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HOUSE BILL 2571

State of Washington 62nd Legislature 2012 Regular Session

By Representatives Parker, Cody, Dammeier, Darneille, Alexander, Schmick, Orcutt, Hurst, and Kelley

Read first time 01/17/12. Referred to Committee on Health Care & Wellness.

AN ACT Relating to waste, fraud, and abuse prevention, detection, and recovery to improve program integrity for medical services programs; adding a new chapter to Title 74 RCW; and providing an effective date.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** It is the intent of the legislature to implement waste, fraud, and abuse detection, prevention, and recovery solutions to:

(1) Improve program integrity for medical services programs in the state and create efficiency and cost savings through a shift from a retrospective "pay and chase" model to a prospective prepayment model; and

(2) Comply with program integrity provisions of the federal patient protection and affordable care act and the health care and education reconciliation act of 2010, as adopted in the centers for medicare and medicaid services' final rule 6028.

NEW SECTION. **Sec. 2.** The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Authority" means the Washington state health care authority.

(2) "Enrollee" means an individual who receives benefits through a medical services program.

(3) "Medical services programs" means those medical programs established under chapter 74.09 RCW, including medical assistance, the limited casualty program, children's health program, medical care services, and state children's health insurance program, including those programs operated as managed care plans.

NEW SECTION. **Sec. 3.** The authority shall implement:

(1) Provider data verification and provider screening technology solutions to check health care billing and provider rendering data against a continually maintained provider information database for the purposes of automating reviews and identifying and preventing inappropriate payments to:

(a) Deceased providers;

(b) Sanctioned providers;

(c) Providers with expired licenses;

(d) Retired providers; and

(e) Confirmed wrong addresses;

(2) A centralized database for medical services programs. Claims for all enrollees in medical services programs must be compiled in the database, regardless of whether they receive their benefits directly from the health care authority or through a contracted private health insurer. The authority shall require that:

(a) The database contains unchanged claims data that is the complete data set as submitted by the provider before any risk of data loss or manipulation as claims pass through processing systems; and

(b) The analytics are performed on the complete data set to support the integrity and appropriate level of payment, not only for the direct care of the enrollees, but also in the establishment of the capitation rates to managed care plans;

(3) Advanced predictive modeling and analytics technologies to provide a comprehensive and accurate view across all providers, enrollees, and geographic locations within the medical services programs in order to:

(a) Identify and analyze those billing or utilization patterns that represent a high risk of fraudulent activity;

(b) Be integrated into the existing medical services programs claims operations;

(c) Undertake and automate such analysis before payment is made to minimize disruptions to agency operations and speed claim resolution;

(d) Prioritize such identified transactions for additional review before payment is made based on the likelihood of potential waste, fraud, or abuse;

(e) Obtain outcome information from adjudicated claims to allow for refinement and enhancement of the predictive analytics technologies based on historical data and algorithms with the system;

(f) Prevent the payment of claims for reimbursement that have been identified as potentially wasteful, fraudulent, or abusive until the claims have been automatically verified as valid;

(4) Fraud investigation services that combine retrospective claims analysis and prospective waste, fraud, or abuse detection techniques. These services must include analysis of historical claims data, medical records, suspect provider databases, and high-risk identification lists, as well as direct enrollee and provider interviews. Emphasis must be placed on providing education to providers and allowing them the opportunity to review and correct any problems identified prior to adjudication; and

(5) Medical services programs claims audit and recovery services to audit claims, identify improper payments due to nonfraudulent issues, obtain provider approval of the audit results, and recover validated overpayments. Reviews following payments must confirm that the diagnosis and procedure codes are accurate and valid based on the supporting physician documentation within the medical records. Core categories of review may include:

(a) Coding compliance diagnosis related group reviews;

(b) Transfers, readmissions, cost outlier reviews;

(c) Outpatient seventy-two hour rule reviews; and

(d) Payment error and billing error reviews.

NEW SECTION. **Sec. 4.** (1) Not later than September 1, 2012, the authority shall issue a request for information to seek input from potential contractors on capabilities and cost structures associated with the scope of work. The results of the request for information

must be used by the authority to create a formal request for proposals to be issued within ninety days of the closing date of the request for information.

(2) Not later than ninety days after the close of the request for information, the authority shall issue a formal request for proposals to carry out this section during the first year of implementation. To the extent appropriate, the authority may include subsequent implementation years and may issue additional requests for proposals with respect to subsequent implementation years.

NEW SECTION. **Sec. 5.** The authority shall provide entities with a contract under this chapter with appropriate access to claims and other data necessary for the entity to carry out the functions included in this chapter. This includes providing current and historical claims and provider database information regarding the medical services programs and taking necessary regulatory action to facilitate appropriate public-private data sharing, including across multiple medicaid managed care entities.

NEW SECTION. **Sec. 6.** (1) The authority shall submit a report to the appropriate committees of the legislature. The report must include:

(a) A description of the implementation and use of technologies included in this chapter during the previous year;

(b) A quantification of the actual and projected savings to the medical services programs as a result of the use of these technologies, including estimates of the amounts of such savings with respect to both improper payments recovered and improper payments avoided;

(c) The actual and projected savings to the medicaid and children's health insurance programs as a result of such use of technologies relative to the return on investment for the use of such technologies and in comparison to other strategies or technologies used to prevent and detect fraud, waste, and abuse;

(d) Any modifications or refinements that should be made to increase the amount of actual or projected savings or mitigate any adverse impact on medicare beneficiaries or providers;

(e) An analysis of the extent to which the use of these

technologies successfully prevented and detected waste, fraud, or abuse in the medical services programs;

(f) A review of whether the technologies affected access to, or the quality of, items and services furnished to medical service program enrollees; and

(g) A review of what effect, if any, the use of these technologies had on medical service program providers, including assessment of provider education efforts and documentation of processes for providers to review and correct problems that are identified.

(2) The authority shall submit an initial report within three months of the completion of the first year of operation of the program. Additional reports must be submitted in each of the two subsequent years within three months of the completion of the second and third years of operation and must provide the same information required in subsection (1) of this section for their respective year.

NEW SECTION. **Sec. 7.** Technology services used in carrying out this chapter must be secured using a shared savings model in which the state's only direct cost is to provide a portion of actual savings achieved to the contractor. To enable this model, a percentage of the achieved savings may be used to fund expenditures under this chapter.

NEW SECTION. **Sec. 8.** Sections 1 through 7 of this act constitute a new chapter in Title 74 RCW.

NEW SECTION. **Sec. 9.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. **Sec. 10.** This act takes effect July 1, 2012.

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