

HOUSE BILL No. 5931

September 20, 2012, Introduced by Rep. Lori and referred to the Committee on
Appropriations.

A bill to amend 1939 PA 280, entitled
"The social welfare act,"
by amending section 111a (MCL 400.111a), as amended by 2000 PA 187.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1 Sec. 111a. (1) The director **OF THE DEPARTMENT OF COMMUNITY**
2 **HEALTH**, after appropriate consultation with affected providers and
3 the medical care advisory council established pursuant ~~to~~ **ACCORDING** to
4 federal regulations, may establish policies and procedures that he
5 or she considers appropriate, relating to the conditions of
6 participation and requirements for providers established by section
7 111b and to applicable federal law and regulations, to assure that
8 the implementation and enforcement of state and federal laws are
9 all of the following:

10 (a) Reasonable, fair, effective, and efficient.

1 (b) In conformance with law.

2 (c) In conformance with the state plan for medical assistance
3 adopted ~~pursuant to~~ **UNDER** section 10 and approved by the United
4 States department of health and human services.

5 (2) The consultation required by this section shall be
6 conducted in accordance with guidelines adopted by the state
7 department ~~pursuant~~ **OF COMMUNITY HEALTH ACCORDING** to section 24 of
8 the administrative procedures act of 1969, 1969 PA 306, MCL 24.224.

9 (3) Except as otherwise provided in section 111i, the director
10 **OF THE DEPARTMENT OF COMMUNITY HEALTH** shall develop, after
11 appropriate consultation with affected providers in accordance with
12 guidelines, forms and instructions to be used in administering the
13 program. Forms developed by the director **OF THE DEPARTMENT OF**
14 **COMMUNITY HEALTH** shall be, to the extent administratively feasible,
15 compatible with forms providers are required to file with 1 or more
16 other third party payers or with 1 or more regulatory agencies and,
17 to the extent administratively feasible, shall be designed to
18 facilitate use of a single form to satisfy requirements imposed on
19 providers by more than 1 payer, agency, or other entity. The forms
20 and instructions shall relate, at a minimum, to standards of
21 performance by providers, conditions of participation, methods of
22 review of claims, and administrative requirements and procedures
23 that the director **OF THE DEPARTMENT OF COMMUNITY HEALTH** considers
24 reasonable and proper to assure all of the following:

25 (a) That claims against the program are timely, substantiated,
26 and not false, misleading, or deceptive.

27 (b) That reimbursement is made for only medically appropriate

1 services.

2 (c) That reimbursement is made for only covered services.

3 (d) That reimbursement is not made to those providers whose
4 services, supplies, or equipment cost the program in excess of the
5 reasonable value received.

6 (e) That the state is a prudent buyer.

7 (f) That access and availability of services to the medically
8 indigent are reasonable.

9 (4) As used in subsection (3), "prudent buyer" means a
10 purchaser who does 1 or more of the following:

11 (a) Buys from only those providers of services, supplies, or
12 equipment to medically indigent individuals whose performance, in
13 terms of quality, quantity, cost, setting, and location is
14 appropriate to the specific needs of those individuals, and who, in
15 the case of providers who receive payment on the basis of costs,
16 comply with the prudent buyer concept of titles XVIII and XIX.

17 (b) Pays for only those services, supplies, or equipment that
18 are needed or appropriate.

19 (c) Seeks to economize by minimizing cost.

20 (5) The director **OF THE DEPARTMENT OF COMMUNITY HEALTH** shall
21 select providers to participate in arrangements such as case
22 management, in supervision of services for recipients who
23 misutilize or abuse the medical services program, and in special
24 projects for the delivery of medical services to eligible
25 recipients. Providers shall be selected based upon criteria that
26 may include a comparison of services and related costs with those
27 of the provider's peers and a review of previous participation

1 warnings or sanctions undertaken against the provider or the
2 provider's employer, employees, related business entities, or
3 others who have a relationship to the provider, by the medicaid,
4 medicare, or other health-related programs. The director **OF THE**
5 **DEPARTMENT OF COMMUNITY HEALTH** may consult with the appropriate
6 peer review advisory committees as appointed by the department **OF**
7 **COMMUNITY HEALTH**.

8 (6) The director **OF THE DEPARTMENT OF COMMUNITY HEALTH** shall
9 give notice to each provider of a change in a policy, procedure,
10 form, or instruction established or developed ~~pursuant to~~**UNDER**
11 this section that affects the provider. For a change that affects 1
12 or more types of providers, a departmental bulletin or updating
13 insert to a departmental manual mailed 30 days before the effective
14 date of the change shall constitute sufficient notice. **THE**
15 **DEPARTMENT OF COMMUNITY HEALTH MAY PROVIDE NOTICE REQUIRED UNDER**
16 **THIS SUBSECTION VIA UNITED STATES MAIL OR ELECTRONIC MAIL.**

17 (7) The director **OF THE DEPARTMENT OF COMMUNITY HEALTH** may do
18 all of the following:

19 (a) Enroll in the program for medical assistance only a
20 provider who has entered into an agreement of enrollment required
21 by section 111b(4), and enter into an agreement only with a
22 provider who satisfies the conditions of participation and
23 requirements for a provider established by sections 111b and 111i
24 and the administrative requirements established or developed
25 ~~pursuant to~~**UNDER** subsections (1), (2), and (3) with the
26 appropriate consultation required by this section.

27 (b) Enforce the requirements established ~~pursuant to~~**UNDER**

1 this act by applying the procedures of sections 111c to 111f. If in
2 these procedures the director **OF THE DEPARTMENT OF COMMUNITY HEALTH**
3 is required to consult with professionals or experts ~~prior to~~
4 **BEFORE** first utilizing these individuals in the program, the
5 director **OF THE DEPARTMENT OF COMMUNITY HEALTH** shall have given the
6 opportunity to review their professional credentials to the
7 appropriate medicaid peer review advisory committee.

8 (c) Except as otherwise provided in section 111i, develop with
9 the appropriate consultation required by this section and require
10 the form or format for claims, applications, certifications, or
11 certifications and recertifications of medical necessity required
12 by section 108, and develop specifications for and require
13 supporting documentation that is compatible with the approved state
14 medical assistance plan under title XIX.

15 (d) Recover payments to a provider in excess of the
16 reimbursement to which the provider is entitled. The department **OF**
17 **COMMUNITY HEALTH** shall have a priority lien on any assets of a
18 provider for any overpayment, as a consequence of fraud or abuse,
19 that is not reimbursed to the department **OF COMMUNITY HEALTH**.

20 (e) Notwithstanding any other provisions of this act, before
21 payment of claims, identify for examination for compliance with the
22 program of medical assistance, including but not limited to medical
23 necessity, the claims submitted by a particular provider based upon
24 a determination that the provider's claims for disputed services
25 exceed the average program dollar amount or volume of the same type
26 of services, submitted by the same type of provider, performed in
27 the same setting, and submitted during the same period. In order to

1 carry out the authority conferred by this subdivision, the director
2 **OF THE DEPARTMENT OF COMMUNITY HEALTH** shall notify the provider in
3 the form of registered mail, receipted by the addressee, or by
4 proof of service to the provider, or representative of the
5 provider, of the state ~~department's~~ **DEPARTMENT OF COMMUNITY**
6 **HEALTH'S** intent to impose specific conditions and controls ~~prior to~~
7 **BEFORE** authorizing payment for specific claims for services. The
8 notice shall contain all of the following:

9 (i) A list of the particular practice or practices disputed by
10 the state department **OF COMMUNITY HEALTH** and a factual description
11 of the nature of the dispute.

12 (ii) A request for specific medical records and any other
13 relevant supporting information that fully discloses the basis and
14 extent to which the disputed practice or practices were rendered.

15 (iii) A date certain for an informal conference between the
16 provider or representative of the provider and the state department
17 **OF COMMUNITY HEALTH** to resolve the differences surrounding the
18 disputed practice or practices.

19 (iv) A statement that unless the provider or representative of
20 the provider demonstrates at the informal conference that the
21 disputed practice or practices are medically necessary, or are in
22 compliance with other program coverages, specific conditions and
23 controls may be imposed on future payments for the disputed
24 practice or practices, and claims may be rejected, beginning on the
25 sixteenth day after delivery of this notice.

26 (8) For any provider who is subject to a notice of intent to
27 impose specific conditions and controls ~~prior to~~ **BEFORE** authorizing

1 payment for specific claims for services, as specified in
2 subsection (7)(e), the state department **OF COMMUNITY HEALTH** shall
3 afford that provider an opportunity for an informal conference
4 before the sixteenth day after delivery of the notice under
5 subsection (7)(e). If the provider fails to appear at the
6 conference, or fails to demonstrate that the disputed practice or
7 practices are medically necessary or are in compliance with program
8 coverages, the state department **OF COMMUNITY HEALTH** beginning on
9 the sixteenth day following receipt of notice by the provider, is
10 authorized to impose specific conditions and controls ~~prior to~~
11 **BEFORE** payment for the disputed practice or practices and may
12 reject claims for payments for the practice or practices. The state
13 department **OF COMMUNITY HEALTH**, within 5 days following the
14 informal conference, shall notify the provider of its decision
15 regarding the imposition of special conditions and controls ~~prior~~
16 ~~to~~ **BEFORE** payment for the disputed practice or practices. Upon the
17 imposition of specific conditions and controls ~~prior to~~ **BEFORE**
18 payment, the provider upon request shall be entitled to an
19 immediate hearing held in conformity with chapter 4 and chapter 6
20 of the administrative procedures act of 1969, 1969 PA 306, MCL
21 24.271 to 24.287 and 24.301 to 24.306, if any of the following
22 occurs:

23 (a) The claim for services rendered is not paid within 30 days
24 of the provider's compliance with the conditions imposed.

25 (b) The claim is rejected.

26 (c) The provider notifies the state department **OF COMMUNITY**
27 **HEALTH** by registered mail that the provider does not intend to

1 comply with the specific conditions and controls imposed, and the
2 claim for services rendered is not paid within 30 days after
3 delivery of this notice.

4 (9) The hearing provided for under subsection (8) shall be
5 conducted in a prompt and expeditious manner. At the hearing, the
6 provider may contest the state ~~department's~~ **DEPARTMENT OF COMMUNITY**
7 **HEALTH'S** decision to impose specific conditions and controls ~~prior~~
8 ~~to~~ **BEFORE** payment. Subsequent hearings may be conducted at the
9 provider's request only if the claims have not been considered at a
10 prior hearing and reflect issues that also have not been considered
11 at a prior hearing, or if a claim for services rendered is not paid
12 within 60 days after the provider's compliance with the conditions
13 imposed.

14 (10) The authority conferred in subsection (8) with respect to
15 the claims submitted by a particular provider does not prohibit the
16 state department **OF COMMUNITY HEALTH** from examining claims or
17 portions of claims before payment of the claims to determine their
18 compliance with the program of medical assistance, in compliance
19 with law. The director **OF THE DEPARTMENT OF COMMUNITY HEALTH** may
20 take additional action ~~pursuant to~~ **UNDER** subsection (8) during the
21 pendency of an appeal taken ~~pursuant to~~ **UNDER** subsection (8).

22 (11) If in the ~~department's~~ **DEPARTMENT OF COMMUNITY HEALTH'S**
23 opinion, the provider shifts his or her claims from the disputed
24 services addressed under subsection (7)(e) to other claims that
25 fall under the purview of subsection (7)(e), the director **OF THE**
26 **DEPARTMENT OF COMMUNITY HEALTH** may impose the claims review process
27 of this section immediately upon delivery of the notice of that

1 imposition to the provider as provided in subsection (7)(e).

2 (12) If in the ~~department's~~ **DEPARTMENT OF COMMUNITY HEALTH'S**
3 opinion, claims similar to the disputed services addressed under
4 subsection (7)(e) are shifted to another provider in the same
5 corporation, partnership, clinic, provider group, or to another
6 provider in the employ of the same employer or contractor, the
7 director **OF THE DEPARTMENT OF COMMUNITY HEALTH** may impose the
8 claims review process of this section immediately upon delivery of
9 notice of that imposition to the new provider as provided in
10 subsection (7)(e). The department **OF COMMUNITY HEALTH** shall afford
11 the new provider an opportunity for an immediate informal
12 conference within 7 days ~~pursuant to~~ **UNDER** subsection (8) after the
13 initiation of the claims process.

14 (13) The director **OF THE DEPARTMENT OF COMMUNITY HEALTH** may
15 request a provider to open books and records in accordance with
16 section 111b(7) and may photocopy, at the state ~~department's~~
17 **DEPARTMENT OF COMMUNITY HEALTH'S** expense, the records of a
18 medically indigent individual. The records shall be confidential,
19 and the state department shall use the records only for purposes
20 directly and specifically related to the administration of the
21 program. The immunity from liability of a provider subject to the
22 ~~director's~~ **DIRECTOR OF THE DEPARTMENT OF COMMUNITY HEALTH'S**
23 authority under this subsection is governed by section 111b(7).

24 (14) The director **OF THE DEPARTMENT OF COMMUNITY HEALTH** shall
25 not pay for services, supplies, or equipment furnished by a
26 provider, or shall recover for payment made, during a period in
27 which the provider does not have on file with the state department

1 **OF COMMUNITY HEALTH** disclosure forms as required by section
2 111b(19).

3 (15) The director **OF THE DEPARTMENT OF COMMUNITY HEALTH** shall
4 make payments to, and collect overpayments from, the provider,
5 unless the provider and the provider's employer satisfy the
6 conditions prescribed in section 111b(25), (26), and (27), in which
7 case the director **OF THE DEPARTMENT OF COMMUNITY HEALTH** may make
8 payments directly to, and collect overpayments from, the provider's
9 employer.

10 (16) The director **OF THE DEPARTMENT OF COMMUNITY HEALTH**, with
11 the appropriate consultation required by this section, may develop
12 specifications for and require estimated cost and charge
13 information to be submitted by a provider under section 111b(13)
14 and the form or format for submission of the information.

15 (17) If the director **OF THE DEPARTMENT OF COMMUNITY HEALTH**
16 decides that a payment under the program has been made to which a
17 provider is not or may not be entitled, or that the amount of a
18 payment is or may be greater or less than the amount to which the
19 provider is entitled, the director **OF THE DEPARTMENT OF COMMUNITY**
20 **HEALTH**, except as otherwise provided in this subsection or under
21 other applicable law or regulation, shall promptly notify the
22 provider of this decision. The director **OF THE DEPARTMENT OF**
23 **COMMUNITY HEALTH** shall withhold notification to the provider of the
24 decision upon advice from the department of attorney general or
25 other state or federal enforcement agency in a case where action by
26 the department of attorney general or other state or federal
27 enforcement agency may be compromised by the notification. If the

1 director **OF THE DEPARTMENT OF COMMUNITY HEALTH** notifies a provider
2 of a decision that the provider has received an underpayment, the
3 state department **OF COMMUNITY HEALTH** shall reimburse the provider,
4 either directly or through an adjustment of payments, in the amount
5 found to be due.