Plan of Action with 2020 Update

The following plan of action was approved by the workgroup to be implemented by DMAS. The purpose of the plan was to address providers' concerns raised throughout the workgroup meetings without causing a serious risk of the loss of substantial federal matching funds.

Issue: Inability to settle cases that do not merit the time and cost of a formal administrative hearing.

Plan: The DMAS attorney for formal administrative hearings shall be available and authorized to discuss and seek approval of settlements at the Informal Appeal level. A settlement at this stage of the process could be for some or all of the findings subject to the retraction. If DMAS and the provider agree to a partial settlement, any non-settled issues can continue through the informal appeal process. DMAS will publish a Medicaid Memo detailing the process and will make reference to the Memo in the final overpayment letters sent to providers. The Memo will be posted on DMAS' Website.

The workgroup proposes DMAS seek emergency regulatory authority to amend 12VAC30-20-540 of the Virginia Administrative Code to allow additional time for issuance of the informal appeal decision beyond 180 days to allow sufficient time for settlement if the provider waives the deadline.

2020 Update: The Workgroup approved Medicaid Memo was published on January 10, 2018.[1] An updated Memo was published on August 14, 2018.[2] Both Memos were issued to all providers and were posted to DMAS' website for convenient reference. DMAS has received informal appeal and formal appeal settlement offers, reviewing them following the process set forth in the updated Memo. In calendar year 2019, there were two formal appeal executed settlements and two informal appeal executed settlements, each of which resolved the appeal to the provider's satisfaction, leading to a withdrawal of each of those appeals.

The 2018 General Assembly Budget Bill granted emergency authority to amend the provider appeal regulations to add information about the settlement process. DMAS enacted emergency regulations that included this information, and are in effect from November 14, 2019, through May 13, 2021. *See* Virginia Register of Regulations, Title 12, Department of Medical Assistance Services, Chapter 20, Emergency Regulation, http://register.dls.virginia.gov/details.aspx?id=7750. The emergency regulations at 12 VAC 30-20-550 establish the process for a settlement agreement resolution for those Medicaid providers who have filed an administrative appeal under 12 VAC 30-20-540 (informal appeals) and 12 VAC 30-20-560 (formal appeals). The emergency regulations at 12 VAC 30-20-550.C state that receipt of a settlement proposal in accordance with 12 VAC 30-20-550.B does not require the DMAS appeal representative to agree to stay the deadline of the informal appeal decision or the formal appeal recommended decision of the hearing officer. However, 12 VAC 30-20-550.C permits the DMAS appeal

[1]https://www.virginiamedicaid.dmas.virginia.gov/ECMPdfWeb/ECMServlet?memospdf=Medicaid+Memo-2018-01-10.pdf

[2]https://www.virginiamedicaid.dmas.virginia.gov/ECMPdfWeb/ECMServlet?memospdf=Medicaid+Memo+2018.08.14.pdf

representative and the provider to agree in writing to stay the decision for up to 60 days to facilitate settlement discussions.[3]

Issue: Provider audits are too lengthy causing hardship in record retrieval.

Plan: DMAS has shortened the review period on all audits to from 15 months to 12 months.

2020 Update: This continues to be the practice.

Issue: Provider education regarding the audit process

Plan: DMAS will share areas of audit emphasis with provider groups prior to beginning that year's audits and clarify how auditors plan to evaluate compliance with the requirements set forth in regulations and the provider manuals. DMAS will ensure that audit points of focus are based upon requirements specified in regulation and/or Agency guidance documents, including citations to such requirements that are being relied upon by the auditor.

Provider groups will be given the opportunity to provide feedback to DMAS regarding proposed audit points of focus. DMAS hopes that these efforts will give providers a more complete understanding of the audit process and the expectations of DMAS auditors with respect to these reviews.

2020 Update: In calendar year 2019, DMAS shared areas of audit emphasis with provider groups (including home health associations and physician associations) prior to beginning that year's audits. Provider groups were given a contact name and number to provide DMAS with feedback regarding proposed audit points of focus. DMAS has ensured, and will continue to ensure, that audit points of focus are based upon requirements specified in regulation and/or Agency guidance documents, including citations to such requirements that are being relied upon by the auditor.

Issue: Provider participation in audit process.

Plan: Auditors will conduct a detailed exit conference prior to leaving the facility in the case of an onsite audit and via phone prior to sending the preliminary findings in the case of a desk audit. At the close of the audit review DMAS will send the preliminary findings to the provider. The provider will then have 30 calendar days from receipt of the preliminary findings to request a re-review and provide additional documentation to the Agency. After 30 days, DMAS follows up with the final findings and the next steps in the process. DMAS is dedicated to reviewing and strengthening this process. DMAS welcomes provider input on methods to improve the process.

2020 Update: Auditors are conducting exit conferences. DMAS and its audit contractors set forth the preliminary findings to the providers in a letter, which specifies that the provider has 30 calendar days to request a re-review and provide additional documentation. After the 30-day period has expired, all information submitted is reviewed by the auditor and a final overpayment letter is issued. That final

[3] The plan of action stated that DMAS would reference the Medicaid Memos in the overpayment letters. However, this is not necessary due to the fact that the regulations contain specific procedures for the settlement process.

overpayment letter notifies the provider of the audit findings, the amount owed to DMAS (if any), and how to appeal the findings.

Issue: Provider education regarding audit findings.

Plan: At the conclusion of each year's audits, DMAS will compile a list of common issues identified in those audits and share those with provider groups. DMAS will also identify a list of common issues that were originally identified in the audits as being an issue but were later overturned in the reconciliation, informal appeal, and/or formal appeal. This information will be used to ensure that the Provider Manuals provide the appropriate direction and explanation. DMAS will also evaluate whether revisions to applicable Provider manuals are necessary or appropriate to clarify standards applied to services.

2020 Update: DMAS has identified a list of common issues for audits performed in calendar year 2019. The issues will be shared with provider groups when the COVID-19 Executive Orders are lifted and DMAS returns to auditing.

DMAS has also reviewed the information regarding issues overturned during reconciliation and the appeal process. For reconciliation (which DMAS defines as the period between when the preliminary findings letter is issued and the final report is issued), the overwhelming reason that issues were overturned in the provider's favor was due to additional documentation being submitted by the provider. Other changes in identified errors were the result of open dialogue with the provider during reconciliation to gain a better understanding of the provider's process or documentation.

In calendar year 2019, DMAS issued informal appeal decisions for 63 audits. Of those cases, 26 had some type of issue either conceded by DMAS or reversed during the informal appeal. An analysis of those 26 cases demonstrated that the primary reason for a retraction being overturned was due to the auditor crediting the provider during the appeal for documentation that was previously deemed as missing during the audit. Although this occurred for a variety of service types and identified errors, it was most common for missing progress notes. Additionally, there were some cases in which the overpayment reduction was based on a review of previously submitted information.

In calendar year 2019, DMAS issued Final Agency Decisions for 14 audits. Most of these cases were upheld fully in favor of DMAS. One resulted in significant issues overturned in favor of the Provider. In this case, the Hearing Officer found a case summary deficiency for some of the retractions, which the DMAS Director upheld. The other cases did not result in a further reduction in overpayment at the formal appeal level.

DMAS routinely evaluates whether revisions to applicable Provider Manuals are necessary or appropriate to clarify standards applied to services, through ongoing communications between the DMAS Appeals Division and the DMAS Policy Division.

Issue: DMAS documentation requirements are unclear to members in the Provider community.

Plan: In accordance with § 32.1-324.4 of the Code of Virginia, DMAS posts its Provider manuals on its website for public comment for 30 days prior to making any amendments to the manuals. This became effective on July 1, 2017. DMAS will evaluate its current manual provisions to ensure that documentation requirements for each service type are clearly identified and described in a manner

designed to allow objective interpretation of the standards by DMAS providers, and auditors. DMAS encourages providers to comment on any areas of the manuals which require clarification.

2020 Update: This continues to be the practice.

Issue: The workgroup has not come to a consensus on the issue of a material breach or substantial compliance standard.

Plan: Due to the fact that the members of the workgroup began with different viewpoints regarding the focus of the group, the feasibility and impact of requiring a material breach standard and the limited time the workgroup had prior to submission of this Report, further work and an ongoing relationship will be necessary to fully address all of the concerns of the providers on the workgroup. DMAS is committed to continue discussion with providers to address these concerns. DMAS will continue to engage with stakeholders on at least an annual basis to revisit the topic of a substantial compliance or material breach standard and monitor the plan of action.

2020 Update: DMAS engages its stakeholders to discuss proposed and impending policy changes. DMAS will need to schedule its annual meeting to revisit the workgroup topic, which may be delayed with the COVID-19 public health emergency. DMAS will work with Jeffrey Palmore, Esq., as counsel to the Virginia Bar Association, to identify attorneys and/or providers to participate in the annual meeting to revisit the workgroup topic and monitor the plan of action.