RON DESANTIS
GOVERNOR

SIMONE MARSTILLER
SECRETARY

SENT VIA EMAIL TO NLANDSBAUM@CENTENE.COM

March 17, 2022

CAP Case No.: 2022004051
File No.: 6

Sanction Case No.: 2022004052
File No.: 6

Mr. Nathan Landsbaum
President/CEO
Sunshine State Health Plan, Inc.
215 South Monroe Street, Ste. 535
Tallahassee, FL 32301

Re: Agency-defined CAP, Monetary Sanction, and Enrollment Freeze for Failure to Comply with Claims Processing Requirements

Dear Mr. Landsbaum:

As the administrator of Florida's Medicaid program, the Agency for Health Care Administration (Agency) takes our obligations seriously to ensure high quality health care is delivered to all enrollees in the Florida Medicaid Program. This obligation is extended to and expected of all Medicaid providers and Managed Care plans.

Pursuant to Attachment II, Section VIII.E., item 1.a., of Contract No. FP060, "The Managed Care Plan shall process claims and pay providers in compliance with the federal and State requirements set forth in 42 CFR 447.45 and 447.46 and Chapter 641, F.S., whichever is more stringent, (s. 409.967(2)(j), F.S.)".

Pursuant to Attachment II, Section E, item 2, "For all electronically submitted claims for services, the Managed Care Plan shall... Within fifteen (15) days after receipt of a non-nursing facility/non-hospice claim, pay the claim or notify the provider or designee that the claim is denied or contested. The notification to the provider of a contested claim shall include an itemized list of denial reasons or codes and additional information or documents necessary to process the claim." "For all non-electronically submitted claims for services, the Managed Care Plan shall...Within twenty (20) days after receipt of the claim, pay the claim or notify the provider or designee that the claim is denied or contested. The notification to the provider of a contested claim shall include an itemized list of additional information or documents necessary to process the claim."

The Agency was notified of multiple claims payment issues by Sunshine State Health Plan, Inc. (Sunshine) through Agency complaints and as self-reported by Sunshine (Attachment A). Sunshine has acknowledged that internal system errors caused incorrect claims denials for several different provider types resulting in delayed payments and/or non-payments to providers.

Pursuant to Attachment II, Section II.A, item 3., "The Managed Care Plan shall comply with all provisions of this Contract including all Attachments, applicable Exhibit(s), and any amendments and shall act in good faith in the performance of these Contract provisions."

Pursuant to Attachment II, Section XIII.A, "The Managed Care Plan shall comply with all requirements and performance standards set forth in this Contract. The Managed Care Plan agrees that failure to comply with all provisions of this Contract and 42 CFR 438.100 may result in the assessment of sanctions and/or termination of this Contract, in whole or in part, in accordance with Section XIII., Sanctions." "In the event the Agency identifies a violation of or other non-compliance with this Contract (to include the failure to meet performance standards), the Agency may sanction the Managed Care Plan pursuant to any of the following, as allowable...Rule 59A-12.0073, F.A.C."

Pursuant to Attachment II, Section XIII.A, item 6, "In addition to imposing sanctions for a Contract violation or other non-compliance, the Agency may require the Managed Care Plan to submit to the Agency a Corrective Action Plan (CAP) within a timeframe specified by the Agency. In the event the Agency identifies a violation of, or other non-compliance with this Contract, to include failure to meet performance standards, the Agency may sanction the Managed Care Plan pursuant to any of the following, as allowable: s. 409.912(4), F.S., s. 409.91212, F.S.; Rule 59A-12.0073, F.A.C.; s. 409.967; F.S., 42 CFR Part 438, Subpart I (Sanctions) and ss.1905(t), 1932 and s. 1903(m) of the Social Security Act. The Agency may impose sanctions in addition to any liquidated damages imposed pursuant to Section XIV., Liquidated Damages." Attachment II, Section XIII.B, item 1 states, "The Managed Care Plan shall accept and implement an Agency defined CAP if required by the Agency."

Pursuant to Attachment II, Section XIII, Sanctions, the Agency is requiring Sunshine to:

1. Provide a detailed summary thoroughly indicating how all provider claims impacted by system issues identified by Sunshine have been appropriately reprocessed and paid as referenced in Attachment A of this letter.

2. Provide a detailed description of steps taken to resolve all identified/known system issues including detailed steps/timeframes taken to implement all system updates impacting claims as referenced in Attachment A of this letter.

3. At a minimum, demonstrate over a thirty (30)-day timeframe that the plan's claims processing systems are able to process claims promptly and fully for all lines of business under contract with the Agency.

4. Conduct robust provider education related to provider claims submission processes for each provider type within all networks. This should include education related to all claims billed through Sunshine and any subcontractor included as part of the plan's network, as appropriate.

5. Submit weekly progress reports to the Agency in addition to participating in weekly operational calls which are to be attended by Florida Plan President & CEO Nathan Landsbaum or another member of executive management.

Please refer to Case No. 2022004051 and AHCA File No. 6 on your CAP, your CAP cover letter, and on any correspondence associated with the CAP. Please submit the CAP within twenty-one (21) days of receipt of this letter (should the date fall on a weekend or holiday, the CAP is due the next business day) to:

Jessica Lane, Contract Manager
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #50
Tallahassee, FL 32308
Email: jessica.lane@ahca.myflorida.com

As authorized by 42 CFR ss.438.700(d)(1) and 438.702, the Agency is imposing the following intermediate sanction: Effective immediately, Sunshine has been placed on an enrollment freeze for all auto assignments and reinstatements for all regions (regions 1-11) for Managed Medical Assistance (MMA) and Long-Term Care (LTC) programs. This sanction will be reported to the Centers for Medicare and Medicaid Services (CMS) in accordance with 42 CFR s. 438.724 and shall remain in place until all conditions of the CAP are deemed completed by the Agency.

Furthermore, the Agency is also imposing a monetary sanction in the amount of $9,092,025 for the plan's non-willful violation calculated at $75 per claim.

Monetary sanctions imposed by the Agency shall be due and payable to the Agency within thirty (30) days after the Managed Care Plan's receipt of the notice of sanction. Should the date fall on a weekend or holiday, the payment is due the next business day.

Please make the $9,092,025 check payable to the Agency for Health Care Administration and mail to the following address:

Agency for Health Care Administration
Division of Health Quality Assurance
Enforcement Unit, MS 26
2727 Mahan Drive
Tallahassee, FL 32308

To ensure proper crediting of the payment, please include a copy of this letter with your check and refer to Case No. 2022004052 and AHCA File No. 6 on the check and all correspondence associated with this issue.

Pursuant to Attachment II, Section XIII.F, to dispute a CAP or sanction, the Managed Care Plan must request that the Agency's Deputy Secretary for Medicaid or designee, hear and decide the dispute.

The Managed Care Plan must submit a written dispute of the CAP or sanction directly to the Agency via an electronic submission process; the Agency will not accept deliveries by U.S. mail, commercial courier service, or hand.

Each dispute request shall include only one (1) electronic file per submission that includes all of the following information:

- A Managed Care Plan appeal letter that is addressed to the Deputy Secretary or designee which includes the case and file number from the original compliance action related to the issue being disputed;

- Exhibit A – A copy of the original action letter received from the Agency; and

- Exhibit B – The Managed Care Plan's supporting documentation related to the dispute, including all arguments, materials, data, and information necessary to resolve the dispute (including all evidence, documentation, and exhibits).

The Managed Care Plan shall submit its dispute request to the Agency by 5:00 P.M., EST on the twenty-first (21st) day after the date of issuance of any CAP or sanction. The Managed Care Plan shall make all submissions to the SMMC_CY 18-23 SFTP site (Port 4443) to the folder titled Submissions\Appeals. The dispute file shall be titled ABC_########## where ABC stands for the Managed Care Plan's three (3)-character identifier and ########## stands for the ten (10)-digit case number for the issue being disputed. The Agency will deny any appeals or disputes that are not delivered in the format and timeframes specified by the Agency.

Pursuant to Attachment II, Section XIII.F, Sunshine waives any dispute not raised within twenty-one (21) days of receiving the CAP or sanction. It also waives any arguments it fails to raise in writing within twenty-one (21) days of receiving the CAP or sanction, and waives the right to use any materials, data, and/or information not contained in or accompanying the Managed Care Plan's submission within the twenty-one (21) days following its receipt of the CAP or sanction in any subsequent legal, equitable, or administrative proceeding (to include circuit court, federal court and any possible administrative venue).

We appreciate your immediate attention to these matters and continued commitment to Florida's most vulnerable. Please contact your Contract Manager, Jessica Lane, at 850-412-4051 or via email at Jessica.Lane@ahca.myflorida.com if you have any questions concerning this matter.

Sincerely,

Brian Meyer
Assistant Deputy Secretary
Medicaid Operations

BM/kb
Enclosure – Attachment A
cc: Aimee Campbell-O'Connor, CMS/CMCHO
Alice Wilkins, Bureau of Finance and Accounting
Tom Wallace, Deputy Secretary of Medicaid

Attachment A

Claims Issue	LOB	Claims Volume	*Sanction Total
Denials of therapy provider claims due to new edit implemented	MMA	2,702	$202,650
	SMI	77	$5,775
	CW	334	$25,050
Denials for invalid diagnosis codes	MMA	11,414	$856,050
	LTC	48,694	$3,652,050
	SMI	5,390	$404,250
	CW	1,515	$113,625
Denials for EVV diagnosis on migrated Staywell authorizations	MMA	1,568	$117,600
	LTC	3,712	$278,400
	SMI	118	$8,850
	CW	53	$3,975
Denials for primary coverage on bypassed codes	LTC	1,939	$145,425
CHD core services not paying CBR rate	MMA	555	$41,625
	SMI	568	$42,600
	CW	20	$1,500
Denials for claims processed under incorrect benefit package (LTC MMA)	MMA	179	$13,425
	LTC	17,727	$1,329,525
Denials for SNF claims with behavioral health diagnosis processing as SIPP claims and denying for age restriction	MMA	28	$2,100
Incorrect claims rejections driven by member eligibility selection and determination	MMA	1,194	$89,550
	LTC	19,657	$1,474,275
	SMI	554	$41,550
	CW	231	$17,325
Incorrect age restriction on procedure code 90957	MMA	7	$525
	CW	4	$300
Behavioral health facilities set up incorrectly	MMA	1,286	$96,450
	SMI	692	$51,900
	CW	455	$34,125
Incorrect load of prescribed drug fee schedule	MMA	538	$40,350
	LTC	4	$300
	SMI	12	$900
	Total:	**121,227**	**$9,092,025**

*Sanction totals are equivalent to $75 per claim