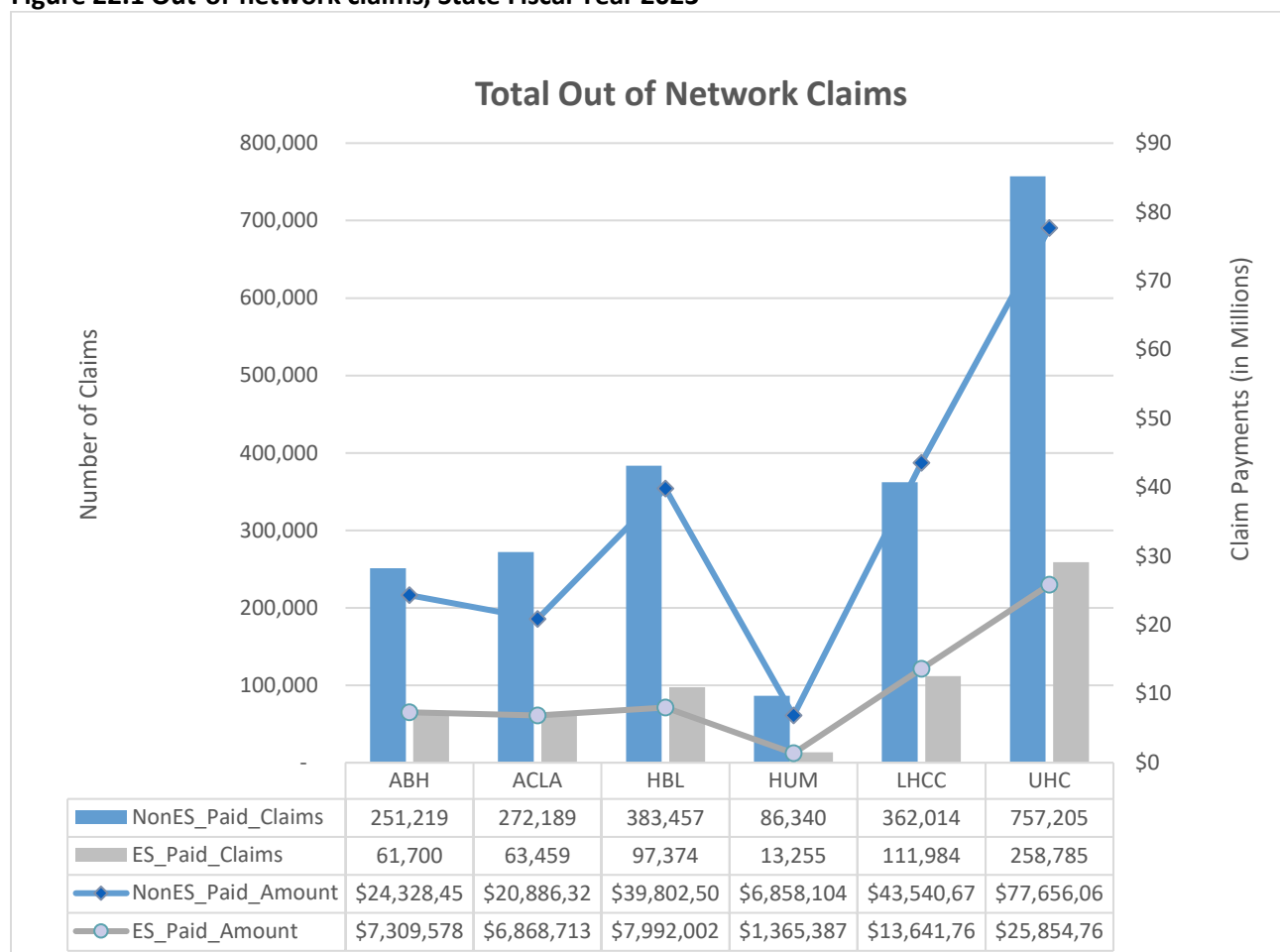
22 CLAIMS PAID TO OUT-OF-NETWORK PROVIDERS

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 the dollar value of payments made by health plans to non-network providers for both emergency and non-emergency services. The data originates from submissions from the health plans on the standing annual report (report 177). Out-of-network claims for all emergency and nonemergency services by parish and claim type are provided in [Appendix VIII](#).

Figure 22.1 Out-of-network claims, State Fiscal Year 2023



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 an 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 who 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 it to a court with jurisdiction to review the independent reviewer's decision.

In SFY 2023, 196 IR cases were completed; 66 of the requests received were deemed ineligible based on statutory requirements, and 130 eligible requests were completed following the provider's request for internal review. Overall, 54.6% of the 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 completed by claim type and status. Table 23.2 provides additional breakdown of requests by MCO.

Table 23.1 Independent review (IR) determinations made, State Fiscal Year 2023

	Behavioral Health ²⁶	Hospital	Physician	Other ²⁷	Total
Total determinations	95	91	7	3	196
Ineligible for IR	28	31	5	2	66
Eligible for IR	67	60	2	1	130
Settled by MCO and provider before IR decision	4	13	1	0	18
Fully overturned by IR	23	27	1	0	51
Partially overturned by IR	2	0	0	0	2
Upheld by IR	38	20	0	1	59
% of eligible cases settled, fully or partially overturned	43.3%	66.7%	100.0%	0%	54.6%

Source: LDH Independent Review Tracking System

²⁶ Includes inpatient, mental health rehab, and Physician/Professional services.

²⁷ Requests for SFY 2023, included DME and Lab services.

Table 23.2 Independent review determinations by claim type and MCO, State Fiscal Year 2023

	ABH	ACLA	HBL	LHCC	UHC
All Claim Types – Total determinations	35	26	18	88	29
Ineligible for IR	8	9	6	35	8
Eligible for IR	27	17	12	53	21
Settled by MCO and provider before IR decision	1	3	2	1	11
Fully overturned by IR	11	7	5	18	10
Partially overturned by IR	0	0	0	2	0
Upheld by IR	15	7	5	32	0
% fully or partially overturned	44.4%	58.8%	58.3%	39.6%	100.0%
Behavioral Health – Total Cases	8	7	4	75	1
Ineligible for IR	2	1	1	24	0
Eligible for IR	6	6	3	51	1
Settled by MCO and provider before IR decision	0	2	1	1	0
Fully overturned by IR	2	2	1	17	1
Partially overturned by IR	0	0	0	2	0
Upheld by IR	4	2	1	31	0
% fully or partially overturned	33.3%	66.7%	66.7%	39.2%	100.0%
Hospital – Total requests	23	18	13	10	27
Ineligible for IR	3	8	4	8	8
Eligible for IR	20	10	9	2	19
Settled by MCO and provider before IR decision	1	1	1	0	10
Fully overturned by IR	9	4	4	1	9
Partially overturned by IR	0	0	0	0	0
Upheld by IR	10	5	4	1	0
% fully or partially overturned	50.0%	50.0%	55.6%	50.0%	100.0%
Physician – Total requests	2	1	1	2	1
Ineligible for IR	2	0	1	2	0
Eligible for IR	0	1	0	0	1
Settled by MCO and provider before IR decision	0	0	0	0	1
Fully overturned by IR	0	1	0	0	0
Partially overturned by IR	0	0	0	0	0
Upheld by IR	0	0	0	0	0
% fully or partially overturned	--	100.0%	--	--	100.0%
Other – Total requests	2	1	1	2	1
Ineligible for IR	2	0	1	2	0
Eligible for IR	0	1	0	0	1
Settled by MCO and provider before IR decision	0	0	0	0	1
Fully overturned by IR	0	1	0	0	0
Partially overturned by IR	0	0	0	0	0
Upheld by IR	0	0	0	0	0
% fully or partially overturned	--	100.0%	--	--	100.0%

Source: LDH Independent Review Tracking System

24 PHARMACY BENEFITS

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

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

In SFY 2023, five health plans managed pharmacy benefits for members enrolled with full benefits coverage. Partial-benefit-only enrollees and all Humana members received pharmacy benefits under fee-for-service Medicaid. According to the contract with the Department, managed care organizations can either self-administer pharmacy benefits or subcontract with a pharmacy benefit manager (PBM). The PBMs for each health plan are listed in Section 25.1, "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. All PBMs were required to utilize the single, statewide preferred drug list (PDL). The variation in the data presented reflects 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 the preferred product(s) before the requested drug would be approved. The monthly details for pharmacy claims, organized by reporting category, are provided in [Appendix IX](#).

Table 24.1 Pharmacy claims comparison, State Fiscal Year 2023

		ABH	ACLA	HBL	LHCC	UHC
Total prescription claims	#	2,859,489	3,708,082	8,457,079	8,916,347	8,225,789
Claims are subject to prior authorization	#	190,915	75,576	368,992	564,227	102,034
	%	6.68%	2.04%	4.36%	6.33%	1.24%
Claims denied	#	767,613	949,116	2,317,202	2,389,137	2,051,854
	%	26.84%	25.60%	27.40%	26.80%	24.94%
Claims are subject to step therapy or fail first protocol	#	20,724	37,704	60,533	165,663	91,710
	%	0.72%	1.02%	0.72%	1.86%	1.11%

Source: Report RX055 - Pharmacy

In 2018, Act 482 of the Regular Legislative Session 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, the MCO must determine prior authorization requests for non-emergency pharmacy services within 24 hours of receiving 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 2023²⁸

	ABH	ACLA	HBL	LHCC	UHC
Average response time (hours)	10.3	5.9	1.5	3.5	2.5
Response time range (hours)²⁹	0 - 32	0 - 24	0 - 126	0 - 651	0 - 143

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 the total counts of denied authorizations by these specified categories.

Table 24.3 Pharmacy prior authorization requests denied, State Fiscal Year 2023

	ABH	ACLA	HBL	LHCC	UHC
Not Medically Appropriate	11,054	1,583	10,287	0	12,949
Not a Covered Benefit	3,663	1,121	938	0	2,143
Administrative - Lack of Information	0	9,409	1	0	944
Reduced Authorized	0	0	1,125	0	1,584
Other	1,997	0	1	21,226	0
Total Denials	16,714	12,113	12,352	21,226	17,620

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 authorization request. However, it is possible and appropriate for claims for approved services to be denied at the time of payment. For example, if the plan limitations have been exceeded or the refill is too soon, the claim would deny. Table 24.4 presents the count of claims with an approved authorization that was denied at the point of sale by the health plan. The complete list of denied claims, along with the approved authorization and the denial reason, is presented in [Appendix X](#).

Table 24.4 Pharmacy claims denied after prior authorization was approved, State Fiscal Year 2023

	ABH	ACLA	HBL	LHCC	UHC
Number of claims denied after prior authorization was approved	28,038	23,429	50,724	72,908	8,859

²⁸Includes all determinations: approved, denied, reduced, voided or withdrawn.

²⁹Minimum 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 manager 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; and
- 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 to be included in the annual transparency report. The summary data for SFY 2023 are presented here in Tables 24.1 through 24.5. The monthly data from each quarterly report is presented in [Appendix XII](#).

Managed care organizations can self-administer their pharmacy benefits or subcontract with a pharmacy benefits manager (PBM). In state fiscal year 2023, five out of six health plans utilized a PBM to manage their pharmacy benefits. 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 2023

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.
HBL	IngenioRx	Healthy Blue is a joint venture between Blue Cross Blue Shield of Louisiana and Amerigroup Partnership Plan, LLC. Anthem, Inc. is the ultimate parent company of Amerigroup and CarelonRx. CarelonRx provides PBM services to Healthy Blue under a master intercompany services agreement.
LHCC	CVS Caremark	Centene Corporation is the parent company of LHCC and Envolve Pharmacy Solutions (EPS). LHCC has a PBM contract with EPS, and CVS is a subcontractor of 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. Limited 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 amendments with each of the MCOs, with a compliance date of May 1, 2019. Before 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 SFY 2023 by MCO.

Before May 1, 2019, transaction fees varied across MCOs. Post May 2019, transaction fees were limited to the Department's established maximum rate of \$1.25 per processed claim. Monthly transaction fee data is provided in [Appendix XI](#).

Table 25.2 Transaction fees paid by MCO to PBM, State Fiscal Year 2023

ABH	ACLA	HBL	LHCC	UHC	Total
\$2,556,185	\$6,255,602	\$5,934,330	\$6,197,728	\$14,129,468	\$35,073,312

Source: 054 Pharmacy Benefit Management & Rebate monthly report

Table 25.3 details the total rebates received and retained by the PBM or MCO in SFY 2023. Monthly rebate collections are available in [Appendix XI](#). No rebates collected by the PBMs in state fiscal year 2023 were remitted to the Department.

Table 25.3 Rebates and discounts retained by the MCO or PBM, State Fiscal Year 2023

ABH	ACLA	HBL	LHCC	UHC	Total
\$1,157,004	\$672,547	\$3,522,345	\$1,676,093	\$2,828,135	\$9,856,124

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 the PBM for the 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 the total amounts retained by the PBM through spread pricing in SFY 2023. Monthly data is available in [Appendix XI](#).

Table 25.4 Amount retained by the PBM through spread pricing, State Fiscal Year 2023

ABH	ACLA	HBL	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 on 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 2023

ABH	ACLA	HBL	LHCC	UHC	Total
\$0	\$0	\$0	\$10,479	\$0	\$10,479

Source: 054 Pharmacy Benefit Management & Rebate monthly report

Adult Expansion Population

Per Executive Order JBE 16-01, effective July 1, 2016, Louisiana expanded Medicaid coverage under the Affordable Care Act to adults aged 19 through 64 who are at or below 138% of the Federal Poverty Level and 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 2023 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 are 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 2023 for compilation of the Medicaid Annual Report. Due to the dynamic nature of Medicaid enrollment and claims processing lag, the updated data presented in this section may not match monthly or year-to-date totals reported 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 SFY 2023, the unduplicated count of expansion enrollees enrolled in a health plan was 823,563. Table 26.1 provides a breakdown of enrollees by age and health plan for SFY 2023. 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 2023³⁰

AGES	ABH	ACLA	HBL	HHH	LHCC	UHC	TOTAL
19- 49	93,027	113,426	189,170	54,740	227,363	226,187	652,795
50 -64	28,247	25,995	46,931	10,847	48,734	54,535	177,619
Total	120,600	138,712	234,769	65,418	274,467	278,979	823,563

Source: Medicaid Data Warehouse

³⁰ Due to the dynamic nature of Medicaid enrollment, and to provide for claims lag, the data set for this annual Transparency Report was extracted in December 2023 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, categorized by earned income, employer-based or self-employment, and 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 69% of the expansion population for SFY 2023 had earned income.

Table 27.1 Expansion enrollees with earned income by age cohort and MCO, State Fiscal Year 2023³¹

AGE	ABH	ACLA	HBL	HHH	LHCC	UHC	TOTAL
19-49	79,966	96,023	128,513	47,947	162,031	160,926	480,119
50-64	15,670	14,792	23,865	5,735	25,502	28,552	93,485
Total	94,880	110,080	151,119	53,545	186,071	187,829	567,536

Source: Medicaid Eligibility Data System

³¹ Due to the dynamic nature of Medicaid enrollment, and to provide for claims lag, the data set for this annual Transparency Report was extracted in December 2022 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 2023, the Department paid \$6,868,922,496 to all six managed care organizations to manage the care of individuals in the adult expansion population for medical, specialized behavioral health, pharmacy, and transportation services.

Table 28.1 Total payments to MCOs for the expansion population, State Fiscal Year 2023

ABH	ACLA	HBL	HHH	LHCC	UHC
\$741,772,906	\$864,462,921	\$1,490,680,901	\$158,750,788	\$1,767,635,206	\$1,845,619,773

Source: LAGOV/CP-012 and Medicaid Data Warehouse

In SFY 2023, expansion enrollees 19 and 20 years old were eligible for all dental services covered under EPSDT. Enrollees 21 years and older are eligible for covered denture services only. These services are provided through the two Dental Benefits Plan Managers (DBPM) contracted with LDH to provide administration of dental benefits to covered members. Payments to the DBPMs totaled \$19,196,644 for SFY 2023. Table 28.2 below shows the total payments made by the Department to each plan.

Table 28.2 Total payments for dental benefits for the expansion population, State Fiscal Year 2023

DentaQuest	MCNA
\$9,503,595	\$9,693,049

Source: LAGOV/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 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 SFY 2023 were \$3,507,928,965 for the expansion population and \$3,288,462,131 for the non-expansion population. This includes only claims payments made to providers by the MCOs for these select services and does not include payments for other service categories or payments made under the fee-for-service program. Approximately 52% 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 2023³²

EXPANSION		Age Cohort 0 to 18	Age Cohort 19 to 49	Age Cohort 50 to 64	Age Cohort 65+	Total
Emergency Department	Recipient	0	258,565	66,667	0	323,779
	Payment	\$0	\$156,760,805	\$43,231,264	\$0	\$199,992,069
Hospital Inpatient	Recipient	0	47,237	14,211	0	613,47
	Payment	\$0	\$407,161,632	\$199,003,613	\$0	\$606,165,244
Hospital Outpatient	Recipient	0	33,8335	11,4551	0	452,886
	Payment	\$0	\$367,842,921	\$239,857,546	\$0	\$607,700,467
NEMT	Recipient	0	17801	9291	0	27,092
	Payment	\$0	\$18,915,562	\$9,268,563	\$0	\$28,184,125
Pharmacy	Recipient	0	436,884	139451	0	576,335
	Payment	\$0	\$1,064,321,850	\$585,964,034	\$0	\$1,650,285,884
Physician	Recipient	0	394,501	127,971	0	522,472
	Payment	\$0	\$271,822,761	\$143,778,416	\$0	\$415,601,177

Source: Medicaid Data Warehouse

Table 29.2 Utilization and expenditures for specified services for non-expansion population enrolled in managed care, State Fiscal Year 2023³²

NON-EXPANSION		Age Cohort 0 to 18	Age Cohort 19 to 49	Age Cohort 50 to 64	Age Cohort 65+	Total
Emergency Department	Recipient	282,032	82,253	24,748	1,426	388,073
	Payment	\$135,504,969	\$55,863,798	\$22,621,467	\$949,177	\$214,939,410
Hospital Inpatient	Recipient	53,426	28,763	11,780	568	90,528
	Payment	\$419,938,121	\$216,899,247	\$143,516,288	\$8,898,338	\$789,251,994
Hospital Outpatient	Recipient	388,307	112,516	121,473,436	2,579	535,204
	Payment	\$229,646,920	\$149,860,582	\$121,473,436	\$6,578,851	\$507,559,790
NEMT	Recipient	8,869	11,445	11,780	5,041	36,481
	Payment	\$4,409,475	\$14,191,733	\$16,420,808	\$6,910,073	\$41,932,089
Pharmacy	Recipient	560,301	139,702	42,283	3,727	736,816
	Payment	\$437,857,267	\$401,191,527	\$302,255,172	\$14,060,344	\$1,155,364,310
Physician	Recipient	603,976	133,209	39,789	3,168	772,091
	Payment	\$400,636,707	\$112,981,438	\$62,171,145	\$3,625,249	\$579,414,538

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 2023, and will not necessarily match the data previously extracted and reported in the quarterly transparency reports

Dental Benefits Program

Dental Benefit Program Managers

On July 1, 2014, the state moved coverage of comprehensive dental services for Medicaid-eligible children and the adult dentures to full-benefit eligible adults to a single prepaid ambulatory health plan (PAHP), which operated 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. In Louisiana, dental PAHPs are referred to as Dental Benefit Program Managers (DBPM or dental plan). DBPMs are contracted to manage and provide dental services to enrollees based on capitation payments or other payment arrangements that do not use state plan payment rates.

All Medicaid-covered individuals who are eligible for dental services were mandatorily enrolled in a dental plan and received state plan covered services based on enrollment category:

- **EPSDT Dental:** 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.
- **Adult Dentures:** Medicaid enrollees 21 years or older are eligible for dentures and related services.
- **Adult DD/ID – Waiver Dental:** Medicaid enrollees 21 years or older with developmental or intellectual disabilities who are enrolled in the New Opportunities Waiver, Residential Options Waiver or the Supports Waiver are eligible for diagnostic, preventive, restorative, endodontic, periodontal, prosthodontics, maxillofacial prosthetics, oral and maxillofacial surgery, orthodontic and adjunctive general services.
- **Adult DD/ID – ICF Dental:** Medicaid enrollees 21 years or older with developmental or intellectual disabilities who reside in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) are eligible for diagnostic, preventive, restorative, endodontic, periodontal, prosthodontics, maxillofacial prosthetics, oral and maxillofacial surgery, orthodontic and adjunctive general services.

The following limited coverage groups do not include coverage for dental services; hence, they are excluded from enrollment in a dental plan:

- 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)
- Qualified Disabled Working Individual (QDWI).

30 CONTRACTED MANAGED CARE ENTITIES – DENTAL

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

For the SFY 2023 reporting period, the Department contracted with two vendors to operate its dental benefit program serving Medicaid enrollees.

Table 30.1 Name of contracted dental benefit program manager entity, State Fiscal Year 2023

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

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 (DBPM) to maintain certain in-state staff. The positions required to domicile in Louisiana include the executive director, the dental director, and staff responsible for provider network development and management. For SFY 2023, both plans reported eight full-time equivalent in-state staff. The combined average annual salary for DentaQuest and MCNA employees based in Louisiana was \$90,476.

Table 31.1 Total number of full-time equivalent (FTE) and average salary for MCNA employees based in Louisiana, State Fiscal Year 2023

	DentaQuest	MCNA
Total number of LA employees (FTEs)	7.0	8.0
Average salary paid	\$99,983	\$82,157

Source: 017 Annual Report to LDH

32 PAYMENTS TO DENTAL BENEFIT PROGRAM MANAGERS

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 SFY 2023, the Department paid \$260,259,362 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 SFY 2023.

Table 32.1 Payments to DBPMs for dental benefit program members by month, State Fiscal Year 2023

	DentaQuest		MCNA	
	Total Payments	Average PMPM	Total Payments	Average PMPM
Jul-22	\$10,916,382	\$11.67	\$10,972,821	\$12.08
Aug-22	\$13,117,265	\$13.93	\$13,051,748	\$14.32
Sep-22	\$12,951,998	\$13.70	\$12,918,314	\$14.14
Oct-22	\$12,156,748	\$12.81	\$12,081,118	\$13.19
Nov-22	\$11,070,929	\$11.60	\$10,980,358	\$11.95
Dec-22	\$11,088,837	\$11.55	\$11,000,268	\$11.93
Jan-23	\$10,738,153	\$11.13	\$10,581,435	\$11.41
Feb-23	\$10,920,278	\$11.29	\$10,878,767	\$11.71
Mar-23	\$10,937,679	\$11.27	\$10,999,310	\$11.81
Apr-23	\$10,202,941	\$10.48	\$10,205,510	\$10.93
May-23	\$6,515,545	\$6.66	\$6,535,080	\$6.99
Jun-23	\$9,795,222	\$10.02	\$9,642,656	\$10.34
Total	\$130,411,977	\$11.32	\$129,847,385	\$11.72

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

Notes:

Jan 2023: PMPMs paid via lump sum pending approval of 1/1/23 rates.

Feb 2023: PMPMs paid via lump sum pending approval of 1/1/23 rates.

Mar 2023: PMPMs paid via lump sum pending approval of 1/1/23 rates.

May 2023: Jan and Feb DOS PMPMs processed in MMIS and lump sum payments recouped.

Jun 2023: Mar DOS PMPMs processed in MMIS and lump sum payment recouped.

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 geospatial 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.

In SFY 2023, 2,124 dental providers contracted with one or both of the DBPMs 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, under more than one taxonomy provider code, and in more than one parish.

Table 33.1 Total unduplicated³³ count of contracted providers in DBPM, State Fiscal Year 2023³⁴

	DentaQuest	MCNA
Total Contracted Providers	1,198	2,045

Source: MARS Data Warehouse, June 29, 2023, Provider Registry

³³ 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 multiple functions and may be counted multiple times.

³⁴ Includes only providers with locations in Louisiana or within a border county.

34 MEDICAL LOSS RATIO – DENTAL BENEFIT PROGRAM MANAGERS

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 to the DBPMs 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).

Dental plans are required to submit audited annual MLR reports summarizing how the plans spent their capitation payments, for each calendar year. The Department established a 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 of the DBPMs for the calendar year ending December 31, 2022. Both plans fell under the 85% minimum allowable MLR for the adult expansion group, resulting in a \$4,331,006 rebate to the department. The audited annual MLR reports are posted on the Medicaid website at <https://ldh.la.gov/page/2142>.

Table 34.1 Medical loss ratios (MLR), Calendar Year 2022

	DentaQuest		MCNA ³⁵	
	Expansion	Non-Expansion	Expansion	Non-Expansion
Adjusted YTD MLR Capitation Revenue	\$12,315,579	\$112,278,552	\$10,872,229	\$113,701,741
Total Adjusted MLR Expense	\$9,508,179	\$97,551,348	\$5,870,418	\$106,915,461
MLR Percentage	77.2%	86.9%	54.0%	94.0%
Rebate Required	\$960,615	\$0	\$3,370,391	\$0

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

Table 34.2 Breakdown of total adjusted MLR expenses, Calendar Year 2022

	DentaQuest		MCNA ³⁵	
	Expansion	Non-Expansion	Expansion	Non-Expansion
Patient Care	\$9,472,025	\$97,497,998	\$5,870,418	\$106,915,461
Quality Improvement	\$0	\$0	\$0	\$0
Information Technology	\$36,154	\$53,350	\$0	\$0
Other	\$0	\$0	\$0	\$0
Total Adjusted MLR Expense	\$9,508,179	\$97,551,348	\$5,870,418	\$106,915,461

³⁵ Audited Medical Loss Report for MCNA still pending Myer and Stauffer review.

Source: MSLC Audited Medical Loss Ratio Reports

35 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 within 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 2023, as it is based on calendar year 2021. MCNA monitors member satisfaction via its 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 2023 can be found in [Appendix XIV DBPM Satisfaction Surveys](#).

36 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 2022 full financial statement for DentaQuest and MCNA can be found in [Appendix XV](#).

37 SANCTIONS LEVIED BY THE DEPARTMENT - DENTAL

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 Dental Benefit Plan Manager contracts. In SFY 2023, there were no sanctions levied against either of the DBPMs.

In addition to sanctions, the Department may take other administrative actions, require corrective action, or impose monetary penalties for noncompliance issues that are not specifically subject to the issuance of a sanction. Additional information on actions taken or penalties imposed is posted on the Department's website, <https://ldh.la.gov/page/administrative-actions>.

38 PROACTIVE CHOICE AND AUTO-ENROLLMENT - DENTAL

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

Dental plan enrollment and disenrollment are 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 enrollees were given the opportunity to select a plan at the time of application. Members who did not choose a dental 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.

In addition to capturing the choice rates for the individual MCOs, Maximus provides the choice rate for the two Dental Benefit Program Managers. Table 38.1 provides the individual dental plan and aggregate choice rates for SFY 2023. The choice rate for 2023 is 40.4%. 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 38.1 Proactive choice rates, State Fiscal Year 2023

	DQ	MCNA	Total
Pro-active Choice Enrollments	46,297	19,373	65,670
Auto Enrollments	49,281	47,591	96,872
Total Enrollments	95,578	66,964	162,542
Choice rate	48.4%	28.9%	40.4%

Source: Maximus Health Services, Report No. 322A

39 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, designated for enrollees under the age of 21, provides coverage of certain diagnostic, endodontic, periodontics, 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 specified in the Louisiana Medicaid State Plan. In addition, federal law mandates that enrollees under 21 years of age are entitled to receive all medically necessary health care, screening, diagnostic services, treatment, and other measures to correct or improve physical conditions (Section 1905(r) of the Social Security Act). The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit is comprehensive in nature and includes coverage of all services described in federal Medicaid statutes and regulations, including those that are not covered for adults, not explicitly described in the Contract, not included in the Medicaid FFS fee schedules, and not covered in the Louisiana Medicaid State Plan.³⁶

In SFY 2023, a total of 922,545 unduplicated individuals under the age of 21 were enrolled in one or both of the Dental Benefit Plan Managers (DBPM). Of these, 411,378 (44.6%) received at least one dental service.

Table 39.1 EPSDT Dental Program members who saw a dentist, State Fiscal Year 2023³⁷

	DentaQuest	MCNA	Total
Total members under age 21	470,536	465,035	922,545
Number who saw a dentist	202,288	212,261	411,378
Percent that saw a dentist	43.0%	45.6%	44.6%

Source: MARS Data Warehouse

³⁶ [DBPMManual-Masterversion5.1.24.pdf \(la.gov\)](#)

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

Table 39.2 shows the utilization rates for the select services specified in legislation for EPSDT Dental Program members who saw a dentist. Oral prophylaxis service, 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, 92% received oral prophylaxis services. Composite fillings were the second most common procedure for this age group, received by 23% of members under the age of 21 who had a dental service.

Table 39.2 Utilization by specified service for members under the age of 21, State Fiscal Year 2023³⁸

Code Description	DentaQuest		MCNA		TOTAL	
	Members	%	Members	%	Members	%
Oral prophylaxis (teeth cleaning)	184,793	91.4%	193,989	91.4%	376,733	91.6%
Composite fillings	46,158	22.8%	48,762	23.0%	94,690	23.0%
Fluoride varnish	41,624	20.6%	40,492	19.1%	81,801	19.9%
Dental sealants	23,563	11.6%	22,629	10.7%	46,149	11.2%
Stainless steel crowns	18,698	9.2%	18,810	8.9%	37,453	9.1%
Extractions of primary teeth	16,765	8.3%	17,707	8.3%	34,418	8.4%
Amalgam fillings	9,060	4.5%	10,246	4.8%	19,271	4.7%
Pulpotomies performed on primary teeth	8,547	4.2%	8,395	4.0%	16,918	4.1%
Extractions of permanent teeth	5,876	2.9%	8,162	3.8%	14,027	3.4%
Root canals performed on permanent teeth	3,439	1.7%	3,356	1.6%	6,791	1.7%

Source: MARS Data Warehouse

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.

Adult Denture Program

The Adult Denture Program is limited to coverage for diagnostics and the provision of removable prosthodontics, including full and partial dentures. Adult restorative or surgical procedures are not covered under this program. A total of 41,193 individuals received services through the Adult Denture Program.

Table 39.3 Adult Denture Program members who saw a dentist, State Fiscal Year 2023³⁹

	DentaQuest	MCNA	Total
Total members age 21 and over⁴⁰	575,525	529,269	1,089,241
Number who saw a dentist	32,373	8,897	41,193
Percent who saw a dentist	5.60%	1.70%	3.78%

Source: MARS Data Warehouse

Table 39.4 Utilization of select procedures for Adult Denture Program members who saw a dentist, State Fiscal Year 2023⁴¹

Code Description	DentaQuest		MCNA		TOTAL	
	Members	%	Members	%	Members	%
Comprehensive Oral Examine	15,498	47.9%	3,459	38.9%	18,942	46.0%
Radiographs	6,322	19.5%	1,030	11.6%	7,350	17.8%
Removable prosthodontics (Dentures)	4,429	13.7%	3,702	41.6%	8,127	19.7%

Source: MARS Data Warehouse

Adult Waiver and Adult ICF/IID Dental Programs

Effective July 1, 2022, Louisiana Medicaid began providing comprehensive dental care for adults with Intellectual/Developmental Disabilities (I/DD), age 21 and older, who are recipients of one of the Developmental Disabilities (DD) Waivers, i.e., New Opportunities Waiver (NOW), Residential Options Waiver (ROW), and the Supports Waiver through the DBPM program. Services provided through the DBPMs include diagnostic, preventive, restorative, endodontic, periodontal, removable prosthodontics, maxillofacial prosthetics, fixed prosthodontics, oral and maxillofacial surgery, orthodontic, and adjunctive general services.

On May 1, 2023, Louisiana expanded coverage for comprehensive dental care for adults aged 21 and older with developmental or intellectual disabilities who reside in an intermediate care facility (ICF). Covered services primarily align with coverage under the Adult Waiver Dental Program, except for radiographs and periodic or comprehensive oral examinations. Federal regulations require Intermediate Care Facilities for the Elderly (ICFs) to provide these services for their beneficiaries when indicated. Consequently, these services are excluded from DBPM coverage for adults residing in an ICF.

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

⁴⁰ Excluding members in the Adults with DD/ID in a Waiver or ICF category of coverage.

⁴¹ 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.

Table 39.5 Adult Waiver and ICF/IID Dental Program members who saw a dentist, State Fiscal Year 2023⁴²

	DentaQuest	MCNA	Total
Total adults with DD/ID in a waiver or ICF	7,623	7,842	15,405
Number who saw a dentist	431	453	882
Percent who saw a dentist	5.65%	5.78%	5.73%

Source: MARS Data Warehouse

Table 39.6 Utilization rates of specified procedures for Waiver and ICF/IID Dental Program members who saw a dentist, State Fiscal Year 2023⁴³

Code Description	DentaQuest		MCNA		TOTAL	
	Members	%	Members	%	Members	%
Oral prophylaxis (teeth cleaning)	225	52.2%	270	59.6%	494	56.0%
Composite fillings	74	17.2%	79	17.4%	153	17.4%
Extractions of permanent teeth	71	16.5%	69	15.2%	140	15.9%
Case management	17	3.9%	28	6.2%	45	5.1%
Amalgam fillings	9	2.1%	13	2.9%	22	2.5%
Stainless steel crowns	6	1.4%	13	2.9%	19	2.2%
Fluoride varnish	13	3.0%	1	0.2%	14	1.6%
Root canals performed on permanent teeth	5	1.2%	9	2.0%	14	1.6%
Extractions of primary teeth	3	0.7%	2	0.4%	5	0.6%
Dental Sealants	2	0.5%	1	0.2%	3	0.3%

Source: MARS Data Warehouse

⁴² The denominator for utilization rates by procedures is the unduplicated count of individuals who had at least one dental service.

⁴³ 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.

MCO Adult Dental Value Added Services (VAS)

While DBPM coverage for adults, not otherwise covered in the Waiver or ICF dental programs, was limited to denture-only services, the MCOs had the option to offer additional dental services as a value-added benefit (VAS) to adult full-benefit enrollees. In SFY 2023, all six MCOs offered a limited VAS adult dental benefit for at least six months of the year⁴⁴ with approximately 100,000 adults (11%) receiving at least one dental service through their MCO. Additional data on value-added adult dental services by health plan are presented in Tables 39.7 and 39.8.

Table 39.7 Eligibility and utilization for value-added dental benefits by MCOs, State Fiscal Year 2023

	ABH	ACLA	HBL	HHH	LHCC	UHC
Full-benefit adults⁴⁵	137,072	159,493	269,326	71,854	310,645	314,618
Number who saw a dentist	15,188	7,215	24,855	3,118	38,447	29,968
Percentage of eligible enrollees who saw a dentist	11.08%	4.52%	9.23%	4.34%	12.38%	9.53%

Source: MARS data warehouse

Teeth cleaning was the most common service received, followed by extraction of permanent teeth and fillings. Table 39.5 provides utilization rates by MCO for common procedures received by adult members who received a dental service provided as a value-added service through their health plan.

Table 39.8 Utilization rates for value-added dental services by MCO, State Fiscal Year 2023⁴⁶

		ABH	ACLA ⁴⁴	HBL	HHH ⁴⁴	LHCC	UHC
Adult oral prophylaxis	Count	6,515	2,788	10,366	1,208	16,719	13,368
	Rate	42.90%	38.64%	41.71%	38.74%	43.49%	44.61%
Extractions of permanent teeth	Count	4,865	2,088	7,508	822	0	7,072
	Rate	32.03%	28.94%	30.21%	26.36%	0.00%	23.60%
Composite fillings	Count	3,641	1,299	5,055	570	8,968	5,116
	Rate	23.97%	18.00%	20.34%	18.28%	23.33%	17.07%
Amalgam fillings	Count	170	88	297	25	476	307
	Rate	1.12%	1.22%	1.19%	0.80%	1.24%	1.02%

Source: MARS Data Warehouse

⁴⁴ ACLA discontinued their VAS adult dental benefit effective December 31, 2022. Humana's Louisiana Medicaid Managed Care contract began January 1, 2024 and included a limited VAS adult dental benefit.

⁴⁵ Includes full benefit enrollees only, partial benefit enrollees were not covered for value-added dental services.

⁴⁶ The denominator for utilization rates by procedures is the unduplicated count of individuals who had at least one dental service.

40 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 have taken:

- Denying or partially denying a requested service, including the 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)
- 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 its 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 SFY 2023, there were 723 determinations made under the dental program administered by both DBPMs with an overall 40% reversal rate.

Table 40.1 Appeals and state fair hearings, State Fiscal Year 2023

	DentaQuest	MCNA	Total
Total Members (unduplicated)	103,685	984,522	1,991,505
Members who filed an appeal	640	65	705
Members who accessed SFH	4	2	6
Total appeals filed at DBPM level	641	66	707
Total appeals filed at SFH level	4	2	6
Total appeal and SFH determinations⁴⁷	657	66	723
Total determinations fully or partially reversed in favor of the member	277	14	291
% of determinations fully or partially reversed in favor of the member	42.2%	21.2%	40.2%

Source: Annual Appeal and Fair Hearing Report

⁴⁷Total determinations may include determinations made in SFY 2023 for appeals received in a prior year.

41 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 SFY 2023, there were 3,589,830 claims submitted to both DentaQuest and MCNA for dental services. The breakdown of unduplicated claim counts for SFY 2023 is presented in Table 41.1.

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

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 nonemergency.

Table 41.1 Total claims submitted, State Fiscal Year 2023

	Rejected Claims ⁴⁸	Emergency Services	Non-Emergency Services	Total
DentaQuest	0	0	1,765,277	1,765,277
MCNA	0	5,282	1,819,271	1,824,553
Total	0	5,282	3,584,548	3,589,830

Source: Report 177 Total and Out-of-Network Claims

⁴⁸ DentaQuest and MCNA do not reject claims. All claims are processed for adjudication to either pay or deny.

42 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 42.1 below provides the total unduplicated claims denied by the DBPMs delineated by emergency and nonemergency services. Table 42.2 provides a listing of the top ten reasons for claim denial which encompass 80% of all claim denials. The complete listing of all CARCs for denied claims for both DentaQuest and MCNA is provided in [Appendix XVI](#).

Table 42.1 Total unduplicated denied claims, State Fiscal Year 2023

	Emergency Services	NonEmergency Services	Total
DentaQuest	0	283,598	283,598
MCNA	392	101,405	101,797
Total	392	385,003	385,395

Source: 177 Total Claims Summary Report

Table 42.2 Ten most prevalent reasons for claim denial by CARC, State Fiscal Year 2023⁴⁹

CARC	Code Description	# Claims Denied	% of Claims Denied
18	Exact duplicate claim/service	67,555	17%
204	This service/equipment/drug is not covered under the patient's current benefit plan.	55,053	14%
169	Alternate benefit has been provided.	38,129	9%
96	Non-covered charge(s).	31,475	8%
150	Payer deems the information submitted does not support this level of service.	31,258	8%
243	Services not authorized by network/primary care providers.	28,491	7%
119	Benefit maximum for this time period or occurrence has been reached.	22,530	6%
22	This care may be covered by another payer per coordination of benefits.	18,915	5%
27	Expenses incurred after coverage terminated.	16,188	4%
6	The procedure/revenue code is inconsistent with the patient's age.	13,366	3%
Total	TOTAL TOP TEN CLAIM DENIAL REASON CODES	322,960	80%

Source: Report 173 Denied Claims

⁴⁹Each claim denied may have multiple CARC codes therefore totals includes duplication.

43 CLEAN CLAIMS – DENTAL

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 SFY 2023, there were 3,011,720 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, 2,807,643 (93%) were paid. This total does not include other claims paid after additional information or verifications were received or the original claim was adjusted.

Table 43.1 Clean claims, State Fiscal Year 2023

	DentaQuest	MCNA	Total
Total clean claims submitted	1,704,591	1,307,129	3,011,720
Clean claims paid	1,546,485	1,261,158	2,807,643

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 43.2 Prompt pay performance for paid clean claims, State Fiscal Year 2023

	Paid within 15 business days		Paid within 30 calendar days	
	DentaQuest	MCNA	DentaQuest	MCNA
EPSDT Dental	99.12%	99.54%	100%	99.9%
Adult Dental	99.85%	100.00%	100%	98.5%

Source: 221 Prompt Pay Report

Table 43.3 Average number of days to pay clean claims, State Fiscal Year 2023

	DentaQuest	MCNA
EPSDT Dental	8.5	6.6
Adult Dental	7.0	8.7

Source: 221 Prompt Pay Report

44 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 SFY 2023, the DPBMs completed prior authorizations on a total of 213,672 requests. In alignment with a more expansive benefit for children, 79% of authorizations were for members under the age of 21. Table 44.1 provides a breakdown by age group and procedure code.

Table 44.1 Number of prior authorization requests processed by DBPMs by type of procedure, State Fiscal Year 2023

Type of Procedure	DentaQuest		MCNA		Total
	EPSDT (under 21)	Adult Dental (21 and over)	EPSDT (under 21)	Adult Dental (21 and over)	
0100-0999 Diagnostic	1,070	2,085	448	1,815	5,418
1000-1999 Preventive	3,837	80	2,223	72	6,212
2000-2999 Restorative	30,872	456	10,244	180	41,752
3000-3999 Endodontics	9,191	51	5,776	38	15,056
4000-4999 Periodontics	1,373	248	792	57	2,470
5000-5899 Removable	36,110	9,801	26,072	2,432	74,415
5900-5999 Maxillofacial	261		327	2	590
6000-6199 Implant	23,654	364	16,868	185	41,071
6200-6999 Fixed	3	1			4
7000-7999 Oral	240	13,945	370	11,918	26,473
8000-8999 Orthodontics	11	31	15	20	77
9000-9999 Adjunctive/other	60	28	33	4	125
Procedure code not specified			9		9
Total	106,682	27,090	63,177	16,723	213,672

Source: 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 within 72 hours after receipt. Tables 44.2 and 44.3 provide the average and range of authorization processing times for both children and adults by type of procedure.

Table 44.2 EPSDT Dental prior authorization response times by DBPM, State Fiscal Year 2023

Type of Procedure	DentaQuest		MCNA	
	Average Time	Range of Times	Average Time	Range of Times
0100-0999 Diagnostic	0.5	0-5	0.7	0-4
1000-1999 Preventive	0.4	0-11	0.5	0-6
2000-2999 Restorative	0.6	0-13	0.5	0-7
3000-3999 Endodontics	0.7	0-13	0.5	0-12
4000-4999 Periodontics	0.9	0-5	0.6	0-12
5000-5899 Removable	0.7	0-5	0.6	0-4
5900-5999 Maxillofacial	0.0	-	0.2	0-1
6000-6199 Implant	2.2	0-4	0.0	0-0
6200-6999 Fixed	0.7	0-4	0.3	0-2
7000-7999 Oral	0.7	0-11	0.5	0-7
8000-8999 Orthodontics	0.8	0-5	1.7	0-6
9000-9999 Adjunctive/other	0.7	0-11	0.5	0-7
Procedure code not specified	0.3	0-1	0.0	-
All prior authorizations	0.7	0-13	0.5	0-12

Source: Quarterly 188 Prior Authorization Reports

Table 44.3 Adult Dental prior authorization response times by DBPM, State Fiscal Year 2023

Type of Procedure	DentaQuest		MCNA	
	Average Time	Range of Times	Average Time	Range of Times
0100-0999 Diagnostic	0.6	0-5	0.4	0-6
1000-1999 Preventive	0.3	0-5	0.7	0-6
2000-2999 Restorative	0.2	0-4	0.6	0-4
3000-3999 Endodontics	0.2	0-2	0.3	0-3
4000-4999 Periodontics	0.1	0-4	0.8	0-4
5000-5899 Removable	0.6	0-13	0.6	0-7
5900-5999 Maxillofacial	0.0	n/a	0.0	n/a
6000-6199 Implant	0.2	0-1	0.9	0-3
6200-6999 Fixed	0.0	0-0	0.0	0-0
7000-7999 Oral	0.5	0-13	0.6	0-12
8000-8999 Orthodontics	0.0	n/a	2.5	0-5
9000-9999 Adjunctive/other	0.3	0-5	0.7	0-6
Procedure code not specified	0.0	0-0	0.0	n/a
All prior authorizations	0.5	0-13	0.5	0-12

Source: Quarterly 188 Prior Authorization Reports

Prior Authorizations Denials

Of the 213,672 prior authorizations the DBPMs completed during SFY 2023, 42,311 (20%) were denied. There can be multiple reasons for denial associated with each authorization request. As a result, the number of denied authorizations by the denial reason code is greater than the number of unduplicated denied authorizations. DentaQuest used 208 unique reasons for the denial of prior authorization. MCNA used 33 unique reasons for the denial of prior authorizations. Tables 44.4 and 44.5 provide the 10 most frequently used authorization denial codes for DentaQuest and MCNA, respectively. A complete count of authorization denials delineated by denial reason is included in [Appendix XVII](#).

Table 44.4 Top ten most prevalent reasons for authorization denial by DentaQuest, State Fiscal Year 2023

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 indication that the tooth is in a position that will not let it break through the gum on its own.	1,699	364	2,063
2040	Service is not covered. Please refer to your Office Reference Manual for definition of covered teeth/quad/arch, patient ages, and procedure codes.	491	1,091	1,582
3307	Anesthetic services are only covered when the associated services are approved.	1,163	311	1,474
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.	1,089	182	1,271
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.	443	761	1,204
1099	Services reviewed on a previously submitted request.	270	825	1,095
3447	Sedation is only covered when the patient needs a lot of dental work done on the same day, needs four or more teeth pulled, or is nervous about their treatment and a different drug has been tried and failed to help the patient relax during treatment.	800	294	1,094
4186	Per dental director review, removal of impacted tooth is denied due to incomplete root development.	710	157	867
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.	658	190	848
3443	Per Dental Director review, crown is denied. The tooth does not appear to have significant breakdown due to decay or trauma.	520	143	663
TOTAL TOP TEN		7,843	4,318	12,161

Source: Quarterly 188 Prior Authorization Reports

Table 44.5 Ten most prevalent reasons for authorization denial by MCNA State Fiscal Year 2023

Denial Code	Code Description	EPDST	ADULT	Total
50	Clinical reviewer has determined that the treatment is in excess of the member's needs.	5,672	41	5,713
18	Request has been previously reported and an approval or denial was issued.	4,671	801	5,472
96	Procedure is considered noncovered in accordance with either the program benefits or the facility contract	14	4,129	4,143
56	Dental director has advised that the x-ray and/or photo imaging do not demonstrate the medical necessity for the treatment submitted.	3,823	1	3,824
49	Please submit x-ray(s) and narrative with this request.	2,667	339	3,006
16	Please submit the patient chart notes/please submit the correct tooth surface/please submit the correct tooth number.	2,536	245	2,781
252	Please provide further rationale for treatment/submit treatment plan/correct x-ray or photograph for review.	2,100	291	2,391
169	Clinical reviewer has recommended an alternate procedure/benefit.	2,200	6	2,206
272	Descriptions varied, related dentures, and tooth extraction	701	1,385	2,086
181	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.	1,824	126	1,950
TOTAL TOP TEN		26,208	7,364	33,572

Source: Quarterly 188 Prior Authorization Reports

Claims Denied After Prior Authorization Approved

In SFY 2023, both dental plans denied a total of 378,063 claims. Of these, 9,454 were claims for services that had been previously prior authorized; however, the claim or documentation provided did not meet the criteria for payment. For SFY 2023, DentaQuest reported that no claims were denied after prior authorization had been approved. Table 44.6 includes the 10 most frequently used CARCs used by MCNA for claims denied after the prior authorization had been previously 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 account for claims that were resubmitted and subsequently paid.

Table 44.6 Top 10 reasons for claim denial by MCNA after prior authorization, State Fiscal Year 2023

Denial Code	Code Description	Total Claims
18	Exact duplicate claim/service	2,254
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided.	1,621
22	This care may be covered by another payer per coordination of benefits.	1,047
96	Non-covered charge(s). At least one Remark Code must be provided.	557
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	546
272	Coverage/program guidelines were not met.	545
16	Claim/service lacks information or has submission/billing error(s).	463
181	Procedure code was invalid on the date of service.	409
133	The disposition of this service line is pending further review.	273
50	These are non-covered services because this is not deemed a "medical necessity" by the payer.	240
TOTAL TOP TEN		7,955

Source: Monthly 173 Denied Claims Reports

45 CLAIMS PAID TO OUT-OF-NETWORK PROVIDERS – DENTAL

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 DBPMs 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 dental 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.

For SFY 2023, both DentaQuest and MCNA reported zero claims paid to out-of-network providers.

46 INDEPENDENT REVIEW - DENTAL

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 a Managed Care Entity (MCE) has partially or totally denied claims incorrectly. An MCE's failure to send a provider payment, 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 a DBPM. In lieu of requesting an 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 them to a reviewer who is neither a state employee nor a contractor and is independent of both the DBPM 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 SFY 2023, the Department received no requests for independent review of any DBPM claims.

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