<u>**SHB 2571**</u> - H AMD **1043**
    By Representative Parker

1   Strike everything after the enacting clause and insert the
2   following:

3   "<u>NEW SECTION.</u> **Sec. 1.** It is the intent of the legislature to:
4   (1) Implement waste, fraud, and abuse detection, prevention, and
5   recovery solutions to improve program integrity for medical services
6   programs in the state and create efficiency and cost savings through a
7   shift from a retrospective "pay and chase" model to a prospective
8   prepayment model; and
9   (2) Invest in the most cost-effective technologies or strategies
10   that yield the highest return on investment.

11   <u>NEW SECTION.</u> **Sec. 2.** The definitions in this section apply
12   throughout this chapter unless the context clearly requires otherwise.
13   (1) "Authority" means the Washington state health care authority.
14   (2) "Enrollee" means an individual who receives benefits through a
15   medical services program.
16   (3) "Medical services programs" means those medical programs
17   established under chapter 74.09 RCW, including medical assistance, the
18   limited casualty program, children's health program, medical care
19   services, and state children's health insurance program.

20   <u>NEW SECTION.</u> **Sec. 3.** (1) Not later than September 1, 2012, the
21   authority shall issue a request for information to seek input from
22   potential contractors on capabilities that the authority does not
23   currently possess, functions that the authority is not currently
24   performing, and the cost structures associated with implementing:
25   (a) Advanced predictive modeling and analytics technologies to
26   provide a comprehensive and accurate view across all providers,
27   enrollees, and geographic locations within the medical services
28   programs in order to:

1   (i) Identify and analyze those billing or utilization patterns that
2 represent a high risk of fraudulent activity;
3   (ii) Be integrated into the existing medical services programs
4 claims operations;
5   (iii) Undertake and automate such analysis before payment is made
6 to minimize disruptions to agency operations and speed claim
7 resolution;
8   (iv) Prioritize such identified transactions for additional review
9 before payment is made based on the likelihood of potential waste,
10 fraud, or abuse;
11   (v) Obtain outcome information from adjudicated claims to allow for
12 refinement and enhancement of the predictive analytics technologies
13 based on historical data and algorithms with the system;
14   (vi) Prevent the payment of claims for reimbursement that have been
15 identified as potentially wasteful, fraudulent, or abusive until the
16 claims have been automatically verified as valid;
17   (b) Provider and enrollee data verification and screening
18 technology solutions, which may use publicly available records, for the
19 purposes of automating reviews and identifying and preventing
20 inappropriate payments by:
21   (i) Identifying associations between providers, practitioners, and
22 beneficiaries which indicate rings of collusive fraudulent activity;
23 and
24   (ii) Discovering enrollee attributes which indicate improper
25 eligibility, including, but not limited to, death, out-of-state
26 residence, inappropriate asset ownership, or incarceration; and
27   (c) Fraud investigation services that combine retrospective claims
28 analysis and prospective waste, fraud, or abuse detection techniques.
29 These services must include analysis of historical claims data, medical
30 records, suspect provider databases, and high-risk identification
31 lists, as well as direct enrollee and provider interviews. Emphasis
32 must be placed on providing education to providers and allowing them
33 the opportunity to review and correct any problems identified prior to
34 adjudication.
35   (2) The authority is encouraged to use the results of the request
36 for information to create a formal request for proposals to carry out
37 the work identified in this section if the following conditions are
38 met:

1   (a) The authority expects to generate state savings by preventing
2 fraud, waste, and abuse;
3   (b) This work can be integrated into the authority's current
4 medical services claims operations without creating additional costs to
5 the state;
6   (c) The reviews or audits are not anticipated to delay or
7 improperly deny the payment of legitimate claims to providers.

8   NEW SECTION. **Sec. 4.** It is the intent of the legislature that the
9 savings achieved through this chapter shall more than cover the cost of
10 implementation and administration. Therefore, to the extent possible,
11 technology services used in carrying out this chapter must be secured
12 using the savings generated by the program, whereby the state's only
13 direct cost will be funded through the actual savings achieved.
14 Further, to enable this model, reimbursement to the contractor may be
15 contracted on the basis of a percentage of achieved savings model, a
16 per beneficiary per month model, a per transaction model, a case-rate
17 model, or any blended model of the aforementioned methodologies.
18 Reimbursement models with the contractor may include performance
19 guarantees of the contractor to ensure savings identified exceeds
20 program costs.

21   NEW SECTION. **Sec. 5.** Sections 1 through 4 of this act constitute
22 a new chapter in Title 74 RCW.

23   NEW SECTION. **Sec. 6.** If any provision of this act or its
24 application to any person or circumstance is held invalid, the
25 remainder of the act or the application of the provision to other
26 persons or circumstances is not affected.

27   NEW SECTION. **Sec. 7.** This act takes effect July 1, 2012."

28   Correct the title.

   EFFECT: Specifies that it is the intent of the legislature to
invest in the most cost-effective technologies or strategies that yield

the highest return on investment. Specifies that the request for information (RFI) should seek input on capabilities that the Health Care Authority (HCA) does not currently possess and functions that the HCA is not currently performing. Includes provider and enrollee data verification, which may use publicly available records, in the topics that the HCA is directed to seek input on in the RFI.

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