C.19 Provider Payment Provisions

REQUIREMENT: RFP Section 60.7.C.19
19. Provider Payment Provisions (Section 29 Provider Payment Provisions)
a. Describe the Vendor's claims adjudication process and capabilities in maintaining high standards in claims processing.
b. Provide information about the Vendor and any entity proposed to process and pay claims. As part of the response, address the following:
   i. Policies and procedures to meet performance standards and prompt pay requirements for all provider types.
   ii. Market specific strategies for addressing potential provider payment issues, including underpayments, overpayments, pre- and post-claims editing policies and provider billing education.
   iii. Proposed average days to payment from claims submission for the Vendor's proposed claims platform for medical and pharmacy claims. Provide the Vendor's last calendar year's report on the "average number of days to pay providers."
c. Describe the Vendor's methodology for ensuring claims payment accuracy standards will be monitored and improved through audit. At a minimum, address the sampling methodology, the process for auditing the sample, documenting of results, and activities conducted to implement changes or required corrective actions.

Efficient claims management and administrative processes benefit all Kentucky Medicaid program stakeholders. Our comprehensive use of technology, policy, reporting, and audit demonstrates our proven capability to support timely and accurate claims processing tailored to the needs of the Commonwealth.

Provider satisfaction matters to Molina. We strive to provide a seamless and reliable experience for providers and be their Plan of Choice. ***Our proposed provider payment strategy will incorporate a comprehensive claims processing program that will aim to increase provider satisfaction while simultaneously decreasing provider abrasion and administrative burden, allowing providers more time to focus on Enrollees.***

From offering multiple methods of claims submission to aggregating required support information and documentation for reporting and analytics, Molina maintains highly organized and collaborative claims processes and provides a solution that harnesses superior automation and data management. Our successful provider payment approach will be developed specifically to meet the needs of the Kentucky Medicaid program.

To better understand the needs of providers in Kentucky, Molina conducted a series of targeted focus groups and meetings with Kentucky Medicaid providers, reviewed the Kentucky Hospital Association report card, and held discussions with hundreds of providers around the Commonwealth. Some of the feedback we received included:

- A lack of engagement with their MCO staff
- Failure to meet 30-day turnaround times for clean claims
- A reported high rate of denials and difficulties with prompt claims adjudication and payment
- High denial rates for prior-authorization claims
- A lack of transparency leading to increased provider abrasion

Our proposed Kentucky claims processing approach includes

- A nimble approach to claims processing tailored to meet the specific needs of the Kentucky Medicaid program
- A Louisville-based claims processing center
- Ongoing provider collaboration designed to decrease provider abrasion
- Transparency between Molina and both our provider network and the Department
- Proven claims processes that continually meet and exceed the Commonwealth's performance standards

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Additionally, nationwide reporting further validates the need for improved provider payments by MCOs. In 2019, CMS estimated:

- A fiscal year 2019 national Medicaid improper payment rate of 14.90%, representing $57.36 billion in improper payments
- A fiscal year 2019 national CHIP improper payment rate of 15.83%, totaling $2.74 billion in improper payments[1]
- Up to $15.5 billion in unnecessary administrative costs for payers due to claims processing inaccuracies

Across all Molina affiliated health plans in 2019, we averaged 10.6 days from receipt of a claim to payment, including claims that required secondary quality review. These statistics also held true for our new implementations.

Our newest health plan in Mississippi had an average receipt-to-payment of 6.3 days for all of 2019.

Given the known concerns of the Kentucky Medicaid provider community and the broader issues with claims processed nationwide, ***Molina will proactively leverage our Payment Integrity Office, which will work with both internal and external partnerships to understand and remediate root cause concerns and develop a tailored strategy to ensure Molina's long-term success.***

This approach will allow all claims processing activities to intersect with corporate and health plan functions, further supporting the overall goal of identifying, resolving, and preventing improper payments.

We have a proven track record across the Molina enterprise that shows our provider claims processing and payment strategy will not only meet but exceed the compliance requirements of the Kentucky Medicaid program. Our goal is to meet or exceed a claims payment accuracy score of 99.5%.

Within the remainder of this section, we provide our proposed approach to meet the needs of the Department and Kentucky Medicaid providers. Our program will comply with all requirements in Attachment C, Draft Medicaid Managed Care Contract and Appendices, Section 29, Provider Payment Provisions.

a. CLAIMS ADJUDICATION PROCESS AND CAPABILITIES

From receipt of a claim to provider payment, ***our claims processing system and operations enable us to consistently deliver impressive and constantly improving average turnaround times with low denial rates across our affiliated health plans.***

2019 Auto-adjudication Rate:

87.6% average enterprise wide

Molina is proud of our ability to process claims, not only to meet service levels in our affiliated health plan contracts, but to consistently exceed them. For example, ***across all our affiliated health plans, we averaged 10.6 days from receipt of a claim to payment in 2019,*** including claims that required secondary quality review. These statistics also held true for new implementations: ***Our newest Medicaid health plan in Mississippi had an average receipt-of-claim-to-payment turnaround time of 6.28 days in 2019.*** This low provider payment turnaround timeline has been consistent across the entire 16-month span of the health plan's operations.

As we continue to provide excellent service to providers and members, ensuring expedited turnaround times for all states from implementation through the contract period remains paramount. For example, our Mississippi affiliate showed strong success, from go-live through the present, due to their rigorous

[1] 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.

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approach to claims payment. Mississippi's Medicaid population and other demographics are similar to Kentucky's, and their results speak to our ability to implement a new health plan operation while exceeding our state partner's performance requirements. Our Mississippi affiliate's average claims turnaround time results for full year 2019 are displayed in Exhibit C.19-1.

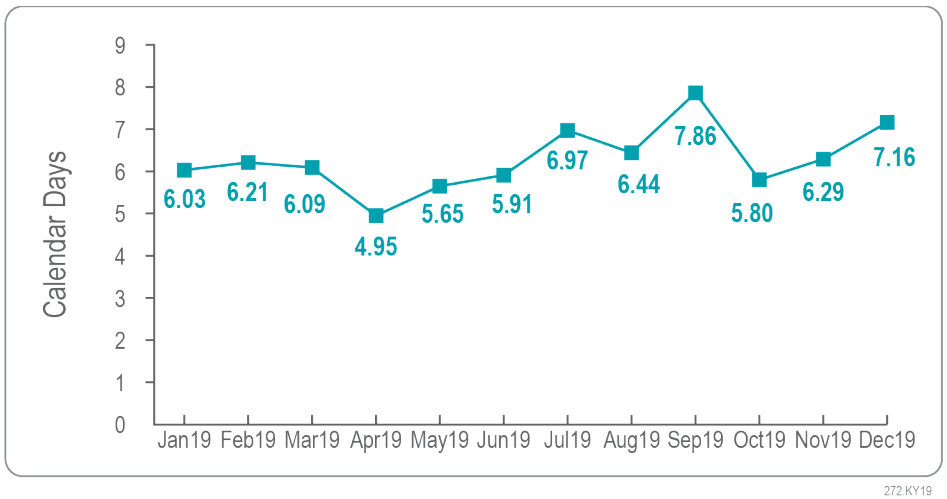

Exhibit C.19-1. Molina Healthcare of Mississippi--Medicaid Claims Average Turnaround Time (Full Contract Year 2019 Health Plan Operations)

Besides new implementations, we have a proven record of maintaining expedited turnaround times throughout our contract terms. ***Molina's affiliated health plans average 87.6% claims adjudication in 10 days or less. They also average 98.68% claims adjudication within 30 days, which well exceeds Kentucky's requirement of 90% in 30 days.*** Table C.19-1 highlights current turnaround times for three of our affiliated health plans who are several years into their contracts.

Table C.19-1. Example Average Turnaround Times for Affiliated Health Plans

State	2018	2019
Florida	6.08 days	4.34 days
Texas	7.92 days	8.96 days
Washington	6.99 days	6.9 days

Using advanced technology for auto adjudication contributes to consistently fast claims turnaround times. Our proven core claims processing system, QNXT, has the capability and capacity to process and pay provider claims in an accurate and timely manner in compliance with all applicable Commonwealth and federal regulations, including full compliance with the HIPAA Implementation Guide and regulations.

Our system's efficiency results in a high percentage of claims being auto-adjudicated, which shortens turnaround times and ensures accuracy. With rates as high as 88%, most of our affiliated health plans currently process 80 to 85% of provider claims via auto-adjudication. We anticipate similar auto-adjudication results for Kentucky.

Additionally, QNXT is fully integrated with our management information system, ensuring streamlined and secure data management and information exchange. We proactively find ways to exceed industry standards, and our Payment Integrity Office is enhancing capabilities through planning and tracking to ensure that claims are paid accurately from end-to-end.

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CLAIMS ADJUDICATION

As evidenced by our enterprise-wide commitment to pay claims accurately and timely, the satisfaction of our providers matters to Molina. Our goal is to be the Plan of Choice for providers. Before submitting their first claim to Molina, we will work with providers and subcontractors to offer training, technical assistance, and other necessary information and resources to help make sure providers successfully submit clean and complete claims upon go-live. This will include end-to-end contract configuration and claims adjudication testing with key providers before go-live.

This process ensures claims can be paid promptly, reducing the risk of denials or the need for resubmissions of corrected claims. We have experience processing claims for multiple provider types and will comply with the requirements in the Draft Contract, Section 29, Provider Payment Provisions related to the identified provider types.

Molina is committed to the provider and Enrollee community in Kentucky.

Establishing our claims processing center in the Commonwealth ensures we will reinvest in the community and provide a local resource for efficient management of Kentucky claims needs. Claims processed in this center will maintain alignment with our Molina standards of excellence, following our established and proven processes for success.

Efficient claims processing begins with providers' ability to submit their claim with ease. Providers can choose their method of submission by using our user-friendly provider Web portal solution, through an electronic data interchange (EDI) clearinghouse, or via mailed paper form. In our experience, working closely with our provider community, ***we can achieve electronic (Web portal or clearinghouse) submission 98% of the time,*** ensuring faster claims receipt and processing. We look forward to working with the Department to promote similar results in Kentucky.

Throughout the life cycle of a claim, providers can view and manage their submissions via our online Web portal. This tool will be available to all providers, allowing real-time access to their data and provider account. The increased visibility provided by the tool will reduce delays in notification regarding claim status, strengthening communication and expediting issue resolution. We know from experience that collaboration is crucial to timely and accurate claim payments. We will leverage this experience in Kentucky to increase provider satisfaction with the claims payment adjudication process end to end.

To further support expedited claim receipt and payment, we will adjudicate all claims in Louisville. Upon receipt, all provider-submitted claims will be immediately processed within QNXT. System edits will then determine if a claim meets denial criteria; verify the provider is Kentucky Medicaid-certified and the right type/specialty to perform the service; determine whether the claim is a covered service; and validate services have been billed appropriately.

Our affiliated health plans regularly **exceed expectations** for claims turnaround and accuracy requirements. Across all plans, we average:

98.7% payment within 30 days

99.9% payment within 90 days

99.5% payment accuracy

Once reviewed, we will pay the claim or issue a denial. QNXT will then store the claim along with an overview of how the determination was made. A claim remittance file will be generated and sent electronically or mailed with all necessary claim payment information, including the HIPAA-compliant reason for denial codes when indicated. Providers will also be able to view specific claim denial reasons through the provider Web portal or contact our Call Center for more information.

We will adjudicate claims in a timely and accurate manner through QNXT. Our system complies with all components of 42 C.F.R. § 433.116 and will enable us to meet and exceed all Kentucky Medicaid program claims processing standards.

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As it does for Molina plans throughout the country, QNXT will collect, analyze, integrate, and report data and provide information on areas including service utilization and claim disputes and appeals. It will integrate Enrollee demographic data, care management information, authorization information, provider information, service provisions, claims submission and reimbursement, and include modules that collect, store, and produce information for financial, medical, and operational management. Our system is HIPAA-compliant and will be modified on an ongoing basis in accordance with the Department's defined rules and requirements.

Our claims adjudication process will ensure claims that pass the validation processes of our EDI system are loaded into QNXT. All claims will be processed in receipt date order, with provider type hierarchy added as needed to meet regulatory requirements. Our processes will ensure a prompt and accurate turnaround that meets all regulatory and program compliance standards. We have demonstrated experience in our affiliated health plans of our ability to adjust priorities to meet state regulatory requirements for selected provider types as needed. For example, Texas and Florida Medicaid have strict skilled nursing facility turnaround time requirements, and we adjusted our core systems to meet these unique requirements.

We anticipate that most claims will be submitted through electronic submission via EDI or our provider Web portal. To meet the needs of our smaller providers, especially those in rural areas where electronic submission may not be possible, providers may opt to submit paper claims, and our systems will convert them into an electronic format.

QNXT will receive EDI claims daily from provider-contracted clearinghouses that format electronic data into standard 837-I or -P file formats and upload them. Then, the claim will be routed through a pre-processor before entering the Molina Claims Gateway for initial claims review and processing. As a result of the pre-load process, which will verify the Enrollee ID, pay-to, rendering physician, and service location, a claim will be either uploaded to QNXT or returned to the provider for review and data correction.

Following pre-process, the claim will be moved to QNXT, and an image of the claim will be generated and stored for retrieval through the Claim Viewer application. As claims are loaded, QNXT will assign a unique 11-digit claim reference number that contains receipt date information in the form of two digits for the year; three digits for the Julian date; and six digits for the claim submission type (i.e., EDI and provider Web portal). The last five digits are typically assigned in sequential order.

For audit purposes, the system will store the username for the individual that created the claim, the create date, the last user who touched the claim, and the date of the last action taken. Each claim will be assigned a status, which will be used to track its progress throughout the claims adjudication process. The claim status is a key element in the inventory management process.

Our Kentucky Claims Management team will monitor inventory through comprehensive reporting and dashboards, assuring claims are processed timely by the examiners assigned to specific claim types for processing. As an examiner processes a claim, the claim may take several courses. The status and system-assigned edit will denote the course a claim has taken and where it is in the life cycle. We will monitor this activity in real time through the Claims K2 Workflow application, tracking the flow of a claim between queues and departments as examiners may seek assistance from other departments such as Provider Services, Configuration, Eligibility, and Utilization Management to investigate a pended claim.

If an exception requires assistance from another department, the claim will be routed accordingly through work queues within the application. Pended claims routed for processing by other departments also will be monitored in real time through reporting within the tool. The Claims K2 Workflow application also will be used to generate reports that provide the age of the claim; the Claims Management team will use this reporting to ensure the responsible departments review or process claims within our internally established time frames. We provide our end-to-end claims workflow process in Exhibit C.19-2.

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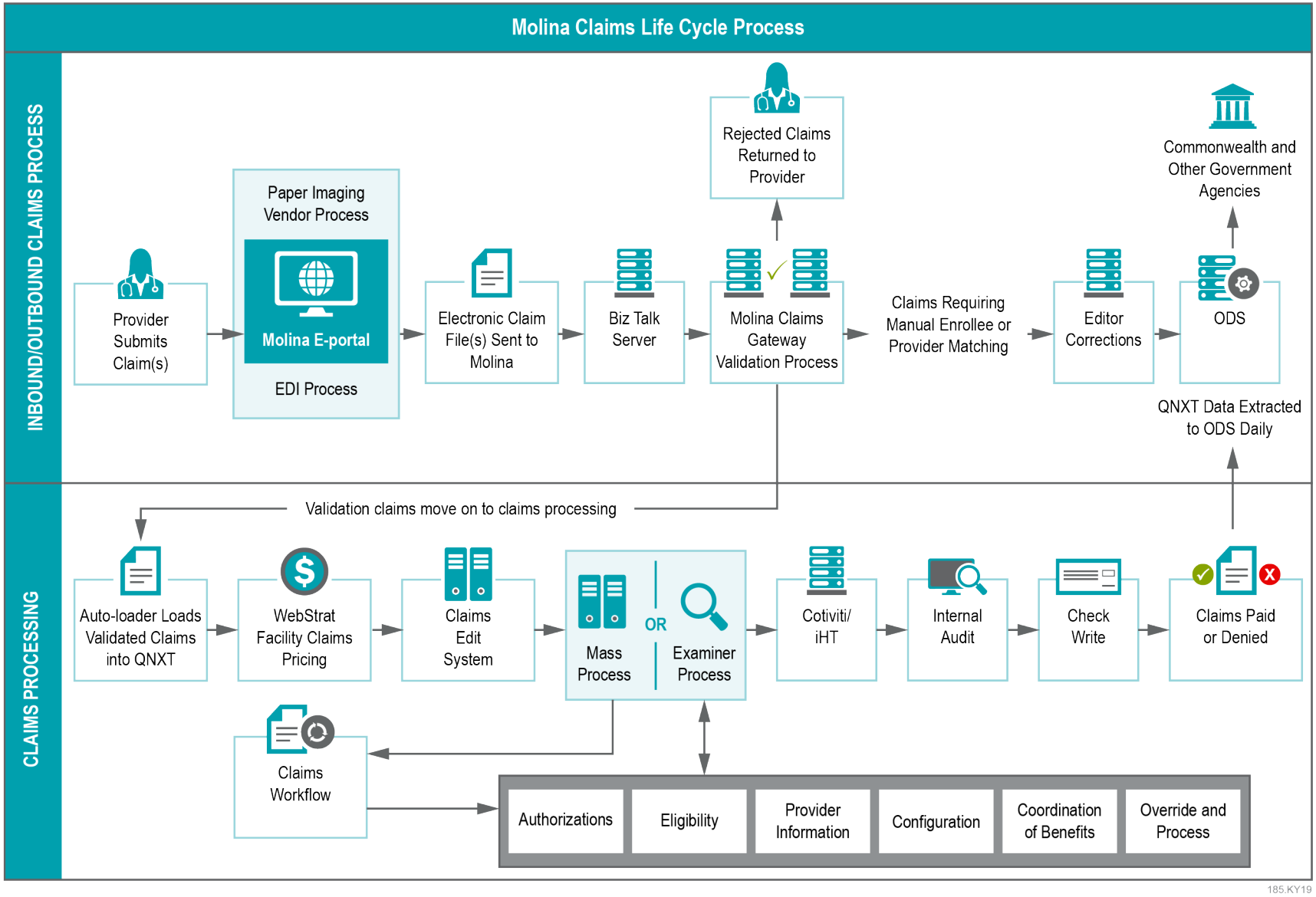

Exhibit C.19-2. Claims Life Cycle Process

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CLAIMS PAYMENT TIMELINESS STANDARDS

In accordance with 42 C.F.R. § 447.46, we will pay or deny 90% of all clean claims for covered services within 30 calendar days of receipt, and 99% of all clean claims within 90 calendar days of receipt.

Additionally, we will comply with the prompt-pay statute, codified within KRS 304.17A-700-730, as may be amended, and KRS 205.593, and KRS 304.14-135 and KRS 304.99-123, as may be amended. We will process and report on all claims in accordance with program requirements.

98.7%

Our enterprise wide average turnaround time for clean claims within 30 days, **exceeding Kentucky's requirement of 90%**

b. INFORMATION ABOUT ENTITIES PROCESSING AND PAYING CLAIMS

b.i. POLICIES AND PROCEDURES

Timely and accurate payment of claims is a high priority for Molina. To facilitate this, we will maintain a suite of Commonwealth-specific claims payment policies and procedures, using a dedicated support team to ensure all documents contain updated and accurate information aimed at meeting performance standards. Additionally, we will implement a comprehensive annual review process with internal subject matter experts, including a Kentucky expert, validating all documentation is current and in line with Commonwealth regulatory requirements. After each document update is posted to the designated library, claims staff will receive real-time alerts to review updated processing strategies.

Supplementing the comprehensive document suite and notification system, we will maintain a dedicated training team at each of our claims processing centers, ***including in Louisville.*** Claims staff will receive hands-on annual training on claims processing, as well as provider-type specific training following new document creation or complex updates. This added training will ensure all claims staff will be aware of new Commonwealth processing requirements, reducing manual errors and expediting timely adjudication. Additionally, detailed classroom and online training will be provided on all claim types and provider types, including topics such as inpatient, outpatient, nursing facility, emergency department, and behavioral health. If a claim requires manual adjudication, we will ensure our claims staff has been trained and assessed before touching the claim.

To further support training initiatives, several tools will be available to all Molina staff including Huddle Chats (updates that are discussed in supervisor-led team discussions), automated training classes available on a variety of topics and claim types via our iLearn learning management system, and additional availability of trainers to our processing staff via the Walk the Floor program. By continually investing in our documentation and trainings, we will provide auditors, examiners, and leadership with the tools necessary to maintain high levels of success via awareness, continuous learning, and ongoing support. Because of these initiatives and this partnership, ***Molina affiliated plans' quality scores enterprise wide exceed 99.5% accuracy.***

Our parent company maintains an exhaustive library of more than 1,000 claims-related policies. These policies will be tailored to meet the exact needs of the Kentucky Medicaid program. Sample policies include:

- **Authorization Business Process.** Defines guidelines for claims personnel when claims require a prior authorization for processing, including visual validation, referring authorization-related claims appropriately and consistently for utilization management medical/clinical review, and applying authorization parameters to accurate claims payment while meeting all internal and regulatory requirements. Please refer to Attachments to Section 19 for our sample Authorization Business Process – All States and LOBs, policy.

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- **Clean and Complete Claim Determination and Development.** Defines appropriate criteria for evaluation of received claims data, ensuring the claim contains all required information to meet CMS requirements for accurate claims processing. This process validates the claim is complete in all aspects, including complete coding, itemization of charges, dates of service, and inclusion of appropriate attachments. Please refer to Attachments to Section 19 for our sample Clean and Complete Claim Determination and Development policy.
- **Exception Claim Processing.** Defines processes for exception payment adjustments for a service or claim that would normally be considered not covered or ineligible in accordance with established internal and regulatory requirements. This process furthers our commitment to process claims in a fair and equitable manner while accounting for prudent and judicious treatment for unusual or extraordinary circumstances that may arise and that warrant exception handling. Please refer to Attachments to Section 19 for our sample Exception Claim Processing policy.
- **Projects, Management, and Distribution of Cases.** Defines processes to effectively manage assignment, monitoring, and completion of adjustments on rework claims efficiently and within regulatory time frames, minimizing negative impacts to providers, Enrollees, and the Commonwealth. Please refer to Attachments to Section 19 for our sample Projects, Management, and Distribution of Cases policy.
- **Timely Filing Requirements by State.** Defines state-specific timely filing limits established by regulators and provider contracts. Also, outlines steps to ensure accurate and consistent review when validating timely filing limits and proof for exceptions based on regulatory guidelines, provider contract terms, and letters of agreement. Please refer to Attachments to Section 19 for our sample Timely Filing Requirements by State policy.

Additional library documents detail claim level, state-specific, and provider contract documents. Claims are processed and audited according to this documentation.

Subcontractor Policies and Procedures

Avesis (Dental)

Our dental subcontractor, Avesis, will process and pay dental claims as a subcontractor to Molina. One of the reasons we partner with Avesis is because they consistently achieve high standards for quality and efficiency. Provider payments will be processed weekly in compliance with federal laws and Commonwealth laws and regulations. Avesis has 14 policies and procedures in place to ensure their Medicaid claims adjudication processes will meet performance standards set by Molina, the Commonwealth, and CMS. These policies and procedures are described below and can be made available to the Commonwealth as needed.

- **Claims Processing and Payment.** Defines the process for ensuring all clean claims are paid within 15 days of receipt, and all claims are finalized no later than 30 calendar days of receipt
- **Claims Adjudication.** Defines the process for ensuring claims are accurately adjudicated against each Enrollee's benefit plan and the provider contract
- **Clean Claim Definition.** Defines the process for assessing whether a claim is "clean" before adjudicating it. A clean claim is a legible claim using either a CMS or standard billing format that has no material impropriety or is unsuitable for accurate processing (including all required documentation), an original invoice (when applicable by contract), or an itemized statement (when applicable by contract)
- **Claims Internal Audit.** Defines the process and standards for engaging an internal third party in conducting daily claims audits to ensure financial and procedural accuracy

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- **Claims Interest Payment.** Defines when and how Avesis claims must include interest in alignment with Prompt Payment interest rates in states which require this
- **Claims Record Retention.** Affirms that all claims documentation must be securely stored for 10 years or longer if required by state or federal regulation
- **Claims Processor Training.** Defines the process for successfully training claims processors to meet organizational, client, and government standards. Policy includes topics that must be addressed in orientation and ongoing team training
- **Coordination of Benefits.** Defines Avesis' process for management of coordination of benefits with other eye care and/or dental carrier when coverage is present
- **Fraud and Abuse Detection.** Defines circumstances when claims must be reviewed for potential fraud and abuse, including claims with handwritten marks, corrections, and changes to billed amounts
- **Claims Appeals.** Affirms the process Avesis uses to ensure Enrollees and providers have a fair and transparent claims appeals process
- **Explanation of Benefits (EOBs) and IDNS.** Affirms Avesis will provide Enrollees with easy-to-read notices of any payments or adverse benefits determinations
- **EDI Claims.** Defines the process for efficiently adjudicating electronic claims
- **Claims with Both Medical and Non-medical Codes.** Applicable only to eye care claims, this policy defines the process for adjudicating claims with medical and non-medical codes when Avesis is not responsible for medical codes
- **Claims Productivity Standards and Objectives.** Defines Avesis' internal standards for efficiency and team monitoring

March Vision Care

March maintains a Timeliness and Interest Policy for Kentucky Medicaid, which can be made available to the Commonwealth as needed. Its purpose is to establish policies and procedures for claims processing requirements for the Commonwealth's Medicaid program. The policy also provides guidelines to ensure appropriate selection of the receipt date to calculate the age of the claim and for paying interest on late claims. March will use the date a claim is received as the receipt date for purposes of calculating the age of the claim. Established timeliness requirements include:

- 100% of paper claims are processed within 30 calendar days
- 100% of EDI claims are processed within 30 calendar days

Daily aging reports will be monitored to identify claims to be processed to meet the timeliness requirements established in the policy. Claims identified on the aging report will be adjudicated and selected for check run. Interest will be calculated on all claims in accordance with the interest requirements outlined below and based on the paid age of a claim by subtracting the date the check is mailed.

Interest will be paid on any paper or EDI claim not paid within 30 calendar days. Computation of interest will begin on the 31st calendar day for both paper and EDI claims and will be calculated as follows:

- Interest of 12% per annum must be paid on any EDI or paper claims that are paid between 1 and 30 days from the date that payment was due
- Interest of 18% per annum must be paid on any EDI or paper claims that are paid between 31 and 60 days from the date that payment was due
- Interest of 21% per annum must be paid on any EDI or paper claims that are paid more than 60 days from the date that payment was due

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- Divide applicable interest rate by 365 days
- Number of Delayed Days X Total Claim Payment X Calculation

The claims manager will be responsible for ensuring that claims are paid in accordance with Kentucky Medicaid requirements. The claims manager also will be responsible for ensuring the most current interest rate is maintained in eyeManager and the correct interest rate is applied to claims requiring an interest payment.

CVS Health (Pharmacy)

CVS Health will reimburse each of their network pharmacies based on their contractual obligation with each pharmacy and in accordance with all applicable Commonwealth and federal laws and regulations. Each independent pharmacy will receive a single payment for all claims submitted and a remittance advice or 835 file detailing each claim that is being reimbursed in that cycle. Each pharmacy will receive one payment covering all units and, if the pharmacy chooses, an 835 payment file that details all claims processed. CVS maintains a provider manual that includes a pharmacy services and standards guide.

Claims submission topics include:

- Electronic submissions / reversals / processing windows
- Software certification
- Data fields and submission requirements
- Prescriber identification
- National Drug Code
- Coordination of benefits
- Claims requiring overrides
- Submission error codes

b.ii. MARKET-SPECIFIC STRATEGIES FOR ADDRESSING POTENTIAL PROVIDER PAYMENT CHALLENGES

Molina and our subcontractors have market-specific strategies for addressing potential provider payment issues, including underpayments, overpayments, pre-and post-claims editing policies, and provider billing education.

Molina Strategies

Our goal is to minimize claims denials and increase provider satisfaction by providing transparent and consistent rules for stakeholders, working to eliminate administrative burdens, and paying claims in a timely and accurate fashion. For example, primary care providers can refer to an in-network specialist without getting a referral authorization. This will remove the possibility of a claim being denied because an authorization was not received.

As described above, efficient claims processing begins with the provider and their ability to submit their claim with ease. We will work with providers and subcontractors to offer training, technical assistance, and other necessary information and resources to help make sure providers successfully submit clean and complete claims no matter the method of submission. This will ensure claims can be paid promptly and reduces the risk of denials or the need for resubmissions of corrected claims.

We will implement a tailored, Kentucky-specific provider education program, timely credentialing, and an accurate claims payment system; demographic and payment identifier loads; a proactive testing approach with providers before go-live; and claims adjudication reports that identify denial levels versus expected levels. This approach will minimize payment issues during implementation and transition. If variances occur beyond 5% from expected, we will troubleshoot the issue and apply proactive root cause analysis and solution planning with providers and EDI vendors. As a result of our experience, we can focus our work with providers on advanced health outcomes strategies instead of addressing network disruptions and mending fractured provider relationships.

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Through proactive claim review and ongoing provider education from our Provider Inquiry teams and other Kentucky-based staff, we will support accurate claim submission resulting in decreased provider abrasion. We know from experience that timely communication and ongoing outreach, including updated bulletins on the provider Web portal, concise remittance messaging, and direct provider contact, increase provider knowledge and provider satisfaction. Provider Services will meet face-to-face with providers and provider associations and will take advantage of these opportunities to provide education on claims processes and updates.

During our claim denials review for Quarter 1 of 2019, we noticed a high volume of claim denials categorized as duplicate claim submissions. Trend analysis showed the number of duplicate denials were outside of standard range for the impacted states. Further analysis revealed 95% of the claims denied as duplicates belonged to a single umbrella provider. ***Molina proactively reached out to the provider, notified them of the billing errors, and assisted the provider in remediating the issue by providing additional data, timelines, and original claim information.*** The provider was able to update their system, stopping future issues, and notify additional MCOs that the billing issue was corrected.

We will proactively monitor emerging trends and perform root-cause analysis to identify and fix the key drivers and process gaps that have the highest impact on operational performance and accurate claims adjudication.

Our Operational Excellence team will use the root cause rapid triage model to develop and execute a roadmap of process improvements with demonstrated financial benefits, limiting errors through streamlined end-to-end processes, fixing technology defects, updating documentation, and delivering focused training that will realize short-term improvements and ultimately align with the larger Research, Development, and Optimization initiatives. We will conduct weekly, monthly, and quarterly reviews with claims, provider, and plan partners to ensure all deep-dive findings are communicated and acted upon in a timely manner.

At Molina, continuous improvement goes beyond in-house teams and technology. We will regularly establish new processes to support the Department's needs, homing in on specific issues within each region. For example, QNXT edits, such as flags for urine drug screening and pricing validation, enhance adjudication for behavioral health claims, ensuring continuity of care for the Enrollee and eliminating delays in payment that might impact the timeliness of treatment by the provider. Growth of this initiative in conjunction with Kentucky Medicaid will further support both Enrollees and providers in addressing opioid concerns, aligning with our overall goals of preventing disease progression from acute to chronic state. At Molina, continuous improvement means we will take an inclusive approach to healthcare, designed to enhance the lives of our Enrollees, providers, and their communities.

Underpayments

While our goal is accurate and timely payments the first time, Molina also will maintain stringent systems designed to remediate any payment errors. Underpaid claims will be adjudicated daily without the core claims processing system by a dedicated Kentucky Adjustments unit. This unit will actively collaborate with the Enrollee Services and Provider Services teams to identify the reason for the underpayment, including the root cause of the underpayment and any system configuration that can mitigate future errors. Underpaid claims will be submitted to the Kentucky Adjustment team via QNXT call tracking, a system function that enables users to route claim-related issues from one department to another, or through an electronic special project request.

Once underpayments are identified, the Adjustments team will review the submission for accuracy, test the claims to ensure updated configuration provides the expected outcome, and adjudicate the claim for immediate payment. To further improve accuracy and reduce underpayments, adjustment projects will be logged in an online system that captures claim details and root causes for analysis and remediation. ***Proactively reviewing underpaid claims data in our affiliated health plans resulted in a 50% reduction in erroneous interest payments and reduced the overall controllable adjustment rate to meet industry standards of 2.5% or less of all claims processed annually.*** We provide our adjustment workflow process in Exhibit C.19-3.

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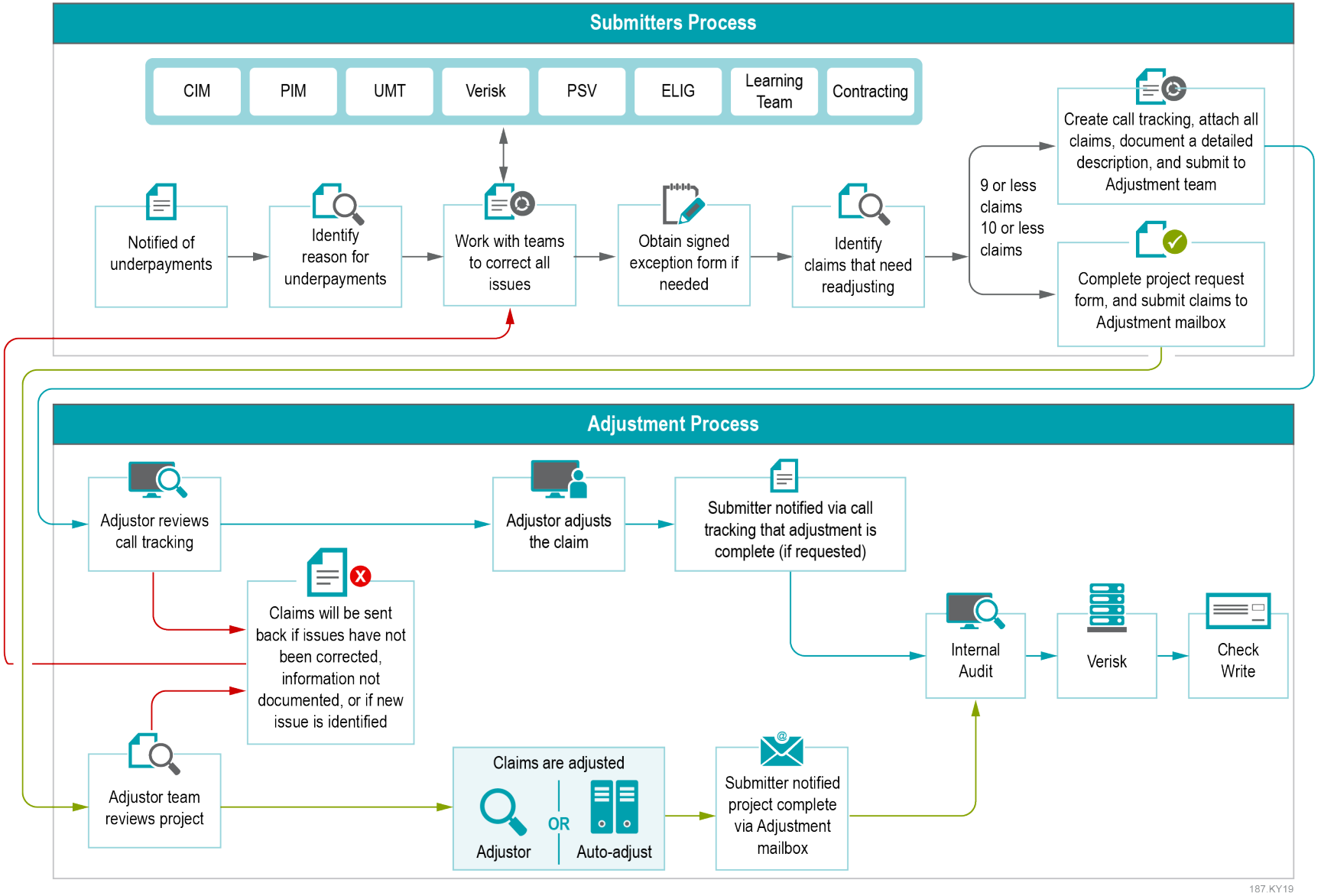

Exhibit C.19-3. Adjustment Workflow Process

Overpayments

Similar to underpayments, overpayments can be a result of a variety of factors, including, but not limited to:

- Fee schedule changes
- Processing errors
- Changes to in-state eligibility guidelines

Our Cost Recovery unit will use a proven "three-way" approach to claims recovery: proactive recovery by looking for overpayments in the claims payment system; reactive recovery following notification received from the provider or the Enrollee; and use of vendors for post-payment review.

Once a claim is identified as overpaid or paid in error, the Cost Recovery unit will verify the validity of the overpayment, review Kentucky requirements to determine if an "auto-debit" or overpayment letter is required and create the recovery record in our Recovery.net processing system. Once we receive the refund, recovery staff will process it and complete recovery retention activities within the Recovery.net application. We provide our cost recovery workflow process in Exhibit C.19-4.

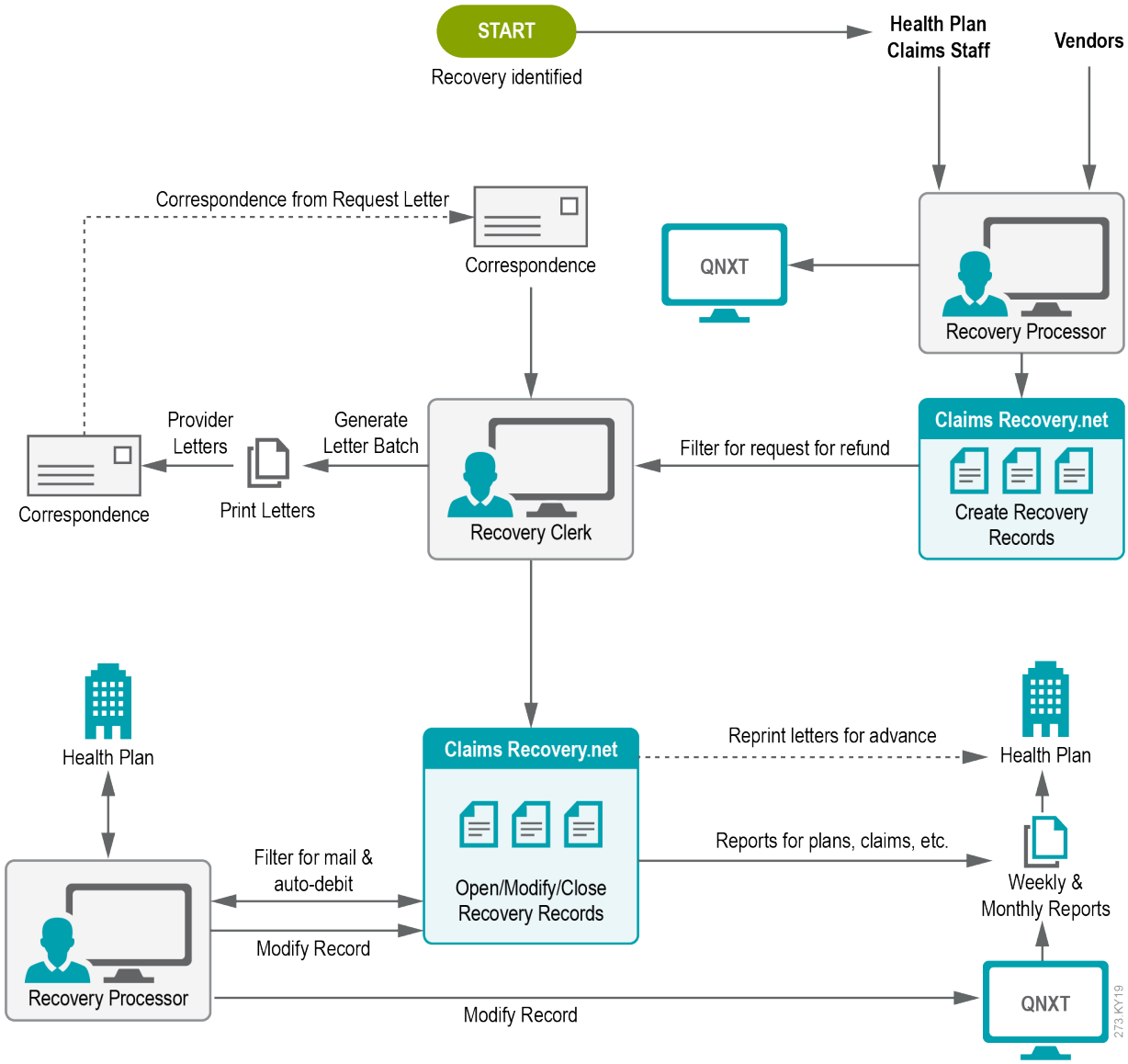

Exhibit C.19-4. Cost Recovery Workflow Process

Pre- and Post-claims Editing Policies

Efforts to reduce incidents of under- or overpayments will be assisted by our electronic pre- and post-claims editing. Molina will perform a claims pre-payment auditing process that identifies frequent correct coding billing errors, ensuring claims are coded appropriately according to Commonwealth and federal coding guidelines. As is done in our other markets, Molina will use two sources for applying code edits on QNXT claims: internal code editing system (CES), an externally sourced application applied to claims pre-adjudication, and Cotiviti/iHT edits, applied post-adjudication.

Claims with CES code edits applied are insourced code edits and will be maintained in collaboration with our Coding Integrity team and the Configuration Information Management team. Cotiviti/iHT coding policies will be maintained by Optum with oversight of the code edit application in QNXT by the Coding Integrity team. Both pre- and post-editing practices will be documented and taught, as applicable, and will serve to reduce errors and flag claims for additional reviews as needed.

Provider Billing Education

We will work closely with our providers and subcontractors to ensure they submit timely, accurate, and complete claims with required encounter data elements, and comply with format and data submission requirements. We will provide education to all providers and subcontractors through training, technical assistance, and other activities to ensure proper claims submission and HIPAA compliance.

Recognizing the importance of all providers and that each relationship within a network is unique, we will tailor our approach to provider notification and education as needed. For example, we may intensify efforts with those providers that serve a significant portion of our membership and have large volumes of claims. When we notice deviations from anticipated denial levels, we will initiate contact and address any issues.

We will also use training, technical assistance, and other activities to educate providers and ensure proper claims submission and HIPAA compliance. Our Provider Manual will contain detailed instructions that cover protocols for submitting accurate and timely claims to prevent denials. Additionally, a dedicated Provider Engagement Team will work directly with providers to ensure transparent rules and timely and efficient claims payment. They also will conduct onsite and web-based educational meetings about online resources and various methods of electronic claims submission for our provider network.

In our experience, coordination of internal review and provider trends has consistently supported a reduction in provider payment errors. We will use an established suite of reports that monitor denial trends by every provider, claim form used, and by specialty. These reports will be monitored monthly and used to spot trends in denials before the provider brings them to our attention. Unusually high denial rates for an individual provider can signal an error in provider setup, a change in a provider's billing address causing claims to deny, the need for provider education, or a change that has occurred in the provider's billing department. Unusually high denial rates for a specialty can signal a configuration error that needs to be addressed or the need for provider education.

Illinois Health Plan Success Story

Using a suite of reports to monitor denial trends by provider, our Illinois affiliate identified an exceptionally high spike in claims from a single provider that were billed on a CMS 1500 claim form incorrectly. During the analysis of the spike, it was determined the provider switched the National Provider Identification (NPI) number they were billing on claims. We shared this information with the provider and their billing team before they realized what had occurred, which was a change implemented at their clearinghouse. This had caused more than 12,000 claims to deny incorrectly.

Our Illinois affiliate gave the provider a list of impacted claims, so they could be paid more than $1.2 million for services performed.

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We will regularly contact our providers to educate them on electronic submission methods and provider Web portal resources. As a result of this approach used across our affiliated health plans, we have dramatically increased our rates of EDI adoption. We also will partner with Change Healthcare, a primary claims clearinghouse, to identify opportunities for providers to use electronic claims submissions and improve the quality of claims submitted.

Providers also will be encouraged to use electronic health records, e-prescribing, and electronic claims / encounter submissions to increase data capture and decrease possible medical errors. We will continually work to identify provider barriers in moving to electronic functionality, including performing an ongoing evaluation of in-house tools (such as the provider Web portal) and systems (such as claims). For example, we enhanced our portal to enable providers to submit claims directly and review the claims adjudication status. This is particularly valuable to low-volume providers or those with limited resources to purchase electronic solutions. We also identified an opportunity to reduce the attachments required for claims adjudication, which allows more claims to be submitted electronically.

Subcontractor Strategies

Avesis (Dental)

Avesis has not experienced administrative payment issues for the Medicaid dental network they manage in Kentucky. If payment issues were to occur, Avesis would activate their standard procedures for handling them:

- **Underpayments.** If an underpayment is identified, Avesis will issue a payment adjustment for the provider. They will pay interest on the claim if relevant.
- **Overpayments.** If an overpayment is identified, most often when an Enrollee has been retroactively terminated or when primary insurance that would cover services rendered has not been reported, Avesis will notify the provider of the overpayment and offer two methods to return the funds:
  - **Check or money order.** If a provider elects to send a check or money order, they must do so within 45 calendar days of receiving notification of the overpayment. The check or money order must be accompanied by all relevant documentation such as coordination of benefits paperwork or explanation of payments or remittance advices.
  - **Recoupment.** Recoupment refers to the withholding of all or a portion of a future payment until an overpayment refund obligation is met. If a check or money order is not received within 45 calendar days of an overpayment notification, we will send a written notice to the practice informing it that the recoupment process will begin, and the dental practice still has an opportunity to repay overpaid funds through check or money order.
- **Provider Billing Education.** If Avesis identifies an individual provider or practice with repeated problems with their billing practices, they will deploy a member of their Kentucky-based External Provider Relations team or in-state Dental Director Dr. Jerry Caudill to visit the office and provide hands-on re-education. If data reveals a pattern of errors, Avesis may host an informational webinar or regional training.

For example, Avesis did this in their Utah market when analysis of utilization management data showed a systemic problem with the way providers were scoring the required orthodontic index. After several rounds of phone calls and emails failed to fix the problem, they decided to bring their clinical director of utilization management, Dr. Jonathan Staker, to Utah for a day of education and training.

Avesis hosted two trainings with nine dentists and five office staff. During each session, Dr. Staker gave a brief presentation on index scoring and claims submissions, followed by a question-and-answer session, and then a case review that gave participants hands-on experience with the scoring process. An email from one participant indicated the event hit the mark: *"… thank you for taking time to show us how to properly submit our patients. The meeting was very informative…"*

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March Vision Care

March will perform a pre-check-run audit before releasing claims for a check run. They will follow established claim audit procedures before generating a claim check run.

It will be the responsibility of the claims manager to oversee pre-check-run audits. Pre-Check-Run reports will be generated before check run. The claims manager will oversee claims audits according to the Pre-Check Run List of Reports and ensure all pre-check-run audits are completed and all applicable corrections are made before the check run is locked.

March maintains established audit procedures for measuring the quality of work performed by the claims department. They focus process improvement efforts on claims adjudication procedures and/or personnel training through the identification of error sources:

- Thirty percent of claims processed by claims examiners are subject to quality audits. Individual examiner quality results are measured, reviewed, and compiled in a monthly report. Monthly audit results are distributed and discussed with the claims manager monthly.
- Three-to-five percent of system adjudicated claims are subject to quality audits. System adjudicated claim quality results are measured, reviewed, and compiled in a monthly report. Monthly audit results for system adjudicated claims are distributed to the database management manager monthly.

Procedural and Coding Accuracy. Procedural and coding accuracy represents the accuracy of claims detail keyed into the system (i.e., received date, date of service, Enrollee ID, provider ID, service code[s], service unit[s], modifier[s], diagnosis code[s], billed charges, various payment policy indicators, and so forth). Claims examiners are required to maintain a 98% procedural and coding accuracy rate. Performance standards are calculated using the number of claims reviewed compared to the number of claims containing a procedural and/or coding accuracy error.

Financial Accuracy. Financial accuracy represents the accuracy of payment and/or non-payment of a claim. Accuracy of the payment amount is based on appropriate application of provider fee schedules, benefit rules, modifiers, procedure units, coordination of benefits, and authorizations that impact the accuracy of the payment. Claims examiners are required to maintain a 99% financial accuracy rate. Financial accuracy is calculated using the number of claims reviewed compared to the number of claims containing a financial error.

Explanation of Payment (EOP) Audit. At least one EOP per client and check run are subject to quality audits. EOP audits are performed once per check run within two weeks from the day the EOPs are generated. When an EOP is not available from one of the categories, an extra EOP will be audited from the previous or next category.

EOB Audit. At least one EOB per unique EOB template and check run are subject to quality audits. EOB audits are performed once per check run within two weeks from the day the EOBs are generated. When an EOB is not available from one of the categories, an extra EOB will be audited from the previous or next category.

Denial Letter Audit. At least one denial letter per unique denial letter template (also known as the denial letter number) per check run are subject to quality audits. Denial letter audits are performed once per check run within two weeks from the day the denial letters are generated. Audit results are used to identify opportunities for training and improving processes. Audit results are stored on a designated network drive that is available to designated colleagues.

The director of quality assurance and recovery and the claims manager ensure audits are conducted in accordance with this policy. The quality analysts and database management manager review and monitor system adjudicated claims quality. The director of quality assurance and recovery and the director of

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business services meet quarterly to review and ensure that tickets are tracking, and proof of training or process changes have occurred to resolve error findings.

Training and Process Improvement. Audit results are used to identify opportunities for training and improving processes. Department results are reviewed by the director of business services, and any opportunities for quality improvement and training are discussed with the claims manager. The claims manager identifies and discusses additional training needs with each claims examiner who fails to meet the minimum quality standards. The claims manager completes a corrective action plan for each claims examiner who fails to meet the minimum quality standards for three consecutive months.

CVS Health (Pharmacy)

CVS addresses potential provider payment issues such as over- or underpayment via an audit process with edits taking place in real time before a claim is paid. Their audit program includes:

- **Onsite Audits.** CVS routinely conducts pharmacy onsite field audits throughout the United States and Puerto Rico.
- **Investigational Audits.** Investigational audits can be more complex. Pharmacies may be selected for an investigational audit in the following situations: if the Pharmacy Performance department's analysis indicates irregularities, if CVS receives a client referral, or if a tip is received from a regulatory agency, Enrollee, provider, or client. The Pharmacy Performance department management then determines which of the following actions may be appropriate:
  - Onsite inspection of pharmacy documentation
  - Contacting the prescriber-of-record for validation
  - Contacting the Enrollee for validation of receipt of drugs
  - Invoice audits
- **Desk Audits.** All participating pharmacies (100%) will be subject to CVS' Desk Audit process, which will audit for erroneous billings through four offsite teams: Daily Review, Compound Claim Audits, Medicare Part D, and Enrollee-submitted Paper Claim Audits. Each team will have its own processes to confirm that claims are properly submitted by the pharmacy or Enrollee.

The following components will comprise CVS' Desk Audit process:

- **Daily Review.** The Daily Review Claims Report will be reviewed for reasonableness of—and consistency in—quantity and dosage. Keying errors are usually the source of incorrectly entered quantities, days' supply, or National Drug Code numbers. When an error is suspected, a phone call will be placed to the pharmacy and the error will be corrected by reversing the claim and subsequently retransmitting the correct and appropriate data.
- **Compound Claim Audits.** High-dollar compound claims and compound claims submitted with abnormal quantities or dosages will be audited daily as a supplement to the system edit process, focusing on the reasonableness of quantity and dosage.
- **Medicare Part D.** Part D claim audits will be conducted to maintain compliance with specific CMS regulations and guidance. These include audits related to hospice, End Stage Renal Disease, invalid prescriber identification, and potential duplicates with Medicare Part A or Part B.
- **Enrollee-submitted Paper Claim Audits.** Enrollee-submitted paper claims with abnormal quantities and/or prices will be audited for validation.
- **Audit Analytics and Procedures.** The Pharmacy Exceptional Activity Report (PEAR), an automated quarterly statistical review, will be used to assist in the selection of pharmacies to be audited. The analysis will identify unusual or improper pharmacy behavior and possible noncompliance with program parameters.

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The PEAR measures criteria and ranks pharmacies based on where their actual claim activity falls within the parameters of an expected norm for their peer group. The content of the PEAR is flexible and can be modified to address changes in claims activity, dispensing patterns, market trends, and the results of CVS' monitoring efforts.

A pharmacy will be targeted for a field audit if CVS' analysis indicates a potential problem, or if referrals or tips are received from Enrollees, providers, or clients. Onsite audits may include the following procedures, as deemed appropriate:

- Inspecting available pharmacy documentation
- Contacting the prescriber-of-record to validate claim data submitted for payment

During an audit, each claim submitted within the audit time frame (generally 12–18 months) may be examined. Each claim must be supported by:

- A prescriber's order authorizing the dispensing of the medication
- Evidence the medication was dispensed in accordance with the prescriber's order and within client benefit plan guidelines

Pre-audit planning will include a systematic review of the claim history to identify claims meeting specific criteria of concern. The entire claim record, as transmitted by the pharmacy and adjudicated by CVS, will be made available at the audit site. Auditors will use the claim record and other information obtained at the pharmacy during the onsite audit and, as necessary, initiate prescriber and Enrollee verification letters.

CVS will provide the pharmacy with a written report listing potentially discrepant claims, along with guidelines for documenting discrepancies within two weeks of the onsite testing or desk audit. The pharmacy will be given at least 30 days to respond, in writing, with proper documentation to support the claims in question. If documentation is not submitted or is unacceptable, the money will be collected from the pharmacy and returned to the client as a credit on the client's invoice.

CVS' audit function is designed to be educational. Auditors provide the pharmacies with tools to assist in the prevention of repeated problems, and answer questions about CVS, inform pharmacists about CVS programs and policies, and alleviate pharmacists' concerns. In addition, audit findings are provided to their retail pharmacy network, so they may place edits in their systems to prevent overpayments from occurring.

State laws and provider contracts serve as critical tools in supporting CVS' right to access and inquiry. Pharmacy Performance personnel conduct each audit in a manner consistent with the laws of the respective states, and within plan guidelines.

Education and Communication. Dedicated CVS account managers in CVS' Network department are assigned to chain pharmacies and groups of independent pharmacies. The close relationships developed by the account managers help improve communications between CVS and their provider networks. To improve the quality and efficiencies of retail pharmacies in their networks, CVS attends annual chain, affiliation, and industry trade shows to help educate pharmacies on their performance in CVS programs. CVS performance reporting to pharmacies helps identify pharmacies that need to improve their performance. In addition, they hold performance reviews with chains and affiliations to proactively identify performance deficiencies. These pharmacy performance reviews occur twice a year, or more frequently as needed.

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b.iii. PROPOSED AVERAGE DAYS TO PAYMENT

Molina Proposed Average Days to Payment (Medical)

We understand that prompt claims payment is important to our providers and critical to both recruiting and retaining network providers. ***The enterprise-wide average turnaround time for payment on clean claims is 10.6 days***, which includes all claims receiving secondary quality review. States engaging in claim quality review cycles can elect to have claims held and validated for payment accuracy. Although the additional review before finalizing the claims payment to the provider contributes to longer turnaround times, participating states experience higher accuracy rates and lower appeal rates. Our affiliated health plans' experience in secondary quality review has demonstrated elevated accuracy scores because of this process.

For Kentucky Medicaid, our proposed average days to payment is in line with our current average turnaround-time for new implementations, which is 10 days. Given the technology, reporting, and auditing capabilities at Molina, the expectations for Kentucky are in line with the enterprise-wide results. Our Provider Payment Turnaround Time Report for 2019 is shown in Exhibit C.19-5.

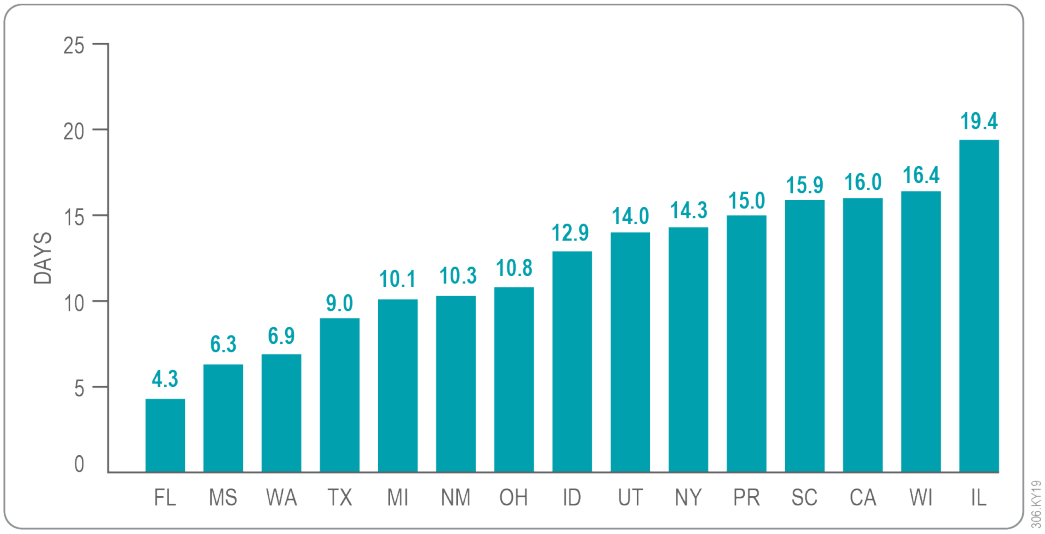

Exhibit C.19-5. 2019 Provider Payment Turnaround Time Report

Subcontractor Proposed Average Days to Payment (Pharmacy)

For Kentucky Medicaid, CVS Health's proposed average days to payment is 11 days. Their Provider Payment Turnaround Time Report for 2019 is shown in Exhibit C.19-6.

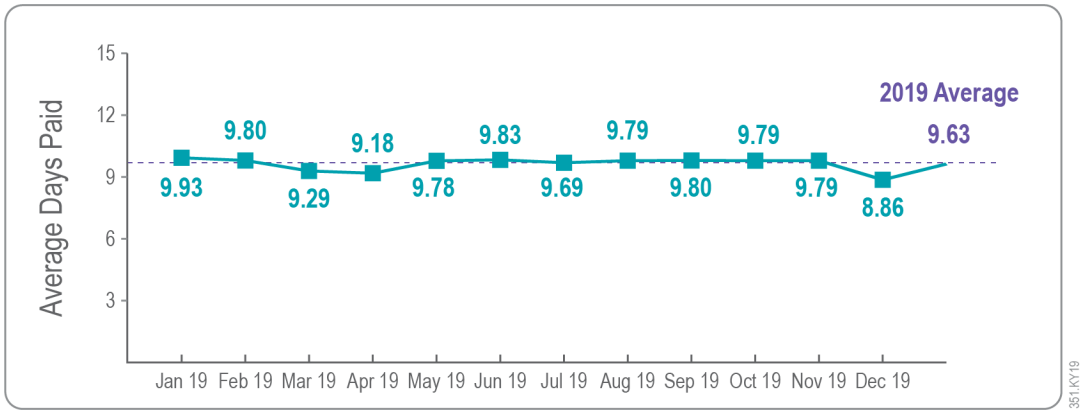

Exhibit C.19-6. CVS Health Provider Payment Turnaround Time Report 2019

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c. METHODOLOGY FOR ENSURING CLAIMS PAYMENT ACCURACY STANDARDS

We will use various reporting tools, including our Claims Key Performance Indicators (KPI) Dashboard and additional in-house applications to manage claims inventory, speed, and accuracy. Our Claims Management team will monitor claims inventory through this dashboard and supplemental KPI reports available through PowerBI, which will be run daily to monitor claims activity and processing to ensure accurate, timely adjudication. Exhibit C.19-7 shows our Claims KPI Dashboard home screen and the available reports for data management, and Exhibit C.19-8 illustrates a sample report.

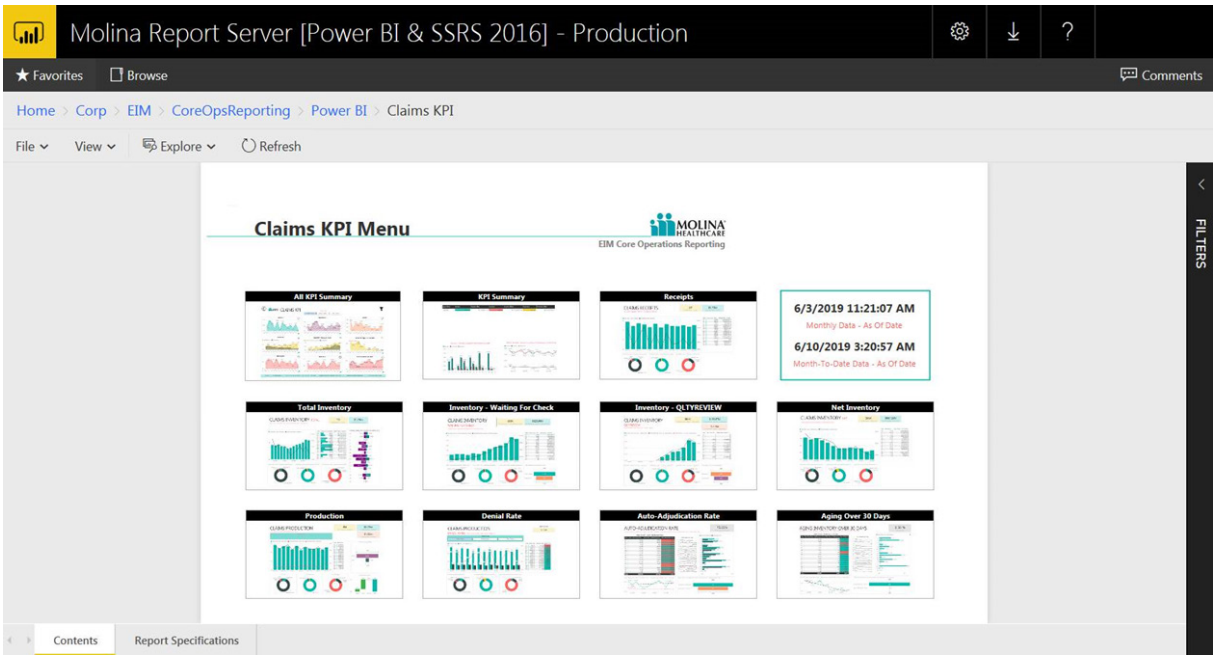

Exhibit C.19-7. Claims KPI Dashboard Home Screen

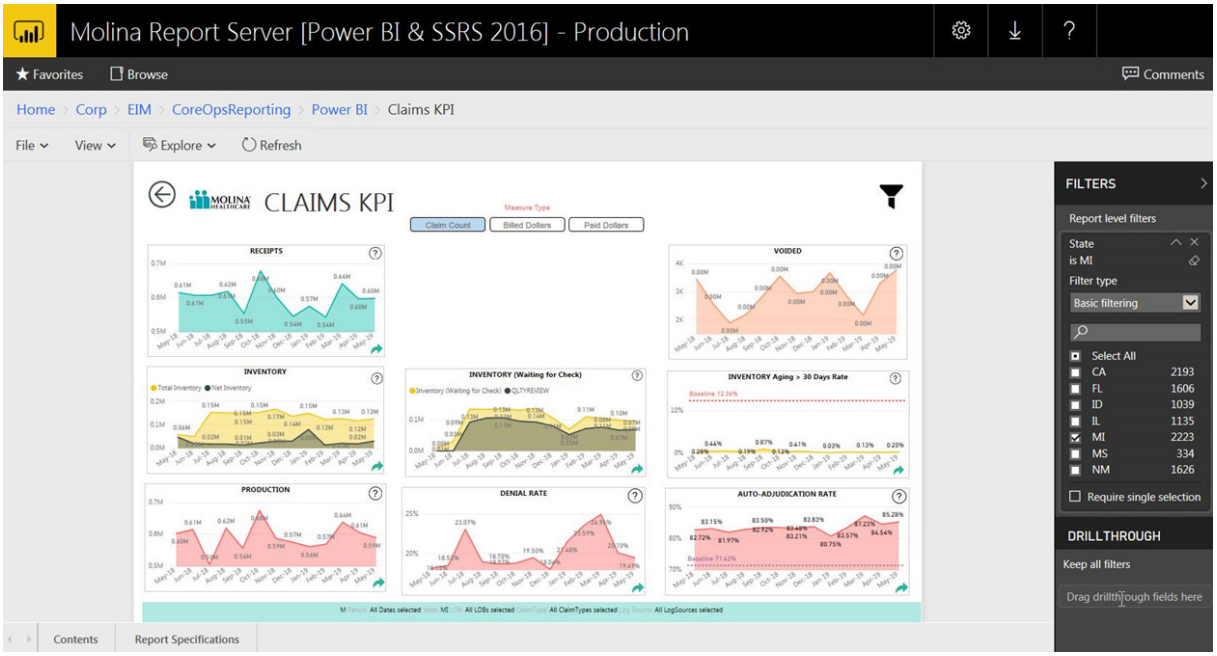

Exhibit C.19-8. Claims KPI Dashboard Sample Report

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Our team also will use proven processes and procedures to ensure all claims are adjudicated in an accurate and timely manner. We will enable both standard compliance and ad hoc reporting to meet timeliness standards and conduct mock compliance and quality audits to ensure payment accuracy. Table C.19-2 summarizes our affiliated health plan performance related to quality and financial incident accuracy.

Table C.19-2. Quality—2019 Financial and Statistical Payment Accuracy

State	Financial Payment Accuracy	Statistical Incident Accuracy
South Carolina	99.8%	99.2%
New York	99.7%	99.6%
Ohio	99.7%	99.1%
Wisconsin	99.7%	99.0%
Florida	99.5%	99.3%

ACCURACY AUDIT SAMPLING METHODOLOGY

Claims accuracy will be validated via our claims audit process. All claims adjudicated to pay greater than $25,000 will be reviewed daily by the Claims Leadership team for accuracy before payment. Our Claims Audit unit completes post-pay reviews for all Medicaid claims with billed charges greater than $40,000. Additionally, all new claims processors will have mandatory pre-pay audits on 100% of all claims processed for a minimum of three months. After this probationary period, processors will be transitioned to our standard post-payment audit procedures. These regular audits will be conducted on a random selection of system and manually adjudicated claims for a statistically valid sample size, providing a 95% confidence rate with a +/-5% margin of error. Our audit sampling thresholds are based on industry best practices and are applied to all processing units, including internal and external teams, for new, adjusted, and recovered claims.

PROCESS FOR AUDITING THE SAMPLE

The claims audit process will start with audit leadership distributing high-dollar (pre-payment) and random (post-payment) claims that have been adjudicated by the Claims teams to the audit staff. The claims auditor will review the claim details for accuracy of payment per provider contract and policies and procedures. Once the claims have been reviewed, audit findings will be communicated to leadership and examiners for coaching.

Claims Audit Tool (CAT.NET) is a third-party application that applies 30 filters when pulling claim samples. Filters include billed and approved amount, service code, claim age, and examiner, and it allows auditors to review random claims. Sample claims and supporting documentation will be compared to ensure proper processing. For each, the following will be tested for accuracy: data entry (that is, data entered correctly in the claims system vs. the claims image), Enrollee eligibility, contracted rate corroboration, proper authorization, duplicate payment, appropriate application of denial reason, correct application of modifier codes, documentation of other insurance considered, and proper coding, including bundling/unbundling.

Regular internal audits will ensure performance requirements and accuracy standards are met. Audits will include verification of payment accuracy against provider contract terms and adherence to regulatory and internal guidelines and policies and will ensure all reimbursement requirements are implemented per our Contract. Vendors also will provide post-payment reviews and inpatient hospital bill and diagnosis-related group validation audits. We also will use Health Management Systems to conducts post-payment reviews of professional and outpatient data mining to identify incorrectly paid claims.

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DOCUMENTING RESULTS

Audit results will be captured in the CAT.NET tool, submitted via reporting to Claims leadership, and logged in the Examiner Coaching website (based on audit type). Rebuttals to the audit process also will be detailed in the CAT.NET application to ensure appropriate accounting for accuracy standards. Audit result data will be tracked via the Audit Results Weekly Dashboard as shown in Exhibit C.19-9. This dashboard will track both high-level reporting groups and processor-/error-level details.

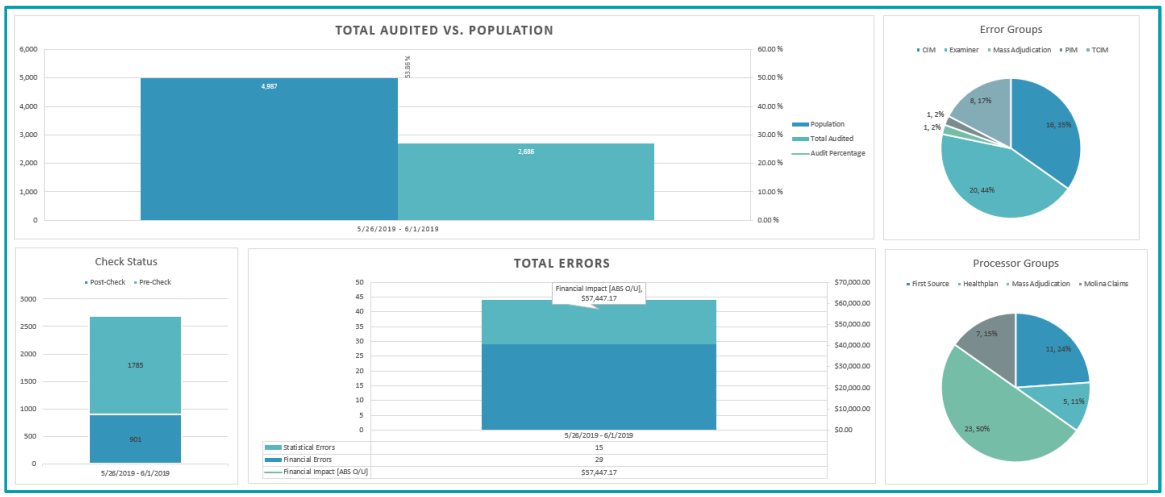

Exhibit C.19-9. Example of Audit Results Weekly Dashboard

ACTIVITIES CONDUCTED TO IMPLEMENT CHANGES OR REQUIRED CORRECTIVE ACTIONS

If the claims processor does not meet denial, financial, or statistical accuracy requirements for total claims processed, progressive coaching and corrective action will be implemented to remediate performance. Coaching will include additional training and pre-pay focal audits to ensure claims accuracy before payment. If performance does not improve, the processor will be placed on a performance improvement plan—a set of explicit goals given to an employee with the intention of improving their level of performance. By laying out clear expectations, employees will know what is required of them and they will have the opportunity and guidance necessary to improve.

Additionally, Molina will take a two-pronged approach to remediation of claims processing errors. In an ongoing effort to reduce manual errors in claims processing, we will prioritize continual automation and system enhancement. By trending errors for claim type and provider type, we will focus on specific enhancements to our robust systems and application, directly increasing payment consistency by increasing the number of system-adjudicated claims. Recent solutions designed to increase automated adjudication include automated nursing facility pricing, system calculated reductions for multiple procedures, custom interest calculator, and systematic sequestration application. Through this approach, Molina has continued to increase accuracy, reduce rework, and exceed turnaround time requirements in our affiliated health plans.

IDENTIFYING AND ADDRESSING DEFICIENCIES AND VARIANCES

Reports will be used to identify deficiencies or issues with individual claims or across the claims processing and payment system. Our Claims Management team will assess deficiencies and develop a corrective action plan to research, resolve, and report back to team leadership on the resolution of identified deficiencies. A cross-functional Research and Resolution team also will identify root causes to proactively reduce under- and overpayments. This team will include individuals with end-to-end work experience who will focus on identifying and implementing more efficient claims processes. They will work closely with other functional teams (such as the centralized provider telephonic and Web portal teams) to understand common payment inquiries and concerns.

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