STATE OF WASHINGTON
HEALTH CARE AUTHORITY
626 8th Avenue, SE • P.O. Box 45503 • Olympia, Washington 98504-5503

February 29, 2024

Via Electronic Transmission

Case ID Number: OPI-MC-2022-00020

Elizabeth Johnson, President and Chief Executive Officer
Coordinated Care of Washington, Inc.
Tacoma Financial Center
1145 Broadway, Suite 300
Tacoma, WA 98402

Notice of Final Audit Report

Dear Ms. Johnson:

Please find the Final Audit Report for the Claims Payment Standards audit included with this Notice of Final Audit Report (Notice) for Coordinated Care of Washington, Inc.

Summary of Audit
The Health Care Authority (HCA), Division of Audit, Integrity & Oversight (AIO) conducted an audit of encounter data submitted by, or on behalf of Coordinated Care of Washington Inc., based on its obligation under Section 9.13 of the Apple Health Integrated Managed Care (AHIMC) Contract. HCA selected 100 encounters from a universe of claims for services rendered to CCW enrollees between January 1, 2021, and December 31, 2021. HCA analyzed the encounter data with information provided by CCW on the Claims Analysis Report.

Summary of Findings
HCA found zero (0) instances in which Coordinated Care of Washington did not meet the claims payment standard of processing 99 percent of clean claims within ninety (90) calendar days of receipt, as required by the AHIMC contract.

At the issuance of this final report, HCA considers this review complete.

If you have question related to this review, please contact the lead analyst at Candy.Rogers@hca.wa.gov.

Sincerely,

Candy Rogers

Candy Rogers
Program Integrity Analyst
Managed Care Oversight Unit
Division of Audit, Integrity & Oversight

Enclosures

cc: Mike Brown, Assistant Director, HCA, AIO
Jason McGill, Assistant Director, HCA, MPD
Annette Schuffenhauer, Chief Legal Officer, HCA

Washington State Health Care Authority

Final Audit Report

Claims Payment Standards Review of Coordinated Care of Washington, Incorporated

Case ID Number: OPI-MC-2022-00020

February 29, 2024

Division of Audit, Integrity & Oversight

Managed Care Oversight

CMS Directive

The Centers for Medicare and Medicaid Services (CMS) issued a report in June 2018 regarding the need for every State Medicaid agency to have better oversight of their contracted Managed Care Organizations (MCOs). The Health Care Authority (HCA) is carrying out its obligations under federal and state law by performing this Claims Payment Standards Audit.

Authority

HCA conducts program integrity activities in accordance with requirements under the United States Code (USC), the Code of Federal Regulations (CFR), the Washington Administrative Code (WAC), the Apple Health Integrated Managed Care (AHIMC) contract, HCA's Encounter Data Reporting Guide (EDRG), and HCA's ProviderOne 5010 HIPAA Transaction Information.

Process of Claims Payment Standards Audit

The HCA Program Integrity Managed Care Oversight (PIMCO) unit initiated a Claims Payment Standards Audit of Coordinated Care of Washington (CCW) on August 2, 2022. The purpose of this audit is to ensure that all MCOs meet the contractual requirement of processing 99 percent of clean claims within ninety (90) calendar days as cited in section 9.13 of the 2021 AHIMC contract.

HCA conducted a review of the contracted MCO's claims payment standards in the following manner:

Random Sample Selection

HCA selected a random sample of one hundred (100) encounters from a universe of claims for services rendered to CCW enrollees between January 1, 2021 and December 31, 2021.

Notice of Intent to Audit

On August 2, 2022, HCA sent a Notice of Intent to Audit (Notice) to CCW. HCA compiled the encounters from the random sample into the Claims Analysis Report. CCW was instructed to complete the fields on the Report to include the date of claim submission from the network provider and the date the claim was processed (MCO paid date).

Documentation Received

On September 2, 2022, HCA received the documentation requested in the notice from CCW.

Documentation Review

HCA analyzed the ProviderOne encounter data and the Claims Analysis Report completed by CCW to identify claims that did not meet the claims payment standard of 99 percent of clean claims within ninety (90) calendar days of receipt, as required by the AHIMC contract. Peer review was also utilized to discover discrepancies that may have been found by the initial analyst to corroborate the findings.

Request for information

During the initial review of claims payment data, HCA found that the MCO paid dates provided by CCW in the Report did not match the paid date from the encounter data in ProviderOne.

A Request for Information letter was sent to CCW on December 7, 2022, requesting clarification as to why MCO paid dates on the Report did not match the encounter data.

Documentation Received

The additional documentation requested was received from CCW on December 14, 2022.

Documentation Reviewed

The additional documentation was reviewed to determine compliance with Claims Payment Standards.

Findings

HCA reviewed a random sample of one hundred (100) encounters from a universe of claims for services rendered to CCW enrollees between January 1, 2021 and December 31, 2021.

- HCA determined that there were no findings.

Conclusion

The Claims Payment Standards Review is completed to ensure MCO compliance with Claims Payment Standards as required in the AHIMC Contract, Section 9.13. The HCA Program Integrity Managed Care Oversight (PIMCO) unit determined that CCW has met Claims Payment Standards (paid or denied within ninety (90) calendar days of receipt) as required in the AHIMC Contract, Section 9.13 and Encounter Data Reporting Guide.

References

Code of Federal Regulations (CFR)

- **42 CFR §438.604 Data, information, and documentation that must be submitted.**
  (a) *Specified data, information, and documentation.* The State must require any MCO... to submit to the State the following data:
  (1) Encounter data in the form and manner described in §438.818.
  (2) Data on the basis of which the State certifies the actuarial soundness of capitation rates to an MCO… under §438.4, including base data described in §438.5(c) that is generated by the MCO…
  (3) Data on the basis of which the State determines the compliance of the MCO… with the medical loss ratio requirement described in §438.8.

(4) Data on the basis of which the State determines that the MCO… has made adequate provision against the risk of insolvency as required under §438.116.

(5) Documentation described in §438.207(b) on which the State bases its certification that the MCO… has complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in §438.206.

(6) Information on ownership and control described in §455.104 of this chapter from MCOs… and subcontractors as governed by §438.230.

(7) The annual report of overpayment recoveries as required in §438.608(d)(3).

(b) *Additional data, documentation, or information.* In addition to the data, documentation, or information specified in paragraph (a) of this section, an MCO, PIHP, PAHP, PCCM or PCCM entity must submit any other data, documentation, or information relating to the performance of the entity's obligations under this part required by the State or the Secretary.

- **42 CFR §438.700 Basis for imposition of sanctions.**

(a) Each State that contracts with an MCO must… establish intermediate sanctions (which may include those specified in §438.702) that it may impose if it makes any of the determinations specified in paragraphs (b) through (d) of this section. The State may base its determinations on findings from onsite surveys, enrollee or other complaints, financial status, or any other source.

(b) A State determines that an MCO acts or fails to act as follows:

(1) Fails substantially to provide medically necessary services that the MCO is required to provide, under law or under its contract with the State, to an enrollee covered under the contract.

(2) Imposes on enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.

(3) Acts to discriminate among enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services.

(4) Misrepresents or falsifies information that it furnishes to CMS or to the State.

(5) Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider.

(6) Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in §§422.208 and 422.210 of this chapter.

(c) A State determines that an MCO, PCCM or PCCM entity has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information.

(d) A State determines that—

(1) An MCO has violated any of the other requirements of sections 1903(m) or 1932 of the Act, or any implementing regulations.

(2) A PCCM or PCCM entity has violated any of the other applicable requirements of sections 1932 or 1905(t)(3) of the Act, or any implementing regulations.

(3) For any of the violations under paragraphs (d)(1) and (2) of this section, only the sanctions specified in §438.702(a)(3), (4), and (5) may be imposed.

- **42 CFR §438.702 Types of intermediate sanctions.**

  (a) The types of intermediate sanctions that a State may impose under this subpart include the following:

  (1) Civil money penalties in the amounts specified in §438.704.

  (2) Appointment of temporary management for an MCO as provided in §438.706.

  (3) Granting enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to disenroll.

  (4) Suspension of all new enrollment, including default enrollment, after the date the Secretary or the State notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Act.

  (5) Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

  (b) State agencies retain authority to impose additional sanctions under State statutes or State regulations that address areas of noncompliance specified in §438.700, as well as additional areas of noncompliance. Nothing in this subpart prevents State agencies from exercising that authority.

- **42 CFR §438.704 Amounts of civil money penalties.**

  (a) *General rule.* If the State imposes civil monetary penalties as provided under §438.702(a)(1), the maximum civil money penalty the State may impose varies depending on the nature of the MCO's, PCCM or PCCM entity's action or failure to act, as provided in this section.

  (b) *Specific limits.*

  (1) The limit is $25,000 for each determination under §438.700(b)(1), (5), (6), and (c).

  (2) The limit is $100,000 for each determination under §438.700(b)(3) or (4).

  (3) The limit is $15,000 for each beneficiary the State determines was not enrolled because of a discriminatory practice under §438.700(b)(3). (This is subject to the overall limit of $100,000 under paragraph (b)(2) of this section).

  (c) *Specific amount.* For premiums or charges in excess of the amounts permitted under the Medicaid program, the maximum amount of the penalty is $25,000 or double the amount of the excess charges, whichever is greater. The State must deduct from the penalty the amount of overcharge and return it to the affected enrollees.

<u>Apple Health Integrated Managed Care (AHIMC) Contract 01/01/2021– 12/31/2021</u>

- Section 5.13 Encounter Data

  5.13.2.2.1 Encounter data must be submitted to HCA at a minimum monthly, and no later than thirty (30) calendar days from the end of the month in which the Contractor paid the financial liability.

- Section 9.13 Claims Payment Standards

  9.13.1 The Contractor shall meet the timeliness of payment standards specified for Medicaid FFS in Section 1902(a)(37) of the Social Security Act, 42 C.F.R. § 447.46 and specified for health carriers in WAC 284-170-431.

These standards shall also be applicable to State-only and federal block grant fund payments. To be compliant with payment standards the Contractor shall pay or deny, and shall require subcontractors to pay or deny, 95 percent of clean claims within thirty (30) calendar days of receipt, 95 percent of all claims within sixty (60) calendar days of receipt and 99 percent of clean claims within ninety (90) calendar days of receipt. The Contractor and its providers may agree to a different payment requirement in writing on an individual claim.

- Section 9.4 Required Provisions

  9.4.9 The requirement to completely and accurately report encounter data and behavioral health supplemental transactions, and to certify the accuracy and completeness of all data submitted to the Contractor. The Contractor shall ensure that all Subcontractors required to report encounter data and behavioral health supplemental transactions have the capacity to submit all HCA required data to enable the Contractor to meet the reporting requirements in the Encounter Data Guide and Behavioral Health Supplemental Transaction Data Guide published by HCA. Behavioral Health Supplemental transactions related to services provided to Enrollees must be submitted within thirty (30) calendar days from the date of service or event.

Encounter Data Reporting Guide (EDRG)

- Page 31 The Paid Date
  - Encounter Data Reporting Guide, "DTP03 – (Date Time Period) – Submit the date the claim was paid in 'CCYYMMDD' format; for capitated encounters, submit the date of when the claim was processed." MCO paid date is expected to be the date the specific TCN provided was paid/processed.

ProviderOne 5010 Companion Guides

Encounter Guide June 2017

- Introduction
  - Encounters are not HIPAA named transactions and the 837I and 837P Implementation Guides were used as a foundation to construct the standardized HCA encounter reporting process.
  - Companion Guides are used to clarify the exchange of information on HIPAA transactions between the HCA ProviderOne system and its trading partners. HCA defines trading partners as covered entities that either submit or retrieve HIPAA batch transactions to and from ProviderOne.
  - Companion Guides are intended to supplement the HIPAA Implementation Guides for each of the HIPAA transactions. Rules for format, content, and field values can be found in the Implementation Guides. This Companion Guide describes the technical interface environment with HCA, including connectivity requirements and protocols, and electronic interchange procedures. This guide also provides specific information on data elements and the values required for transactions sent to or received from HCA.