Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health & Human Services Appropriations & Oversight Committee

HB 2571

Brief Description: Concerning waste, fraud, and abuse prevention, detection, and recovery to improve program integrity for medical services programs.

Sponsors: Representatives Parker, Cody, Dammeier, Darneille, Alexander, Schmick, Orcutt, Hurst and Kelley.

Brief Summary of Bill

- Requires the Health Care Authority (HCA) to implement provider data verification and screening technologies to prevent inappropriate payments to providers.
- Directs the HCA to implement a centralized database of unchanged claims data submitted by providers and perform analytics on the data to support rate-setting processes for direct services and managed care plans.
- Requires the HCA to implement predictive modeling and analytics technologies to find patterns that represent high risks of fraudulent activity and prevent payment of suspect claims until the claims have been verified as valid.
- Directs the HCA to implement investigation services that combine retrospective and prospective analyses of waste, fraud, and abuse.
- Requires the HCA to audit claims and recover payments that were made improperly for reasons unrelated to fraud.
- Directs the HCA to contract for these services through a shared-savings model where the state's only direct cost is providing a portion of the actual savings to the contractor.
- Requires the HCA to provide the contractor with access to claims and data necessary to carry out the work.
- Directs the HCA to report to the Legislature within three months of the completion of each of the first three years of these programs on their progress and effectiveness.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

Hearing Date: 1/26/12

Staff: Erik Cornellier (786-7116).

Background:

State Medical Programs.

The Health Care Authority (HCA) administers various medical programs, including Medicaid, Apple Health for Kids, the Medical Care Services (MCS) program, and the Limited Casualty program.

Medicaid is a health care program for qualifying low-income and needy people, including children, the elderly, and persons with disabilities. The program is a federal-state partnership established under the federal Social Security Act, and implemented at the state level with federal matching funds. Each state program must establish a plan that meets specified requirements mandated by the federal Centers for Medicare and Medicaid Services (CMS).

The Apple Health for Kids program, which provides medical coverage for children under age 19 in families with incomes at or below 300 percent of the federal poverty level (FPL). Apple Health for Kids includes three programs for financing this coverage. The joint state-federal Medicaid program provides coverage for children with family incomes at or below 133 percent of the FPL. The joint state-federal Children's Health Insurance Program (CHIP) provides coverage for children with family incomes above 133 percent and at or below 300 percent of the FPL. The state-funded Children's Health Program (CHP) provides coverage for children with family incomes at or below 300 percent of the FPL who are not eligible for Medicaid or CHIP due to their citizenship status. Children in the CHP with family incomes at or above 200 percent of the FPL must pay premiums equal to the average state per capita cost of other children in the CHP.

The MCS program provides limited scope medical coverage to persons who are incapacitated from gainful employment for a minimum of 90 days. To be eligible, a person must have countable income at or below $339 per month. Additionally, persons who qualify for the Aged, Blind, and Disabled Assistance Program or for services under the Alcohol and Drug Addiction Treatment and Support Act are eligible for the MCS program.

The Limited Casualty program is a medical care program provided to medically needy persons and medically indigent persons without income or resources sufficient to secure necessary medical services. Medically needy persons with incomes higher than the Medicaid eligibility standards are eligible for coverage if their medical expenses are large enough to reduce their remaining incomes to levels consistent with Medicaid eligibility standards.

Managed care is a prepaid, comprehensive system of medical and health care delivery, including preventive, primary, specialty, and ancillary health services. Healthy Options is the Medicaid managed care program for low-income people in Washington. Healthy Options offers eligible families, children under age 19, and pregnant women a complete medical benefits package. The HCA intends to include clients who are eligible for federal Supplemental Security Income payments, but not Medicare, in managed care starting in July 2012.

Patient Protection and Affordable Care Act.

The federal Patient Protection and Affordable Care Act (Affordable Care Act) provided new authorities to federal and state governments to promote program integrity and combat fraud, waste, and abuse in federal health care programs. The CMS is adopting policies to prevent payment of fraudulent claims rather than chasing fraudulent providers after payments have been made. The CMS issued Final Rule 6028, which created enhanced screening procedures for providers and required states to terminate providers that have been terminated for cause by Medicare or another state Medicaid agency. Final Rule 6028 also requires states to withhold payments to Medicaid providers prospectively when there are credible allegations of fraud.

Program Integrity.

The HCA's Office of Program Integrity performs activities designed to ensure correct payment for services to the right providers for eligible clients. The activities include provider enrollment and support, payment system controls, pre-payment adjustments, post-payment reviews, provider audits, and advanced data mining algorithms and models.

Summary of Bill:

Intent.

The bill states that its purpose is to implement waste, fraud, and abuse detection, prevention, and recovery solutions to shift from a retrospective "pay and chase" model to a prospective prepayment model and comply with the program integrity provisions of the Patient Protection and Affordable Care Act and the Centers for Medicare and Medicaid Services' (CMS) Final Rule 6028.

New Program Integrity Provisions.

The new program integrity provisions apply to Medicaid, the Children's Health Insurance Program, the Children's Health Program, the Medical Care Services program, and the Limited Casualty program.

The Health Care Authority (HCA) is required to implement provider data verification and screening technology solutions that check billing data against a continually maintained provider information database. These solutions must automate reviews to identify and prevent inappropriate payments to deceased providers, sanctioned providers, providers with expired licenses, retired providers, and providers with confirmed wrong addresses.

The HCA is also required to implement a centralized database that must contain unchanged claims data submitted by providers. The HCA must perform analytics on the complete data set to support the establishment of appropriate levels of payment for direct care of enrollees and managed care plans.

The HCA must implement predictive modeling and analytics technologies to identify and analyze billing or utilization patterns that represent high risks of fraudulent activity. These

technologies must be integrated into existing claims operations, and the analyses must be conducted before payments are made. The HCA must prioritize identified transactions for additional review before payment is made and prevent payment until the claims have been automatically verified as valid. The HCA must also obtain outcome information from adjudicated claims to allow for refinement and enhancement of the predictive analytics technologies.

The HCA is required to implement fraud investigation services that combine retrospective claims analysis and prospective waste, fraud, and abuse detection techniques. The services must include analysis of historical claims, medical records, suspect provider databases, high-risk identification lists, and direct enrollee and provider interviews. The HCA must also emphasize provider education and allow providers opportunities to review and correct any problems identified prior to adjudication.

The HCA must audit claims, identify improper payments due to nonfraudulent issues, obtain provider approval of audit results, and recover validated overpayments. The reviews must confirm that the diagnosis and procedure codes are accurate and valid based on supporting physician documentation within medical records.

The HCA is required to provide all entities that the HCA contracts with to perform these program integrity activities with appropriate access to claims and data necessary to carry out the work. This includes current and historical claims and provider database information. The HCA must also take necessary regulatory action to facilitate public-private data sharing that includes the Medicaid managed care entities.

Contracting.

By September 1, 2012, the HCA must issue a request for information (RFI) to seek input from potential contractors on capabilities and costs associated with the scope of work. The HCA must use the results of the RFI to issue a formal request for proposals (RFP) that it must issue within 90 days of the closing date of the RFI. The RFP will cover the first year of implementation, and the HCA may include subsequent implementation years.

The HCA must secure required technology services through a shared savings model where the state's only direct cost is providing a portion of the actual savings to the contractor. A percentage of the achieved savings may also be used to fund required expenditures.

Reports to the Legislature.

The HCA must submit reports to the Legislature within three months of the completion of the first, second, and third years of operation of these programs. The reports must include descriptions of the implementation of technologies during the previous year, the actual and projected savings resulting from these technologies, modifications that should be made to increase savings or mitigate adverse impacts on clients or providers, and the extent to which these technologies prevented and detected waste, fraud, and abuse. The reports must also include analyses of whether the technologies affected access and quality for clients and how the technologies and education efforts impacted providers.

Appropriation: None.

Fiscal Note: Requested on January 18, 2012.

Effective Date: The bill takes effect on July 1, 2012.