Healthy Louisiana Claims Report

Response to Act 710 of the 2018 Regular Legislative Session

Quarter 4 Calendar Year 2020

Prepared by:

Louisiana Department of Health

Bureau of Health Services Financing

July 2021

LOUISIANA DEPARTMENT OF HEALTH

Contents

Executive Summary

Background

On June 1, 2018, the Louisiana State Legislature passed Act 710 which requires reporting of data on healthcare provider claims submitted to Medicaid managed care entities (MCEs). The legislation required the Louisiana Department of Health (the Department, or LDH) to produce and submit the Healthy Louisiana Claims Report to the Joint Legislative Committee on the Budget and to the House and Senate Committees on Health and Welfare.

The initial report covered claims paid during Calendar Year (CY) 2017 and was submitted to the legislature October 31, 2018. Subsequent reports are submitted on a quarterly basis. Each subsequent report shows the most recent four quarters of data available. This report covers Quarters 1, 2, 3 and 4 of CY 2020.

LDH has engaged Burns & Associates (B&A), a division of Health Management Associates, to assist in the ongoing data collection, analysis and trending of these measures. B&A also assisted LDH with the initial Act 710 report submission and provided recommendations for future reporting. B&A's full analysis for the quarterly report accompanies this executive summary.

Report Contents

The report contains data from six managed care entities (MCEs) that are contracted that are under contract with Louisiana Medicaid. This includes the five MCEs currently under contract to provide acute care, behavioral health and pharmacy services as well as a single dental benefit program manager (DBPM) under contract to deliver dental benefits only:

Plan Name	Plan Type	Common Abbreviation
Aetna Better Health, Inc.	Managed care organization	ABH
Amerihealth Caritas Louisiana, Inc.	Managed care organization	ACLA
Healthy Blue	Managed care organization	HBL
Louisiana Healthcare Connections, Inc.	Managed care organization	LHC
UnitedHealthcare of Louisiana, Inc.	Managed care organization	UHC
MCNA Insurance Company, Inc.	Dental benefit program manager	MCNA

The measures included in this report are delineated by provider type categories as shown below:

Acute Care Providers	**Behavioral Health**
Inpatient and outpatient hospital	Mental or behavioral health rehabilitation
Home health	Specialized behavioral health services
Primary care and Pediatrician	
OB-GYN	
Therapists (physical, speech and occupational)	
Non-emergency medical transportation	
Medical equipment and supplies	**Pharmacy**
Other professional services not specified above	

The key measures that are reported on in each quarterly update include:

1. The percentage of claims submitted by providers that are accepted or rejected by the MCEs;
2. Of those claims accepted, the percentage of claims paid or denied by the MCEs;
3. The average time it takes each MCE to make the payment or denial decision on claims;
4. For those claims that are denied payment, the top reasons why the claims are denied;
5. The percentage of claims adjudicated (paid or denied) by the MCEs that are successfully submitted to LDH for use in the Medicaid data warehouse (at this point it is called an *encounter submission* to LDH); and
6. The average time it takes each MCE to send its encounter submissions to LDH.

For each of these key measures, data is reported at the statewide level, at the individual MCE level, and at the individual provider category level. Data is also being gathered by each MCE related to each MCE's educational efforts with providers about claims submissions, with a particular focus on those providers that have a high claims denial rate.

Key Findings

Measure #1: Claims Accepted and Rejected by the MCEs

- In the most recent four quarters for which data is available, the overall quarterly claims rejection rate for all Medicaid MCEs combined was between 1.2% and 1.4%. This rate, however, is driven primarily by LHC (rejection rate of 2.9% to 3.7%) with the other MCEs having rejection rates close to zero.

Measure #2: Claims Paid and Denied by the MCEs

- The overall rate of paid claims accepted by the MCEs was between 81.6% and 82.3% in the most recent four quarters. The denial rates, therefore, were between 17.7% and 18.4%.

- At the MCE-specific level, the denial rate in the last four quarters was from a range of 16.9% for LHC to 22% for ABH (this excludes MCNA's dental claims).

- The claim denial rates have been generally consistent since Act 710 reporting began.

- More variation was found when the claims denial rates were examined by provider type. For example, the highest denial rates are found for inpatient hospital services (average 18.2% in the last four quarters) and pharmacy (average 27.2% in the last four quarters). The lowest denial rates are found for non-emergency medical transportation (average 3.2% in the last four quarters) and pediatric dental services (average 9.7% in the last four quarters).

Measure #3: Average Time for the MCEs to Process Claims

LDH requires that 90% of claims be adjudicated within 15 business days and that 99% of claims be adjudicated within 30 calendar days. An adjudicated claim could mean a decision to either pay or to deny. The measurement for turnaround time (TAT) for adjudication is the number of days from receipt of the claim by the MCE to the time in which the provider is paid or notified they will not be paid.

- The MCEs are meeting the target for adjudication within 30 days as set by LDH. In fact, the average TAT is below 10 days in each of the last four quarters for all MCEs.
- The overall TAT for paid claims, all MCEs combined, is between 8.3 and 9.4 days in each quarter. For denied claims, the average is between 7.2 and 8.0 days.
- Claims adjudication average TATs do vary by provider category, but not significantly, from the overall average.

Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
All Claim Types, By MCE and By Quarter

		Adjudicated Within 30 days		Avg Turnaround Time	
		Pct of Paid	Pct of Denied	Paid Claims	Denied Claims
ABH	Q1 2020	99.9%	99.8%	8.1	5.9
	Q2 2020	99.7%	99.0%	8.3	6.0
	Q3 2020	99.7%	99.4%	8.0	5.6
	Q4 2020	99.5%	99.2%	8.0	6.1
ACLA	Q1 2020	100.0%	99.9%	5.2	6.0
	Q2 2020	100.0%	99.9%	5.4	6.5
	Q3 2020	100.0%	100.0%	5.7	7.2
	Q4 2020	100.0%	100.0%	5.5	7.4
HBL	Q1 2020	99.6%	99.6%	6.8	4.3
	Q2 2020	99.0%	98.7%	6.8	4.3
	Q3 2020	99.7%	98.3%	7.2	6.1
	Q4 2020	99.7%	99.2%	7.1	4.6
LHC	Q1 2020	99.7%	99.6%	8.8	9.6
	Q2 2020	99.8%	99.4%	9.0	9.6
	Q3 2020	100.0%	99.9%	8.5	9.2
	Q4 2020	99.9%	99.8%	8.5	9.2
UHC	Q1 2020	99.9%	100.0%	9.4	2.6
	Q2 2020	99.9%	99.5%	8.6	3.2
	Q3 2020	100.0%	100.0%	8.0	2.7
	Q4 2020	99.8%	99.9%	8.9	2.8
MCNA	Q1 2020	100.0%	100.0%	8.6	10.0
	Q2 2020	100.0%	100.0%	3.5	6.5
	Q3 2020	99.9%	99.7%	7.4	9.0
	Q4 2020	100.0%	100.0%	8.6	10.1

Measure #4: Top Reasons for Denied Claims

When a claim is adjudicated, the claims processor will assign codes to indicate the reason(s) why the claim adjudicated the way it did. For medical and dental claims, there is a set of nationally-recognized Claim Adjustment Reason Codes (*CARCs*), about 280 reason codes in all. For pharmacy claims specifically, there are close to 350 reason codes developed by the National Council for Prescription Drug Programs (NCPDP).

Some key findings on CARCs appear below:

- In Q4 2020, LHC and UHC had its top five CARCs within the top 10 CARCs statewide. ABH and ACLA had four, while HBL and MCNA had three of its top five CARCs in the statewide top 10.
- The top five CARCs were also among the top seven in the previous ten quarters reported.

Some key findings on NCPDPs appear below:

- In Q4 2020, every MCE except ABH had their top five NCPDP codes also in the top 10 for all MCEs (ABH had four of its five).
- These five NCPDPs were also among the top six in the previous eight quarters reported.

Measure #5: Encounter Claims Submitted to LDH by the MCEs that are Accepted or Rejected

- In the most recent four quarters studied, 98.0% to 98.9% of the encounters submitted by all MCEs combined were accepted by LDH.

- There were differences at the MCE level. All of UHC's and almost all of HBL's and MCNA's encounters were accepted. ACLA and LHC had at least 96% of their encounters accepted, but ABH had some challenges, particularly in the last three quarters.

Measure #6: Average Time for the MCEs to Submit Encounters

Like claims adjudication, a common benchmark to track the timeliness of encounter submissions is the average turnaround time (TAT). In the case of encounters, the average TAT measures the date from which the MCE gave notice to the provider of payment or denial to the date that the encounter was submitted to LDH. A common benchmark used is that MCEs should submit encounters within 30 days of adjudication. There is some variation in the pace at which each MCE submits it encounters to LDH, and this can vary by claim category.

- For institutional encounters (mostly claims from hospitals), ABH had issues with timely submissions in all four quarters of 2020. ACLA had some issues in Q3 and Q4 2020, while LHC did in Q1 and Q2 of 2020.

- HBL consistently has the highest rate of submission of professional encounters within 30 days followed by UHC and ACLA. ABH had challenges with professional encounter submission timeliness in all four quarters of 2020. ACLA had some issues in Q3 and Q4 2020, while LHC did in Q1 and Q2 of 2020.

- There is greater variation in the timeliness of pharmacy encounter submissions. ACLA had 100% timeliness within 30 days in all quarters of 2020. HBL and UHC had few pharmacy encounters submitted after 30 days in every quarter. ABH and LHC consistently are lowest on pharmacy encounter timeliness—ABH usually near 70% untimely, and LHC has varied from 50% to 72% untimely in the last four quarters.

- MCNA had few issues meeting an average 30-day TAT for its dental encounters in the first three quarters of 2020, but they did have issues in Q4.

Measure #7: Provider Education

LDH is requesting that the MCEs report information on education to providers on claims adjudication on a quarterly basis. The MCEs are reporting on the individual entities who are outreached to, the type of outreach conducted, and the date that the outreach was conducted.

In Q4 2020, a total of 1,227 provider entities were outreached to (down from 1,514 in the prior quarter). The most predominant mode to outreach to providers is 1:1 emails (56.2% of all contacts) followed by 1:1 phone calls (40.4% of contacts). Webinars were 3.3 percent of the total. In-person contact was not done due to the pandemic.

Case Management

In addition to claims adjudication and encounter submission statistics, Act 710 requires the Department to report certain measures pertaining to case management in the Medicaid managed care program:

> *E. The initial report and subsequent quarterly reports shall include the following information relating to case management delineated by a Medicaid managed care organization:*
>
> *(1) The total number of Medicaid enrollees receiving case management services.*
>
> (2) *The total number of Medicaid enrollees eligible for case management services*.

Each of the MCEs is contractually required to develop and implement a case management program through a process which provides appropriate and medically-related services, social services, and/or basic and specialized behavioral health services for members that are identified as having special healthcare needs (SHCN) or who have high risk or unique, chronic or complex needs.

The Department currently monitors the identification and assessment of members in need of case management services and those receiving case management services through MCE self-reported data provided on a quarterly basis. While there are specific contractual standards that require MCEs to complete an assessment of all individuals identified as having a special healthcare need within 90 days of identification, each MCE has their own policies and procedures for identification and assessment. As such, the reporting for case management has shown significant variation across MCEs. LDH has worked to increase the comparability of the data collected. More intensive data analysis is currently underway.

The data presented below is representative of unduplicated totals by MCE for CY 2020 quarter 4.

CY 2020 - Quarter 4: Unduplicated Totals	ABH	ACLA	HB	LHCC	UHC
Eligible for Case Management (CM)	833	4,951	5,453	15,098	15,138
Enrolled in CM at least 1 month	607	2,152	1,472	3,701	2,830
% of eligibles enrolled in CM	72.9%	43.5%	27.0%	24.5%	18.7%
Received CM Service	543	1,864	771	2,730	1,363
% enrolled receiving service	89.5%	86.6%	52.4%	73.8%	48.2%

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INDEPENDENT STUDY OF PROVIDER CLAIMS SUBMITTED TO MEDICAID MANAGED CARE ENTITIES IN THE HEALTHY LOUISIANA PROGRAM

QUARTERLY UPDATE #10

PERIOD COVERING THE 4TH QUARTER

OF CALENDAR YEAR 2020

JULY 1, 2021

BURNS & ASSOCIATES, INC.

A DIVISION OF HEALTH MANAGEMENT ASSOCIATES

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SECTION I: INTRODUCTION

Legislative Overview

On June 1, 2018, the Louisiana State Legislature passed House Bill 734, which subsequently was enrolled and chaptered as Act 710 of the 2018 regular legislative session. The Act requires reporting of data on healthcare provider claims submitted to Medicaid managed care entities (MCEs). The legislation required the Louisiana Department of Health ("the Department", or LDH) to produce and submit the "Healthy Louisiana Claims Report" to the Joint Legislative Committee on the Budget and to the House and Senate Committees on Health and Welfare.

The initial report covered claims paid during Calendar Year (CY) 2017. Subsequent reports are required to be submitted on a quarterly basis. Each subsequent report must cover a more recent three-month period than the previous report. This is the ninth report update.

Report Update	Calendar Year 2018				Calendar Year 2019				Calendar Year 2020			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1	X	X	X									
2	X	X	X	X								
3		X	X	X	X							
4			X	X	X	X						
5				X	X	X	X					
6					X	X	X	X				
7						X	X	X	X			
8							X	X	X	X		
9								X	X	X	X	
10									X	X	X	X

Required Reporting for the Initial Report

The Act requires that information be reported on for behavioral health and non-behavioral health providers separately. Specific information related to claims adjudication that must be reported includes:

- The total number and dollar amount of claims based on the claim status, such as rejected claims, voided claims, duplicate claims, adjusted claims, adjudicated claims and pended claims;
- The total number and dollar amount of claims denied divided by the total number and dollar amount of claims adjudicated;
- The total number and dollar amount of claims for which there was at least one service line denied on the claim; and
- Information on the five billing providers (de-identified in the report) with the highest number of total denied claims (expressed as a ratio to the total claims adjudicated for the provider).

The Department was also required to report on the action steps that it will take in order to address:

- The five most common reasons for denial of claims submitted by healthcare providers (behavioral and non-behavioral health providers separately) and the educational efforts the Department and/or the MCEs will undertake to educate the providers with the highest number of denied claims.
- The methods used to ensure that provider education includes the root cause for the denial reasons.
- Claims denied in error by the Medicaid MCEs.

In addition to MCE claims adjudication information, the Act requires that the Department report on:

- The total number of encounters submitted by each Medicaid MCE to the Department or its designee;
- The total number of encounters submitted by each Medicaid MCE that are not accepted by the Department or its designee;
- The total number of Medicaid enrollees eligible to receive case management services; and
- The total number of Medicaid enrollees receiving case management services.

Steps in Claims Processing and Encounter Submissions

In a typical claims processing system, a provider will submit a claim for services rendered to the payer (in this case, the MCE) using one of the standardized claim formats that have been established nationally. Although it is still possible for claims to be submitted on paper, the vast majority of claims are now submitted in a standardized electronic format.

There are four primary claim "form" types (either in paper or electronic format):

- The *UB-04, or electronic 837I*, is the claim type for institutional providers to submit on. This includes hospitals, nursing homes and home health agencies.

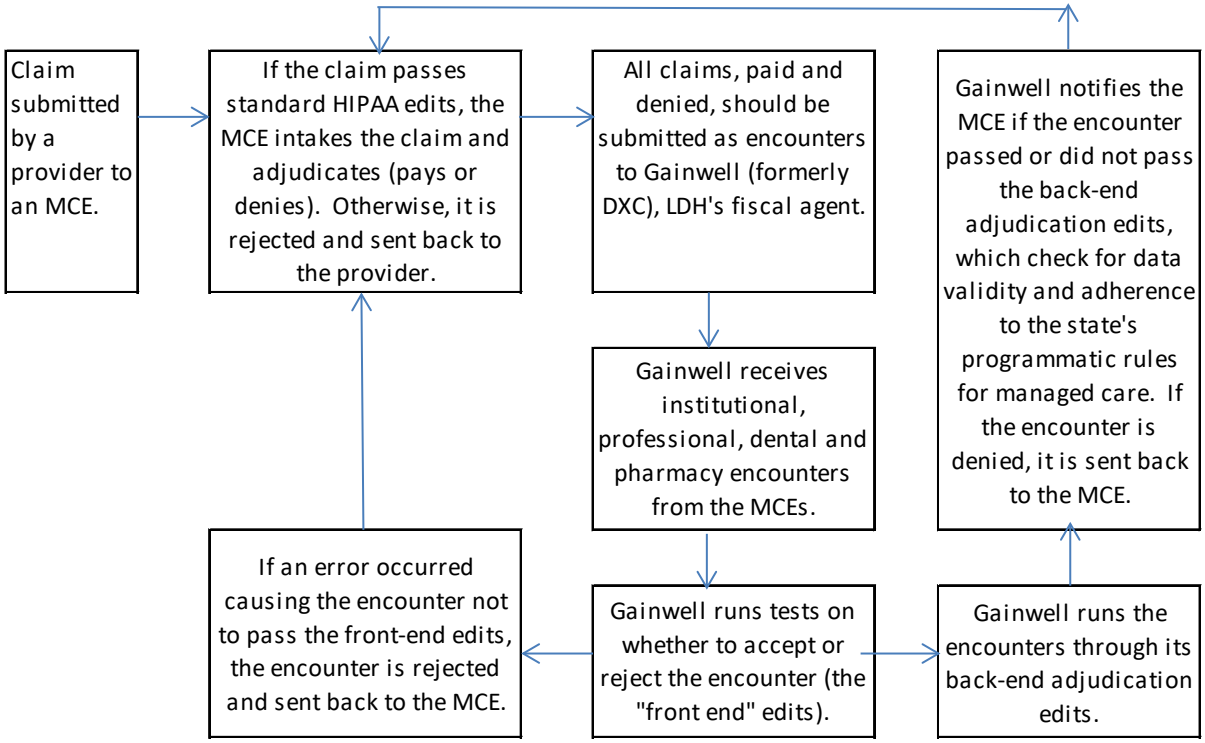
- The *CMS-1500, or electronic 837P*, is the claim type for professional service providers to submit on. This includes a wide array of providers such as physicians, clinics, mental health providers, therapists, transportation providers, suppliers of medical equipment and supplies.

- The paper and *electronic 837D* version of the *dental claim form* were developed and endorsed by a working group sponsored by the American Dental Association and is specific to dental services.

- *Pharmacy claims* are now universally submitted in electronic format also using a format for 837 transactions like the 837I and 837P. The standards for submitted pharmacy claims were developed in collaboration with the National Council for Prescription Drug Programs (NCPDP).

Exhibit I.1 on the next page summarizes how claims are submitted to Medicaid MCEs in Louisiana and, in turn, the process in which the MCEs submit encounters to the Department's fiscal agent, Gainwell (formerly DXC).

Exhibit I.1
Submission, Validation and Processing Flow of Managed Care Claims and Encounters



Terminology Used in this Report

A ***claim*** is the bill that the health care provider submits to the payer (in this case, the MCE). An ***encounter*** is the transaction that contains information from the claim that is submitted by the MCE to the Department.

A claim can be assigned different attributes based on the status of what is being submitted (or returned).

- An *original claim* indicates the first submission made by the provider to the payer.
- At times, there may be a need to make adjustments to the original submission. If the provider does this, then the claim may be tagged as an *adjusted claim*.
- In other situations, the provider realizes that the submission was sent in error or needs to be completely changed. Therefore, claims may be flagged as *voided claims*. Immediately after, there may be a *replacement claim* (but not necessarily).

When a claim is submitted to a payer, there are standards that must be upheld such as the minimum information that is required, the valid values to put in fields, etc. The Health Insurance Portability and Accountability Act (HIPAA) mandated the minimum criteria required on claims submissions. As a result,

claims processors conduct “front-end” edits upon receipt of a claim to ensure that the claim passes “the HIPAA edits”. If a claim does not pass these front-end edits, the claim is flagged as a *rejected claim*. Typically, there is little information retained by payers on rejected claims.

Assuming that a claim passes the front-end edits and gets “through the door”, the claims processor will then conduct *adjudication* on the claim. An *adjudication status* of paid or denied is assigned to the claim. However, this status can be (and usually is) assigned at two different levels:

- A *header claim status* means the status assigned to a claim across all services reported on the claim (since a single claim can contain more than one service billed on it).
- A *detail claim status* means the status assigned to the individual service lines that are billed on a claim.

It is customary for claims processing systems to track the claim status at both levels. When the status is at the header level:

- A *paid status* usually means that at least one service line on the claim was paid.
- A *denied status* usually means that every service line on the claim was denied.

At the detail level, however, the status could be paid or denied, and the status of the individual detail line may differ from the header status. For example, a professional claim contains five service lines. The first four are paid. The fifth service is denied. Each service line will have its own claim status, but the header claim status will be paid.

It is important to factor this information in when analyzing claims and claim trends. The question to ask is if the claim counts shown represent the count of header records or of individual service lines. The count of header lines may be a fraction of the total detail service lines.

The Department has asked the MCEs to report all information on claims adjudication at the service (detail line) level with one exception. For inpatient services, payment is made by LDH and its MCEs on only one line of the claim (the room and board line). Therefore, for inpatient hospital claims, only one service line is reported for each claim. The information shown throughout this report is reported at the service (detail line) level.

For a brief period, claims may be assigned a *pended status*. This means that the payer has not yet decided whether to pay or deny the claim (or claim line). Payers will assign a pended status to claims that require additional research or require manual review. For example, claims may pend because a medical review is required before payment is allowed; or, it could be that a provider is on a list that requires manual review because the provider had previously been identified as submitting potentially inaccurate bills in the past. Claims adjudication systems may assign claims to a pended status for as little as a few minutes or as much as multiple days depending upon the reason the adjudication process was suspended. Each claims processor sets its own criteria for assigning claims to a pended status.

The *turnaround time* factors in any time that a claim is pended. This is the term used to describe the length of time it takes for payers to adjudicate claims. In this study, the average turnaround time represents the time from receipt of the claim by the MCE to the time of notification to the provider (pay or deny).

When a claim is adjudicated, the claims processor will assign codes to indicate the reason(s) for why the claim adjudicated the way it did. Many payers will design codes specific to their own organization. However, there are a set of national codes that have been developed:

- For medical and dental claims, there is set of nationally-recognized Claim Adjustment Reason Codes (*CARCs*), about 280 reason codes in all.
- For pharmacy claims specifically, there are nearly 350 reason codes developed by the *NCPDP* (National Council for Prescription Drug Programs).

The reason codes describe information on both paid claims and denied claims. LDH requires the contracted MCEs to submit information on the CARCs and NCPDP codes that pertain to situations when claim lines are denied. The frequency of CARCs and NCPDP codes for denied services were examined in this study. A service line on a claim may have more than one CARC or NCPDP code as well.

Trends Found in Prior Report Releases

When reviewing trends across all prior quarterly report updates, the trends have been consistent:

Claim Rejection Rate	1.1% to 1.4% of claims submitted by providers are rejected by the MCEs.
Claim Payment Denial Rate, Overall	From a low of 17.0% to a high of 19.4%
For Hospital Claims	Much higher for inpatient hospital services (21%-25%), but outpatient hospital services have one of the lowest denial rates of any service category (8%-10%). Inpatient denial rates have been going down in recent quarters.
For Professional Services	The denial rate range has been steady between 10% and 12%.
For Dental Claims	For child dental services, denial rate has been steady between 8% and 9%.
For Pharmacy Claims	Industry standard is that pharmacy scripts have highest denial rate. LDH is no exception with a denial rate range between 24% and 28%.
Turnaround Time to Process Claims	The time for MCEs to process provider claims has been steady in every report, from 6.9 days to 8.4 days.
Time for MCEs to Submit Claims as Encounters to LDH	There is variation in the timeliness for the MCEs to submit their claims to LDH. This can vary by MCE and by quarter. Generally, Healthy Blue, United and MCNA are most consistently timely (that is, all encounters submitted to LDH within 30 days of processing).

SECTION II: CONSTRUCT OF THE QUARTERLY UPDATE REPORT

Six reports were designed specifically to be able to report information in the Act 710 quarterly updates. LDH requires that each MCE submit these six reports on a quarterly basis. It should be noted that there will be a lag time between the claims adjudication period and the date that the MCEs will submit the reports to LDH as allowed by the Act. This allows time for the MCEs to accumulate data for reporting.

The MCEs analyzed in this review include:

- Aetna Better Health (ABH)
- Amerihealth Caritas Louisiana (ACLA)
- Healthy Blue (HBL)
- Louisiana Healthcare Connections (LHC)
- United Healthcare (UHC)
- Managed Care of North America (MCNA), for dental services only

Measures that will be Reported Each Quarter

The Healthy Louisiana Claims Report quarterly updates are delivered in the same format each quarter. The key measures that are tracked on an ongoing basis include:

- The rate of claims accepted and rejected by each MCE
- The rate of accepted claims that are paid and denied by each MCE
- The timeliness (turnaround time) for each MCE to adjudicate claims
- The top reasons why claims are being denied at each MCE
- Provider education efforts (this measure is presented for the first time in this report)
- The rate of encounters accepted and rejected by LDH for each MCE
- The timeliness for each MCE to submit encounters to LDH on its adjudicated claims

Provider Categories

Act 710 required that behavioral health providers be reported discretely from non-behavioral health providers in the initial report. In consultation with stakeholders, LDH also agreed that there be further segmentation of the non-behavioral health providers for discrete reporting. The provider categories that are reported on an ongoing basis are:

Institutional Claim Type (837I)	**Professional Claim Type (837P)**
Inpatient hospital	Primary care
Outpatient hospital	Pediatrician
Home health	OB-GYN
All other services submitted on an institutional claim not specified above	Therapists (physical, speech and occupational)
	Non-emergency medical transportation
Dental Claims (MCNA Only)*	Medical equipment and supplies
Pediatric dental care	Mental or behavioral health rehabilitation
Adult denture services	Specialized behavioral health services
Pharmacy Claims (no additional breakouts)	All other services submitted on a professional claim not specified above

*MCE value-added dental services are included in the Professional Services category.

How This Report is Organized

Section III contains the results related to MCE claims adjudication measures and MCE provider education pertaining to claim submissions. Section IV reports on the results of findings related to MCE encounter submissions.

In some exhibits, data is displayed for the most recent four quarters. In this report, the four quarters shown are Quarters 1, 2, 3 and 4 in 2020. Other exhibits will display only the data from the most recent quarter. In this edition of the report, the exhibits that contain only the most recent quarter show Q4 2020 data.

Appendix A provides the numeric values for the exhibits shown in the body of the report which are shown in a graphical format. *Appendix B* provides a 1-page summary for each of the 16 provider categories. The summaries in this appendix compile information from the exhibits in the body of the report but focus on a single provider specialty on each page.

Limitations of the Data

In its review of the reports submitted by each MCE to LDH for this quarterly update, Burns & Associates (B&A) would like the reader to keep in mind two known limitations of the data reported:

1. All data is self-reported by the MCEs to LDH. B&A conducts a validation process upon submission of reports to LDH each quarter. In some situations, MCEs are asked to verify and possibly update specific values that were reported to confirm their accuracy if the initial submission deviated from trends reported in a prior period.

2. The Act requested information on the dollar amount of denied claims. If a claim is denied, then the payment is $0. There are multiple limitations to computing a "would have paid" amount.

    - First, some denied claims would never pay anything because they are exact duplicates of a claim previously submitted.
    - Second, there are multiple methods in which to derive a dollar amount of a "would have paid" if the claim had a paid status. Ultimately, B&A selected an approach that estimates the value of each denied claim by applying a value to it that is the average value of every paid claim in that category.

    Because of these limitations, the value of denied claims should be reviewed with caution. It is of the opinion of the B&A reviewers that the values shown for denied claims should not be considered as "lost" money to providers. Instead, they show the relative values of opportunity for improvements in the accuracy and completeness of provider claims submissions.

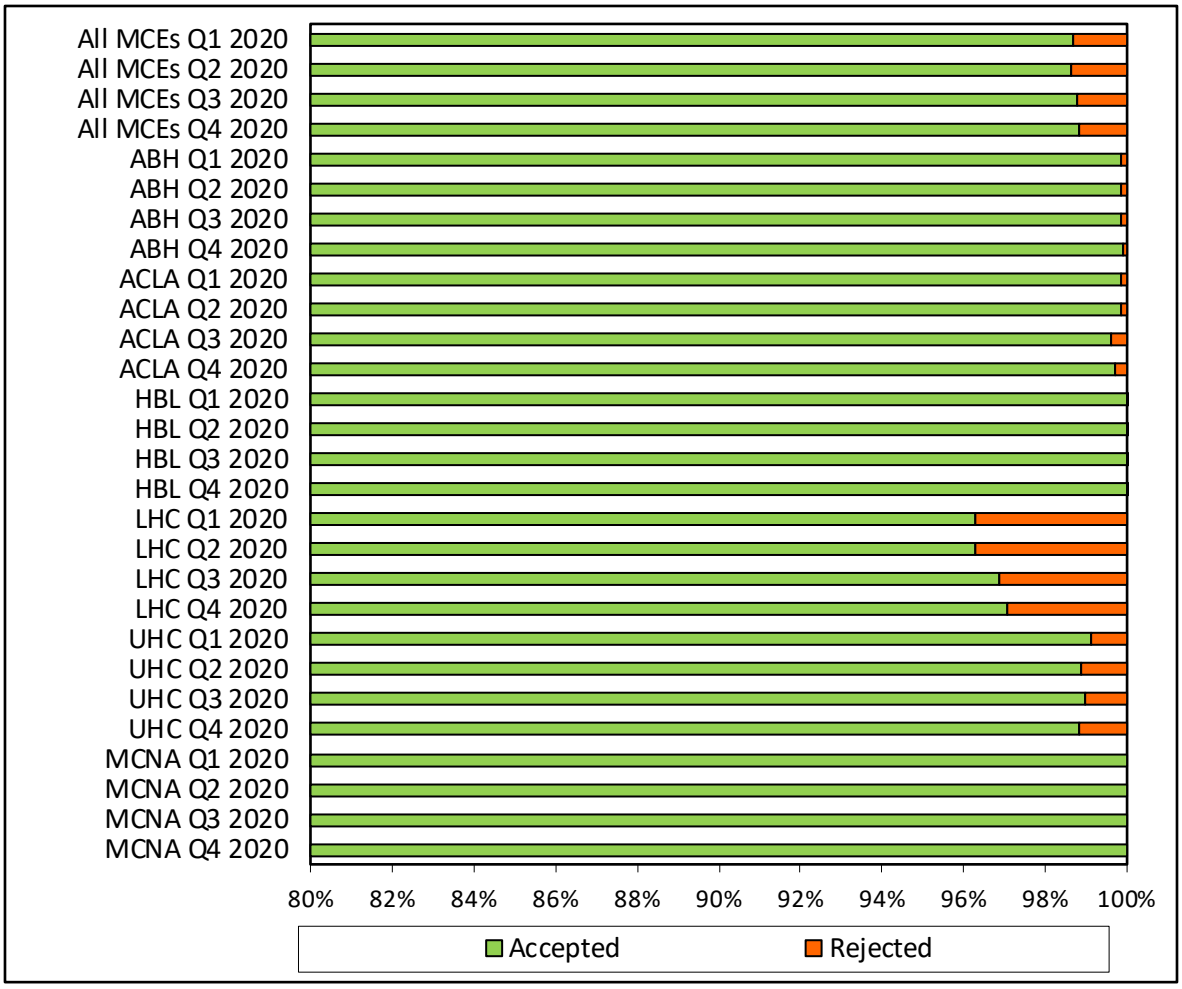
SECTION III: FINDINGS RELATED TO MCE CLAIMS ADJUDICATION

LDH's contracted MCEs or their subcontractor adjudicates all provider claims submitted. The MCEs themselves adjudicate medical claims (those billed in the institutional claims, or 837I, format and those billed in the professional claims, or 837P, format). MCNA adjudicates almost all of the dental claims for the Medicaid program. Each MCE contracts with a pharmacy benefit manager to adjudicate the pharmacy claims.

Claims Accepted and Rejected by the MCEs

In the most recent four quarters for which data is available, the claims rejection rate reported by the Medicaid MCEs was between 1.2% and 1.4%. The rejection rate overall is specifically due to higher rejection rates for LHC (2.9% to 3.7%) with the other MCEs having rejection rates closer to zero.

Exhibit III.1
Claim Accepted and Rejected Rate
All Claim Types
By MCE and By Quarter

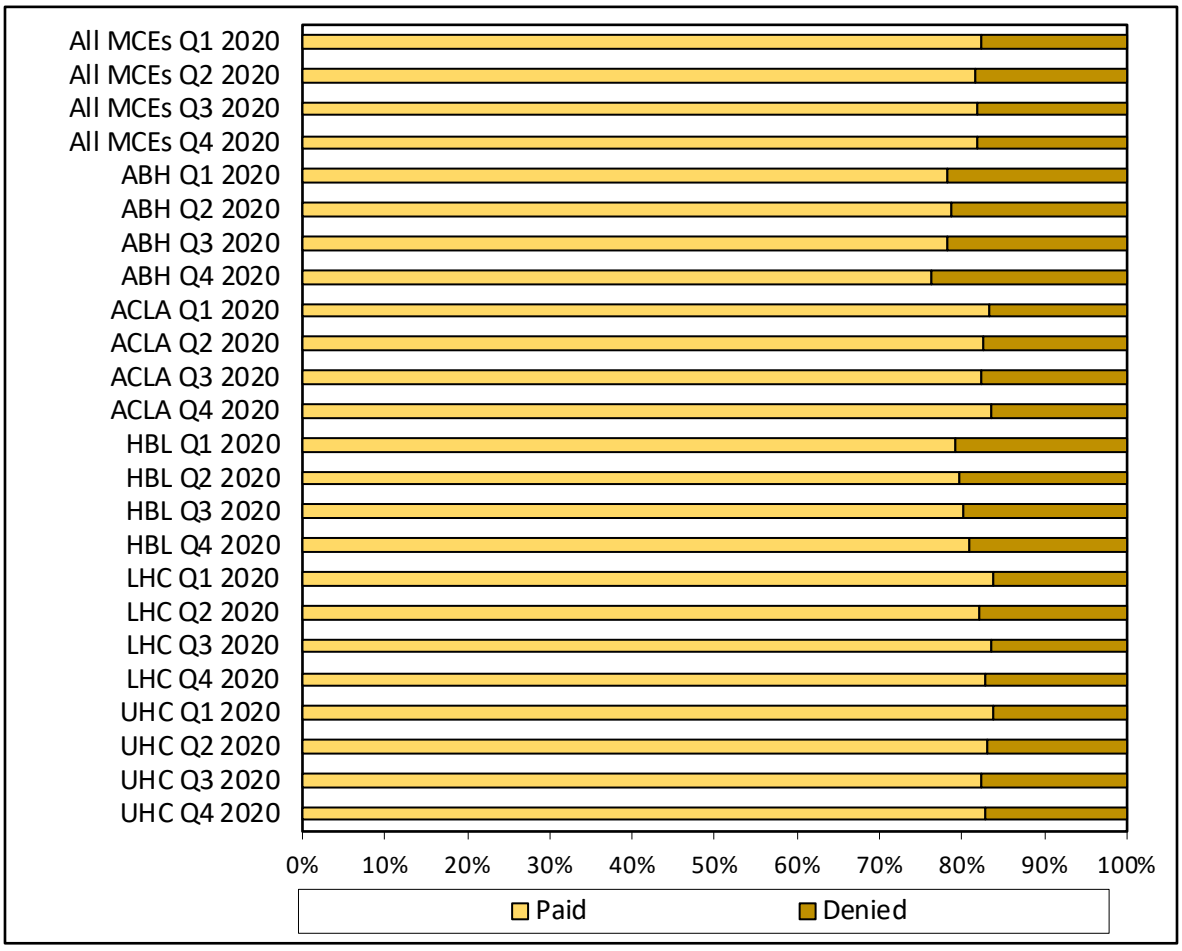


Claims Paid and Denied by the MCEs

For those claims that were accepted into the MCE's claims adjudication system, on average, the overall rate of paid claims was between 81.6% and 82.3% in the most recent four quarters. The denial rates, therefore, were between 17.7% and 18.4%. These denial rates have remained fairly steady since the Act 710 quarterly update reports have been release.

At the MCE-specific level, the range across the four-quarter averages was from an average denial rate of 16.9% for LHC to an average rate of 22.2% for ABH. The denial rates are not going down in any significant manner since the original report showing CY 2017 data. These statistics exclude MCNA dental claims, which can be found in Exhibit III.4 in the categories Dental – Children and Dental – Adult.

Exhibit III.2
Claim Status for Adjudicated Claims
All Claim Types
By MCE and By Quarter



There is more variation found when the claims denial rates are examined by service category. On the next two pages, denial rates are shown for acute care services (Exhibit III.3) and non-acute care services (Exhibit III.4). As seen in both exhibits, the denial rate within a service category is usually very consistent when reviewed quarter by quarter.

Exhibit III.3
Claim Denial Rates by Acute Care Service Category
For All MCEs Combined, By Quarter

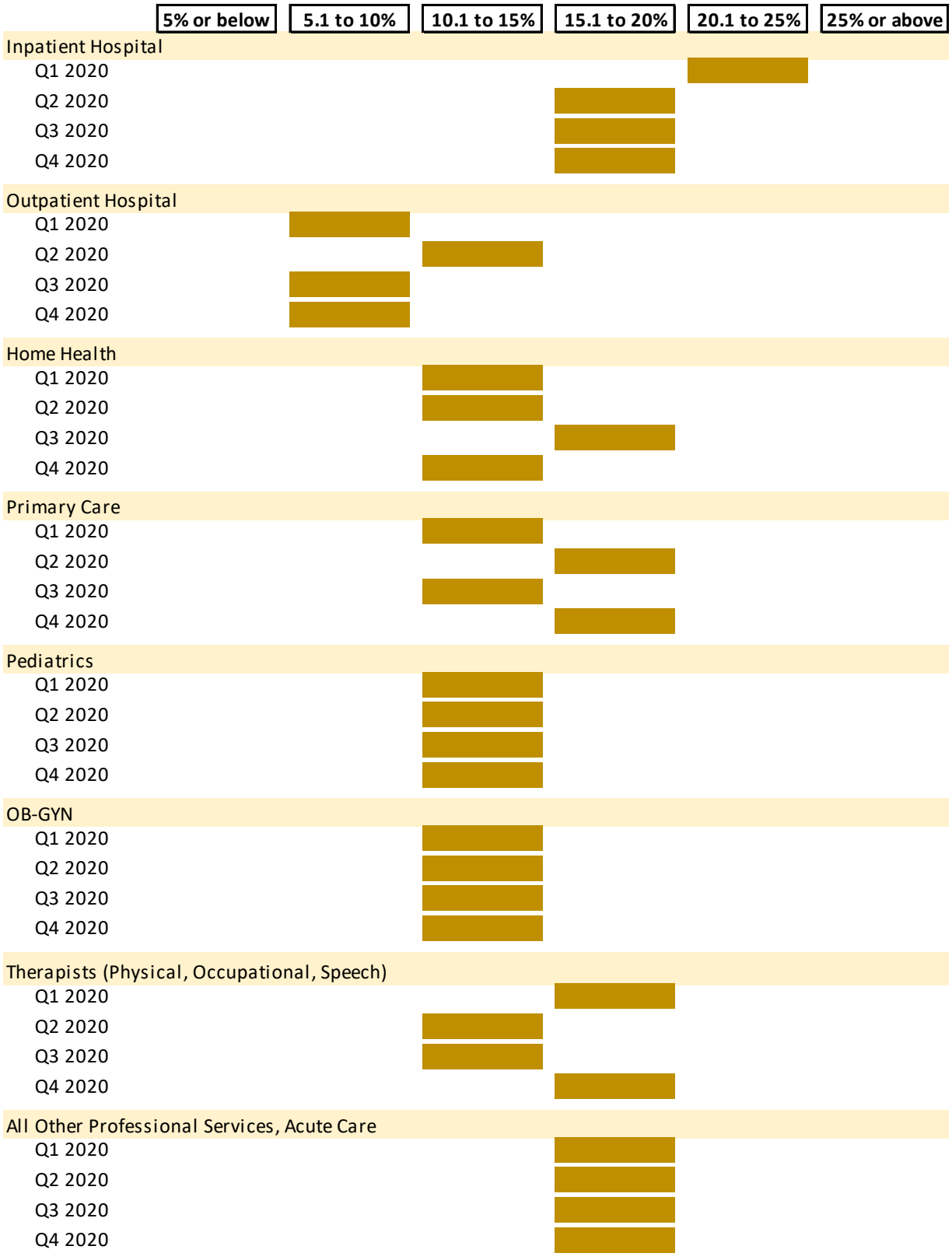


Exhibit III.4
Claim Denial Rates for Non-Acute Care Services
For All MCEs Combined, By Quarter

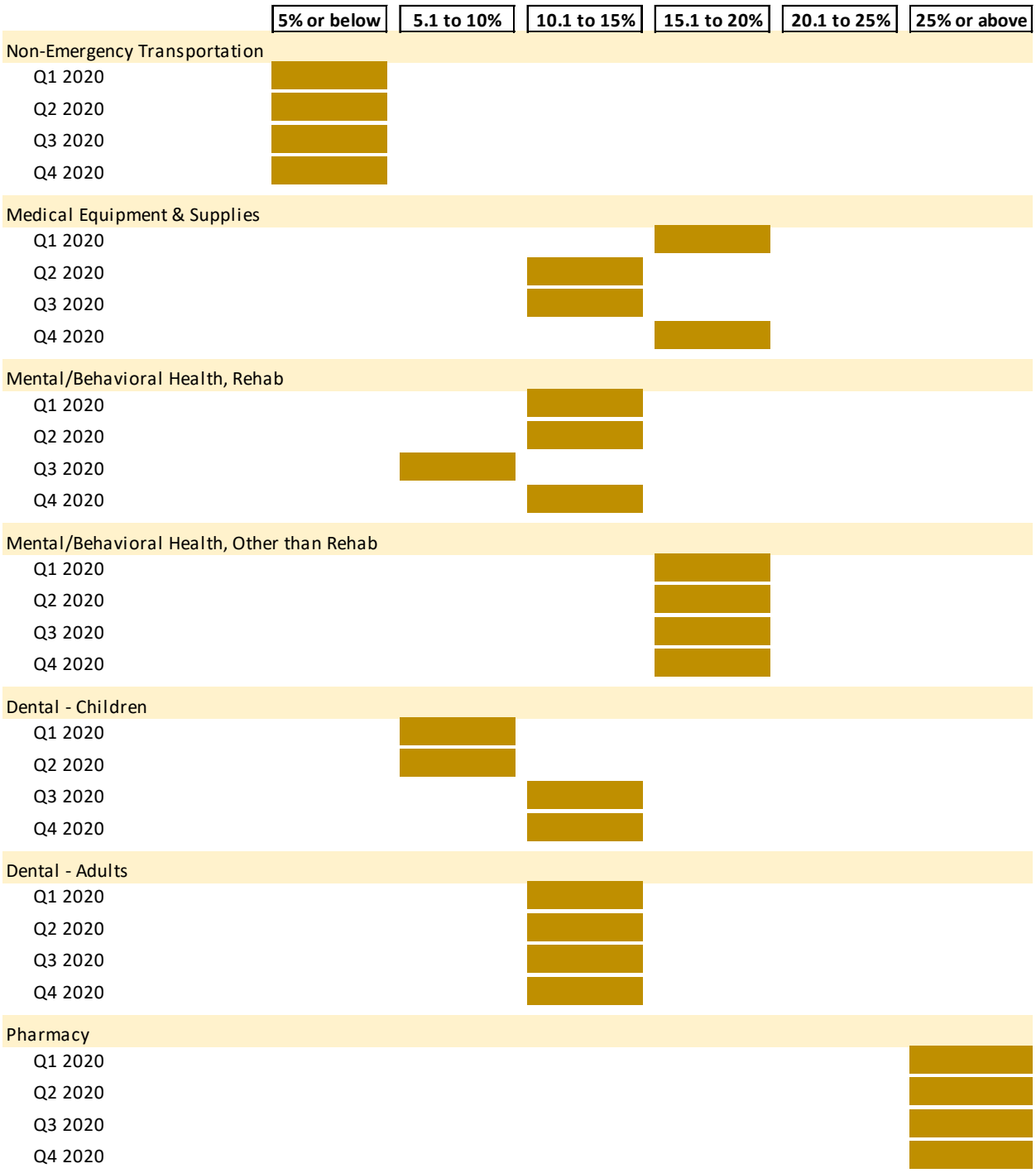
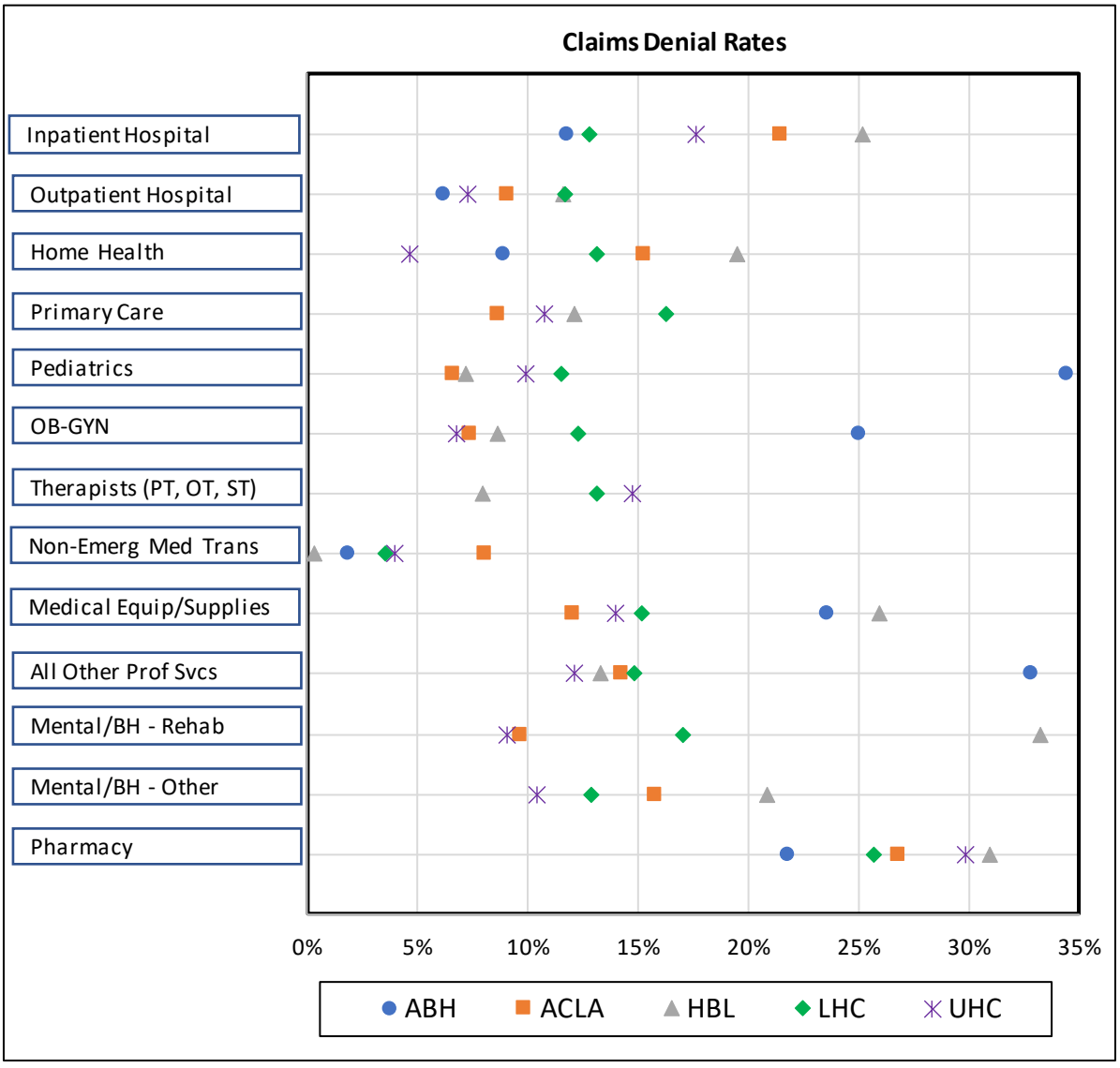


Exhibit III.5 compares the denial rates for these service categories by MCE. The data plotted on this exhibit is the percentage of claims denied in Quarter 4 of CY2020 for each MCE. An icon and color is used to display each MCE's data. Each row in the exhibit represents a specific service category. For example, in the top line of the exhibit, the overall denial rate for inpatient hospital services in Q4 2020 was 17.2%, but this varied from 11.7% for ABH to 25.2% for HBL.

The claims denial rate is clustered for outpatient hospital, therapists and pharmacy. For other services, the denial rates vary significantly by MCE (e.g., medical equipment and supplies, mental and behavioral health services). In other categories, most MCEs have a similar rate, but ABH varies from all of its peers (e.g., primary care, pediatrics, OB-GYN).

Exhibit III.5
Claim Denial Rates for Adjudicated Claims
By Provider Specialty / Service Category
By MCE for Q4 2020 Adjudicated Claims



The Act requires that LDH provide an assigned value to each of the claims that were denied by the MCEs. As discussed in the Limitations of the Data section on page II-2, there are hundreds of edits that are in place at each MCE to ensure that claims are adjudicated properly. Claims may be denied for a number of reasons, but just to name a few:

- Claim submitted is an exact duplicate of another claim submitted;
- The service billed is not a covered service in the Medicaid program;
- The units billed for a covered service exceeds the number of units allowed (e.g., chiropractic visits, number of eyeglasses each year); and
- The service billed requires an authorization by the MCE before the service is rendered and an authorization was not received for the service.

In some of these situations, the claim that was denied could never have received a payment (e.g., exact duplicate submitted). In other situations, the claim that was denied may have received payment if other business rules were followed (e.g., the authorization that was required was obtained).

Because there is such a variety of denial reasons that are based on the circumstances of each claim, it is not appropriate to unilaterally assume that every denied claim could have been paid or should have been paid. With this in mind, B&A tabulated the information on denied claims from each MCE and attempted to assign a value to each denied claim without inferring if the claim could have been paid or should have been paid.

To do this, B&A examined each of the provider specialties separately. Within each category, the MCE reported the number of claims paid and the total payments made. B&A computed an average payment per claim. Then, the MCEs reported the number of denied claims in the provider specialty. B&A used the average payment per claim in the provider specialty and multiplied this by the number of denied claims to impute a value for the denied claims.

It is important to apply this formula at the provider specialty level (as opposed to all claims combined) due to the wide range of reimbursement paid to each provider type. For example, in Q4 2020, the average payment for paid inpatient hospital claims was $6,305; for primary care, it was $43.

B&A not only computed an average payment per claim for each provider specialty separately, but also for each MCE within the provider type as well as a separate value for each calendar quarter.

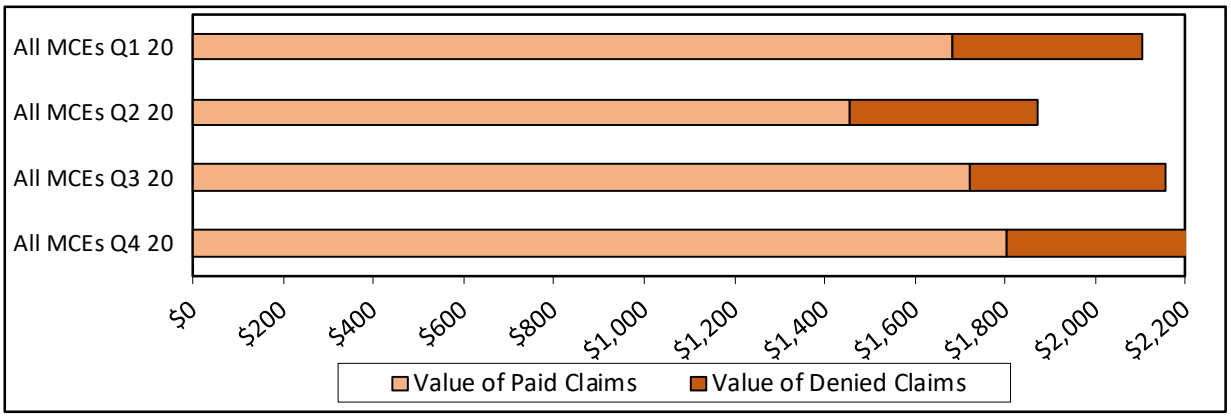
Exhibit III.6 which appears on the next page summarizes the total dollar values of paid claims and denied claims by MCE and by quarter. The denied claims account for between 20.0% and 22.2% of the sum of paid and denied values each quarter. This equates to between $416 million and $452 million. Among the $452 million in denied values in Q4 2020 assigned across the five MCEs that provide medical and pharmacy benefits, $203 million (44.9%) was attributed to medical claims and $249 million (55.1%) was attributed to pharmacy claims. In Q4 2020, the distribution of assigned values to denied claims by MCE was as follows:

- ABH had 66% to medical and 34% to pharmacy claims
- ACLA had 51% to medical and 49% to pharmacy claims
- HBL had 40% to medical and 60% to pharmacy claims
- LHC had 53% to medical and 47% to pharmacy claims
- UHC had 35% to medical and 65% to pharmacy claims

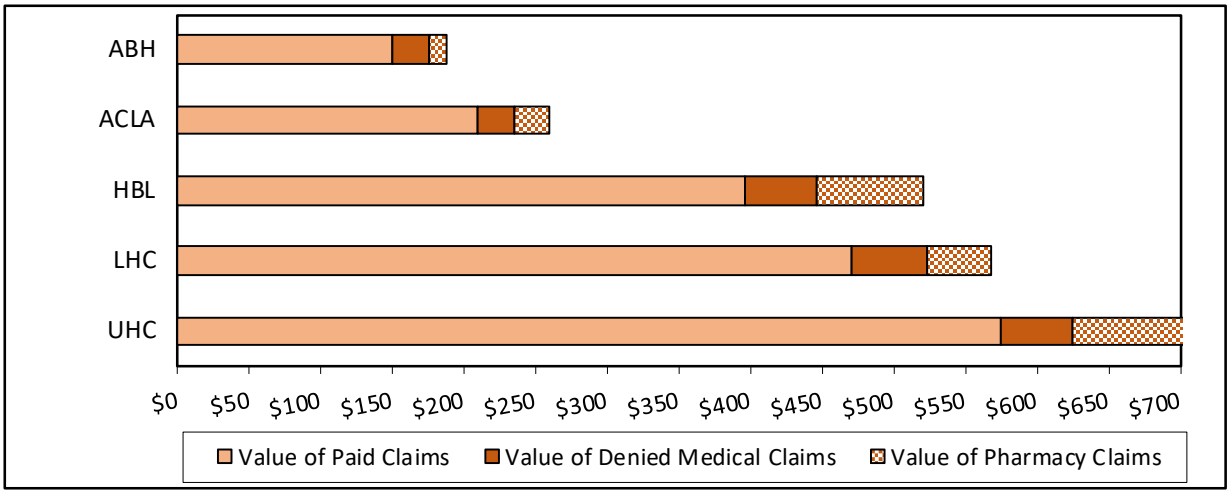
Exhibit III.6

Value of Paid and Denied Claims

The dollar values in the stacked bar represent millions



Q3 2020 Adjudicated Claims Only



MCNA is the MCE that provides dental coverage only.
Their total expenditures are $17 million - $32 million per quarter. They have been excluded from this exhibit.

LDH required the MCEs to further segment each provider specialty's denied claims based on Medicaid volume. The purpose of this is to inform where provider education on claims billing may be of greatest need. For each of the provider specialties, the MCEs divided the specialty into three sub-groups:

- The providers that billed less than 100 claims to the MCE in the quarter ("low")
- The providers that billed between 101 and 250 claims to the MCE in the quarter ("medium")
- The providers that billed more than 250 claims to the MCE in the quarter ("high")

The data submitted by the MCEs was then examined to determine if, for example, a higher proportion of providers with high Medicaid volume had high denial rates compared to those with low Medicaid volume. High denial rate was defined as any provider that had more than 10% of their claims denied by the MCE in the quarter. Statistics were then run to determine what percentage of providers within each group had a high claims denial rate (that is, more than 10%).

With 14 provider specialties (excluding dental) and three groupings within each specialty (low volume, medium volume, high volume), there can be as many as 42 provider/volume groupings to examine. These are then examined for each of the five MCEs (excluding dental services paid by MCNA), so 42 groupings for five MCEs is 210 groupings. The other two provider specialties are specific to dental and specific to MCNA, so this adds six more groupings. That means a total of 216 groupings were examined for each quarter.

B&A reviewed each of the 216 groupings for whether more than half of the providers within the group had a claims denial rate above 10%. There were many provider/volume combinations where the volume of providers was too small (5 or less) to make an assessment.

Exhibit III.7 below shows the instances where the MCE denied more than 10% of the claims for more than half of the providers in the Medicaid volume group (Group A). The second column shows where the denial rate was 10% for less than half of the providers (Group B). There were some combinations where the number of providers small to study (Group C).

The counts represent all MCEs combined. There has been relative consistency in the number of combinations where a majority of providers had a denial rate above 10% in the last three quarters. There were more situations found in Q1 2020 where a majority of providers in each group studied individually had a denial rate greater than 10%. This improved in Q2, Q3 and Q4.

Exhibit III.7
Examination of Individual Providers Who Billed an MCE that Had More than 10% of their Claims Denied

	Group A	Group B	Group C	Groups A, B, C
	Number of combinations where > 50% of providers had a denial rate above 10%	Number of combinations where < 50% of providers had a denial rate above 10%	Number of combinations where the sample of providers was too small to study	Total Groupings
Q1 2020	106	83	27	216
Q2 2020	93	93	30	216
Q3 2020	95	91	30	216
Q4 2020	95	91	30	216

There was no obvious pattern when reviewing the results in Exhibit III.7 except that, in most service categories, the larger-volume providers have lower denial rates than the smaller-volume providers. There are a few differences in the rate of denials where one MCE stands out from the rest.

Timeliness of Claims Adjudication by the MCEs

LDH requires that 90% of claims be adjudicated within 15 business days and that 99% of claims be adjudicated within 30 calendar days. An adjudicated claim could mean a decision to either pay or to deny. The measurement for turnaround time (TAT) for adjudication is the number of days from receipt of the claim by the MCE to the date on which the provider is paid or is notified of the denial.

Exhibit III.8 below shows that the MCEs are meeting the target for adjudication within 30 days as set by LDH. In fact, the average TAT is below 10 days in every quarter for all MCEs with the minor exception of MCNA right at 10 days for denied claims in two quarters. The TAT averages do vary, however, across the MCEs.

Exhibit III.8
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
All Claim Types, By MCE and By Quarter

		Adjudicated Within 30 days		Avg Turnaround Time	
		Pct of Paid	Pct of Denied	Paid Claims	Denied Claims
ABH	Q1 2020	99.9%	99.8%	8.1	5.9
	Q2 2020	99.7%	99.0%	8.3	6.0
	Q3 2020	99.7%	99.4%	8.0	5.6
	Q4 2020	99.5%	99.2%	8.0	6.1
ACLA	Q1 2020	100.0%	99.9%	5.2	6.0
	Q2 2020	100.0%	99.9%	5.4	6.5
	Q3 2020	100.0%	100.0%	5.7	7.2
	Q4 2020	100.0%	100.0%	5.5	7.4
HBL	Q1 2020	99.6%	99.6%	6.8	4.3
	Q2 2020	99.0%	98.7%	6.8	4.3
	Q3 2020	99.7%	98.3%	7.2	6.1
	Q4 2020	99.7%	99.2%	7.1	4.6
LHC	Q1 2020	99.7%	99.6%	8.8	9.6
	Q2 2020	99.8%	99.4%	9.0	9.6
	Q3 2020	100.0%	99.9%	8.5	9.2
	Q4 2020	99.9%	99.8%	8.5	9.2
UHC	Q1 2020	99.9%	100.0%	9.4	2.6
	Q2 2020	99.9%	99.5%	8.6	3.2
	Q3 2020	100.0%	100.0%	8.0	2.7
	Q4 2020	99.8%	99.9%	8.9	2.8
MCNA	Q1 2020	100.0%	100.0%	8.6	10.0
	Q2 2020	100.0%	100.0%	3.5	6.5
	Q3 2020	99.9%	99.7%	7.4	9.0
	Q4 2020	100.0%	100.0%	8.6	10.1

There is little variation found when the average TAT is examined by service category. On the next two pages, statistics are shown for acute care services (Exhibit III.9) and non-acute care services (Exhibit III.10). As seen in both exhibits, the average turnaround time within a service category is usually very consistent when reviewed quarter by quarter.

Exhibit III.9
Turnaround Time for Claims Processing of Adjudicated Acute Care Claims (using average days)
For All MCEs Combined, By Quarter

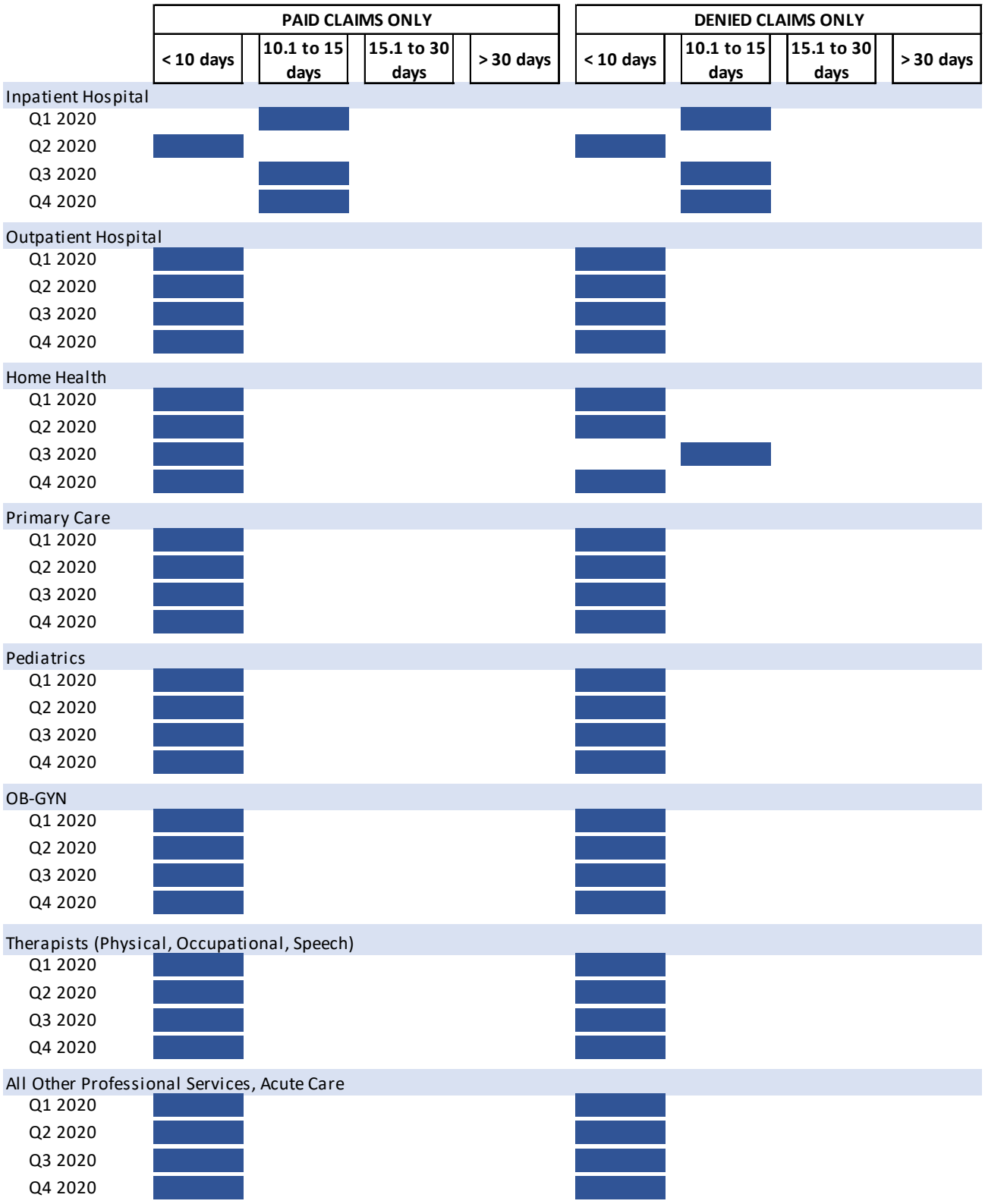
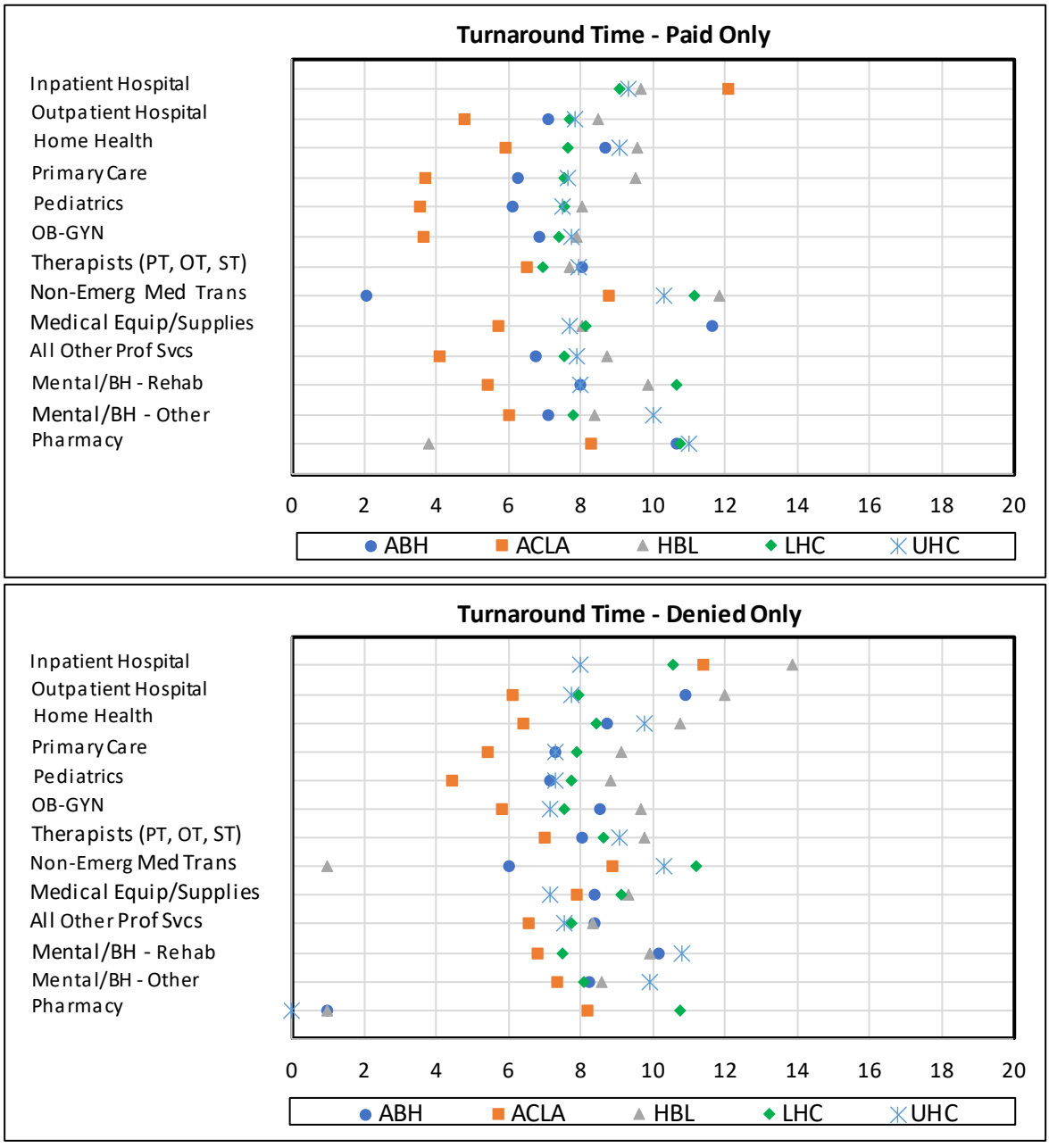


Exhibit III.10
Turnaround Time for Claims Processing of Adjudicated Non-Acute Care Claims (using average days)
For All MCEs Combined, By Quarter

Exhibit III.11 below further breaks down the average paid and denied TAT statistics in Q4 2020, but the results are shown for each MCE within a service category. The top box shows the variation in TAT for paid claims only; the bottom box shows the results for denied claims only. The purpose of this exhibit is to determine if the TAT is consistent across MCEs or if it varies.

The top box shows that there is some variation in the average TAT for paid claims. But there is only one situation where the average TAT exceeded 12 days. In the bottom box, the same variation was seen for denied claims, but average TAT for denied claims is about two days more than for paid claims.

Exhibit III.11
Average Turnaround Time, Paid and Denied Claims, by Service Category
By MCE for Q4 2020 Adjudicated Claims



Reasons for Claim Denials by the MCEs

As stated in Section I, when a claim is adjudicated, the claims processor will assign codes to indicate the reason(s) for why the claim adjudicated the way it did. For medical and dental claims, there is a set of nationally-recognized Claim Adjustment Reason Codes (*CARCs*), about 280 reason codes in all. For pharmacy claims specifically, there are nearly 350 reason codes developed by the *NCPDP*.

The MCEs report to LDH the occurrence of each CARC or NCPDP code on adjudicated claims. For denied claims, the count of each CARC or NCPDP code was tabulated by MCE for claims adjudicated in Quarter 4 of CY 2020.

Exhibit III.12 shows the top 10 CARCs for medical claims across all MCEs and the top 10 NCPDP codes for pharmacy claims across all MCEs. If one of the top CARCs across all MCEs was also a top 5 CARC within an MCE, the rank number is noted. Some key findings on CARCs appear below:

- In Q4 2020, LHC and had its top five CARCs within the top 10 CARCs statewide. ABH and ACLA had four, while HBL and MCNA had three of its top five CARCs in the statewide top 10.
- The top five CARCs in Q4 2020 included the following:
    - 96: Non-covered charge.
    - 18: Exact duplicate claim.
    - 197: Precertification or authorization absent when it is required.
    - 97: The benefit for this service is included in the payment for another service already adjudicated.
    - 16: The claim lacks information or has a billing error which is needed for adjudication.
- These five CARCs were also among the top seven in the previous ten quarters reported.

If one of the top NCPDPs across all MCEs was also a top 10 NCPDP within an MCE, the rank number is noted. Some key findings on NCPDPs appear below:

- In Q4 2020, every MCE except ABH had their top five NCPDP codes also in the top 10 for all MCEs (ABH had four of its five).
- The top five NCPDPs in Q4 2020 included the following:
    - 79: Refill too soon
    - 88: DUR reject error
    - 75: Prior authorization required
    - 7O: Product/service not covered – plan/benefit exclusion
    - 76: Plan limitations exceeded
- These five NCPDPs were also among the top six in the previous eight quarters reported.

Exhibit III.12
Details on Reasons for Denied Claims
By MCE for Q4 2020 Adjudicated Claims

For Medical Claims

			Ranking for Individual MCE					
CARC	Description	Rank Among All MCEs	ABH	ACLA	HBL	LHC	UHC	MCNA
96	Non-covered charge(s).	1	3	1		1	1	1
18	Exact duplicate claim/service	2	4			2	5	3
197	Precertification/authorization/notification absent.	3		2	2		4	
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	4	2			5	3	
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	5	1	3		3		
252	An attachment/other documentation is required to adjudicate this claim/service.	6		4	3		2	5
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	7				4		
256	Service not payable per managed care contract.	8			1			
204	This service/equipment/drug is not covered under the patient's current benefit plan	9						
22	This care may be covered by another payer per coordination of benefits.	10						

For Pharmacy Claims

			Ranking for Individual MCE				
NCPDP	Description	Rank Among All MCEs	ABH	ACLA	HBL	LHC	UHC
79	Refill Too Soon	1	1	1	1	1	4
88	DUR Reject Error	2		4	3	4	1
75	Prior Authorization Required	3	2		2	2	
7Ø	Product/Service Not Covered – Plan/Benefit Exclusion	4	4	3		3	2
76	Plan Limitations Exceeded	5	3			5	3
41	Submit Bill To Other Processor Or Primary Payer	6					
39	Missing/Invalid Diagnosis Code	7		2	5		
MR	Product Not On Formulary	8					
7X	Days Supply Exceeds Plan Limitation	9		5	4		
19	Missing/Invalid Days Supply	10					5

The previous exhibit showed that the top ten denial CARCs are consistent across quarters and were often the top CARCs for each MCE as well. The top five CARCs for each MCE were further reviewed to determine if the same CARCs are appearing on denied claims for all of the provider types that are included in this study.

Exhibit III.13 shows the results when the top CARCs are distributed by provider type for each MCE for claims adjudicated in the Quarter 4 of 2020. Key findings from the exhibit are shown below:

- For ABH, four of its five CARCs overall were also observed for almost every provider category as well. One CARC (#4) was only present for selected provider types.

- For ACLA, four of its five CARCs overall were also observed for almost every provider category as well. One CARCs (#29) was only present for selected provider types.

- For HBL, three of its five CARCs overall were also observed for almost every provider category as well. Two CARCs (#109 and #119) were only present for selected provider types.

- For LHC, three of its five CARCs overall were also observed for almost every provider category as well. Two CARCs (#B7 and #97) were only present for selected provider types.

- For UHC, four of its five CARCs overall were also observed for almost every provider category as well. One CARC (#18) was only present for selected provider types.

- For MCNA, all five of its top CARCs only appear for dental providers since MCNA only delivers dental care.

Exhibit III.13

Details on Reasons for Denied Medical Claims

By MCE and By Provider Category for Q4 2020 Adjudicated Claims

The number indicates the ranking in the top five for the provider category.

CARC	Description	Inpatient Hospital	Outpatient Hospital	Home Health	Other Institutional	Primary Care	Pediatrics	OB-GYN	Therapists	Non-Emerg Transport	Medical Equipment	Other Professional	Mental/Behavioral - Rehab	Mental/Behavioral - Other	Adult Dental	Pediatric Dental
ABH																
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	3	2	1	2	2	2	1	1	3	1	3	1	1		
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	2	1		4	3	3	3		2	4	5				
96	Non-covered charge(s).		3	2	1	1	1	2	3			1	3	3		
18	Exact duplicate claim/service	1	4	3			5	4		1	3	4				
4	The procedure code is inconsistent with the modifier used or a required r		5			5			4			2	5	4		
ACLA																
96	Non-covered charge(s).	3	1	1	1	1	1	1	1	3	1	1		1		
197	Precertification/authorization/notification absent.			2	1	2		5		4	2	2	4	5		
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.		2		1	3	2	2	3	1	4	3				
252	An attachment/other documentation is required to adjudicate this	4	3	3	1	4	4	3	4	4	3	4				
29	The time limit for filing has expired.	5	4		1				5	4			1	3		
HBL																
256	Service not payable per managed care contract.	3	1	1	3	1	1	2	1	2	3	2		2		
197	Precertification/authorization/notification absent.	4	2	2	1	2		3	2	2	2	1	1	1		
252	An attachment/other documentation is required to adjudicate this claim/	5	3	3	4	5	5	4	4	2	1		5	4		
109	Claim/service not covered by this payer/contractor. You must send the cl		4		5	3			5	2		5				
119	Benefit maximum for this time period or occurrence has been reached.							5		2	4		2	3		

Exhibit III.13 (continued)

Details on Reasons for Denied Medical Claims

By MCE and By Provider Category for Q4 2020 Adjudicated Claims

The number indicates the ranking in the Top 5 for the provider category.

CARC	Description	Inpatient Hospital	Outpatient Hospital	Home Health	Other Institutional	Primary Care	Pediatrics	OB-GYN	Therapists	Non-Emerg Transport	Medical Equipment	Other Professional	Mental/Behavioral - Rehab	Mental/Behavioral - Other	Adult Dental	Pediatric Dental
LHC																
96	Non-covered charge(s).		1	1		1	1	4		2		3				
18	Exact duplicate claim/service	3	2		4	4	3	2	4	5	2	2	4	1		
16	Claim/service lacks information or has submission/billing error(s) whic	4	5	4	1	3	5	3	1	1	3		3	3		
B7	This provider was not certified/eligible to be paid for this procedure/serv	5				2	2	5	2			1				
97	The benefit for this service is included in the payment/allowance for ano		3					1				5				
UHC																
96	Non-covered charge(s).	5	2	1	2	1	2	3	2	4	1	1		3		
252	An attachment/other documentation is required to adjudicate this claim/	4	1	1	1	3	3	2	4	2	2	2	2	1		
97	The benefit for this service is included in the payment/allowance for ano	3	3	4		2	1	1	1	2	3	4		5		
197	Precertification/authorization/notification absent.			3		5			3	4	4	3	1	2		
18	Exact duplicate claim/service			4	3		4		5	4	5	5				
MCNA																
96	Non-covered charge(s).														1	1
169	Alternate benefit has been provided.														2	
18	Exact duplicate claim/service														3	3
6	The procedure/revenue code is inconsistent with the patient's age.														4	
252	An attachment/other documentation is required to adjudicate this claim/service.														5	2

Provider Education Related to Claims Adjudication

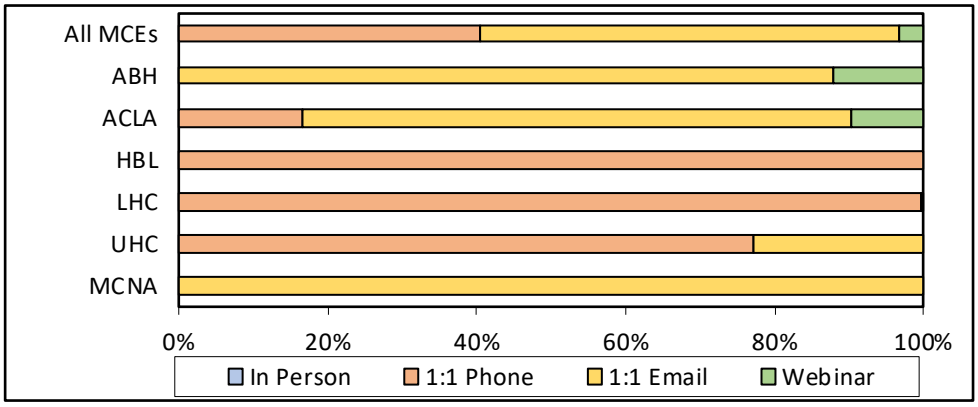
Because many of the denial reason codes have been consistent for some time, LDH initiated specific reporting for MCE provider education with the release of the new reporting requirements pertaining to Act 710 in mid-February 2019. Reporting on provider education first began in the January 2020 report.

LDH is requesting that the MCEs report information on education for providers at the entity tax identification number (TIN). As a result, there may be many provider IDs that are mapped to one TIN (e.g. a hospital and the group physician practices it owns). On a quarterly basis, the MCEs are reporting on the individual entities outreached, the type of outreach, and the date that the outreach was conducted.

Exhibit III.14 summarizes information on provider education conducted in Q4 2020. In all, 1,227 TINs were outreached to by the MCEs (down from 1,514 last quarter). This count represents the unique TINs and modes of communication. In some cases, the MCE reported that they conducted multiple outreach to the same TIN in the quarter (e.g., three emails over the course of six weeks). When this occurred, only one was counted below. It should also be noted, however, that the same TIN may be outreached to by multiple MCEs.

Just over half of the outreach (56.2%) was conducted via 1:1 emails. This was followed by 1:1 phone calls (40.4% of total) and webinars (3.3% of total). In-person was not conducted due to the pandemic.

Exhibit III.14
Provider Education Conducted by the MCEs on Claims Submissions Activity in Q4 2020



	Modality of Outreach				
	In Person	**1:1 Phone**	**1:1 Email**	**Webinar**	**Total TINs**
All MCEs	0	496	690	41	1,227
ABH	0	0	66	9	75
ACLA	0	52	232	31	315
HBL	0	75	0	0	75
LHC	0	342	0	1	343
UHC	0	27	8	0	35
MCNA	0	0	384	0	384

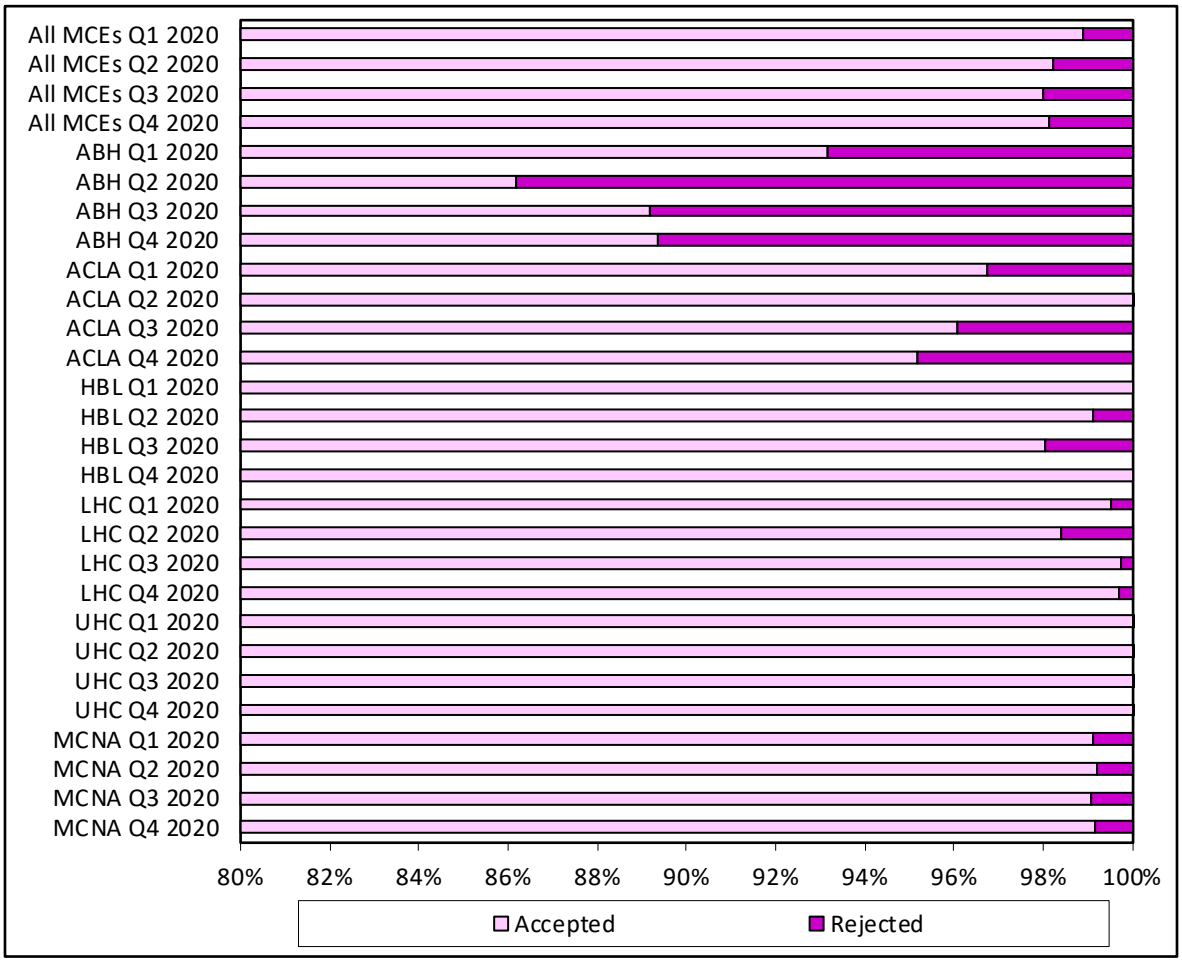
SECTION IV: FINDINGS RELATED TO MCE ENCOUNTER SUBMISSIONS TO LDH

The MCEs are required to send all claims that they have adjudicated—both paid and denied—to LDH in order for LDH to capture all information pertaining to MCE medical expenditures and to track utilization related to outcome measures. Act 710 requested specific information pertaining to encounter submissions, including the number that were accepted by LDH and the number rejected. LDH is also tracking the timeliness in which encounters are being submitted by the MCEs.

MCE Encounters Accepted and Rejected by LDH

In the most recent four quarters studied, 98.0% to 98.9% of the encounters submitted by all MCEs combined were accepted by LDH. There were differences at the MCE level. All of UHC's encounters were accepted. For HBL, LHC and MCNA, at least 98% of their encounters were accepted. ACLA had at least 95% of its encounters accepted. ABH had some challenges, particularly in the last three quarters.

Exhibit IV.1
Encounter Submissions Accepted and Rejected by LDH
All Claim Types
By MCE and By Quarter



There are differences in the encounter acceptance rate when reviewed by claim type. The MCEs are required to submit encounters in a pre-determined format based on the claim type. Encounters are submitted separately for each of the following claim type:

- Institutional encounters (837I)
- Professional encounters (837P)
- Dental encounters (837D)
- Pharmacy encounters

Exhibits IV.2 and IV.3 on the next two pages delineate the acceptance and rejection rates of encounters for each MCE by claim type and by quarter. The key findings from these exhibits show that:

- ABH's lower encounter acceptance rate was due to institutional and professional encounters.

- When ACLA and HBL had issues with encounters being accepted, it was due to institutional encounters; when LHC had a few issues, it was with pharmacy encounters.

Exhibit IV.2
Encounter Submissions Accepted and Rejected by LDH
Institutional and Professional Claim Types
By MCE and By Quarter

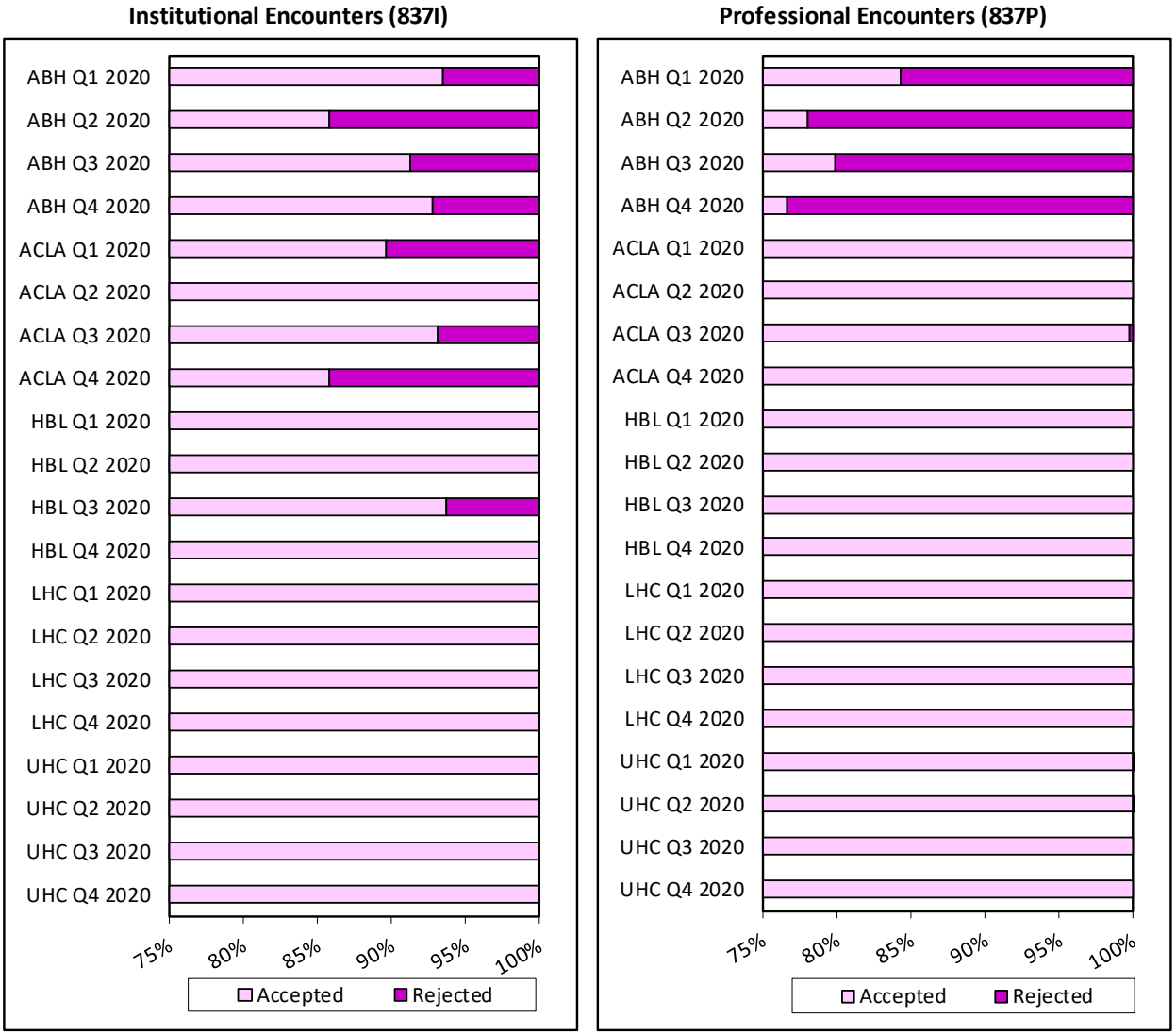
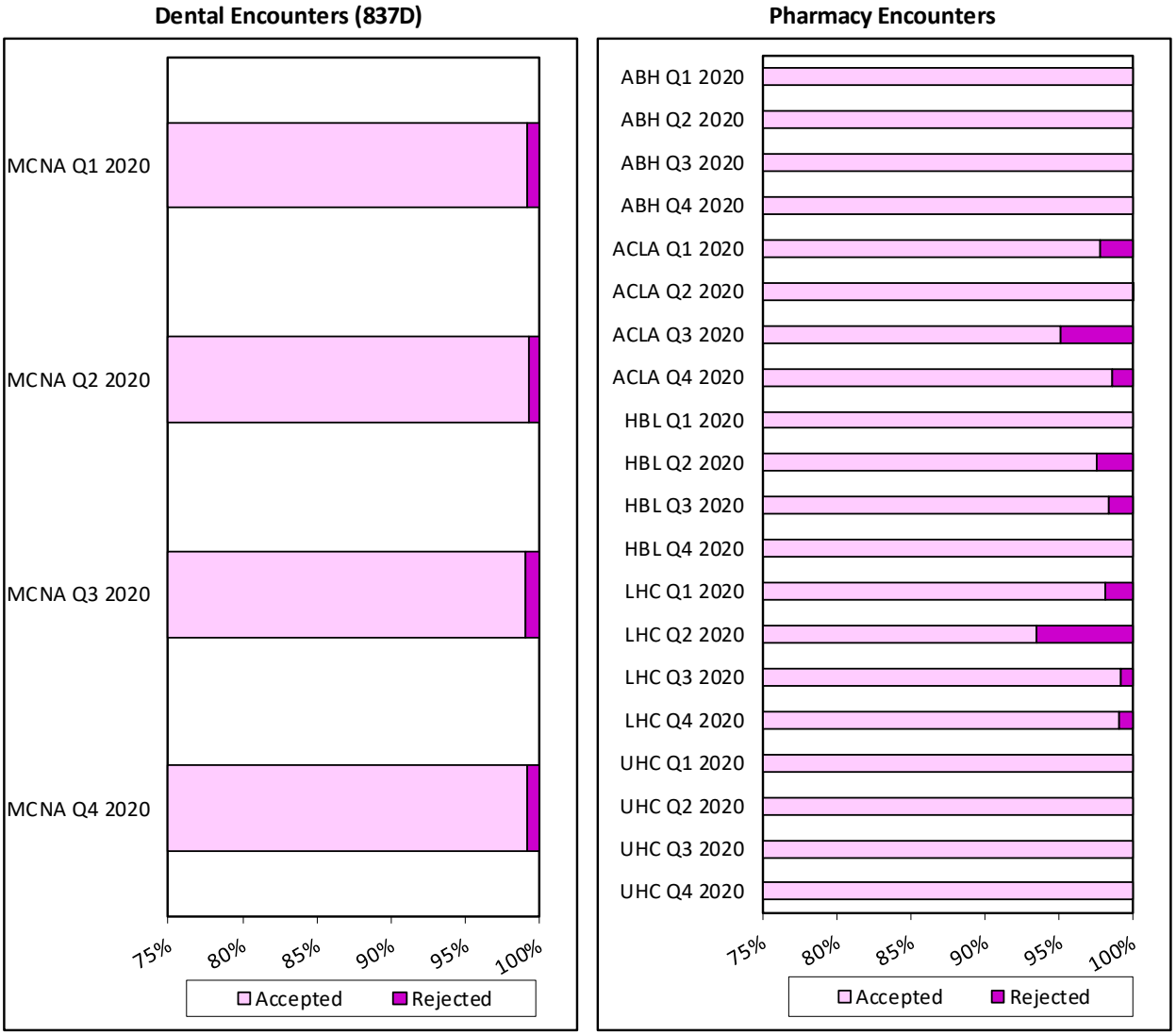


Exhibit IV.3
Encounter Submissions Accepted and Rejected by LDH
Dental and Pharmacy Claim Types
By MCE and By Quarter



Timeliness of Encounter Submissions Accepted by LDH

A common benchmark to track the timeliness of encounter submissions is the average turnaround time (TAT). In the previous section of this report, the average TAT that was measured was the date from which the MCE received the claim from the provider to the date that payment was made to the provider or notice of denial was given. In this section, the average TAT measures the date from which the MCE gave notice to the provider to the date that the encounter was submitted to LDH.

Because of the manner in which the encounters are submitted, the average TAT is computed for each claim type separately. The data in Exhibit IV.4 on the next page tracks the average TAT by MCE, by quarter and by claim type. A common benchmark used is that MCEs should submit encounters within 30 days of adjudication. The results shown in the exhibits show the percentage of encounters accepted by LDH that were submitted within 30 days of adjudication.

Key findings from both exhibits appear below:

- For institutional encounters (mostly claims from hospitals), ABH had issues with timely submissions in all four quarters of 2020. ACLA had some issues in Q3 and Q4 2020, while LHC did in Q1 and Q2 of 2020.

- HBL consistently has the highest rate of submission of professional encounters within 30 days followed by UHC and ACLA. ABH had challenges with professional encounter submission timeliness in all four quarters of 2020. ACLA had some issues in Q3 and Q4 2020, while LHC did in Q1 and Q2 of 2020.

- There is greater variation in the timeliness of pharmacy encounter submissions. ACLA had 100% timeliness within 30 days in all quarters of 2020. HBL and UHC had few pharmacy encounters submitted after 30 days in every quarter. ABH and LHC consistently are lowest on pharmacy encounter timeliness—ABH usually near 70% untimely, and LHC has varied from 50% to 72% untimely in the last four quarters.

- MCNA had few issues meeting an average 30-day TAT for its dental encounters in the first three quarters of 2020, but did have issues in Q4.

Exhibit IV.4

Turnaround Time for Encounter Submissions Accepted by LDH
By MCE and By Quarter

	Institutional Encounters (837I)		Professional Encounters (837D)		Dental Encounters (837D)		Pharmacy Encounters	
	Within 30 Days	After 30 Days	Within 30 Days	After 30 Days	Within 30 Days	After 30 Days	Within 30 Days	After 30 Days
ABH Q1 2020	31.0%	69.0%	9.4%	90.6%			73.1%	26.9%
ABH Q2 2020	69.6%	30.4%	67.2%	32.8%			71.2%	28.8%
ABH Q3 2020	43.3%	56.7%	62.8%	37.2%			69.1%	30.9%
ABH Q4 2020	27.2%	72.8%	69.2%	30.8%			69.1%	30.9%
ACLA Q1 2020	96.3%	3.7%	92.2%	7.8%			100.0%	0.0%
ACLA Q2 2020	97.6%	2.4%	95.2%	4.8%			100.0%	0.0%
ACLA Q3 2020	89.1%	10.9%	86.7%	13.3%			100.0%	0.0%
ACLA Q4 2020	84.0%	16.0%	88.9%	11.1%			100.0%	0.0%
HBL Q1 2020	100.0%	0.0%	99.5%	0.5%			99.8%	0.2%
HBL Q2 2020	100.0%	0.0%	98.6%	1.4%			98.2%	1.8%
HBL Q3 2020	100.0%	0.0%	98.9%	1.1%			98.3%	1.7%
HBL Q4 2020	100.0%	0.0%	94.7%	5.3%			96.6%	3.4%
LHC Q1 2020	35.1%	64.9%	30.3%	69.7%			50.6%	49.4%
LHC Q2 2020	72.7%	27.3%	72.5%	27.5%			64.5%	35.5%
LHC Q3 2020	95.9%	4.1%	97.9%	2.1%			71.9%	28.1%
LHC Q4 2020	99.9%	0.1%	99.8%	0.2%			69.6%	30.4%
UHC Q1 2020	99.3%	0.7%	92.1%	7.9%			99.5%	0.5%
UHC Q2 2020	98.6%	1.4%	93.8%	6.2%			98.7%	1.3%
UHC Q3 2020	98.6%	1.4%	98.6%	1.4%			98.8%	1.2%
UHC Q4 2020	98.8%	1.2%	95.9%	4.1%			98.8%	1.2%
MCNA Q1 2020					96.9%	3.1%		
MCNA Q2 2020					99.7%	0.3%		
MCNA Q3 2020					99.7%	0.3%		
MCNA Q4 2020					48.2%	51.8%		

APPENDIX A

Detailed Information for Exhibits Shown in Sections III and IV of the Report

Appendix A III.1
Claim Accepted and Rejected Rate
All Claim Types
By MCE and By Quarter

	Number Accepted	Number Rejected	Percent Accepted	Percent Rejected
All MCEs Q1 2020	23,026,111	314,265	98.7%	1.3%
All MCEs Q2 2020	18,199,449	264,017	98.6%	1.4%
All MCEs Q3 2020	22,025,167	279,021	98.7%	1.3%
All MCEs Q4 2020	23,621,830	294,350	98.8%	1.2%
ABH Q1 2020	2,089,033	3,292	99.8%	0.2%
ABH Q2 2020	1,695,215	2,185	99.9%	0.1%
ABH Q3 2020	2,012,867	2,416	99.9%	0.1%
ABH Q4 2020	2,124,458	2,292	99.9%	0.1%
ACLA Q1 2020	2,953,541	4,453	99.8%	0.2%
ACLA Q2 2020	2,191,214	3,466	99.8%	0.2%
ACLA Q3 2020	2,755,133	10,830	99.6%	0.4%
ACLA Q4 2020	2,882,688	8,482	99.7%	0.3%
HBL Q1 2020	4,774,863	586	100.0%	0.0%
HBL Q2 2020	3,845,084	759	100.0%	0.0%
HBL Q3 2020	4,599,056	738	100.0%	0.0%
HBL Q4 2020	4,883,134	447	100.0%	0.0%
LHC Q1 2020	6,430,080	246,497	96.3%	3.7%
LHC Q2 2020	5,117,995	197,511	96.3%	3.7%
LHC Q3 2020	6,138,249	197,050	96.9%	3.1%
LHC Q4 2020	6,583,182	198,251	97.1%	2.9%
UHC Q1 2020	6,778,594	59,437	99.1%	0.9%
UHC Q2 2020	5,349,941	60,096	98.9%	1.1%
UHC Q3 2020	6,519,862	67,987	99.0%	1.0%
UHC Q4 2020	7,148,368	84,878	98.8%	1.2%
MCNA Q1 2020	754,389	0	100.0%	0.0%
MCNA Q2 2020	596,122	0	100.0%	0.0%
MCNA Q3 2020	859,517	0	100.0%	0.0%
MCNA Q4 2020	814,807	0	100.0%	0.0%

Appendix A III.2
Claim Status for Adjudicated Claims
All Claim Types
By MCE and By Quarter

	Number Paid	Number Denied	Percent Paid	Percent Denied
All MCEs Q1 2020	19,048,677	4,101,685	82.3%	17.7%
All MCEs Q2 2020	14,782,806	3,325,040	81.6%	18.4%
All MCEs Q3 2020	17,948,253	3,992,025	81.8%	18.2%
All MCEs Q4 2020	19,292,840	4,260,741	81.9%	18.1%
ABH Q1 2020	1,635,248	453,092	78.3%	21.7%
ABH Q2 2020	1,333,483	362,160	78.6%	21.4%
ABH Q3 2020	1,572,783	439,151	78.2%	21.8%
ABH Q4 2020	1,619,705	505,169	76.2%	23.8%
ACLA Q1 2020	2,511,550	501,752	83.3%	16.7%
ACLA Q2 2020	1,777,419	372,466	82.7%	17.3%
ACLA Q3 2020	2,285,744	491,611	82.3%	17.7%
ACLA Q4 2020	2,344,287	460,415	83.6%	16.4%
HBL Q1 2020	3,842,861	1,002,205	79.3%	20.7%
HBL Q2 2020	2,984,635	763,022	79.6%	20.4%
HBL Q3 2020	3,659,680	911,313	80.1%	19.9%
HBL Q4 2020	3,954,955	936,726	80.9%	19.1%
LHC Q1 2020	5,431,672	1,048,262	83.8%	16.2%
LHC Q2 2020	4,165,548	900,980	82.2%	17.8%
LHC Q3 2020	5,057,608	1,003,298	83.4%	16.6%
LHC Q4 2020	5,451,901	1,121,272	82.9%	17.1%
UHC Q1 2020	5,627,346	1,096,374	83.7%	16.3%
UHC Q2 2020	4,521,721	926,412	83.0%	17.0%
UHC Q3 2020	5,372,438	1,146,652	82.4%	17.6%
UHC Q4 2020	5,921,992	1,237,159	82.7%	17.3%

Appendix A III.3
Claim Denial Rates by Acute Care Service Category
For All MCEs Combined, By Quarter

	Number Paid	Number Denied	Percent Paid	Percent Denied
Inpatient Hospital Q1 2020	52,125	13,770	79.1%	20.9%
Inpatient Hospital Q2 2020	47,250	9,975	82.6%	17.4%
Inpatient Hospital Q3 2020	52,707	10,927	82.8%	17.2%
Inpatient Hospital Q4 2020	54,911	11,938	82.1%	17.9%
Outpatient Hospital Q1 2020	4,574,900	453,666	91.0%	9.0%
Outpatient Hospital Q2 2020	3,094,922	348,077	89.9%	10.1%
Outpatient Hospital Q3 2020	4,161,856	425,855	90.7%	9.3%
Outpatient Hospital Q4 2020	4,307,164	454,655	90.5%	9.5%
Home Health Q1 2020	37,091	4,805	88.5%	11.5%
Home Health Q2 2020	38,736	4,653	89.3%	10.7%
Home Health Q3 2020	34,656	6,537	84.1%	15.9%
Home Health Q4 2020	39,446	6,317	86.2%	13.8%
Primary Care Q1 2020	1,732,768	251,432	87.3%	12.7%
Primary Care Q2 2020	1,170,493	217,922	84.3%	15.7%
Primary Care Q3 2020	1,763,204	295,877	85.6%	14.4%
Primary Care Q4 2020	2,025,819	367,356	84.6%	15.4%
Pediatrics Q1 2020	848,135	104,391	89.0%	11.0%
Pediatrics Q2 2020	559,334	82,715	87.1%	12.9%
Pediatrics Q3 2020	689,995	94,543	87.9%	12.1%
Pediatrics Q4 2020	866,106	117,812	88.0%	12.0%
OB-GYN Q1 2020	242,251	37,183	86.7%	13.3%
OB-GYN Q2 2020	225,599	28,640	88.7%	11.3%
OB-GYN Q3 2020	255,748	29,425	89.7%	10.3%
OB-GYN Q4 2020	257,113	32,888	88.7%	11.3%
Therapists (PT/OT/ST) Q1 2020	75,401	16,053	82.4%	17.6%
Therapists (PT/OT/ST) Q2 2020	50,286	8,645	85.3%	14.7%
Therapists (PT/OT/ST) Q3 2020	85,101	14,169	85.7%	14.3%
Therapists (PT/OT/ST) Q4 2020	88,371	17,761	83.3%	16.7%
All Other Professional Q1 2020	4,346,456	876,656	83.2%	16.8%
All Other Professional Q2 2020	3,335,889	688,019	82.9%	17.1%
All Other Professional Q3 2020	3,952,131	790,896	83.3%	16.7%
All Other Professional Q4 2020	4,409,700	784,467	84.9%	15.1%

Appendix A III.4
Claim Denial Rates for Non-Acute Care Services
For All MCEs Combined, By Quarter

	Number Paid	Number Denied	Percent Paid	Percent Denied
Non-Emerg Transport Q1 2020	246,566	7,721	97.0%	3.0%
Non-Emerg Transport Q2 2020	156,403	6,048	96.3%	3.7%
Non-Emerg Transport Q3 2020	190,595	4,836	97.5%	2.5%
Non-Emerg Transport Q4 2020	269,705	10,002	96.4%	3.6%
Medical Equipment/Supplies Q1 2020	119,646	21,238	84.9%	15.1%
Medical Equipment/Supplies Q2 2020	132,339	21,621	86.0%	14.0%
Medical Equipment/Supplies Q3 2020	121,171	20,069	85.8%	14.2%
Medical Equipment/Supplies Q4 2020	128,718	23,110	84.8%	15.2%
Mental/Behavioral Rehab Q1 2020	268,832	40,579	86.9%	13.1%
Mental/Behavioral Rehab Q2 2020	229,259	29,730	88.5%	11.5%
Mental/Behavioral Rehab Q3 2020	232,206	25,070	90.3%	9.7%
Mental/Behavioral Rehab Q4 2020	224,446	26,611	89.4%	10.6%
Mental/Behavioral Other Q1 2020	621,497	119,880	83.8%	16.2%
Mental/Behavioral Other Q2 2020	645,307	120,790	84.2%	15.8%
Mental/Behavioral Other Q3 2020	735,462	140,662	83.9%	16.1%
Mental/Behavioral Other Q4 2020	752,136	158,690	82.6%	17.4%
Dental - Children Q1 2020	658,205	65,373	91.0%	9.0%
Dental - Children Q2 2020	482,503	35,967	93.1%	6.9%
Dental - Children Q3 2020	650,998	79,359	89.1%	10.9%
Dental - Children Q4 2020	653,938	87,295	88.2%	11.8%
Dental - Adults Q1 2020	129,172	17,614	88.0%	12.0%
Dental - Adults Q2 2020	66,441	9,975	86.9%	13.1%
Dental - Adults Q3 2020	106,586	18,715	85.1%	14.9%
Dental - Adults Q4 2020	124,319	20,942	85.6%	14.4%
Pharmacy Q1 2020	5,718,274	2,130,676	72.9%	27.1%
Pharmacy Q2 2020	4,986,416	1,743,525	74.1%	25.9%
Pharmacy Q3 2020	5,525,646	2,107,908	72.4%	27.6%
Pharmacy Q4 2020	5,701,908	2,221,192	72.0%	28.0%

Appendix A III.5
Claim Status for Adjudicated Claims
By Provider Specialty / Service Category
By MCE for Q4 2020 Adjudicated Claims

Inpatient Hospital	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	5,997	798	88.3%	11.7%
ACLA	6,671	1,822	78.5%	21.5%
HBL	11,190	3,767	74.8%	25.2%
LHC	16,212	2,379	87.2%	12.8%
UHC	14,841	3,172	82.4%	17.6%

Outpatient Hospital	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	424,053	27,813	93.8%	6.2%
ACLA	545,284	54,139	91.0%	9.0%
HBL	858,055	112,244	88.4%	11.6%
LHC	1,217,616	161,484	88.3%	11.7%
UHC	1,262,156	98,975	92.7%	7.3%

Home Health	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	2,288	223	91.1%	8.9%
ACLA	3,469	624	84.8%	15.2%
HBL	4,937	1,197	80.5%	19.5%
LHC	28,077	4,240	86.9%	13.1%
UHC	675	33	95.3%	4.7%

Primary Care	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	169,735	96,622	63.7%	36.3%
ACLA	117,873	11,131	91.4%	8.6%
HBL	387,224	53,407	87.9%	12.1%
LHC	581,112	113,130	83.7%	16.3%
UHC	769,875	93,066	89.2%	10.8%

Pediatricians	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	62,058	32,575	65.6%	34.4%
ACLA	103,100	7,238	93.4%	6.6%
HBL	201,600	15,637	92.8%	7.2%
LHC	371,314	48,310	88.5%	11.5%
UHC	128,034	14,052	90.1%	9.9%

OB-GYN	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	22,619	7,545	75.0%	25.0%
ACLA	39,027	3,090	92.7%	7.3%
HBL	73,809	6,975	91.4%	8.6%
LHC	95,311	13,359	87.7%	12.3%
UHC	26,347	1,919	93.2%	6.8%

Therapists (PT, OT, ST)	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	10,931	5,951	64.7%	35.3%
ACLA	484	1,978	19.7%	80.3%
HBL	35,231	3,051	92.0%	8.0%
LHC	20,390	3,087	86.9%	13.1%
UHC	21,335	3,694	85.2%	14.8%

Non-Emergency Medical Transp.	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	20,416	382	98.2%	1.8%
ACLA	32,127	2,813	91.9%	8.1%
HBL	47,176	144	99.7%	0.3%
LHC	66,499	2,415	96.5%	3.5%
UHC	103,487	4,248	96.1%	3.9%

Non-Emergency Medical Transp.	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	11,458	3,533	76.4%	23.6%
ACLA	22,414	3,056	88.0%	12.0%
HBL	2,524	882	74.1%	25.9%
LHC	39,597	7,088	84.8%	15.2%
UHC	52,725	8,551	86.0%	14.0%

All Other Professional	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	293,300	142,919	67.2%	32.8%
ACLA	699,972	115,751	85.8%	14.2%
HBL	889,673	136,157	86.7%	13.3%
LHC	1,139,320	198,709	85.1%	14.9%
UHC	1,387,435	190,931	87.9%	12.1%

Mental/Behav Health - Rehab	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	1,602	947	62.8%	37.2%
ACLA	63,582	6,802	90.3%	9.7%
HBL	5,482	2,730	66.8%	33.2%
LHC	7,443	1,524	83.0%	17.0%
UHC	146,337	14,608	90.9%	9.1%

Mental/Behav Health - Other	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	70,866	41,250	63.2%	36.8%
ACLA	48,106	8,978	84.3%	15.7%
HBL	151,251	39,843	79.2%	20.8%
LHC	404,934	59,692	87.2%	12.8%
UHC	76,979	8,927	89.6%	10.4%

Pharmacy	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	505,561	140,416	78.3%	21.7%
ACLA	649,577	237,062	73.3%	26.7%
HBL	1,221,051	545,962	69.1%	30.9%
LHC	1,461,038	504,505	74.3%	25.7%
UHC	1,864,681	793,247	70.2%	29.8%

Appendix A III.6

Value of Paid and Denied Claims
By MCE for the Most Recent Four Quarters of Adjudicated Claims

	Value of Paid Claims (in millions)	Value of Denied Claims (in millions)
All MCEs Q1 2020	$977.2	$244.9
All MCEs Q2 2020	$1,176.4	$297.0
All MCEs Q3 2020	$1,228.1	$309.2
All MCEs Q4 2020	$1,803.3	$452.3
Quarter 1 2020		
ABH	$136.7	$37.4
ACLA	$222.0	$52.9
HBL	$348.8	$115.7
LHC	$444.8	$89.7
UHC	$531.2	$124.1
Quarter 2 2020		
ABH	$129.3	$32.1
ACLA	$170.0	$39.5
HBL	$300.5	$92.9
LHC	$377.5	$80.4
UHC	$480.1	$171.3
Quarter 3 2020		
ABH	$145.8	$34.4
ACLA	$214.6	$51.1
HBL	$366.5	$124.0
LHC	$449.5	$87.6
UHC	$544.8	$133.5
Quarter 4 2020		
ABH	$150.4	$38.3
ACLA	$210.0	$49.4
HBL	$397.0	$123.7
LHC	$470.8	$97.8
UHC	$575.2	$143.0

MCNA is the MCE that provides dental coverage only.
Their total expenditures are approx. $35M per quarter.
They have been excluded from this exhibit.

Appendix A Exhibit III.7
Examination of Individual Providers Who Billed an MCE that Had More Than 10% of their Claims Denied

Legend

Y means that more than 50% of the providers in this group had 10% or more of their claims denied by the MCE
N means that less than 50% of the providers in this group had 10% or more of their claims denied by the MCE
-- means that the number of providers in the category is too small (5 or less) to make a finding

Provider Category	Group Based on Volume	ABH				ACLA				HBL				LHC				UHC				MCNA			
		Q1 20	Q2 20	Q3 20	Q4 20	Q1 20	Q2 20	Q3 20	Q4 20	Q1 20	Q2 20	Q3 20	Q4 20	Q1 20	Q2 20	Q3 20	Q4 20	Q1 20	Q2 20	Q3 20	Q4 20	Q1 20	Q2 20	Q3 20	Q4 20
Inpatient Hospital	Low	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	N	N	N				
	Medium	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y				
	High	Y	Y	N	Y	--	--	--	--	--	--	--	--	Y	Y	Y	Y	Y	--	N	N				
Outpatient Hospital	Low	Y	Y	Y	N	Y	Y	Y	Y	N	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y				
	Medium	Y	Y	Y	Y	N	N	N	N	Y	Y	N	Y	Y	Y	Y	Y	Y	N	Y	Y				
	High	Y	Y	N	Y	N	N	N	N	N	N	N	N	Y	Y	Y	Y	N	N	N	N				
Home Health	Low	Y	Y	Y	N	N	N	N	N	Y	N	Y	N	N	N	N	N	N	N	N	N				
	Medium	Y	N	Y	Y	N	N	N	N	N	N	Y	N	N	N	N	N	--	--	--	--				
	High	--	--	--	--	--	--	--	--	--	--	--	--	N	N	N	Y	--	--	--	--				
Other Institutional Providers	Low	Y	Y	Y	Y	N	N	Y	--	N	N	Y	Y	Y	Y	Y	Y	N	N	N	N				
	Medium	--	Y	--	--	--	--	--	--	N	N	N	N	--	--	--	Y	N	N	N	N				
	High	--	--	--	--	--	--	--	--	Y	N	N	N	--	--	--	--	--	Y	N	Y				
Primary Care	Low	Y	Y	N	Y	N	N	N	N	Y	Y	N	N	N	Y	Y	Y	Y	Y	Y	Y				
	Medium	Y	Y	Y	Y	N	N	N	N	Y	N	N	N	N	Y	Y	Y	N	N	N	N				
	High	Y	--	Y	Y	N	N	N	N	Y	N	N	N	Y	Y	Y	Y	N	N	N	N				
Pediatrics	Low	N	Y	N	N	N	N	N	N	Y	N	N	N	N	Y	Y	N	Y	Y	Y	N				
	Medium	Y	Y	Y	Y	N	N	N	N	Y	N	N	N	N	Y	Y	Y	N	Y	Y	N				
	High	Y	--	--	Y	N	N	N	N	Y	N	N	N	N	Y	Y	Y	N	N	N	N				
OB-GYN	Low	Y	Y	Y	Y	N	N	N	N	Y	Y	Y	N	N	N	N	N	Y	Y	Y	Y				
	Medium	Y	Y	Y	Y	N	N	N	N	Y	N	N	N	N	N	N	Y	Y	N	N	Y				
	High	--	--	--	--	N	N	N	N	Y	N	N	N	N	N	N	Y	N	N	N	N				
Therapists	Low	N	N	N	Y	Y	N	N	Y	Y	N	N	N	Y	Y	Y	Y	Y	N	N	Y				
	Medium	--	--	Y	Y	Y	N	N	--	Y	N	N	N	Y	Y	Y	Y	N	N	N	Y				
	High	--	--	--	--	Y	--	N	--	Y	Y	N	N	Y	Y	Y	Y	Y	Y	N	N				
Non-Emergency Transportation	Low	N	N	N	N	N	N	Y	Y	N	N	--	--	N	N	N	N	Y	Y	Y	Y				
	Medium	N	N	N	N	N	N	N	N	N	N	--	--	N	N	N	N	--	--	--	--				
	High	N	N	N	N	N	N	N	N	N	N	--	--	N	N	N	N	--	--	--	--				
Medical Equipment/ Supplies	Low	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N	N	N	Y	Y	Y	Y				
	Medium	Y	Y	Y	Y	N	N	N	N	--	Y	Y	N	Y	Y	Y	Y	N	N	N	N				
	High	Y	Y	Y	Y	N	N	N	N	--	--	--	--	N	Y	Y	N	N	N	N	N				
All Other Professional Provid.	Low	N	N	N	N	N	N	Y	Y	N	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y				
	Medium	Y	N	N	N	N	N	N	N	Y	N	N	N	Y	Y	Y	Y	N	N	Y	N				
	High	Y	--	--	N	N	N	N	N	Y	N	N	N	N	Y	Y	N	N	N	N	N				
Behavioral Health Rehab	Low	Y	N	Y	Y	N	Y	N	N	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y				
	Medium	Y	N	Y	Y	N	N	N	N	Y	N	Y	Y	N	N	N	N	N	N	N	N				
	High	--	--	--	--	N	N	N	N	--	--	--	--	N	--	--	--	N	N	N	N				
Behavioral Health All Other	Low	Y	N	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	N	Y	Y	Y	N				
	Medium	--	--	--	--	N	Y	Y	N	Y	Y	Y	Y	N	Y	Y	Y	N	N	N	Y				
	High	--	--	--	--	N	Y	N	N	Y	Y	Y	Y	N	N	N	Y	N	Y	N	N				
Dental - Children	Low																					N	N	N	Y
	Medium																					Y	Y	Y	Y
	High																					Y	Y	Y	Y
Dental - Adults	Low																					Y	Y	Y	Y
	Medium																					--	--	--	--
	High																					--	--	--	--
Pharmacy	Low	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y				
	Medium	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y				
	High	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y				

Appendix A Exhibit III.8
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
All Claim Types
By All MCEs and By Quarter

	Paid Claims	Denied Claims
All MCEs Q1 2020	8.1	5.7
All MCEs Q2 2020	7.8	5.9
All MCEs Q3 2020	7.7	6.0
All MCEs Q4 2020	8.0	5.8
ABH Q1 2020	8.1	5.9
ABH Q2 2020	8.3	6.0
ABH Q3 2020	8.0	5.6
ABH Q4 2020	8.0	6.1
ACLA Q1 2020	5.2	6.0
ACLA Q2 2020	5.4	6.5
ACLA Q3 2020	5.7	7.2
ACLA Q4 2020	5.5	7.4
HBL Q1 2020	6.8	4.3
HBL Q2 2020	6.8	4.3
HBL Q3 2020	7.2	6.1
HBL Q4 2020	7.1	4.6
LHC Q1 2020	8.8	9.6
LHC Q2 2020	9.0	9.6
LHC Q3 2020	8.5	9.2
LHC Q4 2020	8.5	9.2
UHC Q1 2020	9.4	2.6
UHC Q2 2020	8.6	3.2
UHC Q3 2020	8.0	2.7
UHC Q4 2020	8.9	2.8
MCNA Q1 2020	8.6	10.0
MCNA Q2 2020	3.5	6.5
MCNA Q3 2020	7.4	9.0
MCNA Q4 2020	8.6	10.1

Appendix A Exhibit III.9
Turnaround Time for Claims Processing of Adjudicated Acute Care Claims
(using average days)
For All MCEs Combined, By Quarter

	Paid Claims	Denied Claims
Inpatient Hosp Q1 2020	10.3	10.4
Inpatient Hosp Q2 2020	9.3	9.4
Inpatient Hosp Q3 2020	10.7	12.4
Inpatient Hosp Q4 2020	12.1	11.7
Outpatient Hosp Q1 2020	8.2	9.2
Outpatient Hosp Q2 2020	7.6	9.1
Outpatient Hosp Q3 2020	7.5	9.7
Outpatient Hosp Q4 2020	7.5	8.9
Home Health Q1 2020	7.8	8.4
Home Health Q2 2020	7.7	8.3
Home Health Q3 2020	8.0	13.0
Home Health Q4 2020	7.8	8.7
Primary Care Q1 2020	7.6	7.2
Primary Care Q2 2020	7.5	8.0
Primary Care Q3 2020	6.7	8.1
Primary Care Q4 2020	7.6	7.7
Pediatrics Q1 2020	6.9	7.1
Pediatrics Q2 2020	6.8	7.3
Pediatrics Q3 2020	6.4	7.3
Pediatrics Q4 2020	7.1	7.5
OB-GYN Q1 2020	6.9	7.2
OB-GYN Q2 2020	6.5	7.3
OB-GYN Q3 2020	6.6	8.1
OB-GYN Q4 2020	6.9	8.0
Therapists (PT/OT/ST) Q1 2020	7.2	7.6
Therapists (PT/OT/ST) Q2 2020	6.9	8.0
Therapists (PT/OT/ST) Q3 2020	7.3	9.5
Therapists (PT/OT/ST) Q4 2020	7.6	8.5
All Other Professional Q1 2020	7.1	7.3
All Other Professional Q2 2020	6.8	7.6
All Other Professional Q3 2020	6.4	8.1
All Other Professional Q4 2020	7.3	7.7

Appendix A Exhibit III.10
Turnaround Time for Claims Processing of Adjudicated Non-Acute Care Claims
(using average days)
For All MCEs Combined, By Quarter

	Paid Claims	Denied Claims
Non-Emerg Transport Q1 2020	9.3	9.3
Non-Emerg Transport Q2 2020	10.6	9.1
Non-Emerg Transport Q3 2020	10.9	8.5
Non-Emerg Transport Q4 2020	10.0	9.8
Medical Equip/Supplies Q1 2020	7.8	7.9
Medical Equip/Supplies Q2 2020	6.6	7.7
Medical Equip/Supplies Q3 2020	6.6	8.2
Medical Equip/Supplies Q4 2020	7.8	8.1
MH/BH Rehab Q1 2020	7.0	7.3
MH/BH Rehab Q2 2020	6.4	14.9
MH/BH Rehab Q3 2020	6.5	12.8
MH/BH Rehab Q4 2020	7.4	9.5
MH/BH Other Q1 2020	7.7	8.3
MH/BH Other Q2 2020	8.6	9.6
MH/BH Other Q3 2020	8.0	10.4
MH/BH Other Q4 2020	7.9	8.3
Dental - Children Q1 2020	8.6	10.0
Dental - Children Q2 2020	3.5	6.4
Dental - Children Q3 2020	7.3	9.0
Dental - Children Q4 2020	8.5	10.2
Dental - Adults Q1 2020	5.2	5.6
Dental - Adults Q2 2020	5.3	6.7
Dental - Adults Q3 2020	4.7	4.5
Dental - Adults Q4 2020	5.0	4.6
Pharmacy Q1 2020	9.1	3.5
Pharmacy Q2 2020	9.2	3.7
Pharmacy Q3 2020	9.1	3.6
Pharmacy Q4 2020	9.1	3.6

Appendix A Exhibit III.11
Average Turnaround Time (jn days), Paid and Denied Claims, by Service Category
By MCE for Q4 2020 Adjudicated Claims

Inpatient Hospital	Paid	Denied
ABH	32.1	20.4
ACLA	12.1	11.4
HBL	9.7	13.9
LHC	9.1	10.5
UHC	9.3	8.0

Outpatient Hospital	Paid	Denied
ABH	7.1	10.9
ACLA	4.8	6.1
HBL	8.5	12.0
LHC	7.7	7.9
UHC	7.8	7.8

Home Health	Paid	Denied
ABH	8.7	8.7
ACLA	5.9	6.4
HBL	9.6	10.8
LHC	7.7	8.4
UHC	9.1	9.8

Primary Care	Paid	Denied
ABH	6.3	7.3
ACLA	3.7	5.4
HBL	9.5	9.1
LHC	7.5	7.9
UHC	7.6	7.3

Pediatrics	Paid	Denied
ABH	6.1	7.1
ACLA	3.5	4.4
HBL	8.1	8.8
LHC	7.5	7.7
UHC	7.5	7.3

OB-GYN	Paid	Denied
ABH	6.8	8.5
ACLA	3.6	5.8
HBL	7.9	9.7
LHC	7.4	7.6
UHC	7.7	7.1

Therapists (PT, OT, ST)	Paid	Denied
ABH	8.0	8.0
ACLA	6.5	7.0
HBL	7.7	9.8
LHC	7.0	8.6
UHC	7.9	9.1

Non-Emergency Medical Transp	Paid	Denied
ABH	2.1	6.0
ACLA	8.8	8.9
HBL	11.8	1.0
LHC	11.1	11.2
UHC	10.3	10.3

Medical Equipment and Supplies	Paid	Denied
ABH	11.6	8.4
ACLA	5.7	7.9
HBL	8.0	9.3
LHC	8.1	9.1
UHC	7.7	7.2

All Other Professional	Paid	Denied
ABH	6.7	8.4
ACLA	4.1	6.5
HBL	8.7	8.3
LHC	7.5	7.7
UHC	7.9	7.5

Mental/Behavioral Health - Rehab	Paid	Denied
ABH	8.0	10.2
ACLA	5.4	6.8
HBL	9.9	9.9
LHC	10.7	7.5
UHC	8.0	10.8

Mental/Behavioral Health - Other	Paid	Denied
ABH	7.1	8.2
ACLA	6.0	7.4
HBL	8.4	8.6
LHC	7.8	8.1
UHC	10.0	9.9

Pharmacy	Paid	Denied
ABH	10.7	1.0
ACLA	8.3	8.2
HBL	3.8	1.0
LHC	10.7	10.7
UHC	11.0	0.0

Appendix A Exhibit IV.1
Encounter Submissions Accepted and Rejected by LDH
All Claim Types
By MCE and By Quarter

	Accepted	Rejected
All MCEs Q1 2020	98.9%	1.1%
All MCEs Q2 2020	98.2%	1.8%
All MCEs Q3 2020	98.0%	2.0%
All MCEs Q4 2020	98.1%	1.9%
ABH Q1 2020	93.2%	6.8%
ABH Q2 2020	86.2%	13.8%
ABH Q3 2020	89.2%	10.8%
ABH Q4 2020	89.4%	10.6%
ACLA Q1 2020	96.9%	3.2%
ACLA Q2 2020	100.0%	0.0%
ACLA Q3 2020	96.2%	3.9%
ACLA Q4 2020	95.4%	4.8%
HBL Q1 2020	100.0%	0.0%
HBL Q2 2020	99.1%	0.9%
HBL Q3 2020	98.0%	2.0%
HBL Q4 2020	100.0%	0.0%
LHC Q1 2020	99.5%	0.5%
LHC Q2 2020	98.4%	1.6%
LHC Q3 2020	99.8%	0.2%
LHC Q4 2020	99.7%	0.3%
UHC Q1 2020	100.0%	0.0%
UHC Q2 2020	100.0%	0.0%
UHC Q3 2020	100.0%	0.0%
UHC Q4 2020	100.0%	0.0%
MCNA Q1 2020	99.1%	0.9%
MCNA Q2 2020	99.2%	0.8%
MCNA Q3 2020	99.1%	0.9%
MCNA Q4 2020	99.2%	0.8%

Appendix A Exhibit IV.2 and Exhibit IV.3
Encounter Submissions Accepted and Rejected by LDH
Institutional, Professional, Dental, and Pharmacy Claim Types
By MCE and By Quarter

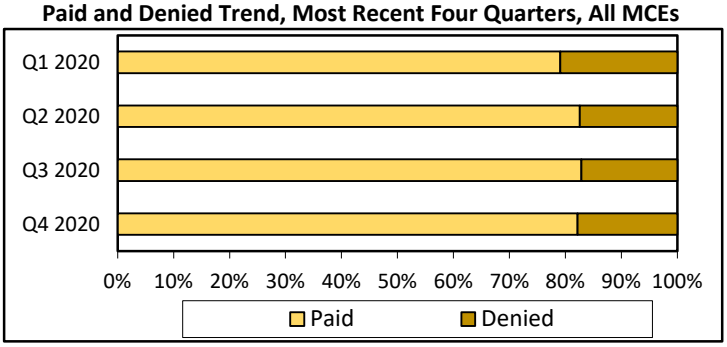
	Institutional Encounters (837I)		Professional Encounters (837D)		Dental Encounters (837D)		Pharmacy Encounters	
	Accepted	Rejected	Accepted	Rejected	Accepted	Rejected	Accepted	Rejected
ABH Q1 2020	93.4%	6.6%	84.3%	15.7%			100.0%	0.0%
ABH Q2 2020	85.8%	14.2%	78.0%	22.0%			100.0%	0.0%
ABH Q3 2020	91.3%	8.7%	79.9%	20.1%			100.0%	0.0%
ABH Q4 2020	92.7%	7.3%	76.6%	23.4%			100.0%	0.0%
ACLA Q1 2020	89.6%	10.4%	100.0%	0.0%			97.7%	2.3%
ACLA Q2 2020	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
ACLA Q3 2020	93.1%	6.9%	99.7%	0.3%			95.0%	5.0%
ACLA Q4 2020	85.9%	14.1%	100.0%	0.0%			98.5%	1.5%
HBL Q1 2020	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
HBL Q2 2020	100.0%	0.0%	100.0%	0.0%			97.6%	2.4%
HBL Q3 2020	93.7%	6.3%	100.0%	0.0%			98.3%	1.7%
HBL Q4 2020	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
LHC Q1 2020	100.0%	0.0%	100.0%	0.0%			98.1%	1.9%
LHC Q2 2020	100.0%	0.0%	100.0%	0.0%			93.5%	6.5%
LHC Q3 2020	100.0%	0.0%	100.0%	0.0%			99.2%	0.8%
LHC Q4 2020	100.0%	0.0%	100.0%	0.0%			99.1%	0.9%
UHC Q1 2020	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
UHC Q2 2020	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
UHC Q3 2020	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
UHC Q4 2020	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
MCNA Q1 2020					99.1%	0.9%		
MCNA Q2 2020					99.2%	0.8%		
MCNA Q3 2020					99.1%	0.9%		
MCNA Q4 2020					99.1%	0.9%		

APPENDIX B

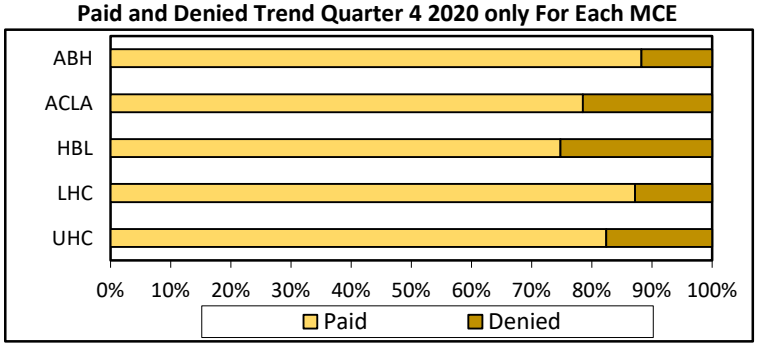
One-Page Summaries of Information on Claims for Each of the 16 Provider Types Shown in this Report

Summary of Information on Claims for Inpatient Hospital Services

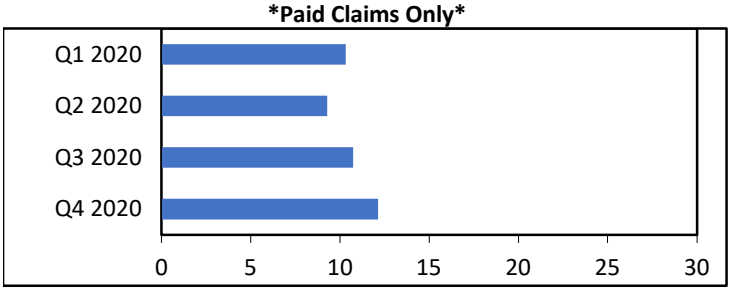
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



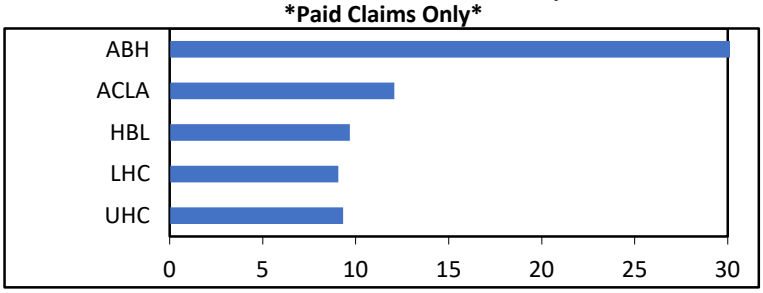
Paid and Denied Trend Quarter 4 2020 only For Each MCE



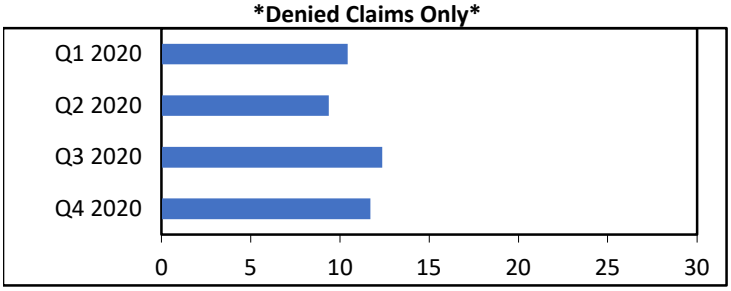
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



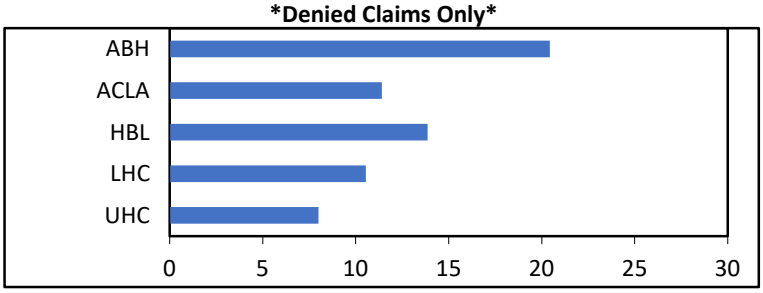
Claims Turnaround Time Quarter 4 2020 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter 4 2020 only)

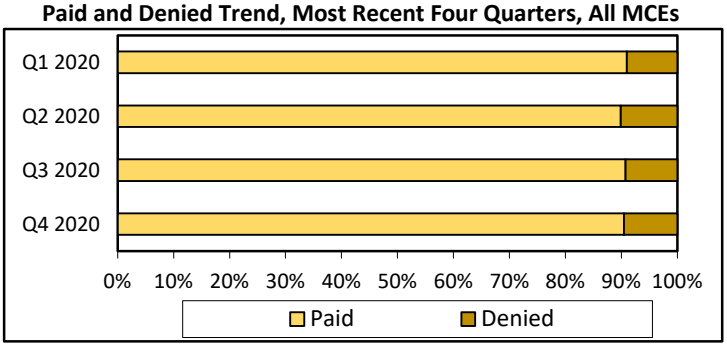
	ABH		ACLA		HBL		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	200	85	277	184	298	199	301	145	390	161
101 - 250	56	33	26	17	39	37	41	29	43	31
> 250 claims	34	18	0	0	2	1	11	9	5	0

Top Denial Reasons this Quarter (An X means it was a top denial reason for the MCE.)

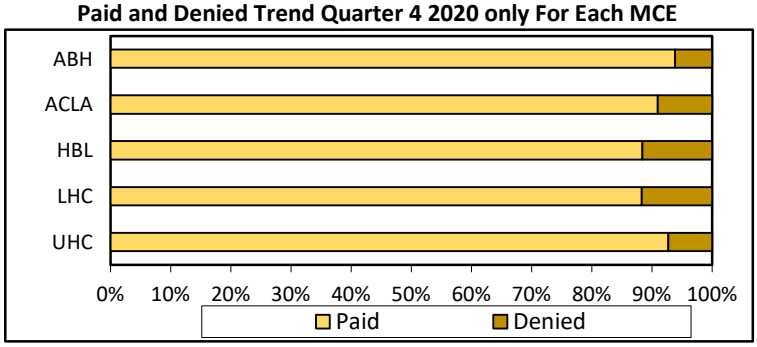
CARC Code	Description	ABH	ACLA	HBL	LHC	UHC
128	Newborn's services are covered in the mother's Allowance.		X	X		X
18	Exact duplicate claim/service	X			X	
97	The benefit for this service is included in the payment/allowance f	X				X
16	Claim/service lacks information or has submission/billing error(s) v	X			X	
197	Precertification/authorization/notification absent.	X		X	X	

Summary of Information on Claims for Outpatient Hospital Services

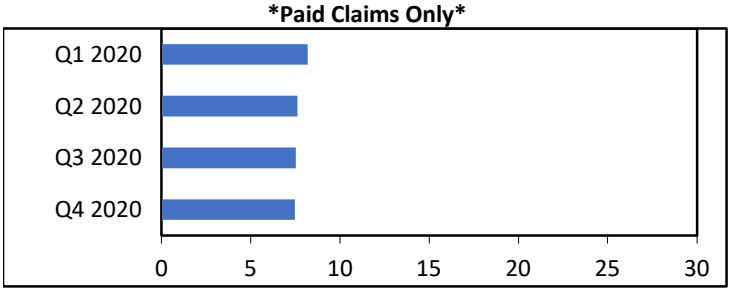
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



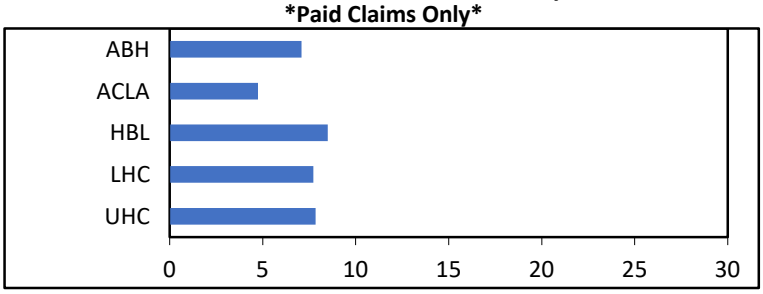
Paid and Denied Trend Quarter 4 2020 only For Each MCE



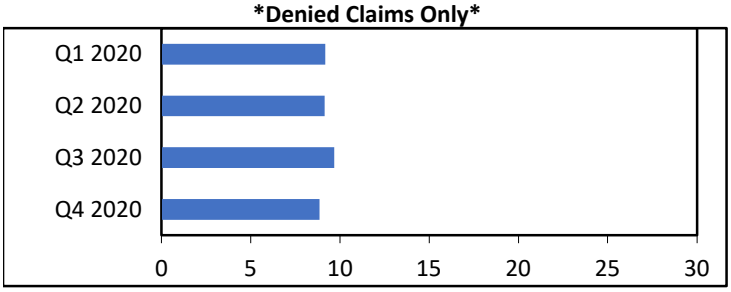
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



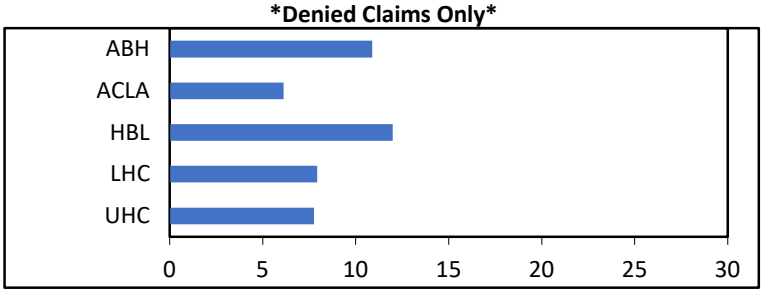
Claims Turnaround Time Quarter 4 2020 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter 4 2020 only)

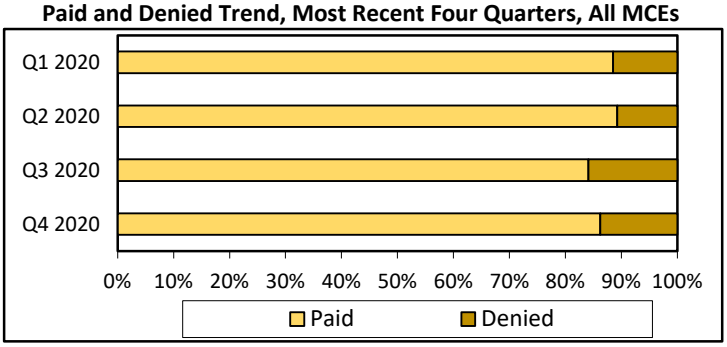
	ABH		ACLA		HBL		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	563	198	424	343	375	145	566	329	390	161
101 - 250	132	85	80	25	34	20	129	108	43	31
> 250 claims	115	70	118	33	99	43	164	87	5	0

Top Denial Reasons this Quarter (An X means it was a top denial reason for the MCE.)

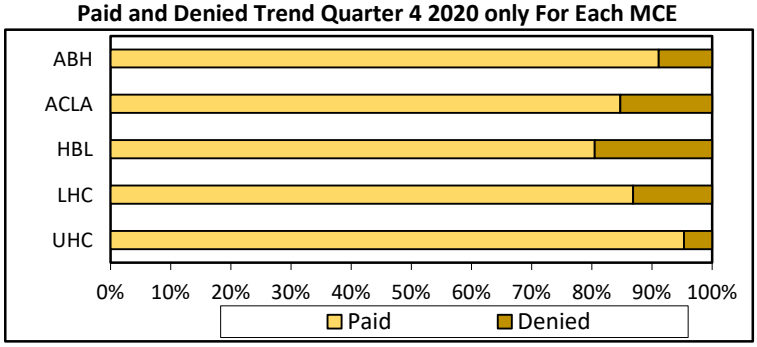
CARC Code	Description	ABH	ACLA	HBL	LHC	UHC
96	Non-covered charge(s).	X	X		X	X
97	The benefit for this service is included in the payment/allowance f	X	X		X	X
16	Claim/service lacks information or has submission/billing error(s) v	X	X		X	
18	Exact duplicate claim/service	X			X	
252	An attachment/other documentation is required to adjudicate this		X	X		X

Summary of Information on Claims for Home Health Services

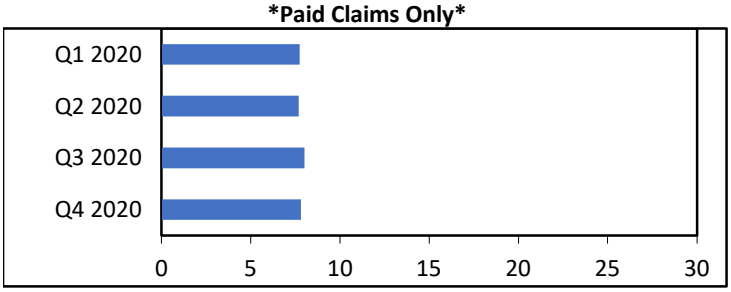
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



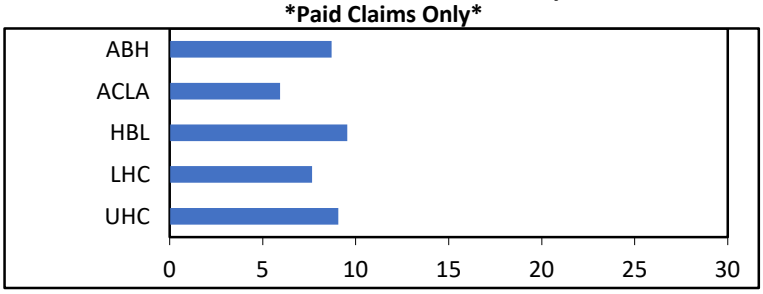
Paid and Denied Trend Quarter 4 2020 only For Each MCE



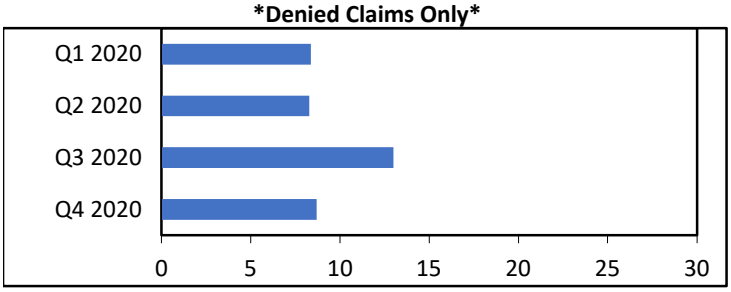
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



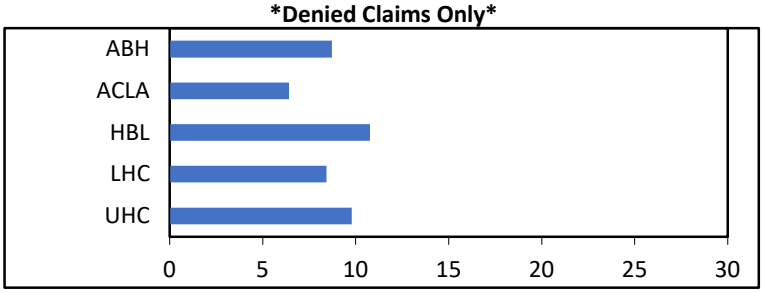
Claims Turnaround Time Quarter 4 2020 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter 4 2020 only)

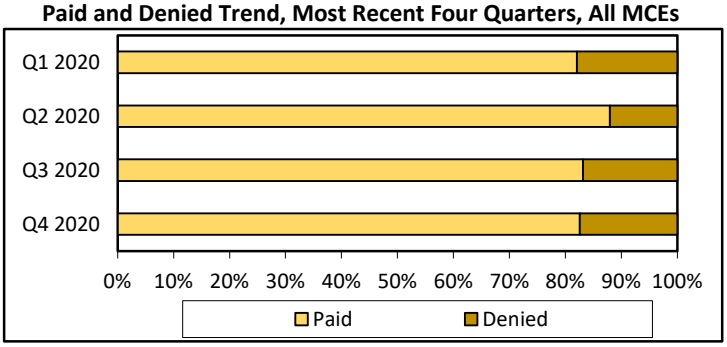
	ABH		ACLA		HBL		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	31	9	43	18	53	14	86	29	28	3
101 - 250	13	7	12	2	15	4	53	14	1	0
> 250 claims	0	0	1	0	2	2	22	14	0	0

Top Denial Reasons this Quarter (An X means it was a top denial reason for the MCE.)

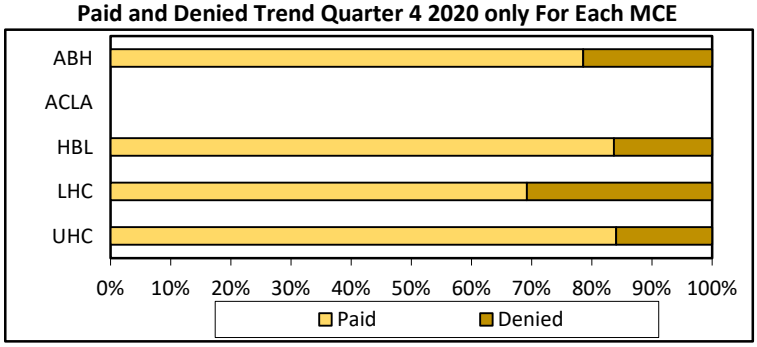
CARC Code	Description	ABH	ACLA	HBL	LHC	UHC
96	Non-covered charge(s).	X	X		X	X
146	Diagnosis was invalid for the date(s) of service reported.				X	X
16	Claim/service lacks information or has submission/billing error(s) v	X			X	X
197	Precertification/authorization/notification absent.	X	X	X		X
256	Service not payable per managed care contract.			X		X

Summary of Information on Claims for Other Institutional Services

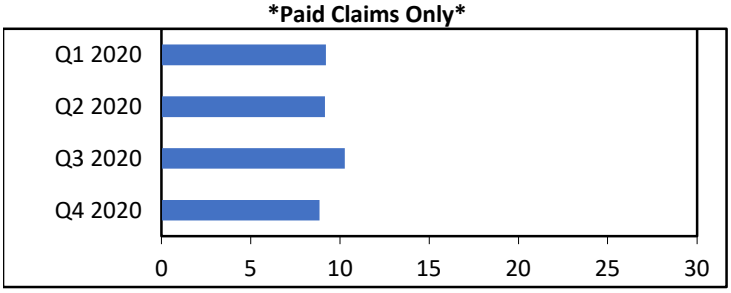
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



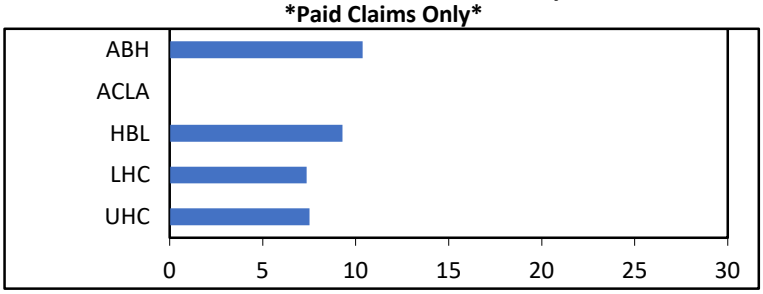
Paid and Denied Trend Quarter 4 2020 only For Each MCE



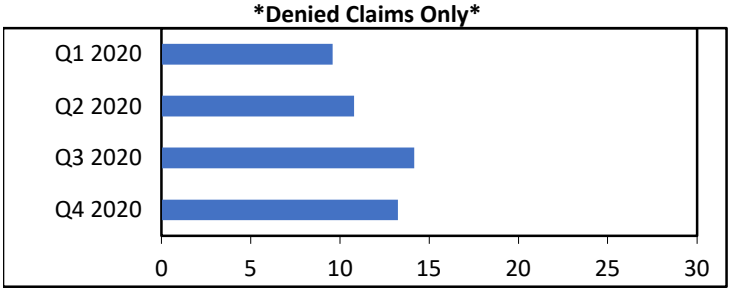
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



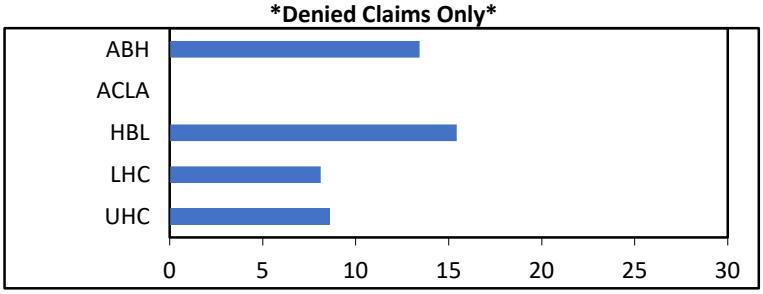
Claims Turnaround Time Quarter 4 2020 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter 4 2020 only)

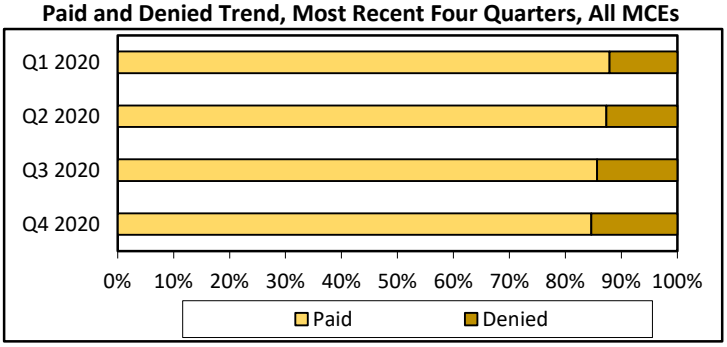
	ABH		ACLA		HBL		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	25	23	0	0	136	75	110	71	22	2
101 - 250	2	2	0	0	64	24	6	6	14	4
> 250 claims	1	0	0	0	29	10	2	0	6	3

Top Denial Reasons this Quarter (An X means it was a top denial reason for the MCE.)

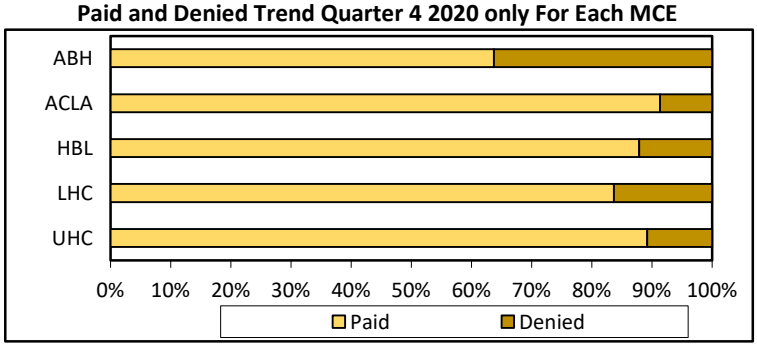
CARC Code	Description	ABH	ACLA	HBL	LHC	UHC
252	An attachment/other documentation is required to adjudicate this		X	X		X
197	Precertification/authorization/notification absent.		X	X		
204	This service/equipment/drug is not covered under the patient's cu		X	X	X	
16	Claim/service lacks information or has submission/billing error(s) v	X	X		X	
256	Service not payable per managed care contract.		X	X		X

Summary of Information on Claims for Primary Care Services

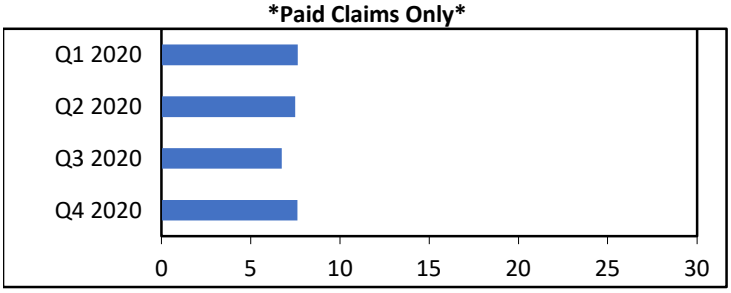
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



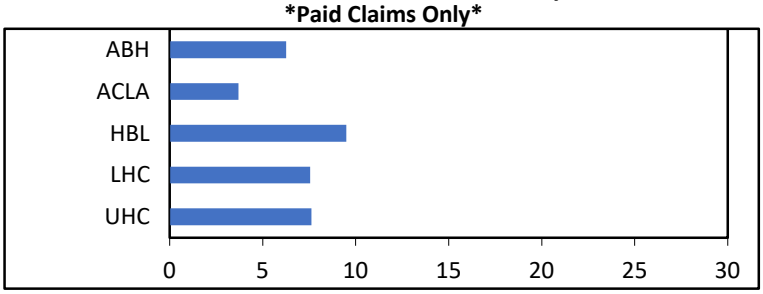
Paid and Denied Trend Quarter 4 2020 only For Each MCE



Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



Claims Turnaround Time Quarter 4 2020 only Each MCE
Paid Claims Only



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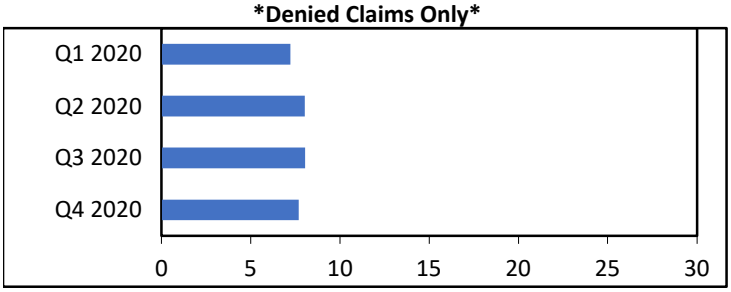
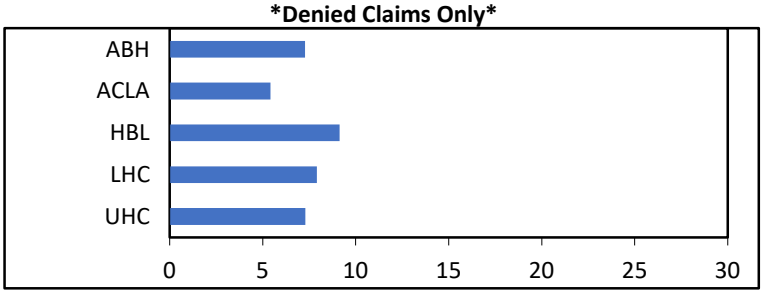


Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter 4 2020 only)

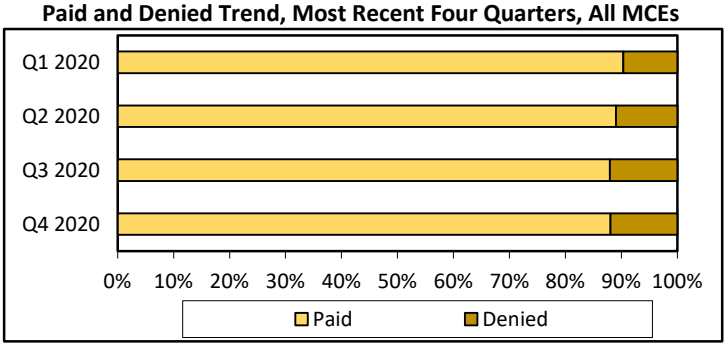
	ABH		ACLA		HBL		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	678	410	617	250	935	428	900	470	1,277	729
101 - 250	111	99	197	58	452	134	434	251	298	124
> 250 claims	18	13	52	11	245	70	353	232	280	91

Top Denial Reasons this Quarter (An X means it was a top denial reason for the MCE.)

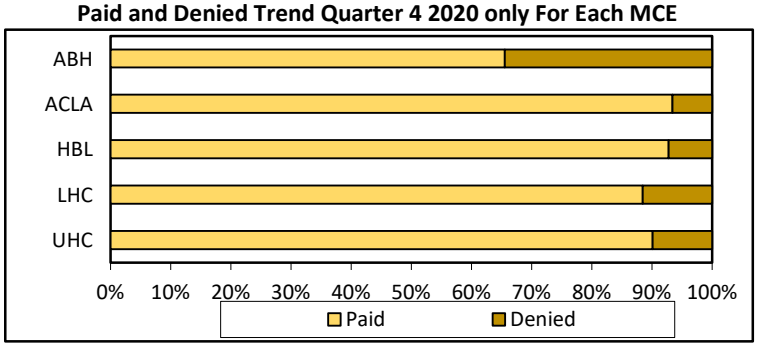
CARC Code	Description	ABH	ACLA	HBL	LHC	UHC
96	Non-covered charge(s).	X	X		X	X
16	Claim/service lacks information or has submission/billing error(s) v	X	X		X	
256	Service not payable per managed care contract.			X		X
B7	This provider was not certified/eligible to be paid for this procedur				X	
97	The benefit for this service is included in the payment/allowance f	X				X

Summary of Information on Claims for Pediatric Services

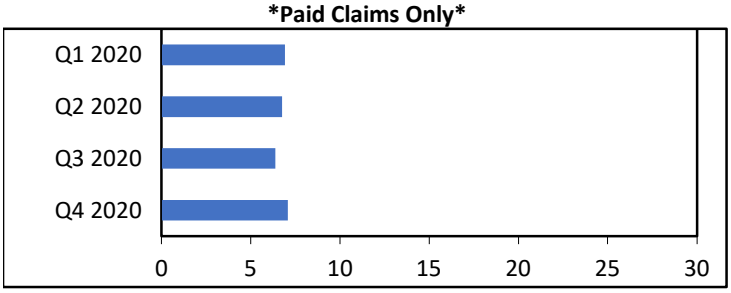
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



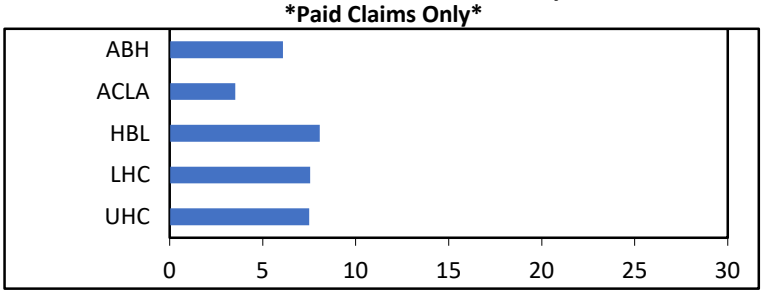
Paid and Denied Trend Quarter 4 2020 only For Each MCE



Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



Claims Turnaround Time Quarter 4 2020 only Each MCE
Paid Claims Only



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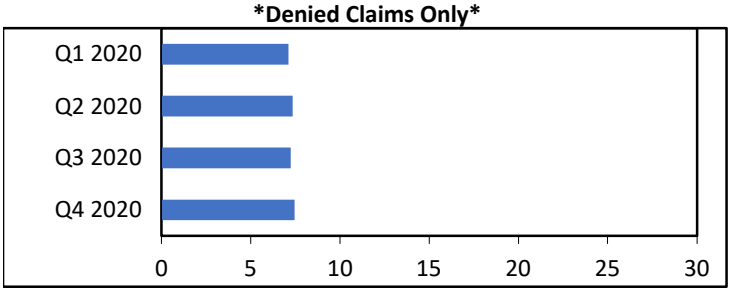

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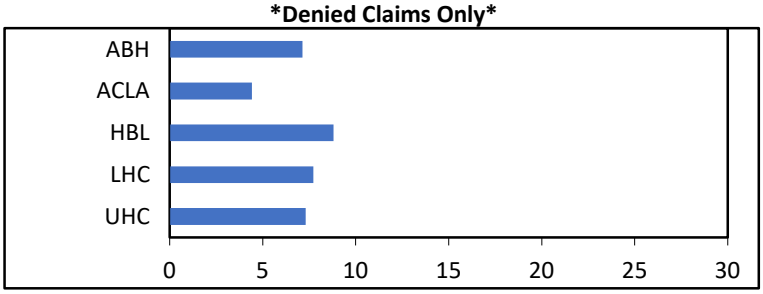


Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter 4 2020 only)

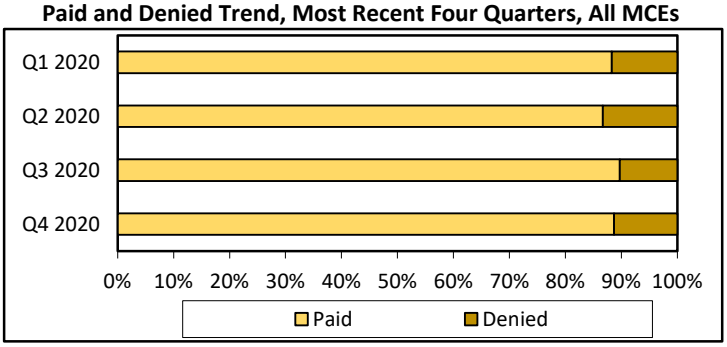
	ABH		ACLA		HBL		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	65	32	109	41	162	59	142	68	39	18
101 - 250	19	15	96	19	99	21	101	58	16	6
> 250 claims	12	8	60	11	110	22	141	80	54	21

Top Denial Reasons this Quarter (An X means it was a top denial reason for the MCE.)

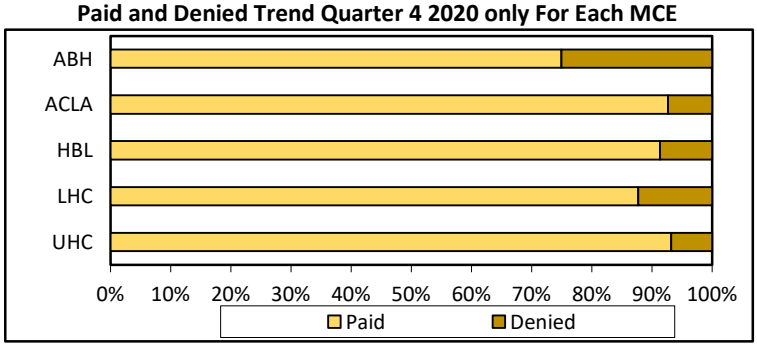
CARC Code	Description	ABH	ACLA	HBL	LHC	UHC
96	Non-covered charge(s).	X	X		X	X
B7	This provider was not certified/eligible to be paid for this procedur				X	
18	Exact duplicate claim/service	X			X	X
97	The benefit for this service is included in the payment/allowance f	X	X			X
256	Service not payable per managed care contract.			X		

Summary of Information on Claims for OBGYN Services

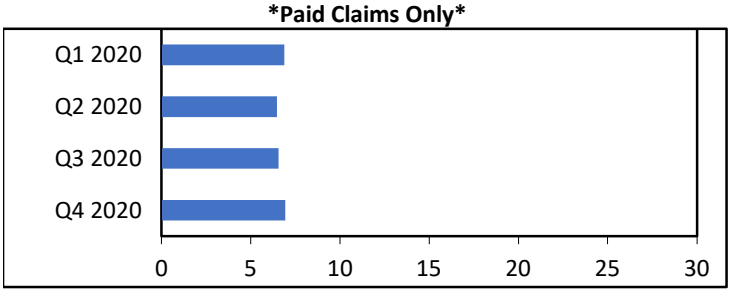
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



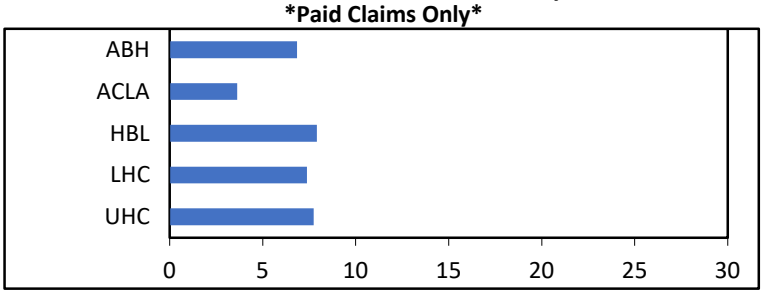
Paid and Denied Trend Quarter 4 2020 only For Each MCE



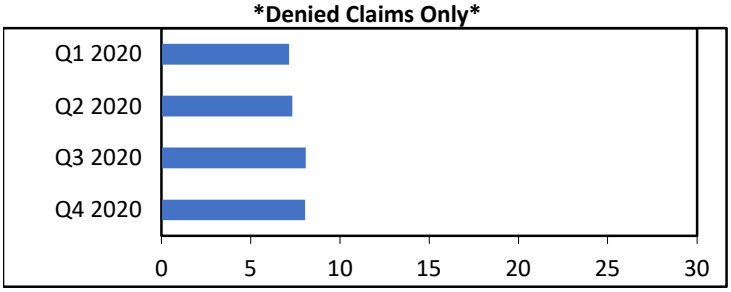
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



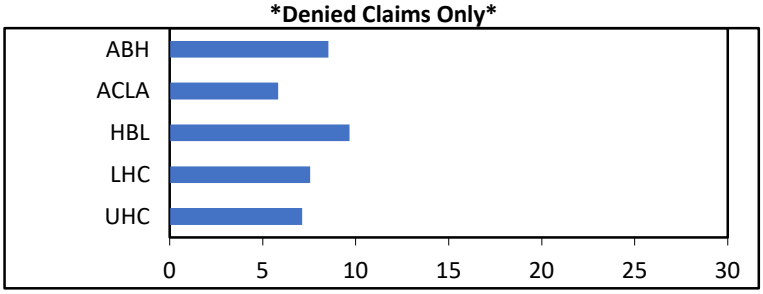
Claims Turnaround Time Quarter 4 2020 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter 4 2020 only)

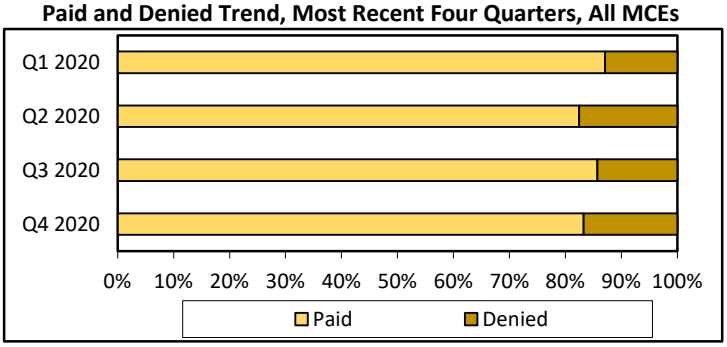
	ABH		ACLA		HBL		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	52	31	91	42	115	56	94	45	33	22
101 - 250	12	9	72	19	68	22	60	32	15	8
> 250 claims	1	1	22	3	46	11	61	35	19	4

Top Denial Reasons this Quarter (An X means it was a top denial reason for the MCE.)

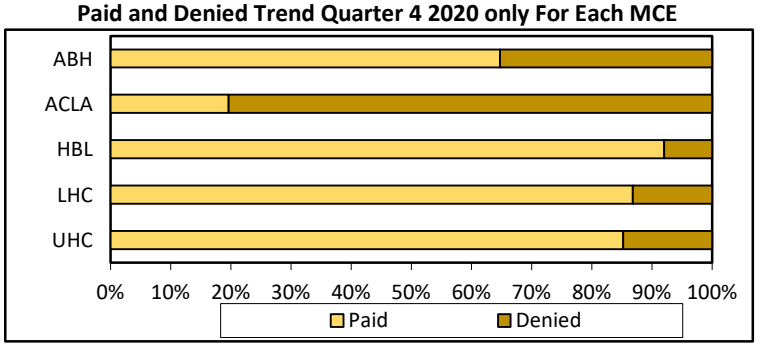
CARC Code	Description	ABH	ACLA	HBL	LHC	UHC
97	The benefit for this service is included in the payment/allowance f	X			X	X
16	Claim/service lacks information or has submission/billing error(s) v	X	X		X	
96	Non-covered charge(s).	X	X		X	X
18	Exact duplicate claim/service	X			X	
260	Processed under Medicaid ACA Enhanced Fee Schedule			X		

Summary of Information on Claims for Therapy Services

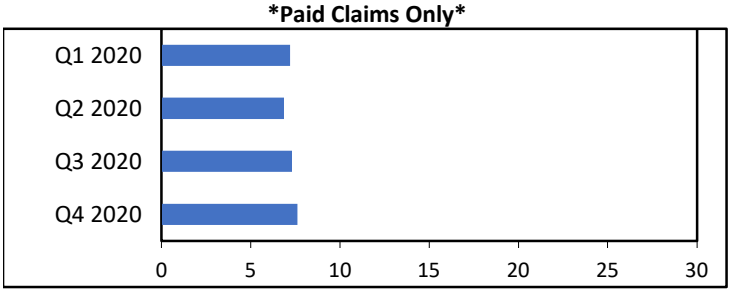
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



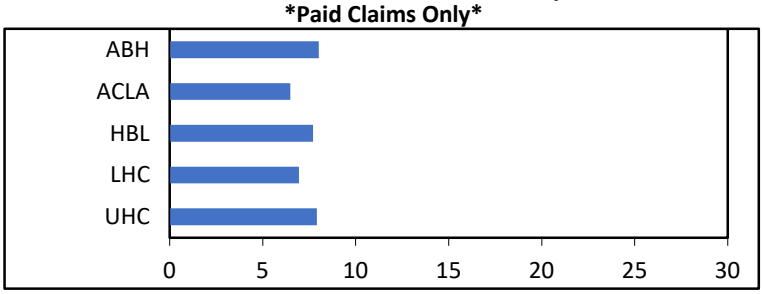
Paid and Denied Trend Quarter 4 2020 only For Each MCE



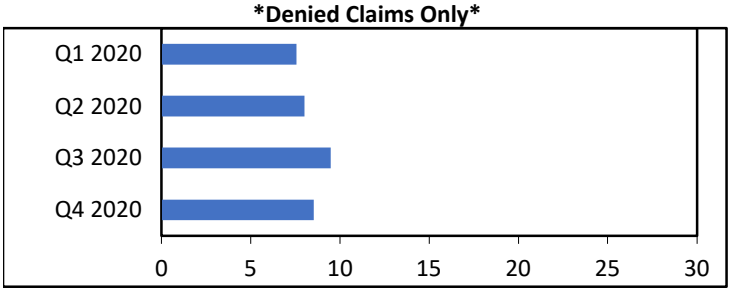
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



Claims Turnaround Time Quarter 4 2020 only Each MCE
Paid Claims Only



Denied Claims Only



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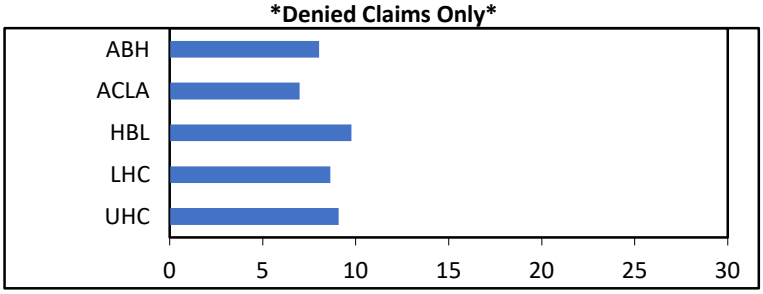


Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter 4 2020 only)

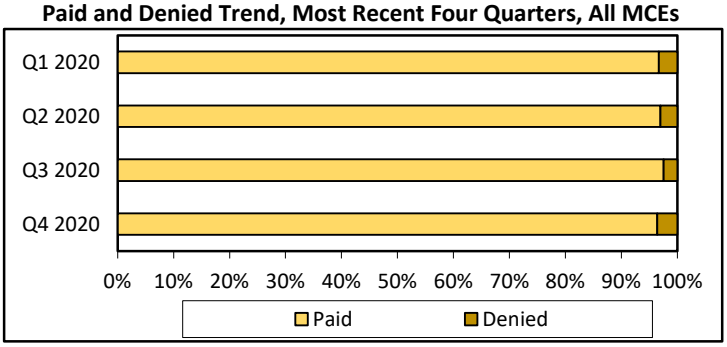
	ABH		ACLA		HBL		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	144	99	31	30	71	30	34	25	17	9
101 - 250	35	28	4	3	41	12	23	12	22	12
> 250 claims	1	1	1	1	22	5	14	10	12	3

Top Denial Reasons this Quarter (An X means it was a top denial reason for the MCE.)

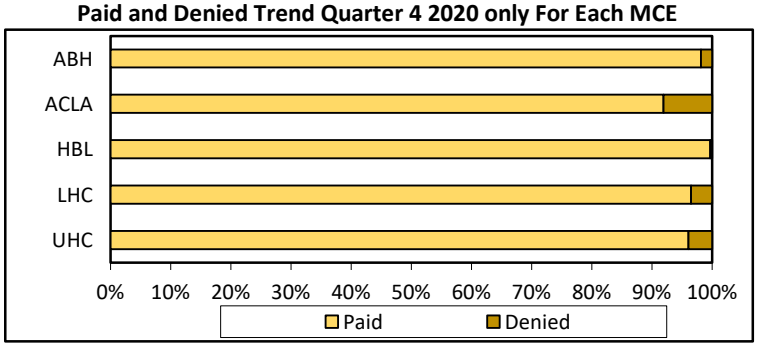
CARC Code	Description	ABH	ACLA	HBL	LHC	UHC
96	Non-covered charge(s).	X	X			X
256	Service not payable per managed care contract.			X		
197	Precertification/authorization/notification absent.	X		X		X
16	Claim/service lacks information or has submission/billing error(s) v	X	X		X	
97	The benefit for this service is included in the payment/allowance f					X

Summary of Information on Claims for NEMT Services

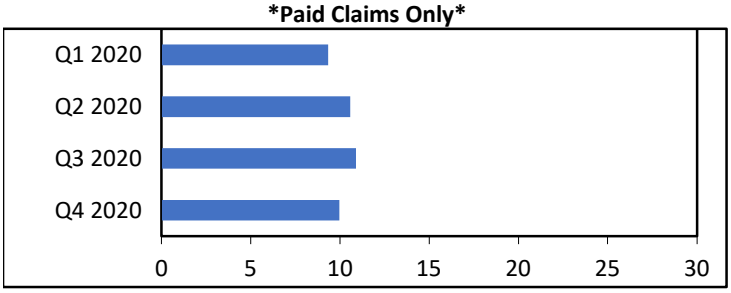
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



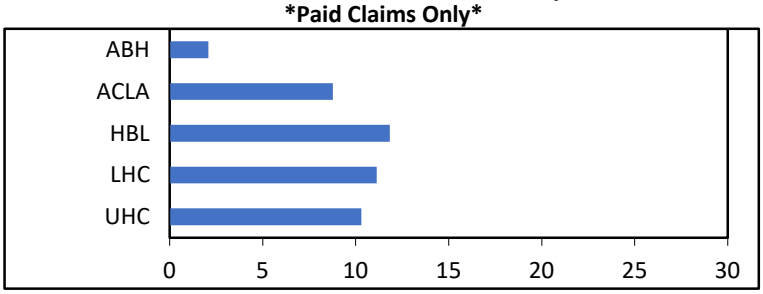
Paid and Denied Trend Quarter 4 2020 only For Each MCE



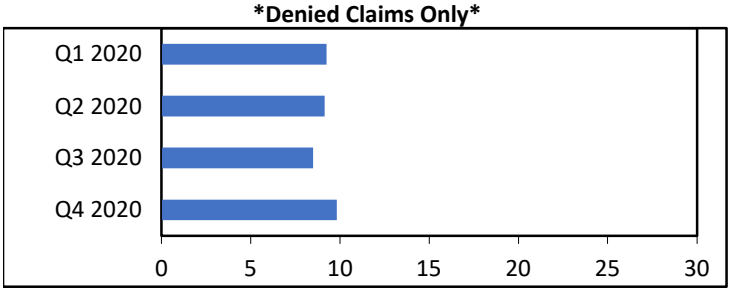
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



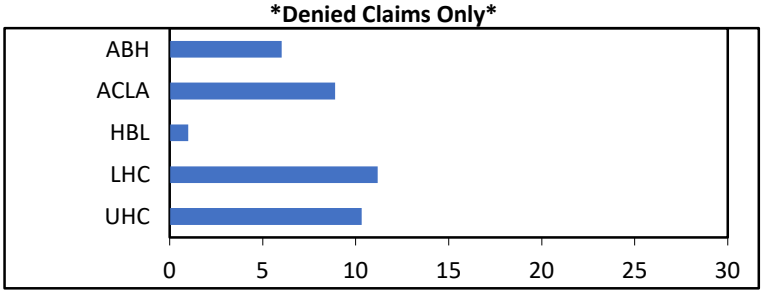
Claims Turnaround Time Quarter 4 2020 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter 4 2020 only)

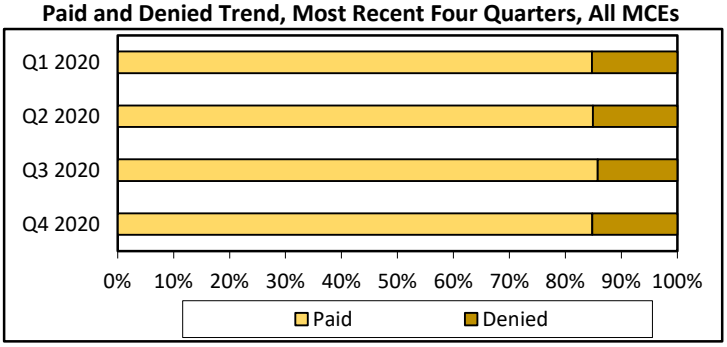
	ABH		ACLA		HBL		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	67	11	58	31	0	0	54	16	11	11
101 - 250	70	8	50	23	0	0	66	14	0	0
> 250 claims	24	1	24	1	0	0	42	3	0	0

Top Denial Reasons this Quarter (An X means it was a top denial reason for the MCE.)

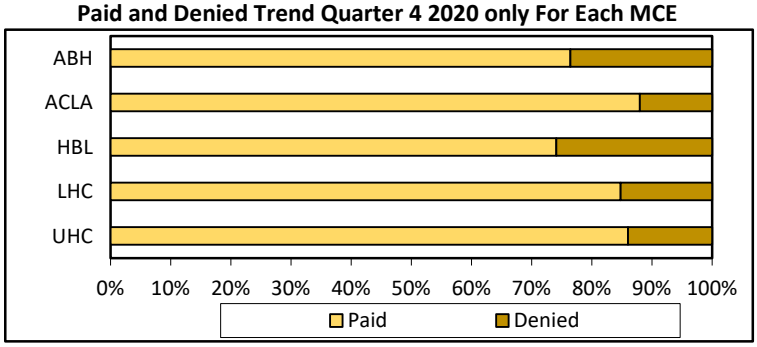
CARC Code	Description	ABH	ACLA	HBL	LHC	UHC
16	Claim/service lacks information or has submission/billing error(s) v	X	X	X	X	X
18	Exact duplicate claim/service	X	X	X	X	X
97	The benefit for this service is included in the payment/allowance f	X	X	X		X
96	Non-covered charge(s).		X	X	X	X

Summary of Information on Claims for Medical Supplies Services

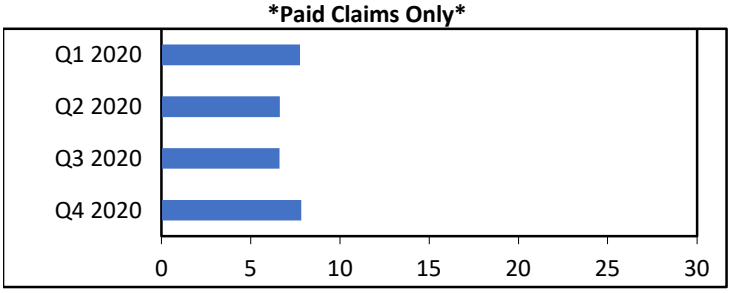
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



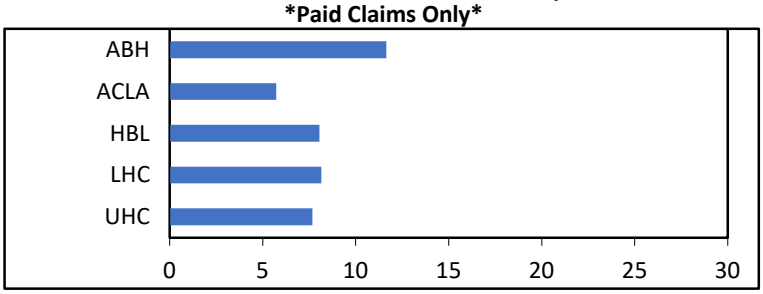
Paid and Denied Trend Quarter 4 2020 only For Each MCE



Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



Claims Turnaround Time Quarter 4 2020 only Each MCE
Paid Claims Only



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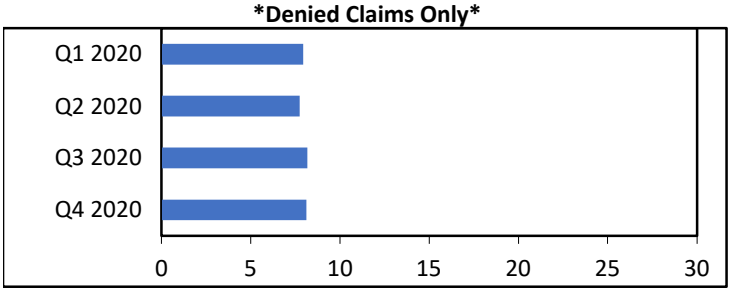
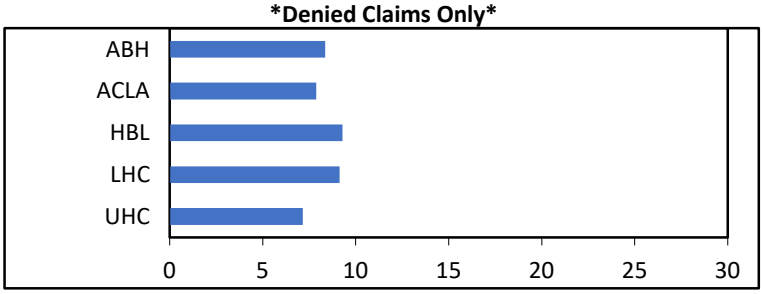


Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter 4 2020 only)

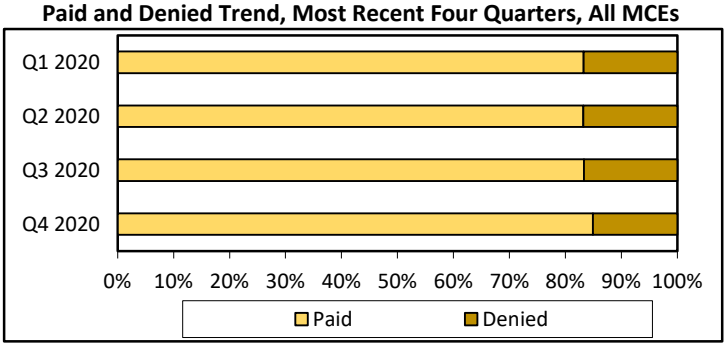
	ABH		ACLA		HBL		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	137	101	145	70	109	58	146	61	334	249
101 - 250	37	34	41	16	11	5	84	56	39	18
> 250 claims	10	9	11	3	0	0	23	11	32	13

Top Denial Reasons this Quarter (An X means it was a top denial reason for the MCE.)

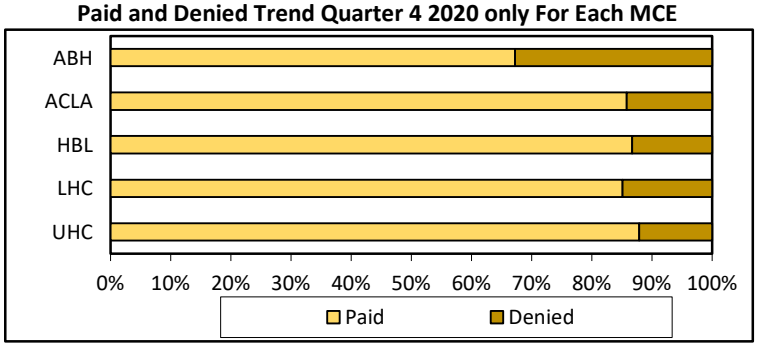
CARC Code	Description	ABH	ACLA	HBL	LHC	UHC
96	Non-covered charge(s).		X			X
16	Claim/service lacks information or has submission/billing error(s) v	X	X		X	
197	Precertification/authorization/notification absent.	X	X	X	X	X
252	An attachment/other documentation is required to adjudicate this		X	X		X
18	Exact duplicate claim/service	X			X	X

Summary of Information on Claims for All Other Professional Claim Services (except Mental Health)

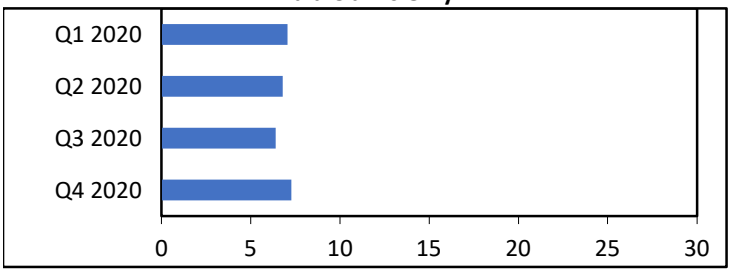
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



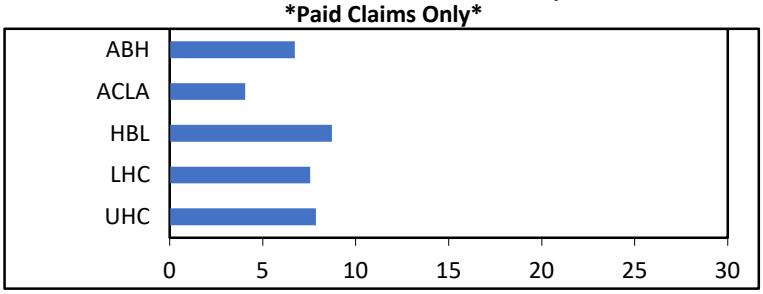
Paid and Denied Trend Quarter 4 2020 only For Each MCE



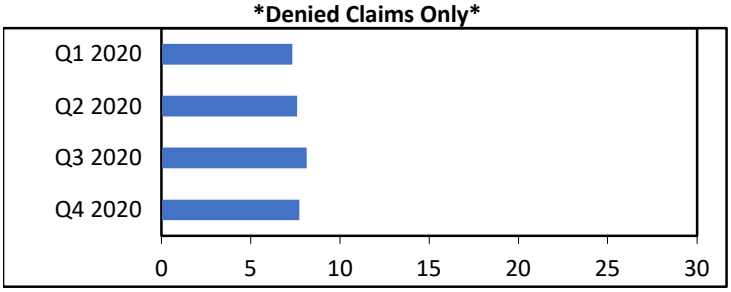
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



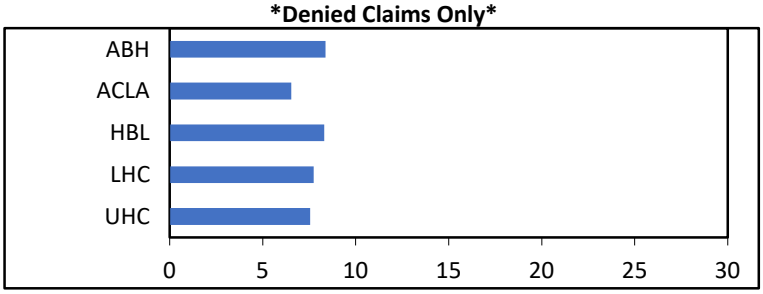
Claims Turnaround Time Quarter 4 2020 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter 4 2020 only)

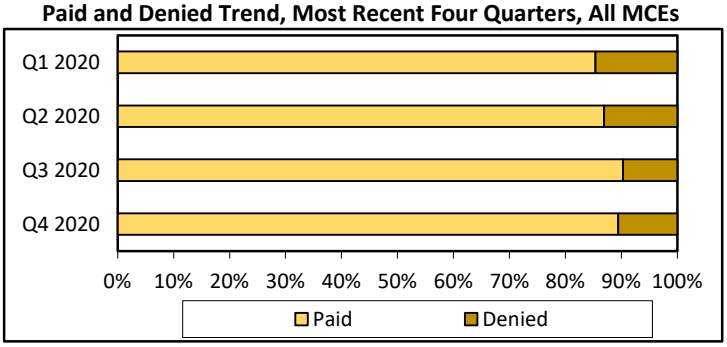
	ABH		ACLA		HBL		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	446	69	2,280	1,203	2,313	951	2,066	1,149	2,811	1,496
101 - 250	16	6	788	340	591	237	691	363	482	236
> 250 claims	14	2	252	81	327	126	463	213	345	135

Top Denial Reasons this Quarter (An X means it was a top denial reason for the MCE.)

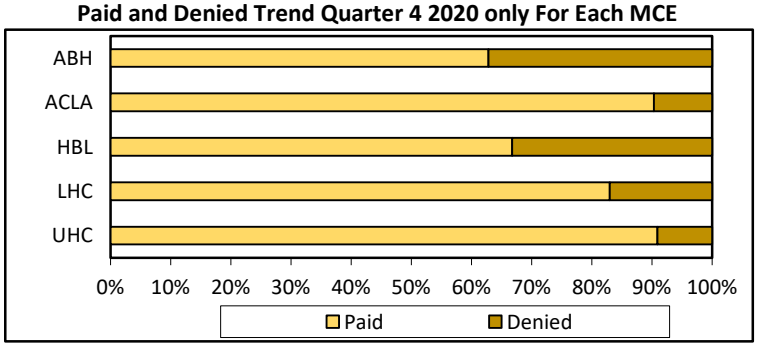
CARC Code	Description	ABH	ACLA	HBL	LHC	UHC
96	Non-covered charge(s).	X	X		X	X
197	Precertification/authorization/notification absent.		X	X		X
18	Exact duplicate claim/service	X			X	X
252	An attachment/other documentation is required to adjudicate this		X			X
97	The benefit for this service is included in the payment/allowance f	X			X	X

Summary of Information on Claims for Mental Health Services- Rehab

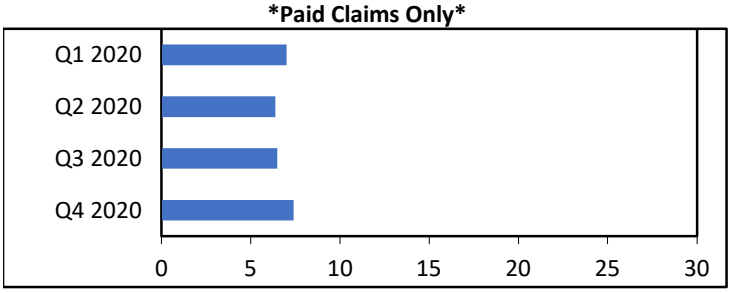
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



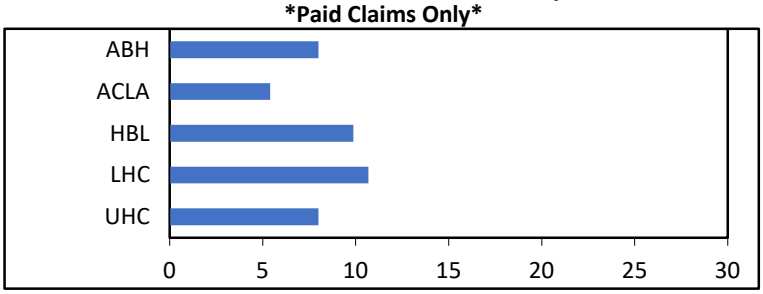
Paid and Denied Trend Quarter 4 2020 only For Each MCE



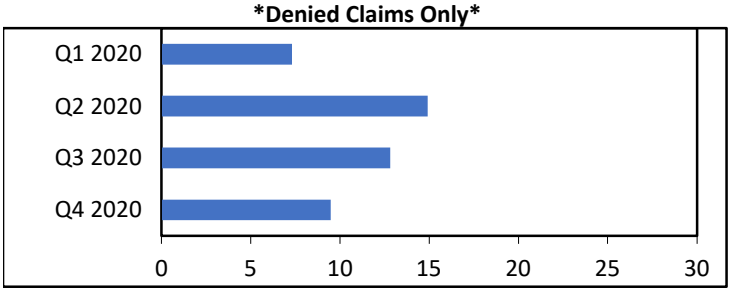
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



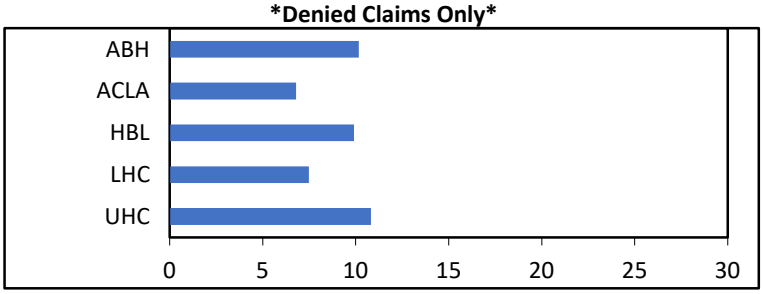
Claims Turnaround Time Quarter 4 2020 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter 4 2020 only)

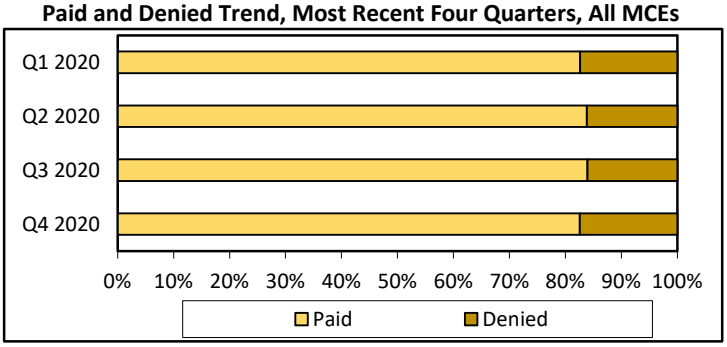
	ABH		ACLA		HBL		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	47	34	90	30	151	131	42	28	70	41
101 - 250	6	4	111	39	20	14	20	5	68	29
> 250 claims	2	2	41	7	2	2	3	2	87	29

Top Denial Reasons this Quarter (An X means it was a top denial reason for the MCE.)

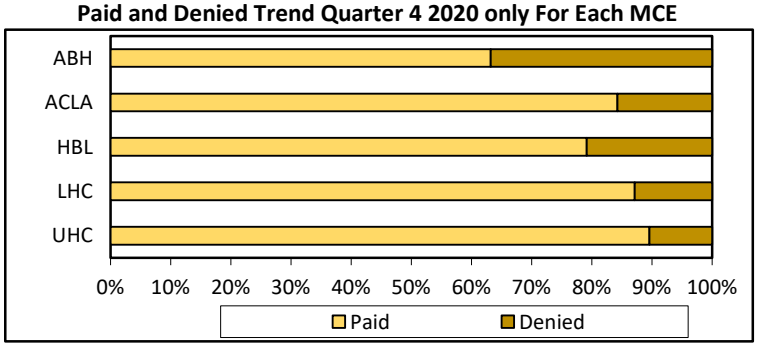
CARC Code	Description	ABH	ACLA	HBL	LHC	UHC
197	Precertification/authorization/notification absent.		X	X	X	X
29	The time limit for filing has expired.		X		X	
8	The procedure code is inconsistent with the provider type/specialt	X	X			
16	Claim/service lacks information or has submission/billing error(s) v	X			X	
198	Precertification/authorization exceeded.		X	X		

Summary of Information on Claims for Behavioral Health Specialized Services other than Rehab

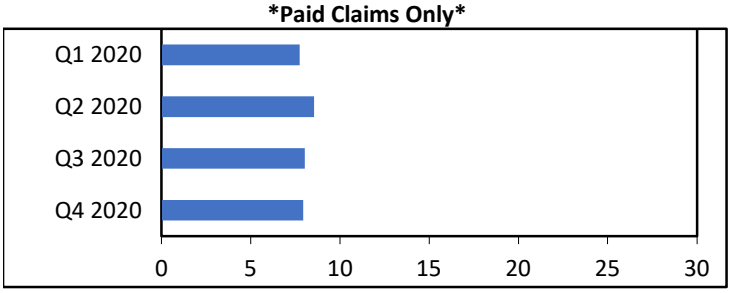
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



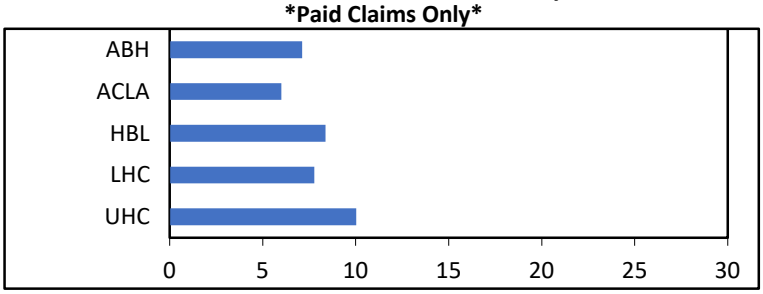
Paid and Denied Trend Quarter 4 2020 only For Each MCE



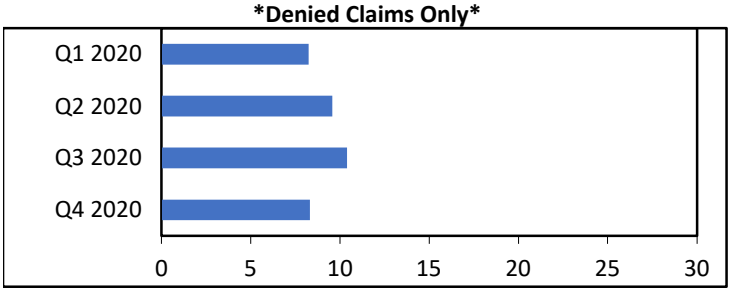
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



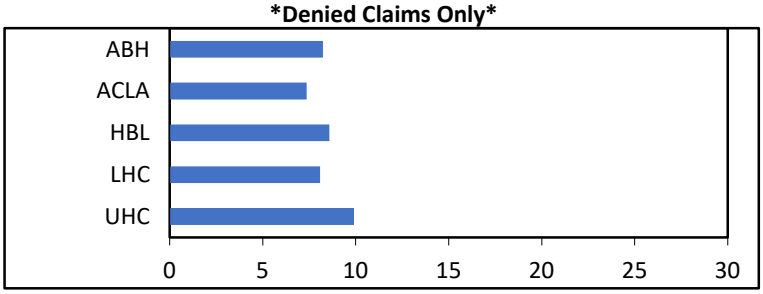
Claims Turnaround Time Quarter 4 2020 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter 4 2020 only)

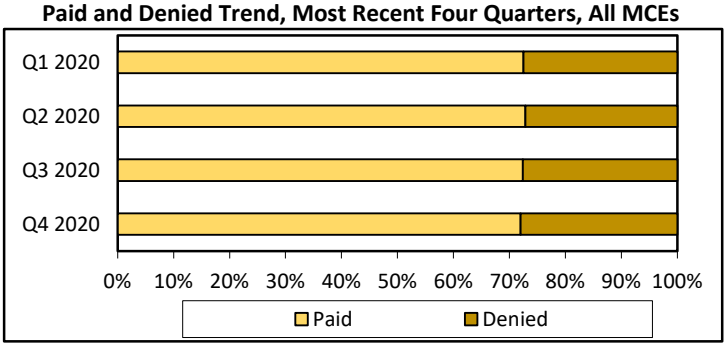
	ABH		ACLA		HBL		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	12	8	524	275	865	482	704	321	224	91
101 - 250	2	0	93	31	274	165	297	157	59	33
> 250 claims	0	0	20	5	93	56	218	111	35	11

Top Denial Reasons this Quarter (An X means it was a top denial reason for the MCE.)

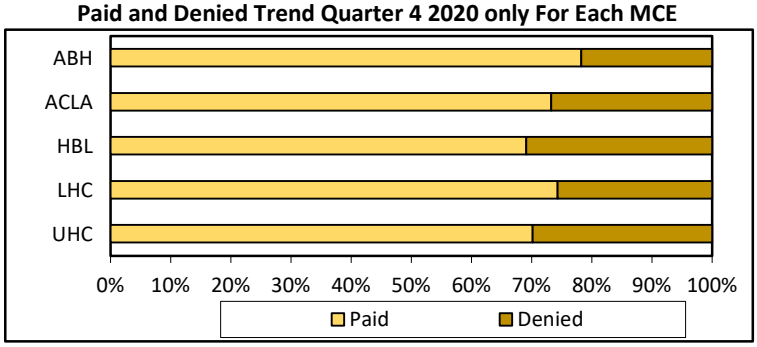
CARC Code	Description	ABH	ACLA	HBL	LHC	UHC
197	Precertification/authorization/notification absent.		X	X	X	X
18	Exact duplicate claim/service				X	
16	Claim/service lacks information or has submission/billing error(s) v	X			X	
119	Benefit maximum for this time period or occurrence has been reac			X	X	
96	Non-covered charge(s).	X	X			X

Summary of Information on Claims for Pharmacy Services

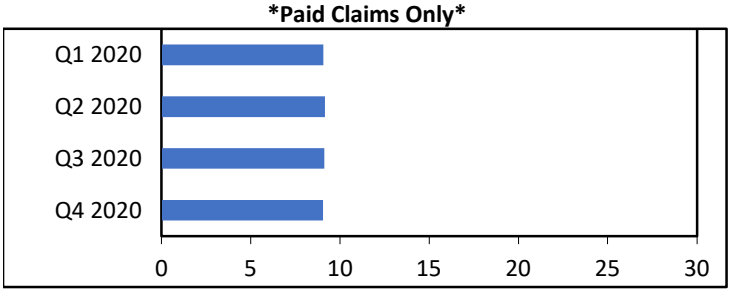
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



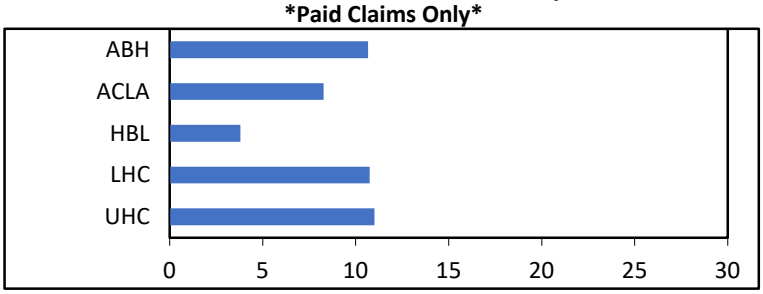
Paid and Denied Trend Quarter 4 2020 only For Each MCE



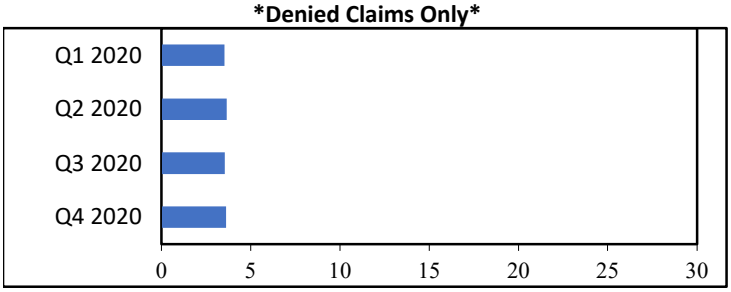
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



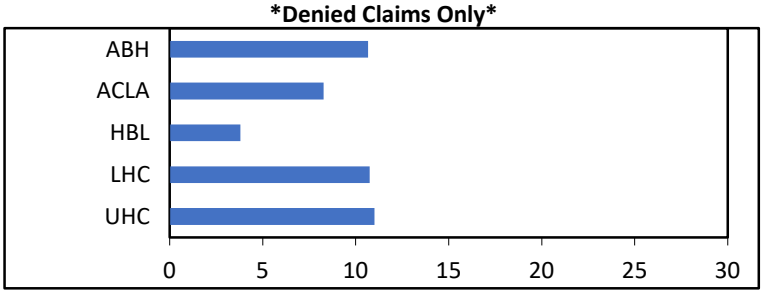
Claims Turnaround Time Quarter 4 2020 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter 4 2020 only)

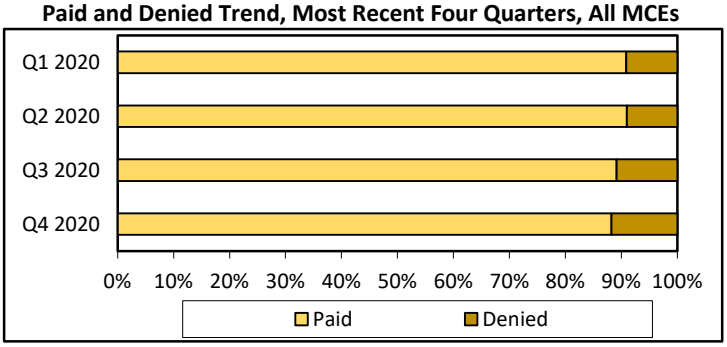
	ABH		ACLA		HBL		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	16,404	10,054	927	907	2,502	2,050	12,846	12,339	20,022	16,284
101 - 250	1,431	1,357	379	370	217	214	3,109	3,080	4,259	4,241
> 250 claims	119	116	647	643	873	873	957	956	1,809	1,807

Top Denial Reasons this Quarter (An X means it was a top denial reason for the MCE.)

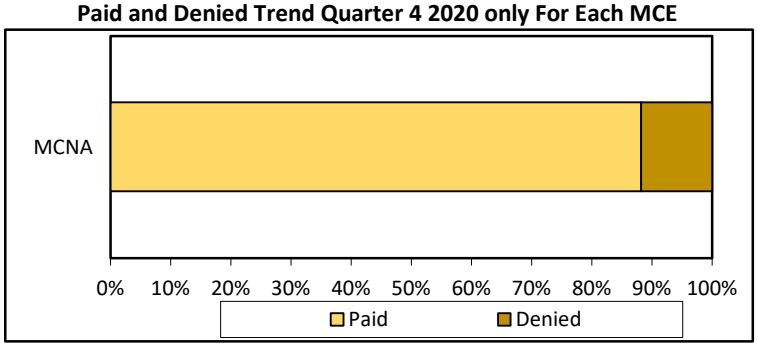
NCDCP Code	Description	ABH	ACLA	HBL	LHC	UHC
79	Refill Too Soon	X	X	X	X	X
88	DUR Reject Error		X	X	X	X
75	Prior Authorization Required	X		X	X	
7Ø	Product/Service Not Covered – Plan/Benefit Exclusion	X	X		X	X
76	Plan Limitations Exceeded	X			X	X

Summary of Information on Claims for Dental Services- Children

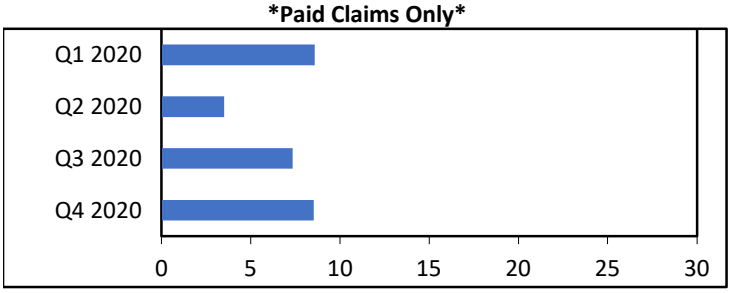
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



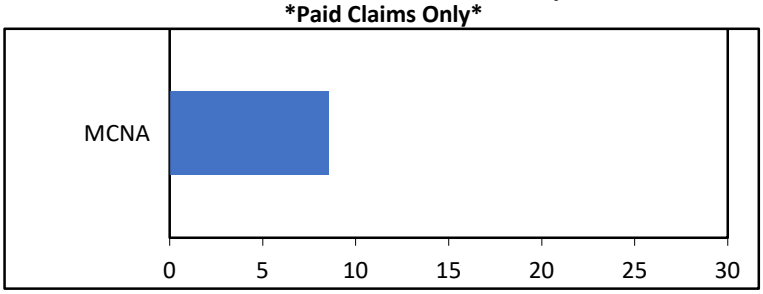
Paid and Denied Trend Quarter 4 2020 only For Each MCE



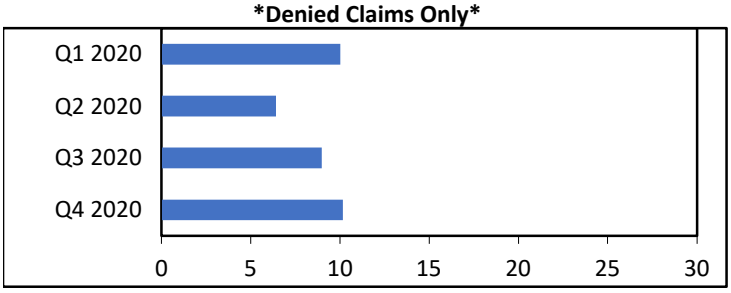
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



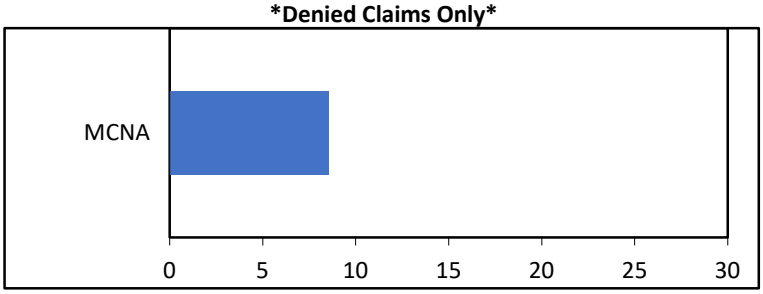
Claims Turnaround Time Quarter 4 2020 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter 4 2020 only)

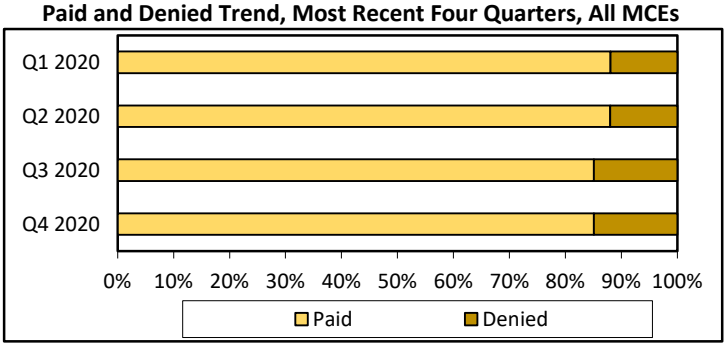
	MCNA	
	# Providers	>10% denied
<100 claims	635	335
101 - 250	169	102
> 250 claims	39	39

Top Denial Reasons this Quarter

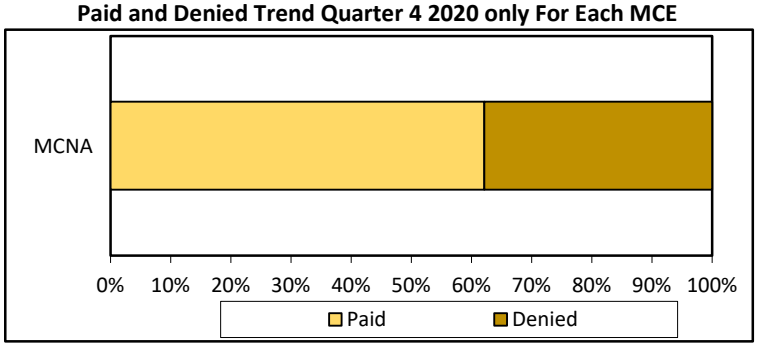
CARC Code	Description	MCNA
96	Non-covered charge(s).	X
169	Alternate benefit has been provided.	X
18	Exact duplicate claim/service	X
6	The procedure/revenue code is inconsistent with the patient's age	X
252	An attachment/other documentation is required to adjudicate this	X

Summary of Information on Claims for Dental Services- Adults

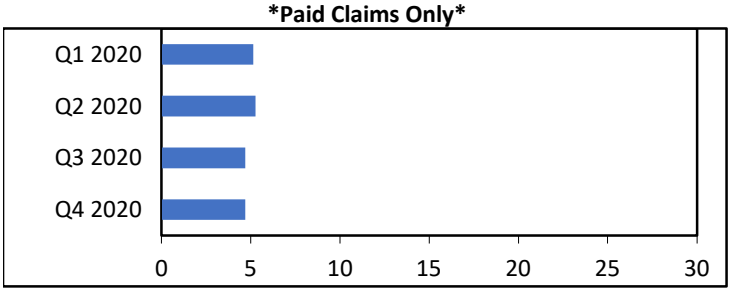
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



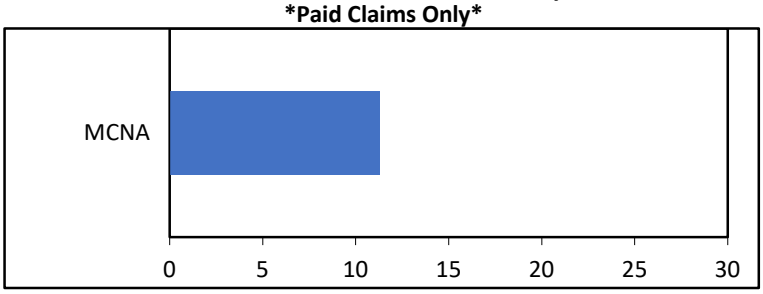
Paid and Denied Trend Quarter 4 2020 only For Each MCE



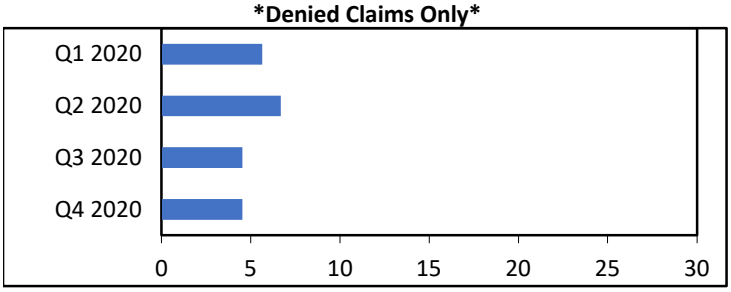
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



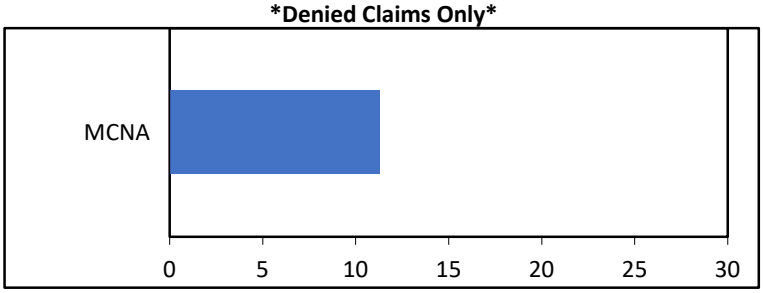
Claims Turnaround Time Quarter 4 2020 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter 4 2020 only)

	MCNA	
	# Providers	>10% denied
<100 claims	318	293
101 - 250	1	1
> 250 claims	0	0

Note: All MCEs had little data for Dental-Adult

Top Denial Reasons this Quarter

CARC Code	Description	MCNA
119	Benefit maximum for this time period or occurrence has been reac	
B7	This provider was not certified/eligible to be paid for this procedur	
96	Non-covered charge(s).	X
18	Exact duplicate claim/service	X
242	Services not provided by network/primary care providers.	