PERFORMANCE AUDIT

Office of the Washington State Auditor
Pat McCarthy

Medicaid Program Integrity

Examining the Health Care Authority's oversight of efforts at state agencies

July 8, 2021

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Executive Summary

Background (page 8)

About two million state residents are enrolled in Medicaid (a program providing health coverage to people with low incomes), representing more than one in four Washingtonians. Every year the cost of Washington's Medicaid program increases, accounting for approximately $14.6 billion in state and federal funding in fiscal year 2020. More than half went to five managed care organizations (MCOs), with one receiving $3.7 billion.

Program integrity efforts focus on paying the right dollar amount to the right provider for the right reason. Federal program integrity requirements include:

- Incorporating specific provisions into contracts with MCOs
- Verifying beneficiaries meet eligibility requirements
- Screening providers to see if they are on federal exclusion lists
- Investigating questionable practices and referring credible allegations of fraud to law enforcement

States must comply with these requirements as a necessary condition to receiving considerable amounts of federal funding. About $9.5 billion of the $14.6 billion spent on Medicaid in fiscal year 2020 came from the federal government. Also, states can choose to go beyond federal program integrity requirements.

Strengthening program integrity efforts helps ensure every Medicaid dollar stretches as far as possible for those insured through Medicaid. Also, as the single state Medicaid agency, the Health Care Authority (HCA) is responsible for overseeing all of Washington's Medicaid programs, including those administered by other agencies.

HCA executives recently created a Division of Program Integrity to highlight its work, but they can improve oversight through strategic planning and performance measurement (page 15)

As the state's Medicaid agency, HCA executives are responsible for oversight of program integrity efforts. In 2020, HCA executives consolidated many of the agency's program integrity efforts into a single division. Before this change, repeated restructuring led to ever-shifting responsibilities and accountability.

Most recently, HCA executives created a Division of Program Integrity (the Division) to increase the visibility of program integrity efforts within the agency. Although HCA executives have taken steps to consolidate program integrity efforts, this work would benefit from improved strategic planning at the agency and division level.

While HCA executives conduct some oversight of program integrity efforts, they can improve their monitoring through better use of performance measures. Current meetings and committees are insufficient to verify the agency is meeting all program integrity requirements. Developing and monitoring performance measures are important leadership oversight activities. HCA has some program integrity measures but lacks others recommended by experts and used by other states. In addition, HCA does not use available measures to monitor program integrity performance.

HCA has not provided federally required oversight of Medicaid program integrity efforts at sister state agencies (page 25)

As Washington's state Medicaid agency, HCA must oversee all program integrity efforts, including those at sister state agencies. Oversight is a safety net to ensure policies are implemented and funding is spent as intended, and can include reviewing reports, monitoring results and implementing corrective action plans when necessary. In Washington, two sister state agencies – the Department of Social and Health Services (DSHS) and the Department of Children, Youth, and Families (DCYF) – spent more than $4 billion total in Medicaid funding in fiscal year 2020. Federal regulations require HCA to oversee program integrity efforts at DSHS and DCYF. HCA executives formalized oversight responsibilities in agency policy and interagency agreements, and assigned this responsibility to the Division of Program Integrity.

However, the Division has not overseen program integrity efforts at sister state agencies. Nonetheless, the Centers for Medicare and Medicaid Services (CMS) expects sound fiscal stewardship of Medicaid funding, and other states provide useful examples of what this could look like. While the sister state agencies say they have processes in place to ensure Medicaid funding is spent properly, the Division has not overseen those program integrity efforts because:

- Division managers have not assigned oversight of sister state agencies to any of the units
- The Division lacks a Statewide Medicaid Fraud and Abuse Prevention Plan outlining roles and responsibilities across key partners
- Change, transition and the lack of a Statewide Medicaid Fraud and Abuse Prevention Plan left managers uncertain of their oversight responsibilities

The Division has expanded its program integrity efforts with MCOs, but it can do more to reduce fraud and other improper payments (page 31)

Managed care changed how Medicaid pays for services, requiring a different approach to program integrity efforts. The Division is establishing ways to hold MCOs accountable for their role in program integrity efforts. For example, HCA executives sanctioned the five MCOs a total of nearly $1 million, based on the Division's audit of the data used to set monthly payment rates. Also, the Division requires MCOs to regularly report on their program integrity efforts, and has been discussing them with the organizations on a quarterly basis. In addition, HCA recently updated the contract to allow additional financial penalties for failure to fulfill program integrity requirements.

However, the Division could improve its oversight of MCOs by directly auditing providers and recovering overpayments. In addition to auditing encounter data, the Division should also audit providers contracted with the MCOs. The Division started reviewing providers contracted with MCOs but never initiated formal audits due to uncertainty as to what to do with the results. Also, Division managers still want guidance on how to handle identified overpayments.

Improvements to audit selection practices would help the Division prioritize resources for high-risk cases and meet federal requirements (page 37)

The Division can improve the ways it generates and evaluates the incoming leads that become reviews, audits and investigations of Medicaid providers. Other states' integrity programs provide examples of how to implement expert recommendations. For example, Florida's integrity program reports that shifting to a risk-based approach for identifying suspicious activity resulted in a significant increase in referrals to law enforcement.

The Division does not use risk assessments or formally established risk factors to guide its audit plans. While Division staff look for outliers and trends, only two of four units rely on proactive data analytics to develop their workplans. The Division recently established a team to review and prioritize leads, but Division managers had different perspectives on whether the team consistently received necessary data.

As the Division does not determine the credibility of fraud allegations for MCOs and DSHS, it cannot take appropriate action for many situations that merit scrutiny. In addition, analyzing all leads from MCOs would help Division staff gain experience and monitor MCO engagement in program integrity. Furthermore, collaborating with a Unified Program Integrity Contractor would allow the Division to pursue fraudsters working across Medicaid and Medicare.

State Auditor's Conclusions (page 44)

Medicaid is our state's largest public assistance program. It provides health coverage to about two million Washingtonians through a state-federal partnership, at a cost of more than $14 billion in fiscal year 2020. Given the size and importance of Medicaid, it needs a robust program integrity function to help ensure money is spent appropriately. Ensuring program integrity for a program this large and complicated is an inherently difficult task. That task is made even more difficult when the responsibility spans several state agencies and managed care organizations (MCOs).

As the single state Medicaid agency, HCA is responsible for overseeing all program integrity efforts — including the work of other agencies and the MCOs. That has not always happened, but to its credit, HCA has taken steps to improve its oversight. These efforts include reorganizing its own program integrity function and welcoming help from our Office in the form of this performance audit. Our audit has identified a number of opportunities for HCA to improve both its own program integrity efforts and its oversight of other entities' efforts. We would strongly encourage HCA to implement these recommendations.

Recommendations (page 45)

We recommend HCA executives improve overall oversight, strategic planning and performance measurement. We also recommend Division of Program Integrity managers improve strategic planning and performance measurement, oversight of program integrity at sister state agencies and MCOs, and the audit selection and assignment process.

Next steps

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

Background

Medicaid is a state and federal partnership that provides health coverage to people with low incomes

Medicaid is a jointly funded state and federal partnership that insures people with low incomes. While all states participate in Medicaid, states have discretion in how they structure their programs, including which services they will provide and eligibility categories, as long as they meet minimum federal requirements. Both states and the federal government pay for these services. The federal contribution varies based on many factors, including the service provided and state poverty levels.

In Washington, Medicaid is referred to as Apple Health, and it offers a wide array of services (see sidebar). These services are available to all low-income Washingtonians, with qualifying income levels varying based on age and conditions like pregnancy. Commonly eligible populations include children, the elderly and people with developmental disabilities. The Health Care Authority (HCA) has been Washington's single state Medicaid agency since 2011. This designation makes HCA responsible for meeting numerous federal requirements, including oversight of Medicaid programs administered by other state agencies.

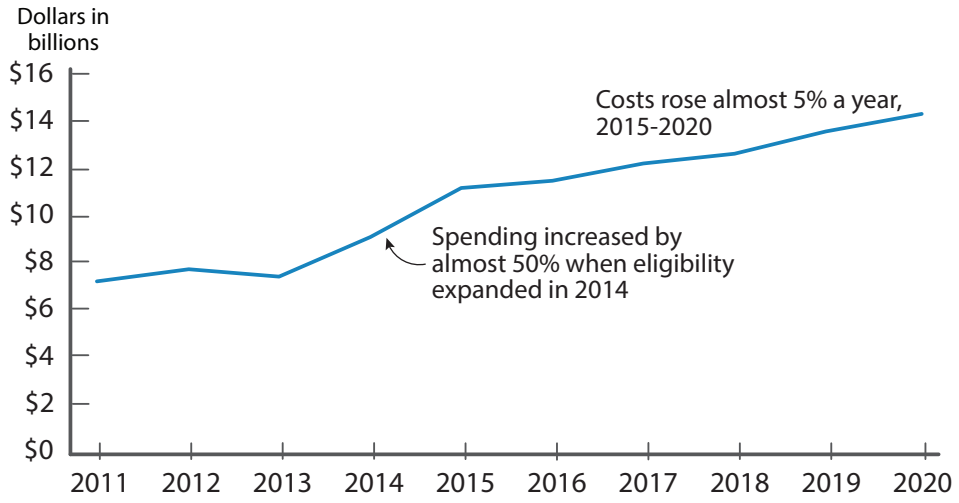
Medicaid offers a wide array of services

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

Medicaid insures one in four Washingtonians, with costs rising during the last decade to more than $14 billion

Medicaid is Washington's largest public assistance program, in terms of both cost and people served. About 2 million state residents were enrolled in Medicaid as of December 2020, representing more than one in four Washingtonians. Beginning January 2014, as part of the Affordable Care Act, Washington expanded Medicaid eligibility to include low-income adults. Two years later, a total of almost 600,000 newly eligible adults had joined the program and overall costs had increased almost 50 percent (see **Exhibit 1**). After that, enrollment was steady until the economic effects of the COVID-19 pandemic resulted in nearly 200,000 additional residents joining the program. Although enrollment had been stable, over the last five years Medicaid's overall costs increased at an average rate of 4.8 percent, until the program accounted for about $14.6 billion in state and federal funding in state fiscal year 2020.

Exhibit 1 – Medicaid spending in Washington
Fiscal years 2011-2020



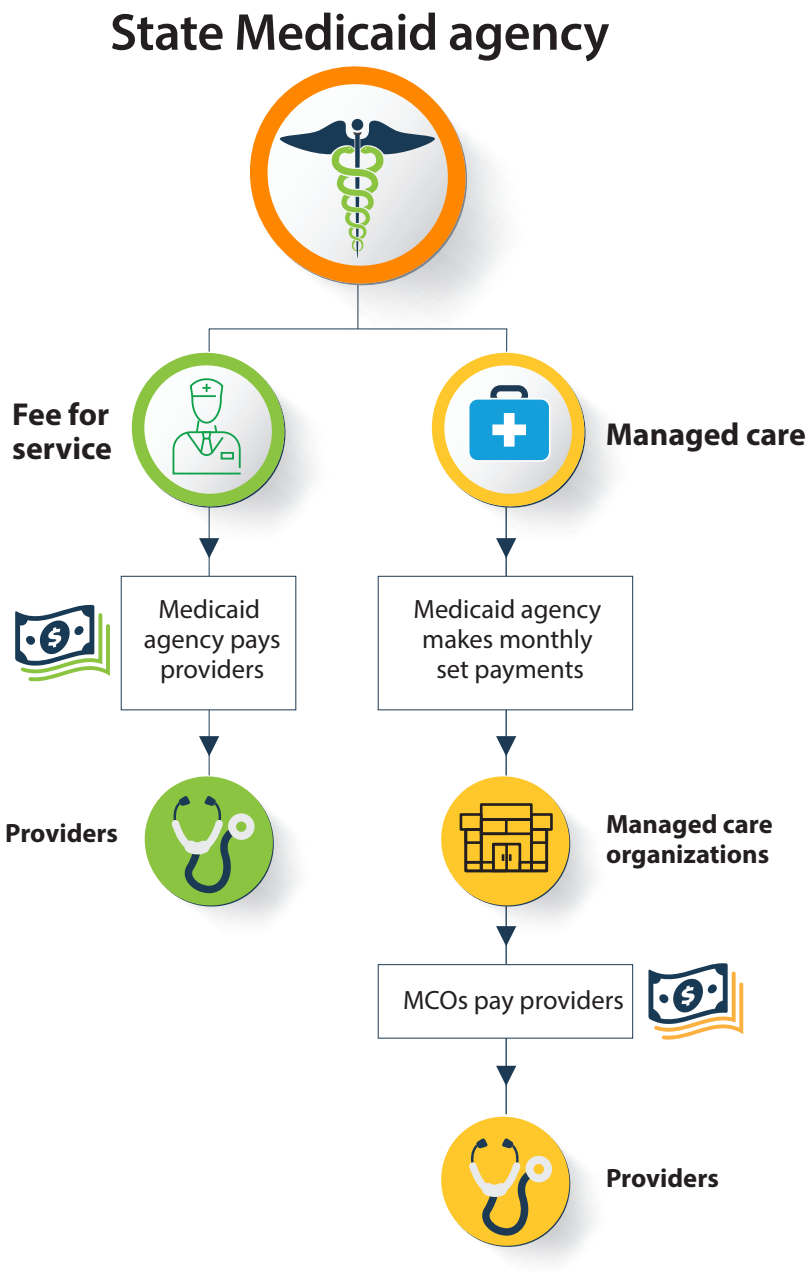
Source: Washington state single audits for fiscal years 2011- 2020.

Similar to many states, Washington has transitioned most clients to managed care

Washington has steadily transitioned most of its clients away from fee-for-service, where the state Medicaid agency pays providers directly for each service rendered, to managed care, where private insurance companies provide specific services in exchange for monthly payments. **Exhibit 2** shows the difference between these payment arrangements. Nationwide, state Medicaid agencies have tried to reduce costs and better manage how health services are used by contracting with managed care organizations (MCOs). These private health insurance companies provide specific services in exchange for monthly payments. The monthly payments are based in part on the actual cost of services the MCOs have paid for in previous years.

Prior to 1987, all Washingtonians covered by Medicaid received services through a fee-for-service program. Currently 85 percent of enrollees receive physical and behavioral health services through one of five MCOs. In fiscal year 2020, the state directed almost $8 billion in payments to the five organizations: one received $3.7 billion to serve approximately 750,000 clients.

Exhibit 2 – Comparing fee-for-service and managed care processes for paying Medicaid service providers



Because Medicaid is a large, high-risk program, federal regulations include numerous program integrity requirements

A large volume of claims and complex rules increase the risk of fraud and other improper payments

Medicaid has been on the Government Accountability Office's high risk list since 2003 due to a diverse and expanding population of clients and providers; large overall payment sums; complex billing and coding systems; and the challenges inherent in providing federal oversight to more than 50 independent programs in the states and territories.

While media reports occasionally describe organized crime rings defrauding Medicaid, most improper payments result from challenges with documentation and complex Medicaid requirements. In September 2020, federal and state law enforcement charged more than 300 defendants nationwide, including more than 100 licensed medical professionals, for their apparent involvement in a $4.5 billion fraud scheme that allegedly billed unnecessary care to clients on Medicare and Medicaid based on brief telehealth calls. These events draw media attention. However, the Centers for Medicare and Medicaid Services (CMS), which provides the federal regulatory framework for Medicaid program integrity, reported significant amounts of improper payments during 2019 were due to two primary reasons. First, insufficient documentation to verify client eligibility. Second, state Medicaid agencies did not comply with federal requirements for screening and enrolling providers. These issues produced a nationwide Medicaid improper payment rate of 14.9 percent. This means approximately one in seven Medicaid payments lacked sufficient documentation or displayed some sort of error.

To combat the risks, states must meet numerous federal program integrity requirements

Program integrity efforts focus on paying the right dollar amount to the right provider for the right reason. These efforts are intended to prevent and detect fraud and other improper payments, so that taxpayer dollars are available for delivering necessary care. Federal program integrity requirements include:

- Incorporating specific provisions into contracts with MCOs, to ensure these private insurance companies identify and address fraud and other improper payments
- Verifying clients meet eligibility requirements, to identify situations like families hiding assets so their elders qualify for financial assistance for long-term care

- Screening providers against federal exclusion lists, to ensure providers with known histories of defrauding government programs do not provide services for Medicaid
- Verifying clients received billed services, to identify providers billing for services that were never rendered
- Investigating questionable practices and referring credible allegations of fraud to law enforcement, to pursue criminal charges when appropriate

States can also choose to do more than the federal requirements – they have as much discretion in structuring their program integrity efforts as they do the rest of their Medicaid programs. A continuum of state program integrity activities – both optional and required – is listed in **Appendix C**.

Gaps in program integrity efforts have financial consequences for Washington

State programs that fail to comply with federal program integrity requirements risk paying back federal funding. This is a substantial sum: about $9.5 billion of the $14.6 billion Washington spent on Medicaid in fiscal year 2020 came from the federal government. Every year, the Office of the Washington State Auditor conducts the federally required Single Audit, to determine if state agencies are complying with specific federal requirements. Concerns are publicly reported as findings. These findings are often resolved within months, but sometimes persist for several years. Ten of Washington's 13 repeat Medicaid Single Audit findings are related to program integrity requirements. Some of these requirements are HCA's responsibility; others are the responsibility of the Department of Social and Health Services (DSHS). While many of these findings did not involve questioned costs, some did. For example, in August 2020 CMS requested a refund of $114 million for one such finding. (The state does not agree with this finding and is currently discussing it with CMS, so the final amount the state must repay may be reduced or eliminated.)

Program integrity efforts ensure available funding goes to needed services, and can help flatten the rising Medicaid cost curve. Potential return on investment depends on the amount of existing fraud and other improper payments, and states' methods for calculating return on investment will differ. Florida regularly publishes a comprehensive report of program integrity efforts. Florida reported that during fiscal year 2019, it recovered nearly $5 for every dollar it spent on program integrity recovery efforts, and nearly $45 for every dollar spent on program integrity prevention efforts.

In Washington, state agencies and managed care organizations play a role in program integrity efforts

Key participants in Washington's program integrity efforts include:

- The **Health Care Authority (HCA),** which has been the state's Medicaid agency and primary payer for health care services since 2011. As the state Medicaid agency, HCA must ensure Washington meets the numerous federal program integrity requirements associated with the federal Medicaid grant award. HCA has a newly established Division of Program Integrity (Division), which is responsible for many – but not all – of the state's Medicaid program integrity efforts.
- The **Department of Social and Health Services (DSHS)** primarily uses Medicaid funding to pay for long-term care for the elderly and people with disabilities. It has its own program integrity efforts for ensuring client and provider eligibility.
- The **Department of Children, Youth, and Families (DCYF)** primarily uses Medicaid funding on supports and services for children and young adults who have complex needs and experience significant behavioral health challenges.
- The **five managed care organizations (MCOs)** operating in Washington are private health insurance companies with large networks of contracted providers, which include doctors, counselors and specialists. The MCOs must establish their own program integrity efforts to identify and address fraud and other improper payments.
- The **Medicaid Fraud Control Division** in the Attorney General's Office handles the law enforcement side of program integrity.

This audit examined opportunities to improve Washington's Medicaid program integrity efforts

The cost of Washington's Medicaid program has risen during the last decade, and the program expands to meet rising needs that come during times of economic decline. Strengthening program integrity efforts helps ensure every Medicaid dollar stretches as far as possible to serve those insured through the program. HCA suggested a performance audit of its program integrity efforts could be beneficial, because the agency is making improvements in this area.

The audit answers the following questions:

1. Are there opportunities for HCA executive management to improve its oversight over program integrity?
2. How can the Division of Program Integrity improve its structure and processes to more effectively reduce fraud and other improper payments?

The audit team identified leading practices for program integrity efforts and worked with HCA and experts to identify states considered nationwide leaders in Medicaid program integrity. We spoke to officials from integrity programs in seven states and reviewed comprehensive reports for an eighth state. We also interviewed leadership and management at HCA and sister state agencies. In addition, we reviewed federal regulations, state laws, the State Medicaid Plan, agreements between HCA and sister state agencies, policies and procedures at HCA and DSHS, contracts between HCA and the MCOs, organizational charts, performance measures, strategic plans, and other related documents. Then, we compared Washington's practices with other states' practices and expert recommendations to identify potential gaps and opportunities for improvement. For more information about our methodology, see Appendix B.

This report organizes our results into four broad areas:

- HCA executives' oversight responsibilities within their own agency
- Oversight of Medicaid program integrity efforts at sister state agencies
- The Division's program integrity efforts with MCOs and its oversight of the MCOs' efforts
- The Division's processes to generate and evaluate the leads that become audits, reviews and investigations of Medicaid providers

Audit Results

HCA executives recently created a Division of Program Integrity to highlight its work, but they can improve oversight through strategic planning and performance measurement

Summary of results

As the state's Medicaid agency, Health Care Authority (HCA) executives are responsible for oversight of program integrity efforts. In 2020, HCA executives consolidated many of the agency's program integrity efforts into a single division. Before this change, repeated restructuring led to ever-shifting responsibilities and accountability. Most recently, HCA executives created a Division of Program Integrity to increase the visibility of program integrity efforts within the agency. Although HCA executives have taken steps to consolidate program integrity efforts, this work would benefit from improved strategic planning at the agency and division level.

While HCA executives conduct some oversight of program integrity efforts, they can improve their monitoring through better use of performance measures. Current meetings and committees are insufficient to verify the agency is meeting all program integrity requirements. Developing and monitoring performance measures are important leadership oversight activities. HCA has some program integrity measures but lacks others recommended by experts and used by other states. In addition, HCA does not use available measures to monitor program integrity performance.

Terms for Health Care Authority's management in this report

"HCA executives" refers to all executive leadership at HCA, including the Director and Deputy Director, their direct reports, and the assistant directors who lead each division at HCA. This includes the State Medicaid Director and the Assistant Director for the Division of Program Integrity.

"Division managers" refers to the Assistant Director for the Division and the managers for the different units within the Division. Depending on context, the Assistant Director for the Division may be part of HCA executives or Division managers.

As the state's Medicaid agency, HCA executives are responsible for oversight of program integrity efforts

Federal regulations place responsibility for all of the numerous program integrity requirements on the state's designated Medicaid agency. Among them is the requirement that the agency develop an internal control system consistent with Government Accountability Office guidance, set out in *Standards for Internal Control in the Federal Government* (2 U.S. Code of Federal Regulations 200.303). This guidance recommends an agency's oversight body monitor the progress made toward key objectives, guide division management, question management's activities, present alternative views and take action when needed to ensure objectives are met. At Washington's HCA, the agency's oversight body is composed of members of HCA executive leadership – including the Director and direct reports. (In this report, HCA executives refers to all executive leadership at HCA, including the Director and Deputy Director, their direct reports and the assistant directors which lead each division at HCA.)

The purpose of executive oversight is to ensure public agencies achieve expected results. Oversight is also a safety net to ensure:

- Policies and strategies are implemented as intended
- Money is spent as intended
- Activities comply with policies, laws and regulations
- Emerging areas of concern are identified and resolved

Insufficient oversight increases the risk that gaps in program integrity efforts will result in fraud and other improper payments going undetected. Appropriate oversight of each program integrity effort can differ depending on HCA executives' confidence in the internal control processes in place. If HCA executives know internal controls are in place and functioning as expected, periodic review of results may be sufficient oversight. However, for new or more complex activities where internal controls do not exist or are unproven, HCA executives may need to give staff more guidance and review the results of the effort more frequently.

In 2020, HCA executives consolidated many of the agency's program integrity efforts into a single division

Repeated restructuring led to ever-shifting responsibilities and accountability

HCA's organizational structure for program integrity efforts has shifted repeatedly in response to concerns about decentralization, accountability and changing operations. **Exhibit 3** shows the changes made in several different reorganizations of program integrity responsibilities since 2015. The first, in 2015, was part of the transition to managed care. Other changes were made after the Centers for Medicare and Medicaid Services (CMS) 2018 recommendation to improve accountability or to centralize certain program integrity responsibilities into a single unit. Specifically, CMS expressed concern that decentralized program integrity duties and responsibilities across the agency created potential risk by separating vital efforts and reducing the authority of some program integrity units.

Exhibit 3 – Changes in HCA organizational structure affecting program integrity efforts

Restructure	Dates
The Section of Program Integrity moved to the Medicaid Program Operations and Integrity Division.	2015
Fraud Investigations moved to Office of Audit and Accountability.	2015
Preadmission Screening and Resident Review team joined the Section of Program Integrity. This team screened all individuals being referred to Medicaid-certified nursing facilities.	July 2018
Fraud Investigations moved from Office of Audit and Accountability to the Section of Program Integrity. Patient Review and Coordination and the Preadmission Screening and Resident Review Team left the Section of Program Integrity.	September 2018
A new unit responsible for Managed Care Oversight was created by consolidating two teams.	December 2018
Provider Enrollment moved to the Division of Program Integrity.	January 2021

Source: Auditor created based on a review by CMS, the Section's draft strategic plan and interviews with the agency.

However, each restructure changed accountability for the related program integrity effort, such that both staff and management had to respond to revised responsibilities and program integrity requirements.

HCA executives created a Division of Program Integrity to increase the visibility of program integrity efforts within the agency

In September 2020, HCA executives decided to increase the visibility of program integrity efforts within the agency by promoting the Section of Program Integrity

to a Division. **Exhibit 4** shows HCA's organizational structure prior to this change: the Section of Program Integrity (Section) reported to the Assistant Director of Medicaid Program Operations and Integrity. **Exhibit 5** shows the structure after the change: the new Division of Program Integrity (Division) reports directly to the State Medicaid Director. As part of this change, the head of the new Division was promoted to an Assistant Director and thus a member of HCA executive leadership. The Assistant Director of the Division now attends meetings with other HCA executives and serves on some leadership committees.

Exhibit 4 – During 2020, two different executive managers oversaw program integrity activities

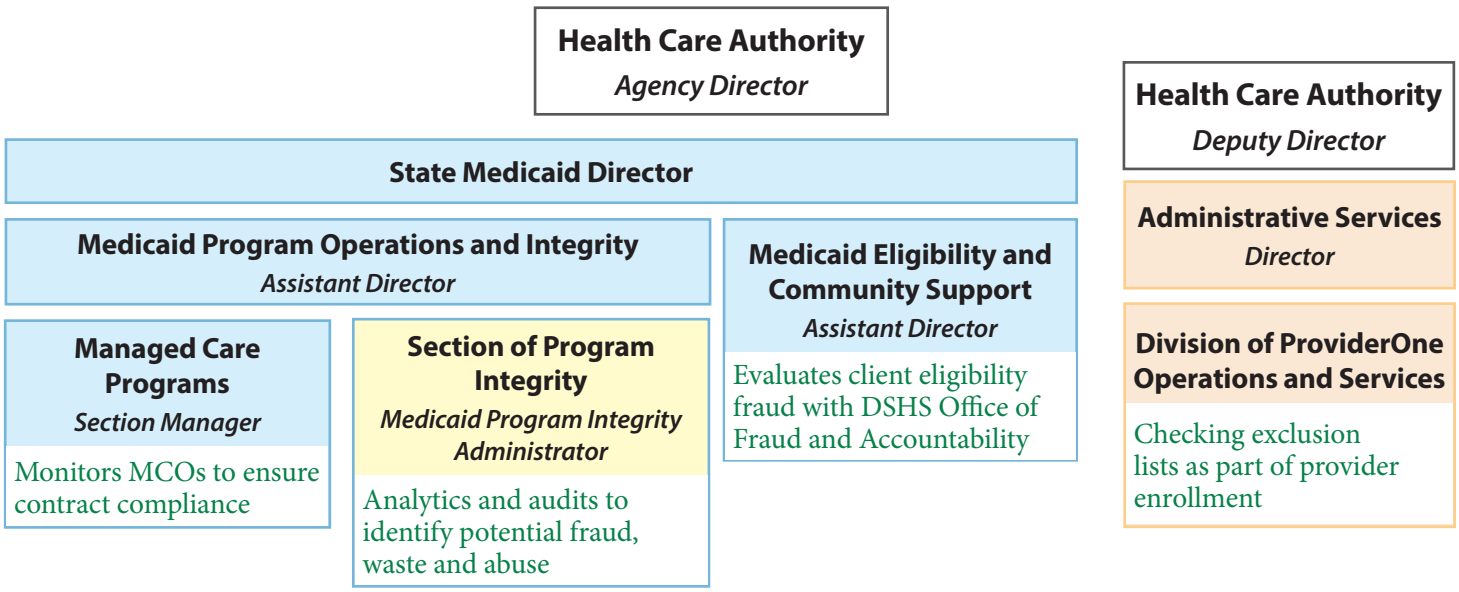
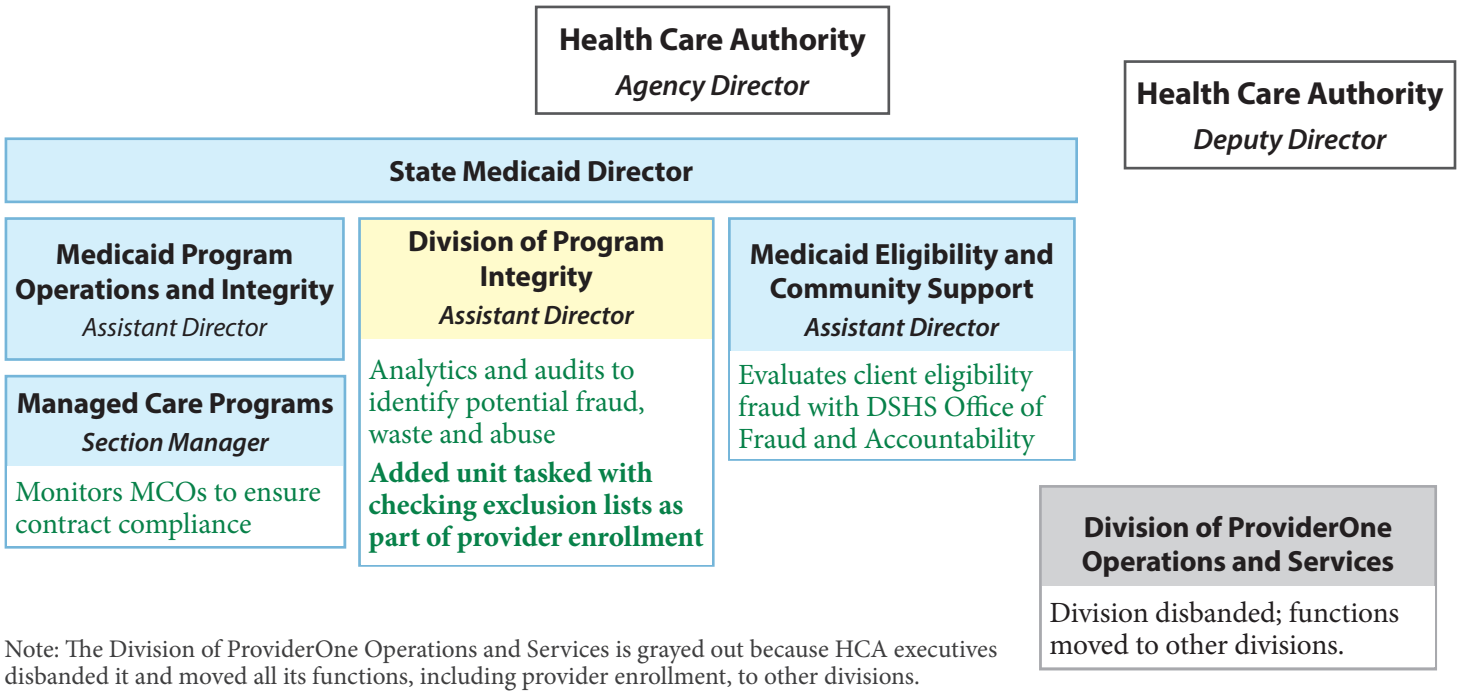


Exhibit 5 – As of 1/2021, tasks for the new Division of Program Integrity include provider enrollment



Note: The Division of ProviderOne Operations and Services is grayed out because HCA executives disbanded it and moved all its functions, including provider enrollment, to other divisions.

Source: Auditor created based on HCA organizational charts and interviews with HCA executive leadership.

The final organizational change listed in Exhibit 3 (page 17) integrated provider enrollment with other crucial program integrity efforts on January 1, 2021. Provider enrollment is an important aspect of program integrity because staff check federal exclusion lists during the process to ensure providers with known histories of fraud, waste or abuse do not provide services for Medicaid. By moving provider enrollment to the new Division of Program Integrity, HCA executives addressed a recommendation by CMS aimed at reducing the fragmented responsibility for program integrity. Previously, the Administrative Services Director was responsible for oversight of provider enrollment and the State Medicaid Director was responsible for oversight of several other program integrity functions within the agency. The result is now a centralized unit that includes provider enrollment, fraud and abuse detection, investigations and law enforcement referrals.

Although HCA executives have taken steps to consolidate program integrity efforts, this work would benefit from improved strategic planning at the agency and division level

Strategic plans with clearly articulated objectives would help all levels of management lead the Division. Improving strategic planning for program integrity – for both the agency and the Division of Program Integrity – would help HCA executives increase the likelihood of success of program integrity efforts. Other benefits of strong strategic plans include:

- **Communicate a common vision.** With clear objectives and a path towards accomplishing them, management and staff will have a common vision on how to achieve results, including prioritization of initiatives.
- **Identify effective internal controls.** Effective internal controls provide reasonable assurance an entity will achieve its objectives. For this to occur, there must be clear, specific and measurable objectives, which should come from the entity's mission and strategic plan.
- **Improve risk assessment.** Setting clear objectives is a first step towards identifying risks and defining risk tolerances.
- **Develop a good performance measurement process.** Strategic Plan Guidelines issued by the Office of Financial Management state good plans convey goals and objectives to be achieved, strategies to accomplish them, and performance measures to track and gauge progress.
- **Comply with state law.** As part of the budget process, RCW 43.88.090 requires state agencies to establish measurable goals with clear strategies and timelines to achieve the goals for each major activity in their budgets.

HCA's agencywide strategic plan makes only limited mention of program integrity, and it does not set clear objectives to focus program integrity efforts. Furthermore, while the agencywide plan includes mention of provider enrollment and data analytics for program integrity, it does not set specific objectives for any program integrity effort. Clearly stating those objectives in the agency strategic plan would further emphasize the importance of program integrity to everyone in the agency.

Guidance from the Office of Financial Management underscores the importance of clear objectives to both the Division and the wider agency. For example, clearly stated objectives would help determine the new Division's priorities and provide staff with a unified understanding of its goals. The guidance goes on to note the most valuable part of an agency's strategic plan is the periodic process of confirming goals, assessing progress toward outcomes, evaluating effectiveness of plans and adjusting strategies to improve performance. Having such processes would be an effective way for HCA executives and Division managers to monitor progress towards stated goals and objectives, and intervene with corrective action if needed.

Aside from the absence of program integrity in HCA's agencywide strategic plan, the new Division also lacks an approved strategic plan. Prior to becoming a division, managers of the Section of Program Integrity developed a draft strategic plan for the 2019-21 biennium. However, after the plan was drafted, four different people assumed the role of assistant director responsible for program integrity. Each person brought a different knowledge and perspective about the focus and priorities for program integrity. The draft strategic plan was never finalized at least in part due to frequent changes in HCA executives and ongoing restructuring of program integrity efforts. As it stands, the draft strategic plan lacks program integrity objectives and priorities, accountability for items listed and a process for monitoring progress.

While HCA executives conduct some oversight of program integrity efforts, they can improve their monitoring through better use of performance measures

Current meetings and committees are insufficient to verify the agency is meeting all program integrity requirements

Recurring meetings between an employee and supervisor are a good way to discuss emerging concerns, but these one-on-ones play a limited role in effective oversight. In the case of HCA, the State Medicaid Director has many oversight responsibilities including oversight of the Division. Recurring meetings between the State Medicaid Director and the Division's Assistant Director provide a forum to hear updates about select program integrity initiatives and to stay apprised of any concerns.

However, these meetings are not intended to be a complete operations overview so the State Medicaid Director cannot use them to verify whether all program integrity requirements are met.

In addition, frequent leadership changes have diminished the continuity of topics prioritized for discussion during one-on-ones. The information shared during these conversations changed with each assistant director and resulted in shifting viewpoints about program integrity needs and priorities.

Several committees support the State Medicaid Director, but none oversee all program integrity efforts. At the HCA executive leadership level, committees such as the Delivery System Leadership Committee and the Major Initiatives Review Committee oversee select program integrity projects or issues. However, not even the collective efforts of these and other committees monitor all program integrity requirements. Without an effective oversight process that monitors all requirements, HCA executives do not know whether program integrity functions are operating as required.

Developing and monitoring performance measures are important leadership oversight activities

Using performance measures to monitor progress toward objectives and hold others accountable is a leadership best practice required by state law and recommended by federal guidance. Here again, the Office of Financial Management offers guidance; it states that performance measures are a tool to help management understand and improve results and ensure resources are being used effectively. **Appendix D** lists the best practices and reasons for developing and monitoring performance measures that align with objectives.

HCA has some program integrity measures but lacks others recommended by experts and used by other states

The Section of Program Integrity developed some limited performance measures. In 2018, it published two program integrity measures on HCA's website: total improper payments identified and the number of audits initiated and completed during the previous year. Division managers have also tracked total recoveries and preliminary audit findings issued within 120 days. In November 2020, one of the Division's four unit managers developed and began tracking measures related to case reviews, audits and site visits for each auditor on her team.

One barrier to developing additional performance measures is the agency's lack of an IT solution that uses data analytics to detect fraud and other improper payments. Most state Medicaid agencies use sophisticated software to identify potential fraud and other improper payments in provider, client and claim data.

The Division lacks a fraud and abuse detection system, and Division managers said this hinders their ability to track additional performance measures. The Division initiated procurement of a new fraud and abuse detection system in 2019, but the procurement process involved many stakeholders – including CMS – and faltered before the purchase was completed. As of 2021, the Division is preparing to solicit a second round of bids.

Other barriers to developing good performance measures include the frequent organizational restructures and the lack of an approved strategic plan with program integrity objectives. Multiple reorganizations in a short period of time reduced the operational stability needed to develop good measures. Performance measurement expert Harry Hatry warns that programs undergoing major change in responsibilities or personnel are poor candidates for developing performance measures. Stability within the Division would help management develop needed measures. In addition, state law and federal guidance suggest performance measures should flow out of clear and measurable program objectives. Without these objectives, managers cannot know which performance measures will best help them achieve desired outcomes. Neither the Section's draft plan nor the agencywide strategic plan included clearly measurable objectives for program integrity.

Based on input from HCA and subject matter experts, we identified eight other states, listed in the sidebar, that are considered nationwide leaders in program integrity. (See Appendix B for additional information on how we selected these states.) Using information from these states and additional research, we identified performance measures HCA should consider when developing measures to demonstrate the Division's ability to identify fraud and other improper payments.

Comparison states

Arizona	Florida
Iowa	Kentucky
Minnesota	New York
Tennesee	West Virginia

Exhibit 6 (on the following page) lists common performance measures recommended by experts and measures tracked by the other states' integrity programs. It shows Washington is not tracking several measures used by other states.

Exhibit 6 – Washington uses fewer performance measures recommended by experts

Measures recommended by experts	Measures used by state Medicaid agencies								
	WA	AZ	FL	IA	KY	MN	NY	TN	WV
Number of referrals generated For example: Referrals from MCOs to the Medicaid Fraud Control Unit Referrals from MCOs to state Medicaid integrity program Referrals from state Medicaid integrity programs to law enforcement		✓	✓	✓	✓	✓	✓	✓	✓
Dollar value of fraud, waste and abuse identified For example: Dollar value of overpayments identified Dollar value of Improper payments identified	✓		✓	✓		✓	✓		✓
Dollar value of fraud, waste and abuse prevented For example: Cost savings generated by MCOs' preventive measures	*	✓	✓			✓	✓	✓	
Dollar value of recoveries related to fraud, waste and abuse For example: Dollar value of overpayments recovered Dollar value of improper payments recovered	✓	✓	✓	✓		✓	✓	✓	✓
Tracking of case status, in various forms For example: Number of cases escalated for investigation by source or type of case Number of investigations opened per quarter or fiscal year Number of open and closed cases Number of cases closed with and without findings Number of audits initiated and completed	✓	✓	✓	✓	✓	✓	✓		✓
Time from open to completion of case For example: Length of time cases are open Number of times preliminary findings issued within 120 days	✓	✓				✓			
Number of successful prosecutions by law enforcement		✓						✓	
Return on investment		✓	✓		✓				✓
Number of providers sanctioned, suspended or terminated / excluded		✓	✓			✓	✓		
What happened to referrals and sources for open and closed cases						✓	✓		
Number of site visits by provider type			✓			✓			

*Note: Division managers report they formerly tracked cost savings, but currently do not due to staff turnover and the lack of a fraud and abuse detection system.

Source: Auditor created based on interviews with and reports provided by Division managers and program managers at other states' integrity programs.

HCA does not use available measures to monitor program integrity performance

Neither HCA executives nor Division managers consistently review the results of available program integrity performance measures. HCA executives use the Executive Leadership Scorecard and the Executive Quarterly Targeted Review report to review agency performance. However, these reports have not included the Division's program integrity measures. While the Division has developed some limited performance measures, Division managers actively monitor only one measure: the requirement in state law that draft audit reports be issued within 120 days of the provider giving HCA all requested information. Even that measure is not examined consistently. One unit manager watches to ensure the deadline is not missed; another unit manager tracks the measure auditor by auditor.

Unlike Washington, other states' integrity programs said they regularly monitor their performance measures and use them in various ways. All of our comparison states said they monitor their results and discuss them with agency leadership. Managers in two of the seven states we interviewed said they use measures to monitor year-to-year trends in performance, while two other states use dashboards or charts to summarize and display results for agency leadership and staff within their programs.

In any organization, leadership must monitor appropriate performance measures to identify areas that need improvement and to demonstrate progress toward meeting objectives. With the current gaps in performance measurement, HCA executives and Division managers cannot use performance measures to:

- Support strategic planning efforts
- Monitor managed care organizations
- Examine and understand changes in performance
- Compare performance to established targets, to prior periods and with similar organizations or programs
- Motivate personnel to improve performance
- Demonstrate program integrity's effectiveness in protecting state and federal funding

The lack of good performance measures also makes it harder to demonstrate success to the Legislature and other stakeholders.

HCA has not provided federally required oversight of Medicaid program integrity efforts at sister state agencies

Summary of results

As Washington's single state Medicaid agency, HCA must oversee all program integrity efforts, including those at sister state agencies. Oversight is a safety net to ensure policies are implemented and funding is spent as intended, and can include reviewing reports, monitoring results and implementing corrective action plans when necessary. The Department of Social and Health Services (DSHS) and the Department of Children, Youth, and Families (DCYF) spent more than $4 billion total in Medicaid funding in fiscal year 2020. Federal regulations require HCA to oversee program integrity efforts at DSHS and DCYF. HCA executives formalized oversight responsibilities in agency policy and interagency agreements, and assigned this responsibility to the Division.

However, the Division has not overseen program integrity efforts at sister state agencies. Nonetheless, CMS expects sound fiscal stewardship of Medicaid funding, and other states provide useful examples of what this could look like. While the sister state agencies say they have processes in place to ensure Medicaid funding is spent properly, the Division has not overseen those program integrity efforts because:

- Division managers have not assigned oversight of sister state agencies to any of the units
- The Division lacks a Statewide Medicaid Fraud and Abuse Prevention Plan outlining roles and responsibilities across key partners
- Change, transition and the lack of a Statewide Medicaid Fraud and Abuse Prevention Plan left managers uncertain of their oversight responsibilities

As Washington's single state Medicaid agency, HCA must oversee all program integrity efforts, including those at sister state agencies

DSHS and DCYF spent more than $4 billion total in Medicaid funding in fiscal year 2020

DSHS and DCYF have both distributed Medicaid funding and are subject to program integrity oversight by the state Medicaid agency.

In fiscal year 2020, HCA distributed about $4.7 billion in Medicaid funding to DSHS and almost $56 million to DCYF (shown in **Exhibit 7**). DSHS primarily spends Medicaid funding on long-term care for clients who are elderly or have developmental disabilities. This care can range from occasional in-home help with activities of daily living to long-term care in a nursing home. DCYF primarily spends Medicaid funding on supports and services for children and young adults who have complex needs and experience significant behavioral health challenges.

Exhibit 7 – HCA distributed one-third of $14.6 billion in combined Medicaid funding through sister state agencies

Fiscal year 2020; $14.6 billion includes $5.1 billion in state and $9.5 billion in federal funds

	HCA	DSHS	DCYF
State funds distributed	$3.1 billion	$2.0 billion	$26.1 million
Federal funds distributed	$6.8 billion	$2.7 billion	$29.7 million
Total Medicaid funds distributed in FY 2020	**$9.9 billion**	**$4.7 billion**	**$55.8 million**

Source: Auditor prepared based on Schedule of Expenditures of Federal Awards and Enterprise Reporting – Web Intelligence.

Federal regulations require HCA to oversee program integrity efforts at DSHS and DCYF

Federal regulations specifically place responsibility for several program integrity requirements on the state Medicaid agency; they also require agencies that receive grants, like the Medicaid grant, to establish and maintain effective internal control over the award to promote accountability and ensure compliance with requirements (2 U.S. Code of Federal Regulations 200.303). As Washington's Medicaid agency, HCA is responsible for providing reasonable oversight of all Medicaid program integrity activities, including those conducted by sister state agencies such as DSHS and DCYF.

HCA executive leadership formalized oversight responsibilities in agency policy and interagency agreements, and assigned this responsibility to the Division

HCA recognizes its oversight role through formal documents, such as internal policy and a cooperative agreement. The Washington State Medicaid Plan says HCA oversees and monitors program functions delegated to DSHS. Part of CMS approval of the State Medicaid Plan was the inclusion of the cooperative agreement between HCA and DSHS, which says HCA has an administrative oversight function that includes ensuring:

- All funds spent under HCA's authority are spent according to federal and state laws and regulations
- Delivery of services aligns with federal statutes and regulations
- Corrective action plans will be put in place if expenditures or services do not align with federal requirements

In addition, HCA's internal policy 1-29 says, "HCA monitors and oversees Apple Health programs run by other state agencies." HCA and DCYF also have a cooperative agreement, as well as service level agreements. However, beyond stating that HCA determines client eligibility, none of these agreements include program integrity requirements.

HCA assigned responsibility for ensuring other state agencies comply with federal program integrity requirements to the Division. HCA also made the Division responsible for ensuring other state agencies report at least annually on program integrity activities conducted, improper payments identified, and the prevention and recovery of overpayments.

The Division has not overseen program integrity efforts at sister state agencies

CMS expects sound fiscal stewardship of Medicaid funding and other states provide useful examples of what this could look like

CMS expects state Medicaid agencies to exercise good stewardship and fiscal integrity, and offers some guidance concerning oversight of sister state agencies. However, CMS guidance is scattered across several sources and does not exist in any consolidated format. CMS has provided some expectations for oversight in its application instructions for a Home and Community-Based Services waiver, guidance for addressing frequent findings and its reviews of state program integrity efforts. For example, the waiver application instructions say state Medicaid

oversight can take various forms, such as requiring the sister state agency to track and periodically report to the Medicaid agency its performance in conducting operational functions. While CMS does not provide states a roadmap for what oversight should look like, CMS clearly expects state Medicaid agencies will ensure sound fiscal stewardship and oversight of program resources.

Other states offer useful examples of what oversight of sister state agencies might entail, including:

- Regularly reviewing delegated work
- Jointly reviewing required reports on terminated or sanctioned providers, compliance data, and application data
- Requiring assurances that operational functions have been implemented
- Reviewing audits performed on the sister state agency
- Assisting with risk assessments, setting goals, and developing policies and procedures

For more information on guidance for oversight of sister state agencies, see **Appendix E**.

While the sister state agencies say they have processes in place to ensure Medicaid funding is spent properly, the Division has not overseen those program integrity efforts

DSHS and DCYF may be managing Medicaid funds appropriately, but the Division cannot know for sure because it does not oversee program integrity efforts at either agency. DSHS has its own program integrity policies and staff. Staff at DSHS report strong collaboration with HCA. This includes meeting regularly, and sending HCA a copy of the referrals they send to Washington's Medicaid Fraud Control Division. Also, executives from both agencies meet quarterly. However, Division managers said they have not been providing formal oversight for DSHS' program integrity efforts, nor have they ensured that DSHS submit program integrity reports required by the cooperative agreement or internal HCA policy.

The Division is in a similar position of poor oversight of DCYF. While the DCYF financial manager said the agency followed good business practices, this manager did not have any contact with or direction from HCA. Nor has the Division required DCYF to report on its program integrity efforts.

Division managers have not assigned oversight of sister state agencies to any of the units

Among reasons for the Division's inadequate oversight are gaps in roles and responsibilities for its units. Division managers initially considered assigning the Regulatory Oversight Compliance unit the role of quality assurance, including overseeing program integrity at other state agencies. However, management's perspective on the unit's appropriate focus has fluctuated with nationwide shifts in program integrity efforts. To date, roles and responsibilities for the Regulatory Oversight Compliance unit have not been defined and Division managers have not assigned oversight of sister state agencies to any of the other units.

The Division lacks a Statewide Medicaid Fraud and Abuse Prevention Plan outlining roles and responsibilities across key partners

The National Medicaid Fraud and Abuse Initiative recommends that state Medicaid agencies have a Statewide Fraud and Abuse Prevention Plan. Such plans outline roles and responsibilities for all partners in the state's fraud and abuse prevention and detection activities.

Instead of a single plan, HCA has multiple documents that outline program integrity roles and responsibilities, created at different times and without reference to each other. The documentation that does exist fails to address several federal requirements, to include all program integrity oversight responsibilities, and to describe current practices. For example:

- The eight-year-old cooperative agreement between HCA and DSHS refers to a steering committee that no longer exists, as well as monthly program integrity reports that DSHS no longer provides.
- The one existing service level agreement between HCA and DSHS concerning program integrity requirements describes an outdated process.

HCA and DSHS agree the cooperative agreement between the agencies is out of date, and they have begun to update it.

The lack of a Statewide Fraud and Abuse Prevention Plan makes it difficult for Division managers to know whom to hold accountable for what, and whether assigned responsibilities are still relevant. Furthermore, the lack of a clear plan contributed to confusion and knowledge gaps described below, which led to a lack of adequate oversight.

Change, transition and the lack of a Statewide Medicaid Fraud and Abuse Prevention Plan left managers uncertain of their oversight responsibilities

In 2011, the Legislature transferred state Medicaid authority from DSHS to HCA as part of a strategy to reduce the costs of health care. This change resulted in confusion about agency responsibilities. Managers at HCA described the two agencies as equal partners and noted that DSHS had been the state Medicaid agency in the recent past, so it was well aware of federal program integrity requirements. Nevertheless, federal law is clear and unambiguous: it is HCA's responsibility to provide oversight of Medicaid funds distributed by all other agencies.

Furthermore, the organizational changes within HCA described above and the absence of a Statewide Medicaid Fraud and Abuse Prevention Plan led to a lack of institutional knowledge within the agency. As described in Exhibit 3, the earlier Section of Program Integrity experienced significant change and reorganization, resulting in instability and lost opportunities to transfer knowledge. Among the consequences:

- One Division manager did not know about the eight-year-old cooperative agreement with DSHS and the program integrity related requirements it contained
- A different Division manager was unaware that DCYF distributes Medicaid funding and therefore must meet program integrity requirements

The Division of Program Integrity has expanded its program integrity efforts with MCOs, but it can do more to reduce fraud and other improper payments

Summary of results

Managed care changed how Medicaid pays for services, requiring a different approach to program integrity efforts. The Division is establishing ways to hold managed care organizations (MCOs) accountable for their role in program integrity efforts. For example, HCA executives sanctioned the five MCOs a total of nearly $1 million, based on the Division's audit of the data used to set monthly payment rates. Also, the Division requires MCOs to regularly report on their program integrity efforts, and has been discussing them with the organizations on a quarterly basis. In addition, HCA recently updated the contract to allow additional financial penalties for failure to fulfill program integrity requirements.

However, the Division could improve its oversight of MCOs by directly auditing providers and recovering overpayments. In addition to auditing encounter data, the Division should also audit providers contracted with the MCOs. The Division started reviewing providers contracted with MCOs but never initiated formal audits due to uncertainty as to what to do with the results. Also, Division managers still want guidance on how to handle identified overpayments.

Managed care changed how Medicaid pays for services, requiring a different approach to program integrity efforts

The transition to managed care means a change in how the state ensures Medicaid program integrity. Under a fee-for-service model, the state pays health care providers directly for their services for patients covered by Medicaid. Program integrity efforts under this model involve simply checking to make sure the right amount was paid to providers for the right service for an eligible client.

Under managed care, MCOs act as intermediaries between state Medicaid agencies and providers. The state Medicaid agency pays an MCO a set monthly amount for each client served; the organization uses that money to pay the healthcare providers who directly treat patients. The MCO must account for how it spent the money, down to each individual encounter between patient and provider, and report this encounter data to the state Medicaid agency. The amount of the set per-client

monthly payment is based on past costs, captured in the encounter data, and adjusted for subsequent years through a regular rate-setting process. In managed care, program integrity is a responsibility of the MCOs, but state Medicaid agencies need to make sure MCOs are fulfilling that responsibility.

The contracts between state Medicaid agencies and their MCOs are expected to spell out what each party must do to ensure program integrity and the consequences organizations face if they do not live up to the requirements. The contract should ensure the penalties are adequate to ensure compliance.

If an MCO overpays providers in error or due to undetected fraud, and allows the incorrect higher payments to become part of its reported encounter data, the consequences to its bottom line are relatively unimportant. The over-stated costs will have driven up the state's per-client monthly payment – compensating the organization for the previous year's loss. Another reason for potential poor compliance with program integrity rules involves a lax attitude toward auditing the organization's providers. Audits can be cumbersome to perform and to undergo; an MCO might decide to forego regular audits of its providers to ensure its network of providers remains robust.

Such considerations mean MCOs lack incentive to perform program integrity efforts on their own, unless they face penalties for not performing them. The state's Medicaid agency must take action to verify MCOs have completed the requirements in their contracts, and enforce the penalties if they do not. Also, in contrast to limited federal guidance for oversight of sister state agencies (as discussed in the previous section), the Code of Federal Regulations details numerous requirements state Medicaid agencies must meet to hold MCOs accountable for their role in program integrity.

In Washington, as the state Medicaid agency, HCA is responsible for ensuring each MCO fulfills its program integrity duties. This is important because 85 percent of clients in Washington are in managed care, seeing providers contracted with MCOs.

The Division is establishing ways to hold MCOs accountable for their role in program integrity efforts

Monitoring MCOs' program integrity efforts is a relatively new responsibility for the Division. When the Division reorganized at the end of 2018, it established a unit dedicated to monitoring MCO program integrity efforts. Since then, the Division's other units have also started planning ways to hold organizations accountable by looking for fraud and other improper payments in their provider networks and conducting independent medical necessity reviews.

HCA executives sanctioned the five MCOs a total of nearly $1 million based on the Division's audit of the data used to set monthly payment rates

The Division recently finished its first audit of encounter data, which describes each visit every patient makes to all the MCOs' providers; it includes codes for type and length of visit, diagnosis and treatment, cost of the visit, and information about the patient and provider. To audit the data, Division staff compared the encounter data submitted to HCA with the billing information that the MCOs received from providers, seeking differences. Every difference is a violation of contract terms. The audit examined 120 claims, and found, on average, more than one violation in each claim. All five of the state's contracted MCOs had violations. The violations ranged from minor administrative errors to changes to the amount paid, which could affect future per-client monthly payments. Most of the violations were in the middle range of severity, involving computer systems changing codes inappropriately.

HCA's contracts with the MCOs include both sanctions and liquidated damages. These two distinct categories of financial penalties are not mutually exclusive.

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

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

The contract between HCA and the MCOs allows the agency to impose sanctions for violations. HCA executives sanctioned the five MCOs a total of nearly $1 million for the issues identified in the encounter data audit. This amount, which was correct as of June 16, 2021, is subject to change through the dispute resolution process.

The Division requires MCOs to regularly report on their program integrity efforts, and has been discussing them with the organizations on a quarterly basis

The Division uses two leading practices – monthly reports and quarterly meetings – to oversee MCOs' efforts. The Division requires each MCO to file monthly reports showing what the organization is doing to maintain program integrity. The reports list the investigations each organization has started or closed, any findings from the investigations, and tips it has received about potential fraud and other improper payments. Division managers meet quarterly with all five MCOs and a representative from the Attorney General's Medicaid Fraud Control Division to discuss program integrity efforts as well as trends in fraud and other improper payments.

Both the monthly report and the quarterly meeting are leading practices recommended by Medicaid experts and used by several of the states we interviewed. Kentucky, for example, holds a quarterly meeting with its MCOs and invites other law enforcement agencies to attend, including the U.S. Attorney's Office and the Internal Revenue Service. Iowa requires its MCOs to submit standardized, monthly reports, using a 10-page spreadsheet that captures tips, audits, investigations, case status and potential recoveries.

HCA recently updated the contract to allow additional financial penalties for failure to fulfill program integrity requirements

As of January 2021, HCA's contract with the MCOs has new accountability provisions, including assessing liquidated damages. Liquidated damage clauses are often invoked when determining a precise value for damages is not possible. They are not punitive, but provide for payment to the party who has been harmed, rather than punishing the party who has been guilty of breach of contract. Before, the contract between HCA and the five MCOs allowed for liquidated damages only if an organization failed to report overpayment recoveries. Under the new provisions, HCA can assess liquidated damages for failing to comply with program integrity requirements. For example, if the Division finds that an organization overpaid a provider, it can collect up to five times the amount overpaid in liquidated damages. The basis for the "five times" provision is that the one MCO's initial overpayment would be reflected in higher monthly payments to all five organizations in the future.

By having financial consequences in its contracts with MCOs, HCA is following a federal recommendation already used by several states. CMS recommends holding MCOs financially accountable if they do not comply with program integrity requirements. The majority of other states we interviewed have sanctions or liquidated damages in their contracts with MCOs. Tennessee is well known within Medicaid circles for having a comprehensive and specific schedule of liquidated damages in its contract. Tennessee program integrity staff we interviewed said the schedule is rarely needed, as its presence incentivizes MCOs to adhere to the contract: a conversation reminding an organization of its obligations is sufficient to ensure rules are followed.

The Division could improve its oversight of MCOs by directly auditing providers and recovering overpayments

In addition to auditing encounter data, the Division should also audit providers contracted with the MCOs

Auditing providers contracted with the MCOs is a leading practice used by the majority of states we interviewed. Federal regulations require that contracts between state Medicaid agencies and their MCOs include provisions allowing agencies to audit transactions between the organizations and their providers. In addition, both CMS and the Government Accountability Office recommend that states take advantage of this provision and audit providers. Most of the states

we interviewed follow this leading practice and audit MCOs' transactions with providers. For example:

- Tennessee's integrity program requires MCOs to report the names of providers under review. The state then checks data from other organizations to see if the provider is defrauding others. By examining one provider across multiple MCOs, the state can identify a pattern of wrongdoing that no one organization could spot on its own – for example, a provider billing a total of more hours than there are in a day.
- West Virginia's integrity program examines two years of claims at a time, and looks for overpayments in the oldest 18 months, while asking the MCOs to check the most recent six months. If the state finds a potential overpayment, it can investigate and recover the funds directly from the provider.

Auditing providers contracted with the MCOs would help ensure future monthly payments reflect actual expenses. These audits can also verify that MCOs are performing their own audits of providers, and provide incentives for the organizations to improve their efforts.

The Division started reviewing providers contracted with MCOs, but never initiated formal audits due to uncertainty about what to do with the results

Directly auditing providers contracted with MCOs is a new challenge for HCA. The Division's Clinical Review Unit is accustomed to conducting "medical necessity reviews" – reviews of visits to make sure the payment is warranted by the diagnosis. For several years, its reviews of in-patient hospital visits, for example, made sure the state did not pay for acute care when less costly observational care would have sufficed. However, all the visits this unit reviewed were fee-for-service visits, where the state paid the provider and could recover overpayments directly from the provider.

Transferring the unit's expertise in fee-for-service care to overseeing managed care has been a challenge. In 2019, the Clinical Review Unit began a preliminary review of providers contracted with the MCOs, looking for potential overpayments. However, after the review was completed, no further action was taken because the unit's manager was unclear about what results HCA executives expected the potential audits to produce. Under the fee-for-service model, the next step would have been clear: since HCA paid providers directly, it would work directly with providers to recover overpayments. But without guidance on how to recover overpayments under managed care, the manager was unsure whether to work with the provider or the MCO. HCA executives later decided that in future audits, HCA should recover the money from the MCOs through liquidated damages, and let each organization in turn recover it from the provider. However, they did not ensure all unit managers were aware of the decision.

Division managers still want guidance on how to handle identified overpayments

While improvements are underway, Division managers still want guidance from HCA executives about how to handle overpayments. As previously mentioned, new provisions in the contract, effective January 2021, allow HCA to recover overpayments from the MCOs through liquidated damages; MCOs can then recover the amount from the provider that was overpaid. Also, in December 2020 the Division adopted a sanctions and liquidated damages procedure which gives staff instructions on the process they should follow to apply penalties and whom to contact. However, the Clinical Review Unit needs additional guidance to transfer its skills to auditing providers contracted with MCOs. For example, the unit manager wants guidance on how to give providers due process once preliminary findings are identified, and how much time the unit should devote to searching for overpayments from managed care versus fee-for-service. Division managers say these processes are currently being finalized, with the Clinical Review Unit manager included as one of the decision makers.

Improvements to audit selection practices would help the Division prioritize resources for high-risk cases and meet federal requirements

Summary of results

The Division can improve the ways it generates and evaluates the leads that become reviews, audits and investigations of Medicaid providers. Other states' integrity programs provide examples of how to implement expert recommendations. For example, Florida's integrity program reports that shifting to a risk-based approach for identifying suspicious activity resulted in a significant increase in referrals to law enforcement.

The Division does not use risk assessments or formally established risk factors to guide its audit plans. While Division staff look for outliers and trends, only two of four units rely on proactive data analytics to develop their workplans. The Division recently established a team to review and prioritize incoming leads, but Division managers had different perspectives on whether the team consistently received necessary data. As the Division does not determine the credibility of fraud allegations for MCOs and DSHS, it cannot take appropriate action for many situations that merit scrutiny. In addition, analyzing all leads from MCOs would help Division staff gain experience and monitor MCO engagement in program integrity. Furthermore, collaborating with a Unified Program Integrity Contractor would allow the Division to pursue fraudsters working across Medicaid and Medicare.

The Division can improve the ways it generates and evaluates the leads that become reviews, audits and investigations of Medicaid providers

In addition to the responsibilities already addressed in previous sections of the report, the Division regularly reviews, audits and investigates providers to identify fraud and other improper payments.

This process often starts with leads, which are complaints and referrals of alleged fraud, waste or abuse concerning Medicaid contractors, providers, clients or programs. The Division receives leads from the general public, MCOs and sister state agencies. It also identifies leads through its own data analytics. The Division recently established a team to review and assign these leads, which become reviews

and audits of providers to monitor compliance with policies, rules and regulations. When these reviews and audits identify potential waste, abuse and other improper payments the Division works to recover the funds. When the Division identifies potential fraud, it conducts a preliminary investigation and sends any credible allegations of fraud to Washington's Medicaid Fraud Control Division at the Attorney General's Office.

Other states' integrity programs provide examples of how to implement expert recommendations

The Division can improve its practices for audit selection and assignment through consideration of expert recommendations and practices in other states (outlined in **Appendix F**). While none of the comparison states' integrity programs follow all expert recommendations for audit selection and assignment, our audit team found various states perform several key activities:

- Conduct risk assessments or evaluate leads with established risk factors
- Rely on data analytics to generate leads
- Conduct a preliminary review of incoming leads, which includes analyzing data about the lead and may include reviewing records like billing histories
- Determine the credibility of all allegations of potential fraud, prior to referral to the state's Medicaid Fraud Control Unit
- Analyze all leads under review by the state's MCOs
- Work with Unified Program Integrity Contractors, federally recognized experts that help state integrity programs improve their data analytics and identify potential fraud across Medicare and Medicaid

We compared the Division's current practices to expert recommendations and other states to identify the opportunities for improvement described in this section.

The Division does not use risk assessments or formally established risk factors to guide its audit plans

Risk assessments help auditors make the best use of limited resources. Washington's Medicaid program is large and complex, with $14.6 billion paid to more than 180,000 different healthcare providers in fiscal year 2020. Even if it wanted to, the Division could not possibly look for fraud or other improper payments in all of these transactions. The best way to prioritize limited audit resources is assessing which situations involve the most risk. Florida, for example, reports its risk-based approach resulted in a nearly five-fold increase in referrals of suspected criminal activity to the state's Medicaid Fraud Control Unit from 2015 to 2018. Most of the other states we interviewed use a risk assessment or established risk factors to evaluate leads.

The Division, however, is less likely to identify potential fraud or other improper payments because it does not conduct risk assessments to identify areas or providers for audit, review or investigation. Instead, its workplans consist primarily of federally required audits and following up on leads it has received. While Division managers said they consider a few risk factors when reviewing leads, such as high dollar value, potential fraud and safety concerns, they have yet to establish these factors as part of a risk assessment in the Division's new policies or procedures. Division managers said they decided to prioritize developing other essential policies and procedures and resolving questions related to recent reorganizations. In addition, as discussed on page 22, the Division lacks a fraud and abuse detection system, which further hampers its ability to conduct risk assessments.

While Division staff look for outliers and trends, only two of four units rely on proactive data analytics to develop their workplans

Proactive data analytics go beyond reacting to incoming leads to proactively looking for suspicious behavior. It can be as simple as looking for providers billing an unusual number of high-cost procedures. These outliers are then investigated further to determine if a pattern indicates suspicious activity. More sophisticated data analytics involve identifying trends or relationships across data sets, such as an unusual number of clients traveling long distances to visit a specific pharmacy. The U.S. Department of Health and Human Services Office of Inspector General describes proactive data analytics as a critical tool for fraud detection.

Although the Division looks for outliers and trends, only two of four units rely on data analytics to build out their workplans. Division staff review data for suspicious activity, such as repeated billing for a procedure that should only occur once for each client. However, only the Clinical Review Unit said it generates most of its cases through data analytics. The Managed Care Oversight unit uses data analytics to generate a portion of its audits. The other two units said they develop their workplans primarily through incoming leads and addressing the Division's needs, which are important but reactive sources for audit workplans.

The Division's ability to pursue more advanced proactive data analytics is constrained by system limitations and staffing classifications. The delays in procuring a new fraud and abuse detection system have constrained the Division's activities in many ways, including its ability to pursue more advanced proactive data analytics. In addition, Division managers said that a statewide IT employee reclassification two years ago resulted in lower pay for the analysts on its former data analytics team. Many of these analysts pursued employment elsewhere, which was detrimental to the Division.

The Division recently established a team to review and prioritize incoming leads, but Division managers had different perspectives on whether the team consistently received necessary data

Federal regulation requires state Medicaid agencies to have methods to identify, evaluate and investigate leads concerning contractors, providers, clients or programs. Similar to other states, in July 2020, the Division established a new team to review and assign incoming leads. This team meets weekly, and brings together Division managers. According to Division procedures, the new team should receive background information, such as provider billing histories, on incoming leads. Division managers had different perspectives on whether the new team consistently received needed information. Division managers had not yet decided how to communicate changes and had not shared all new procedures with staff, so some staff were following older procedures. Without data to help it assess each lead, the new team cannot select and assign the leads most likely to identify significant instances of fraud or other improper payments.

Because the Division does not determine the credibility of fraud allegations from MCOs and DSHS, it cannot take appropriate action for many situations that merit scrutiny

Federal regulations require the state Medicaid agency to determine the credibility of fraud allegations. Federal regulation states:

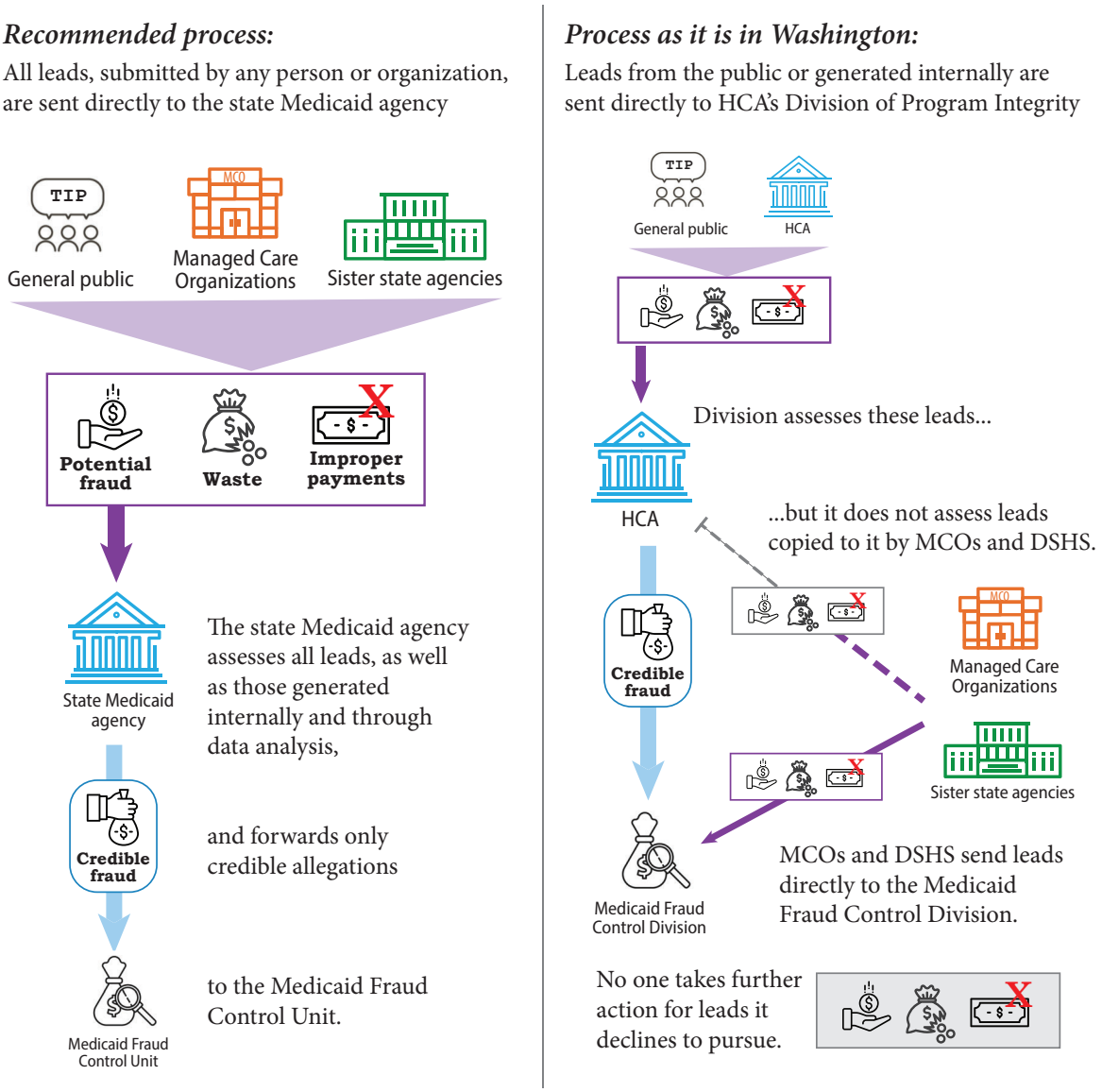
> *The State Medicaid agency must suspend all Medicaid payments to a provider **after the agency determines there is a credible allegation of fraud** for which an investigation is pending.*
>
> 42 U.S. Code of Federal Regulations 455.23(a) – ***emphasis added***

State Medicaid agencies are permitted to consult informally with Medicaid Fraud Control Units and other state agencies in making these determinations. Even if they consult others, CMS emphasizes state Medicaid agencies must carefully review all fraud allegations to determine if they are credible, regardless of whether the source is a contracted vendor or another state agency.

However, the Division does not review fraud allegations it receives from MCOs and DSHS, and is therefore not meeting CMS expectations as well as missing the opportunity to identify situations that merit scrutiny even if they do not rise to the level of fraud.

Exhibit 8 illustrates both the recommended path for processing allegations of fraud and other improper payments and the process in Washington. In Washington, while the Division receives and assesses leads from members of the public, MCOs and DSHS currently send potential fraud allegations and other leads directly to Washington's Medicaid Fraud Control Division in the Attorney General's Office. HCA's Division of Program Integrity receives copies of these referrals, but it does not review them to determine if any of the allegations are credible. The decision to pursue an investigation of any referrals filed by an MCO or DSHS is made instead by the Medicaid Fraud Control Division.

Exhibit 8 – Recommended path for processing allegations of fraud and other improper payments compared to the process in Washington



Source: Auditor created.

The Medicaid Fraud Control Division decides if it will take the case based on factors such as dollar amounts involved and its ability to demonstrate an intent to defraud Medicaid; it then tells the Division of Program Integrity which cases it will pursue. The Division of Program Integrity does not take any further action on declined referrals. This means the Division cannot identify the many provider issues that would be best addressed through administrative remedies, such as additional targeted review of submitted claims, civil monetary penalties or placing a provider on pre-payment review, instead of criminal indictment. This is of particular concern because the Medicaid Fraud Control Division declined the majority of the referrals sent by the MCOs during fiscal year 2020.

The Division does not determine the credibility of these allegations due to staff misunderstanding of some contractual language as well as the Division's reliance on DSHS previously serving as the state Medicaid agency. HCA's current contract with the MCOs directs them to send allegations of potential fraud to both the Medicaid Fraud Control Division and HCA. Division managers report this contractual arrangement may have resulted in Division staff misunderstanding HCA's responsibility to review all allegations they receive. Also, Division managers said they have relied on the historical expertise of staff and managers at DSHS, as it had been the state Medicaid agency prior to 2011. In addition, the Medicaid Fraud Control Division wants to receive referrals as quickly as possible, so it supports direct referrals from MCOs and DSHS and makes it easy for anyone to file a Medicaid fraud complaint.

Division managers said they are changing processes to comply with the federal requirement, and that noncompliance did not affect suspending payments to providers under investigation. After the audit team asked about the practice of not reviewing fraud allegations, Division managers immediately began working with staff to change processes. Division managers said future amendments to MCO contracts will instruct organizations to send fraud allegations only to HCA, with the Division determining the credibility of allegations it forwards to the Medicaid Fraud Control Division. In addition, the Division is updating HCA's cooperative agreement with DSHS. While there has been a gap in HCA determining the credibility of fraud allegations, Division managers said they have always met federal requirements, which are to suspend payment to providers under criminal investigation unless the situation meets federal good cause criteria.

Analyzing all leads from MCOs would help Division staff gain experience while monitoring the organizations' engagement in program integrity

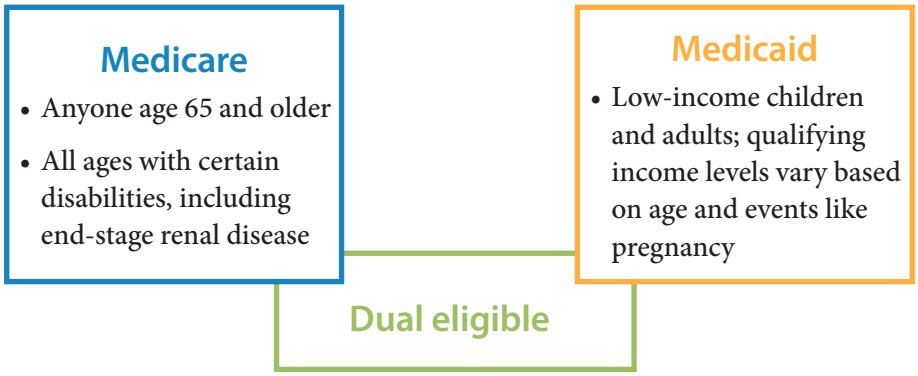
Washington's MCOs regularly report leads to the Division. The Division designed these reports on templates used in other states, but the Division's lack of a fraud and abuse detection system means staff must review multiple, massive Excel spreadsheets. Analyzing these leads could help the Division build experience among its employees as they learn about common program integrity issues in

managed care and build experience auditing these providers. This would benefit the Division as it establishes its own program. In addition, analyzing these leads would serve as another way to monitor that the MCOs are actively engaged in program integrity efforts.

Collaborating with a Unified Program Integrity Contractor would allow the Division to pursue fraudsters working across Medicaid and Medicare

CMS recommends that state Medicaid agencies collaborate with Unified Program Integrity Contractors, which help state integrity programs improve their data analytics and identify potential fraud across Medicare and Medicaid. More than 12 million Americans are simultaneously enrolled in Medicare and Medicaid, most frequently because they are 65 or older and have a low income, as illustrated in **Exhibit 9**. The only way to know if providers are inappropriately billing both programs for these clients depends on bringing together two large and complex data sets. Medicare data belongs to the federal government, so state integrity programs cannot identify this fraud on their own. A Unified Program Integrity Contractor is an expert at combining these data sets and identifying suspicious behavior across the two programs. Contractors also collaborate with state integrity programs in conducting audits and investigations, at no cost to the states.

Exhibit 9 – Dual-eligible people meet the requirements for both Medicare and Medicaid insurance coverage



Source: Auditor created based on federal eligibility requirements.

Disagreements over how to establish a collaboration with the Unified Program Integrity Contractor resulted in the Division lacking access to a federally recognized program integrity expert. Division managers said they want to work with the regional Unified Program Integrity Contractor. However, the effort to establish an agreement stalled because HCA's contracts division and the Unified Program Integrity Contractor had different perspectives on whether the collaboration should occur through a contract or a joint operating agreement. Division managers said the conflict has been resolved; however, the COVID pandemic delayed establishing the collaboration.

State Auditor's Conclusions

Medicaid is our state's largest public assistance program. It provides health coverage to about two million Washingtonians through a state-federal partnership, at a cost of more than $14 billion in fiscal year 2020. Given the size and importance of Medicaid, it needs a robust program integrity function to help ensure money is spent appropriately. Ensuring program integrity for a program this large and complicated is an inherently difficult task. That task is made even more difficult when the responsibility spans several state agencies and managed care organizations (MCOs).

As the single state Medicaid agency, the Health Care Authority (HCA) is responsible for overseeing all program integrity efforts – including the work of other agencies and the MCOs. That has not always happened, but to its credit, HCA has taken steps to improve its oversight. These efforts include reorganizing its own program integrity function and welcoming help from our Office in the form of this performance audit. Our audit has identified a number of opportunities for HCA to improve both its own program integrity efforts and its oversight of other entities' efforts. We would strongly encourage HCA to implement these recommendations.

Recommendations

For the Health Care Authority

To improve executive oversight of the agency's program integrity efforts, as described on pages 15-24, we recommend HCA executives:

1. Provide consistent oversight of program integrity, either through the existing committee structure (for example, by assigning a regular focus on program integrity) or by establishing an operations oversight committee focused on overseeing all program integrity requirements within HCA and at other state agencies.
2. In consultation with Division managers, determine key objectives for Medicaid program integrity and include them in the agency's overall strategic plan.
3. Ensure the most critical measures related to the Division's success are included in the agency's performance measurement processes. Periodically review and update these measures, as necessary.
4. Provide the newly formed Division sufficient organizational support and executive oversight to ensure the Division has an approved strategic plan with clear objectives, Division performance measures are appropriate to monitor progress, and corrective actions are initiated quickly when objectives may not be met.

We also recommend Division managers:

5. Develop a strategic plan for the new Division with stated strategic goals, agreed upon objectives, and a system to monitor progress and hold responsible parties accountable.
6. As part of developing a solid strategic plan, develop a management information and reporting strategy with performance measures and management reports. As Division managers develop this strategy, we recommend they consider the performance measures recommended by experts and used in other states.

To provide federally required oversight of Medicaid program integrity efforts at sister state agencies, as described on pages 25-30, we recommend Division managers:

7. Develop a Statewide Fraud and Abuse Prevention Plan. This plan should include:
   - A clear outline of all of the state's program integrity activities, including regular assessments of which functions are most at risk, as well as the roles and responsibilities of key partners and stakeholders
   - An updated cooperative agreement with DSHS that includes up-to-date service-level agreements, a clear monitoring plan and a schedule for regular reviews and updates of the agreements
   - An updated cooperative agreement and service-level agreements with DCYF, to include all federally required Medicaid program integrity activities, a clear monitoring plan and a schedule for regular reviews and updates of the agreements
   - A communications strategy to ensure management at HCA, DSHS and DCYF are all aware of federal requirements and updated memorandums and agreements. HCA internal policy should be revised to include reference to these requirements and documents.
8. Develop procedures to provide consistent oversight of program integrity efforts at sister state agencies. In developing these procedures, consider other state practices as outlined in Appendix E.
9. Clarify the role of the Regulatory Compliance Unit in overseeing program integrity at sister state agencies, and determine which unit will be assigned this responsibility.

To expand program integrity efforts for MCOs, as described on pages 31-36, we recommend Division managers:

10. Consider other states' practices for auditing providers contracted with the MCOs as they develop guidance that sets out what the Division wants to examine in managed care and the approach they want to take to audit providers contracted with the MCOs.
11. Clarify the Clinical Review Unit's responsibilities regarding audits of providers contracted with the MCOs.

To improve audit selection practices to help the Division prioritize resources for high risk cases and meet federal requirements, as described on pages 37-43, we recommend Division managers:

12. Conduct a program integrity risk assessment to identify the areas and provider types the Division will prioritize for each internal unit's workplan. It could also establish formal risk factors the case management team will use to evaluate leads, and incorporate these risk factors in the Division's case management policy and procedures.
13. Improve the use of data analytics to identify leads. Ensure the new fraud and abuse detection system is able to analyze managed care organization leads and rank areas at greatest risk for improper payments.
14. Ensure the new team reviewing leads consistently receives needed data to determine which leads merit further investigation.
15. Hire and train staff dedicated to performing proactive data analytics. We also recommend HCA consider reclassifying these positions to attract and retain the expertise needed.
16. Establish a process to determine which referrals from MCOs and DSHS are credible allegations of fraud.
17. Develop a process to analyze the leads and other information in reports provided by MCOs.
18. Finalize the necessary arrangements to collaborate with the Unified Program Integrity Contractor and determine how to best use the contractor's services.
19. Establish a communications strategy to ensure staff are aware of new expectations as part of implementing the recommendations listed above.

Agency Response

STATE OF WASHINGTON

June 28, 2021

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

Dear Auditor McCarthy:

Thank you for the opportunity to review and respond to the State Auditor's Office (SAO) performance audit on ways to improve the oversight, structure, and processes of the Medicaid program integrity functions. The Health Care Authority (HCA) and Office of Financial Management worked together to provide this response.

In 2018, the federal Centers for Medicare & Medicaid Services conducted a focused program review that identified areas for improvement in our managed care oversight. That review also gave us an opportunity to reassess the entirety of our program integrity functions and make changes to address the evolving nature of the Medicaid program. The Legislature supported these efforts with funding for additional program integrity staff.

This SAO performance audit came as those organizational and operational changes were still being developed and implemented. We are gratified to see that the SAO's recommendations align with changes we have already made or are in the process of making. We appreciate this independent affirmation that these changes will further strengthen our program integrity functions.

One of the more significant improvements still in progress is the procurement of a new Fraud and Abuse Detection System. This technology solution will provide advanced data mining, analytics, and reporting capabilities to increase the efficiency, effectiveness, and transparency of our program integrity activities. We expect to have this system procured within days.

Program integrity efforts have a significant impact. During fiscal year 2019, HCA recovered more than six dollars for every dollar spent on program integrity efforts. The changes we are making, including implementing the SAO's recommendations, will further improve the work we do.

If you have questions or additional concerns, please contact Lynda Karseboom, Manager, at 360-725-1228 or Lynda.Karseboom@hca.wa.gov.

Sincerely,

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

David Schumacher
Director
Office of Financial Management

The Honorable Pat McCarthy
Washington State Auditor
June 28, 2021
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cc: Jamila Thomas, Chief of Staff, Office of the Governor
Kelly Wicker, Deputy Chief of Staff, Office of the Governor
Keith Phillips, Director of Policy, Office of the Governor
Christine Bezanson, Director, Results Washington, Office of the Governor
Tammy Firkins, Performance Audit Liaison, Results Washington, Office of the Governor
Scott Frank, Director of Performance Audit, SAO
MaryAnne Lindeblad, Medicaid Director, HCA
Michael Brown, Assistant Director, Medicaid Program Integrity, HCA
Lynda Karseboom, Manager, Audit & Accountability, HCA

Official Cabinet Agency Response to Performance Audit on Washington Medicaid Program Integrity – Examining the Health Care Authority's oversight of efforts at state agencies – June 28, 2021

The Health Care Authority and the Office of Financial Management provide this management response to the State Auditor's Office performance audit report received on June 7, 2021.

SAO Performance Audit Objectives:

The purpose of this performance audit was to answer the following questions:

- Are there opportunities for HCA executive management to improve its oversight over program integrity?
- How can the Division of Program Integrity improve its structure and processes to more effectively reduce fraud and other improper payments?

SAO Recommendations to the HCA 1-6: To improve executive oversight of the agency's program integrity efforts, as described on pages 15-24, we recommend HCA executives:

1. Provide consistent oversight of program integrity, either through the existing committee structure (for example, by assigning a regular focus on program integrity) or by establishing an operations oversight committee focused on overseeing all program integrity requirements within HCA and at other state agencies.
2. In consultation with Division managers, determine key objectives for Medicaid program integrity and include them in the agency's overall strategic plan.
3. Ensure the most critical measures related to the Division's success are included in the agency's performance measurement processes. Periodically review and update these measures, as necessary.
4. Provide the newly formed Division sufficient organizational support and executive oversight to ensure the Division has an approved strategic plan with clear objectives, Division performance measures are appropriate to monitor progress, and corrective actions are initiated quickly when objectives may not be met.

STATE RESPONSE: Oversight of the program integrity functions occurs regularly, as evidenced by the significant strategic and organizational changes that have been ongoing. We appreciate the recommendations to further strengthen oversight of the program integrity efforts at the executive level. Further discussion is needed with executive leadership and other divisions that would be impacted by these recommendations before committing to a specific plan of action. HCA will convene a work group to have those discussions and develop a recommended implementation plan to executive leadership.

Action Steps and Time Frame:

- HCA will form a work group to develop recommendations to executive leadership. *By December 31, 2021*

We also recommend Division managers:

5. Develop a strategic plan for the new Division with stated strategic goals, agreed upon objectives, and a system to monitor progress and hold responsible parties accountable.

6. As part of developing a solid strategic plan, develop a management information and reporting strategy with performance measures and management reports. As Division managers develop this strategy, we recommend they consider the performance measures recommended by experts and used in other states.

STATE RESPONSE: We agree with the recommendations and have begun implementing solutions. To ensure a clear path forward, these solutions will need to be informed and driven by the actions taken in response to recommendations 1-4.

Action Steps and Time Frame:

- HCA will have an approved strategic plan for program integrity. *By March 31, 2022*

SAO Recommendations to the HCA 7-9: To provide federally required oversight of Medicaid program integrity efforts at sister state agencies, as described on pages 25-30, we recommend Division managers:

7. Develop a Statewide Fraud and Abuse Prevention Plan. This plan should include:
    - A clear outline of all of the state's program integrity activities, including regular assessments of which functions are most at risk, as well as the roles and responsibilities of key partners and stakeholders
    - An updated cooperative agreement with DSHS that includes up-to-date service-level agreements, a clear monitoring plan and a schedule for regular reviews and updates of the agreements
    - An updated cooperative agreement and service-level agreements with DCYF, to include all federally required Medicaid program integrity activities, a clear monitoring plan and a schedule for regular reviews and updates of the agreements
    - A communications strategy to ensure management at HCA, DSHS and DCYF are all aware of federal requirements and updated memorandums and agreements. HCA internal policy should be revised to include reference to these requirements and documents.
8. Develop procedures to provide consistent oversight of program integrity efforts at sister state agencies. In developing these procedures, consider other state practices as outlined in Appendix E.
9. Clarify the role of the Regulatory Compliance Unit in overseeing program integrity at sister state agencies, and determine which unit will be assigned this responsibility.

STATE RESPONSE: HCA works closely with its sister agencies to help ensure program integrity functions are operating as required. We agree that the roles and responsibilities would benefit from being clarified, updated and documented. Some activities are already in process and others will be initiated to develop a statewide plan as described.

Action Steps and Time Frame:

- Working in partnership with sister agencies, HCA will develop a statewide fraud and abuse prevention plan as described. *By June 30, 2022*

SAO Recommendations to the HCA 10-11: To expand program integrity efforts for MCOs, as described on pages 31-36, we recommend Division managers:

10. Consider other states' practices for auditing providers contracted with the MCOs as they develop guidance that sets out what the Division wants to examine in managed care and the approach they want to take to audit providers contracted with the MCOs.
11. Clarify the Clinical Review Unit's responsibilities regarding audits of providers contracted with the MCOs.

STATE RESPONSE: HCA has developed audit strategies for managed care providers and considered other states' practices as part of that process. We are developing procedures for that audit activity, including the responsibilities of various units within program integrity.

Action Steps and Time Frame:

- HCA will develop and implement a documented process for auditing MCO providers.
  By December 31, 2021

SAO Recommendations to the HCA 12-19: To improve audit selection practices to help the Division prioritize resources for high risk cases and meet federal requirements, as described on pages 37-43, we recommend Division managers:

12. Conduct a program integrity risk assessment to identify the areas and provider types the Division will prioritize for each internal unit's workplan. It could also establish formal risk factors the case management team will use to evaluate leads, and incorporate these risk factors in the Division's case management policy and procedures.
13. Improve the use of data analytics to identify leads. Ensure the new fraud and abuse detection system is able to analyze managed care organization leads and rank areas at greatest risk for improper payments.
14. Ensure the new team reviewing leads consistently receives needed data to determine which leads merit further investigation.
15. Hire and train staff dedicated to performing proactive data analytics. We also recommend HCA consider reclassifying these positions to attract and retain the expertise needed.
16. Establish a process to determine which referrals from MCOs and DSHS are credible allegations of fraud.
17. Develop a process to analyze the leads and other information in reports provided by MCOs.
18. Finalize the necessary arrangements to collaborate with the Unified Program Integrity Contractor and determine how to best use the contractor's services.
19. Establish a communications strategy to ensure staff are aware of new expectations as part of implementing the recommendations listed above.

STATE RESPONSE: HCA agrees with the recommendations. Recommendations 12 and 13 will be best addressed with the implementation of a new Fraud and Abuse Detection System (FADS). Procurement of that system will be complete by the time this audit report is published.

Recommendation 14 has been in place for several months. Addressing recommendation 15, HCA has had highly skilled staff performing proactive data analytics for several years. A new FADS will help the efficiency and effectiveness of that work. We will consider the need and feasibility of a change in classification.

We are in the process of addressing recommendations 16-18. We have an ongoing communications plan (recommendation 19) that will continue.

Action Steps and Time Frame:

- Implement a new FADS. *By June 30, 2022*
- Assess the classification of data analysts. *By December 31, 2021*
- Develop processes around credible allegations of fraud for DSHS and MCO referrals. *By March 31, 2022*
- Develop processes to analyze leads provided by MCOs. *By March 31, 2022*
- Finalize arrangements with Unified Program Integrity Contractor. *By December 31, 2021*

Appendix A: Initiative 900 and Auditing Standards

Initiative 900 requirements

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

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

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

I-900 element	Addressed in the audit
1. Identify cost savings	**No.** The audit did not identify specific cost savings. However, program integrity efforts prevent and recover fraud and other improper payments, and the audit recommendations should increase the effectiveness of these efforts.
2. Identify services that can be reduced or eliminated	**No.** Many Medicaid program integrity efforts are federally mandated and therefore cannot be reduced or eliminated.
3. Identify programs or services that can be transferred to the private sector	**No.** However, the audit did examine if the Division of Program Integrity within the Health Care Authority (HCA) was working with the Unified Program Integrity Contractors, third-party vendors with expertise in finding questionable billing patterns across Medicare and Medicaid.
4. Analyze gaps or overlaps in programs or services and provide recommendations to correct them	**Yes.** The audit reviewed operational plans for statewide Medicaid program integrity efforts, to determine if HCA has adequately defined roles and delegated tasks to reduce the risk of gaps or overlaps in required activities.

I-900 element	Addressed in the audit
5. Assess feasibility of pooling information technology systems within the department	**No.** The audit did not review the feasibility of pooling information technology systems because the state already manages nearly all Medicaid payments through a central system called ProviderOne.
6. Analyze departmental roles and functions, and provide recommendations to change or eliminate them	**Yes.** The audit reviewed departmental roles and functions, within HCA executive leadership's oversight of program integrity across agencies and within HCA's Division of Program Integrity.
7. Provide recommendations for statutory or regulatory changes that may be necessary for the department to properly carry out its functions	**No.** The audit did not identify any recommended statutory or regulatory changes.
8. Analyze departmental performance data, performance measures and self-assessment systems	**Yes.** The audit included HCA's monitoring of program integrity efforts through the development and review of performance measures.
9. Identify relevant best practices	**Yes.** The audit included identifying best or leading practices for Medicaid program integrity oversight, structure and processes.

Compliance with generally accepted government auditing standards

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

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Appendix B: Scope, Objectives and Methodology

Scope

This audit focused on the Health Care Authority's (HCA) oversight of program integrity, including the functions carried out by the Division of Program Integrity (Division) as well as by sister state agencies. It also focused on the Division's structure and staffing; procedures for audit selection and assignment; efforts to hold managed care organizations (MCOs) accountable; and performance measures. We did not review the Division's audits of managed care or fee-for-service transactions. While we gathered and reviewed documentation outlining roles and responsibilities across state agencies for program integrity efforts, we did not confirm whether those activities were occurring.

The audit period included January through December 2020. We learned about HCA's program integrity efforts in previous years to gain an understanding of causes for current gaps. Our audit evidence came from interviews, previous single audits for the state of Washington, and review of documents provided by HCA and sister state agencies.

Objectives

The purpose of this performance audit is to identify ways HCA can strengthen program integrity efforts to ensure every Medicaid dollar stretches as far as possible for Washingtonians covered by Medicaid. The audit addresses the following objectives:

Objective 1: Are there opportunities for HCA executive management to improve its oversight over program integrity?

Objective 2: How can the Division of Program Integrity improve its structure and processes to more effectively reduce the risk of fraud and other improper payments?

For reporting purposes, the audit results have been organized into key findings. The messages relate to the original objectives as follows:

- HCA executives recently created a Division of Program Integrity to highlight its work, but they can improve oversight through strategic planning and performance measurement (page 15-24) – This finding addresses Objectives 1 and 2.
- HCA has not provided federally required oversight of Medicaid program integrity efforts at sister state agencies (pages 25-30) – This finding addresses Objectives 1 and 2.
- The Division has expanded its program integrity efforts with MCOs, but it can do more to reduce fraud and other improper payments (pages 31-36) – This finding addresses Objective 2.

- Improvements to audit selection practices would help the Division prioritize resources for high-risk cases and meet federal requirements (page 37-43) – This finding addresses Objective 2.

Methodology

We obtained the evidence used to support the findings, conclusions and recommendations in this audit report during our fieldwork period (August 2020 to February 2021), with some additional follow-up work afterward. This section summarizes the work we performed to address the audit objectives.

Objective 1: Are there opportunities for HCA executive management to improve its oversight over program integrity?

To understand how HCA executive management could improve its oversight of Medicaid program integrity, we:

- Reviewed federal regulations and state laws
- Interviewed leadership and management at HCA, sister state agencies and other states' integrity programs
- Reviewed documentation and agreements between HCA and sister state agencies
- Reviewed repeat Medicaid Single Audit findings

Reviewed federal regulations and state laws

To gain an understanding of HCA's mandated role for providing program integrity oversight, we reviewed:

- Federal regulations, including guidance for federal grants and requirements for Medicaid program integrity
- Applicable state law (Revised Code of Washington)

Interviewed leadership and management at HCA, sister state agencies and other states

To learn about HCA executives' oversight of program integrity efforts, we conducted semi-structured interviews with four levels of management, from the State Medicaid Director to Division managers. As appropriate, we asked about state-level and agency-level systems created to support management level oversight, including strategic planning and performance measurement. Our interviews included questions about roles and responsibilities of oversight committees within the agency. We also asked about oversight of sister state agencies.

To gain an understanding of what executive management oversight looks like in other states (listed in the sidebar), we conducted semi-structured interviews with other states' integrity programs, as discussed

Comparison states

The audit team interviewed program integrity officials in:

Arizona	Iowa
Kentucky	Minnesota
New York	Tennesee
West Virginia	

Florida's Bureau of Medicaid Program Integrity did not respond to interview requests but publishes a comprehensive report that outlines program integrity efforts and measures used.

below for Objective 2. Our audit team met with people who were familiar with their agency's oversight practices to ask about performance measurement processes and systems.

To understand oversight of Medicaid program integrity efforts at sister state agencies, we conducted semi-structured interviews with program integrity management and staff at the following agencies:

- The Department of Social and Health Services (DSHS) – HCA's sister state agency
- The Department of Children, Youth, and Families (DCYF) – HCA's sister state agency
- The Office of Financial Management (OFM)

We asked about oversight practices required by HCA, and we also asked the sister state agencies about any reports they submit to the Division.

We met with people at OFM to gain an understanding of its role regarding the State of Washington Single Audit.

Reviewed documentation and agreements between HCA and sister state agencies

To gain an understanding of HCA executives' oversight of the Division, we reviewed roles of oversight committees and reports HCA executives received from the prior Section of Program Integrity. Our audit team reviewed documentation received during interviews to help understand the roles and responsibilities of different oversight committees within HCA. In addition, we reviewed weekly reports unit managers submitted to Section management to understand the level of information provided.

To understand what oversight of sister state agencies should look like, we reviewed different oversight requirements and practices from other states. We researched Washington bills, laws and regulations to see what they say about program integrity oversight responsibilities. Our audit team also reviewed the Government Accountability Office's *Standards for Internal Control in the Federal Government* to review what oversight processes should look like according to federal government internal control standards. Furthermore, we reviewed Centers for Medicare and Medicaid Services (CMS) guidance for oversight of sister state agencies (see Appendix E).

To identify gaps or overlaps in oversight of sister state agencies, we reviewed formal documentation such as the State Medicaid Plan, HCA's administrative policy 1-29, the cooperative agreement between HCA and DCYF, the cooperative agreement between HCA and DSHS, and service level agreements between these agencies. We compiled a list of required and optional program integrity efforts (see Appendix C). We analyzed the documentation for gaps or overlaps in responsibilities by comparing the documented roles and responsibilities to what HCA must do (per federal regulation) and what it could do (with optional efforts).

Reviewed repeat Medicaid Single Audit findings

To identify trends in repeat Medicaid State of Washington Single Audit findings, we reviewed repeat findings and compared them to the continuum of potential state Medicaid program integrity activities (see Appendix C) to assess whether findings were related to program integrity work. After identifying repeat program integrity findings, we reviewed CMS's management decision letter to HCA (August 6, 2020) to determine if CMS agreed with the Single Audit finding and if it had requested a refund of the associated questioned costs.

Objective 2: How can the Division improve its structure and processes to more effectively reduce the risk of fraud and other improper payments?

To evaluate the Division's practices, we:

- Interviewed Division management and reviewed documents
- Researched leading practices for state Medicaid programs
- Learned about practices in other states

Interviewed Division management and reviewed documents, including contracts between HCA and MCOs

To learn about Washington's practices, we conducted semi-structured interviews with Division managers. We asked about the operation's structure and staffing; how they select and assign audits; how they hold MCOs accountable; and what performance measures they use.

We obtained and reviewed written policies and procedures, organizational charts, contracts between HCA and the MCOs, available performance measures and the Managed Care Oversight Plan for Program Integrity.

Researched leading practices for state Medicaid programs

To compile expert recommendations, we performed a literature review to find information about programs in other states and general advice for state Medicaid programs. We searched for information on how other states compose their staff; how to perform audit risk assessments; ways to hold MCOs accountable; performance measures for program integrity; selecting and assigning audits; and related best practices. We performed internet searches and followed links in footnotes to find new sources. We compiled resources from:

- Association of Government Accountants
- Bloomberg Law
- Centers for Medicare and Medicaid Services
- Federal Office of Management and Budget
- Governing Institute
- Government Accountability Office
- Institute for Internal Auditors
- International Organization for Standardization
- KPMG
- Medicaid and CHIP Payment Access Commission
- National Health Care Anti-Fraud Association
- National Association of Medicaid Directors

We sorted the recommendations into topic areas and compiled them into several lists, which we used in comparing Washington and other states, as described below. (See the Bibliography for more information.)

Learned about practices in other states

To learn about other states' practices, we began by asking managers in the Division for the names of states they would recommend we talk to. We also asked the State Medicaid Director for her recommendations. She consulted with the National Association of Medicaid Directors and provided us with its response. We contacted the U.S. Department of Health and Human Services Office of the Inspector General, the Medicaid and CHIP Payment Access Commission, and the Government Accountability Office and

asked for recommendations. Finally, we asked Medicaid experts from KPMG, a consulting firm, for recommendations.

We ranked the recommendations and settled on the states directly recommended to us by Division managers, the National Association of Medicaid Directors or KPMG. That gave us a total of eight states. One state on our list, South Dakota, does not use MCOs, so we replaced it with New York, which was recommended in our literature review. We were not able to contact officials in Florida's integrity program but used a comprehensive report that the agency had written for its legislature to learn about its operations. We spoke to officials from integrity programs in Arizona, Iowa, Kentucky, Minnesota, New York, Tennessee and West Virginia. In semi-structured interviews, we asked them about their operations' structure and staffing; how they select and assign audits; how they hold MCOs accountable; what performance measures they use; and how their operation is overseen.

After collecting this information, we compared Washington's practices with other states'. We also compared Washington's and other states' practices with the leading practices we identified. We used these comparisons to identify potential gaps and opportunities to improve Washington's operation.

Work on internal controls

As part of **Objective 1**, to examine HCA's oversight of program integrity, we assessed the agency's internal controls relevant to oversight within HCA and sister state agencies distributing Medicaid funding. For oversight of program integrity activities completed by sister state agencies, we reviewed the effectiveness of:

- Policies and procedures in clearly defining what oversight activities occur, how they will be done, and who will do them
- Agreements between the agencies in specifying program integrity expectations, what HCA oversight will occur, how issues will be resolved and what consequences exist for non-compliance

We also assessed HCA's internal controls relevant to oversight of program integrity within the agency by:

- Reviewing existing strategic plans for clear objectives related to program integrity, action plans and accountability
- Performance measures and the process for monitoring them
- Other oversight processes like meetings and committees for whether they provide oversight of all program integrity requirements

As part of **Objective 2**, we assessed the internal controls relevant to the Division's structure and processes. Specifically, we reviewed:

- Policies and procedures that provide guidance to staff on evaluating all leads and applying sanctions and liquidated damages to MCOs when warranted
- Contracts between HCA and MCOs
- Measures used to monitor and evaluate performance
- The prior Section of Program Integrity's draft strategic plan

Appendix C: Medicaid Program Integrity Activities

Medicaid program integrity activities include verifying clients and providers are eligible to participate, verifying billed services were indeed delivered, ensuring the correct amount was paid for a needed service, and referring credible allegations of fraud to law enforcement. Federal regulations require many of these activities, others are optional. We drew content in these tables from *Improving the Effectiveness of Medicaid Program Integrity*, the Code of Federal Regulations, Health Care Authority internal policy, and practices in other states.

Client enrollment

Determine eligibility
Collect third-party liability information and coordinate benefits
Verify reported information
Check the Public Assistance Reporting Information System to verify that clients are not receiving duplicate federal and state benefits
Conduct monitoring and auditing activities
Conduct Medicaid Eligibility Quality Control and Payment Error Rate Measurement eligibility reviews
Handle client fair hearings for denied or restricted benefits or services
Assist veterans as they maximize their earned benefits from the U.S. Department of Veterans Affairs, along with potential enrollment in Medicaid

Provider enrollment
Screen and enroll eligible providers; reenroll and revalidate providers
Check exclusion lists and other verification databases in accordance with state and federal screening requirements
Ensure appropriate disclosures are reported by providers and fiscal agents
Implement moratoria on providers when federally approved or mandated
Report any adverse provider application actions to the U.S. Department of Health and Human Services Office of Inspector General
Require fingerprint background checks based on categorical risk levels
Conduct pre-enrollment and post-enrollment site visits of moderate or high risk providers to verify submitted information is accurate and to determine compliance with federal and state enrollment requirements
Service delivery
Develop and document coverage, billing and payment policies
Lock in certain beneficiaries to certain providers or pharmacies to prevent pharmacy or doctor shopping
Develop program integrity provisions for managed care contracts
Verify receipt of service using electronic visit verification
Review prior authorization requests consistent with state policy
Review prospective drug utilization review requests
Have methods for verifying whether services were received as authorized and paid for by managed care organizations (MCOs)
Review, validate and independently audit the encounter, financial and network adequacy data reported by each MCO at least once every three years
Payment
Develop, implement and evaluate prepayment edits and audits
Apply third-party liability information
Use predictive modeling and other advanced data analytics to flag potential errors or suspicious activity
Suspend payments to providers based on credible allegations of fraud
Adjudicate final payments
Issue explanation of benefits statements
Submit claims for federal matching funds
Integrate specific system edits into the Medicaid Management Information System to prevent improper payments
Ensure payments are not made to MCOs for individuals who are not eligible for Medicaid due to death or other circumstances

Post-payment review
Create and implement methods and criteria for identifying suspected fraud cases
Conduct preliminary or full investigation on referrals of fraud or abuse
Establish and maintain a timely beneficiary verification procedure
Refer suspected fraud to law enforcement and collaborate with fraud investigations
Coordinate with Medicaid Fraud Control Unit and assist with prosecutions
Participate in federal Payment Error Rate Measurement fee-for-service and managed care reviews
Pursue third-party payments when available
Perform retrospective reviews of care
Conduct surveillance and utilization reviews
Audit payments or ask providers to conduct self-audits
Support federal Unified Program Integrity Contractor audits
Procure and support recovery audit contractors
Supply data for Medicare-Medicaid matches and process results
Conduct federally required audits of hospitals and professionals attesting to receive payment from the Electronic Health Record Incentive Program
Reporting and follow-up
Recover overpayments from providers
Return federal share of overpayments
Calculate return on investment
Compile program integrity statistics
Calculate and report payment suspensions due to credible allegations of fraud
Participate in state program integrity reviews (focused and desk reviews)
Identify and implement corrective actions and sanctions
Oversee MCO program integrity contract compliance
Report the identification and collection of overpayments due to fraud, waste and abuse
Report annually the use of payment suspensions based on credible allegations of fraud
Report administrative expenses associated with program integrity activities
Terminate fraudulent providers and contracts and report such actions to appropriate parties

Reporting and follow-up, *continued*
Post on state Medicaid agency website: • MCO contracts • The documentation on which the state bases its certification that the MCO has complied with requirements for availability and accessibility of services • Information on ownership and controls • Results of any audits of MCO encounter data
Report the number of complaints of fraud and abuse that warranted preliminary investigations, and specific details for all full investigations
Additional activities related to MCOs
Hold regular meetings with the MCOs
Monitor prohibited affiliations within the MCOs
Require MCOs to provide regular reports of their program integrity efforts
Audit the MCOs and their contracted providers
Recover overpayments to providers contracted with the MCOs through liquidated damages, a clawback policy, or a finders-keepers clause in the contract between the state Medicaid agency and the MCO
Impose sanctions, liquidated damages or payment withholds for contract noncompliance
Education
Provide program integrity related education to MCOs
Ensure contracted providers and entities that receive or make payments of five million dollars or more annually provide False Claims Act and whistleblower education to their employees, contractors, subcontractors, etc.

Source: Auditor prepared from *Improving the Effectiveness of Medicaid Program Integrity*, the Code of Federal Regulations, Health Care Authority internal policy, and practices in other states.

Appendix D: Requirements and Best Practices for Performance Measures

Actively managing a program's performance helps organizations determine what they need to improve and the actions necessary to improve performance and achieve objectives.

Government Accountability Office Standards for Internal Control in the Federal Government

Federal regulation requires agencies that receive grants like the Medicaid grant to develop an internal control system consistent with Government Accountability Office guidance, as available in *Standards for Internal Control in the Federal Government* (2 U.S. Code of Federal Regulations 200.303), also known as the Green Book.

The Green Book states that an effective internal control process is one where management, with oversight by an oversight body, evaluates performance and holds individuals accountable. To do this, management communicates quality information internally across reporting lines at all levels.

Washington Office of Financial Management (OFM) Guidance

OFM guidance on performance measures includes:

- RCW 43.88.090 states each agency shall define its mission and establish measurable goals for achieving results.
- OFM requires each agency budget to be linked to performance measures.
- Performance measures help agency management understand, manage and improve.
- Government relies on performance measures to determine agency effectiveness at achieving results.

Harry Hatry

Harry Hatry's book *Performance Measurement: Getting Results* states:

- Performance measures help agency management understand, manage and improve.
- Regular measurement of progress toward specified outcomes is a vital component of any effort to manage for results.
- Comparing outcomes to benchmarks and targets is a fundamental and essential element of performance measurement.
- Performance measurement data should be used to improve programs.
- Performance measures are a tool to hold agencies accountable to taxpayers and the Legislature. Regularly tracking performance measures can give taxpayers and legislators greater confidence in how money is being spent.

State mandated performance target

In addition, Washington state law (RCW 74.09.195) mandates one performance target: Draft program integrity audits must be issued within 120 days of providers giving HCA all requested information.

Appendix E: CMS Guidance and Other State Practices for Sister State Agency Oversight

The Centers for Medicare and Medicaid Services (CMS) has provided limited guidance for how state Medicaid agencies should provide oversight of sister state agencies. However, we found some guidance in CMS program integrity reviews, a CMS toolkit, and in CMS's application for Home and Community-Based services waivers. CMS program integrity reviews of Florida and Kentucky said the state Medicaid agencies needed to develop written policies and procedures or an interagency agreement outlining which department would be responsible for various program integrity oversight functions. In addition, CMS offers toolkits to address frequent findings. The toolkit for 42 U.S. Code of Federal Regulations 455.436 describes one common issue:

> *Where states have Medicaid services provided by sister agencies, and providers for these services are not enrolled directly through the State Medicaid Agency, the sister agency is not conducting appropriate database checks. This is often due to the sister agency not being familiar with the requirements for screening providers prior to enrollment.*

The toolkit offers the following solution:

> *Where ancillary services may be provided by a sister agency, the State Medicaid Agency should communicate to the sister agency all requirements for provider screening. This can be done through an Interagency Agreement or similar document.*

Furthermore, CMS's application instructions for Home and Community-Based services waivers say oversight may be exercised in a variety of ways. For example, the sister state agency could track and periodically report to the Medicaid agency its performance in conducting operational functions.

CMS does expect good stewardship and fiscal integrity. Although CMS does not give states a roadmap for what oversight should look like, it has published its expectations for related outcomes. CMS clearly expects state Medicaid agencies will ensure sound stewardship and oversight of program resources. In addition, CMS has emphasized the importance of oversight in ensuring fiscal integrity.

Other states provide useful examples of what oversight of sister state agencies could look like. Our audit team reviewed formal documents, such as CMS reports and state Medicaid plans, to identify examples of how other states oversee sister state agencies, including:

- Regularly reviewing delegated work
- Jointly reviewing required reports on terminated or sanctioned providers, compliance data and application data
- Requiring assurances operational functions have been implemented
- Reviewing audits performed on the sister state agency
- Assisting with risk assessments, setting goals, and developing policies and procedures

According to the Home and Community-Based services waiver application, Missouri's single state Medicaid agency provides oversight in several ways, including:

- Creating a memorandum of understanding with the sister state agency
- Meeting quarterly to discuss administrative and operational components of the waiver
- Working together to address any deficiencies, outlining the steps to be taken to ensure the waiver assurances are being met

In addition, the waiver states that the Missouri state Medicaid agency reviews reports submitted no less than annually by the sister state agency to ensure operational functions are being implemented as specified in the waiver application. The state Medicaid agency works closely with the sister state agency to set goals and establish timeframes for remediation and improvement activities. If significant problems are identified in the reporting process, the state Medicaid agency may decide to follow up with a targeted review to ensure the problem is remediated.

Appendix F: State Usage of Selected Expert Recommendations

This appendix contains information drawn from semi-structured interviews the audit team conducted with other states' integrity programs. Auditors met with people who were familiar with their agency's oversight practices to ask about performance measurement processes and systems. Florida's Bureau of Medicaid Program Integrity did not respond to interview requests but publishes a comprehensive report that outlines program integrity efforts and measures used. Please note these comments are reported activities, and we did not audit or confirm the information states provided. If a state did not specifically mention that it used a certain practice, that space is left blank in the following tables.

Recommended practices **page number**

Figure 1 – Introducing the five practice areas

Risk analysis	Risk analysis evaluates causes, sources, probabilities and potential impacts of risks, then prioritizes the results. ***Key benefits:*** It informs decisions on identifying risks and developing appropriate strategies to either avoid the risks or mitigate their impacts. ***Recommended by:*** Government Accountability Office; Institute of Internal Auditors; International Organization for Standardization; Office of Management and Budget.
Risk factors	Risk factors are conditions likely to be associated with a high probability of significant risk consequences. ***Key benefits:*** Using risk factors allows an objective consideration of conditions that indicate a higher probability of significant consequences. Risk factors can include: relative level of activity; magnitude of revenue or expense; impact on public perception; failure to meet goals; degree of change in systems, policies, procedures, contracts or relationships; susceptibility to fraud; complexity of operations or requirements; strength of internal controls; time since last assessment or audit. ***Recommended by:*** Association of Government Accountants; Government Accountability Office; Institute of Internal Auditors.
Proactive data analytics	Proactive data analytics identify suspicious trends in data, which can then be investigated in the same way as other leads. ***Key benefits:*** The most effective, comprehensive approach to program integrity employs proactive analytics throughout the claims cycle – from provider screening to pre-payment processes to retrospective recovery. ***Recommended by:*** Governing Institute; National Healthcare Anti-Fraud Assocation; Optum; U.S. Department of Health and Human Services Office of Inspector General.
Allegation triage	Allegation triage is determining the level and type of investigation warranted based upon the nature, scope and seriousness of the allegations. ***Key benefits:*** Clearly defining who makes the determination as to when a complaint should be escalated to a formal investigation can help establish accountability around the process as well as provide for efficient and timely case investigation. It is important to document the criteria and rationale used to make such determinations. Having clear protocols relating to investigator assignment and supervisory assignment, as well as referrals both within and outside of organizations, can aid in establishing a consistent approach. ***Recommended by:*** Deloitte.
Unified Program Integrity Contractors (UPIC)	Unified Program Integrity Contractors (UPIC) identify concerns across Medicare and Medicaid and help states improve their program integrity efforts. ***Key benefits:*** Analyzing Medicare and Medicaid data together enables CMS and states to detect duplicate and other improper payments for services billed to both programs. UPIC contractors also work with state integrity programs to conduct proactive data analysis, investigations and audits of all types of Medicaid providers. UPIC contractors work across many states so they are experts in emerging trends. ***Recommended by:*** Centers for Medicare and Medicaid Services.

Figure 2 – Washington

Practice area	Washington
Risk analysis	WA does not conduct a risk assessment.
Risk factors	The risk factors WA considers, but which have not been formally established, include cases with high dollar value, cases involving fraud and cases with safety issues.
Proactive data analytics	While WA looks for outliers and trends, only two of four units rely on data analytics to build out their workplans.
Allegation triage	A new case management team considers the availablility of information needed by the auditors, the monetary value of the case, and how many hours of staff time they think it will take to go after the case. Policy provides a basic framework for the Case Management Team, including frequency of meetings, what should occur with each lead and how action will be documented.
UPIC	WA has not worked with the UPIC, but it is trying to establish a collaboration.

Figure 3 – Arizona

Practice area	Arizona
Risk analysis	AZ would like to do more risk assessment. It is trying to move toward basing decisions on the viability of the case and the case's impact in dollars on state programs.
Risk factors	
Proactive data analytics	AZ relies on data analytics to produce many of its cases.
Allegation triage	The deputy inspector general for the fraud compliance team serves as intake coordinator.
UPIC	

Figure 4 – Florida

Practice area	Florida*
Risk analysis	FL emphasizes the use of fraud risk models to focus program integrity activities on the greatest vulnerabilities and risks. Its risk models draw on many sources of information (including those identified by the state Medicaid agency, other programs in FL and programs in other states) to determine the level of risk as a detection tool to guide investigations.
Risk factors	FL uses specific factors (typically provider characteristics) it believes contributes to the risk of fraud or abuse. FL is also developing a risk model for managed care that includes MCO financial health, sanctions/audit findings, provider networks and claims, and priorities for CMS and law enforcement.
Proactive data analytics	FL has a data analysis team that develops complex queries and algorithms. FL also uses risk-based detection tools built on proactive data analytics.
Allegation triage	The complaint review process involves assessing initial information gathered and determining whether the lead merits further review or investigation.
UPIC	

* Note: Florida's Bureau of Medicaid Program Integrity did not respond to interview requests but publishes a comprehensive report that outlines program integrity efforts and measures used.

Figure 5 – Iowa

Practice area	Iowa
Risk analysis	IA completes an annual vulnerability assessment, which is a risk assessment guided by data analytics, to drive its work plan for the year.
Risk factors	Risk factors used include areas and providers with data outliers and current events (for example, COVID-19).
Proactive data analytics	IA uses data analytics to identify vulnerabilities, which drives its annual work plan.
Allegation triage	
UPIC	IA plans to work with the UPIC.

Figure 6 – Kentucky

Practice area	Kentucky
Risk analysis	
Risk factors	Risk factors used include areas and providers with data outliers; areas deemed high risk (for example, substance abuse treatment, opioids, home health, hospice).
Proactive data analytics	KY relies on risk assessment, data mining and referrals in deciding where to focus audits. It looks for national trends and has the state's managed care organizations run analytics on its behalf.
Allegation triage	
UPIC	KY works with the UPIC to learn about analytics and trends in other states.

Figure 7 – Minnesota

Practice area	Minnesota
Risk analysis	Does not use risk assessment; driven by complaints.
Risk factors	Risk factors used include safety concerns, public interests (high dollar amounts), then age of case (oldest to newest).
Proactive data analytics	MN has a data analysis team. During 2020, the majority of its identified overpayments were initially detected through data analytics.
Allegation triage	MN has a provider investigations unit that triages leads as they come in. The unit conducts a high level overview of the issue, requests records, and recommends whether or not to proceed with the case.
UPIC	MN relies on the UPIC vendor for medical necessity determinations.

Figure 8 – New York

Practice area	New York
Risk analysis	NY does not conduct a formal risk assessment to determine what to audit, but looks at high risk areas.
Risk factors	Risk factors used include high dollar amounts and high-risk provider types or categories of services.
Proactive data analytics	NY has a data analysis team, which uses several different systems to extract, organize and analyze data for the audit teams. Developing innovative data analytics is a high priority within the program's strategic plan.
Allegation triage	
UPIC	

Figure 9 – Tennessee

Practice area	Tennessee
Risk analysis	TN identifies certain areas that, based on past activities, are areas of concern. It notifies MCOs which areas were identified, monitors MCO activities throughout the year, and possibly forms a group of all MCOs to see if they can reduce certain activities.
Risk factors	TN follows up on specific cases based on past reviews and as new information is available on providers reviewed in the past.
Proactive data analytics	TN's data analytics team generates referrals for the audit teams. Audit teams also note trends and make requests of the data analytics team.
Allegation triage	Each MCO makes referrals, which the investigations unit examines further to see if the provider engaged in the same behavior with other MCOs (useful because one MCO is unlikely to know about a provider's behavior with another). TN puts together a comprehensive report that covers the life cycle of information within the lead.
UPIC	TN receives referrals from the UPIC.

Figure 10 – West Virgina

Practice area	West Virginia
Risk analysis	WV would like to conduct a risk assessment, but is not yet fully ready to do so. It relies on referrals and data analytics.
Risk factors	Risk factors used include high dollar amounts, areas prone to fraud such as nursing and hospice, and areas and providers with data outliers.
Proactive data analytics	Data manager runs monthly reports on data outliers for hospitals and providers to identify which areas or providers to audit.
Allegation triage	
UPIC	WV receives referrals from the UPIC, and relies on it for medical necessity determinations.

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