Wash State Health Care Authority

2025-27 First Supplemental Budget Session

Maintenance Level - ZS - Restore Program Integrity Savings

Agency Recommendation Summary

The Washington State Health Care Authority requests resources in the 2026 Supplemental budget to reduce the program integrity cost savings that are assumed in the Apple Health medical assistance expenditures forecast. The savings assumed are too aggressive, which results in a budget that is not sufficient to cover projected Apple Health healthcare costs.

Fiscal Summary

Fiscal Summary *Dollars in Thousands*	Fiscal Years		Biennial	Fiscal Years		Biennial
	2026	2027	2025-27	2028	2029	2027-29
Operating Expenditures						
Fund 001 - 1	$71,000	$71,000	**$142,000**	$71,000	$71,000	**$142,000**
Fund 001 - C	$159,000	$159,000	**$318,000**	$159,000	$159,000	**$318,000**
Total Expenditures	**$230,000**	**$230,000**	**$460,000**	**$230,000**	**$230,000**	**$460,000**
Revenue						
001 - 0393	$159,000	$159,000	**$318,000**	$159,000	$159,000	**$318,000**
Total Revenue	**$159,000**	**$159,000**	**$318,000**	**$159,000**	**$159,000**	**$318,000**

Decision Package Description

Problem Statement

The Apple Health (AH)/Medicaid medical assistance program is underfunded because the February 2025 medical assistance expenditures forecast – which determined the 2025-2027 biennium base funding for the program – assumes program integrity (PI) cost savings that is higher than the agency can achieve. Since most of the AH program is an entitlement in state statute, it must enroll and cover anyone eligible for healthcare coverage through the program. This means the agency is at risk of overspending its existing budget.

Proposed Solution

The Washington State Health Care Authority (HCA) requests resources in the 2026 Supplemental budget to restore the unachievable amounts of PI savings that are assumed in its 2025-2027 budget appropriations.

Background Information

PI is federally mandated to prevent, identify, and investigate potential fraud, waste, and abuse within the AH program. Credible allegations of fraud are referred to the Attorney General's Office's Medicaid Fraud Control Division or other law enforcement. Paid claims and managed care organization (MCO) encounters are reviewed to ensure AH funds are used appropriately.

HCA is developing a managed care strategic plan to ensure the state achieves value and that people are well-served in the AH/Medicaid program. It is making significant changes, such as reorganizing, training recently hired staff that filled vacant positions, adding staff, and revising MCO contract language to meet both the legislative budget proviso mandates and related PI recommendations from the federal Centers for Medicare & Medicaid Services (CMS). These efforts have enhanced managed care PI efforts and increased oversight of MCOs. These changes are consistent with efforts underway in all states. Through inquiries with CMS and other states, no state seems to have a mature managed care PI division that is performing to the level that CMS has indicated interest in achieving, which is also consistent with the legislative vision.

HCA has determined several related PI savings that HCA has been able to achieve. Specifically:

- Through the Coordination of Benefits (COB) program, HCA has avoided $116,498,307 and recovered $12,287,260 throughout fiscal years 2021 and 2022 for a total of $128,785,568;
- The Patient Review and Coordination program has led to a savings of $25,714,000 for the last biennium;
- HCA has settled with Centene for a recovery of $33,333,333 in fiscal year 2023; and
- Through HCA's Division of Program Integrity (DPI), there have been $7,307,031 in overpayments identified; $29,479,236 in total recoveries; and $27,746,485 in total cost avoidance. These total $64,532,752.

These measures saved an estimated $252,365,653 ($77,474,872 GF-State), which means 54 percent of the original PI savings ($460,000,000 per biennium) assumed in the underlying budget was achieved.

The following is a description of other ongoing work that HCA will pursue to realize the remaining 46 percent of the assumed savings in future years.

These goals are dependent on continuing to build capacity of additional staff resources, tools, and managed care contract language amendments. A defined model is not yet attainable. HCA is in compliance with or is in the process of becoming compliant with 2018 CMS PI recommendations and 2019 legislative budget proviso mandates.

Work is underway on several program integrity initiatives, which may lead to increased long-term savings and/or cost offsets or avoidances:

- A federally-required financial audit is currently reviewing the 2021 medical loss ratio (MLR) documentation the MCOs are required to submit annually;
- HCA is addressing concerns around third party liability (TPL) and birth deliveries where the service base enhancement payments have been made by the agency in error as the beneficiary has primary TPL coverage that pays for the delivery. HCA is finalizing and sending notifications of overpayments to MCOs;
- Performance assessment with TPL work that the MCOs are contracted to perform are being reviewed and an audit is pending. DPI is also working with external contractors to assess opportunities to review past TPL work performed by MCOs; and
- HCA is addressing concerns from multiple provider communities about MCOs not paying claims in a timely manner. Additional information has been requested from MCOs as initial reviews brought on more questions.
- HCA is strengthening organizational structure and staffing to support enhanced efforts:
  - PI work continues to dive deeper into MCO provider networks. The new Fraud and Abuse Detection System (FADS) that recently went live is providing more fraud, waste, and abuse hits, resulting in reassessing organizational structure to ensure adequate ability to manage incoming referrals;
  - DPI is working to bridge the knowledge gap of current fee-for-service (FFS) in comparison to auditing MCO network providers;
  - DPI is utilizing the CMS Unified Program Integrity Contract (UPIC) to help conduct investigations and analysis on some FFS programs and providers, as well as MCO network providers; and
  - DPI is in the process of hiring staff to conduct fellow state agency oversight as required by CMS. This manager will also have responsibilities of other state agency oversight related to federal expenditures.
- HCA is reviewing MCO contract language to ensure proper oversight:
  - The agency continually reviews contracts for areas of concern to conduct oversight and ensure MCOs are meeting contractual requirements;
  - HCA is reviewing the severity of penalties for performance deficiencies to determine if increased penalties are warranted. This review also looks to not harm the rate-setting process;
  - HCA continues to update and strengthen its ability to assess damages as needed to ensure HCA can assess penalties for overpayments;
  - Using the CMS Managed Care Program Assessment Report, HCA is utilizing CMS calculations on overpayment metrics. With these metrics, HCA is incorporating an overpayment recovery percentage performance requirement and assessing liquidated damages when MCOs do not meet the percentage; and
  - HCA is updating contract and WAC language to allow the agency more flexibility to apply sanctions on MCOs depending on the severity of the contract violation.
- HCA is updating technology to meet the needs:
  - HCA went live with a new FADS system as of November 30, 2022. DPI is developing processes and updating workflows to capitalize on the tools the FADS provides;
  - Since previous data algorithm processes are not compatible with the new FADS system. HCA is working through previous data algorithms and developing a process with the new FADS to complete this work;
  - DPI is capitalizing on ServiceNow to help manage and capture all PI audit work in a single location. This allows management to better determine the needs of the division, adjust, and prioritize work. It also allows for better reporting; and
  - DPI is exploring data mining opportunities with outside contractors to identify areas of concern with MCOs.

There are many factors to consider in procuring savings from PI activities. For example:

- An audit typically takes six to nine months to complete. If there is a dispute or formal appeal of the audit findings, which often occurs, it could take years to see the recoupment and savings, if any, depending on the outcome of the appeal;
- Managed care contract changes within HCA happen twice a year. Implementing new managed care contract language has to fall within these two timeframes;
- Vacant and new staff hiring of all PI staff is completed. Training new staff is progressing to meet legislative mandates; and
- HCA continues to improve collaboration with actuarial rate setting to look for opportunities, such as the related pharmacy savings and metrics for accountability.

HCA along with other states, are looking to evolve the way program integrity is done for managed care – this is not all traditional audits and recovery, it is critical to look to different approaches such as encounter validation, contract, and oversight changes. It is important to work together across the program management and oversight to ensure accountability.

Anticipated Outcomes

Through this proposal, the state can assure that it dedicates sufficient resources to the AH program, as HCA continues to increase in PI activities to achieve more value for the state.

Assumptions and Calculations

Expansion, Reduction, Elimination or Alteration of a current program or service:

This request does not propose to expand or alter the current program.

Detailed Assumptions and Calculations:

The original model that was used to calculate PI savings in the 2019-2021 biennium operating budget assumed additional recoveries within managed care. Total projected expenditures for managed care eligible populations – called AH/Medicaid eligibility groups (MEGs) in the forecasting process – were calculated. Non-benefit costs were then removed from these projected amounts. This final number was used to calculate the additional recoveries as a percentage of total expenditure.

In reviewing the original model, HCA made three adjustments. First, it excluded several of the non-managed care MEGs used in the original model. These MEGs include Medically Needy (MN) aged (MEG 1330), MN blind/disabled (1350), Alien Emergency Medical (1480), and noncitizen pregnant women (1470).

Second, HCA excluded services that are provided via FFS, even to managed care clients, outside of the services provided by the MCOs. These include dental, interpreter services, transportation, and other benefits not included in the managed care premiums paid to MCOs.

Third, HCA corrected a formula error that resulted in a change in the savings fund split between state and federal dollars.

Workforce Assumptions:

Not applicable.

Historical Funding:

HCA's underlying 2025-2027 biennium budget to support the AH program includes a PI savings assumption of $460,000,000.

Strategic and Performance Outcomes

Strategic Framework:

This request supports HCA's 2022-2025 strategic plan's Goal 2 - Achieve value-based care through aligned payments and systems.

Performance Outcomes:

As outlined, PI fosters stewardship, transparency, and accountability by:

- Holding the MCOs accountable through contracts and contract deliverables;
- Complying with 2018 CMS Program Integrity Review recommendations and 2019 legislative budget proviso program integrity mandates;
- Complying with federal and state regulations;
- Detecting and preventing provider and contractor fraud, waste and abuse through algorithms, audits, reviews, and investigations;
- Ensuring program and managed care payments are proper;
- Recovering improper payments;
- Assessing liquidated damages to MCOs when fraud, waste, or abuse with managed care providers is identified;
- Providing collaborative ongoing training to MCOs with MFCD;
- Ensuring provider and MCO businesses are operational and in compliance with HCA agreements and contracts, as well as federal and state regulations; and
- Mitigating risks within program policy, system edits, and contracts.

Equity Impacts

Community Outreach and Engagement:

There was no community outreach or engagement associated with this proposal.

Disproportional Impact Considerations:

No disproportional impacts are expected to result from this proposal. Accordingly, this proposal does not require strategies to mitigate unintended consequences.

Target Communities and Populations:

The AH/Medicaid program provides access to quality health care services for the state's vulnerable populations. This proposal does not create any equity impacts to under-represented communities.

Community Inputs and Incorporation:

There was no community input associated with this proposal.

Other Collateral Connections

HEAL Act Agencies Supplemental Questions

Not applicable.

Puget Sound Recovery:

Not applicable.

State Workforce Impacts:

Not applicable.

Intergovernmental:

Not applicable.

Stakeholder Impacts:

Not applicable.

State Facilities Impacts:

Not applicable.

Changes from Current Law:

Not applicable.

Legal or Administrative Mandates:

Not applicable.

Governor's Salmon Strategy:

Not applicable.

IT Addendum

Does this Decision Package include funding for any IT-related costs, including hardware, software, (including cloud-based services), contracts or IT staff?

No

Objects of Expenditure

Objects of Expenditure	Fiscal Years		Biennial	Fiscal Years		Biennial
Dollars in Thousands	2026	2027	2025-27	2028	2029	2027-29
Obj. E	$230,000	$230,000	**$460,000**	$230,000	$230,000	**$460,000**

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