HOUSE BILL 336

51ST LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 2014

INTRODUCED BY

Emily Kane

AN ACT

RELATING TO HEALTH CARE; REQUIRING THE CORRECTIONS DEPARTMENT TO IMPLEMENT COST-SAVING MEASURES AND AUTOMATED HEALTH CARE BILLING; REQUIRING THE CORRECTIONS DEPARTMENT TO BILL MEDICAID FOR ELIGIBLE HEALTH CARE SERVICES; PROVIDING FOR THE SHARING OF COST SAVINGS WITH VENDORS.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. [NEW MATERIAL] HEALTH CARE BILLING AND CLAIMS RESOLUTION TECHNOLOGY--MEDICAID BILLING FOR ELIGIBLE EXPENSES--SHARED SAVINGS.--

A. The department shall implement or leverage existing state-of-the-art clinical code editing technology to further automate claims resolution and enhance cost containment for the health care items and services that it provides directly or pursuant to contract. The technology shall

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identify and prevent errors or potential overbilling using the automated protocols that the American medical association or the centers for medicare and medicaid services of the United States department of health and human services has developed.

B. The department shall automatically apply clinical code editing technology to claims after it has made an initial adjudication and before claims are paid to achieve the following outcomes:

(1) faster claims processing;

(2) a reduction in the number of pended claims or rejected claims;

(3) an efficient, consistent and transparent claims resolution process; and

(4) the prevention of delays in provider reimbursement.

C. The department shall implement health care claims audit and recovery services to:

(1) identify payments that the department deems to be improper due to nonfraudulent reasons;

(2) audit claims;

(3) obtain provider review of audit results; and

(4) recover payments that the department has identified as overpayments.

D. The department shall conduct automated reviews

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of claims after payment to ensure that diagnoses and procedure codes are accurate and valid, based upon the supporting provider documentation within the pertinent medical records. The department's automated claims reviews shall include, at a minimum, reviews of:

(1) coding compliance for diagnosis-related groups;

(2) patient transfers;

(3) patient readmissions;

(4) cost outliers;

(5) payment errors; and

(6) billing errors.

E. To the extent permissible by federal law, the department shall require that any eligible inpatient hospital and health care services be billed to the state's medicaid program. The department shall implement automated claims payment detection, prevention and recovery solutions to facilitate the identification of hospital and health care items and services that are eligible for medicaid billing. To implement the provisions of this subsection, the department shall leverage any existing automated payment detection, prevention and recovery solutions already in use by the human services department.

F. To the extent possible, the department shall fund technology services for the clinical code editing

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technology required pursuant to this section by entering into shared savings agreements with vendors. A shared savings agreement may include vendor performance guarantees to ensure that the savings achieved pursuant to implementation of the provisions of this section exceed the costs of implementing the provisions of this section.

G. As used in this section:

(1) "claim" means a written or electronically submitted request for payment for items and services rendered to a medicaid recipient;

(2) "department" means the corrections department;

(3) "diagnosis-related groups" means the coding required pursuant to federal law to group health care items and services that inpatient hospitals provide to certain individuals;

(4) "medicaid" means the medical assistance program established pursuant to Title 19 and Title 21 of the federal Social Security Act and regulations and waivers issued pursuant to that act;

(5) "patient" means a person whom the department has determined to be eligible to receive department-funded health care items or services;

(6) "pended claim" means a claim that requires additional information before a claims resolution process may

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be completed;

(7) "provider" means a person that provides health care items or services for which it bills the department or a person with which the department contracts; and

(8) "vendor" means a person that provides information technology services or infrastructure to the department pursuant to the provisions of this section.

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