Illinois Health and Hospital Association

July 17, 2018

MCO Administrative Performance Survey Results

IHA continues to conduct quarterly surveys as part of the Association's ongoing efforts to work with the Department of Healthcare and Family Services (HFS) to improve Medicaid managed care organization (MCO) transparency and performance and reduce unnecessary burdens and costs on our members. We greatly appreciate the outstanding participation of members of IHA's Insurance and Managed Care (IMC) Forum in responding to the surveys.

Outlined below are the results of IHA's most recent member survey on MCO performance for encounters submitted in the fourth quarter of 2017 (October through December 2017).

Overall Results:

- Survey results showed that initial denial rates remain high, as compared to industry averages, with a median denial rate of 17 percent, while the overall range of median denial rates varies among MCOs from 5 percent to 28 percent. Denied claims also remain unresolved for unacceptably long periods of time. The median percentage of denials still unresolved at the time of the survey, approximately five months after claim submission, was 17 percent, which is consistent with results from the previous quarter's survey.
- The survey results for this quarter show a drop in the overall percentage of denials, from a median of 23.2 percent of encounters reported as receiving an initial denial in Q3 2017 to a median of 16.5 percent in Q4 2017. Six of the seven MCOs showed a drop in their median denial rate.
- In addition, results for this quarter also generally show more consistency among respondents, as demonstrated by a tightening of the range of denial percentages reported. For example, the middle 50 percent of respondents reported an overall denial rate of 5.4 percent - 37.5 percent for all MCOs this quarter, down from a range of 9.1 percent - 46.7 percent for Q3 2017. This range tightening was seen for four of the seven MCOs.

It is important to note that two quarters of data are not sufficient to demonstrate trends; at least a year's worth of data is needed before conclusions can be made about changes in MCO performance.

IHA expects that these denial rates are fairly conservative, representing an understatement of the true volume of denials. Because the survey collects information on initial denials only, claims that go through an iterative process with an MCO (e.g., initial denial, claim resubmission, subsequent denial(s)) are counted as only one denial when in fact a single encounter may generate multiple denials from an MCO. In addition, the survey does not collect information about portions of an encounter that may be denied. For example, if two days of a five-day inpatient stay are denied but three days are paid, the claim is not counted as a denial in the data.

Rates/Reasons for Initial Denials:
Survey respondents were asked to itemize the most frequent reasons for initial claim denials. In response to member feedback, the current survey was expanded to provide ten potential denial reasons. The most common reasons for initial denials across all MCOs were:

- Non-covered services – 24 percent of initial denials;
- Pending information requests from the MCO – 21 percent of initial denials;
- Coding issues that resulted in denials – 14 percent of initial denials;

- Lack of authorization even though appropriate steps were followed – 10 percent of initial denials; and
- Payer billing and payment policies that resulted in denials – 9 percent of initial denials.

The percentage of claims denied for “non-covered services” was higher than anticipated. IHA examined the data to determine the types of denials that were categorized as “non-covered services.” Initial findings indicate that the category included a wide range of claims denials, not normally associated with non-covered services; yet the reporting provided by the MCOs was misleading and not uniform. Denials were classified as “non-covered services” for the following reasons: provider is not enrolled with the specific MCO; invalid place of service for the service provided; diagnosis does not match procedure; service rendered is not covered under the benefit plan; provider is not using the correct provider identifier or tax identification number; potential liability by a secondary payer; and procedure code is invalid for the date of service. As a result we have revised the survey to remove the “non-covered services” category and further expanded the number of reasons for denial categories. This change should allow for a more accurate categorization of actual denial reasons.

The response rate to the second quarter survey was 94 percent, with 84 of the 89 IMC Forum member hospitals participating. The results also included responses from all behavioral health facilities represented on the IMC Forum, which is a key step to developing additional advocacy efforts pertinent to behavioral health specific MCO issues. The survey results were based on 473,000 encounters.

Next Steps:
Results from this survey will be shared with HFS, along with recommendations for HFS on appropriate follow up based on MCO-specific results. IHA will also share blinded survey results with IMC Forum members along with a summary of key denial trends. Results of all 2018 surveys will also continue to be shared with IHA’s Board of Trustees in support of 2018 advocacy for improvement in the oversight of Medicaid MCOs.

IHA staff will conduct additional follow up with survey participants to assess ways in which to further standardize the list of denial reasons, capture multiple denial reasons and account for denial of specific days within an encounter.

Click here to access the survey results.
Click here to review a copy of the survey questions and definitions.

The next scheduled MCO survey will be distributed on July 18 with a final communication to the Board of Trustees and IMC Forum Members on September 8.