H. B. 3036

(By Delegate Manypenny (By Request))

[Introduced March 21, 2013; referred to the
Committee on Health and Human Resources then Finance.]

A BILL to amend the Code of West Virginia, 1931, as amended, by adding thereto a new article, designated §9-7A-1, §9-7A-2, §9-7A-3, §9-7A-4, §9-7A-5, §9-7A-6, §9-7A-7, §9-7A-8, §9-7A-9, §9-7A-10, §9-7A-11, §9-7A-12 and §9-7A-13, all relating to improving program integrity for Medicaid and the Children's Health Insurance Program by implementing additional waste, fraud and abuse, prevention, detection and recovery solutions.

Be it enacted by the Legislature of West Virginia:

That the Code of West Virginia, 1931, as amended, be amended by adding thereto a new article, designated §9-7A-1, §9-7A-2, §9-7A-3, §9-7A-4, §9-7A-5, §9-7A-6, §9-7A-7, §9-7A-8, §9-7A-9, §9-7A-10, §9-7A-11, §9-7A-12 and §9-7A-13, all to read as follows:

ARTICLE 7A. IMPROVING PROGRAM INTEGRITY FOR MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM.

§9-7A-1. Legislative purpose and findings.

It is the intent of the Legislature to implement additional waste, fraud and abuse detection, prevention and recovery solutions to enhance existing programs such as the Medicare Fraud Unit established in article seven of this chapter to:

(1) Improve program integrity for Medicaid and the Children's Health Insurance Program 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 promulgated in the Centers for Medicare and Medicaid Services Final Rule 6028.

§9-7A-2. Definitions.

As used in this article:

(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) "CHIP" 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 the Medicaid or CHIP programs.

(4) "Secretary" means the U.S. Secretary of Health and Human

1 Services, acting through the Administrator of the Centers for
2 Medicare and Medicaid Services.
3 (5) "Department" means the West Virginia Department of Health
4 and Human Resources.
5 **§9-7A-3. Application.**
6 This article shall specifically apply to:
7 (1) State Medicaid managed care programs operated under the
8 provisions of this chapter;
9 (2) State Medicaid programs operated under the provisions of
10 this chapter; and
11 (3) The state CHIP program operated under the provisions of
12 article sixteen-b, chapter five of this code. The department shall
13 coordinate with the Department of Administration when implementing
14 any provision of this article with respect to the state CHIP
15 program.
16 **§9-7A-4. Implementation generally.**
17 The department shall implement provider data verification and
18 provider screening technology solutions to check healthcare billing
19 and provider rendering data against a continually maintained
20 provider information database for the purposes of automating
21 reviews and identifying and preventing inappropriate payments to:
22 (1) Deceased providers;
23 (2) Sanctioned providers;
24 (3) License expiration/retired providers; and

1 (4) Confirmed wrong addresses.

2 **§9-7A-5. Implementation of clinical code editing technology**
3 **solutions.**

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

15 **§9-7A-6. Implementation of predictive modeling and analytics**
16 **technologies.**

17 The department shall implement state-of-the-art predictive
18 modeling and analytics technologies to provide a more comprehensive
19 and accurate view across all providers, beneficiaries and
20 geographies within the Medicaid and CHIP programs in order to:

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

23 (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.

§9-7A-7. Integration of retrospective claims analysis and prospective detection techniques.

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.

§9-7A-8. Implementation of Medicaid and CHIP claims audit and recovery services.

The department shall implement Medicaid and CHIP claims audit and recovery services to identify improper payments due to nonfraudulent 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 reviews could include: Coding Compliance Diagnosis Related Group (DRG) Reviews, Transfers, Readmissions, Cost Outlier Reviews, Outpatient 72-Hour Rule Reviews, Payment Errors, Billing Errors and others.

§9-7A-9. Selection of contractor.

To implement this article, the department shall either contract with The Cooperative Purchasing Network (TCPN) to issue an RFP to select a contractor or use the following contractor selection process:

(1) Not later than January 1, 2014, 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 article. The results of the RFI shall be used by the department to create a formal request for proposals (RFP) to be issued within ninety days of the closing date of the RFI.

(2) No later than ninety days after the close of the RFI, the department shall issue a formal RFP to carry out this article 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 article using competitive procedures as provided in article three, chapter five-a of this code.

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

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

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

(5) The department may only enter into a contract under this article with an entity to the extent the entity complies with state procurement conflict of interest standards.

§9-7A-10. Access to data.

The department shall provide entities with a contract under this article with appropriate access to claims and other data necessary for the entity to carry out the functions included in this article. This includes, but is not limited to: providing

1 current and historical Medicaid and CHIP claims and provider
2 database information; and taking necessary regulatory action to
3 facilitate appropriate public-private data sharing, including
4 across multiple Medicaid managed care entities.
5 **§9-7A-11. Report and certification.**
6 (1) The following reports shall be completed by the
7 department:
8 Not later than three months after the completion of the first
9 implementation year under this article, the department shall submit
10 to the Legislature's Joint Committee on Government and Finance and
11 make available to the public a report that includes the following:
12 (A) A description of the implementation and use of
13 technologies included in this article during the year;
14 (B) A certification by department that specifies the actual
15 and projected savings to the Medicaid and CHIP programs as a result
16 of the use of these technologies, including estimates of the
17 amounts of such savings with respect to both improper payments
18 recovered and improper payments avoided;
19 (C) The actual and projected savings to the Medicaid and CHIP
20 programs as a result of such use of technologies relative to the
21 return on investment for the use of such technologies and in
22 comparison to other strategies or technologies used to prevent and
23 detect fraud, waste, and abuse;
24 (D) Any modifications or refinements that should be made to

1 increase the amount of actual or projected savings or mitigate any
2 adverse impact on Medicare beneficiaries or providers;
3 (E) An analysis of the extent to which the use of these
4 technologies successfully prevented and detected waste, fraud, or
5 abuse in the Medicaid and CHIP programs;
6 (F) A review of whether the technologies affected access to,
7 or the quality of, items and services furnished to Medicaid and
8 CHIP beneficiaries; and
9 (G) A review of what effect, if any, the use of these
10 technologies had on Medicaid and CHIP providers, including
11 assessment of provider education efforts and documentation of
12 processes for providers to review and correct problems that are
13 identified.
14 (2) Not later than three months after the completion of the
15 second implementation year under this article, the department shall
16 submit to the Legislature's Joint Committee on Government and
17 Finance and make available to the public a report that includes,
18 with respect to such year, the items required under (1) as well as
19 any other additional items determined appropriate with respect to
20 the report for such year.
21 (3) Not later than three months after the completion of the
22 third implementation year under this article, the department shall
23 submit to the Legislature's Joint Committee on Government and
24 Finance, and make available to the public, a report that includes

1 with respect to such year, the items required under (1), as well as
2 any other additional items determined appropriate with respect to
3 the report for such year.

4 **§9-7A-12. Shared savings model.**

5 It is the intent of the Legislature that the savings achieved
6 through this article shall more than cover the costs of
7 implementation. Therefore, to the extent possible, technology
8 services used in carrying out this article shall be secured using
9 a shared savings model, whereby the state's only direct cost will
10 be a percentage of actual savings achieved. Further, to enable
11 this model, a percentage of achieved savings may be used to fund
12 expenditures under this article.

13 **§9-7A-13. Effective date.** This article takes effect on July 1,
14 2013.

NOTE: The purpose of this bill is to improve program integrity for Medicaid and the Children's Health Insurance Program by implementing additional waste, fraud and abuse, prevention, detection and recovery solutions.

This article is new; therefore, it has been completely underscored.