HUMANA MINUTES
July 18, 2016 RIC/RAC Meeting

HUMANA REPRESENTATIVES PRESENT:
Mr. Andrew Winkler
Mr. Ron Harris
Mr. Marquis Vaughn
Ms. Stephanie Sponburg

FACILITATORS PRESENT:
Mr. Wesley Ashmore
Ms. Debbie Rubio

MR. ASHMORE: Today, we have Humana joining us and I'm going to turn it over to Andrew Winkler to introduce himself and his team.

MR. WINKLER: Hi, everybody. Thanks for having us today. My name is Andrew Winkler. I'm with Humana's Provider Payment Integrity Department. I'm in an area that specifically works with our hospital partners, and we work to help facilitate and make our post-pay audit process more provider friendly and try to work to improve the provider experiences. We work through various post-payment audits as well as some of our prepayment work as well.

And I brought with me some of my team. Marquis Vaughn, here on the laptop, is going to be helping out today. He actually works and supports this region as a regional consultant on my team, as does Ron Harris. Ron is relatively new to our team and has a lot of clinical background from our audit area and is going to be supporting this region as well. We do make on-site visits to providers and work with providers to work through these issues.

And then we also brought Stephanie Sponburg, who is with our utilization management area. She's going to be here to answer questions related to our front-end review process, if you're familiar with that.

(PowerPoint presentation)

MR. WINKLER: That was a quick overview of our audit process. Some of the things we heard from the group, we didn't have any specific questions to address, but we had heard concerns with lost medical records. So I do think the opportunity to work with the group here on use of the medical record management tool is a big opportunity. We have not done a lot of engagement directly with facilities here to customize addresses.

We can also customize the refund request address. If it's going to a P.O. Box and you would rather have that sent to, say, the refunds department, we can do that. We can even do it to the attention of Ron Harris, although, he won't respond on behalf of your facility, but we can customize it down to the individual person that you would like to review and respond. So just trying to make the process more provider friendly.

And last, but not least, we can also customize the address to which we send our appeals outcomes. So if there is a disputes or appeals department within your organization that needs

to receive those as opposed to maybe your P.O. Box, we have the ability to customize that as well.

And then another thing we got some feedback on was our customer service process. And for those of you that are familiar, we do have an IVR, or interactive voice response system, that handles our actual calls. And initially, the concept behind it was these things don't generally get resolved quickly.

When we get a provider question, we need to do some research. And so what we've started doing is essentially leave a message model where you go through a series of IVR prompts, supply information related to your question. And the idea behind it is then the rep can research that off-line and come back and give you a comprehensive, thought-out answer.

I know, from talking to many hospitals, that's not been their experience for one reason or another. They either miss the call-back, they tried multiple times, or were not able to get in touch with the rep that they were looking for. You know, I will tell you those guys handle I think it's 2200 calls a week and we average somewhere around 30 complaints. So I don't want to make it sound like they're terrible, but if you're one of those 30 folks that didn't get a call-back, that's a bad provider experience, and we want to work to fix that.

So not only are we constantly working to better develop our customer service reps, make sure that they're following the process, understand what we're doing and understand how to resolve issues, we've also developed a tool that we're introducing to providers called a claim information exchange tool, or the CIA tool.

And it is a realtime direct connect claims exchange information tool. Very often you will get a notification that you had an overpayment before a letter ever gets sent to your facility. They show up in realtime, you can review them in the tool, and you can respond with questions, disputes, or refunds through that tool and never call customer service if you don't like.

Additionally, one of the benefits of this tool is you can opt out of getting letters, you know, it is 2016, and we can finally get a little less paper in the system. That's a great thing. So you can actually get your notification through the tool and dispute through the tool, ask questions, and have basically a dialogue within the tool to get that issue resolved instead of sitting on the phone listening to somebody pecking their keyboard or, in our case, doing the IVR process and maybe having trouble getting the call back, et cetera.

So we're really excited about that tool. It's currently being used by about 30 providers nationwide. We've done demos for about 400 providers nationwide. The feedback has been tremendous. It's been really exciting to watch that tool grow and the impact it's making to our provider relationships where we've had, to be quite honest, a lot of challenges around the way we audit and how that impacts a provider from an administrative cost perspective. And so we see this as one of many ways we have to work to better improve that process.

Additionally, we've done IT enhancements coming in the year ahead; humana.com, the website is on its way out. We're sunsetting it in favor of the combined Availity platform. Availity is a multipayor platform solution that we also leverage. And it gives a lot of new and exciting functionality that we are exploring as well as the ability to post our financial

recovery letters on line. So a high number of the calls we're receiving in customer service are very basic and transactional needs. We're in trouble, I didn't receive letter X or letter Y.

Well, what we'd ask in these cases is that you be able to log into availity.com under your tax ID, and you'll be able to pull a copy of any letter that we've sent to you. Any piece of correspondence that came from provider payment integrity would be stored there. You'd be able to search by claim number, tax ID, and get your hands on a copy of that letter yourself. And I know personally any opportunity I have to self serve, I usually choose that over waiting in line for customer service.

So that's a big project that's underway this year. We're calling it a letter reduction in provider experience enhancement. We want to stop sending as much paper out the door, because that's a big complaint we get, and we want to improve the provider experience with that.

Additionally, we are working to offer what they call EFT recoupments. You guys are familiar with EFT payments, electronic fund transfers. A lot of our competitors have offered electronic fund transfer recoupments, EFT recoupments, where you can actually use a direct transaction with the bank to reconcile these debts as opposed to having to recoup off of multiple payments where you wind up with a lot of problems.

So these are all things that you would have the opportunity to opt into. Not every solution that we put forward is going to help every facility. But what we're trying to do is provide a suite of solutions for a variety of problems and then offer those out to the provider community and see which of them may or may not provide support or help to help make this process better and reduce some of the friction that's created by it.

And then just one other thing I'll mention while I've got your attention is just that Humana, as a company, has evolved over the years to become one of the big players in the Medicare space. And in that time we've learned a lot. So if you have not gone through the process of one of these audits in a while, if you haven't worked with our team in a while, if you haven't contacted our service areas in some time, I would encourage you to have your staff call again, try and see if they don't find that the experience has improved. And as we continue to advance the ball with some of these various enhancements that we're working on to try to create greater transparency, work with our provider community, take the voice of the customer back to our leadership and try to advocate for enhancements and improvements in our systems, we really want to hear from you.

So I know Ron and Marquis are going to be available for questions afterwards. We have business cards. We're happy to get in touch with you. We can work with you through issues, help get things resolved. If you have things that you've been unable to get successfully resolved through the customer service channels, we're happy to take that on and see if we can't provide a solution for it. But the key message I wanted to send is we are really looking to be a partner to the provider community, and we hope that you will be happy enough to meet us in the middle.

MR. ASHMORE: We'll open it up now for questions.

AUDIENCE: I have a question regarding your primary review process. Those patients are generally certified that we've sent that information in; but we still find that we get request and denials after the fact, which is a little misleading.

MR. WINKLER: So that generally shouldn't happen. And I will pass the mike to Stephanie. But I will say one of the occasions where we see that is, in essence, when the front-end review nurses complete their review and provide an authorization, it's simple enough, there's a check box that they say a clinical review has been done. And if they do that properly, my area of the provider payment integrity department cannot select that claim. Our system will disallow that from audit.

So, individual associates, we have turnover within those nursing areas, and we need to just do some basic coaching. That's usually what I've experienced with that, and the box just didn't get checked.

AUDIENCE: But that's denied retrospective. So even so, once it's audited, you would think that they would be able to see the authorization and that documentation where it was approved when the patient was in-house.

MR. WINKLER: Yeah. And that's another thing we're working on. And I'm glad you mentioned it. The reality of the situation is that when the front-end review nurse is reviewing, it's a very high pressure, fast, and a very quickened environment, and they're making the most informed decision they can on the fly.

We do find that there's a bit of a discrepancy in what they would approve versus what we would approve with unlimited time, like we do after the payment. So when we're reviewing it and reviewing all the details, there are times when we will identify something that, had we known it on the front-end, wouldn't have received an authorization.

But, as I said, our process is such that if you go through that clinical authorization process and they check the box, we had our chance to look at the claim, whether we missed it or not, and we shouldn't be subjecting that to a subsequent audit.

Also, just to be clear, that only relates to the front-end review short-stay combo. Right? So if it's reviewed on the front-end review process for intensity of service, it would still be eligible for other things like coding, other things that were not reviewed in that front-end process. But there shouldn't be a denial for noncovered or a denial for no auth.

AUDIENCE: We're seeing that. And I know that we're out of time, but I need to say this. We need some type of support because we're seeing a lot of five- and six-day observation patients that we have no recourse. They meet our InterQual screen.

(Applause)

AUDIENCE: And that's a burden for us at the hospital because we do have a patient that we believe is sick and that's not safe to discharge, but we can't get an inpatient reimbursement for that patient. And I don't know what it does to your member either financially, but I know what it's doing at the hospital.

MR. WINKLER: Sure. And so just for context, and obviously, that's a shared sentiment, let me just ask is that with the front-end review?

(Consensus voiced by the audience)

AUDIENCE: That's with the front-end review.

MR. WINKLER: Not in any way to put you on the hot seat there, Stephanie, but I'm going to ask you to handle that.

MS. SPONBURG: You are going to put me on the hot seat, and that's okay. I'll actually give you my information too on the way out. What's really, really important about your members is making sure that before they get discharged, to call Humana and get a notification, get that approval. Because what's happening is, they will go to the hospital hypothetically on a Friday and maybe the billing office is closed or someone is out of town or you're unable, you're busy, you're a busy facility. You come in on a Monday, and then you call Humana, but the patient has already been discharged. That's where it turns into a review. So is that your situation?

AUDIENCE: We actually have on-site reviewers, and we're still getting exactly what she's talking about.

AUDIENCE: Yes.

AUDIENCE: Yes.

AUDIENCE: So we have on-site, and it's not waiting until Monday. And we have those going on-line as well through the portal, those notifications.

MS. SPONBURG: Okay. I'm definitely going to take that back.

AUDIENCE: I was just going to follow-up real quickly to what we were talking about, the checkmark box. That is actually one of the things I had written down that she was talking about. And we actually had a few recently, and we had to call and get Teresa to look into that. And these were all approved concurrently. And your concurrent nurse approved them. She's on-site. And they had hit the post-pay audit.

If it's been approved concurrently, Humana approved it and said it was inpatient appropriate. So it's sort of a conflict to say that on the back end it's denied and I'm not talking about a DRG audit or a coding audit, but just a flatout medical necessity, which is what these were. That's in conflict with the fact that Humana has already approved it. So is there some sort of a hard stop that Humana can look at in the long term to prevent the provider from having to manage these and police these, which is what we're having to do?

MR. WINKLER: Yes. That's a great question. And I really do want to be respectful of time. And I think that's an important one to cover. So if I can have one more moment.

We're in agreement. So just so we're clear, Humana is in agreement with you guys. If we do a front-end clinical review and clinician-to-clinician authorized services for inpatient stay, that should not be subjected to a post-payment review for the same thing. And when that happens, it is an error. So if that's happening with frequency, that's when we need to look at some examples. And I know Stephanie is going to be very interested to understand what could be creating that. But as I said, the most common example that we've seen from that is human error or somebody didn't check the box to exclude it.

And, you know, I think it's a valid question, shouldn't we also know that there's an authorization; but unfortunately, this stuff in the claims selection for audits is done through an automated query that looks at different criteria and tries to select claims that would be a potential problem.

So we really rely on that check-box for it to be excluded. So I think what we want is to take as many examples as we can for those types of scenarios and see where the breakdown was. And you know, if we have something systematic, that's a problem we need to fix. But I just want to be clear, as it relates to short-stays or bed necessity, intensity of service, whatever you want to call it, if you follow our front-end review process, we should not be auditing. And so I absolutely agree with you. And I would be as frustrated as the room full of you if I was having that happen to me.

So I apologize if that's happened at all; but I can assure you that between Stephanie and myself and our respective organizations, we will dig in, see if we can't figure out what's creating that. It sounds like it's happening in a trended manner here, and we want to get our hands around that quickly.

MR. ASHMORE: We'll take one more question.

AUDIENCE: So again, on the front-end reviews, once the MOON notification goes into effect, are you guys going to issue us the denial letter based on the inpatient within the 24 to 36 hours so that we can give that letter to the patient as well in addition to the MOON? Because the patient is going to have questions when their physician has ordered inpatient, they're treated in the inpatient setting, and yet we're issuing them the MOON notification that you're observation based on Humana's determination.

MS. SPONBURG: For a denial for Humana, we actually do notify the member and the provider.

AUDIENCE: While the patient is in the hospital? Because we will have to issue the MOON while they're in the hospital.

MS. SPONBURG: That question I'll have to take back. Andrew, do you know that? I'm not familiar with that.

MR. ASHMORE: Last question here.

AUDIENCE: So whenever we do get a denial issued and we get the notification from you, we get the same letter that you would send a patient. We don't get any clinical rationale for the denial. So like a Blue Cross of Alabama, other HMO providers, and even on our KEPRO back-end audits, we get feedback from the payers as to the clinical reason for the denial. So then as a provider, we are left guessing at why you may have denied the claim for medical necessity, is what I'm referring to. And so that makes it very hard for us to formulate an appeal.

And then to build off that, I got an answer from our regional hospital reviewer for Humana that said if they don't have the ability to make the determination as inpatient or outpatient observation status, they're not checking that box. They are going ahead and giving us inpatient because they have not come to the determination in a timely manner.

And so we don't know that. We don't know that's why we're getting the inpatient. And so that's why it's hitting your back-end. Just FYI. It's super frustrating.

MR. WINKLER: So I'm slightly aware of that issue, but I want to make sure I understand. So when you're pursuing a front-end denial, you're not getting clinical detail on those, correct?

AUDIENCE: Right.

MR. WINKLER: Okay. Because I know on the post date, it's a very detailed letter. But that's a different process, so I wanted to be clear on that.

AUDIENCE: Right.

MR. WINKLER: And then when you've requested an authorization through our front-end review process, and if they are not able to get to them in time, they get released, and it gives a notification number, not an authorization number.

AUDIENCE: No. We're getting communication when it's approved as inpatient.

MR. WINKLER: Yes. And so I'm also aware of that. So what happens is, and we have an IT project working to fix this. But I absolutely understand your perspective and, quite frankly, share the frustration that we have this limitation right now. But basically, they're two very different experiences if you're talking to a clinician going through a clinical review process or going through the front-end review process, you're getting approved days of an inpatient stay. When it goes to the off path and nobody gets to it, it essentially creates a notification number, which comes with a bunch of disclaimers that says no guarantee of payment, et cetera.

But that all assumes that you're on the phone. And a lot of folks use the internet, and so it's not as clear.

AUDIENCE: We're on the phone. We have an on-site reviewer.

MR. WINKLER: Okay. So what happens if they don't get to it timely and then it gets auto approved, is it generates a notification number, but it puts it in the same place in our system as our authorization number. And we recognize that's very misleading and very confusing. And that's the enhancement that I'm talking about.

So what our position is on that in general is that if we are not able to do a pre-authorization, we feel that we are obligated by CMS to monitor the intensity of service by necessity issue. So if we do not get a chance to do it on a prepayment basis, we believe that claim needs to be eligible at least for audit. It may very well not get selected, but it needs to at least be eligible for audit if it has a problem because no med necessity determination has been made.

But to your very valid and understandable point, the frustrating part now is as our system's limitations exist today, it's not always obvious that you have an approved service or just a notification number, and we are working to fix that. There's a lot of senior leadership activity working on that project right now. It's my understanding an IT enhancement is forthcoming that will then show you whether it's an authorization number or just a notification number saying if Mr. Winkler is in your lobby having an heart attack, you can treat him because he's got insurance.

And that's really the distinction. You know, one of them is saying we've reviewed the case, we know the clinical criteria have been met, you're approved for a patient versus this guy has got coverage and you can treat him. You know, and again, from the system standpoint, I understand they do look very similar, so that's something we're working to correct.

AUDIENCE: Okay. And then whenever we have, let's say a concurrent denial in-house, a lot of times I don't know why you're denying it. Usually we hear it doesn't meet Milliman criteria, in all honesty. Most of the hospitals use InterQual because that's what we use for Blue Cross of Alabama. I understand that you guys use Milliman. And that's fine for a first-level nurse reviewer; but whenever we're having our physicians do peer-to-peer reviews with your

physicians, they're also responding that it doesn't meet Milliman criteria. And I don't think that that's necessarily the intent of having a physician-level reviewer.

So that was our other concern is that sometimes we feel like people do meet medical necessity that you guys aren't approving concurrently.

MS. SPONBURG: So when you're doing the peer-to-peer with your physician, the patient, you said, is in-house still?

AUDIENCE: Yes.

MS. SPONBURG: They have not been discharged?

AUDIENCE: Yes, that's correct. We have an on-site physician advisor who you guys will not talk to. We have to try to track down the attending physician.

(Laughter)

AUDIENCE: We're not the only one. We have to try to chase down our attending physician, which is very difficult and burdensome and probably presents a lot of administrative burden on our part to get done. A lot of our attending physicians and surgeons are not skilled in the area of utilization review. They don't understand it. They think the patient is thinking you don't pay. Where our physician advisors have specific training in place to be able to plead a case with your physicians, who have got the same level of training.

I mean, it presents a significant disadvantage for us to not know, number one, why it's denied and, number two, not have a physician with the same amount of training that yours has in the process.

(Applause)

MS. SPONBURG: I'm going to have to take the question back, to be honest with you, and work with our concurrent business partners to really get down to that point for you. Within the department that I'm in, I'm on the retro end, so the patient has already been discharged. So your patient is still in-house, you're having some issues with speaking with medical directors, the peer-to-peer, and then the medical necessity of it and the criteria; is that correct?

AUDIENCE: Yes. Talk to our physician advisors. That's all we're asking for more than anything.

MS. SPONBURG: Okay. I will definitely take that back.

MR. ASHMORE: Okay. Since we are out of time here, if you want to just submit more formal questions to Humana, just like you would the regular RIC/RAC process. And we can pass them on to Andrew and his team, and hopefully they'll come back to our next meeting with some prepared answers.

MR. WINKLER: And since we are over time, I just wanted to say obviously I can tell from just the response in the room there's been a lot of challenges around these processes. And that's one of the reasons we came today is we wanted to talk to you. This is a growing market for Humana. There's a lot of hospitals in this market in a state that we have not done direct engagement with, and it is high time that we do that. So that's one of the reasons we're here today. I wanted to introduce Ron, Marquis, and the group, but also to let you know that these resources exist.

So I know sometimes the big, bad insurance company, it can seem like you're throwing your complaint over the wall and you're just hoping somebody will respond. We very much try not to be that company. So we want to partner with you. We want to hear these types of problems, these types of concerns. It is a little painful, I'm not going to lie, but we need to learn from them.

And so, what I'm looking to do with this group and what we're looking to do with the Alabama market is be a business partner and work through issues so that you can happily accept our Humana members, know how to work through our processes, and not deal with unnecessary burdens of the very complex business that we're all in.

So I appreciate the time today. I appreciate your attention and time. And hopefully we can work together to provide some resolution on some of the challenges you have been dealing with.

MR. ASHMORE: Thank you.

AUDIENCE: So are you planning to be back here in the fall to address all these concerns that we have?

MR. WINKLER: If you would like to submit some specific questions. First of all, we'll be here after.

AUDIENCE: I think we probably addressed a lot of things that are concerns. And I think as a group, we'd like to hear response and what you're doing to address these concerns.

MR. ASHMORE: So I think the best way to do that is to submit a formal question to Peggy, just like we would with Cahaba and Medicaid and all the others, so that way they have a formal question that they can prepare an answer for, for the next meeting, which is our November meeting.

MS. CARSTENS: Yes, November 7th.

MR. WINKLER: Yeah. Sure. So just to be clear, absolutely, we'll happily sit down, myself or our regional manager for this area, John Potts, who really wanted to be here today. So I'd love to bring John with me next time. And you may have worked with John Potts and his team or Marquis or Ron. These are folks within my organization that work with providers in this area.

So I would love to bring John back, answer specific questions. And I just ask again, to Wesley's point, if we could get documentation all around, examples even would be great. We have some business cards we can give out to folks who may have examples. If you want to send those to our attention, we'll happily have them researched and respond to you directly, but we can also take the more broad questions that you have about our larger process issues and come back with a formal response at the next meeting. I'll be happy to do that.

MS. CARSTENS: And so for my information, you're going to provide this presentation you just did to me and I can distribute? And it will also have contact information?

MR. WINKLER: Yes. Absolutely. You are welcome to distribute it. It's got some useful links in it as well as some basic process flows. If you have questions about those we're happy to give out our contact information so that you can reach us directly and ask some more specific or detailed questions. If your staff has those questions, we want to give you access to our team so that you can get those issues resolved.

So again, we'll be around afterwards and happy to take questions about anything else we didn't get to.

MR. ASHMORE: Thank you for coming to be with us today.