Washington State Health Care Authority

Medicaid Program Integrity Today

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Washington State Health Care Authority

Washington Medicaid & CHIP aka Washington Apple Health (WAH)

- Medicaid is jointly funded by state and federal governments
- Medicaid is authorized by Title XIX of the Social Security Act and became law in 1965
- Provides health coverage to eligible low-income adults, children, pregnant women, elderly adults and people with disabilities

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Washington Medicaid & CHIP aka Washington Apple Health (WAH)

- Children's Health Insurance Program (CHIP) is jointly funded by state and federal governments.
- CHIP is authorized by Title XXI of the Social Security Act and became law in 1997.
- Provides health coverage to children in families with incomes too high to qualify for Medicaid, but who can't afford private coverage.

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Health Care Agency (HCA)

- Is the Single State or Medicaid Agency
- Responsible for administering Medicaid and CHIP
- Shares this responsibility with Department of Social and Health Services as of July 1, 2011
- Pays certain programs/services fee-for-service
- Contracts with 5 Managed Care Organizations

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HCA Program Integrity (PI)

- Conducts program integrity activities (PIAs) to identify fraud, waste and abuse in fee-for-service and MCOs, PIA include:
  - Audits, pre- and post-payment
  - Clinical Reviews
  - Utilization Data Analytics
  - Investigations of Potential Fraud
  - Education and Outreach

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PI Audits

- Focus - any provider type and MCO
- Based on referrals/complaints, outliers-data mining, identified system edit/policy vulnerabilities or are routinely scheduled
- Records review results in draft/ final notices and reports, informal dispute process, and formal appeal process
- Improper payment resolution

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PI Clinical Reviews

- Primary Focus – inpatient hospital
- Based on screening criteria, referrals/ complaints, outliers-data mining, or routinely scheduled
- Records review results in preliminary/final notices and findings, informal dispute process, and formal appeal process
- Improper payment resolution

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PI Utilization Data Analytics/Algorithms

- Focus – any provider type and MCO
- Based on referrals/complaints, outliers-data mining, identified system edit/policy vulnerabilities
- May not involve a records review if algorithm is indicative of overpayment, results in an overpayment notice, informal dispute and formal appeal process
- Overpayment resolution

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PI Investigations

- Focus – any provider type and MCO
- Based on referrals/complaints
- Involves research into provider background and billing patterns, data and records review, interviews, potential onsite visits, etc.
- If found to be credible allegation of fraud, referred to Medicaid Fraud Control Unit
- Payment suspension may be invoked

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PI Referrals

If an audit, clinical review, utilization data analysis or investigation identifies a potential fraud, licensing or quality issue, the case will be referred to the appropriate oversight authority, which includes but is not limited to:

- Medicaid Fraud Control Unit
- Department of Health
- Other Law Enforcement Agency

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Most Common PI Findings

- Documentation includes
  - Missing
  - Insufficient
- Upcoding includes but not limited to
  - DRG
  - Procedures (CPT, CDT)
- Non-covered includes, but not limited to
  - Over the limit
  - Unbundling
- Services not rendered

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Documentation Pitfalls

- No documentation/record –
  "If it's not documented, it's not done."
- Documentation is insufficient to support the level of service or level of care
- Missing dates, times, units, signatures for authentication
- Incorrect dates, procedures, diagnosis, etc.
- Copy/paste in electronic health/medical records

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Internal Compliance Program

- Goal: Prevent potential fraud, waste and abuse – improper payments
  - Compliance Officer
  - Policies and Procedures
  - Training for providers and staff
  - Methodology that encourages staff to report potential problems
  - Prompt review and initiation of corrective action(s)
- Provider Self-Audit, WAC 182-502A-0501

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Preparing for an Audit or Review

- Understand HCA's obligation to audit/review
  - An audit or review can identify vulnerabilities in a system or process and/or improper payments
- Ensure all requested information is provided
- Ask questions as needed
- Pay attention to deadlines, request an extension if necessary
- Refer to chapter 182-502A WAC

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Other Audit/Review Entities

- Managed Care Organizations
- Medicaid Recovery Audit Contractor (RAC)
  - Federally required, State contracts
- State Auditors Office (SAO)
- HHS/CMS Contracts
  - Payment Error Rate Measurement (PERM) Review Contractor(s)
  - Medicaid Integrity Contractor (MIC)
- HHS/OIG

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Achieving the Triple Aim

- Analytics, Interoperability, and Measurement (AIM)
  - Utilizing data to achieve the Triple Aim - better health, better care, and lower costs
- Data + Analytics = Information
- AIM is a strategy to:
  - Work collaboratively across state agencies and public and private sector partners to break down data-related silos.
  - Address long-term needs for health data management solutions, services and tools.
  - Serve as a key tool to implement population health improvement strategies around Washington.

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Medicaid Transformation

- Accountable Communities of Health (ACH)
  - Improve health and health equity
  - Align local health resources and activities to improve whole person health and wellness
  - Support local and statewide initiatives to improve outcomes
  - Currently 9 ACHs within the regional service areas across the state
- Expanded long-term care services and support
- Supportive housing and employment

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Alternative Payment Models

- Integrated physical and behavioral health care
  - Payment and delivery of physical and behavioral health services for people enrolled in Medicaid, through managed care
- Value-based Payment
  - Managed Care Organizations
  - Federally Qualified and Rural Health Centers with Critical Access Hospitals
- Accountable Care Program
- Greater Washington Multi-Payer

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Questions?

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