Medicaid Managed Care Transparency Report 2024

Agency Response to La. Revised Statute 40:1253.2

Louisiana Department of Health

Bureau of Health Services Financing

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Introduction

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

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

The program initially included two coordinated care models: a full-risk managed care organization (MCO) model, delivered by "prepaid health plans," and a primary care case management (PCCM) model, delivered by "shared savings plans." Over time, LDH integrated services and populations into the managed care program, achieving significant milestones along the way. The most significant change in the MCO program for SFY 2023 was the re-procurement of MCO contractors, expanding the number of MCOs from five to six, effective January 1, 2023. The populations and services in Managed Care remained relatively unchanged.

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

Transparency Report Measures and Data

This annual transparency report includes 46 areas of measurement outlined in Louisiana Revised Statute 40:1253.2 and covers program operations for state fiscal year (SFY) 2024. All measures are reported for the SFY 2024, July 1, 2023, through June 30, 2024, unless otherwise indicated. The first four sections of this report cover operations and outcomes for Managed Care Organizations, specifically health plans. Subsections 5.1 through 5.17 cover Dental Benefit Plan Management (DBPM) operations and outcomes.

The information included in this report was collected from multiple sources. To the greatest extent possible, the data were extracted from state systems that routinely collect and maintain operational data on the Medicaid managed care program. When unavailable from state sources, data were collected from the managed care entities or sourced from either routine reporting deliverables[2] or ad hoc reports requested specifically for this purpose. The Medicaid Management Information System (MMIS) and the Management Administrative Reporting Subsystem (MARS Data Warehouse or MDW) are maintained by the Medicaid program's contracted fiscal intermediary, Gainwell. Detailed enrollee and provider information, as well as claims payment data for this report, were extracted from the MARS Data Warehouse. The state administrative system, LaGOV Enterprise Resource Planning System – Finance

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

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

Module (LaGOV), maintained by the Office of Technology Services within the Division of Administration, was used to extract information on payments to the MCOs and DBPMs.

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

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

Section 1 - Medicaid Managed Care Organizations

During state fiscal year (SFY) 2024, more than 2 million Louisiana Medicaid and Louisiana Children's Health Insurance Program (LaCHIP) enrollees received coverage for physical health, basic and specialized behavioral health services, or transportation services under the Medicaid managed care program through one of six managed care organizations.

Managed Care Organizations (MCOs)

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

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

A small number of individuals remained excluded entirely from enrollment in an MCO and continued to receive services under FFS. Medicaid populations excluded from enrollment in an MCO in SFY 2024 included:

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

Additionally, the following services continued to be provided only under the Medicaid fee-for-service program and were not included in the managed care benefit package in SFY 2024:

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

Subsection 1.1 - Contracted Managed Care Organizations

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

For the SFY 2024 reporting period, the Department contracted with six MCOs to manage physical and behavioral healthcare services. The contracted entity names and common abbreviations used in this report are detailed in Table 1.1.1 in alphabetical order.

Table 1.1.1 Contracted Managed Care Organizations, State Fiscal Year 2024

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

Source: Medicaid managed care contracts

The state also contracted for the managed care of covered dental services through two dental benefit program managers (DBPMs) as detailed in subsections 5.1 through 5.17 of this report.

Subsection 1.2 - Managed Care Employees

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

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

Table 1.2.1 Total number of full-time equivalent (FTE) and average salary for MCO employees based in Louisiana, State Fiscal Year 2024

	ABH	ACLA	HBL	HHH	LHCC	UHC
Total number of LA employees (FTEs)	227	207	196	340	563	329
Average salary paid	$84,954	$85,242	$85,500	$83,896	$86,473	$120,773

Source: Annual 017 Staffing Report

The average annual salary, weighted across all health plans, was $91,640. Variances in the average salary across plans largely reflect the mix of positions located in the state. Some plans have a larger share of lower salary positions in the state, such as call center staff, whereas others have a larger share of higher salary positions in the state, such as clinical staff performing prior authorization functions.

Subsection 1.3 - Payments to Managed Care Organizations

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

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

In SFY 2024, the Department paid a total of $13,992,957,466[3] to the six contracted MCOs for all health plan members combined. The payments to each health plan were based on the number of members enrolled in one of two distinct member groups based on eligibility and coverage:

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

Total unduplicated enrollment in a Medicaid managed care plan for SFY 2024 was 2,028,712. Total enrollment, unduplicated within each group, was 1,874,056 full-benefit enrollees and 167,389 partial-benefit enrollees (NOTE: members can switch between full-benefit and partial-benefit coverage during the year based on their eligibility status). Variation in the average PMPM rate reflects differences in enrollment mix and risk adjustment across health plans. Managed care organizations with a larger share of enrollment from higher-cost eligibility groups had a higher average PMPM payment and vice-versa.

The data on payments to the health plans for each member group are provided separately in tables 1.3.1 for full-benefit enrollees and 1.3.2 for partial-benefit enrollees. The average PMPMs for each plan were calculated as the total of all payments made to a plan in a given month divided by the total membership for that plan in the same month.

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

[3] The payments to the MCOs is net of monetary penalties and adjustments assessed against the MCOs in SFY 2024 and may not equal payments to MCOs as reported in the Monthly Medicaid Forecast and the Medicaid Annual Report.

Table 1.3.1 Payments to MCOs for full-benefit enrollees by month, State Fiscal Year 2024

	ABH		ACLA		HBL	
	Total Payments	Average PMPM	Total Payments	Average PMPM	Total Payments	Average PMPM
Jul-23	$95,304,022	$619.17	$123,432,543	$598.38	$205,410,207	$634.61
Aug-23	$84,982,026	$560.94	$105,993,571	$523.74	$177,127,974	$557.09
Sep-23	$94,932,609	$639.52	$119,608,576	$604.49	$196,292,596	$631.64
Oct-23	$170,121,200	$1,166.60	$221,277,612	$1,144.34	$361,542,852	$1,190.52
Nov-23	$90,309,020	$628.98	$106,364,658	$562.32	$172,653,449	$578.82
Dec-23	$175,649,662	$1,243.26	$232,828,443	$1,255.28	$376,510,909	$1,288.33
Jan-24	$83,076,856	$578.18	$101,102,710	$578.50	$164,493,606	$571.32
Feb-24	$82,005,332	$579.15	$101,752,111	$594.41	$172,042,185	$608.50
Mar-24	$184,782,997	$1,325.77	$230,691,984	$1,375.67	$368,377,600	$1,327.56
Apr-24	$97,519,460	$711.09	$93,201,442	$568.59	$153,620,954	$566.80
May-24	$108,630,510	$806.31	$79,918,741	$499.63	$160,879,296	$608.90
Jun-24	$156,154,019	$1,179.56	$169,946,857	$1,090.37	$297,291,792	$1,156.83
Total	**$1,423,467,714**	**$830.76**	**$1,686,119,247**	**$777.77**	**$2,806,243,419**	**$804.78**
	HHH		**LHCC**		**UHC**	
	Total Payments	Average PMPM	Total Payments	Average PMPM	Total Payments	Average PMPM
Jul-23	$48,511,701	$357.07	$271,128,449	$558.27	$255,247,053	$597.81
Aug-23	$47,831,048	$352.72	$235,344,416	$491.68	$216,213,351	$514.78
Sep-23	$46,609,750	$347.71	$263,943,041	$560.84	$243,291,836	$591.06
Oct-23	$33,149,647	$248.70	$502,326,821	$1,082.93	$469,758,354	$1,162.08
Nov-23	$10,396,483	$77.15	$247,747,822	$541.52	$216,511,470	$543.67
Dec-23	$39,625,487	$291.73	$526,414,717	$1,165.36	$498,941,332	$1,272.18
Jan-24	$23,589,335	$174.43	$228,911,020	$514.73	$209,928,904	$543.47
Feb-24	$42,512,452	$316.68	$221,667,782	$506.15	$205,422,017	$541.06
Mar-24	$70,880,775	$532.75	$527,875,514	$1,225.18	$474,289,691	$1,273.56
Apr-24	$57,801,430	$443.94	$255,703,505	$604.60	$212,672,249	$582.76
May-24	$40,500,891	$320.99	$253,359,372	$611.98	$218,572,013	$613.31
Jun-24	$59,453,028	$486.49	$420,869,621	$1,036.98	$380,124,706	$1,091.22
Total	**$520,862,028**	**$327.48**	**$3,955,292,081**	**$737.33**	**$3,600,972,976**	**$772.53**

Source: LaGov and MARS Data Warehouse (MDW)

Notes - off-cycle payment adjustments for the managed care organization, SFY 2024:
Jul '23: Includes $129.5M in Managed Care Incentive Program (MCIP) payments.
Aug '23: July DOS PMPMs paid via lump sum pending approval of 7/1/23 rates
Sep '23: Aug DOS PMPMs paid via lump sum pending approval of 7/1/23 rates. Includes $134.9M in MCIP payments.
Oct '23: Sep DOS PMPMs paid via lump sum pending approval of 7/1/23 rates. Includes $739.9M in Directed Payments and $179.2M in MCIP payments.
Nov '23: Oct DOS PMPMs paid via lump sum pending approval of 7/1/23 rates. Includes -$36M for the Hepatitis C Risk Corridor reconciliation.
Dec '23: Nov DOS PMPMs paid via lump sum pending approval of 7/1/23 rates. Includes $739.9M in Directed Payments, $166.4M in MCIP payments, $826.2M for lump sum kick payment, and -$22M for Hepatitis C Risk Corridor reconciliation.
Jan '24: Dec DOS PMPMs paid via lump sum pending approval of 7/1/23 rates.
Feb '24: Jan DOS PMPMs paid via lump sum pending approval of 1/1/24 rates. Includes $22M in Directed Payments.
Mar '24: Feb DOS PMPMs paid via lump sum pending approval of 1/1/24 rates; Jul-Sep DOS PMPMs paid and previous lump sums recouped. Includes $735.3M in Directed Payments and $69.8M in MCIP payments.
Apr '24: Mar DOS PMPMs paid via lump sum pending approval of 1/1/24 rates; Oct-Dec 2023 and Jan 2024 DOS PMPMs paid and previous lump sums recouped.
May '24: Feb and Mar DOS PMPMs paid and previous lump sums recouped.
Jun '24: Includes $731.6M in Directed Payments and $51.2M in MCIP payments.

Table 1.3.2 Payments to MCOs for partial-benefit enrollees by month, State Fiscal Year 2024[4]

	ABH		ACLA		HBL	
	Total Payments	Average PMPM	Total Payments	Average PMPM	Total Payments	Average PMPM
Jul-23	$929,863	$41.64	$930,868	$43.42	$1,142,627	$43.02
Aug-23	$20,836	$0.95	$3,534	$0.17	$8,464	$0.32
Sep-23	($7,106)	($0.33)	($4,877)	($0.23)	$7,004	$0.27
Oct-23	($58,109)	($2.74)	($24,816)	($1.22)	($28,837)	($1.15)
Nov-23	$21,599	$1.04	$6,420	$0.32	$12,882	$0.52
Dec-23	($30,817)	($1.52)	($15,929)	($0.81)	($14,576)	($0.60)
Jan-24	($163,464)	($8.17)	($17,811)	($0.93)	($34,628)	($1.46)
Feb-24	($4,105)	($0.21)	$178	$0.01	($6,816)	($0.29)
Mar-24	$2,611,334	$135.04	$2,609,700	$140.59	$3,198,121	$138.80
Apr-24	$3,264,631	$172.16	$3,164,344	$173.22	$4,001,588	$176.70
May-24	$2,804,002	$149.50	$2,759,685	$152.73	$3,473,338	$155.66
Jun-24	$846,614	$46.24	$818,300	$45.85	$1,081,544	$49.30
Total	**$10,235,279**	**$42.10**	**$10,229,595**	**$43.71**	**$12,840,712**	**$44.38**
	HHH		**LHCC**		**UHC**	
	Total Payments	Average PMPM	Total Payments	Average PMPM	Total Payments	Average PMPM
Jul-23	$242,949	$31.28	$1,384,550	$43.93	$1,401,674	$41.64
Aug-23	$55,950	$6.62	$11,692	$0.38	$20,749	$0.63
Sep-23	($58,563)	($6.46)	($11,789)	($0.38)	$11,772	$0.36
Oct-23	($96,196)	($10.07)	($57,375)	($1.90)	($66,166)	($2.07)
Nov-23	$7,634	$0.78	$15,485	$0.52	$19,553	$0.62
Dec-23	($37,466)	($3.66)	($28,720)	($0.99)	($52,653)	($1.71)
Jan-24	($23,727)	($2.08)	($48,003)	($1.68)	($84,645)	($2.78)
Feb-24	($11,076)	($0.96)	($10,515)	($0.37)	($10,758)	($0.36)
Mar-24	$921,512	$78.82	$3,878,391	$139.94	$3,994,215	$134.85
Apr-24	$1,488,109	$127.98	$4,831,901	$176.75	$4,968,132	$170.48
May-24	$1,552,818	$135.35	$4,206,566	$156.05	$4,340,863	$151.24
Jun-24	$466,510	$41.56	$1,290,178	$48.78	$1,312,176	$46.65
Total	**$4,508,454**	**$36.40**	**$15,462,362**	**$44.51**	**$15,854,913**	**$42.87**

Source: LaGOV and MARS Data Warehouse (MDW).

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

Subsection 1.4 - Number of Healthcare Providers

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

Timely access to necessary healthcare for Medicaid members is an important goal of the Medicaid managed care program. Contracts with the health plans required them to maintain minimum ratios of contracted providers to enrollees for both primary care and specialty physicians. The Department conducts ongoing monitoring of the number of contracted providers in each health plan and requires plans to submit geospatial analyses with provider locations. The Department receives the total number of contracted providers for each health plan through weekly provider network registries submitted by the plans. It is important to note that the total number of healthcare providers contracting with a health plan cannot be used in isolation as an indicator of network adequacy and member access. Provider networks may consist of both in-state and out-of-state providers. Some contracted providers may limit the number of health plan enrollees they will see or have "closed their panels" to new plan members, in order to maintain access and quality of care for current clients. Subsection 1.6 includes data on primary care providers with closed panels.

Per contract requirements, the health plans submitted a registry of all providers that have contracted with the health plan, as well as any provider who was not in-network but was paid for services as an out-of-network provider or under a single-case agreement. As specified in the authorizing legislation, the data reported in subsections 1.4, 1.5, and 1.6 of this report are for contracted providers to reflect the in-network capacity of each health plan. Based on LDH findings and data user recommendations for improving the utility of this data set, the methodology for compilation of network providers was refined in 2017 to exclude out-of-state providers, unless they were located in a county directly bordering Louisiana. This is considered more reflective of local accessibility and is consistent with prior years' reporting.

In SFY 2024, one or more of the six managed care plans contracted 69,933 providers to provide services to the Louisiana Medicaid managed care population. Provider counts by plan, provider type, taxonomy, and parish are provided in Appendix I. It should be noted, however, that the unduplicated totals below will not match the provider totals in Appendix I, as providers can enroll as more than one provider type, under multiple taxonomies, and in more than one parish.

Table 1.4.1 Total unduplicated[5] count of contracted providers by health plan, State Fiscal Year 2024[6]

	ABH	ACLA	HBL	HHH	LHCC	UHC	Total
Total Contracted Providers	17,672	39,842	36,711	28,327	45,579	37,722	**69,933**

Source: MARS Data Warehouse, June 28, 2024 Provider Registry

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

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

Subsection 1.5 - Primary Care Service Providers

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

The methodology for identifying primary care providers changed in the current SFY. Previously, primary care providers were based on both the provider's designation as a primary care provider (i.e., PCP indicator code) and the provider's specialty of general practice, gynecology, pediatrics, internal medicine, federally qualified health center, clinic or other group practice, nurse practitioner, rural health clinic, or physician assistant. In the current SFY, primary care providers were identified by the provider's designation as a primary care provider (i.e., PCP indicator code) regardless of the provider's specialty.

Total unduplicated provider counts for SFY 2024 are presented in Table 1.5.1. Appendix II lists primary care providers, categorized by provider type, provider taxonomy, and parish, with at least one claim. It should be noted, however, that the unduplicated totals in Table 1.5.1 below may not match the provider totals in Appendix II as PCPs can enroll as more than one provider type, under multiple taxonomies and in more than one parish.

Table 1.5.1 Total contracted primary care providers with at least one claim, State Fiscal Year 2024[7,8]

	ABH	ACLA	HBL	HHH	LHCC	UHC	Total
Total Contracted PCPs	1,434	5,069	4,445	5,095	3,909	6,587	**11,107**
PCPs with at least one claim	780	3,826	3,612	3,296	2,924	4,822	**7,079**
Percent with at least one claim	54.4%	75.5%	81.3%	64.7%	74.8%	73.2%	**63.7%**

Source: MARS Data Warehouse; June 28, 2024 Provider Registry

[7] Individual provider counts for each plan are unduplicated by National Provider Identifier numbers; however, some provider groups or clinics may have multiple National Provider Identifier numbers for their multiple functions and may be counted multiple times. Total is a count of unique NPIs across all plans.
[8] Includes only providers with locations in Louisiana or within a border county.

Subsection 1.6 - Contracted Providers with a Closed Panel

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

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

PCPs that contracted with health plans had the option to close their panels or stop accepting new patients under certain circumstances, such as ensuring the quality of care for members. Each health plan sets a plan-specific policy on which providers can close their panels, when a panel can be closed, how to inform the health plan when a panel is closed or reopened, and how closed panels are tracked.

The Department extracted data for the providers with a closed panel from provider registry files submitted by each MCO. Table 1.6.1 displays the number of primary care physicians (PCPs) with a closed panel by health plan as of June 28, 2024. Additional data, organized, by provider type, taxonomy, and parish, can be found in Appendix III. The unduplicated totals in Table 1.6.1 below do not necessarily align with the provider totals in Appendix III as providers can enroll as more than one provider type, under multiple taxonomies, and in more than one parish.

Table 1.6.1 Total contracted primary care providers with a closed panel, State Fiscal Year 2024[9,10]

	ABH	ACLA	HBL	HHH	LHCC	UHC	Total
Total Contracted PCPs	**1,434**	**5,069**	**4,445**	**5,095**	**3,909**	**6,587**	**11,107**
PCPs with a Closed Panel	249	820	887	592	1,378	1,587	**3,901**
Percent with a Closed Panel	17.4%	16.2%	20.0%	11.6%	35.3%	24.1%	**35.1%**

Source: MARS Data Warehouse; June 28, 2024 Provider Registry

[9] Individual provider counts for each plan are unduplicated by National Provider Identifier numbers; however, some provider groups or clinics may have multiple National Provider Identifier numbers for its multiple functions and may be counted multiple times. Total is a count of unique NPIs across all plans.
[10] Includes only providers with locations in Louisiana or within a border county.

Subsection 1.7 - Medical Loss Ratio

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

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

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

Note: During the current SFY, the MLR reports changed from a calendar year (CY) reporting basis to a SFY reporting basis. As a result, Myers and Stauffer performed an examination of each MCO's MLR data for the period January 1, 2023 through June 30, 2023.

Table 1.7.1 Medical loss ratios (MLR), Calendar Year 2023[11]

	Adjusted YTD MLR Capitation Revenue	Total Adjusted MLR Expense	MLR Percentage	Rebate Required
ABH	$613,367,166	$564,443,517	92.0%	$0
ACLA	$798,753,099	$729,359,220	91.3%	$0
HBL	$1,284,323,358	$1,207,365,140	94.0%	$0
HHH	$0	$0	0.0%	$0
LHCC	$1,784,934,556	$1,707,011,677	95.6%	$0
UHC	$1,654,567,149	$1,596,181,697	96.5%	$0

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

Table 1.7.2 Breakdown of total adjusted MLR, Calendar Year 2023[11]

	Patient Care	Quality Improvement	Information Technology	Other	Total Adjusted MLR Expense
ABH	$556,353,547	$8,089,969	$0	$0	$564,443,517
ACLA	$719,623,039	$7,478,156	$2,258,025	$0	$729,359,220
HBL	$1,197,087,959	$9,110,530	$1,757,981	$0	$1,207,365,140
HHH	$146,994,901	$10,232,191	$682,650	$0	$0
LHCC	$1,691,911,535	$13,103,547	$1,996,596	$0	$1,707,011,677
UHC	$1,574,085,564	$17,423,004	$4,918,955	$0	$1,596,181,697

Source: MSLC Audited Medical Loss Ratio Reports

[11] Includes Expansion and Non-Expansion populations

Subsection 1.8 - External Quality Review

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

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

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

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

Among the various processes and measures reviewed by the EQRO, each annual report includes two years of data on 31 standard HEDIS® measures, as compared to the Quality Compass® South Central Medicaid Benchmark and the most current Healthy Louisiana average. The technical reports are available online at ldh.la.gov/resources/EQR.

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

Subsection 1.9 - Member and Provider Satisfaction Surveys

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

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

Member Satisfaction Survey

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

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

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

Provider Satisfaction Survey

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

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

The full provider survey reports for each health plan are available in Appendix IV: MCO Satisfaction Surveys.

Subsection 1.10 - Audited Financial Statements

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

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

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

The full financial statements for each plan are available in Appendix V. These statements cover the calendar Year 2023, which was reported during the state fiscal year 2024.

Subsection 1.11 - Sanctions Levied by the Department

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

Actions or inactions by the Medicaid managed care entities that are subject to sanction by the Department are specified in 42 CFR §438.700, et seq., and delineated in the LDH Medicaid managed care contracts. In SFY 2024, no sanctions were levied against any of the Medicaid managed care entities.

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

Section 2 - Managed Care Organization Enrollees

Subsection 2.1 - 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.

Of the total 2,186,060 unduplicated individuals enrolled in Louisiana Medicaid in SFY 2024, 2,028,712 (93%) unduplicated individuals were enrolled in a health plan for one or more months during the year. The majority of health plan members received full-benefit coverage. Some enrollees are enrolled in a health plan for partial benefits only, specifically covering nonemergency medical transportation and specialized behavioral health services. These enrollees receive their physical and acute care through fee for service.

Table 2.1.1 below provides a breakdown of enrollment totals by health plan and benefit group. This table represents unduplicated enrollment in each health plan throughout the year.

Table 2.1.1 Total enrollees by health plan and benefit group, State Fiscal Year 2024

	ABH	ACLA	HBL	HHH	LHCC	UHC	Total[12]
Full-benefit enrollees	186,798	223,503	366,543	182,485	530,419	472,242	**1,874,056**
Partial-benefit enrollees	25,513	23,755	30,690	15,827	35,943	39,105	**167,389**
Total (unduplicated)	210,791	245,751	394,561	197,620	563,378	508,300	**2,028,712**

Source: MARS Data Warehouse

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

For purposes of health plan reimbursement, enrollees were assigned to one of the eligibility categories listed below in SFY 2024:

- *Families and Children*: Children and teens under the age of 19 whose basis of Medicaid or LaCHIP eligibility was age, along with their parents or caregivers. This group also includes pregnant women whose primary basis of eligibility for Medicaid is pregnancy. Children with disabilities are not included in this group.

- *People with disabilities and Supplemental Security Income (SSI) seniors*: Individuals 65 and above, as well as individuals of any age, including children with disabilities.

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

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

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

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

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

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

- *Adult Group Expansion*: Adults between the ages of 19 and 64 (including both parents and adults without dependent children) with household incomes below 138% of FPL, not otherwise qualified for Medicaid or Medicare.

- *Act 421 Children's Medicaid Option, TEFRA Program:* Certain children under 19 years of age who qualify as an individual with a disability under Section 1614(a) of the Social Security Act, even if their parents earn too much money to qualify for Medicaid.

Tables 2.1.2 and 2.1.3 below provide the average monthly number of enrollees by eligibility category for full-benefit and partial-benefit coverage, respectively.

Table 2.1.2 Average full-benefit enrollees each month by eligibility category, State Fiscal Year 2024

	ABH	ACLA	HBL	HHH	LHCC	UHC
Families & Children	60,030	93,250	124,566	70,166	242,725	201,886
Foster Care	1,166	515	4,445	193	6,944	1,422
LaCHIP Affordable Plan	181	229	423	261	667	669
SSI	9,136	13,641	19,849	5,399	27,804	25,600
BCC	26	42	63	13	71	83
IMD	6	7	11	2	3	9
HCBS Waiver	470	533	911	65	1,418	1,241
Chisholm	325	499	957	99	1,767	1,286
Act 421 (TEFRA)	216	106	556	126	365	414
Adult Group Expansion	71,234	71,837	138,801	56,220	165,265	155,832
Total – All Categories	142,788	180,659	290,582	132,543	447,027	388,441

Source: MARS Data Warehouse

For the partial-benefit-only population, the breakdown of average monthly membership by health plan and eligibility category for state fiscal year 2024 is presented in Table 2.1.3. The average monthly enrollment is lower than the total unduplicated count for the year presented in Table 2.1.1 because each month some members lost eligibility, while others were newly enrolled.

Table 2.1.3 Average partial-benefit enrollees each month by eligibility category, State Fiscal Year 2024

	ABH	ACLA	HBL	HHH	LHCC	UHC
Chisholm	151	187	315	31	403	353
HCBS Waiver	646	603	852	46	924	983
Dual Eligible	19,019	18,265	22,229	10,114	26,762	28,608
Other[13]	445	449	716	131	861	874
Total - All Categories	20,261	19,504	24,112	10,321	28,950	30,817

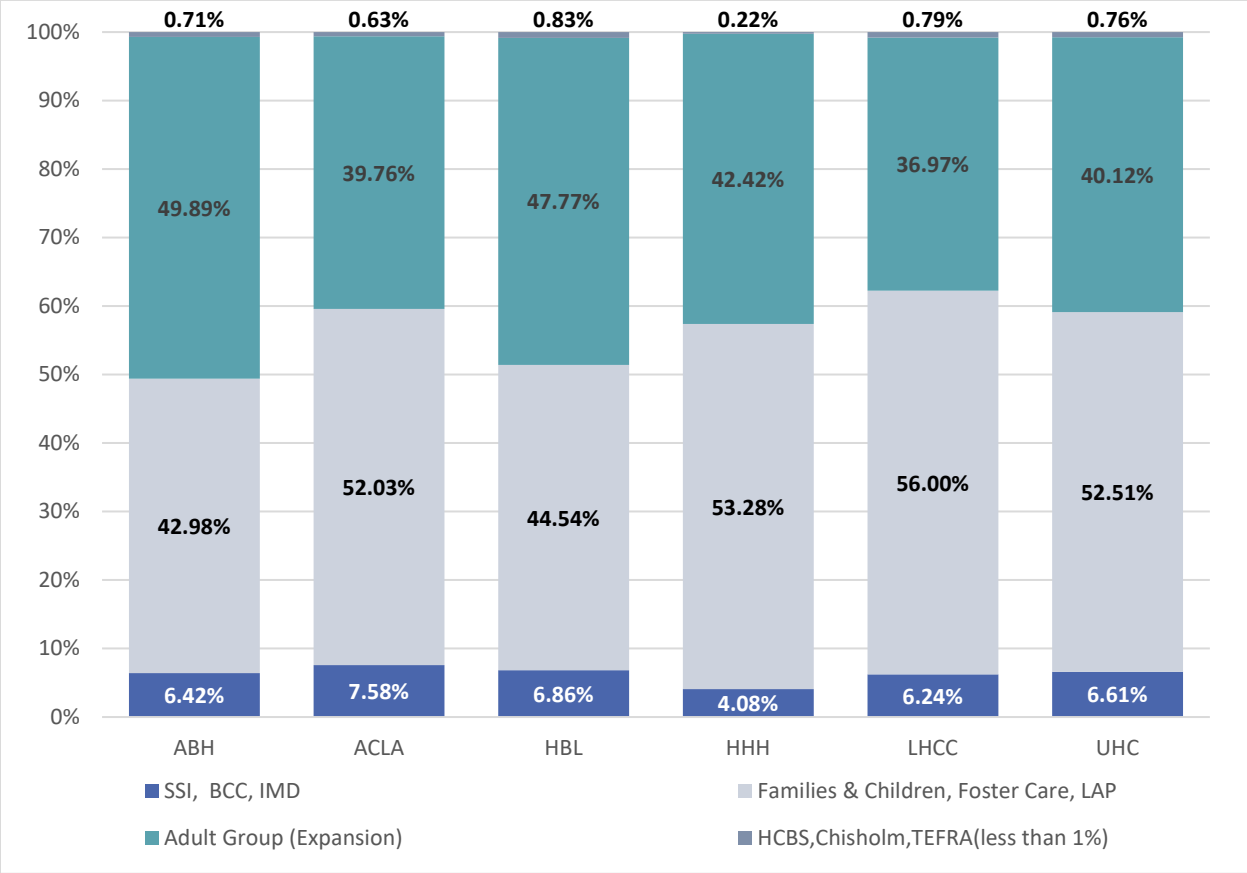
Source: MARS Data Warehouse

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

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

population. As an example, individuals in the Family and Children and the LaCHIP Affordable Plan eligibility categories are generally healthier and less costly per member as compared to the SSI, Foster Care, Breast and Cervical Cancer, Home and Community-Based Services, IMD, and Chisholm groups. Differences in the percent distribution of total enrollment by member demographics are important factors when examining the number and types of providers, services, utilization, and costs for each health plan. The distribution of full benefit members enrolled in each health plan by eligibility category and enrollment type is displayed in Figure 2.1.1.

Figure 2.1.1 Full benefit membership distribution by eligibility category, State Fiscal Year 2024



Source: MARS Data Warehouse

Subsection 2.2 - Proactive Choice and Auto-Enrollment

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

One of the goals of the Medicaid managed care program is to engage members in selecting the health plan that best meets their needs. Factors that influence the decision include the value-added benefits offered by a given plan and whether one's preferred providers participate in the plan's network. Health plan enrollment and disenrollment are managed by the Department's contracted enrollment broker, Maximus. As required by federal Medicaid regulations, the enrollment broker is independent and free from conflict of interest. Through the enrollment broker, members can self-select their health plan when initially enrolled in Medicaid and once annually thereafter during open enrollment.

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

Existing Medicaid members can change their health plan during the specified open enrollment period. The open enrollment period in SFY 2024 was from October 15, 2023, to November 30, 2023. Changes made during this period took effect on January 1, 2024. If a member did not make a change, they kept their current health plan. Open Enrollment is the only time, outside of the initial enrollment period, that Medicaid enrollees can change health plans without a qualifying reason.

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

Table 2.2.1 provides the individual plan and aggregate choice rates for SFY 2024. There were no changes in the methodology used for calculating the choice rate. In aggregate, the proactive choice rate was just under 65% for SFY 2024. The rate varies by plan. The Department continues to work with the enrollment broker and other stakeholders to inform and educate members about Medicaid managed care, available health plans, and the process for selecting the plan of their choice.

Table 2.2.1 Proactive choice rates, State Fiscal Year 2024

	ABH	ACLA	HBL	HHH	LHCC	UHC	Total
Pro-active Choice Enrollments	19,238	12,521	33,210	9,328	38,434	39,675	**152,406**
Auto Enrollments	7,176	6,921	9,692	42,121	8,837	7,577	**82,324**
Total Enrollments	26,414	19,442	42,902	51,449	47,271	47,252	**234,730**
Choice rate	72.83%	64.40%	77.41%	18.13%	81.31%	83.96%	**64.93%**

Source: Maximus Health Services

Subsection 2.3 - Enrollees Who Received Services

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

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

Table 2.3.1 shows the unduplicated counts and percent of members who received services in SFY 2024. During this reporting period, 1,649,626 members received one or more Medicaid services through their health plan, resulting in an overall rate of 81.31% of members across all plans. Rates for individual plans demonstrate variation across plans with a range of 67% (Humana) to 90% (United HealthCare).

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

Table 2.3.1 Enrollees who received services, State Fiscal Year 2024

	ABH	ACLA	HBL	HHH	LHCC	UHC	Total[14]
Unduplicated count of enrollees	210,791	245,751	394,561	197,620	563,378	508,300	**2,028,712**
# Receiving 1 or more service	175,198	219,349	323,194	132,694	495,203	458,981	**1,649,626**
% Receiving 1 or more service	83.11%	89.26%	81.91%	67.15%	87.90%	90.30%	**81.31%**

Source: MARS Data Warehouse

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

Subsection 2.4 - Enrollees Who Had a Primary Care Visit

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

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

The data in Table 2.4.1 shows the number and percentage of members who had at least one visit with a PCP to which they were linked during SFY 2024. Though members are linked to a PCP, they are not prohibited from seeking care from other providers. It is important to note that this table does not include data on members who had a visit for primary care services rendered by an individual provider to which the member was not linked at the time. The data reflect legislative reporting specific to R.S. 40:1253.2 and, as such, may exclude other primary care access points.

Table 2.4.1 Enrollees who had at least one visit with their primary care provider, State Fiscal Year 2024

	ABH	ACLA	HBL	HHH	LHCC	UHC	Total[15]
Full-benefit enrollees	186,798	223,503	366,543	182,485	530,419	472,242	**1,874,056**
With at least 1 PCP visit	15,431	60,654	72,758	10,805	124,088	97,429	**380,543**
Percentage	8.26%	27.14%	19.85%	5.92%	23.39%	20.63%	**20.31%**

Source: MARS Data Warehouse

To provide additional information on access to primary care beyond a member's linked PCP, the counts of members who had at least one visit to any primary care provider are also compiled and presented in Table 2.4.2. This expanded data demonstrates that 57% of all managed care enrollees had at least one primary care visit with any PCP versus 20% who received at least one visit with their specific PCP.

Table 2.4.2 Enrollees who had at least one visit with any primary care provider, State Fiscal Year 2024

	ABH	ACLA	HBL	HHH	LHCC	UHC	Total[15]
Full-benefit enrollees	186,798	223,503	366,543	182,485	530,419	472,242	**1,874,071**
With at least 1 PCP visit	76,853	130,675	191,260	85,152	313,697	295,776	**1,069,781**
Percentage	41.14%	58.47%	52.18%	46.66%	59.14%	62.63%	**57.08%**

Source: MARS Data Warehouse

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

Subsection 2.5 - Hospital Services Provided

The following information concerning hospital services provided to Medicaid enrollees:

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

Table 2.5.1 lists the total number of members receiving unduplicated outpatient emergency services for SFY 2024. For comparability across health plans, the rate per 1,000 total health plan members was calculated to account for variation in total member counts. Louisiana Healthcare Connections had the highest rate of members receiving unduplicated outpatient emergency services, at 332 per 1,000 members, while Humana had the lowest rate of 245 per 1,000 members, however no plan was a significant outlier. In total, the rate across all health plans was 324 per 1,000 total health plan members.

Table 2.5.1 Enrollees who received outpatient emergency services, State Fiscal Year 2024

	ABH	ACLA	HBL	HHH	LHCC	UHC	Total[16]
Enrollees Receiving outpatient emergency services	58,473	70,608	112,833	44,773	175,911	152,160	**606,841**
Total full-benefit enrollees	186,798	223,503	366,543	182,485	530,419	472,242	**1,874,056**
Rate per 1,000 full-benefit enrollee	313	316	308	245	332	322	**324**

Source: MARS Data Warehouse

Table 2.5.2 lists the total inpatient Medicaid days for SFY 2024. As with other data, variability is expected because of the distinct characteristics of each plan's membership. The rate of total inpatient Medicaid days across all health plans for SFY 2024 was 370 per 1,000 enrollees.

Table 2.5.2 Total inpatient Medicaid days, State Fiscal Year 2024

	ABH	ACLA	HBL	HHH	LHCC	UHC	Total[16]
Total Inpatient Medicaid Days	67,613	78,979	140,240	54,676	192,113	158,930	**692,551**
Rate per 1,000 full-benefit enrollees	362	353	383	300	362	337	**370**

Source: MARS Data Warehouse

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

To better understand the relationship between access to primary care and the use of outpatient emergency services, the Department has expanded the data to examine not only the 12 months preceding the use of outpatient emergency services, but also the six months following its use. Table 2.5.3 summarizes the data for individual periods before and after receiving emergency services. Both unduplicated enrollee counts and rates per total enrollees receiving outpatient emergency services are presented for comparability across health plans.

Table 2.5.3 Enrollees who saw a PCP before or after an emergency room visit, State Fiscal Year 2024[17]

		ABH	ACLA	HBL	HHH	LHCC	UHC	Total[18]
12 months before outpatient emergency service[19]	#	37,689	55,150	79,929	28,689	128,271	118,923	**443,037**
	%	64.5%	78.1%	70.8%	64.1%	72.9%	78.2%	**73.0%**
6 months after outpatient emergency service[19]	#	31,283	47,032	67,763	25,254	106,650	103,115	**376,911**
	%	53.5%	66.6%	60.1%	56.4%	60.6%	67.8%	**62.1%**
12 months before or 6 months after outpatient emergency service[19]	#	42,726	60,030	88,360	33,730	139,562	128,970	**486,775**
	%	73.1%	85.0%	78.3%	75.3%	79.3%	84.8%	**80.2%**

Source: MARS Data Warehouse

[17] In this section, a primary care provider is defined as any provider of primary care services and is not necessarily the primary care provider the member is linked to, as identified in Subsection 2.4 of this report.
[18] Totals by health plan cannot be summed as members can switch between health plans throughout the year and may be counted in each health plan total, but are only once in the unduplicated total.
[19] The percentage is calculated as the percent of total unduplicated members who received an outpatient emergency service as identified in Subsection 2.5.

Subsection 2.6 - Members That Filed Appeals or Accessed State Fair Hearings

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

Health plan enrollees have the right to file appeals with both the health plan and the state if they believe they have been unfairly denied benefits or access to services. Federal law requires health plans to administer a system for members to file appeals, and all states are required to review health plan reports on both the frequency and nature of appeals filed, as well as the steps health plans take to remedy such appeals. States must also provide an opportunity for a fair hearing to members whose appeal is either denied or not promptly acted upon by the health plan. An appeal, which must be acted on within 30 days, is a request by a member to review one of the following actions that a health plan has taken:

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

As part of its quality strategy, each state must require health plans to maintain records of appeals and submit them for state review. When reviewing the records, the Department analyzed the subjects of the plans' appeals to determine the extent to which they are valid and are actually under the control of the health plan. The health plans and the Department both sought trends and utilized the reports to identify the need for operational changes and improvements.

Across all six health plans, a total of 5,736 appeals and state fair hearing (SFH) determinations were made in state fiscal year 2024, 36.3% of which resulted in a full or partial reversal in favor of the member.

Table 2.6.1 Appeals and state fair hearings, State Fiscal Year 2024

	ABH	ACLA	HBL	HHH	LHCC	UHC
Total Members (unduplicated)	**210,791**	**245,751**	**394,561**	**197,620**	**563,378**	**508,300**
Members who filed an appeal	360	544	1,289	71	1,552	1,297
Members who accessed SFH	14	7	18	3	50	31
Total appeals filed at MCO level	375	554	1,327	86	1,887	1,365
Total appeals filed at SFH level	15	7	18	2	51	31
Total appeal & SFH determinations[20]	390	591	1,355	86	1,913	1,401
Total determinations fully or partially reversed in favor of the member	153	240	211	27	907	542
% of determinations fully or partially reversed in favor of the member	39.2%	40.6%	15.6%	31.4%	47.4%	38.7%

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

[20] Total determinations may include determinations made in SFY 2024 for appeals received in a prior year.

Section 3 - Healthcare Services Provided to Enrollees

Subsection 3.1 - Claims Submitted by Healthcare Providers

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

Health plans report claims data annually using the revised 177 reporting template developed by the Department, which captures unduplicated counts of claims received by each health plan. This report captures not only claims that are adjudicated (processed for payment or denial) but also rejected claim counts that are not reported in encounter submissions to the fiscal intermediary. In SFY 2024, the aggregate count of claims submitted to all health plans totaled 123,455,590. The breakdown of claim counts for SFY 2024 is presented in Table 3.1.1.

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

All claims accepted in the system for adjudication (i.e., determination of payment or denial) can be categorized as either emergency or nonemergency. Of the total claims adjudicated by a health plan, 4% were for emergency services. For this report, the Department defined emergency services as outpatient services provided in an emergency room, excluding the Emergency Medical Treatment and Labor Act (EMTALA) screening or urgent care, and professional services, specifically the evaluation and management of a patient, provided in an emergency room setting. Nonemergency services are defined as all claims that do not fall under the definition of emergency services.

Table 3.1.1 Total claims submitted, State Fiscal Year 2024

	Total Claims Submitted	Rejected	Emergency Services[21]	Non-Emergency Services
ABH	13,327,610	109	452,406	12,875,204
ACLA	13,426,795	32,980	346,623	13,080,172
HBL	21,884,514	9,473	2,279,624	19,604,890
HHH	2,721,657	39,098	192,086	2,529,571
LHCC	32,164,985	520,071	821,266	31,343,719
UHC	39,930,029	56,935	1,144,687	38,785,342
Total	**123,455,590**	**658,666**	**5,236,692**	**118,218,898**

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

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

Subsection 3.2 - Denied Claims

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

Table 3.2.1 below provides total unduplicated denied claims by health plan, delineated by emergency and nonemergency services.

Table 3.2.1 Total unduplicated denied claims, State Fiscal Year 2024

	Emergency Services	Non-Emergency Services	Total
ABH	59,825	3,084,526	**3,144,351**
ACLA	24,694	2,469,797	**2,494,491**
HBL	138,468	4,141,686	**4,280,154**
HHH	15,621	615,530	**631,151**
LHCC	63,482	7,252,575	**7,316,057**
UHC	152,816	10,763,136	**10,915,952**
Total	**454,906**	**28,327,250**	**28,782,156**

Source: 177 Total Claims Summary Report

Records for each denied claim must include a reason for the denial. The Department required plans to report these denials using claim adjustment reason codes (CARC) for medical and behavioral health claims, as well as the National Council for Prescription Drug Program (NCPDP) reject codes for pharmacy claims, both of which are national standards. Since each claim line can have more than one CARC or NCPDP reject code, the number of CARC and NCPDP codes will be greater than the unduplicated number of total denied claims presented in Table 3.2.1. In other words, a claim can be denied or adjusted for multiple reasons. As a claim cycles through the payment logic, the claims processing system applies all applicable CARC or NCPDP reject codes randomly, and one is not primary in comparison to another.

Table 3.2.2 shows the ten most frequently used CARC codes for emergency and nonemergency medical and behavioral health claims. The primary causes for denial were duplicate claims, non-covered charges, claim/service lacking information, the benefits for this service are included in the payment/allowance for another service, and precertification/authorization is absent. A breakout of all CARCs for denied claims, listed in numerical order by health plan, is provided in Appendix VII.

Table 3.2.2 Top ten claim adjustment reason codes (CARCs), State Fiscal Year 2024

CARC	CARC Description	Emergency Claims[22]	Non-Emergency Claims	Total
96	Non-covered charge(s).	30,448	1,899,537	**1,929,985**
16	Claim/service lacks information or has submission/billing error(s).	42,576	1,453,093	**1,495,669**
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	37,834	1,295,146	**1,332,980**
147	Provider contracted/negotiated rate expired or not on file.	1,115	945,526	**946,641**
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	37,155	850,305	**887,460**
252	An attachment/other documentation is required to adjudicate this claim/service.	46,816	824,710	**871,526**
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	17,679	829,080	**846,759**
197	Precertification/authorization/notification/pre-treatment absent.	1,042	707,892	**708,934**
133	The disposition of this service line is pending further review.	35,929	636,909	**672,838**
246	This non-payable code is for required reporting only.	5	608,735	**608,740**

Source: 173 Denied Claims Report

[22] Emergency services are defined as Claim Type 03 (Outpatient Services) with Revenue Codes 450, 451, and 981 (Outpatient Hospital) and Claim Type 04 (Professional Services) with Procedure Codes 99281 through 99285 (Professional).

Table 3.2.3 shows the ten most frequently used NCPDP reject codes for emergency and non-emergency pharmacy claims. Pharmacy claims utilize a distinct national coding structure compared to medical or behavioral health claims. For consistency with encounter data, the Department has utilized the structure published by NCPDP to monitor reasons for claims denials.

Table 3.2.3 Top Ten NCPDP codes for denial of pharmacy services, State Fiscal Year 2024

NCPDP Code	NCPDP Description	Emergency Claims[23]	Non-Emergency Claims	Total
88	Drug Utilization Review (DUR) Reject Error	355	3,631,995	**3,632,350**
79	Refill Too Soon	186	1,742,703	**1,742,889**
76	Plan Limitations Exceeded	730	1,740,266	**1,740,996**
39	M/I Diagnosis Code	111	1,579,204	**1,579,315**
80	Drug-Diagnosis Mismatch	0	1,110,821	**1,110,821**
70	Product/Service Not Covered – Plan/Benefit Exclusion	41	1,103,207	**1,103,248**
75	"Prior Authorization Required (may be used when drug formulary status is set as prior authorization required)"	153	1,097,468	**1,097,621**
41	Submit Bill To Other Processor Or Primary Payer	25	883,817	**883,842**
69	Filled After Coverage Terminated	8	880,393	**880,401**
68	Filled After Coverage Expired	2	527,133	**527,135**

Source: 173 Denied Claims Report

[23] Emergency pharmaceutical services are defined as Claim Type 12 (Pharmacy) with NCPDP field 418-DI value of 3.

Subsection 3.3 - Clean Claims

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

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

Table 3.3.1 lists the total clean claims submitted to each health plan. This total includes claims that were paid, denied, or otherwise adjudicated. It does not include rejected claims or those that do not meet the definition of a clean claim.

Table 3.3.1 Clean claims Submitted, State Fiscal Year 2024

	ABH	ACLA	HBL	HHH	LHCC	UHC
Total Submitted	**11,130,407**	**12,364,489**	**22,202,652**	**5,265,820**	**31,552,988**	**26,592,724**
Paid	7,779,736	9,885,158	16,941,134	3,656,648	24,805,909	20,699,547
Denied	3,350,671	2,479,331	5,261,518	1,609,172	6,747,079	5,893,177

Source: 221 Prompt Pay Report

Beginning January 1, 2023, health plans were required by contract to pay 90% of all payable clean claims within 15 calendar days of the date of receipt of the claim. The percentages reported in Table 3.3.2 reflect total contract compliance, based on the criteria in effect since January 1, 2023.

In addition, health plans are required to pay 99% of all clean claims within 30 calendar days of the date of receipt (Table 3.3.2). For any clean claim not paid within 30 days, the plan must pay providers interest at 12% per annum of the amount payable, calculated daily, for the full period in which the clean claim remains unpaid beyond the 30-day claims processing deadline.

It is worth noting that the adjudicated date and paid date may not be the same. It often occurs that a claim is adjudicated, i.e. the decision is made to pay or deny, but payment may not be issued until the next weekly check cycle. This information reflects the actual payment date as required by statutory reporting requirements.

Table 3.3.2 Percent of paid clean claims that were paid within 15 days[24], State Fiscal Year 2024

CLAIM TYPE	ABH	ACLA	HBL	HHH	LHCC	UHC
Inpatient Hospital	90.64%	97.45%	91.50%	99.63%	93.63%	99.96%
Outpatient Hospital	95.75%	93.31%	97.71%	99.88%	99.28%	99.99%
Professional	97.88%	96.54%	99.49%	99.88%	99.55%	99.97%
Rehabilitation	98.58%	n/a	99.41%	99.96%	n/a	99.98%
Home Health	89.72%	93.97%	97.30%	99.70%	99.80%	100.00%
Ambulance (Emergency & Non-Emergency)	96.95%	98.76%	99.18%	99.83%	96.85%	99.97%
Non-Emergency Medical Transportation	99.99%	99.68%	99.99%	100.00%	99.67%	99.27%
Durable Medical Equipment (DME)	97.55%	94.62%	98.34%	99.86%	99.52%	99.96%
Dental Adult (value added service)	100.00%	n/a	100.00%	100.00%	99.82%	100.00%
Pharmacy	99.78%	99.79%	99.76%	99.77%	99.78%	99.81%
Total - All Claim Types	**98.00%**	**96.72%**	**99.16%**	**99.86%**	**99.53%**	**99.91%**

Source: 221 Prompt Pay Report

Table 3.3.3 Percent of paid clean claims that were paid within 30 calendar days, State Fiscal Year 2024

CLAIM TYPE	ABH	ACLA	HBL	HHH	LHCC	UHC
Inpatient Hospital	99.76%	100.00%	97.40%	99.99%	99.57%	100.00%
Outpatient Hospital	99.15%	100.00%	99.51%	99.99%	99.97%	100.00%
Professional	99.80%	100.00%	99.97%	99.98%	99.95%	100.00%
Rehabilitation	100.00%	n/a	99.95%	100.00%	n/a	100.00%
Home Health	99.55%	100.00%	99.79%	100.00%	100.00%	100.00%
Ambulance (EMT & NEAT)	99.82%	100.00%	99.88%	99.94%	99.98%	100.00%
Non-Emergency Medical Transportation	99.99%	100.00%	99.99%	100.00%	99.95%	100.00%
Durable Medical Equipment (DME)	99.83%	99.97%	99.91%	99.96%	99.99%	100.00%
Dental Adult (VAS)	100.00%	n/a	100.00%	100.00%	100.00%	100.00%
Pharmacy	99.79%	99.79%	99.80%	99.77%	99.78%	99.81%
Total - All Claim Types	**99.65%**	**99.95%**	**99.82%**	**99.95%**	**99.91%**	**99.94%**

Source: 221 Prompt Pay Report

[24] Starting January 1, 2023, the contract requirement specified compliance to 15 "calendar" days. The percentages reported are total contract compliance based on the updated criteria in effect since January 1, 2023.

On average, health plans took longer to issue payments for the following claim types: Inpatient, Non-Emergency Medical Transportation (NEMT), and Pharmacy. However, all health plans paid the vast majority of clean claims for all provider types within two weeks or less.

Table 3.3.4 Average number of days to pay clean claims, State Fiscal Year 2024

CLAIM TYPE	ABH	ACLA	HBL	HHH	LHCC	UHC
Inpatient Hospital	8.2	11.0	9.0	2.8	9.2	7.7
Outpatient Hospital	6.6	8.0	6.5	3.8	7.5	5.8
Professional	6.1	7.3	5.9	4.4	7.3	5.5
Rehabilitation	5.8	n/a	6.1	5.7	n/a	5.4
Home Health	9.1	8.7	6.7	2.1	7.4	6.6
Ambulance (EMT & NEAT)	7.1	6.9	9.1	4.2	8.0	7.2
Non-Emergency Medical Transportation	11.5	8.3	11.5	11.5	9.6	10.8
Durable Medical Equipment (DME)	6.4	8.1	6.5	4.4	7.3	5.5
Dental Adult (VAS)	9.0	n/a	6.2	7.7	4.6	7.0
Pharmacy	11.2	9.9	11.2	11.5	11.2	11.2
Total - All Claim Types	**8.0**	**8.2**	**7.7**	**5.5**	**8.4**	**7.4**

Source: 221 Prompt Pay Report

Subsection 3.4 - Regular and Expedited Service Requests Processed

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

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

Federal regulations and health plan contracts stipulate that standard service authorizations must be processed within 14 calendar days of receiving the service request. Per the Code of Federal Regulations, an extension of up to 14 days could be granted if the member or the health plan justified a need for additional information and how the extension is in the member's best interest. The contract sets additional limits on the number of hours or days the plan has to make a determination after receipt of needed documentation.

Contracted timeframes and compliance standards are applied in total for both medical and behavioral health service authorizations. Data for SFY 2024 are presented in Table 3.4.1. Variations in the number of authorizations processed by individual health plans can be attributed to plan policy, as well as membership size and complexity.

Table 3.4.1 Standard service authorizations processed, State Fiscal Year 2024

TIMEFRAME (COMPLIANCE STANDARD)		ABH	ACLA	HBL	HHH	LHCC	UHC
Non-Extended: Processed within 14 days of receipt of request for authorization	#	165,617	138,421	306,345	50,823	369,541	204,058
	%	99.4%	95.9%	98.6%	98.9%	99.3%	99.0%
Extended: Processed within 28 days of receipt of request for authorization	#	120,947	109,065	256,222	42,937	246,493	167,155
	%	100.0%	100.0%	100.0%	99.9%	99.9%	100.0%
Processed within contract timeframe from receipt of needed documentation	#	0	56	0	0	16,397	86
	%	n/a	100.0%	n/a	n/a	99.8%	100.0%

Source: 188 & 188BH Service Authorization - Quarterly Reports

If the situation warranted, the provider could request an expedited determination, in which case the request must be acted on within 72 hours or less, depending on the medical urgency. An extension of up to 14 days could be granted if the member or the health plan justifies a need for additional information and demonstrates that the extension is in the member's best interest. The number of expedited service authorizations processed for SFY 2024 and timeframe compliance by a health plan is provided in Table 3.4.2.

Table 3.4.2 Expedited service authorizations processed, State Fiscal Year 2024

TIME FRAME (COMPLIANCE STANDARD)		ABH	ACLA	HBL	HHH	LHCC	UHC
Non-extended: Processed within 72 hours of receipt of request for authorization (100%)	#	2,326	2,555	0	222	2,694	3,292
	%	100.0%	100.0%	n/a	100.0%	99.8%	98.9%
Extended: Processed within 14 days of receipt of request for authorization (100%)	#	0	0	0	0	167	0
	%	n/a	n/a	n/a	n/a	99.4%	n/a

Source: 188 & 188BH Service Authorization - Quarterly Reports

The percent of prior authorizations that resulted in a denial of services are presented in Table 3.4.3. Note that the counts presented are unduplicated denials based on the initial service authorization determination.

Table 3.4.3 Service authorizations denied, State Fiscal Year 2024

	ABH	ACLA	HBL	HHH	LHCC	UHC
Total service authorizations	168,992	146,912	310,770	51,620	375,014	209,448
Number denied	19,165	13,369	17,820	2,485	64,699	15,316
Percent denied	11.3%	9.1%	5.7%	4.9%	17.3%	7.3%

Source: 188 & 188BH Service Authorization - Quarterly Reports

Some denials may have subsequently been reversed by the health plans upon reconsideration by appeal, or through the state fair hearing process. See Subsection 2.6 of this report for additional information on appeals and state fair hearings.

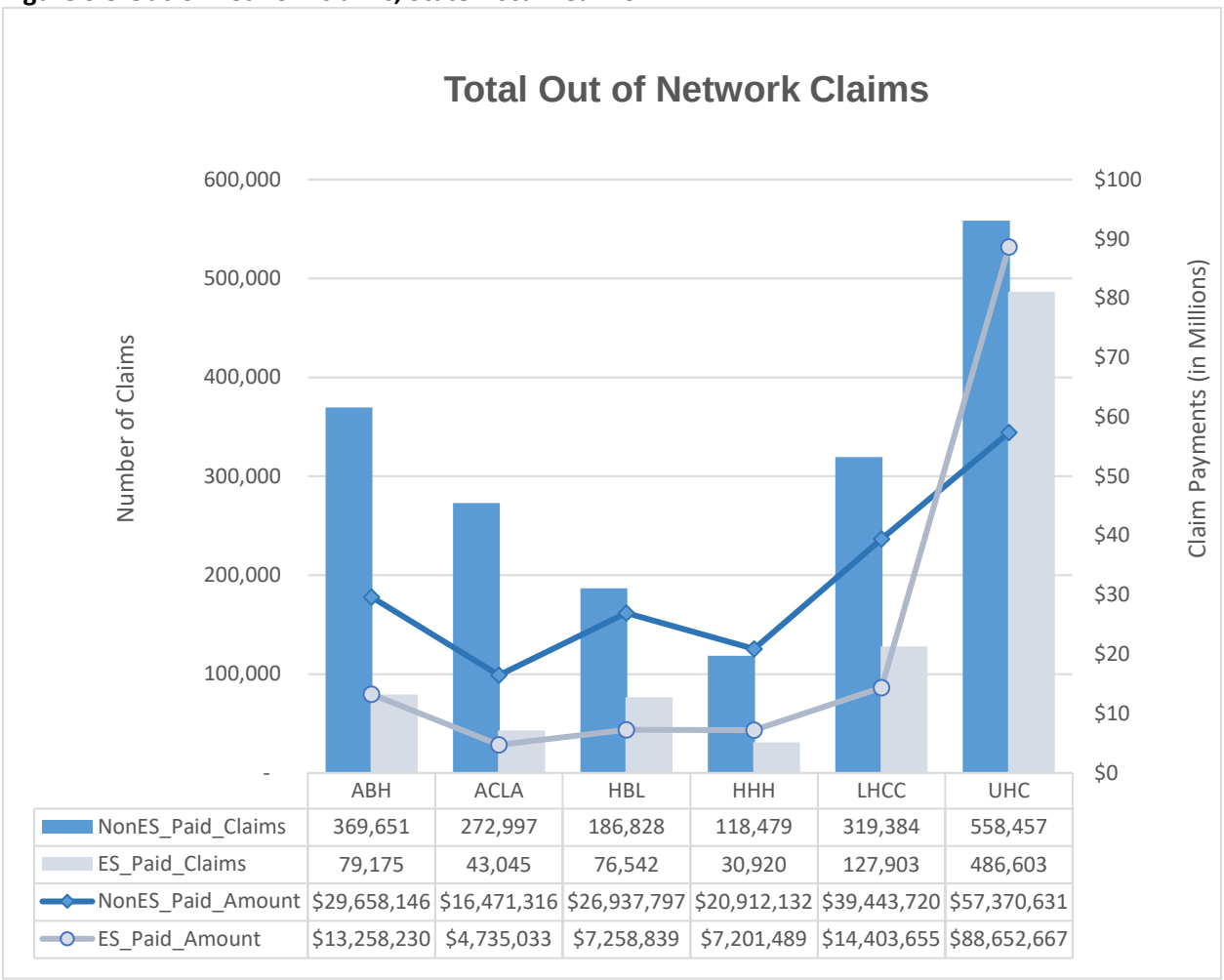
Subsection 3.5 - Claims Paid to Out-of-Network Providers

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

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

The information in Figure 3.5 reflects the number of claims and the dollar value of payments made by health plans to non-network providers for both emergency and nonemergency services. The data originates from submissions from the health plans on the standing annual report (report 177). Out-of-network claims for all emergency and non-emergency services by parish and claim type are provided in Appendix VIII.

Figure 3.5 Out-of-network claims, State Fiscal Year 2024



	ABH	ACLA	HBL	HHH	LHCC	UHC
NonES_Paid_Claims	369,651	272,997	186,828	118,479	319,384	558,457
ES_Paid_Claims	79,175	43,045	76,542	30,920	127,903	486,603
NonES_Paid_Amount	$29,658,146	$16,471,316	$26,937,797	$20,912,132	$39,443,720	$57,370,631
ES_Paid_Amount	$13,258,230	$4,735,033	$7,258,839	$7,201,489	$14,403,655	$88,652,667

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

Subsection 3.6 - Independent Review

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

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

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

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

In SFY 2024, 262 IR cases were completed; 92 of the requests received were deemed ineligible based on statutory requirements, and 170 eligible requests were completed following the provider's request for internal review. Overall, 49.4% of the eligible cases resulted in full or partial payment to the provider, as a result of a completed independent review or MCO settlement prior to the review decision. Table 3.6.1 provides a breakdown of total independent review requests completed by claim type and status. Table 3.6.2 provides additional breakdown of requests by MCO.

Table 3.6.1 Independent review (IR) determinations made, State Fiscal Year 2024

	Behavioral Health[25]	Hospital	Physician	Other[26]	Total
Total determinations	**127**	**131**	**3**	**1**	**262**
Ineligible for IR	38	51	2	1	**92**
Eligible for IR	89	80	1	0	**170**
Settled by MCO & provider before IR decision	7	17	1	0	**25**
Fully overturned by IR	28	28	0	0	**56**
Partially overturned by IR	3	0	0	0	**3**
Upheld by IR	51	35	0	0	**86**
% of eligible cases settled, fully or partially overturned	42.7%	56.3%	100.0%	n/a	**49.4%**

Source: LDH Independent Review Tracking System

[25] Includes inpatient, mental health rehab, and Physician/Professional services.
[26] Requests for SFY 2024, included Lab services.

Table 3.6.2 Independent review determinations by claim type and MCO, State Fiscal Year 2024

	ABH	ACLA	HBL	HHH	LHCC	UHC
All Claim Types – Total determinations	**35**	**39**	**51**	**7**	**84**	**46**
Ineligible for IR	14	13	19	4	22	20
Eligible for IR	21	26	32	3	62	26
Settled by MCO & provider before IR decision	1	1	4	2	1	16
Fully overturned by IR	12	14	6	0	19	5
Partially overturned by IR	0	0	1	0	1	1
Upheld by IR	8	11	21	1	41	4
% fully or partially overturned	61.9%	57.7%	34.4%	66.7%	33.9%	84.6%
Behavioral Health – Total Cases	**9**	**18**	**14**	**2**	**76**	**8**
Ineligible for IR	5	4	5	2	19	3
Eligible for IR	4	14	9	0	57	5
Settled by MCO & provider before IR decision	1	1	3	0	0	2
Fully overturned by IR	2	8	1	0	17	0
Partially overturned by IR	0	0	1	0	1	1
Upheld by IR	1	5	4	0	39	2
% fully or partially overturned	75.0%	64.3%	55.6%	n/a	31.6%	60.0%
Hospital – Total requests	**25**	**20**	**36**	**5**	**8**	**37**
Ineligible for IR	8	8	13	2	3	17
Eligible for IR	17	12	23	3	5	20
Settled by MCO & provider before IR decision	0	0	1	2	1	13
Fully overturned by IR	10	6	5	0	2	5
Partially overturned by IR	0	0	0	0	0	0
Upheld by IR	7	6	17	1	2	2
% fully or partially overturned	58.8%	50.0%	26.1%	66.7%	60.0%	90.0%
Physician – Total requests	**1**	**1**	**0**	**0**	**0**	**1**
Ineligible for IR	1	1	0	0	0	0
Eligible for IR	0	0	0	0	0	1
Settled by MCO & provider before IR decision	0	0	0	0	0	1
Fully overturned by IR	0	0	0	0	0	0
Partially overturned by IR	0	0	0	0	0	0
Upheld by IR	0	0	0	0	0	0
% fully or partially overturned	n/a	n/a	n/a	n/a	n/a	100.0%
Other – Total requests	**0**	**0**	**1**	**0**	**0**	**0**
Ineligible for IR	0	0	1	0	0	0
Eligible for IR	0	0	0	0	0	0
Settled by MCO & provider before IR decision	0	0	0	0	0	0
Fully overturned by IR	0	0	0	0	0	0
Partially overturned by IR	0	0	0	0	0	0
Upheld by IR	0	0	0	0	0	0
% fully or partially overturned	n/a	n/a	n/a	n/a	n/a	n/a

Source: LDH Independent Review Tracking System

Subsection 3.7 - Pharmacy Benefits

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

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

In SFY 2024, five health plans managed pharmacy benefits for members enrolled with full benefits coverage. Partial-benefit-only enrollees and all Humana members received pharmacy benefits under fee-for-service Medicaid. According to the contract with the Department, managed care organizations can either self-administer pharmacy benefits or subcontract with a pharmacy benefit manager (PBM). The PBMs for each health plan are listed in Subsection 3.8 "Pharmacy Benefit Managers and Rebates."

Table 3.7.1 lists the unduplicated total number of pharmacy claims received by each health plan, as well as a breakdown of claims by select categories. All PBMs were required to utilize the single, statewide preferred drug list (PDL). The variation in the data presented reflects the variation across health plans in implementing alternative approaches to managing pharmacy benefits, particularly in step therapy and fail-first protocols. When a drug was requested that required step therapy and fail-first protocols, the enrollee was required to try the preferred product(s) before the requested drug would be approved. The monthly details for pharmacy claims, organized by reporting category, are provided in Appendix IX.

Table 3.7.1 Pharmacy claims comparison, State Fiscal Year 2024

		ABH	ACLA	HBL	HHH	LHCC	UHC
Total prescription claims	**#**	**3,302,164**	**3,609,279**	**7,444,282**	**851,018**	**9,224,600**	**8,421,390**
Claims subject to prior authorization	**#**	321,930	292,611	650,373	91,637	851,379	667,640
	%	9.75%	8.11%	8.74%	10.77%	9.23%	7.93%
Claims denied	**#**	1,076,734	1,131,817	2,518,399	288,267	2,765,974	2,690,000
	%	32.61%	31.36%	33.83%	33.87%	29.98%	31.94%
Claims subject to step therapy or fail first protocol	**#**	12,766	23,148	33,875	2,917	80,839	51,719
	%	0.39%	0.64%	0.46%	0.34%	0.88%	0.61%

Source: Report RX055 - Pharmacy

In 2018, Act 482 of the Regular Legislative Session amended La RS 40:1253.2 to require the reporting of additional data on prior authorizations for pharmacy services and related denied claims, including determination response times, authorization denials, and claims with an approved prior authorization denied at claim adjudication. These items are presented in Tables 3.7.2 through 3.7.4.

Per federal regulations and MCO contract requirements, the MCO must determine prior authorization requests for non-emergency pharmacy services within 24 hours of receiving of all necessary documentation. Table 3.7.2 provides the average and range of response times by health plan. The data presented includes all determinations, approved, denied, reduced, voided, or withdrawn.

Table 3.7.2 Response times for pharmacy prior authorization requests, State Fiscal Year 2024[27]

	ABH	ACLA	HBL	HHH	LHCC	UHC
Average response time (hours)	4.7	3.8	1.3	2.0	1.7	1.8
Response time range (hours)[28]	0.0-220.4	0.0-240.1	0.0-121.5	0.0-166.9	0.0-287.3	0.0-243.8

Source: Report RX055 - Pharmacy

For reporting purposes, health plans are required to categorize authorization denials into one of five standard categories specified by the Department. Table 3.7.3 provides the total counts of denied authorizations by these specified categories.

Table 3.7.3 Pharmacy prior authorization requests denied, State Fiscal Year 2024

	ABH	ACLA	HBL	HHH	LHCC	UHC
Not Medically Appropriate	5,642	2,637	7,422	946	5,357	10,602
Not a Covered Benefit	1,440	778	961	111	588	1,600
Administrative - Lack of Information	450	4,259	899	234	1,264	1,355
Reduced Authorized	0	0	460	0	0	438
Other	764	0	2	0	6,610	0
Total Denials	**8,296**	**7,674**	**9,744**	**1,291**	**13,819**	**13,995**

Source: Report RX055 - Pharmacy

[27] Includes all determinations: approved, denied, reduced, voided or withdrawn.
[28] Minimum response time of zero hours indicates a response time of less than three minutes.

For prescriptions that require a prior authorization, the PBM makes the determination to approve, reduce, or deny the service, based on the clinical information provided by the prescriber at the time of the authorization request. However, it is possible and appropriate for claims for approved services to be denied at the time of payment. For example, if the plan limitations have been exceeded or the refill is too soon, the claim would deny. Table 3.7.4 presents the count of claims with an approved authorization that was denied at the point of sale by the health plan. The complete list of denied claims, along with the approved authorization and the denial reason is presented in Appendix X.

Table 3.7.4 Pharmacy claims denied after prior authorization was approved, State Fiscal Year 2024

	ABH	ACLA	HBL	HHH	LHCC	UHC
Number of claims denied after prior authorization was approved	37,067	38,218	72,523	9,569	90,529	80,021

Source: Report 173 Denied Claims - Pharmacy

Subsection 3.8 - Pharmacy Benefit Managers and Drug Rebates

The Louisiana Department of Health shall submit quarterly reports (and annual summary) to the Senate and House Committees on Health and Welfare encompassing the following data regarding the Medicaid managed care organizations' pharmacy benefit managers:

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

As required by Act 482 of the 2018 Regular Legislative Session, this section has been expanded to include additional data on each MCO's pharmacy benefits program as listed above. The legislation amended Louisiana Revised Statute 40:1253.2 to require quarterly reporting on the pharmacy benefit managers and rebates collected under managed care. The act further required an annual summary of quarterly reports to be included in the annual transparency report. The summary data for SFY 2024 are presented here in tables 3.8.1 through 3.8.5. The monthly data from each quarterly report is presented in Appendix XI.

Managed care organizations can self-administer their pharmacy benefits or subcontract with a pharmacy benefits manager (PBM). In state fiscal year 2024, effective October 28, 2023, all six health plans utilized a single PBM to manage their pharmacy benefits. Table 3.8.1 identifies the PBM for each managed care organization and indicates the contractual/ownership relationship between the MCO and the PBM.

Table 3.8.1 Pharmacy Benefit Managers (PBM), State Fiscal Year 2024

MCO	PBM (July 1, 2023 - Oct 27, 2023)	MCO/PBM Relationship	PBM effective: Oct 28, 2023
ABH	**CaremarkPCS Health**	CVS Health Corporation is the ultimate owner of both Aetna (MCO) and Caremark (PBM). Aetna has an intercompany agreement with Caremark for PBM services.	Prime Therapeutics State Government Solutions, LLC (Prime) As required by LDH, each MCO individually contracts with Prime to provide PBM services for its Louisiana Medicaid members. Prime is not a subsidiary of the parent company of any of the six current MCOs.
ACLA	**PerformRx**	Both AmeriHealth Caritas Louisiana, Inc. and PerformRx are wholly owned by AmeriHealth Caritas Health Plan. ACLA subcontracts with PerformRx for PBM services.	
HBL	**CareIonRx**	Healthy Blue is a joint venture between Blue Cross Blue Shield Louisiana and Amerigroup Partnership Plan, LLC. Anthem, Inc. is the ultimate parent company of Amerigroup and CareIonRx. CareIonRx provides PBM service to Healthy Blue under a master intercompany services agreement.	
LHCC	**CVS Caremark**	Centene Corporation is the parent company of Louisiana Healthcare Connections and Envolve Pharmacy Solutions (EPS). LHCC has a PBM contract with EPS and CVS is a subcontractor of EPS.	
UHC	**OptumRx**	UnitedHealth Group is the parent company of both OptumRx and UnitedHealthcare of Louisiana. UHC of Louisiana has a contractual relationship with OptumRx for PBM Services.	

Source: MCO self-reported

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

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

The Department implemented these limitations through contract amendments with each of the MCOs, with a compliance date of May 1, 2019. Before the implementation of the new contract requirements, the five MCOs used various combinations of payment methodologies for PBM services, including, but not limited to, a per-claim transaction fee. Table 3.8.2 provides a summary of transaction fees paid in SFY 2024 by MCO.

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

Table 3.8.2 Transaction fees paid by MCO to PBM, State Fiscal Year 2024

ABH	ACLA	HBL	HHH	LHCC	UHC	Total
$1,931,707.36	$3,651,877.88	$4,081,128.75	$390,207.75	$4,958,192.87	$9,294,578.50	$24,307,693.11

Source: 054 Pharmacy Benefit Management & Rebate monthly report

Table 3.8.3 details the total rebates received and retained by the PBM or MCO in SFY 2024. Monthly rebate collections are available in Appendix XI. No rebates collected by the PBMs in state fiscal year 2024 were remitted to the Department.

Table 3.8.3 Rebates and discounts retained by the MCO or PBM, State Fiscal Year 2024

ABH	ACLA	HBL	HHH	LHCC	UHC	Total
$789,068.68	$896,025.09	$1,537,719.95	$0	$750,778.77	$1,763,320.78	$5,736,913.27

Source: 054 Pharmacy Benefit Management & Rebate monthly report

Spread pricing refers to the difference in the amount charged by the PBM and the amount paid to the pharmacist that is then retained by the PBM for the management of pharmacy benefits. Act 482 prohibited the continued use of spread pricing, which was implemented by the Department for services after April 30, 2019. Table 3.8.4 reflects the total amounts retained by the PBM through spread pricing in SFY 2024. Monthly data is available in Appendix XI.

Table 3.8.4 Amount retained by the PBM through spread pricing, State Fiscal Year 2024

ABH	ACLA	HBL	HHH	LHCC	UHC	Total
$0	$0	$0	$0	$0	$0	$0

Source: 054 Pharmacy Benefit Management & Rebate monthly report

All other monies paid to the PBM and not reimbursed to pharmacies are captured in Table 3.8.5. Prior to the implementation of Act 482 limiting payments for pharmacy benefit management to a transaction fee basis, some MCOs used other payment methodologies that included administrative fees. For services beginning on May 1, 2019, they discontinued the PMPM fees and transitioned to the required per claim transaction fee.

Table 3.8.5 Other monies retained by the PBM that are not reimbursed to pharmacists, State Fiscal Year 2024

ABH	ACLA	HBL	HHH	LHCC	UHC	Total
$0	$0	$0	$0	$0	$(6,604.03)	$(6,604.03)

Source: 054 Pharmacy Benefit Management & Rebate monthly report

Section 4 - Adult Expansion Population

Per Executive Order JBE 16-01, effective July 1, 2016, Louisiana expanded Medicaid coverage under the Affordable Care Act to adults aged 19 through 64 who are at or below 138% of the Federal Poverty Level and do not meet other Medicaid categorical requirements or are not eligible for or enrolled in Medicare. Act 482 of the 2018 Regular Legislative Session requires the Department to submit a quarterly report containing requested Medicaid managed care program data on the adult expansion population and payments to the health plans. The quarterly reports submitted provide monthly data for the reporting period, as well as unduplicated year-to-date (YTD) totals for the 2024 state fiscal year. In addition to quarterly reporting, the legislation requires annual and monthly data to be included in the transparency report.

Included in this section of the transparency report are the requested annual data, as per Act 482, on the adult expansion population. As part of the Medicaid Managed Care Transparency Report, this section includes only those expansion population counts and expenditures for individuals enrolled in a health plan for either full or partial benefits. The monthly and annual year-to-date totals presented in this section of the annual Transparency Report are compiled using the same static eligibility and claims datasets pulled in December 2024 for compilation of the Medicaid Annual Report. Due to the dynamic nature of Medicaid enrollment and claims processing lag, the updated data presented in this section may not match monthly or year-to-date totals reported in previously published quarterly transparency reports. Monthly totals for all data sets are provided in Appendix XII.

Subsection 4.1 - Expansion Enrollment by Age Cohort and Health Plan

Medicaid expansion population data, which shall include the following:

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

In SFY 2024, the unduplicated count of expansion enrollees enrolled in a health plan was 877,418. Table 4.1.1 provides a breakdown of enrollees by age and health plan for SFY 2024. Fiscal year totals are unduplicated and therefore will not equal the sum or counts by health or age cohort.

Table 4.1.1 Expansion enrollment by age cohort and MCO, State Fiscal Year 2024[29]

AGES	ABH	ACLA	HBL	HHH	LHCC	UHC	TOTAL
19- 49	77,388	80,321	152,541	68,451	182,146	169,153	702,233
50 -64	24,994	20,186	41,492	17,862	42,497	46,200	187,016
Total	**100,917**	**99,233**	**191,505**	**85,427**	**221,951**	**212,455**	**877,418**

Source: Medicaid Data Warehouse

[29] Due to the dynamic nature of Medicaid enrollment and to provide for claim lag, the dataset for this annual Transparency Report was extracted in October 2024, and will not necessarily match the data previously extracted and reported in the quarterly transparency reports.

Subsection 4.2 - Expansion Enrollees with Earned Income

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

Table 4.2.1 presents the number of expansion enrollees in each MCO, categorized by earned income, employer-based or self-employment, and age cohort. This analysis was not restricted to only able-bodied adults and therefore may include individuals with a disability or other persons identified by CMS guidance whose ability to work may be limited, such as students and individuals with complex medical conditions. Approximately 70% of the expansion population for SFY 2024 had earned income.

Table 4.2.1 Expansion enrollees with earned income by age cohort and MCO, State Fiscal Year 2024[30]

AGE	ABH	ACLA	HBL	HHH	LHCC	UHC	TOTAL
19- 49	72,144	78,401	112,874	55,622	137,141	129,705	**516,374**
50 -64	14,673	12,675	22,456	8,921	23,496	25,566	**99,528**
Total	**86,181**	**90,484**	**134,294**	**64,173**	**159,492**	**154,033**	**610,916**

Source: Medicaid Eligibility Data System

[30] Due to the dynamic nature of Medicaid enrollment, and to provide for claims lag the data set for this annual Transparency Report was extracted in October 2024, and will not necessarily match the data previously extracted and reported in the quarterly transparency reports.

Subsection 4.3 - Expansion Per Member Per Month Payments

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

In state fiscal year 2024, the Department paid $7,035,944,816 to all six managed care organizations to manage the care of individuals in the adult expansion population for medical, specialized behavioral health, pharmacy, and transportation services.

Table 4.3.1 Total payments to MCOs for the expansion population, State Fiscal Year 2024

ABH	ACLA	HBL	HHH	LHCC	UHC
$794,861,860	$806,258,968	$1,538,642,858	$401,236,993	$1,753,850,720	$1,741,093,416

Source: LAGOV/CP-012 and Medicaid Data Warehouse

In SFY 2024, expansion enrollees 19 and 20 years old were eligible for all dental services covered under EPSDT. Enrollees 21 years and older are eligible for covered denture services only. These services are provided through the two Dental Benefits Plan Managers (DBPM) contracted with LDH to provide administration of dental benefits to covered members. Payments to the DBPMs totaled $9,332,233 for SFY 2024. Table 4.3.2 below shows the total payments made by the Department to each plan.

Table 4.3.2 Total payments for dental benefits for the expansion population, State Fiscal Year 2024

DentaQuest	MCNA
$4,807,136	$4,525,097

Source: LAGOV/CP-012 and Medicaid Data Warehouse

Subsection 4.4 - Medicaid Expansion Population Service Utilization

Medicaid expansion population utilization data which shall include the following:

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

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

The number of recipients who received services is unduplicated within each service category and reporting period and, as a result, cannot be added to ascertain the total number of recipients who received services each month. The total MCO expenditures within the specified service categories in SFY 2024 were $3,483,287,754 for the expansion population and $3,269,914,565 for the non-expansion population. This includes only claims payments made to providers by the MCOs for these select services and does not include payments for other service categories or payments made under the fee-for-service program. Approximately 52% of total payments by the MCOs to providers for the selected category of service presented below are attributed to the utilization by the expansion population. Tables 4.4.1 and 4.4.2 on the following page provide the expenditures for the expansion population and the non-expansion population.

Table 4.4.1 Utilization and expenditures for specified services for expansion population enrolled in managed care, State Fiscal Year 2024[31]

EXPANSION		Age Cohort 0 to 18	Age Cohort 19 to 49	Age Cohort 50 to 64	Age Cohort 65+	Total
Emergency Department	Recipient	0	256,491	65,381	0	**320,413**
	Payment	$0	$168,432,953	$46,422,511	$0	**$214,855,464**
Hospital Inpatient	Recipient	0	44,311	13,882	0	**58,112**
	Payment	$0	$373,241,799	$182,262,783	$0	**$555,504,582**
Hospital Outpatient	Recipient	0	340,059	113,366	0	**449,954**
	Payment	$0	$391,178,867	$255,224,266	$0	**$646,403,133**
NEMT	Recipient	0	18,990	9,692	0	**28,461**
	Payment	$0	$20,244,737	$8,853,972	$0	**$29,098,709**
Pharmacy	Recipient	0	429,259	137,862	0	**561,423**
	Payment	$0	$1,041,617,062	$587,847,161	$0	**$1,629,464,223**
Physician	Recipient	0	446,332	134,348	0	**515,411**
	Payment	$0	$268,642,696	$139,318,947	$0	**$407,961,643**

Source: Medicaid Data Warehouse

Table 4.4.2 Utilization and expenditures for specified services for non-expansion population enrolled in managed care, State Fiscal Year 2024[31]

NON-EXPANSION		Age Cohort 0 to 18	Age Cohort 19 to 49	Age Cohort 50 to 64	Age Cohort 65+	Total
Emergency Department	Recipient	275,485	82,678	23,957	1,393	**381,292**
	Payment	$148,083,706	$61,196,955	$24,135,619	$972,347	**$234,388,628**
Hospital Inpatient	Recipient	51,345	29,123	7,497	568	**88,378**
	Payment	$405,986,063	$202,188,597	$126,654,406	$7,741,153	**$742,570,220**
Hospital Outpatient	Recipient	382,536	114,361	35,038	2,606	**530,612**
	Payment	$249,252,022	$162,265,517	$130,819,855	$6,452,874	**$548,790,268**
NEMT	Recipient	10,115	11,795	11,462	5,217	**37,868**
	Payment	$4,490,916	$13,839,825	$15,203,342	$6,450,985	**$39,985,068**
Pharmacy	Recipient	540,031	139,562	40,387	3,579	**715,889**
	Payment	$409,344,271	$384,601,475	$302,466,221	$12,755,879	**$1,109,167,846**
Physician	Recipient	634,429	148,673	40,268	3,446	**764,166**
	Payment	$415,647,004	$114,526,361	$61,484,168	$3,355,002	**$595,012,536**

Source: Medicaid Data Warehouse

[31] Due to the dynamic nature of Medicaid enrollment and to provide claims lag the dataset for this annual Transparency Report was extracted in October 2024, and will not necessarily match the data previously extracted and reported in the quarterly transparency reports.

Section 5 - Dental Benefits Program

Dental Benefit Program Managers

On July 1, 2014, the state moved coverage of comprehensive dental services for Medicaid-eligible children and the adult dentures to full-benefit eligible adults to a single prepaid ambulatory health plan (PAHP), which operated under federal authority, as provided in Sections 1902(a)(4) and 1932(a) (1)(A) of the Social Security Act, and 42 CFR Part 438. In Louisiana, dental PAHPs are referred to as Dental Benefit Program Managers (DBPM or dental plan). DBPMs are contracted to manage and provide dental services to enrollees based on capitation payments, or other payment arrangements that do not use state plan payment rates.

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

- **EPSDT Dental:** Medicaid enrollees under the age of 21 are eligible for diagnostic, preventive, restorative, endodontic, periodontal, prosthodontics, maxillofacial prosthetics, oral and maxillofacial surgery, orthodontic and other screening and treatment services applicable under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program
- **Adult Dentures:** Medicaid enrollees 21 years or older are eligible for dentures and related services.
- **Adult DD/ID – Waiver Dental:** Medicaid enrollees 21 years or older with developmental or intellectual disabilities who are enrolled in the New Opportunities Waiver, Residential Options Waiver or the Supports Waiver are eligible for diagnostic, preventive, restorative, endodontic, periodontal, prosthodontics, maxillofacial prosthetics, oral and maxillofacial surgery, orthodontic and adjunctive general services.
- **Adult DD/ID – ICF Dental:** Medicaid enrollees 21 years or older with developmental or intellectual disabilities who reside in an intermediate care facility for individuals with intellectual disabilities (ICF/IID) are eligible for diagnostic, preventive, restorative, endodontic, periodontal, prosthodontics, maxillofacial prosthetics, oral and maxillofacial surgery, orthodontic and adjunctive general services.

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

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

Subsection 5.1 - Contracted Managed Care Entities – Dental

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

For the SFY 2024 reporting period, the Department contracted with two vendors to operate its dental benefit program serving Medicaid enrollees.

Table 5.1.1 Name of contracted dental benefit program manager entity, State Fiscal Year 2024

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

Source: Medicaid managed care contracts

Subsection 5.2 - Managed Care Employees – Dental

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

The Department requires the Dental Benefit Program Managers (DBPM) to maintain certain in-state staff. The positions required to domicile in Louisiana include the executive director, the dental director and staff responsible for provider network development and management. For SFY 2024, DentaQuest reported seven in-state full-time equivalent (FTE) staff, and MCNA reported eight in-state FTE staff. The combined average annual salary for DentaQuest and MCNA employees based in Louisiana was $95,044.

Table 5.2.1 Total number of full-time equivalent (FTE) and average salary for MCNA employees based in Louisiana, State Fiscal Year 2024

	DentaQuest	MCNA
Total number of LA employees (FTEs)	7.0	8.0
Average salary paid	$104,830	$86,481

Source: 017 Annual Report to LDH

Subsection 5.3 - Payments to Dental Benefit Program Managers

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

In SFY 2024, the Department paid $231,673,938 to the DBPMs for the administration of the Medicaid dental benefits management program. Capitation payments were determined with assistance from the Department's contracted actuary, Mercer, based on the number of Medicaid enrollees eligible for and enrolled in the dental program for the month and were paid in the month following enrollment, i.e., June enrollment was paid in July. Table 32.1 below shows the total payments the Department made to the DBPMs and the average PMPM for each month in SFY 2024.

Table 5.3.1 Payments to DBPMs for dental benefit program members by month, State Fiscal Year 2024

	DentaQuest		MCNA	
	Total Payments	Average PMPM	Total Payments	Average PMPM
Jul-23	$10,103,402	$10.47	$10,018,760	$10.91
Aug-23	$9,717,662	$10.20	$9,662,949	$10.70
Sep-23	$10,525,291	$11.25	$10,238,924	$11.56
Oct-23	$9,635,973	$10.47	$9,715,068	$11.17
Nov-23	$9,978,478	$10.98	$9,779,781	$11.41
Dec-23	$9,978,593	$11.13	$9,746,653	$11.55
Jan-24	$9,679,907	$10.96	$9,512,230	$11.46
Feb-24	$9,665,454	$11.10	$9,464,527	$11.61
Mar-24	$9,588,333	$11.18	$9,362,105	$11.71
Apr-24	$9,472,161	$11.24	$9,211,631	$11.78
May-24	$9,427,110	$11.42	$9,095,043	$11.94
Jun-24	$9,203,161	$11.40	$8,890,742	$11.97
Total	**$116,975,525**	**$10.97**	**$114,698,413**	**$11.46**

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

Notes:
Jul 2023: PMPMs paid via lump sum pending approval of 7/1/23 rates.
Aug 2023: PMPMs paid via lump sum pending approval of 7/1/23 rates.
Sep 2023: Jul and Aug DOS PMPMs processed in MMIS and lump sum payments recouped.
Jun 2024: Includes $3.4M in rebates from MCEs for CY2022 Medical Loss Ratio (MLR) results

Subsection 5.4 - Number of Healthcare Providers - Dental

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

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

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

In SFY 2024, 2,203 dental providers contracted with one or both of the DBPMs to provide Medicaid-covered dental services. Provider counts by provider type, taxonomy and parish are provided in Appendix XIII. It should be noted, however, that the unduplicated totals below will not match the provider totals in Appendix XIII, as providers can enroll as more than one provider type, under more than one taxonomy provider code, and in more than one parish.

Table 5.4.1 Total unduplicated[32] count of contracted providers in DBPM, State Fiscal Year 2024[33]

	DentaQuest	MCNA
Total Contracted Providers	1,285	2,091

Source: MARS Data Warehouse, June 28, 2024 Provider Registry

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

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

Subsection 5.5 - Medical Loss Ratio – Dental Benefit Program Managers

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

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

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

The MLR data presented are based on the independent auditor's reports prepared by Myers and Stauffer for the Adjusted Medical Loss Ratio Rebate Calculation of the DBPMs for the period January 1, 2023, through June 30, 2023. The prior audited annual MLR reports are posted on the Medicaid website at https://ldh.la.gov/resources/MLR.

Table 5.5.1 Medical loss ratios (MLR), January, 2023-June, 2023

	DentaQuest		MCNA	
	Expansion	Non-Expansion	Expansion	Non-Expansion
Adjusted YTD MLR Capitation Revenue	$4,655,877	$52,224,575	$4,792,961	$55,332,851
Total Adjusted MLR Expense	$4,385,150	$48,007,778	$4,236,735	$52,035,194
MLR Percentage	94.2%	91.9%	88.4%	94.0%
Rebate Required	$0	$0	$0	$0

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

Table 5.5.2 Breakdown of total adjusted MLR expenses, January, 2023-June, 2023

	DentaQuest		MCNA	
	Expansion	Non-Expansion	Expansion	Non-Expansion
Patient Care	$4,371,715	$47,988,735	$4,232,923	$51,992,566
Quality Improvement	$0	$0	$3,812	$42,629
Information Technology	$13,435	$19,043	$0	$0
Other	$0	$0	$0	$0
Total Adjusted MLR Expense	$4,385,150	$48,007,778	$4,236,735	$52,035,195

Source: MSLC Audited Medical Loss Ratio Draft Reports

Subsection 5.6 - Member and Provider Satisfaction Surveys - Dental

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

Member and provider satisfaction are measures of a patient's experience of care. Member satisfaction with their healthcare, which is considered an important component in managed care quality, can be defined as how members value and regard their care. The new contracts require the member satisfaction survey to be completed within 120 days after the first of the year on a calendar year basis. Both DBPMs monitor member satisfaction via their inbound call centers. The results are summarized and reported to the Louisiana Department of Health on an annual basis. The full member and provider survey reports for SFY 2024 can be found in Appendix XIV DBPM Satisfaction Surveys.

Subsection 5.7 - Audited Financial Statements - Dental

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

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

Further, the Department required the DBPMs to have a license or certificate of authority issued by LDI to operate as Medicaid risk-bearing entities, pursuant to Title 22:1016 of the Louisiana Revised Statutes. The calendar year 2023 full financial statement for DentaQuest and MCNA can be found in Appendix XV.

Subsection 5.8 - Sanctions Levied by the Department - Dental

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

Actions or inactions by the Medicaid managed care entities that are subject to sanction by the Department are specified in 42 CFR §438.700, et seq., and delineated in the LDH Dental Benefit Plan Manager contracts. In SFY 2024, there were no sanctions levied against either of the DBPMs.

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

Subsection 5.9 - Proactive Choice and Auto-Enrollment - Dental

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.

Dental plan enrollment and disenrollment are managed by the Department's contracted enrollment broker, Maximus. As required by federal Medicaid regulations, the enrollment broker is independent and free from conflict of interest.

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

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

In addition to capturing the choice rates for the individual MCOs, Maximus provides the choice rate for the two Dental Benefit Program Managers. Table 38.1 provides the individual dental plan and aggregate choice rates for SFY 2024. The choice rate for 2024 is 48.25%. The Department continues to work with the enrollment broker and other stakeholders to inform and educate members about Medicaid Managed Care, available health plans, and the process for selecting the plan of their choice.

Table 5.9.1 Proactive choice rates, State Fiscal Year 2024

	DentaQuest	MCNA	Total
Pro-active Choice Enrollments	78,902	36,572	**115,474**
Auto Enrollments	62,993	60,858	**123,851**
Total Enrollments	141,895	97,430	**239,325**
Choice rate	55.61%	37.54%	**48.25%**

Source: Maximus Health Services, Report No. 312A

Subsection 5.10 - Benefit Health Outcomes - Dental

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

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

EPSDT Dental Program

The EPSDT Dental Program, designated for enrollees under the age of 21, provides coverage of certain diagnostic, endodontic, periodontics, removable prosthodontic, maxillofacial prosthetic, oral and maxillofacial surgery, orthodontic, adjunctive general services, preventive, and maintenance and restoration services, such as fillings, fluoride treatments and cleanings specified in the Louisiana Medicaid State Plan. In addition, federal law mandates that enrollees under 21 years of age are entitled to receive all medically necessary health care, screening, diagnostic services, treatment, and other measures to correct or improve physical conditions (Section 1905(r) of the Social Security Act). The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit is comprehensive in nature and includes coverage of all services described in federal Medicaid statutes and regulations, including those that are not covered for adults, not explicitly described in the Contract, not included in the Medicaid FFS fee schedules, and not covered in the Louisiana Medicaid State Plan.[34]

In SFY 2024, 930,088 unduplicated individuals under the age of 21 were enrolled in one or both of the Dental Benefit Plan Managers (DBPM). Of these, 402,974 (43.3%) received at least one dental service.

Table 5.10.1 EPSDT Dental Program members who saw a dentist, State Fiscal Year 2024[35]

	DentaQuest	MCNA	Total
Total members under age 21	482,491	467,793	**930,088**
Number who saw a dentist	198,861	207,100	**402,974**
Percent that saw a dentist	41.2%	44.3%	**43.3%**

Source: MARS Data Warehouse

[34] https://ldh.la.gov/assets/medicaid/DBPMP/DBPMManual-Masterversion5.1.24.pdf

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

Table 5.10.2 shows the utilization rates for the select services specified in legislation for EPSDT Dental Program members who saw a dentist. Oral prophylaxis service, which is generally defined as the removal of deposits from the tooth surfaces (teeth cleaning), was the most common dental procedure received by members under the age of 21. Of members who saw a dentist, 91.2% received oral prophylaxis services. Fluoride Varnish was the second most common procedure for this age group, received by 26.6% of members under 21 who had a dental service.

Table 5.10.2 Utilization by specified service for members under the age of 21, State Fiscal Year 2024[36]

Code Description	DentaQuest		MCNA		TOTAL	
	Members	%	Members	%	Members	%
Oral prophylaxis (teeth cleaning)	180,875	91.0%	188,889	91.2%	**367,592**	**91.2%**
Fluoride varnish	55,239	27.8%	52,321	25.3%	**107,021**	**26.6%**
Composite fillings	44,787	22.5%	47,601	23.0%	**92,212**	**22.9%**
Dental sealants	24,561	12.4%	24,116	11.6%	**48,628**	**12.1%**
Stainless steel crowns	18,377	9.2%	18,765	9.1%	**37,110**	**9.2%**
Extractions of primary teeth	16,317	8.2%	17,128	8.3%	**33,421**	**8.3%**
Amalgam fillings	8,912	4.5%	9,651	4.7%	**18,533**	**4.6%**
Pulpotomies performed on primary teeth	8,222	4.1%	8,251	4.0%	**16,461**	**4.1%**
Extractions of permanent teeth	6,038	3.0%	8,391	4.1%	**14,421**	**3.6%**
Root canals performed on permanent teeth	3,591	1.8%	3,511	1.7%	**7,099**	**1.8%**

Source: MARS Data Warehouse

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

Adult Denture Program

The Adult Denture Program is limited to coverage for diagnostics and the provision of removable prosthodontics, including full and partial dentures. Adult restorative or surgical procedures are not covered under this program. A total of 42,129 individuals received services through the Adult Denture Program.

Table 5.10.3 Adult Denture Program members who saw a dentist, State Fiscal Year 2024[37]

	DentaQuest	MCNA	Total
Total members age 21 and over[38]	604,105	536,733	**1,118,888**
Number who saw a dentist	34,367	7,823	**42,129**
Percent who saw a dentist	5.69%	1.46%	**3.77%**

Source: MARS Data Warehouse

Table 5.10.4 Utilization of select procedures for Adult Denture Program members who saw a dentist, State Fiscal Year 2024[39]

Code Description	DentaQuest		MCNA		TOTAL	
	Members	%	Members	%	Members	%
Comprehensive oral examine	16,501	48.0%	2,959	37.8%	**19,450**	**46.2%**
Radiographs	7,417	21.6%	881	11.3%	**8,294**	**19.7%**
Removable prosthodontics (Dentures)	4,144	12.1%	3,353	42.9%	**7,496**	**17.8%**

Source: MARS Data Warehouse

Adult Waiver and Adult ICF/IID Dental Programs

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

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

[37] Totals by DBPM cannot be summed as members can switch plans throughout the year and are counted in each plan total but only once in the unduplicated total.
[38] Excluding members in the Adults with DD/ID in a Waiver or ICF category of coverage.
[39] Counts are the number of members who received one or more service by category. The rate is expressed as a percent of total members who saw a dentist.

Table 5.10.5 Adult Waiver and ICF/IID Dental Program members who saw a dentist, State Fiscal Year 2024[40]

	DentaQuest	MCNA	Total
Total adults with DD/ID in a waiver or ICF	7,888	8,118	**15,825**
Number who saw a dentist	494	668	**1,155**
Percent who saw a dentist	6.26%	8.23%	**7.30%**

Source: MARS Data Warehouse

Table 5.10.6 Utilization rates of specified procedures for Waiver and ICF/IID Dental Program members who saw a dentist, State Fiscal Year 2024[41]

Code Description	DentaQuest		MCNA		TOTAL	
	Members	%	Members	%	Members	%
Oral prophylaxis (teeth cleaning)	319	64.6%	507	75.9%	**820**	**71.0%**
Composite fillings	96	19.4%	128	19.2%	**222**	**19.2%**
Extractions of permanent teeth	79	16.0%	71	10.6%	**150**	**13.0%**
Case management	27	5.5%	75	11.2%	**100**	**8.7%**
Fluoride varnish	23	4.7%	45	6.7%	**67**	**5.8%**
Stainless steel crowns	5	1.0%	23	3.4%	**28**	**2.4%**
Amalgam fillings	9	1.8%	8	1.2%	**17**	**1.5%**
Root canals performed on permanent teeth	5	1.0%	7	1.0%	**12**	**1.0%**
Extractions of primary teeth	3	0.6%	3	0.4%	**6**	**0.5%**
Dental sealants	2	0.4%	0	0.0%	**2**	**0.2%**

Source: MARS Data Warehouse

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

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

MCO Adult Dental Value Added Services (VAS)

While DBPM coverage for adults, not otherwise covered in the Waiver or ICF dental programs, was limited to denture-only services, the MCOs had the option to offer additional dental services as a value-added benefit (VAS) to adult full-benefit enrollees. Additional data on value-added adult dental services by health plan are presented in Tables 5.10.7 and 5.10.8.

Table 5.10.7 Eligibility and utilization for value-added dental benefits by MCOs, State Fiscal Year 2024

	ABH	ACLA	HBL	HHH	LHCC	UHC
Full-benefit adults[42]	113,480	111,805	215,860	93,004	244,759	234,088
Number who saw a dentist	18,462	0	22,103	7,868	21,655	20,396
Percentage of eligible enrollees who saw a dentist	16.27%	0.00%	10.24%	8.46%	8.85%	8.71%

Source: MARS data warehouse

Teeth cleaning was the most common service received, followed by extraction of permanent teeth and fillings. Table 5.10.8 provides utilization rates by MCO for common procedures received by adult members who received a dental service provided as a value-added service through their health plan.

Table 5.10.8 Utilization rates for value-added dental services by MCO, State Fiscal Year 2024[43]

		ABH	ACLA[44]	HBL	HHH	LHCC	UHC
Adult oral prophylaxis	**Count**	8,786	n/a	9,524	3,163	9,450	9,801
	Rate	47.59%	n/a	43.09%	40.20%	43.64%	48.05%
Extractions of permanent teeth	**Count**	6,092	n/a	6,364	2,251	0	1,696
	Rate	33.00%	n/a	28.79%	28.61%	0.00%	8.32%
Composite fillings	**Count**	5,154	n/a	4,340	1,632	4,216	1,106
	Rate	27.92%	n/a	19.64%	20.74%	19.47%	5.42%
Amalgam fillings	**Count**	207	n/a	267	65	197	51
	Rate	1.12%	n/a	1.21%	0.83%	0.91%	0.25%

Source: MARS Data Warehouse

[42] Includes full benefit enrollees only, partial benefit enrollees were not covered by value-added dental services.
[43] The denominator for utilization rates by procedures is the unduplicated count of individuals who had at least one dental service.
[44] ACLA discounted their VAS adult dental benefit effective December 31, 2022. Humana's Louisiana Medicaid Managed Care contract began January 1, 2024 and included a limited VAS adult dental benefit.

Subsection 5.11 - Members that filed appeals or accessed state fair hearing process and results - Dental

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

Enrollees have the right to file appeals with both the DBPMs and the state if they believe they have been unfairly denied benefits or access to services. Federal law requires the DBPMs to administer a system for members to file appeals, and all states are required to review reports on both the frequency and nature of appeals filed, as well as the steps dental plans take to remedy such appeals. States must also provide an opportunity for a fair hearing to members whose appeal is either denied or not promptly acted upon by the dental plans. An appeal, which must be acted on within 30 days, is a request by a member to review one of the following actions that the DBPMs have taken:

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

As part of its quality strategy, states must require the DBPMs to maintain records of appeals and submit them for state review. When reviewing the records, the Department analyzed the subjects of the appeals to identify the extent to which they are valid or are in the actual control of the health plan. In SFY 2024, there were 478 determinations made under the dental program administered by both DBPMs with an overall 8.4% reversal rate.

Table 5.11.1 Appeals and state fair hearings, State Fiscal Year 2024

	DentaQuest	MCNA	Total
Total members (unduplicated)	**1,080,113**	**998,624**	**2,036,070**
Members who filed an appeal	346	112	458
Members who accessed SFH	1	1	2
Total appeals filed at DBPM level	356	113	469
Total appeals filed at SFH level	1	2	3
Total appeal & SFH determinations[45]	363	115	478
Total determinations fully or partially reversed in favor of the member	35	5	40
% of determinations fully or partially reversed in favor of the member	9.6%	4.3%	8.4%

Source: Annual Appeal and Fair Hearing Report

[45] Total determinations may include determinations made in SFY 2024 for appeals received in a prior year.

Subsection 5.12 - Claims Submitted by Healthcare Providers - Dental

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

DBPMs report claims data annually using the revised 177 reporting template developed by the Department, which captures unduplicated counts of claims received by each managed care entity. This report captures not only claims that are adjudicated (processed for payment or denial) but also the rejected claim counts that are not reported in encounter submissions to the fiscal intermediary. In SFY 2024, there were 3,686,580 claims submitted to both DQ and MCNA for dental services. The breakdown of unduplicated claim counts for SFY 2024 is presented in Table 5.12.1.

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

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

Table 5.12.1 Total claims submitted, State Fiscal Year 2024

	Rejected Claims[46]	Emergency Services	Non-Emergency Services	Total
DentaQuest	0	0	1,840,181	**1,840,181**
MCNA	0	6,780	1,839,619	**1,846,399**
Total	**0**	**6,780**	**3,679,800**	**3,686,580**

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

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

Subsection 5.13 - Denied Claims - Dental

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

Table 5.13.1 below provides the total unduplicated claims denied by the DBPMs delineated by emergency and nonemergency services. Table 5.13.2 provides a listing of the top ten reasons for claim denial which encompass 82% of all claim denials. The complete listing of all CARCs for denied claims for both DentaQuest and MCNA is provided in Appendix XVI.

Table 5.13.1 Total unduplicated denied claims, State Fiscal Year 2024

	Emergency Services	Non-Emergency Services	Total
DentaQuest	0	232,214	**232,214**
MCNA	371	111,010	**111,381**
Total	**371**	**343,224**	**343,595**

Source: 177 Total Claims Summary Report

Table 5.13.2 Ten most prevalent reasons for claim denial by CARC, State Fiscal Year 2024[47]

CARC	Code Description	# Claims Denied	% of Claims Denied
204	This service/equipment/drug is not covered under the patient's current benefit plan	97,169	20%
18	Exact duplicate claim	94,563	20%
169	Alternate benefit has been provided.	41,039	9%
96	Non-covered charge(s).	37,614	8%
150	Payer deems the information submitted does not support this level of service.	33,456	7%
243	Services not authorized by network/primary care providers.	25,712	5%
119	Benefit maximum for this time period or occurrence has been reached.	24,722	5%
27	Expenses incurred after coverage terminated.	12,746	3%
22	This care may be covered by another payer per coordination of benefits.	12,286	3%
4	The procedure code is inconsistent with the modifier used.	9,864	2%
Total	**TOTAL TOP TEN CLAIM DENIAL REASON CODES**	**389,171**	**82%**

Source: Report 173 Denied Claims

[47] Each claim denied may have multiple CARC codes therefore totals include duplication.

Subsection 5.14 - Clean Claims – Dental

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

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

In SFY 2024, there were 3,097,880 clean claims submitted to both DBPMs. This total includes claims that were paid, denied, or otherwise adjudicated based on the original claim submittal without the need for additional information. It does not include rejected claims, which do not meet the definition of a clean claim. Of the clean claims submitted, 2,854,932 (92%) were paid. This total does not include other claims paid after additional information or verifications were received or the original claim was adjusted.

Table 5.14.1 Clean Claims, State Fiscal Year 2024

	DentaQuest	MCNA	Total
Total clean claims submitted	1,747,797	1,350,083	**3,097,880**
Clean claims paid	1,560,139	1,294,793	**2,854,932**

Source: 221 Prompt Pay Report

The DBPMs are required by contract to pay 90% of all payable clean claims within 15 business days of the date of receipt and 99% within 30 calendar days of the date of receipt. The DBPMs must pay providers interest at 12% per annum of the amount payable, calculated daily, for the full period in which the clean claim remains unpaid beyond the 30-day claims processing deadline.

Table 5.14.2 Prompt pay performance for paid clean claims, State Fiscal Year 2024

	Paid within 15 business days		Paid within 30 calendar days	
	DentaQuest	MCNA	DentaQuest	MCNA
EPSDT Dental	99.12%	100.00%	100.00%	100.00%
Adult Dental	99.95%	99.79%	100.00%	100.00%

Source: 221 Prompt Pay Report

Table 5.14.3 Average number of days to pay clean claims, State Fiscal Year 2024

	DentaQuest	MCNA
EPSDT Dental	13.5	6.3
Adult Dental	6.8	8.0

Source: 221 Prompt Pay Report

Subsection 5.15 - Prior Authorization Requests - Dental

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

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

In SFY 2024, the DPBMs completed prior authorizations on a total of 217,338 requests. In alignment with a more expansive benefit for children, 79.32% of authorizations were for members under the age of 21. Table 5.15.1 provides a breakdown by age group and procedure code.

Table 5.15.1 Number of prior authorization requests processed by DBPMs by type of procedure, State Fiscal Year 2024

Type of Procedure	DentaQuest		MCNA		Total
	EPSDT (under 21)	Adult Dental (21 & over)	EPSDT (under 21)	Adult Dental (21 & over)	
0100-0999 Diagnostic	1,397	1,485	421	1,145	**4,448**
1000-1999 Preventive	3,813	111	2,009	67	**6,000**
2000-2999 Restorative	31,597	720	12,834	232	**45,383**
3000-3999 Endodontics	9,719	95	5,336	41	**15,191**
4000-4999 Periodontics	1,443	292	769	79	**2,583**
5000-5899 Removable	227	13,707	364	10,708	**25,006**
5900-5999 Maxillofacial	-	-	-	-	**-**
6000-6199 Implant	10	78	11	39	**138**
6200-6999 Fixed	74	50	43	11	**178**
7000-7999 Oral	36,337	12,436	22,701	2,669	**74,143**
8000-8999 Orthodontics	263		360	2	**625**
9000-9999 Adjunctive/other	23,333	551	19,326	430	**43,640**
Procedure code not specified	2	1	-	-	**3**
Total	**108,215**	**29,526**	**64,174**	**15,423**	**217,338**

Source: Quarterly 188 Prior Authorization Reports

The Dental Benefit Program Managers contract specifies requirements for timely processing of prior authorization requests. For standard authorizations, 80% must be processed within two business days and 100% within 14 calendar days. For expedited authorizations, 100% must be processed within 72 hours after receipt. Tables 5.15.2 and 5.15.3 provide the average and range of authorization processing times for both children and adults by type of procedure.

Table 5.15.2 EPSDT Dental prior authorization response times by DBPM, State Fiscal Year 2024

Type of Procedure	DentaQuest		MCNA	
	Average Time	Range of Times	Average Time	Range of Times
0100-0999 Diagnostic	0.6	0-6	1.1	0-4
1000-1999 Preventive	0.4	0-9	1.0	0-5
2000-2999 Restorative	0.7	0-13	0.9	0-5
3000-3999 Endodontics	0.9	0-12	0.8	0-5
4000-4999 Periodontics	0.9	0-9	1.0	0-5
5000-5899 Removable	0.8	0-6	1.0	0-5
5900-5999 Maxillofacial	-	-	-	-
6000-6199 Implant	1.0	0-3	1.0	0-2
6200-6999 Fixed	0.7	0-4	0.7	0-3
7000-7999 Oral	0.8	0-11	0.9	0-5
8000-8999 Orthodontics	0.6	0-3	1.8	0-5
9000-9999 Adjunctive/other	0.8	0-11	0.9	0-5
Procedure code not specified	0.5	0-1	0.0	-
All prior authorizations	**0.8**	**0-13**	**0.9**	**0-5**

Source: Quarterly 188 Prior Authorization Reports

Table 5.15.3 Adult Dental prior authorization response times by DBPM, State Fiscal Year 2024

Type of Procedure	DentaQuest		MCNA	
	Average Time	Range of Times	Average Time	Range of Times
0100-0999 Diagnostic	0.7	0-7	0.8	0-4
1000-1999 Preventive	0.2	0-5	0.9	0-4
2000-2999 Restorative	0.2	0-7	1.3	0-4
3000-3999 Endodontics	0.2	0-3	1.3	0-6
4000-4999 Periodontics	0.3	0-7	1.2	0-4
5000-5899 Removable	1.0	0-14	1.0	0-7
5900-5999 Maxillofacial	-	-	-	-
6000-6199 Implant	0.2	0-6	1.0	0-4
6200-6999 Fixed	0.6	0-4	1.2	0-3
7000-7999 Oral	0.9	0-11	1.1	0-7
8000-8999 Orthodontics	0.0	-	3.5	2-5
9000-9999 Adjunctive/other	0.2	0-6	1.1	0-6
Procedure code not specified	6.0	6-6	0.0	-
All prior authorizations	**0.9**	**0-14**	**1.0**	**0-7**

Source: Quarterly 188 Prior Authorization Reports

Prior Authorizations Denials

Of the 217,338 prior authorizations the DBPMs completed during SFY 2024, 35,792 (16%) were denied. There can be multiple reasons for denial associated with each authorization request. As a result, the number of denied authorizations by denial reason code is greater than the number of unduplicated denied authorizations. DentaQuest used 209 unique reasons for the denial of prior authorization. MCNA used 31 unique reasons for the denial of prior authorizations. Tables 44.4 and 44.5 provide the 10 most frequently used authorization denial codes for DentaQuest and MCNA, respectively. A complete count of authorization denials delineated by denial reason is included in Appendix XVII.

Table 5.15.4 Top ten most prevalent reasons for authorization denial by DentaQuest, State Fiscal Year 2024

Denial Code	Code Description	EPDST	ADULT	Total
3931	Per Dental Director review, removal of impacted tooth is denied. There is no sign of infection, pain beyond normal eruption, or that the tooth is in a position that will not let it break through the gum on its own.	2,163	362	**2,525**
2040	Service is not covered. Please refer to your Office Reference Manual for definition of covered teeth/quad/arch, patient ages, and procedure codes.	485	1,869	**2,354**
3307	Anesthetic services are only covered when the associated services are approved.	1,241	318	**1,559**
3445	Per dental director review, the X-rays do not show the need for bone removal or sectioning of the tooth. This is needed for teeth that have formed abnormal or multiple roots or teeth with 75% of the clinical crown destroyed by decay. A less severe extraction code would be considered	393	834	**1,227**
3430	We have approved the amount of anesthesia that is normally needed to safely complete the services requested. Based on dental director review, the additional time requested is not medically necessary.	1,025	190	**1,215**
1099	Services reviewed on a previously submitted request.	270	825	**1,095**
3447	Sedation is only covered when the patient needs a lot of dental work done on the same day, four or more teeth pulled, or the patient is nervous about their treatment and a different drug has been tried and failed to help the patient relax during treatment.	755	302	**1,057**
2099	Services provided by an Out-of- Network or Non-contracted provider are not provided under this benefit program.	450	498	**948**
3782	Per dental director review, the X-rays do not support the code requested. A less severe extraction code would be considered. Please review the ADA code you requested and resubmit with the appropriate ADA code.	614	194	**808**
3799	Per Dental Director review, periodontal scaling and root planning is denied due to no evidence of significant bone loss. Demonstrating radiographic evidence of root surface calculus, apical to the CEJ, and/or bone loss is necessary to indicate a true periodontics disease state.	539	133	**672**
	TOTAL TOP TEN	**7,935**	**5,525**	**13,460**

Source: Quarterly 188 Prior Authorization Reports

Table 5.15.5 Ten most prevalent reasons for authorization denial by MCNA State Fiscal Year 2024

Denial Code	Code Description	EPDST	ADULT	Total
96	Procedure is considered non-covered in accordance with either the program benefits or the facility contract	0	6,013	**6,013**
49	Please submit x-ray(s) and narrative with this request.	2,104	314	**2,418**
252	Please provide further rationale for treatment/submit treatment plan/correct x-ray or photograph for review	2,416	292	**2,708**
50	Clinical reviewer has determined that the treatment is in excess of the member's needs.	2,343	87	**2,430**
18	Request has been previously reported and an approval or denial was issued.	1,020	289	**1,309**
259	Coverage for this procedure is limited to three times in a twelve month period.	0	2,130	**2,130**
16	Please submit the patient chart notes/please submit the correct tooth surface/please submit the correct tooth number	1,807	142	**1,949**
181	Per Dental Director review, the x-rays do not support the code requested. A less severe extraction code would be considered. Please review the ADA code you requested and resubmit with the appropriate ADA code.	1,697	102	**1,799**
272	Descriptions varied, related dentures & tooth extraction	362	1,356	**1,718**
169	This procedure can only be considered when reported and performed in conjunction with covered services.	1,194	11	**1,205**
	TOTAL TOP TEN	**12,943**	**10,736**	**23,679**

Source: Quarterly 188 Prior Authorization Reports

Claims Denied After Prior Authorization Approved

In SFY 2024, both dental plans denied a total of 440,050 claims. Of these, 10,103 were claims for services that had been previously prior authorized; however, the claim or documentation provided did not meet the criteria for payment. For SFY 2024, DentaQuest reported that no claims were denied after prior authorization had been approved. Table 44.6 includes the 10 most frequently used CARCs used by MCNA for claims denied after the prior authorization had been previously approved. All denials delineated by reason for denial are included in Appendix XVII. It should be noted that the data reflect only initial denials and do not account for claims that were resubmitted and subsequently paid.

Table 5.15.6 Top Ten reasons for claim denial by MCNA after prior authorization, State Fiscal Year 2024

Denial Code	Code Description	Total Claims
18	Exact duplicate claim/service	2,591
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided.	1,616
22	This care may be covered by another payer per coordination of benefits.	1,065
96	Non-covered charge(s). At least one Remark Code must be provided.	977
16	Claim/service lacks information or has submission/billing error(s).	600
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	600
272	Coverage/program guidelines were not met.	494
119	Benefit maximum for this time period or occurrence has been reached.	296
49	This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam.	209
259	Additional payment for Dental/Vision service utilization.	179
	TOTAL TOP TEN	**8,627**

Source: Monthly 173 Denied Claims Reports

Subsection 5.16 - Claims Paid to Out-of-Network Providers – Dental

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

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

For SFY 2024, both DentaQuest and MCNA reported zero claims paid to out-of-network providers.

Subsection 5.17 - Independent Review - Dental

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

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

The independent review (IR) process was established by La. RS 46:460.81, et seq. to resolve claims disputes when a provider believes a Managed Care Entity (MCE) has partially or totally denied claims incorrectly. An MCE's failure to send a provider payment, remittance advice, or other written or electronic notice, either partially or totally denying a claim within 60 days of the MCO's receipt of the claim is considered a claim denial. The IR process is only one option a provider has to resolve claims payment disputes with a DBPM. In lieu of requesting an independent review, a provider may pursue any available legal or contractual remedy to resolve the dispute. LDH administers the IR process, but does not perform the IR of the disputed claims. When the Department receives a request for IR, it determines if the disputed claims are eligible for IR based on the statutory requirements. If the claims are eligible, the Department forwards them to a reviewer who is neither a state employee nor a contractor and is independent of both the DBPM and the provider. The independent reviewer's decision is binding unless either party appeals the decision to a court having jurisdiction to review the independent reviewer's decision.

In SFY 2024, the Department received no requests for independent review of any DBPM claims.

Appendices

MANAGED CARE ORGANIZATIONS

I Total number of healthcare providers contracted (Subsection 1.4)

II Primary care service providers (Subsection 1.5)

III Contracted providers with closed panels (Subsection 1.6)

IV Member and Provider Satisfaction Surveys (Subsection 1.9)

- IV.1a ABH CAHPS-Child
- IV.1b ABH CAHPS-Adult
- IV.2a ACLA CAHPS-Child
- IV.2b ACLA CAHPS-Adult
- IV.3a HB CAHPS-Child
- IV.3b HB CAHPS-Adult
- IV.4a HHH CAHPS-Child
- IV.4b HHH CAHPS-Adult
- IV.5a LHCC CAHPS-Child
- IV.5b LHCC CAHPS-Adult
- IV.6a UHC CAHPS-Child
- IV.6b UHC CAHPS-Adult
- IV.7 ABH-Provider Survey
- IV.8 ACLA-Provider Survey
- IV.9 HBL-Provider Survey
- IV.10 HHH-Provider Survey
- IV.11 LHCC-Provider Survey
- IV.12 UHC-Provider Survey

V Annual audited financial statements (Subsection 1.10)

- V.1 ABH
- V.2 ACLA
- V.3 HBL
- V.4 HHH
- V.5 LHCC
- V.6 UHC

VI Number of enrollees who received services (Subsection 2.3)

VII Total number of denied claims (Subsection 3.2)

VIII Claims paid to out-of-network providers (Subsection 3.5)

IX Pharmacy Benefits by Month (Subsection 3.7)

X Pharmacy claims denied after authorization (Subsection 3.7)

XI PBM and drug rebate – monthly data (Subsection 3.8)

ADULT EXPANSION

XII Adult expansion population (Section 4)

DENTAL BENEFITS

XIII Total number of healthcare providers contracted – DBPM (Subsection 5.4)

XIV Member and Provider satisfaction surveys – DBPM (Subsection 5.6)

XIV.1 DentaQuest Member Survey

XIV.2 MCNA Member Survey

XIV.3 DentaQuest Provider Survey

XIV.4 MCNA Provider Survey

XV Annual audited financial statements – DBPM (Subsection 5.7)

XV.1 DentaQuest

XV.2 MCNA

XVI Total number of denied claims – DBPM (Subsection 5.13)

XVII Prior Authorization Denials - DBPM (Subsection 5.15)

XVIII Claims Denied with Prior Authorization - DBPM (Subsection 5.15)

XIX Meyers and Stauffer MCO survey instrument

XX Meyers and Stauffer DBPM survey instrument

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