Healthy Louisiana Claims Report

Response to Act 710 of the 2018 Regular Legislative Session

Quarter 1 Calendar Year 2021

Prepared by:

Louisiana Department of Health

Bureau of Health Services Financing

October 2021

LOUISIANA DEPARTMENT OF HEALTH

Contents

Executive Summary

Background

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

The initial report covered claims paid during Calendar Year (CY) 2017 and was submitted to the legislature October 31, 2018. Subsequent reports are submitted on a quarterly basis. Each subsequent report shows the most recent four quarters of data available. This report covers Quarters 2, 3, 4 of CY 2020 and Quarter 1 of CY 2021.

Beginning with this report for CY 2021, LDH assumed the responsibility for the ongoing data collection, analysis and trending of these measures. As such the report is now integrated into a single document, utilizing the methodology and templates originally developed by the contracted vendor, Burns & Associates.

Report Contents

The report contains data from seven managed care entities (MCEs) that are under contract with Louisiana Medicaid. This includes the five full-risk health plans currently under contract to provide acute care, behavioral health and pharmacy services, as well as, two dental benefit program managers (DBPM) under contract to deliver dental benefits only.

Plan Name	Plan Type	Common Abbreviation
Aetna Better Health, Inc.	Managed care organization	ABH
Amerihealth Caritas Louisiana, Inc.	Managed care organization	ACLA
Healthy Blue	Managed care organization	HBL
Louisiana Healthcare Connections, Inc.	Managed care organization	LHC
UnitedHealthcare of Louisiana, Inc.	Managed care organization	UHC
MCNA Insurance Company, Inc.	Dental benefit program manager	MCNA
DentaQuest (contracted 1/1/2021)	Dental benefit program manager	DQ

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

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

The key measures that are reported in each quarter include:

1. The percentage of claims submitted by providers that are accepted or rejected by the MCEs;
2. Of those claims accepted, the percentage of claims paid or denied by the MCEs;
3. The average time it takes each MCE to make the payment or denial decision on claims;
4. For those claims that are denied payment, the top reasons why the claims are denied;
5. The percentage of claims adjudicated (paid or denied) by the MCEs that are successfully submitted to LDH for use in the Medicaid data warehouse (at this point it is called an *encounter submission* to LDH);
6. The average time it takes each MCE to send its encounter submissions to LDH;
7. The number providers contacted by each MCE for education on claims submissions by mode of contact; and
8. The number of members eligible for case management (CM), the percent of eligible members enrolled in CM and the percentage of those enrolled in CM receiving one or more CM service/contact during the quarter.

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

Key Findings

Measure #1: Claims Accepted and Rejected by the MCEs

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

Measure #2: Claims Paid and Denied by the MCEs

- The overall rate of paid claims accepted by the MCEs was between 80.2% and 81.9% in the most recent four quarters. The denial rates, therefore, were between 18.1% and 19.8%.

- At the MCE-specific level, the average denial rate for the 5 health plans in the last four quarters was from a range of 17.2% for ACLA to 23.7% for ABH.

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

- More variation was found when the claims denial rates were examined by provider type. For example, the highest denial rates are found for mental/behavioral health, other than rehab services (average 18.0% in the last four quarters) and pharmacy (average 27.9% in the last four quarters). The lowest denial rates are found for non-emergency medical transportation (average 3.2% in the last four quarters) and outpatient hospital services (average 9.5% in the last four quarters).

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

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

- The MCEs are meeting the target for adjudication within 30 days as set by LDH. In fact, the average TAT is below 10 days in each of the last four quarters for all MCEs.
- The overall TAT for paid claims, all MCEs combined, is between 7.7 and 8.0 days in each quarter. For denied claims, the average is between 5.8 and 6.3 days.
- Claims adjudication average TATs do vary by provider category, but not significantly, from the overall average.

Measure #4: Top Reasons for Denied Claims

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

Key findings by CARCs:

- In Q1 2021, ACLA and UHC had its top five CARCs within the top 10 CARCs statewide. ABH and LHC had four, MCNA had three, while HBL and DQ had two of its top five CARCs in the statewide top 10.
- The top five CARCs were also among the top seven in the previous ten quarters reported.

Key findings on NCPDPs appear below:

- In Q1 2021, every MCE except ABH had their top five NCPDP codes also in the top 10 for all MCEs (ABH had four of its five).
- These five NCPDPs were also among the top six in the previous eight quarters reported.

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

- In the most recent four quarters studied, 96.5% to 98.2% of the encounters submitted by all MCEs combined were accepted by LDH.
- There were differences at the MCE level. All of UHC's and almost all of HBL's, LHC's and MCNA's encounters were accepted. ACLA had at least 95% of their encounters accepted for the previous three quarters, but with 86% for the current quarter, however, ABH and DQ had some challenges, where 84% to 89% encounters were accepted. ACLA's drop in the rate of accepted encounters can be attributed to filing encounters at the header level instead of the claim line level.

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

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

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

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

- There is greater variation in the timeliness of pharmacy encounter submissions. ACLA had 100% timeliness within 30 days in all four current quarters. HBL and UHC had few pharmacy encounters submitted after 30 days in every quarter. ABH and LHC consistently are lowest on pharmacy encounter timeliness—ABH usually near 70% untimely, and LHC has varied from 65% to 76% untimely in the last four quarters.

- MCNA had few issues meeting an average 30-day TAT for its dental encounters in the first three quarters of 2020, however, they did have issues for Quarter 4 2020 but improved for quarter 1 2021. DentaQuest, has 56% encounters submitted within the timeline.

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

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

In Q1 2021, a total of 1,546 provider entities were outreached to (1,227 in the prior quarter). The most predominant mode to outreach to providers is 1:1 emails (50.6% of all contacts) followed by 1:1 phone calls (46.2% of contacts). Webinars were 3.2 percent of the total. In-person contact was not done due to the pandemic.

Measure #8: Case Management

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

In Q1 2021, a total of 44,118 unduplicated individuals enrolled in the Louisiana Medicaid Managed Care program were identified as potentially eligible or in need of case management services. Of these 25% or 11,073 were enrolled in case management for at least one month during the first quarter of CY 2021 and 7,974 (72%) actively received one or more case management services.

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. Subsequent reports are required to be submitted on a quarterly basis. Each subsequent report must cover a more recent three-month period than the previous report. This is eleventh report update.

Report Update	Calendar Year 2018				Calendar Year 2019				Calendar Year 2020				Calendar Year 2021			
	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			

Required Reporting for the Initial Report

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

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

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

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

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

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

Steps in Claims Processing and Encounter Submissions

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

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

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

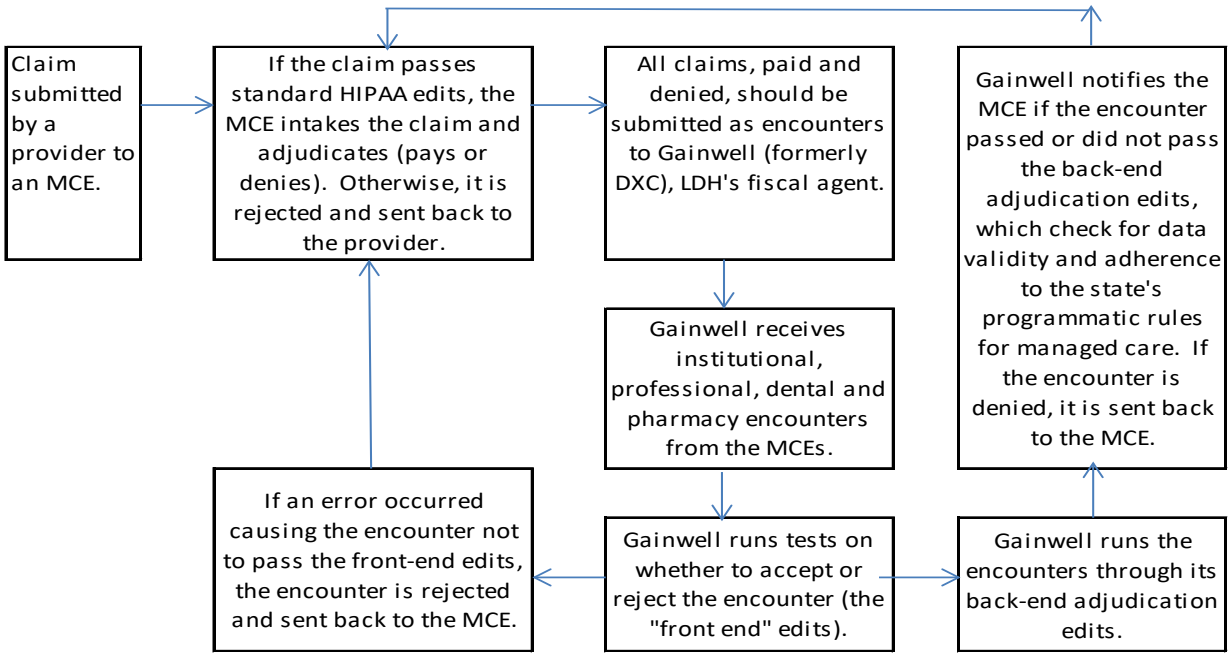
- The *CMS-1500, or electronic 837P*, is the claim type for professional service providers to submit. This includes a wide array of providers such as physicians, clinics, mental health providers, therapists, transportation providers, suppliers of medical equipment and supplies.

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

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

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

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



Terminology Used in this Report

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

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

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

When a claim is submitted to a payer, there are standards that must be upheld such as the minimum information that is required, the valid values to put in fields, etc. The Health Insurance Portability and Accountability Act (HIPAA) mandated the minimum criteria required on claims submissions. As a result, claims processors conduct "front-end" edits upon receipt of a claim to ensure that the claim passes "the HIPAA edits". If a claim does not pass these front-end edits, the claim is flagged as a *rejected claim*. Typically, there is little information retained by payers on rejected claims.

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

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

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

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

At the detail level, however, the status could be paid or denied, and the status of the individual detail line may differ from the header status. For example, a professional claim contains five service lines. The first four are paid. The fifth service is denied. Each service line will have its own claim status, but the header claim status will be paid. It is important to factor this information in when analyzing claims and claim trends. The count of header lines may be a fraction of the total detail service lines.

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

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

The *turnaround time* factors in any time that a claim is pended. This is the term used to describe the length of time it takes for payers to adjudicate claims. In this study, the average turnaround time

represents the time from receipt of the claim by the MCE to the time of notification to the provider (pay or deny).

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

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

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

Trends Found in Prior Report Releases

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

Claim Rejection Rate	1.1% to 1.4% of claims submitted by providers are rejected by the MCEs.
Claim Payment Denial Rate, Overall	From a low of 17.5% to a high of 19.8%
For Hospital Claims Denial Rate	Much higher for inpatient hospital services (17.2%-22.9%), but outpatient hospital services have one of the lowest denial rates of any service category (8.4%-10.6%). Inpatient denial rates have been going down around 4% in recent four quarters.
For Professional Services	The denial rate range has been steady between 11% and 14%
For Dental Claims	For child dental services, denial rate has been steady between 7% and 9% before Quarter 2, 2020, while steadily increasing to 13% for current 3 quarters.
For Pharmacy Claims	Industry standard is that pharmacy scripts have highest denial rate. LDH is no exception with a denial rate range between 26% and 30%. This is a result of pharmacy claims being a Point of Sale system.
Turnaround Time to Process Claims	The time for MCEs to process provider claims has been steady in every report, from 7.7 days to 8.4 days.
Time for MCEs to Submit Claims as Encounters to LDH	There is variation in the timeliness for the MCEs to submit encounters to LDH. This can vary by MCE and by quarter. Generally, HBL is most consistently timely (that is, all encounters submitted to LDH within 30 days of processing). LHC and UHC submit over 90% of their encounters within 30 days.

Section II: Construct of the Quarterly Report

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

The MCEs analyzed in this review include:

- Aetna Better Health (ABH)
- Amerihealth Caritas Louisiana (ACLA)
- Healthy Blue (HBL)
- Louisiana Healthcare Connections (LHC)
- UnitedHealthcare (UHC)
- Managed Care of North America (MCNA), for dental services only
- DentaQuest (DQ), for dental services only (contracted since January 1, 2021).

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

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

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

Reporting Structure

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

In some exhibits, data is displayed for the most recent four quarters. In this report, the four quarters shown are Quarters 2, 3 and 4 in 2020 and Quarter 1 in 2021. 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 2021 data.

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

Limitations of the Data

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

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

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

    Because of these limitations, the value of denied claims should be reviewed with caution. The Department urges that the 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.

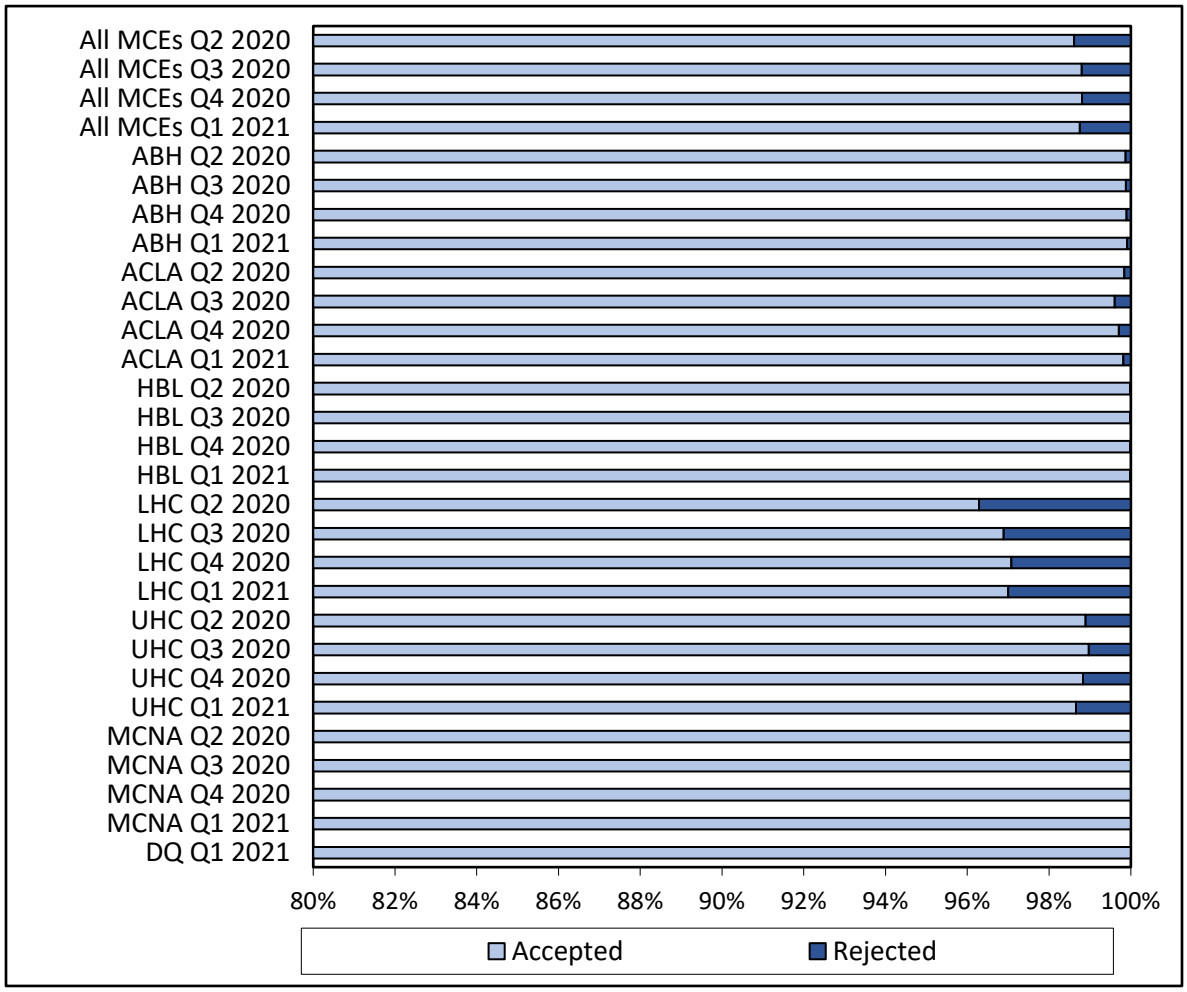
Section III: Findings Related to MCE Claims Adjudication

LDH's contracted MCEs or their subcontractor adjudicates all provider claims submitted. 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 adjudicates all of the dental claims for the Medicaid program.

Claims Accepted and Rejected by the MCEs

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

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

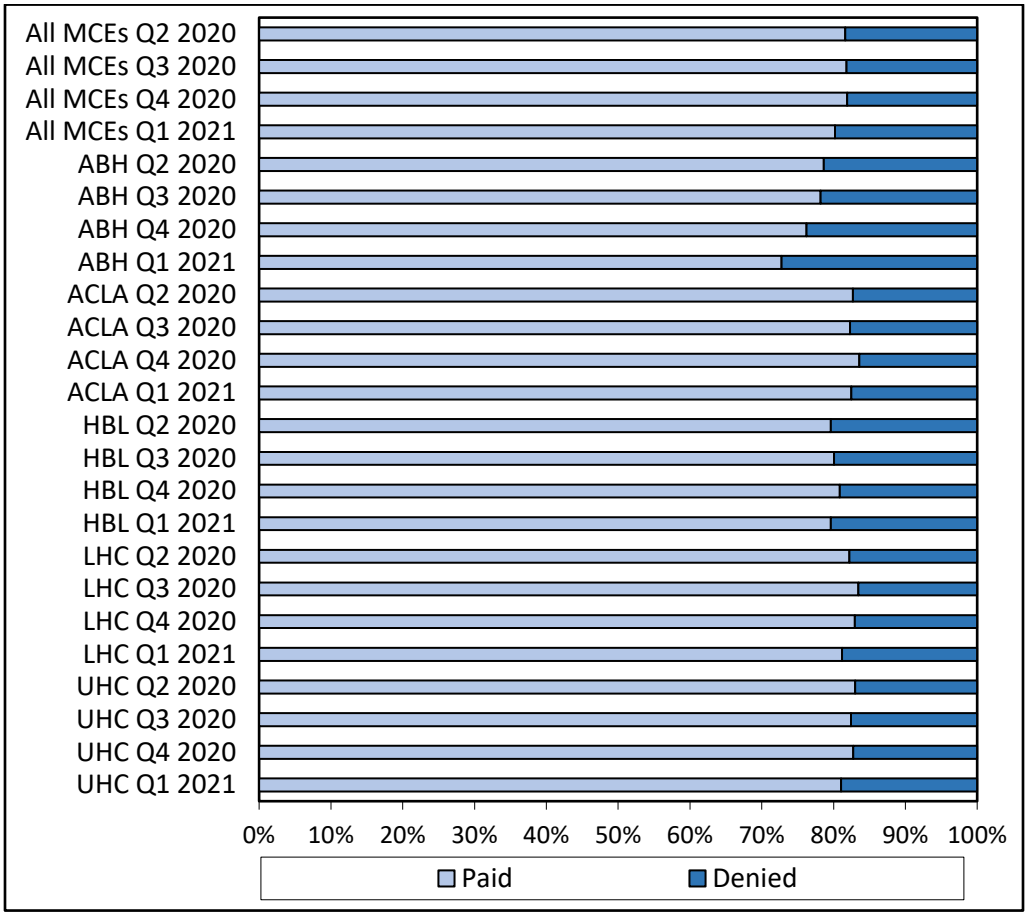


Claims Paid and Denied by the MCEs

For those claims that were accepted into the MCE's claims adjudication system, on average, the overall rate of paid claims was between 80.2% and 81.9% in the most recent four quarters. The denial rates, therefore, were between 18.1% and 19.8%. These denial rates have remained fairly steady since the Act 710 quarterly update reports have been release.

At the MCE-specific level, the range across the four-quarter averages was from an average denial rate of 17.2% for ACLA to an average rate of 23.7% for ABH. The denial rates are not going down in any significant manner since the original report showing CY 2017 data. These statistics exclude MCNA dental claims, which can be found in Exhibit III.4 in the categories Dental – Children and Dental – Adult.

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



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

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

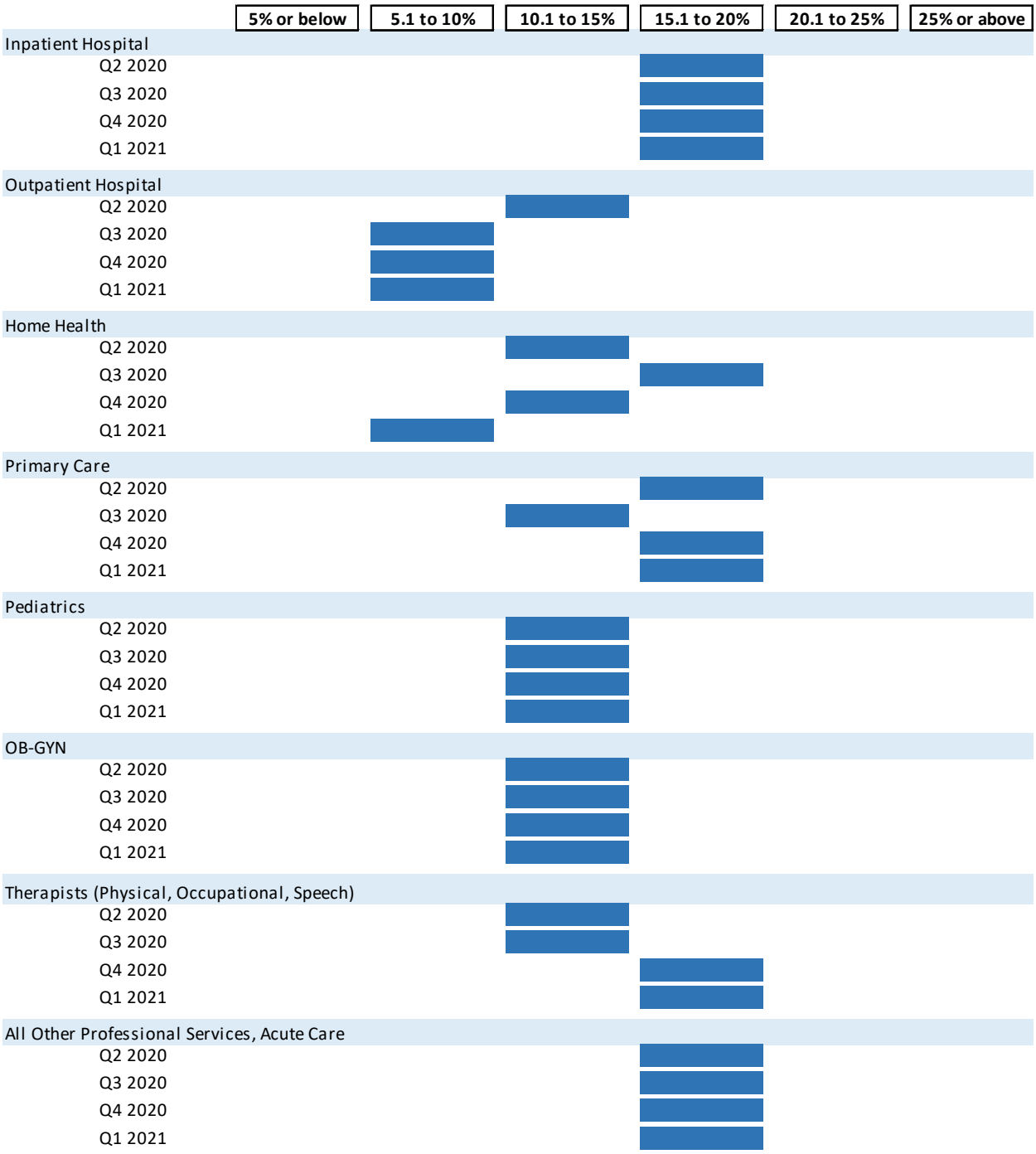


Exhibit III.4
Claim Denial Rates for Non-Acute Care Services
For All MCEs Combined by Quarter

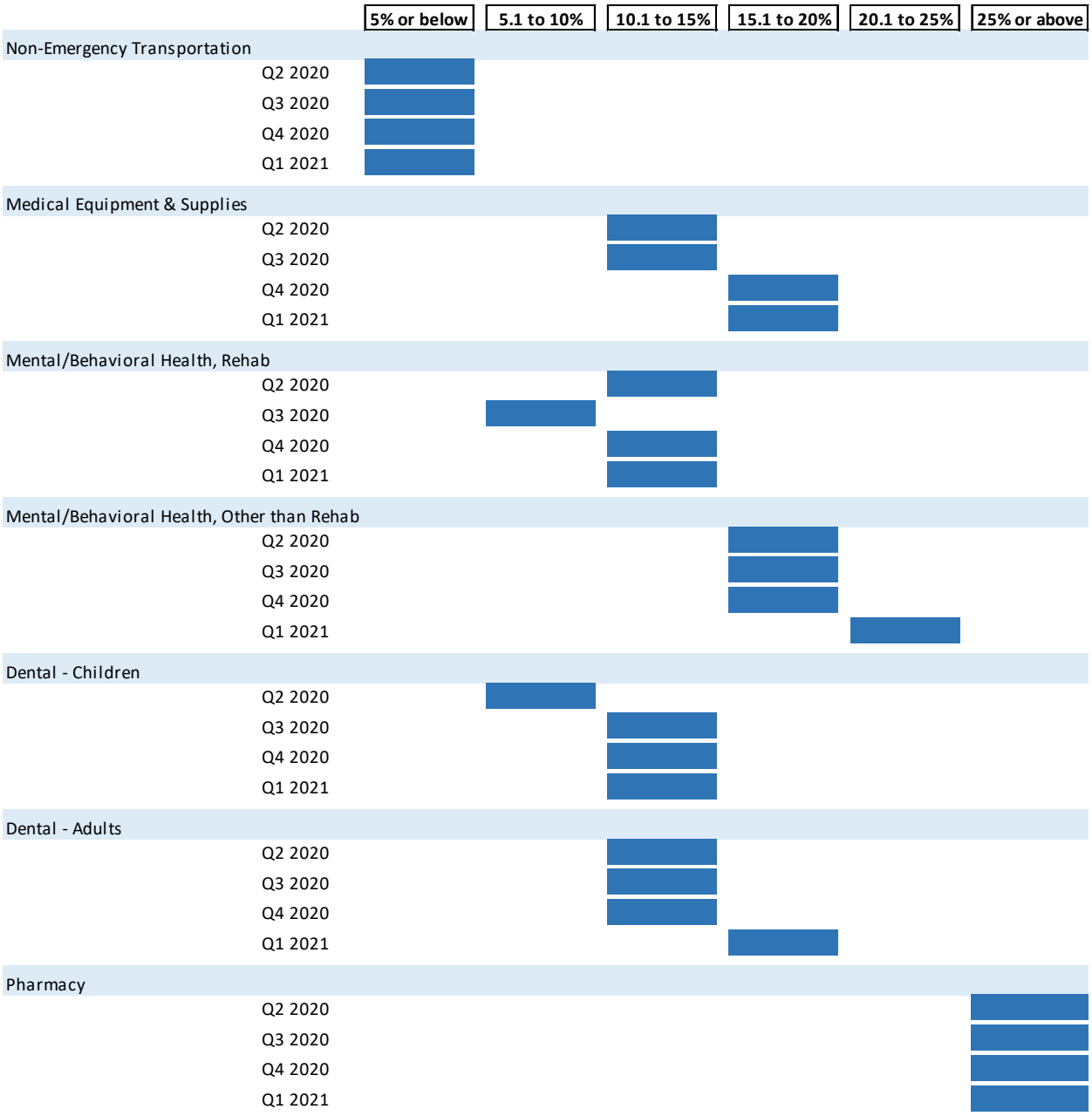
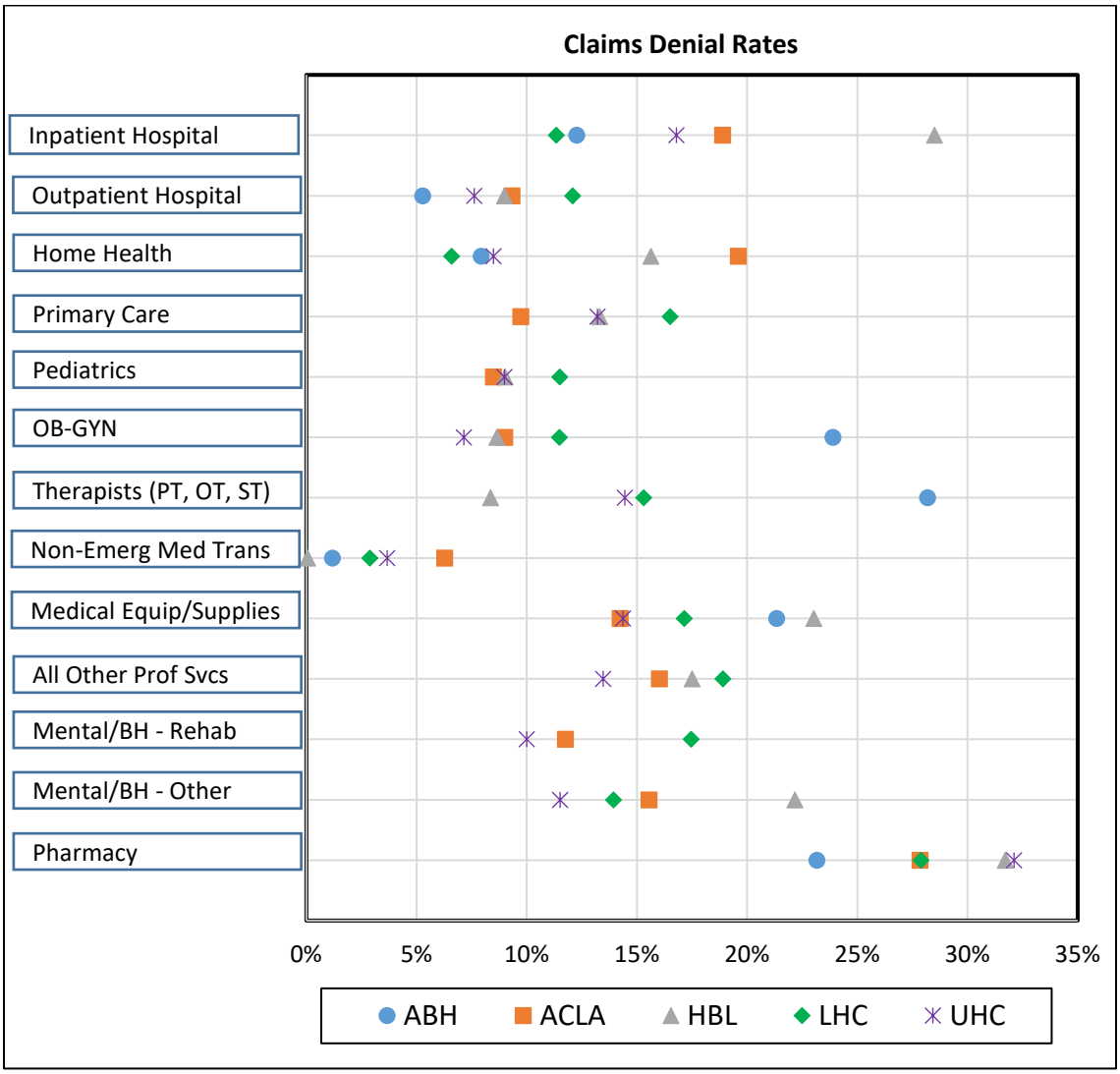


Exhibit III.5 compares the denial rates for these service categories by MCE. The data plotted on this exhibit is the percentage of claims denied in Quarter 1 of CY2021 for each MCE. An icon and color is used to display each MCE's data. Each row in the exhibit represents a specific service category. For example, in the top line of the exhibit, the overall denial rate for inpatient hospital services in Q1 2021 was 17.6%, but this varied from 11.3% for LHC to 28.5% for HBL.

The claims denial rate is clustered for outpatient hospital, pediatrics, and NEMT. For other services, the denial rates vary significantly by MCE (e.g., home health, mental/behavioral health services). In other categories, most MCEs have a similar rate, but ABH (e.g., OB-GYN, therapies) and HBL (e.g., inpatient, mental/behavioral health) vary from all of their peers.

Exhibit III.5
Claim Denial Rates for Adjudicated Claims
by Provider Specialty / Service Category
by MCE for Q1 2021



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

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

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

Because there is such a variety of denial reasons that are based on the circumstances of each claim, it is not appropriate to unilaterally assume that every denied claim could have been paid or should have been paid. With this in mind for the initial report, B&A developed a model to tabulate the information on denied claims from each MCE and assigned a value to each denied claim without inferring if the claim could have been paid or should have been paid. Medicaid Business Analytics continues to use this model for the quarterly updates.

To do this, each of the provider specialties was examined separately. Within each category, the MCE reported the number of claims paid and the total payments made. An average payment per claim was computed. Then, 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.

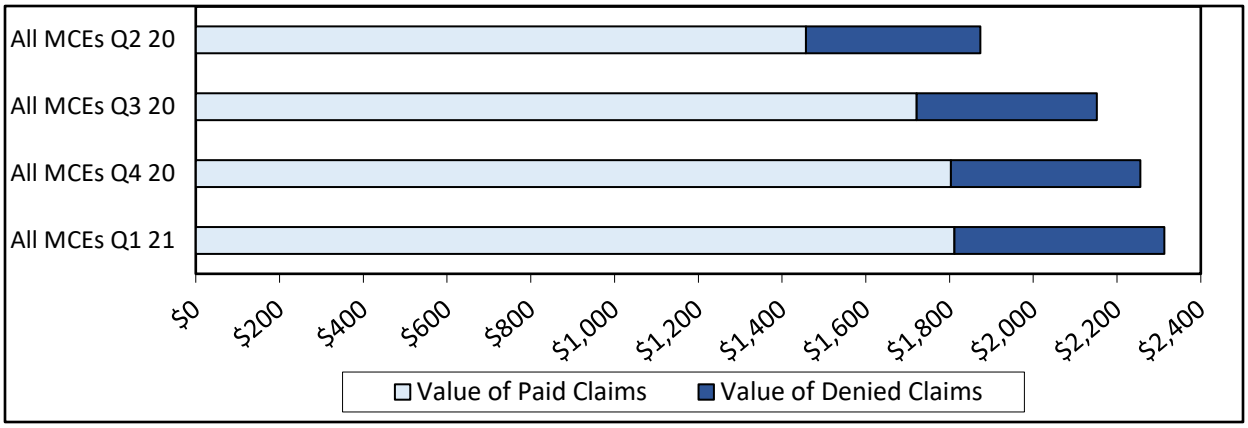
It is important to apply this formula at the provider specialty level (as opposed to all claims combined) due to the wide range of reimbursement paid to each provider type. For example, in Q1 2021, the average payment for paid inpatient hospital claims was $6,542; for primary care, it was $44.

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

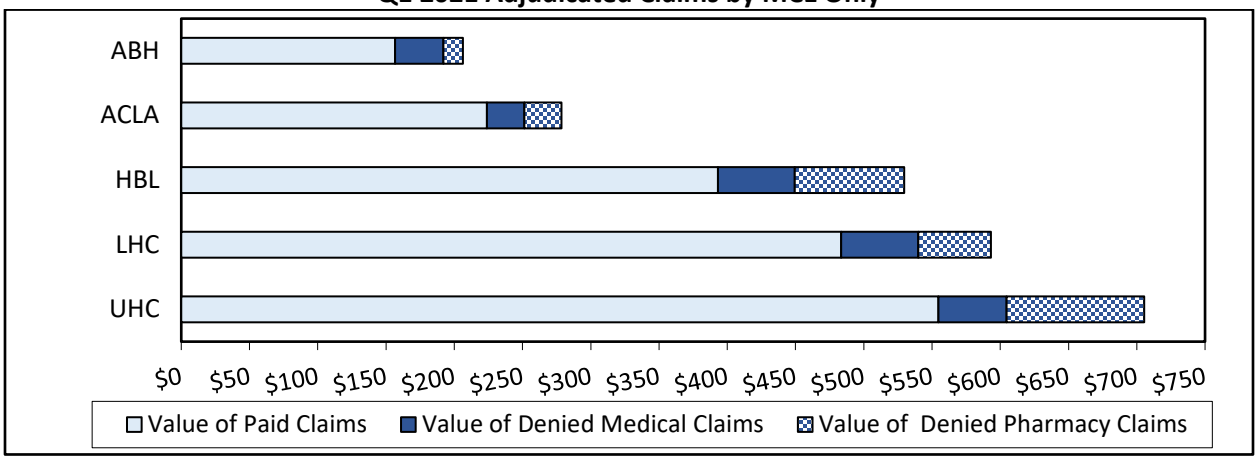
Exhibit III.6 summarizes the total dollar values of paid claims and denied claims by MCE and by quarter. The denied claims account for between 20.0% and 22.2% of the sum of paid and denied values each quarter. This equates to between $416 million and $501 million. Among the $501 million in denied values in Q1 2021 assigned across the five MCEs that provide medical and pharmacy benefits, $225 million (45.0%) was attributed to medical claims and $275 million (55.0%) was attributed to pharmacy claims. In Q1 2021, the distribution of assigned values to denied claims by MCE was as follows:

- ABH had 71% medical and 29% pharmacy claims
- ACLA had 51% medical and 49% pharmacy claims
- HBL had 41% medical and 59% pharmacy claims
- LHC had 51% medical and 49% pharmacy claims
- UHC had 33% medical and 67% pharmacy claims

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



Q1 2021 Adjudicated Claims by MCE Only



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

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

The data submitted by the MCEs was then examined to determine if, for example, a higher proportion of providers with high Medicaid volume had high denial rates compared to those with low Medicaid volume. High denial rate was defined as any provider that had more than 10% of their claims denied by the MCE in the quarter. Statistics were then run to determine what percentage of providers within each group had a high claims denial rate (that is, more than 10%). With 14 provider specialties (excluding dental) and three groupings within each specialty (low volume, medium volume, high volume), there can be as many as 42 provider/volume groupings to examine.

These are then examined for each of the five MCEs (excluding dental services paid by MCNA and DentaQuest), so 42 groupings for five MCEs is 210 groupings. The other two provider specialties are specific to dental, so this adds 12 more groupings. That means a total of 222 groupings were examined for each quarter.

Each of the 222 groupings are reviewed for whether more than half of the providers within the group had a claims denial rate above 10%. There were many provider/volume combinations where the volume of providers was too small (five or less) to make an assessment.

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

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 2020	93	93	30	216
Q3 2020	95	91	30	216
Q4 2020	95	91	30	216
Q1 2021*	96	92	34	222

*Due to a new dental plan DentaQuest joined from Q1, 2021, 6 more groups were added.

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

Timeliness of Claims Adjudication by the MCEs

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

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

Exhibit III.8

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

		Adjudicated Within 30 days		Avg Turnaround Time	
		Pct of Paid	Pct of Denied	Paid Claims	Denied Claims
ABH	Q2 2020	99.7%	99.0%	8.3	6.0
	Q3 2020	99.7%	99.4%	8.0	5.6
	Q4 2020	99.5%	99.2%	8.0	6.1
	Q1 2021	99.3%	99.3%	8.5	6.2
ACLA	Q2 2020	100.0%	99.9%	5.4	6.5
	Q3 2020	100.0%	100.0%	5.7	7.2
	Q4 2020	100.0%	100.0%	5.5	7.4
	Q1 2021	100.0%	99.8%	5.7	7.5
HBL	Q2 2020	99.0%	98.7%	6.8	4.3
	Q3 2020	99.7%	98.3%	7.2	6.1
	Q4 2020	99.7%	99.2%	7.1	4.6
	Q1 2021	99.8%	99.1%	6.3	5.5
LHC	Q2 2020	99.8%	99.4%	9.0	9.6
	Q3 2020	100.0%	99.9%	8.5	9.2
	Q4 2020	99.9%	99.8%	8.5	9.2
	Q1 2021	99.9%	99.6%	8.4	9.6
UHC	Q2 2020	99.9%	99.5%	8.6	3.2
	Q3 2020	100.0%	100.0%	8.0	2.7
	Q4 2020	99.8%	99.9%	8.9	2.8
	Q1 2021	99.7%	99.8%	9.1	2.8
MCNA	Q2 2020	100.0%	100.0%	3.5	6.5
	Q3 2020	99.9%	99.7%	7.4	9.0
	Q4 2020	100.0%	100.0%	8.6	10.1
	Q1 2021	100.0%	100.0%	9.9	10.9
DQ	Q1 2021	100.0%	100.0%	5.7	5.9
ALL MCEs	Q2 2020	99.7%	99.3%	7.8	5.9
	Q3 2020	99.9%	99.5%	7.7	6.0
	Q4 2020	99.8%	99.7%	8.0	5.8
	Q1 2021	99.8%	99.6%	7.8	6.3

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

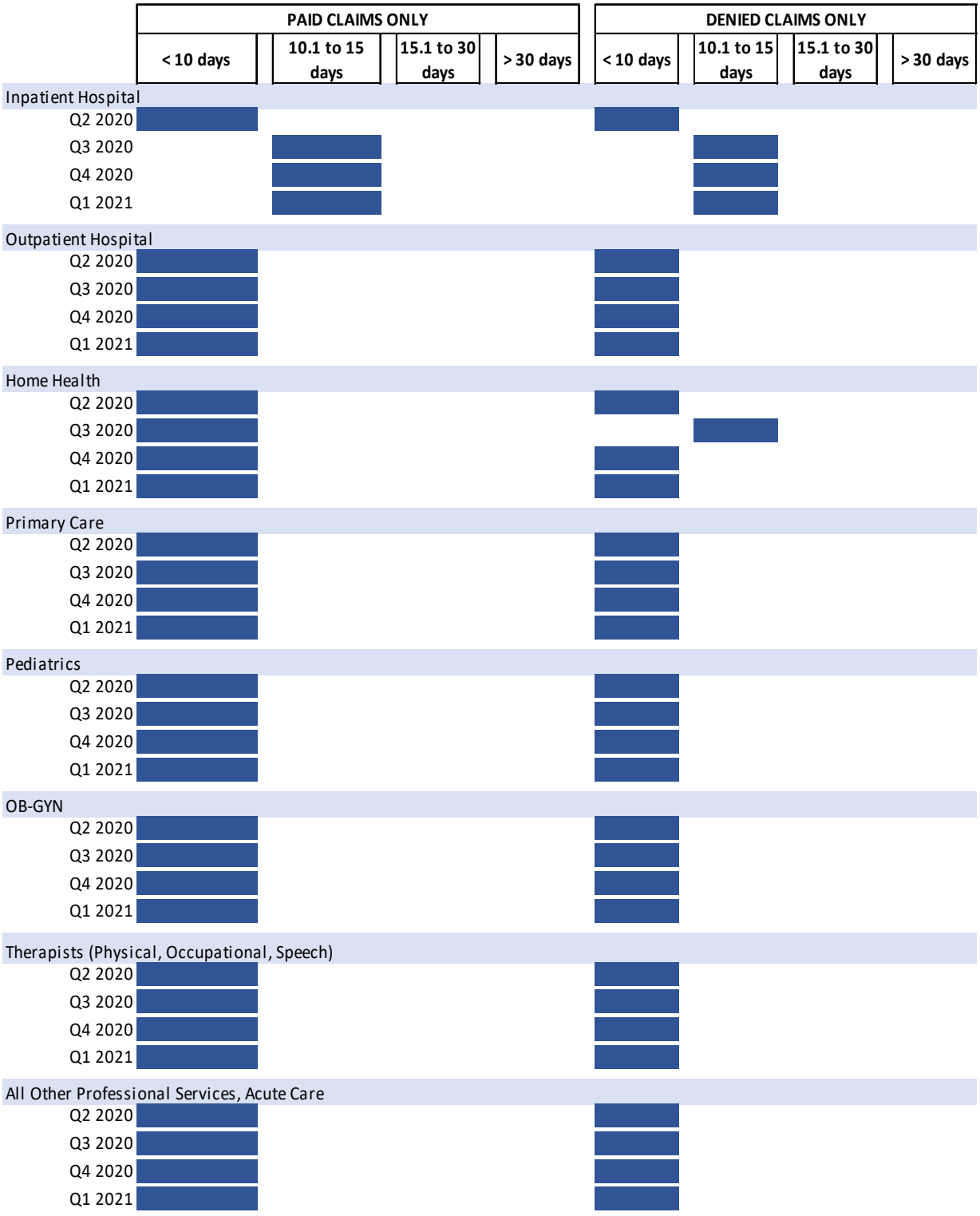


Exhibit III.10

Turnaround Time for Claims Processing of Adjudicated Non-Acute Care Claims (using average days)

For All MCEs Combined, By Quarter

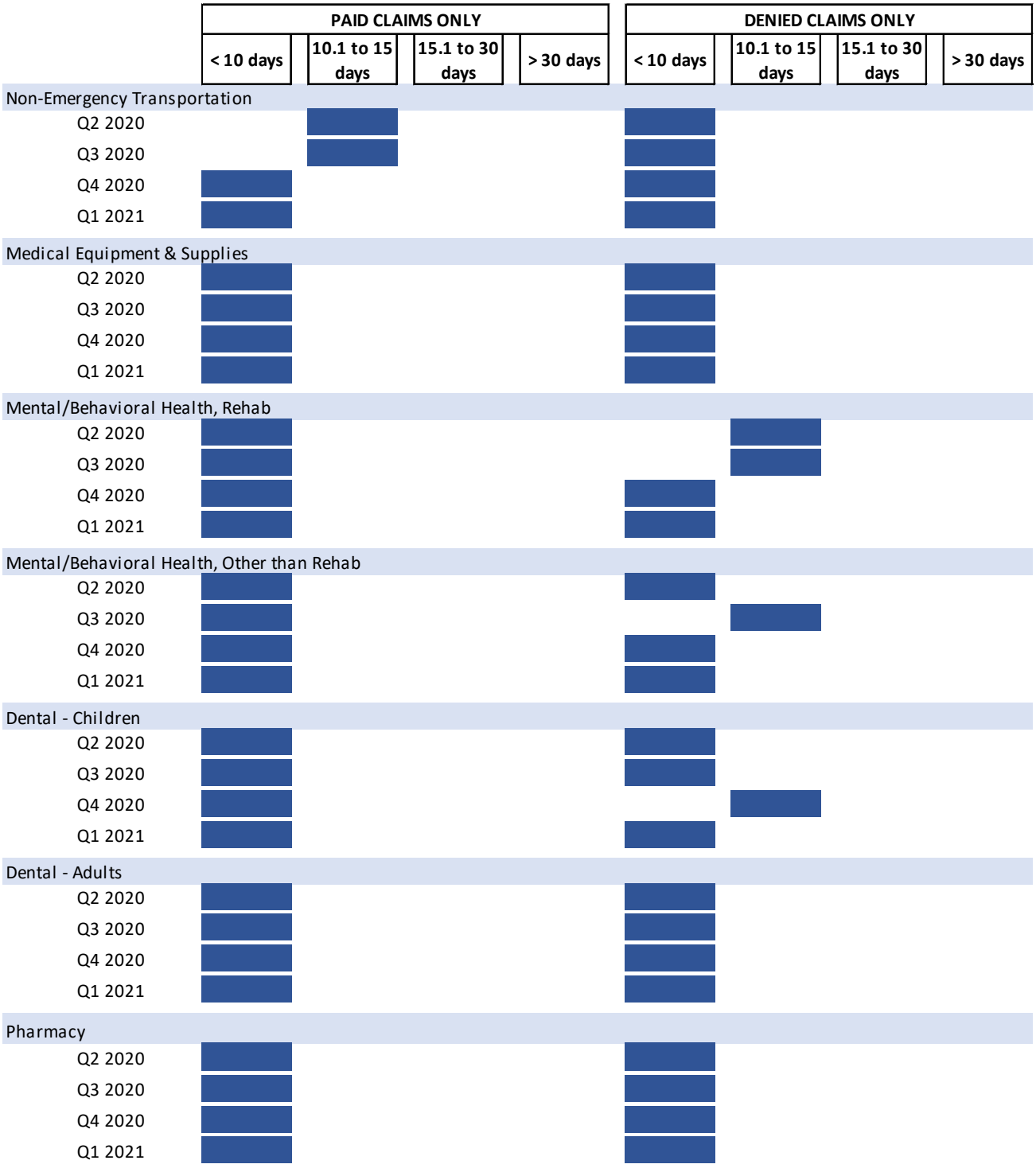
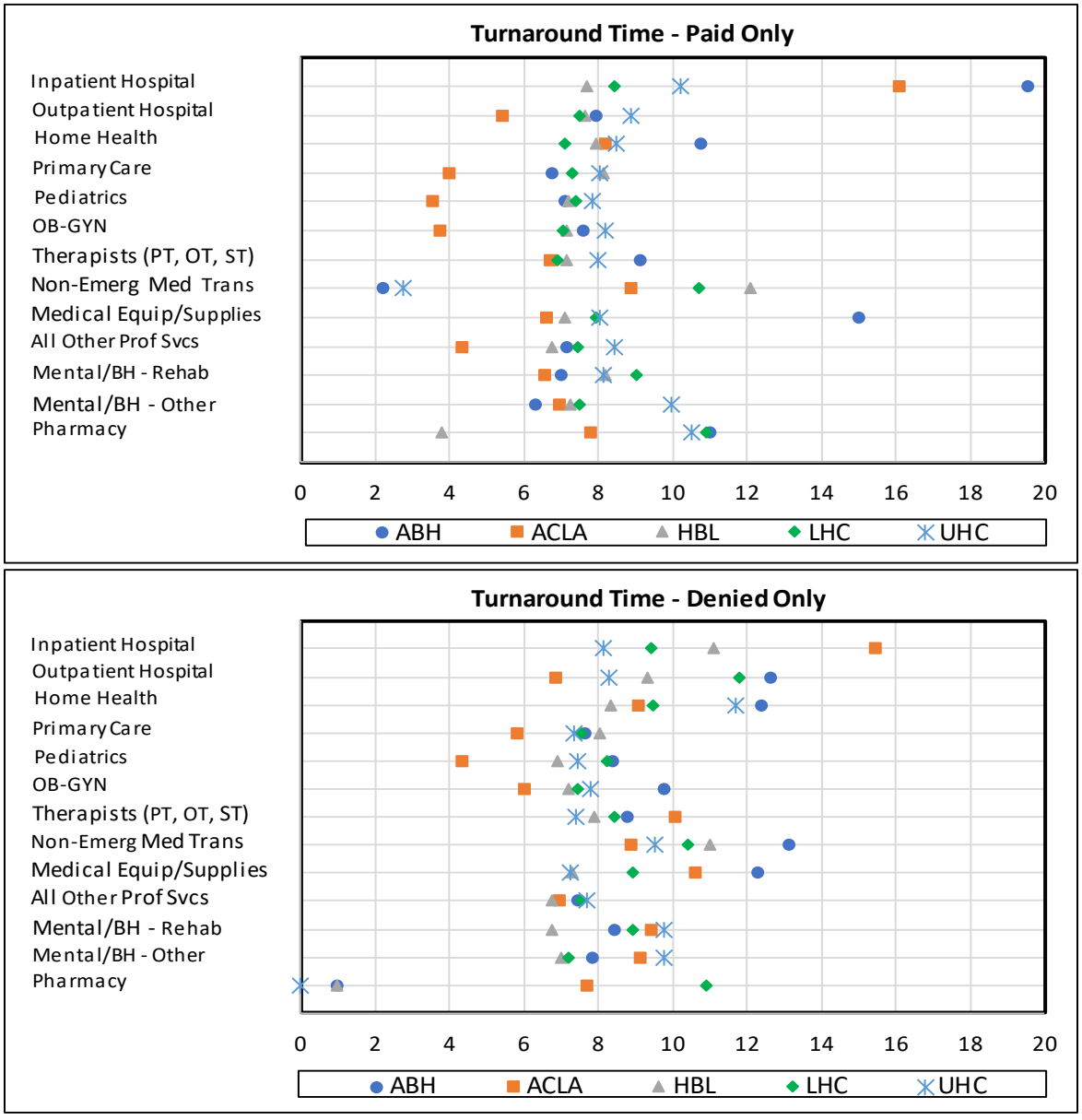


Exhibit III.11 below further breaks down the average paid and denied TAT statistics in Q1 2021, but the results are shown for each MCE within a service category. The top box shows the variation in TAT for paid claims only; the bottom box shows the results for denied claims only. The purpose of this exhibit is to determine if the TAT is consistent across MCEs or if it varies.

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

Exhibit III.11

Average Turnaround Time, Paid and Denied Claims, by Service Category
By MCE for Q1 2021 Adjudicated Claims



Reasons for Claim Denials by the MCEs

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

The MCEs report to LDH the occurrence of each CARC or NCPDP code on adjudicated claims. For denied claims, the count of each CARC or NCPDP code was tabulated by MCE for claims adjudicated in Quarter 1 of CY 2021.

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 2021, ACLA and UHC had their top five CARCs within the top 10 CARCs statewide. ABH and LHC had four, MCNA had three, while HBL and DentaQuest had two of their top five CARCs in the statewide top 10.
- The top five CARCs in Q1 2021 included the following:
    - 96: Non-covered charge.
    - 16: The claim lacks information or has a billing error which is needed for adjudication.
    - 18: Exact duplicate claim.
    - 97: The benefit for this service is included in the payment for another service already adjudicated.
    - 197: Precertification or authorization absent when it is required.

- These five CARCs were also among the top seven 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 2021, every MCE except ABH had their top five NCPDP codes also in the top 10 for all MCEs (ABH had four of its five).
- The top five NCPDPs in Q4 2020 included the following:
    - 79: Refill too soon
    - 88: Drug Utilization Review (DUR) reject error
    - 76: Plan limitations exceeded
    - 75: Prior authorization required
    - 7O: Product/service not covered – plan/benefit exclusion

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

Exhibit III.12
Details on Reasons for Denied Claims
By MCE for Q1 2021 Adjudicated Claims

For Medical Claims

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

For Pharmacy Claims

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

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

Exhibit III.13 shows the results when the top CARCs are distributed by provider type for each MCE for claims adjudicated in the Quarter 1 of 2021. Key findings from the exhibit are shown below:

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

- For ACLA, four of its five CARCs overall were also observed for almost every provider category as well. One CARCs (#B7) was only present for selected provider types.

- For HBL, two of its five CARCs overall were also observed for almost every provider category as well. Three CARCs (#242, #109 and #119) were only present for selected provider types.

- For LHC, three of its five CARCs overall were also observed for almost every provider category as well. Two CARCs (#B7 and #204) were only present for selected provider types.

- For UHC, four of its five CARCs overall were also observed for almost every provider category as well. One CARC (#197) was only present for selected provider types.

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

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

Exhibit III.13

Details on Reasons for Denied Medical Claims

By MCE and By Provider Category for Q1 2021 Adjudicated Claims

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

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

Exhibit III.13 (continued)

CARC	Description	Inpatient Hospital	Outpatient Hospital	Home Health	Other Institutional	Primary Care	Pediatrics	OB-GYN	Therapists	Non-Emerg Transport	Medical Equipment	Other Professional	Mental/Behavioral - Rehab	Mental/Behavioral - Other	Adult Dental	Pediatric Dental
LHC																
96	Non-covered charge(s).		1		4	1	1	3	3	2		3		5		
16	Claim/service lacks information or has submission/billing error(s) whic	3	4	2		3	5	2	1	1	3	1	1	3		
18	Exact duplicate claim/service	4	2	1	3	4	3	1	5	5	2	5	5	1		
B7	This provider was not certified/eligible to be paid for this procedure/serv			5		2	2	4	2			2				
204	This service/equipment/drug is not covered under the patient's current b	5		4	2						4					
UHC																
252	An attachment/other documentation is required to adjudicate this claim/		1	2	3	3	4	4		2	2	1	5	3		
96	Non-covered charge(s).		2	3	1	2	1	3	2	4	1	2				
97	The benefit for this service is included in the payment/allowance for ano	5	3	5		1	2	2	1	4	5	5				
197	Precertification/authorization/notification absent.			5		4			3	4		3	3	1		
18	Exact duplicate claim/service	3	4	1			3	1	4	4	4	4	2			
MCNA																
27	Expenses incurred after coverage terminated.														1	3
96	Non-covered charge(s).														2	1
18	Exact duplicate claim/service														3	2
169	Alternate benefit has been provided.														4	
119	Benefit maximum for this time period or occurrence has been reached.														5	
DQ																
18	Exact duplicate claim/service														1	1
204	This service/equipment/drug is not covered under the patient's current benefit plan														2	3
181	Procedure code was invalid on the date of service.														3	2
119	Benefit maximum for this time period or occurrence has been reached.														4	4
22	This care may be covered by another payer per coordination of benefits.														5	5

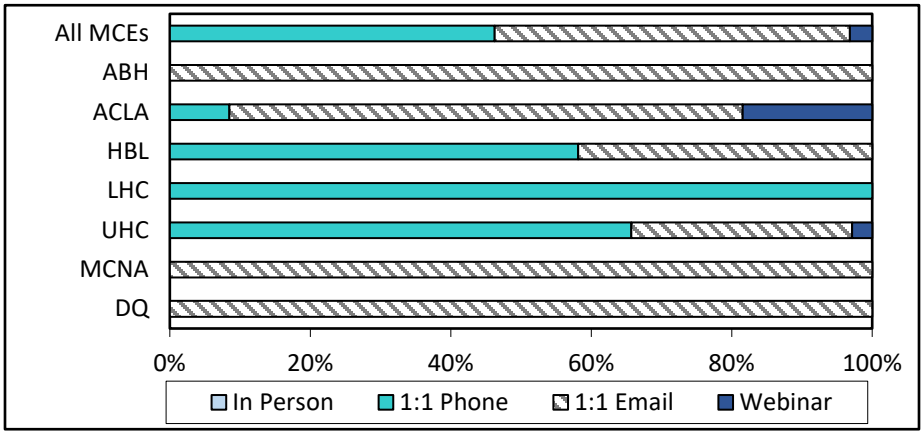
Provider Education Related to Claims Adjudication

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

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

Exhibit III.14 summarizes information on provider education conducted in Q1 2021. In all, 1,546 TINs were outreached to by the MCEs (1,227 last quarter). This count represents the unique TINs and modes of communication. In some cases, the MCE reported that they conducted multiple outreach efforts to the same TIN in the quarter (e.g., three emails over the course of six weeks). When this occurred, only one was counted below. It should also be noted, however, that the same TIN may be outreached to by multiple MCEs. Just over half of the outreach (50.6%) was conducted via 1:1 emails. This was followed by 1:1 phone calls (46.2% of total) and webinars (3.2% of total). In-person was not conducted due to the pandemic.

Exhibit III.14
Provider Education Conducted by the MCEs on Claims Submissions Activity in Q1 2021



	Modality of Outreach				
	In Person	**1:1 Phone**	**1:1 Email**	**Webinar**	**Total TINs**
All MCEs	0	715	782	49	1,546
ABH	0	0	68	0	68
ACLA	0	22	190	48	260
HBL	0	93	67	0	160
LHC	0	577	0	0	577
UHC	0	23	11	1	35
MCNA	0	0	379	0	379
DQ	0	0	67	0	67

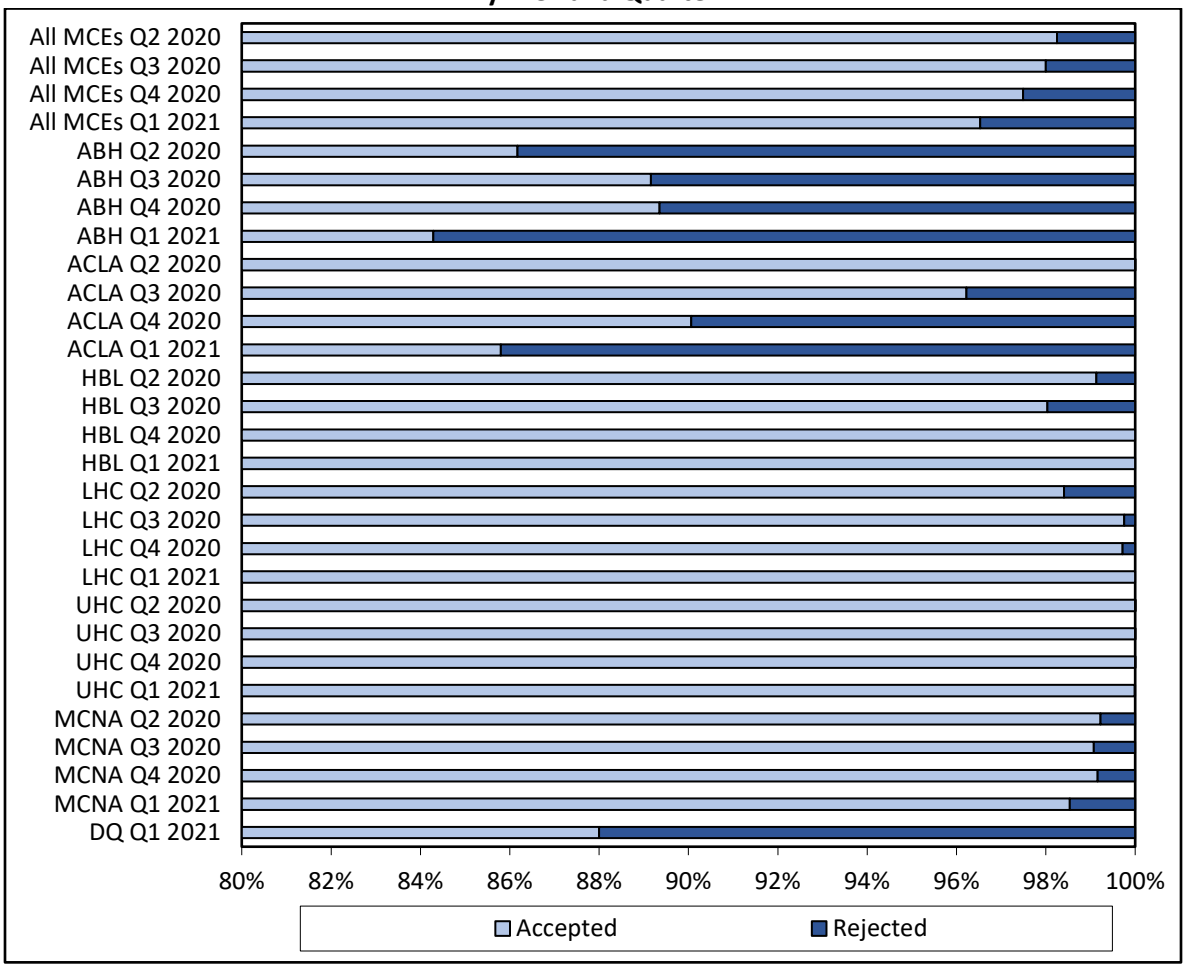
Section IV: Findings Related to MCE Encounter Submissions to LDH

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

MCE Encounters Accepted and Rejected by LDH

In the most recent four quarters studied, 96.5% to 98.2% of the encounters submitted by all MCEs combined were accepted by LDH. There were differences at the MCE level. All of UHC's encounters were accepted. For HBL, LHC and MCNA, at least 98% of their encounters were accepted. ACLA dropped to 86% for their accepted encounters for Q1, 2021. ABH had some challenges, particularly in the last four quarters, which accept rates were continuously less than 90%. DQ, as a new joined member since Q1, 2021, have 88% of their encounters were accepted.

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. Encounters are submitted separately for each of the following claim type:

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

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

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

- ACLA and HBL had issues with encounters being accepted which was mostly due to institutional encounters. For quarter 1, 2021, this was mostly caused by professional encounters for ACLA.

- LHC had a few issues related to pharmacy encounters.

- DQ had some issues with encounters been accepted.

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

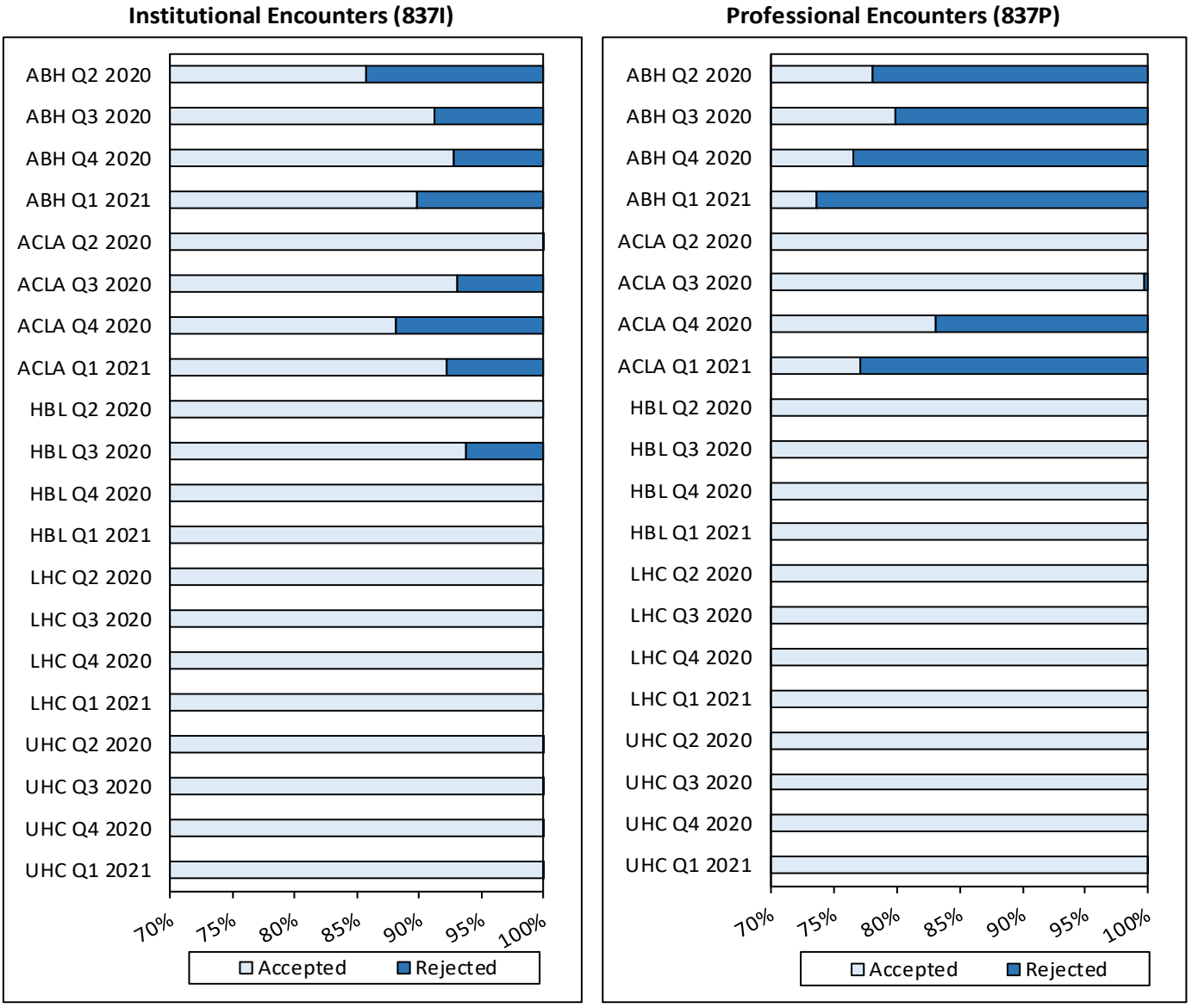
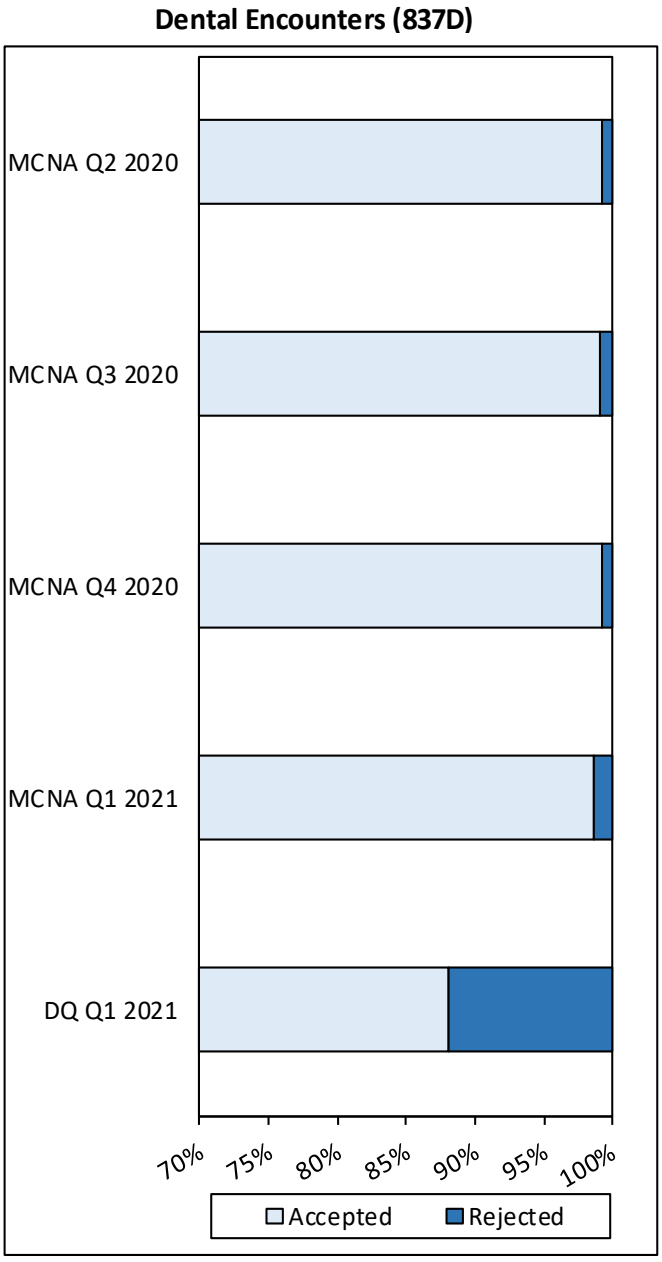
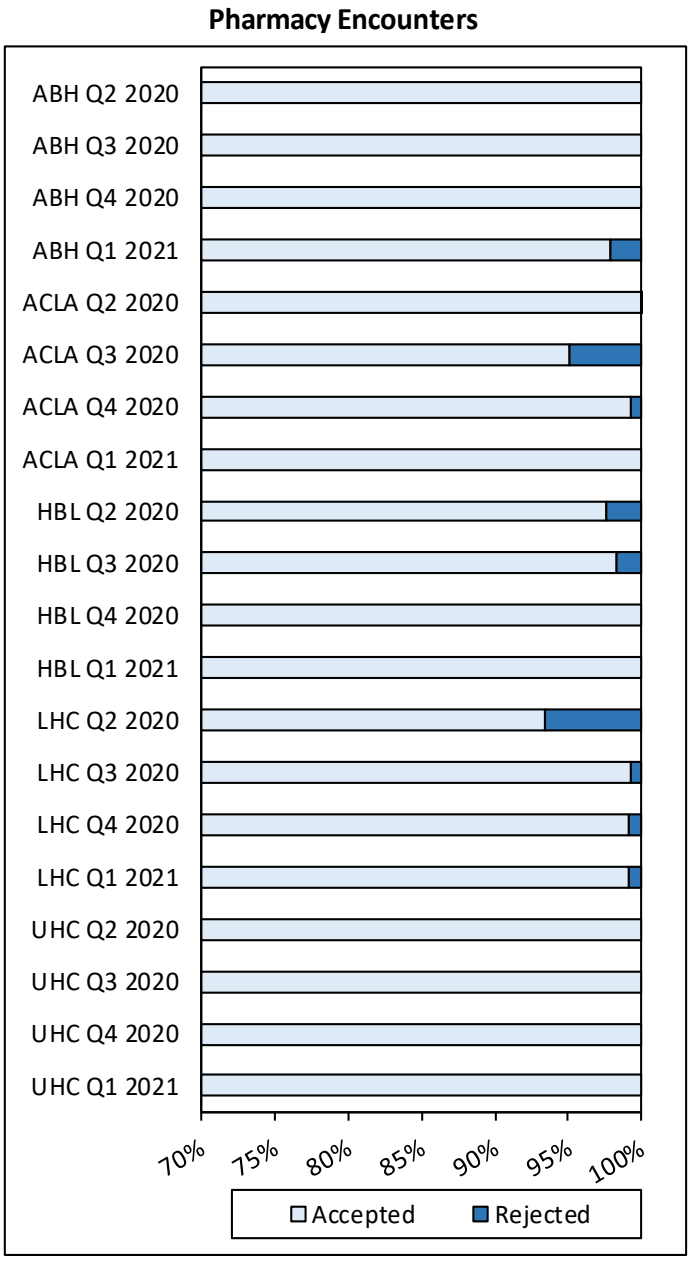


Exhibit IV.3
Encounter Submissions Accepted and Rejected by LDH
Dental and Pharmacy Claim Types
By MCE and Quarter





Timeliness of Encounter Submissions Accepted by LDH

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

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

Key findings from both exhibits appear below:

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

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

- There is greater variation in the timeliness of pharmacy encounter submissions. ACLA had 100% timeliness within 30 days in all quarters. HBL and UHC had few pharmacy encounters submitted after 30 days in every quarter. ABH and LHC consistently are lowest on pharmacy encounter timeliness—ABH usually near 70% untimely, and LHC has varied from 65% to 76% untimely in the last four quarters.

- MCNA had few issues meeting an average 30-day TAT for its dental encounters in the first three quarters of 2020, but did have issues in Q4, improved for Q1, 2021.

- DQ, as a new joined member, had some issues to meet the 30-day TAT, which had 56% encounters submitted within the timeline.

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 2020	69.6%	30.4%	67.2%	32.8%			71.2%	28.8%
ABH Q3 2020	43.3%	56.7%	62.8%	37.2%			69.1%	30.9%
ABH Q4 2020	27.2%	72.8%	69.2%	30.8%			69.1%	30.9%
ABH Q1 2021	39.0%	61.0%	54.8%	45.2%			70.9%	29.1%
ACLA Q2 2020	97.6%	2.4%	95.2%	4.8%			100.0%	0.0%
ACLA Q3 2020	89.1%	10.9%	86.7%	13.3%			100.0%	0.0%
ACLA Q4 2020	52.1%	47.9%	60.6%	39.4%			91.5%	8.5%
ACLA Q1 2021	91.2%	8.8%	90.1%	9.9%			100.0%	0.0%
HBL Q2 2020	100.0%	0.0%	98.6%	1.4%			98.2%	1.8%
HBL Q3 2020	100.0%	0.0%	98.9%	1.1%			98.3%	1.7%
HBL Q4 2020	100.0%	0.0%	94.7%	5.3%			96.6%	3.4%
HBL Q1 2021	100.0%	0.0%	99.9%	0.1%			99.6%	0.4%
LHC Q2 2020	72.7%	27.3%	72.5%	27.5%			64.5%	35.5%
LHC Q3 2020	95.9%	4.1%	97.9%	2.1%			71.9%	28.1%
LHC Q4 2020	99.9%	0.1%	99.8%	0.2%			69.6%	30.4%
LHC Q1 2021	98.7%	1.3%	96.1%	3.9%			76.1%	23.9%
UHC Q2 2020	98.6%	1.4%	93.8%	6.2%			98.7%	1.3%
UHC Q3 2020	98.6%	1.4%	98.6%	1.4%			98.8%	1.2%
UHC Q4 2020	98.8%	1.2%	95.9%	4.1%			98.8%	1.2%
UHC Q1 2021	76.3%	23.7%	97.1%	2.9%			98.7%	1.3%
MCNA Q2 2020					99.7%	0.3%		
MCNA Q3 2020					99.7%	0.3%		
MCNA Q4 2020					48.2%	51.8%		
MCNA Q1 2021					84.9%	15.1%		
DQ Q1 2021					56.0%	51.8%		

Section V: Case Management

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

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

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

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

The data presented below is representative of unduplicated totals by MCE for Q1 of CY 2021. Across all five MCEs a total of 44,118 unduplicated individuals were eligible or in need of case management services. Of these 25% or 11,073 were enrolled in case management for at least one month during the quarter. Seventy-two percent (7,944) of those enrolled in CM where engaged in one or more CM services or contact with a case manager.

CY 2021- Quarter 1: Unduplicated Totals	ABH	ACLA	HB	LHC	UHC	Total[1]
Eligible for Case Management (CM)	988	5,314	5,728	16,929	15,194	44,118
Enrolled in CM at least 1 month	696	1,995	1,682	3,807	2,902	11,073
% of eligible enrolled in CM	70.4%	37.5%	29.4%	22.5%	19.1%	25.1%
Received CM Service	591	1,700	958	3,125	1,606	7,974
% enrolled receiving service	84.9%	85.2%	57.0%	82.1%	55.3%	72.0%

Source: MCE Monthly Report 039 Case Management

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

Appendix A:

Detailed Information for Exhibits Shown in Sections III and IV

Appendix B:

One-Page Summaries of Information on Claims for Each

of the 16 Provider Types Shown in this Report

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

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

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

	Number Accepted	Number Rejected	Percent Accepted	Percent Rejected
All MCEs Q2 2020	18,795,571	264,017	98.6%	1.4%
All MCEs Q3 2020	22,884,684	279,021	98.8%	1.2%
All MCEs Q4 2020	24,436,637	294,350	98.8%	1.2%
All MCEs Q1 2021	24,601,700	312,239	98.7%	1.3%
ABH Q2 2020	1,695,215	2,185	99.9%	0.1%
ABH Q3 2020	2,012,867	2,416	99.9%	0.1%
ABH Q4 2020	2,124,458	2,292	99.9%	0.1%
ABH Q1 2021	2,124,458	2,292	99.9%	0.1%
ACLA Q2 2020	2,191,214	3,466	99.8%	0.2%
ACLA Q3 2020	2,755,133	10,830	99.6%	0.4%
ACLA Q4 2020	2,882,688	8,482	99.7%	0.3%
ACLA Q1 2021	2,835,723	5,245	99.8%	0.2%
HBL Q2 2020	3,845,084	759	100.0%	0.0%
HBL Q3 2020	4,599,056	738	100.0%	0.0%
HBL Q4 2020	4,883,134	447	100.0%	0.0%
HBL Q1 2021	4,990,313	514	100.0%	0.0%
LHC Q2 2020	5,117,995	197,511	96.3%	3.7%
LHC Q3 2020	6,138,249	197,050	96.9%	3.1%
LHC Q4 2020	6,583,182	198,251	97.1%	2.9%
LHC Q1 2021	6,719,384	207,844	97.0%	3.0%
UHC Q2 2020	5,349,941	60,096	98.9%	1.1%
UHC Q3 2020	6,519,862	67,987	99.0%	1.0%
UHC Q4 2020	7,148,368	84,878	98.8%	1.2%
UHC Q1 2021	7,083,687	96,344	98.7%	1.3%
MCNA Q2 2020	596,122	0	100.0%	0.0%
MCNA Q3 2020	859,517	0	100.0%	0.0%
MCNA Q4 2020	814,807	0	100.0%	0.0%
MCNA Q1 2021	495,403	0	100.0%	0.0%
DQ Q1 2021	352,732	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 2020	14,782,806	3,325,040	81.6%	18.4%
All MCEs Q3 2020	17,948,253	3,992,025	81.8%	18.2%
All MCEs Q4 2020	19,292,840	4,260,741	81.9%	18.1%
All MCEs Q1 2021	19,006,687	4,698,041	80.2%	19.8%
ABH Q2 2020	1,333,483	362,160	78.6%	21.4%
ABH Q3 2020	1,572,783	439,151	78.2%	21.8%
ABH Q4 2020	1,619,705	505,169	76.2%	23.8%
ABH Q1 2021	1,609,700	602,635	72.8%	27.2%
ACLA Q2 2020	1,777,419	372,466	82.7%	17.3%
ACLA Q3 2020	2,285,744	491,611	82.3%	17.7%
ACLA Q4 2020	2,344,287	460,415	83.6%	16.4%
ACLA Q1 2021	2,397,474	508,985	82.5%	17.5%
HBL Q2 2020	2,984,635	763,022	79.6%	20.4%
HBL Q3 2020	3,659,680	911,313	80.1%	19.9%
HBL Q4 2020	3,954,955	936,726	80.9%	19.1%
HBL Q1 2021	3,977,816	1,019,175	79.6%	20.4%
LHC Q2 2020	4,165,548	900,980	82.2%	17.8%
LHC Q3 2020	5,057,608	1,003,298	83.4%	16.6%
LHC Q4 2020	5,451,901	1,121,272	82.9%	17.1%
LHC Q1 2021	5,403,178	1,253,630	81.2%	18.8%
UHC Q2 2020	4,521,721	926,412	83.0%	17.0%
UHC Q3 2020	5,372,438	1,146,652	82.4%	17.6%
UHC Q4 2020	5,921,992	1,237,159	82.7%	17.3%
UHC Q1 2021	5,618,519	1,313,616	81.1%	18.9%

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 2020	47,250	9,975	82.6%	17.4%
Inpatient Hospital Q3 2020	52,707	10,927	82.8%	17.2%
Inpatient Hospital Q4 2020	54,911	11,938	82.1%	17.9%
Inpatient Hospital Q1 2021	53,146	11,354	82.4%	17.6%
Outpatient Hospital Q2 2020	3,094,922	348,077	89.9%	10.1%
Outpatient Hospital Q3 2020	4,161,856	425,855	90.7%	9.3%
Outpatient Hospital Q4 2020	4,307,164	454,655	90.5%	9.5%
Outpatient Hospital Q1 2021	4,223,616	426,608	90.8%	9.2%
Home Health Q2 2020	38,736	4,653	89.3%	10.7%
Home Health Q3 2020	34,656	6,537	84.1%	15.9%
Home Health Q4 2020	39,446	6,317	86.2%	13.8%
Home Health Q1 2021	40,287	4,183	90.6%	9.4%
Primary Care Q2 2020	1,170,493	217,922	84.3%	15.7%
Primary Care Q3 2020	1,763,204	295,877	85.6%	14.4%
Primary Care Q4 2020	2,025,819	367,356	84.6%	15.4%
Primary Care Q1 2021	2,016,551	415,772	82.9%	17.1%
Pediatrics Q2 2020	559,334	82,715	87.1%	12.9%
Pediatrics Q3 2020	689,995	94,543	87.9%	12.1%
Pediatrics Q4 2020	866,106	117,812	88.0%	12.0%
Pediatrics Q1 2021	802,178	120,299	87.0%	13.0%
OB-GYN Q2 2020	225,599	28,640	88.7%	11.3%
OB-GYN Q3 2020	255,748	29,425	89.7%	10.3%
OB-GYN Q4 2020	257,113	32,888	88.7%	11.3%
OB-GYN Q1 2021	251,450	31,844	88.8%	11.2%
Therapists (PT/OT/ST) Q2 2020	50,286	8,645	85.3%	14.7%
Therapists (PT/OT/ST) Q3 2020	85,101	14,169	85.7%	14.3%
Therapists (PT/OT/ST) Q4 2020	88,371	17,761	83.3%	16.7%
Therapists (PT/OT/ST) Q1 2021	89,993	16,862	84.2%	15.8%
All Other Professional Q2 2020	3,335,889	688,019	82.9%	17.1%
All Other Professional Q3 2020	3,952,131	790,896	83.3%	16.7%
All Other Professional Q4 2020	4,409,700	784,467	84.9%	15.1%
All Other Professional Q1 2021	4,414,951	974,900	81.9%	18.1%

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

	Number Paid	Number Denied	Percent Paid	Percent Denied
Non-Emerg Transport Q2 2020	156,403	6,048	96.3%	3.7%
Non-Emerg Transport Q3 2020	190,595	4,836	97.5%	2.5%
Non-Emerg Transport Q4 2020	269,705	10,002	96.4%	3.6%
Non-Emerg Transport Q1 2021	221,737	6,498	97.2%	2.8%
Medical Equipment/Supplies Q2 2020	132,339	21,621	86.0%	14.0%
Medical Equipment/Supplies Q3 2020	121,171	20,069	85.8%	14.2%
Medical Equipment/Supplies Q4 2020	128,718	23,110	84.8%	15.2%
Medical Equipment/Supplies Q1 2021	131,186	25,295	83.8%	16.2%
Mental/Behavioral Rehab Q2 2020	229,259	29,730	88.5%	11.5%
Mental/Behavioral Rehab Q3 2020	232,206	25,070	90.3%	9.7%
Mental/Behavioral Rehab Q4 2020	224,446	26,611	89.4%	10.6%
Mental/Behavioral Rehab Q1 2021	229,133	35,320	86.6%	13.4%
Mental/Behavioral Other Q2 2020	645,307	120,790	84.2%	15.8%
Mental/Behavioral Other Q3 2020	735,462	140,662	83.9%	16.1%
Mental/Behavioral Other Q4 2020	752,136	158,690	82.6%	17.4%
Mental/Behavioral Other Q1 2021	757,152	216,035	77.8%	22.2%
Dental - Children Q2 2020	482,503	35,967	93.1%	6.9%
Dental - Children Q3 2020	650,998	79,359	89.1%	10.9%
Dental - Children Q4 2020	653,938	87,295	88.2%	11.8%
Dental - Children Q1 2021	645,368	98,809	86.7%	13.3%
Dental - Adults Q2 2020	66,441	9,975	86.9%	13.1%
Dental - Adults Q3 2020	106,586	18,715	85.1%	14.9%
Dental - Adults Q4 2020	124,319	20,942	85.6%	14.4%
Dental - Adults Q1 2021	117,464	26,684	81.5%	18.5%
Pharmacy Q2 2020	4,986,416	1,743,525	74.1%	25.9%
Pharmacy Q3 2020	5,525,646	2,107,908	72.4%	27.6%
Pharmacy Q4 2020	5,701,908	2,221,192	72.0%	28.0%
Pharmacy Q1 2021	5,615,836	2,378,178	70.3%	29.7%

Appendix A III.5
Claim Status for Adjudicated Claims
By Provider Specialty / Service Category
By MCE for Q1 2021 Adjudicated Claims

Inpatient Hospital	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	5,927	829	87.7%	12.3%
ACLA	6,831	1,591	81.1%	18.9%
HBL	10,053	4,008	71.5%	28.5%
LHC	16,142	2,063	88.7%	11.3%
UHC	14,193	2,863	83.2%	16.8%

Outpatient Hospital	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	424,971	23,696	94.7%	5.3%
ACLA	559,044	57,484	90.7%	9.3%
HBL	861,329	85,003	91.0%	9.0%
LHC	1,171,331	160,943	87.9%	12.1%
UHC	1,206,941	99,482	92.4%	7.6%

Home Health	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	2,543	219	92.1%	7.9%
ACLA	3,238	789	80.4%	19.6%
HBL	6,296	1,167	84.4%	15.6%
LHC	27,379	1,931	93.4%	6.6%
UHC	831	77	91.5%	8.5%

Primary Care	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	175,626	113,400	60.8%	39.2%
ACLA	124,266	13,385	90.3%	9.7%
HBL	392,517	60,267	86.7%	13.3%
LHC	600,670	118,675	83.5%	16.5%
UHC	723,472	110,045	86.8%	13.2%

Pediatricians	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	58,157	36,652	61.3%	38.7%
ACLA	97,143	9,002	91.5%	8.5%
HBL	189,727	18,799	91.0%	9.0%
LHC	343,040	44,582	88.5%	11.5%
UHC	114,111	11,264	91.0%	9.0%

OB-GYN	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	22,801	7,156	76.1%	23.9%
ACLA	39,980	3,956	91.0%	9.0%
HBL	72,175	6,831	91.4%	8.6%
LHC	93,547	12,136	88.5%	11.5%
UHC	22,947	1,765	92.9%	7.1%

Therapists (PT, OT, ST)	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	12,645	4,963	71.8%	28.2%
ACLA	421	1,357	23.7%	76.3%
HBL	34,311	3,131	91.6%	8.4%
LHC	18,332	3,312	84.7%	15.3%
UHC	24,284	4,099	85.6%	14.4%

Non-Emergency Medical Transp.	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	18,536	222	98.8%	1.2%
ACLA	34,371	2,300	93.7%	6.3%
HBL	52,672	26	100.0%	0.0%
LHC	55,475	1,646	97.1%	2.9%
UHC	60,683	2,304	96.3%	3.7%

Medical Equipment and Supplies	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	13,778	3,737	78.7%	21.3%
ACLA	23,495	3,901	85.8%	14.2%
HBL	2,859	855	77.0%	23.0%
LHC	39,005	8,069	82.9%	17.1%
UHC	52,049	8,733	85.6%	14.4%

All Other Professional	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	310,203	170,762	64.5%	35.5%
ACLA	737,903	140,721	84.0%	16.0%
HBL	883,123	187,402	82.5%	17.5%
LHC	1,155,946	269,453	81.1%	18.9%
UHC	1,327,776	206,562	86.5%	13.5%

Mental/Behav Health - Rehab	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	1,585	1,513	51.2%	48.8%
ACLA	66,331	8,832	88.2%	11.8%
HBL	3,037	6,657	31.3%	68.7%
LHC	7,421	1,569	82.5%	17.5%
UHC	150,759	16,749	90.0%	10.0%

Mental/Behav Health - Other	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	46,446	84,016	35.6%	64.4%
ACLA	50,072	9,217	84.5%	15.5%
HBL	150,990	42,989	77.8%	22.2%
LHC	426,155	68,959	86.1%	13.9%
UHC	83,489	10,854	88.5%	11.5%

Pharmacy	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	503,310	151,777	76.8%	23.2%
ACLA	640,108	246,942	72.2%	27.8%
HBL	1,255,095	582,574	68.3%	31.7%
LHC	1,445,329	558,746	72.1%	27.9%
UHC	1,771,994	838,139	67.9%	32.1%

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 2020	$1,457.4	$416.2
All MCEs Q3 2020	$1,721.2	$430.6
All MCEs Q4 2020	$1,803.3	$452.3
All MCEs Q1 2021	$1,811.8	$501.0
Quarter 2 2020		
ABH	$129.3	$32.1
ACLA	$170.0	$39.5
HBL	$300.5	$92.9
LHC	$377.5	$80.4
UHC	$480.1	$171.3
Quarter 3 2020		
ABH	$145.8	$34.4
ACLA	$214.6	$51.1
HBL	$366.5	$124.0
LHC	$449.5	$87.6
UHC	$544.8	$133.5
Quarter 4 2020		
ABH	$150.4	$38.3
ACLA	$210.0	$49.4
HBL	$397.0	$123.7
LHC	$470.8	$97.8
UHC	$575.2	$143.0
Quarter 1 2021		
ABH	$156.7	$49.7
ACLA	$223.8	$54.6
HBL	$393.1	$136.4
LHC	$483.4	$109.6
UHC	$554.8	$150.6

MCNA and DentaQuest are the MCEs that provides dental coverage only.
MCNA total expenditures are approx. $17M - $33M per quarter.
DentaQuest total expenditure are $12M per quarter.
They have been excluded from this exhibit.

Appendix A Exhibit III.7

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

Legend

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

Provider Category	Group Based on Volume	ABH				ACLA				HBL				LHC				UHC				MCNA				DQ
		Q2 20	Q3 20	Q4 20	Q1 21	Q2 20	Q3 20	Q4 20	Q1 21	Q2 20	Q3 20	Q4 20	Q1 21	Q2 20	Q3 20	Q4 20	Q1 21	Q2 20	Q3 20	Q4 20	Q1 21	Q2 20	Q3 20	Q4 20	Q1 21	Q1 21
Inpatient Hospital	Low	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	N	N	N					
	Medium	Y	Y	Y	N	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y					
	High	Y	N	Y	N	--	--	--	--	--	--	--	--	Y	Y	Y	Y	--	N	N	--					
Outpatient Hospital	Low	Y	Y	N	N	Y	Y	Y	Y	N	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y					
	Medium	Y	Y	Y	Y	N	N	N	N	Y	N	Y	Y	Y	Y	Y	Y	N	Y	Y	Y					
	High	Y	N	Y	Y	N	N	N	N	N	N	N	N	Y	Y	Y	Y	N	N	N	N					
Home Health	Low	Y	Y	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N					
	Medium	N	Y	Y	N	N	N	N	N	N	Y	N	N	N	N	N	N	--	--	--	--					
	High	--	--	--	--	--	--	--	--	--	--	--	--	N	N	Y	N	--	--	--	--					
Other Institutional Providers	Low	Y	Y	Y	Y	N	Y	--	--	N	Y	Y	Y	Y	Y	Y	Y	N	N	N	N					
	Medium	Y	--	--	--	--	--	--	--	N	N	N	N	--	--	Y	Y	N	N	N	N					
	High	--	--	--	--	--	--	--	--	N	N	N	N	--	--	--	--	Y	N	Y	N					
Primary Care	Low	Y	N	Y	Y	N	N	N	N	Y	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y					
	Medium	Y	Y	Y	Y	N	N	N	N	N	N	N	N	Y	Y	Y	Y	N	N	N	N					
	High	--	Y	Y	Y	N	N	N	N	N	N	N	N	Y	Y	Y	Y	N	N	N	N					
Pediatrics	Low	Y	N	N	Y	N	N	N	N	N	N	N	N	Y	Y	N	N	Y	Y	N	Y					
	Medium	Y	Y	Y	Y	N	N	N	N	N	N	N	N	Y	Y	Y	N	Y	Y	N	N					
	High	--	--	Y	--	N	N	N	N	N	N	N	N	Y	Y	Y	N	N	N	N	N					
OB-GYN	Low	Y	Y	Y	Y	N	N	N	N	Y	Y	N	N	N	N	N	Y	Y	Y	Y	Y					
	Medium	Y	Y	Y	Y	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	Y	Y					
	High	--	--	--	--	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N					
Therapists	Low	N	N	Y	Y	N	N	Y	Y	N	N	N	Y	Y	Y	Y	Y	N	N	Y	Y					
	Medium	--	Y	Y	Y	N	N	--	Y	N	N	N	N	Y	Y	Y	Y	N	N	Y	N					
	High	--	--	--	--	--	N	--	--	Y	N	N	N	Y	Y	Y	Y	Y	N	N	N					
Non-Emergency Transportation	Low	N	N	N	Y	N	Y	Y	N	N	--	--	--	N	N	N	N	Y	Y	Y	Y					
	Medium	N	N	N	--	N	N	N	N	N	--	--	--	N	N	N	N	--	--	--	--					
	High	N	N	N	--	N	N	N	N	N	--	--	--	N	N	N	N	--	--	--	--					
Medical Equipment/ Supplies	Low	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N	N	N	N	Y	Y	Y	Y					
	Medium	Y	Y	Y	Y	N	N	N	N	Y	Y	N	N	Y	Y	Y	Y	N	N	N	N					
	High	Y	Y	Y	Y	N	N	N	N	--	--	--	--	Y	Y	N	Y	N	N	N	Y					
All Other Professional Provid.	Low	N	N	N	N	N	Y	Y	Y	N	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y					
	Medium	N	N	N	N	N	N	N	N	N	N	N	N	Y	Y	Y	Y	N	Y	N	Y					
	High	--	--	N	Y	N	N	N	N	N	N	N	N	Y	Y	N	Y	N	N	N	N					
Behavioral Health Rehab	Low	N	Y	Y	Y	Y	N	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y					
	Medium	N	Y	Y	Y	N	N	N	N	N	Y	Y	Y	N	N	N	N	N	N	N	N					
	High	--	--	--	--	N	N	N	N	--	--	--	--	--	--	--	--	N	N	N	N					
Behavioral Health All Other	Low	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	Y	Y	N	Y					
	Medium	--	--	--	--	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y	N	N	N	Y	Y					
	High	--	--	--	--	Y	N	N	N	Y	Y	Y	Y	N	N	Y	N	Y	N	N	N					
Dental - Children	Low																					N	N	Y	Y	N
	Medium																					Y	Y	Y	Y	N
	High																					Y	Y	Y	Y	N
Dental - Adults	Low																					Y	Y	Y	Y	Y
	Medium																					--	--	--	--	Y
	High																					--	--	--	--	--
Pharmacy	Low	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y					
	Medium	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y					
	High	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y					

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

	Paid Claims	Denied Claims
All MCEs Q2 2020	7.8	5.9
All MCEs Q3 2020	7.7	6.0
All MCEs Q4 2020	8.0	5.8
All MCEs Q1 2021	7.8	6.3
ABH Q2 2020	8.3	6.0
ABH Q3 2020	8.0	5.6
ABH Q4 2020	8.0	6.1
ABH Q1 2021	8.5	6.2
ACLA Q2 2020	5.4	6.5
ACLA Q3 2020	5.7	7.2
ACLA Q4 2020	5.5	7.4
ACLA Q1 2021	5.7	7.5
HBL Q2 2020	6.8	4.3
HBL Q3 2020	7.2	6.1
HBL Q4 2020	7.1	4.6
HBL Q1 2021	6.3	5.5
LHC Q2 2020	9.0	9.6
LHC Q3 2020	8.5	9.2
LHC Q4 2020	8.5	9.2
LHC Q1 2021	8.4	9.6
UHC Q2 2020	8.6	3.2
UHC Q3 2020	8.0	2.7
UHC Q4 2020	8.9	2.8
UHC Q1 2021	9.1	2.8
MCNA Q2 2020	3.5	6.5
MCNA Q3 2020	7.4	9.0
MCNA Q4 2020	8.6	10.1
MCNA Q1 2021	9.9	10.9
DQ Q1 2021	5.7	5.9

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

	Paid Claims	Denied Claims
Inpatient Hosp Q2 2020	9.3	9.4
Inpatient Hosp Q3 2020	10.7	12.4
Inpatient Hosp Q4 2020	12.1	11.7
Inpatient Hosp Q1 2021	11.0	11.5
Outpatient Hosp Q2 2020	7.6	9.1
Outpatient Hosp Q3 2020	7.5	9.7
Outpatient Hosp Q4 2020	7.5	8.9
Outpatient Hosp Q1 2021	7.7	9.9
Home Health Q2 2020	7.7	8.3
Home Health Q3 2020	8.0	13.0
Home Health Q4 2020	7.8	8.7
Home Health Q1 2021	7.6	9.3
Primary Care Q2 2020	7.5	8.0
Primary Care Q3 2020	6.7	8.1
Primary Care Q4 2020	7.6	7.7
Primary Care Q1 2021	7.5	7.5
Pediatrics Q2 2020	6.8	7.3
Pediatrics Q3 2020	6.4	7.3
Pediatrics Q4 2020	7.1	7.5
Pediatrics Q1 2021	6.9	7.7
OB-GYN Q2 2020	6.5	7.3
OB-GYN Q3 2020	6.6	8.1
OB-GYN Q4 2020	6.9	8.0
OB-GYN Q1 2021	6.7	7.7
Therapists (PT/OT/ST) Q2 2020	6.9	8.0
Therapists (PT/OT/ST) Q3 2020	7.3	9.5
Therapists (PT/OT/ST) Q4 2020	7.6	8.5
Therapists (PT/OT/ST) Q1 2021	7.6	8.3
All Other Professional Q2 2020	6.8	7.6
All Other Professional Q3 2020	6.4	8.1
All Other Professional Q4 2020	7.3	7.7
All Other Professional Q1 2021	7.1	7.3

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 2020	10.6	9.1
Non-Emerg Transport Q3 2020	10.9	8.5
Non-Emerg Transport Q4 2020	10.0	9.8
Non-Emerg Transport Q1 2021	7.9	9.6
Medical Equip/Supplies Q2 2020	6.6	7.7
Medical Equip/Supplies Q3 2020	6.6	8.2
Medical Equip/Supplies Q4 2020	7.8	8.1
Medical Equip/Supplies Q1 2021	8.5	9.0
MH/BH Rehab Q2 2020	6.4	14.9
MH/BH Rehab Q3 2020	6.5	12.8
MH/BH Rehab Q4 2020	7.4	9.5
MH/BH Rehab Q1 2021	7.7	9.0
MH/BH Other Q2 2020	8.6	9.6
MH/BH Other Q3 2020	8.0	10.4
MH/BH Other Q4 2020	7.9	8.3
MH/BH Other Q1 2021	7.6	7.6
Dental - Children Q2 2020	3.5	6.4
Dental - Children Q3 2020	7.3	9.0
Dental - Children Q4 2020	8.5	10.2
Dental - Children Q1 2021	8.1	9.9
Dental - Adults Q2 2020	5.3	6.7
Dental - Adults Q3 2020	4.7	4.5
Dental - Adults Q4 2020	5.0	4.6
Dental - Adults Q1 2021	5.2	7.0
Pharmacy Q2 2020	9.2	3.7
Pharmacy Q3 2020	9.1	3.6
Pharmacy Q4 2020	9.1	3.6
Pharmacy Q1 2021	8.8	3.7

Appendix A Exhibit III.11
Average Turnaround Time (jn days), Paid and Denied Claims, by Service Category
By MCE for Q1 2021 Adjudicated Claims

Inpatient Hospital	Paid	Denied
ABH	19.5	23.2
ACLA	16.1	15.5
HBL	7.7	11.1
LHC	8.4	9.4
UHC	10.2	8.1

Outpatient Hospital	Paid	Denied
ABH	8.0	12.6
ACLA	5.4	6.9
HBL	7.6	9.3
LHC	7.5	11.8
UHC	8.9	8.3

Home Health	Paid	Denied
ABH	10.7	12.4
ACLA	8.2	9.0
HBL	7.9	8.3
LHC	7.1	9.5
UHC	8.5	11.7

Primary Care	Paid	Denied
ABH	6.7	7.6
ACLA	4.0	5.8
HBL	8.2	8.1
LHC	7.3	7.5
UHC	8.0	7.4

Pediatrics	Paid	Denied
ABH	7.1	8.4
ACLA	3.5	4.4
HBL	7.2	6.9
LHC	7.4	8.2
UHC	7.8	7.4

OB-GYN	Paid	Denied
ABH	7.6	9.8
ACLA	3.7	6.0
HBL	7.2	7.2
LHC	7.1	7.4
UHC	8.2	7.8

Therapists (PT, OT, ST)	Paid	Denied
ABH	9.1	8.8
ACLA	6.7	10.1
HBL	7.1	7.9
LHC	6.9	8.4
UHC	8.0	7.4

Non-Emergency Medical Transp	Paid	Denied
ABH	2.2	13.1
ACLA	8.9	8.9
HBL	12.1	11.0
LHC	10.7	10.4
UHC	2.8	9.5

Medical Equipment and Supplies	Paid	Denied
ABH	15.0	12.3
ACLA	6.6	10.6
HBL	7.1	7.3
LHC	7.9	8.9
UHC	8.0	7.3

All Other Professional	Paid	Denied
ABH	7.2	7.4
ACLA	4.3	7.0
HBL	6.8	6.8
LHC	7.4	7.5
UHC	8.4	7.7

Mental/Behavioral Health - Rehab	Paid	Denied
ABH	7.0	8.4
ACLA	6.6	9.4
HBL	8.2	6.8
LHC	9.0	8.9
UHC	8.1	9.8

Mental/Behavioral Health - Other	Paid	Denied
ABH	6.3	7.8
ACLA	6.9	9.1
HBL	7.2	7.0
LHC	7.5	7.2
UHC	10.0	9.8

Pharmacy	Paid	Denied
ABH	11.0	1.0
ACLA	7.8	7.7
HBL	3.8	1.0
LHC	10.9	10.9
UHC	10.5	0.0

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

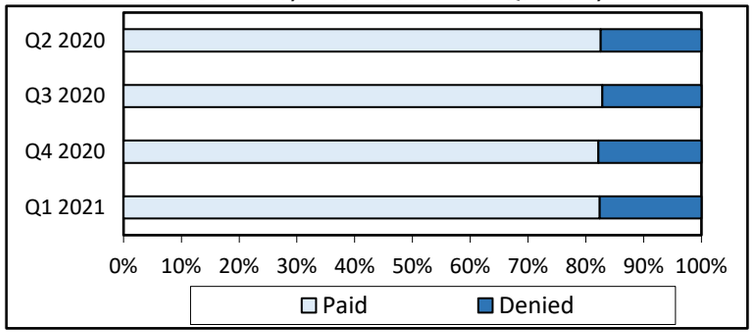
	Accepted	Rejected
All MCEs Q2 2020	98.2%	1.8%
All MCEs Q3 2020	98.0%	2.0%
All MCEs Q4 2020	97.5%	2.5%
All MCEs Q1 2021	96.5%	3.5%
ABH Q2 2020	86.2%	13.8%
ABH Q3 2020	89.2%	10.8%
ABH Q4 2020	89.4%	10.6%
ABH Q1 2021	84.3%	15.7%
ACLA Q2 2020	100.0%	0.0%
ACLA Q3 2020	96.2%	3.8%
ACLA Q4 2020	90.1%	9.9%
ACLA Q1 2021	85.8%	14.2%
HBL Q2 2020	99.1%	0.9%
HBL Q3 2020	98.0%	2.0%
HBL Q4 2020	100.0%	0.0%
HBL Q1 2021	100.0%	0.0%
LHC Q2 2020	98.4%	1.6%
LHC Q3 2020	99.8%	0.2%
LHC Q4 2020	99.7%	0.3%
LHC Q1 2021	100.0%	0.0%
UHC Q2 2020	100.0%	0.0%
UHC Q3 2020	100.0%	0.0%
UHC Q4 2020	100.0%	0.0%
UHC Q1 2021	100.0%	0.0%
MCNA Q2 2020	99.2%	0.8%
MCNA Q3 2020	99.1%	0.9%
MCNA Q4 2020	99.2%	0.8%
MCNA Q1 2021	98.5%	1.5%
DQ Q1 2021	88.0%	12.0%

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

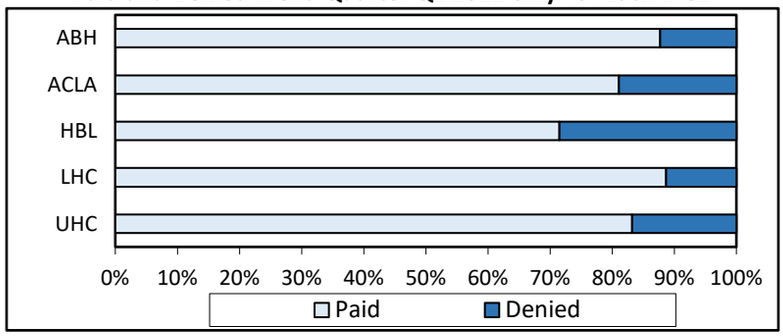
	Institutional Encounters (837I)		Professional Encounters (837D)		Dental Encounters (837D)		Pharmacy Encounters	
	Accepted	Rejected	Accepted	Rejected	Accepted	Rejected	Accepted	Rejected
ABH Q2 2020	85.8%	14.2%	78.0%	22.0%			100.0%	0.0%
ABH Q3 2020	91.3%	8.7%	79.9%	20.1%			100.0%	0.0%
ABH Q4 2020	92.7%	7.3%	76.6%	23.4%			100.0%	0.0%
ABH Q1 2021	89.8%	10.2%	73.6%	26.4%			97.9%	2.1%
ACLA Q2 2020	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
ACLA Q3 2020	93.1%	6.9%	99.7%	0.3%			95.0%	5.0%
ACLA Q4 2020	88.1%	11.9%	83.2%	16.8%			99.3%	0.7%
ACLA Q1 2021	92.2%	7.8%	77.1%	22.9%			100.0%	0.0%
HBL Q2 2020	100.0%	0.0%	100.0%	0.0%			97.6%	2.4%
HBL Q3 2020	93.7%	6.3%	100.0%	0.0%			98.3%	1.7%
HBL Q4 2020	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
HBL Q1 2021	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
LHC Q2 2020	100.0%	0.0%	100.0%	0.0%			93.5%	6.5%
LHC Q3 2020	100.0%	0.0%	100.0%	0.0%			99.2%	0.8%
LHC Q4 2020	100.0%	0.0%	100.0%	0.0%			99.1%	0.9%
LHC Q1 2021	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
UHC Q2 2020	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
UHC Q3 2020	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
UHC Q4 2020	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
UHC Q1 2021	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
MCNA Q2 2020					99.2%	0.8%		
MCNA Q3 2020					99.1%	0.9%		
MCNA Q4 2020					99.2%	0.8%		
MCNA Q1 2021					98.5%	1.5%		
DQ Q1 2021					88.0%	12.0%		

Summary of Information on Claims for Inpatient Hospital Services

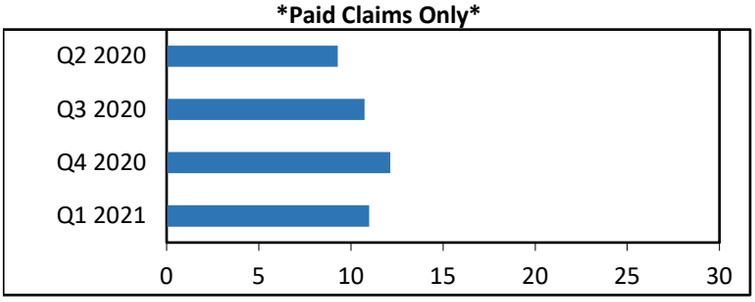
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



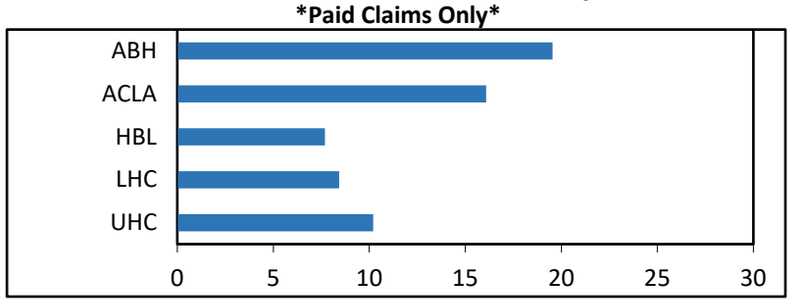
Paid and Denied Trend Quarter Q1 2021 only For Each MCE



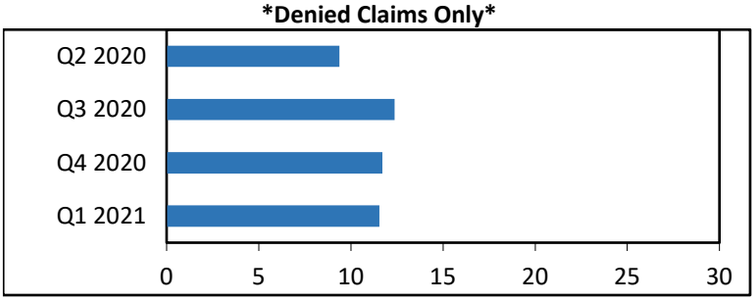
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



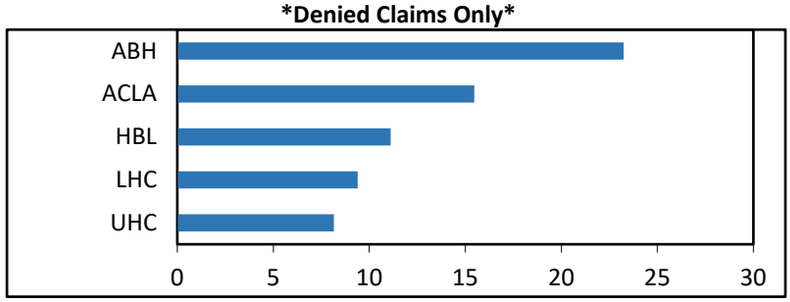
Claims Turnaround Time Quarter Q1 2021 only Each MCE
Paid Claims Only



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 2021 only)

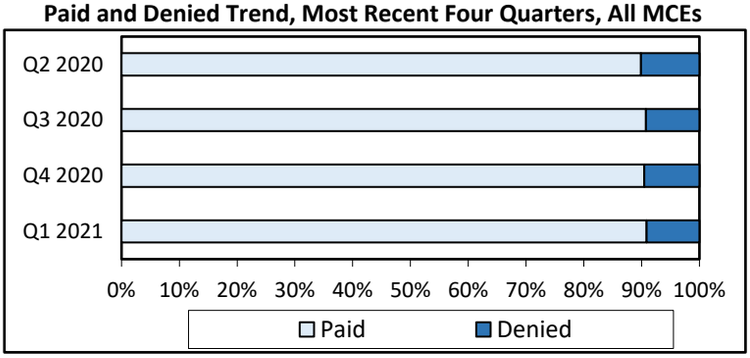
	ABH		ACLA		HBL		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	211	86	296	180	308	184	304	146	400	178
101 - 250	62	28	22	12	40	36	45	30	41	31
> 250 claims	30	12	0	0	1	1	9	5	4	0

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

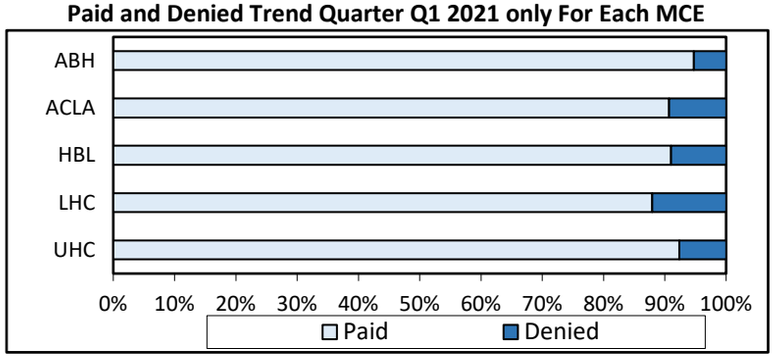
CARC Code	Description	ABH	ACLA	HBL	LHC	UHC
128	Newborn's services are covered in the mother's Allowance.		X	X		X
18	Exact duplicate claim/service	X	X		X	X
16	Claim/service lacks information or has submission/billing error(s) v	X			X	X
256	Service not payable per managed care contract.			X		X
97	The benefit for this service is included in the payment/allowance f	X				X

Summary of Information on Claims for Outpatient Hospital Services

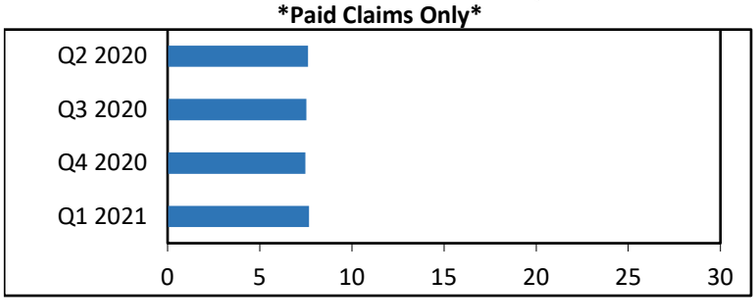
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



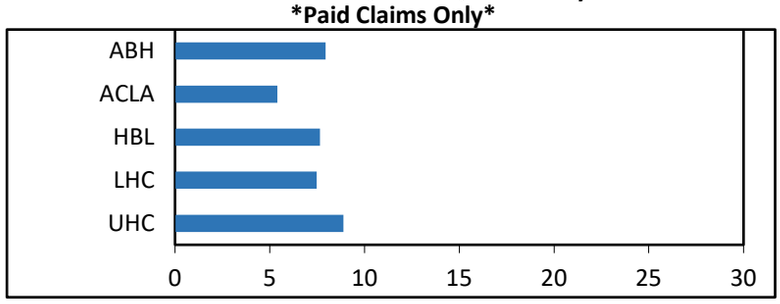
Paid and Denied Trend Quarter Q1 2021 only For Each MCE



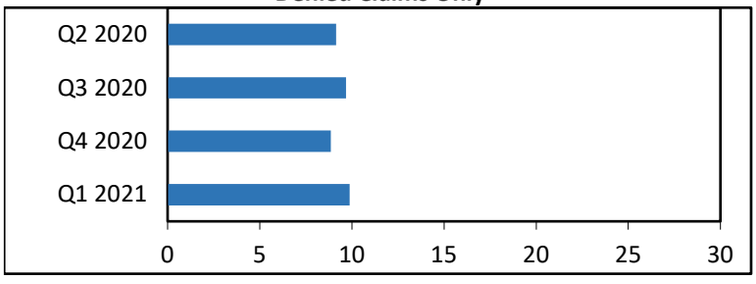
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



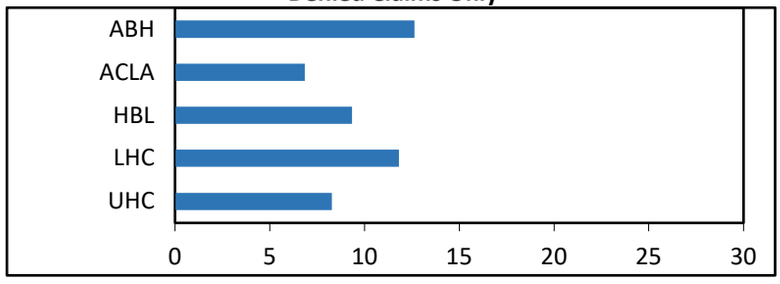
Claims Turnaround Time Quarter Q1 2021 only Each MCE
Paid Claims Only



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 2021 only)

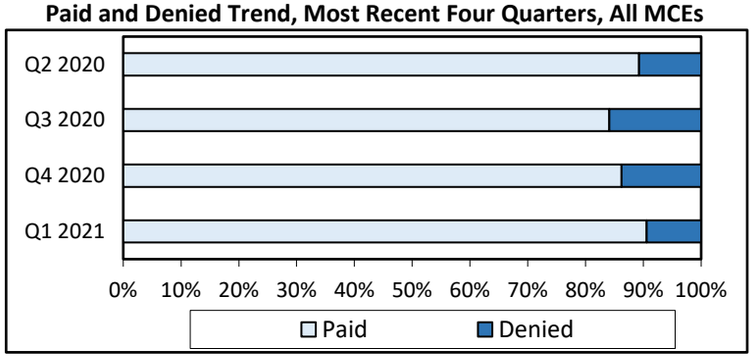
	ABH		ACLA		HBL		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	386	187	370	309	421	141	617	369	400	178
101 - 250	95	87	93	31	28	15	133	103	41	31
> 250 claims	107	63	120	37	97	31	162	109	4	0

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

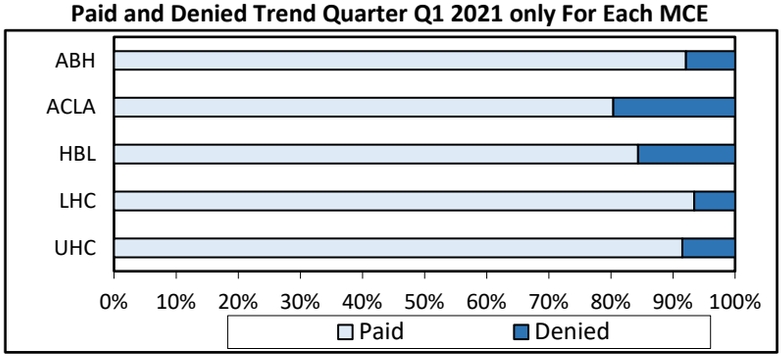
CARC Code	Description	ABH	ACLA	HBL	LHC	UHC
96	Non-covered charge(s).	X	X		X	X
97	The benefit for this service is included in the payment/allowance f	X			X	X
16	Claim/service lacks information or has submission/billing error(s) v	X	X		X	X
18	Exact duplicate claim/service	X			X	X
252	An attachment/other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

Summary of Information on Claims for Home Health Services

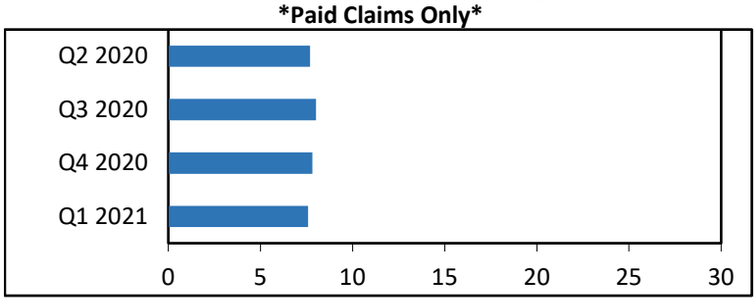
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



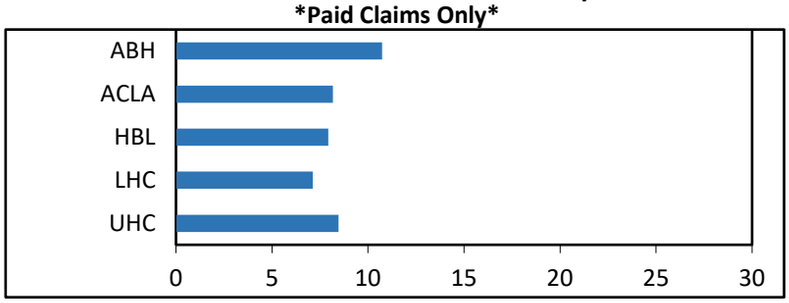
Paid and Denied Trend Quarter Q1 2021 only For Each MCE



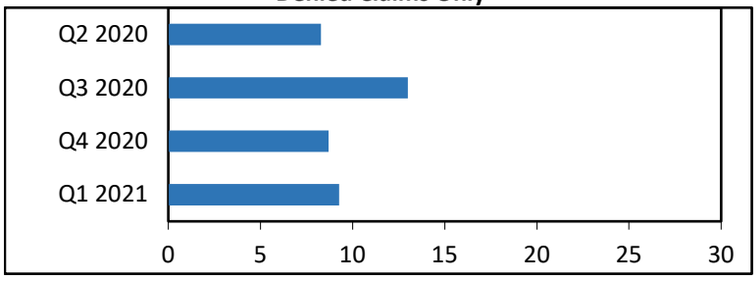
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



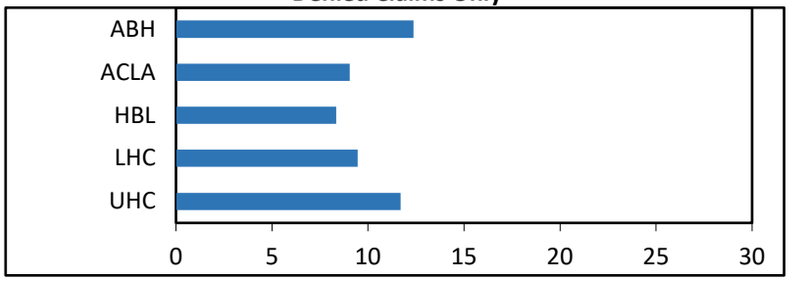
Claims Turnaround Time Quarter Q1 2021 only Each MCE
Paid Claims Only



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 2021 only)

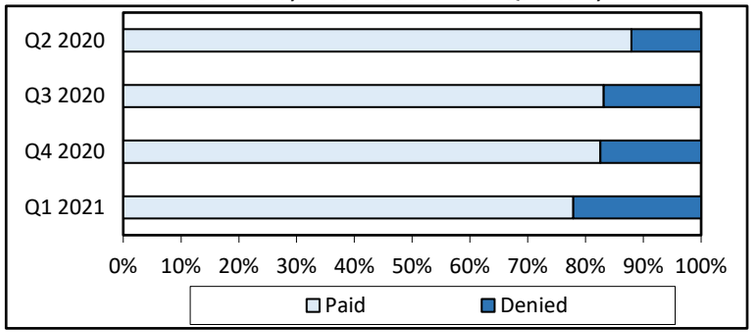
	ABH		ACLA		HBL		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	36	10	46	22	42	12	100	39	34	4
101 - 250	10	3	15	5	24	7	56	11	1	1
> 250 claims	0	0	0	0	3	1	18	5	0	0

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

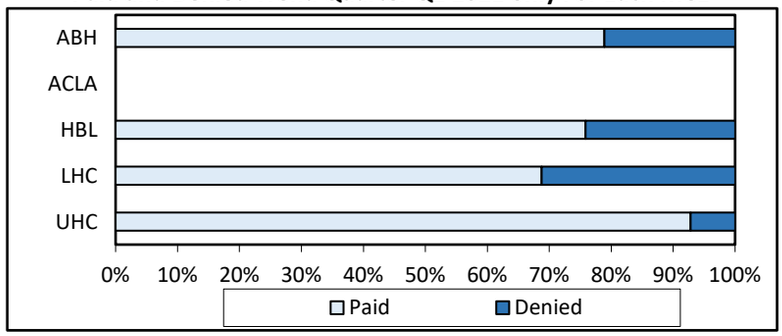
CARC Code	Description	ABH	ACLA	HBL	LHC	UHC
18	Exact duplicate claim/service	X			X	X
256	Service not payable per managed care contract.			X		X
96	Non-covered charge(s).	X	X			X
197	Precertification/authorization/notification absent.	X	X	X		X
16	Claim/service lacks information or has submission/billing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

Summary of Information on Claims for Other Institutional Services

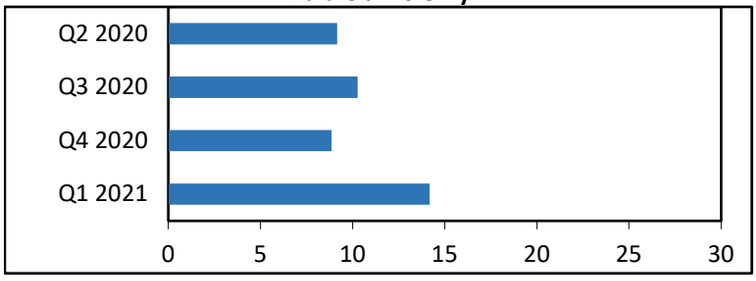
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



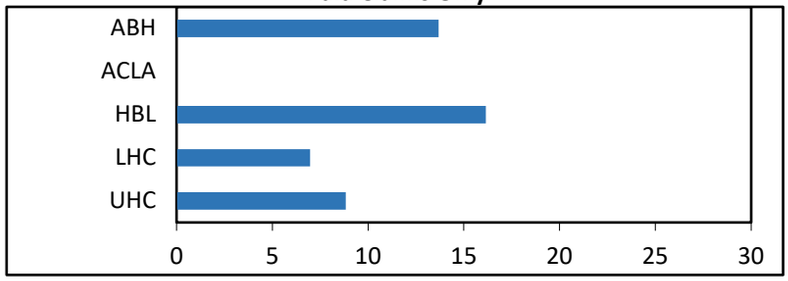
Paid and Denied Trend Quarter Q1 2021 only For Each MCE



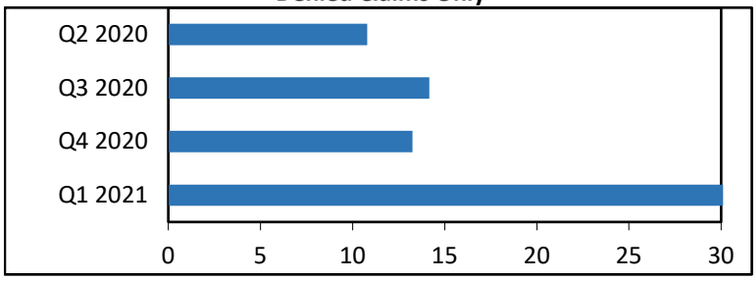
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



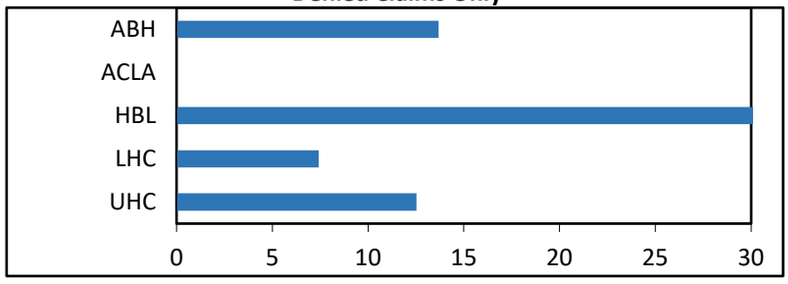
Claims Turnaround Time Quarter Q1 2021 only Each MCE
Paid Claims Only



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 2021 only)

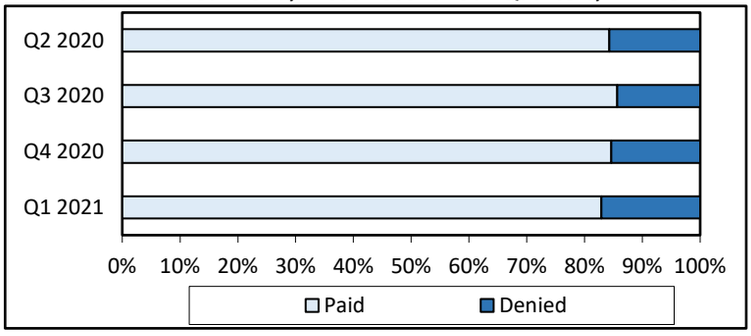
	ABH		ACLA		HBL		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	0% denied
<100 claims	18	17	0	0	136	78	122	77	23	3
101 - 250	4	4	0	0	89	36	6	6	11	4
> 250 claims	1	1	0	0	24	7	2	1	7	1

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

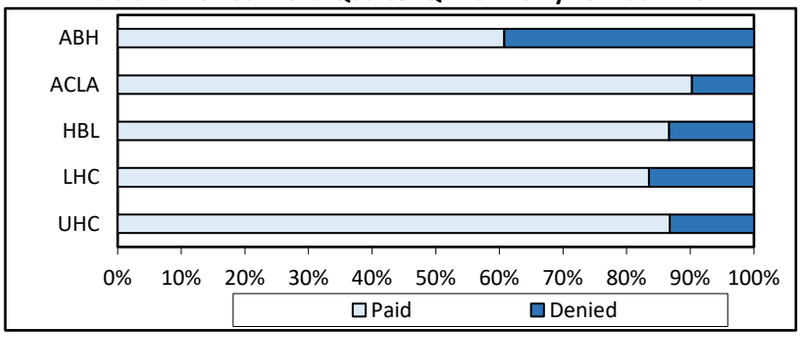
CARC Code	Description	ABH	ACLA	HBL	LHC	UHC
197	Precertification/authorization/notification absent.		X	X		
256	Service not payable per managed care contract.		X	X		
22	This care may be covered by another payer per coordination of be		X		X	
204	This service/equipment/drug is not covered under the patient's cu		X	X	X	
96	Non-covered charge(s).	X	X		X	X

Summary of Information on Claims for Primary Care Services

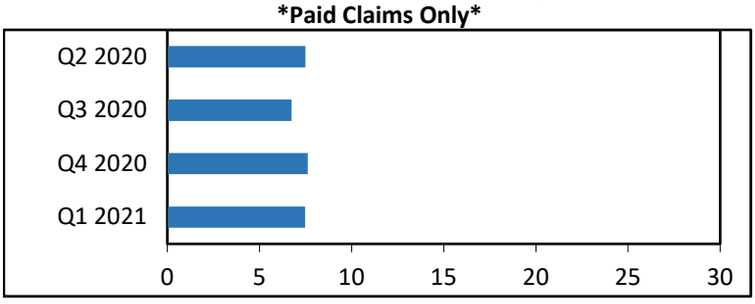
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



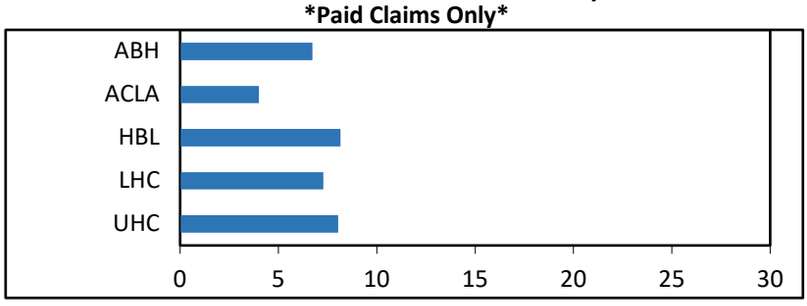
Paid and Denied Trend Quarter Q1 2021 only For Each MCE



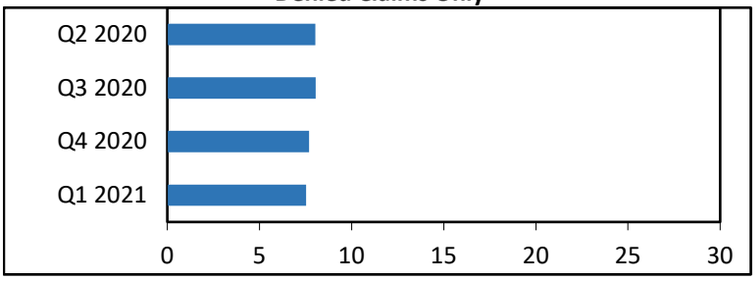
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



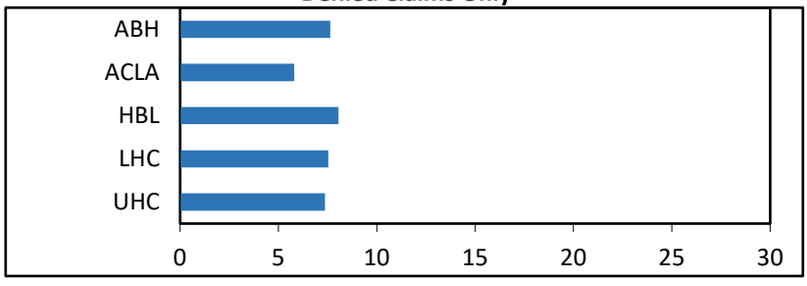
Claims Turnaround Time Quarter Q1 2021 only Each MCE
Paid Claims Only



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 2021 only)

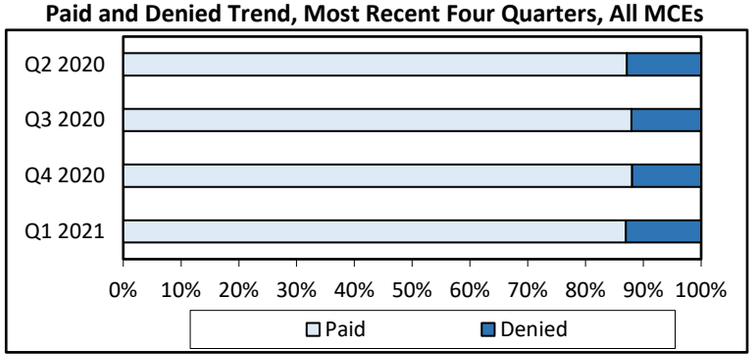
	ABH		ACLA		HBL		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	731	436	581	250	1,033	483	981	515	1,390	817
101 - 250	128	114	199	59	457	159	447	253	302	136
> 250 claims	24	23	59	15	245	87	334	206	289	116

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

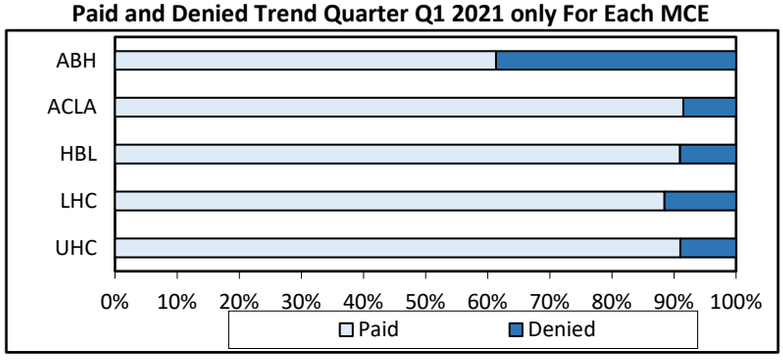
CARC Code	Description	ABH	ACLA	HBL	LHC	UHC
96	Non-covered charge(s).	X	X		X	X
97	The benefit for this service is included in the payment/allowance f	X				X
16	Claim/service lacks information or has submission/billing error(s) v	X	X		X	
B7	This provider was not certified/eligible to be paid for this procedur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

Summary of Information on Claims for Pediatric Services

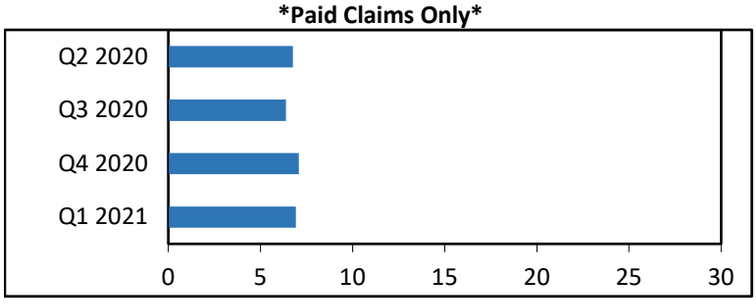
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



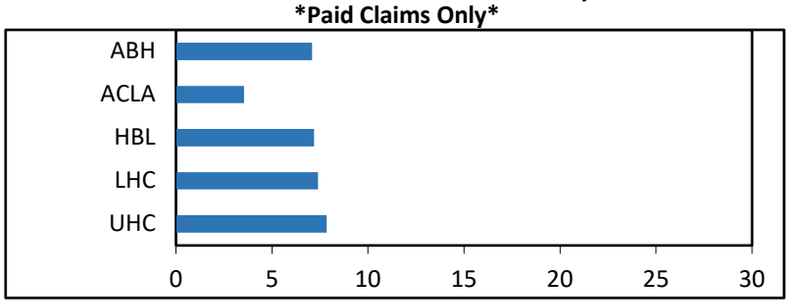
Paid and Denied Trend Quarter Q1 2021 only For Each MCE



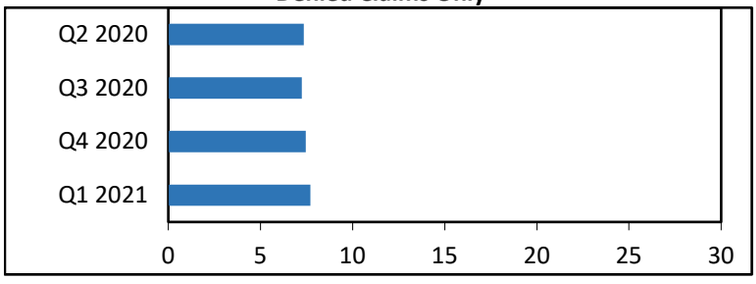
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



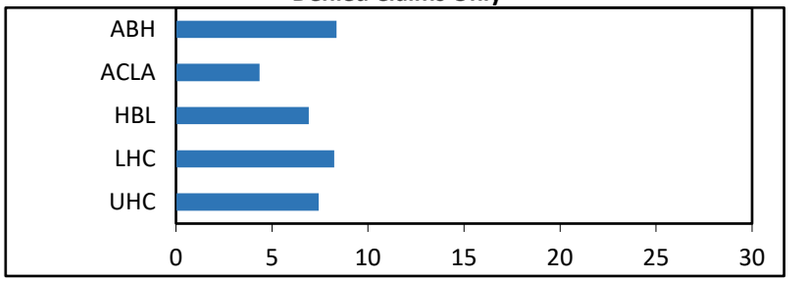
Claims Turnaround Time Quarter Q1 2021 only Each MCE
Paid Claims Only



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 2021 only)

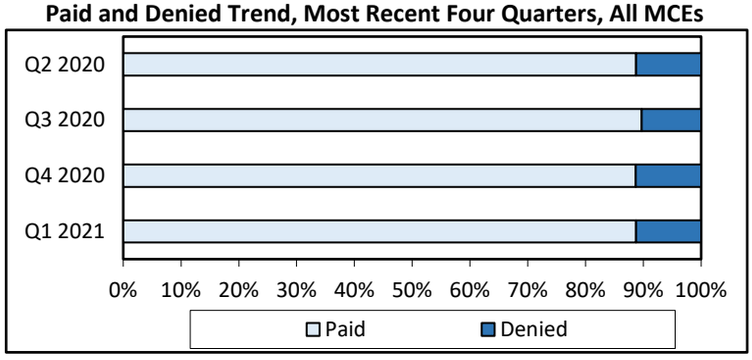
	ABH		ACLA		HBL		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	70	37	102	40	177	76	157	72	29	16
101 - 250	28	27	97	20	105	28	95	44	16	5
> 250 claims	4	4	55	9	105	14	134	63	53	16

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

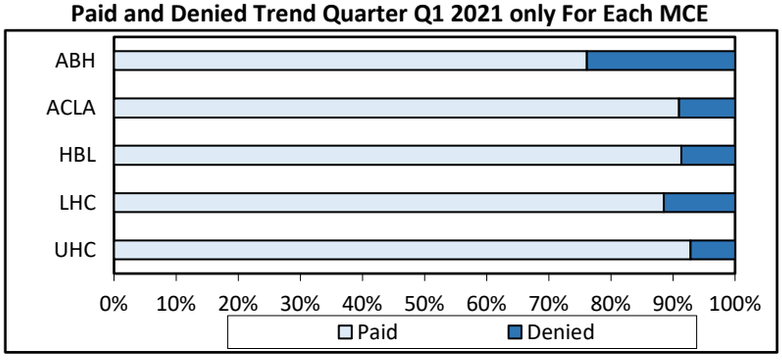
CARC Code	Description	ABH	ACLA	HBL	LHC	UHC
96	Non-covered charge(s).	X	X		X	X
18	Exact duplicate claim/service	X			X	X
B7	This provider was not certified/eligible to be paid for this procedur				X	
256	Service not payable per managed care contract.			X		
97	The benefit for this service is included in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

Summary of Information on Claims for OBGYN Services

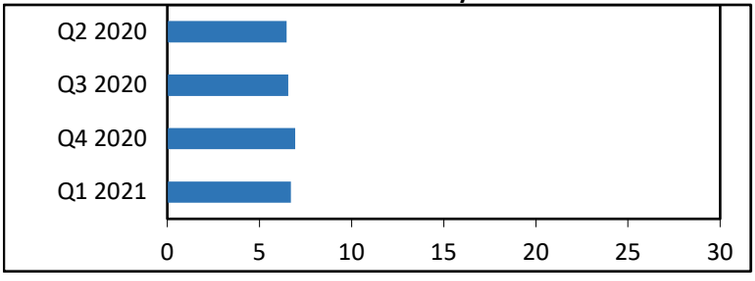
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



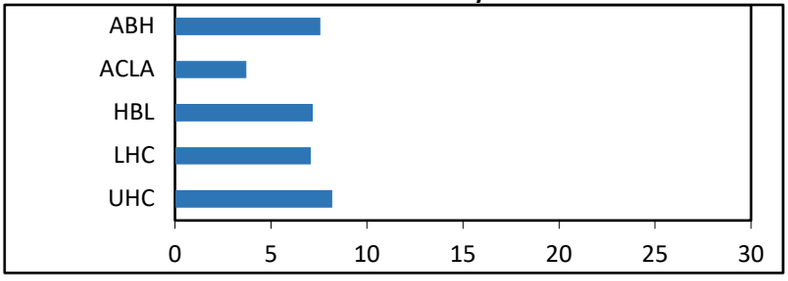
Paid and Denied Trend Quarter Q1 2021 only For Each MCE



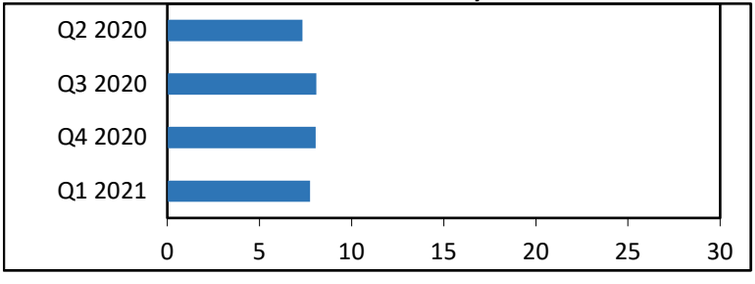
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



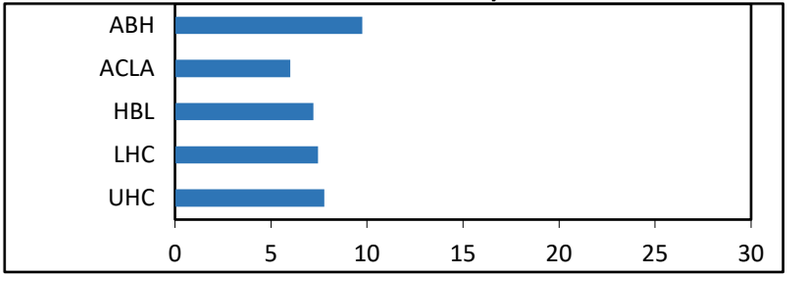
Claims Turnaround Time Quarter Q1 2021 only Each MCE
Paid Claims Only



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 2021 only)

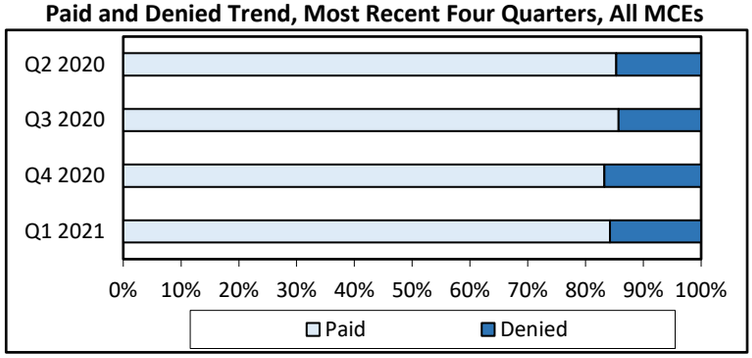
	ABH		ACLA		HBL		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	56	30	96	37	120	51	112	66	36	25
101 - 250	8	5	74	19	73	17	58	27	18	9
> 250 claims	1	1	19	4	39	11	59	29	18	3

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

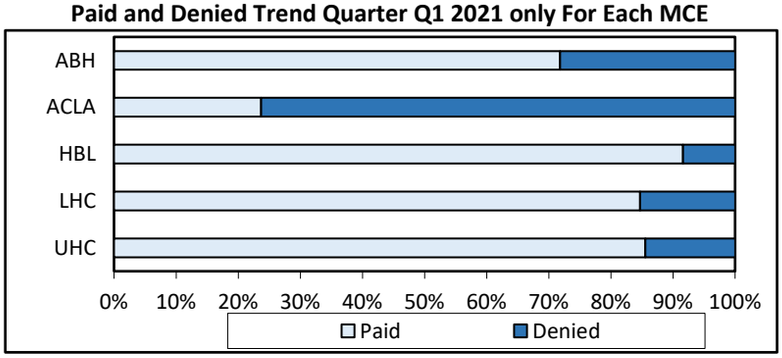
CARC Code	Description	ABH	ACLA	HBL	LHC	UHC
16	Claim/service lacks information or has submission/billing error(s) v	X	X		X	
18	Exact duplicate claim/service	X			X	X
96	Non-covered charge(s).	X	X		X	X
B7	This provider was not certified/eligible to be paid for this procedur				X	
260	Processed under Medicaid ACA Enhanced Fee Schedule			X		

Summary of Information on Claims for Therapy Services

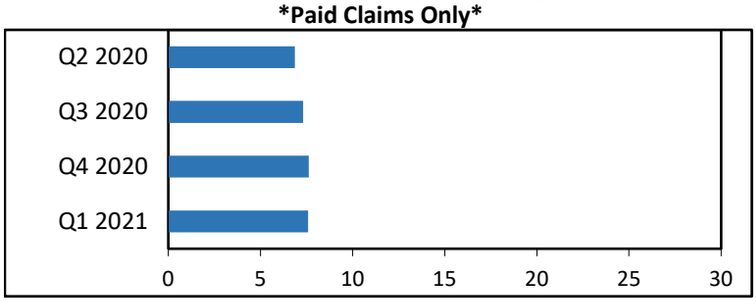
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



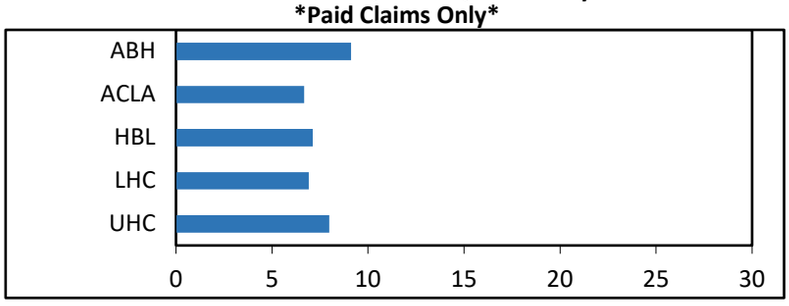
Paid and Denied Trend Quarter Q1 2021 only For Each MCE



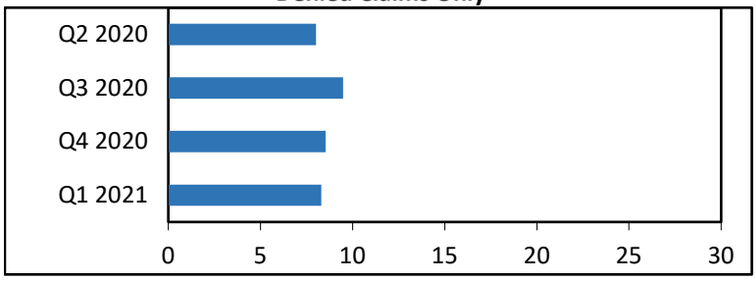
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



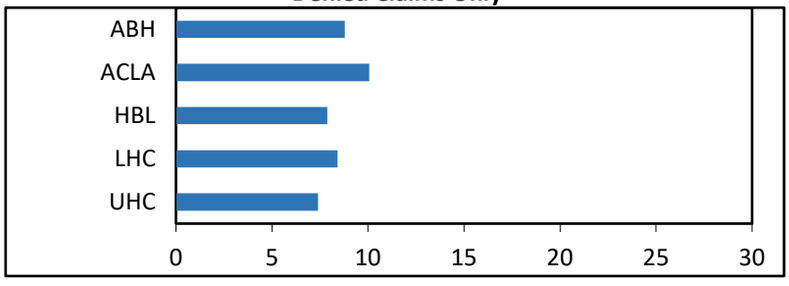
Claims Turnaround Time Quarter Q1 2021 only Each MCE
Paid Claims Only



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 2021 only)

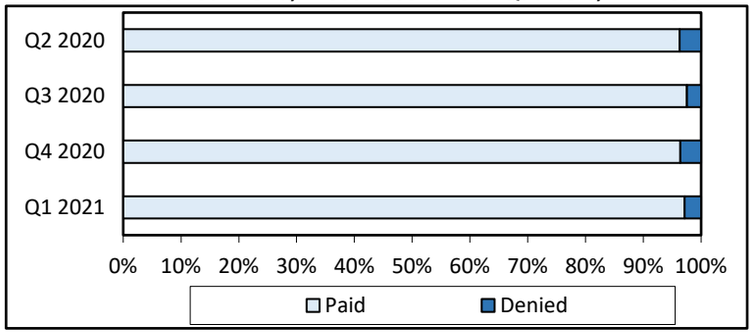
	ABH		ACLA		HBL		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	142	74	37	37	83	43	31	18	18	10
101 - 250	43	26	5	4	48	17	31	19	22	8
> 250 claims	0	0	0	0	19	4	9	6	12	5

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

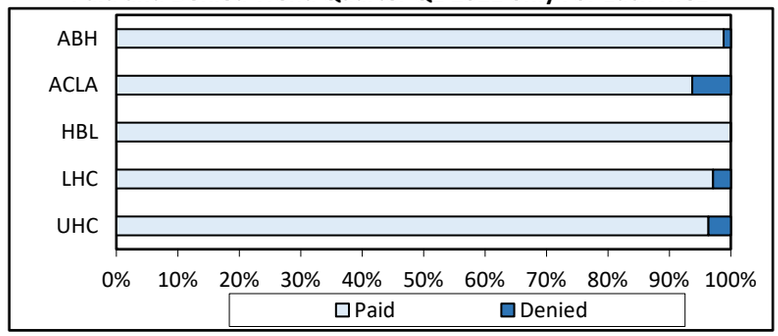
CARC Code	Description	ABH	ACLA	HBL	LHC	UHC
256	Service not payable per managed care contract.			X		
96	Non-covered charge(s).	X	X		X	X
197	Precertification/authorization/notification absent.	X	X	X	X	X
16	Claim/service lacks information or has submission/billing error(s) v	X	X		X	
97	The benefit for this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

Summary of Information on Claims for NEMT Services

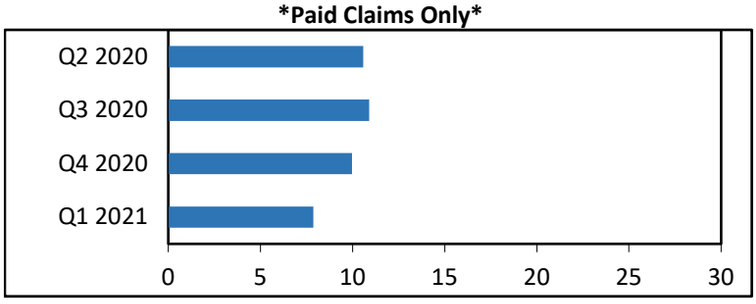
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



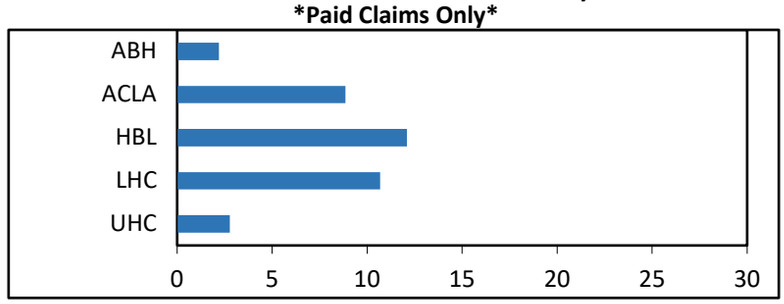
Paid and Denied Trend Quarter Q1 2021 only For Each MCE



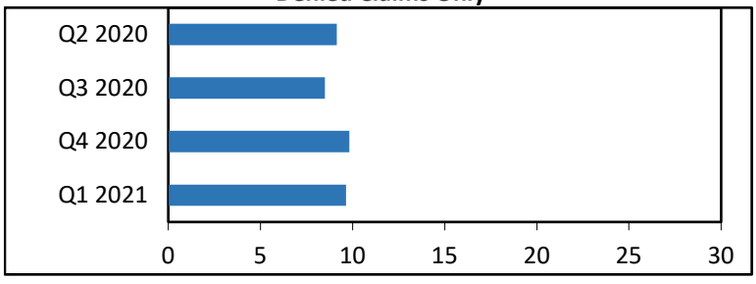
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



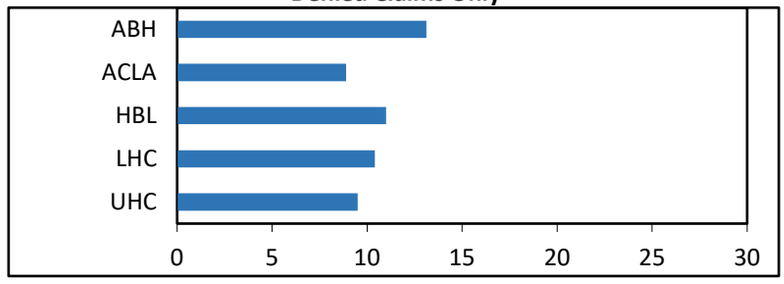
Claims Turnaround Time Quarter Q1 2021 only Each MCE
Paid Claims Only



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 2021 only)

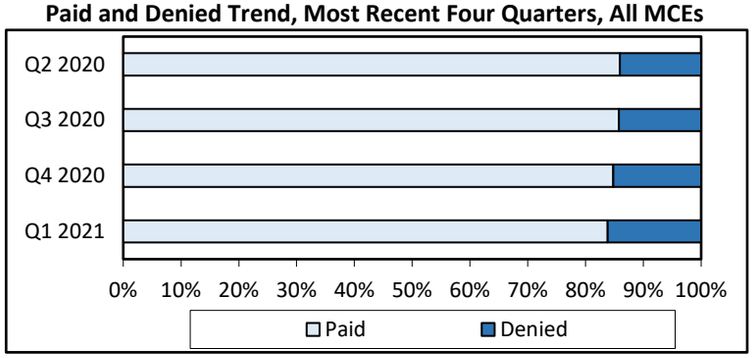
	ABH		ACLA		HBL		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	40	27	67	32	1	1	57	21	11	11
101 - 250	3	3	62	15	0	0	77	17	0	0
> 250 claims	0	0	20	1	0	0	33	1	0	0

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

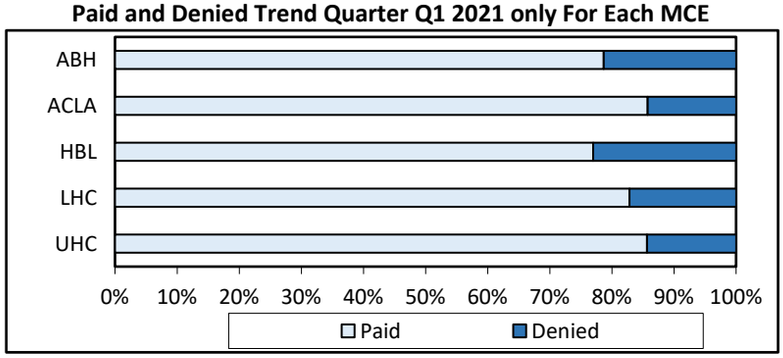
CARC Code	Description	ABH	ACLA	HBL	LHC	UHC
16	Claim/service lacks information or has submission/billing error(s) v	X	X	X	X	X
18	Exact duplicate claim/service	X		X	X	X
97	The benefit for this service is included in the payment/allowance f	X		X		X
96	Non-covered charge(s).		X	X	X	X
197	Precertification/authorization/notification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

Summary of Information on Claims for Medical Supplies Services

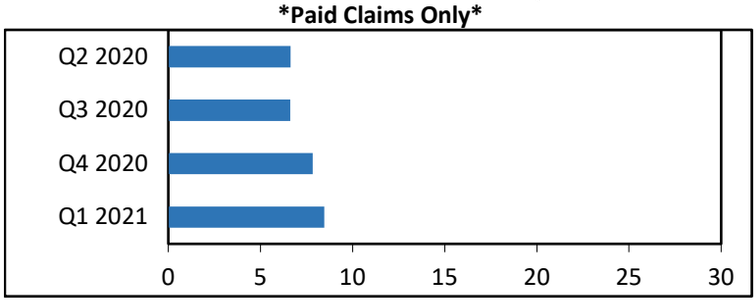
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



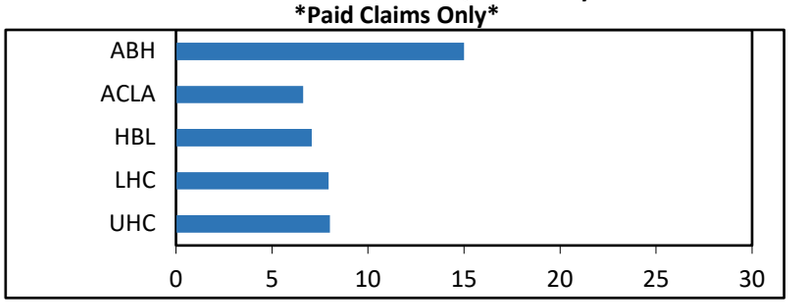
Paid and Denied Trend Quarter Q1 2021 only For Each MCE



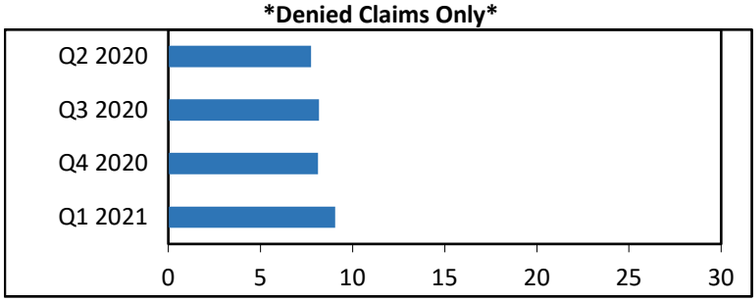
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



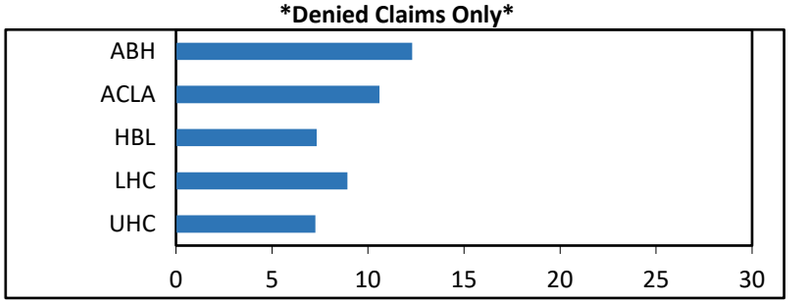
Claims Turnaround Time Quarter Q1 2021 only Each MCE
Paid Claims Only



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 2021 only)

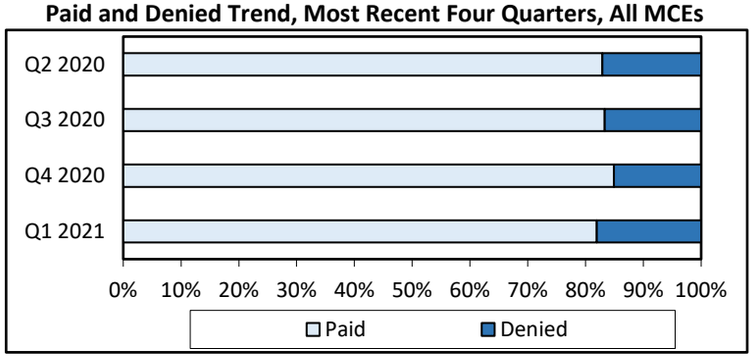
	ABH		ACLA		HBL		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	138	93	134	67	116	58	147	64	330	230
101 - 250	40	29	44	20	9	3	84	52	41	18
> 250 claims	11	8	12	5	1	1	22	16	34	17

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

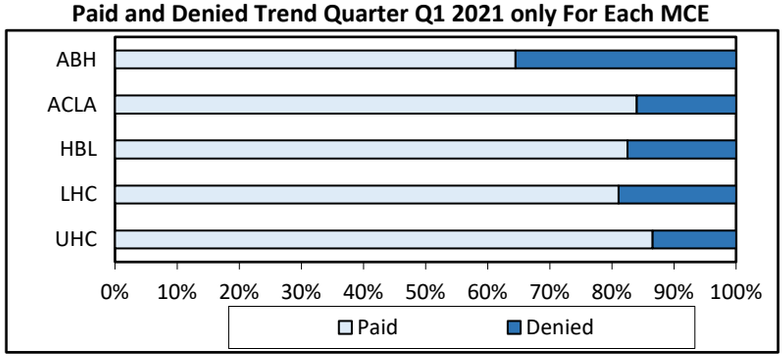
CARC Code	Description	ABH	ACLA	HBL	LHC	UHC
96	Non-covered charge(s).	X	X			X
16	Claim/service lacks information or has submission/billing error(s) v	X			X	
18	Exact duplicate claim/service	X			X	X
252	An attachment/other documentation is required to adjudicate this		X	X		X
197	Precertification/authorization/notification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

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

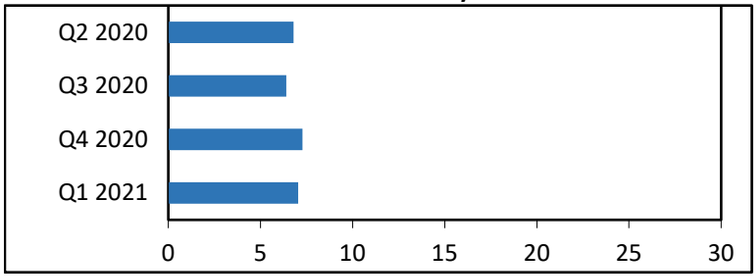
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



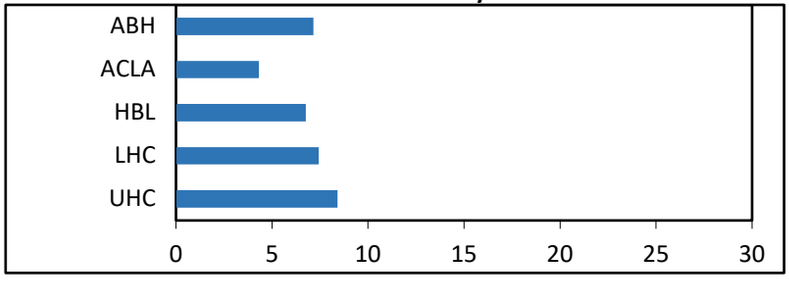
Paid and Denied Trend Quarter Q1 2021 only For Each MCE



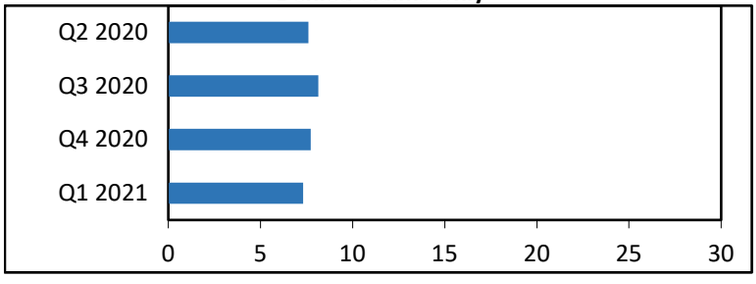
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



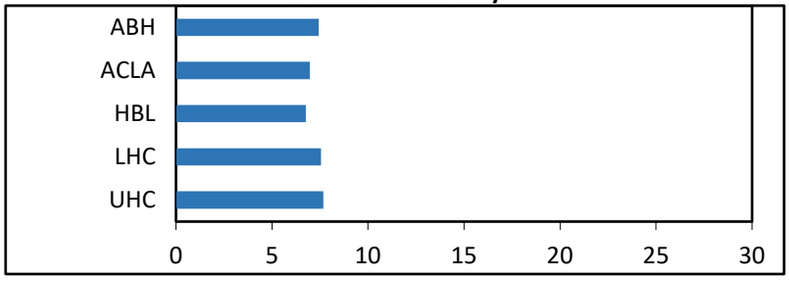
Claims Turnaround Time Quarter Q1 2021 only Each MCE
Paid Claims Only



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 2021 only)

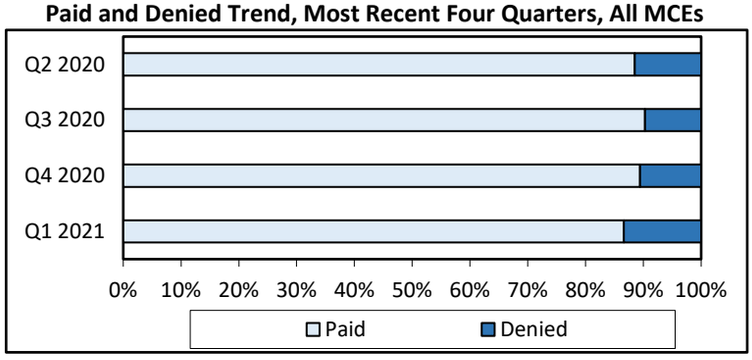
	ABH		ACLA		HBL		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	464	92	2,112	1,120	2,470	1,059	2,100	1,220	2,778	1,529
101 - 250	21	6	769	356	587	289	687	371	484	259
> 250 claims	9	7	292	102	332	149	504	254	342	149

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

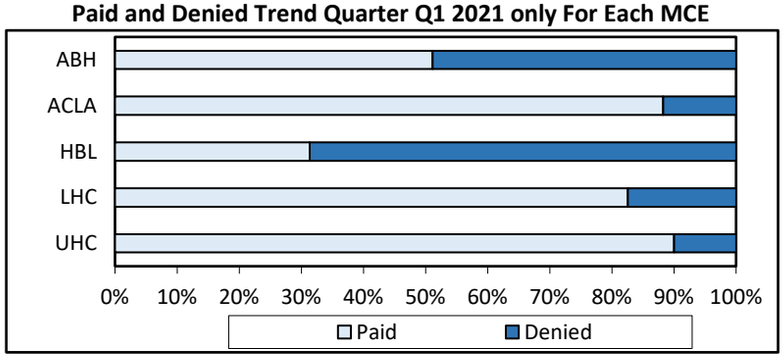
CARC Code	Description	ABH	ACLA	HBL	LHC	UHC
96	Non-covered charge(s).	X	X		X	X
197	Precertification/authorization/notification absent.		X	X		X
16	Claim/service lacks information or has submission/billing error(s) v	X	X		X	
B7	This provider was not certified/eligible to be paid for this procedur		X		X	
252	An attachment/other documentation is required to adjudicate this		X			X

Summary of Information on Claims for Mental Health Services- Rehab

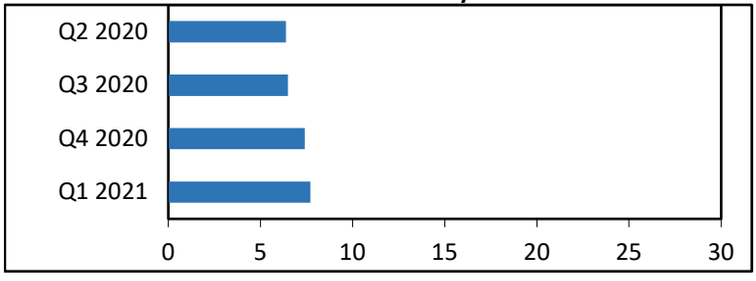
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



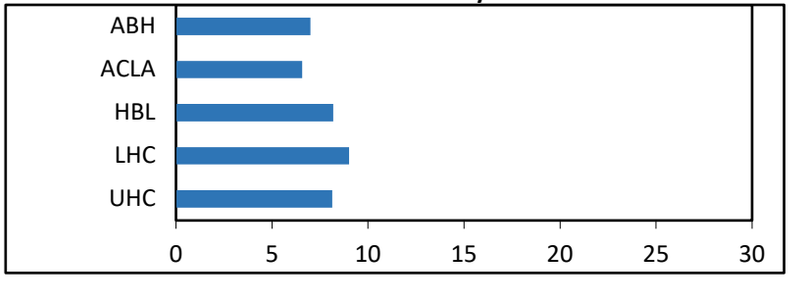
Paid and Denied Trend Quarter Q1 2021 only For Each MCE



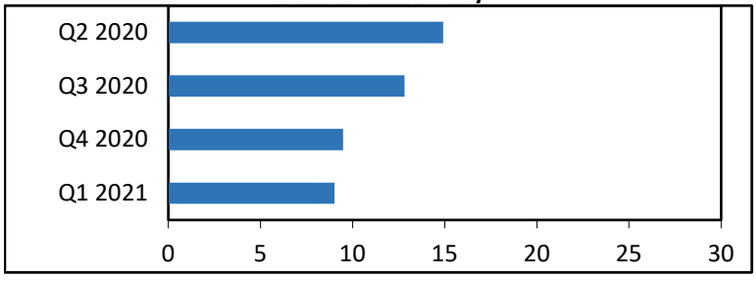
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



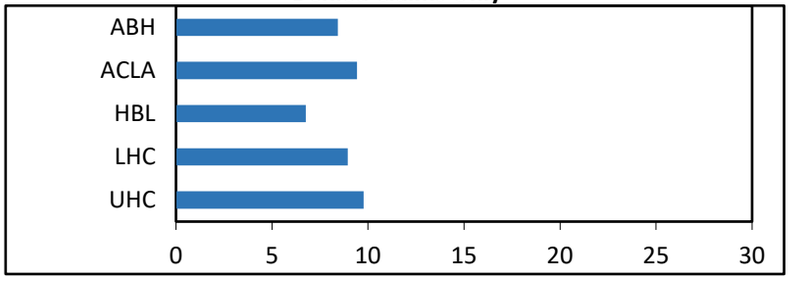
Claims Turnaround Time Quarter Q1 2021 only Each MCE
Paid Claims Only



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 2021 only)

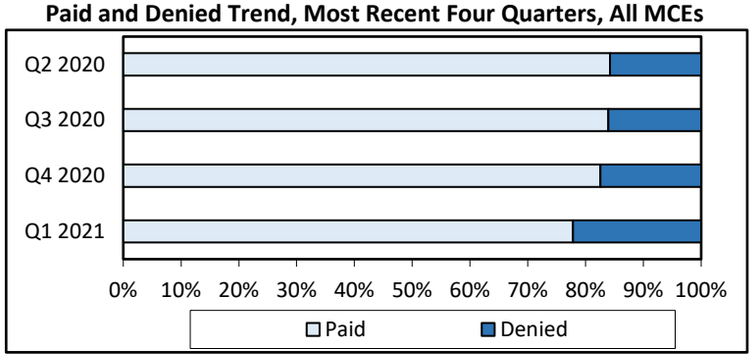
	ABH		ACLA		HBL		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	44	34	74	31	146	138	45	27	67	37
101 - 250	14	11	118	39	26	22	21	10	71	24
> 250 claims	2	2	43	10	2	2	4	4	87	33

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

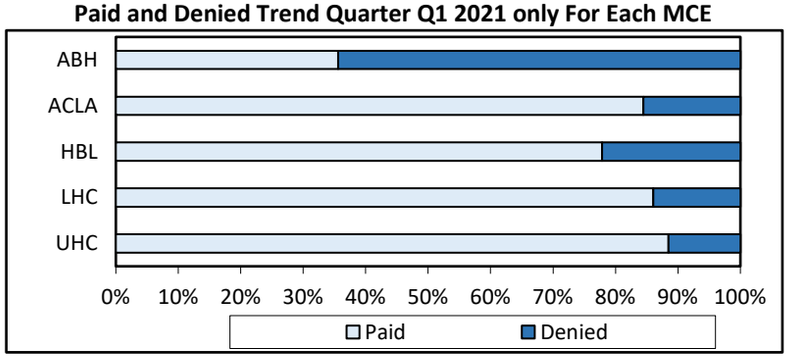
CARC Code	Description	ABH	ACLA	HBL	LHC	UHC
16	Claim/service lacks information or has submission/billing error(s) v	X			X	X
18	Exact duplicate claim/service				X	X
242	Services not provided by network/primary care providers.			X		
29	The time limit for filing has expired.	X	X			
197	Precertification/authorization/notification absent.			X	X	X

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

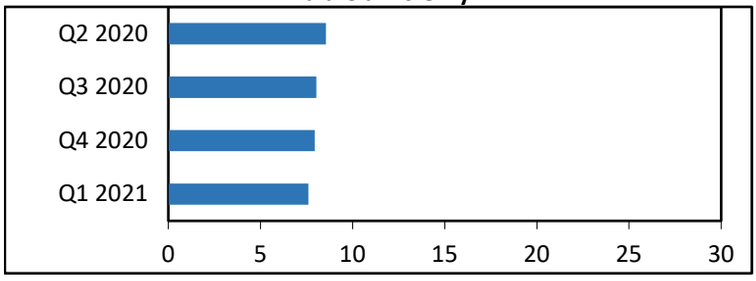
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



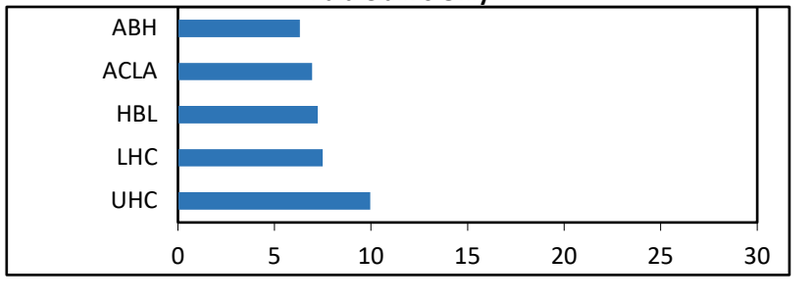
Paid and Denied Trend Quarter Q1 2021 only For Each MCE



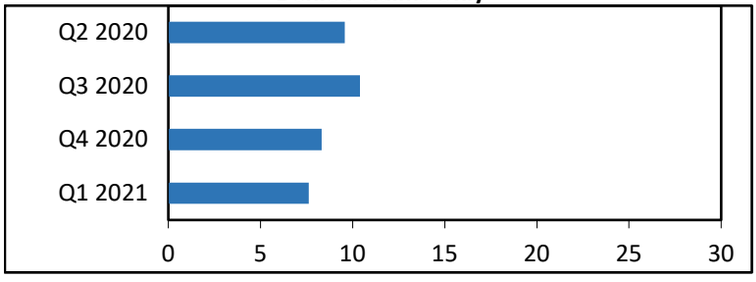
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



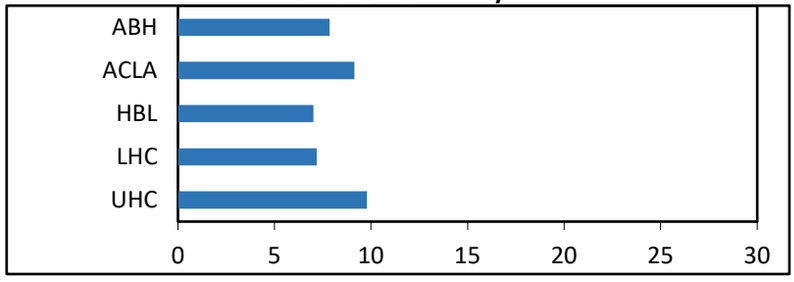
Claims Turnaround Time Quarter Q1 2021 only Each MCE
Paid Claims Only



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 2021 only)

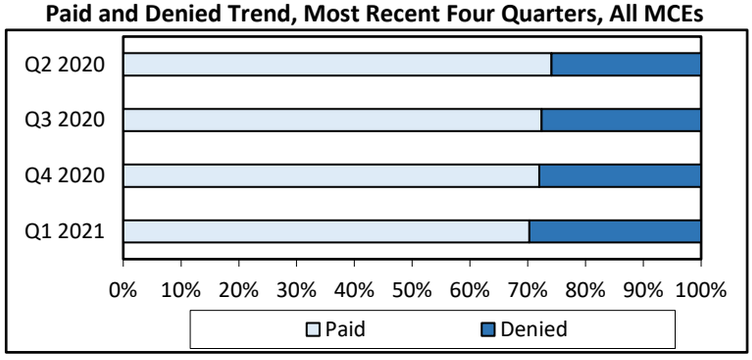
	ABH		ACLA		HBL		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	10	7	526	265	954	575	754	331	223	113
101 - 250	2	1	97	36	258	148	284	140	63	35
> 250 claims	0	0	21	5	98	56	227	105	43	14

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

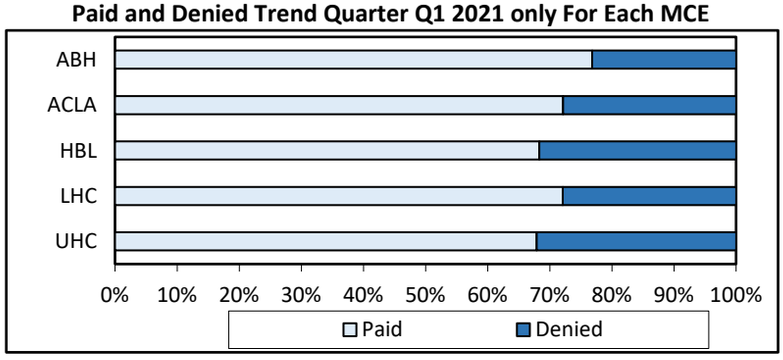
CARC Code	Description	ABH	ACLA	HBL	LHC	UHC
96	Non-covered charge(s).	X	X		X	
97	The benefit for this service is included in the payment/allowance f					
16	Claim/service lacks information or has submission/billing error(s) v	X			X	X
18	Exact duplicate claim/service				X	
252	An attachment/other documentation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

Summary of Information on Claims for Pharmacy Services

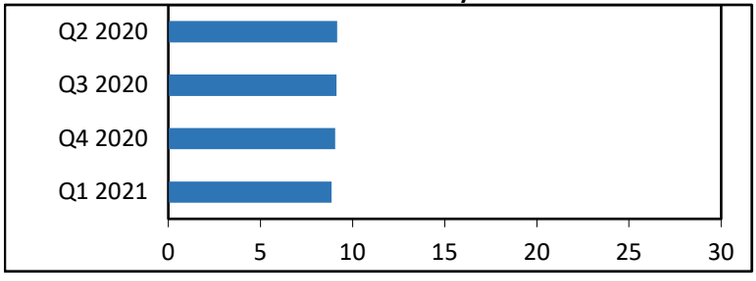
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



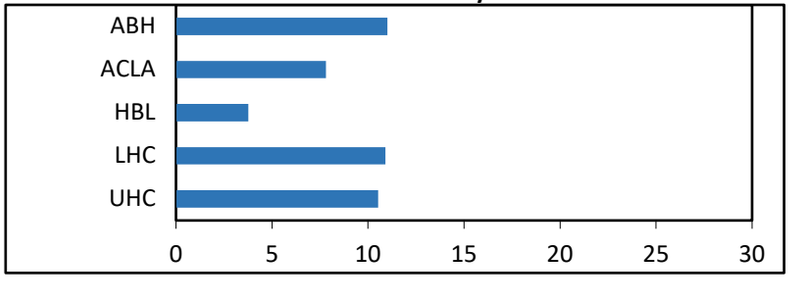
Paid and Denied Trend Quarter Q1 2021 only For Each MCE



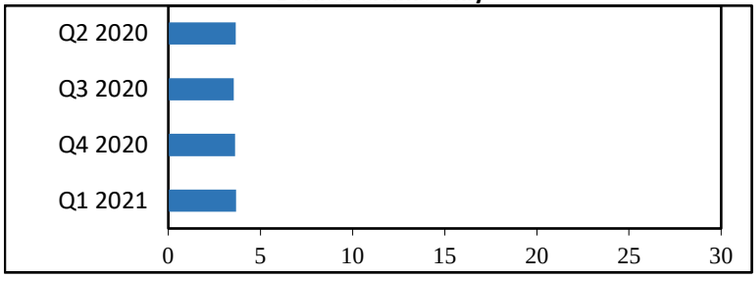
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



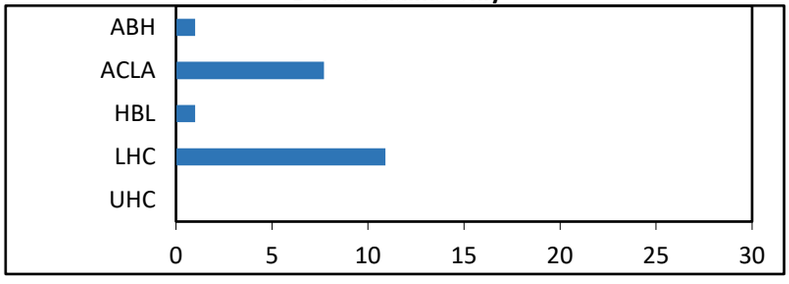
Claims Turnaround Time Quarter Q1 2021 only Each MCE
Paid Claims Only



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 2021 only)

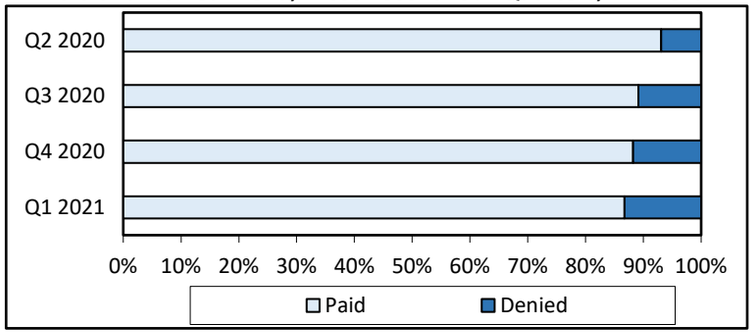
	ABH		ACLA		HBL		LHC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	16,478	10,534	902	887	2,478	2,000	12,546	11,600	18,244	14,331
101 - 250	1,454	1,411	392	391	213	212	3,478	3,327	3,863	3,852
> 250 claims	105	103	637	635	887	887	1,218	1,195	1,288	1,288

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

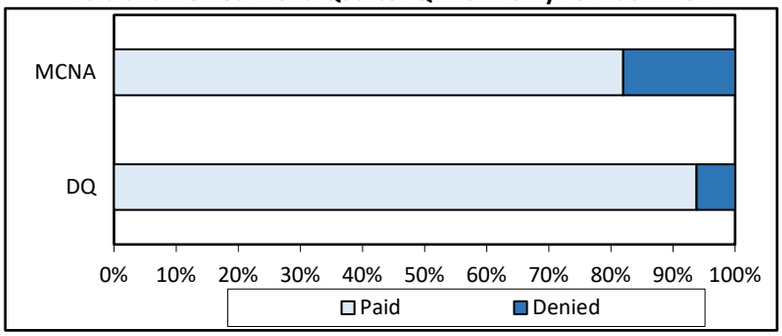
NCDCP Code	Description	ABH	ACLA	HBL	LHC	UHC
79	Refill Too Soon	X	X	X	X	X
88	DUR Reject Error		X	X	X	X
76	Plan Limitations Exceeded	X		X	X	X
75	Prior Authorization Required	X		X	X	
7Ø	Product/Service Not Covered – Plan/Benefit Exclusion	X	X		X	X

Summary of Information on Claims for Dental Services- Children

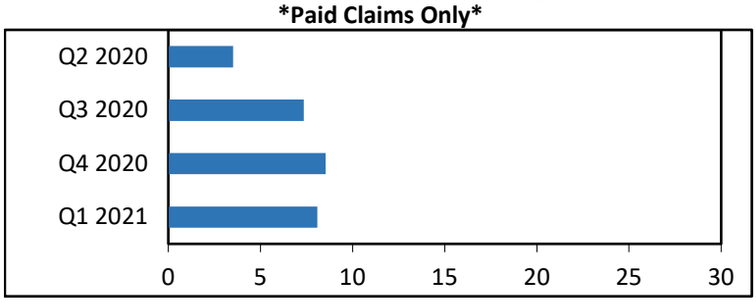
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



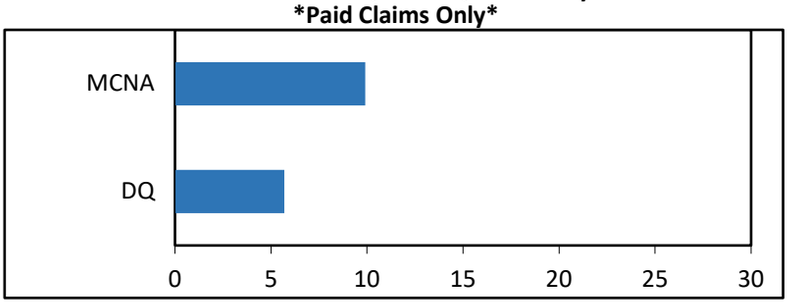
Paid and Denied Trend Quarter Q1 2021 only For Each MCE



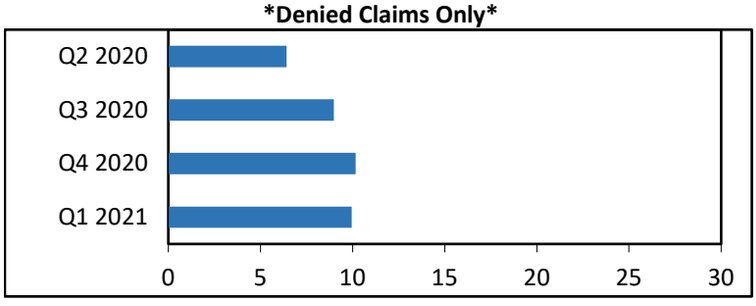
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



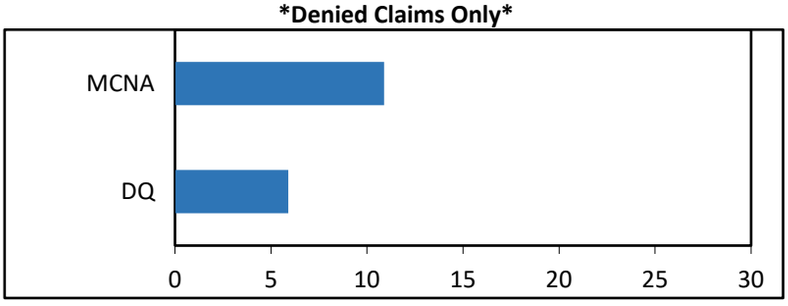
Claims Turnaround Time Quarter Q1 2021 only Each MCE
Paid Claims Only



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 2021 only)

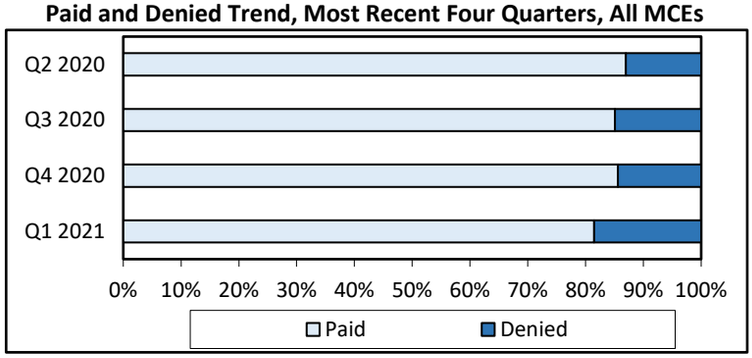
	MCNA		DQ	
	# Providers	>10% denied	# Providers	>10% denied
<100 claims	630	457	97	40
101 - 250	163	138	276	62
> 250 claims	37	37	156	45

Top Denial Reasons this Quarter

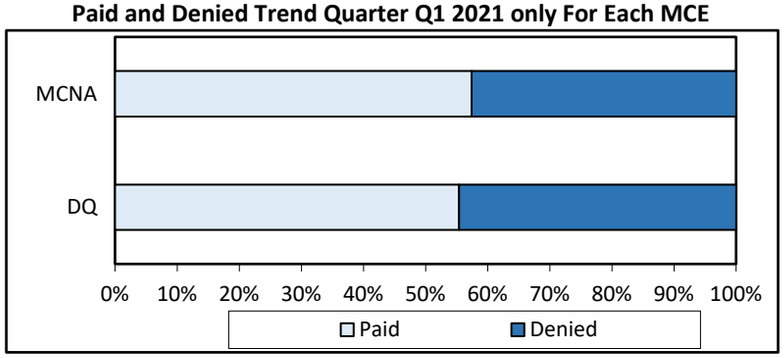
CARC Code	Description	MCNA	MCNA
27	Expenses incurred after coverage terminated.	X	
18	Exact duplicate claim/service	X	X
96	Non-covered charge(s).	X	
169	Alternate benefit has been provided.	X	
119	Benefit maximum for this time period or occurrence has been reac	X	X

Summary of Information on Claims for Dental Services- Adults

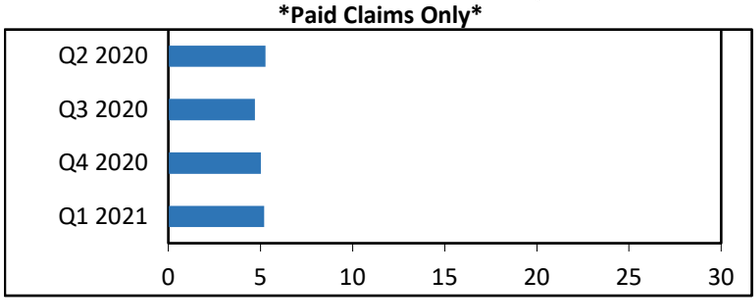
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



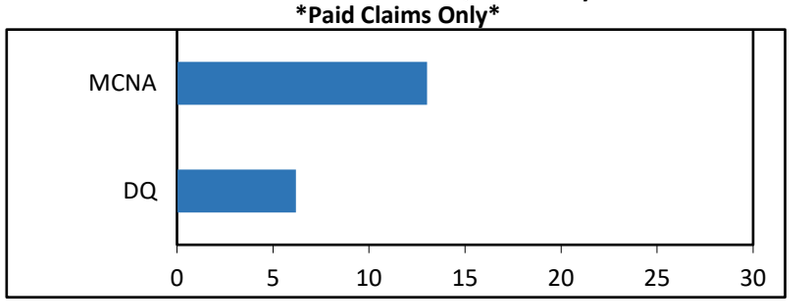
Paid and Denied Trend Quarter Q1 2021 only For Each MCE



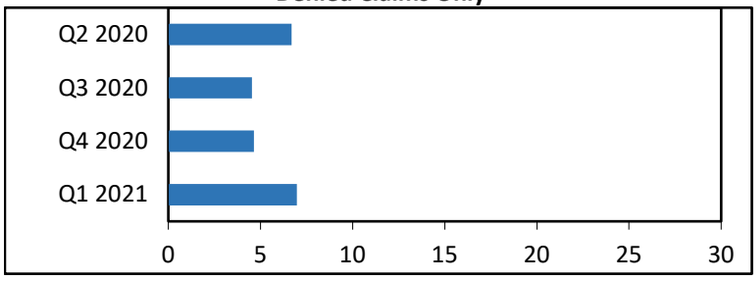
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



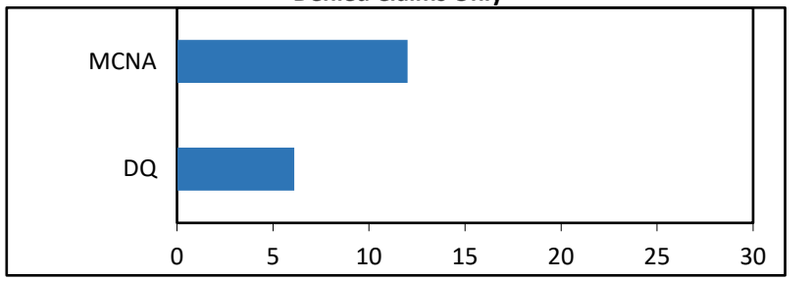
Claims Turnaround Time Quarter Q1 2021 only Each MCE
Paid Claims Only



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 2021 only)

	MCNA		DQ	
	# Providers	>10% denied	# Providers	>10% denied
<100 claims	299	290	112	68
101 - 250	2	2	8	6
> 250 claims	0	0	0	0

Note: All MCEs had little data for Dental-Adult

Top Denial Reasons this Quarter

CARC Code	Description	MCNA	DQ
B7	This provider was not certified/eligible to be paid for this procedur		
119	Benefit maximum for this time period or occurrence has been reac		X
96	Non-covered charge(s).	X	
18	Exact duplicate claim/service	X	X
186	Level of care change adjustment.		