HOUSE BILL REPORT
ESHB 2571

As Passed Legislature

Title: An act relating to waste, fraud, and abuse prevention, detection, and recovery to improve program integrity for medical services programs.

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).

Brief History:

Committee Activity:

Health & Human Services Appropriations & Oversight: 1/26/12, 1/31/12, 2/2/12 [DPS].

Floor Activity:

Passed House: 2/13/12, 96-1.
Passed Senate: 3/8/12, 49-0.
Passed Legislature.

Brief Summary of Engrossed Substitute Bill

- Requires the Health Care Authority (HCA) to issue a request for information (RFI) about implementing new program integrity provisions for various low-income medical programs.
- Requires the RFI to request input on 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.
- Requires the RFI to seek input on provider and enrollee data verification technologies.
- Requires the RFI to request input on investigation services that combine retrospective and prospective analyses of waste, fraud, and abuse.
- Encourages the HCA to issue a request for proposals to implement these program integrity provisions under specified conditions.

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.

- Requires contracts for these services to use a shared-savings model where the state's only direct cost is providing a portion of the actual savings to the contractor.

HOUSE COMMITTEE ON HEALTH & HUMAN SERVICES APPROPRIATIONS & OVERSIGHT

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 11 members: Representatives Dickerson, Chair; Appleton, Vice Chair; Johnson, Ranking Minority Member; Schmick, Assistant Ranking Minority Member; Cody, Green, Harris, Kagi, Overstreet, Pettigrew and Walsh.

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 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 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 of Engrossed Substitute 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. The bill 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 bill's stated intent is that the savings achieved through the program integrity provisions shall 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.

Appropriation: None.

Fiscal Note: Available.

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

Staff Summary of Public Testimony:

(In support) The Health Care Authority (HCA) has done a great job and is ahead of many states in fighting fraud, waste, and abuse. In the face of budget constraints and increasing enrollment under the federal Affordable Care Act, Washington should implement multiple proven safety nets to stop fraud, waste, and abuse. The federal General Accounting Office estimated nationwide Medicaid fraud at $48 billion in 2011. This ranges from organized crime to petty theft, and it is an epidemic that is growing. A person does not have to be a provider to open up a storefront, get a provider's Medicaid number, find a non-English-speaking individual to act as the front person, issue bills to the government, and collect paychecks in the mail.

This bill requires predictive modeling and doctor verification to prevent fraud. The HCA currently uses a rules-based system that criminals can adapt to. The HCA would use algorithms to prevent payments when fraud is likely, similar to the systems at gas stations that require customers to enter their zip codes when using credit or debit cards. This is not for data mining purposes or advertising. This is a prevention and detection model instead of a pay and chase model. Claims must be verified before they are paid. This would not delay payments because it is based on real-time claims data, and there will be no impacts on beneficiaries. Typically no more than 1 to 2 percent of the claims would be flagged for likelihood of fraud, and of those no more than 50 percent would be recommended for investigation. The remainder of the claims would be processed with no more than a 24-hour delay.

One question is when Medicare fraud is translating to Medicaid fraud, how does Washington stay one step ahead? These solutions are used in the private sector and the federal government is investigating them for Medicare. States will be the last adopters for Medicaid, which will cause adverse selection. Slower adopters will be targets of fraud.

This is model legislation that could save states an average of $80 million by preventing fraud, waste, and abuse. There are no startup costs because it is based on a shared savings model. Washington can expect savings from $5 to $20 million. These savings could prevent future drastic measures such as decreased benefits or provider rates that would hurt all providers when only the bad actors should be punished.

The legislation is not specific to any vendor. There are about five vendors that provide these services.

The bill would also help the state comply with federal rules.

(Neutral) It would be beneficial to have a provider information database to stop inappropriate payments, especially if this could help doctors by keeping money in the system for doctors instead of fraud. There are some concerns, however, about whether this will cause delays in legitimate payments. Delays are a real-life burden on practices and cause doctors to opt out of participating in Medicaid.

Under a shared savings approach, the contractor would have an incentive to block legitimate claims.

There is no way to ensure that the retrospective auditing system in this bill is different than the current auditing system.

(Opposed) The HCA is not against rooting out fraud, waste, and abuse in Medicaid. Washington is an established leader in this area. This bill directs the HCA to do what federal law already requires under program integrity statutes from the 1970s through to the present in the Affordable Care Act. Currently Washington is compliant with those requirements.

The HCA also issued a number of competitive acquisitions recently to enhance program integrity, and has a second generation Fraud and Abuse Detection System contract under a federal transformation grant. The HCA also has a contract for data analytics and modeling and a contingency-based contract to find third party liability. The ProviderOne system uses prepayment editing to ensure Medicaid payment accuracy. The HCA already has a request for proposals for recovery audit contractors.

This bill is modeled after the federal Small Business Jobs Act and requires predictive modeling. The federal bill required Medicare to try predictive modeling at a cost of $77 million and report back about the applicability to Medicaid in 2015. The HCA would rather learn from Medicare's experience with these technologies.

When a claim comes in there are 1,100 edits in the system related to provider eligibility, coding, and quantity limits. Predictive modeling software would create limitations for providers above a certain number of claims, which the HCA already does through the edits process.

Under the shared savings model, it will be very difficult to figure out which exact edits denied the claims and what savings were generated. It will be very hard to base this kind of a contract and procurement on that model.

This technology comes from the credit card industry and there are some differences in the health care world. Grouping providers with their peers and deciding the providers are billing outside of the normal range of their peers is a problem in the Medicaid world because it does not show the total picture of what the provider is doing. When the HCA runs predictive modeling on a post pay basis it sometimes finds providers that only provide Medicaid services. The technology is not ready yet but the HCA plans to watch it as it matures.

Persons Testifying: (In support) Representative Parker, prime sponsor; Noah Reandeau, Gordon Thomas Honeywell; Robin Kingston, Emdeon; and Patrick Connor, National Federation of Independent Business.

(Neutral) Katie Kolan, Washington State Medical Association.

(Opposed) Heidi Robbins-Brown and Cathie Ott, Health Care Authority.

Persons Signed In To Testify But Not Testifying: None.