GOVERNMENT PROGRAMS
Compliance Officer Newsletter

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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.

This newsletter edition will look at the importance of good root cause analysis to prevent recurrence of errors or events with risky or negative impact. Incidents occur every day that put our organization at risk. How we deal with these problems makes a difference. We need to stay in compliance with regulatory guidelines and contractual requirements, so it's important we investigate and address issues or risks correctly and completely to ensure that same issue doesn't happen again.

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
Government Programs Compliance

GPC Resources:

Enterprise Medicaid/Debarment
Melissa Lupella, Senior Director

NM Medicaid
Jeanene Kerestes, Senior Director

IL Medicaid
Yvonne Yang, Director

TX Medicaid
Kirstie Reck, Director

Medicare/MMAI
Kathleen Klein, Director

What is Root Cause Analysis (RCA)?

Root cause analysis is the process of discovering the causes of problems in order to identify appropriate solutions. When an issue has occurred, you need to identify the *true* cause, referred to as the *root* cause. The 5 Whys is an excellent analysis tool to use. Start with the event and ask why it happened, then why the 1st why happened, etc. until you can't ask why anymore. Continue asking why until you feel you have reached the root; you don't have to stop at five.
Keep in mind there can be more than one root cause or multiple factors contributing to the event that should be explored. Take the time to examine the causes and effects thoroughly. The goal is to look beneath the surface to find what really caused the event so you can prevent it from happening again.

When Would I Use RCA?

Anytime you have an issue, RCA is necessary for developing effective remediation. When you work with GPC on an issue, we will request an RCA and expect to see remediation efforts and preventive action plans that address the root cause.

We Had an "Uh-oh;" What Do I Do Now?

If you find an issue, tell your management, even if you think it might be small – it could be part of a larger issue or an issue of non-compliance. Managers, be sure to notify GPC of the event right away if you know or suspect it is non-compliance. GPC will work with you as you develop:

1. Immediate corrective action(s)
2. Identify what happened through root cause analysis (RCA)
3. Put preventive measures in place that address the root cause of the issue

EXAMPLE

Issue/Event/Symptom	Immediate Cause	Root Cause	Resolution
Materials submitted late	Heavy workload	Understaffed	Conduct a staffing analysis to determine if hiring or realignment of staff is warranted
Call Center missing performance standards	CAs spend lots of time explaining details to members on calls to minimize confusion	Materials mailed to members were unclear	In future, write correspondence to more clearly state objective
Regulator returns inaccurate report	Employee pulls information from an incorrect source	Regulatory requirements are not known No quality check process in place	Additional training Verify that a quality check process exists and/or institute a quality check process

GPC
Government Programs Compliance

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What Are the 3 P's of Analysis?

Regardless of the root cause, start by looking at the 3 P's, which are at the heart of any RCA.

People – Most RCA leads back to a person (or persons) making an error. But a true root cause would explain what caused the person to make the error. Look at all the factors that led to the person acting outside what is expected.

Process – Look critically at your existing process: Was it sound and proven or was it a process that was designed to fail? Look for ways to hardwire the process for your team. Make sure someone is responsible for all points of the process. If you feel you need a new process, make sure it's in alignment with the organization's policies and with your area's risk assessment findings.

Policy – Are you supporting your team by having adequate P&Ps, Job Aids, SOPs, etc.? If you have those things, were your expectations clear to the team members or does your documentation need updates or clearer language?

Wrapping Up

1. ***Root Cause Analysis is not an "extra."*** It is essential to developing effective remediation.
2. ***Root cause analysis doesn't have to be lengthy or complicated.*** But you do need to have an objective and non-judgmental attitude and be willing to dig deep enough to get to the bottom of why the event happened. Only then can you devise a meaningful solution to prevent recurrence.
3. ***Keep an open mind.*** Preconceived ideas of what caused the issue can lead you down the wrong path. It wastes time and effort when you implement a change that has no impact and allows the same event to occur again and again in the future.
4. ***Managers don't have to go it alone.*** Get the team involved in the RCA process. Allow and encourage brainstorming. No suggested cause or solution is a bad one – write them all down to get the most diverse ideas available.
5. ***Make it fun.*** Treat it as a puzzle to solve rather than an unpleasant chore.

Additional tools/resources:

- ***Ishikawa Diagram ("Fishbone" chart)*** – list of causes leading to the event related to 4-6 categories. Most commonly used categories are: Environment, Tools, People, Materials, Method, & Measurement.
- ***Process Mapping*** – flow chart for process steps.
- ***Lean or Six Sigma tools*** – for more in-depth analysis.