

**Chapter 74.64 RCW**  
**MEDICAL SERVICES PROGRAM—WASTE, FRAUD, ABUSE DETECTION, PREVENTION,**  
**AND RECOVERY SOLUTIONS**

**Sections**

74.64.005 Intent.  
74.64.010 Definitions.  
74.64.020 Contracting for services.  
74.64.030 Funding for chapter—Reimbursement methods.  
74.64.900 Effective date—2012 c 234.

**RCW 74.64.005 Intent.** It is the intent of the legislature to:

(1) Implement waste, fraud, and abuse detection, prevention, and recovery solutions to improve program integrity for medical services programs 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) Invest in the most cost-effective technologies or strategies that yield the highest return on investment. [2012 c 234 s 1.]

**RCW 74.64.010 Definitions.** The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Authority" means the Washington state health care authority.

(2) "Enrollee" means an individual who receives benefits through a medical services program.

(3) "Medical services programs" means those medical programs established under chapter 74.09 RCW or other applicable law, including medical assistance, the limited casualty program, children's health program, medical care services, and state children's health insurance program. [2018 c 201 s 7022; 2012 c 234 s 2.]

**Findings—Intent—Effective date—2018 c 201:** See notes following RCW 41.05.018.

**RCW 74.64.020 Contracting for services.** (1) Not later than September 1, 2012, the authority shall issue a request for information to seek input from potential contractors on capabilities that the authority does not currently possess, functions that the authority is not currently performing, and the cost structures associated with implementing:

(a) Advanced predictive modeling and analytics technologies to provide a comprehensive and accurate view across all providers, enrollees, and geographic locations within the medical services programs in order to:

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

(ii) Be integrated into the existing medical services programs claims operations;

(iii) Undertake and automate such analysis before payment is made to minimize disruptions to agency operations and speed claim resolution;

(iv) Prioritize such identified transactions for additional review before payment is made based on the likelihood of potential waste, fraud, or abuse;

(v) Obtain outcome information from adjudicated claims to allow for refinement and enhancement of the predictive analytics technologies based on historical data and algorithms with the system;

(vi) 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;

(b) Provider and enrollee data verification and screening technology solutions, which may use publicly available records, for the purposes of automating reviews and identifying and preventing inappropriate payments by:

(i) Identifying associations between providers, practitioners, and beneficiaries which indicate rings of collusive fraudulent activity; and

(ii) Discovering enrollee attributes which indicate improper eligibility, including, but not limited to, death, out-of-state residence, inappropriate asset ownership, or incarceration; and

(c) Fraud investigation services that combine retrospective claims analysis and prospective waste, fraud, or abuse detection techniques. These services must include analysis of historical claims data, medical records, suspect provider databases, and high-risk identification lists, as well as direct enrollee and provider interviews. Emphasis must be placed on providing education to providers and allowing them the opportunity to review and correct any problems identified prior to adjudication.

(2) The authority is encouraged to use the results of the request for information to create a formal request for proposals to carry out the work identified in this section if the following conditions are met:

(a) The authority expects to generate state savings by preventing fraud, waste, and abuse;

(b) This work can be integrated into the authority's current medical services claims operations without creating additional costs to the state;

(c) The reviews or audits are not anticipated to delay or improperly deny the payment of legitimate claims to providers. [2012 c 234 s 3.]

**RCW 74.64.030 Funding for chapter—Reimbursement methods.** It is the intent of the legislature that the savings achieved through this chapter shall more than cover the cost of implementation and administration. Therefore, to the extent possible, technology services used in carrying out this chapter must be secured using the savings generated by the program, whereby the state's only direct cost will be funded through the actual savings achieved. Further, to enable this model, reimbursement to the contractor may be contracted on the basis of a percentage of achieved savings model, a per beneficiary per month model, a per transaction model, a case-rate model, or any blended model of the aforementioned methodologies. Reimbursement models with the contractor may include performance guarantees of the contractor to ensure savings identified exceeds [exceed] program costs. [2012 c 234 s 4.]

**RCW 74.64.900 Effective date—2012 c 234.** This act takes effect  
July 1, 2012. [2012 c 234 s 7.]