

## C.5 Third Party Resources

### REQUIREMENT: RFP Section 60.7.C.5

#### 5. Third Party Resources (Section 14.0 Third Party Resources)

**Led by our integrated Payment Integrity Office, our proven in-house process ensuring optimal end-to-end claims payment accuracy maximizes recoveries, helps drive collaboration with the Department to pursue subrogation, and ensures Kentucky Medicaid is the payer of last resort.**

Payment integrity has been and remains a critical area of focus for Molina and our affiliated health plans, CMS, and Medicaid agencies nationwide. Statistically:

- CMS estimates that improper Medicaid payments nationwide were approximately \$57.4 billion with an improper payment rate of 14.9% in 2019 (fiscal year), versus improper payments of \$36.3 billion and a 9.79% improper payment rate in 2018<sup>1</sup>.
- Improper payments tied to CHIP programs totaled \$2.74 billion with a 15.8% improper payment rate in 2019, up from 2018 totals of approximately \$1.4 billion in improper payments and a 8.57% improper payment rate.
- In 2018, CMS estimated \$2.76 billion in improper payments were made due to incorrect coding.
- Up to \$15.5 billion in unnecessary administrative costs could be saved by payers if insurance companies improve their claims processing accuracy.

#### Enterprise wide, Molina's affiliates:

- Achieved **\$1.2 billion in combined savings in 2019** (TPL, COB, post-pay, pre-pay, subrogation)
- Avoided improper payments of **\$598 million in gross savings in 2019 and \$627 million in gross savings in 2018**
- Achieved **\$16.5 million in subrogation savings** enterprise wide in 2019

To meet this ongoing challenge, conserve Kentucky Medicaid funds, and ensure overall program integrity, our parent company Molina Healthcare, Inc's (MHI) Payment Integrity Office strengthens our in-house capability to ensure claims are paid accurately from end-to-end by the responsible party across all value streams, including third party liability (TPL), coordination of benefits (COB), pre-pay, pause and pay, post-pay, subrogation, and fraud, waste and abuse (FWA).

The extensive experience of Molina's affiliated health plans with coordinating benefits and facilitating post-payment recoveries for TPL will enable us to maximize cost avoidance and cost recovery for claims. We will pay for covered services and make every possible effort to recover payments when other health insurance is in effect and care has been rendered.

Leveraging our dedicated Payment Integrity teams for our TPL/COB and cost-avoidance systems, we will consistently and correctly identify Enrollees' primary insurance. ***Enterprise wide, Molina's affiliates avoided payments of approximately \$598 million or \$16.63 per member per year in gross savings in 2019 compared to \$627 million or \$14.78 per member per year in gross savings in 2018, an increase of \$1.85 or 12.5% per member per year.***

<sup>1</sup> Source: cms.gov, 2019 Estimated Improper Payment Rates for Centers for Medicare & Medicaid Services (CMS) Programs; Medicaid and CHIP 2019 estimated improper payments are not comparable to previous years due to the reintegration of the PERM eligibility component.

Table C.5-1 depicts how our Payment Integrity Office is driving consistent and significant year-over-year cost savings and recoveries performance improvement.

**Table C.5-1. Cost Savings and Recoveries**

	2018	2019
COB—Post-pay	\$59,985,423	\$51,433,178
COB—Pre-pay	\$567,223,085	\$546,625,622
FWA	\$2,461,937	\$17,434,415
Post-pay	\$13,431,180	\$26,867,793
Pre-pay	\$383,241,443	\$552,533,718
Subrogation	\$20,301,030	\$16,594,809
<b>Grand Total</b>	<b>\$1,046,644,098</b>	<b>\$1,211,489,535</b>

Molina understands, agrees, and will comply with all requirements set forth in Attachment C, Draft Medicaid Managed Care Contract and Appendices, Section 14, Third Party Resources. Most notably, we understand and agree that Enrollee access to Kentucky Medicaid covered services will not be restricted due to COB collection.

For more details about our overall Program Integrity program and our Payment Integrity Office, please see Proposal Section C.26, Program Integrity.

### **PAYMENT INTEGRITY OFFICE OVERVIEW**

The Payment Integrity Office oversees and is responsible for payment integrity activities including pre-payment, front-end code editing, pre- and post-payment audit work such as TPL, COB, subrogation, diagnosis-related group hospital bill reviews, and so forth; overpayment recoupment and collection activities; and our Special Investigation Unit’s investigative activities into fraud, waste, and abuse.

Based at our parent’s corporate headquarters, our Payment Integrity Office is a centralized unit that puts us at the forefront of any trends and allows us to share best practices across all Molina affiliate health plans. The Payment Integrity Office team uses comprehensive data analysis to monitor developments in all affiliate health plans as well as trends throughout the healthcare industry, and will regularly update our practices to best serve the Kentucky Medicaid program.

The Payment Integrity Office’s mission is to pay the right party, at the right time, for the right amount. We do this by:

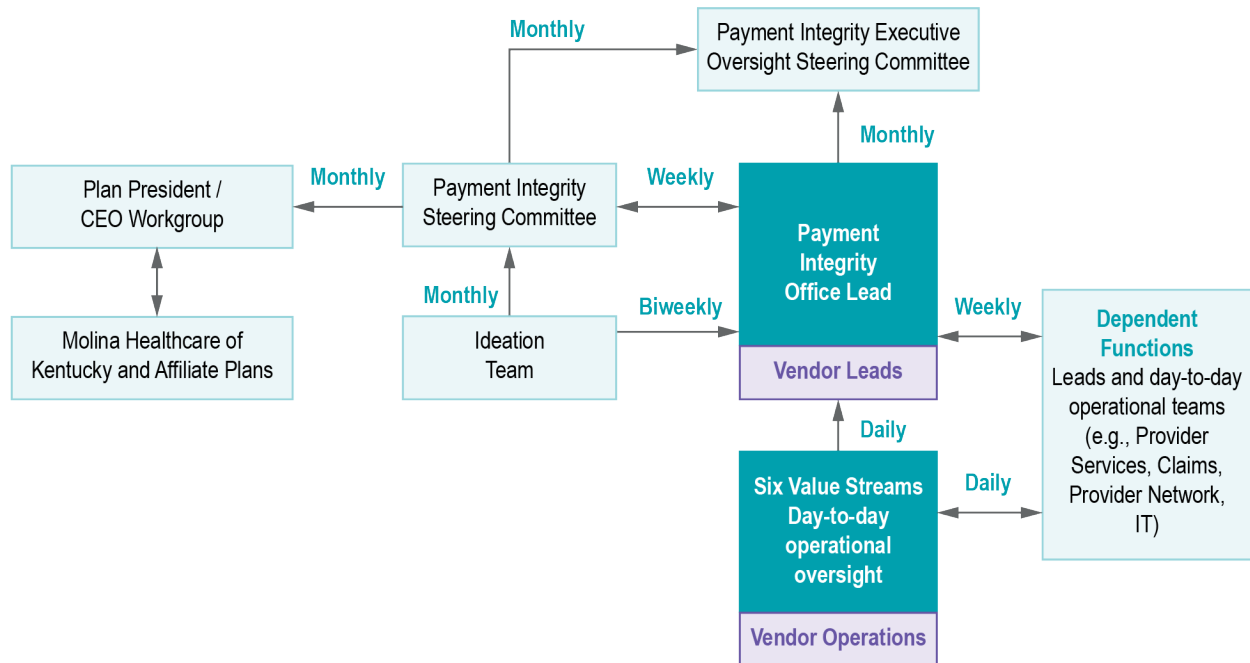
- Deploying best-in-class payment integrity technology solutions that maximize our ability to manage claims, reimbursement, and recovery analytics tools and ensure comprehensive accuracy across all transactions
- Creating a viable payment integrity governance framework that governs and monitors with actionable levels of authority and maintains appropriate communication with all stakeholders, while adhering to federal/Commonwealth regulations and contracts
- Ensuring program oversight through our Program Integrity Executive Oversight Steering Committee, which conducts monthly leadership meetings to review program successes, challenges, and process refinements
- Managing payment integrity value streams that promote pre-payment value capture to increase program efficiency and effectiveness
- Including incremental savings benchmarks to measure program performance against set targets

The Program Integrity Office is governed by the Payment Integrity Executive Oversight Steering Committee, which includes representatives from across multiple key corporate operational areas, as depicted in Table C.5-2.

**Table C.5-2. Program Integrity Executive Oversight Steering Committee Membership**

Corporate Operational Areas	
Program Integrity (Payment Integrity, FWA, Recoveries, and Code Edits)	Core Operations
Clinical Support / Healthcare Services	Legal
Affiliate Health Plan Leadership	Provider Network / Provider Services
Pharmacy	Health Plan Operations

The Payment Integrity Executive Oversight Steering Committee is the primary escalation committee for the Payment Integrity program and helps bridge gaps on overall company performance by reviewing and implementing key savings opportunities. Exhibit C.5-1 depicts the Payment Integrity Office’s overall governance and interaction model and functional committees designed to promote collaboration for operational success and appropriate oversight.



**Key Interactions / Objectives**

<b>Payment Integrity Executive Oversight Steering Committee</b>	Oversees Payment Integrity Office's financial savings commitments, provides guidance for any material changes in payment integrity policy, makes determinations on unresolved issues
<b>Payment Integrity Steering Committee</b>	Oversees/addresses payment integrity innovations, issues, and concerns
<b>Plan President / CEO Workgroup</b>	Forum to share new payment integrity initiatives, communicate decisions on requested input, and keep affiliate health plans informed of changes, decisions, and requested input.
<b>Ideation Team</b>	Vets and presents new payment integrity savings opportunities to Payment Integrity Steering Committee

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**Exhibit C.5-1. Payment Integrity Office Governance and Functional Committees**

Ultimately, our enterprise wide collaborative approach improves our ability to identify, prevent, and/or resolve improperly paid claims and help us achieve medical cost savings to support margin recovery while maintaining our commitment to quality care.

We identify ways to recover amounts due from other sources of health insurance coverage—and persevere in that recovery. Tracking, monitoring, and reporting on our activities along the way, we draw on seasoned leadership as well as our fully integrated claims operating system and TPL and COB processes that identify, determine, and recover benefits or coordinate them with other payers. Our core claims administration system supports full coordination of benefits functionality and will serve as the authoritative source of Enrollee eligibility and enrollment data.

***Supported by robust national corporate resources and technologies, our Kentucky-based chief financial officer will oversee subrogation and TPL activities for the health plan.*** Our Kentucky-based compliance officer, meanwhile, will serve as the single point of contact for the Commonwealth regarding COB and TPL subrogation, and will further ensure that we and our subcontractors adhere to all Draft Contract requirements and applicable Kentucky Medicaid regulatory mandates. Our claims processing director will lead a team of claims examiners and adjusters tasked with reviewing and investigating claims for possible recovery.

## **CAPTURING TPL/COB COLLECTIONS AND PAYMENT INFORMATION**

Subject to the Department’s approval, we will use a sophisticated data-matching and file-search strategy to help identify liable third parties. Data matching includes the Enrollee’s full name, date of birth, sex, and Social Security Number, as well as the period of coverage for the Enrollee and their family members.

Sources of data matching will include, but are not limited to, the daily Department file containing known insurance coverage, all commercial insurance carriers operating in the Commonwealth of Kentucky, and other governmental carriers. We will also capture data from provider calls, claims submitted with a primary explanation of benefits (EOB), and the National Eligibility Database.

Upon receiving proof of other coverage, our Enrollment team will update the system to reflect the other coverage information and eligibility dates, so we avoid paying as the primary payer. Claims received when there is other primary insurance—except for maternity and preventive pediatric claims—will be processed with our COB intelligence technology and will deny requesting primary carrier EOB to process as secondary.

## **Retrospective Post-payment Recoveries**

We will use several methods to recover claims from providers and from primary carriers that paid primary when other coverage is primary. We will submit claims to commercial insurance carriers or, for pharmacy claims, to PBMs. Primary carriers and PBMs will send payment to us, and the medical claim will be processed in our systems by the Recovery team reflecting payment received.

In other cases, such as Medicare primary claims, the Recovery team will send the Medicaid provider a recovery letter with notification of other coverage eligibility within the Commonwealth’s regulatory requirements. If we do not receive a refund from the provider, we will process an “auto-deduct” within our system, so these claims will be deducted from the provider’s future payment. All refunds received by the liable carrier or Medicaid provider will be processed in our claims operating system.

We will report cost-avoidance dollars and recovered dollars on a monthly basis and in the appropriate format required by the Department.

## **Adjudicating Claims for Third Party Coverage**

All TPL claims paying as secondary or denied will be processed and released in compliance with the Draft Contract following our normal claims processing guidelines. Our comprehensive Order of Benefits Determination process will ensure accurate determination of which carrier pays benefits first, second, and so forth. Some of the most common scenarios that will fall under the TPL umbrella include:

- Some lawsuits
- Slips and falls in a store/business where the business assumes liability
- Injuries on private property where a homeowner is deemed liable and a homeowner’s policy pays, or there is a resulting lawsuit (dog bites, slip and fall or injuries by domestic workers, gardeners, carpenters, plumbers, etc.)
- Product liability cases (illness or injury caused by consuming certain foods or drugs), and the manufacturer is deemed liable
- Workers’ compensation cases
- Auto insurance

For scenarios falling under TPL, Molina will pursue recovery after the fact—post-payment or “pay and pursue.”

### **Identifying, Recouping, and Releasing Claims**

We will employ multiple TPL controls to maintain payment integrity and control program costs. The following paragraphs describe our methods for identifying, recouping, and releasing claims.

#### ***Identifying Claims***

Our claims processing system will identify Enrollees with other available health insurance / TPL and if the alternative insurance has been designated as “primary.” The system will process and coordinate claims using data provided from several different sources, including the Department, our parent’s COB and subrogation operations, and our Cost Recovery team, to support full COB functionality. Moreover, our parent’s subrogation vendor will search claims for injury codes to begin appropriate investigative processes. Once other insurance information is received from any of those sources, our claims operating system will be configured to recognize us as a secondary payer as defined by an Enrollee’s primary coverage.

#### ***Recouping Claims***

We will pay for covered services and make every effort to recover payments when other insurance is in effect. We will work with our parent’s COB and subrogation vendors to recover payments that have already been issued. Our parent’s vendors will provide up-to-date information captured on their platforms. We will update our records in our claims operating system to reflect the presence of third-party insurance, and we will submit recovery claims to commercial insurance carriers, other liable third-party insurers, or, in the case of pharmacy claims, PBMs seeking repayment. Primary carriers and PBMs will send payment to us, which will be reflected in our claims operating system. If the service provider does not submit a refund as requested, our claims operating system will support off-setting claims payments against monies to be recovered.

#### ***Releasing Claims***

After subrogation review, we will release claims for payment immediately after an investigation and determination that we are liable for such claims according to all Commonwealth and federal guidelines.

As an example of the process, to control costs in subrogation issues, we will flag TPL/third-party recovery cases associated with accidents/trauma via Healthcare Common Procedure Coding System codes. An automatic Enrollee questionnaire meeting Commonwealth regulations and requirements will be generated for the Enrollee to complete, and the claim will be pended until further analysis determines liability. We will provide this lead to the Department’s third party unit and coordinate closely with the Department to determine a course of payment recovery for confirmed TPL. If it is determined that there is no TPL, the claim will be paid according to claims payment policy.

Our parent's comprehensive claims release process helped achieve *consistently strong subrogation savings on a per-member-per-year (PMPY) basis over the past two years, including \$20.3 million or \$0.48 PMPY and \$16.6 million or \$0.46 PMPY in gross savings for 2018 and 2019, respectively. We fully expect this strong subrogation performance trend to continue in 2020.*

## **COORDINATION OF BENEFITS**

In compliance with the Draft Contract, Section 14.1, Coordination of Benefits (COB), Molina will specify the threshold amount or other guidelines used in determining whether to seek reimbursement from a liable third party. We will also develop tailored policies and procedures, currently in use by our affiliate health plans, to determine specified circumstances in which seeking reimbursement is not cost effective.

Molina will require primary payment information to be submitted with every claim, even when our core claims processing platform denotes an edit code indicating that a COB enrollment segment exists. This information will be needed to accurately calculate and reimburse secondary payment. The following types of notices from the primary payer will be accepted:

- An EOB
- An explanation of Medicare benefits
- A Notice of Exclusion from Medicare Benefits (NEMB form)
- A denial letter

This required information regarding primary payment can also be submitted and accepted electronically via electronic data interchange. If an Enrollee has two or more plans, we will require all payment or denial notices from the other carriers for processing (except for TPL). If the other carrier's payment notice is not present, we will deny the claim, requesting primary payer information using the appropriate remit remark code.

### **COB Procedures**

The following are highlights of Molina's defined policies and procedures that will guide determination of payer hierarchy:

- Primary plan will pay as if no other plan exists
- Secondary plan will not pay benefits until benefits have been paid by primary plan and reduces its benefits, so the total benefits paid or provided by all plans does not exceed 100% of the allowable
- Secondary payment will be determined by the differences between the amounts paid as if plan was primary and actual payment made from primary plan
- Secondary plan will not pay an amount the primary plan did not cover because of failure to follow primary rules and procedures
- Where there is other coverage, the provider should indicate this information in the appropriate spaces of the UB-04 or CMS-1500 forms

### **Identifying COB Claims and Primary Payers**

Molina will employ a framework of rules for accurate COB, including:

- When a person is covered by two or more plans, the primary plan must pay or provide its benefits as if the secondary plan or plans did not exist.
- A plan that does not contain a COB provision is always primary.
- A plan may consider the benefits paid or provided by another plan only when it is secondary to that other plan.
- If/when Medicaid coverage is involved, Medicaid is the payer of last resort, paying after any commercial plan, employer-sponsored plan, and/or Medicare.

Moreover, we will specifically train our claims processing staff to accurately identify COB claims in a variety of ways, including looking for:

- COB-related edits. Upon adjudication, our claims processing system will generate a COB-related edit because an Enrollee has a primary external enrollment segment and Molina is the secondary payer
- A claim pended with a COB-related pend code
- COB-related memos attached to a claim
- Another carrier/payer name identified on the claim form
- Another payer’s EOB submitted with the claim
- “Flags” that may include other key insurance information on the CMS-1500 form and any FL-54 entries on the UB-04 form

### **Order of Benefits Determination**

Our Order of Benefits Determination process will determine which carrier pays benefits first, second, and so forth. We will train our claims processing staff to adhere to the following rules to determine which plan will pay benefits as primary. Table C.5-3 depicts our guidelines for Order of Benefits Determination:

**Table C.5-3. Order of Benefits Determination Guidelines**

Non-dependent or Dependent
<ul style="list-style-type: none"> <li>• The plan that covers the person as an employee/Enrollee/subscriber/or retiree is the primary plan.</li> <li>• Medicare beneficiary plans are secondary to the plan covering the person as a dependent and primary to the plan covering the person as the Enrollee/subscriber/or retiree.</li> </ul>
Active Employee or Inactive Employee
<ul style="list-style-type: none"> <li>• The primary payer is the plan that covers a person as an employee (or as that employee’s dependent) who is neither laid off nor retired.</li> <li>• This rule applies to the situation where the individual (or dependent) is covered under one policy as an active worker and under another plan as a retired worker.</li> </ul>
Children Covered Under More than One Plan
<ul style="list-style-type: none"> <li>• The primary payer is the plan of the parent whose birthday is earlier in the year if both parents are married / not separated or if a court decree does not specify that one parent must provide healthcare coverage for the child.</li> <li>• The primary payer is the plan that has covered a parent the longest if both parents have the same birthday.</li> <li>• If a court decree states that a parent is responsible for the child’s healthcare coverage, then the responsible parent’s health plan is designated as primary. If the designated parent does not have healthcare coverage, the spouse’s plan becomes the primary payer. (The parent’s plan must have knowledge of this arrangement.)</li> <li>• In instances where the child’s parents are not married/separated/divorced, and no court decree allocates the child’s healthcare coverage responsibility, then the order of determination is as follows:                         <ul style="list-style-type: none"> <li>– Plan of custodial parent</li> <li>– Plan of custodial parent’s spouse</li> <li>– Plan of non-custodial parent</li> <li>– Plan of non-custodial parent’s spouse</li> </ul> </li> </ul>

### **Subcontractor COB Reporting**

Per Draft Contract, Section 14.1, Coordination of Benefits (COB), COB collections will be the responsibility of Molina or our subcontractors. Subcontractors will report COB information to Molina. ***Molina and our subcontractors will not pursue collection from the Enrollee but directly from the third-party payer.***

Please note that as is our standard practice for our affiliate health plans across our enterprise, our parent is solely responsible for all COB activities and monetary pursuits. We will neither supply nor will our

subcontractors have access to the cohort of Enrollee or provider information that could lead to COB collections by our subcontractors.

## **COB/TPL TRAINING AND DATA ANALYTICS SUPPORTS**

### **COB/TPL Training for Staff and Subcontractors**

We will mandate training for all employees and offer training to providers. Claims processing staff will receive comprehensive “COB/TPL 101” training when hired and at least annually thereafter, or more frequently if we enact major process changes. Training curriculum will generally include:

- Basic COB concepts and definitions
- Determining primary payment order (i.e., non-dependent/dependent, active/inactive employee, children, coordination of coverage)
- Rules for coordination
- Plan procedures
- COB form field locators (e.g., UB-04)

The training will be either instructor-led or Web-based, and staff will be able to access current policies and procedures at any time.

Per requirements in the Draft Contract, Section 14.2, Third Party Liability, Molina will respond to Enrollee and provider requests for COB or TPL updates within 48 hours for urgent requests and within 3 business days for routine requests. As a standard practice across our affiliate health plans, all COB and TPL issues will be considered urgent. Claims staff will be trained to process COB/TPL update requests within 24 hours of receipt. Requests marked urgent will be processed within one hour of receipt and must be cleared before the end of the day.

We will further educate providers and subcontractors specific to the roles or functions they will perform regarding program integrity. Moreover, our educational materials and trainings will be tailored specifically to meet Contract requirements. Further, we will provide oversight and additional trainings, if needed, to ensure our subcontractors have the information they require for success. See Proposal Section C.1, Subcontracts, for more information on our approach to subcontractor coordination and oversight.

### **Data Analytics and Informatics Support Process**

Our clinical staff members, including Utilization Management nurses, Care Management staff, and our medical director will be responsible for referring potential TPL cases. We will then work to identify if subrogation dollars are available. This can begin before claims payment is received, which may result in recovery sooner. In addition, we will develop routine analytic reports to identify third-party coverage and look for certain types of accident/trauma diagnosis (such as via Healthcare Common Procedure Coding System codes as detailed previously) and key “clinical” word indicators that imply a potential TPL opportunity within our COB, authorization data, and claims data.

In addition, we will use a predictive analytics application to identify potential opportunities for recovery after receiving claims data. The application will use proprietary algorithms to analyze all paid claims and review all levels of claim coding. It will then complete data mining and generate an Enrollee questionnaire within five business days of receipt.

We will contact selected Enrollees to determine if the incident is eligible for subrogation and to obtain recovery source information. Enrollees can respond with a pre-paid envelope or call a toll-free number and speak to an Enrollee advocate. A second questionnaire will be sent if a response is not received within 21 days. We will continue to follow up with the liable third party until the issue is resolved. Then, responses will be reviewed by a team of attorneys with expertise in personal injury litigation, commercial litigation, nursing, and bankruptcy.



## Providing Supplemental Third-party Data and Files to the Department

Per requirements in the Draft Contract, Section 14.1, Coordination of Benefits (COB), Molina will submit all required reports to the Department in required time frames to include subrogation collections from auto, homeowners, or malpractice insurance, and others as prescribed. Moreover, we can generate and submit tailored reports to the Department on an ad hoc basis, as requested.

We will track and report all TPL/COB activity in accordance with Kentucky Medicaid requirements and will submit the following monthly reports to the Department:

**Third-party subrogation leads.** This information will include, at minimum, the Enrollee's name, Medicaid ID number, date of accident, lien amount, and third party's name and contact information. The Department's third party unit will review the report and inform us whether the Commonwealth has a claim for services related to the date of accident. In those cases, we will coordinate efforts with the Department.

**Third-party resources report.** This report will list all Kentucky Medicaid Enrollees who have been identified as potentially having a policy with full health coverage. If that policy is valid, the Office of Eligibility will begin the disqualification process. The report will include, at minimum, the Enrollee's name, Medicaid ID number, carrier name, date of birth, policy holder, policy number, and policy eligibility period.

**Total claims denied (cost avoided) and total monies recovered.** These reports, submitted to the Office of Recovery, will show the total amount of all claims that were denied due to the existence of an allowed TPL policy (dental or vision) on file. They will also show the total dollar amount recovered from an allowed TPL policy (dental or vision) and full health coverage policies identified after we initially paid the claim as primary.

To produce these reports, we will track and monitor TPL activities using these methods:

- Our claims operating system will track all primary coverage, such as commercial coverage, for each Enrollee through the COB module. This module can be updated manually or systematically through the Department discovery process under data matching.
- All recovery activities, including requests for refunds, provider refunds, and/or recoupments from future claims, will be tracked using our web-based recovery database application.
- Deductible and copayment information will be stored in our claims operating system and can also be retrieved through the system.

Supported by best-in-class technologies, we will capture all requisite third-party resource and payment information, which will enable us further to maintain the most accurate records possible. This capability also will allow us to submit to the Department all required monthly COB collections reports on all Enrollee activity, including cost-avoided dollars and provider-reported savings. These reports will be made available for regular audit by the Department or its agent no less than every six months in compliance with Draft Contract requirements.

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