Review of Program Integrity Managed Care Oversight, Accountability, and Savings

Engrossed Substitute Senate Bill 5187; Section 211(32)(c); Chapter 475; Laws of 2023

October 1, 2023

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Executive summary

This report is a review of operational improvements within HCA's Medicaid program integrity since 2019 and details how these activities have resulted in significant savings and have impacted the Medicaid rate setting process. In January 2019, the Centers for Medicare and Medicaid Services (CMS) issued to HCA a focused review of Washington to determine the extent of program integrity oversight of the managed care program at the state level and to assess program activities performed by select managed care organizations (MCOs). The report concluded with 14 recommendations for operational improvements to enhance HCA's Medicaid program integrity activities. Those recommendations are detailed later in this report. Despite nationwide complications associated with the COVID-19 pandemic, HCA was able to address all recommendations and implemented additional processes to better enhance the integrity of Medicaid payments. Beyond the CMS recommendations the state has invested $5.9 million in the past two biennia in Medicaid program activity to expand managed care oversight, including investment in a dedicated team to conduct oversight activities; procure state-of-the-art technology to detect and prevent fraud, waste, and abuse; and implement processes resulting in cost avoidance.

It is important to note that although program integrity activities directly impact Medicaid rates and result in savings, the dollars will not always be clearly identified as a budget line item. These recoveries and savings are accounted for in various places of the state budget, including through lower annual managed care rates. However, these recoveries have no connection to biennial savings assumptions that have been presumed as a separate line item in HCA's FY2024 budget.

Engrossed Substitute Senate Bill 5187; Section 211(32)(c); Chapter 475; Laws of 2023 (ESSB 5187) requires HCA to submit a report to the governor and appropriate committees of the legislature by October 1, 2023, that includes, but is not limited to:

i. Specific, quantified actions that have been taken to date related to CMS's Center for Program Integrity recommendations provided to HCA in January 2019;
ii. Specific, quantified information regarding the work done with HCA's contracted actuary and the medical assistance expenditure forecast work group to develop methods and metrics related to managed care program integrity activity that shall be incorporated into annual rate setting;
iii. Specific, quantified information regarding the work done with the medical assistance expenditure forecast work group to ensure the results of program integrity activity are incorporated into the rate setting process in a transparent, timely, measurable, and quantifiable manner;
iv. Accounting by fiscal year, Medicaid eligibility group, and service, beginning with state fiscal year 2020 to include all program integrity recoveries attributable to the authority, including how these recoveries are categorized, which year they are reported, how these recoveries are applied to legislative savings requirements, and what recoveries are attributable to the Office of Attorney General's Medicaid Fraud Control Division, and how these recoveries are considered when reporting program integrity activity and determining managed care rates; and
v. Information detailing when the agency acquired a new fraud and abuse detection system and to what extent this system is being utilized.

Each section in the above list is detailed in sequence below.

Centers for Medicare and Medicaid Services recommendations

Section 32(c)(i) asks HCA to provide specific, quantified actions that have been taken to date related to CMS's Center for Program Integrity recommendations provided to the authority in January 2019.

The final report contained 14 recommendations to improve program integrity efforts. Each are addressed separately below.

Recommendation No. 1: Separating program integrity from the Medicaid programs

CMS recommended that HCA 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.

In September 2018, HCA realigned fraud investigations and law enforcement referrals to the Division of Medicaid Program Operations and Integrity (MPOI), Section of Program Integrity (PI). Under this structure, program integrity activities were centralized but still remained within MPOI. In November 2020, HCA further separated Program Integrity from MPOI and created a distinct division now known as the Division of Program Integrity (DPI). This new division was memorialized in Agency Policy 01-29 *Apple Health Program Integrity*. DPI is solely responsible for evaluating, analyzing, and investigating allegations of fraud, waste, and abuse by providers and beneficiaries and analyzing functions across the Apple Health (Medicaid) program to determine compliance with applicate laws, rules, or agreements and to prevent, detect, and recover improper payments.

This policy further memorialized Provider Enrollment as a distinct program within HCA, and Provider Enrollment officially transferred to DPI in January 2021. The Provider Enrollment section is responsible for screening new provider applicants and monitoring existing providers to ensure eligibility requirements are met.

Recommendation No. 2: Resource allocation

CMS recommended that HCA ensure that both HCA and MCOs are allocating sufficient resources to the prevention, detection, investigation and referral of suspected provider fraud.

With the November 2020 reorganization, the new DPI now has 44 FTE, including two section managers, to focus on managed care program integrity oversight. The dedicated FTEs have expanded the oversight of MCO operations to include reviews of MCO provider credentialing files, MCO ownership disclosures, provider network adequacy checks, audits of submitted encounter data to verify accuracy and completeness, validation of MCO reported recoveries and allegations, and reviews of MCO network provider utilization to determine areas of potential audit.

To increase MCO program integrity activities and Special Investigation Unit (SIU) dedication to prevention, detection, investigation, and referrals of suspected provider fraud, DPI proposed a ratio of MCO PI/SIU staff per covered enrollee for January 2020, which was ultimately incorporated into the MCO contracts. The language in the MCO contracts today requires all MCOs to maintain staffing levels of one (1) FTE for every 50,000 enrollees. Our language further requires that said staff have appropriate education and

expertise to conduct federal, state, and contract-required program integrity activities that (1) prevent, detect, and investigate fraud, waste, and abuse; (2) refer potential fraud to HCA or the Medicaid Fraud Control Unit (MFCU) of the state Attorney General's Office; and (3) produce cost avoidance savings or post-payment recoveries of improper payments.

Recommendation No. 3: More robust contractual language regarding program integrity

CMS recommended that HCA seek to enhance/improve the program integrity contract language with MCOs to ensure there are no contractual impediments to provider auditing and collaborative audits with the MCOs, as well as audits of the MCOs themselves.

HCA contracts have historically included provisions that required MCO contractors, and their subcontractors, to allow access to records to state and federal auditors. However, in response to this recommendation, HCA revised contract language to ensure a broader interpretation of what access means, what records are encompassed in this requirement, and who has access. The MCO contracts today require unfettered access to HCA, MFCU, state auditors, and federal agencies including, but not limited to, CMS, Government Accountability Office, Office of Management and Budget, Office of Inspector General, Comptroller General, and their designees to all records, premises, physical facilities, and equipment where Medicaid-related activities or work is conducted, at any time. Records may include, but are not limited to, (1) medical records; (2) billing records; (3) financial records; (4) any record related to services rendered, quality, appropriateness, and timeliness of services; (5) any records relevant to an administrative, civil, or criminal investigation or prosecution; and (6) any record of a contractor-paid claim or encounter, or a contractor-denied claim or encounter. This language is required to be passed on to provider subcontractors to ensure the same level of access to records, premises, facilities, and equipment at the provider level.

Furthermore, DPI has a new dedicated MCO oversight team to review MCO program integrity activities and ensure adherence to state, federal, and contract requirements. DPI's MCO oversight team reviews MCO network provider utilization to determine areas of potential risk and collaborates with the MCOs to investigate and mitigate fraud, waste, and abuse.

Recommendation No. 4: Policies and procedures

CMS recommended that HCA review program integrity policies and procedures relative to any contract modifications to ensure all program integrity functions are adequately addressed.

By December 2019, HCA had created Agency Policy 01-29 *Apple Health Program Integrity*. This new policy established, among many other things, DPIs direct responsibilities relating to overseeing, reviewing, and auditing the operations of contracted entities and their subcontractors. This includes, but is not limited to, contract requirements related to program integrity, encounter data validation, provider credentialing, and financial records. This policy further requires DPI to identify, track, and report fraud, waste, and abuse that results in improper payments in managed care, identify, track, and report on vulnerabilities in MCO policies and procedures that could result in improper payments, to investigate potential fraud and determine whether a credible allegation of fraud exists, and to refer to MFCU in those instances.

Additionally, DPI has created an internal provider fraud referral process that requires logging and tracking all instances of provider fraud referrals and provides the required steps for intake, conducting audits, and conducting preliminary investigations.

Recommendation No. 5: Mandatory referrals and training

CMS recommended that HCA ensure the mandatory referral of any potential fraud, waste, or abuse to the state Medicaid program integrity unit or any potential fraud to the MFCU. This includes, but not limited to, ensuring that the MCO SIU staff receive sufficient program integrity training in identifying, investigating, referring, and reporting providers with suspected fraudulent billing practices. This training should be accomplished in conjunction with the MFCU, when possible, to enhance case referrals from MCOs.

HCA facilitated a four-hour Spring Fraud, Waste, and Abuse Symposium in March 2019 in collaboration with the MFCU to address MCOs' responsibility to provide oversight of provider billing to identify and investigate potential fraud, waste, and abuse. Other topics at the symposium were (1) how to recover overpayments; (2) prevention techniques; and (3) how to build a good fraud case and referral. A similar four-hour Fall Fraud, Waste, and Abuse Symposium was facilitated in September 2019.

Additionally, the 2019 HCA/MFCU Memorandum of Understanding (MOU) requires that HCA and MFCU develop a collaborative training plan by January 15 of each year. Each year, the plan will include a bi-annual HCA/MFCU joint training for MCO Compliance/Program Integrity and Special Investigations Unit (SIU) staff. Training topics will include but are not limited to (1) developing quality fraud referrals; (2) understanding good cause exceptions to payment suspensions; (3) provider screening requirements; (4) provider audits and reviews to identify improper payments; (5) recovering improper payments; and (6) compliance with contract requirements, and federal/state regulations.

Further, the current (July 1, 2023) Apple Health Integrated Managed Care contracts require all MCOs to participate in MCO-specific quarterly Program Integrity meetings with HCA and the MFCU to discuss case development and monitoring. MCOs are also required to participate in a bi-annual forum to discuss best practices, performance metrics, provider risk assessments, analytics, and lessons learned, and also go over quality control and submitted encounter data (See Section 12.1.5 of the July 1, 2023, Apple Health Integrated Managed Care Model Contract posted on HCA's external website).

Recommendation No. 6: MCO fraud referral standards

CMS recommended that HCA improve tracking of MCO investigation referrals and enhance use of the customized Washington fraud referral form for reporting purposes, making any appropriate modifications to the form as needed. CMS also recommended that HCA 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.

The current (July 1, 2023) Apple Health Integrated Managed Care contracts contain language that require the MCOs to report to HCA/MFCU within five business days any suspicions of potential fraud and to simultaneously stop any further action to include overpayment issuance, collection, or any other steps. MCOs are further required to report using the current MCO Fraud Referral Form. This form, included as **Appendix A**, was completed in 2018 and includes all CMS standards.

Once a fraud referral is received, it is logged and tracked in HCA's Case Management System for further review, investigation, and potential referral to MFCU.

In 2018, HCA established internal policies and procedures to memorialize the fraud referral process, to include tracking and monitoring activities.

Recommendation No. 7: Random sampling of MCO provider enrollment files

CMS recommends that HCA expand its program integrity scope to include random sampling of MCO provider enrollment files to verify that all appropriate documentation is present.

In 2019, DPI developed a new MCO oversight plan for conducting audits of MCO provider enrollment files to ensure all required checks are conducted and appropriate information is collected and verified. The first audit based on this plan was initiated in the Spring of 2020.

Recommendation No. 8: Collaborative meetings aimed at educating MCOs on suspected fraud referrals

CMS recommended that HCA continue fostering better interaction with MCOs and the MFCU. It also recommended collaborative meetings aimed at improving HCA/MFCU interactions and educating MCOs regarding suspected fraud referrals. This would include any necessary MFCU MOU revisions. In addition, CMS recommended HCA communicate and obtain feedback from the MFCU regarding the quantity and quality of MCO referrals reviewed and develop a strategy for improving MCO referrals.

HCA and MFCU updated their MOU in November 2019 to include ad hoc and regularly scheduled meetings with MFCU to enhance communication and increase collaboration with MCOs. Of note, the updated MOU contains a more robust description of roles and responsibilities as they pertain to fraud referrals. Additionally, the updated MOU provides more direction on communication during fraud investigations and requires substantial collaboration on training for MCOs as it relates to fraud referrals. For example, Section IV(D) Training Plan, requires biannual HCA/MFCU joint training sessions for MCO Compliance/Program Integrity and SIU staff. Training topics may include (1) developing quality fraud referrals; (2) understanding good cause exceptions to payment suspensions; (3) provider screening requirements; (4) provider audits and reviews to identify improper payments; (5) recovering improper payments; and (6) compliance with contract requirements and federal/state regulations.

Agency Policy 01-29 *Apple Health Program Integrity* further requires DPI to conduct program integrity trainings for providers and contracted entities at least annually and host an annual HCA Fraud Summit to include MFCU, providers, and contracted entities.

Recommendation No. 9: Improve HCA's ability to analyze encounter data reported by MCOs and perform data mining activities to identify fraud, waste, and abuse

CMS recommended that HCA continue efforts to improve the state's ability to analyze encounter data reported by MCOs and proactively perform state-initiated data mining activities to identify fraud, waste, and abuse issues with MCO providers. CMS also recommended HCA implement proactive data mining and routine audits of validated managed care claims encounter data.

HCA's Managed Care Oversight Plan includes conducting random sample and focused audits of managed care encounter data with an onsite review of the MCO's payment systems, and if appropriate, managed care network provider documentation for billed services. These audits compare and validate the accuracy of the encounter data submitted to HCA's Medicaid Management Information System (MMIS), ProviderOne. These audits began in April 2019.

The state receives standard 837 encounter (a national data standard) transactions and National Council for Prescription Drug Programs (NCPDP) encounter transactions from MCOs consistent with the technical specifications defined in HCA's Encounter Data Reporting Guide. These transactions represent member utilization activity for both claims paid by the MCO on a on a fee-for-service basis as well as encounters for services delivered under subcontracted arrangements. Reporting of 837 and NCPDP transactions by the managed care entities is a standard ongoing reporting requirement defined in the Apple Health Integrated Managed Care contract. Detail encounter data is validated by HCA through a combination of standard reports comparing to MCO financials and ad hoc data audits conducted by DPI.

ProviderOne categorizes encounter transactions based on adjudication rules that are mostly consistent with rules applied to fee-for-service claims paid by HCA. The system rejects transactions if the records contain insufficient information (such as missing provider information), are inappropriate services for the member served, are not covered under the program, or are delivered by a non-enrolled provider, among other front-end quality control checks. ProviderOne's adjudication rules and algorithms assign claim categorization fields onto the encounter data to facilitate monthly MCO utilization reports that are monitored by HCA. Further, HCA transfers the detailed encounter records to its contracted actuary, who employ several additional data mining techniques monthly as part of standard data warehouse management for the data that the actuaries use in capitation rate development and other actuarial analyses on behalf of HCA. The data warehouse maintained by the actuaries employs several data mining techniques to ensure only appropriate transactions are included in analysis. In addition, the state data mines encounter data and fee-for-service (FFS) data in a variety of program integrity activities, to include identifying aberrant billing patterns in specific provider types across all MCOs and FFS, identifying duplicate paid services (FFS and MCO both paid).

Recommendation No. 10: Contractually ensure MCOs submit accurate reports on overpayments

CMS recommended that HCA contractually ensure 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.

Effective July 1, 2019, all Apple Health Integrated Managed Care contracts contained appropriate terminology to improve and maintain accurate MCO reporting of identified and recouped overpayments to allow and support a reconciliation process. MCOs are now required to identify and recover all overpayments and submit monthly reports to HCA in accordance with WAC 182-502A-1101. Additionally, MCOs must have internal policies and procedures for the documentation, retention, and recovery of all overpayments, specifically due to fraud, waste, and abuse. All MCOs are further required to pass down to their subcontractors/providers a requirement to establish a mechanism for the subcontractor/providers to

report to the MCO when it has received an overpayment, to return the overpayment within 60 days, and to notify the MCO in writing the reason for the overpayment.

Recommendation No. 11: Implement processes to ensure the integrity of data is being used for rate setting purposes

CMS recommended that HCA 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.

DPI has established regular meetings with HCA's contracted actuary, Milliman, and has implemented processes to ensure supplemental data concerning overpayments and recoveries, submitted directly to Milliman from the MCOs, is used for rate setting. The Apple Health Integrated Managed Care contracts contain language requiring MCOs to submit this supplemental data directly to HCA's contracted actuary to incorporate into the rate setting process.

To address the integrity of the data being transferred directly from MCOs to Milliman, DPI collects monthly data from the MCOs on actual overpayments and recoveries collected. Annually, DPI compiles the monthly reports and sends them to Milliman.

Recommendation No. 12: Payment suspension procedures

CMS recommended that HCA review regulation 438.608(a)(8) regarding payment suspensions and modify the MCO contract as necessary and consequently, assess if the MOU with the MFCU should be revised to incorporate enhancements to case referral and payment suspension procedures that fully comply with regulation 438.608(a) (8) and therefore, 455.23. CMS also recommended that HCA conduct training to all contracted entities and law enforcement agencies as required.

The MOU between HCA and MFCU was revised in November 2019 with enhanced language regarding case referrals and suspensions to ensure a full understanding of payment suspension terminology and processes. Under the revised language, once a credible allegation of fraud is determined by HCA, HCA will provide MFCU 30 days written notice of our intent to suspend payments to the provider pending a full investigation. MFCU must provide HCA quarterly updates on the status of the investigation and if continued payment suspensions are still appropriate. The revised language also provides for good cause exemptions to payment suspensions and the associated processes when one of these situations occurs.

As mentioned under recommendation No. 8, HCA and MFCU updated our MOU in November 2019 to include ad hoc and regularly scheduled meetings with MFCU to enhance communication and increase collaboration with MCOs.

Agency Policy 01-29 *Apple Health Program Integrity* further requires DPI to conduct program integrity trainings for providers and contracted entities on at least an annual basis and host an annual HCA Fraud Summit to include MFCU, providers, and contracted entities.

Recommendation No. 13: Credible allegations of fraud

CMS recommends that HCA 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 MFCU 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 MFCU independently rather than routinely issuing good cause exceptions.

Agency Policy 01-29 *Apple Health Program Integrity* was established in December 2019, and again updated in December 2022. This policy defines HCA's role of determining what a credible allegation of fraud is and when a good cause exemption exists to not suspend payments to providers during a fraud investigation.

In June 2023, DPI further established DPI Policy No. 120.030 *Internal Controls* to enforce HCA's role in determining when a credible allegation of fraud exists, steps required for referrals to MFCU, and the process for suspending payments once a credible allegation of fraud is determined by HCA.

Recommendation No. 14: Federal database exclusions

CMS recommended HCA ensure all federal database exclusions checks, particularly the federal System for Award Management (SAM), are performed for all subcontractors at enrollment, re-enrollment and monthly.

In November 2018, HCA Provider Enrollment (PE) implemented a new Automated Provider Screening (APS) tool from Lexis Nexis which includes checks of all federal exclusion databases at enrollment and revalidation/re-enrollment. If potential exclusion hits are identified by APS, the tool will flag the provider and HCA staff manually investigate the hit by checking directly with the SAM database or the List of Excluded Individuals/Entities that is administered by the U.S. Department of Health and Humans Services, Office of the Inspector General. Database checks in the APS were later expanded to be completed monthly which ensures HCA is compliant with federal requirements.

Medical assistance expenditure forecast workgroup

Section 32(c)(ii) asks HCA to report on specific, quantified information regarding the work done with its contracted actuary and the medical assistance expenditure forecast work group to develop methods and metrics related to managed care program integrity activity that shall be incorporated into annual rate setting.

Milliman report on CY 2022 capitation rate development

HCA's contracted actuary, Milliman, provided a comprehensive report on calendar year 2022 capitation rate development. This report detailed the process for receiving MCO overpayment data and reported the impact on rate development. In building this report, Milliman received overpayment information from both the state and MCOs, specifically overpayment recovery reports from HCA, and summarized recovery amounts by population and service period from MCOs.

Milliman was able to verify that the majority of provider overpayments have been reflected in the encounter data. An adjustment was applied to reduce experience for additional recoveries not reflected in the encounter data. MCOs reported recoveries from overpayments and third-party liability, coordination of benefits, and subrogation separately. Some were adjusted in encounters in the PI systems and others were reported outside the systems. (See excerpt from the Milliman Report on CY 2022 Capitation Rate Development below.)

Image 1: MCO-reported program integrity recoveries in CY 2019

Section I.3.B.ii(c) (Page 20) of the Milliman Report on CY 2022 Capitation Rate Development.

TABLE 36: MCO-REPORTED PROGRAM INTEGRITY RECOVERIES IN CY 2019

CATEGORY	EXPENDITURES	PMPM
Claims payment recoveries (TPL/COB/subrogation) adjusted in claims	7,776,024	0.43
Claims payment recoveries (TPL/COB/subrogation) settled outside of claims	1,715,546	0.09
Claims payment recoveries (overpayment recoveries) adjusted in claims	62,450,250	3.43
Claims payment recoveries (overpayment recoveries) settled outside of claims	8,026,096	0.44
Total	**$ 79,967,917**	**$ 4.39**

Potential new methods/metrics and resources for discussion

HCA will continue to explore different methods of data collection that could potentially impact the rate setting process. HCA anticipates taking a deeper dive into the following methods in furtherance of this goal:

- Accounting for retro-Medicare recoupment of PMPM due to disenrollment in rate setting
- Accounting for services after death PMPM recoveries in rate setting
- Development of overpayment recovery benchmark percentage based on historical average recoveries

To explore these opportunities, HCA will utilize state-of-the-art technology provided through our recently procured Fraud and Abuse Detection System (FADS), which uses advanced analytic tools, as well as investigation leads generated by CMS's Unified Program Integrity Contract (UPIC) and the Healthcare Fraud Prevention Partnership (HFPP). Additionally, the UPIC improves DPI's capacity to conduct investigations and analysis on fee-for-service programs and providers as well as managed care network providers.

Program integrity activity incorporation into managed care contracts

Section 32(c)(iii) asks HCA to provide specific, quantified information regarding the work done with the medical assistance expenditure forecast work group to ensure the results of program integrity activity are incorporated into the rate setting process in a transparent, timely, measurable, quantifiable manner.

Improper payment recoveries and prepayment cost avoidance

After analyzing the first CMS Managed Care Programs Annual Report (MCPAR), which HCA submitted to CMS in June, HCA determined that incoporating a 1% minimum standard for improper payment recoveries and prepayment cost avoidance into all Apple Health Integrated Managed Care contracts was appropriate. Current language in the contracts is stated below:

Section 12.5.10 For the reporting period January 1, 2024 through December 31, 2024, and annually thereafer, the Contractor shall achieve a minimum standard of Improper Payment recoveries equal to or greater than 1 percent of the Contractor's total premium revenue for that calendar year.

Section 12.5.11 For the purposes of this Section, the term "total premium revenue" means the amount reported in the MLR Report for the year pursuant to the Medical Loss Ratio (MLR) Report Section of the Contract.

HCA anticipates utilizing the calendar year 2024 data to baseline and gain a better understanding of the appopriateness of improper payment recovery percentages. HCA will re-evaluate improper payment rate recovery percentages as appropriate.

Program integrity recoveries

Section 32(c)(iv) asks HCA to provide accounting by fiscal year, Medicaid eligibility group, and service, beginning with state fiscal year 2020 to include all program integrity recoveries attributable to the authority, including how these recoveries are categorized, to which year they are reported, how these recoveries are applied against legislative savings requirements, and what recoveries are attributable to the Office of Attorney General's MFCU and how these recoveries are considered when reporting program integrity activity and determining managed care rates.

MCO contractual sanctions and liquidated damages

The Payment and Sanctions Section of the Apple Health Integrated Managed Care contracts requires MCOs to submit to HCA complete, accurate, and timely data for all services for which the contractor has incurred any financial liability, whether directly or through subcontracts or other arrangements in compliance with encounter submission guidelines as published by HCA and that adhere to data quality standards established and communicated by HCA. If MCOs do not adhere to these requirements, they may be subject to sanctions or in some instances liquidated damages.

There are two situations we may see associated with accountability under the MCO contracts: payments for sanctions and recoveries of liquidated damages.

For MCO sanctions, HCA has established a revenue sub-source for MCO sanctions, (04/05 020001, MCO Sanctions/Penalties). DPI sends HCA's accounting division a copy of any sanction letter they send to MCOs. Accounting uses this to record an entry in our receipts log. Accounting, upon receipt of the sanction, will notify DPI that the funds have been received.

Liquidated damages received from MCOs are recorded as a recovery of expenditures. HCA Accounting works with DPI to understand what the expenditure was and recover the funds at the same line of account coding with one exception, the sub sub-object (SSO). All recoveries will use the SSO "NB M997 - MCO Liquidated Damages."

Clarifications to the Program Integrity Reporting Section of the Apple Health Integrated Managed Care contracts have been made for January 2024 to increase MCO accountability, further reiterating untimely reports may be subject to sanctions or liquidated damages.

Assessed sanctions and liquidated damages

Below is a snapshot of actual recoveries for fiscal years 2020 through 2023. Recoveries are separated into two categories: (1) MCO Sanctions/Penalties, and (2) MCO Liquidated Damages. Note that there were no liquidated damages assessed in fiscal years 2020 and 2021.

Table 1: Snapshot of actual recoveries for FY 2020 – FY 2023

GL	MS	Source	Ssource	Ssource Title	SFY 2020	SFY 2021	Sum:
3210		05	020001	Mco Sanctions/Penalties		($25,000.00)	($25,000.00)
	04				$0.00	($25,000.00)	($25,000.00)

GL	MS	Source	Ssource	Ssource Title	SFY 2022	SFY 2023	Sum:
3210		05	020001	Mco Sanctions/Penalties	($642,500.00)	($1,072,250.00)	($1,714,750.00)
	04				($642,500.00)	($1,072,250.00)	($1,714,750.00)

GL	SOBJ	SSOBJ	SSOBJ TITLE	2022	2023	Sum:
0159	NB	M997	Mco Liquidated Damages		($113,189.83)	($113,189.83)
6510		M997	Mco Liquidated Damages	($121,910.97)	($64,572.96)	($186,483.93)
	NB			($121,910.97)	($177,762.79)	($299,673.76)

Application to legislative savings requirements

On April 6, 2023, HCA provided the Legislature an update on program integrity efforts and their application to legislative savings requirements. HCA's program integrity efforts, including expanded MCO oversight and procurement of FADS, have generated more than $320 million in savings through cost avoidance, recoveries, and settlements over the past several years. In CY 2022, program integrity recoveries included more than $13 million in overpayments, more than $870,000 in liquidated damages and sanctions, as well as other fraud and abuse related recoveries through MFCU totaling more than $33 million.

Savings are calculated through cost avoidance activities. As an example, HCA saved more than $150 million on pharmacy spending through program integrity activities. However, these savings were either already captured in other budget steps, avoided costs, or funds that come back to the state but do not have an HCA-specific budget impact, such as settlements negotiated by the MFCU. Given this, HCA requested a full restoration of the program integrity related savings assumed in the underlying budget ($230 million total funds, $71 million GFS per year).

HCA continues to evolve managed care program integrity to include approaches like encounter validation, contract, and oversight changes, in addition to traditional activities like audits and recoveries. We will continue implementing oversight mechanisms to drive better MCO performance. However, while we expect these efforts to lead to additional cost avoidance and recoveries, it is important to emphasize that: 1) savings from these activities are often already accounted for in other budget steps or savings already revert directly to the general fund; 2) additional budget line items for program integrity savings overstate the impact of program integrity activities; and 3) there can be a high degree of volatility from year to year.

Medicaid Fraud Control Division

RCW 74.09.215 established the Medicaid fraud penalty account in the state treasury. All sanctions, liquidated damages, settlements, and other fines received under the Medicaid fraud false claim act (RCW 74.66) are deposited into this account. This money can only be spent after appropriation and must be used only for Medicaid services, fraud detection and prevention activities, recovery of improper payments, for other Medicaid fraud enforcement activities, and the prescription monitoring program.

Application to rate setting

HCA will continue implementing oversight mechanisms and enforceable metrics to drive better performance by MCOs. Significant savings can be accounted for through contract changes. Additionally, we will continue to identify overpayments made by the MCOs and assess damages and sanctions where appropriate. Nonetheless, HCA cannot reasonably estimate a level of savings or cost avoidance at this time and may continue to have difficulty accurately predicting it in the future. HCA continues to improve collaboration with actuarial rate setting to look for opportunities, such as related pharmacy savings and metrics for accountability.

Fraud and Abuse Detection System

Section 32(c)(v) asks HCA to provide information detailing when the agency acquired a new fraud and abuse detection system and to what extent this system is being utilized.

Status of procurement

The Medicaid Fraud and Abuse Detection Solution (FADS) is a Software as a Service (SaaS) solution that supports DPI in the identification of potential fraud, waste, and abuse leads among paid Medicaid claims and encounters through alerts/algorithms. The system must be certified by the Centers for Medicare and Medicaid Services (CMS) through the certification review (CR) process. This includes producing documentation of meeting six consecutive months of outcome metrics and supporting information as a live system, a Disaster Recovery Plan Test and the CR itself.

HCA's prior fraud, waste, and abuse system was procured in 2008; however, DPI released a competitive request for proposals (RFP) for a new, more state-of-the-art, FADS in February 2021. After a thorough evaluation process, HCA selected Thomson Reuters (TR) as the successful vendor and began system implementation in October 2021. The system went live on November 30, 2022, and we have entered into operations and maintenance, and pre-certification phase.

HCA took an additional step and developed in-house a case management tool through an enterprise-wide instance of ServiceNow which has a direct interface with FADS. With ServiceNow (SNOW), HCA can track the status of DPI's fraud, waste and abuse leads and cases identified from alerts/algorithms, from additional research using FADS functionality and through external means (such as tips reported to HCA).

Outcomes and utilization

The new FADS systems operates in alignment with HCA's 2022 Annual Audit Plan which consists of five categories of audit activities:

- CMS directed audits
- Follow-up audits from previous year
- CFR-required audits
- Leadership-directed audits
- Ad hoc and recurring audits

The anticipated outcomes of these audits include:

- Assessment of sanctions and liquidated damages imposed on MCOs
- Recovery of PMPM and Service Based Enhancement payment transactions from MCOs
- Recovery of duplicate fee-for-service payments
- Generation of fraud referrals to MFCU

Appendix A: MCO fraud referral form

Washington State Health Care Authority

Section of Program Integrity
P.O. Box 45503
Olympia, WA 98504-5503

Credible Allegation of Fraud Referral Form

☒ **MFCD** ☐ **HHS/OIG** ☐ **Other** _____

General Referral Information		
Referred By (Name, Title, HCA Unit):		**Contact information for staff person with practical knowledge of the relevant program:**
Date:	**Phone:**	
Email:	**Mailstop:**	

Facility / Provider Information	
Name:	**ProviderOne ID / NPI:**
Payee Address (Street, City, State, Zip):	**Phone / FAX:**
Location Address (Street, City, State, Zip) – if different from Payee Address:	**Phone / FAX:**
Provider Type (e.g. DME; Physician; Hospital; etc.):	**Amounts paid to provider in past three years:**

Details of Allegation		
Source / Origination of complaint:		**Date reported to HCA/ PI:**
		Case ID:
Category of service:	**Dates of conduct:**	**Potential exposed dollar amount:**
Factual explanation of the allegation: - SUPPORTING DOCUMENTATION ATTACHED ☒		
Specific Medicaid statutes, rules, regulations, and/or policies violated: 18 USC § 1347, RCW 74.09.230, WAC 182-502-0020		
Communications between HCA and provider concerning conduct: - SUPPORTING DOCUMENTATION ATTACHED ☐		

Program Integrity Management Authorization	
Referral for credible allegation of fraud reviewed and approved by Program Integrity Section Manager or their delegate.	
Signature and Title: Scott Best, Section Manager	**Date:**

To be completed by MFCD, HHS/OIG or other Law Enforcement:

MFCD, HHS/OIG or other Law Enforcement Determination:

☐ Accepts referral for purpose of opening an investigation
☐ Does **not** accept referral for purpose of opening an investigation

PAYMENT SUSPENSION: