OHIO LEGISLATIVE SERVICE COMMISSION

www.lsc.ohio.gov

Office of Research and Drafting

Legislative Budget Office

H.B. 691
133rd General Assembly

Bill Analysis

Version: As Introduced

Primary Sponsors: Reps. Manchester and Plummer

Yosef Schiff, Attorney
Erika Kramer, Attorney

SUMMARY

- Redefines "third-party payer" (TPP) to include managed care organizations and Medicaid managed care organizations, thereby requiring them to comply with the Ohio Prompt Pay Law.
- Revises the time periods for paying or denying a claim that apply when a TPP requires supporting documentation to process the claim.
- Updates the process by which a TPP can request supporting documentation.
- Changes the requirements that apply when a TPP denies a claim.
- Allows a provider to notify the Superintendent of Insurance or Medicaid Director of a TPP's failure to comply with the Prompt Pay Law in certain situations and requires the Superintendent or Director to investigate such a claim.
- Requires the Superintendent or Director to impose monetary penalties for certain violations of the Prompt Pay Law.
- Requires Medicaid managed care organizations and the Medicaid Director to comply with the Prompt Pay Law.

DETAILED ANALYSIS

Overview

The Ohio Prompt Pay Law[1] contains provisions regarding how a third-party payer (TPP) must go about processing claims and reimbursing a provider or beneficiary for health care services provided under a health benefits contract (a sickness and accident policy providing medical coverage or a health insuring corporation contract or other agreement under which a TPP reimburses health care or dental services). The bill makes several changes to the provisions regarding the time periods in which payment must be rendered, when and how a TPP may seek supporting documentation to establish its responsibility to pay, and investigations into a TPP's noncompliance. It also redefines "third-party payer" to include managed care organizations and Medicaid managed care organizations, thus requiring them to comply with the Prompt Pay Law (see "**Medicaid**" below).[2] A managed care organization is defined in the Third Party Administrator Law as an entity that provides medical management and cost containment services and includes a Medicaid managed care organization. A Medicaid managed care organization is a managed care organization under contract with the Department of Medicaid to provide health care services to Medicaid recipients under the managed care component of Medicaid, otherwise known as the "care management system."[3]

Time periods, supporting documentation, and denials

The following table compares the bill's provisions regarding time periods, supporting documentation, and denials to current law. In short, while the bill retains the basic requirement that a TPP pay or deny a claim within 30 days of receiving the claim, it:

1. Revises the time periods that apply when supporting documentation is required;
2. Updates the provisions regarding when and how a TPP may seek supporting documentation; and
3. Changes the requirements regarding the denial of a claim.

These provisions apply when a provider or beneficiary submits a claim on the standard claim form, which is a form developed by the Superintendent of Insurance and used by all TPPs and providers for reimbursement of health care services and supplies. In the case of a TPP providing coverage under the Medicaid care management system, these provisions apply when the claim is submitted on the claim form required by the TPP.[4]

---

[1] R.C. 3901.38 through 3901.3814; Ohio Department of Insurance, *Ohio's Prompt Pay Law*, July 1, 2019, https://insurance.ohio.gov/wps/portal/gov/odi/about-us/divisions/market-conduct/resources/ohios-prompt-pay-law (accessed July 17, 2020).

[2] R.C. 3901.38 and 5167.104.

[3] R.C. 3959.01 and 5167.01, not in the bill.

[4] R.C. 3901.381(B)(1); R.C. 3902.22, not in the bill.

Current law	H.B. 691 (As Introduced)
Claim submitted, supporting documentation is not needed, and claim is not materially deficient	
Requires, generally, the TPP to pay or deny the claim within 30 days *(R.C. 3901.381(B)(1)).*	Same *(R.C. 3901.381(B)(1)).*
If denied, requires the TPP to notify the provider and beneficiary and state with specificity the reason for the denial *(R.C. 3901.381(B)(1)).*	Same, but requires the TPP to notify the beneficiary through appropriate means and the provider through the remittance process with industry-standard codes *(R.C. 3901.381(B)(2)(a)).*
No provision.	Requires a denial to be returned to the provider in the 835 file (an electronic transaction that is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 and is used by providers to record and document claim payment information) *(R.C. 3901.381(B)(2)(c) and (F)).*
No provision.	Prohibits a TPP from denying a claim solely because the claim lacks supporting documentation *(R.C. 3901.381(B)(3)(a)).*
Claim submitted, supporting documentation is needed, but claim is not materially deficient	
Generally, requires, if supporting documentation is needed, the TPP to pay or deny the claim within 45 days if the claim is not materially deficient but permits the TPP to request supporting documentation within 30 days (see below).	Gives the TPP ten days to request supporting documentation and requires the TPP to pay or deny the claim not later than five days after receipt of the documentation.
Supporting documentation to establish the TPP's responsibility to pay includes the following: ▪ Verification of employer and beneficiary coverage; ▪ Confirmation of premium payment; ▪ Medical information; ▪ Information on the responsibility of another TPP to pay or confirm the amount of payment by another TPP; ▪ Information needed to correct material deficiencies related to diagnosis or treatment or the provider's identification. *(R.C. 3901.381(B)(2)(a).)*	Same, but also includes a determination of eligibility for benefits. *(R.C. 3901.381(B)(1) and (3)(c).)*

Current law	H.B. 691 (As Introduced)
Unless claim is materially deficient (see "**Claim submitted but is materially deficient**" below) requires the TPP to notify all relevant external sources of documents not later than 30 days after receipt of claim that supporting documentation is needed. Each notice must specify the documents needed. If notice was not provided in writing, the provider, beneficiary, or other TPP may request the TPP to provide it in writing, and the TPP must then do so. If any of the documents are under control of the beneficiary, the beneficiary must provide them to the TPP *(R.C. 3901.381(B)(2)(a)).*	Same, but requires this notice to always be *in writing* and shortens the deadline for the notice from 30 days to not later than ten days after receipt of claim. Also requires the provider to provide the requested documentation in writing. *(R.C. 3901.381(B)(3)(h.)).*
Requires a TPP to pay or deny a claim within 45 days, as follows: ▪ Days between TPP's initial request for supporting documentation and receipt of that documentation do not count towards the 45 days (payment or denial of claim can go beyond 45 days); ▪ If the TPP requests additional supporting documentation after receipt of the initial documentation, days between the TPP's request and receipt of the additional documentation generally does count (45-day clock resumes after receipt of initial set); ▪ If the requested additional documentation relates to an unknown preexisting condition, days between the request for the additional supporting documentation and receipt of the documentation do not count. *(R.C. 3901.381(B)(2)(a) and (b)).*	If supporting documentation was requested, requires the TPP to pay or deny the claim within five days of receipt of the documentation *(R.C. 3901.381(B)(3)(b))*.
If the TPP determines that supporting documentation related to medical information is routinely necessary regarding a particular service, requires the TPP to establish a description of the documentation that is routinely necessary and make the description available to providers in a readily accessible format *(R.C. 3901.381(B)(2)(d))*.	Limits this requirement to the 20 most claimed health care services and requires the TPP to publicly post the description on its website, updated annually. Requires a TPP to accept all such documentation electronically. *(R.C. 3901.381(B)(3)(j).)*

Current law	H.B. 691 (As Introduced)
No provision.	Requires all requests for information to be returned to the provider in the 835 file *(R.C. 3901.381(B)(3)(d))*.
No provision.	Prohibits a TPP from requesting medical records or itemized reports prior to payment for any of the following *reasons*: ▪ For purposes of determining whether services billed are documented in the record; ▪ For purposes of utilization management, if the services were to treat an emergency medical condition; ▪ The amount of the claim *(R.C. 3901.381(B)(3)(f))*.
No provision.	Prohibits a TPP from requesting medical records or itemized reports prior to payment for any of the following *claim types*: ▪ The claim is for services that were prior authorized; ▪ The claim is for inpatient services for which the provider notified the plan within 48 hours of admission or the plan requested medical records during the course of the inpatient stay; ▪ The claim was subject to any other type of prepayment review *(R.C. 3901.381(B)(3)(g))*.
No provision	Requires managed care organizations to: ▪ Provide claim and remark adjustment reason codes that specify the type of documentation requested; ▪ Update the claim status on its portal with a date and time stamp upon receipt of supporting documentation *(R.C. 3901.381(B)(3)(e)).*

Current law	H.B. 691 (As Introduced)
Claim submitted but is materially deficient	
Requires the TPP to notify the provider or beneficiary of material deficiencies in the claim not related to a diagnosis or treatment or the provider's identification not later than 15 days following receipt of the claim. The notice must specify the information needed to correct the deficiencies. Once corrected, the TPP must pay or deny the claim or request supporting documentation as described above. The 15-day time period does not apply if the material deficiencies relate to a diagnosis or treatment or the provider's identification. In that case, a TPP may request information to correct the deficiencies after 15 days has elapsed. Such requests are to be made in the same manner as requests for other supporting documentation as described above, and payment or denial is subject to the same time periods as other claims that need supporting documentation. *(R.C. 3901.381(B)(3).)*	No provision: claims that are materially deficient are treated the same as other claims that require supporting documentation *(R.C. 3901.381(B)(3)(c)(vi) and (E)).*
No action by TPP within established timelines	
No provision.	Requires a TPP to immediately remit full payment of a claim if the TPP does not approve, request supporting documentation, or deny a claim within the above timelines *(R.C. 3901.381(B)(4))*.

Investigations and fines

The bill allows a provider to notify the Superintendent of Insurance or the Medicaid Director of a TPP's failure to comply with the above requirements in either of the following situations:

- Twenty per cent or more of the claims submitted by the provider to the TPP violate the above requirements;
- An individual claim violates the above requirements and the claim cannot be resolved through a claim dispute process.

The bill requires the Superintendent or Director to investigate such claims within 15 days of receipt according to the investigation procedure outlined below.[5]

Under continuing law, following the completion of an examination involving information collected over a six-month period, the Superintendent may impose administrative penalties on a TPP that has engaged in a consistent pattern or practice of violating the Prompt Pay Law. The bill retains these provisions, but adds that the Superintendent or Director must also conduct an investigation upon receiving notification *from a provider* that the TPP is in violation of the Prompt Pay Law. In that case, the provider and TPP must provide all requested documentation to the Superintendent or Director. The bill allows the Superintendent and Director to adopt rules as needed to carry out this provision.[6]

If the Superintendent or Director determines that a TPP has committed the violation described in the first bullet point above (the TPP has violated the requirements with respect to 20% or more of a provider's claims), the Superintendent or Director must impose a fine equal to 100% of the aggregated bill claims that were found delinquent. If the TPP committed the violation described in the second bullet point (unresolved individual violations), the required fine is 50% of the billed claim for every 14 days the claim remains delinquent. The bill requires these fines to be paid to the provider in question. The Superintendent and Director are required to adopt rules prescribing how the fines are paid to the provider. The bill exempts these rules from the continuing law requirement that an agency must eliminate two rules for each new rule it imposes.[7]

Administrative remedies

Under current law, if the Superintendent of Insurance finds, after an examination involving information collected from a six-month period, that a TPP has committed a series of violations that constitute a consistent pattern of violating the time limits described above, the Superintendent can impose on the TPP certain administrative remedies, including:

- Levying a monetary penalty;
- Ordering the TPP to pay interest on the claims directly to the provider;
- Ordering the TPP to cease and desist from engaging in the violation;
- If a monetary penalty is not levied, imposing any of the sanctions permitted under continuing law for unfair and deceptive acts or practices in the business of insurance (the bill clarifies that this remedy does not apply to TPPs that provide coverage under the Medicaid care management system, such as Medicaid managed care organizations).[8]

[5] R.C. 3901.3811(B) and 3901.3812.

[6] R.C. 3901.3812(A)(1).

[7] R.C. 3901.3812(A)(2) through (4) and R.C. 121.95(F), not in the bill.

[8] R.C. 3901.3812(B) and (C).

With respect to TPPs that are Medicaid managed care organizations, the bill generally authorizes the Medicaid Director to impose the same administrative remedies as the Superintendent.[9]

Except as provided above, the bill requires all fines collected by the Medicaid Director to be deposited into the General Revenue Fund and clarifies that fines collected by the Superintendent of Insurance are to be credited to certain funds in specified amounts, in accordance with current law.[10]

Medicaid

As described above, the bill amends the Ohio Prompt Pay Law to include Medicaid managed care organizations as TPPs subject to that law. It also requires Medicaid MCOs and the Department of Medicaid to comply with that law.[11] Under current law, Medicaid managed care organizations are exempt from the Prompt Pay Law and are instead regulated under federal Medicaid law and regulations.[12] The bill clarifies that TPPs providing coverage under the fee-for-service component of Medicaid remain exempt from the Prompt Pay Law.[13]

Federal Medicaid prompt pay regulations

Ohio law requires the Medicaid program to be implemented in accordance with all federal and state law and requires the Department of Medicaid to obtain federal approval for changes to Medicaid, if required by federal law.[14] Federal Medicaid regulations establish claims processing and payment time limits for Medicaid managed care organizations.

The regulations require a Medicaid managed care organization to:

1. Pay 90% of all clean claims from health care providers within 30 days of receipt (as indicated by the claim's date stamp);
2. Pay 99% of all clean claims within 90 days of receipt.[15]

Current law and the bill prohibit TPPs, including TPPs that provide coverage under the Medicaid program, from entering into a contractual arrangement that contains longer time periods for the payment and processing of claims than those established under federal

[9] R.C. 3901.3812.

[10] R.C. 3901.3812(D)(2).

[11] R.C. 3901.38(F), 3901.381, 3901.3812, and 5167.104, with conforming changes in R.C. 3901.383, 3901.3811, and 3901.3814.

[12] R.C. 3901.3814(D); Ohio Department of Insurance, *Ohio's Prompt Pay Law*, July 1, 2019, https://insurance.ohio.gov/wps/portal/gov/odi/about-us/divisions/market-conduct/resources/ohios-prompt-pay-law (accessed July 17, 2020).

[13] R.C. 3901.3814(D).

[14] 42 Code of Federal Regulations (C.F.R.) 438.3(f); R.C. 5162.05 and 5162.06.

[15] 42 C.F.R. 447.46 and 447.45(d).

Medicaid regulations. As part of including Medicaid managed care organizations as TPPs subject to Ohio's Prompt Pay Law, the bill removes language specifying that the contract prohibition applies regardless of whether a TPP is exempt from the Prompt Pay Law.[16]

COMMENT

Former law required the Medicaid Director to apply to CMS for a waiver from the federal Medicaid prompt payment regulations. The waiver would have required Medicaid managed care organizations to process and pay claims in accordance with Ohio's Prompt Pay Law instead of those regulations. If a waiver was granted, or if the Director determined that a waiver was not necessary, the Director was required to send notice to the Superintendent of Insurance and implement the Prompt Pay Law with respect to Medicaid managed care organizations beginning 180 days after the notice. These requirements were repealed in 2019 by H.B. 166 of the 133rd General Assembly.[17]

HISTORY

Action	Date
Introduced	06-08-20

H0691-I-133/ts

[16] R.C. 3901.383(B).

[17] R.C. 5167.25, repealed, with conforming changes in R.C. 3901.3814.