2012 -- S 2248

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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

Introduced By: Senators Crowley, Perry, Miller, Nesselbush, and DeVall

Date Introduced: January 26, 2012

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

SECTION 1. Title 42 of the General Laws entitled "State Affairs and Government" is hereby amended by adding thereto the following chapter:

CHAPTER 14.7

THE MEDICAID, RITE CARE AND RITE SHARE PROGRAM INTEGRITY ACT

42-14.7-1. Short title. – This act shall be known and may be cited as the "Medicaid and RIte Care and RIte Share Integrity Act."

42-14.7-2. Legislative intent. – It is the intent of the legislature to implement waste, fraud and abuse detection, prevention and recovery solutions to:

(1) Improve program integrity for Medicaid and the RIte care and RIte share programs in the state and 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.

42-14.7-3. Definitions. – The definitions in this section shall apply throughout this chapter unless the context requires otherwise:

(1) "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.).

(2) "RIte care and RIte share" means the children's health insurance program established under title XXI of the social security act (42 U.S.C. 1397aa et seq.).

(3) "Enrollee" means an individual who is eligible to receive benefits and is enrolled in either medicaid or RIte care and RIte share programs.

(4) “Secretary” means the U.S. secretary of health and human services, acting through the administrator of the centers for medicare and medicaid services.

42-14.7-4. Application. – This chapter shall specifically apply to:

(1) State medicaid managed care programs operated under section 42-12.4-2 of the Rhode Island general laws.

(2) The RIte care and RIte share state programs operated under Rhode Island general laws, chapter 40-84.

42-14.7-5. Data verification. – The state shall implement provider data verification and provides 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.

42-14.7-6. Clinical code editing. – The state 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.

42-14.7-7. Predictive modeling. – The state shall implement state-of-the-art predictive modeling and analytics technologies to provide more comprehensive and accurate view across all providers, beneficiaries and geographies within the Medicaid, RIte care and RIte share 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 RIte care and RIte share 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.

42-14.7-8. Fraud investigations. –– The state 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

42-14.7-9. Recovery of improper payments. –– The state shall implement medicaid 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. Core categories of review include: coding compliance diagnosis related group (DRG) reviews, transfers, readmissions, cost outlier reviews, outpatient 72-Hour rule reviews, payment errors, billing errors and others.

42-14.7-10. Reporting. –– The following reports shall be completed by the department of health and human services:

(1) Not later than three (3) months after the completion of the first implementation year under this chapter, the state shall submit to the appropriate committees of the legislature, and make available to the public, a report that includes the following:

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

(ii) A certification by the department of human services that specifies the actual and projected savings to the medicaid, RIte care and RIte share 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 RIte care and RIte share 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) 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 RIte care and RIte share programs;

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

(vii) A review of what effect, if any, the use of these technologies had on Medicaid, RIte care and RIte share 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 state shall submit to the appropriate committees of the legislature and make available to the public a report that includes, with respect to such year, the items required under subdivision (1) 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 implementation year under this chapter, the state shall submit to the appropriate committees of the legislature, and make available to the public, a report that includes with respect to such year, the items required under subdivision (1), as well as any other additional items determined appropriate with respect to the report for such year.

SECTION 2. Severability. If any provision of this chapter or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of the chapter, which can be given effect without the invalid provisions or applications, and to this end the provisions of this chapter are declared to be severable.

SECTION 3. This act shall take effect upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO MEDICAID AN D RITE CARE AN DRITE SHARE PROGRAM INTEGRITY

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This act would create a review process for medicare, RIte care and RIte share payment accuracy.

This act would take effect upon passage.

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