# SENATE BILL REPORT
# SB 6466

As Reported by Senate Committee On:
Health & Long-Term Care, February 2, 2012

**Title**: An act relating to improving program integrity for medicaid and the children's health insurance program by implementing waste, fraud, and abuse prevention, detection, and recovery.

**Brief Description**: Concerning fraud prevention and detection in the medicaid and the children's health insurance program.

**Sponsors**: Senators Holmquist Newbry, Harper, Hewitt, Hatfield, Kilmer, Fain, Schoesler, Ericksen, Shin, Sheldon, Keiser, Becker, King and Padden.

**Brief History:**
**Committee Activity**: Health & Long-Term Care: 1/26/12, 2/02/12 [DP-WM, w/oRec].

## SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

**Majority Report**: Do pass and be referred to Committee on Ways & Means.
Signed by Senators Keiser, Chair; Conway, Vice Chair; Carrell, Frockt and Kline.

**Minority Report**: That it be referred without recommendation.
Signed by Senators Becker, Ranking Minority Member; Parlette and Pflug.

**Staff**: Kathleen Buchli (786-7488)

**Background**: The Health Care Authority (HCA) administers various medical programs, including Medicaid and Apple Health for Kids. 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. Federal law requires each state administering a Medicaid program to establish and maintain an adequate internal control structure to ensure that Medicaid is administered in compliance with federal law. This control structure must be part of the approved state plan required to receive federal funding.

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

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enrollment and support, payment system controls, pre-payment adjustments, post-payment reviews, provider audits, and advanced data mining algorithms and models. ProviderOne, a Medicaid Management Information System, is the state's Medicaid payment system which performs pre-payment edits that verify client and provider eligibility, performs procedure and diagnosis code validation and limits, verifies duplicates and conflicts and calculates rates in accordance with appropriate rate structures. The contractor for ProviderOne was selected through a competitive bid process.

**Summary of Bill**: The state must implement waste, fraud, and abuse detection and prevention and recovery solutions to improve program integrity for Medicaid and the state Children's Health Insurance Program (SCHIP). This includes a requirement to implement state-of-the-art clinical code editing technology solutions to automate claims resolution and enhance cost containment through improved claims accuracy and appropriate code correction. Errors or potential overbilling must be identified based on widely accepted and transparent protocols such as the American Medical Association and the CMS. Edits must be applied before claims are adjudicated to speed processing and reduce the number of pended or rejected claims. Additionally, the state is to implement state-of-the-art predictive modeling and analytics technologies to provide a comprehensive and accurate view across all providers, beneficiaries, and geographies within the Medicaid and SCHIP. Billing or utilization patterns must be identified that represent a high risk of fraudulent activities, undertake analysis before payment is made, and prevent payment of claims that have been identified as potentially wasteful, fraudulent, or abusive under the claim has been automatically verified as valid.

Fraud investigative services must be implemented that combine retrospective claims analysis and prospective waste, fraud, or abuse detection techniques. Emphasis must be placed on providing education to providers and ensuring that they have the opportunity to review and correct any problems identified prior to adjudication. Medicaid and SCHIP claims audit and recovery services must be implemented to identify improper payments due to nonfraudulent issues, audit claims, obtain provider sign-off on the audit results, and recover validated overpayments. Post-payment reviews must ensure that the diagnoses and procedure codes are accurate and valid based on supporting physician documentation within the medical records.

The state must either contract with The Cooperative Purchasing Network to issue a request for proposals to select a contractor or they must contract as provided in the state procurement statute.

The state must issue three reports to the Legislature on the implementation of the waste, fraud, and abuse detection and prevention technologies. The reports must include actual and projected savings with respect to improper payments recovered or avoided and the return on investment of these technologies compared to other fraud detection methods; modifications to increase savings or reduce adverse impact on beneficiaries or providers; how these technologies prevented or detected fraud; and whether access to services has been affected.

The savings achieved through implementation of these technologies is intended to cover the costs of implementation. Technology is to be secured using a shared savings model, with the state's direct cost to be a percentage of the actual savings achieved.

**Appropriation**: None.

**Fiscal Note**: Available.

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

**Effective Date**: Ninety days after adjournment of session in which bill is passed.

**Staff Summary of Public Testimony**: PRO: This bill will have no fiscal note and will save the state between $5 million and $20 million. We use a pay and chase system right now and this bill would provide us with an additional tool, providing for prevention and detection. The federal government is looking at this model for Medicare. This would mirror the Affordable Care Act requirements and goes further by implementing a shared savings model. The systems used for this analysis employ a predictive modeling solution and it would not impact delivery to patients or providers.

CON: This bill will have a fiscal note. The bill would require a new claims data base and the state has already created one. The state does employ predictive modeling and uses prepayment auditing. Adding the state's particular requirements to a prepayment system would add a level of complexity in programming a new model.

**Persons Testifying**: PRO: Senator Holmquist Newbry, prime sponsor; Noah Reandeau, Gordon Thomas, Honeywell; Robin Kingston, Emdeon.

CON: Heidi Robbins Brown, Cathie Ott, HCA.