# FINAL BILL REPORT
# ESHB 2571

**C 234 L 12**
Synopsis as Enacted

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

**Sponsors**: House Committee on Health & Human Services Appropriations & Oversight (originally sponsored by Representatives Parker, Cody, Dammeier, Darneille, Alexander, Schmick, Orcutt, Hurst and Kelley).

**House Committee on Health Care & Wellness**
**House Committee on Health & Human Services Appropriations & Oversight**
**Senate Committee on Ways & Means**

**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 Medicaid 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 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: (1) the joint state-federal Medicaid program which provides coverage for children with family incomes at or below 133 percent of the FPL; (2) the joint state-federal Children's Health Insurance Program (CHIP) which provides coverage for children with family incomes above 133 percent and at or below 300 percent of the FPL; and (3) the state-funded Children's Health Program (CHP) which 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

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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, prepayment adjustments, postpayment reviews, provider audits, and advanced data mining algorithms and models.

**Summary**:

Intent.

The act's stated 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. The act also states that it is the Legislature's intent to invest in the most cost-effective technologies or strategies that yield the highest returns on investment.

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 issue a request for information (RFI) by September 1, 2012, to seek input from potential contractors on implementing program integrity measures. The RFI will focus on capabilities that the HCA does not currently possess and functions that the HCA is not currently performing.

The RFI will seek input about predictive modeling and analytics technologies to identify and analyze billing or utilization patterns that represent high risks of fraudulent activity. The technologies would be integrated into existing claims operations and conducted before payments are made. The technologies would also prioritize identified transactions for additional review before payment is made and prevent payment until the claims have been automatically verified as valid.

The RFI will also seek input on provider and enrollee data verification and screening technologies to automate reviews and prevent inappropriate payments. The technologies should identify associations between providers and beneficiaries that indicate rings of collusive fraudulent activity. They should also discover enrollee attributes which indicate improper eligibility such as death, out-of-state residence, inappropriate asset ownership, or incarceration. These technologies may use publicly available records.

The RFI will inquire about 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 RFI must also emphasize provider education and allow providers opportunities to review and correct any problems identified prior to adjudication.

Upon completion of the RFI, the HCA is encouraged to issue a request for proposals to carry out the work if the HCA expects to generate state savings, the work can be integrated into the HCA's current claims operations without additional costs, and the reviews or audits are not anticipated to delay or improperly deny the payment of legitimate claims.

Contracting.

The act's stated intent is that the savings achieved through the program integrity provisions must more than cover the cost of implementation and administration. The HCA must secure any 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.

**Votes on Final Passage:**

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| House | 96 | 1 |
| Senate | 49 | 0 |

**Effective:** July 1, 2012