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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

H O U S E R E S O L U T I O N

RESPECTFULLY REQUESTING THE GOVERNOR OF THE STATE OF RHODE ISLAND TO IMPLEMENT PROGRAMS AND METHODOLOGY TO IMPROVE MEDICAID INTEGRITY IN THE STATE

Introduced By: Representatives Serpa, Tarro, Mattiello, Silva, and Morgan

Date Introduced: January 25, 2012

Referred To: House Finance

WHEREAS, The federal government has estimated that fraud, waste, and abuse have cost state Medicaid programs around $18 billion dollars annually; and

WHEREAS, Implementation of modern fraud screening and prevention solutions to detect fraud and abuse prior to Medicaid claims being paid is essential in protecting taxpayer dollars; and

WHEREAS, In addition, federal law now requires states to improve program integrity for Medicaid and Children's Health Insurance Programs by implementing waste, and fraud and abuse, prevention, detection, and recovery solutions; and

WHEREAS, Rhode Island's Medicaid program is an Executive function administered by the state's Department of Human Services in conjunction with the state's Department of Administration and the Department of Health; now, therefore be it

RESOLVED, That this House of Representatives of the State of Rhode Island and Providence Plantations hereby respectfully requests the Governor of the State of Rhode Island 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; and be it further

RESOLVED, That the subsequent words and phrases used in this resolution will 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”) in the Rhode Island General Laws;

(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.); and

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

RESOLVED, That programs and provisions referenced in this resolution include:

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

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

(3) The state CHIP program operated under title 40 (Human Services) of the Rhode Island General Laws 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”) of the Rhode Island General Laws; and be it further

RESOLVED, That the department will 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; and be it further

RESOLVED, The department will 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 will 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 will 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; and be it further

RESOLVED, That the department will 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; and be it further

RESOLVED, That the department will implement fraud investigative services that combine retrospective claims analysis and prospective waste, fraud or abuse detection techniques. These services will 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 will be placed on providing education to providers and ensuring that they have the opportunity to review and correct any problems identified prior to adjudication; and be it further

RESOLVED, That the department will 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 will ensure that the diagnoses and procedure codes are accurate and valid based on the supporting physician documentation within the medical records.

The core categories of reviews will 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; and be it further

RESOLVED, That in order to implement these provisions, the department will 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 will issue a request for information ("RFI") to seek input from potential contractors on capabilities and cost structures associated with the scope of work in this resolution. The results of the RFI will 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 will issue a formal RFP to carry out the provisions outlined in this resolution 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 will select contractors to carry out provisions outlined in this resolution using competitive procedures as provided for in chapter 37-2 ("State Purchases") of the Rhode Island General Laws.

(4) The department will enter into a contract under the provisions of this resolution 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 resolution; or

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

(5) The department will only enter into a contract under the provisions outlined in this resolution 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) of the Rhode Island General Laws; and be it further

RESOLVED, That the state department of human services will provide entities with a contract pursuant to the provisions of this resolution with appropriate access to claims and other

data necessary for the entity to carry out the functions included in this resolution. This will include, but will 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; and be it further

RESOLVED, That the following reports will be completed by the state department of human services:

(1) Not later than three (3) months after the completion of the first implementation year outlined in this resolution , the department will 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 resolution 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 outlined in this resolution, the department will 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 will

include, with respect to such year, the items requested 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 outlined in this resolution, the department will submit to the clerk of the house of representatives and the clerk of the senate, and make available to the public, a report that will 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; and be it further

RESOLVED, That this House of Representatives hereby believes that the savings achieved through the implementation of this resolution will be sufficient to cover the costs of implementation. Therefore, to the extent possible, technology services used in carrying out this resolution will 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 outlined in this resolution; and be it further

RESOLVED, That the Secretary of State be and he hereby is authorized and directed to transmit duly certified copies of this resolution to the Governor of the State of Rhode Island, the Director of the Department of Human Services, the Director of the Department of Administration, and the Director of the Department of Health.

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