Healthy Louisiana Claims Report

Response to Act 710 of the 2018 Regular Legislative Session

Louisiana Department of Health

Bureau of Health Services Financing

October 2018

LOUISIANA DEPARTMENT OF HEALTH

Contents

Executive Summary

In response to Act 710 of the 2018 regular session of the Louisiana Legislature ("the Act"), the "Healthy Louisiana Claims Report" is submitted to the Joint Legislative Committee on the Budget and the House and Senate Committees on Health and Welfare. The Act requires the Department to conduct a number of activities and analyses pertaining to each Medicaid managed care organization (MCO) for the purpose of ensuring each MCO's compliance with the terms of its contract with the Louisiana Department of Health ("the Department" or LDH). The Act stipulates that results of these activities and analyses be used to generate an initial report to the legislature and inform the contents of ongoing quarterly reporting.

LDH engaged Burns & Associates, Inc. to analyze the MCO claims data and advise on future action steps the Department can take to improve its oversight of MCO contractual provisions regarding claims processing. Specifically, Burns & Associates conducted activities to ensure compliance with the following provisions of the Act:

- Conduct an independent review of claims submitted by healthcare providers to MCOs during calendar year (CY) 2017;
- Develop action steps the department can to take in order to address the five most common reasons for claims denial, provider education needed, and claims denied in error by managed care organizations; and
- Recommend defining measures to be reported on a quarterly basis, including participation in stakeholder meetings hosted by LDH to solicit provider feedback on initial report findings and future report design.

LDH supplied additional information required by the Act, as listed below:

- Data on encounters submitted by the managed care organizations; and
- Information on case management services provided by managed care organizations.

In its review, Burns & Associates found a general consistency across MCOs in regard to the number of claims denied, adjusted, voided, pended, etc. However, where outliers were noted, investigation revealed inconsistencies in MCO definitions and classification of claims into the various reporting categories. In light of this feedback, LDH will place a heavy focus on definitional alignment for future reporting purposes in order to improve data utility.

Background

Healthy Louisiana Managed Care Program

Managed care organizations are risk-bearing entities that provide a wide array of Medicaid-covered benefits and services to enrolled members in exchange for a monthly capitation payment for each member. During Calendar Year 2017, more than 1.7 million Louisiana Medicaid and Louisiana Children's Health Insurance Program (LaCHIP) enrollees received physical health and basic and specialized behavioral services under the Medicaid Managed Care Program through one of five managed care organizations contracted with the state. Each plan contracts directly with healthcare providers and manages all aspects of service delivery, including claims adjudication and reimbursement of providers.

There are two distinct groups of MCO members:

- **Full Benefit**: Those who receive all physical, behavioral health, and transportation services through their health plan.
- **Partial Benefit**: Those who receive only specialized behavioral health and non-emergency medical transportation through their health plan.

The state provides comprehensive dental services to Medicaid eligible children and adult denture services to full-benefit eligible adults through a single prepaid ambulatory health plan, MCNA. The majority of Medicaid covered individuals are mandatorily enrolled in the dental plan and receive covered services through the MCNA dental plan based on age category:

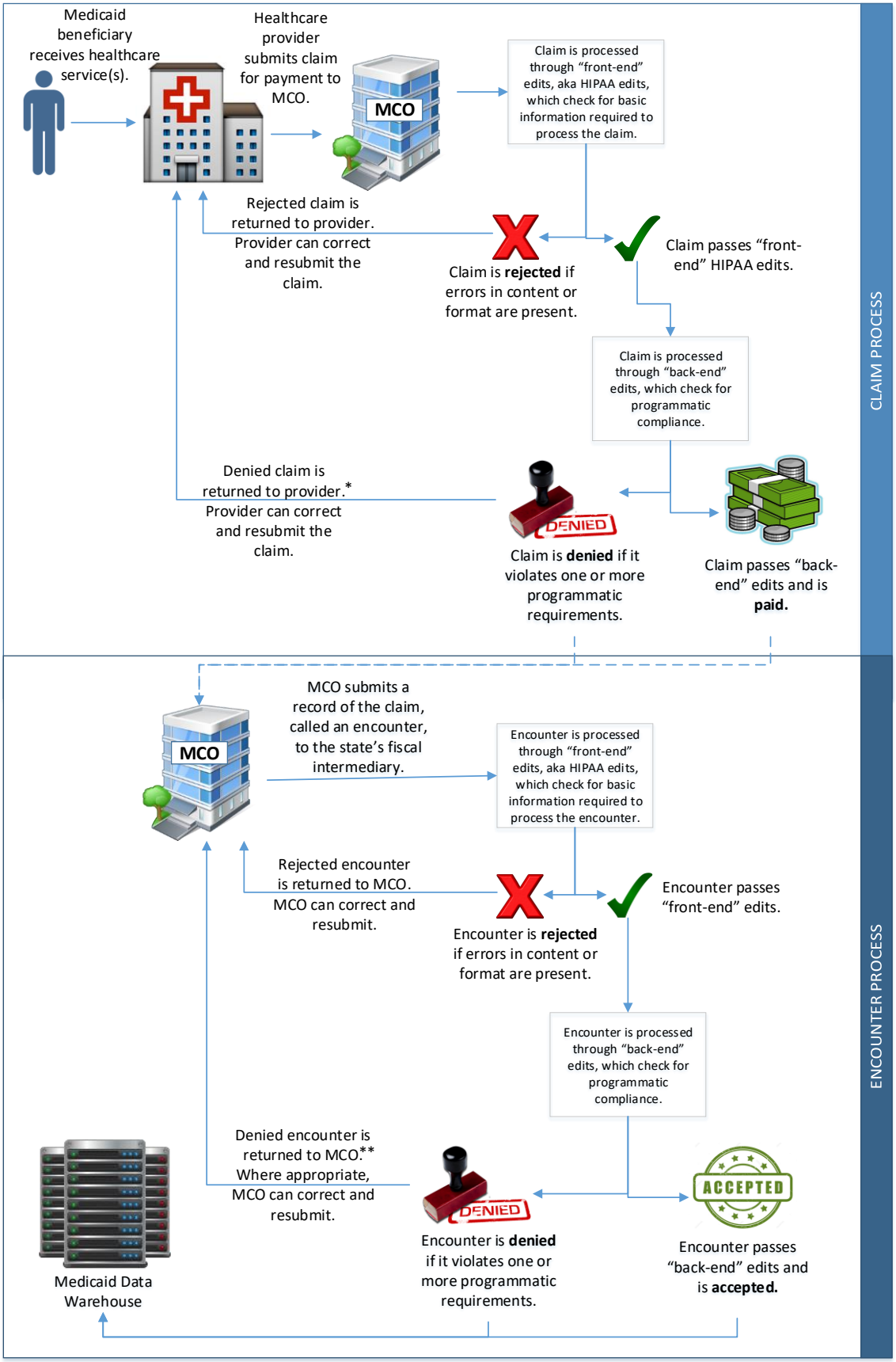
- **Medicaid Recipients under the age of 21** – diagnostic, preventive, restorative, endodontic, periodontal, prosthodontics, maxillofacial prosthetics, oral and maxillofacial surgery, orthodontic and other screening and treatment services applicable under the EPSDT program.
- **Adults 21 years of age and over** – dentures and related services are the only dental services for adults provided by MCNA.

Additionally, all five managed care organizations offer a limited adult dental benefit beyond the denture benefit covered by MCNA. The adult dental benefit provided by MCOs is a value-added benefit available to full-benefit MCO members only.

Managed Care Claims and Encounters

An encounter is a record of a claim that was adjudicated (paid or denied) by an MCO, or in some cases, the MCO's subcontractor. Each MCO is required to submit complete and accurate encounter data on paid, denied, adjusted, and voided claims to LDH's fiscal intermediary (Molina) in HIPAA-compliant, standardized formats. Once Molina has received an encounter record, it is processed against system edits applicable to the Louisiana Medicaid managed care program. This process identifies encounters that represent claims that were paid by the MCO but are not compliant with programmatic requirements as set forth by LDH.

Encounters are stored in Medicaid's data warehouse and are used both for program monitoring and capitation rate-setting purposes. The following figure describes claims and encounter adjudication processes and associated terms.



This figure is representative of the general claims and encounter adjudication processes and is not an exhaustive depiction of all related processes and procedures.

* *Providers are also provided with information on paid claims.*

** *MCO response files also contain information on accepted encounters.*

MCO Contractual Requirements for Claims Processing

Each MCO's contract with the state sets minimum standards for claims processing and payment. These contractual provisions include, but are not limited to:

- Informing all network providers about "clean claims" requirements and providing adequate notice to providers prior to implementing changes to claims coding and processing guidelines. A "clean claim" is defined as a claim that can be processed without obtaining additional information from the provider or a third party; claims from providers under investigation for fraud or abuse and claims under review for medical necessity are not included in this category.
- Processing and paying or denying "clean claims" within specified timeframes:
    - Process and pay or deny at least ninety percent of clean claims for each claim type within fifteen business days of receipt.
    - Process and pay or deny at least 99 percent of all clean claims for each claim type within thirty calendar days of receipt.
- Processing and paying or denying all pended claims within sixty calendar days of receipt.

The contracts also stipulate actions LDH may take when an MCO has a pattern of inappropriately denying or delaying provider payments for services.

Managed Care Program Monitoring

LDH employs a variety of strategies to monitor each MCO's compliance with contractual requirements, including claims processing requirements. These strategies include but are not limited to data analysis and monitoring and addressing provider complaints. In the event a deficiency is identified, the MCO may be asked to submit a corrective action plan, or LDH may choose to assess a monetary penalty or take other action pursuant to the terms of the contract.

Data Analysis

Each MCO is required to submit a number of recurring reports to LDH, each of which is responsive to a contractual or legislative requirement. Each report is accompanied by an attestation from the MCO that the contents are accurate, complete, and truthful based on the signatory's best knowledge, information, and belief. LDH assigns a business owner to each report, who is responsible for reviewing the report's contents and assessing it against contractual obligations and performance standards.

Provider Complaints

LDH maintains a dedicated Provider Relations unit to monitor and facilitate the resolution of provider complaints against MCOs. This unit records and systematically tracks all complaints received against an MCO and the resulting resolution. This process is used to identify patterns, systemic or global problems, and/or recurring issues with one or more MCOs.

Independent Analysis of Healthy Louisiana Claims Data

Sections B and C of the Act require LDH to examine claims submitted by healthcare providers to Medicaid MCOs and report on a number of measures pertaining to claims adjudication and reasons for claim denials. As a result of stakeholder input during the legislative process, claims data obtained directly from each MCO was used in lieu of encounter data to conduct the required analysis. LDH engaged Burns & Associates, Inc. to conduct this analysis for claims submitted to the managed care entities listed below.

Plan Name	Plan Type	Common Abbreviation
Aetna Better Health, Inc.	Managed Care Organization	ABH
Healthy Blue	Managed Care Organization	HB
Amerihealth Caritas Louisiana, Inc.	Managed Care Organization	ACLA
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

Detailed findings responsive to sections B and C of the Act can be found in Burns & Associates' independent report located in Appendix A.

Provider Stakeholder Engagement

As noted in Burns & Associates' report, as per Act 710, LDH engaged provider stakeholders representing the physician, hospital, community health, behavioral health, pharmacy and dental provider communities when evaluating the utility of statistics provided in the initial report and designing future report metrics. The meetings were held on October 9, 2018, and again on October 22, 2018, after written comments and suggestions were received. A summary of stakeholder feedback received, which was used to guide the development of future reports, can be found in Appendix B.

Future Report Measures and MCO Monitoring

Burns & Associates' Recommendations

As a result of its independent review, Burns & Associates offered several suggestions to LDH to improve its MCO monitoring activities as well as the quality and value of reports received from MCOs. A summary of the recommendations, along with LDH responses, is provided below. Full recommendations can be found in Section IV of the attached Burns and Associates 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. These terms would be used to assign flags for reporting purposes to LDH.

LDH agrees with this recommendation and is working with the MCOs to develop detailed, standardized definitions for the following terms:

- Paid Claim

- Denied Claim
- Original Claim
- Adjusted Claim
- Void Claim
- Pended Claim
- Rejected Claim

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. These terms would be used to assign flags for reporting purposes to LDH.

LDH agrees with this recommendation and is developing standardized definitions for the following terms:

- Received Encounter
- Accepted Encounter
- Rejected Encounter
- Denied Encounter
- Denied Claim

Recommendation 3:
LDH should build guidance or requirements about the expectations that the MCOs will perform root causes analyses pertaining to claims adjudication and/or encounter submissions.

LDH agrees and will set clear expectations regarding root cause analyses and what resulting corrective actions should be established.

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. Each report should contain a purpose statement, a definition of terms, and line-by-line instructions.

LDH has reviewed the reports that focus on claims and is reviewing for potential consolidation or elimination of existing standing reports for the future. Currently, existing reports are responsive to a specific legislative or contractual requirement and cannot be retired. See section Ongoing Monitoring and Reporting for a list and description of reports that will be produced to facilitate effective monitoring of MCO claims processing.

Recommendation 5:
For any new measures or reports that get introduced as part of quarterly reporting required by this Act, LDH should convene all of the MCOs to review the new report templates, to confirm understanding of the specifications related to reporting, and to vet the instructions that accompany any new report.

LDH is scheduled to meet with the MCOs in November 2018 regarding new reporting requirements resulting from the study undertaken pursuant to this Act in an effort to ensure definitional and procedural alignment across all 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.

LDH agrees and will establish a protocol for reviewing periodic samples of claims denied by MCOs.

Ongoing Monitoring and Reporting

LDH is implementing a comprehensive approach to monitoring MCO claims processing procedures and outcomes in order to address stakeholder concerns and legislative mandates. This is inclusive of not only additional, improved reporting, but improved internal monitoring processes as well.

In order to improve monitoring and evaluation of MCO claims processing procedures, LDH will:

- *Require MCOs to submit a crosswalk that maps their internal adjudication codes to Claims Adjustment Reason Codes (CARC) and National Council for Prescription Drug Programs (NCPDP) codes.*
  This will allow LDH to assess and address any inconsistencies in MCO CARC/NCPDP mapping to ensure "top denial reason" results that are comparable between plans.

- *Assign a programmatic business owner to the current MCO Denied Claims Report.*
  The current MCO Denied Claims Report business owner performs data analytics and validation and produces high-level statistics including the number of denied claims by denial reason as well as the number of denied claims by claim type in order to assess reporting accuracy. These analyses are currently available for staff to inspect as needed. However, LDH will newly add an additional business owner to analyze the data from a programmatic perspective. This programmatic business owner will assess the reports for trends in common denial reasons across MCOs and within each MCO; trends in denial rates by claim type, across MCOs and within each MCO; etc. and will hold MCOs accountable when denial rates exceed reasonable expectations.

- *Report claims at the detail line level to the greatest extent possible.*
  In ongoing claims reporting relative to this study, LDH will report all claims at the detail line-level, with the exception of inpatient hospital claims, which will be reported at the header level. This will give LDH a better understanding of how the MCOs are adjudicating the individual claims components.

- *Implement all Burns & Associates recommendations for quarterly claims and encounter reporting.*
  LDH will design the following reports pursuant to the Burns & Associates' recommendations:

    - **Claims Adjudication Statistics Report**
      This report will be used to track the timeliness of claims adjudication and payment (in days) by claim type, selected provider types, and final claim disposition (rejected, paid, denied). These statistics will be delineated by specialized behavioral health and non-specialized behavioral health services as appropriate. MCOs will produce this report in quadruplicate to capture the following reporting categories: Clean Claims, Claims Pended for Medical Review, Claims Pended for Fraud and Abuse, Total Claims.

      Claim type and provider type groupings that will be used include:
        - Institutional Claim Type (Form UB-04, 837-I)
            - Inpatient Hospital
                - Distinct Part Psychiatric Unit, Freestanding Psychiatric
                - All Other
            - Outpatient Hospital
            - Home Health
            - All Other

        - Professional Claim Type (Form CMS-1500, 837-P)
            - Professional Services
                - Specialized Behavioral Health
                    - Mental Health Rehab Agencies
                    - All Other Specialized Behavioral Health
                - Primary Care
                - Pediatricians
                - Ob/Gyn and Maternal-Fetal Medicine
                - Neonatologists
                - Anesthesiologists
                - Therapies (Physical, Occupational, and Speech Therapy)
                - Applied Behavioral Analysis
                - All Other
            - Emergency Medical Transportation
            - Non-Emergency Medical Transportation & Non-Emergency Ambulance Transportation
            - Durable Medical Equipment
            - All Other
        - Pharmacy Claim Form (NCPDP)
        - Dental Services
            - MCO Value-Added Services
            - MCNA Adult Denture Services (dental benefit plan only)
            - MCNA EPSDT (Child) Dental Services (dental benefit plan only)

    - **Encounter Submission Statistics Report**
      This report will be used to monitor timely submission of claims as encounters to LDH. MCOs will report the number of claims adjudicated in the quarter as well as when the claims were submitted to LDH as encounters, delineated by claim type. LDH will establish a monitoring protocol to compare the number of encounters reported by the MCO to the actual number of encounters received and take steps to resolve any discrepancies.

    - **Denied Claims by Provider**
      On this report, MCOs will identify, by selected provider type, any provider with a denied claims percentage of over 10 percent. This report will be used in conjunction with the Provider Education Report described below.

    - **Provider Education Report**
      For each of the five providers with the highest number of denied claims by provider type identified on the Denied Claims by Provider report, the MCO will be required to (1) conduct a root cause analysis of the provider's denials and (2) conduct the appropriate outreach and education. The Provider Education report will include the top denial reasons for each provider and the resulting education provided.

- *In addition to the reports recommended by Burns & Associates, LDH will develop an additional report to track claims recycled as a result of inappropriate MCO claim denials.*

When LDH discovers that an MCO has inappropriately applied claim edits, LDH directs the MCO to "recycle," or reprocess, the affected claims. LDH will utilize this report to systematically track such recycles undertaken by each MCO.

Further Investigation Required

In the course of conducting this initial review, LDH, Burns & Associates, and provider stakeholders noted the high incidence of claims denied as duplicates of previously submitted claims. It seems unusual that providers would submit so many duplicate claims and is a topic that LDH feels warrants further investigation. Burns & Associates is conducting an additional review of this data, the findings of which will be included in a future supplement to this report.

Encounter Data

Section D of the Act requests specific information relating to encounters submitted by each MCO to the state or its designee:

> *D. The report shall include all of the following data relating to encounters:*
> *(1) The total number of encounters submitted by each Medicaid managed care organization to the state or its designee.*
> *(2) The total number of encounters submitted by each Medicaid managed care organization that are not accepted by the department or its designee.*

The encounter data for the calendar year 2017 study period are presented in the table below. The data reflects the total number of encounters received by the fiscal intermediary (FI) for claims adjudicated (paid or denied) by the MCOs during calendar year 2017. Total encounters received are divided into three groups:

- Encounters Accepted by FI – MCO Denied Claims
  Count of claims that were denied by the MCO, were submitted as encounters to the FI, and passed the front-end encounter edits. Denied claims that pass the front-end encounter edits always pass the back-end edits and are therefore always accepted.
- Encounters Accepted by FI – MCO Paid Claims
  Count of claims that were paid by the MCO, were submitted as encounters to the FI, and passed both the front-end and back-end encounter edits.
- Encounters Not Accepted by FI – MCO Paid Claims
  Count of claims that were paid by the MCO, were submitted as encounters to the FI, passed the front-end edits, but did not pass the back-end edits.

Number of Encounters Received in MARS Data Warehouse (MDW), Calendar Year 2017

	Total Encounters Received by FI	MCO Denied Claims	MCO Paid Claims	
		Encounters Accepted by FI	Encounters Accepted by FI	Encounters Not Accepted by FI
Aetna	8,547,002	890,733	6,955,066	701,203
ACLA	15,162,925	3,603,951	11,282,781	276,193
HB	19,248,618	1,581,065	16,348,599	1,318,954
LHCC	30,418,143	2,554,804	25,092,936	2,770,403
UHC	31,816,711	4,238,387	26,532,313	1,046,011
MCNA	4,156,313	356,141	3,571,851	228,321

Source: MARS Data Warehouse (MDW), extracted by Medicaid Business Analytics on 10/8/2018.

[1]Encounter data extracted based on date of payment or denial by the MCO. Inpatient hospital claims are reported at the header level. All other claim types are reported at the line level.

The calendar year 2017 encounter data is not directly comparable to the calendar year 2017 claims data used by Burns & Associates in its independent review. The Burns & Associates data is aggregated at the claim header level for all claim types, while the encounter data is at the header level for inpatient hospital claims only and at the individual line level for all other claim types. Additionally, MCOs were not required to submit encounters for denied pharmacy claims before August 2018; therefore 2017 encounter data does not include encounters for denied pharmacy claims. Going forward, the proposed encounter reconciliation report will provide for monthly monitoring of encounter submissions as compared to the MCO claims processed.

Case Management

Section E of the Act requests data relating to case management delineated by Medicaid managed care organization:

> *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 Healthy Louisiana plans are 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 need (SHCN) or who have high risk or have 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 to the department. 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 health plan has their own policies and procedures for identification and assessment. As such, the reporting for case management has shown significant variation across plans. LDH has been working with the health plans and various providers to increase the comparability of the data collected.

The data presented below is for the single month of June 2018. This is the most current data available following the last revision to the case management report template.

Healthy Louisiana Case Management (CM) Services for the Month of June 2018

Health Plan	Members Needing CM	Members Receiving CM	Percent Receiving CM
ABH	**32,163**	**32,042**	**99.6%**
ACLA	**4,421**	**2,752**	**62.2%**
HB	**2,925**	**1,296**	**44.3%**
LHCC	**4,255**	**3,639**	**85.5%**
UHC	**5,254**	**3,212**	**61.1%**
Total	**44,597**	**40,189**	**90.1%**

Source: 039 Case Management Report

Following the last quarterly report submissions, the Department has continued to work with the MCOs to further streamline data collection. A new template for case management is currently under LDH review and will be released to the health plans in early November 2018. The health plans will resubmit their case management data for the months of April through November 2018 to the department by December 31, 2018, then will continue reporting on a regular quarterly schedule. This data will be included in subsequent quarterly reports as required by this legislation.

Appendix A

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

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

FINAL REPORT
OCTOBER 31, 2018

BURNS & ASSOCIATES, INC.
Health Policy Consultants

3030 NORTH THIRD STREET, SUITE 200
PHOENIX, AZ 85012
(602) 241-8520

Mark Podrazik, Principal Investigator

Analytics team:

Akhilesh Pasupulati
Debbie Saxe

FINAL REPORT
Independent Study of Provider Claims Submitted to Medicaid Managed Care Organizations in the Healthy Louisiana Program

TABLE OF CONTENTS

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 Louisiana Revised Statutes, which 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 is to cover 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 must present detailed findings about CY 2017 claims, the subsequent quarterly reports will include the reporting on measures that will be defined as an outcome of the findings from the initial report.

Required Reporting for the Initial Report

The following items are required to be included in the initial report. For each item, information must be reported on for behavioral health providers separately from non-behavioral health providers:

- The total number and dollar amount of claims with the following attributes:
  - Rejected claims
  - Voided claims
  - Duplicate claims
  - Adjusted claims
  - Adjudicated claims
  - 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 is 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 and the educational efforts the Department and/or the MCOs will undertake to educate the providers with the highest number of denied claims. The providers identified must be distinguished separately for behavioral health and non-behavioral health services.
- 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.

Burns & Associates is the Independent Reviewer

Burns & Associates, Inc. (B&A), a health care consulting firm with headquarters in Phoenix, Arizona, was contracted by the Department to conduct the independent review of claims submitted by health care providers to the Medicaid MCOs. As such, the report contained herein was written by B&A and includes all of the requirements for reporting called for in the Act related to Medicaid MCO claims processing. This report also includes the recommendations independently derived from B&A's review of this MCO function.

The B&A report accompanies a cover report that was produced by the Department. In the Department's report, it responds to the recommendations put forth by B&A related to improving MCO processes related to claims processing as well as the recommendations for future measures to be reported on in subsequent quarterly reports. The Department's report includes the information required in the Act pertaining to encounter submissions and case management services.

B&A is currently engaged with the LDH to provide technical assistance in the design, development, and implementation of rates that will be paid to hospitals for inpatient care using diagnosis related groupings (DRGs) that will become effective on January 1, 2019. In this work, B&A has gained familiarity with the Louisiana hospital landscape with respect to services provided to Medicaid beneficiaries. The B&A team has also worked with the Medicaid MCOs in both group settings as well as in one-on-one meetings at each MCO's office in Baton Rouge.

Also of significance to this report, B&A serves as the External Quality Review Organization (EQRO) for Indiana's Medicaid program. Each State Medicaid Agency must contract with an EQRO to review its Medicaid MCOs that are under contract for its managed care programs. B&A has conducted an annual review of Indiana's MCOs since 2007 and has written an External Quality Review (EQR) report each year since that time. These reports have all been submitted to the Centers for Medicare and Medicaid (CMS). One of the criteria for serving as an EQRO is to assert independence from any of the MCOs which it reviews.

In addition to reviewing the mandatory requirements that relate to Medicaid managed care regulations, over the years B&A has also conducted 28 different focus studies for Indiana Medicaid's managed care programs on a wide variety of topics. In the EQR conducted in CY 2017, B&A conducted a focus study of each of the three MCO's claims adjudication processes. In the EQR conducted in CY 2018, B&A followed this up with a focus study on encounter submissions made by each MCO to Indiana Medicaid with tests conducted for timeliness, accuracy and completeness. The results of this study were recently submitted to the Medicaid agency and are currently being reviewed with each MCO in one-on-one in-person meetings with state representatives in attendance.

Steps in Claims Processing and Encounter Submissions

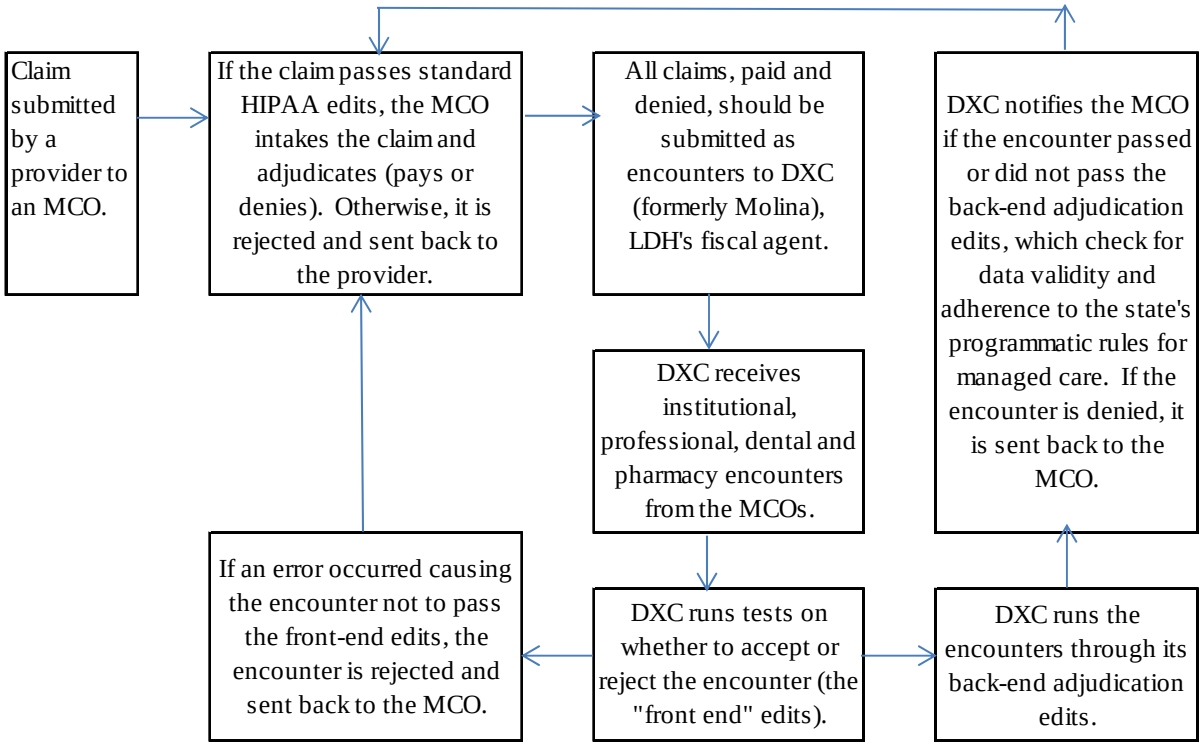
In a typical claims processing system, a provider will submit a claim for services rendered to the payer (in this case, the MCO) using one of the standardized claim formats that have been established nationally. Although it is still possible for claims to be submitted on paper, the vast majority of claims 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 universally submitted in electronic format now 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 below 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. 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 that 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). In some claims processing systems, the numbering sequence determines the combination of original-void-replacement claims.

When a claim is submitted to a payer, there are minimum 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 (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 this differs 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.

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, although almost all claims processing is automated, a payer may put a claim in pended status for manual review if the payment that will be made exceeds a certain threshold (e.g., above $50,000). This serves as an additional audit that a human being must "clear" the claim for payment before it is automatically released.

Claims adjudication systems may assign claims to a pended status for as a little as a few minutes to multiple days depending upon the reason to suspend the claim in the first place. Each claims processor sets its own criteria for assigning claims to a pended status.

The *turnaround time* is the term used to describe the length of time it takes for payers to adjudicate claims. In this study, the average time was examined from the receipt of the claim from the provider to when it was adjudicated as well as the average time for adjudication to notification (pay or deny) to the provider.

When a claim is adjudicated, the claims processor will assign codes to indicate the reason(s) for why it adjudicated the claim 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*) with over 200 in all.
- For pharmacy claims specifically, there are over 350 codes developed by the *NCPDP*.

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.

SECTION II: APPROACH TO CONDUCTING THIS INDEPENDENT STUDY

The approach that Burns & Associates, Inc. (B&A) used to conduct this independent assessment of health care claims submitted by providers to Healthy Louisiana managed care organizations (MCOs) is similar to what B&A has used to conduct similar projects for other state Medicaid agencies. The team that conducted this assessment also worked on the project for the Louisiana Department of Health (LDH) to set the hospital diagnosis related group (DRG) payment methodology. As a result, there were efficiencies gained from the team's familiarity with Healthy Louisiana MCOs and providers as well as the methods in which claims are submitted in this program.

The MCOs that were part of this review include:

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

Methodology

At a summary level, the following steps were completed to conduct the assessment:

1. B&A's Principal Investigator convened the MCOs with LDH on June 7 to discuss the proposed approach to collecting data from the MCOs and terminology that will be used in the project.

2. A data request was released to the MCOs on June 12 based on their initial feedback from a previous draft. Standard templates with variable names and allowable values for each variable were provided. The actual data request appears in Appendix A of this report.

3. One month of data designated as a test run was submitted to B&A by June 29.

4. B&A conducted a validation of the test file formats as well as the sum of key values in the individual files versus a control totals spreadsheet submitted by each MCO.

5. B&A sent out individual responses to each MCO on July 11 about the validations conducted on the data that they submitted.

6. The MCOs submitted the full 12 months of data for CY 2017 by July 20.

7. B&A read in and validated the MCO files for all 12 months for accuracy and completeness. Each MCO submitted 76 files in total.

8. B&A shared results with the MCOs about initial findings related to trends found on claims adjudication on August 21 and on CARC and NCPCP codes in particular on September 24.

9. B&A worked with each MCO, as needed, to understand and validate their data throughout August and September.

10. On an as needed basis, MCOs submitted additional data as requested by B&A.

11. B&A worked with LDH on the method to define behavioral and non-behavioral providers so that they could be reported separately as required by the Act.

12. B&A meets with the Department on the draft recommendations from the study on October 5.

13. Findings from the study are shared with provider stakeholder representatives in an in-person meeting on October 9. Examples of future reports with measures to be tracked are also shared.

14. A follow-up conference call is held with provider representatives on October 22 to respond to written feedback and to respond to additional feedback obtained during the call.

15. B&A writes the report of findings and offers recommendations and actions to be taken by LDH related to MCO claims processing, provider education, and tracking measures.

Data Sources

The primary source for all data used in the assessment came from each MCO directly. The MCOs were required to provide the information in the prescribed format, including file layout and naming convention, as described in the data request.

B&A requested that claim files be sent in mutually exclusive groupings by claim type (institutional, professional, dental and pharmacy). Information was requested separately for header-level claims and detail-level claims because the information on each portion of the claim record that was needed for analysis varies. Upon mutual agreement with the MCOs, claim files were delivered in monthly segments based on adjudication date. The exception to this is dental claims which were delivered in one file for the entire year for all but one MCO since their dental services volume is very low. For MCNA, whose sole focus is dental services, the MCO provided only dental files but these were provided on a monthly basis.

The claims files were delivered in a standard format so that they could be read the data into SAS, a statistical software package that B&A uses for analytics on large claim files.

B&A also requested two additional files from each MCO besides the claims data:

- A control totals file gave summary information on the contents of each claim type such as total claim lines and total charges.
- A table that provided the crosswalk of MCO-specific adjudication codes to the national CARC or NCPDP codes.

Identifying Behavioral Health and Non-Behavioral Health Providers

B&A requested a provider reference file from LDH to assist with assigning behavioral health and non-behavioral health providers. The rendering national provider identifier (NPI) was used for this purpose. B&A worked with the LDH and the Office of Behavioral Health (OBH) to define the list of specialized services delivered by behavioral health providers a way to assign providers. The list of these specialized services appears in Appendix B. For purposes of this study, therefore, behavioral health providers are defined as either (a) rendering NPI providers who deliver services listed in Appendix B or (b) free-standing psychiatric hospitals or acute care hospitals with a distinct part unit for psychiatric services. If the hospital has a distinct part psychiatric unit, then the services from this unit are counted with behavioral health providers while all other services from the hospital are categorized with non-behavioral health providers.

It should be noted that other providers could also be split between the behavioral health and non-behavioral health provider group depending upon the service that they are providing. For example, a physician who was delivering a behavioral health service would be classified under behavioral health only when he/she is providing a service listed in Appendix B. For all other services, the physician is classified with non-behavioral health providers. Individual claims, however, can only be classified under one category.

Detailed Analysis

The following illustrates the types of validations completed on the data for all files delivered to B&A by the MCOs:

- *Initial Intake*. Were all files received and can they be opened?
- *Match to MCO Control Totals File*. Do totals in detail files match the values on the Control Totals file submitted by the MCOs?
- *Variable Values*. Did the MCOs submit valid values for each variable?
- *Trends Across Key Metrics*. How do the MCOs measure against each other on key metrics?
- *Adjudication (CARC/NCPDP) Codes*. Did each MCO report CARC/NCPCP codes and, if they use other proprietary codes, were those codes mapped to the national code sets?

For the matching to control totals and variable values, B&A sent back to each MCO a checklist with explanations specific to each MCO about the data reviewed and clarification questions where needed.

For the trends across key metrics, B&A reviewed each claim type independently. To assess completeness of the data submitted, B&A assessed the total claims per 1,000 member months for each MCO/claim type. This allowed for an equitable comparison across the MCOs since their Healthy Louisiana enrollment varies. Additionally, B&A compared the per member per month payments for each MCO/claim type to determine if any MCO was a low or high outlier from its peers. For both of these measures, B&A compared the results for the MCO against the statewide average and against the other MCO's results.

Information on the trends across key metrics was shared in an all-MCO meeting convened by B&A on August 21. After this meeting, B&A delivered files to each MCO showing their MCO's specific results. B&A identified items that we requested the MCO conduct further research on. Where necessary, B&A accepted updated claims files if the MCO deemed that this was necessary based on their follow-up research. A status update was provided in the webinar that B&A held with the MCOs on September 24.

For the trends in adjudication codes, B&A reviewed the frequency of CARCs and NCPDP codes reported by each MCO. More than one CARC or NCPDP can be reported for a specific service claim line. B&A accepted up to five CARCs/NCPDPs per service line. B&A ensured first that every service line billed had at least one CARC or NCPDP. Then, we examined patterns within each MCO as to the prevalence of a single or multiple CARCs or NCPDP codes on each claim line.

B&A's focus was on adjudication codes that relate to denials. B&A compared the results for denial codes reported by each MCO on their claim files against what was reported on the Medicaid Managed Care Transparency Report for State Fiscal Year 2017 as well as monthly reports submitted by the MCOs of self-reported information on CARCs and NCPDP codes (LDH Report 173, the Prepaid Claims Denial Report). In both instances, the results independently computed by B&A shows high similarities to what was reported on these two independent data sources.

B&A prepared frequency distributions of CARC and NCPDP codes at the statewide level and for each MCO. We then identified the top five CARC and NCPDP codes by claim type for denied claims. B&A assessed the prevalence of the top 5 CARC and NCPDP codes as compared to all codes combined. B&A ranked the frequency of the top 5 CARC and NCPDP codes for each MCO to determine if there were similarities for the top denial codes across all MCOs.

The results of the information tabulated specific to adjudication codes were shared in an all-MCO webinar held on September 24. After the meeting, B&A delivered files to each MCO showing their own results in a manner similar to what was shared after the August 21 meeting. In some cases, B&A clarified MCO-specific adjudication codes that were mapped to the national CARCs.

Limitations in the Study

Throughout the course of the study, B&A determined that there were some limitations to the data that was being requested in the Act. These limitations are summarized below:

1. With respect to reporting the total number and dollar amount of rejected claims, as was described previously the MCOs do not track much detail related to claims which are rejected by their systems on the front-end. This is not unusual for a claims adjudication system. Therefore, although the number of rejected claims could be tracked in the study, the dollar amount associated with them could not.

2. The MCOs have built internal systems that vary on when and how a claim is tagged as pended. Consequently, the findings shown in the next section of this report reveal high variability on pended status due to differing definitions across the MCOs. Because this study covers a look-back period, the MCOs could not reconfigure claims with pended status using a definition different from the one that they have. Therefore, B&A is reporting the results of pended claims as reported to us by the MCOs without manipulation. A recommendation is forthcoming to streamline the definition of pended claims for reporting to the Department.

3. The Act requested information on the dollar amount of denied claims. If a claim is denied, then the payment will be $0. B&A did test multiple ways in which to derive a “would have paid” amount if the denied claim had been paid. This method was shared with the provider community in the meeting with them. There are multiple limitations to computing a “would have paid” amount.

    - One is the sheer number (thousands) of available services that could have been denied that all have a different rate on file. To compute this value most precisely, it would involve matching each denied service to the rate on file, then also employing any other pricing logic that is conducted in the claims adjudication systems in addition to determining the rate (such as checking for third party liability).

    - A second limitation is that each MCO may have a different type of contract with a provider that pays them a rate other than the Louisiana Medicaid fee-for-service rate. Without this knowledge, B&A could have over- or under-estimated a “would have paid” amount at the individual provider level.

    - Third, there are situations where a claim may have been denied, but this claim was later voided and resubmitted where the ultimate disposition was paid. In this situation, the valuation of denied claims would be overstated since the claim was ultimately paid.

For these and other reasons, it was mutually agreed with the provider community to show the rates of denied claims based on the number of claims but not to report an assigned dollar amount to these claims.

4. The Act required reporting of the rate of claims denied in error by the MCOs. There are two limitations as to why this cannot be reported on in this initial report. The first limitation is a timing issue. To conduct a thorough assessment of the extent to which this may be occurring would involve an iterative, multi-month process to select a sample of claims and to conduct an onsite review at each MCO. Although this was considered for the study, the more important limitation at the moment is the recognition that occurred early on in the study that the MCOs use different definitions for assigned paid or denied status at the service line level on a claim. In some cases, the MCO assigns a status of denied even if the claim line was "paid" but the paid amount is $0 because the valuation is factored into a bundled rate with another claim line. Other MCOs treat this example of the service line paid $0 as paid. Once this was determined, B&A realized that claim lines with a paid amount equal to $0 with a status of denied may not be denied in error after all. This particular issue is being resolved in a recommendation to the Department to clarify terminology for reporting on a go-forward basis.

Stakeholder Engagement

The Act required that the Department actively engage provider representatives in the review for design through completion.

Prior to meeting with the providers, B&A and the Department met with the MCOs to ensure the integrity and completeness of the data that was being analyzed in the study. Meetings in which all MCOs were convened included:

- A kickoff meeting on June 7 to review terminology and the data request to the MCOs as required for the study.
- A face-to-face meeting on August 21 to review findings to date and to identify areas for further research.
- A webinar meeting on September 24 to review additional findings since the prior meeting and to recap the findings previously shared based on more current research.

Once it was determined that the analysis was complete, B&A and the Department met with provider stakeholders in a face-to-face meeting on October 9. During this meeting, B&A described the data that was requested from the MCOs, the validations that occurred on the data received, the results of the meetings with the MCOs, and a walk through of each report that was generated pertaining to the requirements in the Act. Also at this meeting, B&A offered draft recommendations to the LDH and sought feedback from the provider community. With these recommendations, mockups of potential new reports that the MCOs would be required to submit to the Department on proposed new measures were shared.

Because of the depth of information shared, it was agreed that B&A, the Department and the providers would reconvene after sufficient time for stakeholders to review materials and to prepare feedback. A conference call was held on October 22 for this purpose. The Department addressed feedback that had been offered in writing in advance of the call as well as solicited verbal feedback during the call.

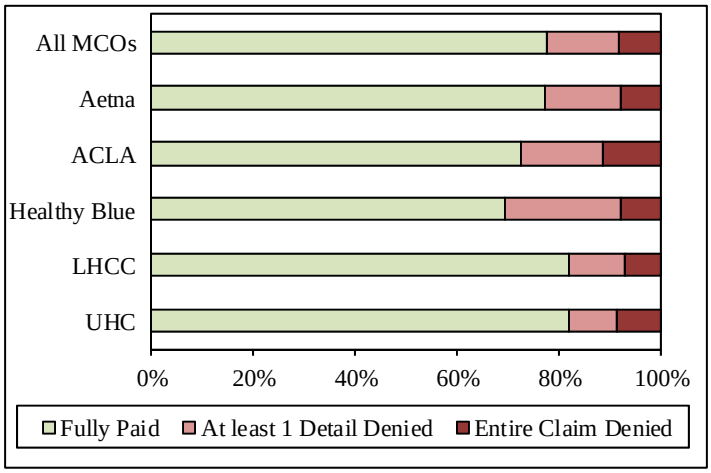
SECTION III: FINDINGS RELATED TO CLAIMS ADJUDICATION

How the Exhibits are Organized

The elements that are required by the Act to be reported on are organized into seven topics. Each topic area is designated by a letter in the exhibit numbers in this section as follows:

- The Exhibit A series reports the results by the claim source;
- The Exhibit B series reports the results by the adjudication status;
- The Exhibit C series reports the results by category of denial;
- The Exhibit D series reports the results by pended claim status;
- The Exhibit E series reports the results on MCO turnaround time for claims adjudication;
- The Exhibit F series reports the results of the analysis of denial reason codes; and
- The Exhibit G series reports the results of the analysis of the top providers with denials.

Most of the exhibits are displayed in a horizontal bar manner. An example from the Exhibit C series is shown below. The data represented by the horizontal bars is shown in the table below the box. Looking at the top line, this tells the reader that for all MCOs combined, on average in CY 2017 there were 77 percent of all institutional claims that were fully paid. This is shown in the green portion of the horizontal bar. The pink portion of the bar shows the 14 percent of the time where at least one service line on institutional claims was denied. The brick red portion of the bar represents the nine percent of the time when the entire claim was denied.



	Institutional Header Claims (excl. pended)		
	Fully Paid	At least 1 Detail Denied	Entire Claim Denied
All MCOs	77%	14%	9%
Aetna	77%	15%	8%
ACLA	72%	16%	12%
Healthy Blue	69%	23%	8%
LHCC	82%	11%	7%
UHC	82%	9%	9%

The color-coded horizontal bars were used for the reader to easily visualize where there are variances across each MCO or against the All MCO average. When the horizontal bars are displaying information as percentages, then the bar going across will add up to 100 percent. Other exhibits like those in Exhibit E series display information in days, not percentages. The range that is shown is from zero to 30 days.

Because the Act required that information be displayed for each claim type separately, on many exhibits there are either four boxes or two boxes of horizontal bars. The exhibits with four boxes each represent one of the claim types (institutional, professional, dental and pharmacy). Exhibits that have only two boxes show only the institutional and professional claim types. These exhibits are for when data is being presented on behavioral health providers only or non-behavioral health providers. The reason why there are only two boxes is because the behavioral health provider group does not bill dental or pharmacy claims. The results for dental and pharmacy appear on exhibits for all providers combined.

The Act also required that information be reported for behavioral health and non-behavioral health providers separately. This is noted both in the exhibit numbering as well as in the title of the exhibits. For example,

- Exhibit A.1 shows the results of claims in CY 2017 by header claim source for institutional and professional claim types for all providers combined.
- Exhibit A.1.1 shows the same information for behavioral health providers only.
- Exhibit A.1.2 shows the same information for non-behavioral health providers only.

When an exhibit contains a numbering sequence out to the third position (e.g., A.1.1), then this means that the exhibit is breaking out information for the behavioral health or non-behavioral health providers separately.

All of the source information that was used to compute the percentages that are plotted on the horizontal bars is provided in detail in Appendix C.

A summary of the findings related to each exhibit series appears prior to the exhibits starting on the next page.

Results by Source of Claim

Exhibits A.1, A.1.1, A.1.2 and A.2 on the following pages show the findings related to this topic. The items reviewed were the distribution of claims adjudicated in CY 2017 by the MCOs that were classified as original claims, adjusted claims, voided claims, duplicate claims or rejected claims.

In the three reports that comprise the A.1 series, it was found that institutional claims (primarily hospital billings) had a higher percentage of adjusted claims than the other claim types (professional, dental and pharmacy). This is true whether using the percentage based on the number of claims (for example, in the top two boxes of Exhibit A.1) or the percentage based on payments (for example, the bottom two boxes of Exhibit A.1). This trend carried forward when examining behavioral health providers only (Exhibit A.1.1) or non-behavioral health providers only (Exhibit A.1.2).

For the other three claim types, it was usually true that more than 90 percent of the claims were classified as original claims and the remaining ten percent of claims were the combination of adjusted, voided, duplicate and rejected claims. (Refer to Exhibit A.1 and A.2). There were some exceptions to this:

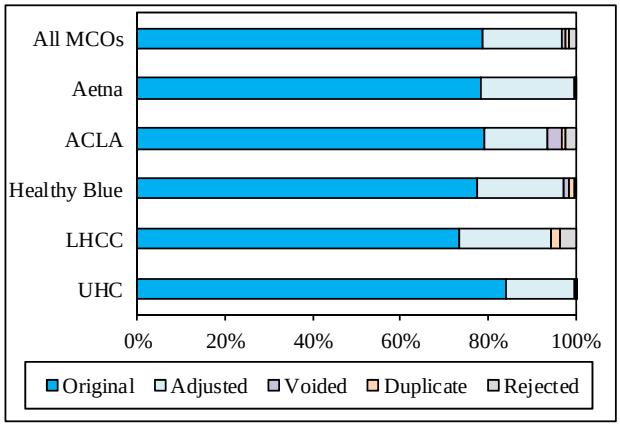
- Aetna had 13 percent of its professional claims marked as adjusted (Exhibit A.1, upper right).
- Healthy Blue and LHCC had 21 and 22 percent, respectively of their pharmacy claims marked as adjusted (Exhibit A.2, upper right).

The frequency of voided, duplicate and rejected claims as percentage of all claims received by the MCOs in CY 2017 is minimal, with the exception that ACLA reported 10 percent of its pharmacy claims as duplicate and Aetna reported that 22 percent of its pharmacy claims were rejected. Because Aetna differs so greatly from the other MCOs in this regard (the rest of the MCOs had zero pharmacy rejected claims), B&A assumes that this may be a definitions issue.

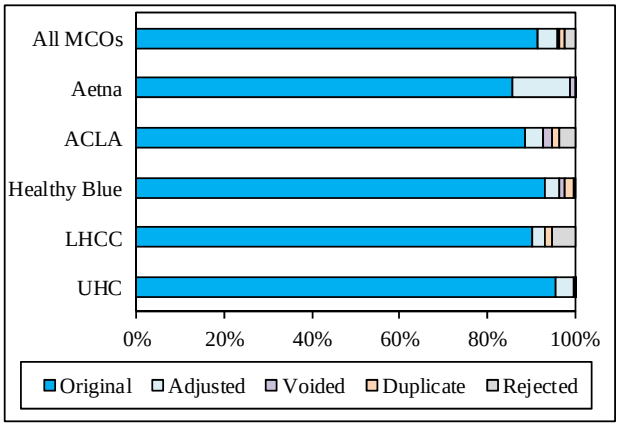
It should also be noted that LHCC reported payments on claims marked as duplicates but the other MCOs did not even though they stated that they had duplicate claims. (Compare, for example, the top boxes on Exhibit A.1 to the bottom boxes and review the column for Duplicates.)

Exhibit A.1
Stratification of CY 2017 Adjudicated Claims by Header Source for Institutional and Professional Claim Types
By MCO, Combined (BH + Non-BH) Providers

Institutional Header Claims



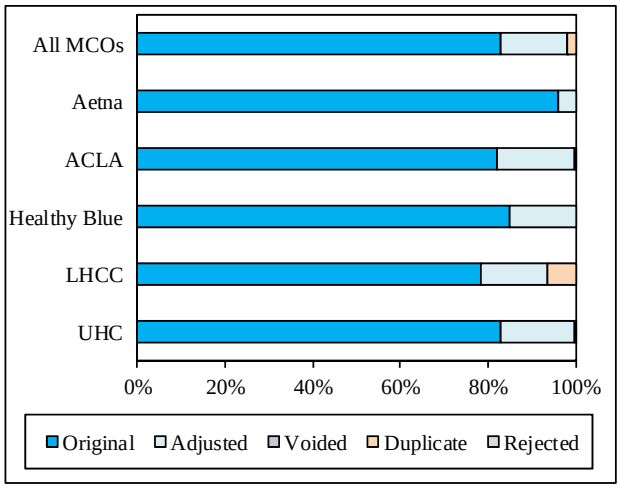
Professional Header Claims



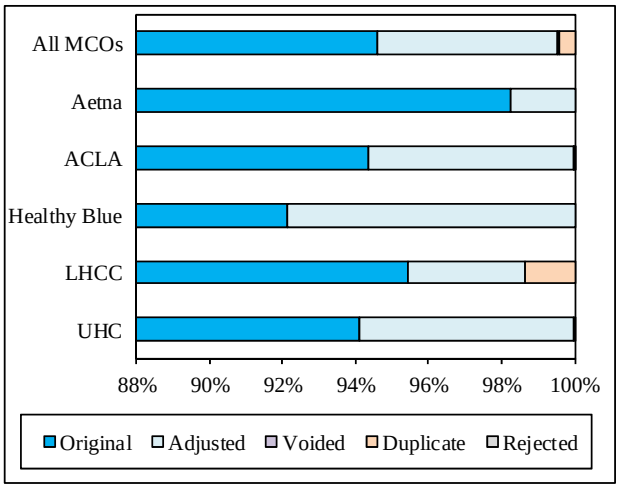
	Institutional Header Claims				
	Original	**Adjusted**	**Voided**	**Duplicate**	**Rejected**
All MCOs	79%	18%	1%	1%	1%
Aetna	78%	22%	0%	0%	0%
ACLA	79%	15%	3%	1%	2%
Healthy Blue	77%	20%	1%	1%	0%
LHCC	74%	21%	0%	2%	3%
UHC	84%	16%	0%	0%	0%

	Professional Header Claims				
	Original	**Adjusted**	**Voided**	**Duplicate**	**Rejected**
All MCOs	92%	4%	1%	1%	2%
Aetna	86%	13%	1%	0%	0%
ACLA	89%	4%	2%	2%	4%
Healthy Blue	93%	4%	1%	2%	0%
LHCC	90%	3%	0%	1%	5%
UHC	96%	4%	0%	0%	0%

Institutional Header Dollars



Professional Header Dollars

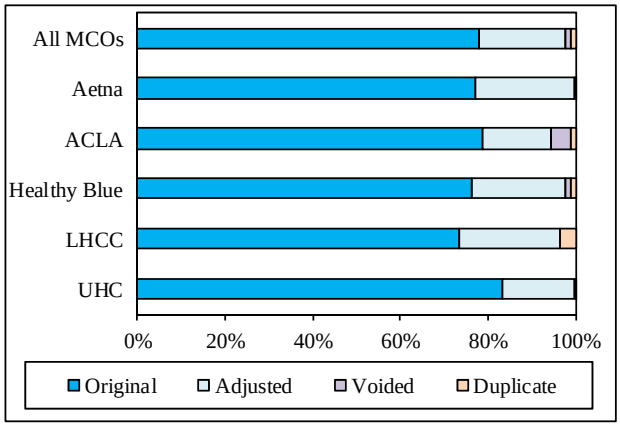


	Institutional Header Dollars				
	Original	**Adjusted**	**Voided**	**Duplicate**	**Rejected**
All MCOs	83%	15%	0%	2%	0%
Aetna	96%	4%	0%	0%	0%
ACLA	82%	18%	0%	0%	0%
Healthy Blue	85%	15%	0%	0%	0%
LHCC	78%	15%	0%	6%	0%
UHC	83%	17%	0%	0%	0%

	Professional Header Dollars				
	Original	**Adjusted**	**Voided**	**Duplicate**	**Rejected**
All MCOs	95%	5%	0%	0%	0%
Aetna	98%	2%	0%	0%	0%
ACLA	94%	6%	0%	0%	0%
Healthy Blue	92%	8%	0%	0%	0%
LHCC	95%	3%	0%	1%	0%
UHC	94%	6%	0%	0%	0%

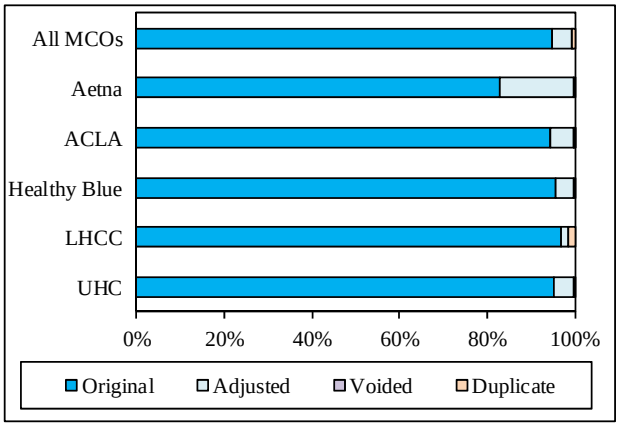
Exhibit A.1.1
Stratification of CY 2017 Adjudicated Claims by Header Source for Institutional and Professional Claim Types
By MCO, Behavioral Health Providers ONLY

Institutional Header Claims



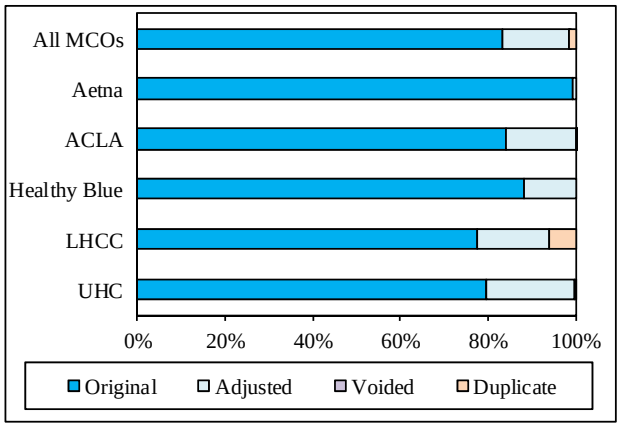
	Institutional Header Claims			
	Original	**Adjusted**	**Voided**	**Duplicate**
All MCOs	78%	20%	1%	1%
Aetna	77%	23%	0%	0%
ACLA	79%	16%	4%	1%
Healthy Blue	76%	21%	1%	1%
LHCC	73%	23%	0%	3%
UHC	83%	16%	0%	0%

Professional Header Claims



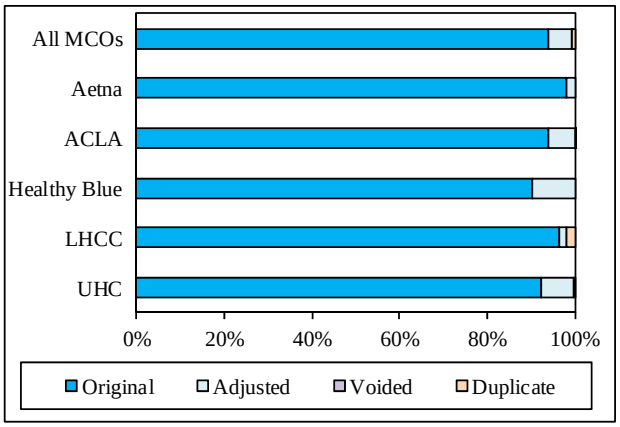
	Professional Header Claims			
	Original	**Adjusted**	**Voided**	**Duplicate**
All MCOs	95%	5%	0%	0%
Aetna	83%	17%	0%	0%
ACLA	94%	5%	0%	0%
Healthy Blue	96%	4%	0%	0%
LHCC	97%	2%	0%	1%
UHC	95%	5%	0%	0%

Institutional Header Dollars



	Institutional Header Dollars			
	Original	**Adjusted**	**Voided**	**Duplicate**
All MCOs	83%	15%	0%	1%
Aetna	99%	1%	0%	0%
ACLA	84%	16%	0%	0%
Healthy Blue	88%	12%	0%	0%
LHCC	78%	16%	0%	6%
UHC	80%	20%	0%	0%

Professional Header Dollars

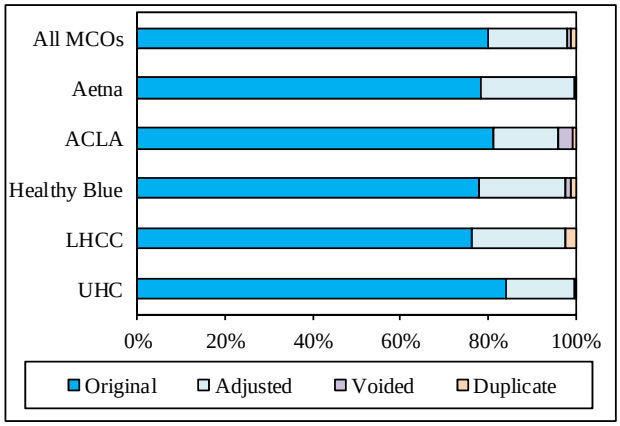


	Professional Header Dollars			
	Original	**Adjusted**	**Voided**	**Duplicate**
All MCOs	94%	5%	0%	1%
Aetna	98%	2%	0%	0%
ACLA	94%	6%	0%	0%
Healthy Blue	90%	10%	0%	0%
LHCC	96%	2%	0%	2%
UHC	92%	7%	0%	0%

Note: Rejected claims are not broken out between BH and non-BH because the provider ID is not always stored to differentiate.

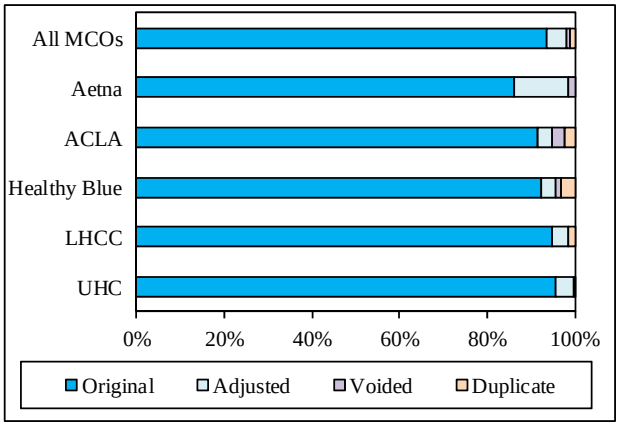
Exhibit A.1.2
Stratification of CY 2017 Adjudicated Claims by Header Source for Institutional and Professional Claim Types
By MCO, Non-Behavioral Health Providers ONLY

Institutional Header Claims



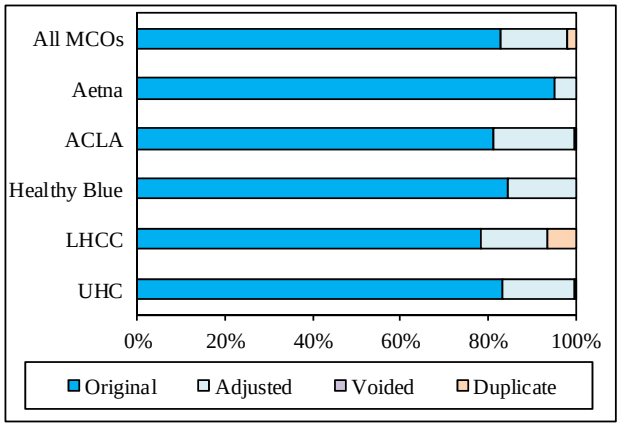
	Institutional Header Claims			
	Original	Adjusted	Voided	Duplicate
All MCOs	80%	18%	1%	1%
Aetna	78%	21%	0%	0%
ACLA	81%	15%	3%	1%
Healthy Blue	78%	20%	1%	1%
LHCC	77%	21%	0%	2%
UHC	84%	16%	0%	0%

Professional Header Claims



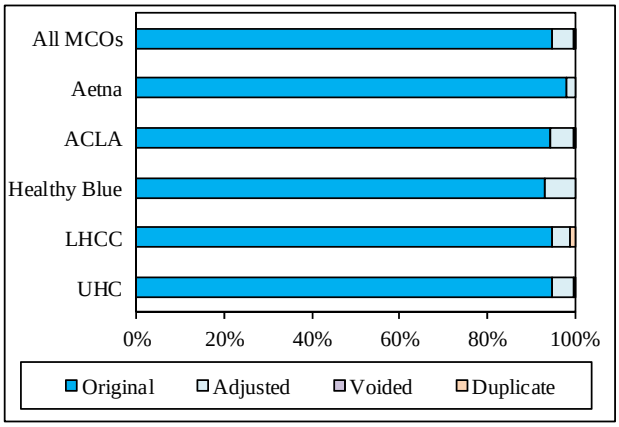
	Professional Header Claims			
	Original	Adjusted	Voided	Duplicate
All MCOs	94%	4%	1%	1%
Aetna	86%	12%	1%	0%
ACLA	92%	4%	3%	2%
Healthy Blue	92%	3%	1%	3%
LHCC	95%	4%	0%	1%
UHC	96%	4%	0%	0%

Institutional Header Dollars



	Institutional Header Dollars			
	Original	Adjusted	Voided	Duplicate
All MCOs	83%	15%	0%	2%
Aetna	95%	5%	0%	0%
ACLA	81%	19%	0%	0%
Healthy Blue	84%	16%	0%	0%
LHCC	78%	15%	0%	7%
UHC	83%	17%	0%	0%

Professional Header Dollars

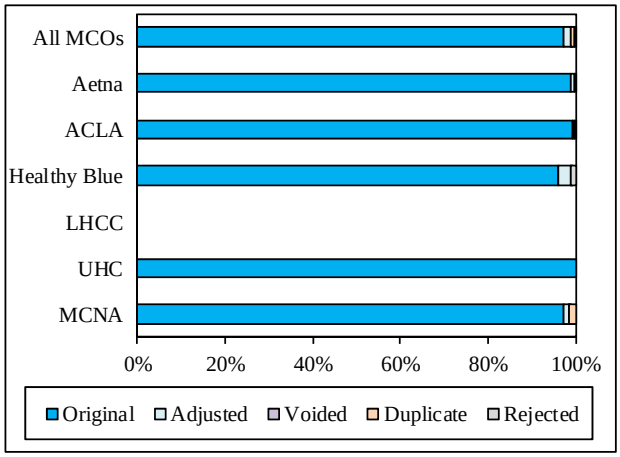


	Professional Header Dollars			
	Original	Adjusted	Voided	Duplicate
All MCOs	95%	5%	0%	0%
Aetna	98%	2%	0%	0%
ACLA	95%	5%	0%	0%
Healthy Blue	93%	7%	0%	0%
LHCC	95%	4%	0%	1%
UHC	95%	5%	0%	0%

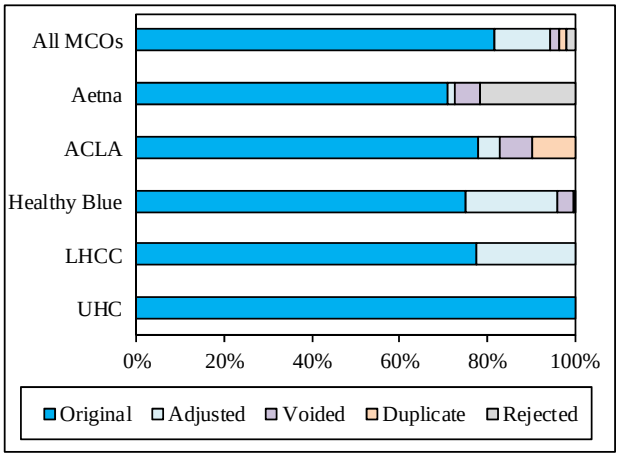
Note: Rejected claims are not broken out between BH and non-BH because the provider ID is not always stored to differentiate.

Exhibit A.2
Stratification of CY 2017 Adjudicated Claims by Header Source for Dental and Pharmacy Claim Types
By MCO, Combined (BH + Non-BH) Providers

Dental Header Claims



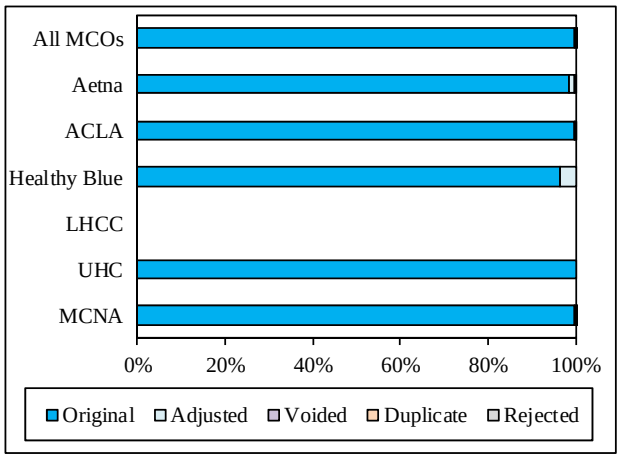
Pharmacy Header Claims



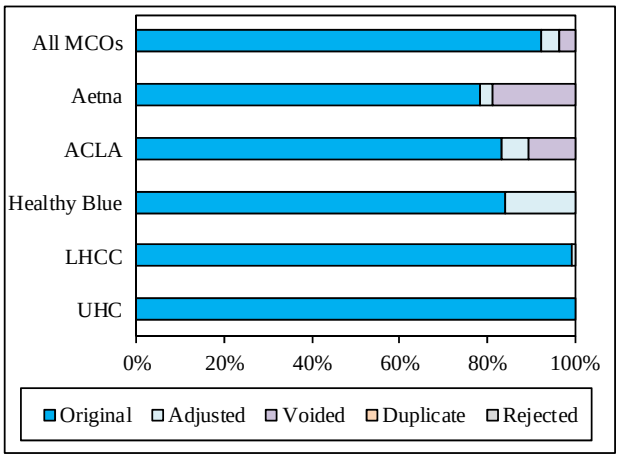
	Dental Header Claims				
	Original	**Adjusted**	**Voided**	**Duplicate**	**Rejected**
All MCOs	97%	1%	0%	1%	0%
Aetna	99%	1%	0%	0%	0%
ACLA	100%	0%	0%	0%	0%
Healthy Blue	96%	3%	0%	0%	1%
LHCC	LHCC had no dental claims to report.				
UHC	100%	0%	0%	0%	0%
MCNA	97%	1%	0%	1%	0%

	Pharmacy Header Claims				
	Original	**Adjusted**	**Voided**	**Duplicate**	**Rejected**
All MCOs	82%	12%	2%	1%	2%
Aetna	71%	2%	6%	0%	22%
ACLA	78%	5%	8%	10%	0%
Healthy Blue	75%	21%	4%	0%	0%
LHCC	78%	22%	0%	0%	0%
UHC	100%	0%	0%	0%	0%

Dental Header Dollars



Pharmacy Header Dollars



	Dental Header Dollars				
	Original	**Adjusted**	**Voided**	**Duplicate**	**Rejected**
All MCOs	100%	0%	0%	0%	0%
Aetna	99%	1%	0%	0%	0%
ACLA	100%	0%	0%	0%	0%
Healthy Blue	96%	4%	0%	0%	0%
LHCC	LHCC had no dental claims to report.				
UHC	100%	0%	0%	0%	0%
MCNA	100%	0%	0%	0%	0%

	Pharmacy Header Dollars				
	Original	**Adjusted**	**Voided**	**Duplicate**	**Rejected**
All MCOs	92%	4%	4%	0%	0%
Aetna	78%	3%	19%	0%	0%
ACLA	83%	6%	11%	0%	0%
Healthy Blue	84%	16%	0%	0%	0%
LHCC	100%	0%	0%	0%	0%
UHC	100%	0%	0%	0%	0%

Results by Adjudication Status

Exhibit B.1 shows the distribution of claims adjudicated in CY 2017 by the MCOs that were classified as paid claims, denied claims or pended claims (as of December 31, 2017). This exhibit shows all providers combined. Exhibit B.1.1 breaks the results out further for behavioral health providers (top box) and non-behavioral health providers (bottom box) separately.

Exhibit B.1 shows the following denial rates at the header claim level for CY 2017 by claim type:

- For institutional claims, the weighted average across MCOs was 8%, with a variation across the MCOs from 7% to 11%.

- For professional claims, the weighted average across MCOs was 12%, with a variation across the MCOs from 9% to 14%

- For dental claims, the weighted average across MCOs was 5%. This average is driven by MCNA since this MCO has 85 percent of all dental claims. The denial range across the other MCOs of 0% to 15% is less meaningful since the other five MCOs combined represent the remaining 15 percent or all dental claims.

- For pharmacy claims, the weighted average across MCOs was 27%, with a variation across the MCOs from 16% to 36%.

The denial rates for pharmacy are significantly higher than the other claim types. B&A has observed this in other claim studies we have conducted and this was verified with the Healthy Louisiana MCOs. An electronic pharmacy claim is generated at the point-of-sale at a pharmacy. A common occurrence is that a pharmacist will key the information in for a refill. The refill exceeds a quantity limit or the refill is occurring too early from the previous fill. When the data is entered, this claim will deny for a reason like this. The pharmacist may continually enter information until the refill quantity is accepted (i.e., passes the system edit). All prior entries are tagged as denials, even though there may have been five claims generated in a five-minute span of time.

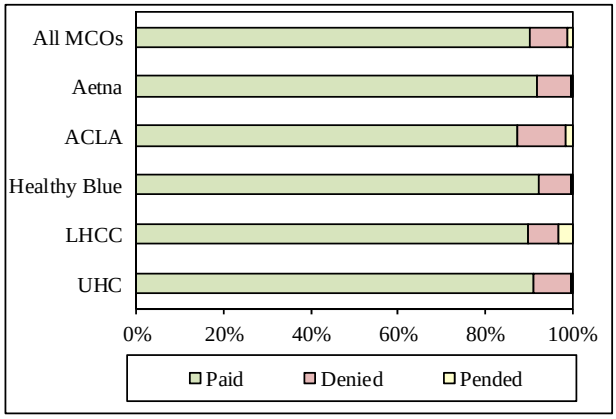
Exhibit B.1.1 compares the findings between the behavioral health and non-behavioral health providers for the claim types that both provider groups bill on (institutional and professional). There were differences found:

- For institutional claims, the all provider average denial rate was 8%. For behavioral health providers, it was 11%; for non-behavioral health providers, it was 8%. This means that non-behavioral health providers are driving the overall average.

- For professional claims, the all provider average denial rate was 12%. For behavioral health providers, it was 0%; for non-behavioral health providers, it was 15%. This information reports the adjudication status at the *header level*, not the individual service line level. Recall from the previous section that a header claim status may be deemed paid if at least one (but not all) service lines were paid. This may be why the behavioral health providers had 0% claims denied at the header level, although this finding is still questionable. There were denials found for behavioral health services at the individual service line level as shown in the Exhibit C series coming up next.

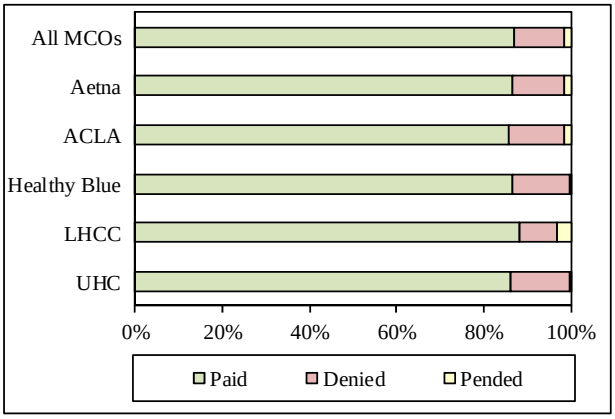
Exhibit B.1
Stratification of CY 2017 Adjudicted Claims by Adjudication Status Institutional, Professional, Dental & Pharmacy Claim Types By MCO, Combined (BH + Non-BH) Providers

Institutional Header Claims



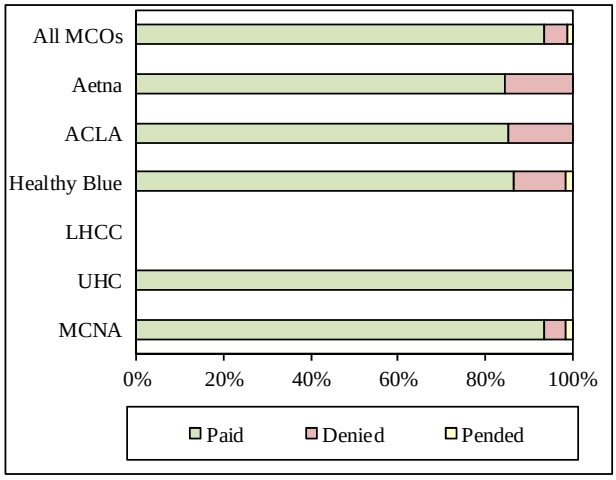
	Institutional Header Claims		
	Paid	Denied	Pended
All MCOs	90%	8%	1%
Aetna	92%	8%	0%
ACLA	87%	11%	1%
Healthy Blue	92%	8%	0%
LHCC	90%	7%	3%
UHC	91%	9%	0%

Professional Header Claims



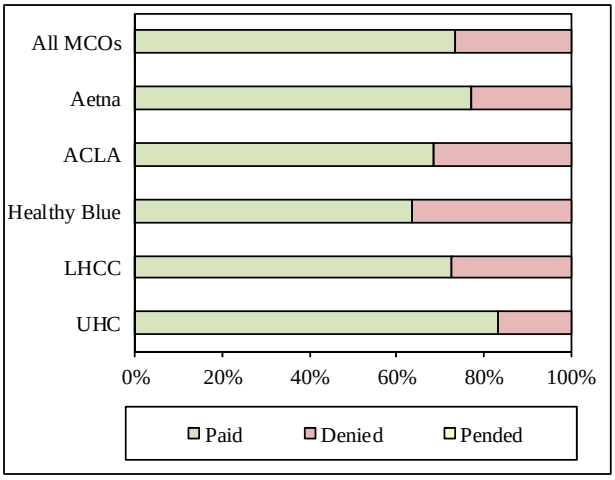
	Professional Header Claims		
	Paid	Denied	Pended
All MCOs	87%	12%	1%
Aetna	87%	12%	2%
ACLA	86%	13%	1%
Healthy Blue	86%	14%	0%
LHCC	88%	9%	3%
UHC	86%	14%	0%

Dental Header Claims



	Dental Header Claims		
	Paid	Denied	Pended
All MCOs	94%	5%	1%
Aetna	85%	15%	0%
ACLA	85%	15%	0%
Healthy Blue	87%	12%	2%
LHCC	0%	0%	0%
UHC	100%	0%	0%
MCNA	94%	5%	1%

Pharmacy Header Claims



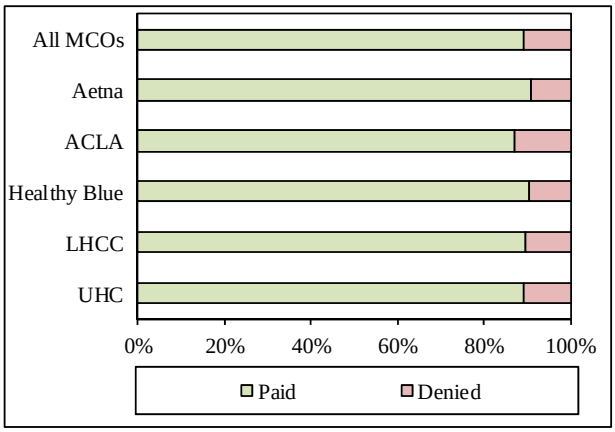
	Pharmacy Header Claims		
	Paid	Denied	Pended
All MCOs	73%	27%	0%
Aetna	77%	23%	0%
ACLA	69%	31%	0%
Healthy Blue	64%	36%	0%
LHCC	73%	27%	0%
UHC	84%	16%	0%

Note: LHCC had no dental claims to report.

Exhibit B.1.1
Stratification of CY 2017 Adjudicated Claims by Adjudication Status for Institutional and Professional Claim Types
By MCO, Behavioral Health Providers and Non-Behavioral Health Providers SEPARATELY

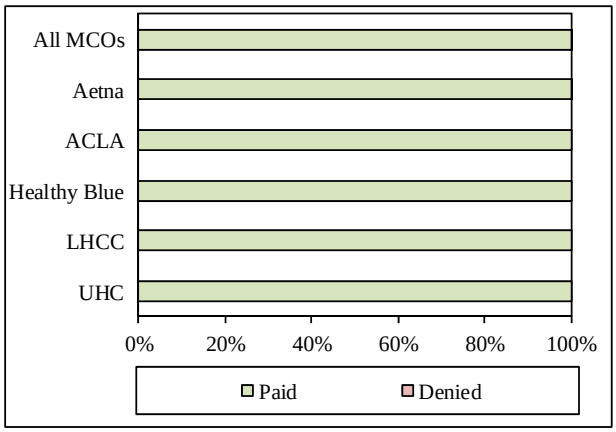
BEHAVIORAL HEALTH PROVIDERS ONLY

Institutional Header Claims



	Institutional Header Claims	
	Paid	**Denied**
All MCOs	89%	11%
Aetna	91%	9%
ACLA	87%	13%
Healthy Blue	91%	9%
LHCC	90%	10%
UHC	89%	11%

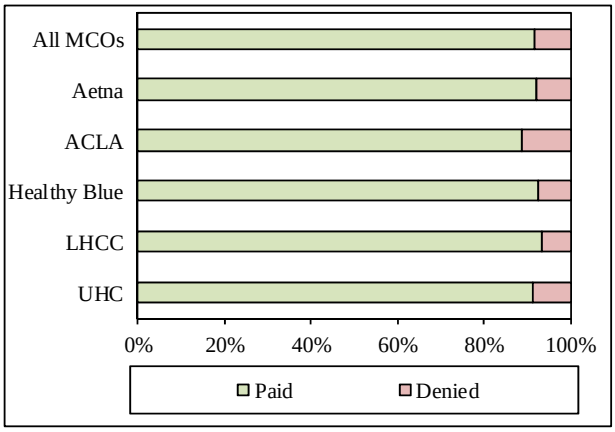
Professional Header Claims



	Professional Header Claims	
	Paid	**Denied**
All MCOs	100%	0%
Aetna	100%	0%
ACLA	100%	0%
Healthy Blue	100%	0%
LHCC	100%	0%
UHC	100%	0%

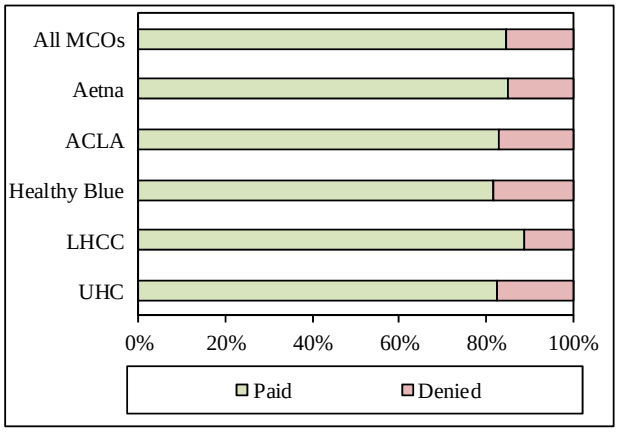
NON-BEHAVIORAL HEALTH PROVIDERS ONLY

Institutional Header Claims



	Institutional Header Claims	
	Paid	**Denied**
All MCOs	92%	8%
Aetna	92%	8%
ACLA	89%	11%
Healthy Blue	92%	8%
LHCC	93%	7%
UHC	91%	9%

Professional Header Claims



	Professional Header Claims	
	Paid	**Denied**
All MCOs	85%	15%
Aetna	85%	15%
ACLA	83%	17%
Healthy Blue	82%	18%
LHCC	89%	11%
UHC	83%	17%

Results by Category of Denial

Exhibits C.1 and C.1.1 are simply a variation on the information shown in Exhibits B.1 and B.1.1. Instead of showing header claims with a status of paid, denied or pended as shown in the Exhibit B series, the Exhibit C series excludes the few pended claims but breaks out the other claims between fully paid, fully denied, or paid status but at least one service line denied.

When all CY 2017 claims were examined, the results for all MCOs combined based on volume as shown in Exhibit C.1 are as follows:

- For institutional claims, 77% fully paid, 14% with at least one line denied, and 9% fully denied.
- For professional claims, 80% fully paid, 8% with at least one line denied, and 12% fully denied.
- For dental claims, 83% fully paid, 12% with at least one line denied, and 5% fully denied.
- For pharmacy clams, 73% full paid, 0% with at least one line denied, and 27% fully denied.

With respect to the statistic of claims with at least one line denied, there was some variation found across the MCOs (Exhibit C.1 is the reference):

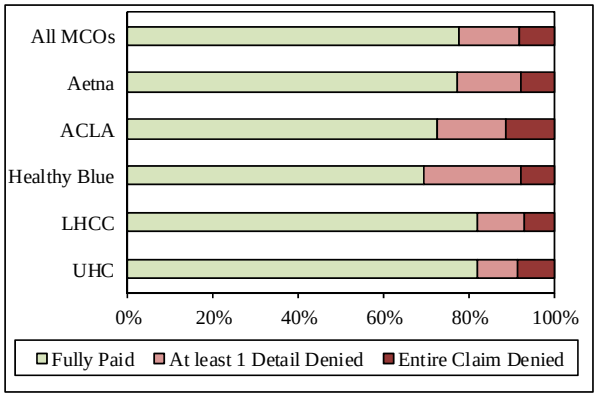
- For institutional claims, Healthy Blue had a much higher percentage than its peers (23%).
- For professional claims, ACLA and Healthy Blue had higher percentages than their peers (11% and 14%, respectively).
- For dental claims, there is variation across MCOs but this is driven by low volume for all except MCNA.

In reviewing Exhibit C.1.1, the behavioral health providers had findings that differed from the non-behavioral health providers which drove the overall averages. Among the behavioral health providers only, the results for all MCOs combined based on volume were:

- For institutional claims, 74% fully paid, 15% with at least one line denied, and 11% fully denied.
- For professional claims, 94% fully paid, 6% with at least one line denied, and 0% fully denied.

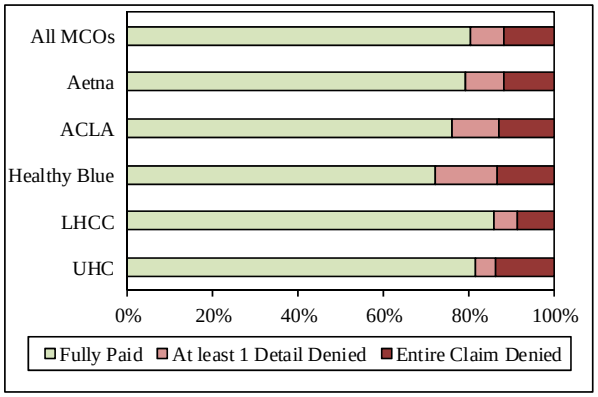
Exhibit C.1
Stratification of CY 2017 Adjudicated Claims by Adjudication Status for Institutional, Professional, Dental & Pharmacy Claim Types
By MCO, Combined (BH + Non-BH) Providers

Institutional Header Claims



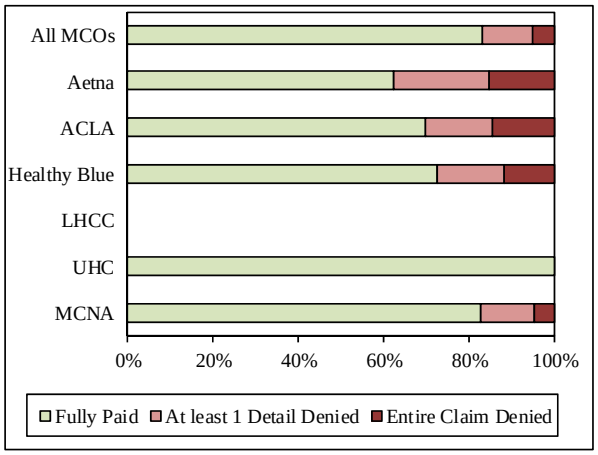
	Institutional Header Claims (excl. pended)		
	Fully Paid	At least 1 Detail Denied	Entire Claim Denied
All MCOs	77%	14%	9%
Aetna	77%	15%	8%
ACLA	72%	16%	12%
Healthy Blue	69%	23%	8%
LHCC	82%	11%	7%
UHC	82%	9%	9%

Professional Header Claims



	Professional Header Claims (excl. pended)		
	Fully Paid	At least 1 Detail Denied	Entire Claim Denied
All MCOs	80%	8%	12%
Aetna	79%	9%	12%
ACLA	76%	11%	13%
Healthy Blue	72%	14%	14%
LHCC	86%	5%	9%
UHC	81%	5%	14%

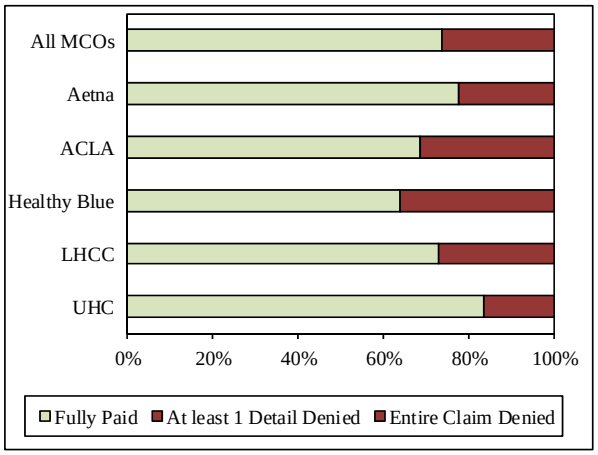
Dental Header Claims



	Dental Header Claims (excl. pended)		
	Fully Paid	At least 1 Detail Denied	Entire Claim Denied
All MCOs	83%	12%	5%
Aetna	62%	22%	15%
ACLA	70%	16%	15%
Healthy Blue	73%	15%	12%
LHCC	0%	0%	0%
UHC	100%	0%	0%
MCNA	83%	12%	5%

Note: LHCC had no dental claims to report.

Pharmacy Header Claims

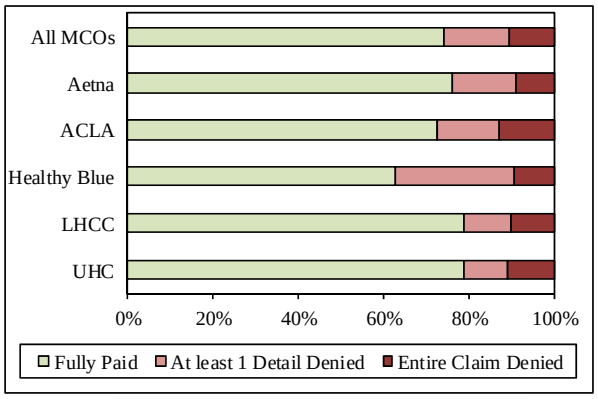


	Pharmacy Header Claims (excl. pended)		
	Fully Paid	At least 1 Detail Denied	Entire Claim Denied
All MCOs	73%	0%	27%
Aetna	77%	0%	23%
ACLA	69%	0%	31%
Healthy Blue	64%	0%	36%
LHCC	73%	0%	27%
UHC	84%	0%	16%

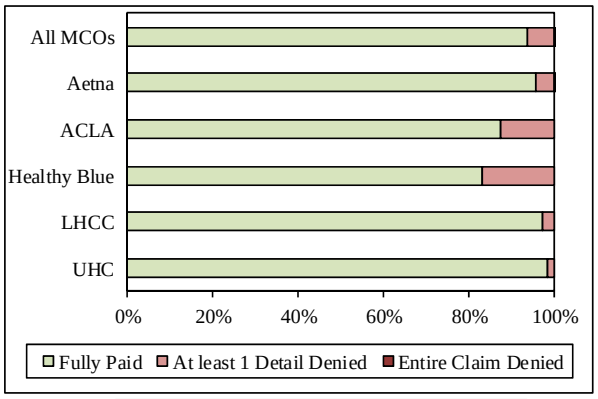
Exhibit C.1.1
Stratification of CY 2017 Adjudicated Claims by Adjudication Status for Institutional and Professional Claim Types
By MCO, Behavioral Health Providers and Non-Behavioral Health Providers SEPARATELY

BEHAVIORAL HEALTH PROVIDERS ONLY

Institutional Header Claims



Professional Header Claims

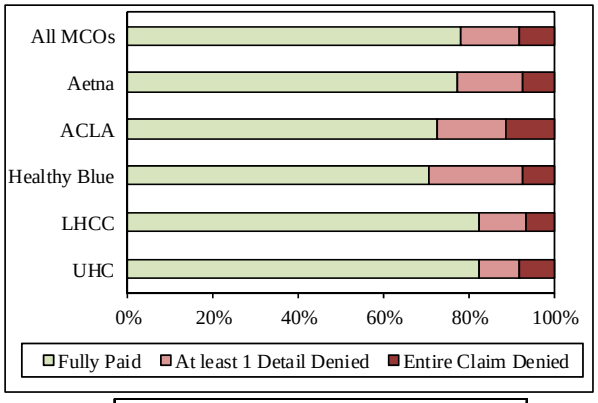


	Institutional Header Claims (excl. pended)		
	Fully Paid	**At least 1 Detail Denied**	**Entire Claim Denied**
All MCOs	74%	15%	11%
Aetna	76%	15%	9%
ACLA	73%	15%	13%
Healthy Blue	63%	28%	9%
LHCC	79%	11%	10%
UHC	79%	11%	11%

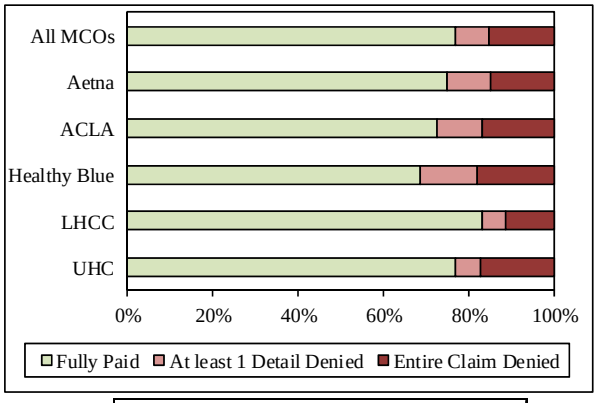
	Professional Header Claims (excl. pended)		
	Fully Paid	**At least 1 Detail Denied**	**Entire Claim Denied**
All MCOs	94%	6%	0%
Aetna	96%	4%	0%
ACLA	87%	13%	0%
Healthy Blue	83%	17%	0%
LHCC	97%	3%	0%
UHC	98%	2%	0%

NON-BEHAVIORAL HEALTH PROVIDERS ONLY

Institutional Header Claims



Professional Header Claims



	Institutional Header Claims (excl. pended)		
	Fully Paid	**At least 1 Detail Denied**	**Entire Claim Denied**
All MCOs	78%	14%	8%
Aetna	77%	15%	8%
ACLA	72%	16%	11%
Healthy Blue	71%	22%	8%
LHCC	82%	11%	7%
UHC	82%	9%	9%

	Professional Header Claims (excl. pended)		
	Fully Paid	**At least 1 Detail Denied**	**Entire Claim Denied**
All MCOs	77%	8%	15%
Aetna	75%	10%	15%
ACLA	73%	11%	17%
Healthy Blue	69%	13%	18%
LHCC	83%	6%	11%
UHC	77%	6%	17%

Results by Pended Status

Exhibits D.1, D.1.1, D.1.2 and D.2 on the following pages show the findings related to this topic. The items reviewed were the distribution of claims that were tagged as ever pended by the MCO or never pended by the MCO.

Exhibit D.1 shows this distribution for institutional and professional claims, all providers combined, based on both volume and claim payments. Exhibit D.2 shows this same information for the dental and pharmacy claim types. Based on discussions with the MCOs, it was learned that the definition of the term pended and how it is applied to claims varies across the MCOs. This is evidenced by the findings in this exhibit.

- For institutional claims, the all MCO average was 24% ever pended and 76% never pended. The variation across MCOs for ever pended was from 18% to 47%.

- For professional claims, the all MCO average was 15% ever pended and 85% never pended. The variation across MCOs for ever pended was from 8% to 26%.

- For dental claims, the all MCO average was 16% ever pended and 84% never pended. The variation across MCOs is not meaningful to report here since the volume is almost all MCNA.

- For pharmacy claims, the all MCO average was 0% ever pended and 100% never pended. This is one area where the MCOs are consistent since no MCO had any pended pharmacy claims due to the fact that the claim is generated at the point-of-sale.

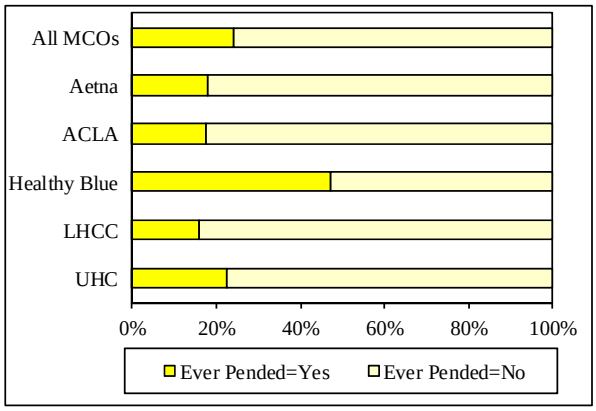
Exhibits D.1.1 and D.1.2 show that there is some variation in these results when comparing behavioral health and non-behavioral health providers:

- For institutional claims, the all MCO average was 24% ever pended and 76% never pended.
  - For behavioral health providers, it was 30% ever pended and 70% never pended.
  - For non-behavioral health providers, it was 23% ever pended and 77% never pended.

- For professional claims, the all MCO average was 15% ever pended and 85% never pended.
  - For behavioral health providers, it was 16% ever pended and 84% never pended.
  - For non-behavioral health providers, it was 14% ever pended and 86% never pended.

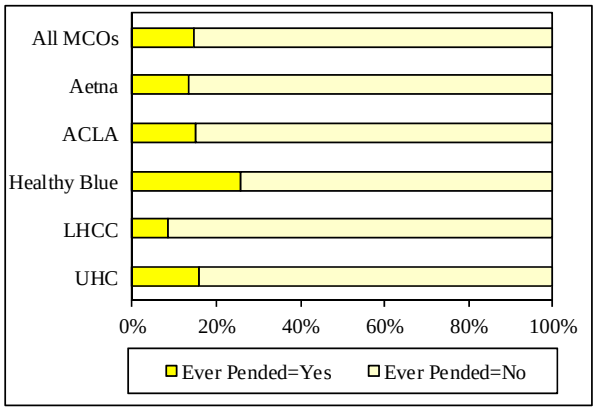
Exhibit D.1
Stratification of CY 2017 Adjudicated Claims by Header Pended Status for Institutional and Professional Claim Types
By MCO, Combined (BH + Non-BH) Providers

Institutional Header Claims



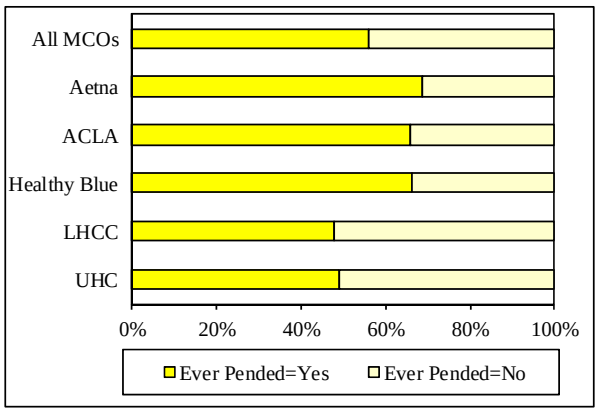
	Institutional Header Claims	
	Ever Pended=Yes	**Ever Pended=No**
All MCOs	24%	76%
Aetna	18%	82%
ACLA	18%	82%
Healthy Blue	47%	53%
LHCC	16%	84%
UHC	22%	78%

Professional Header Claims



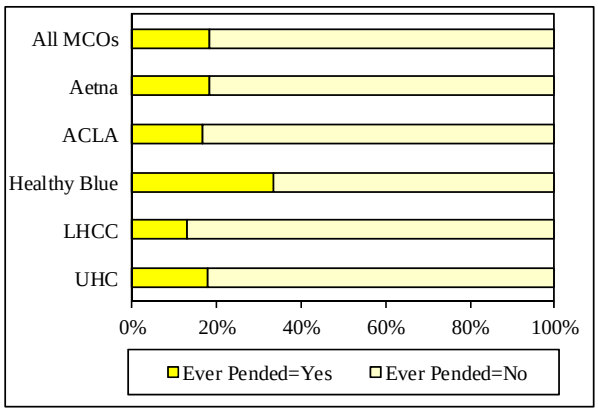
	Professional Header Claims	
	Ever Pended=Yes	**Ever Pended=No**
All MCOs	15%	85%
Aetna	14%	86%
ACLA	15%	85%
Healthy Blue	26%	74%
LHCC	8%	92%
UHC	16%	84%

Institutional Header Dollars



	Institutional Header Dollars	
	Ever Pended=Yes	**Ever Pended=No**
All MCOs	56%	44%
Aetna	69%	31%
ACLA	66%	34%
Healthy Blue	66%	34%
LHCC	48%	52%
UHC	49%	51%

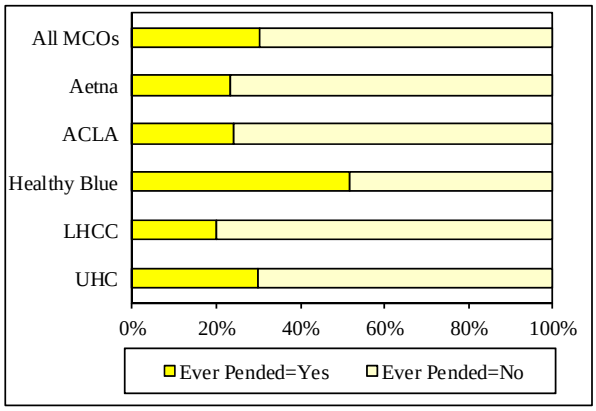
Professional Header Dollars



	Professional Header Dollars	
	Ever Pended=Yes	**Ever Pended=No**
All MCOs	18%	82%
Aetna	18%	82%
ACLA	16%	84%
Healthy Blue	34%	66%
LHCC	13%	87%
UHC	18%	82%

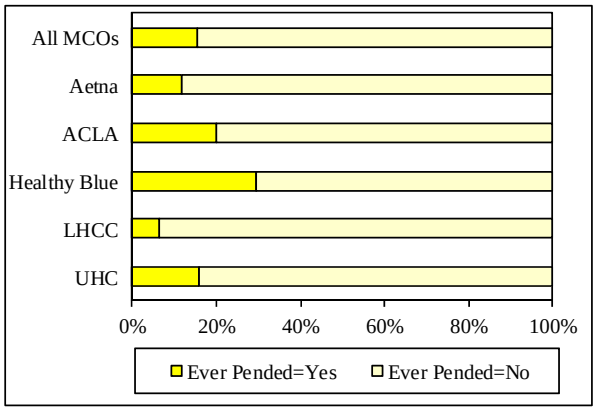
Exhibit D.1.1
Stratification of CY 2017 Adjudicated Claims by Header Pended Status for Institutional and Professional Claim Types
By MCO, Behavioral Health Providers ONLY

Institutional Header Claims



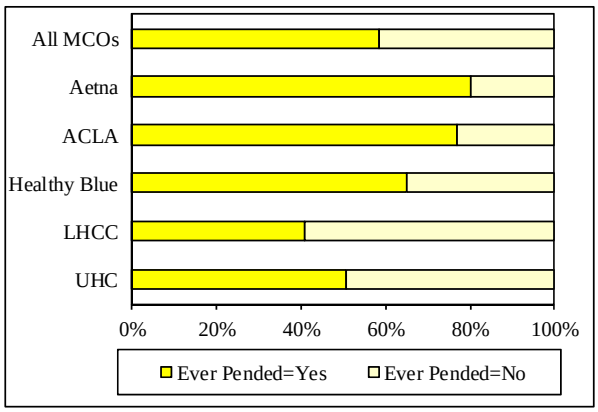
	Institutional Header Claims	
	Ever Pended=Yes	**Ever Pended=No**
All MCOs	30%	70%
Aetna	23%	77%
ACLA	24%	76%
Healthy Blue	52%	48%
LHCC	20%	80%
UHC	30%	70%

Professional Header Claims



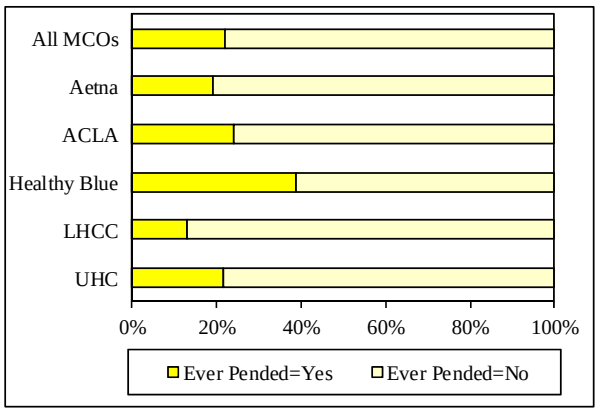
	Professional Header Claims	
	Ever Pended=Yes	**Ever Pended=No**
All MCOs	16%	84%
Aetna	12%	88%
ACLA	20%	80%
Healthy Blue	29%	71%
LHCC	7%	93%
UHC	16%	84%

Institutional Header Dollars



	Institutional Header Dollars	
	Ever Pended=Yes	**Ever Pended=No**
All MCOs	58%	42%
Aetna	80%	20%
ACLA	77%	23%
Healthy Blue	65%	35%
LHCC	41%	59%
UHC	50%	50%

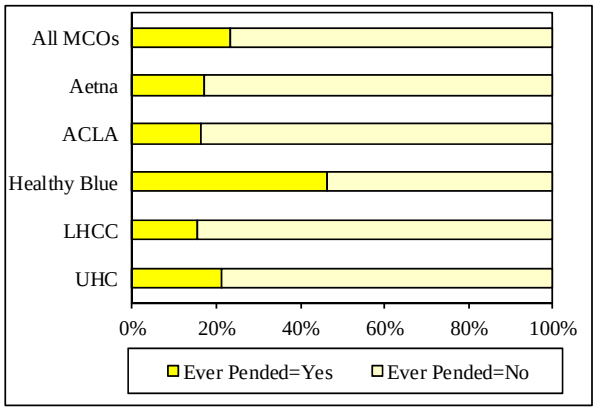
Professional Header Dollars



	Professional Header Dollars	
	Ever Pended=Yes	**Ever Pended=No**
All MCOs	22%	78%
Aetna	19%	81%
ACLA	24%	76%
Healthy Blue	39%	61%
LHCC	13%	87%
UHC	22%	78%

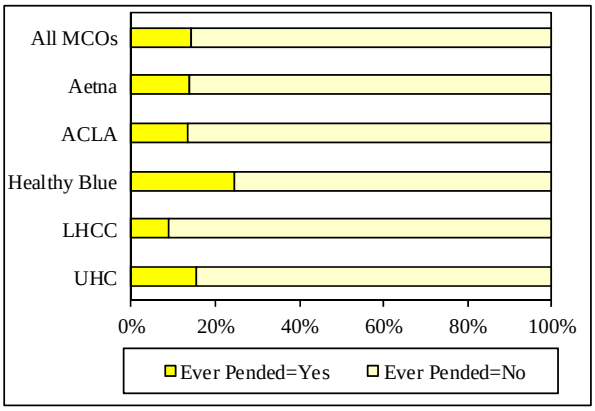
Exhibit D.1.2
Stratification of CY 2017 Adjudicated Claims by Header Pended Status for Institutional and Professional Claim Types
By MCO, Non-Behavioral Health Providers ONLY

Institutional Header Claims



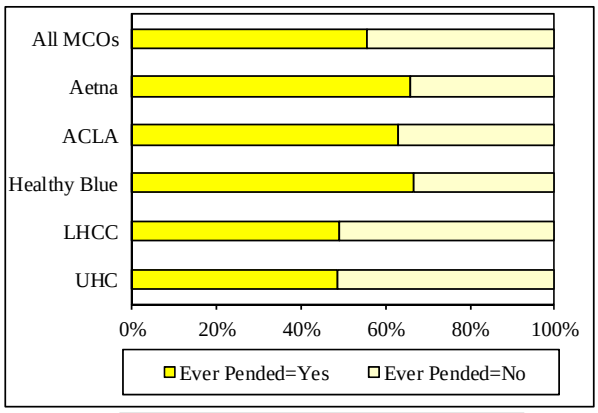
	Institutional Header Claims	
	Ever Pended=Yes	**Ever Pended=No**
All MCOs	23%	77%
Aetna	17%	83%
ACLA	16%	84%
Healthy Blue	46%	54%
LHCC	16%	84%
UHC	21%	79%

Professional Header Claims



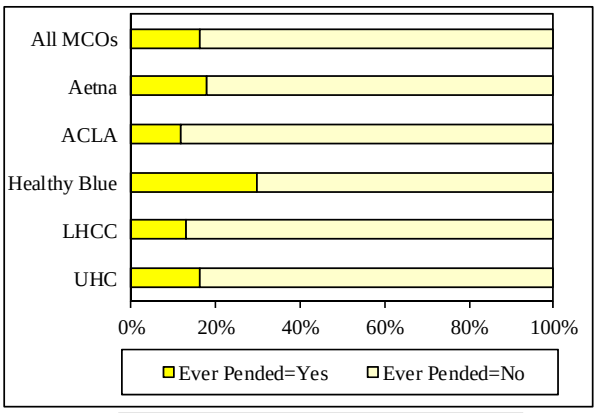
	Professional Header Claims	
	Ever Pended=Yes	**Ever Pended=No**
All MCOs	14%	86%
Aetna	14%	86%
ACLA	14%	86%
Healthy Blue	25%	75%
LHCC	9%	91%
UHC	16%	84%

Institutional Header Dollars



	Institutional Header Dollars	
	Ever Pended=Yes	**Ever Pended=No**
All MCOs	56%	44%
Aetna	66%	34%
ACLA	63%	37%
Healthy Blue	67%	33%
LHCC	49%	51%
UHC	48%	52%

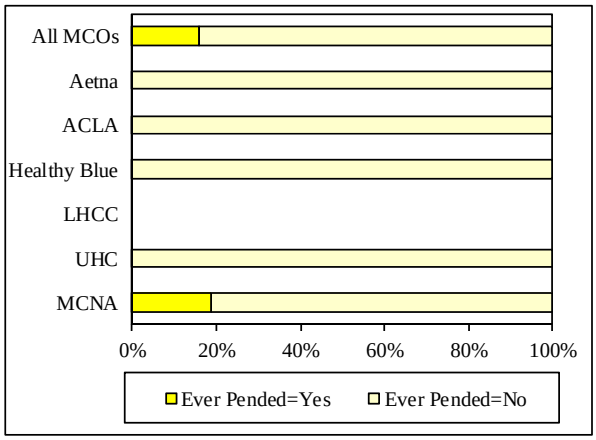
Professional Header Dollars



	Professional Header Dollars	
	Ever Pended=Yes	**Ever Pended=No**
All MCOs	16%	84%
Aetna	18%	82%
ACLA	12%	88%
Healthy Blue	30%	70%
LHCC	13%	87%
UHC	16%	84%

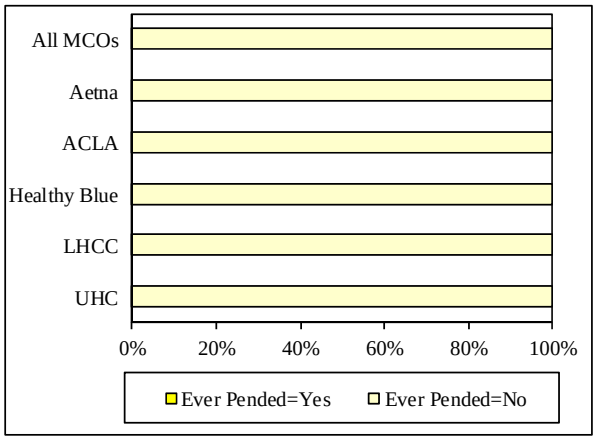
Exhibit D.2
Stratification of CY 2017 Adjudicated Claims by Header Pended Status for Dental and Pharmacy Claim Types
By MCO, Combined (BH + Non-BH) Providers

Dental Header Claims



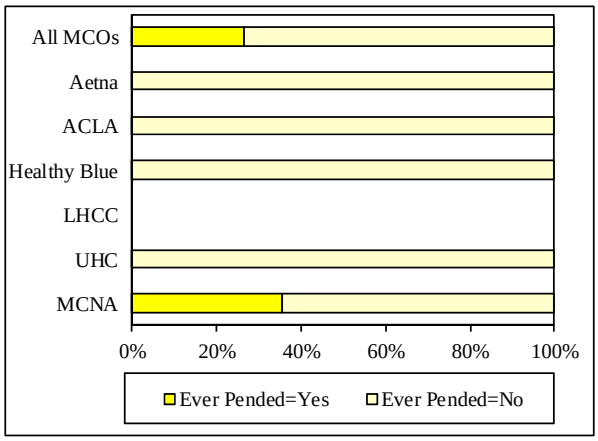
	Dental Header Claims	
	Ever Pended=Yes	**Ever Pended=No**
All MCOs	16%	84%
Aetna	0%	100%
ACLA	0%	100%
Healthy Blue	0%	100%
LHCC	LHCC had no dental claims to report.	
UHC	0%	100%
MCNA	19%	81%

Pharmacy Header Claims



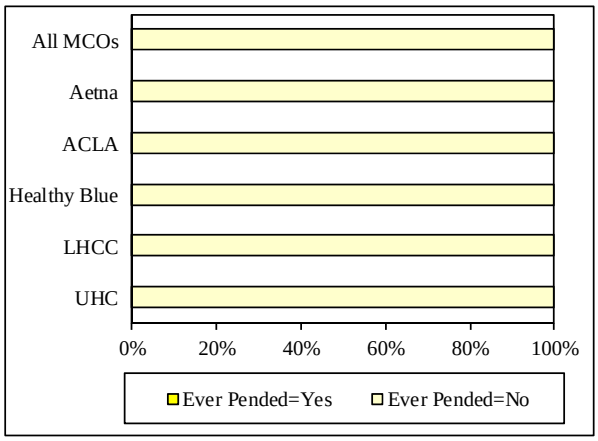
	Pharmacy Header Claims	
	Ever Pended=Yes	**Ever Pended=No**
All MCOs	0%	100%
Aetna	0%	100%
ACLA	0%	100%
Healthy Blue	0%	100%
LHCC	0%	100%
UHC	0%	100%

Dental Header Dollars



	Dental Header Dollars	
	Ever Pended=Yes	**Ever Pended=No**
All MCOs	26%	74%
Aetna	0%	100%
ACLA	0%	100%
Healthy Blue	0%	100%
LHCC	LHCC had no dental claims to report.	
UHC	0%	100%
MCNA	35%	65%

Pharmacy Header Dollars



	Pharmacy Header Dollars	
	Ever Pended=Yes	**Ever Pended=No**
All MCOs	0%	100%
Aetna	0%	100%
ACLA	0%	100%
Healthy Blue	0%	100%
LHCC	0%	100%
UHC	0%	100%

MCO Turnaround Time for Claims Adjudication

The Exhibit E series shows the results of the average turnaround time for the MCOs to adjudicate claims after receipt from the provider. The total turnaround time is divided into two periods—first, from the time between the receipt of the claim from the provider to the adjudication date; second—from the time of adjudication to the time of notification to provider that the claim was paid or denied. For display purposes, turnaround time results are truncated to one decimal point. Results across the two time periods are displayed in the Exhibit E series and the totals of the two figures are shown in the Appendix C reports.

There are two reasons to distinguish these time periods. One reason is to better assess the pended status. If claims are being pended, this would show up in the first turnaround time measure. The second reason is that some payers adjudicate on a daily basis but only do the notification on a weekly basis. In other words, the MCO may know that they will pay a claim on Monday, but may hold the payment for a weekly check run on Friday.

The six exhibits shown here are in three sets of pairs. Exhibit E.1 shows the turnaround time averages for all providers and all claims by claim type. Exhibit E.1.1 splits the data from Exhibit E.1 into claims that were ultimately paid and those that were ultimately denied. Exhibit E.2 is a subset of Exhibit E.1 but only includes data for behavioral health providers. This is then further segmented into paid and denied claims in Exhibit E.2.1. The same process is repeated for non-behavioral health providers in Exhibits E.3 and E.3.1, respectively.

When examining the total turnaround times in CY 2017 (Exhibit E.1), in most all cases the average was less than 15 days for all MCOs and for all claim types. The exceptions to this are as follows:

- For institutional claims, Aetna had an average turnaround time of 25.5 days and UHC had an average of 26.6 days.
- For professional claims, Aetna had an average turnaround time of 21.9 days.

There were many instances where the average turnaround time was less than 10 days:

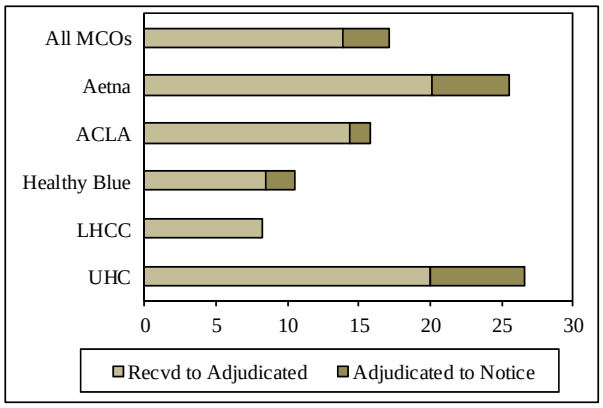
- For institutional claims, LHCC had an average turnaround time of 8.3 days.
- For professional claims, ACLA had an average turnaround time of 9.9 days and Healthy Blue was 6.8 days.
- For dental claims, MCNA had an average turnaround time of 8.3 days. Although low volume, three of the other MCOs had an average below five days.
- For pharmacy claims, all MCOs had an average turnaround time of less than 10 days.

When comparing the turnaround times for paid versus denied claims (Exhibit E.1.1), there was no distinction found for institutional and dental claims. Denied professional claims overall had higher turnaround time average of almost five days compared to paid claims. Conversely, for pharmacy claims, the turnaround time is quicker for denied claims than for paid claims.

The findings for turnaround time for behavioral health providers (Exhibits E.2 and E.2.1) and non-behavioral health providers (Exhibits E.3 and E.3.1) were found to be similar to the findings for all providers combined (Exhibits E.1 and E.1.1).

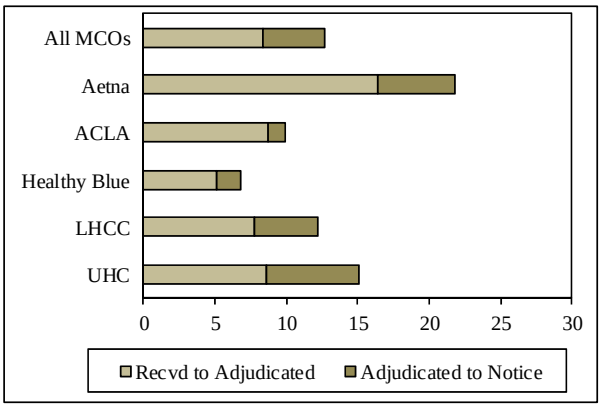
Exhibit E.1
Stratification of CY 2017 Adjudicated Claims by Turnaround Time (using average days)
By MCO, Combined (BH + Non-BH) Providers, Paid and Denied Claims COMBINED

Institutional Header Claims



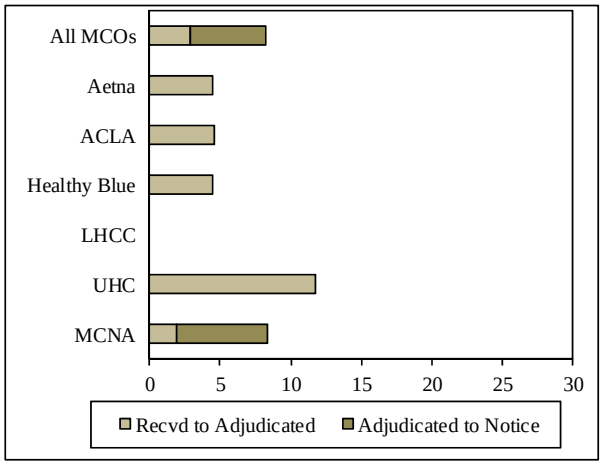
	Institutional Header Claims	
	Recvd to Adjudicated	Adjudicated to Notice
All MCOs	13.9	3.1
Aetna	20.1	5.5
ACLA	14.3	1.4
Healthy Blue	8.5	2.0
LHCC	8.3	0.0
UHC	20.0	6.6

Professional Header Claims



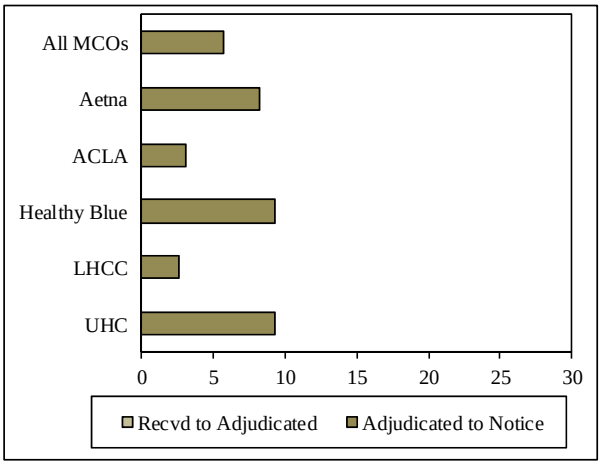
	Professional Header Claims	
	Recvd to Adjudicated	Adjudicated to Notice
All MCOs	8.4	4.3
Aetna	16.3	5.5
ACLA	8.7	1.3
Healthy Blue	5.1	1.8
LHCC	7.7	4.5
UHC	8.6	6.5

Dental Header Claims



	Dental Header Claims	
	Recvd to Adjudicated	Adjudicated to Notice
All MCOs	2.8	5.4
Aetna	4.5	0.0
ACLA	4.6	0.0
Healthy Blue	4.5	0.0
LHCC	LHCC had no dental claims to report.	
UHC	11.8	0.0
MCNA	1.9	6.4

Pharmacy Header Claims



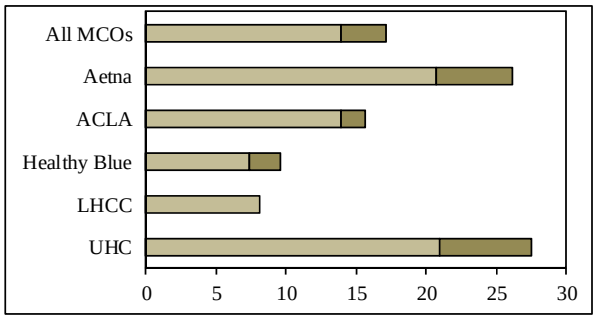
	Pharmacy Header Claims	
	Recvd to Adjudicated	Adjudicated to Notice
All MCOs	0.0	5.7
Aetna	0.0	8.2
ACLA	0.0	3.1
Healthy Blue	0.0	9.2
LHCC	0.0	2.6
UHC	0.0	9.4

Note: Value of 0 means events occurred on the same day (received to adjudicated or adjudicated to notified)

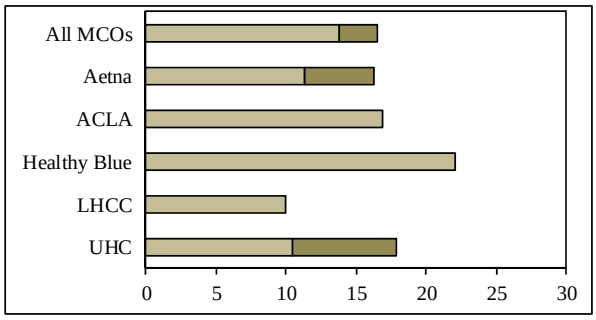
Exhibit E.1.1
Stratification of CY 2017 Adjudicated Claims by Turnaround Time (using average days)
By MCO, Combined (BH + Non-BH) Providers, Paid and Denied Claims SEPARATELY

PAID CLAIMS ONLY	DENIED CLAIMS ONLY

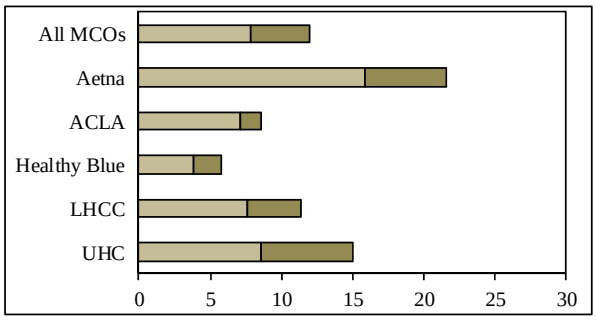
Institutional Header Claims



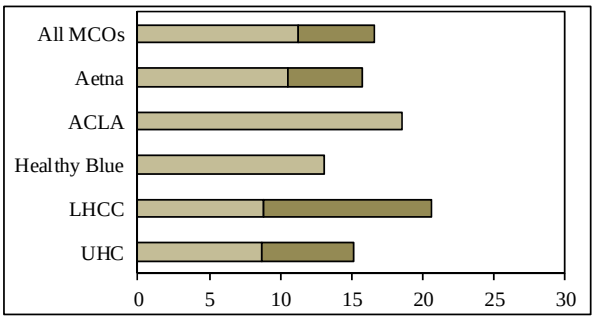
Institutional Header Claims



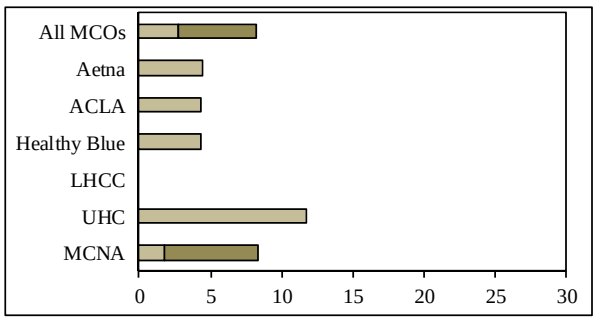
Professional Header Claims



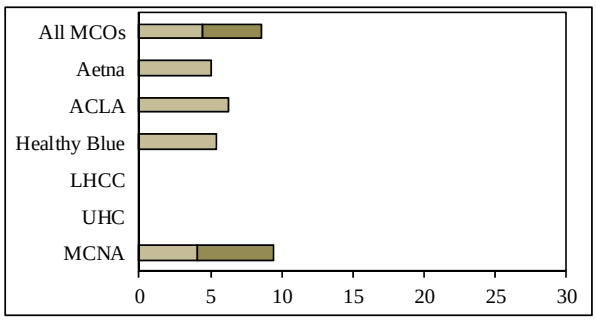
Professional Header Claims



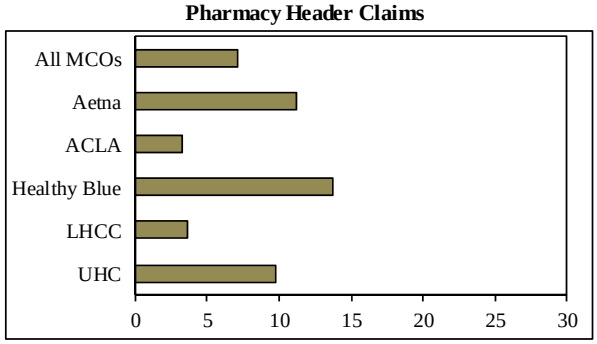
Dental Header Claims



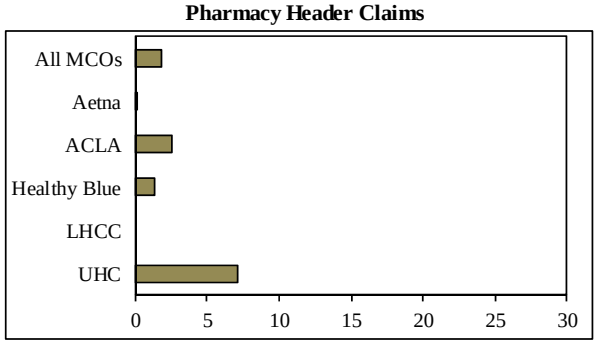
Dental Header Claims



Pharmacy Header Claims



Pharmacy Header Claims



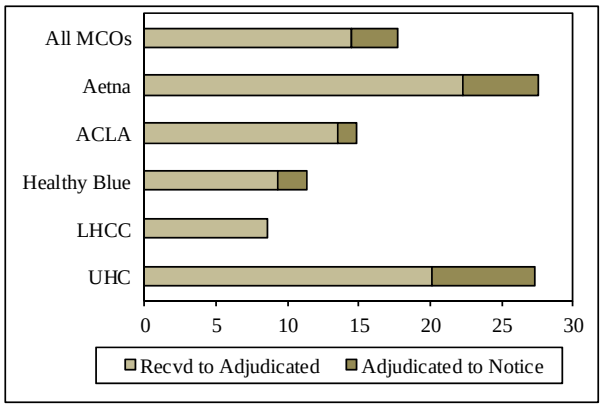
Average Number of Days from MCO Received Date to Adjudication Date

Average Number of Days from MCO Received Date to Notification Date (Paid or Denied)

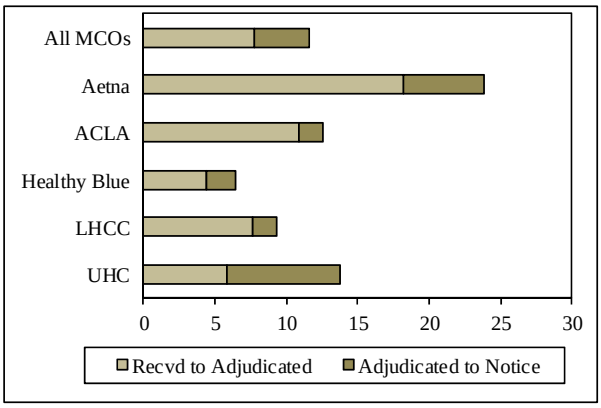
Note: Value of 0 means events occurred on the same day (received to adjudicated or adjudicated to notified)

Exhibit E.2
Stratification of CY 2017 Adjudicated Claims by Turnaround Time (using average days)
By MCO, Behavioral Health Providers ONLY, Paid and Denied Claims COMBINED

Institutional Header Claims



Professional Header Claims

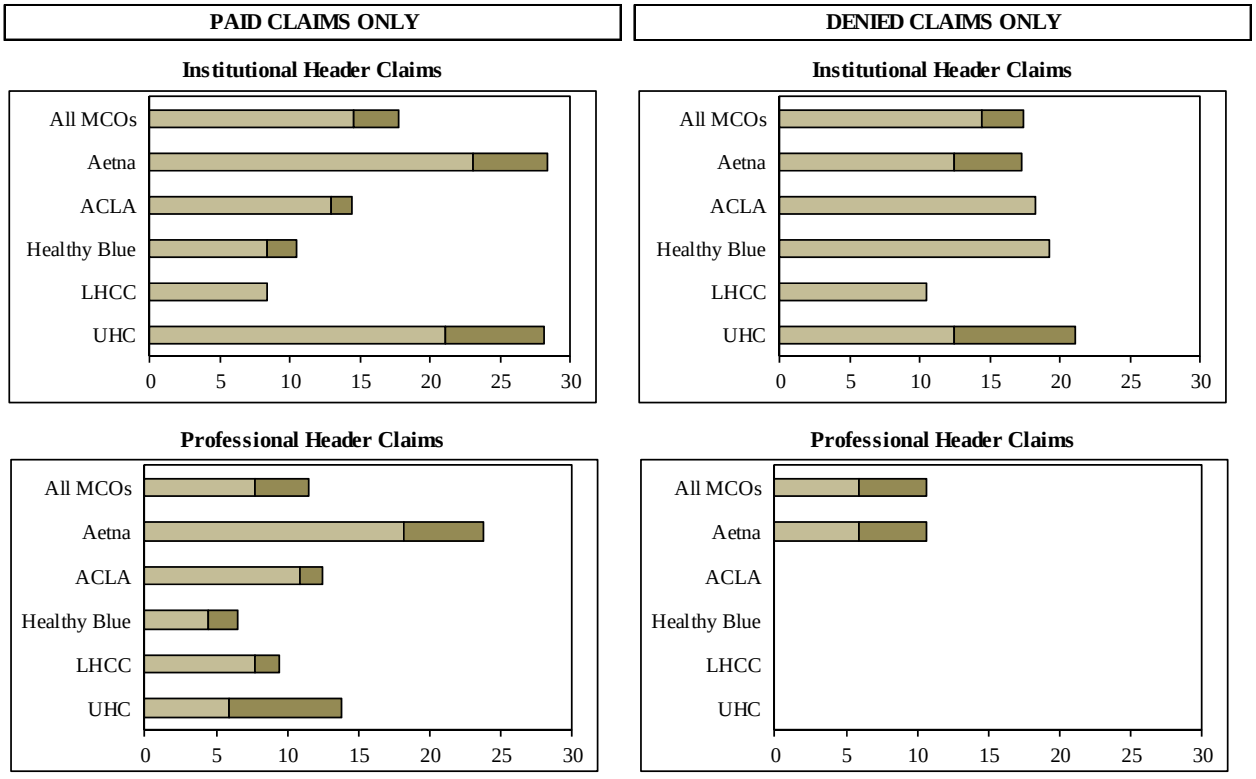


	Institutional Header Claims	
	Recvd to Adjudicated	**Adjudicated to Notice**
All MCOs	14.5	3.3
Aetna	22.3	5.3
ACLA	13.5	1.3
Healthy Blue	9.4	2.0
LHCC	8.6	0.0
UHC	20.2	7.2

	Professional Header Claims	
	Recvd to Adjudicated	**Adjudicated to Notice**
All MCOs	7.7	3.8
Aetna	18.2	5.6
ACLA	10.9	1.6
Healthy Blue	4.4	2.1
LHCC	7.7	1.7
UHC	5.9	7.9

Note: Value of 0 means events occurred on the same day (received to adjudicated or adjudicated to notified)

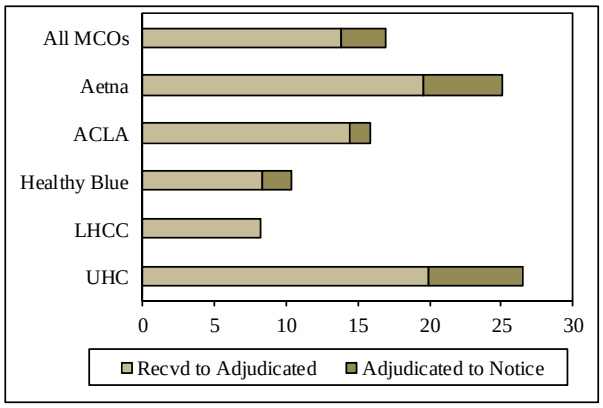
Exhibit E.2.1
Stratification of CY 2017 Adjudicated Claims by Turnaround Time (using average days)
By MCO, Behavioral Health Providers ONLY, Paid and Denied Claims SEPARATELY



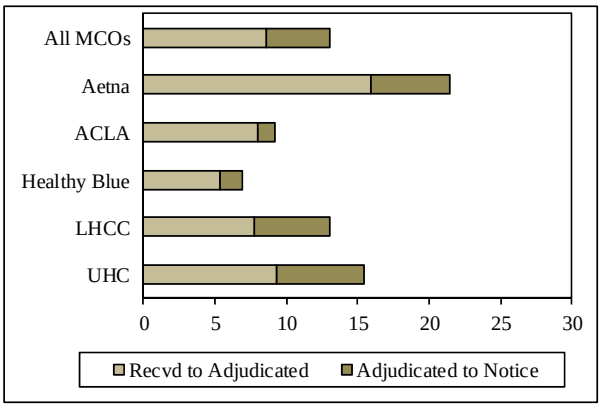
Note: Value of 0 means events occurred on the same day (received to adjudicated or adjudicated to notified)

Exhibit E.3
Stratification of CY 2017 Adjudicated Claims by Turnaround Time (using average days)
By MCO, Non-Behavioral Health Providers, Paid and Denied Claims COMBINED

Institutional Header Claims



Professional Header Claims

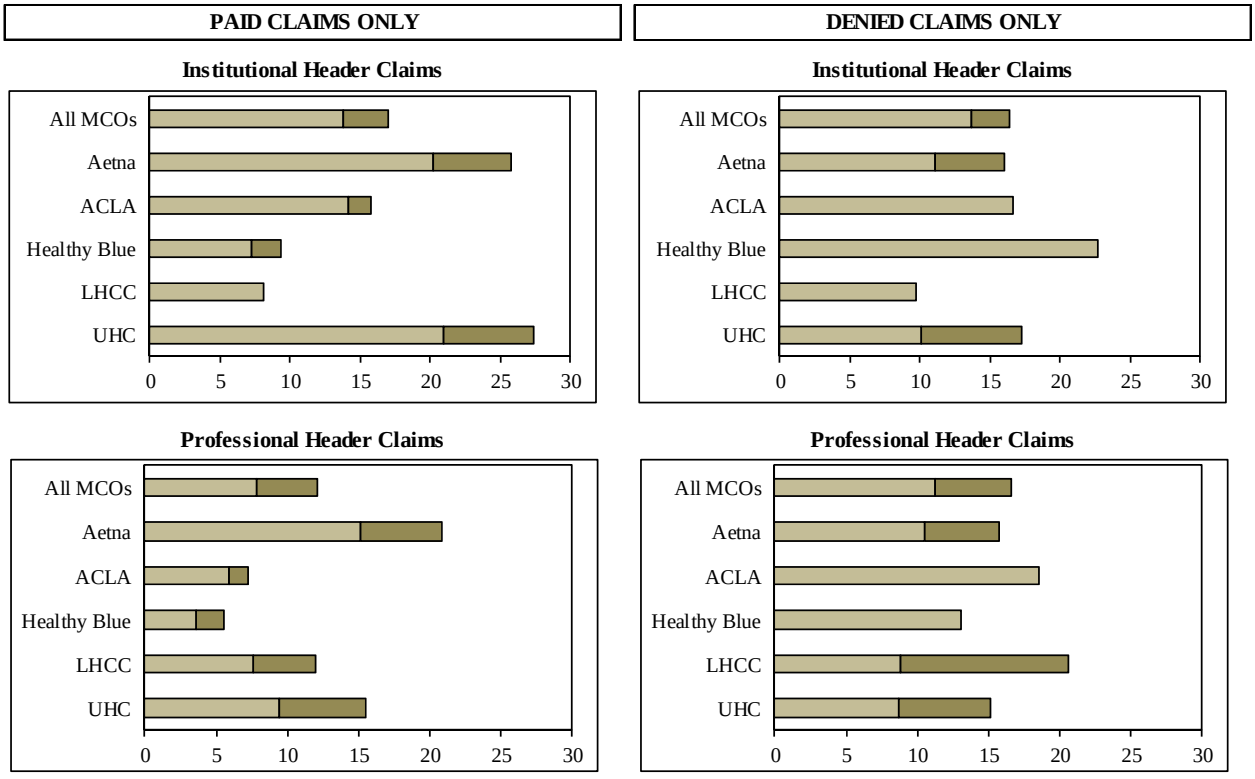


	Institutional Header Claims	
	Recvd to Adjudicated	**Adjudicated to Notice**
All MCOs	13.8	3.1
Aetna	19.6	5.5
ACLA	14.5	1.5
Healthy Blue	8.4	2.0
LHCC	8.2	0.0
UHC	20.0	6.6

	Professional Header Claims	
	Recvd to Adjudicated	**Adjudicated to Notice**
All MCOs	8.6	4.4
Aetna	15.9	5.5
ACLA	8.0	1.1
Healthy Blue	5.3	1.7
LHCC	7.8	5.3
UHC	9.3	6.1

Note: Value of 0 means events occurred on the same day (received to adjudicated or adjudicated to notified)

Exhibit E.3.1
Stratification of CY 2017 Adjudicated Claims by Turnaround Time (using average days)
By MCO, Non-Behavioral Health Providers ONLY, Paid and Denied Claims SEPARATELY



Note: Value of 0 means events occurred on the same day (received to adjudicated or adjudicated to notified)

Analysis of Denial Reason Codes

The Exhibit F series examines the prevalence of denial reason codes reported on denied service lines in CY 2017. Both the CARC (for medical and dental) and NCPDP (for pharmacy) codes were examined.

It should be noted that a service line may have more than one CARC or NCPDP code assigned to it. So when the results are shown as percentages, this is not the percentage of all claim lines. Rather, it is the percentage of all CARC or NCPDP occurrences on claim lines.

Exhibit F.1 shows the volume split between the top five CARC or NCPDP occurrences for each MCO compared to all other CARC and NCPDP codes that appeared. The overall finding is that some CARC and NCPDP codes are most common among the denied claims in CY 2017.

- For institutional claims, the top 5 denial CARCs represented 50% of all denial CARC occurrences. This finding was true for most MCOs as well. UHC was lowest with its top 5 denial CARCs representing 42% of its total denied CARCs.

- For professional claims, there was a similar finding overall with the top 5 denial CARCs representing 53% of all denial CARCs. Here there was more variation, however, by MCO. The top 5 denial CARCs represented anywhere from 31% (Healthy Blue) to 65% (UHC) of an MCO's total denial CARCs.

- For dental claims, due to volume differences the most meaningful statistic is what is shown for MCNA. For this MCO, the top 5 denial CARCs represented 71% of all of its denial CARCs.

- For pharmacy claims, the top 5 denial NCPDP codes represented 64% of all denial codes. This was true for most MCOs as well except for Healthy Blue where the top 5 NCPDP codes represented only 50% of all of its denial codes.

When the denial codes were further stratified between behavioral health and non-behavioral health providers (Exhibit F.1.1), there was no significant variation found for institutional claims. For professional claims, there was more variation found in the denial codes for behavioral health providers than non-behavioral health providers. This is evidenced by the fact that, among all MCOs combined, the top 5 denial CARCs for behavioral health providers represented 38% of all denial codes found, but for non-behavioral health providers this was 54%.

Exhibits F.2 and F.3 show the actual top 5 CARC or NCPDP codes by claim type for behavioral health providers (Exhibit F.2) and non-behavioral health providers (Exhibit F.3). B&A examined to see if the top CARC or NCPDP denial codes were also common across the MCOs.

- For institutional claims, three of the top five CARCs among behavioral and non-behavioral providers are common among MCOs.

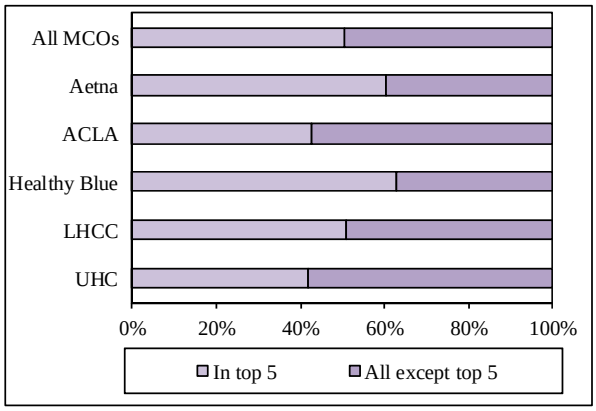
- For professional claims, two of the top five CARCs among behavioral health providers are common among the MCOs but three of the top five are common among non-behavioral health providers.

- For dental claims, the top five CARCs are all driven by MCNA's volume.

- For pharmacy claims, all five of the top NCPDP codes are common to all of the MCOs.

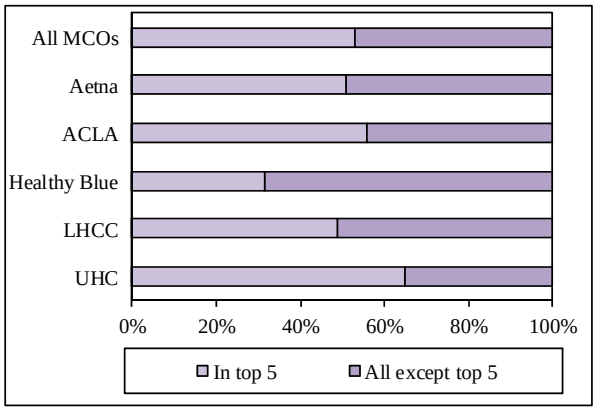
Exhibit F.1
Stratification of Adjudicated Claims by Denial Reason (using occurrence at detail level)
By MCO, Combined (BH + Non-BH) Providers

Institutional Detail Claims



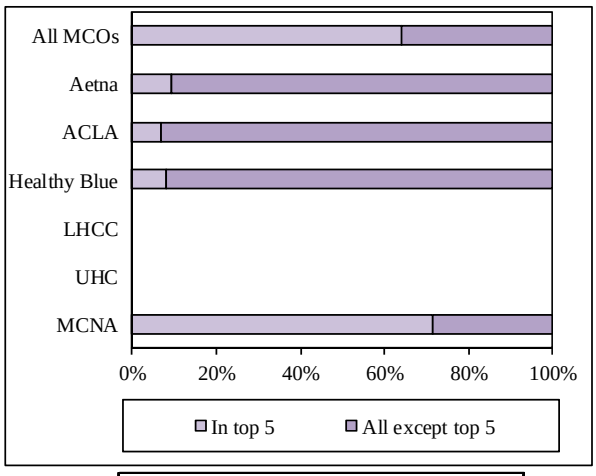
	Institutional Detail CARC Occurrences	
	In top 5	**All except top 5**
All MCOs	50%	50%
Aetna	61%	39%
ACLA	43%	57%
Healthy Blue	63%	37%
LHCC	51%	49%
UHC	42%	58%

Professional Detail Claims



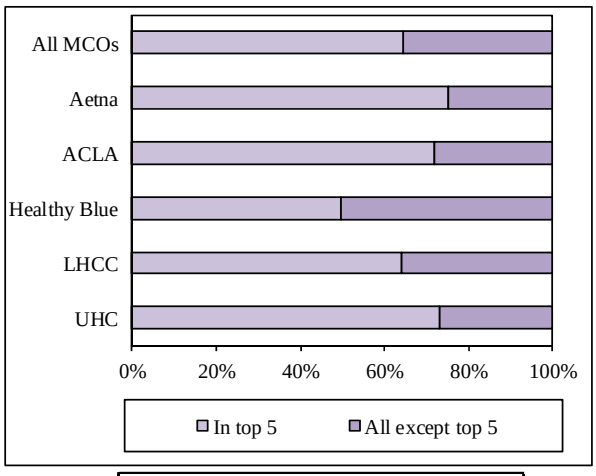
	Professional Detail CARC Occcurrences	
	In top 5	**All except top 5**
All MCOs	53%	47%
Aetna	51%	49%
ACLA	56%	44%
Healthy Blue	31%	69%
LHCC	49%	51%
UHC	65%	35%

Dental Detail Claims



	Dental Detail CARC Occurrences	
	In top 5	**All except top 5**
All MCOs	64%	36%
Aetna	9%	91%
ACLA	7%	93%
Healthy Blue	8%	92%
LHCC	0%	0%
UHC	0%	0%
MCNA	71%	29%

Pharmacy Detail Claims



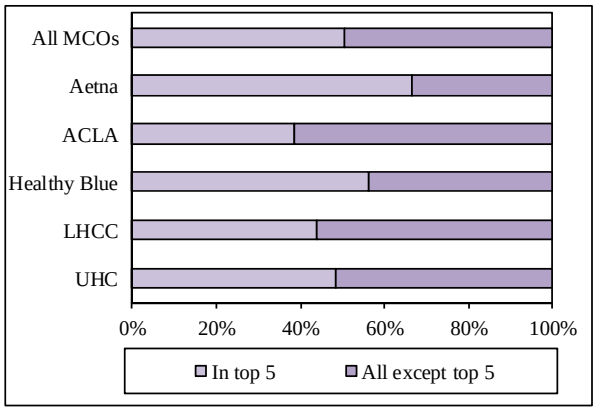
	Pharmacy Detail NCPDP Occurrences	
	In top 5	**All except top 5**
All MCOs	64%	36%
Aetna	75%	25%
ACLA	72%	28%
Healthy Blue	50%	50%
LHCC	64%	36%
UHC	73%	27%

Note: LHCC had no dental claims to report. UHC had dental claims, but they were all paid.

Exhibit F.1.1
Stratification of CY 2017 Adjudicated Claims by Denial Reason (using occurrence at detail level)
By MCO, Behavioral Health Providers and Non-Behavioral Health Providers SEPARATELY

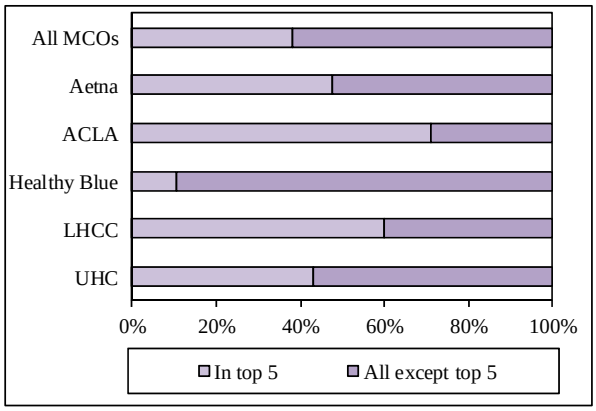
BEHAVIORAL HEALTH PROVIDERS ONLY

Institutional Detail Claims



	Institutional Detail CARC Occurrences	
	In top 5	**All except top 5**
All MCOs	50%	50%
Aetna	66%	34%
ACLA	39%	61%
Healthy Blue	56%	44%
LHCC	44%	56%
UHC	48%	52%

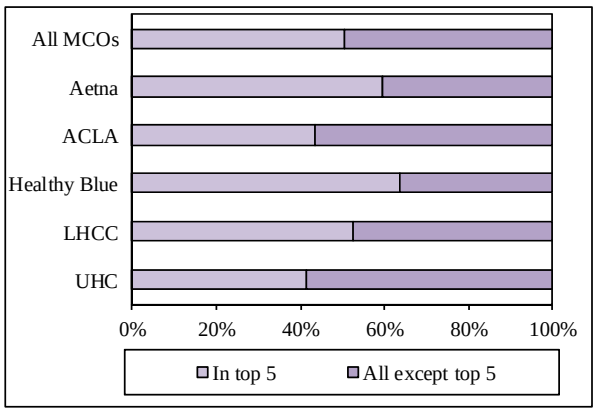
Professional Detail Claims



	Professional Detail CARC Occcurrences	
	In top 5	**All except top 5**
All MCOs	38%	62%
Aetna	48%	52%
ACLA	71%	29%
Healthy Blue	11%	89%
LHCC	60%	40%
UHC	43%	57%

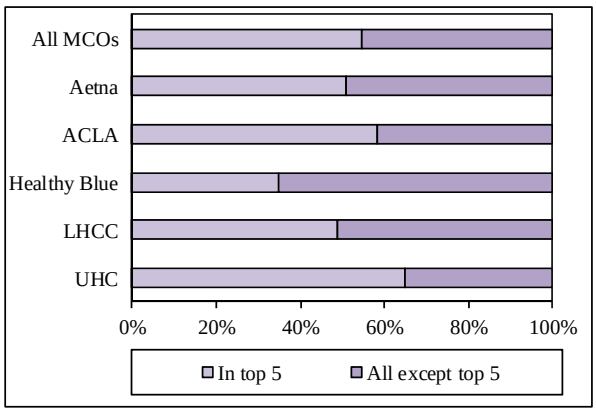
NON-BEHAVIORAL HEALTH PROVIDERS ONLY

Institutional Detail Claims



	Institutional Detail CARC Occurrences	
	In top 5	**All except top 5**
All MCOs	51%	49%
Aetna	59%	41%
ACLA	44%	56%
Healthy Blue	64%	36%
LHCC	52%	48%
UHC	42%	58%

Professional Detail Claims



	Professional Detail CARC Occcurrences	
	In top 5	**All except top 5**
All MCOs	54%	46%
Aetna	51%	49%
ACLA	58%	42%
Healthy Blue	35%	65%
LHCC	49%	51%
UHC	65%	35%

Exhibit F.2
Stratification of CY 2017 Adjudicated Claims by Denial Reason Codes
By MCO, Behavioral Health Providers ONLY

Top 5 Statewide UB-04 BH Provider CARCs			*Is this CARC also in the MCO's Top 5 CARCs?*				
			Aetna	Amerihealth Caritas	Healthy Blue	Louisiana Health Care Connections	United Healthcare
CARC	Rank	Description					
18	1	Exact duplicate claim/service	Yes	Yes	Yes	Yes	No
16	2	Claim/service lacks information or has submission/billing error(s).	Yes	Yes	No	Yes	Yes
97	3	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	Yes	Yes	Yes	No	No
96	4	Non-covered charge(s).	No	Yes	No	Yes	No
B13	5	Previously paid.	No	No	No	No	Yes

Top 5 Statewide CMS-1500 BH Provider CARCs			*Is this CARC also in the MCO's Top 5 CARCs?*				
			Aetna	Amerihealth Caritas	Healthy Blue	Louisiana Health Care Connections	United Healthcare
CARC	Rank	Description					
95	1	Plan procedures not followed.	No	Yes	No	No	No
18	2	Exact duplicate claim/service	Yes	Yes	Yes	Yes	Yes
96	3	Non-covered charge(s).	Yes	Yes	Yes	Yes	Yes
198	4	Precertification/authorization exceeded.	No	No	Yes	Yes	No
16	5	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	Yes	Yes	No	No	No

Exhibit F.3
Stratification of CY 2017 Adjudicated Claims by Denial Reason Codes
By MCO, Non-Behavioral Health Providers ONLY

Top 5 Statewide UB-04 Non-BH Provider CARCs			*Is this CARC also in the MCO's Top 5 CARCs?*				
			Aetna	Amerihealth Caritas	Healthy Blue	Louisiana Health Care Connections	United Healthcare
CARC	Rank	Description					
18	1	Exact duplicate claim/service	Yes	Yes	Yes	Yes	Yes
16	2	Claim/service lacks information or has submission/billing error(s).	Yes	Yes	Yes	Yes	Yes
97	3	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	Yes	Yes	Yes	No	No
96	4	Non-covered charge(s).	No	Yes	No	Yes	No
0252	5	An attachment/other documentation is required to adjudicate this claim/service.	No	No	Yes	No	Yes

Top 5 Statewide CMS-1500 Non-BH Provider CARCs			*Is this CARC also in the MCO's Top 5 CARCs?*				
			Aetna	Amerihealth Caritas	Healthy Blue	Louisiana Health Care Connections	United Healthcare
CARC	Rank	Description					
197	1	Precertification/authorization/notification absent.	No	No	Yes	Yes	Yes
45	2	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	No	Yes	No	No	Yes
18	3	Exact duplicate claim/service	Yes	No	Yes	Yes	Yes
16	4	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	Yes	Yes	No	No	No
96	5	Non-covered charge(s).	Yes	Yes	No	Yes	Yes

Exhibit F.3 (continued)
Stratification of CY 2017 Adjudicated Claims by Denial Reason Codes
By MCO, Non-Behavioral Health Providers ONLY

Is this CARC also in the MCO's Top 5 CARCs?

Top 5 Statewide Dental Non-BH Provider CARCs			Aetna	Amerihealth Caritas	Healthy Blue	Louisiana Health Care Connections	United Healthcare	MCNA Dental
CARC	**Rank**	**Description**						
169	1	Alternate benefit has been provided.	**No**	**No**	**No**			**Yes**
18	2	Exact duplicate claim/service	**Yes**	**Yes**	**Yes**			**Yes**
96	3	Non-covered charge(s).	**No**	**No**	**No**			**Yes**
222	4	Exceeds the contracted maximum number of hours/days/units by this provider for this period.	**No**	**No**	**No**			**Yes**
6	5	The procedure/revenue code is inconsistent with the patient's age.	**No**	**No**	**No**			**Yes**

No dental CARCs reported. LHCC had no dental claims to report. UHC had dental claims, but they were all paid.

Is this NCPDP also in the MCO's Top 5 NCPDPs?

Top 5 Statewide Pharmacy Non - BH NCPDPs			Aetna	Amerihealth Caritas	Healthy Blue	Louisiana Health Care Connections	United Healthcare
NCPDP	**Rank**	**Description**					
76	1	Plan Limitations Exceeded	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
79	2	Refill Too Soon	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
70	3	Product/Service Not Covered – Plan/Benefit Exclusion	**Yes**	**Yes**	**No**	**Yes**	**Yes**
75	4	Prior Authorization Required	**Yes**	**No**	**Yes**	**Yes**	**No**
88	5	DUR Reject Error	**No**	**Yes**	**Yes**	**No**	**Yes**

Analysis of Top Providers with Denials

As requested by the Act, B&A determined the top five behavioral health and non-behavioral health providers with denied claims based solely on volume. These providers (de-identified) appear in Exhibit G.1 below. Both boxes show the number of denied claim lines in descending order. Given the different volume for each provider, the absolute number of denied claim lines varies when reviewed as a percentage of all of the claim lines billed (the next column to the right). For behavioral health providers, none of the top denial providers had more than 12% of all of their claims denied. But for non-behavioral health providers, this varied greatly. One provider, in fact, had almost all of its claims denied. It should be noted, however, that this provider only contracts with two of the five MCOs (MCNA was excluded).

For the top denial providers in the behavioral health group, all of the providers contract with all five MCOs and they appear as top denial providers with every MCO. Among the non-behavioral health providers, two of the top five contract with all MCOs and appear as top denial providers across all of them.

Exhibit G.1
Listing of Top 5 Providers with Denials Among CY 2017 Adjudicated Claims
By MCO, Behavioral Health Providers and Non-Behavioral Health Providers SEPARATELY

BEHAVIORAL HEALTH PROVIDERS ONLY

					Provider Rank by MCO				
Rank	**Number of Claims**	**Number of Denied Claims**	**Percent of All Claims Denied**	**Dollar Value of Paid Claims**	**Aetna**	**Amerihealth Caritas**	**Healthy Blue**	**Louisiana Health Care Connections**	**United Healthcare**
1	271,683	24,367	9.0%	$81,611,065	**1**	**1**	**1**	**1**	**1**
2	66,911	6,995	10.5%	$21,611,572	**2**	**2**	**2**	**2**	**4**
3	59,283	5,646	9.5%	$23,210,264	**5**	**3**	**4**	**3**	**2**
4	40,989	4,683	11.4%	$13,513,468	**3**	**5**	**3**	**5**	**3**
5	59,197	3,936	6.6%	$7,454,281	**4**	**4**	**5**	**4**	**5**

NON-BEHAVIORAL HEALTH PROVIDERS ONLY

					Provider Rank by MCO				
Rank	**Number of Claims**	**Number of Denied Claims**	**Percent of All Claims Denied**	**Dollar Value of Paid Claims**	**Aetna**	**Amerihealth Caritas**	**Healthy Blue**	**Louisiana Health Care Connections**	**United Healthcare**
1	186,327	82,050	44.0%	$3,999,459	**1**	**1**	**2**	**2**	**2**
2	137,985	49,749	36.1%	$2,518,540					**1**
3	45,201	44,837	99.2%	$20,122				**4**	**3**
4	461,906	43,248	9.4%	$31,933,901	**2**	**4**	**1**		**4**
5	113,791	34,167	30.0%	$2,468,303				**2**	

Not in MCO Top 5

SECTION IV: RECOMMENDATIONS AND ACTION STEPS

Burns & Associates, Inc. (B&A) offers recommendations to both the Louisiana Department of Health (LDH) and the managed care organizations (MCOs) that it contracts with for the Healthy Louisiana program for continuous quality improvement related to claims adjudication and reporting. The recommendations stem from:

- B&A's review of individual claims adjudicated by each MCO in Calendar Year (CY) 2017 and the MCO's submission of these claims to B&A for review;
- The reporting requirements mandated by the LDH to the MCOs related to claims adjudication; and
- The results from the claims reports submitted by the MCOs for the CY 2017 period.

Recommendations to the LDH

1. **The 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. These terms would be used to assign flags for reporting purposes to LDH**.

   During the data collection process, B&A observed that MCOs did not follow the same processes when flagging detail lines and claim header records to reflect MCO processing. In some examples,

   - MCOs stated that they flagged paid claims that were subsequently adjusted or voided as denied lines or claims (meaning that the denial rate could be overstated).
   - One MCO stated that procedures or services that are considered to be included in a global payment, or are incident to a primary procedure, were paid at $0, but subsequently marked as denials, even though the provider received payment in full for the service. In B&A's experience, these detail lines would be flagged as paid even though the payment amount is $0 because the presumption is that the payment is part of another line on the claim.

   B&A suggests that standard terms include, but not be limited to, the following:

   - *Paid Claims*
     - Assign paid status at the individual service line level, with the one exception being inpatient hospital claims since these claims are only adjudicated at the header level and not at the detail level.
     - In the situation where individual services are "incident to" or "packaged with" another service line and payment is $0, if the other service line is assigned a paid status then the "incident to" line should also be assigned a paid status even though the actual payment is $0.

     Subcategories of paid claims include:
     - Original claims
     - Adjusted claims – either in part or complete replacements
     - Void/replacement claims – There are two options for consideration here. One is if a claim is voided and it later results in a complete replacement claim. Then the voided claim could be flagged as an adjusted claim. The other option is to leave

any voided claim tagged as a voided claim; however, any replacement claim would most likely be tagged as a new original claim.

- *Denied Claims*
  - Assign denied status at the individual service line level, with the one exception being inpatient hospital claims since these claims are only adjudicated at the header level and not at the detail level.

- *Pended Claims* – Typically, if a payer pends a claim, they are pending all lines on the claim even if not all lines need to be pended. This would imply that the pended status could be counted at the header level only. However, if the LDH chooses to have all other claims adjudication statistics reported at the individual service line level (the exception being inpatient hospital claims), then the pended status should also be assigned at the detail level.

  For reporting to LDH, the MCO should only count a claim as pended if the claim had not been assigned a paid or denied status at the time of the MCO's regular check writing cycle. It is recognized that the MCO may choose to pend a claim for a brief period (e.g., a few hours) for a manual review, but this situation should not be counted as pended if it did not interrupt the check writing process.

- *Rejected Claims* – B&A recommends that the term rejected only be used for claims that do not pass the standard, front-end HIPAA edits that all MCOs and LDH employ. These edits indicate that there is data that is either missing or invalid such that there is not enough information to even process the claim.

2. **The LDH should develop a common set of definitions for *encounter adjudication terms* that would be used by all MCOs as well as the LDH. These terms would be used to assign flags for reporting purposes to LDH**.

   B&A suggests that standard terms include, but not be limited to, the following:

   - *Received Encounter* – B&A recommends that the term received encounter means that the claim passed the initial or "front-end" edits used by the Department's fiscal agent. Received encounters may ultimately not pass all of the adjudication edits that are tested, but the encounter got "through the front door".

   - *Rejected Encounter* – B&A recommends that the term rejected is used for all claims that were not received encounters by the Department's fiscal agent.

   - *Accepted Encounter* – B&A recommends that this term be applied to detail-level encounter lines (or, in the case of inpatient hospital claims, the header-level) that were accepted by LDH's fiscal agent and passed the pricing, or "back-end", edits.

   - *Denied Encounter* – B&A recommends that this term be applied to detail-level encounter lines (or, in the case of inpatient hospital claims, the header-level) that were accepted by LDH's fiscal agent but did not pass pricing, or "back-end", edits.

   - *Denied Claim* – The MCOs are required to submit as encounters to LDH any claims that they denied. Since they were denied upfront, these claims are not required to go through

the "back-end" edits described above. The distinction between a denied claim and a denied encounter is that the denied encounter represents claims that were paid by the MCO but were not accepted by the Department due to one or more issues with data validity and/or program compliance.

3. **The 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**. One example of a place for the Department to start mandating root cause analyses is related to a prioritized list of current high-volume denial CARC and NCPDP codes that were found in this study (e.g., the top 5). Any root cause analytics required does not waive the obligation of the MCOs to report on all CARCs and NCPDP codes that are used for editing (this is a current requirement placed on the MCOs by the Department).

4. **The LDH should review the MCO reports that focus on claims and consider modifying, consolidating or eliminating existing reports**. More information pertaining to this recommendation appears under "Recommended Measures for Quality Reporting" that appears on page IV-4.

5. **For any new measures or reports that get introduced as part of quarterly reporting required by this Act, the LDH should convene all of the MCOs to review the new report templates, to confirm understanding of the specifications related to reporting, and to vet the instructions that accompany any new report.** The LDH should conduct a side-by-side comparison of the results of any new quarterly reports that are introduced and provide timely and constructive feedback after the first quarterly submission to ensure that each MCO complied with the specifications as expected.

6. **The 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**.

Recommendations to the MCOs

1. **Each MCO should implement the LDH common claim submission and disposition definitions into their claims and encounter reporting to ensure that future Healthy Louisiana Claims Report submissions produce comparable results across MCOs**.

2. **If not already doing so, B&A encourages the MCOs to track claims and encounter submission completeness and accuracy rates**. B&A recommends that each MCO build an internal dashboard to track metrics at the claim type level as well as the category of service level. Accuracy measures for claims encounters could include rejection rates, acceptance rates and denial rates.

3. **If the MCO uses proprietary adjudication codes and not CARC and NCPDP codes in their adjudication systems, then the MCO should provide to the LDH any changes in their crosswalk between their codes and the CARCs/NCPDP codes whenever changes are made**.

4. **The MCOs should track providers with high rates of claim denials and develop an outreach for corrective action in anticipation of LDH future directives to report on this activity**. The MCOs should be prepared for LDH to review an MCO written policy and procedure on this item.

5. **The MCOs should develop a root cause analysis procedure and conduct this on the high-priority CARCs and NCPDPs to further determine the root cause for the denial**. This procedure may be subject to review by the Department. Suggested variables to use to potentially assess root cause include examining each CARC or NCPDP code by provider type, provider specialty, billing NPI, procedure (HCPCS/CPT/NDC) code, revenue center code (as applicable), and place of service.

Recommended Measures for Quarterly Reporting

Based on our review of current reports that the Department requires the MCOs to submit along with the findings from this study, B&A offers the following recommendations pertaining to measures that would be reported on quarterly to comply with the intent of the Act.

For any new reports that are developed, each report should contain a purpose statement, a definition of terms, and line-by-line instructions.

1. A **Claims Adjudication Statistics** report should be created by LDH and submitted by the MCOs at least quarterly. The purpose of the report is to track the timeliness of claims adjudication (in days) by claim type and by selected provider types. Some key measures that B&A recommends to be included in this report are:

    - Number of claims that were pended from the prior quarter and carried forward to this quarter
    - Number of claims received in the quarter
    - Number of claims rejected in the quarter
    - Number of claims accepted in the quarter
    - Number of claims adjudicated in the quarter (includes carryover and new this quarter)
    - Number of claims pended for greater than [threshold] number of days (e.g., 7 days)
    - Reason code for pended claims (e.g., medical review, potential fraud and abuse)
    - Average number of days to adjudicate across each cohort of claim types reported

    Claims should be segmented by claim type and subcategories within each claim type. The counts of claims would be at the service line level with the exception of inpatient hospital claims which will be at the header level. Examples of segmentation:

    - For institutional claims: inpatient hospital non-behavioral health, inpatient hospital behavioral health, outpatient hospital non-behavioral health, outpatient hospital behavioral health, home health

    - For professional claims: physician, behavioral health providers (to be defined), federally qualified health centers and rural health clinics (FQHCs/RHCs), therapists (physical, occupational and speech), durable medical equipment (DME), non-emergency transportation (NEMT)

    - For dental claims: child (EPSDT) dental, adult dental

    - For pharmacy: no further breakout needed

2. An **Encounter Submission Statistics** report should be created by LDH and submitted by the MCOs on a quarterly basis. The purpose of the report is to track both the completeness and

timeliness of the claims that the MCO adjudicated to ensure that each claim is submitted as an encounter. Some of the measures that should be captured on the report include:

- The number of claims submitted as encounters in the current quarter
  - The number rejected by the Department's fiscal agent in front-end edits
  - The number accepted by the Department's fiscal agent
    - Among those accepted, the number that were paid by the MCO and approved by the Department's fiscal agent
    - Among those accepted, the number that were paid by the MCO and denied by the Department's fiscal agent in back-end edits
    - Among those accepted, the number that were claims denied by the MCO

3. A **Provider Denial Claims Report** should be created by LDH and submitted by the MCOs quarterly. The purpose of this report is to have the MCOs report on individual providers that have a denial rate in excess of a stated threshold (e.g., 10% of the total claim lines that the provider billed in the previous quarter). Information on each of these providers specifically should include:

   - Billing NPI and name
   - Provider type
   - Number of claims received by the provider in the prior quarter
   - Number of claims adjudicated by the MCO for the provider among those received
   - Number of claims adjudicated and paid
   - Number of claims adjudicated and denied
   - Percent of claims denied of total claims adjudicated
   - An indicator if the provider was on the previous quarter's report

4. Related to the report above, a **Provider Education Report** should be created by LDH and submitted by the MCOs quarterly. Using the information from the previous quarter's Provider Denial Claims Report, the Provider Education Report would document for each high denial provider the top CARC or NCPDP codes among the claims that were denied. Additional information that would be tracked on this report includes:

   - Date of outreach to conduct education
   - Indicator if education was accepted
   - Date that education to the provider occurred
   - Mode in which education occurred (e.g. by phone, by webinar, in person)

Appendix A:
Data Request to the MCOs for Data to be Used in the Act 710 Study

Overview of the Process and Instructions

Related to this claims study, Burns & Associates is asking each MCO for the following:

1 Control Totals file containing two summary reports (see Control Totals tab)
37 header claim file extracts (see Header Claim Template)
37 detail line file extracts (see Medical Detail Line Template and Pharmacy Detail Line Template).
1 file that crosswalks the MCO's adjudication codes to CARCs

Please remit the Control Totals file in Excel. Please remit the CARC crosswalk file in Excel.
The header and detail files for each claim type may be submitted in .csv, .txt or .xlsx format.

Please use the following naming conventions when submitting these files.
Please use your four character MCO code on all files:

ACLA Amerihealth Caritas
AETN Aetna
BLUE Healthy Blue
LHCC Louisiana Health Care Connections
UNHC United Health Care
MCNA

The [mm17] indicates the month of adjudication that you processed the claims.
Since it is expected that the dental files will be small, these will be reported for the entire year [CY17].
The [date] always means the date the file is submitted. For June 29 submissions, enter as 06292018.
This is necessary in the event that some files need to be resubmitted.

The request is for the data files in red to be uploaded to the LDH SFTP site by Friday, June 29.
B&A will run validations on the file and outreach if any corrections are needed.
All remaining files are due to the LDH FTP site by Friday, July 20.

File #	Content	Naming Convention
1	Control Totals	[MCE Name]_Control Totals_[date].xlsx
*	On June 29, send us the control totals only for the files 2, 14, 26, 39, 51 and 63. On July 20, resend this file with the summation of all files inclusive of the June 29 submissions.	
2	UB-04 Header	[MCE Name]_INSTHDR_0117_[date].xlsx
3	UB-04 Header	[MCE Name]_INSTHDR_0217_[date].xlsx
4	UB-04 Header	[MCE Name]_INSTHDR_0317_[date].xlsx
5	UB-04 Header	[MCE Name]_INSTHDR_0417_[date].xlsx
6	UB-04 Header	[MCE Name]_INSTHDR_0517_[date].xlsx
7	UB-04 Header	[MCE Name]_INSTHDR_0617_[date].xlsx
8	UB-04 Header	[MCE Name]_INSTHDR_0717_[date].xlsx
9	UB-04 Header	[MCE Name]_INSTHDR_0817_[date].xlsx
10	UB-04 Header	[MCE Name]_INSTHDR_0917_[date].xlsx
11	UB-04 Header	[MCE Name]_INSTHDR_1017_[date].xlsx
12	UB-04 Header	[MCE Name]_INSTHDR_1117_[date].xlsx
13	UB-04 Header	[MCE Name]_INSTHDR_1217_[date].xlsx
14	CMS-1500 Header	[MCE Name]_PROFHDR_0117_[date].xlsx
15	CMS-1500 Header	[MCE Name]_PROFHDR_0217_[date].xlsx
16	CMS-1500 Header	[MCE Name]_PROFHDR_0317_[date].xlsx

17	CMS-1500 Header	[MCE Name]_PROFHDR_0417_[date].xlsx
18	CMS-1500 Header	[MCE Name]_PROFHDR_0517_[date].xlsx
19	CMS-1500 Header	[MCE Name]_PROFHDR_0617_[date].xlsx
20	CMS-1500 Header	[MCE Name]_PROFHDR_0717_[date].xlsx
21	CMS-1500 Header	[MCE Name]_PROFHDR_0817_[date].xlsx
22	CMS-1500 Header	[MCE Name]_PROFHDR_0917_[date].xlsx
23	CMS-1500 Header	[MCE Name]_PROFHDR_1017_[date].xlsx
24	CMS-1500 Header	[MCE Name]_PROFHDR_1117_[date].xlsx
25	CMS-1500 Header	[MCE Name]_PROFHDR_1217_[date].xlsx
26	Pharmacy Header	[MCE Name]_PHRMHDR_0117_[date].xlsx
27	Pharmacy Header	[MCE Name]_PHRMHDR_0217_[date].xlsx
28	Pharmacy Header	[MCE Name]_PHRMHDR_0317_[date].xlsx
29	Pharmacy Header	[MCE Name]_PHRMHDR_0417_[date].xlsx
30	Pharmacy Header	[MCE Name]_PHRMHDR_0517_[date].xlsx
31	Pharmacy Header	[MCE Name]_PHRMHDR_0617_[date].xlsx
32	Pharmacy Header	[MCE Name]_PHRMHDR_0717_[date].xlsx
33	Pharmacy Header	[MCE Name]_PHRMHDR_0817_[date].xlsx
34	Pharmacy Header	[MCE Name]_PHRMHDR_0917_[date].xlsx
35	Pharmacy Header	[MCE Name]_PHRMHDR_1017_[date].xlsx
36	Pharmacy Header	[MCE Name]_PHRMHDR_1117_[date].xlsx
37	Pharmacy Header	[MCE Name]_PHRMHDR_1217_[date].xlsx
38	Dental Header	[MCE Name]_DENTHDR_CY17_[date].xlsx
39	UB-04 Detail	[MCE Name]_INSTDTL_0117_[date].xlsx
40	UB-04 Detail	[MCE Name]_INSTDTL_0217_[date].xlsx
41	UB-04 Detail	[MCE Name]_INSTDTL_0317_[date].xlsx
42	UB-04 Detail	[MCE Name]_INSTDTL_0417_[date].xlsx
43	UB-04 Detail	[MCE Name]_INSTDTL_0517_[date].xlsx
44	UB-04 Detail	[MCE Name]_INSTDTL_0617_[date].xlsx
45	UB-04 Detail	[MCE Name]_INSTDTL_0717_[date].xlsx
46	UB-04 Detail	[MCE Name]_INSTDTL_0817_[date].xlsx
47	UB-04 Detail	[MCE Name]_INSTDTL_0917_[date].xlsx
48	UB-04 Detail	[MCE Name]_INSTDTL_1017_[date].xlsx
49	UB-04 Detail	[MCE Name]_INSTDTL_1117_[date].xlsx
50	UB-04 Detail	[MCE Name]_INSTDTL_1217_[date].xlsx
51	CMS-1500 Detail	[MCE Name]_PROFDTL_0117_[date].xlsx
52	CMS-1500 Detail	[MCE Name]_PROFDTL_0217_[date].xlsx
53	CMS-1500 Detail	[MCE Name]_PROFDTL_0317_[date].xlsx
54	CMS-1500 Detail	[MCE Name]_PROFDTL_0417_[date].xlsx
55	CMS-1500 Detail	[MCE Name]_PROFDTL_0517_[date].xlsx
56	CMS-1500 Detail	[MCE Name]_PROFDTL_0617_[date].xlsx
57	CMS-1500 Detail	[MCE Name]_PROFDTL_0717_[date].xlsx
58	CMS-1500 Detail	[MCE Name]_PROFDTL_0817_[date].xlsx
59	CMS-1500 Detail	[MCE Name]_PROFDTL_0917_[date].xlsx
60	CMS-1500 Detail	[MCE Name]_PROFDTL_1017_[date].xlsx
61	CMS-1500 Detail	[MCE Name]_PROFDTL_1117_[date].xlsx
62	CMS-1500 Detail	[MCE Name]_PROFDTL_1217_[date].xlsx
63	Pharmacy Detail	[MCE Name]_PHRMDTL_0117_[date].xlsx

64	Pharmacy Detail	[MCE Name]_PHRMDTL_0217_[date].xlsx
65	Pharmacy Detail	[MCE Name]_PHRMDTL_0317_[date].xlsx
66	Pharmacy Detail	[MCE Name]_PHRMDTL_0417_[date].xlsx
67	Pharmacy Detail	[MCE Name]_PHRMDTL_0517_[date].xlsx
68	Pharmacy Detail	[MCE Name]_PHRMDTL_0617_[date].xlsx
69	Pharmacy Detail	[MCE Name]_PHRMDTL_0717_[date].xlsx
70	Pharmacy Detail	[MCE Name]_PHRMDTL_0817_[date].xlsx
71	Pharmacy Detail	[MCE Name]_PHRMDTL_0917_[date].xlsx
72	Pharmacy Detail	[MCE Name]_PHRMDTL_1017_[date].xlsx
73	Pharmacy Detail	[MCE Name]_PHRMDTL_1117_[date].xlsx
74	Pharmacy Detail	[MCE Name]_PHRMDTL_1217_[date].xlsx
75	Dental Detail	[MCE Name]_DENTDTL_CY17_[date].xlsx
76	Adj Code Crosswalk	Crosswalk of MCO's Adjudication Codes to CARCs

Template for MCO Claim Submissions for HB 734 Study_updated (06-12-18).xlsx
Control Totals

Control Totals Report #1
For All Claims Received by the MCO During January 1, 2017 - December 31, 2017 regardless of Date of Service on the Claim
Header Records

		UB-04				CMS-1500		Dental		Pharmacy	
		Inpatient Hospital		All Other UB-04 Claims Not Inpatient Hospital		All		All		All	
		Claim Count	Claim Charges	Claim Count	Claim Charges	Claim Count	Claim Charges	Claim Count	Claim Charges	Claim Count	Claim Charges
1	Header Record Claims Received										
2	Header Record Claims Rejected										
3	Header Record Claims Brought in for Adjudication										
4	Header Record Claims Not Adjudicated as of 12/31/17										
5	Header Record Claims Adjudicated as of 12/31/17										
	Adjudicated Claims by Source Status										
	5a Original Claim										
	5b Voided Claim										
	5c Adjusted Claim										
	5d Duplicate Claim										
	Adjudicated Claims by Payment Status										
	5e Paid										
	5f Denied										

	Pended Claims										
	6a Claims Ever Pended in CY17										
	6b Claims Never Pended in CY17										

Formulas:

Line 3 equals Line 1 minus Line 2.
Line 4 plus Line 5 = Line 3.
Lines 5a + 5b + 5c + 5d = Line 5.
Lines 5e + 5f = Line 5.
Lines 6a + 6b = Line 5.

Definitions:

Original Claim means the first time that a claim was submitted by a provider.
Voided Claim means that the original claim submitted was reversed out.
Adjusted Claim means either (a) the replacement claims in a triplicate series (Original-Void-Replacement) or simply an adjustment to an Original Claim.
Duplicate Claim means a replica of an original claim previously submitted.

Claims Never Pended means those that claims that only went through auto-adjudication.
Claims Ever Pended means those that claims that went through any process outside of auto-adjudication.
Claims Ever Pended does not imply the claim denied. It simply means the claim went through an additional review.

Control Totals Report #2
For All Claims Received by the MCO During January 1, 2017 - December 31, 2017 regardless of Date of Service on the Claim
Detail Records

		UB-04				CMS-1500		Dental		Pharmacy	
		Inpatient Hospital		All Other UB-04 Claims Not Inpatient Hospital		All		All		All	
		Details Count	Detail Charges	Details Count	Detail Charges	Details Count	Detail Charges	Details Count	Detail Charges	Details Count	Detail Charges
7	Detail Lines Brought in for Adjudication										
7a	Detail Lines that Appear on Header Paid Claims										
7b	Detail Lines that Appear on Header Denied Claims										

Notes:

The details on Line 7 should map to the header claims reported on Line 5.
Therefore, the sum of the Detail Charges on Line 7 should be the same value as the sum of the Header Charges on Line 5.

The sum of the details on Lines 7a + 7b should equal the total details on Line 7.
The sum of the charges on Lines 7a + 7b should equal the total charges on Line 7.

Header Claims Extract File Layout *For files 2 through 38*

MCO Claim ID (ICN)	Header Claim Acceptance Status	Header Claim Source Status	Header Claim Ever Pended	Header Claim Adjudication Payment Status	Member Medicaid ID	LDH Billing Provider ID	Billing Provider NPI	Servicing Provider NPI	Header From Date of Service	Header To Date of Service	Date Claim Received by the MCO	Date Claim Adjudicated by the MCO	Date Claim Paid by the MCO	Billed Charges	MCO Paid Amount

Submit 4 files all in this same format:

File 1 is UB-04/837I claims.
File 2 is CMS-1500/837P claims.
File 3 is Dental claims.
File 4 is Pharmacy claims.

Variable Name	Field Type	Field Length	Description
MCO Claim ID (ICN)	character	20	Insert the claim number that you assigned to the claim in your internal system.
Header Claim Acceptance Status	character	1	Enter A for claims accepted into your adjudication system and X for claims that were rejected.
Header Claim Source Status	character	2	Enter OR for original claims into your system, VD for voided claims, AJ for Adjusted and DP for Duplicate claims.
Header Claim Ever Pended	character	1	Enter Y if this claim line was every pended for manual review. If not, enter N.
Header Claim Adjudication Payment Status	character	1	Enter P for header claims your MCO adjudicated as paid and D for header claims that you denied.
Member Medicaid ID	numeric	13	The ID assigned by LDH to the member.
LDH Billing Provider ID	numeric	7	The legacy ID assigned by LDH to the provider (not an MCO-specific provider ID). *This field is optional* .
Billing Provider NPI	numeric	10	The National Provider ID for the billing provider.
Servicing Provider NPI	numeric	10	The National Provider ID for the servicing provider.
Header From Date of Service	date	8	Use YYYY-MM-DD format
Header To Date of Service	date	8	Use YYYY-MM-DD format
Date Claim Received by the MCO	date	8	Use YYYY-MM-DD format. This is the date the claim was received by the MCO for intake.
Date Claim Adjudicated by the MCO	date	8	Use YYYY-MM-DD format. This is the date that the MCO made its adjudication decision on the claim.
Date Claim Paid by the MCO	date	8	Use YYYY-MM-DD format. For paid claims only, this is the date that payment was made on the claim (the check run date).
Billed Charges	numeric	9	Enter the Billed Charges value at the header level for the claim. Set field as 9999999.99
MCO Paid Amount	numeric	9	Enter the MCO Paid Amount value at the header level for the claim. If denied, enter $0. Set field as 9999999.99

Template for MCO Claim Submissions for HB 734 Study_updated (06-12-18).xlsx
Medical Detail Line Template

Detail Lines Extract File Layout *For files 39 through 62 and 75*

MCO Claim ID (ICN)	MCO Detail Number	Detail Line Adjudication Status	Detail Line Ever Pended	Detail From Date of Service	Detail To Date of Service	Revenue Code	CPT or HCPCS	Billed Charges	MCO Paid Amount	Adjudication Code 1	Adjudication Code 2	Adjudication Code 3	Adjudication Code 4	Adjudication Code 5

Submit 3 files all in this same format:

File 1 is UB-04/837I claim details. For Inpatient claims, submit only the details that have payment amounts on them.
These will be the accommodation revenue codes that show the per diem payments.
File 2 is CMS-1500/837P claim details.
File 3 is Dental claim details.

Variable Name	Field Type	Field Length	Description
MCO Claim ID (ICN)	character	20	Insert the claim number that you assigned to the header claim in your internal system.
MCO Detail Number	numeric	3	Enter sequential numbers to indicate each unique detail line number on the claim. The first number should start with 1.
Detail Line Adjudication Status	character	1	Enter P for lines your MCO adjudicated as paid, D for detail lines that you denied, and A for lines you adjusted.
Detail Line Ever Pended	character	1	Enter Y if this detail line was every pended for manual review. If not, enter N.
Detail From Date of Service	date	8	Use YYYY-MM-DD format
Detail To Date of Service	date	8	Use YYYY-MM-DD format
Revenue Code	numeric	3	The revenue code associated with the detail line. This field should always be populated with a value.
CPT or HCPCS	character	5	The procedure code or HCPCS code associated with the detail line. If there is none, then leave this field blank.
Billed Charges	numeric	9	Enter the Billed Charges value at the detail level for the claim. Set field as 9999999.99
MCO Paid Amount	numeric	9	Enter the MCO Paid Amount value at the detail line level for the claim. If denied, enter $0. Set field as 9999999.99
Adjudication Code 1	character	3	Enter the first MCO adjudication code related to claims adjudication.
Adjudication Code 2	character	3	Enter the second MCO adjudication code related to claims adjudication (may be left blank).
Adjudication Code 3	character	3	Enter the third MCO adjudication code related to claims adjudication (may be left blank).
Adjudication Code 4	character	3	Enter the fourth MCO adjudication code related to claims adjudication (may be left blank).
Adjudication Code 5	character	3	Enter the fifth MCO adjudication code related to claims adjudication (may be left blank).

Template for MCO Claim Submissions for HB 734 Study_updated (06-12-18).xlsx
Pharmacy Detail Line Template

Detail Lines Extract File Layout *For files 63 through 74*

MCO Claim ID (ICN)	MCO Detail Number	Detail Line Adjudication Status	Detail Line Ever Suspended	Detail From Date of Service	Detail To Date of Service	NDC	Billed Charges	MCO Paid Amount	NCPDP Code 1	NCPDP Code 2	NCPDP Code 3	NCPDP Code 4	NCPDP Code 5

Submit 1 file for pharmacy details only in this format.

Variable Name	Field Type	Field Length	Description
MCO Claim ID (ICN)	character	20	Insert the claim number that you assigned to the header claim in your internal system.
MCO Detail Number	numeric	3	Enter sequential numbers to indicate each unique detail line number on the claim. The first number should start with 1.
Detail Line Adjudication Status	character	1	Enter P for lines your MCO adjudicated as paid, D for detail lines that you denied, and A for lines you adjusted.
Detail Line Ever Suspended	character	1	Enter Y if this detail line was every suspended for manual review. If not, enter N.
Detail From Date of Service	date	8	Use YYYY-MM-DD format
Detail To Date of Service	date	8	Use YYYY-MM-DD format
NDC	character	12	The national drug code associated with the detail line. If there is none, then leave this field blank.
Billed Charges	numeric	9	Enter the Billed Charges value at the detail level for the claim. Set field as 9999999.99
MCO Paid Amount	numeric	9	Enter the MCO Paid Amount value at the detail line level for the claim. If denied, enter $0. Set field as 9999999.99
NCPDP Code 1	character	3	Enter the first NCPDP related to claims adjudication.
NCPDP Code 2	character	3	Enter the second NCPDP related to claims adjudication (may be left blank).
NCPDP Code 3	character	3	Enter the third NCPDP related to claims adjudication (may be left blank).
NCPDP Code 4	character	3	Enter the fourth NCPDP related to claims adjudication (may be left blank).
NCPDP Code 5	character	3	Enter the fifth NCPDP related to claims adjudication (may be left blank).

Adjudication Code Crosswalk *For file 76*

MCO Code	MCO Code Description	CARC

MCO Code	List all codes you as the MCO use in your internal adjudication system.
MCO Code Description	A description of the adjudication code.
CARC	Map your MCO adjudication code to the most relevant CARC code.

Appendix B:
List of Services that Map to Definition of Specialized Behavioral Health Services

SPECIALIZED BEHAVIORAL HEALTH SERVICES - CPT Codes (V3 Effective 7.1.18)

Code	Description	Age	Psychiatrist	APRN/CNS/PA	Medical Psychologist	Psychologist	LCSW	LPC	LMFT	LAC
	Modifier >	HA=Child HB=Adult	AF	SA	HP	AH	AJ	HO	HO	HF
90785	INTERACTIVE COMPLEXITY, ADD ON	0-20	$3.44	$2.75	$2.75	$2.75	$2.41	$2.41	$2.41	
90785	INTERACTIVE COMPLEXITY, ADD ON	21+	$3.44	$2.75	$2.75	$2.75	$2.41	$2.41	$2.41	
90791	PSYCHIATRIC DIAGNOSTIC EVALUATION	0-20	$108.39	$86.71	$86.71	$86.71	$75.87	$75.87	$75.87	
90791	PSYCHIATRIC DIAGNOSTIC EVALUATION	21+	$108.39	$75.87	$86.71	$86.71	$75.87	$75.87	$75.87	
90792	PSYCHIATRIC DIAGNOSTIC EVALUATION WITH MEDICAL SERVICES	0-20	$115.62	$92.50	$92.50					
90792	PSYCHIATRIC DIAGNOSTIC EVALUATION WITH MEDICAL SERVICES	21+	$108.39	$75.86	$86.71					
90832	PSYCHOTHERAPY, 30 MINUTES WITH PATIENT PRESENT	0-20	$47.65	$38.12	$38.12	$38.12	$33.36	$33.36	$33.36	$33.36
90832	PSYCHOTHERAPY, 30 MINUTES WITH PATIENT PRESENT	21+	$47.65	$38.12	$38.12	$38.12	$33.36	$33.36	$33.36	$33.36
90833	PSYCHOTHERAPY, 30 MINUTES WITH PATIENT PRESENT, ADD ON	0-20	$30.24	$24.19	$24.19					
90833	PSYCHOTHERAPY, 30 MINUTES WITH PATIENT PRESENT, ADD ON	21+	$43.60	$30.52	$34.88					
90834	PSYCHOTHERAPY, 45 MINUTES WITH PATIENT PRESENT	0-20	$67.08	$53.66	$53.66	$53.66	$46.96	$46.96	$46.96	$46.96
90834	PSYCHOTHERAPY, 45 MINUTES WITH PATIENT PRESENT	21+	$69.76	$55.81	$55.81	$55.81	$48.83	$48.83	$48.83	$48.83
90836	PSYCHOTHERAPY, 45 MINUTES WITH PATIENT PRESENT, ADD ON	0-20	$49.13	$39.30	$39.30					
90836	PSYCHOTHERAPY, 45 MINUTES WITH PATIENT PRESENT, ADD ON	21+	$50.31	$40.25	$40.25					
90837	PSYCHOTHERAPY, 60 MINUTES WITH PATIENT PRESENT	0-20	$98.78	$79.02	$79.02	$79.02	$69.15	$69.15	$69.15	
90837	PSYCHOTHERAPY, 60 MINUTES WITH PATIENT PRESENT	21+	$76.74	$61.39	$61.39	$61.39	$53.72	$53.72	$53.72	
90838	PSYCHOTHERAPY, 60 MINUTES WITH PATIENT PRESENT, ADD ON	0-20	$79.31	$63.45	$63.45					
90838	PSYCHOTHERAPY, 60 MINUTES WITH PATIENT PRESENT, ADD ON	21+	$57.02	$45.62	$45.62					
90839	PSYCHOTHERAPY FOR CRISIS; FIRST 60 MINUTES	0-20	$123.60	$98.88	$98.88	$98.88	$86.52	$86.52	$86.52	$86.52
90839	PSYCHOTHERAPY FOR CRISIS; FIRST 60 MINUTES	21+	$125.53	$100.42	$100.42	$100.42	$87.87	$87.87	$87.87	$87.87
90840	PSYCHOTHERAPY FOR CRISIS; EACH ADDITIONAL 30 MINUTE ADD ON	0-20	$61.50	$49.20	$49.20	$49.20	$43.05	$43.05	$43.05	$43.05
90840	PSYCHOTHERAPY FOR CRISIS; EACH ADDITIONAL 30 MINUTE ADD ON	21+	$50.21	$40.17	$40.17	$40.17	$35.15	$35.15	$35.15	$35.15
90845	MEDICAL PSYCHOANALYSIS	0-20	$58.98							
90845	MEDICAL PSYCHOANALYSIS	21+	$58.98							
90846	FAMILY PSYCHOTHERAPY WITHOUT PATIENT PRESENT	0-20	$62.62	$50.10	$50.10	$50.10	$43.83	$43.83	$43.83	$43.83
90846	FAMILY PSYCHOTHERAPY WITHOUT PATIENT PRESENT	21+	$62.62	$50.10	$50.10	$50.10	$46.79	$46.79	$46.79	$46.79
90847	FAMILY PSYCHOTHERAPY WITH PATIENT PRESENT	0-20	$77.67	$62.14	$62.14	$62.14	$54.37	$54.37	$54.37	$54.37
90847	FAMILY PSYCHOTHERAPY WITH PATIENT PRESENT	21+	$77.67	$62.14	$62.14	$62.14	$54.37	$54.37	$54.37	$54.37
90849	MULTIPLE FAMILY GROUP PSYCHOTHERAPY	0-20	$23.23	$18.58	$18.58	$18.58				
90849	MULTIPLE FAMILY GROUP PSYCHOTHERAPY	21+	$23.23	$18.58	$18.58	$18.58				
90853	GROUP PSYCHOTHERAPY	0-20	$22.05	$17.64	$17.64	$17.64	$15.44	$15.44	$15.44	$15.44
90853	GROUP PSYCHOTHERAPY	21+	$22.05	$17.64	$17.64	$17.64	$15.44	$15.44	$15.44	$15.44
90863	PHARMACOLOGIC MANAGEMENT ADD ON	0-20			$31.13					
90863	PHARMACOLOGIC MANAGEMENT ADD ON	21+			$52.92					
90870	ELECTROCONVULSIVE THERAPY	0-20	$94.84							
90870	ELECTROCONVULSIVE THERAPY	21+	$94.84							
90875	PSYCHOPHYSIOLOGICAL THERAPY WITH BIOFEEDBACK 20-30 MINUTES	0-20	$50.05							
90875	PSYCHOPHYSIOLOGICAL THERAPY WITH BIOFEEDBACK 20-30 MINUTES	21+	$50.05							
90876	PSYCHOPHYSIOLOGICAL THERAPY WITH BIOFEEDBACK 45-50 MINUTES	0-20	$74.34							
90876	PSYCHOPHYSIOLOGICAL THERAPY WITH BIOFEEDBACK 45-50 MINUTES	21+	$74.34							
90880	MEDICAL HYPNOTHERAPY	0-20	$75.96	$60.77	$60.77					
90880	MEDICAL HYPNOTHERAPY	21+	$75.96	$60.77	$60.77					
96101	PSYCHOLOGICAL TESTING WITH INTERPRET FACE TO FACE	0-20	$60.84		$48.67	$48.67				
96101	PSYCHOLOGICAL TESTING WITH INTERPRET FACE TO FACE	21+	$60.84		$48.67	$48.67				
96102	PSYCHOLOGICAL TESTING WITH INTERPRET TECHNICIAN	0-20	$34.79		$34.79	$34.79				
96102	PSYCHOLOGICAL TESTING WITH INTERPRET TECHNICIAN	21+	$34.79		$34.79	$34.79				
96103	PSYCHOLOGICAL TESTING WITH INTERPRET COMPUTER	0-20	$31.63		$31.63	$31.63				
96103	PSYCHOLOGICAL TESTING WITH INTERPRET COMPUTER	21+	$31.63		$31.63	$31.63				
96105	ASSESSMENT OF APHASIA	0-20	$47.82							
96105	ASSESSMENT OF APHASIA	21+	$47.82							
96116	NEUROBEHAVIORAL STATUS EXAMINATION,	0-20	$68.14							

SPECIALIZED BEHAVIORAL HEALTH SERVICES - CPT Codes (V3 Effective 7.1.18)

Code	Description	Age	Psychiatrist	APRN/CNS/PA	Medical Psychologist	Psychologist	LCSW	LPC	LMFT	LAC
96116	NEUROBEHAVIORAL STATUS EXAMINATION,	21+	$68.14							
96118	PSYCHOLOGICAL TESTING WITH INTERPRET FACE TO FACE	0-20	$76.33		$61.06	$61.06				
96118	PSYCHOLOGICAL TESTING WITH INTERPRET FACE TO FACE	21+	$76.33		$61.06	$61.06				
96119	PSYCHOLOGICAL TESTING WITH INTERPRET TECHNICIAN	0-20	$50.08		$40.06	$40.06				
96119	PSYCHOLOGICAL TESTING WITH INTERPRET TECHNICIAN	21+	$50.08		$50.08	$50.08				
96120	PSYCHOLOGICAL TESTING WITH INTERPRET COMPUTER	0-20	$46.15		$36.92	$36.92				
96120	PSYCHOLOGICAL TESTING WITH INTERPRET COMPUTER	21+	$46.15		$46.15	$46.15				
96150	ASSESS HLTH/BEHAVE, INIT	0-20	$13.10	$10.48	$10.48	$10.48				
96150	ASSESS HLTH/BEHAVE, INIT	21+	$16.37		$13.10	$13.10				
96151	ASSESS HLTH/BEHAVE, SUBSEQ	0-20	$12.67	$10.14	$10.14	$10.14				
96151	ASSESS HLTH/BEHAVE, SUBSEQ	21+	$15.84		$12.67	$12.67				
96152	INTERVENE HLTH/BEHAVE, INDIV	0-20	$12.06		$9.65	$9.65				
96152	INTERVENE HLTH/BEHAVE, INDIV	21+	$15.08		$12.06	$12.06				
96153	INTERVENE HLTH/BEHAVE, GROUP	0-20	$2.89		$2.31	$2.31				
96153	INTERVENE HLTH/BEHAVE, GROUP	21+	$3.61		$2.89	$2.89				
96154	INTERV HLTH/BEHAV, FAM W/PT	0-20	$11.85		$9.48	$9.48				
96154	INTERV HLTH/BEHAV, FAM W/PT	21+	$14.80		$11.84	$11.84				
96155	INTERV HLTH/BEHAV FAM NO PT	0-20	$12.76		$10.21	$10.21				
96155	INTERV HLTH/BEHAV FAM NO PT	21+	$15.96		$12.77	$12.77				
96372	THERAPEUTIC, PROPHYLACTIC OR DIAGNOSTIC INJECTION	0-20	$21.68	$17.34	$17.34					
96372	THERAPEUTIC, PROPHYLACTIC OR DIAGNOSTIC INJECTION	21+	$21.68	$16.26	$16.26					
99201	NEW PATIENT OFFICE OUTPATIENT - PROBLEM FOCUSED (10 Min)	0-20	$25.36	$20.29	$20.29					
99201	NEW PATIENT OFFICE OUTPATIENT - PROBLEM FOCUSED (10 Min)	21+	$25.36	$20.29	$20.29					
99202	NEW PATIENT OFFICE OUTPATIENT - EXPANDED PROBLEM FOCUSED (20 Min)	0-20	$44.08	$35.26	$35.26					
99202	NEW PATIENT OFFICE OUTPATIENT - EXPANDED PROBLEM FOCUSED (20 Min)	21+	$44.08	$35.26	$35.26					
99203	NEW PATIENT OFFICE OUTPATIENT - DETAILED (30 Min)	0-20	$64.08	$51.26	$51.26					
99203	NEW PATIENT OFFICE OUTPATIENT - DETAILED (30 Min)	21+	$64.08	$51.26	$51.26					
99204	NEW PATIENT OFFICE OUTPATIENT - COMPREHENSIVE MODERATE COMPLEXITY (45 Min)	0-20	$99.52	$79.62	$79.62					
99204	NEW PATIENT OFFICE OUTPATIENT - COMPREHENSIVE MODERATE COMPLEXITY (45 Min)	21+	$99.52	$79.62	$79.62					
99205	NEW PATIENT OFFICE OUTPATIENT - COMPREHENSIVE HIGH COMPLEXITY (60 Min)	0-20	$125.53	$100.42	$100.42					
99205	NEW PATIENT OFFICE OR OTHER OUTPATIENT - COMPREHENSIVE HIGH COMPLEXITY (60 Min)	21+	$125.53	$100.42	$100.42					
99211	ESTABLISHED PATIENT OFFICE OUTPATIENT - MINIMAL PROBLEMS (5 Min)	0-20	$12.73	$10.18	$10.18					
99211	ESTABLISHED PATIENT OFFICE OUTPATIENT - MINIMAL PROBLEMS (5 Min)	21+	$21.64	$21.64	$17.31					
99212	ESTABLISHED PATIENT OFFICE OUTPATIENT - PROBLEM FOCUSED (10 Min)	0-20	$27.29	$21.83	$21.83					
99212	ESTABLISHED PATIENT OFFICE OUTPATIENT - PROBLEM FOCUSED (10 Min)	21+	$46.39	$37.11	$37.11					
99213	ESTABLISHED PATIENT OFFICE OUTPATIENT - EXPANDED PROBLEM FOCUSED (15 Min)	0-20	$42.80	$34.24	$34.24					
99213	ESTABLISHED PATIENT OFFICE OUTPATIENT - EXPANDED PROBLEM FOCUSED (15 Min)	21+	$72.76	$58.21	$58.21					
99214	ESTABLISHED PATIENT OFFICE OUTPATIENT - DETAILED (25 Min)	0-20	$64.57	$51.66	$51.66					
99214	ESTABLISHED PATIENT OFFICE OUTPATIENT - DETAILED (25 Min)	21+	$109.77	$87.82	$87.82					
99215	ESTABLISHED PATIENT OFFICE OUTPATIENT - COMPREHENSIVE HIGH COMPLEXITY (40 Min)	0-20	$93.37	$74.70	$74.70					
99215	ESTABLISHED PATIENT OFFICE OUTPATIENT - COMPREHENSIVE HIGH COMPLEXITY (40 Min)	21+	$158.73	$126.98	$126.98					
99218	HOSPITAL OBSERVATION CARE - LOW COMPLEXITY (30 Min)	0-20	$44.91	$35.93	$35.93					
99218	HOSPITAL OBSERVATION CARE - LOW COMPLEXITY (30 Min)	21+	$44.91	$35.93	$35.93					
99219	HOSPITAL OBSERVATION CARE - MODERATE COMPLEXITY (50 Min)	0-20	$74.41	$59.53	$59.53					
99219	HOSPITAL OBSERVATION CARE - MODERATE COMPLEXITY (50 Min)	21+	$74.41	$59.53	$59.53					
99220	HOSPITAL OBSERVATION CARE - HIGH COMPLEXITY (70 Min)	0-20	$104.35	$83.48	$83.48					
99220	HOSPITAL OBSERVATION CARE - HIGH COMPLEXITY (70 Min)	21+	$104.35	$83.48	$83.48					
99221	INITIAL HOSPITAL INPATIENT CARE, LOW COMPLEXITY (30 Min)	0-20	$64.43	$51.54	$51.54					
99221	INITIAL HOSPITAL INPATIENT CARE, LOW COMPLEXITY (30 Min)	21+	$64.43	$51.54						
99222	INITIAL HOSPITAL INPATIENT CARE, MODERATE COMPLEXITY (50 Min)	0-20	$87.95	$70.36	$70.36					
99222	INITIAL HOSPITAL INPATIENT CARE, MODERATE COMPLEXITY (50 Min)	21+	$87.95	$70.36						
99223	INITIAL HOSPITAL INPATIENT CARE, HIGH COMPLEXITY (70 Min)	0-20	$129.38	$103.50	$103.50					

SPECIALIZED BEHAVIORAL HEALTH SERVICES - CPT Codes (V3 Effective 7.1.18)

Code	Description	Age	Psychiatrist	APRN/CNS/PA	Medical Psychologist	Psychologist	LCSW	LPC	LMFT	LAC
99223	INITIAL HOSPITAL INPATIENT CARE, HIGH COMPLEXITY (70 Min)	21+	$129.38	$103.50						
99231	SUBSEQUENT HOSPITAL INPATIENT CARE, LOW (15 Min)	0-20	$26.60	$21.28	$21.28					
99231	SUBSEQUENT HOSPITAL INPATIENT CARE, LOW (15 Min)	21+	$26.60	$21.28	$21.28					
99232	SUBSEQUENT HOSPITAL INPATIENT CARE, MODERATE (25 Min)	0-20	$47.84	$38.27	$38.27					
99232	SUBSEQUENT HOSPITAL INPATIENT CARE, MODERATE (25 Min)	21+	$47.84	$38.27	$38.27					
99233	SUBSEQUENT HOSPITAL INPATIENT CARE, HIGH (35 Min)	0-20	$68.56	$54.85	$54.85					
99233	SUBSEQUENT HOSPITAL INPATIENT CARE, HIGH (35 Min)	21+	$68.56	$54.85	$54.85					
99234	HOSPITAL OBSERVATION OR INPATIENT CARE - LOW (40 Min)	0-20	$91.00	$72.80	$72.80					
99234	HOSPITAL OBSERVATION OR INPATIENT CARE - LOW (40 Min)	21+	$91.00	$72.80	$72.80					
99235	HOSPITAL OBSERVATION OR INPATIENT CARE - MODERATE (50 Min)	0-20	$119.53	$95.62	$95.62					
99235	HOSPITAL OBSERVATION OR INPATIENT CARE - MODERATE (50 Min)	21+	$119.53	$95.62	$95.62					
99236	HOSPITAL OBSERVATION OR INPATIENT CARE - HIGH (55 Min)	0-20	$148.52	$118.82	$118.82					
99236	HOSPITAL OBSERVATION OR INPATIENT CARE - HIGH (55 Min)	21+	$148.52	$118.82	$118.82					
99238	HOSPITAL DISCHARGE DAY MANAGEMENT (<30 Min)	0-20	$47.25	$37.80	$37.80					
99238	HOSPITAL DISCHARGE DAY MANAGEMENT (<30 Min)	21+	$47.25	$37.80	$37.80					
99239	HOSPITAL DISCHARGE DAY (>30 Min)	0-20	$68.71	$54.97	$54.97					
99239	HOSPITAL DISCHARGE DAY (>30 Min)	21+	$68.71	$54.97	$54.97					
99281	EMERGENCY DEPARTMENT VISIT, SELF LIM	0-20	$14.58	$11.66	$11.66					
99281	EMERGENCY DEPARTMENT VISIT, SELF LIM	21+	$14.58	$11.66	$11.66					
99282	EMERGENCY DEPARTMENT VISIT, LOW	0-20	$28.40	$22.72	$22.72					
99282	EMERGENCY DEPARTMENT VISIT, LOW	21+	$28.40	$22.72	$22.72					
99283	EMERGENCY DEPARTMENT VISIT, MODERATE	0-20	$44.18	$35.34	$35.34					
99283	EMERGENCY DEPARTMENT VISIT, MODERATE	21+	$44.18	$35.34	$35.34					
99284	EMERGENCY DEPARTMENT VISIT, PROBLEM	0-20	$82.58	$66.06	$66.06					
99284	EMERGENCY DEPARTMENT VISIT, PROBLEM	21+	$82.58	$66.06	$66.06					
99285	EMERGENCY DEPARTMENT VISIT, PROBLEM EXPANDED	0-20	$122.93	$98.34	$98.34					
99285	EMERGENCY DEPARTMENT VISIT, PROBLEM EXPANDED	21+	$122.93	$98.34	$98.34					
99408	ALCOHOL AND/OR DRUG SCREENING AND BRIEF INTERVENTION (15-30 Min)	0-20	$47.65	$38.12	$38.12					
99408	ALCOHOL AND/OR DRUG SCREENING AND BRIEF INTERVENTION (15-30 Min)	21+	$47.65	$38.12	$38.12					
99201 TH	NEW PATIENT - PROBLEM FOCUSED (PRENATAL/POST PARTUM) (10 Min)	10-59	$27.04							
99202 TH	NEW PATIENT - EXPANDED PROBLEM FOCUSED (PRENATAL/POST PARTUM) (20 Min)	10-59	$47.01							
99203 TH	NEW PATIENT - DETAILED (PRENATAL/POST PARTUM) (30 Min)	10-59	$68.35							
99204 TH	NEW PATIENT - COMPREHENSIVE MODERATE COMPLEXITY (PRENATAL/POST PARTUM) (45 Min)	10-59	$106.15							
99205 TH	NEW PATIENT - COMPREHENSIVE HIGH COMPLEXITY (PRENATAL/POST PARTUM) (60 Min)	10-59	$134.33							
99211 TH	ESTABLISHED PATIENT - MINIMAL PROBLEMS (PRENATAL/POST PARTUM) (5 Min)	10-20	$13.78							
99211 TH	ESTABLISHED PATIENT - MINIMAL PROBLEMS (PRENATAL/POST PARTUM) (5 Min)	21-59	$23.43							
99212 TH	ESTABLISHED PATIENT - PROBLEM FOCUSED (PRENATAL/POST PARTUM) (10 Min)	10-20	$27.29							
99212 TH	ESTABLISHED PATIENT - PROBLEM FOCUSED (PRENATAL/POST PARTUM) (10 Min)	21-59	$46.39							
99213 TH	ESTABLISHED PATIENT - EXPANDED PROBLEM FOCUSED (PRENATAL/POST PARTUM) (15 Min)	10-20	$45.65							
99213 TH	ESTABLISHED PATIENT - EXPANDED PROBLEM FOCUSED (PRENATAL/POST PARTUM) (15 Min)	21-59	$77.61							
99214 TH	ESTABLISHED PATIENT - DETAILED (PRENATAL/POST PARTUM) (25 Min)	10-20	$67.88							
99214 TH	ESTABLISHED PATIENT - DETAILED (PRENATAL/POST PARTUM) (25 Min)	21-59	$115.40							
99215 TH	ESTABLISHED PATIENT - COMPREHENSIVE HIGH COMPLEXITY (PRENATAL/POST PARTUM) (40 Min)	10-20	$93.37							
99215 TH	ESTABLISHED PATIENT - COMPREHENSIVE HIGH COMPLEXITY (PRENATAL/POST PARTUM) (40 Min)	21-59	$158.73							
H0049	ALCOHOL AND/OR DRUG SCREENING	0-20	$14.78	$11.82	$11.82					
H0049	ALCOHOL AND/OR DRUG SCREENING	21+	$14.78							
H0050	ALCOHOL AND/OR DRUG SERVICES, BRIEF (Per 15 Min)	0-20	$34.50	$27.60	$27.60					
H0050	ALCOHOL AND/OR DRUG SERVICES, BRIEF (Per 15 Min)	21+	$34.50							

SPECIALIZED BEHAVIORAL HEALTH SERVICES - HCPC CODES (V3 Effective 7.1.18)

Code	Description	Modifier*	Unit	Age - HA=Child HB=Adult	Master's Level (HO)	Bachelor's Level (HN)	Less than Bachelor's (HM)	Other Per Diem
H0001	ALCOHOL AND/OR DRUG ASSESSMENT		Visit	0+	$65.27	$65.27	$43.44	
H0004	ALCOHOL AND/OR DRUG SERVICES - INDIVIDUAL	HF	Visit	0+	$42.38	$42.38	$34.25	
H0005	ALCOHOL AND/OR DRUG SERVICES - GROUP (PER PERSON)	HQ	Visit	0+	$9.23	$9.23	$6.52	
H0005	ALCOHOL AND/OR DRUG SERVICES - FAMILY (PER FAMILY MEMBER)	HR, HS	Visit	0+	$21.53	$21.53	$15.23	
H0011	ALCOHOL AND/OR DRUG SERVICES - ACUTE DETOX 3.7-WM**	TG	Day	21+				$290.00
H0011	ALCOHOL AND/OR DRUG SERVICES - ACUTE DETOX 3.7-WM ROOM AND BOARD**	SE	Day	21+				$43.50
H0012	ALCOHOL AND/OR DRUG SERVICES - SUBACUTE DETOX 3.2-WM		Day	0-20				$72.15
H0012	ALCOHOL AND/OR DRUG SERVICES - SUBACUTE DETOX 3.2-WM**		Day	21+				$72.15
H0012	ALCOHOL AND/OR DRUG SERVICES - SUBACUTE DETOX 3.2-WM ROOM AND BOARD**	SE	Day	21+				$17.85
H0015	ALCOHOL AND/OR DRUG SERVICES - INTENSIVE OUTPATIENT 2.1 INDIVIDUAL		15 min	0+	$16.17	$16.17	$11.44	
H0015	ALCOHOL AND/OR DRUG SERVICES - INTENSIVE OUTPATIENT 2.1 GROUP	HQ	15 min	0-20	$2.31	$2.31	$1.64	
H0015	ALCOHOL AND/OR DRUG SERVICES - INTENSIVE OUTPATIENT 2.1 GROUP	HQ	15 min	21+	$12.00	$12.00	$8.00	
H0018	THERAPEUTIC GROUP HOME PER DIEM		Day	0-20				$178.39
H0018	THERAPEUTIC GROUP HOME PER DIEM - CO-OCCURRING	HH	Day	0-20				$178.39
H0018	THERAPEUTIC GROUP HOME PER DIEM - SEXUAL OFFENDERS	HK	Day	0-20				$178.39
H0019	BEHAVIORAL HEALTH LONG TERM RESIDENTIAL - 3.3**	HF	Day	21+				$83.50
H0019	BEHAVIORAL HEALTH LONG TERM RESIDENTIAL - 3.3 ROOM AND BOARD**	SE, HF	Day	21+				$21.50
H0036	COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT INDIVIDUAL OFFICE		15 min	0+	$18.06	$14.87	$14.87	
H0036	COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT INDIVIDUAL COMMUNITY	U8	15 min	0+	$20.28	$16.85	$16.85	
H0036	COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT - HOMEBUILDERS	HK	15 min	0+	$37.03	$30.61		
H0036	COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT - FUNCTIONAL FAMILY THERAPY	HE	15 min	0+	$38.55	$31.70		
H0036	COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT - PSH INDIVIDUAL OFFICE	TG	15 min	0+	$19.00	$15.60	$15.60	
H0036	COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT - PSH INDIVIDUAL COMMUNITY	TG, U8	15 min	0+	$21.30	$17.70	$17.70	
H0039	ASSERTIVE COMMUNITY TREATMENT - NON PHYSICIAN PER DIEM		Day	18-20	$151.11	$112.63	$86.04	
H0039	ASSERTIVE COMMUNITY TREATMENT - PHYSICIAN PER DIEM	AM	Day	18-20				$373.88
H0039	ASSERTIVE COMMUNITY TREATMENT - 1ST MONTH IF ENROLLED 1-10TH DAY OF MONTH	U1	Month	21+				$1,100.00
H0039	ASSERTIVE COMMUNITY TREATMENT - 1ST MONTH IF ENROLLED 11-20TH DAY OF MONTH	U2	Month	21+				$900.00
H0039	ASSERTIVE COMMUNITY TREATMENT - 1ST MONTH IF ENROLLED 21-31ST DAY OF MONTH	U3	Month	21+				$750.00
H0039	ASSERTIVE COMMUNITY TREATMENT - SUBSEQUENT MONTHS		Month	21+				$1,100.00
H0045	CRISIS STABILIZATION – INDIVIDUAL - EFFECTIVE 10/01/16	HA	Day	0-20				$180.00
H2011	CRISIS INTERVENTION FOLLOW UP		15 min	0-20	$31.69	$31.69	$23.17	
H2011	CRISIS INTERVENTION FOLLOW UP		15 min	21+	$31.69	$31.69	$23.17	
H2013	PSYCHIATRIC HEALTH FACILITY SERVICE PER DIEM - PRTF		Day	0-20				$335.49
H2013	PSYCHIATRIC HEALTH FACILITY SERVICE PER DIEM - PRTF (SPECIALIZED)	TG	Day	0-20				$335.49
H2013	PSYCHIATRIC HEALTH FACILITY SERVICE PER DIEM - PRTF (SPECIALIZED ASAM 3.7)	TG, HF	Day	0-20				$335.49
H2017	PSYCHOSOCIAL REHABILITATION INDIVIDUAL OFFICE		15 min	0+	$10.99	$10.99	$10.99	
H2017	PSYCHOSOCIAL REHABILITATION INDIVIDUAL COMMUNITY	U8	15 min	0+	$12.67	$12.67	$12.67	
H2017	PSYCHOSOCIAL REHABILITATION PSH INDIVIDUAL OFFICE	TG	15 min	0+	$10.99	$10.99	$10.99	
H2017	PSYCHOSOCIAL REHABILITATION PSH INDIVIDUAL COMMUNITY	TG, U8	15 min	0+	$12.67	$12.67	$12.67	
H2017	PSYCHOSOCIAL REHABILITATION GROUP OFFICE	HQ	15 min	0-20	$2.20	$2.20	$2.20	
H2017	PSYCHOSOCIAL REHABILITATION GROUP COMMUNITY	U8, HQ	15 min	0-20	$2.53	$2.53	$2.53	
H2017	PSYCHOSOCIAL REHABILITATION PSH GROUP OFFICE	TG, HQ	15 min	0-20	$2.20	$2.20	$2.20	
H2017	PSYCHOSOCIAL REHABILITATION PSH GROUP COMMUNITY	TG, U8, HQ	15 min	0-20	$2.53	$2.53	$2.53	
H2017	PSYCHOSOCIAL REHABILITATION GROUP OFFICE	HQ	15 min	21+	$1.37	$1.37	$1.37	
H2017	PSYCHOSOCIAL REHABILITATION GROUP COMMUNITY	U8, HQ	15 min	21+	$1.59	$1.59	$1.59	
H2017	PSYCHOSOCIAL REHABILITATION PSH GROUP OFFICE	TG, HQ	15 min	21+	$1.37	$1.37	$1.37	
H2017	PSYCHOSOCIAL REHABILITATION PSH GROUP COMMUNITY	TG, U8, HQ	15 min	21+	$1.59	$1.59	$1.59	
H2033	MULTI SYSTEMIC THERAPY - 12 - 17 YEAR OLD TARGET POPULATION		15 min	0-20	$36.01	$30.23		
H2034	ALCOHOL AND/OR DRUG SERVICES - HALFWAY HOUSE 3.1		Day	0-20				$60.15
H2034	ALCOHOL AND/OR DRUG SERVICES - HALFWAY HOUSE 3.1**		Day	21+				$70.30
H2034	ALCOHOL AND/OR DRUG SERVICES - HALFWAY HOUSE 3.1 ROOM AND BOARD**	SE	Day	21+				$14.70
H2036	ALCOHOL AND/OR DRUG TREATMENT PROGRAM - 3.5		Day	0+				$212.47
H2036	ALCOHOL AND/OR DRUG TREATMENT PROGRAM - 3.5 ROOM AND BOARD**	SE	Day	21+				$31.62
H2036	ALCOHOL AND/OR DRUG TREATMENT PROGRAM - 3.7**	TG	Day	21+				$290.00
H2036	ALCOHOL AND/OR DRUG TREATMENT PROGRAM - 3.7 ROOM AND BOARD**	SE, TG	Day	21+				$56.26
S9485	CRISIS INTERVENTION PER DIEM		Day	0-20	$353.65	$353.65	$278.05	
S9485	CRISIS INTERVENTION PER DIEM		Day	21+	$353.65	$353.65	$278.05	

*Note: Add Age and Degree Level Modifiers as applicable which are indicated in columns E-H. If service is provided by an LMHP, code accordingly

**Note: Specified services are not State Plan services when provided to adults between the ages of 21-64 in an Institute of Mental Disease (IMD). Services were historically covered under LBHP at the rates listed.

COMMONLY USED MODIFIERS FOR BILLING		
AF	PSYCHIATRIST	Used to bill for services provided by a Psychiatrist
AH	CLINICAL PSYCHOLOGIST	Used to bill for services provided by a Psychologist
AJ	CLINICAL SOCIAL WORKER	Used to bill for services provided by a LCSW
AM	PHYSICIAN, TEAM MEMBER SERVICE	Used to bill Physician's rate for ACT - H0039
SA	APRN, CNS, PHYSICIANS ASSISTANT	Used to bill for services provided by an APRN, CNS or PA
GC	RESIDENT	Used to bill for services provided by a Resident
GT	TELEMEDICINE	Used to bill for services (CPT code) provided via teleheath
HA	CHILD/ADOLESCENT PROGRAM	Used to bill for a service provided to a child or adolescent to distinguish rate
HB	ADULT PROGRAM	Used to bill for a service provided to an adult to distinguish rate
HE	MENTAL HEALTH PROGRAM	Used to bill CPST - Functional Family Therapy - H0036
HF	SUBSTANCE USE PROGRAM	Used to bill ASAM 3.3 - H0019
HF	SUBSTANCE USE PROGRAM	Used to bill for Alcohol and/or Drug Services Individual provided by an unlicensed provider - H0004
HH	INTEGRATED MENTAL HEALTH/SUBSTANCE USE PROGRAM	Used to bill TGH - Co-occurring - H0018
HK	SPECIALIZED MENTAL HEALTH PROGRAMS FOR HIGH RISK POPULATIONS	Used to bill CPST - Homebuilders - H0036
HK	SPECIALIZED MENTAL HEALTH PROGRAMS FOR HIGH RISK POPULATIONS	Used to bill TGH - Sexual Offenders - H0018
HM	LESS THAN BACHELORS DEGREE LEVEL	Used to bill for clinician with less than a Bachelors degree
HN	BACHELORS DEGREE LEVEL	Used to bill for clinician with a Bachelors degree
HO	MASTERS DEGREE LEVEL	Used to bill for clinician with a Masters degree
HP	DOCTORAL DEGREE LEVEL/MEDICAL PSYCHOLOGIST	Used to bill for services provided by a Medical Psychologist, effective 7/1/16
HQ	GROUP SETTING	Used to bill for services provided in a group setting
HR	FAMILY/COUPLE WITH CLIENT PRESENT	Used to bill family therapy specifically - H0005
HS	FAMILY/COUPLE WITHOUT CLIENT PRESENT	Used to bill family therapy specifically - H0005
SE	STATE AND/OR FEDERALLY-FUNDED PROGRAMS/SERVICES	Used to bill for room and board for residential treatment for adults
TD	REGISTERED NURSE	Used to bill for services provided by a Registered Nurse
TG	COMPLEX HIGH TECH LEVEL OF CARE	Used to bill for ASAM 3.7 - H2036
TG	COMPLEX HIGH TECH LEVEL OF CARE	Used to bill Specialized PRTF - H2013
TG	COMPLEX HIGH TECH LEVEL OF CARE	Used to bill 3.7-WM - H0011
TG	COMPLEX HIGH TECH LEVEL OF CARE	Used with 'HF' modifier to bill PRTF providing ASAM 3.7 - H2013
TG	COMPLEX HIGH TECH LEVEL OF CARE	Used to bill CPST and PSR under Permanent Supportive Housing (PSH) - H0036, H2017
TH	OBSTETRICAL TREATMENT/SERVICES, PRENATAL OR POSTPARTUM	Used to bill for services provided prenatally or postpartum (Age 10-59)
TS	FOLLOW UP SERVICES	Used to bill for services provided subsequent to initial service billed
U8	SERVICES PROVIDED IN NATURAL ENVIRONMENT	Used to bill for services provided in the community - H0036, H2017

SPECIALIZED BEHAVIORAL HEALTH SERVICES - PROVIDER SPECIFIC RATES (V3 Effective 7.1.18)

Code	Description	Provider Name	Modifier	Unit	Rate
N/A	INPATIENT PSYCHIATRIC TREATMENT PER DIEM (Effective 12/1/15-12/31/17) The standard Medicaid "Inpatient Hospital Per Diems" fee schedule rate is effective from 1/1/18 forward.	Northlake Behavioral Health Services		Day	$581.11
N/A	INPATIENT PSYCHIATRIC TREATMENT PER DIEM; ADULT ONLY (Effective 12/1/15-12/31/17) The standard Medicaid "Inpatient Hospital Per Diems" fee schedule rate is effective from 1/1/18 forward.	Brentwood Hospital		Day	$548.06
N/A	INPATIENT PSYCHIATRIC TREATMENT PER DIEM; CHILD ONLY	Children's Hospital - New Orleans DPP		Day	$669.64
90791	PSYCHIATRIC DIAGNOSTIC EVALUATION BY PSYCHIATRIST	Addiction Recovery	AF	Visit	$150.00
90791	PSYCHIATRIC DIAGNOSTIC EVALUATION BY PSYCHIATRIST	Addiction Counseling and Educational Resources, Inc.	AF	Visit	$150.00
H0014	ALCOHOL AND/OR DRUG SERVICES - AMBULATORY DETOXIFICATION 2-WM	Addiction Counseling and Educational Resources, Inc.		Day	$225.00
H0015	ALCOHOL AND/OR DRUG SERVICES - INTENSIVE OUTPATIENT 2.1 INDIVIDUAL	Addiction Counseling and Educational Resources, Inc.	HM	15 min.	$25.00
		Addiction Counseling and Educational Resources, Inc.	HN or HO	15 min.	$25.00
H2017	PSYCHOSOCIAL REHABILITATION GROUP OFFICE	VOA North Louisiana	HB,HQ	15 min.	$2.10
	PSYCHOSOCIAL REHABILITATION GROUP COMMUNITY	VOA North Louisiana	HB,HQ	15 min.	$2.10
	PSYCHOSOCIAL REHABILITATION - 1ST MONTH IF ENROLLED 1-10TH DAY OF MONTH	VOA North Louisiana	HB,U1	Month	$900.00
	PSYCHOSOCIAL REHABILITATION - 1ST MONTH IF ENROLLED 11-20TH DAY OF MONTH	VOA North Louisiana	HB,U2	Month	$600.00
	PSYCHOSOCIAL REHABILITATION - 1ST MONTH IF ENROLLED 21-31ST DAY OF MONTH	VOA North Louisiana	HB,U3	Month	$300.00
	PSYCHOSOCIAL REHABILITATION - SUBSEQUENT MONTHS	VOA North Louisiana	HB	Month	$900.00
H2013	PSYCHIATRIC HEALTH FACILITY SERVICE PER DIEM - PRTF	Louisiana Methodist Children's Home - Greater New Orleans		Day	$456.62
	PSYCHIATRIC HEALTH FACILITY SERVICE PER DIEM - PRTF	Louisiana Methodist Children's Home - Ruston		Day	$421.15
	PSYCHIATRIC HEALTH FACILITY SERVICE PER DIEM - PRTF	Louisiana Methodist Children's Home - Sulphur		Day	$501.70
H0019	BEHAVIORAL HEALTH LONG TERM RESIDENTIAL - ASAM Level 3.3*	Resources for Human Development - Family House	HB, HF	Day	$156.15
H2034	ALCOHOL AND/OR DRUG SERVICES - HALFWAY HOUSE ASAM Level 3.1*	Resources for Human Development - Family House	HB, HF	Day	$111.15
H0045	CRISIS STABILIZATION – INDIVIDUAL **	Resources for Human Development - Metro Crisis Continuum	HB	Day	$390.50

Modifier	Description
U1	1st - 10th calendar day of the month
U2	11th - 20th calendar day of the month
U3	21st - 31st calendar day of the month

*Note: Specified services are not State Plan services when provided to adults between the ages of 21-64 in an Institute of Mental Disease (IMD). Services were historically covered under LBHP at the rates listed.

** Note: Crisis Stabilization, HB - Adult Only, is not a State Plan service when provided to adults ages 21 and over. Services were historically covered under LBHP at the rate listed for this provider only.

Appendix C:
Detailed Information for Exhibits Shown in Section III of the Report

Exhibit A.1 Source Data
Stratification of CY 2017 Adjudicated Claims by Header Source for Institutional and Professional Claim Types
By MCO, Combined (BH + Non-BH) Providers

	Institutional Header Claims					
	Original	Adjusted	Voided	Duplicate	Rejected	Total
All MCOs	3,907,795	905,014	42,431	44,197	62,232	4,961,669
Aetna	370,024	101,708	1,186	0	7	472,925
ACLA	614,925	114,104	24,939	6,055	17,017	777,040
Healthy Blue	720,024	185,405	12,266	10,022	1,955	929,672
LHCC	958,534	272,314	0	28,120	43,242	1,302,210
UHC	1,244,288	231,483	4,040	0	11	1,479,822

	Professional Header Claims					
	Original	Adjusted	Voided	Duplicate	Rejected	Total
All MCOs	18,997,754	902,826	129,199	213,492	474,776	20,718,047
Aetna	1,269,098	194,003	17,337	0	7	1,480,445
ACLA	2,801,047	120,427	64,373	54,654	113,222	3,153,723
Healthy Blue	2,800,558	107,158	31,595	67,757	3,080	3,010,148
LHCC	6,101,452	213,649	0	91,081	358,439	6,764,621
UHC	6,025,599	267,589	15,894	0	28	6,309,110

	Institutional Header Dollars					
	Original	Adjusted	Voided	Duplicate	Rejected	Total
All MCOs	1,470,388,811	268,566,813	169,496	29,988,555	0	1,769,113,674
Aetna	156,236,873	6,275,904	0	0	0	162,512,778
ACLA	226,495,133	49,656,699	11,198	46	0	276,163,075
Healthy Blue	261,115,064	45,415,346	0	0	0	306,530,410
LHCC	365,012,978	71,194,947	0	29,988,509	0	466,196,435
UHC	461,528,763	96,023,916	158,298	0	0	557,710,977

	Professional Header Dollars					
	Original	Adjusted	Voided	Duplicate	Rejected	Total
All MCOs	1,633,877,630	86,018,209	235,699	7,483,310	0	1,727,614,848
Aetna	118,431,191	2,124,799	0	0	0	120,555,990
ACLA	225,544,872	13,551,444	2,579	11,493	0	239,110,388
Healthy Blue	225,041,449	19,212,250	0	0	0	244,253,699
LHCC	528,473,922	17,873,814	0	7,471,817	0	553,819,553
UHC	536,386,196	33,255,902	233,120	0	0	569,875,218

Exhibit A.1.1 Source Data
Stratification of CY 2017 Adjudicated Claims by Header Source for Institutional and Professional Claim Types
By MCO, Behavioral Health Providers ONLY

	Institutional Header Claims				
	Original	**Adjusted**	**Voided**	**Duplicate**	**Total**
All MCOs	545,204	136,153	7,829	8,025	697,211
Aetna	61,210	17,900	193	0	79,303
ACLA	95,959	19,321	5,452	1,179	121,911
Healthy Blue	105,233	29,442	1,605	1,433	137,713
LHCC	116,040	36,479	0	5,413	157,932
UHC	166,762	33,011	579	0	200,352

	Professional Header Claims				
	Original	**Adjusted**	**Voided**	**Duplicate**	**Total**
All MCOs	4,199,914	202,403	3,851	20,640	4,426,808
Aetna	242,283	49,556	40	0	291,879
ACLA	631,802	36,432	1,966	36	670,236
Healthy Blue	730,062	31,528	173	0	761,763
LHCC	1,343,175	23,167	0	20,604	1,386,946
UHC	1,252,592	61,720	1,672	0	1,315,984

	Institutional Header Dollars				
	Original	**Adjusted**	**Voided**	**Duplicate**	**Total**
All MCOs	273,350,642	49,848,910	51,372	4,596,973	327,847,897
Aetna	30,288,909	191,748	0	0	30,480,657
ACLA	48,044,773	9,051,713	64	46	57,096,596
Healthy Blue	53,483,077	7,200,068	0	0	60,683,145
LHCC	59,008,170	12,320,512	0	4,596,927	75,925,610
UHC	82,525,713	21,084,868	51,308	0	103,661,889

	Professional Header Dollars				
	Original	**Adjusted**	**Voided**	**Duplicate**	**Total**
All MCOs	567,345,561	33,059,041	198,655	3,178,464	603,781,721
Aetna	39,604,670	771,594	0	0	40,376,264
ACLA	84,228,456	5,461,764	379	635	89,691,233
Healthy Blue	91,179,455	9,753,375	0	0	100,932,830
LHCC	182,949,693	3,462,099	0	3,177,830	189,589,622
UHC	169,383,287	13,610,208	198,275	0	183,191,770

Note: Rejected claims are not broken out between BH and non-BH because the provider ID is not always stored to differentiate.

Exhibit A.1.2 Source Data
Stratification of CY 2017 Adjudicated Claims by Header Source for Institutional and Professional Claim Types
By MCO, Non-Behavioral Health Providers ONLY

	Institutional Header Claims				
	Original	**Adjusted**	**Voided**	**Duplicate**	**Total**
All MCOs	3,362,591	768,861	34,602	36,172	4,202,226
Aetna	308,814	83,808	993	0	393,615
ACLA	518,966	94,783	19,487	4,876	638,112
Healthy Blue	614,791	155,963	10,661	8,589	790,004
LHCC	842,494	235,835	0	22,707	1,101,036
UHC	1,077,526	198,472	3,461	0	1,279,459

	Professional Header Claims				
	Original	**Adjusted**	**Voided**	**Duplicate**	**Total**
All MCOs	14,797,840	700,423	125,348	192,852	15,816,463
Aetna	1,026,815	144,447	17,297	0	1,188,559
ACLA	2,169,245	83,995	62,407	54,618	2,370,265
Healthy Blue	2,070,496	75,630	31,422	67,757	2,245,305
LHCC	4,758,277	190,482	0	70,477	5,019,236
UHC	4,773,007	205,869	14,222	0	4,993,098

	Institutional Header Dollars				
	Original	**Adjusted**	**Voided**	**Duplicate**	**Total**
All MCOs	1,197,038,169	218,717,903	118,124	25,391,582	1,441,265,777
Aetna	125,947,964	6,084,156	0	0	132,032,121
ACLA	178,450,360	40,604,985	11,134	0	219,066,479
Healthy Blue	207,631,987	38,215,278	0	0	245,847,265
LHCC	306,004,808	58,874,435	0	25,391,582	390,270,825
UHC	379,003,050	74,939,048	106,990	0	454,049,088

	Professional Header Dollars				
	Original	**Adjusted**	**Voided**	**Duplicate**	**Total**
All MCOs	1,066,532,069	52,959,168	37,044	4,304,846	1,123,833,127
Aetna	78,826,520	1,353,205	0	0	80,179,725
ACLA	141,316,417	8,089,680	2,199	10,858	149,419,154
Healthy Blue	133,861,994	9,458,874	0	0	143,320,869
LHCC	345,524,229	14,411,715	0	4,293,988	364,229,931
UHC	367,002,909	19,645,693	34,845	0	386,683,447

Note: Rejected claims are not broken out between BH and non-BH because the provider ID is not always stored to differentiate.

Exhibit A.2 Source Data
Stratification of CY 2017 Adjudicated Claims by Header Source for Dental and Pharmacy Claim Types
By MCO, Combined (BH + Non-BH) Providers

	Dental Header Claims					
	Original	**Adjusted**	**Voided**	**Duplicate**	**Rejected**	**Total**
All MCOs	1,136,975	15,704	140	13,223	364	1,166,406
Aetna	21,498	236	24	0	0	21,758
ACLA	32,859	91	46	0	0	32,996
Healthy Blue	35,937	1,044	46	0	364	37,391
LHCC	LHCC had no dental claims to report.					
UHC	86,020	0	0	0	0	86,020
MCNA	960,661	14,333	24	13,223	0	988,241

	Pharmacy Header Claims					
	Original	**Adjusted**	**Voided**	**Duplicate**	**Rejected**	**Total**
All MCOs	24,376,053	3,715,373	674,695	446,924	585,211	29,798,256
Aetna	1,916,209	47,338	153,685	0	585,210	2,702,442
ACLA	3,593,251	213,360	346,133	442,569	0	4,595,313
Healthy Blue	3,508,139	992,569	174,877	4,355	0	4,679,940
LHCC	8,532,948	2,462,106	0	0	0	10,995,054
UHC	6,825,506	0	0	0	1	6,825,507

	Dental Header Dollars					
	Original	**Adjusted**	**Voided**	**Duplicate**	**Rejected**	**Total**
All MCOs	177,481,772	626,696	2,114	0	0	178,110,582
Aetna	1,768,296	26,214	90	0	0	1,794,600
ACLA	3,205,219	7,340	686	0	0	3,213,245
Healthy Blue	3,660,171	137,891	0	0	0	3,798,062
LHCC	LHCC had no dental claims to report.					
UHC	36,146,398	0	0	0	0	36,146,398
MCNA	132,701,687	455,251	1,338	0	0	133,158,276

	Pharmacy Header Dollars					
	Original	**Adjusted**	**Voided**	**Duplicate**	**Rejected**	**Total**
All MCOs	1,198,471,850	55,069,595	46,118,466	0	0	1,299,659,911
Aetna	105,139,654	3,652,979	25,369,329	0	0	134,161,962
ACLA	164,524,057	11,998,923	20,749,137	0	0	197,272,117
Healthy Blue	199,223,476	37,756,216	0	0	0	236,979,692
LHCC	360,452,790	1,661,478	0	0	0	362,114,268
UHC	369,131,873	0	0	0	0	369,131,873

Exhibit B.1 Source Data

Stratification of CY 2017 Adjudicated Claims by Adjudication Status for Institutional, Professional, Dental and Pharmacy Claim Types

By MCO, Combined (BH + Non-BH) Providers

	Institutional Header Claims			
	Paid	**Denied**	**Pended**	**Total**
All MCOs	4,480,263	417,903	52,776	4,950,942
Aetna	434,817	36,915	1,628	473,360
ACLA	672,031	87,992	9,524	769,547
Healthy Blue	855,499	72,218	24	927,741
LHCC	1,169,125	89,758	41,579	1,300,462
UHC	1,348,791	131,020	21	1,479,832

	Professional Header Claims			
	Paid	**Denied**	**Pended**	**Total**
All MCOs	17,810,406	2,415,364	258,358	20,484,128
Aetna	1,287,333	175,768	24,313	1,487,414
ACLA	2,638,591	401,900	39,366	3,079,857
Healthy Blue	2,600,736	406,332	98	3,007,166
LHCC	5,836,593	569,435	193,939	6,599,967
UHC	5,447,153	861,929	642	6,309,724

	Dental Header Claims			
	Paid	**Denied**	**Pended**	**Total**
All MCOs	1,103,936	62,106	13,661	1,179,703
Aetna	18,432	3,326	0	21,758
ACLA	28,167	4,829	0	32,996
Healthy Blue	32,587	4,440	617	37,644
LHCC	0	0	0	0
UHC	86,020	0	0	86,020
MCNA	938,730	49,511	13,044	1,001,285

	Pharmacy Header Claims			
	Paid	**Denied**	**Pended**	**Total**
All MCOs	21,182,587	7,658,871	0	28,841,458
Aetna	1,350,650	394,995	0	1,745,645
ACLA	3,153,271	1,442,042	0	4,595,313
Healthy Blue	2,984,645	1,695,295	0	4,679,940
LHCC	7,991,879	3,003,175	0	10,995,054
UHC	5,702,142	1,123,364	0	6,825,506

Note: LHCC had no dental claims to report.

Exhibit B.1.1 Source Data
Stratification of CY 2017 Adjudicated Claims by Adjudication Status for Institutional and Professional Claim Types
By MCO, Behavioral Health Providers and Non-Behavioral Health Providers SEPARATELY

BEHAVIORAL HEALTH PROVIDERS ONLY

	Institutional Header Claims		
	Paid	Denied	Total
All MCOs	622,872	74,144	697,016
Aetna	72,014	7,096	79,110
ACLA	106,193	15,718	121,911
Healthy Blue	124,772	12,941	137,713
LHCC	141,425	16,505	157,930
UHC	178,468	21,884	200,352

	Professional Header Claims		
	Paid	Denied	Total
All MCOs	4,426,680	82	4,426,762
Aetna	291,757	82	291,839
ACLA	670,236	0	670,236
Healthy Blue	761,763	0	761,763
LHCC	1,386,940	0	1,386,940
UHC	1,315,984	0	1,315,984

NON-BEHAVIORAL HEALTH PROVIDERS ONLY

	Institutional Header Claims		
	Paid	Denied	Total
All MCOs	3,857,391	343,759	4,201,150
Aetna	362,803	29,819	392,622
ACLA	565,838	72,274	638,112
Healthy Blue	730,727	59,277	790,004
LHCC	1,027,700	73,253	1,100,953
UHC	1,170,323	109,136	1,279,459

	Professional Header Claims		
	Paid	Denied	Total
All MCOs	13,383,726	2,415,282	15,799,008
Aetna	995,576	175,686	1,171,262
ACLA	1,968,355	401,900	2,370,255
Healthy Blue	1,838,973	406,332	2,245,305
LHCC	4,449,653	569,435	5,019,088
UHC	4,131,169	861,929	4,993,098

Exhibit C.1 Source Data

Stratification of CY 2017 Adjudicated Claims by Adjudication Status for Institutional, Professional, Dental and Pharmacy Claim Types

By MCO, Combined (BH + Non-BH) Providers

	Institutional Header Claims (excl. pended)			
	Fully Paid	**At least 1 Detail Denied**	**Entire Claim Denied**	**Total**
All MCOs	3,792,831	687,432	417,903	4,898,166
Aetna	363,186	71,631	36,915	471,732
ACLA	549,482	122,549	87,992	760,023
Healthy Blue	643,224	212,275	72,218	927,717
LHCC	1,028,113	141,012	89,758	1,258,883
UHC	1,208,826	139,965	131,020	1,479,811

	Professional Header Claims (excl. pended)			
	Fully Paid	**At least 1 Detail Denied**	**Entire Claim Denied**	**Total**
All MCOs	16,267,600	1,542,806	2,415,364	20,225,770
Aetna	1,155,458	131,875	175,768	1,463,101
ACLA	2,305,136	333,455	401,900	3,040,491
Healthy Blue	2,170,817	429,919	406,332	3,007,068
LHCC	5,506,118	330,475	569,435	6,406,028
UHC	5,130,071	317,082	861,929	6,309,082

	Dental Header Claims (excl. pended)			
	Fully Paid	**At least 1 Detail Denied**	**Entire Claim Denied**	**Total**
All MCOs	966,107	137,829	62,106	1,166,042
Aetna	13,567	4,865	3,326	21,758
ACLA	23,012	5,155	4,829	32,996
Healthy Blue	26,852	5,735	4,440	37,027
LHCC	0	0	0	0
UHC	86,020	0	0	86,020
MCNA	816,656	122,074	49,511	988,241

Note: LHCC had no dental claims to report.

	Pharmacy Header Claims (excl. pended)			
	Fully Paid	**At least 1 Detail Denied**	**Entire Claim Denied**	**Total**
All MCOs	21,182,587	0	7,658,871	28,841,458
Aetna	1,350,650	0	394,995	1,745,645
ACLA	3,153,271	0	1,442,042	4,595,313
Healthy Blue	2,984,645	0	1,695,295	4,679,940
LHCC	7,991,879	0	3,003,175	10,995,054
UHC	5,702,142	0	1,123,364	6,825,506

Exhibit C.1.1 Source Data
Stratification of CY 2017 Adjudicated Claims by Adjudication Status for Institutional and Professional Claim Types
By MCO, Behavioral Health Providers and Non-Behavioral Health Providers SEPARATELY

BEHAVIORAL HEALTH PROVIDERS ONLY

	Institutional Header Claims (excl. pended)			
	Fully Paid	At least 1 Detail Denied	Entire Claim Denied	Total
All MCOs	516,326	106,546	74,144	697,016
Aetna	60,173	11,841	7,096	79,110
ACLA	88,450	17,743	15,718	121,911
Healthy Blue	86,146	38,626	12,941	137,713
LHCC	124,160	17,265	16,505	157,930
UHC	157,397	21,071	21,884	200,352

	Professional Header Claims (excl. pended)			
	Fully Paid	At least 1 Detail Denied	Entire Claim Denied	Total
All MCOs	4,139,457	287,223	82	4,426,762
Aetna	279,027	12,730	82	291,839
ACLA	586,248	83,988	0	670,236
Healthy Blue	632,057	129,706	0	761,763
LHCC	1,348,882	38,058	0	1,386,940
UHC	1,293,243	22,741	0	1,315,984

NON-BEHAVIORAL HEALTH PROVIDERS ONLY

	Institutional Header Claims (excl. pended)			
	Fully Paid	At least 1 Detail Denied	Entire Claim Denied	Total
All MCOs	3,276,505	580,886	343,759	4,201,150
Aetna	303,013	59,790	29,819	392,622
ACLA	461,032	104,806	72,274	638,112
Healthy Blue	557,078	173,649	59,277	790,004
LHCC	903,953	123,747	73,253	1,100,953
UHC	1,051,429	118,894	109,136	1,279,459

	Professional Header Claims (excl. pended)			
	Fully Paid	At least 1 Detail Denied	Entire Claim Denied	Total
All MCOs	12,128,143	1,255,583	2,415,282	15,799,008
Aetna	876,431	119,145	175,686	1,171,262
ACLA	1,718,888	249,467	401,900	2,370,255
Healthy Blue	1,538,760	300,213	406,332	2,245,305
LHCC	4,157,236	292,417	569,435	5,019,088
UHC	3,836,828	294,341	861,929	4,993,098

Exhibit D.1 Source Data
Stratification of CY 2017 Adjudicated Claims by Header Pended Status for Institutional and Professional Claim Types
By MCO, Combined (BH + Non-BH) Providers

	Institutional Header Claims		
	Ever Pended=Yes	**Ever Pended=No**	**Total**
All MCOs	1,192,032	3,707,405	4,899,437
Aetna	85,486	387,432	472,918
ACLA	133,195	626,828	760,023
Healthy Blue	438,355	489,362	927,717
LHCC	202,537	1,056,431	1,258,968
UHC	332,459	1,147,352	1,479,811

	Professional Header Claims		
	Ever Pended=Yes	**Ever Pended=No**	**Total**
All MCOs	2,955,299	17,287,972	20,243,271
Aetna	201,520	1,278,918	1,480,438
ACLA	457,574	2,582,927	3,040,501
Healthy Blue	774,257	2,232,811	3,007,068
LHCC	531,133	5,875,049	6,406,182
UHC	990,815	5,318,267	6,309,082

	Institutional Header Dollars		
	Ever Pended=Yes	**Ever Pended=No**	**Total**
All MCOs	992,499,884	776,613,790	1,769,113,674
Aetna	111,394,005	51,118,773	162,512,778
ACLA	182,318,990	93,844,085	276,163,075
Healthy Blue	203,326,877	103,203,532	306,530,410
LHCC	223,019,757	243,176,677	466,196,435
UHC	272,440,255	285,270,722	557,710,977

	Professional Header Dollars		
	Ever Pended=Yes	**Ever Pended=No**	**Total**
All MCOs	316,371,352	1,411,243,495	1,727,614,848
Aetna	21,938,077	98,617,913	120,555,990
ACLA	39,347,704	199,762,684	239,110,388
Healthy Blue	82,120,105	162,133,594	244,253,699
LHCC	71,513,475	482,306,078	553,819,553
UHC	101,451,991	468,423,227	569,875,218

Exhibit D.1.1 Source Data
Stratification of CY 2017 Adjudicated Claims by Header Pended Status for Institutional and Professional Claim Types
By MCO, Behavioral Health Providers ONLY

	Institutional Header Claims		
	Ever Pended=Yes	**Ever Pended=No**	**Total**
All MCOs	210,513	486,698	697,211
Aetna	18,425	60,878	79,303
ACLA	29,386	92,525	121,911
Healthy Blue	71,272	66,441	137,713
LHCC	31,738	126,194	157,932
UHC	59,692	140,660	200,352

	Professional Header Claims		
	Ever Pended=Yes	**Ever Pended=No**	**Total**
All MCOs	692,061	3,734,747	4,426,808
Aetna	34,683	257,196	291,879
ACLA	134,258	535,978	670,236
Healthy Blue	223,360	538,403	761,763
LHCC	90,806	1,296,140	1,386,946
UHC	208,954	1,107,030	1,315,984

	Institutional Header Dollars		
	Ever Pended=Yes	**Ever Pended=No**	**Total**
All MCOs	191,293,140	136,554,757	327,847,897
Aetna	24,429,390	6,051,268	30,480,657
ACLA	43,954,072	13,142,524	57,096,596
Healthy Blue	39,425,900	21,257,245	60,683,145
LHCC	31,155,426	44,770,183	75,925,610
UHC	52,328,352	51,333,537	103,661,889

	Professional Header Dollars		
	Ever Pended=Yes	**Ever Pended=No**	**Total**
All MCOs	132,558,552	471,223,168	603,781,721
Aetna	7,654,602	32,721,662	40,376,264
ACLA	21,611,901	68,079,333	89,691,233
Healthy Blue	39,343,740	61,589,090	100,932,830
LHCC	24,557,020	165,032,602	189,589,622
UHC	39,391,289	143,800,481	183,191,770

Exhibit D.1.2 Source Data
Stratification of CY 2017 Adjudicated Claims by Header Pended Status for Institutional and Professional Claim Types
By MCO, Non-Behavioral Health Providers ONLY

	Institutional Header Claims		
	Ever Pended=Yes	**Ever Pended=No**	**Total**
All MCOs	981,519	3,220,707	4,202,226
Aetna	67,061	326,554	393,615
ACLA	103,809	534,303	638,112
Healthy Blue	367,083	422,921	790,004
LHCC	170,799	930,237	1,101,036
UHC	272,767	1,006,692	1,279,459

	Professional Header Claims		
	Ever Pended=Yes	**Ever Pended=No**	**Total**
All MCOs	2,263,238	13,553,225	15,816,463
Aetna	166,837	1,021,722	1,188,559
ACLA	323,316	2,046,949	2,370,265
Healthy Blue	550,897	1,694,408	2,245,305
LHCC	440,327	4,578,909	5,019,236
UHC	781,861	4,211,237	4,993,098

	Institutional Header Dollars		
	Ever Pended=Yes	**Ever Pended=No**	**Total**
All MCOs	801,206,745	640,059,033	1,441,265,777
Aetna	86,964,615	45,067,505	132,032,121
ACLA	138,364,918	80,701,562	219,066,479
Healthy Blue	163,900,978	81,946,287	245,847,265
LHCC	191,864,331	198,406,494	390,270,825
UHC	220,111,903	233,937,185	454,049,088

	Professional Header Dollars		
	Ever Pended=Yes	**Ever Pended=No**	**Total**
All MCOs	183,812,800	940,020,327	1,123,833,127
Aetna	14,283,475	65,896,251	80,179,725
ACLA	17,735,803	131,683,351	149,419,154
Healthy Blue	42,776,365	100,544,504	143,320,869
LHCC	46,956,455	317,273,476	364,229,931
UHC	62,060,702	324,622,745	386,683,447

Exhibit D.2 Source Data
Stratification of CY 2017 Adjudicated Claims by Header Pended Status for Dental and Pharmacy Claim Types
By MCO, Combined (BH + Non-BH) Providers

	Dental Header Claims		
	Ever Pended=Yes	**Ever Pended=No**	Total
All MCOs	187,589	978,453	1,166,042
Aetna	0	21,758	21,758
ACLA	0	32,996	32,996
Healthy Blue	0	37,027	37,027
LHCC	LHCC had no dental claims to report.		
UHC	0	86,020	86,020
MCNA	187,589	800,652	988,241

	Pharmacy Header Claims		
	Ever Pended=Yes	**Ever Pended=No**	Total
All MCOs	0	29,213,045	29,213,045
Aetna	0	2,117,232	2,117,232
ACLA	0	4,595,313	4,595,313
Healthy Blue	0	4,679,940	4,679,940
LHCC	0	10,995,054	10,995,054
UHC	0	6,825,506	6,825,506

	Dental Header Dollars		
	Ever Pended=Yes	**Ever Pended=No**	**Total**
All MCOs	47,185,519	130,925,062	178,110,581
Aetna	0	1,794,600	1,794,600
ACLA	0	3,213,245	3,213,245
Healthy Blue	0	3,798,062	3,798,062
LHCC	LHCC had no dental claims to report.		
UHC	0	36,146,398	36,146,398
MCNA	47,185,519	85,972,757	133,158,276

	Pharmacy Header Dollars		
	Ever Pended=Yes	**Ever Pended=No**	**Total**
All MCOs	0	1,299,659,912	1,299,659,912
Aetna	0	134,161,962	134,161,962
ACLA	0	197,272,117	197,272,117
Healthy Blue	0	236,979,692	236,979,692
LHCC	0	362,114,268	362,114,268
UHC	0	369,131,873	369,131,873

Exhibit E.1 Source Data
Stratification of CY 2017 Adjudicated Claims by Turnaround Time (using average days)
By MCO, Combined (BH + Non-BH) Providers, Paid and Denied Claims COMBINED

	Institutional Header Claims		
	Recvd to Adjudicated	Adjudicated to Notice	Total
All MCOs	13.9	3.1	16.2
Aetna	20.1	5.5	25.5
ACLA	14.3	1.4	15.7
Healthy Blue	8.5	2.0	10.5
LHCC	8.3	0.0	8.3
UHC	20.0	6.6	26.6

	Professional Header Claims		
	Recvd to Adjudicated	Adjudicated to Notice	Total
All MCOs	8.4	4.3	11.9
Aetna	16.3	5.5	21.9
ACLA	8.7	1.3	9.9
Healthy Blue	5.1	1.8	6.8
LHCC	7.7	4.5	12.2
UHC	8.6	6.5	15.1

	Dental Header Claims		
	Recvd to Adjudicated	Adjudicated to Notice	Total
All MCOs	2.8	5.4	8.4
Aetna	4.5	0.0	4.5
ACLA	4.6	0.0	4.6
Healthy Blue	4.5	0.0	4.5
LHCC	LHCC had no dental claims to report.		
UHC	11.8	0.0	11.8
MCNA	1.9	6.4	8.3

	Pharmacy Header Claims		
	Recvd to Adjudicated	Adjudicated to Notice	Total
All MCOs	0.0	5.7	5.5
Aetna	0.0	8.2	0.0
ACLA	0.0	3.1	3.1
Healthy Blue	0.0	9.2	9.2
LHCC	0.0	2.6	2.6
UHC	0.0	9.4	9.4

Note: Value of 0 means events occurred on the same day (received to adjudicated or adjudicated to notified)

Exhibit E.1.1 Source Data
Stratification of CY 2017 Adjudicated Claims by Turnaround Time (using average days)
By MCO, Combined (BH + Non-BH) Providers, Paid and Denied Claims SEPARATELY

PAID CLAIMS ONLY

Institutional Header Claims

	Recvd to Adjudicated	Adjudicated to Notice	Total
All MCOs	13.9	3.2	17.1
Aetna	20.7	5.5	26.2
ACLA	14.0	1.6	15.6
Healthy Blue	7.4	2.2	9.6
LHCC	8.2	0.0	8.2
UHC	20.9	6.6	27.5

Professional Header Claims

	Recvd to Adjudicated	Adjudicated to Notice	Total
All MCOs	7.9	4.1	12.0
Aetna	15.9	5.6	21.5
ACLA	7.2	1.4	8.6
Healthy Blue	3.8	2.0	5.8
LHCC	7.6	3.7	11.3
UHC	8.6	6.5	15.1

Dental Header Claims

	Recvd to Adjudicated	Adjudicated to Notice	Total
All MCOs	2.8	5.5	8.3
Aetna	4.4	0.0	4.4
ACLA	4.4	0.0	4.4
Healthy Blue	4.4	0.0	4.4
LHCC	LHCC had no dental claims to report.		
UHC	11.8	0.0	11.8
MCNA	1.8	6.5	8.3

Pharmacy Header Claims

	Recvd to Adjudicated	Adjudicated to Notice	Total
All MCOs	0.0	7.1	7.1
Aetna	0.0	11.3	11.3
ACLA	0.0	3.3	3.3
Healthy Blue	0.0	13.7	13.7
LHCC	0.0	3.6	3.6
UHC	0.0	9.8	9.8

DENIED CLAIMS ONLY

Institutional Header Claims

	Recvd to Adjudicated	Adjudicated to Notice	Total
All MCOs	13.8	2.7	16.5
Aetna	11.3	4.9	16.2
ACLA	16.9	0.0	16.9
Healthy Blue	22.1	0.0	22.1
LHCC	9.9	0.0	9.9
UHC	10.5	7.4	17.9

Professional Header Claims

	Recvd to Adjudicated	Adjudicated to Notice	Total
All MCOs	11.2	5.4	16.6
Aetna	10.5	5.2	15.7
ACLA	18.5	0.0	18.5
Healthy Blue	13.1	0.0	13.1
LHCC	8.8	11.8	20.6
UHC	8.7	6.4	15.1

Dental Header Claims

	Recvd to Adjudicated	Adjudicated to Notice	Total
All MCOs	4.4	4.2	8.6
Aetna	5.0	0.0	5.0
ACLA	6.3	0.0	6.3
Healthy Blue	5.4	0.0	5.4
LHCC	LHCC had no dental claims to report.		
UHC	UHC had dental claims, but they were all paid.		
MCNA	4.1	5.3	9.4

Pharmacy Header Claims

	Recvd to Adjudicated	Adjudicated to Notice	Total
All MCOs	0.0	1.8	1.8
Aetna	0.0	0.1	0.1
ACLA	0.0	2.5	2.5
Healthy Blue	0.0	1.4	1.4
LHCC	0.0	0.0	0.0
UHC	0.0	7.1	7.1

Note: Value of 0 means events occurred on the same day (received to adjudicated or adjudicated to notified)

Exhibit E.2 Source Data
Stratification of CY 2017 Adjudicated Claims by Turnaround Time (using average days)
By MCO, Behavioral Health Providers ONLY, Paid and Denied Claims COMBINED

	Institutional Header Claims		
	Recvd to Adjudicated	Adjudicated to Notice	Total
All MCOs	14.5	3.3	17.8
Aetna	22.3	5.3	27.5
ACLA	13.5	1.3	14.9
Healthy Blue	9.4	2.0	11.4
LHCC	8.6	0.0	8.6
UHC	20.2	7.2	27.3

	Professional Header Claims		
	Recvd to Adjudicated	Adjudicated to Notice	Total
All MCOs	7.7	3.8	11.58
Aetna	18.2	5.6	23.79
ACLA	10.9	1.6	12.51
Healthy Blue	4.4	2.1	6.44
LHCC	7.7	1.7	9.33
UHC	5.9	7.9	13.75

Note: Value of 0 means events occurred on the same day (received to adjudicated or adjudicated to notified)

Exhibit E.2.1 Source Data
Stratification of CY 2017 Adjudicated Claims by Turnaround Time (using average days)
By MCO, Behavioral Health Providers ONLY, Paid and Denied Claims SEPARATELY

PAID CLAIMS ONLY

	Institutional Header Claims		
	Recvd to Adjudicated	Adjudicated to Notice	Total
All MCOs	14.5	3.3	17.8
Aetna	23.1	5.3	28.4
ACLA	12.9	1.5	14.4
Healthy Blue	8.3	2.2	10.5
LHCC	8.4	0.0	8.4
UHC	21.1	7.0	28.1

	Professional Header Claims		
	Recvd to Adjudicated	Adjudicated to Notice	Total
All MCOs	7.7	3.8	11.5
Aetna	18.2	5.6	23.8
ACLA	10.9	1.6	12.5
Healthy Blue	4.4	2.1	6.5
LHCC	7.7	1.7	9.4
UHC	5.9	7.9	13.8

DENIED CLAIMS ONLY

	Institutional Header Claims		
	Recvd to Adjudicated	Adjudicated to Notice	Total
All MCOs	14.4	3.0	17.4
Aetna	12.4	4.8	17.2
ACLA	18.2	0.0	18.2
Healthy Blue	19.2	0.0	19.2
LHCC	10.4	0.0	10.4
UHC	12.4	8.7	21.1

	Professional Header Claims		
	Recvd to Adjudicated	Adjudicated to Notice	Total
All MCOs	5.9	4.7	10.6
Aetna	5.9	4.7	10.6
ACLA	none reported	none reported	none reported
Healthy Blue	none reported	none reported	none reported
LHCC	none reported	none reported	none reported
UHC	none reported	none reported	none reported

Note: Value of 0 means events occurred on the same day (received to adjudicated or adjudicated to notified)

Exhibit E.3 Source Data
Stratification of CY 2017 Adjudicated Claims by Turnaround Time (using average days)
By MCO, Non-Behavioral Health Providers, Paid and Denied Claims COMBINED

	Institutional Header Claims		
	Recvd to Adjudicated	Adjudicated to Notice	Total
All MCOs	13.8	3.1	17.0
Aetna	19.6	5.5	25.1
ACLA	14.5	1.5	15.9
Healthy Blue	8.4	2.0	10.4
LHCC	8.2	0.0	8.2
UHC	20.0	6.6	26.5

	Professional Header Claims		
	Recvd to Adjudicated	Adjudicated to Notice	Total
All MCOs	8.6	4.4	13.0
Aetna	15.9	5.5	21.4
ACLA	8.0	1.1	9.2
Healthy Blue	5.3	1.7	7.0
LHCC	7.8	5.3	13.0
UHC	9.3	6.1	15.4

Note: Value of 0 means events occurred on the same day (received to adjudicated or adjudicated to notified)

Exhibit E.3.1 Source Data
Stratification of CY 2017 Adjudicated Claims by Turnaround Time (using average days)
By MCO, Non-Behavioral Health Providers ONLY, Paid and Denied Claims SEPARATELY

PAID CLAIMS ONLY

	Institutional Header Claims		
	Recvd to Adjudicated	Adjudicated to Notice	Total
All MCOs	13.8	3.2	17.0
Aetna	20.2	5.6	25.8
ACLA	14.2	1.6	15.8
Healthy Blue	7.2	2.2	9.4
LHCC	8.1	0.0	8.1
UHC	20.9	6.5	27.4

	Professional Header Claims		
	Recvd to Adjudicated	Adjudicated to Notice	Total
All MCOs	7.9	4.2	12.1
Aetna	15.2	5.7	20.9
ACLA	5.9	1.4	7.3
Healthy Blue	3.6	2.0	5.6
LHCC	7.6	4.4	12.0
UHC	9.4	6.1	15.5

DENIED CLAIMS ONLY

	Institutional Header Claims		
	Recvd to Adjudicated	Adjudicated to Notice	Total
All MCOs	13.7	2.7	16.4
Aetna	11.1	4.9	16.0
ACLA	16.6	0.0	16.6
Healthy Blue	22.7	0.0	22.7
LHCC	9.7	0.0	9.7
UHC	10.1	7.1	17.2

	Professional Header Claims		
	Recvd to Adjudicated	Adjudicated to Notice	Total
All MCOs	11.2	5.4	16.6
Aetna	10.5	5.2	15.7
ACLA	18.5	0.0	18.5
Healthy Blue	13.1	0.0	13.1
LHCC	8.8	11.8	20.6
UHC	8.7	6.4	15.1

Note: Value of 0 means events occurred on the same day (received to adjudicated or adjudicated to notified)

Exhibit F.1 Source Data
Stratification of CY 2017 Adjudicated Claims by Denial Reason (using occurrence at detail level)
By MCO, Combined (BH + Non-BH) Providers

	Institutional Detail CARC Occurrences		
	In top 5	All except top 5	Total
All MCOs	2,239,563	2,212,409	4,451,972
Aetna	391,883	255,212	647,095
ACLA	392,618	524,503	917,121
Healthy Blue	546,502	325,939	872,441
LHCC	365,818	355,032	720,850
UHC	542,742	751,723	1,294,465

	Professional Detail CARC Occcurrences		
	In top 5	All except top 5	Total
All MCOs	5,481,852	4,878,222	10,360,074
Aetna	517,345	495,997	1,013,342
ACLA	1,176,400	930,101	2,106,501
Healthy Blue	550,376	1,201,892	1,752,268
LHCC	996,241	1,040,431	2,036,672
UHC	2,241,490	1,209,801	3,451,291

	Dental Detail CARC Occurrences		
	In top 5	All except top 5	Total
All MCOs	278,387	155,932	434,319
Aetna	1,140	11,076	12,216
ACLA	1,285	17,870	19,155
Healthy Blue	1,511	17,012	18,523
LHCC	0	0	0
UHC	0	0	0
MCNA	274,451	109,974	384,425

	Pharmacy Detail NCPDP Occurrences		
	In top 5	All except top 5	Total
All MCOs	5,859,731	3,241,010	9,100,741
Aetna	337,630	112,371	450,001
ACLA	1,464,519	574,359	2,038,878
Healthy Blue	944,698	957,887	1,902,585
LHCC	2,290,158	1,295,755	3,585,913
UHC	822,726	300,638	1,123,364

Note: LHCC had no dental claims to report. UHC had dental claims, but they were all paid.

Exhibit F.1.1 Source Data
Stratification of CY 2017 Adjudicated Claims by Denial Reason (using occurrence at detail level)
By MCO, Behavioral Health Providers and Non-Behavioral Health Providers SEPARATELY

BEHAVIORAL HEALTH PROVIDERS ONLY

	Institutional Detail CARC Occurrences		
	In top 5	All except top 5	Total
All MCOs	360,845	354,346	715,191
Aetna	73,397	37,120	110,517
ACLA	51,184	81,342	132,526
Healthy Blue	90,466	70,861	161,327
LHCC	45,524	57,797	103,321
UHC	100,274	107,226	207,500

	Professional Detail CARC Occcurrences		
	In top 5	All except top 5	Total
All MCOs	208,465	337,622	546,087
Aetna	15,378	16,878	32,256
ACLA	103,108	41,779	144,887
Healthy Blue	26,669	221,464	248,133
LHCC	40,270	27,102	67,372
UHC	23,040	30,399	53,439

NON-BEHAVIORAL HEALTH PROVIDERS ONLY

	Institutional Detail CARC Occurrences		
	In top 5	All except top 5	Total
All MCOs	1,889,928	1,846,853	3,736,781
Aetna	318,607	217,971	536,578
ACLA	342,650	441,945	784,595
Healthy Blue	452,584	258,530	711,114
LHCC	323,580	293,949	617,529
UHC	452,507	634,458	1,086,965

	Professional Detail CARC Occcurrences		
	In top 5	All except top 5	Total
All MCOs	5,344,613	4,469,374	9,813,987
Aetna	501,218	479,868	981,086
ACLA	1,145,968	815,646	1,961,614
Healthy Blue	524,846	979,289	1,504,135
LHCC	962,532	1,006,768	1,969,300
UHC	2,210,049	1,187,803	3,397,852

Appendix B

Stakeholder Feedback Summary

- In a number of examples, the content and consistency of the data appears conflicting and questionable. Stakeholders recommended that LDH verify/validate data using the LDH encounter data. Going forward, the proposed encounter reconciliation report will provide for monthly monitoring of encounter submissions as compared to the MCO claims processed.
- Data being reported at the "header" level was another concern. It was recommended, at a minimum, that professional services claims be reported at the detail level.
- The claim type delineation into only four types: dental, pharmacy, institutional and professional is too aggregated for meaningful review. In order for the data to be useful, at a minimum, institutional claims should be separated by outpatient and inpatient and professional claims should be separated by DME, physician, home health and other service categories. This will be considered for a potential reporting supplement, but could not be accomplished in the initial reporting timeframe.
- The MCOs are not utilizing the same definitions in reporting the data. Some MCOs attribute a dollar amount to duplicate and voided claims and some do not. The stakeholder workgroup recommended reporting be performed utilizing the same definitions for the same terms/processes.
- It was also recommended to reprice denied claims based on the Medical fee schedule; however, this could not be performed in the timeframe for the initial report.
- The stakeholder group felt that LDH should consider that if at least one detail denied, then the claim should be considered denied for calculation of the denial percentage.
- It was further recommended that reporting be performed utilizing the same definitions for the same terms/processes and for pended claims, and that reporting claims that pended longer than 15 and 30 days would be a meaningful element.
- For 4 of the 5 MCO's, CARC 18 (exact duplicate) is in the top five CARCs used. The stakeholders expressed interest in understanding the rationale behind providers submitting a large percent of duplicate claims. They recommended that LD segregate claims (at the detail level) that were denied as duplicate and further analyze the cause to help inform the process relative to provider education, identification of system errors, delayed payments, etc.
- The disparity among the MCOs in numbers of beneficiaries eligible for case management indicates that different definitions are used for eligibility and likely for service delivery. It was recommended by the stakeholder group that all health plans be provided with consistent definitions of eligible populations and case management services for reporting purposes.

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

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