C. Technical Approach

19. Provider Payment Provisions *(Section 29 Provider Payment Provisions)*

CLAIMS MISSION AND VISION

Humana's state-of-the-art claims processing system meets all federal and Commonwealth requirements for accuracy and timeliness and performs the required claims processing and payment functions outlined in the Draft Medicaid Contract. In 2019 we processed, on average, more than 480,000 medical and dental claims and encounters per day across our Commercial, Medicare Advantage (MA), and Medicaid lines of business nationwide. Our claims processing mission is to "Pay It Right the First Time," which means we aim to adjudicate and reimburse claims correctly at or near the point of service. We strive to achieve successful "first pass" claims processing and payment by educating and listening to providers and designing our systems to be flexible and responsive. In 2019, Humana paid or denied 99.1% of Medicaid medical claims (primary care, hospital, specialty care, and other) within 10 calendar days of receipt. That same year, in our largest Medicaid market, non-pharmacy encounters were accepted at a 98.8% rate and pharmacy encounters at a 99.8% rate.

STRATEGIC PRIORITIES

We have designed our claims strategy with the ultimate goals of supporting providers and being an effective partner to the Commonwealth in administering Medicaid Covered Services. Over the last several years, we have focused our claims management strategy in the following areas:

- **Provider Training and Education**: We employ multiple methods, including phone outreach, webinars, online training, mailings, in-person meetings, and workshops to engage providers and their staff on coding, claims submission, and Humana's claims payment policies and processes. We offer comprehensive provider training and accessible claims associates, such as Provider Claims Educators (PCE), to support providers. Information regarding claims processing is readily available on our website and in the Provider Manual. Our Provider Services staff are also available via our Provider Services Call Center to respond to claims inquiries.
- **Online Claims Editing:** To maximize our claims acceptance rate, our provider portal, Availity, has a unique suite of claims editing tools that allow users to receive status notifications in real time on claims submissions, edit claims submissions, and to file corrections and add attachments, thereby avoiding common reasons for rejections. More than 80% of Humana's providers use Availity for claims submissions and other functions.
- **Electronic Claims Submission:** Our multi-pronged strategy to increase electronic claims submission includes a direct data entry form on Availity, targeted outreach focused on providers who submit paper claims, promotional inserts mailed with paper checks, and remits, and phone and email outreach. Humana's eBusiness team (a dedicated group of provider-facing consultants) targets providers based on opportunities to drive efficiencies using self-service tools, including electronic funds transfer (EFT). As a result of these strategies, in the past year, 96% of Medicaid claims were submitted electronically. We will employ a similar strategy in Kentucky.
- **Gold Carding:** Humana is waiving prior authorization (PA) requirements for providers who consistently exceed PA performance and quality criteria. We are currently implementing this provider-friendly innovation in our Florida Medicaid market and will expand into the Commonwealth.
- **Fraud Detection and Auditing:** Based on decades of experience with claims processing, we have honed our automatic claims fraud detection, audit, and review processes.

We have assembled a team of experts with deep experience in our claims processing operations. Under the leadership of the Claims Administrator, claims associates dedicated exclusively to Medicaid will augment their

strong understanding of Medicaid contracts with training on Kentucky's specific requirements. We are prepared to hire additional claims associates as necessary.

a.	Describe the Vendor's claims adjudication process and capabilities in maintaining high standards in claims processing.

Humana has systems in place to educate providers on and facilitate the accurate and timely submission of an 837 claims file. If a provider bills electronically, the provider can use a range of clearinghouses or billing agencies to submit the claim to Availity, which aggregates 77% of claims our providers submit. Availity also serves as Humana's provider engagement portal and includes a feature to submit claims via direct data entry. This is a no-cost-to-provider mechanism that is commonly used among smaller providers. We also work with Waystar (formerly known as ZirMed®) and other claims submission platforms to directly submit claims to eHub, our front-end claims system. These platforms automate the claims conversion via the provider's practice management system to an 837 claims file we can then process.

Providers who submit paper claims to Humana use a standard claims form, such as CMS-1500 or UB-04. We subcontract with Conduent to manage the paper claims process from the time we receive the claim at our P.O. Box until eHub receives the claim after being converted into an electronic format. Humana has implemented a deliberate strategy to transition our paper claim-submitting providers to Availity's direct data entry form or other electronic claim submission options. Our corporate team works in partnership with local associates through a targeted outreach strategy to engage, train, and support providers in the adoption of electronic claims submission tools.

When Humana receives a claims file from a clearinghouse or billing agency, eHub returns an electronic acknowledgment, indicating our receipt of the claim. The 999 acknowledgment, a structured American National Standards Institute (ANSI) 999 X12 Acknowledgment for Health Care Insurance, offers notice to the submitter that the claim either failed or passed Health Insurance Portability and Accountability Act (HIPAA) compliance edits. A 277CA acknowledgment (a structured ANSI 277CA Health Care Claim Acknowledgement) offers payer-specific descriptions for failed claims outside of HIPAA compliance edits, giving the provider a clear understanding of reasons for rejections. Our providers can access the status of any claim submitted to our platform via Availity and resubmit those that have been rejected.

Claims that successfully pass initial front-end edits are sent electronically to Humana for processing in eHub. All claims are subject to edits that confirm that the procedure and diagnosis codes are valid, the procedure codes are appropriate for the diagnosis code submitted, and the claim is in the correct format (i.e., a structured ANSI 837 X12 Health Care Claim transaction with HIPAA-compliant information). Additionally, we have designed eHub to match all claims with authorizations, if one is required for the service being billed. Non-participating providers can submit claims through Availity or other clearinghouses, as they are processed with the same set of checks and balances.

ADJUDICATION

Adjudication is the stage in the claims process when Humana determines whether to pay a claim and how much to pay the provider. The vast majority of claims that move through Humana's system are processed and paid without any manual intervention. Nearly 90% of all claims we process for our government businesses are automatically adjudicated and pass the first time, through our edits.

Our Claims Adjudication System (CAS) automatically assesses each claim to identify the Enrollee, identify the provider, verify benefits, complete a series of automatic edits, verify that the Enrollee record shows no other insurance, and apply pricing. Edits include industry standard applications as well as internal Humana edits based on internal policies and contract and program parameters.

Determining whether a claim can be paid

When CAS receives a claim from eHub, it determines whether the claim includes all the information necessary for adjudication and for our subsequent encounter submissions to the Commonwealth. **CAS sends an electronic acknowledgment back to eHub and maintains 100% traceability between systems to ensure no claim is lost**. Edits include industry standard applications (e.g., McKesson ClaimsXten™ to verify accuracy of professional claim coding, and iHealth verifies professional, outpatient, and durable medical equipment claims), as well as internal Humana, edits based on internal policies and contract and program parameters.

The edits process verifies:

- Provider match (e.g., "same provider" checks individual providers with group providers)
- Diagnosis and procedure code appropriateness
- Benefit eligibility and design
- Patient data and procedure and diagnosis code appropriateness (e.g., gender, age)
- Non-automated contract terms
- Manual pricing criteria
- Pricing
- Service authorization
- Duplicate claims

For non-par providers who do not have a single case agreement (SCA) or contract, claims are pended. Our Provider Pend group works with our Provider Relations Team to load the provider's information into our system to ensure claims can be processed. We categorize claims that pass these edits and that do not need further assessment as clean and route them for payment. Clean claims may still pend for review. Claims that are not clean either failed our edits or were rejected because we need additional information to process the claim. Humana may perform outreach to the provider to obtain the necessary information to finalize these claims.

CAS finds claims with inconsistent data (such as type code, group number, or contracted provider number) and flags the claim as requiring manual processing. CAS may pend a claim for other reasons as well. We assign pended claims to our adjustors, who are highly trained within the type of pend reason or code in which they specialize. Our adjustors specialize in addressing claims and are easily able to identify trends and conduct root cause analyses to correct issues. Our adjustors conduct manual research and complete the adjudication guided by documentation.

In 2017, we launched a process improvement effort that makes our claims adjudication process even better. **CAS Next Gen** further develops system capabilities to support enhanced real-time adjudication.

If a claim fails the CAS edits, Humana may deny it and return the claim to the provider for correction and resubmission. Claims that are rejected return to our providers via our provider portal, Availity, and mail remittance. Humana will clearly indicate to the provider what information is needed in the explanation of benefits (EOB) so that the provider can readily make the correction and resubmit the claim. Humana never makes any changes to the information that a provider submits on a claim; only the provider can make any corrections and then resubmit the claim.

Pricing the claim

Prior to pricing the claim, the CAS platform verifies the service rendered is within the scope of Enrollees' benefits. We then price the claim by comparing the total charge submitted for each claim with the total of individually-entered amounts for each treatment or service within the claim. If the totals do not balance, the claim cannot be processed. The second step is pricing each service billed in the claim against the fee schedule for that provider and calculating the amount due to the provider. (If a claim has been pended, adjustors may manually price it using the same steps.) According to the Draft Medicaid Contract and State statutory requirements, once the claim has been paid, it is priced and sent to the Payments department for payment issuance.

In 2019, Humana auto-adjudicated 99.9% of Florida Medicaid Managed Medical Assistance (MMA) pharmacy claims electronically in real time and at the point of sale, giving the pharmacy an immediate electronic decision (within 15 seconds) on whether its claim can be paid and the payment amount. Pharmacy claims receive two rounds of edits: The first round checks for completeness, and the second round checks for duplicate claims, PAs (if required), deductible information, and prescriber information. **Our claims processing system performs an average of 150 edits in approximately one second of processing time on each submission**.

Attachment I.C.19-1 Claims Adjudication Process Flow depicts the processes described above.

Encounter Workgroups

Humana is an active participant in the Encounter Technical Workgroups in the states where we offer Medicaid managed care. In our more than 20 years of working with the Centers for Medicare and Medicaid Services (CMS), we have developed certain initiatives that have improved the accuracy, quality, and completeness of our encounter submissions. We created an internal Encounter Escalation Workgroup, which has served as a forum for internal problem solving and a vehicle for raising issues to the State. This is a bi-weekly meeting between claims subject matter experts, encounter submissions experts, and Information Technology (IT) systems support. This workgroup identifies encounter submission problems, analyzes root causes, and develops sustainable solutions. Initiatives such as the updating of National Drug Code editing logic, Federally Qualified Health Centers/Rural Health Clinic (FQHC/RHC) billing logic, and Child Health CheckUp logic has all recently emerged from the efforts of this workgroup.

b.	Provide information about the Vendor and any entity proposed to process and pay claims. As part of the response, address the following:

b.i.	Policies and procedures to meet performance standards and prompt pay requirements for all provider types.

Humana's state-of-the-art claims processing system meets all federal and Commonwealth requirements for accuracy and timeliness and performs all required functions outlined in the Draft Medicaid Contract. In particular, we are aware of and comply with the Commonwealth's prompt pay laws and regulations for our Commercial and MA lines of business. We ensure that we will adhere to these prompt pay requirements for Medicaid as well. **Attachment I.C.19-2** contains our updated Policies and Procedures that reflect our compliance with the Kentucky Medicaid managed care program's performance standards and prompt pay requirements for all provider types.

Our Claims Process Vision statement is to "Pay It Right the First Time," which means we aim to adjudicate and reimburse claims correctly at or near the point of service.

Humana strives to achieve successful "first pass" claims processing and payment by educating and listening to providers, as well as designing our systems to be flexible and responsive. For example, in 2019, in our Florida Medicaid MMA program, we maintained a weekly average of 98.8% of clean claims [non-Skilled Nursing Facility (NF), non-hospice] processed to payment within 15 days of receipt.

We have achieved considerable success in converting providers from paper claims submission to electronic. Over the last five years (Q1 2015 to Q4 2019), the percentage of total claims submitted electronically in our Florida Medicaid MMA program grew from 94.4% to more than 96.7%.

Humana Pharmacy Solutions, Inc®. (HPS), a wholly-owned subsidiary of Humana Inc., provides pharmacy benefit management (PBM) services for more than 10 million Enrollees across the country, including approximately 7.4 million MA lives, 2.9 million Commercial lives, and over 600,000 Medicaid lives. Using our point of sale approval systems, we process more than 300 million prescriptions annually and manage approximately $18 billion in prescription drug spending. In 2019, 99.99% of the more than 3.6 million Florida Medicaid MMA pharmacy

claims were submitted electronically. Moreover, HPS uses spread pricing, which ensures transparency at the MCO, provider, and agency levels and complies with Kentucky Senate Bill 5 (2018) and agency intent.

b.ii. Market specific strategies for addressing potential provider payment issues, including underpayments, overpayments, pre-and post-claims editing policies and provider billing education.

Our flexible, proprietary systems allow us to easily configure code edits and processes to tailor our proven approach to Kentucky-specific requirements. We will fine-tune our claims process to meet the unique requirements of the Draft Medicaid Contract. Humana manages medical, behavioral health (BH), and pharmacy benefits in-house, ensuring consistent claims processing practices in these areas and granting us the ability to quickly prioritize and modify authorizations, fee schedules, and claims adjudication rules. For example, within a 24-hour period in our Florida Medicaid MMA implementation, we edited our claims authorizations to allow payment to providers of Early Intervention Services (EIS) for children with special needs. Subsequently, we trained our claims adjusters on the EIS program and the edits required to enable this important service.

Humana adjudicates pharmacy claims at the point of sale; we make immediate electronic decisions on whether to make the payment and on the payment amount within 15 seconds. Our subcontracted providers for transportation, dental, and vision benefits support claims submissions in paper, electronically, and through portals in order to produce HIPAA-compliant encounter files for submission to Humana. We attest to our ability to meet or exceed claims provider payment processing standards as defined in the Draft Medicaid Contract.

UNDERPAYMENTS AND OVERPAYMENTS

Humana's Claims Cost Management (CCM) department is responsible for detecting and preventing incorrect payments and recommending process improvements related to fraud, waste, and abuse (FWA) investigation and detection. Humana's CCM department investigates healthcare FWA related to all lines of business, with the exception of Humana Military business.

Operating for more than 30 years, CCM manages various services to monitor the accuracy of claim and encounter payments and limit Humana's exposure to fraudulent, wasteful, and abusive healthcare clinical and billing practices. We use data analytics to review claims payments and determine contract and coding accuracy for billed services, running more than 12,000 data analytics on both pre-pay and post-pay claims to:

- Identify and recover provider payment inaccuracies and reimbursement issues (underpayments and overpayments)
- Move post-payment review results to pre-payment edits to reduce recoupment activities
- Substantiate medical services, coding and billing validation, and clinical necessity auditing, recovery, and loss prevention
- Conduct medical coding edits, policy validation (including payments in accordance with local and national coverage determinations for Medicare claims), and proactive billing corrections
- Ensure proactive benefit coordination for Enrollees where another payer or Medicare is the primary payer
- Investigate healthcare FWA detection and prevention
- Identify, investigate, and coordinate payment with third-party liability holders

Each area described below has a specific area of focus related to payment issues, and all areas work collaboratively to ensure we handle issues appropriately.

- **Coordination of Enrollee Benefits (COB)/Medicare Secondary Payor (MSP):** Proactive benefit coordination for Enrollees where another payer or CMS is the primary payer; validation of Enrollees' Other Insurance (OI) information to determine primacy.
- **Medical Coding Integrity Review (Code Editing):** Medical coding edits, policy validation (including payments in accordance with local and national coverage determinations), and proactive billing corrections. Humana develops claim code editing logic internally and partners with several outside organizations to obtain recommendations for claim code editing logic.

- **Provider Payment Integrity (PPI) Review:**
  - Non-Clinical Review: Ensures identification, recovery, and loss prevention for provider payment inaccuracies and reimbursement issues. Focuses on pre-payment reviews, post-payment contractual-based audits, subcontractor management, and overpayment collections via data mining audits. Conducts pre- and post-payment audits to identify potential overpayments in relation to waste and abuse.
  - Clinical Integrity Review: Focus on pre-payment reviews, post-payment contractual-based audits, subcontractor management via medical records reviews; medical service substantiation, coding, and billing validation; and clinical necessity auditing, recovery, and loss prevention.
- **Claims Cost Research and Opportunities (CCRO):** Helps to minimize Humana's risk and provide expertise for trend analysis on corporate initiatives through three teams:
  - Overpayment Solutions and Opportunities (OSO): Development of concepts that create opportunities for financial recovery.
  - Contract Category Grouping (CCG): Build one query to cover an entire contract from inpatient to outpatient.
  - Fraud Research Analytics and Concepts (FRAC): High-level identification of fraud schemes to generate referrals to Special Investigations Unit (SIU) for investigation.
- **Risk Adjustment Integrity Unit (RAIU):** Value-based provider risk adjustment investigation and fraud detection.
- **Special Investigations Unit (SIU):** Responsible for the detection, investigation, and prevention of suspected fraud for all lines of business for both Enrollees and providers; the SIU works with all departments within the organization, as appropriate, when investigating all types of healthcare fraud.
  - SIU Clinical Lab: Medical service substantiation, coding, and billing validation; clinical necessity auditing, recovery, and loss prevention in support of SIU cases; and clinical consultation to investigators on clinical cases.
- **Subrogation:** Identification, investigation, and payment coordination with third-party liability holders.
- **Value-Shared Payment Integrity Review/Contestations:** Identification, recovery, and loss prevention for value-based provider reimbursements where Humana manages contested paid claims from Primary Care Provider (PCP) groups with risk-sharing deals. Overpayment of claims or applying claims to the wrong risk fund could impact the PCP groups' surplus payment. PCP groups routinely hire consultants to review paid claims data for the Enrollees assigned to them to contest instances where they believe the claim was paid incorrectly, either due to pricing or funding.
- **CCM Shared Services:** A centralized internal service team with cross-functional responsibilities supporting the CCM organization. The functions within Shared Services are:
  - Code Edit Support team: Reviews provider disputes for adjudicated claims that have received a denial Humana has classified as a Code Edit Denial; contacts each provider to discuss findings; interacts with multiple business areas; and receives inquiries through phone call, email, and correspondence.
  - Compliance team: Focuses on partnership with CCM business units, Regulatory Compliance (RC), and other compliance teams throughout Humana as well as external government agencies to comply with FWA-related regulations and requirements and assists in preparation to ensure CCM operations is audit-ready.
  - Department of Insurance (DOI) Financial Recovery (FR) Disputes team: Reviews overpayment disputes received from a government entity.
  - Education team: Develops and highlights relevant in-person training, conferences, webinars, lunch and learns, and many more educational opportunities in which we encourage CCM associates to take part and strives to implement Humana's core values while driving our associates forward to new heights of education and opportunity.

- Issue Resolution team: Answers escalated inquiries using a variety of methods, including online tools, phone, email, and correspondence handles overpayment disputes, and interacts with multiple business areas.
- Market Liaison team: Focuses on provider engagement and relationship management with market and key provider partners along with critical provider issue mitigation; settlement navigation support, and oversight; and Contract issues. Ensures CCM stays aligned with Humana enterprise goals while protecting critical rights to monitor for fraud, waste, and abuse.
- Provider Services team: As providers' single point of contact, this team answers initial inquiries through a variety of methods, including online tools, phone, email, and correspondence. Focuses on making it easy for our customers to obtain the timely support they need by offering a simple, reliable, and personalized experience.
- Quality Audit and Risk team: Performs unbiased quality audits and risk assessments of the CCM organization by identifying process- and associate-level gaps in performance.
- Claim Recovery Research team: Handles cash posting, Humana returned checks, postal errors, and stop payment requests.
- Service Transformation team: Focuses on its mission to provide service excellence by leveraging project management, process improvement, and technology capabilities. Identifies opportunities, aligns, and focuses on initiatives that drive measurable improvements while transforming the experience of both internal and external customers.

Humana's CCM Shared Services team connects our best in class, company-wide claims processing and payment systems with our in-market Provider Education efforts – our boots on the ground in Kentucky and other states.

CCM uses the state-of-the-art systems described below and the latest analytical software, such as QlikView and Tableau, to identify and analyze inappropriate claiming patterns and develop systematic solutions.

Table I.C.19-1: Claims Cost Management Systems

System	Function
Associate Remittance Inquiry (ARI)	Used when a remittance is needed for a provider that has selected not to receive hard copies of the remits
CCP2	Used to log and document all calls taken in by the Provider Support Service Team
CGX 2.0	Used to search for an authorization from a provider for a specific Enrollee and their claim
Check Status Inquiry Tool	Allows a provider or Enrollee to locate the details of a check
Cipro	Used to price claims for the allowable amount and to determine the correct amount Humana should pay on a claim
Claims Adjudication System (CAS)	The claims platform that houses all claims, excluding Commercial and pharmacy, processed by Humana
ClaimsXten™	Verifies the clinical accuracy of professional and certain outpatient facility claim coding
Claims Explorer	Used to extract all claims that contain the same codes ever processed by Humana for a specific Enrollee
Contract Information System (CIS)	Contains the Contract details of a provider's specific Contract with Humana related to reimbursement

Table I.C.19-1: Claims Cost Management Systems

System	Function
Customer Relationship Management (CRM)	The system used for logging and documenting all calls received by Provider Support Service Team, which will replace CCP2
Customer Interface (CI)	Houses the Enrollee's policy/demographic information
DIG Toolbar	Application that automates the tasks associates perform regularly to allow more time for assisting providers with their concerns
Enterprise Financial Recovery (EFR)	Used to view recoveries to determine if a refund check has been posted, to verify if Humana has received a refund check sent by the provider or Enrollee, to verify if an accounts payable check has been requested for the provider or Enrollee, and to verify if the refund check was a result of a Subrogation refund in which the check is sent to that area
EFR Cash Posting	Used to verify if Humana received a refund check from a provider or Enrollee
EFR External Audit	Used to check the status of a provider dispute for a clinical audit
eHUB	Used to view the detailed electronic claim image
Enterprise Messaging (EMME)	Houses corresponding letters Humana produces
Financial Recovery (FR)	Houses all post-pay audited claims that we have identified were overpaid. Related systems: FR Archival Data System (used to pull archived claim information) and FR Portal (houses databases used for various CCM functions)
Fraud Investigation Tracking (FIT)	Used to track all incoming complaints/referrals. As the case progresses, investigative steps are documented in the appropriate activity in FIT, and electronic copies of all documents pertaining to the case are attached. Details of relevant case documentation can be viewed by SIU and can be extracted for reporting from the electronic data warehouse (EDW).
Humana Image Viewer	Used to view the claim images for paper claims
LaunchPad	Houses multiple different systems used within Humana
MARx	Used to lookup an Enrollee's Hospice policy
Medical Records Management (MRM)	Generates requests sent to the providers asking for medical records that Humana needs to audit. Enables seamless, real time sharing of medical record information between and among our valued healthcare providers, subcontractors, and the requesting Humana departments.
Mentor	Database houses all process documents and definitions of Current Procedural Terminology and diagnosis codes
Managing Operations and Audit Tracker (MOAT)	Displays the full clinical process for a claim from the medical record request to the determination of an appeal/dispute
Mobius	Document viewer used to pull refund request letters and charts that are sent to providers
MTV Toolbar	Database that houses Commercial claims

Table I.C.19-1: Claims Cost Management Systems

System	Function
Post Pay Routing Tool	Shows view of all source codes with routing details for transferring or dispute information
Query Doc	Houses auditor instructions to validate overpayments on claim(s)
SCIOMINE	Subcontractor-owned system that internal teams use to conduct reviews and houses claim information for claims selected for review by internal teams such as Clinical Audit
Total Humana Overpayment Resolution (THOR)	A transferrable and foundational platform being developed outside of Humana's claims system to enable Humana to ensure accurate first-time provider reimbursement by aggregating multiple data sources from across the enterprise

PRE- AND POST-CLAIMS EDITING

Humana associates are experienced at managing claims across varying service types, including physical health, BH, pharmacy, and transportation. We understand the importance of differentiating the attending and billing provider to assess Enrollee attribution and enabling providers to submit zero dollar claims to capture non-billable services, including social services and services by an at-risk, capitated provider. A trained and experienced team responsible for tracking performance of claims system edits manages each stage of the claims' lifecycle, ensuring we catch and correct errors immediately and adjudicate claims accurately and efficiently. The edits (inclusive of HIPAA level 7 edits) ensure that the 837 files submitted by our providers or through clearinghouses and billing agencies are not rejected when they enter our claims adjudication platform. As a result of these edits and front-end review of 837 claim files, we can reduce the number of claims denials a provider receives.

As depicted in **Attachment I.C.19-3 Claims Editing Process Flow**, there are five key points in the claims' lifecycle where claims editing occurs:

- Clearinghouses and Availity edit for compliance with HIPAA standards upon receipt of the claim, prior to entering Humana's claims processing system
- Upon receipt by Humana, eHub validates Enrollee eligibility, name, ID number, and date of service
- CAS validates Enrollee eligibility, name, ID number, date of service, determination of medical necessity, covered services, PA, duplicate claims, provider validation, quantity of service, and numerous other detailed edits
- In the post-adjudication phase, the system validates date and quantity of services
- Post-payment review validates for medical necessity

Humana has more than 100 code checks in place at the front-end of Availity to ensure that the claim has all the necessary fields completed and coded fields have valid values.

Our claims management system complies with claims editing standards as defined in the Draft Medicaid Contract; we can adjust to meet any and all program requirements that may be added. Humana's Claims Administrator will oversee all functions of the claims adjudication process and work in tandem with the Provider Services Manager and PCEs.

PROVIDER BILLING EDUCATION

Humana's claims process and payment methodology is available to providers and the public in our Provider Manual and also via easy-to-understand online videos on our public-facing website at www.humana.com/provider. In addition, providers may request a printed copy of the Provider Manual. The claims information outlined in the Provider Manual includes the steps necessary to submit a claim for reimbursement, benefit limits, services which require PA, copay procedures, and third-party liability rules and requirements. We have developed all materials to offer an easy-to-understand manual for our provider offices,

including providers, their billing, and other administrative staff, to submit proper claims. See the diagram in **Attachment I.C.19-4 Electronic Claims Payment Data Flow**.

Humana has implemented a multi-faceted campaign in Florida to increase the proportion of providers paid by direct deposit. We have had particular success with medical doctors, physician assistants, and nurse practitioners. Some of the strategies we have employed in Florida (and will use in Kentucky) include:

Our outreach to providers is continuous, and strategies are constructed using CCM analytics that show which providers are ready for conversion to EFT.

- eBusiness team activities supported by CCM analytics: Humana's eBusiness team (a dedicated group of provider-facing consultants supported by analysts from the CCM department) targets providers based on opportunities to drive efficiencies through self-service tools, including electronic funds transfer (EFT).
- Track and measure adoption on an ongoing basis to measure progress toward annual goals: The eBusiness team sets annual goals for conversion of providers from paper checks to receipt of electronic payments. For example, in our Texas Commercial market in 2018, our eBusiness team improved the percentage of payments made by EFT to 61%, a 10% improvement over the 55% level in 2017. Typically, we have measured success based on the percentage of checks and remittances converted to EFT by provider type but can enhance our metrics to include other metrics based on Commonwealth requirements.
- Mail promotional inserts with paper checks and remits (quarterly campaign): On a quarterly basis, we enclose an EFT promotional insert in the mailing with the paper claims check and remit paid to providers. The insert includes messaging on the risk of paper checks getting lost or misplaced, faster payment processing with EFT, no manual effort required with EFT, access to remittance information online, and no-cost claiming options.
- Outreach to largest paper receivers via phone/email to promote and assist in enrollment: Based on analytics, we prioritize the largest paper receivers (as measured by paper check volume) for our outreach campaigns. Through direct contact with providers' offices, we are able to address many obstacles to EFT adoption. There are also instances where provider feedback leads to changes in how we implement EFT. For example, because providers in our Commercial line of business advocated for payment by EFT using the National Provider Identifier (NPI) (in addition to tax identification number), we adjusted our processes accordingly. This resulted in many more providers converting to EFT.
- Choice of enrollment options: Providers have two choices currently for enrolling in Electronic Remittance Advice (ERA) and EFT with Humana: a) they can access the secure Availity web portal or b) they can visit Council for Affordable Quality Healthcare (CAQH) EnrollHub. One of the advantages of enrolling through CAQH is that it is a multi-payer solution.
- Virtual card solution: To maximize payment options for providers, Humana is exploring the use of a virtual card solution. This would allow providers to deposit funds directly into their bank accounts by entering a 16-digit code.

b.iii. Proposed average days to payment from claims submission for the Vendor's proposed claims platform for medical and pharmacy claims. Provide the Vendor's last calendar year's report on the "average number of days to pay providers."

Humana accommodates providers with both paper-based and electronic claims payment workflows and processes claims that have been finalized for payment automatically. If the provider has elected EFT, Humana's PayPilot system assigns a payment trace number and pay-by date, upon which the payment will be automatically transmitted to the provider's bank account in accordance with HIPAA, National Automated Clearing House Association (NACHA) rules, and CAQH Committee on Operating Rules for Information Exchange (CORE). If the provider is not set up for EFT, we generate a paper check and mail it to the provider. Humana generates an Explanation of Remittance (EOR) for paper remit distribution and an ERA for electronic remit

distribution. For electronic remittance, a provider can download the remittance from Availity. We pay providers enrolled in EFT on a daily basis.

In 2019, in our Florida Medicaid MMA program, the average number of days to pay medical providers was 2.85 days: 16.3% were paid within a day, 49.3% were paid between one and two days, 34.0% between three and 15 days, and less than 0.4% were paid in greater than 15 days. In 2018, in our Florida Medicaid program, 100% of pharmacy claims were paid within 20 days, 59% with 10 days, and 17% within seven days. 73.5% of Humana Medicaid pharmacy prescriptions are prescribed through e-prescribing to HPS.

More than **90%** of our Florida Medicaid MMA program payments have been via EFT for each of the last four quarters through Q4 2019.

In 2019, in our Florida Medicaid MMA program, 96% of providers were paid via EFT. This high level of electronic payment to providers has reduced the turnaround time from receipt of claims to payment. The table below displays our adherence to payment timeliness standards. Based on our existing relationships with providers in the Commonwealth, we anticipate that we will be able to achieve similar results.

Table I.C.19-2: Humana – Florida Managed Medical Assistance (MMA)

Provider Payment Timeliness Standards	Goal	2019-Q1	2019-Q2	2019-Q3	2019-Q4	2019
Electronic Clean Claims Payment Cycle Time: Non-Nursing Facility (NF)/Non-Hospice	LT 15 days	99.65%	99.54%	99.62%	99.63%	99.61%
Electronic Clean Claims Payment Cycle Time: NF and Hospice	LT 10 days	99.43%	98.93%	98.91%	99.50%	99.19%
Paper Claims Payment Cycle Time	LT 20 days	98.63%	98.32%	99.07%	99.00%	98.76%
Clean Claims Paid within seven calendar days	50%	98.11%	96.48%	96.63%	96.54%	96.94%
Clean Claims Paid within 10 calendar days	70%	99.55%	98.72%	99.08%	99.18%	99.13%
Clean Claims paid within 20 calendar days	90%	99.92%	99.89%	99.82%	99.83%	99.87%

c. Describe the Vendor's methodology for ensuring claims payment accuracy standards will be monitored and improved through audit. At a minimum, address the sampling methodology, the process for auditing the sample, documenting of results, and activities conducted to implement changes or required corrective actions.

As shown in **Attachment I.C.19-5 Claims Auditing Process Flow**, Humana concurrently conducts five types of proactive pre-pay audits to identify, prevent, and correct errors. These include:

- Audits for front-end coding, including HIPAA level 7
- Audits for Enrollee eligibility
- Audits for High Dollar Screening and other criteria conducted by operations manager for claims more than $500,000
- Quality audits including performance guarantee, platform, focused, pre-disbursement, and performance management

We issue payments every business day to e-claiming providers and at least twice weekly to all other providers. **88%** of our Medicaid providers agree or strongly agree that our claims are paid in a timely manner.

- Pre-pay audits conducted through THOR, which include high dollar screening, coding guidelines, and provider Contract

To perform these audits, we randomly select 500 claims per month according to the expectations of 42 CFR§ 455.20.

In addition, Humana's Enterprise FR system conducts a post-pay review to assess over- and underpayments. As claims errors arise, our associates work with leaders and experts to resolve and correct them in a timely fashion. Periodic system upgrades and improvements that drive efficiency and effectiveness are core to our approach. As described earlier, our PPI Review unit conducts clinical and non-clinical audits to discover the root causes of payment problems. As a learning organization, we use the results of these reviews to improve our internal systems and to educate providers about appropriate claims processes.

Humana provides specialized, State-specific support to our providers, recognizing that every provider network is unique. Our expert Provider Relations Team will be on the ground in Kentucky conducting in-office trainings with providers to ensure they understand the claims process, listening to issues they may be experiencing, adjusting our systems as appropriate, and offering additional targeted trainings as needed. We have multiple channels for hearing from and talking to providers, including in-person, our provider portal, and our toll-free line. We will take every opportunity to learn Kentucky-specific issues and respond with tailored solutions.

Humana also understands the importance of assessing claims to ensure our Enrollees receive appropriate care. Humana's Provider 360 Committee, comprised of a broad cross-section of market and corporate personnel, reviews processes that contribute to improved provider experiences and continuously looks for improvement and innovation in claims processing.