UNITED HEALTHCARE MINUTES
November 7, 2016 RIC/RAC Meeting

UNITED REPRESENTATIVES PRESENT:
Ms. Linda Fetsch

FACILITATORS PRESENT:
Mr. Wesley Ashmore
Ms. Karen Northcutt

MR. ASHMORE: Let me welcome here with us today from United Healthcare, Linda Fetsch.

1. On several occasions lately, patients are refusing to pay their portion upfront, stating that they called United, and the United rep advised them to never pay upfront and that they should always just wait until they received a bill from the hospital. My question is…have United representatives been instructed to tell patients this? And if so, why? The hospitals have every right to encourage upfront payments with good faith estimates.

   Response: **Hospitals have every right to request member responsibility upfront. We would not tell patients not to pay nor would we tell the hospitals not to ask. We would need an example to pursue whether or not customer service made that comment.**

Discussion at meeting

MS. FETSCH: We would ask that you get the member's responsibility at the time of the visit.

2. When is United going to start keeping the Medicare payment rates updated in their system so they can pay the correct amounts initially and not request so many refunds? Example: Payment reason on letter: 070-paid in excess of the Medicare allowable**.**

   Response: **Participating facility agreements include language that provides United sufficient time, from the date modified information regarding reimbursement methodology, applicable reimbursement components and/or rates is placed by CMS in the public domain, to update reimbursement methodology, reimbursement components and/or rates in its systems with the updated MS-DRG and APC information to be consistent with CMS. For CMS retroactive modifications or changes to previously announced modifications, United will update its systems within a specified time frame after the date on which CMS places that information in the public domain. Standard contract language also indicates that no adjustments will be made to claims that were processed correctly in accordance with the applicable Payment Methods in effect prior to United updating their systems.**

Discussion at meeting

MS. FETSCH: Now, I did not have any actual examples for this, so I had to get with our legal department for this response.

3. When is United going to start keeping the FL. Medicaid out of state payment rates updated in their system so they will pay the correct amounts and not request so many refunds? Example: Payment reason on letter: 082-paid in excess of the Medicaid allowable.

Response: **AHCA issues specific out of state outpatient per line item rates for both teaching and non-teaching facilities, and inpatient reimbursement is APR-DRG. United will update system configurations to accommodate these rates as quickly as reasonably possible for out of state providers. The most recent newly issued AHCA outpatient rates for out of state providers were published on 10/5/16 with an effective date 7/1/16.**

4. Please give an overview of the PEEHIP change.

Response: **Will discuss at meeting.**

Discussion at meeting

MS. FETSCH: As of 1/1/2017, United Healthcare is taking on the over-65 Medicare retiree population of PEEHIP. This is a PPO plan. It's going to be the same level of care member cost share in or out of network. The plan is allowing members to use contracted care providers as well as noncontracted care providers. That plan includes all of the coverage included in original care plus some additional benefits.

We would like for you to identify those members. There's going to be a PEEHIP logo on the member's ID card, so we would ask, of course, that you get the member's ID card. And you can verify the eligibility as well on Link.

If you're not using Link, I would recommend that you do. United Healthcare online is phasing out. So your Optum ID is what you would use to sign in on Link. And most of you, I'm sure, are already probably familiar with that; if not, please reach out to me. I'd be happy to get you a demonstration on how and what you use Link for.

Let's see. They have worldwide emergency coverage. They do not have to select a primary care physician. Referrals are not required to see a specialist. Members do not have to notify the plan before receiving plan care from a contracted provider away from home. Some limitations may apply; and if they do, you would look at the prior authorization notification tool that is on Link, and you would verify that there.

There's two different group numbers affiliated with the PEEHIP, 15500 and 15501. The benefits are a little bit different. But I am going to share those with Peggy, and Peggy is going to forward those out to whoever is in attendance at the meeting, or you can feel free to reach out to me directly and I'll be happy to share that.

And that was pretty much all, unless you have questions regarding PEEHIP that I can answer.

AUDIENCE: The PEEHIP, you said that they're going to still have the same benefits as the original Medicare, plus extras.

MS. FETSCH: Additional, correct.

AUDIENCE: Okay. So if they come in our facility and they're meeting the two-midnight criteria that original Medicare has, are you going to approve that stay or is it going to be going by Milliman like they're doing now?

MS. FETSCH: I'll pretty sure it's going to be going by Milliman. Now, I can take that back to the PEEHIP folks and ask for sure.

AUDIENCE: Please do.

MS. FETSCH: Okay. Absolutely. I just want to write a note. You want to give me your contact information or do you want me to respond to Peggy with the response to that question and she can share that with everybody?

AUDIENCE: Send that to Peggy so she can get it out.

MS. FETSCH: Okay. Definitely.

AUDIENCE: This is more a point of clarification just for the room. You had mentioned Medicare over-65, but it's really Medicare eligible. So that's any disabled or over-65 member. So I just wanted to clarify that.

MS. FETSCH: Thank you, Jennifer.

AUDIENCE: For patients that are needing to transfer to a SNF or an IRF, will they be able to certify that now or will you have to get an authorization through United? You know, now the nursing home will just do the certification or the IRF does the certification.

MS. FETSCH: I'm not really sure how to answer that question. Say that for me one more time.

AUDIENCE: If the patient was in the facility and needed to transfer to a SNF or an IRF, who would do the authorization? I mean, with traditional Medicare, they would make that determination, and they are subject to being audited later. Now, is it going to require an authorization prior to transitioning?

MS. FETSCH: My recommendation is to go out to our website. There's a list of things that are going to need prior authorization. I would recommend going there and looking there.

MR. ASHMORE: All right. Do we have any more questions? If not, thank you for being here, Linda.

MS. FETSCH: My pleasure. Thank you.