Healthy Louisiana Claims Report

Response to Act 710 of the 2018 Regular Legislative Session

Quarter 1 Calendar Year 2022

Prepared by:

Louisiana Department of Health

Bureau of Health Services Financing

November 2022

LOUISIANA DEPARTMENT OF HEALTH

Contents

Executive Summary

Background

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

The initial report covered claims paid during Calendar Year (CY) 2017, and Medicaid submitted this to the legislature October 31, 2018. Medicaid submits subsequent reports on a quarterly basis with each report presenting the most recent four quarters of data available. This report covers Quarters 2, 3, and 4 of CY 2021 and Quarter 1 of CY 2022.

Key Findings

Measure #1: Claims Accepted and Rejected by the MCEs

- The claim acceptance rate for all MCEs combined has held constant at 99% for the past four quarters.

- In the most recent four quarters for which data is available, the claims rejection rate reported by the MCEs was between 1.0% and 1.3%. This rate, however, is driven primarily by Louisiana Healthcare Connections (rejection rate of 2.4% to 2.7%) and UnitedHealthcare (rejection rate of 1.0% to 1.8%) with the other MCEs having rejection rates close to zero.

Measure #2: Claims Paid and Denied by the MCEs

- The claim denial rates have been generally consistent since Act 710 reporting began. The overall rate of accepted claims paid by the MCEs was between 80.8% and 81.5% in the most recent four quarters. The denial rates, therefore, were between 18.5% and 19.2%.

- At the MCE-specific level, the average denial rate in the last four quarters ranged from 9.0% for DentaQuest to 24.1% for Aetna Better Health.

- Medicaid found more variation when it examined the claims denial rates by provider type. For example, pharmacy (average 29.8% in the last four quarters) and dental - adults (average 21.2% in the last four quarters) have the highest denial rates while non-emergency medical transportation (average 2.5% in the last four quarters) and outpatient hospital services (average 9.1% in the last four quarters) have the lowest denial rates.

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

LDH requires that 90% of clean claims be adjudicated (paid or denied) within 15 business days and that 100% of clean claims be adjudicated within 30 calendar days. The measurement for turnaround time (TAT) for adjudication is the number of days from receipt of the claim by the MCE to the time in which the provider is paid or notified they will not be paid.

- The MCEs are meeting LDH's target for adjudication within 30 days. The average TAT is at or below 9 days in the last four quarters for all MCEs with the minor exception of MCNA with an average TAT of 11 days.
- The overall TAT for paid claims, all MCEs combined, is between 7.9 days and 8.0 days in each quarter. For denied claims, the average is between 5.6 days and 7.0 days.
- Average claims adjudication TATs do vary by provider category, but not significantly, from the overall average.

Measure #4: Top Reasons for Denied Claims

When a claim is adjudicated, the claims processor will assign codes to indicate the reason(s) why the claim adjudicated the way it did. For medical and dental claims, there is a set of nationally recognized Claim Adjustment Reason Codes (CARCs), about 290 reason codes in all. For pharmacy claims, there are close to 350 reason codes developed by the National Council for Prescription Drug Programs (NCPDP*)*.

Key findings by CARCs:

- The top five CARCS for Q1 2022 were:

CARC Code	Description
96	Non-covered charge
16	The claim lacks information or has a billing error which is needed for adjudication
252	An attachment/other documentation is required to adjudicate this claim/service
97	The benefit for this service is included in the payment for another service already adjudicated
18	Exact duplicate claim/service

- The top five CARCs in this quarter were also among the top seven in the previous 12 quarters reported, demonstrating a level of consistency in top reasons for denial over time.

Key findings on NCPDPs appear below:

- The top five NCPDPs in Q1 2022 were:

NCPDP Code	Description
88	Drug Utilization Review (DUR) reject error
79	Refill Too Soon
76	Plan limitations exceeded
75	Prior Authorization Required
39	Missing/invalid diagnosis code

- These five NCPDPs were also among the top six in the previous 10 quarters reported.

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

- In the most recent four quarters studied, LDH accepted 96.4% to 98.7% of the encounters submitted by all MCEs.

- There were differences at the MCE level. All of UnitedHealthcare's encounters were accepted. Almost all of Louisiana Healthcare Connections' encounters were accepted over the past four quarters. Healthy Blue averaged 98.3% of encounters accepted. AmeriHealth Caritas Louisiana averaged 96.2% of encounters accepted for the previous four quarters. DentaQuest averaged 91.5% over the last four submitted quarters. Aetna Better Health's four-quarter average of encounters accepted is 86.1%.

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

A common benchmark used to measure timeliness of encounter submissions is that MCEs should submit encounters within 30 days of adjudication. There is some variation in the pace at which each MCE submits its encounters to LDH, and this can vary by claim category.

- Across all MCEs, the overall average rate of submission within 30 days for institutional, professional, dental, and pharmacy encounters was 91.4%. The rate of submission improved by 1.8% from the previous four quarters (89.6%).

- UnitedHealthcare has been the most consistent over the past four quarters with an overall average of 98.2%.

- AmeriHealth Caritas Louisiana had the second highest rate of timeliness for encounter submissions with an average of 97.4% over the past four quarters.

- Aetna Better Health had issues with timely submissions for pharmacy encounters but continue to show improvements with institutional and professional encounters this quarter.

- In regards to dental encounters, DentaQuest has been the most consistent over the past four quarters with an average of 100%. MCNA's fourth quarter rate of submission average was 96.6%.

Measure #7: Provider Education Conducted by the MCEs on Claims Submissions

LDH requires that the MCEs report information on education to providers on claims adjudication on a quarterly basis. The MCEs are reporting on the number of individual entities to whom they outreach, the type of outreach conducted, and the date that the outreach occurred.

In Q1 2022, Medicaid reached out to 1,024 provider entities (1,060 in the prior quarter). The most predominant mode of outreach to providers is 1:1 phone calls (64.7% of all contacts) followed by 1:1 emails (28.7% of contacts). Webinars were 6.2% of the total. Very few in-person provider education took place due to the COVID-19 pandemic.

Measure #8: Case Management

Each of the five health plans is contractually required to develop and implement a case management program through a process that 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.

Key findings for Q1 2022:

- A total of 48,552 of unduplicated individuals enrolled in the Louisiana Medicaid Managed Care program were identified as potentially eligible or in need of case management services.
- Of these, 29.4% or 10,284 were enrolled in case management for at least one month during the first quarter of CY 2022 and;
- A total of 6,258 (59.5%) actively received one or more case management service(s).

Listing of Exhibits

Section I: Introduction

Legislative Overview

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

The initial report covered claims paid during Calendar Year (CY) 2017. Medicaid submits subsequent reports on a quarterly basis. Each subsequent report must cover a more recent three-month period than the previous report. This is the fifteenth report update.

Report Update	Calendar Year 2018				Calendar Year 2019				Calendar Year 2020				Calendar Year 2021				Calendar Year 2022			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1	X	X	X																	
2	X	X	X	X																
3		X	X	X	X															
4			X	X	X	X														
5				X	X	X	X													
6					X	X	X	X												
7						X	X	X	X											
8							X	X	X	X										
9								X	X	X	X									
10									X	X	X	X								
11										X	X	X	X							
12											X	X	X	X						
13												X	X	X	X					
14													X	X	X	X				
15														X	X	X	X			

Terminology Used in this Report

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

Steps in Claims Processing and Encounter Submissions

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

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

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

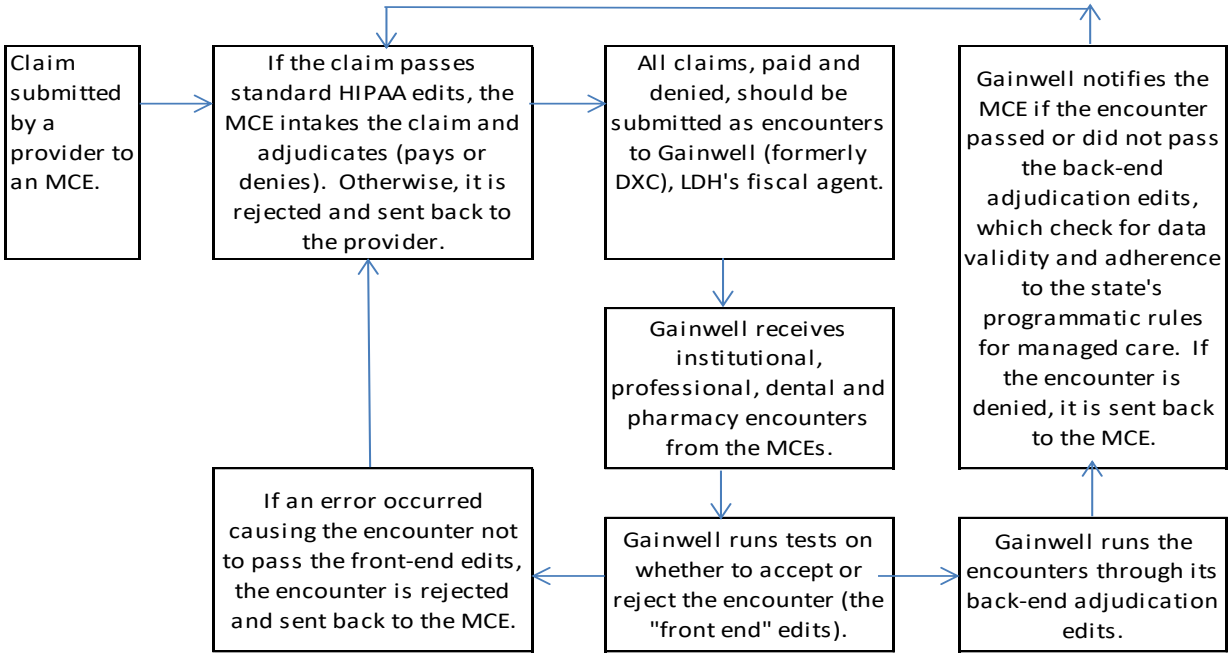
- The *CMS-1500, or electronic 837P*, is the claim type for professional service providers to submit. This includes a wide array of providers such as physicians, clinics, mental health providers, therapists, transportation providers, suppliers of medical equipment and supplies.

- The paper and *electronic 837D* versions 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 summarizes how claims are submitted to MCEs in Louisiana and, in turn, the process in which the MCEs submit encounters to the Department's fiscal agent, Gainwell Technologies (formerly DXC/Molina).

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



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 becomes 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. Medicaid then assigns an *adjudication status* of paid or denied to the claim. However, this status can have 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, but 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 in this information when analyzing claims and claim trends. The count of header lines may be a fraction of the total detail service lines.

The Department has asked the MCEs to report all information on claims adjudication at the service (detail line) level with one exception. For inpatient services, LDH and its MCEs make the payment 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 have 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 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 term is 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 the MCE's receipt of the claim to the time of provider notification (pay or deny).

When a claim is adjudicated, the claims processor will assign codes to indicate the reason(s) why the claim adjudicated the way it did. Many payers will design codes specific to their own organization. However, there are sets of industry standard codes used nationally and required by LDH:

- For medical and dental claims, there is set of nationally recognized Claim Adjustment Reason Codes (CARCs), nearly 290 reason codes in all; and
- For pharmacy claims specifically, there are nearly 350 reason codes developed by the National Council for Prescription Drug Programs (NCPDP).

LDH requires the contracted MCEs to submit information on the CARCs and NCPDP codes that pertain to situations when claim lines are denied. This study examines the frequency of CARCs and NCPDP codes for denied services. A service line on a claim may have more than one CARC or NCPDP code as well.

MCEs Analyzed in this Quarter's Review Include:

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	LHCC
UnitedHealthcare of Louisiana, Inc.	Managed care organization	UHC
MCNA Insurance Company, Inc.	Dental benefit program manager	MCNA
DentaQuest	Dental benefit program manager	DQ

Measures Reported Each Quarter

The key measures that are tracked on an ongoing basis include:

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

Provider Categories

Act 710 requires 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 Services 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 (DQ and 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)	

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

Data Collection

Medicaid designed templates for six reporting areas specifically to report information in the Act 710 quarterly updates and incorporate them into a consolidated reporting template—Report 152. LDH requires that each MCE submit the 152 report on a quarterly basis. To allow time for the MCEs to accumulate data to report, there is a lag time between the claims adjudication period and the date that the MCEs submit the reports to LDH as allowed by the Act.

Limitations of the Data

1. MCEs self-report all data to LDH. LDH conducts a validation process upon submission of reports each quarter. In some situations, LDH asks the MCEs 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, the approach selected 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. Values shown for denied claims should not be considered as "lost" money to providers, as not all claims are payable. Instead, they provide useful information on key areas to target for improvement both in the Department and with provider education.

Report Structure

Section II contains a summary table of data trends across all quarterly reports, Q1 2018 through Q1 2022. Section III contains the results related to MCE claims adjudication measures and MCE provider education pertaining to claim submissions. Section IV reports on the results of findings related to MCE encounter submissions and Section V presents summary data on case management by MCE for the quarter.

In some exhibits, data displays the most recent four quarters. In this report, the four quarters shown are Quarters 2, 3, and 4 in 2021 and Quarter 1 in 2022. 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 Q1 2022 data.

Appendix A provides the numeric values for the exhibits shown in the body of the report, which are shown in a graphical format. *Appendix B* provides a one-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.

Section II: Data Trends

Q1 2018 to Q1 2022

When reviewing trends across all prior quarterly report updates, the trends have been fairly consistent over time with the greatest variation occurring in the timeliness of encounter submissions:

Claim Rejection Rate	MCEs reject 1.0% to 1.4% of provider claims
Claim Payment Denial Rate, Overall	From a low of 17.5% to a high of 19.6%
For Hospital Claims Denial Rate	Much higher for inpatient hospital services (16.7%-22.9%), but outpatient hospital services have one of the lowest denial rates of any service category (8.4%-10.6%).
For Professional Services	The denial rate range has been steady between 11.3% and 14.3%
For Dental Claims	For child dental services, denial rate had been steady between 6.9% and 13.3%. The denial rate for adult dental services has fluctuated between 10% and 24.2%
For Pharmacy Claims	Industry standard is that pharmacy scripts have highest denial rate. Louisiana Medicaid Managed Care is no exception with a denial rate range between 25.9% and 32.1%. This is a result of pharmacy claims being a Point of Sale system.
Turnaround Time to Process Claims	The average time for MCEs to process provider claims has been steady in every report, from 7.7 days to 8.4 days. The overall average since the implementation of this report is 8 days.
Time for MCEs to Submit Claims as Encounters to LDH	There is variation in the timeliness for the MCEs to submit encounters to LDH. This can vary by MCE and by quarter. Generally, UHC is most consistent timely (that is, all encounters submitted to LDH within 30 days of processing) with 98.2%. ACLA has a 97.4% submission rate. HB submit over 90.6% of their encounters within 30 days. LHCC has an 89.8% submission rate. ABH has a lower submission rate of 76.5% of encounters submitted within 30 days. For dental, DQ has a 100% submission rate and MCNA has 96.6%.

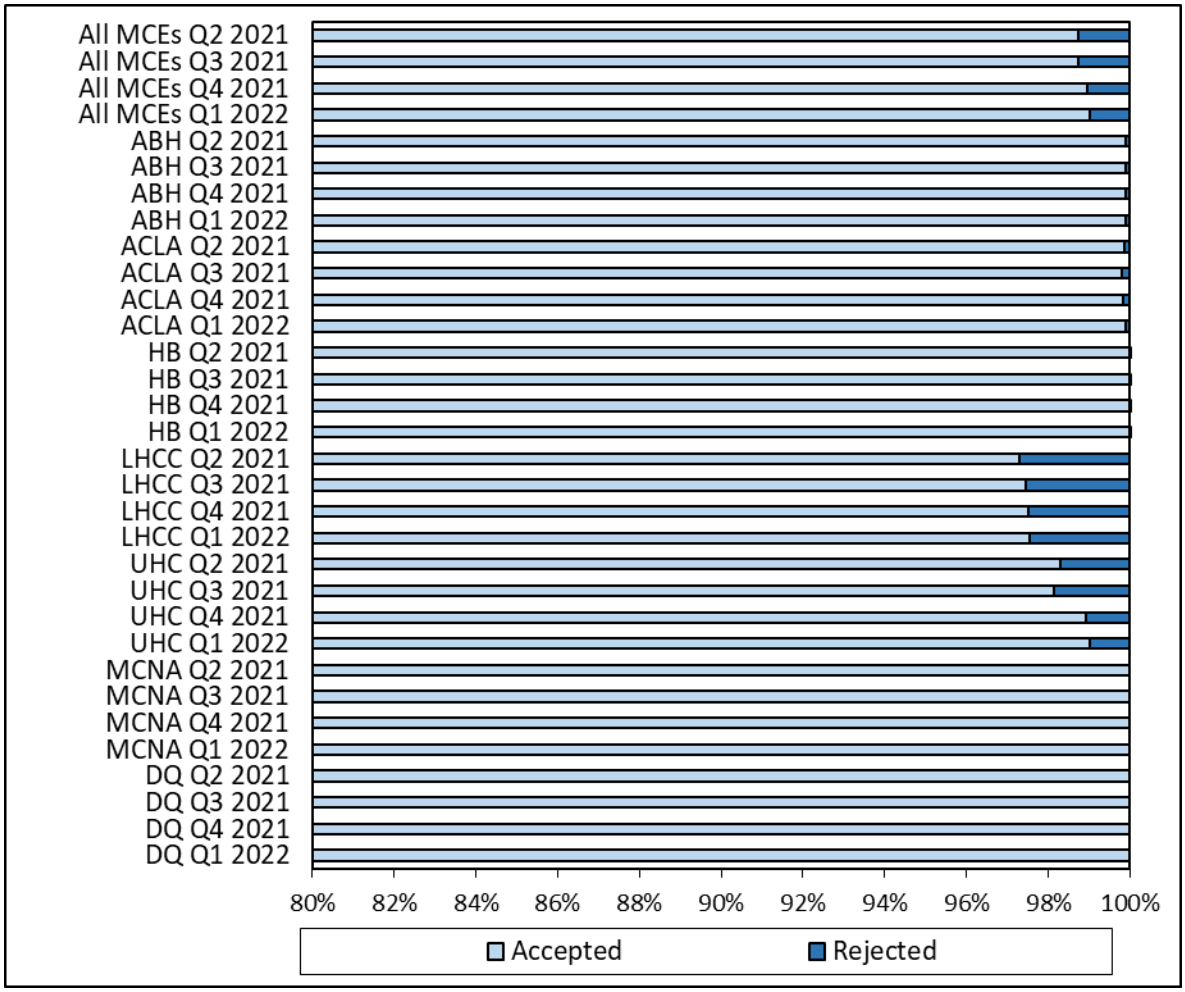
Section III: Findings Related to MCE Claims Adjudication

The MCEs or their subcontractor first process claims from providers for payment of services against the standard HIPAA edits. If the claim does not meet HIPPA edit requirements, it is "rejected" and returned to the provider without adjudication.

Claims Accepted and Rejected by the MCEs

In the most recent four quarters for which data is available, the MCEs claims rejection rate was between 1.0% and 1.3%. The rejection rate overall is specifically due to higher rejection rates for LHCC (2.4% to 2.7%) followed by UHC (1.0% to 1.8%) with the other MCEs having rejection rates closer to zero.

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



Claims Paid and Denied by the MCEs

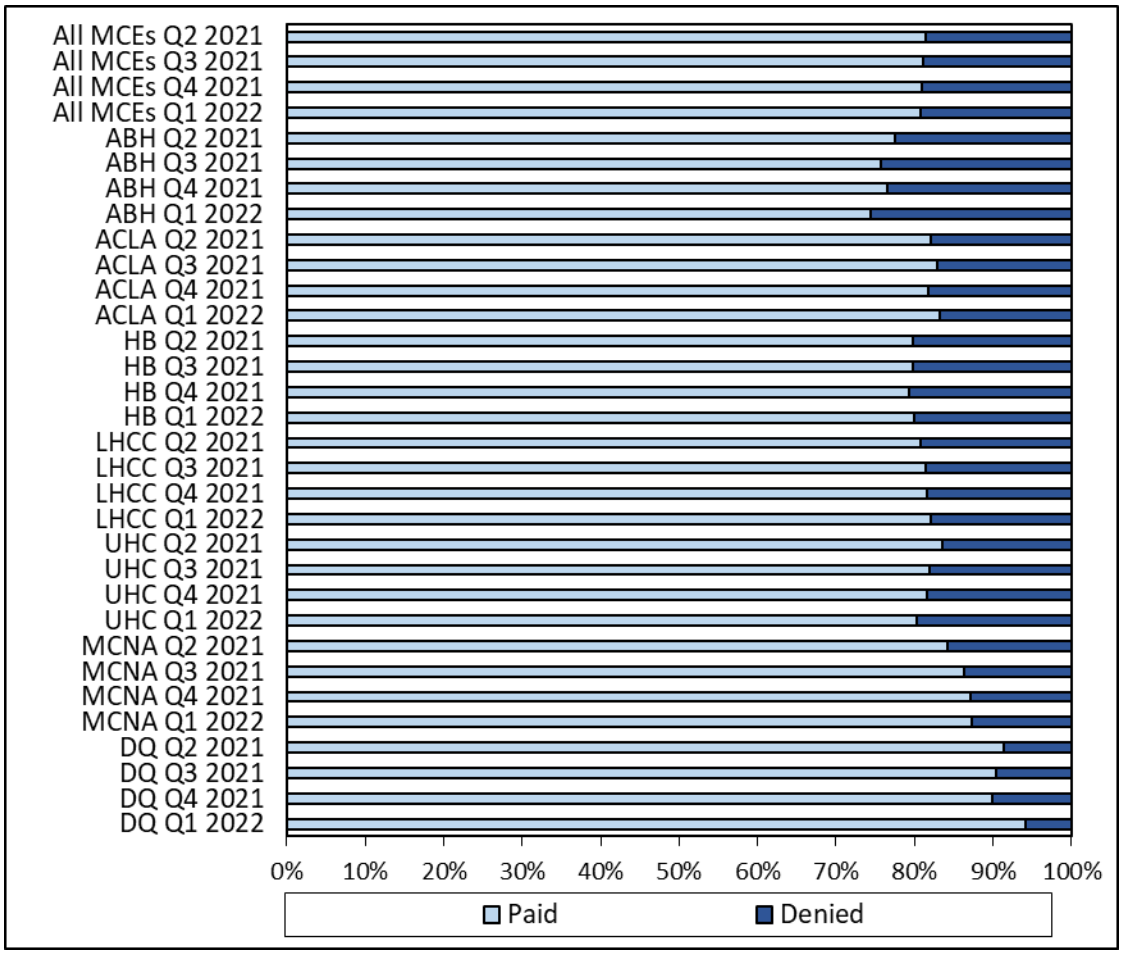
LDH's contracted MCEs or their subcontractor adjudicates all provider claims that pass standard HIPPA edits. The five health plans adjudicate medical claims (those billed in the institutional claims, or 837I, format and those billed in the professional claims, or 837P, format) themselves. Each MCE uses a pharmacy benefit manager to adjudicate the pharmacy claims. MCNA and DQ adjudicate all of their dental claims for the Medicaid program.

For those claims that were accepted into the MCE's claims adjudication system, on average, the overall rate of paid claims was between 80.8% and 81.5% in the most recent four quarters. The denial rates, therefore, were between 18.5% and 19.2%. These denial rates have remained fairly steady since the Act 710 quarterly update reports have been release.

At the MCE-specific level, the range across the four-quarter averages was from an average denial rate of 9.0% for DQ to an average rate of 24.1% for ABH. The denial rates are not going down in any significant manner since the original report showing CY 2017 data.

ABH noted their increase in claim denials in Quarter 1 for home health, OBGYN, and primary care was most likely due to COVID rebound in appointments. HB stated their increase in claim denials for primary care and OBGYN was due to an increase in providers submitting claims outside of timely filing as well as claims billed without prior authorization on file or claims for services outside of the authorization on file. HB also detected a small increase for last quarter of claims submitted that were duplicate claims. ACLA increase in claim denials for therapies were due to more counts of no prior authorization. In addition, the claims team is auditing mental/behavioral health providers to identify possible provider education or a claims system issue to address the increase in mental/behavioral health denials. UHC noted their claim classification criteria was refined to align with LDH requirements which resulted in an increase in claim denials for outpatient hospital, other specialized behavioral health, and mental/behavioral health in Quarter 1.

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



Denial rates are shown for acute care services (Exhibit III.3) and non-acute care services (Exhibit III.4). As seen in both exhibits, the denial rate trends vary by service category.

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

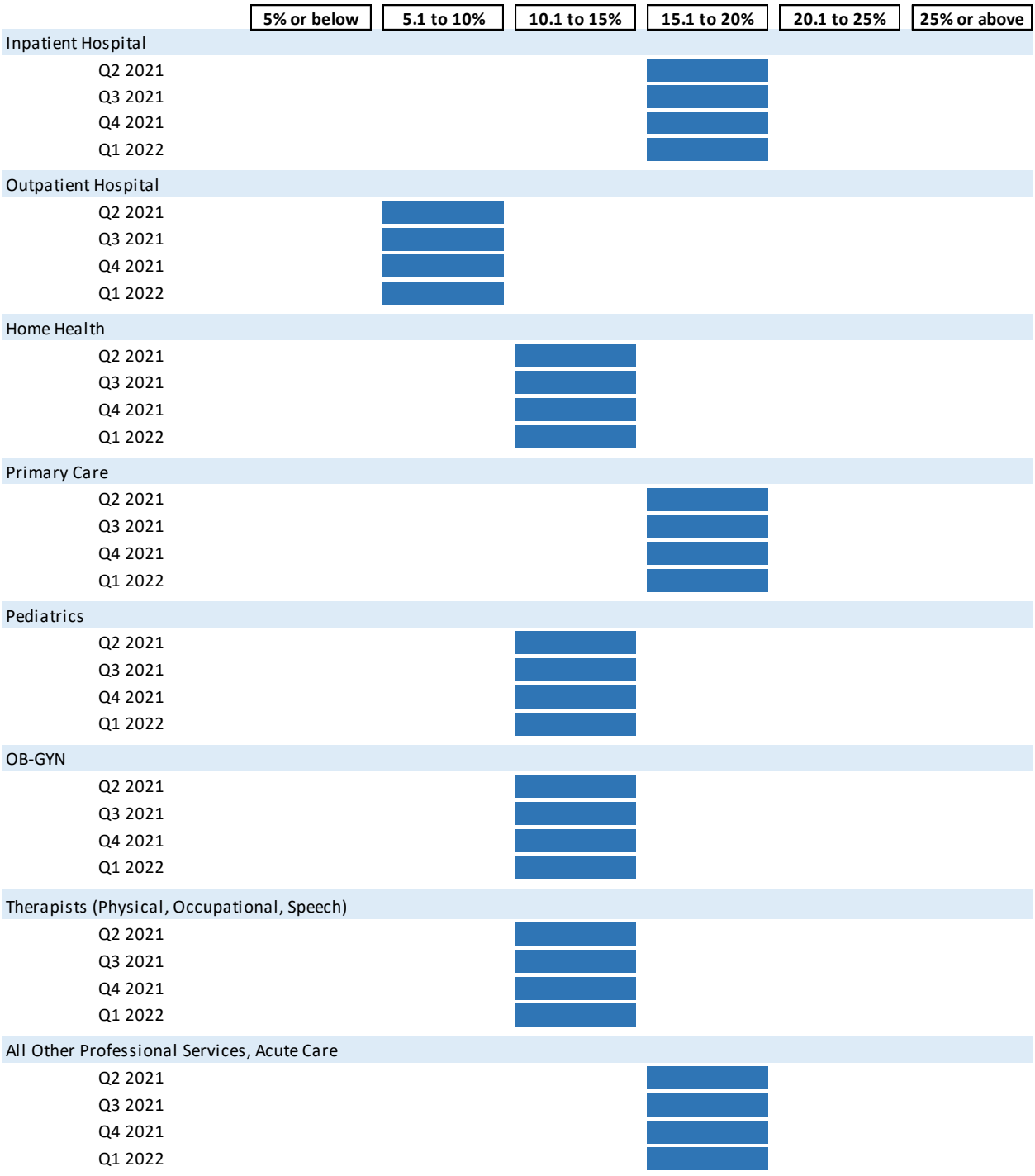


Exhibit III.4
Claim Denial Rates for Non-Acute Care Services
For All MCEs Combined, By Quarter

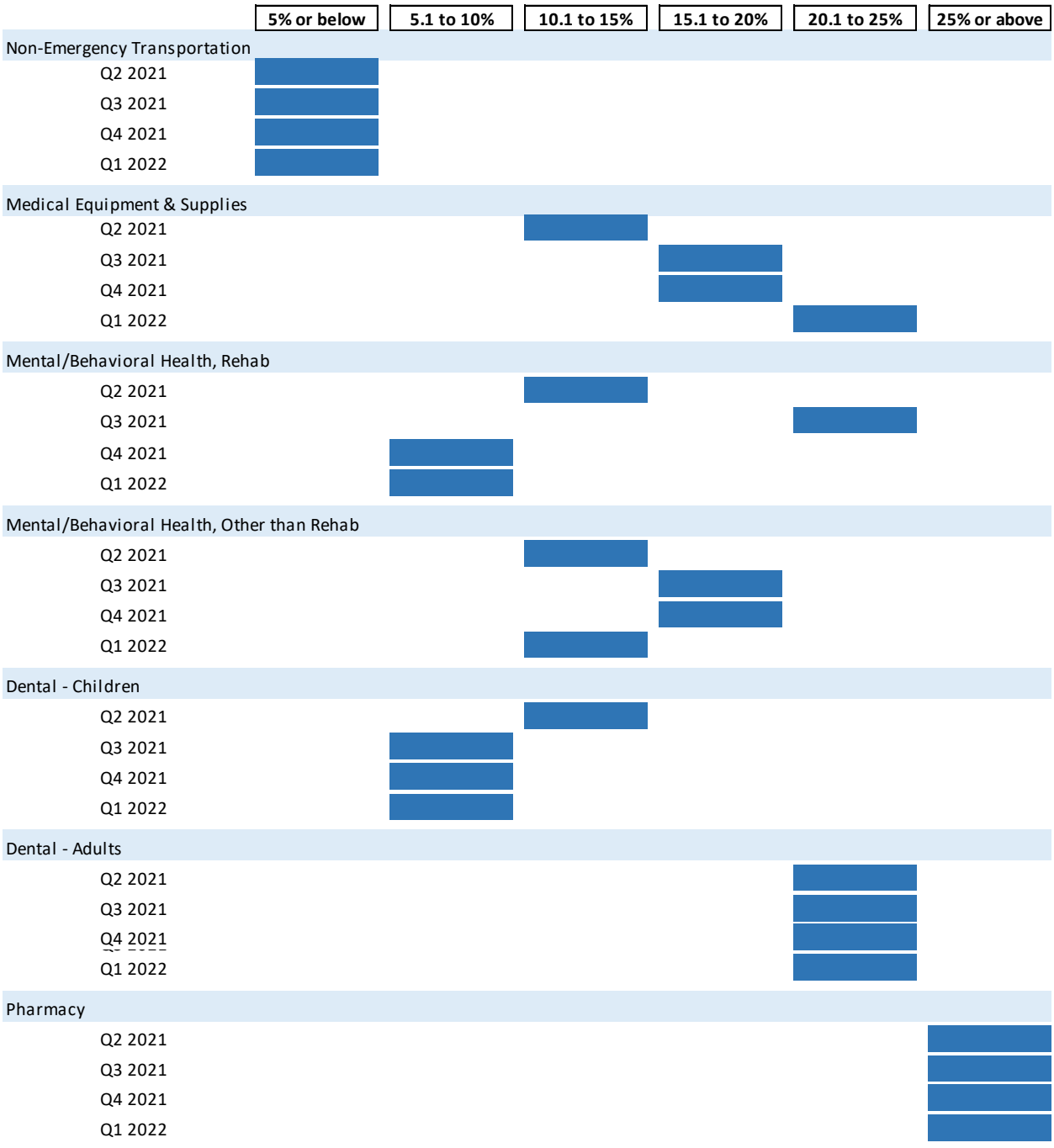
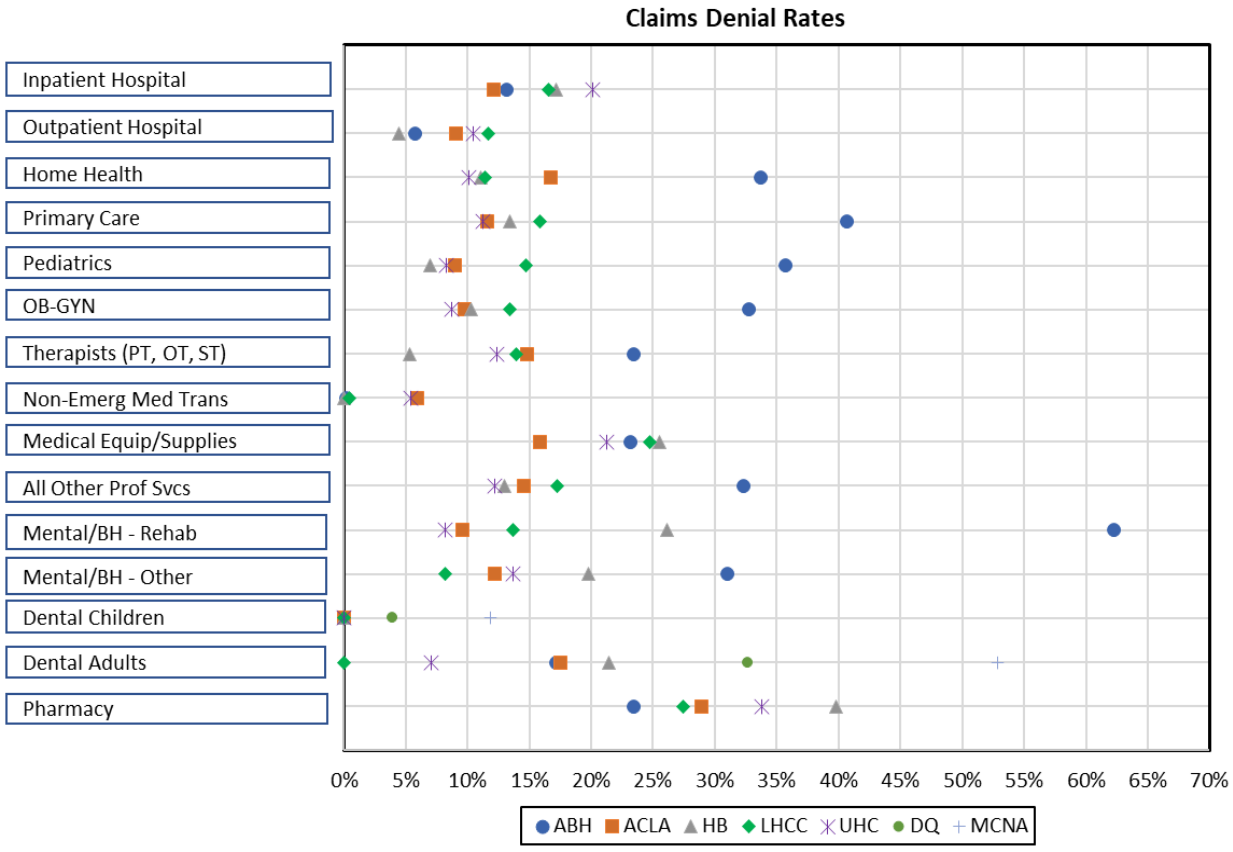


Exhibit III.5 compares the denial rates for these service categories by MCE. The data plotted on this exhibit is the percentage of claims denied in Q4 of CY 2021 for each MCE. An icon and color are used to display each MCE's data. Each row in the exhibit represents a specific service category. For example, in the top line of the exhibit, the overall denial rate for inpatient hospital services in Q1 2022 was 15.8%, but this varied from 12.1% for ACLA to 20.2% for UHC.

The claims denial rate is clustered for home health, primary care, pediatrics, OB-GYN, non-emergency medical transportation, and dental. For other services, the denial rates vary significantly by MCE (e.g., mental/behavioral health services). In other categories, most MCEs have a similar rate, but ABH (e.g., home health, primary care, pediatrics, OB-GYN, therapies, other professional services, and mental/behavioral health) vary from all of their peers.

Exhibit III.5
Claim Denial Rates for Adjudicated Claims
By Provider Specialty / Service Category
By MCE for Q1 2022



Act 710 requires LDH to provide an assigned value to each of the claims that the MCEs denied. As discussed in the Limitations of the Data section on page II-2, there are hundreds of edits that are in place at each MCE to ensure that claims are adjudicated properly. Claims may be denied for a number of reasons, but just to name a few:

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

In some of these situations, the denied claim could never have received a payment (e.g., exact duplicate submitted). In other situations, the denied claim 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 for the initial report, LDH contracted with Burns & Associates, Inc. to develop a model to tabulate the information on denied claims from each MCE and assign a value to each denied claim without inferring if the claim could have been paid or should have been paid. Medicaid Business Analytics, the Medicaid section responsible for compilation of the data used in the ACT 710 Healthy Louisiana Claims report, continues to use this model for the quarterly updates.

To do this, Medicaid examined each of the provider specialties separately. Within each category, the MCE reported the number of claims paid and the total payments made. After computing an average payment per claim, the MCEs reported the number of denied claims in the provider specialty. The average payment per claim in the provider specialty is multiplied 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 reimbursements paid to each provider type. For example, in Q1 2022, the average payment for paid inpatient hospital claims was $6,637; for primary care, it was $42.

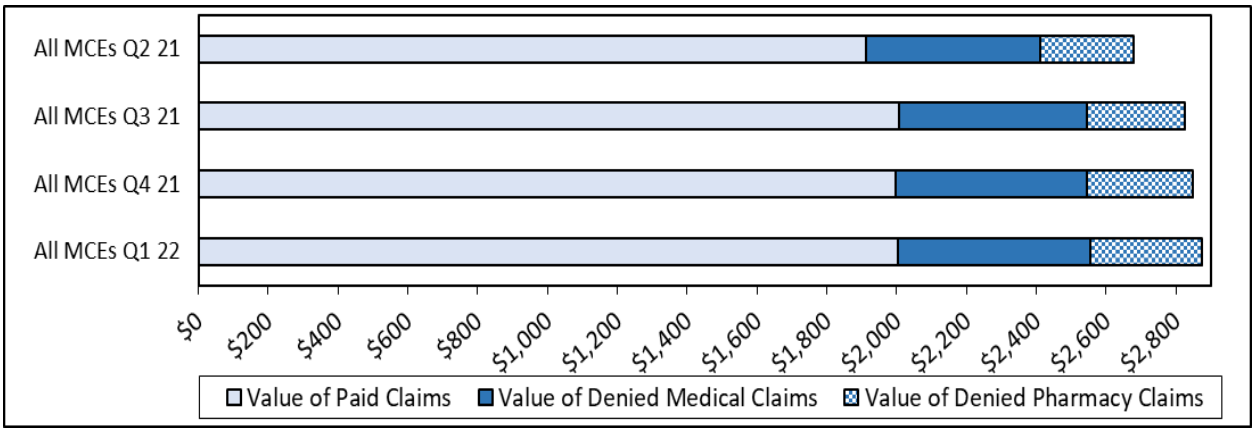
Not only was an average payment per claim computed for each provider specialty separately, but one was also computed for each MCE within the provider type as well as a separate value for each calendar quarter.

Exhibit III.6 summarizes the total dollar values of paid claims and denied claims by MCE and by quarter. The denied claims account for between 20.6% and 21.6% of the sum of paid and denied values each quarter. This equates to between $498 million and $551 million. Among the $551 million in denied

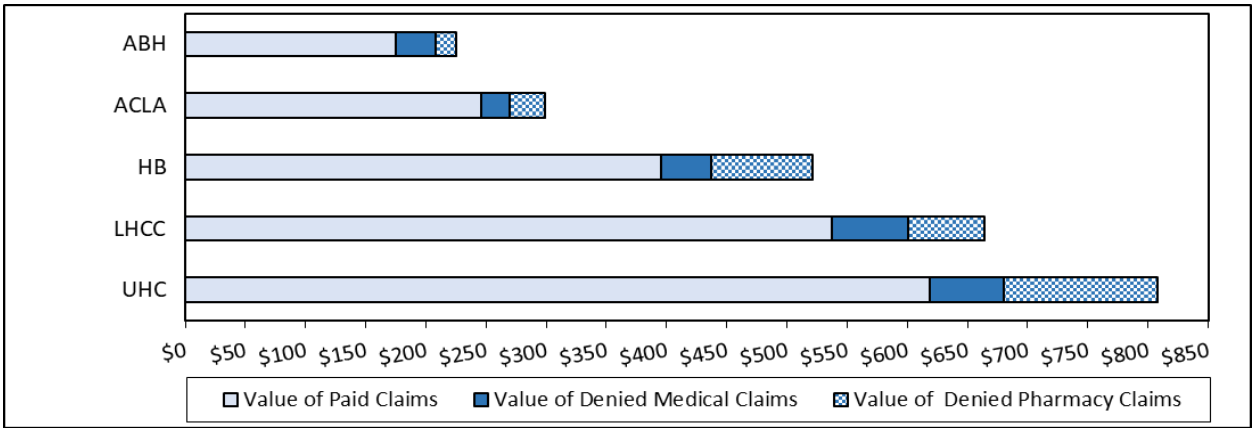
values in Q1 2022 assigned across the five MCEs that provide medical and pharmacy benefits, $225 million (41.1%) was attributed to medical claims and $322 million (58.9%) was attributed to pharmacy claims. In Q1 2022, the distribution of assigned values to denied claims by MCE was as follows:

- ABH had 66.0% medical and 34.0% pharmacy claims
- ACLA had 43.8% medical and 56.2% pharmacy claims
- HB had 33.6% medical and 66.4% pharmacy claims
- LHCC had 50.2% medical and 49.8% pharmacy claims
- UHC had 32.6% medical and 67.4% pharmacy claims
- MCNA and DQ had a total value of $33 million (88.6%) paid claims and $4.3 million (11.4%) value of denied medical claims.

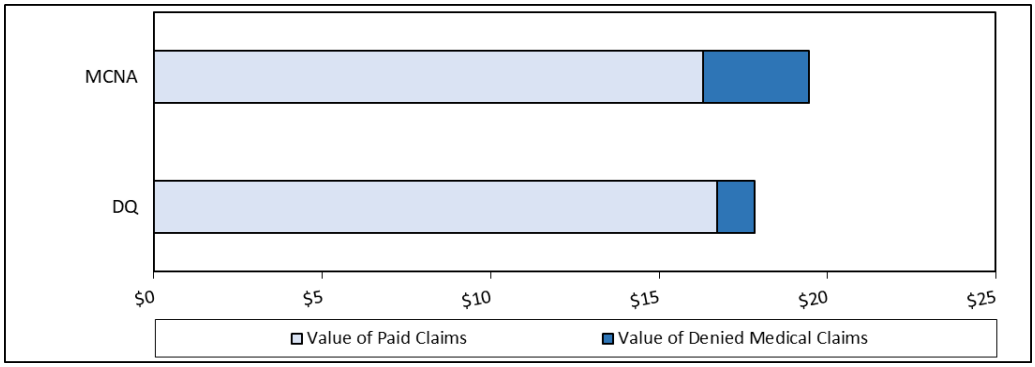
Exhibit III.6
Value of Paid and Denied Claims
The dollar values in the stacked bar represent millions



Value of Paid and Denied Claims by MCE – Q1 2022



Value of Paid and Denied Dental Claims – Q1 2022



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

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

LDH then examined the data submitted by the MCEs 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. LDH defined a high denial rate as any provider that had more than 10% of their claims denied by the MCE in the quarter. LDH then ran statistical analyses to determine what percentage of providers within each group had a high claims denial rate (that is, more than 10%). With 14 provider specialties (excluding dental) and three groupings within each specialty (low volume, medium volume, high volume), there can be as many as 42 provider/volume groupings to examine. These are then examined for each of the five MCEs (excluding dental services paid by MCNA and DentaQuest), so 42 groupings for five MCEs is 210 groupings. The other two provider specialties are specific to dental, so this adds 12 more groupings. That means LDH examined 222 groupings for each quarter.

Each of the 222 groupings are reviewed 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 (five or less) to make an assessment.

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

The counts represent all MCEs combined. There has been relative consistency in the number of combinations where a majority of providers had a denial rate above 10% in the last four quarters. There was no obvious pattern when reviewing the results in Exhibit III.7 except that, in most service categories, the larger-volume providers have lower denial rates than the smaller-volume providers. There are a few differences in the rate of denials where one MCE stands out from the rest.

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

	Group A	Group B	Group C	Groups A, B, C
	Number of combinations where > 50% of providers had a denial rate above 10%	Number of combinations where < 50% of providers had a denial rate above 10%	Number of combinations where the sample of providers was too small to study	Total Groupings
Q2 2021	92	94	36	222
Q3 2021	97	93	32	222
Q4 2021	102	84	36	222
Q1 2022	105	83	34	222

Timeliness of Claims Adjudication by the MCEs

LDH requires that 90% of clean claims be adjudicated within 15 business days and that 100% of clean claims be adjudicated within 30 calendar days. An adjudicated claim could mean a decision to either pay or to deny. The measurement for TAT for adjudication is the number of days from receipt of the claim by the MCE to the date on which the provider is paid or is notified of the denial.

Exhibit III.8 below shows that the MCEs are meeting the target for adjudication within 30 days as set by LDH. In fact, the average TAT is at or below 9 days in every quarter for all MCEs with the minor exception of MCNA with an average of 11 days for paid and denied claims over the past four quarters. The TAT averages do vary, however, across the MCEs.

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

		Adjudicated Within 30 days		Avg Turnaround Time	
		Pct of Paid	Pct of Denied	Paid Claims	Denied Claims
ABH	Q2 2021	99.7%	99.2%	8.2	5.6
	Q3 2021	99.8%	99.6%	8.3	6.1
	Q4 2021	98.7%	97.7%	8.3	6.5
	Q1 2022	99.5%	98.8%	8.1	6.9
ACLA	Q2 2021	100.0%	100.0%	6.5	7.3
	Q3 2021	100.0%	100.0%	7.2	8.3
	Q4 2021	99.6%	99.7%	7.1	7.7
	Q1 2022	98.7%	98.8%	6.8	7.4
HB	Q2 2021	99.8%	99.6%	6.8	4.4
	Q3 2021	99.2%	98.6%	6.4	8.3
	Q4 2021	99.9%	99.8%	7.7	3.4
	Q1 2022	99.4%	99.7%	8.3	3.5
LHCC	Q2 2021	99.9%	99.8%	8.5	9.2
	Q3 2021	99.9%	99.8%	8.7	9.2
	Q4 2021	99.9%	99.8%	8.7	9.3
	Q1 2022	99.9%	99.9%	8.3	9.1
UHC	Q2 2021	100.0%	99.8%	9.1	3.8
	Q3 2021	99.9%	99.8%	9.0	3.4
	Q4 2021	100.0%	99.8%	7.7	2.8
	Q1 2022	99.9%	99.7%	7.9	2.9
MCNA	Q2 2021	100.0%	100.0%	10.0	11.2
	Q3 2021	97.6%	95.8%	11.1	13.3
	Q4 2021	100.0%	100.0%	10.1	12.0
	Q1 2022	100.0%	100.0%	8.9	10.6
DQ	Q2 2021	100.0%	100.0%	5.8	4.9
	Q3 2021	100.0%	100.0%	5.3	3.9
	Q4 2021	100.0%	100.0%	5.4	3.8
	Q1 2022	100.0%	100.0%	3.9	5.0
ALL MCEs	Q2 2021	99.9%	99.7%	8.0	6.2
	Q3 2021	99.7%	99.5%	8.0	7.0
	Q4 2021	99.8%	99.6%	8.0	5.7
	Q1 2022	99.6%	99.6%	7.9	5.6

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

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

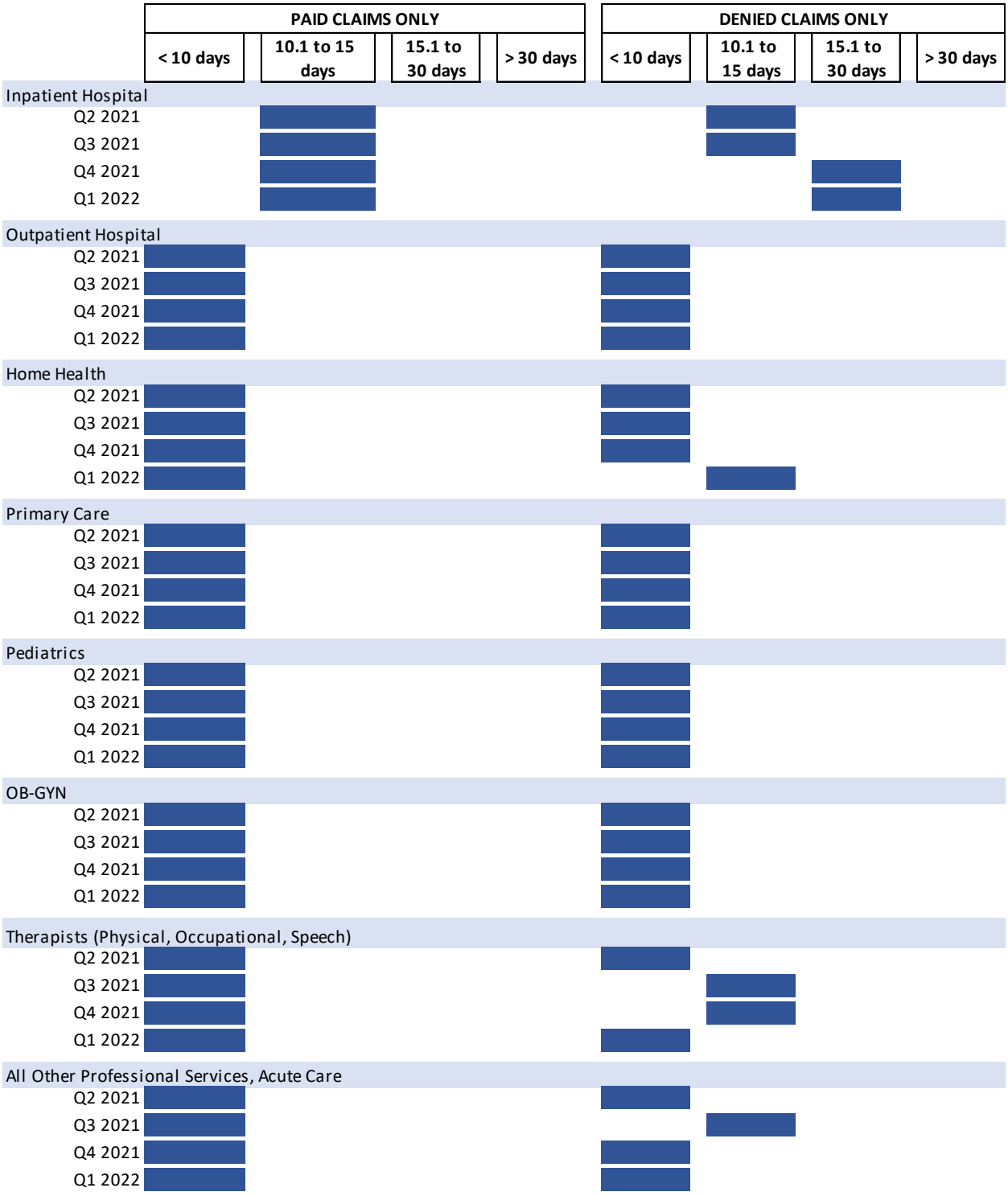


Exhibit III.10
Turnaround Time for Claims Processing of Adjudicated Non-Acute Care Claims (using average days)
For All MCEs Combined, By Quarter

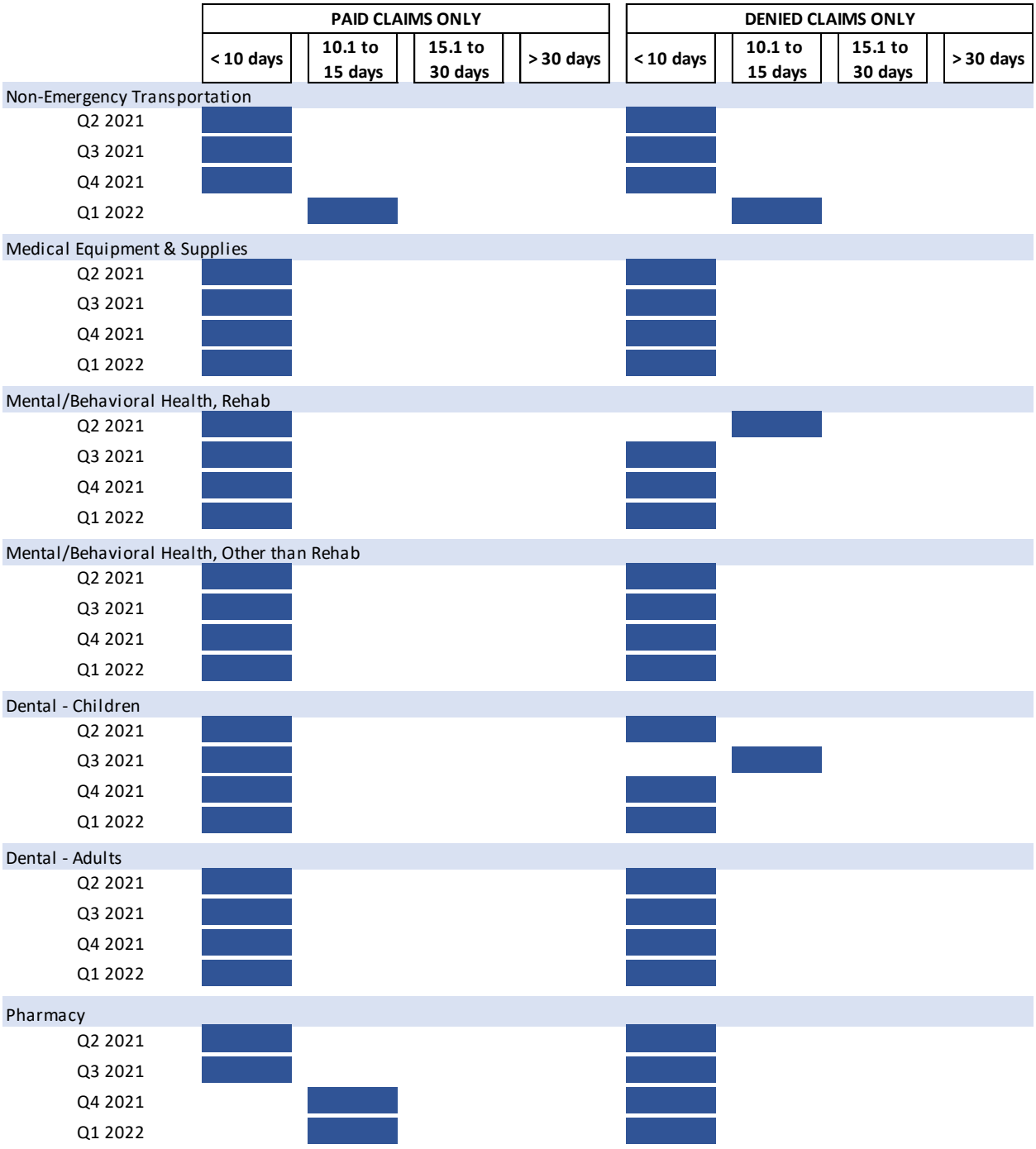
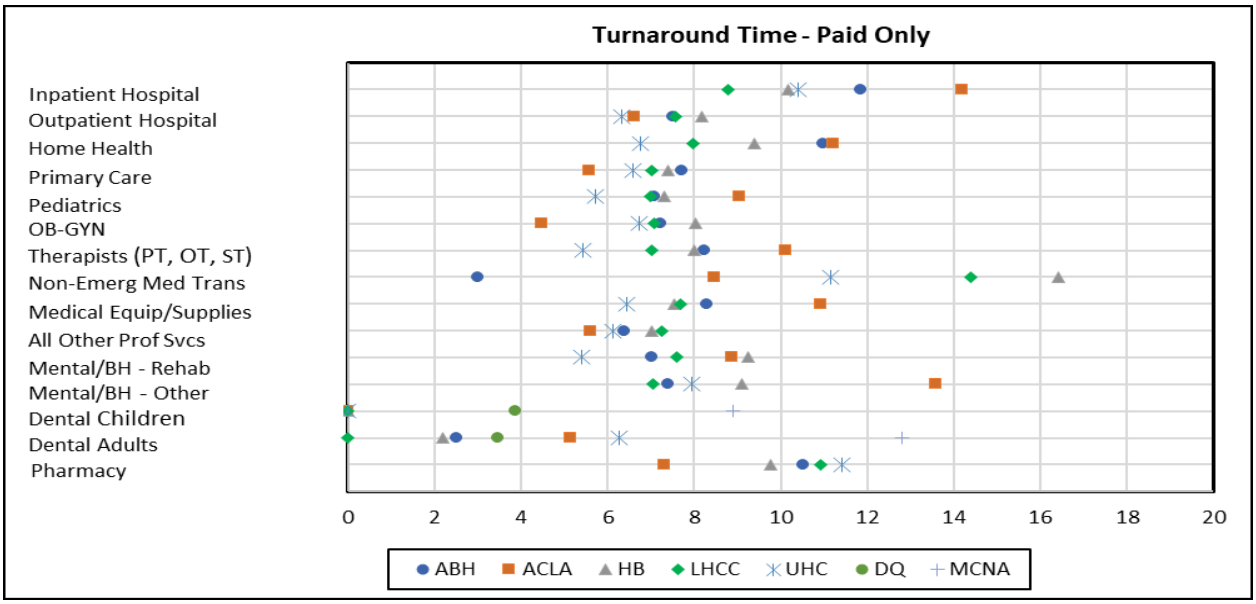
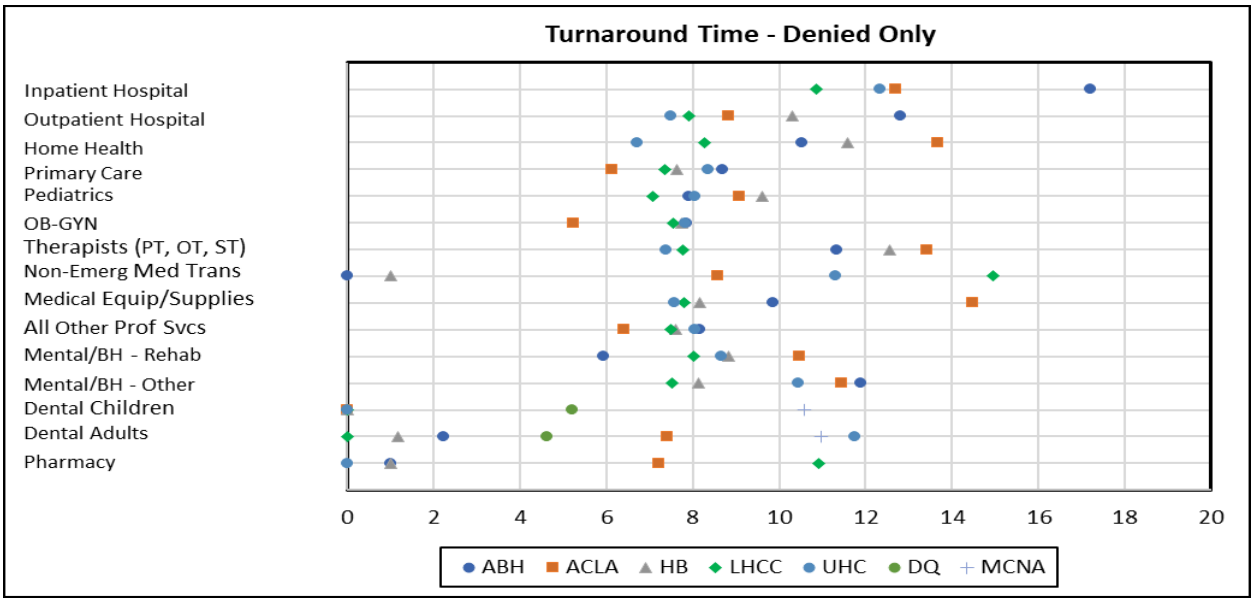


Exhibit III.11 below further breaks down the average paid and denied TAT statistics in Q1 2022, with the results shown for each MCE within a service category. The top box shows the variation in TAT for paid claims only; the bottom box shows the results for denied claims only. This exhibit determines if the TAT is consistent across MCEs or if it varies.

The top box shows that there is some variation in the average TAT for paid claims. There are three situations where the average TAT exceeded 12 days (ACLA, HB, LHCC, and MCNA). In the bottom box, the similar variation was seen for denied claims, but average TAT for denied claims is about one day more than for paid claims.

Exhibit III.11
Average Turnaround Time, Paid and Denied Claims, by Service Category
By MCE for Q1 2022 Adjudicated Claims





Reasons for Claim Denials by the MCEs

As stated in Section I, when a claim is adjudicated, the claims processor will assign codes to indicate the reason(s) 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), around 290 reason codes in all. For pharmacy claims specifically, there are nearly 350 reason codes developed by the NCPDP.

The MCEs report to LDH the occurrence of each CARC or NCPDP code on adjudicated claims. For denied claims, an MCE tabulates the count of each CARC or NCPDP code for claims adjudicated in Q1 of CY 2022.

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

- In Q1 2022, ACLA, and UHC had their top five CARCs within the top 10 CARCs statewide. ABH and LHCC had four, while HB had three, and MCNA had two of their top five CARCs in the statewide top 10.
- The top five CARCs in Q1 2022 included the following:
    - 96: Non-covered charge.
    - 16: The claim lacks information or has a billing error, which is needed for adjudication.
    - 252: An attachment/other documentation is required to adjudicate this claim/service.
    - 97: The benefit for this service is included in the payment for another service already adjudicated.
    - 18: Exact duplicate claim.

- These five CARCs were also among the top five in the previous quarters reported.

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

- In Q1 2022, each MCE with the exception of ABH, had their top five NCPDP codes within the top 10 NCPDP codes statewide. ABH had two of their top five NCPDP codes within the top 10 NCPDP codes statewide.
- The top five NCPDPs in Q1 2022 included the following:
    - 88: Drug Utilization Review (DUR) reject error
    - 79: Refill too soon
    - 76: Plan limitations exceeded
    - 75: Prior Authorization Required
    - 39: Missing/invalid diagnosis code

- These five NCPDPs were also among the top six in the previous quarters reported.

Exhibit III.12
Details on Reasons for Denied Claims
By MCE for Q1 2022 Adjudicated Claims

For Medical Claims

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

For Pharmacy Claims

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

The previous exhibit showed that the top 10 denial CARCs are consistent across quarters and were often the top CARCs for each MCE as well. LDH further reviewed the top five CARCs for each MCE to determine if the same CARCs are appearing on denied claims for all of the provider types that are included in this study.

Exhibit III.13 shows the results when the top CARCs are distributed by provider type for each MCE for claims adjudicated in the Quarter 1 of 2022. Key findings from the exhibit are shown below:

- For ABH, four of its five CARCs overall were observed for almost every provider category. One CARC (#133) was only present for selected provider types.

- For ACLA, three of its five CARCs overall were observed for almost every provider category as well. Two CARCs (#197 and #B7) were only present for selected provider types.

- For HB, only one of its top five CARCs overall were observed for every provider category within the statewide top five CARCs. Four CARCs (#256, #197, #109, and #242) were only present for selected provider types.

- For LHCC, two of its five CARCs overall were observed for almost every provider category as well. Three CARCs (#18, #B7, and #204)) were only present for selected provider types.

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

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

- For DQ, CARCs only appear for dental providers since DQ only delivers dental care. DQ only submitted CARC (#A1) for selected provider types for the past four quarters.

Exhibit III.13
Details on Reasons for Denied Medical Claims
By MCE and By Provider Category for Q1 2022 Adjudicated Claims

CARC	Description	Inpatient Hospital	Outpatient Hospital	Home Health	Other Institutional	Primary Care	Pediatrics	OB-GYN	Therapists	Non-Emerg Transport	Medical Equipment	Other Professional	Mental/Behavioral - Rehab	Mental/Behavioral - Other	Adult Dental	Pediatric Dental
ABH																
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	1	2	4	2	2	2	2	1	1	1	1	2	2		
96	Non-covered charge(s).	5	3	1	1	1	1	1	3	5	2	2	3	1		
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	3	1	3		3	3	3		3	4	5				
18	Exact duplicate claim/service	2	4	2		4	4	4	4	2	3	3				
133	The disposition of this service line is pending further review.		5													
ACLA																
96	Non-covered charge(s).	2	1	1	1	1	1	4	2	4	3	1		3		
197	Precertification/authorization/notification absent.	4		2	1	2	3	1	1	4	1	2	1	5		
252	An attachment/other documentation is required to adjudicate this claim/service.	1	2	3	1	3		2	3	4	2	3		1		
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.		3	4	1	5		3	5	1	4	5				
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.				1					4		4				
HB																
256	Service not payable per managed care contract.	4	1	1	2	1	1	2	1	2		1				
197	Precertification/authorization/notification absent.	3	2	2	4	2	2	1	2	2	1	2		2		
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.		3	5	3	3			3	2		3				
242	Services not provided by network/primary care providers.			5						2		4	1	1		
252	An attachment/other documentation is required to adjudicate this claim/service.		4	3	1			4	5	2	2					

Exhibit III.13 (continued)
Details on Reasons for Denied Medical Claims
By MCE and By Provider Category for Q1 2022 Adjudicated Claims

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																
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	3	2	3	1	2	1	1	3	2	1	1	3	1		
96	Non-covered charge(s).		1	2	4	1	2	2	1	2		2		5		
18	Exact duplicate claim/service	4	3	1	5	4	4	3	4	2	3	4	1	2		
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.					3	3	5	2	2		3				
204	This service/equipment/drug is not covered under the patient's current benefit plan				2	5				2		5	5			
UHC																
252	An attachment/other documentation is required to adjudicate this claim/service.		2	3	3	2	3	2		2	1	1		2		
96	Non-covered charge(s).		3	4	1	3	2	5	1	4	2	2				
29	The time limit for filing has expired.	3	1		4	5	5	1	3	3	4	5		5		
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	4				1	1	4	5							
18	Exact duplicate claim/service	5	5	2		4	4	3	2		5	4	3	4		
MCNA																
18	Exact duplicate claim/service														1	2
169	Alternate benefit has been provided.														2	
27	Expenses incurred after coverage terminated.														3	
96	Non-covered charge(s).														4	1
119	Benefit maximum for this time period or occurrence has been reached.														5	
DQ																
A1	Claim/Service denied.														1	1

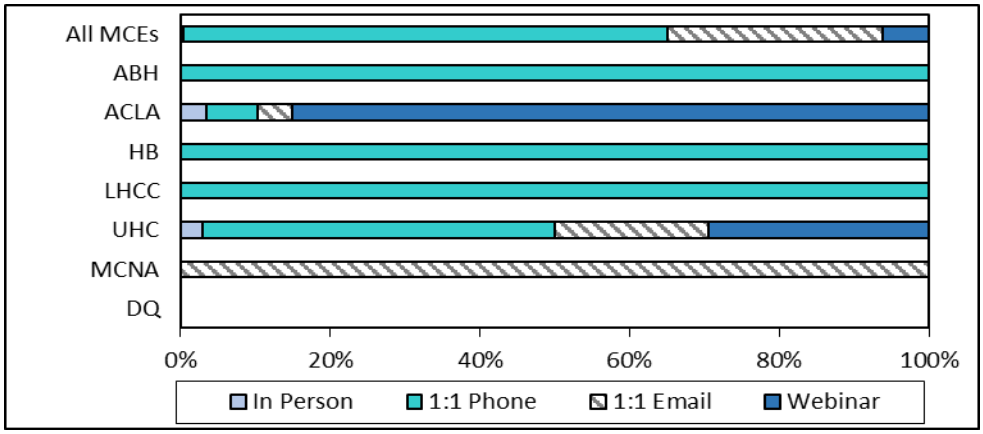
Provider Education Related to Claims Adjudication

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

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

Exhibit III.14 summarizes information on provider education conducted in Q1 2022. In all, 1,024 distinct TINs were outreached to by the MCEs. This count represents the unique TINs and modes of communication. In some cases, the MCE reported that they conducted multiple outreach efforts to the same TIN in the quarter (e.g., three emails over the course of six weeks). It should also be noted, however, that multiple MCEs may reach out to the same TIN. Over half of the outreach (64.7% of total) was conducted via 1:1 phone calls. This was followed by 1:1 emails (28.7% of total) and webinars (6.2% of total). There were very few in-person outreach conducted due to the COVID-19 pandemic.

Exhibit III.14
Provider Education Conducted by the MCEs on Claims Submissions Activity in Q1 2022



	Modality of Outreach				
	In Person	**1:1 Phone**	**1:1 Email**	**Webinar**	**Total TINs**
All MCEs	4	874	388	84	1,350
ABH	0	468	0	0	468
ACLA	3	6	4	74	87
HB	0	35	0	0	35
LHCC	0	349	0	0	349
UHC	1	16	7	10	34
MCNA	0	0	377	0	377
DQ	0	0	0	0	0

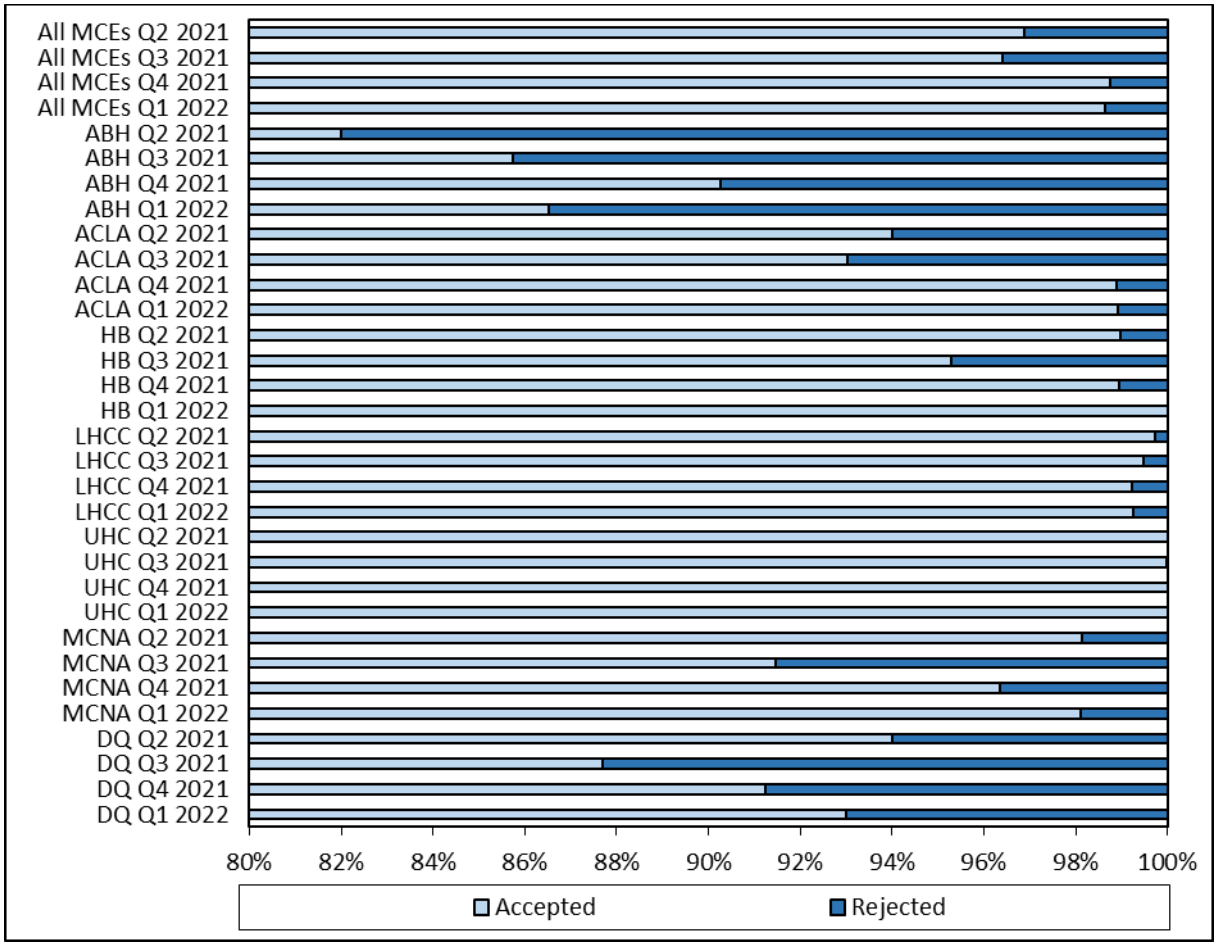
Section IV: Findings Related to MCE Encounter Submissions to LDH

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

MCE Encounters Accepted and Rejected by LDH

In the most recent four quarters studied, LDH accepted 96.4% to 98.7% of the encounters submitted by all of the MCEs. There were differences at the MCE level. LDH accepted all of UHC's encounters. For LHCC, LDH accepted 99.4% of their encounters. LDH also accepted 98.3% of HB's encounters over the past four quarters. ACLA improved to 99% over the past two quarters after averaging 94% for Quarters 2 and 3 of 2021. ABH had some challenges over the past three quarters, but showed improvement for Quarter 4 with an acceptance rate of 90.3%. DQ, as a new joined member since Q1 2021, has averaged 92% over the past four quarters.

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



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

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

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

- Institutional and professional encounters led to ABH's lower encounter acceptance rate.
- ACLA had very few issues with institutional, professional, and pharmacy encounters accepted in Quarter 1 (99.1%).
- HB had a 100% acceptance rate for Quarter 1 encounters.
- LHCC had a few issues related to pharmacy encounters (97.4%), but continue to have a 100% acceptance rate for institutional and professional encounters.
- DQ improved to 93% of encounters accepted for Quarter 1.
- MCNA improved to 98.1% of encounters accepted for Quarter 1.

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

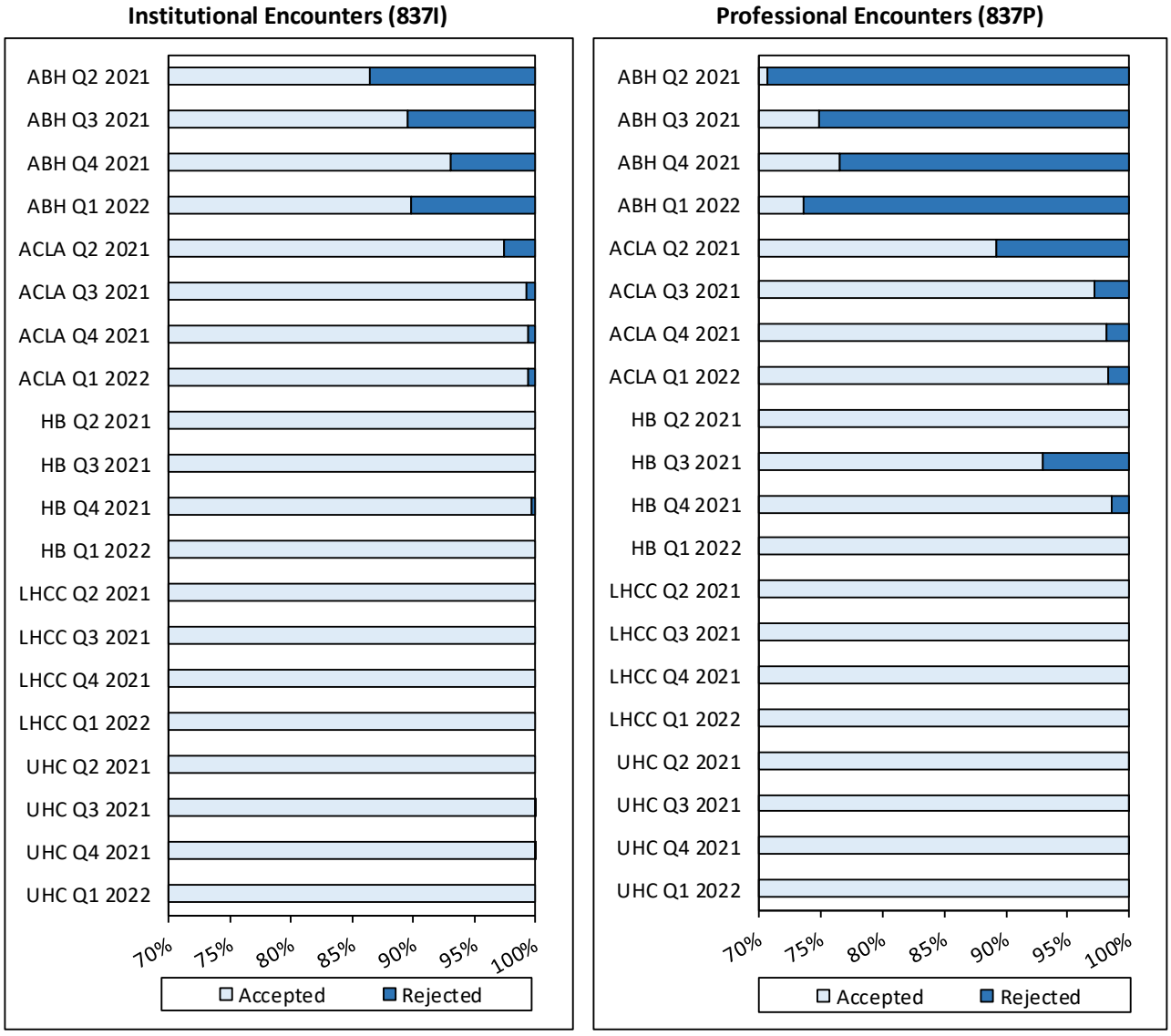
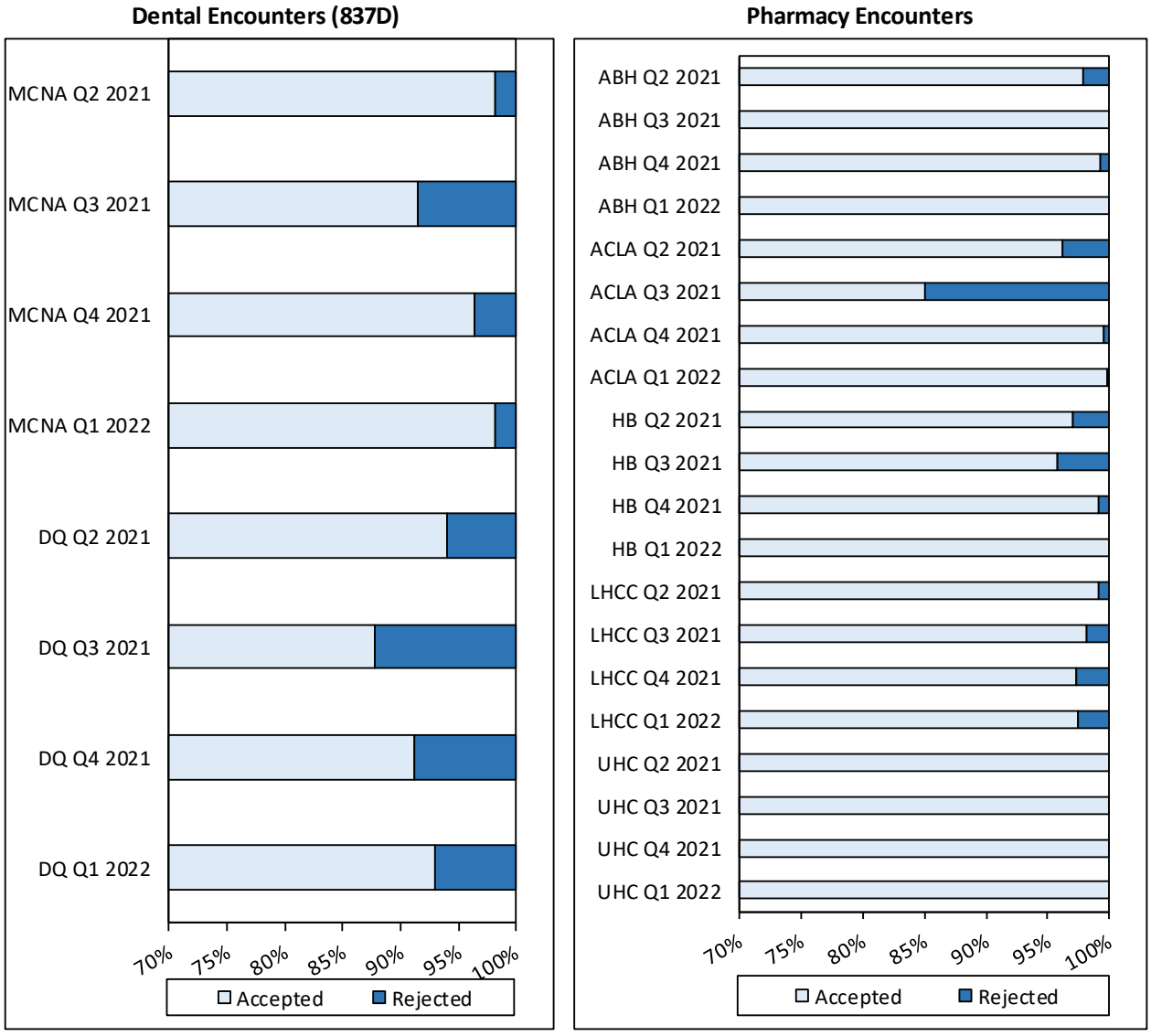


Exhibit IV.3
Encounter Submissions Accepted and Rejected by LDH
Dental and Pharmacy Claim Types
By MCE and Quarter



Timeliness of Encounter Submissions Accepted by LDH

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

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

Key findings from both exhibits appear below:

- For institutional encounters (mostly claims from hospitals), ABH had issues with timely submissions in all four quarters. ACLA had few issues in Q3 of 2021. HB had issues in Q4 of 2021 with a 26.5% decrease from Q3 of 2021. LHCC had few issues in Q4 of 2021. UHC had some issues in Q3 of 2021.

- LHCC and UHC consistently has the highest rate of submission of professional encounters within 30 days followed by ACLA and HB. ABH had challenges with professional encounter submission timeliness in all four quarters, however, showed improvement in Q1 2022 (90.8%).

- There is greater variation in the timeliness of pharmacy encounter submissions. HB and ACLA had few pharmacy encounters submitted after 30 days in every quarter. UHC had 97% timeliness within 30 days in all quarters. ABH and LHCC consistently are lowest on pharmacy encounter timeliness—ABH usually near 29.5% untimely and LHCC usually near 27.9% untimely in the last four quarters.

- MCNA had a few issues meeting an average 30-day TAT for its dental encounters in Q3 2021 (87.7%), but improved timeliness in Q4 2021 and Q1 2022 (99.6%).

- DQ continues to have a 100% submission rate for the past four quarters.

Exhibit IV.4
Turnaround Time for Encounter Submissions Accepted by LDH
By MCE and By Quarter

	Institutional Encounters (837I)		Professional Encounters (837D)		Dental Encounters (837D)		Pharmacy Encounters	
	Within 30 Days	After 30 Days	Within 30 Days	After 30 Days	Within 30 Days	After 30 Days	Within 30 Days	After 30 Days
ABH Q2 2021	74.9%	25.1%	82.2%	17.8%			70.9%	29.1%
ABH Q3 2021	74.7%	25.3%	79.2%	20.8%			70.5%	29.5%
ABH Q4 2021	72.7%	27.3%	83.6%	16.4%			72.2%	27.8%
ABH Q1 2022	77.7%	22.3%	90.8%	9.2%			68.6%	31.4%
ACLA Q2 2021	96.3%	3.7%	98.7%	1.3%			97.0%	3.0%
ACLA Q3 2021	95.9%	4.1%	90.2%	9.8%			99.5%	0.5%
ACLA Q4 2021	98.8%	1.2%	98.1%	1.9%			99.7%	0.3%
ACLA Q1 2022	96.8%	3.2%	97.8%	2.2%			99.5%	0.5%
HB Q2 2021	100.0%	0.0%	100.0%	0.0%			99.5%	0.5%
HB Q3 2021	94.4%	5.6%	95.7%	4.3%			99.7%	0.3%
HB Q4 2021	67.9%	32.1%	77.0%	23.0%			97.1%	2.9%
HB Q1 2022	78.3%	21.7%	78.0%	22.0%			99.8%	0.2%
LHCC Q2 2021	99.8%	0.2%	99.6%	0.4%			71.9%	28.1%
LHCC Q3 2021	99.5%	0.5%	99.5%	0.5%			72.4%	27.6%
LHCC Q4 2021	93.8%	6.2%	99.3%	0.7%			72.8%	27.2%
LHCC Q1 2022	99.1%	0.9%	98.6%	1.4%			71.2%	28.8%
UHC Q2 2021	99.7%	0.3%	99.3%	0.7%			99.7%	0.3%
UHC Q3 2021	96.2%	3.8%	98.8%	1.2%			91.9%	8.1%
UHC Q4 2021	99.3%	0.7%	99.2%	0.8%			99.7%	0.3%
UHC Q1 2022	99.9%	0.1%	98.4%	1.6%			96.7%	3.3%
MCNA Q2 2021					99.5%	0.5%		
MCNA Q3 2021					87.7%	12.3%		
MCNA Q4 2021					99.6%	0.4%		
MCNA Q1 2022					99.7%	0.3%		
DQ Q2 2021					100.0%	0.0%		
DQ Q3 2021					100.0%	0.0%		
DQ Q4 2021					100.0%	0.0%		
DQ Q1 2022					100.0%	0.0%		

Section V: Case Management

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

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

Each of the MCEs is contractually required to develop and implement a case management program through a process that 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 (CM) services through MCE self-reported data provided on a quarterly basis. While there are specific contractual standards that require MCEs to complete an assessment of all individuals identified as having a special healthcare need within 90 days of identification, each MCE has their own policies and procedures for identification and assessment. As such, the reporting for case management has shown some variation across MCEs.

Across all five MCEs, 48,552 unduplicated individuals were eligible or in need of case management services in SFY 2022-Q1. Of these, 29.4% (10,284) were enrolled in case management for at least one month during the quarter. 59.5% (6,258) of those enrolled in CM where engaged in one or more CM services or contact with a case manager during the quarter.

Exhibit V.1
CY 2022 - Quarter 1: Case Management

	ABH	ACLA	HB	LHCC	UHC	Total[1]
Eligible for Case Management (CM)	2,208	6,072	8,215	15,523	16,534	**48,552**
Enrolled in CM at least 1 month	1,530	1,528	1,190	3,340	2,696	**10,284**
% of eligibles enrolled in CM	69.3%	25.2%	14.5%	21.5%	16.3%	**29.35%**
Received CM Service	439	1,310	715	2,464	1,330	**6,258**
% enrolled receiving service	28.7%	85.7%	60.1%	73.8%	49.3%	**59.52%**

Source: MCE Monthly Report 039 Case Management

[1] Totals across MCEs are unduplicated and may not equal the sum of MCE counts due to individuals who transferred to a different plan during the quarter.

Appendix A:

Detailed Information for Exhibits Shown in Sections III and IV

Appendix B:

One-Page Summaries of Information on Claims for Each

of the 16 Provider Types Shown in this Report

Louisiana Department of Health
628 North Fourth Street, Baton Rouge, Louisiana 70802
(225) 342-9500
www.ldh.la.gov

www.facebook.com/LaHealthDept. www.twitter.com/LADeptHealth

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

	Number Accepted	Number Rejected	Percent Accepted	Percent Rejected
All MCEs Q2 2021	25,565,798	329,381	98.7%	1.3%
All MCEs Q3 2021	26,437,342	338,552	98.7%	1.3%
All MCEs Q4 2021	26,720,214	278,905	99.0%	1.0%
All MCEs Q1 2022	27,727,834	278,880	99.0%	1.0%
ABH Q2 2021	1,820,212	1,874	99.9%	0.1%
ABH Q3 2021	2,257,004	2,133	99.9%	0.1%
ABH Q4 2021	2,301,923	2,311	99.9%	0.1%
ABH Q1 2022	2,516,968	2,441	99.9%	0.1%
ACLA Q2 2021	3,088,884	4,806	99.8%	0.2%
ACLA Q3 2021	2,960,947	5,801	99.8%	0.2%
ACLA Q4 2021	3,155,203	5,033	99.8%	0.2%
ACLA Q1 2022	3,143,493	3,847	99.9%	0.1%
HB Q2 2021	5,514,096	614	100.0%	0.0%
HB Q3 2021	5,633,282	591	100.0%	0.0%
HB Q4 2021	5,304,850	513	100.0%	0.0%
HB Q1 2022	5,420,520	526	100.0%	0.0%
LHCC Q2 2021	7,162,144	198,270	97.3%	2.7%
LHCC Q3 2021	7,202,216	188,400	97.5%	2.5%
LHCC Q4 2021	7,328,132	186,870	97.5%	2.5%
LHCC Q1 2022	7,633,192	191,560	97.6%	2.4%
UHC Q2 2021	7,133,961	123,817	98.3%	1.7%
UHC Q3 2021	7,525,421	141,627	98.2%	1.8%
UHC Q4 2021	7,778,435	84,178	98.9%	1.1%
UHC Q1 2022	8,168,930	80,506	99.0%	1.0%
MCNA Q2 2021	450,746	0	100.0%	0.0%
MCNA Q3 2021	434,824	0	100.0%	0.0%
MCNA Q4 2021	439,363	0	100.0%	0.0%
MCNA Q1 2022	440,103	0	100.0%	0.0%
DQ Q2 2021	395,755	0	100.0%	0.0%
DQ Q3 2021	423,648	0	100.0%	0.0%
DQ Q4 2021	412,308	0	100.0%	0.0%
DQ Q1 2022	404,628	0	100.0%	0.0%

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

	Number Paid	Number Denied	Percent Paid	Percent Denied
All MCEs Q2 2021	20,857,152	4,729,851	81.5%	18.5%
All MCEs Q3 2021	21,481,185	4,992,491	81.1%	18.9%
All MCEs Q4 2021	21,559,458	5,078,188	80.9%	19.1%
All MCEs Q1 2022	22,269,564	5,293,460	80.8%	19.2%
ABH Q2 2021	1,412,667	407,908	77.6%	22.4%
ABH Q3 2021	1,707,170	549,022	75.7%	24.3%
ABH Q4 2021	1,762,333	540,243	76.5%	23.5%
ABH Q1 2022	1,871,023	645,752	74.3%	25.7%
ACLA Q2 2021	2,516,679	547,269	82.1%	17.9%
ACLA Q3 2021	2,425,187	498,434	83.0%	17.0%
ACLA Q4 2021	2,467,153	552,213	81.7%	18.3%
ACLA Q1 2022	2,727,106	551,712	83.2%	16.8%
HB Q2 2021	4,325,637	1,094,575	79.8%	20.2%
HB Q3 2021	4,593,920	1,160,510	79.8%	20.2%
HB Q4 2021	4,154,203	1,079,266	79.4%	20.6%
HB Q1 2022	4,345,187	1,091,910	79.9%	20.1%
LHCC Q2 2021	5,769,422	1,378,011	80.7%	19.3%
LHCC Q3 2021	5,826,680	1,322,455	81.5%	18.5%
LHCC Q4 2021	6,047,140	1,365,878	81.6%	18.4%
LHCC Q1 2022	6,131,113	1,339,831	82.1%	17.9%
UHC Q2 2021	6,156,003	1,208,668	83.6%	16.4%
UHC Q3 2021	6,236,078	1,372,710	82.0%	18.0%
UHC Q4 2021	6,409,577	1,447,735	81.6%	18.4%
UHC Q1 2022	6,471,134	1,591,328	80.3%	19.7%
MCNA Q2 2021	318,463	59,452	84.3%	15.7%
MCNA Q3 2021	310,145	48,851	86.4%	13.6%
MCNA Q4 2021	347,212	51,481	87.1%	12.9%
MCNA Q1 2022	343,205	49,529	87.4%	12.6%
DQ Q2 2021	358,281	33,968	91.3%	8.7%
DQ Q3 2021	382,005	40,509	90.4%	9.6%
DQ Q4 2021	371,840	41,372	90.0%	10.0%
DQ Q1 2022	380,796	23,398	94.2%	5.8%

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

	Number Paid	Number Denied	Percent Paid	Percent Denied
Inpatient Hospital Q2 2021	50,491	11,838	81.0%	19.0%
Inpatient Hospital Q3 2021	55,753	13,246	80.8%	19.2%
Inpatient Hospital Q4 2021	54,014	13,093	80.5%	19.5%
Inpatient Hospital Q1 2022	55,034	11,059	83.3%	16.7%
Outpatient Hospital Q2 2021	4,708,249	473,309	90.9%	9.1%
Outpatient Hospital Q3 2021	4,795,220	506,672	90.4%	9.6%
Outpatient Hospital Q4 2021	4,690,899	446,407	91.3%	8.7%
Outpatient Hospital Q1 2022	4,770,496	470,662	91.0%	9.0%
Home Health Q2 2021	42,809	6,082	87.6%	12.4%
Home Health Q3 2021	42,208	6,143	87.3%	12.7%
Home Health Q4 2021	39,079	4,474	89.7%	10.3%
Home Health Q1 2022	34,777	5,658	86.0%	14.0%
Primary Care Q2 2021	2,213,483	400,278	84.7%	15.3%
Primary Care Q3 2021	2,357,595	446,968	84.1%	15.9%
Primary Care Q4 2021	2,484,514	466,856	84.2%	15.8%
Primary Care Q1 2022	2,755,985	551,864	83.3%	16.7%
Pediatrics Q2 2021	830,922	116,916	87.7%	12.3%
Pediatrics Q3 2021	864,212	120,178	87.8%	12.2%
Pediatrics Q4 2021	963,454	167,649	85.2%	14.8%
Pediatrics Q1 2022	976,031	155,823	86.2%	13.8%
OB-GYN Q2 2021	253,620	33,011	88.5%	11.5%
OB-GYN Q3 2021	248,127	34,594	87.8%	12.2%
OB-GYN Q4 2021	255,431	35,220	87.9%	12.1%
OB-GYN Q1 2022	266,821	43,929	85.9%	14.1%
Therapists (PT/OT/ST) Q2 2021	95,209	13,410	87.7%	12.3%
Therapists (PT/OT/ST) Q3 2021	117,075	16,311	87.8%	12.2%
Therapists (PT/OT/ST) Q4 2021	147,973	18,087	89.1%	10.9%
Therapists (PT/OT/ST) Q1 2022	152,130	21,899	87.4%	12.6%
All Other Professional Q2 2021	4,432,723	1,015,281	81.4%	18.6%
All Other Professional Q3 2021	4,718,290	1,030,718	82.1%	17.9%
All Other Professional Q4 2021	4,636,039	927,381	83.3%	16.7%
All Other Professional Q1 2022	5,131,092	967,110	84.1%	15.9%

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

	Number Paid	Number Denied	Percent Paid	Percent Denied
Non-Emerg Transport Q2 2021	176,899	7,060	96.2%	3.8%
Non-Emerg Transport Q3 2021	236,140	5,871	97.6%	2.4%
Non-Emerg Transport Q4 2021	234,486	3,990	98.3%	1.7%
Non-Emerg Transport Q1 2022	239,431	5,430	97.8%	2.2%
Medical Equipment/Supplies Q2 2021	140,627	24,705	85.1%	14.9%
Medical Equipment/Supplies Q3 2021	149,277	32,473	82.1%	17.9%
Medical Equipment/Supplies Q4 2021	144,285	33,658	81.1%	18.9%
Medical Equipment/Supplies Q1 2022	146,694	40,370	78.4%	21.6%
Mental/Behavioral Rehab Q2 2021	198,184	25,663	88.5%	11.5%
Mental/Behavioral Rehab Q3 2021	190,011	48,362	79.7%	20.3%
Mental/Behavioral Rehab Q4 2021	193,203	20,899	90.2%	9.8%
Mental/Behavioral Rehab Q1 2022	193,506	21,236	90.1%	9.9%
Mental/Behavioral Other Q2 2021	809,408	138,114	85.4%	14.6%
Mental/Behavioral Other Q3 2021	763,249	179,184	81.0%	19.0%
Mental/Behavioral Other Q4 2021	793,743	162,428	83.0%	17.0%
Mental/Behavioral Other Q1 2022	841,128	143,081	85.5%	14.5%
Dental - Children Q2 2021	663,869	82,236	89.0%	11.0%
Dental - Children Q3 2021	673,138	70,207	90.6%	9.4%
Dental - Children Q4 2021	701,897	73,245	90.6%	9.4%
Dental - Children Q1 2022	703,195	60,743	92.0%	8.0%
Dental - Adults Q2 2021	135,808	34,873	79.6%	20.4%
Dental - Adults Q3 2021	136,364	36,553	78.9%	21.1%
Dental - Adults Q4 2021	132,206	38,857	77.3%	22.7%
Dental - Adults Q1 2022	115,141	29,586	79.6%	20.4%
Pharmacy Q2 2021	6,056,806	2,335,177	72.2%	27.8%
Pharmacy Q3 2021	6,071,869	2,432,376	71.4%	28.6%
Pharmacy Q4 2021	6,033,617	2,655,547	69.4%	30.6%
Pharmacy Q1 2022	5,823,067	2,755,741	67.9%	32.1%

Appendix A III.5
Claim Status for Adjudicated Claims
By Provider Specialty / Service Category
By MCE for Q1 2022 Adjudicated Claims

Inpatient Hospital	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	5,646	857	86.8%	13.2%
ACLA	7,529	1,037	87.9%	12.1%
HB	12,708	2,636	82.8%	17.2%
LHCC	15,480	3,075	83.4%	16.6%
UHC	13,671	3,454	79.8%	20.2%

Outpatient Hospital	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	456,138	27,783	94.3%	5.7%
ACLA	631,267	62,836	90.9%	9.1%
HB	990,116	45,778	95.6%	4.4%
LHCC	1,318,272	174,148	88.3%	11.7%
UHC	1,374,703	160,117	89.6%	10.4%

Home Health	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	2,549	1,295	66.3%	33.7%
ACLA	3,443	693	83.2%	16.8%
HB	8,095	1,009	88.9%	11.1%
LHCC	20,129	2,598	88.6%	11.4%
UHC	561	63	89.9%	10.1%

Primary Care	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	238,578	163,431	59.3%	40.7%
ACLA	142,450	18,748	88.4%	11.6%
HB	583,686	90,285	86.6%	13.4%
LHCC	849,020	159,750	84.2%	15.8%
UHC	942,251	119,650	88.7%	11.3%

Pediatricians	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	77,051	42,725	64.3%	35.7%
ACLA	129,563	12,831	91.0%	9.0%
HB	234,510	17,537	93.0%	7.0%
LHCC	416,363	72,063	85.2%	14.8%
UHC	118,544	10,667	91.7%	8.3%

OB-GYN	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	25,886	12,603	67.3%	32.7%
ACLA	41,275	4,447	90.3%	9.7%
HB	75,452	8,688	89.7%	10.3%
LHCC	105,675	16,415	86.6%	13.4%
UHC	18,533	1,776	91.3%	8.7%

Therapists (PT, OT, ST)	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	13,637	4,173	76.6%	23.4%
ACLA	18,509	3,226	85.2%	14.8%
HB	39,978	2,237	94.7%	5.3%
LHCC	47,341	7,651	86.1%	13.9%
UHC	32,665	4,612	87.6%	12.4%

Non-Emergency Medical Transp.	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	23,023	37	99.8%	0.2%
ACLA	38,997	2,473	94.0%	6.0%
HB	46,169	9	100.0%	0.0%
LHCC	87,613	400	99.5%	0.5%
UHC	43,629	2,511	94.6%	5.4%

Medical Equipment And Supplies	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	14,828	4,468	76.8%	23.2%
ACLA	30,589	5,757	84.2%	15.8%
HB	2,912	999	74.5%	25.5%
LHCC	43,940	14,434	75.3%	24.7%
UHC	54,425	14,712	78.7%	21.3%

All Other Professional	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	378,830	181,120	67.7%	32.3%
ACLA	870,973	148,654	85.4%	14.6%
HB	1,021,214	151,886	87.1%	12.9%
LHCC	1,254,542	262,353	82.7%	17.3%
UHC	1,605,533	223,097	87.8%	12.2%

Mental/Behaviroal Health - Rehab	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	1,342	2,210	37.8%	62.2%
ACLA	59,181	6,251	90.4%	9.6%
HB	2,103	743	73.9%	26.1%
LHCC	5,811	918	86.4%	13.6%
UHC	125,069	11,114	91.8%	8.2%

Mental/Behavioral Health - Other	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	87,191	39,243	69.0%	31.0%
ACLA	71,636	9,927	87.8%	12.2%
HB	164,347	40,429	80.3%	19.7%
LHCC	414,470	37,036	91.8%	8.2%
UHC	103,484	16,446	86.3%	13.7%

Pharmacy	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	530,974	162,519	76.6%	23.4%
ACLA	666,256	271,557	71.0%	29.0%
HB	1,079,456	714,621	60.2%	39.8%
LHCC	1,550,905	587,325	72.5%	27.5%
UHC	1,995,476	1,019,719	66.2%	33.8%

Dental - Adults	Number Paid	Number Denied	Percent Paid	Percent Denied
DQ	17,528	8,511	67.3%	32.7%
MCNA	3,278	3,673	47.2%	52.8%
Dental - Children				
DQ	363,268	14,887	96.1%	3.9%
MCNA	339,927	45,856	88.1%	11.9%

Appendix A III.6
Value of Paid and Denied Claims
By MCE for the Most Recent Four Quarters of Adjudicated Claims

	Value of Paid Claims (in millions)	Value of Denied Claims (in millions)
All MCEs Q2 2021	$1,913.7	$497.8
All MCEs Q3 2021	$2,006.9	$538.4
All MCEs Q4 2021	$1,997.4	$546.4
All MCEs Q1 2022	$2,001.9	$550.5

Quarter 2 2021

ABH	$142.1	$36.9
ACLA	$235.1	$57.9
HB	$415.4	$137.7
LHCC	$503.7	$121.9
UHC	$585.6	$138.2
MCNA	$15.1	$3.2
DQ	$16.6	$2.1

Quarter 3 2021

ABH	$160.3	$44.9
ACLA	$223.8	$53.8
HB	$452.3	$147.5
LHCC	$511.9	$121.7
UHC	$626.4	$165.4
MCNA	$14.5	$2.7
DQ	$17.6	$2.3

Quarter 4 2021

ABH	$172.3	$44.3
ACLA	$228.8	$61.4
HB	$383.2	$132.0
LHCC	$538.5	$128.1
UHC	$641.0	$175.1
MCNA	$16.5	$3.1
DQ	$17.2	$2.4

Quarter 1 2022

ABH	$174.6	$50.2
ACLA	$245.6	$53.7
HB	$395.1	$125.9
LHCC	$535.3	$127.3
UHC	$618.3	$189.1
MCNA	$16.3	$3.2
DQ	$16.7	$1.1

MCNA and DentaQuest are the MCEs that provides dental coverage only.

Appendix A Exhibit III.7

Examination of Individual Providers Who Billed an MCE that Had More Than 10% of their Claims Denied

Legend

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

Provider Category	Group Based on Volume	ABH				ACLA				HB				LHCC				UHC				MCNA				DQ			
		Q2 21	Q3 21	Q4 21	Q1 22	Q2 21	Q3 21	Q4 21	Q1 22	Q2 21	Q3 21	Q4 21	Q1 22	Q2 21	Q3 21	Q4 21	Q1 22	Q2 21	Q3 21	Q4 21	Q1 22	Q2 21	Q3 21	Q4 21	Q1 22	Q2 21	Q3 21	Q4 21	Q1 22
Inpatient Hospital	Low	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	N	N	N	Y								
	Medium	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y								
	High	N	Y	N	N	--	--	--	--	--	--	--	--	Y	N	Y	Y	--	N	--	--								
Outpatient Hospital	Low	N	N	Y	Y	Y	Y	Y	Y	N	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y								
	Medium	Y	Y	Y	Y	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y								
	High	Y	Y	N	Y	N	N	N	N	N	N	N	N	Y	Y	Y	Y	N	N	N	N								
Home Health	Low	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	Y	N	N	N	N								
	Medium	N	N	Y	Y	N	N	N	N	Y	N	N	N	N	N	N	N	--	--	--	--								
	High	--	--	--	--	--	--	--	--	--	--	--	--	N	N	N	N	--	--	--	--								
Other Institutional Providers	Low	Y	Y	--	Y	--	--	--	--	Y	N	N	N	Y	Y	Y	Y	N	N	N	N								
	Medium	--	--	--	--	--	--	--	--	N	N	N	N	Y	Y	Y	Y	Y	N	N	N								
	High	--	--	--	--	--	--	--	--	N	N	N	N	--	--	--	--	N	N	--	N								
Primary Care	Low	Y	Y	Y	Y	N	N	N	N	N	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y								
	Medium	Y	Y	Y	Y	N	N	N	N	N	N	N	N	Y	Y	Y	Y	N	N	N	N								
	High	Y	Y	Y	Y	N	N	N	N	N	N	N	N	Y	Y	Y	Y	N	N	N	N								
Pediatrics	Low	Y	Y	Y	Y	N	N	Y	N	N	N	N	N	Y	Y	N	Y	Y	Y	Y	Y								
	Medium	Y	Y	Y	Y	N	N	Y	N	N	N	N	N	N	Y	Y	Y	N	N	N	N								
	High	--	--	--	--	N	N	Y	N	N	N	N	N	Y	Y	Y	Y	N	N	N	N								
OB-GYN	Low	Y	Y	Y	Y	N	N	N	Y	N	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y								
	Medium	N	Y	Y	Y	N	N	N	N	Y	N	N	N	Y	Y	Y	Y	Y	N	N	Y								
	High	--	--	--	--	N	N	N	N	N	N	N	N	Y	Y	Y	Y	N	N	N	N								
Therapists	Low	N	N	Y	Y	Y	Y	Y	Y	N	N	N	N	Y	Y	Y	Y	N	Y	Y	Y								
	Medium	Y	N	Y	Y	--	Y	N	Y	N	N	N	N	N	N	Y	Y	N	N	N	N								
	High	--	N	--	--	--	N	N	N	N	N	N	N	N	N	N	N	N	Y	Y	Y								
Non-Emergency Transportation	Low	N	N	N	N	N	Y	N	N	--	--	--	--	N	N	N	N	Y	Y	Y	N								
	Medium	--	--	--	--	N	N	N	N	--	--	--	--	N	N	N	N	--	--	--	N								
	High	--	--	--	--	N	N	N	N	--	--	--	--	N	N	N	N	--	--	--	N								
Medical Equipment/ Supplies	Low	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	N	Y	Y	Y	Y	Y	Y	Y								
	Medium	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	Y	Y	Y	Y	Y	N	N	N	Y								
	High	Y	Y	Y	Y	N	N	Y	Y	--	--	--	--	Y	Y	Y	Y	N	N	N	Y								
All Other Professional Provid.	Low	N	N	N	N	Y	Y	Y	Y	N	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y								
	Medium	N	Y	Y	N	N	N	Y	Y	N	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y								
	High	N	Y	Y	--	N	N	N	N	N	N	N	N	N	Y	Y	N	N	N	N	N								
Behavioral Health Rehab	Low	Y	Y	Y	Y	N	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y								
	Medium	N	Y	Y	Y	N	N	N	N	Y	Y	N	N	N	N	N	N	N	N	N	N								
	High	--	--	--	--	N	N	N	N	--	--	--	--	Y	Y	--	--	N	N	N	N								
Behavioral Health All Other	Low	Y	Y	Y	Y	N	N	N	N	Y	Y	Y	Y	N	N	N	N	Y	Y	Y	Y								
	Medium	--	--	--	--	N	N	N	N	Y	Y	Y	Y	N	N	N	N	N	N	N	Y								
	High	--	--	--	--	N	N	N	N	Y	Y	Y	Y	Y	N	N	N	N	N	N	N								
Dental - Children	Low																					Y	Y	Y	Y	--	--	--	--
	Medium																					Y	Y	Y	Y	--	--	--	--
	High																					Y	Y	Y	Y	--	--	--	--
Dental - Adults	Low																					Y	Y	Y	Y	N	N	N	N
	Medium																					--	--	Y	--	N	N	N	N
	High																					--	--	--	--	N	N	N	N
Pharmacy	Low	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y								
	Medium	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y								
	High	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y								

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

	Paid Claims	Denied Claims
All MCEs Q2 2021	8.0	6.2
All MCEs Q3 2021	8.0	7.0
All MCEs Q4 2021	8.0	5.7
All MCEs Q1 2022	7.9	5.6
ABH Q2 2021	8.2	5.6
ABH Q3 2021	8.3	6.1
ABH Q4 2021	8.3	6.5
ABH Q1 2022	8.1	6.9
ACLA Q2 2021	6.5	7.3
ACLA Q3 2021	7.2	8.3
ACLA Q4 2021	7.1	7.7
ACLA Q1 2022	6.8	7.4
HB Q2 2021	6.8	4.4
HB Q3 2021	6.4	8.3
HB Q4 2021	7.7	3.4
HB Q1 2022	8.3	3.5
LHCC Q2 2021	8.5	9.2
LHCC Q3 2021	8.7	9.2
LHCC Q4 2021	8.7	9.3
LHCC Q1 2022	8.3	9.1
UHC Q2 2021	9.1	3.8
UHC Q3 2021	9.0	3.4
UHC Q4 2021	7.7	2.8
UHC Q1 2022	7.9	2.9
MCNA Q2 2021	10.0	11.2
MCNA Q3 2021	11.1	13.3
MCNA Q4 2021	10.1	12.0
MCNA Q1 2022	8.9	10.6
DQ Q2 2021	5.8	4.9
DQ Q3 2021	5.3	3.9
DQ Q4 2021	5.4	3.8
DQ Q1 2022	3.9	5.0

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

	Paid Claims	Denied Claims
Inpatient Hosp Q2 2021	10.9	12.2
Inpatient Hosp Q3 2021	10.6	11.5
Inpatient Hosp Q4 2021	11.5	17.6
Inpatient Hosp Q1 2022	10.6	15.4
Outpatient Hosp Q2 2021	7.9	9.8
Outpatient Hosp Q3 2021	7.9	10.0
Outpatient Hosp Q4 2021	7.3	9.5
Outpatient Hosp Q1 2022	7.2	8.4
Home Health Q2 2021	8.2	9.2
Home Health Q3 2021	8.8	8.6
Home Health Q4 2021	8.5	8.7
Home Health Q1 2022	8.8	10.0
Primary Care Q2 2021	7.9	8.1
Primary Care Q3 2021	7.5	8.3
Primary Care Q4 2021	6.7	7.9
Primary Care Q1 2022	7.0	8.0
Pediatrics Q2 2021	7.3	7.9
Pediatrics Q3 2021	7.0	7.8
Pediatrics Q4 2021	6.8	7.4
Pediatrics Q1 2022	7.2	7.8
OB-GYN Q2 2021	7.3	7.9
OB-GYN Q3 2021	7.7	8.4
OB-GYN Q4 2021	7.2	8.2
OB-GYN Q1 2022	6.9	7.4
Therapists (PT/OT/ST) Q2 2021	7.6	9.3
Therapists (PT/OT/ST) Q3 2021	8.2	10.8
Therapists (PT/OT/ST) Q4 2021	7.5	10.7
Therapists (PT/OT/ST) Q1 2022	7.4	9.7
All Other Professional Q2 2021	7.4	7.9
All Other Professional Q3 2021	7.2	12.1
All Other Professional Q4 2021	6.7	7.6
All Other Professional Q1 2022	6.5	7.6

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

	Paid Claims	Denied Claims
Non-Emerg Transport Q2 2021	8.4	9.8
Non-Emerg Transport Q3 2021	9.4	9.6
Non-Emerg Transport Q4 2021	8.2	9.5
Non-Emerg Transport Q1 2022	12.1	10.2
Medical Equip/Supplies Q2 2021	8.3	9.8
Medical Equip/Supplies Q3 2021	8.4	9.4
Medical Equip/Supplies Q4 2021	7.9	9.6
Medical Equip/Supplies Q1 2022	8.0	8.9
MH/BH Rehab Q2 2021	8.3	10.1
MH/BH Rehab Q3 2021	8.0	8.2
MH/BH Rehab Q4 2021	6.9	9.2
MH/BH Rehab Q1 2022	6.6	8.9
MH/BH Other Q2 2021	8.5	8.6
MH/BH Other Q3 2021	8.7	8.1
MH/BH Other Q4 2021	7.9	7.9
MH/BH Other Q1 2022	8.2	9.5
Dental - Children Q2 2021	7.7	8.9
Dental - Children Q3 2021	7.9	10.0
Dental - Children Q4 2021	7.7	9.1
Dental - Children Q1 2022	6.3	9.3
Dental - Adults Q2 2021	5.6	5.1
Dental - Adults Q3 2021	5.4	4.4
Dental - Adults Q4 2021	5.1	4.2
Dental - Adults Q1 2022	4.3	5.1
Pharmacy Q2 2021	8.7	3.8
Pharmacy Q3 2021	9.1	3.6
Pharmacy Q4 2021	10.3	3.4
Pharmacy Q1 2022	10.4	3.4

Appendix A Exhibit III.11
Average Turnaround Time (in days), Paid and Denied Claims, by Service Category
By MCE for Q1 2022 Adjudicated Claims

Inpatient Hospital	Paid	Denied
ABH	11.9	17.2
ACLA	14.2	12.7
HB	10.2	25.4
LHCC	8.8	10.7
UHC	10.4	12.3

Outpatient Hospital	Paid	Denied
ABH	7.5	12.8
ACLA	6.6	8.8
HB	8.2	10.3
LHCC	7.6	7.9
UHC	6.3	7.5

Home Health	Paid	Denied
ABH	11.0	10.5
ACLA	11.2	13.7
HB	9.4	11.6
LHCC	8.0	8.3
UHC	6.7	6.7

Primary Care	Paid	Denied
ABH	7.7	8.7
ACLA	5.6	6.1
HB	7.4	7.6
LHCC	7.1	7.3
UHC	6.6	8.4

Pediatrics	Paid	Denied
ABH	7.1	7.9
ACLA	9.1	9.1
HB	7.3	9.6
LHCC	7.0	7.1
UHC	5.7	8.1

OB-GYN	Paid	Denied
ABH	7.2	7.9
ACLA	4.5	5.2
HB	8.0	7.7
LHCC	7.1	7.5
UHC	6.7	7.8

Therapists (PT, OT, ST)	Paid	Denied
ABH	8.2	11.3
ACLA	10.1	13.4
HB	8.0	12.6
LHCC	7.0	7.8
UHC	5.4	7.4

Non-Emergency Medical Transp.	Paid	Denied
ABH	3.0	0.0
ACLA	8.5	8.6
HB	16.4	1.0
LHCC	14.4	15.0
UHC	11.2	11.3

Medical Equipment And Supplies	Paid	Denied
ABH	8.3	9.9
ACLA	10.9	14.5
HB	7.5	8.2
LHCC	7.7	7.8
UHC	6.4	7.6

All Other Professional	Paid	Denied
ABH	6.4	8.1
ACLA	5.6	6.4
HB	7.0	7.6
LHCC	7.4	7.6
UHC	6.1	8.1

Mental/Behavioral Health - Rehab	Paid	Denied
ABH	7.0	5.9
ACLA	8.9	10.5
HB	9.2	8.8
LHCC	7.6	8.0
UHC	5.4	8.7

Mental/Behavioral Health - Other	Paid	Denied
ABH	7.4	11.9
ACLA	13.6	11.4
HB	9.1	8.1
LHCC	7.1	7.5
UHC	7.9	10.4

Pharmacy	Paid	Denied
ABH	10.5	1.0
ACLA	7.3	7.2
HB	9.8	1.0
LHCC	10.9	10.9
UHC	11.4	0.0

Dental - Adults	Paid	Denied
DQ	3.5	4.6
MCNA	12.8	11.0
Dental - Children		
DQ	3.9	5.2
MCNA	8.9	10.6

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

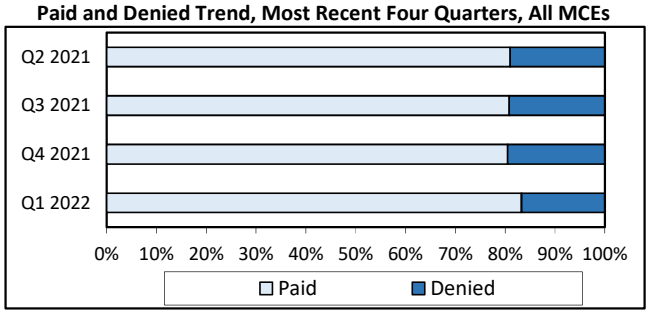
	Accepted	Rejected
All MCEs Q2 2021	96.9%	3.1%
All MCEs Q3 2021	96.4%	3.6%
All MCEs Q4 2021	98.7%	1.3%
All MCEs Q1 2022	98.6%	1.4%
ABH Q2 2021	82.0%	18.0%
ABH Q3 2021	85.7%	14.3%
ABH Q4 2021	90.3%	9.7%
ABH Q1 2022	86.5%	13.5%
ACLA Q2 2021	94.0%	6.0%
ACLA Q3 2021	93.0%	7.0%
ACLA Q4 2021	98.9%	1.1%
ACLA Q1 2022	98.9%	1.1%
HB Q2 2021	99.0%	1.0%
HB Q3 2021	95.3%	4.7%
HB Q4 2021	98.9%	1.1%
HB Q1 2022	100.0%	0.0%
LHCC Q2 2021	99.7%	0.3%
LHCC Q3 2021	99.5%	0.5%
LHCC Q4 2021	99.2%	0.8%
LHCC Q1 2022	99.2%	0.8%
UHC Q2 2021	100.0%	0.0%
UHC Q3 2021	100.0%	0.0%
UHC Q4 2021	100.0%	0.0%
UHC Q1 2022	100.0%	0.0%
MCNA Q2 2021	98.1%	1.9%
MCNA Q3 2021	91.5%	8.5%
MCNA Q4 2021	96.3%	3.7%
MCNA Q1 2022	98.1%	1.9%
DQ Q2 2021	94.0%	6.0%
DQ Q3 2021	87.7%	12.3%
DQ Q4 2021	91.2%	8.8%
DQ Q1 2022	93.0%	7.0%

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

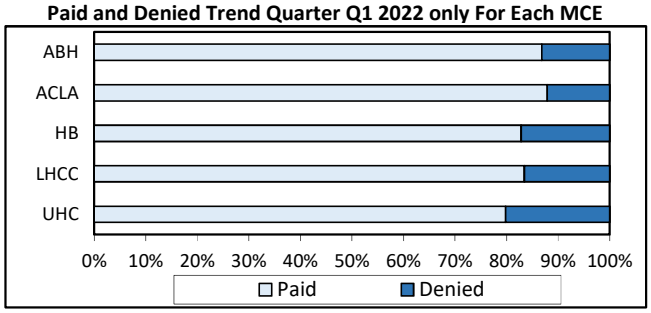
	Institutional Encounters (837I)		Professional Encounters (837D)		Dental Encounters (837D)		Pharmacy Encounters	
	Accepted	Rejected	Accepted	Rejected	Accepted	Rejected	Accepted	Rejected
ABH Q2 2021	86.5%	13.5%	70.8%	29.2%			97.9%	2.1%
ABH Q3 2021	89.5%	10.5%	74.9%	25.1%			100.0%	0.0%
ABH Q4 2021	93.1%	6.9%	76.6%	23.4%			99.2%	0.8%
ABH Q1 2022	89.8%	10.2%	73.7%	26.3%			100.0%	0.0%
ACLA Q2 2021	97.4%	2.6%	89.3%	10.7%			96.2%	3.8%
ACLA Q3 2021	99.2%	0.8%	97.2%	2.8%			85.1%	14.9%
ACLA Q4 2021	99.4%	0.6%	98.2%	1.8%			99.6%	0.4%
ACLA Q1 2022	99.3%	0.7%	98.3%	1.7%			99.8%	0.2%
HB Q2 2021	100.0%	0.0%	100.0%	0.0%			97.1%	2.9%
HB Q3 2021	100.0%	0.0%	93.0%	7.0%			95.8%	4.2%
HB Q4 2021	99.6%	0.4%	98.5%	1.5%			99.1%	0.9%
HB Q1 2022	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
LHCC Q2 2021	100.0%	0.0%	100.0%	0.0%			99.1%	0.9%
LHCC Q3 2021	100.0%	0.0%	100.0%	0.0%			98.2%	1.8%
LHCC Q4 2021	100.0%	0.0%	100.0%	0.0%			97.4%	2.6%
LHCC Q1 2022	100.0%	0.0%	100.0%	0.0%			97.4%	2.6%
UHC Q2 2021	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
UHC Q3 2021	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
UHC Q4 2021	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
UHC Q1 2022	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
MCNA Q2 2021					98.1%	1.9%		
MCNA Q3 2021					91.5%	8.5%		
MCNA Q4 2021					96.3%	3.7%		
MCNA Q1 2022					98.1%	1.9%		
DQ Q2 2021					94.0%	6.0%		
DQ Q3 2021					87.7%	12.3%		
DQ Q4 2021					91.2%	8.8%		
DQ Q1 2022					93.0%	7.0%		

Summary of Information on Claims for Inpatient Hospital Services

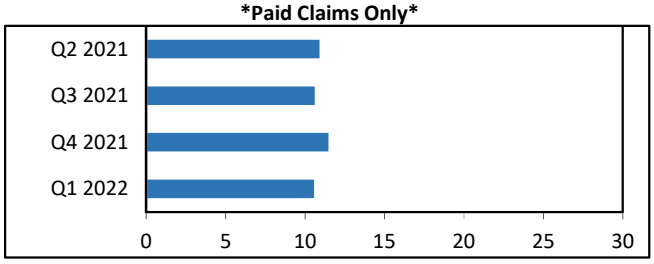
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



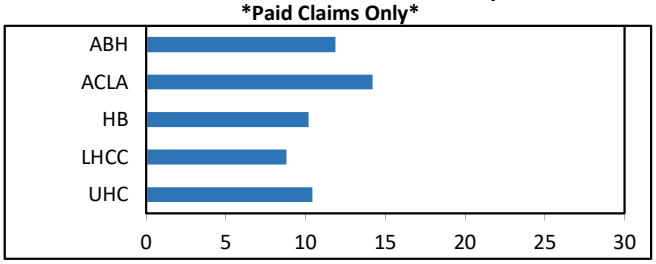
Paid and Denied Trend Quarter Q1 2022 only For Each MCE



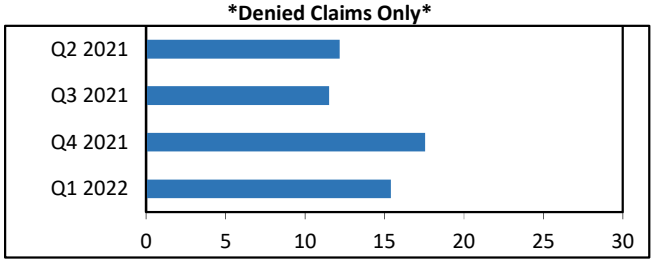
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



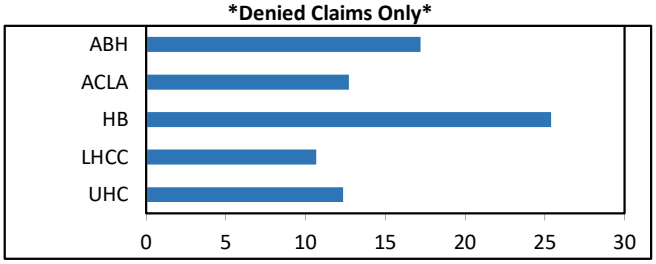
Claims Turnaround Time Quarter Q1 2022 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter Q1 2022 only)

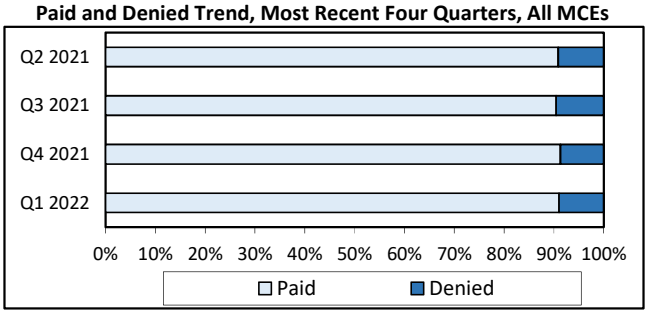
	ABH		ACLA		HB		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	295	175	314	185	373	208	332	196	413	240
101 - 250	67	39	24	6	40	27	46	40	40	34
> 250 claims	34	13	0	0	4	1	10	8	3	1

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

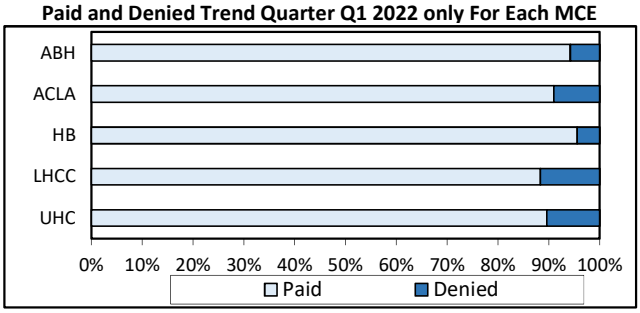
CARC Code	Description	ABH	ACLA	HB	LHCC	UHC
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	X			X	X
18	Exact duplicate claim/service	X			X	X
197	Precertification/authorization/notification absent.		X	X	X	
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	X				X
128	Newborn's services are covered in the mother's Allowance.			X		X

Summary of Information on Claims for Outpatient Hospital Services

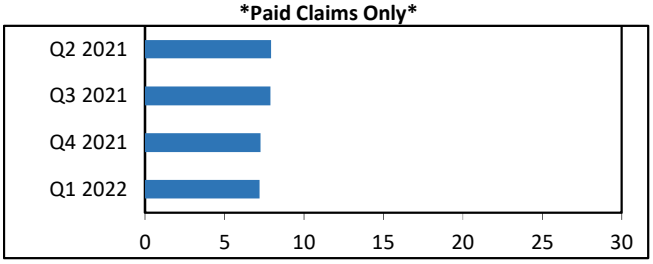
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



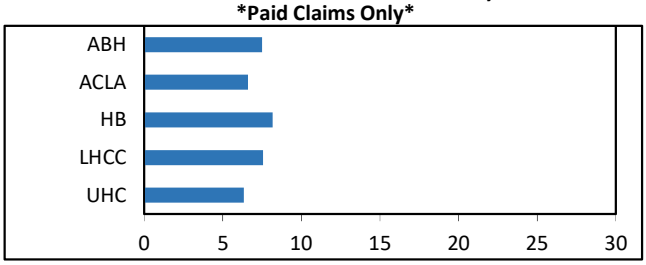
Paid and Denied Trend Quarter Q1 2022 only For Each MCE



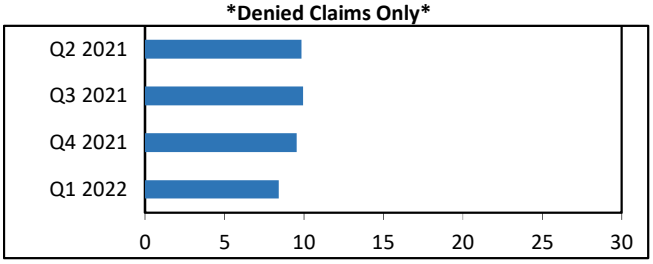
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



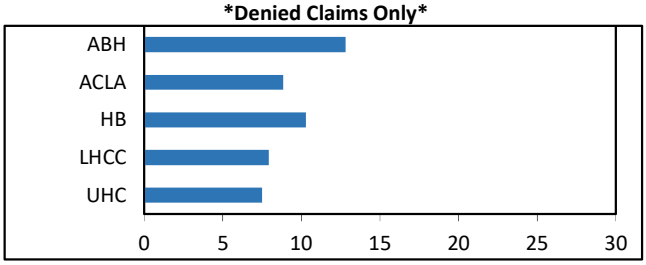
Claims Turnaround Time Quarter Q1 2022 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter Q1 2022 only)

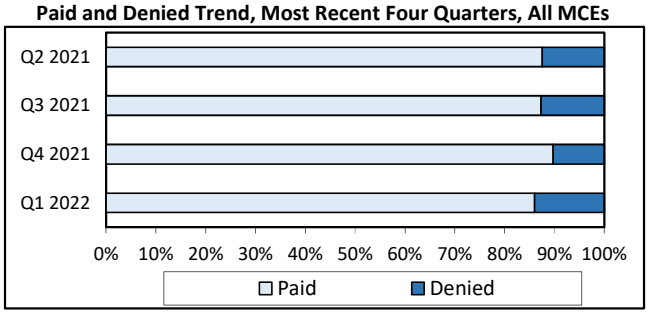
	ABH		ACLA		HB		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	489	270	440	370	498	150	730	428	413	240
101 - 250	100	86	90	45	36	18	122	109	40	34
> 250 claims	104	53	132	31	100	6	172	130	3	1

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

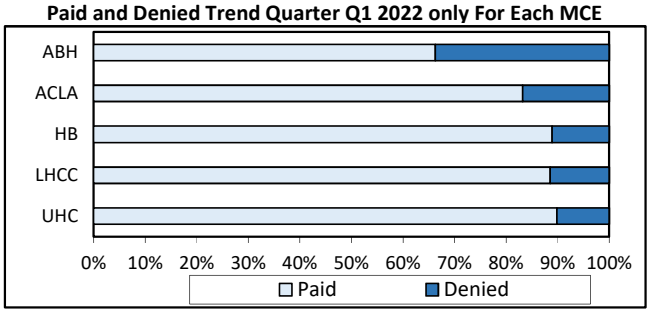
CARC Code	Description	ABH	ACLA	HB	LHCC	UHC
96	Non-covered charge(s).	X	X		X	X
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	X	X		X	X
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	X			X	
29	The time limit for filing has expired.					X
252	An attachment/other documentation is required to adjudicate this claim/service.		X	X		X

Summary of Information on Claims for Home Health Services

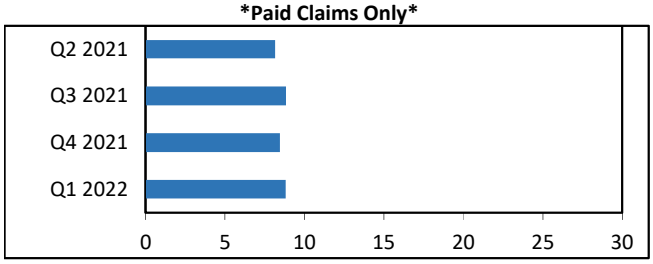
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



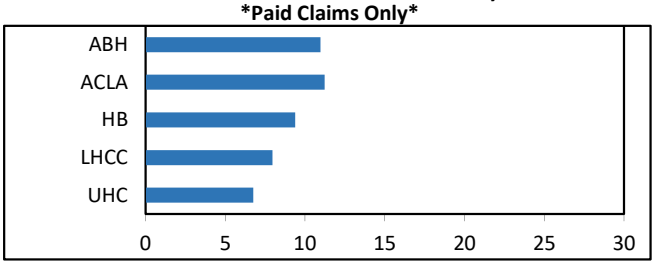
Paid and Denied Trend Quarter Q1 2022 only For Each MCE



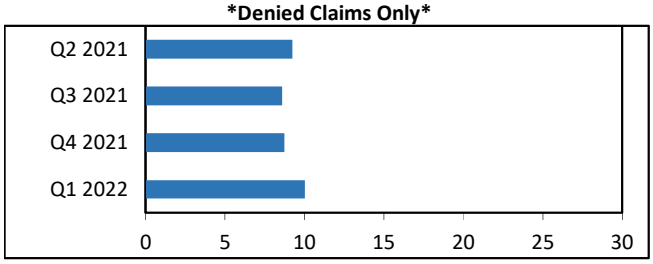
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



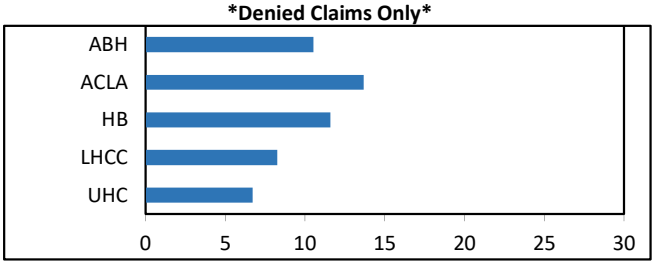
Claims Turnaround Time Quarter Q1 2022 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter Q1 2022 only)

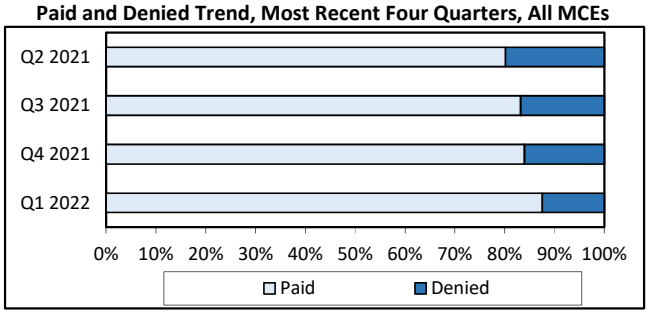
	ABH		ACLA		HB		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	36	16	42	17	63	16	111	69	28	9
101 - 250	8	4	11	5	28	12	44	16	1	0
> 250 claims	1	1	1	0	1	0	12	4	0	0

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

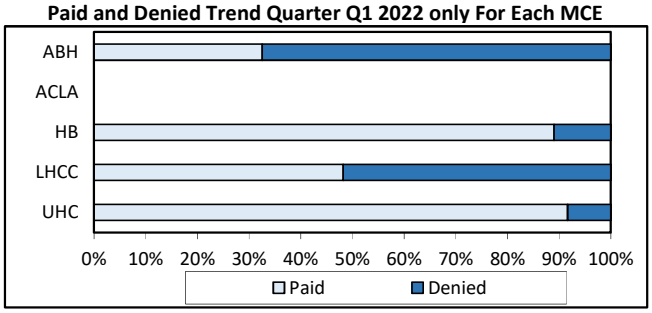
CARC Code	Description	ABH	ACLA	HB	LHCC	UHC
96	Non-covered charge(s).	X	X	X	X	X
18	Exact duplicate claim/service	X		X	X	X
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	X	X	X	X	X
197	Precertification/authorization/notification absent.	X	X	X		X
22	This care may be covered by another payer per coordination of benefits.			X	X	

Summary of Information on Claims for Other Institutional Services

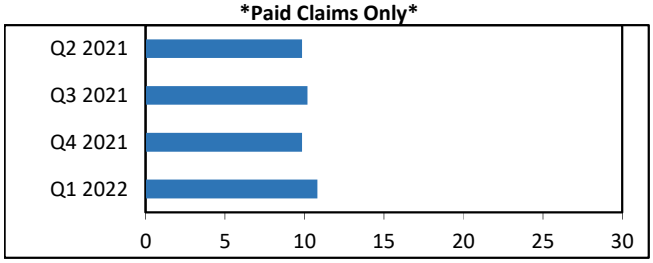
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



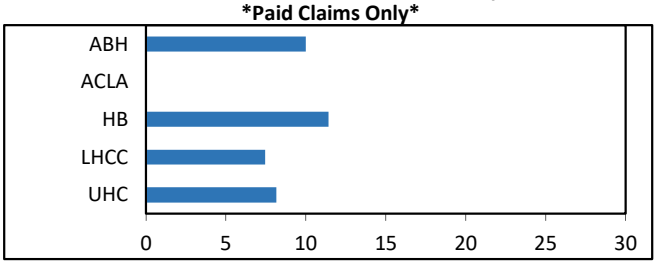
Paid and Denied Trend Quarter Q1 2022 only For Each MCE



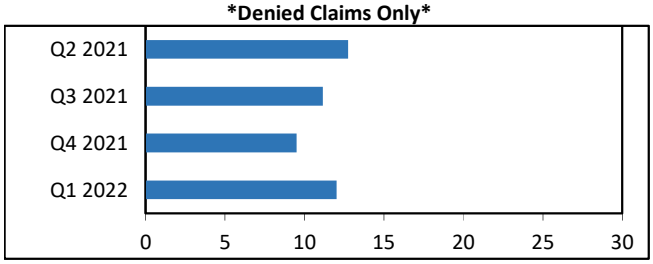
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



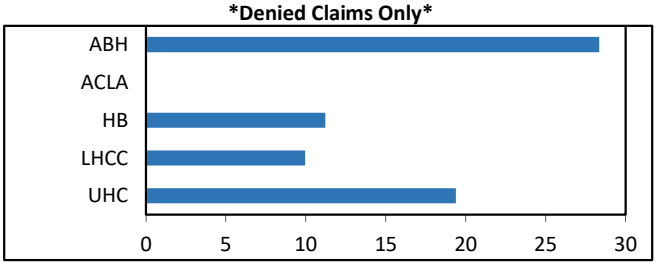
Claims Turnaround Time Quarter Q1 2022 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



HBL has a TAT 163 days for 2021 Q1, the chart was cut due to extreme large data

Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter Q1 2022 only)

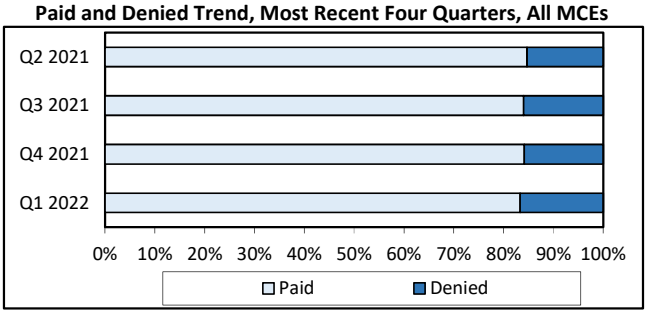
	ABH		ACLA		HB		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	11	10	0	0	203	86	147	116	20	7
101 - 250	0	0	0	0	82	28	13	12	10	4
> 250 claims	0	0	0	0	37	10	1	0	8	1

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

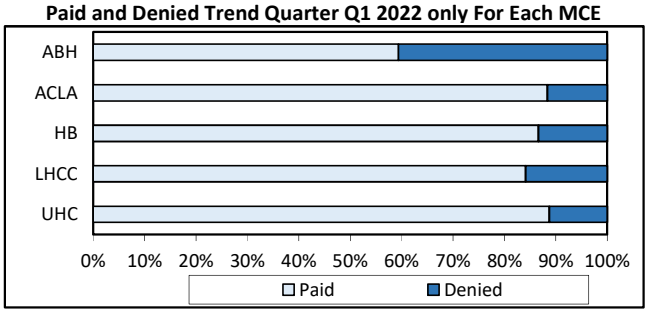
CARC Code	Description	ABH	ACLA	HB	LHCC	UHC
252	An attachment/other documentation is required to adjudicate this claim/service.		X	X		X
256	Service not payable per managed care contract.		X	X		
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	X	X		X	
204	This service/equipment/drug is not covered under the patient's current benefit plan		X	X	X	
197	Precertification/authorization/notification absent.		X	X		

Summary of Information on Claims for Primary Care Services

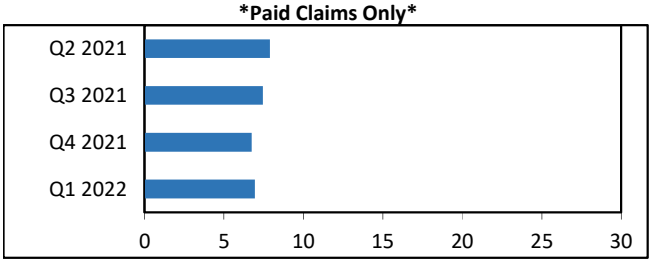
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



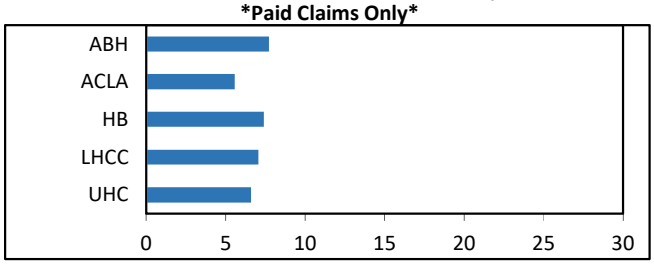
Paid and Denied Trend Quarter Q1 2022 only For Each MCE



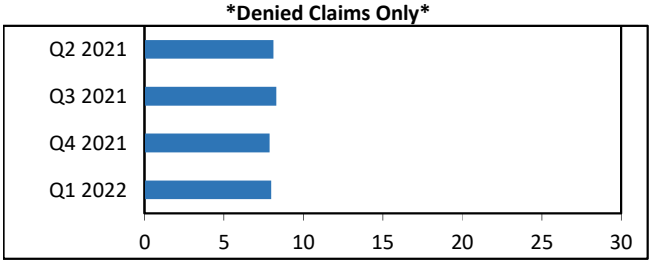
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



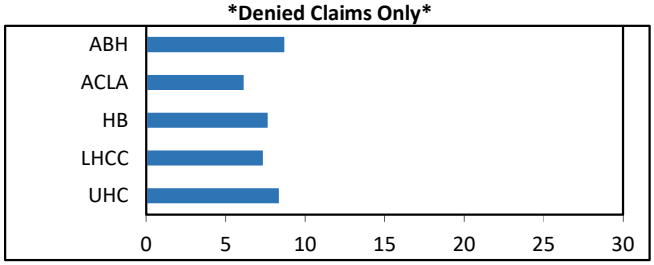
Claims Turnaround Time Quarter Q1 2022 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter Q1 2022 only)

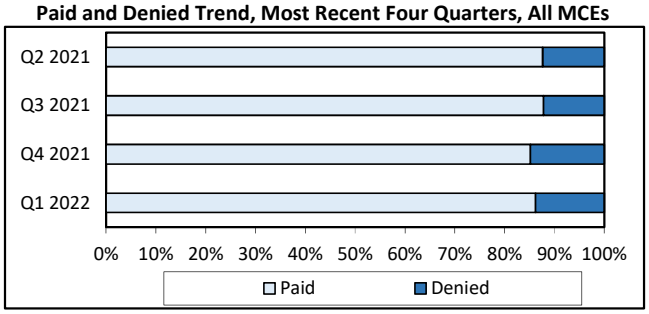
	ABH		ACLA		HB		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	688	472	572	262	1,224	509	999	585	1,821	1,171
101 - 250	138	120	198	77	491	157	450	290	370	174
> 250 claims	33	29	61	19	307	97	422	292	394	114

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

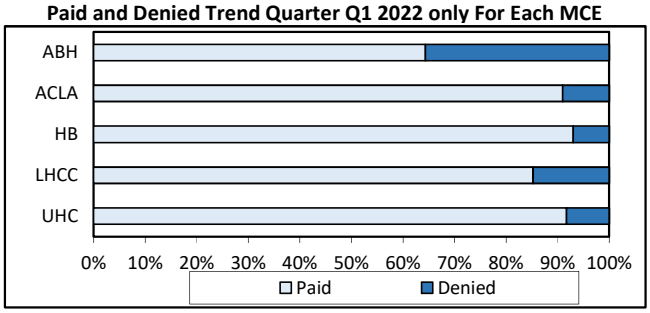
CARC Code	Description	ABH	ACLA	HB	LHCC	UHC
96	Non-covered charge(s).	X	X		X	X
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	X	X		X	
97	The benefit for this service is included in the	X				X
256	Service not payable per managed care contract.		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

Summary of Information on Claims for Pediatric Services

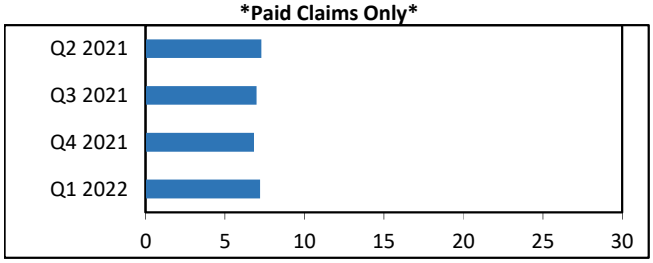
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



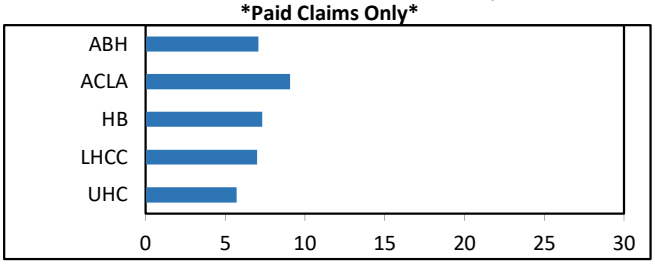
Paid and Denied Trend Quarter Q1 2022 only For Each MCE



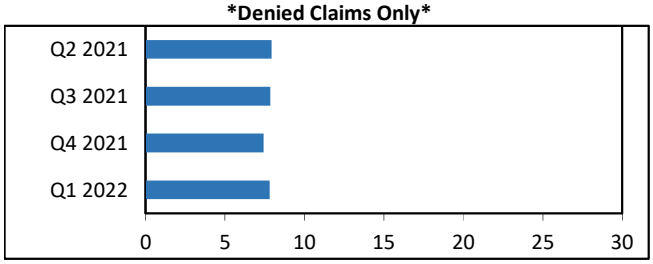
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



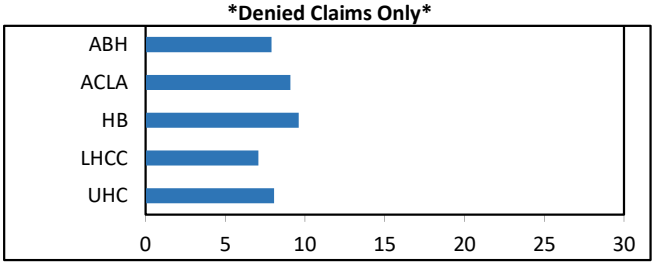
Claims Turnaround Time Quarter Q1 2022 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter Q1 2022 only)

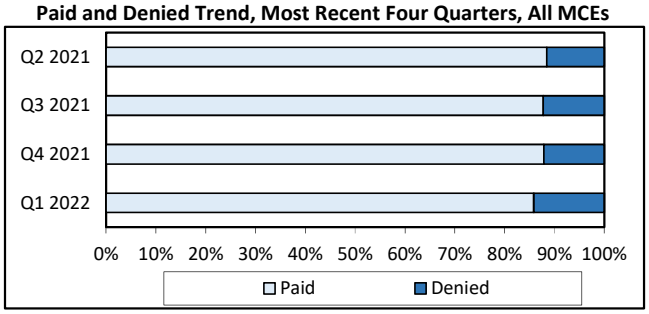
	ABH		ACLA		HB		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	57	39	94	37	189	89	147	79	53	36
101 - 250	33	27	99	22	115	28	100	63	15	7
> 250 claims	1	1	65	11	110	23	173	100	47	14

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

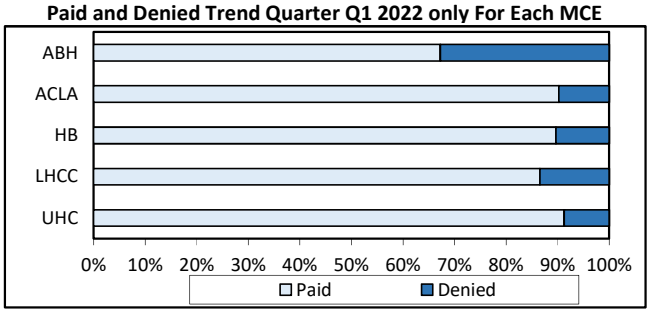
CARC Code	Description	ABH	ACLA	HB	LHCC	UHC
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	X			X	
96	Non-covered charge(s).	X	X		X	X
18	Exact duplicate claim/service	X			X	X
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.				X	
6	The procedure/revenue code is inconsistent with the patient's age.		X		X	

Summary of Information on Claims for OBGYN Services

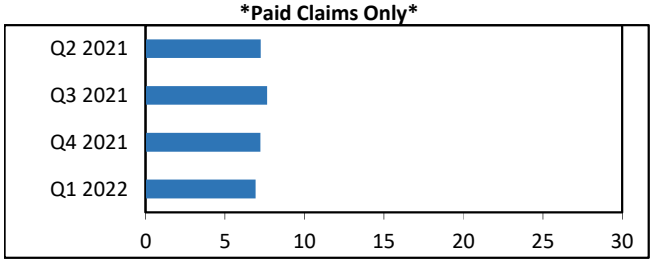
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



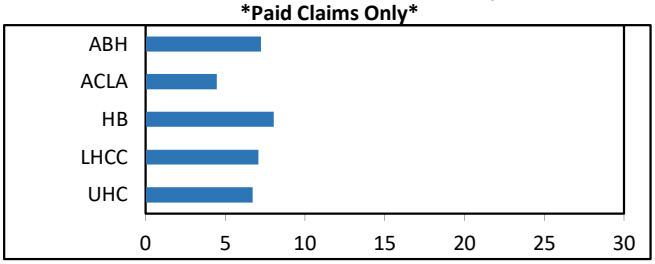
Paid and Denied Trend Quarter Q1 2022 only For Each MCE



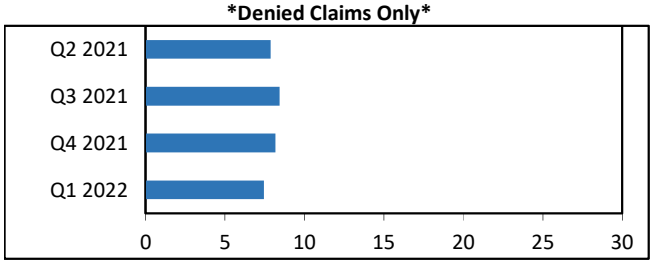
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



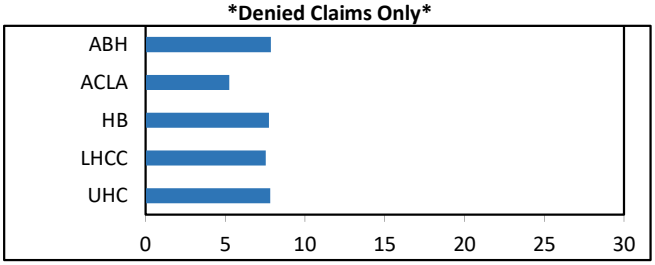
Claims Turnaround Time Quarter Q1 2022 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter Q1 2022 only)

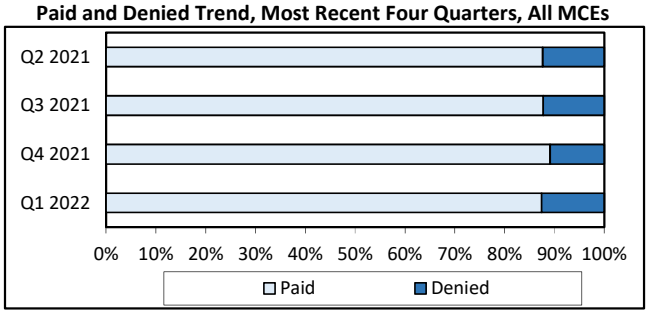
	ABH		ACLA		HB		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	49	35	93	52	152	71	93	53	47	36
101 - 250	18	18	67	28	73	21	65	48	19	13
> 250 claims	1	0	17	5	38	9	64	40	16	4

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

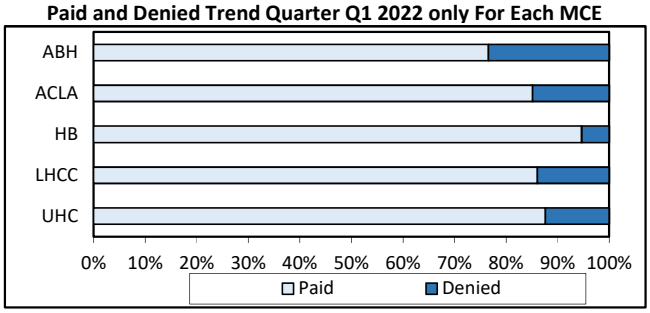
CARC Code	Description	ABH	ACLA	HB	LHCC	UHC
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	X	X		X	
96	Non-covered charge(s).	X	X		X	X
197	Precertification/authorization/notification absent.		X	X		
18	Exact duplicate claim/service	X			X	X
252	An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

Summary of Information on Claims for Therapy Services

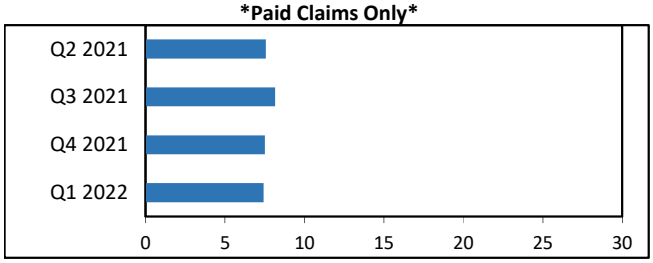
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



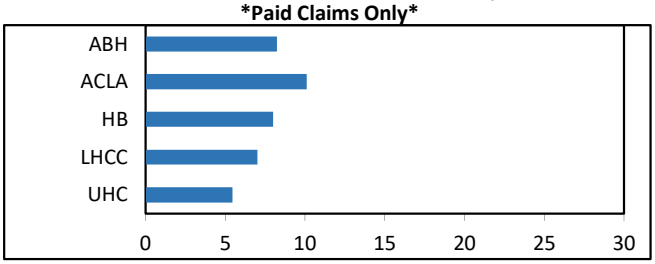
Paid and Denied Trend Quarter Q1 2022 only For Each MCE



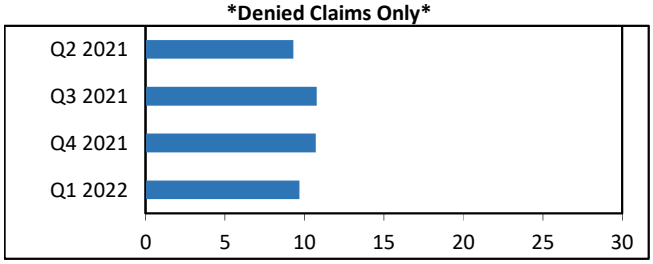
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



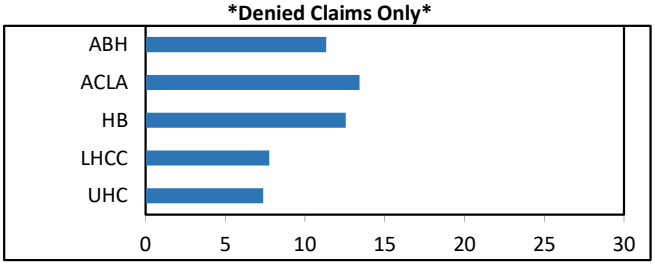
Claims Turnaround Time Quarter Q1 2022 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter Q1 2022 only)

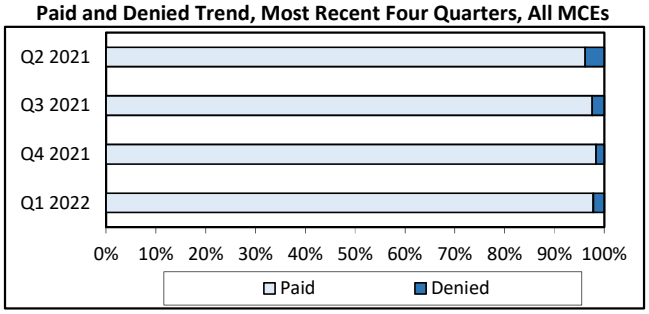
	ABH		ACLA		HB		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	142	75	66	36	97	40	66	37	23	19
101 - 250	30	18	44	23	56	10	61	32	28	11
> 250 claims	2	1	10	3	22	2	29	13	17	9

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

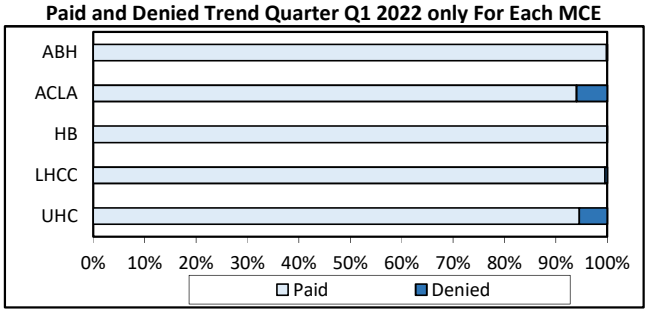
CARC Code	Description	ABH	ACLA	HB	LHCC	UHC
96	Non-covered charge(s).	X	X		X	X
197	Precertification/authorization/notification absent.	X	X	X		X
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	X	X		X	
256	Service not payable per managed care contract.			X		
18	Exact duplicate claim/service	X			X	X

Summary of Information on Claims for NEMT Services

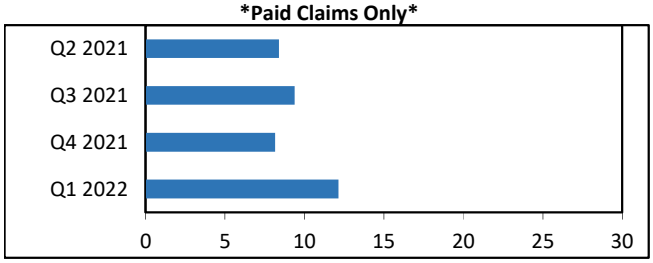
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



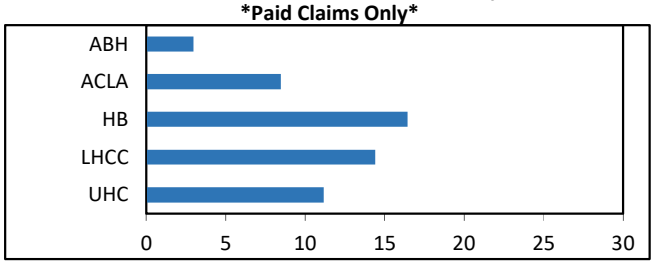
Paid and Denied Trend Quarter Q1 2022 only For Each MCE



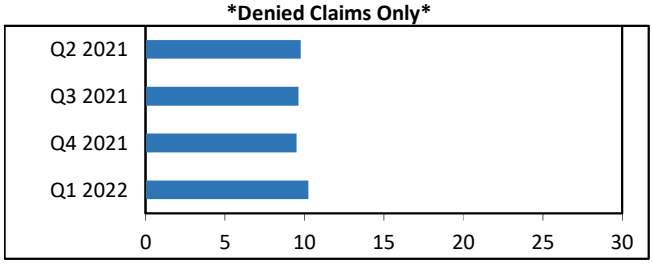
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



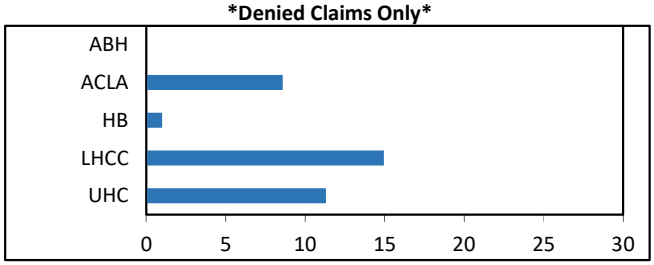
Claims Turnaround Time Quarter Q1 2022 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter Q1 2022 only)

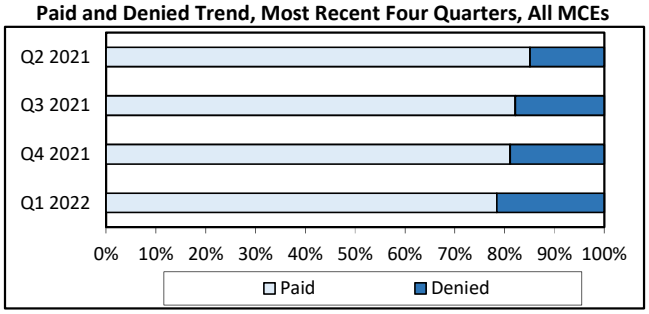
	ABH		ACLA		HB		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	98	0	64	19	0	0	54	1	40	5
101 - 250	0	0	81	23	0	0	80	0	57	8
> 250 claims	0	0	25	2	0	0	53	1	16	6

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

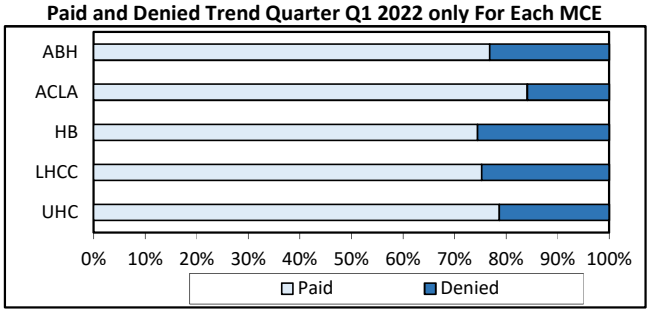
CARC Code	Description	ABH	ACLA	HB	LHCC	UHC
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	X	X	X	X	
A1	Claim/Service denied.		X	X	X	X
18	Exact duplicate claim/service	X	X	X	X	
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	X	X	X	X	
216	Based on the findings of a review organization		X	X	X	

Summary of Information on Claims for Medical Supplies Services

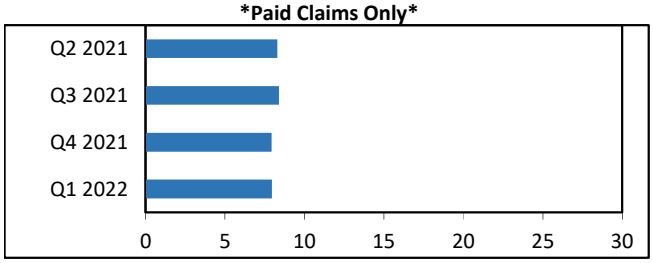
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



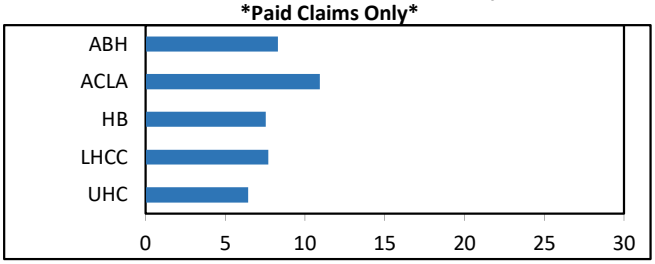
Paid and Denied Trend Quarter Q1 2022 only For Each MCE



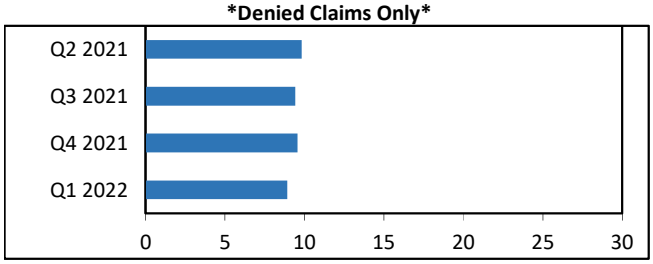
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



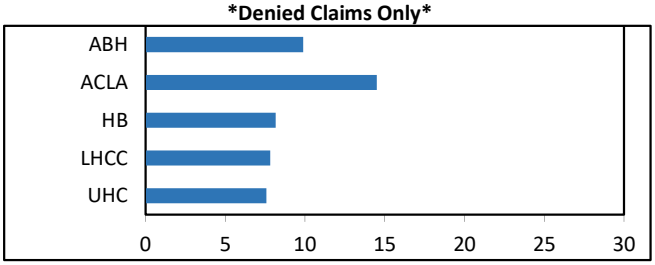
Claims Turnaround Time Quarter Q1 2022 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter Q1 2022 only)

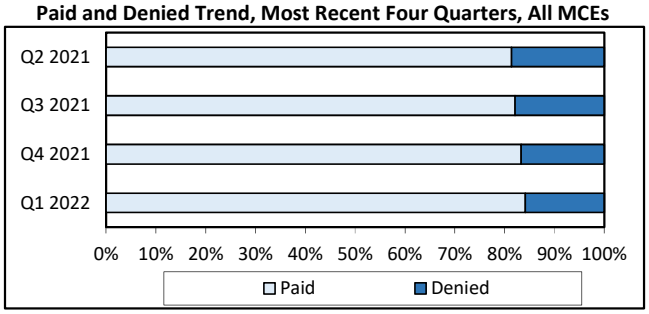
	ABH		ACLA		HB		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	156	113	141	82	111	57	154	93	368	266
101 - 250	42	38	44	27	11	6	82	59	52	34
> 250 claims	9	9	16	10	1	1	30	25	34	22

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

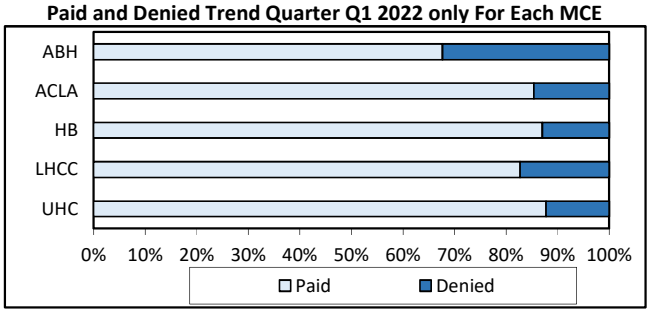
CARC Code	Description	ABH	ACLA	HB	LHCC	UHC
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	X	X		X	
96	Non-covered charge(s).	X	X			X
252	An attachment/other documentation is required to adjudicate this claim/service.		X	X		X
197	Precertification/authorization/notification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

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

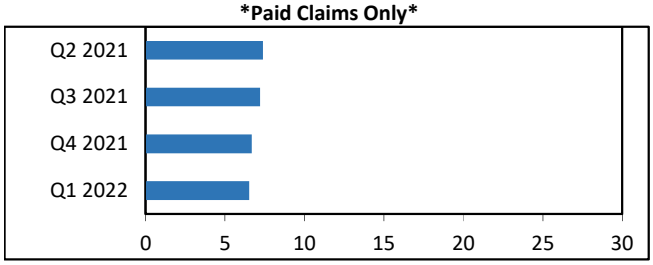
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



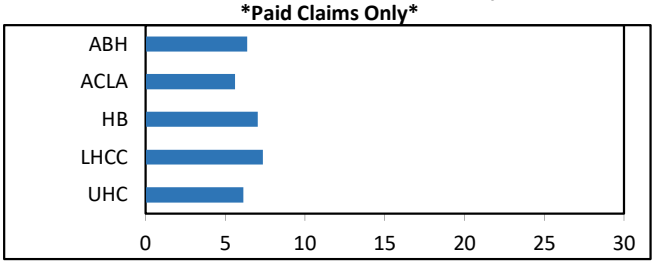
Paid and Denied Trend Quarter Q1 2022 only For Each MCE



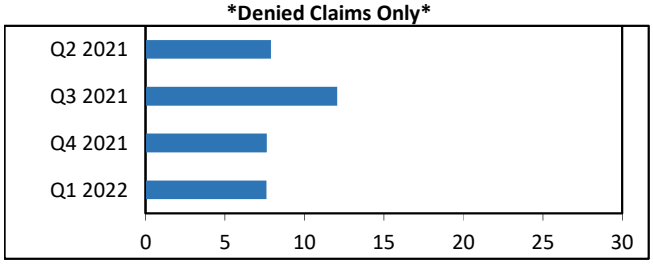
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



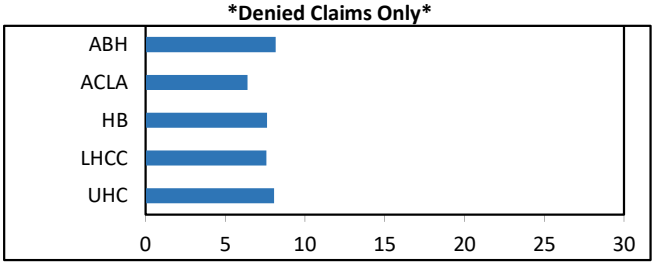
Claims Turnaround Time Quarter Q1 2022 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Note: HB overall turnaround time for denied claims of 30 days for Q3 is due to the processing of aged claims.

Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter Q1 2022 only)

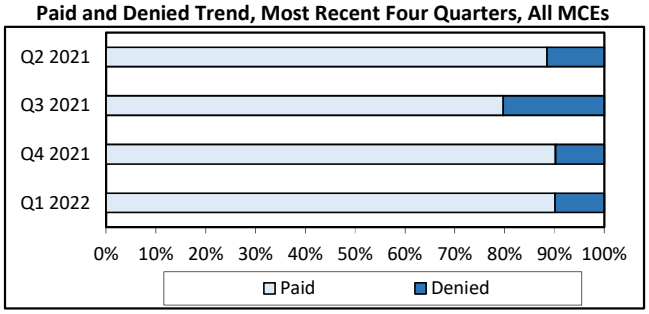
	ABH		ACLA		HB		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	397	76	1,872	1,031	2,653	984	2,220	1,303	3,402	2,042
101 - 250	14	4	758	382	605	217	679	377	537	315
> 250 claims	4	1	336	139	365	119	561	245	343	146

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

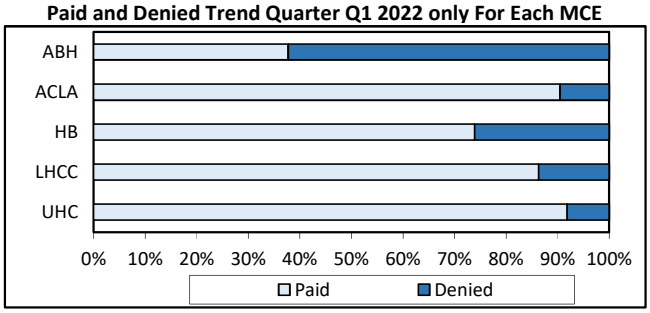
CARC Code	Description	ABH	ACLA	HB	LHCC	UHC
96	Non-covered charge(s).	X	X		X	X
197	Precertification/authorization/notification absent.		X	X		X
16	Claim/service lacks information or has submission/billing erro	X	X		X	
252	An attachment/other documentation is required to adjudicate this claim/service.	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

Summary of Information on Claims for Mental Health Services- Rehab

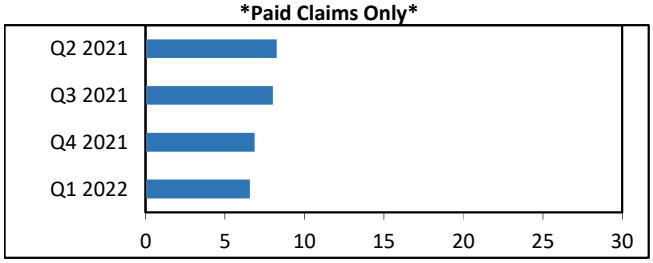
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



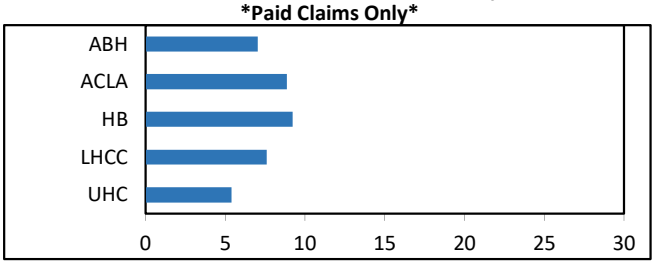
Paid and Denied Trend Quarter Q1 2022 only For Each MCE



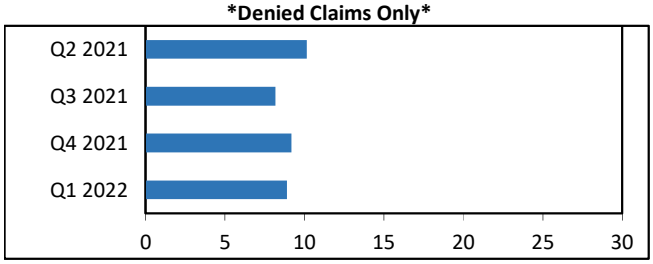
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



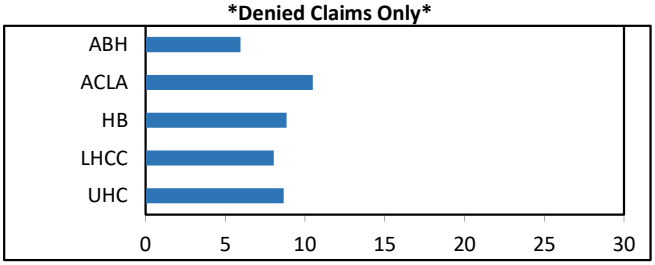
Claims Turnaround Time Quarter Q1 2022 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter Q1 2022 only)

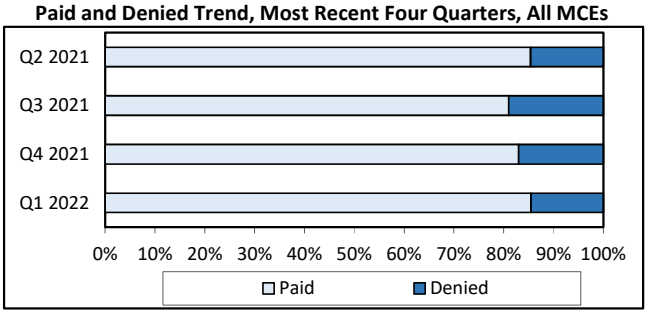
	ABH		ACLA		HB		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	45	39	63	24	53	46	31	22	76	47
101 - 250	6	3	97	40	12	5	19	3	75	37
> 250 claims	1	1	39	8	0	0	2	1	84	24

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

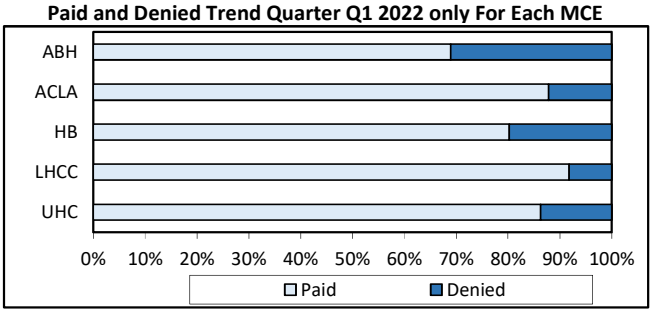
CARC Code	Description	ABH	ACLA	HB	LHCC	UHC
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	X			X	X
197	Precertification/authorization/notification absent.		X		X	X
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	X				
18	Exact duplicate claim/service				X	X
29	The time limit for filing has expired.		X		X	

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

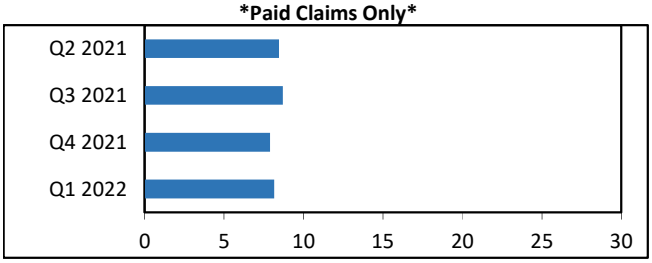
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



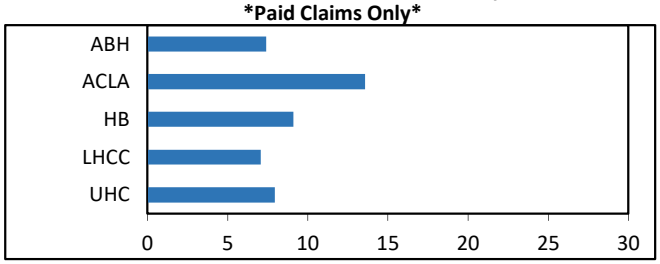
Paid and Denied Trend Quarter Q1 2022 only For Each MCE



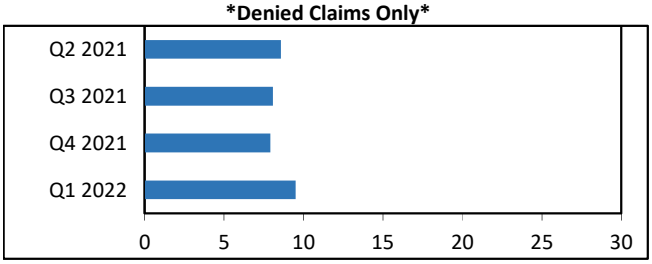
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



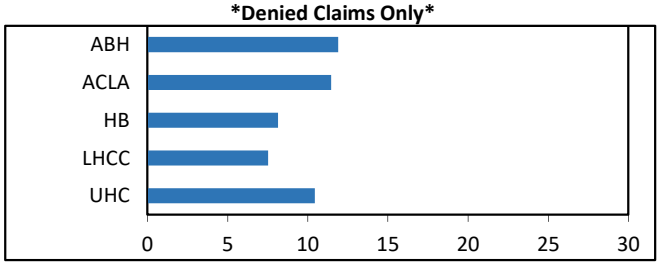
Claims Turnaround Time Quarter Q1 2022 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter Q1 2022 only)

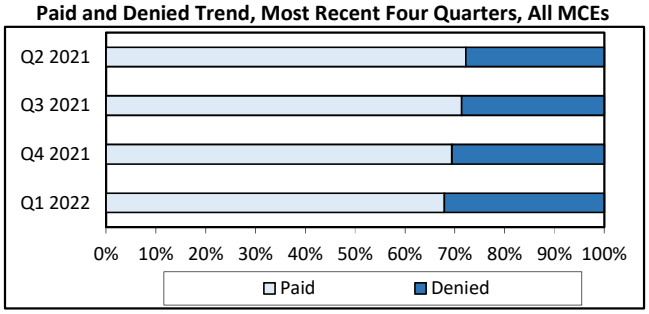
	ABH		ACLA		HB		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	11	8	489	202	1,007	544	740	326	262	131
101 - 250	0	0	87	27	277	155	316	120	58	29
> 250 claims	0	0	36	8	101	58	209	77	45	16

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

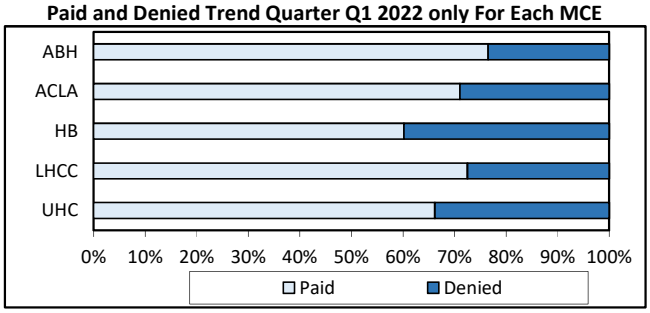
CARC Code	Description	ABH	ACLA	HB	LHCC	UHC
96	Non-covered charge(s).	X	X		X	
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	X			X	
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.					
29	The time limit for filing has expired.	X	X			X
252	An attachment/other documentation is required to adjudicate this claim/service.		X			X

Summary of Information on Claims for Pharmacy Services

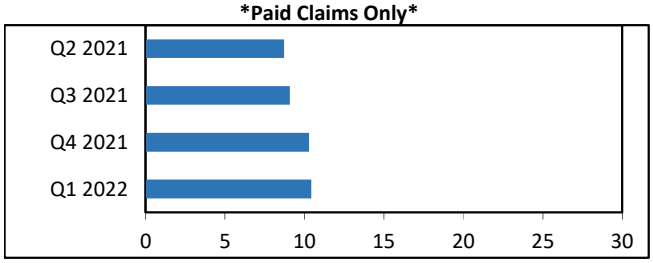
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



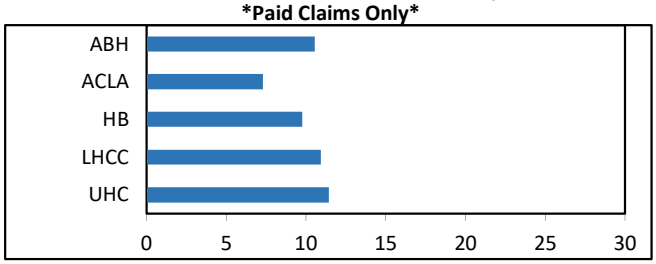
Paid and Denied Trend Quarter Q1 2022 only For Each MCE



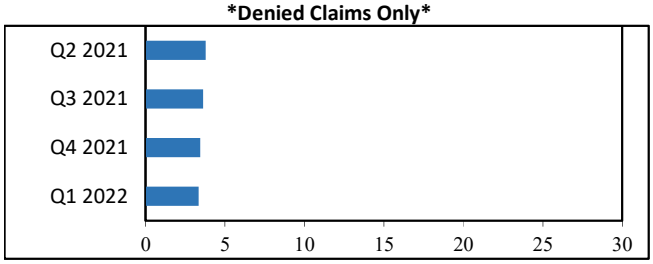
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



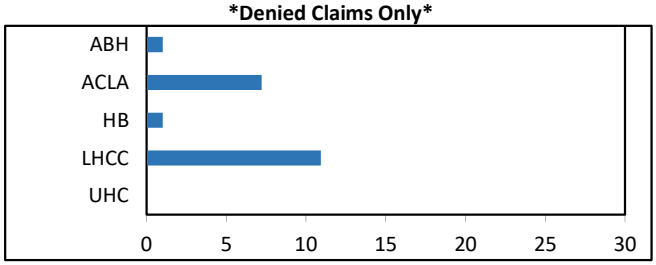
Claims Turnaround Time Quarter Q1 2022 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter Q1 2022 only)

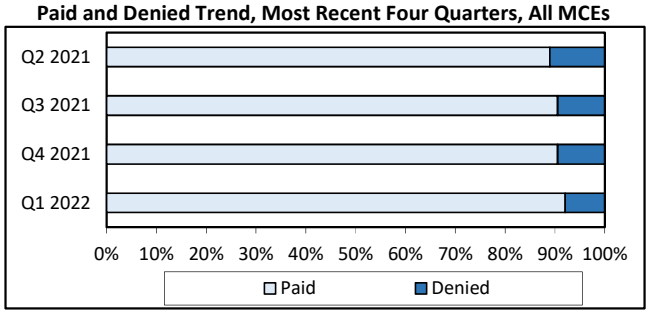
	ABH		ACLA		HB		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	18,359	12,247	1,412	1,398	3,811	3,285	14,010	13,356	21,373	17,132
101 - 250	1,596	1,547	355	352	181	180	3,508	3,467	4,208	4,196
> 250 claims	102	101	689	687	938	938	1,092	1,090	1,534	1,533

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

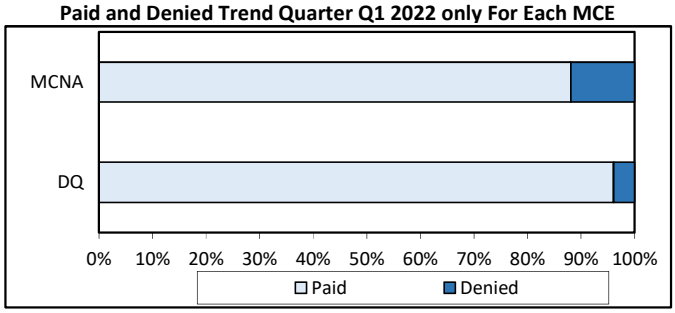
NCDCP Code	Description	ABH	ACLA	HB	LHCC	UHC
88	DUR Reject Error		X	X	X	X
79	Refill Too Soon		X	X	X	
76	Plan Limitations Exceeded			X	X	X
75	Prior Authorization Required			X	X	
39	M/I Diagnosis Code		X	X		X

Summary of Information on Claims for Dental Services- Children

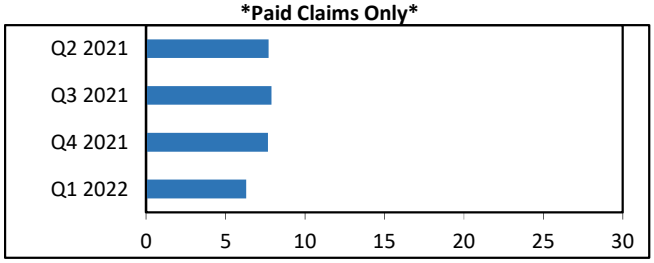
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



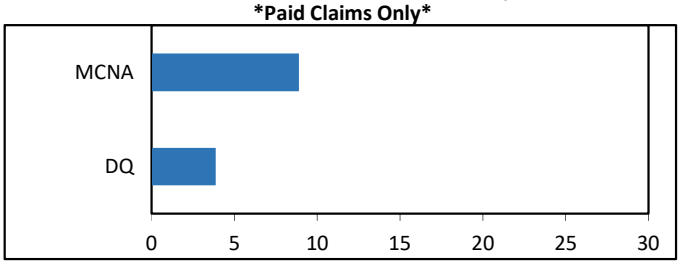
Paid and Denied Trend Quarter Q1 2022 only For Each MCE



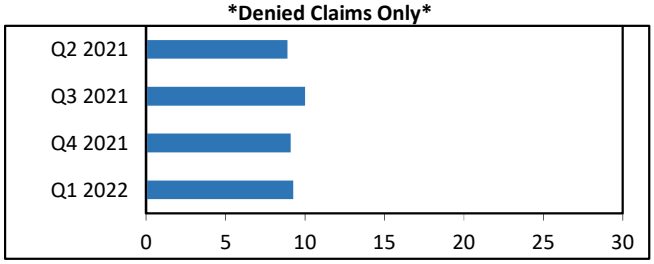
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



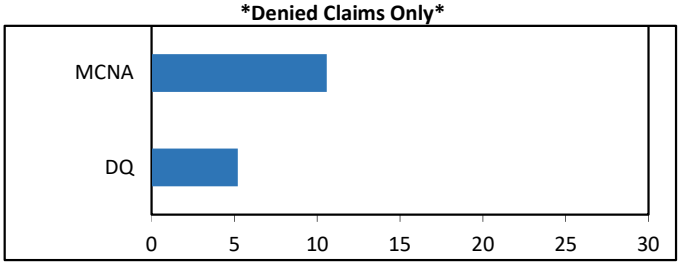
Claims Turnaround Time Quarter Q1 2022 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter Q1 2022 only)

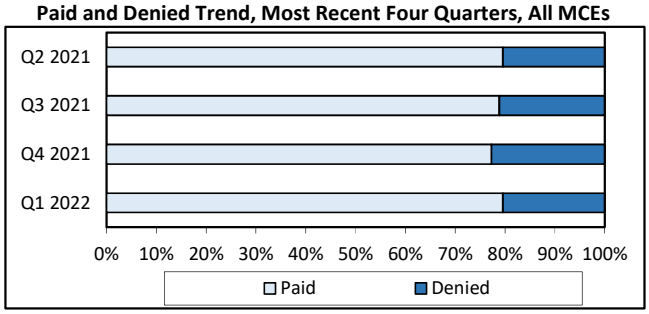
	MCNA		DQ	
	# Providers	>10% denied	# Providers	>10% denied
<100 claims	682	422	0	0
101 - 250	118	76	0	0
> 250 claims	12	11	0	0

Top Denial Reasons this Quarter

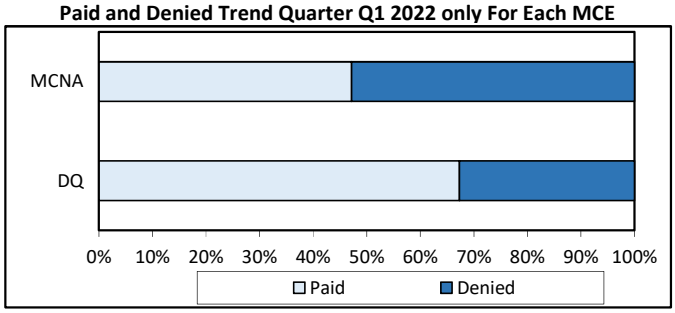
CARC Code	Description	MCNA	DQ
A1	Claim/Service denied.		X
18	Exact duplicate claim/service	X	
169	Alternate benefit has been provided.	X	
27	Expenses incurred after coverage terminated.	X	
96	Non-covered charge(s).	X	

Summary of Information on Claims for Dental Services- Adults

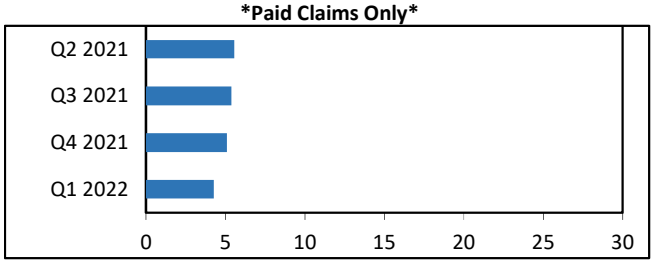
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



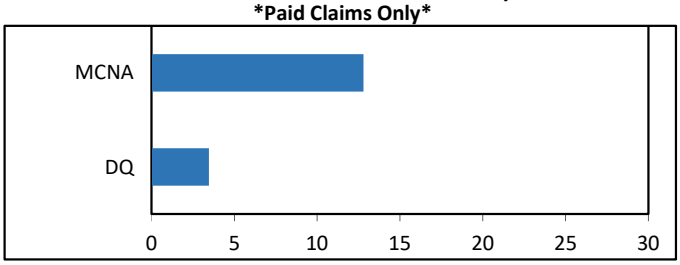
Paid and Denied Trend Quarter Q1 2022 only For Each MCE



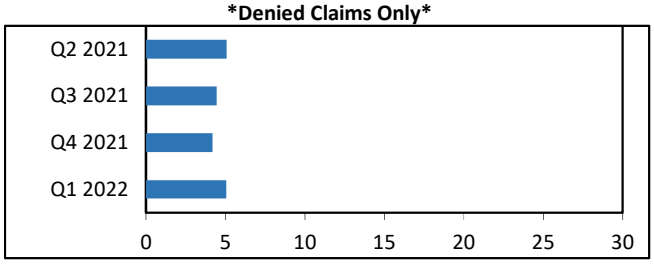
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



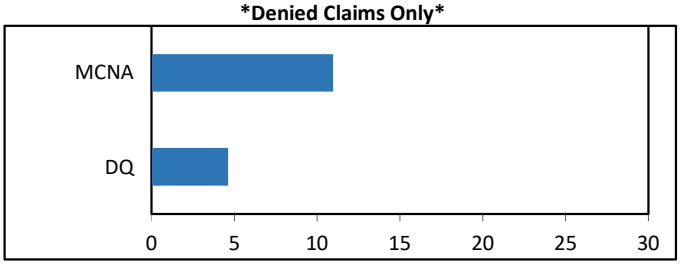
Claims Turnaround Time Quarter Q1 2022 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter Q1 2022 only)

	MCNA		DQ	
	# Providers	>10% denied	# Providers	>10% denied
<100 claims	283	267	52	4
101 - 250	3	3	188	12
> 250 claims	1	1	481	26

Note: All MCEs had little data for Dental-Adult

Top Denial Reasons this Quarter

CARC Code	Description	MCNA	DQ
A1	Claim/Service denied.		X
22	This care may be covered by another payer per coordination of benefits.	X	
119	Benefit maximum for this time period or occurrence has been reached.		
18	Exact duplicate claim/service	X	
96	Non-covered charge(s).	X	