This report is submitted subject to Senate Bill 1573 (Public Act 100-0580) which requires the Department of Healthcare and Family Services (Department or HFS) to "post an analysis" on managed care organization (MCO) claims processing and payment performance on its website every 6 months in regards to hospital claims. In lieu of a 'representative sample' of hospital claims for services in the first quarter, the Department has chosen to report on the entirety of hospital claims processed by the MCOs (under the HealthChoice Illinois contracts).

The majority of the report covers only hospital claims. It is also important to note that the reimbursements detailed in this report do not include significant payments to hospitals made as a result of the hospital assessment program, as these are not billed claims.

The data presented below includes claims for services in the first three (3) months of HealthChoice Illinois (January 2018 – March 2018), that were both received and processed by the MCO by 9/30/2018. Since there is a 6-month (180 day) window for providers to submit claims after providing a service, Sept 30th was the last day to submit claims for the end of March, and it is likely that some claims for services in the first quarter were still being processed or appealed on 9/30. However, the data should be mostly complete. The next report, in approximately six months, will cover claims for services during the period April through September 2018, as well as an update on the claims from January through March 2018.

DEFINITIONS:

It is important to understand the definitions being used in any report as well as the complexities of billing in the health care arena overall. There is little comparative analysis on claim denials and even less on rejections. A journal publication in Health Affairs about physician claims noted the following: "We found dramatic variation across different types of insurance. Fee-for-service Medicaid is the most challenging type of insurer to bill, with a claim denial rate that is 17.8 percentage points higher than that for fee-for-service Medicare. The denial rate for Medicaid managed care was 6 percentage points higher than that for fee-for-service Medicare, while the rate for private insurance appeared similar to that of Medicare Advantage." (Health Affairs Vol. 37, No. 4: Culture Of Health, The ACA & More, The Complexity Of Billing And Paying For Physician Care, Gottlieb et al.)

Denied/Denied Claim: A claim where the payment was denied by the MCO to a Provider corresponding to HFS defined administrative reasons/codes. These claims are HIPAA compliant and may be fully processed by the MCO claims system but are denied for payment due to enforcement of payer defined policies. These denials are typically due to the Provider not meeting payer policy requirements around prior authorization, documentation, timeliness, benefits, a service limitation, contractual issue and non-contracted Providers. For purposes of this report, MCOs are to report the relative counts into one of the following seven (7) Denial Reasons. [Note: HFS defines denials as denial of payment for a claim for the seven Denial Reasons described in that section of the report, and only those reasons].

Payable / Paid Claim: An adjudicated claim that the MCO has determined is payable. There may be a slight lag between adjudication and remittance of payment to provider.

Rejected/Rejected Claim: A rejected billing claim is one in which the determination of payment cannot be made. These claims may enter payer claims system (front-end) but do not pass further into adjudication and payment processing (back-end) due to missing administrative elements on the claim.

Rejected claims are:

1) Claims submitted to an MCO that were accepted through the Electronic Data Interchange (EDI), but subsequently removed/deleted from the adjudication system
2) Claims that rejected through the EDI translator for failing any SNIP (see definition below) validations
3) Any custom business rules implemented in EDI that reject claim submissions.

Examples of missing administrative elements include: taxonomy code, value codes, occurrence codes, modifier codes, billed units, covered days, invalid recipient ID, notes, and NDC codes. In most cases, once the administrative element is added and the claim is resubmitted by the Provider to the MCO, the claim may be adjudicated.

Unique Claims: The most recent claim – no matter the action taken – of potentially multiple separate related claims. This means duplicate claims are ignored, and only one claim per service is counted as a Unique Claim.

Note that in general, rejections occur at the very beginning of claims processing, before a claim enters the adjudication system and denials occur after a claim has moved into the MCO's claims adjudication system. However, due to some differences in infrastructure from MCO to MCO, and differences between the definition of a denial in this document and the existing MCO claims processing infrastructure, some claims that were denied in the adjudication process could be considered rejections, and some claims that were not allowed into the claims adjudication system could be considered denials. For example, a claim with provider enrollment issues may not be accepted into the claims adjudication system for an MCO (technically a rejection), but meets the definition of a denial under "Provider" and so is reported as a denial.

ANALYSIS:

The following analysis reflects data from the first quarter of calendar year 2018 and is organized by topical area as required by the legislation.

Total Claim Counts and Paid Amount for Hospital Claims:

Table 1.	Unique Claim count	Charges billed	Amount Paid	Denial Rate
Paid Unique Claims	737,800	$ 4,366,507,005.13	$ 581,959,608.14	
Subset of Paid Unique Claims that were paid on the first non-rejected claim	678,098	$ 3,748,897,405.67	$ 517,775,561.07	
Denied Unique Claims	87,648	$ 630,279,691.00		10.62%
Total	825,448	$ 4,996,786,696.13	$ 581,959,608.14	

In the first quarter of Calendar Year 2018, there were 825,448 unique, non-rejected Hospital claims submitted to MCOs. Of those unique claims, 737,800 were paid and 87,648 were denied, **resulting in a denial rate of 10.62% for Quarter 1**. Of the 737,800 paid unique claims, 678,098 (92%) were paid when the first non-rejected claim for that service was submitted. This means MCOs paid over 90 percent of payments owed during the first pass through claims adjudication (or the first "clean claim").

The amounts paid relative to total charges are misleading. The Illinois Medicaid program does not reimburse on billed charges as hospitals independently develop their charge masters. Billed charges may be significantly higher than the negotiated allowable payments. As a result, they simply represent what the provider says was charged and not paid. It does not represent the value of what would have been paid by the plan. Additionally, hospitals are paid an additional $3.5 billion in hospital-assessment related payments, which are not reflected in the claims-based payments. We point this out only to emphasize the unreliability of hospital charges as a reference point. Since denied claims are not 'priced', it skews the dollar amount and a measurement besides percent of denied claims is not reasonable.

Each MCO negotiates their own payment rates with their provider network. Out-of-network payments are based on the HFS fee schedule. Billed charges may be significantly higher than the negotiated allowable payments. As a result, they simply represent what the provider says was charged and not paid. It does not represent the value of what would have been paid by the MCO.

Denial reasons for hospital claims:

Table 2.	Total Number of Claims Denied	Unique Claims Denied	Percentage of Claims Denied	Percentage of Unique Claims Denied
(Most Denials) Benefit/Covered Serviced	48,924	38,191	46.11%	43.57%
Additional Information	21,316	18,982	20.09%	21.66%
Authorization	19,626	14,855	18.50%	16.95%
Provider	12,380	11,933	11.67%	13.61%
Pre-certification	2,222	2,173	2.09%	2.48%
Timely Filing	1,266	1,151	1.19%	1.31%
(Least Denials) Medical Necessity	366	363	0.34%	0.41%
Total	106,100	87,648	100.00%	100.00%

For the quarter, there were 106,100 claims denied, and 87,648 of those claims were unique claims, meaning there were 18,452 duplicate claims that were both submitted and denied multiple times. Nearly half of the denials were denied because they did not meet the MCO's definition of a Benefit or Covered Service. MCOs are contractually obligated to cover all services in the HFS fee-for-service fee schedule at a minimum.

The seven Denial Reasons are described below and at least one example given of each reason:

> *Additional Information*: Provider claim is Denied because the Provider has failed to supply the required information and the MCO needs the Provider to submit more information to process the claim (Example: doctor's notes to support an enhanced level of service).
>
> *Authorization:* Provider claim is denied by MCO because Provider did not meet MCO's authorization policy on Provider network status, service limits, medical necessity, non-emergency services, or missing/invalid authorization form/record (Example: prior authorization request was not submitted on a diagnostic service, such as an MRI).

Benefit/Covered Service: Provider claim is denied by MCO because Provider did not meet MCO's policy for Covered Services, which are eligible for reimbursement. [Note that the MCO may cover some services which are traditionally not covered by HFS as stated under Section 104 of Chapter 100 – Handbook for Providers of Medical Services https://www.illinois.gov/hfs/SiteCollectionDocuments/100.pdf] If there is TPL benefit for which the MCO Denied coverage, it should be reported as a Benefit/Covered Service denial. (Example: Illinois law restricts Medicaid coverage for inpatient alcohol detoxification to once every 60 days).

Medical Necessity: Provider claim is denied by MCO because Provider did not meet MCO's reimbursement policy for medical necessity. (Example: Member received an expensive MRI during a visit to the Emergency Room for headache when evidence-based guidelines suggest that there is no benefit to performing an MRI at that time. Providers have the right to appeal and provide additional clinical documentation.)

Pre-certification: Provider claim is denied by MCO because Provider did not meet MCO's pre-certification for Hospital or SUPR (formerly DASA) services. (Example: Member was admitted for inpatient and the servicing provider had all information needed to contact Member's MCO. Member was discharged 02/06/2018. Provider called MCO for authorization of the admission 02/13/2018 causing the denial of the authorization since the pre-certification was late).

Provider: Provider claim denied by MCO because: 1) Provider sanctioned by OIG, 2) Provider not registered with HFS, including Providers who are out-of-state and not registered with HFS, and 3) Provider is not certified or eligible to be paid for this procedure/service on this date of service. It is expected that Provider works with HFS IMPACT/OIG team to activate their status so that claims can be reprocessed by MCOs for reimbursement. In each of these cases, MCOs have decided to reimburse $0 and nothing will change that reimbursement value, until the Provider is enrolled with HFS. (Example: A provider has been sanctioned by OIG but continues to submit claims. This is an important component of protecting against fraud/waste/abuse).

Timely Filing: Provider claim is denied by MCO because Provider did not meet MCO's timely filing policy, including any waiver period. (Example: A claim is filed for service more than 180 days after the service date).

Generally, when a claim is rejected or denied, a remittance advice is sent to the billing provider detailing the reason(s) that are causing the rejection or denial. Some MCOs include phone numbers and advice on what to look for in order to remedy the issue.

Timeliness of Processing for Hospital Claims:

Table 3.	Number of Hospital Claims Adjudicated	Percent of Total
Claims Adjudicated in 0-30 days	725,960	76.57%
Claims Adjudicated in 31-60 days	63,272	6.67%
Claims Adjudicated in 61-90 days	57,220	6.04%
Claims Adjudicated in more than 90 days	101,640	10.72%
Total Claims	948,092	100.00%

The claims in this table represent all hospital claims adjudicated with a service date in the first quarter of CY 2018, meaning it includes claims that needed manual review because there was a problem with the claim, and includes any adjustment made to the original claim. There were 948,092 claims adjudicated for the quarter, with 725,960 (76.57%) of them being adjudicated within 30 days, and 846,452 (89.28%) of them being adjudicated within 90 days. Some MCOs report that during the payment slowdown in the first quarter, they had to prioritize claims, and thus had a large backlog of claims to adjudicate. Again, because of the definition of claims utilized, this table does not measure contract compliance regarding the benchmarks for adjudicating claims timely, specifically that MCOs are required to adjudicate 90% of clean claims within 30 days of receipt, and 99% within 90 days.

Most frequent reasons for rejections:

Rejected claims are the only portion of this report that could not be segregated for only hospital providers. The main reason for that is that rejections are often not tracked by provider type or reason because sometimes that information is not even known.

	Blue Cross Community Health Plan		CountyCare Health Plan		Harmony Health Plan		IlliniCare Health		Meridian Health Plan		Molina Healthcare		NextLevel Health Partners	
Table 4.	**Reason Description**	**# Claims Rejected**	**Reason Description**	**# Claims Rejected**	**Reason Description**	**# Claims Rejected**	**Reason Description**	**# Claims Rejected**	**Reason Description**	**# Claims Rejected**	**Reason Description**	**# Claims Rejected**	**Reason Description**	**# Claims Rejected**
Reason 1 (Most Rejections)	NDC BILLED NOT ACTIVE ON DOS BILLED	8,095	INV: SAME DAY DUPLICATE CLAIM	4,030	NO TAXONOMY INFORMATION	9,017	RECIPIENT NOT ELIGIBLE ON DATE OF SERVICE	3,741	APL/HCPCS CODE REQUIRED ON CLAIM	1,418	CANNOT FIND MEMBER IN PLAN DATABASE	442	CLAIM DATE INFORMATION INVALID FOR PAYER	643
Reason 2	BASED ON BILL TYPE, CLAIM SHOULD CONTAIN VALID APL PROCEDURE CODE	5,862	PATIENT CANNOT BE IDENTIFIED AS OUR INSURED.	2,325	PATIENT NOT ENROLLED ON DATE OF SERVICE	6,530	DATE OF BIRTH NOT EQUAL TO DEPT FILES	868	SERVICE NOT COVERED FOR RECIPIENT CATEGORY	1,185	OTHER	287	CLAIM REJECTED ON A FILE ACKNOWLEDGEMENT FROM PAYER.	584
Reason 3	MEMBER WAS NOT ACTIVE ON DOS BILLED	5,062	EXPENSES INCURRED AFTER COVERAGE TERMINATED.	2,240	THE BILL-TO/PAY-TO ADDRESS AND/OR THE TAX ID NUMBER SUBMITTED ON THIS CLAIM DO NOT MATCH THE BILLING INFORMATION IN OUR DATABASE.	4,593	MISSING / INVALID ITEM OR PROCEDURE CODE	391	PRIOR APPROVAL REQUIRED	1,180	NA	0	INV: SAME DAY DUPLICATE CLAIM	242
Reason 4	COMBINATION OF CLAIM TYPE, TAXONOMY BILLED, PROVIDER TYPE REGISTRATION, AND COS COMBINATION INVALID.	1,188	CLAIM ADJUSTMENT REASON CODE: REQUIRED; MUST BE ENTERED WHEN LINE LEVEL ADJUSTMENT INFORMATION IS ENTERED	748	SOME OR ALL OF THE BILLING OR RENDERING PROVIDER INFORMATION ON THIS CLAIM IS EITHER MISSING, INVALID OR ILLEGIBLE.	2,018	ADDITIONAL INFORMATION REQUIRED	247	OBSOLETE CODE - NEW HCPCS CODE REQUIRED	1,180	NA	0	SAME-DAY DUPLICATE CLAIM	112
Reason 5 (Least Rejections)	BASED ON THE PROCEDURE CODE BILLED, A NDC CODE SHOULD BE USED IN ASSOCIATION.	752	EXPENSES INCURRED PRIOR TO COVERAGE.	664	PER HFS PRACTITIONER FEE SCHEDULE; NATIONAL DRUG CODE(NDC) IS REQUIRED	1,320	MISSING / INVALID TAXONOMY CODE	151	OTHER PAYER AMT PD QUALIFIER NOT EQUAL 08	759	NA	0	INV: ADMIT SRCE CODE	53

MCOs reported different most frequently occurring rejection reasons, making aggregation untenable, so each MCO is reported here separately. Some of the common rejections reasons between MCOs that appear in Table 4 are that the recipient on the claim is not enrolled with that MCO on the service date, as well as the claim being a duplicate of an already paid claim. Other common rejection reasons are more technical, missing a code or having an invalid code.

Generally, rejections happen prior to a claim being received in the claims adjudication system. Common claim rejects include submissions with a member that is not enrolled with the MCO, with missing data elements (including diagnoses, type of bill, taxonomy, etc.), or with incorrect data, for example invalid diagnoses or invalid procedure codes. Once rejected, a provider will receive a rejection notice indicating the reason for the rejection and prompting them for a correction and resubmission. These claims are flawed and cannot be processed by an MCO (or other payer).

When providers submit claims electronically, clearinghouses that receive the claims before the MCO apply HIPAA standardized validation edits on claims to ensure the claims contain all the required data and that that data is valid. Those claims that cannot pass these edits are rejected. In the industry, these edits are referred to as WEDI SNIP edits (Workgroup for Electronic Data Interchange Strategic National Implementation Process). The MCO's apply the same WEDI SNIP edits that HFS applies to non-managed care claims.