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 Medicaid Program. The MIG review team conducted the onsite portion of the review at the Health Care Authority (HCA). The review team also visited the office of the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the Office of Program Integrity (OPI), which is responsible for Medicaid program integrity in Washington. This report describes two effective practices, seven regulatory compliance issues, and seven vulnerabilities in the State's program integrity operations.

The CMS is concerned that the review identified two partial or complete repeat findings and four partial or complete repeat vulnerabilities from its 2009 review of Washington. The CMS will work closely with the State to ensure that all issues, particularly those that remain from the previous review, are resolved as soon as possible.

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 HCA administers the Washington Medicaid program. As of January 1, 2011, the program served 1.2 million beneficiaries, 57 percent of whom were enrolled in 10 managed care organizations (MCOs). The State had 57,779 fee-for-service (FFS) enrolled providers and 67,442 MCO providers. Medicaid net expenditures in Washington for the State fiscal year (SFY) ending June 30, 2011 totaled $5.5 billion. This figure includes $1.4 billion in payments to MCOs.

Medicaid Program Integrity Office

In Washington, the OPI is the organizational component dedicated to fraud and abuse activities. The OPI is located in Washington's HCA Division of Systems and Monitoring. At the time of the review, the OPI had 41 full-time equivalent positions allocated to Medicaid program integrity functions with 1 vacant position. The table below presents the total number of investigations and overpayment amounts identified and collected in the last four SFYs as a result of program integrity activities.

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Overpayments Identified Through Program Integrity Activities*****	Overpayments Collected Through Program Integrity Activities*****
2008	375	297	$28,424,355	$29,422,772
2009	0****	465	$18,301,075	$18,081,750***
2010	0****	323	$21,866,785	$5,595,416***
2011	409	33	$7,188,342	$6,952,809***

* 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.
*** This figure represents direct cost savings and excludes savings estimates from cost avoidance efforts.
**** The State converted all SFY 2009 and 2010 cases from the iQCase log. According to HCA staff, the previous log did not distinguish between preliminary and full cases. The State categorized all the cases into the new log as full investigations.
***** According to State program integrity staff, the decrease in overpayments identified and collected from 2008 through 2010 is the result of the aforementioned system conversion and a large hospital lawsuit regarding the State's medical indigent program. These incidents resulted in reduced audit activity.

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/disclosures, and managed care. A four-person team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of December 12, 2011, the MIG review team visited the OPI and the MFCU offices. The team conducted interviews with numerous HCA and Department of Social and Health Services (DSHS) officials as well as with staff from the MFCU. To determine whether MCOs were complying with the contract provisions and other Federal regulations relating to program integrity, the MIG team reviewed the State's managed care contracts. The team conducted in-depth interviews with representatives from five MCOs and met separately with HCA staff to discuss managed care oversight and monitoring. In addition, the team conducted sampling of provider enrollment applications, program integrity cases, and other primary data to validate Washington's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of OPI, but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment, contract management, and provider training. The Washington Children's Health Insurance Program operates as a stand-alone program under Title XXI of the Social Security Act and, therefore, was excluded from this review.

Unless otherwise noted, Washington 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 provided.

Results of the Review

Effective Practices

As part of its comprehensive review process, the CMS invites each State to self-report practices that it believes are effective and demonstrate its commitment to program integrity. The CMS does not conduct a detailed assessment of each State-reported effective practice. Washington reported an agency-wide commitment to program integrity and a strong MCO review process with a focus on program integrity.

Commitment to program integrity throughout the Single State Agency

The HCA maintains a high-level commitment to program integrity, as evidenced by having:

- senior leadership involved in program integrity activities on a national level,
- more than 70 staff members who have attended the Medicaid Integrity Institute for specialized training in program integrity,
- a member of OPI who sits on all cross-divisional State Steering Committees, such as Provider Enrollment, Durable Medical Equipment, Pharmacy and Licensed Health Professional Contracts, and
- OPI staff meets regularly with Provider Enrollment staff to discuss enrollment screening requirements, payment suspensions, reenrollment, and other Patient Protection and Affordable Care Act (ACA) initiatives.

A two-level program review of MCOs that includes program integrity activities

The HCA has created a two-tier system to review MCOs, which includes a focus on program integrity that encompasses anti-fraud and abuse compliance. The HCA staff from managed care and quality care management was combined to create TEAMonitor. This two-tier system reviews MCOs' anti-fraud and abuse compliance and has a significant focus on program integrity. The TEAMonitor review consists of an annual compliance audit of MCOs using the CMS managed care checklist. TEAMonitors examines documents and activities related to fraud and abuse compliance following requirements found at 42 CFR §§ 438.608 and 438.610 and uses both desk review and field audits to focus on: fraud and abuse training of staff; minutes of fraud and abuse workgroups; claims auditing activities; exclusions; compliance plans and annual updates including work plans; provider education documentation; and provider notifications.

In addition, the State's External Quality Review Organization (EQRO) conducts audits of HCA's oversight of MCOs, providing a second level review of activities related to program integrity, provider credentialing, exclusion checking, subcontracting, and delegation functions. On the behavioral health side, the EQRO monitors the State's capitated Prepaid Inpatient Health Plans following protocols similar to those used with

MCOs. The EQRO reviews supplement ongoing utilization review and data mining performed directly by the Division of Behavioral Health and Recovery, a unit of DSHS.

Notwithstanding these effective practices, the review team found problems with lack of coordination and standardization in the program integrity function across sister agencies and non-compliance with the collection of disclosures in managed care. These issues are discussed in the Regulatory Compliance and Vulnerabilities sections below.

Regulatory Compliance Issues

The State does not comply with Federal regulations relating to the collection and reporting of ownership and control, significant business transactions, and criminal conviction disclosures. Issues also include not conducting complete exclusion searches, reporting adverse actions taken on provider participation to the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG), not providing adequate exclusion notices, and non-compliance with the State Plan regarding False Claims education.

The State does not capture all required ownership and control disclosures from disclosing entities.

Under 42 CFR § 455.104(b)(1), a provider (or "disclosing entity"), fiscal agent, or managed care entity (MCE) must disclose to the State Medicaid agency the name, address, date of birth (DOB), and Social Security Number (SSN) of each person or entity with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address. Additionally, under 42 CFR § 455.104(b)(2), a disclosing entity, fiscal agent, or MCE must disclose whether any of the named persons is related to another disclosing entity, fiscal agent, or MCE as spouse, parent, child, or sibling. Moreover, under § 455.104(b)(3), there must be disclosure of the name of any other disclosing entity, fiscal agent, or MCE in which a person with an ownership or controlling interest in the disclosing entity, fiscal agent, or MCE has an ownership or controlling interest. In addition, under § 455.104(b)(4), the disclosing entity must provide the name, address, DOB, and SSN of any managing employee of the disclosing entity, fiscal agent, or MCE. As set forth under § 455.104(c), the State agency must collect the disclosures from disclosing entities, fiscal agents, and MCEs prior to entering into the provider agreement or contract with such disclosing entity, fiscal agent, or MCE.

The HCA uses a Disclosure of or Change in Ownership and Control Interest Statement to enroll Medicaid providers providing general acute care. This form does not request DOB or ownership and control information for managing employees.

Home and community-based service providers and other long-term care providers, with the exception of nursing facilities (which are enrolled by HCA), are contracted with and enrolled by DSHS' Aging and Disability Services Administration (ADSA). The ADSA Contractor Intake Form does not request full ownership and control information for owners and persons with ownership or control interests or managing employees as required by Federal regulation.

The MCO contract and the Request For Proposal require disclosures consistent with Federal regulations. However, the State has not collected the necessary disclosures from plans that are fully consistent with ACA requirements.

Furthermore, the State's contract with non-emergency medical transportation (NEMT) brokers and its procurement process do not require the collection of ownership and control disclosures. State staff reported that they did not collect ownership disclosures consistent with this regulation from brokers but would include this in future procurements.

Recommendations: Develop and implement policies and procedures or modify contracts for the appropriate collection of disclosures from disclosing entities, NEMT brokers, or MCOs regarding persons with an ownership or control interest, or who are managing employees of disclosing entities, NEMT brokers, or MCOs. Modify disclosure forms as necessary to capture all disclosures required under the regulation.

The State does not adequately address business transaction disclosure requirements in its provider agreements or contracts. (Uncorrected Partial Repeat Finding)

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 and Human Services (HHS) information about certain business transactions with wholly owned suppliers or any subcontractors.

As noted by the 2009 CMS review team, the language in the State agency's provider agreement that obligates a provider to disclose "ownership and control as required by 42 CFR, Parts 455.100 through 455.106" does not specifically address the requirements of § 455.105. The 2012 CMS review team noted that the language in the provider agreement has not changed and the provider agreement does not specifically mention business transactions nor obligate providers to provide such information upon request. In addition, the provider agreement misstates the obligation as a disclosure to be made only at the time of contracting, rather than at any time upon request of the State or Secretary of HHS. Likewise, DSHS contracts do not include provisions for providers to provide business transaction information as required by 42 CFR § 455.105(b)(2).

The NEMT program brokers are required to make available to the State all documents they have collected on their subcontractors including business organizations. However, the contract between the State and NEMT brokers does not address 42 CFR § 455.105.

Recommendation: Revise the provider agreements and contracts to require disclosure upon request of the information identified in 42 CFR § 455.105(b). The MIG made this same recommendation in its 2009 review report.

The State does not capture criminal conviction disclosures from providers or contractors.

The regulation at 42 CFR § 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on

request. The regulation further requires that the Medicaid agency notify HHS-OIG whenever such disclosures are made. In addition, pursuant to 42 CFR § 455.106(b)(1), States must report criminal conviction information to HHS-OIG within 20 working days.

The ADSA background authorization form used to collect criminal conviction information only collects criminal conviction information on the applicant. The form does not request the required criminal conviction disclosures from persons with ownership or control interest in the provider, or who is an agent or managing employee of the provider.

Criminal background checks are conducted in the NEMT program and drivers require fingerprinting. However, the State did not demonstrate that it collected criminal history disclosures at the point of contracting with NEMT brokers and whether they include disclosures for persons with ownership and control interests, agents and managing employees. State staff was not aware of the specifics of the procurement process on this specific item.

Recommendations: Develop policies and procedures for the appropriate collection of disclosures from providers and NEMT brokers regarding persons with an ownership or control interest, or persons who are agents or managing employees of the providers and NEMT brokers, who have been convicted of a criminal offense related to Medicare, Medicaid or Title XX since the inception of the programs. Modify disclosure forms as necessary to capture all disclosures required under the regulation.

The State does not conduct complete searches for individuals and entities excluded from participating in Medicaid.

The Federal regulation at 42 CFR § 455.436 requires that the State Medicaid agency must check the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents and managing employees of the provider on HHS-OIG's List of Excluded Individuals/Entities (LEIE) and the General Services Administration's Excluded Parties List System (EPLS) no less frequently than monthly.

The HCA checks the LEIE and the EPLS at initial enrollment and reenrollment for FFS providers and MCOs. Although HCA checks the LEIE monthly for FFS, it does not check the EPLS monthly. The HCA checks disclosures for MCOs at the time of contracting and monthly against the LEIE. However, the State has not yet collected all the required disclosures from MCOs, as noted above, and it has not yet developed a procedure to check names monthly against the EPLS.

The ADSA does not check providers, persons with an ownership or control interest in the provider, and agents and managing employees of the provider against the EPLS.

Although NEMT brokers certify that they are not debarred and must inform the State should they get debarred in the course of their contract term, the CMS review team could not confirm that LEIE and EPLS checking was performed at the point of contracting with NEMT brokers.

Recommendations: Develop policies and procedures for appropriate collection and maintenance of disclosure information about the provider, any person with an ownership or

control interest, or who is an agent or managing employee of the provider. Search the LEIE (or the Medicare Exclusion Database (MED)) and the EPLS upon enrollment, reenrollment, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded persons or entities.

Modify the managed care contract to require MCEs to search the LEIE and EPLS upon contract execution and monthly thereafter by the names of any person with an ownership or control interest in the MCE, or who is an agent, or managing employee of the MCE.

The State does not report all adverse actions taken on provider participation to the HHS-OIG. (Uncorrected Repeat Finding)

The regulation at 42 CFR § 1002.3(b)(3) requires reporting to the HHS-OIG any adverse actions a State takes on provider applications for participation in the program.

The 2009 CMS review team noted that Washington did not report denials of enrollment, settlements, and denials to credential a provider for fraud, integrity, or quality concerns. During the 2012 review, the team noted that HCA has corrected this, as it reports adverse actions taken on provider applications and terminations. However, ADSA confirmed that it does not report contract terminations to either HCA or HHS-OIG.

Recommendation: Develop and implement procedures for reporting to HHS-OIG program integrity-related adverse actions on a provider's participation in the Medicaid program. The MIG made a similar recommendation regarding reporting to HHS-OIG in the 2009 review report.

The State does not provide notice of exclusion consistent with the regulation.

Under the regulation at 42 CFR § 1002.212, if a State agency initiates exclusion pursuant to the regulation at 42 CFR § 1002.210, it must provide notice to the individual or entity subject to the exclusion, as well as other State agencies; the State medical licensing board, as applicable; the public; beneficiaries; and others as provided in §§ 1001.2005 and 1001.2006.

The HCA indicated that when it initiates exclusions, it notifies the provider, other agencies, and HHS-OIG. However, the State does not provide any type of public notice such as bulletins to all providers/beneficiaries, website posting of an exclusion list, or newspapers. Likewise, ADSA confirmed that its Central Contract Services unit does not notify other agencies or the public of contract terminations.

Recommendation: Develop and implement policies and procedures to ensure that all parties identified by the regulation are notified of a State-initiated exclusion.

The State does not comply with its State plan regarding False Claims education monitoring.

Section 1902(a)(68) of the Social Security Act [42 U.S.C. 1396a(a)(68)] requires a State to ensure that providers and contractors receiving or making payments of at least $5 million

annually under a State's Medicaid program have: (a) established written policies for all employees (including management) about the Federal False Claims Act, whistleblower protections, administrative remedies, and any pertinent State laws and rules; (b) included as part of these policies detailed provisions regarding detecting and preventing fraud, waste, and abuse; and (c) included in any employee handbook a discussion of the False Claims Act, whistleblower protections, administrative remedies, and pertinent State laws and rules.

In Washington's State Plan Amendment (SPA), paragraph 4.42 (a)(4), the State declared that, "The requirements of this law should be incorporated into each State's provider enrollment agreements." This SPA was approved and implemented in 2007. The aforementioned regulation was found in contracts with MCEs and in contract provisions used by DSHS. However, language related to false claims education was not found in the "Core Provider Agreement" for individuals and institutions enrolled in FFS.

In addition, while onsite, the team requested the number of providers who met the $5 million threshold, and how many of these had been reviewed for compliance. Following the onsite review, the State provided a spreadsheet indicating that 51 providers met the $5 million threshold for SFY 2011. The majority of these were hospitals and the State planned to review these as part of field audits. However, the State indicated that none of the providers on the spreadsheet had a review of their false claims education in the past three years. The State reported that due to budget cuts, audits have been limited to desk audits, and reviews of this information normally have not been part of the desk audit protocol. Staff indicated that they were working on ways to request this information.

Recommendation: Implement and carry out existing policies and procedures to monitor compliance of all providers and contractors in accordance with the State Plan.

Vulnerabilities

The review team identified seven areas of vulnerability in the State's practices. These are related to not maintaining a centralized program integrity function, not requiring MCOs to verify that enrollees received services, and not capturing disclosures from MCO network providers. Additional issues include incomplete exclusion searches and not reporting adverse actions to HHS-OIG.

Not maintaining a centralized database or a standardized program integrity function.
The HCA was identified as the single State agency in Washington for Medicaid operations effective July 2011. Prior to that, the single State agency was the DSHS Medicaid Purchasing Administration. According to staff, some types of Medicaid programs, such as home and community-based services and long-term care services, are administered through a Cooperative Agreement with the DSHS. The review team noted that the change from DSHS to HCA as the State agency has left the State vulnerable to fraud, waste and abuse.

The Washington Medicaid program pays approximately $5.5 billion in claims through its Medicaid Management Information System (MMIS), referred to in the State as ProviderOne. These are processed through HCA. An additional $1.7 billion is paid outside of the MMIS

through various payment systems and/or programs. The majority of these (approximately $1.3 billion) are paid by DSHS, through a system called the Social Service Payment System (SSPS), which provides authorization and payment processing for health and social services delivered by several administrative units in DSHS. The DSHS pays an additional $212 million through the Residential Program System, which tracks the monthly charges along with Federal Medical Assistance Percentage for state-owned and operated inpatient psychiatric and residential developmental disabilities facilities. The DSHS also processes approximately $61 million for NEMT brokers. In addition, the State outlined various smaller programs and payment systems in its documentation, including one subset of services that are paid manually by DSHS to counties to support employment-related supportive services. These manual payments amounted to nearly $41 million for Federal fiscal year 2011.

The State reported that it plans on incorporating the SSPS data into its MMIS as part of Phase 2 of its new MMIS implementation. The State received Federal funding to do so, but did not receive matching State funding in the last budget cycle. This conversion is currently in the budget to be voted on by the legislature, and if passed, will be implemented in the second quarter of 2013.

During the review, the CMS team identified several vulnerabilities given the largely bifurcated administrative structure in Washington, which includes the following:

- Fragmented enrollment processes between HCA and ADSA reflected in the use of different forms for enrollment, inconsistent screening per Federal regulations, and incomplete and inconsistent reporting of provider terminations and adverse actions to HHS-OIG. This lack of consistency can allow providers terminated in one State program to enroll in another State program undetected.
- Not maintaining a centralized database tracking all cases of provider fraud for FFS, managed care, and waiver programs. This prevents the State from knowing the extent of fraud, waste, and abuse in its entire Medicaid program and reflects a lack of internal controls for monitoring the integrity of what nationally has been found to be high-risk services in waiver programs.
- Lack of coordinated referral processes across programs prevents the State from being able to exercise mandatory payment suspension and law enforcement referral procedures. As a case in point, DSHS disseminated a management bulletin on July 15, 2010 directing staff and consumers to report all cases of suspected provider fraud to the MFCU. Although this process, according to the bulletin, was developed in collaboration with the MFCU, it prevents OPI from being notified of suspected fraud. Although OPI reported that it conducts data mining on SSPS claims stored in the data warehouse, OPI does not conduct any investigations or audits on the information obtained. Instead, reports generated are sent to DSHS for follow-up. However, DSHS could not provide any data to the CMS review team regarding the number of investigations that have occurred over the past three years, or overpayments that have been collected. The DSHS was only able to provide overpayments identified in residential services based on a specific evaluation done in SFY 2010-2011 using four algorithms. Further, DSHS reported that it does not track investigations that occur within the agency based on audits or complaints from consumers or staff (and its investigations are not tracked in the OPI database).

- Staff from ADSA acknowledged that they do not have edits in place to capture personal care services that occur during hospitalizations.
- The ADSA reported that it does not extrapolate identified overpayments, which is allowed by State law and often used by HCA.
- Although OPI meets regularly with Provider Enrollment staff to discuss enrollment issues and ACA initiatives, OPI reported that it does not always know if the provider enrollment unit has re-enrolled a provider that OPI just terminated. This communication gap may allow a terminated provider to re-enter the Medicaid system.

Because it is most effective for all program integrity activities to flow through a centralized system or for units of the State agency to use a common protocol, the differences in activities between DSHS and HCA create program integrity gaps and vulnerabilities. The high dollar amount being expended on services, along with the lack of a structured program integrity system in ADSA, puts the State's Medicaid program at higher risk.

Recommendation: Organize all program integrity activities into a centralized unit or under a common protocol addressing provider enrollment, fraud and abuse detection, investigations and law enforcement referrals.

Not verifying with managed care enrollees whether services billed were received. (Uncorrected Repeat Vulnerability)

The regulation at 42 CFR § 455.20 requires the State Medicaid agency to have a method for verifying with beneficiaries whether services billed by providers were received.

The 2009 review team noted that not all MCOs had a process in place to verify with beneficiaries whether services billed by providers were actually received. The 2012 review team noted that two of three MCOs interviewed have not yet implemented a direct beneficiary verification of services program.

Recommendation: Ensure that a process is in place to verify with MCO enrollees whether services billed by providers were received. The MIG made a similar recommendation regarding beneficiary verification of services in managed care plans in the 2009 review report.

Not capturing ownership and control disclosures from network providers. (Uncorrected Partial Repeat Vulnerability)

Under 42 CFR § 455.104(b)(1), a provider (or "disclosing entity"), fiscal agent, or MCE, must disclose to the State Medicaid agency the name, address, DOB, and SSN of each person or entity with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address. Additionally, under § 455.104(b)(2), a disclosing entity, fiscal agent, or MCE must disclose whether any of the named persons is related to another disclosing entity, fiscal agent, or MCE as spouse, parent, child, or sibling. Moreover, under § 455.104(b)(3), there must be disclosure of the name of any other disclosing entity,

fiscal agent, or MCE in which a person with an ownership or controlling interest in the disclosing entity, fiscal agent, or MCE has an ownership or controlling interest. In addition, under § 455.104(b)(4), the disclosing entity must provide the name, address, DOB, and SSN of any managing employee of the disclosing entity, fiscal agent, or MCE. As set forth under § 455.104(c), the State agency must collect the disclosures from disclosing entities, fiscal agents, and MCEs prior to entering into the provider agreement or contract with such disclosing entity, fiscal agent, or MCE.

The 2009 CMS review team found that MCOs interviewed were not requesting ownership and disclosure information as reflected in 42 CFR § 455.104 and that Washington's contract with MCOs did not require MCOs to collect such information from providers. The 2012 CMS review team noted that only one MCO plan captures some ownership and control disclosures from disclosing entities and no plans fully capture disclosures in line with Federal requirements from persons with ownership and control interest or managing employees.

Based upon interviews with State staff and a review of the NEMT broker contract, the State does not require the collection of ownership disclosures from the broker or its provider network. The CMS review team determined that disclosures that conform to Federal requirements are not being collected from NEMT network providers.

Recommendations: Modify the managed care and NEMT contracts to require, or ensure that managed care provider enrollment forms require, the disclosure of complete ownership, control, and relationship information from all MCE and NEMT network providers. Include contract language requiring MCEs and NEMT brokers to notify the State of such disclosures on a timely basis. The MIG made the same recommendation regarding capturing ownership and control disclosure from MCE network providers in the 2009 review report.

Not adequately addressing business transaction disclosures in network provider contracts. (Uncorrected Partial Repeat Vulnerability)

The regulation at 42 CFR § 455.105(b)(2) requires that, upon request, providers furnish to the State or HHS information about certain business transactions with wholly owned suppliers or any subcontractors.

The 2009 review team noted that provider enrollment applications and credentialing forms for four MCOs did not require disclosure of information related to business transactions, upon request, in accordance with 42 CFR § 455.105. The 2009 review team also noted that the State's managed care contract did not require MCOs to collect the information, nor did the contract require MCOs to report this information within 35 days of the date of request.

The 2012 CMS review team noted that network provider agreements across health plans still do not include the obligation to report business transactions upon request. The CMS review team did not review contracts between transportation brokers and their providers. The State did not provide documentation that the transportation providers are required provide business transaction information upon request.

Recommendation: Modify the managed care and NEMT contracts to require disclosure

upon request of the information identified in 42 CFR § 455.105(b). The MIG made the same recommendation in its 2009 review report.

Not capturing criminal conviction disclosures from network providers. (Uncorrected Partial Repeat Vulnerability)

The regulation at 42 CFR § 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify HHS-OIG whenever such disclosures are made. In addition, pursuant to 42 CFR § 455.106(b)(1), States must report criminal conviction information to HHS-OIG within 20 working days.

Based upon interviews and document review, the CMS team determined that MCO provider network applications solicit criminal history disclosures only from the provider. The MCO applications and enrollment procedures do not inquire about the criminal history of owners, persons with control interests, agents, or managing employees. The 2009 review team also identified this issue regarding MCO disclosures.

Likewise, NEMT brokers complete the ADSA Background Authorization Form, which does not request required disclosures for persons with ownership or control, agents and managing employees. Criminal background checks are required of all transportation drivers; however, the CMS review team is not aware of whether a disclosure is requested in the transportation provider enrollment process.

Recommendations: Modify the managed care and NEMT contracts to require, or ensure that managed care provider enrollment forms require, the disclosure of health care-related criminal convictions on the part of persons with an ownership or control interest, or persons who are agents or managing employees of network providers. Include contract language requiring MCEs to notify the State of such disclosures on a timely basis. The MIG made a similar recommendation regarding MCEs in the 2009 review report.

Not conducting complete searches for individuals and entities excluded from participating in Medicaid.

The regulations at 42 CFR §§ 455.104 through 455.106 require States to solicit disclosure information from disclosing entities, including providers, and require that provider agreements contain language by which the provider agrees to supply disclosures upon request. If the State neither collects nor maintains complete information on owners, officers, and managing employees in the MMIS, then the State cannot conduct adequate searches of the LEIE or the MED.

The CMS issued a State Medicaid Director Letter (SMDL) #08-003 dated June 16, 2008 providing guidance to States on checking providers and contractors for excluded individuals. That SMDL recommended that States check either the LEIE or the MED upon enrollment of providers and monthly thereafter. States should check for providers' exclusions and those of persons with ownership or control interests in the providers. A follow-up SMDL (#09-001)

dated January 16, 2009 provided further guidance to States on how to instruct providers and contractors to screen their own employees and subcontractors for excluded parties, including owners, agents, and managing employees. A new regulation at 42 CFR § 455.436, effective March 25, 2011, now requires States to check enrolled providers, persons with ownership and control interests, and managing employees for exclusions in both the LEIE and the EPLS on a monthly basis.

Although Washington health plans report that they are in compliance on LEIE monthly checking, three MCOs interviewed reported they do not check the EPLS as required and the scope of their disclosure database does the meet the breadth of Federal guidance in this area.

The CMS review team could not confirm that LEIE and EPLS checking was performed for NEMT subcontractors.

Recommendations: Amend the contract to require the appropriate collection and maintenance of disclosure information about disclosing entities, and about any person with a direct or indirect ownership interest of 5 percent or more, or who is an agent or managing employee of the disclosing entity, or who exercises operational or managerial control over the disclosing entity. Require the contractor to search the LEIE and the EPLS upon enrollment, reenrollment, credentialing or re-credentialing of network providers, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded persons or entities.

Not reporting all adverse actions taken on provider participation to the HHS-OIG.
The regulation at 42 CFR § 1002.3(b)(3) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program.

The State Medicaid agency does not have contract requirements directing the six NEMT brokers to report program integrity-related adverse actions a broker may take on a provider's participation in the network, e.g., denials of credentials, enrollment, or contracts, or terminations of credentials, enrollment, or contracts. Program integrity reasons include fraud, integrity, or quality.

Recommendations: Require contracted brokers to notify the State when they take adverse action against a network provider for program integrity-related reasons. Develop and implement procedures for reporting these actions to HHS-OIG.

Conclusion

The State of Washington applies some effective practices that demonstrate program strengths and the State's commitment to program integrity. The CMS supports the State's efforts and encourages it to look for additional opportunities to improve overall program integrity.

However, the identification of seven areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, seven areas of vulnerability were identified. The CMS is particularly concerned over the six uncorrected repeat findings and vulnerabilities. The CMS expects the State to correct them as soon as possible.

To that end, we will require Washington 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 Washington 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.

STATE OF WASHINGTON
HEALTH CARE AUTHORITY
626 8th Avenue, S.E. • P.O. Box 45502 • Olympia, Washington 98504-5502

July 20, 2012

Robb Miller, Director
Division of Field Operations
Center for Program Integrity
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Mr. Miller:

Enclosed, please find the Corrective Action Plan (CAP) detailing how the Washington State Health Care Authority (HCA) will address the areas of non-compliance and vulnerability identified during your review of Washington's program integrity procedures and processes.

You asked us to explain why any corrective action may take longer to correct than 90 days from the date of your letter. As noted in the body of our CAP, many of the corrective actions identified are contingent upon the revision of our Core Provider Agreement (CPA) and our NEMT broker contracts, both of which are slated to be complete and in effect as of January 1, 2013. This additional time, which we've extended to our other corrective actions as well, will allow HCA to fully coordinate and complete these commitments.

Thank you for the opportunity to review and respond to these findings. We appreciate the opportunity to partner with CMS to improve our Program Integrity procedures and processes. If you have any questions, or should you need additional information, please feel free to contact Cathie Ott, Deputy CIO, Systems and Monitoring by email at cathie.ott@hca.wa.gov , or by phone at (360) 725-2116.

Sincerely,

Heidi Robbins Brown, J.D.
Deputy Director

Enclosure
cc: Cathie Ott, Deputy CIO, Systems and Monitoring, HCA
Martin Thies, Section Manager, OPI, Systems and Monitoring, HCA