STATE OF WASHINGTON
**HEALTH CARE AUTHORITY**
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April 8, 2019

The Honorable Christine Rolfes
Washington State Senate
P.O. Box 40423
Olympia, WA 98504-0423

The Honorable Timm Ormsby
Washington State House of Representatives
P.O. Box 40600
Olympia, WA 98504-0600

The Honorable David Frockt
Washington State Senate
P.O. Box 40446
Olympia, WA 98504-0446

The Honorable June Robinson
Washington State Hours of Representatives
P.O. Box 40600
Olympia, WA 98504-0600

Dear Members of the House and Senate:

**SUBJECT: Concerns Regarding Senate and House Budget Proposal Impacts on Medicaid Operations**

The Health Care Authority (HCA) understands and acknowledges the great amount of effort that has gone into crafting both the Senate and House proposed biennial budgets. We note serious concerns with one proposal in the House budget and two proposals in the Senate budget specifically related to Medicaid managed care and managed care performance. HCA believes aspects of these proposals have policy merit that should be explored, but they present significant barriers to the budget maintenance and operation of the state's Medicaid program.

In an effort to work constructively on developing a budget that works, we write to provide additional information about the affected programs to describe why we have concerns and to help provide clarity as these topics are discussed during the remainder of this legislative session. It is our hope that the final budget allows HCA to balance at the end of the fiscal year, ensuring we are able to serve our mission to help children, pregnant women, and low income people with health care coverage, while also treating our health systems partners, including the managed care organizations (MCOs) and providers fairly. Without change to this proposal, we fear real cuts to the Medicaid program will result.

**Proposed Savings from Program Integrity Recoveries – in both budgets**

It is our understanding that beginning January 1, 2020, HCA's funding is reduced by over $300 million dollars over the next biennium to reflect savings from program integrity recoveries from MCOs. That is $101 million general fund state (GFS) and $345 million non-GFS.

We understand that some believe that this is in accordance with recommendations from the Centers for Medicare and Medicaid Services (CMS) and will not result in a cut to providers or to other patient services. However, while it is certainly true CMS recently identified areas of concern with managed care program integrity oversight after a focused review of Washington and select MCOs in July 2018, along with similar efforts across the nation, the audit in no way indicated a level of budget savings that could be achieved congruent with the budget. HCA is simply not able to achieve such a significant savings amount over such a small window of time. Even if a significant amount of money can be saved or costs avoided, which as we explain below is still far less than what the budgets currently estimate, program integrity audits typically take between six to nine months to finish, and if there is a formal appeal of audit findings, it can take years to resolve. During this time, no money is collected and no savings are achieved. Moreover, a provider can request a payment plan for up to a year, further delaying savings.

The following is a short description of the program integrity workflow and may provide additional insight into why savings can be difficult to achieve and not quickly recovered:

- Program integrity activities begin with a tip, complaint or referral and/or data. Data tells the story of a provider's billing patterns, a MCO's payment history with a provider, and identifies outliers in both provider and client populations.

- Risk assessments are performed against the data to identify potential provider billing aberrancies and over-utilization. Providers are then selected for audit or clinical review. Algorithms are run to identify aberrancies in provider payments and MCO premium payments when no record review is required, i.e., ineligible clients, excessive units billed, unbundled codes.

Program integrity activities are conducted in one of two ways:

- Prospectively - prior to payment resulting in cost avoidance with no dollars expended which allows control of expenditures up front. Prospective activities include but are not limited to programmatic policies and payment system edits, prior authorization, and removing ineligible providers and clients from the program. Over a four year period during state fiscal years (SFYs) 2015 through 2018, HCA cost avoidance in fee-for-service (FFS) ranged from $1.7 million to $18 million.

- Retrospectively - after payment, aka "pay and chase" resulting in true dollars recovered and returned to the general state fund. Retrospective activities include algorithms, audits, and clinical reviews. Over a four rear period during SFYs 2015 through 2018, HCA recoveries in FFS ranged from $9.4 million to $18.2 million; and similarly for managed care, premiums ranged from $2.8 million to $38.3 million.

As the ranges above reflect, these amounts are highly variable and difficult to estimate. MCOs are contractually required to report to HCA, program integrity activity prospective cost avoidance and retrospective improper payment recoveries. They conduct more prospective cost avoidance to control expenditures up front, versus recovering improper payments from providers.

The primary goal of program integrity activities is to change providers' billing behavior. Identified aberrancies in providers' billing are not typically fraud cases, because they are often due to billing errors resulting from insufficient or missing documentation, incorrect coding (diagnosis, procedure, revenue, other coverage), or lack of medical necessity for service(s) provided and paid. Potential fraud is identified when the aberrant billing is a pattern and appears to be intentional, and a referral is made to law enforcement.

Recovered dollars related to program integrity activities can vary from year to year and are difficult to forecast since they are largely affected by:

- Specific provider billing behaviors. New procedure codes with associated payment rates are released annually and some providers may not adjust their internal processes to account for these changes, resulting in billing errors that need to be corrected.

- Refunded federal match. HCA must refund the federal match of any identified improper payment within one year of a final program integrity activity determination, regardless of HCA's ability to collect the improper payment. The federal match for FFS averages 50 percent because the match amount is dependent on which program a Medicaid client is eligible for. Managed care premiums, on the other hand, average 70 percent.

- Timeliness of recovery and ability to recover. These are directly impacted by delays due to provider appeals, provider payment plans, provider filing bankruptcy or going out of business.

HCA is actively working towards better program integrity recoveries from MCOs in accordance with recommendations from CMS and as part of their Corrective Action Plan with HCA. It is worth noting that in December 2018, HCA's program integrity office transitioned eight (8) staff to a dedicated Managed Care Oversight Unit. Naturally, it will take time to train this new team, implement sustainable processes, and achieve consistent recoveries. HCA will not be able to achieve the significant amount of savings projected in the Senate's proposed budget over such a small window of time. Even when program integrity efforts are at their best, it will be difficult for HCA to recover the amount assumed in the budgets given all of the variables described above (i.e., the difficulty predicting when HCA will actually recover and what the amount of recovery will be).

**Proposed Savings from Managed Care Performance Withhold – in the Senate budget only**

The Senate budget, beginning January 1, 2020, reduced HCA's funding to reflect savings from Engrossed Substitute Senate Bill (ESSB) 5523 (managed care performance), equal to two percent of managed care premiums.

HCA is committed to accountability and quality in its managed care program and believes that managed care performance assures the best value for the cost. However, the two percent savings assumption is problematic for the following reasons:

- ESSB 5523 requires a withhold of three percent of the total premium paid to each MCO that can be earned back if there is statistically significant improvement. However, the Senate's budget assumes the MCOs will achieve a level of improvement that will return no more than one percent of the three percent withhold, resulting in a two percent cut, assuming the MCOs will fail more than they will succeed. Ideally, there should be little to no savings because we believe it is in the best interest of our Medicaid clients to have successful MCOs as seems to be the intent of the bill – additionally, this is how the hospital withhold works, and it has proven to incentivize performance.

- Based on guidance from our actuary, HCA is proposing an amendment to ESSB 5523, reducing the withhold from three percent to two percent. Two percent savings is equivalent to the maximum amount HCA's actuary has advised we can withhold and still sustain the actuarial soundness of the Medicaid program as required by the CMS. If the percentage is not reduced to at least two percent, HCA may need to increase its managed care rates, which will nullify the intent of the bill and savings will not be possible.

- Even assuming an amendment to the withhold in ESSB 5523 to two percent, the savings assumed in the proposed Senate budget will be equivalent to the entire withhold – meaning, there will be no funding available for returning some percentage of the withhold to any of the five MCOs for actual performance.

- HCA already withholds 1.5 percent of total premiums to incentivize the MCOs if they meet value-based targets and quality attainment goals, in two ways:

    - Up to 75 percent can be earned back by improving performance from the previous year's performance on a set of selected quality measures. **Note**: In the first year HCA implemented this approach, all MCOs earned back the 75 percent.

    - The other 25 percent is earned back by incorporating value-based purchasing methodologies into their enrolled provider contracts. Value-based purchasing is a means to incentivize and reward providers for providing quality care and, thereby, contributing to an MCO's improved quality performance score.

- No adjustments appear to have been made for increased performance, and therefore decreased savings, over time. Again, this appears to defeat the purpose of the underlying policy bill.

HCA began withholding 1.5 percent of total premiums in January 2018 when it implemented value-based contracts with the MCOs. HCA's limited experience does not support data modeling that can predict what percentage of future withholds will be earned back, or in this case, whether the level of additional savings now assumed in the Senate's budget proposal, are even obtainable.

Thank you for the opportunity to bring these critical issues to your attention. In addition to other unfunded proposals, these are of particular concern to the HCA and create a very difficult budget situation for the agency and the people we serve.

Should you have questions or concerns, please do not hesitate to contact me directly by telephone at 360-725-1863 or via email at maryanne.lindeblad@hca.wa.gov.

Sincerely,

MaryAnne Lindeblad, BSN, MPH
Medicaid Director

By email

cc: Representative Eileen Cody, Washington State House of Representatives
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