LEGISLATIVE SERVICES AGENCY
OFFICE OF FISCAL AND MANAGEMENT ANALYSIS

200 W. Washington St., Suite 301
Indianapolis, IN 46204
(317) 233-0696
iga.in.gov

FISCAL IMPACT STATEMENT

LS 7328 **NOTE PREPARED:** Jan 6, 2021
BILL NUMBER: HB 1374 **BILL AMENDED:**

SUBJECT: Medicaid Providers and Managed Care Organizations.

FIRST AUTHOR: Rep. Clere **BILL STATUS:** As Introduced
FIRST SPONSOR:

FUNDS AFFECTED: X **GENERAL** **IMPACT:** State & Local
DEDICATED
X **FEDERAL**

Summary of Legislation: *Administrative Appeal:* The bill allows a provider that has entered into a contract with a managed care organization (MCO), after exhausting any internal procedures of the MCO for provider grievances and appeals, to request an administrative appeal within the Office of Medicaid Policy and Planning (OMPP) of the MCO's action in denying or reducing reimbursement for claims for covered services provided to an applicant, pending applicant, conditionally eligible individual, or member.

The bill establishes a procedure for an administrative appeal, including a hearing before an administrative law judge that could be followed by agency review and then by judicial review.

Contract Provisions Prohibited: It prohibits a provision in a contract between a provider and a managed care organization that would negate or restrict the right of a provider to an administrative appeal and provides that such a contract provision is void and unenforceable.

Conflict: The bill repeals a provision under which Medicaid law is controlling when Medicaid law conflicts with insurance law.

Failed or Denied Claims: It provides that if the Office of the Secretary of Family and Social Services (FSSA) or a contractor of the FSSA fails to pay or denies a clean claim for any eligible Medicaid service within certain time limits due to the FSSA or contractor incorrectly processing the clean claim because of errors attributable to the internal system of an insurer or MCO, the FSSA or contractor may not assert that the provider failed to meet the time filing requirements for the claim.

Effective Date: July 1, 2021.

Explanation of State Expenditures: *Summary* - The bill may increase the number of Medicaid claims that are paid by establishing an appeal process. This may include some claims being litigated. Additional interest payments may result for providers who submit clean claims that were incorrectly processed either by FSSA or its claims processing contractor. The repeal of Medicaid law controlling in a conflict with insurance law would have indeterminate fiscal impact; it could result in certain claims paid with state funds only or federal assessments for overpayment.

The bill would allow an appeal for payment of denied or reduced reimbursement claims. The Office of Administrative Law Proceedings (OALP) provides administrative review support to the FSSA. Under the bill, the Secretary of the FSSA or a designee would be the ultimate authority for certain claims. The decisions of the Secretary or designee could be subject to judicial review. These requirements represent an additional workload and expenditure on the OALP, FSSA, and potentially the Attorney General's Office outside of the agencies' routine administrative functions, and existing staffing and resource levels, if currently being used to capacity, may be insufficient for full implementation. The additional funds and resources required could be supplied through existing staff and resources currently being used in another program or with new appropriations. Ultimately, the source of funds and resources required to satisfy the requirements of this bill will depend on legislative and administrative actions.

Additional Information - For the majority of services provided by Medicaid, an MCO pays providers a per member per month (PMPM) amount and does not pay per procedure. For hospitals, Medicaid pays a diagnosis related group (DRG) payment for a bundle of services on a daily basis. If a single claim is made by an MCO contracted provider, it may be for services that are not covered in the PMPM or DRG, but that are medically necessary or otherwise allowed through Medicaid.

The state Medicaid plan and waivers are an agreement with the federal Centers for Medicare and Medicaid Services about the reimbursement of services. Claims paid outside of the Medicaid plan and waivers may be reimbursed from state only funds or federal penalties may apply. [Medicaid is jointly funded between the state and federal governments. The standard state share of costs for most Medicaid medical services for FFY 2021 is 34%, or 10% for the age 19 to 64 expansion population within the Healthy Indiana Plan. The CHIP state share is 24%. The state share of administrative costs is 50%. Under federal COVID-19 relief legislation, the state share of costs is decreased to 28% for traditional Medicaid enrollees for the duration of the federally declared public health emergency.]

Explanation of State Revenues: *Court Fee Revenue:* If an administrative action is appealed to a court by a nongovermental party, a civil costs fee of $100 would be assessed when a civil case is filed. If additional civil actions occur and court fees are collected, revenue to the state General Fund may increase. A portion of the fee revenue is transferred to the Indiana Bar Foundation, and one fee is deposited into the State User Fee Fund.

Additional fees may be collected at the discretion of the judge and depending upon the particular type of case.

Explanation of Local Expenditures:

Explanation of Local Revenues: *Court Fee Revenue:* If additional civil actions occur and court fees are collected, local governments would receive additional revenue from both a portion of the civil costs fee and other fees that would be collected.

State Agencies Affected: Medicaid, FSSA; OALP; Attorney General.

Local Agencies Affected: Trial courts, city and town courts.

Information Sources:
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mpi115c01.pdf.

Fiscal Analyst: Karen Rossen, 317-234-2106.