Healthy Louisiana Claims Report

Response to Act 710 of the 2018 Regular Legislative Session Quarter 2
Calendar Year 2020

Prepared by:

Louisiana Department of Health

Bureau of Health Services Financing

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LOUISIANA DEPARTMENT OF HEALTH

Contents

Executive Summary

Background

On June 1, 2018, the Louisiana State Legislature passed Act No. 710 which requires reporting of data on healthcare provider claims submitted to Medicaid managed care organizations (MCOs). The legislation required the Louisiana Department of Health ("the Department", or LDH) to produce and submit the "Healthy Louisiana Claims Report" to the Joint Legislative Committee on the Budget and to the House and Senate Committees on Health and Welfare.

The initial report covered claims paid during Calendar Year (CY) 2017 and was submitted to the legislature October 31, 2018. Subsequent reports are submitted on a quarterly basis. Each subsequent report shows the most recent four quarters of data available. This report covers Calendar Q3 and Q4 of 2019 and Q1 and Q2 of 2020.

The LDH has engaged Burns & Associates (B&A), a Division of Health Management Associates, to assist in the ongoing data collection, analysis and trending of these measures. B&A also assisted LDH with the initial Act 710 report submission and provided recommendations for future reporting. B&A's full analysis accompanies this Executive Summary.

Report Contents

The MCOs for which data is reported includes the five MCOs currently under contract to provide acute care, behavioral health and pharmacy services as well as a managed care entity that is under contract to deliver dental benefits only:

Plan Name	Plan Type	Common Abbreviation
Aetna Better Health, Inc.	Managed care organization	ABH
Amerihealth Caritas Louisiana, Inc.	Managed care organization	ACLA
Healthy Blue	Managed care organization	HB
Louisiana Healthcare Connections, Inc.	Managed care organization	LHCC
UnitedHealthcare of Louisiana, Inc.	Managed care organization	UHC
MCNA Insurance Company, Inc.	Dental benefit program manager (prepaid ambulatory health plan)	MCNA

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

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

The key measures that are reported on in each quarterly update include:

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

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

Key Findings

Measure #1: Claims Accepted and Rejected by the MCOs

- In the most recent four quarters for which data is available, the claims rejection rate reported by the Medicaid MCOs was between 1.3% and 1.4%. This rate, however, is driven primarily by LHCC (rejection rate of 3.5% to 3.7%) while the other MCOs have rejection rates close to zero.

Measure #2: Claims paid and denied by the MCOs

- The overall rate of paid claims accepted by the MCOs was between 81.5% and 82.5% in the most recent four quarters. The denial rates, therefore, were between 17.5% and 18.5%.

- At the MCO-specific level, the denial rate in the last four quarters was from a range of 16.9% for LHCC to 21.8% for ABH (this excludes MCNA's dental claims).

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

- More variation was found when the claims denial rates were examined by provider type. For example, the highest denial rates are found for inpatient hospital services (average 20.1% in the last four quarters) and pharmacy (average 26.7% in the last four quarters). The lowest denial rates are found for non-emergency medical transportation (average 3.4% in the last four quarters) and pediatric dental services (average 8.5% in the last four quarters).

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

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

- The MCOs are meeting the target for adjudication within 30 days as set by LDH. In fact, the average TAT is below 10 days in each of the last four quarters for all MCOs.

- The overall TAT for paid claims, all MCOs combined, is between 7.8 and 8.1 days in each quarter. For denied claims, the average is 6.0 days.

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

		Adjudicated Within 30 days		Avg Turnaround Time	
		Pct of Paid	Pct of Denied	Paid Claims	Denied Claims
Aetna	Q3 2019	99.9%	99.7%	7.8	5.8
	Q4 2019	99.9%	99.8%	7.9	6.0
	Q1 2020	99.9%	99.8%	8.1	5.9
	Q2 2020	99.7%	99.0%	8.3	6.0
ACLA	Q3 2019	100.0%	100.0%	5.7	6.7
	Q4 2019	100.0%	100.0%	5.7	7.3
	Q1 2020	100.0%	99.9%	5.2	6.0
	Q2 2020	100.0%	99.9%	5.4	6.5
Healthy Blue	Q3 2019	99.8%	99.6%	5.9	4.9
	Q4 2019	99.9%	99.6%	6.5	4.7
	Q1 2020	99.6%	99.6%	6.8	4.3
	Q2 2020	99.0%	98.7%	6.8	4.3
LHC	Q3 2019	99.8%	99.6%	8.7	9.8
	Q4 2019	99.6%	99.3%	8.8	9.7
	Q1 2020	99.7%	99.6%	8.8	9.6
	Q2 2020	99.8%	99.4%	9.0	9.6
UHC	Q3 2019	100.0%	99.9%	9.5	3.0
	Q4 2019	100.0%	99.9%	9.2	2.8
	Q1 2020	99.9%	100.0%	9.4	2.6
	Q2 2020	99.9%	99.5%	8.6	3.2
MCNA	Q3 2019	100.0%	100.0%	7.6	8.4
	Q4 2019	100.0%	100.0%	8.7	9.6
	Q1 2020	100.0%	100.0%	8.6	10.0
	Q2 2020	100.0%	100.0%	3.5	6.5

- Claims adjudication average TATs do vary by provider category, but not significantly, from the overall average.

Measure #4: Top Reason for Denied Claims

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

Some key findings on CARCs appear below:

- In Q2 2020, LHCC and UHC each had its top 5 CARCs within the top 10 CARCs statewide. ABH and ACLA had four, HB had three and MCNA had two of its top 5 CARCs in the statewide top 10.

- The top five CARCs were also among the top seven in the previous eight quarters reported.

Some key findings on NCPDPs appear below:

- In Q2 2020, ACLA and LHCC each had their top 5 NCPDP codes also in the top 10 for All MCOs. ABH and HB had 4 of its top 5 in the statewide top 10. UHC did not report data in the most recent quarter.

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

Measure #5: Encounter Claims Submitted to LDH by the MCOs that are Accepted and Rejected

- In the most recent four quarters studied, 98.5% to 98.9% of the encounters submitted by all MCOs combined were accepted by LDH.

- There were differences at the MCO level. All of UHC's and almost all of HB's encounters were accepted. For MCNA, the acceptance rate was at least 99% every quarter; for LHCC, at least 96%. ABH, ACLA and LHCC had varying acceptance rates in the last four quarters.

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

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

- For institutional encounters (mostly claims from hospitals), MCOs usually had at least 95% of their encounters submitted within 30 days each quarter.

- HB and UHC consistently have the highest rate of submission of professional encounters within 30 days. HB has had more than 95% in within that time in each of the last four quarters; ACLA and UHC has had more than 92% in within 30 days. ABH and LHCC had challenges with submissions in Q1 and Q2 2020.

- There is greater variation in the timeliness of pharmacy encounter submissions. HB has always had a high rate of pharmacy encounters submitted within 30 days (almost 100%). ACLA and UHC have had a high rate of timely submissions in most quarters. ABH and LHCC consistently are lowest with between 60-75% submitted within 30 days in most quarters.

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

Measure #7: Provider Education

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

In Q2 2020, a total of 1,324 provider entities were outreached to (up from 1,180 in the prior quarter). The most predominant mode to outreach to providers is 1:1 phone calls (50.0% of all contacts) followed by 1:1 email (40.6% of contacts). Webinars were 9.4 percent of the total.

There is variation in the amount of outreach and the modalities used by each MCO. ABH and UHC reported little outreach this quarter. LHCC and MCNA reported the most outreach.

Case Management

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

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

Each of the Healthy Louisiana plans is contractually required to develop and implement a case management program through a process which provides appropriate and medically-related services, social services, and/or basic and specialized behavioral health services for members that are identified as having special healthcare needs (SHCN) or who have high risk or unique, chronic or complex needs.
The Department currently monitors the identification and assessment of members in need of case management services and those receiving case management services through MCO self-reported data provided on a quarterly basis. While there are specific contractual standards that require MCOs to complete an assessment of all individuals identified as having a special healthcare need within 90 days of identification, each MCO has their own policies and procedures for identification and assessment. As such, the reporting for case management has shown significant variation across MCOs. LDH has worked to increase the comparability of the data collected. More intensive data analysis is currently underway.

The data presented below is representative of unduplicated totals by MCO for CY 2020 quarter 2.

CY 2020 - Quarter 2: Unduplicated Totals	ABH	ACLA	HB	LHCC	UHC
Eligible for Case Management (CM)	1,482	8,127	4,922	14,610	15,215
Enrolled in CM at least 1 month	660	5,165	1,692	3,809	3,242
% eligible enrolled in CM	44.5%	63.6%	34.4%	26.1%	21.3%
Received CM Service	371	3,693	774	3,019	1,301
% enrolled receiving service	56.2%	71.5%	45.7%	79.3%	40.1%

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

QUARTERLY UPDATE #8
PERIOD COVERING THE 2ND QUARTER
OF CALENDAR YEAR 2020

DECEMBER 31, 2020

BURNS & ASSOCIATES, INC.
A DIVISION OF HEALTH MANAGEMENT ASSOCIATES

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Listing of Exhibits

SECTION I: INTRODUCTION

Legislative Overview

On June 1, 2018, the Louisiana State Legislature passed House Bill 734, which subsequently was enrolled and chaptered as Act No. 710 of the 2018 regular legislative session. The Act requires reporting of data on healthcare provider claims submitted to Medicaid managed care organizations (MCOs). The legislation required the Louisiana Department of Health ("the Department", or LDH) to produce and submit the "Healthy Louisiana Claims Report" to the Joint Legislative Committee on the Budget and to the House and Senate Committees on Health and Welfare.

The initial report covered claims paid during Calendar Year (CY) 2017. Subsequent reports are required to be submitted on a quarterly basis. Each subsequent report must cover a more recent three-month period than the previous report. The Initial Report was submitted to the legislature on October 31, 2018. This is the 8th report update.

Report Update	Calendar Year 2018				Calendar Year 2019				Calendar Year 2020			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1	X	X	X									
2	X	X	X	X								
3		X	X	X	X							
4			X	X	X	X						
5				X	X	X	X					
6					X	X	X	X				
7						X	X	X	X			
8							X	X	X	X		

Required Reporting for the Initial Report

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

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

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

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

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

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

Steps in Claims Processing and Encounter Submissions

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

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

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

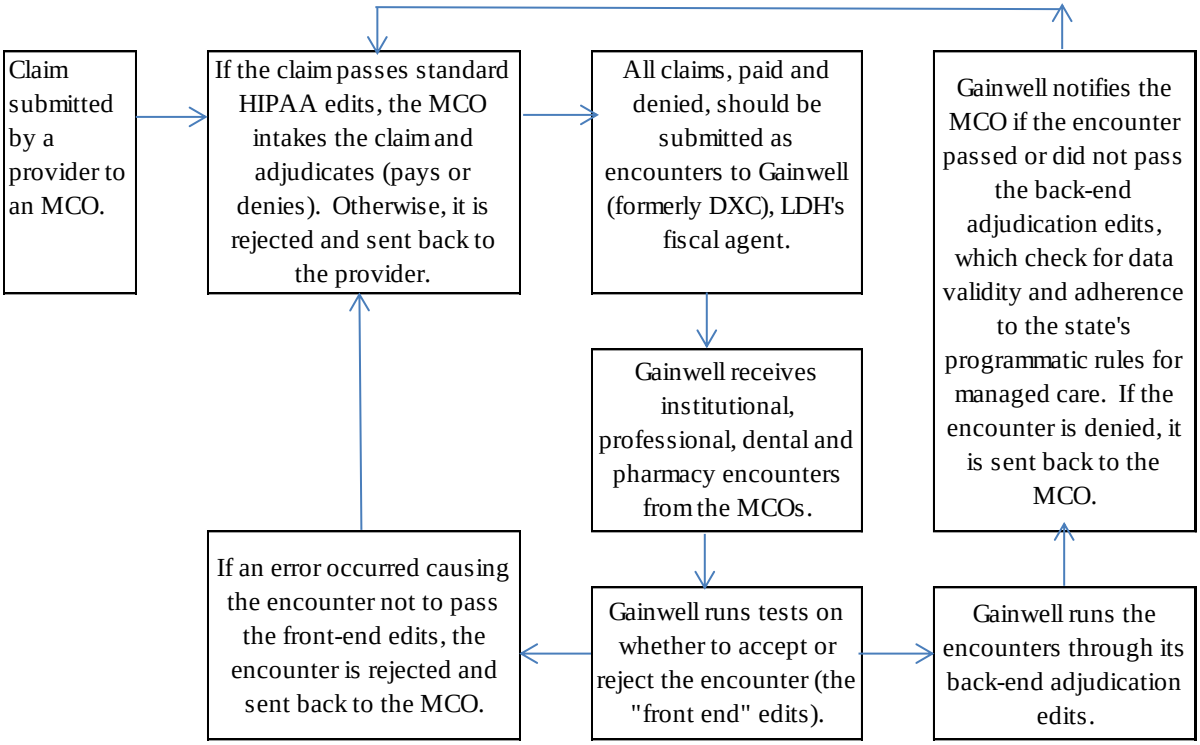
- The *CMS-1500, or electronic 837P*, is the claim type for professional service providers to submit on. This includes a wide array of providers such as physicians, clinics, mental health providers, therapists, transportation providers, suppliers of medical equipment and supplies.

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

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

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

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



Terminology Used in this Report

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

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

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

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

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

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

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

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

At the detail level, however, the status could be paid or denied, and the status of the individual detail line may differ from the header status. For example, a professional claim contains five service lines. The first four are paid. The fifth service is denied. Each service line will have its own claim status, but the header claim status will be paid.

It is important to factor this information in when analyzing claims and claim trends. The question to ask is if the claim counts shown represent the count of header records or of individual service lines. The count of header lines may be a fraction of the total detail service lines.

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

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

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

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

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

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

Trends Found in Prior Report Releases

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

Claim Rejection Rate	1.1% to 1.3% of claims submitted by providers are rejected by the MCOs.
Claim Payment Denial Rate, Overall	From a low of 17.0% to a high of 19.4%
For Hospital Claims	Much higher for inpatient hospital services (21%-25%), but outpatient hospital services have one of the lowest denial rates of any service category (8%-10%).
For Professional Services	The denial rate range has been steady between 10% and 12%.
For Dental Claims	For child dental services, denial rate has been steady between 8% and 9%.
For Pharmacy Claims	Industry standard is that pharmacy scripts have highest denial rate. LDH is no exception with a denial rate range between 24% and 28%.
Turnaround Time to Process Claims	The time for MCOs to process provider claims has been steady in every report, from 6.9 days to 8.4 days.
Time for MCOs to Submit Claims as Encounters to LDH	There is variation in the timeliness for the MCOs to submit their claims to LDH. This can vary by MCO and by quarter. Generally, HB, UHC and MCNA are most consistently timely (that is, all encounters submitted to LDH within 30 days of processing).

SECTION II: CONSTRUCT OF THE QUARTERLY UPDATE REPORT

Six reports were designed specifically to be able to report information in the Act 710 quarterly updates. LDH requires that each MCO submit these six reports on a quarterly basis.

There will be a lag time between the claims adjudication period and the date that the MCOs will submit the reports to LDH as allowed by the Act. For example, the results from the claims adjudication period April 1 – June 30, 2020 were due to LDH by November 15, 2020.

The MCOs analyzed in this review include:

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

Measures that will be Reported Each Quarter

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

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

Provider Categories

Act 710 required that behavioral health providers be reported discretely from non-behavioral health providers in the initial report. In consultation with stakeholders, LDH also agreed that there be further segmentation of the non-behavioral health providers for discrete reporting. The provider categories that are reported on an ongoing basis are:

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

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

How This Report is Organized

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

In some exhibits, data is displayed for the most recent four quarters. In this report, the four quarters shown are Quarters 3 and 4 in 2019 and Quarters and 1 and 2 in 2020. Other exhibits will display only the data from the most recent quarter. In this edition of the report, the exhibits that contain only the most recent quarter show Q2 2020 data.

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

Limitations of the Data

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

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

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

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

    Because of these limitations, the value of denied claims should be reviewed with caution. It is of the opinion of the B&A reviewers that the values shown for denied claims should not be considered as "lost" money to providers. Instead, they show the relative values of opportunity for improvements in the accuracy and completeness of provider claims submissions.

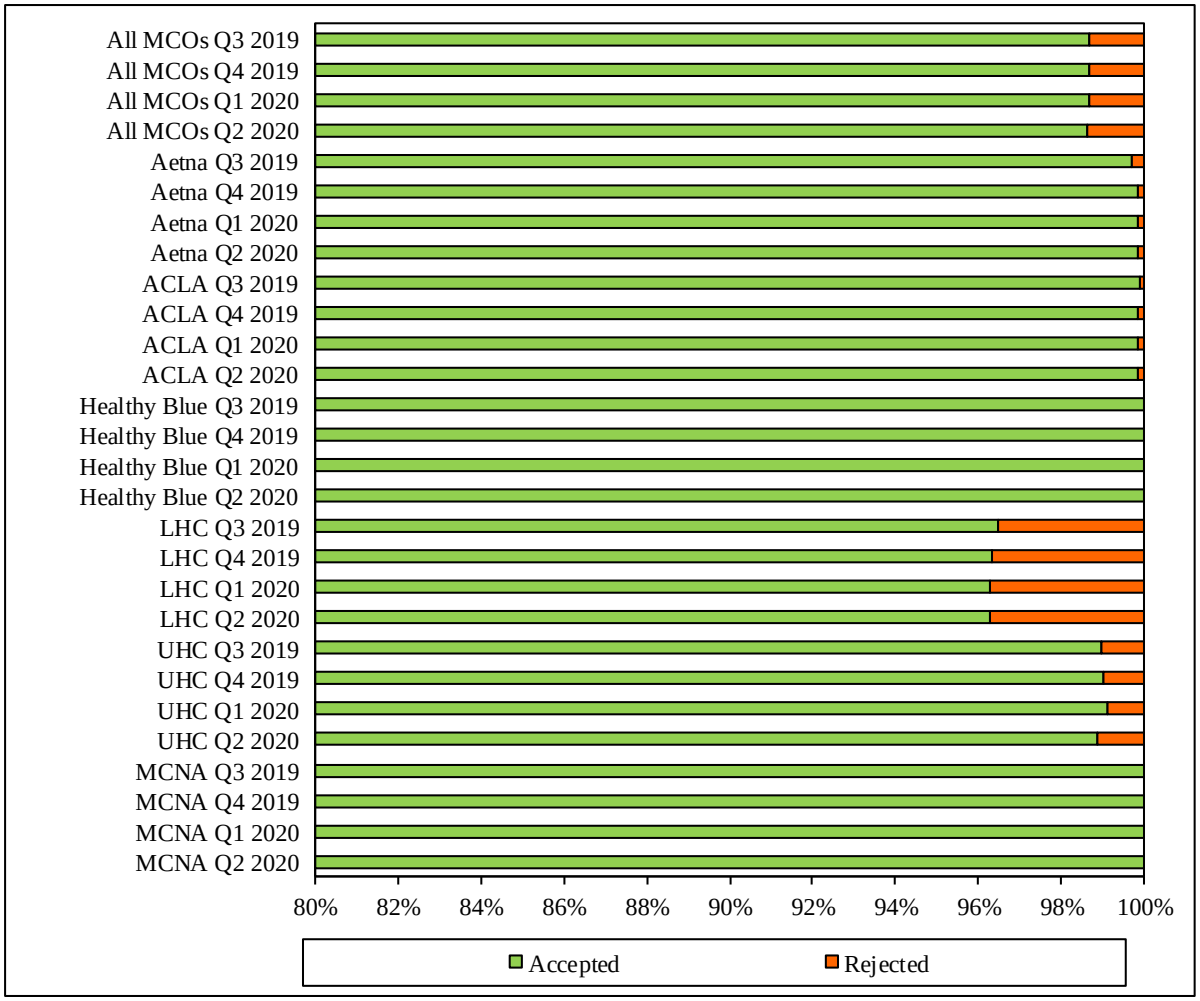
SECTION III: FINDINGS RELATED TO MCO CLAIMS ADJUDICATION

The LDH's contracted MCOs or their subcontractor adjudicates all provider claims submitted. The MCOs themselves adjudicate medical claims (those billed in the institutional claims, or 837I, format and those billed in the professional claims, or 837P, format). MCNA adjudicates almost all of the dental claims for the Medicaid program. Each MCO contracts with a pharmacy benefit manager to adjudicate the pharmacy claims.

Claims Accepted and Rejected by the MCOs

In the most recent four quarters for which data is available, the claims rejection rate reported by the Medicaid MCOs was between 1.3% and 1.4%. The rejection rate overall is specifically due to higher rejection rates for LHCC (3.5% to 3.7%) with the other MCOs having rejection rates closer to zero.

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

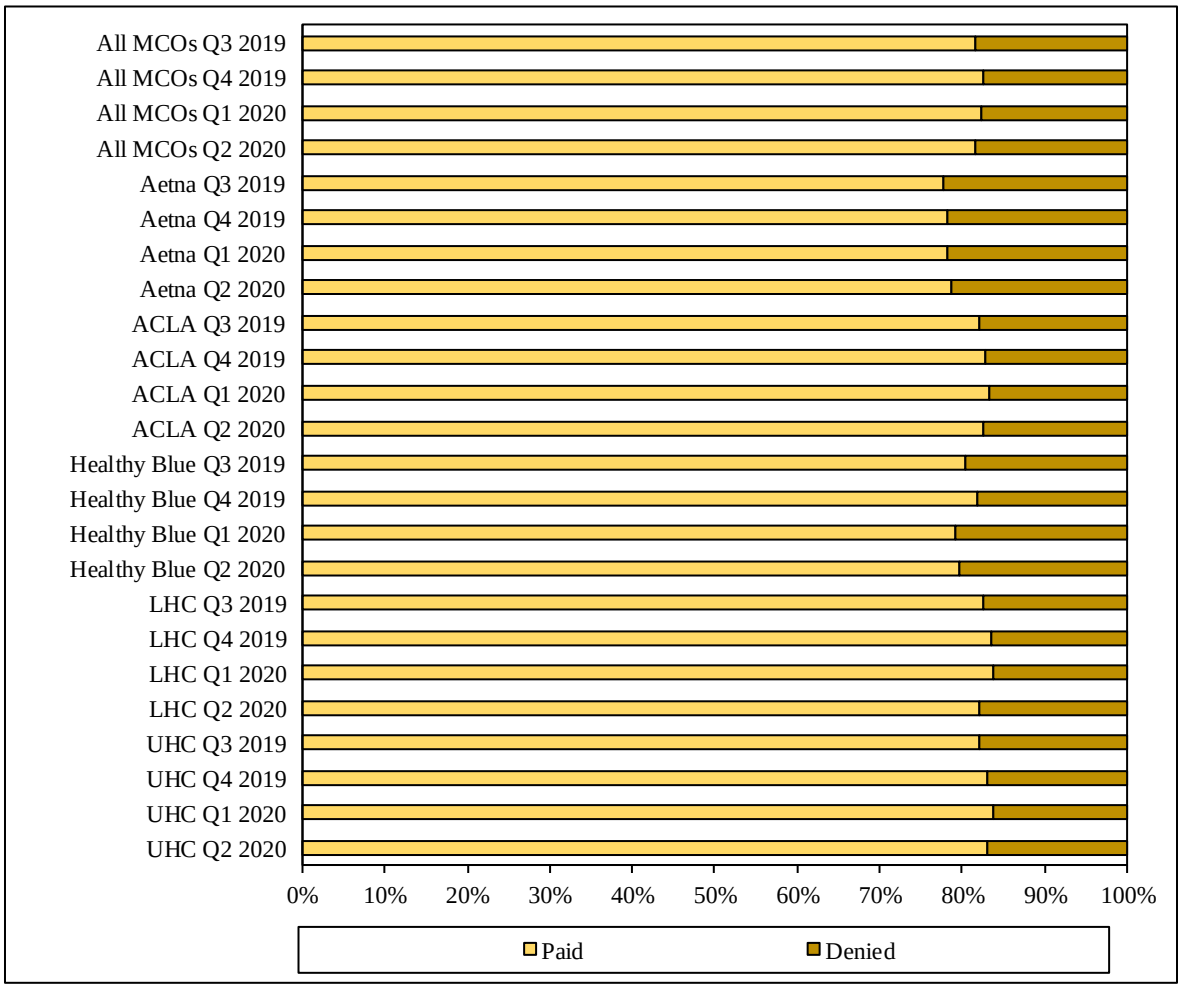


Claims Paid and Denied by the MCOs

For those claims that were accepted into the MCO's claims adjudication system, on average, the overall rate of paid claims was between 81.5% and 82.5% in the most recent four quarters. The denial rates, therefore, were between 17.5% and 18.5%. These denial rates have remained fairly steady since the Act 710 quarterly update reports have been release.

At the MCO-specific level, the range across the 4-quarter averages was from an average denial rate of 16.9% for LHCC to an average rate of 21.8% for ABH. The denial rates are not going down in any significant manner since the original report showing CY 2017 data. These statistics exclude MCNA dental claims, which can be found in Exhibit III.4 in the categories Dental – Children and Dental – Adult.

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



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

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

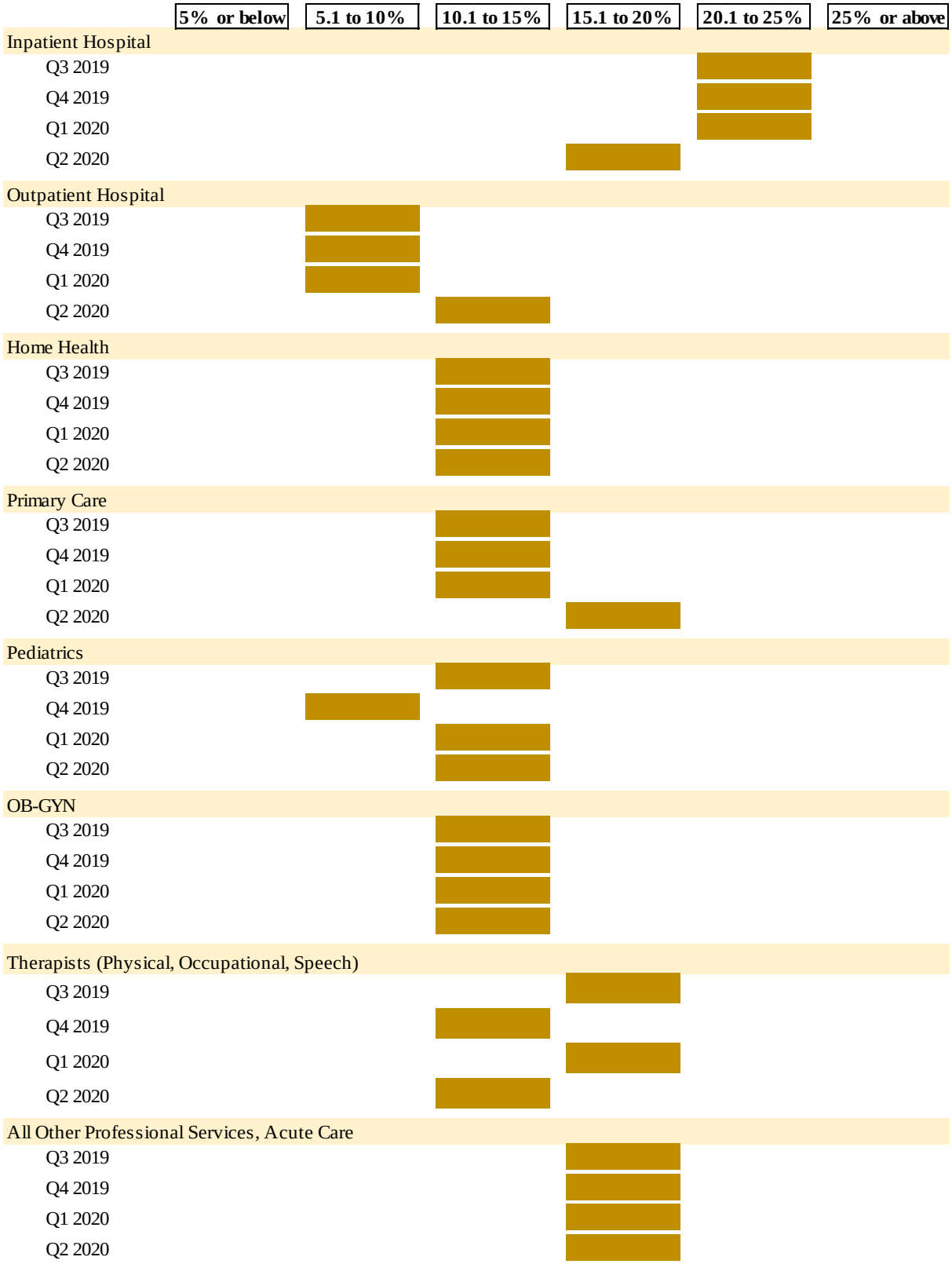


Exhibit III.4
Claim Denial Rates for Non-Acute Care Services
For All MCOs Combined, By Quarter

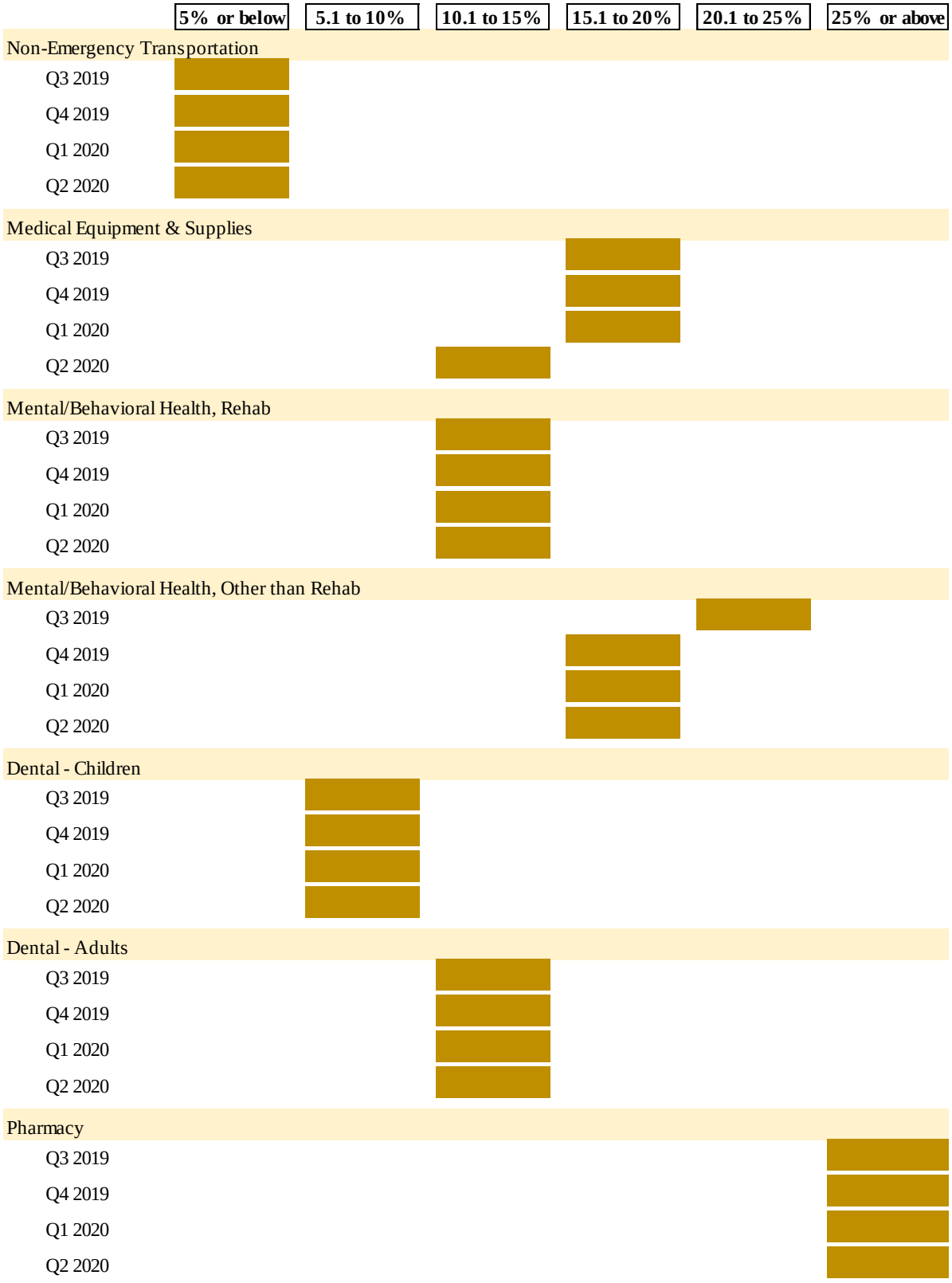
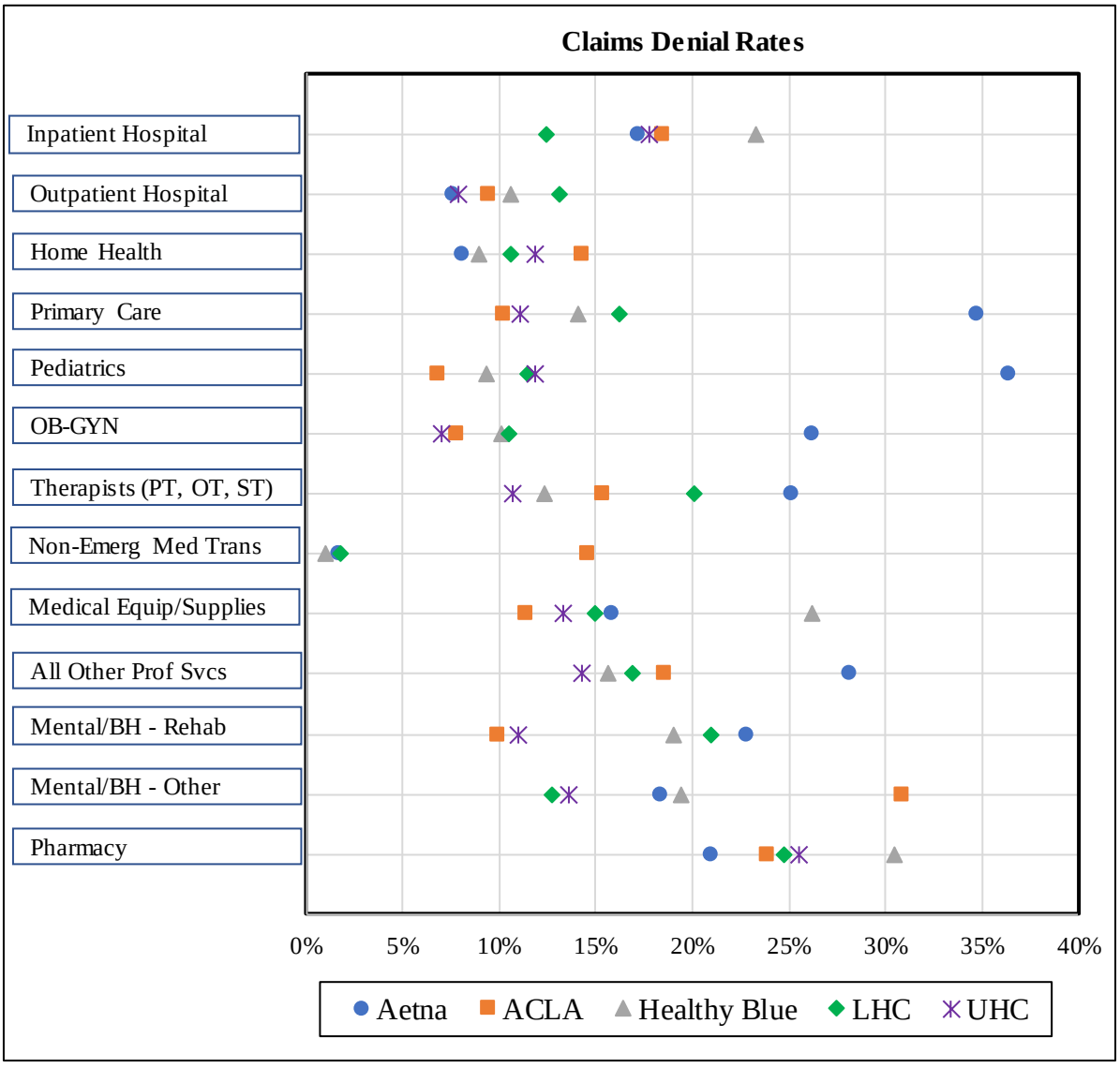


Exhibit III.5 compares the denial rates for these service categories by MCO. The data plotted on this exhibit is the percentage of claims denied in Quarter 2 of CY2020 for each MCO. An icon and color is used to display each MCO's data. Each row in the exhibit represents a specific service category. For example, in the top line of the exhibit, the overall denial rate for inpatient hospital services in Q2 2020 was 17.4%, but this varied from 12.4% for LHCC to 23.3% for HB.

The claims denial rate is more clustered for some services such as outpatient hospital, home health and pharmacy. For other services, the denial rates vary significantly by MCO (e.g., therapists, medical equipment and supplies, mental and behavioral health services). In other categories, most MCOs have a similar rate, but ABH varies from all of its peers (e.g., primary care, pediatrics, OB-GYN).

Exhibit III.5
Claim Denial Rates for Adjudicated Claims
By Provider Specialty / Service Category
By MCO for Q2 2020 Adjudicated Claims



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

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

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

Because there is such a variety of denial reasons that are based on the circumstances of each claim, it is not appropriate to unilaterally assume that every denied claim could have been paid or should have been paid. With this in mind, B&A tabulated the information on denied claims from each MCO and attempted to assign a value to each denied claim without inferring if the claim could have been paid or should have been paid.

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

It is important to apply this formula at the provider specialty level (as opposed to all claims combined) due to the wide range of reimbursement paid to each provider type. For example, in Q2 2020, the average payment for paid inpatient hospital claims was $5,545; for primary care, it was $32.

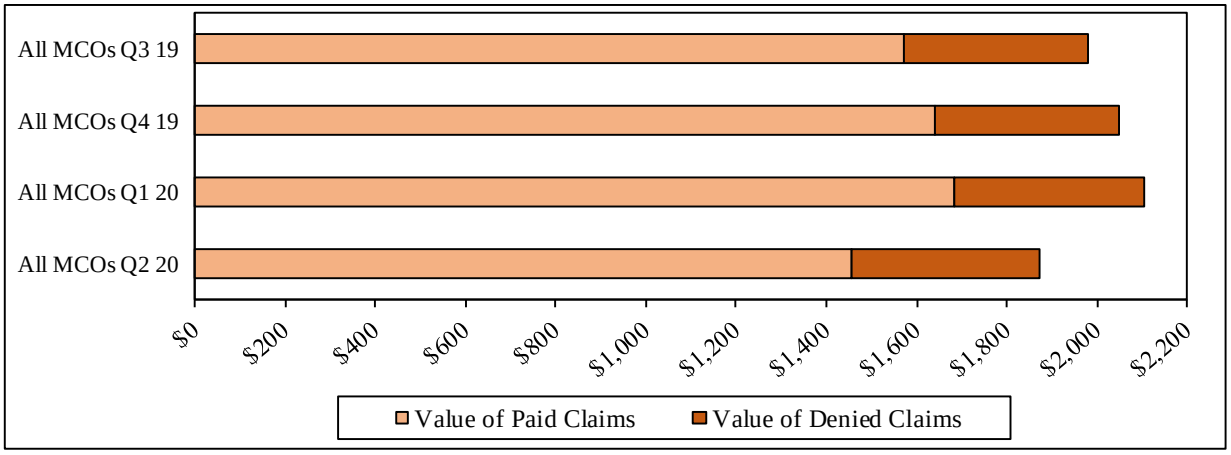
B&A not only computed an average payment per claim for each provider specialty separately, but also for each MCO within the provider type as well as a separate value for each calendar quarter.

Exhibit III.6 which appears on the next page summarizes the total dollar values of paid claims and denied claims by MCO and by quarter.

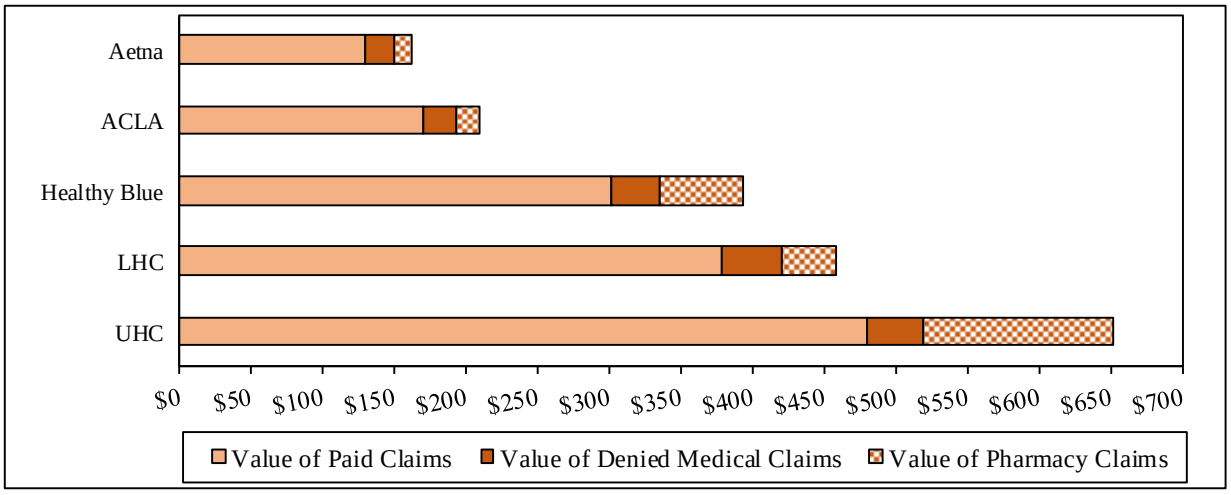
The denied claims account for between 19.9% and 22.2% of the sum of paid and denied values each quarter. This equates to between $408 and $420 million. Among the $416 million in denied values in Q2 2020 assigned across the five MCOs that provide medical and pharmacy benefits, $158 million (37.8%) was attributed to medical claims and $258 million (62.2%) was attributed to pharmacy claims. In Q2 2020, the distribution of assigned values to denied claims by MCO was as follows:

- ABH had 65% to medical and 35% to pharmacy claims
- ACLA had 56% to medical and 44% to pharmacy claims
- HB had 37% to medical and 63% to pharmacy claims
- LHCC had 52% to medical and 48% to pharmacy claims
- UHC had 22% to medical and 78% to pharmacy claims

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



Q2 2020 Adjudicated Claims Only



MCNA is the MCO that provides dental coverage only.
Their total expenditures are $17M - $33M per quarter. They have been excluded from this exhibit.

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

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

The data submitted by the MCOs was then examined to determine if, for example, a higher proportion of providers with high Medicaid volume had high denial rates compared to those with low Medicaid volume. High denial rate was defined as any provider that had more than 10% of their claims denied by the MCO in the quarter. Statistics were then run to determine what percentage of providers within each group had a high claims denial rate (that is, more than 10%).

With 14 provider specialties (excluding dental) and three groupings within each specialty (low volume, medium volume, high volume), there can be as many as 42 provider/volume groupings to examine. These are then examined for each of the five MCOs (excluding dental services paid by MCNA), so 42 groupings for five MCOs is 210 groupings. The other two provider specialties are specific to dental and specific to MCNA, so this adds six more groupings. That means a total of 216 groupings were examined for each quarter.

B&A reviewed each of the 216 groupings for whether more than half of the providers within the group had a claims denial rate above 10%. There were many provider/volume combinations where the volume of providers was too small (5 or less) to make an assessment.

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

The counts represent all MCOs combined. There had been relative consistency in the number of combinations where a majority of providers had a denial rate above 10%. There were more situations found in Q4 2019 where a majority of providers in each group studied individually had a denial rate greater than 10%. There was some improvement in the counts of combinations in Group A in Q1 2020 and Q2 2020.

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

	Group A	Group B	Group C	Groups A, B, C
	Number of combinations where > 50% of providers had a denial rate above 10%	Number of combinations where < 50% of providers had a denial rate above 10%	Number of combinations where the sample of providers was too small to study	Total Groupings
Q3 2019	83	97	36	216
Q4 2019	98	86	32	216
Q1 2020	88	96	32	216
Q2 2020	83	105	28	216

There was no obvious pattern when reviewing the results in Exhibit III.6 except that, in most service categories, the larger-volume providers have lower denial rates than the smaller-volume providers. There are a few differences in the rate of denials where one MCO stands out from the rest.

Timeliness of Claims Adjudication by the MCOs

The LDH requires that 90% of claims be adjudicated within 15 business days and that 99% of claims be adjudicated within 30 calendar days. An adjudicated claim could mean a decision to either pay or to deny. The measurement for turnaround time (TAT) for adjudication is the number of days from receipt of the claim by the MCO to the date on which the provider is paid or is notified that no payment will be made.

Exhibit III.8 below shows that the MCOs are meeting the target for adjudication within 30 days as set by LDH. In fact, the average TAT is below 10 days in every quarter for all MCOs. The TAT averages do vary, however, across the MCOs.

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

		Adjudicated Within 30 days		Avg Turnaround Time	
		Pct of Paid	Pct of Denied	Paid Claims	Denied Claims
Aetna	Q3 2019	99.9%	99.7%	7.8	5.8
	Q4 2019	99.9%	99.8%	7.9	6.0
	Q1 2020	99.9%	99.8%	8.1	5.9
	Q2 2020	99.7%	99.0%	8.3	6.0
ACLA	Q3 2019	100.0%	100.0%	5.7	6.7
	Q4 2019	100.0%	100.0%	5.7	7.3
	Q1 2020	100.0%	99.9%	5.2	6.0
	Q2 2020	100.0%	99.9%	5.4	6.5
Healthy Blue	Q3 2019	99.8%	99.6%	5.9	4.9
	Q4 2019	99.9%	99.6%	6.5	4.7
	Q1 2020	99.6%	99.6%	6.8	4.3
	Q2 2020	99.0%	98.7%	6.8	4.3
LHC	Q3 2019	99.8%	99.6%	8.7	9.8
	Q4 2019	99.6%	99.3%	8.8	9.7
	Q1 2020	99.7%	99.6%	8.8	9.6
	Q2 2020	99.8%	99.4%	9.0	9.6
UHC	Q3 2019	100.0%	99.9%	9.5	3.0
	Q4 2019	100.0%	99.9%	9.2	2.8
	Q1 2020	99.9%	100.0%	9.4	2.6
	Q2 2020	99.9%	99.5%	8.6	3.2
MCNA	Q3 2019	100.0%	100.0%	7.6	8.4
	Q4 2019	100.0%	100.0%	8.7	9.6
	Q1 2020	100.0%	100.0%	8.6	10.0
	Q2 2020	100.0%	100.0%	3.5	6.5

There is little variation found when the average turnaround time is examined by service category. On the next two pages, turnaround time statistics are shown for acute care services (Exhibit III.9) and non-acute care services (Exhibit III.10). As seen in both exhibits, the average turnaround time within a service category is usually very consistent when reviewed quarter by quarter.

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

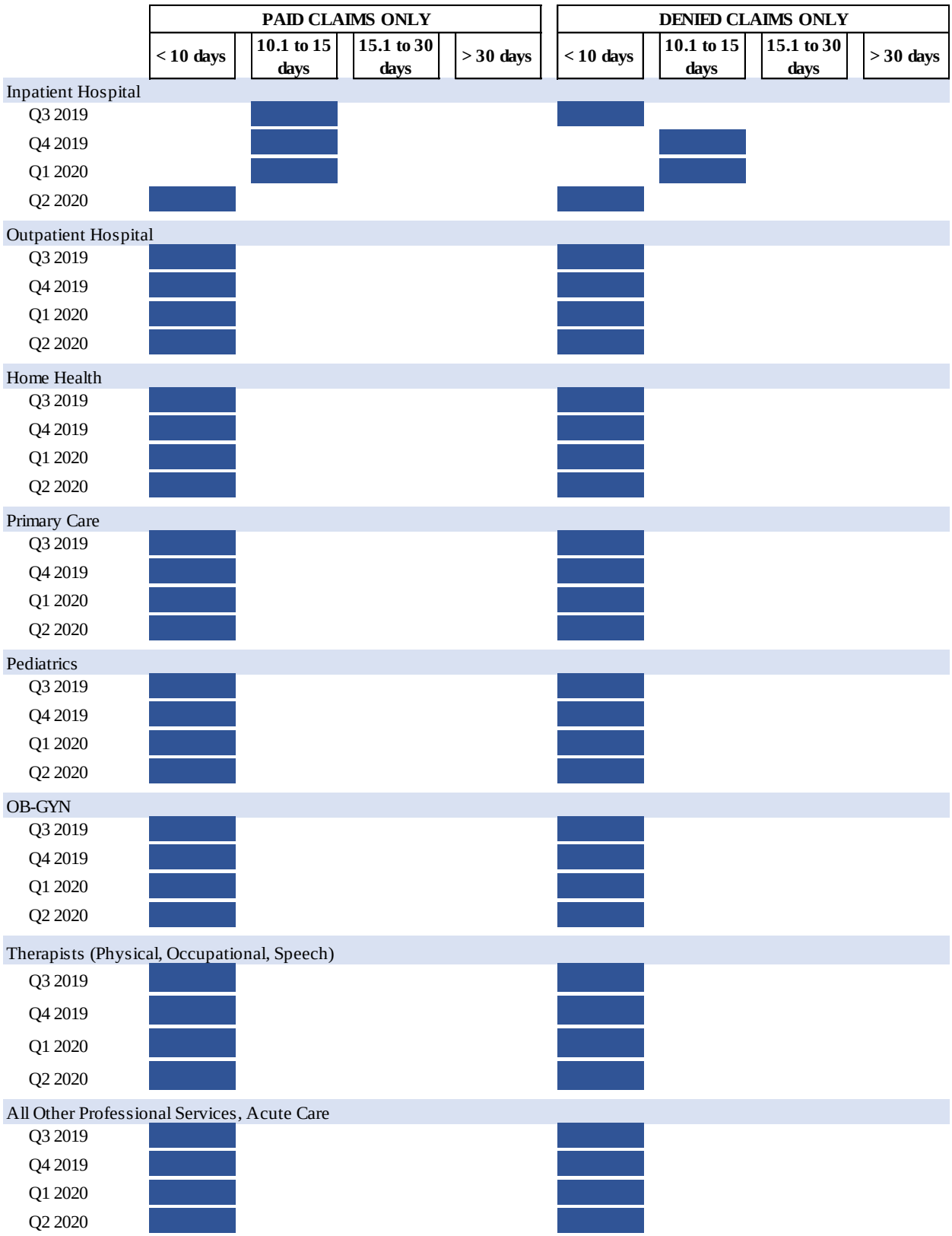
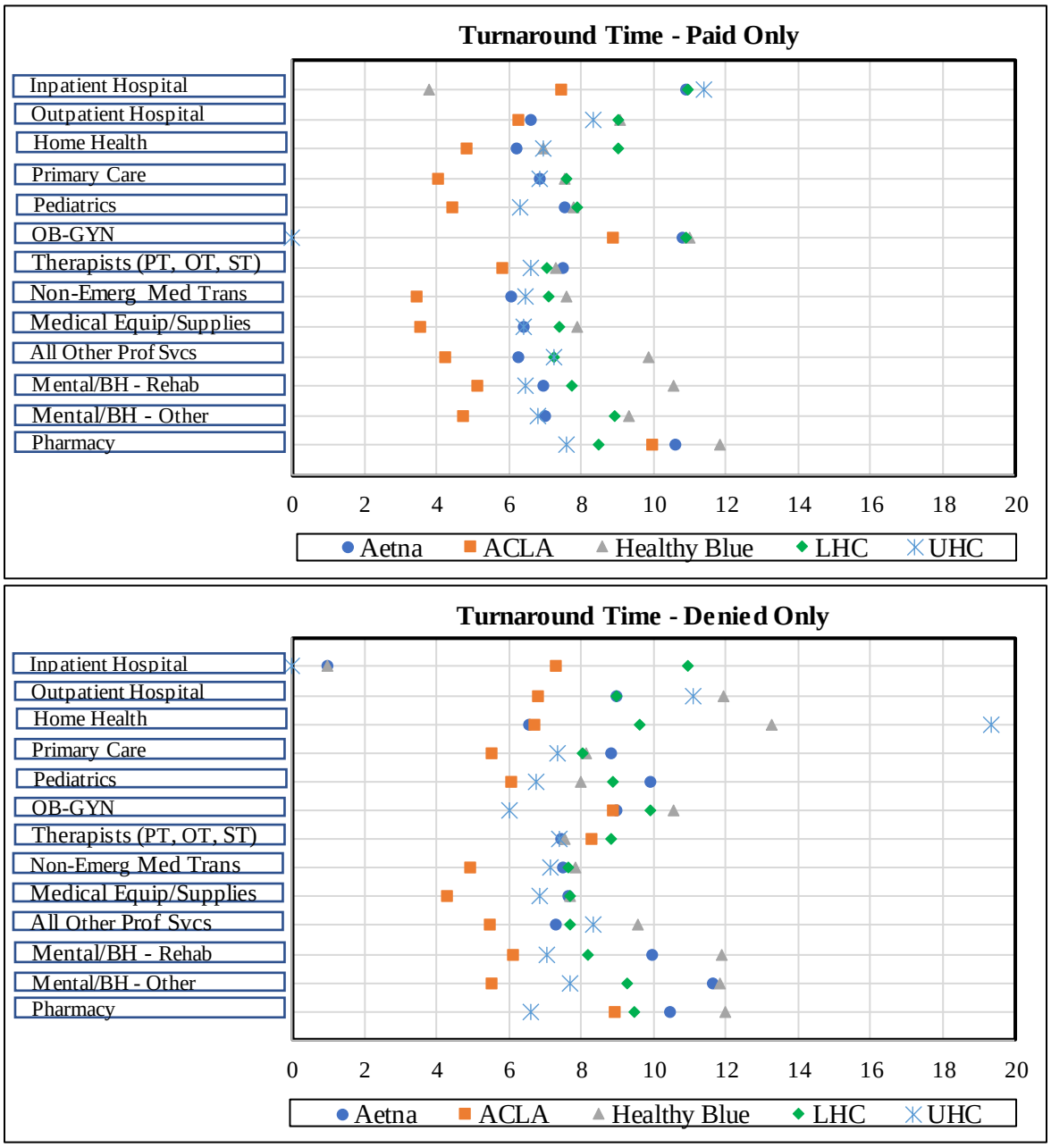


Exhibit III.10
Turnaround Time for Claims Processing of Adjudicated Non-Acute Care Claims (using average days)
For All MCOs Combined, By Quarter

Exhibit III.11 below further breaks down the average paid and denied TAT statistics in Q2 2020, but the results are shown for each MCO within a service category. The top box shows the variation in TAT for paid claims only; the bottom box shows the results for denied claims only. The purpose of this exhibits is to determine if the TAT is consistent across MCOs or if it varies.

The top box shows that there is some variation in the average TAT for paid claims. But there is no situation where the average TAT exceeded 12 days. In the bottom box, the same variation was seen for denied claims, but overall the average TAT for denied claims is about two days more than for paid claims.

Exhibit III.11
Average Turnaround Time, Paid and Denied Claims, by Service Category
By MCO for Q2 2020 Adjudicated Claims



Reasons for Claim Denials by the MCOs

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

The MCOs report to LDH the occurrence of each CARC or NCPDP code on adjudicated claims. For denied claims, the count of each CARC or NCPDP code was tabulated by MCO for claims adjudicated in the 2nd Quarter of CY 2020.

Exhibit III.12 shows the top 10 CARCs for medical claims across all MCOs and the top 10 NCPDP codes for pharmacy claims across all MCOs. If one of the top CARCs across all MCOs was also a top 5 CARC within an MCO, the rank number is noted. Some key findings on CARCs appear below:

- In Q2 2020, LHCC and UHC each had its top 5 CARCs within the top 10 CARCs statewide. ABH and ACLA had four, HB had three and MCNA had two of its top 5 CARCs in the statewide top 10.
- The top five CARCs in Q2 2020 included the following:
    - 96: Non-covered charge.
    - 16: The claim lacks information or has a billing error which is needed for adjudication.
    - 18: Exact duplicate claim.
    - 197: Precertification or authorization absent when it is required.
    - 97: The benefit for this service is included in the payment for another service already adjudicated.
- These five CARCs were also among the top seven in the previous eight quarters reported.

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

- In Q2 2020, ACLA and LHCC each had their top 5 NCPDP codes also in the top 10 for All MCOs. ABH and HB had 4 of its top 5 in the statewide top 10. UHC is not shown because they did not comply with submission of this report.
- The top five NCPDPs in Q2 2020 included the following:
    - 79: Refill too soon
    - 75: Prior authorization required
    - 88: DUR reject error
    - 76: Plan limitations exceeded
    - 7O: Product/service not covered – plan/benefit exclusion
- These five NCPDPs were also among the top six in the previous six quarters reported.

Exhibit III.12
Details on Reasons for Denied Claims
By MCO for Q2 2020 Adjudicated Claims

For Medical Claims

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

For Pharmacy Claims

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

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

Exhibit III.13 shows the results when the top CARCs are distributed by provider type for each MCO for claims adjudicated in the 2nd Quarter of 2020. Key findings from the exhibit are shown below:

- For ABH, three of its five CARCs overall were also observed for almost every provider category as well. Two CARCs (#4 and #96) was only present for selected provider types.

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

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

- For LHCC, only one of its five CARCs overall (#18) was observed for almost every provider category as well. The other four CARCs were only present for selected provider types.

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

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

Exhibit III.13
Details on Reasons for Denied Medical Claims
By MCO and By Provider Category for Q2 2020 Adjudicated Claims

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

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

Exhibit III.13 (continued)
Details on Reasons for Denied Medical Claims
By MCO and By Provider Category for Q2 2020 Adjudicated Claims

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

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

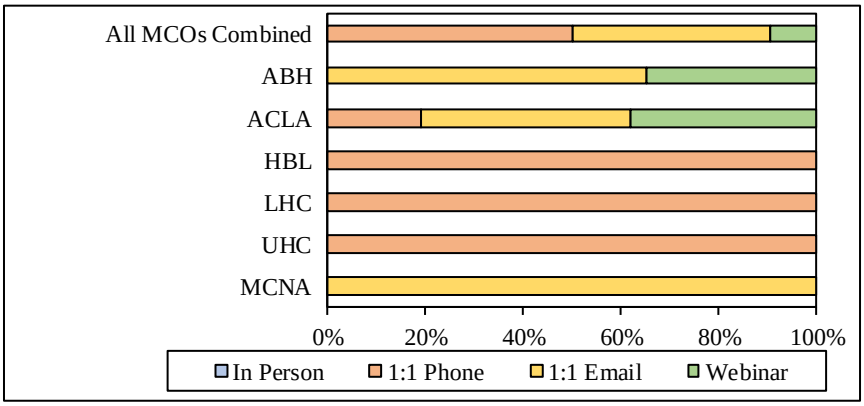
Provider Education Related to Claims Adjudication

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

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

Exhibit III.14 summarizes information on provider education conducted in Q2 2020. In all, 1,324 TINs were outreached to by the MCOs (up from 1,180 last quarter). This count represents the unique TINs and modes of communication. In some cases, the MCO reported that they conducted multiple outreach to the same TIN in the quarter (e.g., three emails over the course of 6 weeks). When this occurred, only one was counted below. It should also be noted, however, that the same TIN may be outreached to by multiple MCOs.

Exhibit III.14
Provider Education Conducted by the MCOs on Claims Submissions Activity in Q2 2020



The most predominant mode to outreach to providers is 1:1 phone calls (50.0% of all contacts) followed by 1:1 email (40.6% of contacts). No in-person meetings were held. Webinars were 9.4 percent of the total.

There is variation in the amount of outreach and the modalities used by each MCO.
ABH and UHC reported little outreach this quarter. LHCC and MCNA reported the most outreach.

	Modality of Outreach				
	In Person	**1:1 Phone**	**1:1 Email**	**Webinar**	**Total TINs**
All MCOs Combined	0	662	538	124	1,324
ABH	0	0	54	29	83
ACLA	0	47	107	95	249
HBL	0	137	0	0	137
LHC	0	448	0	0	448
UHC	0	30	0	0	30
MCNA	0	0	377	0	377

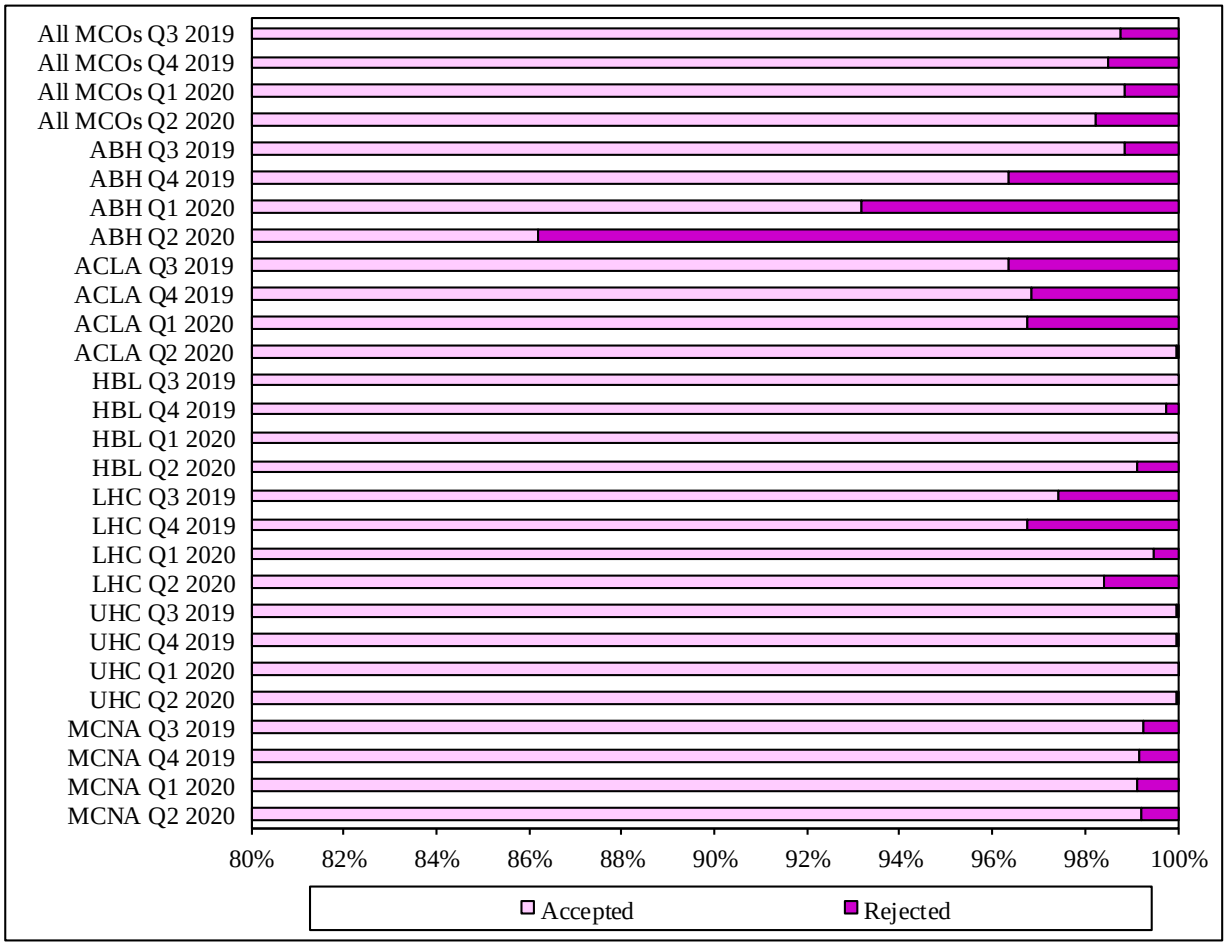
SECTION IV: FINDINGS RELATED TO MCO ENCOUNTER SUBMISSIONS TO LDH

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

MCO Encounters Accepted and Rejected by LDH

In the most recent four quarters studied, 98.5% to 98.9% of the encounters submitted by all MCOs combined were accepted by LDH. There were differences at the MCO level. All of UHC's and almost all of HB's and MCNA's encounters were accepted. ACLA and LHCC had at least 96% of their encounters accepted, but ABH had some challenges, particularly in the most recent quarter.

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



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

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

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

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

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

- When LHCC has had issues with encounters being accepted, it has been with pharmacy encounters.

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

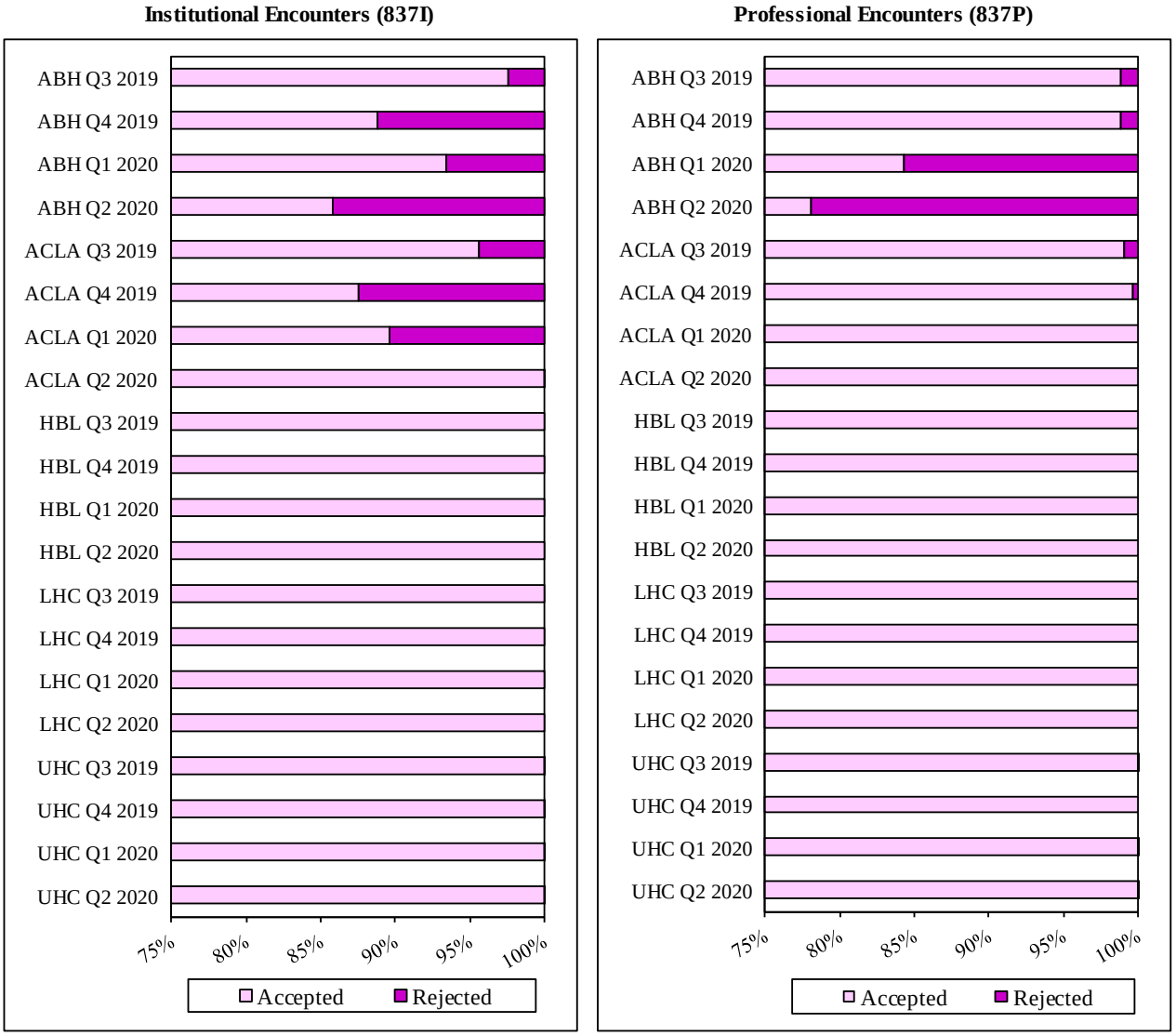
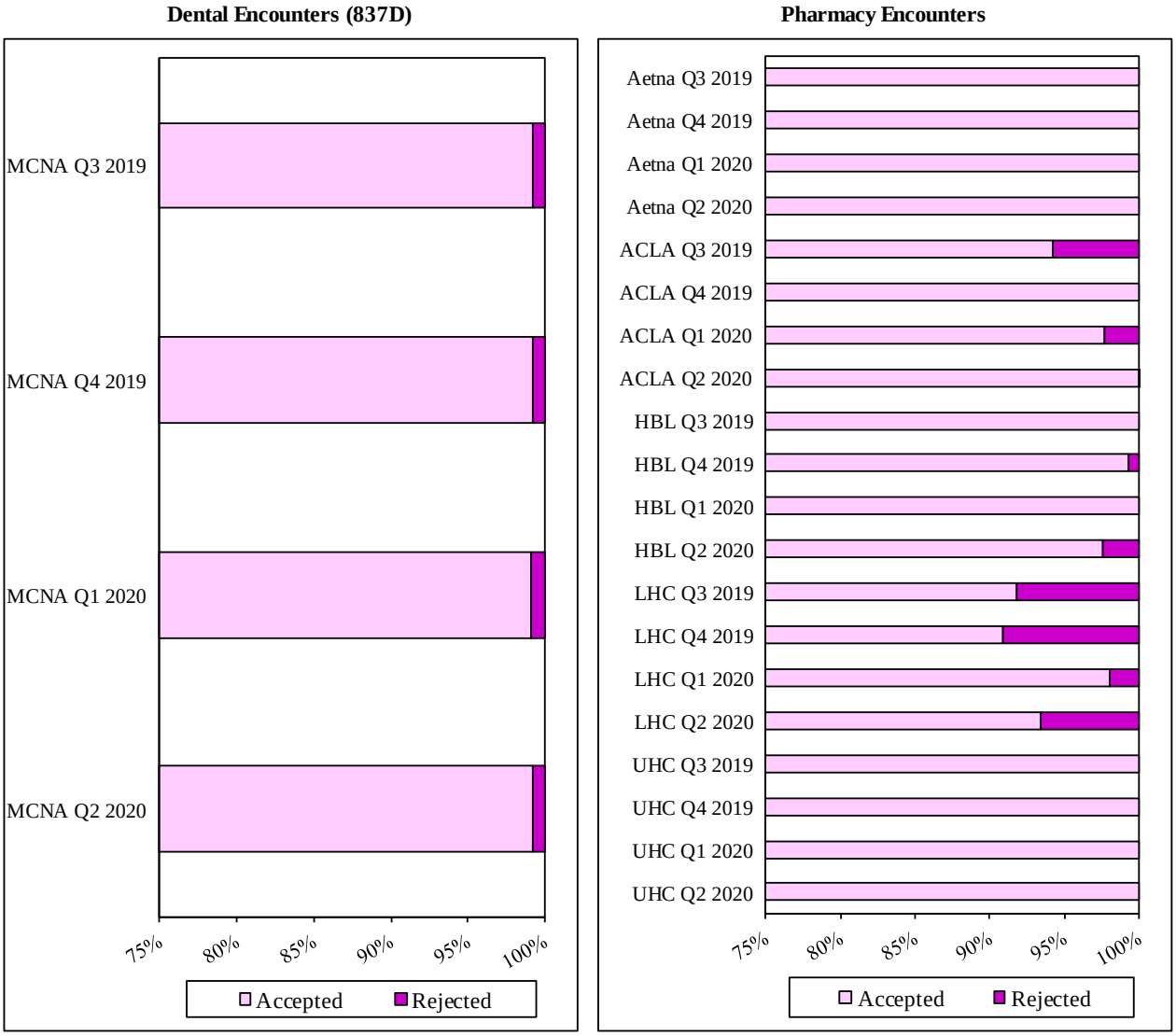


Exhibit IV.3
Encounter Submissions Accepted and Rejected by LDH
Dental and Pharmacy Claim Types
By MCO and By Quarter



Timeliness of Encounter Submissions Accepted by LDH

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

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

Key findings from both exhibits appear below:

- For institutional encounters (mostly claims from hospitals), MCOs usually had at least 95% of their encounters submitted within 30 days each quarter. Exceptions to this were ABH in Q1 2020, ACLA in Q4 2019, LHCC in Q1 and Q2 2020, and UHC in Q4 2019.

- HB and UHC consistently have the highest rate of submission of professional encounters within 30 days. HB has had more than 97% in within that time in each of the last four quarters; ACLA and UHC have had more than 92% in within 30 days. Both ABH and LHCC had challenges with professional encounter submission timeliness in Q1 and Q2 2020.

- There is greater variation in the timeliness of pharmacy encounter submissions. HB has always had a high rate of pharmacy encounters submitted within 30 days (almost 100%). ACLA and UHC have had a high rate of timely submissions in most quarters. ABH and LHCC consistently are lowest with between 60-75% submitted within 30 days in most quarters.

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

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

	Institutional Encounters (837I)		Professional Encounters (837D)		Dental Encounters (837D)		Pharmacy Encounters	
	Within 30 Days	After 30 Days	Within 30 Days	After 30 Days	Within 30 Days	After 30 Days	Within 30 Days	After 30 Days
ABH Q3 2019	98.9%	1.1%	97.1%	2.9%			69.7%	30.3%
ABH Q4 2019	98.9%	1.1%	94.1%	5.9%			72.8%	27.2%
ABH Q1 2020	31.0%	69.0%	9.4%	90.6%			73.1%	26.9%
ABH Q2 2020	69.6%	30.4%	67.2%	32.8%			71.2%	28.8%
ACLA Q3 2019	95.3%	4.7%	97.5%	2.5%			95.0%	5.0%
ACLA Q4 2019	94.6%	5.4%	93.6%	6.4%			100.0%	0.0%
ACLA Q1 2020	96.3%	3.7%	92.2%	7.8%			100.0%	0.0%
ACLA Q2 2020	97.6%	2.4%	95.2%	4.8%			100.0%	0.0%
HBL Q3 2019	97.2%	2.8%	97.7%	2.3%			99.7%	0.3%
HBL Q4 2019	100.0%	0.0%	97.6%	2.4%			99.9%	0.1%
HBL Q1 2020	100.0%	0.0%	99.5%	0.5%			99.8%	0.2%
HBL Q2 2020	100.0%	0.0%	98.6%	1.4%			98.2%	1.8%
LHC Q3 2019	99.2%	0.8%	91.5%	8.5%			66.1%	33.9%
LHC Q4 2019	96.4%	3.6%	92.0%	8.0%			71.0%	29.0%
LHC Q1 2020	35.1%	64.9%	30.3%	69.7%			50.6%	49.4%
LHC Q2 2020	72.7%	27.3%	72.5%	27.5%			64.5%	35.5%
UHC Q3 2019	97.8%	2.2%	93.4%	6.6%			87.5%	12.5%
UHC Q4 2019	89.1%	10.9%	97.3%	2.7%			98.9%	1.1%
UHC Q1 2020	99.3%	0.7%	92.1%	7.9%			99.5%	0.5%
UHC Q2 2020	98.6%	1.4%	93.8%	6.2%			98.7%	1.3%
MCNA Q3 2019					99.1%	0.9%		
MCNA Q4 2019					99.4%	0.6%		
MCNA Q1 2020					96.9%	3.1%		
MCNA Q2 2020					99.7%	0.3%		