A BILL ENTITLED

AN ACT concerning

Administrative Services Organizations – Requirements for Retraction, Repayment, or Mitigation of Claims

FOR the purpose of prohibiting an administrative services organization that administers the delivery of specialty mental health services under the Maryland Medical Assistance Program from retracting, requiring repayment of, or seeking mitigation of certain claims made by health care providers unless the administrative services organization provides to the health care providers certain forms and information; requiring an administrative services organization to incur the expense of retaining an independent auditor to determine amounts owed by health care providers on certain claims under certain circumstances; prohibiting an administrative services organization from using State money or otherwise passing onto the State certain expenses; and generally relating to administrative services organizations.

BY repealing and reenacting, with amendments,

Article – Health – General
Section 15–103(b)(21)(vi)
Annotated Code of Maryland
(2019 Replacement Volume and 2021 Supplement)

BY adding to

Article – Health – General
Section 15–103.8
Annotated Code of Maryland
(2019 Replacement Volume and 2021 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Health – General

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW. [Brackets] indicate matter deleted from existing law.
The provisions of § 15–103.8 of this subtitle and § 15–1005 of the Insurance Article apply to the delivery system for specialty mental health services established under this paragraph and administered by an administrative services organization.

15–103.8.

(A) This section applies only to:

(1) An administrative services organization:

   (i) That administers the delivery system for specialty mental health services under § 15–103(b)(21) of this subtitle; and

   (ii) To which claims were made by health care providers for dates of service:

   1. In 2019 that were processed or reprocessed after January 1, 2020; or

   2. From January 1, 2020, to August 3, 2020, both inclusive; and

(2) With respect to claims made by health care providers for dates of service:

   (i) In 2019 that were processed or reprocessed after January 1, 2020; or

   (ii) From January 1, 2020, to August 3, 2020, both inclusive.

(B) An administrative services organization may not retract, require repayment of, or seek mitigation of a claim unless the administrative services organization provides the health care provider from which it is seeking a retraction, repayment, or mitigation:

   (1) For every encounter, claim, and payment adjustment, a Healthcare Electronic Remittance Advice Form 835 that:

   (i) Is delivered at the same time as the claim payment;
(II) Can be uploaded in a standard format that meets the requirements of the Administrative Simplification Rules of the Federal Health Insurance Portability and Accountability Act;

(III) Contains the denial reason for each claim, using denial codes that comply with the requirements of the Administrative Simplification Rules of the Federal Health Insurance Portability and Accountability Act; and

(IV) For a claim that is denied in whole or in part, identifies all reasons for the denial and the specific additional information necessary for the claim to be considered a clean claim, in accordance with § 15–1005(c)(2) of the Insurance Article;

(2) For all claims processed or reprocessed, a full claims history that includes:

(I) Links for each reprocessed claim to the original claim and original claim number;

(II) The dates of each reprocessing of a claim;

(III) Accurate check numbers associated with each reprocessing of a claim; and

(IV) Accurate check dates associated with each reprocessing of a claim;

(3) For all claims processed or reprocessed, access to electronic reporting and search capacity that meets basic industry standards and includes:

(I) Recipient eligibility status;

(II) Uninsured requests; and

(III) The status of all claims, including those denied;

(4) For each claims batch that fails or is rejected, a 999 Functional Acknowledgement Report; and
(5) For each claim that has not proceeded to adjudication, a 277 Claims Acknowledgement Report that identifies the claim.

(c) (1) If an Administrative Services Organization does not comply with the requirements under subsection (b) of this section, the Administrative Services Organization shall incur the expense of retaining an independent auditor to determine, with input from affected health care providers, any amounts owed by health care providers.

(2) The sole purpose of an independent auditor retained under this subsection is to determine the amounts owed by health care providers and the independent auditor may not make any additional findings.

(3) If a health care provider disagrees with an independent auditor’s findings, the health care provider may appeal the findings under the Administrative Procedures Act.

(d) On the request of a health care provider and following reasonable efforts to reach resolution, an Administrative Services Organization shall retain an independent auditor to determine the amounts owed by the health care provider.

(e) An Administrative Services Organization may not use State money or otherwise pass on to the State the expense for retaining an auditor under subsections (c) and (d) of this section.

(f) The Department shall immediately amend its contract with an Administrative Services Organization to conform the contract to the requirements of this section.

SECTION 2. AND BE IT FURTHER ENACTED, That not later than 30 days after the enactment of this Act, the Maryland Department of Health shall report to the Senate Finance Committee, the Senate Budget and Taxation Committee, the House Health and Government Operations Committee, and the House Appropriations Committee, in accordance with § 2–1257 of the State Government Article, on the following information relating to health care providers who provide services under the delivery system for specialty mental health services established under § 15–103(b)(21) of the Health – General Article:

(1) The differentials between estimated payments paid to health care providers from January 1, 2020 to August 3, 2020, both inclusive, and the amount of claims
submitted by health care providers for the dates of service during the estimated payment period;

(2) the amount of the differential attributed to service disruptions due to the COVID–19 pandemic; and

(3) any plan to forgive health care provider balances because of service disruptions due to the COVID–19 pandemic.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act is an emergency measure, is necessary for the immediate preservation of the public health or safety, has been passed by a yea and nay vote supported by three–fifths of all the members elected to each of the two Houses of the General Assembly, and shall take effect from the date it is enacted. It shall remain effective for a period of two years from the date it is enacted, and, at the end of the 2–year period, this Act, with no further action required by the General Assembly, shall be abrogated and of no further force and effect.