C.19. Provider Payment Provisions

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

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

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

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

   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"

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.

Passport Highlights: Provider Payment Provisions

How We're Different	Why It Matters	Proof
Established, local claims team that works with providers to expedite payment and reduce their administrative burden	• Our local claims team supports our Provider Network team during collaborative, on-site provider visits • Claims staff leverages their expertise during provider calls to increase payment accuracy	• Offer in-person and telephonic guidance to providers needing support in reading remittance advice documents, applying balances, correcting claims submissions and answering general processing-related questions • 81% of providers would recommend Passport to other physician practices (Survey: 2017-2019)
Exceed Department for Medicaid Services (DMS) expectations for claims processing	• Fast and reliable claims processing enables providers to focus on care • Providers see improved cash flow with a significant impact on smaller practices • Providers' staff saves time in reduced administrative follow-up	• 99.8% of all claims processed within ninety (90) days (CY 2019) • 97.5% of clean claims processed within thirty (30) days (CY 2019) • Both exceed the DMS standard of processing ninety percent (90%) of all claims within thirty (30) days and our internal standard of processing ninety-five percent (95%) of all claims within thirty (30) days
Deliver a multidimensional provider support model	• We reprocess claims in real-time while on the phone with providers, as needed • We proactively resolve payment and processing-related errors	• Our Provider Claims Service Unit offers single-call resolution • In 2019, more than ninety-two percent (92%) of calls had first-call resolution; less than two percent (2%) required more than the next business day to resolve • 99.3% financial accuracy (CY 2019) and 98.8% procedural accuracy (CY 2019)

Introduction

As a provider-driven health plan, Passport understands the impact that accurate and timely payments have on provider practice operations, practice finances and overall provider satisfaction.

Our Local Claims Team

Passport's commitment to the community it serves is also reflected in the skilled and local claims processing team located throughout the Commonwealth of Kentucky, with concentrations in Louisville and Prestonsburg. Under the direction of Shawn Elman, Passport's chief operating officer (COO), more than 130 staff members support Passport's dedicated Kentucky claims team in front-end claims processing, funding and recovery, root cause, provider claims rework, quality assurance and post-payment auditing.

Our Provider Relations Representatives (PRRs) leverage the expertise of our local claims team to increase payment accuracy, process claims in real-time during provider calls and educate provider office staff during collaborative, on-site provider visits.

Our Technology

We use a customizable, scalable, proprietary claims processing system, and a nationally recognized edit validation system to ensure accurate and timely provider claims payment.

Identifi

Identifi℠ Health Plan Administration (Identifi HPA) adjudicates almost six (6) million Medicaid claims for Passport each year. Through the use of Identifi HPA, **Passport has consistently exceeded the DMS requirement to pay or deny ninety percent (90%) of all claims within thirty (30) days** and methodically improved claims processing and key performance indicators (KPIs) related to timely payment, accuracy and auto-adjudication.

Edifecs

Edifecs is an upfront edit validation system that streamlines the exchange of Electronic Data Interchange (EDI) data and enforces claims-based data requirements. It integrates into our existing EDI data flow and provides a central hub for our X12 inbound and outbound transactions.

Meeting High Standards - Results

Passport holds itself to a higher standard of ninety-five percent (95%) or more for claims paid or denied within thirty (30) days, which it routinely exceeds. See **Exhibit C.19-1**.

Exhibit C.19-1: Claims Timeliness Performance

First Pass (%) Clean Claims Paid within Thirty (30) Days by Month
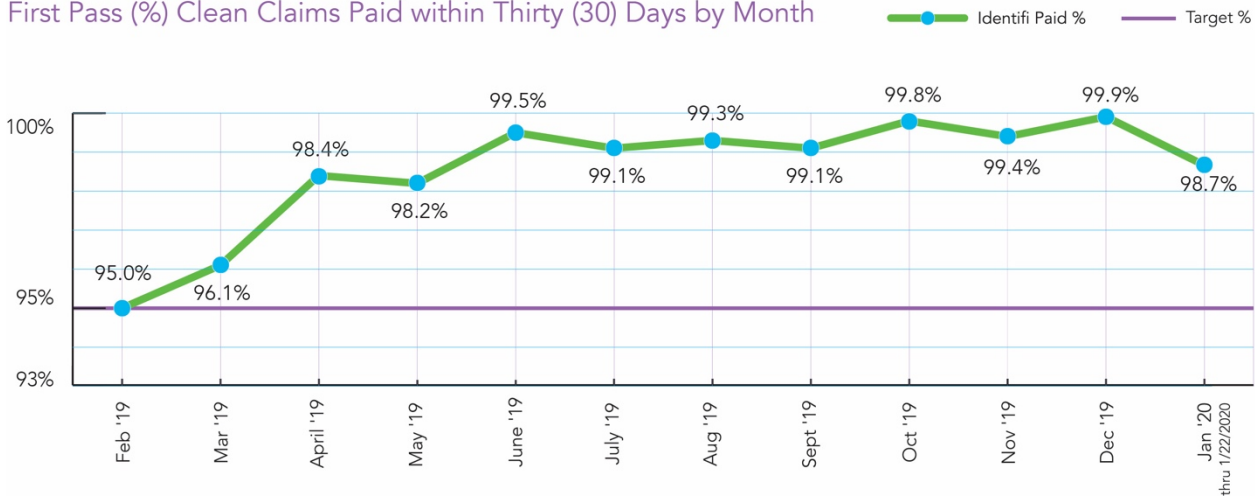
C.19.a.   Describe the Vendor's claims adjudication process and capabilities in maintaining high standards in claims processing.

Our comprehensive claims payment process begins with the receipt of claims from providers and follows through claims adjudication to provider payment using the Identifi HPA platform.

Identifi Overview

Identifi is an extremely flexible platform that enables us to administer highly-customized requirements specific to the Kentucky Medicaid contract including benefits, eligibility, fee schedules, and provider service location configuration. During the various stages of the adjudication process, this integrated MIS interacts with membership eligibility, third-party liability data, product benefit parameters, provider pricing agreements, medical management requirements, and clinical editing information to provide accurate and highly automated adjudication of claims. Claims processing validates diagnosis codes and procedure codes to connect service-based rules, and includes parameters for handling benefit limitations, copays, and coordination of benefits (COB). This powerful software engine:

- Adapts to rapidly changing business and regulatory environments
- Automates business processes
- Enhances efficiency
- Provides the flexibility to administer diverse plan designs
- Integrates with third party solutions

Identifi℠ HPA accommodates and administers all major payment methodologies including but not limited to Fee-for-Service, Capitation, Case Rates, Per Diems, DRG, Percentage of Billed Charges, UCR, percentage of UCR, RBRVS with GPCI, Bundling, Tiered Per Diems, Lesser of Billed Charges, Calculated Rates, and Treatment Case.

Passport Claims Adjudication Process & Capabilities

An overview of the end-to-end steps in the claims adjudication process follows, including the mechanisms by which quality and accuracy are supported, to ensure that providers receive appropriate payment. This process is demonstrated in **Exhibit C.19-2**.

Exhibit C.19-2: Passport Claims Process Flow
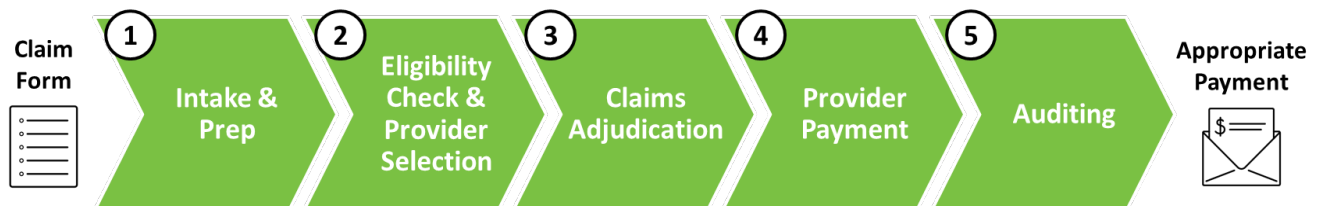
1) Intake & Prep

Providers may submit either electronic claims or paper claims using the DMS-approved uniform claims form We encourage our participating providers to submit claims through Electronic Data Interchange (EDI) powered by the claims clearinghouse Change Health, which allows faster, more efficient and cost-effective claims submission for providers. Approximately ninety-five percent (95%) of our claims are submitted electronically. Paper claims submitted by providers (by mail or by fax) are accepted, inventoried, scanned and compiled into an electronic file (known as an x12 837 file) for processing alongside electronically submitted claims. This allows for all claims, whether submitted electronically or on paper, to pass through the same edits and adjudication processes for consistency. Identifi HPA date and time stamps each claim and assigns a unique claims identifier enabling claims staff to track its progress from initial entry into the Passport systems to final adjudication and ultimate storage. This automatic stamp also allows us to systematically track timeliness of claims process.

Edifecs

All medical claims submitted by providers run through our Edifecs EDI Gateway front-end validation, performing claims rule checks prior to accepting a claim for processing in our Identifi claims system. This smart clearinghouse capability introduced in August 2019 ensures that claims that do not pass initial edits are rejected back to the provider for remediation and that the provider is given a clear and actionable explanation why the claims were rejected.

Through this innovative solution, 1200 edits were installed to improve claims quality with a positive impact on claims payment accuracy and timeliness. Notable categories implemented through EDI Gateway in addition to syntactical and data presence requirements were enhancing claims editing to SNIP Level 4, instituting ORP provider edits and additional Provider NPI/Taxonomy edits to align with DMS encounter data reporting requirements. Accepted claims are then adjudicated in our Identifi HPA claims system.

2) Eligibility Check & Provider Selection

Our Identifi℠ HPA processing system stores member and provider data to allow for a seamless and accurate matching process, including:

- **Eligibility check.** Our Enrollment Operations team validates and manages the daily eligibility files received from KYMMIS. The team loads these files into the system to ensure that we confirm current member eligibility. Once a claim enters the Identifi HPA processing system, it is systematically matched to the correct member through verification of eligibility for each date of service.

- **Provider selection.** Our Provider Data Management team oversees the load and verification of provider data attributes against the National Plan and Provider Enumeration System (NPPES) to prevent erroneous claim finalization. The provider information submitted on the claim is then systematically matched against Passport's provider network through the validation of multiple provider attributes such as DMS enrollment, to ensure selection of the correct provider and servicing location and effective dates against the service date.

3) Claims Adjudication

Validation and Pricing

Identifi applies benefit data and authorization rules to the claim based on the member's benefit structure. The benefit logic is also where copays, if applicable, are assigned. If the service requires an authorization, the system automatically searches for a match. If there is no authorization on file and one is required, the claim then moves to a queue for manual review. The benefit validation and authorization check is a critical step supported by sophisticated rule based logic within the Identifi system to ensure consistent and accurate processing. Identifi is very flexible and allows for changes to be made for new programs or changes, including limits to covered benefits. Changes are first tested in a test environment and upon successful results, moved to the live environment.

Once the member's benefit and authorization rules have been cleared, the system then applies the payment methodology and contract information needed based on the provider selection. This automated process is made possible because the providers, their contracts, fee schedules and payment rules are loaded and maintained by a separate team made up of provider network management experts. Additionally enhanced clinical and National Correct Coding Initiatives edits are applied to each claim. These enhanced edits check for global codes subject to unbundling or medically unlikely edits for multiple codes on a claim that may be incompatible. Additional adjudication edits include:

- Valid dates of service
- Contract and payment methodology selection
- Fraud and abuse detection
- Coordination of benefits (COB)/Third party liability ITPL)

During claims pricing, the system automatically checks each claim for a variety of possible submission errors. If the system finds an error, it routes the claim for manual review or denies it for the identified error reason, depending on which is appropriate. Once benefits, authorizations and pricing are confirmed, the system determines if applicable COB or TPL information is present. If COB or TPL is found, the system then routes

the claim for auto-adjudication or manual review. This ensures claims are processed accurately while maximizing Medicaid Program cost savings.

Manual Claims Review Process

While the majority of claims are auto-adjudicated, claims that cannot go through the auto-adjudication process enter a manual workflow queue. Our local Front-End Claims team manually reviews each claim to ensure accuracy. Manually reviewed claims include, but are not limited to, the following:

- High dollar submitted charge claims
- Coordination of benefits situations that cannot be processed automatically
- Transplant claims
- Grace period claims
- Newborn claims when submitted with mother's member identification
- Complex eligibility with date spans and gaps in coverage
- Corrected and late billings

We stratify our front-end claims adjudicators by skill levels and work types that correspond to the complexity of the claims they are assigned to review. The process is supported by referenceable policy and procedure documents to ensure consistent claims processing, which allows individuals on the team to focus on their areas of expertise to ensure that claims are finalized in a timely manner and in accordance with their corresponding service-level targets. We set our targets at a higher standard than those established by DMS to ensure that we consistently meet and exceed DMS standards. The Claims Management team monitors workflow queues for patterns and trends to ensure that claims are being worked on in a first-in, first-out basis. Teams continuously assess claims inventory to identify potential system updates and enhancements to improve the auto-adjudication rate.

Non-Participating Provider Adjudication Process

The claims adjudication process for non-participating providers is identical to the process for participating providers, with the exception of prior authorization requirements. Our processing rules for claims from non-participating providers are as follows:

- If there is an authorization on file matching the provider and services, the claim will autoadjudicate

- Or, if the claim is for emergency department services, the system overrides the requirement for an authorization and autoadjudicates the claim normally

- Or, if the class of service requires an authorization and there is none on file, the claim pends for manual review by a claims adjudicator

4) Provider Payment

Identifi is highly configurable and has the ability for scheduled check runs, by day and time, and as frequently as on a daily cadence. Our team performs quality checks of claims adjudication and the claims payment file prior to initiating the check issuance process. The system can issue live checks or electronic fund transfers, depending on the provider's preference. Additionally, the system is able to intercept specific

claims scenarios, such as high-dollar claims, claims for select providers, special handling requirements, etc., for management approval before funds are released. The system also maintains check registries and ledgers related to claims payment for financial control, bank reconciliation and accounting activities.

Providers receive notification through a remittance advice if a claim is denied or approved for an amount, duration or scope that is less than requested. The provider's remittance advice cites the reason for denial or partial authorization and the contact information for our Provider Claims Service Unit, should the provider have any questions.

HIPAA Compliant Communications

Provider and DMS communications related to claims processed electronically use Health Insurance Portability and Accountability Act (HIPAA) compliant standards for information exchangeincluding HIPAA Accredited Standards Committee (ASC) X12 version 5010 transaction 837 and National Council for Prescription Drug Programs (NCPDP) version 5.1 to NCPDP version 2.2. file formats.

5) Auditing

All auto-processed and manually processed claims are randomly sampled for financial and processing accuracy. Results are shared with all levels of the organization and are reported monthly in an executive dashboard. Prior to releasing funds for payment, additional audits are conducted to ensure correct payees, identify anomalies, and provide a final comprehensive view of the adjudicated claims ready for payment:

- Concurrent Audits are performed pre-claim adjudication based on specific criteria
- Retrospective Audits are performed on a percentage of claims per adjudicator for continuous performance monitoring with continual feedback for training opportunities

The Audit team works closely with the Claims Proccessing and Training teams to provide timely feedback on audit results. Performance is closely monitored and progressively managed by the Claims team and remedial training is provided based on audit results. Our progressive management approach includes employee actions if expected improvements after additional training and coaching are not achieved. Actions may include an adjustment of claims audits assigned to the employee, an employee performance review, re-assignment to another department within Passport more suited to the employee's skills, or even possible employment termination.

C.19.b.   Provide information about the Vendor and any entity proposed to process and pay claims. As part of the response, address the following:

About Passport

Since our founding as the Commonwealth's first partner in Medicaid managed care, we have worked to develop a strong, consistent claims payment process that provides accurate and timely claims adjudication. We have been committed to meeting the DMS mission to improve the health of all Medicaid members in a

cost efficient and effective manner. This long, successful history of technical innovation and overcoming challenges gives us a unique view into the Kentucky Medicaid Program that benefits the Commonwealth.

We are headquartered in Louisville, Kentucky, with an Executive Leadership Team that is focused on Kentucky Medicaid. The Executive Leadership Team provides oversight of all partners. Passport is fully responsible for subcontractor performance and has carefully selected subcontractors that have proven records of providing high quality services. Passport integrates subcontractors into its delivery model to maximize better access, care, outcomes and financial results. Passport's current subcontract relationships have met all DMS requirements, including but not limited to DMS approval of underlying subcontracts.

Our subcontractors are carefully vetted and due diligence is performed in alignment with our provider- and community-driven governance structure. As part of due diligence, a procurement team works with the appropriate Passport business owner to identify the scope of the need to be subcontracted. Possible vendors are identified and assessed with a specific focus on the vendors' outcomes, quality measures and experience, including facilities assessments to ensure IT security and Protected Health Information (PHI) security are properly addressed. We also review the cost proposal to ensure that we are leveraging the best value for the health plan, the Commonwealth and our members. Furthermore, we contact references and fully consider any past regulatory, compliance or legal issues that a potential subcontractor may have encountered. Once contracted, our subcontractors are managed through ongoing performance measurement and oversight.

About Our Subcontractors

Medical and Behavioral Health Claims: Evolent Health

Evolent is delegated for medical and behavioral health claims processing. To support full alignment between Passport and Evolent as both a strategic partner and subcontractor for core services, an organizational structure has been developed to formalize accountability, reporting relationships and aligned service-level agreement (SLA) achievement and KPIs. This hierarchy of aligned reporting and goals, from executive level through functional ownership, permeates throughout as Evolent delivers services. Our COO, Shawn Elman, is at the center of this model, responsible for operational performance and aligned directly with an Evolent counterpart in service delivery. This matrixed approach creates accountability for performance alignment, promotes participation in goal setting, performance reviews and SLAs, and locks in alignment with the subcontractor contributing to that performance. The matrixed approach also creates direct visibility to potential needs for performance improvement or corrective action planning and creates inherent subcontractor integration with coordinated operations, aligned performance goals and measurements.

Pharmacy Claims: CVS/Caremark

CVS/Caremark is the largest pharmacy benefits manager (PBM) in the nation, serving 21 million members in thirty (30) managed Medicaid markets. CVS/Caremark processed 5.2 million Passport pharmacy claims in 2019 with an average turnaround of less than ten (9.64) days.

Dental, Vision and Hearing: Avesis

Avesis has provided essential vision, dental, and hearing care programs for millions of members for more than thirty-five (35) years and is recognized today as one (1) of the fastest growing managed ancillary health administrators in the nation. Over the past three (3) years, Avesis has processed an average of 26,000 dental and eye care claims each month with an average turnaround time of four (4) days.

We conduct monthly ongoing monitoring, auditing and oversight for all activities conducted by subcontractors in accordance with applicable state and federal laws, regulations and guidelines. Our Compliance, Quality and Claims department representatives conduct functional area-level monitoring of delegated subcontractors to ensure that they fulfill their compliance and contractual requirements.

C.19.b.i.   Policies and procedures to meet performance standards and prompt pay requirements for all provider types.

Meeting Performance Standards

Passport's claims processing operations are focused on the early identification of potential deficiencies and risks to meeting service levels so that they can be addressed in a timely manner before anyone sees an impact on performance metrics. We manage claims inventory and ensure timely processing by using multiple tools and reports available within our claims processing platform and other dashboard and data sources. Data and business analysts in the claims organization create inventory reports that separate the claims into date range categories. Claims management monitors these reports several times each day. This allows the managers to identify claims that are trending toward the beginning, middle and end of the agreed-upon service levels and prioritize them for follow-up action. Daily, the system generates reports on open claims that list all open claims pending adjudication. Passport's Claims Management team monitors these reports to ensure that all claims are processed in a timely manner and in accordance with turnaround requirements. Our process for identifying deficiencies and variance from claims processing standards includes review of:

- Daily inventory reporting, including claims received, unfinalized and targeted claims reporting
- Ad hoc reporting by analysts within the claims team for targeted data analysis
- General claim summary reports, created as needed, that indicate all claims received and their adjudication status (paid, denied and pending)
- Daily EDI files, which allow us to verify that the claims submitted through the clearinghouse have been loaded into the claim system

PASSPORT
H E A L T H ★ P L A N

Meeting Payment Requirements

Passport pays provider claims in accordance with state and federal claims and provider payment requirements set forth in 42 CFR 447.45 and 447.46 and KRS 304.17A-700-730. Claims that are incorrectly paid or denied in error are reprocessed in compliance with KRS 304.17A.17A-708, and no claim is denied for timely filing when submitted timely.

We reimburse out-of-network providers in accordance with the provisions of the Medicaid Managed Care Contract, Section 29.1, Claims Payment at no more than one hundred percent (100%) of the Medicaid fee schedule with the exception of early and periodic screening, diagnostic and treatment (EPSDT) services.

We pay the following claim types in compliance with Kentucky statutes and administrative regulations and in accordance with the provisions of the Medicaid Managed Care Contract, as applicable:

- Payment to providers for serving dual-eligible members
- Payment of federally qualified health centers and rural health centers
- Office for children with special health care needs
- Payment of teaching hospitals
- Intensity operating allowance
- Payment for urban trauma centers
- Critical access hospitals

Passport recognizes DMS' desire to provide reimbursements through directed and supplemental payments to preserve essential services for Kentuckians. We make these directed and supplemental payments in accordance with 42 C.F.R.438.6(d) and provide claims-level cost data to DMS for payment verification purposes upon request.

Any overdue payment of a claim pays interest at a rate of twelve percent (12%) per year for claims paid between one (1) and thirty (30) days from the date payment was due, eighteen percent (18%) per year for claims paid between thirty-one (31) and sixty (60) days from the date payment was due, and twenty-one percent (21%) per year for any claims paid more than sixty (60) days from the date payment was due.

In the unforeseen event that a clean claim remains unpaid in violation of KRS 304.17A-700 to 304.17A-730, a claim remains unpaid for forty-five (45) or more days after the date it is received, or exceeds an aggregate of $2,500, Passport will meet with the provider in person, at the provider's request.

Passport and Evolent Policies and Procedures

Passport's claims processing activities are governed by policies and procedures which are adhered to by all engaged to support the provider payment provisions. Passport's policies and procedures for claims processing have been reviewed and approved by DMS and are fully implemented today. These are as follows:

- Policy PQA.001.E.KY: Quality Auditing of Claims (**Attachment C.19-1_Policy PQA.001.E.KY Quality Auditing of Claims**)

- Policy PRW.002.E.KY: Confidentiality & Privacy Guidelines – Provider Claims (**Attachment C.19-2_Policy PRW.002.E.KY Confidentiality & Provider Claims**)
- Policy PRW.003.E.KY: Processing Projects (**Attachment C.19-3_PRW.003.E.KY Processing Projects**)
- Policy PRW.004.E.KY: Provider Claims Statutory Reporting (**Attachment C.19-3_PRW.004.E.KY Provider Claims Statutory Reporting**)
- Policy PRW.005.E.KY: Timeliness of Claims Payment & Paying Interest (**Attachment C.19-5_Policy PRW.005.E.KY Timeliness of Claims Payment & Paying Interest**)
- Policy PRW.006.E.KY: Processing PLP Claims (**Attachment C.19-6_Policy PRW.006.E.KY Processing PLP Claims**)
- Policy PFR.001.E.KY: Recovery of Overpayments (**Attachment C.19-7_Policy PFR.001.E.KY Recovery of Overpayments**)
- Policy PFR.002.E.KY: High Dollar Claims Review (**Attachment C.19-8_Policy PFR.002.E.KY High Dollar Claims Review**)
- Policy PFE.001.E.KY: Claims Adjudication Process (**Attachment C.19-9_Policy PFE.001.E.KY Claims Adjudication Process**)
- Policy UHG.GEN.33: Delegated Entity Oversight (**Attachment C.19-10_Policy UHG.GEN.33 Delegated Entity Oversight**)

Oversight of Subcontractor Claims Payment

Passport provides rigorous oversight of the claims payment process through review of reports, real-time dashboards and issue identification and corrective actions. Through oversight and constant evaluation of performance and provider satisfaction, we implement changes to ensure subcontracted services meet Passport's high standards for service.

We conduct appropriate ongoing monitoring, auditing and oversight for all activities conducted by subcontractors in accordance with applicable state and federal laws, regulations and guidelines. Our Compliance, Quality and Claims department representatives conduct functional area-level monitoring of delegated subcontractors to ensure that they fulfill their compliance and contractual requirements.

We use the following reports to monitor claims:

- **Pended Claims**, weekly report to monitor appropriateness of claims being held
- **Denied Claims**, weekly report to monitor appropriateness of denial and whether the adjustment reason codes properly reflect member or provider liability
- **Claims Awaiting Check Run**, weekly report showing claims that have been processed and are scheduled for payment in the next check run
- **All Paid Claims**, monthly report to monitor all aspects of correct claim payments including, but not limited to, timeliness, interest payment if appropriate, benefit configuration and benefit changes
- **Adjusted Claims**, monthly report to identify trends and benefits that were misconfigured, and to confirm that adjustment was done correctly
- **Focus Audit**, process performed to confirm changes to plan benefits has been done correctly

In addition to monitoring these reports, Passport conducts biweekly meetings with subcontracted claims teams to assure appropriate processing and timelines. They also meet monthly with the benefit coding team to ensure that benefit change requests and any code editing changes are being updated and tested in a timely manner.

C.19.b.ii.   Market specific strategies for addressing potential provider payment issues, including underpayments, overpayments, pre- and post-claims editing policies and provider billing education.

Strategies for Addressing Provider Payment Issues

Passport has established mechanisms to provide readily available provider claims payment information in real time. Our commitment to this is demonstrated by the personalized support we offer through our our web-based provider resources and Provider Claims Service Unit (PCSU).

Web-Based Provider Resources
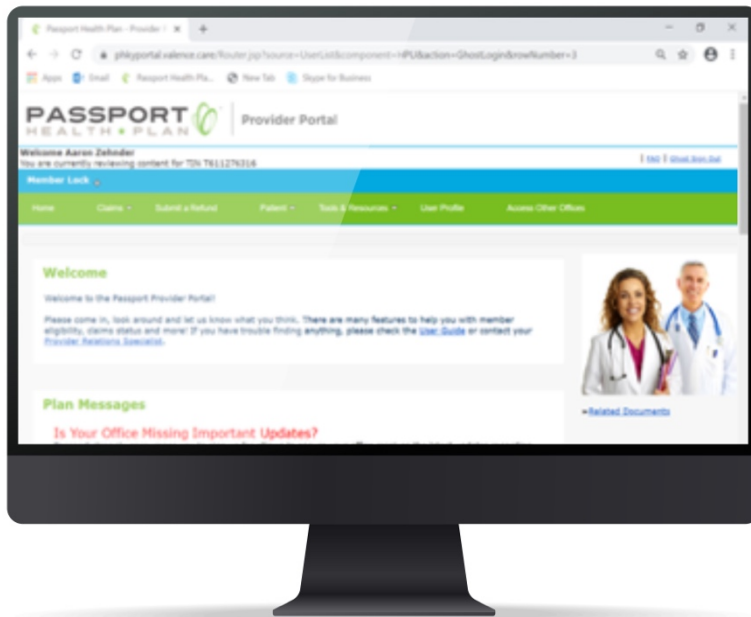
Providers can access claims status information in real time through our provider portal. Claims status reporting shows providers information about their submitted and closed claims as well as claims source (paper vs. electronic), claims volume, billed amounts and paid amounts. Providers can also access information about open claims (claims pending adjudication) and claims awaiting check run.

Provider Claims Service Unit

Providers can call our PCSU, based in Kentucky, and speak directly with one of Passport's highly skilled, provider-focused customer service agents. PCSU can provide claim status, answer provider questions regarding the claims process and/or quickly reprocess and correct claim payment errors in real time with the provider on the phone for single-call resolution. The PCSU management team logs errors based on trends in our provider payment inquiry system. Our Root Cause team determines the cause of the errors, analyzes them to identify the number of providers affected and looks for opportunities for system enhancements or process updates. The Root Cause team then coordinates with our:

- Reimbursement team to resolve the error through coding updates
- Provider Enrollment and Contracting teams for contractual corrections

- Provider Claims Rework team for claim reprocessing
- Provider Network team for provider education and outreach regarding system enhancements

Addressing Deficiencies and Variance From Standards

The Claims Management team closely monitors performance and service levels. This team has access to scheduled, pushed, on-demand and ad hoc reporting to monitor system performance, inventory, inbound and outbound file transfers, turnaround-time, auto-adjudication rates, etc. They investigate any activity that is outside of our expected parameters and escalates for remediation and root cause analysis. Examples of root causes include incomplete or incorrect system configuration, missing or invalid provider data, and claims that require manual intervention or concurrent audit.

Provider Network Team

Our statewide Provider Network team provides ongoing support to answer questions and resolve issues, including any payment issues, for all provider types. PRRs visit providers at their offices on a regular basis. Dependent on provider needs, a PRR may schedule monthly onsite visits or be available on an ad hoc basis to visit providers at any time. The PRR remains engaged with the provider through telephone, email or other provider-preferred methods. PRRs work closely with our claims team for help in reprocessing claims by phone, investigating and reasearching provider claim issues, and coordinating to schedule joint provider meetings for education and provider training.

Under- and Over-Payments

As described above, when one provider reports an over- or underpayment, our Root Cause team investigates the reason for the error. The team then works with various departments, depending on the issue:

- System coding to correct errors
- Provider contracting and enrollment for contract updates
- Provider Network team to provide education to affected providers

If the team finds that the errors were related to manual processing, we review the policies and procedures and complete refresher training for the claims staff.

When we implement changes as the result of claims audits or provider inquiries, our Provider Claims Rework team initiates a claim project to identify and reprocess impacted claims for correct payment or denial. The team runs impact reports to identify all the claims and other providers that are affected by the changes. With these steps, we ensure that the provider receives the correct reimbursement whether that includes additional payment or recoupment of overpayments. For the recoupments, we notify the provider of the overpayment and request a refund of the overpaid amount; otherwise, we will offset the amount against future claims. After completing the analysis and adjusting claims, we run another impact report to verify that all identified claims have been corrected.

Pre- and Post-Claim Editing Policies

Identifi HPA uses a comprehensive set of coding edits developed by the Centers for Medicare and Medicaid Services, DMS and the American Medical Association instead of proprietary edits. During claims editing, the system reviews CPT coding instructions, modifier appropriateness, medical necessity guidelines based on local and national coverage determinations, coding errors, omissions and questionable billing. Coding errors that the system identifies may, for example, include unbundling and frequency limits, which in turn supports the detection and prevention of fraud, waste and abuse. Our claims system also integrates editing software to apply historical editing. With this software, the system can identify related claims that were previously submitted within the member history and apply logic that may result in adjustments or denials. Clean claims that have no errors or edit issues will auto-adjudicate and finalize. If the system identifies issues through the edits, these are either forwarded to the manual claims review process or denied to the provider for correction and resubmission. Through this process, Passport is realizing an upward trend of the claims volume adjudicated automatically through the Identifi HPA system.

Provider Billing Education

Providers play an important role in helping to ensure that claims are processed timely and accurately. The provider must follow the proper billing and coding requirements for this to occur. To provide support, we share claims-related data with providers, familiarize them with the claims process and educate them on what steps they can take to help ensure efficient and accurate claims payment. In addition to provider-specific claims information and reports, we regularly report claims payment system performance data to our entire provider network. We report common billing errors and payment or processing updates through our electronic provider newsletter and Passport *eNews.* Finally, we highlight updates on claims payment performance on our provider website.

Education on the claims process is a key component of our provider orientation and ongoing communications and training. We share information about the claims process and system performance with providers during monthly provider trainings held during the first year of the contract. During these sessions, our local PRR discusses common claims errors and how to avoid them. The Passport provider manual reinforces the training with comprehensive claims submission information. Our exceptional PCSU has been responding to providers' calls regarding claims-specific questions and issues for nearly twenty (20) years. Claims payment education and transparency pays off, by:

- Helping to maintain and improve provider satisfaction
- Minimizing issues including underpayments and overpayments
- Identifying suggested process improvements or policy updates, which may originate from our network providers and their office staff

C.19.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."

## Payment Timeframes for Medical and Pharmacy Claims

Passport completes claims payment in full accordance with requirements set forth in 42 CFR 447.45 and 447.46 and KRS 304.17A-700-730. For any claims that are incorrectly paid or denied in error, we reprocess them in compliance with KRS 304.17A.17A-708. No reprocessed claim is denied for timely filing when the original claim was submitted timely.

> **In 2019, Passport's medical claims were processed in an average of 6.5 days and pharmacy claims in 9.6 days.**

2019 Average Number of Days to Pay Providers

As a result of continuous improvements in auto-adjudication and inventory reduction, Passport and its medical claims subcontractor, Evolent, **processed almost 6 million claims in an average of 6.5 days in 2019**. **Exhibit C.19-3** provides 2019 claims payment volume and average days to payment by month.

Exhibit C.19-3: 2019 Claims Payment Statistics

Processed almost 5 million claims in an average of 9.64 days
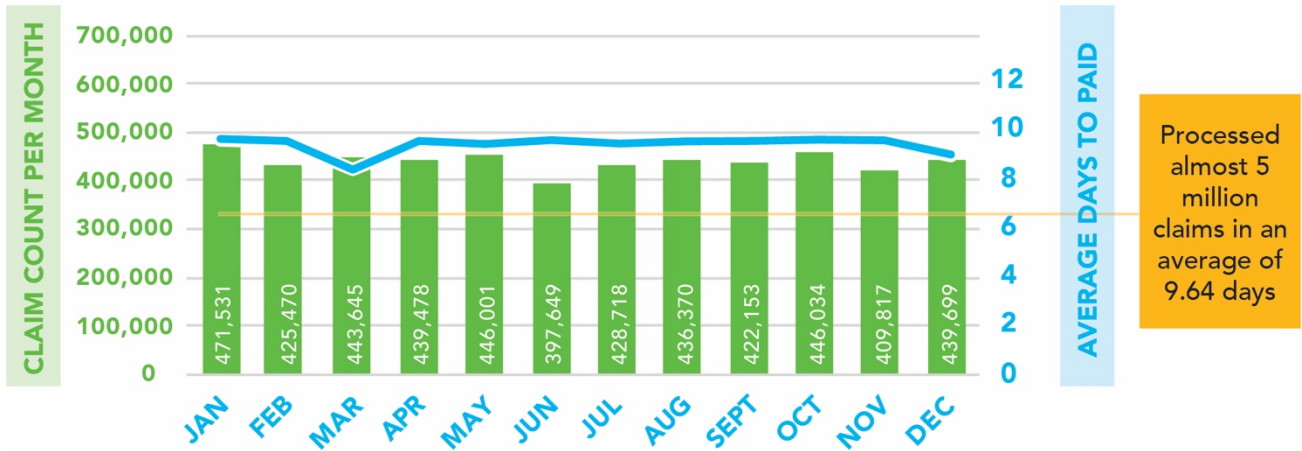
Proposed Number of Days to Payment

Passport has a long history of exceeding the Department's requirements to pay ninety percent (90%) of claims within thirty (30) days and ninety-nine percent (99%) within ninety (90) days. **Exhibit C.19-4** demonstrates that we have consistently exceeded DMS requirements, in addition to the higher standards set internally. We recommend the proposed average days to payment for medical and pharmacy claims be seven (7) days as an annualized average.

Exhibit C.19-4: Passport Timeliness History of All Medical Claims

Processed Claims				
Year	1-30 Days	31-60	61-90	>90 Days
2013	99.60%	0.40%	0.00%	0.00%
2014	99 .70%	0.30%	0.00%	0.00%
2015	98.60%	1.30%	0.10%	0.00%
2016	99.90%	0.10%	0.00%	0.00%
2017	99.50%	0.50%	0.00%	0.00%
2018	96.80%	2.70%	0.30%	0.20%
2019	99.20%	0.50%	0.10%	0.20%

C.19.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.

Auditing to Ensure Claims Payment Accuracy

In addition to tracking the speed of our claims processing system, Passport employs a comprehensive, two (2)-level claims auditing approach to evaluate the performance of our claims payment processes and payment accuracy.

Pre-and Post-Payment Audits

A team of Pre-and Post-Payment auditors (PPAs) review claims that are awaiting a scheduled check run and claims for which payment has been issued. These audits are both random and targeted; the audits help detect possible error trends to minimize impact to our providers. The PPA team leverages data from a review of claims processed through coding guideline algorithms during claim pricing. The audit algorithms follow documented claims policies and procedures to make certain of claims payment accuracy, integrity and compliance with the provisions of the Medicaid Managed Care Contract with the Commonwealth. Pre-payment audits help limit payment anomalies (under/overpayments) prior to the release of funds. We also flag claims that meet certain criteria; these claims have additional pre- and post-payment review by PPAs. The criteria include:

- Member plan types
- Void charges
- Corrected claims and the corresponding original
- Interim bills
- Claims paying more than the submitted charges
- COB
- Medicare crossover

- High dollar review
- Check run validation
- Post-pay chart review for DRG reassignment
- Data mining for anomalies related to NCCI edits, duplicates, readmissions, transfers, max limits, etc.
- Validating COB/TPL primacy, including
- subrogation cases
- Claims with refund checks applied

Quality Assurance Audits

A team of quality assurance (QA) specialists conduct a spectrum of audits to ensure the quality and improvement of claims processing. Each specialist reviews the claim to ensure compliance with DMS and Passport policies and directives. The subgroups within QA do the following:

Group 1. Six (6) QA specialists perform concurrent and retrospective audits of the claims handled by Front-End and Provider Claims Rework adjudicators:

- Concurrent audits are performed after the adjudication process, with a percentage of claims per adjudicator for continuous performance monitoring and continual feedback for training opportunities
- Retrospective audits are performed once the remit payment has been issued to ensure correct payment methodologies are being followed and to identify potential provider billing anomalies

Group 2. QA specialists review and audit the phone calls handled by the PCSU.

Group 3. QA Specialists review and audit the claims adjudicated by the PCSU. In addition, these QA specialists perform an important "audit the auditor" function by auditing the work of the QA specialists in

Sampling Methodology

We select adjudicated, pre-payment claims for audit through a proprietary, internally developed randomizer tool that selects five percent (5%) random audits per claims adjudicator. The randomizer also selects ten percent (10%) of claims per claims adjudicator for new hires, new policy updates and claims adjudicators in performance improvement plans.

> **In 2019, Passport completed 167,373 claims system audits.**

Audit Process

All processed claims are randomly sampled for auditing to confirm financial and processing accuracy. We share the results with all levels of the organization and report them monthly in an executive dashboard. Prior to releasing funds for payment, we conduct additional audits of high dollar claims to ensure correct payees, identify anomalies and provide a final comprehensive view of the adjudicated claims ready for payment.

We distribute selected claims evenly to a team of dedicated quality specialists who review the claims within twenty-four (24) hours for procedural and financial accuracy. Topics audited include:

- Determine if claim is a paper or electronic submission
- Verify form type (UB-04 vs. CMS-1500)
- Verify information submitted on claim matches what is applied in the system
- Verify member eligibility for the date of service
- Review the member's plan type (determine if an authorization/referral is needed)
- Verify that the provider information submitted matches that applied in system
- Determine whether the provider is participating or nonparticipating
- Verify the payment assignment on claim to confirm that it is for the provider, not the member
- Review COB/TPL requirements and corresponding submitted information
- Review and verify receive date to determine if claim is processing and whether any interest due is applying appropriately
- Review and verify member history for possible duplicate submissions
- Review the place of service (POS)/rev code/modifier/proc code/condition code/DX codes/billed units/NDC affects requirements for authorizations/overrides; confirm that all are billed correctly together
- Determine if systematic or manual edits were processed appropriately according to DTPs. Examples include, but are not limited to, the following:
  - Confirm type of bill/frequency code (correction or void submission)
  - Primary care physician requirements
  - Authorization requirements
  - Confirm any special processing instructions/exceptions based on notations on the claim
- View any additional documentation attached to the claim
- Review and verify any additional clinical edits and claim payment methodology
- Confirm if claim is correctly "staged" (held from or pushed out on check run) and why
- Confirm if claim is correctly "locked" to prevent future reprocessing
- Review recent check information to determine if audit is pre- or post-payment

To consistently report our ability to demonstrate excellence, we measure claim accuracy in the following categories:

- **Procedural accuracy**. Measures compliance with established Passport policies, procedures and processing rules. Assesses procedural errors at a claim level. Calculates procedural accuracy by subtracting the number of claims with procedural errors from the total claims reviewed and dividing the difference by the total claims reviewed.

  Procedural noncompliance may include, but is not limited to, the following:

  - Improper claim routing
  - Incomplete or inaccurate claim documentation
  - Incorrect or omitted remark, reject, status or comment codes
  - Failure to investigate per established procedure
  - Incorrect provider selection

- **Financial accuracy**. Measures compliance with benefit, plan and provider calculations and is calculated at a claim level. Calculations are made for the individual claim. To calculate financial accuracy, subtract the payment error dollar amount from the correct dollars payable and divide the difference by the correct dollars payable.

Exhibit C.19-5 demonstrates that we have consistently exceeded the financial and procedural accuracy requirements for claims processing.

Exhibit C.19-5: Passport Claims Financial and Procedural Accuracy for 2019

Month	Total Number of Audits 2019	Financial Accuracy Passport Requirement: 98%	Procedural Accuracy Passport Requirement: 97%
January	19,856	99.69%	99.39%
February	15,310	99.62%	98.58%
March	12,562	99.30%	99.30%
April	11,744	99.57%	99.54%
May	12,099	99.37%	98.36%
June	10,286	99.29%	98.98%
July	13,203	98.86%	98.88%
August	13,490	99.31%	99.28%
September	11,982	99.61%	99.07%
October	13,052	98.56%	97.45%
November	16,536	99.01%	97.92%
December	17,253	99.39%	98.89%

Documenting Results and Implementing Corrective Actions

We log audit results and distribute them to the Claims Management team. Passport's claims team closely monitors and progressively manages performance and provides remedial training based on these audit results.

To provide timely feedback on audit results, the audit team works closely with the claims processing and training leaders in weekly Processing Review Committee (PRC) meetings. Areas discussed include needed staff training, improvements for claims processing desktop procedures and system enhancements or possible "breaks" in the system that must be corrected.

As a result of auditing, processes prone to error have been refined, such as enhanced authorization matching, automated COB/TPL processing, and low-complexity member and provider matching where we can script manual steps to prevent human error.

Conclusion

Throughout this response, we have shown how we are meeting and exceeding DMS requirements for claims processing excellence, timely claims payment, comprehensive dedication to anticipating and resolving provider payment issues, and ensuring full compliance with state and federal requirements through our end-to-end audit processes. Our tenure providing Medicaid services on behalf of the Commonwealth and our experienced Kentucky-based claims team will positively impact Passport's claims processing and provider payment abilities as well as foster increased provider satisfaction. In support of our continuous quality improvement culture, we use the information we learn from our people, our systems and our more than 32,000+ participating Kentucky providers to remain a provider-recommended health plan for Kentucky's Medicaid Managed Care Services Program.

Excellence in claims adjudication and processing is of the upmost importance to Passport, our Board of Directors and our Partnership Council, which consists of both providers and members of the community. We are committed to meeting and exceeding DMS requirements for claims processing excellence and timely claims payment. We are dedicated to anticipating and resolving provider payment issues and ensuring full compliance with all DMS and federal standards.

Passport has been honored to serve the Kentucky Medicaid and foster care populations for 22 years and will continue to comply with all provisions of the Medicaid Managed Care Contract and Appendices (including Kentucky SKY) as we continue to serve them in the future.