

## 11. Monitoring and Oversight (Section 21.0 Monitoring and Oversight)

a. Describe the Vendor's proposed approach to internal monitoring of operations to ensure compliance with this Contract.

UnitedHealthcare Community Plan of Kentucky (UnitedHealthcare) is committed to the highest standards of integrity. Our established compliance program promotes adherence to applicable legal requirements, fosters ethical conduct within the company, and provides guidance to our employees and contractors. Additionally, our compliance program focuses on increasing the likelihood of preventing, detecting and correcting violations of law or company policy. As part of the compliance program, our company has adopted a *Code of Conduct: Our Principles of Ethics and Integrity* (the Code). The Code is a guide to acceptable and appropriate business conduct by the company's employees and subcontractors.

We require compliance to be an essential part of all of our staff's jobs and the local health plan environment. We facilitate and support compliance through the health plan leadership and our Community & State, Operations and Performance Alignment (COPA) team. Our COPA has a local and national presence, which affords us the opportunity to review operational performance and use national information and innovations to benefit the local plan in all operational areas. These operational areas include, but are not limited to: review and analysis of call center reports of performance, weekly claim monitoring, appeals and grievances data. This interplay aids in proactive identification of trends and interventions that should be addressed.

We will collaborate with DMS's monitoring and oversight efforts to ensure compliance with the provisions of Attachment C – Draft Medicaid Managed Care Contract and with applicable federal and state laws and regulations governing the contract. UnitedHealthcare employees are held to the highest standards of integrity through our "Code of Conduct" which establishes our culture of compliance. We have developed, published and provided standards of conduct, policies and procedures, and training relating to expectations for managing our business in accordance with legal/regulatory and business requirements. These standards of conduct, policies and procedures are managed at various levels of the enterprise. We commit to ensuring compliance with this contract through, but not limited to, adherence to our corporate compliance program, which is based upon the seven elements of an effective compliance program and the requirements of 42 CFR 438.608. We structured our program with a core focus on:

- **Prevention:** Creation and maintenance of compliance program guidance, including but not limited to the Code of Conduct and risk assessment process
- **Detection:** Performance of compliance monitoring of emerging and identified risk and support of audit readiness
- **Correction:** Facilitation of response to and remediation of regulatory and self-identified opportunities

Compliance team members are aligned under this model to support the chief compliance officer in her/his duties related to making certain that we establish an effective compliance program in support of beneficiaries, providers, subcontractors and employees. The chief compliance officer will sit as a part of the chief executive officer's (CEO's) executive team, and she/he, along with the broader compliance organization, will support local health plan leaders in conducting effective monitoring and oversight of all subcontractors.

### High Level Oversight – Governance

Our Kentucky-based executive team has full governing authority over our Kentucky Medicaid program. As such, they facilitate coordination and collaboration with all functional areas of the health plan through weekly meetings to further the needs of Kentuckians. For example, should

we initiate a clinical outreach program to improve health conditions, the program would involve not only the clinical team, but also quality, claims, provider services and marketing. These teams are represented on the leadership team and can create a program that is responsive to the operational and compliance requirements of stakeholders to include subcontractors to facilitate optimal coordination to achieve the ultimate outcome. Each functional area works collaboratively to ensure compliance, cost effectiveness and outcomes that improve the health of Kentuckians.

In addition to the executive leadership team meetings, we exercise effective compliance and ethics oversight through program governance by our chief compliance officer and Compliance Oversight Committee, who are charged with operating and monitoring the compliance program and compliance requirements under the contract. The health plan's chief compliance officer and CEO co-chair the health plan's Compliance Oversight Committee, which meets at least quarterly or more frequently if needed. The oversight committee consists of our CEO, Amy Johnston Little; Dr. Jeb Teichman, medical director/chief medical officer (CMO); chief finance officer and other key leadership members of the UnitedHealthcare team. The chief compliance officer also reports to the UnitedHealthcare Board of Directors.

In addition, we will establish a Medicaid Advisory Board to advise the executive team to make certain that the voices of our community, providers and stakeholders are heard and feedback incorporated into our operations. The Board will provide insight to vendor performance and help ensure compliance with contract requirements.

### **Internal Auditing and Monitoring**

The UnitedHealthcare compliance program addresses internal auditing and monitoring needs in part through our prevention, detection and correction approach. As part of this approach, we have audit management teams that support our chief compliance officer as the single person who orchestrates and locally manages, responds to and tracks audit requests. The audit management team assists with confirming timely and accurate responses to audit requests, including External Quality Review (EQR) audits, and assists with preparing required onsite audits. In addition, the corrections team supports the chief compliance officer in responding to required corrective action plans within 10 days and tracking remediation efforts for resolution within 6 months. Our process has continued to improve over time such that the majority of improvement plans are remediated in 90 days or less. The corrections team works with the health plan and the chief compliance officer to analyze the root cause of the issue and assists in validating that information provided reflects resolution. This work clearly outlines remediation with action steps and due dates designed to not only correct the identified issue, but also to prevent future recurrences. Throughout this process, the chief compliance officer helps to educate and train to deepen the understanding of the contract requirements' expectations further to ensure that all health plan staff involved in a process is aware, understand and meet expectations of our health plan and regulators. The detection team identifies areas of opportunity to test to confirm compliance and to verify that prior remediation activities continue to work as intended.

Subcontractors engaged to support a contractually required service are included in all internal and external audit activity. In addition, an internal compliance audit team supports the chief compliance officer by engaging in compliance audits pursuant to an approved annual audit plan. The purpose of these audits is to make sure the organization and other associated contracted entities are meeting expectations, the requirements of the Commonwealth and federal regulations, and other regulatory commitments made by UnitedHealthcare to both internal and external stakeholders.

In support of our daily compliance efforts, each of our health plans is assigned a local COPA partner to work toward ensuring that every state requirement, process, project and service is timely implemented consistent with Commonwealth requirements. One way they do this is by assisting with implementations and, after contract award, with any new contract amendments or requirements by navigating and collaborating across the matrix to proactively develop and implement operational processes. This is done through our regulatory change management program. Our COPA partner also supports the COO by chairing monthly JOC meetings at the plan level.

Measuring our own effectiveness through ongoing monitoring is a key focus of the compliance program. The monitoring activities performed by compliance, business functional areas, UnitedHealthcare personnel or other organizational areas, serve to detect, prevent and correct regulatory and compliance risk for the organization. Monitoring activities also provide verification that the compliance program is effective and drives routine feedback on organizational performance and compliance with our policies, applicable laws and regulations. For example, monitoring activities include reviewing key reporting metrics to identify educational opportunities (e.g., guiding providers to appropriate resources based upon review or analysis of provider-level trends) and process improvements, through the review of grievance and appeal data, claims data or network access and availability data. The data review may happen through the Service Quality and Improvement Subcommittee (SQIS), Provider Advisory Council (PAC) or Healthcare Quality and Management (HQUM) meetings. The appropriate quality committees review any required remediation and improvement efforts, which are part of the overall quality program resulting from EQR or other audit findings.

An example of monitoring that resulted in improvement occurred in one of our state Medicaid health plans. An appeals and grievance report revealed receipt of a high number of post-service appeals related to provider groups who worked out of clinics in five hospitals. While these hospitals were participating in our network, the physicians were nonparticipating. This created dissatisfaction for enrollees and access-to-care challenges for the membership. To solve this problem, team members worked with the network management team to pursue a contract with the affected physicians. After we contracted, credentialed and loaded these providers into our system, we were able to reduce appeals and overturn rates significantly, and improve both enrollee access and enrollee and provider satisfaction. ***Over a 2-year span, we saw a 93% reduction in appeals for these groups.***

Through our compliance program, we verify operational accountability and provide standards of conduct for compliance with the obligations that govern our federal and state programs. We achieve this through a focus on the structures, processes and outcomes that translate our compliance program's values into actions. As discussed herein, our compliance program activities facilitate prevention, early detection and remediation of violations of law and company policies.

Annually our compliance program requires the chief compliance officer, in conjunction with senior leadership, to complete a compliance risk assessment and targeted remediation activities with ongoing monitoring.

## Response to Identified Issues

Our health plan chief compliance officer, in partnership with appropriate business leaders, promptly responds to all credible reported concerns and instances of identified noncompliance and suspected misconduct. If appropriate, we open an inquiry. In doing so, compliance, legal or special investigations personnel conduct preliminary investigations. The timing and urgency of these



inquiries and investigations depend on the specifics of each case. When appropriate, we take corrective and disciplinary actions in response to the associated findings to reduce the potential for recurrence promptly, and we support ongoing compliance with applicable regulatory requirements. When required, we submit timely reports to DMS.



While our program is dynamic to address the specific compliance needs of our plan in Kentucky immediately, we also work with our partners to make sure we exceed minimum requirements. By example, a review of our monitoring results over time and across state Medicaid plans suggested that a deeper more meaningful connection with our subcontractors was needed to address compliance concerns. As a result, we developed an external website for anyone interested in understanding our approach to delegated entity oversight, in addition to a specific understanding of requirements and expectations of our subcontractors both internal and external. We strengthened our baseline oversight approach and partnered with our subcontractors, resulting in greater understanding and adherence to federal, state and contract requirements (e.g., monthly monitoring requirements, required fraud, waste and abuse training) over time.

### **Additional Ongoing Internal Operations Monitoring**

The COPA meets twice a month to address operational and program issues, such as program changes, identified problems and issues, operational improvement projects, Commonwealth-initiated directives and a variety of other topics related to the functional areas of our program delivery. Co-led by chief operating officer the workgroup brings all functional areas together to increase awareness and engagement in addressing agenda items and making sure all functional areas participate in solutions and implementations.

b. Describe the Vendor's proposed approach to providing oversight of its Subcontractors, including examples of actions the Vendor takes when a Subcontractor is found to be non-compliant or when performance improvement opportunities are identified.

For all subcontracted services, we maintain complete accountability and oversight for subcontractors' performance through our vendor oversight manager, who reports to the chief operating officer. The vendor oversight manager makes sure monthly vendor oversight meetings are held and appropriate engagement/follow-up is taken on all outcomes reported. Our CEO and the local leadership team use our vendor oversight processes to support these efforts.

Oversight begins before we select a subcontractor. We select only subcontractors who support us in improving the effectiveness and efficiency of the delivery of services and have a strong reputation for administrative excellence. In accordance with Health Insurance Portability and Accountability Act (HIPAA), we enter into business associate agreements with all subcontracted partners to verify compliance with privacy and security regulations. Upon selecting a vendor, we determine, with the vendor, internal standards and a method for reporting and measuring performance, based upon state contractual requirements (including RFP responses). In addition, if the vendor handles member data or has direct connectivity to our systems, we conduct a thorough data security assessment to confirm full integration of these vendors with our own internal systems and processes. The selection process also includes a due diligence review of the candidate's past performance and experience, financial strength, innovation, ability to perform the activities to be delegated, and the ability to meet our security standards. When selecting new subcontractors, our vendor management team evaluates each vendor in three categories: quality, accessibility and cost. Following our evaluation process, we select a subcontractor and establish an agreement to govern the operating relationship. This agreement

includes delivery of administrative services at a standard to verify the vendor meets all contract requirements.



Every subcontractor relationship has an oversight process in place. The structure of subcontractor oversight will vary in accordance with the size and complexity of the subcontractor operations and the nature of the delegated activity. For affiliated subcontractors we have the added benefit of having a shared corporate culture, which unites us with a common language and structure to address items of opportunity or innovation quickly and easily. In some cases, the oversight process necessitates the creation and ongoing operation of an oversight committee to deliver appropriate oversight of the subcontractor relationship and to provide direct communication channels on business performance and regulatory/compliance issues between UnitedHealthcare and the subcontractor. For other third party vendors, rather than creating a formal committee for each vendor, the structures and processes of the UnitedHealth Group Enterprise Sourcing & Procurement organization may be engaged to deliver effective oversight.

The purpose of our oversight is to:

- Keep communication channels open between UnitedHealthcare and subcontractor
- Make sure accountability is clearly defined
- Fulfill the responsibility of monitoring performance and compliance with compliance program requirements provided in the terms of the mutual contract
- Review clinical, quality and operational performance metrics of subcontracted activities against plan-level targets, as outlined by established service level agreements. Areas of review include, but are not limited to, provider network adequacy, claims and call center operations (appeals are not delegated at this time)
- Discuss necessary/ongoing corrective action plans, remedial actions and opportunity areas
- Discuss ongoing open/significant issues related to enrollee challenges/specific markets
- Collaborate on opportunities for new strategic initiatives and new clinical programs that can improve capabilities and consistency in all of our vendors' markets where we have agreements. This includes a review of any recently implemented programs
- Document output from committee meetings in written minutes. Oversight will result in reporting of identified subcontractor issues to our Compliance Oversight Committee

We will employ appropriate internal monitoring programs to test compliance with key Commonwealth and federal requirements, audit performance and report results through the Compliance Oversight Committee and/or Quality Improvement Committee (QIC) structure as appropriate. The monitoring program will include, as appropriate, the ability to:

- Collect, report and compare monitoring results and findings
- Analyze results to identify risk areas
- Conduct focused reviews, where applicable
- Submit reports, as required and requested by DMS

We use the following additional oversight and monitoring approaches to make sure subcontractors meet compliance and performance requirements.

## Vendor Relationship Owners

As part of our oversight structure, we will hire a Kentucky-based vendor oversight manager reporting to the COO. In addition, we will assign a vendor relationship owner (VRO) to each subcontractor used in support of the MCO contract. The VROs are functional area leaders who regularly interact with subcontractors to share performance indicators, program changes and ideas on improved outcomes in addition to conducting monitoring activities locally along with quality and compliance committees and executive leadership, as appropriate, the VROs will hold regular meetings with our subcontractors. This regular oversight helps to verify subcontractors are meeting performance metrics and confirms subcontractors' staff, policies and resources are appropriate to meet the requirements of their agreement. The findings from these meetings will be presented to the vendor oversight manager monthly or more frequently if needed. We report the results of these monitoring activities in functional area committee meetings (e.g., quality oversight and compliance committee meetings). ***If there are performance issues, these committees recommend next steps of the subcontractor to remedy operational issues and maintain compliance with the contract.*** This may include more intensive reporting or monitoring, a corrective action plan or, if necessary, revocation of the agreement. In addition, we communicate these results and decisions to our Joint Operating Committee (JOC), which oversees the intersegment relationships between UnitedHealthcare and its affiliates and vendors, and, as appropriate, our Board of Directors. As part of our JOCs, we monitor timely claims payments as an indicator of financial stability. Our current subcontractors that pay claims fall within the UnitedHealth Group family of businesses, allowing for additional insight into financial strength. Minutes, reviews and any corrective actions from these meetings roll up to our health plan committee structure, namely Quality Improvement Committee, Provider Advisory Council, Service Quality Improvement Subcommittee and the Healthcare and Quality Utilization Management Committee.

## Operations Meetings

To improve collaboration, we invite representatives from our subcontractors (if appropriate to the meeting agenda) to our regular operations meetings, promoting understanding of how each functional area is dependent upon the success of the others. During these meetings, we provide direction for our subcontractors and verify their quality and effectiveness is sufficient to meet objectives. For example, one way we oversee our clinical vendors through case reviews with our chief medical officer or health services director. We analyze outcomes from these case studies to ensure enrollees' health and wellness are improving and care is received in an efficient manner. Local functional area business owners also report on subcontractor performance and measurements. Operations meetings include:

- Feedback and oversight
- Training and education
- Effective lines of communication
- Review of policies and procedures
- Monitoring of key performance indicators
- Responding to issues/escalating when necessary

## Statistics and Reports

Subcontractors are required to report key performance indicators daily, weekly, monthly or quarterly. These reports allow UnitedHealthcare staff to monitor and evaluate subcontractors, and to determine if there are concerns with the information and indicate action steps for improvements if needed.

We use scorecards (see figure) during our oversight meetings to monitor performance of our subcontractors against contract requirements.

Contract/Performance Measure	Target	Jan	Feb	Mar	Q1	Apr
<b>STATE Medicaid</b>						
% of total calls answered within 30 seconds	> or = 80%					
Average hold time	< 60 seconds					
Average abandonment rate	< 4%					
Average speed to answer incoming calls	< or = 30 seconds					
Provider Calls Receiving a Busy Signal	> or = 99% calls do not receive a busy signal					
% Initial Contact Resolution Resolved Upon Initial Contact	> or = 90%					
% Initial Contact Resolution Resolved Within 2 Days	> or = 95%					
% Initial Contact Resolution Closed Within 5 Days	> or = 98%					
% Initial Contact Resolution Closed Within 15 Days	= 100%					
Ratio of members to providers*	1 provider per 2000 members					
% of members with access - Urban/Semi Urban*	1 provider within 30 miles or 30 minutes					
% of members with access - Rural/Frontier*	1 provider within 30 miles or 30 minutes					
Claim Turnaround Time within 30 Days (All Clean Claims)*	= 100%					*
Claim Turnaround Time within 60 Days (All Unclean Claims)*	> or = 99%					*
Claim Turnaround Time within 90 Days (All Claims)*	= 100%			*		*
Claims adjudication financial accuracy*	> or = 99%					
Claims adjudication clerical accuracy*	> or = 95%					
Credentialed/Recertified Providers	> = 90% Within 30 days & = 100% Within 45 days/Every 3 years					
Provider demographic accuracy*	> or = 90%					
Provider Appeals TAT	Acknowledgement of provider appeals are issued within 10 calendar days. 98% of provider appeals are resolved within 30 calendar days and 100% of provider appeals are resolved within 60 calendar days from the date the appeal is received.					

**Figure 13: Example Scorecard:** We will modify each subcontractor’s scorecard and metrics to meet the Commonwealth’s and the health plan contract requirements, and use it during meetings and oversight calls with our subcontractor.

We confirm our commitment to ensure compliance with the Commonwealth contract requirements, which includes maintaining responsibility, and conducting monitoring and oversight of subcontractors used in the performance of this contract.

### Examples of Vendor Actions for Non-Compliance

An example of action taken when improvement was needed occurred while working with a large medical group in California where care and administrative services were delegated. In this instance, oversight activities revealed noncompliance with contractually required claims processing turnaround timeframes. Consistent with our process, we notified the group and provided 45 days to become compliant. A subsequent review indicated that turnaround timeframes were still not being met at which point we implemented more intensive oversight and an improvement action plan. If the provider had continued to be noncompliant following the cure process, we would initiate sanctions. Following which continued noncompliance would subject the group to termination. However, in this instance, with the direction of the claims vendor oversight team the medical group remediated the issue.

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