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Chairman Brinkman, Vice Chair Antani, Ranking Member Boggs and members of the House Insurance Committee, thank you for the opportunity to provide proponent testimony on HB 691.

My name is Stephan Shehy, and I am the Manager of Advocacy and Health Policy for UC Health. UC Health is an integrated academic health system serving the Greater Cincinnati region. In partnership with the University of Cincinnati, UC Health combines clinical expertise and compassion with research and teaching – offering patients options for even the most complex situations.

As our clinical teams continue to provide this high standard of care to all patients who come through the door at our facilities, we have faced an enormous administrative challenge with claims being processed and adjudicated in a timely manner. HB 691 addresses this issue by providing legislative oversight over the MCO prompt pay provision and includes many other improvements to current law that will standardize the claims process to the benefit of both providers and payers.

My name is Tim Maloney and I am Vice President of Payer Relations for UC Health. Throughout the past several years, we have identified a growing trend of claims being denied at an increasing rate. To put this into context for UC Health, I have outlined several challenges we have faced regarding the approval or denial of claims.

1. Some MCOs are now requesting medical records with claims to verify documentation services were performed and to review for medical necessity. This despite the fact that
   - MCOs are notified within 24 hours when a member is admitted.
   - MCOs receive regular concurrent stay reviews during inpatient stays.
   - MCOs participate in discharge planning.
   - MCOs conduct post-payment reviews at a high rate.
2. Some MCOs will request itemized bills for any and all "high dollar" claims without further basis for the request. For example, in making its request the MCO does not take into account the complexity of the patient's condition, the length of stay, or whether the bill was reasonable under the circumstances based on past experience. Further, as noted above, the MCO is kept aware of the case and the care provided from the time of admission to discharge.
3. Additional documentation is not required to for a claim to be a "complete claim."
4. Requests for additional documentation pre-payment are not uniform among plans[i].
   - One MCO denied $51M, 60% of all denials, in dollar terms. Denials for additional documentation for this plan amounted to 8% of total claims dollars. This one payer accounted for over 40% of pre-payment audits as measured in dollars, although the MCO accounts for less than 15 percent of our total claims dollars.

- Other MCOs and the Medicare program conduct few pre-payment audits. Across all plans, including the plan noted above, pre-payment audits amounted to 3% of claims dollars. The Medicare programs did not conduct a single pre-payment audit in the last year.

5. Plans often also request records to conduct post-payment audits. In addition, in the past year we have seen an increase in the volume of post-payment review from some MCOs despite the fact that these reviews usually result in no findings[ii].
    - Record requests increased by 59 percent.
    - Over 80% of these audits result in no findings.
    - Three MCOs accounted for over 70 percent of all requests – requesting as many as 1,500 records.
    - Percentage increase in requests over prior year across major MCOs varied from -29% to 1,634% (from 30 to 550).
6. At the same time, we have seen some MCOs increase pre-payment audits as well.
    - 15% of claims denials by count (3,502), but
    - 46% of claims denials in terms of dollars ($125M)[iii]
7. MCOs will require medical records when a patient is re-admitted within 30 days of discharge, despite the fact the MCO was advised of the second admission at the time of the admission, was provided concurrent stay review throughout the course of the stay, and was involved in discharge planning.
8. Some plans request itemized bills for pre-payment audit for any claim over a certain dollar threshold without any further basis for believing charges are over-stated.
9. Depending on the requesting MCO, providers may be able to send itemized bills by email, fax, or US Postal Service. At least one MCO requires that records be sent only by US Postal Service.
10. Typically, medical records can be uploaded to an online portal, but again not all MCOs offer this option.
11. When MCOs request additional information, they do it through an electronic transaction. The electronic record is not specific, indicating only that additional information is requested. The provider must then investigate to determine what additional information is requested.
12. Additional documentation sent by providers is sometimes not received by the plans or lost.[iv]
    - An MCO requested an itemized bill. We sent the bill, as directed by the plan, on three occasions: once by fax, once by certified mail, and once by email. The MCO claimed not to have received any of the transmissions. The claim remains un-adjudicated today, 90 days past the date we submitted the claim.
    - An MCO requested an itemized bill on December 26, 2019. The bill was sent same day. Receipt was verified. The MCO did not acknowledge receipt of the record until March 23, 2020 – about 90 days later.

- We uploaded medical records to the MCO's portal on June 11, 2020. As of September 2020 – about 90 days later - the plan was still reviewing the records.

13. Pre-payment audits can substantially delay claims adjudication[v]
    - A plan requested medical records. Records sent on February 4, 2020. The MCO acknowledged receipt February 18, 2020. On March 30, 2020, nearly 60 days later, the MCO said it had completed its review of medical records and was now conducting a high dollar review and a COB review.
    - Medical records were received by the MCO on March 2, 2020. As of March 30, 2020, the MCO was still reviewing the records.
    - Medical records were sent to the MCO on November 1, 2019, and again on February 27, 2020. On March 30, 2020, the MCO was still reviewing records.
14. Numerous complaints filed with ODM regarding prompt pay violations.
    - Through November 13, 2020, we had filed at least seven prompt pay complaints in calendar year 2020.
    - We meet quarterly, or more frequently if needed, with MCOs to review claims problems. Although some MCOs have started to refuse to meet, requiring we communicate only by spreadsheet.

HB 691 addresses these issues through several key reforms. This bill can be divided into three parts: adjudication reform, standardization of claims, and compliance.

Adjudication Reform

With the inclusion of MCOs into Ohio's prompt pay law, HB 691 shortens the timeframe for claims to be adjudicated, and the lines of communication between the providers and plans are standardized to increase efficiency. Under current law, plans have thirty days to either approve or deny a claim. If the plan requests additional information, they receive fifteen additional days to adjudicate the claim after the documentation is received. Under the bill, the thirty-day timelines is not changed. The bill, instead, modifies the timeline for the adjudication process if additional information is requested. This request would have to be made within ten days of receipt of the claim. Once the information is sent by the provider, the plans would have five days to either approve or deny the claim.

In addition to the changes made to the timeline for adjudication, HB 691 prohibits plans from denying a claim based on the lack of supporting documentation. This is an important piece of the legislation because it ensures claims are approved or denied based upon the medical necessity and health benefit coverage offered by the plans, and to Tim's point, claims would no longer be denied because of a request for more information by the payer.

At UC Health, we want to make sure that we provide all relevant information to the plans for them to make an informed decision on every single claim that we submit. Current law enumerates certain items that are considered supporting documentation relevant to a payer's evaluation. To assist plans in making these informed decisions, HB 691 adds documentation necessary for a plan

to make a determination based upon the eligibility of benefits. We believe plans need this information on the front end so they can ensure that they are responsible for the claim.

However, as Tim stated earlier, it has been common practice in the health care claims field that information is requested by the plans that are not relevant to approving or denying a claim. HB 691 prohibits plans from requesting certain documentation on the front end of a claim review. These items can be found on page 5 of the LSC analysis, and include medical records or itemized reports to determine whether services billed are documented in the record, utilization management if the services were provided during a medical emergency, or if the documentation requested by the plan is due to the cost of the claim.

HB 691 also prohibits certain types of documentation be requested by the plans in the front-end process for the reason described, before. These types include claims that were prior authorized, inpatient services when the plan was notified of the patient’s stay within 48 hours of admission, or if the claim was already subjected to a prepayment review.

Standardization of Claims

It has been our experience that there is no standardization of the claims process between the payers and the providers. This causes a large administrative burden for both parties. HB 691 addresses this confusion by requiring communication between the parties to occur through the 835 file through the online portal that Tim has briefly described. All requests for additional documentation must be done through this portal and the providers must submit the documentation through this process. By having all plans and providers work in this manner, adjudications of claims can be completed in a much more efficient and transparent manner when compared to current practice of phone calls, mail and fax.

Compliance

The third component of this bill is compliance. Under current law, the Department of Insurance has the ability to levy several different kinds of fines and could ultimately bar a plan from operating in the state. HB 691 does not eliminate these provisions, but it does add additional enforcement mechanisms available for the department to use to urge compliance.

HB 691 allows for providers to submit complaints of prompt pay violations to ODM and ODI. Under this legislation, there is a two-tiered penalty system for individual complaints and habitually noncompliant entities.

For individual complaints, providers, and plans are encouraged to exhaust current private reconciliation methods to reach an agreement. If those steps do not lead to an agreement, the provider is permitted to file a complaint with the proper department. The department is required to then conduct a review of the claim and determine if the claim indeed violates Ohio’s prompt pay statute. Both the provider and the plan must provide the department with all requested documentation by the department so the claim can be investigated. If the department finds that the plan did not comply with the law, the department shall levy a fine equal to fifty percent of the billed charge every fourteen-days of delinquent payment.

If a health care provider finds that twenty percent of the claims filed within a thirty-day period to a specific plan are outside of prompt pay standards, the provider may file a complaint with the department. The department would follow the same procedure described for individual complaints but would instead levy a fine equal to one-hundred percent of the billed charges for the submitted claims every fourteen days of delinquent payment.

Conclusion

As Representative Manchester stated in her opening testimony, and I have described here, today, HB 691 seeks to ensure that bills that should be paid are paid, and they are paid on time. We also respect and appreciate the important role plans play in ensuring tax dollars and premiums are spent in a responsible manner, free from fraud, waste and abuse. This bill will help improve the entire claim system, and allow all parties to improve their service to patients.

I also want to thank the Department of Medicaid for their willingness to help address this issue through the most recent RFA. A standardization of files and shortening the timeframe for evaluating claims is included in the RFA, and we look forward to working with the administration and the General Assembly on this important issue.

Thank you for your time, and we would be happy to answer any questions.

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[i] From UC Health Revenue Cycle dashboard reports, top 12 payers denials dashboard, 11/18/2109 through 11/6/2020.
[ii] These stats are all from the report compiled by Corporate Director, Medical Records, comparing UC Health FY 2020 to FY 2019.
[iii] UC Health Revenue Cycle dashboard reports cited above.
[iv] These examples are from UC Health operations committee meetings with various MCOs in calendar 2020.
[v] Same source as above.