State Health Care Authority (HCA) Agency: 107

Audit Report: 2013 F

Finding Number: 020

Finding: The Health Care Authority does not comply with the data-sharing requirements of State law and the federal Deficit Reduction Act of 2005, thereby increasing the likelihood that the state is paying claims that should have been paid by liable third parties.

Resolution: The Authority continues to disagree with this finding. The Authority is in compliance with the Deficit Reduction Act of 2005 and associated state law. The Authority meets this standard by making data available to all insurers to use for third party liability reporting and by matching data directly with those insurers most likely to provide third party coverage to Medicaid recipients.

Although the Authority maintains its compliance with the Deficit Reduction Act, it has also taken steps to enhance data sharing to ensure that it continues to have a strong third party liability program.

The Authority implemented the Payer-Initiated Eligibility/Benefit (PIE) Transaction tool in July 2013 and subsequently communicated with major insurers in Washington state requesting their participation in implementation of the PIE Transaction tool and electronic sharing of third party liability data. Although the Authority has successfully implemented the PIE Transaction tool and will continue to encourage carrier adoption, it is important to note that the Authority has no authority to compel carriers to participate in use of the PIE Transaction tool for electronic data exchange. The Authority's successful implementation is viewed by the federal Centers for Medicare and Medicaid Services as a model implementation and best practice.

In addition, since February 2011, the Authority has contracted with Health Management Systems Inc. to provide enhanced data matching and identification of a client's primary medical insurance coverage. The contracted activities include conducting electronic data exchanges with health insurers, and verifying and updating the insurance eligibility of Medicaid recipients for billing liable third parties on behalf of the Authority.

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State Health Care Authority (HCA) Agency: 107

Audit Report: 2013 F

Finding Number: 021

Finding: The Health Care Authority did not have adequate controls in place to ensure all critical access hospitals were paid accurately.

Resolution: The Authority partially disagrees with this finding. The Authority follows its current Washington Administrative Code (WAC) as it relates to the requirement for Critical Access Hospitals (CAH) to submit 'as filed' and 'final settled' versions of their Medicare cost report to the Authority. WAC 182-550-2598 (11) states:

> "The department performs finalized cost settlements using the same methodology as outlined in subsection (10) of this section, except that the department uses the hospital's "final settled" Medicare cost report instead of the initial "as filed" Medicare cost report for the HFY being cost settled. The "final settled" Medicare cost report received from the Medicare fiscal intermediary must be submitted by the CAH to the department by the sixtieth day of the hospital's receipt of that Medicare cost report."

The Authority now uses the Center for Medicare and Medicaid Services Healthcare Cost Report Information System database to obtain final cost report data for these hospitals. The Authority is currently performing the final settlements on the outstanding cost reports identified in the finding.

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State Health Care Authority (HCA) Agency: 107

Audit Report: 2013 F

Finding Number: 022

Finding: The Health Care Authority did not ensure that all individuals who received Medicaid benefits had valid Social Security numbers.

Resolution: The Authority concurs that there were instances of missing social security numbers due to staff errors. The Authority has updated the training provided to staff whose primary duties include processing Medicaid applications. This training includes procedures to follow when an applicant's social security number is invalid.

The Authority has reviewed all cases identified in the finding and re-determined eligibility. When the U.S. Department of Health and Human Services (HHS) contacts the Authority about questioned costs, the Authority will work with HHS to resolve them.

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State Health Care Authority (HCA) Agency: 107

Audit Report: 2013 F

Finding Number: 023

Finding: The Health Care Authority does not have adequate controls to ensure inpatient high outlier payments to hospitals are accurate.

Resolution: The Authority partially disagrees with this finding. The Authority follows its current Washington Administrative Codes (WACs) correctly in calculating outlier costs. It removed "noncovered charges" as they are defined in the Washington Administrative Code (WAC):

- WAC 182-550-3700 (14) "…. The estimated costs of the claim are calculated by multiplying the total submitted charges, minus the noncovered charges on the claim, by the hospital's ratio of costs-to-charges (RCC) rate…"
- WAC 182-550-1050 "….. 'Noncovered charges' means billed charges submitted to the department by a provider on a claim that are indicated by the provider on the claim as noncovered."

The WACs do not address denied charges. The auditor excluded both noncovered and denied charges in the high outlier payments calculation.

The Authority has taken the following steps to address this finding:

- Effective July 1, 2014, the Authority changed the WAC and payment system to align with the auditor's calculation methodology. Denied charges are no longer included in the part of the outlier calculation related to costs.
- The Authority has reallocated the inpatient program workload in order to allow additional capacity for monitoring system and rate changes. All changes are then reviewed by Authority staff for accuracy.

The Authority initiated action to recoup and repay incorrect payments identified by the auditor that were paid with the outdated high outlier calculation. For the other claims, as stated above, the current WAC does not allow the Authority to remove charges, other than those that the WAC defines as "noncovered charges" when the Authority calculates costs for outlier payments.

When the U.S. Department of Health and Human Services (HHS) contacts the Authority about questioned costs, the Authority will work with HHS to resolve them.

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Audit Report: 2013 F

Finding Number: 024

Finding: The Health Care Authority's internal controls are insufficient to ensure payment rates for its Healthy Options managed care program are accurate, resulting in over $95,000 in potential overpayments on premium rates paid to the managed care organizations.

Resolution: The Authority does not concur with this finding.

The Authority disagrees with the methodologies used to identify questioned costs in this audit finding for three reasons.

First, questioned costs were identified in a performance audit which is intended to improve management of the program. No evidence is presented to support that the payments in question directly impact the managed care rates as the auditor claims. As a result, the Authority is unable to confirm the questioned costs.

Second, the audit finding states that items identified as "errors" were "not paid in compliance with standard medical coding practices or were not properly supported with appropriate documentation." This is not necessarily an overpayment; it only shows that documentation should be stronger and practices need to be standardized.

Finally, the audit finding uses an actuarial analysis to assert that "for every $1 in overpayments made by the two audited Managed Care Organizations (MCOs) to their providers in 2010, the state potentially paid an additional $1.26 in premiums to all MCOs in fiscal year 2013." While this analysis can be used to identify performance improvements possible in the managed care program, the analysis clearly states there is only a potential for overpayment. No identification of an actual overpayment is made. In addition, the actuarial analysis is not based on the sample of payments in question.

In the background section of the finding, it is noted that this repeat finding questions the accuracy of encounter data and cites the lack of review of data provided to the actuary and used to set rates.

The Authority agrees that additional oversight and controls of MCOs will strengthen the state's ability to adequately manage the MCO contracts.

Organizational and contract changes that increase oversight were implemented and include:

- In the fall of 2013, establishment of an Encounter Data Quality Control Unit for validation of encounter data.
- Addition of an encounter data reconciliation process into the 2015 MCO contracts. This process validates submitted encounter data against MCO cost reports and includes withhold provisions and return of funds if MCOs are unable to adequately reconcile to cost reports.

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Audit Report: 2013 F

Finding Number: 025

Finding: The Health Care Authority did not invoice Medicaid drug rebates to drug manufacturers in accordance with the time frame stipulated by state and federal laws.

Resolution: The Authority agrees with the finding. The Authority strives to ensure that drug rebate invoices reflect correct utilization and unit rebate amounts. As such, system modifications and unanticipated data patches were required to be implemented which caused the invoice delays.

The Authority has taken the following steps to improve timely invoicing for drug rebates:

- Re-evaluated and streamlined the invoicing workflow established during the ProviderOne implementation.
- Reviewed responsibilities and timeline requirements for each element of the invoicing process.
- Elevated drug rebate system modifications to a higher priority.

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State Health Care Authority (HCA) Agency: 107

Audit Report: 2013 F

Finding Number: 026

Finding: The Health Care Authority's inadequate internal controls over claims from Federally Qualified Health Centers led to more than $226,279.66 in improper payments to providers.

Resolution: The Authority agrees with the finding.

The Authority has performed the following activities to address this finding:

- Completed the update of both the Washington Administrative Code (WAC) and provider billing guide to clearly define allowable encounters; and
- Updated ProviderOne system logic to align with the WAC and billing guide and ensure that system edits are in place to prevent overpayments and improper billings at the point of claim submission. These system edits are scheduled to go live in February 2015.

In addition, the Authority has notified the Federally Qualified Health Centers of the larger improper payments. Once the deadline for appeals has passed, the Authority will finish the recoupment process. When the U.S. Department of Health and Human Services (HHS) contacts the Authority to discuss repayment of questioned costs, the Authority will work with HHS to resolve them.

Many of the improper payments are small amounts ranging from less than $100.00 to four cents. The Authority is considering options for streamlining repayments for these amounts and plans to complete the process by June 2015.

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State Health Care Authority (HCA) Agency: 107

Audit Report: 2013 F

Finding Number: 027

Finding: The Health Care Authority's inadequate internal controls over claims for dental services led to more than $584,511.96 in overpayments to providers.

Resolution: The Authority agrees with the finding. The Authority has taken the following steps to address the audit finding:

- Fluoride treatment for children: The Authority agrees that the billing guide, Washington Administrative Code (WAC), and ProviderOne were not aligned. The Authority's intent is to allow fluoride with limits per client, per provider based on the client's age and client type. The Authority revised the WAC effective April 29, 2014.
- Dental Cleanings: The previous fiscal year's audit identified system issues that have been corrected and the Authority's Office of Payment Integrity is recouping overpayments.
- Oral Evaluations: The previous fiscal year's audit found that the Authority's billing guide and WAC were not aligned with ProviderOne and the Authority's intended policy to allow periodic oral evaluations three times per year for clients of the Developmental Disabilities Administration to coincide with cleanings. The Authority revised the WAC effective April 29, 2014, and the Medicaid Billing Guide was updated to reflect the changes effective May 1, 2014.
- Orthodontic Services: Although Authority rules limit services to once in a lifetime, the rules also permit exceptions to this limit through the Authority's prior authorization process based on early periodic screening, diagnosis and treatment, and exception to rule. The Authority reviewed the seven claims identified in this audit and found that in each case the provider requested prior authorization and the Authority granted authorization based on medical necessity.
- Oral Hygiene Instructions: The Authority identified a system issue which has been corrected.

When the U.S. Department of Health and Human Services (HHS) contacts the Authority about questioned costs, the Authority will work with HHS to resolve them.

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Audit Report: 2013 F

Finding Number: 028

Finding: The Health Care Authority did not complete the required security reviews of ProviderOne, the new Medicaid Management Information System, risking the loss of Medicaid program assets and jeopardizing Medicaid program integrity.

Resolution: The Authority disagrees with this finding. The Authority does not agree that ProviderOne security reviews are lacking or that lack of controls and monitoring in the contract introduce a significant system security review deficiency. While neither expected nor required by the federal government for any Medicaid payment system, to strengthen the Authority's ability to monitor vendor controls, the Authority added a requirement for external audit to the ProviderOne vendor contract in January 2013. This includes security reviews of servers and production databases to provide additional assurance that effective controls are in place. Under the new requirement, the ProviderOne vendor is required to undergo biennial Service Organization Control (SOC) examinations and obtain reports from subcontractors. The satisfaction of this SOC examination requirement occurred in multiple phases.

The following milestones of this SOC examination were completed and the ProviderOne vendor has met all contractual obligations:

- On March 31, 2013, the ProviderOne vendor provided the Authority the required examination reports from subcontractors.
- On December 31, 2013, the ProviderOne vendor completed documentation for the controls and delivered results to the Authority.
- The final phase of this audit was completed in the first quarter of 2014.

The Authority has ensured and continues to ensure that the appropriate safeguards and effective controls are in place to protect Medicaid program integrity and data security.

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Audit Report: 2013 F

Finding Number: 029

Finding: The Health Care Authority improperly claimed $73,788.62 in federal reimbursement for unallowable services provided to undocumented aliens and services that were not rendered to deceased Medicaid clients.

Resolution: The Authority concurs that it made improper reimbursement for Medicaid clients where later research and analysis showed the clients were deceased. The Authority has adequate controls in place to identify deceased clients as soon as possible following the date of death. Specifically, the Authority receives death records from the Department of Health as soon as they are available to identify deceased Medicaid clients. Payments to deceased clients have been significantly reduced.

The Authority also concurs that it made payments on behalf of non-qualified aliens for non-emergency related services. These payments were generated because of manual coding errors. The Authority includes information about proper coding in training documents and has provided training to staff on proper coding of services provided to non-qualified aliens.

When the U.S. Department of Health and Human Services (HHS) contacts the Authority about questioned costs, the Authority will work with HHS to resolve them.

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Audit Report: 2013 F

Finding Number: 030

Finding: The Health Care Authority did not have adequate controls in place to ensure violations of Medicaid laws and regulations by providers are identified, investigated and referred to the Medicaid Fraud Control Unit, risking the loss of public resources.

Resolution: The Authority does not concur with this finding. The Authority maintains that adequate controls are in place to ensure that violations of Medicaid laws and regulations, including all fraud related cases, are identified and referred to the Medicaid Fraud Control Unit (MFCU) in a timely manner.

All referrals received by the Office of Program Integrity (OPI) are initially scrutinized for materiality, severity, and credibility before they are entered into the case tracking application; those deemed most substantive are reviewed immediately, and all fraud related cases are referred to MFCU.

OPI staff has historically entered all referrals into the case tracking tool including both fraud and non-fraud related client complaints, as well as medical service verification cases, even though they reflect cases of historically low risk and low value. The number and age of cases tracked are therefore not accurate measures of how OPI manages referrals or processes allegations of fraud and it is wrong to conclude that the Authority does not have control of its caseload and does not refer all appropriate cases to the MFCU in a timely manner. Processes are in place to prioritize the work of surveillance and utilization review section investigators, ensuring that the Authority is addressing those cases with the highest potential for fraud, waste, and abuse, and properly utilizing resources to focus on cases that yield the highest return on investment.

While disagreeing with the finding, the Authority concurs with several recommendations in the audit. The OPI has increased supervisory oversight and control of staff activities, and plans to replace the current tracking system and revise applicable policies and procedures by June 2015.

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State Health Care Authority (HCA) Agency: 107

Audit Report: 2013 F

Finding Number: 031

Finding: The Health Care Authority did not have adequate controls in place to ensure services billed by providers were rendered to Medicaid beneficiaries, risking the loss of Medicaid resources.

Resolution: The Authority does not concur with this finding and asserts that adequate controls are in place to ensure Medicaid services billed by providers were rendered to Medicaid clients.

The Authority maintains that it is in compliance with federal requirements which state "the agency must have a method for verifying with beneficiaries whether services billed by providers were received." The Authority does have such a method in place, and improvements to that process were not completed during fiscal year 2013, but have now been completed.

Although fraud might be detected by issuing random verification forms, experience has proven that limited staff resources are better utilized when the targets for oversight are strategically selected. Using informed allegations, as well as sophisticated analytical tools (behavior modeling, algorithms, comparisons and trends, spike reports, etc.) the Office of Program Integrity has identified millions in overpayments. By contrast, the Medicaid Services Verification (MSV) process has proven to have no value in detecting fraud, and the Authority maintains that resources spent on MSV processing actually reduces its ability to focus on program integrity activities that increase controls.

While disagreeing with the finding, the Authority concurs with several recommendations in the audit. The change request that refines the service selection process and includes the beneficiary on the form has been approved and implemented. In addition, the Office of Program Integrity has revised policies and procedures and increased documentation, supervisory oversight, and control of staff activities.

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Audit Report: 2013 F

Finding Number: 032

Finding: The Health Care Authority does not have adequate internal controls to ensure Medicaid drug rebate amounts are accurately reported in CMS 64 report.

Resolution: The Authority agrees with this finding.

The formatting and formulas on the report used to prepare the Medicaid Drug Rebate Schedule (CMS-64.9R) have been reviewed and corrected. The CMS-64.9R was completed and reported correctly for the December 2013 quarter.

Should the Center for Medicare and Medicaid Services (CMS) contact the Authority to address the errors on the previously reported CMS-64.9R forms, the Authority will work with CMS to resolve the issues.

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