C.26 Program Integrity

REQUIREMENT: RFP Section 60.7.C.26

26. Program Integrity (Section 36.0 Program Integrity)

a. Provide a detailed summary of Contractor's proposed Program Integrity plan, including a discussion of the following:

 i. The Contractor's fraud and abuse detection/prevention program activities for employees, caregivers and providers, including reporting and follow-up, continuous monitoring of compliance, identification and reporting of issues to all required parties, and ongoing training.

 ii. An overview of the Regulatory Compliance Committee.

 iii. The proposed appeals process.

 iv. Proposed innovations for reporting data in the Program Integrity area. Provide examples of successful innovations implemented in Kentucky or other states.

b. Describe the Contractor's proposed approach to prepayment reviews.

> **Molina will deliver a modernized best-in-class approach to program integrity that will reduce fraud, waste, and abuse and costs.**

The Commonwealth clearly and appropriately places a high priority on anti-fraud, waste, and abuse measures and payment integrity efforts. Molina shares a similar proactive approach to program integrity by using aggressive programs as outlined below. Our comprehensive Program Integrity plan will drive effective prevention and proactive detection resulting in improved cost containment through recovery of overpayments and cost avoidance measures. Molina is best positioned to move the Commonwealth forward in both payment integrity and the successful pursuit of additional fraud, waste, and abuse recoveries.

Cost Avoidance and Recovery Success

• **$946.1 million saved in 2018**

• **$1.1 billion saved in 2019**

As part of our continued commitment to ensuring claims are paid accurately by the responsible party, Molina is consistently improving our Program Integrity plan to leverage best-in-class technology including data mining, machine learning, data scientist analysis, data lake, and interactive analytics. Our enterprise-wide program integrity processes for cost avoidance and overpayment recoveries have saved our Medicaid managed care programs across 15 states $946.1 million ($317.85 per member per year) in 2018, and $1.1 billion ($386.55 per member per year) in 2019.

a. MOLINA'S PROGRAM INTEGRITY PLAN

Molina's comprehensive Program Integrity plan consists of a coordinated approach to *payment integrity, fraud, waste, and abuse, and compliance.* Molina understands, agrees, and will comply with all requirements set forth in Attachment C, Draft Medicaid Managed Care Contract and Appendices, Section 26, Program Integrity. If the Department changes its program integrity activities, Molina will provide a new or revised program within three months.

CENTRALIZED SPECIAL INVESTIGATION UNIT (SIU)

Our Kentucky-based Program Integrity unit will include *at least two local full-time staff who will be dedicated 100% to the Kentucky Medicaid program.* They will have a minimum of three years of Medicaid fraud, waste, and abuse investigatory experience for Kentucky Medicaid-related work.

Our Kentucky-based team will be supported by Molina's SIU at our corporate headquarters. Our centralized SIU and workforce management approach positions us at the forefront of trends and allows us to share best practices across all the states in which our organization operates. We consistently and expeditiously apply standardized processes to ensure we identify and act upon fraud, waste, and abuse.

Our highly qualified and dedicated team uses comprehensive data analysis to monitor anomalies and outliers in all Molina affiliated health plans as well as trends throughout the healthcare industry. Our SIU will regularly update our best practices to best serve the Kentucky Medicaid program. **On a day-to-day basis, our Louisville-based chief compliance officer will work closely with the SIU to monitor and oversee Molina program performance and compliance.**

To most efficiently support Molina's program integrity activities, we use a workload balancing system where staff from other Molina affiliate offices will assist the Kentucky SIU team, as needed. Staff in both locations will execute investigative activities. Although data analytics activities are primarily performed nationally, **our Kentucky-based Program Integrity unit staff and chief compliance officer will be the primary contact with the Department** and maintain Kentucky-specific referrals of fraud and abuse; perform investigations; conduct quarterly onsite visits; and attend required Commonwealth program integrity meetings and trainings.

Best-in-class payment integrity. Our approach to payment integrity includes partnerships with strong and technologically advanced vendors to ensure claims are paid accurately, and the Commonwealth can immediately realize additional benefits and cost savings through reduced fraud and abuse. Molina will continually assess enhancements to our code editing practices to ensure we are optimally positioned to pay claims in accordance with both Commonwealth and federal coding guidelines, help avoid inappropriate payment of claims, and promote effective deployment of solutions to emerging schemes and billing abuse practices.

CROSS-FUNCTIONAL COORDINATION AND COMPLIANCE

Molina's Program Integrity plan comprises complementary programs and incorporates the **Compliance Plan; Anti-Fraud, Waste, and Abuse Plan; and SIU Annual Audit Work Plan** that will work in tandem with each other. From an oversight perspective, program integrity at Molina will be administered through Molina's Kentucky-based Compliance department. Payment integrity is a subpart of program integrity and will be overseen by our parent's Payment Integrity Office.

The **Payment Integrity Office** oversees and is responsible for payment integrity activities including pre-payment, front-end code editing, pre- and post-payment audit work (such as coordination of benefits [COB], subrogation, third party liability [TPL], and diagnosis-related group [DRG] hospital bill reviews), overpayment recoupment and collection activities, and SIU investigative activities into fraud, waste, and abuse.

Our Program Integrity plan reaches enterprise wide and involves disciplined coordination and cooperation between departments. Our **Payment Integrity Executive Oversight Steering Committee** develops, implements, and maintains payment integrity best practices across the enterprise. It includes subject matter experts from a variety of departments, such as Compliance, Claims, SIU, Healthcare Services, Quality Improvement, Provider and Member Services, and Delegation Oversight. On a day-to-day basis, our Louisville-based chief compliance officer will work closely with the SIU to monitor and oversee program performance and compliance.

Other departments also play a key role in prevention and detection, including Claims and Operations, Healthcare Services, Quality and Auditing, Grievances and Appeals, Data Collection, Provider Enrollment/Disenrollment, Provider Services and Contracting, Encounter Data, and Marketing. By providing feedback to the Payment Integrity Office and SIU of potential trends and patterns they may notice within their daily operations, these teams collaborate on ways to best mitigate issues effecting over/underpayments or potential fraud, waste, and abuse, removing silos across the enterprise. For a detailed overview of the key interactions and objectives of our cross-functional Program Integrity plan, please see Exhibit C.26-1.
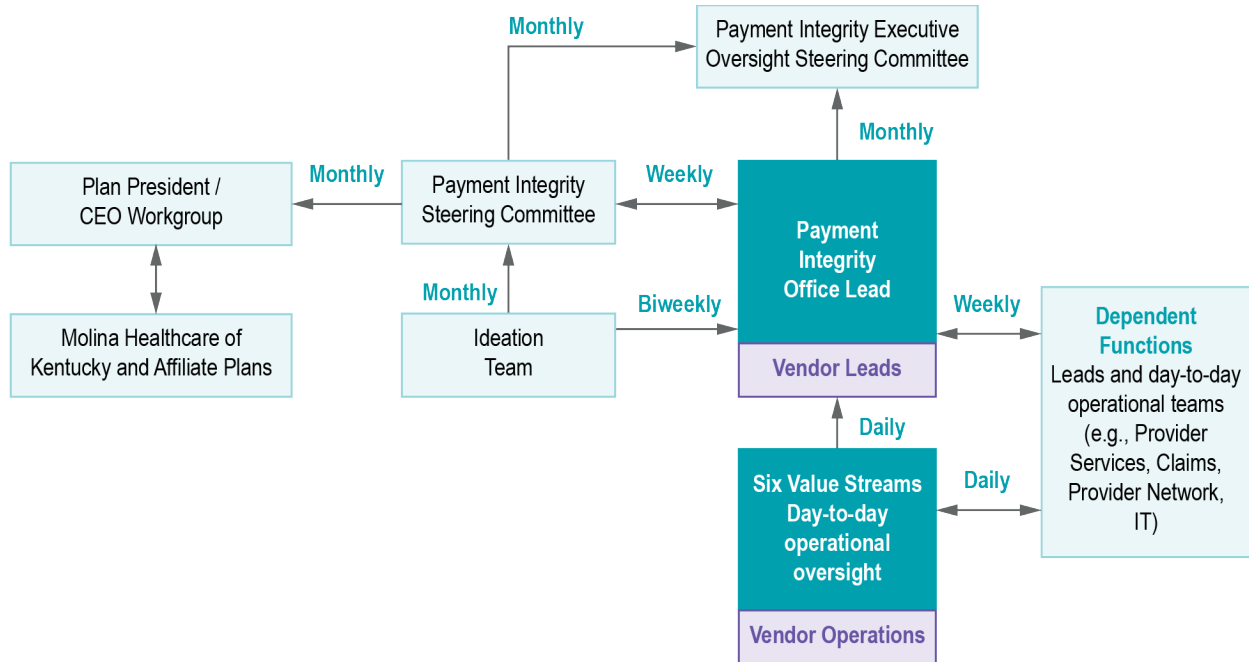
Key Interactions / Objectives

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

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Exhibit C.26-1. Molina's Coordinated Approach Drives Program Integrity Activities

PROGRAM INTEGRITY AND SUBCONTRACTORS

Molina will require subcontractor participation in program integrity requirements and hold them responsible for appropriate screening of their staff and employees against Commonwealth and federal sanction lists, including the Office of Inspector General (OIG) List of Excluded Individuals and Entities List as well as the System for Award Management (SAM) list. Our written subcontractor agreements require that the OIG and SAM lists are reviewed prior to hiring staff and monthly thereafter. Subcontractors will be required to report any positive matches of their staff within five business days of identification.

a.i. FRAUD AND ABUSE DETECTION/PREVENTION PROGRAM ACTIVITIES

Our philosophy is that prevention of fraudulent, wasteful, and abusive events is the most efficient and effective way to combat fraud, waste, and abuse. As part of this philosophy, we will proactively educate and encourage Enrollees/caregivers and providers to recognize and promptly report suspected instances of fraud and abuse. We also will use advanced analytic detection systems, including pre- and post-payment review measures, to actively detect, monitor, report, and communicate issues to all requiried parties.

Advanced Systems Measures

We will apply an extensive array of *prepayment review measures* including claim edits, system setup validation, pre-payment reviews, and claims process improvement based upon monthly trend analysis of leading and lagging quality indicators.

Our success in avoiding fraud and abuse before payment has led to increased claims processing accuracy and better trending of questionable billing practices. We will apply refined processes to screen providers, subcontractors, and employees against Commonwealth and federal exclusions lists at the onset of initial contracting and monthly thereafter to prevent erroneous payment to excluded providers including those who have been debarred or suspended from participating in government programs. We also will gather information on entities that have 5% or more ownership or control of a contracted provider. Table C.26-1 describes additional preventive measures Molina will employ.

Table C.26-1. Preventive Measures to Reduce Fraud and Abuse

Measure	Molina Activity
Fraud and Abuse Reporting	We will encourage anonymous, good faith reporting of suspected fraud and abuse through our dedicated, toll-free 24/7 AlertLine or online through our dedicated, secure website.
Pre-payment Reviews	We will ensure accurate reimbursements based on medical policy, coding accuracy, and contract adherence. We will apply an initial set of edits in QNXT, our core processing system, for pre-adjudication analysis followed by a secondary electronic comparison against local and national edits before releasing claims for payment. Our controls will include suspected medical expense leakage to identify waste trends. Pre-payment prevention and post-payment audit reviews will address improper coding and billing errors. Post-payment review thresholds are on average $4,000. National correct coding initiative rules will ensure claims are coded per Commonwealth and federal coding guidelines.

Follow-up and Continuous Compliance Monitoring

As all instances of fraud and abuse cannot be prevented, it is critical to employ processes that *retrospectively detect and address instances* that may have already occurred. Allegations of potential fraud and abuse will be addressed by our SIU, which investigates suspected cases. Our SIU also will conduct post-payment reviews using a fraud analytics system that employs multiple algorithms to identify billing outliers and aberrant service patterns, potential areas of overutilization or underutilization, changes in billing behavior, and possible improper schemes. The SIU will perform data matching, trending, and statistical analysis to enable peer-to-peer comparisons for cost, service type, and diagnosis type. Post-payment data mining is completed, and system configurations are updated to recover overpayments. The SIU also will conduct investigations and mine claims data to *identify, prevent, and report suspected fraud, waste, and abuse committed by network and out-of-network providers, Enrollees, caregivers, employees, or other third parties.*

As described in Table C.26-2, we will employ a full suite of processes to retrospectively detect and pursue fraud, waste, and abuse.

Table C.26-2. Extensive Post-payment Measures Driving Detection and Recovery

Measure	Molina Activity
Post-payment Reviews	• Categories include SIU investigations; COB / TPL / subrogation / mass tort law; hospital DRG and bill audits; facility credit balance collections; post-payment claim reviews (coding, duplicates, retro terms, fee schedule, and contract rate adjustments); PBM-initiated audits; pharmacy claim accuracy and utilization reviews; and outlier and predictive analytics. • Our Claims Audit unit will perform audits on claims to ensure the quality and accuracy of payments and denials.

Measure	Molina Activity
	• Random post-payment audits will be conducted on a statistically valid sample of auto-adjudicated claims processed by our PBM. • Trends and patterns identified as credible by Molina or vendor partners will be referred to the SIU for review and investigation.
SIU	• Our SIU will conduct post-payment reviews using a fraud analytics system that employs multiple algorithms to identify billing outliers and patterns, overutilization and underutilization, and billing behavior trends. It will conduct peer-to-peer comparisons for cost, service type, and diagnosis to identify outliers that warrant further investigation, matching medical and pharmaceutical transactions for reasonableness. • We will dedicate two full-time employees to serve as SIU investigators at our Kentucky-based Program Integrity unit and conduct at least three onsite audits per quarter. • We will perform risk assessments to drive leads, which will be vetted to determine whether a provider's activity warrants further action. • We will maintain a tip AlertLine system for confidential referrals to the SIU, whereupon the SIU will conduct a preliminary investigation and triage to determine if evidence supports the allegation. An extensive investigation will be conducted if deemed necessary to resolve the allegation. • Our PBM will conduct weekly onsite and offsite audits to identify potential fraud, waste, and abuse.

Identifying and Reporting Issues

Molina will proactively collaborate with numerous parties and sources to identify instances of fraud, waste, and abuse. We will use our extensive contacts within this network to gain information that informs our investigative work. Sources will include:

- Molina's fraud AlertLine
- Internal and external sources such as staff, providers, and Enrollees
- Industry share groups, including the National Health Care Anti-Fraud Association
- State Medicaid agencies and Medicaid Fraud Control Units
- Healthcare investigator forums
- Association of Certified Fraud Examiners
- Internal data analytics

When there is evidence to support an allegation, the SIU will report the issue to the appropriate state regulatory agency or Medicaid Fraud Control Unit and collaborate with them and law enforcement to resolve the matter. For matters not accepted for investigation by the Office of Program Integrity and law enforcement, the SIU may also take administrative actions against providers, including pre-payment review and placing the provider on a corrective action plan, which have proven to be effective tools in deterring and preventing further inappropriate payments to providers. The following examples highlight the SIU's retrospective and investigative audit work for our affiliated health plans:

- The SIU's investigative audit work identified aberrant volumes of a Texas provider's claims for ongoing occupational therapy support services to assist members in maintaining employment. The SIU ultimately identified members who were institutionalized or bedridden, and therefore, not capable of being employed. The investigation concluded services were not rendered and referred the case to the state OIG. *We recovered overpayments of approximately $1.2 million in conjunction with the audit.*

- The SIU's investigative audit, driven from data analytics of high-volume providers under specialty services, identified potential overutilization of chemotherapy services and misrepresentation of

services at a Michigan provider. The SIU reviewed detailed medical records and concluded the records did not identify who was administering the chemotherapy, hydration fluids, adjunct therapy, and subcutaneous injections. The SIU determined that a medical assistant had signed off on all charts for the preparation of the mixture as well as the administration of the chemotherapy, which was outside their scope of practice (i.e., not performed by a nurse/pharmacist/physician as billed). During the appeal, the provider was found to have fabricated and altered originally submitted documents to support the billing. The case was referred to the state OIG. *We identified and recovered overpayments of approximately $754,000.*

- The SIU's investigative audit, driven by data analytics, identified outlier providers billing allergen immunotherapy services in excess of Medically Unlikely Edit guidelines. Providers were found to be billing up to 10 times the maximum number of daily units allowed. Interviews with a top biller indicated a complete lack of training and education on billing protocols. We required a corrective action plan from the provider on their plan to remediate aberrancies pending further participation. *We referred the case to the Department of Insurance and recovered approximately $1.6 million in overpayments.*

Communicating with the Department

Molina will submit our annual plan to the Department for prior approval. Our chief compliance officer will participate in compliance discussions with the Department before implementing initiatives and processes, including best practices and mandates for program compliance. We also will meet quarterly, or as often as necessary, with the appropriate state regulatory agency or Medicaid Fraud Control Unit to exchange information related to potential cases and/or current investigations. We will provide assistance to the Department in any investigation or prosecution of fraud to include assistance with law enforcement agencies. This will include providing access to computerized data we store as requested by the Department. We will provide access to any information possessed or maintained by the provider to which both Molina and the Department are authorized to access. As an organization, we will participate and engage in a number of regulatory program integrity meetings and initiatives in other states, which will expose us to relevant, emerging trends that we will apply to our Program Integrity program, enabling us to share best practices with the Department.

Reporting suspected Fraud and abuse

Molina will use several mechanisms to encourage anonymous, confidential and private, good faith reporting of instances of suspected fraud and abuse. Molina will maintain confidential reporting mechanisms that Molina employees, Enrollees/caregivers, providers, vendors, subcontractors and first-tier downstream and related entities can use to report suspected fraud and abuse. Individuals can call the *Molina Healthcare AlertLine* to report suspected fraud and abuse. The hotline will be available 24/7 and can be reached at any time (day or night), over the weekend, or even on holidays. We also will offer online reporting at https://molinahealthcare.AlertLine.com.

Molina employees can also report issues of concern directly to their supervisor, the Compliance department, or the Legal department.

Educating Employees, Enrollees/Caregivers, and Providers

Fraud, waste, and abuse education is key to Molina's prevention activities. Molina will provide education for all employees, Enrollees/caregivers, and providers on how to recognize, detect, prevent, and report suspected fraud, waste, and abuse.

Employees. All Molina employees and departments are responsible for identifying and reporting suspected fraud, waste, and abuse. In accordance with Molina's anti-fraud and Deficit Reduction Act policies, employees must complete anti-fraud training, which includes reporting, through Molina's iLearn system within 90 calendar days of employment and annually thereafter. We augment this training by

posting monthly articles on fraud, such as red flags and schemes, to Molina's home page for employees to learn from.

Enrollees/Caregivers. We will raise awareness among Enrollees/caregivers through the Enrollee Handbook, which will contain specific instructions for reporting suspected Enrollee and provider fraud and abuse to Molina. Molina's Enrollee website will provide Enrollees with the definitions of fraud and abuse, the False Claims Act, examples of healthcare tips for preventing fraud and abuse, and specific instructions for reporting suspected fraud and abuse to Molina. Additionally, Enrollee, marketing, and advertising materials will be reviewed to ensure they are complete and accurately reflect information about fraud and abuse.

Providers. As part of orientation, providers will receive education on fraud and abuse as found within their Provider Manuals. Each manual will include information on the Deficit Reduction Act, False Claims Act, and fraud, waste, and abuse. We also will identify providers who have received $5 million or more in Medicaid funds from the health plan and notify these providers of their obligation to abide by the Deficit Reduction Act.

Ongoing Training

Molina will provide effective, ongoing training and education for our chief compliance officer, senior management, employees, subcontractors, providers, and Enrollees/caregivers to meet all federal and Commonwealth standards and requirements under the Contract. Ongoing training will address and reinforce:

- The impact of fraud, waste, and abuse on healthcare
- The definitions of fraud, waste, and abuse
- The Deficit Reduction Act and federal False Claims Act
- The Anti-Kickback Statute
- Employees' obligations to report potential fraud and abuse
- The "Whistleblower Provision" and what it means
- Molina's policy on non-retaliation for reporting potential fraud
- How to report suspected fraud and abuse

All employees will be required to complete a post-test through iLearn. Employees must pass the post-test with a score of 100% to receive credit. Employees who fail the post-test must continue to retake the exam until achieving a passing score.

The Compliance department will maintain electronic reports of employee training completed via iLearn to track compliance with Molina's training requirements. Training reports will be maintained for 10 years. Additional training logs will be maintained for advanced training delivered by Compliance staff. These training logs will include the name and title of the trainer; date, time, and location of training; subject matter; and name of the employees attending the training.

Molina's commitment to employee training also will include wall posters placed in conspicuous places that provide information regarding which types of information may be reported to Compliance as well as internal and external Compliance Hotline numbers.

a.ii. OVERVIEW OF REGULATORY COMPLIANCE COMMITTEE

Our chief compliance officer will reside in Kentucky and have ultimate responsibility for carrying out our Program Integrity plan and oversight. The chief compliance officer will report directly to our Kentucky chief executive officer and additionally report directly to our Kentucky Board of Directors.

Molina's Regulatory Compliance Committee and chief compliance officer will approve our Kentucky Program Integrity plan. Because program integrity activities are an important pillar of Molina's Compliance Plan, the SIU's Fraud, Waste, and Abuse Plan is treated as an extension of the Compliance

Plan. Molina's fraud, waste, and abuse program is supported by an annual audit work plan. Because this work is fluid and must be adjusted as needed, both the Fraud, Waste, and Abuse Plan and SIU Audit Work Plan reside outside of Molina's Compliance Plan, so they may be updated as necessary when business requirements or internal policy, structure, process change or new risk has been identified and must be addressed.

Roles and Responsibilities of the Regulatory Compliance Committee

Molina's Kentucky Regulatory Compliance Committee will report to the Board of Directors. It will consist of our entire Executive Leadership team, from which one member will sit on our Kentucky Board of Directors. Each leader who reports to the chief executive officer will be a voting member; therefore, every business and operational unit within Molina will be represented.

Chaired by our Kentucky-based chief compliance officer, the committee's main responsibility of the committee is to support the Compliance program at every level of the organization. As members of the Executive staff, they will set expectations to help employees throughout the organization understand Molina's culture of compliance and their role. For example, it is every employee's job to ask questions and report concerns related to suspected fraud and abuse without fear of retaliation. They are accountable to do their jobs with a high level of integrity and ethics, and they must report and work to effectively and efficiently fix problems as soon as they are discovered. They must recognize that inaction is not acceptable and that Molina employees are expected always to provide high-quality services to our Enrollees, providers, community partners, regulators, and taxpayers.

The committee members will be responsible for the oversight of the Compliance and Program Integrity programs and accountable for operationalizing compliance within the organization and remediating risk and deficiency without delay.

The committee will meet no less than quarterly to review and approve Compliance and Program Integrity plans as well as policies and procedures. The committee also will:

- Oversee corrective action plans, performance on key performance indicators, and internal and external audit results
- Receive and review reports on the following topics: under/overutilization, claims submission and billing, monitoring for prohibited affiliations, theft or embezzlement, trends in AlertLine reporting, SIU operations and recovery, new contract requirements, compliance risk, training and education, and non-compliance actions received by Molina
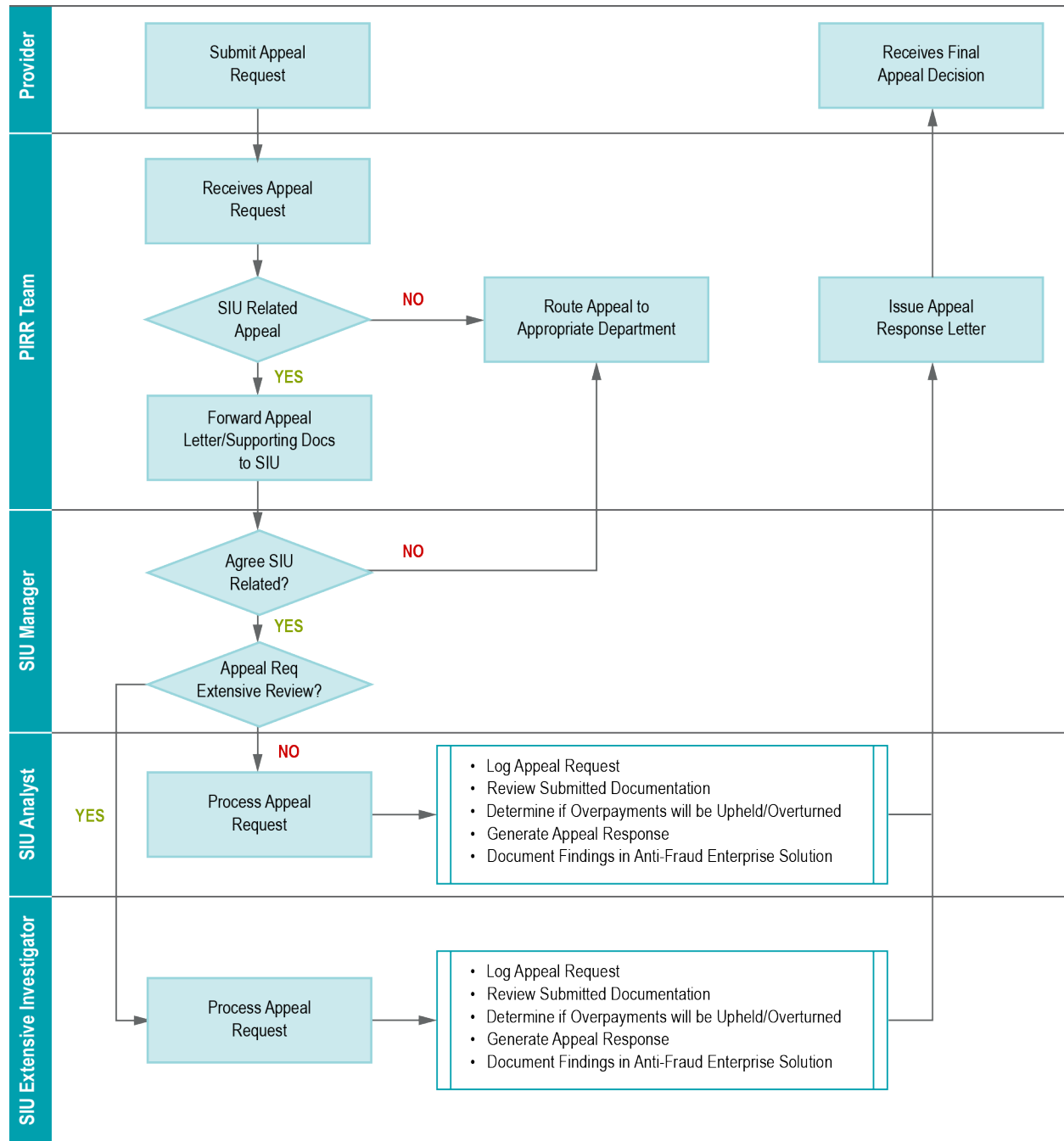
a.iii. APPEALS PROCESS

When providers enter into a contract with Molina, our provider services team works closely with each contracted provider to ensure they have a complete understanding of the grievance and appeals processes. We include a description of the process is included in the Provider Manual, which is published on the public portion of the Molina website.

Molina's Program Integrity unit will have a grievance and appeals process for Enrollees and providers in accordance with 907 KAR 1:671. We will inform providers of our appeals process in the written audit findings letter. The SIU will instruct providers, via the overpayments letter, that they may file a formal appeal through the health plan if they disagree with the findings of the audit.

As further detailed in Exhibit C.26-2, appeals submitted by providers in response to SIU audits will be immediately routed to the SIU for secondary review and analysis. The SIU, after assessment of supporting documents and additional evidence offered by the provider, will make a determination as to the adequacy of the evidence to reaffirm the original findings, or overturn the finding in favor of the provider thus reducing the overpayment identified. A final letter will be sent to the provider informing them of the results of the appeal review. The plan Appeals team will log the appeal received and forward

the supporting documents to the SIU for their review. The SIU will respond back to the Appeals team, and a response will be sent to the provider.

Exhibit C.26-2. Provider Appeals Process

All processes, including payment withholding, time frames, and provider appeal rights and notices, will comply with 907 KAR 1:671.

a.iv. INNOVATIONS FOR REPORTING DATA IN THE PROGRAM INTEGRITY AREA

Molina is committed to innovative data reporting capabilities to ensure continuous improvement of our Program Integrity capabilities and ensuring that claims are paid accurately for the Kentucky Medicaid program. The following are examples of innovative risk-based assessment programs we have implemented in our affiliated health plans.

Molina Healthcare of Ohio – "Pill Mill" Identification

Our Ohio affiliate's SIU implemented a robust data lake that houses both medical and pharmacy transactions, so each may be leveraged against the other to assess for outliers. As a result, our organization has been able to identify potential opioid "pill mills" where prescriptions filled at a pharmacy had no corresponding medical events within the physician's office. One recent case at our Ohio affiliate was accepted by the Ohio Attorney General for potential indictment. Custom report queries within Microsoft Power BI tools further allow for interactive analytics to drive the user deeper into elements in a query to vet leads for potential investigations.

Molina Healthcare of Ohio – Home Health Analytics

Our Ohio affiliate's SIU's used an innovative, interactive reporting tool to profile data and identify an aberrant pattern in in home health personal care service billings for members who were simultaneously billed for extended inpatient stays. This pattern was also repeated across multiple states. Our various state affiliates identified overpayments in excess of $100,000 and made referrals to the appropriate state Medicaid Fraud Control Units. Based on our Ohio SIU's success, best practices from the Home Health Analytics program have been shared with other health plans in Ohio for implementation across their respective enterprises.

Molina has also recently launched, or will soon be launching, innovative new data reporting initiatives across all our affiliate health plans to further strengthen our program integrity operations, including:

- **ED Billing Assessment.** In late 2019, we implemented ED claims analysis protocols designed to review the diagnosis and facility services performed and submitted as billed in a prepayment environment. We then determine the appropriate level of facility service to be billed before payment, thus mitigating potential upcoding within this often-abused area.

- **Level 4 and 5 Evaluation and Management Billing Monitoring.** Launching in the first and second quarters of 2020, we will canvass providers exhibiting a high rate of Level 4 and 5 Evaluation and Management billing in a post-payment environment and compare peers within provider specialties. Under this program, we will send notices to providers on potential outliers in upcoding for educational purposes and to advise the provider to perform a self-audit on higher levels of Evaluation and Management coding. We will also rescreen identified providers in 90 days to determine if there has been a decrease in the use of higher severity level Evaluation and Management billing. For providers who have not shown an improvement in billing patterns, we will conduct an in-depth records review for potential upcoding to validate the billing accuracy. This approach will further strengthen our ability to recover any discrepant overpayments wherever necessary.

Moreover, additional programs scheduled for launch in 2020 across the Molina enterprise include:

- **Advanced Detection for Pause and Pay.** With our California affiliate serving as the initial launch market, Molina has begun the early stages of rolling out a robust "Pause and Pay" program that uses advanced detection engines to identify and flag suspicious claims based on questionable patterns and trends. Suspect claims are subsequently reviewed and scrutinized by experienced clinical and investigative personnel in a prepayment environment, including a medical records review.

- **Risk-adjusted Coding of Evaluation and Management.** Molina also recently initiated a project to roll out a risk-adjusted approach to coding of Evaluation and Management services through a prepayment strategy to ensure the appropriate level of service is warranted. The protocols assess circumstances, considering member illnesses and provider specialty, and pays claims at the supported severity level.

b. PREPAYMENT REVIEW

We will perform prepayment reviews of identified claims or services related to possible fraud and abuse before determination and payment to prevent improper payments. Our approach to prepayment review will be to:

- Administer pre- and post-adjudication prepayment edits systematically to identify improperly billed claims
- Administer manual medical records reviews to support questionable billed charges flagged for prepayment review
- Track and administer Commonwealth-requested reviews
- Administer reviews as a result if identified potential fraud and abuse through investigative activities where warranted
- Conduct reviews determined by dollar thresholds having higher impact to Molina

For prepayment reviews requiring providers to submit medical records, we will send a notice to the provider informing them as to which activities and/or billing codes will be subject to prepayment review, which records to submit for validation, where to send the records, the time frame for the review, and a contact at Molina for questions.

Our initial prepayment claims review dollar threshold will be $15,000 for COB and $25,000 for non-COB claims. Molina also will conduct a prepayment program to assess and review *high-dollar hospital claims exceeding $100,000* that have a stop loss and are flagged as an outlier bill for potential unbundling of room and board charges above the base DRG. Billing details will be requested to support the claim. Should an amount be disallowed, the amount of payment will be reduced before initial payment. There will be no set percentage of claims that are reviewed; the review will be based on a dollar threshold.

Additionally, Molina will maintain prepayment protocols to review prepayment requests directed from regulators or from internally identified cases from the SIU where a closer review of supporting records is determined to be prudent before payment to ensure the accuracy/necessity of the billing. Molina will work with the Division of Program Quality Outcomes and the Division of Program Integrity to gain approvals for such activities where appropriate.

Our proactive methods for prepayment review are described in Table C.26-3.

Table C.26-3. Prepayment Review Methods

Method	Activity
Claim Edits	We will employ a substantial number of edits during claims adjudication, including edits against duplicate claims, deceased Enrollees, age and gender, maximum allowable units, frequency of billing, and medically unlikely coding.
System Setup	Provider agreements, Enrollee covered services, and value-added benefits will be loaded based upon the Department's guidelines and specific Kentucky Medicaid rates. Providers will be validated against the state master certified provider file to ensure they are eligible for appropriate payment. Encounters will be processed according to Department's guidelines.
Pre-payment Coding Reviews	All submitted claims will be subjected to a dual pass prepayment clinical and claim editing of HCPCS/CPT and diagnosis codes to identify frequent coding errors to ensure claims are coded appropriately according to Commonwealth and federal guidelines.
Threshold Driven	Prepayment claims review exceeding set dollar thresholds or for high-cost hospital room and board claims having a stop loss or having outlier aspects for unbundled charges

Method	Activity
Resultant from Investigative Activity	Prepayment reviews driven from prior investigative activity where the provider continued to exhibit high risk in billing accuracy or where efforts to improve billing practices through corrective action were not present. This will limit exposure to the health plan for high-risk providers.
Claims Process Improvement	Our claims process improvement function will perform monthly analysis of trends in leading and lagging quality indicators and perform root cause analysis of issues that might lead to erroneous claims payments and serve as corrections going forward.

Molina's tightly managed prepayment review process will help deter and prevent improper payments and assure the financial integrity of the Commonwealth's Medicaid program.