# TSG Task Force Update

**To: Arkansas Health Reform Task Force**

**Re: State of Kentucky Experience with Full Risk Managed Care**

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## Managed Care in Kentucky

### *Introduction*

The Stephen Group was asked by the Arkansas Health Reform Task Force to research the impact of capitated managed care in the State of Kentucky. We provide the following:

### *History and Background*

In 1997, the Kentucky Health Partnership (KHP), a mandatory comprehensive risk based managed care program, began providing acute, primary and some specialty care (excluding behavioral health) to most Medicaid beneficiaries in Region 3 (Louisville and 16 surrounding counties), using a regional non-profit partnership of providers (Passport Health Plan). The remainder of state continued to be covered under a primary care case management fee for service (FFS) program, similar to the Arkansas patient centered medical home model.

In November 2011, Governor Beshear issued an RFP to expand Medicaid Managed Care statewide (except Region 3 still covered by KHP/Passport). Contracts were awarded to commercial managed care organizations (MCOs) to cover acute, primary and specialty services, including behavioral health and dental, services. The state awarded contracts effective January 2013 to three additional MCOs in Region 3 after the Centers for Medicare and Medicaid Services (CMS) advised that Region 3 could no longer operate with a single managed care provider.

Effective January 1, 2014, Kentucky contracted with three MCOs to provide healthcare services to newly eligible Kentuckians statewide (except Region 3) under the Medicaid expansion provision of the Affordable Care Act, and to current Medicaid members effective July 2014. (The existing contracts in Region 3 provided coverage to the newly eligible population.) Newly eligibles were mandatorily enrolled and existing MCOs were required to expand their networks to accommodate the increased membership. All contracts were due to expire June 2015, with three one-year renewal options.

### *Underlying State of Health in Kentucky*

- Overall health in Kentucky is very poor, with high rates of smoking, substance addiction, diabetes and cancer
- 25% of the population is on Medicaid
- Large problem with opioid use, ranking #1 in the nation in overdose deaths due to heroin
- Heavy use of NICU added to health care costs
- Insufficient mental health and substance abuse providers

- Kentucky has a retroactive payment for Medicaid services

These factors presented challenges to the MCOs contracted to provide Medicaid services.

***Problems in Implementation***

The initial 2011 RFP did not set rates and data provided by the state to help MCOs develop reimbursements was controversial and perceived as skewed, leaving the plans at a disadvantage for providing robust rate bids. One MCO exited the plan within 2 years due to losing money. In 2013, Kentucky amended the contracts with the remaining MCOs to increase rates by 7%. As of 2014, the state no longer bids rates, but sets rates through an administrative process using actuarial analyses.

Implementation moved much too quickly: Initial contracts with MCOs were signed and 560,000 members were transferred to Managed Care within 4 months. MCOs had to rush to recruit and train employees and contract with networks of doctors and hospitals. Delays in getting care and mental health gaps led to an adversarial relationship between the state, the plans and the provider community.

Insufficient time and resources were devoted to strengthening oversight capacity, developing strong contracts, developing care monitoring systems, and training staff. Though they had previously run a Primary Care Case Management (PCCM) system, the State did not have enough staff to expand their oversight effectively, resulting in a loss in accountability.

Provider groups warned of the high use of electronic billing by providers, but MCOs were unprepared: While electronic clearing houses did have up-to-date technology, interfaces did not work properly.

Providers complain of the complexity of dealing with many different formularies.

Providers were very unhappy with MCOs opting physicians into Medicaid unless the provider specifically told them not to.

Although many of the initial problems were resolved as the MCOs gained experience with managing the Kentucky Medicaid population, there continued to be complaints from patients who were denied treatments or having difficulties finding providers, especially in rural areas.

Providers complained of delayed payments, having claims denied, and a cumbersome pre-authorization process.

Mental health advocates said the system of care had deteriorated, with plans denying prescriptions that patients had taken successfully for years, community mental health centers

limiting or canceling programs because plans wouldn't authorize enough treatment, and mental health providers reducing the time spent with patients.

***Changes to MCO Contracts effective July 2015***

In April 2015 Kentucky published a new RFP to rebid contracts to strengthen them, address concerns of advocates and providers, and standardize processes. Changes included in the RFP and new contracts mirrored recommendations in a March 2015 annual state audit report on rural hospitals to improve and strengthen managed care contracts and bring accountability and transparency to taxpayers. Initial one-year contracts are to be followed by 4 one-year renewal options.

The new contracts put standardized processes in place that will help healthcare providers by improving administrative processes; increase oversight in many areas, including appropriate denial of claims; include incentives for MCOs to work with Medicaid members and providers to decrease the overutilization of emergency rooms; encourage MCOs to assist in the continued expansion of behavioral health services; incentivize the MCOs to continue to improve health outcomes for Medicaid members; and address concerns that penalties assessed on the MCOs are not sufficient or stringent enough to ensure contract compliance.

Changes to the contracts reflect longstanding concerns of hospitals, providers and advocates about lax oversight and penalties on MCOs, and inefficient administrative hurdles, and include:

- Establishing a standardized contract for all MCOs with the Commonwealth;
- Requiring statewide coverage from all contracted MCOs;
- Mandating that 82-87 percent of member capitation payments to the MCOs must be expended for direct services to Medicaid members;
- Adding an incentive pool for the MCOs to improve health outcomes;
- Requiring the use of national standards designated by the Cabinet to determine "medical necessity;"
- Ensuring the appropriate medical specialists are making "medical necessity" determinations and reviewing cases on behalf of the MCOs;
- The Cabinet for Health and Family Services (state department) will be reviewing "medical necessity" denials and denials of payment for emergency room use for contract compliance;
- Expanding performance requirements for Medicaid members' pharmacy benefits;
- Requiring the use of standardized forms for prior-authorization requests, grievances or appeals for members and providers, and claims submittal;
- Using nationally accepted uniform standards for credentialing all health professionals;
- Strengthening requirements for the provision of behavioral health services;
- Developing practical and convenient alternatives to non-emergent emergency room utilization;

- Requiring timely updates by the MCOs to their online provider network information within 10 days of changes being made to the network;
- Requiring MCOs to serve persons with Severe Mental Illness (SMI) as persons with special needs; and
- Increasing penalties for non-conformance with contract requirements.

***Populations and Services Covered under Managed Care***

- 829,000 Medicaid beneficiaries were covered prior to 2014
  - Aged, disabled children and adults, children, low-income adults, Medicare-Medicaid dual eligibles, foster children
  - 200,000 aged, blind and disabled adults
- 308,000 additional individuals with incomes below 138% FPL were enrolled in MCOs with Medicaid expansion in 2014, for combined total 1.1 million members covered
- KHP/Passport and the other MCOs all cover Inpatient hospital, Primary and Outpatient care, Pharmacy, and Dental.
  - Behavioral Health Services only covered under the MCOs
  - Personal Care/Home and Community Based Services only covered under KHP
  - None of the programs cover Institutional Long Term Care

***Cost and Savings***

- Capitation Per Member Per Month payments for MCOs range from approximately $400 to over $500.
- Savings of $1.3 billion for 2011-2013, of which $390 million are state dollars.
- Costs per patient remained below forecasted amounts for 2011-2013.
- The effect of the new July 2015 contract requirements on costs and savings have not yet been determined.
- The requirement for 85% MLR will be vetted during the 2017 rate setting process.

***Outcomes and Oversight***

Improvements over the first biennium 2011-2013 compared with statistics before managed care include:

- 93 percent increase in smoking cessation consultations
- 33 percent increase in flu vaccines for children
- 14 percent increase in HPV vaccines
- 4,655 percent increase in 12-lead electrocardiograms (to screen for heart problems)
- 4,538 percent increase in mammograms
- 17 percent decrease in amputations, often due to untreated diabetes
- Nearly 11 percent decrease in CT scans

A Dashboard showing Year to Date comparisons of MCOs' performance since 2013 is available online (http://chfs.ky.gov/dms/pqomcoqbreports.htm#dashboards ), along with annual comparison of MCO performance data to targets and national benchmarks, managed care progress reports, annual MCO compliance reviews, and validation of performance measures, and other reports (http://chfs.ky.gov/dms/pqomcoqbreports.htm#report ).

The dashboard for MCO performance measures includes:

- Claims payment: claims paid, claims suspended, amount paid/member, paid loss ratio, total paid claims within 30 days, total paid claims within 90 days
- Prior Authorizations: number requested and denied, percent denied
- Member Calls: number of calls, percent abandoned, speed to answer
- Provider Calls: number of calls, percent abandoned, speed to answer
- Behavioral Calls: number of calls, percent abandoned, speed to answer, percent answered by 4th ring or within 30 seconds, average length
- Coordination of Benefit Savings, Cost Avoidance, Potential Subrogation and Program Lock-In
- Number of claims processed, claims activity and number of Prior Authorization reports
- Provider credentialing, additions and terminations from network

The September 2015 dashboard for MCO performance is attached at the end of this report

In addition to HEDIS healthcare outcome performance measures, Kentucky also requires MCOs to track state-specific healthcare outcomes, including:

- % of pregnant members who received prenatal/postpartum risk assessment and education/counseling
- % of adults who receive cholesterol screening
- % of adults who received counseling for nutrition/physical activity
- % of children/adults who had height and weight documented and appropriate weight for height
- % of teens with at least one well-care visit and who received counseling on tobacco and alcohol/substance use, sexual abuse, and screening for depression
- % of children and adolescents in SSI, foster care or received services for children with special health needs, who received services defined in HEDIS specifications
- Various measures on dental services for members under age 21

***Results of Revised 2015 Contract with Managed Care Organizations***

Some changes have been made through legislative action: KASPER (Kentucky All Schedule Prescription Electronic Monitoring) is now mandatory to track all prescriptions of controlled

substances for an individual over a specified time period, the prescriber and the dispenser. Also, Prior Authorizations are now required to be completed within 2 days.

However, the larger issues of overall poor health and recovering from the speed of the transition to managed care still exist and continue to be a challenge for both the MCOs and providers. While some improvements have been made (in obesity and oral health), other areas are worse (opioid deaths).

Overall, the new contract is viewed by the state as the best and strongest contract with the managed care organizations. Most of the changes to the contract were not drastic and implementation of some requirements has been delayed by the change in administration in December 2015. In addition, it is too early to determine the financial impact of the changes. The requirement for standardized forms for Prior Authorizations and for Grievances and Appeals was requested by providers. This has been implemented, but only as hard copy forms to be sent to the MCOs, as the state determined it was not able to implement an online version. The requirements around the determination of 'medical necessity' have not been implemented. This was to be contracted to a third party vendor, a process that has been delayed. The requirement for 85% MLR has not yet been vetted, but will be reviewed in the upcoming process of setting rates for 2017.

The biggest change has been the strengthening of penalties related to the 'encounter' process, which is also a priority for the new administration. The new contract spells out very clearly the format in which MCOs are to submit claims to the state, an issue that under the previous contract led to numerous disagreements with the MCOs. Since December there has been an increase in penalties against the MCOs as they are held to the stricter requirements.

Providers accept that managed care is here to stay. Now that the initial hurdles have been mostly overcome, the new administration's initial effort to roll back Medicaid expansion has been replaced by a desire to continue it in a sustainable way. The new Governor is looking at other states' models and some are advocating reducing the number of MCOs from the current 5 to no more than 3. Managed care is seen as a model that can make a positive difference in addressing Kentucky's pervasive health issues. Many of Kentucky Health Now's goals are being met and the MCO's challenges in meeting others are due to a lack of providers to deal with the high medical needs of the population. However, providers still feel that the MCOs are much better at managing money (most are profitable), than in managing patient health care.

One MCO, Passport Health Care, was singled out by a provider group as being particularly good to work with and trying to be innovative. When a two-year federal primary care incentive to pay (higher) Medicare rates for evaluation and management services expired in 2014, Passport elected to continue those payments, rather than revert to the lower Medicaid payments.

***Conclusion***

Kentucky is a state that initially contracted with MCOs in a poor, non state best practice, way but took fairly quick steps to rectify this issue by re-procuring and providing enhanced contractual improvements, most of which TSG has discussed with the Task Force in prior meetings. If Arkansas should decide to move forward on any form of full risk Managed Care, Kentucky is a good example to look at regarding the implementation of Medicaid Managed Care: they successfully expanded from a limited area to a statewide program, contracting with multiple plans to provide additional services, and enhanced state oversight and contract responsibilities. In recent years, the capitation rates have leveled off and accountability to the state has increased, and they seem to have learned lessons from the problems due to quick implementation. Existing health problems in the state, however, continue to be a challenge to MCOs and providers.

***Sources:***

Cindy Arflack, Director, Division of Programs and Quality Outcomes, Kentucky Department for Medicaid Services, 502-564-4321

Lindy Lady, Medical Business Advocacy Manager, Kentucky Medical Association, 502-426-6200

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August 2015 Managed Care Program Progress Report http://chfs.ky.gov/NR/rdonlyres/70F361F6-A402-4BDB-B546-7FD57BFB6BA9/0/2015ManagedCareProgramProgressReport.pdf

Kentucky CHFS Managed Care Oversight Quality Branch Reports: http://chfs.ky.gov/dms/pqomcoqbreports.htm#dashboards

2014 CMS Overview of Managed Care in Kentucky: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/kentucky-mcp.pdf

Validation of Reporting Year 2014: Kentucky Medicaid Managed Care Performance Measures: http://chfs.ky.gov/NR/rdonlyres/BB53603E-7A83-4920-9ABC-8EB0521B22BE/0/2014KentuckyMedicaidMCOPerformanceMeasures.pdf

*Aggressive Action Plan for Managed Care Paying Off*, Kentucky Governor's Office Press Release, 2013, http://migration.kentucky.gov/Newsroom/governor/20131024managedcare.htm

*Kentucky's Rush into Medicaid Managed Care: A Cautionary Tale for Other States*, Kaiser Health News, July 15, 2013 http://khn.org/news/kentucky-medicad-managed-care/

*Managed Care Contracts Awarded to Serve More Kentuckians Newly Eligible for Medicaid*, KY CHFS Press Release, September 13, 2013, http://chfs.ky.gov/news/Expansion+MCO+Contracts+Awarded.htm

*Evaluation of Statewide Risk-Based Managed Care in Kentucky*, Ashley Palmer, et al, Urban Institute, 2012, http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412702-Evaluation-of-Statewide-Risk-Based-Managed-Care-in-Kentucky-A-First-Year-Implementation-Report.PDF

2011 Contract with Coventry Health: http://finance.ky.gov/services/eprocurement/Documents/Medicaid%20Managed%20Care%20Contracts/FinalCoventryMCOContractwithsignature.pdf

## Monthly MCO Dashboard Comparison
### September, 2015

| | | | ANTHEM | COVENTRY AETNA | HUMANA CARESOURCE | PASSPORT | WELLCARE | TOTAL |
|---|---|---|---|---|---|---|---|---|
| Membership | | | 75,124 | 292,827 | 118,794 | 266,586 | 433,750 | 1,187,081 |
| Capitation | | | 37,008,772 | $ 115,903,541 | $ 60,328,160 | $ 134,577,606 | $ 209,500,556 | $ 557,318,635 |
| CAP PMP | | | $ 492.64 | $ 395.81 | $ 507.84 | $ 504.82 | $ 483.00 | $ 469.49 |
| | | | | | | | | |
| Claims Payment | Paid Claims | | $ 17,795,952 | $ 78,065,220 | $ 36,535,965 | $ 106,346,549 | $ 170,398,828 | $ 409,142,513 |
| | Suspended | | $ 1,549,912 | $ 5,842,506 | $ 72,131,081 | $ 135,265,000 | $ 43,681,545 | $ 258,470,043 |
| | % Suspended | | 8.01% | 6.96% | 66.38% | 55.98% | 20.40% | 38.72% |
| | Paid/Member | | $ 236.89 | $ 266.59 | $ 307.56 | $ 398.92 | $ 392.85 | $ 344.66 |
| | Paid Loss Ratio | | 48.09% | 67.35% | 60.56% | 79.02% | 81.34% | 73.41% |
| | Total Paid Claims | 90% paid in 30 Days | 99.29% | 99.95% | 97.67% | 99.68% | 99.93% | 99.51% |
| | Total Paid Claims | 99% paid in 90 Days | 99.36% | 100.00% | 99.48% | 100.00% | 99.97% | 99.87% |
| P/As | Requested | | 12,078 | 32,599 | 6,177 | 21,283 | 42,177 | 114,314 |
| | Denied | | 1,159 | 4,671 | 989 | 1,879 | 9,653 | 18,351 |
| | % Denied | | 9.60% | 14.33% | 16.01% | 8.83% | 22.89% | 16.05% |
| Member Calls Report #11 | # of calls | | 9,830 | 18,341 | 15,752 | 35,537 | 52,147 | 131,607 |
| | # Abandoned | | 110 | 498 | 196 | 271 | 1,573 | 2,648 |
| | % Abandoned | 5% or less | 1.00% | 2.70% | 1.24% | 0.76% | 3.02% | 2.01% |
| | Speed to answer | 30 seconds or less | 11 | 26 | 20 | 18 | 27 | |
| Provider Calls Report #11 | # of calls | | 8,815 | 12,162 | 9,283 | 17,736 | 22,404 | 70,400 |
| | # Abandoned | | 44 | 180 | 18 | 268 | 720 | 1,230 |
| | % Abandoned | 5% or less | 0.50% | 1.50% | 0.19% | 0.97% | 3.21% | 1.75% |
| | Speed to answer | 30 seconds or less | 12 | 35 | 8 | 23 | 37 | |
| Behavioral Calls Report #11 | # of calls | | 326 | 737 | 11 | 1029 | 296 | 2,399 |
| | # Abandoned | | 2 | 0 | 1 | 3 | 2 | 8 |
| | % Abandoned | 7% or less | 1.00% | 0.00% | 9.09% | 0.29% | 0.68% | 0.33% |
| | Speed to answer | 30 seconds or less | 12 | 11 | 13 | 13 | 8 | |
| | Answered by 4th ring | at least 99% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | |
| | Receivng Busy Signal | No Calls | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | |
| | Answered within 30 sec | More than 80% | 94.00% | 98.20% | 81.82% | 86.00% | 95.00% | |
| | Avg length | < 10 min | 8:02 | 4 | 1 | 2 | 3 | |
| Total Calls | Total Calls | | 18,971 | 31,240 | 25,046 | 54,302 | 74,847 | 204,406 |
| | Abandoned | | 156 | 678 | 215 | 542 | 2,295 | 3,886 |
| | % Abandoned | 5% or less | 0.82% | 2.17% | 0.86% | 1.00% | 3.07% | 1.90% |
| COB Savings Report #54 | | MCO paid amount | $ 307,421 | $ 2,170,982 | $ 637,086 | $ 1,243,811 | $ 1,637,333 | $ 5,996,633 |
| | | COB Amount | 1952394.97 | $ 7,975,287 | $ 4,031,283 | $ 7,968,869 | $ 18,649,266 | $ 40,577,100 |
| | | COB/Member | $ 25.99 | $ 27.24 | $ 33.94 | $ 29.89 | $ 43.00 | $ 34.18 |
| | | % of Claims Paid | 10.97% | 10.22% | 11.03% | 7.49% | 10.94% | 9.92% |
| Medicare Cost Avoidance Report #55 | | Denied Amount | $ 718,085 | $ 1,936,834 | $ 143,648 | $ 3,901,703 | $ 3,023,827 | $ 9,724,097 |
| | | % of Claims Paid | 4.04% | 2.48% | 0.39% | 3.67% | 1.77% | 2.38% |
| Non-Medicare Avoidance Report #56 | | Denied Amount | $ 1,768,749 | $ 4,627,955 | $ 2,452,525 | $ 4,348,724 | $ 6,937,235 | $ 20,135,188 |
| | | % of Claims Paid | 9.94% | 5.93% | 6.71% | 4.09% | 4.07% | 4.92% |
| Potential Subrogation Report #57 | | Lien/Claim | $ 2,070 | $ 8,293,184 | $ 1,488,931 | $ 13,980,410 | $ 1,009,018 | $ 24,773,614 |
| | | % of Claims Paid | 0.01% | 10.62% | 4.08% | 13.15% | 0.59% | 6.06% |
| | | Recovered | $ 1,319 | $ 573,039 | $ 78,350 | $ 466,362 | $ 19,610,303 | $ 20,729,372 |

## Monthly MCO Dashboard Comparison
### September, 2015

| | | | ANTHEM | COVENTRY AETNA | HUMANA CARESOURCE | PASSPORT | WELLCARE | TOTAL |
|---|---|---|---|---|---|---|---|---|
| Original Claims Processed Report #58 | Claims Received | Total count | 239,503 | 932,144 | 469,610 | 987,080 | 2,176,802 | $ 4,805,139 |
| | | Processed | 230,518 | 926,497 | 525,037 | 1,071,531 | 1,935 | $ 2,755,518 |
| | | Total Charges | $ 112,657,567 | $ 452,695,206 | $ 212,641,946 | $ 463,111,633 | $ 2,067,193,447 | $ 3,308,299,799 |
| | | Avg Charge | $ 470.38 | $ 485.65 | $ 452.81 | $ 469.17 | $ 949.65 | $ 1,200.61 |
| | | Avg member | $ 1,499.62 | $ 1,545.95 | $ 1,790.01 | $ 1,737.19 | $ 4,765.86 | $ 2,786.92 |
| | Adjudicated to pay status | Total count | 187,740 | 725,533 | 327,139 | 760,435 | 1,564,232 | 3,565,079 |
| | | Percent | 78.39% | 77.83% | 70.00% | 77.00% | 71.86% | 74.19% |
| | | Charges | $ 71,839,766 | $ 347,929,385 | $ 113,167,908 | $ 376,116,781 | $ 778,460,250 | $ 1,687,514,090 |
| | | Avg Charge | $ 382.66 | $ 479.55 | $ 346.19 | $ 494.61 | $ 497.66 | $ 473.35 |
| | | Avg member | $ 956.28 | $ 1,188.17 | $ 952.64 | $ 1,410.86 | $ 1,794.72 | $ 1,421.57 |
| | | Paid | $ 17,795,952 | $ 78,065,220 | $ 36,535,965 | $ 106,346,549 | $ 170,398,828 | $ 409,142,513 |
| | | Average Paid | $ 94.79 | $ 107.60 | $ 111.57 | $ 139.85 | $ 108.93 | $ 114.76 |
| | | Avg member | $ 236.89 | $ 266.59 | $ 307.56 | $ 398.92 | $ 392.85 | $ 344.66 |
| | | % Discount | 75.23% | 77.56% | 67.72% | 71.73% | 78.11% | 75.75% |
| | Adjudicated to deny status | Count | 41,853 | 193,962 | 96,456 | 223,978 | 358,098 | 914,347 |
| | | Percent | 17.40% | 20.81% | 21.10% | 22.70% | 16.45% | 25.65% |
| | | Charges | $ 28,182,962 | $ 73,824,908 | $ 14,225,785 | $ 759,614,154 | $ 165,270,242 | $ 1,041,118,051 |
| | | Avg. Charge | $ 673.38 | $ 380.62 | $ 147.48 | $ 339.15 | $ 436.39 | $ 1,138.65 |
| | Placed in suspended status | Count | 925 | 7,014 | 25,276 | 87,118 | 2,417 | 122,750 |
| | | Percent | 0.39% | 0.75% | 5.40% | 8.80% | 0.11% | 3.44% |
| | | Charges | $ 1,549,912 | $ 5,842,506 | $ 72,131,081 | $ 135,265,000 | $ 43,681,545 | $ 258,470,043 |
| | | Avg Charge | $ 1,675.58 | $ 832.98 | $ 2,853.74 | $ 1,552.66 | $ 18,072.63 | $ 2,105.66 |
| Prior Authorizaton Report #59 | Requested | | 12,078 | 32,599 | 6,177 | 21,283 | 42,177 | 114,314 |
| | Approved | No service limits | 576 | 10,534 | 4,432 | 14,425 | 28,376 | 58,343 |
| | | Within limits | 9,275 | 7,587 | 734 | 4,612 | 3,857 | 26,065 |
| | | Exceed limits | - | 7,144 | - | 87 | 83 | 7,314 |
| | Partially Approved | No service limits | - | 397 | 118 | 166 | - | 681 |
| | | Within limits | 21 | 241 | 1 | 114 | 196 | 573 |
| | | Exceed limits | - | - | - | - | - | - |
| | Denied | | 1,159 | 4,671 | 989 | 1,879 | 9,653 | 18,351 |
| Original Claims Activity #60 | Paid Claims | Total claims | 221,563 | 725,533 | 368,902 | 760,435 | 630,404 | 2,706,837 |
| | | 1-30 - Days | 219,998 | 725,169 | 360,311 | 758,008 | 629,977 | 2,693,463 |
| | | 31 - 60 Days | 152 | 314 | 5,439 | 2,332 | 188 | 8,425 |
| | | 61-90 Days | 1 | 32 | 1,243 | 89 | 29 | 1,394 |
| | | 91+ Days | 22 | 18 | 1,909 | 6 | 210 | 2,165 |
| | Denied Claims | Total claims | 116,324 | 193,962 | 103,286 | 223,978 | 108,036 | 745,586 |
| | | 1-30 - Days | 116,205 | 193,844 | 101,191 | 223,184 | 107,632 | 742,056 |
| | | 31 - 60 Days | 107 | 107 | 1,231 | 759 | 170 | 2,374 |
| | | 61-90 Days | 6 | 3 | 414 | 29 | 33 | 485 |
| | | 91+ Days | 6 | 8 | 450 | 6 | 201 | 671 |
| | Suspended Claims | Total claims | 196 | 7,014 | 53,945 | 87,118 | 13,999 | 162,272 |
| | | 1-30 - Days | 196 | 6,953 | 32,832 | 85,774 | 13,545 | 139,300 |
| | | 31 - 60 Days | - | 60 | 11,096 | 1,289 | 204 | 12,649 |
| | | 61-90 Days | | 1 | 4,877 | 50 | 58 | 4,986 |
| | | 91+ Days | | - | 5,140 | 5 | 192 | 5,337 |
| #67 Provider Credentialing | InProcess | 1-30 Days | 59 | 272 | 44 | 253 | | 628 |
| | | 31-60 Days | 0 | 344 | 1 | | | 345 |
| | | 61-90 Days | 0 | 74 | 1 | | | 75 |
| | | 90+ Days | 0 | 2555 | 0 | | | 2,555 |
| | | Received | 59 | 556 | 60 | 256 | | 931 |
| | | Credentialed | 113 | 157 | 44 | 174 | | 488 |
| | | Processed | 117 | 157 | 41 | 174 | | 489 |
| | | Enrolled | 366 | 36 | 33 | 100 | | 535 |
| | | Denied | 0 | 0 | 5 | 0 | | 5 |
| Additions to Network #68 | | Total Providers | 108 | 81 | 357 | 348 | 157 | 1,051 |
| Termination from MCO #69 | | Total Providers | 5 | 23 | 13 | 53 | 0 | 94 |
| Program Lock-in #74c | | Admitted | 27 | 85 | 0 | 190 | 0 | 302 |
| | | Discharged | 7 | 18 | 0 | 40 | 0 | 65 |
| | | Active | 22 | 941 | 34 | 2,503 | 36 | 3,536 |