Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Washington Comprehensive Program Integrity Review

Final Report

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INTRODUCTION

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Washington State Department of Social and Health Services (DSHS) Medicaid Program. The MIG review team conducted the onsite portion of the review at the offices of DSHS. The MIG review team also visited the office of the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the State's Health and Recovery Services Administration (HRSA), which is responsible for Medicaid program integrity. This report describes five effective practices, two regulatory compliance issues, and five vulnerabilities in the State's program integrity operations.

THE REVIEW

Objectives of the Review

1. Determine compliance with Federal program integrity laws and regulations;
2. Identify program vulnerabilities and effective practices;
3. Help Washington improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Washington's Medicaid Program

The DSHS administers the Washington Medicaid program. As of June 30, 2008, the program served 992,414 recipients, 53 percent of whom are enrolled in managed care. The State had approximately 49,000 active providers participating in the fee-for-service (FFS) program. The managed care program had approximately 81,727 managed care providers in 7 managed care programs. Medicaid FFS expenditures in Washington for the State fiscal year (SFY) 2008 totaled $4,200,000,000. In SFY 2008, the Federal medical assistance percentage was 50 percent.

Program Integrity Section

The HRSA is dedicated to the program integrity function within the DSHS. The Division of Systems and Monitoring (DSM), within HRSA, is primarily responsible for supporting technology and information systems, timely and accurate claims processing, and payment integrity services. Within the DSM, the Office of Payment Review and Audit (OPRA) and Payment Review Program (PRP) have direct responsibility for provider audits and data analysis/reviews. The OPRA and PRP consist of 43.5 authorized full-time equivalent staff and 2 vacant positions. The table below presents the total number of preliminary and full investigations and State administrative actions, and amount of overpayments identified and collected in the past four SFYs as a result of program integrity activities.

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Number of State Administrative Actions	Amount of Overpayments Identified	Amount of Overpayments Collected
2005	561	799	56	$14,498,251	$18,411,390
2006	468	490	44	$14,480,180	$16,301,417
2007	327	281	45	$19,216,087	$16,547,015
2008	375	297	19	$28,424,355	$29,422,722

*Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation.

**Full investigations are conducted when preliminary investigations provide reason to believe fraud or abuse has occurred. They are resolved through a referral to the MFCU or administrative or legal disposition.

Methodology of the Review

In advance of the onsite visit, the review team requested that Washington complete a comprehensive review guide and supply documentation in support of its answers. The review guide included such areas as program integrity, provider enrollment/disclosure, managed care, and the MFCU. A four-person review team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of August 3, 2009, the MIG review team visited the DSHS and MFCU offices. The team conducted interviews with numerous DSHS officials, as well as with staff from the State's transportation providers, managed care organizations (MCOs), and the MFCU. The team also reviewed the managed care contract provisions and gathered information through interviews with representatives of four MCOs. In addition, the team conducted sampling of provider enrollment applications, case files, and other primary data to validate the State's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of HRSA, but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment and non-emergency medical transportation. Washington's Children's Health Insurance Program operates as a stand alone Title XXI program and was, therefore, excluded from this review.

Unless otherwise noted, DSHS provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information that DSHS provided.

RESULTS OF THE REVIEW

Effective Practices

The State has highlighted several practices that demonstrate its commitment to program integrity. These practices include a fraud and abuse detection system upgrade and a provider hotline.

Fraud and Abuse Detection System

Washington was awarded a $5.9 million Medicaid Transformation Grant (MTG) to upgrade its Fraud and Abuse Detection System. The MTG is for the adoption of innovative methods to improve the effectiveness and efficiency in providing medical assistance under Medicaid.

Provider Fraud Hotline

The newly established Provider Fraud Hotline has resulted in uncovering suspected provider billing fraud. For example, three individual employees working for the same employer called separately to report their employer, a dental provider. Reports of altering charts and performing and billing unnecessary services were substantiated by an audit. The provider was referred to the MFCU where a review is being conducted for possible criminal prosecution.

Additionally, the MIG review team identified three practices that are particularly noteworthy. The CMS recognizes Washington's efforts in the overhaul of its program integrity activities, implementation of a provider self review tool, and a hands on approach to managed care in mental health.

Culture changes and shift to data analysis focus

Beginning in 1999, DSHS began overhauling its program integrity activities to be more data driven and began infusing a spirit throughout DSHS that program integrity is everyone's business.

The change involved a shift to more data analysis and overpayment identification based upon data alone, without the need for medical record review or onsite visits. This process is supported by cross-division workgroup efforts resulting in policy revisions and changes to the Medicaid Management Information System payment edits. There is also active program integrity participation and representation, on the part of HRSA, on major Medicaid steering committees. This culture change, which is still a work in progress, has been very successful. DSHS reports an increase in annual savings of $55,517 in 2000 to $31,082,854 in 2008.

Provider self review tool

Washington utilizes a secure online tool to allow providers to conduct a Provider Self Review. This tool gives the provider access to a report that contains the claims that are to be reviewed. The provider is asked a series of questions about the claims. The questions

essentially walk the provider through an educative process as he evaluates the supporting documentation for the service provided. The tool outlines the clinical criteria required for each specific billing code. The provider identifies his own error by determining that his documentation does not support the level of care billed. Providers are invited to participate in the self review. Participation is not mandatory but, by declining, the provider becomes a prime candidate for an onsite review.

Recently, 5 out of 16 invited providers participated in a self review focused on neonatal billing practices. The self reviews of these five providers resulted in a total overpayment of approximately $284,000 based on the difference between the billed revenue code charges and the self review selected revenue code charges.

Proactive activities in mental health managed care fraud and abuse
Washington's Regional Support Network (RSN) Mental Health Department contractually requires managed care contractors to report all fraud and abuse to the RSN as soon as it is discovered. This differs from the physical health managed care contractors which report only verified cases of fraud and abuse. The RSN reporting procedure allows the MFCU the opportunity to make initial assessments and determinations about criminal intent.

The RSN Compliance Officer (CO) functions in an advisory role for the Washington Mental Health Managed Care program. The CO maintains extensive records to document his engagement in all allegations including clinical care meeting notes of the discussions, all actions taken, person responsible for the tasks, date concern resolved, results or outcomes of an investigation, and correction plan requirements.

Additionally, the CO is working with the MFCU in the development of a new annual compliance training tool that will be used to train all RSN providers. The training covers such items as elements of a compliance program, fraud and abuse, administrative oversight, Deficit Reduction Act, False Claims Act, physician self referral law, and a Medicare and Medicaid overview.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations related to disclosure of business transactions and reporting of adverse actions.

Washington's provider agreement does not require the disclosure of business transactions in its FFS operations.
The regulation at 42 CFR § 455.105(b)(2) requires that, upon request, providers furnish to the State or the U.S. Department of Health & Human Services (HHS) information about certain business transactions with wholly owned suppliers or any subcontractors. Washington's provider agreement does not include the required language.

The language in the DSHS provider agreement, "ownership and control as required by 42 CFR, Parts 455.100 through 455.106" is not specific enough to address the requirements of § 455.105.

No other references to disclosures note § 455.105, nor does the agreement specifically mention business transactions.

Recommendation: Modify the provider agreement to require disclosure of required business transaction information upon request.

Washington does not consistently report to HHS Office of Inspector General (HHS-OIG) adverse actions taken on provider applications for participation in the FFS program.
The regulation at 42 CFR §1002.3(b) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program.

Washington does report terminated FFS provider contracts and voluntary disenrollment by a provider to CMS, HHS-OIG, and the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank. However, Washington reported that it does not notify HHS-OIG if it denies the enrollment of a provider, enters into a settlement, or denies credentialing of a provider for fraud, integrity, or quality of FFS providers.

Recommendations: Develop and implement procedures to report to HHS-OIG all adverse actions taken against and limits placed on providers' participation in the FFS program during the enrollment and credentialing process.

Vulnerabilities

The review team identified several areas of vulnerability in Washington's practices regarding disclosure and reporting requirements and verification of billed services for Medicaid recipients.

Not requesting disclosure of ownership and control information on managed care provider enrollment applications and credentialing forms.
One of Washington's MCOs reported using its own internal enrollment/credentialing forms. These forms do not collect disclosure of ownership and control information. The other three MCOs interviewed reported using the Washington Practitioner Application for enrollment of providers. The Washington Practitioner Application, no longer in use by the State, does not request the disclosure of ownership and control information. Therefore, none of the MCOs interviewed are utilizing forms that request ownership and disclosure information as reflected in 42 CFR § 455.104. Washington's contract with the MCOs does not require the MCOs collect such information from providers.

Recommendation: Require MCOs to modify the provider enrollment forms, instructions, and Provider/Supplier Agreement to request all the information required to be disclosed under 42 CFR § 455.104.

Not requiring disclosure of business transactions upon request on MCO provider enrollment applications and credentialing forms.
Provider enrollment applications and credentialing forms for the four MCOs interviewed do not require disclosure of information related to business transactions, upon request, in accordance with 42 CFR § 455.105. Moreover, the State's managed care contract does not require the MCOs to collect this information, nor does the contract require MCOs to report this information within 35 days of the date of request.

Recommendations: Modify the MCO contract and MCO enrollment packages to require disclosure upon request of the information identified in 42 CFR § 455.105. Develop a policy and procedure for reporting such information within the specified timeframe.

Not capturing criminal conviction information on managed care provider enrollment applications and forms.
Washington's MCO provider enrollment applications and enrollment forms do not capture criminal conviction information for persons with control interest in the provider, and agents and managing employees of the provider. The applications and forms do not collect the information for individual practitioners, group practices, partnerships, institutional providers, long term care providers and home and community based providers.

By not collecting such information, Washington is unable to report disclosures made by MCO providers to HHS-OIG, as indicated in 42 CFR § 455.106.

Recommendations: Require MCOs to modify provider enrollment forms and provider agreements to meet the full criminal conviction disclosure requirements of the regulation. Develop and implement a procedure to report criminal conviction information to HHS-OIG within 20 working days.

Not verifying with managed care recipients whether services billed by providers were received.
While Washington meets the requirements of 42 CFR § 455.20 by sending explanations of medical benefits to FFS recipients, two of the four MCOs interviewed reported that verification of billed services is not done for Medicaid recipients. One of the MCOs indicated in its review guide response and during interview that it does not verify receipt of billed services rendered to Healthy Options members, which are Medicaid recipients. The second MCO indicated in the MCO review guide that it does not verify receipt of billed services and does not currently send explanations of medical benefits or service questionnaires to its members.

Recommendation: Require the State managed care program area to develop and implement a policy that addresses MCO verification of Medicaid recipients' receipt of billed services as part of its oversight of MCOs.

Not reporting to HHS-OIG adverse actions taken on managed care provider applications. Washington's MCO contracts do not require the MCO to notify the State of all adverse action it takes in its provider enrollment and credentialing or recredentialing. Therefore, the State is unable to report these actions to the HHS-OIG, as the regulation at 42 CFR § 1002.3(b) would require in the FFS program.

Recommendation: Require MCOs to report all denials of enrollment or credentialing or terminations of providers based on program integrity concerns to DHS.

CONCLUSION

The State of Washington applies some effective practices that demonstrate program strengths and the State's commitment to program integrity. These effective practices include:

- a fraud and abuse detection system upgrade,
- a provider fraud hotline,
- cultural change and a shift to data analysis,
- a provider self review tool, and
- proactive activities in mental health managed care fraud and abuse

The CMS supports the State's efforts and encourages it to look for additional opportunities to improve overall program integrity.

However, the identification of two areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, five areas of vulnerability were identified. The CMS encourages DSHS to closely examine the areas of vulnerability that were identified in this review.

It is important that these issues be rectified as soon as possible. To that end, we will require DSHS to provide a corrective action plan for each area of non-compliance within 30 calendar days from the date of the final report letter. Further, we will request the State include in that plan a description of how it will address the vulnerabilities identified in this report.

The corrective action plan should address how the State of Washington will ensure that the deficiencies will not recur. It should include the timeframes for each correction along with the specific steps the State expects will occur. Please provide an explanation if correcting any of the regulatory compliance issues or vulnerabilities will take more than 90 calendar days from the date of the letter. If DSHS has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

The Medicaid Integrity Group looks forward to working with the State of Washington on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.