Healthy Louisiana Claims Report

Response to Act 710 of the 2018 Legislative Session

Calendar Year 2019 Quarter 3

Prepared by:

Louisiana Department of Health

Bureau of Health Services Financing

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LOUISIANA DEPARTMENT OF HEALTH

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Executive Summary

Background

On June 1, 2018, the Louisiana State Legislature passed Act No. 710 which requires reporting of data on healthcare provider claims submitted to Medicaid managed care organizations (MCOs). 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. The Initial Report was submitted to the legislature on October 31, 2018. Subsequent reports have been submitted as follows:

- Report update #1 covered the three Calendar Quarters 1, 2 and 3 in CY 2018
- Report update #2 covered Quarters 1 through 4 in CY 2018
- Report update #3 covered Calendar Q2 through Q4 of 2018 and Q1 of 2019
- Report update #4 covered Calendar Q3 and Q4 of 2018 and Q1 and Q2 of 2019
- This report (update #5) covers Calendar Q4 of 2018 and Calendar Q1 through Q3 of 2019

In some exhibits of the report, data is shown for the most recent four quarters. It was agreed with stakeholders that, although the Act only required a quarterly update on the most recent quarter, the ability to view a rolling four-quarter trend will allow for more meaningful analysis.

The LDH has engaged Burns & Associates (B&A) 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. In addition to assistance in writing the quarterly reports, B&A is conducting data validation on the information submitted by each MCO in the new reporting requirements released by LDH.

Report Contents

The MCOs for which data will reported on include the five MCOs currently under contract to provide acute care, behavioral health and pharmacy services as well as a 6th MCO that is 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	HB
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 multiple provider type categories as shown below:

Acute Care Providers	**Behavioral Health**
Inpatient hospital	
Outpatient hospital	Mental or behavioral health rehabilitation Specialized behavioral health services
Home health	
Primary care providers	**Dental**
Pediatrician	Pediatric dental care Adult dental care
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 will be reported on in each quarter include:

1. The percentage of claims submitted by providers that are accepted or rejected by the MCOs;
2. Of those claims accepted, the percentage of claims paid or denied by the MCOs;
3. The average time it takes each MCO 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 MCOs 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 MCO to send its encounter submissions to LDH.

For each of these key measures, LDH will report on results at the statewide level, at the individual MCO level, and at the individual provider category level.

Data is also being gathered by each MCO related to each MCO'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 MCOs

- In the most recent four quarters for which data is available, the claims rejection rate reported by the Medicaid MCOs was between 1.1% and 1.4%. The overall rejection rate is significantly impacted by higher rejection rates for LHC (3.2% to 3.6%) while the other MCOs have rejection rates close to zero.

Measure #2: Claims Paid and Denied by the MCOs

- For those claims that were accepted into the MCO's claims adjudication system, on average, the overall rate of paid claims was between 80.6% and 81.7% in the most recent four quarters. The denial rates, therefore, were between 18.3% and 19.4%.

- At the MCO-specific level, the range across the 4-quarter was from an average denial rate of 16.9% for LHC to an average rate of 21.7% for Aetna. These statistics exclude dental claims.

- The claim denial rates are not going down since the original report showing CY 2017 data. For some MCOs, the denial rate has even increased a bit.

- More variation was found when the claims denial rates were examined by provider type. For example, whereas, the overall denial rate across all services in Q3 2019 was 18.5%, the services where the denial rate is higher than the overall average is primarily within:
    - Inpatient hospital services, 20.9%
    - Behavioral health services other than rehab, 21.4%
    - Pharmacy claims, 26.2%

- Conversely, the denial rate in 3rd Quarter 2019 is lower than the overall average primarily within:
    - Outpatient hospital services, 8.6%
    - Primary care, 13.6%
    - Other professional claim providers, e.g., pediatricians 11.4%, OB-GYNs 10.7%
    - Pediatric dental services, 8.9%

Measure #3: Average Time for the MCOs 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 MCO to the time in which the provider is paid or notified they will not be paid.

- The MCOs are meeting the target for adjudication within 30 days as set by LDH. In fact, the average TAT is below 11 days in each of the last four quarters for all MCOs.

- The overall TAT for paid claims, all MCOs combined, is between 7.9 and 8.4 days in each quarter. For denied claims, the average is 6.0 days.

- There is variation between the MCOs on these statistics. The lowest TAT for paid claims was reported by ACLA (between 4.4 and 5.7 days each quarter). The highest TAT was reported by Aetna (between 7.8 and 10.8 days each quarter). The LHC and UHC average is closer to 9 days each quarter, while HealthyBlue and MCNA are closer to an average of 7 days.

- For denied claims, ACLA, HealthyBlue and UHC are similar with average TAT rates near 4 days. Aetna's average varied between 5 and 7 days. LHC varied between 9 and 10 days. MCNA varied between 7 and 9 days.

Exhibit III.7A
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
All Claim Types
By MCO and By Quarter

		Adjudicated Within 30 days		Avg Turnaround Time	
		Pct of Paid	Pct of Denied	Paid Claims	Denied Claims
Aetna	Q4 18	99.8%	99.6%	10.8	10.8
	Q1 19	99.2%	98.8%	9.0	7.1
	Q2 19	99.8%	99.6%	8.0	6.0
	Q3 19	99.7%	92.0%	7.8	5.8
ACLA	Q4 18	100.0%	100.0%	4.4	5.0
	Q1 19	100.0%	99.9%	4.9	5.6
	Q2 19	100.0%	100.0%	5.7	5.9
	Q3 19	100.0%	100.0%	5.7	6.7
HealthyBlue	Q4 18	99.9%	99.8%	7.4	3.4
	Q1 19	99.6%	99.5%	7.9	3.4
	Q2 19	99.6%	99.2%	6.6	5.6
	Q3 19	99.6%	99.8%	5.9	4.9
LHC	Q4 18	99.7%	98.9%	9.2	10.2
	Q1 19	99.7%	99.1%	9.0	10.5
	Q2 19	99.9%	99.7%	8.5	9.3
	Q3 19	99.6%	99.6%	8.7	8.7
UHC	Q4 18	99.1%	98.5%	9.7	4.6
	Q1 19	100.0%	99.9%	9.4	3.2
	Q2 19	100.0%	99.6%	9.2	3.3
	Q3 19	99.9%	100.0%	9.5	3.0
MCNA	Q4 18	100.0%	100.0%	7.3	7.9
	Q1 19	100.0%	100.0%	7.1	7.2
	Q2 19	100.0%	100.0%	8.2	9.2
	Q3 19	100.0%	0.0%	8.4	8.4

- Claims adjudication average TATs do vary by provider category. Numbers below are the average TAT days in the most recent four quarters:
    - For inpatient hospital services, 10.3 days for paid claims and 9.8 for denied claims.
    - For outpatient hospital services, 7.3 days for paid claims and 9.1 days for denied claims.
    - For most professional services, there is little variation in TAT (between 6.4 days and 10.6 days). The TAT for denied professional claims is similar to the rate for paid claims.
    - The average TAT for mental health providers is similar to what was found for professional providers (8.6 days for paid claims). For denied claims, close to 9 days.
    - For dental services, 7.6 days for paid and 8.4 days for denied claims.
    - For pharmacy scripts, 9.4 days for paid and 3.6 days for denied claims.

Measure #4: Top Reasons for Denied Claims

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 close to 350 reason codes developed by the *NCPDP*.

Key findings on CARCs include:

- The top five CARCs in the 3rd Quarter 2019 included the following:
  - 96: Non-covered charge.
  - 197: Precertification or authorization absent when it is required.
  - 18: Exact duplicate claim.
  - 16: The claim lacks information or has a billing error which is needed for adjudication.
  - B7: This provider was not eligible to be paid for this procedure/service on this date.

- These five CARCs were also among the top seven in the previous five quarters reported.
- In Q3 2019, at least four of Aetna's, ACLA's, LHC's and UHC's top 5 CARC codes were also in the top 10 for all MCOs. HealthyBlue had three of their top 5 and MCNA had only two of their top 5 in the all MCO top 10.

Key findings on NCPDP include:

- The top five NCPDPs in the 3rd Quarter 2019 included the following:
  - 79: Refill too soon
  - 75: Prior authorization required
  - 7O: Product/service not covered – plan/benefit exclusion
  - 88: DUR reject error
  - 76: Plan limitations exceeded

- These five NCPDPs were also among the top six in the previous three quarters reported.
- In Q3 2019, all MCOs each had their top 5 NCPDP codes also in the top 10 for all MCOs.

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

- In the most recent four quarters studied, 98.7% to 99.3% of the encounters submitted by all MCOs combined were accepted by LDH.

- There were differences at the MCO level. All of HealthyBlue's and UHC's encounters were accepted. For MCNA, the acceptance rate was at least 99% every quarter; for Aetna and LHC, at least 97%. ACLA had varying acceptance rates between 93% and 98% in the last four quarters.

Measure #6: Average Time for the MCOs 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 MCO 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 MCOs should submit encounters within 30 days of adjudication. There is variation in the percentage of encounters submitted within 30 days to LDH by claim type.

- For institutional encounters (mostly claims from hospitals), most of the MCOs had at least 95% of their encounters submitted within 30 days each quarter. Exceptions were Aetna in Q4 2018 and Q1 2019 and LHC in Q1 2019.

- Aetna, HealthyBlue and UHC consistently have the highest rate of submission of professional encounters within 30 days. HealthyBlue has had more than 95% in within that time in each of the last four quarters; UHC has done so in three of the last four quarters. ACLA had some trouble with submitting professional encounters in Q1 and Q2 2019, but this has improved greatly in Q3 2019 to 97.5% submitted within 30 days. LHC has had the most trouble meeting the 30-day time submission target, but 91.5% were submitted within 30 days in the last two quarters reported.

- There is greater variation in the timeliness of pharmacy encounter submissions. Aetna consistently is lowest with approximately 70% submitted within 30 days. LHC had a very high rate in Q4 2018, but this has eroded in 2019 as far as the percentage submitted within 30 days. UHC has had a high rate of timely submissions in most quarters. ACLA had challenges in Q4 2018 but has improved greatly in 2019. HealthyBlue has always had a high rate of pharmacy encounters submitted within 30 days (above 98%).

- MCNA has few issues meeting an average 30-day TAT for its dental encounters.

Measure #7: Provider Education

Beginning with the 1st Quarter of 2019, LDH is requesting that the MCOs 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 MCOs are reporting on the individual entities outreached (name and TIN), the type of outreach conducted, and the date that the outreach was conducted.

In Q3 2019, the most predominant mode to outreach to providers is 1:1 phone calls (54.1% of all contacts) followed by in-person (28.1% of contacts). Emails and webinars each represent 8% to 10% of all contacts.

There is variation in the modalities used by MCO. ACLA and LHC reported no in-person contact and Aetna reported little. HealthyBlue reported three out of four contacts as in-person. UHC reported 59% of its contacts were in-person. MCNA reported that all provider contacts on claims submissions were in-person.

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 Healthy Louisiana 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 Healthy Louisiana plans 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 MCO self-reported data provided on a quarterly basis. While there are specific contractual standards that require MCOs to complete an assessment of all individuals identified as having a special healthcare need within 30 days of identification, each MCO has their own policies and procedures for identification and assessment. As such, the reporting for case management has shown significant variation across MCOs. LDH continues to work with the MCOs and various providers to increase the comparability of the data collected and more accurately reflect program participation.

The data presented below is representative of unduplicated totals by MCO for CY 2019 quarter 3.

Unduplicated Case Management Summary by MCO – Calendar Year 2019 Quarter 3

	ABH	ACLA	HB	LHC	UHC
Eligible for Case Management (CM)	1,695	6,921	4,229	9,932	13,495
Enrolled in CM at least 1 month	763	3,772	1,289	3,460	4,148
% of eligible enrolled in CM	45.0%	54.5%	30.5%	34.8%	30.7%
Received CM Service	355	3,096	559	2,013	1,707
% enrolled receiving service	46.5%	82.1%	43.4%	58.2%	41.2%

Source: 039 Case Management Report

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

QUARTERLY UPDATE #5
PERIOD COVERING THE 3RD QUARTER
OF CALENDAR YEAR 2019

MARCH 31, 2020

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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 No. 710 of the 2018 regular legislative session. The Act requires reporting of data on healthcare provider claims submitted to Medicaid managed care organizations (MCOs). 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. The Initial Report was submitted to the legislature on October 31, 2018. Subsequent reports have been submitted as follows:

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<u>Required Reporting for the Initial Report</u>

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 MCOs 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 and actions to address those causes.
- Claims denied in error by the Medicaid MCOs.

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

- The total number of encounters submitted by each Medicaid MCO to the Department or its designee;
- The total number of encounters submitted by each Medicaid MCO 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 MCO) 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.

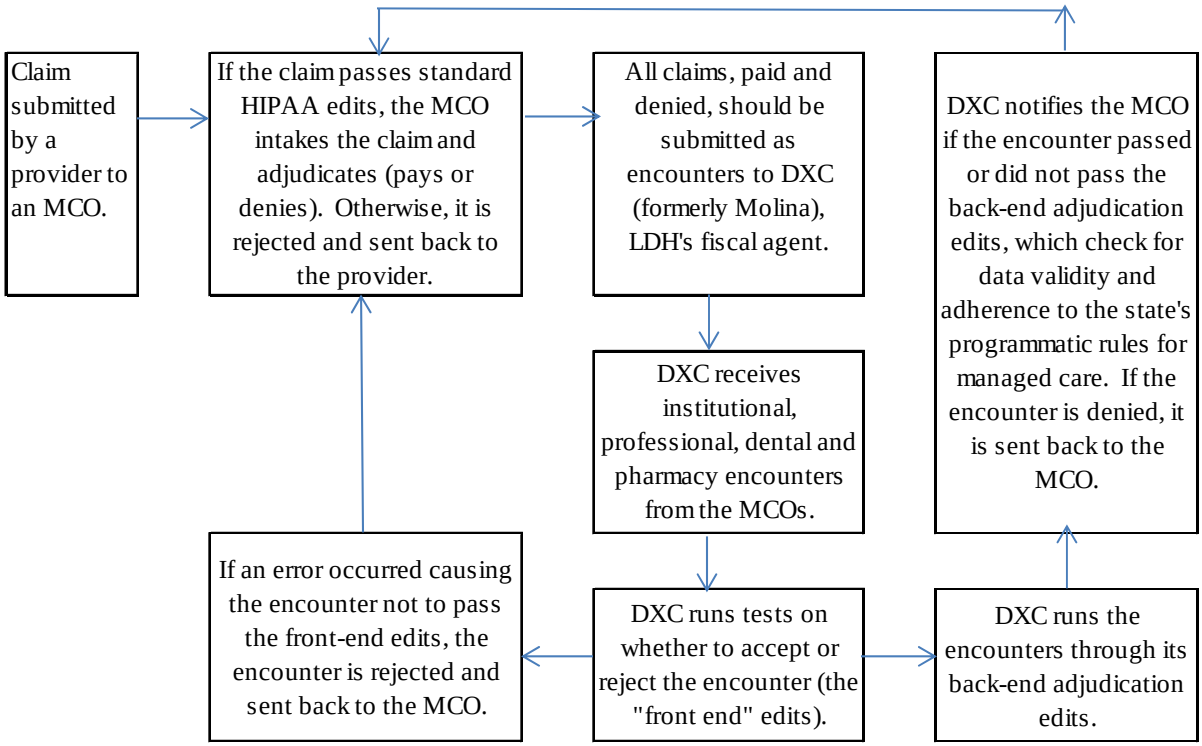
- The *CMS-1500, or electronic 837P*, is the claim type for professional service providers to submit on. This includes a wide array of providers such as physicians, clinics, mental health providers, therapists, transportation providers, suppliers of medical equipment and supplies.

- 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 MCOs in Louisiana and, in turn, the process in which the MCOs submit encounters to the Department's fiscal agent, 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 MCO). An ***encounter*** is the transaction that contains information from the claim that is submitted by the MCO 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 MCOs 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 MCOs 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 MCO 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. The LDH requires the contracted MCOs 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. The full listing of CARCs and NCPDP codes appear in *Appendix B and Appendix C*, respectively.

Findings from Initial Report Covering Calendar Year 2017

Some key findings in the initial report related to the information reviewed for CY 2017 claims and encounters is highlighted below:

- The rate of rejected claims as a percent of total claims submitted is very low (approximately 1%).
- For those claims accepted by the MCOs, the weighted average rates for claims denied were
    - 8% for institutional (mostly hospital) claims, with MCOs ranging from 7% to 11%
    - 12% for professional (e.g. physician) claims, with MCOs ranging from 9% to 14%
    - 5% for dental claims
    - 27% for pharmacy claims, with MCOs ranging from 16% to 36%. The high incidence of denied pharmacy claims is consistent with national trends. This reflects pharmacists at point-of-sale who often try to key in the same script multiple times.
- The average turnaround time (TAT) for the MCOs to adjudicate claims after receipt from the provider was often less than 10 days but almost always less than 15 days with just two exceptions.
    - For institutional claims, Aetna had an average TAT of 25.5 days, UnitedHealthcare's average was 26.6 days.
    - For professional claims, Aetna had an average TAT of 21.9 days.
- There was no distinction in the TAT between paid and denied claims for institutional and dental claims, but the TAT for denied professional claims was five days greater than paid claims.
- The top five denial reason codes for institutional and professional claims represented near 50% of all denial CARC occurrences (out of more than 280 types of CARCs). For dental claims, the top five represented 71% of all CARC occurrences. For pharmacy, the top five NCPDP codes represented 64% of all denial codes (out of approximately 350 NCPDP codes).

Follow-up Consultation with Providers and the MCOs

The provider community was consulted on the results of the initial Healthy Louisiana Claims Report prior to its submission to the Legislature. After the publication, both the providers and the MCOs were convened to review the measures that will be reported on each quarter in the quarterly update reports. Some measures that were included in the initial report were removed from ongoing quarterly reporting, but new measures were added. The updated list of measures was developed to provide the most meaningful information to the provider community, LDH and the MCOs.

LDH has retained Burns & Associates (B&A) to assist with ongoing reporting related to the Act. B&A assisted LDH by conducting the independent study for the initial period of CY 2017. B&A worked with LDH to develop new reporting templates for the MCOs to submit information related to claims adjudication and encounter submissions each quarter. B&A facilitated a webinar with providers on

February 8, 2019 to obtain their feedback on the new reports as well as the layout of the exhibits that appear in this report. After making some modifications, B&A then conducted a webinar with the MCOs to introduce the new reports on February 27, 2019 in preparation for the April 2019 report to the Legislature.

Recommendations Implemented Since Initial Report

LDH has taken action on the following recommendations put forth by B&A in the initial Healthy Louisiana Claims Report:

- Recommendation 1: LDH should develop a common set of definitions for claims adjudication terms that would be used by all MCOs as well as the LDH fee-for-service payment system. **Completed**. This recommendation was accepted and the definitions now appear in the instructions for the new report templates used for Act 710 reporting.

- Recommendation 2: LDH should develop a common set of definitions for encounter adjudication terms that would be used by all MCOs as well as LDH. **Completed**. This recommendation was accepted and the definitions now appear in the instructions for the new report templates.

- Recommendation 3: LDH should build guidance or requirements about the expectations that the MCOs will perform root cause analyses pertaining to claims adjudication and/or encounter submissions. **Completed.** This recommendation was accepted. The new report templates require the MCOs to report on top denial reasons by provider type which will help assist with conducting root cause analysis. The MCOs are also required to report the number of providers with high denial rates segmented by provider Medicaid claims volume (small, mid-size, large) to understand which providers within a specialty are most impacted by the denial rate.

- Recommendation 4: LDH should review the MCO reports that focus on claims and consider modifying, consolidating or eliminating existing reports. LDH should also consider adding a report on encounter submissions. **Completed.** LDH worked with B&A to develop the new report templates that the MCOs are required to submit each quarter to comply with the Act.

- Recommendation 5: For any new measures or reports that get introduced as part of quarterly reporting by this Act, LDH should convene all of the MCOs to review the new report templates, to confirm understanding of the specifications, and to vet the instructions. **Completed.** This was done as part of the February 27, 2019 webinar and follow-up responses to questions from the MCOs.

- Recommendation 6: LDH should develop an audit protocol and conduct a periodic audit of a sample of claims denied by the MCOs to ensure that the claims are not being denied in error by the MCO. **In process.** LDH concurs with this recommendation.

SECTION II: CONSTRUCT OF THE QUARTERLY UPDATE REPORT

Six new reports have been designed specifically for the quarterly report updates. LDH requires that each MCO submit these six reports on a quarterly basis.

There will be a lag time between the claims adjudication period and the date that the MCOs will submit the reports to LDH as allowed by the Act. For example, the results from the claims adjudication period July 1 – September 30, 2019 were due to LDH by February 15, 2020.

The MCOs analyzed in this review include:

- Aetna Better Health (ABH)
- Amerihealth Caritas Louisiana (ACLA)
- HealthyBlue (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. This format was introduced in the April 2019 report to the Legislature and continues in this report. The key measures that will be tracked on an ongoing basis include:

- The rate of claims accepted and rejected by each MCO
- The rate of accepted claims that are paid and denied by each MCO
- The timeliness (turnaround time) for each MCO to adjudicate claims
- The top reasons why claims are being denied at each MCO
- 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 MCO
- The timeliness for each MCO 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	All other services submitted on a professional claim not specified above
(no additional breakouts)	

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

The map of LDH provider type and specialty codes into each of the categories mentioned above appears in *Appendix A.*

How This Report is Organized

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

There are 17 exhibits that will be reported on in each quarterly report—11 pertain to claims adjudication, one pertains to provider education and five pertain to encounter submissions. The format for each exhibit will remain consistent with each quarterly report to allow for ease in trending results over time.

In some exhibits, data will be displayed for the most recent four quarters. In this report, the four quarters shown are Q4 2018 and Q1 through Q3 2019. In the next update, Q4 2018 data will be dropped and Q4 2019 data will be added.

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 Q3 2019 data.

Appendix D provides the numeric values for the exhibits shown in the body of the report which are shown in a graphical format. *Appendix E* 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 MCO 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 MCOs to LDH. B&A conducts a validation process upon submission of reports to LDH each quarter. In some situations, MCOs 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.

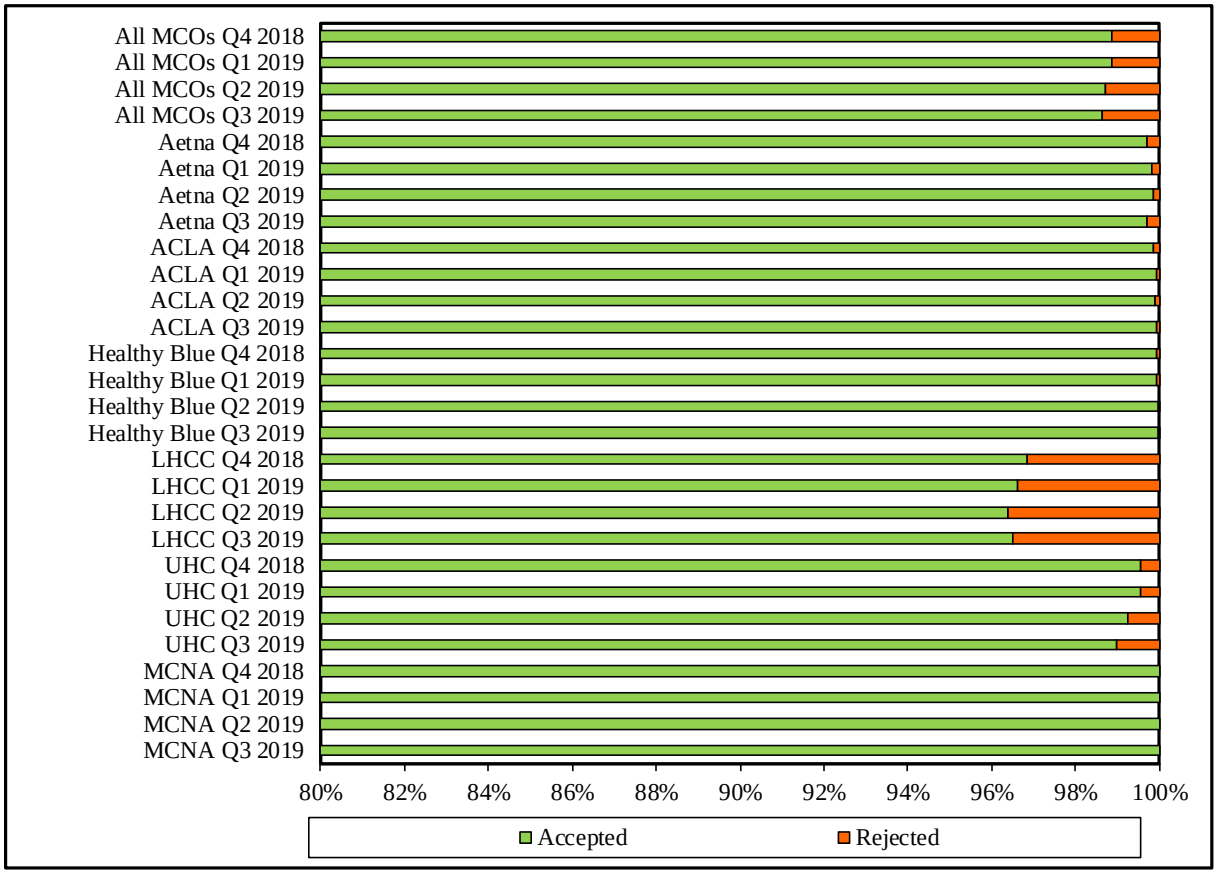
SECTION III: FINDINGS RELATED TO MCO CLAIMS ADJUDICATION

The LDH's contracted MCOs or their subcontractor adjudicates all provider claims submitted. The MCOs 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 MCO contracts with a pharmacy benefit manager to adjudicate the pharmacy claims.

Claims Accepted and Rejected by the MCOs

In the most recent four quarters for which data is available, the claims rejection rate reported by the Medicaid MCOs was between 1.1% and 1.4%. The rejection rate overall is specifically due to higher rejection rates for LHC (3.2% to 3.6%) with the other MCOs having rejection rates closer to zero.

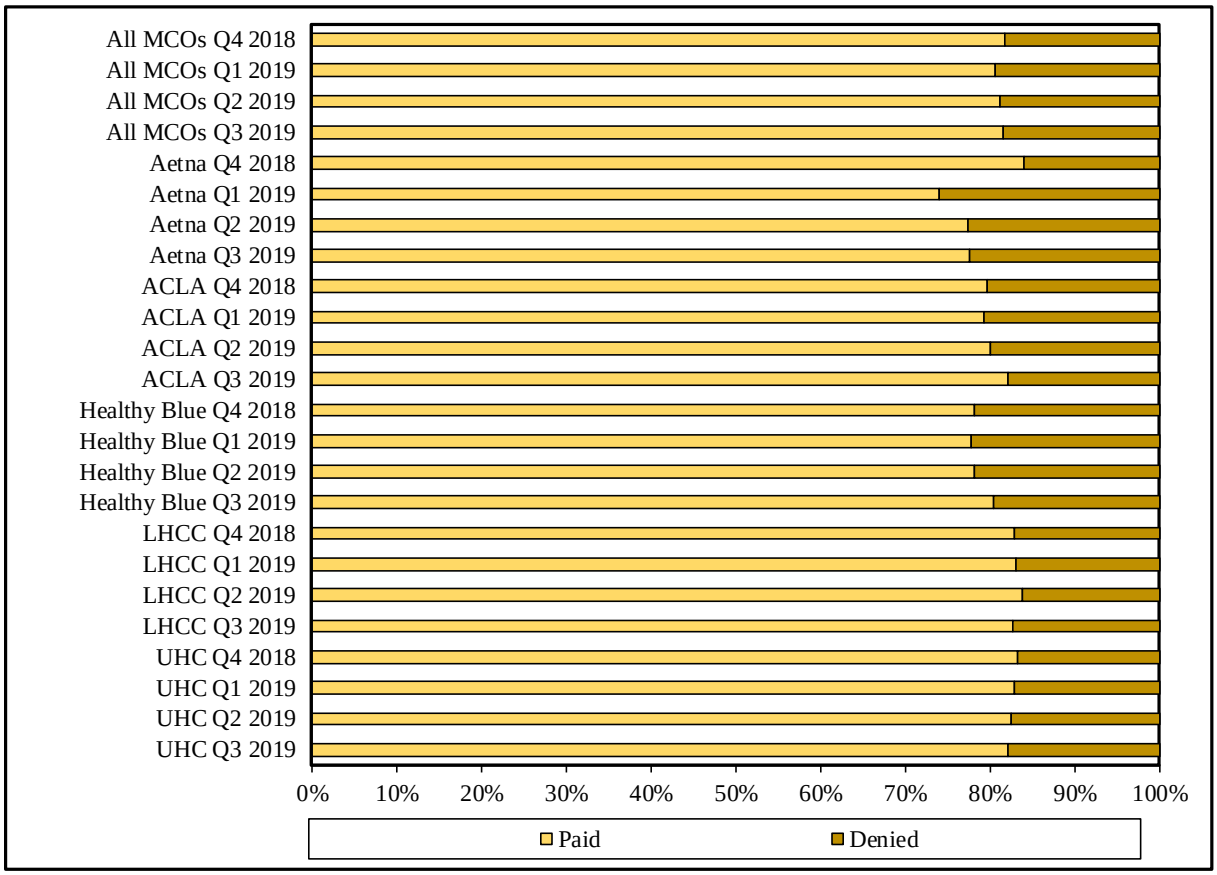
Exhibit III.1
Claim Accepted and Rejected Rate
All Claim Types
By MCO and By Quarter



Claims Paid and Denied by the MCOs

For those claims that were accepted into the MCO's claims adjudication system, on average, the overall rate of paid claims was between 80.6% and 81.7% in the most recent four quarters. The denial rates, therefore, were between 18.3% and 19.4%. At the MCO-specific level, the range across the 4-quarter averages was from an average denial rate of 16.9% for LHC to an average rate of 21.7% for Aetna and 21.3% for HealthyBlue. The denial rates are not going down since the original report showing CY 2017 data. For some MCOs, the denial rate has even increased a bit. These statistics exclude MCNA dental claims, which can be found in Exhibit III.3C in categories Dental – Children and Dental – Adult.

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

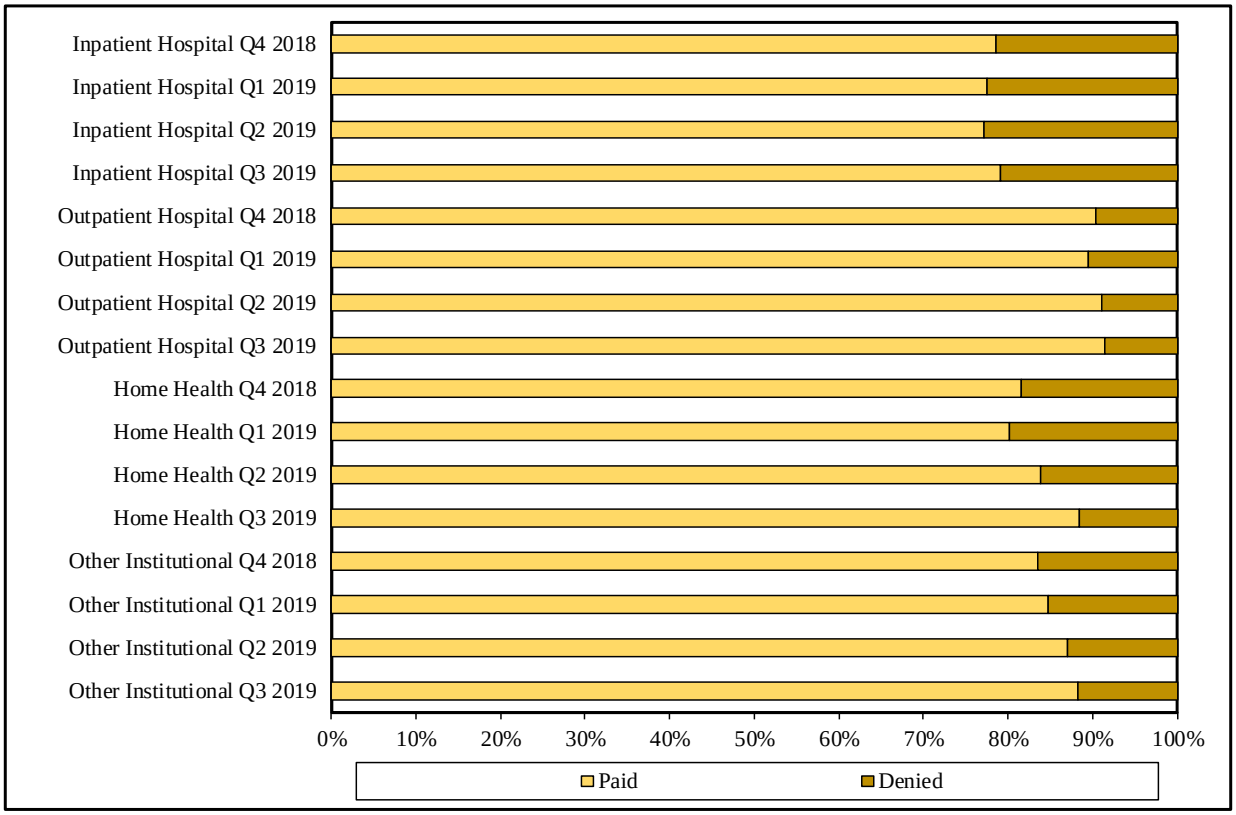


There is more variation found when the claims denial rates are examined by provider type. Exhibits III.3A, III.3B and III.3C on the following pages break out the approval and denial rates by provider type for the most recent four quarters available. Exhibit III.3A shows the providers that bill on the institutional, or 837I, claim type. Exhibit III.3B shows the providers that bill on the professional, or 837P, claim type. Exhibit III.3C shows specialized providers such as behavioral health, dental and pharmacy.

In Exhibit III.3A below, it was found that the denial rates for inpatient hospital were higher (20.9% to 22.9%) than the overall denial average rate (18.3% to 19.4%) for the four quarters examined. This may be related to the fact that all inpatient stays must be prior-approved by the MCOs. If an authorization has not been given, then any claim that is submitted for that day of the stay will be denied.

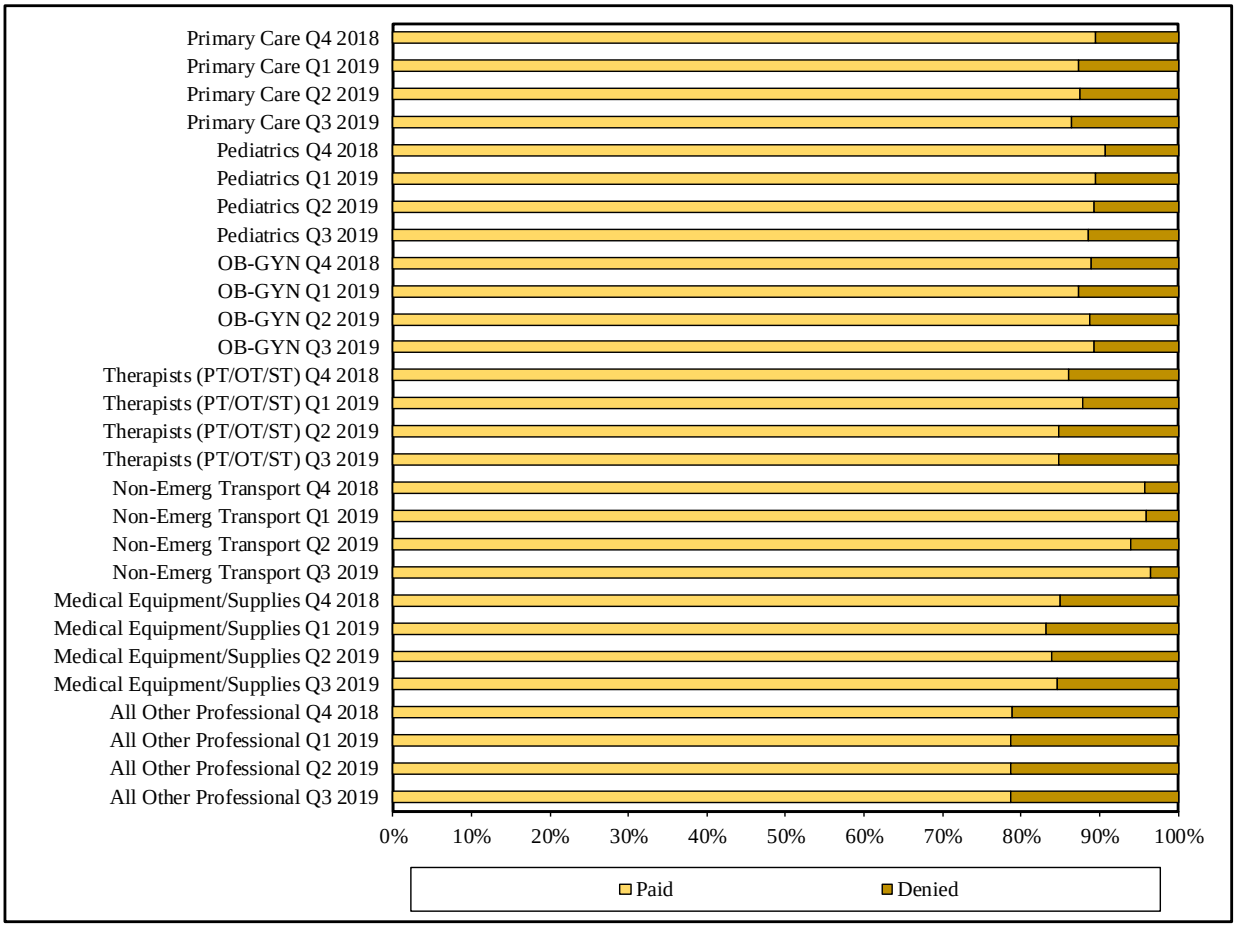
Home health agencies had lower denial rates is the most recent of the four quarters (11.5%) but usually closer to the overall denial average. Interestingly, the denial rate for outpatient hospital services is much lower (9.6% to 10.6%) than the overall average denial rate. The denial rate for the Other Institutional category is 11.7% to 16.4%, but this category represented only 1.0% of all institutional claims adjudicated.

Exhibit III.3A
Claim Status for Adjudicated Claims
Institutional Providers
For All MCOs Combined By Quarter



The claims denial rates for most professional claim providers are below the overall MCO denied claim average. For example, primary care providers and pediatricians have a denial rate in the 10% to 13% range. OB-GYNs have a denial rate closer to 11%. The denial rate for therapists was in the range of 12% to 15% across the four quarters. Non-emergency medical transportation denial rates are the lowest of any provider type between 3.5% and 6.1% across the quarters. Two groups in this exhibit have claim denial rates higher than the overall MCO average. For medical equipment and supplies, the average denied claims rate is 15% to 17% across the four quarters shown. For the All Other Professionals group, the average denied claims rate is 21%.

Exhibit III.3B
Claim Status for Adjudicated Claims
Professional Service Providers
For All MCOs Combined By Quarter

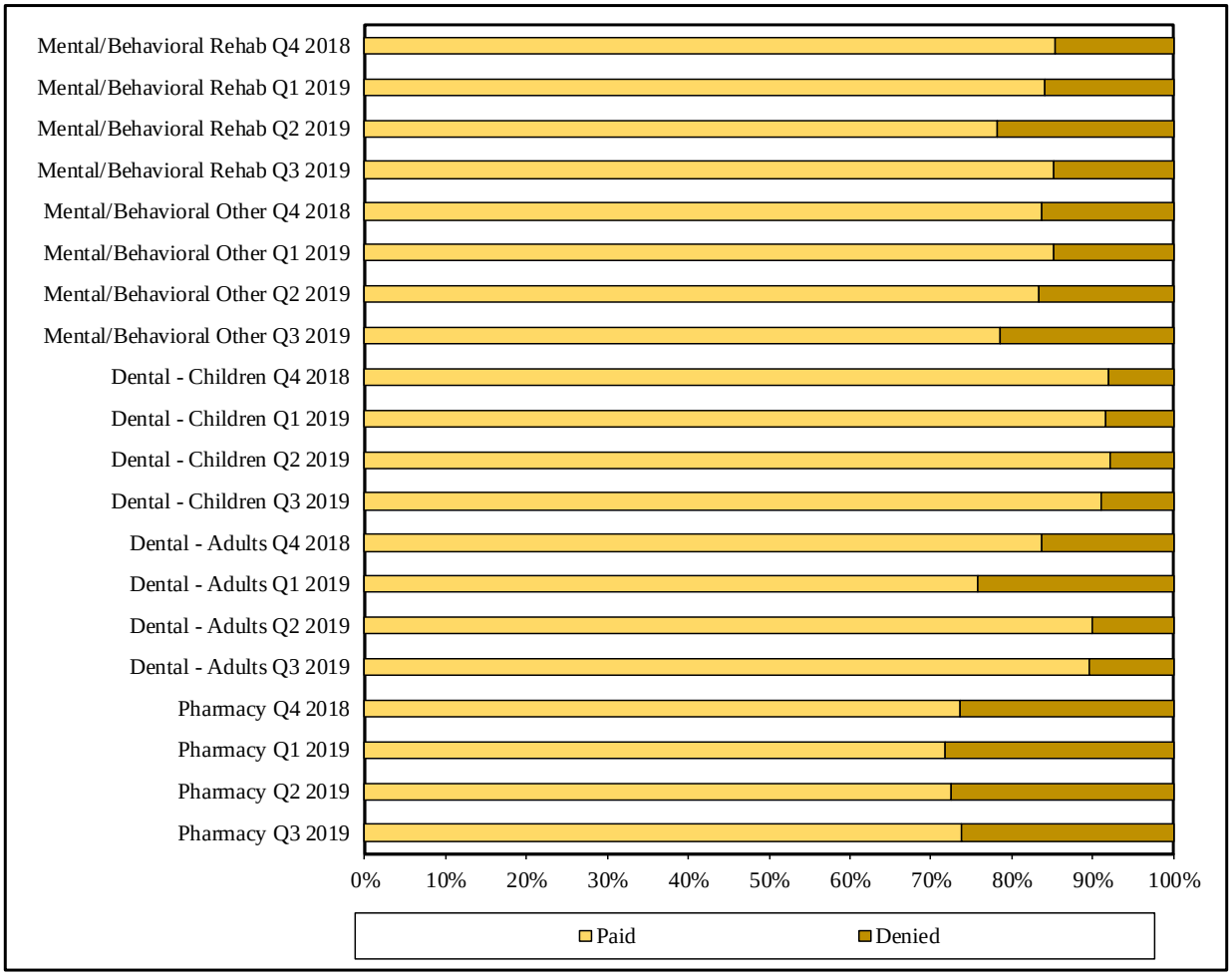


The claims denial rates for behavioral health services are slightly higher than those found for most acute care services on the previous pages. For rehab services, the claims denial rate was between 14.7% and 21.9% in the four quarters reported. *There was a sharp increase in the denial rate in Q2 2019, but this came back down in Q3*. For mental/behavioral health services other than rehab, the claims denial rate was between 14.9% and 21.4%. There was a sharp increase in the denial rate in Q3 2019, the most recent quarter reported.

There is a difference in the claim denial rates for dental services for children and adults. For children, the denial rate average was in the 8% range; for adults, the range was between 16.3% and 24.2% in the first two quarters reported here. The denial rate took a sharp decline in the most recent two quarters down to 10.0%. It should be noted that there are over 3.1 million child dental claims but closer to 0.5 million adult dental claims.

Pharmacy claim denial rates are always higher than other services and Louisiana Medicaid is no exception. The denial rate was between 26.2% and 28.3% across the most recent four quarters examined.

Exhibit III.3C
Claim Status for Adjudicated Claims
Behavioral Health, Dental and Pharmacy
For All MCOs Combined By Quarter



The exhibits on the next three pages further break down the claim paid and denied rates, but in these exhibits the breakdown is for each provider type by each of the MCOs. The purpose of these exhibits is to determine if the claims denial rate for a provider type is consistent across MCOs or if it varies. In Q3 2019, most often at least three of the five MCOs have a denial rate in the same range for the specific service. The MCO with the highest denial rate, however, varies across service categories. The range in denial rates across MCOs continues to be high. This has been a finding in previous reports as well.

Exhibit III.4A correlates with the information shown in Exhibit III.3A (institutional providers). Exhibit III.4B correlates with the information shown in Exhibit III.3B (professional providers). Exhibit III.4C correlates with the information shown in Exhibit III.3C (behavioral health, dental, pharmacy).

The key findings from all three exhibits appearing on pages III-7 through III-9 are summarized here for convenience. The most significant value is the range of denials for inpatient hospital services (in red).

Provider type	**Percentage of MCO Payments In Q3 2019**	**Spread of Percent Denied Across MCOs**	**If there is variation across MCOs, the range of claim denial rates**
Inpatient Hospital	18.2%	16.0 points	Lowest denial rate: Aetna, 14.3% Highest denial rate: HealthyBlue, 30.3%
Outpatient Hospital	16.5%	3.8 points	Lowest denial rate: Aetna, 6.8% Highest denial rate: LHC, 10.6%
Home Health	0.3%	8.4 points	Lowest denial rate: ACLA, 9.9% Highest denial rate: UHC, 18.3%
Other Institutional	0.2%	24.6 points	Lowest denial rate: Aetna, 8.0% Highest denial rate: LHC, 32.6%
Primary Care	5.1%	22.9 points	Lowest denial rate: ACLA and UHC, 9.8% Highest denial rate: Aetna, 32.7%
Pediatrics	1.6%	25.7 points	Lowest denial rate: ACLA, 7.0% Highest denial rate: Aetna, 32.7%
OB-GYN	1.0%	15.8 points	Lowest denial rate: UHC, 8.3% Highest denial rate: Aetna, 24.1%
Therapists	0.2%	25.3 points	Lowest denial rate: HealthyBlue, 8.7% Highest denial rate: Aetna, 34.0%
Non-emergency Transportation	0.6%	9.4 points	Lowest denial rate: Aetna and HBL, 1.0% Highest denial rate: ACLA, 10.4%
Medical Equipment and Supplies	0.9%	29.5 points	Lowest denial rate: LHC, 13.7% Highest denial rate: HealthyBlue, 43.2%
Other Professional	13.8%	15.9 points	Lowest denial rate: UHC, 17.4% Highest denial rate: Aetna, 33.3%
Behavioral Health Rehab	1.9%	37.4 points	Lowest denial rate: ACLA, 12.5% Highest denial rate: Aetna, 49.9%
Behavioral Health Other	3.8%	18.3 points	Lowest denial rate: UHC, 13.4% Highest denial rate: HealthyBlue, 33.8%
Dental – Children	2.0%	N/A, all MCNA	---
Dental – Adult	0.4%	N/A, all MCNA	---
Pharmacy	33.4%	6.2 points	Lowest denial rate: Aetna, 21.6% Highest denial rate: HealthyBlue, 27.8%

Exhibit III.4A
Claim Status for Adjudicated Claims
By Provider Specialty - Institutional Providers
By MCO for Q3 2019 Adjudicated Claims

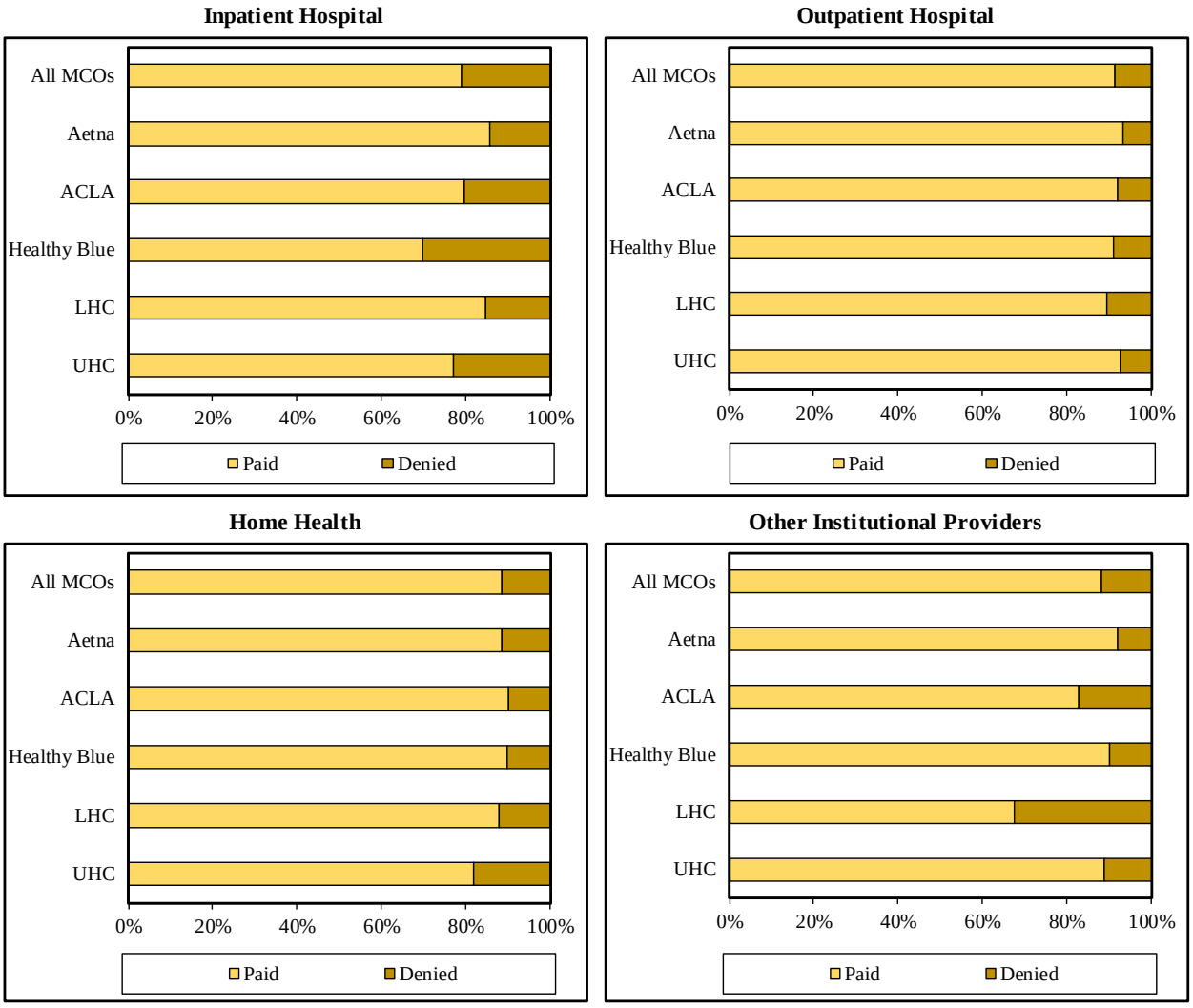
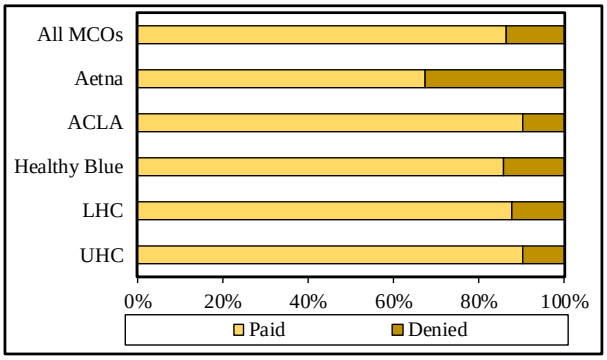
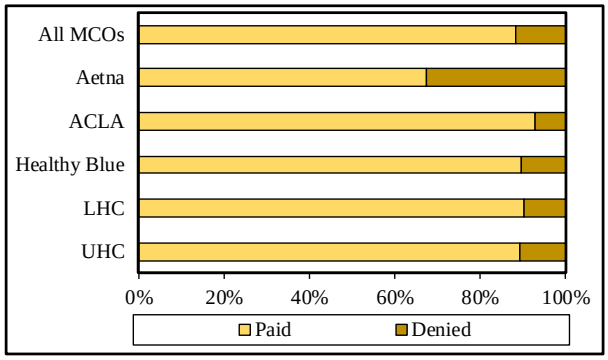


Exhibit III.4B
Claim Status for Adjudicated Claims
By Provider Specialty - Professional Service Providers
By MCO for Q3 2019 Adjudicated Claims

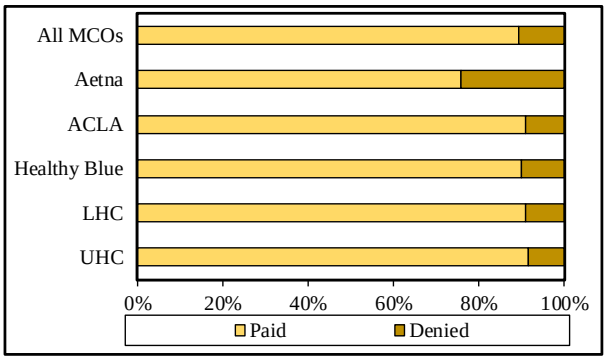
Primary Care



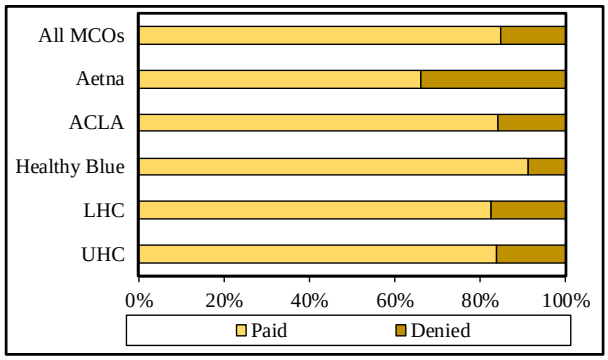
Pediatrics



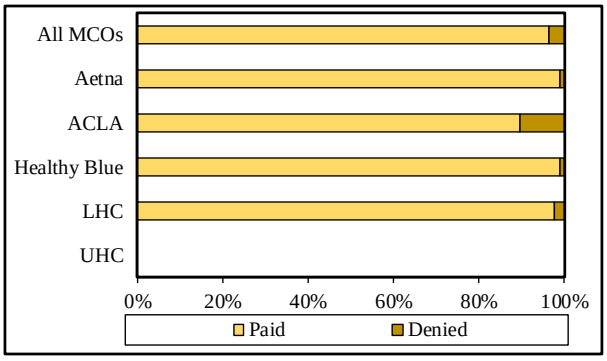
OB-GYN



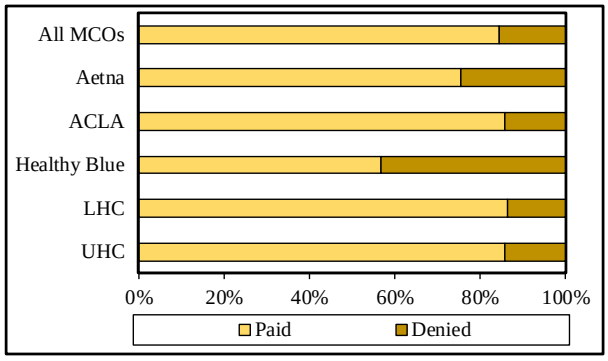
Therapists (Physical, Occupational, Speech)



Non-Emergency Medical Transportation



Medical Equipment & Supplies



All Other Professional Services excluding BH and Dental

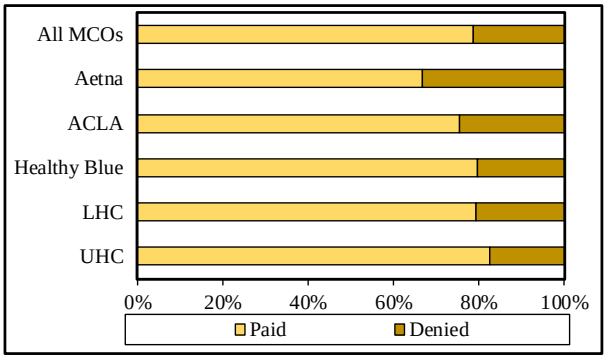
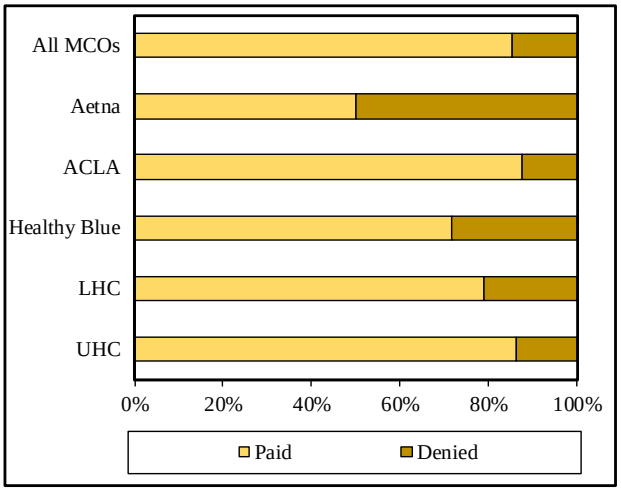
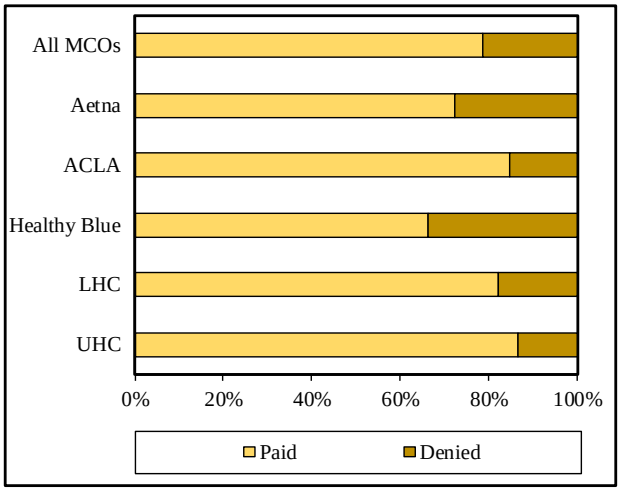


Exhibit III.4C
Claim Status for Adjudicated Claims
By Provider Specialty - Behavioral Health, Dental and Pharmacy
By MCO for Q3 2019 Adjudicated Claims

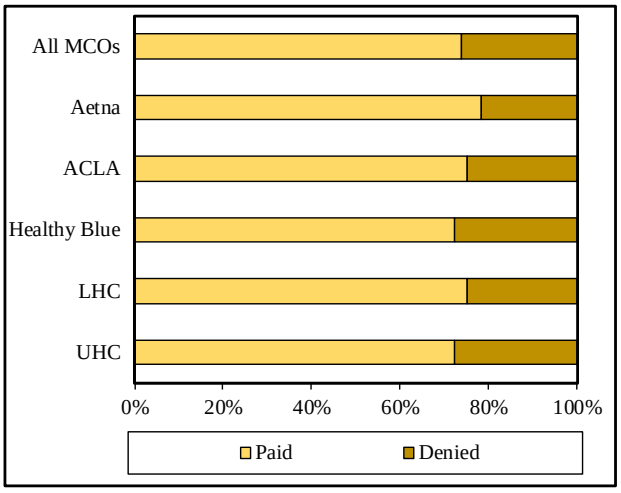
Mental/Behavioral Health - Rehab



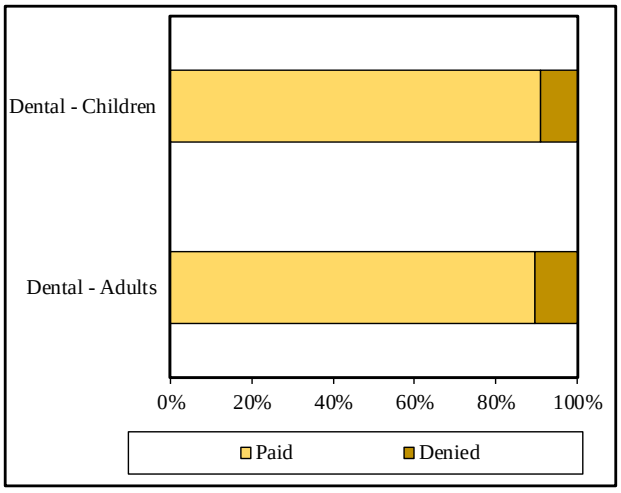
Mental/Behavioral Health - Other



Pharmacy



Dental (MCNA is the only MCO)



The Act requires that LDH provide an assigned value to each of the claims that were denied by the MCOs. As discussed in the Limitations of the Data section on page II-2, there are hundreds of edits that are in place at each MCO 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 MCO 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 MCO 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 16 provider specialties separately. Within each category, the MCO reported the number of claims paid and the total payments made. B&A computed an average payment per claim. Then, the MCOs 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 Q3 2019, the average payment for paid inpatient hospital claims was $5,795; for primary care, it was $40.

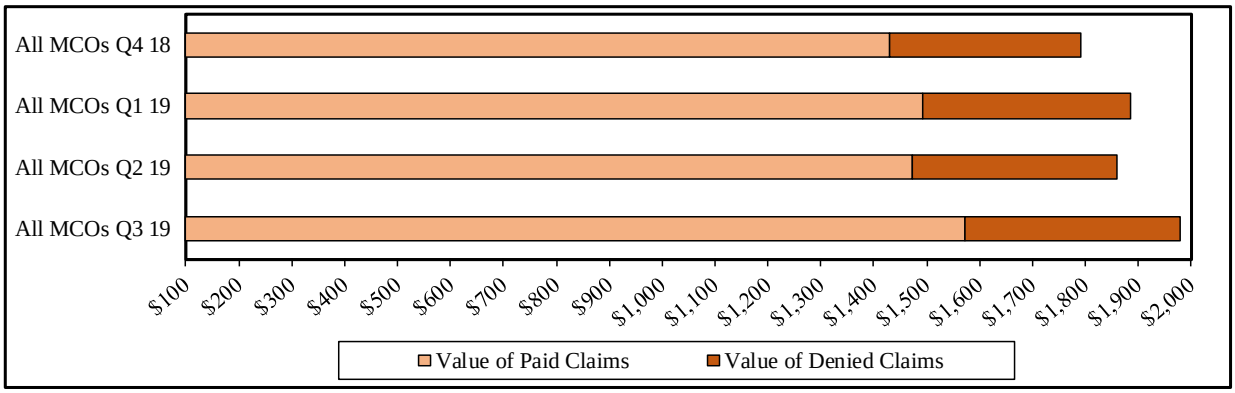
B&A not only computed an average payment per claim for each provider specialty separately, but also for each MCO within the provider type as well as a separate value for each calendar quarter.

Exhibit III.5 which appears on the next page summarizes the total dollar values of paid claims and denied claims by MCO and by quarter. The detailed information for each provider specialty by MCO and by quarter appears on Appendix D.

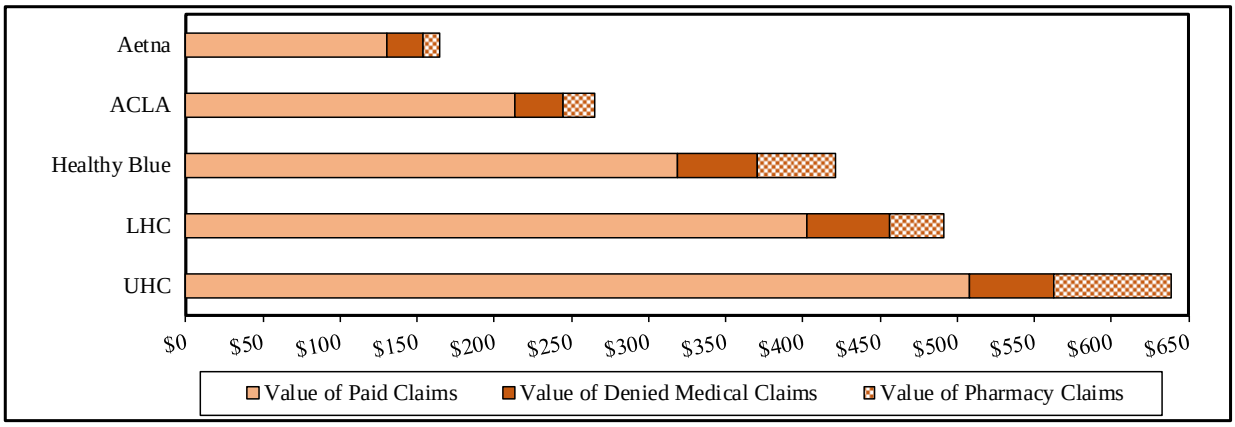
The denied claims account for between 20.2% and 20.9% of the sum of paid and denied values each quarter. This equates to between $361 and $407 million. Among the $407 million in denied values in Q3 2019 assigned across the five MCOs that provide medical and pharmacy benefits, $214 million (53%) was attributed to medical claims and $192 million (47%) was attributed to pharmacy claims. In Q3 2019, the distribution of assigned values to denied claims by MCO was as follows:

- Aetna had 69% to medical and 31% to pharmacy claims
- ACLA had 60% to medical and 40% to pharmacy claims
- HealthyBlue had 50% to medical and 50% to pharmacy claims
- LHC had 42% to medical and 58% to pharmacy claims
- UHC had 53% to medical and 47% to pharmacy claims

Exhibit III.5
Value of Paid and Denied Claims
The dollar values in the stacked bar represent hundreds of millions



Q3 2019 Adjudicated Claims Only



MCNA is the MCO that provides dental coverage only.
Their total expenditures are $33M - $40M per quarter. They have been excluded from this exhibit.

LDH required the MCOs 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 16 provider specialties, the MCOs divided the specialty into three sub-groups:

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

The data submitted by the MCOs 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 MCO 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%).

The key findings from this study appear in Exhibit III.6 on the next page. The details behind these findings for each MCO in each quarter appear in Appendix D.

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 MCOs (excluding MCNA), so 42 groupings for five MCOs 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.6 on page III-13 shows the instances where the MCO denied more than 10% of the claims for more than half of the providers in the Medicaid volume group. In the exhibit, a Y indicates that at least half of the providers in the provider/volume group had a 10% denial rate or greater. An N indicated that less than half had a 10% denial rate or greater. A dash (–) indicates that the sample was too small to study. Within each of the quarters examined, the sample was too small 32 to 37 times for provider/volume combinations.

There has been relative consistency in the number of combinations where a majority of providers had a denial rate above 10%. This is indicated by the number of N values as shown in the table below. The counts represent all MCOs combined. Just over half of all provider categories had less than 10% of their claims denied.

	Number of cells with a Y value	Number of cells with a N value	Number of cells with a – value
Q4 2018	82	97	37
Q1 2019	83	97	36
Q2 2019	98	86	32
Q3 2019	88	96	32

There was no obvious pattern when reviewing the results in Exhibit III.6 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 MCO stands out from the rest. In particular,

- Aetna has a higher denial rate among high-volume outpatient hospitals in three out of four quarters
- LHC also has a higher denial rate among high-volume primary care providers in two quarters while other MCOs do not
- UHC has a higher denial rate among low-volume primary care providers in all four quarters but other MCOs do not
- LHC and UHC have higher denial rates among high-volume behavioral health rehab providers while other MCOs do not

Exhibit III.6
Examination of Individual Providers Who Billed an MCO 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 MCO
N means that less than 50% of the providers in this group had 10% or more of their claims denied by the MCO
-- 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	Aetna				ACLA				HBL				LHC				UHC				MCNA			
		Q4 18	Q1 19	Q2 19	Q3 19	Q4 18	Q1 19	Q2 19	Q3 19	Q4 18	Q1 19	Q2 19	Q3 19	Q4 18	Q1 19	Q2 19	Q3 19	Q4 18	Q1 19	Q2 19	Q3 19	Q4 18	Q1 19	Q2 19	Q3 19
Inpatient Hospital	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				
Outpatient Hospital	Low	N	Y	Y	Y	Y	Y	N	N	N	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y				
	Medium	Y	Y	Y	Y	N	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y				
	High	Y	Y	Y	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N				
Home Health	Low	Y	Y	Y	Y	Y	Y	N	N	N	N	N	N	N	Y	Y	N	N	Y	N	N				
	Medium	Y	--	Y	Y	N	N	N	N	N	N	N	N	Y	Y	Y	N	--	--	--	--				
	High	--	--	--	--	--	--	--	--	--	--	--	--	--	Y	Y	Y	--	--	--	--				
Other Institutional Providers	Low	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	N	Y	Y	Y	Y	N	N	N	N				
	Medium	Y	--	--	--	--	--	--	--	N	N	N	N	--	Y	Y	--	Y	N	N	N				
	High	Y	--	--	--	--	--	--	--	N	N	N	N	--	--	--	--	Y	--	N	N				
Primary Care	Low	N	N	Y	Y	N	N	N	N	N	N	N	N	N	N	N	N	Y	Y	Y	Y				
	Medium	--	--	Y	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N				
	High	--	--	--	--	N	N	N	N	N	N	N	N	Y	Y	N	N	N	N	N	N				
Pediatrics	Low	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	Y	Y	N	Y				
	Medium	--	--	--	Y	N	N	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	N	N				
OB-GYN	Low	--	--	Y	Y	Y	Y	N	N	N	N	Y	Y	Y	N	Y	N	Y	Y	Y	Y				
	Medium	--	--	--	--	Y	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N				
	High	--	--	--	--	Y	Y	N	N	N	N	N	N	--	Y	N	N	N	N	N	N				
Therapists	Low	--	--	--	--	Y	Y	Y	Y	Y	N	N	N	N	N	Y	Y	Y	N	Y	Y				
	Medium	--	--	--	--	Y	N	Y	Y	Y	N	N	N	N	Y	Y	Y	N	N	N	N				
	High	--	--	--	--	--	--	--	--	--	--	N	N	N	Y	Y	Y	N	N	N	N				
Non-Emergency Transportation	Low	N	N	--	N	N	N	Y	N	N	N	N	N	N	N	N	Y	Y	N	N	Y				
	Medium	N	N	--	N	N	N	N	N	N	N	N	N	N	N	N	--	Y	Y	Y	--				
	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	N	N	N	N	Y	Y	N	N	N	N	Y	Y	Y	Y				
	Medium	Y	Y	Y	Y	Y	Y	N	Y	--	--	--	--	N	Y	Y	Y	Y	Y	Y	N				
	High	Y	--	Y	Y	N	Y	N	N	--	--	--	--	N	Y	Y	Y	N	N	N	N				
All Other Professional Provid.	Low	N	N	N	N	N	N	N	N	N	N	N	N	N	N	Y	Y	Y	Y	Y	Y				
	Medium	N	N	Y	Y	N	N	N	N	N	N	N	Y	Y	N	Y	N	Y	Y	Y	N				
	High	N	Y	Y	Y	N	N	N	N	N	N	N	Y	N	Y	N	N	N	N	N	N				
Behavioral Health Rehab	Low	Y	N	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y				
	Medium	--	N	Y	N	N	N	Y	N	Y	N	Y	Y	Y	Y	Y	N	N	Y	Y	Y				
	High	--	--	Y	N	N	N	N	N	N	N	Y	--	Y	Y	Y	Y	N	Y	Y	N				
Behavioral Health All Other	Low	--	N	Y	N	N	N	N	N	N	N	Y	Y	N	N	N	N	Y	N	Y	Y				
	Medium	--	--	--	--	N	N	N	Y	N	N	Y	Y	N	N	Y	N	Y	N	Y	Y				
	High	--	--	--	--	N	N	N	N	N	Y	Y	Y	Y	Y	Y	N	N	N	N	N				
Dental - Children	Low																					N	N	N	N
	Medium																					N	N	N	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				

Timeliness of Claims Adjudication by the MCOs

The 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 MCO to the date on which the provider is paid or is notified that no payment will be made.

Exhibit III.7A below shows that the MCOs are meeting the target for adjudication within 30 days as set by LDH. In fact, the average TAT is below 11 days in every quarter for all MCOs. The TAT averages do vary, however, across the MCOs. In the latest quarter reported, there was a reduction in the TAT for Aetna and HealthyBlue for paid claims.

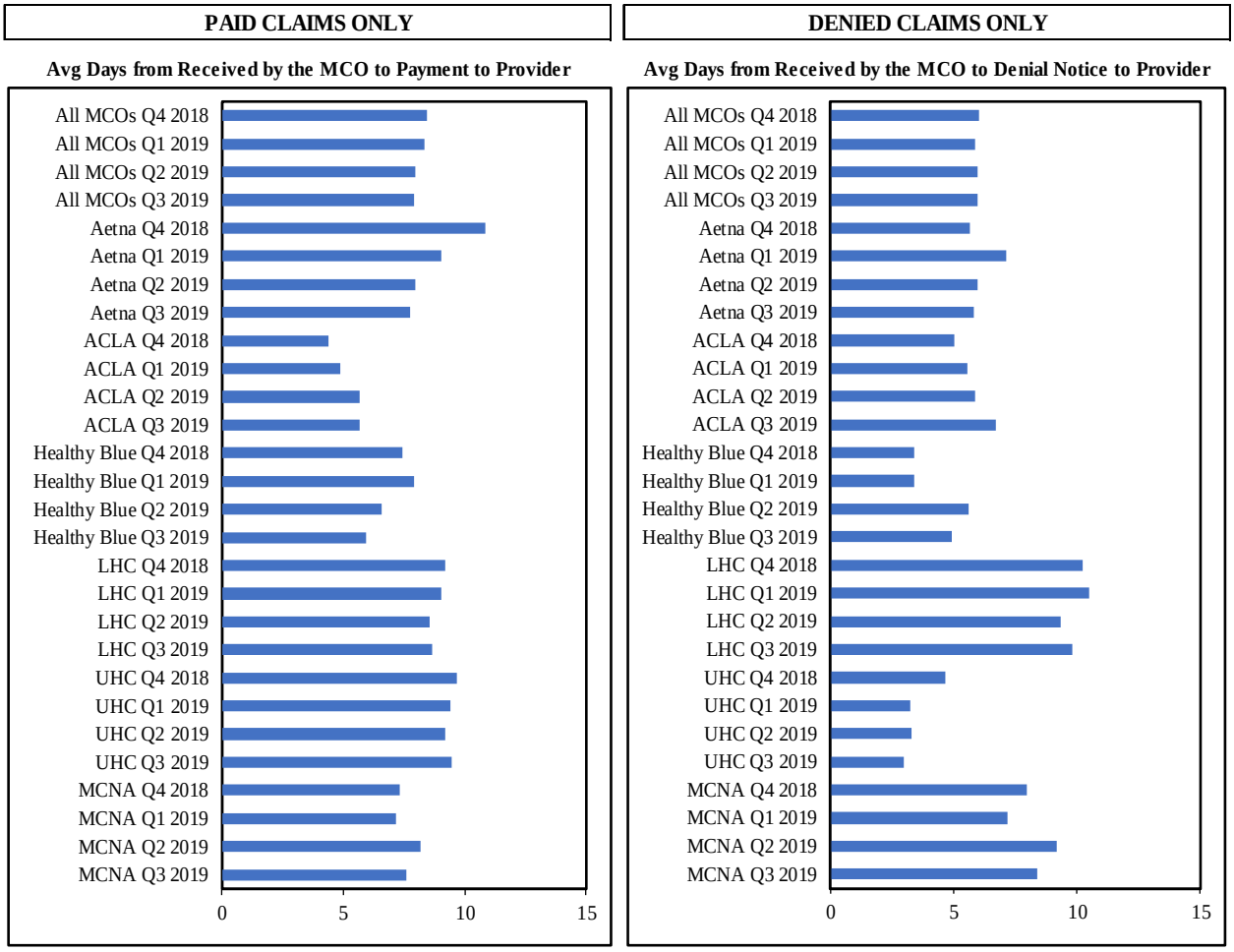
Exhibit III.7A
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
All Claim Types
By MCO and By Quarter

		Adjudicated Within 30 days		Avg Turnaround Time	
		Pct of Paid	Pct of Denied	Paid Claims	Denied Claims
Aetna	Q4 18	99.8%	99.6%	10.8	10.8
	Q1 19	99.2%	98.8%	9.0	7.1
	Q2 19	99.8%	99.6%	8.0	6.0
	Q3 19	99.7%	92.0%	7.8	5.8
ACLA	Q4 18	100.0%	100.0%	4.4	5.0
	Q1 19	100.0%	99.9%	4.9	5.6
	Q2 19	100.0%	100.0%	5.7	5.9
	Q3 19	100.0%	100.0%	5.7	6.7
HealthyBlue	Q4 18	99.9%	99.8%	7.4	3.4
	Q1 19	99.6%	99.5%	7.9	3.4
	Q2 19	99.6%	99.2%	6.6	5.6
	Q3 19	99.6%	99.8%	5.9	4.9
LHC	Q4 18	99.7%	98.9%	9.2	10.2
	Q1 19	99.7%	99.1%	9.0	10.5
	Q2 19	99.9%	99.7%	8.5	9.3
	Q3 19	99.6%	99.6%	8.7	8.7
UHC	Q4 18	99.1%	98.5%	9.7	4.6
	Q1 19	100.0%	99.9%	9.4	3.2
	Q2 19	100.0%	99.6%	9.2	3.3
	Q3 19	99.9%	100.0%	9.5	3.0
MCNA	Q4 18	100.0%	100.0%	7.3	7.9
	Q1 19	100.0%	100.0%	7.1	7.2
	Q2 19	100.0%	100.0%	8.2	9.2
	Q3 19	100.0%	0.0%	8.4	8.4

Exhibit III.7B below compares the TAT between paid claims and denied claims for each MCO by quarter. The overall TAT for paid claims, all MCOs combined, is between 7.9 and 8.4 days in each quarter. For denied claims, the average is 6.0 days every quarter.

There is variation between the MCOs on these statistics. The lowest TAT for paid claims was reported by ACLA (between 4.4 and 5.7 days each quarter). The highest TAT was reported by Aetna (between 7.8 and 10.8 days each quarter). The LHC and UHC average is closer to 9 days each quarter, while HealthyBlue and MCNA are closer to an average of 7 days. For denied claims, HealthyBlue and UHC are similar with average TAT rates near 4 days. Aetna and ACLA's average varied between 5 and 7 days. LHC varied between 9 and 10 days. MCNA varied between 7 and 9 days.

Exhibit III.7B
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
All Claim Types
By MCO and By Quarter



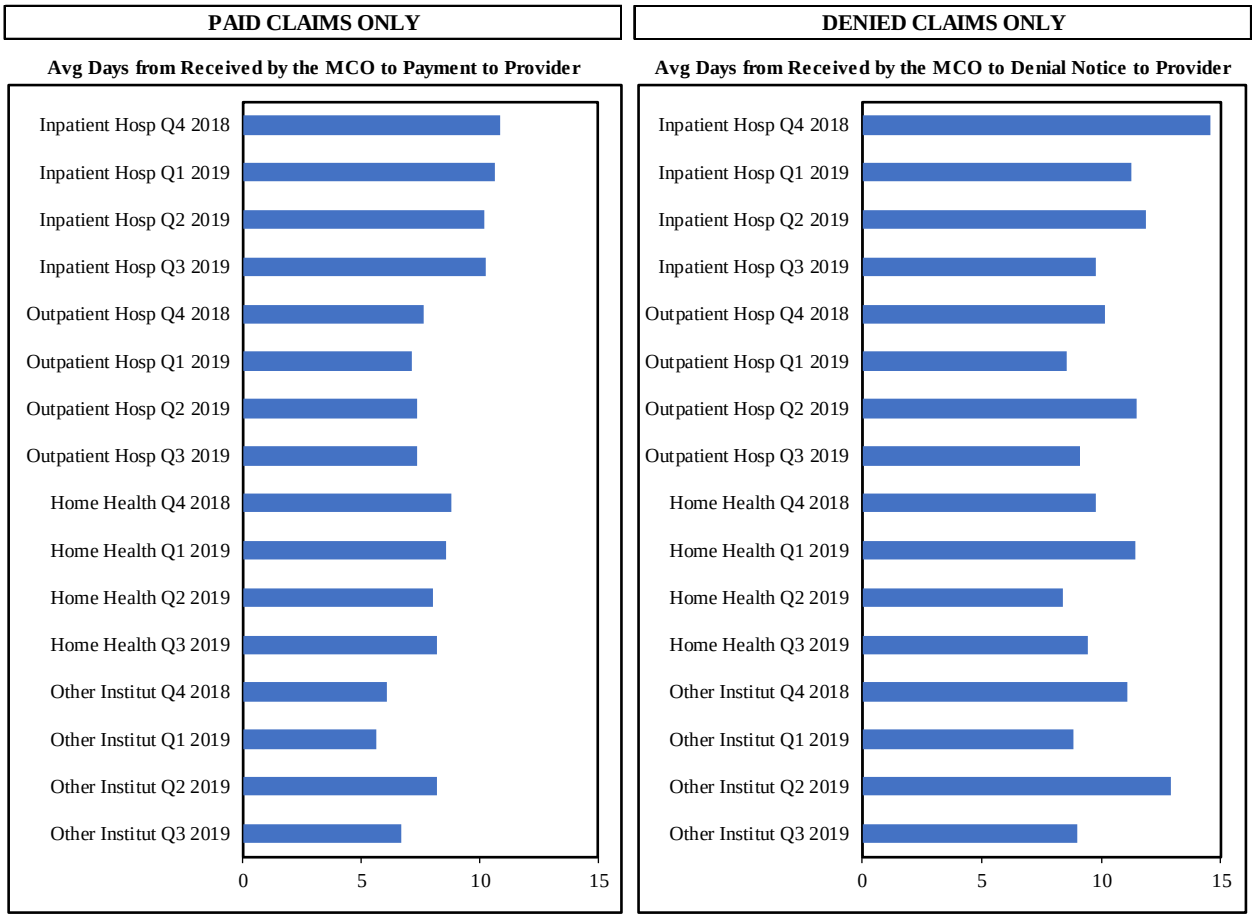
The TAT is influenced in large part by the type of service being delivered and the volume for that service. In other words, a service with a low turnaround time (e.g., pharmacy) can influence the MCO's overall average TAT due to the higher volume of pharmacy claims.

Because of this, the TAT trends were also examined at the provider type level. The same categories shown here are the providers shown earlier in this section measuring the rate of paid and denied claims.

Exhibits III.8A, III.8B and III.8C on the following pages break out the TAT trends by provider type. Exhibit III.8A shows the providers that bill on the institutional, or 837I, claim type. Exhibit III.8B shows the providers that bill on the professional, or 837P, claim type. Exhibit III.8C shows specialized providers such as behavioral health, dental and pharmacy.

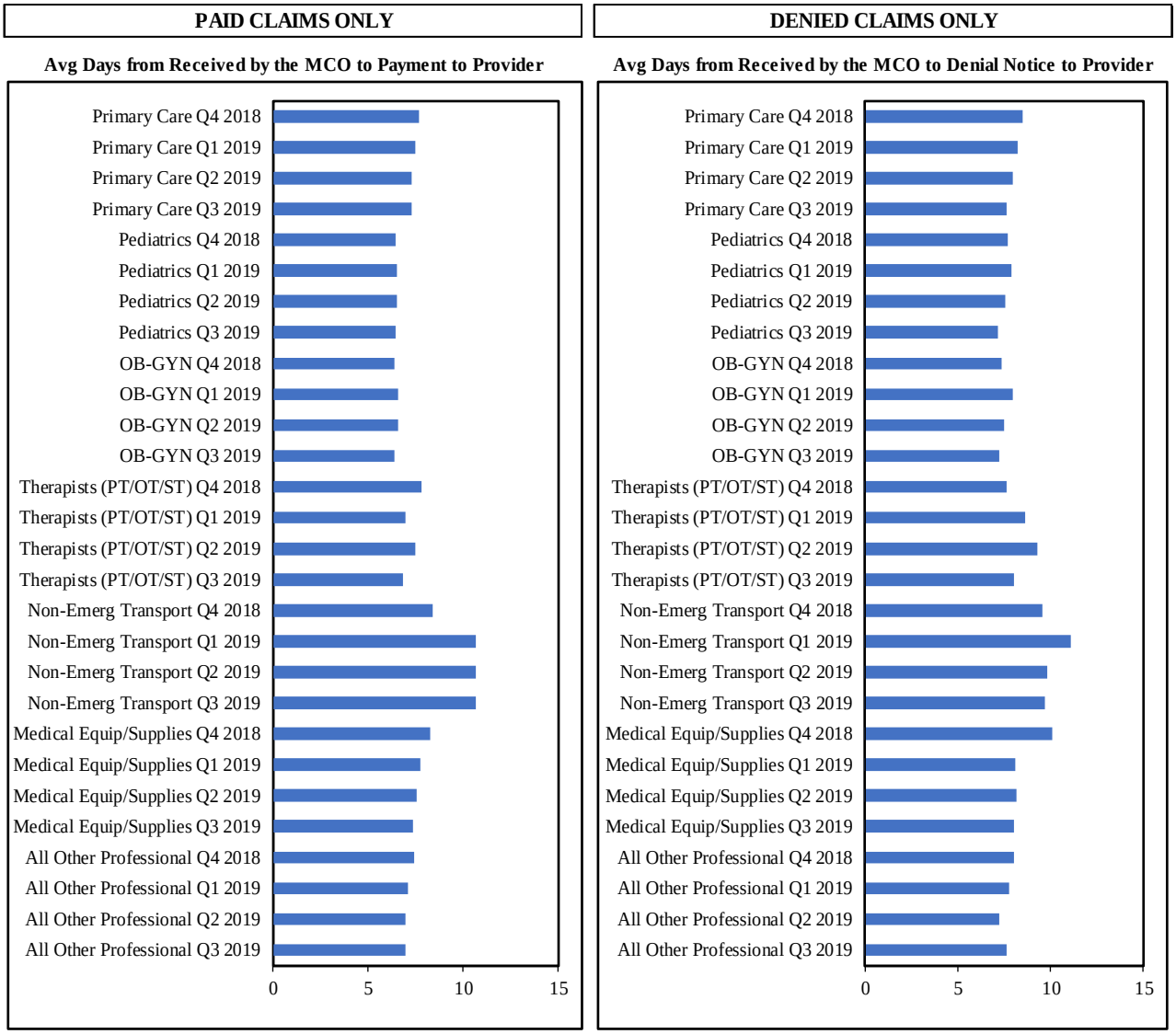
In Exhibit III.8A below, it was found that the TAT is highest for inpatient hospital services compared to other institutional provider services. For inpatient, the average TAT is near 10.5 days each quarter for paid claims and 10 to 14 days for denied claims. For outpatient services, the average TAT is closer to 7.3 days for paid claims and 9 to 11 days for denied claims. The volume is much lower for home health services where the average TAT is close to 8.4 days for paid claims and 9.7 days for denied claims. For other institutional providers, the average TAT is near 6.7 days for paid claims and 10.5 days for denied claims.

Exhibit III.8A
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
Institutional Providers
By All MCOs Combined By Quarter



Among the seven professional service provider type categories examined, the average TAT did not change significantly across the four quarters examined. Further, the average TAT does not vary significantly across the provider types. The lowest average TAT for paid claims was for pediatrics and OB-GYN (average 6.5 days across the quarters) and the highest was for non-emergency transportation (average 10.1 days across the quarters). The average TAT is similar for denied claims within a provider type to what was found for paid claims, or it may be slightly higher by one to two days.

Exhibit III.8B
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
Professional Service Providers
By All MCOs Combined By Quarter

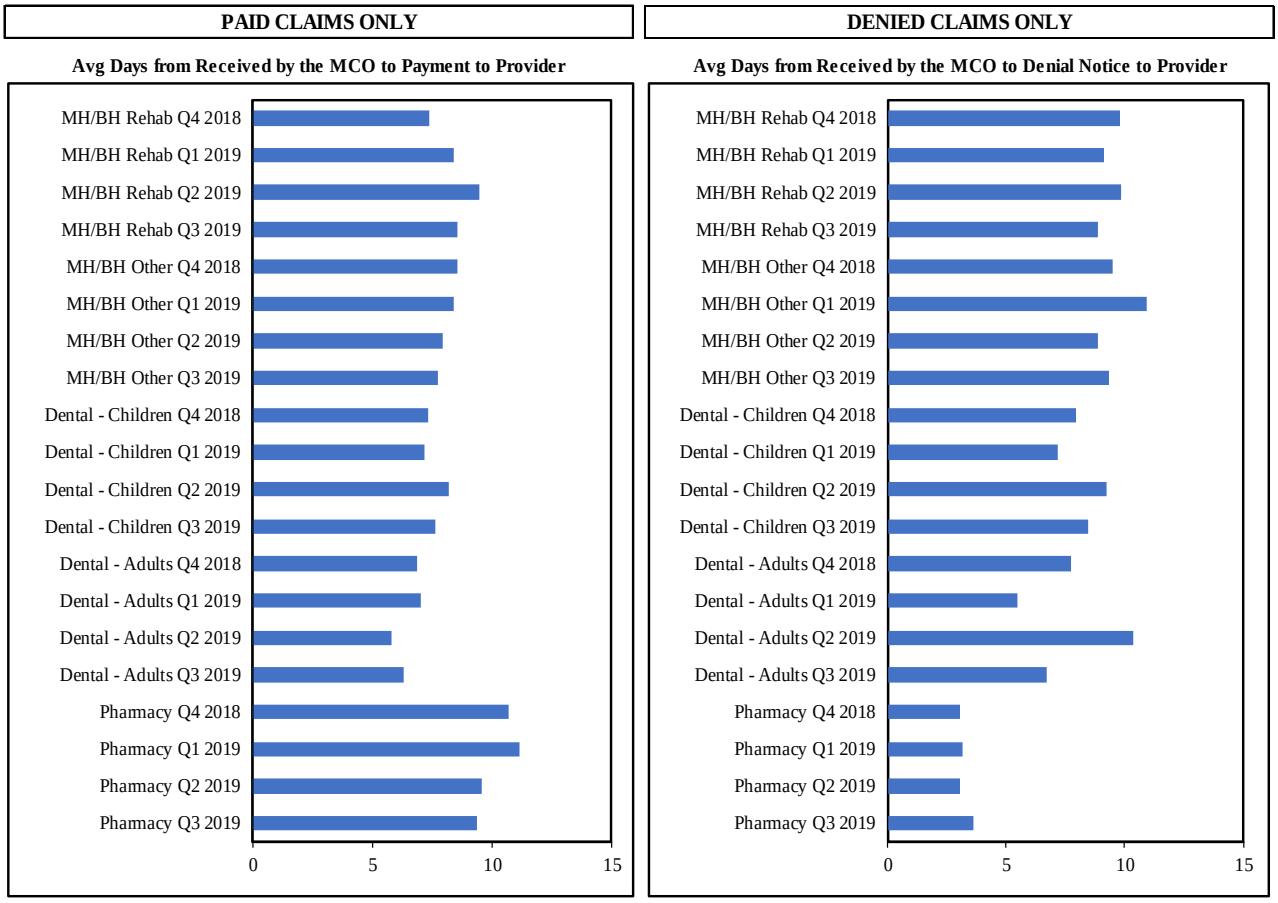


The average TAT for behavioral health and dental services follow similar patterns to what was found for professional services. The average TAT for paid claims for mental health rehab services averaged 8.5 days across the quarters quarter. For non-rehab services, the average TAT was near 8.1 days each quarter. For both of these services, the average TAT for denied claims is one to two days greater than the average TAT for paid claims.

The findings for dental services are similar for children and adults because MCNA is adjudicating both sets of these service claims. The average TAT is near seven days.

The range in the average TAT for paid pharmacy claims was between 9.4 and 11.1 days across the four quarters. The average TAT reported by the MCOs for denied pharmacy claims was closer to three days in the most recent three quarters.

Exhibit III.8C
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
Mental Health/Behavioral Health (MH/BH), Dental and Pharmacy
By All MCOs Combined By Quarter



The exhibits on the next four pages further break down the paid and denied average TATs, but in these exhibits the breakdown is for each provider type by each of the MCOs. The purpose of these exhibits is to determine if the TAT is consistent across MCOs or if it varies.

Exhibit III.9A correlates with the information shown in Exhibit III.8A (institutional providers). Because of the number of provider types, Exhibits III.9B and III.9C correlate with the information shown in Exhibit III.8B (professional providers). Exhibit III.9D correlates with the information shown in Exhibit III.8C (behavioral health, dental, pharmacy).

In the most recent quarter, ACLA or HealthyBlue are often one of the MCOs with the lowest TAT for paid claims. The highest TAT for paid claims varies across MCOs. There are three services where the highest TAT for paid claims is more than 10 days (inpatient hospital, non-emergency transportation and pharmacy). There are eight services where the highest TAT for denied claims is more than 10 days. A summary of other findings from all four exhibits appearing on pages III-20 through III-23 are shown here for convenience:

Provider Category	**Lowest Value, TAT Paid Claims**	**MCO with Lowest TAT, Paid**	**Highest Value, TAT Paid Claims**	**MCO with Highest TAT, Paid**	**Highest Value, TAT Denied**	**MCO with Highest TAT, Denied**
Inpatient Hospital	7.7	HealthyBlue	17.9	Aetna	12.0	ACLA
Outpatient Hospital	4.7	ACLA	8.5	UHC	11.4	HealthyBlue
Home Health	5.8	ACLA	8.8	LHC	10.5	HealthyBlue
Other Institutional (only 1% of all institutional claims)	6.1	HealthyBlue	8.7	ACLA	11.2	ACLA
Primary Care	3.7	ACLA	8.2	UHC	8.7	LHC
Pediatrics	3.6	ACLA	7.8	UHC	8.1	HealthyBlue
OB-GYN	3.6	ACLA	8.0	UHC	8.2	LHC
Therapists	5.9	HealthyBlue	7.8	UHC	9.3	HealthyBlue
Non-emergency Transportation	7.0	UHC	11.1	Aetna, HBL	11.2	Aetna, HealthyBlue
Medical Equipment and Supplies	4.8	ACLA	8.2	UHC	9.4	LHC
Other Professional	4.5	ACLA	8.0	UHC	8.7	LHC
Behavioral Health Rehab	6.0	HealthyBlue	9.6	ACLA	11.5	Aetna
Behavioral Health Other	4.4	ACLA	9.6	UHC	10.3	LHC
Dental – Children	7.6	MCNA	7.6	MCNA	8.4	MCNA
Dental – Adult	7.1	MCNA	7.1	MCNA	6.8	MCNA
Pharmacy	3.9	HealthyBlue	11.8	UHC	10.9	LHC

Exhibit III.9A
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
By Provider Specialty - Institutional Providers
By MCO for Q3 2019 Adjudicated Claims

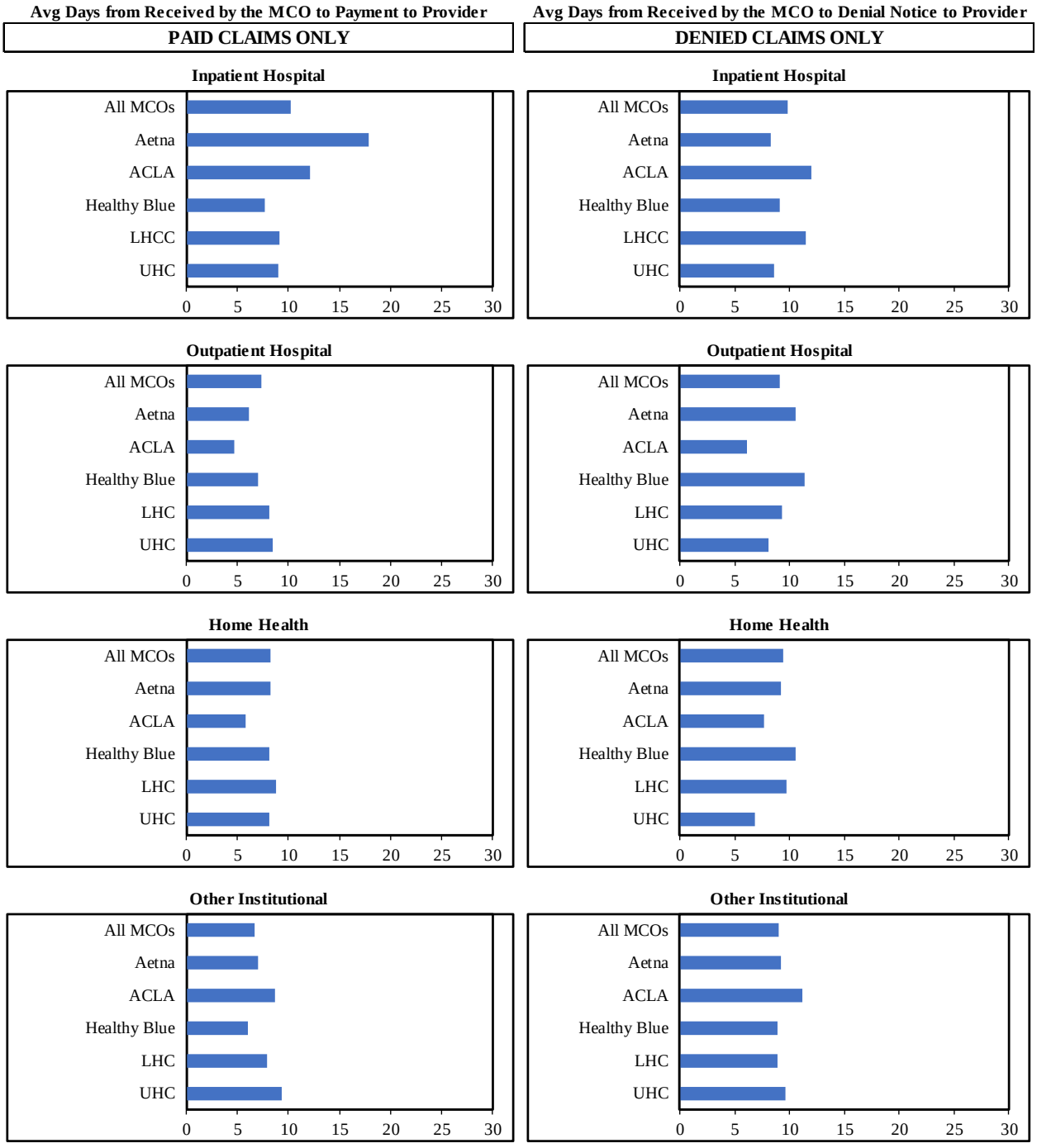


Exhibit III.9B
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
By Provider Specialty - Professional Providers, Part 1
By MCO for Q3 2019 Adjudicated Claims

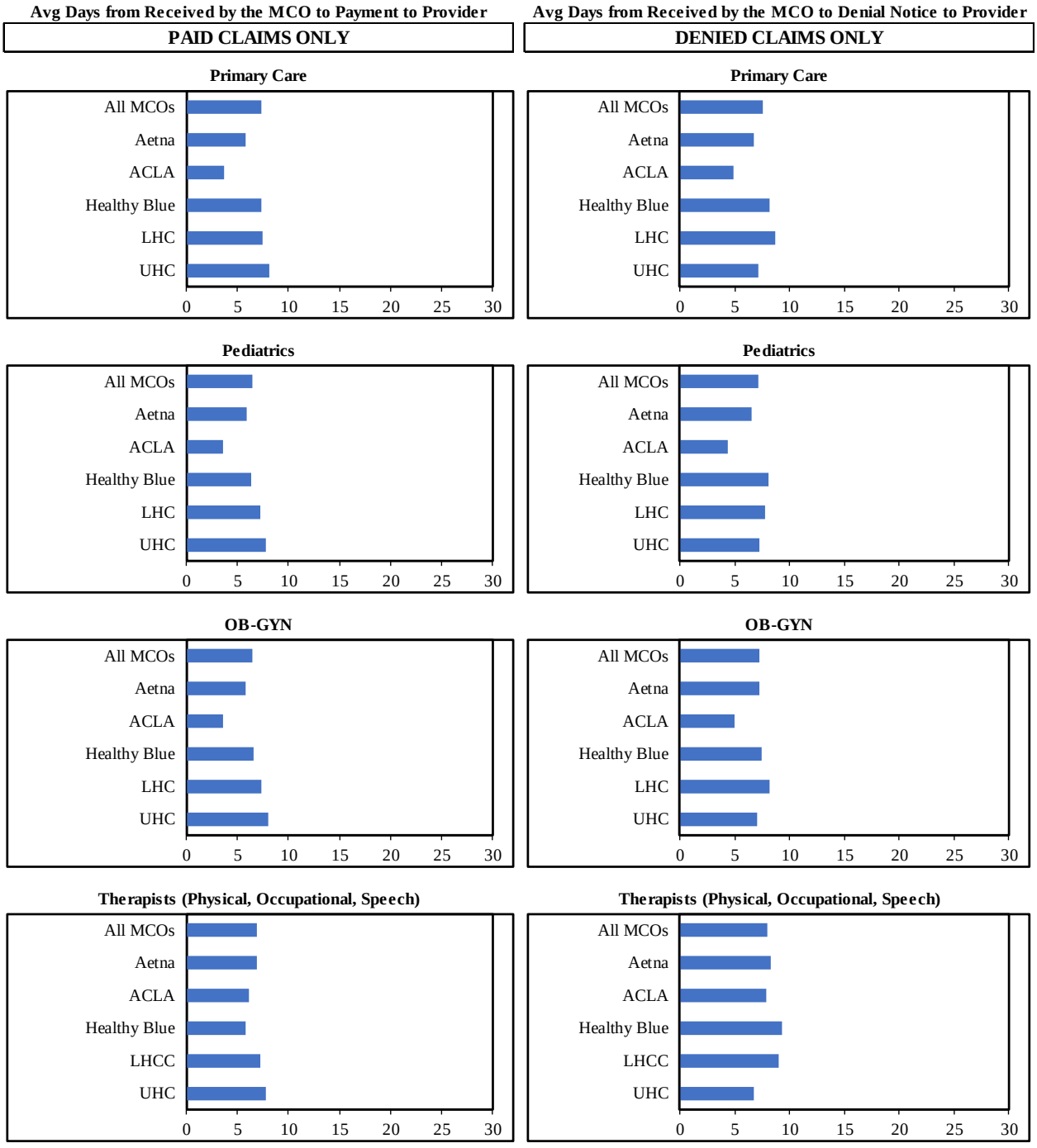
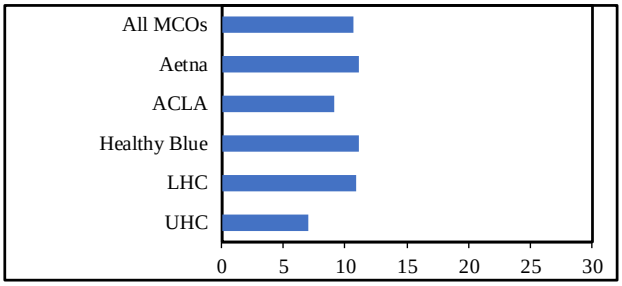


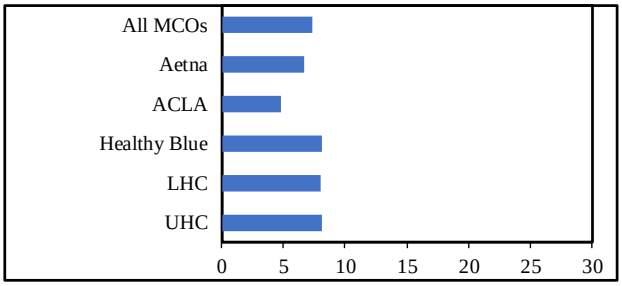
Exhibit III.9C
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
By Provider Specialty - Professional Providers, Part 2
By MCO for Q3 2019 Adjudicated Claims

Avg Days from Received by the MCO to Payment to Provider
PAID CLAIMS ONLY

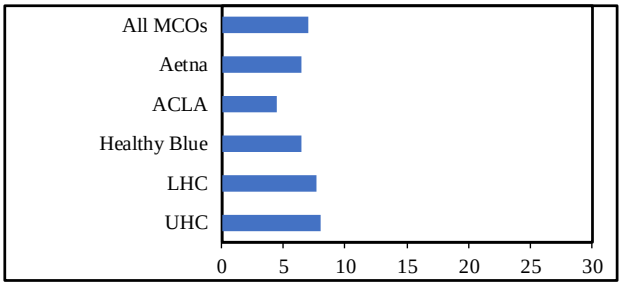
Non-Emergency Medical Transportation



Medical Equipment and Supplies

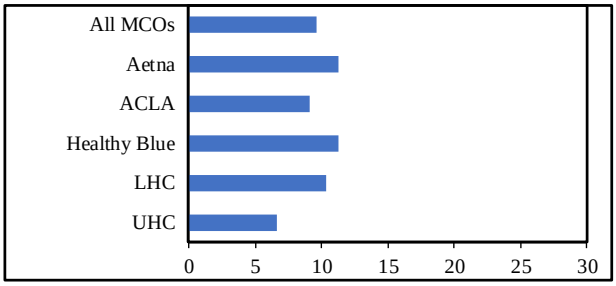


All Other Professional Services exc. BH and Dental

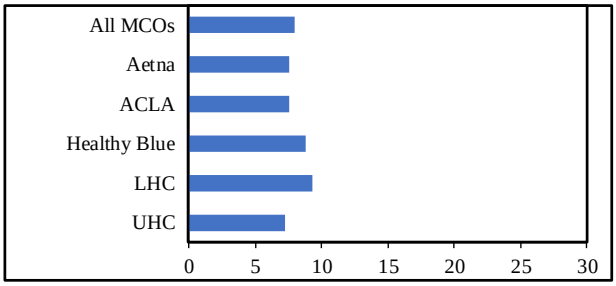


Avg Days from Received by the MCO to Denial Notice to Provider
DENIED CLAIMS ONLY

Non-Emergency Medical Transportation



Medical Equipment and Supplies



All Other Professional Services exc. BH and Dental

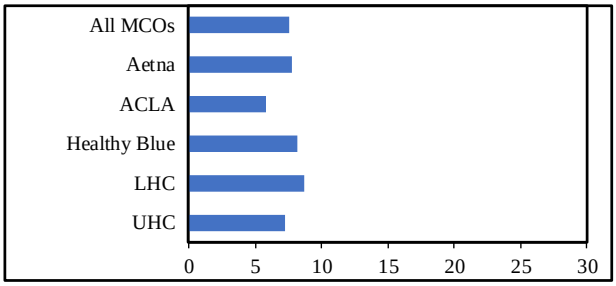
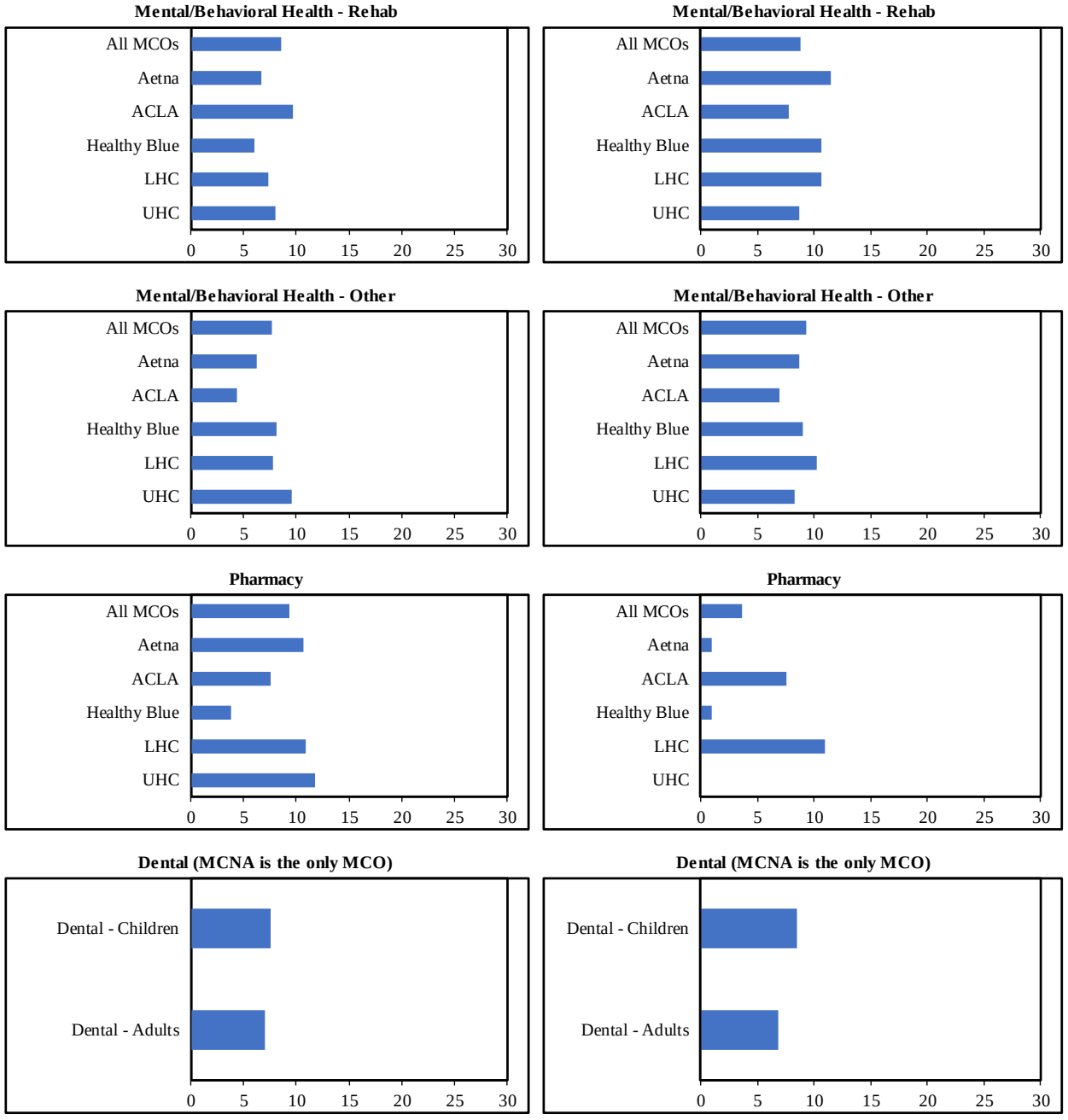


Exhibit III.9D
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
By Provider Specialty - Behavioral Health, Dental and Pharmacy
By MCO for Q3 2019 Adjudicated Claims

Avg Days from Received by the MCO to Payment to Provider
PAID CLAIMS ONLY

Avg Days from Received by the MCO to Denial Notice to Provider
DENIED CLAIMS ONLY



Reasons for Claim Denials by the MCOs

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 MCOs 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 MCO for claims adjudicated in the 3rd Quarter of CY 2019.

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

- In Q3 2019, at least four of Aetna's, ACLA's, LHC's and UHC's top 5 CARC codes were also in the top 10 for All MCOs. HealthyBlue had three of their top 5 and MCNA had only two of their top 5 in the All MCO top 10.
- The top five CARCs in the 3rd Quarter 2019 included the following:
    - 96: Non-covered charge.
    - 197: Precertification or authorization absent when it is required.
    - 18: Exact duplicate claim.
    - 16: The claim lacks information or has a billing error which is needed for adjudication.
    - B7: This provider was not eligible to be paid for this procedure/service on this date.
- These five CARCs were also among the top seven in the previous five quarters reported.

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

- In Q3 2019, all MCOs each had their top 5 NCPDP codes also in the top 10 for All MCOs.
- The top five NCPDPs in the 2nd Quarter 2019 included the following:
    - 79: Refill too soon
    - 75: Prior authorization required
    - 7O: Product/service not covered – plan/benefit exclusion
    - 88: DUR reject error
    - 76: Plan limitations exceeded
- These five NCPDPs were also among the top six in the previous three quarters reported.

Exhibit III.10
Details on Reasons for Denied Claims
By MCO for Q3 2019 Adjudicated Claims

For Medical Claims

			Ranking for Individual MCO					
CARC	Description	Rank Among All MCOs	Aetna	ACLA	Healthy Blue	LHC	UHC	MCNA
96	Non-covered charge(s).	1	4	2		1	1	4
197	Precertification/authorization/notification absent.	2		3	2	3		
18	Exact duplicate claim/service	3	3			2	2	2
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	4	1	4				
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	5		1		5		
97	The benefit for this service is included in the payment/allowance for another service/procedure that	6	2				4	
252	An attachment/other documentation is required to adjudicate this claim/service.	7			3		3	
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that	8				4		
29	The time limit for filing has expired.	9						
256	Service not payable per managed care contract.	10			1			

For Pharmacy Claims

			Ranking for Individual MCO				
NCPDP	Description	Rank Among All MCOs	Aetna	ACLA	Healthy Blue	LHC	UHC
79	Refill Too Soon	1	1	1	1	1	4
75	Prior Authorization Required	2	2	5	2	2	
7Ø	Product/Service Not Covered – Plan/Benefit Exclusion	3	4	2		4	2
88	DUR Reject Error	4					1
76	Plan Limitations Exceeded	5	5		5	3	3
7X	Days Supply Exceeds Plan Limitation	6		3	3		
41	Submit Bill To Other Processor Or Primary Payer	7				5	
69	Filled After Coverage Terminated	8	3		4		5
77	Discontinued Product/Service ID Number	9					
MR	Product Not On Formulary	10		4			

The previous exhibit showed that the top ten denial CARCs are consistent across quarters and were often the top CARCs for each MCO as well. The top five CARCs for each MCO 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.11 shows the results when the top CARCs are distributed by provider type for each MCO for claims adjudicated in the 3rd Quarter of 2019. Key findings from the exhibit are shown below:

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

- For ACLA, two of its five CARCs overall were also observed for almost every provider category as well. Three CARCs were only present for selected provider types.

- For HealthyBlue, three of its five CARCs overall were also observed for almost every provider category as well. Two CARCs were only present for selected provider types.

- For LHC, two of its five CARCs overall were also observed for almost every provider category as well. Three CARC was only present for selected provider types.

- For UHC, three of its five CARCs overall were also observed for almost every provider category as well. Two CARCs were only present for selected provider types.

- For MCNA, all five of its CARCs overall are the same as its provider base because MCNA's provider base only includes dental providers.

Exhibit III.11
Details on Reasons for Denied Medical Claims
By MCO and By Provider Category for Q3 2019 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
Aetna																
16	Claim/service lacks information or has submission/billing error(s) which is needed for a	3	2	3	2	1	1	1	2	1	1	1	1	1		
97	The benefit for this service is included in the payment/allowance for another service/pr	2	1	2	3	5	4	3		2		4	3			
18	Exact duplicate claim/service	1	4	1	4	4	3	2		2	5	3	2	3		
96	Non-covered charge(s).		3		1	2	2		3	2	2	2		5		
4	The procedure code is inconsistent with the modifier used or a required modifier is mi		5						1	2		5				
ACLA																
B7	This provider was not certified/eligible to be paid for this procedure/service on this da						4	5				1	2			
96	Non-covered charge(s).	2	1	1	1	1	1	1	1	3	2	2	1	1		
197	Precertification/authorization/notification absent.	5		4		5			2		1	3	3	4		
16	Claim/service lacks information or has submission/billing error(s) which is needed for a		2	5	2	2	5	2	5	1	3	4				
27	Expenses incurred after coverage terminated.		4		2	3	3			4		5		5		
Healthy Blue																
256	Service not payable per managed care contract.	4	2	3	1	1	1	2	1	2	2	2				
197	Precertification/authorization/notification absent.	3	3	2	3	2	2	4	2	2	3	1	3	1		
252	An attachment/other documentation is required to adjudicate this claim/service.	5	1	1	2	3	4	3	3	2	1	3	5	3		
119	Benefit maximum for this time period or occurrence has been reached.			5				5		2			1	2		
222	Exceeds the contracted maximum number of hours/days/units by this provider for this			5						2	4	4				

Exhibit III.11 (continued)
Details on Reasons for Denied Medical Claims
By MCO and By Provider Category for Q3 2019 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
LHCC																
96	Non-covered charge(s).		1	5	2	1	1	2		2		2				
18	Exact duplicate claim/service	4	2	2	5	2	3	1	4	4	4	3		1		
197	Precertification/authorization/notification absent.	2		3	4				3		2	1	4	3		
P14	The Benefit for this Service is included in the payment/allowance for another service/p		3				5	4				5				
B7	This provider was not certified/eligible to be paid for this procedure/service on this da					3	2	3	5			4				
United																
96	Non-covered charge(s).		2		1	2	2	4	1	4	1	1		4		
18	Exact duplicate claim/service	5	3	1		1	3	2	2	4	5		1	2		
252	An attachment/other documentation is required to adjudicate this claim/service.		1		2	3	4	3	3	4	3	3		5		
97	The benefit for this service is included in the payment/allowance for another service/pr		4			4	1	1		1	2	4				
B13	Previously paid. Payment for this claim/service may have been provided in a previous				4					4		2				
MCNA																
169	Alternate benefit has been provided.														1	
18	Exact duplicate claim/service														3	3
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period.														2	
96	Non-covered charge(s).														4	4
6	The procedure/revenue code is inconsistent with the patient's age.														5	

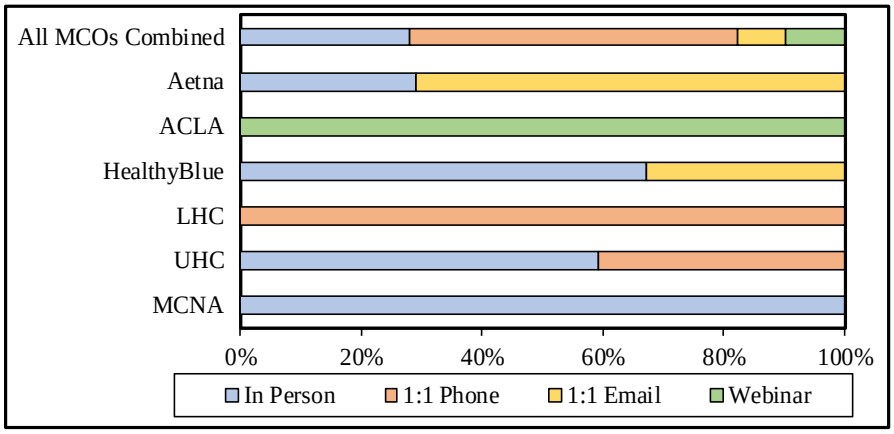
Provider Education Related to Claims Adjudication

Because many of the denial reason codes have been consistent for some time, the LDH initiated specific reporting for MCO 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. This report continues reporting on provider education.

LDH is requesting that the MCOs 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 MCOs are reporting on the individual entity's outreached (name and TIN), whether it was the MCO or its contractor who conducted the outreach, the type of outreach, and the date that the outreach was conducted.

Exhibit III.12 summarizes information on provider education conducted in Q3 2019. In all, 1,232 TINs were outreached to by the MCOs (down from 1,890 last quarter). This count represents the unique TINs and modes of communication. In some cases, the MCO reported that they conducted multiple outreach to the same TIN in the quarter (e.g. three emails over the course of 6 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 MCOs.

Exhibit III.12
Provider Education Conducted by the MCOs on Claims Submissions Activity in Q3 2019



The most predominant mode to outreach to providers is 1:1 phone calls (54.1% of all contacts) followed by in-person (28.1% of contacts). Emails and webinars each represent 8% to 10% of all contacts.

There is variation in the modalities used by MCO. ACLA and LHC reported no in-person contact and Aetna reported little. HealthyBlue reported three out of four contacts as in-person. UHC reported 59% of its contacts were in-person. MCNA reported that all provider contacts on claims submissions were in-person.

	Modality of Outreach				
	In Person	**1:1 Phone**	**1:1 Email**	**Webinar**	**Total TINs**
All MCOs Combined	346	666	99	121	1,232
Aetna	9	0	22	0	31
ACLA	0	0	0	121	121
HealthyBlue	158	0	77	0	235
LHC	0	581	0	0	581
UHC	124	85	0	0	209
MCNA	55	0	0	0	55

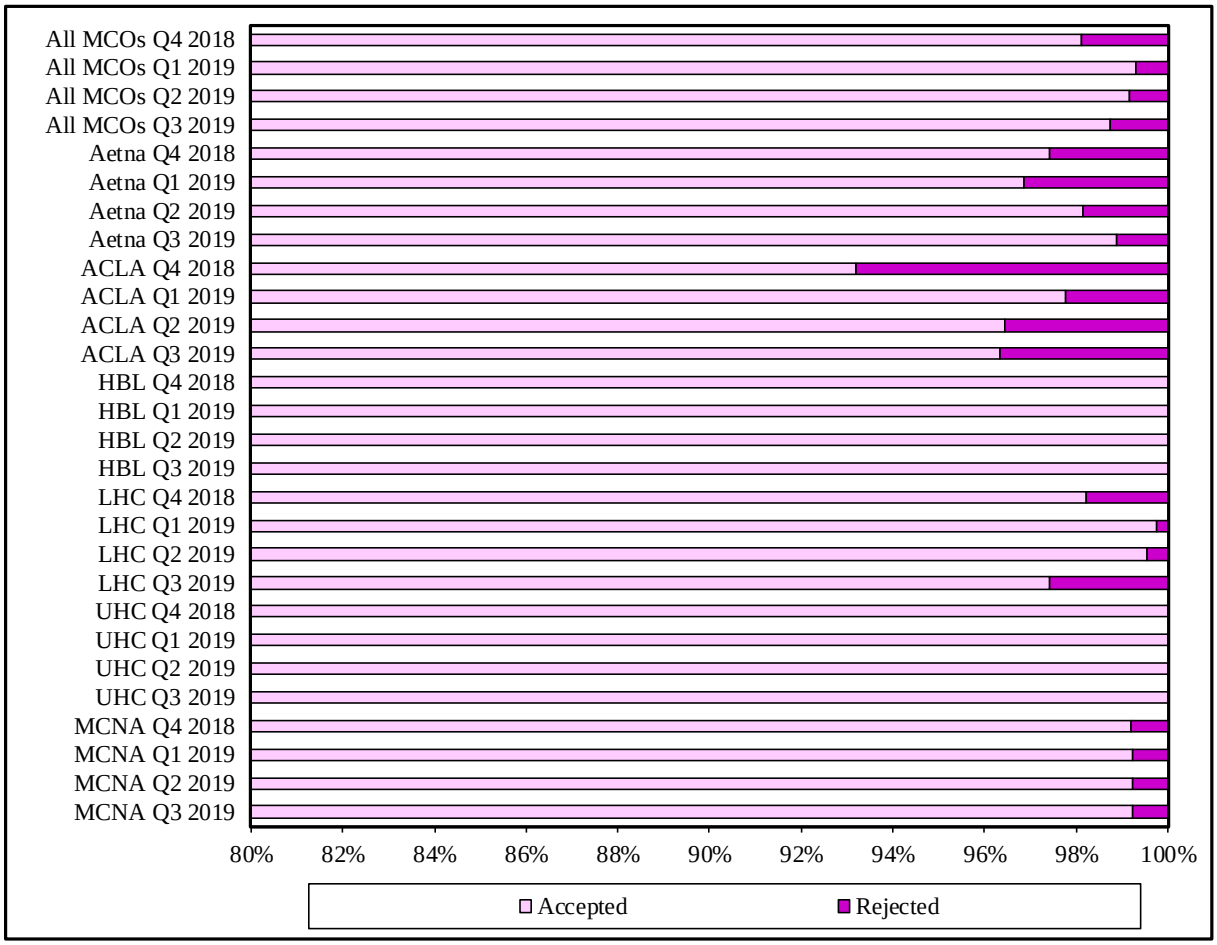
SECTION IV: FINDINGS RELATED TO MCO ENCOUNTER SUBMISSIONS TO LDH

The MCOs 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 MCO 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 MCOs.

MCO Encounters Accepted and Rejected by LDH

In the most recent four quarters studied, 98.7% to 99.3% of the encounters submitted by all MCOs combined were accepted by LDH. There were differences at the MCO level. All of HealthyBlue's and UHC's encounters were accepted. For MCNA, the acceptance rate was at least 99% every quarter; for Aetna and LHC, at least 97%. ACLA had varying acceptance rates between 93% and 98% in the last four quarters.

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



There are differences in the encounter acceptance rate when reviewed by claim type. The MCOs 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 MCO by claim type and by quarter. The key findings from these exhibits show that:

- ACLA's lower encounter acceptance rate overall was due to institutional and pharmacy encounters but not professional encounters.

- When Aetna and LHC had lower encounter acceptance rates than its peers, it was also due to institutional and pharmacy encounters.

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

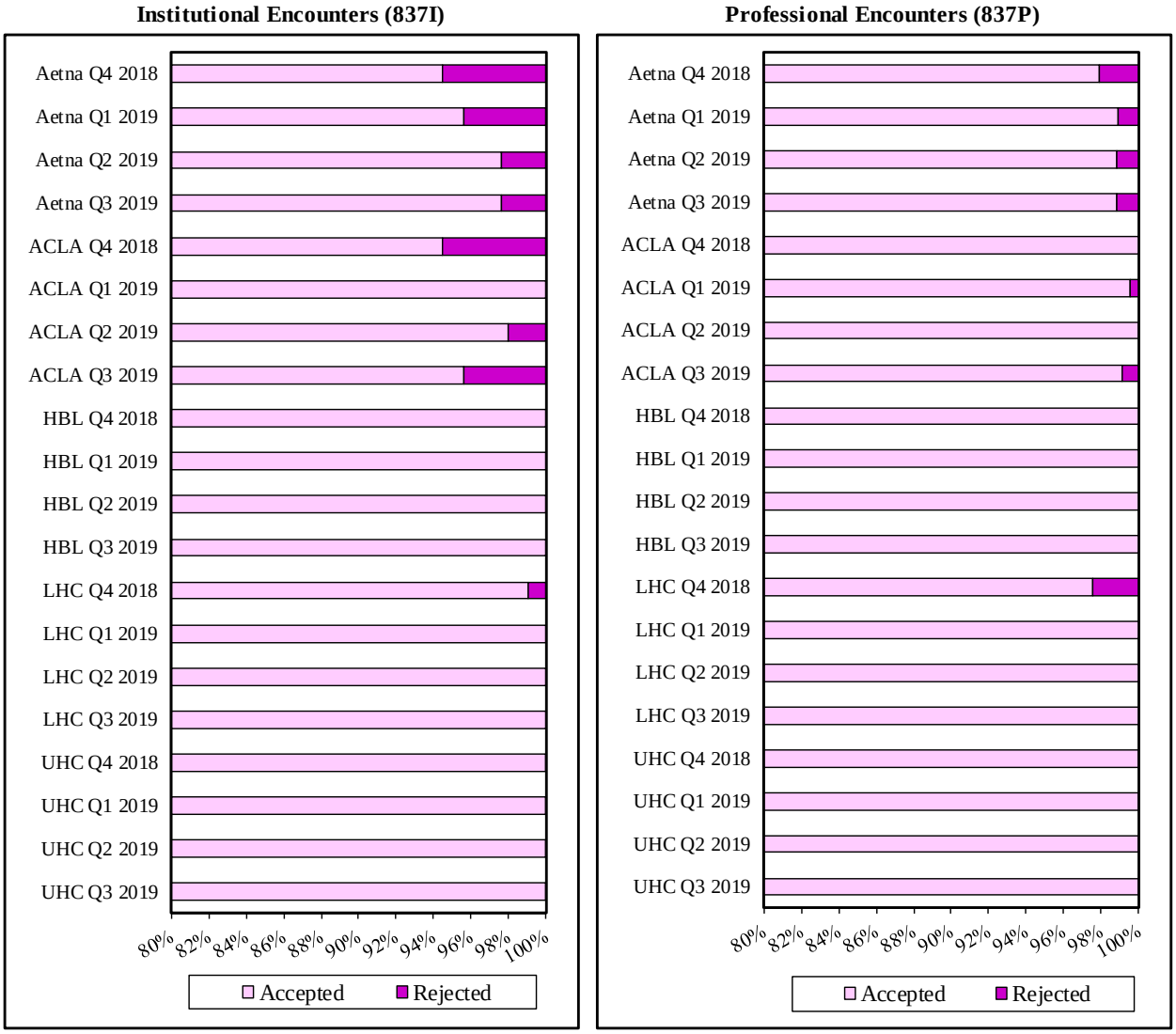
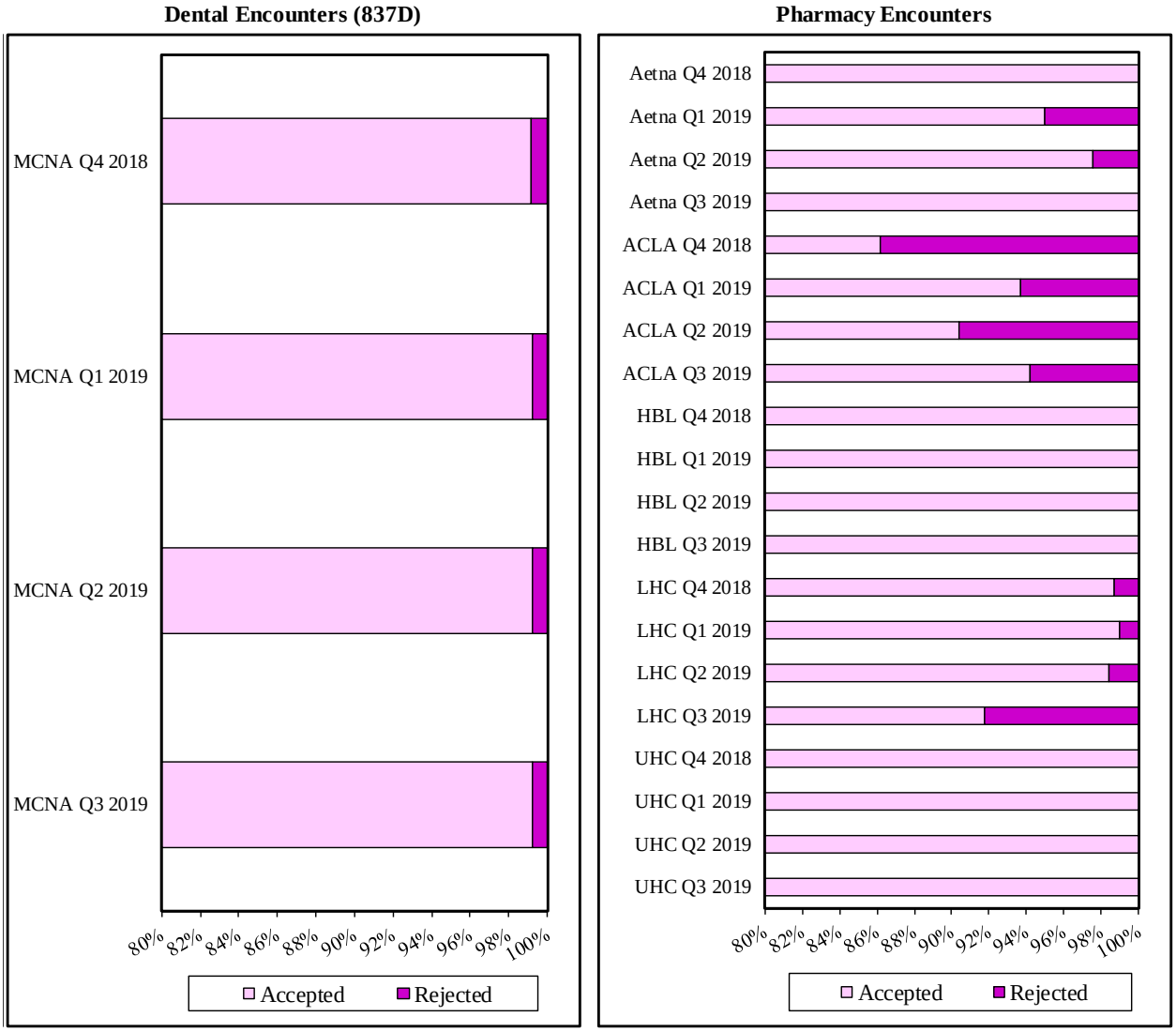


Exhibit IV.3
Encounter Submissions Accepted and Rejected by LDH
Dental and Pharmacy Claim Types
By MCO and By Quarter



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 MCO 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 MCO 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 MCO, by quarter and by claim type. A common benchmark used is that MCOs 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), most of the MCOs had at least 95% of their encounters submitted within 30 days each quarter. Exceptions were Aetna in Q4 2018 and Q1 2019 and LHC in Q1 2019.

- Aetna, HealthyBlue and UHC consistently have the highest rate of submission of professional encounters within 30 days. HealthyBlue has had more than 95% in within that time in each of the last four quarters; UHC has done so in three of the last four quarters. ACLA had some trouble with submitting professional encounters in Q1 and Q2 2019, but this has improved greatly in Q3 2019 to 97.5% submitted within 30 days. LHC has had the most trouble meeting the 30-day time submission target, but 91.5% were submitted within 30 days in the last two quarters reported.

- There is greater variation in the timeliness of pharmacy encounter submissions. Aetna consistently is lowest with approximately 70% submitted within 30 days. LHC had a very high rate in Q4 2018, but this has eroded in 2019 as far as the percentage submitted within 30 days. UHC has had a high rate of timely submissions in most quarters. ACLA had challenges in Q4 2018 but has improved greatly in 2019. HealthyBlue has always had a high rate of pharmacy encounters submitted within 30 days (above 98%).

- MCNA has few issues meeting an average 30-day TAT for its dental encounters.

Exhibit IV.4
Encounter Submissions Accepted or Rejected by LDH
Institutional, Professional, Dental, and Pharmacy Claim Types
By MCO 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
Aetna Q4 2018	87.2%	12.8%	96.2%	3.8%			71.1%	28.9%
Aetna Q1 2019	91.9%	8.1%	93.8%	6.2%			76.5%	23.5%
Aetna Q2 2019	98.9%	1.1%	97.1%	2.9%			69.2%	30.8%
Aetna Q3 2019	98.9%	1.1%	97.1%	2.9%			69.7%	30.3%
ACLA Q4 2018	96.5%	3.5%	95.6%	4.4%			76.3%	23.7%
ACLA Q1 2019	96.8%	3.2%	93.2%	6.8%			90.8%	9.2%
ACLA Q2 2019	95.9%	4.1%	87.0%	13.0%			94.5%	5.5%
ACLA Q3 2019	95.3%	4.7%	97.5%	2.5%			95.0%	5.0%
HBL Q4 2018	100.0%	0.0%	95.1%	4.9%			100.0%	0.0%
HBL Q1 2019	100.0%	0.0%	96.1%	3.9%			98.5%	1.5%
HBL Q2 2019	100.0%	0.0%	95.8%	4.2%			99.7%	0.3%
HBL Q3 2019	97.2%	2.8%	97.7%	2.3%			99.7%	0.3%
LHC Q4 2018	93.9%	6.1%	89.2%	10.8%			98.9%	1.1%
LHC Q1 2019	88.5%	11.5%	79.7%	20.3%			74.6%	25.4%
LHC Q2 2019	97.2%	2.8%	91.5%	8.5%			71.7%	28.3%
LHC Q3 2019	99.2%	0.8%	91.5%	8.5%			66.1%	33.9%
UHC Q4 2018	98.5%	1.5%	97.4%	2.6%			99.0%	1.0%
UHC Q1 2019	99.5%	0.5%	95.1%	4.9%			98.3%	1.7%
UHC Q2 2019	96.2%	3.8%	96.8%	3.2%			93.0%	7.0%
UHC Q3 2019	97.8%	2.2%	93.4%	6.6%			87.5%	12.5%
MCNA Q4 2018					100.0%	0.0%		
MCNA Q1 2019					99.4%	0.6%		
MCNA Q2 2019					99.4%	0.6%		
MCNA Q3 2019					99.1%	0.9%		

APPENDIX A
Map of LDH Provider Types/Specialties to the Provider Categories in this Report

Provider Type Categories	Claim Form	Claim Type	Billing Provider Type/Specialty PT=Provider Type PS=Provider Specialty	Reporting Level	Notes
Inpatient Hospital	UB-04/837-I	01		Header	Include Distinct Part Psych, Freestanding Psych, and Freestanding Rehab hospitals here.
Outpatient Hospital	UB-04/837-I	03		Detail	
Home Health	UB-04/837-I	06		Detail	
All Other - UB-04/837-I	UB-04/837-I	Any Other		Detail	Only include claims billed on claim form UB-04/837-I and has any other CT, PT and/or PS **not already listed in the above UB-04/837-I categories**. This category should not include any claims with CT 01, 03 or 06.
MHR/BHR	CMS-1500/837-P	04	MHR- PT= 77 AND PS= 78 BHR- PT= AG AND PS= 8E	Detail	
All Other Specialized Behavioral Health - Not MHR/BHR	CMS-1500/837-P	04	**See Appendix AD of MCO SCG for PT/PS**	Detail	Do not include MHR/BHR claims in this category.
Primary Care Services - Excluding Pediatricians (Primary Care)	CMS-1500/837-P	04	PS= 01, 08, 41, 42, 79, 94	Detail	Do not include Pediatricians (Primary Care) claims in this category
Pediatricians (Primary Care)	CMS-1500/837-P	04	PS= 37	Detail	
OB-GYN & MFM	CMS-1500/837-P	04	PS= 09, 15, 16, 3C	Detail	
Therapies (PT/OT/ST)	CMS-1500/837-P	04	PS= 65, 71, 74	Detail	
NEMT & NEAT	CMS-1500/837-P	08		Detail	
Medical Equipment / Supplies	CMS-1500/837-P	09		Detail	
All Other CMS-1500	CMS-1500/837-P	Any Other	Any other claim type 04, or other claim type/PT/PS combinations NOT already listed for claim form CMS-1500/837-P	Detail	
Pharmacy[1]	NCPDP	12		Detail	
Dental - EPSDT	ADA/837-D	10		Detail	
Dental - Adult	ADA/837-D	11		Detail	

[1]Pharmacy provider type category should be based off of the prescribing provider's NPI, not the pharmacy's NPI.

APPENDIX B

List of All Claim Adjustment Reason Codes (CARCs)

Active Codes January 1, 2017 - Present

Rows in yellow indicate CARCs that have been deactivated in CY2017 or CY2018 but kept in this list to account for claims processing lag.

CARC	CARC Description
1	Deductible Amount
2	Coinsurance Amount
3	Co-payment Amount
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.
5	The procedure code/bill type is inconsistent with the place of service.
6	The procedure/revenue code is inconsistent with the patient's age.
7	The procedure/revenue code is inconsistent with the patient's gender.
8	The procedure code is inconsistent with the provider type/specialty (taxonomy).
9	The diagnosis is inconsistent with the patient's age.
10	The diagnosis is inconsistent with the patient's gender.
11	The diagnosis is inconsistent with the procedure.
12	The diagnosis is inconsistent with the provider type.
13	The date of death precedes the date of service.
14	The date of birth follows the date of service.
15	The authorization number is missing, invalid, or does not apply to the billed services or provider.
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
18	Exact duplicate claim/service
19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.
20	This injury/illness is covered by the liability carrier.
21	This injury/illness is the liability of the no-fault carrier.
22	This care may be covered by another payer per coordination of benefits.
23	The impact of prior payer(s) adjudication including payments and/or adjustments.
24	Charges are covered under a capitation agreement/managed care plan.
26	Expenses incurred prior to coverage.
27	Expenses incurred after coverage terminated.
29	The time limit for filing has expired.
31	Patient cannot be identified as our insured.
32	Our records indicate that this dependent is not an eligible dependent as defined.
33	Insured has no dependent coverage.
34	Insured has no coverage for newborns.
35	Lifetime benefit maximum has been reached.
39	Services denied at the time authorization/pre-certification was requested.
40	Charges do not meet qualifications for emergent/urgent care.
44	Prompt-pay discount.
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
49	This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam.
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.
51	These are non-covered services because this is a pre-existing condition.
53	Services by an immediate relative or a member of the same household are not covered.
54	Multiple physicians/assistants are not covered in this case.
55	Procedure/treatment/drug is deemed experimental/investigational by the payer.
56	Procedure/treatment has not been deemed 'proven to be effective' by the payer.
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)
60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.
61	Penalty for failure to obtain second surgical opinion.
66	Blood Deductible.
69	Day outlier amount.
70	Cost outlier - Adjustment to compensate for additional costs.
74	Indirect Medical Education Adjustment.
75	Direct Medical Education Adjustment.
76	Disproportionate Share Adjustment.
78	Non-Covered days/Room charge adjustment.
85	Patient Interest Adjustment
89	Professional fees removed from charges.
90	Ingredient cost adjustment. Note: To be used for pharmaceuticals only.
91	Dispensing fee adjustment.
94	Processed in Excess of charges.
95	Plan procedures not followed.
96	Non-covered charge(s). At least one Remark Code must be provided.
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
100	Payment made to patient/insured/responsible party/employer.
101	Predetermination: anticipated payment upon completion of services or claim adjudication.
102	Major Medical Adjustment.
103	Provider promotional discount (e.g., Senior citizen discount).
104	Managed care withholding.

APPENDIX B

List of All Claim Adjustment Reason Codes (CARCs)

Active Codes January 1, 2017 - Present

Rows in yellow indicate CARCs that have been deactivated in CY2017 or CY2018 but kept in this list to account for claims processing lag.

CARC	CARC Description
105	Tax withholding.
106	Patient payment option/election not in effect.
107	The related or qualifying claim/service was not identified on this claim.
108	Rent/purchase guidelines were not met.
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.
110	Billing date predates service date.
111	Not covered unless the provider accepts assignment.
112	Service not furnished directly to the patient and/or not documented.
114	Procedure/product not approved by the Food and Drug Administration.
115	Procedure postponed, canceled, or delayed.
116	The advance indemnification notice signed by the patient did not comply with requirements.
117	Transportation is only covered to the closest facility that can provide the necessary care.
118	ESRD network support adjustment.
119	Benefit maximum for this time period or occurrence has been reached.
121	Indemnification adjustment - compensation for outstanding member responsibility.
122	Psychiatric reduction.
128	Newborn's services are covered in the mother's Allowance.
129	Prior processing information appears incorrect. At least one Remark Code must be provided.
130	Claim submission fee.
131	Claim specific negotiated discount.
132	Prearranged demonstration project adjustment.
133	The disposition of this service line is pending further review.
134	Technical fees removed from charges.
135	Interim bills cannot be processed.
136	Failure to follow prior payer's coverage rules.
137	Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.
138	Appeal procedures not followed or time limits not met.
139	Contracted funding agreement - Subscriber is employed by the provider of services.
140	Patient/Insured health identification number and name do not match.
142	Monthly Medicaid patient liability amount.
143	Portion of payment deferred.
144	Incentive adjustment, e.g. preferred product/service.
146	Diagnosis was invalid for the date(s) of service reported.
147	Provider contracted/negotiated rate expired or not on file.
148	Information from another provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided.
149	Lifetime benefit maximum has been reached for this service/benefit category.
150	Payer deems the information submitted does not support this level of service.
151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.
152	Payer deems the information submitted does not support this length of service.
153	Payer deems the information submitted does not support this dosage.
154	Payer deems the information submitted does not support this day's supply.
155	Patient refused the service/procedure.
157	Service/procedure was provided as a result of an act of war.
158	Service/procedure was provided outside of the United States.
159	Service/procedure was provided as a result of terrorism.
160	Injury/illness was the result of an activity that is a benefit exclusion.
161	Provider performance bonus
163	Attachment/other documentation referenced on the claim was not received.
164	Attachment/other documentation referenced on the claim was not received in a timely fashion.
165	Referral absent or exceeded.
166	These services were submitted after this payers responsibility for processing claims under this plan ended.
167	This (these) diagnosis(es) is (are) not covered.
168	Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan.
169	Alternate benefit has been provided.
170	Payment is denied when performed/billed by this type of provider.
171	Payment is denied when performed/billed by this type of provider in this type of facility.
172	Payment is adjusted when performed/billed by a provider of this specialty.
173	Service/equipment was not prescribed by a physician.
174	Service was not prescribed prior to delivery.
175	Prescription is incomplete.
176	Prescription is not current.
177	Patient has not met the required eligibility requirements.
178	Patient has not met the required spend down requirements.
179	Patient has not met the required waiting requirements.
180	Patient has not met the required residency requirements.
181	Procedure code was invalid on the date of service.

APPENDIX B

List of All Claim Adjustment Reason Codes (CARCs)

Active Codes January 1, 2017 - Present

Rows in yellow indicate CARCs that have been deactivated in CY2017 or CY2018 but kept in this list to account for claims processing lag.

CARC	CARC Description
182	Procedure modifier was invalid on the date of service.
183	The referring provider is not eligible to refer the service billed.
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.
185	The rendering provider is not eligible to perform the service billed.
186	Level of care change adjustment.
187	Consumer Spending Account payments.
188	This product/procedure is only covered when used according to FDA recommendations.
189	Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service.
190	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.
192	Non standard adjustment code from paper remittance.
193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
194	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician.
195	Refund issued to an erroneous priority payer for this claim/service.
197	Precertification/authorization/notification absent.
198	Precertification/authorization exceeded.
199	Revenue code and Procedure code do not match.
200	Expenses incurred during lapse in coverage
201	Patient is responsible for amount of this claim/service through 'set aside arrangement' or other agreement.
202	Non-covered personal comfort or convenience services.
203	Discontinued or reduced service.
204	This service/equipment/drug is not covered under the patient’s current benefit plan
205	Pharmacy discount card processing fee
206	National Provider Identifier - missing.
207	National Provider identifier - Invalid format
208	National Provider Identifier - Not matched.
209	Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected.
210	Payment adjusted because pre-certification/authorization not received in a timely fashion
211	National Drug Codes (NDC) not eligible for rebate, are not covered.
212	Administrative surcharges are not covered
213	Non-compliance with the physician self referral prohibition legislation or payer policy.
215	Based on subrogation of a third party settlement
216	Based on the findings of a review organization
219	Based on extent of injury.
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific.
223	Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created.
224	Patient identification compromised by identity theft. Identity verification required for processing this and future claims.
225	Penalty or Interest Payment by Payer
226	Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. At least one Remark Code must be provided.
227	Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided.
228	Denied for failure of this provider, another provider or the subscriber to supply requested information to a previous payer for their adjudication
229	Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12X.
231	Mutually exclusive procedures cannot be done in the same day/setting. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
232	Institutional Transfer Amount.
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.
234	This procedure is not paid separately. At least one Remark Code must be provided.
235	Sales Tax
236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements.
237	Legislated/Regulatory Penalty. At least one Remark Code must be provided.
238	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period.
239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims.
240	The diagnosis is inconsistent with the patient's birth weight.
241	Low Income Subsidy (LIS) Co-payment Amount
242	Services not provided by network/primary care providers.
243	Services not authorized by network/primary care providers.
245	Provider performance program withhold.
246	This non-payable code is for required reporting only.
247	Deductible for Professional service rendered in an Institutional setting and billed on an Institutional claim.
248	Coinsurance for Professional service rendered in an Institutional setting and billed on an Institutional claim.
249	This claim has been identified as a readmission.
250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing.
251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim.

APPENDIX B

List of All Claim Adjustment Reason Codes (CARCs)

Active Codes January 1, 2017 - Present

Rows in yellow indicate CARCs that have been deactivated in CY2017 or CY2018 but kept in this list to account for claims processing lag.

CARC	CARC Description
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided.
253	Sequestration - reduction in federal payment
254	Claim received by the dental plan, but benefits not available under this plan. Submit these services to the patient's medical plan for further consideration.
256	Service not payable per managed care contract.
257	The disposition of the claim/service is undetermined during the premium payment grace period, per Health Insurance Exchange requirements. This claim/service will be reversed and corrected when the grace period ends (due to premium payment or lack of premium payment).
258	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.
259	Additional payment for Dental/Vision service utilization.
260	Processed under Medicaid ACA Enhanced Fee Schedule
261	The procedure or service is inconsistent with the patient's history.
262	Adjustment for delivery cost. Note: To be used for pharmaceuticals only.
263	Adjustment for shipping cost. Note: To be used for pharmaceuticals only.
264	Adjustment for postage cost. Note: To be used for pharmaceuticals only.
265	Adjustment for administrative cost. Note: To be used for pharmaceuticals only.
266	Adjustment for compound preparation cost. Note: To be used for pharmaceuticals only.
267	Claim/service spans multiple months. At least one Remark Code must be provided.
268	The Claim spans two calendar years. Please resubmit one claim per calendar year.
269	Anesthesia not covered for this service/procedure.
270	Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient’s dental plan for further consideration.
271	Prior contractual reductions related to a current periodic payment as part of a contractual payment schedule when deferred amounts have been previously reported.
272	Coverage/program guidelines were not met.
273	Coverage/program guidelines were exceeded.
274	Fee/Service not payable per patient Care Coordination arrangement.
275	Prior payer's (or payers') patient responsibility (deductible, coinsurance, co-payment) not covered.
276	Services denied by the prior payer(s) are not covered by this payer.
277	The disposition of the claim/service is undetermined during the premium payment grace period, per Health Insurance SHOP Exchange requirements. This claim/service will be reversed and corrected when the grace period ends (due to premium payment or lack of premium payment).
278	Performance program proficiency requirements not met. (Use only with Group Codes CO or PI)
279	Services not provided by Preferred network providers. Usage: Use this code when there are member network limitations.
280	Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient's Pharmacy plan for further consideration.
281	Deductible waived per contractual agreement.
282	The procedure/revenue code is inconsistent with the type of bill.
283	Attending provider is not eligible to provide direction of care.
284	Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the billed services.
285	Appeal procedures not followed
286	Appeal time limits not met
287	Referral exceeded
288	Referral absent
289	Services considered under the dental and medical plans, benefits not available.
290	Claim received by the dental plan, but benefits not available under this plan. Claim has been forwarded to the patient's medical plan for further consideration.
291	Claim received by the medical plan, but benefits not available under this plan. Claim has been forwarded to the patient's dental plan for further consideration.
292	Claim received by the medical plan, but benefits not available under this plan. Claim has been forwarded to the patient's pharmacy plan for further consideration.
293	Payment made to employer.
294	Payment made to attorney.
295	Pharmacy Direct/Indirect Remuneration (DIR)
296	Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the provider.
A0	Patient refund amount.
A1	Claim/Service denied. At least one Remark Code must be provided.
A5	Medicare Claim PPS Capital Cost Outlier Amount.
A6	Prior hospitalization or 30 day transfer requirement not met.
A8	Ungroupable DRG.
B1	Non-covered visits.
B4	Late filing penalty.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.
B8	Alternative services were available, and should have been utilized.
B9	Patient is enrolled in a Hospice.
B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.
B12	Services not documented in patients' medical records.
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.
B14	Only one visit or consultation per physician per day is covered.
B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.
B16	'New Patient' qualifications were not met.

APPENDIX B

List of All Claim Adjustment Reason Codes (CARCs)

Active Codes January 1, 2017 - Present

Rows in yellow indicate CARCs that have been deactivated in CY2017 or CY2018 but kept in this list to account for claims processing lag.

CARC	CARC Description
B20	Procedure/service was partially or fully furnished by another provider.
B22	This payment is adjusted based on the diagnosis.
B23	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test.
P1	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation. To be used for Property and Casualty only.
P2	Not a work related injury/illness and thus not the liability of the workers' compensation carrier. To be used for Workers' Compensation only.
P3	Workers' Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. To be used for Workers' Compensation only.
P4	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment.
P5	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. To be used for Property and Casualty only.
P6	Based on entitlement to benefits. To be used for Property and Casualty only.
P7	The applicable fee schedule/fee database does not contain the billed code. To be used for Property and Casualty only.
P8	Claim is under investigation. To be used for Property and Casualty only.
P9	No available or correlating CPT/HCPCS code to describe this service. To be used for Property and Casualty only.
P10	Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation. To be used for Property and Casualty only.
P11	The disposition of the related Property & Casualty claim (injury or illness) is pending due to litigation. To be used for Property and Casualty only.
P12	Workers' compensation jurisdictional fee schedule adjustment. To be used for Workers' Compensation only.
P13	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable. To be used for Workers' Compensation only.
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. To be used for Property and Casualty only.
P15	Workers' Compensation Medical Treatment Guideline Adjustment. To be used for Workers' Compensation only.
P16	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. To be used for Workers' Compensation only.
P17	Referral not authorized by attending physician per regulatory requirement. To be used for Property and Casualty only.
P18	Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service. To be used for Property and Casualty only.
P19	Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due. To be used for Property and Casualty only.
P20	Service not paid under jurisdiction allowed outpatient facility fee schedule. To be used for Property and Casualty only.
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. To be used for Property and Casualty Auto only.
P22	Payment adjusted based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. . To be used for Property and Casualty Auto only.
P23	Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional fee schedule adjustment. To be used for Property and Casualty Auto only.
P24	Payment adjusted based on Preferred Provider Organization (PPO). To be used for Property and Casualty only.
P25	Payment adjusted based on Medical Provider Network (MPN). To be used for Property and Casualty only. (Use only with Group Code CO).
P26	Payment adjusted based on Voluntary Provider network (VPN). To be used for Property and Casualty only. (Use only with Group Code CO).
P27	Payment denied based on the Liability Coverage Benefits jurisdictional regulations and/or payment policies. To be used for Property and Casualty Auto only.
P28	Payment adjusted based on the Liability Coverage Benefits jurisdictional regulations and/or payment policies. To be used for Property and Casualty Auto only.
P29	Liability Benefits jurisdictional fee schedule adjustment. To be used for Property and Casualty Auto only.

APPENDIX C

List of All National Council for Prescription Drug Programs (NCPDP) Reject Codes

NCPDP Code	Description
Ø1	M/I Bin Number
Ø2	M/I Version/Release Number
Ø3	M/I Transaction Code
Ø4	M/I Processor Control Number
Ø5	M/I Service Provider Number
Ø6	M/I Group ID
Ø7	M/I Cardholder ID
Ø8	M/I Person Code
Ø9	M/I Date Of Birth
1Ø	M/I Patient Gender Code
11	M/I Patient Relationship Code
12	M/I Place of Service
13	M/I Other Coverage Code
14	M/I Eligibility Clarification Code
15	M/I Date of Service
16	M/I Prescription/Service Reference Number
17	M/I Fill Number
19	M/I Days Supply
1W	Multi-Ingredient Compound Must Be A Single Transaction
1Y	Claim Segment Required For Adjudication
1Z	Clinical Segment Required For Adjudication
2C	M/I Pregnancy Indicator
2D	M/I Provider Accept Assignment Indicator
2E	M/I Primary Care Provider ID Qualifier
2G	M/I Compound Ingredient Modifier Code Count
2H	M/I Compound Ingredient Modifier Code
2J	M/I Prescriber First Name
2K	M/I Prescriber Street Address
2M	M/I Prescriber City Address
2N	M/I Prescriber State/Province Address
2P	M/I Prescriber Zip/Postal Zone
2Ø	M/I Compound Code
21	M/I Product/Service ID
22	M/I Dispense As Written (DAW)/Product Selection Code
23	M/I Ingredient Cost Submitted
25	M/I Prescriber ID
26	M/I Unit Of Measure
27	Product Identifier not FDA/NSDE Listed
28	M/I Date Prescription Written
29	M/I Number Of Refills Authorized
31	No matching paid claim found for reversal request.
32	M/I Level Of Service
33	M/I Prescription Origin Code
34	M/I Submission Clarification Code
35	M/I Primary Care Provider ID
39	M/I Diagnosis Code
4S	Compound Product ID Requires a Modifier Code
4X	M/I Patient Residence
4Y	Patient Residence Value Not Supported
4Z	Place of Service Not Supported By Plan
4Ø	Pharmacy Not Contracted With Plan On Date Of Service
41	Submit Bill To Other Processor Or Primary Payer
42	Plan's Prescriber data base indicates the Prescriber ID Submitted is inactive or expired
43	Plan's Prescriber data base indicates the associated DEA to submitted Prescriber ID is inactive
44	Plan's Prescriber data base indicates the associated DEA to submitted Prescriber ID Is not found
46	Plan's Prescriber data base indicates associated DEA to submitted Prescriber ID does not allow this drug DEA Schedule
5C	M/I Other Payer Coverage Type
5E	M/I Other Payer Reject Count
5J	M/I Facility City Address

APPENDIX C
List of All National Council for Prescription Drug Programs (NCPDP) Reject Codes

NCPDP Code	Description
5Ø	Non-Matched Pharmacy Number
51	Non-Matched Group ID
52	Non-Matched Cardholder ID
53	Non-Matched Person Code
54	Non-Matched Product/Service ID Number
55	Non-Matched Product Package Size
56	Non-Matched Prescriber ID
58	Non-Matched Primary Prescriber
6C	M/I Other Payer ID Qualifier
6D	M/I Facility Zip/Postal Zone
6E	M/I Other Payer Reject Code
6G	Coordination Of Benefits/Other Payments Segment Required For Adjudication
6J	Insurance Segment Required For Adjudication
6K	Patient Segment Required For Adjudication
6M	Pharmacy Provider Segment Required For Adjudication
6N	Prescriber Segment Required For Adjudication
6P	Pricing Segment Required For Adjudication
6Q	Prior Authorization Segment Required For Adjudication
6S	Transaction Segment Required For Adjudication
6T	Compound Segment Required For Adjudication
6U	Compound Segment Incorrectly Formatted
6V	Multi-ingredient Compounds Not Supported,
6W	DUR/PPS Segment Required For Adjudication
6X	DUR/PPS Segment Incorrectly Formatted
6Z	Provider Not Eligible To Perform Service/Dispense Product
6Ø	Product/Service Not Covered For Patient Age
61	Product/Service Not Covered For Patient Gender
62	Patient/Card Holder ID Name Mismatch
63	Product/Service ID Not Covered For Institutionalized Patient
64	Claim Submitted Does Not Match Prior Authorization
65	Patient Is Not Covered
66	Patient Age Exceeds Maximum Age
67	Filled Before Coverage Effective
68	Filled After Coverage Expired
69	Filled After Coverage Terminated
7A	Provider Does Not Match Authorization On File
7B	Service Provider ID Qualifier Value Not Supported For Processor/Payer
7C	M/I Other Payer ID
7D	Non-Matched DOB
7G	Future Date Not Allowed For DOB
7H	Non-Matched Gender Code
7J	Patient Relationship Code Value Not Supported
7K	Discrepancy Between Other Coverage Code And Other Payer Amount
7M	Discrepancy Between Other Coverage Code And Other Coverage Information On File
7N	Patient ID Qualifier Value Not Supported
7P	Coordination Of Benefits/Other Payments Count Exceeds Number of Supported Payers
7Q	Other Payer ID Qualifier Value Not Supported
7R	Other Payer Amount Paid Count Exceeds Number of Supported Groupings
7V	Duplicate Refills,
7W	Refills Exceed allowable Refills
7X	Days Supply Exceeds Plan Limitation
7Y	Compounds Not Covered,
7Z	Compound Requires Two Or More Ingredients,
7Ø	Product/Service Not Covered – Plan/Benefit Exclusion
71	Prescriber ID Is Not Covered
72	Primary Prescriber Is Not Covered
73	Refills Are Not Covered
74	Other Carrier Payment Meets Or Exceeds Payable
75	Prior Authorization Required

APPENDIX C
List of All National Council for Prescription Drug Programs (NCPDP) Reject Codes

NCPDP Code	Description
76	Plan Limitations Exceeded
77	Discontinued Product/Service ID Number
78	Cost Exceeds Maximum
79	Refill Too Soon
8A	Compound Requires At Least One Covered Ingredient
8B	Compound Segment Missing On A Compound Claim
8C	M/I Facility ID
8D	Compound Segment Present On A Non- Compound Claim
8E	M/I DUR/PPS Level Of Effort
8G	Product/Service ID (4Ø7-D7) Must Be A Single Zero "Ø" For Compounds
8H	Product/Service Only Covered On Compound Claim
8J	Incorrect Product/Service ID For Processor/Payer
8K	DAW Code Value Not Supported
8M	Sum Of Compound Ingredient Costs Does Not Equal Ingredient Cost Submitted
8N	Future Date Prescription Written Not Allowed,
8P	Date Written Different On Previous Filling
8Q	Excessive Refills Authorized
8R	Submission Clarification Code Value Not Supported
8S	Basis Of Cost Determination Value Not Supported
8T	U&C Must Be Greater Than Zero
8U	GAD Must Be Greater Than Zero
8W	Discrepancy Between Other Coverage Code and Other Payer Amount Paid
8X	Collection From Cardholder Not Allowed
8Y	Excessive Amount Collected
8Z	Product/Service ID Qualifier Value Not Supported
8Ø	Drug-Diagnosis Mismatch
81	Claim Too Old
82	Claim Is Post-Dated
83	Duplicate Paid/Captured Claim
84	Claim Has Not Been Paid/Captured
85	Claim Not Processed
86	Submit Manual Reversal
87	Reversal Not Processed
88	DUR Reject Error
89	Rejected Claim Fees Paid
9B	Reason For Service Code Value Not Supported
9C	Professional Service Code Value Not Supported
9D	Result Of Service Code Value Not Supported
9E	Quantity Does Not Match Dispensing Unit
9G	Quantity Dispensed Exceeds Maximum Allowed
9H	Quantity Not Valid For Product/Service ID Submitted
9J	Future Other Payer Date Not Allowed
9K	Compound Ingredient Component Count Exceeds Number Of Ingredients Supported
9M	Minimum Of Two Ingredients Required
9N	Compound Ingredient Quantity Exceeds Maximum Allowed
9Q	Route Of Administration Submitted Not Covered
9R	Prescription/Service Reference Number Qualifier Submitted Not Covered
9T	Prior Authorization Type Code Submitted Not Covered
9U	Provider ID Qualifier Submitted Not Covered
9V	Prescriber ID Qualifier Submitted Not Covered
9W	DUR/PPS Code Counter Exceeds Number Of Occurrences Supported
9Y	Compound Product ID Qualifier Submitted Not Covered
9Z	Duplicate Product ID In Compound
AB	Date Written Is After Date Filled
AC	Product Not Covered Non-Participating Manufacturer
AD	Billing Provider Not Eligible To Bill This Claim Type
AE	QMB (Qualified Medicare Beneficiary)- Bill Medicare
AF	Patient Enrolled Under Managed Care
AG	Days Supply Limitation For Product/Service

APPENDIX C
List of All National Council for Prescription Drug Programs (NCPDP) Reject Codes

NCPDP Code	Description
AH	Unit Dose Packaging Only Payable For Nursing Home Recipients
AJ	Generic Drug Required
AK	M/I Software Vendor/Certification ID
AM	M/I Segment Identification
AQ	M/I Facility Segment
A1	ID Submitted is associated with a Sanctioned Prescriber
A2	ID Submitted is associated to a Deceased Prescriber
A3	This Product May Be Covered Under Hospice – Medicare A
A4	This Product May Be Covered Under The Medicare- B Bundled Payment To An ESRD Dialysis Facility
A5	Not Covered Under Part D Law
A6	This Product/Service May Be Covered Under Medicare Part B
A7	M/I Internal Control Number
A9	M/I Transaction Count
BA	Compound Basis of Cost Determination Submitted Not Covered
BB	Diagnosis Code Qualifier Submitted Not Covered
BC	Future Measurement Date Not Allowed
BE	M/I Professional Service Fee Submitted
B2	M/I Service Provider ID Qualifier
CA	M/I Patient First Name
CB	M/I Patient Last Name
CC	M/I Cardholder First Name
CD	M/I Cardholder Last Name
CM	M/I Patient Street Address
CN	M/I Patient City Address
CO	M/I Patient State/Province Address
CP	M/I Patient Zip/Postal Zone
CQ	M/I Patient Phone Number
CR	M/I Carrier ID
CW	M/I Alternate ID
CX	M/I Patient ID Qualifier
CY	M/I Patient ID
CZ	M/I Employer ID
DC	M/I Dispensing Fee Submitted
DN	M/I Basis Of Cost Determination
DQ	M/I Usual And Customary Charge
DR	M/I Prescriber Last Name
DT	M/I Special Packaging Indicator
DU	M/I Gross Amount Due
DV	M/I Other Payer Amount Paid
DX	M/I Patient Paid Amount Submitted
DY	M/I Date Of Injury
DZ	M/I Claim/Reference ID
EA	M/I Originally Prescribed Product/Service Code
EB	M/I Originally Prescribed Quantity
EC	M/I Compound Ingredient Component Count
ED	M/I Compound Ingredient Quantity
EE	M/I Compound Ingredient Drug Cost
EF	M/I Compound Dosage Form Description Code
EG	M/I Compound Dispensing Unit Form Indicator
EJ	M/I Originally Prescribed Product/Service ID Qualifier
EK	M/I Scheduled Prescription ID Number
EM	M/I Prescription/Service Reference Number Qualifier
EN	M/I Associated Prescription/Service Reference Number
EP	M/I Associated Prescription/Service Date
ER	M/I Procedure Modifier Code
ET	M/I Quantity Prescribed
EU	M/I Prior Authorization Type Code
EV	M/I Prior Authorization Number Submitted
EY	M/I Provider ID Qualifier

APPENDIX C
List of All National Council for Prescription Drug Programs (NCPDP) Reject Codes

NCPDP Code	Description
EZ	M/I Prescriber ID Qualifier
E1	M/I Product/Service ID Qualifier
E2	M/I Route of Administration
E3	M/I Incentive Amount Submitted
E4	M/I Reason For Service Code
E5	M/I Professional Service Code
E6	M/I Result Of Service Code
E7	M/I Quantity Dispensed
E8	M/I Other Payer Date
E9	M/I Provider ID
FO	M/I Plan ID
GE	M/I Percentage Sales Tax Amount Submitted
G1	M/I Compound Type
G4	Physician must contact plan
G5	Pharmacist must contact plan
G6	Pharmacy Not Contracted in Specialty Network
G7	Pharmacy Not Contracted in Home Infusion Network
G8	Pharmacy Not Contracted in Long Term Care Network
G9	Pharmacy Not Contracted in 9Ø Day Retail Network (this message would be used when the pharmacy is not contracted to provide a 9Ø days supply of drugs)
HA	M/I Flat Sales Tax Amount Submitted
HB	M/I Other Payer Amount Paid Count
HC	M/I Other Payer Amount Paid Qualifier
HD	M/I Dispensing Status
HE	M/I Percentage Sales Tax Rate Submitted
H6	M/I DUR Co-Agent ID
H7	M/I Other Amount Claimed Submitted Count
H8	M/I Other Amount Claimed Submitted Qualifier
H9	M/I Other Amount Claimed Submitted
JE	M/I Percentage Sales Tax Basis Submitted
M1	Patient Not Covered In This Aid Category
M2	Recipient Locked In
M4	Prescription/Service Reference Number/Time Limit Exceeded
MG	M/I Other Payer BIN Number
MH	M/I Other Payer Processor Control Number
MJ	M/I Other Payer Group ID
MK	Non-Matched Other Payer BIN Number
MM	Non-Matched Other Payer Processor Control Number
MN	Non-Matched Other Payer Group ID
MP	Other Payer Cardholder ID Not Covered
MR	Product Not On Formulary
MT	M/I Patient Assignment Indicator (Direct Member Reimbursement Indicator)
NN	Transaction Rejected At Switch Or Intermediary
NP	M/I Other Payer- Patient Responsibility Amount Qualifier
NQ	M/I Other Payer- Patient Responsibility Amount
NR	M/I Other Payer- Patient Responsibility Amount Count
NU	M/I Other Payer Cardholder ID
NV	M/I Delay Reason Code
NX	M/I Submission Clarification Code Count
N1	No patient match found.
N3	M/I Medicaid Paid Amount
N4	M/I Medicaid Subrogation Internal Control Number/Transaction Control Number (ICN/TCN)
N5	M/I Medicaid ID Number
N7	Use Prior Authorization Code Provided During Transition Period
N8	Use Prior Authorization Code Provided For Emergency Fill
N9	Use Prior Authorization Code Provided For Level of Care Change
PA	PA Exhausted/Not Renewable
PY	Non-Matched Unit Form/Route of Administration
PZ	Non-Matched Unit Of Measure To Product/Service ID

APPENDIX C
List of All National Council for Prescription Drug Programs (NCPDP) Reject Codes

NCPDP Code	Description
PØ	Non-zero Value Required for Vaccine Administration
P3	Compound Ingredient Component Count Does Not Match Number Of Repetitions
P4	Coordination Of Benefits/Other Payments Count Does Not Match Number Of Repetitions
P6	Date Of Service Prior To Date Of Birth
RE	M/I Compound Product ID Qualifier
RK	Partial Fill Transaction Not Supported
RV	Multiple Reversals Per Transmission Not Supported
RØ	Professional Service Code of "MA" required for Vaccine Incentive Fee Submitted
SF	Other Payer Amount Paid Count Does Not Match Number Of Repetitions
SG	Submission Clarification Code Count Does Not Match Number of Repetitions
SH	Other Payer-Patient Responsibility Amount Count Does Not Match Number of Repetitions
TE	Missing/Invalid Compound Product ID
TN	Emergency Fill/Resubmit Claim
TP	Level of Care Change/Resubmit Claim
TQ	Dosage Exceeds Product Labeling Limit
TR	M/I Billing Entity Type Indicator
TS	M/I Pay To Qualifier
TT	M/I Pay To ID
TU	M/I Pay To Name
TV	M/I Pay To Street Address
TW	M/I Pay To City Address
TX	M/I Pay to State/ Province Address
TY	M/I Pay To Zip/Postal Zone
TZ	M/I Generic Equivalent Product ID Qualifier
UA	M/I Generic Equivalent Product ID
UE	M/I Compound Ingredient Basis Of Cost Determination
UU	DAW Ø cannot be submitted on a multi- source drug with available generics.
U7	M/I Pharmacy Service Type
VA	Pay To Qualifier Value Not Supported
VB	Generic Equivalent Product ID Qualifier Value Not Supported
VC	Pharmacy Service Type Value Not Supported
VE	M/I Diagnosis Code Count
WE	M/I Diagnosis Code Qualifier
X8	Procedure Modifier Code Count Exceeds Number Of Occurrences Supported
X9	Diagnosis Code Count Exceeds Number Of Occurrences Supported
YA	Compound Ingredient Modifier Code Count Exceeds Number Of Occurrences Supported
YB	Other Amount Claimed Submitted Count Exceeds Number Of Occurrences Supported
YC	Other Payer Reject Count Exceeds Number Of Occurrences Supported
YD	Other Payer-Patient Responsibility Amount Count Exceeds Number Of Occurrences Supported
YE	Submission Clarification Code Count Exceeds Number of Occurrences Supported
YJ	Medicaid Agency Number Not Supported
YK	M/I Service Provider Name
YM	M/I Service Provider Street Address
YN	M/I Service Provider City Address
YP	M/I Service Provider State/Province Code Address
YQ	M/I Service Provider Zip/Postal Code
Z1	Prescriber Alternate ID Qualifier Value Not Supported
Z5	M/I Service Provider Segment
Z9	Prescriber Alternate ID Not Covered
ZA	The Coordination of Benefits/Other Payments Segment is mandatory to a downstream payer.
ZK	M/I Prescriber ID Associated State/Province Address
ZW	M/I Compound Preparation Time
ZZ	Cardholder ID submitted is inactive. New Cardholder ID on file.

APPENDIX D

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

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

	Number Accepted	Number Rejected	Accepted	Rejected
All MCOs Q4 2018	22,700,731	261,998	98.9%	1.1%
All MCOs Q1 2019	24,346,873	278,890	98.9%	1.1%
All MCOs Q2 2019	23,127,128	301,498	98.7%	1.3%
All MCOs Q3 2019	22,855,193	315,751	98.6%	1.4%
Aetna Q4 2018	1,159,476	3,253	99.7%	0.3%
Aetna Q1 2019	2,218,090	4,002	99.8%	0.2%
Aetna Q2 2019	2,069,910	2,735	99.9%	0.1%
Aetna Q3 2019	2,002,309	5,810	99.7%	0.3%
ACLA Q4 2018	3,115,973	4,930	99.8%	0.2%
ACLA Q1 2019	3,238,589	1,983	99.9%	0.1%
ACLA Q2 2019	3,033,232	2,683	99.9%	0.1%
ACLA Q3 2019	2,993,578	2,306	99.9%	0.1%
Healthy Blue Q4 2018	4,486,556	2,922	99.9%	0.1%
Healthy Blue Q1 2019	4,747,539	2,339	100.0%	0.0%
Healthy Blue Q2 2019	4,505,954	641	100.0%	0.0%
Healthy Blue Q3 2019	4,470,191	626	100.0%	0.0%
LHCC Q4 2018	6,696,215	219,329	96.8%	3.2%
LHCC Q1 2019	6,804,623	238,836	96.6%	3.4%
LHCC Q2 2019	6,394,468	240,323	96.4%	3.6%
LHCC Q3 2019	6,491,273	236,531	96.5%	3.5%
UHC Q4 2018	7,242,511	31,564	99.6%	0.4%
UHC Q1 2019	7,338,032	31,730	99.6%	0.4%
UHC Q2 2019	7,123,564	55,116	99.2%	0.8%
UHC Q3 2019	6,897,842	70,478	99.0%	1.0%

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

	Number Paid	Number Denied	Paid	Denied
All MCOs Q4 2018	18,630,400	4,179,312	81.7%	18.3%
All MCOs Q1 2019	19,604,277	4,709,822	80.6%	19.4%
All MCOs Q2 2019	18,741,158	4,329,810	81.2%	18.8%
All MCOs Q3 2019	18,581,361	4,208,246	81.5%	18.5%
Aetna Q4 2018	974,611	185,711	84.0%	16.0%
Aetna Q1 2019	1,642,751	577,057	74.0%	26.0%
Aetna Q2 2019	1,602,818	467,374	77.4%	22.6%
Aetna Q3 2019	1,555,180	447,275	77.7%	22.3%
ACLA Q4 2018	2,477,408	632,305	79.7%	20.3%
ACLA Q1 2019	2,562,954	673,042	79.2%	20.8%
ACLA Q2 2019	2,417,664	600,211	80.1%	19.9%
ACLA Q3 2019	2,502,015	548,050	82.0%	18.0%
Healthy Blue Q4 2018	3,481,783	974,706	78.1%	21.9%
Healthy Blue Q1 2019	3,724,389	1,059,786	77.8%	22.2%
Healthy Blue Q2 2019	3,501,429	977,115	78.2%	21.8%
Healthy Blue Q3 2019	3,589,794	870,672	80.5%	19.5%
LHCC Q4 2018	5,634,122	1,159,633	82.9%	17.1%
LHCC Q1 2019	5,643,477	1,147,757	83.1%	16.9%
LHCC Q2 2019	5,371,425	1,038,523	83.8%	16.2%
LHCC Q3 2019	5,261,521	1,100,220	82.7%	17.3%
UHC Q4 2018	6,062,476	1,226,957	83.2%	16.8%
UHC Q1 2019	6,030,706	1,252,180	82.8%	17.2%
UHC Q2 2019	5,847,822	1,246,587	82.4%	17.6%
UHC Q3 2019	5,672,851	1,242,029	82.0%	18.0%

Exhibit III.3A
Claim Status for Adjudicated Claims
Institutional Providers
For All MCOs Combined By Quarter

	Number Paid	Number Denied	Paid	Denied
Inpatient Hospital Q4 2018	45,395	12,409	78.5%	21.5%
Inpatient Hospital Q1 2019	48,297	13,991	77.5%	22.5%
Inpatient Hospital Q2 2019	41,955	12,428	77.1%	22.9%
Inpatient Hospital Q3 2019	50,536	13,375	79.1%	20.9%
Outpatient Hospital Q4 2018	4,366,507	462,266	90.4%	9.6%
Outpatient Hospital Q1 2019	4,594,832	544,293	89.4%	10.6%
Outpatient Hospital Q2 2019	4,522,360	444,264	91.1%	8.9%
Outpatient Hospital Q3 2019	4,422,934	416,168	91.4%	8.6%
Home Health Q4 2018	26,909	6,079	81.6%	18.4%
Home Health Q1 2019	29,564	7,334	80.1%	19.9%
Home Health Q2 2019	29,182	5,623	83.8%	16.2%
Home Health Q3 2019	32,284	4,212	88.5%	11.5%
Other Institutional Q4 2018	48,260	9,496	83.6%	16.4%
Other Institutional Q1 2019	43,809	7,922	84.7%	15.3%
Other Institutional Q2 2019	51,471	7,700	87.0%	13.0%

Exhibit III.3B
Claim Status for Adjudicated Claims
Professional Service Providers
For All MCOs Combined By Quarter

	Number Paid	Number Denied	Paid	Denied
Primary Care Q4 2018	1,823,520	216,492	89.4%	10.6%
Primary Care Q1 2019	2,094,582	305,067	87.3%	12.7%
Primary Care Q2 2019	2,044,090	295,057	87.4%	12.6%
Primary Care Q3 2019	2,044,035	322,337	86.4%	13.6%
Pediatrics Q4 2018	819,032	84,654	90.6%	9.4%
Pediatrics Q1 2019	879,859	104,011	89.4%	10.6%
Pediatrics Q2 2019	755,624	91,520	89.2%	10.8%
Pediatrics Q3 2019	783,908	101,339	88.6%	11.4%
OB-GYN Q4 2018	210,546	26,466	88.8%	11.2%
OB-GYN Q1 2019	231,181	33,808	87.2%	12.8%
OB-GYN Q2 2019	261,116	32,884	88.8%	11.2%
OB-GYN Q3 2019	278,624	33,427	89.3%	10.7%
Therapists (PT/OT/ST) Q4 2018	54,036	8,766	86.0%	14.0%
Therapists (PT/OT/ST) Q1 2019	54,176	7,561	87.8%	12.2%
Therapists (PT/OT/ST) Q2 2019	58,299	10,452	84.8%	15.2%
Therapists (PT/OT/ST) Q3 2019	61,330	11,082	84.7%	15.3%
Non-Emerg Transport Q4 2018	288,150	12,837	95.7%	4.3%
Non-Emerg Transport Q1 2019	297,704	12,542	96.0%	4.0%
Non-Emerg Transport Q2 2019	279,451	18,218	93.9%	6.1%
Non-Emerg Transport Q3 2019	272,931	9,797	96.5%	3.5%
Medical Equipment/Supplies Q4 2018	121,839	21,673	84.9%	15.1%
Medical Equipment/Supplies Q1 2019	108,389	21,816	83.2%	16.8%
Medical Equipment/Supplies Q2 2019	112,185	21,593	83.9%	16.1%
Medical Equipment/Supplies Q3 2019	108,339	19,648	84.6%	15.4%
All Other Professional Q4 2018	4,276,805	1,143,870	78.9%	21.1%
All Other Professional Q1 2019	4,587,537	1,243,049	78.7%	21.3%
All Other Professional Q2 2019	4,212,820	1,138,226	78.7%	21.3%
All Other Professional Q3 2019	3,942,368	1,072,310	78.6%	21.4%

Exhibit III.3C
Claim Status for Adjudicated Claims
Behavioral Health, Dental and Pharmacy
For All MCOs Combined By Quarter

	Number Paid	Number Denied	Paid	Denied
Mental/Behavioral Rehab Q4 2018	463,010	79,952	85.3%	14.7%
Mental/Behavioral Rehab Q1 2019	400,034	76,287	84.0%	16.0%
Mental/Behavioral Rehab Q2 2019	313,079	87,652	78.1%	21.9%
Mental/Behavioral Rehab Q3 2019	258,543	44,784	85.2%	14.8%
Mental/Behavioral Other Q4 2018	443,737	86,587	83.7%	16.3%
Mental/Behavioral Other Q1 2019	565,416	99,097	85.1%	14.9%
Mental/Behavioral Other Q2 2019	566,288	113,566	83.3%	16.7%
Mental/Behavioral Other Q3 2019	537,164	146,042	78.6%	21.4%
Dental - Children Q4 2018	7,322	2,972	71.1%	28.9%
Dental - Children Q1 2019	6,936	2,912	70.4%	29.6%
Dental - Children Q2 2019	6,974	2,522	73.4%	26.6%
Dental - Children Q3 2019	6,164	2,720	69.4%	30.6%
Dental - Adults Q4 2018	463,010	79,952	85.3%	14.7%
Dental - Adults Q1 2019	400,034	76,287	84.0%	16.0%
Dental - Adults Q2 2019	313,079	87,652	78.1%	21.9%
Dental - Adults Q3 2019	258,543	44,784	85.2%	14.8%
Pharmacy Q4 2018	5,548,338	1,991,023	73.6%	26.4%
Pharmacy Q1 2019	5,576,105	2,204,190	71.7%	28.3%
Pharmacy Q2 2019	5,380,893	2,039,925	72.5%	27.5%
Pharmacy Q3 2019	5,639,525	1,997,621	73.8%	26.2%

Exhibit III.4A
Claim Status for Adjudicated Claims
By Provider Specialty - Institutional Providers
For All MCOs for Q3 2019, for Adjudicated Claims

Inpatient	Q3 2019			
	Number Paid	Number Denied	Paid	Denied
All MCOs	50,536	13,375	79.1%	20.9%
Aetna	5,668	942	85.7%	14.3%
ACLA	7,312	1,879	79.6%	20.4%
Healthy Blue	9,037	3,931	69.7%	30.3%
LHCC	15,340	2,737	84.9%	15.1%
UHC	13,179	3,886	77.2%	22.8%

Outpatient	Q3 2019			
	Number Paid	Number Denied	Paid	Denied
All MCOs	4,422,934	416,168	91.4%	8.6%
Aetna	414,645	30,019	93.2%	6.8%
ACLA	644,459	55,972	92.0%	8.0%
Healthy Blue	840,395	83,391	91.0%	9.0%
LHCC	1,225,727	144,999	89.4%	10.6%
UHC	1,297,708	101,787	92.7%	7.3%

Home Health	Q3 2019			
	Number Paid	Number Denied	Paid	Denied
All MCOs	32,284	4,212	88.5%	11.5%
Aetna	2,644	344	88.5%	11.5%
ACLA	5,174	566	90.1%	9.9%
Healthy Blue	3,922	446	89.8%	10.2%
LHCC	19,787	2,687	88.0%	12.0%
UHC	757	169	81.7%	18.3%

Other Institutional Providers	Q3 2019			
	Number Paid	Number Denied	Paid	Denied
All MCOs	3,942,368	1,072,310	78.6%	21.4%
Aetna	302,811	150,949	66.7%	33.3%
ACLA	613,006	197,485	75.6%	24.4%
Healthy Blue	741,993	190,685	79.6%	20.4%
LHCC	1,118,839	288,319	79.5%	20.5%
UHC	1,165,719	244,872	82.6%	17.4%

Exhibit III.4B
Claim Status for Adjudicated Claims
By Provider Specialty - Professional Service Providers
For All MCOs for Q3 2019, for Adjudicated Claims

Primary Care	**Q3 2019**			
	Number Paid	**Number Denied**	**Paid**	**Denied**
All MCOs	2,044,035	322,337	86.4%	13.6%
Aetna	154,685	75,085	67.3%	32.7%
ACLA	136,944	14,918	90.2%	9.8%
Healthy Blue	369,828	60,865	85.9%	14.1%
LHCC	661,883	93,552	87.6%	12.4%
UHC	720,695	77,917	90.2%	9.8%

Pediatrics	**Q3 2019**			
	Number Paid	**Number Denied**	**Paid**	**Denied**
All MCOs	783,908	101,339	88.6%	11.4%
Aetna	50,237	24,375	67.3%	32.7%
ACLA	123,919	9,265	93.0%	7.0%
Healthy Blue	181,127	20,741	89.7%	10.3%
LHCC	295,739	31,274	90.4%	9.6%
UHC	132,886	15,684	89.4%	10.6%

OB-GYN	**Q3 2019**			
	Number Paid	**Number Denied**	**Paid**	**Denied**
All MCOs	278,624	33,427	89.3%	10.7%
Aetna	24,287	7,714	75.9%	24.1%
ACLA	49,376	4,957	90.9%	9.1%
Healthy Blue	71,153	7,774	90.2%	9.8%
LHCC	100,953	10,002	91.0%	9.0%
UHC	32,855	2,980	91.7%	8.3%

Therapists (Physical, Occupational, Speech)	**Q3 2019**			
	Number Paid	**Number Denied**	**Paid**	**Denied**
All MCOs	61,330	11,082	84.7%	15.3%
Aetna	2,336	1,201	66.0%	34.0%
ACLA	8,906	1,674	84.2%	15.8%
Healthy Blue	17,195	1,641	91.3%	8.7%
LHCC	13,217	2,777	82.6%	17.4%
UHC	19,676	3,789	83.9%	16.1%

Exhibit III.4B (continued)
Claim Status for Adjudicated Claims
By Provider Specialty - Professional Service Providers
For All MCOs by Quarter, for Adjudicated Claims

Non-Emergency Medical Transportation	Q3 2019			
	Number Paid	Number Denied	Paid	Denied
All MCOs	272,931	9,797	96.5%	3.5%
Aetna	52,218	511	99.0%	1.0%
ACLA	53,235	6,179	89.6%	10.4%
Healthy Blue	52,218	511	99.0%	1.0%
LHCC	115,259	2,580	97.8%	2.2%
UHC	1	16	5.9%	94.1%

Medical Equipment & Supplies	Q3 2019			
	Number Paid	Number Denied	Paid	Denied
All MCOs	108,339	19,648	84.6%	15.4%
Aetna	9,067	2,953	75.4%	24.6%
ACLA	20,093	3,282	86.0%	14.0%
Healthy Blue	887	674	56.8%	43.2%
LHCC	34,843	5,519	86.3%	13.7%
UHC	43,449	7,220	85.8%	14.2%

All Other Professional Services exc. BH and Dental	Q3 2019			
	Number Paid	Number Denied	Paid	Denied
All MCOs	3,942,368	1,072,310	78.6%	21.4%
Aetna	302,811	150,949	66.7%	33.3%
ACLA	613,006	197,485	75.6%	24.4%
Healthy Blue	741,993	190,685	79.6%	20.4%
LHCC	1,118,839	288,319	79.5%	20.5%
UHC	1,165,719	244,872	82.6%	17.4%

Exhibit III.4C
Claim Status for Adjudicated Claims
By Provider Specialty - Behavioral Health, Dental and Pharmacy
For All MCOs for Q3 2019, for Adjudicated Claims

Mental/Behavioral Health - Rehab	Q3 2019			
	Number Paid	Number Denied	Paid	Denied
All MCOs	258,543	44,784	85.2%	14.8%
Aetna	3,212	3,201	50.1%	49.9%
ACLA	100,876	14,369	87.5%	12.5%
Healthy Blue	10,108	3,962	71.8%	28.2%
LHCC	6,271	1,657	79.1%	20.9%
UHC	138,076	21,595	86.5%	13.5%

Mental/Behavioral Health - Other	Q3 2019			
	Number Paid	Number Denied	Paid	Denied
All MCOs	537,164	146,042	78.6%	21.4%
Aetna	39,742	15,086	72.5%	27.5%
ACLA	42,475	7,665	84.7%	15.3%
Healthy Blue	101,403	51,675	66.2%	33.8%
LHCC	281,761	60,512	82.3%	17.7%
UHC	71,783	11,104	86.6%	13.4%

Pharmacy	Q3 2019			
	Number Paid	Number Denied	Paid	Denied
All MCOs	5,639,525	1,997,621	73.8%	26.2%
Aetna	480,043	132,347	78.4%	21.6%
ACLA	691,348	227,574	75.2%	24.8%
Healthy Blue	1,129,012	435,184	72.2%	27.8%
LHCC	1,369,399	452,396	75.2%	24.8%
UHC	1,969,723	750,120	72.4%	27.6%

Dental (MCNA is the only MCO)	Q3 2019			
	Number Paid	Number Denied	Paid	Denied
Dental - Children	732,243	71,631	91.1%	8.9%
Dental - Adults	6,164	2,720	69.4%	30.6%

Exhibit III.5
Value of Paid and Denied Claims
By MCO for Q4 2018, Q1 2019, Q2 2019 and Q3 2019 Adjudicated Claims

	Number Paid	Number Denied	Value of Paid Claims	Value of Denied Claims
All MCOs Q4 2018	18,630,400	4,179,312	$1,428,677,391	$361,167,453
All MCOs Q1 2019	19,604,277	4,709,822	$1,492,030,238	$392,923,965
All MCOs Q2 2019	18,741,158	4,329,810	$1,472,418,817	$387,943,532
All MCOs Q3 2019	18,581,361	4,208,246	$1,572,902,654	$406,565,808

Quarter 4 2018

	Number Paid	Number Denied	Value of Paid Claims	Value of Denied Claims
Aetna	974,611	185,711	$86,864,458	$17,446,075
ACLA	2,477,408	632,305	$192,256,232	$50,994,982
Healthy Blue	3,481,783	974,706	$258,605,234	$84,334,897
LHCC	5,634,122	1,159,633	$401,680,564	$86,831,262
UHC	6,062,476	1,226,957	$489,270,903	$121,560,236

Quarter 1 2019

	Number Paid	Number Denied	Value of Paid Claims	Value of Denied Claims
Aetna	1,642,751	577,057	$132,532,778	$47,173,207
ACLA	2,562,954	673,042	$199,264,763	$53,635,981
Healthy Blue	3,724,389	1,059,786	$279,960,165	$91,322,055
LHCC	5,643,477	1,147,757	$402,447,946	$86,201,374
UHC	6,030,706	1,252,180	$477,824,586	$114,591,349

Quarter 2 2019

	Number Paid	Number Denied	Value of Paid Claims	Value of Denied Claims
Aetna	1,602,818	467,374	$123,287,220	$32,451,017
ACLA	2,417,664	600,211	$194,522,189	$51,434,488
Healthy Blue	3,501,429	977,115	$280,005,672	$105,225,827
LHCC	5,371,425	1,038,523	$392,848,712	$79,925,220
UHC	5,847,822	1,246,587	$481,755,023	$118,906,981

Quarter 3 2019

	Number Paid	Number Denied	Value of Paid Claims	Value of Denied Claims
Aetna	1,555,180	447,275	$130,645,025	$33,898,148
ACLA	2,502,015	548,050	$213,468,226	$51,151,701
Healthy Blue	3,589,794	870,672	$318,694,590	$102,307,501
LHCC	5,261,521	1,100,220	$402,559,104	$88,496,796
UHC	5,672,851	1,242,029	$507,535,710	$130,711,661

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

Exhibit III.7B
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
All Claim Types
By All MCOs and By Quarter

	Paid Claims	Denied Claims
All MCOs Q4 2018	8.4	6.0
All MCOs Q1 2019	8.3	5.9
All MCOs Q2 2019	8.0	6.0
All MCOs Q3 2019	7.9	6.0
Aetna Q4 2018	10.8	5.7
Aetna Q1 2019	9.0	7.1
Aetna Q2 2019	8.0	6.0
Aetna Q3 2019	7.8	5.8
ACLA Q4 2018	4.4	5.0
ACLA Q1 2019	4.9	5.6
ACLA Q2 2019	5.7	5.9
ACLA Q3 2019	5.7	6.7
Healthy Blue Q4 2018	7.4	3.4
Healthy Blue Q1 2019	7.9	3.4
Healthy Blue Q2 2019	6.6	5.6
Healthy Blue Q3 2019	5.9	4.9
LHCC Q4 2018	9.2	10.2
LHCC Q1 2019	9.0	10.5
LHCC Q2 2019	8.5	9.3
LHCC Q3 2019	8.7	9.8
UHC Q4 2018	9.7	4.6
UHC Q1 2019	9.4	3.2
UHC Q2 2019	9.2	3.3
UHC Q3 2019	9.5	3.0
MCNA Q4 2018	7.3	7.9
MCNA Q1 2019	7.1	7.2
MCNA Q2 2019	8.2	9.2
MCNA Q3 2019	7.6	8.4

Exhibit III.8A
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
Institutional Providers
By All MCOs Combined By Quarter

	Paid Claims	Denied Claims
Inpatient Hospital Q4 2018	10.9	14.6
Inpatient Hospital Q1 2019	10.6	11.3
Inpatient Hospital Q2 2019	10.2	11.9
Inpatient Hospital Q3 2019	10.3	9.8
Outpatient Hospital Q4 2018	7.7	10.2
Outpatient Hospital Q1 2019	7.1	8.6
Outpatient Hospital Q2 2019	7.4	11.5
Outpatient Hospital Q3 2019	7.3	9.1
Home Health Q4 2018	8.8	9.8
Home Health Q1 2019	8.6	11.4
Home Health Q2 2019	8.0	8.4
Home Health Q3 2019	8.2	9.4
Other Institutional Claims Q4 2018	6.1	11.1
Other Institutional Claims Q1 2019	5.6	8.8
Other Institutional Claims Q2 2019	8.2	12.9
Other Institutional Claims Q3 2019	6.7	9.0

Exhibit III.8B
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
Professional Service Providers
By All MCOs Combined By Quarter

	Paid Claims	Denied Claims
Primary Care Q4 2018	7.7	8.5
Primary Care Q1 2019	7.5	8.2
Primary Care Q2 2019	7.3	8.0
Primary Care Q3 2019	7.3	7.6
Pediatrics Q4 2018	6.4	7.7
Pediatrics Q1 2019	6.5	7.9
Pediatrics Q2 2019	6.5	7.6
Pediatrics Q3 2019	6.5	7.1
OB-GYN Q4 2018	6.4	7.4
OB-GYN Q1 2019	6.6	7.9
OB-GYN Q2 2019	6.6	7.5
OB-GYN Q3 2019	6.4	7.2
Therapists (PT/OT/ST) Q4 2018	7.8	7.6
Therapists (PT/OT/ST) Q1 2019	7.0	8.6
Therapists (PT/OT/ST) Q2 2019	7.5	9.3
Therapists (PT/OT/ST) Q3 2019	6.9	8.0
Non-Emerg Transport Q4 2018	8.4	9.5
Non-Emerg Transport Q1 2019	10.6	11.1
Non-Emerg Transport Q2 2019	10.7	9.8
Non-Emerg Transport Q3 2019	10.6	9.7
Medical Equip/Supplies Q4 2018	8.3	10.1
Medical Equip/Supplies Q1 2019	7.7	8.1
Medical Equip/Supplies Q2 2019	7.5	8.1
Medical Equip/Supplies Q3 2019	7.4	8.0
All Other Professional Q4 2018	7.4	8.0
All Other Professional Q1 2019	7.1	7.7
All Other Professional Q2 2019	7.0	7.2
All Other Professional Q3 2019	7.0	7.6

Exhibit III.8C
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
Behavioral Health, Dental and Pharmacy
By All MCOs Combined By Quarter

	Paid Claims	Denied Claims
Mental/Behavioral Rehab Q4 2018	7.4	9.8
Mental/Behavioral Rehab Q1 2019	8.4	9.1
Mental/Behavioral Rehab Q2 2019	9.5	9.9
Mental/Behavioral Rehab Q3 2019	8.6	8.9
Mental/Behavioral Other Q4 2018	8.6	9.5
Mental/Behavioral Other Q1 2019	8.4	10.9
Mental/Behavioral Other Q2 2019	7.9	8.9
Mental/Behavioral Other Q3 2019	7.7	9.3
Dental - Children Q4 2018	7.3	8.0
Dental - Children Q1 2019	7.1	7.2
Dental - Children Q2 2019	8.2	9.2
Dental - Children Q3 2019	7.6	8.4
Dental - Adults Q4 2018	6.9	7.7
Dental - Adults Q1 2019	7.0	5.5
Dental - Adults Q2 2019	5.8	10.4
Dental - Adults Q3 2019	6.3	6.7
Pharmacy Q4 2018	10.7	3.0
Pharmacy Q1 2019	11.1	3.2
Pharmacy Q2 2019	9.6	3.1
Pharmacy Q3 2019	9.4	3.6

Exhibit III.9A
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
By Provider Specialty - Institutional Providers
By MCO for Q3 2019 Adjudicated Claims

Inpatient Hospital	Quarter 3 2019	
	Paid	Denied
All MCOs	10.3	9.8
Aetna	17.9	8.3
ACLA	12.1	12.0
Healthy Blue	7.7	9.1
LHCC	9.1	11.5
UHC	9.0	8.6

Outpatient Hospital	Quarter 3 2019	
	Paid	Denied
All MCOs	7.3	9.1
Aetna	6.2	10.6
ACLA	4.7	6.1
Healthy Blue	7.0	11.4
LHCC	8.1	9.3
UHC	8.5	8.1

Home Health	Quarter 3 2019	
	Paid	Denied
All MCOs	8.2	9.4
Aetna	8.2	9.2
ACLA	5.8	7.7
Healthy Blue	8.2	10.5
LHCC	8.8	9.8
UHC	8.1	6.9

Other Institutional	Quarter 3 2019	
	Paid	Denied
All MCOs	6.7	9.0
Aetna	7.0	9.2
ACLA	8.7	11.2
Healthy Blue	6.1	8.9
LHCC	7.9	8.9
UHC	9.3	9.7

Exhibit III.9B
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
By Provider Specialty - Professional Providers, Part 1
By MCO for Q3 2019 Adjudicated Claims

Primary Care	**Quarter 3 2019**	
	Paid	**Denied**
All MCOs	7.3	7.6
Aetna	5.8	6.8
ACLA	3.7	4.8
Healthy Blue	7.4	8.2
LHCC	7.5	8.7
UHC	8.2	7.2

Pediatrics	**Quarter 3 2019**	
	Paid	**Denied**
All MCOs	6.5	7.1
Aetna	5.9	6.6
ACLA	3.6	4.4
Healthy Blue	6.4	8.1
LHCC	7.2	7.8
UHC	7.8	7.2

OB-GYN	**Quarter 3 2019**	
	Paid	**Denied**
All MCOs	6.4	7.2
Aetna	5.8	7.3
ACLA	3.6	5.0
Healthy Blue	6.6	7.5
LHCC	7.3	8.2
UHC	8.0	7.0

Therapists (Physical, Occupational, Speech)	**Quarter 3 2019**	
	Paid	**Denied**
All MCOs	6.9	8.0
Aetna	7.0	8.3
ACLA	6.1	7.9
Healthy Blue	5.9	9.3
LHCC	7.3	9.0
UHC	7.8	6.7

Exhibit III.9C
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
By Provider Specialty - Professional Providers, Part 2
By MCO for Q3 2019 Adjudicated Claims

Non-Emergency Medical Transportation	Quarter 3 2019	
	Paid	Denied
All MCOs	10.6	9.7
Aetna	11.1	11.2
ACLA	9.2	9.1
Healthy Blue	11.1	11.2
LHCC	10.9	10.4
UHC	7.0	6.6

Medical Equipment and Supplies	Quarter 3 2019	
	Paid	Denied
All MCOs	7.4	8.0
Aetna	6.7	7.5
ACLA	4.8	7.6
Healthy Blue	8.1	8.8
LHCC	8.0	9.4
UHC	8.2	7.2

All Other Professional Services exc. BH and Dental	Quarter 3 2019	
	Paid	Denied
All MCOs	7.0	26.3
Aetna	6.4	7.8
ACLA	4.5	5.8
Healthy Blue	6.5	8.2
LHCC	7.7	8.7
UHC	8.0	7.2

Exhibit III.9D
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
By Provider Specialty - Behavioral Health, Dental and Pharmacy
By MCO for Q3 2019 Adjudicated Claims

Mental/Behavioral Health - Rehab	Quarter 3 2019	
	Paid	Denied
All MCOs	8.6	8.9
Aetna	6.7	11.5
ACLA	9.6	7.8
Healthy Blue	6.0	10.7
LHCC	7.3	10.6
UHC	8.1	8.7

Mental/Behavioral Health - Other	Quarter 3 2019	
	Paid	Denied
All MCOs	7.7	9.3
Aetna	6.2	8.7
ACLA	4.4	6.9
Healthy Blue	8.1	9.0
LHCC	7.8	10.3
UHC	9.6	8.3

Pharmacy	Quarter 3 2019	
	Paid	Denied
All MCOs	8.6	3.6
Aetna	10.7	1.0
ACLA	7.6	7.6
Healthy Blue	9.4	3.6
LHCC	10.9	10.9
UHC	11.8	0.0

Dental (MCNA is the only MCO)	Quarter 3 2019	
	Paid	Denied
Dental - Children	7.6	8.4
Dental - Adults	7.1	6.8

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

	Accepted	Rejected
All MCOs Q4 2018	98.1%	1.9%
All MCOs Q1 2019	99.3%	0.7%
All MCOs Q2 2019	99.2%	0.8%
All MCOs Q3 2019	98.7%	1.3%
Aetna Q4 2018	97.4%	2.6%
Aetna Q1 2019	96.9%	3.1%
Aetna Q2 2019	98.1%	1.9%
Aetna Q3 2019	98.9%	1.1%
ACLA Q4 2018	93.2%	6.8%
ACLA Q1 2019	97.8%	2.2%
ACLA Q2 2019	96.4%	3.6%
ACLA Q3 2019	96.3%	3.7%
HBL Q4 2018	100.0%	0.0%
HBL Q1 2019	100.0%	0.0%
HBL Q2 2019	100.0%	0.0%
HBL Q3 2019	100.0%	0.0%
LHCC Q4 2018	98.2%	1.8%
LHCC Q1 2019	99.8%	0.2%
LHCC Q2 2019	99.5%	0.5%
LHCC Q3 2019	97.4%	2.6%
UHC Q4 2018	100.0%	0.0%
UHC Q1 2019	100.0%	0.0%
UHC Q2 2019	100.0%	0.0%
UHC Q3 2019	100.0%	0.0%
MCNA Q4 2018	99.2%	0.8%
MCNA Q1 2019	99.2%	0.8%
MCNA Q2 2019	99.2%	0.8%
MCNA Q3 2019	99.2%	0.8%

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

	Institutional Encounters (837I)		Professional Encounters (837D)		Dental Encounters (837D)		Pharmacy Encounters	
	Accepted	**Rejected**	**Accepted**	**Rejected**	**Accepted**	**Rejected**	**Accepted**	**Rejected**
Aetna Q4 2018	94.5%	5.5%	97.9%	2.1%			100.0%	0.0%
Aetna Q1 2019	95.6%	4.4%	98.9%	1.1%			95.0%	5.0%
Aetna Q2 2019	97.6%	2.4%	98.9%	1.1%			97.6%	2.4%
Aetna Q3 2019	97.6%	2.4%	98.9%	1.1%			100.0%	0.0%
ACLA Q4 2018	94.5%	5.5%	100.0%	0.0%			86.2%	13.8%
ACLA Q1 2019	100.0%	0.0%	99.6%	0.4%			93.7%	6.3%
ACLA Q2 2019	98.0%	2.0%	100.0%	0.0%			90.4%	9.6%
ACLA Q3 2019	95.6%	4.4%	99.1%	0.9%			94.2%	5.8%
HBL Q4 2018	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
HBL Q1 2019	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
HBL Q2 2019	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
HBL Q3 2019	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
LHCC Q4 2018	99.1%	0.9%	97.5%	2.5%			98.7%	1.3%
LHCC Q1 2019	100.0%	0.0%	100.0%	0.0%			99.0%	1.0%
LHCC Q2 2019	100.0%	0.0%	100.0%	0.0%			98.4%	1.6%
LHCC Q3 2019	100.0%	0.0%	100.0%	0.0%			91.8%	8.2%
UHC Q4 2018	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
UHC Q1 2019	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
UHC Q2 2019	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
UHC Q3 2019	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
MCNA Q4 2018					99.2%	0.8%		
MCNA Q1 2019					99.2%	0.8%		
MCNA Q2 2019					99.2%	0.8%		
MCNA Q3 2019					99.2%	0.8%		

Exhibit IV.4
Encounter Submissions Accepted and Rejected by LDH
Institutional, Professional, Dental, and Pharmacy Claim Types
By MCO and By Quarter

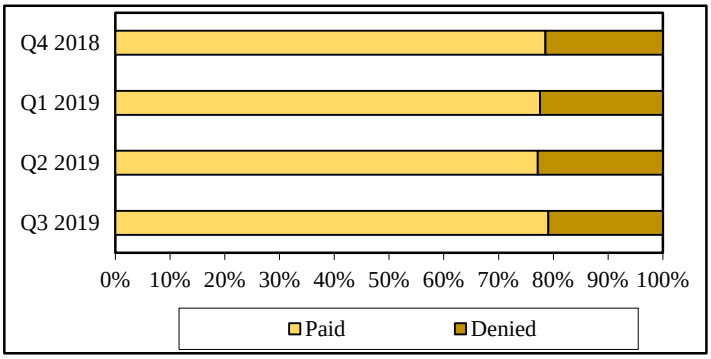
	Institutional Encounters (837I)		Professional Encounters (837D)		Dental Encounters (837D)		Pharmacy Encounters	
	Within 30 Days	After 30 Days	Within 30 Days	After 30 Days	Within 30 Days	After 30 Days	Within 30 Days	After 30 Days
Aetna Q4 2018	87.2%	12.8%	96.2%	3.8%			71.1%	28.9%
Aetna Q1 2019	91.9%	8.1%	93.8%	6.2%			76.5%	23.5%
Aetna Q2 2019	98.9%	1.1%	97.1%	2.9%			69.2%	30.8%
Aetna Q3 2019	98.9%	1.1%	97.1%	2.9%			69.7%	30.3%
ACLA Q4 2018	96.5%	3.5%	95.6%	4.4%			76.3%	23.7%
ACLA Q1 2019	96.8%	3.2%	93.2%	6.8%			90.8%	9.2%
ACLA Q2 2019	95.9%	4.1%	87.0%	13.0%			94.5%	5.5%
ACLA Q3 2019	95.3%	4.7%	97.5%	2.5%			95.0%	5.0%
HBL Q4 2018	100.0%	0.0%	95.1%	4.9%			100.0%	0.0%
HBL Q1 2019	100.0%	0.0%	96.1%	3.9%			98.5%	1.5%
HBL Q2 2019	100.0%	0.0%	95.8%	4.2%			99.7%	0.3%
HBL Q3 2019	97.2%	2.8%	97.7%	2.3%			99.7%	0.3%
LHCC Q4 2018	93.9%	6.1%	89.2%	10.8%			98.9%	1.1%
LHCC Q1 2019	88.5%	11.5%	79.7%	20.3%			74.6%	25.4%
LHCC Q2 2019	97.2%	2.8%	91.5%	8.5%			71.7%	28.3%
LHCC Q3 2019	99.2%	0.8%	91.5%	8.5%			66.1%	33.9%
UHC Q4 2018	98.5%	1.5%	97.4%	2.6%			99.0%	1.0%
UHC Q1 2019	99.5%	0.5%	95.1%	4.9%			98.3%	1.7%
UHC Q2 2019	96.2%	3.8%	96.8%	3.2%			93.0%	7.0%
UHC Q3 2019	97.8%	2.2%	93.4%	6.6%			87.5%	12.5%
MCNA Q4 2018					100.0%	0.0%		
MCNA Q1 2019					99.4%	0.6%		
MCNA Q2 2019					99.4%	0.6%		
MCNA Q3 2019					99.1%	0.9%		

APPENDIX E

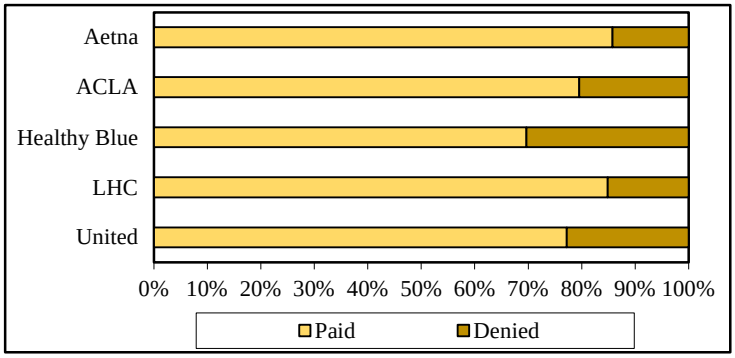
One-Page Summaries of Information on Claims for Each of the 16 Provider Types Shown in this Report

Summary of Information on Claims for Inpatient Hospital Services

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

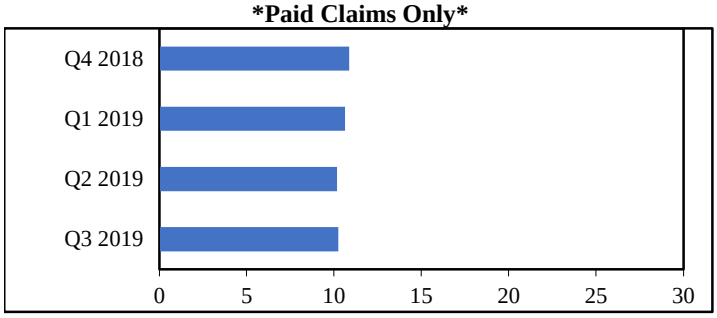


Paid and Denied Trend Quarter 3 2019 only For Each MCO



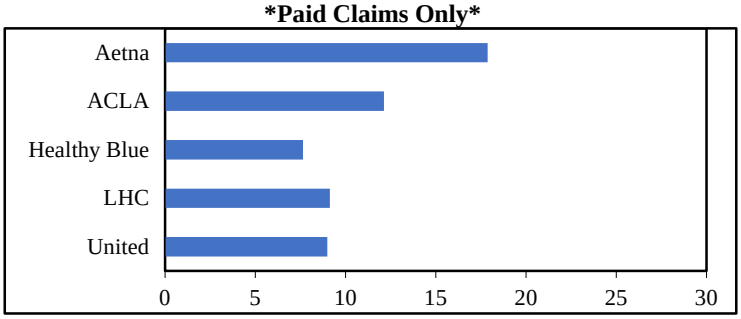
Claims Turnaround Time Most Recent 4 Qtrs All MCOs

Paid Claims Only

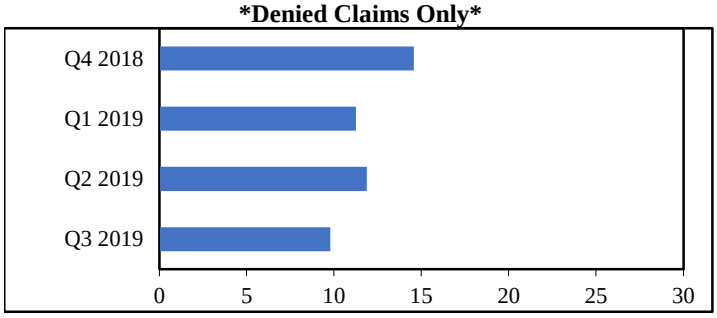


Claims Turnaround Time Quarter 3 2019 only Each MCO

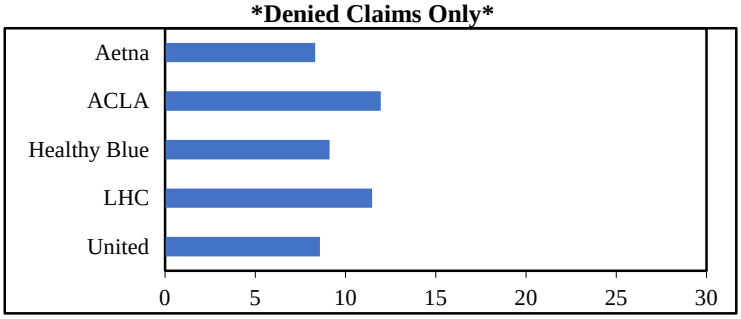
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 3 2019 only)

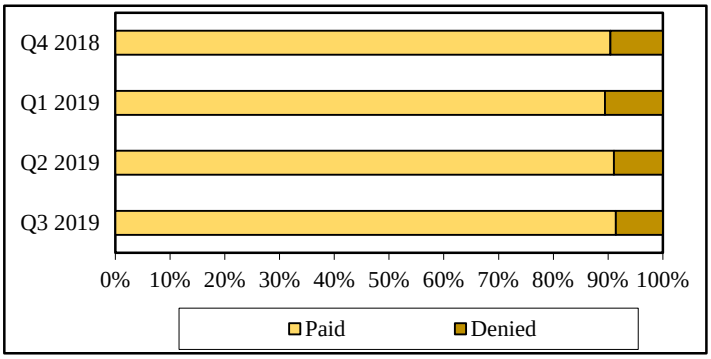
	Aetna		ACLA		Healthy Blue		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	179	95	242	136	263	203	292	181	327	194
101 - 250	47	40	27	19	32	31	43	36	39	33
> 250 claims	34	22	0	0	3	3	11	9	6	5

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

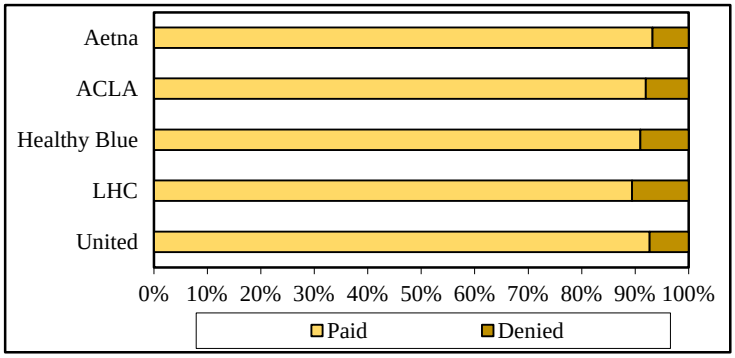
CARC Code	Description	Aetna	ACLA	HBL	LHC	UHC
18	Exact duplicate claim/service	X			X	X
16	Claim/service lacks information or has submission/billing error(s	X			X	X
128	Newborn's services are covered in the mother's Allowance.		X	X		X
97	The benefit for this service is included in the payment/allowance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

Summary of Information on Claims for Outpatient Hospital Services

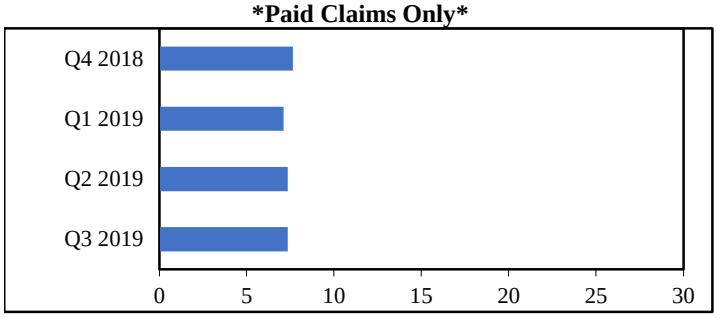
Paid and Denied Trend, Most Recent Four Quarters, All MCOs



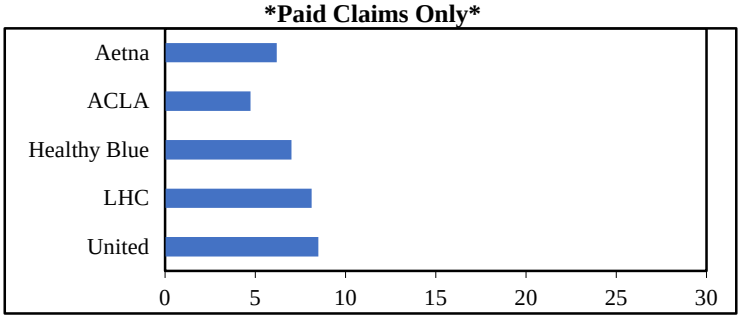
Paid and Denied Trend Quarter 3 2019 only For Each MCO



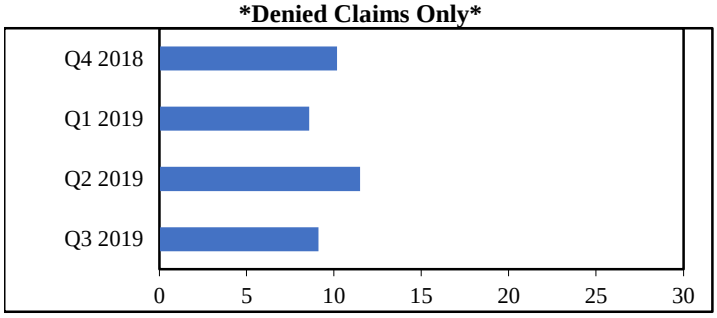
Claims Turnaround Time Most Recent 4 Qtrs All MCOs
Paid Claims Only



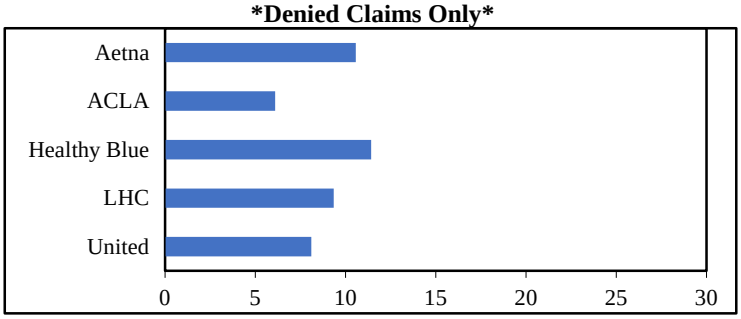
Claims Turnaround Time Quarter 3 2019 only Each MCO
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 3 2019 only)

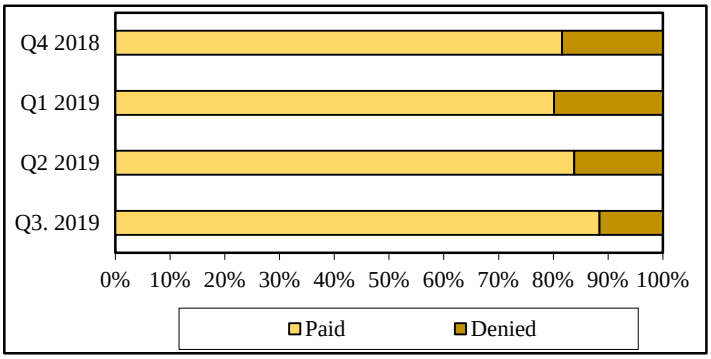
	Aetna		ACLA		Healthy Blue		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	380	191	474	229	436	132	563	317	1,097	661
101 - 250	69	58	96	29	31	22	132	113	128	66
> 250 claims	105	29	121	24	98	32	140	52	138	25

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

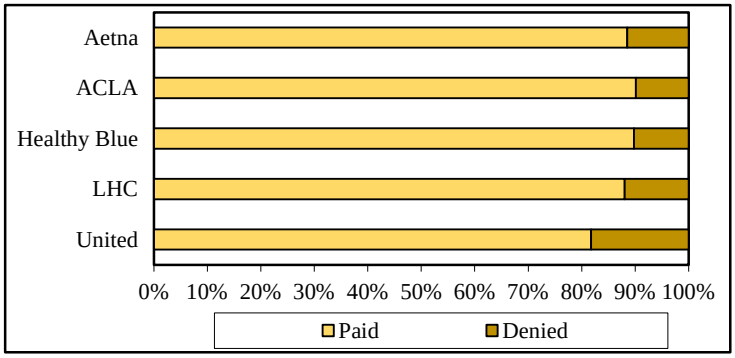
CARC Code	Description	Aetna	ACLA	HBL	LHC	UHC
96	Non-covered charge(s).	X	X		X	X
16	Claim/service lacks information or has submission/billing error(s	X	X		X	X
18	Exact duplicate claim/service	X			X	X
97	The benefit for this service is included in the payment/allowance	X				X
252	An attachment/other documentation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

Summary of Information on Claims for Home Health Services

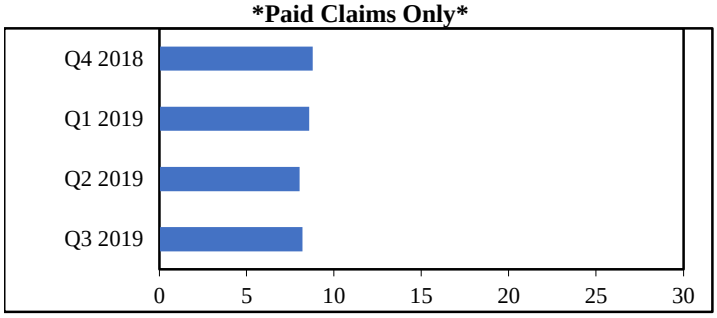
Paid and Denied Trend, Most Recent Four Quarters, All MCOs



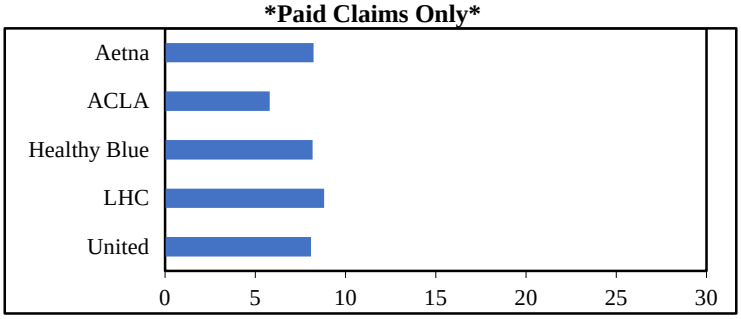
Paid and Denied Trend Quarter 3 2019 only For Each MCO



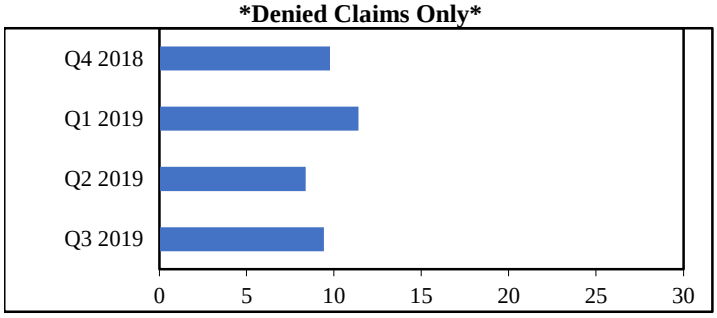
Claims Turnaround Time Most Recent 4 Qtrs All MCOs
Paid Claims Only



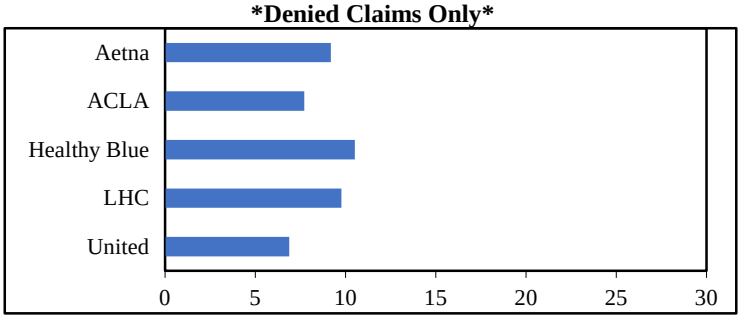
Claims Turnaround Time Quarter 3 2019 only Each MCO
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 3 2019 only)

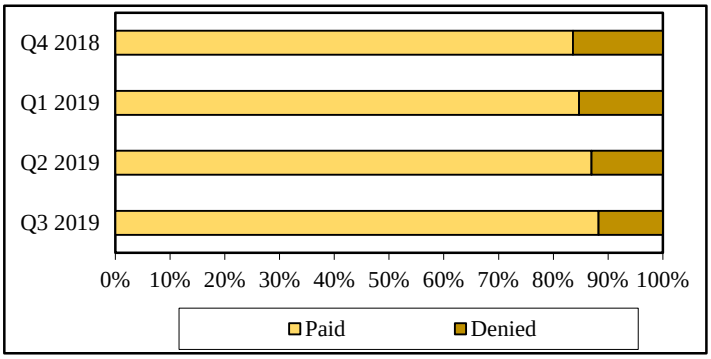
	Aetna		ACLA		Healthy Blue		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	34	21	41	17	43	12	111	45	23	11
101 - 250	10	5	14	3	15	4	56	20	3	1
> 250 claims	0	0	2	0	1	0	8	5	0	0

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

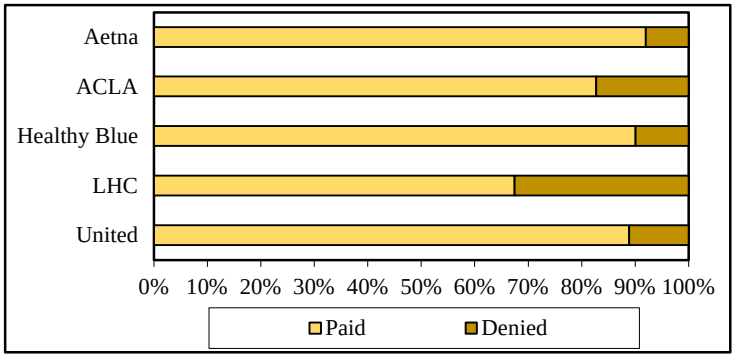
CARC Code	Description	Aetna	ACLA	HBL	LHC	UHC
16	Claim/service lacks information or has submission/billing error(s	X	X	X	X	X
18	Exact duplicate claim/service	X		X	X	X
197	Precertification/authorization/notification absent.		X	X	X	X
A1	Claim/Service denied.			X	X	
96	Non-covered charge(s).		X	X	X	

Summary of Information on Claims for Other Institutional Services

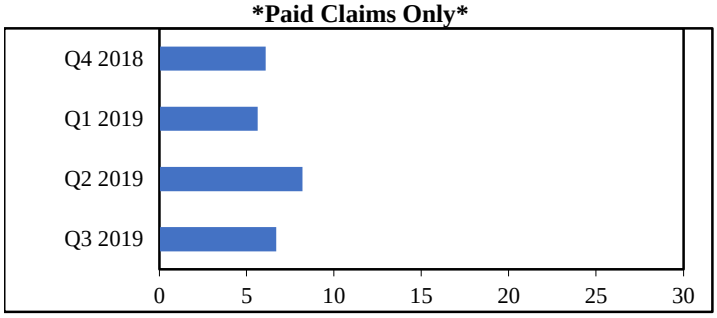
Paid and Denied Trend, Most Recent Four Quarters, All MCOs



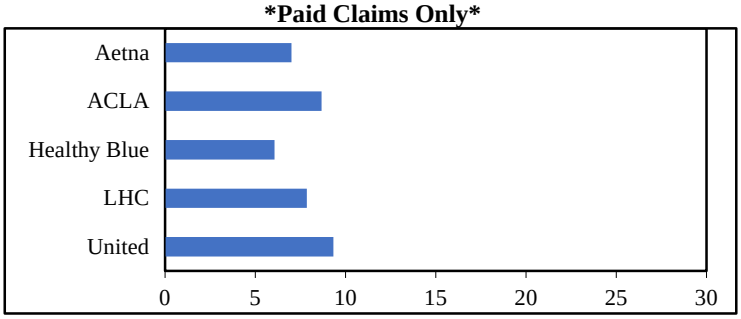
Paid and Denied Trend Quarter 3 2019 only For Each MCO



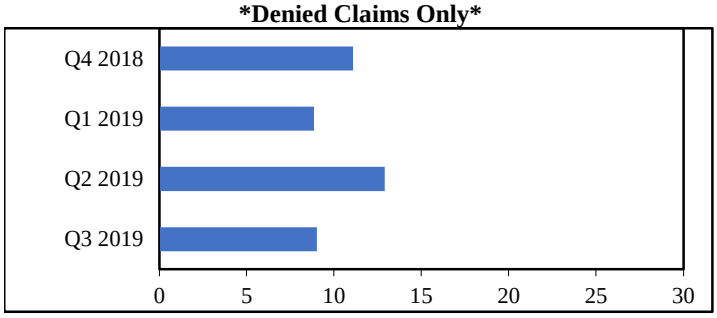
Claims Turnaround Time Most Recent 4 Qtrs All MCOs
Paid Claims Only



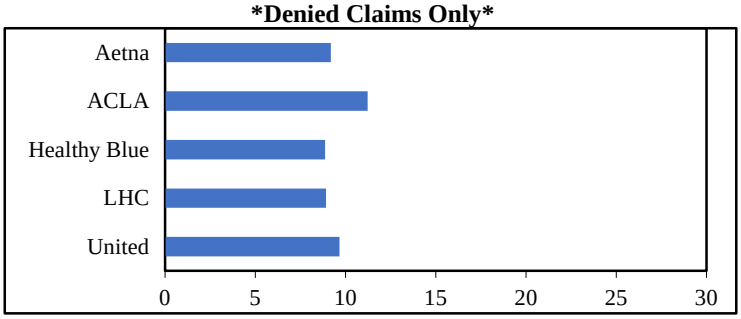
Claims Turnaround Time Quarter 3 2019 only Each MCO
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 3 2019 only)

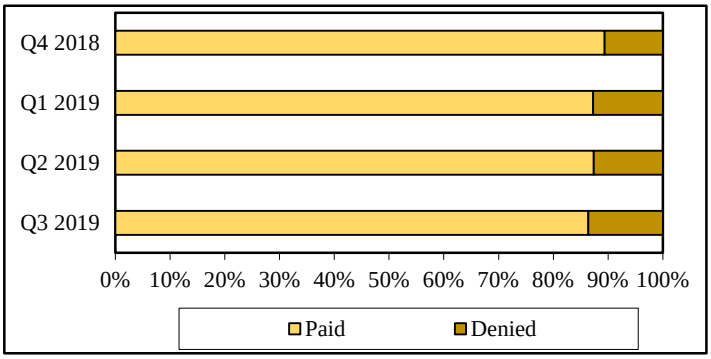
	Aetna		ACLA		Healthy Blue		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	15	11	14	7	122	48	105	75	28	6
101 - 250	3	0	0	0	58	10	4	2	11	4
> 250 claims	0	0	0	0	15	4	1	0	5	2

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

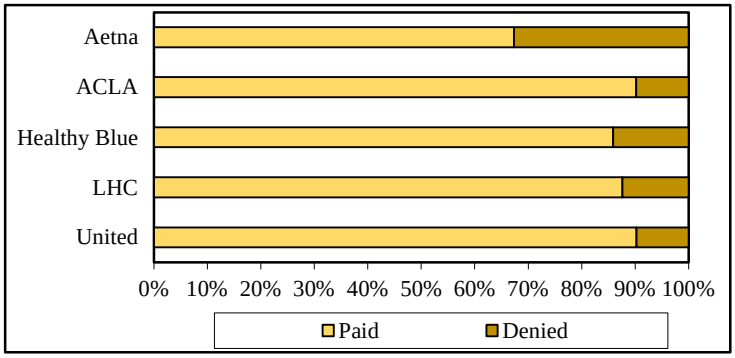
CARC Code	Description	Aetna	ACLA	HBL	LHC	UHC
252	An attachment/other documentation is required to adjudicate this			X		X
16	Claim/service lacks information or has submission/billing error(s	X	X		X	
256	Service not payable per managed care contract.			X		
96	Non-covered charge(s).	X	X		X	X
197	Precertification/authorization/notification absent.			X	X	

Summary of Information on Claims for Primary Care Services

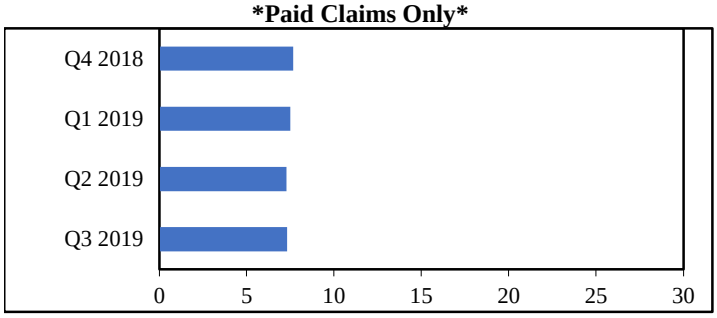
Paid and Denied Trend, Most Recent Four Quarters, All MCOs



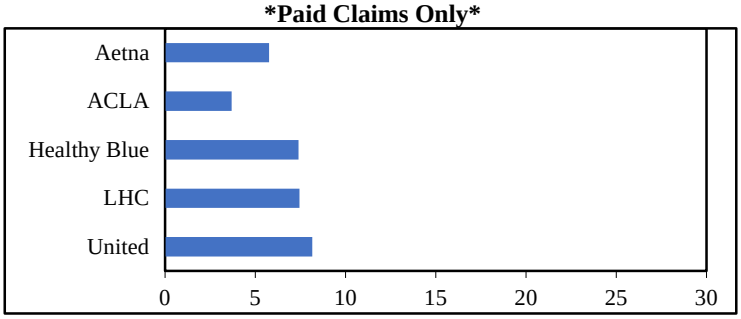
Paid and Denied Trend Quarter 3 2019 only For Each MCO



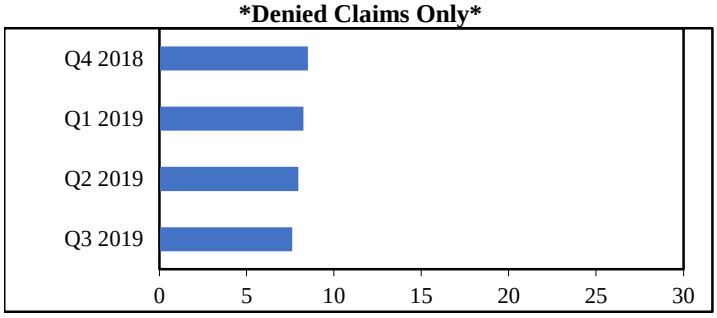
Claims Turnaround Time Most Recent 4 Qtrs All MCOs
Paid Claims Only



Claims Turnaround Time Quarter 3 2019 only Each MCO
Paid Claims Only



Denied Claims Only



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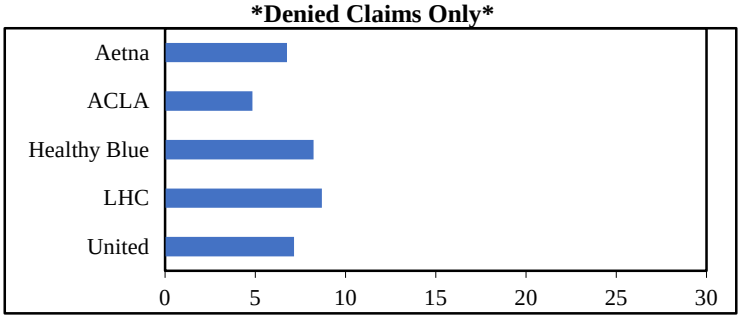


Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 3 2019 only)

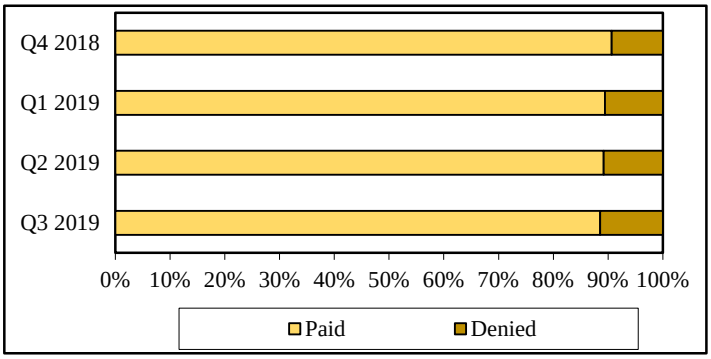
	Aetna		ACLA		Healthy Blue		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	129	66	623	276	992	481	1,015	468	1,226	672
101 - 250	17	13	221	75	420	174	430	213	269	120
> 250 claims	2	2	70	22	227	102	354	173	293	89

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

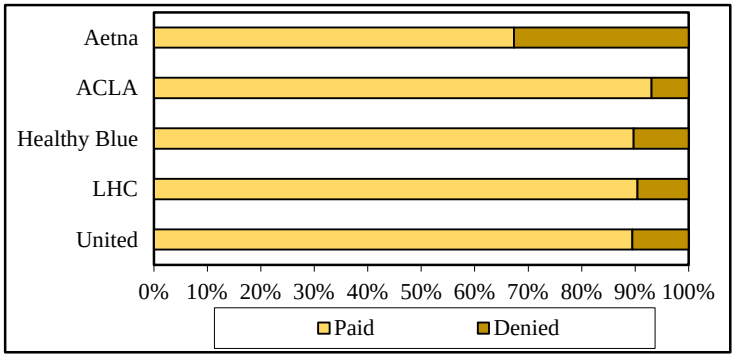
CARC Code	Description	Aetna	ACLA	HBL	LHC	UHC
96	Non-covered charge(s).	X	X		X	X
18	Exact duplicate claim/service	X			X	X
197	Precertification/authorization/notification absent.		X	X		X
B7	This provider was not certified/eligible to be paid for this procedu				X	
256	Service not payable per managed care contract.			X		

Summary of Information on Claims for Pediatric Services

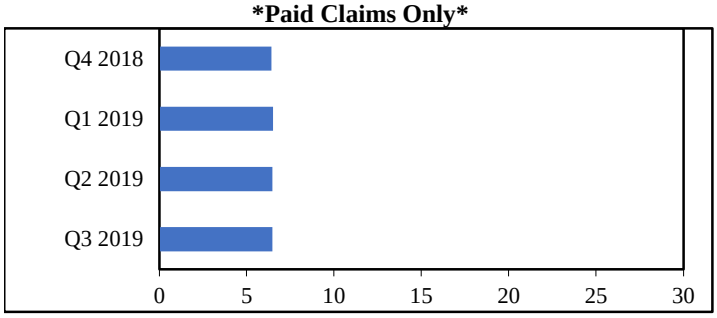
Paid and Denied Trend, Most Recent Four Quarters, All MCOs



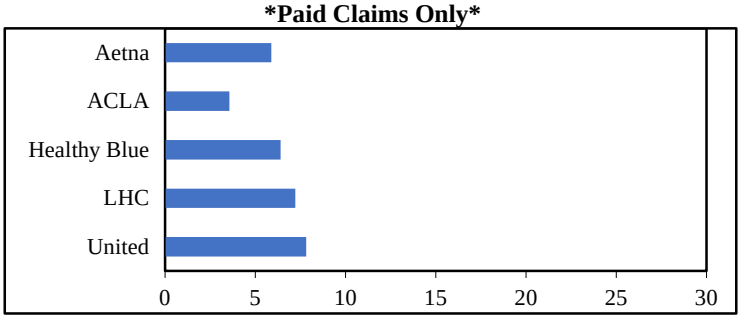
Paid and Denied Trend Quarter 3 2019 only For Each MCO



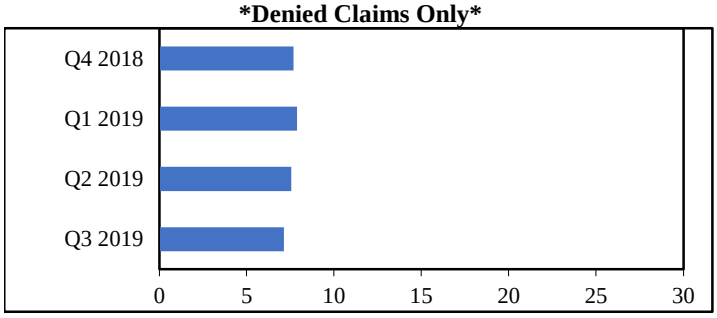
Claims Turnaround Time Most Recent 4 Qtrs All MCOs
Paid Claims Only



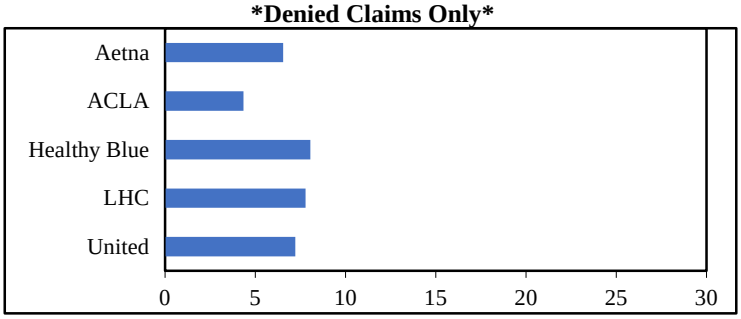
Claims Turnaround Time Quarter 3 2019 only Each MCO
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 3 2019 only)

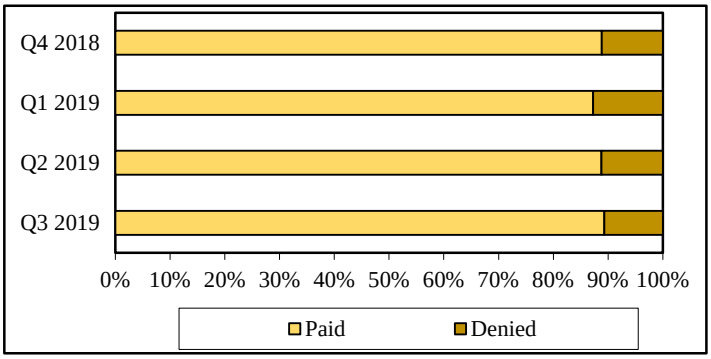
	Aetna		ACLA		Healthy Blue		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	13	6	109	46	178	85	129	55	43	28
101 - 250	5	3	90	28	101	36	83	39	16	4
> 250 claims	3	2	73	14	94	26	135	63	62	23

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

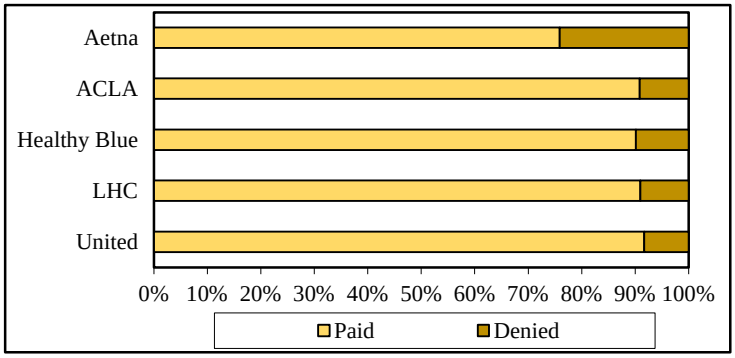
CARC Code	Description	Aetna	ACLA	HBL	LHC	UHC
96	Non-covered charge(s).	X	X		X	X
B7	This provider was not certified/eligible to be paid for this procedu		X		X	
18	Exact duplicate claim/service	X			X	X
97	The benefit for this service is included in the payment/allowance	X	X			X
6	The procedure/revenue code is inconsistent with the patient's age				X	

Summary of Information on Claims for OBGYN Services

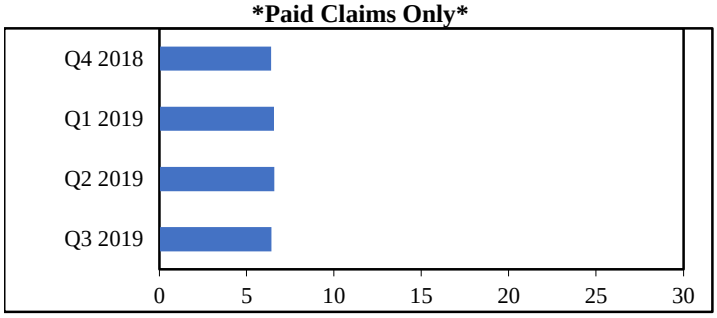
Paid and Denied Trend, Most Recent Four Quarters, All MCOs



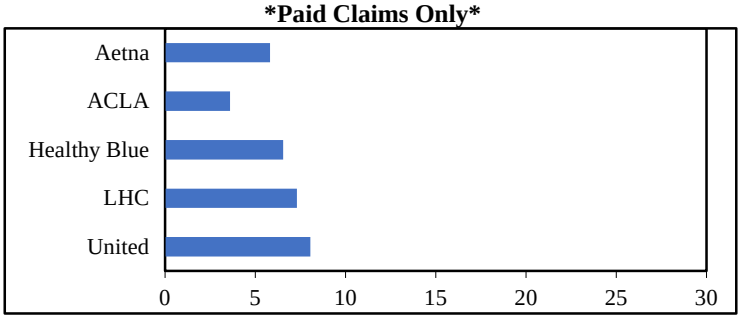
Paid and Denied Trend Quarter 3 2019 only For Each MCO



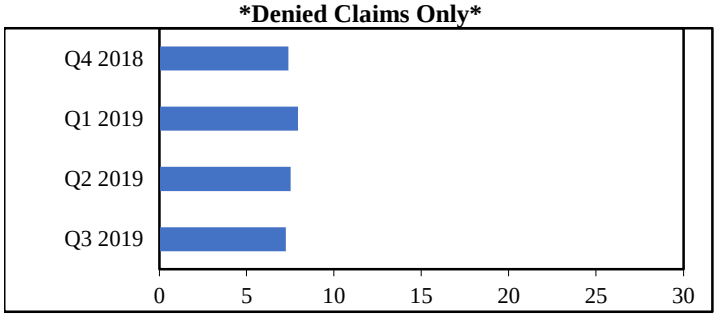
Claims Turnaround Time Most Recent 4 Qtrs All MCOs
Paid Claims Only



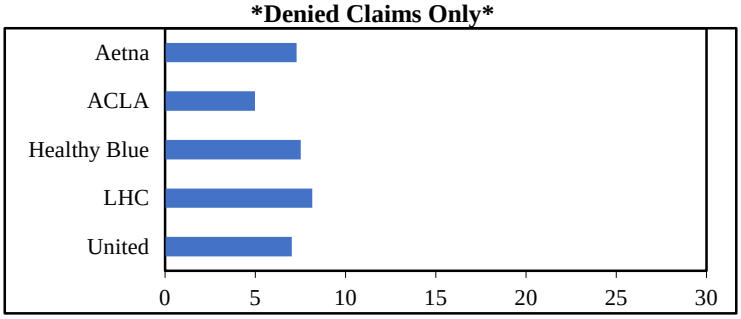
Claims Turnaround Time Quarter 3 2019 only Each MCO
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 3 2019 only)

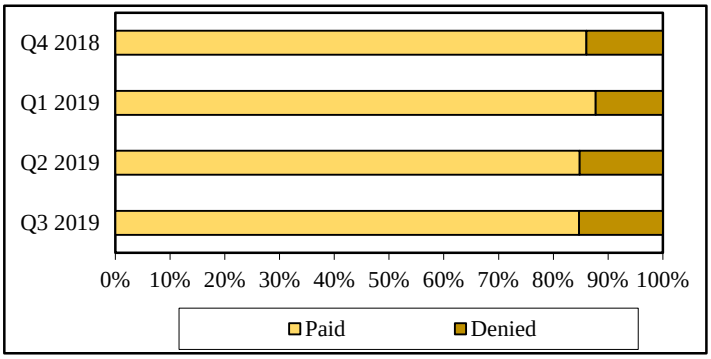
	Aetna		ACLA		Healthy Blue		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	16	9	98	47	110	56	116	44	34	22
101 - 250	1	0	70	21	81	28	80	29	20	9
> 250 claims	0	0	29	11	42	20	56	23	22	7

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

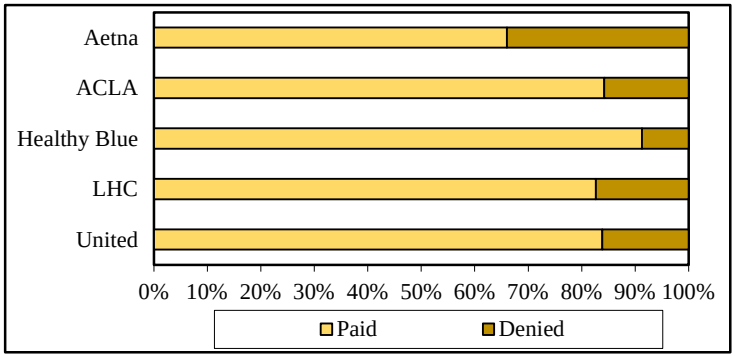
CARC Code	Description	Aetna	ACLA	HBL	LHC	UHC
18	Exact duplicate claim/service	X			X	X
96	Non-covered charge(s).		X		X	X
260	Processed under Medicaid ACA Enhanced Fee Schedule			X		
97	The benefit for this service is included in the payment/allowance	X				X
252	An attachment/other documentation is required to adjudicate this		X	X		X

Summary of Information on Claims for Therapy Services

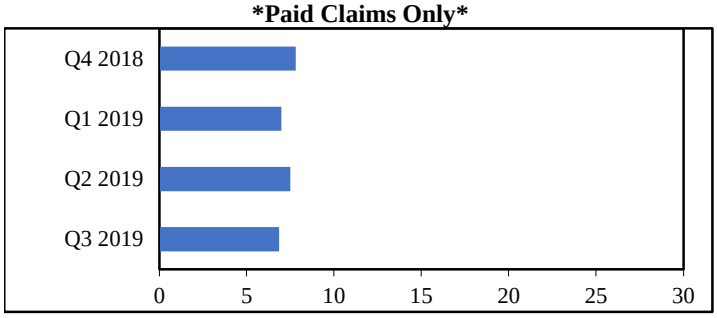
Paid and Denied Trend, Most Recent Four Quarters, All MCOs



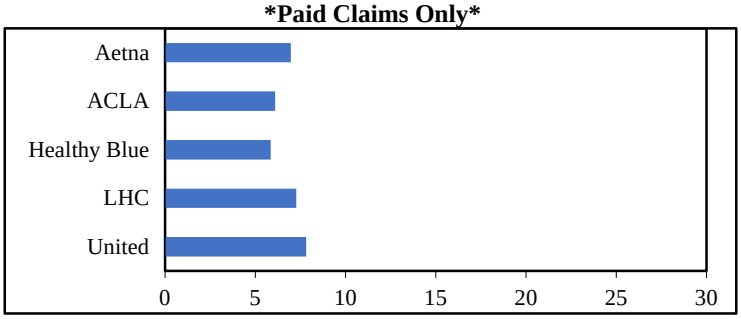
Paid and Denied Trend Quarter 3 2019 only For Each MCO



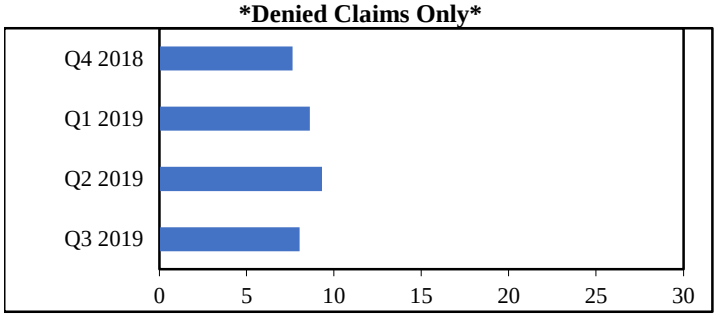
Claims Turnaround Time Most Recent 4 Qtrs All MCOs
Paid Claims Only



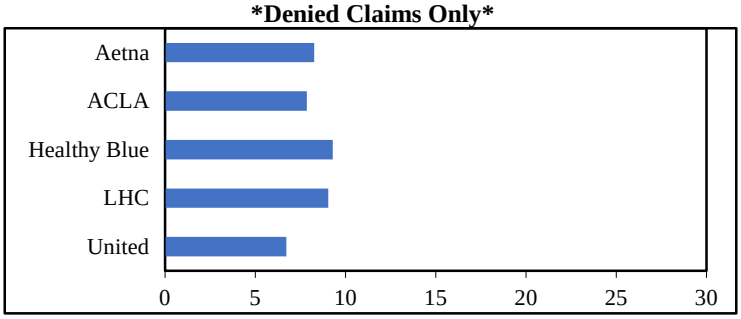
Claims Turnaround Time Quarter 3 2019 only Each MCO
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 3 2019 only)

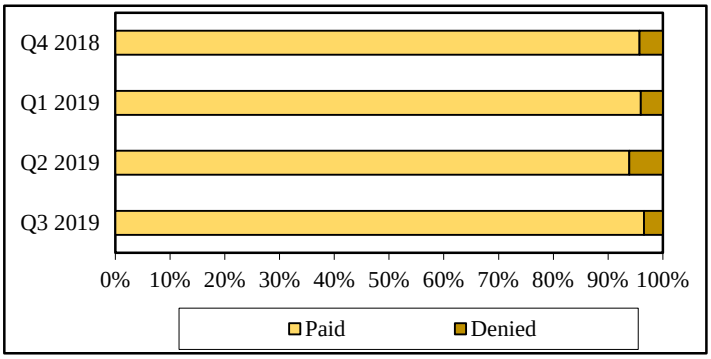
	Aetna		ACLA		Healthy Blue		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	2	1	56	32	57	25	28	19	15	9
101 - 250	1	0	27	16	27	11	28	16	20	7
> 250 claims	0	0	3	0	12	1	9	6	9	3

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

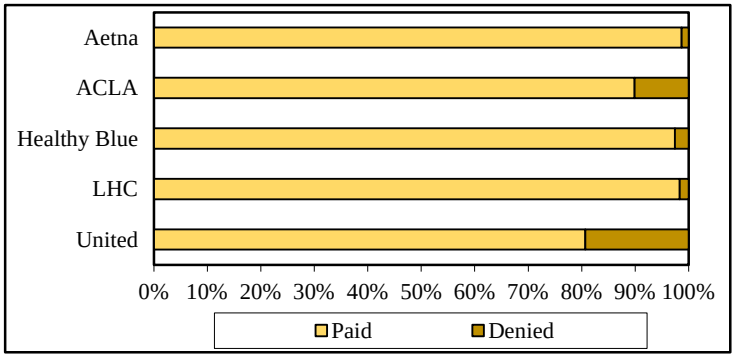
CARC Code	Description	Aetna	ACLA	HBL	LHC	UHC
96	Non-covered charge(s).	X	X			X
256	Service not payable per managed care contract.			X		
197	Precertification/authorization/notification absent.	X	X	X	X	X
16	Claim/service lacks information or has submission/billing error(s	X	X		X	
18	Exact duplicate claim/service				X	X

Summary of Information on Claims for NEMT Services

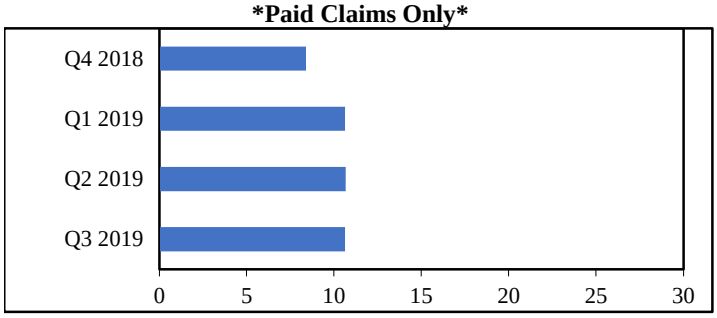
Paid and Denied Trend, Most Recent Four Quarters, All MCOs



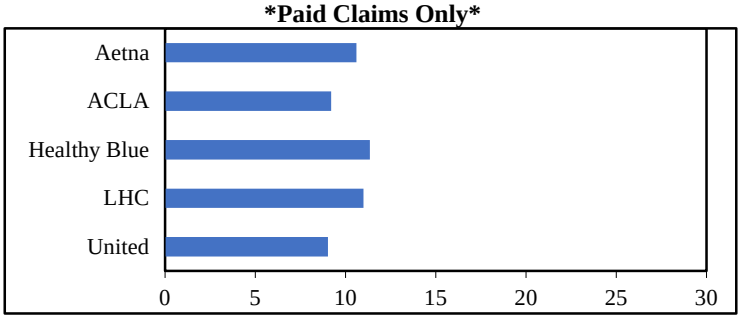
Paid and Denied Trend Quarter 3 2019 only For Each MCO



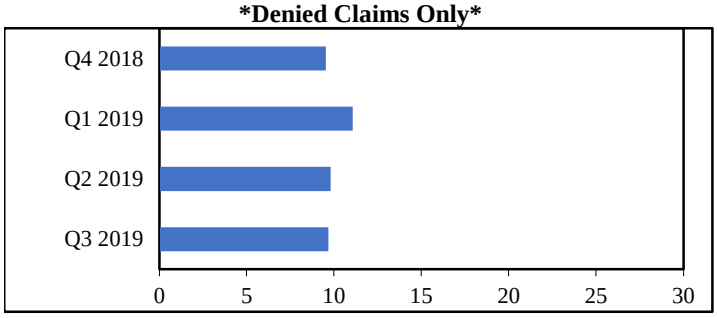
Claims Turnaround Time Most Recent 4 Qtrs All MCOs
Paid Claims Only



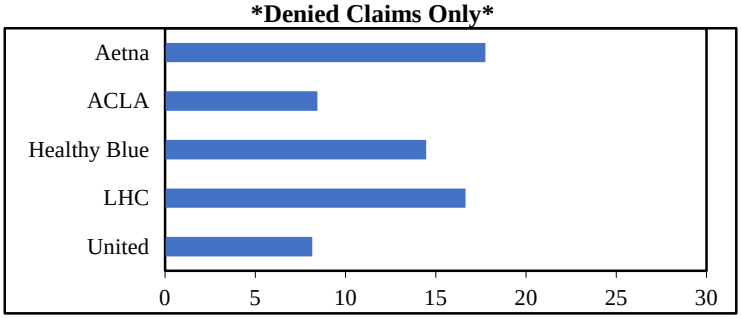
Claims Turnaround Time Quarter 3 2019 only Each MCO
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 3 2019 only)

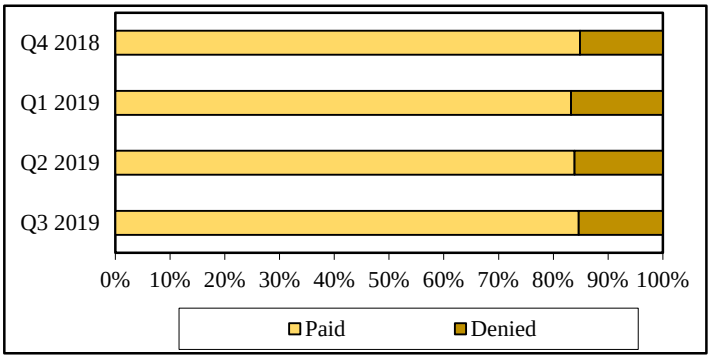
	Aetna		ACLA		Healthy Blue		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	55	6	48	23	55	6	23	13	9	9
101 - 250	81	3	61	27	81	3	4	3	0	0
> 250 claims	23	0	41	11	23	0	1	1	0	0

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

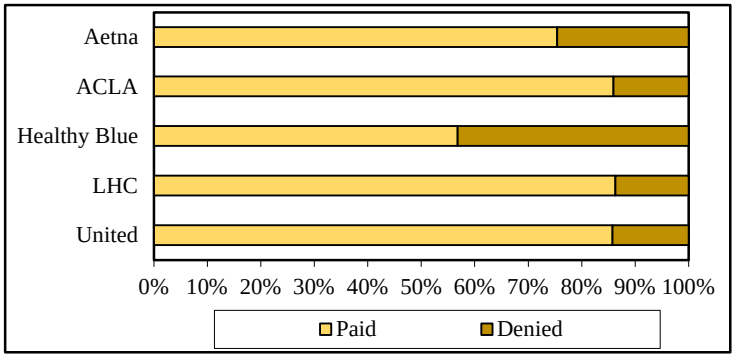
CARC Code	Description	Aetna	ACLA	HBL	LHC	UHC
16	Claim/service lacks information or has submission/billing error(s	X	X	X	X	X
8	The procedure code is inconsistent with the provider type/special	X		X		X
96	Non-covered charge(s).	X	X	X	X	X
109	Claim/service not covered by this payer/contractor. You must sen	X	X	X		X
22	This care may be covered by another payer per coordination of be	X		X	X	X

Summary of Information on Claims for Medical Supplies Services

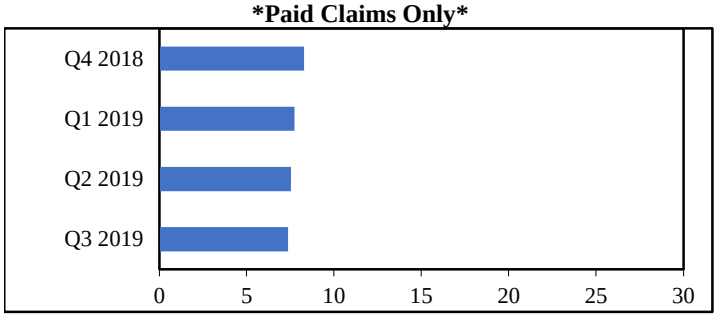
Paid and Denied Trend, Most Recent Four Quarters, All MCOs



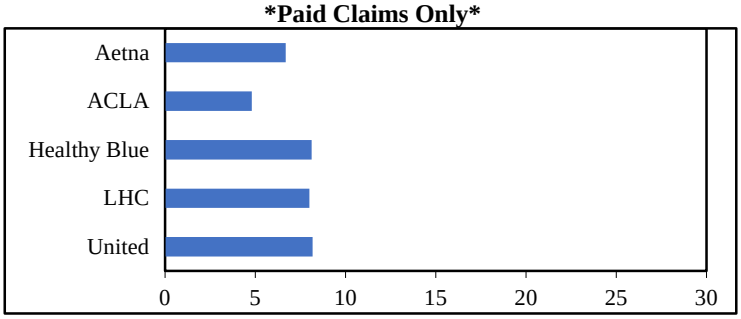
Paid and Denied Trend Quarter 3 2019 only For Each MCO



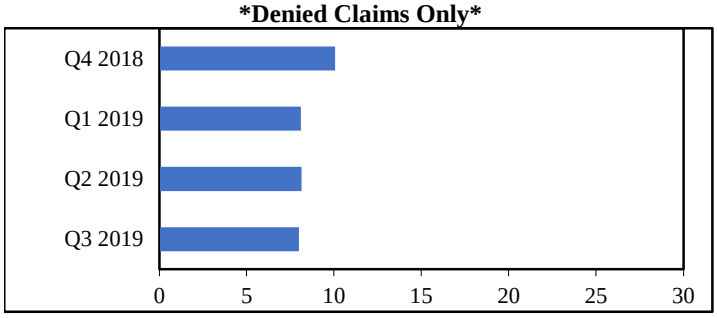
Claims Turnaround Time Most Recent 4 Qtrs All MCOs
Paid Claims Only



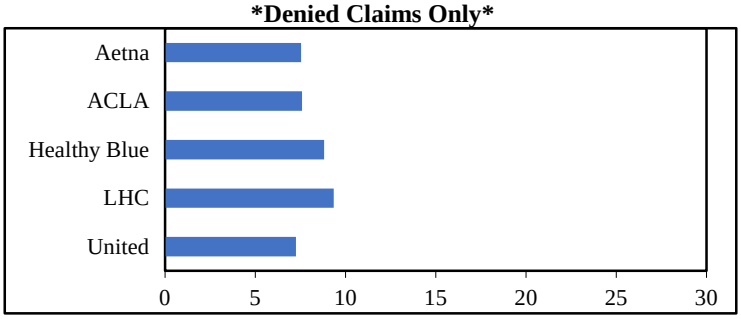
Claims Turnaround Time Quarter 3 2019 only Each MCO
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 3 2019 only)

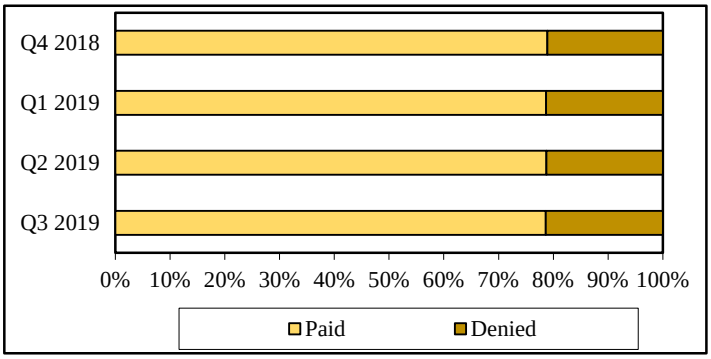
	Aetna		ACLA		Healthy Blue		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	110	76	148	72	97	53	160	64	348	252
101 - 250	34	30	48	25	3	3	74	40	43	21
> 250 claims	5	5	9	1	0	0	23	15	30	11

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

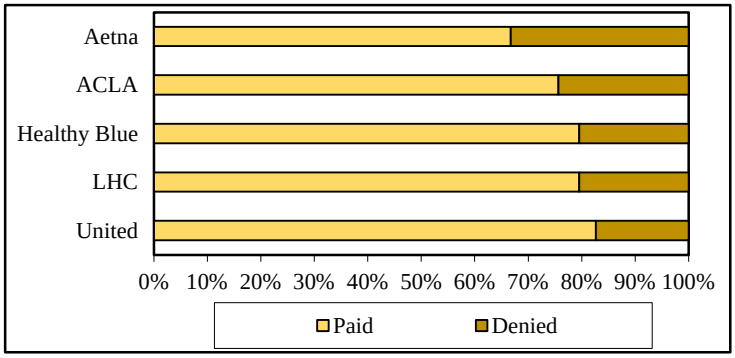
CARC Code	Description	Aetna	ACLA	HBL	LHC	UHC
96	Non-covered charge(s).	X	X			X
16	Claim/service lacks information or has submission/billing error(s	X	X		X	
197	Precertification/authorization/notification absent.	X	X	X	X	
18	Exact duplicate claim/service	X			X	X
97	The benefit for this service is included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

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

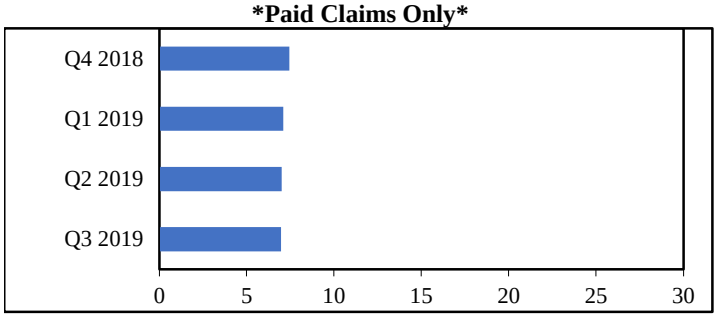
Paid and Denied Trend, Most Recent Four Quarters, All MCOs



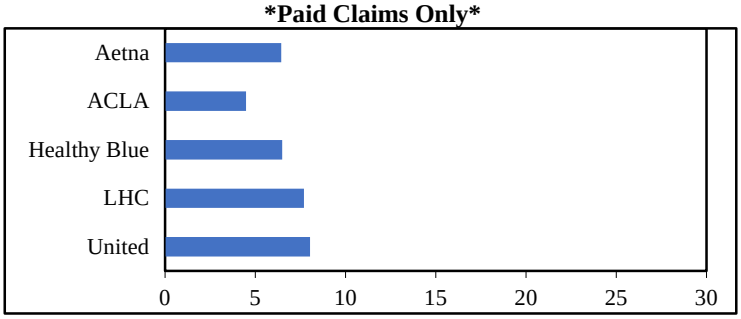
Paid and Denied Trend Quarter 3 2019 only For Each MCO



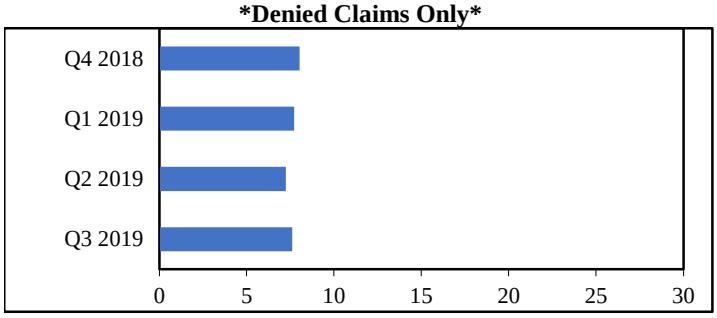
Claims Turnaround Time Most Recent 4 Qtrs All MCOs
Paid Claims Only



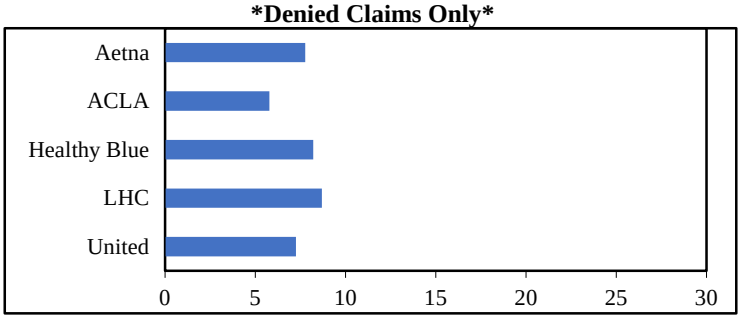
Claims Turnaround Time Quarter 3 2019 only Each MCO
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 3 2019 only)

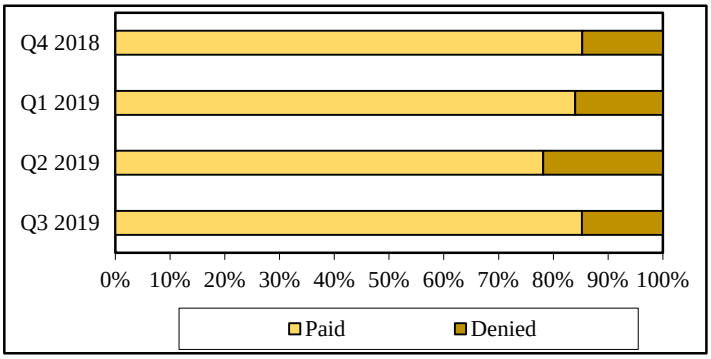
	Aetna		ACLA		Healthy Blue		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	139	67	2,103	986	2,380	961	2,140	1,156	2,720	1,489
101 - 250	12	9	631	291	574	298	726	360	452	222
> 250 claims	7	5	250	100	316	177	493	241	323	152

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

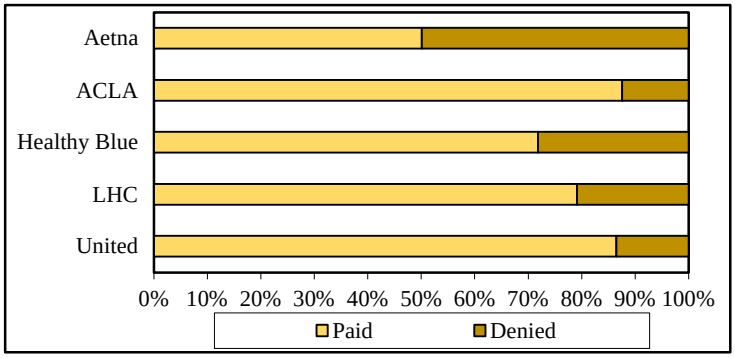
CARC Code	Description	Aetna	ACLA	HBL	LHC	UHC
96	Non-covered charge(s).	X	X		X	X
197	Precertification/authorization/notification absent.		X	X	X	X
B7	This provider was not certified/eligible to be paid for this procedu		X		X	
18	Exact duplicate claim/service	X			X	
252	An attachment/other documentation is required to adjudicate this			X		X

Summary of Information on Claims for Mental Health Services- Rehab

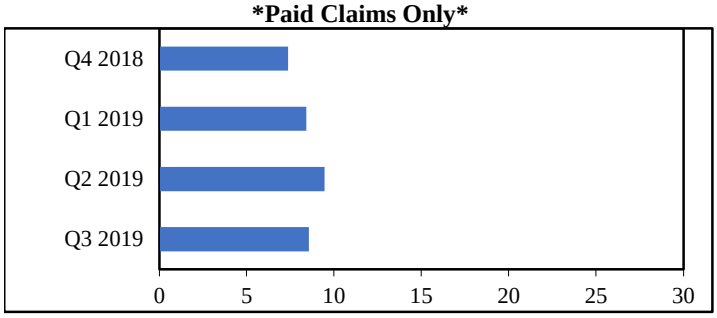
Paid and Denied Trend, Most Recent Four Quarters, All MCOs



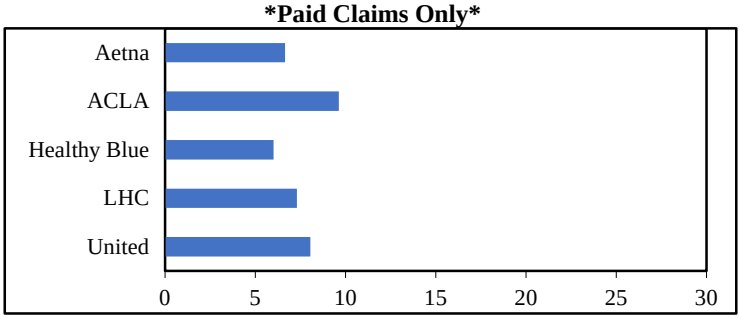
Paid and Denied Trend Quarter 3 2019 only For Each MCO



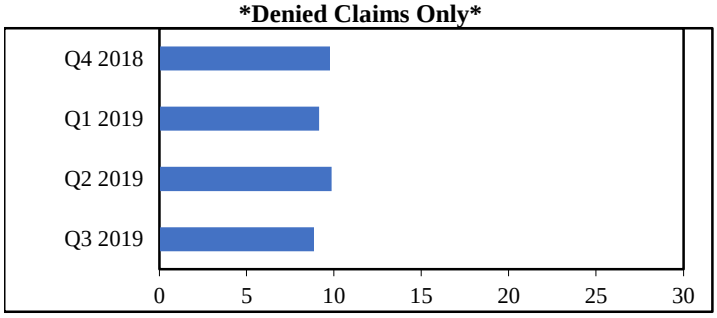
Claims Turnaround Time Most Recent 4 Qtrs All MCOs
Paid Claims Only



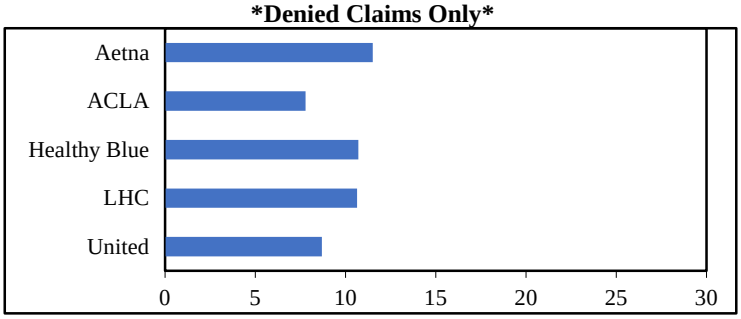
Claims Turnaround Time Quarter 3 2019 only Each MCO
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 3 2019 only)

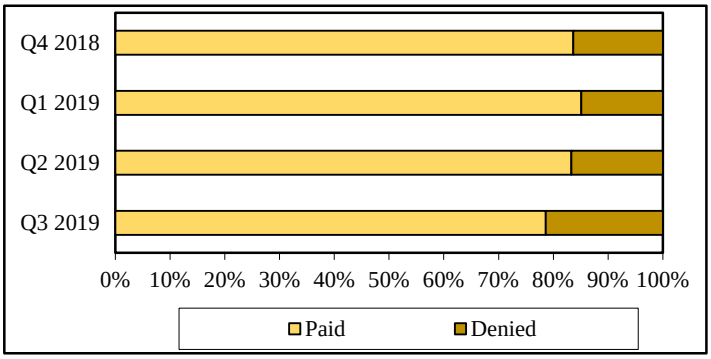
	Aetna		ACLA		Healthy Blue		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	102	52	78	52	186	115	67	40	85	53
101 - 250	48	22	159	67	36	22	32	13	70	40
> 250 claims	13	5	75	30	4	3	6	3	93	33

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

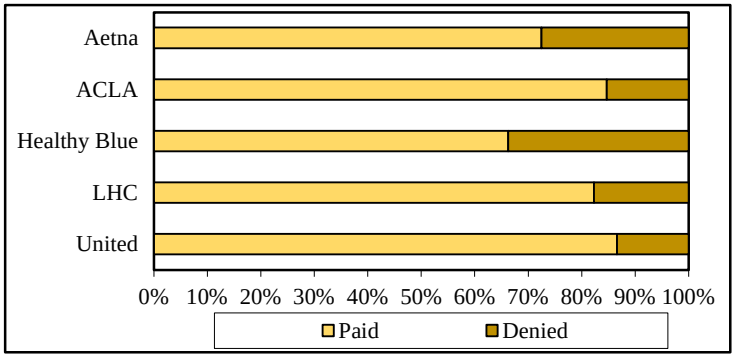
CARC Code	Description	Aetna	ACLA	HBL	LHC	UHC
16	Claim/service lacks information or has submission/billing error(s	X			X	X
18	Exact duplicate claim/service	X				X
197	Precertification/authorization/notification absent.		X	X	X	X
B7	This provider was not certified/eligible to be paid for this procedu		X			X
96	Non-covered charge(s).		X			

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

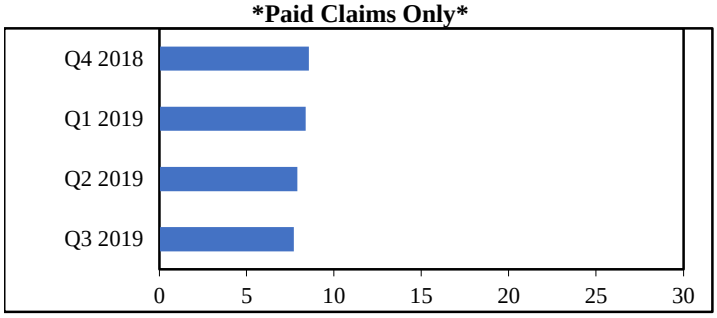
Paid and Denied Trend, Most Recent Four Quarters, All MCOs



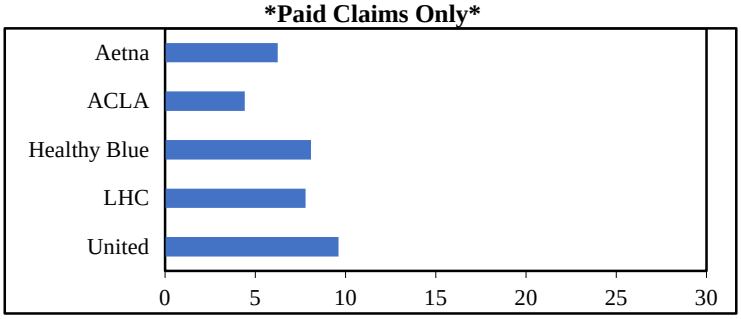
Paid and Denied Trend Quarter 3 2019 only For Each MCO



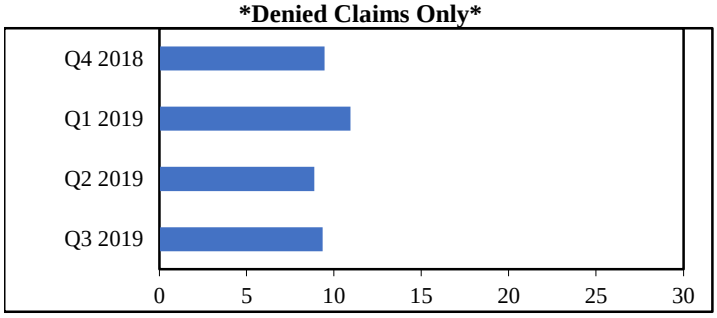
Claims Turnaround Time Most Recent 4 Qtrs All MCOs
Paid Claims Only



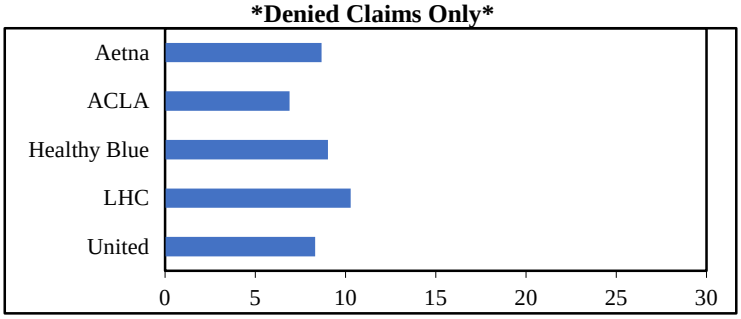
Claims Turnaround Time Quarter 3 2019 only Each MCO
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 3 2019 only)

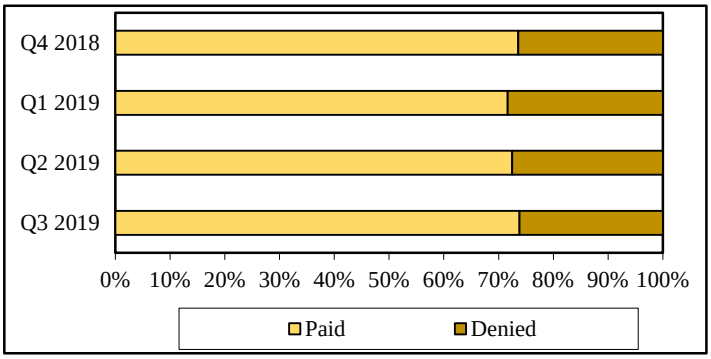
	Aetna		ACLA		Healthy Blue		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	15	7	487	177	856	489	745	302	214	114
101 - 250	0	0	83	44	226	145	253	122	42	21
> 250 claims	0	0	21	8	64	44	176	76	39	16

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

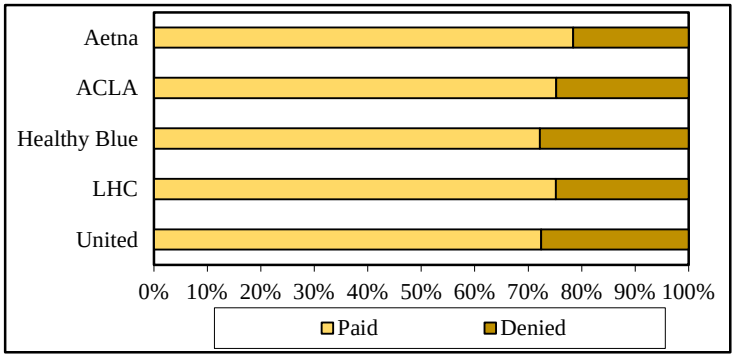
CARC Code	Description	Aetna	ACLA	HBL	LHC	UHC
18	Exact duplicate claim/service	X			X	X
197	Precertification/authorization/notification absent.		X	X	X	X
A1	Claim/Service denied.				X	
29	The time limit for filing has expired.				X	
16	Claim/service lacks information or has submission/billing error(s	X			X	

Summary of Information on Claims for Pharmacy Services

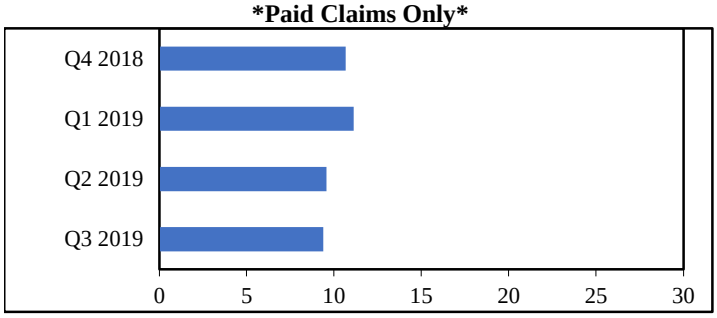
Paid and Denied Trend, Most Recent Four Quarters, All MCOs



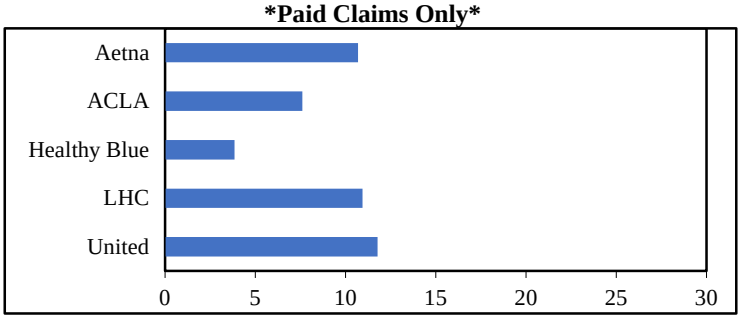
Paid and Denied Trend Quarter 3 2019 only For Each MCO



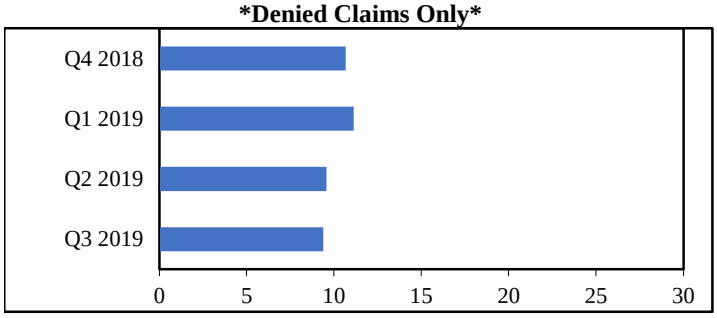
Claims Turnaround Time Most Recent 4 Qtrs All MCOs
Paid Claims Only



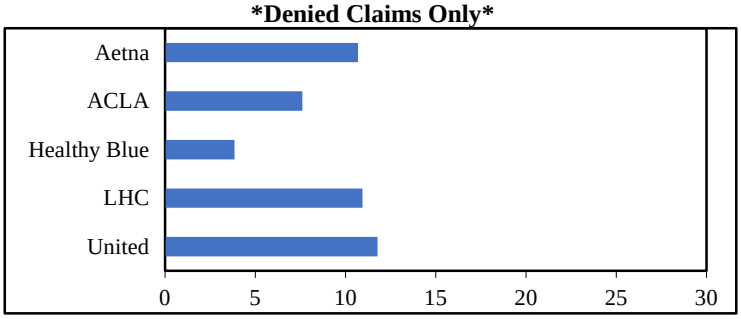
Claims Turnaround Time Quarter 3 2019 only Each MCO
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 3 2019 only)

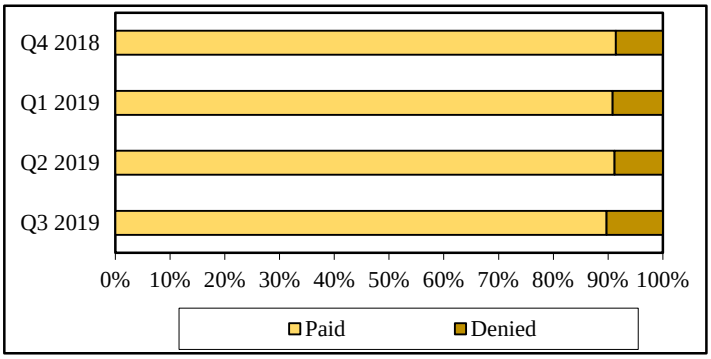
	Aetna		ACLA		Healthy Blue		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	15,849	9604	918	754	1,771	1445	11,815	11,367	17,599	13,334
101 - 250	1,326	1261	387	377	241	236	3,020	2,989	3,696	3,662
> 250 claims	125	124	642	639	834	833	986	985	1,409	1,408

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

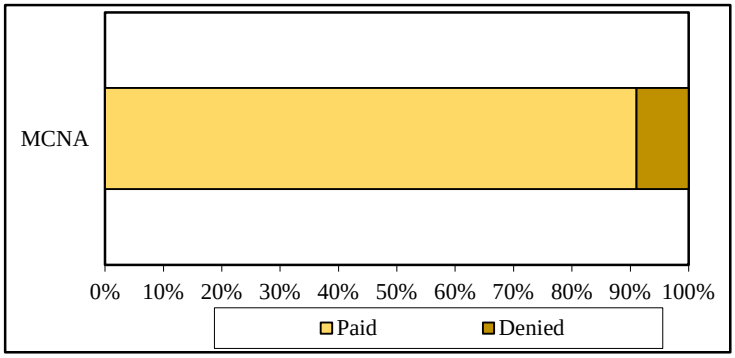
NCDCP Code	Description	Aetna	ACLA	HBL	LHC	UHC
79	Refill Too Soon	X	X	X	X	X
75	Prior Authorization Required	X	X	X	X	
7Ø	Product/Service Not Covered – Plan/Benefit Exclusion	X	X		X	X
88	DUR Reject Error					X
76	Plan Limitations Exceeded	X		X	X	X

Summary of Information on Claims for Dental Services- Children

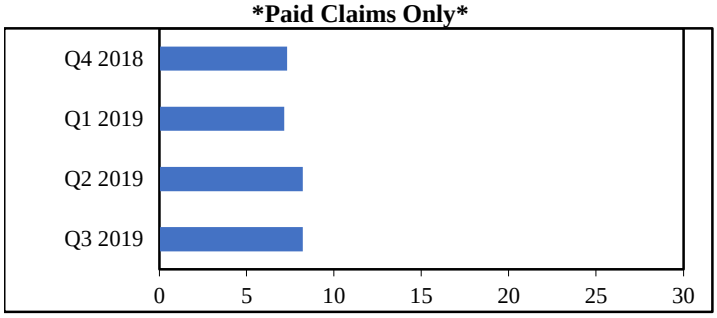
Paid and Denied Trend, Most Recent Four Quarters, All MCOs



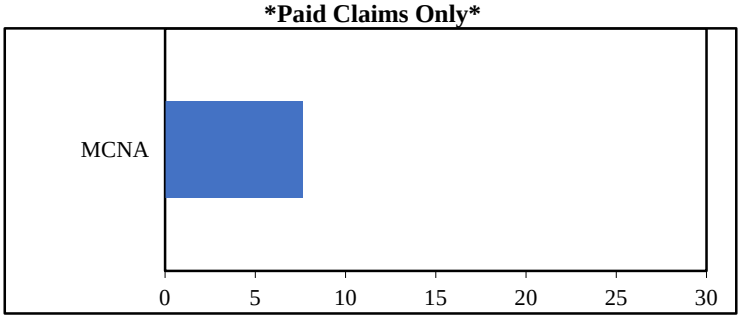
Paid and Denied Trend Quarter 3 2019 only For Each MCO



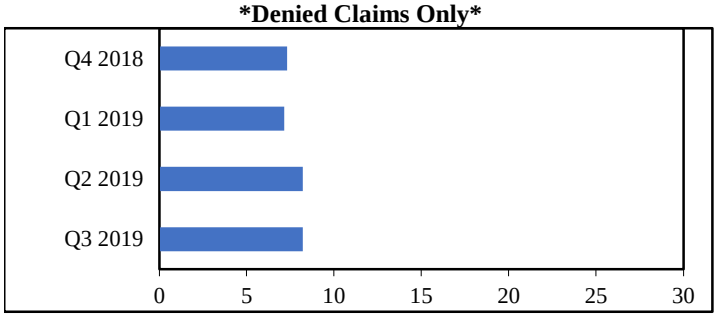
Claims Turnaround Time Most Recent 4 Qtrs All MCOs
Paid Claims Only



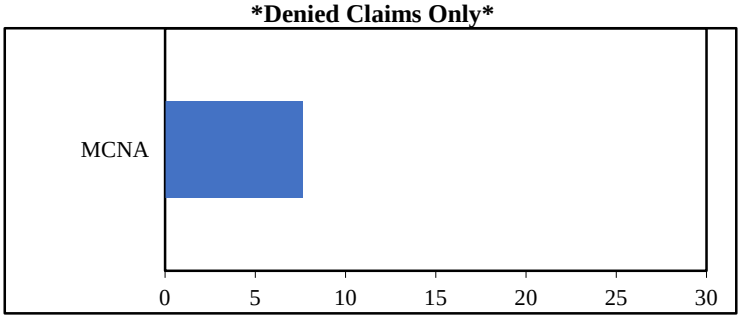
Claims Turnaround Time Quarter 3 2019 only Each MCO
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 3 2019 only)

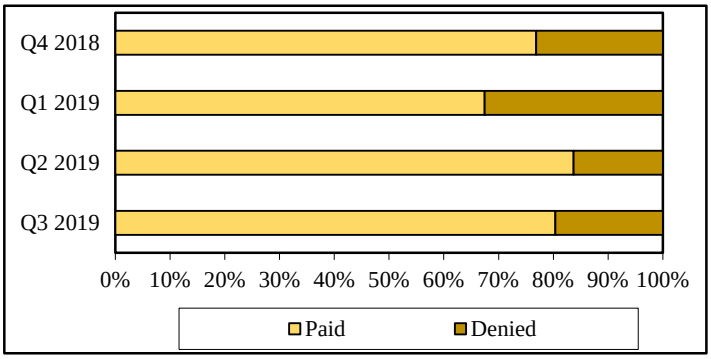
	MCNA	
	# Providers	>10% denied
<100 claims	640	299
101 - 250	179	95
> 250 claims	33	22

Top Denial Reasons this Quarter

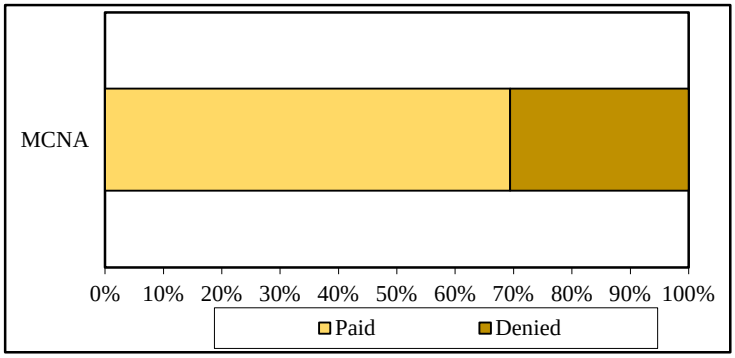
CARC Code	Description	MCNA
169	Alternate benefit has been provided.	X
222	Exceeds the contracted maximum number of hours/days/units by	X
18	Exact duplicate claim/service	X
96	Non-covered charge(s).	X
6	The procedure/revenue code is inconsistent with the patient's age	X

Summary of Information on Claims for Dental Services- Adults

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

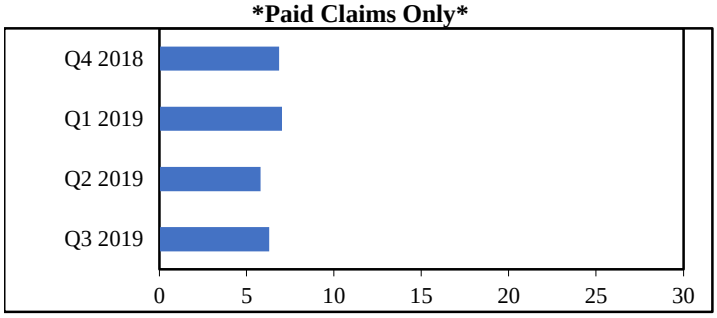


Paid and Denied Trend Quarter 3 2019 only For Each MCO



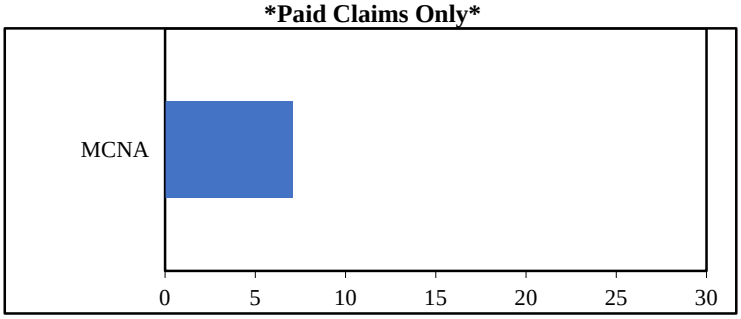
Claims Turnaround Time Most Recent 4 Qtrs All MCOs

Paid Claims Only

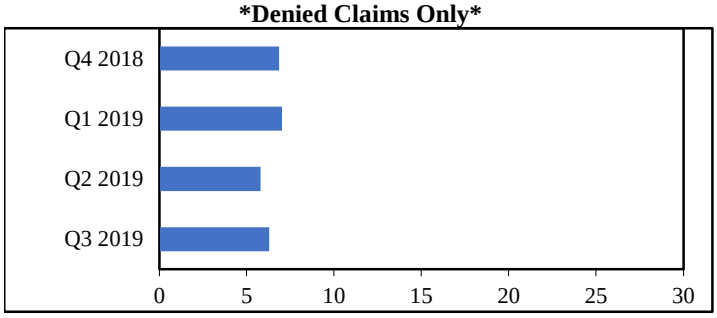


Claims Turnaround Time Quarter 3 2019 only Each MCO

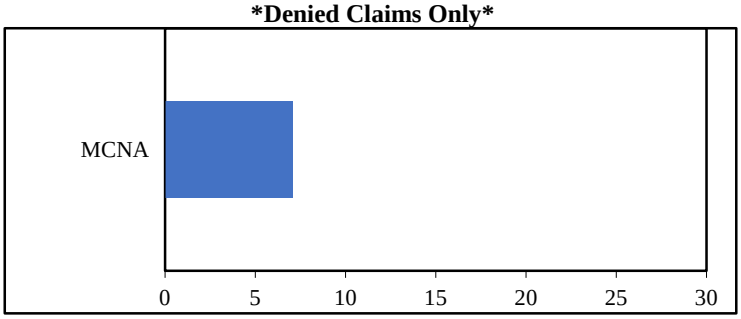
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 3 2019 only)

	MCNA	
	# Providers	>10% denied
<100 claims	343	311
101 - 250	1	1
> 250 claims	0	0

Note: All MCOs 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 rea	
18	Exact duplicate claim/service	X
96	Non-covered charge(s).	X
133	The disposition of this service line is pending further review.	
250	The attachment/other documentation that was received was the in	