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

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

As a trusted source of managed care services across the country, our teams work daily to meet and exceed the expectations of our provider partners in terms of timely and accurate claims payment. Using our advanced infrastructure for claims adjudication, our claims team consistently meets or exceeds federal and state prompt payment requirements while also maintaining the highest levels of accuracy and quality in claims processing. This operational experience provides the foundation for successful claims management and administration for our enrollees and providers. Based upon these established resources, UnitedHealthcare Community Plan of Kentucky (UnitedHealthcare) confirms we will adhere to DMS's expectations and requirements stated in Attachment C – Draft Medicaid Managed Care Contract and Appendices, Section 24.1 General Requirements 29. Provider Payment Provisions.

We will work with our Kentucky providers to encourage and support the submission of clean medical, behavioral and pharmacy claims using DMS-approved uniform claim forms, which results in expedited payment. As part of this, we will communicate that all providers (with the exception of atypical providers) must submit claims with a valid national provider identifier (NPI), whether in-network or out-of-network. We make it easy for providers by ensuring that any UnitedHealthcare employee, no matter what department they are in, can directly assist or guide providers to the most appropriate resource that can best assist them. We call this our "no wrong door" policy. Notably, our Kentucky provider advocates will be available for in-person meeting requests from providers to discuss claims status and issues, and help resolve barriers.

Looking toward the future, we are developing programs to leverage improvement in electronic health records to simply go into a record to recover missing information to correct and pay a claim instead of rejecting, and investing in online banking technologies to allow us to pay claims instantly — significantly reducing administrative burden and cost from the health care system. Said another way, we are standing by our promise to improve the health care system for everyone, including our valued provider partners.

UnitedHealthcare's Claims Adjudication Process and Capabilities

UnitedHealthcare has invested in advanced technology via Facets' Community Strategic Platform (CSP) to give providers the ultimate in claims service that focuses on accurate and timely payment with the first claim submission and keeps claims rework at the lowest levels in the industry. Payment and/or denials are consistently applied based upon enrollee benefits and state and federal regulations. Further, CSP has the capability to complete mass adjustments of adjudicated claims by provider types, claim types and time period. Descriptions of our claims adjudication process, capabilities and systems follow.

Claims payment quality and accuracy across UnitedHealthcare Medicaid and D-SNP programs are demonstrated through 2019 year-to-date averages:

- **Financial Accuracy:** 99.98%
- **Payment Accuracy:** 99.86%
- **Procedural Accuracy:** 99.77%
- **Dollar Accuracy:** 99.84%
- **Overall Accuracy:** 99.63%

We process claims using the Strategic National Implementation Process, version four in their electronic data interchange (EDI) and we comply with applicable claims processing requirements. Our team adjudicates and pays claims using the same processes, tools, systems,

edit checks and timelines regardless of whether the claim was submitted in paper or electronic format. Upon completion of initial validation edits, our team subjects claims to further validation and edits for enrollee eligibility, provider contracting and prior authorization. CSP determines if the claim can be auto-adjudicated and, if the claim criteria indicate auto-adjudication, uses built-in logic to automatically process and price the claim according to claim type. Claims that cannot be auto-adjudicated and require special intervention outside the normal claims processing cycle (e.g., procedures that require medical record review or procedures that require prior authorization) are diverted for manual adjudication by our skilled claims processors.

Our United Front End process delivers claims to the appropriate claims processing platform based upon each enrollee's demographic data and corresponding eligibility information. This allows claims data for various programs to flow through the same channel, verifying appropriate routing for all provider-submitted claims. We provide a flowchart depicting the life of a claim during the adjudication process here.

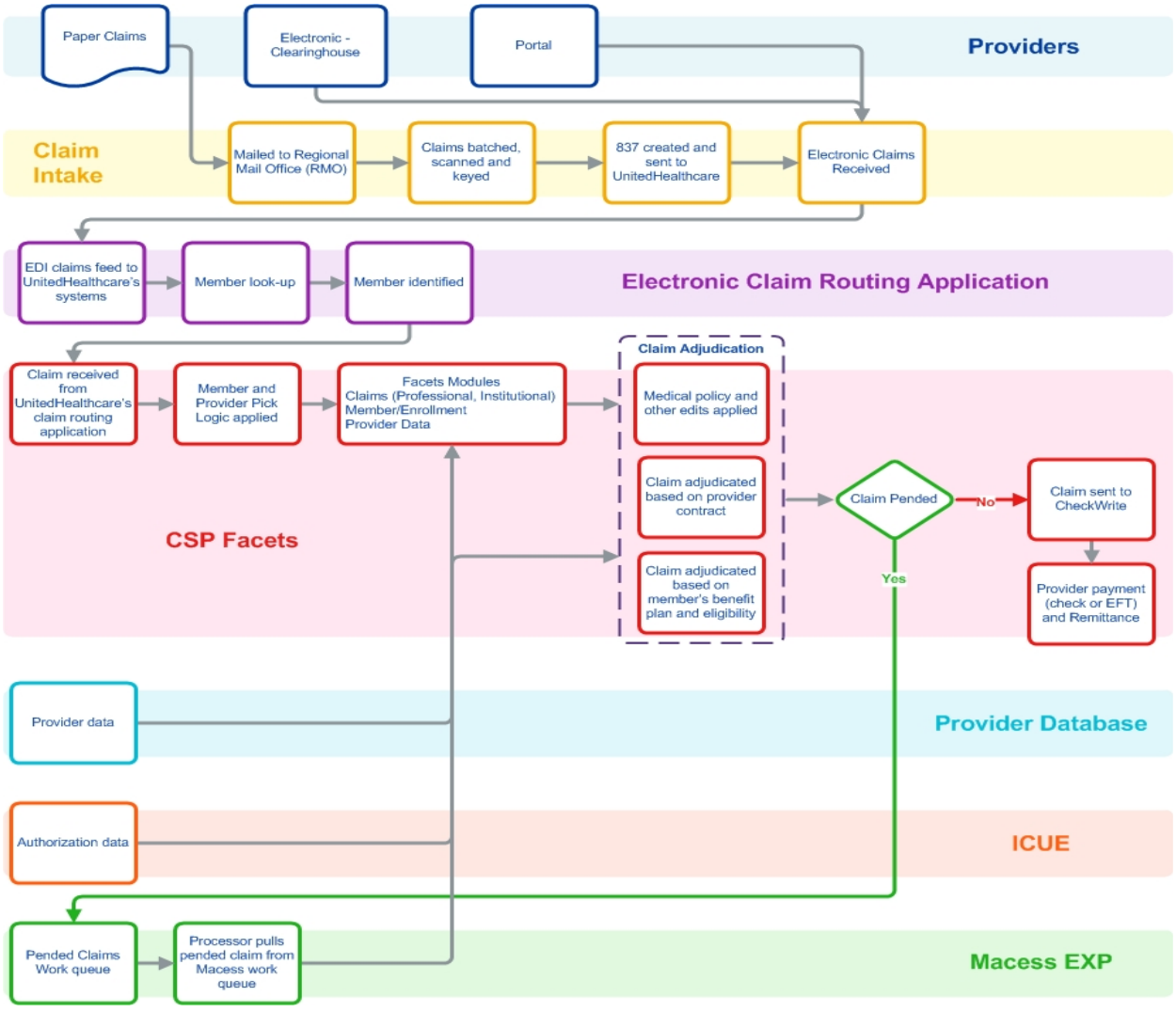

Figure 9. This flow chart depicts the flow of claims from receipt to payment.

Our systems support automated clearinghouse mechanisms to allow providers to request and receive electronic funds transfer of claims payments. Additionally, in accordance with state and

federal law, we adhere to the HIPAA national standards related to claims processing including electronic transactions standards, federally required safeguard requirements.

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

Accurate, efficient and effective claims processing is an important tenet to building trusted partnerships with our providers. UnitedHealthcare will perform MCO program claims processing and payment in-house, including for all services and provider types. We have established Kentucky relationships, including with providers, Commonwealth agency staff, and are already processing and paying Kentucky claims — **continually exceeding our claims payment goals**, as we will for the MCO program. The table demonstrates our 2019 claims payment timeliness across our existing Kentucky programs:

2018	YTD Average %
Kentucky D-SNP Goal time: 30 days, Goal: 95%	99.73
Kentucky Medicare Goal time: 30 days, Goal: 95%	99.23
Kentucky Commercial Goal time: 10 days, Goal: 94%	99.25
All Kentucky Programs	99.40

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

We recognize how important timely claims payment is to providers to support the continuation of their organization and to DMS, and we are committed to paying all providers on a timely basis. Using our previously described claims adjudication policies and procedures, we commit to paying or denying 90% of all submitted clean provider claims, including those from Indian Health Service (I/T/Us), within 30 days of receipt, and 99% of all submitted claims within 90 days of receipt. In addition, we have policies in place to monitor and validate we are meeting and exceeding prompt pay requirements in all Medicaid states we serve. As an example, the following table summarizes the 2018 claims payment performance for our Ohio Medicaid program:

Ohio Medicaid: 2018 Timely Claims Payment Performance			
Goal: 30 days/90%		Goal: 90 days/99%	
January	99.80%	January	99.97%
February	99.84%	February	99.99%
March	99.86%	March	99.99%
April	99.80%	April	99.99%
May	99.76%	May	99.99%
June	99.53%	June	99.99%
July	99.51%	July	99.99%
August	99.42%	August	99.99%
September	98.19%	September	99.99%
October	99.35%	October	99.99%
November	99.74%	November	99.99%
December	99.50%	December	99.99%

We have also attached draft claims payment policies and procedures (P&Ps) for DMS' review and consideration (see Attachment C.19.b.i – UnitedHealthcare Claims Policies-Procedures).

These draft P&Ps have been successfully used in supporting Medicaid providers in other Medicaid states and will be updated to align with requirements noted in the Kentucky MCO RFP. Contents include claims definitions and descriptions of our policies, procedures, areas of responsibilities, training and monitoring/control systems. As a new entrant to Kentucky Medicaid, we want to validate our P&Ps are 100% accurate and therefore this attachment will be considered a draft until we undergo the contract negotiation and implementation phases and receive any additional DMS input related to claims processing requirements.

Further, we acknowledge DMS's special contracting, reimbursement, coordination and reporting requirements associated with the following provider types (as defined in Draft Medicaid Managed Care Contract and Appendices, Sections 29.3 – 29.10): out-of-network providers; providers for serving dual-eligible enrollees; FQHCs and rural health clinics (RHCs); Office for Children with Special Health Care Needs; teaching hospitals; urban trauma centers; critical access hospitals (CAHs); and supplemental payments for provider categories like pediatric teaching hospitals (intensity operating allowance), State-designated urban trauma centers, State-owned or operated university teaching hospital faculty and designated psychiatric hospitals (psychiatric access supplement).

We have experience accommodating similar requirements in our other Medicaid markets and our flexible network contracting can be adjusted to include required special provisions. We are currently pursuing network agreements from the Office for Children with Special Health Care Needs, and are contracting with the various Kentucky CAHs.

Using CSP's flexible platform, our configuration teams will build upon established policies and procedures to configure the system and support Kentucky-specific business rules such as provider data load and setup, claims payment of specific program services, authorization requirements, benefit limits and reporting requirements associated with these noted provider types. Our system captures and reports multiple data elements critical to an effective enrollment process. It accommodates fee schedules, procedure and types of service coding. CSP validates data fields including edits to smooth the process for prompt payment and operations.

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

UnitedHealthcare has substantial successful experience with claims in Kentucky and we already use several strategies to address potential payment issues, including strategies to support our providers and promptly resolve issues. In all instances, we continually strive to minimize the administrative burden of reconciliation after services are rendered, so providers can focus on health care service delivery. The following narrative describes our strategic approach in a sequential flow to the life of a claim.

- We begin by including clearly defined language related to claims submission within our provider contracts. Current **provider agreements** address provider claims responsibilities including the responsibilities of providers to submit appropriate information and documentation for clean claims. We follow policies and procedures for payment issues and reconsiderations that can be amended based upon the contract and review by DMS. For claims disputes, we work with providers through our provider services team to achieve satisfactory resolution. If the provider is not satisfied with the claims resolution or if the provider services staff is unable to resolve the dispute, we escalate it to a claims resolution specialist, who initiates outbound calls for additional information or remediates unmet provider expectations.
- Once we have received the claims from providers, they must undergo our **claims review and payment integrity process** to avoid incorrect claim payment and inappropriate

claim denials resulting in increased cost to the provider, DMS and UnitedHealthcare. As part of this process, we subject all claims to **pre- and post-edit review processes and policies** including:

- Verifying the enrollee and the provider ID and validating all necessary data elements are present to allow claim processing
- Researching questionable enrollee IDs and rejecting and returning claims to the provider when a valid enrollee ID cannot be found in CSP
- Researching invalid provider IDs and, if they cannot be corrected, add a new provider record to our network database (NDB)

Upon completion of these initial validation edits, our team subjects claims to further validation and edits for enrollee eligibility, provider contracting and prior authorization. Further, our daily post go-live performance calls facilitate consistent progress measurement and internal resource sharing, the results of which are shared via daily, and eventually monthly, reports to senior leadership and local leadership teams. Once a claim undergoes and clears these edits and checks, the claim is scheduled for payment.

Described later in this response (19.c), we also will employ our Care Provider Early Warning System (CP-EWS), which uses data collection and analysis to monitor, real-time, the health of claims to provide timely warning when adverse issues threaten provider payments. The CP-EWS tracks and alerts us to trending denials, fluctuations in claims receipts by provider and cash flow interruptions to providers — essentially giving us expanded insight into additional areas that can improve provider satisfaction with claims payment.

Proactive Provider Calls to Improve Provider Satisfaction through Reduced Claim Denials

To resolve provider claims issues with a call instead of rejecting them, we made 40,000 outbound calls to providers across our national plans in 2018 and are projected to make 100,000 calls in 2019. This is an innovative approach that improves provider satisfaction, saves the provider, us, and the system time and money and reduces claim appeals.

- We maintain several options post-payment to help resolve any claims payment discrepancies between UnitedHealthcare and providers. We have a **Claims Reconsideration form** on our public provider website that any provider can complete online and submit through our *Link* system, expediting the claims reconsideration process. For example, if the claim denial reason is lack of a Medicaid ID number, we assist providers in finding out how to obtain the ID number. Once they obtain the information and resubmit the claim, we adjudicate the claim accordingly. We work with out-of-network providers to correct any claims submission errors that caused the denial. If we conclude that the claim was appropriately denied, we advise the provider of this finding, and send the provider a written notice of their right to file an appeal that includes instructions on how to file.

  We also maintain a comprehensive, transparent grievances and appeals process for providers post-payment, if the provider feels the claims payment is in error, which uses established processes, systems and timeframes.
- Post-payment, we also conduct trending and monitoring of claims via analytics (audits, over and underpayment analytics and more.) For prompt reporting of all **overpayments** identified or recovered, we will apply our existing processes and procedures for prompt reporting, and specify the overpayments due to potential fraud, to the Commonwealth. Recovery of overpayments and underpayments will be administered in accordance with

DMS requirements. We will coordinate with DMS to verify **overpayment and underpayment** recovery is accurately reflected in medical loss ratio calculations and capitation rate setting.

- During both initial onboarding and on an ongoing basis, as claim submission inaccuracy trends are identified via the previously described processes, our local field support (e.g., provider advocates, account managers) actively engage with providers and deliver provider billing education related to claims submission procedures to enable prompt, accurate claims payment— making claim filing straightforward and easy to understand. Our provider relations and provider services teams train and educate providers and third-party billers on claim and encounter submission requirements, billing practices, corrections and voids on a continuous basis. They also assist with resolving provider inquiries. We proactively reach out to and assist providers identified on our claims report with high denial rates. Our provider services staff educates providers on our claims processing methods and directs them to our website and the *Link* Dashboard that provides detailed and user-friendly instructions on how to submit claims. Our provider services helpline is also available for prompt assistance, and our toll-free dedicated EDI phone line helps providers receive electronic claims support through our EDI support team.

> We apply a variety of approaches to help our providers become more efficient and accurate in their claims submissions:
>
> - ***Online/Phone Claims Status:*** Providers can access the status of their claims via telephone or on our provider portal 24 hours a day, seven days a week.
> - ***Provider Education:*** We provide ongoing education on the benefits of electronic claims submission through in-person contact, training materials and *Practice Matters*.
> - ***Provider Account Management Program:*** We meet with key providers to assess their accounts receivable days against our payment timeliness and accuracy and identify issues around gaps or discrepancies in processing and payment.

Our provider advocates work one-on-one with Kentucky providers when they experience challenges related to claims and are willing to perform deep dive analyses to work toward mutual resolution. For example, we recently worked with St. Elizabeth Healthcare regarding some claim denials they were receiving due to two separate codes. We reviewed reporting and researched the specific claims to determine the issue. Through this collaboration, we identified a system error and are currently working to implement an update to stop our system from flagging the claim and to stop erroneous requests for medical records. We also will work with Kentucky provider associations on issue resolution efforts, such as the Kentucky Hospital Association (KHA) who implemented such a program with current MCOs early on due to the level of provider complaints. UnitedHealthcare already regularly meets with the Jefferson County Medical Society to share, inform and educate on our provider payment processes and address any issues. In addition, if a provider indicates they are seeing increased denials, we can pull reporting to look at denial trends, identify the cause of the trend and meet with the provider to educate and support them so they can eliminate these types of billing errors in the future and improve their revenue stream. We can also supply reporting on medical records requests and fraud, waste and abuse errors and meet with providers to offer education on how they can reduce some of their auditing.

Provider advocates also use our Field Aligned Support Team (FAST) as another touch point for provider education by providing specific feedback about claim denials. Including representation from the FAST team in daily meetings will increase understanding of issues affecting providers, allowing for a higher level of service and quicker issue resolution.

Continuous Improvement in Data Use to Improve Claims Processing

We will apply our FAST in Kentucky to centralize escalated provider issues for tracking, trending and visibility to actions taken. The FAST, with its single intake portal, integrates information from claims, enrollment, clinical episodes of care and utilization history, and provides an all-inclusive picture of provider pain points. We use this data to identify root causes and develop solutions. Since introducing FAST in April 2015, we have seen a decrease in the overall volume of escalated issues, average days of issues on hand and number of open issues, and improved provider satisfaction. Turnaround time for Medicaid and D-SNP claims has decreased from 42.69 calendar days before FAST to 18.59 calendar days on average — **a reduction of 56.45%**. In addition, the FAST Satisfaction Top Box Survey results increased 29% from March 2017 (start of survey program) through year to date.

- Continuous quality and process improvement occurs based upon enhancement opportunities identified during the previously described steps and activities. As improvements are made, we share process and procedure updates to providers via a variety of communication channels including local meetings, articles in our provider newsletter *Practice Matters*, website postings, and more. These provider outreach mechanisms help providers accurately submit claims, view status and adjustments and, when necessary, edit and resubmit claims, in addition to updating providers on any future process changes.

In summary, we are continuously monitoring our claims process to identify and address any issues (systemic or provider-specific) which would hamper an accurate and prompt provider payment. Throughout the overall process, a partnership is critical, with activities UnitedHealthcare can conduct and steps the provider can take to achieve smooth and efficient claims processing and payment.

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."

UnitedHealthcare uses established methods to manage claims and validate that they are processed accurately and timely. **We will meet or exceed DMS's timelines for claims processing** as follows.

Proposed Claims Processing Time Frames	
Medical Claims	▪ Pay or deny a clean claim less than 30 calendar days of claim receipt or the first scheduled provider reimbursement cycle following adjudication ▪ Pay or deny a pended claim within 30 calendar days of receipt of requested additional information
Pharmacy Claims	Within 14 calendar days of claim receipt

The last calendar year's report showing the average number of days to process claims from providers in our Ohio Medicaid market is shown in the following chart. **As illustrated, in 2018 we processed an average of 99.5% of all Ohio claims in less than 16 days**.

Ohio Medicaid: 2018 Average Days to Claim Payment		
Month	**Days**	**% of Claims Paid in Time Frame**
January	15.1	99.50%
February	15.7	99.50%
March	15.8	99.50%
April	15.2	99.50%
May	16	99.50%
June	15.8	99.50%
July	15.5	99.50%
August	15.7	99.50%
September	15.4	99.50%
October	15.6	99.50%
November	15.9	99.50%
December	14.2	99.50%

Not only does UnitedHealthcare use these internal reporting methods to monitor how long it is taking us to pay provider claims and monitor claims trends, but also we are updating and enhancing provider self-service reporting tools for claims, including our provider portal, *Link*, and access to UHC Insights. UHC Insights is an interactive interface that providers can access to monitor their claim performance at the aggregated level with the ability to identify opportunities to take action related to claims trends. Our provider advocates will use information from UHC Insights during meetings with providers to discuss concerns related to claims payments and help resolve any discrepancies.

Further, we work closely with physicians and other network providers to ensure they can receive and reconcile paid claims quickly and easily. This includes enrollment into our EPS (Electronic Payments and Statements) tool that allows claim payments to be made electronically, via the Automated Clearinghouse Network (ACH), to the bank account designated by the health care professional. Currently, over 95% of UnitedHealthcare physicians in Kentucky are enrolled with this program.

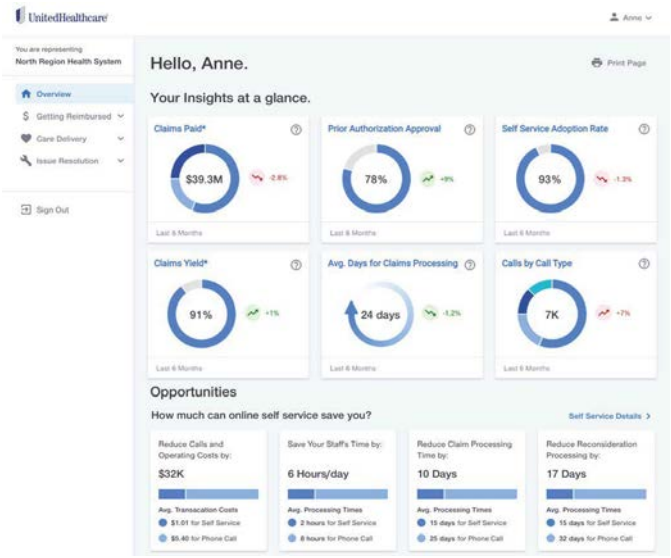

Figure 10. UHC Insights Screenshot. UHC Insights is transforming the way UnitedHealthcare engages providers by centralizing reporting through a simple interface for internal and external users. We will use centralized data, machine learning and technology to deliver operational and clinical reporting at the right level required to drive action, support trusted relationships and drive ease of doing business.

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.

We built our Claims Quality Assurance program upon a set of quantifiable measures to continually verify that we are processing and paying claims on time and accurately. Our Claims Quality Assurance program includes pre-disbursement auditing, post-disbursement auditing and preventive review, including root cause analyses and rapid deployment of solutions to avoid

service dissatisfaction among providers. All audit review outcomes are documented and kept on file for trending and reporting purposes.

Our sampling methods are specifically designed to the relevant algorithms in each of our deployed audit programs. For pre-disbursement auditing, we apply hundreds of filters coded to identify claims scenarios likely to require additional review and apply a secondary manual audit pre-disbursement. For post-disbursement reviews, we extract a stratified sampling by dividing claims into eight categories, called strata, based upon the dollar amount paid; a fixed number of claims are randomly selected for review; and the number of claims selected per strata is based upon the percent of paid dollars per strata. Each individual claims processor's work is selected for a statistically significant random sample audit to confirm accuracy. Conducted as needed and looking at a defined range of claims, we also perform focused claim audit reviews for specific problematic topics to identify patterns and root cause. Furthermore, we use a suite of analytic solutions, which identify outlier, aberrant or suspicious transactions, providers and enrollees using various statistical models and topological and big data techniques. Our advanced analytics team continuously researches new payment integrity technology and methodologies, which enhance our ability to detect and prevent improper payments.

- ***Pre-disbursement auditing:*** We use the Customer Expanded Audit Program (CEAP) to initiate an audit to capture and correct claims containing known issues until a solution can be implemented. The purpose of the CEAP is to reduce defects, eliminate rework and drive process improvement by correcting defective claims in a pre-payment status. CEAP audits focus on configuration, pricing or manual processing defects resulting in an incorrect claim payment. The audit findings initiate system updates, revise processing guidelines and support data-driven results.
- ***Post-disbursement auditing:*** We perform audits post-disbursement in our Smart Audit Master (SAM) program in advance of the monthly report. A random stratified sampling of all claims processed, both paid and denied, based upon total dollars paid is provided during this auditing. Claims with higher paid dollars are audited more frequently. Both auto-adjudicated and manually processed claims are included. Claims are reviewed for overall accuracy to include a financial and procedural accuracy measurement.
- ***Preventive review:*** Preventive reviews are triggered when systemic issues have been identified and when claims submission anomalies become evident for a certain diagnosis code, CPT code, payment category, provider type or geographic origination of claims submissions. We perform a focused audit, as needed that looks at a defined range of claims, service types and providers that have recently experienced disruptions or any other characteristic/demographic that requires additional review. We use a post-training quality assessment to review claims processors' claim payment accuracy and provide post-classroom training to identify training gaps or training opportunities. Claim auditors access the selected claims within SAM and review the claims to determine processing accuracy and to seek clues that point to the cause for the anomaly.

We will supplement our claim audit efforts in Kentucky by identifying areas of risk in the claims process leveraging our **Care Provider Early Warning System (CP-EWS)**. The CP-EWS uses data collection and analysis to provide timely warning when adverse issues threaten, and then elicit the appropriate response. The system not only alerts us to the risk of claims denied in error, but also to fluctuations in claims receipts, and cash flow paid to providers to give us an end-to-end view of the claims process and expand our view to additional areas that can improve provider satisfaction. We specifically designed this system to identify issues before provider impact in a manner that leads to rapid investigation and corrective actions, and greatly reduces the time it takes to discover system errors along with the volume of claims affected. A team of

analysts uses the daily data to perform same-day remediation actions including internal outreach and updates, external outreach to the provider community, and claim holds to prevent further inaccurate denials.

CP-EWS Success Case Study: Tennessee

Situation: State registration files are validated with a claims system edit to ensure providers are correctly registered before finalizing claim payments. The edit implemented several years ago had an end date of 1/1/2020. On 1/6/2020, we identified through CP-EWS that almost 2,400 claims that were receiving registration denials that previously weren't present, specific to Tennessee. These issues, left unattended, lead to corrective action plans, revenue withholding and damage to the UnitedHealthcare brand. Historically, this kind of issue takes a longer time to identify as the issue grows in size and visibility. Tennessee and other states are increasingly requiring us to demonstrate our efforts to identify and address these issues as part of our ongoing operations. In addressing these concerns, we are capitalizing on the opportunity to use this enhanced visibility to address rework and other cost areas. The ability to look at claims issues across states allows us to better understand the global impact of an issue and implement change before issues escalate even further.

- ***Solution:*** CP-EWS distills and analyzes the massive amount of data captured in the claims process to identify areas of risk in our process. The system consists of a hybrid technology of reporting and automated analysis combined with a series of processes and team of analysts to continuously monitor the health of the claims process. CP-EWS monitors claim receipts, rejections, denials and cash flow paid to providers to make certain the claims process is operating as expected. In addition to the reduction of business risk, the system provides a better understanding of the claims process, serving as a platform for continuous operational improvement. Due to the timely review of this issue through CP-EWS, claims were intercepted that would have denied inappropriately. Cross-functional teams across our internal organization were brought together the same day of the identification to diagnose and solution. A temporary hold and work around process was implemented to ensure claims were processing correctly. Two days later, on 1/8/2020, system fixes were in place, and claims were validated as paying appropriately. The previously denied claims were reprocessed without action required by the provider.

Benefits:

- Reduced risk of state CAPs
- Reduced rework
- Reduced risk of revenue withholds
- Increased productivity in remediation
- Reduced provider abrasion
- Reduced interest spend
- Enhanced reputation with state regulators
- Superior service to providers