Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Washington Focused Program Integrity Review

Final Report

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Objective of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review of Washington to determine the extent of program integrity oversight of the managed care program at the state level and to assess the program integrity activities performed by selected managed care organizations (MCOs) under contract with the state Medicaid agency. The review also included a follow up on the states progress in implementing corrective actions related to CMS is previous comprehensive program integrity review conducted in calendar year 2012.

Background: State Medicaid Program Overview

The purpose of this review was to determine whether Washington's Medicaid managed care program integrity procedures satisfy the requirements of federal regulations and applicable provisions of the Social Security Act. A related purpose of the review was to evaluate how the State Medicaid agency receives and uses information about potential fraud, waste, and abuse involving Medicaid managed care providers and how the state works with the Medicaid Fraud Control Unit (MFCU) in coordinating its Medicaid program integrity efforts. Other major focuses of the review may include, but are not limited to: provider enrollment and credentialing activities, pre-payment and post-payment review; False Claims Act education and monitoring, methods for identifying, investigating, and referring fraud, the appropriate use of payment suspensions; and the monitoring and reporting of adverse actions taken to limit a provider's participation in the Medicaid program.

The state Medicaid agency in Washington is the Health Care Authority (HCA). The HCA underwent a realignment of its organizational structure in October 2015. The goal of realignment was to reallocate staff and specific lines of business to align with the growth experienced from moving Washington's Medicaid population into a managed care delivery system. Realignment relocated the Section of Program Integrity to a newly formed Medicaid Program Operations and Integrity (MPOI) Division. The MPOI is the unit responsible for overall program integrity operations, although other units within the organization maintain certain delegated program integrity related responsibilities. Washington is a Medicaid expansion state with approximately 1.84 million Medicaid beneficiaries and expenditures exceeding $10.9 billion. The Federal Medical Assistance Percentage matching rate was 50 percent in 2017.

Methodology of the Review

In advance of the onsite visit, CMS requested that Washington and the MCOs selected for the focused review complete a review guide that provided the CMS review team with detailed insight into the operational activities of the areas that were subject to the focused review. A three member review team has reviewed these responses and materials in advance of the onsite visit.

During the week of July 23-27, 2018, the CMS review team visited the offices of the HCA. The team conducted interviews with numerous state staff involved in program integrity and managed care. The CMS review team also conducted interviews with the state's MCOs and their special investigations units (SIUs). In addition, the CMS review team conducted sampling of program

integrity cases and other primary data to validate the state and the selected MCOs' program integrity practices.

Results of the Review

The CMS review team identified areas of concern with the state's managed care program integrity oversight, thereby creating risk to the Medicaid program. CMS will work closely with the state to ensure that all of the identified issues are satisfactorily resolved as soon as possible, particularly those that might remain from the earlier review. These issues and CMS' recommendations for improvement are described in detail in this report.

Section 1: Managed Care Program Integrity

Overview of the State's Managed Care Program

Washington has approximately 1.58 million beneficiaries, or about 85 percent of the state's Medicaid population, were enrolled in five MCOs during FFY 2017. The state spent approximately $5.83 billion or approximately 56 percent of its annual budget on managed care contracts in FFY2017.

The HCA Realignment in 2015 facilitated the relocation of fraud investigations and referrals from program integrity to the Internal Audit Office, renamed to Audit and Accountability. A team of four full-time equivalents (FTEs) that conduct fraud investigations to determine potential credible allegations of fraud, initiate referrals to MFCU, and are responsible for the suspension of provider payments when warranted. The CMS review team identified oversight issues that appear to be related to the realignment of program integrity staff. In essence, the prior HCA realignment efforts aimed at consolidating program integrity may have fallen short of the state's expectations.

The review team identified a potential risk in how decentralized various program integrity duties and responsibilities were across the HCA. This structure creates tangible division between vital functions and appears to promote a lack of authority for the program integrity unit within the MPOI division. The state should take advantage of this opportunity to pursue further efforts towards consolidating staff involved in the program integrity process. Such reorganization of the agency's program integrity resources should focus on helping address the state's organizational problems, including blurred managed care program integrity accountability, problems with performance of program integrity administrative support services— particularly managed care contracting, to include but may not be limited to, poor program integrity oversight of managed care SIU operations. It is important for HCA to understand how these ongoing internal organizational misalignments may significantly impact how program integrity activities are managed and ultimately how beneficiaries are served in its managed care program. If adopted, HCAs consolidation and reorganization strategies will only serve to benefit the beneficiaries, providers, as well as the state Medicaid agency itself.

Therefore, the CMS team recommends that the state 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. Since Washington is trending upward with its managed care enrollment, a more centralized unit, under a common protocol addressing provider enrollment, fraud and abuse detection, investigations and law enforcement referrals appears to be warranted. In addition, the number of potential risks identified in Washington's managed care program integrity operations also supports the need for a more centralized program integrity unit. The state should consider taking the necessary steps at creating an organizational program integrity structure that centralizes the program integrity activities and ensures the program integrity unit within the MPOI division maintains the proper authority that are more reflective of industry standards.

The MPOI is the organizational component dedicated to anti-fraud and abuse activities for Medicaid managed care in Washington. The state reported having 45 FTE positions within HCA with the responsibility of performing various program integrity duties. However, only three FTEs are dedicated to managed care, while approximately twelve positions perform functions impacting both managed care and Fee-For-Service (FFS). The remaining staff primarily work with only the FFS lines of business. The State mentioned as the FFS population decreases, more staff will be assigned managed care oversight duties. The other four sections within the division consists of the following: 1) Managed Care Programs – MCO contract management/networks with thirteen FTEs fully dedicated to managed care; 2) Medicaid Compliance Review and Analytics – managed care readiness reviews, utilization and quality performance measure monitoring with fifteen FTEs all dedicated to managed care; 3) Medicaid Program Design and Implementation – design and implement new managed care and health care delivery initiatives with thirteen FTEs; 4) Community Services – community service provider contract management with 21 FTEs.

Insufficient managed care program integrity staffing levels may potentially decrease Washington's ability to pursue investigations and perform other core program integrity functions within the Medicaid managed care program. It is operationally important for program integrity units to maintain sufficient staffing levels and appropriate levels of resources in order to perform the activities required to program integrity risks to the Medicaid program. In addition, it is equally important to have staff allocated appropriately across the Medicaid program. The CMS review team was also concerned that the number of FTEs dedicated to managed care appear to be insufficient for a program that is nearly 60 percent of your budget with less than ten percent of the staff is allocated full time. Managed care oversight is less effective when the staffing is less than adequate and reflected in this report by the limited number of provider investigations and referrals by the MCOs along with the low amounts of overpayments and terminations that the MCOs reported. Therefore, the state should ensure that both the HCA and its MCOs are allocating sufficient resources to the prevention, detection, investigation and referral of suspected provider fraud.

Summary Information on the Plans Reviewed

The CMS review team interviewed three MCOs as part of its review. The selected MCOs were UnitedHealthcare Community Plan of Washington (UnitedHealthcare Community Plan), Molina, Healthcare of Washington, Inc. (Molina), and Coordinated Care of Washington (Coordinated Care).

UnitedHealthcare Community Plan is a national, for-profit health plan that provides comprehensive health coverage to approximately 211,844 Medicaid beneficiaries. With its network of 29,084 providers, UnitedHealthcare Community Plan has served the state of Washington since its contract was initiated in 2012. UnitedHealthcare Community Plan operates in 24 markets as a Medicaid MCO and 46 markets nationwide. Compliance activities for UnitedHealthcare Community Plan are supported by a matrix of national and local United Health functional areas.

The compliance unit staff consists of 10.78 FTEs and is headed by the local health plan compliance officer; 8.78 of these FTEs are at the national level and 2 FTEs are at the local level based out of Washington. The local employees are comprised of a Compliance Officer and supporting Senior Compliance Analyst. The local compliance unit reports to a national compliance committee to encourage independence of the compliance and program integrity processes. The SIU performs all investigative functions at the national level. The number of national employees devoted solely to the oversight of Washington fluctuates based on the relevant case volume, and therefore the 8.78 FTEs previously cited is approximate and may vary. The SIU is jointly operated by UnitedHealthcare Community Plan and Optum Insight (Optum), a shared subsidiary and vendor, and is largely located in Minnetonka, Minnesota. Furthermore, Optum performs all triage and determinations of credible allegation of fraud functions, as well as providing specialized SIU units for some areas of expertise. Oversight of Optum is performed by the local Director of Operations and the vendor oversight unit. This unit includes a national vendor relationship manager and is responsible for evaluating overall vendor performance.

Notably, Optum is also the Washington HCA’s data collection and analysis vendor. As Optum is a subsidiary of United HealthCare, a current Medicaid MCO in the state of Washington, there is potential for a conflict of interest between Optum and Optum's parent company, UnitedHealthcare Community Plan. The state should ensure that contract language and processes are sufficiently strengthened to protect the agency against any potential conflict of interest issue.

Molina is a national, for-profit health plan that provides comprehensive health coverage to approximately 748,347 Medicaid beneficiaries, throughout 39 counties. With its network of 35,358 providers, Molina has served the state of Washington since its contract was initiated in 2000. Total plan expenditures amounted to approximately $2.5B for the plan’s Washington Medicaid line of business in 2017. Molina operates in 14 markets as a Medicaid MCO and participates in markets involving Medicare, commercial health plans and products, and specialty products and programs.

The Molina corporate compliance committee is centrally headquartered in Long Beach, CA. This unit, in conjunction with the local SIU, supports and fulfills the health plan's program integrity requirements. The national unit performs all triage and determination of credible allegations of fraud, waste, abuse investigations, related referrals and proactive leads down to the local level, which is based in Bothell, WA. The national compliance unit for the period of this review consisted of 28 FTEs and has recently increased its staffing levels to 32 FTEs.

At the local level, the SIU consists of two full time investigators. These investigators are supported by resources at the national level as needed to complete the plans objectives. The local SIU investigators are assisted by an analyst and nurse investigator, bringing the local compliance dedicated employee total to four FTEs. The average case load per investigator is approximately 25 cases each. The SIU monitors and handles all fraud, waste, and abuse Medicaid audits for its Washington health plan. The SIU partners with Health Management Systems (HMS) who provides analytical tools, data mining, and suspect leads related to fraud, waste, and abuse. Notably, the SIU will be phasing-out its fraud solutions contract with HMS, as the Payment Integrity division is in the process of securing a contract with a new fraud analytics vendor, who will provide enhanced solutions to Molina related to fraud, waste, and abuse identification and investigation, along with an integrated case management tool that will allow the SIU enhanced performance and productivity tracking.

Coordinated Care Health Plan is wholly-owned subsidiary of Centene Corporation (Centene), which provides Medicaid services to approximately 204,000 Medicaid beneficiaries in the state of Washington. Coordinated Care employs approximately 28,000 Medicaid participating providers as part of its contract with the State for the following programs: Medicare Advantage, Apple Health Managed Care, Apple Health Foster Care and Apple Health Integrated Managed Care. Coordinated Care utilizes Centene's SIU in Missouri to address complaints and perform provider oversight of suspected provider or member fraud or abuse. Centene's SIU resources consist of 101 staff members and seven of those staff members (four FTEs) are dedicated to fraud, waste, and abuse activities in Washington.

Enrollment information for each MCO as of January 2017 is summarized below:

Table 1.

	United	**Molina**	**Coordinated Care**
Beneficiary enrollment total	211,844	748,347	204,247
Provider enrollment total	29,084	35,358	28,150
Year originally contracted	2012	2000	2012
Size and composition of SIU	2 local compliance FTEs*	2 local compliance FTEs**	4 local compliance FTEs***
National/local plan	National	National	National

***** Approximately nine national FTEs devoted to Washington Medicaid fraud, waste, and abuse.
**Approximately four national FTEs devoted to Washington Medicaid fraud, waste, and abuse.
***Approximately seven national FTEs devoted to Washington Medicaid fraud, waste, and abuse.

Table 2.

MCOs	FFY 2015	FFY 2016	FFY 2017
United	$579,660,271	$651,310,124	$767,723,014
Molina	$1,570,726,017	$2,225,996,086	$2,451,763,039
Coordinated Care**	$437,534,873	$751,766,010	$745,758,512

*Expenditure amounts depicted were submitted by HCA and varied only slightly from expenditure data submitted by United and Molina.
**Coordinated Care expenditures varied significantly each year represented. The state should look into why the MCO expenditure amounts varied by $151M, $113M, and $56M from FFY2015-17 respectively.

State Oversight of Managed Care Program Integrity Activities

The HCA has several issues that hinder the organization's ability to provide effective state program integrity oversight over its managed care program. The CMS review team found other risks related to the state's program integrity oversight in Washington's Medicaid managed care program that are highlighted in this report.

The main risk the review team identified is associated with Washington's general program integrity contract with its MCOs. The current contract with the MCOs has a fraud, waste, and abuse section (Section 12) that is in need of revisions in order to more adequately comply with the federal regulations governing program integrity in the Managed Care Program. In addition, strengthened program integrity contract language may allow MPOI to maintain better control over its Medicaid managed care program integrity operations.

Therefore, the CMS review team identifies a lack of robust program integrity contract language in the state's general contract with its MCOs. This puts the state at risk in not being able to maintain the necessary program integrity controls, flexibility and oversight capabilities to govern its managed care program effectively. The state should enhance or improve its general program integrity contract language in order to help HCA eliminate any impediments to provider auditing and collaborative audits with the MCOs, as well as audits of the MCOs themselves. The state should also seek to implement contract language that specifies the number of employees that must be devoted to Washington Medicaid fraud, waste, and abuse activities relative to the number of beneficiaries being served. During the course of the review, it was identified that the resources being devoted to the state from its MCOs were largely indeterminable. Having MCO staff specifically devoted to the identification of provider fraud in Washington ensures that all reasonable steps are being taken to strengthen the Washington Medicaid managed care program.

Some of the managed care program integrity activities that HCA might consider addressing in Section 12 of its contract may include, but is not limited to the following: 1) The auditing of managed care encounter data and complaints or allegations of provider fraud, waste, and abuse; 2) Handling (recording, tracking and reporting) of suspected provider fraud referrals to HCA; 3) Development and implementation of written policies and procedures on payment suspensions in accordance with 42 CFR 455.23 and/or 42 CFR 438.608(a)(8); 4) Specific

language around program integrity recoupments or overpayment recoveries after all appeal rights are exhausted; 5) Collaborating and conducting joint audits and initiating routine onsite provider visits during an investigation/audit; 6) Verifying Medicaid services with beneficiaries; 7) Handling of provider adverse actions to include exclusions and terminations; and 8) Enhanced MCO performance metrics included in their annual reviews including sanctions and liquidated damages.

In addition to revising its program integrity contract language, HCA should review program integrity policies and procedures relative to any contract modifications to ensure all program integrity functions are adequately addressed. The state might consider having a formal policy and procedure pertaining to the submission of MCO reports listing all investigations conducted that resulted in no findings of fraud, waste, and abuse, as well as maintaining a tracking log of all incidents of suspected fraud, waste, and abuse received by the MCO regardless of the source.

There appears to also be a need for HCA to have collaborative meetings aimed at educating the MCOs on the differences between how the MCOs evaluate aberrant providers relative to their private lines of business versus how these providers should be evaluated relative to their Medicaid line of business. Emphasis should be placed on how the MCOs investigate and resolve provider fraud, waste, and abuse along with the consequential actions that should be taken.

During a sampling of provider investigative case files conducted by the MCOs, the review team found several instances wherein providers were provided with education rather than being referred to the state for further review. The CMS review team understands this was the way the process was set up originally in the state, however, the process requires updating to come into compliance with the federal regulations and other federal published program integrity policies and guidance documents, such as those identified in the technical assistance section of this report.

MCO Investigations of Fraud, Waste, and Abuse

As required by 42 CFR 455.13, 455.14, 455.15, 455.16, and 455.17, the state does have an established process for the identification, investigation, referral and reporting of suspected fraud, waste, and abuse by providers and MCOs.

Washington's MCO contract states, "the contractor shall ensure compliance with the program integrity provisions of this contract, including proper payments to providers or subcontractors and methods for detection and prevention of fraud, waste, and abuse. It also states that a contractor shall have a staff person dedicated to working collaboratively with HCA on program integrity issues, and with the MFCU on fraud and abuse investigation issues." This includes a host of program integrity activities.

Furthermore, the contract also states "the contractor shall perform ongoing analysis of its authorization, utilization, claims, providers billing patterns, and encounter data to detect

improper payments, and shall perform audits and investigations of subcontractors, providers and provider entities."

The MCOs indicated they refer their suspected credible allegations of fraud to the MFCU and copies the state at the same time. The MCO contract specifically states that the MCO shall establish policies and procedures for MFCU referrals on credible allegations of fraud and for payment suspension when the MCO determines there is a credible allegation of fraud. It goes on to state that when the MCO has concluded that a credible allegation of fraud or abuse exists, the MCO shall make a fraud referral to MFCU and HCA within five business days of the determination.

The review team was unable to determine the accuracy of the MCO referral process without Washington having a formalized referral system in place that the team could use to verify and validate all referrals. Therefore, the review team requested referral figures from HCA and the MCOs independently. The HCA reported referrals varied from the figures reported to the review team by the MCOs, which are depicted in Table 3 below. UnitedHealthcare Community Plan's referral figures varied from HCA's by a total of six referrals in 2015. The variances from Molina crossed each of the years in the review period. The state reported a total of six referrals from Molina during the full three-year review period, while Molina is reported four referrals total. Molina reports no referrals were made to the state in 2015, while HCA reported to CMS that Molina referred one case in 2015. Besides, in table 4B for Molina, the MCO reported having conducted eight preliminary investigations in 2015, and two of them developed into full investigations. In addition, there was one referral variance in 2016 and a two referral variance in 2017 from the figures reported to the review team. Coordinated Care had a reported referral variance of six, two and one referrals for 2015-2017 respectively. HCA reported no referrals in 2015, one referral in 2016 and one referral in 2017.

The review team associates these aforementioned variances with the HCA not having an efficiently coordinated referral processes across the managed care program. The team felt this not only may be preventing the HCA from being notified of suspected fraud by its MCOs, but may also hinder the state from being able to exercise mandatory payment suspension and law enforcement referral procedures. In accordance with 438.608(a)(7), the state should take steps to ensure the mandatory referral of any potential fraud, waste, or abuse to the State Medicaid program integrity unit or any potential fraud to the MFCU. In addition, the adequate tracking of the MCO investigations and referrals would aid HCA in always knowing what cases the MCOs are investigating. The state should clarify with its MCOs the proper use of its customized Washington fraud referral form for reporting purposes, as well as ensure that the referrals always conform to the CMS referral standards.

The UnitedHealthcare Community Plan identifies and investigates potential fraud in accordance with their contract and refers this information to the state when appropriate. The UnitedHealthcare Community Plan's investigations of potential fraud and abuse activities originate with the intake of a referral. Referrals are received through multiple channels, including local tips and nationally administered analytics programs. Local tips are often received through the UnitedHealthcare Community Plan Washington Compliance email inbox. For cases

received through local sources, the local unit acts as liaison; referring allegations to the national level. All cases are tracked and triaged from this initial stage using a comprehensive referral and validation system, DETECTS, accessible at both the national and local level. This system allows for a comprehensive review of data from all available sources, including commercial and Medicaid lines of business, and is administered by Optum.

At this stage, the Optum staff determines the credibility of the allegation through data querying and other relevant intelligence gathering activities. If credibility is established, the case will proceed to the preliminary review stage. All investigations occur at the national level. The UnitedHealthcare Community Plan has specialized SIU departments to address specific subject matter and the appropriate department is determined by a bi-weekly triage committee for all cases requiring preliminary review. These units are operated by UnitedHealthcare Community Plan directly and Optum. Optum administers SIU departments largely devoted to cases of waste, whereas UnitedHealthcare Community Plan SIU departments are primarily responsible for cases deemed likely to have instances of fraud or abuse. When cases are assigned to specialized units, they may be entered into separate tracking systems. However, these systems tie back to the original case number issued by the DETECTS system and can therefore be referenced at all levels. If the appropriate UnitedHealthcare Community Plan or Optum SIU determines that there is insufficient evidence of possible fraud, waste, or abuse, the case will be closed. If a credible allegation of fraud is determined during the preliminary review, an extensive review will be performed by the SIU. Depending on the type of investigation, the provider may be placed on prepayment review during this process; approximately 50-75 percent of providers are placed on review during investigation. Following investigation, relevant information is then communicated back to the local UnitedHealthcare Community Plan staff via the summary investigative report; this unit is then responsible for communicating that information to the state for further review and action directives. All SIU investigations are reported to the state through the quarterly allegations report.

Molina's SIU is headed by an Associate Vice President (AVP) who is responsible for SIU program functions, which include ongoing development and oversight. The AVP works with internal and external partners to address program integrity matters. Molina's SIU monitors, identifies and investigates all potential fraud, waste, and abuse of Medicaid in accordance with their contract and refers this information to the state when appropriate. Molina investigates all suspected cases of fraud, waste and abuse and promptly reports all confirmed incidences to the appropriate government agencies. Molina takes the appropriate disciplinary action including, but not limited to, termination of employment, termination of provider status, and/or termination of membership.

Molina's investigations of potential fraud and abuse activities originate with the intake of a referral. Referrals are received through multiple channels, including local tips and nationally administered data analytics programs. The primary source by which the SIU receives referrals of suspected fraud, waste, or abuse is through the Molina AlertLine system, a secure and confidential hotline available 24/7 either toll-free or online. The Molina AlertLine is provided by vendor, Navex Global. Molina's compliance department owns the vendor relationship with Navex Global, and ensures that all allegations of fraud, waste, and abuse are routed via the

AlertLine system to the SIU. Both the Molina Healthcare Member Handbook and the "Member" section of the Molina web site includes information about how to make anonymous reports of suspected fraud, waste, and abuse.

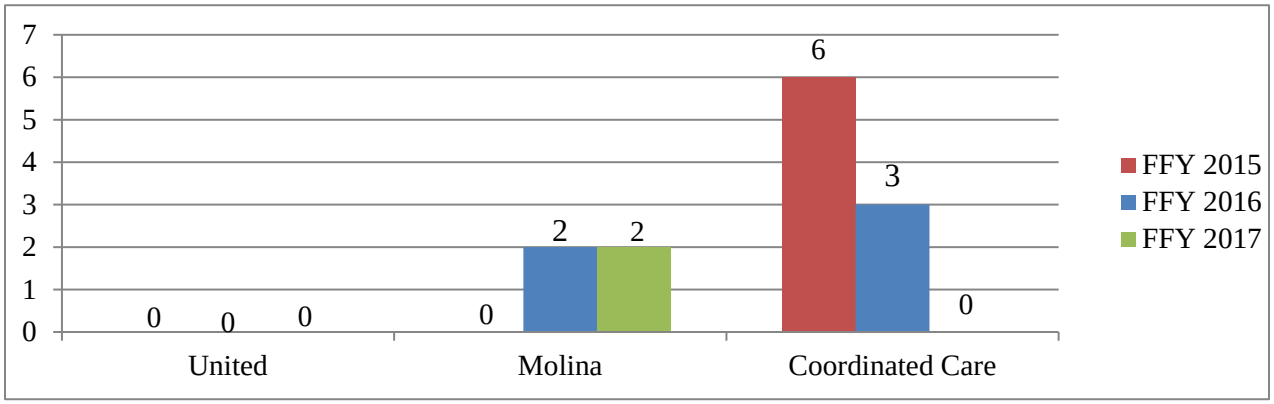
The SIU may receive referrals direct from federal or state regulatory and/or law enforcement agencies, internally from other departments within Molina, or from various anti-fraud outlets (e.g., National Health Care Anti-Fraud Association). In addition, Molina partners with a vendor who provides analytical tools, data mining, and suspect leads related to fraud, waste, and abuse. Molina may also perform its own internal data mining to identify potential leads to investigate. Molina's investigations of potential fraud and abuse activities originate with the intake of a referral.

Coordinated Care's SIU, through Centene, utilizes prepayment reviews as its cost avoidance efforts and to verify services rendered to Coordinated Care beneficiaries prior to paying a claim. There are several factors that help decide if a prepayment review is necessary; including reviewing providers who may have flagged as billing at an abnormal rate in comparison to their peers, allegations of up-coding or un-bundling, excessive services billed, etc. After a provider is placed on prepayment review, twenty claim service lines are pended for medical records review. Once a provider reaches their twenty claims service line limit, all remaining claims are adjudicated as normal. If the provider does not comply with sending medical records, the SIU will take additional measures for non-compliance.

Sampling was performed to verify that the fraud, waste, and abuse case tracking being performed by the MCOs are fulfilling all necessary functions. Sampling was also performed to verify that verification calls resulting in identification of potentially fraudulent or wasteful practices are being appropriately investigated. For UnitedHealthcare Community Plan, this exercise identified potential gaps in information retained by the DETECTS system. For three of the five verification calls selected for review, the MCO was unable to locate record of the tip being entered into the DETECTS system. The MCO was able to identify that the tip was transferred to the fraud, waste, and abuse department, but could not identify the final result of this referral. In addition, UnitedHealthcare Community Plan could not locate the disclosures for one of the provider groups we selected for sampling. It demonstrated that there is a gap in their system that may have allowed this provider to go through credentialing without submitting all required disclosures. Therefore, the HCA should expand its program integrity scope to include random sampling of MCO provider enrollment files to verify that all appropriate disclosures are present.

Table 3 lists the number of referrals that United's SIU, Molina's SIU and Coordinated Care's SIU made to the state in the last three FFYs. Overall, the number of Medicaid provider investigations and referrals by each of the MCOs is extremely low, compared to the size of the MCO plan in Washington. The level of investigative activity by the MCOs has not changed significantly over the three year period of review.

Table 3.



As illustrated above, the MCOs referred relatively few cases of suspected fraud during the review period. The review team noted incidents where MCOs appear to be more invested in educating offending providers, rather than referring cases to HCA. Since the contract does not state that HCA maintains responsible authority to determine a credible allegation of fraud situation exists with a provider, the MCOs in Washington currently make this determination internally. The regulation at 455.23 states the state is to make this determination, however, this is not the case in Washington and may be an important factor in the state's lack of MCO referrals

The fact that the state is allowing the MCOs to make this determination could prevent the state from knowing the extent of fraud, waste, and abuse in its entire Medicaid managed care program and reflects a lack of internal controls for monitoring the integrity of high-risk services that are commonly provided. The state should review the regulation at 455.23 and incorporate the full requirements of this regulation into its contract with its MCOs. In addition, the state should continue fostering better interaction with the MCOs and the MFCU. During the interviews, the review team learned that the program integrity working relationship between the state and the MFCU, has been up and down historically, depending on the leadership that was in place. The state should implement collaborative meetings aimed at improving HCA/MFCU interactions around program integrity activities (investigations, referrals, payment suspensions, terminations, etc.) and educating the MCOs regarding suspected fraud referrals. This would include any necessary MFCU memorandum of understanding (MOU) revisions. Furthermore, the HCA should communicate and obtain feedback from the MFCU regarding the quantity and quality of MCO referrals reviewed and develop a strategy for improving MCO referrals.

MCO Compliance Plans

The state does require its MCOs to have a compliance plan to guard against fraud and abuse in accordance with the requirements at 42 CFR 438.608. The state does have a process to review the compliance plans and programs. As required by 42 CFR 438.608, the state does review the MCOs compliance plan and communicates approval/disapproval to the MCOs.

UnitedHealthcare Community Plan, Molina and Coordinated Care's compliance plans are each a global document applying to all Medicaid lines of business nationally. Their plans meets all

seven required elements outlined in 42 CFR 438.608. Additionally, UnitedHealthcare Community Plan has developed a state addendum to its global compliance plan to ensure compliance with Washington specific contractual requirements. Each MCO submits its compliance plan annually to the state for review, excepting instances wherein the state identified areas requiring corrective action. In those cases, the MCO would be required to submit an updated compliance plan within a specified time frame. The compliance plan of each MCO is intended to be a living document that is reviewed periodically and amended as needed to reflect changes in the law, the healthcare marketplace and the development of the company.

Encounter Data

The HCA does collect encounter data from each of the MCOs; however, HCA does not proactively audit the encounter data to identify fraud, waste, and abuse issues with MCO providers.

The MCOs submits and certifies encounter data and other supporting data. For example, Coordinated Care submits all claims paid to the State on a weekly basis as encounters and includes an attestation with each encounter sent. This MCO submits quarterly reconciliation reports to the State for encounters. Provider network adequacy is submitted to HCA quarterly, and includes a narrative with an analysis and explanation. The information is submitted by all MCOs and is used to adjust capitation rates, however the encounter data submitted by the MCOs is not currently being audited by HCA in order to substantiate the program integrity work being conducted by the SIUs.

The certified MCO encounter data is not utilized by HCA in proactively looking at improper claims that may have been paid inappropriately to managed care providers or for conducting any internal audits of the managed care encounter data to identify possible credible allegations of fraud that otherwise may not be identified by the MCOs.

The state should continue efforts to improve the state's ability to analyze encounter data reported by MCOs and perform state-initiated data mining activities in order to identify fraud, waste, and abuse issues with MCO providers. Implement proactive data mining and routine audits of validated managed care claims encounter data.

Overpayment Recoveries, Audit Activity, and Return on Investment

The state does not require MCOs to return to the state overpayments recovered from providers as a result of MCO fraud and abuse investigations or audits. However, the MCO is required to report overpayments to the state and offset overpayment recoveries on their financial report for rate setting purposes, but HCA does not maintain visibility into the data behind the reported overpayments. Therefore, the overpayment recovery information is based on the good-faith of the MCO reporting it.

The CMS review team suggests that HCA contractually ensure the MCOs submit accurate reports on overpayments in accordance with 438.608(d)(3), the prompt reporting of all

overpayments identified or recovered, specifying overpayments due to fraud, waste, or abuse at 438.608(a)(2). This language should include specifications on terminology for identified and recouped overpayment to maintain continuity for purposes of reconciliation.

The review team also suggest that HCA implement processes to ensure the integrity of data being used for rate setting purposes, since rate setting actuaries receive supplemental data concerning overpayments and recoveries directly from the MCOs.

UnitedHealthcare Community Plan's identified and recovered overpayments are monitored by their national SIU and the local compliance manager. All instances of overpayments and appeal processes, along with appropriate documentation, collections and recovery information are tracked through a web-based application. Recoveries are reported to HCA on the quarterly recoveries reporting form. Reporting is submitted per contractual guidelines.

UnitedHealthcare Community Plan has experienced an increase in their overall identified overpayments and recoveries from 2015 to 2017 due to a company-wide initiative to develop more comprehensives prospective review algorithms. Furthermore, there has been an increase in preliminary and full investigation in the past three FFYs. However, the proportion of overpayments being recovered has fluctuated; the percentage of recoveries made from identified overpayments was approximately 93 percent in 2015, 77 percent in 2016, and 88 percent in 2017. These recoveries may also be inflated due to the inclusion of prospective review activities in reported numbers. The MCO includes these amounts in both identified and recovered amounts reported, but since the amounts are identified prior to payment being issued to the providers, the payment is not truly recovered.

For Molina and Coordinated Care, overpayment recoveries are reported to the state on the quarterly recoveries reporting form as with UnitedHealthcare Community Plan. Molina's policy on overpayment recoveries is that it will conduct an audit and refer its' findings to HCA in order to give them the first opportunity to pursue the overpayment. The findings are submitted to the provider and within a set period of time, if the provider does not repay, future payments are offset. This information is relayed to the HCA quarterly and adjusting of the encounter data is performed to reflect future offsets.

Coordinated Care is expected to take action on provider cases to recoup all dollars found to have identified overpayments and the total extrapolated recoupment. Recoveries from any identified and collected overpayments resulting from joint audits or post-payment review activities shall be split between HCA and the MCO at a rate determined and developed by the purchaser-wide program integrity forum. Overpayment recoveries related to SIU activities are submitted to HCA quarterly on the overpayment recovery log and allegation log.

The tables below show the respective amounts reported by the MCOs for the past three FFYs. In the tables below, 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.

Table 4-A.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2015	59	33	$38,324,361.81	$35,628,379.13
2016	81	40	$48,923,902.87	$37,576,809.34
2017	137	81	$48,949,947.36	$42,865,005.66

*Information included in the table includes both prospective and retrospective review activities. This is due to a new initiative by the MCO to improve prospective review processes in an effort to shift from traditional pay-and-chase methods towards a more effective, system administered approach.

UnitedHealthcare Community Plan preliminary investigations includes all investigations that resulted in a full investigation, as well as all investigations that were terminated following the preliminary process. Therefore, full investigations are represented in both categories.

Overpayment information included in table 4-A includes all program integrity related activities, including both prospective and retrospective review actions. This is due to a new initiative by the MCO to improve prospective review processes in an effort to shift from traditional pay-and-chase methods towards a more effective, system administered approach

Table 4-B.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2015	8	2	$0.00	$0.00
2016	58	7	$42,222.76	$42,222.76
2017	48	10	$41,113.65	$0.00*

*****Four recoveries are in process totaling $20,193.17, while the remaining amount is uncollected at the direction of HCA/MFCU.

Table 4-C.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2015	53	0	$0.00	$0.00
2016	97	15	$358,802.24	$166,108.71*
2017	81	3	$0.00	$1,725.85**

*MCO report the remaining amount is due to the recovery amount being too aged or uncollectible.
**Collected overpayment is associated with prior year.

Payment Suspensions

In Washington, Medicaid MCOs are contractually required to suspend payments to providers at the state's request. The state confirmed that there is contract language mirroring the payment suspension regulation at 42 CFR 455.23, with the exception that the MCO decides an allegation of fraud is credible in Washington.

The regulation at 42 CFR 455.23(a) requires that upon the State Medicaid agency determining that an allegation of fraud is credible, it must suspend all Medicaid payments to a provider, unless the agency has good cause not to suspend payments or to suspend payment only in part. HCA contract calls for the MCO to make the determination, which is contradictory to the federal regulation. While CMS encourages states to communicate frequently with the MFCU and does not limit who a state may consult with in order to determine that an allegation of fraud is credible, the regulation at 42 CFR 455.23(a) requires that upon the State Medicaid agency determining that an allegation of fraud is credible, the state must suspend all Medicaid payments to a provider, unless the agency has good cause to not suspend payments or to suspend payment only in part. The use of alternate sanctions, such as prepayment review, may be part of a good cause exception, but should be documented as such in the case files.

The CMS review team suggest that HCA review the regulation at 438.608(a)(8) regarding payment suspensions and modify the MCO contract as necessary and consequently, assess if the MOU with the MFCU should be revised to incorporate enhancements to case referral and payment suspension procedures that fully comply with the regulation at 438.608(a) (8) and therefore, 455.23. Training should be provided to all contracted entities and law enforcement agencies as required.

Each MCO interviewed claimed to suspend payments to providers when HCA determines that there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity unless HCA or the MFCU has identified good cause for not suspending payments or to suspend payments only in part. The MCOs generally receive this information through email. In addition to acting upon state directives, the MCOs notify the state of all allegations being investigated internally via the quarterly allegations report. This report details actions being taken, including payment suspensions.

The contract with the MCOs provides the MCOs in Washington with broad authority regarding payment suspension decisions and actions the plans are able to take. Therefore, the review team cannot determine if the MCOs only suspend payments at the direction of the state, since they essentially have broad flexibility in regards to the entire payment suspension process as outlined in 455.23. For example, the MCO may find that good cause exists to suspend payments in part, or to convert a payment suspension previously imposed in whole to one only in part, to an individual or entity against which there is an investigation of a credible allegation of fraud in certain situations.

Sampling was performed to verify the MCO is properly handling all cases of provider suspension. The MCOs informed the review team that they all suspended providers at the

direction of the state and followed all additional state directives. No issues were identified during the payment suspension sampling process with any of the MCOs.

The review team confirmed that HCA has provided U.S. Department of Health and Human Services (DHHS) with summary data on payment suspensions and good cause exceptions filed as part of the annual report required under 42 CFR 455.23(g). A review of the FFY16, payment suspensions report shows that HCA did not report dollar amount associated with the payments suspensions; however, HCA did report a total of 46 payment suspensions with seven referrals to law enforcement with all having good cause exceptions not to suspend payments attached to them. Based upon information collected by the review team, it appears that all of the managed care referrals were given a good cause exception not to suspend. This appears to be the routine practice, instead of analyzing each referral on the issues involved in each particular case to determine whether a good cause exception is truly warranted. This is another reason why better interactions with the MFCU should be sought by HCA's program integrity unit.

In addition, HCA should refine its payment suspension policies and procedures to ensure that HCA determines whether an allegation of fraud is credible. Once HCA determines there is a credible allegation of fraud, HCA must refer the case to the MFCU and suspend payment unless there is a basis for a good cause exception not to suspend. When making this good cause exception determination, HCA should consider each case referred to the MFCU independently rather than issuing automatic good cause exceptions for every case.

These recommendations will aid HCA by identifying where it can safely suspend Medicaid payments to potentially fraudulent providers without jeopardizing further investigation of those providers.

Terminated Providers and Adverse Action Reporting

The MCO contract addresses terminated providers but not adverse action reporting. The MCOs are required to provide written notice of termination to the state as outlined in Section 12.9.11 of the general MCO contract. The HCA indicated that the plans rely on the state to notify them of actions taken at the state level against providers before taking any action themselves.

Each MCO submits a quarterly allegations report, which details allegations received and their status. Information regarding providers terminated for reasons of fraud, integrity, or quality is submitted to HCA on a monthly basis through the MCO provider termination reporting form. The report includes providers terminated for any reason, including those terminated for cause, during the preceding month. The HCA compiles the information submitted by the five contracted MCOs to identify common trends and themes across the MCOs. Common trends and themes are shared by the HCA with all MCOs during quarterly program integrity meetings. Recoveries from investigations are reported to HCA on the quarterly recoveries reporting form as per contractual guidelines.

In addition, the MCOs receive a report of providers who have been terminated for cause from HCA through its compliance email inbox. Sampling was performed to verify the MCO is properly handling all cases of provider termination. No issues were identified during the provider termination sampling process.

Table 5:

MCOs	Total # of Providers Disenrolled or Terminated in Last 3 Completed FFYs		Total # of Providers Terminated For Cause in Last 3 Completed FFYs	
United	2015 2016 2017	1183 683 505	2015 2016 2017	16 32 07
Molina	2015 2016 2017	3420 5035 9577	2015 2016 2017	7 33 30
Coordinated Care	2015 2016 2017	1086 1572 1209	2015 2016 2017	16 12 15

Overall, the number of providers terminated for-cause by the plans appear to be low when compared to the number of providers enrolled with the MCOs. The figures are also low when compared to the number of providers disenrolled or terminated for any reason, but the review team was unable to ascertain whether or not the low figures are standard for the level of program integrity activity in the state.

In addition to concerns relating to the expediency of terminations reporting to the state, UnitedHealthcare Community Plan and Coordinated Care revised their for cause terminations on several occasions during the focused review process and did not appear clearly understanding what constitutes a program integrity for-cause action versus a not for-cause action.

This is an area that the CMS review team feels additional education is warranted in order to ensure provider adverse actions are handled appropriately. Furthermore, during sampling of case files, the review team noted incidents where some of the MCOs may have referred a suspected credible allegation of fraud case to the state; however, when termination of the provider resulted, the provider may have not been terminated for cause. These discrepancies create vulnerabilities for the state by obstructing the ability of HCA to evaluate the program integrity performance of MCOs and hindering the appropriate reporting of termination information.

Federal Database Checks

The regulation at 42 CFR 455.436 requires that the state Medicaid agency must check the exclusion status of the provider or persons with an ownership or control interest in the provider, and agents and managing employees of the provider on the U.S. DHHS-Office of Inspector General's List of Excluded Individuals and Entities (LEIE); the Excluded Parties List System (EPLS) on the System for Award Management (SAM); the Social Security Administration's Death Master File (SSA-DMF); the National Plan and Provider Enumeration System (NPPES) upon enrollment and reenrollment, and check the LEIE and EPLS no less frequently than monthly.

All plans were in compliance with all required federal database checks. Each MCO verifies that the entity or individual is not present on the LEIE. Their credentialing and recredentialing unit also performs the federal database exclusion checks every 36 months, as well as a number of other approved and supported sources of sanction information. These lists are checked for all known aliases, as well as the DBA name of institutional providers, which verifies all applicable tax identification numbers.

The HCA is compliant with conducting all required federal database checks with the exception of checking the SAM database on a monthly basis. The SSA-DMF and LEIE are checked automatically prior to enrollment and reenrollment as well as on a monthly basis. The SAM is checked upon enrollment and reenrollment, however the state has not yet implemented the monthly checks of the SAM. This leaves the state at risk by not performing the monthly checks of the SAM database; however, the state is currently in the process of developing a new provider enrollment MMIS tool in conjunction with Lexis Nexus. The state mentioned this tool would take effect by September 2018, after the contracts team and finance team finalize the data share agreement and business associate agreement with the Department of Treasury. Currently, all checks are performed manually by the state staff. However, the data querying process will become automated after the implementation of the new MMIS system. The NPPES is currently checked manually upon enrollment and reenrollment.

Recommendations for Improvement

- 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.

- Ensure HCA and its MCOs are allocating sufficient resources to the prevention, detection, investigation and referral of suspected provider fraud.

- Seek to enhance/improve the program integrity contract language with MCOs. Ensure there are no contractual impediments to provider auditing and collaborative audits with the MCOs, as well as audits of the MCOs themselves.

- Review program integrity policies and procedures relative to any contract modifications to ensure all program integrity functions are adequately addressed.

- Ensure the mandatory referral of any potential fraud, waste, or abuse to the State Medicaid program integrity unit or any potential fraud to the MFCU. To include, but not limited to ensuring that the MCO SIU staff receive sufficient program integrity training in identifying, investigating, referring and reporting on providers with suspected fraudulent billing practices. This training should be accomplished in conjunction with the MFCU, when possible, to enhance case referrals from the MCOs.

- Improve its tracking of the MCO investigation referrals. Enhance its usage of the customized Washington fraud referral form as outlined in the report for reporting purposes, making any appropriate modifications to the form as needed. Clarify with the MCOs, the proper use of the customized Washington fraud referral form for reporting purposes, and ensure the referrals always conform to the CMS referral standards.

- Expand HCAs program integrity scope to include random sampling of MCO provider enrollment files to verify that all appropriate documentation is present.

- Continue fostering better interaction with the MCOs and the MFCU. Implement collaborative meetings aimed at improving HCA/MFCU interactions and educating the MCOs regarding suspected fraud referrals. This would include any necessary MFCU MOU revisions. In addition, the HCA should communicate and obtain feedback from the MFCU regarding the quantity and quality of MCO referrals reviewed and develop a strategy for improving MCO referrals.

- Continue efforts to improve the state's ability to analyze encounter data reported by MCOs and proactively perform state-initiated data mining activities in order to identify fraud, waste, and abuse issues with MCO providers. Implement proactive data mining and routine audits of validated managed care claims encounter data.

- Contractually ensure the MCOs submit accurate reports on overpayments in accordance with 438.608(d)(3)) and the prompt reporting of all overpayments identified or recovered, specifying overpayments due to fraud, waste, or abuse at 438.608(a)(2). This language should potentially include specifications on terminology for identified and recouped overpayment to maintain continuity for purposes of reconciliation.

- Implement processes to ensure the integrity of data being used for rate setting purposes, since rate setting actuaries receive supplemental data concerning overpayments and recoveries directly from the MCOs.

- Review the regulation at 438.608(a)(8) regarding payment suspensions and modify the MCO contract as necessary and consequently, assess if the MOU with the MFCU should be revised to incorporate enhancements to case referral and payment suspension procedures that fully comply with the regulation at 438.608(a) (8) and therefore, 455.23. Conduct any training to all contracted entities and law enforcement agencies as required.

- Refine payment suspension policies and procedures to ensure that HCA determines whether an allegation of fraud is credible. Once HCA determines there is a credible allegation of fraud, HCA must refer the case to the MFCU and suspend payment unless there is a basis for a good cause exception not to suspend. When making this good cause exception determination, HCA should consider each case referred to the MFCU independently rather than routinely issuing good cause exceptions.

- Ensure that all federal database exclusions checks, particularly the SAM, are performed for all subcontractors at enrollment, re-enrollment and on a monthly bases.

Section 2: Status of Corrective Action Plan

Washington's last CMS program integrity review was in December 2011, and the report for that review was issued in June2012. The report contained seven findings and seven areas of vulnerability. During the onsite review in May 2018, the CMS review team conducted a thorough review of the corrective actions taken by Washington to address all issues reported in calendar year 2012. The findings and vulnerabilities from this 2012 review are described below.

Findings –

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

   Status at time of review: Corrected

   The state amended policies and procedures and modified its contracts to account 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. The state also modified its disclosure forms as necessary to capture all disclosures required under the regulation.

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

Status at time of review: Corrected

The state revised the provider agreements and contracts to require disclosure upon request of the information identified in 42 CFR § 455.105(b).

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

Status at time of review: Corrected

The state developed 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. The state modified its disclosure forms to capture all disclosures required under 42 CFR 455.106.

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

Status at time of review: Partially Corrected

The state developed 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. In addition, the state searches the LEIE and SAM 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.

The state modified the managed care contract to require MCEs to search the LEIE and SAM 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. However, since the state's MCEs do not have access to the SAM, they are unable to perform the required SAM checks on a monthly bases. The state is awaiting on their

contracts team and finance team to finalize the data share agreement and business associate agreement. Therefore, this part of the regulation at 42 CFR 455.436 remains uncorrected.

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

Status at time of review: Corrected

The state developed and implemented procedures for reporting to HHS-OIG program integrity-related adverse actions on a provider's participation in the Medicaid program.

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

Status at time of review: Corrected

The state developed and implemented policies and procedures to ensure that all parties pursuant to the regulation at 42 CFR 1002.210 are notified of a State-initiated exclusion.

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

Status at time of review: Corrected

The state has implemented policies and procedures to monitor compliance of all providers and contractors in accordance with the State Plan.

Vulnerabilities –

1. ***Not maintaining a centralized database or a standardized program integrity function.***

   Status at time of review: Corrected

   The state has organized 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 to a greater extent and continues to look for opportunities to consolidate program integrity activities.

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

   Status at time of the review: Corrected

   The state ensures that a process is in place to verify with MCO enrollees whether services billed by providers were received.

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

   Status at time of the review: Corrected

   The state modified 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. The state included contract language requiring MCEs and NEMT brokers to notify the State of such disclosures on a timely basis.

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

   Status at time of the review: Corrected

   The state modified the managed care and NEMT contracts to require disclosure upon request of the information identified in 42 CFR § 455.105(b).

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

Status at time of the review: Corrected

The state modified 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. The state included contract language requiring MCEs to notify the State of such disclosures on a timely basis.

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

Status at time of the review: Corrected

The state amended 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. The state require the contractor to search the LEIE and SAM 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.

7. Not reporting all adverse actions taken on provider participation to the HHS-OIG.

Status at time of review: Corrected

Contracted brokers are required to notify the state when they take adverse action against a network provider for program integrity-related reasons. The state developed and implemented procedures for reporting these actions to HHS-OIG.

Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for Washington to consider utilizing:

- Use the program integrity review guides posted in the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the RISS for information provided by other states including best practices and managed care contracts.
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute which may help address the risk areas identified in this report. Courses that may be helpful to Washington are based on its identified risks include those related to managed care. More information can be found at http://www.justice.gov/usao/training/mii/.
- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- The CMS annual report of program integrity reviews includes highlights of states that have been cited for noteworthy and effective practices in managed care. These reports can be found at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html.
- CMS provides a fraud prevention toolkit located on CMS.gov that includes:
    - The 4Rs (Record, Review, Report, and Remember) brochure
    - Fact sheets on preventing and detecting fraud
    - Frequently Asked Questions
    - The CMS.gov website also contains information regarding the Center for Program Integrity and fraud prevention efforts in Original Medicare (FFS), Part C and Part D, and Medicaid. For more information on the fraud prevention toolkit, visit CMS.gov/outreach-and-education/outreach/partnerships/fraudpreventiontoolkit.
    - For the latest news and information from the Center for Program Integrity, visit CMS.gov/about-cms/components/cpi/center-for-program-integrity.html.

Conclusion

The CMS focused review identified areas of concern and instances of non-compliance with federal regulations which should be addressed immediately.

We require the state to provide a CAP for each of the recommendations within 30 calendar days from the date of the final report letter. The CAP should address all specific risk areas identified in this report and explain how the state will ensure that the deficiencies will not recur. The CAP should include the timeframes for each correction along with the specific steps the state expects will take place, and identify which area of the state Medicaid agency is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the CAP such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of the letter. If the state has already taken action to correct compliance deficiencies or vulnerabilities, the CAP should identify those corrections as well.

CMS looks forward to working with Washington to build an effective and strengthened program integrity function.