STORAGE NAME: h1843.hcr
DATE: April 6, 1998

HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH CARE STANDARDS AND REGULATORY REFORM
BILL RESEARCH & ECONOMIC IMPACT STATEMENT

BILL #: HB 1843

RELATING TO: Medicaid/HMOs/Claims

SPONSOR(S): Representative Effman and Representative Brooks

COMPANION BILL(S): SB 1584(s)

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:

(1) HEALTH CARE STANDARDS AND REGULATORY REFORM
(2) HEALTH AND HUMAN SERVICES APPROPRIATIONS
(3)
(4)
(5)

I. SUMMARY:

HB 1843 requires Medicaid health maintenance organizations (HMOs) to pay all non-contested claims for services or goods provided under contract, within 35 days from the date the provider submits the claim to the HMO.

The bill establishes procedures for denying or contesting claims, and requires Medicaid HMOs to provide notice within prescribed time limits when denying or contesting claims.

Provisions are made for the payment of 10 percent interest annually on overdue claims.

The bill provides for a waiver of a Medicaid HMO's rights under a provider contract and requires Medicaid HMOs to pay the entire amount of the provider's claim if terms of the act are violated.

There is no fiscal impact on state and local government, or the private sector in general.

II. SUBSTANTIVE RESEARCH:

A. PRESENT SITUATION:

Currently, the 1997-98 Medicaid Prepaid Health Plan Contract, Attachment I.D.14, requires Medicaid HMOs to pay claims to providers of goods and services within 35 days. The HMO may agree to the payment of all claims, deny the claim, or make a request for additional information within 35 days from the receipt of the claim by the HMO. The HMO actively agrees to these conditions at the point they sign a contract with the Agency for Health Care Administration (agency) for the provision of Medicaid services on a capitated basis.

In August of 1997, agency staff met with Representative Effman, Senator Campbell (sponsor of the similar Senate Bill), and approximately 90 representatives of the hospital industry concerning prompt payment issues. During the meeting, it became clear that hospitals were frustrated with HMOs across all lines of business (commercial, Medicare, and Medicaid). As a follow-up to the August meeting, the agency met with HMO representatives in an attempt to understand their perspective regarding prompt payment issues. The HMO representatives identified “upcoding” of procedure codes, billing for non-emergency services, and “unbundling” of services as their primary prompt payment problems.

In November of 1997, the agency and the Department of Insurance (DOI) created a prompt payment task force for all interested stakeholders to explore the problems associated with the prompt payment issues. Subsequent meetings have been held, during which the task force identified five major problems: authorization of services related to emergency rooms, access to emergency room services, medical records documentation, timeliness of payment, and balanced billing by providers.

Recently, the task force has begun to identify best practices in the five areas listed above. It is their hope that these best practices may be used to form the basis of a three-industry agreement. At a March, 1998 meeting, the three industries decided that they wanted industry-specific issues to be addressed by each industry. The agency is compiling the issues, which will be sent to each industry for comment. The answers returned will form the basis of the three-industry agreement.

The agency continues to monitor the Medicaid HMO contractors for compliance with the agency requirement that all claims be paid within 35 days of submission.

B. EFFECT OF PROPOSED CHANGES:

Medicaid HMOs are required to pay all non-contested claims for services or goods provided under contract, within 35 days from the date the provider submits the claim to the HMO.

Procedures are established for denying or contesting claims and requirements are put in place to require Medicaid HMOs to provide notice within prescribed time limits when denying or contesting claims.

Payment of 10 percent per year interest on overdue claims is required.

Provisions are made for a waiver of a Medicaid HMO's rights under a provider contract, and requirements are placed for Medicaid HMOs to pay the entire amount of the provider's claim if terms of the act are violated.

C. APPLICATION OF PRINCIPLES:

1. Less Government:

a. Does the bill create, increase or reduce, either directly or indirectly:

(1) any authority to make rules or adjudicate disputes?

No.

(2) any new responsibilities, obligations or work for other governmental or private organizations or individuals?

No.

(3) any entitlement to a government service or benefit?

No.

b. If an agency or program is eliminated or reduced:

(1) what responsibilities, costs and powers are passed on to another program, agency, level of government, or private entity?

N/A

(2) what is the cost of such responsibility at the new level/agency?

N/A

(3) how is the new agency accountable to the people governed?

N/A

2. Lower Taxes:

a. Does the bill increase anyone's taxes?

No.

b. Does the bill require or authorize an increase in any fees?

No.

c. Does the bill reduce total taxes, both rates and revenues?

No.

d. Does the bill reduce total fees, both rates and revenues?

No.

e. Does the bill authorize any fee or tax increase by any local government?

No.

3. Personal Responsibility:

a. Does the bill reduce or eliminate an entitlement to government services or subsidy?

No.

b. Do the beneficiaries of the legislation directly pay any portion of the cost of implementation and operation?

No.

4. Individual Freedom:

a. Does the bill increase the allowable options of individuals or private organizations/associations to conduct their own affairs?

Yes.

b. Does the bill prohibit, or create new government interference with, any presently lawful activity?

No.

5. Family Empowerment:

a. If the bill purports to provide services to families or children:

(1) Who evaluates the family's needs?

N/A

(2) Who makes the decisions?

N/A

(3) Are private alternatives permitted?

N/A

(4) Are families required to participate in a program?

N/A

(5) Are families penalized for not participating in a program?

N/A

b. Does the bill directly affect the legal rights and obligations between family members?

N/A

c. If the bill creates or changes a program providing services to families or children, in which of the following does the bill vest control of the program, either through direct participation or appointment authority:

(1) parents and guardians?

N/A

(2) service providers?

N/A

(3) government employees/agencies?

N/A

D. STATUTE(S) AFFECTED:

Section 409.912, F.S.

E. SECTION-BY-SECTION RESEARCH:

Section 1. Creates s. 409.91221(1), (2), and (3), F.S., to provide that a Medicaid HMO must pay any claim or any portion of a claim made by a provider for any contracted service which the HMO does not contest or deny within 35 days after the provider submits the claim to the HMO. Simple interest at the rate of 10 percent per year is applied on overdue payments. An HMO that violates this section waives its rights under the contract and is required to pay the entire amount of the claim presented by the provider.

Section 2. Provides for an effective date of July 1, 1998.

III. FISCAL RESEARCH & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

None.

2. Recurring Effects:

None.

3. Long Run Effects Other Than Normal Growth:

None.

4. Total Revenues and Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring Effects:

None.

2. Recurring Effects:

None.

3. Long Run Effects Other Than Normal Growth:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

It is anticipated that there would be a fiscal impact on the HMOs.

2. Direct Private Sector Benefits:

None.

3. Effects on Competition, Private Enterprise and Employment Markets:

None.

D. FISCAL COMMENTS:

None.

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that municipalities or counties have to raise revenues in the aggregate.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of a state tax shared with counties or municipalities.

V. COMMENTS:

The bill provides a time frame within which Medicaid HMOs must pay claims for contracted services by a health care provider, and stipulates methods for making payments. Further, it provides procedures for contesting or denying claims and requires a 10 percent per year interest on overdue payment of claims.

The bill addresses only the contractual agreement between the HMO and the provider, and does not address out of-network service providers. HMOs are responsible for a time frame in which to settle claims from the point the provider mails or electronically transfers the claim or follow-up information. Some have indicated concern at the fact that this requires HMOs to “start the clock” at a point prior to that point over which the HMO has control.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

None.

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE STANDARDS AND REGULATORY REFORM:

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