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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2012

A N A C T

RELATING TO HUMAN SERVICES -- MEDICAID

Introduced By: Representatives Reilly, Morgan, Chippendale, Costa, and Newberry

Date Introduced: February 16, 2012

Referred To: House Finance

It is enacted by the General Assembly as follows:

SECTION 1. Title 40 of the General Laws entitled "HUMAN SERVICES" is hereby amended by adding thereto the following chapter:

CHAPTER 8.11

THE MEDICAID INTEGRITY ACT OF 2012

40-8.11-1. Citation. – This chapter shall be known and may be cited as the “Medicaid Integrity Act of 2012.”

40-8.11-2. Legislative intent. – (a) It is the intent of the general assembly to implement waste and fraud and abuse detection, prevention, and recovery solutions to:

(1) Improve program integrity for Medicaid and the children's health insurance program or “CHIP” in the state, and to create efficiency and cost savings through a shift from a retrospective "pay and chase" model to a prospective pre-payment 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 promulgated in the centers for Medicare and Medicaid services final rule 6028.

40-8.11-3. Definitions. – As used in this chapter, the following words and phrases shall have the following meanings, unless the context clearly indicates otherwise:

(1) “CHIP” means the children's health insurance program established under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) and implemented in Rhode Island, including but not limited to, any plans and/or programs implemented pursuant to the provisions of chapter

40-8.4 (“Health Care for Families”).

(2) “Department” means the Rhode Island department of human services.

(3) “Enrollee” means an individual who is eligible to receive benefits and is enrolled in either the Medicaid or CHIP programs.

(4) “Medicaid” means the program to provide grants to states for medical assistance programs established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(5) “Secretary” means the U.S. secretary of health and human services, acting through the administrator of the centers for Medicare and Medicaid Services.

40-8.11-4. Application of chapter. – The provisions of this chapter shall specifically apply to:

(1) State Medicaid managed care programs, including programs operated under and/or pursuant to the provisions of this title 40 (Human Services);

(2) State Medicaid programs operated under and/or pursuant to the provisions of this title 40 (Human Services); and

(3) The state CHIP program operated under this title and implemented in Rhode Island, including but not limited to, any plans and/or programs implemented pursuant to the provisions of chapter 40-8.4 (“Health Care for Families”).

40-8.11-5. State to provide data verification. – The department shall implement provider data verification and provider screening technology solutions to check healthcare 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:

(1) Deceased providers;

(2) Sanctioned providers;

(3) License expiration/retired providers; and

(4) Confirmed wrong addresses.

40-8.11-6. Clinical code editing. – The department shall implement state-of-the-art clinical code editing technology solutions to further automate claims resolution and enhance cost containment through improved claim accuracy and appropriate code correction. The technology shall identify and prevent errors or potential overbilling based on widely accepted and transparent protocols such as the American Medical Association and the Centers for Medicare and Medicaid Services. The edits shall be applied automatically before claims are adjudicated to speed processing and reduce the number of pended or rejected claims and help ensure a smoother, more consistent and more transparent adjudication process and fewer delays in provider reimbursement.

40-8.11-7. Predictive modeling technologies. – The department shall implement state-of-the-art predictive modeling and analytics technologies to provide a more comprehensive and accurate view across all providers, beneficiaries and geographies within the Medicaid and CHIP programs in order to:

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

(2) Be integrated into the existing Medicaid and CHIP claims workflow;

(3) Undertake and automate such analysis before payment is made to minimize disruptions to the workflow and speed claim resolution;

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

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

(6) 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.

40-8.11-8. Fraud investigation services. – The department shall implement fraud investigative services that combine retrospective claims analysis and prospective waste, fraud or abuse detection techniques. These services shall include analysis of historical claims data, medical records, suspect provider databases and high-risk identification lists, as well as direct patient and provider interviews. Emphasis shall be placed on providing education to providers and ensuring that they have the opportunity to review and correct any problems identified prior to adjudication.

40-8.11-9. Claims audit and recovery services. – (a) The department shall implement Medicaid and CHIP claims audit and recovery services to identify improper payments due to non-fraudulent issues, audit claims, obtain provider sign-off on the audit results and recover validated overpayments. Post payment reviews shall ensure that the diagnoses and procedure codes are accurate and valid based on the supporting physician documentation within the medical records.

(b) Core categories of reviews shall include:

(1) Coding compliance diagnosis related group (“DRG”) reviews;

(2) Transfers;

(3) Readmissions;

(4) Cost outlier reviews;

(5) Outpatient seventy-two (72) hour rule reviews;

(6) Payment errors;

(7) Billing errors; and

(8) Such others as may be designated by the department.

40-8.11-10. Selection of contractor. – (a) To implement the provisions of this chapter, the department shall either contract with the cooperative purchasing network ("CPN") to issue a request for proposals ("RFP") to select a contractor or use the following contractor selection process:

(1) On or before January 1, 2013, the department shall issue a request for information ("RFI") to seek input from potential contractors on capabilities and cost structures associated with the scope of work of this chapter. The results of the RFI shall be used by the department to create a formal RFP to be issued within ninety (90) days of the closing date of the RFI.

(2) No later than ninety (90) days after the close of the RFI, the department shall issue a formal RFP to carry out the provisions of this chapter during the first year of implementation. To the extent appropriate, the department may include subsequent implementation years and may issue additional RFPs with respect to subsequent implementation years.

(3) The department shall select contractors to carry out this chapter using competitive procedures as provided for in chapter 37-2 ("State Purchases").

(4) The department shall enter into a contract under this chapter with an entity only if the entity:

(i) Can demonstrate appropriate technical, analytical and clinical knowledge and experience to carry out the functions included in this chapter; or

(ii) Has a contract, or will enter into a contract, with another entity that meets the above criteria.

(5) The department shall only enter into a contract under this chapter with an entity to the extent the entity complies with conflict of interest standards under state law, including but not limited to the provisions of chapter 37-2 ("State Purchases).

40-8.11-11. Department contract. – The state department of human services shall provide entities with a contract pursuant to the provisions of this chapter with appropriate access to claims and other data necessary for the entity to carry out the functions included in this chapter. This shall include, but shall not be limited to, providing current and historical Medicaid and CHIP claims and provider database information, and taking necessary regulatory action to facilitate appropriate public-private data sharing, including across multiple Medicaid managed care entities.

40-8.11-12. Reports. – The following reports shall be completed by the state department of human services:

(1) Not later than three (3) months after the completion of the first implementation year under this chapter, the department shall submit to the clerk of the house of representatives and the clerk of the senate, and also make available to the public, a report that includes the following:

(i) A description of the implementation and use of technologies set forth in this chapter during the year;

(ii) A certification by the department that specifies the actual and projected savings to the Medicaid and CHIP 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;

(iii) The actual and projected savings to the Medicaid and CHIP 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;

(iv) Suggestions for 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;

(v) An analysis of the extent to which the use of these technologies successfully prevented and detected waste, fraud, or abuse in the Medicaid and CHIP programs;

(vi) A review of whether the technologies affected access to, or the quality of, items and services furnished to Medicaid and CHIP beneficiaries; and

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

(2) Not later than three (3) months after the completion of the second implementation year under this chapter, the department shall submit to the clerk of the house of representatives and the clerk of the senate, and also make available to the public, a report that shall include, with respect to such year, the items required under subdivision (1) herein for said second (2nd) year, as well as any other additional items determined appropriate with respect to the report for such year.

(3) Not later than three (3) months after the completion of the third (3rd) implementation year under this chapter, the department shall submit to the clerk of the house of representatives and the clerk of the senate, and make available to the public, a report that shall include with respect to such year, the items required under subdivision (1) herein for said third (3rd) year, as

well as any other additional items determined appropriate with respect to the report for such year.

40-8.11-13. Cost savings intent of chapter. – It is the intent of the general assembly that the savings achieved through this chapter shall be sufficient to cover the costs of implementation. Therefore, to the extent possible, technology services used in carrying out this chapter shall be secured using a shared savings model, whereby the state's only direct cost will be a percentage of actual savings achieved. Further, to enable this model, a percentage of achieved savings may be used to fund expenditures under this chapter.

40-8.11-14. Severability. – If any provision of this chapter is held by a court to be invalid, that invalidity shall not affect the remaining provisions of the chapter, and to this end the provisions of this chapter are declared to be severable.

SECTION 2. This act shall take effect upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

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This act would implement procedures to detect fraud and abuse in regard to the payment of Medicaid claims. Most of these procedures would be implemented by the department of human services.

This act would take effect upon passage.

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