Healthy Louisiana Claims Report

Response to Act 710 of the 2018 Regular Legislative Session

Quarter 2 Calendar Year 2021

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Louisiana Department of Health

Bureau of Health Services Financing

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LOUISIANA DEPARTMENT OF HEALTH

Contents

Executive Summary

Background

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

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

Key Findings

Measure #1: Claims Accepted and Rejected by the MCEs

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

- In the most recent four quarters for which data is available, the claims rejection rate reported by the Medicaid MCEs was between 1.2% and 1.3%. This rate, however, is driven primarily by Louisiana Healthcare Connections (LHCC) with a rejection rate of 2.7% to 3.1%, with the other MCEs having rejection rates close to zero.

Measure #2: Claims Paid and Denied by the MCEs

- The claim denial rates have been generally consistent since Act 710 reporting began. The overall rate of accepted claims paid by the MCEs was between 80.4% and 82.1% in the most recent four quarters. The denial rates, therefore, were between 17.9% and 19.6%.

- At the MCE-specific level, the average denial rate in the last four quarters ranged from 7.9% for DentaQuest (DQ) to 23.9% for Aetna Better Health (ABH).

- More variation was found when the claims denial rates were examined by provider type. For example, the highest denial rates are found for pharmacy (average 28.3% in the last four quarters) and inpatient hospital (average 17.9% 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 9.3% in the last four quarters).

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

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

- The MCEs are meeting the target for adjudication within 30 days as set by LDH. In fact, the average TAT is at or 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.
- Average claims adjudication TATs do vary by provider category, but not significantly, from the overall average.

Measure #4: Top Reasons for Denied Claims

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

Key findings by CARCs:

- The top five CARCS for Q2 2021 were:

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

- The top five CARCs in this quarter were also among the top seven in the previous 10 quarters reported, demonstrating a level of consistency in top reasons for denial over time.

Key findings on NCPDPs appear below:

- The top five NCPDPs in Q2 2021 were:

NCPDP Code	Description
79	Refill too soon
88	Drug Utilization Review (DUR) reject error
76	Plan limitations exceeded
75	Prior authorization required
70	Product/service not covered – plan/benefit exclusion

- 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 98.0% of the encounters submitted by all MCEs combined were accepted by LDH.

- There were differences at the MCE level. All of UnitedHealthcare's (UHC) and almost all of Healthy Blue's (HB), LHCC's and MCNA's encounters were accepted. Amerihealth Caritas (ACLA) had at least 90.7% of their encounters accepted for the previous three quarters, but showed an increase with 94.0% for the current quarter. DQ, as a newly joined MCE, saw an increase in their encounter acceptance rate from 88% in Q1 to 94% in Q2. ABH had some challenges with a declining trend in their acceptance rate of less than 90% for all four most recent quarters.

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

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

- Across all MCEs the overall average rate of submission within 30 days for institutional, professional, dental and pharmacy encounters was 86.1%.

- HB has been the most consistent over the past four quarters with an overall average of 99.0%.

- ACLA had the most significant improvement over the past four quarters with an overall average of 80.0% for Q3 and Q4 2020 to 95.6% for Q1 and Q2 2021.

- ABH had issues with timely submissions in all four current quarters which they attribute to clearing out historical inventory and adjustments from previous quarters. Its Q2 rates are showing improvement.

- MCNA had issues meeting an average 30-day TAT for its dental encounters for Q4 2020 but improved for Q1 and Q2 2021. DQ improved timeliness of dental encounter submissions from 56.0% in Q1 to 100% in Q2 of 2021.

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

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

In Q2 2021, a total of 1,275 provider entities received outreach (1,546 in the prior quarter). The most predominant mode of outreach to providers is 1:1 phone calls (46.2% of all contacts) followed by 1:1 emails (42.8% of contacts). Webinars were 10.9% of the total. Very little in-person contact was made 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 who are identified as having special healthcare needs (SHCN) or who have high-risk or unique, chronic or complex needs.

Key findings for Q2 2021:

- A total of 49,982 (approximately 3%) of unduplicated individuals enrolled in the Louisiana Medicaid Managed Care program were identified as potentially eligible or in need of case management services.
- Of these, 23% or 11,672 were enrolled in case management for at least one month during the second quarter of CY 2021 and;
- 7,533 (65%) actively received one or more case management service.

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 the 12th 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			
12											X	X	X	X		

Terminology Used in this Report

A ***claim*** is the bill that the healthcare 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).

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.

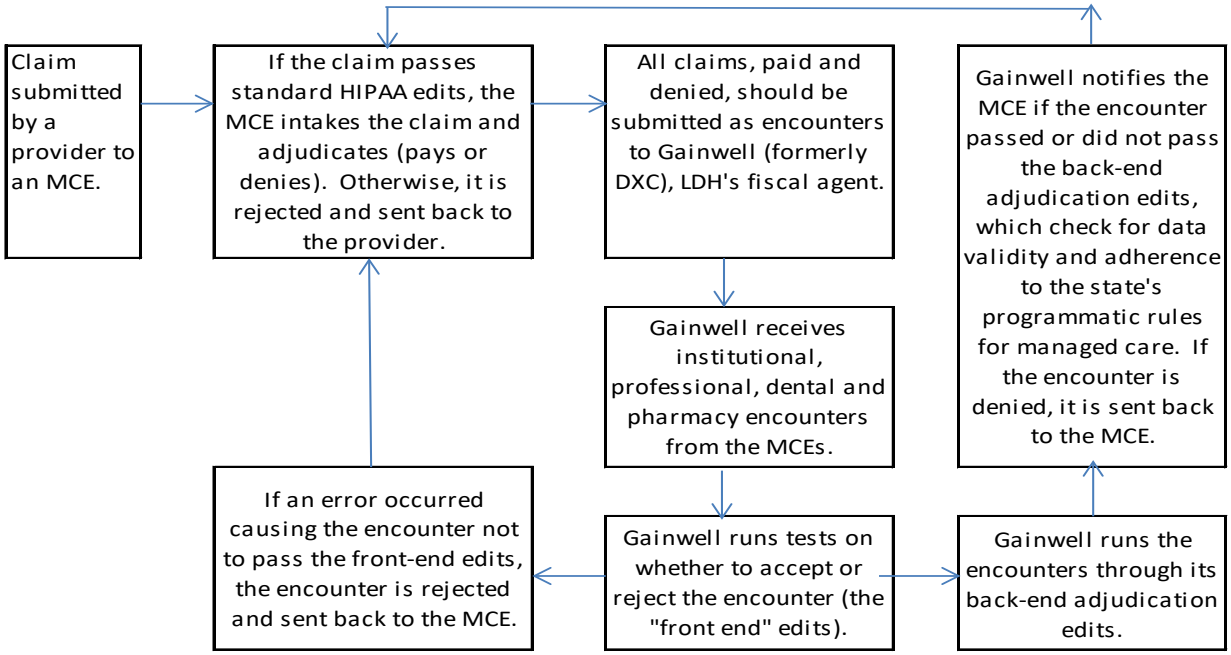
- The *CMS-1500, or electronic 837P*, is the claim type for professional service providers to submit. This includes a wide array of providers such as physicians, clinics, mental health providers, therapists, transportation providers, suppliers of medical equipment and supplies.

- 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 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



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), nearly 290 reason codes in all.
- For pharmacy claims specifically, there are nearly 350 reason codes developed by the National Council for Prescription Drug Programs (NCPDP).

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.

MCEs Analyzed in this Quarter's Review Include:

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

Measures Reported Each Quarter

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

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

Provider Categories

Act 710 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 (DQ and MCNA Only)*	Medical equipment and supplies
Pediatric dental care	Mental or behavioral health rehabilitation
Adult denture services	Specialized behavioral health services
Pharmacy Claims	All other services submitted on a professional claim not specified above
(no additional breakouts)	

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

Data Collection

Templates for six reporting areas were designed specifically to be able to report information in the Act 710 quarterly updates. These six templates were incorporated into a consolidated reporting template — Report 152. LDH requires that each MCE submit the 152 report on a quarterly basis. It should be noted that there is a lag time between the claims adjudication period and the date that the MCEs submit the reports to LDH as allowed by the Act. This allows time for the MCEs to accumulate data for reporting.

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, the approach being selected was 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.

Report Structure

Section II contains a summary table of data trends across all quarterly reports, Q1 2018 through Q2 2021. Section III contains the results related to MCE claims adjudication measures and MCE provider education pertaining to claim submissions. Section IV reports on the results of findings related to MCE encounter submissions and Section V presents summary data on case management by MCE for the quarter.

In some exhibits, data is displayed for the most recent four quarters. In this report, the four quarters shown are Quarters 3 and 4 in 2020 and Quarters 1 and 2 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 Q2 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 one-page summary for each of the 16 provider categories. The summaries in this appendix compile information from the exhibits in the body of the report but focus on a single provider specialty on each page.

Section II: Data Trends Q1 2018 to Q2 2021

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

Claim Rejection Rate	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 19.6%
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%).
For Professional Services	The denial rate range has been steady between 11.3% and 14.3%.
For Dental Claims	For child dental services, denial rate had been steady between 6.9% and 9.0% before Quarter 2, 2020, while steadily increasing 10.9% to 13.3% for the current four quarters.
For Pharmacy Claims	Industry standard is that pharmacy scripts have highest denial rate. Louisiana Medicaid Managed Care is no exception with a denial rate range between 25.9% and 29.7%. 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, HB is most consistently timely (that is, all encounters submitted to LDH within 30 days of processing). UHC submits over 96.7% of its encounters within 30 days.

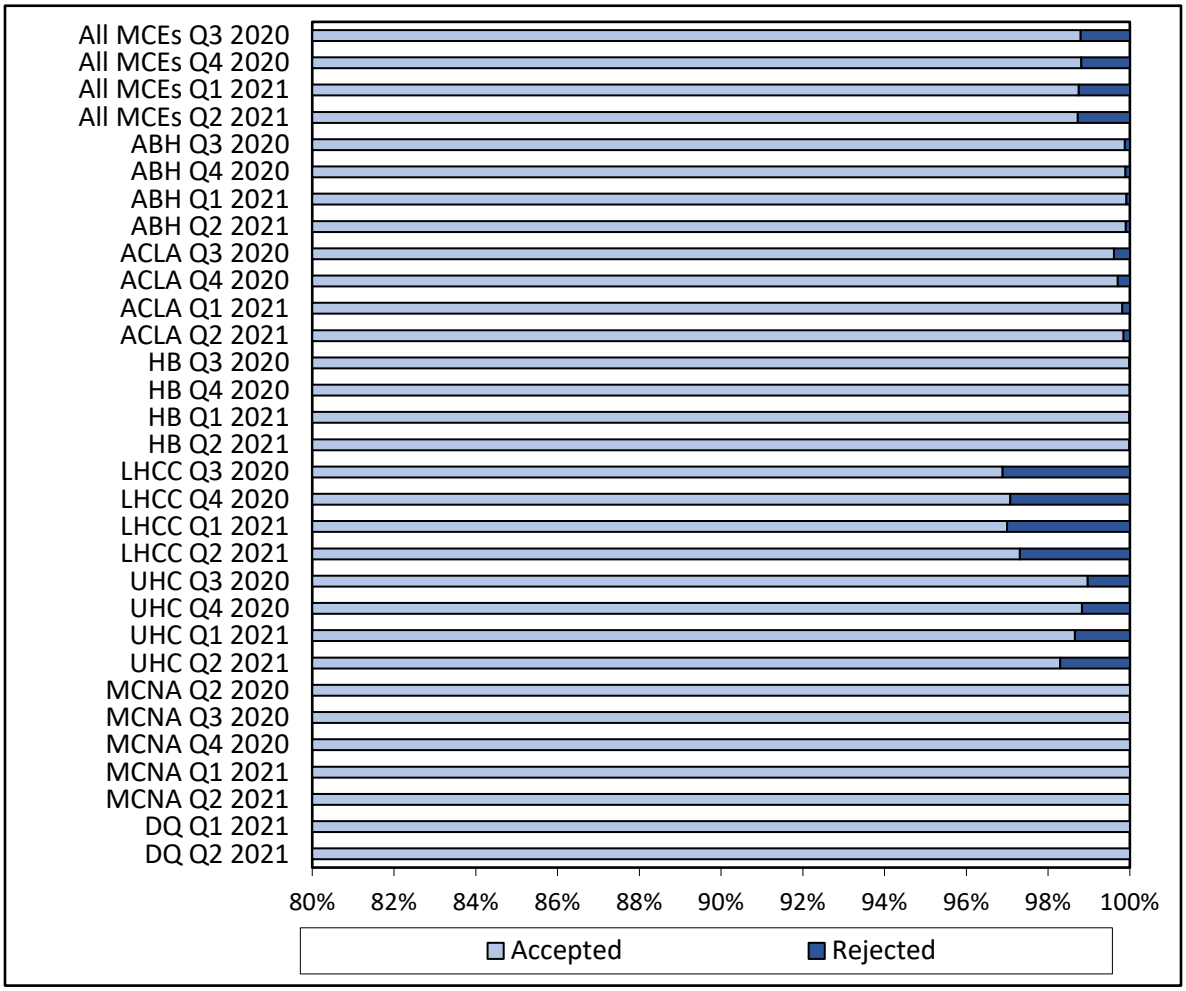
Section III: Findings Related to MCE Claims Adjudication

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

Claims Accepted and Rejected by the MCEs

In the most recent four quarters for which data is available, the claims rejection rate reported by the Medicaid MCEs was between 1.2% and 1.3%. The rejection rate overall is specifically due to higher rejection rates for LHCC (2.7% to 3.1%) with the other MCEs having rejection rates closer to zero.

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



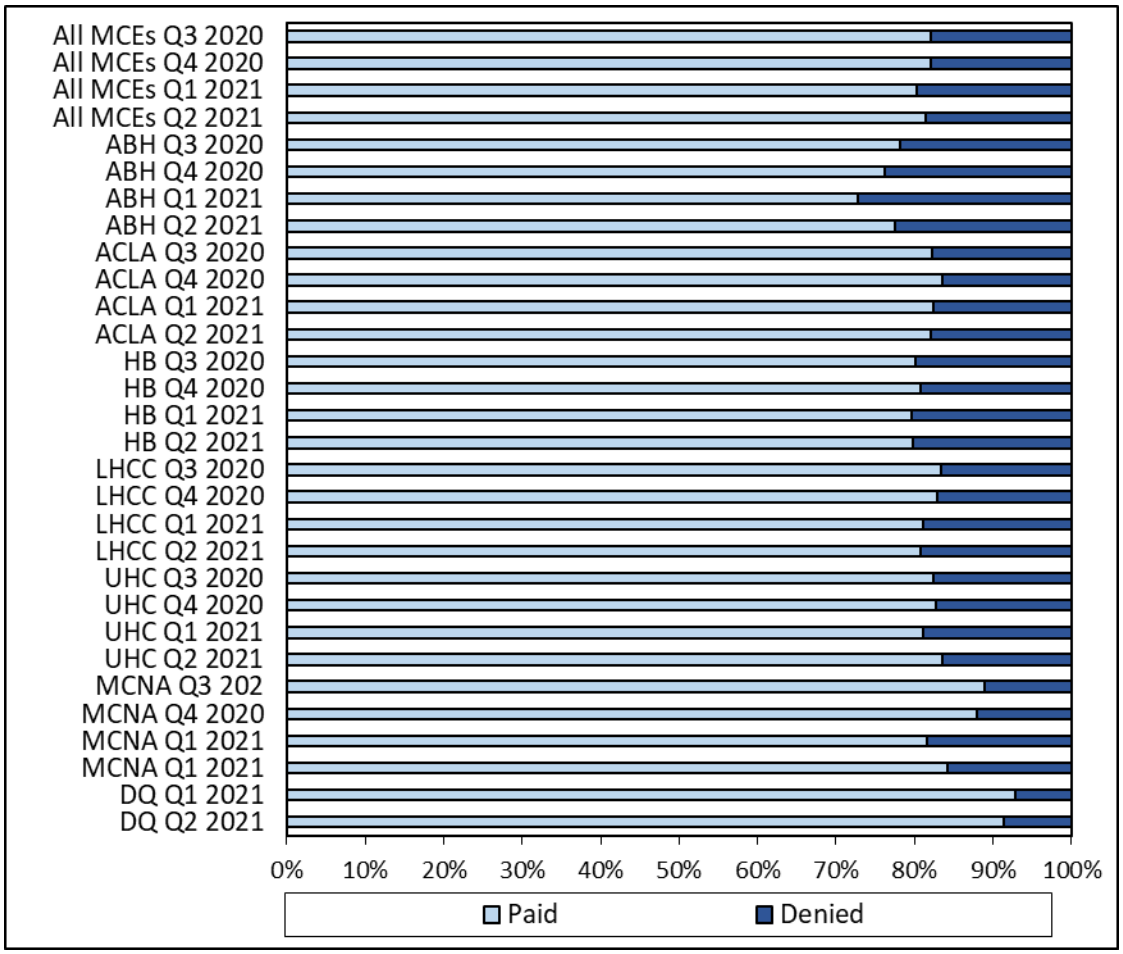
Claims Paid and Denied by the MCEs

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

For those claims that were accepted into the MCE's claims adjudication system, on average, the overall rate of paid claims was between 80.4% and 82.1% in the most recent four quarters. The denial rates, therefore, were between 17.9% and 19.6%. 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 7.9% for DQ to an average rate of 23.9% for ABH. The denial rates are not going down in any significant manner since the original report showing CY 2017 data.

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



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

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

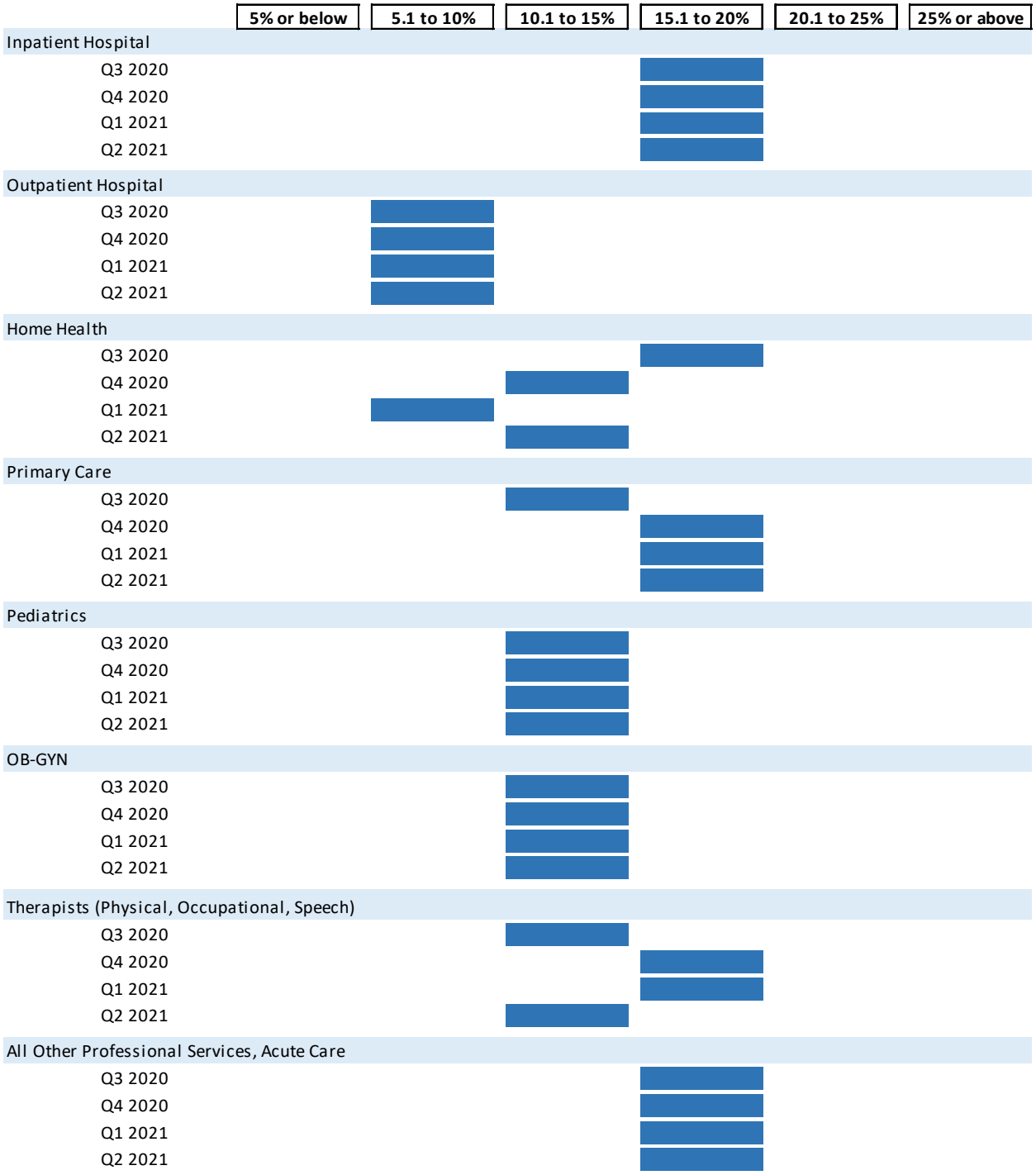


Exhibit III.4
Claim Denial Rates for Non-Acute Care Services
For All MCEs Combined, By Quarter

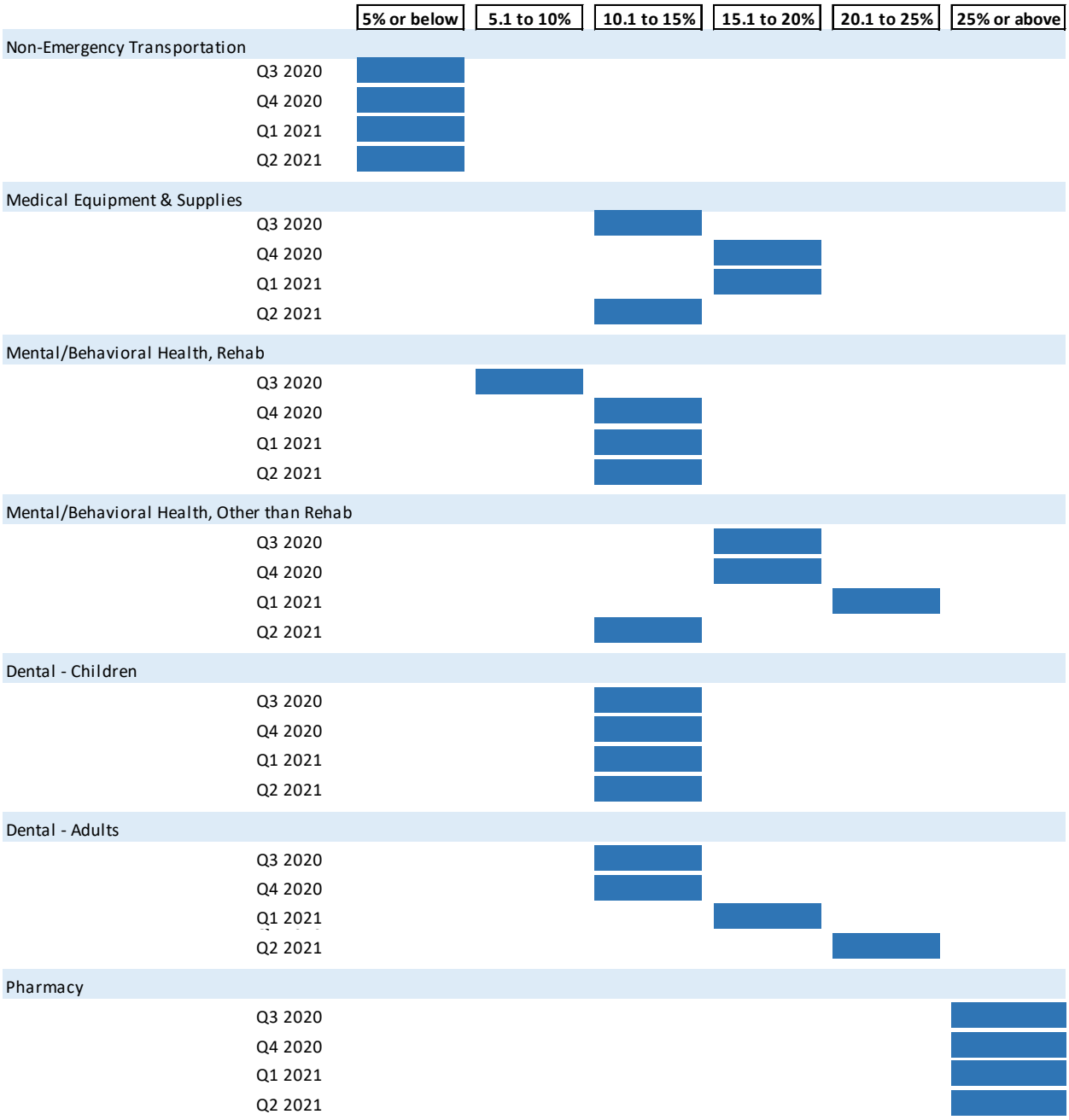
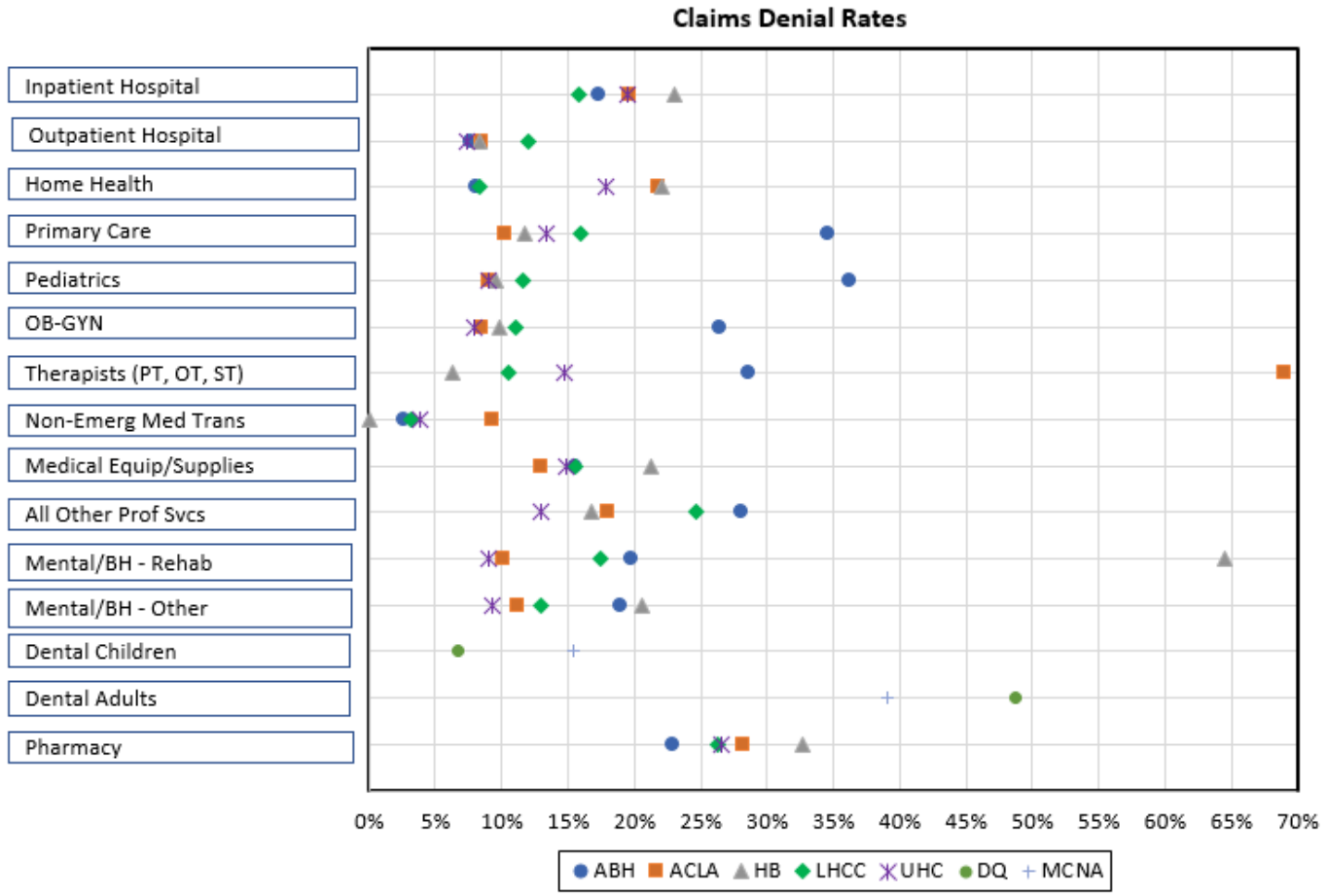


Exhibit III.5 compares the denial rates for these service categories by MCE. The data plotted on this exhibit is the percentage of claims denied in Quarter 2 of CY2021 for each MCE. An icon and color is used to display each MCE's data. Each row in the exhibit represents a specific service category. For example, in the top line of the exhibit, the overall denial rate for inpatient hospital services in Q2 2021 was 19.0%, but this varied from 15.8% for LHCC to 23.0% for HB.

The claims denial rate is clustered for outpatient hospital, pediatrics, OB-GYN 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., Primary Care, Pediatrics, OB-GYN, therapies) and HB (e.g., inpatient, mental/behavioral health, pharmacy) vary from all of their peers.

Exhibit III.5
Claim Denial Rates for Adjudicated Claims
By Provider Specialty / Service Category
By MCE for Q2 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, including:

- 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, Burns & Associates 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 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 Q2 2021, the average payment for paid inpatient hospital claims was $6,689; for primary care, it was $44.

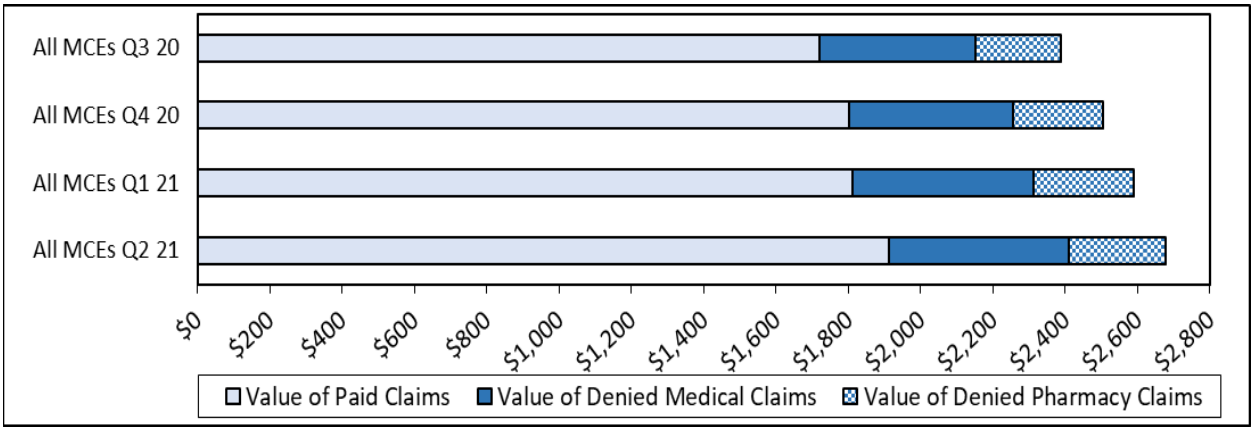
Not only was an average payment per claim computed for each provider specialty separately, but also for each MCE within the provider type as well as a separate value for each calendar quarter.

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 21.7% of the sum of paid and denied values each quarter. This equates to between $431 million and $501 million. Among the $493 million in denied values in Q2 2021 assigned across the five MCEs that provide medical and pharmacy benefits, $226 million (45.9%) was attributed to medical claims and $267 million (54.1%) was attributed to pharmacy claims. In Q2 2021, the distribution of assigned values to denied claims by MCE was as follows:

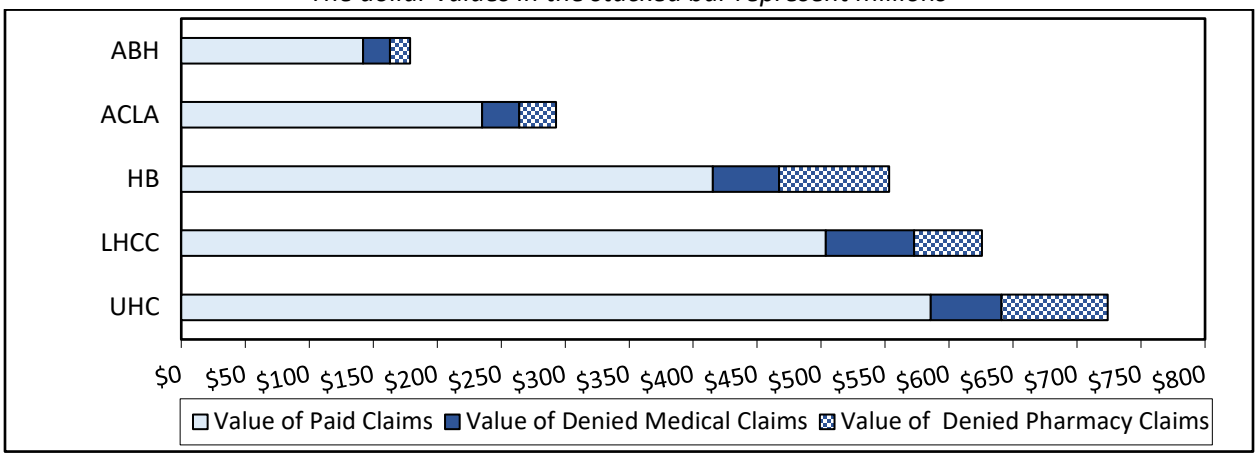
- ABH had 57.2% medical and 42.8% pharmacy claims
- ACLA had 50.2% medical and 49.8% pharmacy claims
- HB had 37.7% medical and 62.3% pharmacy claims
- LHCC had 56.5% medical and 43.5% pharmacy claims

- UHC had 39.9% medical and 60.1% pharmacy claims
- MCNA and DQ had a total value of $32 million (85.7%) paid claims and $5.3 million (14.3%) value of denied medical claims.

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

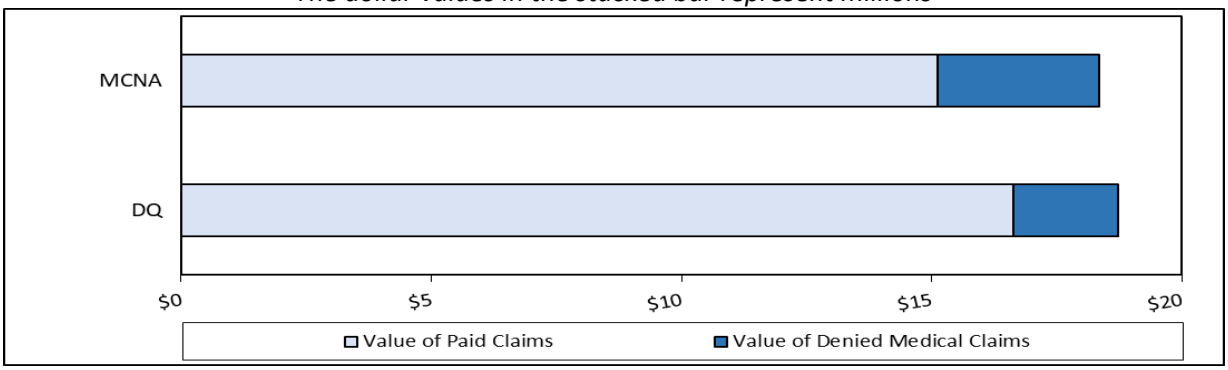


Value of Paid and Denied Claims by MCE – Q2 2021
The dollar values in the stacked bar represent millions



Value of Paid and Denied Dental Claims – Q2 2021

The dollar values in the stacked bar represent millions



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 subgroups:

- 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 was too small to study (Group C).

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

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

	Group A	Group B	Group C	Groups A, B, C
	Number of combinations where > 50% of providers had a denial rate above 10%	Number of combinations where < 50% of providers had a denial rate above 10%	Number of combinations where the sample of providers was too small to study	Total Groupings
Q3 2020	95	91	30	216
Q4 2020	95	91	30	216
Q1 2021*	96	92	34	222
Q2 2021	92	94	36	222

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

Timeliness of Claims Adjudication by the MCEs

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

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

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

		Adjudicated Within 30 days		Avg Turnaround Time	
		Pct of Paid	Pct of Denied	Paid Claims	Denied Claims
ABH	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
	Q2 2021	99.7%	99.2%	8.2	5.6
ACLA	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
	Q2 2021	100.0%	100.0%	6.5	7.3
HB	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
	Q2 2021	99.8%	99.6%	6.8	4.4
LHCC	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
	Q2 2021	99.9%	99.8%	8.5	9.2
UHC	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
	Q2 2021	100.0%	99.8%	9.1	3.8
MCNA	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
	Q2 2021	100.0%	100.0%	10.0	11.2
DQ	Q1 2021	100.0%	100.0%	5.7	5.9
	Q2 2021	100.0%	100.0%	5.8	4.9
ALL MCEs	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
	Q2 2021	99.9%	99.7%	8.0	6.2

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

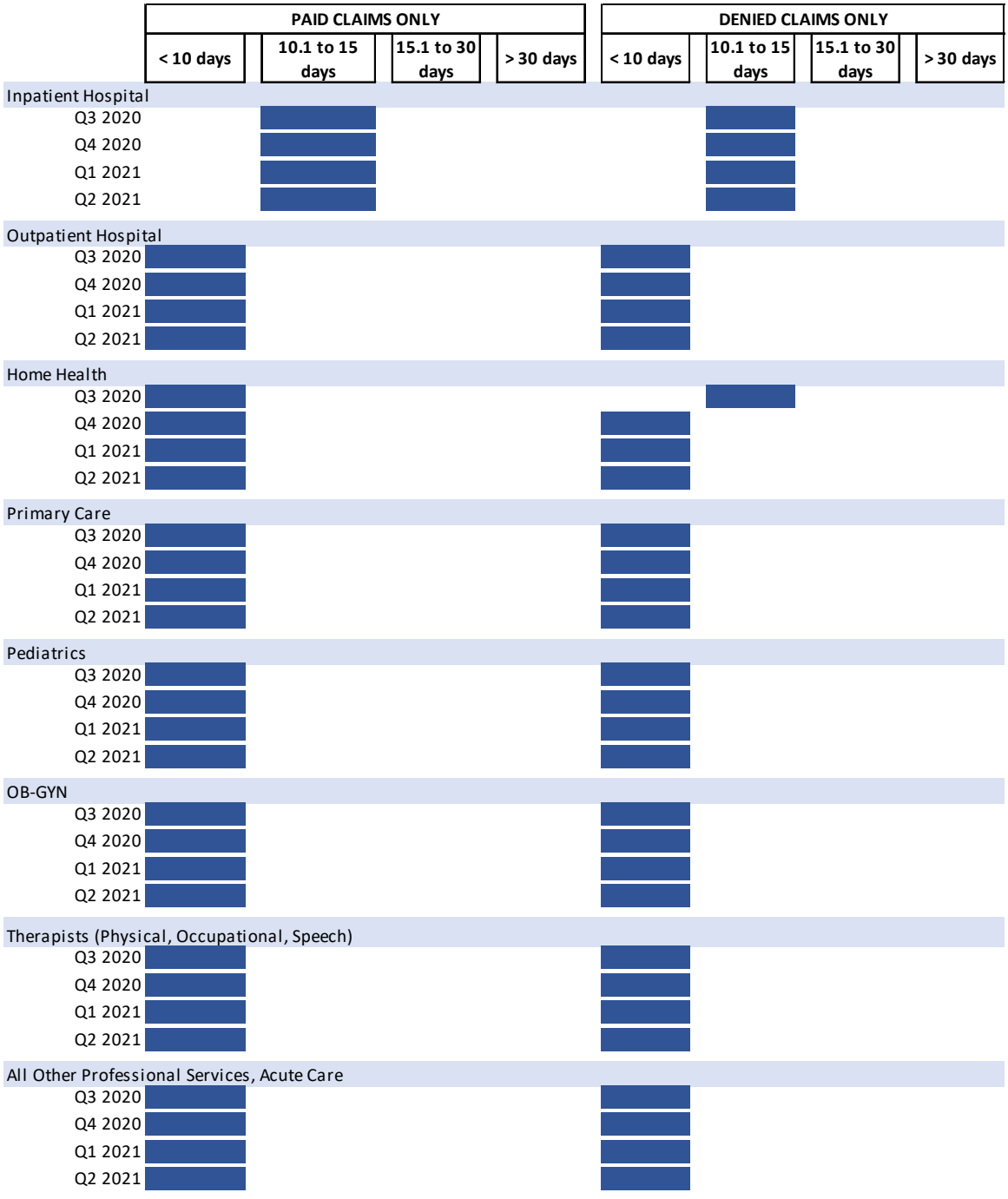


Exhibit III.10
Turnaround Time for Claims Processing of Adjudicated Non-Acute Care Claims (using average days)
For All MCEs Combined, By Quarter

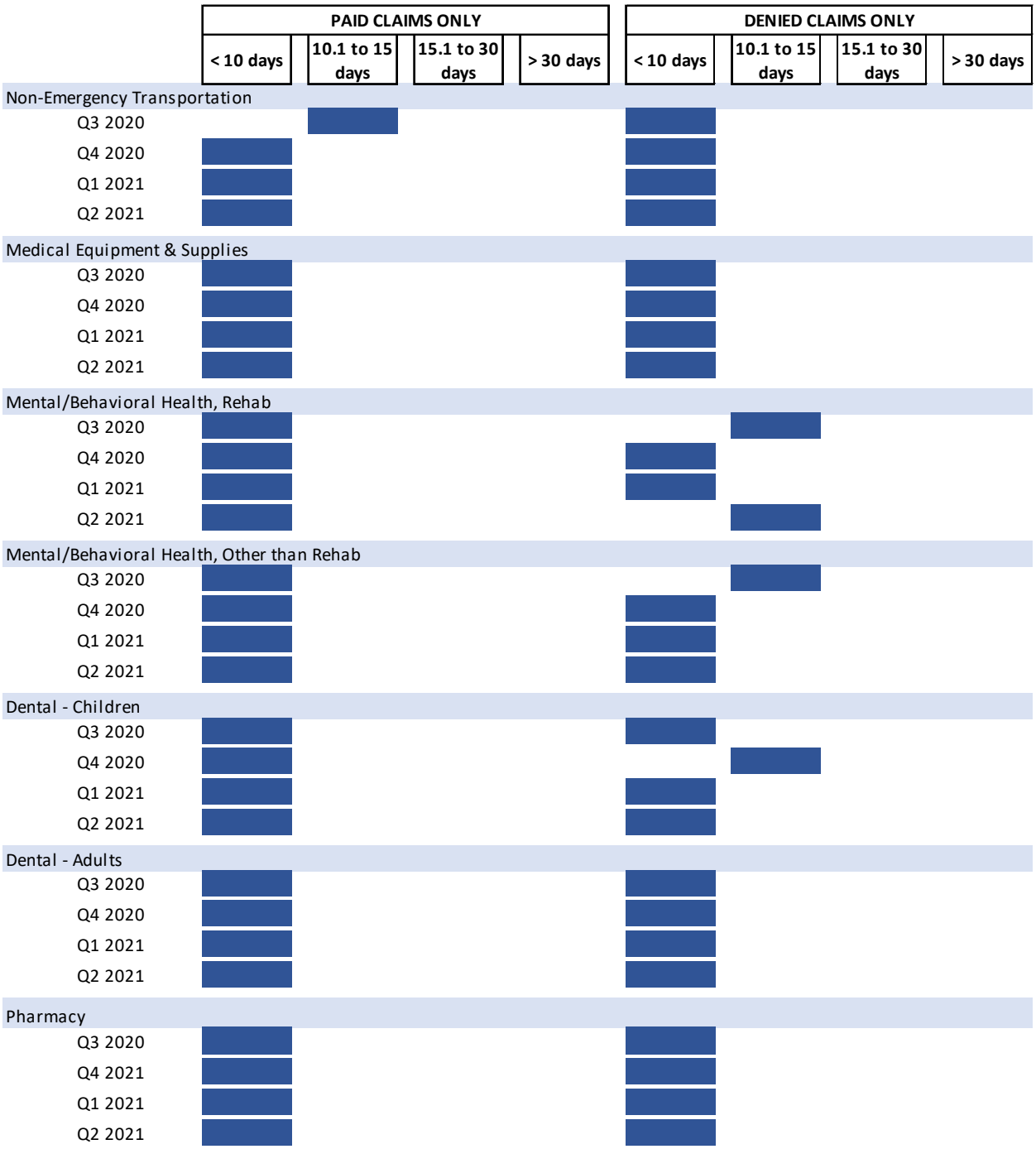
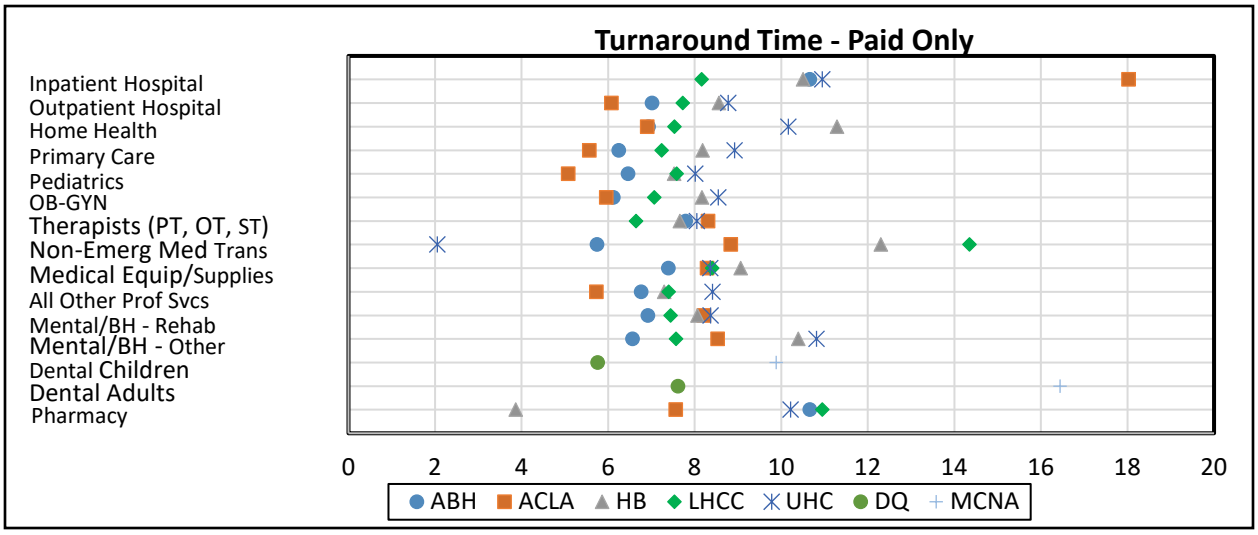
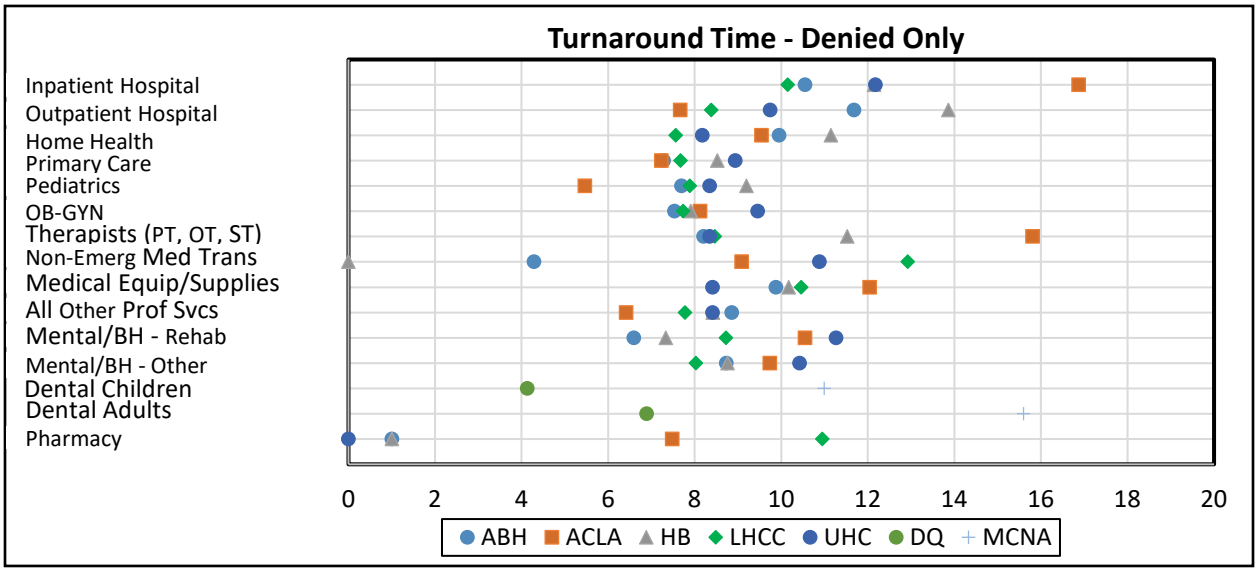


Exhibit III.11 below further breaks down the average paid and denied TAT statistics in Q2 2021, with the results shown for each MCE within a service category. The top box shows the variation in TAT for paid claims only; the bottom box shows the results for denied claims only. The purpose of this exhibit 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 (ACLA, HB, and LHCC). 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 Q2 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), around 290 reason codes in all. For pharmacy claims specifically, there are nearly 350 reason codes developed by the NCPDP.

The MCEs report to LDH the occurrence of each CARC or NCPDP code on adjudicated claims. For denied claims, the count of each CARC or NCPDP code was tabulated by MCE for claims adjudicated in Quarter 2 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:

- In Q2 2021, ACLA, LHCC, and UHC had their top five CARCs within the top 10 CARCs statewide. ABH had four, MCNA had three, while HB had two of their top five CARCs in the statewide top 10.
- The top five CARCs in Q2 2021 included the following:
    - 96: Non-covered charge.
    - 16: The claim lacks information or has a billing error which is needed for adjudication.
    - 97: The benefit for this service is included in the payment for another service already adjudicated.
    - 18: Exact duplicate claim.
    - 252: An attachment/other documentation is required to adjudicate this claim/service.
- These five CARCs were also among the top six in the previous quarters reported.

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

- In Q2 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 five in the previous quarters reported.

Exhibit III.12
Details on Reasons for Denied Claims
By MCE for Q2 2021 Adjudicated Claims

For Medical Claims

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

For Pharmacy Claims

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

The previous exhibit showed that the top 10 denial CARCs are consistent across quarters and were often the top CARCs for each MCE as well. 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 2 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. One CARC (#4) was only present for selected provider types.

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

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

- For LHCC, three of its five CARCs overall were also observed for almost every provider category. Two CARCs (#B7 and #22) were only present for selected provider types.

- For UHC, four of its five CARCs overall were also observed for almost every provider category. 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, CARCs only appear for dental providers since DQ only delivers dental care. For Quarter 2 of 2021, DQ only submitted CARC (#A1) for selected provider types.

Exhibit III.13
Details on Reasons for Denied Medical Claims
By MCE and By Provider Category for Q2 2021 Adjudicated Claims

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

Exhibit III.13 (continued)
Details on Reasons for Denied Medical Claims
By MCE and By Provider Category for Q2 2021 Adjudicated Claims

CARC	Description	Inpatient Hospital	Outpatient Hospital	Home Health	Other Institutional	Primary Care	Pediatrics	OB-GYN	Therapists	Non-Emerg Transport	Medical Equipment	Other Professional	Mental/Behavioral - Rehab	Mental/Behavioral - Other	Adult Dental	Pediatric Dental
LHCC																
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	4	4	3	1	3	5	2	1	2	2	1	1	3		
96	Non-covered charge(s).		1		4	1	1	3	2	4		2				
18	Exact duplicate claim/service	3	2	1		5	3	1	4	3	3	4		1		
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.					2	2	5	3			3				
22	This care may be covered by another payer per coordination of benefits.	5	5	2	3						5					
UHC																
252	An attachment/other documentation is required to adjudicate this claim/service.		1	2	2	3	4	3		3	2	2		2		
96	Non-covered charge(s).		2	4	1	2	2	4	2		1	1		5		
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.		3		5	1	1	2	1	2	3	5				
197	Precertification/authorization/notification absent.					5			3			3	3	3		
18	Exact duplicate claim/service	4	4	1	4		3	1	5		5	4	2	1		
MCNA																
27	Expenses incurred after coverage terminated.														1	5
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																
A1	Claim/Service denied.														1	1

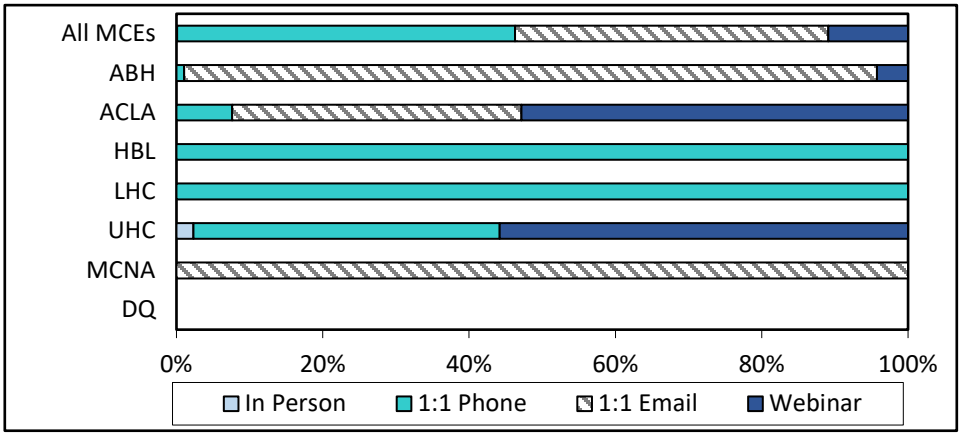
Provider Education Related to Claims Adjudication

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

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

Exhibit III.14 summarizes information on provider education conducted in Q2 2021. In all, 1,073 distinct TINs received outreach from the MCEs. This count represents the unique TINs and modes of communication. In some cases, the MCE reported that they conducted multiple outreach efforts to the same TIN in the quarter (e.g., three emails over the course of six weeks). It should also be noted, however, that the same TIN may be outreached to by multiple MCEs. Under half of the outreach (46.2% of total) was conducted via 1:1 phone calls. This was followed by 1:1 emails (42.8% of total) and webinars (10.9% of total). Very few In-person (0.1% of total) was conducted due to the pandemic.

Exhibit III.14
Provider Education Conducted by the MCEs on Claims Submissions Activity in Q2 2021



	Modality of Outreach			
	In Person	**1:1 Phone**	**1:1 Email**	**Webinar**
All MCEs	1	589	546	139
ABH	0	1	89	4
ACLA	0	16	83	111
HB	0	20	0	0
LHCC	0	534	0	0
UHC	1	18	0	24
MCNA	0	0	374	0
DQ	0	0	0	0

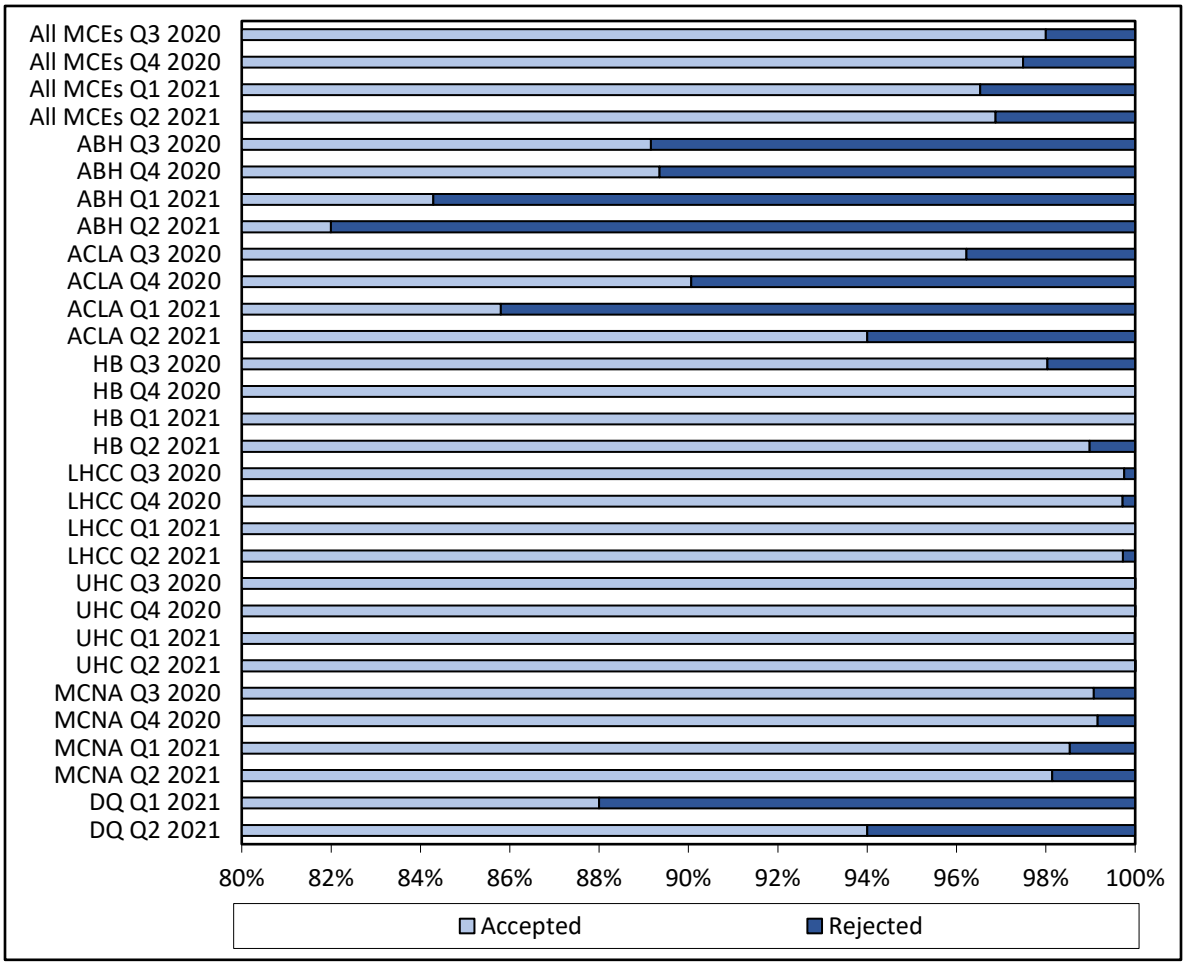
Section IV: Findings Related to MCE Encounter Submissions to LDH

The MCEs are required to send all claims that they have adjudicated — both paid and denied — to LDH in order for LDH to capture all information pertaining to MCE medical expenditures and to track utilization related to outcome measures. Act 710 requested specific information pertaining to encounter submissions, including the number that were accepted by LDH and the number rejected. LDH 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 98.0% 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 HB, LHCC and MCNA, at least 98.0% of their encounters were accepted. ACLA improved to 94.0% (from X% in Q1) for their accepted encounters for Q2, 2021. ABH had some challenges, particularly in the last four quarters, which accepted rates were continuously less than 90.0%. DQ, as a new member since Q1, 2021, saw an increase in its encounter acceptance rate from 88% in Q1 to 94% in Q2.

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 predetermined 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 and ACLA's lower encounter acceptance rates were due to institutional and professional encounters.
- HB had issues with institutional encounters accepted for Q3, 2020.
- LHCC had a few issues related to pharmacy encounters.
- DQ had some issues with dental encounters been accepted.

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

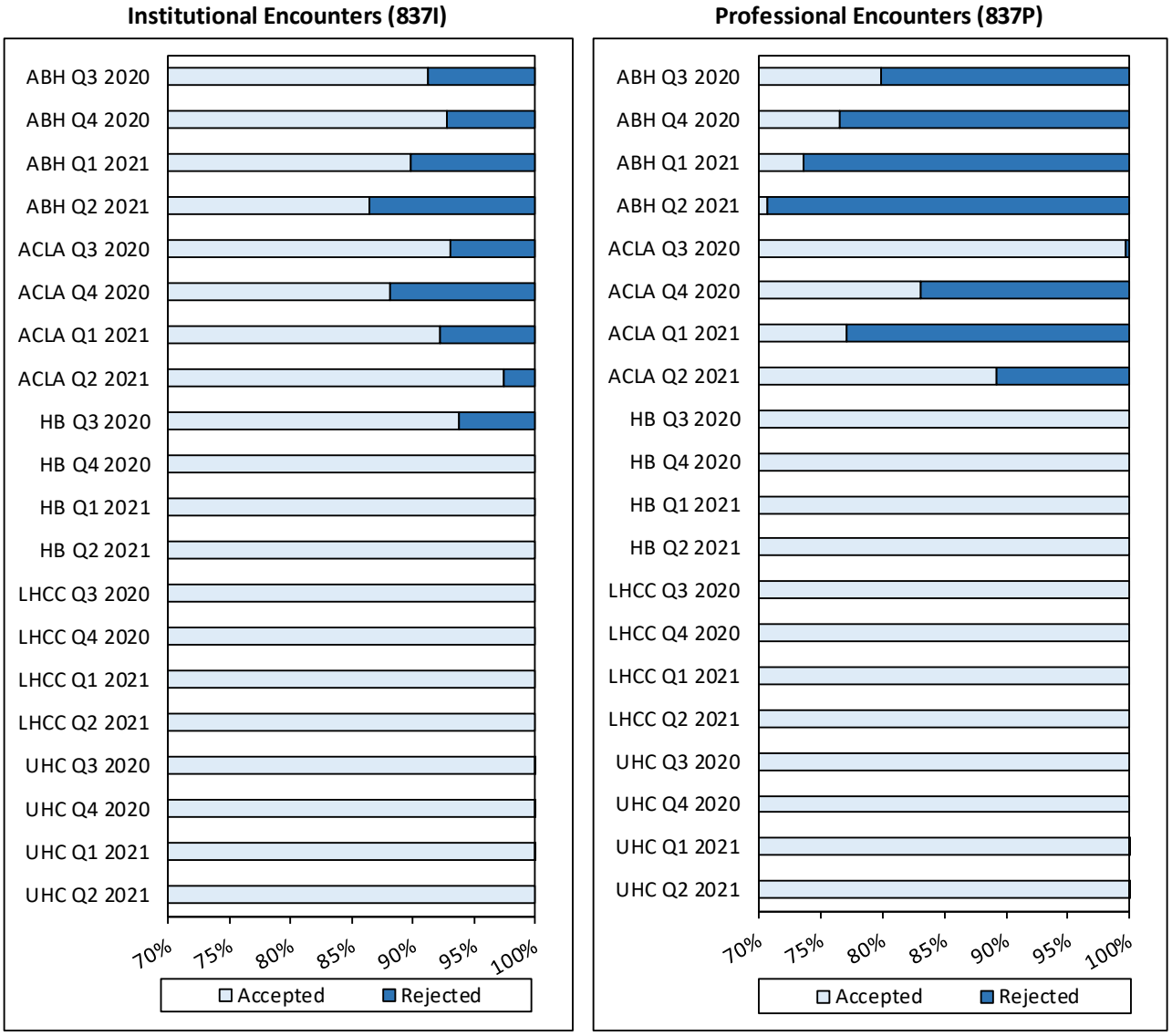
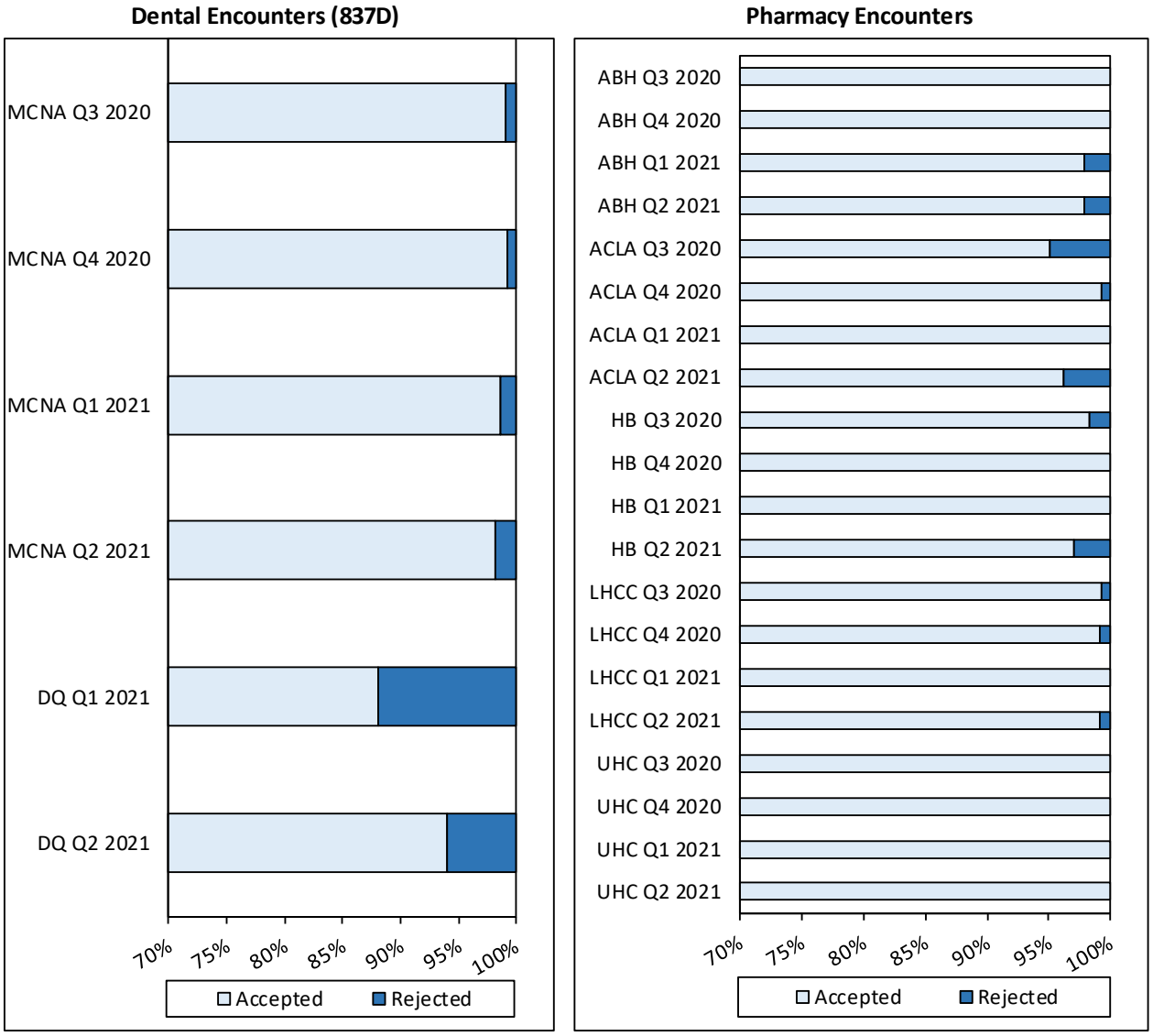


Exhibit IV.3
Encounter Submissions Accepted and Rejected by LDH
Dental and Pharmacy Claim Types
By MCE and Quarter



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 of 2020.

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

- There is greater variation in the timeliness of pharmacy encounter submissions. HB and UHC had few pharmacy encounters submitted after 30 days in every quarter. ACLA had 97.1% timeliness within 30 days in all quarters. ABH and LHCC consistently are lowest on pharmacy encounter timeliness — ABH usually near 30.0% untimely, and LHCC has varied from 23.9% to 30.4% 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 and Q2, 2021.

- DQ, as a new member, had some issues to meet the 30-day TAT, which had 56.0% encounters submitted within the timeline for Q1, 2021, improved to 100% for Q2, 2021.

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 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%
ABH Q2 2021	74.9%	25.1%	82.2%	17.8%			70.9%	29.1%
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%
ACLA Q2 2021	96.3%	3.7%	98.7%	1.3%			97.0%	3.0%
HB Q3 2020	100.0%	0.0%	98.9%	1.1%			98.3%	1.7%
HB Q4 2020	100.0%	0.0%	94.7%	5.3%			96.6%	3.4%
HB Q1 2021	100.0%	0.0%	99.9%	0.1%			99.6%	0.4%
HB Q2 2021	100.0%	0.0%	100.0%	0.0%			99.5%	0.5%
LHCC Q3 2020	95.9%	4.1%	97.9%	2.1%			71.9%	28.1%
LHCC Q4 2020	99.9%	0.1%	99.8%	0.2%			69.6%	30.4%
LHCC Q1 2021	98.7%	1.3%	96.1%	3.9%			76.1%	23.9%
LHCC Q2 2021	99.8%	0.2%	99.6%	0.4%			71.9%	28.1%
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%
UHC Q2 2021	99.7%	0.3%	99.3%	0.7%			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%		
MCNA Q2 2021					99.5%	0.5%		
DQ Q1 2021					56.0%	44.0%		
DQ Q2 2021					100.0%	0.0%		

Section V: Case Management

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

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

Each of the MCEs is contractually required to develop and implement a case management program through a process 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 its own policies and procedures for identification and assessment. As such, the reporting for case management has shown some variation across MCEs.

Across all five MCEs a total of 49,982 unduplicated individuals were eligible or in need of case management services in SFY 2021-Q2. Of these 23% or 11,672 were enrolled in case management for at least one month during the quarter. Sixty-five percent of those enrolled in CM were engaged in one or more CM services or contact with a case manager during the quarter.

Exhibit V.1
CY 2021- Quarter 2: Case Management

	ABH	ACLA	HB	LHCC	UHC	Total[1]
Eligible for Case Management (CM)	2,331	5,470	7,864	18,636	17,162	**49,982**
Enrolled in CM at least 1 month	870	1,855	1,938	4,208	2,806	**11,672**
% of eligible enrolled in CM	37.3%	33.9%	24.6%	22.6%	16.4%	**23.4%**
Received CM service	700	1,652	1,002	3,365	817	**7,533**
% enrolled receiving service	80.5%	89.1%	51.7%	80.0%	29.1%	**64.5%**

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

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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 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	24,336,306	311,884	98.7%	1.3%
All MCEs Q2 2021	25,522,775	329,381	98.7%	1.3%
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	2,211,796	1,937	99.9%	0.1%
ABH Q2 2021	1,820,212	1,874	99.9%	0.1%
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%
ACLA Q2 2021	3,088,884	4,806	99.8%	0.2%
HB Q3 2020	4,599,056	738	100.0%	0.0%
HB Q4 2020	4,883,134	447	100.0%	0.0%
HB Q1 2021	4,990,313	514	100.0%	0.0%
HB Q2 2021	5,514,096	614	100.0%	0.0%
LHCC Q3 2020	6,138,249	197,050	96.9%	3.1%
LHCC Q4 2020	6,583,182	198,251	97.1%	2.9%
LHCC Q1 2021	6,719,384	207,844	97.0%	3.0%
LHCC Q2 2021	7,162,144	198,270	97.3%	2.7%
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%
UHC Q2 2021	7,133,961	123,817	98.3%	1.7%
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%
MCNA Q2 2021	450,746	0	100.0%	0.0%
DQ Q1 2021	352,732	0	100.0%	0.0%
DQ Q2 2021	395,755	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 Q3 2020	18,603,021	4,073,978	82.0%	18.0%
All MCEs Q4 2020	19,951,950	4,351,190	82.1%	17.9%
All MCEs Q1 2021	19,659,649	4,802,737	80.4%	19.6%
All MCEs Q2 2021	20,857,152	4,729,851	81.5%	18.5%
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%
ABH Q2 2021	1,412,667	407,908	77.6%	22.4%
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%
ACLA Q2 2021	2,516,679	547,269	82.1%	17.9%
HB Q3 2020	3,659,680	911,313	80.1%	19.9%
HB Q4 2020	3,954,955	936,726	80.9%	19.1%
HB Q1 2021	3,977,816	1,019,175	79.6%	20.4%
HB Q2 2021	4,325,637	1,094,575	79.8%	20.2%
LHCC Q3 2020	5,057,608	1,003,298	83.4%	16.6%
LHCC Q4 2020	5,451,901	1,121,272	82.9%	17.1%
LHCC Q1 2021	5,403,178	1,253,630	81.2%	18.8%
LHCC Q2 2021	5,769,422	1,378,011	80.7%	19.3%
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%
UHC Q2 2021	6,156,003	1,208,668	83.6%	16.4%
MCNA Q3 2020	654,768	81,953	88.9%	11.1%
MCNA Q4 2020	659,110	90,449	87.9%	12.1%
MCNA Q1 2021	368,384	82,984	81.6%	18.4%
MCNA Q2 2021	318,463	59,452	84.3%	15.7%
DQ Q1 2021	284,578	21,712	92.9%	7.1%
DQ Q2 2021	358,281	33,968	91.3%	8.7%

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 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%
Inpatient Hospital Q2 2021	50,491	11,838	81.0%	19.0%
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%
Outpatient Hospital Q2 2021	4,708,249	473,309	90.9%	9.1%
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%
Home Health Q2 2021	42,809	6,082	87.6%	12.4%
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%
Primary Care Q2 2021	2,213,483	400,278	84.7%	15.3%
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%
Pediatrics Q2 2021	830,922	116,916	87.7%	12.3%
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%
OB-GYN Q2 2021	253,620	33,011	88.5%	11.5%
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%
Therapists (PT/OT/ST) Q2 2021	95,209	13,410	87.7%	12.3%
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%
All Other Professional Q2 2021	4,432,723	1,015,281	81.4%	18.6%

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

	Number Paid	Number Denied	Percent Paid	Percent Denied
Non-Emerg Transport 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%
Non-Emerg Transport Q2 2021	176,899	7,060	96.2%	3.8%
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%
Medical Equipment/Supplies Q2 2021	140,627	24,705	85.1%	14.9%
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 Rehab Q2 2021	198,184	25,663	88.5%	11.5%
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%
Mental/Behavioral Other Q2 2021	809,408	138,114	85.4%	14.6%
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 - Children Q2 2021	663,869	82,236	89.0%	11.0%
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%
Dental - Adults Q2 2021	135,808	34,873	79.6%	20.4%
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%
Pharmacy Q2 2021	6,056,806	2,335,177	72.2%	27.8%

Appendix A III.5
Claim Status for Adjudicated Claims
By Provider Specialty / Service Category
By MCE for Q2 2021 Adjudicated Claims

Inpatient Hospital	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	4,861	1,015	82.7%	17.3%
ACLA	6,688	1,636	80.3%	19.7%
HB	10,527	3,150	77.0%	23.0%
LHCC	15,431	2,899	84.2%	15.8%
UHC	12,984	3,138	80.5%	19.5%

Outpatient Hospital	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	307,703	25,367	92.4%	7.6%
ACLA	647,528	59,672	91.6%	8.4%
HB	984,302	89,938	91.6%	8.4%
LHCC	1,361,940	186,092	88.0%	12.0%
UHC	1,406,776	112,240	92.6%	7.4%

Home Health	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	2,528	221	92.0%	8.0%
ACLA	3,460	966	78.2%	21.8%
HB	7,502	2,126	77.9%	22.1%
LHCC	28,524	2,596	91.7%	8.3%
UHC	795	173	82.1%	17.9%

Primary Care	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	132,628	70,219	65.4%	34.6%
ACLA	119,220	13,664	89.7%	10.3%
HB	462,718	61,441	88.3%	11.7%
LHCC	687,433	130,370	84.1%	15.9%
UHC	811,484	124,584	86.7%	13.3%

Pediatricians	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	44,268	25,079	63.8%	36.2%
ACLA	92,198	9,101	91.0%	9.0%
HB	191,484	20,312	90.4%	9.6%
LHCC	385,481	50,703	88.4%	11.6%
UHC	117,491	11,721	90.9%	9.1%

OB-GYN	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	19,794	7,085	73.6%	26.4%
ACLA	38,074	3,529	91.5%	8.5%
HB	67,772	7,377	90.2%	9.8%
LHCC	104,237	12,986	88.9%	11.1%
UHC	23,743	2,034	92.1%	7.9%

Therapists (PT, OT, ST)	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	6,509	2,614	71.3%	28.7%
ACLA	297	663	30.9%	69.1%
HB	37,673	2,503	93.8%	6.2%
LHCC	20,741	2,433	89.5%	10.5%
UHC	29,989	5,197	85.2%	14.8%

Non-Emergency Medical Transp.	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	18,466	504	97.3%	2.7%
ACLA	35,199	3,627	90.7%	9.3%
HB	45,010	0	100.0%	0.0%
LHCC	28,787	960	96.8%	3.2%
UHC	49,437	1,969	96.2%	3.8%

Medical Equipment and Supplies	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	12,311	2,265	84.5%	15.5%
ACLA	25,044	3,707	87.1%	12.9%
HB	3,296	890	78.7%	21.3%
LHCC	44,035	8,063	84.5%	15.5%
UHC	55,941	9,780	85.1%	14.9%

All Other Professional	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	235,085	91,889	71.9%	28.1%
ACLA	735,546	160,997	82.0%	18.0%
HB	938,984	189,212	83.2%	16.8%
LHCC	1,111,651	362,974	75.4%	24.6%
UHC	1,411,457	210,209	87.0%	13.0%

Mental/Behav Health - Rehab	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	2,512	618	80.3%	19.7%
ACLA	58,592	6,543	90.0%	10.0%
HB	2,430	4,419	35.5%	64.5%
LHCC	7,094	1,496	82.6%	17.4%
UHC	127,556	12,587	91.0%	9.0%

Mental/Behav Health - Other	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	78,960	18,509	81.0%	19.0%
ACLA	54,398	6,884	88.8%	11.2%
HB	151,977	39,423	79.4%	20.6%
LHCC	427,529	63,476	87.1%	12.9%
UHC	96,544	9,822	90.8%	9.2%

Pharmacy	Number Paid	Number Denied	Percent Paid	Percent Denied
ABH	530,003	156,796	77.2%	22.8%
ACLA	684,822	269,659	71.7%	28.3%
HB	1,347,932	653,360	67.4%	32.6%
LHCC	1,543,094	551,436	73.7%	26.3%
UHC	1,950,955	703,926	73.5%	26.5%

Dental - Adults	Number Paid	Number Denied	Percent Paid	Percent Denied
DQ	9,310	8,871	51.2%	48.8%
MCNA	3,612	2,313	61.0%	39.0%
Dental - Children				
DQ	348,971	25,097	93.3%	6.7%
MCNA	314,851	57,139	84.6%	15.4%

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 Q3 2020	$1,750.2	$434.7
All MCEs Q4 2020	$1,835.2	$457.2
All MCEs Q1 2021	$1,841.3	$506.4
All MCEs Q2 2021	$1,913.7	$497.8
Quarter 3 2020		
ABH	$145.8	$34.4
ACLA	$214.6	$51.1
HB	$366.5	$124.0
LHCC	$449.5	$87.6
UHC	$544.8	$133.5
MCNA	$29.0	$4.1
Quarter 4 2020		
ABH	$150.4	$38.3
ACLA	$210.0	$49.4
HB	$397.0	$123.7
LHCC	$470.8	$97.8
UHC	$575.2	$143.0
MCNA	$32.0	$5.0
Quarter 1 2021		
ABH	$156.7	$49.7
ACLA	$223.8	$54.6
HB	$393.1	$136.4
LHCC	$483.4	$109.6
UHC	$554.8	$150.6
DQ	$12.1	$1.1
MCNA	$17.4	$4.4
Quarter 2 2021		
ABH	$142.1	$36.9
ACLA	$235.1	$57.9
HB	$415.4	$137.7
LHCC	$503.7	$121.9
UHC	$585.6	$138.2
DQ	$16.6	$2.1
MCNA	$15.1	$3.2

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

Appendix A Exhibit III.7

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

Legend

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

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

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

	Paid Claims	Denied Claims
All MCEs Q3 2020	7.7	6.0
All MCEs Q4 2020	8.0	5.8
All MCEs Q1 2021	7.8	6.3
All MCEs Q2 2021	8.0	6.2
ABH Q3 2020	8.0	5.6
ABH Q4 2020	8.0	6.1
ABH Q1 2021	8.5	6.2
ABH Q2 2021	8.2	5.6
ACLA Q3 2020	5.7	7.2
ACLA Q4 2020	5.5	7.4
ACLA Q1 2021	5.7	7.5
ACLA Q2 2021	6.5	7.3
HB Q3 2020	7.2	6.1
HB Q4 2020	7.1	4.6
HB Q1 2021	6.3	5.5
HB Q2 2021	6.8	4.4
LHCC Q3 2020	8.5	9.2
LHCC Q4 2020	8.5	9.2
LHCC Q1 2021	8.4	9.6
LHCC Q2 2021	8.5	9.2
UHC Q3 2020	8.0	2.7
UHC Q4 2020	8.9	2.8
UHC Q1 2021	9.1	2.8
UHC Q2 2021	9.1	3.8
MCNA Q3 2020	7.4	9.0
MCNA Q4 2020	8.6	10.1
MCNA Q1 2021	9.9	10.9
MCNA Q2 2021	10.0	11.2
DQ Q1 2021	5.7	5.9
DQ Q2 2022	5.8	4.9

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 Q3 2020	10.7	12.4
Inpatient Hosp Q4 2020	12.1	11.7
Inpatient Hosp Q1 2021	11.0	11.5
Inpatient Hosp Q2 2021	10.9	12.2
Outpatient Hosp Q3 2020	7.5	9.7
Outpatient Hosp Q4 2020	7.5	8.9
Outpatient Hosp Q1 2021	7.7	9.9
Outpatient Hosp Q2 2021	7.9	9.8
Home Health Q3 2020	8.0	13.0
Home Health Q4 2020	7.8	8.7
Home Health Q1 2021	7.6	9.3
Home Health Q2 2021	8.2	9.2
Primary Care Q3 2020	6.7	8.1
Primary Care Q4 2020	7.6	7.7
Primary Care Q1 2021	7.5	7.5
Primary Care Q2 2021	7.9	8.1
Pediatrics Q3 2020	6.4	7.3
Pediatrics Q4 2020	7.1	7.5
Pediatrics Q1 2021	6.9	7.7
Pediatrics Q2 2021	7.3	7.9
OB-GYN Q3 2020	6.6	8.1
OB-GYN Q4 2020	6.9	8.0
OB-GYN Q1 2021	6.7	7.7
OB-GYN Q2 2021	7.3	7.9
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
Therapists (PT/OT/ST) Q2 2021	7.6	9.3
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
All Other Professional Q2 2021	7.4	7.9

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 Q3 2020	10.9	8.5
Non-Emerg Transport Q4 2020	10.0	9.8
Non-Emerg Transport Q1 2021	7.9	9.6
Non-Emerg Transport Q2 2021	8.4	9.8
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
Medical Equip/Supplies Q2 2021	8.3	9.8
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 Rehab Q2 2021	8.3	10.1
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
MH/BH Other Q2 2021	8.5	8.6
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 - Children Q2 2021	7.7	8.9
Dental - Adults Q3 2020	4.7	4.5
Dental - Adults Q4 2020	5.0	4.6
Dental - Adults Q1 2021	5.2	7.0
Dental - Adults Q2 2021	5.6	5.1
Pharmacy Q3 2020	9.1	3.6
Pharmacy Q4 2020	9.1	3.6
Pharmacy Q1 2021	8.8	3.7
Pharmacy Q2 2021	8.7	3.8

Appendix A Exhibit III.11
Average Turnaround Time (jn days), Paid and Denied Claims, by Service Category
By MCE for Q2 2021 Adjudicated Claims

Inpatient Hospital	Paid	Denied
ABH	10.7	10.5
ACLA	18.0	16.9
HB	10.5	12.1
LHCC	8.2	10.2
UHC	10.9	12.2

Outpatient Hospital	Paid	Denied
ABH	7.0	11.7
ACLA	6.1	7.7
HB	8.6	13.9
LHCC	7.7	8.4
UHC	8.8	9.7

Home Health	Paid	Denied
ABH	6.9	10.0
ACLA	6.9	9.5
HB	11.3	11.2
LHCC	7.5	7.6
UHC	10.2	8.2

Primary Care	Paid	Denied
ABH	6.2	7.3
ACLA	5.6	7.2
HB	8.2	8.5
LHCC	7.2	7.7
UHC	8.9	8.9

Pediatrics	Paid	Denied
ABH	6.5	7.7
ACLA	5.1	5.5
HB	7.5	9.2
LHCC	7.6	7.9
UHC	8.0	8.3

OB-GYN	Paid	Denied
ABH	6.1	7.5
ACLA	6.0	8.1
HB	8.2	7.9
LHCC	7.1	7.7
UHC	8.5	9.5

Therapists (PT, OT, ST)	Paid	Denied
ABH	7.8	8.2
ACLA	8.3	15.8
HB	7.7	11.5
LHCC	6.6	8.5
UHC	8.0	8.3

Non-Emergency Medical Transp	Paid	Denied
ABH	5.7	4.3
ACLA	8.8	9.1
HB	12.3	0.0
LHCC	14.3	12.9
UHC	2.0	10.9

Medical Equipment and Supplies	Paid	Denied
ABH	7.4	9.9
ACLA	8.3	12.0
HB	9.1	10.2
LHCC	8.4	10.5
UHC	8.4	8.4

All Other Professional	Paid	Denied
ABH	6.8	8.9
ACLA	5.7	6.4
HB	7.3	8.4
LHCC	7.4	7.8
UHC	8.4	8.4

Mental/Behavioral Health - Rehab	Paid	Denied
ABH	6.9	6.6
ACLA	8.2	10.5
HB	8.1	7.3
LHCC	7.4	8.7
UHC	8.4	11.3

Mental/Behavioral Health - Other	Paid	Denied
ABH	6.6	8.7
ACLA	8.5	9.7
HB	10.4	8.8
LHCC	7.6	8.0
UHC	10.8	10.4

Pharmacy	Paid	Denied
ABH	10.7	1.0
ACLA	7.6	7.5
HB	3.9	1.0
LHCC	10.9	10.9
UHC	10.2	0.0

Dental - Adults	Paid	Denied
DQ	7.6	6.9
MCNA	16.4	15.6
Dental - Children		
DQ	5.8	4.1
MCNA	9.9	11.0

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

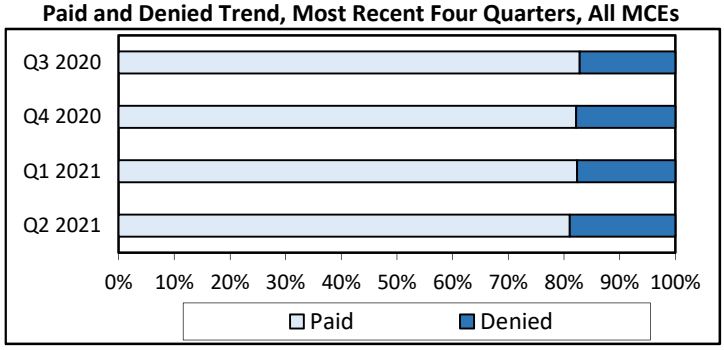
	Accepted	Rejected
All MCEs Q3 2020	98.0%	2.0%
All MCEs Q4 2020	97.5%	2.5%
All MCEs Q1 2020	96.5%	3.5%
All MCEs Q2 2021	96.9%	3.1%
ABH Q3 2020	89.2%	10.8%
ABH Q4 2020	89.4%	10.6%
ABH Q1 2021	84.3%	15.7%
ABH Q2 2021	82.0%	18.0%
ACLA Q3 2020	96.2%	3.8%
ACLA Q4 2020	90.1%	9.9%
ACLA Q1 2021	85.8%	14.2%
ACLA Q2 2021	94.0%	6.0%
HB Q3 2020	98.0%	2.0%
HB Q4 2020	100.0%	0.0%
HB Q1 2021	100.0%	0.0%
HB Q2 2021	99.0%	1.0%
LHCC Q3 2020	99.8%	0.2%
LHCC Q4 2020	99.7%	0.3%
LHCC Q1 2021	100.0%	0.0%
LHCC Q2 2021	99.7%	0.3%
UHC Q3 2020	100.0%	0.0%
UHC Q4 2020	100.0%	0.0%
UHC Q1 2021	100.0%	0.0%
UHC Q2 2021	100.0%	0.0%
MCNA Q3 2020	99.1%	0.9%
MCNA Q4 2020	99.2%	0.8%
MCNA Q1 2021	98.5%	1.5%
MCNA Q2 2021	98.1%	1.9%
DQ Q1 2021	88.0%	12.0%
DQ Q2 2021	94.0%	6.0%

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

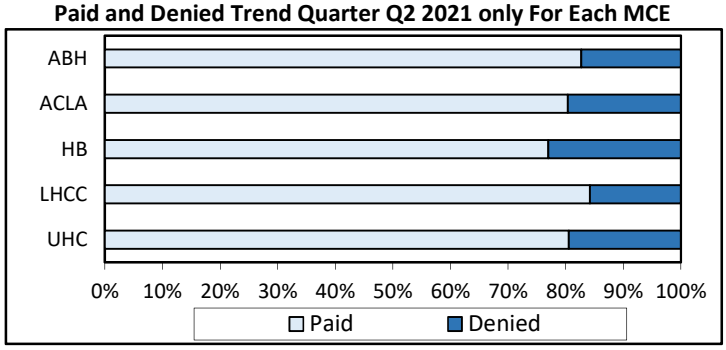
	Institutional Encounters (837I)		Professional Encounters (837D)		Dental Encounters (837D)		Pharmacy Encounters	
	Accepted	Rejected	Accepted	Rejected	Accepted	Rejected	Accepted	Rejected
ABH Q3 2020	91.3%	8.7%	79.9%	20.1%			100.0%	0.0%
ABH Q4 2020	92.7%	7.3%	76.6%	23.4%			100.0%	0.0%
ABH Q1 2021	89.8%	10.2%	73.6%	26.4%			97.9%	2.1%
ABH Q2 2021	86.5%	13.5%	70.8%	29.2%			97.9%	2.1%
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%
ACLA Q2 2021	97.4%	2.6%	89.3%	10.7%			96.2%	3.8%
HB Q3 2020	93.7%	6.3%	100.0%	0.0%			98.3%	1.7%
HB Q4 2020	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
HB Q1 2021	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
HB Q2 2021	100.0%	0.0%	100.0%	0.0%			97.1%	2.9%
LHCC Q3 2020	100.0%	0.0%	100.0%	0.0%			99.2%	0.8%
LHCC Q4 2020	100.0%	0.0%	100.0%	0.0%			99.1%	0.9%
LHCC Q1 2021	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
LHCC Q2 2021	100.0%	0.0%	100.0%	0.0%			99.1%	0.9%
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%	0.0%	0.0%			100.0%	0.0%
UHC Q2 2021	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
MCNA Q3 2020					99.1%	0.9%		
MCNA Q4 2020					99.2%	0.8%		
MCNA Q1 2021					98.5%	1.5%		
MCNA Q2 2021					98.1%	1.9%		
DQ Q1 2021					88.0%	12.0%		
DQ Q2 2021					94.0%	6.0%		

Summary of Information on Claims for Inpatient Hospital Services

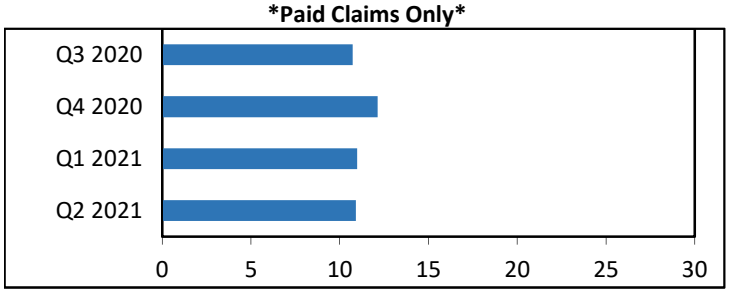
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



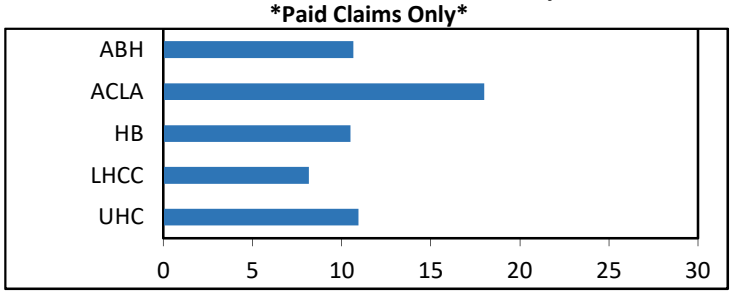
Paid and Denied Trend Quarter Q2 2021 only For Each MCE



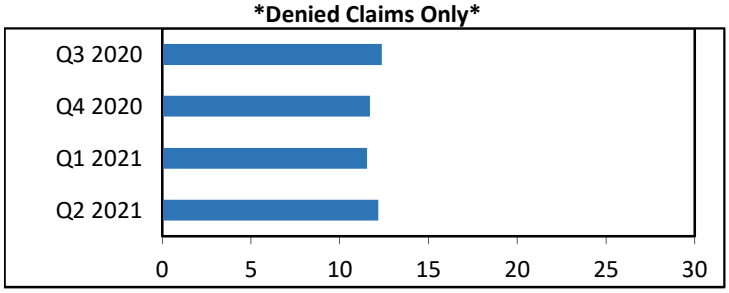
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



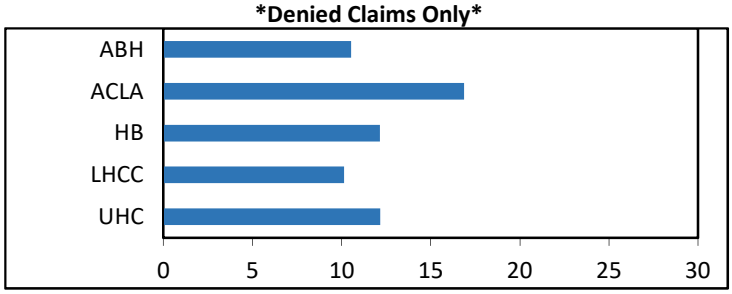
Claims Turnaround Time Quarter Q2 2021 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter Q2 2021 only)

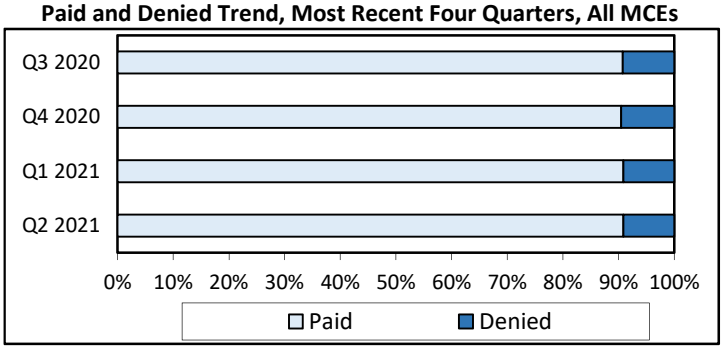
	ABH		ACLA		HB		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	201	109	304	187	327	197	290	140	417	198
101 - 250	49	33	25	17	37	30	46	37	39	32
> 250 claims	42	17	0	0	2	0	11	6	3	0

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

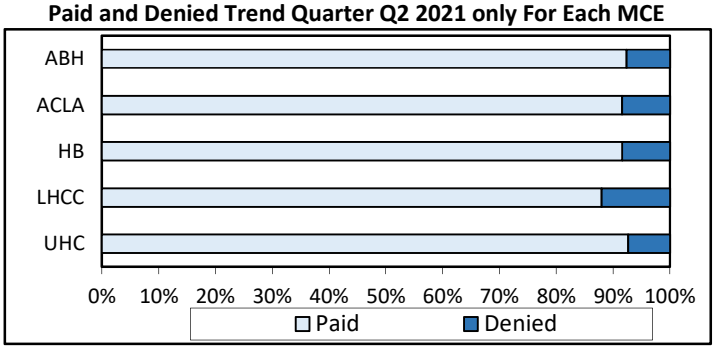
CARC Code	Description	ABH	ACLA	HB	LHCC	UHC
128	Newborn's services are covered in the mother's Allowance.		X	X		X
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	X			X	X
18	Exact duplicate claim/service	X			X	X
39	Services denied at the time authorization/pre-certification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

Summary of Information on Claims for Outpatient Hospital Services

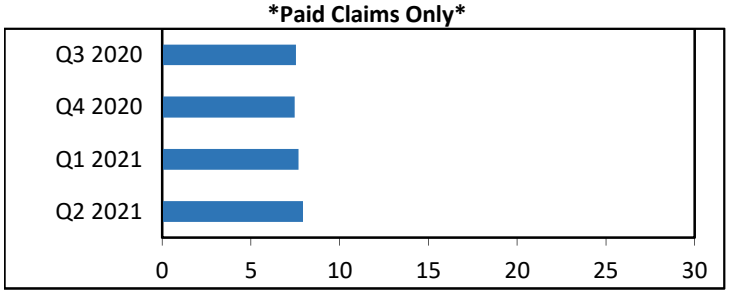
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



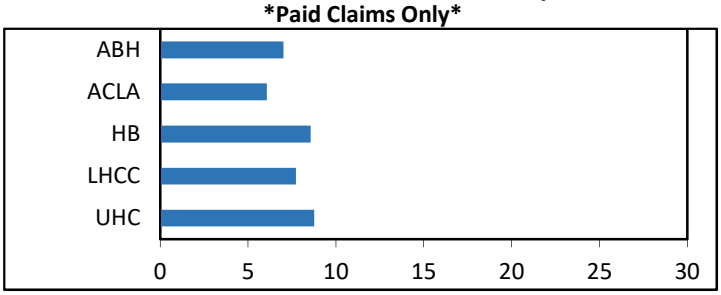
Paid and Denied Trend Quarter Q2 2021 only For Each MCE



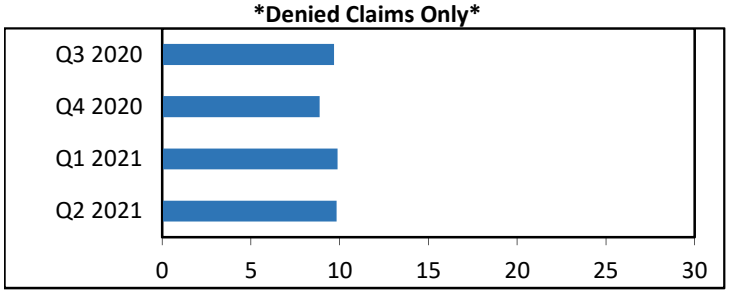
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



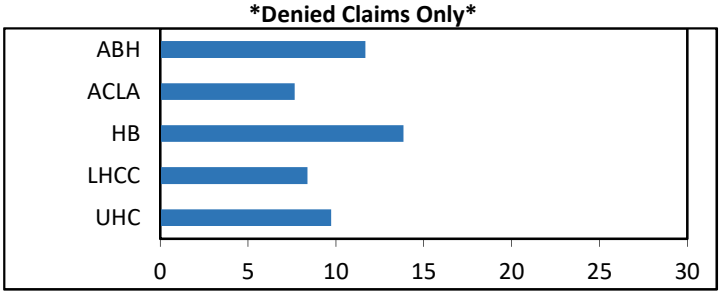
Claims Turnaround Time Quarter Q2 2021 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter Q2 2021 only)

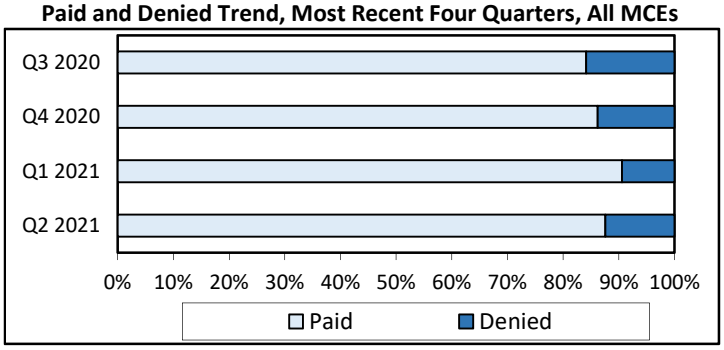
	ABH		ACLA		HB		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	391	183	397	323	422	142	561	335	417	198
101 - 250	88	68	99	32	34	18	110	97	39	32
> 250 claims	112	67	116	29	101	30	170	129	3	0

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

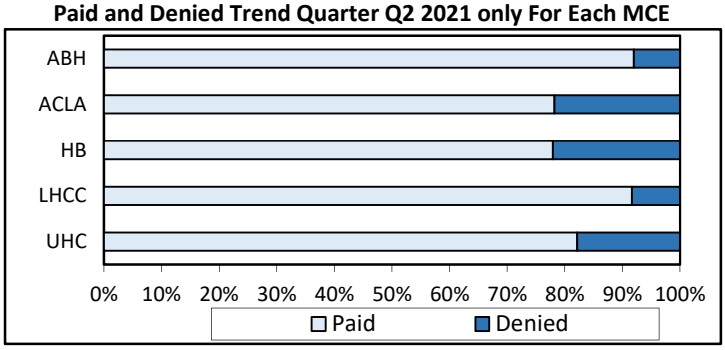
CARC Code	Description	ABH	ACLA	HB	LHCC	UHC
96	Non-covered charge(s).	X	X		X	X
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	X	X		X	X
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already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

Summary of Information on Claims for Home Health Services

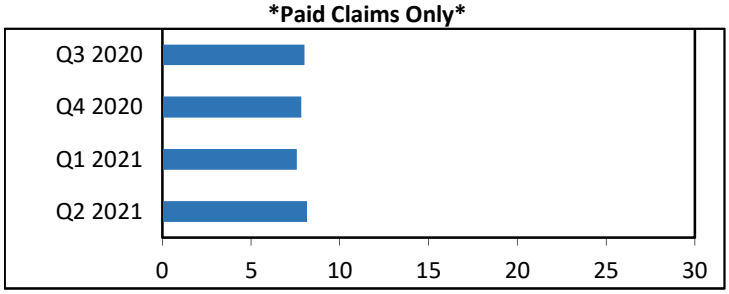
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



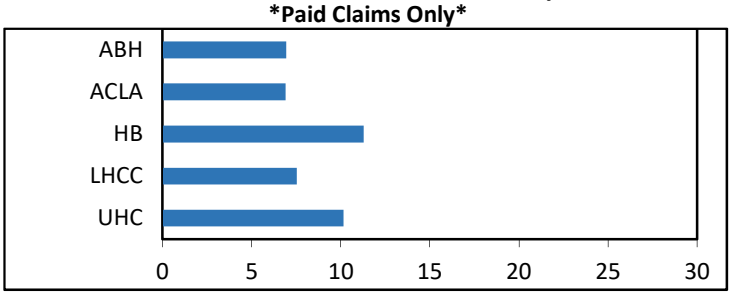
Paid and Denied Trend Quarter Q2 2021 only For Each MCE



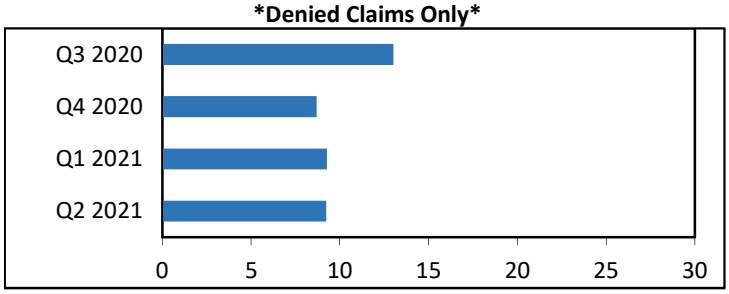
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



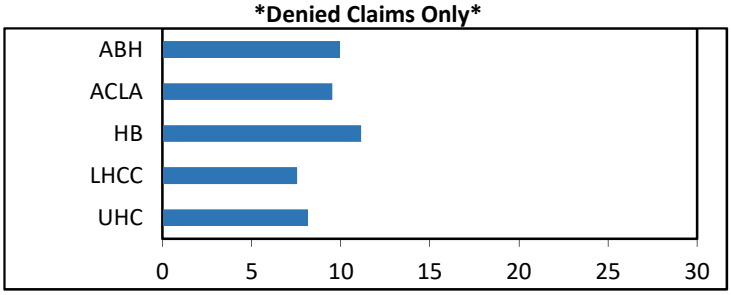
Claims Turnaround Time Quarter Q2 2021 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter Q2 2021 only)

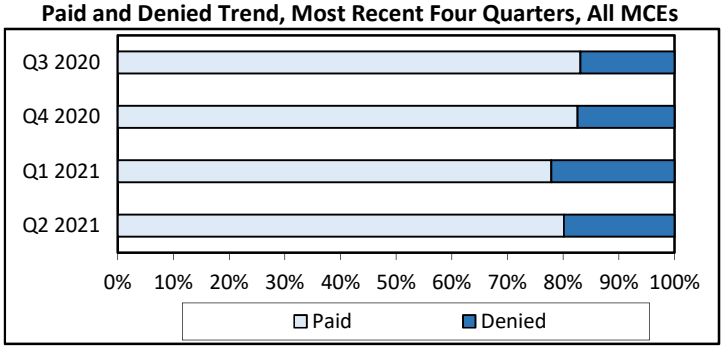
	ABH		ACLA		HB		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	31	9	39	15	44	15	98	44	37	16
101 - 250	15	7	15	5	27	15	51	11	1	1
> 250 claims	0	0	0	0	3	2	25	7	0	0

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

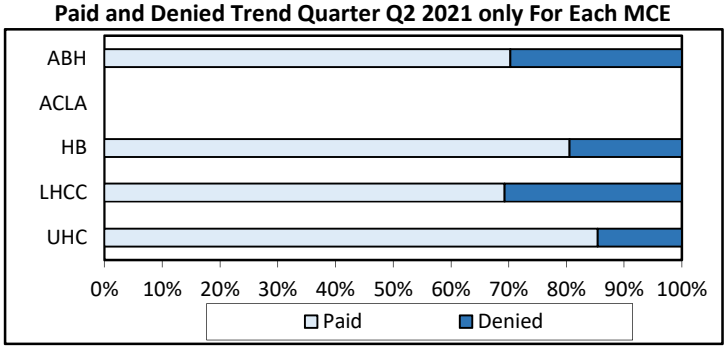
CARC Code	Description	ABH	ACLA	HB	LHCC	UHC
18	Exact duplicate claim/service	X			X	X
96	Non-covered charge(s).	X	X			X
197	Precertification/authorization/notification absent.		X	X	X	
22	This care may be covered by another payer per coordination of benefits.				X	
16	Claim/service lacks information or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

Summary of Information on Claims for Other Institutional Services

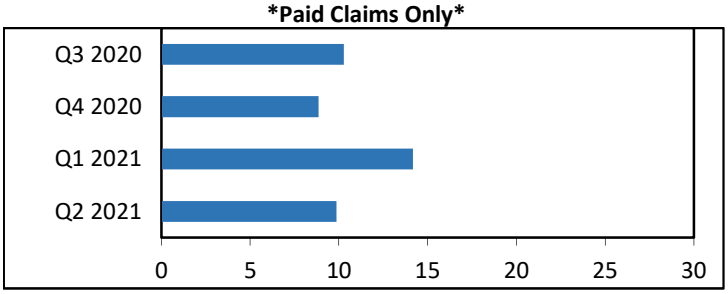
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



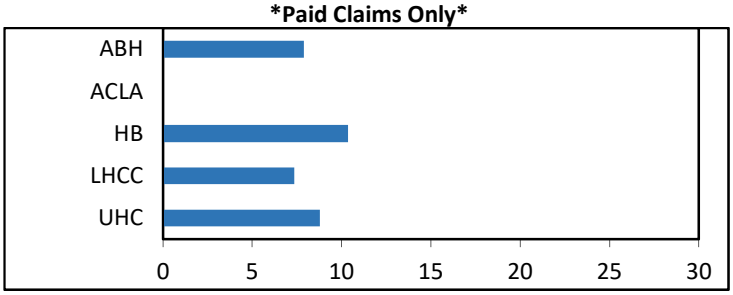
Paid and Denied Trend Quarter Q2 2021 only For Each MCE



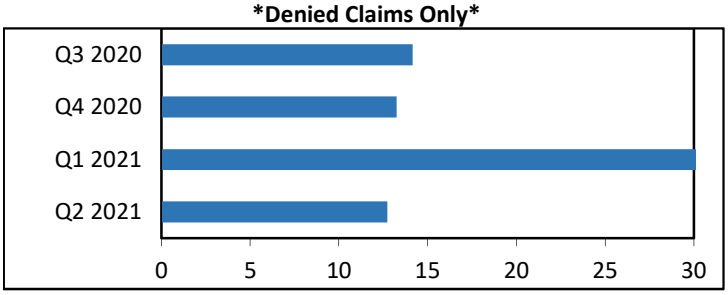
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



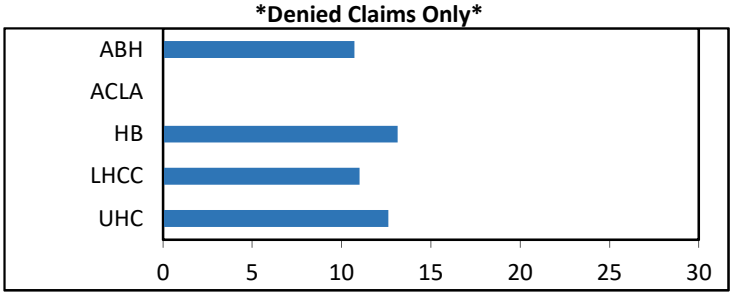
Claims Turnaround Time Quarter Q2 2021 only Each MCE
Paid Claims Only



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 Q2 2021 only)

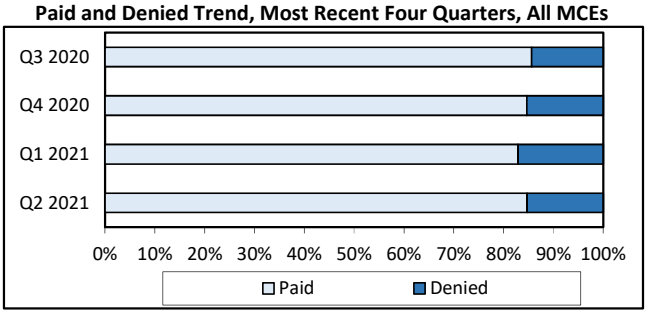
	ABH		ACLA		HB		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	20	17	0	0	159	99	124	91	22	7
101 - 250	4	3	0	0	82	38	5	5	11	6
> 250 claims	3	3	0	0	22	4	2	0	5	0

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

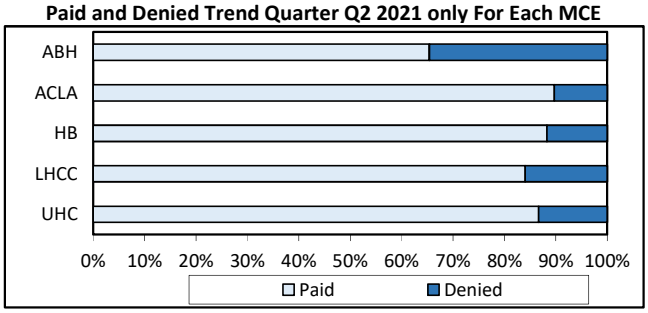
CARC Code	Description	ABH	ACLA	HB	LHCC	UHC
204	This service/equipment/drug is not covered under the patient's current benefit plan		X	X	X	
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	X	X		X	
252	An attachment/other documentation is required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

Summary of Information on Claims for Primary Care Services

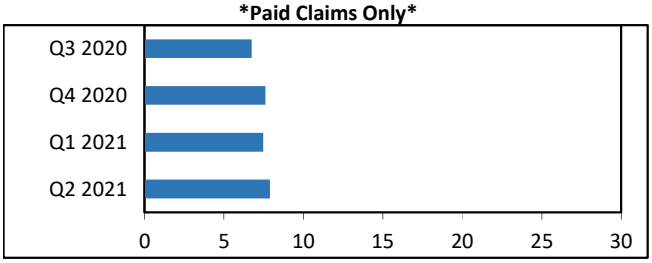
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



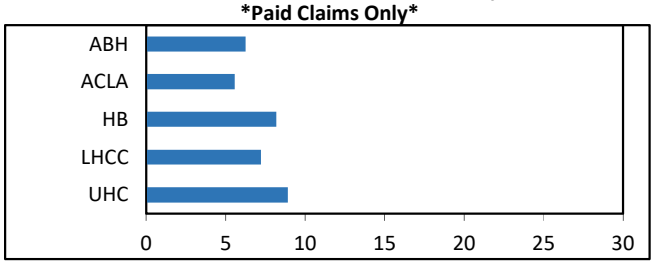
Paid and Denied Trend Quarter Q2 2021 only For Each MCE



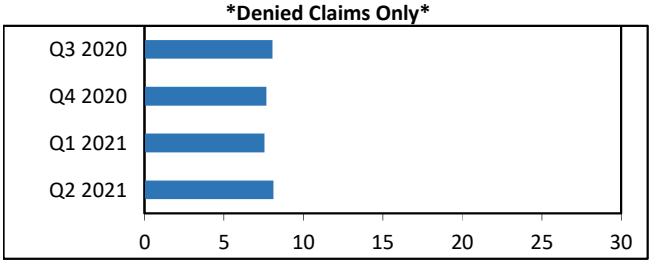
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



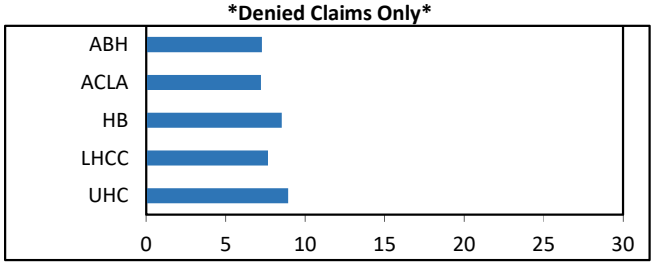
Claims Turnaround Time Quarter Q2 2021 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter Q2 2021 only)

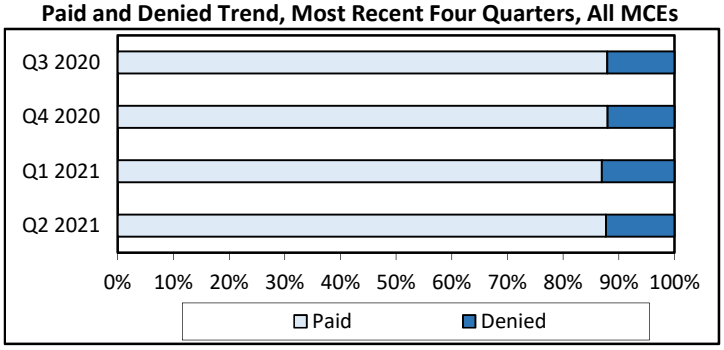
	ABH		ACLA		HB		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	711	406	570	229	1,027	497	940	496	1,429	849
101 - 250	146	128	201	58	448	152	456	277	329	155
> 250 claims	17	16	60	18	280	104	375	233	307	131

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

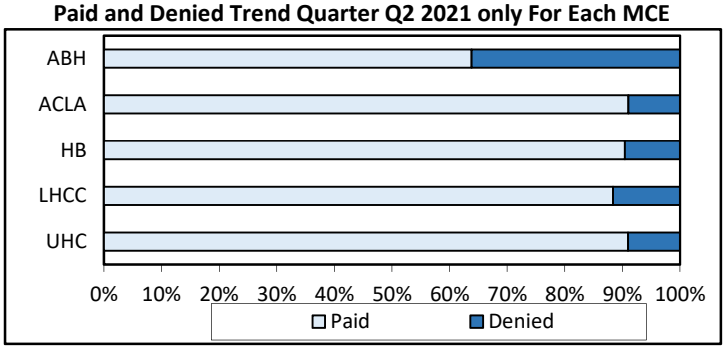
CARC Code	Description	ABH	ACLA	HB	LHCC	UHC
96	Non-covered charge(s).	X	X		X	X
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	X				X
B7	This provider was not certified/eligible to be paid for this procedure/service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

Summary of Information on Claims for Pediatric Services

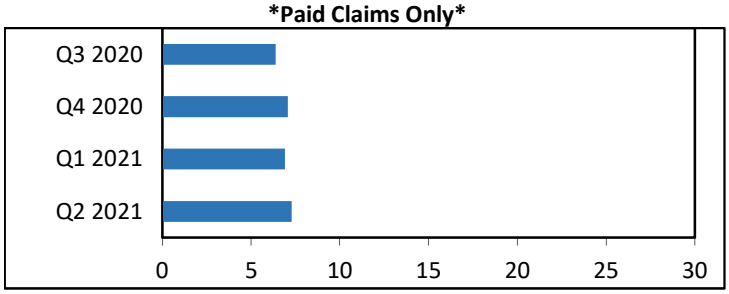
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



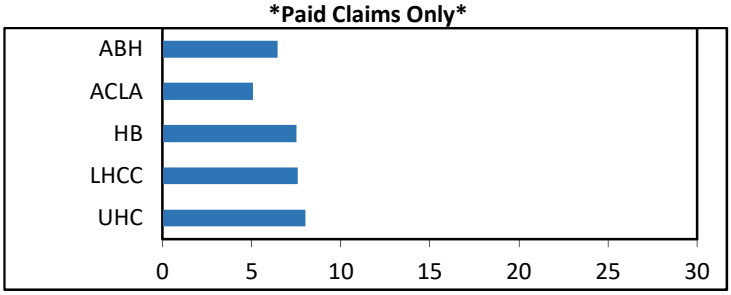
Paid and Denied Trend Quarter Q2 2021 only For Each MCE



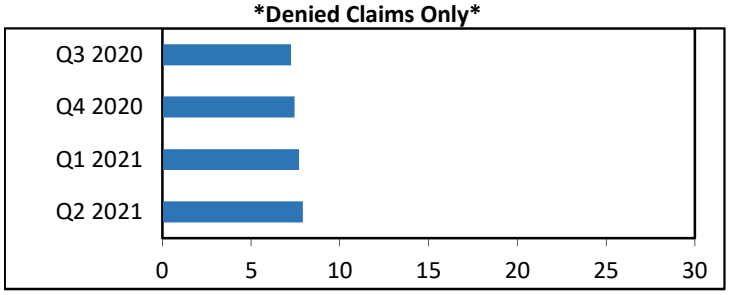
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



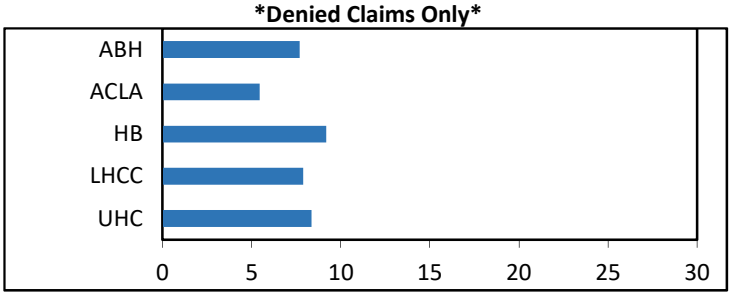
Claims Turnaround Time Quarter Q2 2021 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter Q2 2021 only)

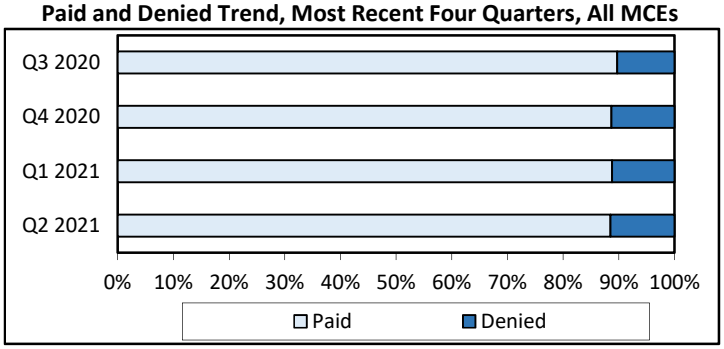
	ABH		ACLA		HB		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	65	38	94	30	175	74	152	76	38	26
101 - 250	29	21	95	21	101	39	105	50	14	4
> 250 claims	4	2	55	8	110	29	171	102	53	12

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

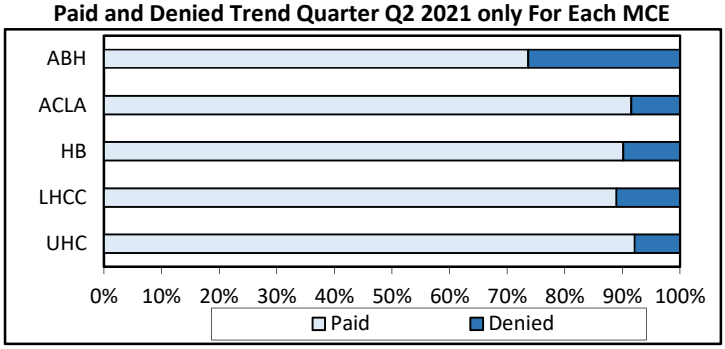
CARC Code	Description	ABH	ACLA	HB	LHCC	UHC
96	Non-covered charge(s).	X	X		X	X
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.				X	
18	Exact duplicate claim/service	X			X	X
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	X	X			X
6	The procedure/revenue code is inconsistent with the patient's age.				X	

Summary of Information on Claims for OBGYN Services

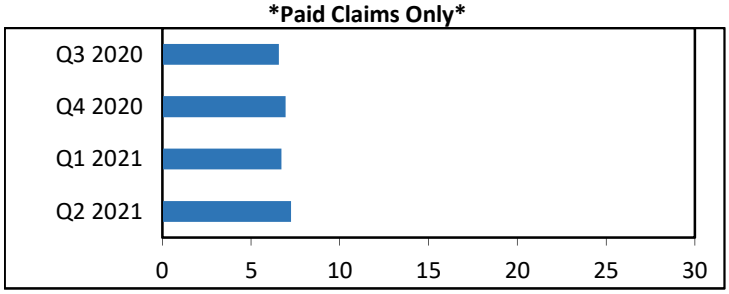
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



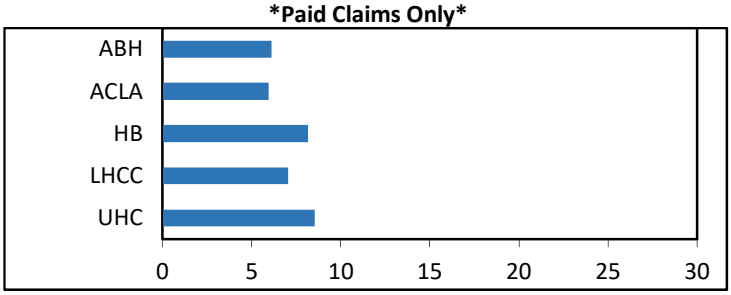
Paid and Denied Trend Quarter Q2 2021 only For Each MCE



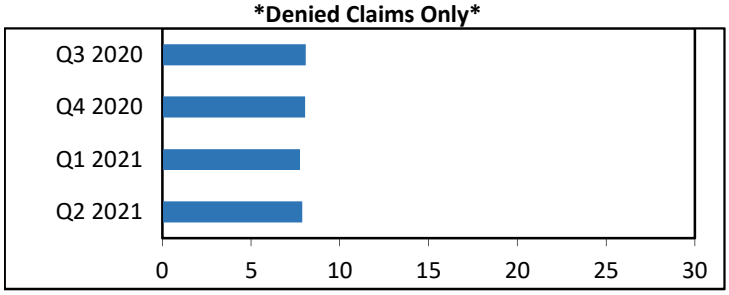
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



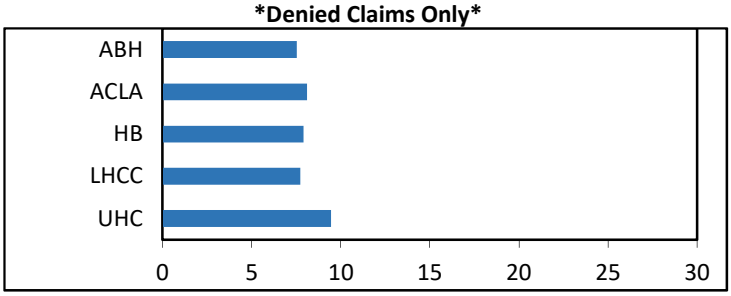
Claims Turnaround Time Quarter Q2 2021 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter Q2 2021 only)

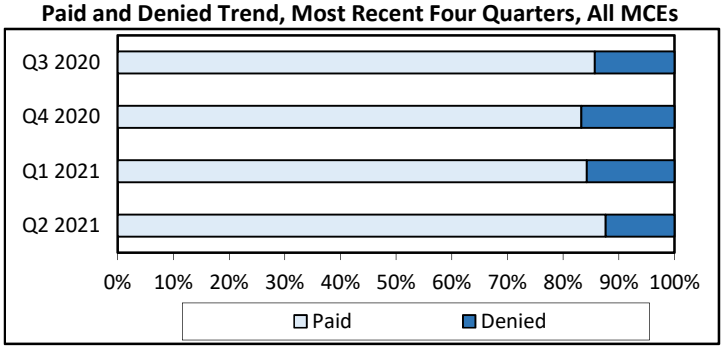
	ABH		ACLA		HB		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	52	32	97	38	115	57	112	64	30	19
101 - 250	11	5	66	17	75	38	59	34	16	8
> 250 claims	1	1	20	5	40	11	68	34	19	4

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

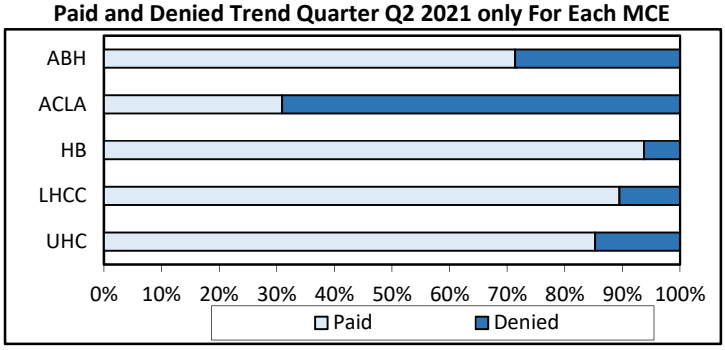
CARC Code	Description	ABH	ACLA	HB	LHCC	UHC
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	X	X		X	
96	Non-covered charge(s).	X	X		X	X
18	Exact duplicate claim/service	X			X	X
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	X			X	X
256	Service not payable per managed care contract.			X		

Summary of Information on Claims for Therapy Services

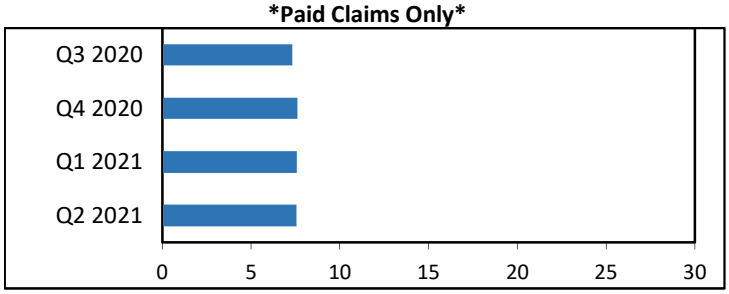
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



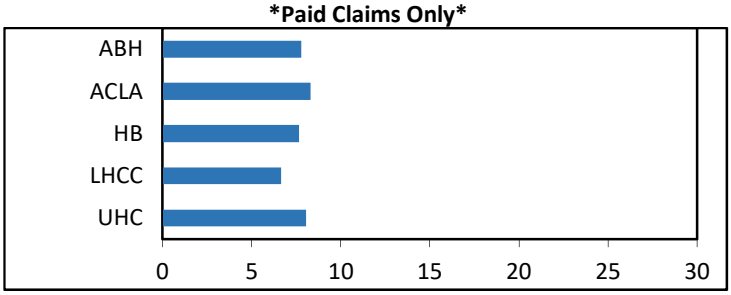
Paid and Denied Trend Quarter Q2 2021 only For Each MCE



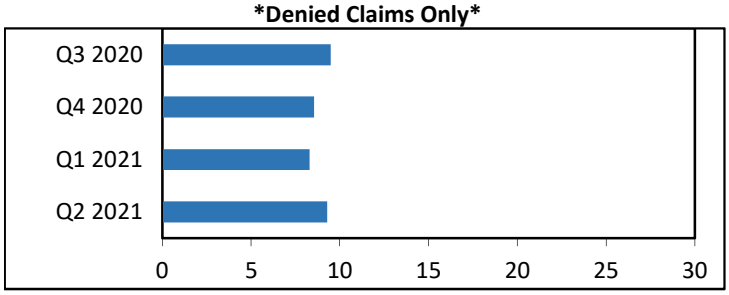
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



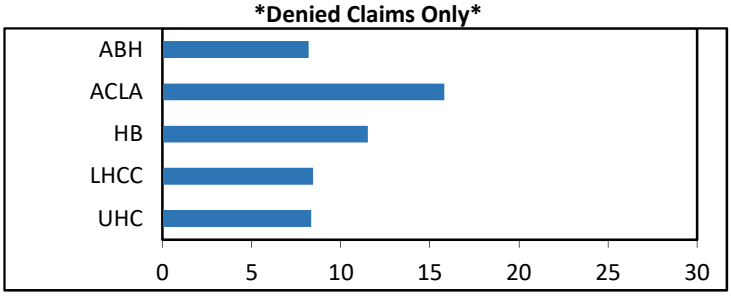
Claims Turnaround Time Quarter Q2 2021 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter Q2 2021 only)

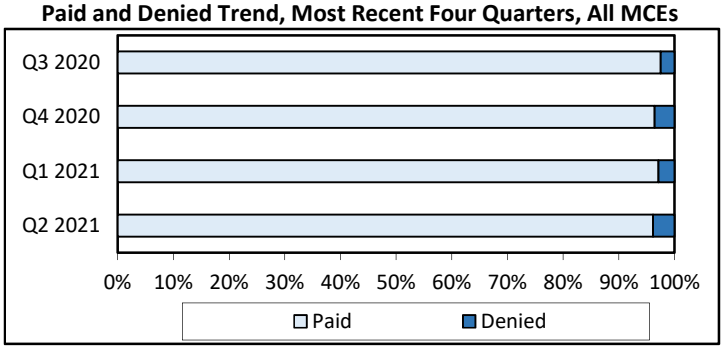
	ABH		ACLA		HB		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	159	75	43	42	88	27	39	21	21	9
101 - 250	32	20	1	1	49	10	27	11	18	7
> 250 claims	1	1	0	0	23	4	11	5	17	8

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

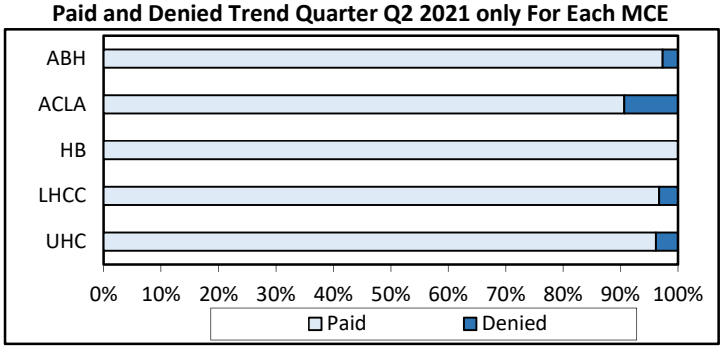
CARC Code	Description	ABH	ACLA	HB	LHCC	UHC
256	Service not payable per managed care contract.			X		
96	Non-covered charge(s).	X	X		X	X
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.					X
16	Claim/service lacks information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

Summary of Information on Claims for NEMT Services

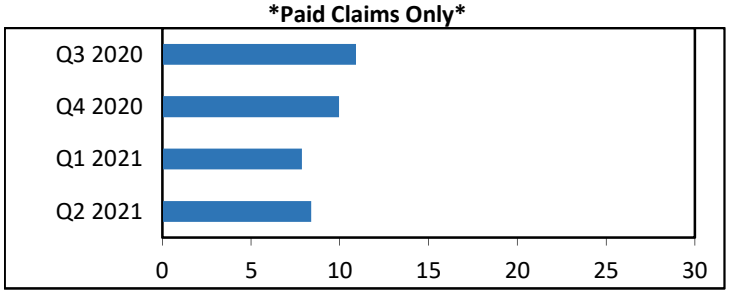
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



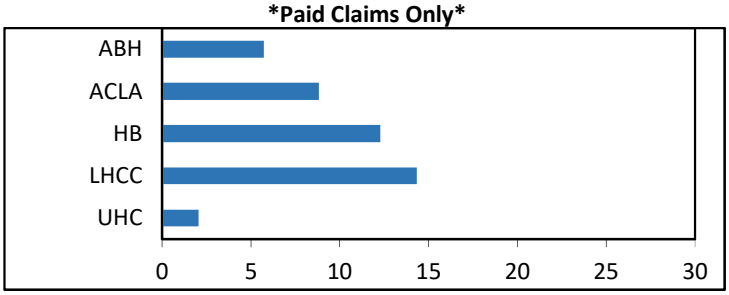
Paid and Denied Trend Quarter Q2 2021 only For Each MCE



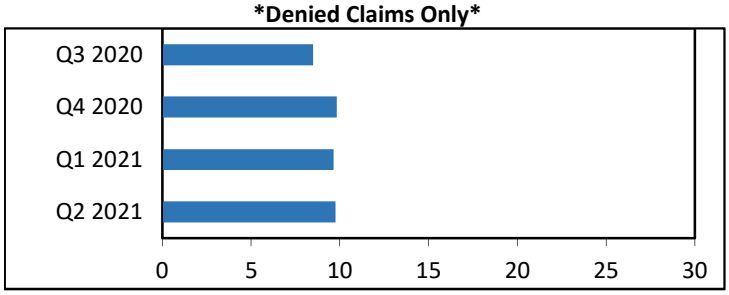
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



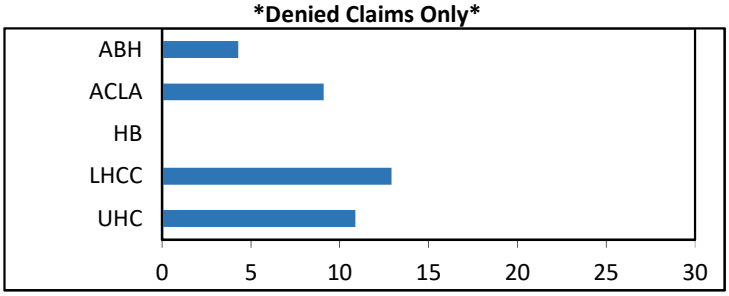
Claims Turnaround Time Quarter Q2 2021 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter Q2 2021 only)

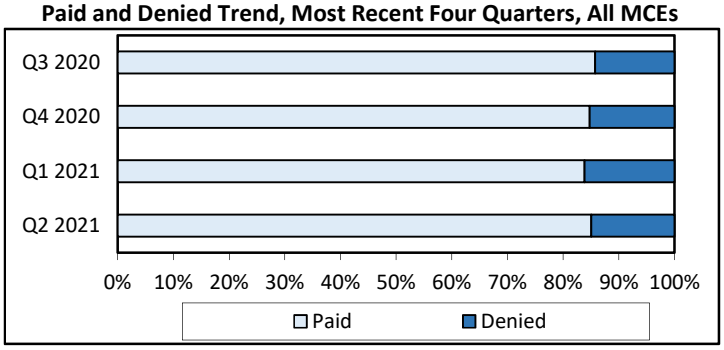
	ABH		ACLA		HB		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	109	6	63	26	0	0	82	20	17	16
101 - 250	1	0	76	27	0	0	63	4	0	0
> 250 claims	0	0	21	4	0	0	10	1	0	0

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

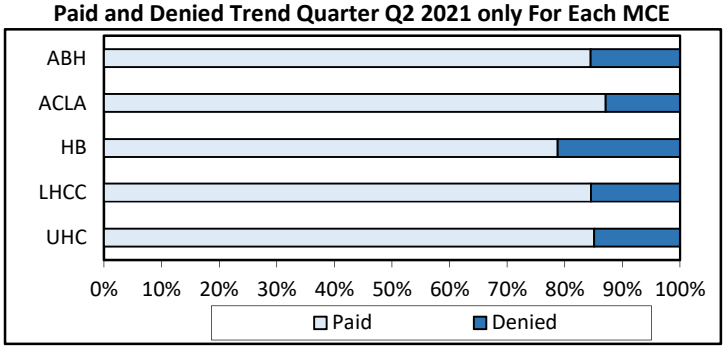
CARC Code	Description	ABH	ACLA	HB	LHCC	UHC
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	X	X	X	X	
18	Exact duplicate claim/service	X	X	X	X	
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	X	X	X		X
252	An attachment/other documentation is required to adjudicate this claim/service.		X	X	X	X
39	Services denied at the time authorization/pre-certification was requested.	X	X	X		

Summary of Information on Claims for Medical Supplies Services

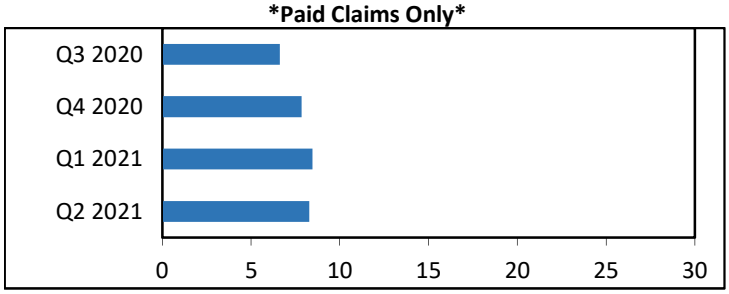
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



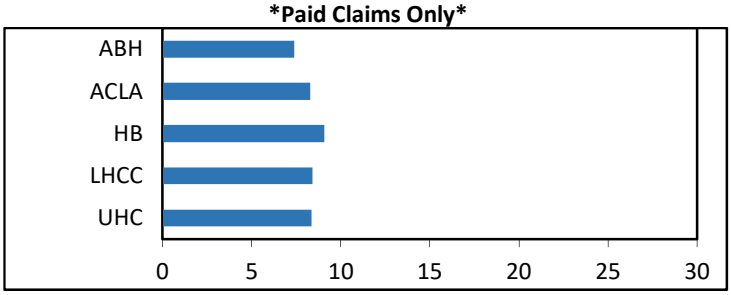
Paid and Denied Trend Quarter Q2 2021 only For Each MCE



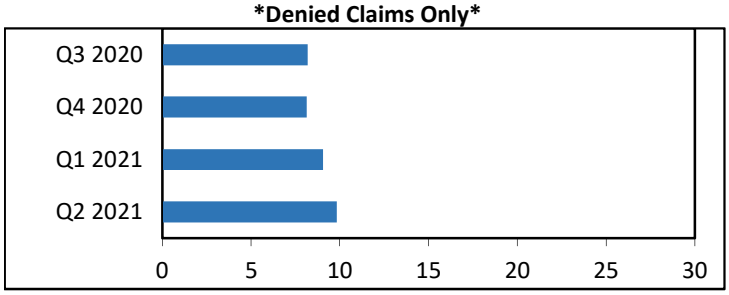
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



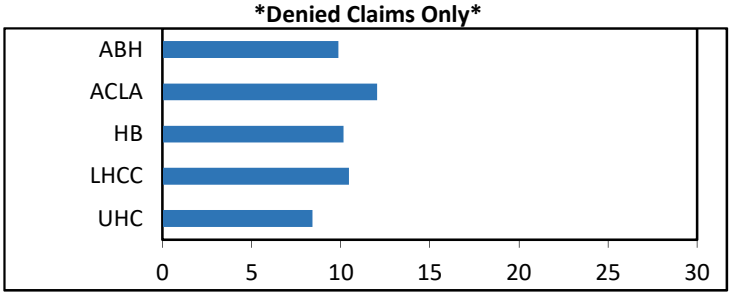
Claims Turnaround Time Quarter Q2 2021 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter Q2 2021 only)

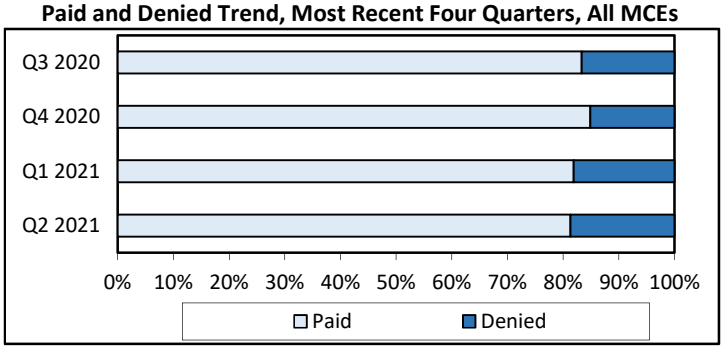
	ABH		ACLA		HB		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	124	81	135	84	112	61	173	81	337	244
101 - 250	44	35	45	27	11	4	81	42	46	20
> 250 claims	11	8	11	3	1	1	26	18	34	14

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

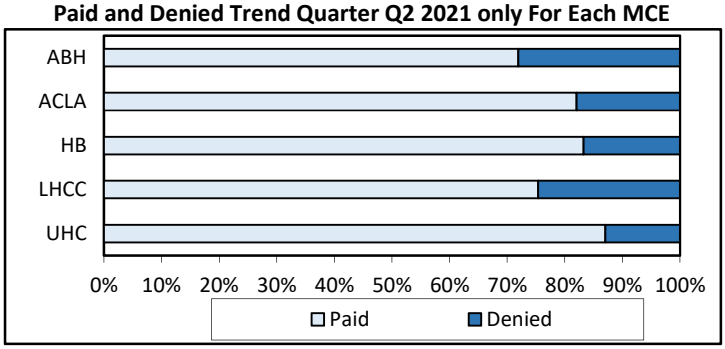
CARC Code	Description	ABH	ACLA	HB	LHCC	UHC
96	Non-covered charge(s).	X	X			X
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	X	X		X	
197	Precertification/authorization/notification absent.	X	X	X		
18	Exact duplicate claim/service	X			X	X
252	An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

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

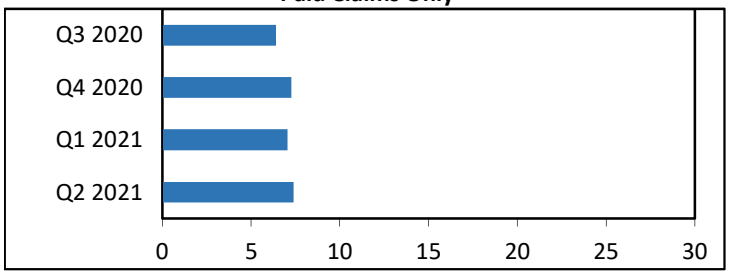
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



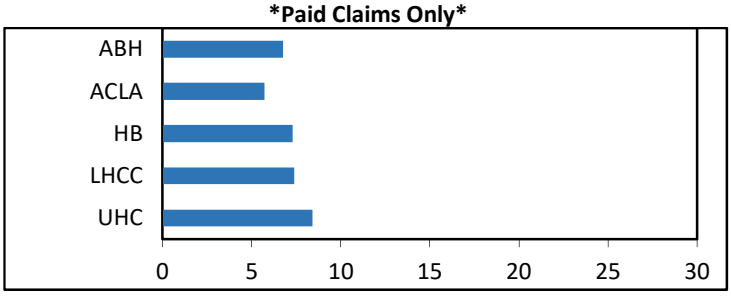
Paid and Denied Trend Quarter Q2 2021 only For Each MCE



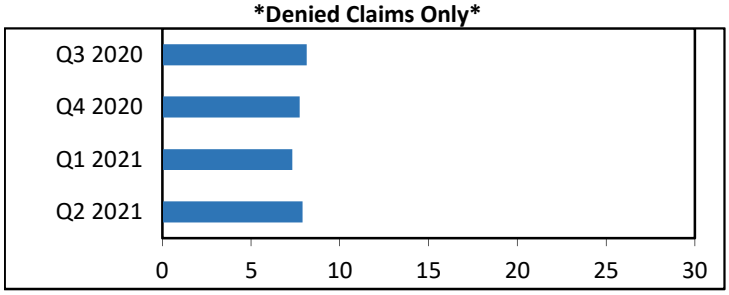
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



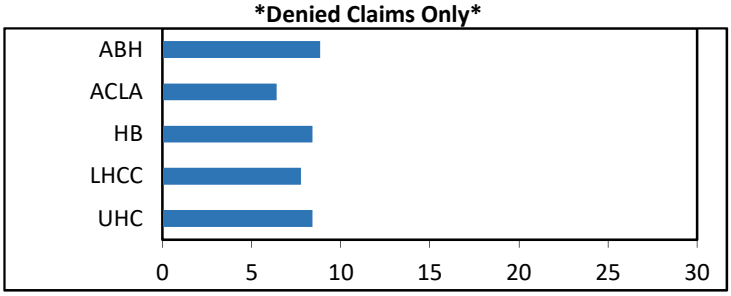
Claims Turnaround Time Quarter Q2 2021 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter Q2 2021 only)

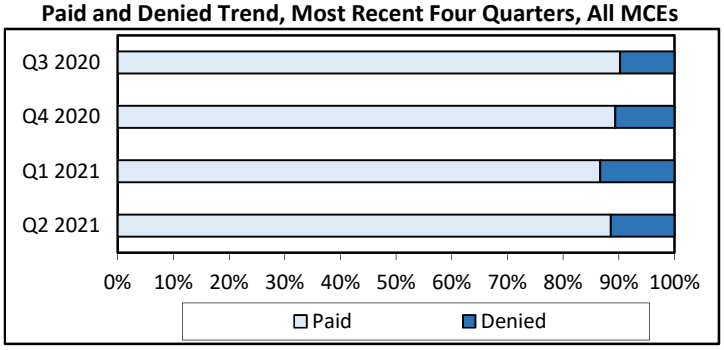
	ABH		ACLA		HB		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	458	73	1,997	1,055	2,402	1,004	2,091	1,231	3,004	1,597
101 - 250	14	5	791	364	602	253	704	405	513	263
> 250 claims	5	1	282	108	345	133	574	277	356	146

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

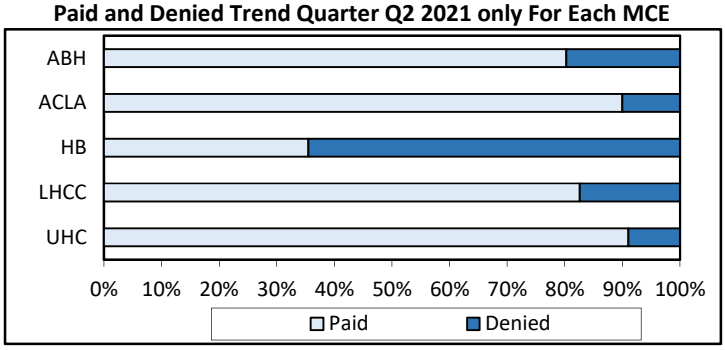
CARC Code	Description	ABH	ACLA	HB	LHCC	UHC
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	X	X		X	
96	Non-covered charge(s).	X	X		X	X
197	Precertification/authorization/notification absent.		X	X		X
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.		X		X	
252	An attachment/other documentation is required to adjudicate this claim/service.					X

Summary of Information on Claims for Mental Health Services- Rehab

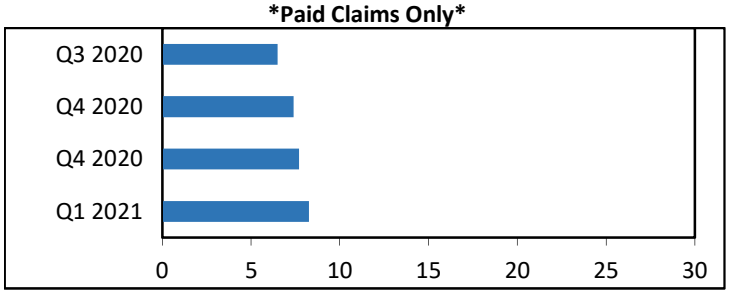
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



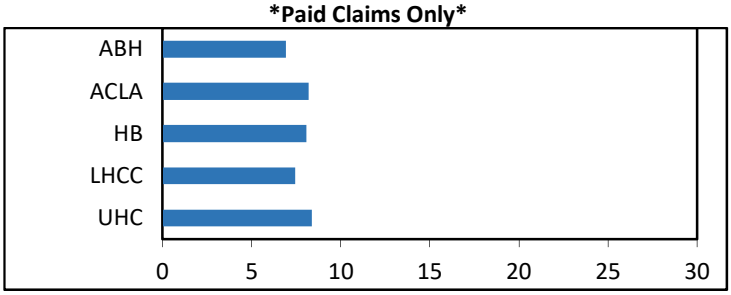
Paid and Denied Trend Quarter Q2 2021 only For Each MCE



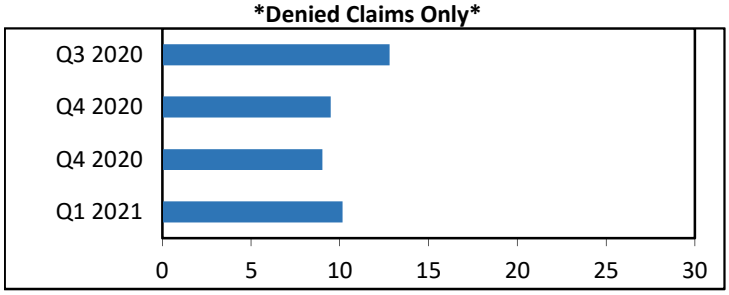
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



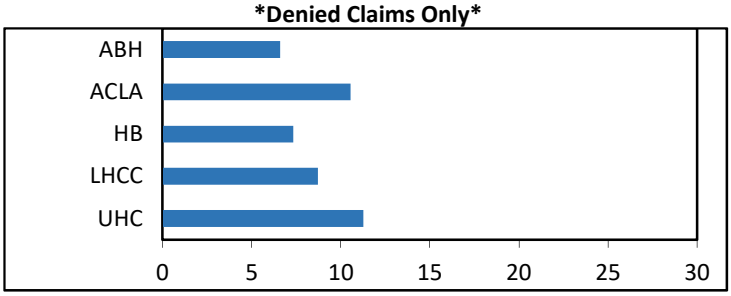
Claims Turnaround Time Quarter Q2 2021 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter Q2 2021 only)

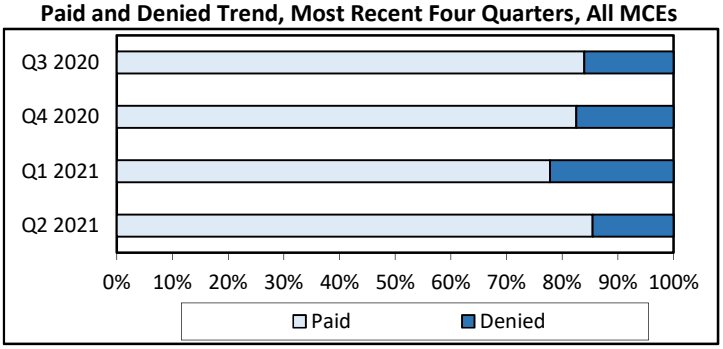
	ABH		ACLA		HB		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	69	63	69	27	130	125	42	22	68	40
101 - 250	12	4	129	49	18	13	20	7	76	30
> 250 claims	1	1	33	6	1	1	6	3	80	26

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

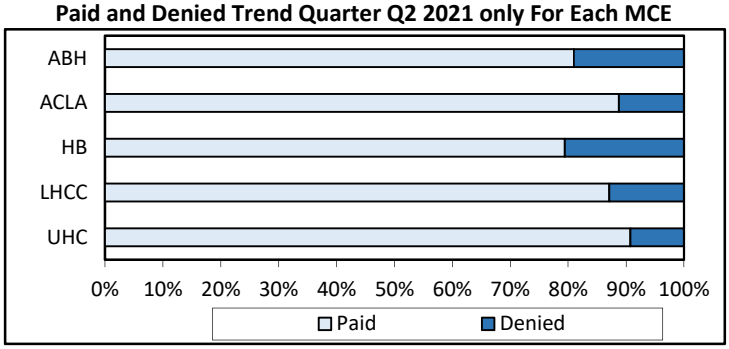
CARC Code	Description	ABH	ACLA	HB	LHCC	UHC
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	X			X	X
242	Services not provided by network/primary care providers.			X		
197	Precertification/authorization/notification absent.		X	X	X	X
18	Exact duplicate claim/service	X				X
198	Precertification/authorization exceeded.		X	X	X	

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

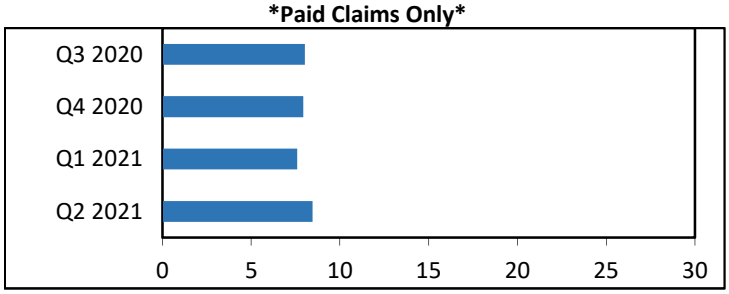
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



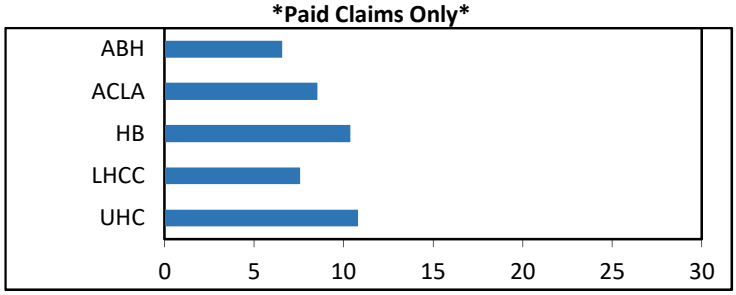
Paid and Denied Trend Quarter Q2 2021 only For Each MCE



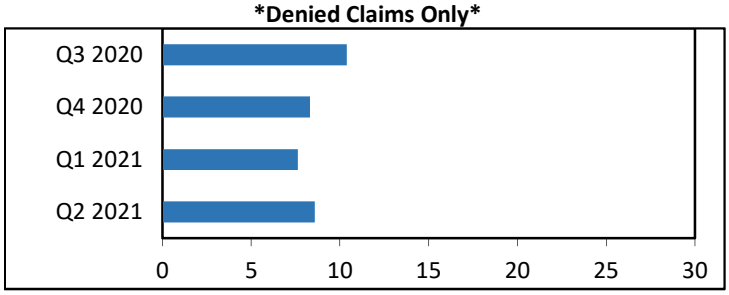
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



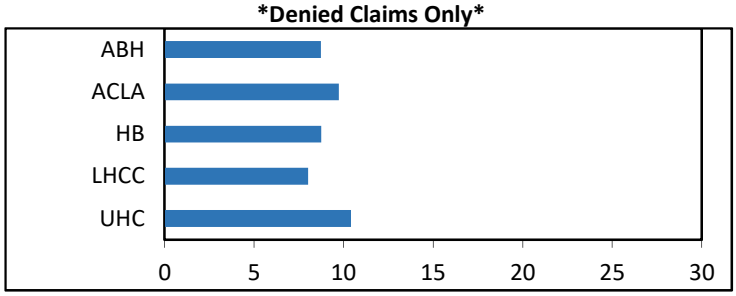
Claims Turnaround Time Quarter Q2 2021 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter Q2 2021 only)

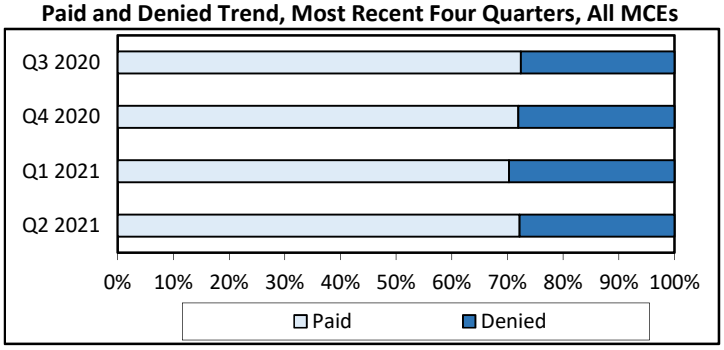
	ABH		ACLA		HB		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	14	12	505	212	963	537	757	302	246	126
101 - 250	3	1	91	34	270	142	297	127	64	31
> 250 claims	0	0	23	3	97	60	239	130	45	13

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

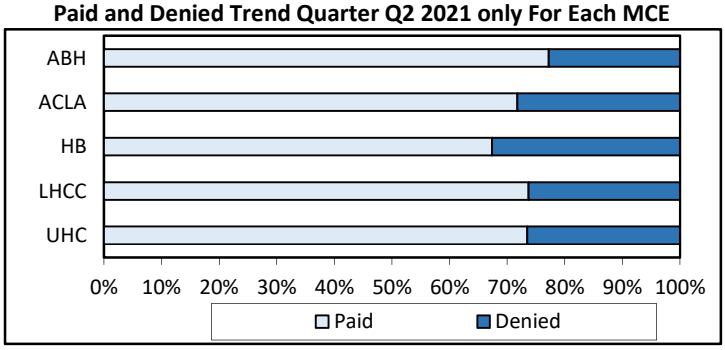
CARC Code	Description	ABH	ACLA	HB	LHCC	UHC
96	Non-covered charge(s).	X	X			X
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	X			X	X
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already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

Summary of Information on Claims for Pharmacy Services

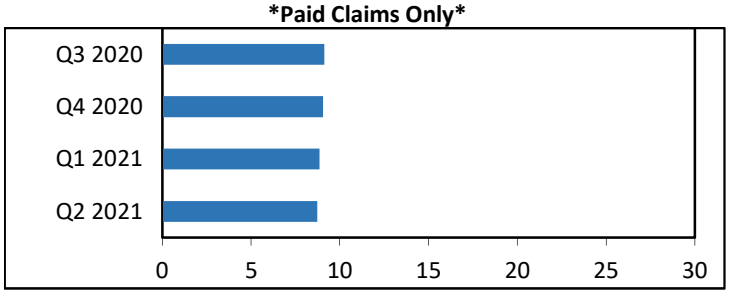
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



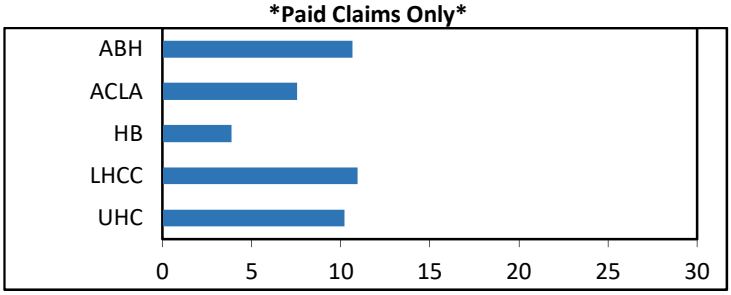
Paid and Denied Trend Quarter Q2 2021 only For Each MCE



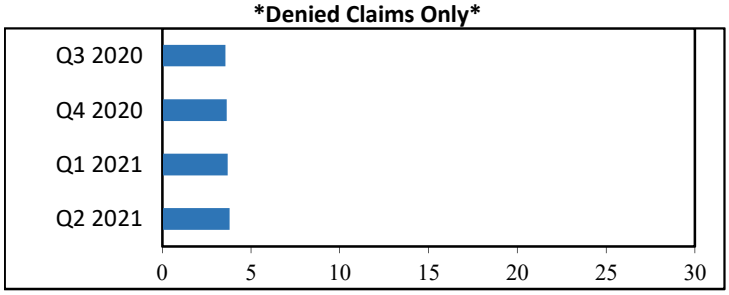
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



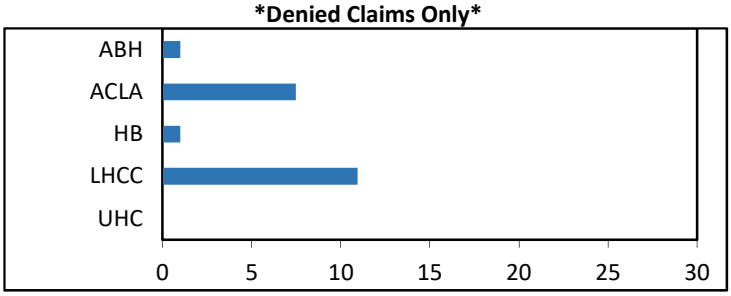
Claims Turnaround Time Quarter Q2 2021 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter Q2 2021 only)

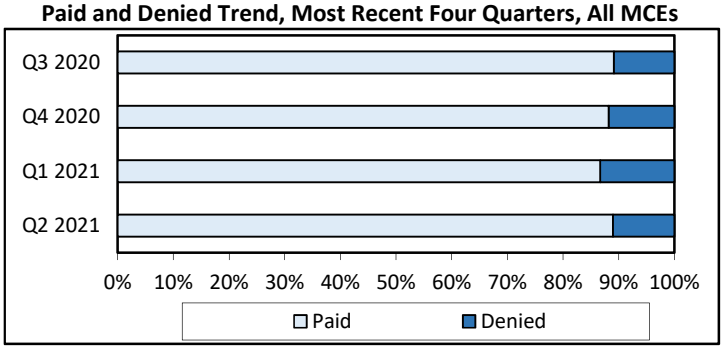
	ABH		ACLA		HB		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	17,064	10,759	1,104	1,085	3,250	2,651	13,273	12,465	18,342	13,607
101 - 250	1,538	1,486	372	369	187	187	3,416	3,373	3,974	3,924
> 250 claims	122	119	666	663	918	918	1,079	1,079	1,324	1,320

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

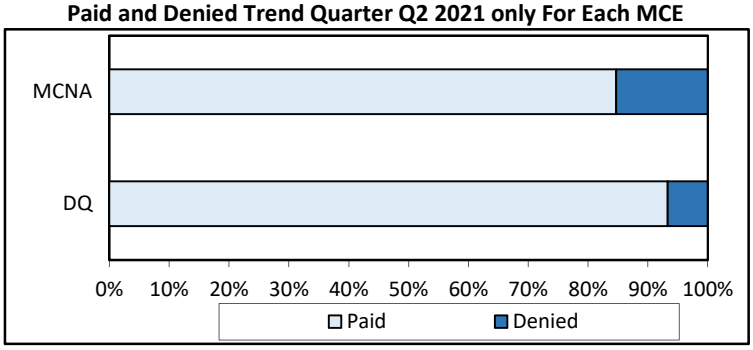
NCDCP Code	Description	ABH	ACLA	HB	LHCC	UHC
79	Refill Too Soon	X	X	X	X	X
88	DUR Reject Error			X	X	X
76	Plan Limitations Exceeded	X		X	X	X
75	Prior Authorization Required	X		X	X	
7Ø	Product/Service Not Covered – Plan/Benefit Exclusion	X	X		X	X

Summary of Information on Claims for Dental Services- Children

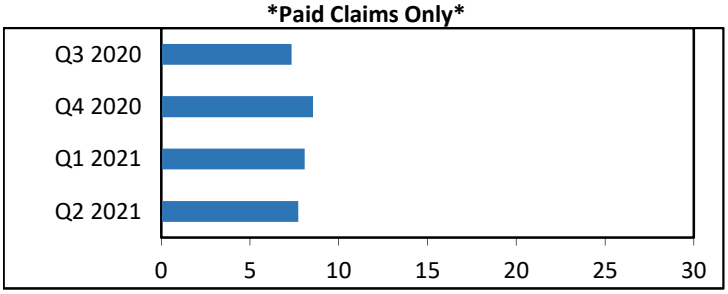
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



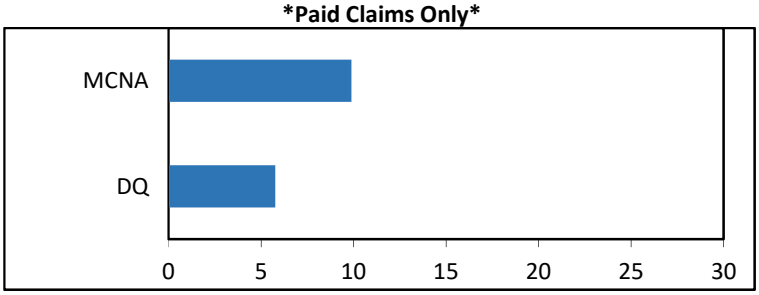
Paid and Denied Trend Quarter Q2 2021 only For Each MCE



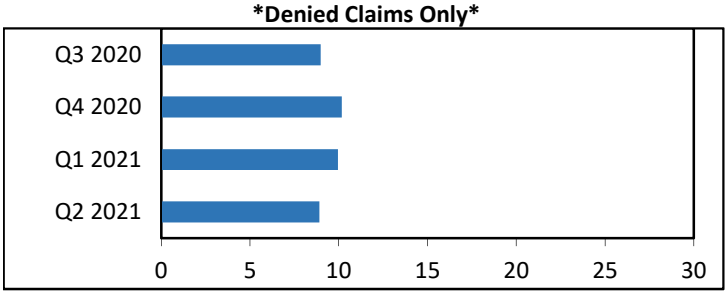
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



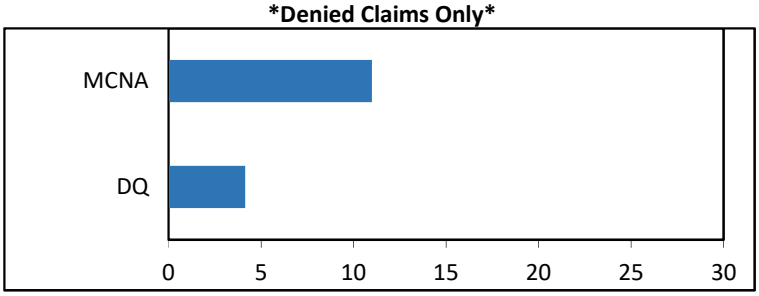
Claims Turnaround Time Quarter Q2 2021 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter Q2 2021 only)

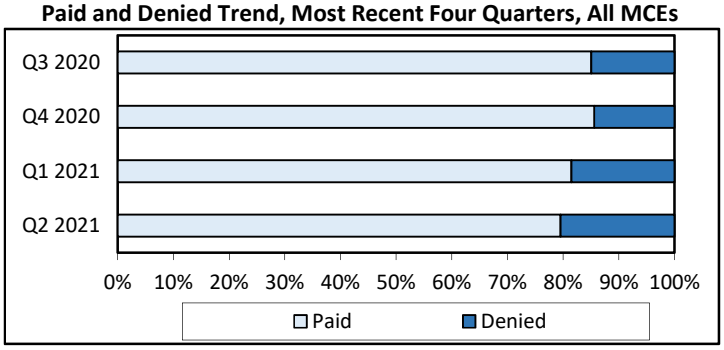
	MCNA		DQ	
	# Providers	>10% denied	# Providers	>10% denied
<100 claims	649	457	0	0
101 - 250	143	138	0	0
> 250 claims	27	37	0	0

Top Denial Reasons this Quarter

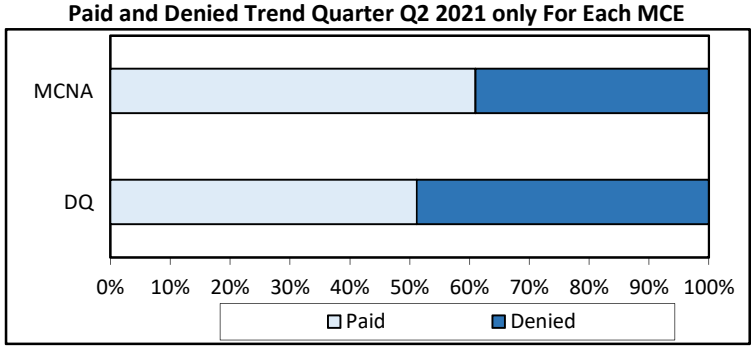
CARC Code	Description	MCNA	DQ
A1	Claim/Service denied.		X
27	Expenses incurred after coverage terminated.	X	
96	Non-covered charge(s).	X	
18	Exact duplicate claim/service	X	
169	Alternate benefit has been provided.	X	

Summary of Information on Claims for Dental Services- Adults

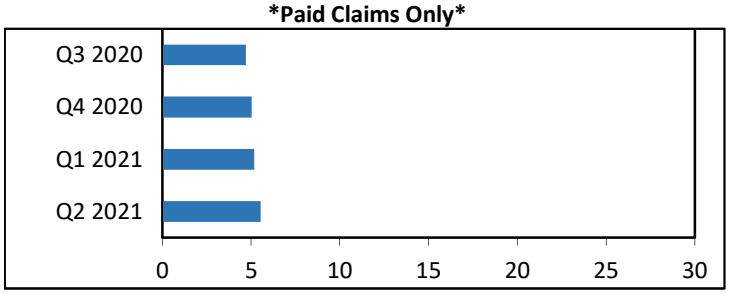
Paid and Denied Trend, Most Recent Four Quarters, All MCEs



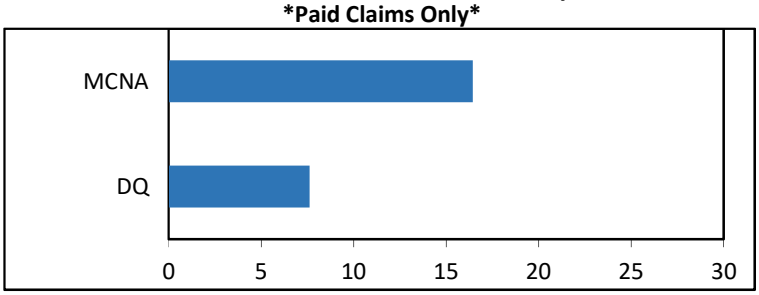
Paid and Denied Trend Quarter Q2 2021 only For Each MCE



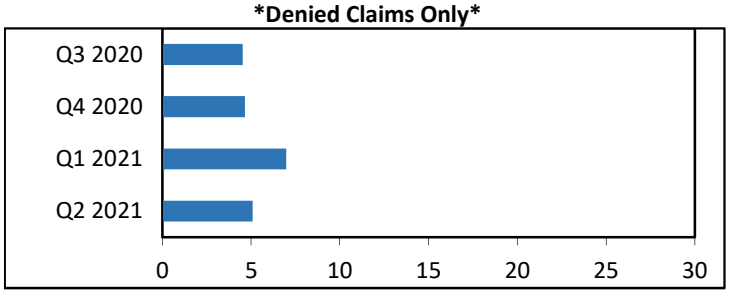
Claims Turnaround Time Most Recent 4 Qtrs All MCEs
Paid Claims Only



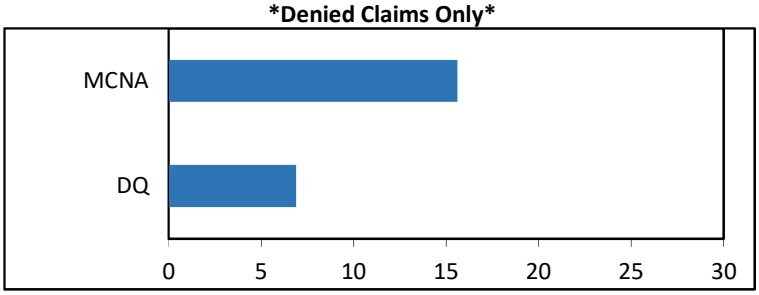
Claims Turnaround Time Quarter Q2 2021 only Each MCE
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCE within Three Provider Volume Ranges (# of claims submitted to the MCE in Quarter Q2 2021 only)

	MCNA		DQ	
	# Providers	>10% denied	# Providers	>10% denied
<100 claims	303	290	437	8
101 - 250	0	2	129	18
> 250 claims	0	0	86	16

Note: All MCEs had little data for Dental-Adult

Top Denial Reasons this Quarter

CARC Code	Description	MCNA	DQ
22	This care may be covered by another payer per coordination of benefits.		
A1	Claim/Service denied.		X
119	Benefit maximum for this time period or occurrence has been reached.		
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.		
18	Exact duplicate claim/service	X	