Program Integrity

- Detection, prevention, mitigation, and investigation of Fraud, Waste, and Abuse (FWA)—we all strive to consistently be good stewards of public dollars and ensure proper care is being delivered to our members.
- **Prevent**—we use data mining algorithms to detect and prevent potential wasteful or abusive billing
  - **Examples:** Incorrect coding, misalignment with CMS requirements for the Medicaid program, or lack of medical necessity for the service being provided
  - Through prevention activities, claims are denied before being paid and MCO staff reach out to ***educate*** on proper billing practices
- **Mitigation and Recovery—**we also use data mining algorithms on *paid* claims to detect for FWA and improperly paid claims or claims paid against medical necessity; we work with the provider to recover the funds that were improperly paid and educate on reasons why and future prevention
- **Investigation—**Each MCO has investigation units to investigate potential fraud and/or abuse activities; if activities are found, we are required to report individual providers or provider agencies to HCA and CMS

Monitoring

All MCOs complete the following monitoring which may result in chart reviews and periodic auditing activities:

- Quality of Care Issues
- Critical Incident Investigations
- Over and Under Utilization Monitoring
- “HEDIS season” chart requests
- Utilization Management
- Annual training attestations (joint MCO training available)
  - Enrollee Rights and Responsibilities
  - Advanced Directives
  - Fraud, Waste, and Abuse
  - False Claims Act

Member Grievance and Appeal

- A Member may express dissatisfaction pertaining to quality of care, the way the member was treated, problems getting care and billing issues.
  - Member should be referred to their MCO to report a grievance. **Only members can file a grievance**, or designate someone to file on their behalf with written authorization.
  - MCO will confirm receipt of the grievance within two business days of receipt.
  - Grievances are resolved within 45 days and the Member will be advised of the resolution.
- A Member or Member Representative may request an appeal for a denied service or authorization within 60 calendar days of the denial.
  - For WISe appeals, please follow the WISe Manual.

How Can a Member Report a Grievance or Request an Appeal?

MCO	Contact Number	Email
Amerigroup	(800) 600-4441	WA-Grievance@Amerigroup.com
Coordinated Care	(877) 644-4613	WAQualityDept@Centene.com
Molina Healthcare	(800) 869-7165	MHWMemberServicesWeb@ MolinaHealthcare.com
UnitedHealthcare Community Plan	(866) 556-8166	WACS_Appeals@UHC.com

Please refer to MCO Provider Manuals for additional information on the Member Grievance and Appeal process.

Advance Directives

An Advance Directive gives written instructions about a patient's medical care in the event that the patient is unable to express his or her medical wishes.

For the State of Washington there are three types of Advance Directives:

1. **Health Care Directive/Living Will:** Specifies an individual's wishes about end of life care.
2. **Durable Power of Attorney:** Names another person to consent to, stop, or refuse treatment if an individual is incapable of doing so.
3. **Mental Health (MH) Advance Directive:** Allows a person with capacity to state mental health treatment preferences in a legal document that will govern during periods of incapacity.

Advance Directives

To be valid, a Mental Health Advance Directive must:

- Be in writing;
- Include language indicating a clear intent to create a directive;
- Be dated and signed by the patient, or be dated and signed in the patient's presence at his or her direction;
- State whether the directive may or may not be revoked during a period of incapacity;
- Be witnessed in writing by at least two adult witnesses;
- Conform substantially to the statutory format.

Providers must know and follow applicable regulations regarding Advance Directives (per WAC and/or RCW) and are expected to comply with a member's Advance Directive appropriate to their available services. MCOs may request provider assistance in obtaining copies of Advance Directives when a member indicates they have them or request assistance in creating them.

Critical Incidents

Definition	Who?
Critical Incident is an event involving a member with impact to health and safety.	Anyone (member, provider, MCO staff, etc.) may identify and report a Critical Incident.

- An event may lead to both a Critical Incident and/or Grievance, but they are separate reports and systems based on the definitions.
- In addition to HCA and MCO requirements, providers are also responsible for maintaining incident and grievance/complaint reporting systems as outlined In WAC and RCW appropriate to their agency and facility licensure.

Critical Incident – Individual vs Population Based Reporting

- HCA provides a category list of incidents to be submitted by the MCO in the Incident Reporting System within one (1) business day.

- Additional events are tracked, monitored, and investigated for Population Based reporting, submitted to HCA by MCO biannually.
  - Review of trends in categories, demographics, etc.
  - Report on efforts in follow-up and prevention actions

- Providers submit Critical Incident reports to MCOs for Individual and Population-Based reporting categories or requirements as requested.

HCA Individual Incident Reporting Categories

The following incidents should be reported if they occurred **to an Enrollee** within a contracted behavioral health facility (inpatient psychiatric, behavioral health agencies), FQHC, or by independent behavioral health provider:

- Abuse, neglect or sexual/financial exploitation; and
- Death.

HCA Individual Incident Reporting Categories

By an Enrollee, with a behavioral health diagnosis; or history of behavioral health treatment within the previous 365 days. Acts allegedly committed, to include:

- Homicide or attempted homicide;
- Arson;
- Assault or action resulting in serious bodily harm which has the potential to cause prolonged disability or death;
- Kidnapping;
- Sexual Assault;
- Unauthorized leave from a behavioral health facility during an involuntary detention; and
- Any event involving an Enrollee that has attracted or is likely to attract media coverage.

Critical Incident Reporting Process

Critical Incident Occurs

- Provider notifies MCO of incident using Critical Incident Report Form within one (1) business day of reporter's awareness of the incident.

Critical Incident is Reported

- MCO enters incident into Incident Reporting System by COB on the date received from the reporter.

Critical Incident is Closed

- MCO completes investigation and follow-up and enters into the Incident Reporting System. HCA may request additional follow-up from the MCO.

Population-Based Reporting Categories

MCOs submit a semi-annual report of all Critical Incidents tracked during the previous six months, which includes analysis of the following:

- Incidents reported through the HCA Individual Reporting System;
- Incidents posing a credible threat to Enrollee safety;
- Suicide and attempted suicide; and
- Poisonings/overdoses unintentional or intention unknown.

Where to Report a Critical Incident

The Critical Incident Form are available on each MCO's website and to be submitted to the emails listed.

MCO	Email
Amerigroup	QMNotification@Anthem.com
Coordinated Care	WABHcriticalincidents@CoordinatedCareHealth.com
Molina Healthcare	MHW_Critical_Incidents@MolinaHealthcare.com
UnitedHealthcare Community Plan	WA_Criticalinc@UHC.com

Behavioral Health Ombudsman

- The Ombuds service:
  - receives, investigates, advocates for, and assists eligible individuals with the resolution of grievances, the appeal processes when applicable, and, if necessary, the administrative fair hearing process;
  - is responsive to the age and demographic character of the region and assists and advocates for individuals with resolving issues, grievances, and appeals at the lowest possible level;
  - is independent of service providers; and
  - coordinates and collaborates with allied services to improve the effectiveness of advocacy and reduce duplication.
- Behavioral Health Ombuds members must be current consumers of the mental health or substance use disorder system, or past consumers or family members of past consumers.

Behavioral Health Ombudsman

Region	Contact Information
Thurston Mason Ombuds	Phone: 1-800-658-4105 or 360-763-5793 Address: 612 Woodland Square Loop SE, #401 Lacey, WA 98503 Fax: 360-584-9745
Great Rivers Ombuds	Cowlitz, Pacific and Wahkiakum Counties Phone: 1-866-731-7403 or 360-414-0237 Lewis and Grays Harbor Counties Phone: 1-833-721-6011 or 360-266-7578

Resources

Interpreter Services • HCA Transportation Broker • MCO Websites • Provider Portals • Frequently Use Forms • Helpful Links

HCA Interpreter Services

The HCA Interpreter Services (IS) program is available to healthcare providers serving limited English proficient (LEP), Deaf, DeafBlind, and Hard of Hearing Medicaid clients and individuals applying for or receiving DSHS or DCYF services.

You must register an HCA account with Universal in order to request an interpreter.

- Universal will train providers how to access an interpreter using their online service portal.

Services will only be covered by the HCA IS program if:

- The client is current Medicaid eligible
- The client is enrolled in a Managed Care plan (IMC eligible)
- Services are covered in their benefit package
- Services are provided by an HCA enrolled Medicaid Provider

HCA Transportation Brokers

- Medicaid clients may be eligible for non-emergency medical transportation, which can be arranged and paid for Medicaid clients with no other means to access medical care through HCA contracted brokers listed below. 7-14 days advance notice is recommended.

- The HCA Non-Emergency Medical Transportation (NEMT) program now allows non-emergency transportation for all clients going to and/or from SUD or MH facilities for any length of stay.

HCA Transportation Brokers

Transportation Broker		
Region	Broker	Contact
Thurston Mason	Paratransit Services	360-377-7007 1-800-846-5438 TDD/TTY: 1-800-934-5438
Great Rivers *Grays Harbor, Lewis and Pacific Counties*	Paratransit Services	360-377-7007 1-800-846-5438 TDD/TTY: 1-800-934-5438
Cowlitz and Wahkiakum Counties	Human Services Council	360-694-9997 1-800-752-9422

MCO Website Content

- Clinical and Payment Policies
- Clinical Practice Guidelines
- Frequently Used Forms
- HEDIS Guides
- Preferred Drug List
- Provider Manuals
- Provider Newsletters and Announcements
- Provider Portal Link
- Provider Training and Resource Materials
- Verify Prior Auth requirements

MCO Website Links for Providers

MCO	Website Link
Amerigroup	https://providers.amerigroup.com/WA
Coordinated Care	www.coordinatedcarehealth.com/providers.html
Molina Healthcare	www.molinahealthcare.com/providers/wa/medicaid/Pages/home.aspx
UnitedHealthcare Community Plan	www.uhcprovider.com/communityplan

Provider Portal Content

- Authorization status and submission
- Case management referrals
- Check member eligibility and benefits
- Claim audit tool
- Claim submission and status
- Claim correction and resubmission
- Member rosters
- Member care gaps
- Secure transactions
- Update practice information

MCO Portal Links for Providers

MCO	Portal Link
Amerigroup	https://apps.availity.com/availity/web/public.elegant.login?source=MBU
Coordinated Care	www.coordinatedcarehealth.com/login.html
Molina Healthcare	Access Molina WebPortal via OneHealthPort. If new to OneHealthPort, register here: http://www.onehealthport.com/sso/register-your-organization
UnitedHealthcare Community Plan	www.uhcprovider.com/en/health-plans-by-state/washington-health-plans/wa-comm-plan-home.html?rfid=UHCCP

Provider Directory Links

- Amerigroup
  https://providers.amerigroup.com/pages/providerdirectory.aspx
- Coordinated Care
  https://providersearch.coordinatedcarehealth.com/
- Molina Healthcare
  https://providersearch.molinahealthcare.com/
- UnitedHealthcare Community Plan:
  https://www.uhcprovider.com/en/find-a-provider-referral-directory.html

Frequently Used Forms

Available on MCO websites:

- PCP Change
- Critical Incident Report
- Release of Information/Authorization for Use and Disclosure of PHI
- Prior Authorization/Concurrent Review Request
- BH Prior Authorization/Concurrent Review Request
- Care Management Referral
- Appeal Consent

Helpful Links

- Provider Manuals
  - Amerigroup: https://providers.amerigroup.com/ProviderDocuments/WAWA_Provider_Manual.pdf
  - Coordinated Care: https://www.coordinatedcarehealth.com/providers/resources/forms-resources.html
  - Molina Healthcare: http://www.molinahealthcare.com/providers/wa/medicaid/manual/Pages/provman.aspx
  - UnitedHealthcare Community Plan: https://www.providerexpress.com/content/dam/ope-provexpr/us/pdfs/clinResourcesMain/guidelines/stateAddendums/waIMC-NetworkManual.pdf
- WISe Manual- https://www.hca.wa.gov/assets/billers-and-providers/wise-wraparound-intensive-services-manual.pdf
- SERI: https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/service-encounter-reporting-instructions-seri
- HCA Billing Guides: https://www.hca.wa.gov/billers-providers/claims-and-billing/professional-rates-and-billing-guides

Questions and Answers

Thank you for joining us today!