C.11 Monitoring and Oversight

REQUIREMENT: RFP Section 60.7.C.11
11. Monitoring and Oversight (Section 21.0 Monitoring and Oversight)
a. Describe the Vendor's proposed approach to internal monitoring of operations to ensure compliance with this Contract.
b. Describe the Vendor's proposed approach to providing oversight of its Subcontractors, including examples of actions the Vendor takes when a Subcontractor is found to be non-compliant or when performance improvement opportunities are identified.

Molina's internal monitoring and subcontractor oversight processes will ensure compliance with Kentucky Medicaid program contractual, regulatory, and legal guidelines and drive process improvements that will enhance our ability to deliver high-quality care to our Enrollees.

Compliance programs are only effective if they include robust and consistent validation that health plan operations and functions meet regulatory and Contract requirements.

Compliance is built into every level of our business. Our approach will focus on transparency, integrity, best practices, and making ethical decisions, while providing quality service to Enrollees, providers, the Department, and other business partners. ***Our approach to internal monitoring of operations is to identify and correct compliance risks before they turn into something bigger.***

With more than 25 years of experience managing Medicaid health plans, the Molina enterprise is uniquely positioned to help the Department address its priorities and meet its goals for the Kentucky Medicaid program, but we can only be an effective partner by conducting regular performance assessments of our internal operations, processes, procedures, and overall management system to ensure we are meeting contractual requirements and the needs of our Enrollees and providers.

- Comprehensive Compliance Plan driving internal monitoring/auditing, oversight, and management of health plan operations
- Periodic multi-phase internal audit approach ensuring operational, contractual, legal/regulatory compliance
- Proven subcontractor oversight program emphasizing open communication, proactive problem-solving

Moreover, to best support our subcontractor partners in effectively serving our Enrollees, we will emphasize open communication and proactive problem-solving. Our subcontractor oversight program for the Kentucky Medicaid program will be guided by a proven framework of policies and procedures developed and customized by our 14 affiliated Medicaid health plans. Our established processes support effective monitoring and continuous evaluation of subcontractor performance to ensure compliance with all requirements while delivering high-quality products and services.

In the following sections, we outline our approach to monitoring and auditing our internal operations as well as our approach to subcontractor oversight to best ensure adherence with all requirements set forth in Attachment C, Draft Medicaid Managed Care Contract and Appendices, Section 21, Monitoring and Oversight.

a. INTERNAL MONITORING OF OPERATIONS TO ENSURE COMPLIANCE

Molina will ensure our comprehensive oversight plan includes mechanisms to closely monitor internal operations of the health plan to benefit Enrollees, the Department, providers, and our subcontractors by increasing efficiency, reducing waste, minimizing confusion, and improving the overall provision and quality of services.

Molina's compliance plan will be guided by written policies and procedures that establish the overall framework for internal mechanisms that will provide guidance and assist employees in complying with applicable Commonwealth and federal laws and regulations.

COMPLIANCE DEPARTMENT FUNCTIONS

Our Compliance department will be responsible for internal monitoring and auditing, oversight, and management of all health plan operations to ensure consistent fulfillment of all relevant contractual, regulatory, and legal requirements. Table C.11-1 below depicts the range of Compliance department oversight responsibilities.

Table C.11-1. Compliance Department Oversight Functions

Compliance Responsibilities	
Ensure compliance with Kentucky Medicaid program requirements, including: • Contractual requirements • Statutory requirements • Regulatory/sub-regulatory requirements	Perform validation audits (validate completion and sustainability of corrective action plans [CAPs])
Monitor ethical tone, culture of compliance, and adherence with Business Code of Conduct and Ethics	Perform less formal spot audits (informal internal reviews) to ensure compliance with Kentucky Medicaid program requirements
Monitor, disseminate, and report compliance information/status to management and the governing board	Oversee internal CAP process (issue, monitor, validate)
Audits / risk assessments	Manage external CAP process (CAPs imposed by outside agencies)
Perform annual risk assessment (all products)	Manage internal CAP process (CAPs imposed by Molina)
Manage external audits (regulator audits); perform internal audits of Molina	Validate CAPs (ensure CAP is implemented and sustained)
Oversee the Privacy & Information Security programs	Ensure key performance indicator (KPI) compliance (track, distribute, refer to CAP process)
Monitor and manage the Molina compliance AlertLine (Molina's compliance and fraud, waste and abuse reporting system staffed by a live operator 24/7)	Perform compliance investigations; ensure compliance infractions are addressed with appropriate enforcement and discipline
Draft, implement, and enforce compliance policies and procedures	Ensure Molina's compliance program constantly improves compliance rates and returns to prevent both new and repeat incidents

INTERNAL MONITORING OVERVIEW AND GOVERNANCE

Molina's chief compliance officer will oversee and be responsible for compliance activities in the health plan including, but not limited to, compliance program implementation and administration. Our Kentucky internal Compliance Committee, which will be made up of senior representatives from our operational areas, will advise the chief compliance officer and assist with the implementation of the compliance program.

The Committee also will oversee the health plan's periodic audits of internal operations aimed at ensuring adherence with Contract requirements, applicable plan policies, and federal and Commonwealth laws to strengthen governance, accountability, and risk management.

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We will use a system to internally audit and monitor compliance with protocols established to comply with all laws, rules, regulations, and policies. The framework will be designed to detect areas of possible violations, and once issues of non-compliance are validated, monitor the corrective actions implemented through their completion.

Molina's chief compliance officer also will receive daily support for all compliance functions from a seasoned group of centralized compliance professionals at our corporate offices who will assist by employing specialized compliance tools and lending their expertise for audits, CAPs, and KPIs, as well as core health plan functions such as claims, utilization management, grievances and appeals, privacy, information security, Enrollee services, encounters, and so forth. These centralized compliance resources will allow Molina's chief compliance officer to focus exclusively on providing executive-level compliance oversight and services to our Kentucky operations.

Molina will use the Inovaare Compliance System to integrate all elements of our compliance program into a single platform for seamless information-sharing of risk assessments, audits, CAPs, KPIs, contracts, the compliance library, and so forth, resulting in more effective compliance oversight. Through Inovaare, Molina's chief compliance officer (as well as other Molina leaders) will be able to oversee compliance matters, incidents, and monitoring in real-time for almost instant identification, which will allow for more expedient remediation of operational compliance incidents.

The three primary processes that are foundational to ensuring robust oversight of health plan operations and contractual requirements are audits, compliance KPIs, and compliance CAPs. These three processes are discussed in detail below.

Audits

Our chief compliance officer will create an annual Compliance Audit Work Plan specifically tailored to our Kentucky operations that will set compliance oversight goals, objectives, and activities for that year. To accurately assess whether we are meeting our contractual obligations, we will undertake an Annual Risk Assessment of all operational areas to ensure potential issues are identified early and addressed proactively. Results from this Annual Risk Assessment will help us identify which operational areas would most benefit from an internal audit to ensure all contractual mandates are met. This list of internal audits will comprise our Annual Audit Work Plan.

The Annual Audit Work Plan (hereafter, "Audit Plan") will identify the specific internal audits and monitoring that will be conducted during the calendar year. The Audit Plan will be approved by Molina's Board of Directors. In addition to the Annual Risk Assessment described above, the specific set of compliance audits that Molina will conduct in a given year also will be decided by evaluation of key oversight priorities from Commonwealth and federal regulators; interviews with health plan leadership; surveys of employees; previous risk assessments; internal and external audit results; and previous CAPs.

Once the Audit Plan is set and approved by the governing body, Molina's Compliance Audit team will begin its extensive system of audits that will occur throughout the year. The audit process will be a critical part of our overall internal monitoring process to ensure efficient operations and Contract compliance. Although each audit will be different, in general, our Compliance team will perform an evaluation of a Molina department's systems of internal control and will perform tests to ensure department compliance with established standards and contractual and regulatory requirements. Exhibit C.11-1 depicts our comprehensive internal operations audit process.

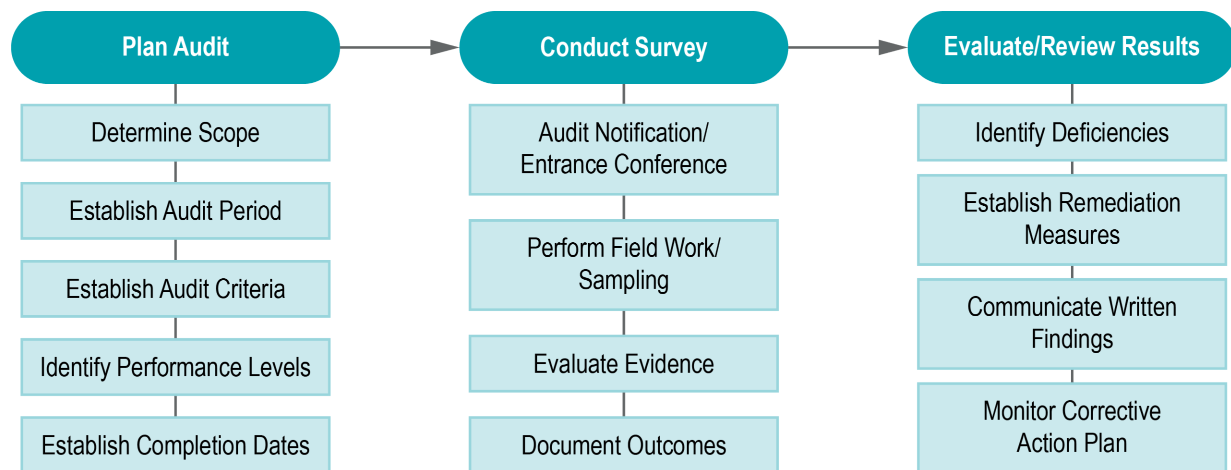

Exhibit C.11-1. Internal Audit Process Workflow

In certain circumstances, focused surveys may be necessary; such "ad hoc" evaluations will be undertaken when deemed appropriate. Since every audit is unique, the audit process can vary slightly. Generally, however, the process will adhere to the following stages.

Stage 1: Research

We will first determine specific contractual requirements, Commonwealth regulations, and/or laws that apply to the operational area under scrutiny. Compliance staff will meet with a subject matter expert in the appropriate department to gain a granular understanding of operations as well as receive updates on any new initiatives.

Stage 2: Internal Monitoring / Audit Scope

The internal monitoring / audit scope will determine what will be audited and set defined boundaries. Scope will be determined according to a review of the following elements depicted in Table C.11-2.

Table C.11-2. Internal Audit Scope Guidelines

Internal Monitoring / Audit Scope Elements	
Audit timeframe	Requirements contained in the Kentucky Medicaid Contract
Office of Inspector General and CMS annual work plans	Requirements contained in CMS application, contract, audit guides, and policy directives
Commonwealth and federal laws and regulations	Consultation with our parent and affiliated health plan management to determine areas of high risk or matters of known non-compliance
Molina Compliance work plan	Special circumstances
Previous audit history or audit that resulted from a CAP	Determination whether audit covers one department or multiple departments

Stage 3: Internal Monitoring / Audit Tool

Our internal monitoring / audit tool will be a Microsoft Excel spreadsheet or Microsoft Word table with a checklist of each specific element defined in the scope. Each field will have a "yes" or "no" response option. A preferred sample audit tool is depicted in Exhibit C.11-2.

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Compliance Audit Tool

Audit Title: Grievances

Date Initiated: 10/01/2013

Auditor(s): Andy Auditor

#	Element	Element Source	Method of Evaluation	Detailed Findings	Met	Not Met	*Risk Level	CAP	Notes
1	Grievance acknowledgement letters (AL) must be sent within 5 business days (BD) of receipt of grievance.	Uniform Managed Care Contract Section 8.1: Grievances	Review 30 grievance files from Q2 2013. Examine the received date and the date the AL was sent to determine if ALs were sent timely.	A review of 30 grievance files showed that 5 ALs were not mailed timely: 1. Grievance #654098 AL was mailed on the 7th BD 2. Grievance #749512 AL was mailed on the 15th BD 3. Grievance #123456 AL was mailed on the 9th BD 4. Grievance #987654 AL was mailed on the 6th BD 5. Grievance #456123 AL was mailed on the 7th BD	☐	☑	2	Yes ☑ No ☐	For each of the five findings, comments in the grievance files indicate that the grievance was received by the plan but was not routed to the Grievance department for processing for several days.
					☐	☐		Yes ☐ No ☐	
					☐	☐		Yes ☐ No ☐	

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*3 = Major Risk (High), 2 = Significant Risk (Medium), 1 = Minor Risk (Low), 0 = No Risk.

Exhibit C.11-2. Sample Audit Tool

Stage 4: Opening Conference

The Opening Conference will be an initial meeting scheduled with internal leadership of each department being audited and will be used to both announce the audit and set expectations.

Stage 5: Universe and Sample Collection

The universe of possible identified items subject to audit will be logged in an organized Excel spreadsheet and housed on Molina's secure SharePoint site. Samples from the universe must be both randomly selected and statistically appropriate. Sample documents will be compared, item by item, using a checklist.

Stage 6: Internal Monitoring Audit Outcomes Documentation

The lead auditor will develop a draft Compliance Audit Report that includes a checklist of identified audit elements. For each item, elements will be identified as "Met" or "Not Met." If an element is "Not Met," it will be determined whether the element is "Significant," "Major," or "Minor." "Significant" category findings will be those operations elements that do not meet Contract requirements, Commonwealth regulations, and/or Commonwealth laws.

Stage 7: Closing Conference

The audit report will be presented to operational department management before the closing conference. At the closing conference, the lead auditor will present a summary of findings, trends, concerns, and issues. The Molina department being audited will then provide a written response to each deficiency, stating whether it agrees with the findings and recommendations for deficiency corrections. Management rebuttal to audit findings will be due typically within seven business days and include processes to achieve compliance with specifications.

Stage 8: Evaluation of Management Response and Final Audit Report

Our Compliance team will review and evaluate department management replies to determine if the information submitted is suitable for augmenting final survey results. Any disagreements remaining

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unresolved at the closing conference meeting or after management rebuttal are received will be referred to our chief compliance officer for final determination.

Final audit findings, which will include corrective action requirements, will be finalized and communicated to department management. The communication will include a formal request for CAPs (as needed) and contain the following elements:

- Deficiencies, observations, and recommendations
- Actions necessary to rectify deficiencies, including the date by which corrective actions must be completed
- Other issues deemed necessary by Molina's Compliance team

KPIs

The tracking, monitoring, and trending of compliance KPIs will be the second primary element of Molina's Compliance program, further ensuring effective and effecient monitoring of health plan operations and compliance with our Kentucky Medicaid Contract. Through our Compliance KPI team, we will establish compliance KPIs that monitor, identify, and report issues related to federal and Commonwealth regulations, as well as sub-regulatory guidance and contractual agreements.

KPIs will be monitored and reported, typically monthly. This effort will comprise results of key compliance metrics reported by functional area. If a KPI indicator fails to meet the established benchmark for a given month, the functional area will be required to submit a CAP that includes a root cause assessment, resolution, actions to prevent future reoccurrence, and an expected date of compliance. KPI outliers will be reported to health plan senior leadership via the monthly KPI Outlier Report, which also will be reviewed by the Compliance Committee.

CAPs

CAPs will be the integral third component of our compliance process to ensure robust internal monitoring that will validate health plan operational compliance with our Kentucky Medicaid Contract. By having an effective CAP process, Molina will ensure that if there are any issues that require remediation, we can correct them in an effective, tracked, compliant, and sustainable manner that will help prevent the issue from repeating in the future. Exhibit C.11-3 below provides an overview of our CAP management process.

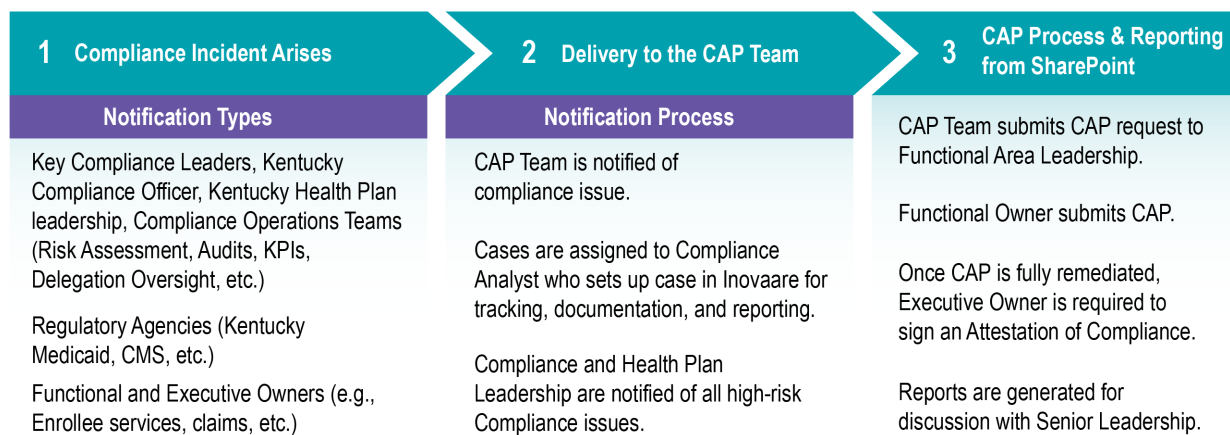

Exhibit C.11-3. CAP Management Process

In total, our audit, KPI, and CAP processes will work in tandem to support a proven, robust process for internal monitoring of operations. These processes ensure consistent compliance with Kentucky Medicaid Contract requirements, as well as the successful and compliant overall operation of our Kentucky health plan.

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b. APPROACH TO SUBCONTRACTOR OVERSIGHT

Ensuring subcontractor compliance and high-quality performance starts on the ground in Kentucky and will be supported throughout Molina. Our vice president of network management and operations will lead this effort to extend our cost-conscious and person-centric culture to our subcontractors.

Our Delegation Oversight staff will oversee the auditing and performance monitoring plan for each subcontractor, including performance requirements for all delegated functions; required reporting and interfaces; a review of the financial operation and amounts paid for covered services, if applicable; and a review of contract compliance, logged complaints, and functional performance measurements.

Delegation Oversight staff will ensure our subcontractors' regulatory reporting is reviewed with appropriate subject matter experts for all delegated functions, and delegated function audits are completed.

Our Delegation Oversight Committee will review and approve all audit results and summaries of monitoring efforts. Delegation Oversight Committee membership will include representatives from our quality improvement, government contracts, compliance, provider network, account management, and delegated functional areas to ensure full visibility of subcontractor performance. Exhibit C.11-4 below highlights how our organization will provide continuous oversight of subcontractors.

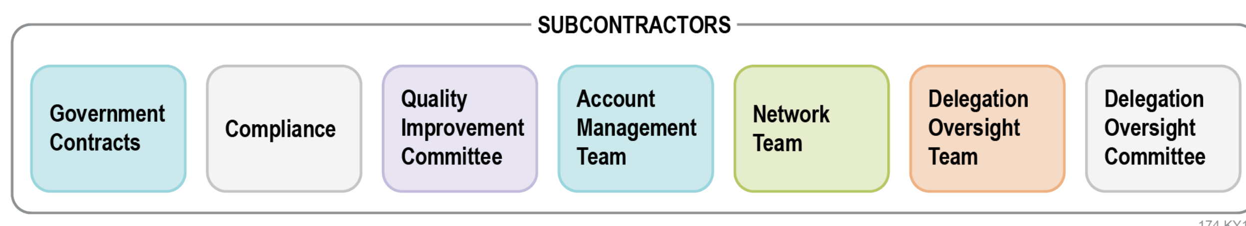

Exhibit C.11-4. Subcontractor Oversight

Both our vice president of network management and Delegation Oversight staff will have primary responsibility for the oversight of delegated functions, including the pre-delegation audit, regular monitoring activities, annual audit activities, Joint Operating Committee meetings, and other delegation oversight activities required under the Medicaid Contract or NCQA accreditation. Daily, to address any issues as they arise, we will communicate with our subcontractors formally and informally, escalating any issues immediately as appropriate. Although Molina and our subcontractors will have regularly scheduled Joint Operating Committee meetings, issues will be communicated, escalated, and addressed as they arise; we will not wait until the next scheduled meeting to discuss issues.

Delegation Oversight staffing will be flexible to meet the needs of our health plan. Subcontractor delegation will be monitored by a team of individuals with specific experience in the function they will be auditing. These subject matter experts will work with the Network team to ensure that pre-assessment audits include robust evaluation of the subcontractor's ability to meet contractual performance expectations through review of subcontractor policies and procedures, work flows, staffing models, and systems. In addition, we will work with our partners at the corporate level to ensure assessment tools meet not only Kentucky Medicaid requirements, but also NCQA and CMS requirements.

Depending on the number of provider groups to which we delegate credentialing and recredentialing activities, we will hire delegation oversight specialists or delegation oversight managers to ensure appropriate monitoring. Delegation oversight specialists will be responsible for pre-assessment audits, monthly and quarterly reporting monitoring, and identification of the need for a CAP when applicable. In our affiliated health plan markets where delegation is a more established process, we have delegation oversight managers who are responsible for negotiating delegation agreements, working with subject matter experts to ensure audit tools and monitoring documents are up to date, and chairing the Delegation Oversight Committee.

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The Delegation Oversight Committee will include director-level department heads from all functional areas involved in the daily management of subcontractors or those who are responsible for monitoring delegated activities (e.g., quality, compliance, government contracts, provider services, and provider network contracting services). This core group of Delegation Oversight Committee members will be supplemented by additional director-level staff who will oversee the functional areas we delegate, including credentialing, healthcare services, and claims services. The Delegation Oversight Committee will meet at least quarterly to review:

- Pre-assessment or annual audits that have been completed since the previous meeting
- Subcontractor responses to corrective action items
- Subcontractor performance
- Updates on any performance issues

The Delegation Oversight Committee can take additional corrective action, up to and including termination of delegated functions. Our parent's national Delegation Oversight Committee will include representation from Molina's Delegation Oversight Committee and will oversee auditing and performance monitoring for all subcontractors that reside at a national level, including subcontractors for dental and vision services. The Molina National Quality Improvement Committee will review summary reports for each local and national Delegation Oversight Committee meeting.

Delegation Oversight Activities

We contract with subcontractors through a due diligence selection process that will help ensure the subcontractor can meet our needs and the needs of our Enrollees. We will conduct pre-assessment audits to determine whether subcontractors have the resources and processes in place to meet the requirements and standards of the Contract (our own readiness review), as well as NCQA and federal requirements for delegation. By completing pre-assessment audits, we will determine if a subcontractor meets Molina, contractual, and regulatory requirements to provide services and if necessary, put in place an alternative plan, including identifying a different subcontractor or keeping the responsibility in-house. A security assessment will be conducted as needed to ensure the subcontractor's infrastructure can protect PHI. This process will include the careful drafting and negotiation (proof of concept through scope of work) of all applicable master services, business associate, nondisclosure, independent contractor, and any other necessary agreements.

The pre-assessment audit will include review policies, procedures, and files when applicable, and also staff interviews. We will submit a summary of pre-assessment audit results, including any identified corrective action items, to the Delegation Oversight Committee for review and decision. The Delegation Oversight Committee will have authority to approve or deny delegation based on the results of the pre-assessment audit.

We will fully adhere to all Commonwealth and federal laws, rules, and regulations regarding subcontractors and the requirements within the Draft Contract, Sections 6, Subcontracts and 21, Monitoring and Oversight. The written agreements also will be drafted to ensure all requirements for subcontractors are included. Molina acknowledges that the existence of a subcontract will not relieve us of any of our responsibilities for the performance of duties. Furthermore, we will immediately apprise the Department of any subcontractor issues, such as the insolvency of a subcontractor or the filing of a petition in bankruptcy by or against a principal subcontractor, and we will have a contingency plan for each subcontract to provide for continuity of care should the subcontractor cease to provide services that are the subject of the subcontract.

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The executed agreement with Molina and the subcontractor will include:

- A description of the activities to be delegated in accordance with regulatory and accrediting organizations
- The process and frequency of reporting expectations the subcontractor will use to keep Molina informed of the status of its activities
- Monitoring and auditing processes to be used by Molina
- The actions to be taken by Molina if non-compliance with the established standards
- The conditions for renewing and/or terminating the contract
- Provisions around the appropriate use of PHI, including safeguards to protect the information from further disclosure and stipulations that the subcontractor will inform Molina if inappropriate use of the information occurs
- Subcontractor compliance with federal Medicaid Final Rule legislation, including allowing CMS, the HHS Inspector General, the Comptroller General or their designee to audit, evaluate, and inspect any books, records, contracts, computer, or other systems of the subcontractor; make subcontractor premises, physical facility, equipment, books, records, contracts, or other electronic systems available; and allowing auditing through 10 years from the find date of the contract, or completion of any audit

Once the pre-assessment audit is completed, recurring implementation meetings and discussions will be scheduled with the subcontractor and our project management team leading the implementation plan. The implementation plan will include coordinating any Enrollee/provider communications related to the new subcontractor; subcontractor/Molina site testing and setup for file sharing for encounters and eligibility extracts; and ensuring the subcontractor has a complete list of reporting needs and due dates, as well as contacts within Molina.

Encounter Submissions Monitoring

As part of our subcontractor monitoring, we also will work proactively and have a process in place to evaluate and ensure provider/subcontractor compliance with encounter data submission requirements. We will perform quality and completeness checks throughout the claims/encounter submission process. Monthly reports will identify, track, and benchmark metrics (e.g., encounter submission rates), enabling us to identify underperforming or non-compliant entities. We will consistently validate encounter data to ensure appropriate volumes of received and submitted encounters.

As part of our quality and completeness checks, we will accept and verify submissions through our secure provider Web portal. Providers, provider groups, and subcontractors will submit claims/encounters through secured socket layer, and submissions will be automatically logged and tracked. Submissions, including errors, can be viewed to enable resubmissions as needed. Further, claims/encounters will be received daily from clearinghouses that format electronic data into standard 837 formats. The claim will be routed through a pre-processor and then through the Molina Claims Gateway. An image of the claim also will be generated and can be retrieved through a claim viewer. Daily files will be loaded into QNXT. We also will work with providers and EDI clearinghouse to identify barriers in moving to electronic functionality and regularly evaluate systems to determine areas for improvement.

Our Claims and Encounters Management System will manage the flow, generation, and submission of encounter data. We will internally monitor claims/encounter inventory, including inventory totals, claims aging, and staff productivity. The system will offer various reports and metrics on enterprise-wide trends across claims and encounter data processed within different stages and environments.

Before encounters are submitted for processing, they will be run through a series of internal outbound edits to ensure data is complete and meets applicable, contract-specific requirements. If we identify

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missing, inaccurate, or invalid data elements, required fields, or code sets during the validation process, we may reject the claim/encounter and return it for correction and resubmission. If data is missing, we will reach out to the provider or subcontractor for remediation/resolution. All encounters will be thoroughly validated before development of Department-required data formats.

In addition to the metrics we will monitor monthly, Molina also will reconcile encounter data to the financial data reports each week, month, or quarter. This quarterly submission and reconciliation will give us another opportunity to monitor gaps in expected encounters.

As part of our oversight process, we also will perform audits on subcontractors to ensure that all encounters are being submitted. We will select specific days and require the subcontractor to submit its complete claims dataset for the dates of service selected. Then, the data will be compared to the encounters Molina has for the subcontractor. Through this process, we will be able to identify gaps with subcontractors and recognize the root cause of encounter failures that are related to a failure during the file upload process. Molina and its subcontractor will immediately take action to ensure the files are resubmitted. We also will work with the subcontractor to improve its monthly reporting to ensure errors such as a file failure are identified and remediated.

We recently rolled out a new custom-developed, Web-based encounters processing and analysis application, "e-Vitals," which automatically performs most of the required encounters submission and compliance functionality. The tool will help monitor the subcontractor submission, identify the resubmissions of the previously denied encounters, check encounter completeness, and monitor file failure.

Our process will generate complete and accurate encounter data and facilitate the timely submission of encounters consistent with required formats, and we will comply with all data completeness monitoring requirements, subject to Department approval.

Oversight of Subcontractor Credentialing and Recredentialing

We will delegate credentialing and recredentialing activities to subcontractors and provider groups that meet our requirements for delegation and when the delegation will improve efficiency and provider satisfaction throughout the onboarding process and improve Enrollee access to quality care and preferred providers. The Delegation Oversight Committee must approve all delegation arrangements, and it will retain the right to limit or revoke any and all delegated credentialing activities when a subcontractor fails to meet NCQA, Commonwealth Medicaid, and/or Molina requirements. To be delegated for credentialing, subcontractors must:

- Agree to our contract terms and conditions for credentialing subcontractors and be compliant with the Contract
- Submit timely and complete reports to Molina as described in policy and procedure
- Correct deficiencies within mutually agreed-upon time frames when issues of non-compliance are identified by Molina
- Comply with all applicable federal and Commonwealth laws

As stated above in Delegation Oversight Activities, we will conduct pre-assessments before delegation to determine compliance with regulatory and accrediting requirements. The pre-assessment will include a compliance review of all applicable delegation requirements and performance standards and a review of the potential subcontractor's credentialing evidence for all activities to be delegated. We will require reports from each subcontractor that contain information needed to ensure accuracy in its information systems for claims payment and network composition. We also will require subcontractors to notify us within two business days of any practitioner terminated for cause, suspended, or when disciplinary action has been taken against a practitioner by any state or federal agency. Each month, the subcontractor must provide us with a list of practitioners who have been credentialed or recredentialed during that month, a

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list of practitioners terminated and termination reason, credentialing timeliness data, and copies of new or revised credentialing policies and procedures approved during the month.

We will monitor for ongoing compliance through review of monthly required reports from the subcontractor and annual assessments. Subcontractors unable to maintain the established standards will be given a CAP to address areas of deficiency. These CAPs will be monitored for timely implementation and successful remediation of the issue. Exhibit C.11-5 demonstrates how we will identify and address subcontractor non-compliance.

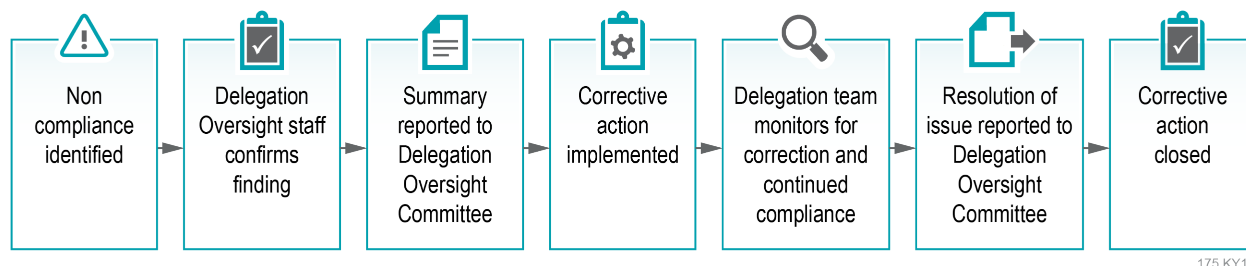

Exhibit C.11-5. How We Will Identify and Address Subcontractor Non-compliance

EXAMPLES OF ACTIONS TAKEN WHEN A SUBCONTRACTOR IS FOUND TO BE NON-COMPLIANT OR FOR PERFORMANCE IMPROVEMENT

Our parent and affiliated health plans have a successful history of effectively monitoring and evaluating services performed by subcontractors. Our policies and procedures will include guidelines for enforcement of non-performance and corrective actions employed to improve performance with positive results. Enforcement of non-performance may include corrective actions, penalties (when a contract contains performance guarantees), revocation of delegated functions, or imposition of other sanctions if subcontractor performance is inadequate.

CAP. The subcontractor agreement will specify activities and reporting responsibilities delegated to the subcontractor and provides remedies for non-performance. In the event Molina becomes aware of any information that suggests or indicates the subcontractor or delegated third party is not operating in accordance with its service-level agreements, the subcontractor will be notified, and a CAP will be required. These CAPs may include, but are not limited to, additional reports, more frequent or focused reporting, a focused audit on specific areas of concern, or termination of delegated activities. Once a CAP is in place, the Delegation Oversight staff will be responsible for monitoring until the subcontractor meets all requirements.

Molina Healthcare of Mississippi—Addressing Subcontractor Non-compliance

Our affiliated health plan in Mississippi recently approved delegation to a local provider group who was non-compliant with a Medicaid contract requirement to primary source verify all active state licenses. The provider group had established processes to verify disciplinary action against licenses, but verification of non-Mississippi active licenses was not something other Medicaid health plans had enforced on them. The provider group agreed to implement a process change, so our Mississippi affiliate’s Delegation Oversight Committee approved delegation with quarterly audits to ensure appropriate verification processes were put in place.

The Mississippi Delegation Oversight team completed quarterly audits to validate the new process was successfully implemented. Results of each audit were brought to the Delegation Oversight Committee for review. By the third audit, the group was able to demonstrate 100% compliance with the requirement for two consecutive quarters, so the Delegation Oversight Committee voted to close out the CAP item. During the annual audit three months later, compliance with this expectation was validated again, and the provider group scored 100% compliance with this element.

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March Vision Subcontractor Example. During our organization's 2018 annual audit of March's credentialing process, we identified a change in documentation for review of the Social Security Administration's Death Master File. March had updated processes to attempt to show proof of a practitioner not being listed on the Death Master File by providing screen shots of the query; however, the verification source being used, and clear documentation of whether the practitioner was included in the list, was not consistent throughout the files we reviewed. Our Delegation Oversight staff worked with March staff to ensure documentation included clear evidence of the verification source, the verification date, and the results of the query. We then collected an example of the updated documentation to be added to the file. Continued compliance with documentation requirements was validated during our annual audit conducted in August 2019.

Avesis Dental Subcontractor Example. Another example of our organization's successful approach to subcontractor oversight and corrective action regards our dental subcontractor, Avesis. During a recent annual claims and utilization management audit, Molina did not receive accurate universal denial reports from Avesis. These reports are critical to determine the selection of files we will review during the audit to determine the appropriateness of both claims and utilization management denials. Avesis' utilization denial report submitted to Molina contained approved authorizations. The claims denial report that was submitted contained adjusted claims. In both cases, these reports should have contained only denials. Upon notice of the deficiency, Avesis submitted two more reports with the same errors. We proactively worked with Avesis to correct the issue until an accurate report was produced. To help mitigate this issue in the future, we requested Avesis add a "status" column on the report to assist in their own review to produce accurate reports. We also had Avesis complete attestations to confirm the accuracy of the reported data.

Further, as a result of this experience and our desire to identify opportunities to strengthen subcontractor monitoring and oversight, we have adopted and implemented the CMS Audit protocol for all Medicaid providers and vendors. The protocol results in a failed file audit after three failed attempts by a vendor to produce accurate reporting from which file selection is made. Follow-up file reviews will be completed 60 calendar days from the date of the last failed universe submission, allowing groups adequate time to correct their universe issues. We have met with Avesis compliance leadership to discuss this new protocol, with both parties agreeing to adoption, as we continue to work in partnership to achieve compliance.

Penalties. All contracts with our subcontractors will include service-level agreements. As such, subcontractors will face financial penalties for failure to perform and comply with contract requirements. We will build performance guarantees into the contract, so non-performance / poor performance will result in financial penalties. For example, all model and executed subcontracts and amendments will require subcontractors to submit timely, complete, and accurate encounter data in accordance with the requirements of Draft Contract, Section 16, Encounter Data.

Molina Healthcare of Ohio—Dental Subcontractor Penalties Example. A dental subcontractor partnered with our Ohio affiliate health plan has a service-level agreement for credentialing application turnaround times that ensures compliance with state administrative code requirements. The subcontractor was non-compliant with the service-level agreement for two months, so the appropriate penalties were applied. The subcontractor implemented an internal CAP that identified a root cause: a temporary decrease in staffing and insufficient training of staff filling in. The CAP was tracked by both the subcontractor and our Ohio affiliate to ensure compliance, and monthly penalties continued until the terms of the service-level agreement was once again met. Both the CAP and updates on penalties were presented to the Delegation Oversight Committee to ensure full visibility to all impacted departments.

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Termination. Molina may terminate a delegation agreement with a subcontractor, according to provisions in the contract, if the subcontractor:

- Fails to adhere to the established standards and procedures
- Has its license, certification, or accreditation revoked, suspended, or canceled
- Has not responded to multiple requests to submit a CAP
- Has filed for bankruptcy

Molina may also terminate a delegation agreement in support of a business improvement decision, if allowed by contract provisions.

If a delegation agreement is recommended for termination and/or at the request of the subcontractor for termination without cause, Molina will notify the Commonwealth with at least 90 but no more than 120 calendar days advance notice. Molina will issue the termination notice to the subcontractor in accordance with its contractual agreement, and Molina / the subcontractor will coordinate Enrollee notifications that will be issued in compliance with Medicaid Contract requirements for transition of services for Enrollees.

Molina will employ these methods (e.g., CAPs, penalties, termination, and so forth) to ensure consistent performance and to improve performance, as needed. As shown in our examples from affiliated health plans, our organization diligently monitors, communicates, and enforces contract adherence to ensure the highest-quality, most consistent services for members.

Molina Healthcare of Florida—Transportation Subcontractor Termination Example. A non-emergent transportation subcontractor that partnered with our Florida affiliate has contract language that passes through any liquidated damages assessed by the Florida Agency for Healthcare Administration. The state assessed liquidated damages for four areas of non-compliance, all of which were imposed against the subcontractor. The subcontractor identified a downstream partner that was not picking up members at agreed-upon pick-up locations, resulting in these members missing important medical appointments. The subcontractor placed the downstream partner on a CAP for non-compliance with contract requirements, and redirected transportation appointments to other downstream partners. After two months of unsuccessful remediation efforts, the contract with the non-compliant downstream partner was terminated.

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