HB4635

LRB09717514KTG62718b

97TH GENERAL ASSEMBLY

State of Illinois

2011 and 2012

HB4635

Introduced 2/1/2012, by Rep. Camille Y Lilly

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. Effective immediately.

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FISCAL NOTE ACT
MAY APPLY

A BILL FOR

1   AN ACT concerning public aid.

2   **Be it enacted by the People of the State of Illinois,**

3   **represented in the General Assembly:**

4   Section 1. Short title. This Act may be cited as the

5   Program Integrity for Medicaid and the Children's Health

6   Insurance Program Act.

7   Section 5. Purpose. It is the intent of the General

8   Assembly to implement waste, fraud, and abuse detection,

9   prevention, and recovery solutions to:

10   (1) improve program integrity for Medicaid and the

11   Children's Health Insurance Program in the State and create

12   efficiency and cost savings through a shift from a

13   retrospective "pay and chase" model to a prospective

14   pre-payment model; and

15   (2) comply with program integrity provisions of the

16   federal Patient Protection and Affordable Care Act and the

17   Health Care and Education Reconciliation Act of 2010, as

18   promulgated in the Centers for Medicare and Medicaid

19   Services Final Rule 6028.

20   Section 10. Definitions. As used in this Act, unless the

21 context indicates otherwise:

22   "Medicaid" means the program to provide grants to states

1   for medical assistance programs established under Title XIX of

2   the Social Security Act (42 U.S.C. 1396 et seq.).

3   "CHIP" means the Children's Health Insurance Program

4   established under Title XXI of the Social Security Act (42

5   U.S.C. 1397aa et seq.).

6   "Enrollee" means an individual who is eligible to receive

7   benefits and is enrolled in either Medicaid or CHIP.

8   "Secretary" means the U.S. Secretary of Health and Human

9   Services, acting through the Administrator of the Centers for

10   Medicare and Medicaid Services.

11   Section 15. Application of Act. This Act shall specifically

12   apply to:

13   (1) State Medicaid managed care programs operated

14   under Article V of the Illinois Public Aid Code.

15   (2) State Medicaid programs operated under Article V of

16   the Illinois Public Aid Code.

17   (3) The State CHIP program operated under the

18   Children's Health Insurance Program Act.

19   Section 20. Provider data verification and provider

20   screening technology. The State shall implement provider data

21   verification and provider screening technology solutions to

22   check healthcare billing and provider rendering data against a

23   continually maintained provider information database for the

24   purposes of automating reviews and identifying and preventing

1   inappropriate payments to:

2   (1) Deceased providers.

3   (2) Sanctioned providers.

4   (3) License expiration or retired providers.

5   (4) Confirmed wrong addresses.

6   Section 25. Clinical code editing technology. The State
7   shall   implement   state-of-the-art   clinical   code   editing
8   technology solutions to further automate claims resolution and
9   enhance cost containment through improved claim accuracy and
10   appropriate code correction. The technology shall identify and
11   prevent   errors   or   potential   over-billing   based   on   widely
12   accepted and transparent protocols such as those adopted by the
13   American Medical Association and the Centers for Medicare and
14   Medicaid Services. The edits shall be applied automatically
15   before claims are adjudicated to speed processing and reduce
16   the number of pending or rejected claims and to help ensure a
17   smoother, more consistent, and more transparent adjudication
18   process and fewer delays in provider reimbursement.

19   Section   30.   Predictive   modeling   and   analytics
20   technologies.   The   State   shall   implement   state-of-the-art
21   predictive modeling and analytics technologies to provide a
22   more   comprehensive   and   accurate   view   across   all   providers,
23   beneficiaries,   and   geographies   within   the   Medicaid   and   CHIP
24   programs in order to:

1   (1) Identify and analyze those billing or utilization

2   patterns that represent a high risk of fraudulent activity.

3   (2) Be integrated into the existing Medicaid and CHIP

4   claims workflow.

5   (3) Undertake and automate such analysis before

6   payment is made to minimize disruptions to the workflow and

7   speed claim resolution.

8   (4) Prioritize such identified transactions for

9   additional review before payment is made based on

10   likelihood of potential waste, fraud, or abuse.

11   (5) Capture outcome information from adjudicated

12   claims to allow for refinement and enhancement of the

13   predictive analytics technologies based on historical data

14   and algorithms within the system.

15   (6) Prevent the payment of claims for reimbursement

16   that have been identified as potentially wasteful,

17   fraudulent, or abusive until the claims have been

18   automatically verified as valid.

19   Section 35. Fraud investigative services. The State shall

20   implement fraud investigative services that combine

21   retrospective claims analysis and prospective waste, fraud, or

22   abuse detection techniques. These services shall include

23   analysis of historical claims data, medical records, suspect

24   provider databases, and high-risk identification lists, as

25   well as direct patient and provider interviews. Emphasis shall

1   be placed on providing education to providers and ensuring that

2   they have the opportunity to review and correct any problems

3   identified prior to adjudication.

4   Section 40. Claims audit and recovery services. The State

5   shall implement Medicaid and CHIP claims audit and recovery

6   services to identify improper payments due to non-fraudulent

7   issues or audit claims and shall obtain provider sign-off on

8   the   audit   results   and   recover   validated   overpayments.

9   Post-payment   reviews   shall   ensure   that   the   diagnoses   and

10   procedure codes are accurate and valid based on the supporting

11   physician   documentation   within   the   medical   records.   Core

12   categories of reviews may include: Coding Compliance Diagnosis

13   Related   Group   (DRG)   Reviews,   Transfers,   Readmissions,   Cost

14   Outlier   Reviews,   Outpatient   72-Hour   Rule   Reviews,   Payment

15   Errors, Billing Errors, and others.

16   Section 45. Cooperative Purchasing Network.

17   (a) To implement this Act, the State shall either contract

18   with   The   Cooperative   Purchasing   Network   (TCPN)   to   issue   a

19   request for proposals (RFP) when selecting a contractor or use

20   the contractor selection process set forth in subsections (b)

21   through (f).

22   (b) Not later than January 1, 2013, the State shall issue a

23   request   for   information   (RFI)   to   seek   input   from   potential

24   contractors   on   capabilities   and   cost   structures   associated

1   with the scope of work under this Act. The results of the RFI

2   shall be used by the State to create a formal RFP to be issued

3   within 90 days after the closing date of the RFI.

4   (c) No later than 90 days after the closing date of the

5   RFI, the State shall issue a formal RFP to carry out this Act

6   during the first year of implementation. To the extent

7   appropriate, the State may include subsequent implementation

8   years and may issue additional RFPs with respect to subsequent

9   implementation years.

10   (d) The State shall select contractors to carry out this

11   Act using competitive procedures set forth under the Illinois

12   Procurement Code.

13   (e) The State shall enter into a contract under this Act

14   with an entity only if the entity:

15   (1) can demonstrate appropriate technical, analytical,

16   and clinical knowledge and experience to carry out the

17   functions included under this Act; or

18   (2) has a contract, or will enter into a contract, with

19   another entity that meets the criteria set forth in

20   paragraph (1).

21   (f) The State shall enter into a contract under this Act

22   with an entity only to the extent the entity complies with

23   conflict-of-interest standards as provided under the Illinois

24   Procurement Code.

25   Section 50. Contracts. The State shall provide an entity

1   with whom it has entered into a contract under this Act with

2   appropriate access to claims and other data necessary for the

3   entity to carry out the functions included in this Act. This

4   includes, but is not limited to, providing current and

5   historical Medicaid and CHIP claims and provider database

6   information and taking necessary regulatory action to

7   facilitate appropriate public-private data sharing, including

8   across multiple Medicaid managed care entities.

9   Section 55. Reports.

10   (a) The Department of Healthcare and Family Services shall

11   complete reports as set forth in subsections (b) through (d).

12   (b) Not later than 3 months after the completion of the

13   first implementation year under this Act, the State shall

14   submit to the appropriate committees of the General Assembly

15   and make available to the public a report that includes the

16   following:

17   (1) A description of the implementation and use of

18   technologies included in this Act during the year.

19   (2) A certification by the Department of Healthcare and

20   Family Services that specifies the actual and projected

21   savings to the Medicaid and CHIP programs as a result of

22   the use of these technologies, including estimates of the

23   amounts of such savings with respect to both improper

24   payments recovered and improper payments avoided.

25   (3) The actual and projected savings to the Medicaid

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

6   (4) Any modifications or refinements that should be
7   made to increase the amount of actual or projected savings
8   or mitigate any adverse impact on Medicare beneficiaries or
9   providers.

10   (5) An analysis of the extent to which the use of these
11   technologies successfully prevented and detected waste,
12   fraud, or abuse in the Medicaid and CHIP programs.

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

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

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

1   with respect to the report for such year.

2   (d) Not later than 3 months after the completion of the

3   third implementation year under this Act, the State shall

4   submit to the appropriate committees of the General Assembly,

5   and make available to the public, a report that includes, with

6   respect to such year, the items required under subsection (b)

7   as well as any other additional items determined appropriate

8   with respect to the report for such year.

9   Section 60. Savings. It is the intent of the General

10   Assembly that the savings achieved through this Act shall more

11   than cover the costs of implementation. Therefore, to the

12   extent possible, technology services used in carrying out this

13   Act shall be secured using a shared savings model, whereby the

14   State's only direct cost will be a percentage of actual savings

15   achieved. Further, to enable this model, a percentage of

16   achieved savings may be used to fund expenditures under this

17   Act.

18   Section 97. Severability. If any provision of this Act or

19   its application to any person or circumstance is held invalid,

20   the invalidity of that provision or application does not affect

21   other provisions or applications of this Act that can be given

22   effect without the invalid provision or application.

23   Section 99. Effective date. This Act takes effect upon

24   becoming law.