HB4118

LRB09717678KTG62889b

97TH GENERAL ASSEMBLY

State of Illinois

2011 and 2012

HB4118

by Rep. Sara Feigenholtz

SYNOPSIS AS INTRODUCED:

New Act

Creates the Program Integrity for Medicaid and the Children's Health Insurance Program Act. Provides that it is the intent of the General Assembly to implement waste, fraud, and abuse detection, prevention, and recovery solutions to 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 pre-payment model; and to comply with program integrity provisions of the federal Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010. In furtherance of these goals, requires the State to implement several technologies and services including (i) provider data verification and provider screening technology; (ii) state-of-the-art clinical code editing technology; (iii) state-of-the-art predictive modeling and analytics technologies; (iv) fraud investigative services; and (v) Medicaid and CHIP claims audit and recovery services. Requires the State to either contract with The Cooperative Purchasing Network (TCPN) to issue a request for proposals (RFP) when selecting a contractor or use the specified contractor selection process. Contains provisions concerning contracts, reporting requirements, and savings.

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FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning public aid.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. Short title. This Act may be cited as the Program Integrity for Medicaid and the Children's Health Insurance Program Act.

Section 5. Purpose. It is the intent of the General Assembly to implement waste, fraud, and abuse detection, prevention, and recovery solutions 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 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.

Section 10. Definitions. As used in this Act, unless the context indicates otherwise:

"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.).

"CHIP" means the Children's Health Insurance Program established under Title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.).

"Enrollee" means an individual who is eligible to receive benefits and is enrolled in either Medicaid or CHIP.

"Secretary" means the U.S. Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare and Medicaid Services.

Section 15. Application of Act. This Act shall specifically apply to:

(1) State Medicaid managed care programs operated under Article V of the Illinois Public Aid Code.

(2) State Medicaid programs operated under Article V of the Illinois Public Aid Code.

(3) The State CHIP program operated under the Children's Health Insurance Program Act.

Section 20. Provider data verification and provider screening technology. The State 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 or retired providers.

(4) Confirmed wrong addresses.

Section 25. Clinical code editing technology. 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 over-billing based on widely accepted and transparent protocols such as those adopted by 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 pending or rejected claims and to help ensure a smoother, more consistent, and more transparent adjudication process and fewer delays in provider reimbursement.

Section 30. Predictive modeling and analytics technologies. The State 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.

(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.

Section 35. Fraud investigative services. 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.

Section 40. Claims audit and recovery services. The State shall implement Medicaid and CHIP claims audit and recovery services to identify improper payments due to non-fraudulent issues or audit claims and shall 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 may include: Coding Compliance Diagnosis Related Group (DRG) Reviews, Transfers, Readmissions, Cost Outlier Reviews, Outpatient 72-Hour Rule Reviews, Payment Errors, Billing Errors, and others.

Section 45. Cooperative Purchasing Network.

(a) To implement this Act, the State shall either contract with The Cooperative Purchasing Network (TCPN) to issue a request for proposals (RFP) when selecting a contractor or use the contractor selection process set forth in subsections (b) through (f).

(b) Not later than November 1, 2012, the State shall issue a request for information (RFI) to seek input from potential contractors on capabilities and cost structures associated

with the scope of work under this Act. The results of the RFI shall be used by the State to create a formal RFP to be issued within 90 days after the closing date of the RFI.

(c) No later than 90 days after the closing date of the RFI, the State shall issue a formal RFP to carry out this Act during the first year of implementation. To the extent appropriate, the State may include subsequent implementation years and may issue additional RFPs with respect to subsequent implementation years.

(d) The State shall select contractors to carry out this Act using competitive procedures set forth under the Illinois Procurement Code.

(e) The State shall enter into a contract under this Act with an entity only if the entity:

(1) can demonstrate appropriate technical, analytical, and clinical knowledge and experience to carry out the functions included under this Act; or

(2) has a contract, or will enter into a contract, with another entity that meets the criteria set forth in paragraph (1).

(f) The State shall enter into a contract under this Act with an entity only to the extent the entity complies with conflict-of-interest standards as provided under the Illinois Procurement Code.

Section 50. Contracts. The State shall provide an entity

with whom it has entered into a contract under this Act with appropriate access to claims and other data necessary for the entity to carry out the functions included in this Act. This includes, but is not 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.

Section 55. Reports.

(a) The Department of Healthcare and Family Services shall complete reports as set forth in subsections (b) through (d).

(b) Not later than 3 months after the completion of the first implementation year under this Act, the State shall submit to the appropriate committees of the General Assembly and make available to the public a report that includes the following:

(1) A description of the implementation and use of technologies included in this Act during the year.

(2) A certification by the Department of Healthcare and Family Services 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.

(3) The actual and projected savings to the Medicaid

and CHIP programs as a result of the use of these technologies relative to the return on investment for the use of these technologies and in comparison to other strategies or technologies used to prevent and detect fraud, waste, and abuse.

(4) 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.

(5) 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.

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

(7) A review of what effect, if any, the use of these technologies 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.

(c) Not later than 3 months after the completion of the second implementation year under this Act, the State shall submit to the appropriate committees of the General Assembly and make available to the public a report that includes, with respect to such year, the items required under subsection (b) as well as any other additional items determined appropriate

with respect to the report for such year.

(d) Not later than 3 months after the completion of the third implementation year under this Act, the State shall submit to the appropriate committees of the General Assembly, and make available to the public, a report that includes, with respect to such year, the items required under subsection (b) as well as any other additional items determined appropriate with respect to the report for such year.

Section 60. Savings. It is the intent of the General Assembly that the savings achieved through this Act shall more than cover the costs of implementation. Therefore, to the extent possible, technology services used in carrying out this Act 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 Act.

Section 97. Severability. If any provision of this Act or its application to any person or circumstance is held invalid, the invalidity of that provision or application does not affect other provisions or applications of this Act that can be given effect without the invalid provision or application.