Healthy Louisiana Claims Report

Response to Act 710 of the 2018 Regular Legislative Session

Calendar Year 2019 Quarter 1

Prepared by:

Louisiana Department of Health

Bureau of Health Services Financing

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LOUISIANA DEPARTMENT OF HEALTH

Contents

Attachment: Burns & Associates, *Independent Study of Provider Claims Submitted to Medicaid Managed Care Organizations in the Healthy Louisiana Program*

Executive Summary

Background

On June 1, 2018, the Louisiana State Legislature passed Act No. 710 which requires reporting of data on healthcare provider claims submitted to Medicaid managed care organizations (MCOs). The legislation required the Louisiana Department of Health (LDH or "the Department") 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 was submitted to the Legislature on October 31, 2018. The information in that report covered trends on MCO claim payments and denials, on measures enumerated in law, during calendar year (CY) 2017. Subsequent reports are required to be submitted on a quarterly basis to the legislature. This report represents the third in the quarterly report series.

The report that accompanies this Executive Summary contains data from CY 2019 quarter 1, as well as data from CY 2018 quarters 2-4 for comparison purposes. In some exhibits, data is shown for the most recent four quarters. Stakeholders agreed that, although the Act only required a quarterly update on the most recent quarter, the ability to view a rolling four-quarter trend will allow for more meaningful analysis.

LDH engaged Burns & Associates (B&A), a healthcare consulting firm whose clients are Medicaid agencies, to assist in the ongoing data collection, analysis and trending of these measures. B&A also assisted LDH with the initial Act 710 report submission and provided recommendations for future reporting. In addition to assistance in writing the quarterly reports, B&A is conducting data validation on the information submitted by each MCO in the new reporting requirements released by LDH.

Report Contents

This report contains data from the five MCOs currently under contract to provide acute care, behavioral health and pharmacy services as well as a sixth managed care entity that is under contract to deliver dental benefits only:

Plan Name	Plan Type	Common Abbreviation
Aetna Better Health, Inc.	Managed care organization	ABH
Amerihealth Caritas Louisiana, Inc.	Managed care organization	ACLA
Healthy Blue	Managed care organization	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

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

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

The key measures that will be reported in each quarter include:

1. The percentage of claim lines submitted by providers that are accepted or rejected by the MCOs;
2. Of the claim lines accepted, the percentage of claim lines paid or denied by the MCOs;
3. The average time it takes each MCO to make the payment or denial decision on claim lines (turnaround time);
4. For those claim lines that are denied payment, the top reasons why the claim lines are denied;
5. The percentage of claims adjudicated (paid or denied) by the MCOs that are successfully submitted to LDH for use in the Medicaid data warehouse (at this point it is called an *encounter submission* to LDH); and
6. The average time it takes each MCO to send its encounter submissions to LDH.
7. The number of providers for which educational outreach was conducted.

For each of these key measures, LDH will report on results at the statewide level, at the individual MCO level, and at the individual provider category level.

Key Findings

Measure #1: Claims Accepted and Rejected by the MCOs

- In the most recent four quarters for which data is available, the claims rejection rate reported by the Medicaid MCOs was near 0.5% in Q2 and Q3 2018 but increased to 1.1% in Q4 2018 and Q1 2019. The overall MCO average higher rejection rate in the last two quarters is specifically due to higher rejection rates for LHCC specifically (3.2% in Q4 2018 and 3.4% in Q1 2019).

Measure #2: Claims Paid and Denied by the MCOs

- For those claims that were accepted into the MCO's claims adjudication system, on average, the overall rate of paid claims was between 80.6% and 82.9% in the most recent four quarters. The denial rates, therefore, were between 17.1% and 19.4%.

- The claim denial rate for all quarters ranged from an average of 16.5% for UHC to an average of 21.0% for HB. These statistics exclude dental claims.
- More variation was found when the claim denial rates were examined by provider type:
    - The denial rates for inpatient hospital were higher (21.5% to 22.8%) than the overall average denial rate in each quarter of 2018. The denial rate for outpatient hospital services, however, is much lower (near 9.6%) than the overall average denial rate.
    - The claim denial rates for most professional claim providers are below the overall MCO denied claim average. For example, primary care providers and pediatricians have a denial rate of about 10.0%, and OB-GYNs have a denial rate of about 12.0%.
    - The claim denial rates for specialized behavioral health services are slightly higher than those found for most non-behavioral health services. For rehab services, the rate was between 10.4% and 16.0% in the four quarters reported. For mental/behavioral health services other than rehab, the denial rate was between 13.8% and 16.3% each quarter.
    - There is a difference in the claim denial rates for dental services for children and adults. For children, the denial rate average was about 8.0% for each of the four quarters reported; for adults, the denial rate ranged from 16.3% to 24.2%.
    - Nationally, pharmacy claim denial rates are always higher than other services, and Louisiana Medicaid is no exception. The denial rate was between 24.8% and 28.3% in the four quarters reported. This is generally due to the different processing system for pharmacy claims, which are done at point-of-sale.

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

LDH contractually requires that MCOs adjudicate (pay or deny) 99% of claims, measured in the aggregate across all service types, within 30 calendar days. The measurement for turnaround time (TAT) for adjudication is the number of days from receipt of the claim by the MCO to the time in which the provider is paid or is notified that no payment will be made.

- Overall, the MCOs are meeting the target for adjudication within 30 days as set by LDH. In fact, the average TAT is below 11 days in each reported quarter for all MCOs.
- The overall TAT for paid claims, all MCOs combined, is between 7.6 days and 8.1 days in each quarter. For denied claims, the average is between 5.9 and 6.2 days.
- There is variation between the MCOs on these statistics. The lowest TAT for paid claims was reported by ACLA (between 3.6 and 4.9 days each quarter). The highest TAT was reported by ABH (between 9.0 and 10.8 days each quarter). Other MCO TATs range from 7 to 9 days.
- For denied claims, ACLA, HB and UHC are similar with average TAT rates near 4 days. ABH's average varied between 5.7 and 7.4 days across the quarters, as did LHCC's (6.0 to 10.5 days) and MCNA's (7.2 to 10.2 days). Refer to the table at the top of the next page for more details.

Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
By MCO and By Quarter in Q2 2018 - Q1 2019

		Adjudicated Within 30 days		Average Turnaround Time	
		Pct of Paid	Pct of Denied	Paid Claims	Denied Claims
ABH	Q2 18	99.5%	99.4%	10.3	7.4
Aetna Better	Q3 18	99.4%	99.4%	10.7	6.4
Health	Q4 18	99.8%	99.6%	10.8	5.7
	Q1 19	99.2%	98.8%	9.0	7.1
ACLA	Q2 18	100.0%	99.9%	3.9	4.3
Amerihealth	Q3 18	100.0%	99.9%	3.6	3.7
Caritas	Q4 18	100.0%	100.0%	4.4	5.0
Louisiana	Q1 19	100.0%	99.9%	4.9	5.6
HB	Q2 18	99.9%	99.8%	7.6	4.0
HealthyBlue	Q3 18	99.9%	99.7%	7.8	4.2
	Q4 18	99.9%	99.8%	7.4	3.4
	Q1 19	99.6%	99.5%	7.9	3.4
LHCC	Q2 18	99.6%	98.8%	6.6	6.0
Louisiana	Q3 18	99.8%	99.5%	8.8	9.7
Healthcare	Q4 18	99.7%	98.9%	9.2	10.2
Connections	Q1 19	99.7%	99.1%	9.0	10.5
UHC	Q2 18	100.0%	99.8%	9.2	3.5
United	Q3 18	99.8%	99.3%	9.0	4.0
Healthcare of	Q4 18	99.1%	98.5%	9.7	4.6
Louisiana	Q1 19	100.0%	99.9%	9.4	3.2
MCNA	Q2 18	100.0%	100.0%	9.0	10.2
MCNA	Q3 18	100.0%	100.0%	7.3	8.1
Insurance	Q4 18	100.0%	100.0%	7.3	7.9
Company	Q1 19	100.0%	100.0%	7.1	7.2

- Claims adjudication average TATs vary by provider category.
    - For example, for inpatient hospital services, the average TAT is about 10.6 days each quarter for paid and is slightly higher for denied claims. For outpatient hospital services, the average TAT is closer to 7.3 days for paid claims and 9.5 days for denied claims.
    - The average TAT for professional services varies slightly by provider category from a low of 6.3 days for pediatricians and OB-GYNs to a high of 9.9 days for non-emergency transportation. The average TAT for denied claims is usually the same or one to two days higher than the paid claim average for each provider type.
    - The average TAT for paid claims for mental health rehab services is near 7.5 days each quarter. For non-rehab services, it was nearly 8.3 days each quarter. For both services, the average TAT for denied claims is one to three days greater than the average for paid claims.
    - For dental services, the average TAT was 7 days for both paid and denied claims in the quarters reported.
    - For pharmacy paid claims, the average TAT was between 8.0 days and 11.1 days for paid claims.

Measure #4: Top Reasons for Denied Claims

When a claim is adjudicated, the claims processor assigns one or more 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*), which contains a total of about 280 reason codes. For pharmacy claims specifically, there are nearly 350 reason codes developed by the National Council for Prescription Drug Programs (*NCPDP)*.

Key findings on CARCs include:

- The top five CARCs in the fourth quarter of 2018 included the following:
    - 16: The claim lacks information or has a billing error which is needed for adjudication.
    - 197: Precertification or authorization absent when it is required.
    - 96: Non-covered charge.
    - 18: Exact duplicate claim.
    - B7: This provider was not eligible to be paid for this procedure/service on this date.
- These five CARCs were also among the top seven in the previous three quarters reported.
- In Q1 2019, all of ACLA's, LHCC's, and UHC's top five CARCs were also in the top 10 for all MCOs. Four of ABH's top five CARCs were in the all MCO top 10. MCNA had three of its top five in the all MCO top 10. HB only had two of its top 5 CARCs in the All MCO top 10.

Key findings on NCPDPs include:

- The top five NCPDP reject codes in the fourth quarter of 2018 were:
    - 79: Refill too soon.
    - 76: Plan limitations exceeded.
    - 88: Drug Utilization Review (DUR) reject error.
    - 7O: Product/service not covered – plan/benefit exclusion.
    - 75: Prior authorization required.
- Four of these five NCPDP reject codes were also among the top five in the previous three quarters reported.
- In Q1 2019, the top five NCPDP reject codes for each MCO were also in the top 10 for all MCOs, with the exception of ACLA. Two of ACLA's top five NCPDP reject codes were in the top 10 overall.

Measure #5: Encounters Accepted and Rejected by LDH

- In the four quarters reported, 97.2% to 99.3% of the encounters submitted by all MCOs combined were accepted by LDH.
- There were differences at the MCO level. All of HB's and UHC's encounters were accepted, and most of ABH's, LHCC's and MCNA's were accepted. ACLA had varying acceptance rates in the four quarters reported, ranging between 88% and 98%.

Measure #6: Average Time for MCOs to Submit Encounters

Like claims adjudication, a common benchmark to track the timeliness of encounter submissions is the average TAT. In the case of encounters, the average TAT measures the date from which the MCO gave notice to the provider of payment or denial to the date that the encounter was submitted to LDH. A common benchmark used is that MCOs should submit encounters within 30 days of adjudication.

- When the encounters are accepted by LDH, HB has the highest percentage submitted within 30 days (almost 100 percent).
- UHC has the second highest TAT. Between 95% and 99% of their encounters were submitted within 30 days, depending upon claim type.
- LHCC had encounter submission rates within 30 days similar to UHC's for three of the four quarters reported. But in the most recent quarter (Q1 2019), the submission rate within 30 days decreased for every claim type.
- ABH has had a mixed record for submitting encounters within 30 days. There have been improvements in the last two quarters for institutional encounters, but the opposite is true for pharmacy. The submission rate for professional encounters has been consistent.
- ACLA has had some challenges with meeting an average 30-day TAT for institutional encounters in Q3 2018 and pharmacy encounters in Q4 2018 and Q1 2019. The submission of professional encounters has not been an issue, however.
- MCNA has had a few issues meeting an average 30-day TAT for its dental encounters.

Measure #7: Provider Education

Beginning with Q1 2019, LDH required that MCOs report information on education for providers at the entity tax identification number (TIN) level. 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 MCOs report on outreach to the individual entities (name and TIN), whether it was the MCO or its contractor who conducted the outreach, the type of outreach, and the date that the outreach was conducted.

The data shown in this first report only covers the second half of Q1 2019 to coincide with the date that LDH released the new reporting template. Within this six-week period:

- The MCOs conducted outreach to 781 TINs.
- The most predominant mode used to contact providers was phone (50.1% of all contacts), followed by in-person meetings (25.7% of contacts) and personalized emails (20.0% of contacts). Webinars represented 4.2% of all contacts.

For a full analysis of each measure, see Burns & Associates' full report, attached herein.

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 Healthy Louisiana 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 MCOs 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 MCO self-reported data provided on a quarterly basis. While there are specific contractual standards that require MCOs to complete an assessment of all individuals identified as having a special healthcare need within 30 days of identification, each MCO has their own policies and procedures for identification and assessment. As such, the reporting for case management has shown significant variation across MCOs. LDH continues to work with the MCOs and various providers to increase the comparability of the data collected and more accurately reflect program participation.

The data presented below is representative of unduplicated totals by MCO for CY 2019 quarter 1.

Unduplicated Case Management Summary by MCO – Calendar Year 2019 Quarter 1

	ABH	ACLA	HBL	LHCC	UHC
Eligible for Case Management (CM)	889	4,555	4,293	9,855	15,125
Enrolled in CM at least 1 month	607	3,498	1,058	4,424	4,222
% of eligibles enrolled in CM	68.3%	76.8%	24.6%	44.9%	27.9%
Received CM Service	69	3,378	524	2,340	2,034
% enrolled receiving service	11.4%	96.6%	49.5%	52.9%	48.2%

Source: 039 Case Management Reports

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INDEPENDENT STUDY OF PROVIDER CLAIMS SUBMITTED TO MEDICAID MANAGED CARE ORGANIZATIONS IN THE HEALTHY LOUISIANA PROGRAM

QUARTERLY UPDATE
PERIOD COVERING THE 1ST QUARTER
OF CALENDAR YEAR 2019

OCTOBER 1, 2019

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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 No. 710 of the 2018 regular legislative session. The Act requires reporting of data on healthcare provider claims submitted to Medicaid managed care organizations (MCOs). 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. Whereas the initial report presented detailed findings about CY 2017 claims on measures enumerated in law, the subsequent quarterly reports will include the reporting on measures that will be defined as an outcome of the findings from the initial report.

The Initial Report was submitted to the legislature on October 31, 2018. The second report, which covered the three Calendar Quarters 1, 2 and 3 in CY 2018, was submitted to the Legislature on April 8, 2019. A third report which reported on information from Quarter 4 of CY 2018 was submitted to the Legislature July 1, 2019. Each subsequent report will be submitted to the Legislature each 90 days and will report on data from the most recent four quarters. This report covers data from Calendar Q2 through Q4 of 2018 and Q1 of 2019.

<u>Required Reporting for the Initial Report</u>

In the initial report, information was reported on for behavioral health providers separately from non-behavioral health providers. The type of information reported included the following:

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

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

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

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

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

Steps in Claims Processing and Encounter Submissions

In a typical claims processing system, a provider will submit a claim for services rendered to the payer (in this case, the MCO) 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 on. This includes hospitals, nursing homes and home health agencies.

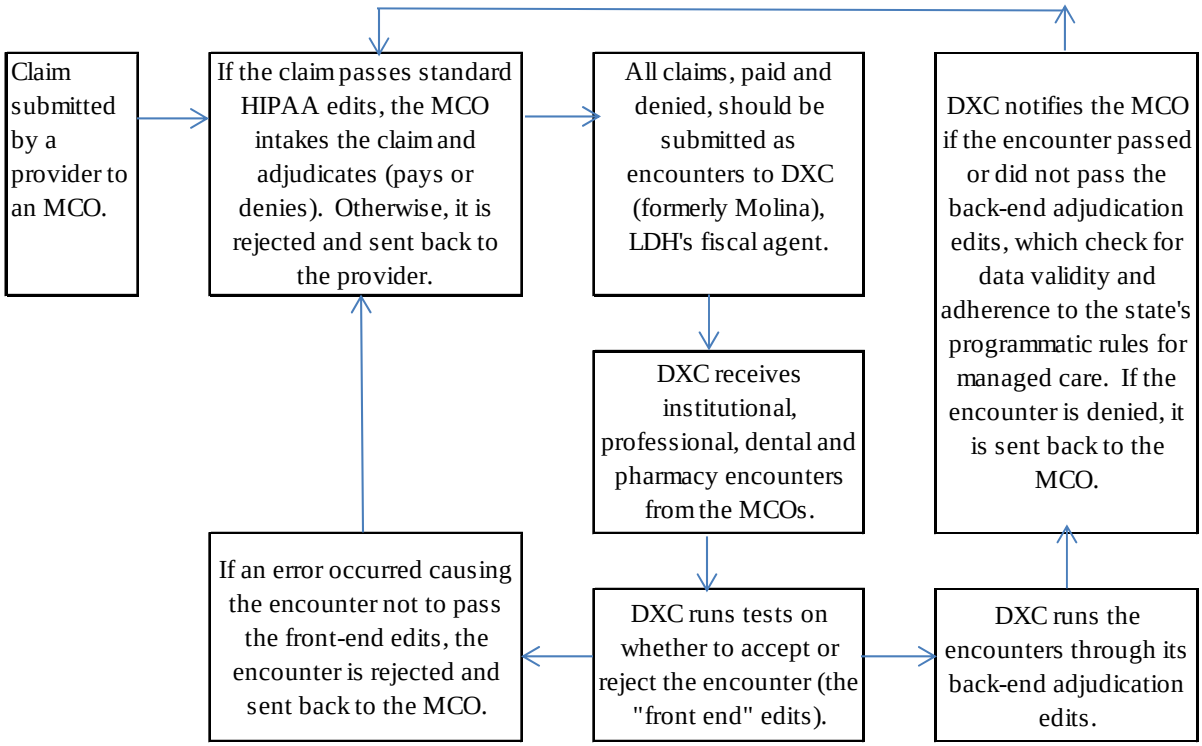
- The *CMS-1500, or electronic 837P*, is the claim type for professional service providers to submit on. This includes a wide array of providers such as physicians, clinics, mental health providers, therapists, transportation providers, suppliers of medical equipment and supplies.

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

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

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

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



Terminology Used in this Report

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

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 (and usually is) 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 question to ask is if the claim counts shown represent the count of header records or of individual service lines. The count of header lines may be a fraction of the total detail service lines.

The Department has asked the MCOs 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 MCOs 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 as much as 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 MCO to the time of notification to the provider (pay or deny).

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

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

The reason codes describe information on both paid claims and denied claims. The LDH requires the contracted MCOs 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. The full listing of CARCs and NCPDP codes appear in *Appendix B and Appendix C*, respectively.

Findings from Initial Report Covering Calendar Year 2017

Some key findings in the initial report related to the information reviewed for CY 2017 claims and encounters is highlighted below:

- The rate of rejected claims as a percent of total claims submitted is very low (approximately 1%).
- For those claims accepted by the MCOs, the weighted average denial rates were
    - 8% for institutional (mostly hospital) claims, with MCOs ranging from 7% to 11%
    - 12% for professional (e.g. physician) claims, with MCOs ranging from 9% to 14%
    - 5% for dental claims
    - 27% for pharmacy claims, with MCOs ranging from 16% to 36%. The high incidence of denied pharmacy claims is consistent with national trends. This reflects pharmacists at point-of-sale who often try to key in the same script multiple times.
- The average turnaround time (TAT) for the MCOs to adjudicate claims after receipt from the provider was often less than 10 days but almost always less than 15 days with just two exceptions.
    - For institutional claims, Aetna had an average TAT of 25.5 days, UnitedHealthcare's average was 26.6 days.
    - For professional claims, Aetna had an average TAT of 21.9 days.
- There was no distinction in the TAT between paid and denied claims for institutional and dental claims, but the TAT for denied professional claims was five days greater than paid claims.
- The top five denial reason codes for institutional and professional claims represented near 50% of all denial CARC occurrences (out of more than 250 types of CARCs). For dental claims, the top five represented 71% of all CARC occurrences. For pharmacy, the top five NCPDP codes represented 64% of all denial codes (out of approximately 350 NCPDP codes).

Follow-up Consultation with Providers and the MCOs

The provider community was consulted on the results of the initial Healthy Louisiana Claims Report prior to its submission to the Legislature. After the publication, both the providers and the MCOs were convened in separate meetings to review the measures that will be reported on each quarter in the quarterly update reports. Some measures that were included in the initial report were removed from ongoing quarterly reporting, but new measures were added. The updated list of measures was developed to provide the most meaningful information to the provider community, LDH and the MCOs.

LDH has retained Burns & Associates (B&A) to assist with ongoing reporting related to the Act. B&A assisted LDH by conducting the independent study for the initial period of CY 2017. B&A worked with LDH to develop new reporting templates for the MCOs to submit information related to claims adjudication and encounter submissions each quarter. B&A facilitated a webinar with providers on

February 8, 2019 to obtain their feedback on the new reports as well as the layout of the exhibits that appear in this report. After making some modifications, B&A then conducted a webinar with the MCOs to introduce the new reports on February 27, 2019 in preparation for the April 2019 report to the Legislature.

Recommendations Implemented Since Initial Report

LDH has taken action on the following recommendations put forth by B&A in the initial Healthy Louisiana Claims Report:

- Recommendation 1: LDH should develop a common set of definitions for claims adjudication terms that would be used by all MCOs as well as the LDH fee-for-service payment system. **Completed**. This recommendation was accepted and the definitions now appear in the instructions for the new report templates used for Act 710 reporting.

- Recommendation 2: LDH should develop a common set of definitions for encounter adjudication terms that would be used by all MCOs as well as LDH. **Completed**. This recommendation was accepted and the definitions now appear in the instructions for the new report templates.

- Recommendation 3: LDH should build guidance or requirements about the expectations that the MCOs will perform root cause analyses pertaining to claims adjudication and/or encounter submissions. **In process.** This recommendation was accepted. The new report templates require the MCOs to report on top denial reasons by provider type which will help assist with conducting root cause analysis. The MCOs are also required to report the number of providers with high denial rates segmented by provider Medicaid claims volume (small, mid-size, large) to understand which providers within a specialty are most impacted by the denial rate.

- Recommendation 4: LDH should review the MCO reports that focus on claims and consider modifying, consolidating or eliminating existing reports. LDH should also consider adding a report on encounter submissions. **Completed.** LDH worked with B&A to develop the new report templates that the MCOs are required to submit each quarter to comply with the Act.

- Recommendation 5: For any new measures or reports that get introduced as part of quarterly reporting by this Act, LDH should convene all of the MCOs to review the new report templates, to confirm understanding of the specifications, and to vet the instructions. **Completed.** This was done as part of the February 27, 2019 webinar and follow-up responses to questions from the MCOs.

- Recommendation 6: LDH should develop an audit protocol and conduct a periodic audit of a sample of claims denied by the MCOs to ensure that the claims are not being denied in error by the MCO. **In process.** LDH concurs with this recommendation and is in the process of developing a protocol for use later in 2019.

SECTION II: CONSTRUCT OF THE QUARTERLY UPDATE REPORT

Six new reports have been designed specifically for the quarterly report updates. LDH requires that each MCO submit these six reports on a quarterly basis.

There will be a lag time between the claims adjudication period and the date that the MCOs will submit the reports to LDH as allowed by the Act. For example, the results from the claims adjudication period January 1 – March 31, 2019 will be due to LDH by July 31, 2019.

The MCOs analyzed in this review include:

- Aetna
- Amerihealth Caritas Louisiana (ACLA)
- HealthyBlue
- Louisiana Health Care Connections (LHCC)
- United Healthcare (UHC)
- Managed Care of North America (MCNA), for dental services only

Measures that will be Reported Each Quarter

The Healthy Louisiana Claims Report quarterly updates will be delivered in the same format each quarter. This format was introduced in the April 2019 report to the Legislature and continues in this report. The key measures that will be tracked on an ongoing basis include:

- The rate of claims accepted and rejected by each MCO
- The rate of accepted claims that are paid and denied by each MCO
- The timeliness (turnaround time) for each MCO to adjudicate claims
- The top reasons why claims are being denied at each MCO
- 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 MCO
- The timeliness for each MCO 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. This will be continued in all quarterly updates. 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 will be reported on an ongoing basis are:

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

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

The map of LDH provider type and specialty codes into each of the categories mentioned above appears in *Appendix A.*

How This Report is Organized

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

There are 17 exhibits that will be reported on in each quarterly report—11 pertain to claims adjudication, one pertains to provider education and five pertain to encounter submissions. The format for each exhibit will remain consistent with each quarterly report to allow for ease in trending results over time.

In some exhibits, data will be displayed for the most recent four quarters. In this report, the four quarters shown are Q2 through Q4 2018 and Q1 2019). In the next update, Q2 2018 data will be dropped and Q2 2019 data will be added.

Other exhibits will display only the data from the most recent quarter. In this edition of the report, the exhibits that contain only the most recent quarter show Q1 2019 data.

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

Limitations of the Data

In its review of the reports submitted by each MCO to LDH for this quarterly update, Burns & Associates (B&A) would like the reader to keep in mind two known limitations of the data reported:

1. All data is self-reported by the MCOs to LDH. B&A conducts a validation process upon submission of reports to LDH each quarter. In some situations, MCOs were asked to verify specific values that were reported to confirm their accuracy if the initial submission deviated from trends reported by other MCOs or the same MCO in a prior period. In some cases, the MCOs did provide updated information after further research into the matter.

2. The Act requested information on the dollar amount of denied claims. If a claim is denied, then the payment will be $0. B&A tested multiple ways in which to derive a "would have paid" amount if the denied claim had been paid. This method was shared in a meeting with the provider community. 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. B&A tested two in particular. Ultimately, B&A selected an approach that estimates the value of each denied claim by applying a value to it that is the average value of every paid claim in that category.

    Although this method allows for some precision, there could have been further precision by pricing each denied service based on the rate that LDH pays for the service. It was deemed that

none of these methods truly reflects “lost” payments since the claims in question were denied for a reason and the payment should be $0. The value of denied claims, therefore, should be reviewed with caution. It is of the opinion of the B&A reviewers that the values shown for denied claims should not be considered as “lost” money to providers but, rather, as an opportunity for improvements in the accuracy and completeness of provider claims submissions.

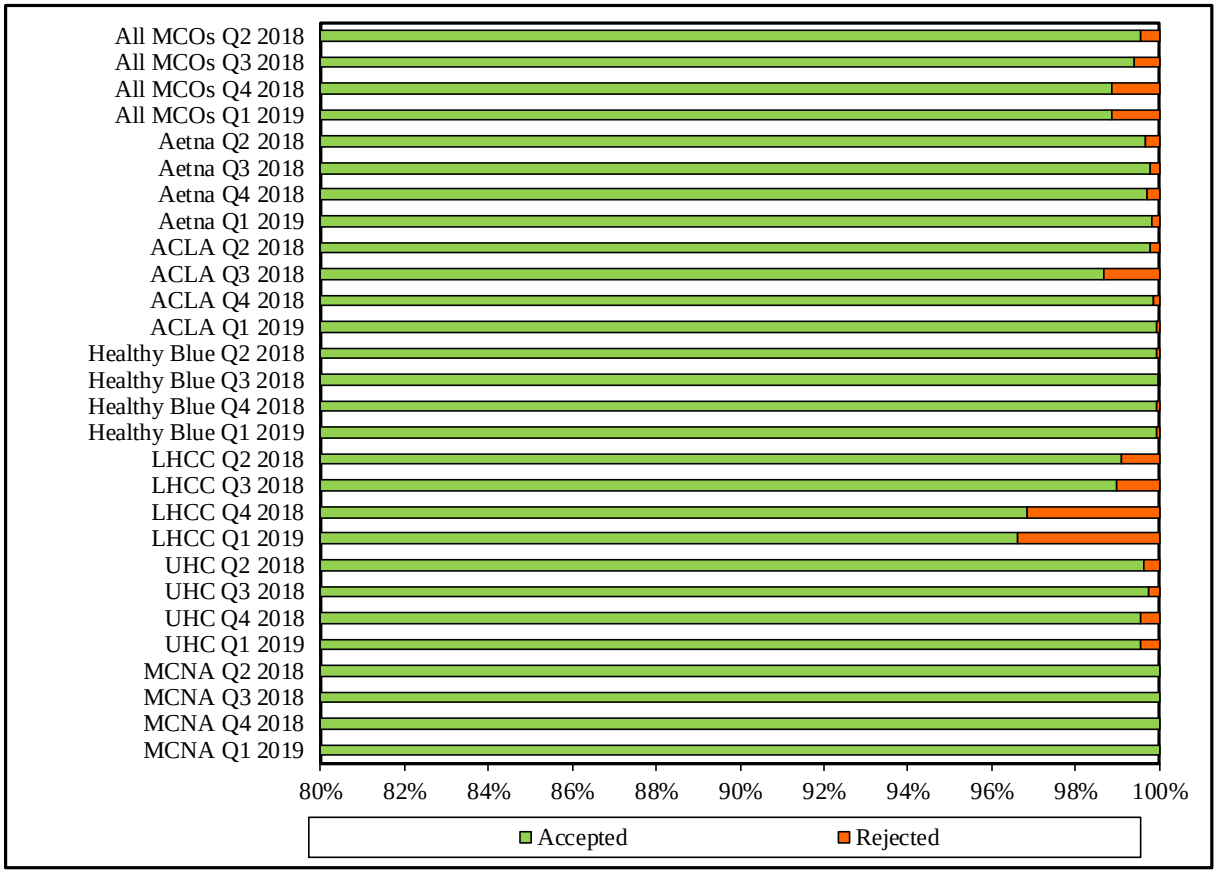
SECTION III: FINDINGS RELATED TO MCO CLAIMS ADJUDICATION

The LDH's contracted MCOs adjudicated between 23.3 and 25.1 million claim service lines in each of the four quarters of Calendar Year (CY) 2018. The MCOs themselves adjudicate medical claims (those billed in the institutional claims, or 837I, format and those billed in the professional claims, or 837P, format). MCNA adjudicates almost all of the dental claims for the Medicaid program. Each MCO contracts with a pharmacy benefit manager to adjudicate the pharmacy claims.

Claims Accepted and Rejected by the MCOs

In the most recent four quarters for which data is available, the claims rejection rate reported by the Medicaid MCOs was near 0.5% in Q2 and Q3 2018 but increased to 1.1% in Q4 2018 and Q1 2019. The overall MCO average higher rejection rate in the last two quarters is specifically due to higher rejection rates for LHCC specifically (3.2% in Q4 2018 and 3.4% n Q1 2019).

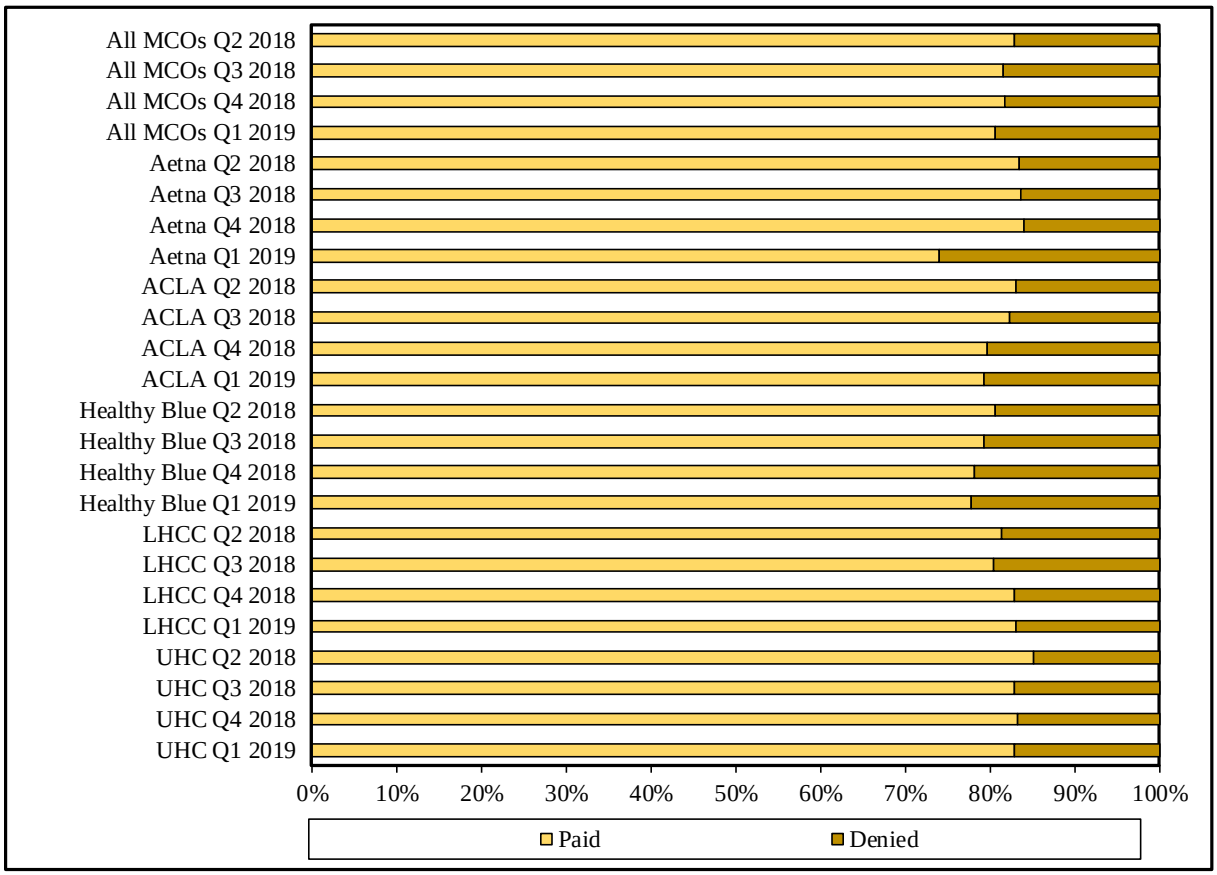
Exhibit III.1
Claim Accepted and Rejected Rate
All Claim Types
By MCO and By Quarter



Claims Paid and Denied by the MCOs

For those claims that were accepted into the MCO's claims adjudication system, on average, the overall rate of paid claims was between 80.6% and 82.9% in the most recent four quarters. The denial rates, therefore, were between 17.1% and 19.4%. At the MCO-specific level, the range across the 4-quarter averages was from an average denial rate of 16.5% for United to an average rate of 21.0% for HealthyBlue. These statistics exclude MCNA dental claims, which can be found in Exhibit III.3C in categories Dental – Children and Dental – Adult.

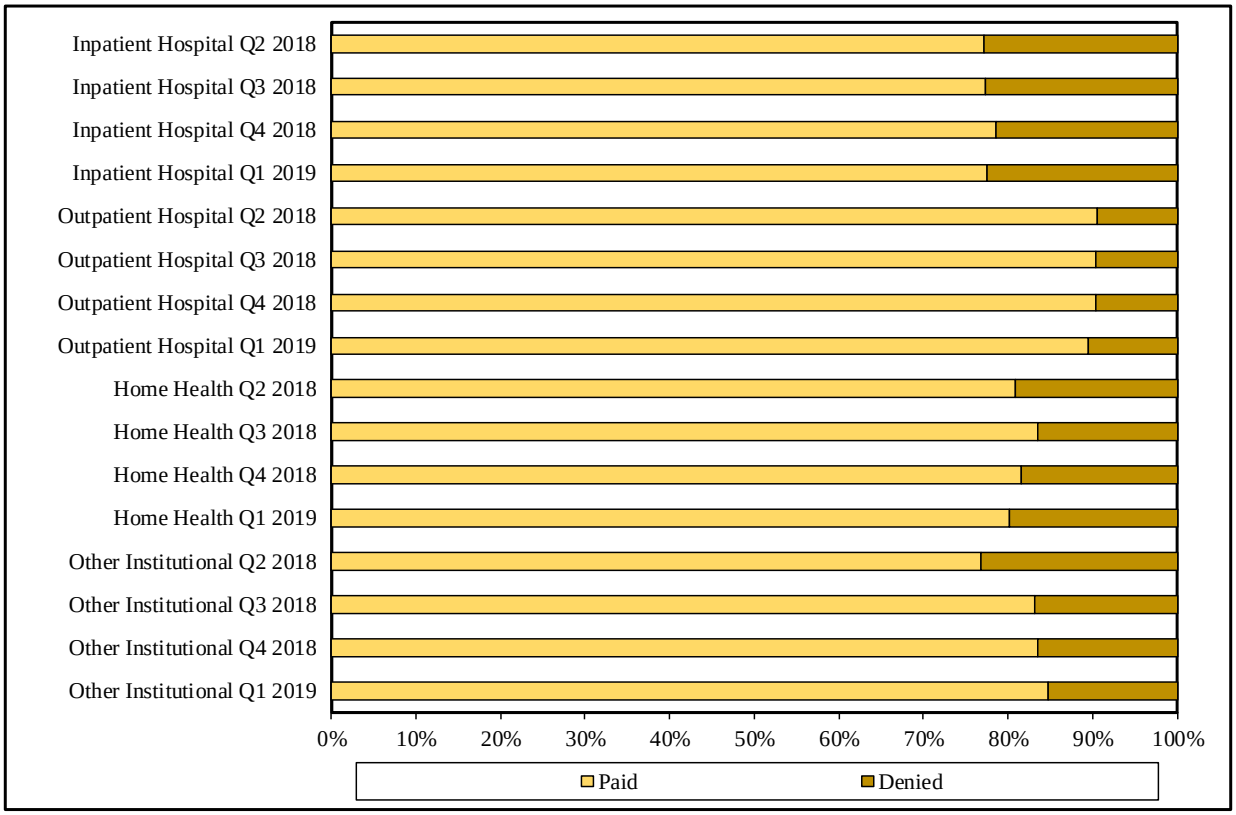
Exhibit III.2
Claim Status for Adjudicated Claims
All Claim Types
By MCO and By Quarter



There is more variation found when the claims denial rates are examined by provider type. Exhibits III.3A, III.3B and III.3C on the following pages break out the approval and denial rates by provider type for each of the four quarters in CY 2018. Exhibit III.3A shows the providers that bill on the institutional, or 837I, claim type. Exhibit III.3B shows the providers that bill on the professional, or 837P, claim type. Exhibit III.3C shows specialized providers such as behavioral health, dental and pharmacy.

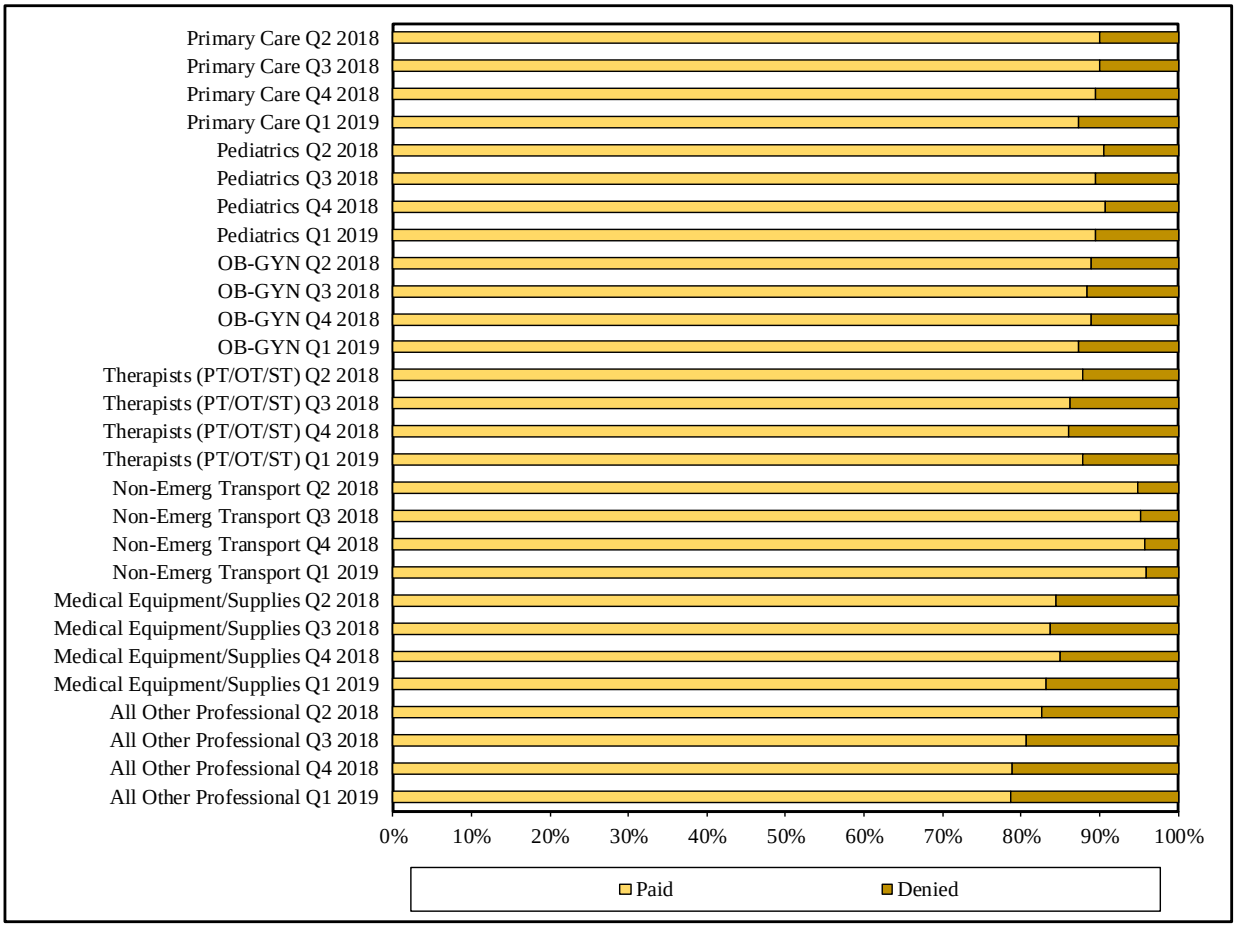
In Exhibit III.3A below, it was found that the denial rates for inpatient hospital were higher (21.5% to 22.8%) than the overall denial average rate (17.1 to 19.4%) for the four quarters examined. Home health agencies had a denial rates closer to the overall denial average (16.5% to 19.9% across the four quarters). Interestingly, the denial rate for outpatient hospital services is much lower (near 9.6%) than the overall average denial rate. There is wider variation in the paid and denied rates in the Other Institutional category because this category represented only 1.0% of all institutional claims adjudicated.

Exhibit III.3A
Claim Status for Adjudicated Claims
Institutional Providers
For All MCOs Combined By Quarter



The claims denial rates for most professional claim providers are below the overall MCO denied claim average. For example, primary care providers and pediatricians have a denial rate closer to 10% (the exception is Primary Care jumped to 12.9% in Q1 2019). OB-GYNs have a denial rate closer to 12%. The denial rate for therapists was in the range of 12% to 14% across the four quarters. Non-emergency medical transportation denial rates are the lowest of any provider type between 4.0% and 5.2% across the quarters. Two groups in this exhibit have claim denial rates higher than the overall MCO average. For medical equipment and supplies, the average denied claims rate is 15% to 17% across the four quarters shown. For the All Other Professionals group, the average denied claims rate is 17% to 21%.

Exhibit III.3B
Claim Status for Adjudicated Claims
Professional Service Providers
For All MCOs Combined By Quarter

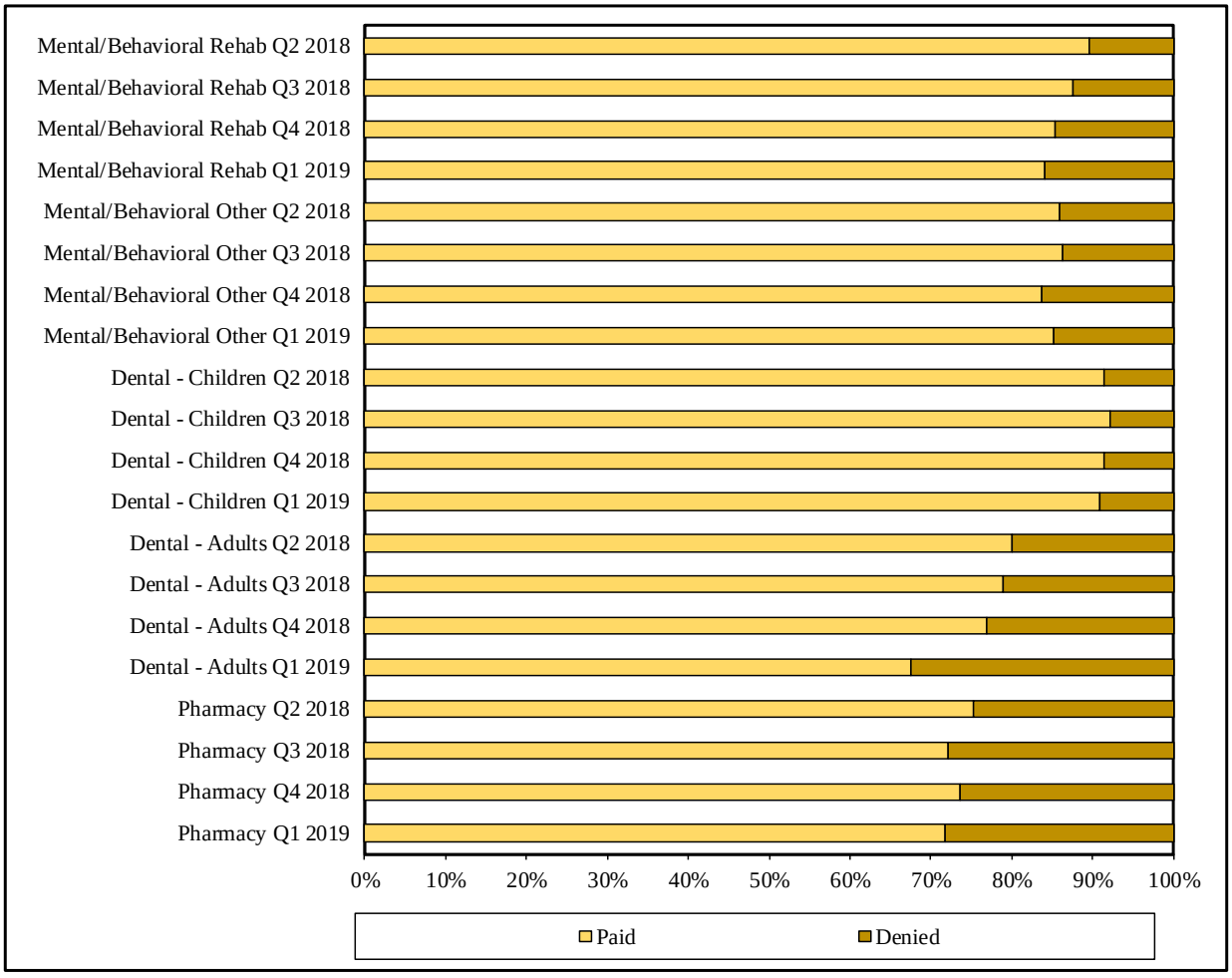


The claims denial rates for behavioral health services are slightly higher than those found for most acute care services on the previous pages. For rehab services, the claims denial rate was between 10.4% and 16.0% in the four quarters reported. For mental/behavioral health services other than rehab, the claims denial rate was between 13.8% and 16.3%.

There is a difference in the claim denial rates for dental services for children and adults. For children, the denial rate average was in the 8% range; for adults, the range was between 16.3% and 24.2%.

Pharmacy claim denial rates are always higher than other services and Louisiana Medicaid is no exception. The denial rate was between 24.8% and 28.3% across the most recent four quarters examined.

Exhibit III.3C
Claim Status for Adjudicated Claims
Behavioral Health, Dental and Pharmacy
For All MCOs Combined By Quarter



The exhibits on the next three pages further break down the claim paid and denied rates, but in these exhibits the breakdown is for each provider type by each of the MCOs. The purpose of these exhibits is to determine if the claims denial rate for a provider type is consistent across MCOs or if it varies. In Q1 2019, most often at least three of the four MCOs have a denial rate in the same range for the specific service. Aetna tends to have a higher rate than the other MCOs for most services reviewed.

Exhibit III.4A correlates with the information shown in Exhibit III.3A (institutional providers). Exhibit III.4B correlates with the information shown in Exhibit III.3B (professional providers). Exhibit III.4C correlates with the information shown in Exhibit III.3C (behavioral health, dental, pharmacy).

The key findings from all three exhibits appearing on pages III-7 through III-9 are summarized here for convenience:

Provider type	**Percentage of MCO Payments In Q1 2019**	**Spread of Percent Denied Across MCOs**	**If there is variation across MCOs, the range of claim denial rates**
Inpatient Hospital	18.0%	9.5 points	Lowest denial rate: LHCC, 17.5% Highest denial rate: HealthyBlue, 27.0%
Outpatient Hospital	19.0%	19.5 points	Lowest denial rate: ACLA, 7.7% Highest denial rate: Aetna, 27.2%
Home Health	0.2%	40.3 points	Lowest denial rate: HealthyBlue, 11.3% Highest denial rate: Aetna, 51.6%
Other Institutional	0.3%	27.9 points	Lowest denial rate: HealthyBlue, 13.0% Highest denial rate: Aetna, 40.9%
Primary Care	5.5%	22.6 points	Lowest denial rate: UHC, 8.4% Highest denial rate: Aetna, 31.0%
Pediatrics	2.0%	19.5 points	Lowest denial rate: ACLA, 7.6% Highest denial rate: Aetna, 27.1%
OB-GYN	0.9%	17.2 points	Lowest denial rate: UHC, 7.2% Highest denial rate: Aetna, 24.4%
Therapists	0.2%	20.6 points	Lowest denial rate: UHC, 8.6% Highest denial rate: Aetna, 29.3%
Non-emergency Transportation	0.7%	18.0 points	Lowest denial rate: Aetna, 1.3%, LHCC, 1.7% Highest denial rate: UHC, 19.3%
Medical Equipment and Supplies	0.9%	13.2 points	Lowest denial rate: ACLA and UHC, 17.0% Highest denial rate: HealthyBlue, 30.2%
Other Professional	15.5%	12.5 points	Lowest denial rate: HB, 20.3%, LHCC 20.4% Highest denial rate: Aetna, 32.9%
Behavioral Health Rehab	3.0%	14.1 points	Lowest denial rate: HB, 14.5%, ACLA, 14.9% Highest denial rate: LHCC, 28.7%
Behavioral Health Other	3.7%	7.9 points	Lowest denial rate: ACLA, 11.3% Highest denial rate: HealthyBlue, 19.3%
Dental – Children	2.0%	N/A, all MCNA	---
Dental – Adult	0.5%	N/A, all MCNA	---
Pharmacy	27.6%	18.0 points	Lowest denial rate: Aetna, 20.0% Highest denial rate: HealthyBlue, 38.0%

Exhibit III.4A
Claim Status for Adjudicated Claims
By Provider Specialty - Institutional Providers
By MCO for Q1 2019 Adjudicated Claims

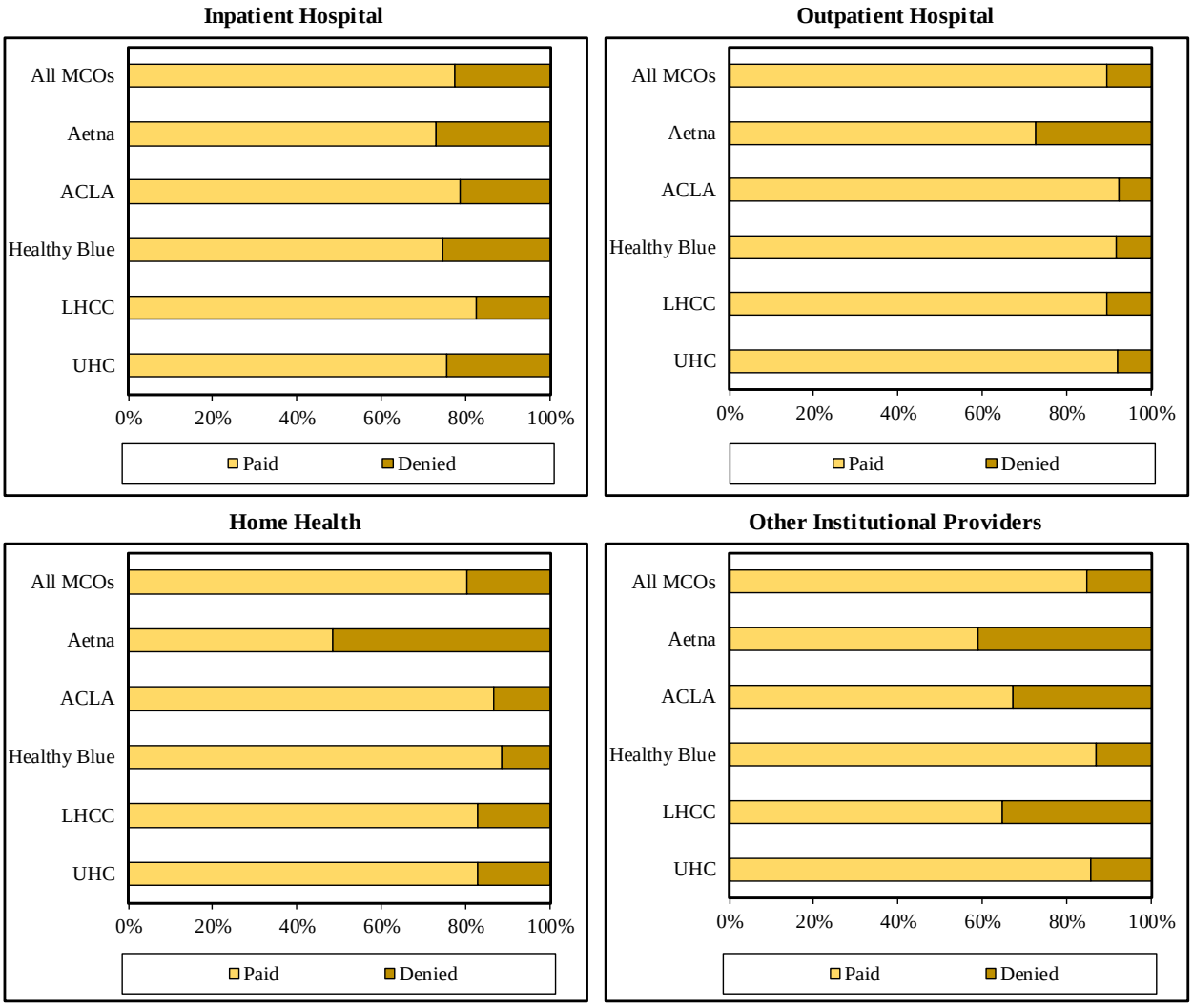
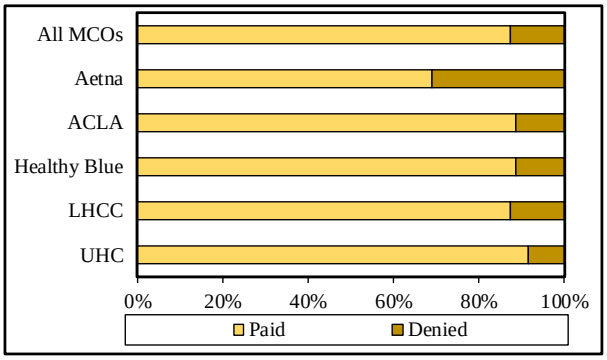
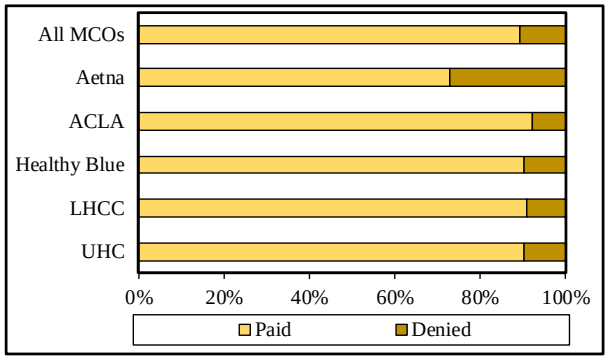


Exhibit III.4B
Claim Status for Adjudicated Claims
By Provider Specialty - Professional Service Providers
By MCO for Q1 2019 Adjudicated Claims

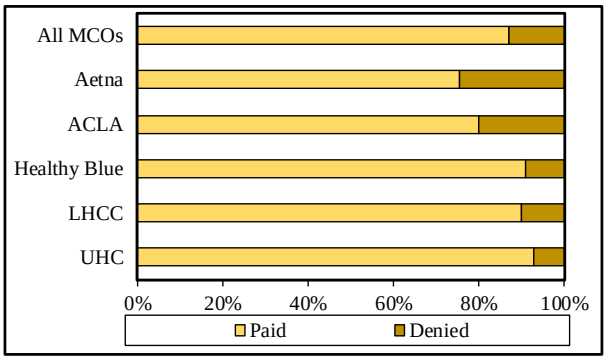
Primary Care



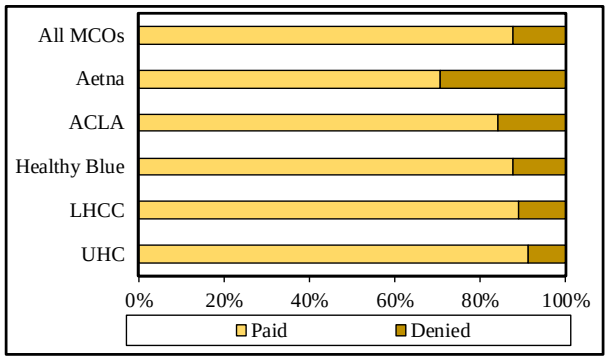
Pediatrics



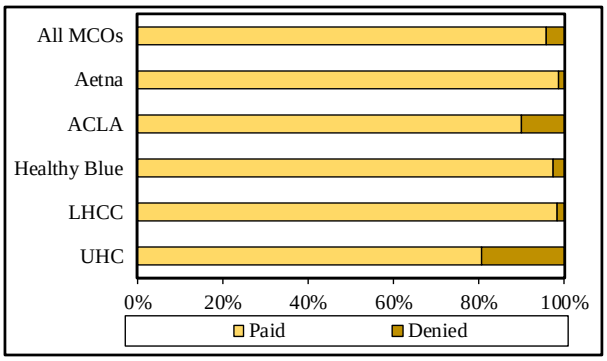
OB-GYN



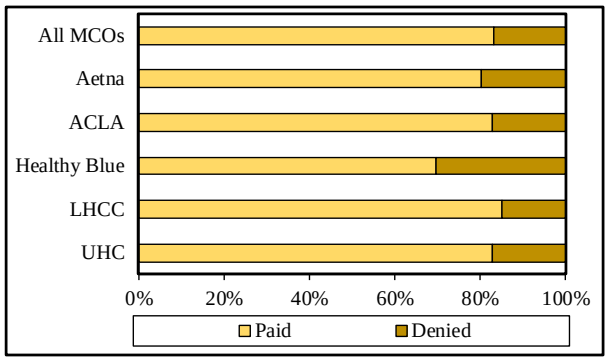
Therapists (Physical, Occupational, Speech)



Non-Emergency Medical Transportation



Medical Equipment & Supplies



All Other Professional Services excluding BH and Dental

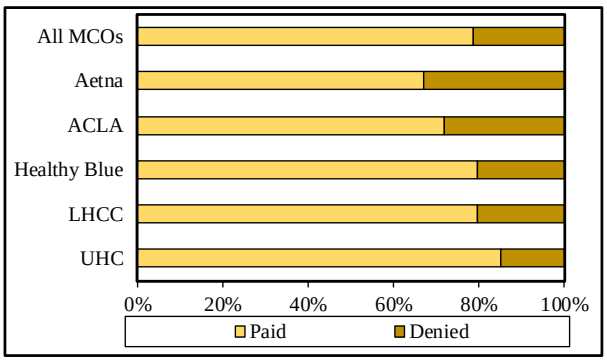
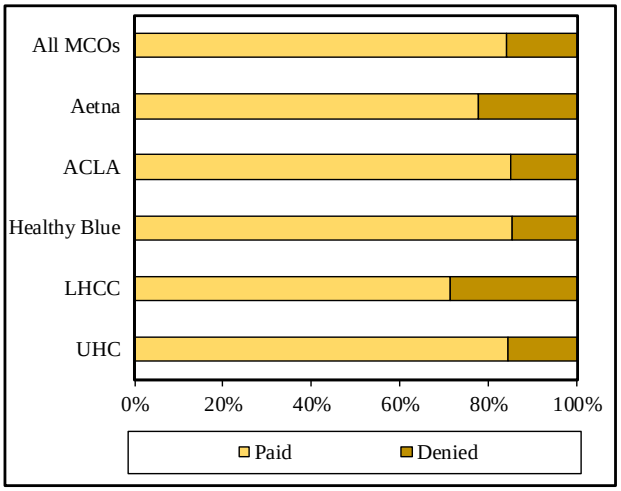
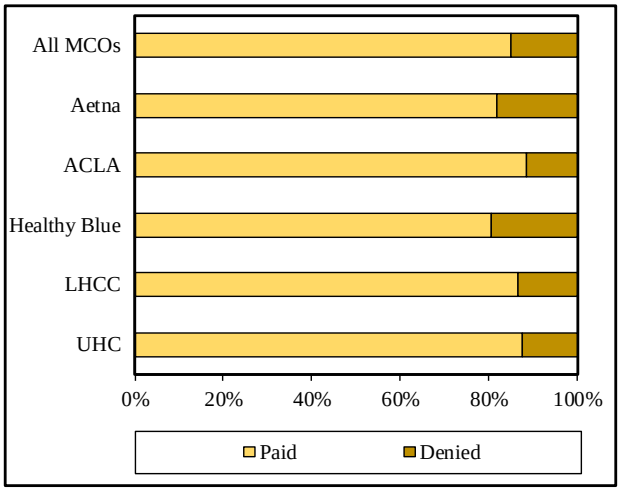


Exhibit III.4C
Claim Status for Adjudicated Claims
By Provider Specialty - Behavioral Health, Dental and Pharmacy
By MCO for Q1 2019 Adjudicated Claims

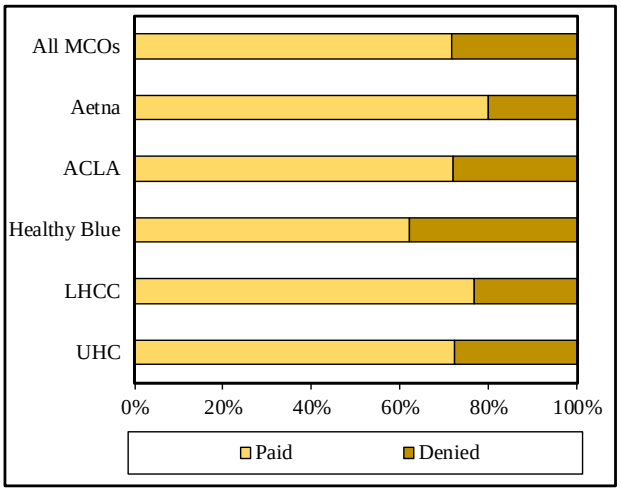
Mental/Behavioral Health - Rehab



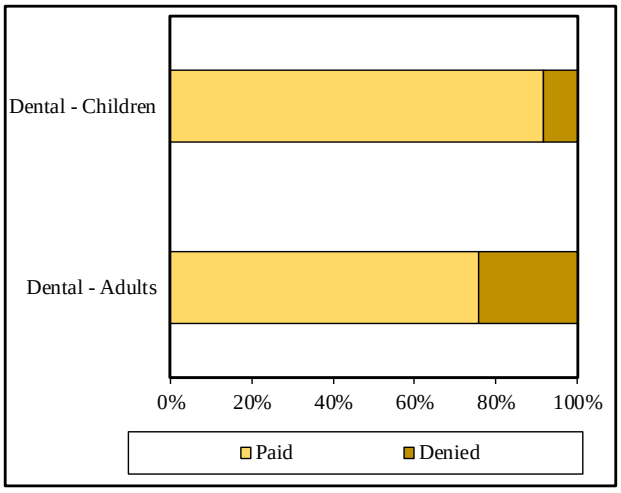
Mental/Behavioral Health - Other



Pharmacy



Dental (MCNA is the only MCO)



The Act requires that LDH provide an assigned value to each of the claims that were denied by the MCOs. As discussed in the Limitations of the Data section on page II-2, there are hundreds of edits that are in place at each MCO 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 exceeds the number of units allowed (e.g., chiropractic visits, number of eyeglasses each year); and
- The service billed requires an authorization by the MCO 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, B&A tabulated the information on denied claims from each MCO and attempted to assign a value to each denied claim without inferring if the claim could have been paid or should have been paid.

To do this, B&A examined each of the 16 provider specialties separately. Within each category, the MCO reported the number of claims paid and the total payments made. B&A computed an average payment per claim. Then, the MCOs reported the number of denied claims in the provider specialty. B&A used the average payment per claim in the provider specialty and multiplied this by the number of denied claims to impute a value for the denied claims.

It is important to apply this formula at the provider specialty level (as opposed to all claims combined) due to the wide range of reimbursement paid to each provider type. For example, in Q1 2019, the average payment for paid inpatient hospital claims was $5,697; for primary care, it was $40.

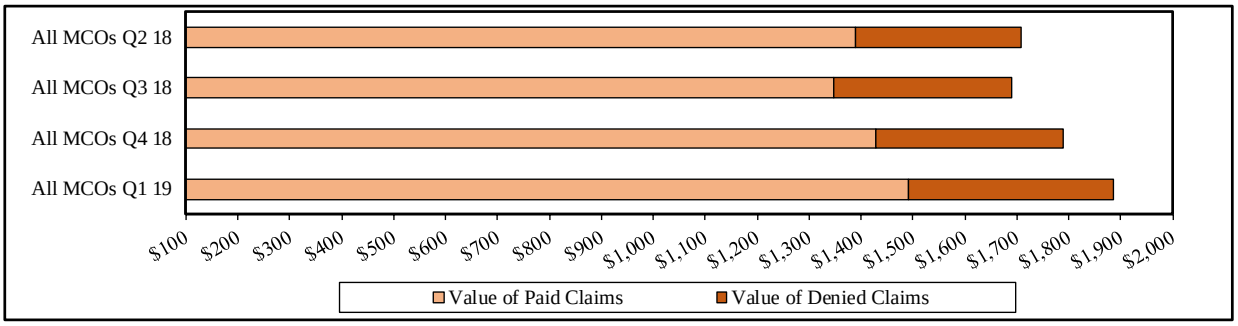
B&A not only computed an average payment per claim for each provider specialty separately, but also for each MCO within the provider type as well as a separate value for each calendar quarter.

Exhibit III.5 which appears on the next page summarizes the total dollar values of paid claims and denied claims by MCO and by quarter. The detailed information for each provider specialty by MCO and by quarter appears on Appendix D.

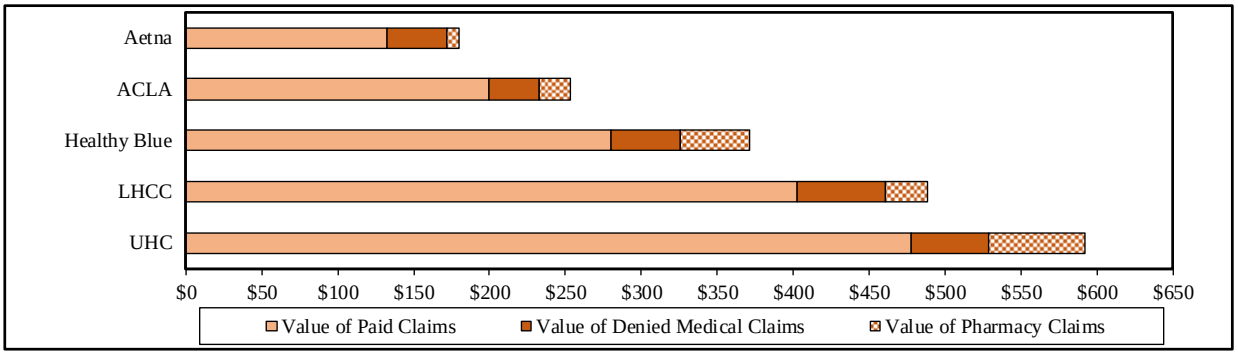
The denied claims account for between 18.6% and 20.6% of the sum of paid and denied values each quarter. This equates to between $320 and $393 million. Among the $393 million in denied values in Q1 2019 assigned across the five MCOs that provide medical and pharmacy benefits, $227 million (58%) was attributed to medical claims and $166 million (42%) was attributed to pharmacy claims. In Q1 2019, the distribution of assigned values to denied claims by MCO was as follows:

- Aetna had 83% to medical and 17% to pharmacy claims
- ACLA had 62% to medical and 38% to pharmacy claims
- HealthyBlue had 50% to medical and 50% to pharmacy claims
- LHCC had 68% to medical and 32% to pharmacy claims
- UHC had 44% to medical and 56% to pharmacy claims

Exhibit III.5
Value of Paid and Denied Claims
The dollar values in the stacked bar represent hundreds of millions



Q1 2019 Adjudicated Claims Only



MCNA is the MCO that provides dental coverage only.
Their total expenditures are $33M - $40M per quarter. They have been excluded from this exhibit.

LDH required the MCOs 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 16 provider specialties, the MCOs divided the specialty into three sub-groups:

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

The data submitted by the MCOs 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 MCO 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%).

The key findings from this study appear in Exhibit III.6 on the next page. The details behind these findings for each MCO in each quarter appear in Appendix D.

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 MCOs (excluding MCNA), so 42 groupings for five MCOs is 210 groupings. The other two provider specialties are specific to dental and specific to MCNA, so this adds six more groupings. That means a total of 216 groupings were examined for each quarter.

B&A reviewed each of the 216 groupings for whether more than half of the providers within the group had a claims denial rate above 50%. There were many provider/volume combinations where the volume of providers was too small (5 or less) to make an assessment.

Exhibit III.6 shows the instances where the MCO denied more than 10% of the claims for more than half of the providers in the Medicaid volume group. In the exhibit, a Y indicates that at least half of the providers in the provider/volume group had a 10% denial rate or greater. An N indicated that less than half had a 10% denial rate or greater. A dash (–) indicates that the sample was too small to study. Within each of the quarters examined, the sample was too small for close to 40 of the provider/volume combinations.

There has been relative consistency in the number of combinations where a majority of providers had a denial rate above 10%. This is indicated by the number of N values as shown in the table below. The counts represent all MCOs combined. Just over half of all provider categories had <u>less than</u> 10% of their claims denied.

	Number of cells with a Y value	Number of cells with a N value	Number of cells with a – value
Q2 2018	75	104	37
Q3 2018	76	103	37
Q4 2018	82	97	37
Q1 2019	83	97	36

There was no obvious pattern when reviewing the results in Exhibit III.6 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 MCO stands out from the rest. In particular,

- LHCC has a higher denial rate among high-volume outpatient hospitals in most quarters compared to other MCOs
- LHCC also has a higher denial rate among high-volume primary care providers in two quarters while other MCOs do not
- UHC has a higher denial rate among low-volume primary care providers in all four quarters but other MCOs do not

Exhibit III.6

Examination of Individual Providers Who Billed an MCO 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 MCO

N means that less than 50% of the providers in this group had 10% or more of their claims denied by the MCO

-- 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	Aetna				ACLA				HBL				LHCC				UHC				MCNA			
		Q2 18	Q3 18	Q4 18	Q1 19	Q2 18	Q3 18	Q4 18	Q1 19	Q2 18	Q3 18	Q4 18	Q1 19	Q2 18	Q3 18	Q4 18	Q1 19	Q2 18	Q3 18	Q4 18	Q1 19	Q2 18	Q3 18	Q4 18	Q1 19
Inpatient Hospital	Low	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	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	--	--	--	--				
Outpatient Hospital	Low	N	N	N	Y	Y	Y	Y	Y	N	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y				
	Medium	Y	Y	Y	Y	N	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y				
	High	N	N	Y	Y	N	N	N	N	N	N	N	N	Y	Y	N	Y	N	N	N	N				
Home Health	Low	Y	Y	Y	Y	N	N	Y	Y	N	Y	N	N	Y	N	N	Y	Y	N	N	Y				
	Medium	Y	Y	Y	--	Y	Y	N	N	N	N	N	N	Y	N	Y	Y	--	--	--	--				
	High	--	--	--	--	--	--	--	--	--	--	--	--	N	Y	--	Y	--	--	--	--				
Other Institutional Providers	Low	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	N	Y	Y	Y	Y	N	N	N	N				
	Medium	Y	Y	Y	--	--	--	--	--	N	N	N	N	--	--	--	Y	Y	Y	Y	N				
	High	Y	Y	Y	--	--	--	--	--	N	N	N	N	--	--	--	--	N	--	Y	--				
Primary Care	Low	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	Y	Y	Y	Y				
	Medium	--	--	--	--	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N				
	High	--	--	--	--	N	N	N	N	N	N	N	N	Y	N	Y	Y	N	N	N	N				
Pediatrics	Low	Y	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	Y	Y	Y	Y				
	Medium	--	--	--	--	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N				
	High	--	--	--	--	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N				
OB-GYN	Low	--	--	--	--	N	Y	Y	Y	N	N	N	N	N	N	Y	N	Y	Y	Y	Y				
	Medium	--	--	--	--	N	N	Y	Y	N	N	N	N	N	N	N	N	N	N	N	N				
	High	--	--	--	--	N	N	Y	Y	N	N	N	N	Y	N	--	Y	N	N	N	N				
Therapists	Low	--	--	--	--	Y	Y	Y	Y	N	Y	Y	N	N	N	N	N	Y	N	Y	N				
	Medium	--	--	--	--	N	Y	Y	N	Y	Y	Y	N	Y	N	N	Y	Y	N	N	N				
	High	--	--	--	--	--	--	--	--	--	--	--	--	--	--	N	Y	N	N	N	N				
Non-Emergency Transportation	Low	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	Y	Y	N				
	Medium	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	Y	Y	Y	Y				
	High	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	--	--	--	--				
Medical Equipment/ Supplies	Low	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	N	N	N	N	Y	Y	Y	Y				
	Medium	Y	Y	Y	Y	Y	Y	Y	Y	--	--	--	--	Y	Y	N	Y	N	N	Y	Y				
	High	--	Y	Y	--	Y	Y	N	Y	--	--	--	--	Y	Y	N	Y	N	N	N	N				
All Other Professional Provid.	Low	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	Y	Y	Y				
	Medium	N	N	N	N	N	N	N	N	N	N	N	N	N	N	Y	N	N	Y	Y	Y				
	High	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	Y	Y	N	N	N				
Behavioral Health Rehab	Low	Y	Y	Y	N	N	N	N	N	N	N	Y	Y	Y	N	Y	Y	Y	Y	Y	Y				
	Medium	--	--	--	N	N	N	N	N	N	N	Y	N	N	N	Y	Y	N	N	N	Y				
	High	--	--	--	--	N	N	N	N	N	N	N	N	N	N	Y	Y	N	N	N	Y				
Behavioral Health All Other	Low	--	--	--	N	N	N	N	N	N	N	N	N	N	N	N	N	N	Y	Y	N				
	Medium	--	--	--	--	N	N	N	N	N	N	N	N	N	N	N	N	N	Y	Y	N				
	High	--	--	--	--	N	N	N	N	N	N	N	Y	Y	Y	Y	Y	Y	N	N	N				
Dental - Children	Low																					N	N	N	N
	Medium																					Y	N	N	N
	High																					Y	Y	Y	Y
Dental - Adults	Low																					Y	Y	Y	Y
	Medium																					--	--	--	--
	High																					--	--	--	--
Pharmacy	Low	Y	Y	Y	Y	Y	Y	Y	Y	N	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				

Timeliness of Claims Adjudication by the MCOs

LDH requires that 99% of claims be adjudicated within 30 calendar days. An adjudicated claim could mean a decision to either pay or to deny. The measurement for turnaround time (TAT) for adjudication is the number of days from receipt of the claim by the MCO to the date on which the provider is paid or is notified that no payment will be made.

Exhibit III.7A below shows that the MCOs are meeting the target for adjudication within 30 days as set by LDH. In fact, the average TAT is below 11 days in every quarter for all MCOs. The TAT averages do vary, however, across the MCOs.

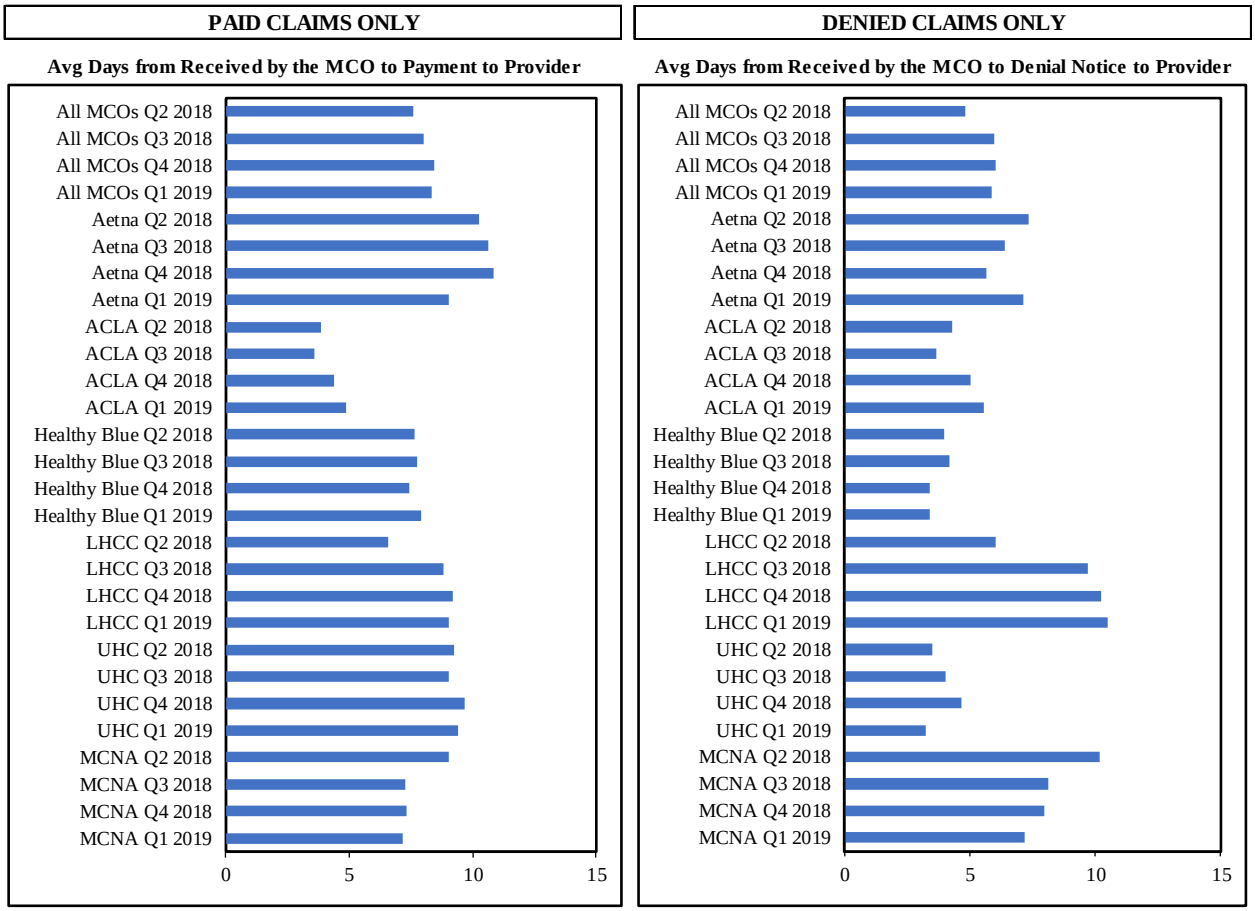
Exhibit III.7A
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
All Claim Types
By MCO and By Quarter

		Adjudicated Within 30 days		Avg Turnaround Time	
		Pct of Paid	Pct of Denied	Paid Claims	Denied Claims
Aetna	Q2 18	99.5%	99.4%	10.3	7.4
	Q3 18	99.4%	99.4%	10.7	6.4
	Q4 18	99.8%	99.6%	10.8	10.8
	Q1 19	99.2%	98.8%	9.0	7.1
ACLA	Q2 18	100.0%	99.9%	3.9	4.3
	Q3 18	100.0%	99.9%	3.6	3.7
	Q4 18	100.0%	100.0%	4.4	5.0
	Q1 19	100.0%	99.9%	4.9	5.6
HealthyBlue	Q2 18	99.9%	99.8%	7.6	4.0
	Q3 18	99.9%	99.7%	7.8	4.2
	Q4 18	99.9%	99.8%	7.4	3.4
	Q1 19	99.6%	99.5%	7.9	3.4
LHCC	Q2 18	99.6%	98.8%	6.6	6.0
	Q3 18	99.8%	99.5%	8.8	9.7
	Q4 18	99.7%	98.9%	9.2	10.2
	Q1 19	99.7%	99.1%	9.0	10.5
UHC	Q2 18	100.0%	99.8%	9.2	3.5
	Q3 18	99.8%	99.3%	9.0	4.0
	Q4 18	99.1%	98.5%	9.7	4.6
	Q1 19	100.0%	99.9%	9.4	3.2
MCNA	Q2 18	100.0%	100.0%	9.0	10.2
	Q3 18	100.0%	100.0%	7.3	8.1
	Q4 18	100.0%	100.0%	7.3	7.9
	Q1 19	100.0%	100.0%	7.1	7.2

Exhibit III.7B below compares the TAT between paid claims and denied claims for each MCO by quarter. The overall TAT for paid claims, all MCOs combined, is between 7.6 and 8.4 days in each quarter. For denied claims, the average is between 4.8 and 6.0 days.

There is variation between the MCOs on these statistics. The lowest TAT for paid claims was reported by ACLA (between 3.6 and 4.9 days each quarter). The highest TAT was reported by Aetna (between 9.0 and 10.8 days each quarter). The UHC average is closer to 9 days each quarter, while HealthyBlue, LHCC and MCNA are closer to an average of 8 days. For denied claims, ACLA, HealthyBlue and UHC are similar with average TAT rates near 4 days. Aetna's average varied between 5 and 7 days across the quarters as did LHCC's (6 to 10 days) and MCNA's (7 to 10 days).

Exhibit III.7B
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
All Claim Types
By MCO and By Quarter



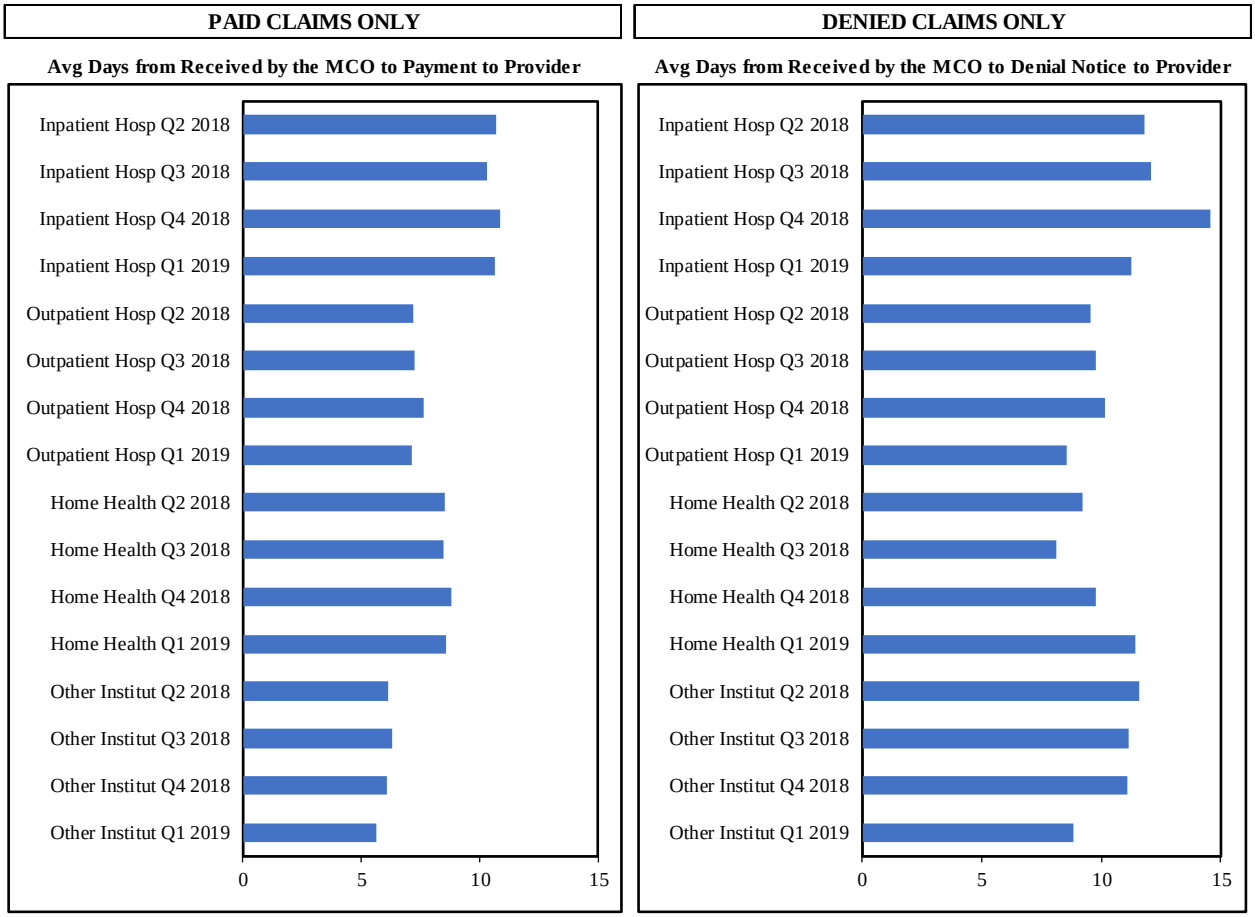
The TAT is influenced in large part by the type of service being delivered and the volume for that service. In other words, a service with a low turnaround time (e.g., pharmacy) can influence the MCO's overall average TAT due to the higher volume of pharmacy claims.

Because of this, the TAT trends were also examined at the provider type level. The same categories shown here are the providers shown earlier in this section measuring the rate of paid and denied claims.

Exhibits III.8A, III.8B and III.8C on the following pages break out the TAT trends by provider type in Q1 2019. Exhibit III.8A shows the providers that bill on the institutional, or 837I, claim type. Exhibit III.8B shows the providers that bill on the professional, or 837P, claim type. Exhibit III.8C shows specialized providers such as behavioral health, dental and pharmacy.

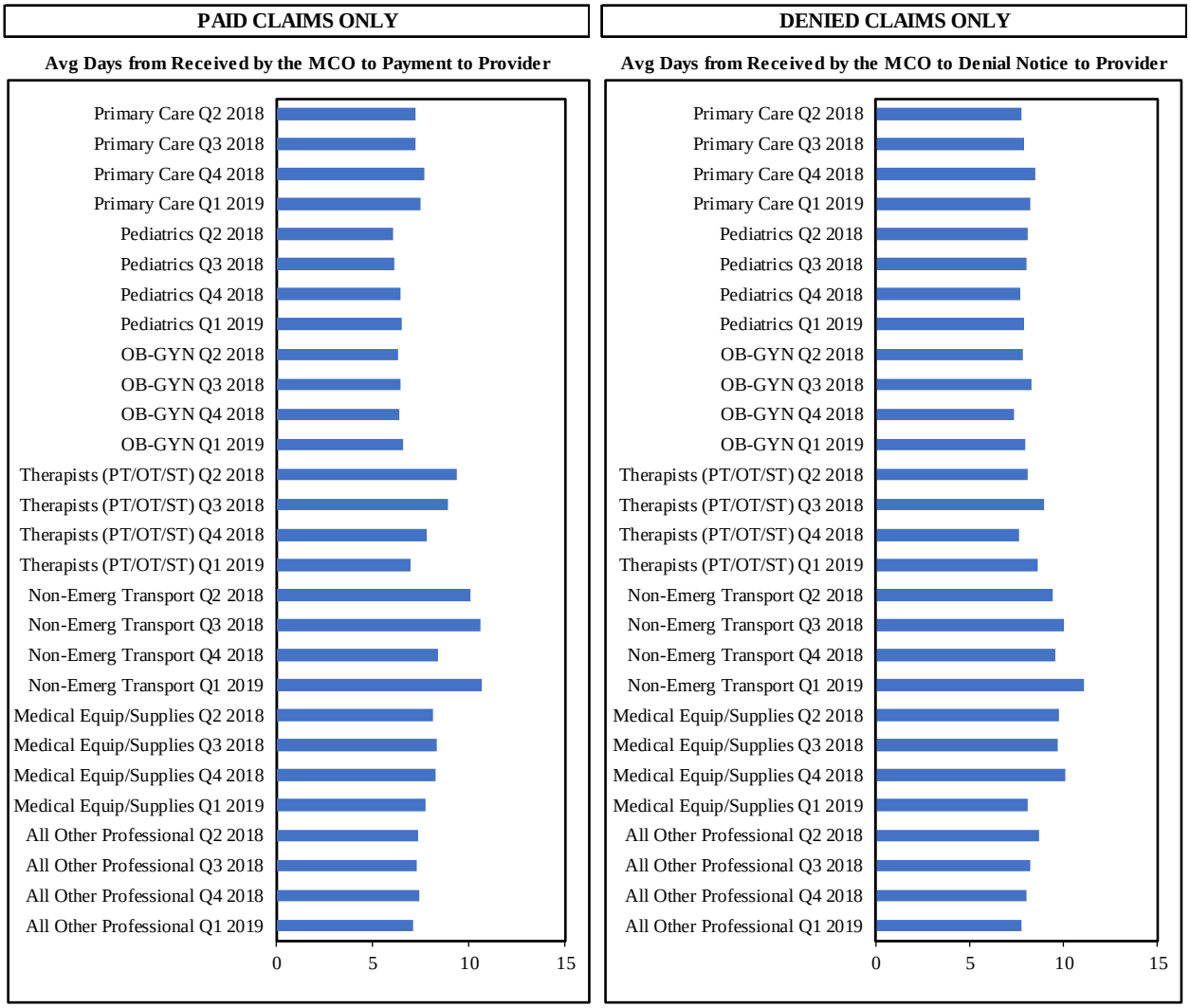
In Exhibit III.8A below, it was found that the TAT is highest for inpatient hospital services compared to other institutional provider services. For inpatient, the average TAT is near 10.6 days each quarter for paid claims and 12.4 days for denied claims. For outpatient services, the average TAT is closer to 7.3 days for paid claims and 9.5 days for denied claims. The volume is much lower for home health services where the average TAT is close to 8.6 days for paid claims and 9.6 days for denied claims. For other institutional providers, the average TAT is near 6.0 days for paid claims and 10.7 days for denied claims.

Exhibit III.8A
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
Institutional Providers
By All MCOs Combined By Quarter



Among the seven professional service provider type categories examined, the average TAT did not change significantly across the four quarters examined. Further, the average TAT does not vary significantly across the provider types. The lowest average TAT for paid claims was for pediatrics and OB-GYN (average 6.3 days across the quarters) and the highest was for non-emergency transportation (average 9.9 days across the quarters). The average TAT is similar for denied claims within a provider type to what was found for paid claims, or it may be slightly higher by one to two days.

Exhibit III.8B
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
Professional Service Providers
By All MCOs Combined By Quarter

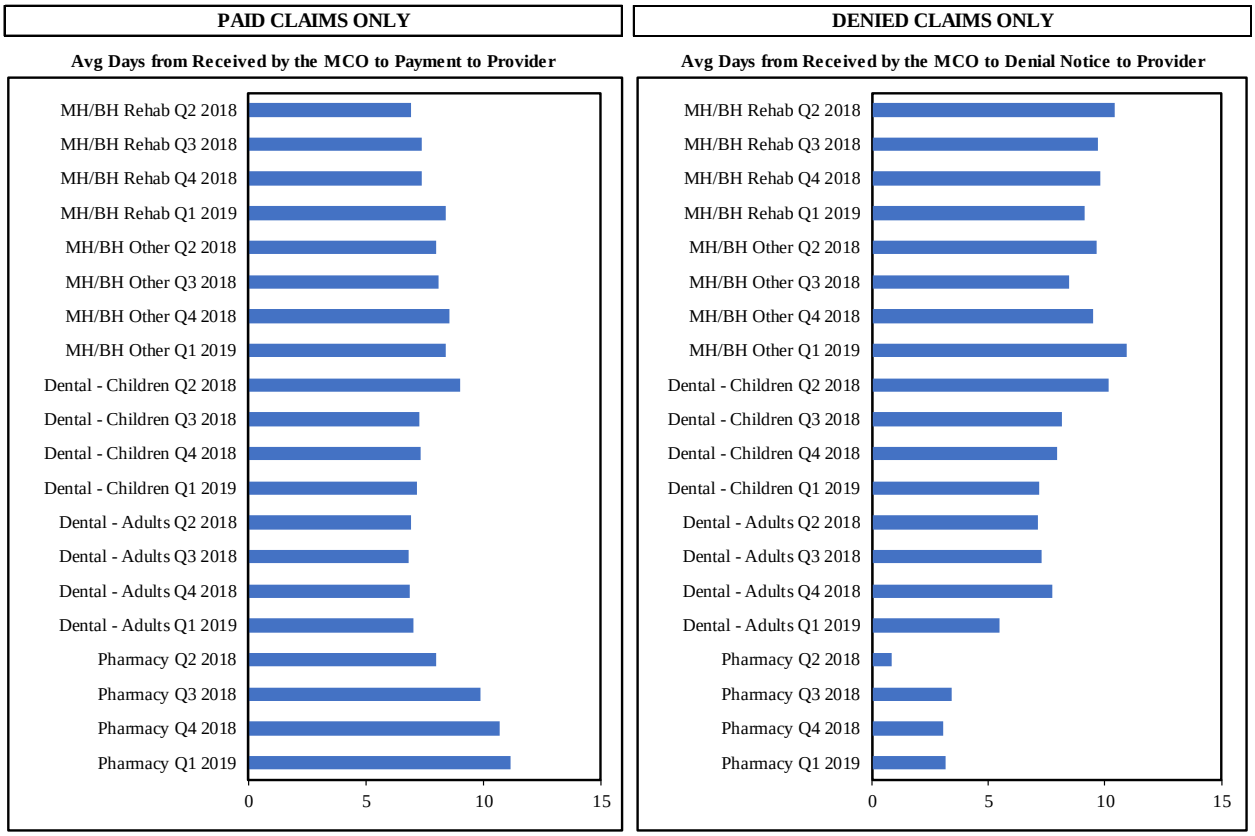


The average TAT for behavioral health and dental services follow similar patterns to what was found for professional services. The average TAT for paid claims for mental health rehab services was near 7.5 days each quarter. For non-rehab services, the average TAT was near 8.3 days each quarter. For both of these services, the average TAT for denied claims is one to three days greater than the average TAT for paid claims.

The findings for dental services are similar for children and adults because MCNA is adjudicating both sets of these service claims. The average TAT is seven days in the latest three quarters for both paid claims and denied claims. Q2 2018 had a slightly higher TAT.

The range in the average TAT for paid pharmacy claims was between 8.0 and 11.1 days across the four quarters. The average TAT reported by the MCOs for denied pharmacy claims was closer to three days in the most recent three quarters.

Exhibit III.8C
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
Mental Health/Behavioral Health (MH/BH), Dental and Pharmacy
By All MCOs Combined By Quarter



The exhibits on the next four pages further break down the paid and denied average TATs, but in these exhibits the breakdown is for each provider type by each of the MCOs. The purpose of these exhibits is to determine if the TAT is consistent across MCOs or if it varies.

Exhibit III.9A correlates with the information shown in Exhibit III.8A (institutional providers). Because of the number of provider types, Exhibits III.9B and III.9C correlate with the information shown in Exhibit III.8B (professional providers). Exhibit III.9D correlates with the information shown in Exhibit III.8C (behavioral health, dental, pharmacy).

The key findings from all four exhibits appearing on pages III-20 through III-23 are summarized here for convenience:

Provider Category	**Lowest Value, TAT Paid Claims**	**MCO with Lowest TAT, Paid**	**Highest Value, TAT Paid Claims**	**MCO with Highest TAT, Paid**	**Highest Value, TAT Denied**	**MCO with Highest TAT, Denied**
Inpatient Hospital	7.5	HealthyBlue	19.6	Aetna	13.3	Aetna
Outpatient Hospital	4.1	ACLA	9.0	Aetna	10.3	LHCC
Home Health	5.1	ACLA	10.2	Aetna, LHCC	16.5	Aetna
Other Institutional (only 1% of all institutional claims)	4.6	HealthyBlue	11.3	Aetna	12.8	UHC
Primary Care	3.7	ACLA	8.2	UHC	9.9	LHCC
Pediatrics	3.7	ACLA	8.9	Aetna	10.4	Aetna
OB-GYN	3.7	ACLA	7.9	UHC	10.1	Aetna
Therapists	4.9	ACLA	9.9	Aetna	11.8	Aetna
Non-emergency Transportation	9.2	ACLA	11.4	HealthyBlue	17.8	Aetna
Medical Equipment and Supplies	4.8	ACLA	9.1	Aetna	11.0	Aetna
Other Professional	4.6	ACLA	8.2	LHCC	9.4	LHCC
Behavioral Health Rehab	5.6	ACLA	9.2	HealthyBlue	11.0	ACLA
Behavioral Health Other	4.3	ACLA	10.7	UHC	15.5	LHCC
Dental – Children	7.1	MCNA	7.1	MCNA	7.2	MCNA
Dental – Adult	7.4	MCNA	7.4	MCNA	7.1	MCNA
Pharmacy	5.9	ACLA	13.6	HealthyBlue	11.2	LHCC

Exhibit III.9A
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
By Provider Specialty - Institutional Providers
By MCO for Q1 2019 Adjudicated Claims

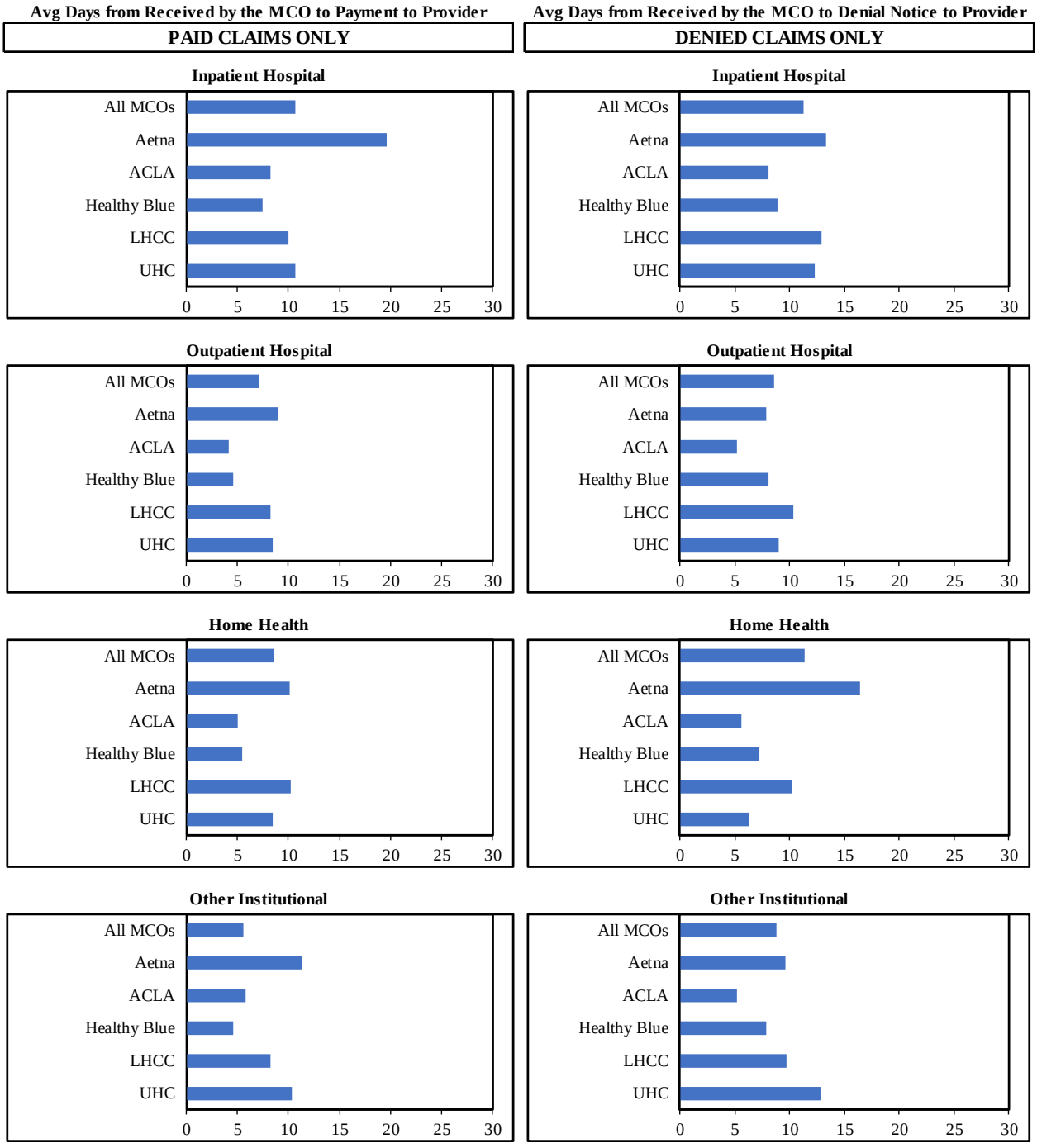


Exhibit III.9B
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
By Provider Specialty - Professional Providers, Part 1
By MCO for Q1 2019 Adjudicated Claims

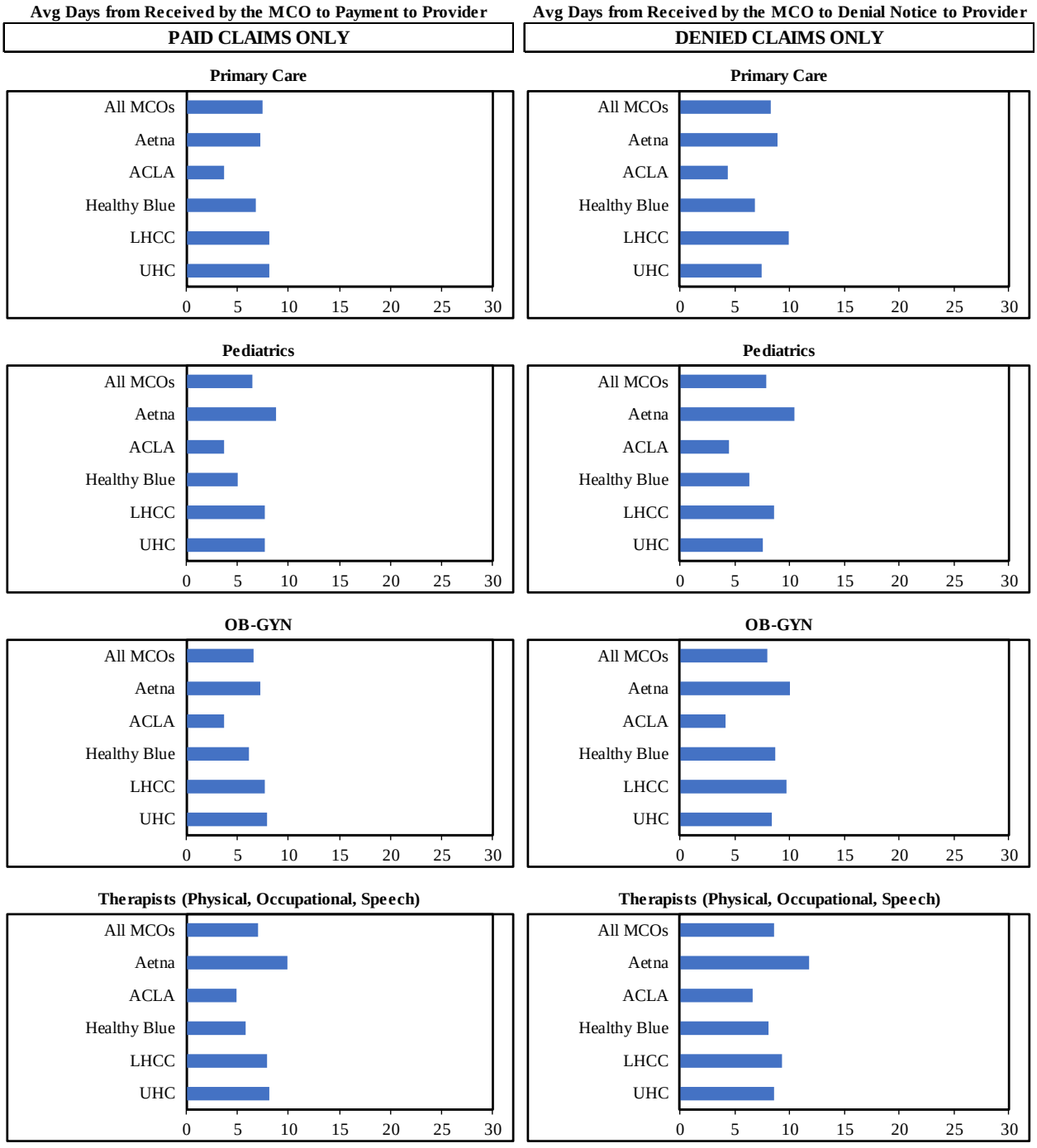


Exhibit III.9C
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
By Provider Specialty - Professional Providers, Part 2
By MCO for Q1 2019 Adjudicated Claims

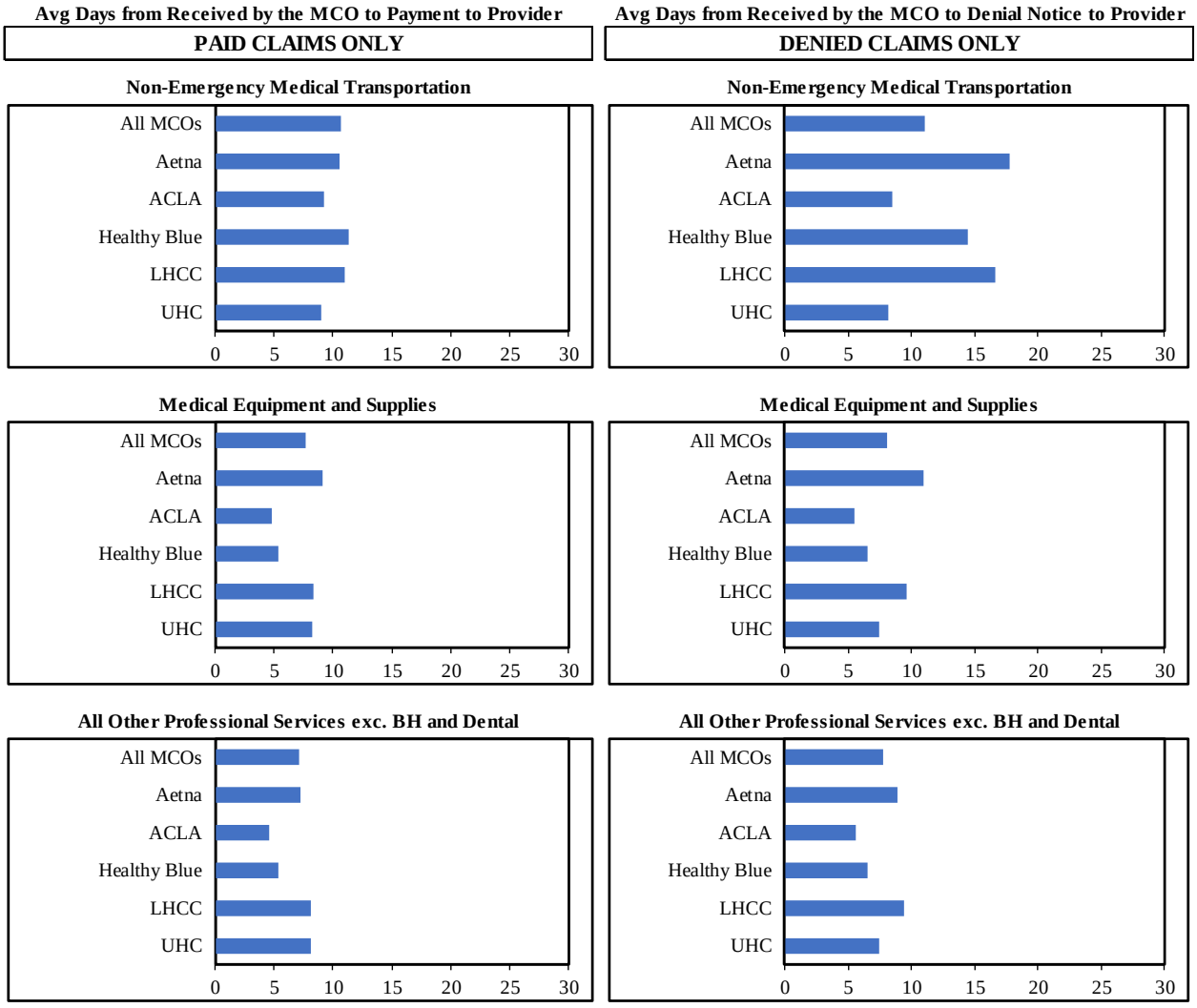
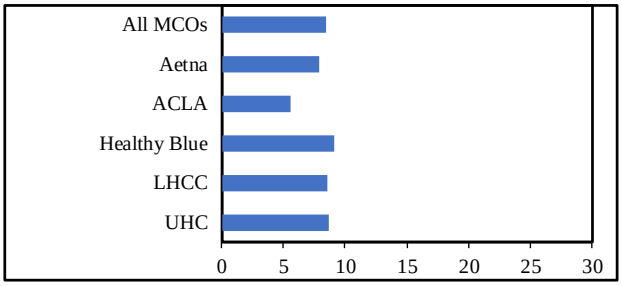
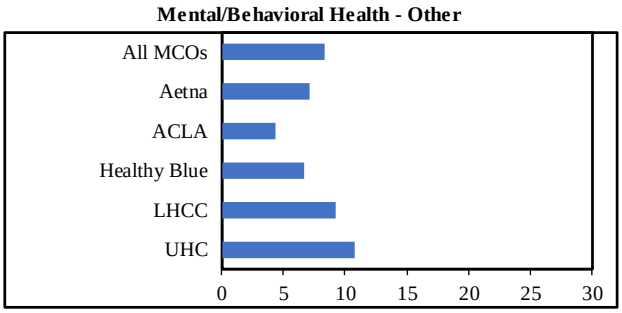
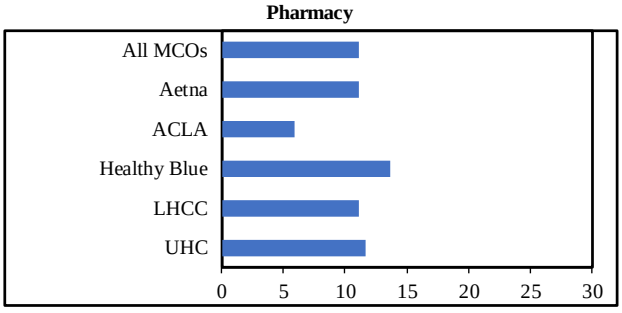


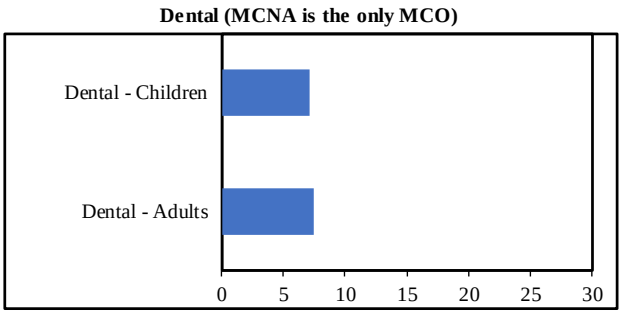
Exhibit III.9D
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
By Provider Specialty - Behavioral Health, Dental and Pharmacy
By MCO for Q1 2019 Adjudicated Claims

Avg Days from Received by the MCO to Payment to Provider
PAID CLAIMS ONLY

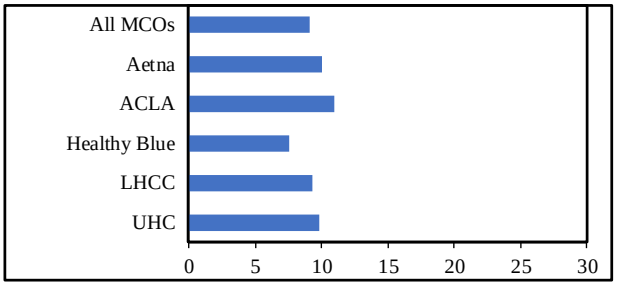


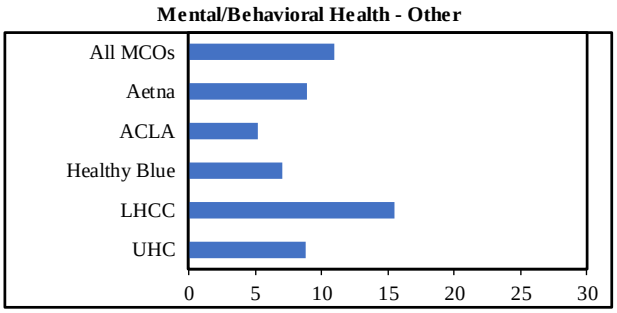


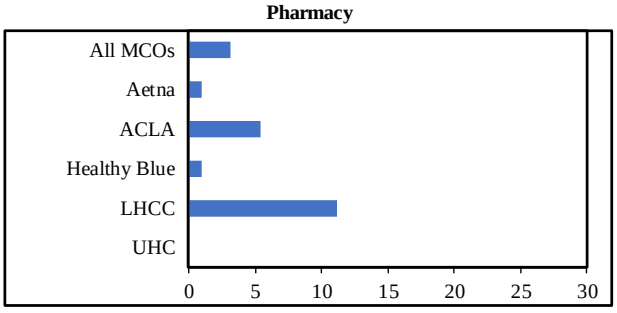


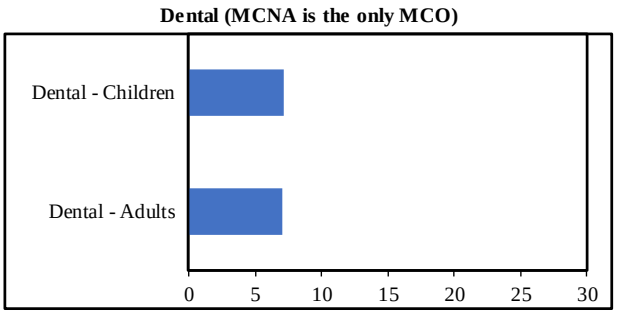


Avg Days from Received by the MCO to Denial Notice to Provider
DENIED CLAIMS ONLY









Reasons for Claim Denials by the MCOs

As stated in Section I, 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. For medical and dental claims, there is a set of nationally-recognized Claim Adjustment Reason Codes (*CARCs*), about 280 reason codes in all. For pharmacy claims specifically, there are nearly 350 reason codes developed by the *NCPDP*.

The MCOs 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 MCO for claims adjudicated in the 1st Quarter of CY 2019.

Exhibit III.10 shows the top 10 CARCs for medical claims across all MCOs and the top 10 NCPDP codes for pharmacy claims across all MCOs. If one of the top CARCs across all MCOs was also a top 5 CARC within an MCO, the rank number is noted. Some key findings on CARCs appear below:

- In Q1 2019, all of ACLA's, LHCC's and UHC's top 5 CARC codes were also in the top 10 for All MCOs. Four of Aetna's top 5 CARCs were in the All MCO top 10. MCNA had three of its top 5 in the All MCO top 10. HealthyBlue only had two of its top 5 CARCs in the All MCO top 10.
- The top five CARCs in the 1st Quarter 2019 included the following:
    - 16: The claim lacks information or has a billing error which is needed for adjudication.
    - 197: Precertification or authorization absent when it is required.
    - 96: Non-covered charge.
    - 18: Exact duplicate claim.
    - B7: This provider was not eligible to be paid for this procedure/service on this date.
- These five CARCs were also among the top seven in the previous three quarters reported. CARCs 16, 197 and 96 have been the top three reported for three quarters in a row.

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

- In Q1 2019, the top 5 NCPDP codes for each MCO were also in the top 10 for All MCOs with the exception of ACLA which had two of its top five codes represented in the top 10 overall.
- The top five NCPDPs in the 1st Quarter 2019 included the following:
    - 79: Refill too soon.
    - 76: Plan limitations exceeded.
    - 88: DUR reject error.
    - 7O: Product/service not covered – plan/benefit exclusion.
    - 75: Prior authorization required.
- Four of these five NCPDPs were also among the top four in the previous three quarters reported. NCPDP 75 is new to the top five in Q1 2019. It was ranked 10th highest in two recent quarters.

Exhibit III.10
Details on Reasons for Denied Claims
By MCO for Q1 2019 Adjudicated Claims

For Medical Claims

CARC	Description	Rank Among All MCOs	Ranking for Individual MCO: Aetna	ACLA	Healthy Blue	LHCC	UHC	MCNA
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	1	1	3		3		
197	Precertification/authorization/notification absent.	2		2	1	1	5	
96	Non-covered charge(s).	3	5	4		2	2	3
18	Exact duplicate claim/service	4	3			4	4	2
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	5		1				
252	An attachment/other documentation is required to adjudicate this claim/service.	6		5	3		3	
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	7	4				1	
22	This care may be covered by another payer per coordination of benefits.	8				5		
204	This service/equipment/drug is not covered under the patient's current benefit plan	9						
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has bee	10						

For Pharmacy Claims

NCPDP	Description	Rank Among All MCOs	Ranking for Individual MCO: Aetna	ACLA	Healthy Blue	LHCC	UHC
79	Refill Too Soon	1	1		2	2	4
76	Plan Limitations Exceeded	2	3		4	1	2
88	DUR Reject Error	3			3		1
7Ø	Product/Service Not Covered – Plan/Benefit Exclusion	4	2			3	3
75	Prior Authorization Required	5	5	2	5		5
MR	Product Not On Formulary	6			1		
39	Missing/Invalid Diagnosis Code	7		4		4	
19	Missing/Invalid Days Supply	8				5	
69	Filled After Coverage Terminated	9	4				
41	Submit Bill To Other Processor Or Primary Payer	10					

The previous exhibit showed that the top ten denial CARCs are consistent across quarters and were often the top CARCs for each MCO as well. The top five CARCs for each MCO 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.11 shows the results when the top CARCs are distributed by provider type for each MCO for claims adjudicated in the 1st Quarter of 2019. Key findings from the exhibit are shown below:

- For Aetna, four of its five CARCs overall were also observed for almost every provider category as well. One CARC (147, Provider contracted/negotiated rate expired or not on file) was only present for selected provider types.

- For ACLA, three of its five CARCs overall were also observed for almost every provider category as well. Two CARCs were only present for selected provider types (B7, Provider not eligible to be paid on this date of service and 252, An attachment/other documentation is required to adjudicate this claim).

- For HealthyBlue, three of its five CARCs overall were also observed for almost every provider category as well. Two CARCs were only present for selected provider types (119, Benefit maximum for this time period or occurrence has been reached and 222, Exceeds the contracted maximum number of hours/days/units by this provider for this service).

- For LHCC, three of its five CARCs overall were also observed for almost every provider category as well. Two CARC was only present for selected provider types (197, Precertification or authorization absent and 22, This care may be covered by another payer per coordination of benefits).

- For UHC, three of its five CARCs overall were also observed for almost every provider category as well. Two CARCs were only present for selected provider types (197, Precertification or authorization absent and 97, The benefit for this service is included in the payment/allowance for another service/procedure).

- For MCNA, all five of its CARCs overall are the same as its provider base because MCNA's provider base only includes dental providers.

The findings described above were also found in the 4th Quarter 2018 reports with the exception of LHCC.

Exhibit III.11
Details on Reasons for Denied Medical Claims
By MCO and By Provider Category for Q1 2019 Adjudicated Claims

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

CARC	Description	Inpatient Hospital	Outpatient Hospital	Home Health	Other Institutional	Primary Care	Pediatrics	OB-GYN	Therapists	Non-Emerg Transport	Medical Equipment	Other Professional	Mental/Behavioral - Rehab	Mental/Behavioral - Other	Adult Dental	Pediatric Dental
Aetna																
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication	1	1	3	1	1	2	1	3	1	1	2	1	1		
147	Provider contracted/negotiated rate expired or not on file.		2	4	5	4	3	5		3						
18	Exact duplicate claim/service	3	5	1	2	5		3	1	3	3	1	2	3		
97	The benefit for this service is included in the payment/allowance for another service/procedure tha	4	4	2	2	5	5	4	2	3	4	4	3	5		
96	Non-covered charge(s).		3		4	2	1	2		3	5	3				
ACLA																
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service							3				1				
197	Precertification/authorization/notification absent.	4	4	2	3	3	2	1	1		1	3	3	1		
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication		2			2	4	4	4	1	3	2				
96	Non-covered charge(s).	2	1	1	1	1	1	2	2	5	2	4	5	3		
252	An attachment/other documentation is required to adjudicate this claim/service.		3					5	3	5			1	4		
Healthy Blue																
197	Precertification/authorization/notification absent.	3	3	3	1	2	3	4	2	3	2	1	2	1		
256	Service not payable per managed care contract.	5	2	1	3	1	1	2	1	3	1	2		5		
252	An attachment/other documentation is required to adjudicate this claim/service.	4	1	4	2	3	5	3	4	2	5	3	4	3		
119	Benefit maximum for this time period or occurrence has been reached.			5				5		3	5		3	4		
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period.		5	5						3	3	4	5	2		

Exhibit III.11 (continued)
Details on Reasons for Denied Medical Claims
By MCO and By Provider Category for Q1 2019 Adjudicated Claims

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

CARC	Description	Inpatient Hospital	Outpatient Hospital	Home Health	Other Institutional	Primary Care	Pediatrics	OB-GYN	Therapists	Non-Emerg Transport	Medical Equipment	Other Professional	Mental/Behavioral - Rehab	Mental/Behavioral - Other	Adult Dental	Pediatric Dental
LHCC																
197	Precertification/authorization/notification absent.	4		3	3				1	3	2	1	4	1		
96	Non-covered charge(s).	5	1		2	1	1	1		3	5	4				
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication	2	2	1	1	4		3	4	1	1	2	1	3		
18	Exact duplicate claim/service		4	2	5	3	3	2		3		3	3	2		
22	This care may be covered by another payer per coordination of benefits.		3			5			2	3						
United																
97	The benefit for this service is included in the payment/allowance for another service/procedure tha		3	4	4	4	1	2			1	1				
96	Non-covered charge(s).	5	2	4	1	1	2	1	1	3	2	2				
252	An attachment/other documentation is required to adjudicate this claim/service.		1		3	2	3	4	5	4	3	3		3		
18	Exact duplicate claim/service	4	5			3	4	3	4		4	5	2	2		
197	Precertification/authorization/notification absent.	3		2		5			3			4	3	1		
MCNA																
169	Alternate benefit has been provided.														1	
18	Exact duplicate claim/service														2	4
96	Non-covered charge(s).														4	1
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period.														3	
6	The procedure/revenue code is inconsistent with the patient's age.														5	

Provider Education Related to Claims Adjudication

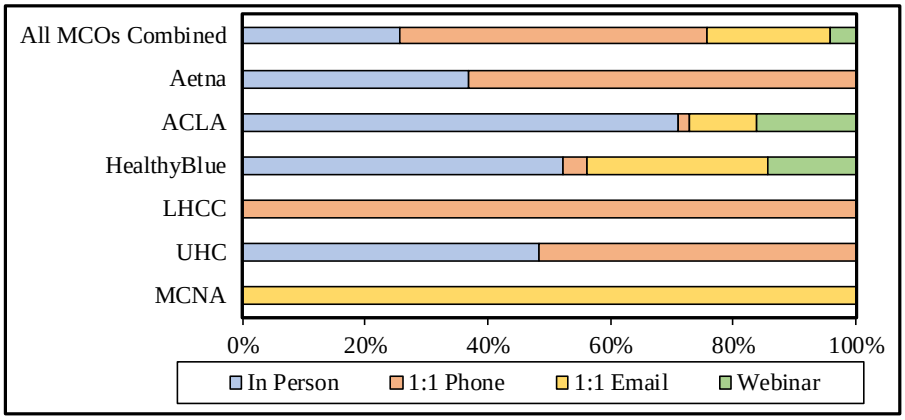
Because many of the denial reason codes have been consistent for some time, the LDH initiated specific reporting for MCO provider education with the release of the new reporting requirements pertaining to Act 710 in mid-February 2019. This report is the first time that results are being shown on provider education. Since the data collection on provider education has recently begun, it should be noted that the data presented is only for the second half of Q1 2019.

LDH is requesting that the MCOs 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 MCOs are reporting on the individual entity's outreached (name and TIN), whether it was the MCO or its contractor who conducted the outreach, the type of outreach, and the date that the outreach was conducted.

Exhibit III.12 begins to summarize this information for the last 6 weeks of the 1st Quarter of CY 2019. In all, 781 TINs were outreached to by the MCOs. This count represents the unique TINs and modes of communication. In some cases, the MCO reported that they conducted multiple outreach to the same TIN in the quarter (e.g. three emails over the course of 6 weeks). When this occurred, only one was counted below. It should also be noted, however, that the same TIN may be outreached to by multiple MCOs.

The most predominant mode to outreach to providers is by phone (50.1% of all contacts) followed by in person meetings (25.7% of contacts) then personalized emails (20.0% of contacts). Webinars represented 4.2% of all contacts.

Exhibit III.12
Provider Education Conducted by the MCOs on Claims Submissions
Activity in Q1 2019



	Modality of Outreach				
	In Person	**1:1 Phone**	**1:1 Email**	**Webinar**	**Total TINs**
All MCOs Combined	201	391	156	33	781
Aetna	21	36	0	0	57
ACLA	79	2	12	18	111
HealthyBlue	55	4	31	15	105
LHCC	0	300	0	0	300
UHC	46	49	0	0	95
MCNA	0	0	113	0	113

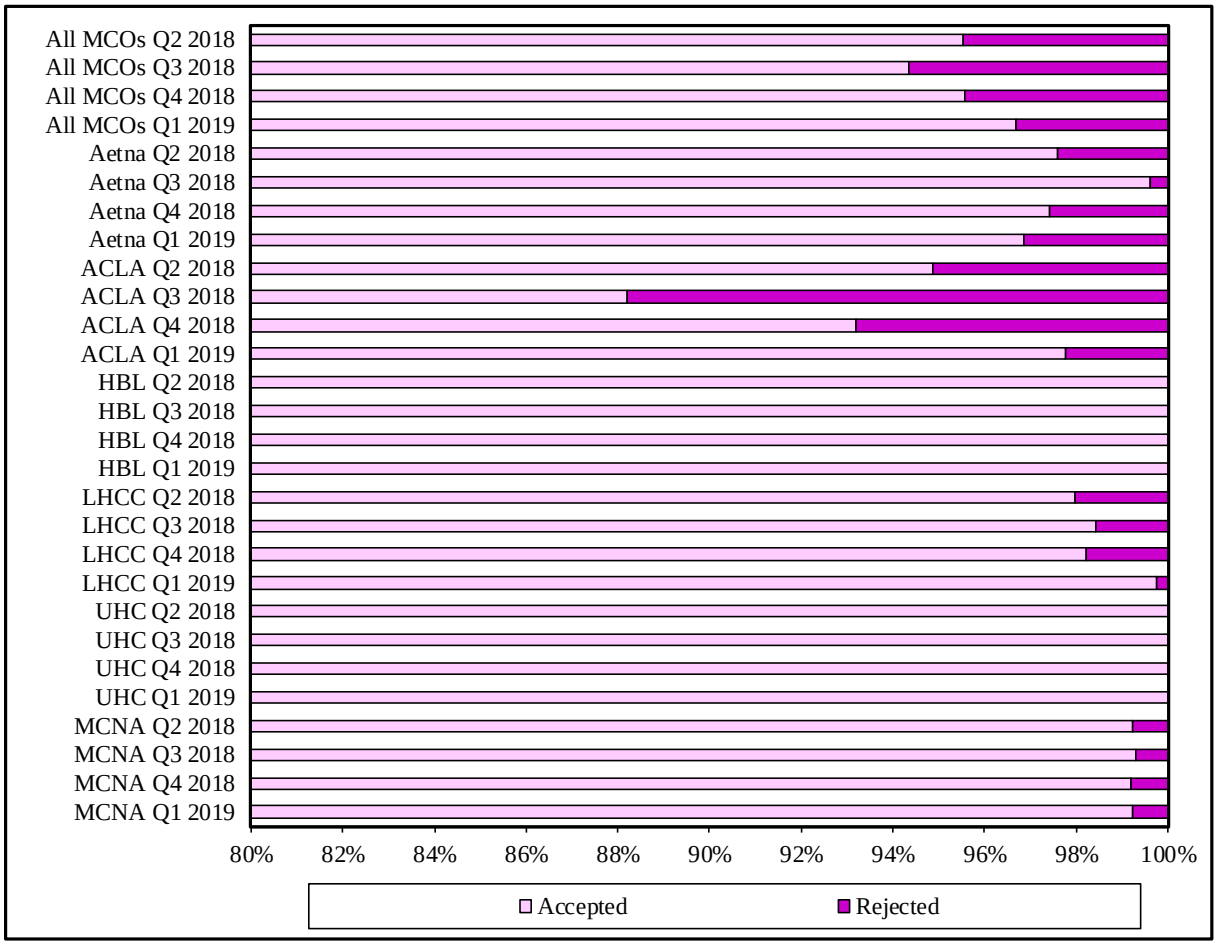
SECTION IV: FINDINGS RELATED TO MCO ENCOUNTER SUBMISSIONS TO LDH

The MCOs 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 MCO 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 MCOs.

MCO Encounters Accepted and Rejected by LDH

In the most recent four quarters studied, 97.2% to 99.3% of the encounters submitted by all MCOs combined were accepted by LDH. There were differences at the MCO level. All of HealthyBlue's and UHC's encounters were accepted. For MCNA, the acceptance rate was at least 99% every quarter; for LHCC, at least 98%. Aetna had a minimum of 96% of its encounters accepted every quarter, but ACLA had varying acceptance rates between 88% and 98% in the last four quarters.

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



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

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

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

- ACLA's lower encounter acceptance rate overall was due to institutional and pharmacy encounters but not professional encounters.

- When Aetna had lower encounter acceptance rates than its peers, it was also due to institutional and pharmacy encounters.

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

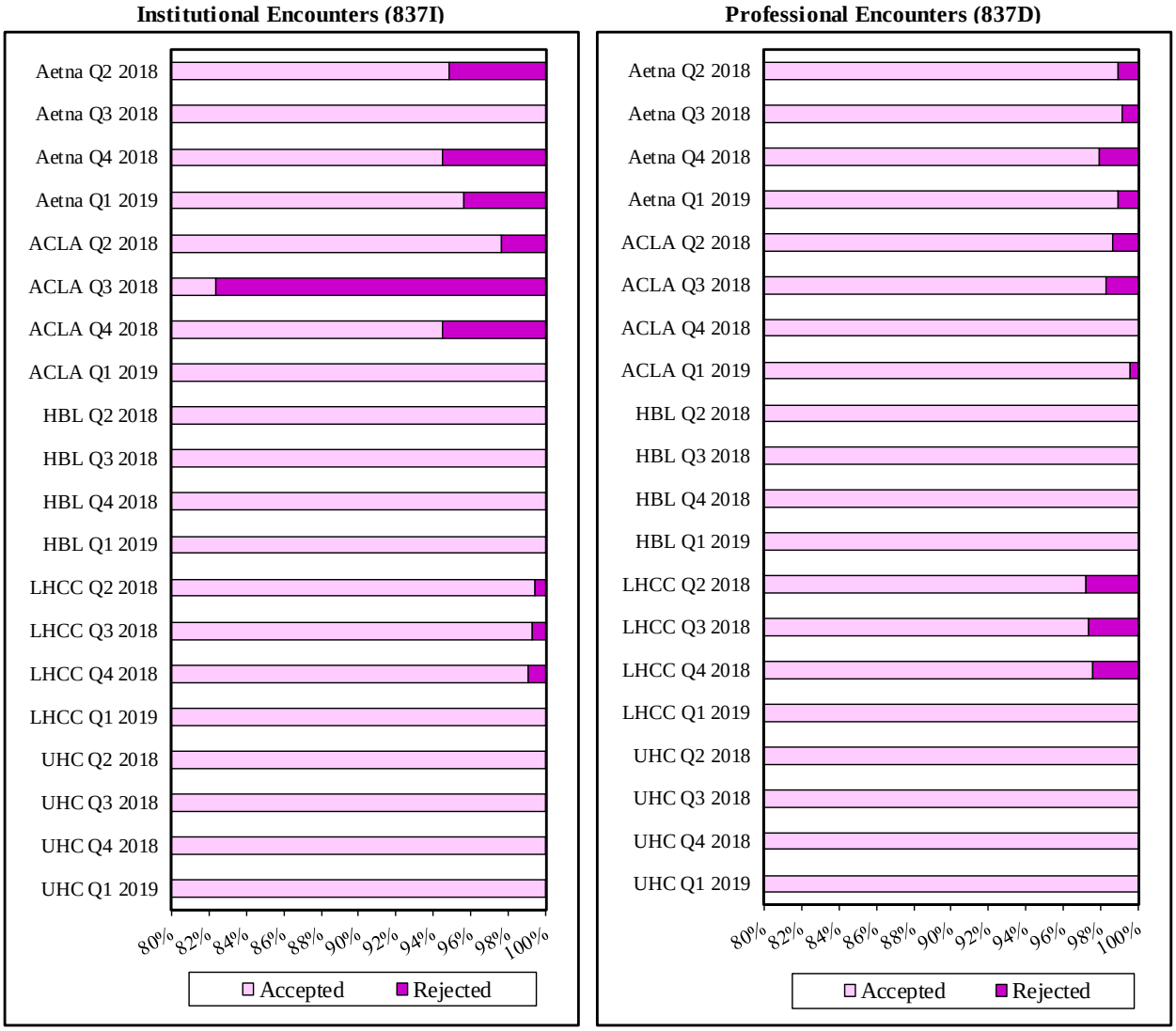
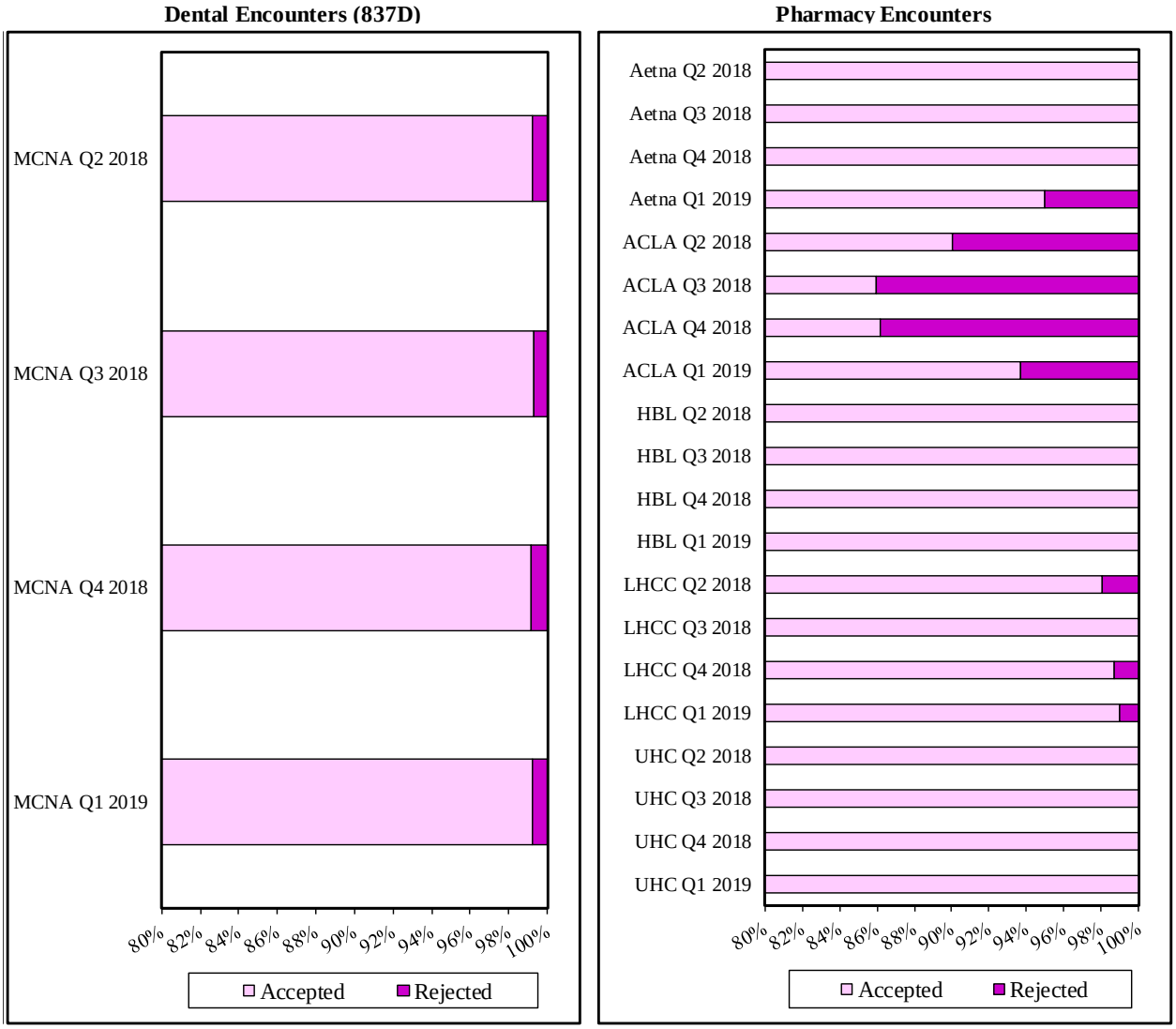


Exhibit IV.3
Encounter Submissions Accepted and Rejected by LDH
Dental and Pharmacy Claim Types
By MCO and By Quarter



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 MCO 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 MCO 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 Exhibits IV.4 and IV.5 on the next two pages track the average TAT by MCO, by quarter and by claim type. A common benchmark used is that MCOs 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:

- When the encounters are accepted by LDH, HealthyBlue has the highest percentage submitted within 30 days. Almost 100% were submitted within 30 days for professional and pharmacy encounters while all institutional encounters were submitted within 30 days.

- UHC has the second highest TAT among the MCOs. Almost 99% of their institutional encounters were submitted within 30 days in each of the four quarters reported here. For professional, the submissions within 30 days have been 95% or better in the most recent three quarters. For pharmacy, the submissions within 30 days have been 98% or better in the most recent three quarters.

- LHCC had encounter submission rates within 30 days similar to what UHC had reported for three of the four quarters reported here. But in the most recent quarter (Q1 2019), the submission rate within 30 days decreased for every claim type.

- Aetna has had a mixed record for submitting encounters within 30 days. There have been improvements in the last two quarters for institutional encounters, but the opposite is true for pharmacy. The submission rate for professional encounters has been consistent.

- ACLA has had some challenges with meeting an average 30-day TAT for institutional encounters in Q3 and pharmacy encounters in the most recent two quarters. The submission of professional encounters has not been an issue, however.

- MCNA has few issues meeting an average 30-day TAT for its dental encounters.

Exhibit IV.4
Turnaround Time for Encounter Submissions Accepted by LDH
(within 30 days or more than 30 days from MCO adjudication)
Institutional and Professional Claim Types
By MCO and By Quarter

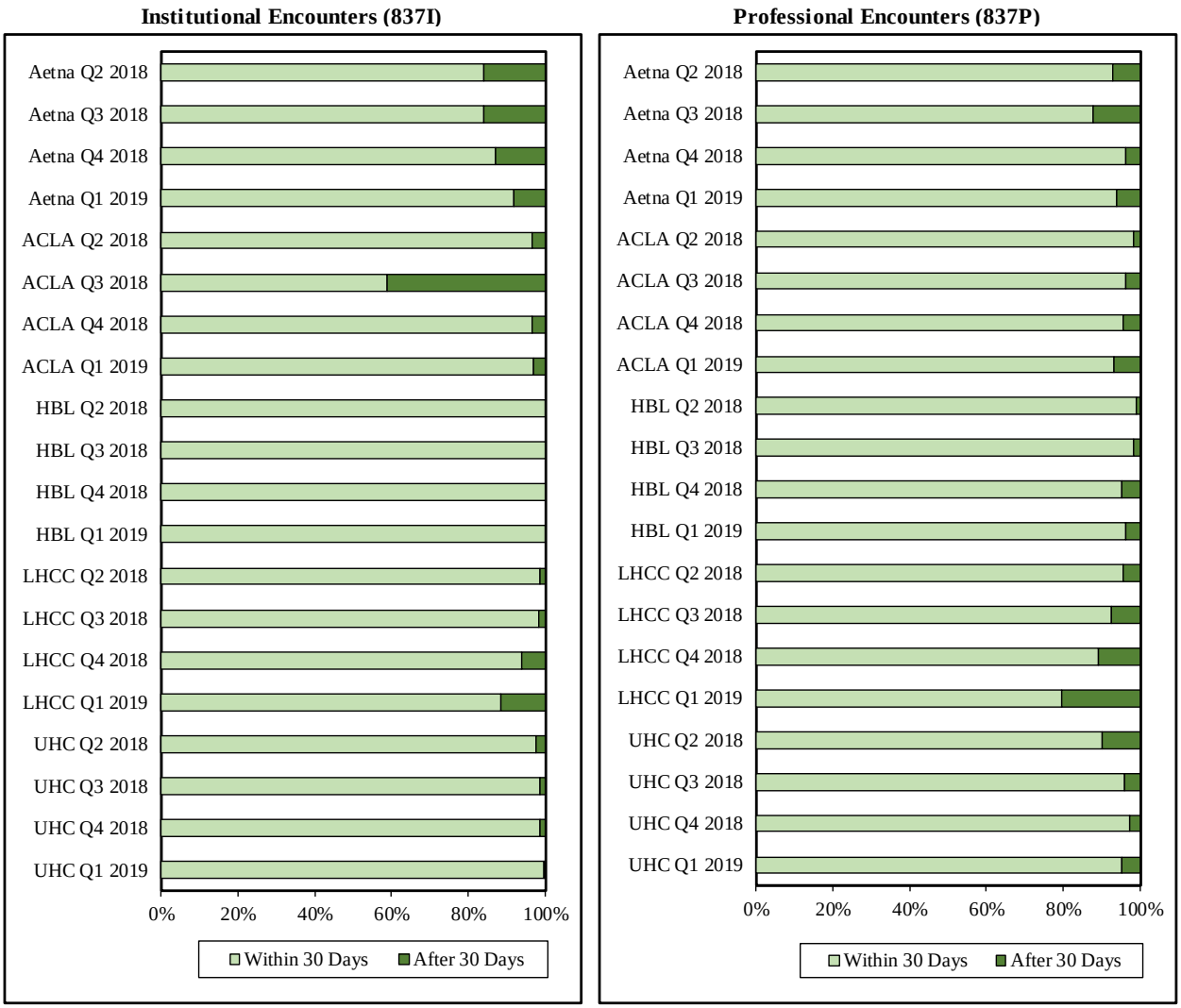
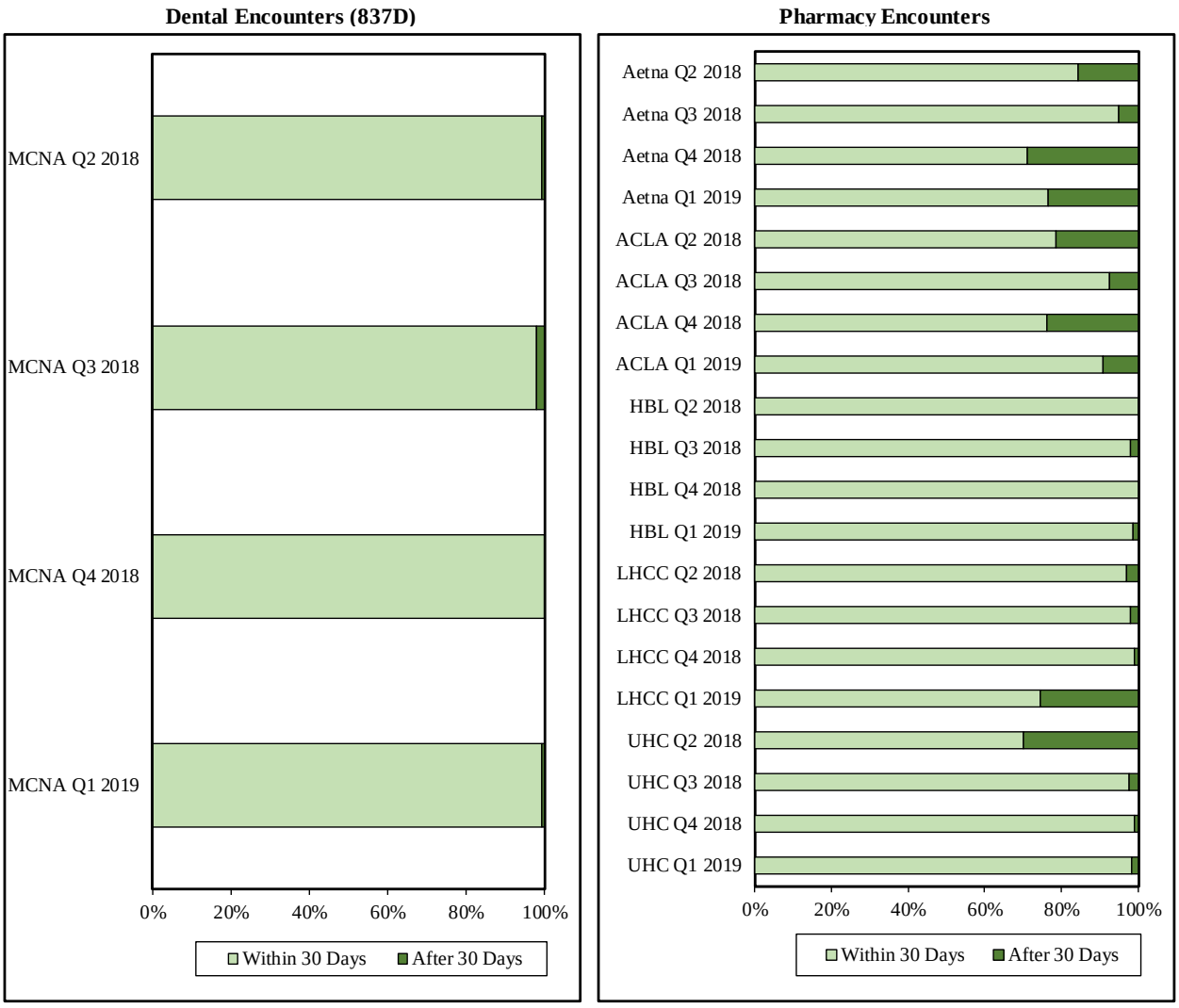


Exhibit IV.5
Turnaround Time for Encounter Submissions Accepted by LDH
(within 30 days or more than 30 days from MCO adjudication)
Dental and Pharmacy Claim Types
By MCO and By Quarter



APPENDIX A
Map of LDH Provider Types/Specialties to the Provider Categories in this Report

Provider Type Categories	Claim Form	Claim Type	Billing Provider Type/Specialty PT=Provider Type PS=Provider Specialty	Reporting Level	Notes
Inpatient Hospital	UB-04/837-I	01		Header	Include Distinct Part Psych, Freestanding Psych, and Freestanding Rehab hospitals here.
Outpatient Hospital	UB-04/837-I	03		Detail	
Home Health	UB-04/837-I	06		Detail	
All Other - UB-04/837-I	UB-04/837-I	Any Other		Detail	Only include claims billed on claim form UB-04/837-I and has any other CT, PT and/or PS **not already listed in the above UB-04/837-I categories**. This category should not include any claims with CT 01, 03 or 06.
MHR/BHR	CMS-1500/837-P	04	MHR- PT= 77 AND PS= 78 BHR- PT= AG AND PS= 8E	Detail	
All Other Specialized Behavioral Health - Not MHR/BHR	CMS-1500/837-P	04	**See Appendix AD of MCO SCG for PT/PS**	Detail	Do not include MHR/BHR claims in this category.
Primary Care Services - Excluding Pediatricians (Primary Care)	CMS-1500/837-P	04	PS= 01, 08, 41, 42, 79, 94	Detail	Do not include Pediatricians (Primary Care) claims in this category
Pediatricians (Primary Care)	CMS-1500/837-P	04	PS= 37	Detail	
OB-GYN & MFM	CMS-1500/837-P	04	PS= 09, 15, 16, 3C	Detail	
Therapies (PT/OT/ST)	CMS-1500/837-P	04	PS= 65, 71, 74	Detail	
NEMT & NEAT	CMS-1500/837-P	08		Detail	
Medical Equipment / Supplies	CMS-1500/837-P	09		Detail	
All Other CMS-1500	CMS-1500/837-P	Any Other	Any other claim type 04, or other claim type/PT/PS combinations NOT already listed for claim form CMS-1500/837-P	Detail	
Pharmacy[1]	NCPDP	12		Detail	
Dental - EPSDT	ADA/837-D	10		Detail	
Dental - Adult	ADA/837-D	11		Detail	

[1]Pharmacy provider type category should be based off of the prescribing provider's NPI, not the pharmacy's NPI.

APPENDIX B

List of All Claim Adjustment Reason Codes (CARCs)

Active Codes January 1, 2017 - Present

Rows in yellow indicate CARCs that have been deactivated in CY2017 or CY2018 but kept in this list to account for claims processing lag.

CARC	CARC Description
1	Deductible Amount
2	Coinsurance Amount
3	Co-payment Amount
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.
5	The procedure code/bill type is inconsistent with the place of service.
6	The procedure/revenue code is inconsistent with the patient's age.
7	The procedure/revenue code is inconsistent with the patient's gender.
8	The procedure code is inconsistent with the provider type/specialty (taxonomy).
9	The diagnosis is inconsistent with the patient's age.
10	The diagnosis is inconsistent with the patient's gender.
11	The diagnosis is inconsistent with the procedure.
12	The diagnosis is inconsistent with the provider type.
13	The date of death precedes the date of service.
14	The date of birth follows the date of service.
15	The authorization number is missing, invalid, or does not apply to the billed services or provider.
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
18	Exact duplicate claim/service
19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.
20	This injury/illness is covered by the liability carrier.
21	This injury/illness is the liability of the no-fault carrier.
22	This care may be covered by another payer per coordination of benefits.
23	The impact of prior payer(s) adjudication including payments and/or adjustments.
24	Charges are covered under a capitation agreement/managed care plan.
26	Expenses incurred prior to coverage.
27	Expenses incurred after coverage terminated.
29	The time limit for filing has expired.
31	Patient cannot be identified as our insured.
32	Our records indicate that this dependent is not an eligible dependent as defined.
33	Insured has no dependent coverage.
34	Insured has no coverage for newborns.
35	Lifetime benefit maximum has been reached.
39	Services denied at the time authorization/pre-certification was requested.
40	Charges do not meet qualifications for emergent/urgent care.
44	Prompt-pay discount.
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
49	This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam.
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.
51	These are non-covered services because this is a pre-existing condition.
53	Services by an immediate relative or a member of the same household are not covered.
54	Multiple physicians/assistants are not covered in this case.
55	Procedure/treatment/drug is deemed experimental/investigational by the payer.
56	Procedure/treatment has not been deemed 'proven to be effective' by the payer.
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)
60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.
61	Penalty for failure to obtain second surgical opinion.
66	Blood Deductible.
69	Day outlier amount.
70	Cost outlier - Adjustment to compensate for additional costs.
74	Indirect Medical Education Adjustment.
75	Direct Medical Education Adjustment.
76	Disproportionate Share Adjustment.
78	Non-Covered days/Room charge adjustment.
85	Patient Interest Adjustment
89	Professional fees removed from charges.
90	Ingredient cost adjustment. Note: To be used for pharmaceuticals only.
91	Dispensing fee adjustment.
94	Processed in Excess of charges.
95	Plan procedures not followed.
96	Non-covered charge(s). At least one Remark Code must be provided.
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
100	Payment made to patient/insured/responsible party/employer.
101	Predetermination: anticipated payment upon completion of services or claim adjudication.
102	Major Medical Adjustment.
103	Provider promotional discount (e.g., Senior citizen discount).
104	Managed care withholding.

APPENDIX B

List of All Claim Adjustment Reason Codes (CARCs)

Active Codes January 1, 2017 - Present

Rows in yellow indicate CARCs that have been deactivated in CY2017 or CY2018 but kept in this list to account for claims processing lag.

CARC	CARC Description
105	Tax withholding.
106	Patient payment option/election not in effect.
107	The related or qualifying claim/service was not identified on this claim.
108	Rent/purchase guidelines were not met.
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.
110	Billing date predates service date.
111	Not covered unless the provider accepts assignment.
112	Service not furnished directly to the patient and/or not documented.
114	Procedure/product not approved by the Food and Drug Administration.
115	Procedure postponed, canceled, or delayed.
116	The advance indemnification notice signed by the patient did not comply with requirements.
117	Transportation is only covered to the closest facility that can provide the necessary care.
118	ESRD network support adjustment.
119	Benefit maximum for this time period or occurrence has been reached.
121	Indemnification adjustment - compensation for outstanding member responsibility.
122	Psychiatric reduction.
128	Newborn's services are covered in the mother's Allowance.
129	Prior processing information appears incorrect. At least one Remark Code must be provided.
130	Claim submission fee.
131	Claim specific negotiated discount.
132	Prearranged demonstration project adjustment.
133	The disposition of this service line is pending further review.
134	Technical fees removed from charges.
135	Interim bills cannot be processed.
136	Failure to follow prior payer's coverage rules.
137	Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.
138	Appeal procedures not followed or time limits not met.
139	Contracted funding agreement - Subscriber is employed by the provider of services.
140	Patient/Insured health identification number and name do not match.
142	Monthly Medicaid patient liability amount.
143	Portion of payment deferred.
144	Incentive adjustment, e.g. preferred product/service.
146	Diagnosis was invalid for the date(s) of service reported.
147	Provider contracted/negotiated rate expired or not on file.
148	Information from another provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided.
149	Lifetime benefit maximum has been reached for this service/benefit category.
150	Payer deems the information submitted does not support this level of service.
151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.
152	Payer deems the information submitted does not support this length of service.
153	Payer deems the information submitted does not support this dosage.
154	Payer deems the information submitted does not support this day's supply.
155	Patient refused the service/procedure.
157	Service/procedure was provided as a result of an act of war.
158	Service/procedure was provided outside of the United States.
159	Service/procedure was provided as a result of terrorism.
160	Injury/illness was the result of an activity that is a benefit exclusion.
161	Provider performance bonus
163	Attachment/other documentation referenced on the claim was not received.
164	Attachment/other documentation referenced on the claim was not received in a timely fashion.
165	Referral absent or exceeded.
166	These services were submitted after this payers responsibility for processing claims under this plan ended.
167	This (these) diagnosis(es) is (are) not covered.
168	Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan.
169	Alternate benefit has been provided.
170	Payment is denied when performed/billed by this type of provider.
171	Payment is denied when performed/billed by this type of provider in this type of facility.
172	Payment is adjusted when performed/billed by a provider of this specialty.
173	Service/equipment was not prescribed by a physician.
174	Service was not prescribed prior to delivery.
175	Prescription is incomplete.
176	Prescription is not current.
177	Patient has not met the required eligibility requirements.
178	Patient has not met the required spend down requirements.
179	Patient has not met the required waiting requirements.
180	Patient has not met the required residency requirements.
181	Procedure code was invalid on the date of service.

APPENDIX B

List of All Claim Adjustment Reason Codes (CARCs)

Active Codes January 1, 2017 - Present

Rows in yellow indicate CARCs that have been deactivated in CY2017 or CY2018 but kept in this list to account for claims processing lag.

CARC	CARC Description
182	Procedure modifier was invalid on the date of service.
183	The referring provider is not eligible to refer the service billed.
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.
185	The rendering provider is not eligible to perform the service billed.
186	Level of care change adjustment.
187	Consumer Spending Account payments.
188	This product/procedure is only covered when used according to FDA recommendations.
189	Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service.
190	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.
192	Non standard adjustment code from paper remittance.
193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
194	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician.
195	Refund issued to an erroneous priority payer for this claim/service.
197	Precertification/authorization/notification absent.
198	Precertification/authorization exceeded.
199	Revenue code and Procedure code do not match.
200	Expenses incurred during lapse in coverage
201	Patient is responsible for amount of this claim/service through 'set aside arrangement' or other agreement.
202	Non-covered personal comfort or convenience services.
203	Discontinued or reduced service.
204	This service/equipment/drug is not covered under the patient’s current benefit plan
205	Pharmacy discount card processing fee
206	National Provider Identifier - missing.
207	National Provider identifier - Invalid format
208	National Provider Identifier - Not matched.
209	Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected.
210	Payment adjusted because pre-certification/authorization not received in a timely fashion
211	National Drug Codes (NDC) not eligible for rebate, are not covered.
212	Administrative surcharges are not covered
213	Non-compliance with the physician self referral prohibition legislation or payer policy.
215	Based on subrogation of a third party settlement
216	Based on the findings of a review organization
219	Based on extent of injury.
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific.
223	Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created.
224	Patient identification compromised by identity theft. Identity verification required for processing this and future claims.
225	Penalty or Interest Payment by Payer
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.
227	Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided.
228	Denied for failure of this provider, another provider or the subscriber to supply requested information to a previous payer for their adjudication
229	Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12X.
231	Mutually exclusive procedures cannot be done in the same day/setting. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
232	Institutional Transfer Amount.
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.
234	This procedure is not paid separately. At least one Remark Code must be provided.
235	Sales Tax
236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements.
237	Legislated/Regulatory Penalty. At least one Remark Code must be provided.
238	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period.
239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims.
240	The diagnosis is inconsistent with the patient's birth weight.
241	Low Income Subsidy (LIS) Co-payment Amount
242	Services not provided by network/primary care providers.
243	Services not authorized by network/primary care providers.
245	Provider performance program withhold.
246	This non-payable code is for required reporting only.
247	Deductible for Professional service rendered in an Institutional setting and billed on an Institutional claim.
248	Coinsurance for Professional service rendered in an Institutional setting and billed on an Institutional claim.
249	This claim has been identified as a readmission.
250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing.
251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim.

APPENDIX B

List of All Claim Adjustment Reason Codes (CARCs)

Active Codes January 1, 2017 - Present

Rows in yellow indicate CARCs that have been deactivated in CY2017 or CY2018 but kept in this list to account for claims processing lag.

CARC	CARC Description
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided.
253	Sequestration - reduction in federal payment
254	Claim received by the dental plan, but benefits not available under this plan. Submit these services to the patient's medical plan for further consideration.
256	Service not payable per managed care contract.
257	The disposition of the claim/service is undetermined during the premium payment grace period, per Health Insurance Exchange requirements. This claim/service will be reversed and corrected when the grace period ends (due to premium payment or lack of premium payment).
258	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.
259	Additional payment for Dental/Vision service utilization.
260	Processed under Medicaid ACA Enhanced Fee Schedule
261	The procedure or service is inconsistent with the patient's history.
262	Adjustment for delivery cost. Note: To be used for pharmaceuticals only.
263	Adjustment for shipping cost. Note: To be used for pharmaceuticals only.
264	Adjustment for postage cost. Note: To be used for pharmaceuticals only.
265	Adjustment for administrative cost. Note: To be used for pharmaceuticals only.
266	Adjustment for compound preparation cost. Note: To be used for pharmaceuticals only.
267	Claim/service spans multiple months. At least one Remark Code must be provided.
268	The Claim spans two calendar years. Please resubmit one claim per calendar year.
269	Anesthesia not covered for this service/procedure.
270	Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient’s dental plan for further consideration.
271	Prior contractual reductions related to a current periodic payment as part of a contractual payment schedule when deferred amounts have been previously reported.
272	Coverage/program guidelines were not met.
273	Coverage/program guidelines were exceeded.
274	Fee/Service not payable per patient Care Coordination arrangement.
275	Prior payer's (or payers') patient responsibility (deductible, coinsurance, co-payment) not covered.
276	Services denied by the prior payer(s) are not covered by this payer.
277	The disposition of the claim/service is undetermined during the premium payment grace period, per Health Insurance SHOP Exchange requirements. This claim/service will be reversed and corrected when the grace period ends (due to premium payment or lack of premium payment).
278	Performance program proficiency requirements not met. (Use only with Group Codes CO or PI)
279	Services not provided by Preferred network providers. Usage: Use this code when there are member network limitations.
280	Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient's Pharmacy plan for further consideration.
281	Deductible waived per contractual agreement.
282	The procedure/revenue code is inconsistent with the type of bill.
283	Attending provider is not eligible to provide direction of care.
284	Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the billed services.
285	Appeal procedures not followed
286	Appeal time limits not met
287	Referral exceeded
288	Referral absent
289	Services considered under the dental and medical plans, benefits not available.
290	Claim received by the dental plan, but benefits not available under this plan. Claim has been forwarded to the patient's medical plan for further consideration.
291	Claim received by the medical plan, but benefits not available under this plan. Claim has been forwarded to the patient's dental plan for further consideration.
292	Claim received by the medical plan, but benefits not available under this plan. Claim has been forwarded to the patient's pharmacy plan for further consideration.
293	Payment made to employer.
294	Payment made to attorney.
295	Pharmacy Direct/Indirect Remuneration (DIR)
296	Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the provider.
A0	Patient refund amount.
A1	Claim/Service denied. At least one Remark Code must be provided.
A5	Medicare Claim PPS Capital Cost Outlier Amount.
A6	Prior hospitalization or 30 day transfer requirement not met.
A8	Ungroupable DRG.
B1	Non-covered visits.
B4	Late filing penalty.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.
B8	Alternative services were available, and should have been utilized.
B9	Patient is enrolled in a Hospice.
B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.
B12	Services not documented in patients' medical records.
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.
B14	Only one visit or consultation per physician per day is covered.
B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.
B16	'New Patient' qualifications were not met.

APPENDIX B

List of All Claim Adjustment Reason Codes (CARCs)

Active Codes January 1, 2017 - Present

Rows in yellow indicate CARCs that have been deactivated in CY2017 or CY2018 but kept in this list to account for claims processing lag.

CARC	CARC Description
B20	Procedure/service was partially or fully furnished by another provider.
B22	This payment is adjusted based on the diagnosis.
B23	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test.
P1	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation. To be used for Property and Casualty only.
P2	Not a work related injury/illness and thus not the liability of the workers' compensation carrier. To be used for Workers' Compensation only.
P3	Workers' Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. To be used for Workers' Compensation only.
P4	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment.
P5	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. To be used for Property and Casualty only.
P6	Based on entitlement to benefits. To be used for Property and Casualty only.
P7	The applicable fee schedule/fee database does not contain the billed code. To be used for Property and Casualty only.
P8	Claim is under investigation. To be used for Property and Casualty only.
P9	No available or correlating CPT/HCPCS code to describe this service. To be used for Property and Casualty only.
P10	Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation. To be used for Property and Casualty only.
P11	The disposition of the related Property & Casualty claim (injury or illness) is pending due to litigation. To be used for Property and Casualty only.
P12	Workers' compensation jurisdictional fee schedule adjustment. To be used for Workers' Compensation only.
P13	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable. To be used for Workers' Compensation only.
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. To be used for Property and Casualty only.
P15	Workers' Compensation Medical Treatment Guideline Adjustment. To be used for Workers' Compensation only.
P16	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. To be used for Workers' Compensation only.
P17	Referral not authorized by attending physician per regulatory requirement. To be used for Property and Casualty only.
P18	Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service. To be used for Property and Casualty only.
P19	Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due. To be used for Property and Casualty only.
P20	Service not paid under jurisdiction allowed outpatient facility fee schedule. To be used for Property and Casualty only.
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. To be used for Property and Casualty Auto only.
P22	Payment adjusted based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. . To be used for Property and Casualty Auto only.
P23	Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional fee schedule adjustment. To be used for Property and Casualty Auto only.
P24	Payment adjusted based on Preferred Provider Organization (PPO). To be used for Property and Casualty only.
P25	Payment adjusted based on Medical Provider Network (MPN). To be used for Property and Casualty only. (Use only with Group Code CO).
P26	Payment adjusted based on Voluntary Provider network (VPN). To be used for Property and Casualty only. (Use only with Group Code CO).
P27	Payment denied based on the Liability Coverage Benefits jurisdictional regulations and/or payment policies. To be used for Property and Casualty Auto only.
P28	Payment adjusted based on the Liability Coverage Benefits jurisdictional regulations and/or payment policies. To be used for Property and Casualty Auto only.
P29	Liability Benefits jurisdictional fee schedule adjustment. To be used for Property and Casualty Auto only.

APPENDIX C

List of All National Council for Prescription Drug Programs (NCPDP) Reject Codes

NCPDP Code	Description
Ø1	M/I Bin Number
Ø2	M/I Version/Release Number
Ø3	M/I Transaction Code
Ø4	M/I Processor Control Number
Ø5	M/I Service Provider Number
Ø6	M/I Group ID
Ø7	M/I Cardholder ID
Ø8	M/I Person Code
Ø9	M/I Date Of Birth
1Ø	M/I Patient Gender Code
11	M/I Patient Relationship Code
12	M/I Place of Service
13	M/I Other Coverage Code
14	M/I Eligibility Clarification Code
15	M/I Date of Service
16	M/I Prescription/Service Reference Number
17	M/I Fill Number
19	M/I Days Supply
1W	Multi-Ingredient Compound Must Be A Single Transaction
1Y	Claim Segment Required For Adjudication
1Z	Clinical Segment Required For Adjudication
2C	M/I Pregnancy Indicator
2D	M/I Provider Accept Assignment Indicator
2E	M/I Primary Care Provider ID Qualifier
2G	M/I Compound Ingredient Modifier Code Count
2H	M/I Compound Ingredient Modifier Code
2J	M/I Prescriber First Name
2K	M/I Prescriber Street Address
2M	M/I Prescriber City Address
2N	M/I Prescriber State/Province Address
2P	M/I Prescriber Zip/Postal Zone
2Ø	M/I Compound Code
21	M/I Product/Service ID
22	M/I Dispense As Written (DAW)/Product Selection Code
23	M/I Ingredient Cost Submitted
25	M/I Prescriber ID
26	M/I Unit Of Measure
27	Product Identifier not FDA/NSDE Listed
28	M/I Date Prescription Written
29	M/I Number Of Refills Authorized
31	No matching paid claim found for reversal request.
32	M/I Level Of Service
33	M/I Prescription Origin Code
34	M/I Submission Clarification Code
35	M/I Primary Care Provider ID
39	M/I Diagnosis Code
4S	Compound Product ID Requires a Modifier Code
4X	M/I Patient Residence
4Y	Patient Residence Value Not Supported
4Z	Place of Service Not Supported By Plan
4Ø	Pharmacy Not Contracted With Plan On Date Of Service
41	Submit Bill To Other Processor Or Primary Payer
42	Plan's Prescriber data base indicates the Prescriber ID Submitted is inactive or expired
43	Plan's Prescriber data base indicates the associated DEA to submitted Prescriber ID is inactive
44	Plan's Prescriber data base indicates the associated DEA to submitted Prescriber ID Is not found
46	Plan's Prescriber data base indicates associated DEA to submitted Prescriber ID does not allow this drug DEA Schedule
5C	M/I Other Payer Coverage Type
5E	M/I Other Payer Reject Count
5J	M/I Facility City Address

APPENDIX C
List of All National Council for Prescription Drug Programs (NCPDP) Reject Codes

NCPDP Code	Description
5Ø	Non-Matched Pharmacy Number
51	Non-Matched Group ID
52	Non-Matched Cardholder ID
53	Non-Matched Person Code
54	Non-Matched Product/Service ID Number
55	Non-Matched Product Package Size
56	Non-Matched Prescriber ID
58	Non-Matched Primary Prescriber
6C	M/I Other Payer ID Qualifier
6D	M/I Facility Zip/Postal Zone
6E	M/I Other Payer Reject Code
6G	Coordination Of Benefits/Other Payments Segment Required For Adjudication
6J	Insurance Segment Required For Adjudication
6K	Patient Segment Required For Adjudication
6M	Pharmacy Provider Segment Required For Adjudication
6N	Prescriber Segment Required For Adjudication
6P	Pricing Segment Required For Adjudication
6Q	Prior Authorization Segment Required For Adjudication
6S	Transaction Segment Required For Adjudication
6T	Compound Segment Required For Adjudication
6U	Compound Segment Incorrectly Formatted
6V	Multi-ingredient Compounds Not Supported,
6W	DUR/PPS Segment Required For Adjudication
6X	DUR/PPS Segment Incorrectly Formatted
6Z	Provider Not Eligible To Perform Service/Dispense Product
6Ø	Product/Service Not Covered For Patient Age
61	Product/Service Not Covered For Patient Gender
62	Patient/Card Holder ID Name Mismatch
63	Product/Service ID Not Covered For Institutionalized Patient
64	Claim Submitted Does Not Match Prior Authorization
65	Patient Is Not Covered
66	Patient Age Exceeds Maximum Age
67	Filled Before Coverage Effective
68	Filled After Coverage Expired
69	Filled After Coverage Terminated
7A	Provider Does Not Match Authorization On File
7B	Service Provider ID Qualifier Value Not Supported For Processor/Payer
7C	M/I Other Payer ID
7D	Non-Matched DOB
7G	Future Date Not Allowed For DOB
7H	Non-Matched Gender Code
7J	Patient Relationship Code Value Not Supported
7K	Discrepancy Between Other Coverage Code And Other Payer Amount
7M	Discrepancy Between Other Coverage Code And Other Coverage Information On File
7N	Patient ID Qualifier Value Not Supported
7P	Coordination Of Benefits/Other Payments Count Exceeds Number of Supported Payers
7Q	Other Payer ID Qualifier Value Not Supported
7R	Other Payer Amount Paid Count Exceeds Number of Supported Groupings
7V	Duplicate Refills,
7W	Refills Exceed allowable Refills
7X	Days Supply Exceeds Plan Limitation
7Y	Compounds Not Covered,
7Z	Compound Requires Two Or More Ingredients,
7Ø	Product/Service Not Covered – Plan/Benefit Exclusion
71	Prescriber ID Is Not Covered
72	Primary Prescriber Is Not Covered
73	Refills Are Not Covered
74	Other Carrier Payment Meets Or Exceeds Payable
75	Prior Authorization Required

APPENDIX C
List of All National Council for Prescription Drug Programs (NCPDP) Reject Codes

NCPDP Code	Description
76	Plan Limitations Exceeded
77	Discontinued Product/Service ID Number
78	Cost Exceeds Maximum
79	Refill Too Soon
8A	Compound Requires At Least One Covered Ingredient
8B	Compound Segment Missing On A Compound Claim
8C	M/I Facility ID
8D	Compound Segment Present On A Non- Compound Claim
8E	M/I DUR/PPS Level Of Effort
8G	Product/Service ID (4Ø7-D7) Must Be A Single Zero "Ø" For Compounds
8H	Product/Service Only Covered On Compound Claim
8J	Incorrect Product/Service ID For Processor/Payer
8K	DAW Code Value Not Supported
8M	Sum Of Compound Ingredient Costs Does Not Equal Ingredient Cost Submitted
8N	Future Date Prescription Written Not Allowed,
8P	Date Written Different On Previous Filling
8Q	Excessive Refills Authorized
8R	Submission Clarification Code Value Not Supported
8S	Basis Of Cost Determination Value Not Supported
8T	U&C Must Be Greater Than Zero
8U	GAD Must Be Greater Than Zero
8W	Discrepancy Between Other Coverage Code and Other Payer Amount Paid
8X	Collection From Cardholder Not Allowed
8Y	Excessive Amount Collected
8Z	Product/Service ID Qualifier Value Not Supported
8Ø	Drug-Diagnosis Mismatch
81	Claim Too Old
82	Claim Is Post-Dated
83	Duplicate Paid/Captured Claim
84	Claim Has Not Been Paid/Captured
85	Claim Not Processed
86	Submit Manual Reversal
87	Reversal Not Processed
88	DUR Reject Error
89	Rejected Claim Fees Paid
9B	Reason For Service Code Value Not Supported
9C	Professional Service Code Value Not Supported
9D	Result Of Service Code Value Not Supported
9E	Quantity Does Not Match Dispensing Unit
9G	Quantity Dispensed Exceeds Maximum Allowed
9H	Quantity Not Valid For Product/Service ID Submitted
9J	Future Other Payer Date Not Allowed
9K	Compound Ingredient Component Count Exceeds Number Of Ingredients Supported
9M	Minimum Of Two Ingredients Required
9N	Compound Ingredient Quantity Exceeds Maximum Allowed
9Q	Route Of Administration Submitted Not Covered
9R	Prescription/Service Reference Number Qualifier Submitted Not Covered
9T	Prior Authorization Type Code Submitted Not Covered
9U	Provider ID Qualifier Submitted Not Covered
9V	Prescriber ID Qualifier Submitted Not Covered
9W	DUR/PPS Code Counter Exceeds Number Of Occurrences Supported
9Y	Compound Product ID Qualifier Submitted Not Covered
9Z	Duplicate Product ID In Compound
AB	Date Written Is After Date Filled
AC	Product Not Covered Non-Participating Manufacturer
AD	Billing Provider Not Eligible To Bill This Claim Type
AE	QMB (Qualified Medicare Beneficiary)- Bill Medicare
AF	Patient Enrolled Under Managed Care
AG	Days Supply Limitation For Product/Service

APPENDIX C
List of All National Council for Prescription Drug Programs (NCPDP) Reject Codes

NCPDP Code	Description
AH	Unit Dose Packaging Only Payable For Nursing Home Recipients
AJ	Generic Drug Required
AK	M/I Software Vendor/Certification ID
AM	M/I Segment Identification
AQ	M/I Facility Segment
A1	ID Submitted is associated with a Sanctioned Prescriber
A2	ID Submitted is associated to a Deceased Prescriber
A3	This Product May Be Covered Under Hospice – Medicare A
A4	This Product May Be Covered Under The Medicare- B Bundled Payment To An ESRD Dialysis Facility
A5	Not Covered Under Part D Law
A6	This Product/Service May Be Covered Under Medicare Part B
A7	M/I Internal Control Number
A9	M/I Transaction Count
BA	Compound Basis of Cost Determination Submitted Not Covered
BB	Diagnosis Code Qualifier Submitted Not Covered
BC	Future Measurement Date Not Allowed
BE	M/I Professional Service Fee Submitted
B2	M/I Service Provider ID Qualifier
CA	M/I Patient First Name
CB	M/I Patient Last Name
CC	M/I Cardholder First Name
CD	M/I Cardholder Last Name
CM	M/I Patient Street Address
CN	M/I Patient City Address
CO	M/I Patient State/Province Address
CP	M/I Patient Zip/Postal Zone
CQ	M/I Patient Phone Number
CR	M/I Carrier ID
CW	M/I Alternate ID
CX	M/I Patient ID Qualifier
CY	M/I Patient ID
CZ	M/I Employer ID
DC	M/I Dispensing Fee Submitted
DN	M/I Basis Of Cost Determination
DQ	M/I Usual And Customary Charge
DR	M/I Prescriber Last Name
DT	M/I Special Packaging Indicator
DU	M/I Gross Amount Due
DV	M/I Other Payer Amount Paid
DX	M/I Patient Paid Amount Submitted
DY	M/I Date Of Injury
DZ	M/I Claim/Reference ID
EA	M/I Originally Prescribed Product/Service Code
EB	M/I Originally Prescribed Quantity
EC	M/I Compound Ingredient Component Count
ED	M/I Compound Ingredient Quantity
EE	M/I Compound Ingredient Drug Cost
EF	M/I Compound Dosage Form Description Code
EG	M/I Compound Dispensing Unit Form Indicator
EJ	M/I Originally Prescribed Product/Service ID Qualifier
EK	M/I Scheduled Prescription ID Number
EM	M/I Prescription/Service Reference Number Qualifier
EN	M/I Associated Prescription/Service Reference Number
EP	M/I Associated Prescription/Service Date
ER	M/I Procedure Modifier Code
ET	M/I Quantity Prescribed
EU	M/I Prior Authorization Type Code
EV	M/I Prior Authorization Number Submitted
EY	M/I Provider ID Qualifier

APPENDIX C
List of All National Council for Prescription Drug Programs (NCPDP) Reject Codes

NCPDP Code	Description
EZ	M/I Prescriber ID Qualifier
E1	M/I Product/Service ID Qualifier
E2	M/I Route of Administration
E3	M/I Incentive Amount Submitted
E4	M/I Reason For Service Code
E5	M/I Professional Service Code
E6	M/I Result Of Service Code
E7	M/I Quantity Dispensed
E8	M/I Other Payer Date
E9	M/I Provider ID
FO	M/I Plan ID
GE	M/I Percentage Sales Tax Amount Submitted
G1	M/I Compound Type
G4	Physician must contact plan
G5	Pharmacist must contact plan
G6	Pharmacy Not Contracted in Specialty Network
G7	Pharmacy Not Contracted in Home Infusion Network
G8	Pharmacy Not Contracted in Long Term Care Network
G9	Pharmacy Not Contracted in 9Ø Day Retail Network (this message would be used when the pharmacy is not contracted to provide a 9Ø days supply of drugs)
HA	M/I Flat Sales Tax Amount Submitted
HB	M/I Other Payer Amount Paid Count
HC	M/I Other Payer Amount Paid Qualifier
HD	M/I Dispensing Status
HE	M/I Percentage Sales Tax Rate Submitted
H6	M/I DUR Co-Agent ID
H7	M/I Other Amount Claimed Submitted Count
H8	M/I Other Amount Claimed Submitted Qualifier
H9	M/I Other Amount Claimed Submitted
JE	M/I Percentage Sales Tax Basis Submitted
M1	Patient Not Covered In This Aid Category
M2	Recipient Locked In
M4	Prescription/Service Reference Number/Time Limit Exceeded
MG	M/I Other Payer BIN Number
MH	M/I Other Payer Processor Control Number
MJ	M/I Other Payer Group ID
MK	Non-Matched Other Payer BIN Number
MM	Non-Matched Other Payer Processor Control Number
MN	Non-Matched Other Payer Group ID
MP	Other Payer Cardholder ID Not Covered
MR	Product Not On Formulary
MT	M/I Patient Assignment Indicator (Direct Member Reimbursement Indicator)
NN	Transaction Rejected At Switch Or Intermediary
NP	M/I Other Payer- Patient Responsibility Amount Qualifier
NQ	M/I Other Payer- Patient Responsibility Amount
NR	M/I Other Payer- Patient Responsibility Amount Count
NU	M/I Other Payer Cardholder ID
NV	M/I Delay Reason Code
NX	M/I Submission Clarification Code Count
N1	No patient match found.
N3	M/I Medicaid Paid Amount
N4	M/I Medicaid Subrogation Internal Control Number/Transaction Control Number (ICN/TCN)
N5	M/I Medicaid ID Number
N7	Use Prior Authorization Code Provided During Transition Period
N8	Use Prior Authorization Code Provided For Emergency Fill
N9	Use Prior Authorization Code Provided For Level of Care Change
PA	PA Exhausted/Not Renewable
PY	Non-Matched Unit Form/Route of Administration
PZ	Non-Matched Unit Of Measure To Product/Service ID

APPENDIX C
List of All National Council for Prescription Drug Programs (NCPDP) Reject Codes

NCPDP Code	Description
PØ	Non-zero Value Required for Vaccine Administration
P3	Compound Ingredient Component Count Does Not Match Number Of Repetitions
P4	Coordination Of Benefits/Other Payments Count Does Not Match Number Of Repetitions
P6	Date Of Service Prior To Date Of Birth
RE	M/I Compound Product ID Qualifier
RK	Partial Fill Transaction Not Supported
RV	Multiple Reversals Per Transmission Not Supported
RØ	Professional Service Code of "MA" required for Vaccine Incentive Fee Submitted
SF	Other Payer Amount Paid Count Does Not Match Number Of Repetitions
SG	Submission Clarification Code Count Does Not Match Number of Repetitions
SH	Other Payer-Patient Responsibility Amount Count Does Not Match Number of Repetitions
TE	Missing/Invalid Compound Product ID
TN	Emergency Fill/Resubmit Claim
TP	Level of Care Change/Resubmit Claim
TQ	Dosage Exceeds Product Labeling Limit
TR	M/I Billing Entity Type Indicator
TS	M/I Pay To Qualifier
TT	M/I Pay To ID
TU	M/I Pay To Name
TV	M/I Pay To Street Address
TW	M/I Pay To City Address
TX	M/I Pay to State/ Province Address
TY	M/I Pay To Zip/Postal Zone
TZ	M/I Generic Equivalent Product ID Qualifier
UA	M/I Generic Equivalent Product ID
UE	M/I Compound Ingredient Basis Of Cost Determination
UU	DAW Ø cannot be submitted on a multi- source drug with available generics.
U7	M/I Pharmacy Service Type
VA	Pay To Qualifier Value Not Supported
VB	Generic Equivalent Product ID Qualifier Value Not Supported
VC	Pharmacy Service Type Value Not Supported
VE	M/I Diagnosis Code Count
WE	M/I Diagnosis Code Qualifier
X8	Procedure Modifier Code Count Exceeds Number Of Occurrences Supported
X9	Diagnosis Code Count Exceeds Number Of Occurrences Supported
YA	Compound Ingredient Modifier Code Count Exceeds Number Of Occurrences Supported
YB	Other Amount Claimed Submitted Count Exceeds Number Of Occurrences Supported
YC	Other Payer Reject Count Exceeds Number Of Occurrences Supported
YD	Other Payer-Patient Responsibility Amount Count Exceeds Number Of Occurrences Supported
YE	Submission Clarification Code Count Exceeds Number of Occurrences Supported
YJ	Medicaid Agency Number Not Supported
YK	M/I Service Provider Name
YM	M/I Service Provider Street Address
YN	M/I Service Provider City Address
YP	M/I Service Provider State/Province Code Address
YQ	M/I Service Provider Zip/Postal Code
Z1	Prescriber Alternate ID Qualifier Value Not Supported
Z5	M/I Service Provider Segment
Z9	Prescriber Alternate ID Not Covered
ZA	The Coordination of Benefits/Other Payments Segment is mandatory to a downstream payer.
ZK	M/I Prescriber ID Associated State/Province Address
ZW	M/I Compound Preparation Time
ZZ	Cardholder ID submitted is inactive. New Cardholder ID on file.

APPENDIX D

Detailed Information for Exhibits Shown in Sections III and IV of the Report

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

	Number Accepted	Number Rejected	Accepted	Rejected
All MCOs Q2 2018	22,498,079	102,126	99.5%	0.5%
All MCOs Q3 2018	21,939,614	131,617	99.4%	0.6%
All MCOs Q4 2018	22,700,731	261,998	98.9%	1.1%
All MCOs Q1 2019	24,346,873	278,890	98.9%	1.1%
Aetna Q2 2018	1,235,697	4,149	99.7%	0.3%
Aetna Q3 2018	1,241,785	2,586	99.8%	0.2%
Aetna Q4 2018	1,159,476	3,253	99.7%	0.3%
Aetna Q1 2019	2,218,090	4,002	99.8%	0.2%
ACLA Q2 2018	3,017,999	6,766	99.8%	0.2%
ACLA Q3 2018	2,998,710	40,019	98.7%	1.3%
ACLA Q4 2018	3,115,973	4,930	99.8%	0.2%
ACLA Q1 2019	3,238,589	1,983	99.9%	0.1%
Healthy Blue Q2 2018	3,960,342	2,848	99.9%	0.1%
Healthy Blue Q3 2018	4,068,357	1,622	100.0%	0.0%
Healthy Blue Q4 2018	4,486,556	2,922	99.9%	0.1%
Healthy Blue Q1 2019	4,747,539	2,339	100.0%	0.0%
LHCC Q2 2018	6,669,222	59,956	99.1%	0.9%
LHCC Q3 2018	6,719,466	69,097	99.0%	1.0%
LHCC Q4 2018	6,696,215	219,329	96.8%	3.2%
LHCC Q1 2019	6,804,623	238,836	96.6%	3.4%
UHC Q2 2018	7,614,819	28,407	99.6%	0.4%
UHC Q3 2018	6,911,296	18,293	99.7%	0.3%
UHC Q4 2018	7,242,511	31,564	99.6%	0.4%
UHC Q1 2019	7,338,032	31,730	99.6%	0.4%

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

	Number Paid	Number Denied	Paid	Denied
All MCOs Q2 2018	18,735,184	3,874,912	82.9%	17.1%
All MCOs Q3 2018	17,711,722	4,021,969	81.5%	18.5%
All MCOs Q4 2018	18,630,400	4,179,312	81.7%	18.3%
All MCOs Q1 2019	19,604,277	4,709,822	80.6%	19.4%
Aetna Q2 2018	1,030,735	205,175	83.4%	16.6%
Aetna Q3 2018	1,037,823	202,564	83.7%	16.3%
Aetna Q4 2018	974,611	185,711	84.0%	16.0%
Aetna Q1 2019	1,642,751	577,057	74.0%	26.0%
ACLA Q2 2018	2,532,447	518,838	83.0%	17.0%
ACLA Q3 2018	2,442,398	524,053	82.3%	17.7%
ACLA Q4 2018	2,477,408	632,305	79.7%	20.3%
ACLA Q1 2019	2,562,954	673,042	79.2%	20.8%
Healthy Blue Q2 2018	3,206,084	768,422	80.7%	19.3%
Healthy Blue Q3 2018	3,208,955	834,543	79.4%	20.6%
Healthy Blue Q4 2018	3,481,783	974,706	78.1%	21.9%
Healthy Blue Q1 2019	3,724,389	1,059,786	77.8%	22.2%
LHCC Q2 2018	5,498,368	1,251,681	81.5%	18.5%
LHCC Q3 2018	5,313,035	1,287,935	80.5%	19.5%
LHCC Q4 2018	5,634,122	1,159,633	82.9%	17.1%
LHCC Q1 2019	5,643,477	1,147,757	83.1%	16.9%
UHC Q2 2018	6,467,550	1,130,796	85.1%	14.9%
UHC Q3 2018	5,709,511	1,172,874	83.0%	17.0%
UHC Q4 2018	6,062,476	1,226,957	83.2%	16.8%
UHC Q1 2019	6,030,706	1,252,180	82.8%	17.2%

Exhibit III.3A
Claim Status for Adjudicated Claims
Institutional Providers
For All MCOs Combined By Quarter

	Number Paid	Number Denied	Paid	Denied
Inpatient Hospital Q2 2018	45,196	13,356	77.2%	22.8%
Inpatient Hospital Q3 2018	43,888	12,814	77.4%	22.6%
Inpatient Hospital Q4 2018	45,395	12,409	78.5%	21.5%
Inpatient Hospital Q1 2019	48,297	13,991	77.5%	22.5%
Outpatient Hospital Q2 2018	4,423,822	467,083	90.4%	9.6%
Outpatient Hospital Q3 2018	4,259,689	453,266	90.4%	9.6%
Outpatient Hospital Q4 2018	4,366,507	462,266	90.4%	9.6%
Outpatient Hospital Q1 2019	4,594,832	544,293	89.4%	10.6%
Home Health Q2 2018	31,049	7,395	80.8%	19.2%
Home Health Q3 2018	33,185	6,538	83.5%	16.5%
Home Health Q4 2018	26,909	6,079	81.6%	18.4%
Home Health Q1 2019	29,564	7,334	80.1%	19.9%
Other Institutional Q2 2018	37,753	11,460	76.7%	23.3%
Other Institutional Q3 2018	43,362	8,797	83.1%	16.9%
Other Institutional Q4 2018	48,260	9,496	83.6%	16.4%
Other Institutional Q1 2019	43,809	7,922	84.7%	15.3%

Exhibit III.3B
Claim Status for Adjudicated Claims
Professional Service Providers
For All MCOs Combined By Quarter

	Number Paid	Number Denied	Paid	Denied
Primary Care Q2 2018	1,471,142	162,806	90.0%	10.0%
Primary Care Q3 2018	1,500,822	168,077	89.9%	10.1%
Primary Care Q4 2018	1,823,520	216,492	89.4%	10.6%
Primary Care Q1 2019	2,094,582	305,067	87.3%	12.7%
Pediatrics Q2 2018	599,716	62,812	90.5%	9.5%
Pediatrics Q3 2018	665,908	77,814	89.5%	10.5%
Pediatrics Q4 2018	819,032	84,654	90.6%	9.4%
Pediatrics Q1 2019	879,859	104,011	89.4%	10.6%
OB-GYN Q2 2018	201,004	25,158	88.9%	11.1%
OB-GYN Q3 2018	206,443	27,261	88.3%	11.7%
OB-GYN Q4 2018	210,546	26,466	88.8%	11.2%
OB-GYN Q1 2019	231,181	33,808	87.2%	12.8%
Therapists (PT/OT/ST) Q2 2018	41,416	5,695	87.9%	12.1%
Therapists (PT/OT/ST) Q3 2018	44,671	7,106	86.3%	13.7%
Therapists (PT/OT/ST) Q4 2018	54,036	8,766	86.0%	14.0%
Therapists (PT/OT/ST) Q1 2019	54,176	7,561	87.8%	12.2%
Non-Emerg Transport Q2 2018	258,293	14,123	94.8%	5.2%
Non-Emerg Transport Q3 2018	274,031	14,000	95.1%	4.9%
Non-Emerg Transport Q4 2018	288,150	12,837	95.7%	4.3%
Non-Emerg Transport Q1 2019	297,704	12,542	96.0%	4.0%
Medical Equipment/Supplies Q2 2018	122,265	22,583	84.4%	15.6%
Medical Equipment/Supplies Q3 2018	114,167	22,381	83.6%	16.4%
Medical Equipment/Supplies Q4 2018	121,839	21,673	84.9%	15.1%
Medical Equipment/Supplies Q1 2019	108,389	21,816	83.2%	16.8%
All Other Professional Q2 2018	4,385,910	927,821	82.5%	17.5%
All Other Professional Q3 2018	4,187,246	1,002,804	80.7%	19.3%
All Other Professional Q4 2018	4,276,805	1,143,870	78.9%	21.1%
All Other Professional Q1 2019	4,587,537	1,243,049	78.7%	21.3%

Exhibit III.3C
Claim Status for Adjudicated Claims
Behavioral Health, Dental and Pharmacy
For All MCOs Combined By Quarter

	Number Paid	Number Denied	Paid	Denied
Mental/Behavioral Rehab Q2 2018	566,187	65,548	89.6%	10.4%
Mental/Behavioral Rehab Q3 2018	503,971	71,654	87.6%	12.4%
Mental/Behavioral Rehab Q4 2018	463,010	79,952	85.3%	14.7%
Mental/Behavioral Rehab Q1 2019	400,034	76,287	84.0%	16.0%
Mental/Behavioral Other Q2 2018	331,627	54,017	86.0%	14.0%
Mental/Behavioral Other Q3 2018	357,069	56,943	86.2%	13.8%
Mental/Behavioral Other Q4 2018	443,737	86,587	83.7%	16.3%
Mental/Behavioral Other Q1 2019	565,416	99,097	85.1%	14.9%
Dental - Children Q2 2018	8,590	3,466	71.3%	28.7%
Dental - Children Q3 2018	7,598	3,123	70.9%	29.1%
Dental - Children Q4 2018	7,322	2,972	71.1%	28.9%
Dental - Children Q1 2019	6,936	2,912	70.4%	29.6%
Dental - Adults Q2 2018	566,187	65,548	89.6%	10.4%
Dental - Adults Q3 2018	503,971	71,654	87.6%	12.4%
Dental - Adults Q4 2018	463,010	79,952	85.3%	14.7%
Dental - Adults Q1 2019	400,034	76,287	84.0%	16.0%
Pharmacy Q2 2018	6,089,605	2,008,226	75.2%	24.8%
Pharmacy Q3 2018	5,357,820	2,066,791	72.2%	27.8%
Pharmacy Q4 2018	5,548,338	1,991,023	73.6%	26.4%
Pharmacy Q1 2019	5,576,105	2,204,190	71.7%	28.3%

Exhibit III.4A
Claim Status for Adjudicated Claims
By Provider Specialty - Institutional Providers
For All MCOs for Q1 2019, for Adjudicated Claims

Inpatient	Q1 2019			
	Number Paid	Number Denied	Paid	Denied
All MCOs	48,297	13,991	77.5%	22.5%
Aetna	6,543	2,424	73.0%	27.0%
ACLA	6,953	1,869	78.8%	21.2%
Healthy Blue	10,169	3,487	74.5%	25.5%
LHCC	16,023	3,403	82.5%	17.5%
UHC	8,609	2,808	75.4%	24.6%

Outpatient	Q1 2019			
	Number Paid	Number Denied	Paid	Denied
All MCOs	4,594,832	544,293	89.4%	10.6%
Aetna	373,552	139,822	72.8%	27.2%
ACLA	644,415	53,998	92.3%	7.7%
Healthy Blue	887,466	78,528	91.9%	8.1%
LHCC	1,293,670	150,342	89.6%	10.4%
UHC	1,395,729	121,603	92.0%	8.0%

Home Health	Q1 2019			
	Number Paid	Number Denied	Paid	Denied
All MCOs	29,564	7,334	80.1%	19.9%
Aetna	2,103	2,245	48.4%	51.6%
ACLA	5,338	819	86.7%	13.3%
Healthy Blue	4,196	535	88.7%	11.3%
LHCC	17,510	3,648	82.8%	17.2%
UHC	417	87	82.7%	17.3%

Other Institutional Providers	Q1 2019			
	Number Paid	Number Denied	Paid	Denied
All MCOs	4,587,537	1,243,049	78.7%	21.3%
Aetna	360,693	176,571	67.1%	32.9%
ACLA	710,075	274,894	72.1%	27.9%
Healthy Blue	692,808	176,923	79.7%	20.3%
LHCC	1,479,190	378,747	79.6%	20.4%
UHC	1,344,771	235,914	85.1%	14.9%

Exhibit III.4B
Claim Status for Adjudicated Claims
By Provider Specialty - Professional Service Providers
For All MCOs for Q1 2019, for Adjudicated Claims

Primary Care	**Q1 2019**			
	Number Paid	**Number Denied**	**Paid**	**Denied**
All MCOs	2,094,582	305,067	87.3%	12.7%
Aetna	175,697	79,021	69.0%	31.0%
ACLA	140,552	18,091	88.6%	11.4%
Healthy Blue	397,129	49,830	88.9%	11.1%
LHCC	602,600	86,912	87.4%	12.6%
UHC	778,604	71,213	91.6%	8.4%

Pediatrics	**Q1 2019**			
	Number Paid	**Number Denied**	**Paid**	**Denied**
All MCOs	879,859	104,011	89.4%	10.6%
Aetna	61,388	22,841	72.9%	27.1%
ACLA	138,860	11,500	92.4%	7.6%
Healthy Blue	213,969	22,769	90.4%	9.6%
LHCC	307,551	30,142	91.1%	8.9%
UHC	158,091	16,759	90.4%	9.6%

OB-GYN	**Q1 2019**			
	Number Paid	**Number Denied**	**Paid**	**Denied**
All MCOs	231,181	33,808	87.2%	12.8%
Aetna	22,571	7,283	75.6%	24.4%
ACLA	38,541	9,608	80.0%	20.0%
Healthy Blue	66,938	6,653	91.0%	9.0%
LHCC	71,222	7,800	90.1%	9.9%
UHC	31,909	2,464	92.8%	7.2%

Therapists (Physical, Occupational, Speech)	**Q1 2019**			
	Number Paid	**Number Denied**	**Paid**	**Denied**
All MCOs	54,176	7,561	87.8%	12.2%
Aetna	2,167	896	70.7%	29.3%
ACLA	7,651	1,432	84.2%	15.8%
Healthy Blue	15,518	2,155	87.8%	12.2%
LHCC	12,976	1,580	89.1%	10.9%
UHC	15,864	1,498	91.4%	8.6%

Exhibit III.4B (continued)
Claim Status for Adjudicated Claims
By Provider Specialty - Professional Service Providers
For All MCOs by Quarter, for Adjudicated Claims

Non-Emergency Medical Transportation	Q1 2019			
	Number Paid	Number Denied	Paid	Denied
All MCOs	297,704	12,542	96.0%	4.0%
Aetna	52,045	701	98.7%	1.3%
ACLA	51,941	5,840	89.9%	10.1%
Healthy Blue	71,137	1,894	97.4%	2.6%
LHCC	113,411	1,911	98.3%	1.7%
UHC	9,170	2,196	80.7%	19.3%

Medical Equipment & Supplies	Q1 2019			
	Number Paid	Number Denied	Paid	Denied
All MCOs	108,389	21,816	83.2%	16.8%
Aetna	10,177	2,474	80.4%	19.6%
ACLA	19,206	3,938	83.0%	17.0%
Healthy Blue	1,107	479	69.8%	30.2%
LHCC	33,370	5,808	85.2%	14.8%
UHC	44,529	9,117	83.0%	17.0%

All Other Professional Services exc. BH and Dental	Q1 2019			
	Number Paid	Number Denied	Paid	Denied
All MCOs	4,587,537	1,243,049	78.7%	21.3%
Aetna	360,693	176,571	67.1%	32.9%
ACLA	710,075	274,894	72.1%	27.9%
Healthy Blue	692,808	176,923	79.7%	20.3%
LHCC	1,479,190	378,747	79.6%	20.4%
UHC	1,344,771	235,914	85.1%	14.9%

Exhibit III.4C
Claim Status for Adjudicated Claims
By Provider Specialty - Behavioral Health, Dental and Pharmacy
For All MCOs for Q1 2019, for Adjudicated Claims

Mental/Behavioral Health - Rehab	Q1 2019			
	Number Paid	Number Denied	Paid	Denied
All MCOs	400,034	76,287	84.0%	16.0%
Aetna	17,605	5,037	77.8%	22.2%
ACLA	53,562	9,344	85.1%	14.9%
Healthy Blue	159,178	27,004	85.5%	14.5%
LHCC	16,243	6,523	71.3%	28.7%
UHC	153,446	28,379	84.4%	15.6%

Mental/Behavioral Health - Other	Q1 2019			
	Number Paid	Number Denied	Paid	Denied
All MCOs	565,416	99,097	85.1%	14.9%
Aetna	47,778	10,502	82.0%	18.0%
ACLA	38,527	4,915	88.7%	11.3%
Healthy Blue	127,603	30,443	80.7%	19.3%
LHCC	271,623	41,881	86.6%	13.4%
UHC	79,885	11,356	87.6%	12.4%

Pharmacy	Q1 2019			
	Number Paid	Number Denied	Paid	Denied
All MCOs	5,576,105	2,204,190	71.7%	28.3%
Aetna	496,129	124,132	80.0%	20.0%
ACLA	701,796	273,821	71.9%	28.1%
Healthy Blue	1,030,487	630,767	62.0%	38.0%
LHCC	1,405,619	427,710	76.7%	23.3%
UHC	1,942,074	747,760	72.2%	27.8%

Dental (MCNA is the only MCO)	Q1 2019			
	Number Paid	Number Denied	Paid	Denied
Dental - Children	711,524	65,548	91.6%	8.4%
Dental - Adults	6,936	2,912	70.4%	29.6%

Exhibit III.5
Value of Paid and Denied Claims
By MCO for Q2 2018, Q3 2018, Q4 2018 and Q1 2019 Adjudicated Claims

	Number Paid	Number Denied	Value of Paid Claims	Value of Denied Claims
All MCOs Q2 2018	18,735,184	3,874,912	$1,388,516,372	$320,435,138
All MCOs Q3 2018	17,711,722	4,021,969	$1,348,678,628	$341,169,789
All MCOs Q4 2018	18,630,400	4,179,312	$1,428,677,391	$361,167,453
All MCOs Q1 2019	19,604,277	4,709,822	$1,492,030,238	$392,923,965

Quarter 2 2018

	Number Paid	Number Denied	Value of Paid Claims	Value of Denied Claims
Aetna	1,030,735	205,175	$97,391,700	$21,517,033
ACLA	2,532,447	518,838	$191,088,168	$46,083,691
Healthy Blue	3,206,084	768,422	$236,935,869	$67,766,521
LHCC	5,498,368	1,251,681	$395,473,392	$95,875,053
UHC	6,467,550	1,130,796	$467,627,243	$89,192,841

Quarter 3 2018

	Number Paid	Number Denied	Value of Paid Claims	Value of Denied Claims
Aetna	1,037,823	202,564	$91,464,597	$18,974,665
ACLA	2,442,398	524,053	$186,145,471	$44,975,254
Healthy Blue	3,208,955	834,543	$240,372,625	$74,843,216
LHCC	5,313,035	1,287,935	$383,882,060	$98,470,875
UHC	5,709,511	1,172,874	$446,813,875	$103,905,779

Quarter 4 2018

	Number Paid	Number Denied	Value of Paid Claims	Value of Denied Claims
Aetna	974,611	185,711	$86,864,458	$17,446,075
ACLA	2,477,408	632,305	$192,256,232	$50,994,982
Healthy Blue	3,481,783	974,706	$258,605,234	$84,334,897
LHCC	5,634,122	1,159,633	$401,680,564	$86,831,262
UHC	6,062,476	1,226,957	$489,270,903	$121,560,236

Quarter 1 2019

	Number Paid	Number Denied	Value of Paid Claims	Value of Denied Claims
Aetna	1,642,751	577,057	$132,532,778	$47,173,207
ACLA	2,562,954	673,042	$199,264,763	$53,635,981
Healthy Blue	3,724,389	1,059,786	$279,960,165	$91,322,055
LHCC	5,643,477	1,147,757	$402,447,946	$86,201,374
UHC	6,030,706	1,252,180	$477,824,586	$114,591,349

MCNA is the MCO that provides dental coverage only.
Their total expenditures are approx. $35M per quarter. They have been excluded from this exhibit.

Exhibit III.6

Examination of Individual Providers Who Billed an MCO 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 MCO

N means that less than 50% of the providers in this group had 10% or more of their claims denied by the MCO

-- 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	Aetna				ACLA				HBL				LHCC				UHC				MCNA			
		Q2 18	Q3 18	Q4 18	Q1 19	Q2 18	Q3 18	Q4 18	Q1 19	Q2 18	Q3 18	Q4 18	Q1 19	Q2 18	Q3 18	Q4 18	Q1 19	Q2 18	Q3 18	Q4 18	Q1 19	Q2 18	Q3 18	Q4 18	Q1 19
Inpatient Hospital	Low	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	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	--	--	--	--				
Outpatient Hospital	Low	N	N	N	Y	Y	Y	Y	Y	N	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y				
	Medium	Y	Y	Y	Y	N	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y				
	High	N	N	Y	Y	N	N	N	N	N	N	N	N	Y	Y	N	Y	N	N	N	N				
Home Health	Low	Y	Y	Y	Y	N	N	Y	Y	N	Y	N	N	Y	N	N	Y	Y	N	N	Y				
	Medium	Y	Y	Y	--	Y	Y	N	N	N	N	N	N	Y	N	Y	Y	--	--	--	--				
	High	--	--	--	--	--	--	--	--	--	--	--	--	N	Y	--	Y	--	--	--	--				
Other Institutional Providers	Low	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	N	Y	Y	Y	Y	N	N	N	N				
	Medium	Y	Y	Y	--	--	--	--	--	N	N	N	N	--	--	--	Y	Y	Y	Y	N				
	High	Y	Y	Y	--	--	--	--	--	N	N	N	N	--	--	--	--	N	--	Y	--				
Primary Care	Low	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	Y	Y	Y	Y				
	Medium	--	--	--	--	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N				
	High	--	--	--	--	N	N	N	N	N	N	N	N	Y	N	Y	Y	N	N	N	N				
Pediatrics	Low	Y	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	Y	Y	Y	Y				
	Medium	--	--	--	--	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N				
	High	--	--	--	--	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N				
OB-GYN	Low	--	--	--	--	N	Y	Y	Y	N	N	N	N	N	N	Y	N	Y	Y	Y	Y				
	Medium	--	--	--	--	N	N	Y	Y	N	N	N	N	N	N	N	N	N	N	N	N				
	High	--	--	--	--	N	N	Y	Y	N	N	N	N	Y	N	--	Y	N	N	N	N				
Therapists	Low	--	--	--	--	Y	Y	Y	Y	N	Y	Y	N	N	N	N	N	Y	N	Y	N				
	Medium	--	--	--	--	N	Y	Y	N	Y	Y	Y	N	Y	N	N	Y	Y	N	N	N				
	High	--	--	--	--	--	--	--	--	--	--	--	--	--	--	N	Y	N	N	N	N				
Non-Emergency Transportation	Low	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	Y	Y	N				
	Medium	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	Y	Y	Y	Y				
	High	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	--	--	--	--				
Medical Equipment/ Supplies	Low	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	N	N	N	N	Y	Y	Y	Y				
	Medium	Y	Y	Y	Y	Y	Y	Y	Y	--	--	--	--	Y	Y	N	Y	N	N	Y	Y				
	High	--	Y	Y	--	Y	Y	N	Y	--	--	--	--	Y	Y	N	Y	N	N	N	N				
All Other Professional Provid.	Low	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	Y	Y	Y				
	Medium	N	N	N	N	N	N	N	N	N	N	N	N	N	N	Y	N	N	Y	Y	Y				
	High	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	Y	Y	N	N	N				
Behavioral Health Rehab	Low	Y	Y	Y	N	N	N	N	N	N	N	Y	Y	Y	N	Y	Y	Y	Y	Y	Y				
	Medium	--	--	--	N	N	N	N	N	N	N	Y	N	N	N	Y	Y	N	N	N	Y				
	High	--	--	--	--	N	N	N	N	N	N	N	N	N	N	Y	Y	N	N	N	Y				
Behavioral Health All Other	Low	--	--	--	N	N	N	N	N	N	N	N	N	N	N	N	N	N	Y	Y	N				
	Medium	--	--	--	--	N	N	N	N	N	N	N	N	N	N	N	N	N	Y	Y	N				
	High	--	--	--	--	N	N	N	N	N	N	N	Y	Y	Y	Y	Y	Y	N	N	N				
Dental - Children	Low																					N	N	N	N
	Medium																					Y	N	N	N
	High																					Y	Y	Y	Y
Dental - Adults	Low																					Y	Y	Y	Y
	Medium																					--	--	--	--
	High																					--	--	--	--
Pharmacy	Low	Y	Y	Y	Y	Y	Y	Y	Y	N	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				

Exhibit III.7B
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
All Claim Types
By All MCOs and By Quarter

	Paid Claims	Denied Claims
All MCOs Q2 2018	7.6	4.8
All MCOs Q3 2018	8.0	6.0
All MCOs Q4 2018	8.4	6.0
All MCOs Q1 2019	8.3	5.9
Aetna Q2 2018	10.3	7.4
Aetna Q3 2018	10.7	6.4
Aetna Q4 2018	10.8	5.7
Aetna Q1 2019	9.0	7.1
ACLA Q2 2018	3.9	4.3
ACLA Q3 2018	3.6	3.7
ACLA Q4 2018	4.4	5.0
ACLA Q1 2019	4.9	5.6
Healthy Blue Q2 2018	7.6	4.0
Healthy Blue Q3 2018	7.8	4.2
Healthy Blue Q4 2018	7.4	3.4
Healthy Blue Q1 2019	7.9	3.4
LHCC Q2 2018	6.6	6.0
LHCC Q3 2018	8.8	9.7
LHCC Q4 2018	9.2	10.2
LHCC Q1 2019	9.0	10.5
UHC Q2 2018	9.2	3.5
UHC Q3 2018	9.0	4.0
UHC Q4 2018	9.7	4.6
UHC Q1 2019	9.4	3.2
MCNA Q2 2018	9.0	10.2
MCNA Q3 2018	7.3	8.1
MCNA Q4 2018	7.3	7.9
MCNA Q1 2019	7.1	7.2

Exhibit III.8A
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
Institutional Providers
By All MCOs Combined By Quarter

	Paid Claims	Denied Claims
Inpatient Hospital Q2 2018	10.7	11.8
Inpatient Hospital Q3 2018	10.3	12.1
Inpatient Hospital Q4 2018	10.9	14.6
Inpatient Hospital Q1 2019	10.6	11.3
Outpatient Hospital Q2 2018	7.2	9.5
Outpatient Hospital Q3 2018	7.3	9.8
Outpatient Hospital Q4 2018	7.7	10.2
Outpatient Hospital Q1 2019	7.1	8.6
Home Health Q2 2018	8.5	9.2
Home Health Q3 2018	8.5	8.1
Home Health Q4 2018	8.8	9.8
Home Health Q1 2019	8.6	11.4
Other Institutional Claims Q2 2018	6.1	11.6
Other Institutional Claims Q3 2018	6.3	11.2
Other Institutional Claims Q4 2018	6.1	11.1
Other Institutional Claims Q1 2019	5.6	8.8

Exhibit III.8B
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
Professional Service Providers
By All MCOs Combined By Quarter

	Paid Claims	Denied Claims
Primary Care Q2 2018	7.2	7.8
Primary Care Q3 2018	7.2	7.9
Primary Care Q4 2018	7.7	8.5
Primary Care Q1 2019	7.5	8.2
Pediatrics Q2 2018	6.1	8.1
Pediatrics Q3 2018	6.1	8.0
Pediatrics Q4 2018	6.4	7.7
Pediatrics Q1 2019	6.5	7.9
OB-GYN Q2 2018	6.3	7.8
OB-GYN Q3 2018	6.4	8.3
OB-GYN Q4 2018	6.4	7.4
OB-GYN Q1 2019	6.6	7.9
Therapists (PT/OT/ST) Q2 2018	9.4	8.1
Therapists (PT/OT/ST) Q3 2018	8.9	9.0
Therapists (PT/OT/ST) Q4 2018	7.8	7.6
Therapists (PT/OT/ST) Q1 2019	7.0	8.6
Non-Emerg Transport Q2 2018	10.1	9.4
Non-Emerg Transport Q3 2018	10.6	10.0
Non-Emerg Transport Q4 2018	8.4	9.5
Non-Emerg Transport Q1 2019	10.6	11.1
Medical Equip/Supplies Q2 2018	8.1	9.8
Medical Equip/Supplies Q3 2018	8.3	9.7
Medical Equip/Supplies Q4 2018	8.3	10.1
Medical Equip/Supplies Q1 2019	7.7	8.1
All Other Professional Q2 2018	7.4	8.7
All Other Professional Q3 2018	7.3	8.2
All Other Professional Q4 2018	7.4	8.0
All Other Professional Q1 2019	7.1	7.7

Exhibit III.8C
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
Behavioral Health, Dental and Pharmacy
By All MCOs Combined By Quarter

	Paid Claims	Denied Claims
Mental/Behavioral Rehab Q2 2018	6.9	10.4
Mental/Behavioral Rehab Q3 2018	7.4	9.7
Mental/Behavioral Rehab Q4 2018	7.4	9.8
Mental/Behavioral Rehab Q1 2019	8.4	9.1
Mental/Behavioral Other Q2 2018	8.0	9.6
Mental/Behavioral Other Q3 2018	8.1	8.4
Mental/Behavioral Other Q4 2018	8.6	9.5
Mental/Behavioral Other Q1 2019	8.4	10.9
Dental - Children Q2 2018	9.0	10.2
Dental - Children Q3 2018	7.3	8.1
Dental - Children Q4 2018	7.3	8.0
Dental - Children Q1 2019	7.1	7.2
Dental - Adults Q2 2018	6.9	7.1
Dental - Adults Q3 2018	6.8	7.3
Dental - Adults Q4 2018	6.9	7.7
Dental - Adults Q1 2019	7.0	5.5
Pharmacy Q2 2018	8.0	0.8
Pharmacy Q3 2018	9.9	3.4
Pharmacy Q4 2018	10.7	3.0
Pharmacy Q1 2019	11.1	3.2

Exhibit III.9A
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
By Provider Specialty - Institutional Providers
By MCO for Q1 2019 Adjudicated Claims

Inpatient Hospital	**Quarter 1 2019**	
	Paid	**Denied**
All MCOs	10.6	11.3
Aetna	19.6	13.3
ACLA	8.3	8.1
Healthy Blue	7.5	9.0
LHCC	10.0	13.0
UHC	10.7	12.3

Outpatient Hospital	**Quarter 1 2019**	
	Paid	**Denied**
All MCOs	7.1	8.6
Aetna	9.0	7.9
ACLA	4.1	5.2
Healthy Blue	4.6	8.1
LHCC	8.3	10.3
UHC	8.5	9.0

Home Health	**Quarter 1 2019**	
	Paid	**Denied**
All MCOs	8.6	11.4
Aetna	10.2	16.5
ACLA	5.1	5.6
Healthy Blue	5.5	7.3
LHCC	10.2	10.3
UHC	8.5	6.3

Other Institutional	**Quarter 1 2019**	
	Paid	**Denied**
All MCOs	5.6	8.8
Aetna	11.3	9.7
ACLA	5.8	5.3
Healthy Blue	4.6	7.9
LHCC	8.2	9.8
UHC	10.3	12.8

Exhibit III.9B
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
By Provider Specialty - Professional Providers, Part 1
By MCO for Q1 2019 Adjudicated Claims

Primary Care	**Quarter 1 2019**	
	Paid	**Denied**
All MCOs	7.5	8.2
Aetna	7.3	8.9
ACLA	3.7	4.4
Healthy Blue	6.8	6.8
LHCC	8.1	9.9
UHC	8.2	7.5

Pediatrics	**Quarter 1 2019**	
	Paid	**Denied**
All MCOs	6.5	7.9
Aetna	8.9	10.4
ACLA	3.7	4.5
Healthy Blue	5.1	6.3
LHCC	7.7	8.6
UHC	7.7	7.5

OB-GYN	**Quarter 1 2019**	
	Paid	**Denied**
All MCOs	6.6	7.9
Aetna	7.2	10.1
ACLA	3.7	4.2
Healthy Blue	6.1	8.7
LHCC	7.7	9.8
UHC	7.9	8.4

Therapists (Physical, Occupational, Speech)	**Quarter 1 2019**	
	Paid	**Denied**
All MCOs	7.0	8.6
Aetna	9.9	11.8
ACLA	4.9	6.7
Healthy Blue	5.8	8.1
LHCC	7.9	9.3
UHC	8.1	8.6

Exhibit III.9C
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
By Provider Specialty - Professional Providers, Part 2
By MCO for Q1 2019 Adjudicated Claims

Non-Emergency Medical Transportation	Quarter 1 2019	
	Paid	Denied
All MCOs	10.6	11.1
Aetna	10.6	17.8
ACLA	9.2	8.5
Healthy Blue	11.4	14.5
LHCC	11.0	16.6
UHC	9.0	8.2

Medical Equipment and Supplies	Quarter 1 2019	
	Paid	Denied
All MCOs	7.7	8.1
Aetna	9.1	11.0
ACLA	4.8	5.5
Healthy Blue	5.4	6.6
LHCC	8.3	9.7
UHC	8.3	7.5

All Other Professional Services exc. BH and Dental	Quarter 1 2019	
	Paid	Denied
All MCOs	7.1	7.7
Aetna	7.2	8.9
ACLA	4.6	5.6
Healthy Blue	5.3	6.5
LHCC	8.2	9.4
UHC	8.1	7.5

Exhibit III.9D
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
By Provider Specialty - Behavioral Health, Dental and Pharmacy
By MCO for Q1 2019 Adjudicated Claims

Mental/Behavioral Health - Rehab	Quarter 1 2019	
	Paid	Denied
All MCOs	8.4	9.1
Aetna	7.9	10.0
ACLA	5.6	11.0
Healthy Blue	9.2	7.6
LHCC	8.6	9.4
UHC	8.6	9.8

Mental/Behavioral Health - Other	Quarter 1 2019	
	Paid	Denied
All MCOs	8.4	10.9
Aetna	7.1	8.9
ACLA	4.3	5.2
Healthy Blue	6.7	7.1
LHCC	9.2	15.5
UHC	10.7	8.8

Pharmacy	Quarter 1 2019	
	Paid	Denied
All MCOs	11.1	3.2
Aetna	11.1	1.0
ACLA	5.9	5.4
Healthy Blue	13.6	1.0
LHCC	11.2	11.2
UHC	11.7	0.0

Dental (MCNA is the only MCO)	Quarter 1 2019	
	Paid	Denied
Dental - Children	7.1	7.2
Dental - Adults	7.4	7.1

Exhibit III.10
Details on Reasons for Denied Claims
By MCO for Q1 2019 Adjudicated Claims

For Medical Claims

			Ranking for the Individual MCO					
CARC	Description	Rank Among All MCOs	Aetna	ACLA	Healthy Blue	LHCC	UHC	MCNA
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	1	1	3		3		
197	Precertification/authorization/notification absent.	2		2	1	1	5	
96	Non-covered charge(s).	3	5	4		2	2	3
18	Exact duplicate claim/service	4	3			4	4	2
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	5		1				
252	An attachment/other documentation is required to adjudicate this claim/service.	6		5	3		3	
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	7	4				1	
22	This care may be covered by another payer per coordination of benefits.	8				5		
204	This service/equipment/drug is not covered under the patient's current benefit plan	9						
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has be	10						

For Pharmacy Claims

		Rank Among	Ranking for the Individual MCO				
NCPDP	Description	All MCOs	Aetna	ACLA	ealthyBlu	LHCC	UHC
79	Refill Too Soon	1	1		2	2	4
76	Plan Limitations Exceeded	2	3		4	1	2
88	DUR Reject Error	3			3		1
7Ø	Product/Service Not Covered – Plan/Benefit Exclusion	4	2			3	3
75	Prior Authorization Required	5	5	2	5		5
MR	Product Not On Formulary	6			1		
39	Missing/Invalid Diagnosis Code	7		4		4	
19	Missing/Invalid Days Supply	8				5	
69	Filled After Coverage Terminated	9	4				
41	Submit Bill To Other Processor Or Primary Payer	10					

Exhibit III.11
Details on Reasons for Denied Medical Claims
By MCO and By Provider Category for Q1 2019 Adjudicated Claims
Top 5 Denial Codes for Each MCO

An X indicates that this denial reason is also in the Top 5 for the provider category.

CARC	Description	Inpatient Hospital	Outpatient Hospital	Home Health	Other Institutional	Primary Care	Pediatrics	OB-GYN	Therapists	Non-Emerg Transport	Medical Equipment	Other Professional	Mental/Behavioral - Rehab	Mental/Behavioral - Other	Adult Dental	Pediatric Dental
Aetna																
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	1	1	3	1	1	2	1	3	1	1	2	1	1		
147	Provider contracted/negotiated rate expired or not on file.		2	4	5	4	3	5		3						
18	Exact duplicate claim/service	3	5	1	2	5		3	1	3	3	1	2	3		
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	4	4	2	2	5	5	4	2	3	4	4	3	5		
96	Non-covered charge(s).		3		4	2	1	2		3	5	3				
ACLA																
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.							3				1				
197	Precertification/authorization/notification absent.	4	4	2	3	3	2	1	1		1	3	3	1		
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.		2			2	4	4	4	1	3	2				
96	Non-covered charge(s).	2	1	1	1	1	1	2	2	5	2	4	5	3		
252	An attachment/other documentation is required to adjudicate this claim/service.		3					5	3	5			1	4		
Healthy Blue																
197	Precertification/authorization/notification absent.	3	3	3	1	2	3	4	2	3	2	1	2	1		
256	Service not payable per managed care contract.	5	2	1	3	1	1	2	1	3	1	2		5		
252	An attachment/other documentation is required to adjudicate this claim/service.	4	1	4	2	3	5	3	4	2	5	3	4	3		
119	Benefit maximum for this time period or occurrence has been reached.			5				5		3	5		3	4		
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period.		5	5						3	3	4	5	2		

Exhibit III.11 (continued)
Details on Reasons for Denied Medical Claims
By MCO and By Provider Category for Q4 2018 Adjudicated Claims
Top 5 Denial Codes for Each MCO

An X indicates that this denial reason is also in the Top 5 for the provider category.

CARC	Description	Inpatient Hospital	Outpatient Hospital	Home Health	Other Institutional	Primary Care	Pediatrics	OB-GYN	Therapists	Non-Emerg Transport	Medical Equipment	Other Professional	Mental/Behavioral - Rehab	Mental/Behavioral - Other	Adult Dental	Pediatric Dental
LHCC																
197	Precertification/authorization/notification absent.	4		3	3				1	3	2	1	4	1		
96	Non-covered charge(s).	5	1		2	1	1	1		3	5	4				
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	2	2	1	1	4		3	4	1	1	2	1	3		
18	Exact duplicate claim/service		4	2	5	3	3	2		3		3	3	2		
22	This care may be covered by another payer per coordination of benefits.		3			5			2	3						
United																
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.		3	4	4	4	1	2			1	1				
96	Non-covered charge(s).	5	2	4	1	1	2	1	1	3	2	2				
252	An attachment/other documentation is required to adjudicate this claim/service.		1		3	2	3	4	5	4	3	3		3		
18	Exact duplicate claim/service	4	5			3	4	3	4		4	5	2	2		
197	Precertification/authorization/notification absent.	3		2		5			3			4	3	1		
MCNA																
169	Alternate benefit has been provided.														1	
18	Exact duplicate claim/service.														2	4
96	Non-covered charge(s).														4	1
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period.														3	
6	The procedure/revenue code is inconsistent with the patient's age.														5	

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

	Accepted	Rejected
All MCOs Q2 2018	98.4%	4.6%
All MCOs Q3 2018	97.2%	5.8%
All MCOs Q4 2018	98.1%	4.6%
All MCOs Q1 2019	99.3%	3.4%
Aetna Q2 2018	97.6%	2.4%
Aetna Q3 2018	99.6%	0.4%
Aetna Q4 2018	97.4%	2.6%
Aetna Q1 2019	96.9%	3.1%
ACLA Q2 2018	94.9%	5.1%
ACLA Q3 2018	88.2%	11.8%
ACLA Q4 2018	93.2%	6.8%
ACLA Q1 2019	97.8%	2.2%
HBL Q2 2018	100.0%	0.0%
HBL Q3 2018	100.0%	0.0%
HBL Q4 2018	100.0%	0.0%
HBL Q1 2019	100.0%	0.0%
LHCC Q2 2018	98.0%	2.0%
LHCC Q3 2018	98.4%	1.6%
LHCC Q4 2018	98.2%	1.8%
LHCC Q1 2019	99.8%	0.2%
UHC Q2 2018	100.0%	0.0%
UHC Q3 2018	100.0%	0.0%
UHC Q4 2018	100.0%	0.0%
UHC Q1 2019	100.0%	0.0%
MCNA Q2 2018	99.2%	0.8%
MCNA Q3 2018	99.3%	0.7%
MCNA Q4 2018	99.2%	0.8%
MCNA Q1 2019	99.2%	0.8%

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

	Institutional Encounters (837I)		Professional Encounters (837D)		Dental Encounters (837D)		Pharmacy Encounters	
	Accepted	Rejected	Accepted	Rejected	Accepted	Rejected	Accepted	Rejected
Aetna Q2 2018	94.8%	5.2%	98.9%	1.1%			100.0%	0.0%
Aetna Q3 2018	100.0%	0.0%	99.1%	0.9%			100.0%	0.0%
Aetna Q4 2018	94.5%	5.5%	97.9%	2.1%			100.0%	0.0%
Aetna Q1 2019	95.6%	4.4%	98.9%	1.1%			95.0%	5.0%
ACLA Q2 2018	97.7%	2.3%	98.6%	1.4%			90.0%	10.0%
ACLA Q3 2018	82.4%	17.6%	98.3%	1.7%			85.9%	14.1%
ACLA Q4 2018	94.5%	5.5%	100.0%	0.0%			86.2%	13.8%
ACLA Q1 2019	100.0%	0.0%	99.6%	0.4%			93.7%	6.3%
HBL Q2 2018	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
HBL Q3 2018	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
HBL Q4 2018	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
HBL Q1 2019	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
LHCC Q2 2018	99.4%	0.6%	97.2%	2.8%			98.0%	2.0%
LHCC Q3 2018	99.3%	0.7%	97.3%	2.7%			100.0%	0.0%
LHCC Q4 2018	99.1%	0.9%	97.5%	2.5%			98.7%	1.3%
LHCC Q1 2019	100.0%	0.0%	100.0%	0.0%			99.0%	1.0%
UHC Q2 2018	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
UHC Q3 2018	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
UHC Q4 2018	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
UHC Q1 2019	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
MCNA Q2 2018					99.2%	0.8%		
MCNA Q3 2018					99.3%	0.7%		
MCNA Q4 2018					99.2%	0.8%		
MCNA Q1 2019					99.2%	0.8%		

Exhibit IV.4 and Exhibit IV.5
Encounter Submissions Accepted and Rejected by LDH
Institutional, Professional, Dental, and Pharmacy Claim Types
By MCO and By Quarter

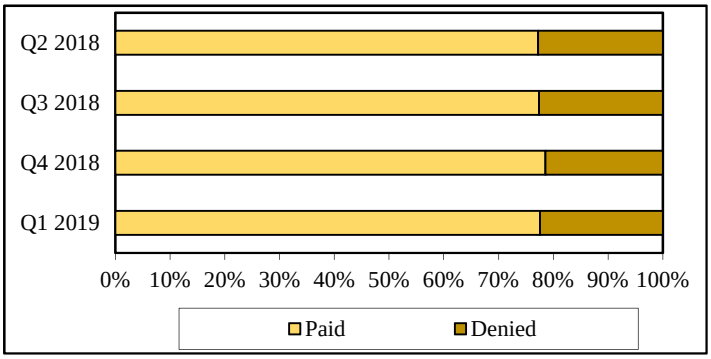
	Institutional Encounters (837I)		Professional Encounters (837D)		Dental Encounters (837D)		Pharmacy Encounters	
	Within 30 Days	After 30 Days	Within 30 Days	After 30 Days	Within 30 Days	After 30 Days	Within 30 Days	After 30 Days
Aetna Q2 2018	84.1%	15.9%	93.0%	7.0%			84.5%	15.5%
Aetna Q3 2018	84.0%	16.0%	87.9%	12.1%			95.0%	5.0%
Aetna Q4 2018	87.2%	12.8%	96.2%	3.8%			71.1%	28.9%
Aetna Q1 2019	91.9%	8.1%	93.8%	6.2%			76.5%	23.5%
ACLA Q2 2018	96.4%	3.6%	98.5%	1.5%			78.6%	21.4%
ACLA Q3 2018	58.9%	41.1%	96.1%	3.9%			92.5%	7.5%
ACLA Q4 2018	96.5%	3.5%	95.6%	4.4%			76.3%	23.7%
ACLA Q1 2019	96.8%	3.2%	93.2%	6.8%			90.8%	9.2%
HBL Q2 2018	100.0%	0.0%	99.0%	1.0%			99.9%	0.1%
HBL Q3 2018	100.0%	0.0%	98.5%	1.5%			98.1%	1.9%
HBL Q4 2018	100.0%	0.0%	95.1%	4.9%			100.0%	0.0%
HBL Q1 2019	100.0%	0.0%	96.1%	3.9%			98.5%	1.5%
LHCC Q2 2018	98.7%	1.3%	95.7%	4.3%			96.9%	3.1%
LHCC Q3 2018	98.3%	1.7%	92.5%	7.5%			98.1%	1.9%
LHCC Q4 2018	93.9%	6.1%	89.2%	10.8%			98.9%	1.1%
LHCC Q1 2019	88.5%	11.5%	79.7%	20.3%			74.6%	25.4%
UHC Q2 2018	97.6%	2.4%	90.1%	9.9%			70.0%	30.0%
UHC Q3 2018	98.7%	1.3%	95.8%	4.2%			97.7%	2.3%
UHC Q4 2018	98.5%	1.5%	97.4%	2.6%			99.0%	1.0%
UHC Q1 2019	99.5%	0.5%	95.1%	4.9%			98.3%	1.7%
MCNA Q2 2018					99.4%	0.6%		
MCNA Q3 2018					98.1%	1.9%		
MCNA Q4 2018					100.0%	0.0%		
MCNA Q1 2019					99.4%	0.6%		

APPENDIX E

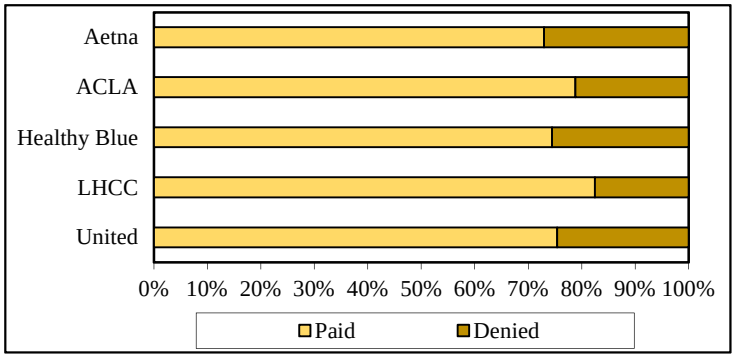
One-Page Summaries of Information on Claims for Each of the 16 Provider Types Shown in this Report

Summary of Information on Claims for Inpatient Hospital Services

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

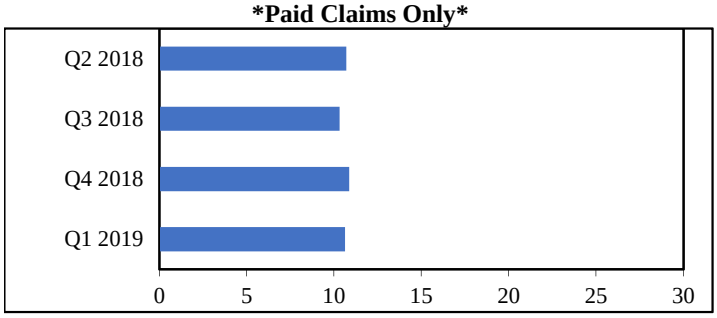


Paid and Denied Trend Quarter 1 2019 only For Each MCO



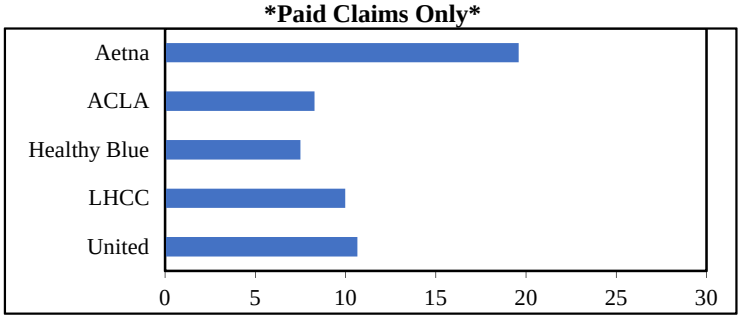
Claims Turnaround Time Most Recent 4 Qtrs All MCOs

Paid Claims Only

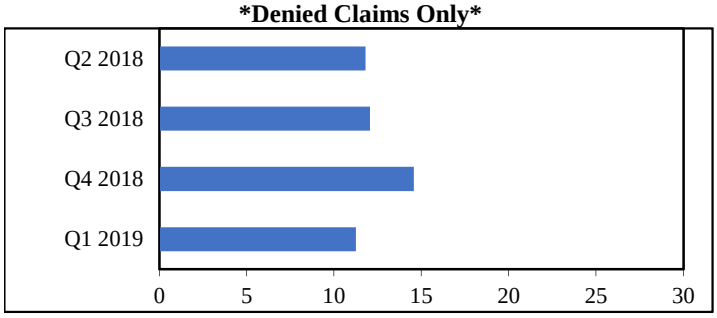


Claims Turnaround Time Quarter 1 2019 only Each MCO

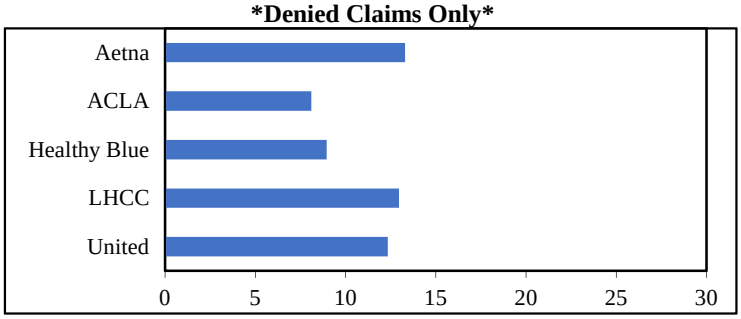
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in the Quarter 1 2019 only)

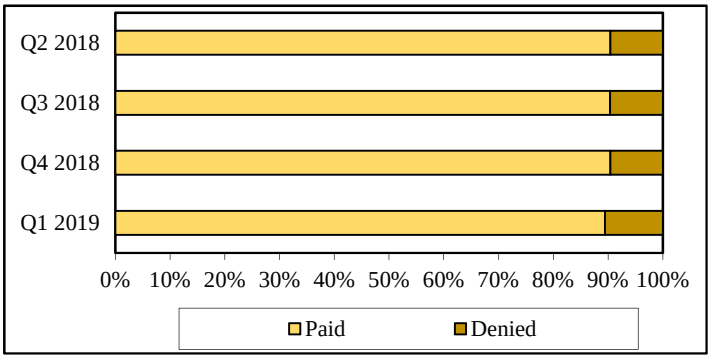
	Aetna		ACLA		Healthy Blue		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	146	109	251	154	269	181	191	137	222	137
101 - 250	33	30	27	17	37	36	42	36	38	32
> 250 claims	16	16	0	0	3	3	107	60	1	0

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

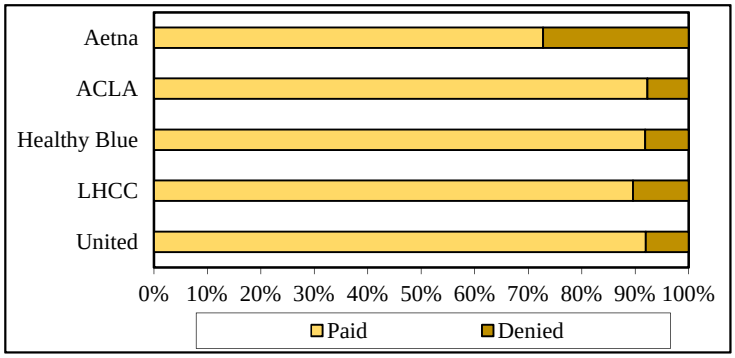
CARC Code	Description	Aetna	ACLA	HBL	LHCC	UHC
16	Claim/service lacks information or has submission/billing error(s	X			X	X
133	The disposition of this service line is pending further review.				X	
199	Revenue code and Procedure code do not match.	X				
18	Exact duplicate claim/service	X				X
128	Newborn's services are covered in the mother's Allowance.		X	X		X

Summary of Information on Claims for Outpatient Hospital Services

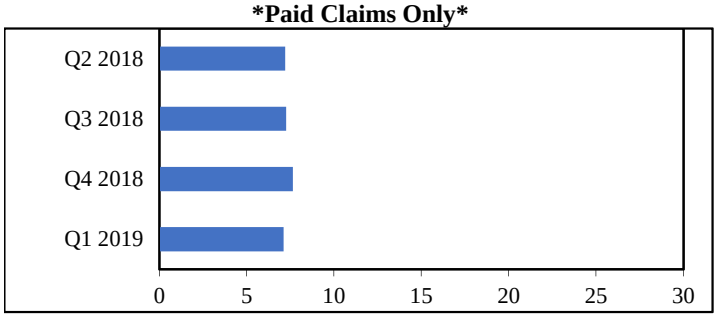
Paid and Denied Trend, Most Recent Four Quarters, All MCOs



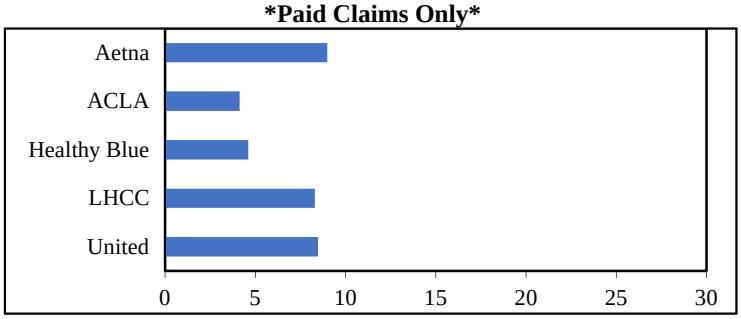
Paid and Denied Trend Quarter 1 2019 only For Each MCO



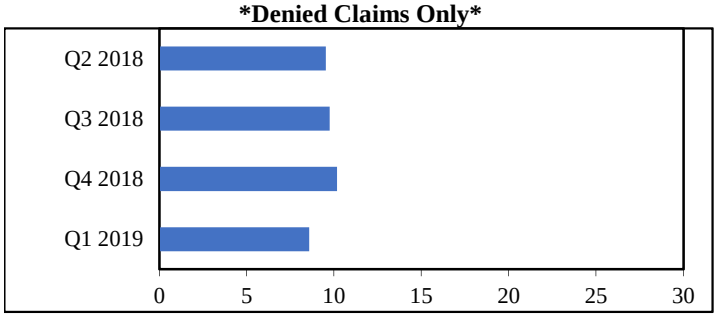
Claims Turnaround Time Most Recent 4 Qtrs All MCOs
Paid Claims Only



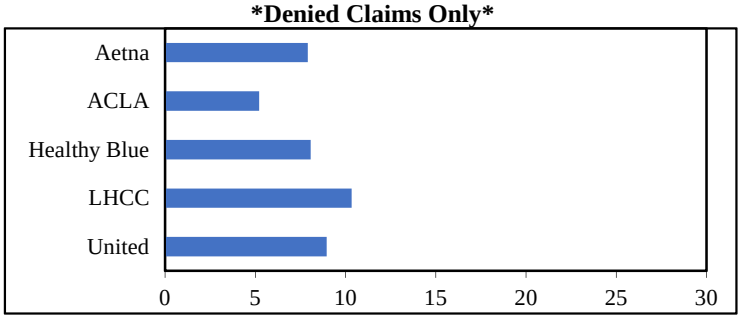
Claims Turnaround Time Quarter 1 2019 only Each MCO
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in the Quarter 1 2019 only)

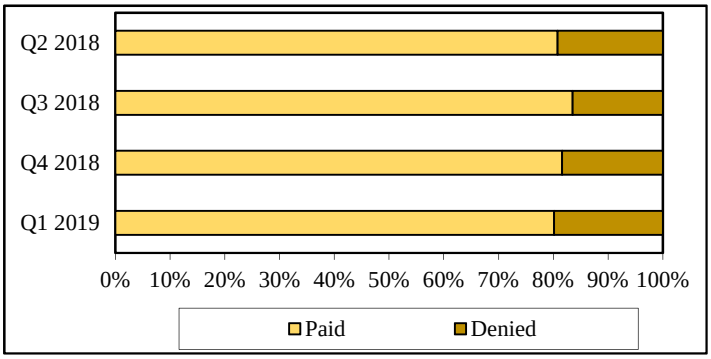
	Aetna		ACLA		Healthy Blue		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	233	144	431	219	401	128	499	263	1,019	614
101 - 250	70	68	80	26	21	16	86	77	130	86
> 250 claims	65	61	121	21	102	33	41	38	140	34

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

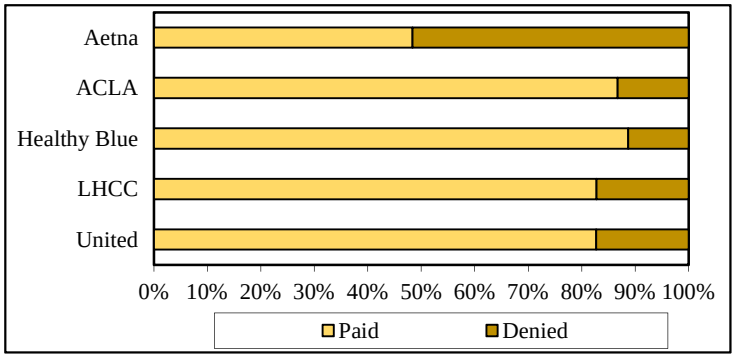
CARC Code	Description	Aetna	ACLA	HBL	LHCC	UHC
16	Claim/service lacks information or has submission/billing error(s	X	X		X	X
96	Non-covered charge(s).	X	X		X	X
252	An attachment/other documentation is required to adjudicate this		X	X		X
18	Exact duplicate claim/service	X			X	X
97	The benefit for this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

Summary of Information on Claims for Home Health Services

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

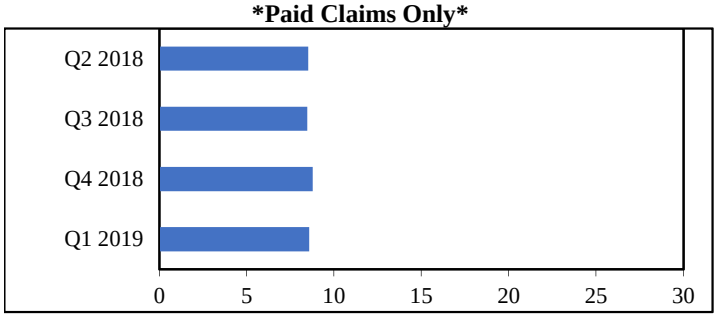


Paid and Denied Trend Quarter 1 2019 only For Each MCO



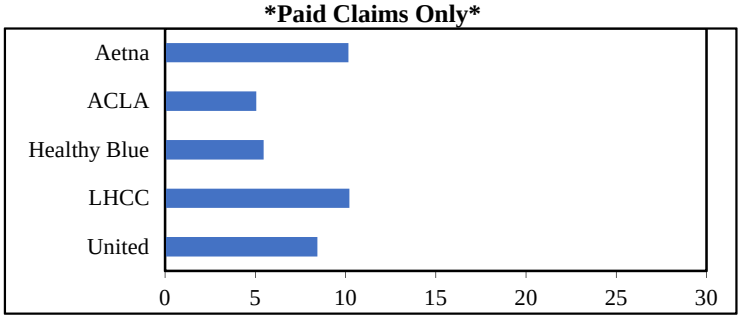
Claims Turnaround Time Most Recent 4 Qtrs All MCOs

Paid Claims Only

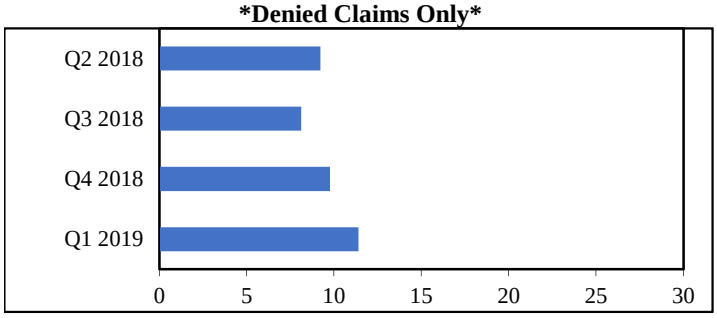


Claims Turnaround Time Quarter 1 2019 only Each MCO

Paid Claims Only



Denied Claims Only



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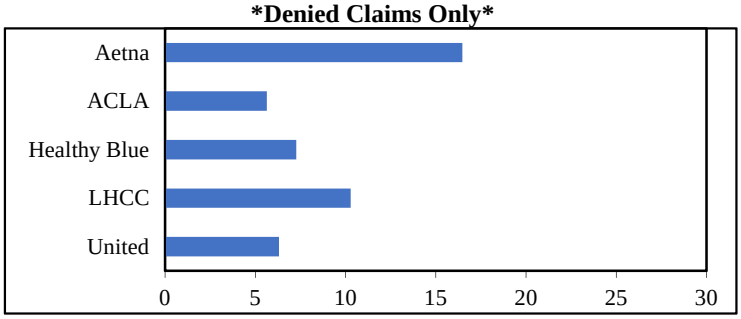


Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 1 2019 only)

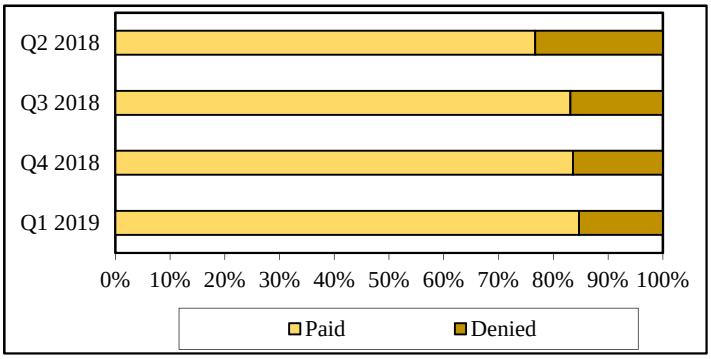
	Aetna		ACLA		Healthy Blue		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	33	24	42	26	46	13	81	50	28	16
101 - 250	3	3	18	7	10	3	49	36	1	0
> 250 claims	1	1	2	0	2	2	15	11	0	0

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

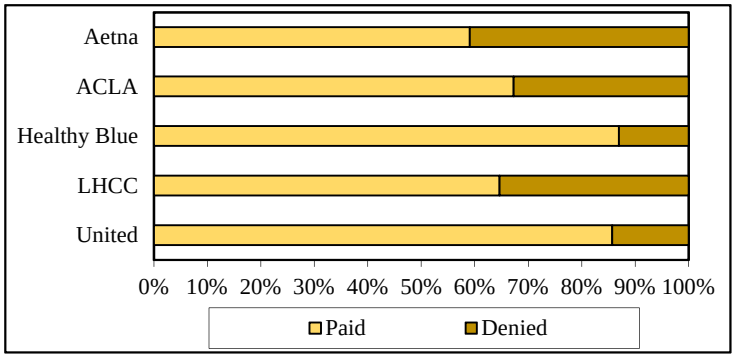
CARC Code	Description	Aetna	ACLA	HBL	LHCC	UHC
16	Claim/service lacks information or has submission/billing error(s	X		X	X	X
18	Exact duplicate claim/service	X		X	X	
97	The benefit for this service is included in the payment/allowance	X		X		X
197	Precertification/authorization/notification absent.		X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

Summary of Information on Claims for Other Institutional Services

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

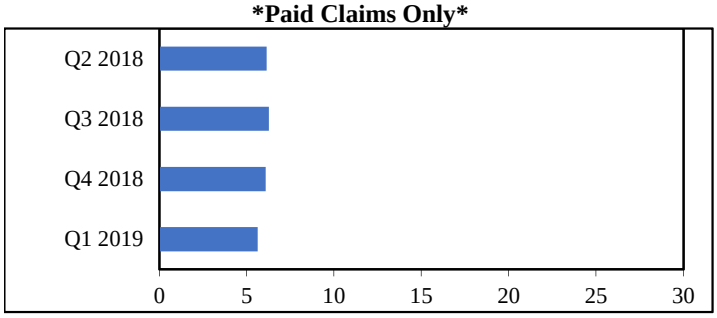


Paid and Denied Trend Quarter 1 2019 only For Each MCO



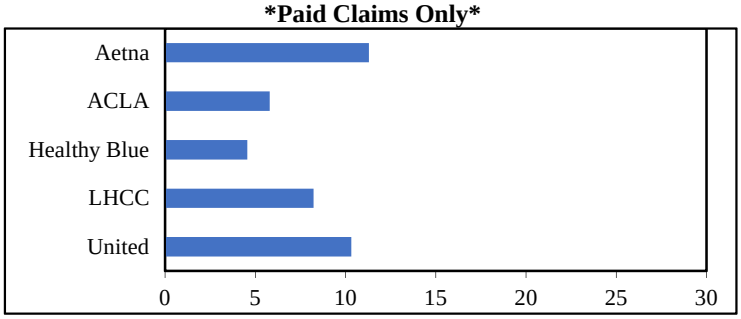
Claims Turnaround Time Most Recent 4 Qtrs All MCOs

Paid Claims Only

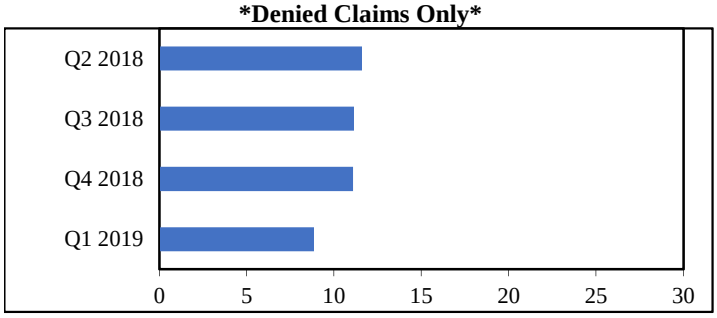


Claims Turnaround Time Quarter 1 2019 only Each MCO

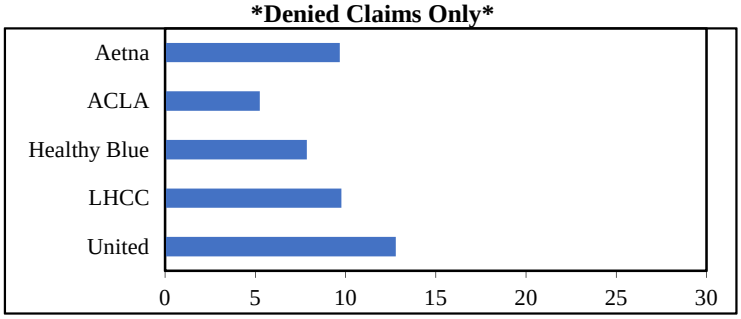
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 1 2019 only)

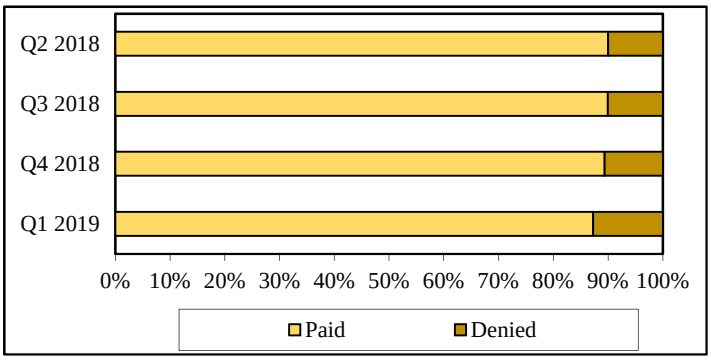
	Aetna		ACLA		Healthy Blue		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	6	3	14	11	123	50	94	69	19	6
101 - 250	0	0	1	0	46	16	5	5	15	3
> 250 claims	0	0	0	0	14	4	0	0	4	3

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

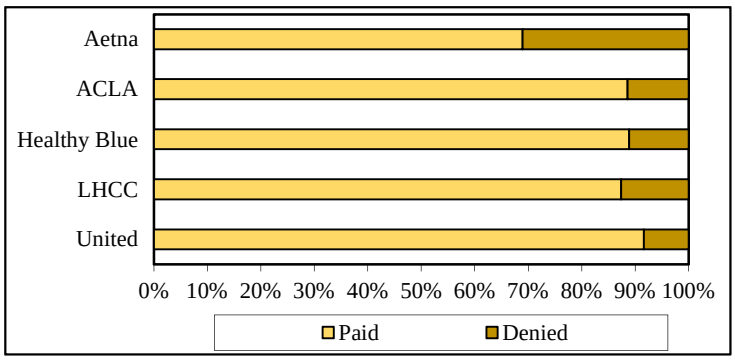
CARC Code	Description	Aetna	ACLA	HBL	LHCC	UHC
147	Provider contracted/negotiated rate expired or not on file.	X				
16	Claim/service lacks information or has submission/billing error(s	X			X	
97	The benefit for this service is included in the payment/allowance	X				X
18	Exact duplicate claim/service	X			X	
96	Non-covered charge(s).	X	X		X	X

Summary of Information on Claims for Primary Care Services

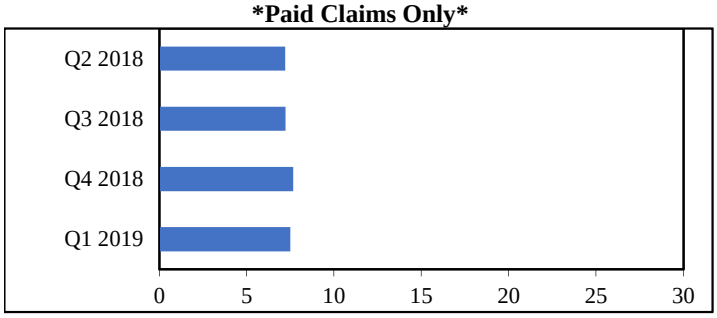
Paid and Denied Trend, Most Recent Four Quarters, All MCOs



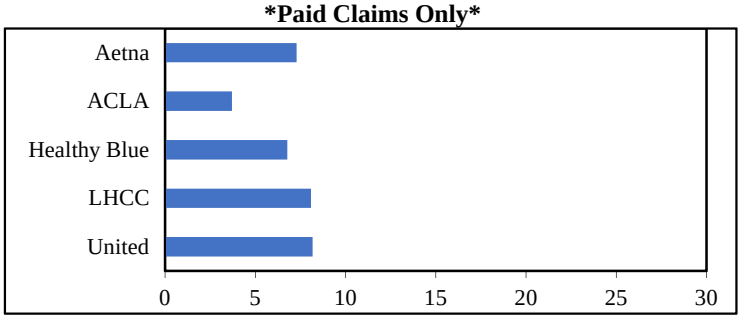
Paid and Denied Trend Quarter 1 2019 only For Each MCO



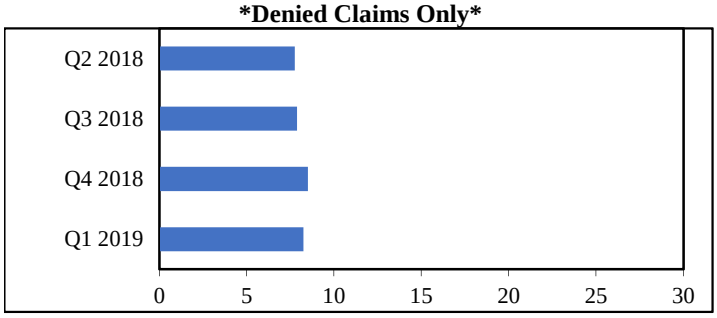
Claims Turnaround Time Most Recent 4 Qtrs All MCOs
Paid Claims Only



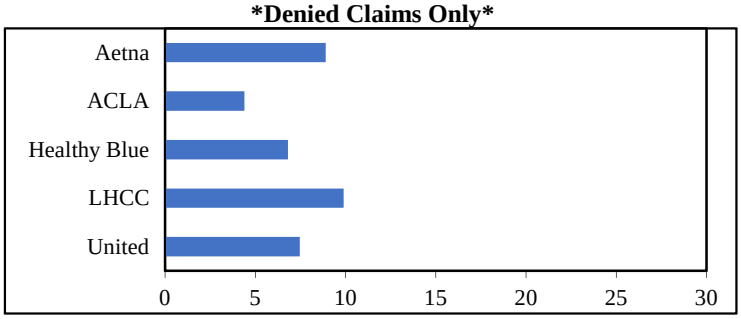
Claims Turnaround Time Quarter 1 2019 only Each MCO
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 1 2019 only)

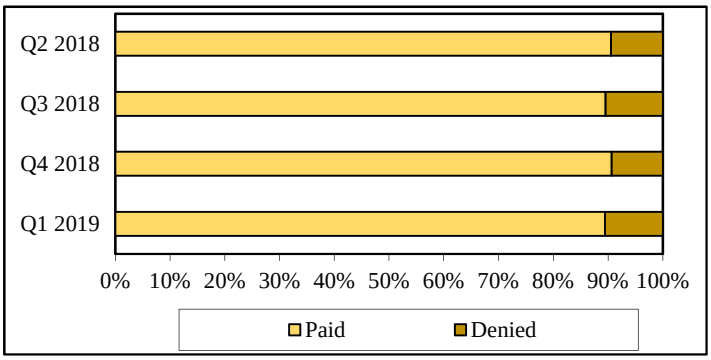
	Aetna		ACLA		Healthy Blue		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	19	8	625	307	3,519	1365	3,318	1420	1,157	677
101 - 250	1	1	230	97	834	256	1,098	513	278	124
> 250 claims	0	0	70	21	187	53	479	268	292	78

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

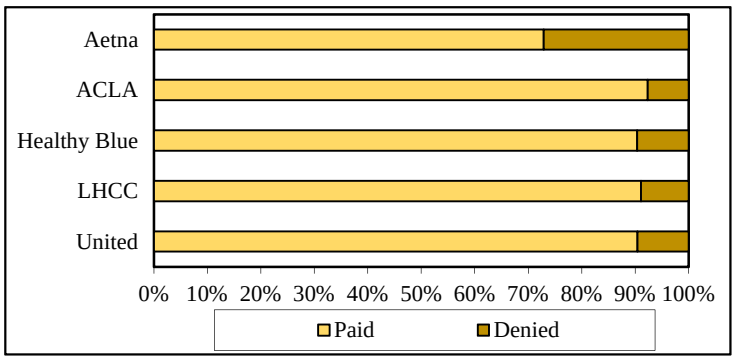
CARC Code	Description	Aetna	ACLA	HBL	LHCC	UHC
96	Non-covered charge(s).	X	X		X	X
256	Service not payable per managed care contract.			X		
197	Precertification/authorization/notification absent.		X	X		X
246	This non-payable code is for required reporting only.					
252	An attachment/other documentation is required to adjudicate this			X		X

Summary of Information on Claims for Pediatric Services

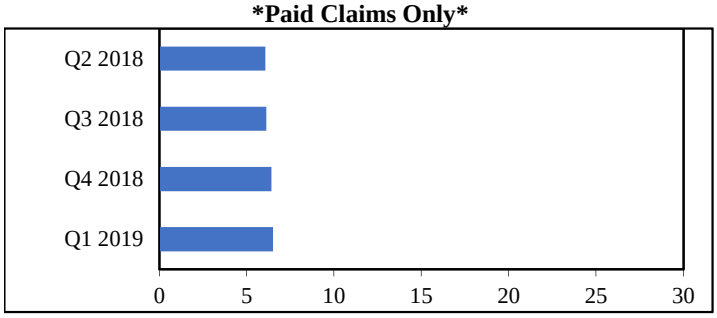
Paid and Denied Trend, Most Recent Four Quarters, All MCOs



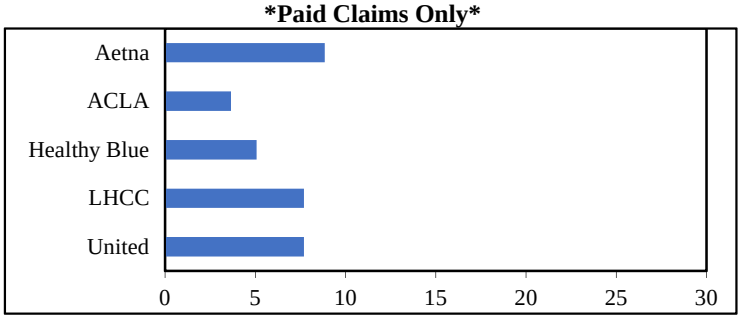
Paid and Denied Trend Quarter 1 2019 only For Each MCO



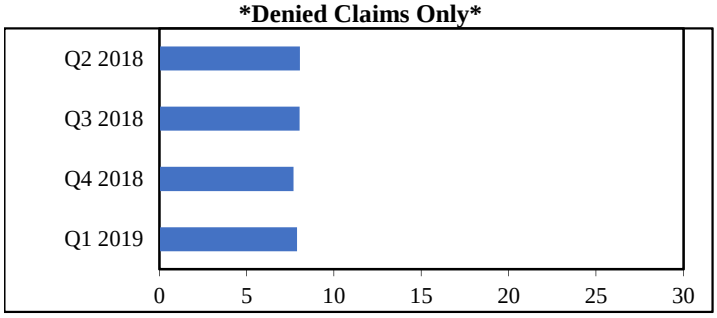
Claims Turnaround Time Most Recent 4 Qtrs All MCOs
Paid Claims Only



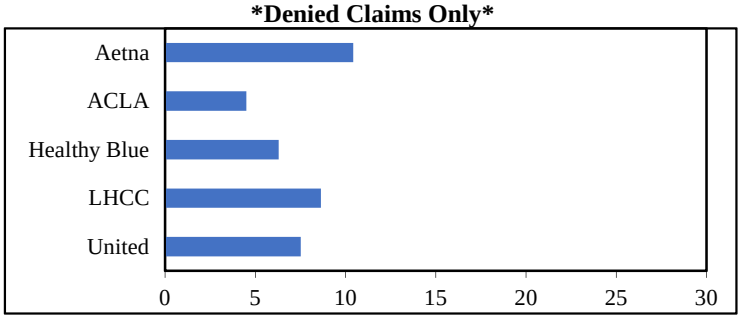
Claims Turnaround Time Quarter 1 2019 only Each MCO
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 1 2019 only)

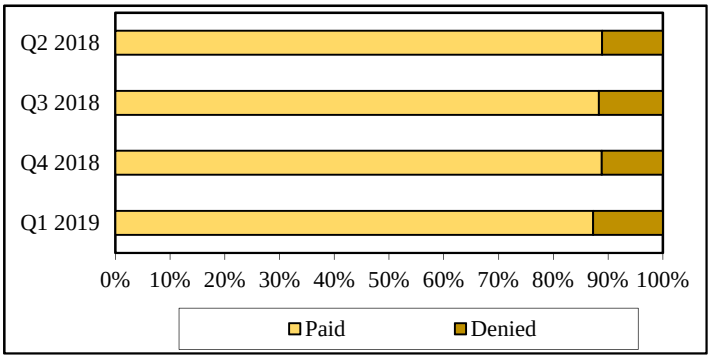
	Aetna		ACLA		Healthy Blue		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	5	2	114	46	365	140	258	85	45	26
101 - 250	1	0	94	17	294	93	208	72	13	6
> 250 claims	0	0	79	19	149	40	234	90	68	20

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

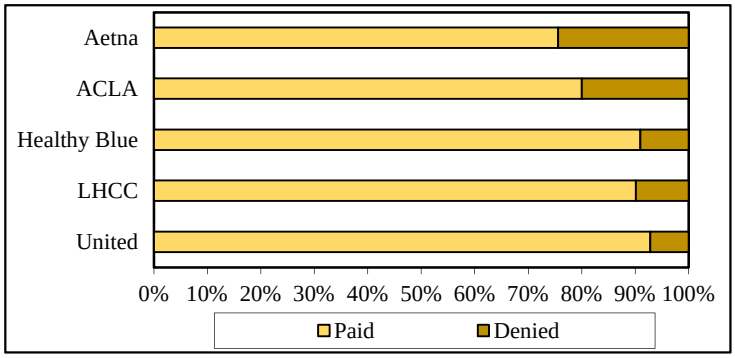
CARC Code	Description	Aetna	ACLA	HBL	LHCC	UHC
97	The benefit for this service is included in the payment/allowance	X	X			X
96	Non-covered charge(s).	X	X		X	X
256	Service not payable per managed care contract.			X		
197	Precertification/authorization/notification absent.		X	X		
252	An attachment/other documentation is required to adjudicate this			X		X

Summary of Information on Claims for OBGYN Services

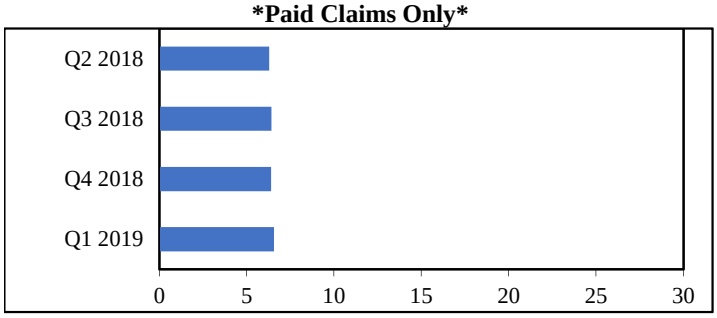
Paid and Denied Trend, Most Recent Four Quarters, All MCOs



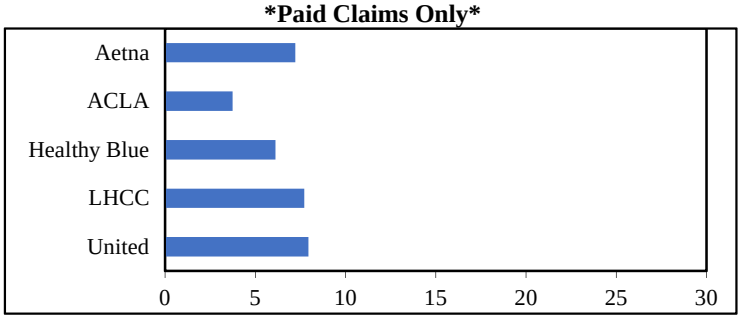
Paid and Denied Trend Quarter 1 2019 only For Each MCO



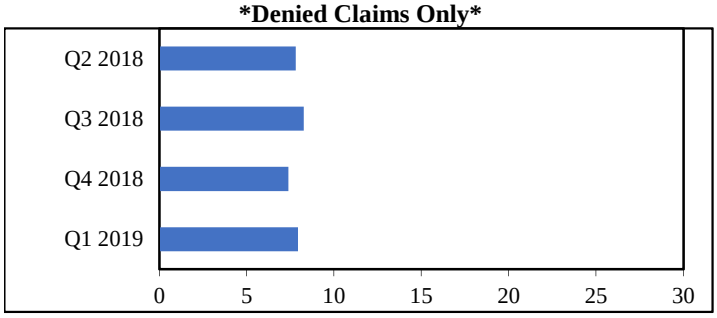
Claims Turnaround Time Most Recent 4 Qtrs All MCOs
Paid Claims Only



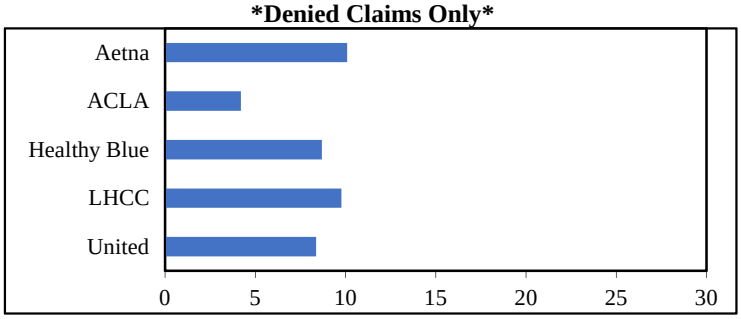
Claims Turnaround Time Quarter 1 2019 only Each MCO
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 1 2019 only)

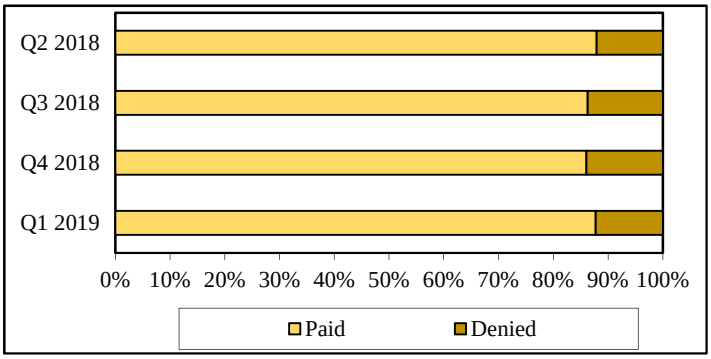
	Aetna		ACLA		Healthy Blue		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	3	1	103	66	303	123	254	110	38	25
101 - 250	0	0	73	52	202	66	195	90	24	8
> 250 claims	0	0	22	15	24	5	57	30	18	3

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

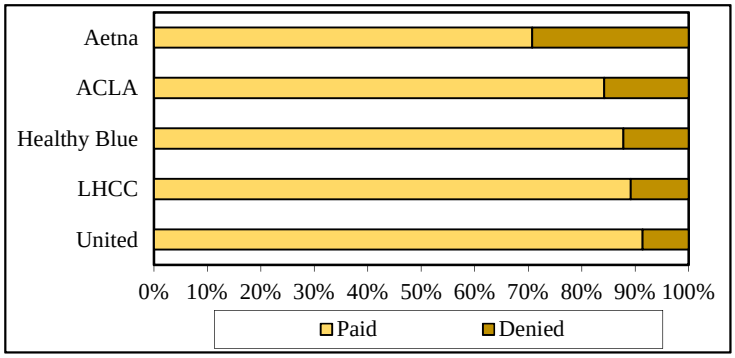
CARC Code	Description	Aetna	ACLA	HBL	LHCC	UHC
197	Precertification/authorization/notification absent.	X	X	X		
260	Processed under Medicaid ACA Enhanced Fee Schedule			X		
B7	This provider was not certified/eligible to be paid for this procedu		X		X	
96	Non-covered charge(s).	X	X		X	X
256	Service not payable per managed care contract.			X		

Summary of Information on Claims for Therapy Services

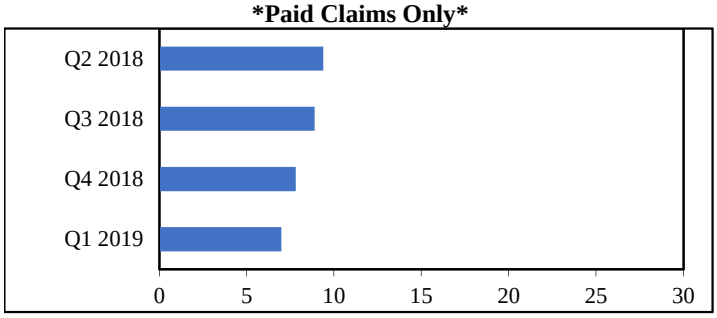
Paid and Denied Trend, Most Recent Four Quarters, All MCOs



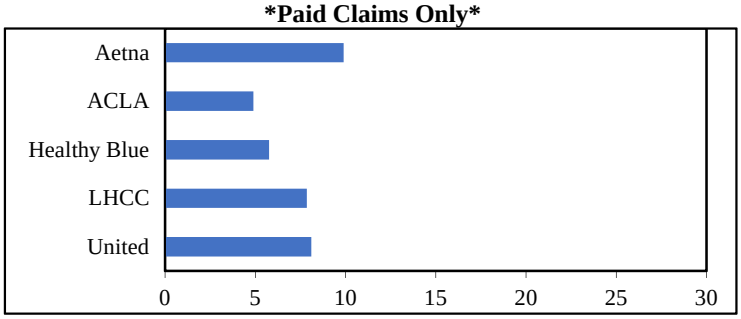
Paid and Denied Trend Quarter 1 2019 only For Each MCO



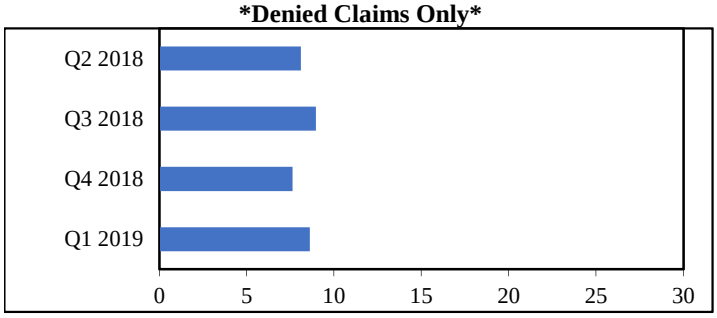
Claims Turnaround Time Most Recent 4 Qtrs All MCOs
Paid Claims Only



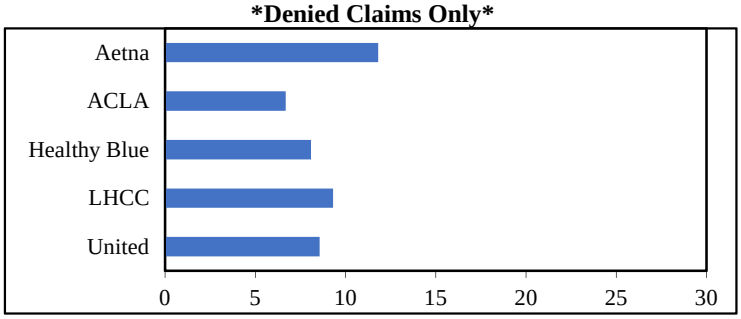
Claims Turnaround Time Quarter 1 2019 only Each MCO
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 1 2019 only)

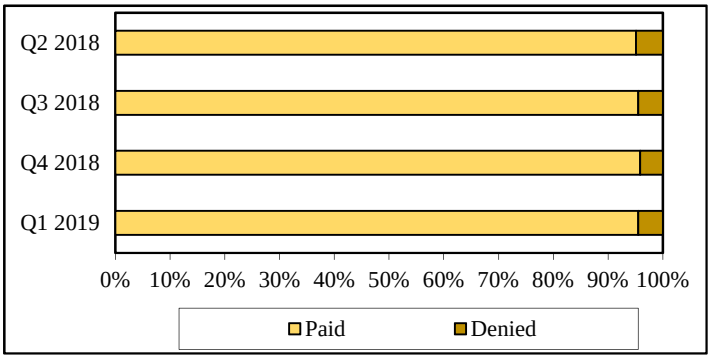
	Aetna		ACLA		Healthy Blue		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	2	0	55	30	197	90	96	42	14	6
101 - 250	1	1	21	10	49	21	34	20	18	7
> 250 claims	0	0	3	2	2	0	7	4	7	2

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

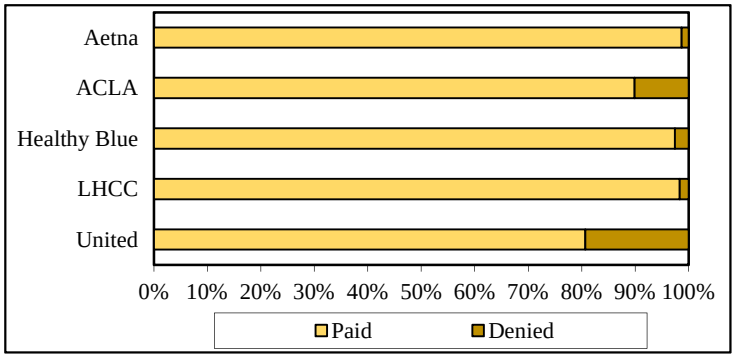
CARC Code	Description	Aetna	ACLA	HBL	LHCC	UHC
197	Precertification/authorization/notification absent.		X	X	X	X
256	Service not payable per managed care contract.			X		
96	Non-covered charge(s).		X			X
198	Precertification/authorization exceeded.			X		
59	Processed based on multiple or concurrent procedure rules. (For					X

Summary of Information on Claims for NEMT Services

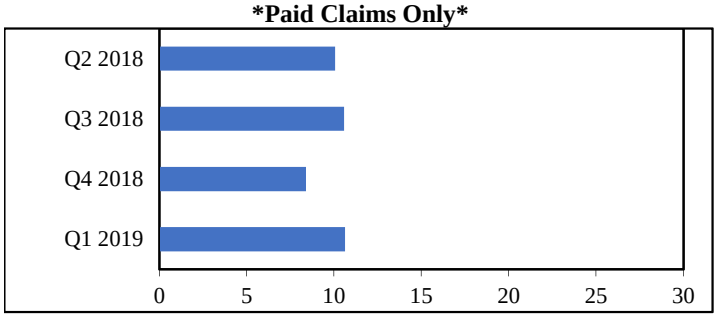
Paid and Denied Trend, Most Recent Four Quarters, All MCOs



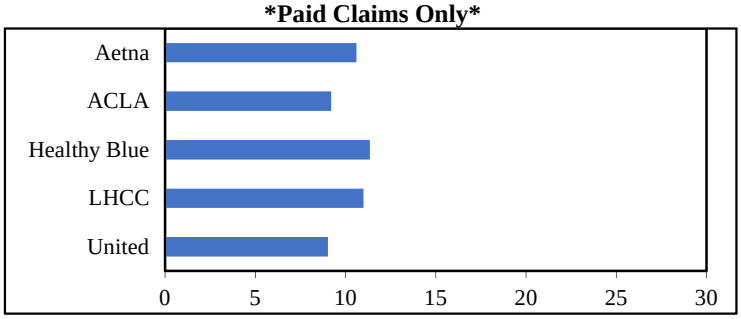
Paid and Denied Trend Quarter 1 2019 only For Each MCO



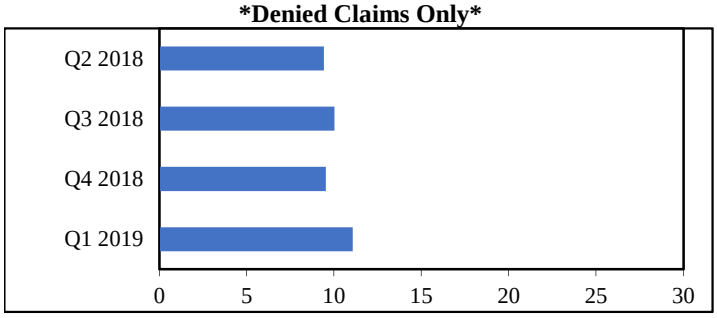
Claims Turnaround Time Most Recent 4 Qtrs All MCOs
Paid Claims Only



Claims Turnaround Time Quarter 1 2019 only Each MCO
Paid Claims Only



Denied Claims Only



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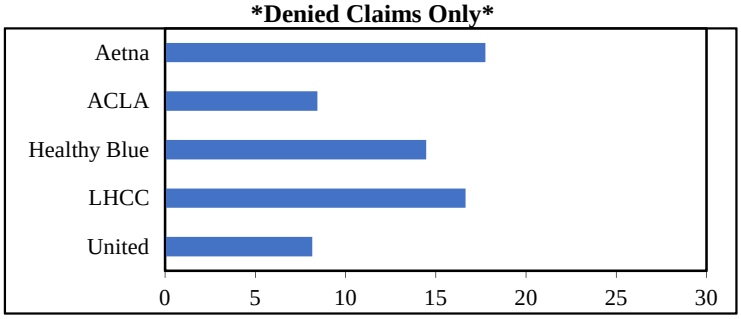


Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 1 2019 only)

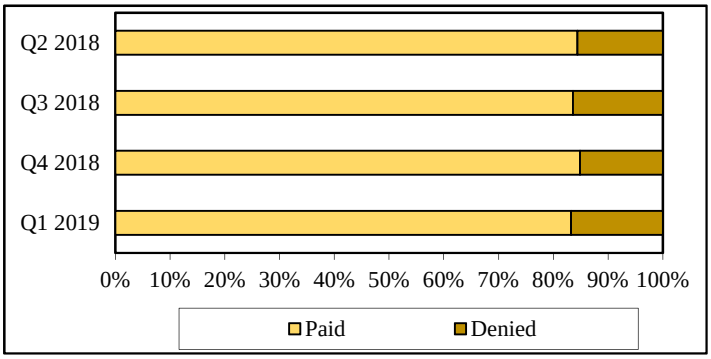
	Aetna		ACLA		Healthy Blue		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	47	6	51	24	89	30	31	3	150	73
101 - 250	78	6	69	32	80	6	71	9	12	6
> 250 claims	26	0	41	9	39	4	59	2	4	4

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

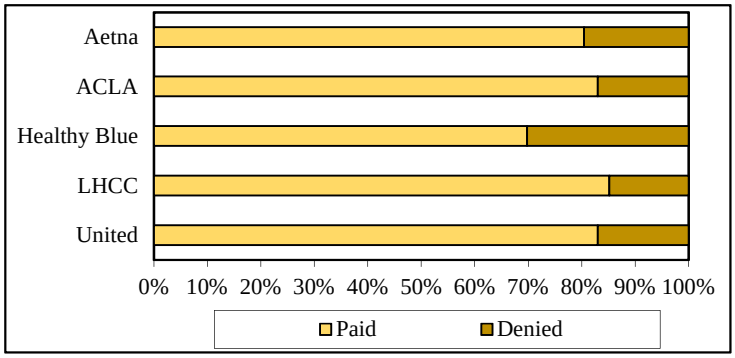
CARC Code	Description	Aetna	ACLA	HBL	LHCC	UHC
16	Claim/service lacks information or has submission/billing error(s	X	X	X	X	
199	Revenue code and Procedure code do not match.	X		X	X	
18	Exact duplicate claim/service	X		X	X	
97	The benefit for this service is included in the payment/allowance	X		X	X	
96	Non-covered charge(s).	X	X	X	X	X

Summary of Information on Claims for Medical Supplies Services

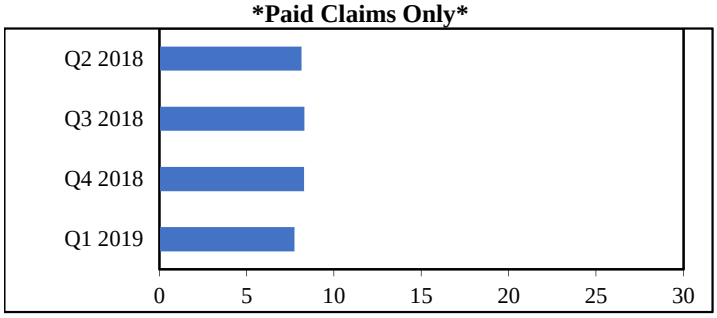
Paid and Denied Trend, Most Recent Four Quarters, All MCOs



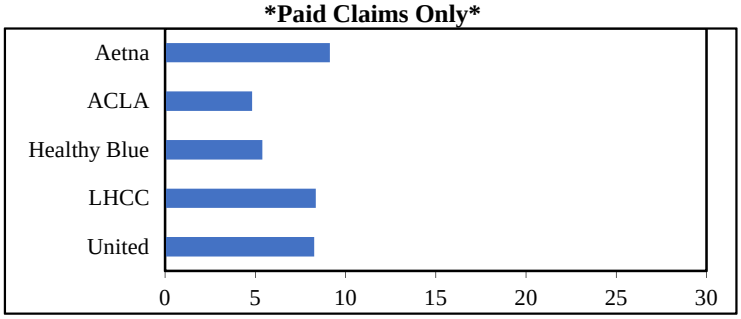
Paid and Denied Trend Quarter 1 2019 only For Each MCO



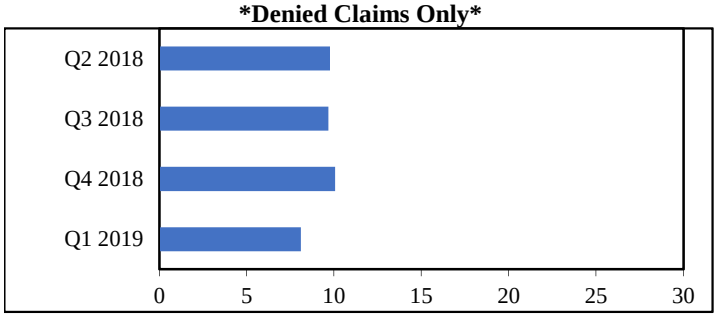
Claims Turnaround Time Most Recent 4 Qtrs All MCOs
Paid Claims Only



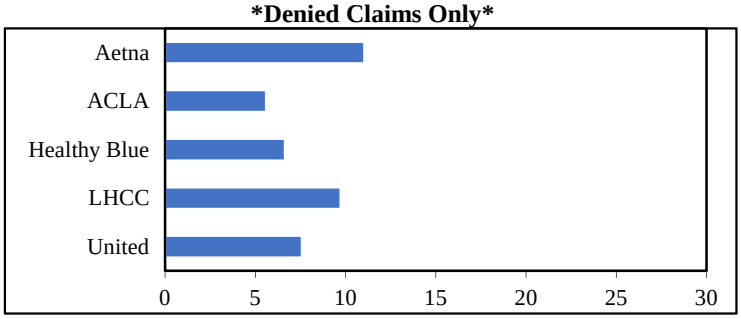
Claims Turnaround Time Quarter 1 2019 only Each MCO
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 1 2019 only)

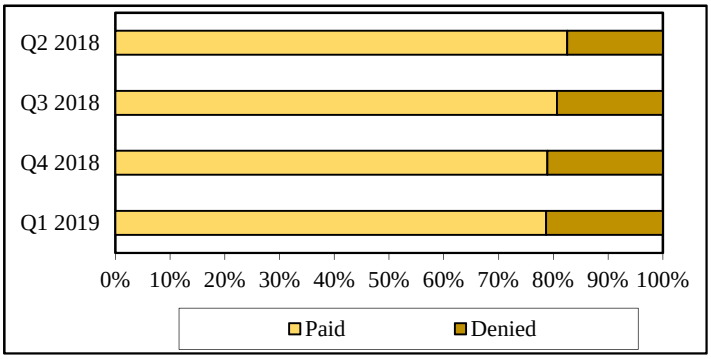
	Aetna		ACLA		Healthy Blue		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	115	73	140	70	116	48	161	76	332	238
101 - 250	11	7	59	32	4	3	82	52	55	29
> 250 claims	0	0	6	3	0	0	22	14	29	12

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

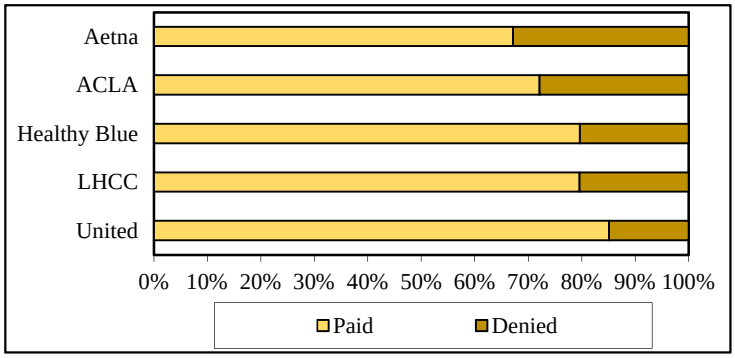
CARC Code	Description	Aetna	ACLA	HBL	LHCC	UHC
16	Claim/service lacks information or has submission/billing error(s	X	X		X	
96	Non-covered charge(s).	X	X		X	X
197	Precertification/authorization/notification absent.	X	X	X	X	
18	Exact duplicate claim/service	X				X
97	The benefit for this service is included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

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

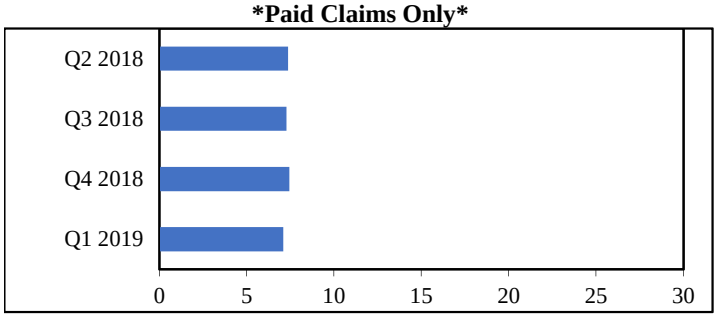
Paid and Denied Trend, Most Recent Four Quarters, All MCOs



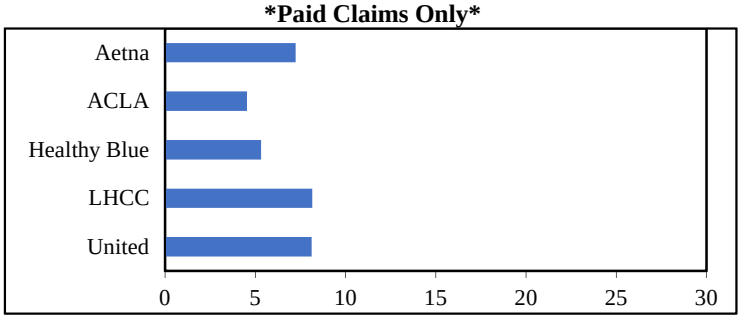
Paid and Denied Trend Quarter 1 2019 only For Each MCO



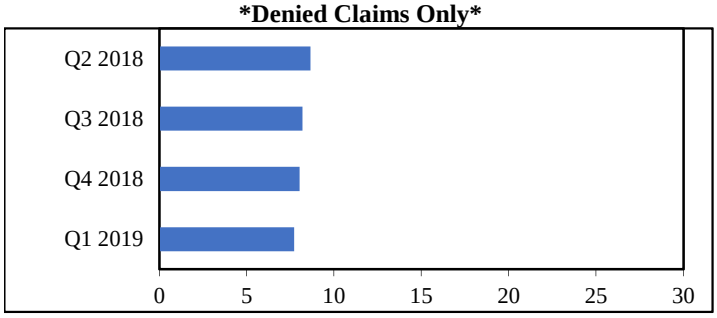
Claims Turnaround Time Most Recent 4 Qtrs All MCOs
Paid Claims Only



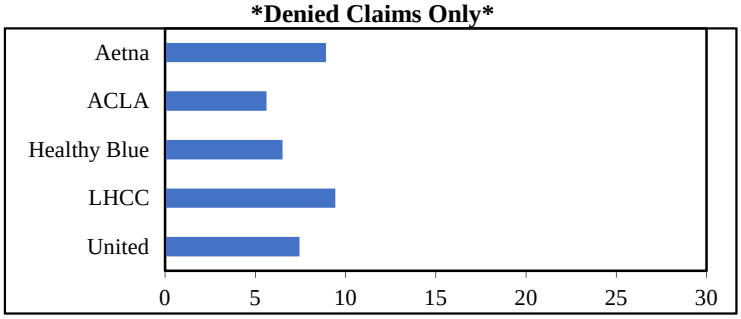
Claims Turnaround Time Quarter 1 2019 only Each MCO
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 1 2019 only)

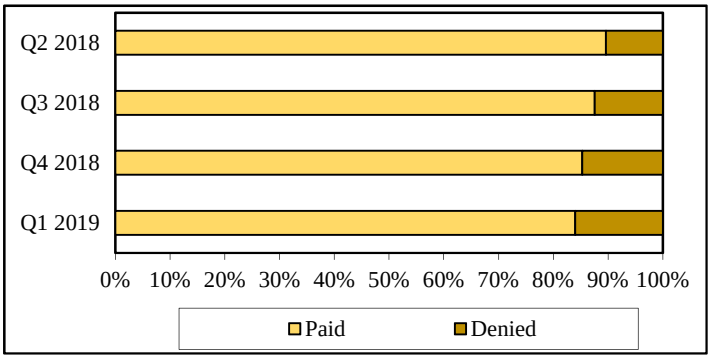
	Aetna		ACLA		Healthy Blue		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	355	78	2,130	1048	8,129	3,250	7,581	3,372	2,566	1,417
101 - 250	16	7	694	317	1,036	352	1,546	733	465	246
> 250 claims	5	5	287	123	131	56	460	232	329	136

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

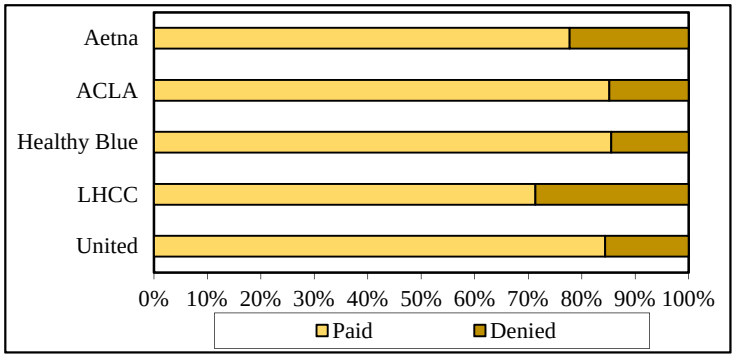
CARC Code	Description	Aetna	ACLA	HBL	LHCC	UHC
197	Precertification/authorization/notification absent.		X	X	X	X
B7	This provider was not certified/eligible to be paid for this proced		X			
96	Non-covered charge(s).	X	X		X	X
16	Claim/service lacks information or has submission/billing error(s	X	X		X	
97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

Summary of Information on Claims for Mental Health Services- Rehab

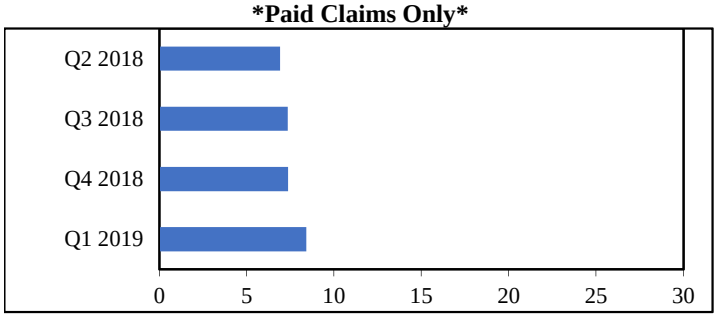
Paid and Denied Trend, Most Recent Four Quarters, All MCOs



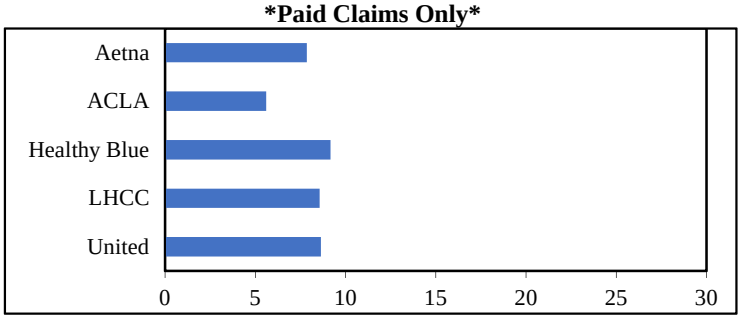
Paid and Denied Trend Quarter 1 2019 only For Each MCO



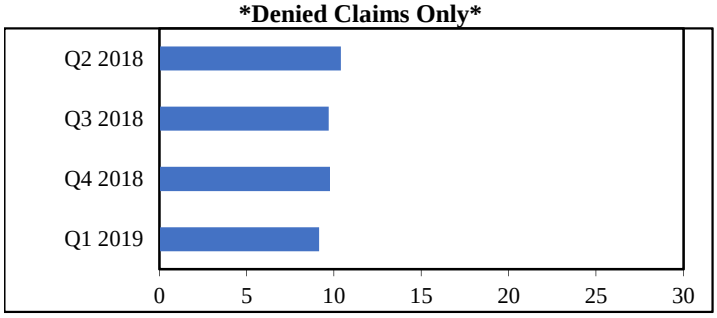
Claims Turnaround Time Most Recent 4 Qtrs All MCOs
Paid Claims Only



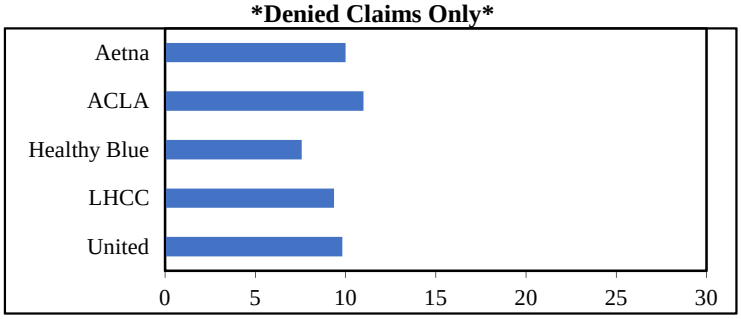
Claims Turnaround Time Quarter 1 2019 only Each MCO
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 1 2019 only)

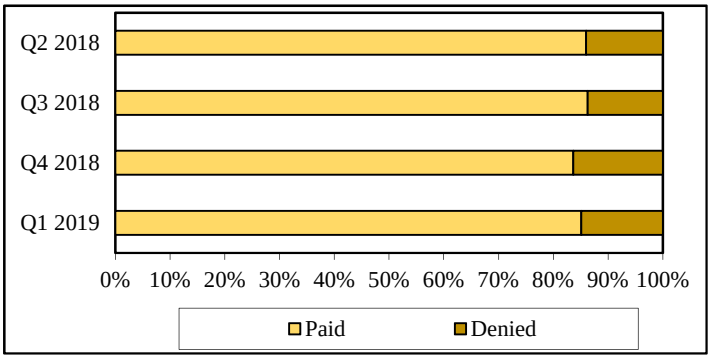
	Aetna		ACLA		Healthy Blue		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	107	27	172	80	70	37	109	75	86	54
101 - 250	28	10	147	69	180	75	44	29	68	40
> 250 claims	1	1	22	6	100	44	15	10	110	55

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

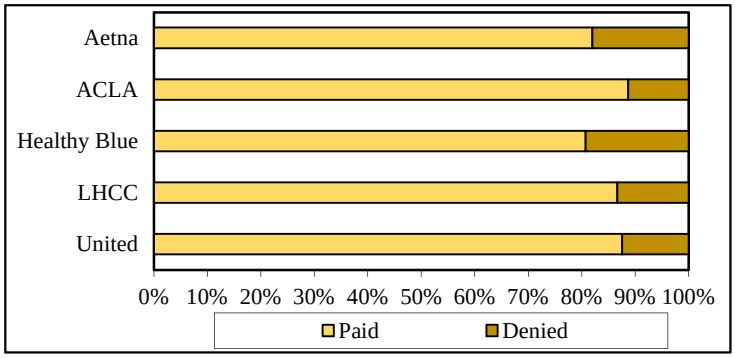
CARC Code	Description	Aetna	ACLA	HBL	LHCC	UHC
197	Precertification/authorization/notification absent.	X	X	X	X	X
18	Exact duplicate claim/service	X			X	X
16	Claim/service lacks information or has submission/billing error(s	X			X	X
198	Precertification/authorization exceeded.		X	X		
150	Payer deems the information submitted does not support this leve					

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

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

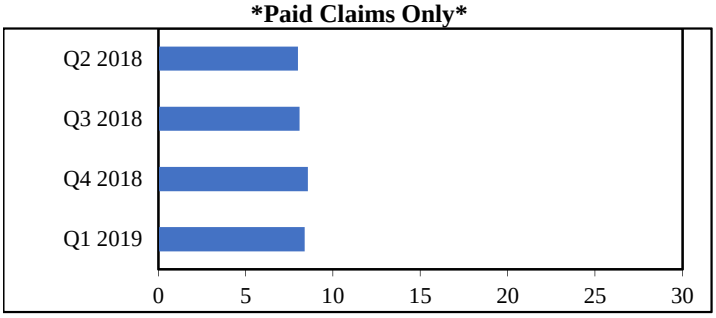


Paid and Denied Trend Quarter 1 2019 only For Each MCO



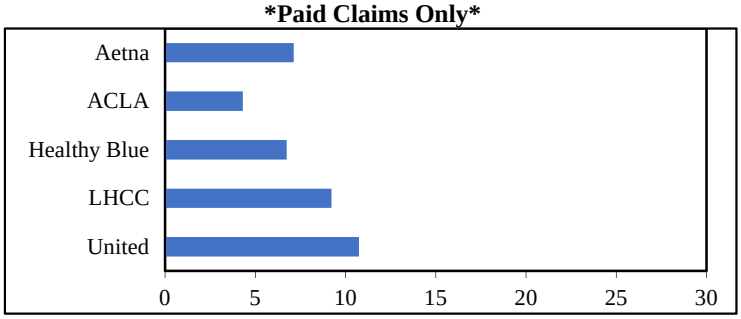
Claims Turnaround Time Most Recent 4 Qtrs All MCOs

Paid Claims Only

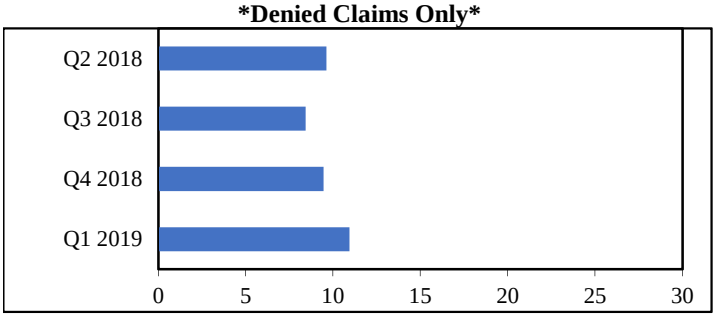


Claims Turnaround Time Quarter 1 2019 only Each MCO

Paid Claims Only



Denied Claims Only



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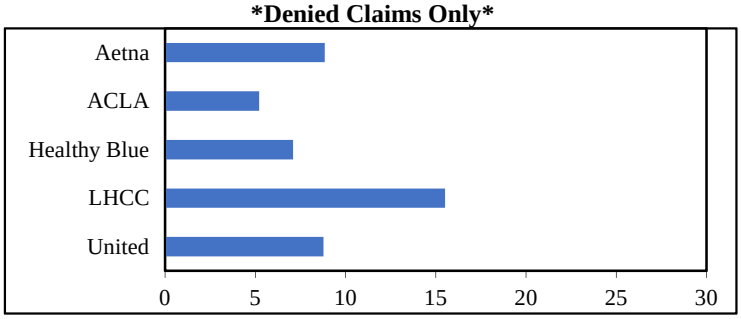


Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 1 2019 only)

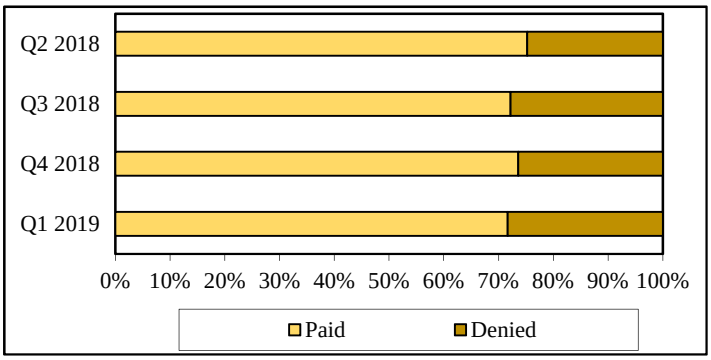
	Aetna		ACLA		Healthy Blue		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	11	4	527	171	1,632	795	3,816	1438	212	101
101 - 250	1	1	67	26	288	137	1,087	425	55	27
> 250 claims	0	0	19	6	52	27	83	45	40	15

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

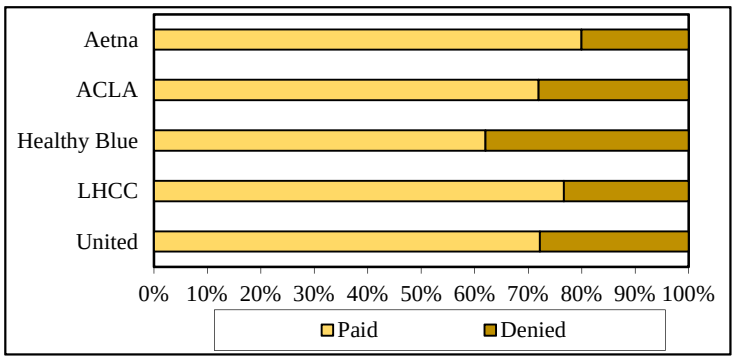
CARC Code	Description	Aetna	ACLA	HBL	LHCC	UHC
197	Precertification/authorization/notification absent.		X	X	X	X
18	Exact duplicate claim/service	X			X	X
16	Claim/service lacks information or has submission/billing error(s	X			X	X
252	An attachment/other documentation is required to adjudicate this		X	X		X
256	Service not payable per managed care contract.			X		X

Summary of Information on Claims for Pharmacy Services

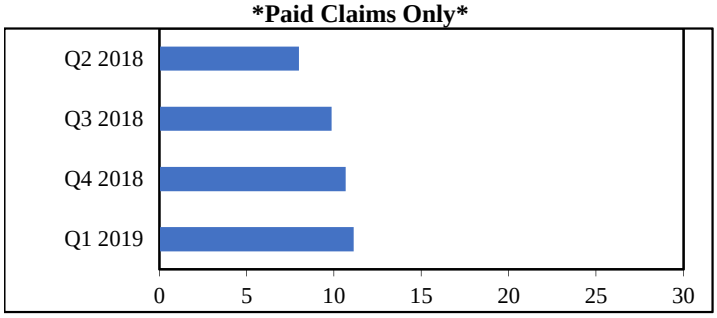
Paid and Denied Trend, Most Recent Four Quarters, All MCOs



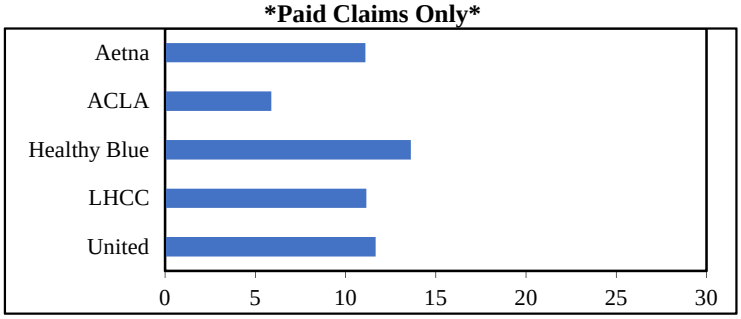
Paid and Denied Trend Quarter 1 2019 only For Each MCO



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



Claims Turnaround Time Quarter 1 2019 only Each MCO
Paid Claims Only



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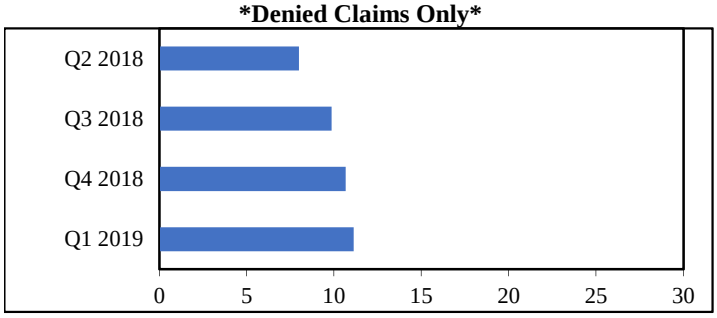
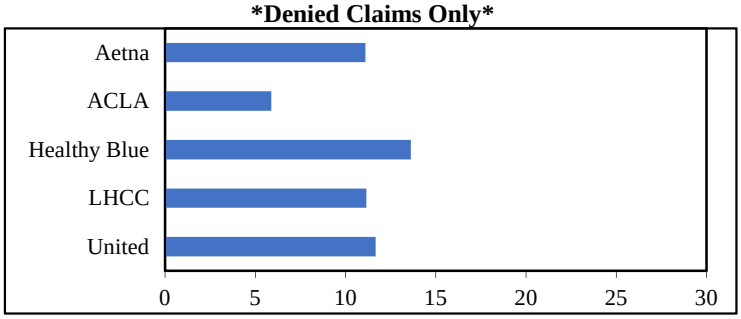


Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 1 2019 only)

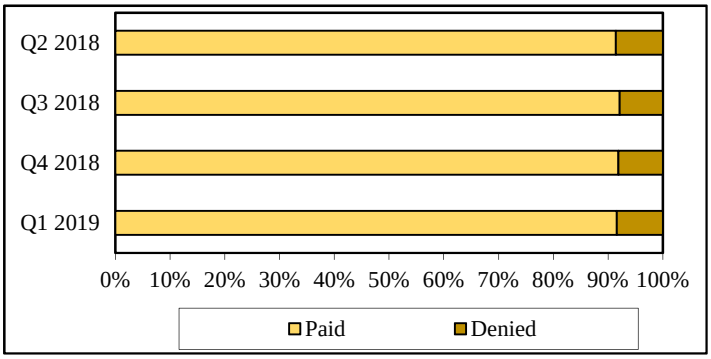
	Aetna		ACLA		Healthy Blue		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	15,305	9076	1,078	1008	1,872	1659	11,164	10,736	16,534	12,382
101 - 250	1,349	1221	348	344	227	225	3,016	2,974	3,612	3,560
> 250 claims	127	125	667	665	850	850	1077	1,074	1,432	1,426

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

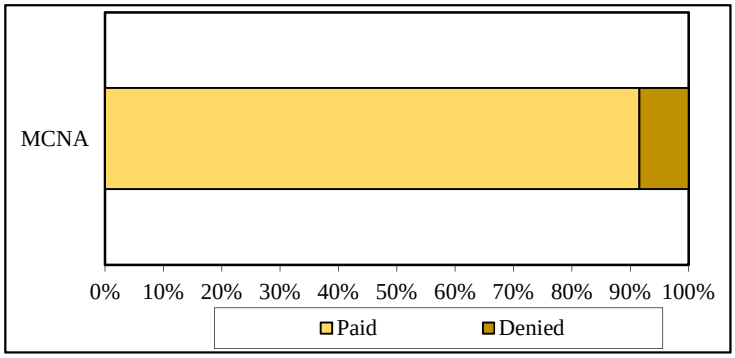
NCDCP Code	Description	Aetna	ACLA	HBL	LHCC	UHC
79	Refill Too Soon	X		X	X	X
76	Plan Limitations Exceeded	X		X	X	X
88	DUR Reject Error			X		X
7Ø	Product/Service Not Covered – Plan/Benefit Exclusion	X			X	X
75	Prior Authorization Required	X	X	X		X

Summary of Information on Claims for Dental Services- Children

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

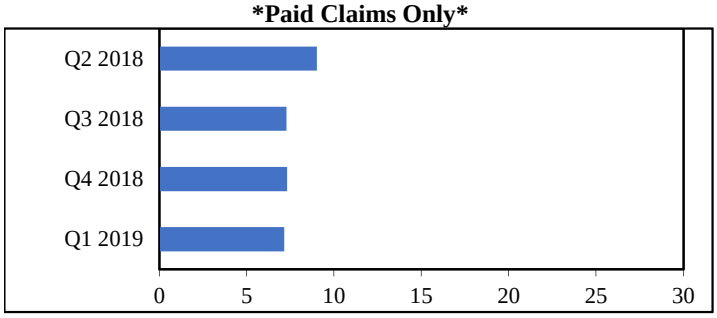


Paid and Denied Trend Quarter 1 2019 only For Each MCO



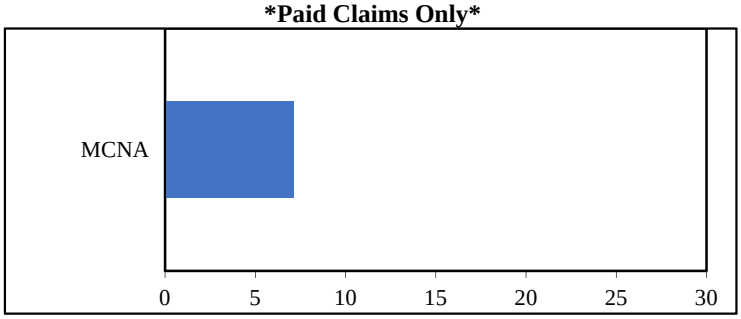
Claims Turnaround Time Most Recent 4 Qtrs All MCOs

Paid Claims Only

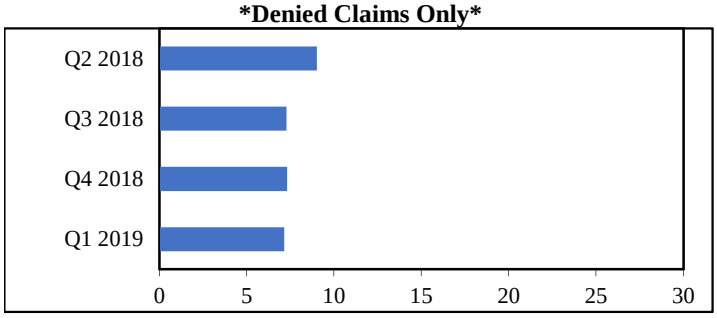


Claims Turnaround Time Quarter 1 2019 only Each MCO

Paid Claims Only



Denied Claims Only



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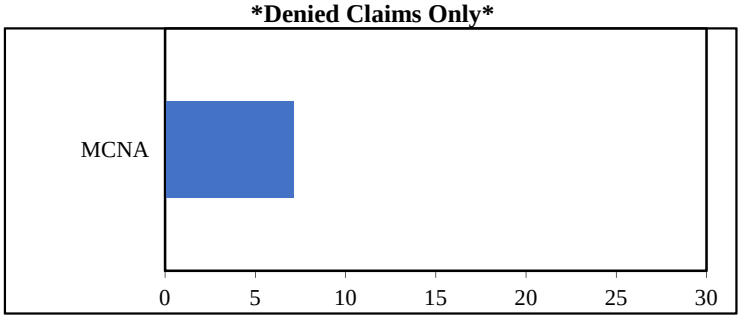


Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 1 2019 only)

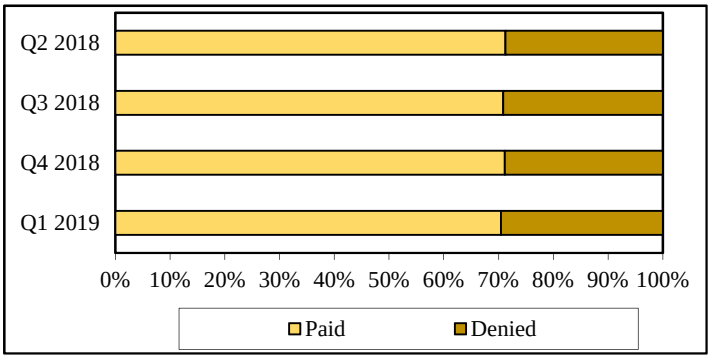
	MCNA	
	# Providers	>10% denied
<100 claims	644	281
101 - 250	172	84
> 250 claims	22	15

Top Denial Reasons this Quarter

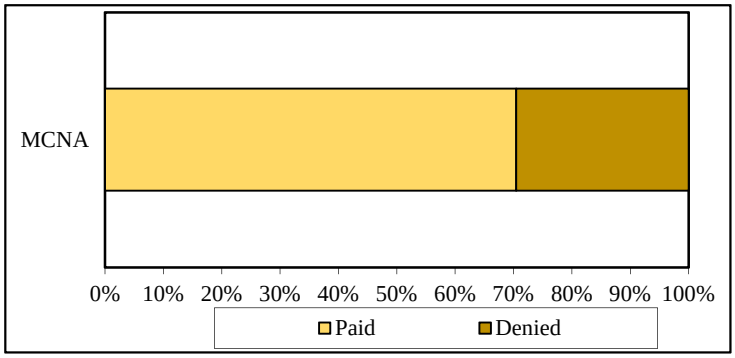
CARC Code	Description	MCNA
169	Alternate benefit has been provided.	X
18	Exact duplicate claim/service	X
222	Exceeds the contracted maximum number of hours/days/units by	X
96	Non-covered charge(s).	X
6	The procedure/revenue code is inconsistent with the patient's age	X

Summary of Information on Claims for Dental Services- Adults

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

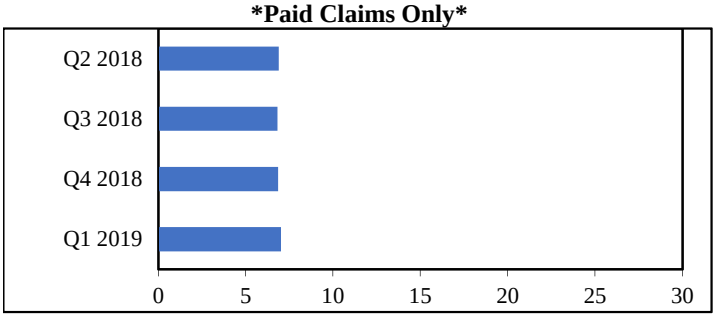


Paid and Denied Trend Quarter 1 2019 only For Each MCO



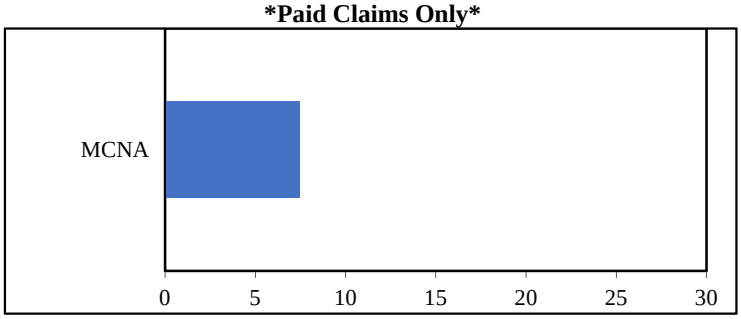
Claims Turnaround Time Most Recent 4 Qtrs All MCOs

Paid Claims Only

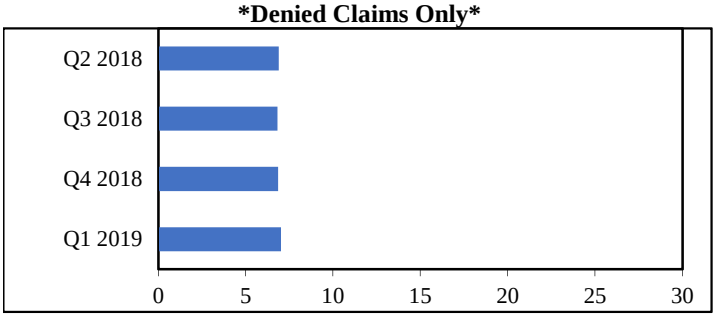


Claims Turnaround Time Quarter 1 2019 only Each MCO

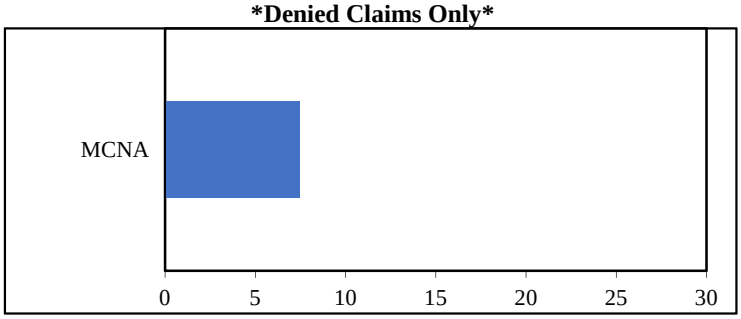
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 1 2019 only)

	MCNA	
	# Providers	>10% denied
<100 claims	323	287
101 - 250	2	2
> 250 claims	0	0

Note: All MCOs had little data for Dental-Adult

Top Denial Reasons this Quarter

CARC Code	Description	MCNA
119	Benefit maximum for this time period or occurrence has been rea	
18	Exact duplicate claim/service	X
242	Services not provided by network/primary care providers.	
96	Non-covered charge(s).	X
252	An attachment/other documentation is required to adjudicate this	X