COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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April 12, 2024

MEMORANDUM

TO: The Honorable Mark Sickles
Chair, House Appropriations Health and Human Resources Subcommittee.

The Honorable R. Creigh Deeds
Chair, Senate Finance and Appropriations Health and Human Resources Subcommittee.

Sarah Stanton
Executive Director, Joint Commission on Health Care

FROM: Cheryl J. Roberts
Director, Virginia Department of Medical Assistance Services

SUBJECT: Managed Care Organization Denied Claims and Resubmissions Report

This report is submitted in compliance with HB2190 and SB1270 of the *2023 General Assembly Session*, which states:

"That the Department of Medical Assistance Services (the Department) shall collect and report (i) the number and percentage of claims submitted to managed care organizations that were denied and the reasons for such denials and (ii) the number and percentage of claims submitted to managed care organizations that required resubmission prior to payment and the reasons for such resubmissions. Such data shall be reported for each fiscal year from fiscal year 2018 through fiscal year 2022 and shall be organized by major provider type, including primary care providers and urgent care centers. The Department shall examine such data and identify barriers that providers encounter when accepting and treating patients enrolled in the state plan for medical assistance services. The Department shall report such data and analysis to the Joint Commission on Health Care and the Joint Subcommittee for Health and Human Resources Oversight by November 1, 2023."

Should you have any questions or need additional information, please feel free to contact me at (804) 664-2660.

CJR/wrf

Enclosure

Pc: The Honorable John Littel, Secretary of Health and Human Resources

Managed Care Organization Denied Claims and Resubmissions Report (HB2190/SB1270)

A Report to the Virginia General Assembly *April 12, 2024*

Report Mandate:

HB2190/SB1270 of the 2023 General Assembly Session Requires DMAS to "collect and report (i) the number and percentage of claims submitted to managed care organizations that were denied and the reasons for such denials and (ii) the number and percentage of claims submitted to managed care organizations that required resubmission prior to payment and the reasons for such resubmissions. Such data shall be reported for each fiscal year from fiscal year 2018 through fiscal year 2022 and shall be organized by major provider type, including primary care providers and urgent care centers. The Department shall examine such data and identify barriers that providers encounter when accepting and treating patients enrolled in the state plan for medical assistance services. The Department shall report such data and analysis to the Joint Commission on Health Care and the Joint Subcommittee for Health and Human Resources Oversight by November 1, 2023."

Summary

This report presents a detailed analysis of claims data received from the six managed care organizations (MCOs) contracted with DMAS. Comprising all claims submitted to the MCOs during a five-year period between July 1, 2017, and June 30, 2022, this data distinguishes both claims denied, and claims denied but paid upon resubmission as well as the reasons behind those denials. All claims' data has been reported by provider type corresponding to the billing provider.

For the purposes of this report, each claim line item was counted as one claim. This approach precluded counting a single claim as both paid and denied in the event that a claim contained both paid and denied line items. Where multiple line items within a single claim were denied, but for different reasons, each line item was counted only within the claim totals for the denial reason(s) that applied to that line item. The term "claim" throughout this report should be regarded as equivalent to "claim line item."

Of more than 372 million claims submitted during the report period, almost 77 million, or nearly 21% of claims submitted, were at least initially denied. The report breaks down the reported claims data into the following categories:

- Total Claims Submitted to MCOs by Provider Type
- Total Claims Paid by MCOs by Provider Type
- Total Claims Paid Only After Resubmission by Provider Type
- Total Claims Denied by Provider Type

About DMAS and Medicaid

The mission of the Virginia Medicaid agency is to improve the health and well-being of Virginians through access to high-quality health care coverage.

The Department of Medical Assistance Services (DMAS) administers Virginia's Medicaid and CHIP programs for over 2 million Virginians. Members have access to primary and specialty health services, inpatient care, dental, behavioral health as well as addiction and recovery treatment services. In addition, Medicaid long-term services and supports enable thousands of Virginians to remain in their homes or to access residential and nursing home care.

Medicaid members historically have included children, pregnant women, parents and caretakers, older adults, and individuals with disabilities. In 2019, Virginia expanded the Medicaid eligibility rules to make health care coverage available to more than 600,000 newly eligible, low-income adults.

Medicaid and CHIP (known in Virginia as Family Access to Medical Insurance Security, or FAMIS) are jointly funded by Virginia and the federal government under Title XIX and Title XXI of the Social Security Act. Virginia generally receives a dollar-for-dollar federal spending match in the Medicaid program. Medicaid expansion qualifies the Commonwealth for a federal funding match of no less than 90% for newly eligible adults, generating cost savings that benefit the overall state budget.

- Top Claim Denial Reasons (>= 100,000 claims)
- Top Claim Denial Reasons by Provider Type (>= 100,000 claims)
- Top Original Denial Reasons for Claims Paid Only Upon Resubmission (>= 10,000 claims)
- Top Original Denial Reasons for Claims Paid Only Upon Resubmission by Provider Type (>= 10,000 claims)

The following tables highlight the most prevalent reasons for claim denials and identify those provider types most highly represented from among all denied claims reported with a provider type. A more complete analysis of denial reasons and provider types can be found in the accompanying spreadsheet.

Virginia Medicaid Managed Care

Claims Denial and Resubmission Totals

For Fiscal Years 2018 - 2022

Summary Totals

State Fiscal Year	Claims Submitted	Total Claims Paid	Claims Paid After Resubmission	Resubmitted Paid Claims as % Total Paid Claims	Claims Denied	% Submitted Claims Denied
2018	39,523,495	28,793,623	455,639	1.6%	9,731,418	24.6%
2019	62,233,429	46,989,274	883,191	1.9%	13,556,839	21.8%
2020	81,568,304	60,044,191	1,049,652	1.7%	17,603,746	21.6%
2021	87,683,180	66,558,505	878,414	1.3%	17,438,568	19.9%
2022	101,121,440	77,123,180	2,198,138	2.9%	18,353,634	18.2%
5-Year Total	**372,129,848**	**279,508,773**	**5,465,034**	**2.0%**	**76,684,205**	**20.6%**

The ten most prevalent reasons for claim denials – accounting for about 62% of all denied claims

Denial Reason	Claims Denied	% of Total Denied Claims
Duplicate claim/service	12,153,044	15.8%
No separate payment; included in payment for other service(s)	10,548,520	13.8%
Charges exceed contracted fee	6,190,134	8.1%
Service not authorized or authorization number is missing, invalid or does not apply to billed services or provider	4,649,261	6.1%
Need Primary Payer EOB	3,052,041	4.0%
Member not eligible on Date(s) of service	2,867,186	3.7%
Invalid, inappropriate or missing modifier	2,701,388	3.5%
Service not covered/non-covered charges	2,249,398	2.9%
Filed after timely filing limit	1,613,125	2.1%
Missing/incomplete/invalid/ deactivated/withdrawn national drug code (NDC)	1,611,583	2.1%

The ten most highly represented provider types for denied claims – accounting for about 90% of all denied claims with an identified provider type

Provider Type	Claims Denied	Percentage of Denied Claims*
Hospital	20,445,216	29.4%
Physician (non-primary care)	16,173,761	23.2%
Laboratory Services	10,497,882	15.1%
Clinic (non-primary care)	3,596,101	5.2%
Behavioral Health	2,916,042	4.2%
Prosthetic and Orthotics	2,501,959	3.6%
Primary Care	2,088,585	3.0%
Home Health Agency	1,686,734	2.4%
Durable Medical Equipment	1,559,131	2.2%
Nurse Practitioner (non-primary care)	1,519,065	2.2%

**This percentage is based on denied claims with an identified provider type. Denied claims reported with no provider type were not included in the calculation of this percentage.*

The ten most prevalent reasons for claim denials prior to payment after resubmission – accounting for about 64% of all such denied claims

Denial Reason	Claims Resubmitted*	% of Total Resubmissions*
Medicare COB Calculation	373,150	13.3%
No separate payment; included in payment for other service(s)	368,442	13.1%
COVID-19 - Adjusted to waive member cost share	255,854	9.1%
Duplicate claim/service	206,543	7.4%
Service not authorized or authorization number is missing, invalid or does not apply to billed services or provider	136,657	4.9%
Commercial COB calculation	122,259	4.4%
Need Primary Payer EOB	95,302	3.4%
Adjusted-maximum payment amount	87,971	3.1%
Claim Requires Manual Processing	83,326	3.0%
Service denied because payment already made for same/similar procedure within set time frame	71,627	2.6%

**These totals and percentages are based on claims paid after resubmission where the previous denial reason was known.*

The ten most highly represented provider types for denied claims paid after resubmission – accounting for about 85% of all such claims with an identified provider type

Provider Type	Claims Resubmitted	% of Total Resubmissions*
Physician (non-primary care)	373,150	13.3%
Hospital	368,442	13.1%
Behavioral Health	255,854	9.1%
Home Health Agency	206,543	7.4%
Primary Care	136,657	4.9%
Laboratory Services	122,259	4.4%
Prosthetic and Orthotics	95,302	3.4%
Group Practice (non-primary care) (non-primary care)	87,971	3.1%
Durable Medical Equipment	83,326	3.0%
Nurse Practitioner (non-primary care)	71,627	2.6%

**This percentage is based on denied claims paid after resubmission with an identified provider type. Such claims reported with no provider type were not included in the calculation of this percentage.*