Healthy Louisiana Claims Report

Response to Act 710 of the 2018 Regular Legislative Session

Quarter 4 Calendar Year 2022

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Louisiana Department of Health

Bureau of Health Services Financing

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LOUISIANA DEPARTMENT OF HEALTH

Contents

Executive Summary

Background

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

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

Key Findings

Measure #1: Claims Accepted and Rejected by the MCEs

- The claim acceptance rate for all MCEs combined has held constant at 99.0% for the first three quarters of CY 2022, and increased slightly to 99.1% in the fourth quarter.

- In the most recent four quarters for which data is available, the claims rejection rate reported by the MCEs averaged at 1.0%. This rate, however, is driven primarily by Louisiana Healthcare Connections (rejection rate of 2.2% to 2.6%) with the other MCEs having rejection rates close to zero.

Measure #2: Claims Paid and Denied by the MCEs

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

- At the MCE-specific level, the average denial rate in the last four quarters ranged from 7.1% for DentaQuest to 23.4% for Aetna Better Health.

- Medicaid found more variation when it examined the claims denial rates by provider type. For example, pharmacy (average 31.9% in the last four quarters) and dental - adults (average 22.2% in the last four quarters) have the highest denial rates while non-emergency medical transportation (average 1.8% in the last four quarters) and dental - children (average 8.2% in the last four quarters) have the lowest denial rates.

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

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

- The MCEs are meeting LDH's target for adjudication within 30 days. The average TAT is below 9 days in the last four quarters for all MCEs with the minor exception of MCNA with an average TAT of 9.7 days.
- The overall TAT for paid claims, all MCEs combined, is between 7.4 days and 7.9 days in each quarter. For denied claims, the average is between 5.1 days and 5.6 days.
- Average claims adjudication TATs do vary by provider category, but not significantly, from the overall average.

Measure #4: Top Reasons for Denied Claims

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

Key findings by CARCs:

- The top five CARCS for Q4 2022 were:

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

- The top five CARCs in this quarter were also among the top five in the previous 15 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 Q4 2022 were:

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

- These five NCPDPs were also among the top six in the previous 13 quarters reported.

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

- In the most recent four quarters studied, LDH accepted 98.6% to 99.6% of the encounters submitted by all MCEs.

- There were differences at the MCE level. All of UnitedHealthcare's encounters were accepted. Almost all of Healthy Blue and Louisiana Healthcare Connections' encounters were accepted over the past four quarters. AmeriHealth Caritas Louisiana averaged 99% of encounters accepted for the previous four quarters. MCNA averaged 97.9% over the last four submitted quarters. Aetna Better Health's four-quarter average of encounters accepted rate was 94.9%. DentaQuest averaged 93.4% over the last four submitted 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 its encounters to LDH, and this can vary by claim category.

- Across all MCEs, the overall average rate of submission within 30 days for institutional, professional, dental, and pharmacy encounters was 91.4%. The rate of submission increased by 0.6% from the previous four quarters (90.8%).

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

- AmeriHealth Caritas Louisiana had the second highest rate of timeliness for encounter submissions with an average of 97.0% over the past four quarters.

- Louisiana Healthcare Connections averaged 89.7% of timeliness for encounter submissions over the past four quarters but had some issues with timely submissions for pharmacy encounters, with an average of 71.1% over the past four quarters.

- Healthy Blue had issues with timely submissions for institutional encounters (62.1%) for Quarter 2 of 2022, with an overall average rate of timeliness for encounter submissions at 88.3% over the past four quarters.

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

- In regards to dental encounters, DentaQuest has been the most consistent over the past four quarters with an average of 100%. MCNA four quarter rate of submission average was 95.5%, with a significant decrease to 83.0% in the Quarter 4 2022.

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

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

In Q4 2022, Medicaid reached out to 883 provider entities (833 in the prior quarter). The most predominant mode of outreach to providers is 1:1 phone calls (53.7% of all contacts) followed by 1:1 emails (40.2% of contacts). Very few in-person and webinar provider education took place, accounting for 4.1% and 2.0% of the total, respectively.

Measure #8: Case Management

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

Key findings for Q4 2022:

- A total of 49,595 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, 22.3% or 11,035 were enrolled in case management for at least one month during the fourth quarter of CY 2022 and;
- A total of 7,492 (67.9 %) actively received one or more case management service(s).

Listing of Exhibits

Section I: Introduction

Legislative Overview

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

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

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

Terminology Used in this Report

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

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

- An *original claim* indicates the first submission made by the provider to the payer.

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

Steps in Claims Processing and Encounter Submissions

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

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

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

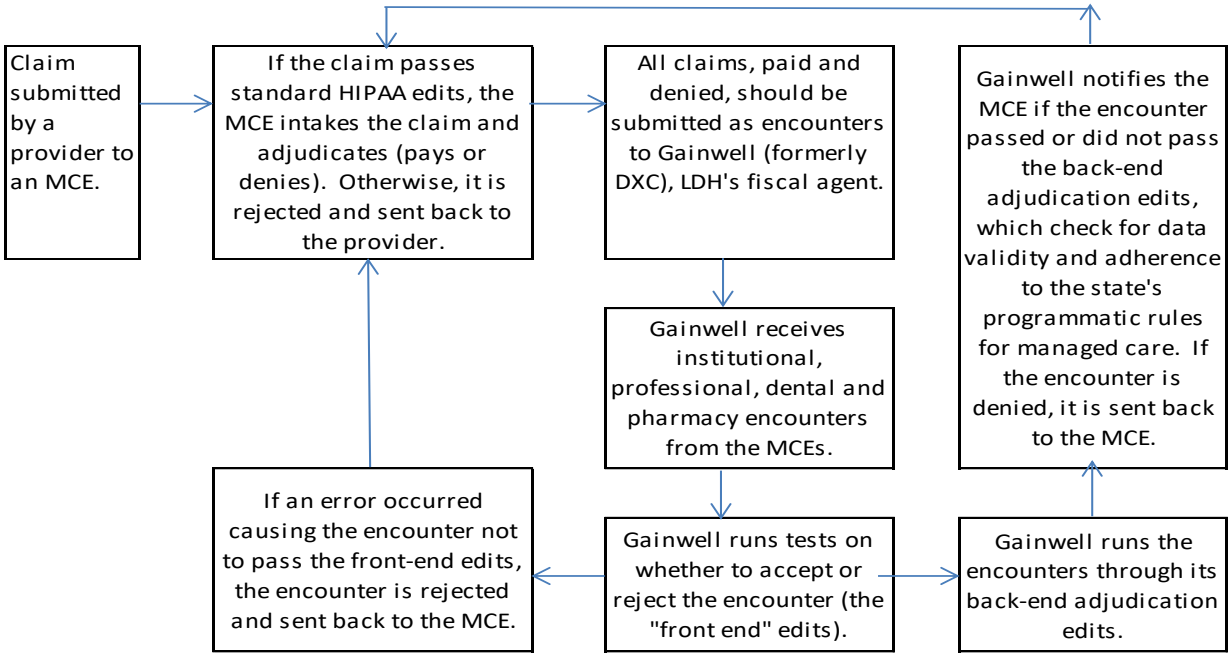
- The *CMS-1500, or electronic 837P*, is the claim type for professional service providers to submit. This includes a wide array of providers such as physicians, clinics, mental health providers, therapists, transportation providers, suppliers of medical equipment and supplies.

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

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

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

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



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

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

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

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

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

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

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

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

The *turnaround time* factors in any time that a claim is pended. This term is used to describe the length of time it takes for payers to adjudicate claims. In this study, the average turnaround time represents the time from the MCE's receipt of the claim to the time of provider notification (pay or deny).

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

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

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

MCEs Analyzed in this Quarter's Review Include:

Plan Name	Plan Type	Common Abbreviation
Aetna Better Health, Inc.	Managed care organization	ABH
AmeriHealth Caritas Louisiana, Inc.	Managed care organization	ACLA
Healthy Blue	Managed care organization	HB
Louisiana Healthcare Connections, Inc.	Managed care organization	LHCC
United Healthcare 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 requires that behavioral health providers be reported discretely from non-behavioral health providers in the initial report. In consultation with stakeholders, LDH also agreed that there be further segmentation of the non-behavioral health providers for discrete reporting. The provider categories that are reported on an ongoing basis are:

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

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

Data Collection

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

Limitations of the Data

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

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

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

    Because of these limitations, the value of denied claims should be reviewed with caution. Values shown for denied claims should not be considered as "lost" money to providers, as not all claims are payable. Instead, they provide useful information on key areas to target for improvement both in the Department and with provider education.

Report Structure

Section II contains a summary table of data trends across all quarterly reports, Q1 2018 through Q4 2022. Section III contains the results related to MCE claims adjudication measures and MCE provider education pertaining to claim submissions. Section IV reports on the results of findings related to MCE encounter submissions and Section V presents summary data on case management by MCE for the quarter.

In some exhibits, data displays the most recent four quarters. In this report, the four quarters shown are Quarters 1, 2, 3, and 4 in 2022. Other exhibits will display only the data from the most recent quarter. In this edition of the report, the exhibits that contain only the most recent quarter show Q4 2022 data.

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

Section II: Data Trends

Q1 2018 to Q4 2022

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

Claim Rejection Rate	MCEs reject 0% to 2.6% of provider claims
Claim Payment Denial Rate, Overall	From a low of 17.5% to a high of 19.2%
For Hospital Claims Denial Rate	Much higher for inpatient hospital services (16.1%-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 varied substantially between 1.6% and 22.0%. All other professional services has the highest average (17.8%), ranging from 15.1% to 21.4% and Non-Emergency Transport has the lowest (3.1%), ranging from 1.6% to 6.1%.
For Dental Claims	For child dental services, denial rate had been steady between 6.9% and 13.3%. The denial rate for adult dental services has fluctuated between 10% and 26.6%
For Pharmacy Claims	Industry standard is that pharmacy scripts have highest denial rate. Louisiana Medicaid Managed Care is no exception with a denial rate range between 25.9% and 32.3%. This is a result of pharmacy claims being a Point of Sale system.
Turnaround Time to Process Claims	The average time for MCEs to process provider claims has been steady in every report, from 5.8 days to 8.7 days. The overall average since the implementation of this report is 7.9 days.
Time for MCEs to Submit Claims as Encounters to LDH	There is variation in the timeliness for the MCEs to submit encounters to LDH. This can vary by MCE and by quarter. Generally, UHC is most consistent timely (that is, all encounters submitted to LDH within 30 days of processing) with 96.7%. ACLA has a 93.8% submission rate. HB submit over 95.1% of their encounters within 30 days. LHCC has an 82.4% submission rate. ABH has a lower submission rate of 72.0% of encounters submitted within 30 days. For dental, DQ has a 94.5% submission rate and MCNA has 93.8%

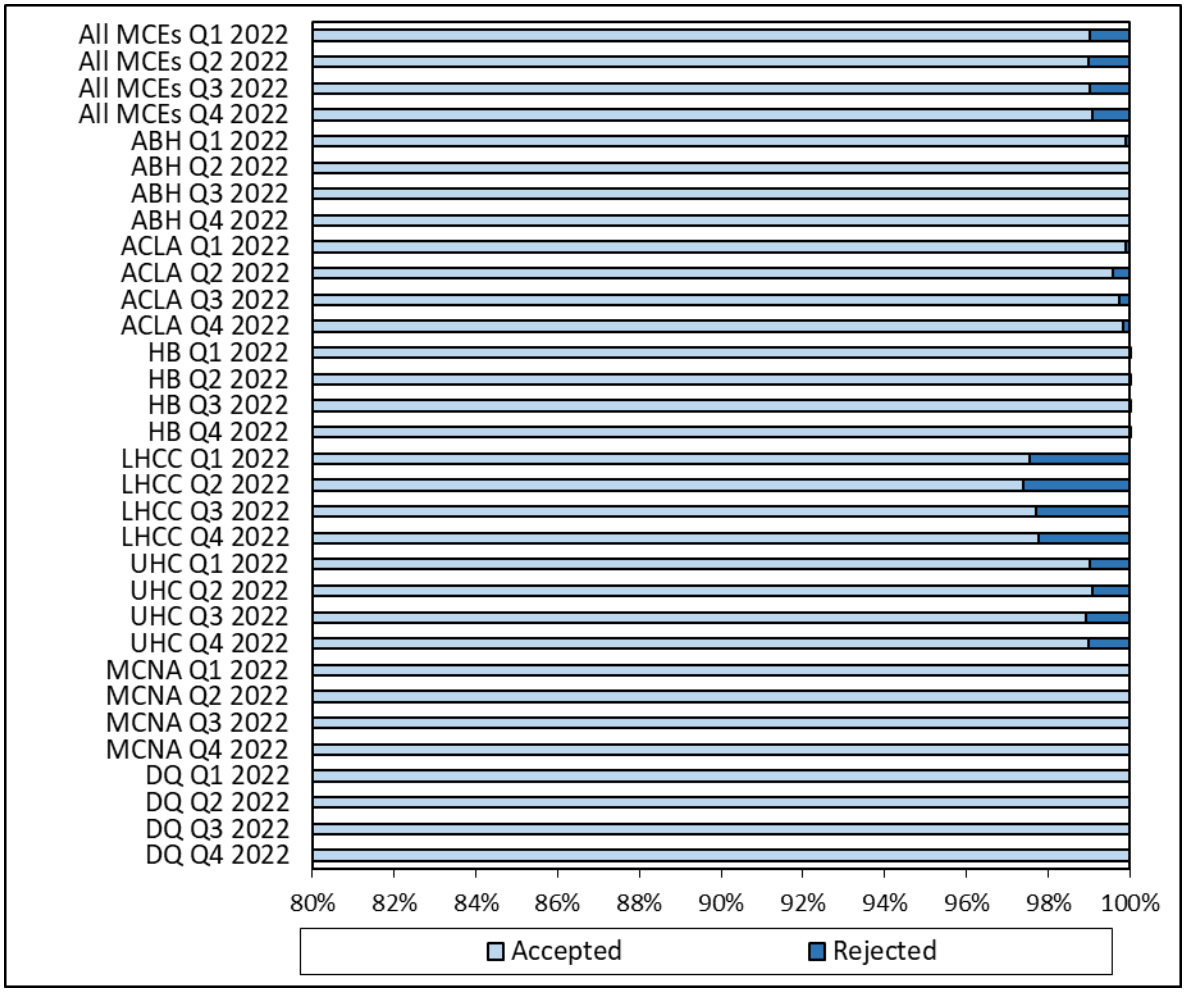
Section III: Findings Related to MCE Claims Adjudication

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

Claims Accepted and Rejected by the MCEs

In the most recent four quarters for which data is available, the MCEs claims rejection rate ranged from 0.9% to 1.0%. The rejection rate overall is specifically due to higher rejection rates for LHCC (2.2% to 2.6%) with the other MCEs having rejection rates closer to zero.

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



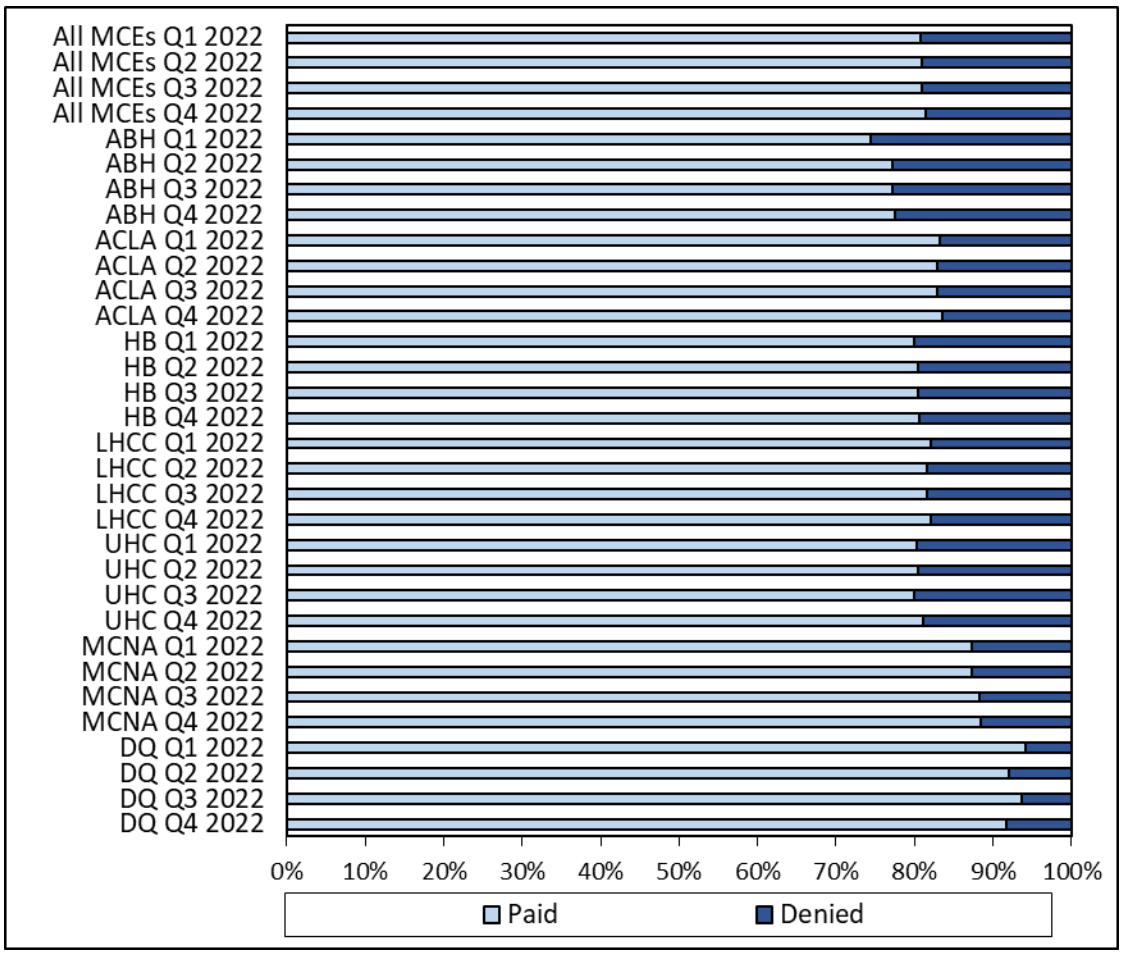
Claims Paid and Denied by the MCEs

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

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

At the MCE-specific level, the range across the four-quarter averages was from an average denial rate of 7.1% for DQ to an average rate of 23.4% 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

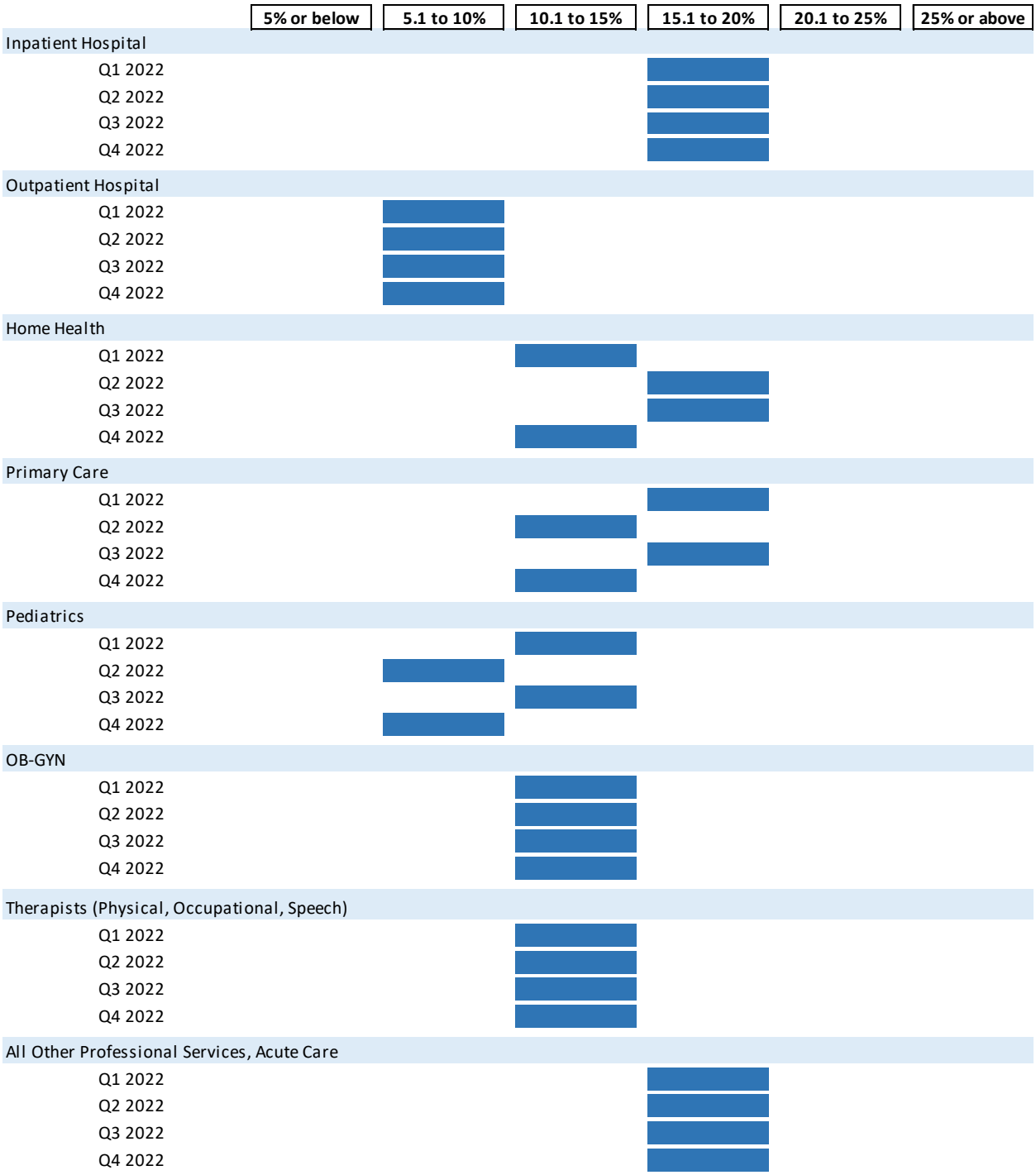


Exhibit III.4
Claim Denial Rates for Non-Acute Care Services
For All MCEs Combined, By Quarter

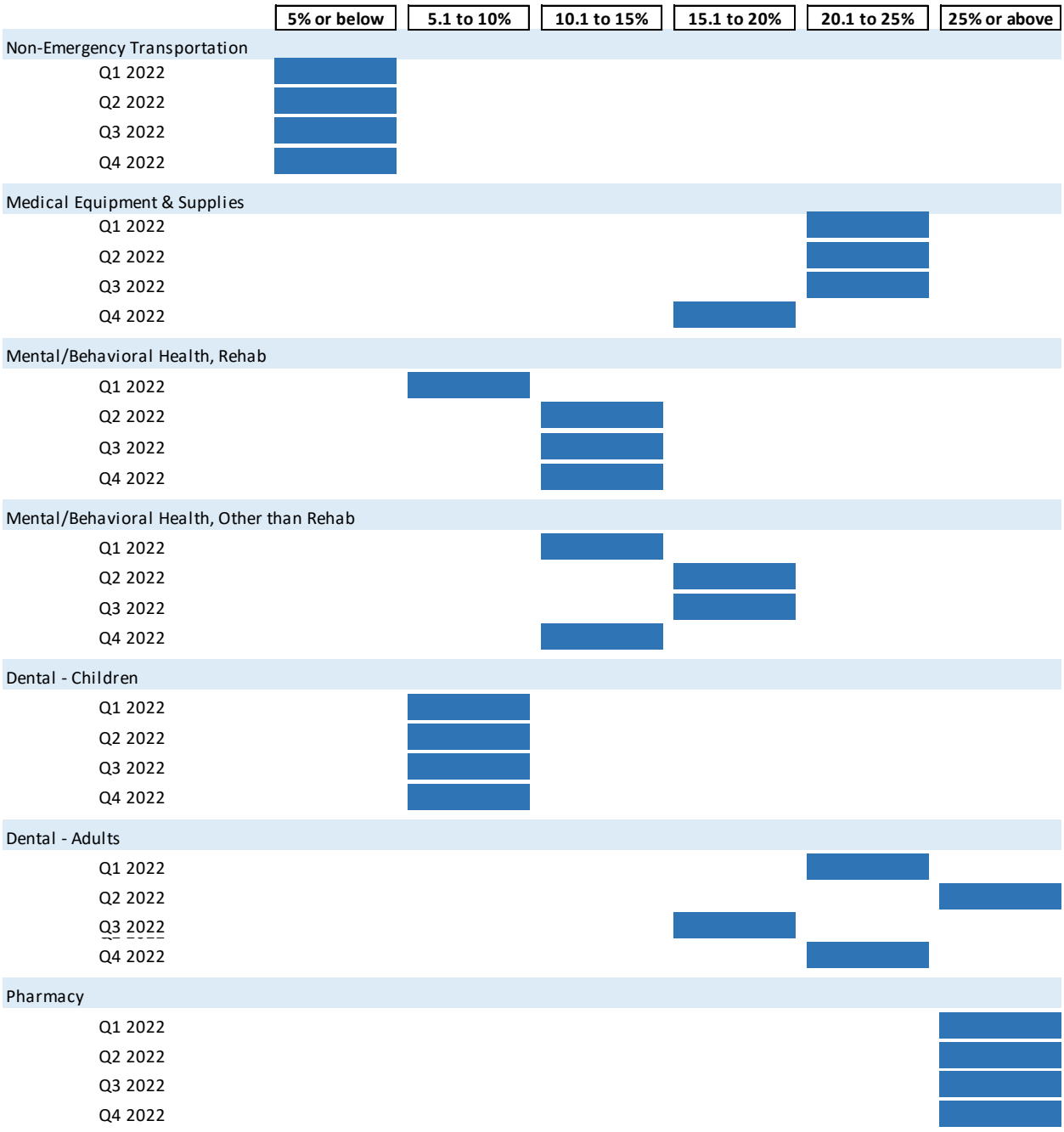
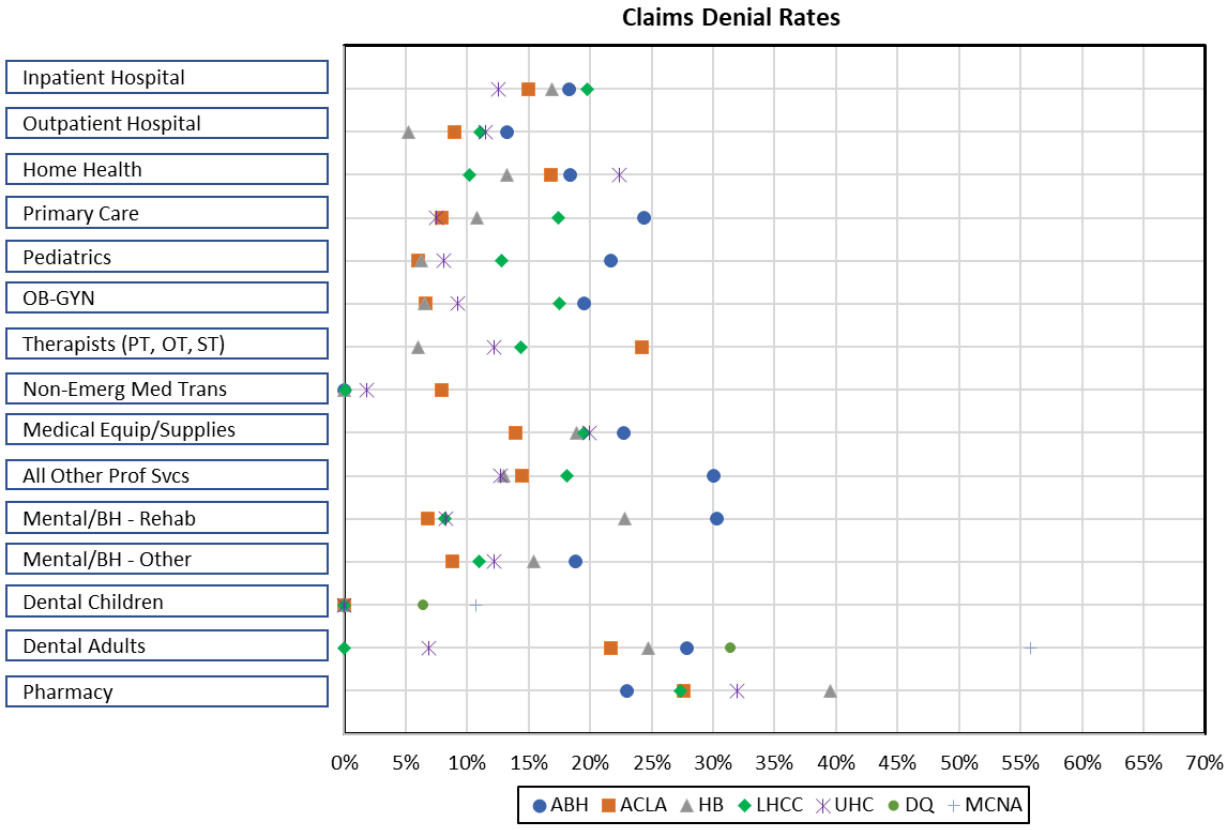


Exhibit III.5 compares the denial rates for these service categories by MCE. The data plotted on this exhibit is the percentage of claims denied in Q4 of CY 2022 for each MCE. An icon and color are used to display each MCE's data. Each row in the exhibit represents a specific service category. For example, in the top line of the exhibit, the overall denial rate for inpatient hospital services in Q4 2022 was 16.5%, but this varied from 12.6% for UHC to 19.8% for LHCC.

The claims denial rate is clustered for home health, primary care, non-emergency medical transportation, dental children and mental/BH – rehab. In other categories, most MCEs have a similar rate, but ABH (e.g., therapies and other professional services) vary from all of their peers. It is noteworthy that ABH reported the highest denial rates in eight out of fifteen categories and relatively high denial rates in the other categories except for Pharmacy claims. ABH reported that their largest denial reasons across 2022 were for billing errors and lack of prior authorization for out of network services. In addition, ABH implemented stringent edits on behavioral health provider credentials as a result of a legislative audit. In many cases these denials reported across all categories are corrected either through provider data updates/documentation or corrected claims and ultimately result in payment through a resubmission.

Exhibit III.5
Claim Denial Rates for Adjudicated Claims
By Provider Specialty / Service Category
By MCE for Q4 2022



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

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

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

Because there is such a variety of denial reasons that are based on the circumstances of each claim, it is not appropriate to unilaterally assume that every denied claim could have been paid or should have been paid. With this in mind for the initial report, LDH contracted with Burns & Associates, Inc. to develop a model to tabulate the information on denied claims from each MCE and assign a value to each denied claim without inferring if the claim could have been paid or should have been paid. Medicaid Business Analytics, the Medicaid section responsible for compilation of the data used in the ACT 710 Healthy Louisiana Claims report, continues to use this model for the quarterly updates.

To do this, Medicaid examined each of the provider specialties separately. Within each category, the MCE reported the number of claims paid and the total payments made. After computing an average payment per claim, the MCEs reported the number of denied claims in the provider specialty. The average payment per claim in the provider specialty is multiplied by the number of denied claims to impute a value for the denied claims.

It is important to apply this formula at the provider specialty level (as opposed to all claims combined) due to the wide range of reimbursements paid to each provider type. For example, in Q4 2022, the average payment for paid inpatient hospital claims was $6,103; for primary care, it was $38.

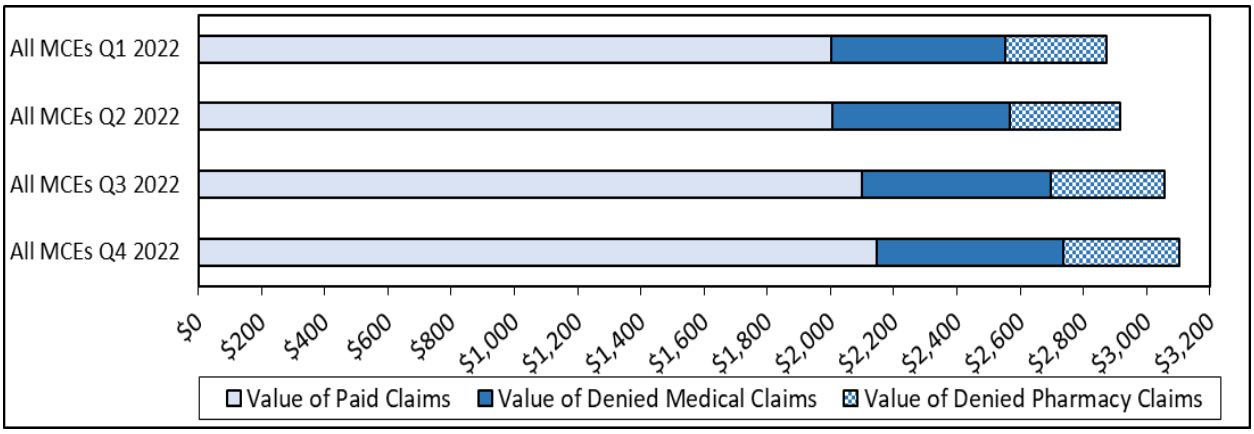
Not only was an average payment per claim computed for each provider specialty separately, but one was also computed for each MCE within the provider type as well as a separate value for each calendar quarter.

Exhibit III.6 summarizes the total dollar values of paid claims and denied claims by MCE and by quarter. The denied claims account for between 21.5% and 22.1% of the sum of paid and denied values each quarter. This equates to between $551 million and $596 million. Among the $590 million in denied values in Q4 2022 assigned across the five MCEs that provide medical and pharmacy benefits, $220 million (37.6%) was attributed to medical claims and $365 million (62.4%) was attributed to pharmacy claims.

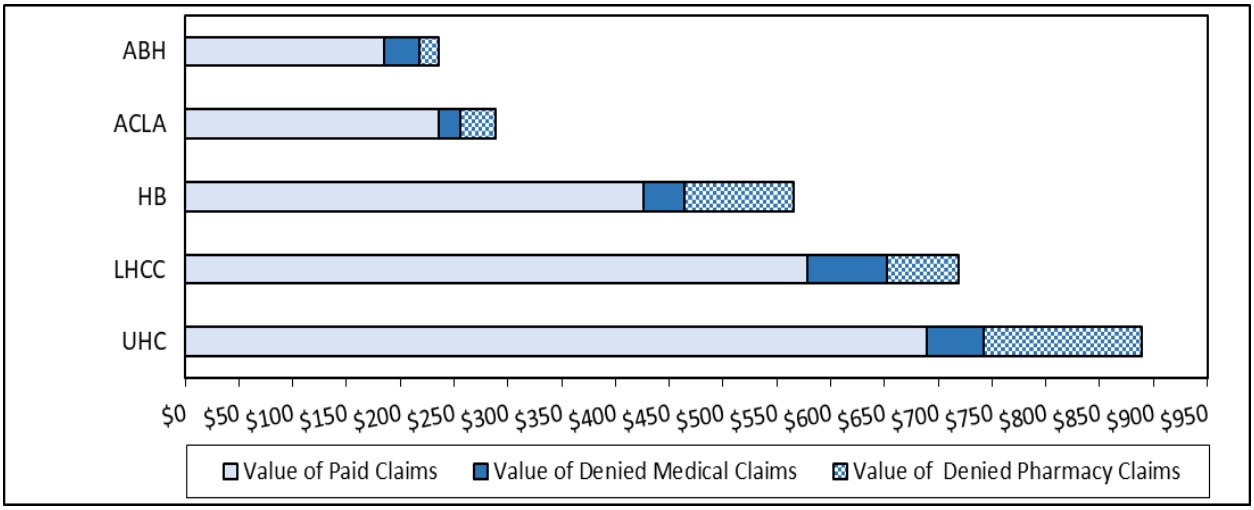
In Q4 2022, the distribution of assigned values to denied claims by MCE was as follows:

- ABH had 65.3% medical and 34.7% pharmacy claims
- ACLA had 39.5% medical and 60.5% pharmacy claims
- HB had 27.7% medical and 72.3% pharmacy claims
- LHCC had 52.4% medical and 47.6% pharmacy claims
- UHC had 26.5% medical and 73.5% pharmacy claims
- MCNA and DQ had a total value of $33.9 million (88.3%) paid claims and $4.5 million (11.7%) value of denied medical claims.

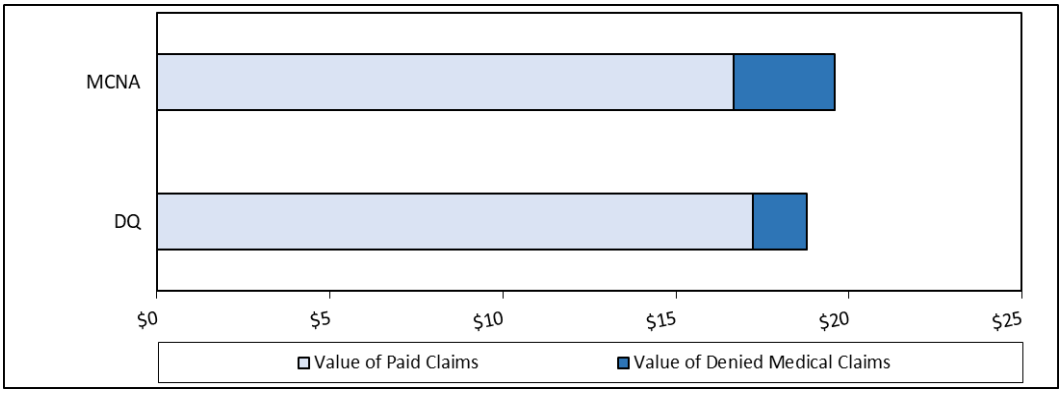
Exhibit III.6
Value of Paid and Denied Claims
The dollar values in the stacked bar represent millions



Value of Paid and Denied Claims by MCE – Q4 2022



Value of Paid and Denied Dental Claims – Q4 2022



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

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

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

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

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

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

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

	Group A	Group B	Group C	Groups A, B, C
	Number of combinations where > 50% of providers had a denial rate above 10%	Number of combinations where < 50% of providers had a denial rate above 10%	Number of combinations where the sample of providers was too small to study	Total Groupings
Q1 2022	105	83	34	222
Q2 2022	96	87	39	222
Q3 2022	100	86	36	222
Q4 2022	98	89	35	222

Timeliness of Claims Adjudication by the MCEs

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

Exhibit III.8 below shows that the MCEs are meeting the target for adjudication within 30 days as set by LDH. In fact, the average TAT is below 9 days in every quarter for all MCEs with the minor exception of MCNA with an average of 9.7 days for paid and denied claims over the past four quarters. The TAT averages do vary, however, across the MCEs.

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

		Adjudicated Within 30 days		Avg Turnaround Time	
		Pct of Paid	Pct of Denied	Paid Claims	Denied Claims
ABH	Q1 2022	99.5%	98.8%	8.1	6.9
	Q2 2022	99.9%	99.8%	7.5	5.5
	Q3 2022	99.9%	99.9%	4.7	5.2
	Q4 2022	99.6%	99.6%	5.0	5.1
ACLA	Q1 2022	98.7%	98.8%	6.8	7.4
	Q2 2022	100.0%	100.0%	5.1	6.0
	Q3 2022	99.9%	99.8%	4.6	5.7
	Q4 2022	99.9%	99.7%	6.8	7.5
HB	Q1 2022	99.4%	99.7%	8.3	3.5
	Q2 2022	99.9%	99.9%	7.4	2.8
	Q3 2022	99.8%	99.8%	8.0	3.4
	Q4 2022	98.1%	97.6%	8.6	4.1
LHCC	Q1 2022	99.9%	99.9%	8.3	9.1
	Q2 2022	99.9%	99.8%	8.2	9.0
	Q3 2022	99.1%	99.5%	8.9	9.1
	Q4 2022	99.1%	99.5%	8.9	9.1
UHC	Q1 2022	99.9%	99.7%	7.9	2.9
	Q2 2022	99.9%	100.0%	7.6	2.5
	Q3 2022	99.2%	99.7%	7.8	2.8
	Q4 2022	99.6%	100.0%	7.9	3.0
MCNA	Q1 2022	100.0%	100.0%	8.9	10.6
	Q2 2022	100.0%	100.0%	9.7	11.8
	Q3 2022	100.0%	100.0%	8.3	10.0
	Q4 2022	100.0%	100.0%	8.5	10.1
DQ	Q1 2022	100.0%	100.0%	3.9	5.0
	Q2 2022	100.0%	100.0%	4.2	4.3
	Q3 2022	100.0%	100.0%	1.0	1.0
	Q4 2022	100.0%	100.0%	0.9	0.8
ALL MCEs	Q1 2022	99.6%	99.6%	7.9	5.6
	Q2 2022	99.9%	99.9%	7.4	5.1
	Q3 2022	99.4%	99.7%	7.4	5.2
	Q4 2022	99.4%	99.3%	7.7	5.5

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

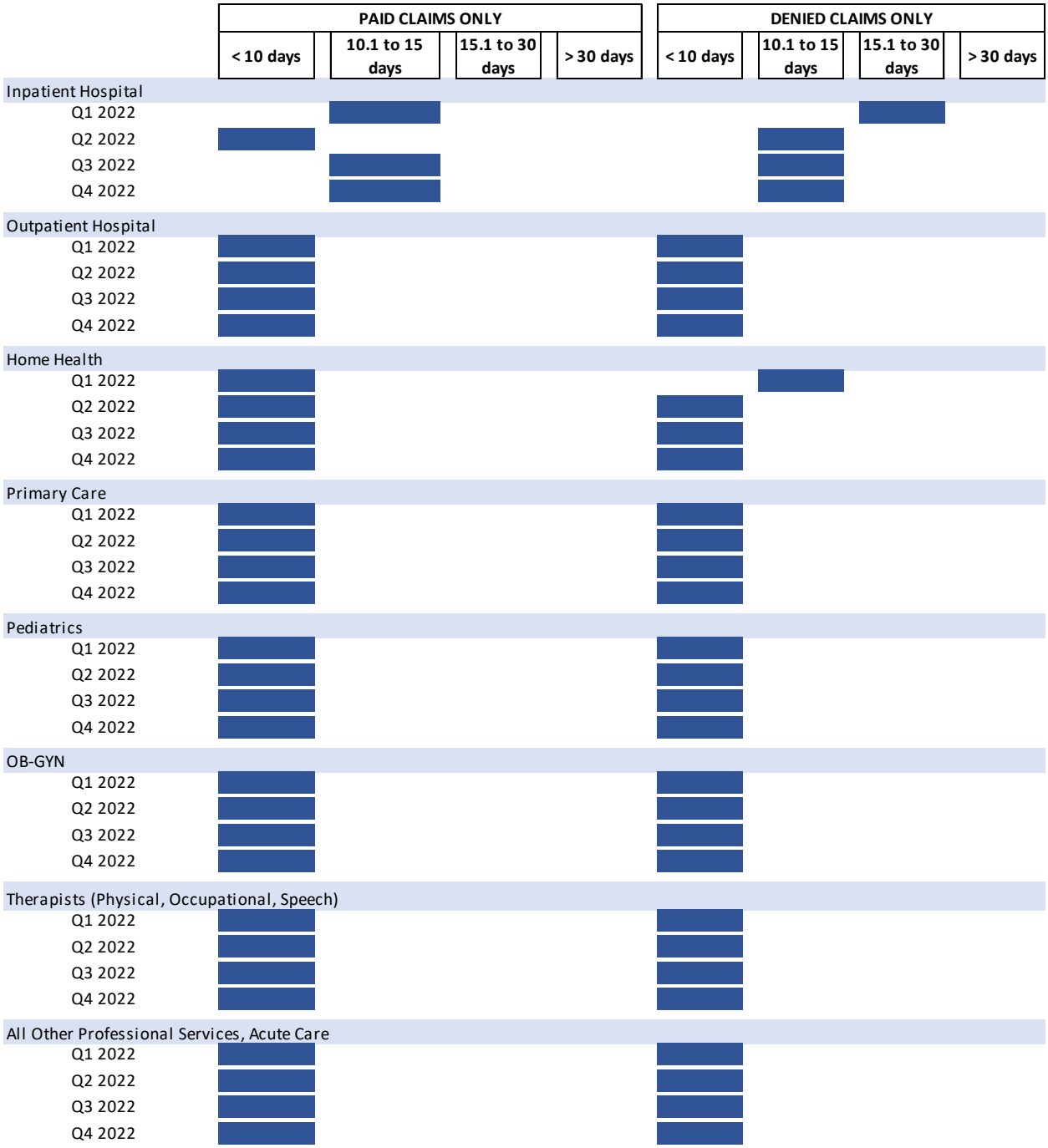


Exhibit III.10
Turnaround Time for Claims Processing of Adjudicated Non-Acute Care Claims (using average days)
For All MCEs Combined, By Quarter

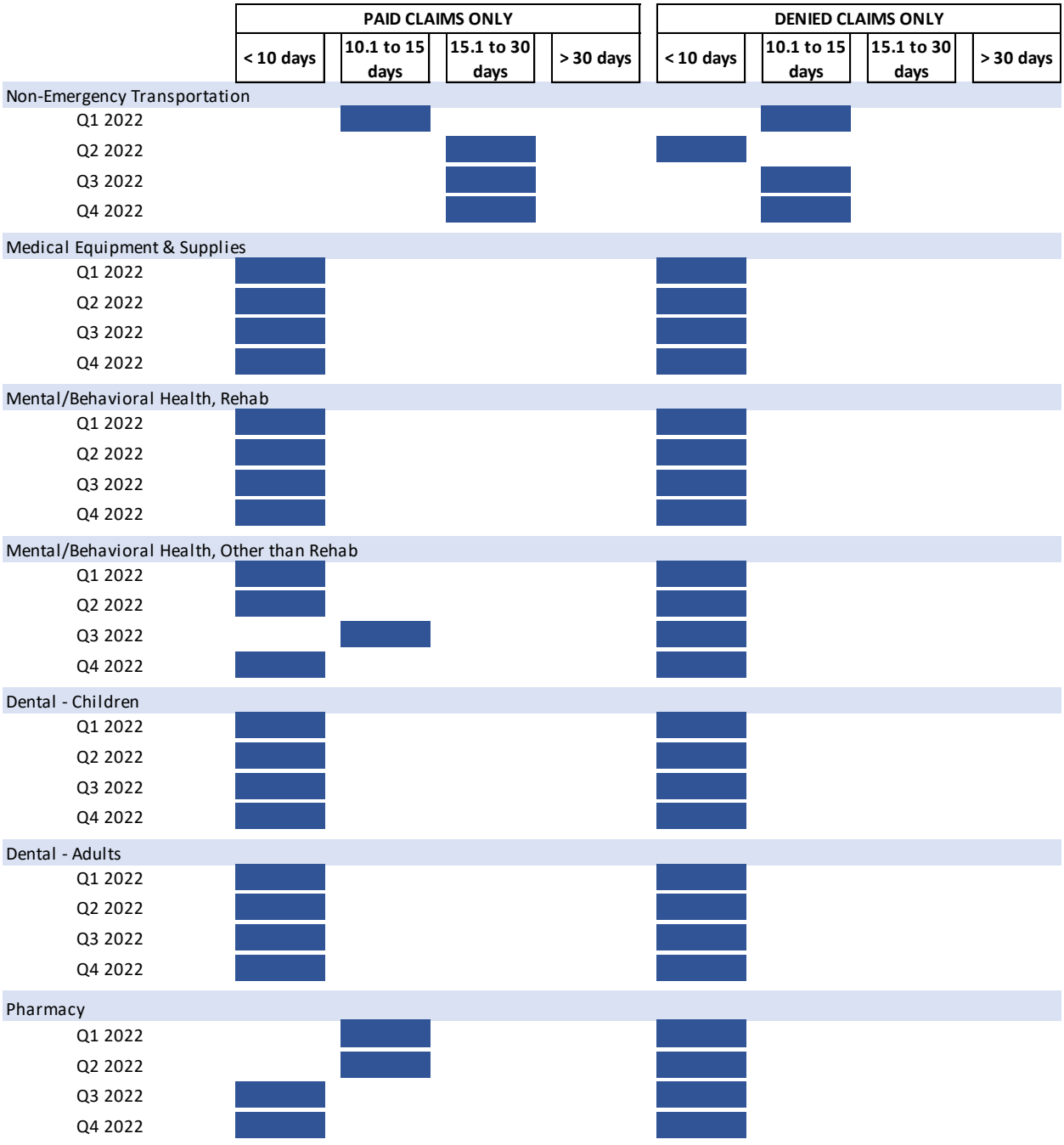
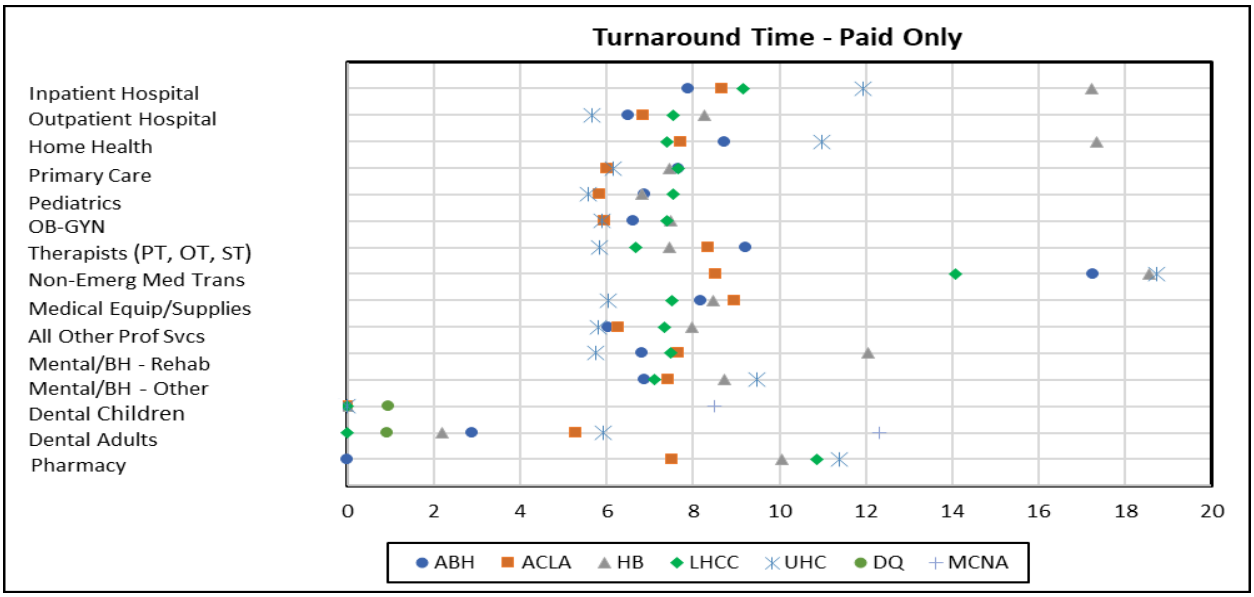
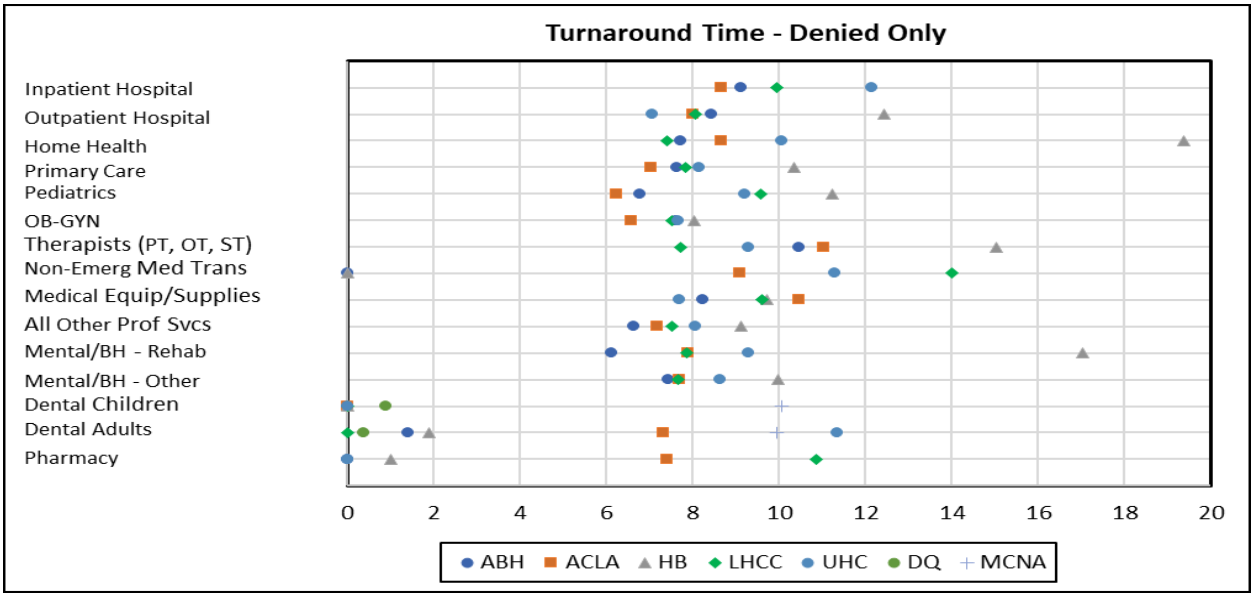


Exhibit III.11 below further breaks down the average paid and denied TAT statistics in Q4 2022, with the results shown for each MCE within a service category. The top box shows the variation in TAT for paid claims only; the bottom box shows the results for denied claims only. This exhibit determines if the TAT is consistent across MCEs or if it varies.

The top box shows that there is some variation in the average TAT for paid claims. For Non-Emergency Medical Transportation, there are four situations where the average TAT exceeded 12 days (ABH, HB, LHCC, and UHC. HB has reported considerable increase in TATs, including three other services (Mental/BH-Rehab, Home Health and Inpatient Hospital) with TAT exceeded 12 days in Q4 2023. HB reported the main reasons for delay in claims processing were 1) authorization confirmation, verification, and validation; 2) manual review for potential duplicate claim submission; and 3) claims received that required extra time for extensive research, e.g. claims requiring coordination of benefits. In the bottom box, the similar variation was seen for denied claims, and average TAT for denied claims is only slightly more than for paid claims.

Exhibit III.11
Average Turnaround Time, Paid and Denied Claims, by Service Category
By MCE for Q4 2022 Adjudicated Claims





Reasons for Claim Denials by the MCEs

As stated in Section I, when a claim is adjudicated, the claims processor will assign codes to indicate the reason(s) why the claim adjudicated the way it did. For medical and dental claims, there is a set of nationally recognized Claim Adjustment Reason Codes (CARCs), around 290 reason codes in all. For pharmacy claims specifically, there are nearly 350 reason codes developed by the NCPDP.

The MCEs report to LDH the occurrence of each CARC or NCPDP code on adjudicated claims. For denied claims, an MCE tabulates the count of each CARC or NCPDP code for claims adjudicated in Q4 of CY 2022.

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

- In Q4 2022, ACLA, LHCC, and UHC had their top five CARCs within the top 10 CARCs statewide. ABH had four, MCNA had two, while HB had one only of their top five CARCs in the statewide top 10.
- The top five CARCs in Q4 2022 included the following:
    - 16: The claim lacks information or has a billing error, which is needed for adjudication.
    - 96: Non-covered charge.
    - 18: Exact duplicate claim.
    - 252: An attachment/other documentation is required to adjudicate this claim/service.
    - 97: The benefit for this service is included in the payment for another service already adjudicated.

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

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

- In Q4 2022, each MCE had their top five NCPDP codes within the top 10 NCPDP codes statewide, except that ABH only had four of their top five within the statewide top 10.
- The top five NCPDPs in Q4 2022 included the following:
    - 79: Refill too soon
    - 88: Drug Utilization Review (DUR) reject error
    - 76: Plan limitations exceeded
    - 7Ø: Product/Service Not Covered – Plan/Benefit Exclusion
    - 75: Prior Authorization Required
- These five NCPDPs were also among the top six in the previous quarters reported.

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

For Medical Claims

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

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	5
88	DUR Reject Error	2		2	2	5	1
76	Plan Limitations Exceeded	3	5			4	3
7Ø	Product/Service Not Covered – Plan/Benefit Exclusion	4		3		3	2
75	Prior Authorization Required	5	2		5	2	
39	Missing/Invalid Diagnosis Code	6		4	4		4
41	Submit Bill To Other Processor Or Primary Payer	7					
7X	Days Supply Exceeds Plan Limitation	8			3		
MR	Product Not On Formulary	9	3	5			
AC	Product Not Covered Non-Participating Manufacturer	10					

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

Exhibit III.13 shows the results when the top CARCs are distributed by provider type for each MCE for claims adjudicated in the Quarter 4 of 2022. Key findings from the exhibit are shown below:

- For ABH, three of its five CARCs overall were observed for almost every provider category. Two CARCs (#96 and #147) was only present for selected provider types.

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

- For HB, two (#256 and #197) of its top five CARCs overall were observed for almost every provider category within the statewide top five CARCs. Three CARCs #109, #242, and #273) were present for selected provider types.

- For LHCC, three of its five CARCs overall were observed for almost every provider category as well. Two CARCs (#226, and #22) were only present for selected provider types.

- For UHC, two (#252 and #18) of its five CARCs overall were observed for almost every provider category as well. Three CARC (#96, #197 and #97) was only present for selected provider types.

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

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

Exhibit III.13
Details on Reasons for Denied Medical Claims
By MCE and By Provider Category for Q4 2022 Adjudicated Claims

For Medical Claims

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

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	5
88	DUR Reject Error	2		2	2	5	1
76	Plan Limitations Exceeded	3	5			4	3
7Ø	Product/Service Not Covered – Plan/Benefit Exclusion	4		3		3	2
75	Prior Authorization Required	5	2		5	2	
39	Missing/Invalid Diagnosis Code	6		4	4		4
41	Submit Bill To Other Processor Or Primary Payer	7					
7X	Days Supply Exceeds Plan Limitation	8			3		
MR	Product Not On Formulary	9	3	5			
AC	Product Not Covered Non-Participating Manufacturer	10					

Exhibit III.13 (continued)
Details on Reasons for Denied Medical Claims
By MCE and By Provider Category for Q4 2022 Adjudicated Claims

CARC	Description	Inpatient Hospital	Outpatient Hospital	Home Health	Other Institutional	Primary Care	Pediatrics	OB-GYN	Therapists	Non-Emerg Transport	Medical Equipment	Other Professional	Mental/Behavioral - Rehab	Mental/Behavioral - Other	Adult Dental	Pediatric Dental
LHCC																
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	4	3	1	1	2	1	1	4	2	1	1	1	1		
96	Non-covered charge(s).		1	2	2	1	2	2	3	2	2	3		5		
18	Exact duplicate claim/service	3	5			4	5	5		2	4	4	5	4		
226	Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. At least one Remark Code must be provided.			4		5			2	2		2	2	3		
22	This care may be covered by another payer per coordination of benefits.	5	2		3					2	5					
UHC																
252	An attachment/other documentation is required to adjudicate this claim/service.	4	1	1		1	4	1		3	2	1		4		
96	Non-covered charge(s).		2	5		2	2		1	3	1	2				
18	Exact duplicate claim/service	5	3	3		3	3		3	3	4	3	3	3		
197	Precertification/authorization/notification absent.	3		2					2	3	5	4	2	1		
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.		5				1	2		3		5				
MCNA																
169	Alternate benefit has been provided.														1	
96	Non-covered charge(s).														3	1
18	Exact duplicate claim/service														2	
119	Benefit maximum for this time period or occurrence has been reached.														4	
27	Expenses incurred after coverage terminated.														5	
DQ																
A1	Claim/Service denied.														1	1

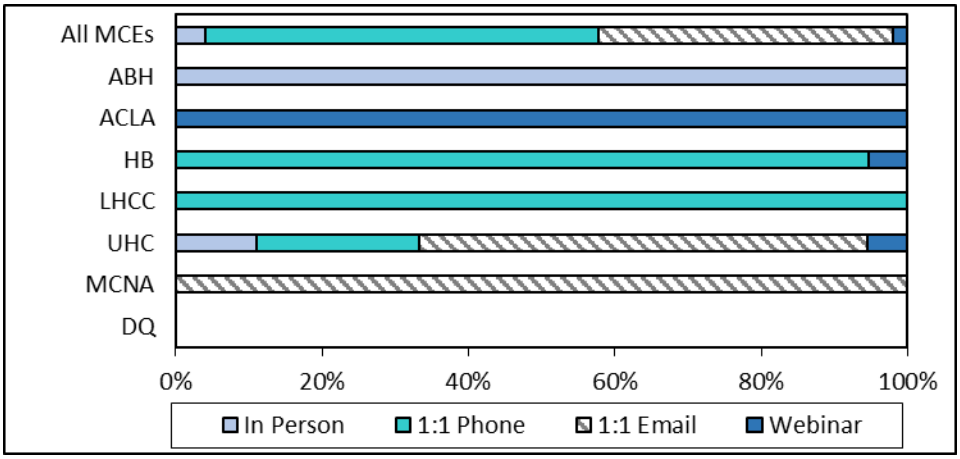
Provider Education Related to Claims Adjudication

Because many of the denial reason codes have been consistent for some time, LDH initiated specific reporting for MCE provider education with the release of the new reporting requirements 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 Q4 2022. In all, 736 distinct TINs were outreached to by the MCEs. This count represents the unique TINs and modes of communication. In some cases, the MCE reported that they conducted multiple outreach efforts to the same TIN in the quarter (e.g., three emails over the course of six weeks). It should also be noted, however, that multiple MCEs may reach out to the same TIN. Over half of the outreach (53.7% of total) was conducted via 1:1 phone calls. This was followed by 1:1 emails (40.2% of total) and webinars (2% of total). In-person outreach increased significantly since the last report quarter as the COVID-19 pandemic ended, accounting for 4.1%.

Exhibit III.14
Provider Education Conducted by the MCEs on Claims Submissions Activity in Q4 2022



	Modality of Outreach				
	In Person	**1:1 Phone**	**1:1 Email**	**Webinar**	**Total TINs**
All MCEs	36	474	355	18	883
ABH	32	0	0	0	32
ACLA	0	0	0	11	11
HB	0	88	0	5	93
LHCC	0	378	0	0	378
UHC	4	8	22	2	36
MCNA	0	0	333	0	333
DQ	0	0	0	0	0

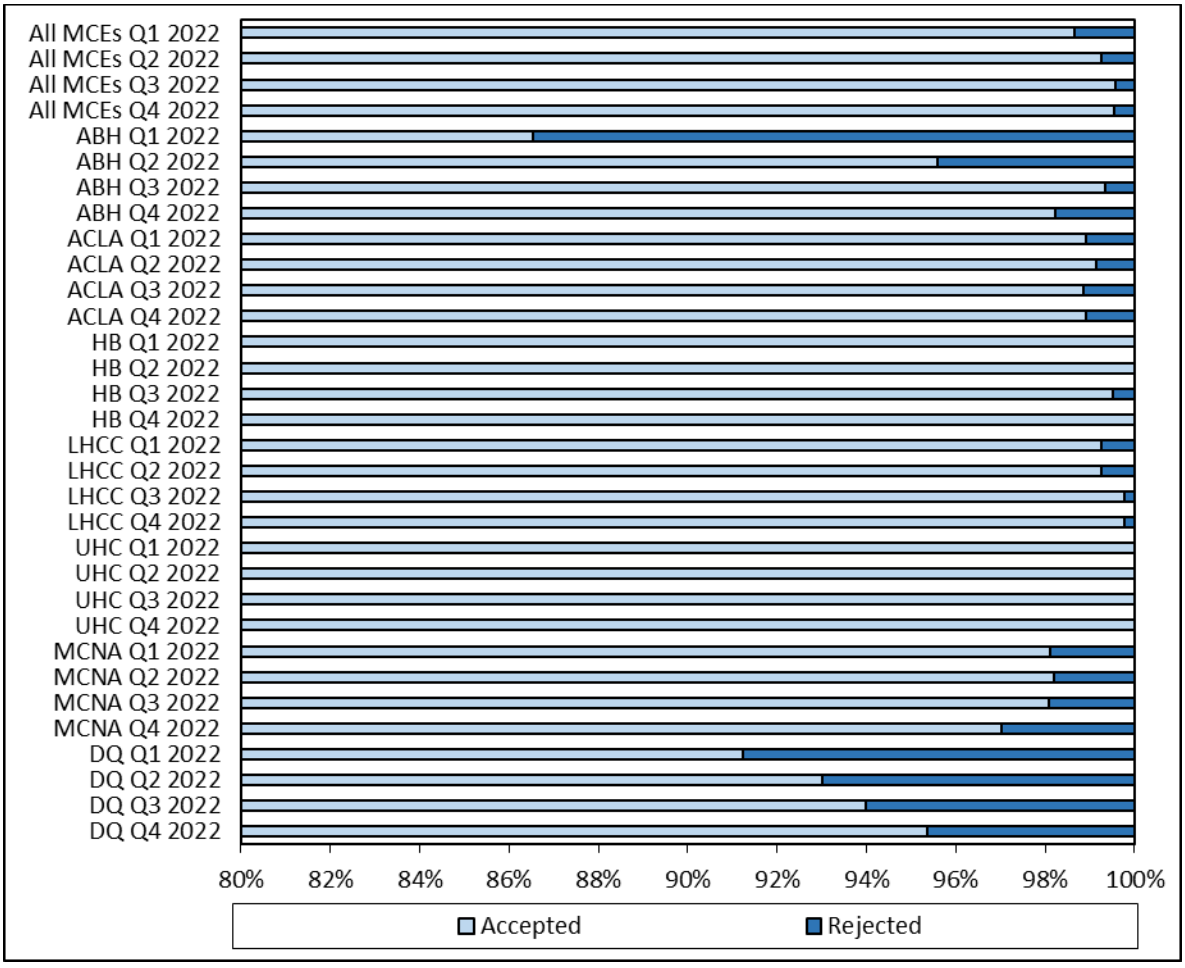
Section IV: Findings Related to MCE Encounter Submissions to LDH

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

MCE Encounters Accepted and Rejected by LDH

In the most recent four quarters studied, LDH accepted 98.6% to 99.6% of the encounters submitted by all of the MCEs. There were differences at the MCE level. LDH accepted all of UHC's encounters. LDH also accepted 99.9% of HB's encounters over the past four quarters. For LHCC, LDH accepted 99.5% of their encounters. ACLA averaged 99% of accepted encounters over the past four quarters. ABH had some challenges with an overall acceptance rate of 94.9%. DQ, as a new joined member since Q1 2021, has averaged 93.4%, showing steady improvement during the last four quarters. MCNA had a four quarter average of 97.9%.

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



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

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

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

- ABH showed improvement with institutional and pharmacy encounters accepted for Quarter 4 of 2022.
- ACLA had a few issues with institutional and professional encounters accepted in Quarter 4 of 2022.
- HB had only a few issues with pharmacy encounters accepted in Quarter 4 of 2022. HB also had a 100% acceptance rate over the past three quarters for institutional and professional encounters.
- LHCC improved their pharmacy encounter acceptance rate in Quarter 4 of 2022 (99.2%), and continue to have a 100% acceptance rate for institutional and professional encounters.
- UHC had a 100% encounter acceptance rate for each encounter type for the past four quarters.
- DQ improved to 93.5% of encounters accepted for Quarter 4 of 2022.
- MCNA had an encounter acceptance rate of 97.0% for Quarter 4 of 2022.

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

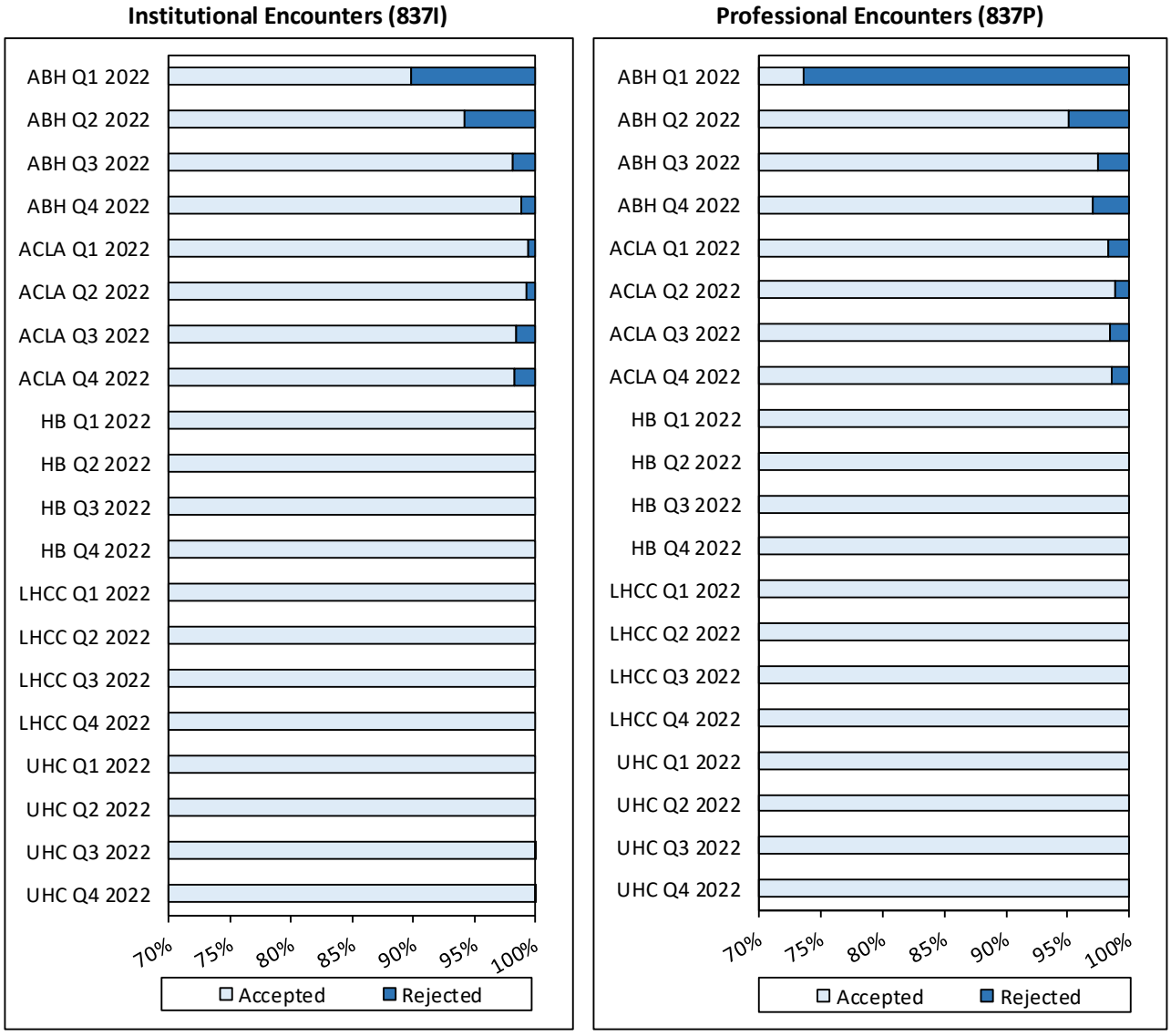
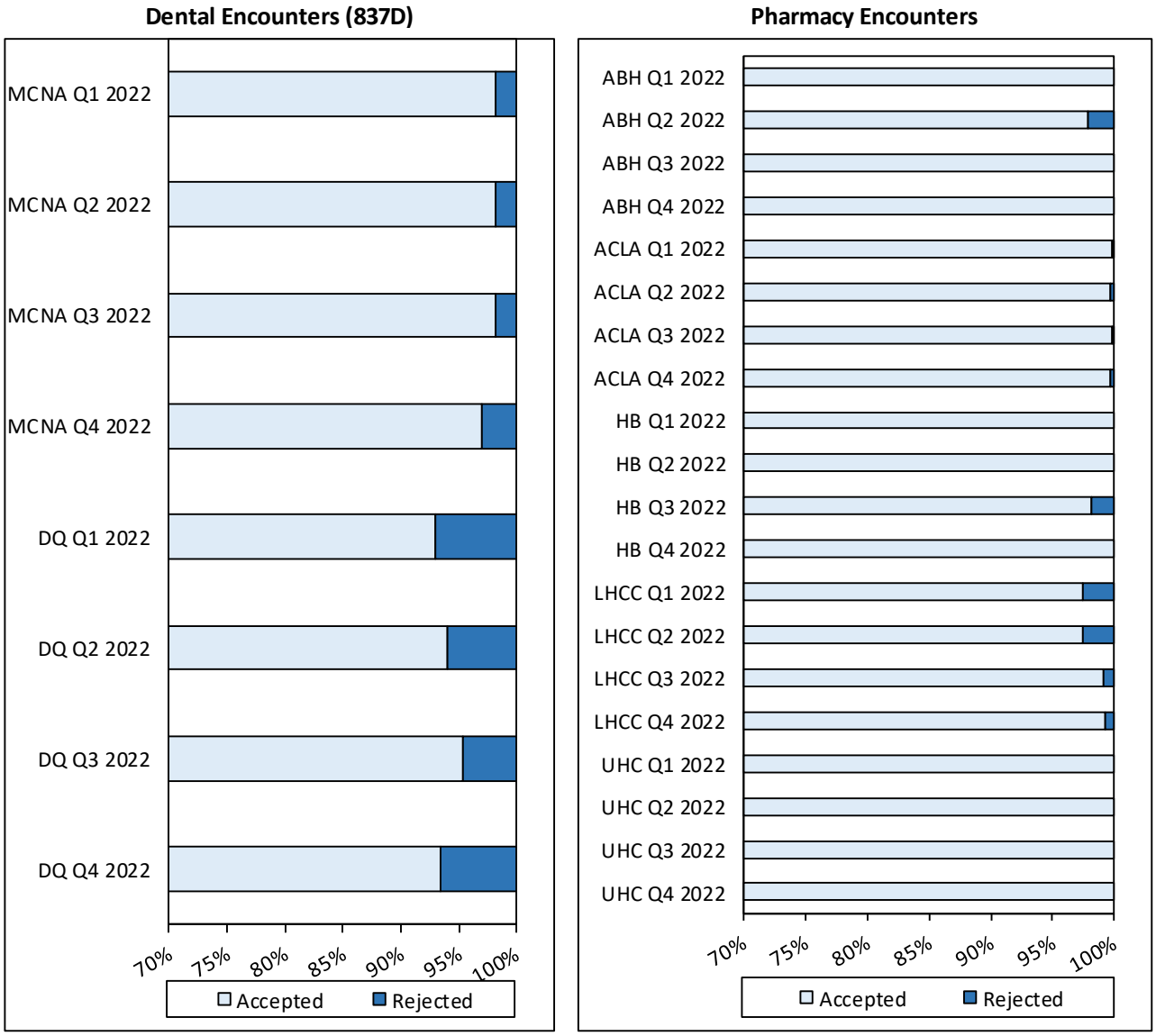


Exhibit IV.3
Encounter Submissions Accepted and Rejected by LDH
Dental and Pharmacy Claim Types
By MCE and Quarter



Timeliness of Encounter Submissions Accepted by LDH

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

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

Key findings from both exhibits appear below:

- For institutional encounters (mostly claims from hospitals), ABH had issues with timely submissions in all four quarters (78.6%). ACLA still had some issues in Q4 of 2022 but showed improvement. HB had issues for the past four quarter, especially for institutional and professional encounters. LHCC had a few issues in Q4 of 2022. UHC was the most consistent with a 98.9% four quarter average.

- LHCC and UHC consistently has the highest rate of submission of professional encounters within 30 days followed by ACLA. HB and ABH had challenges with both institutional professional encounter submission timeliness in but improved since last report quarter.

- There is greater variation in the timeliness of pharmacy encounter submissions. HB had the highest rate of encounter submissions accepted at 99.8% over the past four quarters. ACLA had the second highest rate of encounter submissions accepted at 99.6% followed by UHC (99%) over the past four quarters. ABH and LHCC consistently are lowest on pharmacy encounter timeliness—ABH usually near 30.9% untimely and LHCC usually near 28.9% untimely in the last four quarters.

- MCNA had an average 30-day TAT for its dental encounters of 95.5%, showed a significant decrease in Q4 of 2022, while DQ continues to have a 100% submission rate over the past four quarters.

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

	Institutional Encounters (837I)		Professional Encounters (837D)		Dental Encounters (837D)		Pharmacy Encounters	
	Within 30 Days	After 30 Days	Within 30 Days	After 30 Days	Within 30 Days	After 30 Days	Within 30 Days	After 30 Days
ABH Q1 2022	77.7%	22.3%	90.8%	9.2%			68.6%	31.4%
ABH Q2 2022	84.6%	15.4%	67.3%	32.7%			68.9%	31.1%
ABH Q3 2022	77.8%	22.2%	90.3%	9.7%			69.4%	30.6%
ABH Q4 2022	86.2%	13.8%	93.4%	6.6%			69.5%	30.5%
ACLA Q1 2022	96.8%	3.2%	97.8%	2.2%			99.5%	0.5%
ACLA Q2 2022	97.6%	2.4%	97.7%	2.3%			99.6%	0.4%
ACLA Q3 2022	88.8%	11.2%	96.1%	3.9%			99.7%	0.3%
ACLA Q4 2022	93.8%	6.2%	97.0%	3.0%			99.6%	0.4%
HB Q1 2022	78.3%	21.7%	78.0%	22.0%			99.8%	0.2%
HB Q2 2022	62.1%	37.9%	83.4%	16.6%			99.6%	0.4%
HB Q3 2022	91.3%	8.7%	89.5%	10.5%			99.7%	0.3%
HB Q4 2022	93.8%	6.2%	83.7%	16.3%			99.9%	0.1%
LHCC Q1 2022	99.1%	0.9%	98.6%	1.4%			71.2%	28.8%
LHCC Q2 2022	99.3%	0.7%	99.4%	0.6%			69.9%	30.1%
LHCC Q3 2022	99.5%	0.5%	97.9%	2.1%			70.8%	29.2%
LHCC Q4 2022	99.9%	0.1%	98.8%	1.2%			72.5%	27.5%
UHC Q1 2022	99.9%	0.1%	98.4%	1.6%			96.7%	3.3%
UHC Q2 2022	99.9%	0.1%	95.4%	4.6%			99.8%	0.2%
UHC Q3 2022	99.6%	0.4%	99.4%	0.6%			99.7%	0.3%
UHC Q4 2022	99.3%	0.7%	99.4%	0.6%			99.7%	0.3%
MCNA Q1 2022					99.7%	0.3%		
MCNA Q2 2022					99.6%	0.4%		
MCNA Q3 2022					99.5%	0.5%		
MCNA Q4 2022					83.0%	17.0%		
DQ Q1 2022					100.0%	0.0%		
DQ Q2 2022					100.0%	0.0%		
DQ Q3 2022					100.0%	0.0%		
DQ Q4 2022					100.0%	0.0%		

Section V: Case Management

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

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

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

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

Across all five MCEs, 49,595 unduplicated individuals were identified as eligible or in need of case management services in SFY 2022-Q4. Of these, 22.3% (11,035) were enrolled in case management for at least one month during the quarter. 67.9% (7,492) of those enrolled in CM where engaged in one or more CM services or contact with a case manager during the quarter.

Exhibit V.1
CY 2022 - Quarter 4: Case Management

	ABH	ACLA	HB	LHCC	UHC	**Total[1]**
Eligible for Case Management (CM)	2,562	6,089	7,075	20,807	13,891	49,595
Enrolled in CM at least 1 month	1,914	2,843	1,036	4,027	2,935	11,035
% of eligibles enrolled in CM	74.7%	46.7%	14.6%	19.4%	21.1%	22.3%
Received CM Service	637	2,059	696	2,532	2,098	7,492
% enrolled receiving service	33.3%	72.4%	67.2%	62.9%	71.5%	67.9%

Source: MCE Monthly Reports 039 Case Management & 402 DOJ-AR 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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