Washington State Health Care Authority

Report to the Legislature

Program Integrity action report

Update on the Centers for Medicare and Medicaid Services recommendations

Engrossed Substitute Senate Bill 5092; Section 211(32)(b); Chapter 334; Laws of 2021

October 1, 2021

Division of Program Integrity
P.O. Box 45503
Olympia, WA 98504-5503
Phone: (360) 725-0913
Fax: (360) 586-0212
hca.wa.gov

Executive Summary

Engrossed Substitute Senate Bill 5092; Section 211 (32)(b); Chapter 334; Laws of 2021[1] effective May 18, 2021 directs the Health Care Authority (HCA) to act as follows:

> The authority shall submit a report to the governor and appropriate committees of the legislature by October 1, 2021, that includes but is not limited to:
>
> (i) Specific, quantified actions that have been taken, to date, related to the recommendations of the centers for medicare and medicaid services center for program integrity as provided to the authority in the January 2019 Washington focused program integrity review final report; and
>
> (ii) Specific, quantified information regarding the steps taken toward (a)(i), (iii), and (iv) of this subsection.[2]

HCA has completed recommendations provided by the Centers for Medicare and Medicaid Services (CMS) Center for Program Integrity (CPI)[3] as noted in the timeline below:

- **September 2018**: Fraud investigation and law enforcement referral activities returned to the Program Integrity[4] section of Medicaid Program Operations and Integrity Division (MPOI) of HCA
- **July 2019**
  - Contract(s) amended to:
    - Add clarity allowing HCA to audit Managed Care Organizations (MCO) and MCO network providers
    - Revise payment suspension language
    - Revise collaborative meetings and training language
  - Memorandum of Understanding between HCA and the Attorney General Medicaid Fraud Control Division (MFCD) is revised and executed
  - Encounter data audits begin
- **September 2019**: Program Integrity staff begin work on policies and procedures
- **November 2019**: Provider Enrollment Automated Provider Screening System (APS) is brought online; APS utilizes LexisNexis to support the federal database of exclusion checks
- **December 2019**: HCA begins working to supply MCO reported recoveries and overpayments for rate setting purposes
- **January 2020**: Contract is amended to require MCOs to have one full time equivalent per 50,000 enrollees to ensure sufficient resources are allocated to program integrity activities
- **June 2020**: Managed Care Oversight Unit within MPOI began the credential review
- **November 2020**: Division of Program Integrity (DPI) is created within HCA
- **January 2021**: Provider Enrollment section is transferred into DPI
- **May 2021**: Managed Care Oversight Unit completed the credential review

[1] Certificate of Enrollment, Engrossed Substitute Senate Bill 5092, Chapter 334, Laws of 20201, Washington 67th Legislature, 2021 Regular Session, Operating Budget, Effective Date May 18, 2021, leg.wa.gov, Section 211(32)(b)(i, ii); Chapter 334, page 178 of 1103, lines 20 through 29, 23 July, 2021.

[2] Ibid, page 178, 23 July 2021.

[3] Department of Health and Human Services, CMS/CPI, Washington Focused Program Integrity Review Final Report, cms.gov; pages 19-20, 23 July 2021.

[4] *Program Integrity* (in upper case) is used when referencing state Program Integrity section/division. Conversely, *program integrity* (in lower case) is used when referencing activities mandated by CMS.

HCA continues work on, or is nearing completion of:

- Refinement of DPI policies and procedures to ensure functions are adequately addressed
- Collaboration with HCA's contracted actuary related to recoveries, overpayments and rate setting[5]
- Implementation of case management tracking system
- Federal database exclusions checks and screening tool

[5] Washington Senate Ways and Means, Engrossed Substitute Senate Bill 5092, leg.wa.gov, Section 211(32)(a)(iii) and (a)(iv); page 131 of 967, lines 10 through 17, 23 July 2021.

CMS Recommendations

The 2019 CMS review,[6] "to determine whether Washington's Apple Health (Medicaid) managed care program integrity procedures satisfy the requirements of federal regulations and applicable provisions of the Social Security Act,"[7] highlighted several areas of concern. Theses areas helped to inform many of the changes HCA has made or is currently making to ensure proper and maximum use of both federal and state funds. Below are the **recommendations** and the **actions** HCA has taken to implement them.

Program Integrity organizational structure and staffing

Recommendation: Organize all program integrity activities into a centralized unit or under a common protocol addressing provider enrollment, fraud and abuse detection, investigations and law enforcement referrals.[8]

Action: Made three major organizational changes to centralize the authority's program integrity activities and functions.

In September of 2018, fraud investigations and law enforcement referrals were placed under the care of Program Integrity which was a unit within MPOI at that time. In November of 2020, HCA identified the need for Program Integrity to have its own divison, creating DPI. The organizational change allowed DPI to report directly to the Medicaid Director. In January of 2021, Provider Enrollment was moved to DPI. Today, DPI is inline with CMS structure and staffing recommendations.

Recommendation: Ensure HCA and its MCOs are allocating sufficient resources to the prevention, detection, investigation and referral of suspected provider fraud.[9]

Actions:

1) Made MCO contract amendment(s) to ensure sufficient staff are allocated to program integrity activities
2) Additional MCO contract amendment(s) are expected, as updates occur twice per year

To ensure MCOs allocate sufficient resources to the prevention, detection, investigation, and referral of suspected provider fraud, HCA amended contracts with MCOs to incorporate this recommendation. The amendment requires MCOs to maintain program integrity staff levels at a minimum of one full time equivilant (FTE) for every 50,000 enrollees. The contract change became effective in January 2020, resulting in increased program integrity staffing levels across all five MCOs.

Program Integrity managed care contract language

Recommendation: Seek to enhance/improve the program integrity contract language with MCOs. Ensure there are no contractual impediments to provider auditing and collaboratibe audits with the MCOs, as well as audits of the MCOs themselves.[10]

[6] CMS, *Washington Focused Program Integrity Review Final Report 2019,* cms.gov, page 1, 23 July 2021
[7] CMS, Medicaid Program Integrity Internet-Only Manuals, cms.gov, *23 July 2021.*
[8] CMS, *Washington Focused Program Integrity Review Final Report 2019,* pages 19-20, 23 July 2021
[9] Ibid, pages 19-20, 23 July 2021
[10] CMS, *Washington Focused Program Integrity Review Final Report 2019,* pages 19-20, 23 July 2021

Actions:
1) Made four MCO contract amendment(s) to eliminate audit impediments
2) Additional MCO contract amendment(s) are expected, as updates occur twice per year

HCA managed care contracts are reviewed and amended semiannually. Since the CMS review, Program Integrity has updated managed care contracts to ensure there are no impediments to provider auditing or audits of MCOs. Contract amendments were completed in July 2019 and January 2020 to ensure HCA has the capability and flexibility to perform unimpeded program integrity activities across all MCOs. Additionally, HCA jointly reviewed contract language with the Attorney General MFCD to ensure contract language/terms do not limit or impact performance of their duties. No further amendments were identified following that review.

Program Integrity policies and procedures

Recommendation: Review program integrity policies and procedures relative to any contract modifications to ensure all program integrity functions are adequately addressed.[11]

Actions:
1) Mapped 15 process workflows for program integrity core functions to date
2) Published 19 new or updated program integrity policies/procedures to date
3) Published six new or updated forms and/or attachments to correspond with policies/procedures
4) Reviewed case management team charter

In September 2019, Program Integrity established a workgroup consisting of managers and supervisors to ensure its policies and procedures are reviewed and routinely updated to reflect changes in law, rule and/or contracts. This workgroup is ongoing and continues to meet regularly to ensure policies and procedures adequately address Program Integrity core functions.

[11] Ibid, pages 19-20, 23 July 2021

Program Integrity fraud, waste, and abuse

Recommendation: Ensure the mandatory referral of any potential fraud, waste, or abuse to the State Medicaid program integrity unit or any potential fraud to the MFCD. To include, but not limited to, ensuring that the MCO SIU staff receive sufficient program integrity training in identifying, investigating, referring and reporting on providers with suspected fraudulent billing practices. This training should be accomplished in conjunction with the MFCD, when possible, to enchance case referrals from the MCOs.[12]

Actions:

1) Reviewed and mapped process workflow for MCO reporting of potential fraud to MFCD
2) Made MCO contract amendment(s) to ensure mandatory referrals to MFCD are made
3) Held MCO special investigation training with the five MCOs

Following the CMS review, HCA reviewed its process for ensuring MCOs were reporting potential fraud to MFCD and determined updates were necessary. In July 2021, in coordination with MFCD, HCA updated contract language with the MCOs to ensure suspected fraud referrals would be sent to HCA for quality review and to help strengthen case referrals from the MCOs.

Since the release of the CMS report in 2019, HCA has engaged in training MCO special investigation unit (SIU) staff. HCA has also partnered with MFCD and Health and Human Services Office of Inspector General to host quarterly meetings with MCO SIU staff to provide training on identifying, investigating, and referring suspected providers.

Recommendation: Improve its tracking of the MCO investigation referrals. Enhance its usage of the customized Washington fraud referral form as outlined in the report for reporting purposes, making any appropriate modifications to the form as needed. Clarify with the MCOs, the proper use of the customized Washington fraud referral form for reporting purposes, and ensure the referrals always conform to the CMS referral standards.[13]

Actions:

1) Reviewed and mapped process workflow for investigations and referrals of potential provider fraud to MFCD
2) Published customized fraud referral form to ensure federal referral standards are met

HCA reviewed the investigation referral form and made modifications to support the work needed to meet CMS recommendations. HCA continues work to improve the tracking of referrals once sent to MFCD. The revised MCO contract language was implemented in July 2021 to ensure potential fraud referrals are sent to HCA to determine credibility of potential fraud as outlined in federal statute. Additionally, HCA has invested in a case management system for program integrity that will include tracking for all cases referred for fraud. We expect the case management program to be operational in early 2022.

[12] Ibid, pages 19-20, 23 July 2021
[13] Ibid, pages 19-20, 23 July 2021

Recommendation: Continue fostering better interaction with the MCOs and the MFCD. Implement collaborative meetings aimed at improving HCA/MFCD interactions and educating the MCOs regarding suspected fraud referrals. This would include any necessary MFCD MOU revisions. In addition, HCA should communicate and obtain feedback from the MFCD regarding the quantity and quality of MCO referrals reviewed and develop a strategy for improving MCO referrals.[14]

Action: Reviewed and updated memorandum of understanding with MFCD

Established monthly HCA/MFCD director check-in meetings. In November 2019, HCA coordinated with MFCD to update our memorandum of understanding (MOU), which includes many of the duties and responsibilities of each division. In January 2021, the MFCD director and DPI director established monthly check-in meetings to discuss issues and solutions to problematic items. These meetings have been extremely beneficial to HCA's relationship with MFCD and we expect to continue these meetings indefinitely.

Program Integrity managed care provider enrollment

Recommendation: Expand HCAs program integrity scope to include random sampling of MCO provider enrollment files to verify that all appropriate documentation is present.[15]

Action: Conducted random sampling screening on ten provider enrollment files, with additional audit(s) planned

HCA sought additional guidance from CMS on this recommendation when the report was released; there was indication of missing documentation from one of the MCOs. HCA planned review of the MCO enrollment process in late 2019 to early 2020, and looked to partner with another HCA division on this work. The COVID-19 pandemic and other barriers slowed this work. HCA began review of the credentialing process for each MCO in June 2020. This review concluded in May of 2021 with: three (3) of the plans resulting in no findings; education provided for the other two (2) plans; and one (1) plan resulting in a corrective action request.

Program Integrity encounter data audits

Recommendation: Continue efforts to improve the state's ability to analyze encounter data reported by MCOs and proactively perform state-initiated data mining activities in order to identify fraud, waste, and abuse issues with MCO providers. Implement proactive data mining and routine audits of validated managed care claims encounter data.[16]

Action: Conducted one encounter data audit with resulting sanctions, and additional audit(s) planned

In July 2019, HCA initiated an encounter data validation audit with all five MCOs. The purpose of the audit was to ensure accurate data is received by HCA. Each audit was completed with results issued and

[14] Ibid, pages 19-20, 23 July 2021
[15] Ibid, pages 19-20, 23 July 2021
[16] Ibid, pages 19-20, 23 July 2021

sanctions imposed on the MCOs. All the audits are working their way through the dispute resolution process; we expect final resolutions by fall of 2021.

Program Integrity managed care overpayments

Recommednation: Contractually ensure the MCOs submit accurate reports on overpayments in accordance with 438.608(d)(3) and the prompt reporting of all overpayments identified or recovered, specifying overpayments due to fraud, waste, or abuse at 438.608(a)(2). This language should potentially include specifications on terminology for identified and recouped overpayment to maintain continuity for purposes of reconciliation.[17]

Actions:
1) Made MCO contract amendment(s) to ensure prompt and accurate overpayment reporting
2) Held MCO trainings/education opportunities during quarterly meetings
3) Recoupment recoveries for calendar year January 1, 2020 through December 31, 2020 total $37,865,629.25 across all five MCOs

HCA reviewed contract language around accurate reporting of identified overpayments and recoveries. In July 2019, we amended the contract to ensure accurate reporting of all overpayments. In conjunction with contract changes, HCA has provided education to the MCOs about contract changes and expectations.

Recommendation: Implement processes to ensure the integrity of data being used for rate setting purposes, since rate setting actuaries receive supplemental data concerning overpayments and recoveries directly from the MCOs.[18] [19]

Actions:
1) Amended each of the five MCO contracts to address overpayment and recovery application in the rate setting process
2) Contracted an actuary
3) Established process to provide annual data to the contracted actuary

Following the CMS report, Program Integrity initiated conversations with HCA's contracted actuary to ensure they were receiving information concerning overpayments and recoveries from the MCOs that should be applied to the rate setting process. Beginning in August 2019, HCA established a process to produce overpayment and recovery information from the MCOs to the contracted actuary. That process will repeat each year as part of the rate setting process.

[17] Ibid, pages 19-20, 23 July 2021
[18] Ibid, pages 19-20, 23 July 2021
[19] Washington Senate Ways and Means, Engrossed Substitute Senate Bill 5092, Section 211(32)(a)(iii) and (a)(iv); page 131 of 967, lines 10 through 17, 23 July 2021.

Program Integrity managed care payment suspensions

Recommendation: Review the regulation at 438.608(a)(8) regarding payment suspensions and modify the MCO contract as necessary and consequently, assess if the MOU with the MFCD should be revised to incorporate enhancements to case referral and payment suspension procedures that fully comply with the regulation at 438.608(a)(8) and therefore, 455.23. Conduct any training to all contracted entities and law enforcement agencies as required.[20]

Actions:
1) Reviewed and updated memorandum of understanding with MFCD
2) Reviewed and updated policy/procedure(s) applicable to payment suspension process

During the MFCD MOU revision work, both MFCD and HCA worked to ensure payment suspension procedures were fully compliant with the federal statute. HCA has continued to communicate and work collaboratively with MFCD on referrals and payment suspension.

Recommendations: Refine payment suspension policies and procedures to ensure that HCA determines whether an allegation of fraud is credible. Once HCA determines there is a credible allegation of fraud, HCA must refer the case to the MFCD and suspend payment unless there is a basis for a good cause exception not to suspend. When making this good cause exception determination, HCA should consider each case referred to the MFCD independently rather than routinely issuing good cause exceptions.[21]

Actions:
1) Reviewed and updated process policy/procedure applicable to referrals of credible allegations of fraud
2) Reviewed and updated process policy/procedure applicable to payment suspension

Initial payment suspension policies and procedures along with contract updates were completed and implemented July 2019. In July 2021, HCA updated the MCO contract language to ensure that HCA has the ability to implement payment suspension. The new language became effective with the July 2021 amendment.

Program Integrity federal database exclusion checks

Recommendation: Ensure that all federal database exclusions checks, particularly the SAM, are performed for all subcontractors at enrollment, re-enrollment and on a monthly bases.[22]

Action: Implemented automated screening tool to aid in federal database exclusion checks

HCA has completed this request and recommendation. Historically, HCA had issues accessing the federal System for Award Management (SAM) database. It was an area of deficiency until Provider Enrollment implemented a new automated screening tool. This new tool has allowed Program Integrity to review these edits and confirm or reject them as a false positive. This was implemented and went live fully in August of 2020.

[20] CMS, *Washington Focused Program Integrity Review Final Report 2019,* pages 19-20, 23 July 2021
[21] Ibid, pages 19-20, 23 July 2021
[22] Ibid, pages 19-20, 23 July 2021

ESSB 5092 Subsection (32a(iii)) and (iv)

> (iii) Work with its contracted actuary and the medicaid forecast work group to develop methods and metrics related to managed care program integrity activity that shall be incorporated into annual rate setting; and
>
> (iv) Work with the medicaid forecast work group to ensure the results of program integrity activity are incorporated into the rate setting process in a transparent, timely, measurable, quantifiable manner23

While not included in session law, HCA is including information related to the sections listed above as the legislature has expressed interest that HCA include the actions noted in its rate setting work. HCA has initiated meetings with the HCA contracted actuary and managed care plans to discuss full inclusion of all program integrity activity in the rate setting process. HCA will continue to work with the Medicaid forecast group to ensure program integrity activities are incorporated into the rate setting process.

[23] Washington Senate Ways and Means, Engrossed Substitute Senate Bill 5092, Section 211(32)(a)(iii) and (a)(iv); page 131 of 967, lines 10 through 17, 23 July 2021.

Conclusion

The work completed in this report has set HCA on a path to follow the recommendations outlined in the January 2019 CMS report. Since the report was issued, HCA has taken additional steps to ensure Program Integrity can continue to meet its future obligations. Those steps include 1) restructuring to provide Program Integrity its own division with a direct reporting path to the Medicaid Director, and 2) investments in technology to allow Program Integrity to maximize use of resources.

As the ever evolving landscape of Medicaid continues to change, HCA feels confident the steps outlined by CMS and the additional changes instituted by HCA will allow Washignton to remain a Medicaid leader.

HCA will continue ongoing work towards:

- Refinement of DPI policies and procedures
- Collaboration with HCA actuary