House
Legislative
Analysis
Section

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MEDICAID CLAIMS & PROCEDURES

Senate Bill 938 (Substitute H-4)
First Analysis (5-17-00)

Sponsor: Sen. Joel D. Gougeon
House Committee: Appropriations
Senate Committee: Families, Mental Health and Human Services

THE APPARENT PROBLEM:

The state delivers health care treatment and services to its Medicaid recipients through a managed care system using qualified health plans (QHPs). The majority of Medicaid recipients, over 740,000 individuals, receive health care services via a QHP. Most of the QHPs are health maintenance organizations (eventually, all Medicaid services will be provided by QHPs). These QHPs have bid and been selected and then entered into contractual arrangements with the state to provide Medicaid services in particular regions. In accordance with federal and state laws and policies, a QHP must also contract with health care providers, such as physicians and hospitals, for the actual delivery of health care services. Though contracts between a QHP and health care providers and facilities prescribe, among other things, the duties of both parties for the submission of claims and payment for health care treatment and services, many health care providers have complained about significant delays by the QHPs in regards to processing claims and issuing reimbursements for services provided. According to the Michigan Health & Hospital Association (MHA), since January 2000, three hospitals have announced plans to close their doors. Continued payment delays and inadequate reimbursement levels were cited as major reasons for the closures. Delays in payment also affect physicians and patients. Medical societies and associations report that money that should go to hire more medical staff to increase accessibility to and quality of care must instead go to hiring additional billing staff to deal with payment delays and denials.

In an effort to address this problem, boilerplate language regarding timely payments was placed in the fiscal year 1999-2000 budget, and is included in the proposed fiscal year 2000-2001 budget for the Department of Community Health. In addition, the Senate held a series of hearings on issues facing QHPs and providers in the fall of 1999. Legislation is being proposed that incorporates many of the suggestions raised during the Senate hearings.

THE CONTENT OF THE BILL:

The bill would amend the Social Welfare Act to require the commissioner of the Office of Financial and Insurance Services (OFIS) to establish a timely claims processing and payment procedure to be used by health professionals and facilities in billing for, and qualified health plans (QHP) in processing and paying claims for, Medicaid services rendered. (Note: The bill refers to the commissioner of insurance, but the Insurance Bureau was previously consolidated into the Office of Financial and Insurance Services by Executive Order.) "Qualified health plan" would mean, at a minimum, an organization that met the criteria for delivering the comprehensive package of services under the Department of Community Health's comprehensive health plan. The commissioner would have to consult with the Department of Community Health, health professionals and facilities, and QHPs in establishing the timely payment procedure. The timely claims payment procedure would have to provide that "clean claim" would mean a claim that, at a minimum, would do the following:

• Identified the health professional or health facility that provided treatment or service, including a matching identifying number.

• Identified the patient and plan.

• Was for covered services. (The bill would specify that including one or more rendered services that were determined not to be covered services would not constitute a fraudulent act.)

• Was certified for accuracy and had the proper information identifying the health care provider as required under the act.

• If necessary, substantiated the medical necessity and appropriateness of the care or service provided.

• If prior authorization were required for certain patient care or services, included any applicable authorization number, as appropriate.

• Included additional documentation based upon services rendered as reasonably required by the payer.

The timely claims processing and payment procedure would also have to provide for all the following:

• A universal system of coding to be used for all Medicaid claims submitted to QHPs.

• That a claim would have to be transmitted electronically or as otherwise specified by the commissioner. A QHP would have to be able to receive claims transmitted electronically.

• That a health professional and facility must bill a QHP within 90 days after the date of services. Once billed, the same bill could not be resubmitted unless certain time frames as prescribed in the bill have passed.

• That a clean claim be paid within the current industry standard at the time of the bill's enactment or within 45 days after the QHP received it, whichever was sooner. A clean claim not paid within the time frame would bear simple interest at the rate of 12 percent per year.

• That a QHP would have to state in writing to the health professional or facility any defect in the claim within 30 days after receiving it.

• That a health professional and health facility would have 30 days after receiving a notice that a claim was defective within which to correct the defect. The QHP would have to pay the claim within 15 days after the defect was corrected.

• That a QHP would have to notify the health professional or facility and the commissioner of the defect, if a claim were returned from a health professional or facility within the allowable 30-day period and the claim remained defective for the original reason or a new reason.

• An external review procedure for adverse determinations of payment as provided under the bill. The commissioner would assess costs for the external review procedure.

• Penalties to be applied to health professionals, health facilities, and QHPs for failing to adhere to the timely claims processing and payment procedure.

• A system for notifying the licensing entity for health maintenance organization, QHPs, and other health care insurers if a penalty was incurred.

Further, if a QHP determined that one or more covered services listed on a claim were payable, the QHP would have to pay for those services and not deny the entire claim because other covered services listed on the claim were defective. The bill would also require the commissioner to establish an external review procedure within parameters specified in the bill.

The Department of Community Health would be prohibited from entering into or renewing a contract with a QHP unless the commissioner determined that the QHP:

• Was a health maintenance organization licensed or issued a certificate of authority.

• Used standardized claims, as outlined in the provider contract, and accepted claims submitted electronically in a generally accepted format.

• Demonstrated the ability to provide all required or covered Medicaid services, including specialized care, to the estimated number of enrollees on a regional basis.

• Met the criteria for delivering the comprehensive package of services under the DCH's comprehensive health plan.

By October 1, 2001, the commissioner would have to report to the Senate and House Appropriations subcommittees on community health on the timely claims processing and payment procedures established under the bill.

MCL 400.111a et al.

HOUSE COMMITTEE ACTION:

Significant changes between the Senate-passed version and the House committee-passed version includes requiring providers to bill within 90 days of providing

a service, changes to the external review process (including changes to the time frames listed in the bill), and clarifying that the submission of uncovered services would not be a fraudulent act.

FISCAL IMPLICATIONS:

According to the House Fiscal Agency, establishment of the timely claims payment procedures and the external review process for denied claims would impose additional responsibilities on the commissioner of the Office of Financial and Insurance Services (OFIS). These functions, along with the report requirement, would result in some level of increased staffing needs and added administrative costs to the state. The amount of increased expenditures is indeterminate at this time because it is not known to what extent health professionals and facilities will seek resolution through the external review process for rejected payment claims. The added costs may be significant given the large number of Medicaid patients enrolled in health plans and the high volume of medical claims involved. The bill authorizes the commissioner to assess for the costs associated with the external review procedure which may offset the added expense. (5-11-00)

ARGUMENTS:

For:

When three hospitals have to close their doors within a few months of each other, it is not hard to see that a serious problem exists. Reportedly, a contributing factor of the closure of these facilities was a delay in receiving reimbursement for services provided to Medicaid recipients. No business can operate if services rendered are not paid for in a timely manner. The bill would, therefore, be an important first step by establishing a procedure for the timely submission of claims by health care providers and timely processing and payment of claims by the QHPs under contract with the Department of Community Health to provide services to Medicaid recipients. Further, at the heart of many claim rejections is that many QHPs deny payment when they consider a claim to be missing information, thus setting a long and lengthy exchange in motion between the provider and the QHP before the required information is garnered and documented. The bill would establish specific criteria that the commissioner would have to include in the timely claims processing and payment procedure that would be developed under the bill. In this way, greater uniformity would be established across the board. Providers would know clearly what information needed to be submitted regardless of which QHP the patient was enrolled with.

Response:

The bill specifies in one section that a "clean claim" is for covered services. However, providers maintain that they are required to bill for all services provided, even if the service is not covered by the health plan. Even though the bill in a later provision specifies that billing for an uncovered service would not constitute a fraudulent act, some are concerned that QHPs will still reject claims that bill for uncovered services. If so, little may be accomplished by the timely claims payment process so touted by the bill's supporters.

For:

The bill would provide a much needed mechanism by which health care providers could have a more direct means of resolving disputes with QHPs. The bill's external review process would eliminate having to go through the courts to settle disputes, as is the current situation. This could result in quicker resolution times.

For:

The timely claims processing and payment procedure would include penalties for noncompliance that could be levied against any offending party, whether it was a provider who did not bill correctly or within specified time frames, or a QHP who failed to reimburse within the time frame set up by the bill or who rejected a claim that under the bill should have been considered to be a clean claim. Having equal penalties for both parties should go a long way in encouraging compliance with the bill's requirements, thus benefitting all concerned.

Against:

The bill would require health professionals and facilities to bill a QHP within 90 days of providing service. However, due to circumstances out of a provider's control, this may not always be possible. For instance, hospitals report that they can't always get confirmation from the state regarding a patient's Medicaid eligibility or confirmation of the proper QHP to bill and still be able to submit a claim within the 90-day period specified in the bill. Even though this may only represent ten percent of the claims, it still could open up facilities and providers to penalties.

Against:

The bill could put a tremendous burden on the commissioner of OFIS, especially in regards to mediating disputes. If other legislation that is currently pending before the House becomes law, the commissioner would also be in charge of handling disputed claims between HMOs and commercial

insurers and their enrollees and members, in addition to providing regulatory oversight for HMOs, which currently is handled by the Department of Community Health. Most likely additional staff would have to be added to implement this bill's requirements.

Against:

The proposed legislation would interject a regulatory agency into the contract between a provider and a QHP in cases involving a disputed claim. Two contracting parties already have legal recourse available to resolve disputes that concern breach of contract. Even with the bill's specified time frames for dispute resolution, it is unclear at this time if involvement by the commissioner will indeed result in quicker claims payments.

POSITIONS:

The Michigan State Medical Society (MSMS) supports the bill. (5-16-00)

The Michigan Chiropractic Society supports the bill. (5-16-00)

The Michigan Association of Health Plans supports the bill. (5-16-00)

The Michigan Health & Hospital Association (MHA) supports the bill, but has a concern regarding providers billing within 90 days of service. (5-16-00)

The Office of Financial and Insurance Services (OFIS) agrees with the concept of having the commissioner be involved in establishing a timely claims payment procedure because state funds are involved. (5-16-00)

Analyst: S. Stutzky

■This analysis was prepared by nonpartisan House staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.