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SFA BILL ANALYSIS

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Senate Bill 938 (Substitute S-2 as reported by the Committee of the Whole)
Sponsor: Senator Joel D. Gougeon
Committee: Families, Mental Health and Human Services

Date Completed: 2-22-00

RATIONALE

The State delivers health care treatment and services to its Medicaid recipients through a managed care system using qualified health plans (QHPs). These QHPs have bid and been selected for, and then entered into contractual arrangements with the State to provide Medicaid services in particular regions. The QHPs may establish contracts with health care providers and facilities to deliver Medicaid services in accordance with Federal and State laws and policies. These contracts prescribe, among other things, the duties of both parties for the submission of claims and payment for health care treatment and services. Even though QHP contracts with medical providers and facilities have been negotiated, claims processing and timely payment (i.e., reimbursement for services rendered) evidently have been and continue to be problematic. According to medical care providers, it is increasingly difficult to receive timely payments from QHPs for the providers' Medicaid services. Some people believe that the State should establish a regulatory structure to ensure the timely payment of claims, efficient claim submission and reimbursement procedures, dispute resolution, and penalties for failure to comply with timely payment requirements.

CONTENT

The bill would amend the Social Welfare Act to require the Insurance Commissioner to establish a timely claims payment procedure to be used by health professionals and facilities in billing for, and by qualified health plans in paying claims for, Medicaid services rendered. The bill identifies what the timely claims payment procedure would have to provide for, including a requirement that a "clean claim" be paid within 45 days or bear 12% annual interest, notification and correction of defects in a claim, a dispute resolution process, and penalties for chronic conduct resulting in unreasonable delays. In establishing the timely payment procedure, the Commissioner would have to consult with the Department of Community Health (DCH), health professionals and facilities, and qualified health plans. ("Qualified health plan" would mean, at a minimum, an organization that met the criteria for delivering the comprehensive package of services under the DCH's comprehensive health plan.)

The timely claims payment procedure established by the Insurance Commissioner would have to provide that "clean claim" would mean a claim that, at a minimum:

-- Identified the health professional or facility that provided treatment or service, including a matching identifying number; identified the patient and plan subscriber; and listed the date and place of service.
-- Was for covered services.
-- 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 the date, time, type of care or services authorized, and the name of the person authorizing that care or service.
-- Included additional documentation based upon services rendered, as reasonably required by the payer.

The timely claims payment procedure also would have to provide for all of 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.
-- The number of days after a service was provided within which a health professional and facility would have to bill a QHP for the claim.
-- That a clean claim would have to be paid

within 45 days after receipt of the claim by the QHP. A clean claim not paid within 45 days would bear simple interest at a rate of 12% per annum.

-- 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 a 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.
-- A dispute resolution process to be implemented by the Commissioner or his or her designee to resolve claim disputes after the Commissioner received notice that a claim remained defective.
-- Penalties to be applied to health professionals, health facilities, and QHPs for failing to adhere to the timely claims payment procedure.
-- A system for notifying the licensing entity if a penalty were incurred for chronic patterns of conduct that resulted in unreasonable delays in paying claims.

By October 1, 2000, the DCH would be prohibited from entering into or renewing a contract with a qualified health plan unless the QHP agreed to follow the timely claims payment procedure established under the bill and required health professionals and facilities under contract with the plan to follow that procedure.

The bill would prohibit the DCH from entering into or renewing a contract with a QHP unless the Insurance Commissioner determined that the QHP:

-- Was a health maintenance organization licensed under the Public Health Code.
-- Used standardized claims, as outlined in the provider contract, and accepted claims submitted electronically in a generally accepted format.
-- Demonstrated the ability to provide required Medicaid services 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, and then annually, the Insurance Commissioner would have to report to the Senate and House Appropriations subcommittees on community health on the timely claims payment procedure established under the bill.

MCL 400.111a et al.

ARGUMENTS

(Please note: The arguments contained in this analysis originate from sources outside the Senate Fiscal Agency. The Senate Fiscal Agency neither supports nor opposes legislation.)

Supporting Argument

Michigan's Medicaid managed care system, using QHPs to reimburse health care providers and facilities for treatment and care rendered, is in need of repair. One of the problems, according to health professionals and representatives of health facilities, has been in the area of untimely payments due to disagreements between health care providers and QHPs over whether a claim is "clean". Qualified health plans apparently consider claims not to be clean when some piece of necessary information is missing from a form, the appropriate preauthorization for services is not documented, or the provision of the actual care or treatment is questioned. These claims, then, are not paid or are delayed while the required information in garnered and documented. The bill would establish specific criteria that would have to be included in the Insurance Commissioner's timely claims payment procedure to determine what would be considered a "clean claim".

Response: The timely claims payment procedure would have to require that a claim be for covered services, in order to be considered a clean claim. This could be problematic because almost no claim would ever be considered clean by a QHP and be paid in a timely manner. According to written testimony from a representative of the Michigan Health & Hospital Association (MHA), "...all providers are required to bill for all services rendered in the treatment of a patient, whether every aspect of the service is a covered benefit or not; failure to do so constitutes fraud". As with traditional health insurance, then, the payer approves the covered services and denies payment for services not covered. The requirement for Medicaid QHPs should be no different.

Supporting Argument

One problem in the timely processing of claims is that some QHPs reportedly do not have the capability to process claims that are electronically transmitted. These organizations apparently require submission of actual paperwork for a Medicaid

services claim, which can be delayed by such things as the mail and the physical processing of the claim, and can be easily misplaced as well. Also, some QHPs apparently use different billing codes from others in processing claims for the same type of service. Health care providers and facilities, then, must submit claims with varying billing codes depending on the particular QHP that is billed. The bill would rectify this situation by requiring that the Commissioner's timely claims payment procedure provide for a universal system of coding for all Medicaid claims submitted to QHPs and require a claim to be transmitted electronically or as otherwise specified by the Commissioner. These requirements not only would facilitate prompt reimbursement for covered services, but would establish standards of efficient operation for QHPs.

Supporting Argument

According to the MHA's testimony, Michigan's nonprofit health care systems and hospitals have been experiencing "slower and lower" payments from QHPs since the Medicaid managed care system was implemented in 1997. The system has not worked as smoothly as it could and there is a need to repair both funding and administrative deficiencies. By establishing clean claim, billing submission, and timely payment requirements, as well as requiring the Insurance Commissioner to establish a dispute resolution process and penalties for bad actors, the bill represents a step toward correcting some of the problems inherent in the Medicaid managed care system.

Response: While administrative deficiencies may need to be righted, and would be addressed by the bill, the Senate Fiscal Agency recently released a report challenging the contention that Medicaid providers are receiving lower payments under the managed care system than under the former fee-for-service system ("An Examination of the Impact of Managed Care on Medicaid Provider Revenues", February 2000).

Opposing Argument

Requiring the Insurance Commissioner to regulate contracts for Medicaid services between health care providers and QHPs would not necessarily be the best use of the State's resources or the optimal method to resolve administrative problems in the Medicaid managed care system. Rather than having a State entity intervene in their business relationship, the parties to the contracts (i.e., the providers and the QHPs) should negotiate the terms of their agreements, with due attention to the kinds of detail the bill includes pertaining to clean claims, electronic transmission, universal coding, and payment schedules. These agreements also should include consequences and repercussions that could correct failures to live up to contractual responsibilities, and the parties should avail themselves of these remedies. Ultimately, if a QHP fails to comply with a contractual agreement, health care providers will be free to choose not to renew that contract. The market will serve to drive those payers out of business if they cannot contract with providers to perform services to Medicaid patients. In addition, new responsibilities that the bill would place upon the Insurance Bureau would require greater expense and new staff for that office.

Legislative Analyst: P. Affholter

FISCAL IMPACT

The bill would codify a claims resolution process similar to that contained in boilerplate language in Public Act 114 of 1999, the FY 1999-2000 DCH budget. The inclusion of a specific interest penalty (12%) would not, in and of itself, result in direct costs to the DCH as the penalty apparently would apply to QHPs. It should be noted that this provision may not be consistent with Federal Medicaid laws and regulations.

The bill would require the Department of Consumer and Industry Services to set up a dispute resolution process and perform additional claims administration responsibilities, as well as compile and present a report to the Legislature. These functions would require the hiring of additional staff. The costs would probably be covered from fee revenues already collected by the Insurance Bureau for other insurance regulatory purposes and penalty revenue that could be collected pursuant to this bill.

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