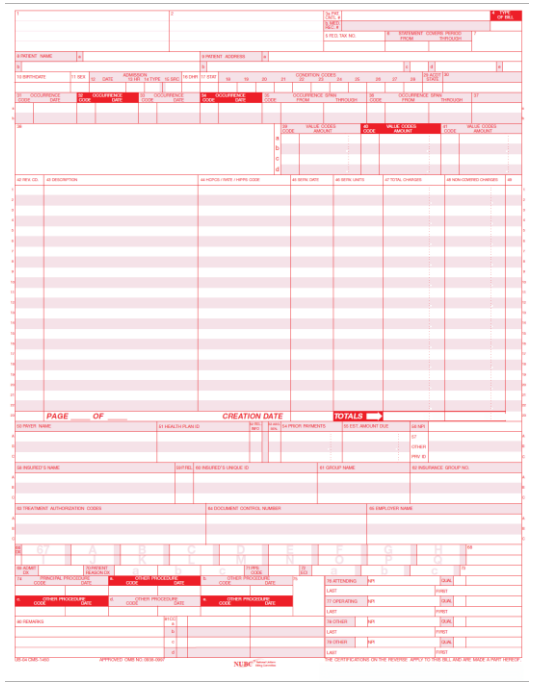
Medicaid Advisory Committee

Managed Care Prompt Payment to Providers

Indiana Family and Social Services Administration
Office of Medicaid Policy and Planning
February 27, 2020

Type of Claims

- The Indiana Health Coverage Programs (IHCP) accepts all major claim forms:
  - *UB-04* (institutional)
  - *CMS-1500* (professional)
  - *ADA 2012* (dental)
  - *Pharmacy*



- Accepted via paper or electronic

Timely Filing Limits

- The IHCP imposes timely filing limits* for providers to submit their claims.

Payer Source	Limitation
Managed Care (in-network providers)	90 calendar days from the date of service
Managed Care (out-of-network providers)	180 calendar days from date of service

* Some circumstances allow for timely filing to be extended or waived. See *BT201829* for a complete list.

Processing Timelines

- The IHCP mandates that payers process (adjudicate) **clean claims** within a time limit.

Type of Claim	Time to Process
Paper	30 calendar days of receipt
Electronic	21 calendar days of receipt

What Happens Upon Submission (Part 1)

- Based upon Federal and State requirements, the IHCP reviews a number of the claim's data points for processing at the **header level**:
  - National Provider Identifier (NPI)
  - Date of Service
  - Recipient Identifier (RID)
  - Provider's Taxonomy

What Happens Upon Submission (Part 2)

- Upon identification of all header-level data, the IHCP applies system logic at the **detail level**:
  - Covered/Non-Covered Procedure Code
  - Unit Limitations
  - Prior Authorization

Why Did My Claim "Deny"?

Claims may be **rejected** or **denied** depending upon the issue with the claim:

Common Rejections	*Common Denial Reasons*
Wrong Member RID	Third-party liability
Missing NPI	Duplicate claim
Missing Modifiers	No prior authorization
	NPI not registered with State
	Timely filing limit

Q4 2019 Data

IHCP Enrollment

- Membership with the IHCP is spread across multiple programs and multiple health plans. The following table provides enrollment as of December 2019:

	Hoosier Healthwise	Hoosier Care Connect	Healthy Indiana Plan	Total Members
Anthem	219,758	56,671	179,005	455,434
CareSource	51,004	N/A	36,145	87,149
MDwise	187,764	N/A	100,011	287,775
MHS	140,700	33,960	71,189	245,849

Adjudication Summary (*CMS-1500*)

	Anthem*	CareSource	MDwise	MHS
Claims Adjudicated	1,663,366	225,321	969,680	539,020
Claims Adjudicated Timely	1,609,585	224,074	770,013	537,805
% Adjudicated Timely	97%	99%	79%**	100%
Claims Paid	1,368,887	205,569	845,142	500,584
Claims Denied	294,479	19,752	124,538	38,436
% Claims Denied	18%	9%	13%	7%

Q4 2019 Data

The data reflected here is inclusive of all programs in which the plan participates; see slide 7 for clarification.
*Anthem includes rejected claims in total claims received, which results in more to adjudicate and inflates denials.
**Numbers are under review and may be incorrect due to a systems issue.

Adjudication Summary (*UB-04*)

	Anthem*	CareSource	MDwise	MHS
Claims Adjudicated	365,230	50,674	201,502	122,201
Claims Adjudicated Timely	347,990	49,992	164,073	121,373
% Adjudicated Timely	95%	99%	81%**	99%
Claims Paid	323,581	39,823	182,505	114,805
Claims Denied	41,649	10,851	18,997	7,396
% Claims Denied	11%	21%	9%	6%

Q4 2019 Data

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*Anthem includes rejected claims in total claims received, which inflates denials.
**Numbers are under review and may be incorrect due to a systems issue.

Adjudication Summary (*ADA 2012*)

	Anthem	CareSource	MDwise	MHS
Claims Adjudicated	120,350	27,937	79,270	70,528
Claims Adjudicated Timely	119,744	27,937	79,268	70,528
% Adjudicated Timely	100%	100%	100%	100%
Claims Paid	110,285	22,857	73,751	65,563
Claims Denied	10,065	5,080	5,519	4,965
% Claims Denied	8%	18%	7%	7%

Q4 2019 Data

The data reflected here is inclusive of all programs in which the plan participates, see slide 7 for clarification.

Adjudication Summary (*Pharmacy*)

	Anthem	CareSource	MDwise	MHS
Claims Adjudicated	3,032,703	269,417	1,738,584	1,039,007
Claims Adjudicated Timely	3,004,169	269,417	1,738,584	1,039,007
% Adjudicated Timely	99%	100%	100%	100%
Claims Paid	1,877,527	202,681	1,380,438	874,799
Claims Denied	1,155,176	66,736	358,146	164,208
% Claims Denied	38%	25%	21%	16%

Q4 2019 Data

The data reflected here is inclusive of all programs in which the plan participates, see slide 7 for clarification.
Pharmacy claims have a higher denial number because they are adjudicated at point of service. If a denial is received, the pharmacist can immediately re-run the prescription for a payment adjudication, provided it is payable.

Financial Cycle

- Upon claim adjudication, the IHCP runs a financial cycle and processes checks for payment:

Payer	Financial Cycle Frequency
Anthem	Daily; checks are mailed on Monday, Tuesday, Wednesday, and Friday
CareSource	Every Tuesday and Wednesday
MDwise	Every Wednesday; checks mailed on Friday
MHS	Every Wednesday, checks mailed on Thursday

OMPP Oversight

- OMPP uses the following means to provide oversight to MCEs on issues related to claims processing:

Oversight Measures
Monthly onsite meetings
Quarterly reporting
Readiness reviews over claims payers prior to approval to implement
Ad-hoc reporting
Sanctions for poor performance (see below)
External quality review audits
Provider education through provider relations

- **MCEs that fail to adjudicate 98% of all claims in a quarter are assessed liquidated damages for each program in which they fail to meet the requirement.**

Recap

- IHCP processes hundreds of thousands of claims in a given quarter.
- Claims can be rejected or denied for a variety of reasons.
- The vast majority of claims are adjudicated in a timely fashion.
- OMPP has a team of individuals responsible for MCE oversight, including claims and payment activities. When MCEs are out of compliance, OMPP expects:
  - Root cause analysis in explanations
  - Claims volume impacted counts
  - Timeframes to remedy
  - Confirmation of remedies
  - Sanctions to be paid
- **Service to providers is an area that can continuously be improved and we are committed to excellence.**

Questions?