COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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May 4, 2018

Linda Hines, CEO
Virginia Premier Health Plan
600 E Broad St, 4th Floor
Richmond, VA 23219

Re: CCC Plus Program – Corrective Action Plan

Dear Ms. Hines:

We believe Virginia Premier Health Plan (Premier) and the Department of Medical Assistance Services (the Department) share a common goal which is to ensure Medicaid members enrolled in the Commonwealth Coordinated Care Plus (CCC Plus) program receive effective, quality and timely health care. To achieve that goal, Premier's role is to provide care coordination with the member, work collaboratively with providers to issue authorizations for care and process claims timely. The Department's responsibility is to monitor health plan performance with Contract standards, including quality of care, reporting and payment to providers.

The Department has conducted weekly CCC Plus implementation calls since August 2017 with Premier's operational staff. Calls included monitoring implementation performance through review of the weekly dashboard to identifying and discussing issues and tracking issues to resolution. Throughout the past months, Premier has remained engaged in these monitoring activities and committed to resolving identified issues.

Despite this effort, there are five (5) areas where Premier's performance is not within Contract standards. See Attachments 1 through 5 for a full description of each of those areas, the related Contract requirement(s) and the areas that Virginia Premier must address in its Corrective Action Plan (CAP) to comply with these Contract standards.

Virginia Premier's written CAP for all five (5) areas listed in the Attachments must be provided to the Department for approval no later than May 29, 2018. Failure to comply with the approved CAP will result in additional sanctions.

Virginia Premier must reply in writing within 15 calendar days from the date of this letter ("Comment Period") to provide any additional information and/or documentation that will affect this determination and/or accept the CAP as drafted. Please address this letter to me.

If you have any questions regarding these concerns, Contract standards or CAP requirements, please let me know.

Sincerely yours,

Jennifer Lee, M.D.
Director
Department of Medical Assistance Services

Attachments

ATTACHMENT 1 – AREA FOR CORRECTIVE ACTION

1.1 – 2018-VAP-001 – Care Coordination:

Ten-year-old Member was enrolled 08/01/2017 with Premier. No Waiver services in place on effective date. Unable to contact (UTC). Contact made and Health Reimbursement Arrangement (HRA) completed 10/10/2017. HRA documents that the member's grandmother stated she needed additional assistance, including Activities of Daily Living (ADL). This identified need was not addressed in notes or Individualized Care Plan (ICP).

According to Premier, a Level of Care (LOC) review was submitted on 10/16/2017. It was confirmed that the member met criteria for the CCC Plus Waiver. No contact is documented with the member's representative and no services were initiated.

A reassessment was performed 04/03/2018. It was documented that the grandmother again stated that she needed assistance with the member's care. This identified need was not addressed in notes or the ICP. The member was still enrolled in the CCC Plus Waiver, receiving no services.

This same member had In-home Services (IIH) authorized through the fee-for-service (FFS) Magellan Behavioral Health Service Administrator (BHSA). The documentation from the HRA performed in October 2017 and the initial ICP addressed neither the receipt of these services nor the need for them.

A continuity of care authorization was generated for these services from 01/01 through 04/01/2018. The provider was out of network. There is no documentation provided to the Department that there was an evaluation of the members needs for ongoing IIH services or any alternative services to best meet the needs of the member. The reassessment performed on 04/03/2018 did not provide the information necessary to determine the actual needs of this member and determine the most appropriate services.

1.2 – CONTRACT REQUIREMENTS:

As explained in section **5.2.1.1 – Global HRS Tool Elements** of the ***Commonwealth Coordinated Care Plus MCO Contract for Managed Long Term Services and Supports (CCC Plus Contract)***, MCOs "At a Minimum, the Contractor's HRA shall effectively identify the Member's unmet needs, and shall encompass social factors (such as housing, informal supports, and employment), functional, medical, behavioral, cognitive, LTSS, wellness and preventive domains, the Member's strengths and goals, the need for any specialists, community resources used or available for the Member, the Member's desires related to their health care needs (as appropriate), and the person-centered **ICP** maintenance."

As explained in section **5.2.3 – HRA Requirements** of the ***CCC Plus Contract***, MCOs
"7) Relevant and comprehensive data sources (including the Member, providers, family/caregivers, etc.) shall be used by the Contractor. Results of the HRA shall be used to confirm the appropriate stratification level for the Member and as the basis for developing the ICP.
8) The Contractor shall ensure that each element of the HRA, including a description of the CCC Plus Waiver and other covered services to be provided until the next person-centered ICP review, is reflected in the ICP. In addition, the Contractor shall ensure that its ICT process ensures that all relevant aspects of the Member's care is addressed in a fully integrated manner on an ongoing basis"

As explained in section **5.3.2 – ICP Required Elements** of the ***CCC Plus Contract***, MCOs "The following elements shall be included in the Contractor's ICP. Other elements may also be necessary depending upon the Member's circumstances. Required elements include but are not limited to:
6) Addressing all needs of the Member (functional, medical, behavioral, cognitive, social, LTSS, wellness and preventive) as well as any preferences as identified by the Individualized Care Team (ICT) and agreed upon by the Member
7) Prioritized list of concerns, preferences, needs, goals, and strengths, as identified with the Member
14) Member's choice of services (including model of service delivery for personal care and respite –consumer-directed vs. agency-directed when appropriate for CCC Plus Waiver Members)"

As explained in section **5.9.1 – Care Coordination** of the ***CCC Plus Contract***, MCOs "In addition, Care Coordinators shall:
11) Monitor the provision of services, including outcomes, assessing appropriate changes or additions to services, and facilitating referrals for the Member
12) Ensure the ICP is developed updated as necessary
15) Solicit and comply with the Member's wishes (e.g., advance directive about wishes for future treatment and health care decisions, prioritization of needs and implementation of strategies, etc.)."

As explained in section **5.14 – Continuity of Care** of the ***CCC Plus Contract***, MCOs "In accordance with 42 CFR § 438.62, the Contractor's strategic processes shall include: the Contractor's compliance with requests for historical utilization data when the Member is enrolled in a new MCO; the ability for the Member to retain the access to services consistent with the access they previously had and is permitted to retain their current provider during the continuity of care period (refer to Section 5.14.1) if that provider is not in the network; the Contractor refers the Member to appropriate providers of service that are in the network.

During the continuity of care period, the Contractor shall make reasonable efforts to contact out-of-network providers who are providing services to Members, and provide them with information on becoming credentialed, in-network providers. If the provider does not join the network, or the Member does not select a new in-network provider, the Contractor shall facilitate a seamless transition to a participating provider (with the exception of NF residents)."

1.3 – CORRECTIVE ACTION NEEDED:

Premier must document and implement a CAP to bring authorization, assessments and Level of Care reviews in compilance with contract standards. Please ensure that the CAP includes the following information:

- Project Plan or a list of deliverables, milestones, due dates and percentage complete that address the fundamental failures between the HRA and the ICP
- A weekly update to this Project Plan to the Department for monitoring progress. Update will be due by close of business each Tuesday, starting May 29, 2018

ATTACHMENT 2 – AREAS FOR CORRECTIVE ACTION

2.1 – 2018-VAP-002 – Billing/Claims:

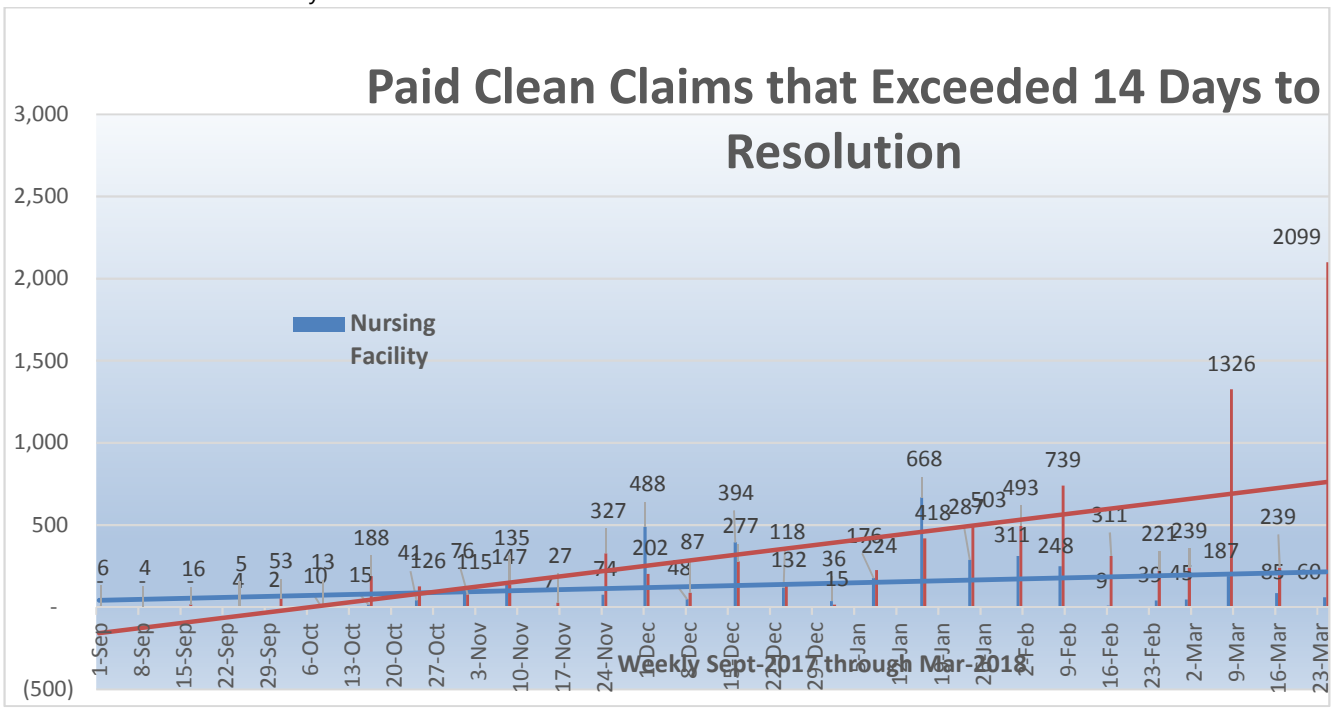
Virginia Premier has reported a significant number of claims paid outside of the contractually required time frames. Nursing facility (NF) claims were seriously in arrears. The Department has convened an ongoing NF claims workgroup with health plan and NF participation in order to resolve issues. At this time, the backlog appears to be resolved based on the latest update from Virginia Premier. Additionally, on 04/10/2018 Premier notified the Department that due to a systems issue, approximately 60,000 claims were "found." Of these, 175 claims had been submitted more than 14 days prior and 13,596 claims had been submitted more than 30 days prior. These claims will not be paid within the contractually required time frames.

2.2 – CONTRACT REQUIREMENTS:

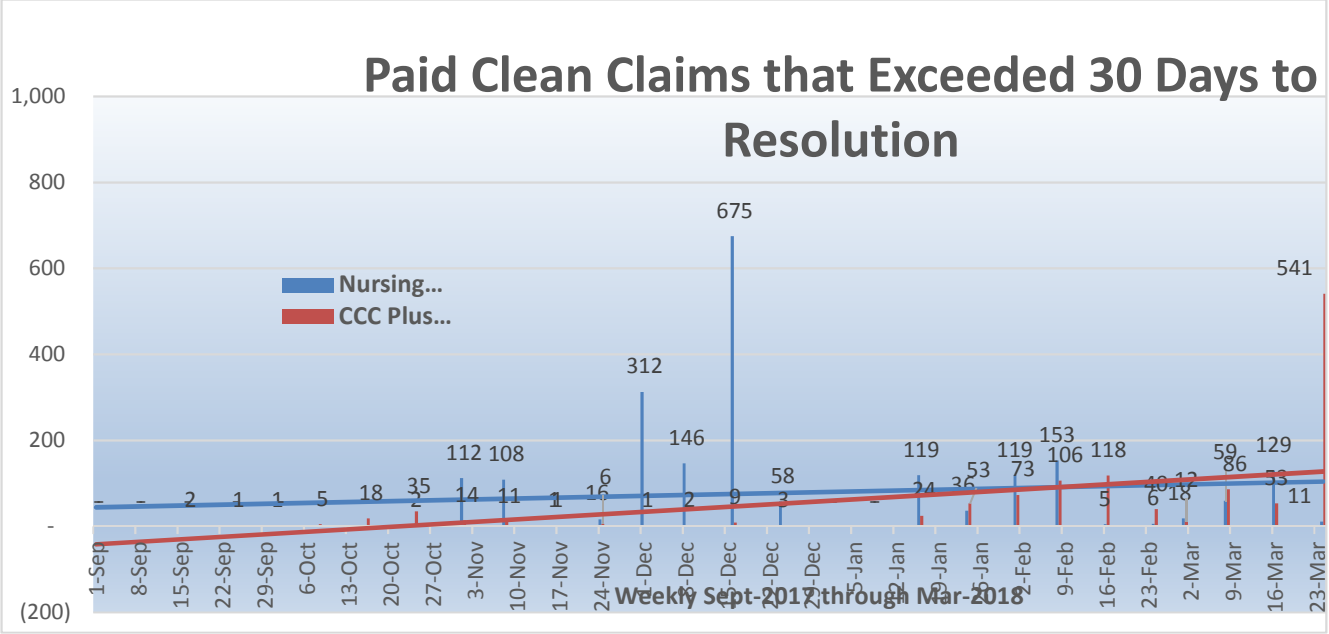
As explained in section **12.4.2 – Exceptional Processing and Payment Rules for Nursing Facility, LTSS, ARTS, CMHRS and Early Intervention** of the **CCC Plus Contract**, MCOs "The Contractor shall ensure clean claims from Nursing Facilities, LTSS (including when LTSS services are covered under EPSDT), ARTS, CMHRS and Early Intervention (EI) providers are processed within fourteen (14) calendar days of receipt of the clean claim, as clean claim is defined in this contract, for covered services rendered to covered Members who are enrolled with the Contractor at the time the service was delivered"

The Paid Claims Trend is identified below;

Paid Claims – Exceed 14 Days:



Paid Claims – Exceed 30 Days:



2.3 – CORRECTIVE ACTION NEEDED:

Premier must document and implement a CAP that addresses how they will adhere to the Claim Adjudication timeframes outlined in the Contract and shall include steps that will be taken to come into compliance with these requirements. Please ensure that the CAP includes the following information:

- Project Plan or a list of deliverables, milestones, due dates and percentage complete that address the backlog and/or any system issues that prevent timely claims processing
- A weekly aging report showing the date of receipt of pended claims, by category as specified on the dashboard
- A weekly update to this Project Plan to the Department for monitoring progress. Update will be due by close of business each Tuesday, starting May 29, 2018

ATTACHMENT 3 – AREAS FOR CORRECTIVE ACTION

3.1 – 2018-VAP-003 – Authorization:

Virginia Premier received an initial medical transition report (MTR) file from the Department on 12/18/2017 inclusive of all active authorizations issued by Magellan BHSA for Community Mental Health Rehabilitative Services (CMHRS) for members in order to allow Premier to issue continuity of care authorizations. Due to systems issues and file transfer issues with their subcontractor, Beacon, authorizations for continuity of care were not issued in a timely manner. This had significant downstream effects and impacted providers' ability to be reimbursed for services. As of 3/13, it was reported that all authorizations were loaded into Premiers VITAL system (a Care Management document system) for the 01/01/2018 transition of CMHRS to CCC Plus health plans. As of 04/05/2018 it was reported that Premier is continuing to make progress in automating the authorizations from Beacon into the VITAL system and the reconciliation as of that date showed approximately 90% of the authorizations were in VITAL (required for claims payment).

3.2 – CONTRACT REQUIREMENTS:

As explained in section **5.14 – Continuity of Care** of the ***CCC Plus Contract***, "The Contractor must have systems and operational processes in place for sharing data to/from DMAS, reviewing the data for potential high-risk Member needs, and utilizing the data to support the transition process. Transition data shall include but not be limited to Member's claims and service authorizations. The process shall require the Contractor to, at a minimum:

1) Ensure that there is no interruption of covered services for Members
2) Accept the transfer of all medical records and care coordination data, as directed by DMAS and,
3) Send service authorization data to support continuity of care for Members transitioning between fee-for-service and CCC Plus. Reference the Medical Transition Report (MTR) File section for more information."

3.3 – CORRECTIVE ACTION NEEDED:

Premier must document and implement a CAP that addresses how they will adhere to the Claim Adjudication timeframes outlined in the Contract and shall include steps that will be taken to come into compliance with these requirements. Please ensure that the CAP includes the following information:

- Project Plan or a list of deliverables, milestones, due dates and percentage completed that address how the Contractor generates service authorizations for continuity of care for Members whose authorization information is included in the MTR file received from the Department prior to enrollment. Plan should also address how this information is disseminated to any subcontractors.
- How the Contractor will notify Members and Providers in writing of continuity of care authorization. Notice shall include the authorized service or item, provider name, units or amounts authorized and authorization dates of service.
- How the Contractor will ensure that medically necessary services are continued without gaps in care at the end of the continuity period and the role of the care coordinator to ensure that needed services on an ongoing basis do not lapse.
- A weekly update to this Project Plan to the Department for monitoring progress. Update will be due by close of business each Tuesday, starting May 29, 2018.

ATTACHMENT 4 – AREAS FOR CORRECTIVE ACTION

4.1 – 2018-VAP-003 – Authorization:

Multiple complaints from providers stating delays in receiving service authorizations for Waiver services. Premier identified that their systems did not include a discreet field to document the receipt date of authorization requests for accurate tracking and reporting and on 3/13, stated modifications were being made to the system to include the actual receipt date. Premier stated on 3/21 that all impacted auths would be corrected by the end of the month. On 4/5, Premier reported that the impacted auths would be corrected by 4/30. Virginia Premier later explained that their system does have a discreet receipt date but the functionality includes auto-entry of the date the request is entered. If the receipt date is different than the current date, a manual override entry is required. Volume of delayed authorizations unknown. Premier was sent three examples of requests from a provider concerned about delays. One member's authorizations were generated one month after receipt for personal care and 5 weeks after receipt for respite. Second member's authorizations were processed 20 business days after receipt (personal care) and 21 business days after receipt (respite). The third member showed no request submitted after continuity of care auth generated.

On the 03/30/2018 CMHRS call, 3 providers were concerned about authorization delays and stated that Beacon staff were giving misinformation to providers stating that authorizations will be processed in "9 to 11" days, or after the authorizations are "loaded in the system" which is contradictory to contract requirements. Premier stated on 4/12 that they had met with Beacon to touch base on these issues. Beacon reported that their staff is trained and there is no delay in loading authorizations. It is unclear if the misinformation given to providers was addressed or if Premier has monitoring strategies in place to determine if Beacon is meeting contract deliverables.

4.2 – CONTRACT REQUIREMENTS:

As explained in section **6.2.10.1 – Standard Authorization** of the ***CCC Plus Contract***, Service Authorization Timeframes are:

Behavioral Health	
Standard UM Review (to include outpatient and CMHS)	3 business days if all clinical information is available or up to 5 business days if additional clinical information is required or as expeditiously as the Member's condition requires.
Long Term Services and Supports to include –CCC Plus Waiver (including waiver services through EPSDT), Nursing Facility, Long Stay Hospital, etc. (Standard)	5 business days

4.3 – CORRECTIVE ACTION NEEDED:

Premier must document and implement a CAP that addresses how they will adhere to the Service Authorization timeframes outlined in the Contract and shall include steps that will be taken to come into compliance with these requirements. Please ensure that the CAP includes the following information:

- Project Plan or a list of deliverables, milestones, due dates and percentage complete that address how the Contractor will adhere to the Service Authorization timeframes outlined in the Contract, steps that will be taken to come into compliance with these requirements, the tracking system in place that monitors the volume and age of received Service Authorization and actions that are ready to be taken when the timeframes are in danger of being exceeded. Additional training requirements for Premier and/or Beacon staff so that correct information is imparted to Providers.
- A weekly update to this Project Plan to the Department for monitoring progress. Update will be due by close of business each Tuesday, starting May 29, 2018.

ATTACHMENT 5 – AREAS FOR CORRECTIVE ACTION

5.1 – 2018-VAP-003 – Authorization & Billing/Claims:

DD Waiver Services / Authorizations
DD Waiver services are carved out of the CCC Plus contract. On 03/13/2018, the Department received an email from DBHDS with a spreadsheet they received from Premier with a list of members indicating that authorizations for certain DD Waiver services were in place. Upon the Department's inquiry, Premier confirmed on 03/21/2018 that there was an internal training issue, written notification had not been sent to the members/providers on the list and that a mechanism was in place to prevent notifications from being sent. On 03/27/2018, a provider asked the Department why authorization letters were being sent by Premier for DD Waiver services. Based on the 03/19/2018 communication, the Department responded that Premier does not send authorization letters for DD Waiver services. Later that same day, the provider sent copies of three authorization letters for DD Waiver-specific services dated 03/16/2018. Premier confirmed that misinformation had been provided to the Department and acknowledged that written notifications for DD Waiver services had been sent to members and providers. Premier put a process into place effective 03/30/2018 to identify DD Waiver services and exclude them from the MTR auth process.

Claims
In February 2018, it was identified that a provider had been reimbursed by Premier for DD Waiver-specific services. On 03/29/2018, another example of a provider being reimbursed by Premier for DD Waiver-specific services was forwarded to Premier. On 03/30/2018, it was reported that Premier "will be updating our system to align with the Department's listing for DD Waiver services that should not be covered for DD waiver members. An impact analysis will be run to determine how many claims have been paid due to this gap in configuration." There is no further information to date)

5.2 – CONTRACT REQUIREMENTS:

As explained in section **4.7.4 – Developmental Disability (DD) Waivers** from the ***CCC Plus Contract***, "Individuals enrolled in one of the Developmental Disability (DD) waivers (the Building Independence (BI), Community Living (CL), and Family and Individual Supports (FIS) waivers) will be enrolled in the CCC Plus program for their non-waiver services (e.g., acute and primary, behavioral health, pharmacy, and non-LTSS waiver transportation services). DD Waiver services (including when covered under EPSDT), targeted case management and transportation to the waiver services, will be paid through Medicaid fee-for-service as "carved-out" services. See *CCC Plus Coverage Chart - Part 4C*."

5.3 – CORRECTIVE ACTION NEEDED:

Premier must document and implement a CAP that addresses how they will address DD Waiver services and authorization requests and provide a workflow showing how requests for services that should be authorized and paid by the Department, are referred correctly. Additionally, review claim edits to ensure that non-covered DD Waivers service cannot be adjudicated as a paid claim. Please ensure that the CAP includes the following information:

- Project Plan or a list of deliverables, milestones, due dates and percentage complete that address DD Waiver services not being authorized or paid by Premier. Include identifying any service authorizations and claims already approved and processed and how they will be adjusted.
- A weekly update to this Project Plan to the Department for monitoring progress. Update will be due by close of business each Tuesday, starting May 29, 2018.

Attachment 6 - Point issuance/Financial Penalties, if applicable with timeframe for Comment

Compliance Points and/or Financial Penalties:

As a result of the critical errors identified above, Virginia Premier shall be issued the following point violations pursuant to ***Section 18.0 of the CCC Plus Contract***.. Assessment of these points are pending, if you have additional information and/or documentation that will affect this determination; please provide this information to **Jason Rachel, Acting Division Director of Integrated Care** within 15 calendar days from the date of this letter ("Comment Period").

Point violations will be finalized upon the expiration of the Comment Period. After this time, no additional communication will be provided by the Department regarding the point issuance.

Virginia Premier has accumulated 40 points total to date. As described in 18.2.2 of the CCC Plus Contract, **Level 3** on the Compliance Deficiency Identification System requires a Financial Sanction in the amount of a one-time **$10,000** deduction. The referenced sanction amount shall be deducted from your monthly capitation payment. Generally, deductions shall be initiated within 30 calendar days from the end of the Comment Period. If Virginia Premier fails to comply with the requirements of this CAP, additional financial sanctions may be levied.

For your reference, please see Exhibit 1 that provides MCO's total point(s) accumulation under the Department's Compliance Monitoring Process (*see Section 18.0*).

Exhibit 1 – Virginia Premier – April 2018 Point Schedule

MCO	Area(s) of Violation	Prior Month Balance	Point(s) Expired	Point(s) Incurred	Point Accumulation Total	Sanctions pursuant to 18.2.2
Virginia Premier	2018-VAP-001: Care Coordination	0	0	10	10	$10,000
Virginia Premier	2018-VAP-002: Billing/Claims	0	0	5	15	
Virginia Premier	2018-VAP-003: Authorization	0	0	10	25	
Virginia Premier	2018-VAP-004: Authorization	0	0	10	35	
Virginia Premier	2018-VAP-005: Authorization & Claims/Billing	0	0	5	40	