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SFA BILL ANALYSIS

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Senate Bill 938 (as enrolled) **PUBLIC ACT 187 of 2000**
Sponsor: Senator Joel D. Gougeon
Senate Committee: Families, Mental Health and Human Services
House Committee: Appropriations

Date Completed: 3-12-01

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 are health maintenance organizations that have bid and been selected, 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. Despite the contracts, medical care providers evidently were having some difficulty in obtaining timely payments from QHPs for the providers' Medicaid services. Some people suggested that the State 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 amended the Social Welfare Act to require the Commissioner of the Office to Financial and Insurance Services to establish a timely claims processing and payment procedure to be used by health professionals and facilities in billing, and by qualified health plans in paying claims, for Medicaid services rendered. The bill identifies what the timely claims payment procedure must 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, an external review procedure (which the Commissioner must establish), and penalties for failure to comply.

The bill defines "qualified health plan" as, at a minimum, an organization that meets the criteria for delivering the comprehensive package of services under the Department of Community Health's comprehensive health plan.

The bill took effect on June 20, 2000.

Requirements for Procedure

In establishing the timely claims processing and payment procedure, the Commissioner must consult with the Department of Community Health (DCH), health professionals and facilities, and qualified health plans. The procedure established by the Commissioner must provide that a "clean claim", for purposes of the bill, means a claim that, at a minimum, does or is all of the following:

-- Identifies the health professional or facility that provided treatment or service, including a matching identifying number.
-- Identifies the patient and plan.
-- Lists the date and place of service.
-- Is for covered services.
-- Is certified for accuracy and has the proper information identifying the health care provider, as required under the Act.
-- If necessary, substantiates the medical necessity and appropriateness of the care or service provided.
-- If prior authorization is required for certain patient care or services, includes any applicable authorization number, as appropriate.

-- Includes additional documentation based upon services rendered, as reasonably required by the payer.

The timely claims processing and payment procedure also must do all of the following:

-- Provide for a universal system of coding to be used for all Medicaid claims submitted to QHPs.
-- Require a claim to be transmitted electronically or as otherwise specified by the Commissioner, and require a QHP to be able to receive a claim transmitted electronically.
-- Require a health professional and facility to bill a QHP within one year after the date of service or date of discharge from the facility.
-- Provide that, after a health professional or facility has submitted a claim to a QHP, the professional or facility may not resubmit the same claim to the QHP unless the time frame for payment has passed or the claim is defective (as provided below).
-- Require a clean claim to be paid within 45 days after its receipt by the QHP. A pharmaceutical clean claim, however, must be paid within the industry standard time frame for paying the claim as of the bill's effective date or within 45 days after the QHP's receipt of the claim, whichever is sooner. A clean claim not paid within this time frame must bear simple interest at a rate of 12% per annum.
-- Require a QHP to state in writing to the health professional or facility any defect in the claim within 30 days after receiving it.
-- Provide that a health professional and a health facility have 30 days after receiving a notice that a claim or portion of a claim is defective within which to correct the defect. The QHP must pay the claim within 30 days after the defect is corrected.
-- Require a QHP to notify the health professional or facility and the Commissioner of the defect, if a claim or portion of a claim is returned from a health professional or facility within the allowed 30-day period and remains defective for the original reason or a new reason.
-- Provide for an external review procedure for adverse determinations of payment (as described below). The costs for the procedure must be assessed as determined by the Commissioner.
-- Provide for penalties to be applied to health professionals, health facilities, and QHPs for failing to adhere to the timely claims processing and payment procedure.
-- Provide for a system for notifying the licensing entity for health maintenance organizations (HMOs), QHPs, and other health care insurers if a penalty is incurred.

If a QHP determines that one or more covered services listed on a claim are payable, the QHP must pay for those services and may not deny the entire claim because one or more other covered services listed on the claim are defective or because one or more other listed services are not covered services.

External Review Procedure

The bill requires the Commissioner to establish an external review procedure, according to the following provisions.

A health professional or facility may request an external review by the Commissioner of a QHP's adverse determination if the professional or facility makes the request within 30 days after receiving a notice that a claim or portion of a claim is defective. Within 10 days after the request, the Commissioner must complete a preliminary review to determine whether the external review may proceed, or request more information from the health professional, facility, or QHP. The professional, facility, or QHP must give the Commissioner the requested information within 10 business days after receiving the request. Within five business days after receiving any requested information, the Commissioner must complete a preliminary review to determine whether the external review may proceed.

If the Commissioner determines that the external review may not proceed, he or she must give written notice to the health professional or facility of the specific reasons for the determination, and may permit the professional or facility to reapply for a preliminary review. If the Commissioner determines that the external review may proceed, he or she must give written notice to the health professional or facility and the QHP, and require the QHP to provide within seven business days after the notice any information it used in making the adverse determination.

Failure by a health professional, facility, or QHP to give the Commissioner requested information permits him or her to terminate a review and issue a decision reversing or affirming an adverse determination.

If the Commissioner determines that an external review may proceed, he or she must immediately assign an independent review organization (IRO) to conduct the review. Only an IRO meeting qualifications established by the Commissioner may be assigned to conduct an external review. The IRO may request the health professional or facility and the QHP to provide information. The IRO must review all pertinent information submitted by the professional or facility and the QHP, along with the terms of coverage under the Medicaid plan.

Within 30 days after being assigned, the IRO must give the Commissioner a written recommendation, including the rationale and supporting documentation and any recommendation for an assessment of interest. Within 15 days after receiving the IRO's recommendation, the Commissioner must give written notice to the health professional or facility and the QHP of his or her decision reversing or affirming the QHP's adverse determination, and include the principal reasons for the decision. If an adverse determination is reversed, the QHP must immediately pay the claim and any interest assessed by the Commissioner.

Contracts with QHPs

The bill prohibits the DCH, beginning no later than October 1, 2000, from entering into or renewing a contract with a QHP unless it agrees to follow the timely claims processing and payment procedure and requires health professionals and facilities under contract with the QHP to follow that procedure.

The bill also prohibits the DCH from entering into or renewing a contract with a QHP unless the Commissioner determines that the QHP satisfies all of the following:

-- Is an HMO licensed or issued a certificate of authority in this State.
-- Uses standardized claims, as outlined in the provider contract, and accepts claims submitted electronically in a generally accepted format.
-- Demonstrates the ability to provide all required or covered Medicaid services, including covered specialty care, to the estimated number of enrollees on a regional basis.
-- Meets the criteria for delivering the comprehensive package of services under the DCH's comprehensive health plan.

Other Provisions

By October 1, 2001, the Commissioner must report to the Senate and House Appropriations Subcommittees on Community Health on the timely claims processing and payment procedure established under the bill.

The bill states that it is not a fraudulent act for a health professional or facility to submit a claim under the bill that includes one or more rendered services that are determined not covered services.

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, was in need of repair. One of the problems, according to health professionals and representatives of health facilities, had been in the area of untimely payments due to disagreements between health care providers and QHPs over whether a claim was "clean". Qualified health plans apparently considered claims not to be clean when some piece of necessary information was missing from a form, the appropriate preauthorization for services was not documented, or the provision of the actual care or treatment was questioned. These claims, then, were not paid or were delayed while the required information was garnered and documented. To address this situation, the bill requires the Commissioner to establish a timely claims processing and payment procedure, and identifies specific criteria that must be included in the procedure to determine what will be considered a "clean claim".

Supporting Argument

One problem in the timely processing of claims was that some QHPs reportedly did not have the capability to process claims that are electronically transmitted. These organizations apparently required 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 used different billing codes from others in processing claims for the same type of service. Health care providers and facilities, then, had to submit claims with varying billing codes depending on the particular QHP that was billed. The bill rectifies 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 establish standards of efficient operation for QHPs, which will facilitate prompt reimbursement for covered services.

Supporting Argument

The bill's provisions for an external review procedure closely resemble those contained in the "Patient's Right to Independent Review Act" (Public Act 251 of 2000). That Act also requires the Commissioner to perform a preliminary review of a health carrier's adverse determination, upon the request of a covered person, and to assign a request that is accepted for review to an independent review organization. While that Act applies to decisions made by health insurers and HMOs concerning individuals' coverage, the bill establishes a similar procedure for decisions made by QHPs in regard to claims of health professionals and facilities.

Opposing Argument

The timely claims payment procedure must require a claim to be for "covered services", in order to be considered clean. Since claims can include both covered and noncovered services, almost no claim will ever be considered clean. According to the testimony on behalf of the Michigan Health & Hospital Association, "...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.

Response: The bill specifically requires QHPs to pay for covered services even though a claim is defective in regard to other covered services or includes noncovered services. The bill also makes it clear that the submission of a claim for noncovered services does not constitute fraud.

Opposing Argument

Requiring the Commissioner to regulate contracts for Medicaid services between health care providers and QHPs will 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 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.

Legislative Analyst: P. Affholter
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FISCAL IMPACT

The bill codifies 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%) will not, in and of itself, result in direct costs to the DCH as the penalty apparently will apply to QHPs. It should be noted that this provision may not be consistent with Federal Medicaid laws and regulations.

The bill requires 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 will require the hiring of additional staff. The costs probably will be covered from fee revenues already collected by the Office of Financial and Insurance Services for other insurance regulatory purposes and penalty revenue that may be collected pursuant to this bill.

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