BAYOU HEALTH TRANSPARENCY REPORT

STATE FISCAL YEAR 2015

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Contents

Introduction

This report is the fourth in a series produced by the Louisiana Department of Health to satisfy statutory reporting requirements intended to ensure the following outcomes are being achieved by Medicaid managed care programs:

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

This report includes 26 measures as outlined in Act 158 of the 2015 Regular Legislative Session. It covers July 2014 through June 2015 (State Fiscal Year 2015), except the following measures which are reported on a calendar year basis per the contract between the Department and the health plans:

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

This report includes data for the Medicaid managed care program that has delivered physical and basic behavioral health services to Medicaid enrollees since February 1, 2012, as well the dental benefit plan that began delivering services on July 1, 2014.

Data in the report includes two different contract periods for the managed care program that delivers physical and basic behavioral health services. The first contract period included two primary care case management entities, referred to as shared savings health plans, and three full-risk managed care organizations (MCOs), called prepaid health plans, and ended January 31, 2015. The second contract period includes five managed care organizations and began on February 1, 2015. Given material differences between the two contracts, data are presented separately for the July 1, 2014, through January 31, 2015, and February 1, 2015, through June 30, 2015, periods.

Information included in this report was collected from multiple sources. The Medicaid Management Information System (MMIS) and the Management Administrative Reporting Subsystem (MARS Data Warehouse) are maintained by the Medicaid program contracted fiscal intermediary, which in State Fiscal Year (SFY) 2015 was Molina Healthcare. The MMIS contains detailed recipient and provider information and the MARS Data Warehouse contains claims payment information. The state administrative system, called ISIS, is maintained by the Office of Technology Services within the Division of Administration and contains information on payments to health plans.

The provider registry is maintained by Molina and contains information submitted by the health plans or their contracted providers. The provider registry is updated weekly with new information overwritten onto older information, which limits the utility of the data to point-in-time information.

To the greatest extent possible, the data originate from state systems rather than the health plans. When unavailable from state sources, data were collected from the health plans, sourced from either routine reporting deliverables or ad hoc reports requested specifically for this purpose.

Data included in this report were independently validated by Myers and Stauffer, an audit contractor of the Department. Myers and Stauffer reviewed for reasonability the data extraction code or process that the health plans or the Department used to generate data. For data originating from the MARS Data Warehouse or the MMIS, Myers and Stauffer generated its own data for each health plan and compared its results to the results the Department produced. For data originating from the health plans, Myers and Stauffer reviewed plan responses to a survey developed by Myers and Stauffer to document the process the plans used to generate the data, as well as policies and procedures in place to collect, track and report data. Where Myers and Stauffer found inconsistencies above or below the 10 percent variance threshold established by the Department, they made recommendations to the Department and/or the health plan to improve the method used to collect data. See Appendix 15.XIV for the survey instrument. To ensure maximum reliability, subject matter experts within the Department and Myers and Stauffer also reviewed the data. In some cases, the health plans also reviewed data pulled on their plans by the Department for reasonability.

In addition, health plans' internal policies and procedures for collection of data were validated by the Department's contracted external quality review organization (EQRO), Island Peer Review Organization (IPRO), in conjunction with annual external quality reviews. An additional validation was performed by either the National Committee for Quality Assurance (NCQA) or the Utilization Review Accreditation Commission (URAC) as part of the contractually required health plan accreditation process. Plans are contractually required to obtain accreditation from either NCQA or URAC for their Bayou Health plan serving Louisiana members. All Bayou Health plans have obtained accreditation from these national accrediting bodies, which are rigorous processes involving comprehensive reviews of the plans' policies, procedures and practices.

Health Plans

During State Fiscal Year 2015, more than one million Louisiana Medicaid and Louisiana Children's Health Insurance Program (LaCHIP) enrollees received physical health and basic behavioral services through a managed care delivery system known as Bayou Health. This report includes two distinct Bayou Health contract periods. Each contract period, including covered populations, covered services and participating health plans, is described separately below.

Original Bayou Health Contract (February 1, 2012 through January 31, 2015)
The Bayou Health contracts that ended in January 2015 were comprised of two Medicaid-managed care models as defined in federal Medicaid regulations: managed care organizations (MCOs) and primary care case management (PCCM) entities. The five health plans were selected through a competitive procurement in 2011.

Managed care organizations, also called prepaid health plans in Louisiana, are risk-bearing entities that provide a wide array of Medicaid-covered benefits and services to enrolled members in exchange for a monthly capitation payment for each member. The plans contract directly with providers and manage all aspects of service delivery, including reimbursement of providers. The three MCO model Bayou Health plans, which operated statewide, are:

- Amerigroup Louisiana (AMG) (parent company Anthem, formerly WellPoint)
- AmeriHealth Caritas of Louisiana (AHC) (formerly LaCare)
- Louisiana Healthcare Connections (LHCC) (parent company Centene)

PCCM entities, also called shared savings health plans in Louisiana, are paid a monthly management fee for each enrolled member in exchange for coordinating care for enrolled members. Shared savings health plans only contract with primary care providers (PCPs). All other services that they coordinate are provided through the Louisiana Medicaid program's provider network. While the plan is responsible for service utilization, actual provider payments are made by the Department. Shared savings health plans are at limited risk for repaying a portion of the monthly management fee in the event savings benchmarks are not achieved. A portion of any savings realized as a result of improved coordination of care are "shared" with the entity. The two PCCM model Bayou Health plans, which operated statewide, were:

- Community Health Solutions (CHS) (owned by Louisiana Healthcare Connections as of July 1, 2014)
- UnitedHealthcare Community Plan (UHC)

While shared savings health plans were responsible for service utilization for most Medicaid core benefits and services, the fee-for-service legacy Medicaid program continued to authorize durable medical equipment, prosthetics, orthotics, and certain supplies (DMEPOS); pharmacy; and non-emergency medical transportation (NEMT) to members of these plans.

Medicaid Populations and Services in Bayou Health
The Bayou Health program operates under the federal authority in Section 1932(a)(1) of the Social Security Act. Participating Medicaid enrollee populations, as well as included benefits and services, must be specified in Louisiana's approved Medicaid State Plan. While most Medicaid enrollees are required to enroll in a Bayou Health plan, there are individuals who can voluntarily enroll. These individuals are referred to as optional enrollees. In addition, there are individuals that are excluded from enrolling in a Bayou Health plan. Certain health services are also excluded from Bayou Health core benefits and services.

During State Fiscal Year 2015, Medicaid populations excluded from Bayou Health in the July 2014 through January 2015 contract period included:

- persons residing in nursing facilities or a facility for persons with intellectual and/or developmental disabilities;
- persons receiving hospice services;
- children under 21 years of age who were listed on the New Opportunities Waiver Request for Services Registry (Chisholm class members);
- persons receiving services through the Program of All-Inclusive Care for the Elderly (PACE);
- persons who had a limited period of eligibility such as eligibility through the Spend-down Medically Needy Program or Emergency Services Only;
- Medicare dual eligibles including those who received both Medicare and full Medicaid benefits;
- Medicare dual eligibles with incomes between 75 percent and 135 percent of the federal poverty level (FPL) for whom Medicaid paid only the Medicare Part B monthly premium, and enrollees below 100 percent FPL with limited Medicare crossover payments as the secondary payer;
- enrollees in the Louisiana Health Insurance Premium Payment (LaHIPP) Program; and
- individuals receiving limited Medicaid benefits, including enrollees in the Greater New Orleans Community Health Connection (GNOCHC) and those who were enrolled in Take Charge Section 1115 Medicaid demonstration waivers.[1]

Services excluded from Bayou Health core benefits and services in the July 2014 through January 2015 period included:

- long term services and supports;
- personal care services;
- hospice;
- applied behavioral analysis (ABA);
- services provided through the Department's Early Steps Program;
- nursing facility services;
- targeted case management;
- individualized education program (IEP) services;
- school nursing; and
- dental and specialized behavioral health that were managed by other health plans.[2]

Second Bayou Health Contract (February 1, 2015 through January 31, 2018)
On July 28, 2014, the Department issued a Request for Proposals for a second generation managed care program for physical and basic behavioral health services, including full-risk managed care organizations only. Managed care organizations are risk-bearing entities that provide a wide array of Medicaid-covered benefits and services to enrolled members in exchange for a monthly capitation payment for each member. The plans contract directly with providers and manage all aspects of service delivery, including reimbursement of providers.

[1] Effective July 1, 2014, most individuals eligible to receive services through the Take Charge demonstration waiver were eligible to receive family planning-related services through Take Charge Plus, part of the CMS-approved state plan.

[2] In addition to the Bayou Health MCOs and PCCMs, in the July 2014 through January 2015 period, Louisiana provided specialized Medicaid behavioral health services through a single, prepaid inpatient health plan (PIHP) operated by Magellan and Medicaid dental services through a single, prepaid ambulatory health plan (PAHP) operated by Managed Care of North America (MCNA).

On January 31, 2015, shared savings health plans ceased service delivery, and on February 1, 2015, five competitively procured managed care organizations assumed responsibility for physical and basic behavioral health service delivery to all of the nearly one million Bayou Health members. The five managed care organizations operating statewide, included:

- Aetna Better Health (parent company Aetna)
- Amerigroup Louisiana (AMG) (parent company Anthem, formerly WellPoint)
- AmeriHealth Caritas of Louisiana (AHC) (formerly LaCare)
- Louisiana Healthcare Connections (LHCC) (parent company Centene)
- UnitedHealthcare Community Plan (parent company UnitedHealthcare)

Medicaid Populations and Services in Bayou Health

The second generation Bayou Health program operates under the federal authority in Section 1932(a)(1) of the Social Security Act. Participating Medicaid enrollees as well as included benefits and services must be specified in Louisiana's approved Medicaid State Plan. While most Medicaid enrollees are required to enroll in a Bayou Health plan, there are individuals who can voluntarily enroll. These individuals are referred to as optional enrollees. In addition, there are individuals that were excluded from enrolling in a Bayou Health plan.

Medicaid populations excluded from Bayou Health in the February through June 2015 period included:

- persons residing in nursing facilities or a facility for persons with intellectual and/or developmental disabilities;
- persons receiving services through the Program of All-Inclusive Care for the Elderly (PACE);
- persons who had a limited period of eligibility such as eligibility through the Spend-down Medically Needy Program or Emergency Services Only;
- Medicare dual eligibles including those who received both Medicare and full Medicaid benefits;
- Medicare dual eligibles with incomes between 75 percent and 135 percent of the federal poverty level (FPL) for whom Medicaid paid only the Medicare Part B monthly premium, and enrollees below 100 percent FPL with limited Medicare crossover payments as the secondary payer; and
- individuals receiving limited Medicaid benefits, including those who were enrolled in Take Charge Section 1115 Medicaid demonstration waivers.[3]

No longer excluded populations included:

- persons receiving hospice services in a home or community-based setting;
- children under 21 years of age who were listed on the New Opportunities Waiver Request for Services Registry (Chisholm class members);
- enrollees in the Louisiana Health Insurance Premium Payment (LaHIPP) Program; and
- enrollees in Section 1915(c) home and community based (HCBS) waivers or children and youth under age 21 on the waiting list for an HCBS waiver[4].

Services excluded from Bayou Health core benefits and services in the February through June 2015 period included:

- long term services and supports;

[3] Effective July 1, 2014, most individuals eligible to receive services through the Take Charge demonstration waiver were eligible to receive family planning-related services through Take Charge Plus, part of the CMS-approved state plan.

[4] Effective July 1, 2014, individuals enrolled in an HCBS waiver could "opt in" to Bayou Health.

- Personal Care Services for those ages 21 and older;
- applied behavioral analysis (ABA);
- services provided through the Department's Early Steps Program;
- nursing facility services;
- targeted case management;
- individualized education program (IEP) services; and
- dental and specialized behavioral health that were managed by other health plans.

Services no longer excluded included:

- hospice received in a home or community-based setting; and
- Personal Care Services for those under age 21.

In addition to the Bayou Health managed care organizations, in the February through June 2015 period, Louisiana provided specialized Medicaid behavioral health services through a single, prepaid inpatient health plan (PIHP) operated by Magellan and Medicaid dental services through a single, prepaid ambulatory health plan (PAHP) operated by Managed Care of North America (MCNA).

1 HEALTH PLANS

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

With the implementation of the second Bayou Health contract on February 1, 2015, the health plans contracted with the Department changed. From July 1, 2014, through January 31, 2015, the Department contracted with two shared savings health plans and three managed care organizations. From February 1 through June 30, 2015, the Department contracted with five managed care organizations.

Throughout State Fiscal Year 2015, the Department contracted with a single vendor, Managed Care of North America, Inc., to operate its dental benefit plan serving all Medicaid enrollees.

The names and common abbreviations of the Bayou Health plans and the dental benefit plan are in Tables 1.1 and 1.2 in alphabetical order by plan type:

Table 1.1: Names of health plans July 2014 – January 2015

Health Plan Name	Plan Type	Common Abbreviation
Amerigroup Louisiana, Inc.	Managed Care Organization	AMG
Amerihealth Caritas Louisiana, Inc. (formerly LaCare)	Managed Care Organization	ACLA
Louisiana Healthcare Connections, Inc.	Managed Care Organization	LHCC
Community Health Solutions of America, LLC	Shared Savings	CHS
UnitedHealthcare of Louisiana, Inc.	Shared Savings	UHC
Managed Care of North America, Inc.	Dental	MCNA

Source: Health plan contracts

Table 1.2: Names of health plans February – June, 2015

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

Source: Health plan contracts

2 HEALTH PLAN EMPLOYEES

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

Managed care organizations and shared savings health plans have different contract requirements for Louisiana-based staff. However, both models require certain high level staff be domiciled in-state, such as the chief executive officer, medical director, maternal/child health coordinator, contract compliance officer, member management coordinator, provider services manager and others. For other positions, plans have the choice to staff locally or leverage parent company resources out of state, such as call center staff.

Local staffing functions for managed care organizations and shared savings health plans are substantially similar under the first and second Bayou Health contracts. However, the second contract requires managed care organizations to domicile additional positions in-state. These positions include: behavioral health medical director; program integrity officer; member services manager; encounter data quality coordinator; case management staff; and fraud, waste and abuse investigators.

The health plans submitted the information in Tables 2.1 and 2.2 in response to a survey the Department sent to all plans. The survey requested the position or title, salary, and percent of time allocated to the Louisiana contract for all Bayou Health staff domiciled in Louisiana. Using the information submitted, the Department calculated the total number of employees and average salary for four of the five plans. UnitedHealthcare provided only the list of position titles and the total average salary along with an attestation that the information was correct.

For the original Bayou Health contract, as shown in Table 2.1 the total number and average salary of all health plans, both managed care organizations and shared savings health plans are in line with those reported in State Fiscal Year 2014. All health plans reported increased local staff after the implementation of the new contracts, shown in Table 2.2. For the second Bayou Health contract, incumbent managed care organizations (Amerigroup, Amerihealth Caritas and Louisiana Healthcare Connections) also reported higher average salaries. UnitedHealthcare, which went from a shared savings health plan to a managed care organization with the new contract period reported more than twice the local staff and a lower average salary. As in State Fiscal Year 2014, Louisiana Health Care Connections reports the largest local staff in both contract periods, including an additional 52 staff members compared to State Fiscal Year 2014, primarily due to the purchase of Community Health Solutions.

Variation among health plans exists in both number of employees and average salary of Louisiana-based employees. The plan type accounts for much of the difference; for example, during the first contract period, shared savings health plans did not pay claims or have claims processing staff. However, there is also variation within the plan types. Variances in the average salary across plans largely reflect the mix of positions located in state. Some plans have a larger share of lower salary positions in state, such as call center staff, whereas others have a larger share of higher salary positions in state, such as clinical staff performing prior authorization functions.

Table 2.1: Total number of Louisiana employees and average salary July 2014 - January 2015

	AMG	ACLA	LHCC	CHS	UHC
Total number of LA Based Employees	106	123	280	33	72
Average Salary	$76,188.27	$61,412.97	$58,799.95	$69,534.65	$79,281.38

Source: MSLC Survey Results

Table 2.2: Total number of Louisiana employees and average salary February – June 2015

	Aetna	AMG	ACLA	LHCC	UHC
Total number of LA Based Employees	122	108	132	372	187
Average Salary	$65,000.00	$78,750.68	$62,855.70	$59,495.80	$55,468.62

Source: MSLC Survey Results

The Department also requires the dental benefits manager to maintain in-state staff. The positions that Managed Care of North America, Inc. (MCNA) is required to domicile in Louisiana are the executive director, the dental director and staff responsible for provider network development and management. MCNA reported 11 local staff with an average salary of $62,932 as shown in Table 2.3. MCNA reported that contracted clinical reviewers and member and provider relations staff were domiciled in Louisiana in addition to the required local staff.

Table 2.3: Total number of Louisiana employees and average salary in dental benefit management State Fiscal Year 2015

	MCNA
Total number of LA Based Employees	11
Average Salary	$62,932.00

Source: MSLC Survey Results

3 PAYMENTS TO HEALTH PLANS

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 and monthly care management fees are 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 receive a supplemental, one-time, fixed payment referred to as a maternity kick payment for each delivery billed by hospitals. This payment is for the costs associated with newborns. Factors such as age, gender, geographic region of residence, eligibility group, and the plan's risk score are considered in determining the PMPM for a member and account for the differences in average PMPM.

Under the original contract, the Department made capitation payments for the month of enrollment during the month of enrollment, e.g., payment for February enrollment was made in mid-February. Under the second contract, the Department made capitation payments for the month of enrollment during the month after enrollment, e.g., payment for February enrollment was made in mid-March. As a result of this PMPM payment timing change between the two contracts, the Department made no payment to health plans in February 2015, but resumed monthly payments in March 2015.

Payments to the managed care organizations were atypically high in November 2014 because of a lump sum reimbursement of the Health Insurance Providers Fee (HIPF), which is a fee assessed by the Internal Revenue Service to managed care organizations under Section 9010 of the Affordable Care Act. Payments to the managed care organizations were atypically high in January 2015 as they included both routine PMPM payments made on January 13, 2015, and a one-time payment made on January 27, 2015, for a retrospective adjustment due to the addition of Full Medicaid Payment to capitation rates effective retroactively to April 1, 2014. Full Medicaid Payment accounts for the difference between the amount paid for inpatient and outpatient hospital services under the Medicaid fee schedule and the maximum amount otherwise allowed by the Centers for Medicare and Medicaid Services. The addition of Full Medicaid Payments is the primary explanation for increase in average PMPM payments from State Fiscal Years 2014 to 2015.

In State Fiscal Year 2015, the Department paid $2,189,541,585 to the Bayou Health plans; $ 1,022,880,727 during the first contract period and $166,660,858 during the second contract period. Ninety-six percent of all payments during the first contract period were made to the three managed care organizations, which were directly responsible for payment of enrollee claims. The remainder, over $37 million, was paid to the two entities operating plans under the shared savings model; the shared plans are directly responsible for primary care case management but not payment of enrollee claims.

As shown in Table 3.1, during the first contract period, average PMPM payments to managed care organizations ranged from $310.32 to $342.54. Variation in the average PMPM rate reflects differences in enrollment mix and risk adjustment across health plans. Managed care organizations with a larger share of enrollment from higher cost eligibility groups had a higher average PMPM payment, and vice-versa. Similarly, health plans with higher risk scores had higher average PMPM rates. Risk scores reflect the health status of total plan membership. A risk score of 1.0 reflects a membership of average health. A risk score of greater than 1.0 reflects a membership sicker than the average. A risk score of less than 1.0 reflects a membership healthier than the average. Risk adjustment applies risk scores to a universal PMPM rate to compensate plans for the relative health care needs of their membership.

The two plans operating under the shared savings model each had average PMPM payments of $10.92 and $11.01. This rate reflected a universal monthly care management fee for each enrolled member that was not risk-adjusted.

Table 3.1: Total payments and average PMPM for each plan July 2014 – January 2015

	Total Payments	Average PMPM	Total Payments	Average PMPM	Total Payments	Average PMPM	Total Payments	Average PMPM	Total Payments	Average PMPM
	AMG		ACLA		LHCC		CHS		UHC	
July-14	$32,527,610	$253.84	$37,571,858	$263.57	$34,797,628	$232.99	$2,301,941	$10.95	$3,043,048	$11.06
Aug-14	$32,983,935	$255.32	$37,209,648	$259.46	$37,028,368	$246.53	$2,296,320	$10.90	$3,051,516	$11.02
Sep-14	$33,665,644	$258.57	$37,356,838	$259.28	$36,281,958	$240.43	$2,307,121	$10.93	$3,076,283	$11.06
Oct-14	$33,590,286	$254.07	$39,508,493	$271.16	$36,719,283	$240.65	$2,336,788	$11.01	$3,093,298	$11.00
Nov-14	$51,653,200	$388.01	$57,684,840	$393.65	$53,118,661	$346.59	$2,315,759	$10.89	$3,103,605	$10.99
Dec-14	$40,504,813	$302.52	$45,761,038	$311.34	$44,077,512	$286.15	$2,330,205	$10.98	$3,128,546	$11.07
Jan-15	$81,422,471	$605.42	$93,061,667	$632.59	$88,631,805	$571.11	$2,276,451	$10.81	$3,062,287	$10.88
Total	**$306,347,959**	**$332.54**	**$348,154,383**	**$342.54**	**$330,655,215**	**$310.32**	**$16,164,586**	**$10.92**	**$21,558,584**	**$11.01**

Source: Unduplicated member counts are from the MARS Data Warehouse and total payments are from the state accounting system, ISIS. Payments are reported on a date of payment basis.

Table 3.2: Total payments and average PMPM for each plan February – June 2015

	Total Payments	Average PMPM	Total Payments	Average PMPM	Total Payments	Average PMPM	Total Payments	Average PMPM	Total Payments	Average PMPM
	Aetna		AMG		ACLA		LHCC		UHC	
Feb-15[5]	$-	$-	$370,000	$-	$-	$-	$3,159,160	$-	$-	$-
Mar-15	$ 8,915,479	$440.73	$48,863,755	$332.68	$51,086,025	$331.35	$95,287,909	$ 264.58	$75,513,397	$ 262.86
Apr-15	$ 8,811,460	$390.98	$52,801,666	$354.20	$56,469,923	$363.92	$100,079,435	$ 277.41	$ 77,283,508	$ 268.45
May-15	$ 9,582,397	$388.55	$47,683,023	$319.36	$55,111,685	$355.70	$101,032,387	$ 280.89	$89,754,711	$ 312.20
Jun-15	$11,368,207	$394.76	$51,706,890	$347.07	$51,702,264	$335.04	$95,281,570	$ 265.45	$78,325,166	$ 272.62
Total[6]	**$38,677,543**	**$401.94**	**$201,055,334**	**$338.34**	**$214,369,897**	**$346.54**	**$391,681,302**	**$272.09**	**320,876,782**	**$279.03**

Source: Unduplicated member counts are from the MARS Data Warehouse and total payments are from the state accounting system, ISIS. Payments are reported on a date of payment basis.

[5] As noted in the narrative, due to a change in capitation payment timing from the original contract to its successor, no regular capitation payments were made in February 2015. Payments made to plans in February 2015 are for services provided to enrollees determined eligible retroactively.

[6] Total payment and average PMPM is based on payments and enrollment for March through June 2015.

Table 3.2 shows the total monthly payments and average PMPM payment for each plan for February 1, 2015, through June 30, 2015. During the second contract period, on an average PMPM basis, the payments ranged from $272.09 to $401.34. The average PMPM was calculated by dividing the total payment by the total enrollment for the month. Also affecting the average payment amounts made during the second contract period was movement of members between plans during the 90-day choice period following initial enrollment. For example, Aetna's average PMPM is highest in March 2015 for members enrolled in February 2015, their first month in operation. However, from February to March 2015, 23 members in the Chisholm eligibility category moved from Aetna to other plans. These members are under the age of 21 and are on the Developmental Disabilities Request for Services Registry, are among the most expensive to cover, and have relatively high PMPMs. Additionally, the membership for Louisiana Healthcare Connections more than doubled at the implementation of the second contract due to their acquisition of Community Health Solutions. In May of 2015, UnitedHealthcare's total payments increased due to kick payments on May 19, 2015 for retroactive eligibility changes.

Additional payments not reflected in Table 3.2 are payments made to the two shared savings health plans for savings earned during the original contract period. Shared savings payments were based on determinations made by the Department's actuary, specifically, whether the actual cost of care for a shared savings health plan's membership was more or less than the fee-for-service cost estimated by the actuaries. Determinations are made on an interim and final basis for each year of the three year contract term. Determinations are made more than a year after the close of the reporting period to allow sufficient time for all applicable claims to be filed by service providers. In March 2015, the Department paid $341,230 to Community Health Solutions for its final year one payment, and in June 2015, the Department paid $5,343,800 for the interim year two payment. In March 2015, the Department paid $492,455 to UnitedHealthcare for their final year one payment and $8,950,874 for the interim year two payment.

The Department treated capitation payments for the dental benefit management program as it did for the health plans under the original contract. The capitation payment was based on the number of Medicaid recipients eligible for and enrolled in the dental program for the month and was paid during the month of enrollment, i.e., July enrollment paid for in July. Table 3.3 below shows the total payments the Department made to MCNA and the average PMPM for each month.

Table 3.3: Total payments and average PMPM for each plan based on date of payment for dental benefit program State Fiscal Year 2015

	Total Payments	Average PMPM
	MCNA	
July-14	$12,039,097	$12.53
Aug-14	$12,107,884	$12.46
Sep-14	$12,186,720	$12.40
Oct-14	$12,205,737	$11.56
Nov-14	$12,223,062	$11.44
Dec-14	$12,829,641	$11.77
Jan-15	$12,406,738	$11.22
Feb-15	$12,596,061	$11.22
Mar-15	$12,606,945	$11.06
Apr-15	$12,707,494	$10.96
May-15	$12,710,114	$10.78
Jun-15	$12,684,840	$10.58
Total	**$149,304,335**	**$11.45**

Source: Unduplicated member counts came from the MARS Data Warehouse and total payments are from the state accounting system, ISIS.

4 HEALTH CARE PROVIDERS

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

Timely access to necessary health care for Medicaid members is an important goal of the Bayou Health program. Contracts with the health plans require them to maintain minimum ratios of specialty physicians to enrollees, and both plan types must meet primary care provider (PCP) ratios. The Department conducts ongoing monitoring of the number of contracted providers in each health plan, and requires plans to submit geo-spatial analyses with provider locations. The Department receives the total number of contracted providers for each health plan through weekly provider network registries submitted by the plans. Network development and areas for additional focus are standing topics for discussion at quarterly business reviews between the Department and the health plans. Since the inception of Bayou Health, the Department has held quarterly meetings with each health plan's leadership individually for the purpose of reviewing overall performance and outcomes and to identify opportunities for improvement and any needed adjustments.

It is important to note that the total number of health care providers contracting with a Bayou Health plan cannot be used in isolation as an indicator of network adequacy and member access. Provider networks may consist of both in-state and out-of-state providers, and some contracted providers may limit the number of Bayou Health enrollees they will see or have closed their panels to new Bayou Health enrollees. Section 6 includes data on providers with closed panels. Appendix 15.I lists contracted providers by provider type, provider taxonomy, and parish.

Table 4.1: Total contracted providers in each health plan July 2014 - January 2015

	AMG	ACLA	LHCC	CHS	UHC
Total Contracted Providers	12,666	14,264	13,045	2,417	5,369

Source: MSLC Survey Results

Under the second Bayou Health contract, the Department requires all plans to contract with the full range of providers necessary to provide comprehensive health care services to their members. The three incumbent managed care organizations, Amerigroup, Amerihealth Caritas and Louisiana Healthcare Connections, reported modest increases in their provider networks. Former shared savings health plan UnitedHealthcare reported a large increase in their network attributable to the expansion of provider participation beyond primary care. The new entrant, Aetna, joined Bayou Health with the second contract period and built its network to begin service delivery on February 1, 2015.

Table 4.2: Total contracted providers in each health plan February – June, 2015

	Aetna	AMG	ACLA	LHCC	UHC
Total Contracted Providers	8,934	13,045	14,556	14,559	17,109

Source: MSLC Survey Results

MCNA, the dental benefit plan, reported 998 providers contracted during the entirety of State Fiscal Year 2015. State Fiscal Year 2015 was the first year of operation of the dental managed care program.

Table 4.3 Total contracted providers in dental benefit program State Fiscal Year 2015

	MCNA
Total Contracted Providers	998

Source: MSLC Survey Results

5 PRIMARY CARE SERVICE PROVIDERS

The total number of providers contracted to provide health care 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.

For this section, primary care providers are defined as any contracted provider that submitted at least one claim for payment for services using specific procedure codes identified as a primary care service. These services included regular office visits with new or established patients and comprehensive preventive evaluations for both new and established patients (i.e., CPT codes 99201-99215 and 99381-99397).

The data in Tables 5.1 and 5.2 are unduplicated by National Provider Identifier numbers. Some provider groups or facilities (e.g. hospitals, labs) may have multiple National Provider Identifier numbers for their multiple functions and therefore may be counted multiple times.

No data is reported for MCNA as dental providers are not considered primary care providers.

Appendix 15.II lists primary care providers with at least one claim by provider type, provider taxonomy and parish.

Table 5.1 shows the number of providers specifically contracted by the health plans to provide primary care that had at least one claim during the first contract period.

Table 5.1: Total contracted primary care providers with at least one claim July 2014 – January 2015

	AMG	ACLA	LHCC	CHS	UHC
PCPs with one claim	4,665	5,644	4,492	693	1,603

Source: MSLC Survey Results

Table 5.2 shows the number of providers specifically contracted by the health plans to provide primary care that had at least one claim during the second contract period.

Table 5.2: Total contracted primary care providers with at least one claim February – June, 2015

	Aetna	AMG	ACLA	LHCC	UHC
PCPs with one claim	3,137	4,581	5,926	4,776	5,905

Source: MSLC Survey Results

6 CONTRACTED PROVIDERS WITH A CLOSED PANEL

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

Providers that contracted with health plans had the option to close their panels, or stop accepting new patients, under certain circumstances. Each health plan had its own policy on which providers could close their panels and when a panel could be closed, how to inform the health plan when a panel is closed or reopened, and how closed panels were tracked. Additionally, each health plan has its own policy for closing network provider panels to ensure quality of care for members. For example, a managed care organization may cap physician panels at 3,000 patients so that appropriate care and time is given to each patient.

Table 6.1 shows the providers with a closed panel under the original contract period of State Fiscal Year 2015. The health plans counted the providers with a closed panel differently, which accounts for the wide variation in closed panels reported across plans. For example, whereas Amerihealth Caritas and Louisiana Healthcare Connections reported only on the panel status of their primary care physicians, Amerigroup reported a closed panel inclusive of all specialists as well.

The data in Table 6.1 are unduplicated by National Provider Identifier numbers. Some provider groups or facilities (e.g. hospitals, labs) may have multiple National Provider Identifier numbers for their multiple functions and therefore may be counted multiple times.

See Appendix 15.III for the data delineated by provider type, provider taxonomy code, and parish.

Table 6.1: Contracted providers with a closed panel July 2014 – January 2015

	AMG	ACLA	LHCC	CHS	UHC
Providers with a Closed Panel	298	130	60	122	929

Source: MSLC Survey Results

Table 6.2 shows the providers with a closed panel during the second contract period of State Fiscal Year 2015. The health plans counted the providers with a closed panel differently, which accounts for the wide variation in closed panels reported across plans. Aetna was unable to provide information on closed panels as their system is a point in time system with no ability to report on historical closed panel data. Aetna is changing its system to provide this information in the future.

The data in Table 6.2 are unduplicated by National Provider Identifier numbers. Some provider groups or facilities (e.g. hospitals, labs) may have multiple National Provider Identifier numbers for their multiple functions and therefore may be counted multiple times.

Table 6.2: Contracted providers with a closed panel February – June 2015

	Aetna	AMG	ACLA	LHCC	UHC
Providers with a Closed Panel	Not Provided	436	132	70	1,031

Source: MSLC Survey Results

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.

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

Health plans are required to submit audited annual medical loss ratio reports, which are based on a calendar year, by June 1 of the following year that summarized how the plans spent their capitation payments. The methodology established by the Department to calculate the annual medical loss ratio is adapted from the methodology the Centers for Medicare and Medicaid Services (CMS) established in 2011 for calculating the medical loss ratio by commercial health plans. This methodology may differ from the methodology used by health plans in quarterly filings to the Department of Insurance and shareholders.

If a health plan does not meet the 85 percent minimum requirement, it is required to pay the Department a rebate. In Calendar Year (CY) 2014, all three managed care organizations met the 85-percent minimum and were not required to pay any rebates. Louisiana Healthcare Connections had the lowest medical loss ratio at 90.6 percent, and Amerihealth Caritas had the highest at 93.3 percent. For more detail, refer to Table 7.1.

Appendix 15.IV includes the medical loss ratio reports from each managed care organization for Calendar Year 2014. As required by the Bayou Health Administrative Rule, the medical loss ratio reports are independently audited, and the audited reports are posted on the Medicaid website at http://ldh.louisiana.gov/index.cfm/page/2142.

Table 7.1: Medical Loss Ratios by managed care organization Calendar Year 2014

	AMG	ACLA	LHCC
Adjusted Current YTD MLR Capitation Revenue	$442,422,604	$511,207,027	$480,219,586
Total Adjusted MLR Expenses	$410,889,229	$476,863,651	$435,232,748
MLR Percentage Achieved	92.9%	93.3%	90.6%
Dollar Amount of Rebate Requirement	$0	$0	$0

Source: Bayou Health Report #019 (Medical Loss Ratio)

8 HEALTH OUTCOMES

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

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

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

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

Results for the prior calendar year are due to the Department at the end of the subsequent year; as such, Calendar Year 2014 measures were due by the end of 2015. Table 8.1 shows the summary of health outcomes from Calendar Year 2014.

Table 8.1: Health Outcomes Calendar Year 2014

	AMG	ACLA	LHCC	CHS	UHC
Adult Asthma Admission Rate[7,8,9]	7.33	9.33	5.86	5.42	3.87
Congestive Heart Failure Admission Rate[6,7,10]	46.83	46.03	44.62	34.60	31.09
Uncontrolled Diabetes Admission Rate[6,7,9]	2.36	0.74	1.95	3.25	1.75
Adult Access to Preventative/Ambulatory Health Services	81.26%	81.76%	81.28%	80.82%	82.48%
Breast Cancer Screening Rate[11]	52.98%	57.23%	54.10%	47.98%	52.93%
Well Child Visits[12]	64.81%	62.21%	60.82%	66.21%	63.40%
Childhood Immunization Rates					
Diphtheria, pertussis, and tetanus (DTaP)	75.93%	59.03%	70.71%	53.73%	74.21%

[7] Rate per 100,000 Member Months

[8] Differences in the lag time for the plans submitting encounter claims could impact the rates for 2014.

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

[10] Rate is reported for members ages 18 to 64.

[11] The age range changed from 40-69 to 50-74 and the continuous enrollment criteria changed from the measurement year and the year prior to the measurement back to October 1 of two years prior.

[12] Stricter PCP definition excludes claims where the servicing provider is not an identifiable PCP. This excludes clinic or group practices, KIDMED, Children's Choice Waiver, and FQHC/Regional Health Center (RHC) settings if PCP was not identified as servicing provider. This measure may be under-reported for Louisiana Medicaid as some PCP visits may be excluded due to group billing.

Polio Vaccine (IPV)	91.44%	78.70%	82.86%	66.38%	93.19%
Measles, mumps, and rubella (MMR)	89.12%	81.02%	85.24%	81.59%	90.27%
Haemophilus influenzae type B (HiB)	89.58%	79.17%	83.33%	74.14%	90.27%
Hepatitis B	93.75%	68.29%	73.33%	31.02%	94.40%
Varicella zoster virus (VZV)	88.66%	80.32%	84.76%	81.98%	90.27%
Pneumococcal Conjugate	76.85%	63.19%	69.05%	54.73%	78.59%
Hepatitis A	85.88%	73.15%	80.71%	76.36%	87.10%
Rotavirus	62.50%	55.09%	56.43%	48.70%	67.88%
Influenza	36.34%	32.87%	34.52%	35.32%	45.50%
Combo 2	73.84%	49.31%	60.00%	23.59%	72.75%
Combo 3	68.98%	47.92%	55.48%	21.79%	71.53%

Source: 2015 HEDIS® (Jan 1-Dec 31, 2014 Measurement Year)

Table 8.2 shows the aggregate health plan outcomes for Calendar Year 2014, as compared to the Calendar Year 2013 aggregate health plan outcomes and the pre-managed care baseline of Calendar Year 2011.

Table 8.2: CY 2014 aggregate MCO outcomes compared to CY 2013 prior year and CY 2011 pre-managed care as baseline comparisons

	CY 2011 Total Medicaid	**CY 2013 Aggregate Health Plan Rate**	**CY 2014 Aggregate Health Plan Rate**
Adult Asthma Admission Rate	9.14[13]	7.73	6.14
Congestive Heart Failure Admission Rate	49.9[13]	37.09	39.79
Uncontrolled Diabetes Admission Rate	5.93[13]	3.00	1.92
Adult Access to Preventative/Ambulatory Health Services	78.35%	82.95%	82.13%
Breast Cancer Screening Rate	42.65%	N/A	53.63%
Well Child Visits	35.45%	67.46%	63.74%
Childhood immunization rates			
Diphtheria, pertussis, and tetanus (DTaP)	58.78%	68.30%	66.53%
Polio Vaccine (IPV)	72.97%	82.87%	82.41%
Measles, mumps, and rubella (MMR)	81.05%	86.15%	85.83%
Haemophilus influenzae type B (HiB)	77.98%	84.62%	83.40%
Hepatitis B	20.66%	75.60%	70.98%
Varicella zoster virus (VZV)	81.25%	85.96%	85.71%
Pneumococcal Conjugate	60.10%	69.49%	68.58%
Hepatitis A	35.30%	81.13%	81.28%
Rotavirus	49.96%	62.75%	58.65%
Influenza	27.86%	37.23%	38.21%
Combo 2	15.02%	53.07%	54.94%
Combo 3	13.73%	50.30%	52.54%

Source: 2012 HEDIS® (Jan 1 – Dec 31, 2010 Measurement Year); 2014 HEDIS® (Jan1-Dec 31, 2013 Measurement Year) and 2015 HEDIS® (Jan 1-Dec 31, 2014 Measurement Year)

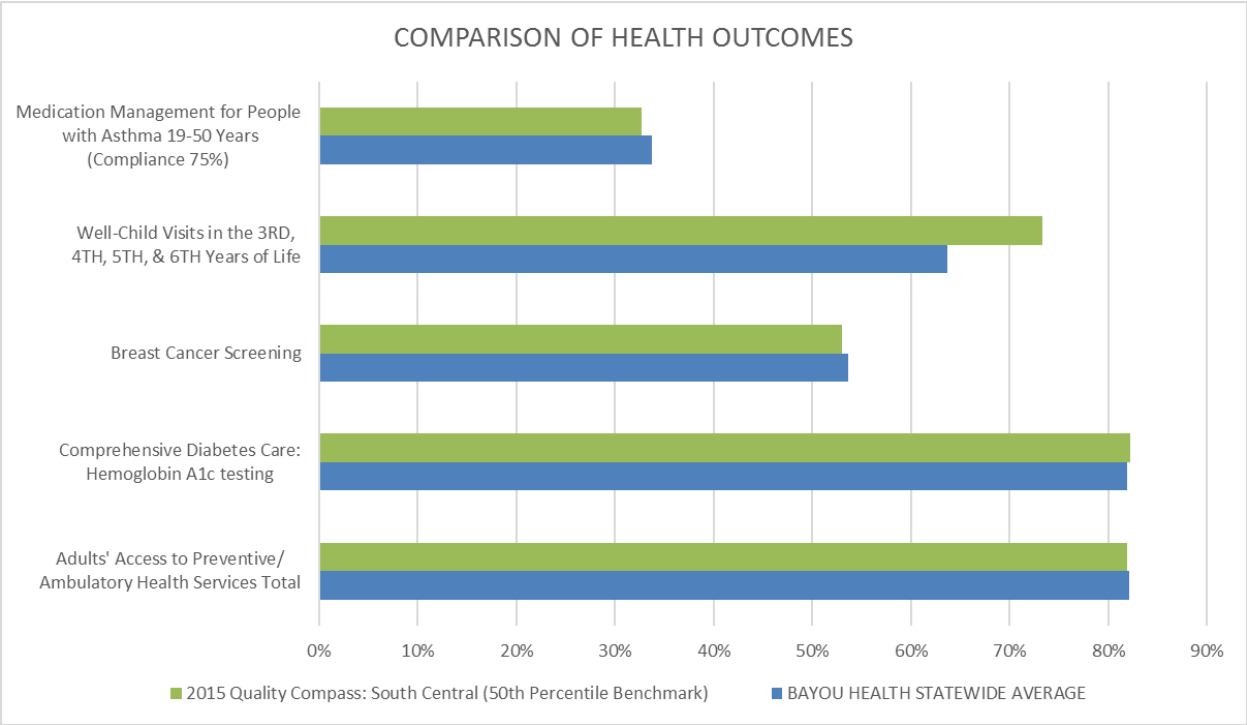
The Island Peer Review Organization (IPRO) validates all HEDIS performance measures by following CMS's most current "validating performance measures" protocol. The validation of performance

[13] 2011 PQIs were recalculated to match current specifications (per 100,000 member months)

measures is conducted annually and results are published in the annual technical report in compliance with the requirements set forth in 42 C.F.R. § 438.240(b)(2). Validation of the health plans' quality assessment and performance improvement programs includes: (1) Review of the data management processes of the Medicaid managed care plan; (2) Algorithmic compliance (the translation of captured data into actual statistics) with specifications defined by the Department; and (3) Verification of performance measures to confirm that the reported results are based on accurate source information. The technical report also describes the manner in which the data from the validation of performance measures were aggregated and analyzed and conclusions were drawn as to the quality, timeliness and access to the care furnished by the health plans.

As part of its validation, IPRO also provides a comparison of Louisiana Medicaid measures to regional data presented corresponding to the U.S. Census Southern Central region which pertains only to Medicaid HMO products reporting to the National Committee for Quality Assurance database.[14] Table 8.2 below reflects four of the transparency reporting requirements for illustration.

Table 8.2: Comparison of 2014 Louisiana Health Outcomes to 2015 NCQA Quality Compass



Source: 2015 HEDIS® (Jan 1-Dec 31, 2014 Measurement Year); Island Peer Review Organization (IPRO)

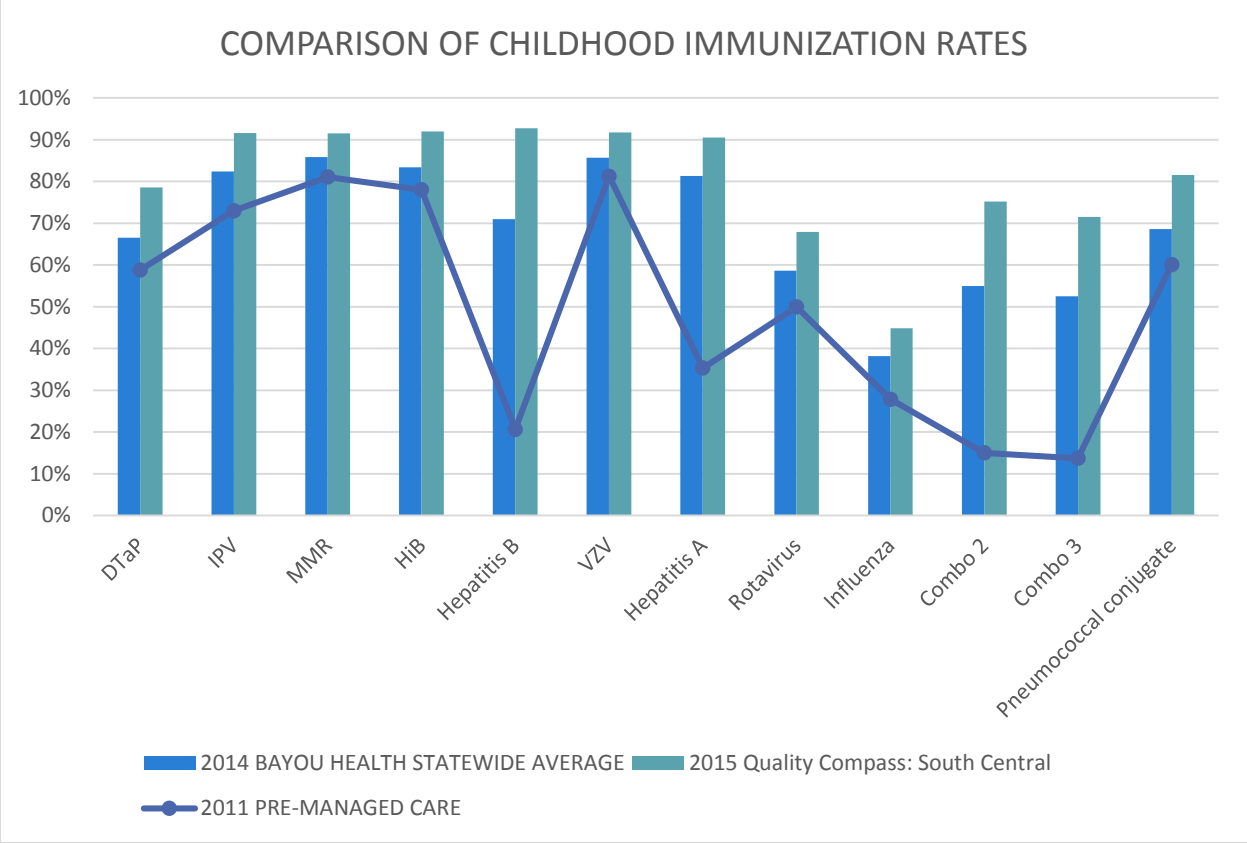
Though not required, plans are allowed to supplement claims data for the childhood immunization status measure by selecting a random sample of the population and supplementing claims data with data from medical records. When choosing this option, plans may identify additional immunizations and report more favorable and accurate rates. However, this hybrid method is more costly and time-consuming and requires nurses or other authorized personnel to review confidential medical records. This hybrid method may result in significant differences in HEDIS scores due to differing levels of investment by the health plans.

Table 8.3 below reflects a comparison of the Bayou Health immunization rates by vaccine against the South Central regional average as published in the 2015 Quality Compass by NCQA and

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

immunization rate outcomes pre-managed care in 2011. Though the Department continues to strive toward better outcomes, there has been significant improvement in the application of childhood immunizations since the implementation of managed care, especially with regard to Hepatitis A & B and Combo 2 & 3 vaccines, which on average have improved approximately 44 percent due to the heightened outreach and linkages to care through an enhanced provider network afforded by managed care.

Table 8.3: Comparison of 2014 Louisiana immunization rates to 2015 NCQA Quality Compass



Source: 2012 HEDIS® (Jan 1 – Dec 31, 2010 Measurement Year) and 2015 HEDIS® (Jan 1-Dec 31, 2014 Measurement Year); Island Peer Review Organization (IPRO)

9 MEMBER AND PROVIDER SATISFACTION SURVEYS

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

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

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

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

The Department required health plans to submit an annual member satisfaction survey report within 120 days of the end of the contract year.

The health plans conducted an annual survey of providers to determine the level of satisfaction and identify areas for improvement. The survey instruments, which were approved by the Department along with the methodology included: provider enrollment, education and complaints; utilization management processes; claims processing and reimbursement; and, for primary care providers, availability of technical assistance in creating patient-centered medical homes.

See Appendices 15.V and 15.VI for the Calendar Year 2014 member and provider satisfaction surveys for Amerigroup, Amerihealth Caritas, Louisiana Healthcare Connections, and UnitedHealthcare. Community Health Solutions did not submit Calendar Year 2014 satisfaction surveys due to their merger with Louisiana Healthcare Connections and the ending of their contract on January 31, 2015, which was prior to the contractually required submission deadline. As a result, the Department did not require a 2014 submission from Community Health Solutions. MCNA did not submit Calendar Year 2014 satisfaction surveys as their contract began on July 1, 2014.

In order to validate the information provided in these reports, Myers and Stauffer asked each health plan to explain the approach used to obtain the results. All five health plans used an independent, third-party NCQA-certified vendor to administer the CAHPS survey. CAHPS 5.0H measures of patient experience with health plans and providers are also collected by NCQA as part of its accreditation program.

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 important information for assessing a company's financial condition, including but not limited to profitability and solvency. The Securities and Exchange Commission (SEC) requires that all publicly held entities must file audited annual financial statements. Audits independently evaluated whether a company's financial statements were prepared in accordance with generally accepted accounting principles (GAAP) and presented a fair picture of the financial position and performance of the company.

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

The full financial statements for each health plan can be found in Appendix 15.VII. The statements are for Calendar Year 2014 which were reported during State Fiscal Year 2015.

11 SANCTIONS LEVIED BY THE DEPARTMENT

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

During State Fiscal Year 2015, the Department twice assessed sanctions on Amerigroup Louisiana, Inc. for an adjusted total of $240,000 for failure to meet contract requirements. Both infractions occurred under the first contract which required the health plans to submit 95 percent of encounter data monthly by the 25th calendar day of the month following the month in which they were processed and approved/paid, including encounters reflecting a zero-dollar amount, and encounters in which the health plan has a capitation arrangement with a provider. The penalty included in the contract for failure to meet this requirement was $10,000 per day out of compliance.

On October 21, 2014, the Department withheld $90,000 from Amerigroup's monthly capitation payment for being out of compliance with this requirement from September 16, 2014, the date the plan was notified of noncompliance, to September 24, 2014, the date on which the plan completed their corrective action plan. This penalty was assessed with the understanding that, should the November reconciliation report show continued non-compliance, a reassessment would be made back to the effective date of noncompliance, which was July 26, 2014, through September 24, 2014. Upon receipt of the November reconciliation report demonstrating continued noncompliance, the Department withheld an additional $520,000. After an appeal by Amerigroup, the Department reduced the penalty to $150,000 and credited the balance of $370,000 to Amerigroup on February 10, 2015.

More detailed information on this sanction is posted on the Department's website: http://new.dhh.louisiana.gov/index.cfm/page/1610.

12 DENTAL BENEFIT HEALTH OUTCOMES

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

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

The dental benefit program began on July 1, 2014. For Medicaid enrollees under the age of 21, the dental program covered preventive, maintenance and restoration services such as fillings, fluoride treatments and cleanings. For Medicaid enrollees over the age of 21 that were eligible for full Medicaid benefits, the dental program was limited to denture services included in the Medicaid state plan. In State Fiscal Year 2015, the Department's dental benefits manager, MCNA, covered 849,572 Medicaid members under the age of 21 and 370,315 members over the age of 21. During the first year of implementation, 393,097 (or 46.27 percent) of the eligible Medicaid enrollees under the age of 21 saw a dentist and 7,770 (or 2.10 percent) of the eligible Medicaid enrollees over the age of 21 saw a dentist.

Table 12.1 shows the rates of utilization by members. Eligible members who saw a dentist most commonly accessed prophylaxis services for children in the EPSDT[15] program, followed by composite fillings on children, then prophylaxis on adults in the EPSDT program.

Table 12.1: Rates of procedures performed on those patients who accessed dental services

	Total members received procedure	Rate of members who saw a dentist
Adult oral prophylaxis	93,516	23.79%
Child oral prophylaxis	261,759	66.59%
Dental sealants	90,511	23.02%
Fluoride varnish	78,927	20.08%
Amalgam fillings	91,754	23.34%
Composite fillings	153,100	38.95%
Stainless steel crowns	66,480	16.91%
Extractions of primary teeth	15,035	3.82%
Extractions of permanent teeth	56,400	14.35%
Pulpotomies performed on primary teeth	25,779	6.56%
Root canals performed on permanent teeth	5,287	1.34%

Source: MCNA Data Warehouse

[15] The Early Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit guarantees coverage of "screening services" which must, at a minimum, include "a comprehensive health and developmental history – including assessment of both physical and mental health."

Health Plan Enrollees

13 MEMBERS ENROLLED

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

During the original contract period of July 2014 through January 2015, the Department enrolled 1,005,615 Medicaid recipients into the five Bayou Health plans. Shown in Chart 13.1, the two shared savings health plans had the largest percentage of members; UnitedHealthcare had the most members enrolled with 30 percent of enrollment and Community Health Solutions of Louisiana had the second-largest number of members with 22 percent of enrollment. Together, these shared savings health plans accounted for 52 percent of all Bayou Health members. The remaining 48 percent was divided across the three managed care organizations, with Louisiana Healthcare Connections, AmeriHealth Caritas of Louisiana and Amerigroup Louisiana each enrolling 17 percent, 16 percent and 15 percent of all members, respectively.

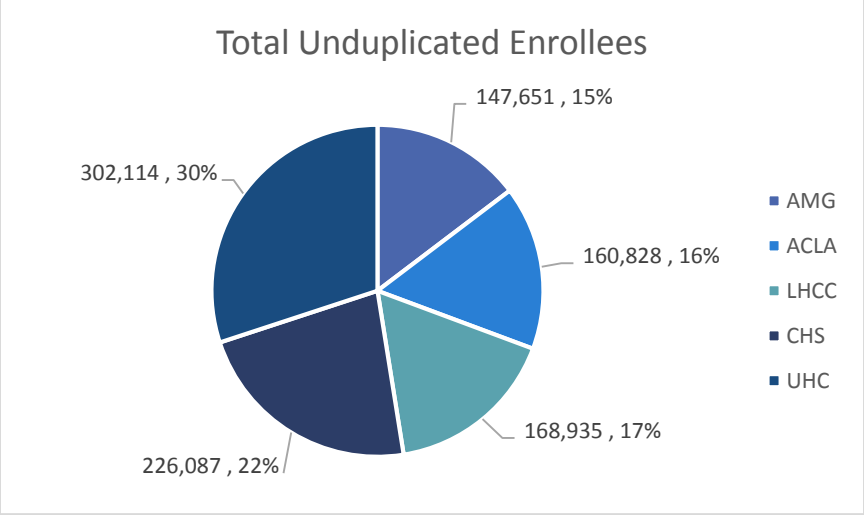
During the second contract period of February through June 2015, the Department enrolled 1,043,026 Medicaid recipients into the five health plans. Shown in Chart 13.2, Louisiana Healthcare Connections, which purchased Community Health Solutions and assumed its membership, had the most members enrolled with 36 percent of total Bayou Health enrollment and UnitedHealthcare had the second-largest number of members with 29 percent. AmeriHealth Caritas of Louisiana and Amerigroup Louisiana each enrolled 16 percent and 15 percent of all Bayou Health members, respectively. Aetna, the newest health plan had the smallest share of enrollment at 4 percent.

Table 13.1: Total unduplicated enrollees July 2014 – January 2015

	AMG[16]	ACLA[16]	LHCC[16]	CHS	UHC
Enrollees	147,651	160,828	168,935	226,087	302,114

Source: MARS Data Warehouse

Chart 13.1: Total unduplicated enrollees July 2014 – January 2015



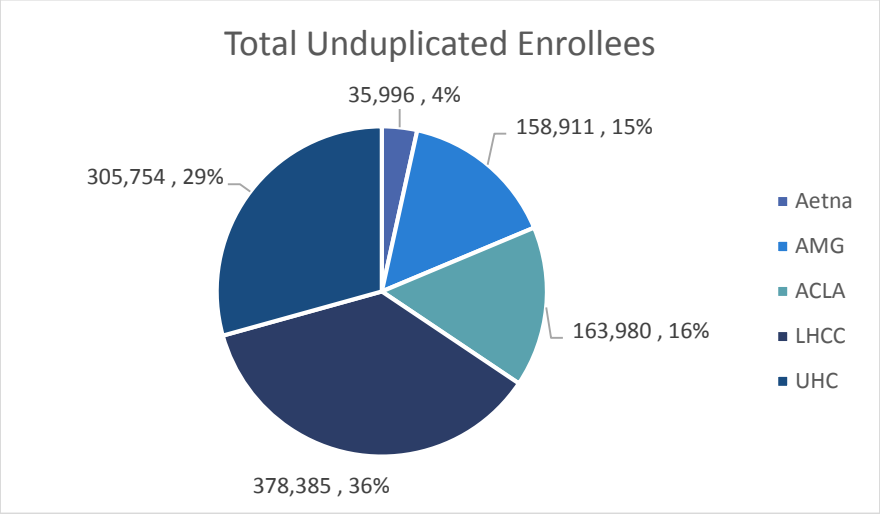
[16] For the original three MCOs, retroactively eligible members are reported during the period their eligibility was certified as opposed to the period they were actually enrolled in a health plan. For example, any person enrolled in a health plan in March 2015 who was found to be eligible for Medicaid in October 2014 will be counted during the original contract period.

Table 13.2: Total unduplicated enrollees February – June, 2015

	Aetna[17]	AMG[17]	ACLA[17]	LHCC	UHC
Enrollees	35,996	158,911	163,980	378,385	305,754

Source: MARS Data Warehouse

Chart 13.2: Total unduplicated enrollees February – June, 2015



For purposes of reimbursement, Bayou Health managed care organization enrollees are assigned to one of the eligibility categories listed below.

- *Families and Children*: Includes children and teens under the age of 19 whose basis of Medicaid or LaCHIP eligibility is age (children with disabilities are not included in this group) and their parents or caregivers. Also includes pregnant women whose primary basis of eligibility for Medicaid is pregnancy.
- *People with disabilities and Supplemental Security Income (SSI)-related seniors*: Includes individuals who are aged 65 and above as well as individuals of any age, including children, with disabilities.
- *Foster children*: Children who receive 24-hour substitute care from someone other than a parent or guardian and for whom the Department of Children and Family Services (DCFS) has responsibility for placement and care.
- *Breast and Cervical Cancer (BCC)*: Includes uninsured women who have already been diagnosed by a Centers for Disease Control and Prevention (CDC)-approved screening entity with breast or cervical cancer or a precancerous condition and who are not otherwise eligible for Medicaid.
- *LaCHIP Affordable Plan enrollees*: With the implementation of the Affordance Care Act, includes children and youth under the age of 19 with incomes between 217 and 255 percent of the FPL due to Modified Adjusted Gross Income (MAGI) conversions and a 5 percent disregard. Families pay a monthly premium of $50.

[17] For the original three MCOs, retroactively eligible members are reported during the period their eligibility was certified as opposed to the period they were actually enrolled in a health plan. For example, any person enrolled in a health plan in March 2015 who was found to be eligible for Medicaid in October 2014 will be counted during the original contract period.

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

Shared savings health plan enrollees are assigned to one of the following two eligibility categories to which the monthly management fee corresponds:

- Parents and children whose basis of eligibility is not disability or pregnancy. Plans receive a management fee of $10.24 per-member per-month for enrollees in this group.
- Individuals with disabilities, including children, and pregnant women whose sole basis of eligibility is pregnancy. Plans receive a management fee of $15.74 per-member per-month for enrollees in this group.

Tables 13.3 and 13.4 show the breakdown of Medicaid enrollees by eligibility category for each of the contract periods. The majority of members were enrolled in the Families and Children category. Supplemental Security Income (SSI) members were a distant second. The Foster Care, Breast and Cervical Cancer, LaCHIP Affordable Plan, Home and Community Based Waiver, and Chisholm eligibility categories contain the fewest members.

Table 13.3: Monthly average of enrollees in each health plan delineated by eligibility category July 2014 – January 2015

	AMG	ACLA	LHCC	CHS	UHC	Total
SSI	18,482	22,886	21,554	17,576	28,390	**108,888**
Families & Children	111,083	120,209	128,321	189,903	246,278	**795,794**
Foster Care	1,288	1,285	1,543	2,719	2,988	**9,823**
BCC	221	310	180	104	251	**1,066**
LAP	346	311	394	781	1,303	**3,135**
HCBS Waiver	42	55	58	38	123	**316**
Chisholm	144	140	169	260	322	**1,035**
Total Sum	**131,606**	**145,196**	**152,219**	**211,381**	**279,655**	**920,057**

Source: MARS Data Warehouse

Table 13.4 Monthly average of enrollees in each managed care organization delineated by eligibility category February – June, 2015

	Aetna	AMG	ACLA	LHCC	UHC	Total
SSI	3,885	19,390	22,960	37,634	28,002	**111,871**
Families & Children	18,347	125,875	128,961	316,112	254,541	**843,836**
Foster Care	171	1,394	1,382	4,122	2,926	**9,995**
BCC	57	255	326	298	270	**1,206**
LAP	300	468	430	1,161	682	**3,041**
HCBS Waiver	26	132	136	201	234	**729**
Chisholm	82	170	158	387	321	**1,118**
Total Sum	**22,868**	**147,684**	**154,353**	**359,915**	**286,976**	**971,796**

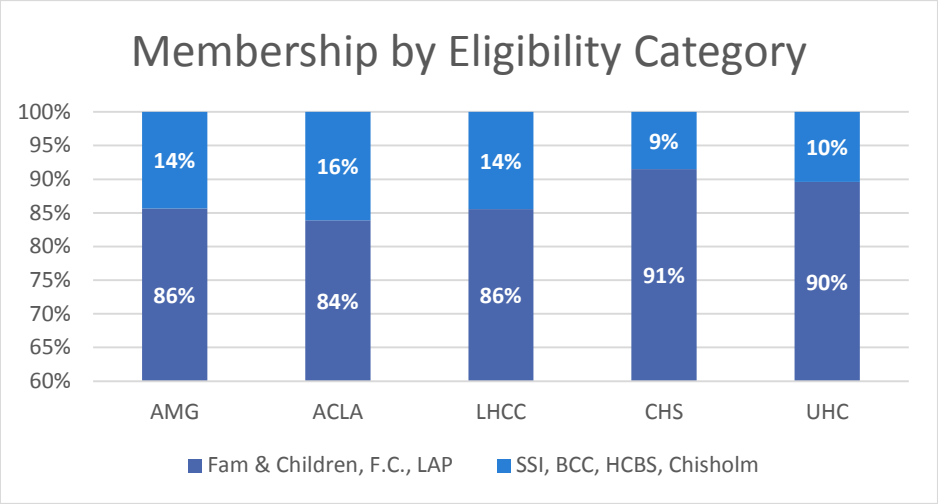
Source: MARS Data Warehouse

When comparing membership, the mix of members by eligibility category was similar across plans of the same type. However, significant differences in membership mix were noted when comparing managed care organizations to shared savings health plans. During the first contract period, the three managed care organizations had larger proportions of their membership consisting of Supplemental Security Income (SSI)-related recipients when compared to the shared savings health plans. Conversely, the shared savings health plans had larger proportions of their total membership consisting of recipients from the Families and Children eligibility group. The disproportionate share of Families and Children membership among the shared savings health plans relative to the managed care organizations affected utilization and outcomes measurement.

Differences in member demographics for each of the five health plans are important factors when looking at the number and types of providers, services, utilization and costs. The differences in demographics are reflected by the eligibility group to which an enrollee is assigned.

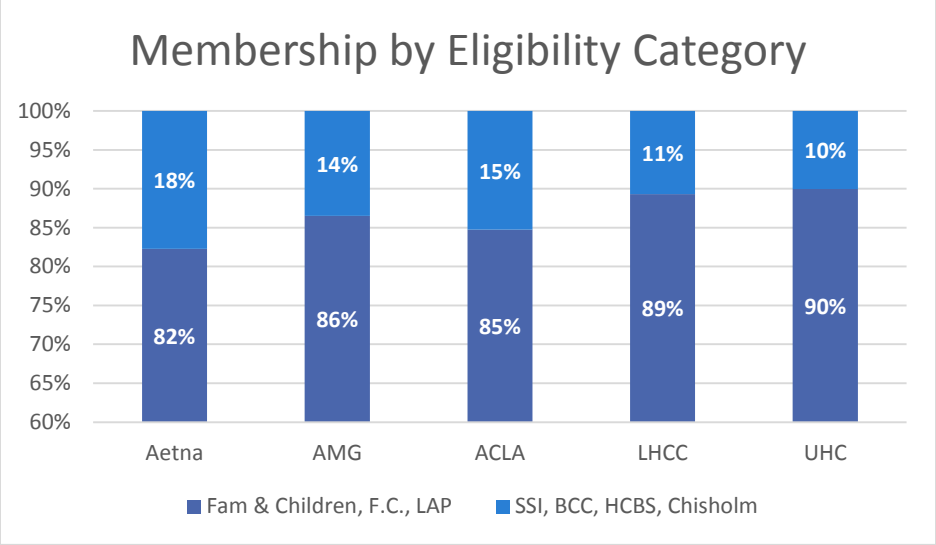
Charts 13.3 and 13.4 show the distribution of members enrolled in each health plan by eligibility category.

Chart 13.3: Membership distribution July 2014 – January 2015



Source: MARS Data Warehouse

Chart 13.4: Membership distribution February – June, 2015



Source: MARS Data Warehouse

14 PROACTIVE CHOICE AND AUTO-ENROLLMENT

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

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

New Medicaid enrollees receive all benefits and services through the legacy, fee-for-service Medicaid program pending their enrollment in a Bayou Health plan. Shortly after enrollment in Medicaid, members receive a choice letter with instructions on how to submit their choice of plan and notifying them of the availability of choice counseling. Members who do not choose a health plan within 30 days are 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 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 expiration of the 90 days, members have to wait until the next annual open enrollment period to switch plans unless they can show good cause for doing so, for example, poor quality of care, to enroll in same plan as family members, or documented lack of access to needed services.

Table 14.1 provides the number of members who actively chose to enroll in each plan and the number of members who were auto-assigned to each plan during the first contract period. The proportion of members who chose their health plan ranges from 51 percent for Louisiana Healthcare Connections and Amerihealth Caritas to 74 percent for UnitedHealthcare. The two shared savings health plans, Community Health Solutions and UnitedHealthcare, had the two highest ratios of self-selections to auto-assigned members as well as the majority of all self-selections across all plans (59 percent).

Table 14.1: Proactive choice rates July 2014 – January 2015

	AMG	ACLA	LHCC	CHS	UHC	Total
Pro-active Choice Enrollments	8,853	7,613	7,712	8,650	19,421	**52,249**
Auto Enrollments	7,369	7,223	7,378	6,622	6,977	**35,569**
Total Enrollments	16,222	14,836	15,090	15,272	26,398	**87,818**
Choice rate	55%	51%	51%	57%	74%	**59%**

Source: Maximus Health Services

The implementation of the second contract period for Bayou Health in February 2015 brought both a new managed care organization and a change in the procedure for new enrollees to choose their health plan, which had significant impact on the choice rates. Instead of being sent an enrollment letter encouraging plan selection after enrollment, as of February 1, 2015, members could select a plan at the time of application. The enrollment broker auto-assigned members who did not select a health

plan based on the Department-approved algorithm. Members were given a 90-day grace period to change health plans, but no longer had a 30-day choice period prior to final linkage.

During the development of the second Bayou Health contract, the Department designed a process to assign members to any new plan in order to ensure more even distribution. Beginning with open enrollment on December 30, 2014, all new members that had neither an existing relationship with a health plan nor a primary care provider visit in the previous six months were assigned to the new entrant, Aetna. Beginning January 30, 2015, Aetna received two randomly assigned members for each one member that the incumbent plans received. Beginning May 30, 2015, Aetna received all randomly assigned members until it reached 30,000 members.

Table 14.2 shows the choice rates after implementation of the second Bayou Health contract. Aetna has the lowest choice rate and UnitedHealthcare's rate remains the highest, though lower compared to the original contract period. The overall choice rate was lower due to the relatively low choice rate for Aetna. After February 1, 2015, three members were enrolled in UnitedHealthcare's shared savings health plan. These were newborns born after February 1, 2015, to mothers who had pro-actively chosen that plan and were automatically enrolled in their mother's health plan but considered a pro-active enrollment. There were also nine members who pro-actively chose to remain in Legacy Medicaid.

Table 14.2: Proactive choice rates February – June, 2015

	Aetna	AMG	ACLA	LHCC	UHC	Total
Pro-active Choice Enrollments	3,016	9,096	5,322	10,552	14,110	**42,108**
Auto Enrollments	13,325	6,644	6,630	10,157	8,914	**45,670**
Total Enrollments	16,341	15,740	11,952	20,709	23,024	**87,778**
Choice rate	18%	58%	45%	51%	61%	**48%**

Source: Maximus Health Services

15 ENROLLEES WHO RECEIVED SERVICES

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

In monitoring the effectiveness and quality of the Bayou Health program, the Department tracks utilization of core benefits and services, i.e., the extent to which enrollees use a Bayou Health Medicaid service in a specified period, such as within a given month or year. Section 15 provides information on Medicaid services provided under Bayou Health. Data are inclusive of paid and denied claims but are reported by unduplicated members within each contract period, not by claim count.

Table 15.1 shows unduplicated counts and percent of members receiving services by health plan in State Fiscal Year 2015. During the first contract period, 931,560 unduplicated members received one or more Medicaid services through their health plan, for an overall rate of 86.2 percent across all plans. Of the plans, Amerihealth Caritas had the highest percentage of members receiving one or more services. Rates for individual plans demonstrate variation across plans with a range of 60.3 percent (Aetna) to 89 percent (Amerihealth Caritas). As with other utilization measures, Aetna, the newest plan in Louisiana which was in operation for only five months of the fiscal year, had the lowest percentage of members receiving one or more services. Data are representative of all claims, approved and denied.

Table 15.1: Enrollees who received services State Fiscal Year 2015

	Aetna[18]	AMG	ACLA	LHCC	UHC-MCO[18]	CHS-Shared[19]	UHC-Shared[19]	Unduplicated Total
Unduplicated Members	35,938	174,414	180,472	393,813	305,629	226,091	302,118	**1,080,773**
Members Receiving One or More Services	21,658	146,979	160,577	312,484	233,685	181,128	243,857	**931,560**
Percent Receiving One or More Services	60.3%	84.3%	89.0%	79.3%	76.5%	80.1%	80.7%	**86.2%**

Source: MARS Data Warehouse

[18] Data for Aetna and UHC-MCO are for the period from February 1, 2015, to June 30, 2015, reflective of the Bayou Health contract for managed care organizations only.

[19] Data for the CHS shared savings health plan and the UHC shared savings health plans are for the period from July 1, 2014, to January 31, 2015, under the original contract.

As shown in Table 15.2, 438,646 Medicaid enrollees received services through the dental benefit program, representing nearly 36 percent of all members eligible for dental services. State Fiscal Year 2015 was the first time Medicaid enrollees were eligible for the managed care dental benefit program. Dental coverage was limited to preventive, maintenance and restoration services for enrollees under the age of 21. Coverage was limited to denture services included in the state plan for Medicaid enrollees over the age of 21 who were eligible for full Medicaid benefits. Appendix 15.VIII provides additional detail of members served by provider taxonomy, provider type, and place of service broken out by contract year.

Table 15.2: MCNA enrollees who received dental services State Fiscal Year 2015

	MCNA
Unduplicated Members	1,219,887
Number Receiving One or More Services	438,646
Percent Receiving One or More Services	35.96%

Source: MCNA Data Warehouse

16 ENROLLEES WHO HAD A PRIMARY CARE VISIT

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

Once a Medicaid recipient is assigned to a health plan, either by choice or by auto assignment, the health plan assigns them to a primary care provider (PCP). These are providers who contract with the health plan explicitly to provide primary care services and to serve as a medical home for their patients. Enrollees are contacted by their health plan to make a selection. If no selection is made within 10 days of enrollment into the health plan, they are assigned one. The algorithm for auto assignment considers past history with a PCP or a family history with a PCP. The Department requires each health plan to have a process through which members can request to change their PCP for cause.

The data in Tables 16.1 and 16.2 show the number and percentage of members who had at least one visit with the PCP to which they were linked during the two contract periods in State Fiscal Year 2015. Though all members were linked to a PCP, they are not prohibited from seeking care from other providers. Not included in this table is data on members who had a visit with a provider for primary care services to which the member was not linked at the time.

Table 16.1 shows the number of enrollees that saw their primary care provider during the first contract period of State Fiscal Year 2015. There is a variation of over 12 percentage points UnitedHealthcare, which had the highest percentage of members who had a visit with their linked PCP and the plan with the lowest, Community Health Solutions.

Table 16.1: The total number and percentage of enrollees of each health plan who had at least one visit with their primary care provider July 2014 – January 2015

	AMG	ACLA	LHCC	CHS	UHC
Recipients with at Least one PCP Visit	47,149	54,483	51,318	59,195	117,251
Percentage	31.93%	33.88%	30.38%	26.18%	38.81%

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

Table 16.2 shows the number of enrollees that saw their primary care provider during the second contract period of State Fiscal Year 2015. Across the board, the managed care organizations had lower percentages of members who saw their primary care provider during the reporting period. UnitedHealthcare, previously contracted as a shared savings health plan, maintained their rank as the health plan with the highest percentage of members that had a visit with their primary care provider. Aetna, the newest managed care organization had the lowest percentage.

Table 16.2: The total number and percentage of enrollees of each health plan who had at least one visit with their primary care provider February – June, 2015

	Aetna	AMG	ACLA	LHCC	UHC
Recipients with at Least One PCP Visit	3,330	41,603	44,334	111,207	98,797
Percentage	9.24%	26.17%	27.03%	29.39%	32.31%

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

The percentage of enrollees with a primary care provider visit is lower in both State Fiscal Year 2015 contract periods than in State Fiscal Year 2014, as State Fiscal Year 2014 covers a full twelve months, whereas the two State Fiscal Year 2015 contract periods are only seven and five months, respectively.

17 HOSPITAL SERVICES PROVIDED

The following information concerning hospital services provided to Medicaid enrollees:

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

The data in Section 17 show the number of members who received inpatient and outpatient hospital services. Additionally, it shows the number of members who received emergency services within a year after having seen their primary care provider. Across the board, during the first contract period, the shared savings health plans had a higher volume of hospital services than the managed care organizations. This is primarily due to the larger memberships in the shared savings health plans compared to the managed care organizations.

Tables 17.1 and 17.2 list the number of members receiving unduplicated outpatient emergency services for the first and second contract periods of State Fiscal Year 2015 respectively. UnitedHealthcare had the most members receiving outpatient emergency services in the first contract period and Louisiana Healthcare Connections had the most in the second contract period. As with other data, wide variability is expected because the characteristics of a plan's membership impact this number.

Table 17.1: The number of members who received unduplicated outpatient emergency services July 1, 2014 – January 31, 2015

	AMG	ACLA	LHCC	CHS	UHC	Total
Members	43,065	46,703	49,609	62,863	83,533	**285,773**

Source: MARS Data Warehouse

Table 17.2: The number of members who received unduplicated outpatient emergency services February – June, 2015

	Aetna	AMG	ACLA	LHCC	UHC	Total
Members	7,223	37,194	37,467	82,713	65,829	**230,426**

Source: MARS Data Warehouse

Tables 17.3 and 17.4 list the total inpatient Medicaid days for the first and second contract periods of State Fiscal Year 2015 respectively. UnitedHealthcare had the most inpatient days in the first contract period and Louisiana Healthcare Connections had the most in the second contract period. As with other data, wide variability is expected because the characteristics of a plan's membership impact this number.

Table 17.3: The number of total inpatient Medicaid days July 1, 2014 – January 31, 2015

	AMG	ACLA	LHCC	CHS	UHC	Total
Total Inpatient Medicaid Days	43,109	47,676	50,476	53,472	77,122	**271,855**

Source: MARS Data Warehouse

Table 17.4: The number of total inpatient Medicaid days February – June, 2015

	Aetna	AMG	ACLA	LHCC	UHC	Total
Total Inpatient Medicaid Days	7,622	32,833	34,064	61,589	32,264	**168,372**

Source: MARS Data Warehouse

Tables 17.5 and 17.6 list the number of unduplicated members receiving outpatient emergency services within a year after having seen their primary care provider for the first and second contract periods of State Fiscal Year 2015 respectively. UnitedHealthcare had the most members who had at least one visit to a primary care provider within a year after their outpatient emergency room service in the first contract period and Louisiana Healthcare Connections had the most in the second contract period. Of the 285,773 Medicaid members who received outpatient emergency services during the original contract period, 258,009 had at least one visit to a primary care provider within one year after their emergency room visit. Of the 230,426 Medicaid members who received outpatient emergency services during the new contract period, 199,948 had at least one visit to a primary care provider within one year after their emergency room visit. In this section, a primary care provider is defined as any provider of primary care services, and is not necessarily the primary care provider the member is linked to as identified in Section 16 of this report.

Table 17.5: 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 July 2014 – January 2015

	AMG	ACLA	LHCC	CHS	UHC	Total
Members	38,439	41,801	44,396	57,541	75,832	**258,009**

Source: MARS Data Warehouse

Table 17.6: 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 February – June, 2015

	Aetna	AMG	ACLA	LHCC	UHC	Total
Members	5,981	32,170	32,420	72,309	57,068	**199,948**

Source: MARS Data Warehouse

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

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.

Bayou Health enrollees have the right to file grievances and appeals with both the health plan and with the state if they believe they have been unfairly denied benefits or access to services. Federal law requires health plans to administer a system for members to file appeals, and all states are required to review health plan reports on both the frequency and nature of grievances and appeals filed as well as the steps health plans take to remedy such grievances and appeals. States must also provide an opportunity for a fair hearing to members whose grievance or appeal is either denied or not promptly acted upon by the managed care organization. In contrast to managed care organizations, shared savings health plans were required to log appeals and forward them directly to the Division of Administrative Law for a state fair hearing rather than adjudicate appeals internally. As such, all shared savings plan appeals are counted solely as state fair hearings in Table 18.1 below.

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

- denying or partially denying a requested service, including type or level of service;
- reducing, suspending or terminating a previously authorized service;
- denying, in whole or in part, payment for a service;
- failure to provide services in a timely manner (as defined by the state); and
- failure to act within 90 days on a grievance.

In contrast, a grievance means an expression of dissatisfaction about any matter other than one of the above actions. Examples of subjects for grievances include, but are not limited to: the quality of care or services provided; aspects of interpersonal relationships, such as rudeness of a provider or employee; or failure to respect the member's rights. As stated above, the failure of a plan to act within 90 days of a member's grievance is an appealable action.

As part of their quality strategy, states must require health plans to maintain records of grievances and appeals and submit them for state review. In reviewing the records, the Department analyzes the subjects of the plan's grievances and appeals to identify the extent to which they are valid and/or are in the actual control of the health plan. Health plans and the Department both look for trends and use the reports to determine the need for operational changes and improvements.

Table 18.1: Appeals, state fair hearings and appeals overturned State Fiscal Year 2015

	Aetna	AMG	ACLA	LHCC[20]	UHC-MCO	CHS-Shared	UHC-Shared	MCNA Dental
Appeals	6	543	268	867	275	N/A	N/A	101
Appeals Reversed at the Plan Level	1	64	71	422	63	N/A	N/A	23
Appeals Reversed at the Plan Level - Percentage	17%	12%	26%	49%	23%	N/A	N/A	23%
State Fair Hearings Accessed	0	7	9	12	1	8	6	2
Number of Appeals Reversed at State Fair Hearing	0	0	0	0	0	0	0	0
Percentage of Appeals Reversed at State Fair Hearing	0%	0%	0%	0%	0%	0%	0%	0%

Source: Bayou Health Reports 114 and 117

[20] LHCC's data includes pharmacy appeals. The overturns were also reflective of lack of documentation submitted by the provider with the initial UM review.

Health Care Services Provided to Enrollees

To collect the data in this section, the Department defined emergency services as outpatient services provided in an emergency room, exclusive of EMTALA screening or urgent care, and professional services, specifically the evaluation and management of a patient, provided in an emergency room. [21] Non-emergency services are defined as all the other claims that do not fit the definition of emergency services above.

19 CLAIMS SUBMITTED BY HEALTH CARE PROVIDERS

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

Health plans reported claims data using a reporting template developed by the Department. The template cross walked Louisiana Medicaid provider type codes to national taxonomy codes in an effort to standardize claims data reporting. Louisiana Medicaid provider type codes are unique to its fiscal intermediary contractor, Molina. Taxonomy codes are standardized for all providers in the United States. Data are inclusive of paid and denied claims.

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

Table 19.1 shows data on total claims the health plans received during the two contract periods of State Fiscal Year 2015. These claims were ultimately paid or denied, however, the data does not include rejected claims. Rejected claims are different from denied claims as they are not adjudicated, but are rejected before entering the health plans' systems for reasons such as Electronic Data Interchange (EDI) formatting issues on the transaction, the system cannot read the claim, or systems limitations. .Since rejected claims are not processed through the health plans' systems, whether a service is coded as emergency or non-emergency cannot be ascertained.

Table 19.1 Total claims processed by health plans for emergency and non-emergency services

	Emergency Services	Non-Emergency Services	Total
Aetna	17,875	181,447	199,322
AMG	302,923	3,768,513	4,071,436
ACLA	275,918	6,391,915	6,667,833
LHCC[22]	372,861	6,678,974	7,051,835
UHC - MCO	148,844	2,310,703	2,459,547
CHS - Shared	274,733	4,260,703	4,535,436
UHC - Shared	235,506	3,469,648	3,705,154
MCNA Dental	-	891,520	891,520
Total	**1,628,660**	**27,953,423**	**29,582,083**

Source: Health Plans' Data Warehouses

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

[22] LHCC total claim count is at the claim header level and the clean claim count is at the service line level.

20 DENIED CLAIMS

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

Certain types of claim denials by health plans that bear special scrutiny and ongoing monitoring to assure that claims are not being inappropriately denied, including:

- lack of medical necessity;
- prior authorization not on file;
- a primary payer must be billed first before Bayou Health is billed as a secondary payer;
- initial claim filing failed to occur before the deadline of 365 days after the date of service; or
- service is not covered by Medicaid.

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

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

Table 20.1: Total denied clean claims by health plan

	Emergency Services	Non-Emergency Services
Aetna	1,588	32,417
AMG	12,885	333,577
ACLA	25,707	1,407,219
LHCC	16,320	637,765
UHC - MCO	9,418	188,259
CHS - Shared	22,502	795,625
UHC - Shared	21,690	746,327
MCNA Dental	-	29,544
Total	**110,110**	**4,170,733**

Source: Health Plans' Data Warehouses

Table 20.2 shows the ten most frequently used claim adjustment codes for emergency and non-emergency claims. The primary causes for adjustments or denials stemmed from a lack of information on the claim submission that was needed for adjudication, submission/billing errors and duplicate

claims. A breakout of all claim adjustment reason codes for denied claims for each health plan in numerical order is provided in Appendix 15.IX.

Table 20.2: Top claim adjustment reason codes (CARCs) for emergency and non-emergency services

	Emergency Claims	Non-Emergency Claims	Total
Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO); Start: 01/01/1995 | Last Modified: 06/02/2013	33,298	866,083	**899,381**
Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject	32,032	573,422	**605,454**
Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 S)	6,711	454,304	**461,015**
The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; Start: 01/01/1995 | Last Modified: 09/20/2009	10	360,345	**360,355**
The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	7,656	277,993	**285,649**
Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability) This change effective 11/1/2015: Charge exceeds fee schedule/maximum allowable or contracted/legislated	9,224	243,792	**253,016**
Precertification/authorization/notification absent.; Start: 10/31/2006 | Last Modified: 09/30/2007	70	215,785	**215,855**
Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	739	207,222	**207,961**
Duplicate Claim Line (Same Provider/Member/DOS/CPT(Rev))	6,913	190,080	**196,993**
The time limit for filing has expired.; Start: 01/01/1995	8,813	162,296	**171,109**

Source: Health Plans' Data Warehouses

21 CLEAN CLAIMS

The total number of claims submitted by the health care 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 health care providers delineated by provider type.

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

Table 21.1 lists the total clean claims submitted for each health plan. While shared savings plans do not pay claims submitted by health care providers, the data includes claims that were subsequently paid by the state's fiscal intermediary after preprocessing conducted by the shared savings plan.

Appendix 15.X lists total clean claims, percentage of claims paid within 15 and 30 days, and average number of days to pay all claims by provider type for each health plan. All health plans paid the vast majority of provider types in approximately two weeks, with the average number of days being less than one week for many provider types. The variation among provider types indicated in the appendix is due in part to the complexity of cross-walking fee-for-service legacy Medicaid provider types to the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12N standard, which regulates and establishes standards for claims filing. Provider type classifications used by Louisiana Medicaid are unique to its fiscal intermediary, and considerable work had to be performed to map them back to standard taxonomy codes in use by other health care organizations in the United States. All Health Insurance Portability and Accountability Act (HIPAA)-covered entities are required to be compliant with the ASC X12 version 5010, which only requires reporting of taxonomy on claims if a provider has multiple taxonomies associated with their National Provider Identifier on file. As health care terminology standards continue to evolve, the Department will continue to work to ensure health plan compliance to this standard and ensure provider directories are accurate and complete.

Table 21.1: Total clean claims by health plan

	Total Clean Claims
Aetna	162,558
AMG	3,517,888
ACLA	6,667,833
LHCC	6,717,154
UHC - MCO	2,433,300
CHS - Shared	3,711,129
UHC - Shared	3,705,154
MCNA Dental	768,493
Total	**27,683,509**

Source: Health Plans' Data Warehouses

22 REGULAR AND EXPEDITED SERVICE REQUESTS PROCESSED

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

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

Health plan contracts with the Department stipulate that service authorizations must be processed within 14 days unless an extension is requested by the provider to submit additional requested information. If the situation warrants, the provider can request an expedited determination, in which case the request must be acted on within 72 hours or less, depending on the medical urgency. Contracts require that at least 95 percent of requests be processed within these timeframes.

The Department monitors timeliness of action on service authorizations through the review of monthly reports submitted by the health plans and analysis of member and provider complaints and grievances. Pursuant to the Consent Agreement in *Dickson v. Fischer*, which became an order of the federal district court for the Eastern District of Louisiana on June 3, 1981, the timeframe for processing requests for prior authorization of medical appliances, equipment and supplies is 25 days or within 24 hours in emergency cases. This agreement requires "[d]efendants and their successors and employees" to act (e.g., approve, deny, etc.) within 25 days or within 24 hours in emergency cases "on all . . . requests for prior approval of medical appliances, equipment and supplies on behalf of Medicaid recipients"; failure to do so constitutes automatic approval.

Tables 22.1 and 22.2 show the number and percentages of regular, expedited and durable medical equipment (DME) authorizations processed within the timeframes included in the contracts for the first and second contract periods respectively. In order to validate the information reported by the health plans, Myers and Stauffer asked each plan how regular and expedited authorization requests are defined, how prior authorizations are monitored and tracked, and how reports on prior authorizations are generated. Myers and Stauffer also requested that the plans provide supporting documentation for its response.

Louisiana Healthcare Connections reported that during the new contract period reviews tripled, in part related to acquisition of Community Health Solutions, which accounts for the low percentage of claims processed within two days. Each month showed consistent increases in volume and the plan saw an increase in retroactive eligibility reviews during that time due to a Department policy change. Louisiana Healthcare Connections has since staffed to accommodate this growth.

Table 22.1 Service authorizations processed July 2014 – January 2015

		AMG	ACLA	LHCC	CHS	UHC
Regular Processed within 2 Business Days	**Number**	23,820	5,793	10,576	17,229	17,647
	Percent	93.17%	86.97%	90.13%	93.00%	82.80%
Regular Processed within 14 Business Days	**Number**	25,386	6,634	11,621	18,493	18,011
	Percent	99.30%	99.59%	99.04%	99.80%	97.90%
Regular Processed within 28 Business Days	**Number**	25,508	6,649	11,660	18,523	18,100
	Percent	99.78%	99.82%	99.37%	99.97%	99.67%
Expedited Processed within 72 Hours	**Number**	1,538	89	52	4	1,530
	Percent	89.21%	97.80%	100.00%	66.7%	93.10%
DME Processed within 25 Business Days	**Number**	3,429	2,492	1,313	11	1
	Percent	99.87%	99.92%	99.48%	100.00%	100.00%

Sources: Percentages from Bayou Health Report #188. Totals numbers from MSLC survey.

Table 22.2 Service authorizations processed February – June, 2015

		Aetna	AMG	ACLA	LHCC	UHC
Regular Processed within 2 Business Days	**Number**	403	19,098	4,391	15,974	27,008
	Percent	93.00%	86.72%	89.21%	80.71%	92.02%
Regular Processed within 14 Business Days	**Number**	433	21,888	4,898	19,521	28,107
	Percent	100.00%	99.39%	99.51%	98.63%	97.69%
Regular Processed within 28 Business Days	**Number**	433	21,976	4,913	19,663	28,140
	Percent	100.00%	99.79%	99.82%	99.35%	99.55%
Expedited Processed within 72 Hours	**Number**	21	1,165	87	57	1,068
	Percent	78%	90.59%	98.86%	96.61	95.90%
DME Processed within 25 Business Days	**Number**	143	3,064	1,913	1,999	3,161
	Percent	100.00%	99.09%	99.64%	99.03%	99.70%

Sources: Percentages from Bayou Health Report #188. Totals numbers from MSLC survey.

Tables 22.3 and 22.4 show the percent of prior authorizations that resulted in a denial of services. During both contract periods, the health plans reported wide variation in percentages of denials.

Table 22.3: Percent of prior authorizations that resulted in denial July 2014 – January 2015

	AMG	ACLA	LHCC	CHS	UHC
Denied Prior Authorizations	6.25%	12.10%	8.36%	10.50%	4.90%

Source: MSLC Survey Results

Table 22.4: Percent of prior authorizations that resulted in denial February – June, 2015

	Aetna	AMG	ACLA	LHCC	UHC
Denied prior authorizations	2.14%	5.53%	9.63%	9.51%	8.10%

Source: MSLC Survey Results

23 CLAIMS PAID TO OUT-OF-NETWORK PROVIDERS

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

This measure applies to the managed care organizations only as they are required to maintain their own provider networks and pay their own claims. It does not apply to shared savings health plans whose networks are limited to Medicaid-enrolled providers and provider claims are paid by the Department.

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

The following information in tables 23.1 and 23.2 reflects the number of claims and dollar value of payments by the managed care organizations to non-network providers for both emergency services and non-emergency services. The data originate from submissions from the managed care organizations on the claims reporting template developed by the Department. Myers and Stauffer asked the plans to explain the assumptions and criteria used in reporting these data while attempting to validate these figures. Myers and Stauffer found that certain emergency services included in the Department's reporting requirements may have been excluded from the analysis. Specifically, hospital revenue codes 451, 452 and 456 were not included for any managed care organization. However, these three revenue codes have never been payable under the Louisiana Medicaid fee-for-service schedule, making their exclusion appropriate.

Appendix 15.XI shows out of network claims for all emergency and non-emergency services broken out by parish.

Table 23.1: Out of network claims for emergency services State Fiscal Year 2015

	Aetna	AMG	ACLA	LHCC	UHC
Total Claims	31,784	100,217	94,999	106,955	63,035
Total Amount	$2,562,027	$7,474,213	$7,503,252	$13,395,258	$6,490,211

Source: MCO Data Warehouses

Table 23.2: Out of network claims for non-emergency services State Fiscal Year 2015

	Aetna	AMG	ACLA	LHCC	UHC
Total Claims	1,081,518	149,001	231,439	183,085	171,420
Total Amount	$79,785,321	$11,464,494	$17,452,964	$33,080,812	$26,553,209

Source: MCO Data Warehouses

24 PHARMACY BENEFITS

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

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

This measure applies to prepaid health plans which are required to manage pharmacy benefits for their members. It does not apply to shared savings health plans for which the pharmacy benefit was managed by the Department.

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

Table 24.1: MCO pharmacy benefit managers

	Aetna	AMG	ACLA	LHCC	UHC
July 2014 – January 2015	N/A	CVS Caremark Contracted	PerformRx Owned	US Script Owned	N/A
February – January 2015	CVS Caremark Contracted	Express Scripts Contracted	PerformRx Owned	US Script Owned	OptumRx Owned

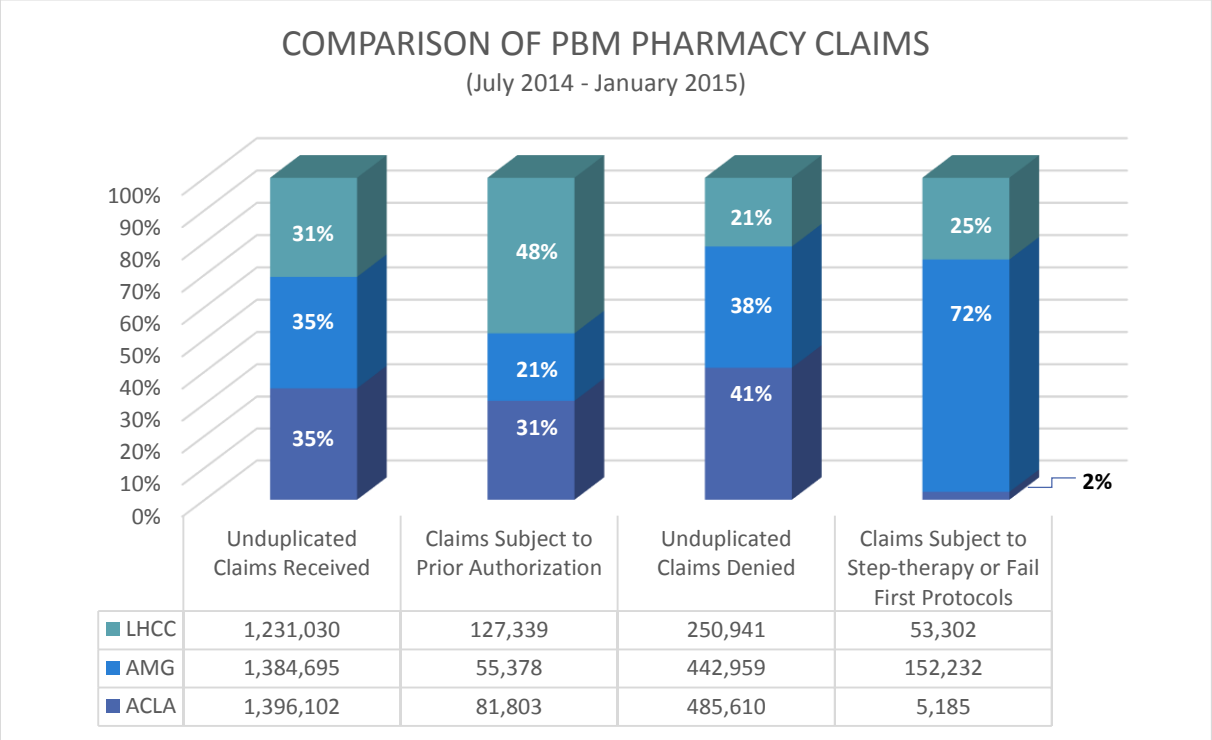
Source: MCO self-reported

Managed care organizations have flexibility in how to address appropriateness of medication therapy. Additionally, each pharmacy benefit manager has its own protocols for utilization management and decision making as to which drugs to include in its preferred drug list. A preferred drug list is a list of preferred brand name and generic drugs that are most cost-effective and do not require prior authorization. There are drugs assigned for each therapeutic drug class.

Variation in claims data reflected in the charts below is due to the ability of the managed care organizations to take alternative approaches to managing pharmacy benefits. As a result, the data from each plan varies significantly, particularly in the categories of claims denied, claims subject to prior authorization, and claims subject to step therapy or fail first protocols.

Charts 24.1 and 24.2 list the unduplicated total number of pharmacy claims received by health plan broken out by the separate contracting periods for State Fiscal Year 2015. They also give the number of claims denied, claims subject to prior authorization and the number of claims subject to step-therapy or fail first protocols. The monthly details for claims by reporting category are provided in Appendix 15.XII.

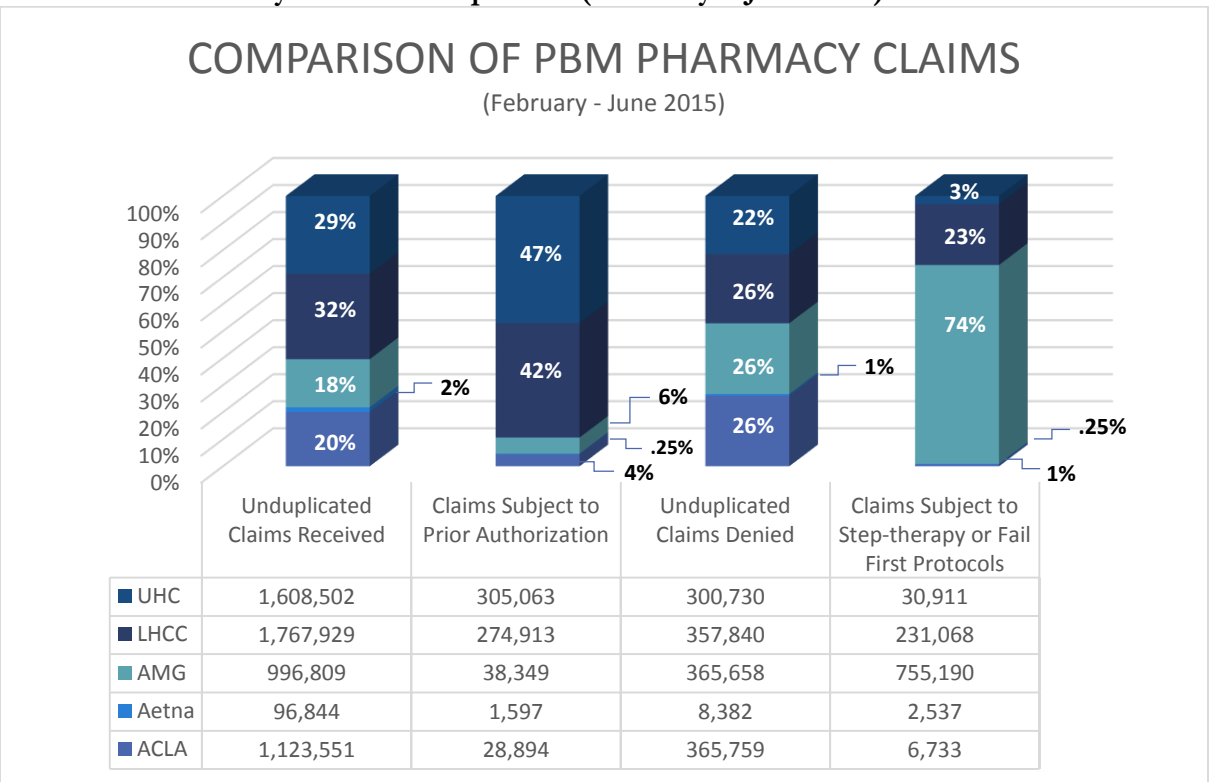
Chart 24.1: Pharmacy benefits comparison (July 2014 – January 2015)



	Unduplicated Claims Received	Claims Subject to Prior Authorization	Unduplicated Claims Denied	Claims Subject to Step-therapy or Fail First Protocols
LHCC	1,231,030	127,339	250,941	53,302
AMG	1,384,695	55,378	442,959	152,232
ACLA	1,396,102	81,803	485,610	5,185

Source: Monthly RX055 Pharmacy Report

Chart 24.2: Pharmacy benefits comparison (February – June 2015)



	Unduplicated Claims Received	Claims Subject to Prior Authorization	Unduplicated Claims Denied	Claims Subject to Step-therapy or Fail First Protocols
UHC	1,608,502	305,063	300,730	30,911
LHCC	1,767,929	274,913	357,840	231,068
AMG	996,809	38,349	365,658	755,190
Aetna	96,844	1,597	8,382	2,537
ACLA	1,123,551	28,894	365,759	6,733

Source: Monthly RX055 Pharmacy Report

25 MEDICAID DRUG REBATES

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

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

This measure applies to managed care organizations which are required to manage pharmacy benefits for their members. It does not apply to shared savings health plans for which the pharmacy benefit was managed by the Department. The managed care organizations submit this data on a calendar year basis in the audited annual financial report.

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

For Medicaid enrollees in a fee-for-service delivery system, manufacturer discounts and drug rebates (both federal and State supplemental) accrue directly to the state. For Medicaid enrollees in a full-risk managed care organization, only federal rebates accrue directly to the state. In Louisiana, since managed care organizations determine their own unique preferred drug list, supplemental rebates are not available to the state.

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

Table 25.1 provides the amount of Medicaid drug rebates and manufacturer discounts collected and used as well as remitted to the Department during Calendar Year 2014, as reported by managed care organizations in their audited annual financial statement for that year. Table 25.2 shows the monthly breakdown.

Table 25.1: Pharmacy rebates in Calendar Year 2014

	AMG	ACLA	LHCC	Total
Amount of Medicaid Drug Rebates and Manufacturer Discounts Collected and Used	$1,068,842	$3,847,000	$1,723,377	**$6,639,219**
Amount of Medicaid Drug Rebates and Manufacturer Discounts Collected and Remitted to the Department	$0	$0	$0	**$0**

Source: Audited Annual Financial Report

Table 25.3: Monthly pharmacy rebates in Calendar Year 2014

	AMG	ACLA	LHCC
January	$119,393	$353,000	$43,865
February	$104,577	$313,000	$43,865
March	$199,701	$317,000	$43,865
April	$97,186	$334,000	$52,969
May	$116,678	$260,000	$179,287
June	$136,576	$280,000	$77,997
July	$98,886	$284,000	$109,315
August	$103,474	$329,000	$378,828
September	-$131,567	$328,000	$351,784
October	$73,897	$380,000	$150,444
November	$65,823	$392,000	$176,080
December	$84,218	$277,000	$115,078
2014 Total	**$1,068,842**	**$3,847,000**	**$1,723,377**

Source: Audited Annual Financial Report

26 PRIOR AUTHORIZATION REQUESTS

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

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

MCNA, which administers the Louisiana Medicaid dental benefit plan, defines prior authorizations as the prior review of a service by a qualified health professional to authorize, partially deny, or deny the payment of a service, including a service requested by a member. In State Fiscal Year 2015, MCNA completed prior authorizations on a total of 193,288 requests. As shown in Table 26.1, the two most common types of procedures prior authorized were oral/maxillofacial surgery and restorative procedures, which accounted for over half of all prior authorizations. Oral/maxillofacial surgery included extractions, TMJ procedures and other surgery on the mouth, jaws and face. Restorative services included tooth restorations, crowns and appliance removals, among others (these types of services are the most commonly performed, and thus the most commonly prior authorized).

Table 26.1: The number of prior authorization requests by type of procedure State Fiscal Year 2015

Type of Procedure	Total Number of Prior Authorization Requests
Oral & Maxillofacial Surgery	57,132
Restorative	54,381
Adjunctive General Services	21,468
Endodontics	20,005
Removable Prosthodontics	15,075
Diagnostic	11,901
Preventive	9,624
Periodontics	2,850
Orthodontics	785
Fixed Prosthodontics	41
Maxillofacial Prosthetics	15
Implant Services	11
Total	**193,288**

Source: Report 188 – Prior authorization summary

The Department included in the dental benefits manager contract requirements for timely processing of prior authorization requests. For standard authorizations, 80 percent must be processed within two days and 100 percent within 14 calendar days. For expedited authorizations, 100 percent must be processed no later than 72 hours after receipt. As shown in table 26.2, MCNA reported that all procedure types were prior authorized within the contract requirement for standard authorizations

and all had an average prior authorization time of less than one day. With the exception of restorative and periodontics procedures, the range of times to prior authorize services correlates with the total number of prior authorizations requested. Oral/maxillofacial surgery and adjunctive general services had the longest time range (up to 12 days). Implant services had the shortest time range as well as the fewest total number of prior authorizations requested.

Table 26.2: The overall average and range of times for responding to prior authorization requests State Fiscal Year 2015

Type of Procedure	Average Time	Range of Times
Oral & Maxillofacial Surgery	0.745	0 - 12 days
Adjunctive General Services	0.747	0 - 12 days
Restorative	0.744	0 - 8 days
Endodontics	0.728	0 - 8 days
Periodontics	0.842	0 - 3 days
Removable Prosthodontics	0.595	0 - 5 days
Diagnostic	0.688	0 - 5 days
Preventive	0.778	0 - 5 days
Orthodontics	0.637	0 - 3 days
Fixed Prosthodontics	0.837	0 - 2 days
Maxillofacial Prosthetics	0.947	0 - 2 days
Implant Services	0.333	0 - 1 days
Overall Average	**0.731 Days**	**5.5 days**

Source: MCNA Data Warehouse

Of the 193,288 prior authorizations MCNA completed during State Fiscal Year 2015, 32,264 were denied. MCNA used a total of 112 unique denial reasons. Table 26.3 includes the ten most frequently used denial reasons which accounted for 24,158, or 75 percent of all denials. The most common denial reason, Code 2, was due to a duplicate claim that had already been approved or denied. Other common reasons were for services that were either not covered or were limited and because MCNA determined that either the procedure was not medically necessary or that the supporting documentation did not meet the company's guidelines. All denials delineated by denial reason are included in Appendix 15.XIII.

Table 26.3: Ten most prevalent reasons for denial State Fiscal Year 2015

Code Used	Code Description	Total Times Used
2	This request has been previously reported and an approval or denial was issued.	8,513
571	Coverage is limited to the plan guidelines as specified in your provider manual.	4,695
48	Please submit x-ray(s) and narrative with this request.	2,493
17	This is a non-covered service per the covered services outlined in your provider manual.	1,773
400	Clinical criteria were not met.	1,385
150	The dental director has advised that the x-rays received do not demonstrate the need for treatment submitted.	1,351
121	This procedure can only be considered when reported and performed in conjunction with covered services.	1,095

535	No benefit is provided for the extraction of asymptomatic teeth which show no signs of infection; including but not limited to the removal of third molars. The member's condition does not meet MCNA's oral surgery guidelines.	986
399	MCNA does not issue retrospective authorizations. Requests for authorizations. Requests for authorizations after we have processed the claim are not approved.	972
111	The clinical reviewer has determined that the x-ray and/or photos submitted were not of diagnostic x-ray indicating the right and left sides and/or diagnostic quality photos.	895

Source: MCNA Data Warehouse

In State Fiscal Year 2015, MCNA denied 19,574 claims that they had been previously approved. Table 26.4 includes the ten most frequently used denial reasons (out of 145 total reason codes) for prior authorizations that had been previously approved. These ten denial reasons accounted for 13,312, or 68 percent of all denials after prior authorization was approved. As with total denials, the most commonly used denial reason is Code 2, "this request has been previously reported and an approval or denial was issued." All denials delineated by reasons for denial are included in Appendix 15.XIII.

Table 26.4: Ten most prevalent reasons for denial after prior authorization was approved State Fiscal Year 2015

Code Used	Code Description	Total Times Used
2	This request has been previously reported and an approval or denial was issued.	5,657
19	Payment for this procedure has been provided under a prior claim or procedure.	2,064
76	Resubmit claim with pre- and post-operative x-rays.	978
517	Please submit a completed copy of the anesthesia time record for review with your claim. This document must include the name of the rendering provider for the anesthesia. The provider name must be legible.	837
571	Coverage is limited to the plan guidelines as specified in your provider manual.	823
115	This claim/procedure has been previously reported with a different date of service. Please submit the patient chart notes for date of service confirmation.	656
197	This procedure is only covered in conjunction with root canal therapy.	647
247	Service did not meet plan coverage criteria.	606
463	MCNA will review this procedure once endodontic therapy is completed to an acceptable standard of care. A pre-payment review of the pre- and post-op x-rays.	525
48	Please submit x-ray(s) and narrative with this request.	519

Source: MCNA Data Warehouse

List of Appendices