Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Virginia Focused Program Integrity Review

Final Report

February 2017

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Objective of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review of Virginia 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. Due to the length of time that has lapsed since CMS's previous comprehensive program integrity review conducted in calendar year 2009, this review did not include a follow up on the state's progress in implementing corrective actions for the findings previously identified.

Background: State Medicaid Program Overview

The Virginia Medicaid program provides health and long-term care coverage for approximately 1.3 million enrollees and is administered through the Department of Medical Assistance Services (DMAS). The DMAS provides Medicaid to individuals through both commercial MCOs and fee-for-service delivery models. Virginia's first managed care program, MEDALLION primary care case management, began in 1993 in four pilot cities. In July 2014, the current statewide version of the managed care program, MEDALLION 3.0, includes an expedited enrollment process and expansion of family services to improve access and network adequacy. As of December 2015, just over 68 percent of Medicaid beneficiaries were enrolled in managed care. Virginia's total Medicaid expenditures in state fiscal year (SFY) 2015 were $8.0 billion which covered 1,277,214 enrollees. Virginia partners with six managed care plans: Anthem HealthKeepers Plus; CoventryCares of Virginia; INTotal Health; Kaiser Permanente; Optima Family Care; and VA Premier. Virginia's Federal Medical Assistance Percentage is 50 percent.

Methodology of the Review

In advance of the onsite visit, CMS requested that Virginia and the MCOs selected for the focused review complete a review guide that provided the CMS review team with detailed insight into the operational activities of the areas that were subject to the focused review. The CMS review team has reviewed these responses and materials in advance of the onsite visit.

During the week of March 7, 2016, the CMS review team visited the DMAS. It conducted interviews with numerous state staff involved in program integrity and managed care. The CMS review team also conducted interviews with the MCOs and their special investigations units (SIUs). In addition, the CMS review team conducted sampling of program integrity cases and other primary data to validate the state and the selected MCOs' program integrity practices.

Results of the Review

The CMS review team identified areas of concern with the state's managed care program integrity oversight, thereby creating 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. These issues and CMS's recommendations for improvement are described in detail in this report.

Section 1: Managed Care Program Integrity

Overview of the State's Managed Care Program

As mentioned earlier, approximately 1,277,214 beneficiaries, or 68 percent of the state's Medicaid population, were enrolled in MCOs during SFY 2015. The state's total Medicaid expenditures in SFY 2015 was approximately $8.0 billion.

Summary Information on the Plans Reviewed

The CMS review team interviewed three MCOs as part of its review.

Anthem HealthKeepers Plus (HealthKeepers) is the largest Medicaid health plan in Virginia and is the only statewide plan. HealthKeepers is a subsidiary of Anthem HealthKeepers, Inc., which is a national plan. The parent company is headquartered in Indianapolis, Indiana and is owned by Anthem Blue Cross Blue Shield. Presently, the parent company serves millions of Medicaid members in California, Florida, Georgia, Indiana, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Nevada, New Jersey, New York, South Carolina, Tennessee, Texas, Virginia, Washington, West Virginia, and Wisconsin. The SIU resources for each market are allocated based upon the following: total member population; volume of claims processed; number of suspect cases/claims; perceived vulnerability; investigator caseload; case clearance; rates; and contractual requirements.

CoventryCares of Virginia (CoventryCares) is a subsidiary owned by its parent company, Aetna. Aetna is a national plan that currently services eight markets. Shortly after the conclusion of the onsite review, CoventryCares changed its name to Aetna Better Health of Virginia. The majority of the activities of the SIU are conducted nationally.

Virginia Premier Health Plan, Inc., (VA Premier) is a nonprofit MCO formed to coordinate health care for low-income individuals; its parent company is Virginia Commonwealth University Health System. VA Premier is a local plan that operates in over 100 counties across the state. The MCO began operations as a full-service Medicaid health plan in 1995 and provided services to Medicaid recipients in the following programs: Family Access to Medical Insurance Security; Health and Acute Care Program; Temporary Aid for Needy Families; and Aged, Blind, and Deaf Residents. Committees provide oversight and guidance to the program integrity officer (PIO) in administering program integrity initiatives to prevent, detect, and eliminate fraud, waste, and abuse.
Enrollment and expenditure information for each MCO as of February 2016 is summarized below:

Table 1.

	HealthKeepers	**CoventryCares**	**VA Premier**
Beneficiary enrollment total	280,887	40,669	187,590
Provider enrollment total	25,379	23,696	9,868
Year originally contracted	1995	1996	1995
Size and composition of SIU	2 FTEs	13 FTEs	5 FTEs
National/local plan	National	National	Local

Table 2.

MCOs	FFY 2013	FFY 2014	FFY 2015
HealthKeepers	$818.1 million	$876.5 million	$1.0 billion
CoventryCares	$138.2 million	$156.5 million	$158.8 million
VA Premier	$585.4 million	$622.5 million	$724.3 million

State Oversight of MCO Program Integrity Activities

Oversight of the MCOs in the Virginia Medicaid program is conducted by the DMAS's Division of Health Care Services (DHCS). The DMAS's Program Integrity Division (PID) provides support and functions in an advisory capacity regarding MCO contract oversight; however, the DHCS has final authority.

The DMAS conducts the Program Integrity Compliance Audit (PICA) on each MCO annually. The PICA review information is submitted by the MCOs and allows the DMAS to evaluate the MCOs' efforts in preventing; detecting; and addressing fraud, waste, and abuse. The MCOs each provide their internal monitoring and audit plan for review. The PICA submission also captures information regarding all allegations received by the MCO; investigations conducted; and other program integrity activities from the prior year. The PICA captures program integrity allegations of fraud, waste, and abuse, including leads from data analysis and non-fraud referrals. During the PICA review, each MCO is required to explain how program integrity risk is assessed by their plan and demonstrate how that risk assessment directs their activities. Furthermore, the MCO is required to project activities for the current contract year and explain any changes occurring from the prior year to the current year.

The DMAS also requires the MCOs to submit failed credentialing reports on a quarterly basis. The credentialing report lists all providers who have failed accreditation; credentialing; or recredentialing; and who were denied application or terminated for program integrity related reasons. Also, the DMAS receives quarterly reports of fraud, waste, and abuse activity from the MCOs, which is then forwarded to the MFCU for review. The DMAS receives individual notifications of suspected provider fraud and planned provider investigations (whether or not fraud is suspected). The DMAS then receives a quarterly summary of these referrals. Only referrals of suspected fraud are sent to the MFCU. These suspected fraud referrals are forwarded to the MFCU on an individual basis and upon receipt using the referral form; they are not sent on the basis of the quarterly reports.

Lastly, the Medallion 3.0 contract states that, "The [Internal Monitoring and Audit] plan shall include a schedule that includes a list of all the monitoring and auditing activities for the calendar year. Contractors shall consider a combination of desk and onsite audits, including unannounced internal audits or 'spot checks', when developing the schedule." This contract provision addresses the inclusion of annual onsite reviews, in conjunction with the PICA tool, as a means to evaluate MCO program integrity activities and as an aid in preventing; detecting; and addressing fraud, waste, and abuse. Although the balance of onsite reviews and/or PICA is not specified, in recognition of the value of onsite visits, the state has included the following

language in its MCO model contract affirming, "Contractors shall include in work plan the number of subcontractors that will be audited each year, how the subcontractors will be identified for auditing, and should make it a priority to conduct a certain number of onsite audits." The CMS review team found that annual onsite reviews of the MCOs were not being conducted by either the state or its delegate. Annual onsite reviews aid in the assessment as to whether MCO contractual deliverables, processes, or current program integrity parameters implemented by the state require revision.

MCO Investigations of Fraud, Waste, and Abuse

As required by 42 CFR 455.13, 455.14, 455.15, 455.16, and 455.17, the state does have an established process for the identification, investigation, referral and reporting of suspected fraud, waste, and abuse by providers and MCOs.

Virginia's MCO contract states, that the MCO shall submit electronically to the Department each quarter all activities conducted on behalf of PI by the Contractor and include findings related to these activities."

All providers suspected of fraud or abuse must be reported to the PID within 48 hours of discovery and prior to conducting an initial investigation. Whether the provider is scheduled for immediate audit or is awaiting audit, prompt notification to the state is mandatory. In addition, MCO cases referred as suspected fraud to the DMAS are also forwarded to the Office of the Attorney General's Medicaid Fraud Control Unit (MFCU), according to the contractual requirements. The MCOs refer cases of suspected fraud to DMAS. The determination of a credible allegation of fraud may only be made by the state Medicaid agency, according to the final rule on payment suspension. This final rule makes clear that a suspicion of fraud and a credible allegation of fraud are not synonymous and require different levels of scrutiny.

The PID receives quarterly reports of all activities conducted on its behalf by the MCOs and the findings related to those activities. The MCO is required to use the PID's templates, formats, and the methodologies specified in the state's *Managed Care Technical Manual* and found on the Medallion 3.0 website.
The DMAS has not historically conducted any investigations of its MCOs directly related to allegations of fraud and abuse committed by those entities.

The majority of CoventryCares' SIU functions are conducted at the national level by its parent company, Aetna. Aetna's SIU maintains access to the huge volume of claims data that spans all of their subsidiaries' health products. On a daily basis, the MCO's SIU coordinates efforts with the program integrity lead and the program integrity committee. Every allegation referred to and/or investigation opened by CoventryCares' SIU is first crosschecked at the national level against all of the parent company's Medicaid MCO providers and providers in their other lines of business; based upon the results of that crosscheck, the case is assigned accordingly to the appropriate plan. Monthly collaborative meetings are held between the SIU and PID; quarterly program integrity committee meetings are conducted between the MCO and Aetna's SIU staff at the national level.

A daily communications log between the national SIU and the plan's program integrity unit is maintained. The CoventryCares' SIU generates monthly trend reports of its program integrity activities and its Quality Management and Compliance Department makes referrals and reports to the state. Data mining is conducted at the national level as well as at the state plan level.

HealthKeepers' SIU resources for each market are allocated based upon total member population; volume of claims processed; number of suspect cases and/or claims; perceived vulnerability; investigator caseload; and case clearance rates. HealthKeepers maintains separate SIUs for its Medicare, Medicaid, and commercial lines of business; each SIU is independently managed and fully dedicated to a specific line of business. The SIUs meet regularly to share information on trends, schemes, and collaborate on specific cases that may cross lines of business. The function of HealthKeepers' Medicaid Special Investigations Unit (MSIU) is to establish controls; develop a coordinated and consistent approach to fraud, waste and abuse efforts; and to ensure compliance with mandated regulatory requirements. The MSIU is fully dedicated to the detection; prevention; investigation; and prosecution of fraud, waste, and abuse. The MSIU is independent from the claims and operations departments.

VA Premier has established committees that are responsible for program integrity and compliance efforts. The committees provide oversight and guidance to the PIO in administering the program integrity and compliance plan, as well as other program integrity initiatives. The PIO and its program integrity committees are responsible for developing; operating; and monitoring the fraud, waste, and abuse program. Also, the PIO coordinates the activities of the internal audit unit and the SIU. VA Premier's SIU conducts and monitors investigations. In addition, the PIO has the authority to report credible allegations of fraud to the DMAS; CMS; MEDIC; and law enforcement.

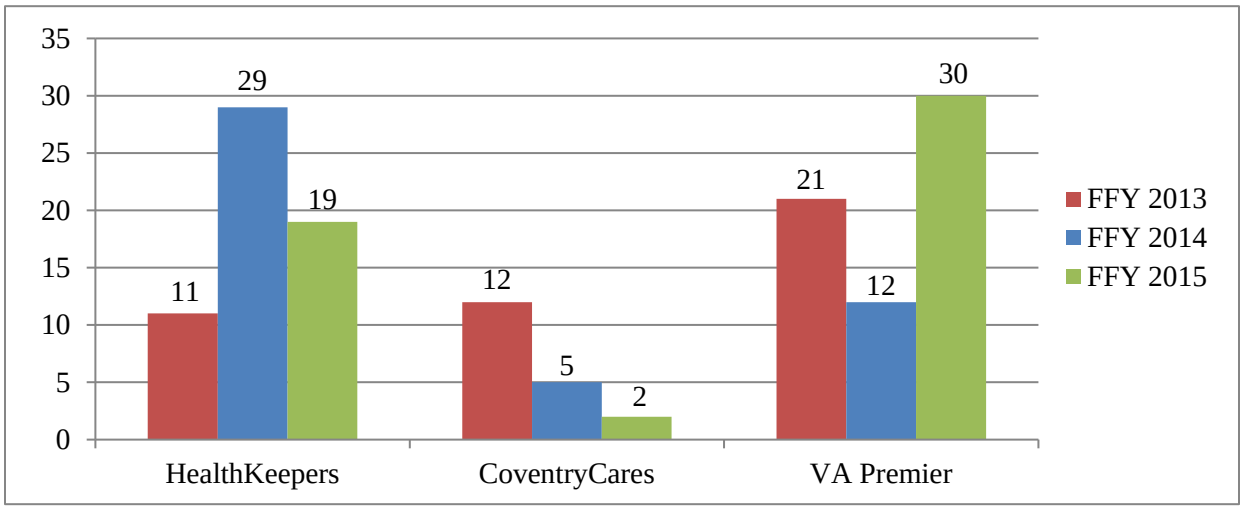
Also, each MCO utilizes a tracking system that captures essential details of investigations on a quarterly basis. Each MCO's tracking spreadsheet summarizes investigations opened; investigations closed; fraud referrals; a summary of cost containment activities; and lists the monies identified, recovered, and avoided. CoventryCares uses the SharePoint system to track cases. Both VA Premier and HealthKeepers utilize proprietary systems for reporting that are designed to track investigations and daily program integrity activities based upon the specifications defined by each of the MCOs. All tracking systems were found to adequately summarize the necessary elements of cases.

Table 3 lists the number of referrals that the MCOs made to the state in the last three FFYs. Overall, the number of Medicaid provider investigations and referrals by each of the MCOs is relatively low, compared to the size of the plan, and the volume of monies overpaid to providers and identified for recovery.

The level of investigative activity has changed over time for all three MCOs. HealthKeepers implemented a new claims system (EDIWatch) and began loading claims data into EDIWatch data analysis software in November 2013. As a result of this new detection process, HealthKeepers identified additional targets for investigation in FFY 2014. According to the state, CoventryCares began to implement substantially more prepayment reviews in FFY 2014, which resulted in a decrease in referrals in FFY 2014. Virginia Premier began utilizing a new

anti-fraud, waste, and abuse software program which increased the number of identified targets in many of their audit areas in FFY 2015.

Table 3.



A sample size of fraud referrals made by MCOs during the last four FFYs was requested from the DMAS. The DMAS stated that referrals are forwarded to the MFCU for investigation of credible allegations of fraud. The DMAS does not investigate the providers, but may provide technical support during the MFCU's investigation.

As a law enforcement agency and a separate government entity, the MFCU does not provide the DMAS with any investigatory documentation. Although they do not receive any investigatory documentation, the DMAS does work closely with the MFCU on their investigations and is kept informed of investigatory activity through monthly meetings with the MFCU. At these meetings, the MFCU provides updates on the status of all cases including data analysis conducted; records subpoenaed; individuals interviewed; plea agreements underway; scheduled court dates; and sentencing.

Meetings and Trainings

Neither the state nor the MFCU has provided any program integrity training for the MCOs during the past FFY. However, the MFCU has provided some instruction regarding the elements of good fraud referrals, during the quarterly program integrity collaborative meetings. In past FFYs, the state conducted appeals training for MCO staff on three separate occasions; two trainings regarding informal and formal appeals process were presented in 2013, and a training on construction of a case summary was held in 2014.

MCO Compliance Plans

The state does require its MCOs to have a compliance plan to guard against fraud and abuse in accordance with the requirements at 42 CFR 438.608.

The state does have a process to review the compliance plans and programs.

As required by 42 CFR 438.608, the state does review the MCE's compliance plan and communicates approval/disapproval with the MCEs.

The staff of the DHCS and PID review each MCO's internal monitoring and audit plan and the required program integrity policies during an annual PICA review. As previously mentioned, the PICA reviews are an evaluation of organizational level compliance and adherence to the terms of the managed care contract and best practice models. Both a summary of program integrity activities conducted in the prior year and the projection of program integrity activities throughout the current year are reviewed. This information allows the DMAS to analyze trends and assess changes in MCO program integrity activities based on issues identified. Also, the overall number of allegations and investigations projected in comparison to the actual number conducted allows the DMAS to assess the MCOs' fulfillment of their program integrity obligations. The DMAS also reviews audit reports from completed MCO program integrity investigations to evaluate the conduct and outcome of these investigations. In addition, the DMAS has amended the contract to grant the state Medicaid agency the authority to audit the MCOs' networks and conduct joint audits with the MCOs of their network providers with a focus on fraud and abuse activities.

The MCO's Compliance Monitoring Process (CMP) detects and responds to issues of noncompliance and remediates contractual violations. The CMP uses a tiered points system to achieve the department's goal of contract compliance. The most recent review of the compliance plan was conducted in early 2015 by DHCS and PID staff. The review revealed minimal issues. Most of these issues involved lack of consistency in definitions to allow the DMAS to compare year-to-year changes. The state reports that, due to continuing improvements in the standardization of reporting methods, assessing the MCOs' program integrity activities and compliance has become more efficient than in previous timeframes.

All of the MCOs provided the review team with a copy of their compliance plans that have been submitted to the state. A review of these plans revealed they were in compliance with 42 CFR 438.608.

Encounter Data

The MCO contract with the state requires certification of data submitted in accordance with 42 CFR 438.606. Encounter data must be submitted on a monthly basis; meet the standards for accuracy; include all clean claims adjudicated by the MCO; and detail all services provided to the managed care client, whether contracted or delegated. The state will annually reconcile encounter data submitted to the Medicaid Management Information System by the MCO against the data submitted to the DMAS by the MCO for rate setting purposes. The state will assess a monetary sanction for each service type with more than a five percent variance between the rate data and the encounter data submitted. The state does currently use this data to inform program integrity investigations.

Overpayment Recoveries, Audit Activity, and Return on Investment

The state does require MCOs to report on overpayments recovered from providers as a result of MCO fraud and abuse investigations or audits. The DMAS does require the MCOs to report on overpayments recovered from providers, as a result of MCO fraud and abuse investigations or audits. Recoveries are reported on the quarterly financial report and are broken out by the type of program integrity activity. These recoveries are also reported for each individual case, as a part of the annual PICA review. Both the quarterly report and the PICA require MCOs to report the amount of overpayments identified, as well as what has been recovered. In addition, plans must report any savings from program integrity prevention activities that stop payments from being made and, therefore, do not need to be recovered.

Subsequently, overpayments are adjusted in each MCO's claims data utilized in the rate setting process. The MCO follows the DMAS directive to refer all cases of suspected fraud and abuse, where there is an identified overpayment. This information is reported to the DMAS via the *Abuse, Corrective Action, Overpayment/Recovery Activity Report* on a quarterly and annual basis.

The table below shows the respective amounts reported by the MCOs for the past three FFYs.

Table 4-A.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2013	13	9	$9.06 million	$4.02 million
2014	75	40	$4.28 million	$3.88 million
2015	57	18	$6.84 million	$10.54 million

Table 4-B.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2013	20	15	$1.50 million	$1.46 million
2014	33	16	$1.98 million	$1.94 million
2015	35	8	$1.79 million	$1.57 million

Table 4-C.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2013	60	26	$1.57 million	$1.03 million
2014	37	17	$1.58 million	$1.45 million
2015	92	21	$1.92 million	$1.91 million

Overall, total overpayments recovered have continued to increase over the past three FFYs. HealthKeepers experienced higher than usual monies recovered in FFY 2015, due to payments

received from recovery efforts conducted during previous FFYs. CoventryCares recovered most of the overpayments identified; during the past three FFYs. According to the state, the MCO has experienced a slight decline in overpayments identified and recovered as a result of their implementation of a prepayment review process. The state maintains that the prepay review process has resulted in fewer overpayments and reduced the necessity for recovery activities. VA Premier has also recovered most of the monies identified as overpaid to providers; the MCO has also experienced a gradually increasing trend in overpayments identified and recovered. As previously mentioned, HealthKeepers implemented a new claims system and began loading claims data into EDIWatch data analysis software which resulted in a significant increase in full investigations in FFY 2014.

Additionally, the CMS review team found that two of the three MCOs interviewed placed providers on prepayment review for a time period of one year or longer. Prepayment review is a process that pends claims payments and requires providers to submit medical records which are reviewed before those claims are paid. The MCOs appear to place providers on prepayment for periods of one year or longer, rather than utilizing other measures to deter overpayments to providers with aberrant billing practices, such as provider termination. Plans have terminated providers who had negative findings resulting from prepayment review; however, the plans may choose to keep providers they deem necessary to their network adequacy under prepayment review to ensure their claims are adequately scrutinized before payment. CoventryCares noted that providers on prepayment review are evaluated after 120 days; if billing behaviors have not changed after 120 days, the provider issue is discussed in the program integrity committee meeting to determine if this provider should continue on prepayment review or should be terminated from the network.

Payment Suspensions

In Virginia, Medicaid MCOs are contractually required to suspend payments to providers at the state's request. The state confirmed that there is contract language mirroring the payment suspension regulation at 42 CFR 455.23.

The state instructs the MCOs to suspend payments to MCO network providers based upon a pending investigation of a credible allegation of fraud. As previously mentioned, the MCO contract with the DMAS requires referral of credible allegations of fraud to the state within 48 hours. All three MCOs follow this requirement and only suspend payments to network providers upon credible allegation of fraud determinations by the state and at the direction of either the DMAS or the MFCU, according to the state's MCO model contract. The final rule on payment suspension specifies that only the state Medicaid agency may make the determination that a credible allegation of fraud exists against a provider. If it is determined that an allegation is credible, the state will submit a formal written referral to its MFCU regardless of whether the MFCU assisted in validating an allegation's credibility.

Neither HealthKeepers nor CoventryCares has suspended any provider payments in the past four FFYs; however, VA Premier has suspended payments to eight providers in the past four FFYs. During the past three FFYs, all MCOs have reported sending fraud referrals to the state. As previously mentioned, the DMAS forwards those referrals to the MFCU for investigation. However, the volume of referrals resulting in provider payments suspended is relatively low in

comparison to the number of cases referred to the state and volume of monies overpaid to providers. Many of the cases referred by the MCOs are currently under investigation by the MFCU, which has imposed good cause exemptions based on the law enforcement exceptions in 42 CFR 455.23.

The state Medicaid agency explained that the number of providers suspended differs between plans, since the suspended provider may not participate with every plan. If the provider does not participate, the plan has nothing to suspend.

Terminated Providers and Adverse Action Reporting

The MCO contract with the DMAS states, "The Contractor shall report quarterly all providers who have failed to meet accreditation/credentialing standards or been denied application (including MCO-terminated providers), this includes program integrity-related and adverse actions."

The contract also contains, "Procedures to provide a good faith effort to give written notice of termination of a contracted provider within 15 days after receipt or issuance of the termination notice to each member who received care on a regular basis from the terminated provider."

The DMAS requires the MCOs to submit failed credentialing reports on a quarterly basis. The credentialing report lists all providers who have failed accreditation; credentialing; or recredentialing; and who were denied application or terminated for program integrity related reasons. The DMAS reports for cause terminations to CMS via email for inclusion in the TIBCO system. Providers for state Medicaid program terminations are placed on the national Medicaid State Information Sharing (MCSIS) database.

Table 5.

MCOs	Total # of Providers Disenrolled or Terminated in Last 3 Completed FFYs		Total # of Providers Terminated For Cause in Last 3 Completed FFYs	
HealthKeepers	2013 2014 2015	69 89 117	2013 2014 2015	15 16 18
CoventryCares	2013 2014 2015	947 808 705	2013 2014 2015	10 6 9

MCOs	Total # of Providers Disenrolled or Terminated in Last 3 Completed FFYs		Total # of Providers Terminated For Cause in Last 3 Completed FFYs	
VA Premier	2013 2014 2015	1,666 1,311 2,076	2013 2014 2015	2 0 0

Overall, the number of providers terminated for cause by all three of the plans appears to be relatively low, compared to the number of providers in each of the MCO's networks and compared to the number of providers disenrolled or terminated for any reason. Also, the review team notified the state that they were utilizing the incorrect email to report providers terminated for cause to CMS.

Federal Database Checks

The regulation at 42 CFR 455.436 requires that the state Medicaid agency must check the exclusion status of the provider or persons with an ownership or control interest in the provider, and agents and managing employees of the provider on the U.S. Department of Health and Human Services-Office of Inspector General's (HHS-OIG) List of Excluded Individuals and Entities (LEIE); the Excluded Parties List System (EPLS) on the System for Award Management (SAM); the Social Security Administration's Death Master File (SSA-DMF); the National Plan and Provider Enumeration System upon enrollment and reenrollment, and check the LEIE and EPLS no less frequently than monthly. Per the state contract, the MCOs are responsible for provider screening and enrollment.

The three health plans were not in full compliance with checking all the federal databases required at 42 CFR 455.436 for all required persons identified at the organizational level and those the health plan subcontracts with in accordance with 42 CFR 438.610. This was confirmed during MCO interviews and by reviewing the MCO responses to the review guide module.

All three MCOs confirm the identity, exclusion and debarred status of plan providers by checking them against the LEIE and EPLS at initial enrollment and monthly thereafter. Only HealthKeepers checks the SSA-DMF upon screening and enrollment of providers; however, it does not check the database for credentialing or recredentialing. HealthKeepers also checks the NPPES. CoventryCares does check the NPPES; however, it does not check the SSA-DMF. VA Premier checks the NPPES, but does not check the SSA-DMF.

Recommendations for Improvement

- The DMAS should ensure that the MCOs build program integrity units with sufficient resources and staffing commensurate with the size of their managed care programs to conduct the full range of program integrity functions including the review, investigation, and auditing of provider types where Medicaid dollars are most at risk.
- The DMAS should conduct MCO onsite visits at least once a year. Regular onsite visits would provide increased oversight by the state Medicaid agency, in addition to review tools such as the PICA submission.

- The DMAS should obtain feedback from the MFCU regarding the quantity and quality of MCO referrals reviewed.
- The state should work with the MCOs to develop and provide program integrity training on a routine basis to enhance case referrals from the MCOs. The state should ensure that MCO staff is receiving adequate training in identifying, investigating, and referring potential fraudulent billing practices by providers.
- The DMAS and the MCOs should work together to strengthen parameters regarding prepayment rules, policies, and requirements. The length of time that providers remain on prepayment should be evaluated with regard to the effectiveness and resources allocated to monitoring providers over an extended duration.
- The state should obtain evidence from its MCOs in support of any statements attributing a decline in overpayments as the direct result of cost avoidance activities or proactive measures in place. Some tangible examples of cost avoidance include a walk-through of the Medicaid Management Information System edits; written policies and procedures specifically addressing cost avoidance activities; documentation from contractors regarding measures instituted and resulting in cost avoidance; screenshots, documentation, tracking spreadsheets, samples, etc. from systems that demonstrate cost avoidance measures; or an explanation of any methodology employed that has resulted in deterring overpayments to providers.
- The state Medicaid agency should ensure that payments are suspended to providers with credible allegations of fraud to decrease the monies overpaid and lessen the need for recovery measures.
- The state should ensure that they are downloading and checking the monthly Medicare revocation list from TIBCO. The state should also consider providing the downloaded TIBCO list of terminated providers to their MCOs to assist in identifying providers who should be terminated from the plans' networks and to decrease reliance on disenrollment as the primary method for removal of terminated providers. The state should ensure that terminated providers are being forwarded for entry into the TIBCO system.
- The state should ensure that the MCOs are performing all required federal database checks for the organization (42 CFR 455.436) and for all others required (42 CFR 438.610) at the appropriate time intervals specified in the regulations.

Section 2: Status of Corrective Action Plan

Virginia did not have a CAP to review and allow for the reporting of progression. Also, the findings and vulnerabilities in the 2011 review report related to ownership, control disclosures, and exclusion searches were based on regulations that have since changed. As a result, it has been determined that Virginia made a good faith effort to address all findings and vulnerabilities identified during the previous onsite review in 2009.

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:

- Use the program integrity review guides posted in the Regional Information Sharing Systems as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the Regional Information Sharing Systems for information provided by other states including best practices and managed care contracts.
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute which can help address the risk areas identified in this report. Courses that may be helpful to Virginia are based on its identified risks include those related to managed care. More information can be found at http://www.justice.gov/usao/training/mii/.
- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- 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. The CMS annual report of program integrity reviews includes highlights of states that have been cited for noteworthy and effective practices in managed care. These reports can be found at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html
- Access the Toolkits to Address Frequent Findings: 42 CFR 455.436 Federal Database Checks website at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/fftoolkit-federal-database-checks.pdf.

Conclusion

The CMS focused review identified areas of concern with federal regulations which should be addressed immediately.

We require the state to provide a CAP for each of the recommendations within 30 calendar days from the date of the final report letter. The CAP should address all specific risk areas identified in this report and explain how the state will ensure that the deficiencies will not recur. The CAP should include the timeframes for each correction 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 CAP 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 the letter. If the state has already taken action to correct compliance deficiencies or vulnerabilities, the CAP should identify those corrections as well.

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

Official Response from Virginia
March 2017

COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

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March 16, 2017

Laurie Battaglia, Director of the Division of State Program Integrity
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Laurie.Battaglia@cms.hhs.gov

Dear Ms. Battaglia:

We have reviewed the final report for the focused review of the Virginia Medicaid program integrity procedures and processes. The review was conducted during the week of March 7, 2016 by a team from the CMS Investigations and Audit Group. We would like to thank you for the opportunity to review and respond to the report and for the assistance you have provided in strengthening Virginia's program integrity efforts.

Overall, DMAS appreciates the opportunity to learn about opportunities to improve the integrity of the Medicaid program, particularly as it relates to our oversight of managed care organizations. DMAS was troubled that the final report contained three new recommendations that were not mentioned anywhere in the draft report. As a result, DMAS was not given an opportunity to respond to those recommendations during our review. We believe that they mischaracterize our program and suggest that DMAS is not performing certain activities that are currently being performed. In addition, the first sentence of the "Results of the Review" section indicates that CMS identified "areas of concern" that create "risk to the Medicaid program." However, those terms are not used anywhere in the body of the report that describes DMAS program integrity. We respectfully request that CMS revise the language to "recommendations for improvement" in the final published report.

Once again, we appreciate the assistance CMS has provided to Virginia's program integrity efforts and look forward to working with you in the future. Attached is our Corrective Action Plan addressing each of the recommendations in the report. If you have any questions regarding the attached corrective action plan, please contact Louis Elie, Director, Program Integrity, at (804) 786-5590 or Louis.elie@dmas.virginia.gov.

Sincerely,

Cindi B. Jones Director
Virginia Department of Medical Assistance Services

Enc.

Cc: Louis Elie, Director, Program Integrity Division