

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**WASHINGTON STATE DID NOT COMPLY
WITH FEDERAL AND STATE
REQUIREMENTS FOR CLAIMING
ENHANCED FEDERAL REIMBURSEMENT
FOR MEDICAID MANAGED-CARE HEALTH
HOME SERVICE EXPENDITURES**

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Office of Inspector General

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Report in Brief

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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Audit

A health home is a designated provider or a team of health care providers that coordinates health care services for Medicaid beneficiaries with chronic medical conditions at a reasonable cost. States were authorized to receive Federal reimbursement at an enhanced Federal Medical Assistance Percentage (FMAP) of 90 percent (enhanced FMAP) for health home service payments they made to providers during the first eight quarters their programs were in effect.

Our objective was to determine whether Washington State complied with Federal and State requirements for claiming health home service expenditures under Medicaid managed care at the enhanced FMAP.

How OIG Did This Audit

Our audit covered the \$1,957,622 (\$1,770,860 Federal share) that Washington claimed as managed-care health home expenditures at the enhanced FMAP from April 1, 2017, through March 31, 2019. We reviewed the journal vouchers that Washington used to assign the enhanced FMAP to its managed-care health home expenditures, the managed-care encounter data that it used to support the claimed amount, and its capitation rate documentation that identified the portion of the managed-care capitation payments that was attributable to health home services.

Washington State Did Not Comply With Federal and State Requirements for Claiming Enhanced Federal Reimbursement for Medicaid Managed-Care Health Home Service Expenditures

What OIG Found

Washington did not comply with Federal and State requirements for claiming health home service expenditures under Medicaid managed care at the enhanced FMAP. Specifically, Washington improperly used fee-for-service health home reimbursement rates instead of the portion of the managed-care capitation payments that was specifically attributable to health home services to calculate and claim enhanced Federal reimbursement for its managed-care health home expenditures, totaling \$1,770,860. In addition, of the \$1,770,860 that Washington claimed, \$374,579 was not supported by encounter data, and \$29,161 was claimed for encounters that exceeded the number of encounters that managed-care organizations were allowed to report for a beneficiary. These issues occurred because Washington did not follow its State plan or Federal guidance and lacked adequate procedures and Medicaid Management Information System (MMIS) edits.

What OIG Recommends and Washington Comments

We recommend that Washington: (1) refund to the Federal Government \$374,579 for the encounters that were no longer supported and the \$29,161 that exceeded the number of allowable encounters; (2) determine the portion of the remaining \$1,367,120 that should have been claimed based on the portion of the managed-care capitation rate attributable to health home services and refund any unallowable amounts; (3) review all managed-care health home encounters from July 1, 2013, through March 31, 2017, to determine the amount that should have been claimed based on the portion of the managed-care capitation rate attributable to health home services; (4) implement a procedure to identify whether encounters used to support journal vouchers have been removed from the encounter data; and (5) strengthen its MMIS edits to ensure that encounters comply with State reporting requirements. The full text of our recommendations is shown in the report.

Washington concurred with all of our recommendations and described corrective actions it had taken or planned to take, such as implementing MMIS edits to prevent multiple payments within a single calendar month. However, the corrective actions that Washington described did not fully address our first, second, and fifth recommendations. Therefore, we continue to recommend that Washington implement those recommendations.

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INTRODUCTION

WHY WE DID THIS AUDIT

The Patient Protection and Affordable Care Act (the ACA) authorized States to implement a Medicaid health home program.¹ A health home is not a physical space. Rather, it is a designated provider or a team of health care providers that coordinates health care services for Medicaid beneficiaries with chronic medical conditions throughout their lifespan at a reasonable cost. Health home services include comprehensive care management, care coordination, health promotion, comprehensive transitional care, patient and family support, and referrals to community and social support services.²

States electing the health home option were authorized to receive Federal reimbursement at an enhanced Federal Medical Assistance Percentage (FMAP) of 90 percent (enhanced FMAP) for health home service payments they made to providers during the first eight quarters their programs were in effect.³

This audit is part of a series of audits to determine whether selected States complied with Federal and State requirements for claiming Federal Medicaid reimbursement for payments made to health home providers. (See Appendix B for a list of the related OIG reports.) We reviewed the Medicaid managed-care expenditures that the Washington State Health Care Authority (State agency) claimed at the enhanced FMAP.

OBJECTIVE

Our objective was to determine whether the State agency complied with Federal and State requirements for claiming health home service expenditures under Medicaid managed care at the enhanced FMAP.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved

¹ The ACA § 2703(a), P.L. No. 111-148 (Mar. 23, 2010). The ACA added section 1945 to the Social Security Act (the Act) for the health home option.

² Transitional care includes appropriate followup from an inpatient setting to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care.

³ The Act § 1945(c)(1).

State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

States use two primary models to pay for Medicaid services: fee-for-service (FFS) and managed care. Under the FFS model, States pay providers directly for each service delivered to a Medicaid beneficiary. Under the managed-care model, States pay managed-care organizations (MCOs) a predetermined periodic payment, known as a capitation payment, to provide a set of specific services to each enrolled Medicaid beneficiary.⁴ Capitation payments are fixed, upfront payments to cover MCOs' expected costs for services and administrative costs, and to provide MCOs with a certain amount of profit.⁵ States make capitation payments to MCOs for each enrolled beneficiary regardless of whether the beneficiary receives services during the period covered by the payment.

When a beneficiary receives a service under managed care, it is referred to as an "encounter."⁶ MCOs are required to maintain records (encounter data) of the services that are delivered to enrolled Medicaid beneficiaries and the payments that the MCOs made to providers for those services. MCOs are required to transmit their encounter data to the State to allow the State to track the services provided to beneficiaries enrolled in Medicaid managed-care plans. The State, in turn, is required to use the encounter data to develop the MCOs' capitation rates.⁷

The Federal Government pays its share of a State's medical assistance expenditures based on the FMAP, which varies depending on the State. During our audit period, Washington State's regular FMAP was 50 percent. To claim Federal reimbursement, States report their Medicaid expenditures on the Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program.⁸

Medicaid Health Homes

Section 2703 of the ACA added section 1945 to the Social Security Act (the Act) and created an optional Medicaid State plan benefit for States to establish health homes (a designated health care provider or a team of health care providers) to coordinate care for Medicaid beneficiaries

⁴ MCOs generally contract with providers to deliver services to enrolled Medicaid beneficiaries.

⁵ Capitation payments are based on capitation rates that are developed in accordance with Federal rate-setting standards for the provision of services under the State plan. Capitation rates are developed from, among other things, validated encounter data, FFS data (as appropriate), and audited financial reports that reflect the actual experience of the Medicaid population or a similar population to be served. CMS reviews and approves the State agency's capitation rates (42 CFR §§ 438.2, 438.4, and 438.5).

⁶ An encounter represents a single health care service or a group of services provided in a certain period.

⁷ 42 CFR §§ 438.3(u) and 438.5(c). States are required to use encounter data for at least the 3 most recent and complete years prior to the rating period when developing MCOs' capitation rates (42 CFR § 438.5(c)).

⁸ 42 CFR § 430.30(c).

with chronic medical conditions. Health home services are provided to Medicaid beneficiaries who elect health home services and who have at least two chronic conditions, have one chronic condition and are at risk for developing a second chronic condition, or have a serious and persistent mental health condition.⁹ A State’s health home program must provide eligible beneficiaries with six core services: comprehensive care management, care coordination, health promotion, comprehensive transitional care, patient and family support, and referrals to community and social support services.

A State that elected to create a health home program was required to amend its State plan by submitting to CMS a State plan amendment (SPA) that included, among other things, the methodology it planned to use to determine payment for health home services.¹⁰ States receive Federal reimbursement at an enhanced FMAP of 90 percent for health home service payments made during the first eight quarters of an effective SPA.¹¹

Washington State’s Medicaid Health Home Program

The State agency administers the Medicaid program in Washington State. The State agency implemented its health home program in 2013 using a phased-in approach. The State agency authorized health home services to be provided in 14 counties in July 2013, in an additional 23 counties in October 2013, and in the remaining 2 counties in April 2017.¹²

The State agency defined three tiers of care coordination that providers and MCOs were required to use to document health home services, each with a unique procedure code.¹³ The tiers were based on the level of care coordination that was necessary for a beneficiary. (See the table on the following page.)

⁹ Chronic conditions include, but are not limited to, mental health conditions, substance abuse disorders, asthma, diabetes, heart disease, and obesity (the Act § 1945(h)(2)).

¹⁰ The Act § 1945(c)(2)(A).

¹¹ After the first eight quarters of an effective SPA, the State’s regular FMAP applies to health home service payments.

¹² State agency’s SPA transmittal numbers 13-08, 13-17, and 16-0026, respectively.

¹³ “Procedure code” is an abbreviated term for the codes used in the Healthcare Common Procedure Coding System. Procedure codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

Table: Health Home Service Tiers

Tier	Description	Procedure Code
1	Initial engagement and health action plan completion *	G9148
2	Intensive level of care coordination	G9149
3	Low level of care coordination	G9150

* Initial engagement is establishing contact with the beneficiary and conducting a health assessment. A health action plan is the plan of care for the beneficiary, which includes the beneficiary's goals.

The State agency limited how often MCOs could report the three tiers of service. MCOs were limited to reporting only one encounter in a month for a health home service tier. The tier-1 service was to be reported only once in a beneficiary's lifetime. A tier-2 or tier-3 service could be reported in any month after a month in which a tier-1 service was reported.¹⁴

Under its FFS payment model, the State agency paid providers of health home services a service-based payment for each tier of service provided to a beneficiary. The FFS reimbursement rates for the tiers ranged from \$281.28 for a tier-1 service to \$83.34 for a tier-3 service.¹⁵

Under its managed-care payment model, the State agency paid MCOs a monthly capitation payment for each enrolled beneficiary for all plan services. Included within the MCOs' capitation payments was an amount specifically attributable to health home services. This amount was as much as \$34.94, depending upon the managed-care plan in which the beneficiary was enrolled.¹⁶

Washington State's Medicaid Claims Processing System and Manual Financial Adjustments

The State agency used the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process payments and maintain beneficiary eligibility and enrollment information. The MMIS processed payments for FFS health home claims, validated managed-care encounters for accuracy and completeness, and processed capitation payments to MCOs. The State agency validated each encounter using edits, which are instructions programmed into the MMIS to compare encounters with program requirements.

¹⁴ State agency's *Encounter Data Reporting Guide*, "Health Home Lead Entity Section."

¹⁵ The FFS payments include an amount to cover administrative costs related to the provision of health home services.

¹⁶ We identified the amounts included in the capitation payments by using information contained in the capitation rate documentation and appendices that the State agency's actuary prepared for calendar years 2016 through 2019.

The State agency used journal vouchers to generate manual financial adjustments, made outside of the MMIS, to account balances.¹⁷ Journal vouchers are used to, among other things, record the transfer of costs between accounts and record adjustments to account balances. For the health home program, the State agency used journal vouchers to assign the enhanced FMAP to expenditures related to managed-care encounters and to determine the enhanced Federal reimbursement that it claimed for those expenditures on the Form CMS-64.

HOW WE CONDUCTED THIS AUDIT

From April 1, 2017, through March 31, 2019 (audit period), the State agency claimed Federal Medicaid reimbursement at the enhanced FMAP for managed-care health home expenditures totaling \$1,967,622 (\$1,770,860 Federal share). The health home expenditures claimed at the enhanced FMAP during our audit period were for the last two counties the State agency phased into its health home program.

We reviewed: (1) the nine journal vouchers that the State agency used to assign the enhanced FMAP to its managed-care health home expenditures, (2) the encounter data that the State agency used to support the amounts claimed at the enhanced FMAP, (3) the State agency's capitation rate documentation that identified the portion within the MCOs' monthly capitation payments that was attributable to health home services, and (4) other State agency documentation related to its claim for enhanced Federal reimbursement for Medicaid managed-care health home expenditures.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A describes our audit scope and methodology.

FINDINGS

The State agency did not comply with Federal and State requirements for claiming health home service expenditures under Medicaid managed care at the enhanced FMAP. Specifically, the State agency improperly used FFS health home reimbursement rates instead of the portion of the MCOs' capitation payments that was specifically attributable to health home services to calculate and claim enhanced Federal reimbursement for its managed-care health home expenditures, totaling \$1,770,860. In addition, of the \$1,770,860 that the State agency claimed, \$374,579 was not supported by encounter data, and \$29,161 was claimed for encounters that exceeded the number of encounters that MCOs were allowed to report for a

¹⁷ Financial adjustments are increases or decreases to expenditures or transfers of expenditure amounts between accounts.

beneficiary. These issues occurred because the State agency did not follow its State plan or Federal guidance and lacked adequate procedures and MMIS edits.

THE STATE AGENCY IMPROPERLY USED ITS FEE-FOR-SERVICE HEALTH HOME REIMBURSEMENT RATES TO CALCULATE AND CLAIM ENHANCED FEDERAL REIMBURSEMENT FOR ITS MANAGED-CARE HEALTH HOME EXPENDITURES

The State agency was entitled to receive Federal reimbursement for services identified in the approved SPA and was required to specify within the SPA the methodology that it would use to determine payment for health home services.¹⁸ The SPA stated that payment for health home services provided to eligible managed-care beneficiaries was included in the MCOs' capitation rate and that no additional payment for those services would be made. The State agency also provided an assurance in its SPA that at least annually it would submit to CMS, as part of its capitated rate certification, a separate health homes section that outlined, among other things, how the final capitation amount would be determined.¹⁹

In addition, CMS provided States with Federal guidance on avoiding a duplication of services and payments to MCOs for managed-care health home services. In its guidance, CMS stated that payments for health home services may be "claimed at the enhanced 90 percent Federal match rate for the first eight quarters. The State agency's actuary must identify the portion of the capitation payment associated with the health home services to be able to claim them."²⁰

Contrary to its State plan and Federal guidance, the State agency improperly used its FFS health home reimbursement rates to calculate and claim enhanced Federal reimbursement totaling \$1,770,860 for its managed-care health home expenditures. Rather than using the portion of the MCOs' capitation payments that was specifically attributable to health home services, the State agency used its FFS health home service reimbursement rates to claim the enhanced Federal reimbursement.

Specifically, the State agency identified its managed-care encounters for health home services, the tier level of care coordination that was provided during each of the encounters (i.e., tiers 1, 2, or 3), and the FFS reimbursement rates associated with each tier of service that was provided. Using journal vouchers, the State agency manually assigned the identified FFS reimbursement rates and the enhanced FMAP to each encounter and claimed the total of the assigned FFS reimbursement rates as its managed-care health home expenditures.

The State agency did not follow its State plan or Federal guidance when it used its FFS health home reimbursement rates to calculate and claim enhanced Federal reimbursement totaling

¹⁸ The Act § 1945(c)(2)(A).

¹⁹ SPA transmittal numbers 16-0026 and 18-0028.

²⁰ CMS's technical assistance tool "Health Home Considerations for a Medicaid Managed Care Delivery System: Avoiding Duplication of Services and Payments" (February 2012).

\$1,770,860 for its managed-care health home expenditures. State agency officials said they thought it was more appropriate to use the FFS health home reimbursement rates instead of the portion of the capitation payment that was specifically attributable to health home services to claim enhanced reimbursement because the FFS rates were closer to the amounts that the MCOs paid to providers for health home services.

As a result of using FFS rates instead of the portion of the capitation payment that was specifically attributable to health home services, the State agency claimed more Federal reimbursement than it was entitled to receive. However, the State agency was entitled to receive some portion of the \$1,770,860 in enhanced Federal reimbursement that it claimed.

THE STATE AGENCY DID NOT IDENTIFY AND REFUND FEDERAL REIMBURSEMENT FOR HEALTH HOME SERVICE EXPENDITURES THAT WERE NO LONGER SUPPORTED BY ENCOUNTER DATA

To be allowable under Federal awards, costs must meet general criteria, including that the costs be adequately documented.²¹ Additionally, the State agency is required to maintain supporting fiscal records to assure that claims for Federal funds are in accordance with applicable Federal requirements.²² Payments made for costs that the Federal awarding agency determines to be unallowable must be refunded to the Federal Government.²³

Contrary to Federal regulations, the State agency did not identify and refund Federal reimbursement totaling \$374,579 that it had claimed for managed-care health home service encounters that were no longer supported. At the time of our audit, the State agency did not have encounter data to support \$374,579 of the \$1,770,860 it had claimed. According to State agency officials, MCOs submitted encounters that supported the entire \$1,770,860 that it had previously claimed. However, after the State agency claimed the Federal reimbursement, MCOs removed from the encounter data the encounters supporting \$374,579 of the amount claimed.²⁴ The State agency was not aware that these encounters were removed until we requested the encounter data.

The State agency did not identify and refund the Federal reimbursement because it did not have a procedure to ensure that managed-care encounters recorded in journal vouchers to identify and calculate Federal reimbursement were not subsequently removed from the State agency's encounter data. State agency officials said that they had a procedure to identify new health home encounters that MCOs submitted, but they did not have a procedure to identify

²¹ 45 CFR § 75.403.

²² 42 CFR § 433.32.

²³ 45 CFR § 75.410.

²⁴ An MCO may remove encounters from the encounter data for various reasons, such as when the State agency retroactively determines that a beneficiary is no longer eligible for Medicaid health home services.

whether MCOs removed encounters from the encounter data after the State agency claimed Federal reimbursement.

THE STATE AGENCY CLAIMED FEDERAL REIMBURSEMENT FOR ENCOUNTERS THAT EXCEEDED THE NUMBER OF REPORTABLE HEALTH HOME SERVICE ENCOUNTERS THAT WERE ALLOWED FOR A BENEFICIARY

To be allowable under Federal awards, costs must be necessary and reasonable for the performance of the Federal award and conform to any limitations or exclusions set forth in the cost principles or in the Federal award as to types or amounts of cost items.²⁵ The State agency's contract with MCOs required the MCOs to report encounters in accordance with the State agency's *Encounter Data Reporting Guide*.^{26, 27} The guide stated that MCOs were limited to reporting only one encounter for a health home service tier for a beneficiary each month and reporting an encounter for a tier-1 service only once in a beneficiary's lifetime.

Contrary to Federal regulations and guidance, the State agency claimed Federal reimbursement of \$29,161 for 195 encounters that exceeded the number of health home service encounters that MCOs were allowed to report for a beneficiary. Specifically, the MCOs improperly reported more than one encounter for a tier-1 service in a beneficiary's lifetime and multiple encounters in a month for any combination of tiers of service.

The State agency's MMIS had the following three edits related to the reporting of health home service encounters by MCOs: (1) One edit limited the reporting of a tier-1 service to once in a beneficiary's lifetime, (2) another edit required that a tier-1 service be paid before payment of a tier-2 or tier-3 service, and (3) a third edit identified and rejected an encounter that was an exact duplicate of another encounter (i.e., an encounter that had the same procedure code and same date of service, among other things).

Although the State agency had included in the MMIS specific edits to reject certain encounters, the State agency improperly claimed the \$29,161 because its edit to limit the reporting of an encounter for a tier-1 service to once in a beneficiary's lifetime was not always turned on. According to State agency officials, this edit was turned off during our audit period because it was not working correctly. In addition, the State agency did not have an MMIS edit to ensure that only one encounter for a health home service tier was reported each month.

Furthermore, the edit to reject duplicate encounters was not designed to detect multiple encounters for a beneficiary in the same month that were not exact duplicates. For example,

²⁵ 45 CFR § 75.403.

²⁶ The State agency's SPA transmittal numbers 16-0026 and 18-0028 required the MCOs' contracts to include encounter data reporting requirements for health home services. The State agency included those requirements in "Exhibit H Health Homes" of the MCOs' contracts.

²⁷ State agency's *Encounter Data Reporting Guide*, "Health Home Lead Entity Section."

the edit could not detect multiple encounters for a beneficiary in the same month if the encounters had different procedure codes or different dates of service. State agency officials said that they intend to void the unallowable encounters and that State agency systems and program staff were reviewing the MMIS edits and associated policy to ensure consistency with requirements in the State agency's *Encounter Data Reporting Guide*.

CONCLUSION

The State agency's improper use of FFS health home reimbursement rates instead of the portion of the MCOs' capitation payment that was specifically attributable to health home services to calculate and claim enhanced Federal reimbursement, totaling \$1,770,860, for its managed-care health home expenditures resulted in the State agency claiming more Federal reimbursement than it was entitled to receive. State agency officials said that they used the FFS rates instead of the health home services portion of the capitation payment because the FFS rates were closer to the amounts that the MCOs paid to providers for health home services.

In addition, of the \$1,770,860 that the State agency claimed, \$403,740 was not allowable: \$374,579 was not supported by encounter data, and \$29,161 was claimed for encounters that exceeded the number of encounters that MCOs were allowed to report to the State agency for a beneficiary. The State agency did not identify that \$374,579 of its claim for Federal reimbursement was not supported and that a refund to the Federal Government was required because it did not have a procedure to identify whether encounters recorded in journal vouchers to claim Federal reimbursement were subsequently removed from the encounter data. Furthermore, although the State agency's MMIS contained edits to reject certain encounters in accordance with its own guidance, the State agency claimed \$29,161 for the excessive number of encounters because: (1) one of its MMIS edits was not always turned on and (2) other MMIS edits were not adequate to ensure that encounters submitted by MCOs did not exceed the number of reportable encounters allowed for a beneficiary.

The State agency was entitled to receive some portion of the \$1,770,860 that it claimed in enhanced Federal reimbursement. After removing the \$403,740 in unallowable Federal reimbursement from the \$1,770,860 that was claimed, we are setting aside the remaining \$1,367,120 for CMS and the State agency to determine the actual expenditures that the State agency should have claimed at the enhanced FMAP using the portion of the MCOs' capitation payment rate that was specifically attributable to health home services.

RECOMMENDATIONS

We recommend that the Washington State Health Care Authority:

- refund to the Federal Government:
 - \$374,579 for managed-care health home service encounters that were no longer supported and
 - \$29,161 for the 195 encounters that exceeded the number of reportable health home service encounters that were allowed for a beneficiary;
- determine the portion of the remaining \$1,367,120 that should have been claimed for managed-care health home service expenditures based on the portion of the MCOs' capitation payment rate that was specifically attributable to health home services, and refund any unallowable amounts;
- review all managed-care health home encounters from July 1, 2013, through March 31, 2017, to:
 - determine the enhanced Federal reimbursement that should have been claimed for Medicaid managed-care health home service expenditures based on the portion of the MCOs' capitation payment rate that was specifically attributable to health home services and refund to the Federal Government any unallowable amounts,
 - identify whether the encounters used to support claims for enhanced Federal reimbursement have since been removed from the encounter data and refund to the Federal Government any amounts that are no longer supported, and
 - identify whether the encounters exceeded the number of reportable encounters that were allowed for an enrolled beneficiary and refund to the Federal Government any amounts related to unallowable encounters;
- implement a procedure to identify whether encounters used to support journal vouchers have been removed from the encounter data and refund to the Federal Government any Federal reimbursement that was claimed and is no longer supported; and
- strengthen its MMIS edits to: (1) limit the reporting of an encounter for a tier-1 health home service to only once in a beneficiary's lifetime and (2) ensure that only one encounter per beneficiary is reported each month.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency concurred with all of our recommendations and described actions that it had taken or planned to take to address our recommendations. The State agency's comments are included as Appendix C.²⁸

The corrective actions that the State agency described did not fully address our first, second, and fifth recommendations. Therefore, we continue to recommend that the State agency implement those recommendations.

STATE AGENCY COMMENTS

The State agency's comments on our recommendations are summarized below:

- Regarding our first recommendation, the State agency said that additional "data pulls" were not done to identify any adjustments/reversals to encounters that were made after the data were used for claiming the enhanced match. The State agency also said that MMIS edits were implemented to prevent multiple payments within a single calendar month. The State agency did not explicitly state that it would refund the recommended amounts for our audit period.
- Regarding our second recommendation, the State agency said that the report it provided from its contracted actuaries details the portion of the managed-care capitation rates that were attributable to health home services for the audit period. The State agency said that it believes the delivery of this report puts the State in compliance with the CMS guidance from 2012 that said: "The State agency's actuary must identify the portion of the capitation payment associated with the health home services to be able to claim them."
- Regarding our third recommendation, the State agency said that additional analysis will be done by the State agency's contracted actuaries to confirm that the amounts claimed during the earlier periods of eligibility for enhanced match rates were correct.
- Regarding our fourth recommendation, the State agency said that if any portion of the claim for the enhanced match rate is found to be unsupported by the State agency actuaries' analysis for managed care or by the FFS encounter data, the unsupported claim of Federal reimbursement will be returned.

²⁸ As part of its comments, the State agency included an attachment with a report from its contracted actuaries. We did not attach the report because the report stated that it was prepared for the State agency and was confidential and for internal discussion only. Although this attachment is not included as an appendix in our final report, we considered the entirety of the actuaries' report in preparing our final report and will provide the State agency's comments in their entirety to CMS.

- Regarding our fifth recommendation, the State agency said that MMIS edits were implemented to prevent multiple payments within a single calendar month.

OFFICE OF INSPECTOR GENERAL RESPONSE

Although the State agency commented that it concurred with all of our recommendations and described actions that it had taken or planned to take to address our recommendations, the State agency's corrective actions did not fully address our first, second, and fifth recommendations:

- Regarding our first recommendation, because the State agency did not explicitly state that it would refund the recommended amounts we identified for our audit period, we continue to recommend that the State agency refund those amounts.
- Regarding our second recommendation, the actuaries' report that the State agency provided did not identify the portion of the capitated payment rate that was attributable to health home services. Rather, the report recalculated health home managed-care expenditures that the MCOs made and expressed those amounts as a percentage of capitated payments. Therefore, we continue to recommend that the State agency determine the portion of the \$1,367,120 that should have been claimed for managed-care health home service expenditures based on the portion of the MCOs' capitation payment rate that was specifically attributable to health home services, and refund any unallowable amounts.
- Regarding our fifth recommendation, the State agency did not address how the MMIS edits would limit the number of encounters reported each month but rather how they would limit multiple payments within a single calendar month. Therefore, we continue to recommend that the State agency strengthen its MMIS edits to limit the reporting of encounters in accordance with State requirements.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

From April 1, 2017, through March 31, 2019, the State agency claimed Federal Medicaid reimbursement at the enhanced FMAP for managed-care health home expenditures totaling \$1,967,622 (\$1,770,860 Federal share). The health home expenditures claimed at the enhanced FMAP during our audit period were for the last two counties the State agency phased into its health home program.

We did not perform an overall assessment of the State agency's internal control structure. Rather, we reviewed only the internal controls that pertained to our objective. Specifically, we obtained an understanding of the internal controls that were significant to how the State agency claimed health home service expenditures under Medicaid managed care at the enhanced FMAP. We reviewed the State agency's design and implementation of control activities (i.e., policies, procedures, techniques, and mechanisms) related to its processes for identifying health home services provided under Medicaid managed care and claiming Federal reimbursement for those services at the enhanced FMAP. We also assessed whether the State agency designed and implemented the control activities to achieve their intended objectives and respond to risks related to our audit objective.

To assess the control activities, we: (1) conducted interviews of State agency officials, (2) reviewed the State agency's policies and procedures for the journal voucher process, (3) obtained a walk-through of the State agency's MMIS managed-care subsystem and accounting system involved in processing health home encounter data and payments, (4) analyzed outputs from those systems, and (5) reviewed the State agency's mechanisms for claiming expenditures at the enhanced FMAP on the Form CMS-64.

We conducted our audit from August 2020 to February 2022.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance, and the State agency's State plan;
- held discussions with CMS financial and program management officials to gain an understanding of and to obtain information on the health home program;
- held discussions with State agency officials to gain an understanding of the State agency's administration and oversight of the health home program, and policies and procedures, processes, and systems related to identifying and claiming health home service expenditures at the enhanced FMAP;

- reviewed the State agency’s capitation rate documentation and obtained a detailed walk-through from State agency officials on how amounts for health home services were included in the State agency’s monthly capitation payments;
- reviewed other State agency documentation related to its claim for enhanced Federal reimbursement for Medicaid managed-care health home expenditures;
- reviewed the State agency’s managed-care encounter data that the State agency used to support the amounts claimed at the enhanced FMAP, the nine journal vouchers that the State agency used to assign the enhanced FMAP to its managed-care health home service expenditures, and accounting data to determine whether the amounts that the State agency claimed for Federal reimbursement were supported;
- reconciled the health home expenditures that the State agency claimed at the enhanced FMAP on the Form CMS-64 with the encounter data, journal vouchers, and accounting data; and
- discussed the results of our audit with the State agency and CMS officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>Missouri Claimed Federal Reimbursement for \$3.4 Million in Payments to Health Home Providers That Did Not Meet Medicaid Requirements</i>	<u>A-07-20-04117</u>	8/12/2021
<i>New York's Claims for Federal Reimbursement for Payments to Health Home Providers on Behalf of Beneficiaries Diagnosed With Serious Mental Illness or Substance Use Disorder Generally Met Medicaid Requirements But It Still Made \$6 Million in Improper Payments to Some Providers</i>	<u>A-02-19-01007</u>	7/7/2021
<i>North Carolina Received \$30 Million in Excess Federal Funds Related to Improperly Claimed Health Home Expenditures</i>	<u>A-04-18-00120</u>	4/29/2020
<i>Iowa Inadequately Monitored Its Medicaid Health Home Providers, Resulting in Tens of Millions in Improperly Claimed Reimbursement</i>	<u>A-07-18-04109</u>	4/7/2020
<i>New York Claimed Federal Reimbursement for Some Payments to Health Home Providers That Did Not Meet Medicaid Requirements</i>	<u>A-02-17-01004</u>	7/1/2019

APPENDIX C: STATE AGENCY COMMENTS



STATE OF WASHINGTON HEALTH CARE AUTHORITY

626 8th Avenue, SE • P.O. Box 45502 • Olympia, Washington 98504-5502

April 11, 2022

Lori Ahlstrand
Regional Inspector General for Audit Services
90 – 7th Street, Suite 3-650
San Francisco, California 94103

SUBJECT: Report Number: A-09-20-02008

Dear Ms. Ahlstrand:

Thank you for the opportunity to respond to the Department of Health and Human Services, Office of Inspector General (OIG), draft report *Washington State Did Not Comply With Federal and State Requirements for Claiming Enhanced Federal Reimbursement for Medicaid Managed-Care Health Home Service Expenditures*. Please find our response summarized in the following table:

Recommendation	Concurrence/non-concurrence	Corrective action taken or planned
Refund to the Federal Government \$374,579 for the encounters that were no longer supported and the \$29,161 that exceeded the number of allowable encounters.	HCA concurs with this recommendation.	After the initial claiming for the eight eligible quarters had passed, HCA did not perform additional data pulls to identify any adjustments/reversals to encounters that were reported after the data was used to claim the enhanced match. MMIS edits were implemented to prevent multiple payments within a single calendar month. Prior to the implementation of the edits, there were months with more than one encounter that were included in the enhanced match claiming.
Determine the portion of the remaining \$1,367,120 that should have been claimed based on the portion in the managed-care capitation rate attributable to health homes and refund any unallowable amounts.	HCA concurs with this recommendation.	The report provided from HCA's contracted actuaries details the portion of the managed-care capitation rates that were attributable to Health Homes services delivered to clients in King and Snohomish Counties between April 1, 2017, and March 31, 2019. HCA believes delivery of this report puts the State in compliance with the CMS guidance from 2012 that said that payments for health home services may be "claimed at the enhanced 90 percent

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Regional Inspector
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		Federal match rate for the first eight quarters. The State agency's actuary must identify the portion of the capitation payment associated with the health home services to be able to claim them."
Review all managed-care home encounters from July 1, 2013 through March 31, 2017 to: -determine the enhanced Federal reimbursement that should have been claimed for Medicaid Managed-care health home service expenditures based on the portion of the MCO's capitation payment rate that was specifically attributable to health home services and refund to the Federal Government any unallowable amounts, -identify whether the encounters used to support claims for enhanced Federal reimbursement have since been removed from the encounter data and refund to the Federal Governments any amounts that are no longer supported, -identify whether the encounters exceeded the number of reportable encounters that were allowed for an enrolled beneficiary and refund to the Federal Government any amounts related to unallowable encounters.	HCA concurs with this recommendation.	Additional analysis will be done by HCA's contracted actuaries to confirm that the amounts claimed during the earlier periods of eligibility for enhanced match rates were correct.
Implement a procedure to identify whether encounters used to support journal vouchers have been removed and refund any Federal reimbursement that was claimed and is no longer supported.	HCA concurs with this recommendation.	If any portion of the claiming for the enhanced match rate are found to be unsupported by the analysis by HCA's actuaries for managed care or by FFS encounter data, the unsupported claiming of Federal reimbursement will be returned. Since there are no current or prospective periods of eligibility for enhanced match rates, this would apply only to the historical health homes data.

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Strengthen its MMIS edits to ensure that encounters comply with State reporting requirements.	HCA concurs with this recommendation.	MMIS edits were implemented to prevent multiple payments within a single calendar month.
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We would like to thank the audit staff for their efforts and diligence in reviewing this complex area. Please do not hesitate to contact me by telephone at 360-725-1222 or via email at megan.atkinson@hca.wa.gov with any questions.

Sincerely,



Megan Atkinson
Chief Financial Officer
Washington State Health Care Authority

cc: Christy Vaughn, Section Manager, Health Care Rates and Finance, HCA
Lydia Barbour, Senior Auditor, HHS/OIG/OAS
Kari Summerour, External Audit Liaison, HCA