SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based only on the provisions contained in the legislation as of the latest date listed below.)

BILL: CS/CS/CS/SB 1508 and CS/SBs 706 and 2234

SPONSOR: Fiscal Policy Committee, Health, Aging and Long-Term Care Committee, Banking and Insurance Committee, and Senator Brown-Waite

SUBJECT: Health Maintenance Organizations; Claims Payment

DATE: April 26, 2000 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Deffenbaugh	Deffenbaugh	BI	Favorable/CS
2.	Carter	Wilson	HC	Favorable/CS
3.	Peters	Hadi	FP	Favorable/CS
4.				
5.				

I. Summary:

The 1999 Florida Legislature authorized the Director of the Agency for Health Care Administration (AHCA) to establish the Advisory Group on the Submission and Payment of Health Claims to prepare recommendations on prompt payment of health claims and related issues. The Advisory Group issued its report and recommendations on February 1, 2000. The Proposed Committee Substitute makes the following changes, based on these recommendations and subsequent discussions among the bill sponsors and affected parties:

- Requires HMOs to pay a claim for treatment if a provider follows the HMO's authorization procedures and receives authorizaiton for a covered service for an eligible subscriber, unless the provider provided information to the HMO with the intent to misinform the HMO.

- Creates the Statewide Provider and Managed Care Organization Claim Dispute Resolution Program. The agency must contract with independent resolution organizations to recommend to the agency an appropriate resolution of disputes between a managed care organization and providers with regard to claim disputes in violation of the prompt payment statute, s. 641.3155, F.S., subject to a final agency order.

- Requires HMOs to provide treatment authorization 24 hours a day, 7 days a week. Requests for treatment authorization may not be held pending by the HMO unless the requesting provider contractually agrees to take a pending or tracking number.

- Clarifies the "balance billing" provisions by prohibiting a provider from collecting or attempting to collect from a subscriber any money for services authorized by an HMO; specifying that the prohibition applies to both contract and noncontract providers rendering covered services; prohibiting a provider from billing the subscriber during the pendency of any claim for payment and during any legal or dispute resolution process; prohibiting a provider from reporting a subscriber to a credit agency for unpaid claims due from an HMO;

and requiring referral of violations by physicians and facilities to the appropriate regulatory agency for final disciplinary action.

- The prompt payment requirements of s. 641.3155, F.S., would be applied to claims made by either contract *or noncontract* providers. The requirement for an HMO to pay claims within 35 days of receipt, would be limited to a "clean claim" or any portion of a "clean claim" filed by a provider. "Clean claim" is defined until such time as the Department of Insurance adopts a revised definition, consistent with federal standards.

- Clarifies that the current 10 percent annual simple interest penalty on a claim against an HMO begins to accrue on the 36th day after the clean claim has been received, and requires that the interest be payable with the payment of the claim.

- Requires an HMO to file a claim against a provider for an overpayment and prohibits the HMO from reducing payment to the provider ("take back"), unless the provider agrees to the reduction or fails to respond to the HMO's claim pursuant to specified time frames and requirements, which are the same requirements that apply to provider claims against HMOs.

- Entitles providers who bill electronically to electronic acknowledgment of receipts of claims within 72 hours.

- Prohibits an HMO from retroactively denying a claim due to subscriber ineligibility more than 1 year after the date of payment of the clean claim.

- Prohibits as an unfair claim settlement practice, an HMO committing or performing with such frequency as to indicate a general business practice, systematic downcoding with the intent to deny reimbursement otherwise due.

- Authorizes AHCA to impose fines against hospitals and other regulated facilities for a violation of the "balance billing" prohibitions of s. 641.3154, F.S., or a violation of s. 641.3155(5), F.S., related to payment of claims for overpayment made by an HMO, if sufficient claims do not exist to enable the take-back of an overpayment. Maximum fines would be in the same amounts that AHCA may impose against HMOs.

- Provides that in addition to any other provision of law, systematic upcoding by a provider, with the intent to obtain reimbursement otherwise not due from an insurer is punishable by fines in amounts the same as those that may be imposed against an HMO for a violation of chapter 641.

- Amends the current criminal fraud statute which makes it a second degree misdemeanor for a person to fraudulently obtain goods or services from a hospital, to cover fraudulently obtaining goods or services from any "provider," as defined in the HMO chapter.

- Provides an appropriation of $38,928 from the Health Care Trust Fund and one position to the Agency for Health Care Administration for the purposes of carrying out the provisions of the act during the 2000-2001 fiscal year.

This bill substantially amends the following sections of the *Florida Statutes* (F.S.): 395.1065, 631.818, 641.31, 641.315, 641.3155, 641.3903, 641.3909, 641.495, 817.324, and 817.50. The bill creates ss. 408.7057, 641.3154, and 641.3156, F.S.

II. Present Situation:

Health Maintenance Organization "Prompt Payment" Statute (s. 641.3155, F.S.)

In 1998, the Legislature enacted s. 641.3155, F.S., requiring HMOs to pay claims within certain time frames. [Ch. 98-79, L.O.F.; CS/SB 1584 (1998)] This statute (referred to as the "prompt payment" law) requires an HMO to reimburse any claim or any portion of any claim made by a contract provider for services or goods provided under a contract with the HMO which the HMO does not contest or deny within 35 days after receipt of the claim. If the claim is contested by the HMO, the HMO must notify the contract provider, in writing, within 35 days after receipt of the claim, identify the contested portion of the claim and the specific reason for contesting or denying the claim. This notice may also include a request for additional information.

If the HMO requests additional information, the provider must provide the information within 35 days of the receipt of such request. Within 45 days after receipt of the information requested, the HMO must pay or deny the contested claim or portion of the contested claim.

In any event, an insurer must pay or deny any claim no later than 120 days after receiving the claim. Payment of the claim is considered made on the date the payment was received or electronically transmitted or otherwise delivered. An overdue payment of a claim bears simple interest at the rate of 10 percent per year.

In 1999, the prompt payment statute was amended to address the issue of HMOs deducting past overpayments from a provider's claim, commonly referred to as "take backs." [Ch. 99-393, L.O.F.; CS/HBs 1927 and 961 (1999)] Section 641.3155(4), F.S., requires any retroactive reduction of payments or demands for refund of previous overpayments to be reconciled to specific claims unless the parties agree to other reconciliation methods and terms. This also applies to providers who make retroactive demands for payment due to underpayments or nonpayment. The look-back period may be specified by the terms of the contract.

Balance Billing Prohibition (s. 641.315, F.S.)

In 1988, the Legislature enacted amendments to s. 641.315, F.S., which provide that no subscriber of an HMO is liable to any provider of health care services for any services covered by the HMO. This law also prohibits a provider of services from collecting or attempting to collect from an HMO subscriber any money for services covered by an HMO. This statute is interpreted by the Department of Insurance and the Agency for Health Care Administration as applying to both contract and non-contract providers in those cases where services are covered by the HMO. For example, if a subscriber obtains a covered service at a contract hospital from a non-contract physician, the HMO is liable and the physician may not bill the subscriber. However, some providers argue that the statute is limited to balance billing by contract providers, due to the heading of the statute that reads, "Provider contracts." There are no appellate court decisions on this point.

The Statewide Provider and Subscriber Assistance Program

The Statewide Provider and Subscriber Assistance Program is authorized by s. 408.7056, F.S., under the administration of AHCA. The program is designed to assist subscribers and policyholders of managed care entities and providers whose grievances are not resolved by the managed care entity to the satisfaction of the subscriber or provider. The agency refers grievances to panels that hold hearings on the grievance and issue recommendations to the agency or to the Department of Insurance for a final order. However, the program does not provide assistance for grievances related to providers unless it is related to the quality of care provided to a subscriber. Also, the program does not provide assistance for a grievance for "unpaid balances." Therefore, the program does not typically provide assistance for grievances related to provider disputes for late payments or underpayments.

HMO Claims for Emergency Care and Treatment

The Proposed Committee Substitute does not specifically address claims filed with HMOs for emergency care and treatment, but problems in this area led to the enactment of legislation that is relevant to the issue of prompt payment. Florida law requires HMOs to provide coverage for emergency services and care without prior authorization or referral. This requirement encompasses coverage for emergency care and treatment at non-contract hospitals in emergency situations not permitting treatment through the HMO's providers.[1]

In summary, an *emergency medical condition* is defined as a medical condition manifesting itself by acute symptoms of sufficient severity, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the health of a patient, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

When a subscriber is present at a hospital seeking emergency services and care, the determination of whether an emergency medical condition exists must be made by a physician of the hospital or, to the extent permitted by law, by other appropriate licensed professional hospital personnel under the supervision of the hospital physician. The HMO must compensate the provider for screening, evaluation, and examination reasonably calculated to assist the health care provider in making this determination (even if the provider determines that an emergency medical condition does not exist). If the provider determines that an emergency medical condition does exist, the HMO must also compensate the provider for *emergency services and care*, which are defined to include the care, treatment, or surgery for a covered service by a physician necessary to relieve or eliminate the emergency medical condition within the service capability of a hospital.

The current law requires the hospital to make a reasonable attempt to notify the subscriber's primary care physician or HMO, if known, and prescribes certain time frames for such notice, but the law provides that an HMO may not deny payment for emergency services and care based on a hospital's failure to comply with the notice requirements.

[1]Sections 641.31(12), 641.47(7)-(8), and 641.513, F.S.

A subscriber may be charged a reasonable copayment, up to $100, for the use of an emergency room. Net of this copayment, an HMO must reimburse a non-contract provider for emergency services and care at the lesser of: (a) the provider's charges; (b) the usual and customary provider charges for similar services in the community where the services were provided; or (c) the charge mutually agreed to by the HMO and the provider within 60 days of submittal of the claim.

Federal HIPAA Requirements for "Clean Claims" and Electronic Billing

The federal Health Insurance Portability and Accountability Act (HIPAA) requires the Health Care Financing Administration (HCFA) to identify and implement standard electronic formats for health insurance transactions, including claims, eligibility and payment. There have been problems and delays with the implementation of HIPAA. An industry group working on the implementation, the National Uniform Billing Committee (NUBC) recently agreed to a definition of an institutional clean claim. A parallel group, the National Uniform Claims Committee (NUCC) is expected to agree to an equivalent definition of a practitioner clean claim. Both of these committee recommendations, and other administrative simplification recommendations, will be submitted to the federal Secretary of Health and Human Services for adoption and implementation.

Florida Advisory Group on the Submission and Payment of Health Claims

The health care provider community has voiced concerns about delays in payment of HMO claims, underpayment of claims, and difficulty in obtaining authorization for treatment from HMOs. The providers assert that the current prompt payment law is not being observed. Estimates generated by the Florida Hospital Association show that as of May 1999, 16.1 percent of outstanding claims dollars had been in accounts receivable for 120 days or more. A 1999 survey by the South Florida Hospital and Healthcare Association found that the average age of HMO receivables in the hospitals in question were over 70 days old, with about 30 percent of the receivables being over 60 days old. However, none of this information has been independently verified or assessed for accuracy.

The Agency for Health Care Administration performed an emergency room claims payment survey. The summary of its survey indicates that 4924 emergency room claims (commercial claims; not Medicaid) from 26 HMOs were reviewed and that 32 claims were improperly denied or not paid. (AHCA Emergency Room Claims Payment Survey Summary, March 23, 2000)

On March 30, 2000, the Department of Insurance issued a Notice and Order to Show Cause ("Order") to each of two HMOs, resulting from a target examination of their claims payment practices. Each of the orders found that the HMO failed to pay, contest, or deny claims within the 35 days, as required by s. 641.3155, F.S., and failed to pay the 10 percent penalty for late payments as required under that section, among other allegations. The orders included notice that the department intends to impose administrative penalties of $100,000 against one HMO and $75,000 against the other HMO.

The managed care community disputes the magnitude of this problem and maintains that most delays in payment are caused by a provider's failure to include essential and accurate information with their claims.

In response to these concerns and divided opinions, the Florida Legislature in 1999 authorized the Director of AHCA to establish the Advisory Group on the Submission and Payment of Health Claims to prepare recommendations on prompt payment of health claims and related issues. (Ch. 99-393, L.O.F.; CS/HB's 927 and 961). The Advisory Group issued its report and recommendations on February 1, 2000 ("Advisory Group Report").

Summary of Advisory Group Report

The following is a committee staff summary of the recommendations of the Advisory Group Report, with the page number of the report where the recommendation is contained. The staff summary uses the term "HMO," rather than "MCOs" or managed care organizations, as used in the report, which are synonymous terms (as stated on page 1 of the report).

Issues and Recommendations: Non-Emergent Treatments

A) Authorization to Treat

1. *24-Hour Service* -- HMOs should have the capability to provide authorization 24 hours a day, 7 days a week for all services for which pre-authorization is required. (p. 16)

2. *Binding Authorization of Services* -- If a provider follows authorization procedures and applicable laws, and receives authorization for a covered service for an eligible employee, then the plan is bound by its authorization to pay and the service is deemed medically necessary. (p. 16)

3. *Pend Numbers* -- It is inappropriate for HMOs to respond to pre-authorization requests with pending or tracking numbers that do not constitute a substantive response to the request. Such policies are only acceptable when the requesting provider contractually agrees to take a pending or tracking number. (p.16)

B) Electronic Billing and Clean Claims

1. *Definition of Clean Claim* -- Recommend adoption of the recently adopted National Uniform Billing Committee (NUBC) definition of institutional clean claim. However, no national definition has yet been agreed on for non-institutional claims, and the Advisory Group made no recommendation for them. (p. 17)

2. *HIPAA Standards* (Federal Health Insurance Portability and Accountability Act) -- The federal HIPAA law includes requirements for electronic filing of claims, but these provisions have not yet been implemented. It is believed that implementation will take place within the next 3 years. Recommend that Florida adopt the expected federal schedule for implementation of HIPAA Administrative Simplification standards and that the standards be applied to all HMOs and providers. AHCA staff estimate the costs of HIPAA implementation in Florida to average between $24,000 and $30,000 per office practice. (p. 17)

C) Late Payments

1. *Interest Payments* -- Section 641.3155 should be clarified to indicate that interest on the late payment of a claim begins to accrue when the payment is overdue, i.e., 35 days after the receipt of a clean claim. The statute should also clarify that the accrued interest must automatically be included with any late payment of a claim. This revised statute should apply equally to payment to contracted and non-contracted providers. (p. 18)

2. *Venue for Complaints and Dispute Resolution* -- Florida needs to institute and supervise a mechanism for resolving claims disputes that are not satisfactorily resolved by the plans' internal provider appeals processes. This mechanism should be available to both contracted and non-contracted providers. The scope and procedures of such a mechanism need to be carefully defined so as not to be invoked in an enormous volume of disputes and not to create incentives for frivolous or unmerited appeals. (p. 18)

3. *Sub-Contractor Processing and Payment of Claims* -- In instances where an HMO delegates authority for issuing authorization or processing or paying claims to a third-party subcontractor, the current policy of the Department of Insurance is to hold the licensed HMO financially and legally responsible for all actions or failures to act of the third-party subcontractor. The Advisory Group and the agency support this policy. (p. 19)

D) Claims Review

1. *Eligibility Determination* -- Insurers should not be permitted to deny claims because of member ineligibility more than 1 year after the date of service. Employers should be required to notify insurers of changes in eligibility status within 30 days. (p. 19)

2. *Receipts* -- Providers who submit claims electronically should be entitled to electronic acknowledgment of receipts of claims. Providers who receive acknowledgment of receipts of claims should be prohibited from sending a duplicate bill for 45 days. (p. 19)

3. *Take Backs* -- Take backs should be treated as claims made by an HMO to a provider. Insurers should provide written notice to providers of all over-payments, and providers should have a standard amount of time to return such payments or appeal the insurer's determination. The time period and penalties for repayment should be the same as for initial payment, 35 days to pay or contest, then so many days to resolve the conflict, etc. Only after all the requirements concerning notification and correspondence are satisfied, which can take as long as 120 days, can the insurer reduce payments to compensate for prior overpayments. (p. 19)

E) Balance and Duplicate Billing

1. *Enforcement of Balance Billing Prohibition* -- The appropriate authorities to enforce the prohibition against balance billing by professionals are the Board of Medicine and other state professional boards, and such boards shall enforce the prohibition. AHCA, in its role as investigatory agency, shall refer cases of repeated balance billing to professional boards. Balance billing by facilities shall be referred to AHCA in its role of assuring health facility compliance. Providers should be prohibited from balance billing a subscriber for covered

services. Providers may not balance bill patients while billing disputes are going through any future state supervised dispute resolution process. (p. 20)

2. *Medical Necessity* -- Except in emergency situations, if an HMO denies authorization for a service on the grounds that it is not medically necessary, then the treatment is not covered by the HMO, and the provider is entitled to bill the patient for the service. It is important to educate the subscriber that he or she will be responsible for payment of services under these conditions. (p. 20)

3. *Non-Covered Services* -- Providers have a right to bill patients for non-covered services. (p. 20)

4. *Non-Participating Providers* -- Current s. 641.315, F.S., is ambiguous because the heading refers to provider contracts, but the language says no provider is permitted to balance bill. The Advisory Group recommends eliminating this ambiguity by changing the heading of the statute. Non-participating providers should not bill patients (beyond HMO copayments) if they are billing the HMO, going through a dispute resolution process to secure payment from an HMO or have accepted HMO payment for the specific service. (p. 20)

5. *Restriction on Referral to Credit Agencies* -- It is inappropriate for providers to refer patients to credit agencies for failing to pay bills that are illegal balance bills, as clarified by the above recommendations.

F) Non-Participating Providers

Recommends that when a physician empowered by an HMO (through formal delegation of authority) to make referrals and authorize treatment refers a patient to another provider, then the HMO is obligated to reimburse that other provider for the authorized services. (p. 21)

G) Fraud and Abuse

1. *Automated Recoding of Claims* -- Systematic downcoding by payors or upcoding by providers, which are distinct from bundling, when the only information available is the original code, are clearly inappropriate. The Department of Insurance has already issued a Statement to that effect. (p. 22)

2. *Incentives for Billing Agent to Submit Fraudulent Claims* -- Florida should follow the same policies as Medicare. Under current Medicare regulations, billing agents who receive a percentage of charges or receipts are prohibited from collecting payments. This policy may or may not be strengthened, revised or enforced more stringently by the Health Care Financing Administration in the near future. Similarly, if Medicare implements a policy against percentage incentives for HMO audit or credit collection firms, the Advisory Group recommends that Florida do likewise. (p. 22)

3. *Reporting Liability of Additional Payors* -- The Advisory Group urges all providers to ascertain and report liability of additional payors besides commercial HMOs. (p. 22)

4. *Auditing of Claims* -- Providers should not charge HMOs for auditing claims on site as long as there are no copying costs or significant demands on provider staff time. If there are such costs, the provider can charge them to the HMO, but still should not add an extra charge for HMO staff reviewing provider records. (p. 22)

5. *Civil Liability of Whistleblowers* -- Requested the Department of Insurance to research and determine whether there needs to be additional immunity for private individuals or private sector employees who report or investigate suspected fraud. (p. 22)

Issues and Recommendations: Emergency Treatments

1. *Hospital Code System* -- The Advisory Group acknowledges AHCA's review of Medicaid standards concerning the coding of hospital emergency department treatments. The group recommends that AHCA look into redoing the Florida Medical Quality Assurance Inc. (FMQAI) study of hospital emergency room coding in light of the objections to that study that have been presented to the group. (p. 26)

2. *Availability of Specialized Physicians for Emergency Treatment* -- In cases where hospitals or other providers have difficulty finding contracted specialists or other needed providers who are affiliated with a specific HMO, the hospital should notify the HMO as soon as possible. If a serious problem persists, the provider experiencing difficulty should notify the AHCA Bureau of Managed Care, which assesses HMO network adequacy. Access to emergency care is addressed in s. 395.1041. This law gives the agency comprehensive and detailed responsibility for assuring that all parts of the state have an adequate emergency care network and that all persons have access to the emergency care they need. (p. 26)

III. Effect of Proposed Changes:

Section 1. Amends s. 641.315, F.S., relating to provider contracts. The bill deletes subsections (1), (2), (3), and (5) which currently provide that an HMO is liable, rather than the subscriber, for covered services, and which prohibit the provider from collecting from the subscriber any money for covered services (commonly referred to as "balance billing."). The bill addresses the issue of HMO and subscriber liability in new subsection (1) [current subsection (4)], and prohibits balanced billing in newly created s. 641.3154, F.S., in section 2.

Currently, subsection (4) requires a written contract between an HMO and a provider to contain a provision that the subscriber is not liable to the provider for any services "covered by the subscriber's contact with the HMO." The bill revises this language to require the HMO-provider contract to contain a provision that the subscriber is not liable to the provider for any service "for which the HMO is liable, as specified in s. 641.3154, F.S.," created by section 2 of the bill. (See Section 2, which provides that an HMO is liable when it authorizes services, but does not appear to address circumstances where an HMO is liable for non-authorized treatment, such as emergency care and treatment. It is unclear whether subscribers would be liable in such other circumstances.)

Two new subsections are added. New subsection (4) requires an HMO to disclose to contract providers: (a) the mailing address or electronic address where claims should be sent for

processing; (b) the telephone number a provider may call to have questions addressed; and (c) the address of any separate claims processing centers for specific types of services. The HMO must also provide written notice to contract providers at least 30 days prior to any change in this information. New subsection (8) requires that the contract between an HMO and a provider establish procedures for a provider to request and the HMO to grant authorization for utilization of health care services. The HMO is required to give providers written notice prior to any changes in such procedures.

Section 2. Creates s. 641.3154, F.S., relating to HMO liability and provider billing ("balance billing"), to provide the following:

- If an HMO is liable for services rendered to a subscriber by a provider, regardless of whether a contract between the provider and the HMO exists, the HMO is liable for payment of fees to the provider and the subscriber is not liable for payment of fees to the provider. (This language was moved from s. 641.315, F.S., and modified.)

- For purposes of this section, an HMO is liable for services rendered to a subscriber by a provider if a provider follows the HMO's authorization procedures and receives authorization for a covered service for an eligible subscriber, unless the provider provided information to the HMO with the willful intention to misinform the HMO. (This is similar to the provision in s. 641.3156, F.S, created by section 4 of the bill, requiring HMO's to pay for authorized treatment. However, this does not appear to cover all circumstances under which an HMO may be liable under the subscriber's contract or under applicable law, such as when an HMO is liable for non-authorized treatment, such as emergency care and treatment as required by s. 641.513, F.S. It is unclear whether providers would be prohibited from balance billing subscribers in such other circumstances.)

- An HMO's liability for payment of fees for services is not affected by a contract with third parties to perform authorizing, processing, or claims payment functions.

- A provider, whether under contract with the HMO or not, or any representative of the provider, may not collect or attempt to collect money from, maintain a legal action against, or report to a credit agency, a subscriber of an HMO when a provider in good faith knows or should know that the HMO is liable for payment of fees for services. This prohibition also applies during the pendency of any claim for payment made by the provider to the HMO for payment of the services or during any legal proceeding or dispute resolution to determine whether the HMO is liable, if the provider is informed of such proceedings.

- A presumption is created that a provider does not know and should not know that an organization is liable, *unless* one of the following three conditions exists: (1) the provider is informed by the organization that it accepts liability; (2) a court of competent jurisdiction determines that the organization is liable; or (3) the Department of Insurance or AHCA makes a final determination that the organization is required to pay for such services subsequent to a recommendation made by the Statewide Provider and Subscriber Assistance Panel.

- An HMO and the Department of Insurance must report any suspected violations of the balance billing prohibitions by hospitals and other facilities to AHCA, and report any suspected violations by health care practitioners to the Department of Health. These agencies shall take such actions against violators as authorized by law. (In section 9, the bill amends s. 395.1065, to authorize AHCA to impose fines against facilities that violate this section. Current law in s. 455.624(1)(k), F.S., provides that "failing to perform any statutory or legal obligation placed upon a licensee" is a ground for discipline for an individual health care practitioner by the board which has regulatory authority over that practitioner, including the Board of Medicine over physicians.)

Section 3. Amends s. 641.3155, F.S., relating to payment of claims, to define the term *clean claim* as "a claim submitted on a HCFA 1500 from that has no defect or impropriety, including lack of required substantiating documentation for noncontracted providers and suppliers, or particular circumstances requiring special treatment that prevent a timely payment from being made on the claim." Additional language provides clarification that a claim may not be considered not clean solely because an HMO refers the claim to a medical specialist within the HMO for examination, but may be considered not clean if additional substantiating documentation, such as a medical record or encounter data, is required from a source outside the HMO.

The above definition of clean claim is repealed on the effective date of rules adopted by the Department of Insurance which define the term. The department is required to adopt rules to establish claim forms that are consistent with federal claim filing standards for HMOs required by the federal Health Care Financing Administration (HCFA). The department is authorized to adopt rules to establish coding standards that are consistent with Medicare coding standards adopted by HCFA.

The bill requires a health maintenance organization to pay any clean claim or portion of a clean claim made by a contract *or noncontract* provider. An HMO's denial or contesting of a portion of a claim is made subject to the statutory time frames applicable to denial or contesting of the entire claim.

Subsection (3) does not impose additional penalties for late payments of claims by HMOs, but clarifies when the interest begins to accrue. Interest on overdue payments for a clean claim or for any uncontested portion of a clean claim would begin to accrue on the 36th day after the claim has been received. Interest is payable with the payment of the claim. With regard to the current law requirement that an HMO pay or deny a claim within 120 days after receiving the claim, the bill in subsection (4) states that an HMO's failure to meet this deadline imposes an uncontestable obligation on the HMO to pay the claim.

Under subsection (5), an HMO would be required to make a claim against a provider for an overpayment that the HMO determines that it has made as a result of retroactive review of coverage decisions or payment levels. The HMO would be prohibited from reducing payment to the provider for other services unless the provider agrees to the reduction or fails to respond to the organization's claim as required by this new subsection. The time frames and requirements of this subsection are the same time frames and requirements that apply to provider claims against HMOs. Specifically, providers would be required to pay an uncontested or undenied claim for overpayment within 35 days after receipt of a mailed or electronically transferred claim. Providers

would be required to notify, in writing, an HMO within 35 days after the claim for overpayment is received that the claim is contested or denied. Such notice must identify the contested portion of the claim, specify the reason for contesting or denying the claim, and must include a request for additional information. When submitting requested additional information, an HMO must, within 35 days after receipt of the request, mail or electronically transfer the information to the provider. The provider would be required to pay or deny the claim for overpayment within 45 days after receipt of the additional information.

Payment of a claim for overpayment is considered made, as provided in the bill, on the date payment is received or electronically transferred or otherwise delivered to the HMO, or the date that the provider receives a payment from the organization that reduces or deducts the overpayment. Providers are made subject to a 10 percent *per annum* simple interest penalty applied to overdue payment of a claim. The interest on an overdue payment of a claim for overpayment or for any uncontested portion of a claim for overpayment begins to accrue on the 36th day after the claim for overpayment was received. Providers are required to pay or deny a claim for overpayment within 120 days after receiving such a claim. Failure to pay or deny a claim for overpayment within 120 days creates an uncontestable obligation to the provider to pay the claim. [HMOs are subject to the same interest sanctions and timeframes under s. 641.3155(2)-(4), F.S., as provided in the bill].

Under subsection (7), both provider claims and HMO claims for overpayment are deemed to be *received* when receipt is verified electronically, if the claim is electronically transmitted, or, if the claim is mailed, to the address disclosed by the HMO on the date indicated on the return receipt. An HMO and a provider may agree to other methods of transmission and receipt of claims. Providers and HMOs are required to wait 45 days after receipt of a claim, by the other party, before submitting a duplicate claim. Providers that bill electronically are entitled to electronic acknowledgement of receipt of a claim within 72 hours.

A health maintenance organization may not retroactively deny a claim for payment due to subscriber ineligibility more than 1 year after the date of payment of a clean claim.

Section 4. Creates section 641.3156, F.S., relating to treatment authorization and payment of claims. The bill requires HMOs to pay a hospital-service claim or referral-service claim for treatment of an eligible subscriber which was authorized by a provider empowered by contract with the HMO to authorize or direct the patient's utilization of health care services and that was also authorized in accordance with the HMO's current and communicated procedures, unless the physician provided information to the HMO with the willful intention to misinform the HMO. Also, an HMO could not deny authorized claims for treatment if the provider follows the HMO's authorization procedures and receives authorization for a covered service for an eligible subscriber, unless the provider provided information to the HMO with the willful intention to misinform the HMO. Emergency services are excluded from the provisions of this section and explicitly made solely subject to the provisions of s. 641.513, F.S., providing statutory requirements for emergency services and care for subscribers of HMOs.

Section 5. Amends s. 641.3903(5), F.S., relating to unfair methods of competition and unfair or deceptive acts or practices. The bill would prohibit, as an unfair claim settlement practice, an HMO committing or performing with such frequency as to indicate a general business practice,

systematic downcoding with the intent to deny reimbursement otherwise due. The term "downcoding" is not defined, but is generally understood to mean reimbursing a provider for a lower level of services, with a different procedure code and a correspondingly lower reimbursement rate, than the procedure code submitted by the provider. As a prohibited unfair claim settlement practice, downcoding must be committed or performed with such frequency as to indicate a general business practice [which applies to all such unfair claim settlement practices in subsection (5)(c)], must be "systematic," and must be "with the intent to deny reimbursement otherwise due."

Section 6. Amends s. 641.3909, F.S., relating to cease and desist and penalty orders. The bill adds a reference to a violation of s. 641.3155, F.S., which are the "prompt pay" requirements, authorizing the Department of Insurance to suspend or revoke the certificate of authority of an HMO that violates that section, if the HMO knew, or reasonably should have known, it was in violation of this part. (However, the bill does not add a reference to s. 641.3155, F.S. to the provision that authorizes the department to issue an order requiring the HMO to cease and desist from engaging in such act, which appears to be a drafting error.)

Section 7. Amends s. 641.495, F.S., providing requirements for the issuance and maintenance of an HMO certificate of authority. The bill requires HMOs to provide treatment authorization 24 hours a day, 7 days a week. Requests for treatment authorization may not be held pending by the HMO unless the requesting provider contractually agrees to take a pending or tracking number.

Section 8. Creates s. 408.7057, F.S., relating to the Statewide Provider and Managed Care Organization Claim Dispute Resolution Program. The bill requires AHCA to establish such a program by January 1, 2001, by contract with a qualified independent third-party claims dispute resolution organization, to provide assistance to contracted and noncontracted providers and managed care organizations in resolving those claim disputes arising under the prompt payment statute, s. 641.3155, F.S., and that are not resolved by the provider and the managed care organization. The bill defines the terms "managed care organization" and "resolution organization."

The resolution organization would be required to timely review and consider claims disputes and recommend to AHCA an appropriate resolution of the disputes. The agency is required to establish, by rule, jurisdictional amounts and methods of aggregations for claims disputes that may be considered by the resolution organization.

Certain exclusions from the panel's jurisdiction are enumerated in the bill. These exclusions prohibit the panel from hearing any claim that is subject to a binding claims dispute resolution process provided by contract entered into prior to October 1, 2000, between the provider and the managed care organization. Contracts entered into or renewed on or after October 1, 2000, may require exhaustion of an internal dispute-resolution process as a prerequisite to the submission of a claim by a provider or HMO to the resolution organization. Other exclusions include claims related to interest payments, claims that do not meet the jurisdictional thresholds established by AHCA rule, disputes based on any action that is pending in state or federal court, and claims related to Medicare and Medicaid. A provider or HMO would not be permitted to file a claim dispute with the resolution organization more than 12 months after a final determination has been made on a claim by an HMO.

The agency would be required to adopt rules to establish a process for the consideration by the resolution organization of claims disputes, which must include the issuance of a written recommendation to AHCA, supported by findings of fact, within 60 days after receipt of the claims dispute submission. Within 30 days after receipt of the recommendation of the resolution organization, AHCA must issue a final order. The bill does not specify the allowable scope of the recommendations by the review organization, other than to recommend "an appropriate resolution of the dispute." The bill also does not specify what actions or penalties may be ordered by AHCA against either the managed care entity or the provider. In addition to penalties authorized under current law for violations, the bill may be interpreted to allow the agency to order managed care entities to pay claims, but this is not clear.

The entity that does not prevail in the agency's order must pay a review cost to the review organization as determined by agency rule with must include an apportionment of the fee in those cases where both parties may prevail in part. The failure of the nonprevailing party to pay the ordered review cost within 35 days of the agency's order subjects the nonpaying party to a penalty of not more than $500 per day until the penalty is paid.

Section 9. Amends s. 395.1065, F.S., related to criminal and administrative penalties for purposes of regulation of hospitals, ambulatory surgical centers, and mobile surgical facilities ["licensed facility" as defined in s. 395.002(17), F.S.]. The bill provides that AHCA may impose an administrative fine for the violation of s. 641.3154, F.S., as created in the bill, which prohibits providers from "balance billing" subscribers of HMOs when the HMO is liable for such payment as specified in that section. The bill also allows AHCA to impose administrative fines against hospitals for a violation of s. 641.3155(5), F.S., related to prompt payment of claims for overpayment made by an HMO against the facility, if sufficient claims due to a provider from a HMO do not exist to enable the take-back of an overpayment. The fines that may be imposed by AHCA for a violation by a licensed facility of either of these two provisions would be in the amounts specified in s. 641.52(5), F.S., which are the fines that AHCA may impose against HMOs for violations of any provision of part III of chapter 641 (and which are also the same fines that the department may levy against an HMO for a violation of part I of chapter 641, F.S.). With respect to any nonwillful violation, the fine may not exceed $2,500 per violation, up to an aggregate amount of $25,000 for all nonwillful violations arising out of the same action. With respect to any knowing and willful violation, the fine may not exceed $20,000 for each violation, up to an aggregate amount of $250,000 for all knowing and willful violations arising out of the same action.

Section 10. Amends s. 631.818, F.S.**,** relating to powers and duties of the plan to make a conforming change to a statutory cross-reference. Current law requires the HMO Consumer Assistance Plan to defend a subscriber of an insolvent HMO for any claims filed against the subscriber contrary to the provisions of s. 641.315, F.S. This statutory reference is to the prohibition in current law against a health care provider billing a subscriber for services for which an HMO is liable. The bill transfers some of the provisions of s. 641.315 F. S., to s. 641.3154, F.S.

Section 11. Amends s. 817.234, F.S., relating to false and fraudulent insurance claims. The bill provides: *In addition to any other provision of law, systematic upcoding by a provider, as*

defined in s. 641.19(15), with the intent to obtain reimbursement otherwise not due from an insurer is punishable as provided in s. 641.52(5).

Under s. 641.52(5), with respect to any nonwillful violation, the fine may not exceed $2,500 per violation, up to an aggregate amount of $25,000 for all nonwillful violations arising out of the same action. With respect to any knowing and willful violation, the fine may not exceed $20,000 for each violation, up to an aggregate amount of $250,000 for all knowing and willful violations arising out of the same action.

There is no definition of "upcoding" but this term is generally understood to mean filing a claim with an insurer for a service with a procedure code that is a higher level of service with a correspondingly higher reimbursement rate than the procedure actually performed by the provider. In order to be punishable as provided in s. 641.52(5), this practice must be performed with the intent to obtain reimbursement otherwise not due from an insurer.

Whether the quoted prohibited practice is punishable as *fraud* under the felony provisions of subsection (11) of this statute, without establishing any other element, is not clear. By saying "in addition to any other provision of law" and by republishing the felony penalties of subsection (11), the bill implies that such an action may be insurance fraud, but it is unclear if any other element of the crime must be established, such as the intent to commit fraud.

The provision also implies, but does not express, that the Agency for Health Care Administration would impose the administrative fines specified in s. 641.52(5), F.S., against a hospital, ambulatory surgical center, or mobile surgical facility regulated by AHCA. AHCA currently imposes fines under the cited section against HMOs. The bill might also be implied to authorize the various boards that regulate individual practitioners, such as the Board of Medicine which regulates physicians, to impose the referenced fines against practitioners who violate the upcoding prohibition, in the amounts provided in s. 641.52(5), F.S., but this is not clear. Current law in s. 455.624(1)(k), F.S., provides that "failing to perform any statutory or legal obligation placed upon a licensee" is a ground for discipline for an individual health care practitioner by the board which has regulatory authority over that practitioner. Therefore, a violation of the upcoding prohibition in s. 817.234, F.S., may allow for administrative sanctions by the appropriate board, and the board may be authorized to levy the fines provided in s. 641.52(5), F.S. However, it is questionable whether such multiple statutory cross-references can legally be, or practically be expected to be, the basis for enhanced regulatory penalties.

Section 12. Amends s. 817.50, F.S., relating to fraudulently obtaining goods or services from a hospital, to expand the criminal penalty of the current law by applying it to persons who defraud other providers, as that term is defined for purposes of Department of Insurance regulation of HMOs under part I of chapter 641, F.S. Otherwise, the current law is unchanged. This law would provide that it is a second degree misdemeanor for anyone who willfully and with the intent to defraud, obtains or attempts to obtain goods, products, merchandise, or services from any *provider* (rather than hospital). Further, it is deemed to be *prima facie* evidence of the intent to defraud when a person gives a provider a false or fictitious name or a false or fictitious address or assigns to a provider the proceeds of a health maintenance contract or an insurance contract, knowing that such contract is no longer in force, is invalid, or is void.

Section 13. Amends s. 641.31(38), F.S., to make a conforming change to a statutory cross-reference. The current law allows HMOs to sell a point-of service rider under which the subscriber may obtain coverage for services from non-contract providers. The current law also states that s. 641.315(2) and (3) do not apply to such products, which are the provisions that state a subscriber is not liable to any provider for any services covered by the HMO and that a provider may not collect or attempt to collect from a subscriber any money for services covered by an HMO. Because the provisions that prohibit "balance billing" by providers are transferred to newly created s. 641.3154, F.S., that section is cited in place of s. 641.314(2) and (3), F.S.

Section 14. Appropriates $38,928 from the Health Care Trust Fund and one position to the Agency for Health Care Administration to carry out the provisions of the act in fiscal year 2000-2001.

Section 15. Provides an effective date of October 1, 2000, and applies to claims for services rendered after such date and to all requests for claim dispute resolution which are submitted by a provider or managed care organization 60 days after the effective date of the contract between the resolution organization and the agency.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, Subsections 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill creates additional protections for all parties to an HMO contract, including providers, subscribers, and HMOs and clarifies many of the current requirements, which should help alleviate claims disputes and clarify legal requirements.

Managed care entities and providers will incur fees to fund the activities of the claims dispute resolution organization. The provider or managed care entity that does not prevail in the agency's order must pay a review cost to the review organization as determined by agency rule. AHCA would also be authorized to issue a final order subsequent to the recommendation of the review organization, but the bill does not specify the allowable scope of the order. In addition to penalties authorized under current law for statutory penalties for violations, the bill may be interpreted to allow the agency to order managed care entities to pay claims.

Hospitals may be sanctioned for balance billing of subscribers and for violation of violations of the prompt payment statute as it relates to HMO claims for overpayment, under the provisions of the bill. Due to current law cross-references, individual practitioners may also be sanctioned for such violations.

Health maintenance organizations would incur costs from the requirement to provide treatment authorization 24 hours a day, 7 days a week.

C. Government Sector Impact:

The Agency for Health Care Administration is required to contract with an independent claims dispute resolution organization; however, the bill provides that the provider or managed care entity that does not prevail in the agency's order must pay a review cost to the review organization as determined by agency rule. Therefore, there will be no cost to the agency for the review costs.

The agency would incur costs related to issuing final orders following receipt of recommendations of the resolution organization. The agency estimated that one Senior Attorney would be required (650 cases x an average of 2.8 hours = 1,820 hours annually). The cost for FY 2000-01 is $38,928 which was lapsed because the program does not become effective until January 1, 2001. The cost for FY 2001-02 is $56,201. These costs will be funded from the Health Care Trust Fund from HMO assessments.

Expenditures	**FY 2000-01**	**FY 2001-02**
1. Non-Recurring		
Expenses	$2,659	
OCO	$2640	
Total Non-Recurring	$5,299	
2. Recurring		
Salaries & Benefits	$22,572	$45,144
Expenses	$11,057	$11,057
Total Recurring	$33,629	$56,201

TOTAL ALL	$38,928	$56,201

VI. Technical Deficiencies:

Section 6 amends s. 641.3909, F.S., relating to cease and desist orders, to add a reference to a violation of s. 641.3155, F.S., (the "prompt pay" statute). However, the statutory reference is added only to a provision that authorizes the department to suspend or revoke the HMO's certificate of authority, and is not added to the provision that authorizes the department to issue a cease and desist order.

VII. Related Issues:

None.

VIII. Amendments:

None.