**South Carolina General Assembly**

119th Session, 2011-2012

**H. 4501**

**STATUS INFORMATION**

General Bill

Sponsors: Rep. Sellers

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Introduced in the House on January 10, 2012

Currently residing in the House Committee on **Ways and Means**

Summary: Medicaid and children's health programs

**HISTORY OF LEGISLATIVE ACTIONS**

Date Body Action Description with journal page number

12/6/2011 House Prefiled

12/6/2011 House Referred to Committee on **Ways and Means**

1/10/2012 House Introduced and read first time ([House Journal‑page 63](file:///h:\hj%20archive\2012\01-10-12.docx))

1/10/2012 House Referred to Committee on **Ways and Means** ([House Journal‑page 63](file:///h:\hj%20archive\2012\01-10-12.docx))

**VERSIONS OF THIS BILL**

[12/6/2011](file:///p:\pprever\2011-12\4501_20111206.docx)

**A** **BILL**

TO AMEND THE CODE OF LAWS OF SOUTH CAROLINA, 1976, BY ADDING ARTICLE 10 TO CHAPTER 6, TITLE 44 SO AS TO REQUIRE CERTAIN WASTE, FRAUD, AND ABUSE DETECTION, PREVENTION, AND RECOVERY SOLUTIONS CONCERNING MEDICAID AND CHILDREN’S’ HEALTH PROGRAMS IN THIS STATE, TO PROVIDE FOR THE IMPLEMENTATION OF THESE SOLUTIONS, AND TO DEFINE CERTAIN RELATED TERMS.

Be it enacted by the General Assembly of the State of South Carolina:

SECTION 1. Chapter 6, Title 44 of the 1976 Code is amended by adding:

“Article 10

Medicaid and the Children’s Health Program Integrity Improvement

Section 44‑6‑1210. This article is intended 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 this 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.

Section 44‑6‑1215. As used in this article:

(1) ‘CHIP’ means the Children’s Health Insurance Program also known as the State Children’s Health Insurance Program established under Title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.);

(2) ‘Enrollee’ means an individual who is eligible to receive benefits and is enrolled in either the Medicaid or CHIP programs;

(3) ‘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

(4) ‘Secretary’ means the United States Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare and Medicaid Services.

Section 44‑6‑1220. The provisions of the article apply to State Medicaid programs and the State CHIP program.

Section 44‑6‑1225. The department shall implement provider data verification and provider screening technology solutions to check health care 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.

Section 44‑6‑1230. The department 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. This technology must 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. These edits must 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.

Section 44‑6‑1235. The department 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 this analysis before payment is made to minimize disruptions to the workflow and speed claim resolution;

(4) prioritize these 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.

Section 44‑6‑1240. 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, high‑risk identification lists, and direct patient and provider interviews. These services must emphasize providing education to providers and ensuring that these educators may review and correct any problems identified before adjudication.

Section 44‑6‑1245. (A) The department shall implement Medicaid and CHIP claims audit and recovery services to:

(1) identify improper payments due to nonfraudulent issues;

(2) audit claims;

(3) obtain provider sign‑off on the audit results; and

(4) recover validated overpayments.

(B) Post payment reviews must ensure that the diagnoses and procedure codes are accurate and valid based on the supporting physician documentation within the medical records.

(C) Additional core categories of reviews may be implemented, including reviews of:

(1) Coding Compliance Diagnosis Related Group (DRG);

(2) transfers, readmissions, and cost outliers;

(3) outpatient 72‑Hour Rule Reviews; and

(4) errors relating to payments and billing.”

SECTION 2. If any section, subsection, paragraph, subparagraph, sentence, clause, phrase, or word of this act is for any reason held to be unconstitutional or invalid, such holding shall not affect the constitutionality or validity of the remaining portions of this act, the General Assembly hereby declaring that it would have passed this act, and each and every section, subsection, paragraph, subparagraph, sentence, clause, phrase, and word thereof, irrespective of the fact that any one or more other sections, subsections, paragraphs, subparagraphs, sentences, clauses, phrases, or words hereof may be declared to be unconstitutional, invalid, or otherwise ineffective.

SECTION 3. This act takes effect upon approval by the Governor.

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