Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Washington Focused Program Integrity Review

Medicaid Managed Care Oversight

May 2024

Final Report

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I. Executive Summary

Objectives

The Centers for Medicare & Medicaid Services' (CMS) conducted a focused program integrity review to assess Washington's program integrity oversight efforts of its Medicaid managed care program for the Fiscal Years (FY) 2020 – 2022. This focused review specifically assessed the state's compliance with CMS regulatory requirements at 42 CFR Part 438, Subpart H. A secondary objective of this review was to provide the state with feedback, technical assistance, and educational resources that may be used to enhance program integrity in Medicaid managed care.

To meet the objectives of this focused review, CMS reviewed information and documents provided in response to the CMS managed care review tool provided at the initiation of the review. CMS also conducted in-depth interviews with the State Medicaid Agency (SMA) and evaluated program integrity activities performed by selected managed care organizations (MCOs) under contract with the SMA.

This report includes CMS' observations that were identified during the focused review.

Findings and Recommendations

Findings represent areas of non-compliance with federal and/or state Medicaid statutory, regulatory, sub-regulatory, or contractual requirements. CMS identified no findings that create risk to the Washington Medicaid program related to managed care program integrity oversight.

Observations

Observations represent operational or policy suggestions that may be useful to the state in the oversight of its Medicaid managed care program. CMS identified **four** observations related to Washington's managed care program integrity oversight. While observations do not represent areas of non-compliance with federal and/or state requirements, observations identify areas that may pose a vulnerability or could be improved by the implementation of leading practices. The observations identified during this review include the following:

State Oversight of Managed Care Program Integrity Activities

Observation#1: CMS encourages Washington to consider the inclusion of contract language requiring all MCOs to have a toll-free hotline 24 hours a day, seven days a week.

MCO Investigations of fraud, waste, and abuse

Observation #2: CMS encourages Washington to work with the MCOs to improve the

quality and quantity of case referrals through routine program integrity training and frequent feedback to the MCOs regarding their case referral performance. CMS also encourages Washington to consider establishing metrics to uniformly assess the quality and quantity of case referrals.

Observation #3: CMS encourages Washington to ensure that MCOs have sufficient corrective action plan procedures in place per contract requirements and utilize them appropriately to address non-compliant Medicaid providers.

Observation #4: CMS encourages Washington to ensure case referral declinations are communicated timely to all MCOs.

II. Background

Focused Program Integrity Reviews

In the Comprehensive Medicaid Integrity Plan for Fiscal Years (FYs) 2019-2023, CMS set forth its strategy to safeguard the integrity of the Medicaid program.[1] This plan encompasses efforts to ensure that states are adhering to key program integrity principles, including the requirement that state Medicaid programs have effective oversight and monitoring strategies that meet federal standards.

As a part of these efforts, CMS conducts focused program integrity reviews on high-risk areas in the Medicaid program, such as managed care, new statutory and regulatory provisions, non-emergency medical transportation, telehealth, and personal care services. These reviews include onsite or virtual state visits to assess the effectiveness of each state's program integrity oversight functions and to identify areas of regulatory non-compliance and program vulnerabilities. Through these reviews, CMS also provides states with feedback, technical assistance, and educational resources that may be used to enhance program integrity in Medicaid.

Medicaid Managed Care

Medicaid managed care is a health care delivery system organized to manage cost, utilization, and quality. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care. This approach provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that receive a set per member per month (capitation) payment for these services. By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services.

Overview of the Washington Managed Care Program and the Focused Program Integrity Review

[1] https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf

The Health Care Authority (HCA) is responsible for the administration of the Washington Medicaid program, Washington Apple Health. Within HCA, the Division of Program Integrity (DPI) is the organizational unit tasked with oversight of program integrity-related functions for the managed care program. During the review period, Washington contracted with five MCOs to provide health services to the Medicaid population. As part of this review, three of these MCOs were interviewed: Amerigroup Washington (Amerigroup), Community Health Plan of Washington (CHPW), and Molina Healthcare of Washington (Molina). Appendix C provides enrollment and expenditure data for each of the selected MCOs.

In May 2023, CMS conducted a virtual focused program integrity review of Washington's managed care program. This review assessed the state's compliance with CMS regulatory requirements at 42 CFR Part 438, Subpart H. As a part of this review, CMS also evaluated program integrity activities performed by selected MCOs under contract with the state Medicaid agency. CMS interviewed key staff of the MCOs Special Investigations Units (SIUs), as well as reviewed other primary data. CMS also evaluated the status of Washington's previous corrective action plan that was developed in response to a previous focused program integrity review of Washington's managed care program conducted by CMS in 2018, the results of which can be found in Appendix A.

During this review, CMS identified a total of four observations. CMS also included technical assistance and educational resources for the state, which can be found in Appendix B. The state's response to CMS' draft report can be found in Appendix D, and the final report reflects changes CMS made based on the state's response.

This review encompasses the following five areas:

A. **State Oversight of Managed Care Program Integrity Activities** - CMS established requirements at §§ 438.66 and 438.602 that require the SMA to have a monitoring system that includes mechanisms for the evaluation of MCO performance in several program integrity areas. These areas include, but are not limited to: data, information, and documentation that must be submitted under §§ 438.604 – 606, as well as compliance with contractual program integrity requirements under §§ 438.608.
B. **MCO Contract Compliance** - Regulations at § 438.608 require the state, through its contracts with the MCOs, to ensure that MCOs implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse, such as implementing compliance plans, payment suspensions based on credible allegations of fraud, and overpayment reporting.
C. **Interagency and MCO Program Integrity Coordination** - Within a Medicaid managed care delivery system, MCO SIUs, the SMA, and the state Medicaid Fraud Control Unit (MFCU) play important roles in facilitating efforts to prevent, detect, and reduce fraud and abuse to safeguard taxpayer dollars. Under § 455.21, the SMA is required to cooperate with the state MFCU by entering into a written agreement with the MFCU. The agreement must provide a process for the referral of suspected provider fraud to the MFCU and establish certain parameters for the relationship between the MFCU and the SMA.

D. MCO Investigations of Fraud, Waste, and Abuse - Regulations at § 438.608(a)(7) require states to ensure that MCOs promptly refer any potential fraud, waste, and abuse that the MCO identifies to the state Program Integrity Unit (PIU) or any potential fraud directly to the state's MFCU. Similarly, as required by § 455.13-17, states must have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCOs.

E. Encounter Data - In accordance with § 438.242, the state must ensure, through its contracts, that each MCO maintains a health information system that collects, analyzes, integrates, and reports encounter data. In addition, in accordance with § 438.602(e), the state must periodically, but no less frequently than once every 3 years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter data submitted by, or on behalf of, each MCO.

III. Results of the Review

A. State Oversight of Managed Care Program Integrity Activities

State oversight of managed care program integrity activities is critical to ensuring that MCOs are meeting all CMS requirements and state contractual requirements. CMS established state monitoring requirements at §§ 438.66 and 438.602 that require the SMA to have a monitoring system that includes mechanisms for the evaluation of MCO performance in several program integrity areas, including but not limited to, data, information, and documentation that must be submitted under §§ 438.604 – 606, as well as compliance with contractual program integrity requirements under §§ 438.608.

CMS determined that the oversight and monitoring requirements set forth at §§ 438.66 and 438.602 were addressed within the HCA MCO general contract. Section 12.1.6 states that the MCO shall "…sustain adequate staffing resources in the Contractor's Program Integrity and Special Investigative Units who are dedicated to identifying fraud, waste, and abuse." The contract further supports this in Section 12.1.6.2, requiring the MCOs to have "…one (1) full-time equivalent (FTE) dedicated to Washington Medicaid for every 50,000 Enrollees."

The HCA requires its MCO network providers to be enrolled with HCA. The HCA assesses and monitors the managed care plan performance through the Medicaid Compliance Review Unit by performing an annual review. During the annual review, if an MCO's performance is less than adequate, the MCO is required to respond with documentation that corrects the identified deficiency. If the MCO's response is not adequate, a corrective action plan may be implemented.

CMS observed that there was no specific contract language requiring MCOs to have a toll-free hotline 24 hours a day, seven days a week. Amerigroup and Molina did have a hotline, while CHPW did not utilize a hotline. However, CMS observed that CHPW does provide the number to customer service (during business hours only) as well as provide an email address and fax number if an individual wanted to submit a complaint.

CMS observed that the contract language of the MCO Medicaid contract section 12.5.5.1 states that the MCO must, "[p]rovide a thirty (30) day notice to a provider or subcontractor prior to an

onsite audit unless there is evidence of danger to public health and safety or fraudulent activities." The HCA MCOs are conducting site visits with a 30-day notice to comply with state legislation. However, unannounced provider site visits are also an important program integrity tool that can be used to garner transparent, accurate information regarding provider practices. Many states allow or require unannounced provider site visits, and CMS has identified it as a promising practice for Medicaid managed care oversight. Therefore, CMS recognizes the importance of Washington seeking a statutory amendment to allow Washington to conduct investigative unannounced provider site visits.

Observation #1: CMS encourages Washington to consider the inclusion of contract language to require all MCOs to have a toll-free hotline available 24 hours a day, seven days a week.

B. MCO Contract Compliance

Regulations at § 438.608 require the state, through its contracts with the MCOs, to ensure that MCOs implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. These requirements extend to any subcontractor that is delegated responsibility for coverage of services and payment of claims under the contract between the state and the MCO. As part of this review, the MCO general contract was evaluated for compliance with several of these requirements, which are described in greater detail below.

The MCO general contract for providing Washington's Apple Health Integrated Managed Care program is developed by the HCA Medicaid Programs Division/Medicaid Contracts and Compliance Division. The HCA DPI monitors contract compliance with the fraud, waste, and abuse requirements.

Compliance Plans

In accordance with §§ 438.608(a)(1)(i)-(vii), states must require MCOs to implement compliance programs that meet certain minimal standards, which include the following:

1. Written policies, procedures, and standards of conduct that articulate the MCO's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and state requirements
2. Designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the Chief Executive Officer and the board of directors
3. Establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the MCO's compliance program and its compliance with the requirements under the contract
4. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the Federal and State standards and requirements under the contract
5. Effective lines of communication between the compliance officer and employees

6. Enforcement of standards through well-publicized disciplinary guidelines
7. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract

Section 12.5.1.1.1 through 12.5.1.1.7 of HCA's MCO general contract does explicitly address the requirement that all seven compliance plan elements listed above be addressed. A review of the MCOs' compliance plans and programs found that each MCOs compliance plan contained the required elements in accordance with §§ 438.608(a)(1)(i)-(vii).

CMS did not identify any findings or observations related to these requirements.

Beneficiary Verification of Services

In accordance with § 438.608(a)(5), the state, through its contract with the MCO, must require a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis.

CMS determined that Washington met this requirement for the review period. The MCO general contract, Section 12.5.1.4, requires that MCOs maintain a program for beneficiary verification. Each of the MCOs conducted beneficiary verifications for the review period. The MCOs are only contractually-required to submit a report of beneficiary verifications upon request from HCA.

CMS did not identify any findings or observations related to these requirements.

False Claims Act Information

In accordance with § 438.608(a)(6), the state, through its contract with the MCO, must require that, in the case of MCOs that make or receive annual payments under the contract of at least $5,000,000, there are written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.

CMS found that Washington is compliant with this requirement. A review of the state's policy found that the state has written policies for HCA Medicaid employees, contractors, MCOs, and agents that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers. Further, in the MCO general contract at 12.5.1.5, MCOs are required to have written policies for all employees that provide detailed information about the False Claims Act, including information about the rights of employees to be protected as whistleblowers.

CMS did not identify any findings or observations related to these requirements.

Payment Suspensions Based on Credible Allegations of Fraud

Pursuant to § 438.608(a)(8), states must ensure that MCOs suspend payments to a network provider for which the state determines there is a credible allegation of fraud in accordance with § 455.23.

The HCA Medicaid MCOs are contractually-required to only suspend payments to providers, but only at the state's request unless a good cause exists not to suspend payments, according to MCO general contract Section 12.8.1 and 12.8.1.1. According to Section 12.8.2, upon receipt of notice from HCA to suspend payments, the MCO must send notice of the decision to suspend payments within five (5) calendar days of HCA's notice to suspend payment unless the MFCU or other law enforcement agency requests a temporary withhold of the notice.

CMS did not identify any findings or observations related to these requirements.

Overpayments

Regulations at §§ 438.608(a)(2) and (d) require states to maintain oversight of MCOs' overpayment recoveries. Specifically, § 438.608(a)(2) requires states to ensure that MCOs promptly report all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the state. In addition, § 438.608(d) requires states to specify in MCOs' contracts how the MCOs should treat overpayment recoveries. This must include retention policies for recoveries of all overpayments, including overpayments due to fraud, waste, and abuse; the process, timeframes, and documentation requirements for reporting the recovery of all overpayments; and the process, timeframes, and documentation requirements for payment of recoveries to the state in situations where the MCO is not permitted to retain some or all of the recoveries. States must also ensure that MCOs have a process for network providers to report to the MCO when it has received an overpayment (including the reason for the overpayment), and to return the overpayment to the MCO within 60 calendar days. Each MCO must report annually to the state on their recoveries of overpayments, and the state must use the results of the information in setting actuarially sound capitation rates, consistent with the requirements in § 438.4.

The state adequately addressed the requirements of §§ 438.608(a)(2) and (d) in the MCO contract; Section 12.1.7. of the HCA general contract states, "[w]hen the Contractor identifies an Overpayment, the Contractor will report the Overpayment to HCA and recover the Overpayment pursuant to this Contract, WAC 182-502A-1101, and other state or federal law and regulations." The contract continues in 12.5.4.1.1 requiring the MCO to, "…have internal policies and procedures for the documentation, retention, and recovery of all Overpayments, specifically for the recovery of Overpayments due to fraud, waste, or abuse".

CMS did not identify any findings or observations related to these requirements.

C. Interagency and MCO Program Integrity Coordination

Within a Medicaid managed care delivery system, MCO SIUs, the SMA, and the state MFCU play important roles in facilitating efforts to prevent, detect, and reduce fraud and abuse to safeguard taxpayer dollars and beneficiaries. Each of these entities performs unique functions that are critical to providing effective oversight of the Medicaid program. The ability to reduce fraud in Medicaid managed care will be greatly enhanced as these entities develop methods and strategies to coordinate efforts. Ineffective collaboration can adversely affect oversight efforts, putting taxpayer dollars and beneficiaries at risk.

Under § 455.21, the SMA is required to cooperate with the state MFCU by entering into a written agreement with the MFCU. The agreement must provide a process for the referral of suspected provider fraud to the MFCU and establish certain parameters for the relationship between the MFCU and the SMA. Washington has a Memorandum of Understanding (MOU) in place, dated November 2019 with the MFCU that meets the regulatory criteria. Specifically, there is a MOU that contains procedures by which the MFCU will receive referrals of potential fraud from MCOs as required by 455.21(c)(3)(iv). Additionally, the state meets with the MFCU quarterly to discuss case referrals.

While there is no requirement for SMAs to meet on a regular basis with its MCOs for collaborative sessions to discuss pertinent program integrity issues regarding fraud, waste, and abuse and relevant contractual concerns, such collaborative sessions are an effective and important process to ensure open communication and strong partnerships. The SMA does hold monthly collaborative sessions with its MCOs to discuss program integrity issues, such as case referrals, leads, and administrative actions. The HCA and the MFCU completed quarterly training with the MCOs during the review period.

CMS did not identify any findings or observations related to these requirements.

D. MCO Investigations of Fraud, Waste, and Abuse

State Oversight of MCOs

Regulations at § 438.608(a)(7) require states to ensure that MCOs promptly refer any potential fraud, waste, and abuse that the MCO identifies to the state PIU or any potential fraud directly to the state's MFCU. Similarly, as required by §§ 455.13-17, states must have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCOs.

Washington has a process in accordance with §§ 455.13-17 and § 438.608(a)(7). Section 12.6.1-4 of the MCO contract outlines the fraud referral process. When the MCO suspects potential fraud, the MCO must make a fraud referral to HCA or the MFCU within five (5) business days of the determination and stop any further action, including overpayment issuance, collection, or other steps. Using the Fraud Referral Form, referrals must be submitted to HCA through the state's fraud referral system, MC-Track or emailed to the MFCU. The fraud referrals are then reviewed and verified by HCA. When HCA reviews and determines the MCO's referral of

potential fraud is credible, HCA must notify the MCO's compliance officer in writing that the referral is credible and is being sent to the MFCU for investigation. The HCA will then inform the MCO of steps that must be taken regarding the referral.

Overall, CMS observed a lack in the quality and quantity of case referrals from the MCO SIUs. The MFCU also indicated during the interview with CMS that there was a decrease in the quality and quantity of fraud referrals for the review period.

The CHPW reported that there is a difference in the required amount of time that is allowed for HCA to make a determination about accepting or declining a referral. According to CHPW, HCA typically reports declined referrals within two-weeks, while there can be up to a four-month period before a referral is accepted. Also, CHPW reported that they were not receiving the reason for the declined referral, which CHPW believed to be credible allegations of fraud.

MCO Oversight of Network Providers

CMS verified whether each Washington MCO had an established process for conducting investigations and making referrals to the state, consistent with CMS requirements and the state's contract requirements.

Washington's MCO general contract requires that each MCO have an established process to monitor its providers for non-compliance with contractual agreements and medical governance standards. A promising practice for MCOs to maintain such oversight is to implement corrective action plans for its network providers found to be non-compliant. CMS found that Amerigroup and Molina did utilize corrective action plans; however, CHPW did not utilize corrective action plans during the review period.

Overall, CMS found the reported MCO processes for the investigation of suspected fraud, waste, and abuse to adequately meet CMS and state MCO contract requirements. All three MCOs reported use of an internal or contracted SIU tasked with identifying and conducting investigations of potential fraud, waste, and abuse. Indicators of potential issues were identified through different sources including but not limited to claims, hotline calls, referrals from subcontractors, referrals from HCA. Cases that are determined to be credible are documented and reported to the SMA and MFCU simultaneously.

Figure 1 below describes the number of investigations referred to Washington by each MCO. The HCA reported some gaps in overpayments identified and recovered from the MCOs during the review period. The overpayments recovered that were identified as waste were significantly larger than those due to fraud and abuse for the review period. The numbers below in *Table 1* represent the overpayments for fraud and abuse only.

Figure 1. Number of Investigations Referred to Washington by each MCO

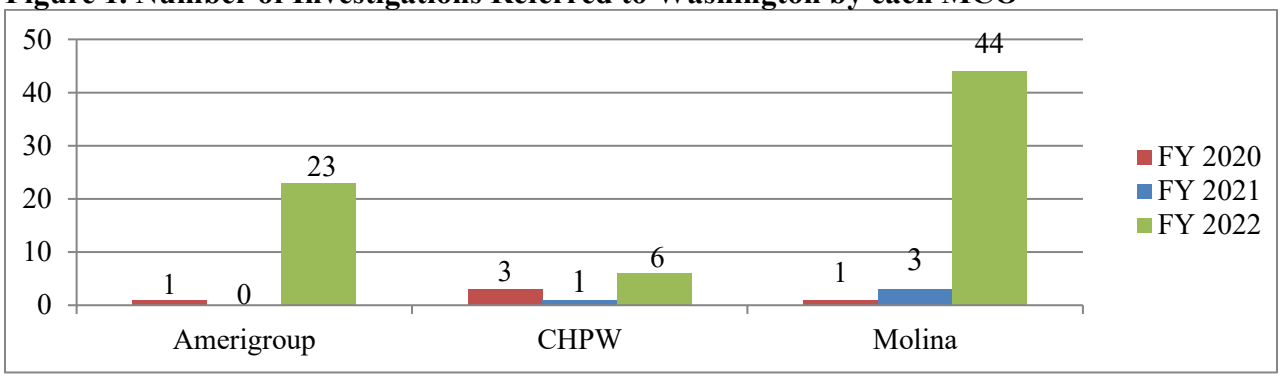

Table 1, below, describes each MCO's recoveries from program integrity activities. The state must obtain a clear accounting of any recoupments for these dollars to be accounted for in the annual rate-setting process (§ 438.608(d)(4)). Without these adjustments, MCOs could be receiving inflated rates per member per month.

Table 1: MCO Recoveries from Program Integrity Activities

Amerigroup's Recoveries from Program Integrity Activities

FY	Investigations	Total Overpayments Identified	Total Overpayments Recovered
2020	119	$302,800.00	$0.00
2021	135	$1,814,699.25	$0.00
2022	133	$0.00	$0.00

CHPW's Recoveries from Program Integrity Activities

FY	Investigations	Total Overpayments Identified	Total Overpayments Recovered
2020	90	$0.00	$0.00
2021	46	$2,330.16	$0.00
2022	89	$33,800.00	$33,095.00

Molina's Recoveries from Program Integrity Activities

FY	Investigations	Total Overpayments Identified	Total Overpayments Recovered
2020	376	$129,268.68	$6,709.71
2021	377	$1,078,112.92	$119,512.57
2022	261	$1,473,572.43	$1,046.06

Observation #2: CMS encourages Washington to work with the MCOs to improve the quality and quantity of case referrals through routine program integrity training and frequent feedback to the MCOs regarding their case referral performance. CMS also encourages Washington to consider establishing metrics to uniformly assess the quality and quantity of case referrals.

Observation #3: CMS encourages Washington to ensure that MCOs have sufficient corrective action plan procedures in place, per contract requirements, and utilize them appropriately to address non-compliant Medicaid providers.

Observation #4: CMS encourages Washington to ensure case referral declinations are communicated timely to all MCOs.

E. Encounter Data

In accordance with § 438.242, the state must ensure, through its contracts, that each MCO maintains a health information system that collects, analyzes, integrates, and reports encounter data. Additionally, § 438.242 further states that states MCO contracts must specify the frequency and level of detail of beneficiary encounter data, including allowed amount and paid amount, that the state is required to report to CMS under § 438.818. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility.

Through a review of the Washington MCO general contract and interviews with each of the MCOs, CMS determined that Washington was in compliance with § 438.242. Specifically, the contract language states the MCOs must have a system(s) that will provide information on areas including, but not limited to, utilization, claims, grievances, appeals, and disenrollment for other loss of Medicaid eligibility.

In addition, in accordance with § 438.602(e), the state must periodically, but no less frequently than once every 3 years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter data submitted by, or on behalf of, each MCO. Specifically, the HCA completed an encounter data validation review for each MCO in July 2021. HCA was in compliance with § 438.602(e) for the review period.

In addition, while it is not a requirement, regularly analyzing the encounter data submitted by MCOs will allow the state to conduct additional program integrity activities, such as identifying

outlier billing patterns, payments for non-covered services, and fraudulent billing. The HCA has a process to regularly analyze MCO encounter data for program integrity purposes. Specifically, Section 5.15.2.2 states, "Submit to HCA complete, accurate and timely data for all services for which the Contractor has incurred any financial liability, whether directly or through subcontracts or other arrangements in compliance with current encounter submission guidelines as published by HCA…"

In addition, the contract section 5.15.7.2 states the MCO encounter data must be submitted and accepted on Form D and will be validated against submitted and accepted data captured within HCA's ProviderOne System. The data must be within 1 percent of what HCA captured. Contract section 5.15.7.3 states, "…HCA may charge the Contractor $25,000 for nonperformance if the Contractor fails to demonstrate that the encounter data submitted and accepted within required timing reconciles to the general ledger amounts within 1 percent".

CMS did not identify any findings or observations related to these requirements.

IV. Conclusion

CMS supports Washington's efforts and encourages the state to look for additional opportunities to improve overall program integrity. CMS' focused review identified four observations that require the state's attention.

The state is not required to develop a corrective action plan for any observations included in this report. However, CMS encourages the state to take the observations into account when evaluating its program integrity operations going forward.

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

V. Appendices

Appendix A: Status of Prior Review

Washington's last CMS program integrity review was in July 2018, and the report for that review was issued in January 2019. The report contained fourteen recommendations. During the virtual review in May 2023, the CMS review team conducted a thorough review of the corrective actions taken by Washington to address all recommendations reported in calendar year 2018. The findings from the 2018 Washington focused PI review report have all been satisfied by the state.

Appendix B: Technical Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance and educational resources for the SMA.

- Access the Resources for State Medicaid Agencies website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Resources-for-SMAs to address techniques for collaborating with MFCUs.
- Access the Medicaid Payment Suspension Toolkit at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf, to address overpayment and recoveries.
- 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. http://www.riss.net/
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute. More information can be found at https://www.cms.gov/medicaid-integrity-institute
- Regularly attend the Fraud, Waste, and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Participate in Healthcare Fraud Prevention Partnership studies and information-sharing activities. More information can be found at https://www.cms.gov/hfpp.
- Consult with other states that have Medicaid managed care programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and training of managed care staff in program integrity issues. Use the Medicaid PI Promising Practices information posted in the RISS as a tool to identify effective program integrity practices.

Appendix C: Enrollment and Expenditure Data

Table C-1 and Table C-2 below provide enrollment and expenditure data for each of the selected MCOs.

Table C-1. Summary Data for Washington MCOs

Washington MCO Data	Amerigroup	CHPW	Molina
Beneficiary enrollment total	219,916	234,199	946,288
Provider enrollment total	25,324	19,684	27,788
Year originally contracted	2012	2003	2003
Size and composition of SIU	6	14	27
National/local plan	National	Local	National

Table C-2. Medicaid Expenditure Data for Washington MCOs

MCOs	FY 2020	FY 2021	FY 2022
Amerigroup	$989,452,414	$1,146,750,939	$1,231,744,001
CHPW	$973,352,395	$1,047,822,326	$1,174,643,689
Molina	$3,585,906,571	$4,203,976,189	$4,525,467,803
Total MCO Expenditures	$5,548,711,380	$6,398,549,454	$6,931,855,493

Appendix D: State Response

State PI Review Response Form

INSTRUCTIONS:

For each draft recommendation listed below, please indicate your agreement or disagreement by placing an "X" in the appropriate column. For any disagreements, please provide a detailed explanation and supporting documentation.

Classification	Issue Description	Agree	Disagree
N/A	No recommendations are included in this report.		

Acknowledged by:

_____
[Name], [Title]

_____
Date (MM/DD/YYYY)