HOUSE BILL REPORT
SB 5497

As Reported by House Committee On:
Health Care & Wellness
Appropriations

Title: An act relating to medicaid expenditures.

Brief Description: Concerning medicaid expenditures.

Sponsors: Senators Wilson, L. and Rolfes.

Brief History:
Committee Activity:
Health Care & Wellness: 3/22/23, 3/24/23 [DP];
Appropriations: 4/4/23 [DPA].

Brief Summary of Bill
(As Amended By Committee)

- Declares the Health Care Authority (Authority) to be responsible for oversight of program integrity activities for all Medicaid funding received by state agencies.
- Directs the Authority to use specific best practices for identifying improper Medicaid spending and establishes standards for contracts between the Authority and managed care organizations regarding responsibilities for maintaining program integrity.
- Requires the Authority to develop a strategic plan for Medicaid program integrity and a single, statewide Medicaid fraud and abuse prevention plan.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: Do pass. Signed by 17 members: Representatives Riccelli, Chair;

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not part of the legislation nor does it constitute a statement of legislative intent.

Bateman, Vice Chair; Schmick, Ranking Minority Member; Hutchins, Assistant Ranking Minority Member; Barnard, Bronoske, Davis, Graham, Harris, Macri, Maycumber, Mosbrucker, Orwall, Simmons, Stonier, Thai and Tharinger.

Staff: Christopher Blake (786-7392).

Background:

Medicaid Program Integrity Activities.
The Health Care Authority (Authority) administers the Medicaid program which is a state-federal program that pays for health care for low-income state residents who meet certain eligibility criteria. Among the requirements that states and service providers must comply with under the federal program are provisions to submit information for the purpose of determining improper payments under Medicaid. Other agencies besides the Authority use Medicaid funds, including the Department of Social and Health Services for long-term care for the elderly and persons with disabilities and the Department of Children, Youth, and Families for children and young adults with complex needs and significant behavioral health challenges.

The Authority is responsible for verifying entities' compliance with applicable laws, rules, regulations, and agreements through program integrity activities. Program integrity activity methods include: data mining, audits and reviews, investigations of suspected fraud and abuse, algorithms to identify irregularities leading to improper payments, on-site reviews and inspections, referral of enforcement actions to law enforcement agencies or licensing agencies, technical assistance and education, outreach to and education for entities and clients, and initiating and reviewing entity self-audits.

The Authority also requires that managed care organizations comply with and enforce all program integrity requirements. Managed care organizations must: adopt and enforce program integrity policies and procedures; include and enforce program integrity requirements in their subcontracts and provider credentialing processes; adopt and implement methods for detecting and preventing fraud and waste to assure that payments are proper and comply with Medicaid standards; perform ongoing analyses to detect improper payments; conduct reviews, audits, and investigations of subcontractors and providers; report any fraud, waste, and abuse; report any overpayments and recoveries; recover any overpayments to any subcontractor or provider; and refer any suspected or potential fraud to the Authority and the Medicaid Fraud Control Division or other law enforcement agency. The Authority may sanction a managed care organization or assess liquidated damages when the Authority identifies fraud, waste, or abuse by a managed care organization provider or the managed care organization fails to report provider overpayments.

The Office of the Attorney General maintains the Medicaid Fraud Control Division which is responsible for civil and criminal investigations and prosecutions of health care provider

fraud in Washington's Medicaid program.

In July 2021 the State Auditor's Office issued a performance audit of the Authority's Medicaid program integrity efforts. The findings made several recommendations, including:

- improving executive oversight of the agencies' program integrity efforts;
- providing federally required oversight of Medicaid program integrity efforts at sister agencies;
- developing a statewide fraud and abuse prevention plan;
- developing procedures to provide consistent oversight of program integrity efforts at sister agencies;
- expanding program integrity efforts for managed care organizations; and
- improving audit selection practices to prioritize resources for high-risk cases and meet federal requirements.

Medical Assistance Expenditures Forecast Work Group.
The Medical Assistance Expenditures Forecast Work Group (Work Group) is responsible for overseeing the preparation and approval of the official Medical Assistance Expenditure Forecasts (Forecasts) and consists of staff from the Office of Financial Management (OFM), the Authority, the House of Representatives, and the Senate. The Forecast is the primary component of the state's official estimate of future maintenance-level medical assistance expenditures which is used by the Governor and the Legislature for updating Authority expenditures. Work Group members are required to review financial data, caseloads, primary trends, and step adjustments to support the creation of the Forecasts.

Summary of Bill:

Medicaid Program Integrity Activities.
The Health Care Authority (Authority) is declared to be the agency responsible for providing oversight of all federal Medicaid program integrity activities. The Authority must establish and maintain effective internal control over any state agency that receives Medicaid funding in compliance with federal regulations.

The Authority must provide administrative oversight for all medical assistance program funds to ensure that funds are spent according to federal and state laws, services are delivered according to federal requirements, corrective actions are established if expenditures do not align with federal requirements, and sound fiscal stewardship is exercised by all agencies over Medicaid funding.

The Authority must oversee the Medicaid program resources of state agencies that expend Medicaid resources by:

- regularly reviewing delegated work;
- jointly reviewing required reports on terminated or sanctioned providers, compliance

data, and application data;
- requiring assurances that operational functions have been implemented;
- reviewing audits performed on other agencies using Medicaid funding; and
- assisting with risk assessments, setting goals, and developing policies and procedures.

When implementing program integrity activities, the Authority must follow best practices for identifying improper Medicaid spending, including:
- conducting risk assessments or evaluating leads with established risk factors;
- relying on data analytics to generate leads;
- conducting a preliminary review of incoming leads;
- determining the credibility of all allegations of potential fraud prior to referral to the state's Medicaid Fraud Control Unit;
- analyzing all leads under review by managed care organizations;
- working with experts that help state integrity programs improve data analytics and identify potential fraud across Medicare and Medicaid, such as unified program integrity contractors; and
- maintaining a current fraud and abuse detection system.

The Authority must develop a strategic plan for Medicaid program integrity that includes strategic goals, agreed-upon objectives, performance measures, and a system to monitor progress and hold responsible parties accountable. The Authority must create a management information and reporting strategy with performance measures and management reports. In addition, the Authority must develop and maintain a single, statewide Medicaid fraud and abuse prevention plan that is consistent with national initiatives or federal best practices, as recognized by the federal Centers for Medicare and Medicaid Services.

Contracts between the Authority and managed care organizations must specify each party's responsibilities for maintaining program integrity and the consequences for noncompliance, with adequate penalties to assure compliance. The contracts must follow leading program integrity requirements recommended by the federal Centers for Medicare and Medicaid Services, including:
- monthly and quarterly meetings between the Authority and the managed care organizations to discuss program integrity issues and findings and to identify trends in fraud and improper payments;
- financial penalties for failure to fulfill program integrity requirements;
- directly auditing providers and recovering overpayments from the providers or assessing liquidated damages against the managed care organizations;
- ensuring that recoveries and liquidated damages from overpayments are accounted for and applied to managed care encounters for future rate setting; and
- ensuring that contracts with managed care organizations are updated to reflect program integrity requirements.

Medicaid Expenditure Forecast Work Group.

The Medicaid Expenditure Forecast Work Group (Work Group) is established in statute. The Work Group consists of assigned staff from the Office of Financial Management (OFM), the senior analyst assigned to Medicaid from OFM, staff from the Authority, senior fiscal analysts from the Legislature assigned to Medicaid, an actuary from the Office of the State Actuary, and other necessary staff.

The OFM is responsible for managing the Work Group and providing staffing, including a forecast manager. The OFM must adopt a charter for the Work Group to address such things as roles and responsibilities of Work Group members, decision making, and ways to compare prior forecasts against expenditures. The Authority must provide access to all information related to the Medicaid expenditure forecast and work with its actuary and the Work Group to develop methods for incorporating managed care program integrity activity into the managed care rate setting process.

The Work Group is responsible for providing technical support to the Governor's Office and the fiscal committees of the Legislature. The forecast manager must prepare an official Medicaid expenditure forecast, as well as other forecasts based on alternative assumptions. Members of the Work Group must review information necessary to prepare the Medicaid expenditure forecast and approve the official Medicaid expenditure forecast and alternative forecasts. The forecast manager must submit official and unofficial forecasts to the OFM and the appropriate fiscal committees of the Legislature at least twice a year. The official forecast must be used as the basis for the Governor's budget document and used by the Legislature in the development of the biennial appropriations act.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony:

(In support) One in seven Medicaid claims are improper amounts and there are about two million people enrolled in Medicaid in Washington. In 2021 the State Auditor's Office released a performance audit of the Medicaid program with several recommendations for the Health Care Authority to improve its program. These recommendations will ensure that state tax dollars are spent on allowable Medicaid claims in the appropriate amount. This bill will require establishing and maintaining effective internal control over any state agency that receives Medicaid funding. The goal of this legislation is to assure payments are in the right amount to the right provider for the right reason. This bill has good accountability and transparency measures.

(Opposed) None.

Persons Testifying: Senator Lynda Wilson, prime sponsor.

Persons Signed In To Testify But Not Testifying: None.

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: Do pass as amended. Signed by 31 members: Representatives Ormsby, Chair; Bergquist, Vice Chair; Gregerson, Vice Chair; Macri, Vice Chair; Stokesbary, Ranking Minority Member; Chambers, Assistant Ranking Minority Member; Corry, Assistant Ranking Minority Member; Berg, Chandler, Chopp, Connors, Couture, Davis, Dye, Fitzgibbon, Hansen, Harris, Lekanoff, Pollet, Riccelli, Rude, Ryu, Sandlin, Schmick, Senn, Simmons, Slatter, Springer, Steele, Stonier and Tharinger.

Staff: Meghan Morris (786-7119).

Summary of Recommendation of Committee On Appropriations Compared to Recommendation of Committee On Health Care & Wellness:

The amended bill removes the Work Group and the Authority responsibilities associated with supporting the Work Group and developing Medicaid expenditure forecasts.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Amended Bill: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony:

(In support) None.

(Opposed) None.

Persons Testifying: None.

Persons Signed In To Testify But Not Testifying: None.