Medicaid Program Integrity
Today

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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.

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.
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

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

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
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

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

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
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

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

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
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

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

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
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.

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

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
Questions?

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