
ENGROSSED SUBSTITUTE HOUSE BILL 2571

State of Washington 62nd Legislature 2012 Regular Session

By House Health & Human Services Appropriations & Oversight (originally sponsored by Representatives Parker, Cody, Dammeier, Darneille, Alexander, Schmick, Orcutt, Hurst, and Kelley)

READ FIRST TIME 02/06/12.

- AN ACT Relating to waste, fraud, and abuse prevention, detection,
- 2 and recovery to improve program integrity for medical services
- 3 programs; adding a new chapter to Title 74 RCW; and providing an
- 4 effective date.
- 5 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:
- 6 <u>NEW SECTION.</u> **Sec. 1.** It is the intent of the legislature to:
- 7 (1) Implement waste, fraud, and abuse detection, prevention, and
- 8 recovery solutions to improve program integrity for medical services
- 9 programs in the state and create efficiency and cost savings through a
- 10 shift from a retrospective "pay and chase" model to a prospective
- 11 prepayment model; and
- 12 (2) Invest in the most cost-effective technologies or strategies
- 13 that yield the highest return on investment.
- 14 <u>NEW SECTION.</u> **Sec. 2.** The definitions in this section apply
- 15 throughout this chapter unless the context clearly requires otherwise.
- 16 (1) "Authority" means the Washington state health care authority.
- 17 (2) "Enrollee" means an individual who receives benefits through a
- 18 medical services program.

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1 (3) "Medical services programs" means those medical programs 2 established under chapter 74.09 RCW, including medical assistance, the 3 limited casualty program, children's health program, medical care 4 services, and state children's health insurance program.

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- NEW SECTION. Sec. 3. (1) Not later than September 1, 2012, the authority shall issue a request for information to seek input from potential contractors on capabilities that the authority does not currently possess, functions that the authority is not currently performing, and the cost structures associated with implementing:
- (a) 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:
- 14 (i) Identify and analyze those billing or utilization patterns that 15 represent a high risk of fraudulent activity;
 - (ii) Be integrated into the existing medical services programs claims operations;
 - (iii) Undertake and automate such analysis before payment is made to minimize disruptions to agency operations and speed claim resolution;
- (iv) Prioritize such identified transactions for additional review before payment is made based on the likelihood of potential waste, fraud, or abuse;
 - (v) 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;
 - (vi) 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;
- 30 (b) Provider and enrollee data verification and screening 31 technology solutions, which may use publicly available records, for the 32 purposes of automating reviews and identifying and preventing 33 inappropriate payments by:
- (i) Identifying associations between providers, practitioners, and beneficiaries which indicate rings of collusive fraudulent activity; and

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(ii) Discovering enrollee attributes which indicate improper eligibility, including, but not limited to, death, out-of-state residence, inappropriate asset ownership, or incarceration; and

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- (c) 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.
- (2) The authority is encouraged to use the results of the request for information to create a formal request for proposals to carry out the work identified in this section if the following conditions are met:
- 16 (a) The authority expects to generate state savings by preventing fraud, waste, and abuse;
 - (b) This work can be integrated into the authority's current medical services claims operations without creating additional costs to the state;
- 21 (c) The reviews or audits are not anticipated to delay or 22 improperly deny the payment of legitimate claims to providers.
- 23 NEW SECTION. Sec. 4. It is the intent of the legislature that the 24 savings achieved through this chapter shall more than cover the cost of implementation and administration. Therefore, to the extent possible, 25 26 technology services used in carrying out this chapter must be secured using the savings generated by the program, whereby the state's only 27 direct cost will be funded through the actual savings achieved. 28 Further, to enable this model, reimbursement to the contractor may be 29 contracted on the basis of a percentage of achieved savings model, a 30 31 per beneficiary per month model, a per transaction model, a case-rate model, or any blended model of the aforementioned methodologies. 32 Reimbursement models with the contractor may include performance 33 34 guarantees of the contractor to ensure savings identified exceeds 35 program costs.

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- NEW SECTION. **Sec. 5.** Sections 1 through 4 of this act constitute a new chapter in Title 74 RCW.
- NEW_SECTION. Sec. 6. 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.
- 7 NEW SECTION. Sec. 7. This act takes effect July 1, 2012.

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