SENATE BILL 2712

By Ketron

AN ACT to amend Tennessee Code Annotated, Title 41, relative to reducing correctional healthcare costs.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 41, Chapter 21, is amended by adding the following as a new part thereto:

41-21-1001.

It is the intent of the general assembly to:

(1) Reduce the state's correctional healthcare costs by requiring hospitals and other medical service providers to bill medicaid for eligible inmate inpatient hospital and professional services;

(2) Implement improper payment detection, prevention and recovery solutions to reduce correctional healthcare costs by introducing prospective solutions to eliminate overpayments and retrospective solutions to recover those overpayments that have already occurred;

(3) Cap non-contract correctional healthcare reimbursement rates at one hundred ten percent (110%) of the medicare reimbursement rate; and

(4) Embrace technologies to better manage correctional healthcare expenses.

41-21-1002.

This part shall apply to state correctional healthcare systems and services and state contracted managed correctional healthcare services.

41-21-1003.

The department shall cap non-contract payments to correctional healthcare providers at one hundred ten percent (110%) of the federal medicare reimbursement rate.

41-21-1004.

To the maximum extent practicable, all non-contract correctional healthcare claims shall be submitted to the department in an electronic format.

41-21-1005.

Hospitals and other medical service providers shall bill medicaid for all eligible inmate inpatient hospital and professional services.

41-21-1006.

(a) 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. The technology shall identify and prevent errors or potential overbilling based on widely accepted and referenceable protocols such as the American Medical Association and the centers for medicare and medicaid services. The edits shall 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 open adjudication process and fewer delays in provider reimbursement.

(b) 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 correctional healthcare programs in order to:

(1) Assure that hospitals and medical service providers bill medicaid for all eligible inmate inpatient hospital and professional services;

(2) Identify and analyze those billing or utilization patterns that represent a high risk of inappropriate, inaccurate or erroneous activity;

(3) Undertake and automate such analysis before payment is made to minimize disruptions to the workflow and speed claim resolution;

(4) Prioritize such identified transactions for additional review before payment is made based on likelihood of potential inappropriate, inaccurate or erroneous activity;

(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;

(6) Prevent the payment of claims for reimbursement that have been identified as potentially inappropriate, inaccurate or erroneous until the claims have been automatically verified as valid; and

(7) Audit and recover improper payments made to providers based upon inappropriate, inaccurate or erroneous billing or payment activity.

(c) The department shall implement correctional healthcare claims audit and recovery services to identify improper payments due to non-fraudulent issues, audit claims, obtain provider sign-off on the audit results and recover validated overpayments. Post-payment reviews shall ensure that the diagnoses and procedure codes are accurate and valid based on the supporting physician documentation within the medical records.

41-21-1007.

To implement the inappropriate, inaccurate or erroneous detection, prevention and recovery solutions in this part, the department may sign an intergovernmental agreement with another state already receiving these services.

41-21-1008.

(a) Within three (3) months, after the completion of the first implementation year under this part, the department shall submit to the senate and house of representatives state and local government committees, and make available to the public, a report that includes the following:

(1) A description of the implementation and use of technologies included in this part during the year;

(2) A certification by the department that specifies the actual and projected savings to state correctional healthcare programs as a result of the use of these technologies, including estimates of the amounts of such savings with respect to both improper payments recovered and improper payments avoided;

(3) The actual and projected savings in correctional healthcare services as a result of such use of technologies relative to the return on investment for the use of such technologies and in comparison to other strategies or technologies used to prevent and detect inappropriate, inaccurate or erroneous activity;

(4) Any modifications or refinements that should be made to increase the amount of actual or projected savings or mitigate any adverse impact on correctional healthcare beneficiaries or providers;

(5) An analysis of the extent to which the use of these technologies successfully prevented and detected inappropriate, inaccurate or erroneous activity in correctional healthcare programs;

(6) A review of whether the technologies affected access to, or the quality of, items and services furnished to correctional healthcare beneficiaries; and

(7) A review of what effect, if any, the use of these technologies had on correctional healthcare providers, including assessment of provider education efforts and documentation of processes for providers to review and correct problems that are identified.

(b) Not later than three (3) months after the completion of the second implementation year under this part, the department shall submit to the senate and house of representatives state and local government committees, and make available to the public, a report that includes, with respect to such year, the items required under subsection (a) as well as any other additional items determined appropriate with respect to the report for such year.

(c) Not later than three (3) months after the completion of the third implementation year under this part, the department shall submit to the senate and house of representatives state and local government committees, and make available to the public, a report that includes with respect to such year, the items required under subsection (a), as well as any other additional items determined appropriate with respect to the report for such year.

SECTION 2. If any provision of this act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to that end the provisions of this act are declared to be severable.

SECTION 3. This act shall take effect July 1, 2012, the public welfare requiring it.