



Tom Suehs, Executive Commissioner

**Request for Information
For
Pre-Payment Review of Claims and Other Strategies to
Reduce Medicaid Fraud**

RFI No. 529-12-0056

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Table of Contents

1. Introduction	3
1.1. Background	3
1.2. Purpose	3
1.3. Definition of Terms	4
1.4. Mission Statement.....	4
1.5. Mission Objectives	4
2. Scope of Work	6
2.1. General Scope	6
2.2. HHSC Disclaimer	6
2.3. Medicaid Management Information System and Business Areas	7
3. General Instructions	10
3.1. Response Submission, Date, Time and Location	10
3.2. Copies of Response	10
3.3. Designated Point of Contact	10
3.4. Texas Public Information Act	11
3.5. Disclaimers.....	11
Attachment 1: Response To Request For Information – Executive Summary and qualifications ..	12
Attachment 2: Response To Request For Information – Detailed information	13

1. Introduction

1.1. Background

Since 1991, the Texas Health and Human Services Commission (HHSC) has overseen and coordinated the planning and delivery of health and human service programs in Texas. HHSC is established in accordance with Texas Government Code Chapter 531, and is responsible for the oversight of all Texas health and human service agencies (HHS Agencies). HHSC was later designated as the single state agency responsible for administering the Texas Medicaid program. HHSC's chief executive officer is Thomas M. Suehs, Executive Commissioner of Health and Human Services.

1.2. Purpose

This Request for Information (RFI) is issued for the purpose of HHSC obtaining information to identify and solicit feedback from capable sources regarding:

- 1) Leading cutting-edge technology capabilities for Predictive Modeling/Management software as well as administrative claim review services and workflow management tools for Texas Medicaid claims, including pre-payment screening, editing, and selective review of claims;
- 2) Strategies for consideration for policy and procedure changes related to identifying fraudulent or improper Medicaid payments; and
- 3) Preparing specifications for a potential future procurement.

HHSC is looking for predictive modeling techniques that can screen, score and select claims that have a high probability of payment error and refer them for review and/or verification. Comprehensive pre-payment review will assist in the prevention of suspect claims from being reimbursed.

HHSC is seeking to determine to what extent products exist in the marketplace which will enable it to achieve its mission of pre-payment fraud elimination and, where products are not ready, when product release is planned. HHSC supports the concept of optimized Medicaid business services potentially operated by multiple vendors who collaborate with HHSC in delivering services to Medicaid beneficiaries and providers and other stakeholders.

All interested parties are encouraged to respond to this RFI. All parties (including individuals, organizations, corporations and partnerships) responding to this RFI must identify themselves and provide a brief explanation of their involvement in working with identifying fraud and improper payments. Responses received on time will be reviewed completely. Vendors whose products most closely align with HHSC's objective might be asked to demonstrate their products for State staff and other stakeholders.

1.3. Definition of Terms

- Abuse--Practices that are inconsistent with sound fiscal, business, or medical practices and that result in unnecessary program cost or in reimbursement for services that are not medically necessary; do not meet professionally recognized standards for health care; or do not meet standards required by contract, statute, regulation, previously sent interpretations of any of the items listed, or authorized governmental explanations of any of the foregoing
- Fraud--Any act that constitutes fraud under applicable federal or state law, including any intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to that person or some other person.
- Waste--Practices that spend carelessly and /or allow inefficient use of resources, items, or services.
- For the purpose of this RFI and the Texas Medicaid program, the following definition of improper payment applies:
 - Payments made to the wrong person, for the wrong amount, the wrong reason or with incomplete documentation. Some of the wrongful payments are due to fraud, while many are due to errors or incomplete data.

1.4. Mission Statement

HHSC requests a comprehensive presentation of:

- leading cutting-edge technology capabilities for Predictive Modeling/Management software as well as administrative claim review services and workflow management tools for Texas Medicaid claims, including pre-payment screening, editing, and selective review of claims;
- compatible technology that can transition into the managed care Encounter environment; and
- strategies for consideration for HHSC and OIG policy and procedure changes related to identifying fraudulent or improper Medicaid payments-

This includes information that will allow HHSC to prepare specifications for a potential future procurement.

1.5. Mission Objectives

It is HHSC's intent that through this RFI, it will gain the necessary knowledge, understanding and information about predictive modeling solution(s) that are able to:

- a. Handle high volume of transactions
- b. Integrate into the existing Medicaid claims flow with minimal effort, time and cost
- c. Integrate into multiple points along a health care claim flow (pre or post adjudication) for the identification of high-risk claims, encounters and providers.
- d. Provide a rapid, real time or near real time solution with large data storing, data mining and pooling capabilities.
- e. Limit the amount of manual effort and review time of the flagged claims, encounters and providers.
- f. Analyze Medicaid managed care encounter data as HHSC transitions from Fee For Service (FFS) to a Managed Care Operations (MCO) delivery system
- g. Maintain current claims processing times.
- h. Utilize a statistically sound, empirically derived predictive modeling technology designed to prevent improper payments and identify suspect billing patterns in both fee for service and encounter data.
- i. Provide advanced predictive modeling techniques based on historical transaction data.
- j. Provide continuous recalibration of scoring models and allow for regular updates through a feedback loop.
- k. Utilize integrated real-time transaction risk scoring and referral strategy capabilities to identify claims that are unusual or demonstrate signs of potential fraud, waste or abuse.
- l. Permit modification to the software in a rapid and timely manner.
- m. Provide a change control process that applies quick changes to react to changing patterns of behavior.
- n. Mark each flagged claim with a Medicaid-defined reason code or model rule explaining to the human reviewer the reason the claim is potentially improper and providing a recommended action (research, obtain medical records).
- o. Allow HHSC visibility into data analysis so that patterns of excessive usage, unusual patterns, comparison to peers, etc are identified, scored, and implemented rapidly.
- p. Provide views for all provider and patient activities across all federal health program payers.
- q. Provide workflow management and workstation tools that have the ability to systematically present scores, reason codes, and treatment actions for high-risk scored transactions.

2. Scope of Work

2.1. General Scope

HHSC is requesting information to determine to what extent Medicaid anti-fraud products and/or strategies exist in the marketplace, which will enable it to achieve its mission of pre-payment fraud and improper payment elimination, early identification of suspicious billing patterns, unusual treatment patterns in claims and encounter data and, where products are not ready, when product release is planned. HHSC may use the information received pursuant to this RFI to develop a procurement that would study, develop and possibly implement a system and or processes specific to anti-fraud and improper payment pre-payment reviews.

2.2. HHSC Disclaimer

This RFI and RFI process is solely for HHSC's benefit and is intended to provide information to HHSC. The RFI is designed to provide respondents with the information necessary for the preparation of informative responses. The RFI is not intended to be comprehensive, and each respondent is responsible for determining all the factors necessary for submission of a response. The RFI response will not be subject to a Request For Proposal (RFP)-type evaluation, but only to a review of the information respondents provide.

HHSC reserves the right not to review or otherwise to reject, in whole or in part and at any time, any or all responses received in response to the RFI. An RFI response might be rejected outright and not reviewed for any or no reason. Issuance of the RFI in no way constitutes a commitment or guarantee by HHSC to award any contract or any RFP for the goods and services described in the RFI. However, Vendors who submit a proposal to this RFI may participate in a future RFP and their participation may be considered a factor in a Best Value procurement.

HHSC is subject to strict accountability and reporting requirements as a recipient of funds from public sources. Any response or other information submitted by a respondent to HHSC is subject to disclosure by HHSC as required by applicable law. HHSC makes no agreements or representations of any kind, and expressly disclaims any requirement to maintain the confidentiality of any information provided by respondents in response to this RFI. All material and information provided to HHSC in response to this RFI shall upon receipt become the property of HHSC and will not be returned.

By submitting a response, the respondent agrees that HHSC may copy the response for purposes of facilitating HHSC's review or use of the information. HHSC will have the right to use ideas that are presented in the response. The respondent represents that such copying will not violate any copyrights, licenses, or other agreements with response to the materials submitted.

HHSC reserves the right to modify this RFI at any time. HHSC reserves the right to contact respondents after the submission of responses for the purpose of clarifying any response. By submitting a response, each respondent agrees that it will not bring any claim, or have any cause or action against, HHSC or any agent of HHSC or the State of Texas, based on any misunderstanding concerning the information provided in the RFI or concerning HHSC's failure, negligent or otherwise, to provide the respondent with pertinent information as intended by this RFI.

HHSC is not responsible for any costs incurred by a respondent that are related to the preparation or delivery of the response, or any other activities of respondent related to this RFI.

Vendors who are currently sanctioned or excluded by CMS or the State of Texas are ineligible to participate in this RFI or any resulting RFP.

2.3. Medicaid Management Information System and Business Areas

Federal Medicaid Management Information System (MMIS) certification is the procedure by which CMS validates that State Medicaid Systems are designed to support the efficient and effective management of the program and satisfy the requirements set forth in Part 11 of the State Medicaid Manual (SMM), as well as subsequent laws, regulations, directives, and State Medicaid Director (SMD) letters.

The certification process also validates that the systems are operating as described in the prior approval documents, i.e., Advance Planning Documents (APDs), Requests for Proposal (RFPs), and all associated contracts submitted to CMS for the purpose of receiving Federal financial participation (FFP).

The Medicaid Enterprise Certification Toolkit (Toolkit for short) was developed to assist States in all phases of the MMIS life cycle beginning with the preparation of an APD through the certification review process. The main features of the Toolkit are the twenty (20) checklists that were developed for six (6) different Business Areas. The checklists contain the Business Area objectives and related systems review criteria necessary to meet the requirements specified in Federal and State laws and regulations.

The State MMIS is called Compass 21 which is compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended or modified by the Health Information Technology for Economic and Clinical Health (“HITECH”) Act, Title XIII of Division A and Title IV of Division B of The American recovery and Reinvestment Act of 2009. Listed below are the eight Medicaid Information Technology Architecture (MITA) Business Areas with selected examples of business functionality derived from the Toolkit or HHSC-specific business functionality:

1. Member Management

- a. Beneficiary Management (Enrollment/Eligibility)**
- b. Automated Eligibility Verification and Claims Submission (AEVCS)**
- c. Web Portal**

2. Provider Management

- a. Enrollment/Credentialing**
- b. Provider Audits/Rates**

- c. **Waiver Programs (Home and Community Based Services [HCBS])**
 - d. **Prepaid Inpatient Health Plans (PIHP) and Prepaid Ambulatory Health Plans (PAHP) Managed Care**
 - e. **Immunization Registry**
- 9. Other Services**
- a. **Print and Mail Services**
 - b. **Document Imaging/Optical Character Recognition (OCR)/Workflow Management**

The above list provides examples of business functionality information HHSC is seeking from vendors responding to this RFI. This is not an all-inclusive list.

3. General Instructions

This RFI is issued for the purpose of obtaining information for consideration by HHSC and/or its agencies for the general understanding of Predictive Modeling Management Software prior to Medicaid claims payments and strategies for policy and procedural changes related to identifying Medicaid payments and in preparing specifications for potential future procurements. Information should be provided in the attachment tables beginning on page 12 of this RFI.

This RFI does not constitute a solicitation of proposals, a commitment to conduct procurement, or an offer to contract or prospective contract. HHSC will not award a contract as a result of this RFI. HHSC will not be liable for any costs incurred by respondents in the preparation and submission of information in responses to this RFI.

All information received by HHSC becomes HHSC's property and will not be returned to the sender. There will be no acknowledgment by HHSC or receipt of the information. Acceptance of responses to this RFI places no obligations of any kind upon HHSC.

3.1. Response Submission, Date, Time and Location

Responses to this RFI are due on December 10, 2011 at 2:00 p.m. Central Time. Responses must be submitted to HHSC's designated point-of-contact, as identified in Section 3.3 below. If after the review of the responses, HHSC determines that it is in the best interests of HHSC and the state, HHSC staff may contact respondents for further information.

3.2. Copies of Response

Respondents must submit seven (7) hardcopy and one (1) electronic copy to the designated HHSC point-of-contact by the date and time specified in this RFI. Electronic submissions must be in, or compatible with, Microsoft Office applications.

3.3. Designated Point of Contact

HHSC's official single point of contact for this RFI and the delivery point for all communications, responses and correspondence is as follows:

Steve R. Bailey
Health and Human Services Commission
Enterprise Contract and Procurement Services (ECPS) Division
4405 N. Lamar Blvd
Austin, TX 78756-3422
Telephone: (512) 206-4653
FAX: (512) 206-5475
steve.bailey@hhsc.state.tx.us

3.4. Texas Public Information Act

A response to this RFI is subject to public disclosure under the Texas Public Information Act, Texas Government Code, Chapter 552 (the Act), unless the response, or any part of the response, can be shown to fall within one or more of the Act's exceptions to required public disclosure. If a respondent believes that parts of the response are exempt from the required public disclosure the respondent must specify those parts and the exception(s) that it believes apply, with specific detailed reasons. HHSC will process any public information request for all or part of a response in accordance with the Act's procedures. Respondents should consult the Texas Attorney General's web site at www.oag.state.tx.us for information concerning the application of the Act's provisions to responses and potentially proprietary information.

3.5. Disclaimers

HHSC, at its sole discretion, may or may not issue a related solicitation or may issue multiple solicitations based on the responses to this RFI. Responding to this RFI is not a condition for eligibility to respond to any subsequent solicitation. Responses to this RFI will not have any bearing, positive or negative, on the evaluation and respondent selection resulting from any proposals that may be received in response to any subsequent solicitation.

Any information received from respondents to the RFI in any form may be used by HHSC without restriction for any purpose determined by HHSC.

HHSC reserves the right to request presentations from any or all respondents to this RFI to further understand the submittal responses. Respondents who are requested to make such presentations are under no legal obligation to make them. Respondents to this RFI will not be reimbursed for any expense incurred in preparing a response.

ATTACHMENT 1: RESPONSE TO REQUEST FOR INFORMATION – EXECUTIVE SUMMARY AND QUALIFICATIONS

Section A: Vendor Identification and Description

Please provide answers, in the space provided, to the following questions. (This template is a MS Word document and cells will expand to fit your response).

1. Provide a clear and concise summary of your qualifications and experience as it relates to this Request for Information.

2. Provide a clear identification and description of your organization.

4. Provide a brief explanation of your interest and experience in publicly funded health and human services.

ATTACHMENT 2: RESPONSE TO REQUEST FOR INFORMATION – DETAILED INFORMATION

Section A: Problem Solving Approach

Please provide answers, in the space provided, to the following questions. (This template is a MS Word document and cells will expand to fit your response).

1. Describe the approach you would use to carry out this task (give examples as needed).
2. Reference any studies or reports that support your recommended approach. Where appropriate, include links to referenced documents.
3. Identify best practices being employed in other states that might impact your recommended approach and implementation strategies.
4. Identify trends in public policy and health and human services delivery that may affect case management and the way it is delivered through your recommended approach. Also indicate how you propose to integrate the Medicaid managed care encounter data into this project in light of HHSC’s transition from FFS to an MCO delivery system.
5. Reference any supportive materials that may be available (brochures, fact sheets, articles, reports, bibliographies, etc.) with links to those documents.
6. Describe the method you would use to determine the cost of carrying out each initiative.
7. Describe how you would involve consumers and providers of case management, advocates, and other stakeholders.
8. Describe the methodology you would use to evaluate the effectiveness of this approach.

Section B: Fraud Detection for HHSC

Please list and describe, in the space provided, the tools you would recommend to meet the following business needs. (This template is a MS Word document and cells will expand to fit your response.)

9. Describe approach to identify behavior patterns by individuals and	List Tools (Add rows as necessary)	Describe Tool Functions	Provide Technical Specifications for Tools
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organizations that indicate potential fraud and/or improper payments.			
10. Describe approach to resolving identities for a single view, holistic picture of an individual's activities across time and across programs, regardless of variations in name, contact information, or other identity information. Identify resolution can also assist in detecting fictitious names or organization or use of information derived through identity theft.			
11. Describe approach to resolving relationships to detect patterns indicative of collusion or other fraud.			

Section C: Pre-Payment Authorization			
Please list and describe, in the space provided, the tools and techniques you would recommend to meet the following business needs. (This template is a MS Word document and cells will expand to fit your response.)			
12. Describe scoring approach for prioritization of	List Tools (Add rows as necessary)	Describe Tool Functions	Describe Techniques Associated with Tools

potential fraud cases so that resources are targeted toward most likely cases.			
13. List the tools and techniques used for top-down analysis of priority cases.			
14. List the tools and techniques used for comprehensive pre-payment review to prevent suspect claims from being reimbursed.			
15. List the tools and techniques used to insure HHSC real-time visibility into data analysis so that patterns of excessive usage, unusual patterns, comparison to peers are identified, scored across all federal health program payers and changes implemented rapidly.			
16. List previous experience with the analysis of HHS domain and data.	Organization	Experience	Reference (name, phone, e-mail)

Section D: Data Analysis Capability and Responsiveness

Please list and describe, in the space provided, the tools and techniques you would recommend to meet the following business needs. (This template is a MS Word document and cells will expand to fit your response.)

17. List the tools and techniques used for handling high volume of HHSC Medicaid claims NOTE: Consider federal health data standards and models.	List Tools	Describe Tool Functions	Describe Techniques Associated with Tools
18. List the tools and techniques used for integrating into the existing Medicaid claims flow with minimal effort, time and cost.			
19. List the tools and techniques used for integrating into multiple points along a health care claim flow (pre or post adjudication) for the identification of high-risk claims.			
20. List the tools and techniques used for providing a rapid, real time or near real time solution with large data storing, data mining and pooling capabilities.			

21. List the tools and techniques used for providing workflow management and workstation tools that have the ability to systematically present scores, reason codes, and treatment actions for high-risk scored transactions.			
22. List any previous experience with the standardization of HHS data.	Organization	Experience	Reference (name, phone, email)

<p>Section E: Privacy and Access Control Please list and describe, in the space provided, the tools and techniques you would recommend to meet the following business needs. (This template is a MS Word document and cells will expand to fit your response.)</p>			
23. List the tools and techniques used for providing role-based access controls for pre-formatted reports. NOTE: Consider federal health data standards and models.	List Tools	Describe Functions	Tool Describe Techniques Associated with Tools
24. List the tools and techniques used for providing role-based access controls for ad hoc reports. NOTE: Consider federal health data standards and models.			
25. List the tools and techniques used			

for providing role-based dashboards for monitoring pre-payment reviews			
26. List the tools and techniques used for identifying data, as necessary.			

Section F: Cost Projections				
Please indicate your order of magnitude cost projections for the various phases of a Medicaid anti-fraud pre-payment project as described using the tools and techniques you have recommended.				
Phase	Time in Months	Hardware Costs	Software Costs	Labor Costs
27. Acquisition of Technology				
28. Development				
29. Deployment				
30. Year 1 Operations & Maintenance				
31. Year 2 Operations & Maintenance				