THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Jennifer Carlson
Associate Vice President for Government Affairs
The Ohio State University Wexner Medical Center and Health Sciences
Written Testimony on SB 691
November 17, 2020

Chairman Brinkman, Vice Chairman Antani, and Ranking Member Boggs, thank you for the opportunity to submit written testimony in support of HB 691. I commend Representatives Manchester and Plummer for introducing legislation to clarify prompt pay requirements by third party payers.

Part of one of the most comprehensive health sciences campuses in North America, The Ohio State University Wexner Medical Center (OSUWMC) includes the College of Medicine and its School of Health and Rehabilitation Sciences; the Office of Health Sciences, including the Ohio State Faculty Group Practice; various research centers, programs and institutes; The Ohio State University Comprehensive Cancer Center – Arthur G. James Cancer Hospital and Richard J. Solove Research Institute; and the Ohio State Health System, which includes University Hospital, East Hospital, Ohio State Harding Hospital, the Richard M. Ross Heart Hospital, Dodd Rehabilitation Hospital, the Ohio State Brain and Spine Hospital, the Ohio State Primary Care Network, Outpatient Care multispecialty facilities and Ohio State Walk-in Care Upper Arlington.

In 2020, U.S. News & World Report recognized four Ohio State Wexner Medical Center specialties in its "Best Hospitals" rankings, based on outcomes, structure, patient experience and reputation, for the 28th consecutive year. In addition, the College of Medicine ranked 34th among medical schools in the 2021 edition of "Best Graduate Schools," according to U.S. News.

OSUWMC, like other hospitals, has faced continued delays in payment. Although third party payers (TPPs) generally are to pay or deny a claim within 30 days, payers frequently deny claims and restart the 30 day window to endlessly delay payments. The Ohio Hospital Association reports that hospitals currently are owed billions in payments as a direct result of the endless delays.

Requests for supporting documentation from providers, including itemized bills and medical records, have continued to increase and impose an administrative burden due to lack of standardization and response expectations across TPP's.

We are pleased that H.B. 691 would clarify and streamline requirements for hospitals' payment by TPPs, including managed care organizations (MCOs) and Medicaid MCOs.

H.B. 691 would make the following beneficial changes to the process:

- Providing specific allowed scenarios for TPPs to request additional information will improve the process substantially, eliminating the ability of TPP's to request itemized statements or medical records inconsistently and at will.
- Requiring the use of remark adjustment reason codes that identify the supporting documentation requested.
- Requiring immediate remittance of payment in full if the TPP fails to approve, request supporting documentation, or deny a claim reduces provider burden to work to counter a TPP's lack of response.
- Requiring the denial reason to be sent in the 835 file (a standardized electronic transaction used by providers to record and document claim payment information), which will eliminate hardcopy paper requests that are more costly and time consuming to process.
- Requiring the denial reason to be sent in the 835 file using industry standard codes that specify the type of documentation requested, which will ensure that requests are received timely by the provider and could eliminate manual intervention required to clarify the reason for the denial.
- Requiring documentation requests to be in writing, within 10 days of receipt of the claim. These requests should be returned to the provider in the 835 file.
- Requiring TPPs to accept the documentation electronically and update the time stamped confirmation of receipt, which will help ensure we do not encounter further delays due to documentation not being received by the TPP. Currently, with TPP's having various methods to receive the documentation (mail, fax, portal) and no requirement to provide a receipt status on their portal, providers encounter significant delays and wasted administrative effort to submit documentation multiple times.
- Requiring the TPP's to publicly post descriptions of the 20 most claimed health care services that require supporting documentation may help providers be proactive in preparing the documentation requests. Ideally, if a population of services is known to always require documentation, the provider would be able to submit that documentation electronically with the initial claim and eliminate the need for the TPP to request it.
- Prohibiting documentation requests for specified reasons and claim types prior to payment will significantly improve the turnaround time for providers to be reimbursed. This will likely increase the number of post payment requests we receive, but better that the provider holds on to the money while the TPP completes their documentation review.
- Requiring a date/time stamp on supporting documentation receipt on TPP's portals empowers providers in the appeal process.
- Requiring TPP's to provide written supporting documentation specifically referencing relevant policy/regulation for all upheld appeals.

We believe these changes would improve the payment process significantly. Creating a reliable, consistent process would establish fairness for providers and TPPs and ensure hospitals receive timely payment for services. OSUWMC stands ready to work with you to achieve these aims.

We urge the Insurance Committee's favorable consideration of HB 691.