Tribal Consultation: Compliance and Program Integrity

Sue Crystal Conference Center, Cherry Street Plaza, 626 – 8th Ave SE, Olympia
September 12, 2018
1:00 – 3:00 pm

Washington State Health Care Authority

Welcome, Blessing, and Introductions

Washington State Health Care Authority

Opening Statements

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Background

2014

- Corrective Action Plan from CMS for HCA to conduct oversight of tribal payments

2015

- HCA realignment

2016

- Presentations on Program Integrity function at three TCOW meetings

2017

- Letter sent to Tribes on Tribal Compliance Plan and proposed schedule
- Tribal Compliance Specialist hired
- Three site visits

2018

- Four site visits

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HCA Obligations

As the Washington State Single Medicaid Agency, HCA is obligated and mandated, per federal and state regulations to:

- Monitor and audit claims and encounters submitted to and paid by the Agency;
- Recover overpayments discovered during monitoring and auditing or when self-disclosed;
- Identify and prevent fraud, waste and abuse in Medicaid/Apple Health programs; and
- Refer credible allegations of fraud or professional licensing issues to the appropriate authorities.

Federal and State Requirements

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Federal Regulations (with select sections)

- 42 CFR Part 433 - State Fiscal Administration
  - State must refund Federal share of overpayments whether or not the State has recovered the overpayment from the provider. (433.312)
- 42 CFR Part 438, Subpart H – Managed Care: Program Integrity Safeguards
  - State must monitor managed care entity compliance with federal regulations. (438.602)
- 42 CFR Part 447 – Payments for Services
  - State must assure appropriate audit of records if payment is based on costs of services or on a fee plus cost of materials. (447.202)
- 42 CFR Part 455 – Program Integrity: Medicaid
  - State must have methods to identify and investigate suspected fraud. (455.13)
- 42 CFR Part 456 – Utilization Control
  - State must have process for state personnel to develop and review beneficiary utilization profiles, provider service profiles, and exceptions criteria. (456.23)
- 42 CFR Part 495 – Standards for the EHR Technology Incentive Program

Additional Federal Laws

- 42 USC 1396(j) – Section 1911 of the Social Security Act
  - Authorizes Medicaid payments to Indian Health Service (IHS) facilities, whether operated by IHS or a tribe or tribal organization.
- 25 USC 1641(d)(2)(B) – Section 401 of the IHCIA
  - Authorizes audits of Medicaid payments in accordance with the requirements under titles XIX and XXI of the Social Security Act.

State Laws (with select sections)

- RCW 74.09.195 – Audits of health care providers by HCA
  - Various procedural requirements, including 30 days' prior notice for on-site audits and annual training for providers.
- RCW 74.09.200 – Audits and investigations
  - Acceptance of Medicaid payment authorizes HCA to inspect and audit all records in connection with the providing of such services.
- RCW 74.09.210 – Fraudulent practices
  - Prohibits fraudulent practices.
- Chapter 74.66 RCW – Medicaid Fraud False Claims Act
  - Authorizes qui tam actions.
- Chapter 41.05A RCW – Overpayments of Assistance and Coordination
  - Authorizes coordination between HCA and DSHS for collection of overpayments.

State Regulations (with select sections)

- Chapter 182-502A WAC, *Program Integrity*
- Chapter 182-501 WAC, *Administration of medical programs-General*
- Chapter 182-502 WAC, *Administration of medical programs-Providers*
  - 182-502-0002 *Eligible provider types*
  - 182-502-0005 *Core provider agreement (CPA)*
  - 182-502-0020 *Health care record requirements*
  - 182-502-0100 *General conditions of payment*
- All other applicable eligibility and program WACs

Corrective Action Plan with CMS

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Corrective Action Plan (CAP) with CMS

- Sufficient and effective oversight, monitoring and safeguarding of all aspects of healthcare provided by the tribes including, but not limited to ensuring:
  - Medicaid services are being provided as needed to beneficiaries;
  - Medicaid services are delivered in accordance with all applicable quality standards, payment requirements, and standards of care, including supervision and practitioner qualification standards; and
  - All claims submitted by tribal providers are supported by appropriate documentation to qualify for payment.
- Have administrative structure within DSHS and HCA for adequate and timely oversight by and ultimate authority of HCA.

Program Integrity Activities

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Program Integrity

- The Section of Program Integrity (Section) supports HCA's mission to ensure Washingtonians have access to better health and better care at a lower price through innovative health policies and purchasing strategies.

- The Section promotes awareness that public funds are always at risk and in need of protection. It is responsible for reasonable, consistent, and fair oversight of Apple Health programs in both fee-for-service and managed care environments; and to ensure compliance with applicable federal and state regulations.

Program Integrity Activities

The Section of Program Integrity engages in a variety of of activities to prevent and identify Medicaid fraud, waste, and abuse including but not limited to:

- Investigating leads, complaints and tips of provider billing and behavior.
- Reviewing claims identified through risk assessments and rule-based analytics/algorithms.
- Performing routine desk audits and clinical reviews of hospitals and providers to ensure services billed to and paid by HCA were provided, documented and appropriately paid.
- Conducting unscheduled on-site audits of hospitals and providers identified for potential fraud or risk to public health and safety.

Tribal Compliance Program

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Tribal Compliance Program

The objective of the HCA Tribal Compliance Program is to ensure tribal payments for healthcare services are accurate. The Section of Program Integrity conducts site visits for:

- Compliance Review – Verify documentation supports the services paid and identify outliers that require closer review.
- Clinical Review – Determine if medical necessity is sufficiently documented and established and medical coding is appropriate.
- Utilization Review – Identify potential underutilization and overutilization.
- Professional Licensure – Determine if all professional licenses are up-to-date, background checks are completed and documented, and required training is documented in personnel file.
- Technical Assistance – Provide tribes with guidance on how to conduct self-compliance reviews and how to improve performance in such reviews, i.e., accurate billings and payments, and contract compliance.

HCA proposed a three year cycle for tribal site visits.

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Discussion

- How can HCA and the tribes work together to ensure compliance with federal and state regulations?

Closing Statements

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