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GOVERNMENT PROGRAMS

Compliance Officer Newsletter

A Message from Kim Green:

My goal for each Government Programs Compliance Officer Newsletter is to provide you with information about the various government programs administered by HCSC.

HCSC is a Plan Sponsor that administers several Federal and State Government Programs, including:

- Medicare Advantage
- Medicare Prescription Drug Plan
- Illinois Medicare-Medicaid Alignment Initiative (MMAI) and
- Medicaid

As a Plan Sponsor, we have the responsibility to know and adhere to the requirements of all the contracts we administer. If we fail to meet those requirements, we are at risk for being subjected to various enforcement actions.

In our previous newsletter, we reviewed the importance of having robust issue management processes for government programs business areas. To effectively respond to issues as they arise, business areas supporting government programs must seek out and address the root cause of an issue in order to respond and minimize impacts and the chance of reoccurrence. In this volume we highlight root cause considerations, elements, and examples of root cause analysis.

As the Government Programs Compliance Officer, please know you can always contact me directly at 312-653-5110.

Kim Green

HCSC Government Programs Compliance Officer





GPC Resources:

NM Medicaid

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IL Medicaid

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Kirstie Reck,
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Medicare/MMAI

Kathleen Klein,
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Debarment

Denise Anderson, Senior Manager



Root Cause Analysis (RCA)

Root cause analysis is a method of investigation that is often used to seek out the *true underlying cause* of an issue to better understand the problem: *why* it occurred, *what* can be done to address the immediate harm caused by the issue (remediation), and *what* can be done moving forward to prevent reoccurrence (corrective action).



The root cause is the true underlying cause of an issue.



Root cause **is not** a restatement of the issue or timeline of events that occurred leading to the outcome.

Root Cause Considerations

Root cause can come from a variety of sources and can be impacted by different contributing factors. In particular, and as covered in a previous GPCO newsletter (Q3 2022), root causes often tie back to 3 common areas – people, processes, and policy. Things to consider when looking at each area include:





POLICY

Awareness of personnel impacts or changes and other contributing factors are key considerations when getting started on any RCA. For example, if there is an organizational change and work is not properly transitioned or new staff are not properly trained on regulatory requirements, this could be a root cause of an issue of noncompliance.

Evaluate whether currently processes adhere to contract and regulatory standards. **Ensuring accountability** across process steps helps to mitigate risks before they become issues. Broken or siloed processes that are missing required steps can lead to gaps that create issues of noncompliance (e.g., failure to develop end-to end processes that consider all key stakeholder departments.)

Assess whether the process is completely and clearly documented in a manner that articulates what the requirement demands. Missing or incomplete documentation that doesn't include all operational departments can lead to issues of noncompliance.



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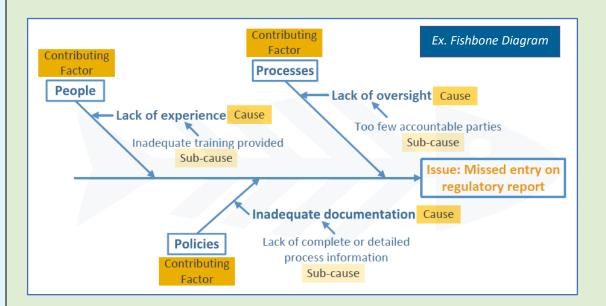
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RCA Example

A common RCA method is known as an *Ishikawa "Fishbone" Diagram*¹. A Fishbone diagram can be used to brainstorm what elements may have contributed to the problem to assess different factors as you work towards the **root cause**. It allows teams to jointly assess some of the considerations outlined above to drill down to the root cause of the issue (*see example below*).

¹More information about Fishbone Diagrams and their use can be found at the American Society for Quality's website (https://asq.org/quality-resources/fishbone)



Once root cause is determined, develop the appropriate solution for short term (immediate) remediation and long-term corrective action (prevent reoccurrence).

1 ISSUE:

There was a missed entry on a report that was sent to a regulator.

(2) ROOT CAUSE ANALYSIS:

The individual who usually reviews and submits the report was on PTO, so a colleague covered the submission. It was found that quality checks for accuracy and completeness were not a documented part of the responsible party's pre-submission process.

3 REMEDIATION:

A review of the data was conducted, and a corrected report was sent to the regulator, ensuring the final submission was accurate.

4 CORRECTIVE ACTION:

The responsible department's SOPs were updated to include quality checks to ensure anyone covering this activity performs the appropriate reviews.



Root Cause and Your Role

RCA uncovers both the 'what' and 'why' behind problems to inform corrective actions. Corrective actions addressing root causes offer a preventative approach to tackling issues at their source and avoiding reoccurrence.

1 RECOGNIZE:

Evaluate impacts. Investigate what initiated a particular event rather than merely tackling its symptoms.

(2) RECTIFY:

Create restorative process measures. RCA helps our organization study events that resulted in undesired outcomes and identify strategies to reduce future error and improve member experience.

3 REPLICATE:

Monitor, document and verify results. Chosen strategies must be monitored for effectiveness to prevent similar issues from occurring at a later time.

In Summary...

- Root Cause Analysis (RCA) is an important component of issue resolution and corrective action activities that aid in more targeted solutions aimed at preventing issue reoccurrence.
- Stakeholder engagement, coordination, and cooperation is important for confirming that all details and facts about the issue are accurately documented, reported, and applied when conducting RCA, remediation, and corrective action activities.
- Understanding the regulatory and contractual requirements impacting the line
 of business helps to keep teams focused on assessing gaps related to processes
 and our P&Ps, SOPs, etc.
- Take away: the root cause of any issue is quickly identified, a targeted solution is developed and acted upon, and results are documented and monitored to avoid reoccurrence.