Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Virginia Focused Program Integrity Review

Final Report

December 2021

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Virginia Focused Program Integrity Review Final Report
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Executive Summary

In the Comprehensive Medicaid Integrity Plan for Fiscal Years (FYs) 2019-2023, the Centers for Medicare & Medicaid Services (CMS) set forth its strategy to safeguard the integrity of the Medicaid program.[1] State Medicaid programs are required to have a fraud detection and investigation program and oversight strategy that meet minimal federal standards. To ensure states are meeting these requirements, CMS conducts focused program integrity reviews on high-risk areas, such as managed care, new statutory and regulatory provisions, nonemergency medical transportation, and personal care services. These reviews include onsite or virtual state visits to assess the effectiveness of each state's program integrity oversight functions and identify areas of regulatory non-compliance and program vulnerabilities. The value of performing focused program integrity reviews include: (1) providing states with effective tools/strategies to improve program integrity operations and performance; (2) providing the opportunity for technical assistance related to program integrity trends; (3) assisting CMS in determining/identifying future guidance that would be beneficial to states; and (4) assisting with identifying and sharing promising practices related to program integrity.

In April 2021, CMS conducted a virtual focused review of Virginia's single state Medicaid agency, the Department of Medical Assistance Services (DMAS), which is responsible for program integrity oversight of Virginia's Medicaid program. The purpose of this focused review was to determine the extent of program integrity oversight of the managed care program at the state level and to assess the program integrity activities performed by selected managed care organizations (MCOs) under contract with the state Medicaid agency. CMS interviewed key staff and reviewed a sample of program integrity cases investigated by the MCOs Special Investigations Units (SIUs), as well as other primary data, to assess the state's and selected MCOs' program integrity practices. CMS also evaluated the status of Virginia's previous corrective action plan, which was developed by the state in response to a managed care focused review conducted by CMS in 2016.

During this review, CMS identified a total of 3 recommendations based upon the completed focused review modules, supporting documentation, and discussions and/or interviews with key staff. CMS also included technical assistance resources for the state to consider utilizing for its oversight of managed care. The review and recommendations encompass the following six areas:

1. State oversight of managed care program integrity activities
2. Provider screening and enrollment
3. MCO investigations of fraud, waste, and abuse
4. Encounter data
5. Payment suspensions based on credible allegations of fraud
6. Terminated providers and adverse action reporting

Overview of Virginia Medicaid

The DMAS is the single state agency responsible for providing oversight of the Medical Assistance

[1] https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf

plans in Virginia. The DMAS administers the state's Medicaid managed care under two programs: Commonwealth Coordinated Care (CCC) Plus and Medallion 4.0.

- *Commonwealth Coordinated Care (CCC) Plus*. This is a Medicaid-managed long-term service and support program that serves over 245,000 individuals throughout Virginia. The CCC Plus uses an integrated delivery model across a comprehensive range of health services to assist members with complex care needs. Enrollment in the program is required for qualifying individuals who benefit from the person-centered care management program. The CCC Plus strives to improve health care quality, access, and efficiency for its members through contracted managed care organizations.
- *Medallion 4.0*. This is a statewide Medicaid program and serves approximately 1.1 million members. The Medallion 4.0 program provides services to infants, children, pregnant women and adults in low-income families with children in the areas of maternity care, including early prenatal care, case management, and postpartum care; care for infants and children, including early intervention services, immunizations, screening, and preventive care; and wellness, behavioral health, community mental health services, behavioral therapy, family planning, prescription drugs coverage, acute and primary healthcare services, and chronic disease support for adults.

The Program Integrity Division (PID) is the organizational unit responsible for the overall program integrity operations for the managed care program, along with Health Care Services (HCS) Division and the Integrated Care (IC) Division. The PID is divided into two main sections: Provider and Member. The HCS has oversight responsibility for the Medallion 4.0 managed care contracts, while the IC Division has oversight responsibility for the CCC Plus program.

In FY 2019, Virginia's Medicaid expenditures exceeded $11 billion, and the state had approximately 1,752,588 beneficiaries enrolled. The Federal Medical Assistance Percentage matching rate was 93 percent. Approximately 90 percent of the Medicaid population was enrolled in six managed care plans under the CCC Plus and Medallion 4.0 programs. Virginia Managed Care expenditures were approximately $6,472,175,290, which includes both Medicaid and Children's Health Insurance Program (CHIP), representing approximately 57 percent of total Medicaid expenditures.

Three out of the six operating MCOs were selected for interview during the virtual PI review, based on size and expenditures: Anthem Health Keepers Plus, Optima Health, and Virginia Premier. CMS did not interview Aetna Better Health, Molina Complete Care, or United Healthcare Community Plan. Table 1 and Table 2 below provide enrollment/SIU and expenditure data for each MCO that CMS interviewed.

Table 1. Summary Data for Virginia MCOs[2]

	Optima Health	Anthem Health Keepers Plus	Virginia Premier
Beneficiary enrollment total	301,499	1,738,028	278,691
Provider enrollment total	40,776	35,922	29,599
Year originally contracted	Medallion 4.0 2018	1996	1995

[2] The beneficiary enrollment numbers for each plan are as of 12/31/2020.

	Optima Health	Anthem Health Keepers Plus	Virginia Premier
	CCC+ 2017		
Size and composition of SIU (FTEs)	14	5 local / 339 corporate	6
National/local plan	Local	National	Local

Table 2. Medicaid Expenditure Data for Virginia MCOs[3]

MCO	FY 2017	FY 2018	FY 2019
Optima Health	$797,295,762.29	$1,115,960,794.44	$1,651.569,601.73
Anthem Health Keepers Plus	$1,280,250,747.47	$1,903,943,285.62	$2,559,094,975.09
Virginia Premier	$932,918,671.55	$2,231,118,269.35	$1,860,600,923.55

Results of the Review

CMS evaluated the following six areas of Virginia's managed care program:

1. State oversight of managed care program integrity activities
2. Provider screening and enrollment
3. MCO investigations of fraud, waste, and abuse
4. Encounter data
5. Payment suspensions based on credible allegations of fraud
6. Terminated providers and adverse action reporting

CMS identified three areas of concern with Virginia's managed care program integrity oversight that may create risk to the Medicaid program. CMS will work closely with the state to ensure that all of the identified issues are satisfactorily resolved as soon as possible through implementation of a corrective action plan. These areas of concern and CMS' recommendations for improvement are described in detail below.

1. State Oversight of Managed Care Program Integrity Activities

The DMAS has two divisions that have contract oversight responsibility for the programmatic area of the managed care program: the HCS division for the Medallion 4.0 managed care contracts and the IC division for the CCC Plus program contracts. In addition, the state's PI efforts are primarily the role of the PID, which is responsible for all investigatory efforts for both managed care programs. The PID is divided into two main sections: Provider and Member.

[3] Each of the MCOs submitted the expenditure data reported in Table 2. The state confirmed expenditure data during the review process. Discrepancies (if identified) were clarified prior to development of this report.

- *Provider Section*: Within the Provider section is the External Provider Audit & Policy (EPAP) unit. The EPAP unit has nine full-time employees (FTEs) and oversees the managed care program integrity oversight and a wide variety of audit contracts. The EPAP unit consists of a Program Integrity Analyst who monitors twelve managed care contracts and two national auditing contracts, and provides policy analysis and expertise related to program integrity issues. Also, within the Provider section is the Provider Review Unit (PRU), which has seven FTEs and two part-time employees. The PRU's main function is to identify and review providers who may be practicing abusive or fraudulent billing. The PRU ensures DMAS' compliance to several federal regulations, including 42 CFR 456.3 (statewide surveillance and utilization control program) and 42 CFR 447.45(f) (prepayment and post-payment claims review). The PRU reviews fee-for-service; Early and Periodic Screening, Diagnostic and Treatment (EPSDT); and Children's Health Insurance Program (CHIP) claims, medical documentation, medical reports, and prior authorizations (if applicable) to identify potentially fraudulent, abusive, or incorrect billing practices. The EPAP unit also conducts quarterly on-site reviews of managed care plans to verify compliance with its state's fraud and abuse contract requirements and with federal requirements under 42 CFR 438.608(a)(1)(i). The Program Integrity Analyst selects three to five investigations to review at on-site reviews. On-site reviews are documented in a summary report that is used for internal oversight.

- *Member Section:* Within the Member section are the Recipient Audit Unit (RAU). The RAU has eight FTEs who investigate referrals of fraudulent activity and abuse by Medicaid and Family Access to Medical Insurance Security (FAMIS) plan enrollees. Allegations typically include recipient eligibility issues, such as deceit in an application, illegal use/sharing of a Medicaid card, uncompensated transfer of property, excess resources or income, and fraudulent household composition. The RAU also investigates drug diversion and performs joint investigations with law enforcement, Virginia State Police, Social Security Administration, Federal Bureau of Investigations, and other federal/state agencies. In addition to investigations conducted by RAU staff, the RAU also engages a contractor to conduct additional recipient eligibility reviews.

In Virginia, MCOs are contractually required to have administrative and management arrangements or procedures designed to prevent, detect, reduce, investigate, and report known or suspected fraud, waste, and abuse activities in accordance with the requirements at 42 CFR 438.608(a)(1). Compliance plans are required to be provided by the contract operational start date, and annually thereafter. The contract-monitoring units for HCS and IC divisions are responsible for obtaining and reviewing the compliance plans in accordance with the state's contract requirements. CMS observed that all three MCOs interviewed had compliance programs that met the minimum requirements outlined in 42 CFR 438.608(a)(1).

Additionally, the DMAS contract-monitoring unit advised that the MCOs complied with the contractual requirements set forth by the state and federal regulations pertaining to compliance with 42 CFR 438.608(a)(1); however, the contract-monitoring units could not provide written documentation that the compliance plans were reviewed.

During the review, CMS found that the DMAS does not have a documented process for coordinating with the various intra-agency units for comprehensive oversight. CMS recognizes that DMAS utilizes processes that they consider effective, but those processes are not documented in written policy or process. CMS believes that DMAS could benefit from a more formal, documented process that helps ensure the appropriate section is notified as needed. Formally adopting procedures for reporting responsibilities, detailing defined oversight roles, and document guidelines for collaboration on program integrity issues will enhance oversight of the managed care program.

Recommendation #1: The DMAS should document its existing processes in an intra-agency agreement that clearly describes the administrative roles, responsibilities, and notification process for each division or unit related to Medallion 4.0 and CCC Plus oversight of program integrity activities.

Recommendation #2: The state should develop an effective monitoring tool for the annual submission, review, and approval of MCO compliance plans by DMAS contract-monitoring units.

2. Provider Screening and Enrollment

To comply with 42 CFR §§ 438.602(b)(1) and (b)(2), 438.608(b), 455.100-106, 455.400-470, and Section 5005(b)(2) of the 21st Century Cures Act, all providers furnishing services to Virginia Medicaid members, including providers participating in an MCO provider network, are required to be screened and enrolled with DMAS at the time Medicaid Enterprise Systems (MES) is implemented. The MCO must integrate their information systems with the Provider Services Solution to assure a smooth transition to meet 21st Century Cures Act requirements. In supporting the Department's implementation of the MES and its provider enrollment module, the MCO must submit all tax identification numbers (Federal Employee Identification Number), or social security numbers if no tax identification number exists, for each MCO provider to the Department through the enrollment wizard as requested by the Department. The MCO must ensure that all providers are registered in Virginia's provider enrollment system prior to contracting and credentialing with the provider. This rule applies to all provider types and specialties and is inclusive of the billing, rendering, ordering, prescribing, referring, sponsoring, and attending providers.

The MCO must require its providers and subcontractors to fully comply with federal requirements for disclosure of ownership and control, business transactions, and information for persons convicted of crimes against federal related health care programs, including Medicare, Medicaid, and/or CHIP programs, as described in 42 CFR 455 Subpart B and E. The MCO must comply with the requirements detailed at 42 CFR 455.436, requiring the MCO to, at a minimum, check the OIG List of Excluded Individuals Entities (LEIE) and other federal databases (1) at least monthly for its non-Medicaid enrolled providers, (2) before contracting with providers, and (3) at the time of a provider’s credentialing and re-credentialing.

The MCO must obtain federally-required disclosures from all non-Medicaid enrolled network providers and applicants in accordance with 42 CFR 455 Subpart B and 42 CFR 1002.3, as related to ownership and control, business transactions, and criminal conviction for offenses against federally related health care programs including Medicare, Medicaid, or CHIP. The MCO must screen all individuals listed on the disclosure form including providers and non-providers, such as board members, owners, agents, and managing employees. The information shall be obtained through provider enrollment forms and credentialing and re-credentialing packages. The MCO must maintain such disclosed information in a manner that can be periodically searched by the MCO for exclusions and provided to DMAS in accordance with this contract and relevant state and federal laws and regulations.

The MCO must conduct monthly checks and shall require subcontractors to conduct monthly checks to screen non-Medicaid enrolled providers for exclusion, using the Social Security Administration's Death Master File (SSA-DMF), the National Plan and Provider Enumeration System (NPPES), the LEIE, the System for Award Management (SAM), and any other databases as the state may prescribe. These databases must be consulted upon contracting and no less frequently than monthly thereafter. The MCO must also check the DMAS provider file or conduct its own checks against the federal exclusion files (named above) to ensure that any of its network providers who are "Medicaid enrolled" providers remain enrolled with DMAS.

The MCO's screening process must also include: verifying licenses, conducting revalidations at least every five years, site visits for providers categorized under federal and state program integrity rules and plans at moderate or high risk, criminal background checks as required by state law, federal database checks for excluded providers at least monthly, and reviewing all ownership and control disclosures submitted by subcontractors and providers.

CMS regulations at 42 CFR 455.432 requires that the state Medicaid agency conduct pre-enrollment and post-enrollment site visits of providers who are designated as ''moderate'' or ''high'' categorical risks to the Medicaid program. The MCO's contract outlines that the MCO's screening processes shall include site visits for providers categorized under federal and state program integrity rules and plans at moderate or high risk. **All three MCOs interviewed indicated that they are not currently conducting site visits, even though they were contractually required to conduct site visits. Anthem advised that they do not conduct site visits but will conduct, if necessary; Optima advised that they only conduct audits but do not conduct site visits; and Virginia Premier advised that they only conduct desk reviews.**

The MCO/Subcontractor must terminate a network provider immediately upon notification from the state that the network provider cannot be enrolled. The MCO must immediately notify the Department of any action taken by the MCO to exclude, based on the provisions of this section, an entity currently participating.

The MCO must inform providers and subcontractors about federal requirements regarding providers and entities excluded from participation in federal health care programs (including Medicare, Medicaid, and CHIP). In addition, the MCO should inform providers and subcontractors about the federal Health and Human Services – Office of Inspector General (HHS-OIG) online exclusions database, available at http://exclusions.oig.hhs.gov/. This is where providers/subcontractors can screen managing employees

and contractors against the HHS-OIG website monthly to determine whether any of them have been excluded from participating in federal health care programs. Providers and subcontractors should also be advised to immediately report to the MCO any exclusion information discovered.

Recommendation #3: The state should ensure that site visits are being conducted by all MCOs according to contractual requirements.

3. MCO Investigations of Fraud, Waste, and Abuse

As required by 42 CFR §§ 455.13-17, Virginia has an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCOs. Virginia's Medicaid contracts with its MCOs state that "the MCO must have in place policies and procedures for ensuring protections against actual or potential fraud, waste, and abuse. The MCO must have a formal comprehensive Virginia Medicaid Program Integrity Plan, reviewed and updated annually, to detect, correct, and prevent fraud, waste, and abuse; and supports correction and prevention efforts. All fraudulent activities or other program abuses shall be subject to the laws and regulations of the Commonwealth of Virginia and/or the federal government."

The contracts also specify that the Virginia Medicaid Program Integrity Plan must define how the MCO will adequately identify and report suspected fraud, waste, and abuse by members, network providers, and the subcontractors. The MCO must develop a written integrity plan specific to the contract that identifies the specific resources dedicated to program integrity activities related to claims, members, providers, and subcontractors involved in delivering the services outlined in this contract.

The PID conducts quarterly Program Integrity Collaborative sessions with the MCOs and other stakeholders to discuss pertinent program integrity issues pertaining to fraud, waste, and abuse matters and relevant contractual concerns. The attendees include representatives from the MCOs' program integrity divisions (the designated program integrity lead), DMAS PID, Medicaid Fraud Control Unit (MFCU), HCS, and IC. During these meetings, DMAS staff has provided educational guidance to all of the MCOs on MFCU referral standards to ensure only quality cases are being referred.

Additionally, on a quarterly basis, the MCOs submit electronically to DMAS all activities conducted on behalf of program integrity by the MCO and include findings related to these activities. The report includes: allegations received and results of the preliminary review, investigations conducted and outcome, payment suspension notices received and suspended payments summary, claims edits/automated review summary, coordination of benefits/Third-Party Liability savings and recoveries, service authorization/medical necessity savings, provider education savings; provider screening reviews and denials, providers terminated, unsolicited refunds (Provider-Identified Overpayments), archived referrals (Historical Cases), and other activities.

Upon submission, DMAS reviews the Quarterly Fraud/Waste/Abuse Overpayment Report. This

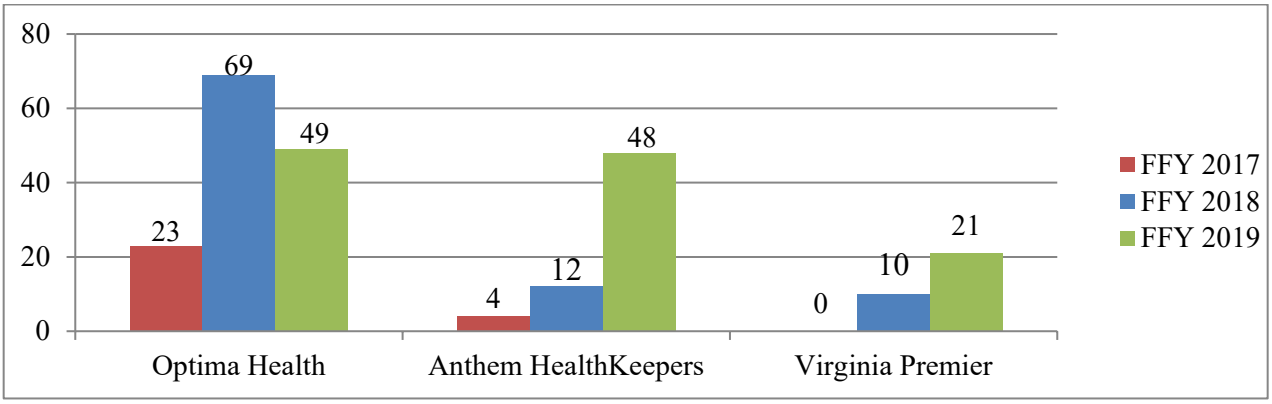
evaluation examines ongoing reporting, as well as the contents of the report to ensure that all contractual requirements are being met. The DMAS evaluates progress towards the Internal Monitoring and Audit Plan required under section 10.2.C of the contract to identify any major changes or shortcomings to projected program integrity activity. According to the MCO contract, "The MCO must have methods for identification, investigation, and referral of suspected fraud cases (42 CFR §§ 455.13 and 455.14). When the MCO identifies suspected fraud (as defined in 42 CFR 455.2) by one of its providers or subcontractors, it shall be reported to the Department within forty-eight (48) hours of discovery on the Referral of Suspected Provider Fraud form. This notification should be sent to DMAS via the email address provided on the form. Any case sent to DMAS as a Referral of Suspected Medicaid Fraud will be forwarded to the Medicaid Fraud Control Unit (MFCU)."

All referrals submitted by the MCOs are submitted to a DMAS program integrity analyst for review for quality before it is sent to the MFCU. CMS noted that DMAS' Program Integrity Division (PID) holds a quarterly program integrity/managed care organization (PI/MCO) collaborative meeting which includes attendees from PID, other DMAS Divisions, the MCO Plans (includes SIU or equivalent and/or compliance officer), and the MFCU. DMAS has also enhanced the referral process by assigning a DMAS Program Integrity Analyst to review every referral submitted by the MCO plans to assure accuracy and completeness of referral information, oftentimes providing feedback to the MCOs, further improving the referral process.

CMS confirmed that each of the MCOs interviewed has SIUs. The SIU staffing levels reported by all three plans ranged between 5 to 14 FTEs dedicated to Virginia Medicaid. The program integrity efforts of two of the three reviewed SIUs in terms of provider referrals and investigations, appear to be adequate.

Table 3 describes the number of investigations referred to Virginia by each MCO. As stated previously, the MCO provider case referrals of the reviewed SIUs appears to be adequate for Optima Health and Anthem Health Keepers. However, Virginia Premier provider case referrals are minimal in relation to the total annual Medicaid expenditure amounts, along with the beneficiary enrollment totals, and the total number of providers reported for all three plans in FY 2017-2019. During the interview with Virginia Premier, they acknowledged changes within their organization's analytical capabilities but elected to only meet the Virginia's three percent requirement. The DMAS MCO contract under Minimum Investigation Requirements states that "investigations conducted by the MCO must involve the review of medical records for claims representing at least 3 percent of total medical expenditures."

Table 3. Number of Investigations Referred to Virginia by Each MCO



Additionally, even though the three MCOs referred 238 cases to the state between FY 2017-2019, CMS discovered that the MFCU rejects a substantial portion of the MCO referrals. Specifically, during the period between FY 2017-2019, the MFCU only accepted six case referrals related to the MCO's investigations. CMS is unable to opine on the reason for the MFCU accepting so few referrals.

Per DMAS MCOs are required to amend encounters to reflect all overpayments that have been identified and resubmitted through the claims processing system. The DMAS Program Integrity Analyst is required to conduct a random review of all resubmitted claims to ensure appropriateness in processing.

Overall, the amount of overpayments identified and recovered by Virginia Premier appears to be exceedingly low. Further, although the MCOs are not normally required to return overpayments from their network providers to the state, the state must obtain a clear accounting of any recoupments for these dollars to be accounted for in the annual rate-setting process. Without these adjustments, MCOs could be receiving inflated rates per member per month. Tables 4-A, 4-B, and 4-C describe each MCO's recoveries from program integrity activities.

Table 4-A Optima Health's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2017	647	572	$2,351,109.19	$2,332,841.11
2018	613	556	$3,205,621.73	$3,205,621.73
2019	232	218	$5,248,441.27	$5,246,441.27

Table 4-B. Anthem Health Keepers Plus Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2017	19	96	$18,239,272.66	$17,915,806.59
2018	175	69	$25,235,665.87	$25,220,693.63
2019	220	124	$25,671,553.83	$24,836,371.50

Table 4-C. Virginia Premier Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2017	71	71	$1,375,537.00	$1,388,716.00
2018	126	126	$6,205,410.40	$2,407,426.16
2019	141	141	$0	$2,265,703.31

4. Encounter Data

The DMAS receives complete encounter data from the MCOs. The timeframe for MCOs to submit encounter data to the state is within 30 days of MCO claims payment. Encounter data is submitted per the Accredited Standards Committee (ASC X12) and National Council for Prescription Drug Program (NCPDP) national Electronic Data Interchange (EDI) formats. The HCS and IC are responsible for the collection and validation of the encounter data but do not perform any data mining of this data. All encounters are loaded to the DMAS data warehouse and are available for reporting by other divisions (functional areas) within the agency. The DMAS receives and validates data submitted by the MCOs through the Encounter Processing Solution (EPS) system. The EPS provides a secure portal for the MCOs to submit encounters and file certifications, and to receive validation reports. The EPS is a proprietary application that was developed by DMAS Information Technology staff and has been certified as an MES module by CMS. The EPS uses a combination of Commercial-Off-The-Shelf (COTS) EDI compliance checks, JAVA code, and COTS business rules engine.

With respect to the encounter data used for actuarial soundness of rates, DMAS reviews summaries of the encounter for each MCO by category of service. This data is evaluated in comparison to past summaries and comparison to each MCO. The data is further evaluated in comparison to the data the MCOs report in their annual financial statements provided to the Bureau of Insurance. The MCOs are questioned about material differences in the data as compared to their financial statements or in comparison to other MCOs or historical data. In addition, the actuarial contractor, Mercer, performs their own review of the data and forwards any concerns they find to DMAS and the MCOs. The MCO Medical Loss Ratio reports are a form of encounter data accepted by the state.

The PID does use encounter data in its new Fraud Abuse Detection System (FADS). The DMAS data warehouse houses fee-for-service (FFS) and MCO claims. The FADS can analyze abnormalities in claims data for FFS and MCO billings separately and together.

CMS did not identify any recommendations regarding Virginia's use of encounter data for Medicaid oversight.

5. Payment Suspensions

In Virginia, Medicaid MCOs are contractually required to suspend payments to providers at the state's request. The MCO contract requires plans to suspend payments to a network provider on notice that the state determined a credible allegation of fraud in accordance with 42 CFR 455.23. Suspension of payments must be implemented immediately and applies to all Medicaid claims (FFS and encounter/managed care based) submitted by the provider.

The DMAS contract pursuant to 42 CFR §§ 455.23 and 438.608(a)(8) states that "the MCO must suspend payments to providers or subcontractors against whom the Department has determined there to be a credible allegation of fraud. Upon notification from the Department that such a determination has been made, and provided the Department has not determined good cause exists to not suspend payments or to suspend payment only in part, the MCO must suspend payment as soon as possible and no later than the date indicated in the notice from the Department. If the MCO believes there is a good cause, as defined in 42 CFR 455.23, to not suspend payments or to suspend payment only in part to such provider or subcontractor, the MCO must notify the Department immediately and a good cause exemption form must be submitted to the Department outlining the reasons for exempting the provider or subcontractor from payment suspension.

The DMAS will evaluate the merit of the request for good cause exemption and notify the MCO of the decision. Upon notification from the Department of a determination that good cause does not exist, the MCO shall suspend payments as of the date in the Department's notice. The MCO must send a letter of the suspension of program payments to the suspended provider and a copy of the letter to the agency within five business days of receiving notice from the Department unless requested in writing by a law enforcement agency to temporarily withhold such notice. The letter must address all points in 42 CFR 455.23(b)(2) and must set forth the provider's right to the state's administrative appeals process."

All three MCOs have a suspension policy and comply with the terms of their contract. As such, CMS did not identify any recommendations regarding Virginia's payment suspension policies and processes.

6. Terminated Providers and Adverse Action Reporting.

The DMAS advised that, per Section 4 of the Medallion 4.0 contract, "[t]he MCE [Managed Care Entity] may terminate, suspend, sanction, and/or educate providers according to the terms described in its agreements with its network providers, including but not limited to 'for cause' terminations, such as access, program integrity, or quality of care issues, as well as 'not-for-cause' or 'at-will' terminations under authority granted by the Medallion 4.0 Contract." Further, Section 4.5.G of the Medallion 4.0

contract and 8.4.8 of the CCC Plus contract states that "[t]he MCE/Subcontractor shall terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled. The MCE shall immediately notify DMAS of any action taken by the MCE to exclude, based on the provisions of this section, an entity currently participating."

Also, Section 16.2.C of the Medallion 4.0 contract states that "in accordance with 1902(a)(39) and (41), 1128, and 1128A of the Social Security Act, 42 CFR § 438-610 and § 1002, and 12 VAC 30-10-690 of the Virginia Administrative Code and other applicable federal and state statutes and regulations, the MCE (including subcontractors and providers of subcontractors) shall neither participate with nor enter into any provider agreement with any individual or entity that has been excluded from participation in Federal health care programs or who have a relationship with excluded providers of the type described in paragraph 1(b) above. Additionally, the MCE and its subcontractor are further prohibited from contracting with providers who have been terminated from the Medicaid program by the Department for fraud, waste, and abuse." Section 7.1 of the CCC Plus contract states that "the MCO must neither participate with nor enter into any provider agreement with any individual or entity that has been excluded from participation in Federal health care programs."

Finally, there is currently a process and procedure that involves the referral of providers with adverse actions noted during their initial enrollment or self-disclosure, as well as received from licensing entities. These referrals are reviewed by the Provider Enrollment Services (PES) unit and then referred to Executive Management Team (EMT) for recommendation to deny, continue, or terminate enrollment for a provider. This process involves notifying all provider networks. The DMAS' Program Operations Division PES unit loads terminated providers into CMS' Data Exchange System (DEX).

Overall, the number of providers terminated "for cause" by the plans appears low, compared to the number of providers enrolled with the MCOs and compared to the number of providers dis-enrolled or terminated for cause. Table 5 depicts the number of provider terminations by MCO.

Table 5: Provider Terminations in Managed Care

MCOs	Total # of Providers Disenrolled or Terminated in Last 3 Completed FYs	Total # of Providers Terminated for Cause in Last 3 Completed FYs
Optima Health	2017 838 2018 1004 2019 859	2017 23 2018 22 2019 15
Anthem Health Keepers, Plus	2017 397 2018 3,560 2019 3,225	2017 21 2018 13 2019 16
Virginia Premier	2017 0 2018 7 2019 42	2017 0 2018 0 2019 0

CMS did not identify any recommendations regarding Virginia's terminated providers and adverse

action reporting policies and procedures.

Status of Virginia's 2016 Corrective Action Plan

Virginia's previous focused program integrity review was in March 2016, and the final report was issued in February 2017. The report contained nine recommendations. CMS completed a desk review of the corrective action plan in March 2019, which indicated that the findings from the 2016 review have all been satisfied by the state.

Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for Virginia to consider utilizing:

- Access COVID-19 Program Integrity educational materials at the following links:
  - Risk Assessment Tool Webinar (PDF) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-tool-webinar.pdf
  - Risk Assessment Template (DOCX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.docx
  - Risk Assessment Template (XLSX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.xlsx
- Access the Provider Requirements website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Provider-Requirements to address site visit requirements.
- Access the Resources for State Medicaid Agencies website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Resources-for-SMAs to address techniques for collaborating with MFCU.
- Access the Medicaid Payment Suspension Toolkit at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf, to address Overpayment and Recoveries.
- Use the program integrity review guides posted in the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the RISS for information provided by other states including best practices and managed care contracts. http://www.riss.net/
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute. More information can be found at https://www.cms.gov/medicaid-integrity-institute
- Regularly attend the Fraud, Waste, and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Participate in Healthcare Fraud Prevention Partnership studies and information-sharing activities. More information can be found at https://www.cms.gov/hfpp.
- Consult with other states that have Medicaid managed care programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and training of managed care staff in program integrity issues. Use the Medicaid PI Promising Practices information posted in the RISS as a tool to identify effective program integrity practices.

Conclusion

CMS supports Virginia's efforts and encourages the state to look for additional opportunities to improve overall program integrity. CMS' focused review identified three areas of concern and instances of non-compliance with federal regulations that should be addressed immediately.

We require the state to provide a corrective action plan for each of the recommendations within 30 calendar days from the date of issuance of the final report. The corrective action plan should address all specific risk areas identified in this report and explain how the state will ensure that the deficiencies have been addressed and will not reoccur. The corrective action plan should include the timeframes for each corrective action along with the specific steps the state expects will take place, and identify which area of the state Medicaid agency is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the corrective action plan, such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of issuance of the final report. If the state has already acted to correct compliance deficiencies or vulnerabilities, the corrective action plan should identify those corrections as well.

CMS looks forward to working with Virginia to build an effective and strengthened program integrity function.