PERFORMANCE AUDIT

Office of the Washington State Auditor
Pat McCarthy

Medicaid and Managed Care Organizations:

Ensuring strong program integrity efforts and accurate encounter data

October 31, 2023

Report Number: 1033443

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Executive Summary

State Auditor's Conclusions (page 36)

More than one out of four Washingtonians relies on Medicaid for health care coverage, making it one of our largest and most important public services. We audit Medicaid in multiple ways, providing multifaceted reviews of the program's finances and operations.

This performance audit found the state Health Care Authority and contracted managed care organizations are taking key steps to prevent fraud and to ensure they are using accurate data about patient care and its costs. This report also offers a robust set of recommendations for improving their processes, especially in terms of providing accurate information used to establish the premiums paid by the state.

Each improvement in a large, complex system can yield substantial rewards, and in the case of Washington's managed care model we see the potential for significant gains. Managed care provides services to about 85 percent of the 2.3 million Medicaid enrollees in our state. In the past fiscal year, each of the state's five contracted managed care organizations received at least $1 billion in premiums – and one received several times that amount.

By putting in place our detailed recommendations to improve program integrity, the Health Care Authority can do even more to prevent fraud, reduce overall costs, and ensure Medicaid funding is available to deliver care to millions of Washingtonians.

Background (page 7)

Medicaid is Washington's largest public assistance program, providing health insurance for more than one in four Washingtonians. In fiscal year 2022, federal and Washington state funds for Medicaid spending totaled more than $17.6 billion.

State Medicaid agencies have turned toward a managed care model to reduce costs and better manage how health services are used. Under the managed care model, the Health Care Authority (HCA) contracts with managed care organizations (MCOs) to provide services. HCA pays each of the MCOs a monthly premium for each person enrolled with them. In exchange, the MCOs must provide covered services for all enrollees and comply with HCA's contracts. MCOs must send HCA encounter data, which details all services provided. Encounter data is also one factor used in calculating the premiums paid to the MCOs each month.

Program integrity efforts focus on paying the right dollar amount to the right provider for the right reason. These efforts are intended to prevent fraud and other improper payments so that taxpayer dollars are available for delivering necessary care. By ensuring only correct payments are made to providers, strong program integrity efforts can also help reduce overall medical costs – and costs are an important factor in setting premium rates for the MCOs.

The state has engaged a private actuary, Milliman, to develop Medicaid premium rates; HCA supplies the actuary with both the encounter data and information about MCO program integrity efforts and overpayment recoveries. The actuary reviews this information for elements like completeness and reasonableness, and then uses it as factors in the process to set future premiums. If the actuary does not receive accurate information for rate setting, the premiums may also be inaccurate.

MCOs took many key steps to prevent fraud and improve encounter data, but additional leading practices could strengthen these efforts (page 14)

The three audited MCOs followed all required and most leading program integrity practices to identify potential fraud or other improper payments. MCOs met their contractual obligations for program integrity activities, such as identifying providers that should not participate in Medicaid due to past fraudulent behavior and verifying patients received billed services. All three MCOs used basic data analytics, such as identifying outliers that could indicate fraud or other improper payments, and two of the MCOs used advanced predictive analytics, which uses historical data to flag possibly fraudulent activity. However, program integrity efforts could be strengthened by applying additional data analytics that are recommended by leading practices.

Note: HCA contracts with five MCOs. This audit examined only the three MCOs responsible for the most enrollees.

MCO procedures also included key overpayment reporting requirements, but HCA did not verify the completeness of these reports. Overpayment recoveries are considered in the rate setting process, so incomplete or inaccurate information could affect the accuracy of premium rates.

The audited MCOs had many tools and processes in place to ensure complete and accurate encounter data. For example, MCOs followed all required and leading practices for receiving information from providers, such as collecting data from providers in standardized formats and providing feedback to providers on submission issues. All MCOs also monitored encounter data they submitted to HCA, and during the audit period one conducted its own internal audits that retrospectively compared provider claims to encounters. Finally, all audited MCOs used automated system checks to screen encounter data for complete and accurate information before they submitted it to HCA.

HCA has strengthened oversight of MCO efforts, but could improve performance measures, information verification and formal processes for penalties (page 25)

Although HCA has strengthened oversight of MCO program integrity efforts, it could include related performance measures in its contracts. HCA has increased efforts related to oversight of managed care program integrity efforts and incorporated related requirements into its contracts. These requirements touch on issues ranging from the penalties for MCO contract noncompliance to documentation and communication. However, adding performance measures specific to MCO program integrity efforts to its contracts would offer additional assurance that MCOs meet expectations.

HCA had many practices in place to monitor MCO encounter data, but could improve information verification. We found contracts incorporated most required and leading practices around encounter data, but lacked performance targets for key encounter data fields, such as unacceptable rates of error for missing data, record rejections and duplicate records. HCA also validated encounter data in multiple ways, such as through automated system checks recommended by CMS. In addition, HCA regularly compared encounter records to MCO reported information, however, managers did not request supporting documentation for reported paid claim amounts.

In general, HCA implemented many monitoring and communication practices to ensure accurate encounter data submissions. For example, HCA conducted audits of MCO encounter data and provided regular communication and technical assistance to MCOs on encounter data issues. Finally, HCA can impose financial penalties against MCOs that do not meet contractual obligations, but lacked documented policies for doing so, which could lead to penalties being applied inconsistently.

Recommendations (page 37)

We made a series of recommendations to HCA to improve oversight of MCO program integrity efforts and encounter data quality. We also communicated several other potential improvements related to internal controls to HCA management and those charged with governance in a letter dated August 25, 2023.

Next steps

Our performance audits of state programs and services are reviewed by the Joint Legislative Audit and Review Committee (JLARC) and/or by other legislative committees whose members wish to consider findings and recommendations on specific topics. Representatives of the Office of the State Auditor will review this audit with JLARC's Initiative 900 Subcommittee in Olympia. The public will have the opportunity to comment at this hearing. Please check the JLARC website for the exact date, time, and location (www.leg.wa.gov/JLARC). The Office conducts periodic follow-up evaluations to assess the status of recommendations and may conduct follow-up audits at its discretion. See **Appendix A**, which addresses the I-900 areas covered in the audit. **Appendix B** contains information about our methodology. See the **Bibliography** for a list of references and resources used to develop our understanding of the topic area.

Background

Medicaid provides health insurance for more than one out of four Washingtonians

Medicaid is a jointly funded state and federal partnership that provides medical coverage for people with low incomes. The federal contribution for Medicaid varies based on many factors, including the service provided and state poverty levels, with states funding the rest of the cost. The Centers for Medicare and Medicaid Services (CMS) is the federal agency that works in partnership with state agencies to administer Medicaid.

Medicaid in Washington is referred to as Apple Health and covers a wide array of services. These services are available to Washingtonians with qualifying income levels which vary based on age and factors like family size and pregnancy. The Health Care Authority (HCA) is Washington's state Medicaid agency and is responsible for meeting numerous federal requirements, including oversight of Medicaid programs administered through other organizations.

Medicaid is Washington's largest public assistance program. About 2.3 million people were enrolled in Medicaid as of May 2023, representing more than one in four Washingtonians. In fiscal year 2022, federal and Washington state funds for Medicaid spending totaled more than $17.6 billion, with Medicaid spending being slightly more than one quarter of the state budget.

Medicaid offers a wide array of services

- Office visits with a doctor or health care professional
- Emergency medical care
- Maternity and newborn care
- Behavioral health services
- Long-term care services and support
- Treatment for chemical or alcohol dependence
- Pediatric services, including well-child visits, immunizations, dental and vision care
- Limited dental and vision care for adults
- Hospitalizations
- Prescription medications
- Laboratory services
- Transportation to and from medical appointments
- An interpreter for appointments

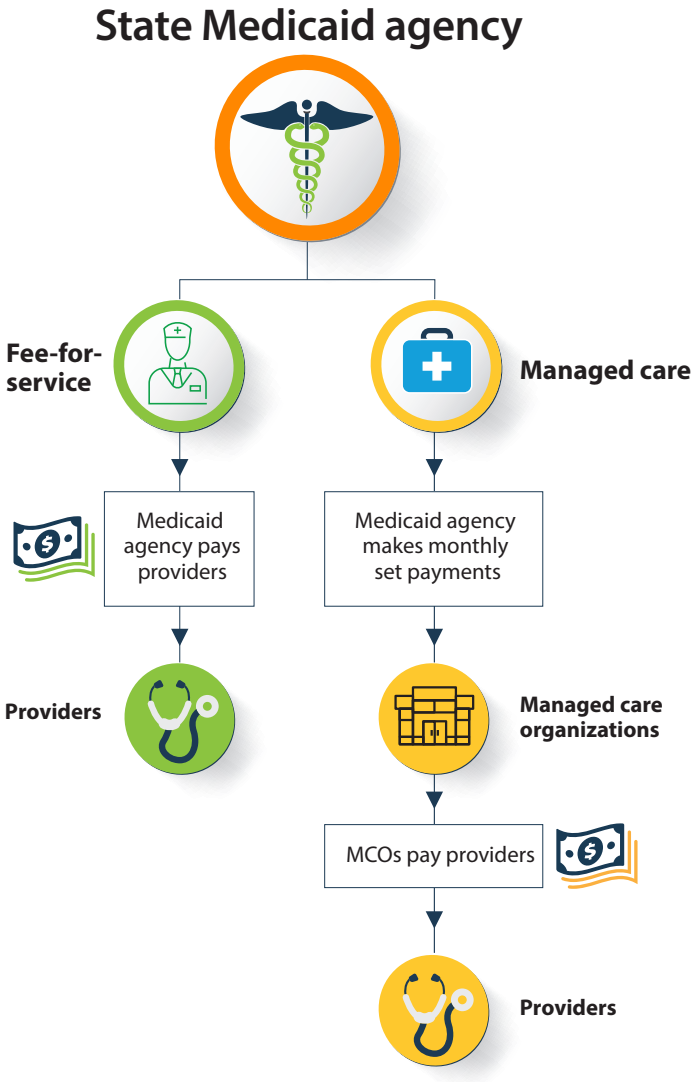
Managed care is the primary means of providing healthcare services to Washington's Medicaid enrollees

State Medicaid agencies across the country have turned toward a managed care model to reduce costs and better manage how health services are used. Under Washington's managed care model, HCA contracts with managed care

organizations (MCOs) to provide services. MCOs are private companies that provide eligible people enrolled in an approved insurance program, including Medicaid, with access to health care services. They vary in size and structure: Some MCOs are large, publicly traded for-profit companies operating in multiple states, while others are not-for-profit companies working within a single state.

HCA pays each of the MCOs a monthly premium for each person enrolled with them (illustrated in **Exhibit 1**). In exchange, the MCOs must provide covered services for all enrollees and comply with HCA's contracts. Each MCO also contracts with different providers to provide and document care. These two types of contracts are the main ways to regulate and account for services provided to Medicaid enrollees. This differs from the older model of fee-for-service, in which the state Medicaid agency pays providers directly for each service.

Exhibit 1 – Comparing fee-for-service and managed care processes for paying Medicaid service providers



Source: Auditor prepared.

Approximately 85 percent of Washington's 2.3 million Medicaid enrollees receive physical and behavioral health service through one of five MCOs, as shown in **Exhibit 2**.

Exhibit 2 – Summary of Washington Medicaid managed care enrollees served through managed care organizations

All numbers are rounded; enrollee numbers current as of May 2023.

Name of MCO	Number of enrollees	Percent of managed care enrollees in plan	Amounts paid to MCO in FY 2022
Molina Healthcare of Washington	993,000	50%	$4.7 billion
Community Health Plan of Washington	272,000	14%	$1.3 billion
UnitedHealthcare of Washington	256,000	13%	$1.3 billion
Amerigroup Washington, Inc.	229,000	12%	$1.3 billion
Coordinated Care of Washington	220,000	11%	$1.1 billion
Total	**1.96 million**	**100%**	**$9.7 billion**

Source: HCA and Washington's Office of Financial Management.

In fiscal year 2022, managed care accounted for about half of all Medicaid spending, with roughly $9.7 billion paid to the five MCOs. The remainder was paid to fee-for-service providers. While these providers see fewer patients, they deliver far more costly services such as long-term care. Although Washington has been transitioning away from fee-for-service and towards managed care, HCA's contracts with the MCOs do not include all Medicaid services because there are some situations where HCA has determined that fee-for-service is a more cost-effective option.

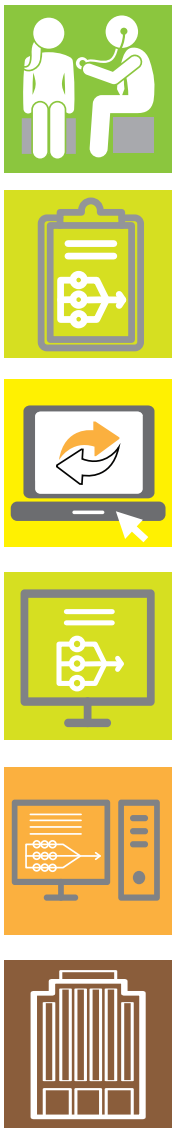
MCOs must send HCA encounter data, which details all services provided

Data about patient care and its costs underpins the processes that allow the state to manage Medicaid insurance premiums. As **Exhibit 3** illustrates, the process begins as health care providers submit millions of detailed claims to their affiliated MCO, reporting the services they provided. Each MCO in turn processes the claims, recording them in their systems as patient encounters. The MCO must send HCA encounter records, so the agency can track services received by enrollees. The encounter data helps HCA measure and monitor managed care plan quality, service use and each company's compliance with contract requirements. Encounter data is also one factor used in calculating the premiums paid to the five MCOs each month. HCA contracts with a private actuarial firm, Milliman, to develop these premium rates – the last step shown in the exhibit.

Almost all provider claims are transferred automatically from providers' computers to the MCOs' systems. MCOs submit encounter data to HCA through ProviderOne, Washington's system for managing Medicaid information. ProviderOne is programmed to automatically check encounter data for potential errors and either accept encounters or send rejected encounters back to the MCOs so they can resolve the concerns.

The contracts between HCA and the MCOs outline numerous provisions for ensuring they supply timely, complete and accurate encounter data. MCOs must submit this data to HCA no later than 30 days from the end of the month in which the MCO paid the claim. The MCOs typically submit encounter data weekly, if not daily.

Exhibit 3 – *Claims* become *encounters* as data moves from provider to actuarial firm



Source: Auditor prepared.

CMS assessments of national encounter data quality indicate Washington is comparable to other states

The 2021 data quality assessment conducted by CMS, available on the Data Quality Atlas website, suggests that Washington's encounter data quality is comparable to other states but could also be improved. CMS regularly reviews encounter data elements for each state using different measures and categorizes them as either a low, medium or high concern or as unusable data. We reviewed a selection of 31 measures most applicable to this audit and compared Washington's assessment to the other states and U.S. territories.

Examples of measures we reviewed include the percent of records with valid diagnosis codes, missing procedure codes and missing provider information. Based on our analysis, Washington was neither at the forefront nor significantly behind in terms of encounter data quality and in most measures performed similarly to the other states. However, most other states scored better than Washington on seven of the metrics assessed: these metrics dealt mostly with different types of provider information. This placement suggests that while Washington is on par with other states, there are opportunities to improve its encounter data quality.

Program integrity focuses on ensuring accurate payment for services received

Program integrity efforts focus on paying the right dollar amount to the right provider for the right reason. These efforts are intended to prevent fraud and other improper payments so that taxpayer dollars are available for delivering necessary care. By ensuring only correct payments are made to providers, strong program integrity efforts can also help reduce overall medical costs – and costs are an important factor in setting premium rates for the MCOs.

Program integrity involves coordinated activities among multiple organizations, including the MCOs, HCA, the Medicaid Fraud Control Division in the Washington State Office of the Attorney General, and federal partners. HCA oversees MCO program integrity activities, including setting definitions of required activities in the contract and penalties if an MCO does not comply. The Medicaid Fraud Control Division is responsible for criminal and civil investigations, and prosecuting healthcare provider fraud committed against the program. In addition, federal partners for program integrity efforts include both CMS and the U.S. Department of Health and Human Services Office of the Inspector General. CMS sets regulatory frameworks for the state Medicaid agencies, and the Office of the Inspector General shares tips on conducting audits and investigations. All parties are responsible for participating in collaborative discussions of their ongoing efforts.

Examples of **required activities** for MCO program integrity include:

- Screening providers against federal exclusion lists so that providers with histories of fraud do not provide Medicaid services
- Verifying that enrollees received services recorded as being delivered by network providers
- Having methods and criteria for identifying potential fraud, methods for investigation and procedures for referrals

Examples of **leading practices** for MCO program integrity include:

- Conducting risk assessments to prioritize areas and provider types for additional review
- Partnering with the state Medicaid agency to determine processes for collective application of data analytics and other tools that prevent fraud, waste and abuse of public resources
- Using predictive analytic tools to identify potentially fraudulent activity

As a part of program integrity efforts, the MCOs must submit monthly and annual program integrity reports to HCA. These reports include information on overpayment recoveries that are also considered in rate development.

Both encounter data and program integrity activities are integral to the state's rate-setting process

The state has engaged a private actuary, Milliman, to develop Medicaid premium rates; HCA supplies the actuary with both the encounter data and information about program integrity efforts provided by MCOs. The actuary uses the encounter data to calculate a cost per service that is included as one factor in the process to set future premiums. Other factors include enrollee demographic information and risk factors, MCOs' reported financial information, and trends such as the Consumer Price Index.

Although the actuary validates the reasonableness of the encounter data, HCA and the MCOs must ensure the actuary receives accurate information. The actuary takes several steps to validate the encounter data before using it in the rate-setting process. These steps include reviewing for missing data, looking at the information in aggregate for reasonableness, and comparing the encounter data to summary information provided separately by the MCOs. However, the actuary does not audit the encounter data, and the actuary's validation process cannot substitute for HCA and the MCOs providing accurate information.

If the actuary does not receive accurate information for rate setting, the premiums may also be inaccurate. For example, inaccurate encounter data with reported services that did not occur could artificially inflate the total cost of services and contribute to inflated premium rates. Ensuring that the underlying data is complete and accurate is an important program integrity focus.

This audit examined ways HCA and MCOs prevent fraud and ensure accurate encounter data

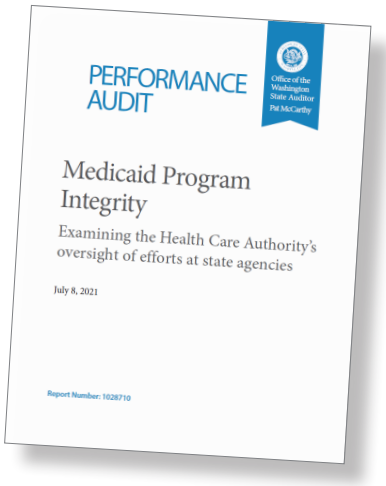
This is our second performance audit focusing on Medicaid program integrity, following the 2021 report (shown in the sidebar) that focused on HCA's Division of Program Integrity. At the time, HCA had just reorganized its program integrity function into a new Division of Program Integrity so we were unable to fully assess HCA's oversight of MCO program integrity efforts.

In this audit, we examined how HCA and selected MCOs ensure that sufficient program integrity efforts are in place and encounter data is complete and accurate. We focused on the three MCOs responsible for 77 percent of Medicaid enrollees (as of May 2023): Molina Healthcare of Washington, Community Health Plan of Washington and UnitedHealthcare of Washington.

The audit answered the following questions:

- Are there opportunities to improve MCO program integrity efforts and HCA's related oversight?
- How do HCA and the MCOs ensure accurate encounter data and MCO program integrity efforts are reported to the actuarial firm and reflected in future premiums paid to MCOs?

Note: While the rate-setting process is an essential element of the managed care model, we did not review this work. Instead, we focused on the controls in place to ensure the actuary receives complete and accurate information. See Appendix B for detailed information on the audit scope and methodology.



Read the report on our website: portal.sao.wa.gov/ReportSearch/Home/ViewReportFile?arn=1028710&isFinding=false&sp=false

Audit Results

MCOs took many key steps to prevent fraud and improve encounter data, but additional leading practices could strengthen these efforts

Results in brief

The three audited MCOs followed all required and most leading program integrity practices to identify potential fraud or other improper payments. MCOs met their contractual obligations for program integrity activities, such as identifying providers that should not participate in Medicaid due to past fraudulent behavior and verifying patients received billed services. All three MCOs used basic data analytics, such as identifying outliers that could indicate fraud or other improper payments, and two of the MCOs used advanced predictive analytics, which uses historical data to flag possibly fraudulent activity. However, program integrity efforts could be strengthened by applying additional data analytics that are recommended by leading practices.

MCO procedures also included key overpayment reporting requirements, but HCA did not verify the completeness of these reports. Overpayment recoveries are considered in the rate setting process, so incomplete or inaccurate information could affect the accuracy of premium rates.

The audited MCOs had many tools and processes in place to ensure complete and accurate encounter data. For example, MCOs followed all required and leading practices for receiving information from providers, such as collecting data from providers in standardized formats and providing feedback to providers on submission issues. All MCOs also monitored encounter data they submitted to HCA, and during the audit period one conducted its own internal audits that retrospectively compared provider claims to encounters. Finally, all audited MCOs used automated system checks to screen encounter data for complete and accurate information before they submitted it to HCA.

Note: HCA contracts with five MCOs. This audit examined only the three MCOs responsible for the most enrollees.

MCOs followed all required and most leading program integrity practices to identify potential fraud or other improper payments

The audited MCOs met their contractual obligations for program integrity activities

Program integrity refers to activities that ensure the right dollar amount is paid to the right provider for the right reason. HCA conducts program integrity activities concerning fee-for-service Medicaid provider payments, but MCOs are responsible for their own program integrity efforts. As the state Medicaid agency, HCA has incorporated program integrity requirements into its contracts with the MCOs, reflecting federal requirements as well as many leading practices.

The contractually required program integrity functions include:

- Identify providers who should not participate in Medicaid
- Use automated system checks to detect and prevent improper claims
- Have policies and procedures for fraud investigations
- Verify patients received billed services

As **Exhibit 4** shows, the three MCOs included in this audit met all these requirements. On the following page, we describe how they did so.

Exhibit 4 – All three MCOs met contractual obligations for program integrity activities

MCO is contractually required to:	Requirement met?		
	CHPW	Molina	UHC
Have a process to **identify providers** who should not participate in Medicaid, given known histories of fraud or abuse	✓	✓	✓
Use **automated system checks** to detect and prevent improper claims from being paid	✓	✓	✓
Establish policies and procedures for **fraud investigations**	✓	✓	✓
Regularly **verify** that patients received care billed by providers	✓	✓	✓

Source: Auditor analysis of federal regulations, contracts between HCA and MCOs, and MCO policies and procedures.

- **Identify excluded providers.** Some providers are barred from participating in Medicaid due to past fraudulent activity or other concerns. HCA required the MCOs to check lists of excluded providers maintained by the Centers for Medicare and Medicaid Services (CMS), the U.S. Department of Health and Human Services Office of Inspector General, the U.S. General Services Administration and others; the MCOs must then ensure they do not contract with any excluded providers. We found that all three MCOs had policies and procedures to regularly check key exclusion lists, and confirmed they were doing so.
- **Automated system checks.** These automated checks compare information across multiple data fields to identify improper submissions and prevent them from being paid without further staff review. (See the sidebar for a few examples of such checks.) HCA required MCOs to follow national standards for these comparisons. Additionally, leading practices recommend that the MCOs use claims systems that can detect different kinds of improper claims. All three MCOs had policies and procedures incorporating required comparisons. We confirmed that they also used many recommended types of comparisons and regularly reviewed the results to ensure they had been correctly implemented.
- **Fraud investigations.** Federal regulations and HCA's contracts require MCOs to have procedures for identifying and investigating potential fraud. These procedures must include methods and criteria for identifying suspected fraud, conducting investigations, and referring potential fraud to HCA. We found the audited MCOs had all established these procedures.
- **Verify services.** Federal regulations and HCA's contracts require MCOs to have processes for verifying whether providers actually delivered billed services, which helps identify suspicious activity and potential fraud. All three MCOs had documented guidance for performing these verifications, and we confirmed they performed required verifications. For example, Molina Healthcare of Washington (Molina) and UnitedHealthcare of Washington (UHC) initiate surveys to samples of enrollees monthly to ask if they received billed services; if enrollees say they did not, staff follow up with providers to determine if the service was billed in error or fraudulently.

Examples of comparisons made by automated system checks

- *Procedure type versus patient information* – Identifies procedures that are inconsistent with patient characteristics such as age or previous medical history
- *Procedure type versus provider information* – Identifies procedures that are inconsistent with the provider's specialty area or certification
- *Service frequency* – Identifies procedures billed more often than allowed or typical

Program integrity efforts could be strengthened by applying additional data analytics recommended by leading practices

Leading practices recommend that MCOs use data analytics to help detect and prevent fraud. (The sidebar provides a brief description of some data analytic tools.) These practices – recommended by the Association of Government Accountants and the federal Medicaid and CHIP Payment and Access Commission, among others – include:

- Descriptive analytics to identify outlier claims
- Predictive analytics to flag potentially fraudulent providers
- Network-based analytics to identify connections between potentially fraudulent providers

As **Exhibit 5** shows, although all three MCOs used the first practice, they did not all fully apply the other two.

Examples of data analytics

Data analytics includes a range of tools and technologies that find trends in data. Areas of data analytics include:

- *Descriptive,* which answers the question, "What happened?"
- *Predictive,* which answers the question, "What might happen in the future?"
- *Network-based,* which answers the question, "How are people connected?"

Exhibit 5 – MCOs conducted basic data analytics and some advanced analytics

Leading practices recommend MCOs use:	Practice in place at MCO?		
	CHPW	Molina	UHC
Descriptive analytics to identify outlier claims	✓	✓	✓
Predictive analytics to identify potentially fraudulent providers	✗	✓	✓
Network-based analytics to identify connections between known and potentially fraudulent providers	*Partial*	*Partial*	*Partial*

Source: Auditor analysis of leading practice literature and MCO procedures.

- **All three MCOs used descriptive analytics to identify outliers that could indicate fraud or other improper payments.** These analytics help identify suspicious behavior that deviates from the norm to detect potential fraud or other improper payments, and they detect a significant fraction of fraudulent cases. **Exhibit 6** lists some descriptive analytics techniques MCOs used to identify suspicious behavior. The MCOs also had processes to update their data analytics based on new information such as emerging fraud schemes.

Exhibit 6 – Descriptive analytics to detect outliers

Peer group comparisons – Identifying providers that are outliers compared to their peers, such as performing certain procedures significantly more often
"Impossible events" – Services that are logically inconsistent, such as a second appendectomy or services provided after a patient has died
Trends – Changes in provider activity over time, such as increases in the number of patients seen or services provided that are outside of expectations

Source: Auditor prepared.

- **Two MCOs used predictive analytics to identify potential fraud or improper payments based on historical data.** These analytics use models based on a wide range of historical fraud or improper payment information to predict the likelihood that a provider's current behavior is likewise inappropriate. One such tool is risk scoring, similar to a consumer credit score, which analyzes many risky activities and develops a score to represent an overall risk level. Managers at the Community Health Plan of Washington (CHPW) said that although the company has the capacity to perform this analysis, it has not yet done so for program integrity purposes.
- **All three MCOs made limited use of network-based analytics to identify possibly fraudulent providers based on their connections to known fraudulent providers.** These analytics use information from many sources to identify potentially fraudulent providers based on their associations with known fraudulent providers. The three MCOs used network-based analytics in limited situations, such as to investigate alleged or suspected fraud. However, none of them used these analytics to proactively identify potentially fraudulent providers by, for example, looking for unusual patterns of connections between multiple providers.

HCA does not currently require MCOs to apply these analytic tools

HCA does not require MCOs to conduct a full range of data analytics recommended by leading practices. HCA managers expressed concern that setting contractual requirements that are too specific could result in MCOs focusing only on specific requirements and not on the broad scope of program integrity activities.

However, while two MCOs contracted with vendors for robust data analytic tools, expectations that have not been made explicit in a contract are difficult to enforce. The *WA-State Contract Management Manual* states that clear and defined requirements are an important factor in contract performance. During the audit period, we found that in the absence of contractual requirements, one of the MCOs was not using all recommended categories of data analytics.

MCO procedures included requirements for reporting overpayment recoveries, but HCA did not verify the completeness of these reports

MCO procedures included key requirements for reporting and recovering overpayments they made to health care providers. Federal and state law, as well as HCA's contracts, require MCOs to recover overpayments and report on related activities. To ensure their employees meet these requirements, the MCOs should establish procedures that clearly explain what staff are expected to do. **Exhibit 7** sets out the contractual requirements and whether MCO guidance included procedures describing how to meet these requirements.

Exhibit 7 – MCO policies and procedures included key reporting requirements

Contractually required activity:	Did MCO's internal guidance include procedures for meeting the requirement?		
	CHPW	Molina	UHC
Recover overpayments and request refunds within required timeframes	✓	✓	✓
Report the following to HCA:			
• Overpayments	✓	✓	✓
• Recoveries	✓	✓	✓
• Fraud, waste and abuse	✓	✓	✓

Source: Auditor analysis of federal and state regulations, contracts between HCA and MCOs, and MCO policies and procedures.

All three MCOs had procedures for recovering overpayments, as well as for reporting overpayments and potential fraud to HCA. Their procedures explained how staff should fill out HCA's monthly reporting template, which asks for data on overpayments, recoveries and potential fraud.

HCA's processes did not ensure that staff could verify the completeness and accuracy of overpayment recoveries

Leading practices advise verifying important data, preferably against source materials. For example, the *WA-State Contract Management Manual* considers checking for data accuracy as an important step in verifying work was completed. The U.S. Government Accountability Office's (GAO) guidance around evaluating data reliability mentions corroborating evidence and determining whether data is consistent with original source documents.

While HCA managers have several processes in place to verify information received from the MCOs, these processes do not assess the completeness of the MCOs' overpayment recovery reports. HCA conducted encounter validation audits, as discussed on page 33, and other audits of MCO providers, all of which include requesting supporting documentation from the MCOs. However, HCA did not have a process to verify the completeness of the overpayment recovery reports, such as periodically requesting supporting documentation or reviewing how the MCOs produce their reports. Also, while HCA managers said they verified whether reported transactions were reflected in ProviderOne, they did not compare any of the transactions in the overpayment recovery reports with the information in the MCOs' systems. The managers said they did not think this would be necessary or viable.

We examined the overpayment recovery reports and found some inaccuracies in these reports, and it was challenging to verify completeness. For example, reports for CHPW and UHC contained inaccuracies such as mistyped data, duplications and recoveries that had not actually occurred. Furthermore, even though all three MCOs tried, they experienced challenges providing documentation to verify completeness of reports previously provided to HCA. This was because claims data is updated regularly, which means reports representing a single point in time will be different if they are re-run at a later date.

However, Molina was able to show us the method they used to produce an overpayment recovery report. If HCA required the MCOs to share this or other suitable supporting documentation, it would provide HCA greater assurance over reported information. For example, MCOs could periodically demonstrate how they obtained the reported information or submit a screenshot of aggregate overpayment recovery amounts in the MCOs' system. Either of these options would increase the likelihood that reported information is complete and accurate, which is important because the data in these reports is used in rate setting.

MCOs had many tools and processes in place to ensure complete and accurate encounter data

The audited MCOs followed all required and leading practices for receiving information from providers

When a patient visits a health care provider, the provider creates a claim to document the services performed and the associated costs. Under managed care, the provider sends the claim to the MCO that insures the patient.

Federal requirements and leading practices speak to the processes involved in submitting claims and addressing claim errors, summarized in **Exhibit 8**. We found all three MCOs followed all federally required and recommended leading practices.

Exhibit 8 – Requirements and leading practices for claims sent by providers to MCOs

Requirement or leading practice	Requirement or practice in place at MCO?		
	CHPW	Molina	UHC
Federally required practices for MCOs:			
Collect data from providers in **standardized formats**	✓	✓	✓
Leading practices encourage MCOs to:			
Incorporate requirements for **timely and high-quality** data submissions in provider contracts	✓	✓	✓
Track provider **submission errors** and identify patterns	✓	✓	✓
Provide **feedback** on issues to providers	✓	✓	✓

Source: Auditor analysis of federal regulations, leading practices, MCO procedures, and contracts between MCOs and providers.

- **MCOs collected data from providers in standardized formats.** MCOs' contract templates required providers and vendors to submit claims in standardized formats. This helps ensure MCOs consistently receive all required information from providers while reducing the risk of errors as information is transferred between systems.
- **MCOs included requirements for timely and high-quality data submissions in provider contracts.** After reviewing a sample of contracts, we found audited MCOs followed this leading practice. As a result, MCOs are more likely to receive complete and accurate information from providers.
- **MCOs tracked provider submission errors and identified patterns.** We found MCOs used various methods to address this practice. CHPW produced a report that included the most frequently used error codes and descriptions of what those codes mean. Molina and UHC used lists of denied claims with the reasons why the claims were denied and the most frequent denial reasons. Tracking issues and identifying patterns makes it easier to determine where errors occurred and helps staff decide how to resolve them.
- **MCOs gave providers feedback on problematic claim submissions and worked with them to address concerns.** We found all three MCOs offered feedback through provider education and technical assistance, such as an FAQ document and a bulletin that provided guidance on specific issues. All the MCOs said they held meetings with providers to discuss submission issues. In addition, UHC used an early warning system that flagged certain problems to identify providers who needed one-on-one support. Offering feedback and working with providers reduces the likelihood a problem will persist.

All three MCOs monitored encounter data they submitted to HCA, with one conducting its own internal audits during the audit period

The next step for MCOs after processing provider claims is to submit encounter data to HCA. We identified one contract requirement and other leading practices concerning how MCOs should monitor encounter data submissions:

- Reconcile accepted encounters to total claims paid for a particular quarter (required)
- Track and review errors in submitted encounters (recommended)
- Conduct retrospective internal audits of claims to encounters (recommended)

As **Exhibit 9** shows, all three MCOs met the required practice plus one of the leading practices, and CHPW performed all of them.

Exhibit 9 – Requirements and leading practices for ensuring MCOs send accurate encounter data

Requirement or leading practice	Requirement or practice in place at MCO?		
	CHPW	Molina	UHC
Contractually required practices for MCOs:			
Regularly **reconcile** their encounters to their general ledgers	✓	✓	✓
Leading practices encourage MCOs to:			
Monitor processes to submit encounter data, and **track and review errors**	✓	✓	✓
Conduct their own **internal audits** comparing claims to encounters	✓	✗	✗

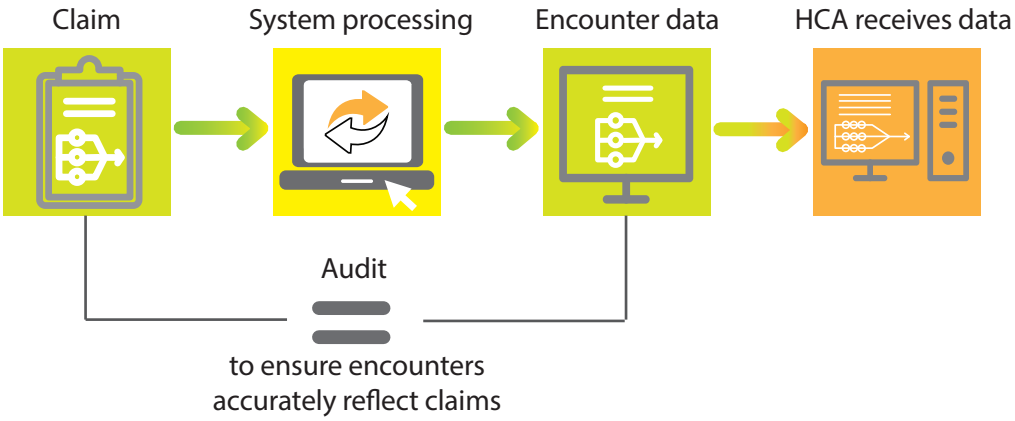
Source: Auditor analysis of leading practices, MCO procedures, and contracts between HCA and MCOs.

- **All three MCOs reconciled financial information for paid claims with records of accepted and rejected encounters.** This quarterly reconciliation uses two measurements for evaluation: 1) MCO paid claims information compared with MCO records of accepted encounters; and 2) encounter information in ProviderOne, Washington's system for managing Medicaid information, compared with MCO records of accepted encounters. HCA calls this the "Form D reconciliation," and it is required by contract that both comparisons be within one percent. This report addresses ways HCA can coordinate with the MCOs and potentially improve this step on pages 31-32. CHPW and UHC also conducted their own reconciliations at least monthly to help prepare for the required quarterly reconciliation.

- **All three MCOs monitored encounter data submission processes and tracked errors to identify potential improvements.** This included monitoring to help ensure the right information is submitted on time. They also reviewed rejected encounters and related errors so they could be updated and resubmitted. The MCOs also used the monitoring results to identify possible process improvements. For example, CHPW monitored encounter submission rejections and if patterns were identified, managers followed an operational excellence procedure to make improvements.
- **Only one MCO conducted internal audits during the audit period to ensure submitted encounters accurately reflected claims.** Retrospective audits that compare a sample of accepted and rejected encounters to their underlying claims are an effective way to ensure that any discrepancies are detected and corrected. These audits can identify errors by reviewing claims and encounters together, which other review methods – such as automated system checks – review separately. **Exhibit 10** illustrates this audit approach.

  Only CHPW conducted such audits, comparing a sample of accepted and rejected encounters to their underlying claims each quarter. Managers at Molina said the MCO plans to start conducting similar audits in late 2023, and developed a procedure for doing so before this audit report was published.

Exhibit 10 – Internal audit process comparing claims to encounters



Source: Auditor prepared.

Although these audits are an effective tool, HCA does not require MCOs to conduct them because managers said the agency expects the MCOs are already doing so. They also said HCA can sanction the MCOs if it finds problems such as claims not matching encounters, which motivates the MCOs to take steps on their own. Specifically, HCA conducts federally required encounter data validation audits, which also compare claims to encounters and are the basis for potential sanctions.

Nonetheless, codifying an expectation as a clear and defined requirement is an important factor in managing contract performance, as recommended in the *WA-State Contract Management Manual*. Furthermore, the federally required encounter data validation audits are only scheduled to occur every three years. The MCOs can complete internal audits on a more frequent basis, which would result in any potential discrepancies being identified sooner.

All three audited MCOs used automated system checks to screen encounter data for complete and accurate information before they submitted it to HCA

Federal law requires MCOs to review and confirm encounter data has been entered in a logically consistent way before sending it to the state Medicaid agency. All three MCOs used automated system checks to review claims to help ensure all necessary and only valid information was submitted as encounters to HCA. For example, MCO automated checks included checking for necessary information in valid formats and ensuring only appropriate providers and eligible enrollees and services were included. Depending on the automated check and type of issue identified, information was rejected, returned to the provider for correction, or manually reviewed.

We tested a selection of automated checks from each MCO and found they worked appropriately. Examples of checks we tested included those for different types of missing information, such as provider identifiers or amounts.

HCA has strengthened oversight of MCO efforts, but could improve performance measures, information verification and formal processes for penalties

Results in brief

Although HCA has strengthened oversight of MCO program integrity efforts, it could include related performance measures in its contracts. HCA has increased efforts related to managed care and incorporated program integrity requirements into its contracts. These requirements touch on issues ranging from the penalties for MCO contract noncompliance to documentation and communication. However, adding performance measures specific to MCOs' program integrity efforts to its contracts would offer additional assurance that MCOs meet expectations.

HCA had many practices in place to monitor MCO encounter data, but could improve information verification. We found contracts incorporated most required and leading practices around encounter data, but lacked performance targets for key encounter data fields, such as unacceptable rates of error for missing data, record rejections and duplicate records. HCA also validated encounter data in multiple ways, for example, through automated system checks recommended by CMS. In addition, HCA regularly compared encounter records to MCO reported information; however, managers did not request supporting documentation for reported paid claim amounts.

In general, HCA implemented many monitoring and communication practices to ensure accurate encounter data submissions. For example, HCA conducted audits of MCO encounter data and provided regular communication and technical assistance to MCOs on encounter data issues. Finally, HCA can impose financial penalties against MCOs that do not meet contractual obligations, but lacked documented policies for doing so, which could lead to penalties being applied inconsistently.

Although HCA has strengthened oversight of MCO program integrity efforts, it could include related performance measures in its contracts

During our 2021 audit, HCA's Division of Program Integrity had only recently taken on oversight of managed care program integrity. Since then, the Division of Program Integrity has developed its oversight activities to monitor MCO efforts in this area and implemented a recommendation from the 2021 audit to outline the state's fraud prevention strategies.

HCA has specified many program integrity requirements in its contracts with the MCOs. These requirements touch on issues ranging from the penalties for MCO contract noncompliance to documentation and communication. The requirements are also in line with leading practices from organizations such as CMS, GAO and the U.S. Department of Health and Human Services Office of Inspector General, among others. **Exhibit 11** summarizes several practices around program integrity efforts which HCA has included in its contracts with MCOs.

Exhibit 11 – Requirements and leading practices for program integrity efforts in MCO contracts

Requirement or leading practice	Present in HCA's contracts?
State required practices for all state agencies:	
To the extent practicable, include consequences (such as penalties) or incentives or both in their contracts to ensure contractors meet desired outcomes	✓
Leading practices encourage state Medicaid agencies to:	
Standardize fraud referrals across all MCOs	✓
Provide clear requirements for the information MCOs must report regarding providers that are terminated or otherwise leave the MCO network	✓
Require MCOs to maintain and periodically submit documentation that supports their program integrity activities	✓
Require MCOs to report corrective actions taken against providers suspected of fraud or abuse	✓
Meet regularly with MCOs to discuss program integrity efforts and the extent to which MCOs are meeting expectations	✓
Ensure the contract permits the agency to investigate and act against providers if MCOs do not address concerns	✓

Source: Auditor analysis of state regulations, leading practices, and contracts between HCA and MCOs.

HCA's contracts with the MCOs allow it to assess monetary penalties when the MCOs do not meet requirements. State law and leading practices both recommend doing so to ensure contractors deliver their expected value to the state. HCA has several contractual options to assess penalties for contract noncompliance. For example, if the Division of Program Integrity identifies overpayments to MCO-contracted providers that the MCOs did not find through their own program integrity efforts, it can assess liquidated damages equal to five times the overpayment. HCA can also impose sanctions on the MCOs for any nonperformance of contractually required program integrity activities.

Sanctions and liquidated damages

Sanctions are intended to be monetary penalties for noncompliance with the contract.

Liquidated damages are an estimate of loss and are intended as a remedy for noncompliance.

Contracts also included several provisions to ensure the MCOs consistently provide information to HCA. For example, HCA requires MCOs to use a standardized form to submit fraud referrals: this form includes instructions and examples to promote consistent, standardized reporting. MCOs must report a variety of information about their program integrity efforts, including information about any corrective actions the MCOs take against providers for fraud, waste and abuse. In addition, MCOs must meet regularly with the Division of Program Integrity to work on program integrity issues.

Finally, the Division of Program Integrity directly audits MCO-contracted providers. One such audit in 2022 found that MCO-contracted providers had billed Medicaid more than $900,000 over 13 months for substance use disorder treatments that should have been billed to Medicare. Again, if the Division of Program Integrity audits identify issues that the MCOs missed, HCA can impose monetary penalties on the MCOs.

Adding program integrity performance measures to MCO contracts would offer additional assurance that MCOs meet expectations

Since 2013, state law (RCW 39.26.180) has required agencies to include performance measures and benchmarks in their contracts. While HCA has other performance measures in its contracts with the MCOs, as of July 1, 2023, the model contract had not incorporated performance measures, benchmarks or objectives specific to the MCOs' program integrity efforts, even though it is integral to responsible administration.

When asked about the absence of contractual performance measures for MCOs' program integrity efforts, HCA managers said they were developing performance measures that would align with federal requirements that would become effective June 2023 (shown in **Exhibit 12**). While they also said HCA can fulfill these federal reporting requirements using existing reports, adding some or all of these performance measures to HCA's contracts, together with associated benchmarks or targets, would strengthen HCA's authority should issues arise with MCO program integrity efforts. Furthermore, performance measures provide an objective means to determine if contractor performance meets expectations and when damages should be assessed for poor performance.

Exhibit 12 – Selected measures related to MCOs' program integrity efforts that HCA must report to CMS

- Ratio of opened program integrity investigations to enrollees
- Ratio of resolved program integrity investigations to enrollees
- Number of fraud referrals forwarded to the Medicaid Fraud Control Division
- Ratio of program integrity referrals to enrollees

Source: CMS.

HCA had many practices in place to monitor MCO encounter data, but could improve information verification and procedures for potential penalties

Multiple teams within HCA are responsible for ensuring complete and accurate encounter data. HCA's Medicaid Programs Division ensures that MCOs meet their contractual obligations and handles any potential penalties for noncompliance. The ProviderOne Operations team manages ProviderOne, monitors for complete and accurate encounter data, and provides technical assistance with encounter data submissions. The Division of Program Integrity completes federally required encounter data audits and works with other teams if it identifies issues.

Contracts incorporated most required and leading practices around encounter data, but lacked performance targets for key fields

As **Exhibit 13** (on the following page) shows, HCA's contracts with the MCOs incorporated all federal requirements and most leading practices for ensuring complete and accurate encounter data.

Exhibit 13 – Required and leading contract provisions for encounter data

Requirement or leading practice	Present in HCA's contracts?
Federally required practices for state Medicaid agencies:	
Require MCOs to certify that data submissions are complete and accurate	✓
Require MCOs to submit information about servicing providers in encounter data	✓
Specify the level of detail MCOs will provide in encounter data	✓
Specify timing requirements for encounter data submissions	✓
Require MCOs to validate claim and encounter data	✓
Require MCOs to collect encounter data in nationally recognized, standard file formats	✓
Leading practices encourage state Medicaid agencies to:	
Include provisions to guide MCOs interactions with their providers	✓
Require the use of specific companion guides, data dictionaries and other ancillary guidance documents	✓
Set clear expectations for correcting errors in encounter data fields	✓
Require MCOs to participate in regular meetings about encounter data issues	✓
Include detailed information about financial penalties in their contracts, including amounts and the conditions under which the state will apply them	*Partial*
Connect incentives to key state standards, data fields or focus areas (for example, reducing the amount of missing data) that support the intended uses of the data	*Partial*
Describe their expectations regarding encounter data quality. This can include establishing (un)acceptable error rates for key encounter data fields.	✘

Source: Auditor analysis of federal regulations, leading practices, and contracts between HCA and MCOs.

Our review showed that many recommended contract provisions were in place, including provisions for how MCOs should interact with their providers, such as requiring complete and accurate encounter data. Also, the contract requires the MCOs to use a guidance document that defines many encounter data expectations. For example, the guidance sets out timelines for reporting encounters monthly, expectations around the level of detail for encounter records, and instances when encounter records must be voided or replaced.

The contract also outlines several financial penalties. The most clearly defined sanction allowed HCA to assess a $25,000 penalty if an MCO's data did not reconcile within 1 percent on the quarterly Form D reconciliation. However, other penalties mentioned in MCO contracts were more general and did not include

details such as specific triggers or penalty amounts. These issues are discussed in more detail on pages 34-35; penalties are listed in Exhibit 16 on page 34.

While the contracts establish expectations for submitting encounter data, they have not established performance measures including metrics such as unacceptable rates of error for missing data, record rejections and duplicate records. For example, CMS cited one state whose MCO contracts specify that rejected encounters should not exceed two percent of submitted encounters. This state also enforces the expectation through a clearly defined penalty. HCA does set expectations about encounter data quality, such as requiring MCOs to submit the data exactly as it is received from the provider, through automated system checks during submission (see page 31), and through the quarterly Form D Reconciliation (discussed further on pages 31-32). However, HCA has not set requirements defining unacceptable rates of error for specific data elements and fields. By having targeted error rates that MCOs must meet, initial submissions could be more accurate, leading to fewer adjustments and resubmissions. When asked about the lack of such targets, HCA managers said they did not think performance targets were beneficial for a state like Washington because it has other system processes in place that help ensure that encounter data is complete and accurate.

Although HCA validated encounter data in multiple ways, verifying reported information would provide more assurance over the data

Federal law requires state Medicaid agencies to take steps to ensure that encounter data is complete and accurate. As **Exhibit 14** shows, HCA fully applied all but one of the audited practices for validating MCO encounter data.

CMS recommends that state Medicaid agencies use multiple types of data validation to ensure all necessary information is submitted correctly and reflects eligible providers, enrollees and services. Any approach the agency develops should combine both automated system checks and comparisons to external data sources.

Exhibit 14 – Required and leading practices for data validation

Requirement or leading practice	Practice in place?
Federally required practices for state Medicaid agencies:	
Establish procedures to ensure that enrollee encounter data is a complete and accurate representation of services provided	✓
Provide clear feedback to MCOs about the timeliness, accuracy, completeness and consistency of encounter data submissions	✓
Leading practices encourage state Medicaid agencies to:	
Monitor whether MCOs submit encounter data files on time	✓
Use multiple validation techniques to ensure the accuracy, completeness, timeliness and consistency of encounter data, including:	
• Automated system checks	✓
• Comparing encounter data to external information	*Partial*

Source: Auditor analysis of federal regulations, leading practices, and HCA procedures.

Just as MCOs use automated system checks to review submitted information for specific conditions before it is accepted (described on page 24), HCA also uses these checks to help ensure MCO encounter submissions comply with federal and state requirements. For example, the automated checks in HCA's ProviderOne system confirm that MCOs submitted encounters within required timeframes and only for eligible providers, enrollees and services. These checks reflected all CMS-recommended validation types. As part of this audit and previous financial audits conducted by our Office, we reviewed a selection of these automated checks and confirmed they worked appropriately. (See **Appendix C** for more information about automated validation methods recommended by CMS.)

HCA also provided feedback to MCOs regarding their encounter submissions. The ProviderOne system generated automated responses, using recommended formats, to inform MCOs whether data was accepted or rejected. The responses include information on errors identified by the check, such as whether an MCO submitted a duplicate encounter or did not submit it on time.

Although HCA regularly compared encounter records to MCO reported information, managers did not request supporting documentation for reported amounts

CMS recommends that state Medicaid agencies regularly compare encounter data to external records such as provider records and MCO financial information maintained in their general ledger of transactions. HCA requires MCOs to compare accepted encounter data to financial information for paid claims as part of the Form D reconciliation process. HCA then reviews the reconciliation and also compares the information with its own record of encounters. Once finalized, the reconciliation must be within 1 percent for both comparisons – if it is not, HCA can assess financial penalties (see Exhibit 16 on page 34 for more information).

We confirmed the Form D reconciliation process took place regularly throughout the audit period. However, when we asked the MCOs to show in their general ledgers the amounts reported to HCA, they were unable to do so. Instead, due to fluctuations in claims data over time, they could only show us the steps they had taken to arrive at the reported amounts. We also confirmed that while HCA requests the overall number of encounters as part of the Form D process, it does not reconcile this information to any external data source.

We identified two ways HCA could improve the Form D reconciliation:

- **Request supporting documentation for MCO general ledger amounts.** HCA did not require MCOs to submit supporting documentation because managers did not consider it was within their role to do so. If MCOs provided such documentation at the time of the quarterly reconciliation, HCA would have greater assurance over the general ledger amounts.

- **Reconcile the overall volume of encounters.** Many encounters do not have an associated dollar value because they are paid using alternative payment arrangements (see panel below for an example). One recommended practice to help ensure complete encounter data is to compare current encounter submissions with previous trends in encounter data. While HCA managers requested encounter counts, they did not have a formal process to reconcile these encounters. They said this was because the risk of missing encounters was addressed by other processes, such as MCOs wanting to qualify for financial incentives. While these processes may motivate MCOs to submit all encounters, without verification any potential gap is still unknown.

An example of alternative payment arrangements

An *alternative payment method* is a payment approach that gives health care providers added incentive payments to provide high-quality and cost-efficient care. For example, rather than pay the provider for each individual service, MCOs might pay providers a specific amount each month for each patient. In return, the providers deliver whatever quantity or types of services are necessary to meet patient health needs. With these arrangements, providers and MCOs continue to submit encounters for the services rendered, but these encounters do not include dollar amounts.

Another method of comparing encounter data to external records takes place during HCA's audits comparing encounters to the underlying claims. This is discussed on page 33.

HCA implemented many monitoring and communication practices to ensure accurate encounter data submissions

HCA must monitor the encounter data it receives from the MCOs to ensure that the data is complete and accurate. Federal requirements and leading practices outline several activities HCA should use to monitor MCO encounter data and effectively communicate with the MCOs. **Exhibit 15** on the following page summarizes these practices and shows HCA's implementation.

Exhibit 15 – Required and leading practices for monitoring and communicating with MCOs

Requirement or leading practice	Practice in place?
Federally required practices for state Medicaid agencies:	
Conduct encounter data audits at least once every three years	✓
Leading practices encourage state Medicaid agencies to:	
Establish processes so that other teams (such as program integrity) can share concerns they observe with those responsible for monitoring the accuracy of encounter data	✓
Establish mechanisms for regular, clear communication with MCOs regarding state expectations for encounter data and any changes in expectations or processes for data collection	✓
Have clearly identified points of contact responsible for encounter data quality who can work with their counterparts at MCOs	✓
Provide technical assistance to MCOs on encounter data topics such as state requirements, submission processes and interpreting state feedback	✓

Source: Auditor analysis of federal regulations, leading practices and HCA procedures.

HCA conducted required audits of MCO encounter data. These audits are required by federal regulation at least once every three years and are a key method for ensuring encounter data accurately reflects provided services. To conduct the audits, HCA compared a sample of submitted encounters to the original claims and other supporting documentation to ensure the encounters were accurate. For example, one of these audits found 75 instances in which provider identification and similar codes in the encounter did not match the original claim. HCA published its first audits in 2021 and is working on its next series.

HCA has established processes so that other teams within the agency can share concerns about encounter data. For example, the team that manages encounter data issues scheduled monthly meetings with the Division of Program Integrity to discuss any concerns. That team also set up a help desk system so other HCA staff could submit questions and concerns about encounter data.

The agency has also implemented CMS recommended practices by providing regular communication and technical assistance to the MCOs on encounter data issues. For example, HCA has assigned dedicated contacts MCOs can consult with on data issues. These staff scheduled regular meetings with MCOs in which they shared updates and discussed problems. In addition, HCA developed a guide for MCOs on how to submit encounter data. Finally, HCA set up an external help

desk system the MCOs can use to submit encounter data questions. Although some MCOs noted they would appreciate even more engagement from HCA, to learn about changes sooner and identify concerns before corrective action is taken, they said they appreciated the assistance HCA provided.

HCA can impose financial penalties against MCOs that do not meet encounter data obligations, but lacked documented policies for doing so

HCA incorporated penalties concerning MCOs' encounter data reporting into its contracts. Indeed, leading practices from CMS and other sources recommend that HCA use contractual financial incentives to encourage MCOs to improve their data accuracy, including clear details about dollar amounts and the conditions that will trigger them.

HCA had several options at its disposal to penalize MCOs for contract noncompliance related to encounter data accuracy. These contractual penalties are listed in **Exhibit 16**.

Exhibit 16 – Monetary penalties available to HCA to address issues with encounter data

HCA can use the following monetary penalties to address issues with MCOs' encounter data:

- $25,000 penalty if an MCO does not reconcile within 1% on the quarterly Form D process
- Liquidated damages if an MCO fails to report or inaccurately reports encounter data
- Monetary sanctions if an MCO fails to meet one or more obligations under the contract, including submitting reports, documents, data or any other information that is inaccurate, incomplete, untruthful or untimely
- As of January 2023, monetary sanctions or liquidated damages if an MCO submits inadequate encounter data that results in harm to the rate setting process
- Proposed for July 2023, liquidated damages for any default on a material obligation in the contract

Source: HCA contracts with MCOs, and interviews with HCA management.

The most clearly defined sanction allowed HCA to assess a $25,000 penalty if an MCO's data did not reconcile within 1 percent on the quarterly Form D reconciliation. However, this penalty lacked documented timelines to address noncompliance. The process to resolve reconciliation issues could stretch out over multiple quarters, until HCA determined an MCO could not meet the 1 percent target. Other penalties mentioned in MCO contracts were more general and did not include details such as specific triggers or penalty amounts.

In addition, HCA lacked written policies to guide staff or management decisions about when and how to impose a penalty. When asked about the absence of written guidance, HCA managers said they did not document their process to impose penalties because it could limit their flexibility when responding to MCO noncompliance. However, without policies and procedures, HCA's expectations for both the MCOs and its own staff are unclear, and HCA could apply penalties inconsistently.

State Auditor's Conclusions

More than one out of four Washingtonians relies on Medicaid for health care coverage, making it one of our largest and most important public services. We audit Medicaid in multiple ways, providing multifaceted reviews of the program's finances and operations.

This performance audit found the state Health Care Authority and contracted managed care organizations are taking key steps to prevent fraud and to ensure they are using accurate data about patient care and its costs. This report also offers a robust set of recommendations for improving their processes, especially in terms of providing accurate information used to establish the premiums paid by the state.

Each improvement in a large, complex system can yield substantial rewards, and in the case of Washington's managed care model we see the potential for significant gains. Managed care provides services to about 85 percent of the 2.3 million Medicaid enrollees in our state. In the past fiscal year, each of the state's five contracted managed care organizations received at least $1 billion in premiums – and one received several times that amount.

By putting in place our detailed recommendations to improve program integrity, the Health Care Authority can do even more to prevent fraud, reduce overall costs, and ensure Medicaid funding is available to deliver care to millions of Washingtonians.

Recommendations

For the Health Care Authority

To address the need for better guidance regarding how MCOs ensure their encounter data is complete and accurate, as described on pages 23-24, we recommend:

1. Provide written expectations in the MCO contracts for conducting retrospective internal audits that compare approved and rejected encounters to their underlying claims.

To address the need for stronger contractual provisions to ensure MCOs meet program integrity expectations, as described on page 27, we recommend:

2. Incorporate performance measures and objectives for MCO program integrity efforts, such as the new Centers for Medicare and Medicaid Services (CMS) performance measures, into the MCO contracts.

To address the opportunity for clearer contractual expectations related to MCO program integrity efforts, as described on page 18, we recommend:

3. Set a minimum standard for conducting program integrity data analytics in the MCO contracts.

To address the lack of verification of MCO reported overpayments, as described on pages 19-20, we recommend:

4. Develop a process to verify the completeness and accuracy of MCOs' reported information.

To address the lack of targeted error rates for key fields in encounter data submissions and to encourage MCOs to submit accurate and complete encounter data with initial submissions, as described on page 30, we recommend:

5. Establish unacceptable error rates for key fields involved in encounter data submissions and then monitor and report on MCO submissions compared to the established targets. This would be in addition to the existing Form D reconciliation requirements.

To address issues with the quarterly reconciliation, as described on pages 31-32, we recommend:

6. Develop a process to verify MCOs' reported general ledger amounts at the time of the reconciliation.

7. Include a reconciliation of counts of encounters, in addition to amounts, to ensure that all encounters are submitted and received.

To address the lack of documented policy for applying financial penalties, as described on pages 34-35, we recommend:

8. Formalize the process for applying financial penalties in a policy or procedure.

We also communicated several other potential improvements related to internal controls with HCA management and those charged with governance in a letter dated August 25, 2023. Those improvements were not significant enough to include in this report, but could still result in some minor improvements to HCA's oversight of encounter data processes and program integrity efforts at the MCOs.

Agency Response

STATE OF WASHINGTON

October 17, 2023

Honorable Pat McCarthy
Washington State Auditor
P.O. Box 40021
Olympia, WA 98504-0021

Dear Auditor McCarthy:

Thank you for the opportunity to review and respond to the State Auditor's Office performance audit report, *"Medicaid and Managed Care Organizations: Ensuring strong program integrity efforts and accurate encounter data."* The Health Care Authority (HCA) and the Office of Financial Management worked together to provide this response.

Under federal regulations, HCA, as the single state Medicaid agency (SMA), is required to contractually ensure managed care organizations (MCOs) submit accurate and complete enrollee encounter data that complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In addition, federal regulations require the SMA to review, validate, and audit the encounter data submitted by MCOs.

Many of the SAO performance audit recommendations were pulled from a host of reports gathered from work other states have done to complete their validation process. Medicaid programs are not the same from state to state, and as such, the tools from those reports may not be applicable to every program and are not required by the Centers for Medicare and Medicaid Services to validate and ensure accurate encounter data is received.

HCA complied with all federal requirements reviewed during the audit to ensure accurate encounter data is received. HCA has implemented tools within its Medicaid Management Information System to utilize HIPAA standards and protocols for proper submission of files containing the encounter data. HCA requires MCOs to validate data quarterly and be within a one percent threshold of accuracy. HCA considers encounter data validated through this quarterly process to be accepted and accounted for. In addition, HCA has conducted, and currently is conducting, an audit on submitted encounter data in compliance with federal regulations.

HCA believes the actions it has taken promote the highest degree of accuracy in the encounter data. However, HCA embraces all opportunities to improve and will review the SAO recommendations to determine if there are benefits to incorporating them. As some of the recommendations may require additional staff or other system updates or purchases, the agency will review and determine if the return on investment warrants a request for future funds to incorporate the recommendations.

Sincerely,

Sue Birch, MBA, MSN, RN
Director
Health Care Authority

David Schumacher
Director
Office of Financial Management

cc: Jamila Thomas, Chief of Staff, Office of the Governor
Kelly Wicker, Deputy Chief of Staff, Office of the Governor
Rob Duff, Executive Director of Policy and Outreach, Office of the Governor
Emily Beck, Deputy Director, Office of Financial Management
Mandeep Kaundal, Director, Results Washington, Office of the Governor
Tammy Firkins, Performance Audit Liaison, Results Washington, Office of the Governor
Scott Frank, Director of Performance Audit, Office of the Washington State Auditor

OFFICIAL RESPONSE TO THE PERFORMANCE AUDIT ON MEDICAID AND MANAGED CARE ORGANIZATIONS: ENSURING STRONG PROGRAM INTEGRITY EFFORTS AND ACCURATE ENCOUNTER DATA

OCTOBER 17, 2023

The Health Care Authority (HCA) and the Office of Financial Management (OFM) provide this management response to the State Auditor's Office (SAO) performance audit report received on September 19, 2023.

SAO PERFORMANCE AUDIT OBJECTIVES

The SAO's performance audit addressed two questions:

- Are there opportunities to improve MCO program integrity efforts and HCA's related oversight?
- How do HCA and the MCOs ensure accurate encounter data and MCO program integrity efforts are reported to the actuarial firm and reflected in future premiums paid to MCOs?

Recommendations to HCA in brief:

SAO Recommendation 1: To address the need for better guidance regarding how MCOs ensure their encounter data is complete and accurate:

1. Provide written expectations in the MCO contracts for conducting retrospective internal audits that compare approved and rejected encounters to their underlying claims.

STATE RESPONSE: HCA concurs with the recommendation.

Action Steps and Time Frame

- HCA will determine an appropriate frequency for MCOs to conduct retrospective internal audits. *By February 1, 2024.*
- HCA will add contract language that directs MCOs to conduct retrospective internal audits that compare approved and rejected encounters to their underlying claims. *By July 1, 2024.*

SAO Recommendation 2: To address the need for stronger contractual provisions to ensure MCOs meet program integrity expectations:

2. Incorporate performance measures and objectives for MCO program integrity efforts, such as the new Centers for Medicare and Medicaid Services (CMS) performance measures, into the MCO contracts.

STATE RESPONSE: HCA concurs with the recommendation and is one of only two states that have applied performance measures that implement a minimum standard for MCO improper payment recoveries.

Action Steps and Time Frame

- Section 12.10.5 was added to the MCO contract, effective July 1, 2023, that implements minimum standards for improper payment recoveries. *Completed July 1, 2023.*

SAO Recommendation 3: To address the opportunity for clearer contractual expectations related to MCO program integrity efforts:

3. Set a minimum standard for conducting program integrity data analytics in the MCO contracts.

STATE RESPONSE: HCA agrees that program integrity data analytics are important and partially concurs with the recommendation. HCA's requirements for the conduct of program integrity activities, including the use of data analytics, are included in Section 12 of the contract. The required activities and deliverables support HCA's expected outcomes for MCO program integrity efforts.

Action Steps and Time Frame

- HCA will re-evaluate the contract language to determine if changes to the current contract are needed. *By June 1, 2024.*

SAO Recommendation 4: To address the lack of verification of MCO reported overpayments:

4. Develop a process to verify the completeness and accuracy of MCOs' reported information.

STATE RESPONSE: HCA agrees that MCOs should report accurate and complete information and partially concurs with the recommendation. HCA currently validates the completeness and accuracy of the MCOs' reported information through the audit and validation of encounter data. HCA meets with MCOs monthly to discuss aberrancies and current schemes, and to provide technical assistance when necessary.

HCA has documented processes for the audit, review, and validation of data submitted on MCO deliverables. Procedures 420.011 and 420.011a, dated June 15, 2021, provide detail and a visual workflow of the deliverable review and audit processes.

Action Steps and Time Frame

- HCA will review and update existing process documents to ensure an adequate verification process remains in place. *By September 30, 2024.*

SAO Recommendation 5: To address the lack of targeted error rates for key fields in encounter data submissions and to encourage MCOs to submit accurate and complete encounter data with initial submissions:

5. Establish unacceptable error rates for key fields involved in encounter data submissions and then monitor and report on MCO submissions compared to the established targets. This would be in addition to the existing Form D reconciliation requirements.

STATE RESPONSE: HCA agrees that validating encounter data in multiple ways is an important step in the validation process and partially concurs with the recommendation.

Action Steps and Time Frame

- HCA will review and analyze this recommendation to determine if adding this additional process to the multiple ways it currently validates data will result in associated costs in terms of system and/or software updates or purchases, and the need to add additional FTEs to support the recommendation. *By September 30, 2024.*

SAO Recommendations 6-7: To address issues with the quarterly reconciliation:

6. Develop a process to verify MCOs' reported general ledger amounts at the time of the reconciliation.
7. Include a reconciliation of counts of encounters, in addition to amounts, to ensure that all encounters are submitted and received.

STATE RESPONSE: HCA agrees that even greater assurance over the reconciliation processes is optimal and partially concurs with the recommendation.

Action Steps and Time Frame

- Related to verifying general ledger amounts at the time of reconciliation, HCA will determine if the current system, software, and staff are able to support this recommendation or if additional staff with accounting knowledge and/or an upgrade or purchase of a new system and software would be required. *By October 31, 2024.*
- Related to the reconciliation of encounter counts, HCA will determine if the data lag would cause undue hardship on both the MCO and HCA to reconcile counts. Due to the nature of the data, HCA will need to assess whether there is a cost associated to help automate this process through current systems. *By October 31, 2024.*

SAO Recommendation 8: To address the lack of documented policy for applying financial penalties:

8. Formalize the process for applying financial penalties in a policy or procedure.

STATE RESPONSE: HCA concurs with the recommendation.

Action Steps and Time Frame

- HCA currently has a workgroup established to develop written guidance to address financial penalties for MCOs that do not meet contractual obligations. *By July 1, 2025.*

MOLINA HEALTHCARE

MolinaHealthcare.com

October 17, 2023

Lori Reimann Garretson, MPA
Senior Performance Auditor,
Office of the Washington State Auditor

Molina Healthcare, Inc. appreciates the opportunity to provide a formal response to the SAO Performance Audit of Medicaid and Managed Care Organizations. We have appreciated the deliberative work the SAO has done and their willingness to hear and incorporate our feedback in the technical portions of the audit. We do have a few concerns with the recommendations contained in the report that we would like to share:

All new program integrity requirements should only be implemented after a careful assessment of the return on investment. The audit confirms that the state has a robust program integrity program currently. Any new efforts should be weighed in light of how much the new program integrity measures will cost versus the amount of money they are likely to save the program and the state, or the efficiency and/or incremental validation impact the effort produces. They should also consider whether new requirements will provide more accurate results. We believe that several of these recommendations are additional options to what is currently being provided today in oversight of payment integrity and encounter data accuracy, and additional options would not necessarily result in material incremental performance results.

Link Analysis (AI) reporting may still be considered an emerging technology and not yet fully vetted as the most cost-effective method within payment integrity. Molina has not yet seen qualitative evidence that artificial Intelligence (AI) link analysis, currently emerging in its development phase in the industry and under limited vendor offerings, will drive sufficient incremental FWA leads above Molina's extensive predictive fraud analytics and algorithms in place today. Additionally, the new technology is critically expensive to justify the added value and ROI at this time and should not be a required component of our program integrity program.

Sincerely,

Grace Campbell, AVP Compliance
Compliance
Molina Healthcare, Inc.
Grace.Campbell@molinahealthcare.com

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MOLINA HEALTHCARE

October 17, 2023

Lori Reimann Garretson, MPA
Senior performance Auditor
Office of the Washington State Auditor
P.O. Box 40031
Olympia, WA 98504

RE: UnitedHealthcare Community Plan of Washington's append statement to the Office of the Washington State Auditor's Report of the 2022 Performance Audit of the Washington State Health Care Authority's Medicaid Managed Care Program.

Dear Ms. Garretson:

UnitedHealthcare Community Plan of Washington ("UnitedHealthcare" or the "Plan") appreciates the opportunity to respond to the final report of the 2022 Office of the Washington State Auditor's Performance Audit of the Washington State Health Care Authority's ("HCA's") Medicaid Managed Care Program, provided on September 19, 2023.

The revised scope and objectives of this audit included:

1. Are there opportunities to improve MCO program integrity efforts and HCA's related oversight?
2. How do HCA and the MCOs ensure accurate encounter data and MCO program integrity efforts are reported to the actuaries and reflected in premiums paid to MCOs?

UnitedHealthcare has reviewed findings and recommendations contained in the audit report and request the following feedback be appended to the Final Audit Report to be presented to the Joint Legislative Audit Review Committee on November 29, 2023

Recommendation 1: Provide written expectations in the MCO contracts for conducting retrospective internal audits that compare approved and rejected encounters to their underlying claims

> **UnitedHealthcare's Response:** UnitedHealthcare agrees with this recommendation. UnitedHealthcare began exploring opportunities to conduct retrospective internal audits to compare approved and rejected encounters to their underlying claims prior to identification of this recommendation. We anticipate rolling out these audits during calendar year 2024.

Recommendation 2: Incorporate performance measures and objectives for MCO program integrity efforts, such as the new Centers for Medicare and Medicaid Services (CMS) performance measures, into the MCO contracts.

> **UnitedHealthcare's Response:** UnitedHealthcare believes the HCA has already taken steps to address this recommendation. Section 12.5.10 of Amendment #16 to the Integrated Managed Care (IMC) Contract between the HCA and Managed Care Organizations (MCOs) has already added the requirement "to 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". MCOs will be required to begin reporting this information for the reporting period beginning 1/1/2024 through 12/31/2024, and annually thereafter.

In numerous states, UHC has seen CMS discuss ratios, similar to those included on Page 27 of the report; however, have not yet seen them implemented. UnitedHealthcare believes implementation of fraud referral performance ratios, based on the number of enrollees, may lead to premature referral submissions to the HCA and/or the Washington Medicaid Fraud Control Division (MFCD).

Recommendation 3: Set a minimum standard for conducting program integrity data analytics in the MCO contracts.

UnitedHealthcare's Response: UnitedHealthcare is already taking alternative steps to address this recommendation. During the September 13, 2022 interview with the SAO, UnitedHealthcare reviewed the document titled "Combined WA Payment Integrity FWAE_FINAL" with the auditors. This presentation included a slide reflecting provider, member, and claim centric methods utilized for detecting fraud, waste, abuse, and error (FWAE). The methods reviewed included:

- Provider-centric methods that filter out known providers with a history of fraud, abuse, or waste
- Provider-centric methods using peer-to-peer comparisons of historical data to detect unfamiliar claims patters
- Member-centric methods based on claims for a member to ensure the services, diagnosis, and clinical specialties make sense
- Claim-centric methods that filter out known patterns associated with overpaid claims
- Claim-centric methods that score individual claims that reflect complex and suspicious claim patters associated with overpayment behavior.

Recommendation 4: Develop a process to verify the completeness and accuracy of MCO's reported information.

UnitedHealthcare's Response: We will continue to monitor the data for completeness and accuracy.

Recommendation 5: Establish unacceptable error rates for key fields involved in encounter data submissions and then monitor and report on MCO submission compared to the established targets. This would be in addition to the existing Form D reconciliation requirements.

UnitedHealthcare's Response: UnitedHealthcare believes the HCA has already taken steps to address this recommendation. Section 5.15.7.3 the IMC Contract, Amendment 16 version, currently contains a quarterly non-performance penalty of $25,000, if MCOs fail to demonstrate submitted and accepted encounters reconcile to the general ledger amounts within 1 %.

UnitedHealthcare continuously monitors all encounter fields to identify errors and opportunities for improvement. Our error rate is consistently below the 1% contractually required error threshold. We believe applying non-performance penalties to targeted encounter fields, will result in utilization of additional HCA and MCO resources, with little opportunity for improvement, due to the existing threshold already in place.

Recommendation 6: Develop a process to verify MCO's reported general ledger amounts at the time of the reconciliation.

UnitedHealthcare's Response: UnitedHealthcare believes the HCA has already taken steps to address this recommendation. As contained in the response provided for Recommendation 5 above, The IMC contract, Amendment 16 version, currently requires the general ledger to reconcile to accepted and rejected encounters within 1%. The general ledger is a living document and amounts reflected at the time of reconciliation can only represent a snapshot in time due circumstances such as, but not limited to:

- Delay in provider claim submission
- Processing of a corrected claim
- Overpayment recovery
- Coordination of benefits and subrogation recoveries
- Retroactive enrollee eligibility changes.
- Release of payment suspension holds

UnitedHealthcare's internal benchmark is 99% accuracy for accepted and rejected encounters reconciling to the general ledger. This reconciliation is included in the existing Form D reconciliation process required under Section 5.15.7.1 of the IMC Contract.

The HCA also currently validates the encounter data submitted and accepted on the MCO Form D reconciliation in within 1% of what is reflected in the ProviderOne system.

Recommendation 7: Include a reconciliation of counts of encounters, in addition to amounts, to ensure that all encounters are submitted and received.

UnitedHealthcare's Response: UnitedHealthcare believes the HCA has already taken steps to address this recommendation. This process is currently included in UnitedHealthcare's encounter Form D reconciliation process. In addition to fee-for-service claims, UnitedHealthcare also engages in capitated provider payment arrangements, in which providers are paid a per member, per month (PMPM) amount to provide care to their patients. Services provided by these providers are reported as "zero dollar" encounters; and are captured on the "Capitation Payment" tab of the Form D Reconciliation Form submitted to the HCA on a quarterly basis. Additionally, the total PMPM amounts for the year are also reported to the HCA's actuaries through the Experience Data Reporting Modules, as required under Section 5.20.2.1.2 of the IMC Contract, Amendment 16 version. Submitting dollar amounts on the encounters from our capitated providers will inflate our claims cost and will not reconcile with the general ledger.

Recommendation 8: Formalize the process for applying financial penalties in a policy or procedure.

UnitedHealthcare Response: No comments to add to this recommendation.

Sincerely,

Valerie L. Martinolich
Compliance Officer
UnitedHealthcare Community Plan of Washington

State Auditor's Response

As part of the audit process, our Office provides a final draft of reports to audited entities and offers management an opportunity to respond. For this audit, these organizations were:

- Washington Health Care Authority
- Community Health Plan of Washington (CHPW)
- Molina Healthcare of Washington (Molina)
- UnitedHealthcare of Washington (UHC)

These responses are included in every published audit report. In this case, CHPW declined to submit a response; the other responses are included on pages 39-47 of this report. Two responses require some clarification, which we set out below.

From the Health Care Authority

In Recommendation #4, we recommended that HCA develop a process to verify the completeness and accuracy of the MCOs' overpayment recovery reports. HCA responded that it currently validates MCOs' reported information through its encounter data and MCO provider audits, meetings it holds with the MCOs, and its current documented process to review the MCOs' deliverables.

Auditor's Response

While HCA conducted both encounter data validation audits and direct audits of MCO providers, these audits did not verify the completeness of the MCOs' overpayment recovery reports. Additionally, the procedures HCA referred to in its formal response do not speak to the process we recommend. As a result, we did not change our recommendation.

From Molina Healthcare

In response to our Recommendation #3, that HCA set a minimum standard for program integrity data analytics in the MCO contracts, Molina expressed concerns that artificial link analysis is expensive and the return on investment is unknown.

Auditor's Response

Our recommendation is not intended to suggest the required use of artificial intelligence, especially in its current emergent form. Rather, it is simply that HCA set a minimum standard for program integrity data analytics. Whether that includes the use of artificial intelligence would be for HCA to determine.

Appendix A: Initiative 900 and Auditing Standards

Initiative 900 requirements

Initiative 900, approved by Washington voters in 2005 and enacted into state law in 2006, authorized the State Auditor's Office to conduct independent, comprehensive performance audits of state and local governments.

Specifically, the law directs the Auditor's Office to "review and analyze the economy, efficiency, and effectiveness of the policies, management, fiscal affairs, and operations of state and local governments, agencies, programs, and accounts." Performance audits are to be conducted according to U.S. Government Accountability Office government auditing standards.

In addition, the law identifies nine elements that are to be considered within the scope of each performance audit. The State Auditor's Office evaluates the relevance of all nine elements to each audit. The table below indicates which elements are addressed in the audit. Specific issues are discussed in the Results and Recommendations sections of this report.

I-900 element	Addressed in the audit
1. Identify cost savings	**No.**
2. Identify services that can be reduced or eliminated	**No.**
3. Identify programs or services that can be transferred to the private sector	**No.**
4. Analyze gaps or overlaps in programs or services and provide recommendations to correct them	**No.**
5. Assess feasibility of pooling information technology systems within the department	**No.**

I-900 element	Addressed in the audit
6. Analyze departmental roles and functions, and provide recommendations to change or eliminate them	**No.**
7. Provide recommendations for statutory or regulatory changes that may be necessary for the department to properly carry out its functions	**No.**
8. Analyze departmental performance data, performance measures and self-assessment systems	**No.**
9. Identify relevant best practices	**Yes.** The audit identified leading practices related to improving managed care organizations' program integrity efforts and the Health Care Authority's related oversight, and related to ensuring complete and accurate encounter data.

Compliance with generally accepted government auditing standards

We conducted this performance audit under the authority of state law (RCW 43.09.470), approved as Initiative 900 by Washington voters in 2005, and in accordance with generally accepted government auditing standards as published in *Government Auditing Standards* (July 2018 revision) issued by the U.S. Government Accountability Office. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The mission of the Office of the Washington State Auditor

To provide citizens with independent and transparent examinations of how state and local governments use public funds, and develop strategies that make government more efficient and effective. The results of our work are widely distributed through a variety of reports, which are available on our website and through our free, electronic subscription service. We take our role as partners in accountability seriously. We provide training and technical assistance to governments and have an extensive quality assurance program. For more information about the State Auditor's Office, visit www.sao.wa.gov.

Appendix B: Objectives, Scope and Methodology

Objectives

The purpose of this performance audit is to identify opportunities for the Health Care Authority (HCA) to strengthen its oversight of program integrity efforts at managed care organizations (MCOs). It also examined the controls HCA and the MCOs have in place to ensure accurate encounter data is submitted to the state's contracted actuarial firm, Milliman. The audit addresses the following objectives:

1. Are there opportunities to improve MCO program integrity efforts and HCA's related oversight?
2. How do HCA and the MCOs ensure accurate encounter data and MCO program integrity efforts are reported to the actuarial firm and reflected in future premiums paid to MCOs?

For reporting purposes, the answers to these objectives are found in multiple areas throughout the results section of this report.

Scope

This audit focused on program integrity efforts at MCOs and HCA's related oversight. It also examined the controls MCOs and HCA have in place to ensure that complete and accurate encounter data is reported to the actuarial firm. For the purposes of this audit, we focused on the three MCOs serving the greatest percentages of enrollees: Molina Healthcare, Community Health Plan of Washington and UnitedHealthcare. (See **Figure 1** for details.)

Figure 1 – The three MCOs included in this performance audit

All numbers are rounded; enrollee numbers current as of May 2023.

Name of MCO	Number of enrollees	Percent of managed care enrollees in plan	Amounts paid to MCO in FY 2022
Molina Healthcare of Washington	993,000	50%	$4.7 billion
Community Health Plan of Washington	272,000	14%	$1.3 billion
UnitedHealthcare of Washington	256,000	13%	$1.3 billion
Total	**1.52 million**	**77%**	**$7.3 billion**

Source: HCA and Washington's Office of Financial Management.

The audit period included January 2021 through December 2022. Audit work built on efforts in previous years, including our 2021 Medicaid Program Integrity performance audit, to understand potential present gaps. Most of our audit evidence came from interviews, reviews of documents and the contracts between HCA and the MCOs, and testing certain internal controls for HCA and the MCOs.

Methodology

We obtained the evidence used to support the findings, conclusions and recommendations in this audit report during our fieldwork period (September 2022 – June 2023), with some additional follow-up work afterward. We have summarized the work we performed to address each of the audit objectives. The bibliography at the end of this report contains a full list of sources used for leading practices in both objectives.

Objective 1: Are there opportunities to improve MCO program integrity efforts and HCA's related oversight?

To understand the effectiveness of **MCO program integrity efforts** during the audit period, we:

- Reviewed federal regulations and leading practices for MCO program integrity efforts
- Reviewed documentation and policies from the MCOs
- Interviewed relevant staff at MCOs

Reviewed federal regulations and leading practices for Medicaid program integrity

Methods for establishing criteria for MCOs program integrity activities included reviewing:

- Federal regulations, including requirements from the Centers for Medicare and Medicaid Services (CMS)
- Leading practices for Medicaid program integrity from sources including CMS, the U.S. Government Accountability Office (GAO), Bloomberg Law, Milliman and others

Reviewed documentation and policies at each MCO

We reviewed policies and procedures supplied by each of the three MCOs concerning risk assessments, prepayment review, data analytics, post-payment review, and reporting. We reviewed documents regarding risk assessments, submitting annual and monthly program integrity reports, automated system checks, excluded provider screening, and verifying services; reviewed lists of automated system checks and their descriptions; read reports of provider exclusion and termination lists; and observed dashboards for prepayment edits and performance measures.

Interviewed relevant staff at MCOs

We conducted semi-structured interviews with MCO staff to learn about program integrity activities across different teams at the three audited MCOs. Interviews ranged from topics such as risk assessments, prepayment review and data analytics, to post-payment review and reporting activities. Interview questions also included confirming our understanding of who is responsible for different activities.

To understand **HCA's oversight of MCO program integrity efforts**, we:

- Reviewed federal regulations, state laws and leading practices for state Medicaid agencies
- Reviewed documentation from HCA as well as the contracts between HCA and the MCOs
- Interviewed HCA staff and leadership

Federal regulations, state laws and leading practices for state Medicaid agencies

The following sources helped us develop criteria for HCA's oversight of MCO program integrity efforts:

- Federal regulations, including requirements from CMS on state Medicaid agencies' oversight of MCOs
- State laws (Revised Code of Washington) and regulations (Washington Administrative Code) governing Medicaid
- Leading practices for state Medicaid agencies from sources including: CMS, GAO, the U.S. Department of Health and Human Services Office of Inspector General, and the Governing Institute Handbook for Medicaid program integrity
- Previous SAO audit recommendations

Reviewed documentation from HCA and contracts between HCA and the MCOs

To determine whether HCA had implemented an earlier audit recommendation to develop a Statewide Fraud and Abuse Prevention Plan, we reviewed the agency's fiscal year 2023 Fraud Plan. To gain an understanding of the ways HCA oversees MCO program integrity efforts, we also reviewed documents MCOs used to submit information, such as any credible allegations of fraud or abuse. We also reviewed the contract between HCA and each of the MCOs to learn about expectations around program integrity procedures and contract compliance.

Interviewed HCA staff and leadership

We conducted semi-structured interviews with people at different levels of management within the Division of Program Integrity. We asked about the policies and procedures related to different aspects of oversight of the MCOs. Interviews included questions about roles and responsibilities of specific teams within the division. We asked HCA staff to attest to whether the MCOs had submitted required program integrity deliverables on time from January 2021 to April 2022. We also asked about collaborative aspects of their work with the MCOs and the Medicaid Fraud Control Division.

Objective 2: How do HCA and the MCOs ensure accurate encounter data and MCO program integrity efforts are reported to the actuarial firm and reflected in future premiums paid to MCOs?

Our assessment of HCA and MCO efforts to ensure accurate encounter data is reported to the actuarial firm involved primarily examining internal controls, described in greater detail in the internal controls section below.

For our work concerning overpayments and recoveries, we identified policies and procedures in place at the MCOs for retaining, recovering and reporting overpayments, and then compared them to identified

criteria. We then confirmed this understanding with MCO management. We also obtained and reviewed overpayment recovery reports the actuarial firm used in the most recent rate setting process and attempted to verify the completeness and accuracy of these reports.

Work on internal controls

Objective 1: Are there opportunities to improve MCO program integrity efforts and HCA's related oversight?

As a part of Objective 1, we assessed internal controls regarding HCA's oversight of the MCOs' program integrity efforts based on criteria from federal and state regulations and leading practices. This work included reviewing:

- Policies and procedures defining MCO activities including templates and forms related to fraud referrals, program integrity reports and excluded providers
- Contractual agreements between HCA and the MCOs that specify expectations, HCA responsibilities, how issues will be addressed, and various penalties for noncompliance

While we confirmed that MCOs performed program integrity activities, determining the efficacy of these activities was outside the scope of this audit.

Objective 2: How do HCA and the MCOs ensure accurate encounter data and MCO program integrity efforts are reported to the actuarial firm and reflected in future premiums paid to MCOs?

For internal controls relating to Objective 2, we:

- Identified relevant criteria for what controls should be in place
- Determined what controls HCA and MCOs have in place
- Conducted additional testing in selected areas

Identified relevant criteria for what controls should be in place

To identify relevant criteria related to ensuring complete and accurate encounter data, we conducted an extensive literature review for requirements including federal and state regulations and leading practices. We also confirmed the identified criteria with HCA and the MCOs.

Determined what controls HCA and MCOs have in place

To determine if HCA and MCO processes reflected the identified criteria, we reviewed related HCA and MCO documentation including applicable policies, procedures and other guidance, and interviewed relevant management and staff. We then compared the resulting information to the identified criteria. We also confirmed information by reviewing referenced reports, communications and other information as applicable.

Conducted additional testing in select areas

In Objective 2, we conducted additional testing on internal controls, including:

- Automated system checks – Information technology auditors reviewed edit logic and confirmed operation of a selection of system checks.
- Form D reconciliation – In addition to gaining an understanding of HCA and MCO processes for the reconciliation, we attempted to verify reported general ledger amounts with information in the MCOs' financial systems.
- MCO contracts with providers – We randomly selected 11 contracts from each MCO and verified that they included specific requirements.
- MCO audits of encounters to claims – One MCO conducted audits of encounters to claims during the audit period. For this MCO, in addition to gaining an understanding of the audit process, we reviewed a small selection of audit documentation to confirm that the work was done.

The following list summarizes the limitations for the internal controls work for Objective 2:

- Automated system checks – Audit procedures were limited and did not constitute a comprehensive cybersecurity or application review. Had we performed additional procedures, other matters might have come to our attention that would have been reported. While we confirmed the selected automated system checks worked appropriately at each MCO, we were unable to do so using our typical audit procedures.

  Instead, we altered our testing approach based on limitations related to the audit schedule and MCO capabilities to show their automated system checks while actively adjudicating new claims. For system checks related to pharmacy claims submitted to HCA, we were unable to confirm logic due to a vendor-operated system and limitations related to the audit schedule, but we did confirm operation of the selected system checks. Since we were limited to a select list of system checks for this testing, we cannot make a conclusive assessment for all system checks.
- Form D reconciliation – We were unable to verify exact information to financial systems as noted in Audit Results (see page 31, which addresses ways HCA can coordinate with the MCOs to potentially improve this step).

Appendix C: Recommended Validation Types

The Centers for Medicare and Medicaid Services (CMS) recommends that state Medicaid agencies validate encounter data through a multifaceted approach that combines both automated system checks and comparisons of encounter data to other, external data sources.

As described on pages 30-31, the Health Care Authority (HCA) validated the encounter data with both automated system checks and comparisons to external data sources.

CMS recommends that automated system checks include the following validation types:

- **Intrafield:** Validates that the data in each field complies with specific rules. For example, checking for missing values and verifying dates are valid and in the correct format. Another example would be verifying data values are within specified ranges.
- **Interfield:** Compares data to other fields or records in the same file to validate accuracy or appropriateness. For example, verifying that discharge date is after admission date. Other examples include comparing procedure codes to diagnosis codes and comparing procedure codes to the place of service.
- **Interfile:** Compares data to information from other state Medicaid files. For example, validating enrollee eligibility on the date of service using state eligibility files. Other examples include comparing encounter data totals to benchmarks developed based on historical encounter data.

Source: Centers for Medicare & Medicaid Services. "State Toolkit for Validating Medicaid Managed Care Encounter Data."

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