Senate Bill 753

Sponsored by Senators KNOPP, KRUSE

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.**

Requires Oregon Health Authority to request specified information from potential contractors and, if certain conditions are met, to request proposals to establish and operate systems and technologies designed to detect and prevent improper payments in state medical assistance program.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to payment integrity for the state medical assistance program; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. The Legislative Assembly intends to:

(1) Implement waste, fraud and abuse detection, prevention and recovery solutions to improve payment integrity for the state medical assistance program 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 and strategies to yield the highest return on investment.

SECTION 2. (1) Not later than September 1, 2013, the Oregon Health Authority shall issue a request for information seeking input from potential contractors on the capabilities that the authority lacks, functions the authority is not performing and the costs of implementing:

(a) Advanced predictive modeling and analytics technologies integrated into the medical assistance claims processing system to provide a comprehensive and accurate view across all providers, recipients and geographic regions within the state medical assistance program that will enable the authority to:

(A) Identify and analyze billing or utilization patterns that represent a high risk of fraudulent activity before payment is made in order to minimize disruptions in claims processing operations and speed the resolution of medical assistance claims;

(B) Prioritize transactions identified as likely for potential waste, fraud or abuse to receive additional review before payment is made;

(C) Obtain 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

(D) 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 recipient data verification and screening technologies that use publicly available records for the purpose of automating reviews and identifying and preventing in-

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

appropriate payments by:

(A) Identifying associations within and between providers and provider groups that indicate potential collusive fraudulent activity;

(B) Identifying recipient attributes that indicate potential ineligibility; and

(C) Using fraud investigation 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 and high-risk identification lists, as well as direct patient and provider interviews. Emphasis shall be placed on providing education to providers and ensuring that providers have the opportunity to review and correct any problems identified prior to adjudication.

(2) The authority may use the results of the request for information to create a formal request for proposals to implement the systems and technologies identified in this section if the authority determines that:

(a) Savings will be generated by preventing fraud, waste and abuse;

(b) The systems and technologies can be integrated into the authority's current medical assistance claims processing operations without incurring additional costs to the state; and

(c) The reviews described in subsection (1)(b) of this section are unlikely to delay or improperly deny payment of valid claims.

SECTION 3. The Legislative Assembly intends that the savings achieved through section 2 of this 2013 Act will exceed the costs of implementation and administration. Therefore, to the extent possible, technology services used in carrying out section 2 of this 2013 Act shall be secured using the savings generated under section 2 of this 2013 Act, whereby the state's only direct cost will be funded through the actual savings achieved. Further, to enable this model, contractor reimbursement may be based on a percentage of the achieved savings, or on the number of recipients per month, the number of transactions per month, the number of cases per month or a blend of any of these methodologies. The contractor may be required to guarantee performance that ensures that the savings identified exceed the costs of implementing section 2 of this 2013 Act.

SECTION 4. This 2013 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2013 Act takes effect on its passage.