# SENATE BILL REPORT
# ESHB 2571

As Reported by Senate Committee On:
Ways & Means, February 21, 2012

**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:** Passed House: 2/13/12, 96-1.
**Committee Activity**: Ways & Means: 2/20/12, 2/21/12 [DP].

## SENATE COMMITTEE ON WAYS & MEANS

**Majority Report**: Do pass.
Signed by Senators Murray, Chair; Kilmer, Vice Chair, Capital Budget Chair; Zarelli, Ranking Minority Member; Parlette, Ranking Minority Member Capital; Baumgartner, Conway, Fraser, Harper, Hatfield, Hewitt, Holmquist Newbry, Honeyford, Kastama, Keiser, Kohl-Welles, Padden, Pflug, Pridemore, Regala, Schoesler and Tom.

**Staff**: Tim Yowell (786-7435)

**Background**: At maintenance level, the state is expected to spend $4.8 billion on low-income medical assistance programs this year. Of that total, $2.2 billion will be from state funds, and most of the rest from the federal Medicaid program. The state's low-income medical assistance programs include Medicaid, the State Children's Health Insurance Program, the Basic Health Plan, and the Disability Lifeline and Alcohol and Drug Abuse Treatment and Support Act medical care services programs. These programs are administered by the state Health Care Authority (HCA), and together they will provide coverage for an average of about 1.2 million people per month this year.

The HCA Office of Program Integrity is responsible for detecting, recovering, and to the extent possible preventing inaccurate, excessive, and/or fraudulent payments by the state

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medical assistance programs. The office and its contracted fraud and abuse detection system vendor expend approximately $6.1 million per year in this effort on activities that include:

- applying over 1100 electronic edits through the new ProviderOne electronic payment system to verify prior to payment client and provider eligibility for the services billed and the accuracy, reasonableness, and non-duplication of billings in terms of dates, procedures, quantities, and amounts billed;
- post-payment electronic data mining and predictive analysis to identify billings and billing patterns that are suspicious in terms of amounts, dates, or combinations of services billed;
- on-site checks and audits of billing records and practices;
- recovery of amounts inaccurately paid; and
- referral of potentially fraudulent billing to the Medicaid fraud control unit in the Office of the Attorney General and support for investigations by that office.

The federal Medicare program is in the first year of a three-year project to build and apply predictive profiles that will flag suspicious billings and billing patterns prior to payment. The ProviderOne electronic billing and payment system does not presently employ this type of pre-payment predictive profiling.

**Summary of Bill**: By September 1, 2012, HCA must seek information from potential contractors on their ability to provide fraud prevention, detection, and recovery activities that the HCA is not presently performing, and potential costs and payment arrangements for incorporating those into current HCA systems. HCA is encouraged to issue a formal request for proposals if it concludes from the information provided that it can generate savings from the additional functions; they can be integrated into current claims operations without creating additional costs for the state; and the new functions are not expected to delay or improperly deny legitimate claims. The Legislature intends for the savings achieved from any such new functions to exceed the cost of implementing and administering them. A variety of contractor payment arrangements are identified as possibilities for achieving this.

**Appropriation**: None.

**Fiscal Note**: Available.

**Committee/Commission/Task Force Created**: No.

**Effective Date**: July 1, 2012.

**Staff Summary of Public Testimony**: PRO: Fraud, particularly in the eastern part of the U.S., is thought to consume as much as 20 percent of all health care spending. The legislation requires that HCA issue a request for information to determine whether predictive analytics can save funds for Washington medical assistance programs. Over 20 other states are considering similar legislation.

**Persons Testifying**: PRO: Representative Parker, prime sponsor; Noah Reandeau, Gordon Smith Honeywell Governmental Affairs.