Washington State Health Care Authority

Safeguarding Medicaid from False Claims

Cathie Ott, Assistant Director, ProviderOne Operations and Services
cathie.ott@hca.wa.gov
360-725-2116

Preston Cody, Assistant Director, Health Care Services
preston.cody@hca.wa.gov
360-725-1786

HCA Program Integrity, Fraud Detection and Prevention

Who we are and what we do:

- We are Data Analysts, Auditors, Nurses, Coders, and Investigators
- We conduct various program integrity activities to ensure correct payments are made to legitimate providers for covered services for eligible clients.
- We identify vulnerabilities in program policies and systems, and work with appropriate staff to prevent further improper billing.
- We educate individual providers, provider associations and managed care entities.
- We identify potential false claims, fraud and/or quality of care issues and refer to the appropriate entity for further investigation.

HCA Responsibilities to Combat Fraud, Waste and Abuse

We are responsible to:

- Conduct data analysis, utilization reviews and audits of provider billing.
- Refer potential credible allegations of fraud to the Medicaid Fraud Control Unit (MFCU).
- Support MFCU by conducting preliminary investigations of HCA HotTips complaints and allegations against Medicaid providers, and suspicious billing patterns.

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Supporting the State Medicaid False Claims Act

Interaction with MFCU supports the State Medicaid False Claims Act:

- Active Memorandum of Understanding details HCA and MFCU roles and responsibilities.
- HCA conducts intake and triage of all HCA HotTips complaints and allegations.
- Following preliminary investigations, HCA refers potential credible allegation of fraud to MFCU.
- Monthly meetings between HCA and MFCU to discuss active leads and cases.
- Joint training seminars held between HCA and MFCU and with the Managed Care plans.

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HCA Program Integrity Business Plan and Performance Metrics

In accordance with the HCA Program Integrity Business Plan:

- Recoveries lead to preventative measures with refinement of system edits and program policies.
- Recoveries and Cost Avoidance
  - Over $24 million in first half SFY 2016
  - Over $32 million in SFY 2015
  - Over $28 million in SFY 2014
- Prevention in SFY 2015
  - Dozens of program policy and payment system vulnerabilities corrected
  - Four educational presentations to Provider Associations along with routine provider education during audit process

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Outcomes of the State Medicaid False Claims Act

To date, the State False Claims Act has:

- Increased collaboration between HCA and Medicaid Fraud Control Unit (MFCU)
- Increased referrals from HCA to MFCU
  - 62 cases referred to HCA Fraud Investigators since 10/12 (less than 10 referrals to MFCU in previous 2 years)
    - 47 referrals from HCA, 18 referrals from False Claims Act Team, 12 accepted by MFCU with 6 payment suspensions
    - 8 referrals from MFCU requesting HCA assistance or payment suspensions on active MFCU investigations

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Federal Requirements

- 42 CFR 455 Program Integrity
  - State fraud detection and investigation program
  - Includes initiatives that states must have in place
  - Includes a variety of federal reviews of Program Integrity activities
- 42 CFR 456 Utilization Control
  - Statewide program of control of the utilization of all Medicaid services

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Questions?