Healthy Louisiana Claims Report

Response to Act 710 of the 2018 Regular Legislative Session

Quarter 1 Calendar Year 2023

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Louisiana Department of Health

Bureau of Health Services Financing

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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 on October 31, 2018. Medicaid submits subsequent reports quarterly with each report presenting the most recent four quarters of data available. This report covers Quarters 2, 3, and 4 of CY 2022 and Quarter 1 of 2023.

Key Findings

Measure #1: Claims Accepted and Rejected by the MCEs

- The claim acceptance rate for all MCEs combined has held constant at 99.0% for the last three quarters of CY 2022 and decreased slightly to 98.9% in the first quarter of 2023. The decrease is mainly attributed to Louisiana Healthcare Connections, with the accepted rate decreased from 97.8% in Q4 2022 to 96.4% in Q1 2023.

- In the most recent four quarters for which data is available, the claims rejection rate reported by the MCEs averaged 1.1%. This rate, however, is driven primarily by Louisiana Healthcare Connections (rejection rate of 2.2% to 3.6%) 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 78.0% and 81.5% in the most recent four quarters. The denial rates, therefore, were between 18.5% and 22.0%.

- At the MCE-specific level, the average denial rate in the last four quarters ranged from 8.2% for DentaQuest to 23.6% for Aetna Better Health. For all the MCEs, except for Humana (which is reported as a MCE started in Q1 2023), the denial rates of Q1 2023 are considerably higher than those of Q4 2022, with increases ranging from 1.4% (MCNA Dental) to 5.2% (United HealthCare).

- Medicaid found more variation when it examined the claims denial rates by provider type. For example, pharmacy (average of 32.4% in the last four quarters) and dental-adults (average of 25.4% in the last four quarters) have the highest denial rates while non-emergency medical transportation (average of 1.6% in the last four quarters) and dental - children (average of 8.5% 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 below 9 days in the last four quarters for all MCEs with the minor exception of MCNA with an average TAT of 10.1 days.
- The overall TAT for paid claims, all MCEs combined, is between 7.4 days and 7.7 days in each quarter. For denied claims, the average is between 5.1 days and 5.5 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) for the determination. 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 2023 were:

CARC Code	Description
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
96	Non-covered charge(s).
18	Exact duplicate claim/service
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.
252	An attachment/other documentation is required to adjudicate this claim/service.

- The top five CARCs in this quarter were also among the top six in the previous 16 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 2023 were:

NCPDP Code	Description
79	Refill Too Soon
88	DUR Reject Error
76	Plan Limitations Exceeded
7Ø	Product/Service Not Covered – Plan/Benefit Exclusion
75	Prior Authorization Required

- These five NCPDPs were also among the top six in the previous 14 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 99.2% to 99.6% of the encounters submitted by all MCEs.

- There were differences at the MCE level. All of UnitedHealthcare's encounters were accepted. Almost all of Healthy Blue and Louisiana Healthcare Connections' encounters were accepted over the past four quarters. AmeriHealth Caritas Louisiana averaged 98.8% of encounters accepted for the previous four quarters. Aetna Better Health's four-quarter average of encounters accepted rate was 97.8%. MCNA averaged 97.3% over the last four submitted quarters. DentaQuest averaged 94.0% over the last four submitted quarters.

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

A common benchmark used to measure the 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 88.4%. The rate of submission within 30 days decreased by 3% from the previous four quarters (91.4%).

- UnitedHealthcare has been the most consistent over the past four quarters with an overall average of 98.9%.

- AmeriHealth Caritas Louisiana had the second-highest rate of timeliness for encounter submissions with an average of 96.9% over the past four quarters.

- Louisiana Healthcare Connections averaged 89.7% of timeliness for encounter submissions over the past four quarters but had some issues with timely submissions for pharmacy encounters, with an average of 70.9% over the past four quarters.

- Healthy Blue had issues with timely submissions for institutional encounters (62.1%) for Quarter 2 of 2022, with an overall average rate of timeliness for encounter submissions at 88.7% over the past four quarters.

- Aetna Better Health had issues with timely submissions for professional and pharmacy encounters, with an average of 81.1% and 69.1% for the past four quarters, respectively.

- In regards to dental encounter submissions to LDH, DentaQuest has been the most consistent over the past four quarters with an average submission rate of 100%. MCNA's four-quarter rate of submission average was 95.5%, with a significant improvement from 83.0% in Quarter 4 of 2022 to close to 100% in Q1 2023.

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 quarterly. 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 Q4 2022, Medicaid the MCEs reached out to 885 provider entities (883 in the prior quarter). The most predominant mode of outreach to providers is 1:1 phone calls (54.1% of all contacts) followed by 1:1 emails (42.0% of contacts). Very few in-person contacts or provider education webinars took place, accounting for 3.6% and 0.2% of the total, respectively.

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 who are identified as having special healthcare needs (SHCN) or who have high risk or unique, chronic, or complex needs.

Key findings for Q1 2023:

- A total of 46,807 individuals enrolled in the Louisiana Medicaid Managed Care program were identified as potentially eligible or in need of case management services.
- Of these, 19.2% or 9,002 were enrolled in case management for at least one month during the first quarter of CY 2023 and;
- A total of 5,880 (65.3 %) 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 every quarter. Each subsequent report must cover a more recent three-month period than the previous report. This is the nineteenth report update.

Report Update	Calendar Year 2018				Calendar Year 2019				Calendar Year 2020				Calendar Year 2021				Calendar Year 2022				Calendar Year 2023			
	Q1	Q2	Q3	Q4	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							
16															X	X	X	X						
17																X	X	X	X					
18																	X	X	X	X				
19																		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 a 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.

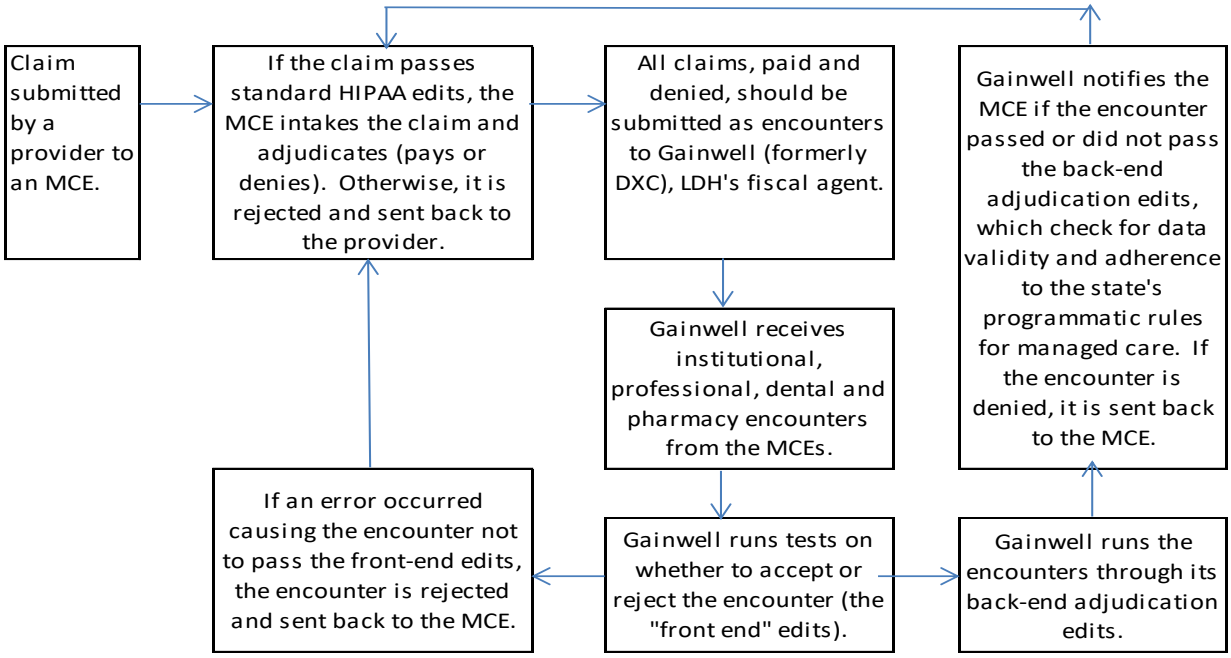
- The *CMS-1500, or electronic 837P*, is the claim type for professional service providers to submit. This includes a wide array of providers such as physicians, clinics, mental health providers, therapists, transportation providers, and suppliers of medical equipment and supplies.

- 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 are 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 by 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, some standards 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 for 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 *detailed 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 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 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 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) for the determination. Many payers will design codes specific to their organization. However, there are sets of industry-standard codes used nationally and required by LDH:

- For medical and dental claims, there is a 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
Humana	Managed care organization	HUM
Louisiana Healthcare Connections, Inc.	Managed care organization	LHCC
United Healthcare of Louisiana, Inc.	Managed care organization	UHC
MCNA Insurance Company, Inc.	Dental benefits program manager	MCNA
DentaQuest (contracted 1/1/2021)	Dental benefits 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 Act 710 quarterly updates and incorporate them into a consolidated reporting template—Report 152. LDH requires that each MCE submit the 152 report every quarter. 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 2023. Section III contains the results related to MCE claims adjudication measures and MCE provider education about 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 2022 and Quarter 1 in 2023. 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 2023 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 2023

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 0% to 7.2% of provider claims
Claim Payment Denial Rate, Overall	From a low of 17.5% to a high of 22.0%
For Hospital Claims Denial Rate	Much higher for inpatient hospital services (16.1%-17.2%), but outpatient hospital services have one of the lowest denial rates of any service category (8.4%-12.5%).
For Professional Services	The denial rate range has varied substantially between 1.6% and 22.9%. All other professional service has the highest average (18.2%), ranging from 15.1% to 21.4% and Non-Emergency Medical Transportation has the lowest (3.0%), ranging from 1.5% to 6.1%.
For Dental Claims	For child dental services, the denial rate had been steady between 6.9% and 13.3%. The denial rate for adult dental services has fluctuated between 10.0% and 33.3%.
For Pharmacy Claims	The industry standard is that pharmacy scripts have the highest denial rate. Louisiana Medicaid Managed Care is no exception with a denial rate range between 25.9% and 33.8%. 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 7.0 days to 8.0 days. The overall average since the implementation of this report is 7.5 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. For all quarters of all MCEs, about 88.8% of encounters were submitted to LDH within 30 days of processing. Generally, UHC is most consistent and timely (that is, all encounters submitted to LDH within 30 days of processing) with 97.0%. ACLA has a 90.2% submission rate. HB submitted over 93.8% of their encounters within 30 days. LHCC has an 84.7% submission rate. ABH has a lower submission rate of 67.9% of encounters submitted within 30 days. HUM has a very low submission rate of 37.8% as Q1 2023 is its first quarter in the business. For dental, DQ has a 95.1% submission rate and MCNA has a 94.2%

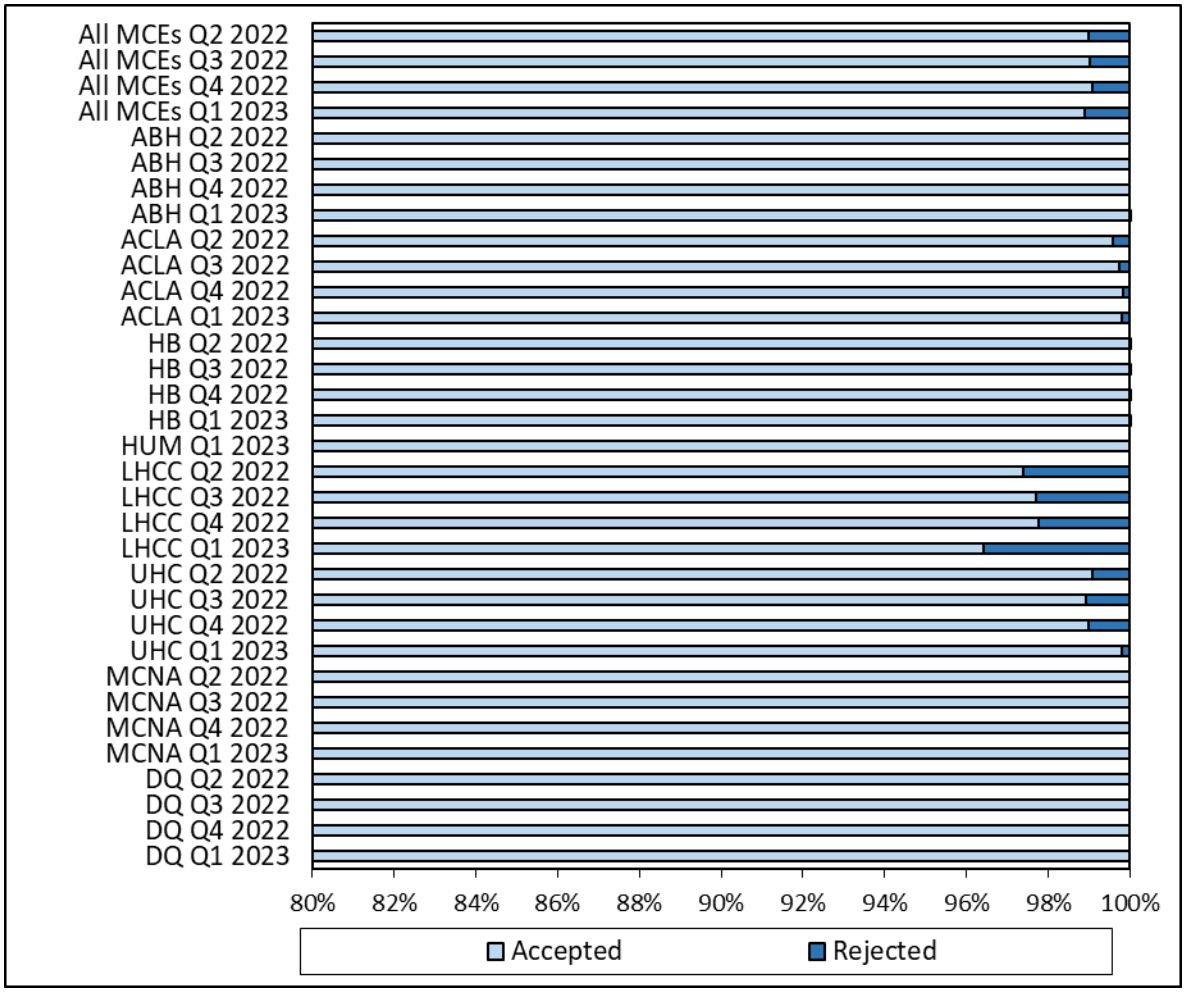
Section III: Findings Related to MCE Claims Adjudication

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 ranged from 0.9% to 1.1%. The rejection rate overall is specifically due to higher rejection rates for LHCC (2.2% to 3.6%) 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



Within the parameters of the contract, MCEs have some discretion on their claims adjudication processes, including front-end claims edits applied; hence rejection rates vary among the MCEs for various reasons such as:

- Whether or not the MCEs are performing any front-end HIPPA edits, which of the HIPPA edit levels (1-7) they have implemented and if they apply custom edits,
- Whether or not the MCEs are using clearinghouses/vendors/subcontractors to perform front-end edits before submitting the claims into their adjudication systems,
- Whether or not the providers are using front-end edits before submitting their claims to the MCEs.

LDH has periodically surveyed the MCEs to understand differences in their claims processing and specifically in the application of front-end edits for claims rejections or acceptance for adjudication. According to the response of the MCEs to a recent survey:

- The DBPMs (DQ, MCNA) are not applying any front-end pre-adjudication edits. All claims are currently accepted into their claims adjudication system and processed directly for payment or denial. So they are reporting no rejection at all.
- ABH and ACLA had reported that they are using independent clearinghouses to clean the claim data before submission (could potentially under-report rejections not counted)
- For LHCC, all pre-adjudication screening/edits are applied by LHCC's internal systems and all claim rejections are counted and reported.
- UHC is using their SMART Edit Rejection system to screen the claims they received, but indicated that they were erroneously reporting some informational edits as rejections; hence overstating the rejection count.

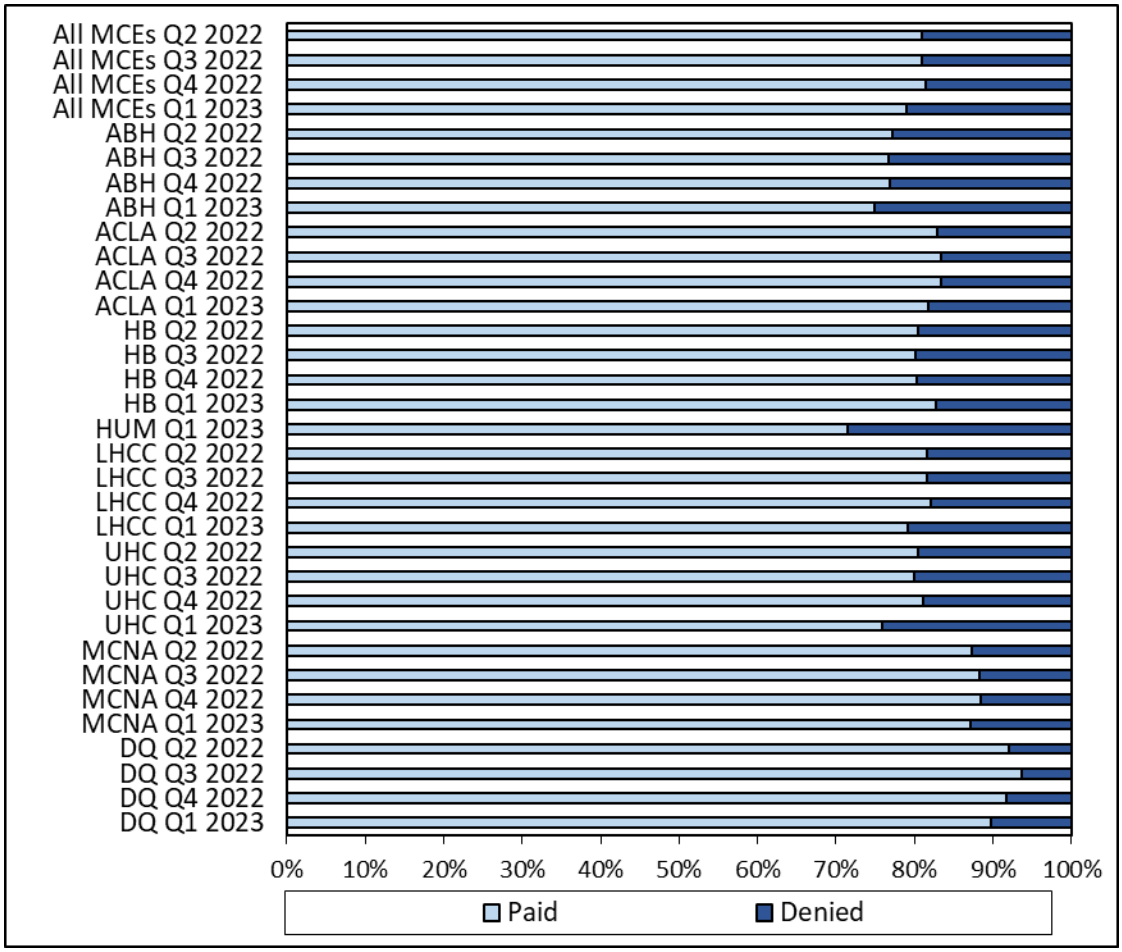
Claims Paid and Denied by the MCEs

LDH's contracted MCEs or their subcontractor adjudicate 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 78.0% and 81.5% in the most recent four quarters. The denial rates, therefore, were between 18.5% and 22.0%. These denial rates have remained fairly steady since the Act 710 quarterly update reports were released.

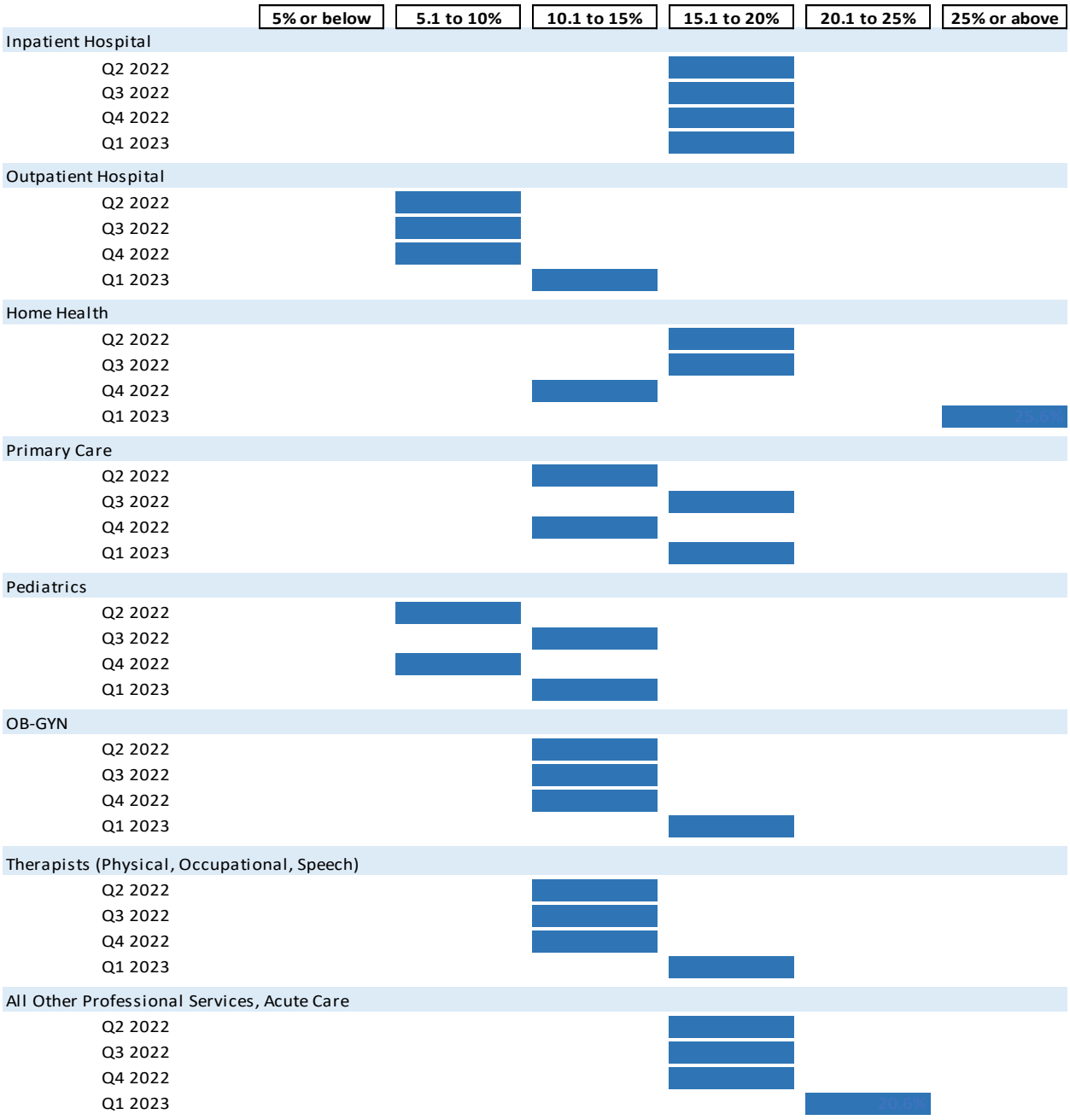
At the MCE-specific level, the range across the four-quarter averages was from an average denial rate of 8.2% for DQ to an average rate of 28.4% for HUM. The denial rates have not gone down in any significant manner since the original report showing CY 2017 data.

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. It is worth noting that the denial rate of Home Health changed significantly from 13.0% in Q4 2022 to 25.6% in Q1 2023, owing to the increase of denials reported by LHCC. LHCC processes the majority of Home Health claims, ranging from 55% to 75% of Home Health claims across all MCEs. LHCC reported their abnormal increase in denials of Home Health claims in Q1 2023 was mainly due to providers not enrolled with Louisiana Medicaid.

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



Similarly, the denial rate of Mental/Behavioral Health and rehab claims increased from 12.0% to 21.0% in Q1 2023. The increases were seen in all MCEs, due to the implementation of the 21st Century Cures provider enrollment process – all MCEs began denying claims in January 2023 if rendering and billing providers on the claim, who were required to enroll, were not enrolled.

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

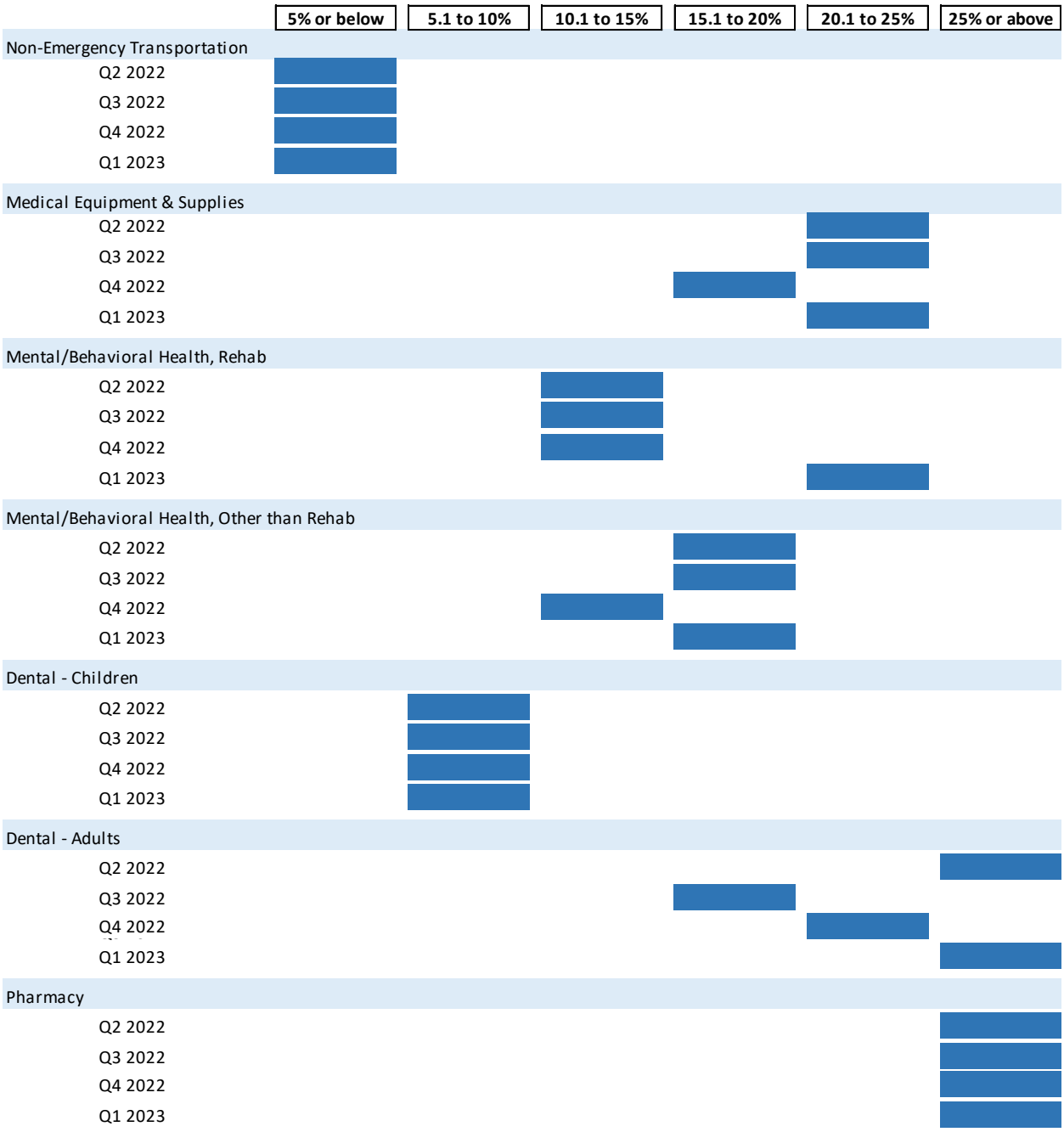
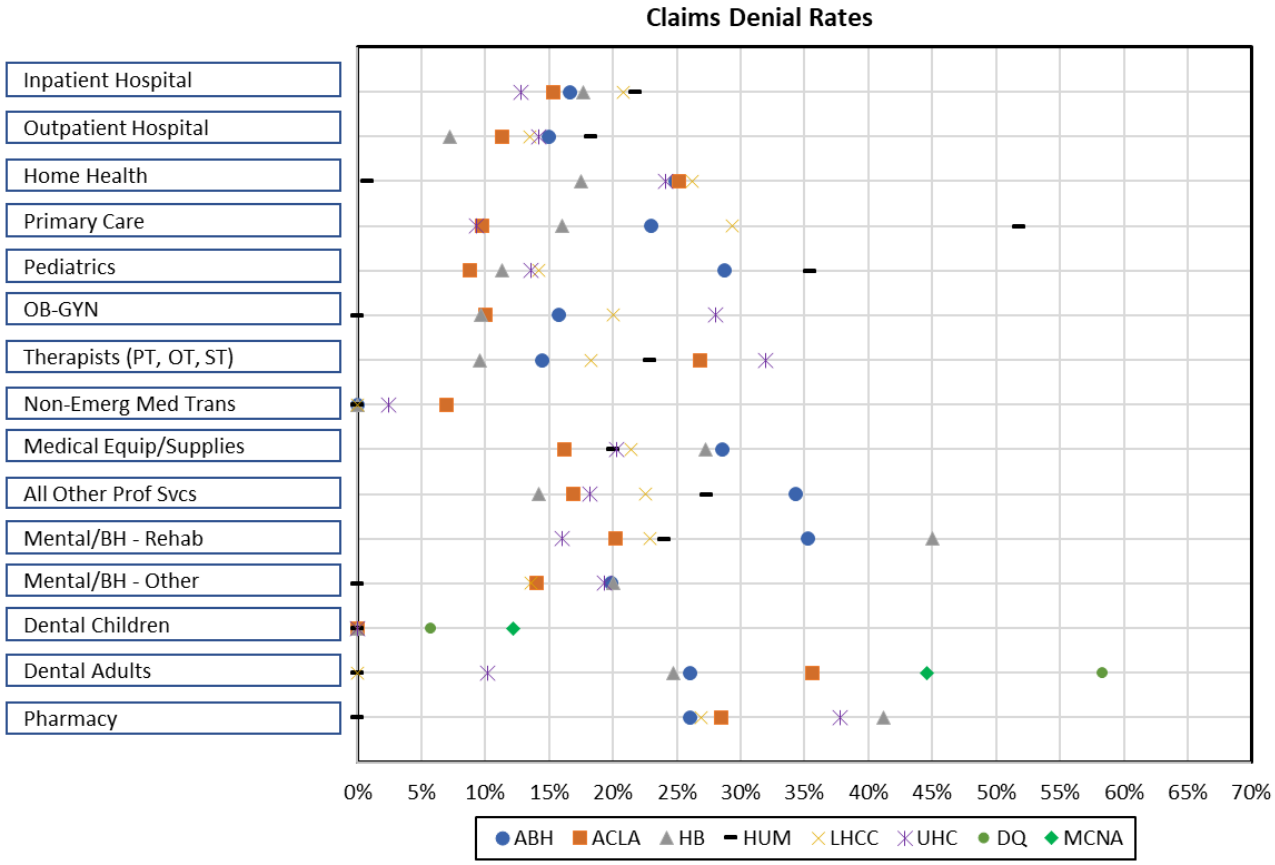


Exhibit III.5 compares the denial rates for these service categories by MCE. The data plotted on this exhibit is the percentage of claims denied in Q1 of CY 2023 for each MCE. An icon and color are used to display each MCE's data. Each row in the exhibit represents a specific service category. For example, in the top line of the exhibit, the overall denial rate for inpatient hospital services in Q1 2023 was 17.5%, but this varied from 12.8% for UHC to 20.8% for LHCC.

The claims denial rates for adjudicated claims varied greatly among provider categories of each MCE. For example, HB has the smallest denial rate of 0.0% for their Non-Emergency Medical Transportation claims but has a high denial rate of 45.1% for their Mental/Behavior Health Rehab claims. The denial rates also varied considerably for the same provider categories across MCEs, with the varying ranges differing among provider categories. For example, the denial rates of Inpatient Hospitals varied in a relatively small range from 12.8% (UHC) to 21.7% (HUM), while the denial rates of Primary Care ranged from 9.3% (UHC) to 51.8% (HUM).

Exhibit III.5
Claim Denial Rates for Adjudicated Claims
By Provider Specialty / Service Category
By MCE for Q1 2023



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 several reasons, but just to name a few:

- The 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 authorization by the MCE before the service is rendered and authorization was not received for the service.

In some of these situations, the denied claim could never have received a payment (e.g., an 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 the compilation of the data used in the Act 710 Healthy Louisiana Claims report, continues to use this model for 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 2023, the average payment for paid inpatient hospital claims was $6,036; for primary care, it was $38.

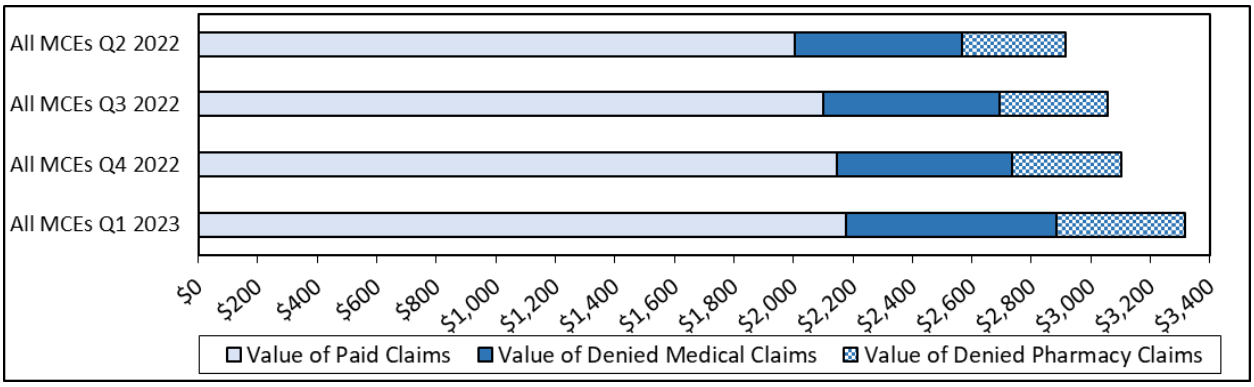
Not only was an average payment per claim computed for each provider specialty separately but one was also computed for each MCE within the provider type as well as a separate value for each calendar quarter.

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 21.5% and 24.6% of the sum of paid and denied values each quarter. This equates to between $561.9 million and $709.5 million. Among the $709.5 million in denied values in Q1 2023 assigned across the six MCEs that provide medical and pharmacy benefits, $272.7 million (38.7%) was attributed to medical claims, and $431.3 million (61.3%) was attributed to pharmacy claims.

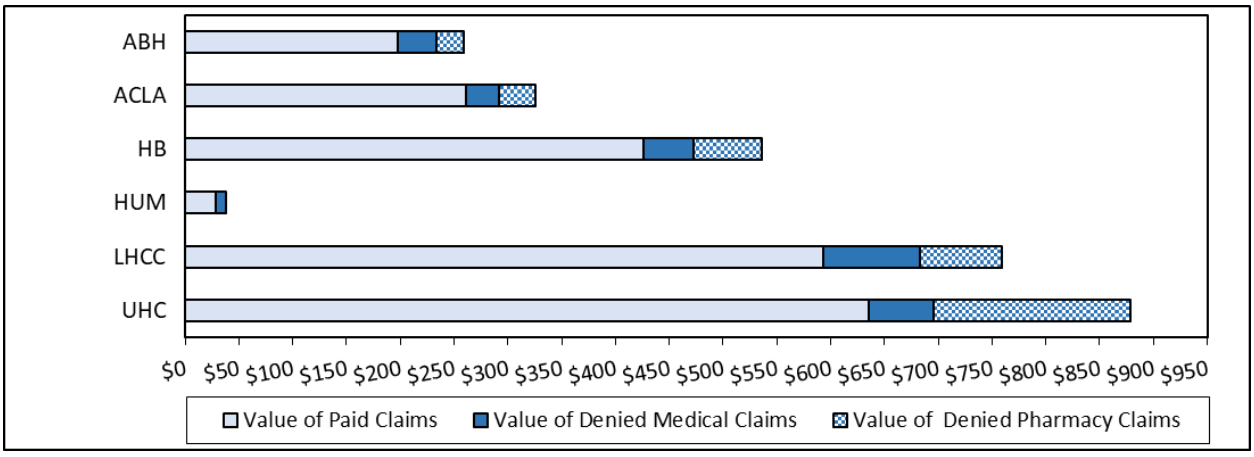
In Q1 2023, the distribution of denials between medical and pharmacy claims for each MCE was as follows:

- ABH - 59.2% medical and 40.8% pharmacy claims
- ACLA - 46.4% medical and 53.6% pharmacy claims
- HB - 29.4% medical and 70.6% pharmacy claims
- HUM - 100% medical, as pharmacy services for HUM members are provided through the state fee for service vendor.
- LHCC - 54.2% medical and 45.8% pharmacy claims
- UHC - 24.7% medical and 75.3% pharmacy claims

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

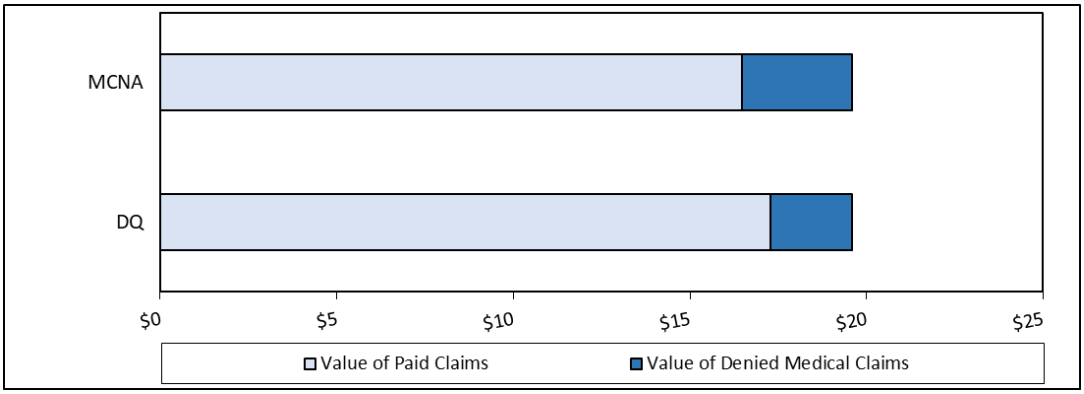


Value of Paid and Denied Claims by MCE – Q1 2023



MCNA and DQ had a total value of $33.8 million (86.2%) of paid claims and $5.4 million (13.8%) value of denied medical claims.

Value of Paid and Denied Dental Claims – Q1 2023



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 six MCEs (excluding dental services paid by MCNA and DentaQuest), so 42 groupings for six 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 is 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 fewer) to make an assessment.

Exhibit III.7 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 2022	96	87	39	222
Q3 2022	100	86	36	222
Q4 2022	104	83	35	222
Q1 2023	133	54	35	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 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. The average TAT is below 9 days in every quarter for all MCEs with the minor exception of MCNA with an average of 10.1 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 2022	99.9%	99.8%	7.5	5.5
	Q3 2022	99.9%	99.9%	4.7	5.2
	Q4 2022	99.6%	99.6%	5.0	5.1
	Q1 2023	99.7%	99.6%	4.6	4.6
ACLA	Q2 2022	100.0%	100.0%	5.1	6.0
	Q3 2022	99.9%	99.8%	4.6	5.7
	Q4 2022	99.9%	99.7%	6.8	7.5
	Q1 2023	100.0%	100.0%	8.2	8.4
HB	Q2 2022	99.9%	99.9%	7.4	2.8
	Q3 2022	99.8%	99.8%	8.0	3.4
	Q4 2022	98.1%	97.6%	8.6	4.1
	Q1 2023	96.4%	94.6%	6.3	5.0
HUM	Q1 2023	100.0%	100.0%	4.7	3.9
LHCC	Q2 2022	99.9%	99.8%	8.2	9.0
	Q3 2022	99.1%	99.5%	8.9	9.1
	Q4 2022	99.8%	99.6%	8.4	9.1
	Q1 2023	99.8%	99.6%	8.4	9.1
UHC	Q2 2022	99.9%	100.0%	7.6	2.5
	Q3 2022	99.2%	99.7%	7.8	2.8
	Q4 2022	99.6%	100.0%	7.9	3.0
	Q1 2023	100.0%	100.0%	7.8	2.8
MCNA	Q2 2022	100.0%	100.0%	9.7	11.8
	Q3 2022	100.0%	100.0%	8.3	10.0
	Q4 2022	100.0%	100.0%	8.5	10.1
	Q1 2023	100.0%	100.0%	10.1	12.0
DQ	Q2 2022	100.0%	100.0%	4.2	4.3
	Q3 2022	100.0%	100.0%	1.0	1.0
	Q4 2022	100.0%	100.0%	0.9	0.8
	Q1 2023	100.0%	100.0%	14.7	10.4
ALL MCEs	Q2 2022	99.9%	99.9%	7.4	5.1
	Q3 2022	99.4%	99.7%	7.4	5.2
	Q4 2022	99.4%	99.3%	7.7	5.5
	Q1 2023	99.2%	99.1%	7.5	5.7

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

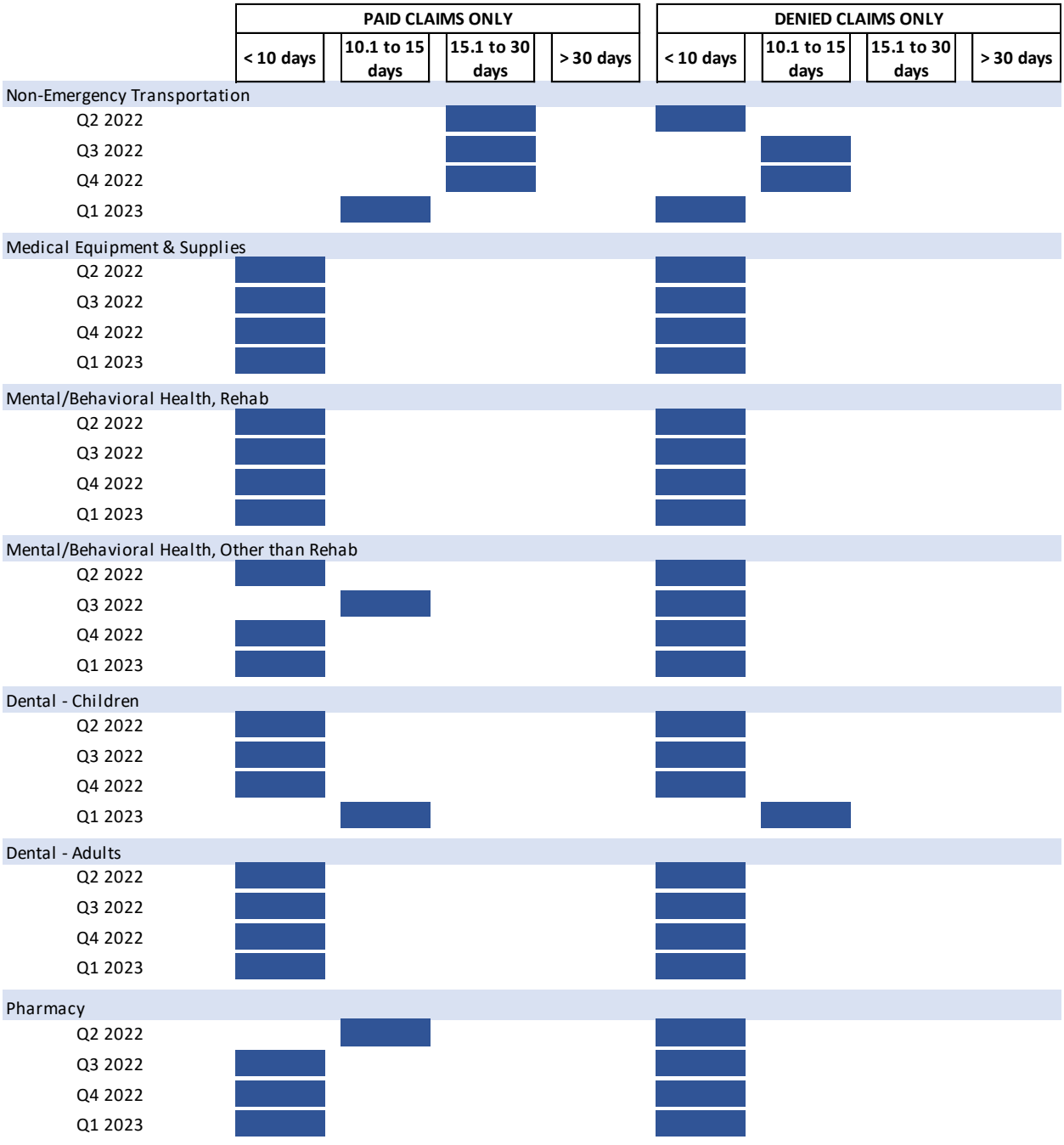
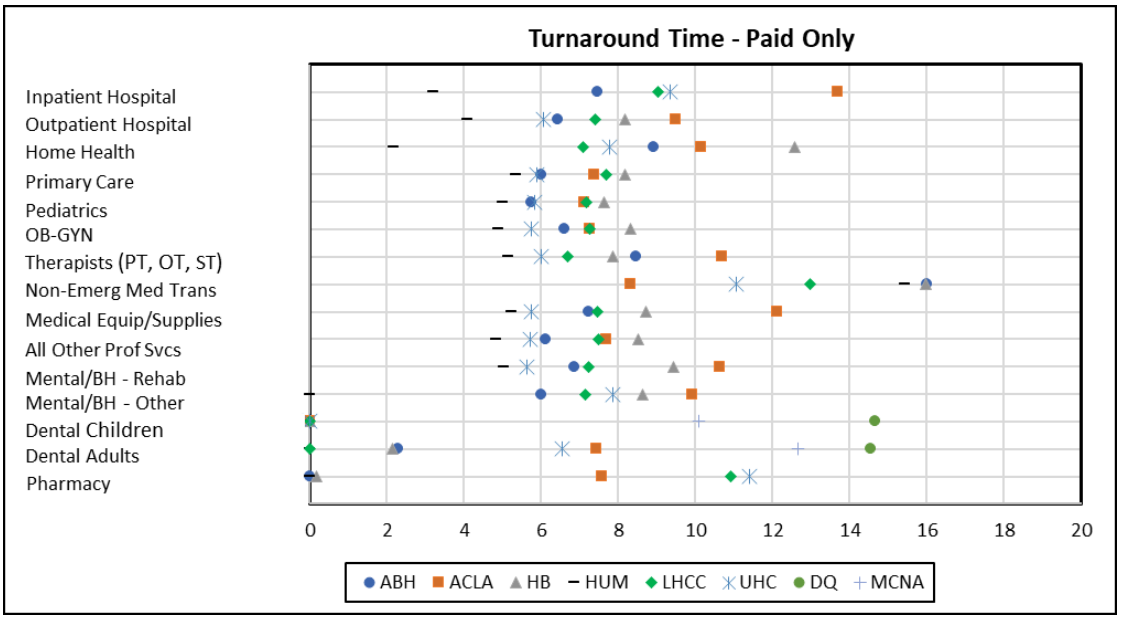
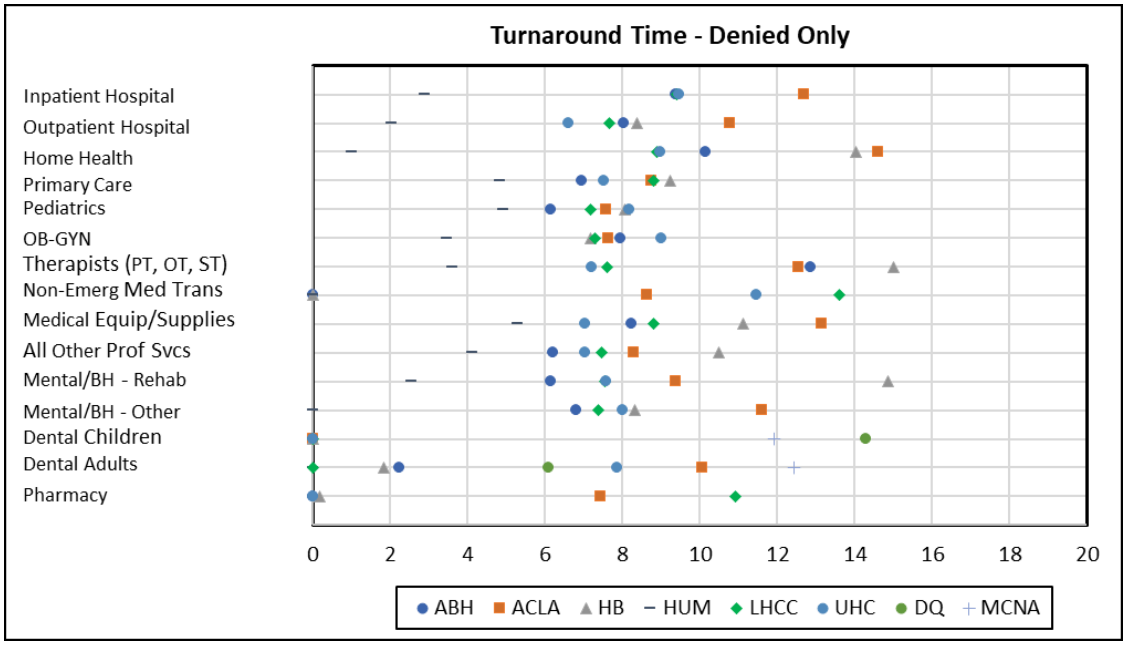


Exhibit III.11 below further breaks down the average paid and denied TAT statistics in Q1 2023, with the results shown for each MCE within a service category. The top box shows the variation in TAT for paid claims only; the bottom box shows the results for denied claims only. This exhibit determines 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 four situations where the average TAT exceeds 12 days (ABH, HB, LHCC, and UHC). In the bottom box, a similar variation was seen for denied claims, and the average TAT for denied claims is only slightly more than for paid claims.

Exhibit III.11
Average Turnaround Time, Paid and Denied Claims, by Service Category
By MCE for Q1 2023 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 was adjudicated the way it was. 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 2023.

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 2023, ACLA, LHCC, and UHC had their top five CARCs within the top 10 CARCs statewide. ABH had four, HB had two, while MCNA and DQ had none only of its top five CARCs in the statewide top 10.
- The top five CARCs in Q1 2023 included the following:
    - 16: The claim lacks information or has a billing error, which is needed for adjudication.
    - 96: Non-covered charge.
    - 18: Exact duplicate claim.
    - B7: This provider was not certified/eligible to be paid for this procedure/service on this date of service.
    - 252: An attachment/other documentation is required to adjudicate this claim/service.

- These five CARCs were also among the top six 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 2023, LHCC had their top five NCPDP codes within the top 10 NCPDP codes statewide, while ACLA and UHC had four, ABH had three, and HB only had two of their top five within the statewide top 10. Note that HUM had no pharmacy claims.
- The top five NCPDPs in Q4 2022 included the following:
    - 79: Refill too soon
    - 88: Drug Utilization Review (DUR) reject error
    - 76: Plan limitations exceeded
    - 7Ø: Product/Service Not Covered – Plan/Benefit Exclusion
    - 75: Prior Authorization Required
- These five NCPDPs were also among the top five in the previous quarters reported.

Exhibit III.12
Details on Reasons for Denied Claims
By MCE for Q4 2022 Adjudicated Claims

For Medical Claims

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

For Pharmacy Claims

NCPDP	Description	Rank Among All MCEs	Ranking for Individual MCE					
			ABH	ACLA	HB	HUM	LHCC	UHC
79	Refill Too Soon	1	1	1			1	
88	DUR Reject Error	2		2			4	1
76	Plan Limitations Exceeded	3					3	2
7Ø	Product/Service Not Covered – Plan/Benefit Exclusion	4	4	4			5	3
75	Prior Authorization Required	5	3				2	
71	Prescriber ID Is Not Covered	6			1			
39	Missing/Invalid Diagnosis Code	7		3				4
41	Submit Bill To Other Processor Or Primary Payer	8						
8Ø	Drug-Diagnosis Mismatch	9			2			
7X	Days Supply Exceeds Plan Limitation	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 Quarter 1 of 2023. 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 (#147) 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 (#16 and #197) were only present for selected provider types.

- For HB, two (#256 and #197) of its top five CARCs overall were observed for almost every provider category within the statewide top five CARCs. Three CARCs #109, #208, and #242) were present for selected provider types.

- For HUM, three of its five CARCs overall were observed for almost every provider category as well. Two CARCs (#96 and #246) were only present for selected provider types.

- For LHCC, four of its five CARCs overall were observed for almost every provider category as well. One CARC (#22) was only present for selected provider types.

- For UHC, two (#16 and #18) of its five CARCs overall were observed for almost every provider category as well. Three CARCs (#27, #96, and #252) were only present for selected provider types.

- For MCNA, all five of its top CARCs appear for Adult Dental providers while two of the top five CARCs appear for Pediatric Dental only.

- 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 seven quarters.

Exhibit III.13
Details on Reasons for Denied Medical Claims
By MCE and By Provider Category for Q1 2023 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
ABH														
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	1	1	1	1	1	1	1	1	1	1	1	1	1
96	Non-covered charge(s).		4	2	2	2	2			1	4	2	2	2
147	Provider contracted/negotiated rate expired or not on file.				5	3	3			1		3		5
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.		2		5	5	4	2	5	1	5	5		4
18	Exact duplicate claim/service	3	3	4	5	4	5	3	2	1	3	4	3	3
ACLA														
252	An attachment/other documentation is required to adjudicate this claim/service.	2	1	3	1	2	4	1	5	4	2	3		2
96	Non-covered charge(s).	1	3	1	1	1	3		4	4	4	2		1
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	3	4	4	1	4		3		1		1		
27	Expenses incurred after coverage terminated.		2		1	3	1	2	3	3	3	5	4	4
197	Precertification/authorization/notification absent.			2	1				1	4	1	4	2	5
HB														
256	Service not payable per managed care contract.		1	1	3	1	2	1	1	1		1	3	
197	Precertification/authorization/notification absent.	4	3	2		3	3	3	2	1	1	2		1
242	Services not provided by network/primary care providers.			4		2	1			1				2
208	National Provider Identifier - Not matched.	3	2			4		2	3	1	4	4		3
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.		4		4	5			5	1		5		

Exhibit III.13 (continued)
Details on Reasons for Denied Medical Claims
By MCE and By Provider Category for Q1 2023 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
HUM														
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	2	1	2	1	2	3	2	1	1		2		1
246	This non-payable code is for required reporting only.			2	5	1	2	1		1		1		1
96	Non-covered charge(s).	3	4	2	2	3	1			1	2			1
252	An attachment/other documentation is required to adjudicate this claim/service.	5	2	2	3	5		3		1	3	5	5	1
147	Provider contracted/negotiated rate expired or not on file.			2		4	4	5	2	1	1	3	4	1
LHCC														
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	4	5	1	1	5	3	1	3	2	1	1	4	3
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	5	3			2	1	4	1	2		2	2	1
96	Non-covered charge(s).		1		3	4	2	2	4	2	4	3		5
18	Exact duplicate claim/service	3	4	4		3	4	3	5	2	5	4		2
22	This care may be covered by another payer per coordination of benefits.		2	3	2					2		5		
UHC														
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjuc	1	2	3		1	5		3	4	3	1	1	1
252	An attachment/other documentation is required to adjudicate this claim/service.	2	1	1		2		4	5	4	2	2		
96	Non-covered charge(s).		3	5		5	2		2	4	1	3		
27	Expenses incurred after coverage terminated.		4			3	1	5		4	4	5	3	4
18	Exact duplicate claim/service	4	5	2		4	4	1	3	4		4	2	5

Exhibit III.13 (continued)
Details on Reasons for Denied Medical Claims
By MCE and By Provider Category for Q1 2023 Adjudicated Claims

CARC	Description	Adult Dental	Pediatric Dental
MCNA			
18	Exact duplicate claim/service	2	4
169	Alternate benefit has been provided.	1	
96	Non-covered charge(s).	3	1
119	Benefit maximum for this time period or occurrence has been reached.	4	
27	Expenses incurred after coverage terminated.	5	
DQ			
A1	Claim/Service denied.	1	1

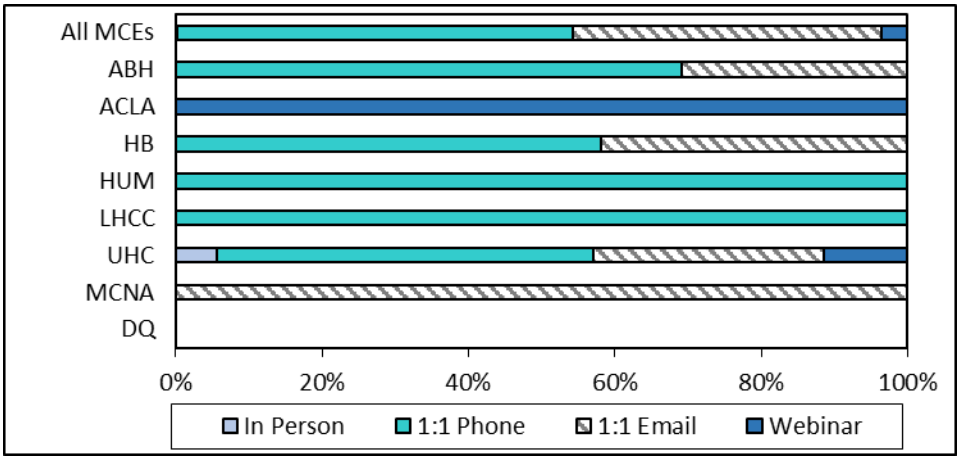
Provider Education Related to Claims Adjudication

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 on 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). Quarterly, the MCEs report 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 2023. In all, 860 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 six weeks). It should also be noted, however, that multiple MCEs may reach out to the same TIN. Over half of the outreach (54.1% of the total) was conducted via 1:1 phone calls. This was followed by 1:1 emails (42.0% of the total) and webinars (3.6% of the total). In-person outreach dropped significantly again since the last report quarter's temporal increase, accounting for 0.2% only.

Exhibit III.14
Provider Education Conducted by the MCEs on Claims Submissions Activity in Q1 2023



	Modality of Outreach				
	In Person	**1:1 Phone**	**1:1 Email**	**Webinar**	**Total TINs**
All MCEs	2	479	372	32	885
ABH	0	18	8	0	26
ACLA	0	0	0	28	28
HB	0	32	23	0	55
HUM	0	77	0	0	77
LHCC	0	334	0	0	334
UHC	2	18	11	4	35
MCNA	0	0	330	0	330
DQ	0	0	0	0	0

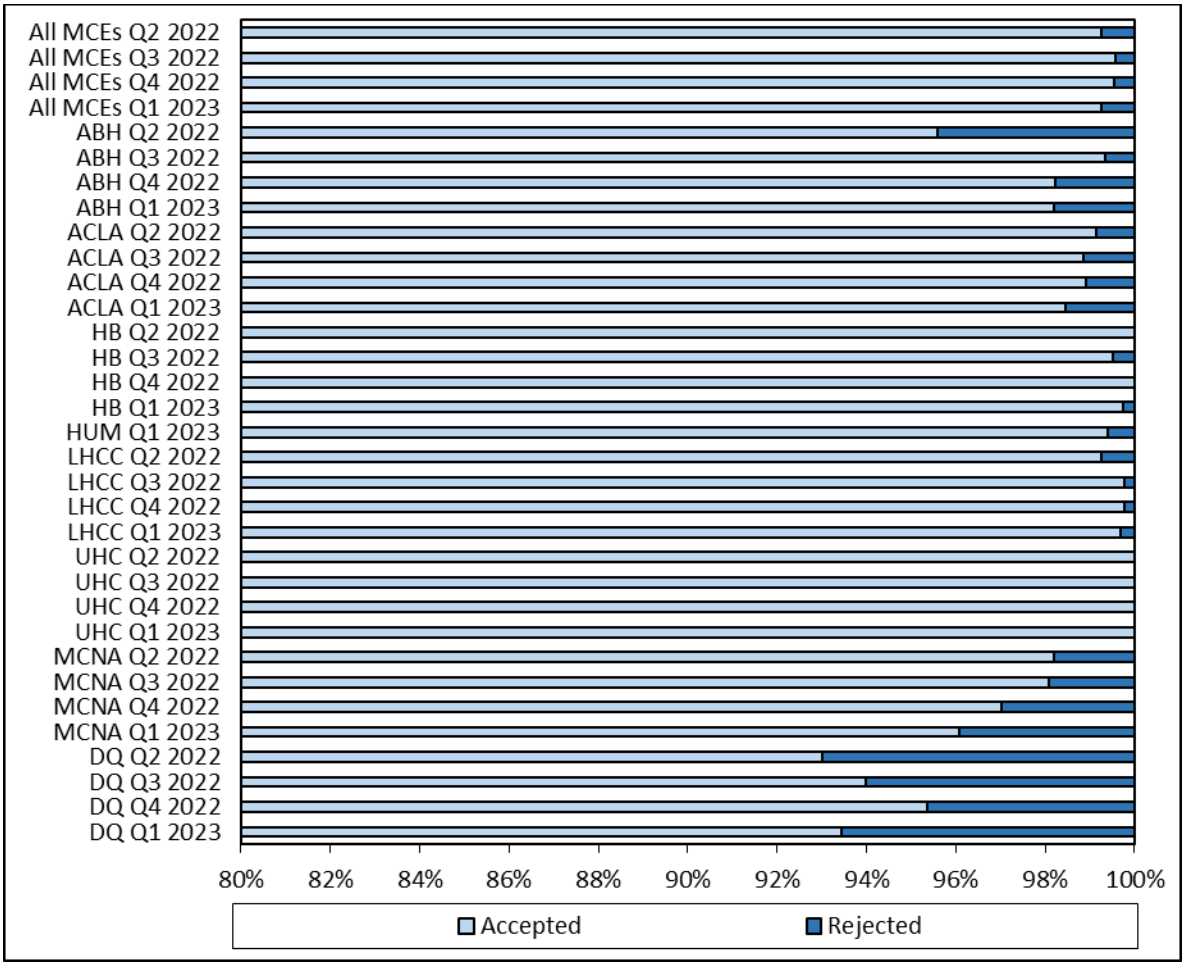
Section IV: Findings Related to MCE Encounter Submissions to LDH

The MCEs are required to send all claims that they have adjudicated—both paid and denied—to LDH for LDH to capture all information about MCE medical expenditures and to track utilization related to outcome measures. Act 710 requested specific information on 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 99.2% to 99.6% of the encounters submitted by all of the MCEs. There were differences at the MCE level. LDH accepted all of UHC's encounters. LDH also accepted 99.8% of HB's encounters over the past four quarters. For LHCC, LDH accepted 99.6% of their encounters. ACLA averaged 98.8% of accepted encounters over the past four quarters. ABH had some challenges with an overall acceptance rate of 97.8%. HUM as a newly joined member since Q1 2023 had an acceptance rate of 99.4%. DQ, as a newly joined member since Q1 2021, has averaged 94.0%. MCNA had a four-quarter average of 97.3%.

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 types:

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

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

- ABH showed improvement with institutional and pharmacy encounters accepted for Quarter 1 of 2023.
- ACLA had a few issues with institutional and professional encounters accepted in Quarter 1 of 2023.
- HB had only minor issues with pharmacy encounters accepted in Quarter 1 of 2023. HB also had a 100% acceptance rate over the past three quarters for institutional and professional encounters.
- LHCC kept its pharmacy encounter acceptance rate (99.2%), which is the same as last quarter, and continues to have a 100% acceptance rate for institutional and professional encounters.
- UHC had a 100% encounter acceptance rate for each encounter type for the past four quarters.
- DQ's encounter acceptance rate dropped significantly, from 93.5% in the last quarter to 84.0% in Quarter 1 of 2023, owing to some providers not complying with the state's new rule and an increase in the number of providers.
- MCNA had an encounter acceptance rate of 96.1% for Quarter 1 of 2023, which decreased slightly in comparison to the rate of the last report quarter.

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

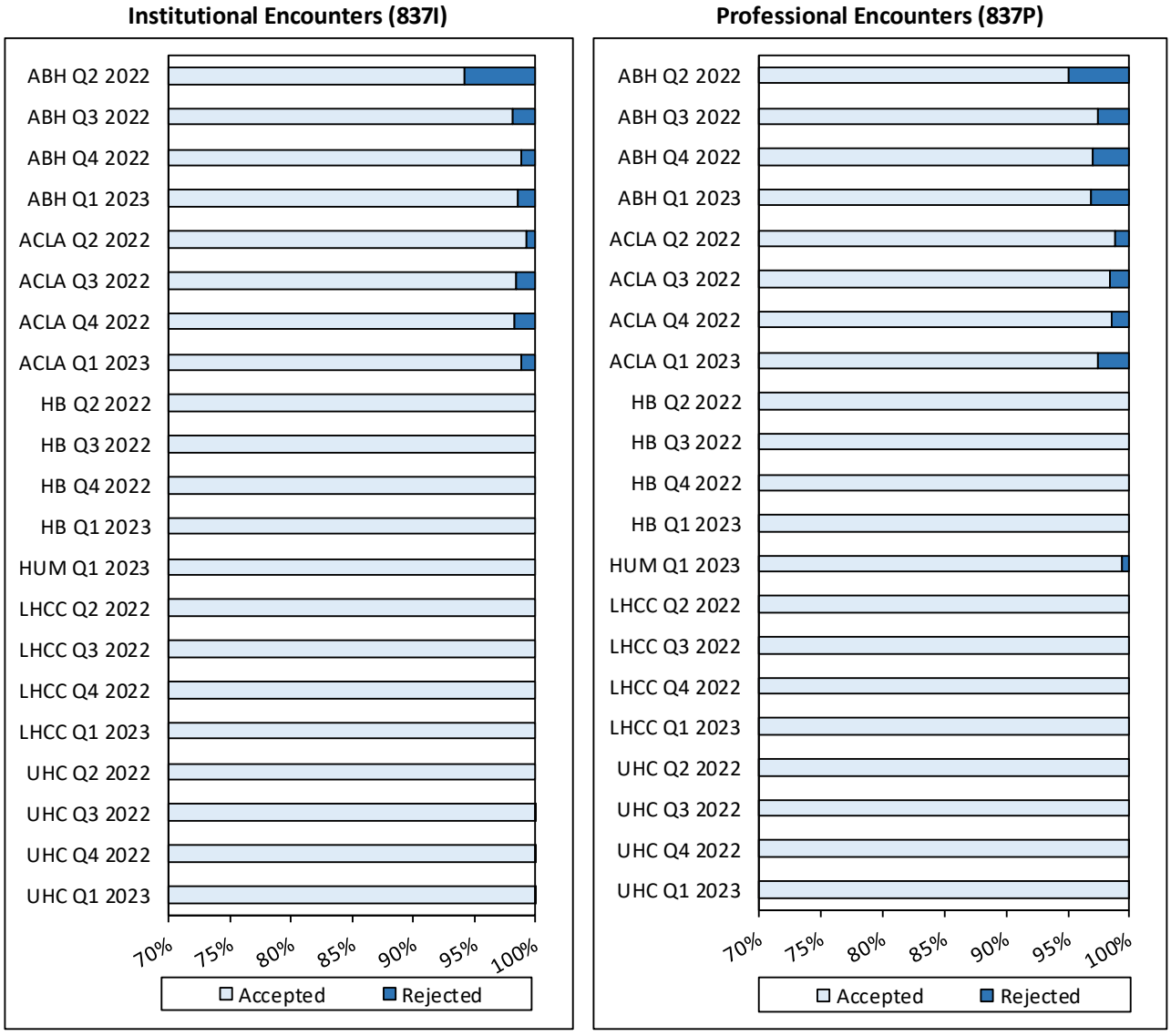
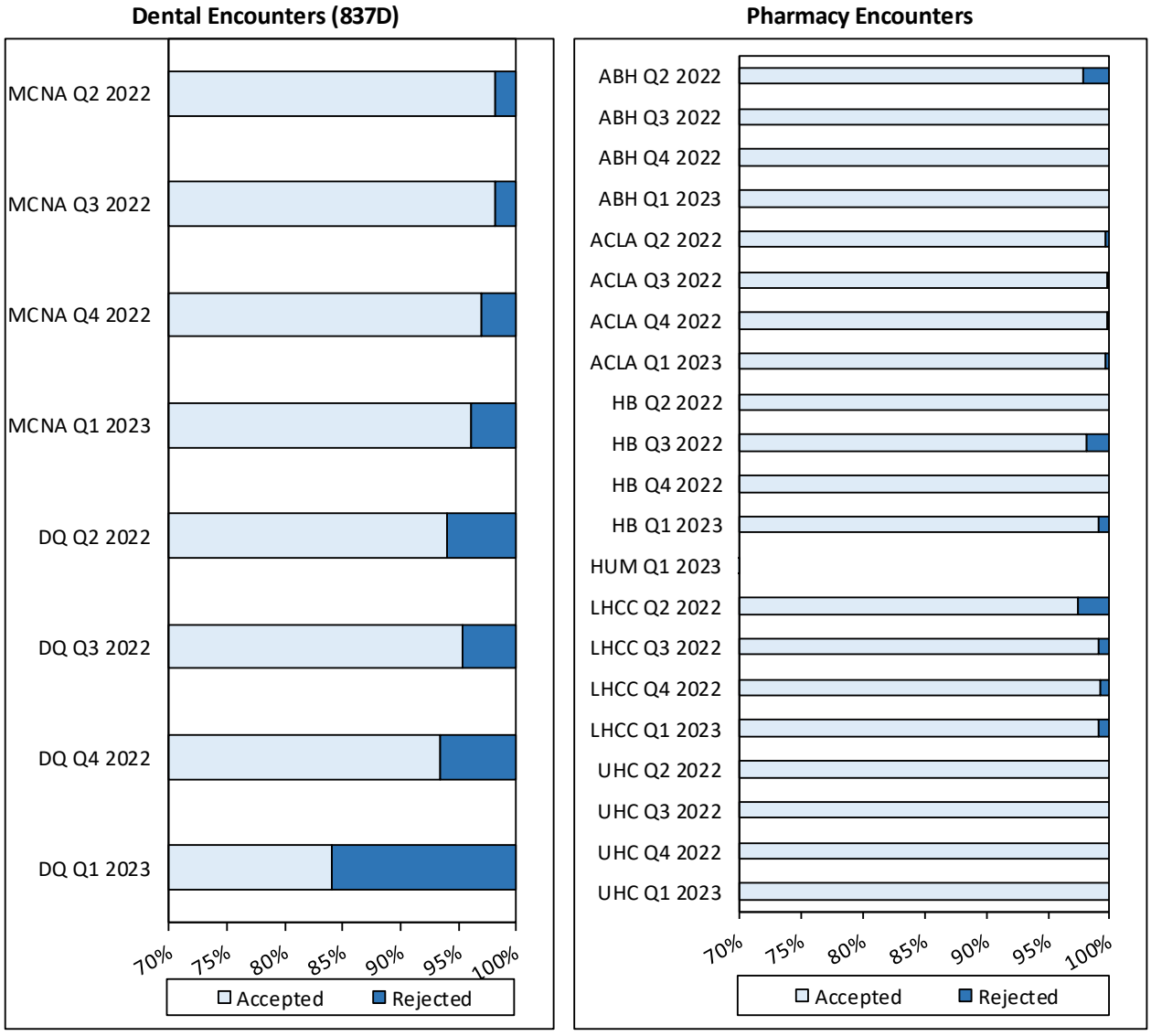


Exhibit IV.3
Encounter Submissions Accepted and Rejected by LDH
Dental and Pharmacy Claim Types
By MCE and Quarter



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 how 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 on timeliness of encounter Submissions (Exhibit IV.4):

- For institutional encounters (mostly claims from hospitals), ABH had issues with timely submissions in all four quarters (82.5%). ACLA still had some issues in Q1 of 2023 but showed improvement. HB had issues for the past four quarters and its acceptance rate dropped significantly from 93.8% in the last report quarter to 77.0% in Q1 2023. LHCC had a few issues in Q1 of 2023. UHC was the most consistent with a 98.7% four-quarter average but also showed a decrease in Q1 of 2023.

- LHCC and UHC consistently have the highest rate of submission of professional encounters within 30 days followed by ACLA. HB and ABH had challenges with institutional professional encounter submission timeliness. HUM, as the new member started in Q1 2023, had the lowest acceptance rate of professional encounters within 30 days of submission.

- There is greater variation in the timeliness of pharmacy encounter submissions. HB had the highest rate of encounter submissions accepted at 99.8% over the past four quarters. ACLA had the second-highest rate of encounter submissions accepted at 99.7% followed by UHC (98.9%) over the past four quarters. ABH and LHCC consistently are lowest on pharmacy encounter timeliness—ABH usually near 31.0% untimely and LHCC usually near 29.1% untimely in the last four quarters. HUM did not submit any pharmacy encounters in Q1 of 2023.

- MCNA had an average 30-day TAT for its dental encounters of 95.5%, which showed a significant bounce back in Q1 of 2023 from the last report quarter, while DQ continues to have a 100% submission rate over 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 2022	84.6%	15.4%	67.3%	32.7%			68.9%	31.1%
ABH Q3 2022	76.1%	23.9%	90.3%	9.7%			69.4%	30.6%
ABH Q4 2022	86.2%	13.8%	93.4%	6.6%			69.5%	30.5%
ABH Q1 2023	83.2%	16.8%	92.3%	7.7%			68.2%	31.8%
ACLA Q2 2022	97.6%	2.4%	97.7%	2.3%			99.6%	0.4%
ACLA Q3 2022	88.8%	11.2%	96.1%	3.9%			99.7%	0.3%
ACLA Q4 2022	93.8%	6.2%	97.0%	3.0%			99.6%	0.4%
ACLA Q1 2023	97.6%	2.4%	95.7%	4.3%			99.7%	0.3%
HB Q2 2022	62.1%	37.9%	83.4%	16.6%			99.6%	0.4%
HB Q3 2022	91.3%	8.7%	89.5%	10.5%			99.7%	0.3%
HB Q4 2022	93.8%	6.2%	83.7%	16.3%			99.9%	0.1%
HB Q1 2023	77.0%	23.0%	84.0%	16.0%			99.8%	0.2%
HUM Q1 2023	100.0%	0.0%	37.9%	62.1%			0.0%	0.0%
LHCC Q2 2022	99.3%	0.7%	99.4%	0.6%			69.9%	30.1%
LHCC Q3 2022	99.5%	0.5%	97.9%	2.1%			70.8%	29.2%
LHCC Q4 2022	99.9%	0.1%	98.8%	1.2%			72.5%	27.5%
LHCC Q1 2023	99.2%	0.8%	98.9%	1.1%			70.4%	29.6%
UHC Q2 2022	99.9%	0.1%	95.4%	4.6%			99.8%	0.2%
UHC Q3 2022	99.6%	0.4%	99.4%	0.6%			99.7%	0.3%
UHC Q4 2022	99.3%	0.7%	99.4%	0.6%			99.7%	0.3%
UHC Q1 2023	95.9%	4.1%	99.1%	0.9%			99.7%	0.3%
MCNA Q2 2022					99.6%	0.4%		
MCNA Q3 2022					99.5%	0.5%		
MCNA Q4 2022					83.0%	17.0%		
MCNA Q1 2023					100.0%	0.0%		
DQ Q2 2022					100.0%	0.0%		
DQ Q3 2022					100.0%	0.0%		
DQ Q4 2022					100.0%	0.0%		
DQ Q1 2023					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 on 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 who 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 quarterly. 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 its policies and procedures for identification and assessment. As such, the reporting for case management has shown some variation across MCEs.

Across all six MCEs, 46,807 individuals were eligible or in need of case management services in CY 2022-Q1. Of these, 19.2 % (9,002) were enrolled in case management for at least one month during the quarter. 65.3% (5,880) of those enrolled in CM were engaged in one or more CM services or contact with a case manager during the quarter.

Exhibit V.1
CY 2023 - Quarter 1: Case Management

	ABH	ACLA	HB	HUM	LHCC	UHC	Total[1]
Eligible for Case Management (CM)	2,521	6,086	2,267	3,224	25,646	7,063	**46,807**
Enrolled in CM for at least 1 month	651	1,558	248	398	3,420	2,727	**9,002**
% of eligible enrolled in CM	25.8%	25.6%	10.9%	12.3%	13.3%	38.6%	**19.2%**
Received CM Service	601	1,246	224	366	1906	1,537	**5,880**
% enrolled receiving service	92.3%	80.0%	90.3%	92.0%	55.7%	56.4%	**65.3%**

Source: MCE 039 Case Management Quarterly Report.

[1] Totals are the sum of MCE data reported and may include duplication of individuals who transferred to a new MCE during the quarter.

Appendix A:

Detailed Information for Exhibits Shown in Sections III and IV

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 2022	27,553,720	286,765	99.0%	1.0%
All MCEs Q3 2022	29,179,656	287,344	99.0%	1.0%
All MCEs Q4 2022	29,791,603	281,611	99.1%	0.9%
All MCEs Q1 2023	28,978,723	324,163	98.9%	1.1%
ABH Q2 2022	2,514,473	0	100.0%	0.0%
ABH Q3 2022	2,691,428	0	100.0%	0.0%
ABH Q4 2022	2,772,231	0	100.0%	0.0%
ABH Q1 2023	2,819,397	1	100.0%	0.0%
ACLA Q2 2022	3,057,587	13,219	99.6%	0.4%
ACLA Q3 2022	3,156,210	8,457	99.7%	0.3%
ACLA Q4 2022	3,256,622	5,581	99.8%	0.2%
ACLA Q1 2023	3,240,508	6,148	99.8%	0.2%
HB Q2 2022	5,762,405	535	100.0%	0.0%
HB Q3 2022	6,063,762	774	100.0%	0.0%
HB Q4 2022	6,063,456	1,105	100.0%	0.0%
HB Q1 2023	5,392,426	1,554	100.0%	0.0%
HUM Q1 2023	493,560	0	100.0%	0.0%
LHCC Q2 2022	7,458,216	199,310	97.4%	2.6%
LHCC Q3 2022	7,898,773	185,705	97.7%	2.3%
LHCC Q4 2022	8,077,984	185,763	97.8%	2.2%
LHCC Q1 2023	8,059,456	299,239	96.4%	3.6%
UHC Q2 2022	7,934,023	73,701	99.1%	0.9%
UHC Q3 2022	8,459,833	92,408	98.9%	1.1%
UHC Q4 2022	8,769,646	89,162	99.0%	1.0%
UHC Q1 2023	8,249,270	17,221	99.8%	0.2%
MCNA Q2 2022	435,216	0	100.0%	0.0%
MCNA Q3 2022	474,673	0	100.0%	0.0%
MCNA Q4 2022	431,083	0	100.0%	0.0%
MCNA Q1 2023	439,363	0	100.0%	0.0%
DQ Q2 2022	391,800	0	100.0%	0.0%
DQ Q3 2022	434,977	0	100.0%	0.0%
DQ Q4 2022	420,581	0	100.0%	0.0%
DQ Q1 2023	420,400	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 2022	22,076,021	5,172,755	81.0%	19.0%
All MCEs Q3 2022	22,930,002	5,417,721	80.9%	19.1%
All MCEs Q4 2022	24,247,444	5,518,042	81.5%	18.5%
All MCEs Q1 2023	22,565,687	6,337,583	78.1%	21.9%
ABH Q2 2022	1,883,638	555,364	77.2%	22.8%
ABH Q3 2022	1,918,606	580,711	76.8%	23.2%
ABH Q4 2022	2,074,823	601,367	77.5%	22.5%
ABH Q1 2023	2,095,282	704,044	74.8%	25.2%
ACLA Q2 2022	2,541,442	527,086	82.8%	17.2%
ACLA Q3 2022	2,657,032	529,206	83.4%	16.6%
ACLA Q4 2022	2,557,391	502,995	83.6%	16.4%
ACLA Q1 2023	2,725,333	605,070	81.8%	18.2%
HB Q2 2022	4,399,882	1,064,201	80.5%	19.5%
HB Q3 2022	4,464,805	1,104,284	80.2%	19.8%
HB Q4 2022	4,928,755	1,183,177	80.6%	19.4%
HB Q1 2023	4,478,174	937,310	82.7%	17.3%
HUM Q1 2023	352,600	140,954	71.4%	28.6%
LHCC Q2 2022	6,102,696	1,380,757	81.5%	18.5%
LHCC Q3 2022	6,428,700	1,447,466	81.6%	18.4%
LHCC Q4 2022	6,711,733	1,463,094	82.1%	17.9%
LHCC Q1 2023	6,323,230	1,663,641	79.2%	20.8%
UHC Q2 2022	6,443,773	1,564,918	80.5%	19.5%
UHC Q3 2022	6,677,699	1,678,490	79.9%	20.1%
UHC Q4 2022	7,241,290	1,687,115	81.1%	18.9%
UHC Q1 2023	6,217,495	1,976,638	75.9%	24.1%
MCNA Q2 2022	340,977	49,246	87.4%	12.6%
MCNA Q3 2022	373,476	49,930	88.2%	11.8%
MCNA Q4 2022	347,941	45,394	88.5%	11.5%
MCNA Q1 2023	347,212	51,481	87.1%	12.9%
DQ Q2 2022	363,613	31,183	92.1%	7.9%
DQ Q3 2022	409,684	27,634	93.7%	6.3%
DQ Q4 2022	385,511	34,900	91.7%	8.3%
DQ Q1 2023	377,579	42,878	89.8%	10.2%

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 2022	51,872	9,974	83.9%	16.1%
Inpatient Hospital Q3 2022	55,868	11,215	83.3%	16.7%
Inpatient Hospital Q4 2022	52,573	10,460	83.4%	16.6%
Inpatient Hospital Q1 2023	56,943	11,839	82.8%	17.2%
Outpatient Hospital Q2 2022	4,804,713	457,099	91.3%	8.7%
Outpatient Hospital Q3 2022	4,861,579	534,262	90.1%	9.9%
Outpatient Hospital Q4 2022	5,065,073	560,422	90.0%	10.0%
Outpatient Hospital Q1 2023	4,693,892	668,741	87.5%	12.5%
Home Health Q2 2022	43,632	8,634	83.5%	16.5%
Home Health Q3 2022	46,971	9,043	83.9%	16.1%
Home Health Q4 2022	48,109	7,183	87.0%	13.0%
Home Health Q1 2023	52,721	18,174	74.4%	25.6%
Primary Care Q2 2022	2,076,214	344,426	85.8%	14.2%
Primary Care Q3 2022	2,217,143	404,847	84.6%	15.4%
Primary Care Q4 2022	2,523,953	391,548	86.6%	13.4%
Primary Care Q1 2023	1,746,267	379,661	82.1%	17.9%
Pediatrics Q2 2022	757,297	83,080	90.1%	9.9%
Pediatrics Q3 2022	826,295	96,269	89.6%	10.4%
Pediatrics Q4 2022	937,190	102,656	90.1%	9.9%
Pediatrics Q1 2023	862,441	140,953	86.0%	14.0%
OB-GYN Q2 2022	248,182	27,931	89.9%	10.1%
OB-GYN Q3 2022	257,870	33,346	88.5%	11.5%
OB-GYN Q4 2022	243,840	33,487	87.9%	12.1%
OB-GYN Q1 2023	262,133	50,469	83.9%	16.1%
Therapists (PT/OT/ST) Q2 2022	124,968	14,656	89.5%	10.5%
Therapists (PT/OT/ST) Q3 2022	130,813	16,526	88.8%	11.2%
Therapists (PT/OT/ST) Q4 2022	127,558	18,521	87.3%	12.7%
Therapists (PT/OT/ST) Q1 2023	139,919	29,351	82.7%	17.3%
All Other Professional Q2 2022	5,637,008	1,092,220	83.8%	16.2%
All Other Professional Q3 2022	5,654,955	1,115,562	83.5%	16.5%
All Other Professional Q4 2022	6,091,161	1,167,667	83.9%	16.1%
All Other Professional Q1 2023	6,286,058	1,627,128	79.4%	20.6%

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 2022	265,082	4,728	98.2%	1.8%
Non-Emerg Transport Q3 2022	448,415	7,297	98.4%	1.6%
Non-Emerg Transport Q4 2022	474,376	7,614	98.4%	1.6%
Non-Emerg Transport Q1 2023	443,890	6,751	98.5%	1.5%
Medical Equipment/Supplies Q2 2022	166,599	44,499	78.9%	21.1%
Medical Equipment/Supplies Q3 2022	170,042	47,944	78.0%	22.0%
Medical Equipment/Supplies Q4 2022	176,411	42,778	80.5%	19.5%
Medical Equipment/Supplies Q1 2023	172,596	47,441	78.4%	21.6%
Mental/Behavioral Rehab Q2 2022	231,623	33,354	87.4%	12.6%
Mental/Behavioral Rehab Q3 2022	223,853	28,735	88.6%	11.4%
Mental/Behavioral Rehab Q4 2022	215,595	29,496	88.0%	12.0%
Mental/Behavioral Rehab Q1 2023	187,921	49,830	79.0%	21.0%
Mental/Behavioral Other Q2 2022	994,363	187,157	84.2%	15.8%
Mental/Behavioral Other Q3 2022	1,056,796	199,023	84.2%	15.8%
Mental/Behavioral Other Q4 2022	1,074,009	170,505	86.3%	13.7%
Mental/Behavioral Other Q1 2023	1,024,794	210,425	83.0%	17.0%
Dental - Children Q2 2022	692,966	61,167	91.9%	8.1%
Dental - Children Q3 2022	758,825	68,957	91.7%	8.3%
Dental - Children Q4 2022	709,274	66,720	91.4%	8.6%
Dental - Children Q1 2023	705,461	70,022	91.0%	9.0%
Dental - Adults Q2 2022	111,004	40,316	73.4%	26.6%
Dental - Adults Q3 2022	119,797	28,266	80.9%	19.1%
Dental - Adults Q4 2022	104,532	30,666	77.3%	22.7%
Dental - Adults Q1 2023	81,758	41,724	66.2%	33.8%
Pharmacy Q2 2022	5,749,562	2,747,930	67.7%	32.3%
Pharmacy Q3 2022	5,961,974	2,799,434	68.0%	32.0%
Pharmacy Q4 2022	6,270,295	2,857,530	68.7%	31.3%
Pharmacy Q1 2023	6,057,458	2,742,872	68.8%	31.2%

Appendix A III.5
Claim Status for Adjudicated Claims
By Provider Specialty / Service Category
By MCE for Q1 2023 Adjudicated Claims

Inpatient Hospital	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	4,952	989	83.4%	16.6%
ACLA	8,112	1,471	84.6%	15.4%
HB	12,857	2,767	82.3%	17.7%
HUM	1,633	453	78.3%	21.7%
LHCC	15,845	4,163	79.2%	20.8%
UHC	13,544	1,996	87.2%	12.8%

Outpatient Hospital	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	447,294	78,640	85.0%	15.0%
ACLA	631,952	80,493	88.7%	11.3%
HB	959,294	74,520	92.8%	7.2%
HUM	122,510	27,365	81.7%	18.3%
LHCC	1,322,791	207,017	86.5%	13.5%
UHC	1,210,051	200,706	85.8%	14.2%

Home Health	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	1,936	643	75.1%	24.9%
ACLA	3,202	1,078	74.8%	25.2%
HB	1,291	274	82.5%	17.5%
HUM	139	1	99.3%	0.7%
LHCC	39,601	14,094	73.8%	26.2%
UHC	6,552	2,084	75.9%	24.1%

Primary Care	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	140,231	41,870	77.0%	23.0%
ACLA	139,670	15,084	90.3%	9.7%
HB	618,828	118,071	84.0%	16.0%
HUM	30,797	33,055	48.2%	51.8%
LHCC	280,571	116,644	70.6%	29.4%
UHC	536,170	54,937	90.7%	9.3%

Pediatricians	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	4,250	1,711	71.3%	28.7%
ACLA	136,470	13,153	91.2%	8.8%
HB	211,952	27,136	88.7%	11.3%
HUM	39,127	21,436	64.6%	35.4%
LHCC	437,200	72,258	85.8%	14.2%
UHC	33,442	5,259	86.4%	13.6%

OB-GYN	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	943	177	84.2%	15.8%
ACLA	44,582	4,958	90.0%	10.0%
HB	84,601	9,018	90.4%	9.6%
HUM	10,529	4,065	72.1%	27.9%
LHCC	108,309	27,113	80.0%	20.0%
UHC	13,169	5,138	71.9%	28.1%

Therapists (PT, OT, ST)	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	681	115	85.6%	14.4%
ACLA	20,843	7,633	73.2%	26.8%
HB	48,605	5,149	90.4%	9.6%
HUM	3,209	950	77.2%	22.8%
LHCC	64,035	14,308	81.7%	18.3%
UHC	2,546	1,196	68.0%	32.0%

Non-Emergency Medical Transp.	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	51,629	0	100.0%	0.0%
ACLA	48,138	3,593	93.1%	6.9%
HB	77,414	0	100.0%	0.0%
HUM	3,635	0	100.0%	0.0%
LHCC	141,637	64	100.0%	0.0%
UHC	121,437	3,094	97.5%	2.5%

Medical Equipment And Supplies	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	27,763	11,101	71.4%	28.6%
ACLA	29,741	5,735	83.8%	16.2%
HB	3,399	1,276	72.7%	27.3%
HUM	1,436	358	80.0%	20.0%
LHCC	50,414	13,731	78.6%	21.4%
UHC	59,843	15,240	79.7%	20.3%

All Other Professional	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	528,457	276,123	65.7%	34.3%
ACLA	863,688	176,179	83.1%	16.9%
HB	1,009,685	166,925	85.8%	14.2%
HUM	132,153	49,535	72.7%	27.3%
LHCC	1,820,401	529,319	77.5%	22.5%
UHC	1,931,674	429,047	81.8%	18.2%

Mental/Behaviroal Health - Rehab	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	22,932	12,487	64.7%	35.3%
ACLA	47,113	11,961	79.8%	20.2%
HB	3,386	2,777	54.9%	45.1%
HUM	567	179	76.0%	24.0%
LHCC	6,160	1,830	77.1%	22.9%
UHC	107,763	20,596	84.0%	16.0%

Mental/Behavioral Health - Other	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	234,295	58,106	80.1%	19.9%
ACLA	69,427	11,334	86.0%	14.0%
HB	202,966	50,824	80.0%	20.0%
HUM	0	0	0.0%	0.0%
LHCC	414,343	65,322	86.4%	13.6%
UHC	103,763	24,839	80.7%	19.3%

Pharmacy	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	619,933	218,472	73.9%	26.1%
ACLA	680,929	271,588	71.5%	28.5%
HB	1,164,701	458,740	71.7%	28.3%
HUM	0	0	0.0%	0.0%
LHCC	1,620,109	595,774	73.1%	26.9%
UHC	1,971,786	1,198,298	62.2%	37.8%

Dental - Adults	Number Paid	Number Denied	Percent Paid	Percent Denied
DQ	14,752	20,648	41.7%	58.3%
MCNA	4,578	3,689	55.4%	44.6%
Dental - Children				
DQ	362,827	22,230	94.2%	5.8%
MCNA	342,634	47,792	87.8%	12.2%

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 2022	$2,005.2	$561.9
All MCEs Q3 2022	$2,098.8	$596.1
All MCEs Q4 2022	$2,147.0	$589.8
All MCEs Q1 2023	$2,175.1	$660.6

Quarter 2 2022

ABH	$178.9	$48.9
ACLA	$234.3	$53.0
HB	$392.3	$131.4
LHCC	$546.8	$138.3
UHC	$619.8	$184.6
MCNA	$16.2	$3.2
DQ	$16.9	$2.5

Quarter 3 2022

ABH	$180.3	$52.7
ACLA	$248.1	$57.0
HB	$408.0	$137.3
LHCC	$585.4	$145.4
UHC	$641.0	$199.2
MCNA	$17.5	$3.3
DQ	$18.4	$1.3

Quarter 4 2022

ABH	$184.5	$50.8
ACLA	$235.3	$53.3
HB	$425.7	$140.4
LHCC	$578.4	$141.0
UHC	$689.2	$199.6
MCNA	$16.7	$2.9
DQ	$17.2	$1.6

Quarter 1 2023

ABH	$197.4	$61.5
ACLA	$261.6	$64.1
HB	$426.0	$110.0
HUM	$28.3	$10.0
LHCC	$593.0	$165.6
UHC	$635.0	$244.0
MCNA	$16.5	$3.1
DQ	$17.3	$2.3

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				HUM	LHCC				UHC				MCNA				DQ			
		Q2 22	Q3 22	Q4 22	Q1 23	Q2 22	Q3 22	Q4 22	Q1 23	Q2 22	Q3 22	Q4 22	Q1 23	Q1 23	Q2 22	Q3 22	Q4 22	Q1 23	Q2 22	Q3 22	Q4 22	Q1 23	Q2 22	Q3 22	Q4 22	Q1 23	Q2 22	Q3 22	Q4 22	Q1 23
Inpatient Hospital	Low	Y	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	N	N	N	N	Y	Y	Y	Y	--	Y	Y	Y	Y	N	Y	Y	Y								
	High	--	--	--	--	--	--	--	--	--	--	--	--	--	Y	Y	Y	Y	--	--	--	--								
Outpatient Hospital	Low	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	Y	N	Y	Y	Y	Y	Y	Y	Y	Y								
	Medium	Y	Y	Y	Y	N	N	N	Y	N	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	Y	N	N	N	N								
Home Health	Low	N	N	N	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	Y	Y	Y	Y								
	Medium	--	--	--	--	Y	N	Y	N	N	N	N	--	--	N	N	N	N	Y	Y	Y	Y								
	High	--	--	--	--	--	--	--	--	--	--	--	--	--	N	Y	N	N	--	--	--	--								
Other Institutional Providers	Low	--	--	--	--	--	--	--	--	N	N	N	N	Y	Y	Y	Y	Y	N	N	Y	Y								
	Medium	--	--	--	--	--	--	--	--	N	N	N	N	--	Y	Y	Y	Y	N	N	Y	Y								
	High	--	--	--	--	--	--	--	--	N	N	N	N	--	--	--	--	--	--	--	Y	Y								
Primary Care	Low	Y	Y	Y	Y	N	N	N	Y	N	N	N	Y	Y	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	Y	N	N	N	Y								
	High	Y	Y	Y	Y	N	N	N	N	N	N	N	N	Y	Y	Y	Y	Y	N	N	N	N								
Pediatrics	Low	Y	Y	Y	Y	N	N	N	N	N	N	N	N	Y	N	Y	Y	Y	Y	Y	Y	Y								
	Medium	Y	Y	Y	Y	N	N	N	N	N	N	N	N	Y	Y	Y	Y	Y	N	N	Y	Y								
	High	--	--	--	Y	N	N	N	N	N	N	N	N	Y	Y	Y	Y	Y	N	N	N	Y								
OB-GYN	Low	Y	Y	Y	Y	N	N	N	N	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y	N	Y								
	Medium	--	--	--	--	N	N	N	Y	N	N	N	N	Y	Y	Y	Y	Y	N	N	N	Y								
	High	--	--	--	--	N	N	N	N	N	N	N	N	--	Y	Y	Y	Y	N	N	N	Y								
Therapists	Low	N	Y	N	Y	N	N	Y	Y	N	N	N	N	N	Y	Y	Y	Y	Y	N	Y	Y								
	Medium	--	--	--	--	Y	Y	Y	Y	N	N	N	N	--	N	Y	Y	Y	Y	Y	N	Y								
	High	--	--	--	--	N	N	Y	Y	N	N	N	N	--	N	N	Y	Y	--	--	--	--								
Non-Emergency Transportation	Low	N	--	--	N	N	Y	N	N	--	--	--	--	--	--	N	N	N	N	N	N	N								
	Medium	--	--	--	N	N	N	N	N	--	--	--	--	--	--	--	--	--	N	N	N	N								
	High	--	--	--	N	N	N	N	N	--	--	--	--	--	N	--	--	--	N	N	N	N								
Medical Equipment / Supplies	Low	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	N	N	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	N	Y								
	High	Y	Y	Y	Y	Y	Y	N	Y	--	--	--	--	--	Y	Y	Y	Y	Y	Y	Y	Y								
All Other Professional Provid.	Low	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y								
	Medium	Y	Y	Y	Y	N	N	N	N	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y	N	Y								
	High	Y	Y	Y	Y	N	N	N	N	N	N	N	N	Y	N	N	Y	Y	N	N	N	Y								
Behavioral Health Rehab	Low	N	N	N	Y	N	N	N	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	N	Y								
	Medium	Y	Y	Y	Y	N	N	N	Y	N	N	N	Y	--	N	N	N	N	N	N	N	Y								
	High	--	--	Y	--	N	N	N	Y	--	--	--	--	--	--	--	--	--	N	N	N	Y								
Behavioral Health All Other	Low	Y	Y	Y	Y	N	N	N	N	Y	Y	Y	Y	--	Y	Y	N	Y	N	N	N	Y								
	Medium	Y	Y	Y	Y	N	N	N	N	Y	Y	N	Y	--	N	N	Y	Y	N	N	N	Y								
	High	Y	N	N	Y	N	N	N	N	Y	Y	N	N	--	N	N	N	Y	N	N	N	Y								
Dental - Children	Low																						Y	Y	Y	Y	--	N	N	--
	Medium																						Y	Y	Y	Y	--	N	N	--
	High																						Y	Y	Y	Y	--	N	N	--
Dental - Adults	Low																						Y	Y	Y	Y	N	N	N	N
	Medium																						--	Y	--	Y	N	N	N	N
	High																						--	--	--	--	N	N	N	N
Pharmacy	Low	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	--	Y	Y	Y	Y	Y	Y	Y	Y								
	Medium	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	--	Y	Y	Y	Y	Y	Y	Y	Y								
	High	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	--	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 2022	7.4	5.1
All MCEs Q3 2022	7.4	5.2
All MCEs Q4 2022	7.7	5.5
All MCEs Q1 2023	7.5	5.4
ABH Q2 2022	7.5	5.5
ABH Q3 2022	4.7	5.2
ABH Q4 2022	5.0	5.1
ABH Q1 2023	4.6	4.6
ACLA Q2 2022	5.1	6.0
ACLA Q3 2022	4.6	5.7
ACLA Q4 2022	6.8	7.5
ACLA Q1 2023	8.2	8.4
HB Q2 2022	7.4	2.8
HB Q3 2022	8.0	3.4
HB Q4 2022	8.6	4.1
HB Q1 2023	6.3	5.0
HUM Q1 2023	4.7	3.9
LHCC Q2 2022	8.2	9.0
LHCC Q3 2022	8.9	9.1
LHCC Q4 2022	8.4	9.1
LHCC Q1 2023	8.4	8.8
UHC Q2 2022	7.6	2.5
UHC Q3 2022	7.8	2.8
UHC Q4 2022	7.9	3.0
UHC Q1 2023	7.8	2.8
MCNA Q2 2022	9.7	11.8
MCNA Q3 2022	8.3	10.0
MCNA Q4 2022	8.5	10.1
MCNA Q1 2023	10.1	12.0
DQ Q2 2022	4.2	4.3
DQ Q3 2022	1.0	1.0
DQ Q4 2022	0.9	0.8
DQ Q1 2023	14.7	10.4

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 Hospital Q2 2022	9.2	10.6
Inpatient Hospital Q3 2022	10.3	12.2
Inpatient Hospital Q4 2022	11.6	12.7
Inpatient Hospital Q1 2023	12.5	13.3
Outpatient Hospital Q2 2022	6.3	7.5
Outpatient Hospital Q3 2022	6.4	7.6
Outpatient Hospital Q4 2022	7.0	8.3
Outpatient Hospital Q1 2023	7.3	7.6
Home Health Q2 2022	8.4	7.5
Home Health Q3 2022	8.4	8.0
Home Health Q4 2022	8.7	9.1
Home Health Q1 2023	7.5	9.4
Primary Care Q2 2022	6.4	7.3
Primary Care Q3 2022	6.5	7.5
Primary Care Q4 2022	7.2	8.4
Primary Care Q1 2023	7.1	8.2
Pediatrics Q2 2022	6.3	6.9
Pediatrics Q3 2022	6.5	7.3
Pediatrics Q4 2022	7.0	9.6
Pediatrics Q1 2023	7.1	7.1
OB-GYN Q2 2022	6.3	7.1
OB-GYN Q3 2022	6.7	7.2
OB-GYN Q4 2022	7.1	7.6
OB-GYN Q1 2023	7.4	7.2
Therapists (PT/OT/ST) Q2 2022	7.1	8.8
Therapists (PT/OT/ST) Q3 2022	7.0	8.5
Therapists (PT/OT/ST) Q4 2022	7.2	10.0
Therapists (PT/OT/ST) Q1 2023	7.6	10.1
All Other Professional Q2 2022	6.0	6.7
All Other Professional Q3 2022	6.1	7.0
All Other Professional Q4 2022	6.6	7.7
All Other Professional Q1 2023	7.0	7.4

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 2022	16.9	9.8
Non-Emerg Transport Q3 2022	17.0	10.2
Non-Emerg Transport Q4 2022	16.2	10.1
Non-Emerg Transport Q1 2023	12.8	10.0
Medical Equipment/Supplies Q2 2022	6.7	7.8
Medical Equipment/Supplies Q3 2022	6.9	8.4
Medical Equipment/Supplies Q4 2022	7.3	8.7
Medical Equipment/Supplies Q1 2023	7.6	8.7
MH/BH Rehab Q2 2022	5.7	7.5
MH/BH Rehab Q3 2022	5.6	7.2
MH/BH Rehab Q4 2022	6.5	8.0
MH/BH Rehab Q1 2023	7.2	8.0
MH/BH Other Q2 2022	7.1	7.0
MH/BH Other Q3 2022	10.1	7.1
MH/BH Other Q4 2022	7.7	8.2
MH/BH Other Q1 2023	7.4	7.7
Dental - Children Q2 2022	6.9	9.8
Dental - Children Q3 2022	4.5	7.0
Dental - Children Q4 2022	4.6	6.6
Dental - Children Q1 2023	12.4	12.7
Dental - Adults Q2 2022	4.4	5.4
Dental - Adults Q3 2022	4.0	4.5
Dental - Adults Q4 2022	3.9	3.8
Dental - Adults Q1 2023	6.5	5.7
Pharmacy Q2 2022	10.1	3.3
Pharmacy Q3 2022	9.2	3.2
Pharmacy Q4 2022	9.5	3.2
Pharmacy Q1 2023	7.5	3.2

Appendix A Exhibit III.11
Average Turnaround Time (in days), Paid and Denied Claims, by Service Category
By MCE for Q1 2023 Adjudicated Claims

Inpatient Hospital	Paid	Denied
ABH	7.5	9.4
ACLA	13.7	12.7
HB	22.3	25.5
HUM	3.2	2.9
LHCC	9.0	9.4
UHC	9.3	9.5

Outpatient Hospital	Paid	Denied
ABH	6.4	8.1
ACLA	9.5	10.8
HB	8.2	8.4
HUM	4.1	2.0
LHCC	7.4	7.7
UHC	6.1	6.6

Home Health	Paid	Denied
ABH	8.9	10.2
ACLA	10.1	14.6
HB	12.6	14.1
HUM	2.2	0.0
LHCC	7.1	8.9
UHC	7.8	9.0

Primary Care	Paid	Denied
ABH	6.0	7.0
ACLA	7.4	8.8
HB	8.2	9.2
HUM	5.3	1.0
LHCC	7.7	8.8
UHC	5.9	7.5

Pediatrics	Paid	Denied
ABH	5.8	6.2
ACLA	7.1	7.6
HB	7.6	8.1
HUM	5.0	4.9
LHCC	7.2	7.2
UHC	5.8	8.2

OB-GYN	Paid	Denied
ABH	6.6	8.0
ACLA	7.3	7.6
HB	8.3	7.2
HUM	4.9	3.5
LHCC	7.3	7.3
UHC	5.8	9.0

Therapists (PT, OT, ST)	Paid	Denied
ABH	8.5	12.9
ACLA	10.7	12.6
HB	7.9	15.0
HUM	5.1	3.6
LHCC	6.7	7.6
UHC	6.0	7.2

Non-Emergency Medical Transp.	Paid	Denied
ABH	16.0	0.0
ACLA	8.3	8.6
HB	16.0	0.0
HUM	15.4	0.0
LHCC	13.0	13.6
UHC	11.1	11.5

Medical Equipment And Supplies	Paid	Denied
ABH	7.2	8.2
ACLA	12.1	13.2
HB	8.7	11.1
HUM	5.2	5.3
LHCC	7.5	8.8
UHC	5.8	7.0

All Other Professional	Paid	Denied
ABH	6.1	6.2
ACLA	7.7	8.3
HB	8.5	10.5
HUM	4.8	4.1
LHCC	7.5	7.5
UHC	5.7	7.0

Mental/Behavioral Health - Rehab	Paid	Denied
ABH	6.9	6.2
ACLA	10.6	9.4
HB	9.4	14.9
HUM	0.0	2.5
LHCC	7.2	7.6
UHC	5.6	7.6

Mental/Behavioral Health - Other	Paid	Denied
ABH	6.0	6.8
ACLA	9.9	11.6
HB	8.6	8.3
HUM	0.0	0.0
LHCC	7.2	7.4
UHC	7.9	8.0

Pharmacy	Paid	Denied
ABH	0.0	0.0
ACLA	7.6	7.5
HB	0.2	0.3
HUM	0.0	0.0
LHCC	10.9	10.9
UHC	11.4	0.0

Dental - Adults	Paid	Denied
DQ	14.5	6.1
MCNA	12.7	12.5
Dental - Children		
DQ	14.7	14.3
MCNA	10.1	11.9

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 2022	99.3%	0.7%
All MCEs Q3 2022	99.6%	0.4%
All MCEs Q4 2022	99.5%	0.5%
All MCEs Q1 2023	99.2%	0.8%
ABH Q2 2022	95.6%	4.4%
ABH Q3 2022	99.3%	0.7%
ABH Q4 2022	98.2%	1.8%
ABH Q1 2023	98.2%	1.8%
ACLA Q2 2022	99.2%	0.8%
ACLA Q3 2022	98.9%	1.1%
ACLA Q4 2022	98.9%	1.1%
ACLA Q1 2023	98.5%	1.5%
HB Q2 2022	100.0%	0.0%
HB Q3 2022	99.5%	0.5%
HB Q4 2022	100.0%	0.0%
HB Q1 2023	99.7%	0.3%
HUM Q1 2023	99.4%	0.6%
LHCC Q2 2022	99.3%	0.7%
LHCC Q3 2022	99.8%	0.2%
LHCC Q4 2022	99.8%	0.2%
LHCC Q1 2023	99.7%	0.3%
UHC Q2 2022	100.0%	0.0%
UHC Q3 2022	100.0%	0.0%
UHC Q4 2022	100.0%	0.0%
UHC Q1 2023	100.0%	0.0%
MCNA Q2 2022	98.2%	1.8%
MCNA Q3 2022	98.1%	1.9%
MCNA Q4 2022	97.0%	3.0%
MCNA Q1 2023	96.1%	3.9%
DQ Q2 2022	93.0%	7.0%
DQ Q3 2022	94.0%	6.0%
DQ Q4 2022	95.4%	4.6%
DQ Q1 2023	93.5%	6.5%

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 2022	94.2%	5.8%	95.0%	5.0%			97.9%	2.1%
ABH Q3 2022	98.1%	1.9%	97.4%	2.6%			100.0%	0.0%
ABH Q4 2022	98.8%	1.2%	97.0%	3.0%			100.0%	0.0%
ABH Q1 2023	98.5%	1.5%	96.9%	3.1%			100.0%	0.0%
ACLA Q2 2022	99.2%	0.8%	98.9%	1.1%			99.7%	0.3%
ACLA Q3 2022	98.3%	1.7%	98.4%	1.6%			99.8%	0.2%
ACLA Q4 2022	98.2%	1.8%	98.6%	1.4%			99.7%	0.3%
ACLA Q1 2023	98.8%	1.2%	97.4%	2.6%			99.7%	0.3%
HB Q2 2022	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
HB Q3 2022	100.0%	0.0%	100.0%	0.0%			98.1%	1.9%
HB Q4 2022	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
HB Q1 2023	100.0%	0.0%	100.0%	0.0%			99.1%	0.9%
HUM Q1 2023	100.0%	0.0%	99.4%	0.6%			0.0%	0.0%
LHCC Q2 2022	100.0%	0.0%	100.0%	0.0%			97.4%	2.6%
LHCC Q3 2022	100.0%	0.0%	100.0%	0.0%			99.1%	0.9%
LHCC Q4 2022	100.0%	0.0%	100.0%	0.0%			99.2%	0.8%
LHCC Q1 2023	100.0%	0.0%	100.0%	0.0%			99.2%	0.8%
UHC Q2 2022	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
UHC Q3 2022	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
UHC Q4 2022	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
UHC Q1 2023	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
MCNA Q2 2022					98.2%	1.8%		
MCNA Q3 2022					98.1%	1.9%		
MCNA Q4 2022					97.0%	3.0%		
MCNA Q1 2023					96.1%	3.9%		
DQ Q2 2022					93.0%	7.0%		
DQ Q3 2022					94.0%	6.0%		
DQ Q4 2022					95.4%	4.6%		
DQ Q1 2023					93.5%	6.5%		

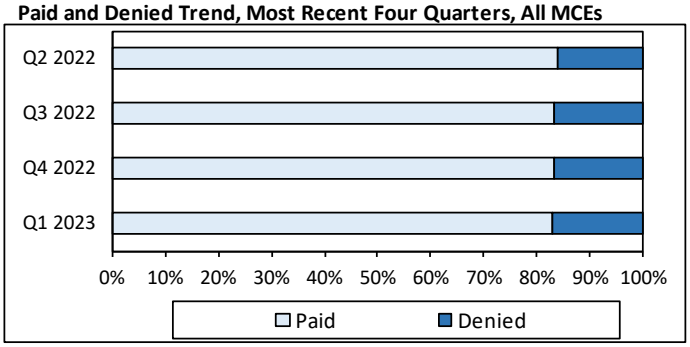
Appendix B:

One-page summaries of Information on Claims for Each

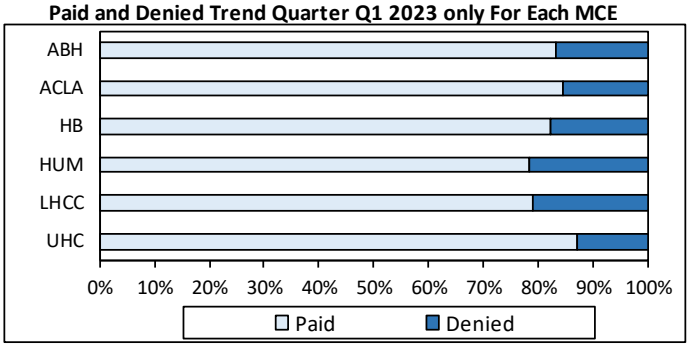
of the 16 Provider Types Shown in this Report

Summary of Information on Claims for Inpatient Hospital Services

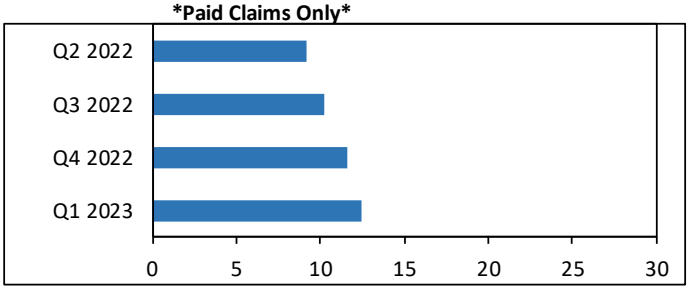
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



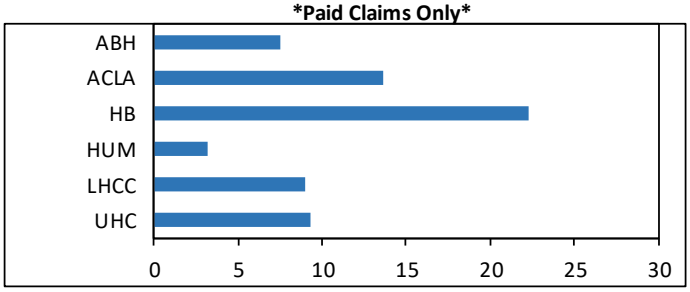
Paid and Denied Trend Quarter Q1 2023 only For Each MCE



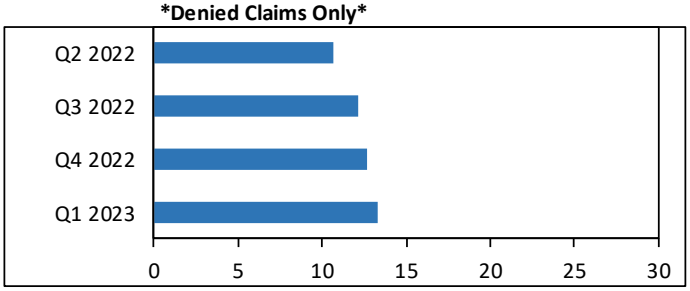
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



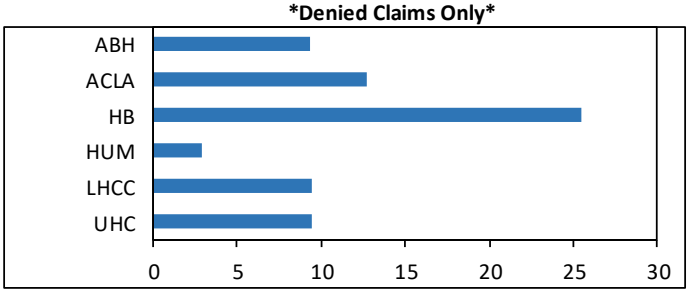
Claims Turnaround Time Quarter Q1 2023 only Each MCE
Paid Claims Only



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 2023 only)

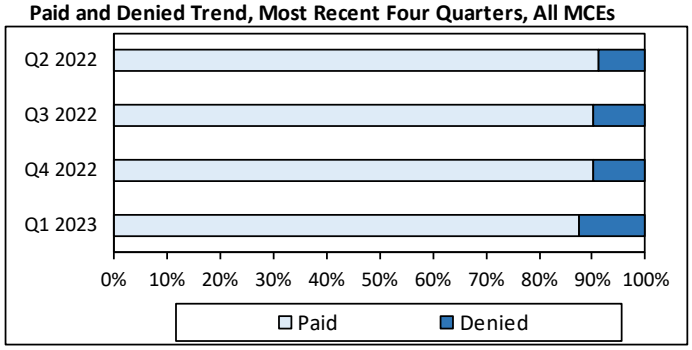
	ABH		ACLA		HB		HUM		LHCC		UHC	
	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied
<100 claims	270	165	290	175	304	193	119	61	297	214	395	234
101 - 250	15	9	27	11	42	31	3	2	53	48	36	18
> 250 claims	0	0	1	0	2	0	0	0	13	9	4	3

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

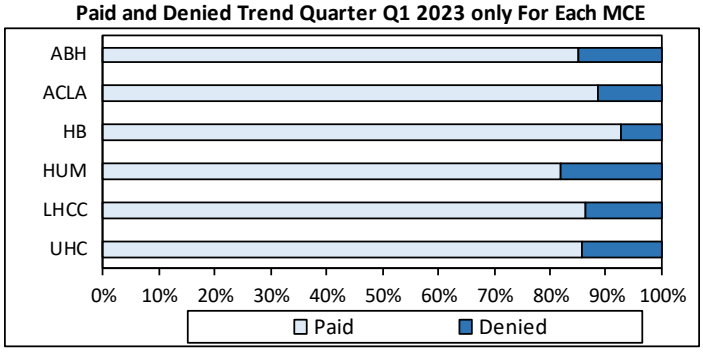
CARC Code	Description	ABH	ACLA	HB	HUM	LHCC	UHC
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	X	X		X	X	X
39	Services denied at the time authorization/pre-certification was requested.		X		X	X	X
197	Precertification/authorization/notification absent.	X		X		X	X
18	Exact duplicate claim/service	X				X	X
198	Precertification/authorization exceeded.	X		X			

Summary of Information on Claims for Outpatient Hospital Services

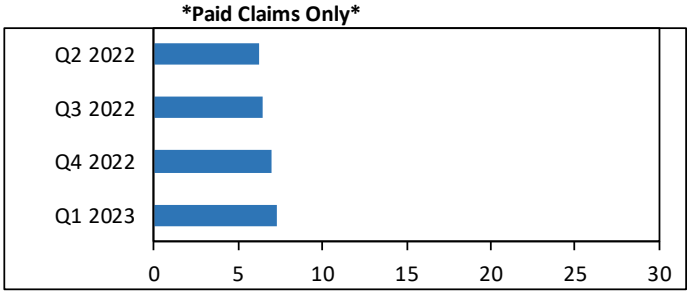
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



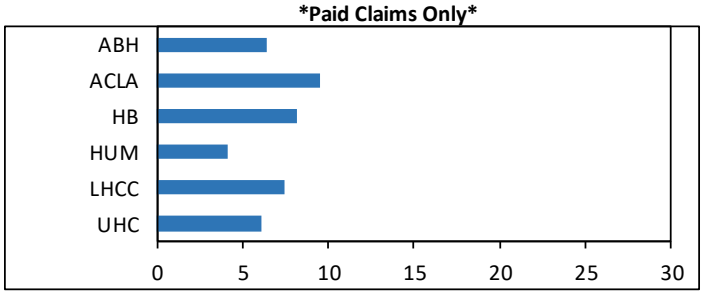
Paid and Denied Trend Quarter Q1 2023 only For Each MCE



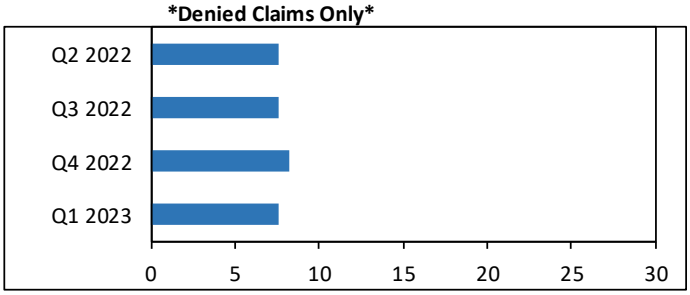
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



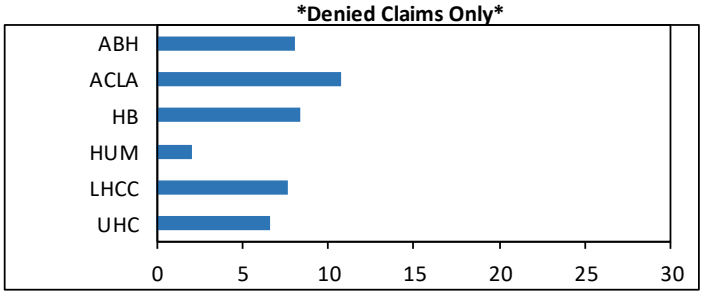
Claims Turnaround Time Quarter Q1 2023 only Each MCE
Paid Claims Only



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 2023 only)

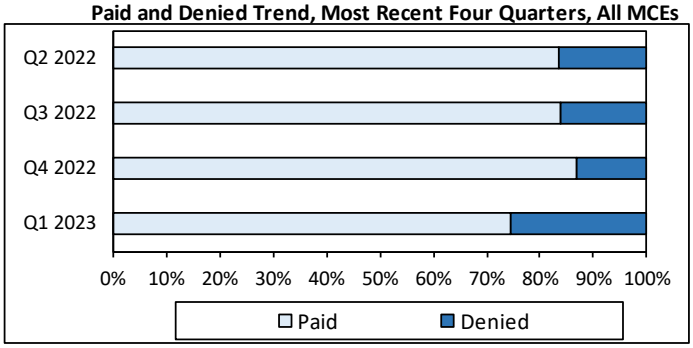
	ABH		ACLA		HB		HUM		LHCC		UHC	
	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied
<100 claims	451	321	435	371	457	234	136	66	612	440	395	234
101 - 250	104	90	100	53	41	30	28	15	145	126	36	18
> 250 claims	99	58	125	50	105	17	49	42	174	122	4	3

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

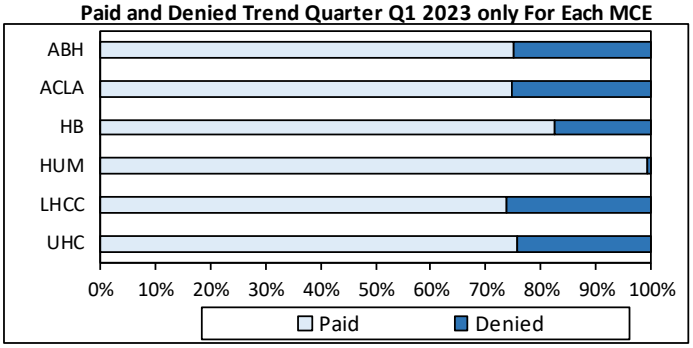
CARC Code	Description	ABH	ACLA	HB	HUM	LHCC	UHC
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	X	X		X	X	X
96	Non-covered charge(s).	X	X		X	X	X
97	The benefit for this service is included in the payment/allowance for another service/procedure that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

Summary of Information on Claims for Home Health Services

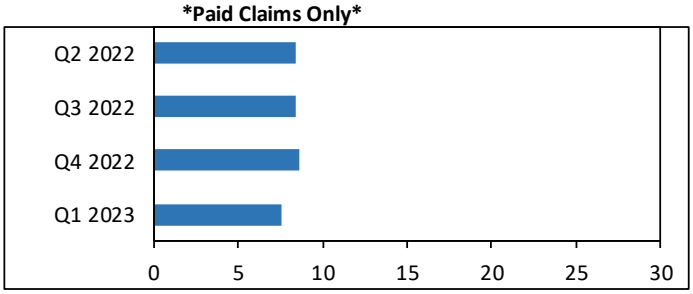
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



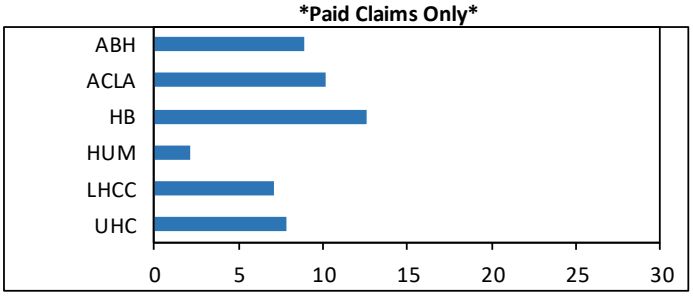
Paid and Denied Trend Quarter Q1 2023 only For Each MCE



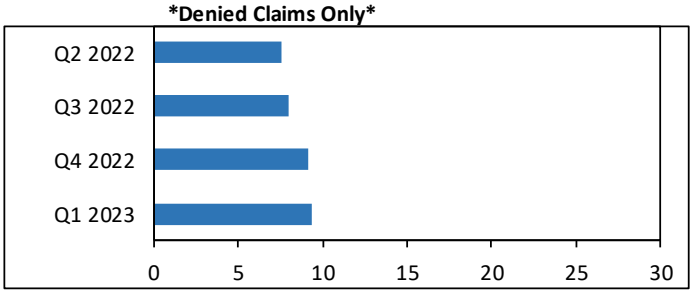
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



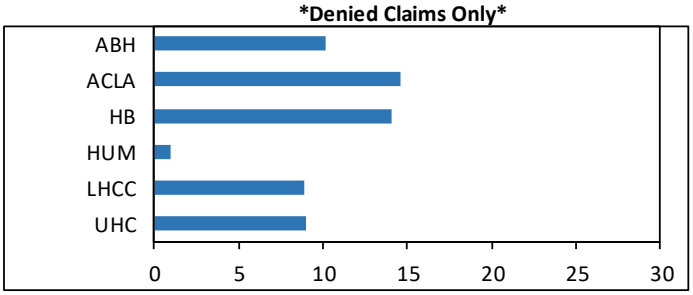
Claims Turnaround Time Quarter Q1 2023 only Each MCE
Paid Claims Only



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 2023 only)

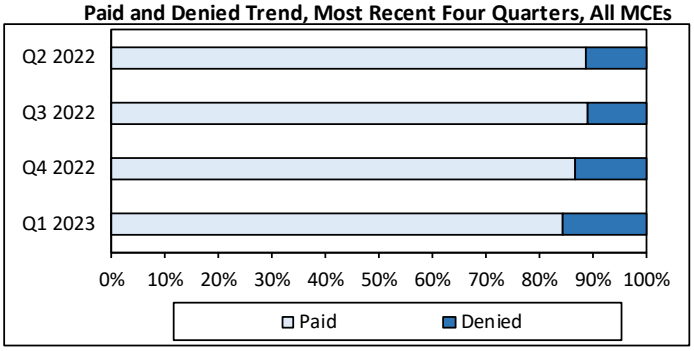
	ABH		ACLA		HB		HUM		LHCC		UHC	
	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied
<100 claims	38	16	34	14	49	22	11	1	75	37	51	30
101 - 250	0	0	13	6	3	3	0	0	38	18	20	14
> 250 claims	0	0	1	0	0	0	0	0	45	13	3	2

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

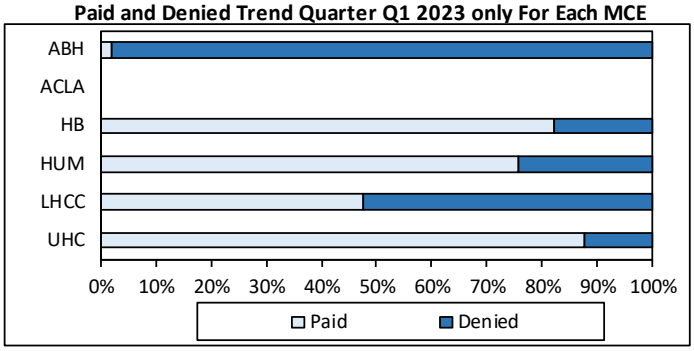
CARC Code	Description	ABH	ACLA	HB	HUM	LHCC	UHC
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	X	X		X	X	X
29	The time limit for filing has expired.		X		X	X	
18	Exact duplicate claim/service	X			X	X	X
22	This care may be covered by another payer per coordination of benefits.				X	X	
95	Plan procedures not followed.				X	X	

Summary of Information on Claims for Other Institutional Services

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

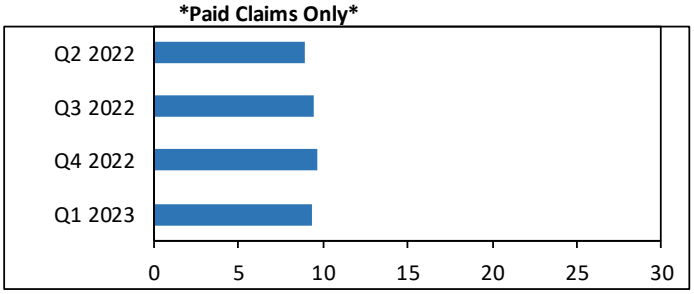


Paid and Denied Trend Quarter Q1 2023 only For Each MCE



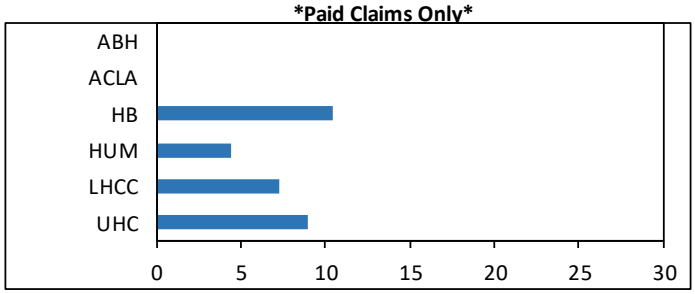
Claims Turnaround Time Most Recent 4 Qtrs All MCEs

Paid Claims Only

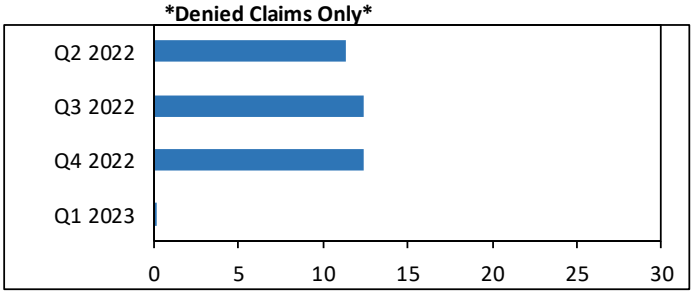


Claims Turnaround Time Quarter Q1 2023 only Each MCE

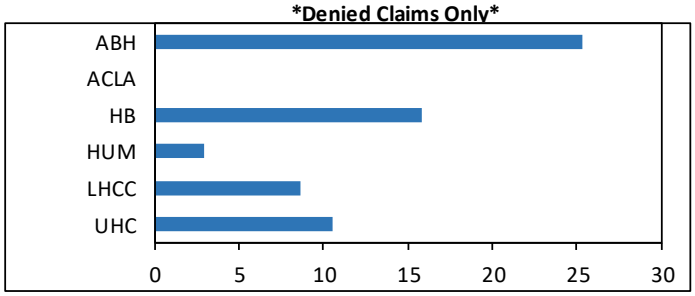
Paid Claims Only



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 2023 only)

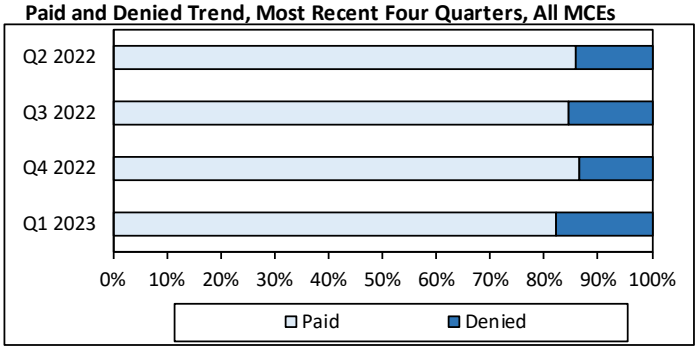
	ABH		ACLA		HB		HUM		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied
<100 claims	4	3	0	0	276	98	87	65	160	125	227	135
101 - 250	0	0	0	0	107	45	2	0	9	9	99	58
> 250 claims	0	0	0	0	35	15	1	1	1	1	6	6

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

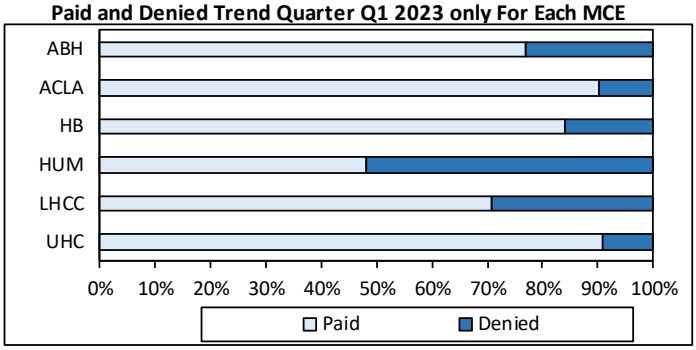
CARC Code	Description	ABH	ACLA	HB	HUM	LHCC	UHC
119	Benefit maximum for this time period or occurrence has been reached.	X	X				X
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	X	X		X	X	
204	This service/equipment/drug is not covered under the patient's current benefit plan	X	X	X		X	
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	X	X				X
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	X	X				

Summary of Information on Claims for Primary Care Services

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

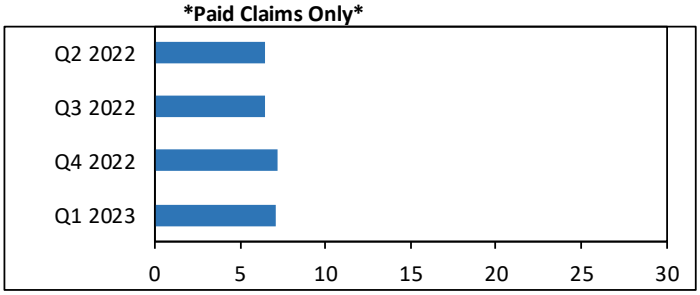


Paid and Denied Trend Quarter Q1 2023 only For Each MCE



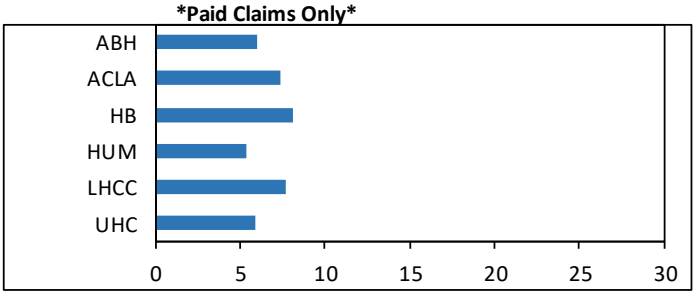
Claims Turnaround Time Most Recent 4 Qtrs All MCEs

Paid Claims Only

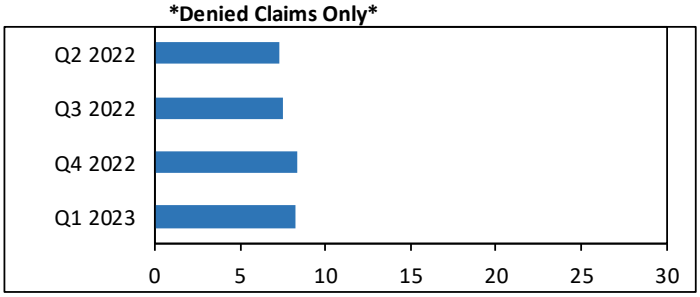


Claims Turnaround Time Quarter Q1 2023 only Each MCE

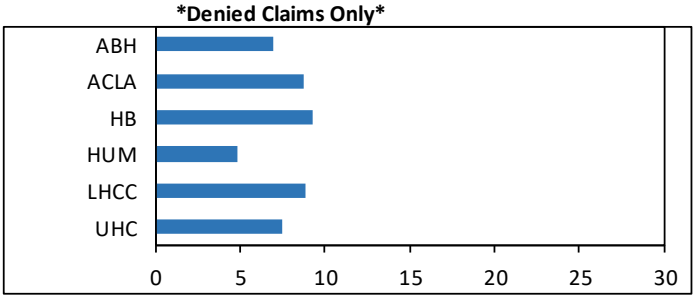
Paid Claims Only



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 2023 only)

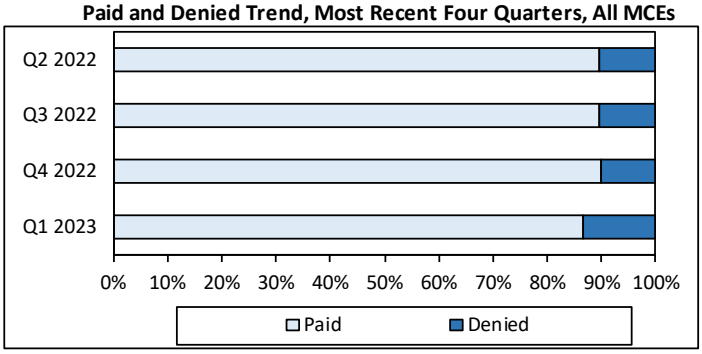
	ABH		ACLA		HB		HUM		LHCC		UHC	
	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied
<100 claims	1,221	753	544	273	1,081	592	553	315	683	435	411	310
101 - 250	543	336	190	59	510	231	79	70	240	155	175	91
> 250 claims	43	31	63	19	352	169	28	28	137	106	283	89

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

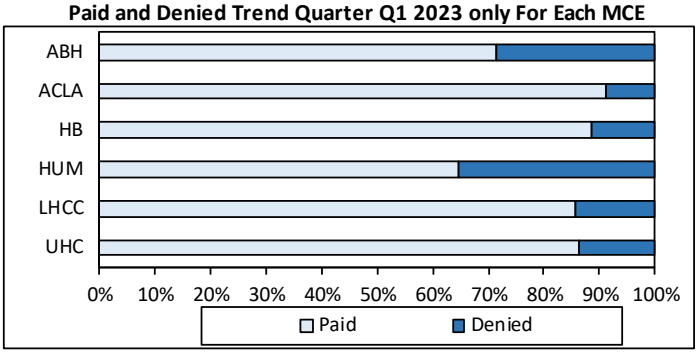
CARC Code	Description	ABH	ACLA	HB	HUM	LHCC	UHC
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	X	X		X	X	X
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period.					X	
96	Non-covered charge(s).	X	X		X	X	X
18	Exact duplicate claim/service	X				X	X
256	Service not payable per managed care contract.			X			

Summary of Information on Claims for Pediatric Services

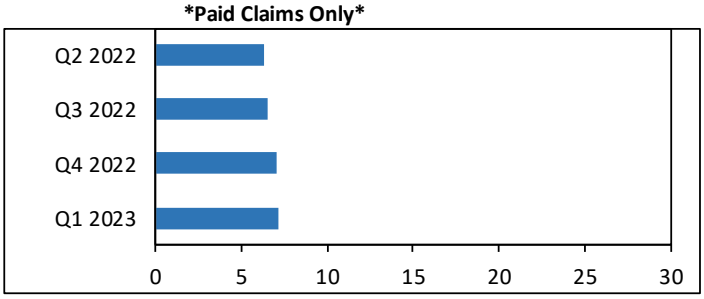
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



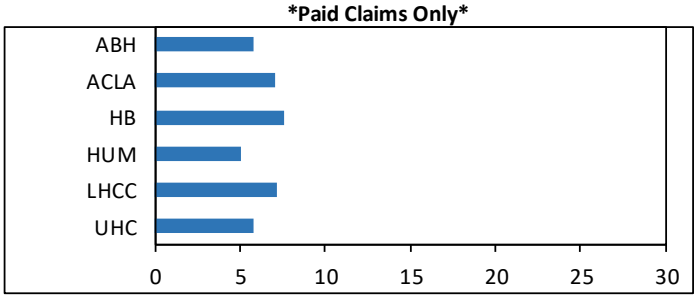
Paid and Denied Trend Quarter Q1 2023 only For Each MCE



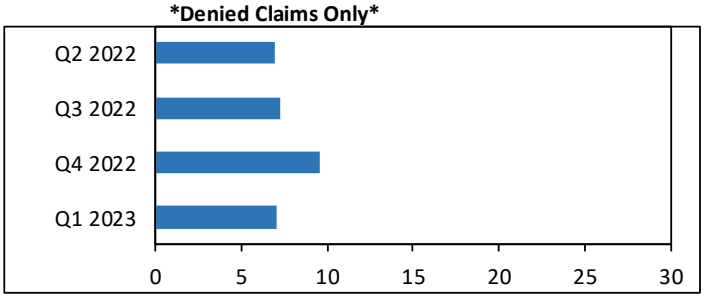
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



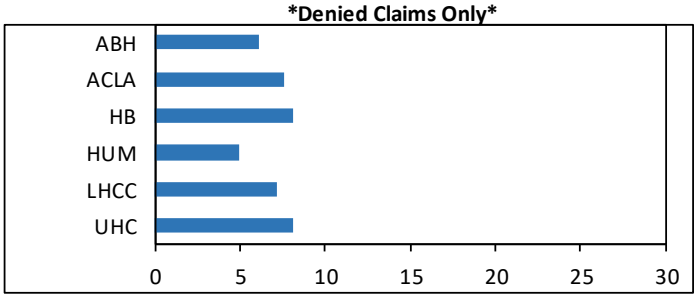
Claims Turnaround Time Quarter Q1 2023 only Each MCE
Paid Claims Only



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 2023 only)

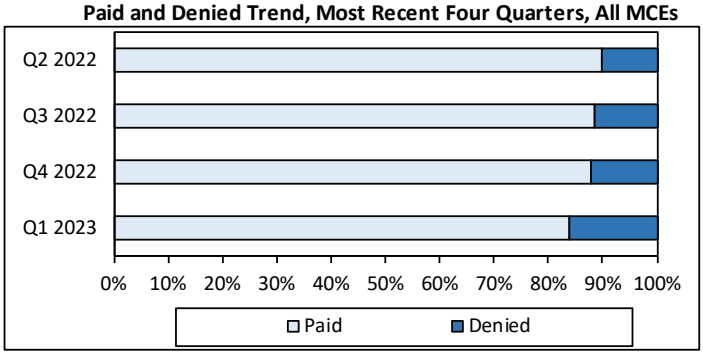
	ABH		ACLA		HB		HUM		LHCC		UHC	
	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied
<100 claims	15	8	93	38	143	63	119	74	142	89	56	46
101 - 250	12	9	84	27	111	48	47	47	88	59	14	10
> 250 claims	5	4	83	25	124	42	16	15	182	117	26	14

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

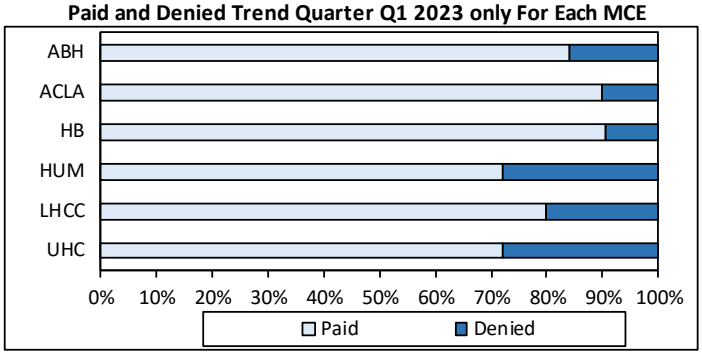
CARC Code	Description	ABH	ACLA	HB	HUM	LHCC	UHC
96	Non-covered charge(s).	X	X		X	X	X
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	X			X	X	X
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.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

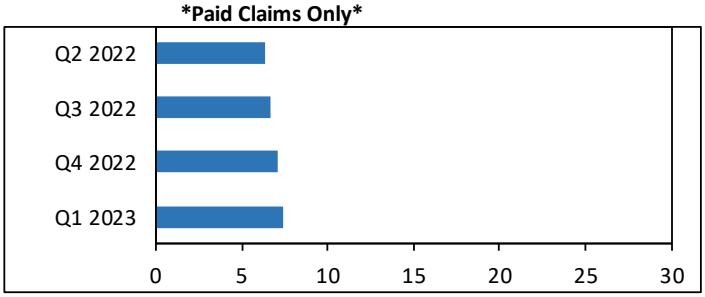


Paid and Denied Trend Quarter Q1 2023 only For Each MCE



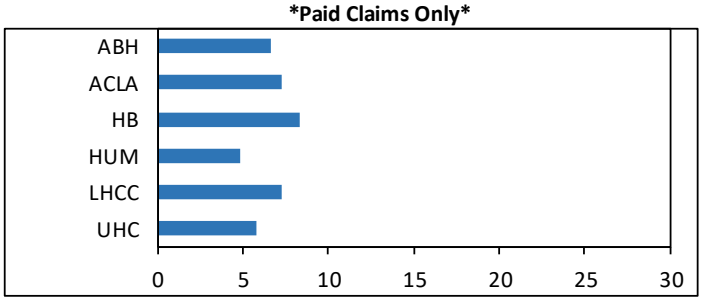
Claims Turnaround Time Most Recent 4 Qtrs All MCEs

Paid Claims Only

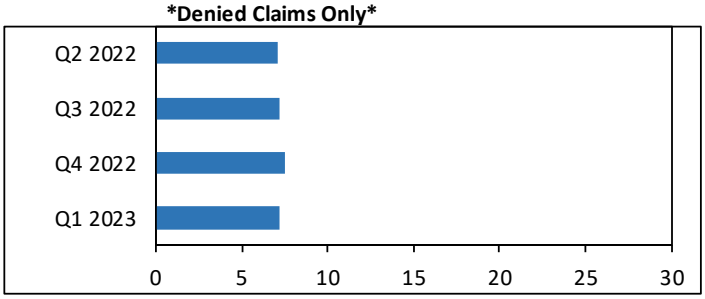


Claims Turnaround Time Quarter Q1 2023 only Each MCE

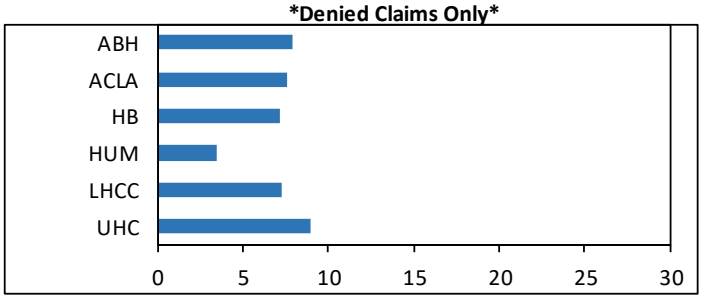
Paid Claims Only



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 2023 only)

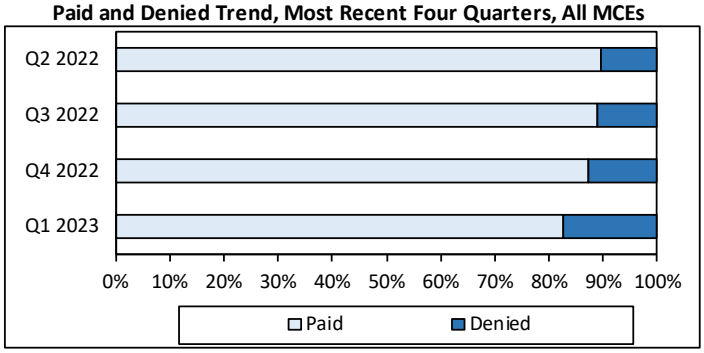
	ABH		ACLA		HB		HUM		LHCC		UHC	
	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied
<100 claims	19	11	93	46	109	62	102	53	96	67	26	18
101 - 250	3	1	67	34	66	27	23	15	57	47	19	14
> 250 claims	0	0	17	5	44	12	4	3	67	55	6	4

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

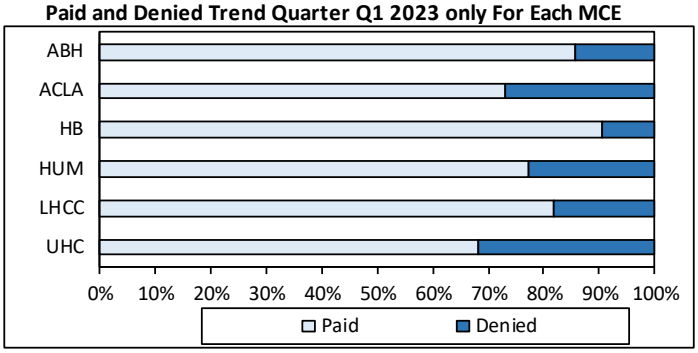
CARC Code	Description	ABH	ACLA	HB	HUM	LHCC	UHC
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	X	X		X	X	
18	Exact duplicate claim/service	X			X	X	X
96	Non-covered charge(s).					X	
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	X					X
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.					X	

Summary of Information on Claims for Therapy Services

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

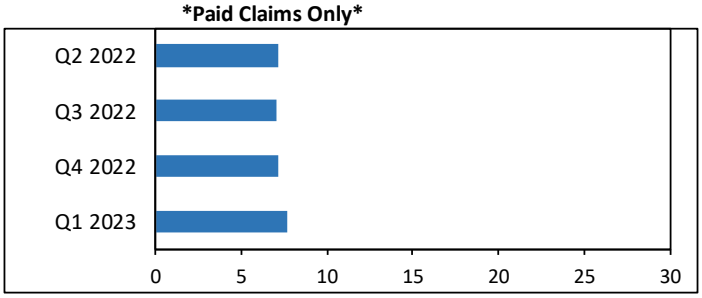


Paid and Denied Trend Quarter Q1 2023 only For Each MCE



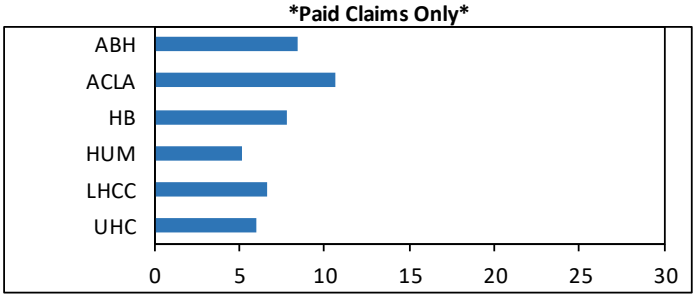
Claims Turnaround Time Most Recent 4 Qtrs All MCEs

Paid Claims Only

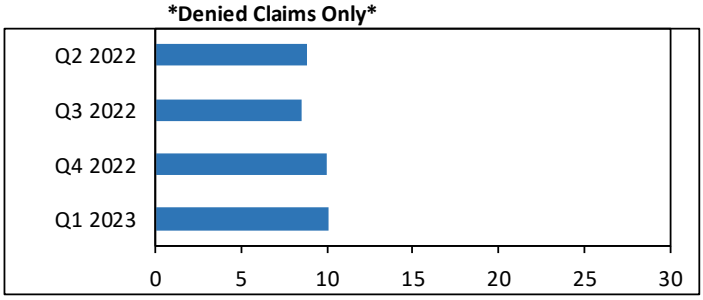


Claims Turnaround Time Quarter Q1 2023 only Each MCE

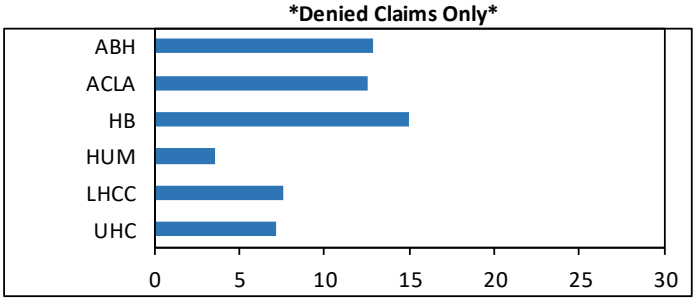
Paid Claims Only



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 2023 only)

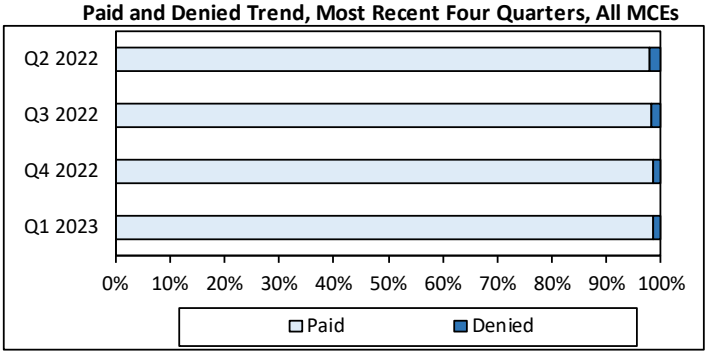
	ABH		ACLA		HB		HUM		LHCC		UHC	
	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied
<100 claims	12	7	77	54	117	43	47	11	84	58	59	43
101 - 250	2	1	42	34	61	24	2	1	60	35	10	7
> 250 claims	0	0	16	14	28	9	2	2	45	32	1	1

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

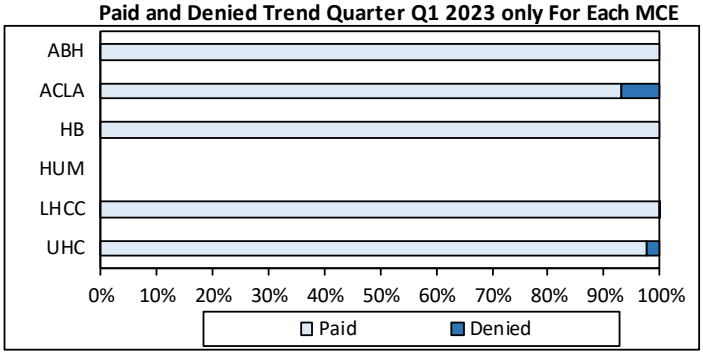
CARC Code	Description	ABH	ACLA	HB	HUM	LHCC	UHC
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.					X	
197	Precertification/authorization/notification absent.	X	X	X			X
256	Service not payable per managed care contract.			X			
96	Non-covered charge(s).		X			X	X
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	X			X	X	X

Summary of Information on Claims for NEMT Services

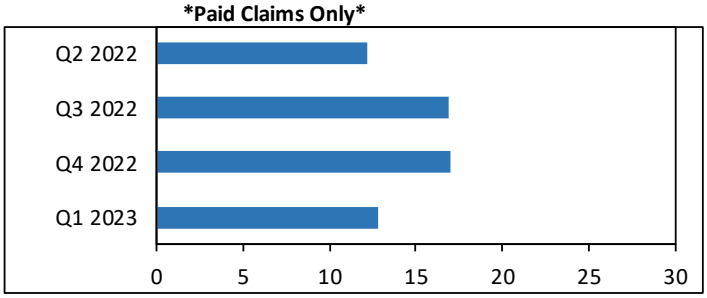
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



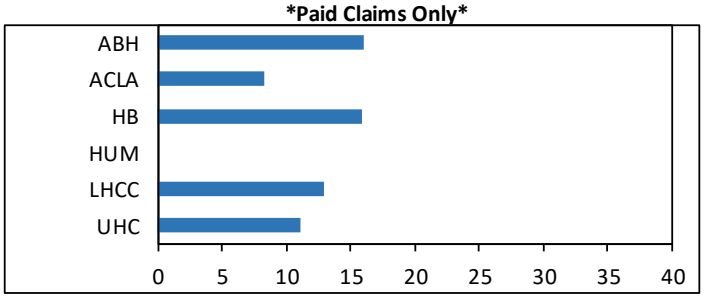
Paid and Denied Trend Quarter Q1 2023 only For Each MCE



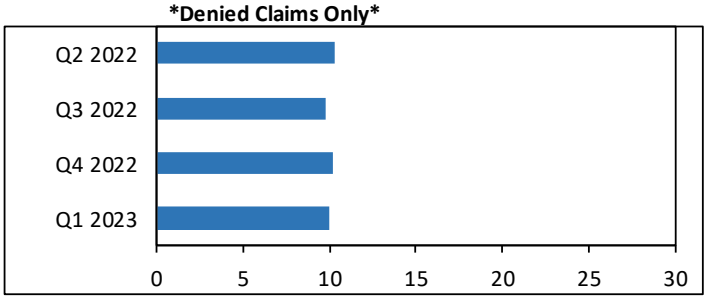
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



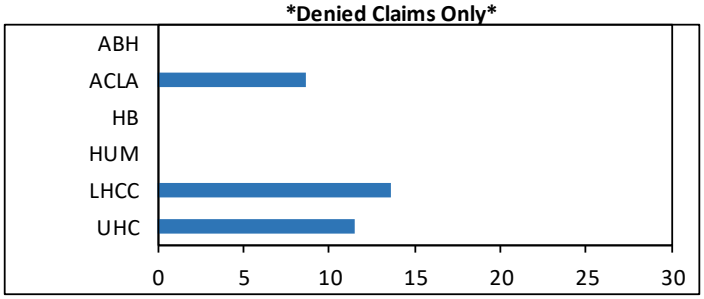
Claims Turnaround Time Quarter Q1 2023 only Each MCE
Paid Claims Only



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 2023 only)

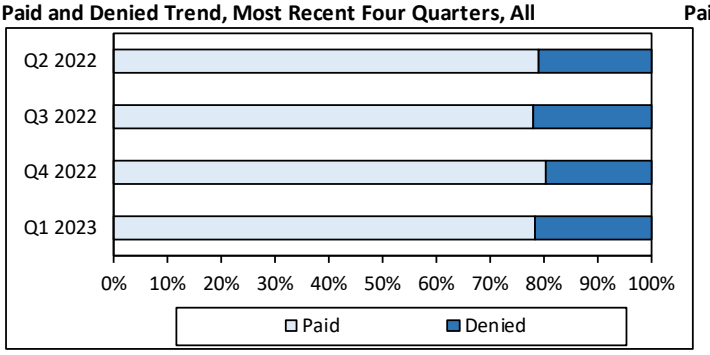
	ABH		ACLA		HB		HUM		LHCC		UHC	
	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied
<100 claims	84	0	54	18	0	0	0	0	9	0	10	3
101 - 250	72	0	69	16	0	0	0	0	0	0	30	3
> 250 claims	32	0	39	4	0	0	0	0	1	0	61	4

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

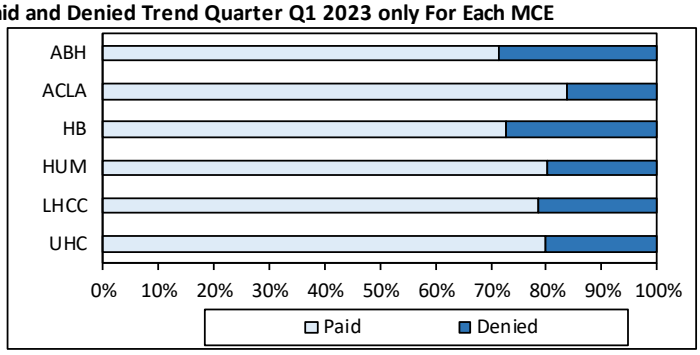
CARC Code	Description	ABH	ACLA	HB	HUM	LHCC	UHC
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	X	X	X	X	X	X
A1	Claim/Service denied.	X	X	X	X	X	X
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	X	X	X	X	X	X
216	Based on the findings of a review organization	X	X	X	X	X	X
27	Expenses incurred after coverage terminated.	X	X	X	X	X	X

Summary of Information on Claims for Medical Supplies Services

Paid and Denied Trend, Most Recent Four Quarters, All

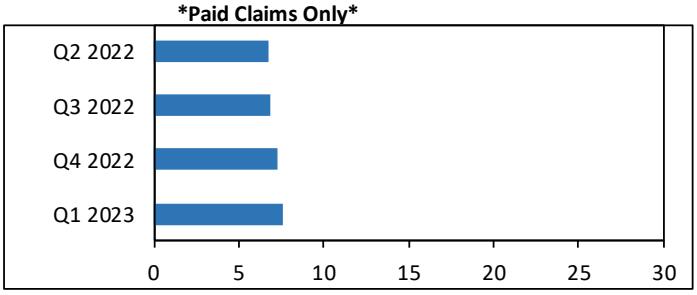


Paid and Denied Trend Quarter Q1 2023 only For Each MCE



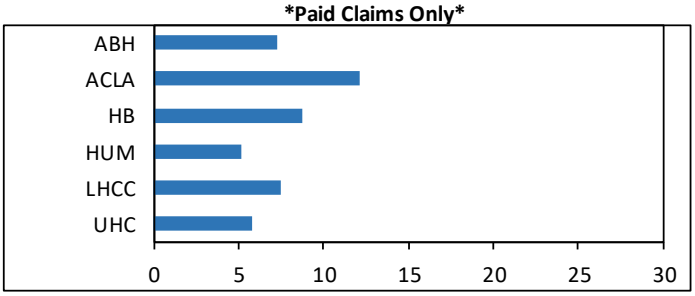
Claims Turnaround Time Most Recent 4 Qtrs All MCEs

Paid Claims Only

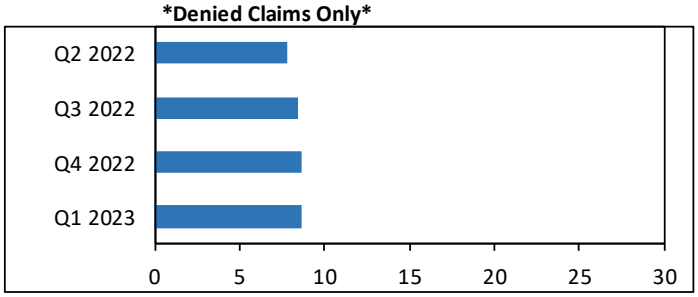


Claims Turnaround Time Quarter Q1 2023 only Each MCE

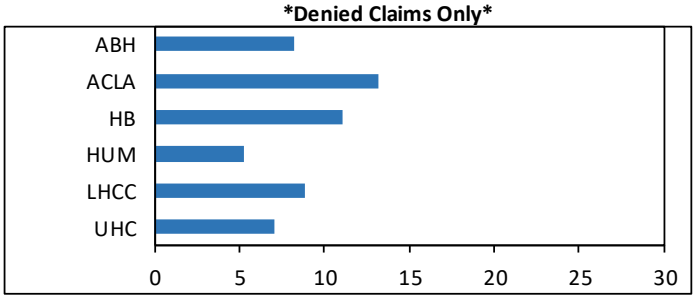
Paid Claims Only



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 2023 only)

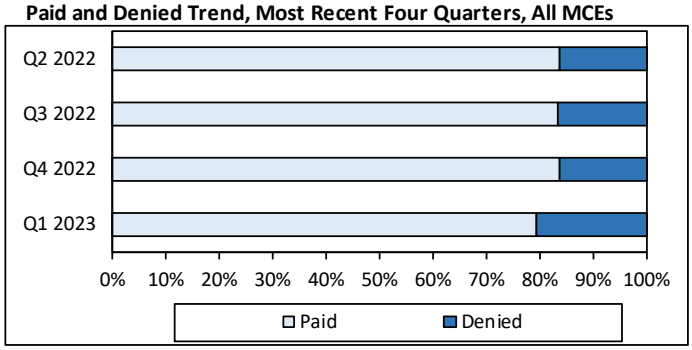
	ABH		ACLA		HB		HUM		LHCC		UHC	
	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied
<100 claims	155	102	139	85	99	49	68	28	262	201	228	148
101 - 250	38	35	35	23	14	12	3	2	79	62	64	39
> 250 claims	17	12	19	10	1	1	0	0	38	29	45	33

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

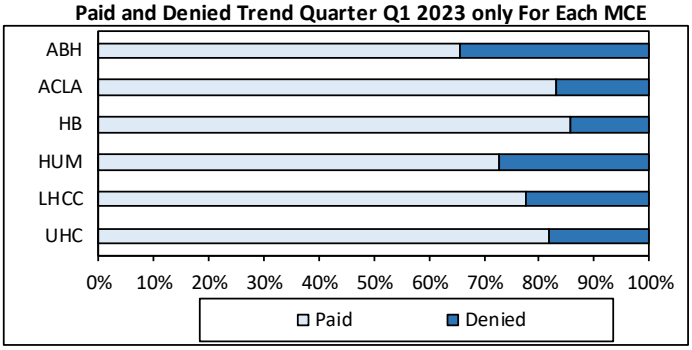
CARC Code	Description	ABH	ACLA	HB	HUM	LHCC	UHC
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	X				X	X
96	Non-covered charge(s).	X	X		X	X	X
197	Precertification/authorization/notification absent.	X	X	X		X	
252	An attachment/other documentation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

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

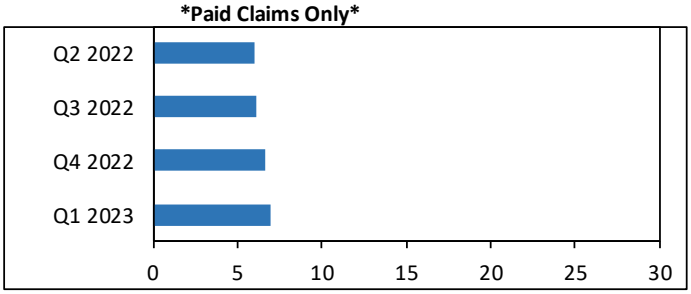
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



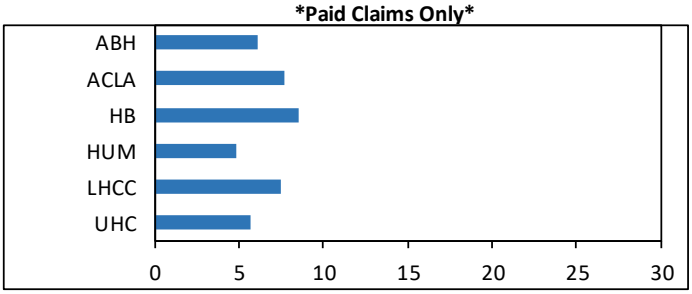
Paid and Denied Trend Quarter Q1 2023 only For Each MCE



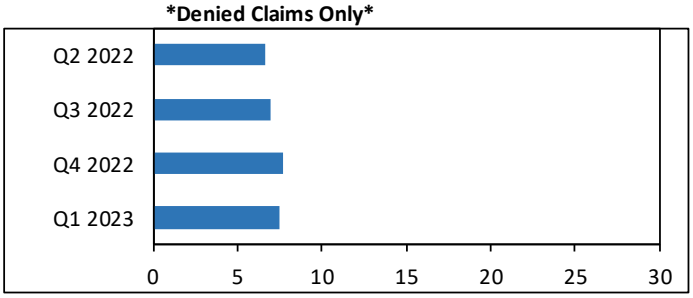
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



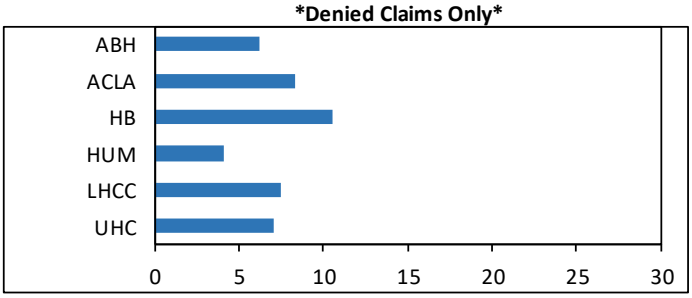
Claims Turnaround Time Quarter Q1 2023 only Each MCE
Paid Claims Only



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 2023 only)

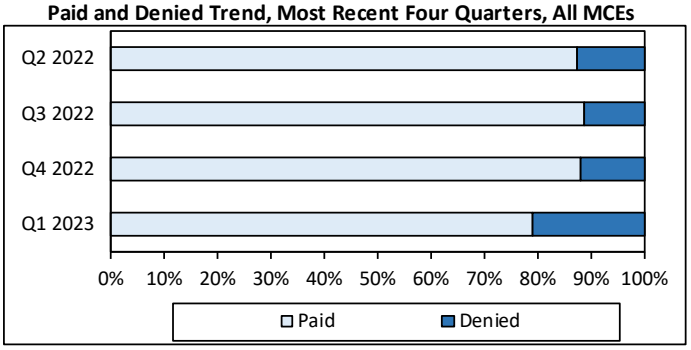
	ABH		ACLA		HB		HUM		LHCC		UHC	
	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied
<100 claims	13,994	8,423	1,735	1,046	2,499	1,430	1,534	888	2,391	1,647	4,568	3,258
101 - 250	1,391	1,141	736	349	627	320	167	107	868	618	868	599
> 250 claims	121	105	362	154	367	181	51	39	910	596	582	364

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

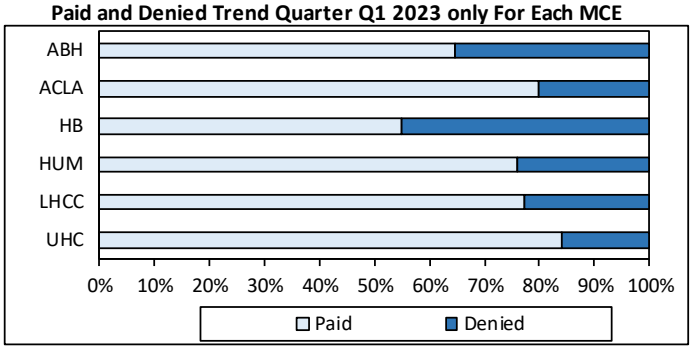
CARC Code	Description	ABH	ACLA	HB	HUM	LHCC	UHC
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	X	X		X	X	X
96	Non-covered charge(s).	X	X			X	X
18	Exact duplicate claim/service	X				X	X
B7	procedure/service on this date of service.					X	
197	Precertification/authorization/notification absent.		X	X			

Summary of Information on Claims for Mental Health Services- Rehab

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

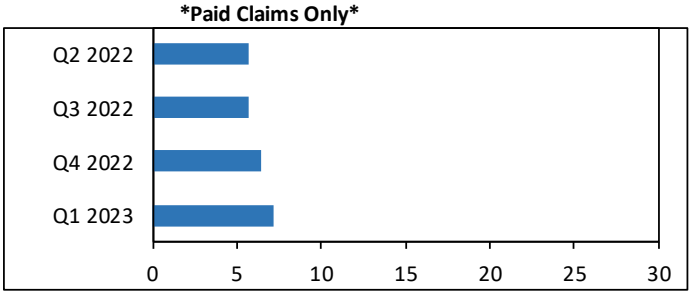


Paid and Denied Trend Quarter Q1 2023 only For Each MCE



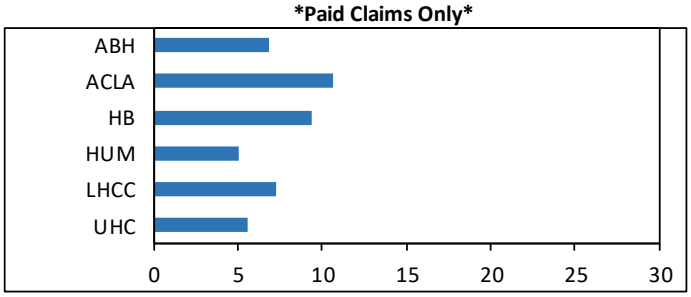
Claims Turnaround Time Most Recent 4 Qtrs All MCEs

Paid Claims Only

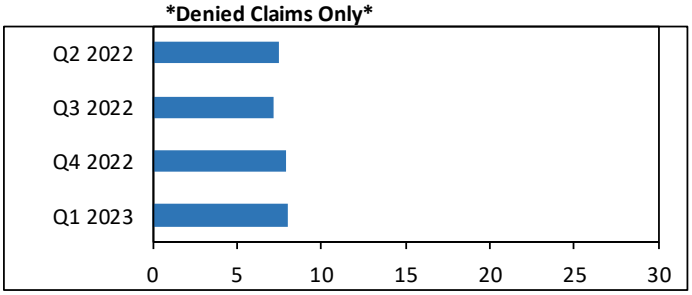


Claims Turnaround Time Quarter Q1 2023 only Each MCE

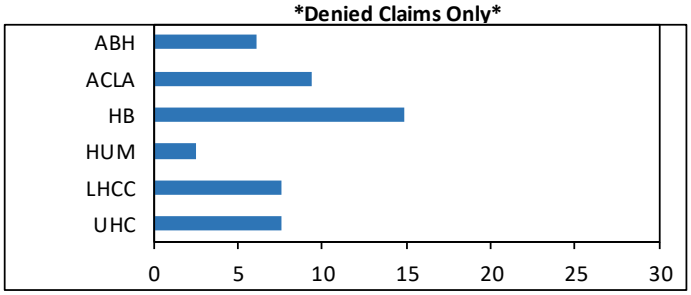
Paid Claims Only



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 2023 only)

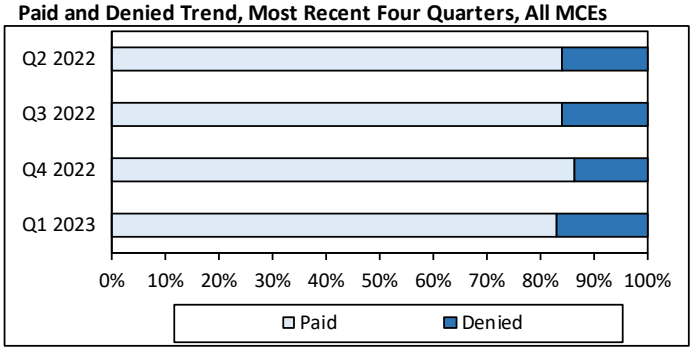
	ABH		ACLA		HB		HUM		LHCC		UHC	
	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied
<100 claims	1,620	955	64	49	38	34	33	15	56	40	73	54
101 - 250	44	34	104	75	12	10	1	1	16	3	94	62
> 250 claims	2	2	28	19	4	3	0	0	3	3	73	41

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

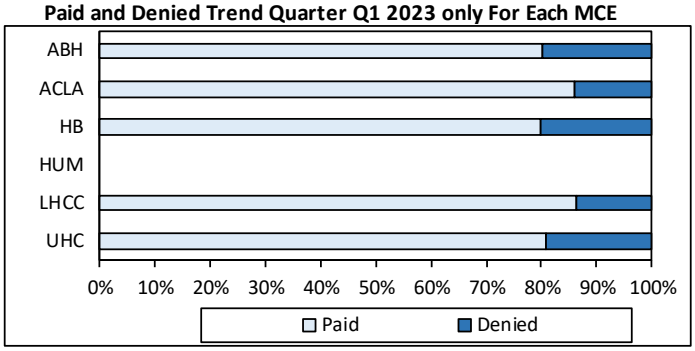
CARC Code	Description	ABH	ACLA	HB	HUM	LHCC	UHC
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	X				X	X
197	Precertification/authorization/notification absent.	X	X			X	X
18	Exact duplicate claim/service	X			X		X
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.		X			X	
27	Expenses incurred after coverage terminated.		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

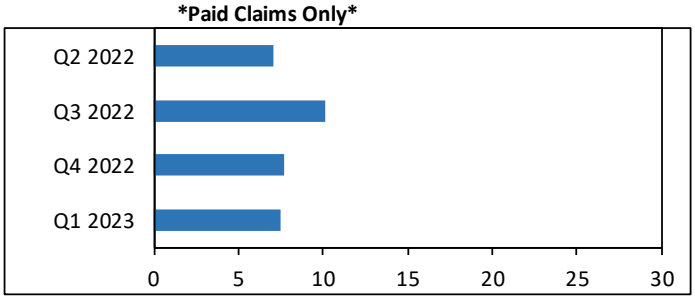


Paid and Denied Trend Quarter Q1 2023 only For Each MCE



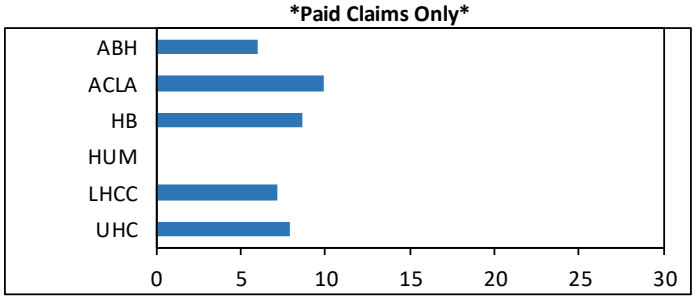
Claims Turnaround Time Most Recent 4 Qtrs All MCEs

Paid Claims Only

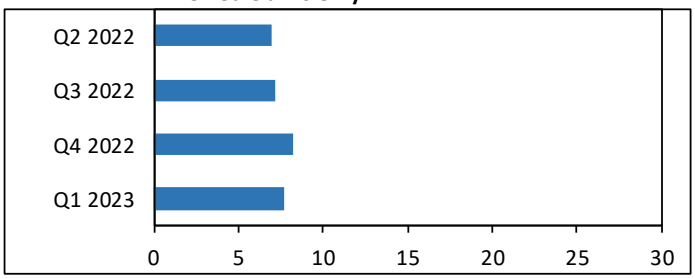


Claims Turnaround Time Quarter Q1 2023 only Each MCE

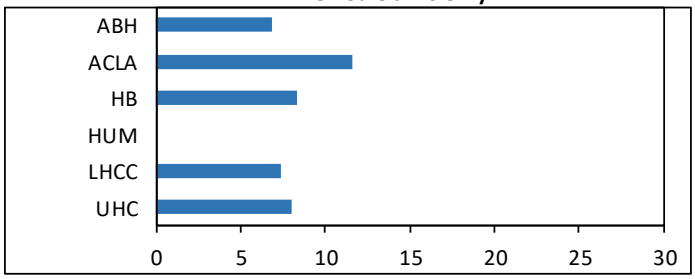
Paid Claims Only



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 2023 only)

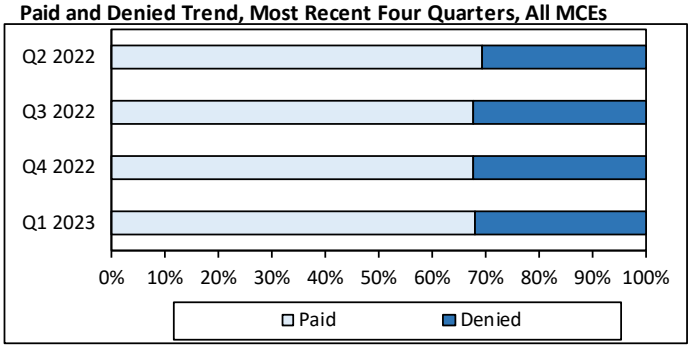
	ABH		ACLA		HB		HUM		LHCC		UHC	
	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied
<100 claims	2,246	1,353	498	240	941	607	0	0	760	397	396	228
101 - 250	598	375	108	41	295	179	0	0	355	202	90	62
> 250 claims	76	44	30	11	130	64	0	0	215	117	57	34

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

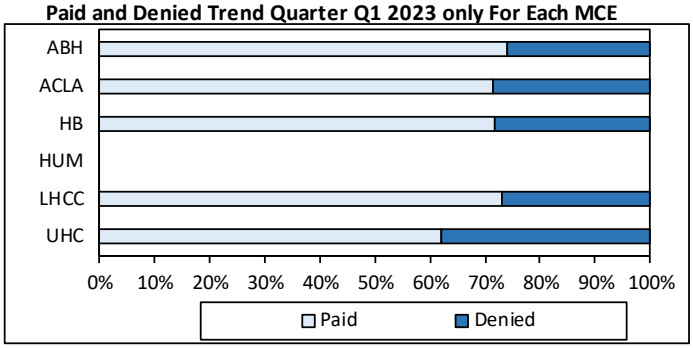
CARC Code	Description	ABH	ACLA	HB	HUM	LHCC	UHC
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	X			X	X	X
96	Non-covered charge(s).	X	X		X	X	
97	The benefit for this service is included in the payment/allowance for another service/procedure that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

Summary of Information on Claims for Pharmacy Services

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

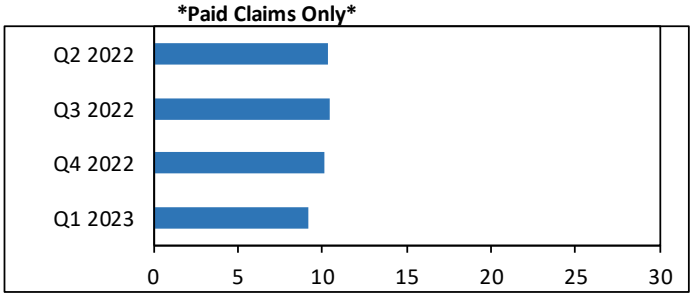


Paid and Denied Trend Quarter Q1 2023 only For Each MCE



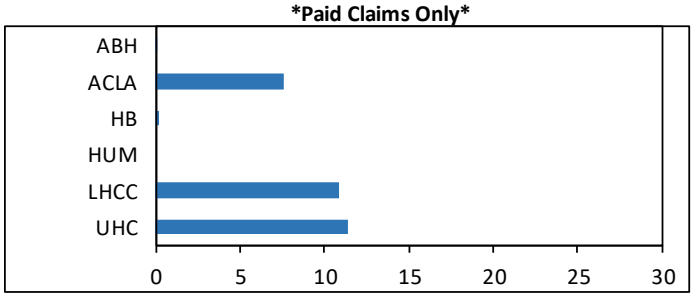
Claims Turnaround Time Most Recent 4 Qtrs All MCEs

Paid Claims Only

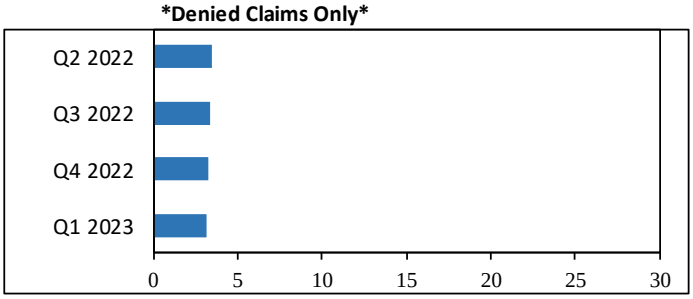


Claims Turnaround Time Quarter Q1 2023 only Each MCE

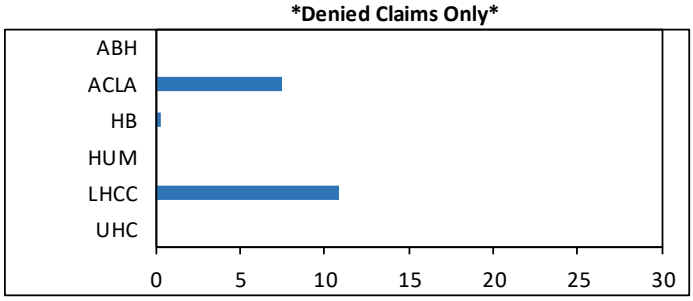
Paid Claims Only



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 2023 only)

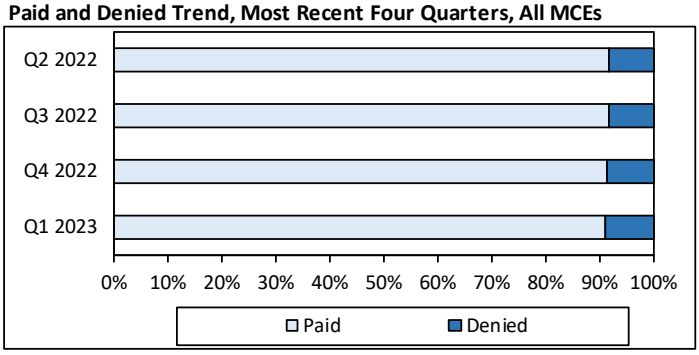
	ABH		ACLA		HB		HUM		LHCC		UHC	
	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied	# Providers	# >10% denied
<100 claims	19,274	14,255	1,382	1,369	3,902	0	0	0	14,086	13,696	21,328	18,023
101 - 250	2,034	2,004	363	358	474	0	0	0	3,771	3,755	4,443	4,440
> 250 claims	146	145	698	692	581	0	0	0	1,239	1,238	1,685	1,685

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

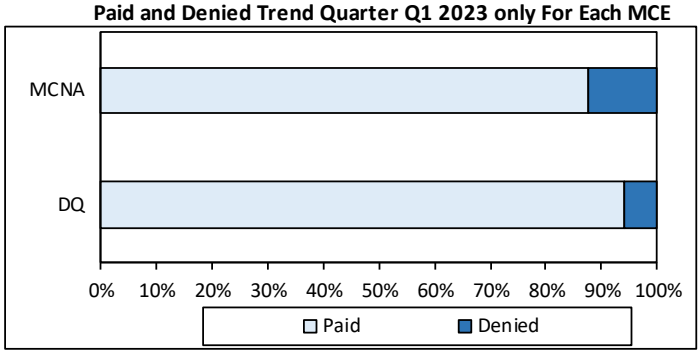
NCDCP Code	Description	ABH	ACLA	HB	HUM	LHCC	UHC
79	Refill Too Soon	X	X			X	
88	DUR Reject Error		X			X	X
76	Plan Limitations Exceeded					X	X
7Ø	Product/Service Not Covered – Plan/Benefit Exclusion	X	X			X	X
75	Prior Authorization Required	X				X	

Summary of Information on Claims for Dental Services- Children

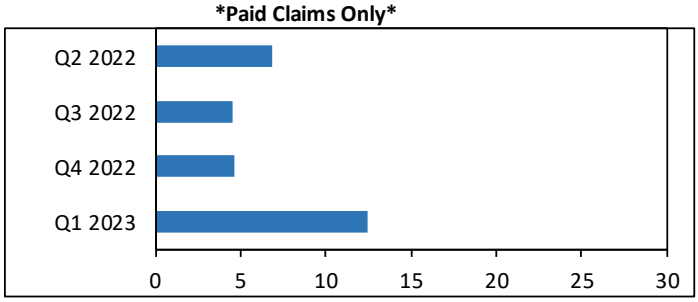
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



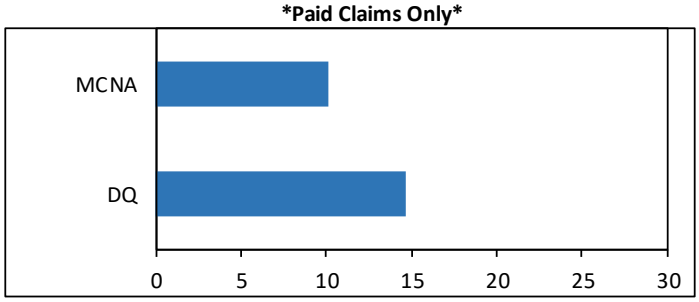
Paid and Denied Trend Quarter Q1 2023 only For Each MCE



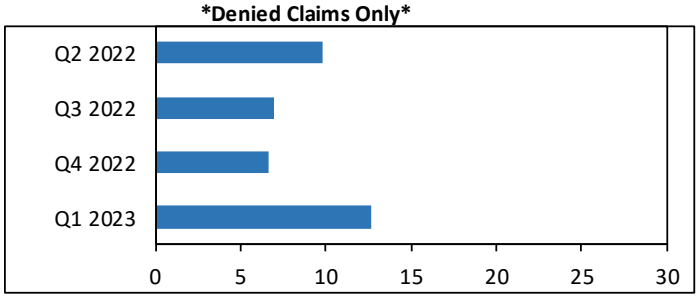
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



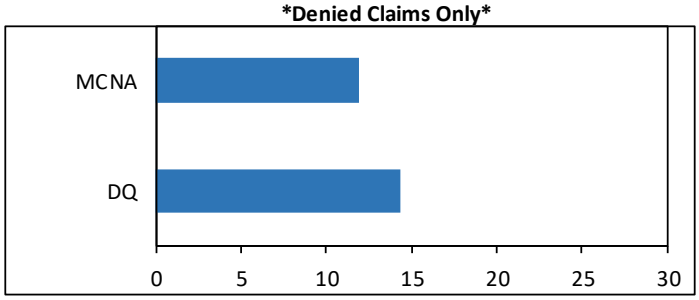
Claims Turnaround Time Quarter Q1 2023 only Each MCE
Paid Claims Only



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 2023 only)

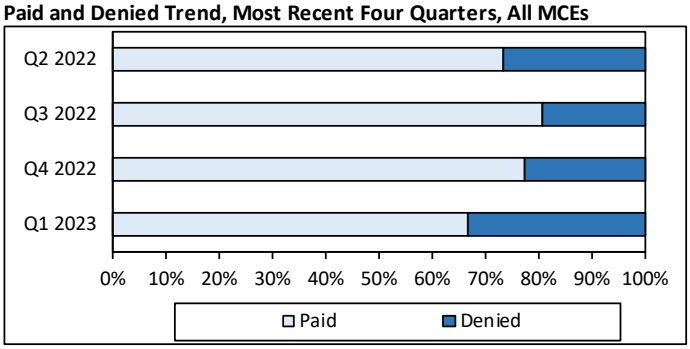
	MCNA		DQ	
	# Providers	# >10% denied	# Providers	# >10% denied
<100 claims	721	442	0	0
101 - 250	131	83	0	0
> 250 claims	10	9	0	0

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

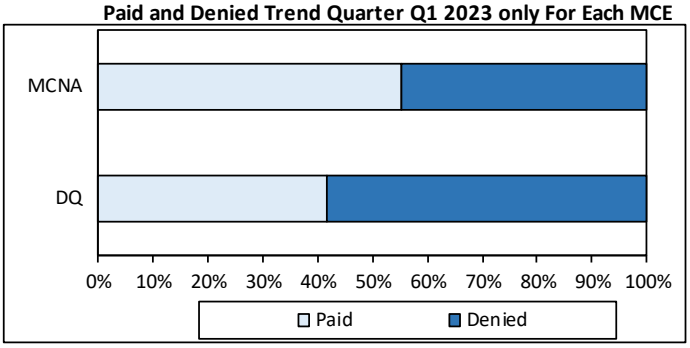
CARC Code	Description	MCNA	DQ
A1	Claim/Service denied.		X
229	Partial charge amount not considered by Medicare due to the initial claim Ty	X	
20	This injury/illness is covered by the liability carrier.	X	
144	Incentive adjustment, e.g. preferred product/service.	X	
172	Payment is adjusted when performed/billed by a provider of this specialty.	X	

Summary of Information on Claims for Dental Services- Adults

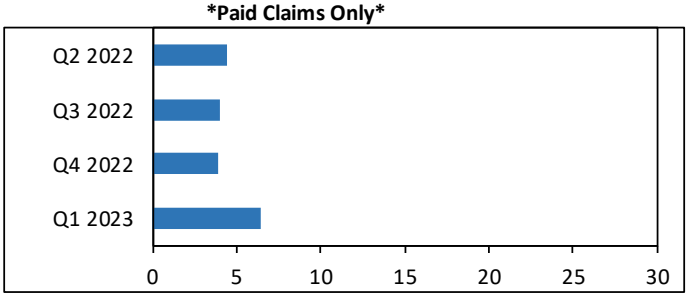
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



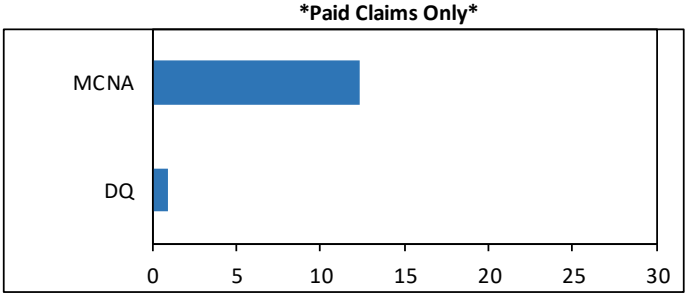
Paid and Denied Trend Quarter Q1 2023 only For Each MCE



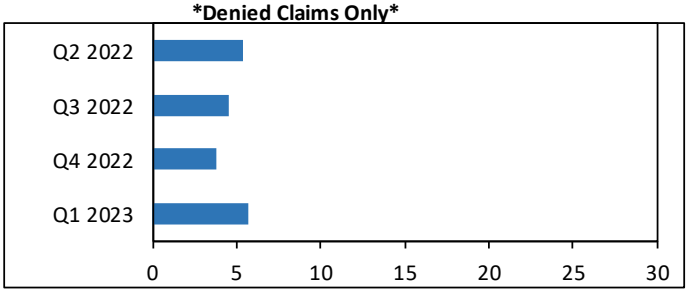
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



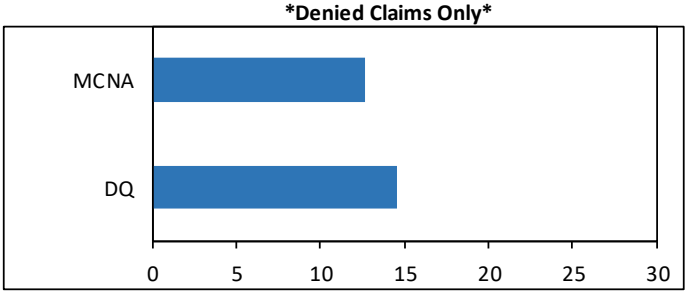
Claims Turnaround Time Quarter Q1 2023 only Each MCE
Paid Claims Only



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 2023 only)

	MCNA		DQ	
	# Providers	# >10% denied	# Providers	# >10% denied
<100 claims	340	325	203	79
101 - 250	6	6	221	38
> 250 claims	0	0	17	5

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

CARC Code	Description	MCNA	DQ
A1	Claim/Service denied.		X
22	This care may be covered by another payer per coordination of benefits.		
18	Exact duplicate claim/service		
119	Benefit maximum for this time period or occurrence has been reached.		
144	Incentive adjustment, e.g. preferred product/service.	X	

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