



Performance Audit

Health Care Authority's Oversight of the Medicaid Managed Care Program

April 14, 2014

We conducted this performance audit of the Health Care Authority's Medicaid managed care program to determine if the state had controls in place to effectively oversee the organizations in charge of providing health care and to prevent overpayments.

We found weaknesses in HCA's oversight led to these organizations paying providers more than was appropriate, which in turn may have led to the state paying higher premiums to these organizations in fiscal year 2013 and beyond.

We provide recommendations to help HCA improve its oversight of managed care organizations.



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The State Auditor's Office contracted with Myers and Stauffer LC to conduct this audit.

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Executive Summary

Medicaid managed care is large and growing

Washington's Medicaid managed care program, jointly funded by the federal and state government, provided health coverage for about 796,000 residents and cost almost \$1.4 billion in 2013. The Health Care Authority (HCA) expects federal health care reforms starting in January 2014 will expand Medicaid coverage to about 328,000 more people in Washington in the next five years, most of whom are expected to receive managed care.

We conducted this performance audit of the managed care program to determine if the state had controls in place to effectively oversee the organizations in charge of providing health care and to prevent overpayments. We found that weaknesses in HCA's oversight led to these organizations paying providers more than was appropriate, which in turn led to the state paying higher premiums to these organizations in fiscal year 2013 and beyond.

AUDIT ISSUES

-  **Inadequate oversight and data analysis led to overpayments**
-  **Undetected overpayments in 2010 resulted in potential higher premium costs in 2013**
-  **Data used to set 2013 premium rates was not verified and retained**
-  **Inconsistent reporting of administrative costs, recoveries and rebates**

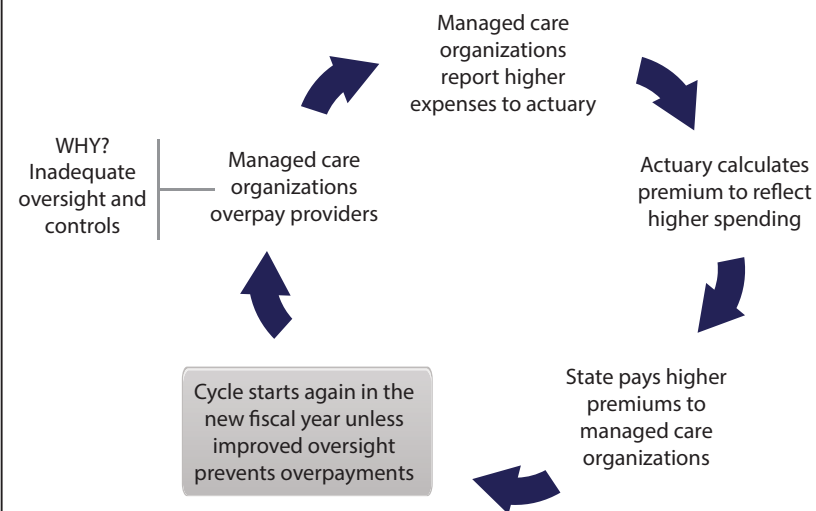
RECOMMENDATIONS

-  **Create a comprehensive monitoring and reporting system**
-  **Review and improve the controls used to prevent overpayments**
-  **Review and retain data used by the actuary to set premium rates**
-  **Provide better guidance and require more reporting of key information**

Managed care organizations receive from the state monthly per-person payments. They use that money to pay doctors and other providers for client care. The system limits the state's exposure to increasing medical costs. However, the per-person rate the state pays is based in part on how much spending managed care organizations report. Because overpayments by the organizations inflate those figures, they put the state at risk of paying unnecessarily high premium rates in the future.

The state's contracted managed care organizations annually process millions of claims for hundreds of thousands of members. Our objective was to determine whether overpayments occurred in an amount sufficient to warrant additional monitoring of claims. After evaluating similar work in other states and examining the reporting requirements in Washington, we focused our analysis on eight areas which pose the greatest risk for loss of public funds.

Overpayment/Premium increase cycle



This approach allowed us to limit the cost of the audit. Because we intentionally chose claims areas with the greatest risk of errors in only eight high-risk areas, we cannot use this approach to estimate the amount of overpayments in the entire system or to estimate amounts for potential recovery. Our approach did, however, provide us with evidence that additional monitoring of claims is warranted.

Inadequate monitoring and insufficient controls led to inappropriate payments in 2010, which potentially affected 2013 premium rates

We found inadequate oversight of the managed care program and limited controls over expenditures. For example, although the HCA's contract requires its managed care organizations to perform data checks to prevent improper payments, the organizations only had checks to analyze hospital claims and did not perform similar checks on professional claims by doctors and other specialists. Performing additional checks and data analysis, particularly for high risk claims, could help the state and its managed care organizations identify and reduce overpayments. Failure to resolve these issues will lead to higher Medicaid costs, especially as growth and enrollment in Medicaid managed care increase with federal health care reform.

To determine whether overpayments to providers were detected, we examined eight of the highest-risk payment types at the two largest managed care organizations. Our best estimate is that the two managed care organizations overpaid their providers \$17.5 million for claims paid within the eight outlier populations reviewed.

These estimated overpayments in 2010 may have resulted in additional costs to the state, because the 2010 expenditures reported by managed care organizations were used to calculate the premium rates paid by the state to managed care organizations starting in 2013.

To determine how overpayments may have impacted premium payments, we conducted an actuarial analysis that showed that for every \$1 million in overpayments in 2010, the state potentially paid an additional \$1.26 million in premiums in fiscal year 2013. However, because we don't know whether there were net overpayments in the entire system, we cannot estimate the impact on premium costs to the state.

While the overpayments we estimated are a relatively small percentage of the \$1 billion of payments the managed care organizations make to their providers annually, we made the estimate based solely on the limited testing of eight high-risk areas. The estimated impact on future premiums was based on a high-level analysis that applied the same assumptions and used the same limited amount of information disclosed in the actuary's rate setting memo. Access to more detailed information on the actuary's rate setting process might have yielded different results. The effect of these estimated overpayments on state premiums therefore warrants improved state oversight of the managed care program.

Examples of inappropriate charges:

- Charging for a more complex medical evaluation than was performed.
- Extra charge for a medical evaluation when the evaluation is already included in the cost of a medical procedure.
- Charging for a hospital stay when there is no evidence the physician ordered inpatient admission.
- No documentation to support the services billed.

HCA did not review relevant managed care organizations' cost data

The state needs to ensure its managed care organizations correctly report administrative costs and cost recoveries, such as pharmacy rebates and recoveries received from other insurance companies. The HCA's current system does not capture, review or audit the actual administrative costs incurred by the state's managed care organizations, but relies on the organizations to report cost information directly to the HCA's actuary, without state oversight.

High error rates (8 percent and 12 percent for the two organizations) of unallowable administrative expenses in the risk-based sample we reviewed suggest that the administrative costs reported to the actuary may be higher than their actual expenditures. In addition, the organizations also included some administrative costs in their medical costs, which is against program rules.

The HCA's third-party actuary told us that it does not use the administrative cost data reported by the organizations to calculate the portion of the premium rate that applies to administrative expenses. Instead, the actuary uses national averages to set a rate of 13.5 percent of the premium to cover allowable administrative costs, premium tax and risk margin. It is a common practice among insurance actuaries to use national averages, which are not based on audited cost data, to compute premium rates.

Does that mean errors in administrative costs do not matter? We believe that while use of national averages to set administrative expense rates may be common practice, the HCA would benefit from periodically analyzing actual administrative cost data reported by managed care organizations to ensure that it is accurate and reimbursement rates are reasonable. This would ensure that using national average administrative cost reimbursement rates is the right approach for Washington.

Improving Medicaid managed care oversight

Washington needs to collect more information about the performance of its independent contractors. It would benefit from a comprehensive cost reporting and monitoring system to keep managed care organizations accountable for the terms in the contract. An integral part of oversight is giving guidance to the managed care organizations. We found some circumstances in which the state did not provide proper guidance, and others in which the managed care organizations' processes were not consistent or complete.

Our recommendations for HCA include:

- ensuring the managed care organizations improve their controls to prevent overpayments
- establishing a comprehensive cost reporting and monitoring system
- providing better guidance and standards for reporting costs, recoveries and prescription rebates.

The HCA should also seek to change the contract to allow it to recover a portion of any future overpayments identified and collected following state audits. The current contract is silent on whether or not the state can recover overpayments identified in state and other audits.

Introduction

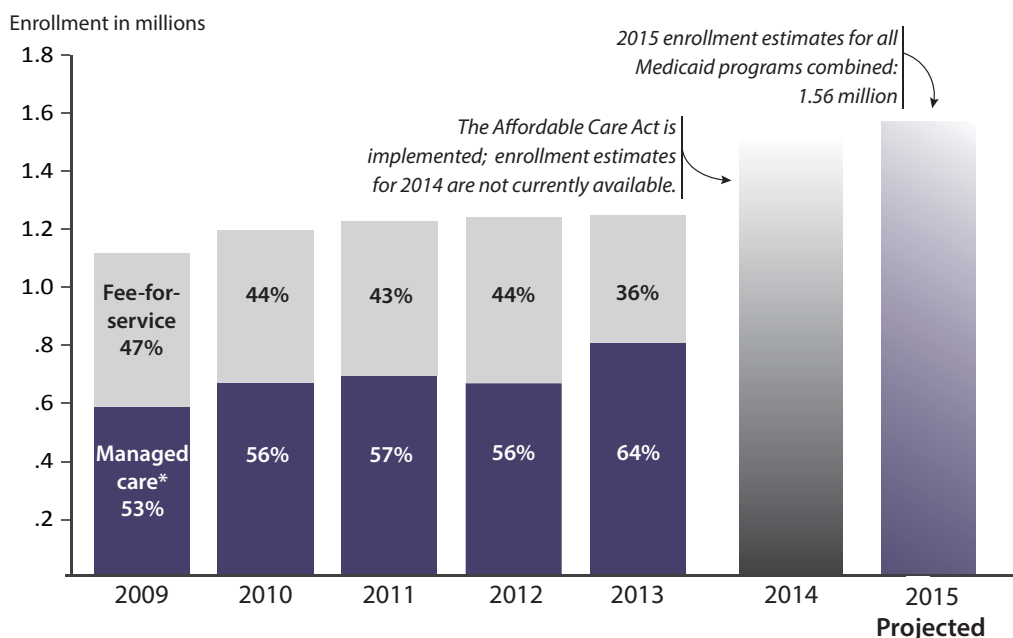
Medicaid managed care programs help those who need health care but can least afford it – and the programs are likely to grow in coming years

The public insurance program known as Medicaid is the single largest health care program in the United States. A partnership between federal and state government, it gives 67 million low-income Americans access to health care and related services. Those served include people with disabilities, children in low-income families, and low-income seniors who have Medicare. About 50 million of them are covered by some type of managed care program. Under a managed care program, the state pays an organization a monthly premium to manage all the healthcare services provided to plan participants. The remaining eligible individuals are covered under the more traditional fee-for-service type program. In a fee-for-service arrangement, the state reimburses providers for each specific service provided to plan participants. Beginning in 2014, the Patient Protection and Affordable Care Act will begin to expand Medicaid eligibility to cover an estimated 16 million more Americans – mostly uninsured adults – by 2019.

About 1.2 million people – almost 18 percent of Washington’s population – were enrolled in the state’s Medicaid program in 2013. As shown in **Exhibit 1**, around 796,000 people – 64 percent of members – now receive medical care through managed care, with the remainder covered under a fee-for-service arrangement. The number covered under a managed care program will almost certainly go up because most new members added under the Affordable Care Act are likely to be directed to managed care programs. The Washington State Health Care Authority (HCA) estimates a total of 1.56 million people will be enrolled in all its Medicaid programs by 2015.

Exhibit 1 - Medicaid managed care is growing

In 2013, about 796,000 Washington Medicaid members received managed care



**Includes Healthy Options and other types of Medicaid managed care programs.*

This increasingly popular care model allows the state to engage one or more managed care organizations to deliver services through their networks of providers: doctors, hospitals, clinics and so forth. Managed care organizations may be non-profit or for-profit businesses; some companies also operate clinics or provide community health programs, but their primary business is health insurance. The organizations contract with doctors, hospitals and other care providers to establish a network that provides health care services for the enrolled, eligible, plan participants.

In Washington, the state pays the managed care organizations monthly premiums, allowing members to access covered services delivered by plan providers. The HCA hires an independent actuarial firm to determine these per-member monthly premium rates, based on data and costs reported by the managed care organizations. Periodically, the actuary revises the premium rate based on updated costs. An overstatement of costs can drive up the premium rate, which in turn drives up the amount the state spends in coming years for health care.

HCA has focused its oversight on fee-for-service programs, and relies on managed care organizations to ensure costs reported to the actuary for rate setting are accurate. Its oversight of the managed care organizations is primarily focused on quality of care and not on the prevention and detection of improper payments within the managed care system.

In fiscal year 2013, combined state and federal Medicaid spending in Washington totaled around \$7.9 billion for medical and other support services. The amount spent on medical assistance in both the fee-for-service program and the managed care program was \$4.6 billion. Federal funds from the Federal Medical Assistance Program paid about 54 percent of the total bill; Washington paid the remaining 46 percent, roughly \$2.1 billion. Payments to the Medicaid managed care organizations from state and federal funds came to more than \$1.4 billion.

In conducting this audit, we engaged Myers and Stauffer LC to perform an analysis of the Medicaid managed care program Healthy Options, administered by the HCA. Myers and Stauffer is a nationally-based certified public accounting firm focused solely on providing accounting, consulting, program integrity and operational support services to public health care and social service agencies. We wanted to know if overpayments exist within managed care and how well the HCA did at monitoring the organizations' costs, and preventing and detecting overpayments. This audit asked the following questions:

1. Are managed care organizations overpaying for medical expenses? If they are, why did overpayments go undetected, and how do the overpayments affect premium rates?
2. Are policies and procedures in place to ensure costs reported by managed care organizations to the third-party actuary:
 - Offset recoveries, rebates and refunds against medical costs
 - Include only allowable administrative expenses and allocate costs on a reasonable basis; and
 - Report costs related to subcontractors properly?

The audit focused on a few potentially high-risk areas

To examine every possible source of overpayments would have required an audit many times larger than this one. To keep within a reasonable scope, we examined only a limited number of carefully selected areas where claims overpayments or other errors in reporting are most likely to appear.

The results of our work must be looked at in that context: we did not estimate overpayments on non-outlier claims or other medical claim groups. Because problematic areas change over time, as gaps in practices are fixed, the issues we identified in this audit may not be the areas to reexamine five years from now. Instead, regular vigilance to prevent and detect overpayments, across the program, should become the HCA's routine practice.

Answer in brief

Washington should improve its oversight of managed care organizations' costs used to set premium rates.

We selected for our study the two largest managed care organizations contracted by the HCA to provide Medicaid managed care in the Healthy Options program; together they cover about 80 percent of the program's members and represent about \$1 billion a year in Medicaid spending. We found that, in general, the organizations follow the requirements of their contracts with the HCA.

However, we also found errors resulting in overpayments to providers within the high-risk claims areas we examined in detail. These overpayments were the result of incomplete systems' checks and review processes conducted by the managed care organizations that should be designed to catch overpayment possibilities. Overpayments also occurred because the HCA does not have a comprehensive system to monitor the review procedures performed or the costs incurred by the managed care organizations. Neither HCA nor other Washington state audit entities have conducted a detailed review of the kind undertaken in this audit.

Overpayments for managed care services can result in higher costs to the state

Our limited, risk-based review of transactions identified \$96,860 in overpayments and one significant underpayment of \$21,169. After projecting these results using statistical analysis, our best estimate is that the two managed care organizations overpaid their providers \$17.5 million for claims paid within the eight outlier populations reviewed.

Our approach was designed to identify only potential overpayments and our results do not include overpayments and underpayments that may have been found in a random test of the entire population. We therefore don't know whether there were net overpayments in the entire system.

Overpayments are a cost to the managed care organizations, but they also potentially affect the future premium rates paid by the state. Premium rates starting in fiscal 2013 were based on costs reported by managed care organizations in 2010, the year we reviewed.

Net overpayments in the entire Medicaid managed care system lead to increased premium payments by the state. Based on an estimated 695,000 Medicaid managed care members, if there are net overpayments, we estimate that for every \$1 million paid by organizations to their providers in 2010, the state would pay an additional \$1.26 million in premiums to all managed care organizations. However, because we don't know whether there were net overpayments in the entire system, we cannot conclude that 2013 premiums paid by the state were higher or lower than they should have been.

We estimated the impact on future premiums using a high-level analysis that applied the same assumptions and used the same limited amount of information disclosed in the actuary's rate setting memo. Access to more detailed information on the actuary's rate setting process might have yielded different results. Additional premiums paid in one year will compound due to increased enrollment as long as premium rates are based on inflated costs.

The potential effect of overpayments to providers on state costs warrants increased monitoring.

Washington could also contain Medicaid costs by reviewing medical cost recoveries and administrative expenses

When we examined administrative expenses and recoveries, such as pharmacy rebates and overpayment recoveries, in the financial reports sent to the actuary, we found that organizations generally reduced the medical claim costs by the amount of recoveries or rebates received. However, we found some errors that overstated the medical expenses the organizations reported to the actuary.

- We found third-party recoveries totaling \$1.1 million were not used to offset the cost of related medical claims, resulting in overstated medical expenses reported to the actuary.
- We found unallowable administrative expenses totaling \$395,000 were reported to the actuary, representing an error rate of 8 percent and 12 percent for the two managed care organizations in our sample.
- We could not determine how the HCA's third-party actuary used cost information related to capitated providers in calculating the premium rate. The actuary had received two sets of costs from one of the organizations: projected costs based on fee-for-service rates and actual costs based on capitated payments paid to their providers. Capitated payments were \$3.3 million less than the projected costs. The actuary could not give us documentation showing how they considered the two sets of costs when calculating the rate, and did not maintain information that was used in the calculation of the capitation rate in an accessible format.

The actuary does not review administrative costs for accuracy or improper payments when calculating the portion of the premium rate that applies to administrative expenses. To assure the state that the rate being applied to Washington is appropriate, the administrative expenses applied to the administrative cost percentage rate should be reviewed and verified.

Washington should require managed care organizations to retain and report complete accurate cost data reported for rate setting purposes

In addition, we found that the HCA's contract with the managed care organizations does not contain requirements that would allow the HCA to thoroughly and accurately monitor the data they report to the actuary.

Although the organizations we audited provide financial reports to the HCA's third-party actuary that contain cost data from the previous year, neither kept the detailed medical claims cost data as it was submitted to the actuary. In order to receive federal Medicaid funds, Washington must meet numerous requirements regarding the proper and efficient administration of their Medicaid programs, including its use of managed care. By not requiring the organizations to report cost data to HCA and retain the data files for review, the HCA is not in a position to adequately monitor the costs the organizations have incurred and reported to the actuary.

HCA should strengthen the guidance it provides to its contracted managed care organizations

We found several instances in which clearer guidance from the HCA could improve the way the managed care organizations compute and report data to the actuary. For example, we found that the two organizations in our study calculated and reported their pharmacy rebates differently – one on an accrual basis, one on a cash basis – making it difficult to compare their results and performance accurately.

Nationally, as more states expand the number of members served by managed care organizations, there is a move towards more accountability and transparency regarding the Medicaid dollars these companies are paid. The Centers for Medicare and Medicaid Services (CMS) and the U.S. Senate Judiciary Committee addressed these issues through a request to the State Medicaid Directors, and proposed legislation that would require annual audits of these programs. At the state level, some states, such as Georgia and Texas, have already established comprehensive monitoring programs; some require audits conducted by independent auditors. If Washington is to keep pace with managed care's increasing role in Medicaid and fulfill its obligation to administer the program effectively, it must improve the way it monitors managed care organizations and holds them accountable. See **Appendix D** for monitoring best practices and the states that use them.

Summary of recommendations

The Health Care Authority should improve its oversight of managed care organizations to ensure appropriate controls are in place to detect and prevent medical and administrative cost overpayments, and also provide guidance on the reporting of medical cost recoveries and administrative costs. By examining and updating its contract language with the managed care organizations as appropriate, the HCA should be able to address our recommendations and allow the state to recover any future overpayments identified in state and other audits.

Our recommendations include these key elements:

1. Review and improve the controls used to prevent overpayments by requiring the managed care organizations to review their system edit checks and post-payment procedures to ensure claims are reviewed in sufficient detail to identify miscoding and other causes of overpayments. The contract should require that organizations use edits such as those established by the National Correct Coding Initiative (NCCI).
2. Update contract language with the managed care organizations to allow the HCA to recover overpayments identified in state and other audits where appropriate.
3. Require the organizations to report detailed claims and administrative cost data to the HCA in a prescribed format on a periodic basis.
4. Create and implement a comprehensive revenue, cost reporting and monitoring system to enhance accountability for the managed care organizations' compliance with contract provisions.
5. Provide better guidance and criteria for defining medical and administrative expenses and recoveries, including what are allowable expenses and when rebates and recoveries should be reported.

For our full recommendations, please see pages 42 and 43.

What's next

We conducted this performance audit under the authority of the state's performance audit law which was enacted in 2005 through the statewide citizen initiative I-900. The law requires the responsible legislative body to hold a public hearing within 30 days of its publication.

Representatives of the State Auditor's Office will report on this performance audit to the Joint Legislative Audit and Review Committee or another legislative committee. Please check the state Legislature's website (www.leg.wa.gov) for the exact date, time, and location. The public will have the opportunity to comment at this meeting.

Appendix A describes the provisions of Initiative 900 and how the audit addressed these provisions.

Appendix B provides more detail on our objectives and methodology.

Background on Medicaid Managed Care

Medicaid managed care programs provide greater control and predictability over Medicaid spending

The goals of a managed care program are to improve care, reduce costs, expand service delivery options, reduce inappropriate utilization, and assure adequate access to quality health care for Medicaid beneficiaries. Such programs deliver covered health benefits and additional services through a risk-based contract between the state Medicaid agency and a managed care organization; states usually contract with more than one organization to provide services statewide.

Under a risk-based contract, the managed care organization assumes a portion of the short-term financial risk for the cost of covered services and plan administration. It negotiates with providers to create a network that will provide services to plan members at specified rates. In return, the state pays the organization a fixed periodic (usually monthly) payment for a defined package of benefits. These payments are commonly known as premiums or capitation payments; they are typically made on a per-member, per-month basis. This structure is designed to provide the state with greater control and predictability over Medicaid spending.

In determining premium rates, third-party actuaries predict members' use of health care services and the expected cost of these services based on a number of factors, such as:

- Baseline cost of claims data
- Expected trends
- State fiscal conditions
- Services that are not covered by managed care
- Payments in addition to the base premium rate
- Incentives

Federal regulations require a state's premium rates to be actuarially sound and certified by a qualified actuary. Rates are actuarially sound if they "provide for all reasonable, appropriate, and attainable costs" that are incurred by the managed care organizations. However, this determination by the actuary does not include reviewing the costs for overpayments or allowability under the Medicaid program. Since the rates paid to the organizations are based in part on the actual cost of medical and administrative services they have paid for, it is essential that states have an effective oversight program in place to ensure only reasonable and allowable costs are factored into the actuary's rate setting equation.

Federal laws and guidance (see page 59) also set out what states should regard as errors and overpayments, which are defined as:

- Payments made to ineligible recipients
- Payments for services that are not covered by the member's plan
- Payments for services that the member did not receive
- Payments for incorrect amounts
- Duplicate payments
- Payments where an audit or review by the state agency cannot determine if the payment was correct because of insufficient or absent documentation

In addition, in order to receive federal Medicaid funds, Washington must meet numerous requirements regarding the proper and efficient administration of its Medicaid programs. Given the magnitude of these programs, Washington has a statutory obligation to know whether or not it is paying appropriately for quality care and whether members have adequate access to necessary care.

Robust program integrity efforts by managed care organizations, combined with accountability efforts by the state in managing their managed care organization contracts help to control Medicaid costs.

As an integral component of program accountability, program integrity efforts seek to ensure proper payment for appropriate, high quality health care services. This includes addressing not only fraud, waste, and abuse by providers and plan members, but also program management issues. Program accountability measures also extend to the managed care organizations.

In Washington, the organizations' Healthy Options contract with the state requires them to follow all applicable federal and state program integrity requirements. Under prudent contract management practices, the state must monitor the organizations' program integrity efforts. Indeed, the organizations have their own incentives to identify and address possible fraud, waste and abuse because they are paid a set rate for each person enrolled in their plan. Any undetected fraud, waste and abuse in managed care that results in overpayment of medical and administrative costs means the organization would bear the short term responsibility to cover that cost. A robust process for monitoring and detecting overpayments of claims and other expenses – though in itself an administrative cost – can go a long way toward preventing and detecting problem expenditures.

It is important for all states to actively monitor and manage their Medicaid managed care contractors because without robust processes in place, overpayments of medical and administrative costs are more likely to occur and not be caught. Over the long term, these overpayments will increase future premium rates, which means the managed care organizations will eventually recover their short-term losses. The burden thus falls on the state through higher premium rates. It is in the state's interest to limit cost increases today if it wishes to reduce the overall cost of its Medicaid managed care program tomorrow. Increased monitoring on the part of HCA can provide the oversight and effective management needed to achieve cost savings.

Without adequate oversight, states risk paying Medicaid managed care premium rates that are too high

Three factors drive managed care premium rates set by the HCA's third-party actuary:

- Medical expenses (how much did each medical service in a claim cost)
- Claims experience (how many encounters with the medical community did members have in a year)
- Administrative costs (how much does it cost an organization to run its business)

Generally, overpayments in managed care programs can be the result of the following:

- Overpaying medical costs through miscoding of medical claims, use of improper reimbursement rates to providers, or lack of documentation to support a claim.
- Failure to offset rebates and recoveries against medical costs.
- Overpaying administrative costs through inflated fees for related party cost.
- Inaccurate reporting of encounter data.
- Misallocating non-Medicaid costs to the Medicaid program.
- Misallocating corporate overhead expenses to the Medicaid program.
- Charging unallowable costs to the program such as specified costs that don't qualify for federal reimbursement under regulations
- Unknown costs and excessive fees for delegated vendors or related parties.

Question 1 of this report addresses the claims payments that make up the medical expenses. If a managed care organization overpays on medical claims and reports uncorrected data to the actuary, premium rates are likely to be set higher to reflect the high expenditures.

Question 2 examines how managed care organizations report the recovery of medical expenses from third parties like insurance companies, and manage their administrative costs. If the organization recovers money but doesn't report it to the actuary, the higher original expense is used to calculate the premium rate; if it inappropriately includes certain administrative costs as medical costs or includes unallowable administrative costs, total expenses would be overstated – and again, the premium rate would be incorrectly calculated.

Preventing the risk of fraud, waste and abuse is often discussed in terms of efficient and effective operation of state Medicaid programs and prudent fiscal management of Medicaid funding. However, states might underestimate the risks to their Medicaid budgets under the premium payment structure because, in some instances, they have limited their short-term cost exposure to the premium payment made to the managed care organizations. States might also assume that the managed care organizations address these risks as part of their program integrity function, or the state's actuary firm monitors them as it calculates the premium rates for the program. In reality, none of these entities necessarily address these risks without specific contractual requirements imposed by the state.

While the state contracts with various managed care organizations to operate the Medicaid managed care program, it is still responsible for making sure that they comply with all aspects of the contract. Among the most important elements that best practices recommend a contract include are requirements that:

- The costs to operate the program are allowable and reported accurately
- Premium payments are based on accurate member eligibility counts
- Adequate physician and medical facility networks are established
- Medical services are provided promptly and properly
- Personal health information is protected adequately
- Claims are paid properly and on time to the providers

Careful terms set out in the contracts between the state and its managed care organizations can encourage improved, more comprehensive oversight, and help keep costs down.

Four key risks states can mitigate by monitoring costs and operations at managed care organizations

Four important risks can be mitigated if the state establishes a comprehensive monitoring program that ensures oversight of the costs incurred to operate the Medicaid program under managed care. These risks – and their remedies – are:

- 1. Premium rates set higher than they should be** – By checking that providers have not been overpaid, expenditures have been accurately offset with recoveries, and administrative costs are properly allowable, program management can ensure that rates are not set higher than is appropriate.
- 2. Misstated medical loss ratio calculations** – State contracts generally require managed care organizations to comply with a certain medical loss ratio target, which ensures that the organization spends a minimum percentage of premium revenues on medical services for members, restricting the amount spent to operate the program. The usual ratio is 80 percent to 85 percent on medical expenses; Washington's required medical loss ratio is 80 percent. By reviewing cost allocations, agency management can ensure that this ratio is correctly calculated. Inaccurate medical loss ratio calculations can disguise a lack of access to care for members and conversely over-spending on administrative costs. Managed care organizations that do not comply with the required ratio may incur a penalty – which could create an incentive to report inflated medical expenses.
- 3. Paying for duplicate or ineligible plan members** – By regularly reviewing member files for accuracy, management can find and remove double-counted members or people enrolled who are not eligible to receive Medicaid benefits.
- 4. Problems arising from non-compliance with contract performance requirements** – State contracts generally contain provisions that require the organizations meet specified performance standards. By monitoring compliance with these contract provisions, management can ensure adequate medical coverage for Medicaid plan members, good customer service, and reduce the chances of Health Information and Portability Accountability Act (HIPAA) violations.

Typical contract requirements include:

- Adequate network coverage
- Adequate access to provision of care
- Accurate provider directories that reflect actual experience
- Timely and adequate call center operations
- Member and provider satisfaction
- Adequate information technology (IT) security systems to protect personal health information
- Timely and comprehensive claims processing complaint handling

Background information specific to Washington's Medicaid Managed Care program

Since July 2011, the HCA has administered Medicaid and state-only funded managed care contracts in Washington, including Healthy Options. Our audit work focused on Healthy Options, the largest state managed care program, which provides no-cost health care services for people receiving Medicaid.

During the one-year period of our audit – January 1 through December 31, 2010 – the Medicaid Healthy Options program was administered by the Department of Social and Health Services (DSHS). The agency was also responsible for determining Medicaid eligibility for members and maintaining the Automated Client Eligibility System that processes Medicaid eligibility. This system, updated daily, interacts with HCA's Medicaid Management Information System (MMIS) called ProviderOne. The ProviderOne system:

- Contains rules regarding a client's eligibility for managed care enrollment
- Processes member enrollment in managed care
- Processes payments to managed care organizations.

In 2010, the state had contracted with seven managed care organizations to provide services:

- Community Health Plan of Washington (CHPW)
- Molina Healthcare of Washington, Inc. (Molina)
- Asuris Northwest Health
- Columbia United Providers
- Group Health Cooperative
- Kaiser Foundation Health Plan
- Regence BlueShield

Changes in 2012 reduced the number of contracts

The number of contracted managed care organizations was reduced to five in 2012, with only two of the original seven continuing to provide services under new contracts. As of July 1, 2012, the HCA entered into 18-month contracts with the five managed care organizations: Amerigroup, Coordinated Care Corp, and United Healthcare Community Plan, as well as CHPW and Molina. The contract covered provision of health care services to members of Healthy Options and the state's Basic Health Plan, a subsidy program for low income residents not eligible for Medicaid.

Audit Scope & Methodology

The state's contracted managed care organizations annually process millions of claims for hundreds of thousands of members. Because the first objective of this audit was to determine whether overpayments occurred, and not to estimate amounts for potential reimbursement, we were able to limit the number of transactions tested while still meeting a 90 percent confidence interval for statistical estimates.

The risk-based approach we applied does have its limitations, however. Because we selected our samples from selected groups of claims with potentially high risk of overpayments, we cannot use this approach to estimate the amount of overpayments or underpayments in the entire population of claims incurred in 2010. Nonetheless, this analysis provides evidence of the magnitude of potential overpayments – information that is useful to determine whether additional monitoring of claims is warranted.

Appendix B contains more details about our methodology and sampling.

Analysis conducted to identify overpayments

We analyzed calendar year 2010 claims because these were used by the third-party actuary to determine reimbursement rates starting in fiscal year 2013. Our risk-based approach was performed as follows.

We included the two largest managed care organizations (Molina and CHPW) in our analyses. These two organizations cover more than 80 percent of Healthy Options enrollees and received about \$1 billion in premium payments in calendar year 2010.

We identified 31 medical claim groups that had significant potential risk of overpayment based on a risk assessment that included a review of laws, regulations, contracts and data analysis, as well as the contractor's prior experience and expertise, including familiarity with other state programs.

We identified claims that were "outliers." These are claims that appear to be different in volume, value, nature or timing from others in a group of similar claims. The 31 high-risk groups accounted for \$130 million of outlier claims in 2010.

We narrowed the number of groups in our analysis to eight, based on the potential for amounts overpaid in outlier claims and the ability to identify overpayments in the medical records. These eight groups, described in the table on the following page, accounted for \$90 million of outlier claims in 2010.

We then determined the sample size needed to have a confidence interval of 90 percent for each of the eight high-risk areas. We randomly selected 575 claims for testing, amounting to \$2.4 million.

We conducted an expert review based on an examination of the medical files on 575 randomly-selected claims. Our initial testing of the medical claims was based on what was documented in the medical files received from the managed care organizations. For pharmacy claims, we also reviewed prior authorizations and related policies and procedures. The two organizations were given the opportunity to provide additional support for any initial exceptions identified before final errors were determined. The claims we identified as errors in our sample were not paid in compliance with standard medical coding practices or were not properly supported with appropriate documentation.

The eight high-risk claims groups we examined in this audit

What the claims group does or includes	Potential overpayment issues in this group
‘Upcoding’ diagnosis-related group (DRG) codes. Medical billing systems offer several diagnosis-related group (DRG) codes, which ascend numerically as the amount of effort required of the provider increases. High numbered DRG codes pay at a higher rate. They are applied for the greater levels of service performed for inpatient procedures in hospitals.	A provider who frequently applies higher numbered DRG codes could be a specialist, but it is also possible the provider is misusing the codes to get a greater reimbursement rate. It may also indicate incorrect usage of these codes.
Unbundling CT (computerized tomography) scans. Certain related services are bundled into a single payment to the provider. If a claim is submitted for a service that must be bundled with an additional code for one of the procedures included in the bundle, the payment for the additional code should be denied. Some of the CT scan procedure codes are bundled with other related services, generally where a CT scan would be a normal procedure in order to diagnose the illness or injury.	The potential for overcharging may occur when providers bill additional, separate CT scan codes with the bundled procedures without the proper documentation to support the additional payment. Additionally, services may be charged separately instead of bundled resulting in higher overall charges.
One-day inpatient stay. For the same service, inpatient (admitted) hospital reimbursement rates are typically higher than outpatient (not admitted) rates.	The potential for overcharging may occur when a provider admits the patient into a hospital when it was not medically necessary and treatment could have been provided on an outpatient basis, or when outpatient procedures are incorrectly billed as inpatient procedures.
Excessive billing using Modifier 25 code. Providers apply a Modifier 25 code to indicate that on the day of a procedure, the patient’s condition required a significant, separately identifiable evaluation and management service, above and beyond the usual pre- and post-operative care associated with the procedure or service performed. Under normal circumstances, we would expect to see the use of the Modifier 25 code only in exceptional circumstances.	An unusually high percentage of billing under the Modifier 25 code might indicate potential duplicate payment, coding errors, or the intention of bypassing certain review controls. Since applying the Modifier 25 code gains the provider a higher rate for the services performed for that patient, the incentive to misuse Modifier 25 coding can result in overpayment of these claims.
Duplicate payment of evaluation & management (E&M) codes. These codes are often included within other procedure codes. Many surgical procedure codes build in a component that includes an evaluation & management activity that is performed within one, ten or 90 days of the procedure date.	The potential for overcharging may occur when providers bill additional, separate E&M codes with these procedures without the proper documentation to support the additional payment. The use of codes with an embedded E&M code may indicate that the separately billed E&M did not occur or was not necessary.
Upcoding evaluation & management (E&M) codes. Medical billing systems offer several evaluation and management codes, which ascend numerically as the amount of effort required of the provider increases. A higher numbered E&M code pays at a higher rate.	Providers with a high percentage of using the higher level E&M codes could indicate the provider is a specialist or that the provider is misusing the codes to get a higher reimbursement rate. The potential for overcharging may occur when a provider uses a higher level E&M code when it was not medically necessary and the documentation does not support the additional effort reflected by the higher code.
Recurring orders for controlled substance drugs. Controlled substance medications (identified in schedules II, III, and IV) have an increased potential for abuse; they include drugs such as methadone, OxyContin, anabolic steroids, codeine, Valium, and Xanax. They are typically prescribed for short-term use only.	Recurring orders for multiple months may indicate patients with addiction problems seeking excessive quantities of drugs or illegal selling schemes run by the patient or the provider writing the prescriptions, as many of these drugs have a high street value.
Recurring orders for atypical antipsychotic drugs. Similar to controlled substances, certain atypical antipsychotics drugs have an increased potential for abuse. Drugs in this class include Abilify, Seroquel and Zyprexa.	Recurring orders for multiple months may indicate patients with addiction problems seeking excessive quantities of drugs or illegal selling schemes run by the patient or the provider writing the prescriptions, as many of these drugs have a high street value.

We projected the results of our analysis to all outliers in the eight high-risk groups. Because we selected claims to test based on risk, this extrapolation was only performed on the limited population of outliers in the eight high-risk groups. We did not estimate overpayments on non-outlier claims or other medical claim groups.

We then estimated the effects of potential overpayments on premium rates paid to the managed care organizations. Fiscal year 2013 was the first year in which reimbursement rates to the organizations were determined based on 2010 claims. We were able to estimate the additional premiums paid to all managed care organizations in fiscal year 2013 based on the effect of the estimated overpayments on per-member rates, assuming average enrollment of 695,000 people in the Healthy Options program. Thus, while the organizations absorb these medical costs in the year they occur, overpayments directly increase premium rates because they are included in the expense data reported to the actuary. The state budget is affected by these overpayments through the higher premium rates paid to the organizations in subsequent years.

Exhibit 3 on page 24 illustrates the process we used in auditing claims.

The benefits of a risk-based approach

Our risk-based approach – testing only a small fraction of the claims from two managed care organizations – enabled us to determine whether overpayments were being made and the estimated effects on premium rates paid to the managed care organizations. While the limited number of claims gave us an estimate of overpayments that meets a 90 percent confidence interval, the estimate is less precise than it would have been with a larger sample size. To assure full disclosure, we will provide a “not less than” estimate of overpayments as well as the point estimate itself.

Examining other costs

In the second part of our audit, we reviewed a selection of other 2010 financial transactions at the two managed care organizations that, if incorrectly reported, could affect the premium rate calculation. The items we examined that present a risk of overstated costs included:

- **Overpayment recoveries** – payments received from providers for overpaid claims. They should be applied against the claim to reduce costs.
- **Third party recoveries** – payments from other responsible parties, such as group health plans, liability insurer settlements, or worker’s compensation coverage. They should be applied against the claim to reduce costs.
- **Reinsurance recoveries** – payments from the organization’s insurance coverage for unforeseen or extraordinary losses exceeding a certain amount. They should be reported in the cost data as an offset to corresponding medical expenses.
- **Pharmacy rebates** – payments from drug manufacturers for prescriptions filled for Medicaid patients. They should be reported in the cost data as an offset to medical expenses.
- **Administrative expenses** – expenses incurred by the managed care organizations to administer their services. They should be permitted by law, correctly categorized, and correctly allocated to the Washington Medicaid program.

- **Related party costs** – payments to affiliated management companies or providers. They should not include a profit component or be higher than the rate paid to unrelated providers for similar services.
- **Subcontractor costs** – payments made by the managed care organizations to their subcontractors who provide administrative services to the organizations or medical services directly to Medicaid clients. The organizations should properly allocate and categorize administrative and medical costs for services provided by these subcontractors to comply with contract provisions.
- **Payments to subcapitated providers** – regular monthly payments made by the managed care organizations to providers who render medical services to Medicaid clients. The actuary should provide the HCA with information used to calculate the capitation rate including how subcapitation payments and related fee-for-service equivalents were taken into account in the rate setting process. This would improve the transparency of the process and help the state monitor the development of the premium rates being paid to the managed care organizations to insure these special pricing arrangements are properly considered in the rate setting process.

During the audit, we also interviewed staff and managers at the Health Care Authority, the two managed care organizations, and the third-party actuary.

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 (December 2011 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.

Appendix B provides more detail on our objectives and methodology.

Subcapitation

Just as the managed care organizations are paid per-member, per-month premiums by HCA for Medicaid services, so the managed care organizations can arrange to pay the care providers they have contracted with in the same way. Generally, these arrangements, known as subcapitation agreements, allow the organizations to pay less for claims expenses than they would pay under the fee-for-service model.

Audit Results

Question 1. Claims overpayments

Are managed care organizations overpaying for medical expenses? If they are, why did overpayments go undetected, and how do the overpayments affect premium rates?

Answer in brief

We found the managed care organizations had undetected overpayments in 2010. Our detailed analysis of 575 outlier claims in eight high-risk claims areas found 96 where payment errors occurred either because of improper coding or inadequate documentation on the part of the care providers in the managed care organizations' networks. The error rates for the eight high-risk claims areas ranged from zero to a high of 65 percent. This produces an overall weighted control error rate for the high-risk claims included in our analysis of 15 percent for one organization and 22 percent for the other.

To place these problematic claims in context, we can project the errors identified in the reviewed claims to all the outlier claims in the eight high-risk groups. We estimate the overpayments were not less than \$3.9 million in 2010. Based on a 90 percent confidence interval, our best estimate is that the two managed care organizations that we reviewed overpaid their providers \$17.5 million for just these eight areas in 2010.

The payment errors were not detected by either the managed care organizations or the HCA for several reasons.

- First, the managed care organizations did not conduct claims reviews for every type of payment equally.
- Second, they did not consistently retain data from medical claims in such a way that either the HCA or an outside auditor could easily audit the data sent to the HCA's third-party actuary.
- Third, HCA did not fully exercise its contract authority to monitor or audit the managed care organizations.

We were not able to more accurately calculate the total effect of the \$17.5 million estimated overpayments in 2010 on premium rates paid because our testing of costs was done on limited sample sizes drawn only from the eight high-risk claims areas.

Our risk-based approach was designed to identify potential overpayments and does not include overpayments and underpayments that may have been found in a random test of the entire population. As a result, our estimates reflect only the potential impact to rates paid by the state and are not calculated for purposes of recovering overpayments made to providers.

We can conclude from our limited testing that for every \$1 million in net overpayments by managed care organizations to their providers in 2010, the state paid an additional \$1.26 million in premiums to all managed care organizations in fiscal year 2013, based on an estimated 695,000 Medicaid managed care members. However, because we don't know whether there were net overpayments in the entire system, we cannot conclude that 2013 premiums paid by the state were higher or lower than they should have been.

Our conclusion was based on a high-level analysis that utilized the same assumptions applied and the limited amount of information disclosed in the actuary's rate setting memo. Access to more detailed information on the actuary's

rate setting process might have yielded different results. These additional premiums continued into fiscal year 2014 and will compound due to increased enrollment so long as premium rates are based on 2010 reported costs.

What we found

Our first question was designed to determine if there are undetected overpayments in the managed care system and if so, how they affect the amount the state pays the managed care organizations for medical care provided to Washington's Medicaid clients.

To prevent overpayments from occurring, the state should effectively and efficiently manage its Medicaid managed care programs. Based on best practices identified in other states, effective and efficient management of Medicaid managed care organization programs should entail:

- Receiving timely, complete, patient-provider encounter data with cost information in a standard format from all its managed care organizations
- Receiving managed care organization medical claims and administrative costs data in an experience report or other financial reporting form
- A regular monitoring program to include reviews and validation of the above data before it goes to the state's third-party actuary
- Incorporating the data into a decision support system
- Applying analytic tools to ensure that accurate cost data is reported to the actuaries; analysis should identify duplicate payments (fee-for-service and managed care), upcoding, and other abusive claims processing practices that result in overpayments
- Assuring itself that appropriate services were delivered to properly enrolled beneficiaries by the most appropriate, licensed professionals

This is particularly important because the federal agency responsible for overseeing the states' Medicaid programs, the Centers for Medicare and Medicaid Services (CMS), does not conduct in-depth monitoring of the state's managed care programs. According to the General Accountability Office (in its publication *Medicaid Managed Care: CMS' Oversight of States' Rate Setting Needs Improvement*) (GAO-10-810 Aug. 4, 2010):

"CMS's regulations do not include standards for the type, amount, or age of the data used to set rates, and states are not required to report to CMS on the quality of the data. When reviewing states' descriptions of the data used to set rates, CMS officials focused primarily on the appropriateness of the data rather than their reliability. With limited information on data quality, CMS cannot ensure that states' managed care rates are appropriate, which places billions of federal and state dollars at risk for misspending."

This effectively means that the federal agency focuses on the appropriateness of the data (Are they reporting the right things?) rather than its reliability (Is the data they're reporting as correct as it can be?). As a consequence, states often do not verify the accuracy of the cost data sent to the actuaries for rate setting. Without sufficient policies and procedures to ensure that the administering state agency as well as the managed care organizations are verifying the accuracy of the cost data, medical expenses may be overstated.

On the other hand, federal guidance in the Medicaid Program Integrity Manual outlines the requirements for data used to pay claims. Because the HCA's contract with the managed care organizations does not explicitly set out definitions of

overpayments or incorrect payments, but only directs organizations to apply “federal, state, and local laws and guidance” when they pay claims, we applied the federal guidance in assessing whether a claim was paid incorrectly or not since federal funds are involved in supporting the state’s Medicaid program. There are no state laws and guidelines defining overpayment and incorrect payment.

In Washington, the data regarding patient-provider encounters or medical claims and cost data goes directly from the managed care organizations to the actuarial firms. Although HCA receives the patient-provider encounter data, it does not receive cost data. The HCA does not verify the accuracy of the data. This has been reported as a concern in the Statewide Single Audit Report for the last ten years. Actuaries rely on the data “as submitted” and do not attempt to verify its accuracy. In fact, Section 3.6 of Actuarial Standard of Practice (ASOP) No. 23 describes the limitation of the actuary’s responsibility. It states in part:

“The actuary is not required to do any of the following: a. determine whether data or other information supplied by others are falsified or intentionally misleading; b. develop additional data compilations solely for the purpose of searching for questionable or inconsistent data; or c. audit the data.”

Such a process exposes the state to considerable risk. Unexamined data may contain errors that allow overpaid claims and the inclusion of unallowable costs to go undetected, affecting the premium computations made by the actuary, increasing the following years’ rates. Audits conducted in other states have found such problems, but Washington has not previously conducted a comprehensive examination of improper payments in its managed care program.

A more transparent review process is shown in **Exhibit 2**, which compares the current process to a proposed process that would go much further toward ensuring the integrity of the data used to set the premium rates. One of our recommendations to the HCA is that the agency periodically review the managed care organizations’ cost and experience data, and submit the reviewed data to the actuary for rate setting. This review step would give the agency and the state greater assurance of the reasonableness of the actuary’s recommended rate.

Exhibit 2 – Current and potential future processes for reviewing data

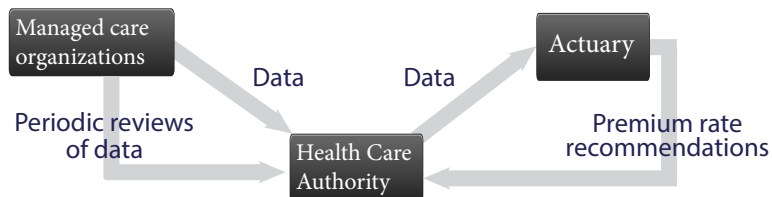
Current process

Health Care Authority does not review accuracy of data. Actuary’s rate setting is opaque, so determining the reasonableness of the premium rate is difficult.



Proposed process

Health Care Authority reviews data periodically, seeing the same data the actuary reviews. Actuary’s considerations are clear, so rate setting is more transparent.



Note: Data includes cost and encounter information.

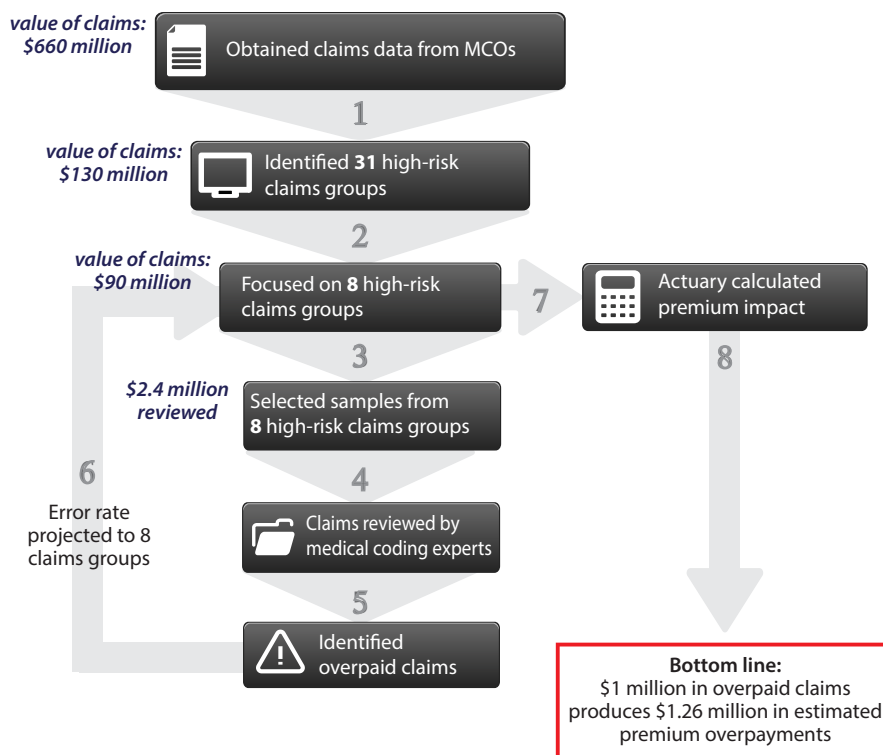
Examining high-risk claims areas allowed us to find unusual claims for closer review. Because we wanted to determine the impact of undetected overpayments on current rates, we asked the two organizations participating in the review for all 2010 calendar year claims data that was submitted to the HCA’s third-party actuary for rate setting. Rates paid in 2013 were set using 2010 data. We ran a series of computer tests to identify the high-risk claims groups that could contain potential overpayments. High-risk claims groups were identified through a risk assessment based on prior industry experience and audit results from similar reviews in other states.

Claims outside the normal range of frequency were our “outlier” claims

As shown in Exhibit 3, our initial data analysis aimed at looking for claims that were markedly different in frequency from the others in the group, falling well outside the normal range of frequency we would expect to see for that type of claim.

Exhibit 3 – Mapping the audit process

Exhibit 3 - How we audited medical claims



Note: Based on an enrollment of 695,000 members.

Our initial results included 31 groups containing potential overpayments and resulted in thousands of ‘outlier’ claims. To meet our objective of only identifying examples of overpayments, we narrowed the groups to the eight highest-risk areas, representing about \$90 million in claims, based on potential amounts overpaid and the ability to identify overpayments in the medical records. We then ran a statistical sample on each of the eight high-risk groups and selected 575 claims for detailed review. To determine if actual overpayments had occurred, we asked the managed care organizations to obtain the medical files for the 575 claims from their medical providers.

We then turned from computer analysis to human review. Our medical and bill-coding experts examined medical files for the selected claims, reviewing roughly \$2.4 million in claims that they considered potentially overpaid. Our testing of the medical claims was based solely on what was documented in the medical files.

For instance, if we could not review a physician's admission and discharge orders, either because they were not in the file or because the provider or organization did not give them to us, a one-day hospital stay was considered an error for our testing, regardless of the procedures performed. If the file contained an order to admit from the physician, we did not question whether it was medically necessary to admit the patient.

Both organizations were given the opportunity to review our preliminary findings, which were adjusted, where appropriate, to reflect additional support provided by the organizations.

This work gave us the dollar value of overpayments as well as the percentage of the claims group the errors represented. We found both organizations had made overpayments, even though they had certain types of checks in place and did some limited post-payment reviews of inpatient claims. We did find one significant underpayment in one of the high-risk claims groups, but we found far more overpayments in our review. While underpayments reduce instead of inflate the cost data, they are considered just as incorrect by the federal guidelines we applied.

Projecting the value of the eight claims groups to all outlier claims

With these values in hand, we could project the errors out to the total outlier population of the eight high-risk claims groups. We used the statistically valid methodology known as the Point Estimate to project the results over the total outlier population for each high-risk claims group. We then estimated the effect overpayments would have on premium payments.

In the subsections that follow, we will discuss the eight categories of high-risk claims in detail and what we found. The eight claims areas were (in order of total payments for the claim type):

1. 'Upcoding' diagnosis related group (DRG) codes
2. Duplicate payment on evaluation and management codes
3. Excessive billing using a certain billing modification code (Modifier 25)
4. Unbundling computerized tomography (CT or CAT) scans
5. 'Upcoding' evaluation and management codes
6. One-day inpatient stay
7. Recurring orders for controlled substance medications
8. Recurring orders for atypical antipsychotic drugs

We could now analyze the data at the claim level, the service provider level, or the member level. Generally, analyzing data at a provider level is done when the objective is to identify fraud, waste and abuse. Since our objective was to look for examples of potential overpayments across a broad range of claims, we chose to analyze the medical claims at the claim level and the pharmacy claims at the member level.

Retrieving needed data revealed inefficiencies

HCA does not require the managed care organizations to provide them a copy of the claims data submitted to the actuary. Neither organization had retained the claims data they submitted to the actuary, while the actuary's copy of the original data submissions lacked the data fields we needed for our detailed analysis. Therefore, to perform necessary audit work, we had to ask the managed care organizations to reconstruct the data files of 2010 claims. We were able to satisfy ourselves that the data was materially similar to the original files, but requiring the managed care organizations to retain the material in the first place would have been more efficient and is an essential element of an effective monitoring program.

A summary of the overall claims group numbers, payments and sample sizes for both managed care organizations studied is shown in **Exhibit 4**. It illustrates the magnitude of the claims involved in our review and the relative outlier populations associated with those claims.

Exhibit 4 - We examined medical files for 575 out of more than 646,000 'outlier' 2010 claims from both organizations, worth a total of about \$2.44 million

Dollars are rounded, in millions shown by m. Ordered by overall value of claim group

Claims group examined	Total payment for claims in this group	Total payments for outlier claims	Number of outlier claims identified	Number of outlier claims reviewed	Total payment amount of reviewed claims
'Upcoding' diagnosis related group (DRG) codes	\$239.7m	\$20.5m	3,486	105	\$1.64m
Duplicate payment of evaluation & management (E&M) codes	\$169.8m	\$11.9m	129,494	68	\$19,000
Excessive billing using Modifier 25 code	\$140.3m	\$14.6m	138,943	65	\$19,000
Unbundling CT Scans	\$132.5m	\$4.1m	7,365	66	\$118,000
'Upcoding' evaluation & management codes	\$72.9m	\$12.7m	145,669	67	\$11,000
One day inpatient stay	\$43.7m	\$10.1m	2,679	66	\$366,000
Recurring orders for controlled substance medications	\$16.5m	\$14.5m	217,115	73	\$73,000
Recurring orders for atypical antipsychotic drugs	\$2.8m	\$1.8m	2,116	65	\$196,000
Total	\$818.2m	\$90m	646,867	575	\$2.44m

The claims we identified as errors in our sample were not paid in compliance with standard medical coding practices or were not properly supported with appropriate documentation, which resulted in overpayments of claims to providers. Although the expectation for managing publicly funded programs is that errors are kept to a bare minimum, it is understandable that certain errors will occur when processing the millions of claims involved in the state's Medicaid managed care program.

In **Exhibit 5**, we see that two of the high-risk claims areas had less than five errors. However, several high-risk claims groups had a significantly higher number of errors, whether we consider only those due to missing documents or those not being properly coded before being submitted for payment. The most problematic of the high-risk claims group is the ‘Upcoding of evaluation and management codes’ group, in which 30 of the 67 claims we reviewed had errors.

Exhibit 5 – Some overpaid outlier claims were not properly coded. Others lacked either sufficient records or any records for us to evaluate the claim

The table below combines the results of both managed care organizations we reviewed. For results for each of the managed care organization, see appendices E and F.

Claims group examined	Number of outlier claims reviewed	Total errors	Causes of errors	
			Not properly coded	Insufficient or missing documents
‘Upcoding’ diagnosis related group (DRG) codes	105	2	1	1
Duplicate payment of evaluation & management codes	68	24	18	6
Excessive billing using Modifier 25 code	65	10	5	5
Unbundling CT Scans	66	7	7	0
‘Upcoding’ evaluation & management codes	67	30	21	9
One day inpatient stay	66	15	15	0
Recurring orders for controlled substance medications	73	5	0	5 ¹
Recurring orders for atypical antipsychotic drugs	65	3	2	1 ¹
Total	575	96		

Note 1. It did not appear there was any doctor shopping, pharmacy shopping, or excessive amounts of controlled substances or antipsychotics in the claims.

Errors found in medical claims have some common causes

The eight high-risk claims groups we examined fall into two main categories: claims related to medical services, including professional services and facilities, and claims for prescription drugs. Both managed care organizations in this audit have some review processes in place, but neither fully addressed potential problems in all the high-risk claims areas we looked at in detail.

At both organizations, the focus for professional services and facility claims is to make sure they were paid correctly based on information submitted by providers. For these types of claims, neither organization had a procedure to see whether all claims were billed properly in the first place based on documentation in the medical file. Neither organization monitored providers to ensure that medical files needed to substantiate claims were kept in a format suitable for audit.

CHPW has pre-payment system review controls for all claims, and manual audits of high-dollar claims. The organization is working on establishing a post-payment review process for professional services claims, but none was in place for the period we audited. CHPW conducts a post-payment review for payments to facilities, but that process only began in 2012 for the claims incurred in 2010, creating a lag in the timing of reviews. Medical records for facilities claims are only requested after an initial review of the claim if the reviewer determines that a medical-necessity review is warranted.

CHPW also audits claims processors, reviewing four percent of each processor's claims each month; they do not review medical records for these audits.

Molina uses vendors for code-editing on both professional services and facility claims, except for 'Upcoding evaluation & management.' Molina did not have any systems, edits or processes to identify and evaluate these cases. The organization also uses vendors for medical chart reviews for facility claims. They conduct post-payment reviews only on 'Diagnosis-related group (DRG)' claims and on 'One-day inpatient stays' for the fourth quarter of 2010, which left other claims groups more exposed to errors or problems.

Both organizations have prior-authorization processes in place for controlled substance and atypical antipsychotic drug prescriptions to detect misuse or excessive use.

Some specific causes for the overpayments arose in certain high-risk claims groups. For example, for the high-risk claims group 'Upcoding' diagnosis-related group (DRG) codes, CHPW placed some DRG codes on an exclusion list for 2010 claims audits, which means they were not reviewed through the organization's usual process. In a separate issue, CHPW had negotiated a special contract with the University of Washington and its affiliates in which the organization agreed it would not do a concurrent review unless the inpatient stay was greater than seven days or the member was under case management. As a result, DRG claims from these facilities were also not reviewed.

Molina conducts post payment reviews on DRG claims only. The error we found in our testing for DRG is due to insufficient or no documentation to support the charges.

For the high-risk claims group one day inpatient stay, Molina does not ordinarily conduct a post-payment review, but in the fourth quarter of 2010 Molina engaged a vendor for a post-payment review of inpatient claims specific to one-day stays. However, this review did not catch the error we identified. None of the eight one-day-stay exceptions that we noted were reviewed by this third-party vendor.

For the two high-risk claims groups involving prescription drugs – controlled substances and antipsychotic drug prescriptions – we found several claims that were inappropriately coded, or lacked sufficient documentation to support the claim or to justify the amount billed. Molina was able to provide evidence of diagnoses from medical claims to support the prescribed medication on some of their pharmacy claims. However, for the eight pharmacy claims noted as errors in the two high-risk groups tested, there was no documentation of prior authorizations to support the claims or any diagnosis from medical claims to support the prescribed medication.

Overpayments for managed care services can result in higher costs to the state

Finally, we projected the overpayment errors to the outlier populations of the related claims groups. **Exhibit 6**, below, shows the total amount actually in error and our best estimate of the projected amounts for the eight claims groups. The actual overpayments in our sample totaled \$96,860. Note that we also identified one significant underpayment of \$21,169, for a net overpayment amount of \$75,691. We estimate the extrapolated overpayments were not less than \$3.9 million in 2010.

Our best estimate, based on a 90 percent confidence interval, is that the two managed care organizations overpaid their providers \$17.5 million in 2010 for claims paid within the eight outlier populations reviewed. For more detail on our testing results, see **Appendix E** (CHPW) and **Appendix F** (Molina).

Exhibit 6 - Projected error amounts across all outlier claims in the eight high-risk claims groups for 2010

Ordered by overall value of claim group

Claims group examined	Total error amount	Minimum projected error amount across all outlier claims	Best estimate projected error amount across all outlier claims
'Upcoding' diagnosis related group (DRG) codes	(\$15,814)	(\$177,444)	(\$84,149)
Duplicate payment of evaluation & management codes	\$2,210	\$1,759,386	\$4,967,313
Excessive billing using Modifier 25 code	\$2,315	(\$699,329)	\$7,405,492
Unbundling CT Scans	\$6,740	\$17,186	\$162,667
'Upcoding' evaluation & management codes	\$1,845	\$1,634,102	\$2,477,729
One day inpatient stay	\$75,760	\$1,031,764	\$1,766,180
Recurring orders for controlled substance medications	\$1,011	\$322,979	\$718,757
Recurring orders for atypical antipsychotic drugs	\$1,624	\$13,928	\$58,730
Total	\$75,691	\$3,902,572	\$17,472,719

Note 1: Includes an overpayment of \$5,355 and an underpayment of \$21,169.

We analyzed the impact these estimated overpayments had on the computation of the premium rate paid to the organizations from July 1, 2012, through June 30, 2013. In recomputing the premium rate without the overpayments, we estimate that for the \$17.5 million of potential overpayments identified, the premium rate would have decreased by about \$2.65 per person per month. We estimated an average of 695,000 members enrolled in the state's Medicaid Healthy Options program each month for all managed care organizations, even those not enrolled with Molina or CHPW, starting July 1, 2012.

We were not able to calculate the total effect of the \$17.5 million estimated overpayments in 2010 on premium rates paid because our testing of costs was done on limited sample sizes and on only the eight high-risk claims areas. Our risk-based approach was designed to identify potential overpayments and does not include overpayments and underpayments that may have been found in a random test of the entire population.

As a result, our estimates reflect only the potential impact to rates paid by the state and are not calculated for purposes of recovering overpayments to providers. However, we can conclude based on our limited testing that for every \$1 million in net overpayments by managed care organizations to their providers in 2010, the state paid an additional \$1.26 million in premiums to all managed care organizations in fiscal year 2013 based on an estimated 695,000 Medicaid managed care members.

The estimated impact on future premiums was based on a high level analysis that utilized the same assumptions applied and the limited amount of information disclosed in the actuary's rate setting memo. Access to more detailed information on the actuary's rate setting process might have yielded different results. These additional premiums continued into fiscal year 2014 and will compound due to increased enrollment as long as premium rates are based on 2010 reported costs.

It is questionable whether the state can recover this money

HCA's contract with the managed care organizations is unclear about whether the state can recover overpayments identified as a result of an outside audit. The contract includes language in Section 13.2.3 regarding treatment of recoveries. The section states,

"Recoveries from any identified and collected overpayments resulting from Joint Contractor/HCA audit or post-payment review activities shall be split between HCA and the Contractor at a rate determined and developed by the purchaser-wide program integrity forum."

It is not appropriate for this audit to consider how or whether the state can recover the estimated amount of overpayments we determined as a result of our work due to the limited sample sizes used during our testing.

However, the results of our testing show the likelihood of significant errors and indicate that more comprehensive testing, implemented as part of a comprehensive monitoring program, is likely to be worth the investment of future resources needed to determine accurate medical claims costs and to pursue potential overpayments. The HCA should implement a comprehensive monitoring program and pursue this comprehensive testing and determine to what extent this provision of the contract would apply to recovering overpayments identified in the future.

Our review of other states' practices shows it is possible to offset the cost of program monitoring

Some states have established regular revenue and cost reporting systems that enable them to conduct regular monitoring of organization financial results, so that subsequent recoveries are included in the revenue and cost reporting for the period received. These additional recoveries are then factored into the calculation of subsequent premium rates or recovered under an experience rebate system.

We saw that states can more than offset the additional expense of closely monitoring the costs incurred by the managed care organizations with the estimated overpayments identified if they have a strict, enforceable process for recovering these overpayments. See **Appendix D** for a review of states with such systems in place.

Question 2: Recoveries and administrative costs

Are policies and procedures in place to ensure costs reported by the managed care organizations to the third-party actuary:

- *Offset recoveries, rebates and refunds against medical costs*
- *Include only allowable administrative expenses and allocate costs on a reasonable basis*
- *Report costs related to subcontractors properly*

Answer in brief

When we examined medical expense recoveries and administrative costs in the Experience Reports sent to the actuary, we found that the two managed care organizations' policies and procedures were generally adequate to ensure administrative costs were allowable and accurately reported, and that recovery transactions were properly recorded to offset medical claim costs prior to reporting those costs to the actuary, which was due March 7, 2011. However, there was no mechanism for updating any information provided to the actuary for additional claims payment or recoveries occurring after the reporting date. We identified the following areas for improvement:

1. Because one of the managed care organization's subcontractors was unable to provide certain needed documentation, we could not determine the amount of recorded medical expenses that was misclassified and should have been reported as administrative expenses.
2. One of the organizations did not offset its costs by \$1.1 million for third-party recoveries on claims paid in 2010 because the recoveries were received and recorded after the reporting cutoff date to the actuary.
3. Because of a lack of guidance from the HCA, the two managed care organizations applied different methods for reporting pharmacy rebates.
4. Both of the organizations had a high error rate of unallowable administrative expenses, totaling about \$395,000 in our sample of expenses reviewed.
5. Because of a lack of guidance from the HCA, the organizations defined allowable administrative and medical expenses differently. This could impact their compliance with the Medical Loss Ratio provision in their contracts with the HCA.
6. The HCA cannot determine whether its actuary calculated the premium rate using actual capitated payments one of the managed care organizations paid to its subcontracted providers or higher fee-for-service equivalent amounts reported for the services provided.
The actual capitated payments were \$3.3 million less than the fee-for-service equivalents.
7. The HCA does not have a monitoring program in place to review and assess the allowability of expenses and the proper application of recoveries incurred by the managed care organizations.

See **Appendices E and F** for more information about the expense categories selected at each company and our testing methods.

The HCA's third-party actuary told us that it does not use the administrative cost data reported by the organizations to calculate the portion of the premium rate that applies to administrative expenses. Instead, the actuary uses national averages to set a rate of 13.5 percent of the premium to cover allowable administrative costs, premium tax and risk margin. It is a common practice among insurance actuaries to use national averages, which are not based on audited cost data, to compute premium rates.

Does that mean errors in administrative costs do not matter? We believe that while use of national averages to set administrative expense rates may be common practice, the HCA would benefit from periodically analyzing actual administrative cost data reported by managed care organizations to ensure that it is accurate and reimbursement rates are reasonable. This would ensure that using national average administrative cost reimbursement rates is the right approach for Washington.

What we found

To address the second question in this audit, we reviewed other aspects of the managed care organizations' businesses for transactions that – if incorrectly calculated or reported – could affect the premium rate calculations performed by the actuary. The topics we reviewed fell into these categories:

- **Recoveries** Money received from overpaid providers, liable third parties, and reinsurance companies are offset against claims costs.
- **Rebates** Off-setting money spent for patient drugs with rebates received from drug manufacturers.
- **Administrative expenses** Correctly identifying and coding administrative expenses so they do not inflate reported amounts for medical expenses and ensuring those expenses are allowable under federal cost principals; administrative services from parent companies are appropriately charged to the managed care organizations at cost.
- **Payments to related parties** Appropriate payment levels for providers or companies affiliated in some way with the managed care organization.
- **Medical expense classification** Correctly coding medical and administrative cost components of subcontracted work to ensure the medical expense ratio is accurate.
- **Cost reporting to the actuary** Costs for the managed care organizations' capitated providers are accurately reported to the actuary, and actual costs incurred are used when calculating the premium rate.

The ability to identify and reclaim money or correctly account for medical and administrative expenses is important. HCA's contracts with the organizations require it; such accounting requirements are often put in place by state or federal regulations. (See **Appendix C** for a full list of statutes and regulations that apply to the issues in this section.) If a managed care organization does not report net medical expenses accurately, the premium rate could be set higher than it would have been had the correct amounts been reported, subsequently raising the overall cost to the state for the Healthy Options program.

In addition, if the HCA does not review and monitor the financial information of its contracted managed care organizations, the agency cannot determine whether they are making excessive profit or are having financial performance problems. Nor can it compare the organizations to see how efficiently they are run, which might allow the agency to identify best practices that could be shared with other contractors.

We consistently saw that the HCA's contracts do not currently require the kind of reporting or oversight that would truly enable it to evaluate its contractors on these aspects of the managed care program. We recommend the agency revise its contracts with managed care organizations as well as update its formal monitoring processes to include requirements for data collection, reporting and retention by the organizations. (See **Appendix D** for best practices the HCA could explore.)

For most cases reviewed in this section, the managed care organizations sent us their program policies or described their procedures so we could examine them, and gave us the documentation we needed to review so we could understand how the policies were applied. In many instances, the procedures served them well, allowing the organizations to recover money due to them from providers or others. While we examined only the two largest managed care organizations, all other managed care organizations that work with the HCA should apply the recommendations discussed in this report to ensure they have effective policies and procedures to properly manage their contract responsibilities.

Recovering overpayments from providers

It can be reasonably expected that even well-run managed care organizations will inadvertently overpay providers for services from time to time. To accurately report net medical costs, the organizations must be able to identify and recover overpayments from providers but also offset these overpayment collections against corresponding medical expenses.

Federal and state requirements instruct the managed care organizations to identify and recover funds that were paid in excess of amounts due and payable under statute and regulations. These recovered funds are to be offset against the claims costs to which they apply.

Both organizations had similar policies. Generally, an overpayment is identified and, if required, a letter is sent to the provider requesting the refund. By law in Washington, the provider can dispute the amount in question, ignore the refund request, or send in a payment. If the refund is disputed, a process is started to resolve the dispute. However, if the request is ignored, an automatic adjustment is made to the claim to recover the overpayment. Recoveries are applied directly to the claims in question or netted against future payments in certain circumstances.

To see if the process worked as the policy said it would, we requested all overpayment recoveries received for claims paid in 2010 and reviewed a non-statistical sample of 25 recovery claims from each organization. By tracing the refunds to the screenshots in the claims processing system for the medical expenses, we could test whether the recovered money was appropriately applied to the original claim.

We found that both organizations had recovered overpayments from providers, and that the recovered money had been appropriately applied to the original claim. For claims paid in 2010, CHPW recovered about \$14 million from providers and Molina recovered about \$32 million.

We also reviewed the contract and interviewed staff at the HCA to determine what the organizations are required to report and what procedures, if any, HCA performs to monitor the identification and recovery of overpayments.

As we found in other instances in this part of our review, the contract did not address the reporting of overpayments nor does it require regular reporting of overpayments identified to the HCA. The HCA does not have a monitoring

program in place to review and ensure claims expenses were appropriately reduced by the amount of recoveries received. In addition, there is no alternative provision in the contract to ensure the state shares in these recoveries.

Recovering money from liable third parties

In some cases, a third party other than Medicaid and the patient has a legal obligation to pay expenses for medical services provided under a state plan. According to HCA, clients with known primary third party insurance are automatically exempt from enrollment in managed care. However, these liable third parties are not always identified at the time of enrollment. Therefore, the managed care organizations must identify and pursue recoveries from these parties.

Some examples of third parties that may be liable to pay for services are group health plans, a liability insurer, and workers' compensation plans. By law, third parties must meet their obligation before Medicaid pays for medical expenses, but third-party liability is sometimes not recognized and fulfilled until after Medicaid has paid for the services. Recovering these funds, by or on behalf of the state, reduces the medical costs incurred by the Medicaid program for that member.

HCA's contract delegates responsibility for pursuing third-party recoveries to the managed care organizations, which must be able to identify and offset them against corresponding medical expenses. If the offsets are not properly done, medical expenses reported to the actuary will be overstated. It is important to recognize that not all funds are recovered in the year the original bill was paid by Medicaid. Actuaries generally account for subsequent recoveries but the amounts are estimated.

The current contract does not address how organizations should report third-party liability recoveries to HCA, nor does it state how the organizations should report money recovered after costs have been reported to the state actuary for a given year. In effect, neither the actuary nor the HCA knows the actual amounts recovered subsequent to the reporting of information to the actuary, which could result in the over- or under-reporting of medical costs depending on how actual recoveries compare to the estimates.

Both managed care organizations had policies and processes for identifying and recording third-party liability, and both used outside vendors to identify and recover claims. Both also outlined the steps the organizations must take to account for recoveries and apply them to the original claims. To see if the process worked as the policies said it would, we asked the organizations to give us a list of all 2010 third-party recoveries so we could select a judgmental sample to examine in detail.

Molina was able to give us both the list and the sample data we asked for. The organization recovered \$1.1 million for third-party liabilities that year, and we found that all 25 original claims in the sample were adjusted properly.

Our ability to examine how CHPW managed third-party recoveries in 2010 was hampered by two things: changes the organization made to its processing system that year, and how recovered funds are apportioned between CHPW and its parent company, Community Health Network of Washington.

Following the 2010 change to the processing system, both CHPW and its third-party collections vendors pursued some of the same claims, with duplicated recoveries. Recoveries related to this period – totaling about \$1.1 million – were not recorded until 2011, 2012 and 2013, because staff were uncertain about how

to report them. Recoveries related to some members are recorded at the parent company level and some are recorded at the plan level. Further complicating the reporting, CHPW received most of the recoveries we reviewed after it had submitted its experience report to the HCA's third-party actuary.

CHPW told us that the question about how to allocate these recoveries was resolved in 2011, 2012 and 2013, and recorded to the appropriate entity. CHPW indicated the Network recorded about \$19,000 and CHPW recorded about \$1.1 million in 2010 recoveries received in subsequent years. This means that the total costs of the related claims reported to the actuary to be included in the rate setting process for 2010 were overstated by about \$1.1 million. Obtaining the breakout of the recoveries between the Network and CHPW took repeated requests and is based on what CHPW told us. For more detail about the relationship of CHPW, its parent company, and the exact distribution of recoveries between the two entities, please see Appendix E.

The system conversion in 2010 restricted CHPW's ability to accurately identify and account for recoveries for that year. Because it lacked a formal process to account for recoveries accurately and timely at CHPW's level, the organization could not provide the breakdown of recoveries allocated to CHPW and the Network in a timely manner.

Actuaries generally account for subsequent recoveries but the amounts are estimated. Since the organizations are not required to report these subsequent recoveries on a regular basis, neither the actuary nor the HCA knows the actual amounts recovered.

Some states have established regular revenue and cost reporting systems that enable them to conduct regular monitoring of organization financial results, so that subsequent recoveries are included in the revenue and cost reporting for the period received. These additional recoveries are then factored into the calculation of subsequent premium rates or recovered under an experience rebate system.

Recovering money from reinsurance companies

Reinsurance, or secondary insurance, can be described as insurance for insurance companies. Much like insurance for individuals, the purpose of reinsurance is to protect insurance companies such as managed care organizations against unforeseen or extraordinary claims that exceed their resources. Examples of the most costly claims can include treatment for organ transplants, treating patients with hemophilia who need expensive blood clotting drugs, and treating babies in neonatal intensive care units. The managed care organization typically pays a reinsurer a monthly fee for any covered members. In exchange, the reinsurer will reimburse the insured managed care organization for all individual members' accumulated annual medical expenses that exceed an agreed-upon dollar amount, thus limiting the organization's risk.

While the managed care organizations remain ultimately liable to the HCA for providing services to members, the contract allows them to obtain reinsurance. To accurately report net expenses as required by the contract, organizations that choose to obtain reinsurance must be able to identify reinsurance recoveries and offset them against corresponding medical expenses. The contract does not specifically address the reporting of reinsurance recoveries – and the requirements of the HCA's third-party actuary regarding how to report recoveries that take place outside the reporting period.

We found that Molina does not have formal policies related to reinsurance recoveries; but was able to give us a written description of their process. The organization did not receive any money from general reinsurance recoveries in 2010; we verified this by searching that year's claims data and we did not find any members that met the reinsurance deductible thresholds for 2010.

CHPW was able to give us a copy of company policies that addressed reinsurance claims processing and how to account for paid and unpaid reinsurance recoverable amounts, offsetting them against medical expenses. The organization also has in place arrangements with some providers to share recoveries.

In 2010, CHPW received a total of about \$3.9 million in general recoveries for its two main programs. We verified these were reported in the Experience Report. When we examined a sample of 25 recoveries and traced the amounts to bank statements to ensure the recoveries were accurately reported, we found that the recoveries agreed without exception.

Rebates from drug manufacturers

Pharmacy expenses – prescriptions for patients, drugs used in treatments or procedures, etc. – are a significant factor in the overall rising cost of health care in the United States. Prices for brand-name drugs have risen faster than inflation since 2002. Overall national Medicaid spending for prescription drugs in 2009 was roughly \$26 billion. However, the federal government has required drug manufacturers to enter into rebate agreements that reduce the net cost to the Medicaid program, and thus to the states that are partners in Medicaid – see the note in the sidebar at right about the Medicaid Drug Rebate Program.

Correctly reporting pharmacy expenses on the part of the managed care organizations is important for three reasons:

1. Reporting accurate data to the actuary prevents improper increases in future premium rates.
2. Correctly stating drug expenses helps ensure accurate calculation of medical loss ratios.
3. Correctly reporting pharmacy utilization data ensures both the state and federal governments receive the right rebate amounts they are owed from drug manufacturers.

We found that both managed care organizations in our review have processes in place to identify pharmacy rebates and appropriately offset those rebates against medical expenses. CHPW had formal policies and procedures; Molina was able to describe their procedures to us. Generally, rebates are negotiated between the pharmacy benefit manager and drug manufacturing companies; amounts are rebated to the managed care organizations on a lag basis since they are usually a per-prescription amount. CHPW reported rebates of about \$2 million and Molina reported about \$1.7 million, and we were able to trace these amounts to the general ledgers with immaterial variances.

However, in the process we learned that their methods for reporting their pharmacy rebates on the Experience Report are different. CHPW reports on a cash basis, while Molina estimates the amount of rebates based on the number of pharmacy claims processed and reports on an accrual basis. This creates inconsistencies in the data between organizations, which in turn affects HCA's ability to compare them to gauge efficiencies and performance.

The Medicaid Drug Rebate Program is a federal policy that requires drug manufacturers to sign agreements and pay rebates each time a manufacturer's drug is dispensed to Medicaid patients. The rebates are collected by the states and shared between the State and Federal government.

It didn't apply to managed care organizations that provide Medicaid pharmacy services until March 23, 2010. Before then, organizations were 'expected' to reduce or offset reported medical expenses to account for these savings.

Following the expansion of the Medicaid Drug Rebate Program on March 23, 2010, states now bill drug manufacturers directly for pharmacy rebates based on utilization data reported by the managed care organization. This means organizations must have policies and procedures to make sure they provide accurate pharmacy utilization data to the state.

See Appendix C for the laws that apply to the Medicaid Drug Rebate Program before and after March 2010.

When we reviewed the contract and interviewed HCA management to determine what reporting is required and if guidance is provided for calculating and reporting pharmacy rebates, we found that the contract does not require regular reporting of pharmacy rebates to the HCA. The lack of monitoring increases the risk of reporting errors going undetected.

Administrative expenses

Every organization requires administrative departments, such as information technology, claims processing, and legal affairs. Managed care organizations that serve numerous states or programs often find it more efficient to centralize common functions at a corporate level and allocate those indirect expenses to states and programs based on various methods such as the amount of revenue generated by each, payroll dollars, or square footage of office space devoted to each program.

Because states want to maximize the dollars spent on medical care and limit the dollars spent on an organization's administrative expenses, several states have provided specific guidance on which administrative costs can and cannot be included as a cost in the Medicaid program. Among those often specifically excluded are lobbying costs, excessive corporate officer bonuses, and expenditures on alcoholic beverages. The guidance provided for allowable costs is generally referred to as "cost principles."

In Washington, the administrative costs reported for all services to the HCA's third-party actuary by the two managed care organizations we reviewed totaled about \$141.4 million in 2010. Within the total are dozens of expense categories, representing costs that were included in the company's Experience Report.

To understand the nature of administrative expense and any allocations, we interviewed each organization's personnel and reviewed descriptions of the administrative expense process. We wanted to determine if the administrative expenses of the managed care organizations were allowed, and properly allocated among the business units if a related company was involved. In general, allocations are made based on the amount of revenue generated by each line of business. We selected for review high-risk expense categories totaling roughly \$13.2 million, and in our sample found about \$395,000, in unallowable expenses reported, and so potentially affecting the premium rate set by the actuary.

Twelve percent of the 50 administrative expenses we examined at CHPW and 8 percent of the 75 examined at Molina included errors. While the actual dollar amount of errors we found was relatively minor compared to the millions of dollars at risk and the selection of transactions to review was risked-based, if those error rates appeared in all the expense categories, or the dollar value of the errors were higher, the amount of unallowable administrative expenses included in the Experience Report could be significant.

It is important to periodically review the organizations' spending on administrative functions for two reasons:

- To ensure that the amounts are relevant and allowable in the Experience Report
- To ensure that the allocation of costs among different clients or lines of business is reasonable, does not recover more than the actual cost of the services, and does not allocate costs disproportionately.

The actuary does not review administrative costs for accuracy or improper payments when calculating the portion of the premium rate that applies to administrative expenses. Instead, the actuary uses national averages to set a rate of 13.5 percent of the premium to cover allowable administrative costs, premium tax and risk margin. To assure the state that the rate being applied to Washington is appropriate, the administrative expenses applied to the administrative cost percentage rate should be reviewed and verified. Otherwise, the risk exists that actual allowable administrative costs could be substantially lower than the national average, in which case the resulting capitated rate would be overstated, or the actual costs could be higher in Washington than the national average, in which case the capitated rate may be understated.

HCA's Healthy Options contract does not have any specific instructions regarding which administrative expenses are allowable, but simply directs managed care organizations to comply with all applicable federal, state, and local laws and regulations. For the purposes of our study, we used federal guidance, which applies because the organizations receive federal funds through the Medicaid program and because there was no other guidance. Nor does the current contract require a monitoring program, and so the HCA does not review what the managed care organizations report to the HCA's third-party actuary.

Payments to related parties

The business relationships of managed care organizations can be complex. A managed care organization might be owned or controlled by another corporation, or may itself own or control other companies. They might subcontract with their own affiliated businesses to provide Medicaid services to members, for example, contracting with affiliated hospitals to provide inpatient care.

Given that related-party transactions are not governed by arms-length negotiations of price, it is always possible that unreasonable profit components might be included in these transactions, resulting in overstated costs. Since a profit component is already factored into the premium rates calculated by the state's actuary, the risk to HCA is that managed care organizations could be generating multiple layers of profits through including additional profit components in related-party transaction costs.

HCA's contract does require managed care organizations to report ownership and control of related parties, but does not explicitly define an allowable profit component between the organizations and their affiliated parties for medical expenses. However, federal guidelines require that they pay affiliates no more than they would pay unrelated third parties for the same medical services and that related party costs for administrative services be limited to cost or market price.

Both organizations we reviewed are fairly complex, with parent companies, wholly or partially owned subsidiaries, and an assortment of subcontracted health care providers. We examined their management structure (both organizations provided a detailed explanation of their relationships) and their medical expense pricing agreements (by reviewing contracts to see if pricing for related and non-related providers was the same or reviewing contracts for similar services between similar organizations). We also reviewed how Molina's parent company allocated administrative costs to ensure the allocation was reasonable.

We found that the payments they made to related party companies did not contain profit in excess of what would be paid to an unrelated provider. We also found that the amount of administrative expenses allocated by Molina's parent company was reasonable and limited to cost.

Reporting administrative costs in subcontract arrangements

The ratio of a company's total medical costs to total revenue is known as the medical loss ratio (MLR). Typically, federal contracts with insurance companies require that at least 80 percent to 85 percent of total premium revenue must be spent providing medical services to the plan's members. In the case of HCA's contracts with managed care organizations in Washington, the organizations must spend a minimum of 80 percent of premium revenue on medical services; if they do not meet this requirement, they must pay a financial penalty to the HCA.

Managed care organizations must correctly categorize medical and administrative expenses, both to manage their businesses and to ensure they accurately report their medical expenses to the actuary. Spending too little on medical services to the Medicaid patients being served by the plan could reduce the quality of care provided to those patients; overstating cost data to the actuary could lead to improper increases in future premium rates paid to them in the future. There is a further temptation to report an inaccurate medical loss ratio calculation: doing so might help an organization avoid financial penalties imposed under the contract for not complying with their MLR requirement.

Establishing specific guidance and recording it in contractual language is important. We found that the HCA contract requires the managed care organizations to include clear descriptions of any administrative functions they delegate to a subcontractor; it provides examples of administrative expenses: utilization/medical management, claims processing, member grievances and appeals. However, the contract does not require the organizations' subcontracts to break out the cost of services between administrative and medical services.

Both managed care organizations had policies and procedures for dealing with subcontractors. Generally, subcontractors or vendors must demonstrate they have the systems and procedures in place to carry out the delegated task before any contract is signed; they agree that the organizations will monitor their vendors to ensure compliance with the contract terms. However, neither organization's policies said how the expenses associated with a subcontractor's work should be reported in the Experience Report.

To verify that the organizations were reporting subcontractor expenses appropriately, including correctly categorizing medical and administrative expenses, we asked both organizations for a list of the subcontractors who provide services for them. We reviewed the contracts of five of the seven subcontractors working with CHPW, and the one subcontractor reported by Molina, to understand the services provided and see how well they complied with the requirements of the HCA's contract that subcontracts contain clear descriptions of administrative functions.

We found that the CHPW was reporting the subcontractor expenses appropriately according to the HCA contract and federal guidance for commercial insurance carriers.

Molina reported the total cost of its subcontractor expenses as a medical expense, even though the subcontractor also provided administrative services. Its subcontract did not contain clear descriptions of administrative functions. The total amount paid to the subcontractor for all services in 2010 was about \$3.8 million; the lack of definitions meant that we were unable to estimate the portion of these expenses related to the administrative services. However, Molina believes that it has complied with the terms of the HCA contract and does not believe the federal guidance was applicable.

The lack of clear guidance regarding the definition of medical and administrative expenses results in a lack of accuracy and consistency in how expenses are reported between the two managed care organizations we reviewed. One reported the administrative cost components of subcontracted arrangements properly as administrative costs on the Experience Report. The other reported total expenses as medical expenses even though a portion of the services the subcontractor provides are administrative in nature.

Washington's contract with managed care organizations could benefit from national guidance on cost principles used to calculate medical loss ratios

The Patient Protection and Affordable Care Act (PPACA) established consistent medical loss ratios for non-Medicaid and Medicare health insurers, and gave insurers guidance on how to calculate them. This is important because without guidance and standards, insurance carriers categorized expenses differently.

For example, insurance companies often decide to offer members a phone line, staffed by a nurse, which they can call for advice. The service could be categorized as either medical or administrative, depending on the level of information provided. If one company reports the cost as a medical expense and another as an administrative expense, the one that reports the cost as medical will have a more favorable medical loss ratio. If a nurse line has both an administrative and a medical component, the expenses should be separated so they can be reported accurately.

Similarly, if a managed care organization delegates through subcontracting some of its medical care and administrative services, such as claims processing, and charges the entire cost to medical care without allocating the expenses between the medical and administrative components of the expense, it is effectively overstating its medical cost and understating its administrative cost for the medical loss ratio calculation.

Such expenses should be reported and reviewed against the same standards whether the insurer provides the service directly or hires a subcontractor to do the work. The requirement also applies to more obviously administrative tasks, such as claims processing.

Many states, including Washington, usually include a medical loss ratio limit in their contracts with managed care organizations. However, HCA's contract does not define or provide guidance as to what should be categorized as medical expenses and what should be categorized as administrative expenses. As we have done in other parts of our review, where there was no specific language in the contract, we relied on federal guidance, as the HCA contract instructs the managed care organizations to comply with federal, state and local laws and guidance.

The National Association of Insurance Carriers (NAIC) provides national guidance for defining medical and administrative costs, and was adopted by the federal Department of Health and Human Services for use in the Medicare program. Short of creating guidance specific to Washington, the HCA would benefit from using these guidelines.

We were not able to determine the amount of administrative costs that were improperly recorded as medical expenses. Therefore, we were also not able to determine the impact this had on the MLR calculation and contract requirements for an 80 percent minimum MLR. Without regular monitoring, managed care organizations could report amounts inconsistently or inaccurately. Such inconsistencies in the data between them lessen HCA's ability to compare them to each other to gauge efficiencies and performance.

Improving transparency in the actuarial rate-setting process could help HCA review and control costs

The HCA's third-party actuary fills a pivotal role in translating the information submitted by the managed care organizations in their Experience Reports into premium rates for the coming years. The HCA does not obtain from either the organizations or the actuary the claims cost data that the actuary considers in calculating the rate. The result is that the process is to a large degree opaque. The state relies on the actuary to do what it says it does: take all submitted data and reports into account and set the rate fairly.

While reviewing the detailed claims data received from CHPW, we noticed services provided by subcapitated providers had attached to them a specific paid amount, similar to the way they note costs for fee-for-service providers, which were higher than the premiums actually paid to these providers. Because the actuary uses detailed cost information when calculating premium rates, we were concerned that the costs reflected in the data did not represent the true costs incurred by CHPW since the organization already pays set monthly premiums to these capitated providers. If the actuary used the detailed cost information in its calculations, premium rates could be overstated.

To determine if the costs reported to the actuary for subcapitated providers were indeed overstated, we compared the amount of premium payments made to CHPW's subcapitated providers to the amount of the claims encounter data provided to the actuary. We found that it paid less for claims expenses by entering into capitation agreements with providers than it would have paid without the agreements. Consequently, by reporting a fee-for-service amount for capitated claims, the cost of services was overstated by about \$3.34 million in the detailed cost data provided to the actuary. In its Experience Report, CHPW also gave the actuary the total annual amount it paid to their subcapitated providers.

In our discussions with the actuary, they said that both amounts are taken into consideration when determining rates. However, because they do not retain the data used in an accessible format, they were unable to give us any calculations or documentation that would show how these different numbers were factored into the calculations. There is no specific requirement for HCA to obtain information that the actuary considered in the calculation of premium rates. As a result, we are not able to determine if the true cost of these services to the organization was properly taken into account in calculating the premium rates. If the higher fee for service amounts that were reported were used in the calculation, the rate may have been overstated.

Recommendations

The Health Care Authority should improve its oversight of managed care organizations to ensure appropriate controls are in place to prevent and detect medical and administrative cost overpayments from inflating the premium rates paid to managed care organizations. This audit offers a number of recommendations to help improve accountability under this program.

Creating and implementing a comprehensive monitoring and management process of the Medicaid managed care program is a complicated process that will require additional resources and costs. Many states have chosen to contract with outside firms to provide those resources, provide technical expertise, and assist them in designing and implementing an effective program. The cost of this additional oversight can be offset by an effective mechanism to recover overpayments identified from the managed care organizations. Also, additional federal funds can be obtained to help cover a portion of the administrative costs for oversight of the program.

In taking the steps to implement such a program, the state should prioritize its focus on those specific recommendations below that address the following areas:

Step 1: Creating a comprehensive reporting system to obtain complete data on a timely basis

Step 2: Implement a regular program of auditing the data obtained to ensure accuracy and allowability

Step 3: Clarify contract language and requirements to provide clear guidance and criteria to the managed care organizations and agency in monitoring performance under the managed care contract especially in the areas of recovery of overpayments and definitions for allowable costs.

We recommend the HCA:

1. Create and implement a comprehensive revenue, cost reporting and monitoring system to enhance accountability and ensure the managed care organizations comply with contract provisions. This should include requiring the managed care organizations to report detailed claims and administrative cost data to the HCA in a prescribed format on a periodic basis, and reviewing the profitability of the organizations with respect to the Washington State Medicaid program. Best practices that could be followed to create a comprehensive monitoring program have been provided in Appendix D as guidance. Instructions for the regular reporting should include guidance on how to handle recoveries that apply to claims that were paid in a prior period.
2. Conduct regular audits according to a routine, ongoing schedule to ensure compliance with respect to appropriate medical costs, allowable administrative costs, cost recoveries and compliance with specific contract performance requirements.
3. Establish clear criteria, specific to Washington, to define cost principles in determining allowable expenses.

4. Provide specific guidance for the Medical Loss Ratio calculation, including the definition of medical and administrative costs.
Using the National Association of Insurance Commissioners' recommendations would make the guidance consistent with commercial insurance industry practices and give the organizations clear instruction to perform the calculation on a consistent, comparable basis.
5. Create procedures and instructions for the organizations that address recording and reporting costs incurred and recoveries realized, including those following the date of submission of the Experience Reports to the HCA's third-party actuary.
6. Establish clear, specific, cost reporting guidance for the organizations that addresses the timing of reporting pharmacy rebates to ensure they all calculate and report pharmacy rebates consistently.
7. Establish a specific schedule for the timing of rate re-determinations.
8. Work with the actuary to require transparency and support in the rate setting process. We have included an example of actuarial review as a best practice for establishing a comprehensive monitoring program in Appendix D.
9. Require the actuary to give the HCA information used to calculate the capitation rate, including how subcapitation payments and related fee-for-service equivalents were taken into account in the rate setting process. By making this process more transparent, the state could monitor the development of premium rates and ensure these special pricing arrangements are properly considered in the rate setting process.

We also recommend the HCA ensure that the managed care organizations:

10. Review system edit checks and post-payment procedures to ensure claims are reviewed in sufficient detail to identify miscoding and other causes of overpayments. The contract should require that the managed care organizations use edits such as those of the National Correct Coding Initiative (NCCI).
11. Retain a copy of the data file that is sent to the third-party actuary, with sufficiently detailed data fields to allow audit of the data.
12. Strengthen their review process to determine if administrative expenses are allowable and properly allocated.
13. Create formal documented policies and procedures for the calculation and reporting of pharmacy rebates and reinsurance recoveries that comply with instructions provided by the HCA's third-party actuary.
14. Structure contracts with delegated entities to ensure medical and administrative costs are clearly defined and distinguishable.
15. Are transparent in the treatment of claims and recoveries involving CHPW and the Network. These transactions should be recorded accurately and timely and appropriate documentation should be available for review by HCA when requested.

We further recommend the Health Care Authority update its contract language with the managed care organizations to:

16. Address these recommendations.
17. Allow the state to recover overpayments identified in state and other audits.

Agency Response



STATE OF WASHINGTON

April 8, 2014

The Honorable Troy Kelley
Washington State Auditor
P.O. Box 40021
Olympia, WA 98504-0021

Dear Auditor Kelley:

Thank you for the opportunity to review and respond to the State Auditor's Office (SAO) performance audit of the Health Care Authority's (HCA) oversight of the Medicaid Managed Care program. We appreciate the efforts of the audit team and believe that implementation of its recommendations will strengthen managed care financial and program integrity oversight, as well as increase overall effectiveness in our stewardship of Medicaid funds.

HCA appreciates the SAO's analysis and thoughtful recommendations. While the agency concurs with recommendations regarding the value of, and the need for, increased managed care oversight, we continue to question the validity of the projected calculation of \$17.5 million in estimated overpayments as the basis for those recommendations.

HCA has begun implementing some of the recommendations contained in this report, but a number of them represent a significant undertaking that will take a few years to complete. An important component of the process is putting in place the structure and staffing necessary to move from a Medicaid fee-for-service organization to a purchaser of health care through a managed care framework. As a part of that effort, HCA is working to redirect staff resources to managed care monitoring, data analytics and contract oversight.

The performance audit reviewed HCA and Managed Care Organization (MCO) processes in place during state fiscal year 2010. Since that time, HCA has implemented a number of significant organizational improvements and MCO contract changes to reinforce the oversight function. Improvements already implemented or in progress include:

- ✓ HCA established an Encounter Data Quality Control Unit in the fall of 2013. The unit is responsible for collecting and validating encounter data from plans, and developing processes that utilize the data for quality monitoring, rate setting, and other critical analytic and strategic purposes. Accurate encounter data strengthens the agency's ability to measure and oversee managed care plan quality, utilization, finances, and contract compliance.
- ✓ HCA is in the process of transitioning the base data source to encounter data based on the principle that the best source of data for actuarial analysis is encounter data submitted by MCOs. This will ensure that HCA has access to, and understands, the data on which rates are based. It will also provide an additional incentive for MCOs to submit complete and accurate encounter data to HCA. MCOs have responded to the change by increasing their focus on the quality and completeness of the encounter data submitted.

- ✓ The 2014 MCO contract incorporated explicit financial penalties for failing to submit timely and accurate claims/encounter data. HCA is implementing a reconciliation process to validate submitted encounter data against MCO cost reports. The contract also includes provisions to return funds withheld from monthly capitation payments if MCOs can adequately reconcile encounter data submissions to the cost reports.
- ✓ HCA began a Managed Care Program Integrity Initiative in the spring of 2012 to examine strategies to refocus program integrity and accountability efforts from fee-for-service to managed care. Initial efforts examined the quality of encounter data and led to establishing the HCA Encounter Data Quality Unit discussed above. The Initiative is now focused on the use of encounter data analytics to identify patterns of fraud, waste and abuse, and to ensure adequate utilization of services.
- ✓ HCA is strengthening its quality and monitoring activities. HCA conducts an annual monitoring review of each MCO with additional scrutiny on enrollee grievances, care coordination activities, and program integrity activities. The agency also contracts with an External Quality Review Organization to provide a federally required annual external review of the quality, access and timeliness of care.

We recognize and fully support the need for adequate MCO monitoring and oversight. HCA believes the progress we have already made will serve us well in planning and implementing the recommendations included in this performance audit report.

Thank you for the opportunity to respond to the draft audit report and to highlight our continued commitment to further enhance the oversight of the Medicaid Managed Care program. We appreciate the efforts of your staff in conducting the audit and engaging HCA early on its draft findings.

Sincerely,



Dorothy F. Teeter, MHA
Director
Health Care Authority



David Schumacher
Director
Office of Financial Management

cc: Joby Shimomura, Chief of Staff, Office of the Governor
Kelly Wicker, Deputy Chief of Staff, Office of the Governor
Ted Sturdevant, Executive Director for Legislative Affairs, Office of the Governor
Tracy Guerin, Deputy Director, Office of Financial Management
Wendy Korthuis-Smith, Director, Results Washington, Office of the Governor
Tammy Firkins, Performance Audit Liaison, Results Washington, Office of the Governor
MaryAnne Lindeblad, Medicaid Director, Health Care Authority
Thuy Hua-Ly, Chief Financial Officer, Health Care Authority
Cathie Ott, Division Director, Program and Payment Integrity, Health Care Authority

This coordinated management response to the State Auditor's Office (SAO) performance audit report received March 12, 2014, is provided by the Washington State Health Care Authority (HCA) and the Office of Financial Management (OFM).

SAO Performance Audit Objectives:

Are managed care organizations overpaying for medical expenses? If so, why did they go undetected and how do the overpayments affect premium rates?

1. Are policies and procedures in place to ensure costs reported by managed care organizations to the third-party actuary:
 - Offset recoveries, rebates and refunds against medical costs;
 - Include only allowable administrative expenses and allocate costs on a reasonable basis; and
 - Report costs related to subcontractors properly?
-

SAO Issue 1: Inadequate oversight and data analysis led to overpayments.

SAO Issue 2: Undetected overpayments in 2010 resulted in potentially higher premium costs in 2013.

SAO Issue 3: Data used to set 2013 premium rates was not verified and retained.

SAO Issue 4: Inconsistent reporting of administrative costs, recoveries and rebates.

Please note that the state grouped some of the SAO's recommendations in a different order to allow for a more concise response.

SAO Recommendation 1: Create and implement a comprehensive revenue, cost reporting and monitoring system to enhance accountability and ensure the managed care organizations comply with contract provisions. This should include requiring the managed care organizations to report detailed claims and administrative cost data to the HCA in a prescribed format on a periodic basis, and reviewing the profitability of the organizations with respect to the Washington State Medicaid program. Best practices that could be followed to create a comprehensive monitoring program have been provided in Appendix D as guidance. Instructions for the regular reporting should include guidance on how to handle recoveries that apply to claims paid in a prior period.

STATE RESPONSE: HCA concurs with the recommendation to create and implement comprehensive revenue, cost-reporting and monitoring systems, as they will further strengthen HCA's ability to effectively manage and oversee the Medicaid Managed Care Plans. The development of these systems is a significant undertaking and will take considerable time to achieve. HCA must create a new infrastructure and develop staff expertise to accomplish this task.

As a part of these strategies, HCA implemented a process in the Managed Care Organizations (MCO) contract, effective January 2014, for reconciliation of submitted encounter data with MCO cost reports. This process will measure the completeness of encounter data submission. Associated withholding provisions reinforce the need for accurate, complete and timely encounter data. The data will be used to measure and monitor managed care plan quality, evaluate audit service utilization, monitor finance and rate setting, and ensure compliance with contract requirements.

Action Steps and Time Frame

HCA has established a Managed Care Executive Oversight Committee. The Committee will analyze other states' best practices and build upon an existing draft action plan and implementation strategy for the development of monitoring systems to address the areas noted in the recommendation. This action plan and implementation strategy will identify next steps, estimated timelines and resource needs.

- Develop Action Plan and Implementation Strategy. *By December 31, 2014.*
-

SAO Recommendation 2: Conduct regular audits according to a routine, ongoing schedule to ensure compliance with respect to appropriate medical costs, allowable administrative costs, cost recoveries and compliance with specific contract performance requirements.

STATE RESPONSE: HCA concurs that conducting regular audits of these areas is a critical component of appropriate MCO oversight.

Action Steps and Time Frame

The Managed Care Executive Oversight Committee will develop regular audit plans as a part of the action plan and implementation strategy noted above (response to SAO Recommendation 1).

- Complete Action Plan and Implementation Strategy. *By December 31, 2014.*
-

SAO Recommendation 3: Establish clear criteria, specific to Washington, to define cost principles in determining allowable expenses.

SAO Recommendation 12: Ensure that MCOs . . . strengthen their review process to determine if administrative expenses are allowable and properly allocated.

SAO Recommendation 14: Ensure that MCOs . . . structure contracts with delegated entities to ensure medical and administrative costs are clearly defined and distinguishable.

STATE RESPONSE: HCA partially agrees with the recommendations. HCA can establish cost principles with the MCO through the contract. MCOs can be required to ensure administrative expenses are allowable and allocation is appropriate. MCOs are responsible for contracting with providers and other entities to ensure accurate encounter data are reported and costs are maintained within the rate provided by the state. Appropriate designation of costs and the allowability of costs are determined through these processes.

The current rate-setting process does not rely on use of the plan's direct administrative costs but rather relies on industry standards.

Action Steps and Time Frame

- HCA will define cost principles for use by the MCOs in determining allowable expenses for inclusion in the 2015 contract. *By January 2015.*
-

SAO Recommendation 4: Provide specific guidance for the Medical Loss Ratio calculation, including the definition of medical and administrative costs. Using the National Association of Insurance Commissioners' recommendations would make the guidance consistent with commercial insurance industry practices and give the organizations clear instruction to perform the calculation on a consistent, comparable basis.

STATE RESPONSE: HCA agrees and has addressed this recommendation in the 2014 MCO contract.

Action Steps and Time Frame

- HCA has provided clearer guidance for the calculation of the Medical Loss Ratio in the 2014 contract. *Complete.*
-

SAO Recommendation 5: Create procedures and instructions for the organizations that addresses recording and reporting costs incurred and recoveries realized, including those following the date of submission of the Experience Reports to the HCA's third-party actuary.

STATE RESPONSE: HCA agrees with this recommendation.

Action Steps and Time Frame

- Procedures and instructions will be developed for inclusion in the MCO contract. *By January 2015.*
-

SAO Recommendation 6: Establish clear, specific, cost reporting guidance for the organizations that addresses the timing of reporting pharmacy rebates to ensure they all calculate and report pharmacy rebates consistently.

SAO Recommendation 13: Ensure that MCOs . . . create formal documented policies and procedures for the calculation and reporting of pharmacy rebates and reinsurance recoveries that comply with instructions provided by the HCA's third-party actuary.

STATE RESPONSE: HCA agrees with these recommendations.

Action Steps and Time Frame

- Procedures and instructions will be developed for inclusion in the MCO contract. *By January 2015.*
-

SAO Recommendation 7: Establish a specific schedule for the timing of rate re-determinations.

SAO Recommendation 8: Work with the actuary to require transparency and support in the rate setting process. We have included an example of actuarial review as a best practice for establishing a comprehensive monitoring program in Appendix D.

SAO Recommendation 9: Require the actuary to give the HCA information used to calculate the capitation rate, including how sub-capitation payments and related fee-for-service equivalents were taken into account in the rate setting process. By making this process more transparent, the state could monitor the development of premium rates and ensure these special pricing arrangements are properly considered in the rate setting process.

STATE RESPONSE: HCA agrees that the timing and transparency of managed care rate setting are important. As noted in the cover letter, HCA is working to implement the structure and staffing necessary to become a purchaser of quality health care, rather than a fee-for-service provider of health care. Part of this process involves developing internal expertise on managed care rate-setting processes to ensure appropriate time frames and development of structures for transparent rate-setting methodologies. These processes are significantly more complex than historical Washington state Medicaid fee-for-service rate-setting activities, and improvement requires development of staffing expertise not currently found at the state level.

Action Steps and Time Frame

HCA is implementing a process to continue to develop improved managed care rate-setting methodologies and standards. Time frames for implementation are as follows:

- Identify new expertise needed to implement the managed care rate-setting function. *Complete.*
- Recruit staff resources identified. *By December 2014.*
- Amend actuarial contract to require sharing of rate-setting information. *By January 2015.*
- Develop systems and processes to increase rate-setting transparency. *By July 2015.*
- Develop processes to appropriately review and communicate rate-setting information to the agency and the authorizing environment. *By July 2015.*

SAO Recommendation 10: Ensure that MCOs . . . review system edit checks and post-payment procedures to ensure claims are reviewed in sufficient detail to identify miscoding and other causes of overpayments. The contract should require that the managed care organizations use edits such as those of the National Correct Coding Initiative (NCCI).

STATE RESPONSE: HCA partially concurs with this recommendation. While system edit checks and post-payment procedures are critical to correcting claims payments, these activities exist on a continuum in an IT system. Claims adjudication systems cannot edit for every variable, and post-payment reviews must adapt to ever-changing provider behaviors. MCOs use different hardware and software to process claims, and the level of technical sophistication will affect the system edits and post-payment review functions as well as the MCOs' ability to implement the full complement of NCCI edits in their systems.

Action Steps and Time Frame

HCA will review best practices related to Medicaid review of MCO claims adjudication systems. This review may include a survey of other states and on-site visits to view systems in place. HCA will develop contract language and action plans to improve Washington's system to a level commensurate with other states.

- Research complete. *By December 2014.*
 - HCA will add language to the MCO contracts to require the use of NCCI edits. *By January 2015.*
 - Improvement plans adopted. *By April 2015.*
 - MCO contract improvements implemented. *By January 2016.*
-

SAO Recommendation 11: Ensure that MCOs . . . retain a copy of the data file that is sent to the third-party actuary, with sufficiently detailed data fields to allow audit of the data.

STATE RESPONSE: HCA concurs that MCOs should retain a copy of the data file they send to the third-party actuary to facilitate the rate-setting process.

Action Steps and Time Frame

- HCA will add language to the MCO contracts to require retention of the data files sent to the actuary. *By January 2015.*
-

SAO Recommendation 15: Ensure that MCOs . . . are transparent in the treatment of claims and recoveries involving CHPW and the Network. These transactions should be recorded accurately and timely and appropriate documentation should be available for review by HCA when requested.

STATE RESPONSE: HCA agrees with the recommendation that Community Health Plan of Washington (CHPW) and its network must accurately record transactions between these entities on a timely basis.

Action Steps and Time Frame

- The 2015 CHPW contract will include a provision to require accurate and timely recording of transactions between CHPW and its network. *By January 2015.*
-

SAO Recommendation 16: Address these recommendations.

SAO Recommendation 17: HCA update its contract language with the managed care organizations to allow the state to recover overpayments identified in state and other audits.

STATE RESPONSE: HCA partially concurs with these recommendations. While we are in agreement about the need for clear contract language on the recovery of overpayments, recoveries identified as a result of state audits of MCOs or their providers is a complex issue that requires coordination among MCOs, the state Medicaid agency and federal funding authorities. HCA agrees

that policies and procedures related to the recovery of overpayments must be established, but the state may not be able to recover overpayments in every case.

Action Steps and Time Frame

HCA will review best practices of other states and develop a comprehensive strategy for the structure of an MCO audit plan, including provisions related to the recovery of identified overpayments. As stated in the response to SAO Recommendation 1, the action plan will include the development of internal audit guidelines, plans for processing state-identified provider overpayments, changes to state rule or law, if needed, and the addition of MCO contract language to specifically support the audits.

- Develop Action Plan and Implementation Strategy. *By December 31, 2014.*

Appendix A: Initiative 900

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. General 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 section of this report.

I-900 element	Addressed in the audit
1. Identification of cost savings	Yes. The audit identified and estimated overpayments made by the managed care organizations to their network providers and their potential impact on premiums paid by the state. The audit made recommendations that could yield costs savings.
2. Identification of services that can be reduced or eliminated	No. The audit focused on identifying overpayments in managed care. We did not identify services that could be reduced or eliminated.
3. Identification of programs or services that can be transferred to the private sector	No. The audit scope did not include identifying programs or services that can be transferred to the private sector.
4. Analysis of gaps or overlaps in programs or services and recommendations to correct gaps or overlaps	Yes. The audit recommends actions to correct gaps and weaknesses in oversight, cost reporting and internal controls over provider payments.
5. Feasibility of pooling information technology systems within the department	No. The Health Care Authority already has a system that pools information for the managed care organizations (Provider One). We did not review this area.
6. Analysis of the roles and functions of the department, and recommendations to change or eliminate departmental roles or functions	Yes. The audit included a review of how the Health Care Authority monitors the managed care organizations' program integrity efforts. We have made recommendations to improve these efforts.
7. Recommendations for statutory or regulatory changes that may be necessary for the department to properly carry out its functions	No. Although the audit included a review of the statutes and regulations impacting managed care organizations, we did not identify any opportunities to make recommendations for statutory or regulatory changes.
8. Analysis of departmental performance, data performance measures, and self-assessment systems	No. The audit scope did not include analysis of performance measures or data.
9. Identification of best practices	Yes. The audit compared Washington's Medicaid managed care oversight practices to best oversight practices and made recommendations for improvement.

Appendix B: Methodology

The audit was designed to answer the following questions:

Question 1. Determine if there are overpayments. If there are, why did they go undetected, and what impact do they have on premium rates?

Question 2. Are policies and procedures in place to ensure costs reported by the managed care organizations to the third-party actuary:

- Offset recoveries, rebates and refunds against medical costs
- Include only allowable administrative expenses and allocate costs on a reasonable basis
- Report costs related to subcontractors properly?

To address the issues raised by question 2, we examined these individual issues:

- a. Determine if policies and procedures are in place to bill providers for overpayments for services and determine if collections are properly offset against medical expenses.
- b. Determine if policies and procedures are in place to identify third party recoveries and determine if collections are offset against medical expenses.
- c. Determine if policies and procedures are in place to identify reinsurance recoveries and determine if collections are offset against medical expenses.
- d. Determine if policies and procedures are in place to calculate pharmacy rebates and determine if collected rebates are offset against medical expenses.
- e. Determine if indirect administrative expenses are allocated among business units, and if so determine the allocation methodology used.
- f. Determine if administrative expenses include costs that would be disallowed using Federal Acquisition Regulations (FAR) or cost principles used in other state plans as guidance for reasonable allowable costs.
- g. Determine if expenses are paid to related parties, and if so whether the payments include a profit component.
- h. Determine if any administrative costs components of subcontract arrangements are being improperly reported as medical costs and thereby misstating the medical loss ratio.
- i. Compare the amount of payments made to Community Health Plan of Washington's (CHPW) capitated providers to the amount of the claims encounter data provided by these providers.

Sampling methodology

The methodology applied to the claims population was designed to estimate overpayments in high-risk claims groups. We analyzed the data at a claims level and ran various algorithms (high-risk claims groups) to identify outlier populations. Outliers are claims that appear to be different in volume, value, nature, or timing from other claims in a group of similar claims. Outliers are more likely to contain overpaid amounts. For some of these high-risk claims groups, we used edits from the National Correct Coding Initiative (NCCI), designed by the Centers for Medicare and Medicaid Services (CMS), to identify claims groups that may have been miscoded. Although managed care organizations are not required to use NCCI edits, they are a good tool to identify potential cases of miscoding and improper payments. For more information on NCCI edits, see **Appendix C**, page 57. Although NCCI edits were used to identify outlier claims groups, claims were not considered to be paid in error based solely on these edits.

The results of 31 algorithms were reviewed and eight were ultimately selected for detailed testing. We used a variable, stratified random sample to estimate overpayments in the high-risk claims for each algorithm. Stratification was done on the claim amount. The outlier populations were divided into six strata to increase the level of precision of the results.

To calculate the sample size of each stratum, the mean and standard deviation were calculated. These amounts were then entered into RAT-STATs to estimate the sample size for each stratum. RAT-STATs is a program that was developed by the United States Department of Health and Human Services Office of Inspector General to assist in claims reviews. Sample selection within each stratum was performed on a simple random sample basis using RAT-STATs. We used the optimum allocation to determine stratum sample size.

The sampling methodology selected, and resulting sample sizes, was intended solely to determine the existence and identify examples of estimated overpayments. It was not intended to estimate or extrapolate overpayments with sufficient accuracy to recover overpayments. Given this objective and the resulting limited sample sizes within certain strata, we selected the Point Estimate Under the Difference method to extrapolate the error amounts. CMS, the federal program responsible for overseeing state Medicaid programs, both frequently uses this method and recognizes it as unbiased.

Section 8.4.5.1 of *The Medicare Program Integrity Manual* [The Point Estimate (Rev. 377, Issued: 05-27-11, Effective: 06-28-11, Implementation: 06-28-11)] reads:

“In simple random or systematic sampling the total overpayment in the frame may be estimated by calculating the mean overpayment, net of underpayment in the sample and multiplying it by the number of units in the frame. In this estimation procedure, which is unbiased, the amount of overpayment dollars in the sample is expanded to yield an overpayment figure for the universe....The resulting estimated total is called the point estimate of the overpayment, i.e., the difference between what was paid and what should have been paid. In stratified sampling, an estimate is found for each stratum separately, and the weighted stratum estimates are added together to produce an overall point estimate.”

Additionally, the *AICPA Audit Sampling Practice Guide* says the “point estimate” is the “most likely amount of the population characteristic based on the extrapolation of the sample results.”

The Medicare Program Integrity Manual also advises: “Exercise caution about using alternatives such as ratio or regression estimation because serious biases can be introduced if sample sizes are very small.” In addition, the Mean-Per-Unit method can also be imprecise given that its calculation is the direct extension of the audit value to the population without the limiting effect of the book value. That is, the number can lack the context provided by the fact that, generally speaking, audit values do not exceed book values.

Extrapolation of the error was performed only to the outlier populations. For example, any errors found in an algorithm were extrapolated to the outlier population for just that algorithm. In extrapolating the results, we used the midpoint estimate and a one-sided 90 percent confidence interval. If an estimated overpayment amount was greater than the dollar value of the stratum population, the overpayment estimate was reduced to the population stratum dollar value.

For purposes of determining the weighted error rate for controls testing, all tested items were included. The weighted error rate is based on the error rate for each strata weighted by the proportion of claims in that strata. For purposes of determining the estimated extrapolated overpayment in the claims population, we only considered strata with a sample size greater than one to eliminate some of the variability resulting from small sample sizes.

As stated above, the overall objective of this audit was to identify examples of overpayments, should they exist. To maximize the efficiency of limited available resources in service of this specific objective, we used small sample sizes on a variety of algorithms. Had the objective of this audit been to identify overpayments for potential recovery, larger sample sizes would have been required.

The two sets of tables on the following pages show the summary of the population, the sample size and the statistical projections.

Community Health Plan of Washington (CHPW): Total population and the sample size

Claims group examined	Total payment for claims applicable to this algorithm	Total payment for outlier claims	Number of outlier claims	Total payment amount of sample	Sample size
'Upcoding' diagnosis related group (DRG) codes	\$104,337,093	\$9,716,388	1,718	\$717,676	49
Duplicate payment of evaluation & management codes	\$55,065,659	\$1,297,681	23,433	\$4,625	33
Excessive billing using Modifier 25 code	\$30,424,087	\$1,408,399	19,860	\$5,032	33
Unbundling CT scans	\$92,460,403	\$1,829,252	3,020	\$70,655	33
'Upcoding' evaluation & management codes	\$15,482,591	\$3,149,826	43,877	\$7,290	32
One day inpatient stay	\$15,933,171	\$4,009,052	919	\$173,324	33
Recurring orders for controlled substance medications	\$5,119,290	\$4,373,160	9,492	\$67,711	39
Recurring orders for atypical antipsychotic drugs	\$1,484,428	\$981,205	277	\$179,310	33

Community Health Plan of Washington (CHPW): Sample results

Claims group examined	Sample results			Projection (90% one-way confidence interval)	
	Sample size	Number of claims paid in error	Amount of unsupported payments	Midpoint	Not-less-than (lower bound of the interval)
'Upcoding' diagnosis related group (DRG) codes	49	1	(\$21,169)	(\$84,149)	(\$177,443)
Duplicate payment of evaluation & management codes	33	7	\$319	\$210,641	\$62,030
Excessive billing using Modifier 25 code	33	2	\$160	\$44,908	\$2,593
Unbundling CT scans	33	4	\$4,804	\$124,413	\$25,991
'Upcoding' evaluation & management codes	32	11	\$586	\$461,888	\$207,754
One day inpatient stay	33	7	\$44,350	\$1,084,293	\$746,243
Recurring orders for controlled substance medications	39	0	\$0	\$0	\$0
Recurring orders for atypical antipsychotic drugs	33	0	\$0	\$0	\$0
Total	285	32	\$29,050		

Molina: Total population and the sample size

Claims group examined	Total payment for claims applicable to this algorithm	Total payment for outlier claims	Number of outlier claims	Total payment amount of sample	Sample size
'Upcoding' diagnosis related group (DRG) codes	\$135,410,198	\$10,744,081	1,768	\$918,098	56
Duplicate payment of evaluation & management codes	\$114,703,322	\$10,558,121	106,061	\$14,489	35
Excessive billing using Modifier 25 code	\$109,910,247	\$13,240,213	119,083	\$14,329	32
Unbundling CT scans	\$40,077,902	\$2,281,176	4,345	\$47,508	33
'Upcoding' evaluation & management codes	\$57,430,446	\$9,509,412	101,792	\$3,561	35
One day inpatient stay	\$27,760,274	\$6,088,371	1,760	\$192,824	33
Recurring orders for controlled substance medications	\$11,347,418	\$10,099,947	207,623	\$5,236	34
Recurring orders for atypical antipsychotic drugs	\$1,279,118	\$776,908	1,839	\$16,421	32

Molina: Sample results

Claims group examined	Sample results			Projection (90% one-way confidence interval)	
	Sample size	Number of claims paid in error	Amount of unsupported payments	Midpoint	Not-less-than (lower bound of the interval)
'Upcoding' diagnosis related group (DRG) codes	56	1	\$0 ¹	\$0 ¹	\$0 ¹
Duplicate payment of evaluation & management codes	35	17	\$1,891	\$4,756,672	\$1,697,356
Excessive billing using Modifier 25 code	32	8	\$2,155	\$7,360,584	(\$701,922)
Unbundling CT scans	33	3	\$1,936	\$38,254	(\$8,805)
'Upcoding' evaluation & management codes	35	19	\$1,259	\$2,015,841	\$1,426,348
One day inpatient stay	33	8	\$31,410	\$681,887	\$285,521
Recurring orders for controlled substance medications	34	5	\$1,011	\$718,757	\$322,979
Recurring orders for atypical antipsychotic drugs	32	3	\$1,624	\$58,730	\$13,928
Total	290	64	\$41,286		

Note 1. For purposes of extrapolating the estimated overpayments, only strata with sample sizes greater than one were included. The error noted here was the only item in that strata and was therefore eliminated in the calculation of the estimated overpayment.

Appendix C: Criteria

Claims overpayments

We used several standard medical coding guidelines used by providers throughout the country to evaluate if claims were properly coded:

- All Patient Diagnosis Related Group (AP-DRG) or Medicare Severity Diagnosis Related Group (MS-DRG) (proprietary)
- CPT 2010 American Medical Association Manual (proprietary)
- Medicare 1995/1997 documentation guidelines
- National Correct Coding Initiative (NCCI) edits
- WAC 182-550-3000, which states that the Health Care Authority (HCA) uses the all-patient grouper (AP-DRG) to assign a DRG to each inpatient hospital stay.

Some sources were either proprietary or too long to include in the report.

National Correct Coding Initiative (NCCI) edits

This initiative was developed by CMS and is designed to promote national correct coding methodologies and reduce improper payments of Medicaid claims. Medicaid state agencies are required to build edits into their payment systems for fee-for-service claims to identify cases where certain coding patterns could indicate improper coding. The initiative contains two types of edits: 1) pairs of procedures that should not be coded together and 2) medically unlikely edits. Although managed care organizations are not required to use these edits, they are a good tool to identify potential cases of claims that are miscoded. In this audit, NCCI edits were used to develop algorithms and identify outlier populations. They were not the sole method of determining that a claim was overpaid in the detailed testing of the sample.

Healthy Options contract between the HCA and managed care organizations

Section 1.35 of the Healthy Options Contract states, “The Contractor and its subcontractors shall maintain financial, medical and other records pertinent to this Contract....Medical records and supporting management systems shall include all pertinent information related to the medical management of each enrollee....All records and reports relating to this Contract shall be retained by the Contractor and its subcontractors for a minimum of six (6) years after final payment is made under this Contract.” (pg. 18 of 158)

Section 1.25.8.14 under the heading, 1.25 – Compliance with Applicable Law states, “In the provision of services under this Contract, the Contractor and its subcontractors shall comply with all applicable federal, state and local laws and regulations, and all amendments thereto, that are in effect when the Contract is signed or that come into effect during the terms of this Contract (42 CFR 438.6(f)(1) and 438.100(d)). This includes, but is not limited to: ... Any other requirements associated with the receipt of federal funds.” The stipulation would include FAR 31 – Contract Cost Principles and Procedures and the cost principles contained therein.

Section 10.6 of the Healthy Options Contract also states the following regarding provider contracts, “Health Care Provider Subcontracts, including those for facilities and pharmacy benefit management, shall also contain the following provisions:

Section 10.6.3 A means to keep records necessary to adequately document services provided to enrollees for all delegated activities including Quality Improvement, Utilization Management, Member Rights and Responsibilities, and Credentialing and Recredentialing.” (pg. 90 of 158)

Section 13.2.2 The Contractor shall work with HCA to perform individual and corporate extrapolation audits of the plan’s providers’ billings.

Section 13.2.3 Recoveries from any identified and collected overpayments resulting from joint Contractor/HCA audit or post-payment review activities shall be split between HCA and the Contractor at a rate determined and developed by the purchaser-wide program integrity forum.

The state's authority and procedures for auditing Medicaid claims

The Revised Code of Washington (RCW 74.09) and the Washington Administrative Code (WAC 182) outline the HCA's authority and procedures for auditing Medicaid claims. They also describe how the HCA conducts these audits on the fee-for-service (FFS) claims.

RCW 74.09.200 Audits and investigations – Legislative declaration – State authority.

The legislature finds and declares it to be in the public interest and for the protection of the health and welfare of the residents of the state of Washington that a proper regulatory and inspection program be instituted in connection with the providing of medical, dental, and other health services to recipients of public assistance and medically indigent persons. In order to effectively accomplish such purpose and to assure that the recipient of such services receives such services as are paid for by the state of Washington, the acceptance by the recipient of such services, and by practitioners of reimbursement for performing such services, shall authorize the Secretary or Director, to inspect and audit all records in connection with the providing of such services.

WAC 182-502A-0800 Auditing process

WAC 182-538 relating to managed care does not include any guidance on the auditing process. Therefore, we looked to guidance in the auditing of providers under fee-for-service as being the most relevant guidance for auditing managed care organizations and their providers.

- (1) The department inspects provider records for objective data consistent with the purpose defined under WAC (1). The department may require a provider to furnish original records for the department to review.
- (2) The department may assess an overpayment for medical services and terminate the core provider agreement if a provider fails to retain adequate documentation for services billed to the department.
- (3) As part of the audit:
 - (a) The department may examine provider financial records, client medical records, employee records, provider appointment books, and any other applicable records that are related to the services billed to the department. The examination may:
 - (i) Verify usual and customary charges and payables including receivable accounts;
 - (ii) Verify third-party liability;
 - (iii) Compare clinical and fiscal records to each claim; and
 - (iv) Compare Medicaid charges to other insured or private pay patient charges to determine that the amount billed to the department is not more than the usual and customary charge documented in the provider's charge master.
 - (b) The department's procedures for auditing providers may include:
 - (i) Use of random sampling;
 - (ii) Extrapolation of principal and interest;
 - (iii) Conducting a claim audit;
 - (iv) Interviews with clients, providers, and/or their employees;
 - (v) Investigating complaints or allegations;
 - (vi) Investigating actions taken regarding Medicare or medical assistance; and
 - (vii) Investigating actions taken by the health profession's quality assurance commissions with the department of health.
- (4) Per RCW , the department may issue a subpoena for records from the provider or a third party including taking depositions or testimony under oath.
- (5) When possible, the department works with the provider to minimize inconvenience and disruption of health care delivery during the audit.
- (6) The department does not reimburse a provider's administrative fees, such as copying fees, for records requested during an audit.

Federal guidance for auditing healthcare claims is provided under the Social Security Act and the Medicaid Manual published by the Centers for Medicare and Medicaid Services (CMS)

Social Security Act

Social Security Act, Title XIX Sec. 1902. [42 U.S.C. 1396a] (a) A State plan for medical assistance must —

(27) provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, and (B) to furnish the State agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request.

CMS Medicaid Manual

CMS Medicaid Program Integrity Manual, Chapter 1, Section 1035 states the following:

1035 – OVERPAYMENT AND ERRORS VERSUS FRAUD, WASTE, AND ABUSE

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

An improper payment is any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements. Incorrect amounts include overpayments and underpayments. An improper payment includes any payment that was made to an ineligible recipient, payment for non-covered services, duplicate payments, payments for services not received, and payments that are for the incorrect amount. In addition, when an Agency's review is unable to discern whether a payment was proper because of insufficient or lack of documentation, this payment must also be considered an improper payment. (42 CFR § 431.958; Improper Payments Elimination and Recovery Act (IPERA); and Appendix C to OMB Circular A-123 (M-10-13)).

Code of Federal Regulations (CFR)

Title 42, Section 431.960(c)(3) of the CFR further explains the types of payment errors in Medicaid and CHIP, stating that, "Medical review errors include, but are not limited to the following: (i) Lack of documentation. (ii) Insufficient documentation. (iii) Procedure coding errors. (iv) Diagnosis coding errors. (v) Unbundling. (vi) Number of unit errors. (vii) Medically unnecessary services. (viii) Policy violations. (ix) Administrative errors."

Medicare Financial Management Manual

The Medicaid manual is silent with regard to specific guidance relating to cost principles. In situations like this, and in the absence of specific state guidelines, it is common practice to look to corresponding similar federal guidelines relevant to the use of Federal funds in comparable programs for guidance. In this case, the most relevant similar guidance would be found in the Medicare manuals.

Chapter 3, Section 10

- Overpayments are Medicare payments a provider or beneficiary has received in excess of amounts due and payable under the statute and regulations. Once a determination of an overpayment has been made, the amount is a debt owed by the debtor to the United States Government.
- Under the Federal Claims Collection Act of 1966, as amended, each agency of the Federal Government (pursuant to regulations jointly promulgated by the Attorney General and the Comptroller General of the U.S.) must attempt collection of claims of the Federal Government for money arising out of the activities of the agency. The financial intermediary (FI) or carrier will not be liable for overpayments it makes to debtors in the absence of fraud or gross negligence on its part; however, once an intermediary or carrier determines an overpayment has been made, it must attempt recovery of overpayments in accordance with the Centers for Medicare and Medicaid Services (CMS) regulations.
- The Federal Claims Collection Act requires timely and aggressive efforts to recover overpayments, including: efforts to locate the debtor where necessary; demands for repayment and establishment of repayment schedules; suspension of interim payments by intermediaries to institutional providers; and recoupment or setoff, where appropriate.

Medicare Program Integrity Manual [The Point Estimate (Rev. 377, Issued: 05-27-11, Effective: 06-28-11, Implementation: 06-28-11)]

This manual is used by CMS to estimate overpayment. We utilized this manual in our calculation of overpayments. The State Medicaid program is partially funded with federal dollars and lacking any guidance at the State level, so we feel it is appropriate to use federal guidance for comparable programs.

Section 8.4.5.1:

“In simple random or systematic sampling the total overpayment in the frame may be estimated by calculating the mean overpayment, net of underpayment, in the sample and multiplying it by the number of units in the frame. In this estimation procedure, which is unbiased, the amount of overpayment dollars in the sample is expanded to yield an overpayment figure for the universe....The resulting estimated total is called the point estimate of the overpayment, i.e., the difference between what was paid and what should have been paid. In stratified sampling, an estimate is found for each stratum separately, and the weighted stratum estimates are added together to produce an overall point estimate.”

Reference/Citation for the Claims Algorithms Reviewed

1. Excessive Billing Modifier 25:

- a. Reference: CPT, Professional Edition, any year, American Medical Association Appendix A, Modifiers, 25, Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure of Other Service
- b. Definition of Modifier 25: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure of Other Service. It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E&M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E&M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E&M service to be reported. The E&M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E&M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E&M service.
- c. Definition of excessive billing modifier 25: inappropriate/excessive use of modifier 25 to expedite payment for E&M service billed.

2. Duplicate E&M Codes:

- a. Reference: CPT, Professional Edition, any year, American Medical Association Evaluation and Management (E&M) Services Guideline
- b. Definition: E&M coding is the process by which physician-patient encounters are translated into five digit CPT codes to facilitate billing. There are different E&M codes for different types of encounters such as office visits or hospital visits
- c. Definition of duplicate E&M codes: billing for service rendered more than once.

3. Unbundling of Computerized Tomography (CT):

- a. Reference: McGraw-Hill Concise Dictionary of Modern Medicine, CPT, Professional Edition, any year, American Medical Association, Radiology Guidelines (Including Nuclear Medicine and Diagnostic Ultrasound), and AAPC
- b. Definition: Expanding reimbursement of a practice in which a provider service – e.g., CT units are broken down to their individual components, resulting in a higher payment by insurers.
- c. Level of service of Unbundling of CT: billing for CT scan with contrast when contrast was not used.

4. One Day Stay:

- a. Reference: CPT, Professional Edition, any year, American Medical Association, Evaluation and Management (E&M) Services Guideline, Observation or Inpatient Care Services (Including Admission and Discharge Services).
- b. Definition: The patient is admitted on one day and discharged the next day, usually less than a 24 hour stay. The issue is that the patient could have gone home after appropriate treatment without having to be admitted.
- c. Medicaid State Plan Attachment 4.19A Part I [c](12) Inpatient vs. Outpatient Stay Policy (page 53 of 334)
 - Through October 31, 2004, stays of less than, approximating, or exceeding 24 hours where an inpatient admission was not appropriate will be reimbursed on an outpatient basis. Stays of less than 24 hours involving the death of the patient, transfer to another acute care hospital, a delivery, or initial care of a newborn are considered inpatient and are reimbursed under the respective inpatient payment method designated for the hospital and/ or the covered services. On and after November 1, 2004, a new clinical-based inpatient vs. outpatient stay determination rule is in effect.
 - An inpatient stay is an admission to a hospital based on an evaluation of the client using objective clinical indicators for the purpose of providing medically necessary inpatient care, including assessment, monitoring, and therapeutic services as required, to best manage the client's illness or injury, and that is documented in the client's medical record.
 - An outpatient hospital stay consists of outpatient hospital services that are within a hospital's licensure and provided to a client who is designated as an outpatient based on an evaluation of the client using objective clinical indicators for the purpose of providing medically necessary ambulatory care, including assessment, monitoring, and therapeutic services as required to best manage the client's illness or injury, and that is documented in the client's medical record.

5. Diagnosis-related group (DRG) Coding:

- a. Reference: American Academy of Professional Codes (AAPC), Web site: <http://www.aapc.com/medical-coding/medical-coding.aspx>
- b. Definition: "Diagnosis-related groups (DRGs)" are categories used by hospitals on discharge billing.
- c. Definition of DRG Coding: based on the documentation, an assignment is made of the appropriate code taking into account the diagnoses, complications and comorbidities as well as the procedures performed to treat the patient during an encounter.
- d. Medicaid State Plan Attachment 4.19A Part I (B) defines DRGs as follows: (page 36 of 334)
 - DRG means the patient classification system originally developed for the Federal Medicare program which classifies patients into groups based on the International Classification of Diseases, the presence of a surgical procedure, patient age, presence or absence of significant comorbidities or complications, and other relevant criteria.
 - The DRGs categorize patients into clinically coherent and homogenous groups with respect to resource use. The Washington State Medicaid program uses the All Patient Diagnosis Related Group (AP-DRG) classification software (Grouper) to classify claims into a DRG classification.
 - For dates of admission before August 1, 2007, the Agency uses version 14.1 of the AP-DRG Grouper for this purpose, and has established relative weights for 400 valid DRGs for its DRG payment system. There are an additional 168 DRGs that are not used and another 241 DRGs with no weights assigned. Of the 241 DRGs with no weights, two are used in identifying ungroupable claims under DRG 469 and 470.
 - The remainder of the 241 DRGs is exempt from the DRG payment method. The All Patient Grouper, Version 14.1 has a total of 809 DRGs.

- For dates of admission on and after August 1, 2007, the Agency uses version 23.0 of the AP-DRG Grouper to classify claims into a DRG classification, and has established relative weights for 423 DRG classifications used in the DRG payment system. Of the remaining DRG classifications, two are used to identify ungroupable claims under DRG 469 and 470. The remainder of the DRG classifications in version 23.0 of the AP-DRG Grouper are either not used by the grouper software, or are used by the Agency to pay claims using a non-DRG payment method.

6. Upcoding E&M

- Reference: CPT, Professional Edition, any year, American Medical Association, Evaluation and Management (E&M) Services Guideline
- Definition: E&M coding is the process by which physician-patient encounters are translated into five digit CPT codes to facilitate billing. There are different E&M codes for different types of encounters such as office visits or hospital visits
- Definition of upcoding E&M codes: billing a higher level of service than what was provided and documented.
- 1997 Documentation Guidelines for Evaluation and Management Services, section I What do Payers Want and Why? Because payers have a contractual obligation to enrollees, they may require reasonable documentation that services are consistent with the insurance coverage provided. They may request information to validate:
 - The site of service;
 - The medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or
 - That services provided have been accurately reported.

7. Pharmacy algorithms

- *Medicaid State Plan 4.26 Drug Utilization Review Program (Citation 1927g 42 CFR 456.700)*
 - The Medicaid agency meets the requirements of Section 1927(g) of the Act for a drug use review (DUR) program for outpatient drug claims.
 - The DUR program assures that prescriptions for outpatient drugs are:
 - Appropriate
 - Medically necessary
 - Are not likely to result in adverse medical results
- *Medicaid State Plan Attachment 4.19B (IV) Pharmacy Services*

General Information:

- The department reimburses only for prescription drugs provided by manufacturers that have a signed drug rebate agreement with the Department of Health and Human Services (HHS). Prescriptions for drugs may be filled and refilled at the discretion of the prescriber. For those drugs specified by the department, prior approval is required.
- Payment for drugs purchased in bulk by a public agency is made in accordance with governmental statutes and regulations governing such purchases.
- Each Medical Assistance client is granted the freedom to choose his or her source of medications, except when the client is covered under a managed care plan that includes the drug benefit.

Extrapolation

In the absence of specific state guidelines, it is common practice to look to corresponding similar federal guidelines relevant to the use of Federal funds in comparable programs for guidance. The following methodology is readily accepted by the Governmental Accounting Office and the Office of the Inspector General.

Section 8.4.5.1 of the Medicare Program Integrity Manual [The Point Estimate (Rev. 377, Issued: 05-27-11, Effective: 06-28-11, Implementation: 06-28-11)] states:

“In simple random or systematic sampling the total overpayment in the frame may be estimated by calculating the mean overpayment, net of underpayment, in the sample and multiplying it by the number of units in the frame. In this estimation procedure, which is unbiased, the amount of overpayment dollars in the sample is expanded to yield an overpayment figure for the universe...the resulting estimated total is called the point estimate of the overpayment, i.e., the difference between what was paid and what should have been paid. In stratified sampling, an estimate is found for each stratum separately, and the weighted stratum estimates are added together to produce an overall point estimate.”

Recoveries and Administrative Costs

Recoveries

Medicare Financial Management Manual, Chapter 3, Section 10

See criteria quoted above on page 57.

Revised Code of Washington (RCW) 48.43.600

The RCW provides guidance on the notification that must be sent to providers when attempting to recover funds determined to be an overpayment. The carrier must make the request for a refund from the provider in writing within twenty-four months after the date the payment was made. The request must specify why the carrier believes the provider owes the refund. If the provider fails to contest the request in writing within thirty days of its receipt, the request is deemed accepted and the refund must be paid.

Milliman Experience Report Instructions to managed care organizations

Letter from Milliman to all managed care organizations participating in the Washington State Medicaid Program, dated February 14, 2011.

- As part of the rate setting process by Milliman, the third-party actuary, information including claims data and an experience report with certain financial information is requested from the managed care organizations. Milliman provides a document titled, “Reporting Instructions for Healthy Options” to the managed care organizations for the preparation and submission of this information.
- In the “General Procedures” section of the letter, it states: “Each plan must provide an Actuarial Memorandum signed by a Qualified Actuary. The memorandum must address the following issues...(3) Claim costs reflect all offsets, such as third party recoveries and pharmacy rebates.”
- Section, Report 1 – “Detailed Income Statement” Section D – Other Claim Information defines reinsurance recoveries, Reinsurance Recoveries – “Amounts recovered and recoverable from reinsurers on losses incurred during the experience period.”

Healthy Options Contract effective during 2010

Washington State Health Care Authority 2008 – June 30, 2012 Contract, Updated through Amendment 12 For Healthy Options Medicaid Managed Care Program.

- Section 6.5 of the contract states, “Reinsurance/Risk Protection: The Contractor may obtain reinsurance for coverage of enrollees only to the extent that it obtains such reinsurance for other groups enrolled by the Contractor, provided that the Contractor remains ultimately liable to HCA for the services rendered.”
- Section 9.1.1.5 states that the Contractor must have and follow written policies and procedures related to the Coordination of Benefits. The HCA Healthy Options Contract requires Contractors to attempt to recover any third-party resources available to enrollees (15.16.1). The Healthy Options Contract also assigns the HCA’s right to the managed care organization for third-party payments for medical care provided to an enrollee on behalf of the HCA in cases of subrogation rights (15.16.2).

Pharmacy rebates

Milliman Experience Report Instructions to managed care organizations

Letter from Milliman to all managed care organizations participating in the Washington State Medicaid Program, dated February 14, 2011.

- As part of the rate setting process by Milliman, the third-party actuary, information including claims data and an Experience Report with certain financial information is requested from the managed care organizations. Milliman provides a document titled, “Reporting Instructions for Healthy Options” to the managed care organizations for the preparation and submission of this information.
 - In the “General Procedures” section of the letter, “Each plan must provide an Actuarial Memorandum signed by a Qualified Actuary. The memorandum must address the following issues...(3) Claim costs reflect all offsets, such as third party recoveries and pharmacy rebates.”

Title 42 – Public and Welfare, Chapter – Social Security, Subchapter XIX – Grants to States for Medical Assistance Programs, Section 1396r-8

Payment for covered outpatient drugs Section (b) Terms of Rebate Agreement (B) Offset against medical expense states, “Amounts received by a State under this section (or under an agreement authorized by the Secretary under subsection (a)(1) of this section or an agreement described in subsection (a)(4) of this section) in any quarter shall be considered to be a reduction in the amount expended under the State plan in the quarter for medical assistance for purposes of section 1396b (a)(1) of this title.”

Although managed care organizations were exempt from this section, it would be expected that they would reduce or offset medical expenses to account for these savings.

Administrative Expenses

Healthy Options Contract effective during 2010

Washington State Health Care Authority 2008 – June 30, 2012 Contract, Updated through Amendment 12 For Healthy Options Medicaid Managed Care Program.

Section 1.25.8.14 under the heading, 1.25 – Compliance with Applicable Law states,

“In the provision of services under this Contract, the Contractor and its subcontractors shall comply with all applicable federal, state and local laws and regulations, and all amendments thereto, that are in effect when the Contract is signed or that come into effect during the terms of this Contract (42 CFR 438.6(f)(1) and 438.100(d)). This includes, but is not limited to:Any other requirements associated with the receipt of federal funds.”

The stipulation would include FAR 31, Contract Cost Principles and Procedures and the cost principles it contains.

Milliman Experience Report Instructions to managed care organizations

Letter from Milliman to All managed care organizations participating in the Washington State Medicaid Program, dated February 14, 2011.

- In the “General Procedures” section of the letter, “Each plan must provide an Actuarial Memorandum signed by a Qualified Actuary. The memorandum must address the following issues: ... (4) Administrative expenses reflect the Medicaid block of business to the extent possible. (5) Administrative expenses include no risk margins or profits.”

The letter provides for seven types of administrative expenses:

1. Rent
2. Salaries, Wages, and Other Benefits
3. Legal Fees and Expenses
4. Marketing and Advertising
5. Outsourced Services
6. Other Expenses
7. Premium Tax

Federal Acquisition Regulations (FAR) Section 31.2

Contracts with Commercial Organizations, effective December 2009, as referenced in the Healthy Options Contract, Section 1.25.8.14.

- Section 31.2 of FAR contains the cost principles to be used in contracts with commercial organizations. This section covers such things as allowability, allocation methodology, reasonableness, and the proper treatment of indirect costs. Additionally, the section provides detailed guidance regarding the allowability of certain types of costs.
- Given that the managed care organizations receive partial funding from the federal government through a state contract, the cost principles from the FAR are relevant under section 31.102 and 31.103 which describe the applicability of the FAR cost principles to fixed-priced contracts and contracts with commercial organizations, respectively.

Office of Management and Budget (OMB) Circular A-87 (Circular)

As referenced in the Healthy Options Contract, Section 2.12.1.6.

The specific criteria of the Circular are too voluminous to include here, but generally cover expense types such as advertising and public relations costs, bad debts, compensation for personal services, entertainment costs, fines and penalties, lobbying, proposal costs, training costs, etc.

Related party costs

Healthy Options Contract (Contract) effective during 2010

Washington State Health Care Authority 2008 – June 30, 2012 Contract, Updated through Amendment 12 For Healthy Options Medicaid Managed Care Program.

The Contract does not contain any specific criteria for related party transactions. Section 13.3 requires disclosure of information on ownership and control, but does not address the potential for layering profit through related party transactions.

Milliman Experience Report Instructions to managed care organizations

Letter from Milliman to all managed care organizations participating in the Washington State Medicaid Program, dated February 14, 2011.

- In the “General Procedures” section of the letter, “Each plan must provide an Actuarial Memorandum signed by a Qualified Actuary. The memorandum must address the following issues...(5) Administrative expenses include no risk margins or profits.”

Federal Acquisition Regulations (FAR) Section 16.601

As referenced in the Healthy Options Contract, Section 1.25.8.14. Given that the managed care organizations receive partial funding from the federal government through a state contract, the cost principles from FAR are relevant.

- For contract actions that are not awarded using competitive procedures, unless exempt under paragraph (c)(2)(iv) of this section, the fixed hourly rates for services transferred between divisions, subsidiaries, or affiliates of the contractor under common control:
 - Shall not include profit for the transferring organization; but
 - May include profit for the prime contractor.

The exception referenced in this section states:

- For contract actions that are not awarded using competitive procedures, the fixed hourly rates for services that meet the definition of commercial item at 2.101 that are transferred between divisions, subsidiaries, or affiliates of the contractor under a common control may be the established catalog or market rate when:
 - It is the established practice of the transferring organization to price the inter-organizational transfers at other than cost for commercial work of the contractor or any division, subsidiary, or affiliate of the contractor under a common control; and
 - The contracting officer has not determined the price to be unreasonable.

Section 2.101 referred to above, defines a commercial item relevant to this use as:

- (6) Services of a type offered and sold competitively in substantial quantities in the commercial marketplace based on established catalog or market prices for specific tasks performed or specific outcomes to be achieved and under standard commercial terms and conditions. For purposes of these services –
- (i) “Catalog price” means a price included in a catalog, price list, schedule, or other form that is regularly maintained by the manufacturer or vendor, is either published or otherwise available for inspection by customers, and states prices at which sales are currently, or were last, made to a significant number of buyers constituting the general public; and
 - (ii) “Market prices” means current prices that are established in the course of ordinary trade between buyers and sellers free to bargain and that can be substantiated through competition or from sources independent of the offerors.

This portion of the cost principles applies to Time-and-Materials contracts. Absent other specific cost principles relating to fixed fee contracts, we believe it is appropriate to apply the cost principles set forth in this criteria to payments from the managed care organizations to related party providers since the provider payments would be made based on the services/level of effort expended by the providers. Since there is a profit component built into the capitation rate that is paid to the managed care organization, it would be inappropriate to have additional profit built into the fees paid to a related party since the costs for such related party services are used to determine the capitated rate, unless otherwise allowed by the cost principles set forth in FAR.

Costs of subcontract arrangements

Healthy Options Contract (Contract) effective during 2010

Washington State Health Care Authority 2008 – June 30, 2012 Contract, Updated through Amendment 12 For Healthy Options Medicaid Managed Care Program.

- 6.2 Medical Loss Ratio (MLR) Limitation: For calendar years 2009 to 2011, the HCA will implement an MLR of eighty (80) percent in each calendar year. MLR shall be as defined by the Office of the Insurance Commissioner (OIC) in RCW 48.43.049, with the additional inclusion of any quality incentive payments made directly to Participating Providers prior to the end of the year. If the Contractor’s actual MLR in calendar years 2009 - 2011, as determined by the HCA and its actuaries using the Contractor’s financial information, is less than eighty (80) percent, the HCA will calculate an amount due from the Contractor by subtracting the Contractor’s actual MLR related to its performance under this Contract in the calendar year from eighty (80) percent and multiplying the result by the total premiums paid to the Contractor for the calendar year, including the Delivery Case Rate. The Contractor shall remit to the HCA the amount due within ninety (90) days of the date that the HCA provides notice to the Contractor of that amount. This provision shall survive the expiration or termination of this Contract. (RCW 48.43.049 (iv) states, “The medical loss ratio that is computed by dividing the total amount of hospital and medical payments by the total amount of revenues.”)

10.7 Healthcare Provider Subcontracts Delegating Administrative Functions:

- o 10.7.1 Subcontractors that delegate administrative functions under the terms of this contract shall include the following additional provisions:
 - o 10.7.1.2 Clear descriptions of any administrative functions delegated by the Contractor in the subcontract. Administrative functions are any obligations of the Contractor under this contract other than the direct provision of services to enrollees and include, but are not limited to, utilization/medical management, claims processing, enrollee grievances and appeals, and the provision of data or information necessary to fulfill any of the Contractor’s obligations under this Contract.

National Association of Insurance Commissioners' (NAIC) Guidance

October 2010 recommendations to the Secretary of the Health and Human Services Department for definitions and methodology related to the calculation of the medical loss ratio:

NAIC's definitions require a medical expense to provide for improvement of health care and provide a general definition of a quality improvement expense as

“Quality Improvement (QI) expenses are expenses, other than those billed or allocated by a provider for care delivery (i.e., clinical or claims costs), for all plan activities that are designed to improve health care quality and increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements. The expenses must be directed toward individual enrollees or may be incurred for the benefit of specified segments of enrollees, recognizing that such activities may provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees other than allowable QI expenses associated with self-insured plans. Qualifying QI expenses should be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical societies, accreditation bodies, government agencies or other nationally recognized health care quality organizations. They should not be designed primarily to control or contain cost, although they may have cost reducing or cost neutral benefits as long as the primary focus is to improve quality.”

NAIC's definitions and methodology applies to commercial insurance carriers. Absent other specific criteria relating to the categorization of costs for MLR calculations, we believe it is appropriate to apply NAIC's definitions set forth in this criteria since the intent behind the calculation is the same, just with a different result if the standard ratio is not met. If a Medicaid insurance carrier does not meet the standard for the ratio, an assessment is paid to the State; and if a commercial insurance carrier does not meet the standard ratio, a rebate is given back to the members who paid the premium cost.

Appendix D: Best practices

In this appendix, we set out many of the best practices in monitoring Medicaid managed care cost accountability and programs found during our research.

Best practices in monitoring managed care organization accountability

Medicaid managed care programs are generally some of the largest third-party contracts entered into by the state. In addition to prudent management of the programs, state procurement regulations generally require such contracts to be monitored and managed closely for compliance.

The best, most comprehensive monitoring programs are based on three principles:

1. Clear contractual requirements
2. Periodic submission of data in a prescribed format to the state
3. Implementation of regular monitoring programs

1. Clear contractual requirements

To implement a comprehensive monitoring program, the state must first establish clear criteria for performance in its contracts with a managed care organization. Without them, the state cannot compel the organization to comply with desired performance standards. In addition, the most successful states have created a guidance manual to supplement contractual requirements. Such manuals help establish and communicate clear expectations to the organization, so it can reasonably be held accountable for meeting performance requirements.

The following areas should be addressed:

- **Clearly defined cost principles** Linking Medicaid-allowable cost principles to Medicare and Federal Acquisition Regulations (FAR) principles helps supplement Medicaid rules and gives the managed care organization more complete definitions for allowable costs and treatment of other cost and revenue components, including payments made to related parties. Medical providers continue to consolidate and develop new operating structures resulting in related party transactions. Guidance should be given as to the expectations, allowability and reporting of payments to related parties to prevent an unintended layering of profits earned by the organization.
- **How to treat third party recoveries, reinsurance recoveries and pharmacy rebates** Recoveries should be recorded as an offset to the costs of the program. Because some of the recoveries can be received in later years, the state should indicate how and when the organization should report these recoveries to the state and the actuary.
- **How to retain and submit data** For a state to monitor the costs and operations of a managed care organization, it needs access to the organization's data. Contracts should include comprehensive record retention rules including all the data fields needed for future analysis of claims, administrative costs, premium revenue, and internal performance data reporting. Retention rules should include the specific duration for retention, format of the data, and electronically accessible medium in which they should be retained.

The contract should set out the submission requirements for encounters. The organization should submit accurate and complete encounters in accordance with the fiscal agent's companion guide. The organization should be required to submit a stated percentage of encounters within 60 days of payment. Many states use a threshold of 98 percent or 99 percent completion and accuracy within this period.

A common performance measure pertaining to data submission is to require 95 percent of submitted encounters accepted by the fiscal agent. This encourages the organization to avoid making errors that result in transmission file rejections from the fiscal agent (FAC).

- **Ensure the state has the right to audit** The managed care organization contract should include a provision protecting the state's right to audit its operations and requiring performance and cost data to be retained.
- **How to handle non-compliance problems** (liquidated damages; Corrective Action Plans (CAPs)) Contracts and/or guidance manuals should provide for penalties if the organization does not meet performance standards. Penalties can help ensure accountability of the state's Medicaid program by encouraging the organization to cooperate with required data retention and reporting provisions, specific contract performance provisions, and audit and other accountability provisions.
- **How to handle overpayments and excess profits** (rate adjustments; recoupment; experience rebates) To administer fiscally responsible Medicaid managed care programs, the state and the managed care organization must form a sincere and honest partnership. Essential contract provisions to achieve this goal allow the state to share in recoupment of identified overpayments and overcharges, but also enable the state to limit profitability of the organization to reasonable returns on its investment. These provisions should include:
 - a. Refunds and recoveries of overpayments identified by the organization's operations, through its own program integrity or recoupment efforts
 - b. Recoupment of overpayments identified through the state's post-payment monitoring and audit efforts (Consult with Georgia for best practices in this area related to medical costs, and Texas for best practices in this area relating to administrative costs recoupment.)
 - c. Working with state actuaries to calculate interim capitated rate adjustments where significant over- or under-payments result from subsequent events or significant events outside normal expected operations
 - d. Experience rebate provisions that are designed to allow the organization to retain a reasonable return on its investment by establishing a tiered risk-sharing arrangement that involves recoupment for profitability that exceeds pre-determined thresholds. (Consult with Texas for best practices in this area.)

2. Periodically submit data to the state in a prescribed format

The state should establish a data reporting system that requires the managed care organization to report its encounter data and medical claims and administrative cost data promptly and regularly, in a prescribed format.

The most successful states have created specific cost reports (often referred to as financial statistical reports or experience reports) that the managed care organizations must complete and submit on a monthly (or at least quarterly) basis. In addition, they should submit an annual summary of costs, with any year-end adjustments for the entire year's operations. The most successful states have established an on-line reporting system so they can capture data in interactive electronic databases which permit further data analysis on the information provided. (Consult with Louisiana and Texas for best practices in this area.)

3. Implement regular monitoring programs

An effective comprehensive monitoring program establishes regular reviews of the organization's data, financial reports, and performance, through formal audits or less formal desk reviews. Doing so reassures the state that the data provided by the organization is accurate, its costs allowable, its profits accurate and reasonable, and its operations meet contract performance standards. And the managed care organization is prompted to perform at a high standard because it knows the results of its operations will be closely reviewed by its state partners. (Consult with Louisiana, Georgia and Texas for best practices in this area.)

Areas to be monitored

All cost-effective monitoring programs are founded on a comprehensive risk assessment of the managed care organization's operations. Since no state can devote unlimited resources to monitoring contracts, a risk assessment helps focus limited resources on areas with the greatest likelihood of problems. Risks should be assessed on a scale (for example, high/medium/low) in the following areas:

1. **Financial risks** What would prevent the organization from reporting costs that were allowable and accurate?
2. **Service risks** What would prevent it from serving Medicaid program members properly and so not complying with contract requirements?
3. **Business risks** What would prevent it from operating overall business systems effectively and supplying complete and accurate reporting data to the state?
4. **Systems risks** What would prevent it from maintaining and operating secure IT systems in compliance with HIPAA?

The most successful states conduct risk assessments at the start of their monitoring programs and update them annually or every other year. (Consult with Georgia and Texas for best practices in this area.)

Once risk assessments are completed, the state has a better idea of where to spend its monitoring dollars. An annual work plan can then be developed to address the high risk areas. The most successful states conduct audits and/or desk reviews covering the following areas:

- Allowability and accuracy of medical claims and administrative costs, and timeliness and completeness of recoveries as reported on the quarterly/annual cost reports. Review of costs and recoveries are essential in keeping overall costs of the program low. By identifying overpayments, unallowable costs and unreported recoveries, current total net costs can be reduced through potential recoupments, and future overstatement of capitation rates would be prevented.
- Accuracy and completeness of encounter data. Since encounters are the basis for making capitated payments to the managed care organizations, and utilized heavily by the actuary in establishing rates, a reconciliation of encounters for completeness and testing for accuracy is important.
- Member enrollment files to ensure accurate capitation payments have been made. The state pays a per-member/per month capitation rate to the managed care organizations for each member enrolled in managed care. Errors in the enrollment file, including duplicate member IDs, non-eligible members, or incorrect rate cell codes, can result in significant overpayments. A routine audit of the enrollment file is important to correct errors and to prevent continued overpayments.
- Compliance with contract performance provisions. These audits are often overlooked by states but they are essential in making sure the organization meets its contractual obligation to operate and administer the Medicaid managed care program effectively. Performance audits can be used to review any area within the contract that contains performance expectations and criteria such as adequacy of network coverage, handling of member complaints, management of call center operations, processing claims promptly, prior authorization procedures, program integrity procedures, etc. These audits can also check the accuracy of self-reported performance data.
- Confirm that problems have been corrected. It is essential that the state follow up on Corrective Action Plans (CAPs) that required the organization to address a problem identified in an earlier review or audit. CAPs are a vital component in the monitoring process to ensure the managed care organizations take timely action to address problems that are identified.
- Compliance with HIPAA laws and the required security of IT systems. HIPAA compliance reviews and SSAE 16 audits are often overlooked by states even though their contracts generally contain specific compliance provisions in these areas, which are essential to protect personal health information and patient confidentiality. It is important to also perform such reviews at the organization's delegated vendors, such as providers of dental, therapy, or vision services.

- Benefit administration. These reviews help ensure the organization is properly administering contractual benefits for beneficiaries; they can identify problems such as restricting access to care or improperly denying coverage.
- Actuarial reviews. These reviews give the state an independent assessment of its own actuarial process and the assumptions that are used in calculating the capitated rate.

Timing of audits and reviews

The most successful states conduct audits and/or desk reviews of cost and recoveries data submitted by the organizations at least annually. They audit both medical and administrative costs, and recovery of overpayments for accuracy and compliance with allowable cost principles reported on the cost reports. Some states conduct quarterly desk reviews, sampling data based on risk, then conduct a more comprehensive annual audit at the end of the fiscal year; similar timing applies to the review of member enrollment data. The most successful states reconcile submitted encounters to other available financial documents on a monthly or bi-monthly basis, which not only identifies missing encounters, but also identifies duplicates or other common errors. (Consult with Louisiana, Georgia and Texas for best practices in this area.)

States generally develop a performance audit schedule that ensures that each organization is subject to a performance audit at least once in a three-year cycle. The audit objectives are selected as a result of the risk assessment process, but should also address specific issues as needed. (Consult with Georgia and Texas for best practices in this area.)

Follow-up audits and reviews are often conducted on a set schedule (such as every three, six, or 12 months), depending on the problem to be fixed and its impact on services for members and/or cost savings. (Consult with Louisiana, Georgia and Texas for best practices in this area.)

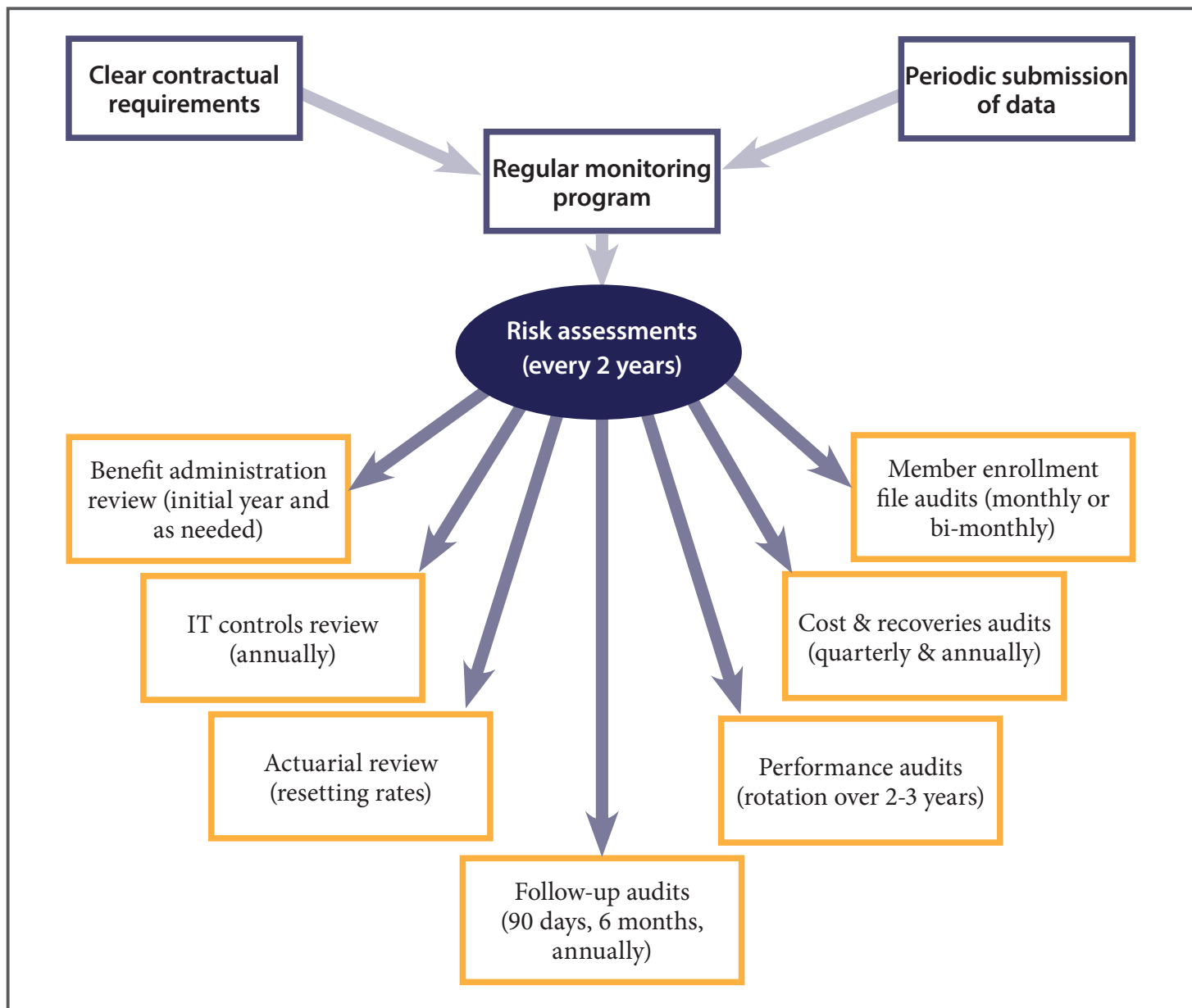
HIPPA compliance reviews and SSAE 16 audits are generally conducted annually, either by the state or by the organization as a contractual requirement. The organization is often required to send the results of IT systems reviews to the state. The most successful states thus pass the expense of conducting such reviews to the organizations while retaining control of their content and timeliness. (Consult with Texas for best practices in this area.)

Benefit administration reviews are generally conducted on an “as-needed” basis in response to complaints from program members. The state should conduct these reviews when launching its Medicaid managed care programs or when a new organization is added to existing programs, but they can also be performed periodically after the first year to ensure the new organization is complying with its obligations.

Actuarial reviews are generally conducted to coincide with period rate adjustment recalculations. Prudent states conduct them to ensure that the state’s actuary complies with contract provisions.

The diagram on the following page illustrates aspects of a ‘best practice’ management system for monitoring Medicaid managed care programs.

Best Practices in Monitoring Medicaid Managed Care Programs



Risk to capitated rate computation

- Overpayment of medical costs
- Overpayment of administrative costs
- Unallowable costs
- Unreported recoveries

Risk to MLR cost compliance

- Underserved Medicaid population

Risk of excessive capitated payments

- Inaccurate encounter data
- Ineligibles
- Duplicates

Risk to operational performance & contract compliance

- Network coverage
- Access to care
- Call center operations
- Timeliness of claims processing
- Member complaints

Appendix E: Community Health Plan of Washington (CHPW) additional testing results

CHPW claims population and sample amounts

Claims group examined	Total payment for 'outlier' claims	Number of 'outlier' claims	Total payment amount of sample	Control error rate (weighted) ¹	Estimated over/(under) payment amount ²
'Upcoding' diagnosis related group (DRG) codes	\$9,716,388	1,718	\$717,676	<1 %	(\$84,149)
Duplicate payment of evaluation & management codes	\$1,297,681	23,433	\$4,625	23%	\$210,641
Excessive billing using Modifier 25 code	\$1,408,399	19,860	\$5,032	3%	\$44,908
Unbundling CT Scans	\$1,829,252	3,020	\$70,655	7%	\$124,413
'Upcoding' evaluation & management codes	\$3,149,826	43,877	\$7,290	41%	\$461,888
One day inpatient stay	\$4,009,052	919	\$173,324	25%	\$1,084,293
Recurring orders for controlled substance medications	\$4,373,160	9,492	\$67,711	0%	\$0
Recurring orders for atypical antipsychotic drugs	\$981,205	277	\$179,310	0%	\$0
Total	\$26,764,963	102,596	\$1,225,625	15%	\$1,841,994

Notes: 1. The weighted error rate combines the results of individual strata into a single metric for the entire algorithm.
 2. Over/(under) payment was estimated from a statistically valid extrapolation process. See Appendix B for the statistical methodology used.

CHPW detailed results and overpayments

Algorithm name	Stratified sample reviewed	Number of results
'Upcoding' diagnosis related group (DRG) codes	49	1 inappropriately coded
Duplicate payment of evaluation & management codes	33	6 inappropriately coded 1 insufficient or lacked documentation
Excessive billing using Modifier 25 code	33	2 inappropriately coded
Unbundling CT scans	33	4 inappropriately coded
'Upcoding' evaluation & management codes	32	9 inappropriately coded 2 insufficient or lacked documentation
One day inpatient stay	33	7 inappropriately coded
Recurring orders for controlled substance medications	39	0 exceptions ¹
Recurring orders for atypical antipsychotic drugs	33	0 exceptions ¹
Total	285	

Note 1. It did not appear there was any doctor shopping, pharmacy shopping, or excessive amounts of controlled substances or antipsychotics in the claims

Third party recoveries

CHPW has a capitation agreement with its parent company, Community Health Network of Washington (the Network) for about 70 percent of its members. CHPW retains partial risk of claims expenses for those members, and recoveries relating to them are allocated based on the amount of risk retained. CHPW retains the full risk on the remaining 30 percent of its members and receives any related recoveries.

As the result of a system conversion in 2010, CHPW and their vendors pursued collection on some of the same recoveries resulting in duplications. Because of the uncertainty at year end as to the proper disposition of recoveries that had been received, the recoveries were not reported in income at either the CHPW or Network level and the allocation of the recoveries between these two entities was delayed pending further investigation. Additionally, the majority of the \$1,162,070 of recoveries was received subsequent to the submission of the experience report to the third-party actuary. CHPW told us that the question regarding the allocation of these recoveries was resolved in 2011, 2012, and 2013, and recorded to the appropriate entity. Of the recoveries relating to 2010 and received in subsequent years, \$19,210 was recorded by the Network and \$1,142,860 was recorded by the Plan. Obtaining the breakout of the recoveries between the Network and the Plan took repeated requests and is based on representations from the Plan.

Correctly coding administrative expenses

To understand the nature of administrative expense and any allocations we interviewed CHPW personnel and reviewed descriptions of the administrative expense process. In general, allocations are made based on the number of personnel assigned to each line of business.

To test the allowability and allocation methodology of administrative expenses, we first obtained the population of administrative expenses that were included in the Experience Report submitted to Milliman. The total amount of 2010 administrative expenses reported in the Experience Report was \$55,075,736. We obtained the general ledger detail of those expenses and traced them to the Experience Report.

We then selected a judgmental sample of 15 direct and 35 indirect expenses for detail testing. An indirect expense would be an expenditure that benefits multiple lines of business and is allocated on a reasonable basis. Our sample was selected to include expense categories that we felt were more likely to include unallowable expenses, based on past experience. Our sample of 50 expenses represented \$5,275,314 of the total administrative expenses included in the Experience Report.

We tested the 50 expenses for the following attributes:

- Was the disbursement properly supported by a vendor invoice or other documentation?
- Was the administrative expense allowable per OMB Circular A-87?
- Was the administrative expense allowable per FAR 31.2?
- If the expense was allocated from the parent company, was the allocation reasonable?

We determined that the allocation methodology used to allocate the indirect expenses charged from the parent company was reasonable and the expenses were allocated properly across the managed care organizations' lines of business including Washington.

We identified errors in six (12 percent) of the 50 administrative expenses reviewed. Three of the 50 indirect expenses reviewed were unallowable lobbying expenses according to OMB Circular A-87, #24 and two of the 50 indirect expenses were unallowable as public relations and advertising costs according to OMB Circular A-87, #1. OMB Circular A-87, #24, specifically states: "The costs of certain influencing activities associated with obtaining grants, contracts, cooperative agreements, or loans is an unallowable cost." OMB Circular A-87, #1, item (2)(b) specifically states: "Unallowable advertising and public relations costs include the following: Costs of meeting rooms, hospitality suites, and other special facilities used in conjunction with shows and other special events." In addition, item (3) in this section states, "Costs of promotional items and memorabilia including models, gifts and souvenirs" are also unallowable. These expenses were also unallowable per FAR 31.2. Finally, one of the 50 expenses sampled was for a direct expense for Medicare-related items and should not have been charged to Medicaid. The total amount paid for these six expenses was \$349,136.

These unallowable charges went unnoticed because CHPW did not have a policy and review process in place to identify them as unallowable, and therefore exclude them from statutory reporting and from the Experience report worksheets. According to the Director of Financial Reporting, beginning in 2011, CHPW stopped reporting lobbying expenses in the statutory reporting of the Plan. Similarly, no specific review procedure was in place to detect or prevent misallocations of Medicare expenses to all lines of business from occurring.

In total, we reviewed 50 administrative expenses and found that six or 12 percent totaling \$349,136 were unallowable and paid in error. Although this amount is not a significant amount of the total administrative expenses, the error rate found in our sample is a significant percentage. If the error rate of the sample were consistent throughout the population, the amount paid could potentially be significant thus overstating the amount of allowable administrative expenses reported by CHPW. In the rate setting process the actuary included an add-on administrative expense of 13.5 percent of premium revenue for total administrative costs, premium taxes and risk margin based on historical experience of this and other plans. Overstating the reported costs could potentially have resulted in an overstated add-on percentage factor.

Related party costs

In order to determine the existence of related parties to CHPW, we asked CHPW to provide an organizational chart of all related companies. An explanation of the relationship with the sole corporate member of CHPW, Community Health Network of Washington, was provided in lieu of an organizational chart. To verify we identified all related parties, we reviewed the registration information CHPW filed with the Washington State Office of the Insurance Commission and the financial statements of the parent company.

Based on CHPW's explanation and our review of documents, we found that Community Health Plan of Washington (CHPW or the Plan) is a controlled affiliate of Community Health Network of Washington (CHNW or the Network), a Washington State nonprofit corporation. The Network operates as a health care delivery network under the direction of 19 community and migrant health centers (the Centers) in Washington and comprises the clinics operated by these health care centers and other sites of care within the Network's service area.

In 2010, the Network was owned by 19 Federally Qualified Healthcare Centers (FQHCs), whose doctors could also be primary care providers (PCP) for CHPW members. If a member selected a related FQHC doctor, the capitation payments to the doctors would be related party payments due to the ownership structure. The contract governing the relationship specifically states that the Network warrants that payments made to member providers are similar to payments to non-member providers.

CHPW pays 85 percent of its premium revenue to CHNW to cover the medical claims of its members. Payments are made into a risk pool which is settled at the end of each year; once the settlement is determined, the FQHCs either pay into or receive funds from the pool. The Network is responsible for claims payments up to certain limits for the members of CHPW. Upon reaching those limits, there is a risk sharing arrangement between CHPW and the Network.

When assessing related party transactions, the cost principles in FAR generally categorize related party costs as either administrative or medical. Administrative related party costs are those costs incurred for administrative type functions such as finance, human resources, information technology, etc. Contracts for these type services are generally structured as management service agreements, where one company pays the other a management fee, which is typically some percentage of premium revenue. Medical related costs are those incurred to contract with a related party to provide ancillary medical services such as vision or behavioral health. We noted no administrative services provided by related parties for CHPW.

The costs incurred by CHPW for services provided by CHPN would be categorized as medical related party costs due to the nature of the services included in the related party payment. As a result, we determined that the services met the definition of commercial item under 2.101 and would be covered by the exemption under paragraph (c)(2) (iv) of section 16.601 of FAR.

Upon request, CHPW provided a complete list of Network providers. From that list we selected two related party providers and two non-related party providers and obtained a copy of the contracts with those providers. We reviewed those contracts to determine if the pricing for related and non-related providers was the same and found that the rates paid to related and non-related providers were comparable and did not appear to favor the Network related party providers.

Based on the contract language and our testing of provider contracts, the payments made to related parties do not contain profit in excess of what would be paid to an unrelated provider. Therefore, we determined that the full amount of related party medical costs incurred by CHPW would be allowable.

Appendix F: Molina additional testing results

Molina claims population and sample amounts

Claims group examined	Total payment for 'outlier' claims	Number of 'outlier' claims	Total payment amount of sample	Control error rate (weighted) ¹	Estimated over/(under) payment amount ²
'Upcoding' diagnosis related group (DRG) codes	\$10,744,081	1,768	\$918,098	19%	\$0 ³
Duplicate payment of evaluation & management codes	\$10,558,121	106,061	\$14,489	52%	\$4,756,672
Excessive billing using Modifier 25 code	\$13,240,213	119,083	\$14,329	38%	\$7,360,584
Unbundling CT Scans	\$2,281,176	4,345	\$47,508	19%	\$38,254
'Upcoding' evaluation & management codes	\$9,509,412	101,792	\$3,561	65%	\$2,015,841
One day inpatient stay	\$6,088,371	1,760	\$192,824	42%	\$681,887
Recurring orders for controlled substance medications	\$10,099,947	207,623	\$5,236	3%	\$718,757
Recurring orders for atypical antipsychotic drugs	\$776,908	1,839	\$16,421	8%	\$58,730
Total	\$63,298,229	544,271	\$1,212,466	22%	\$15,630,725

Notes: 1. The weighted error rate combines the results of individual strata into a single metric for the entire algorithm.

2. Over/(under) payment was estimated from a statistically valid extrapolation process. See Appendix B for the statistical methodology used.

3. For purposes of extrapolating the estimated overpayments, only strata with sample sizes greater than one were included. The error for this high-risk group had only one item in the strata and was therefore eliminated in the calculation of the estimated overpayment.

Molina detailed results and overpayments

Algorithm name	Stratified sample reviewed	Number of results
'Upcoding' diagnosis related group (DRG) codes	56	1 insufficient or lacked documentation
Duplicate payment of evaluation & management codes	35	12 inappropriately coded 5 insufficient or lacked documentation
Excessive billing using Modifier 25 code	32	3 inappropriately coded 5 insufficient or lacked documentation
Unbundling CT scans	33	3 inappropriately coded
'Upcoding' evaluation & management codes	35	12 inappropriately coded 7 insufficient or lacked documentation
One day inpatient stay	33	8 inappropriately coded
Recurring orders for controlled substance medications	34	5 insufficient or lacked documentation ¹
Recurring orders for atypical antipsychotic drugs	32	2 inappropriately coded 1 insufficient or lacked documentation ¹
Total	290	

Note 1. It did not appear there was any doctor shopping, pharmacy shopping, or excessive amounts of controlled substances or antipsychotics in the claims

Correctly coding administrative costs

To understand the nature of administrative expense and any allocations we interviewed Molina personnel and reviewed descriptions of the administrative expense process. In general, allocations are made based on the amount of revenue generated by each line of business including Washington.

To test the allowability and allocation methodology of administrative expenses we first obtained the population of administrative expenses that were included in the Experience Report submitted to Milliman. The total amount of administrative expenses reported in the Experience Report was \$86,372,638. We obtained the general ledger detail of those expenses and agreed them to the Experience Report.

We then selected a judgmental sample of 25 indirect and 25 direct expenses for detail testing. An indirect expense would be an expenditure that benefits multiple lines of business and is allocated on a reasonable basis. Our sample included expense categories that we felt were more likely to include unallowable expenses based on prior experience. Our sample of 50 expenses represented \$7,955,505 of the administrative expenses included in the Experience Report.

We reviewed the 50 expenses for the following attributes:

- Was the disbursement properly supported by a vendor invoice or other documentation?
- Was the administrative expense allowable per OMB Circular A-87?
- Was the administrative expense allowable per FAR 31.2?
- If the expense was allocated, was the allocation reasonable?

We identified two errors in the 50 expenses sampled, resulting in a total error rate of four percent. One did not include adequate documentation for us to determine if it was an allowable expense chargeable to the Healthy Options program. The second was not allowable according to OMB Circular A-87, #16, because it was a settlement with an employee for violating federal law. The Circular specifically states that fines and penalties are not allowable expenses:

“Fines, penalties, damages, and other settlements resulting from violations (or alleged violations) of, or failure of the governmental unit to comply with, Federal, State, local, or Indian tribal laws and regulations are unallowable except when incurred as a result of compliance with specific provisions of the Federal award or written instructions by the awarding agency authorizing in advance such payments.”

These expenses were also unallowable per FAR 31.2. The total amount paid in error was \$10,114.

Part of the administrative expenses charged to the Contract are administrative expenses allocated to the health plan by the parent company. Since the allocated corporate charges are ultimately included in the administrative expenses on the Experience Report, we also reviewed these expenses. We selected a sample of 25 corporate expenses and reviewed them to determine if they were allowable according to the above federal guidelines and if there was any inappropriate markup charged by the corporate office.

For the corporate charges, we found that four of the 25 corporate expenses were either unsupported or unallowable. One was supported by an invoice that did not match the amount in the general ledger, and for three expenses we were not provided adequate documentation to support the charge to the health plan. These errors resulted in a total amount paid in error of \$35,928 after we applied the corporate allocation rate to the total invoice amount.

The identified errors occurred because an adequate process was not in place to review the parent company expenses allocated to Molina to ensure they were allowable and should be charged to the Medicaid managed care line of business. Additionally, an adequate process was not in place to review expenses incurred by Molina to ensure they were allowable, adequately supported with appropriate documentation, and appropriately charged to the program.

In total, we sampled 75 administrative expenses and found that six (8 percent) were unallowable. Although the amount paid in error, \$46,042, is an insignificant amount when compared to total expenditures, the error rate (8 percent) found in our sample is a significant percentage. If the error rate of the sample was consistent throughout

the population of administrative costs, the amount paid could potentially be significant, thus overstating the amount of allowable administrative expenses reported by the plan. In the rate setting process the actuary included an add-on administrative expense of 13.5 percent of premium revenue for total administrative costs, premium taxes and risk margin based on historical experience of this and other plans. Overstating the reported costs could potentially have resulted in an overstated add-on percentage factor.

The corporate allocation allocates expenses across different states; the managed care organization also has administrative expenses which are allocated across the various lines of business. To ensure the allocation was appropriate and accurate, we asked Molina to provide the allocation methodology for the 25 indirect expenses we selected. We reviewed the allocation methodology and found it was on a reasonable basis and the expenses were allocated properly across the lines of business.

Related party costs

In order to determine the existence of related parties, we asked Molina to provide an organizational chart of all related companies. Molina gave us an explanation of their relationship with their parent company in lieu of an organizational chart. Molina also informed us that their subcontractor, March Vision, is a related party. We reviewed the registration information Molina filed with the Washington State Office of the Insurance Commission to ensure that all related parties were disclosed to us.

Based on Molina's explanation and our review of documents, we determined Molina Healthcare of Washington, Inc. (Molina) is a wholly owned subsidiary of Molina Healthcare, Inc. (MH), a for-profit, multi-state managed care organization that arranges for the delivery of health care services to its members. There are certain administrative services that MH provides for Molina which are allocated to the MH subsidiaries on a monthly basis. MH also holds an equity investment in a vision services company, March Vision Care Group, Inc. (March Vision), with which Molina contracts.

When assessing related party transactions, the cost principles in FAR generally categorize related party costs as either administrative or medical. Administrative related party costs are those costs incurred for administrative type functions such as finance, human resources, information technology, etc. Contracts for these types of services are generally structured as management service agreements, where one company pays the other a management fee, which is typically some percentage of premium revenue. Medical related costs are those incurred by contract with a related party to provide ancillary medical services such as vision or behavioral health.

The costs incurred by MH for services provided to Molina would be categorized as administrative related party costs due to the nature of the services included in the related party contract. We would categorize March Vision as medical related party costs due to the nature of the services included in the related party contract.

The administrative relationship between MH and Molina involves the payment of certain administrative expenses by MH on behalf of Molina. MH is reimbursed by its subsidiaries through a monthly charge. Expenses are budgeted at the beginning of the year and then allocated to each of the subsidiaries. The allocated amount based on the budgets is the amount invoiced to Molina each month. We reviewed the allocation to ensure that the basis of allocation was reasonable and that the allocated amounts did not exceed 100 percent of the expenses to be allocated. We also compared the amounts on the allocation worksheet to the December 2010 invoices to ensure that the calculated amounts were included on the actual invoice. We found that the basis of allocating the corporate charges and the allocation methodology were reasonable.

To ensure that the amounts allocated from the parent company were free from additional markup we selected a judgmental sample of 25 corporate charges and reviewed them to ensure the amount charged in the general ledger matched the amount of the invoice or other supporting documentation. We did not find that there was any additional markup of the corporate expenses.

Based on our review of the allocation and detailed testing, we determined that the payments made to MH for administrative services did not contain any profit component and were therefore allowable under the FAR cost principles.

Molina contracts with March Vision to provide vision related health services to its members. As noted above, MH has an equity interest in March Vision, thereby making it a related party to Molina. During 2010, March Vision provided vision related health services to only related parties. We determined that the services met the definition of commercial item under 2.101 and would need to be covered by the exemption under paragraph (c)(2)(iv) of section 16.601 of the FAR in order to be allowable.

We reviewed the contract between Molina and March Vision and compared the rates charged in it to a contract for similar services from another unrelated for-profit managed care organization. We found that the amounts paid by Molina for capitated vision services for its members were comparable to rates paid by other managed care organizations in an arm's length transaction. As a result, the payments made to related parties do not contain profit in excess of what would be paid to an unrelated provider. Therefore, we determined that the full amount of related party medical costs incurred by Molina would be allowable.

Appendix G: Glossary

Term	Definition
Actuary	A statistician who computes insurance risks and premiums. The Health Care Authority's third-party actuary calculates capitated rates which were used as the basis for setting the premiums paid to the managed care organizations.
Capitation	A payment method for health care services. The physician, hospital, managed care organization or other health care provider is paid a contracted rate for each member assigned, referred to as a "per-member-per-month" rate, regardless of the number or nature of services provided. The contractual rates are usually adjusted for age, gender, illness, and regional differences.
Computerized tomography (CT)	Combines a series of X-ray views taken from many different angles and computer processing to create cross-sectional images of the bones and soft tissue inside the body.
Diagnosis Related Group (DRG) codes	Codes used by hospitals to group ailments and the procedures used to treat those ailments into one code that can be charged to the payer.
Evaluation and Management (E&M)	Procedure codes used by all physician types to describe the level of effort and setting of general services provided to patients.
Fee-for-service	Charging a fee for each service performed. This is the payment system the Health Care Authority uses to pay for services for Medicaid members who are not enrolled in managed care or who need services that are not covered by managed care.
Managed Care Organizations	Companies that agree to provide most Medicaid benefits to people in exchange for a monthly payment from the state.
Medical Loss Ratio	The minimum percentage of each premium dollar a managed care organization must spend on medical services.
Modifier	A two character code that indicates a service or a procedure has been altered by some specific circumstance but has not changed in its definition or code.
Other Support Services covered by Medicaid	The following services are also funded by Medicaid, but administered by the Department of Social and Health Services: • Long term care • Home and community based care • Medicaid personal care • Developmental disabilities • Mental health • Chemical dependency
Outliers	A statistical observation that is markedly different in value or frequency of occurrence from the others of the sample.
Qualifications for Medicaid	To qualify for Medicaid in Washington, you must be: • A state resident and a US national, citizen, permanent resident, or legal alien • Low or very low income • In need of health care/insurance help And meet at least one of these conditions: • Pregnant • Under the age of 19, or over the age of 65 • A parent or relative caretaker of dependent children under age 19 • Blind • Disabled, or have a disabled family member in your household

Term	Definition
Subcapitation	Just as the managed care organizations are paid per-member, per-month premiums by HCA for Medicaid services, so the managed care organizations can arrange to pay the care providers they have contracted with in the same way. Generally, these arrangements, known as subcapitation agreements, allow the organizations to pay less for claims expenses than they would pay under the fee-for-service model.
Upcoding	Billing for services at a level of complexity that is higher than the service actually provided or documented.