Department of Legislative Services

Maryland General Assembly
2023 Session

FISCAL AND POLICY NOTE
Third Reader - Revised

House Bill 716 (Delegate Guzzone, *et al.*)
Health and Government Operations Finance

Managed Care Organizations - Retroactive Denial of Reimbursement - Information in Written Statement

This emergency bill alters the information that must be included in a written statement to a health care provider from a Medicaid managed care organization (MCO) when the MCO retroactively denies reimbursement as a result of coordination of benefits. The written statement must include the name and address of the entity that the MCO has identified as responsible for payment of the claim. An MCO is not required to obtain an acknowledgement of responsibility from the responsible payor to retroactively deny the claim based on coordination of benefits.

Fiscal Summary

State Effect: The bill does not materially affect governmental operations or finances.

Local Effect: None.

Small Business Effect: Minimal.

Analysis

Current Law: A carrier (including an MCO) may only retroactively deny reimbursement for services within six months after the date that the carrier paid the provider. Claims for services subject to coordination of benefits with another carrier, Medicaid, or Medicare may be denied for up to 18 months.

A carrier that retroactively denies reimbursement to a health care provider must provide the health care provider with a written statement specifying the basis for the retroactive

denial. Under § 15-1008(c)(2)(ii) of the Insurance Article, if the retroactive denial of reimbursement results from coordination of benefits, the written statement must provide the name and address of the entity acknowledging responsibility for payment of the denied claim.

A carrier that does not comply with these requirements may not retroactively deny reimbursement or attempt in any manner to retroactively collect reimbursement already paid to a health care provider.

A carrier may retroactively deny reimbursement at any time if information submitted was fraudulent or improperly coded, if the claim was duplicative, or, for a claim submitted to an MCO, if the claim was for services provided during a time period for which Medicaid has permanently retracted the capitation payment for the recipient from the MCO. If a carrier retroactively denies reimbursement for services as a result of coordination of benefits, the health care provider must have six months from the date of denial (unless the carrier permits a longer time period) to submit a claim for reimbursement for the service to the carrier, Medicaid, or Medicare program responsible for the payment.

Additional Comments: When an individual has commercial insurance in addition to Medicaid or Medicare, the commercial insurer is the primary payor responsible for the payment of claims and Medicaid is the payor of last resort and considered a supplemental insurance.

According to the Maryland Insurance Administration (MIA), during the time period that a claim can be reversed on a coordination of benefits ground, the reversal cannot be based on the *identification* of a primary payor but only if the identified primary payor has *acknowledged* the claim obligation. MIA advises that MCOs believe that they should have greater flexibility to recoup costs when a primary payor is *identified*. However, in cases where the MCO has identified a primary payor and recouped payment, if the primary payor disputes liability or declines the claim, a health care provider may have to pursue the coverage, absorb the loss, or pursue payment from the patient.

Additional Information

Prior Introductions: Similar legislation has not been introduced within the last three years.

Designated Cross File: SB 474 (Senator Klausmeier) - Finance.

Information Source(s): Department of Budget and Management; Maryland Department of Health; Maryland Insurance Administration; Department of Legislative Services

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