The Straight Talk team is in missing man formation w/out Brother McKenzie here to join us.
Kudos to your MCEP leadership & chapter for preparing for these challenges for several years: my 2017 Straight Talk 26 slide title

Out of network & balance billing restrictions: coming to a state near you (it’s a question of when not whether)

And special thanks to Dr. Kevin Monfette for his years of service as course director!
HE WORKED ON SURPRISE MEDICAL BILLING.

(Insert the gratuitous picture of a Ludington landmark—long time attendees—wait for it).
What is out of network (OON) balance billing or “Surprise Medical Billing” (SMB)?

➢ ED group has no contract (K) w/ UHC.

➢ ED visit 99285 full charge (approx. 4.5X of CMS) or $800
  UHC reimburses at 125% of CMS or $220
  Patient’s OON cost sharing for ED $150
  Balance remaining/balance bill of $430

➢ For example, in NJ & IL the $430 is adjusted off to zero.

Why should you care about changes in OON laws even if less than 5 or 3% of your group’s health plans are OON?

➢ Congressional Budget Office (CBO) & “Pay As You Go” (PAYGO) Rules.

➢ CBO “scored” HR 2328, the E&C bill—no IDR.

➢ “The vast majority of health care is delivered inside a patient’s network, and more than 80% of the estimated budgetary effects of Title IV [SMB provisions] would arise from changes in in-network payment rates.”

➢ “CBO and the JCT [Joint Committee on Taxation] estimate that by creating a method for reimbursing OON care at median in network rates, payments to providers—inside and outside of networks—would converge around those median rates.” (emphasis added)
Causes of the OON conundrum—what do the health plans want & why? Answer: “benchmarking”

Medicare Trustees Report—physician reimbursement > 0.4% per yr. vs. costs of running a practice at 1.7% per yr.
In the ACA, she sees narrower networks & in some plans no OON coverage=more costs & less benefit coverage for her premiums.

Nearly 45% of large employers offer only a high deductible health plan (HDHP)

[Link](https://www.beckershospitalreview.com/payer-issues/analysis-high-deductible-health-plans-broke-the-us-health-insurance-system.html)

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**Case study--CA: How does “benchmarking” work for clinicians who do not have access to IDR?**

- 88% of physicians said the California law allowed insurers to shrink physician networks, decreasing patient access to in-network physicians in their community.
- 92% said the law has reduced physician leverage to negotiate fair and reasonable contracts.
- 94% of physicians have experienced contracting difficulties since the passage of California’s law.
- 91% of physicians agree that the Congressional proposals modeled after the California law will accelerate consolidation of independent physician practices into larger hospital systems or private equity groups.

You can read the survey results [here](https://www.beckershospitalreview.com/payer-issues/analysis-high-deductible-health-plans-broke-the-us-health-insurance-system.html).
NJ case study: what's the downside?

➢ Coalition of clinicians fought against this bill for > 10 yrs.
➢ NJ stat. effective 8/29/18.
➢ No minimum benefit std. (MBS)—“reasonable reimbursement” as determined by health plans.
➢ 1 week after the law became effective, Horizon BCBS announced that standard was 110% of Medicare.
➢ UHC has announced that “reasonable payment” is one that they will determine & they provide a link to the arbitration 3rd party adjudicator.
➢ No EM access to arbitration b/c of the way the standard was written.

What do clinicians want?

➢ Congressman (and Doctors) Ruiz (ED) (D-CA) & Roe (OB) (R-TN)—HR 3502 “Surprise Medical Bills Act”
➢ Protects Pts from OON bills for “unanticipated care” at in-network facilities + OON imaging and labs.
➢ Plans: ERISA, FEHBP & private plans in states w/out Pt protections.
➢ Pts. pay their “in-network” cost sharing.
➢ Health plans initial reimbursement at “commercially reasonable” rates w/in 30 days.
➢ Over 100 bi-partisan co-sponsors in the House.
➢ “Baseball styled” independent dispute resolution (IDR)
Why all the fuss?
➢ Debate has shifted.
➢ Sept. 2019 according to ACEP Reimbursement Dept.
  ➢ 37 states have considered nearly 100 separate OON bills.
  ➢ Over 1700 pages of text.
  ➢ New statutes in CO, NM, NV, TX and WA.
  ➢ “In play” now: MI, OH, PA and VA

➢ 8 bills in Congress—ERISA plans are their focus.

➢ Federalism—state bills will keep coming despite Feds.

2019 State Balance Billing Summary

10 New State OON Laws
AZ, CO, MO, OR, NH, NM, NJ, NV, TX, WA

25 States Introduced OON Legislation
CA, CT, LA, GA, HI, IN, KY, LA, MA, MI, MS, MT, MO, NE, NC, NY, OH, PA, RI, TN, VA, WV, WA, UT, VT (in red)

Fuchsia—either no bills or laws currently in place
And so who has been winning?

Making “our” case:

➢ NY OON law w/ “IDR” est. in 2015.

➢ NY DFS Report Sept. 2019—key takeaways:
  ➢ OON balance billing declined -34%
  ➢ In-network ED $ was reduced -9% over 4 yrs.
  ➢ Back out Gov’t payors and IDR are .02262% of 3.75 Million ED comm. visits.
MI HB 4459 as written and possible substitute language:

- OON reimbursement for “emergent” and “non-emergent” care is set at the > of—
  - 1. 150% of CMS or
  - 2. the average in network rates.

- Notice and consent by the Pt. to OON clinician and OON billing permitted for non-ED services—also CA and TX.
- No IDR.

MI HB 4459 as written and possible substitute language:

- “Facilities” defined broadly to include hospitals, free standing OP facilities, SNF, phys. Offices or other OP settings, labs, imaging center or radiology settings.

- Applicable to EM services whether the Pt. was treated at a par or non-par hospital.
  - Also a non-par clinician at an in network hospital + emergency Pt. who was admitted + w/in 72 hours after rec’g EM services
Draft 4 Substitute for MI House bill 4459—uses the blended rate formula of charges & allowed amounts—original bill only has the green shading.

➢ Reimbursement is at the > of:
1. Ave. in network rate per a benchmarking database & excluding the Pts. cost sharing;
2. 150% of CMS excluding the Pt cost sharing; or
3. Ave. of the 80th percentile billed charge & 50th percentile of allowed amounts paid to par clinicians per a benchmarking database.

Fair Health data on charges & allowed amounts for MI—Metro DTW, GR, TC and state wide

➢ Available in the updated slides at time of presentation.
How important is being able to reference FH charge data in the formula?

Pro forma calculation of the blended rate in TX & OH:

- **TX:** 80th percentile charges in 2018 for CPT 99285 is $1900.
- 80th percentile of median allowed amounts are $386.
- Average is $1143 or 6.5X of CMS for 99285 ($176 nat’l average Medicare reimbursement w/ no GPCI.

- **OH:** 80th percentile of charges in 2018 for CPT 99285 is $1397.
- 80th percentile of allowed amounts is $373.
- Average is $885 or 5X of CMS.
What really worries members of Congress? The “law of unintended consequences”

➢ >110 rural hospitals have closed since 2010.

➢ 21% of rural hospitals are nearly insolvent.

➢ Midwestern & Southern states’ hospitals are most exposed.


SMB summary:

➢ Federal legislation very difficult to predict—if not by the end of Q1 2020, issues will fall into 2021.

➢ MI substitute #4 to HB 4459 could be favorable.

➢ Big victory in TX (2019) and in the “red zone” on OH SB 198 (Sen. Huffman, an ED doc).

➢ GA (2020), MA, PA, & VA (2020) will be major contests.
Gentle reminder that ACEP Reimbursement & Coding will be in Austin TX, Jan. 27-31, 21020

“Patients Over Paperwork” & the 2020 Medicare Physician Fee Schedule (MPFS) Final Rule

- Physician Supervision Requirements.
- Review & verification of medical record documentation.
- Medicare Beneficiaries Identifiers (MIB)
- Ambulance Certification Statements.
- Stark & AKS changes.
The WPS PA/NP standard was one of the more exacting—not as of 1/1/20

Documentation requirements for NPP shared visits—WPS Part B MAC (MI)

- Documentation that both EDP and NPP provided face to face Pt svs on the same day.
- Document what portion of the Hx, Ex and MDM was documented by the physician and the NPP.
- CC and procedures are an exception.
- Include legible/electronic authentication.

The WPS PA/NP standard was one of the more exacting—(cont.)
Physician Supervision Requirements for PAs

- We are modifying our regulation on physician supervision for PA professional services to give PAs greater flexibility to practice more broadly in the current health care system in accordance with state law and state scope of practice rules in the state in which the PA professional services are furnished.

- Accordingly, a PA must furnish professional services in accordance with any state laws or state scope of practice rules that describe the required practice relationship between physicians and PAs, including explicit supervisory or collaborative practice requirements that describe a form of supervision for purposes of section 1861(s)(2)(K)(i) of the Act.

- In the absence of any state rules for physician supervision of PA services, we are finalizing a revision to the current supervision requirement to clarify that physician supervision is a process in which a PA has a working relationship with one or more physicians to supervise the delivery of their health care services.

MI “scope of practice” for PAs—request & obtain competent healthcare counsel legal advice given the many 1000s of claims under the “new” standard.
NP scope of practice: ditto on legal advice & this is not an official MI website [http://scopeofpracticepolicy.org/states/mi/]

Further expansion of PA & NP scope of practice coming in 2020 from DHHS and CMS?

➢ POTUS Executive Order 10/3/19:

- proposing a regulation that would eliminate burdensome regulatory billing requirements, conditions of participation, supervision requirements, benefit definitions, and all other licensure requirements of the Medicare program that are more stringent than applicable Federal or State laws require and that limit professionals from practicing at the top of their professions;

- proposing a regulation that would ensure appropriate reimbursement by Medicare for time spent with patients by both primary and specialist health providers practicing in all types of health professions; and

- conducting a comprehensive review of regulatory policies that create disparities in reimbursement between physicians and non-physician practitioners and proposing a regulation that would, to the extent allowed by law, ensure that items and services provided by clinicians, including physicians, physician assistants, and nurse practitioners, are appropriately reimbursed in accordance with the work performed rather than the clinician’s occupation.
Review & verification of medical record documentation under the 2020 MPFS—effective 1/1/20.

➢ PA, NP or medical student old rule: document only the PFSH or ROS for CMS under the 1995 Medicare DGs.

➢ If other Hx, Ex or MDM, EDP required to perform & redocument under the current policies. CMS Transmittal 1780, 7/24/2009.

➢ Changes as of 1/1/20:
  ➢ Phys., PA, NP review & verify (sign & date) notes made by students or others on the medical team.
  ➢ No “redocumenting” is required.
  ➢ Rule extends to notes on physical presence & participation.

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Code of federal regulations (CFR) also codified the teaching physician rules pre-2019.

https://www.law.cornell.edu/cfr/text/42/415.174

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2019 Medicare Physician Fee Schedule (MPFS) final rule--perhaps the performance requirements have not changed (blue/top) but documentation has changed (orange/bottom)

➢ “We proposed to add new paragraph (a)(6) to §415.174 to provide that the medical record must document the extent of the teaching physician’s participation in the review and direction of services furnished to each beneficiary”

➢ “[T]he revised paragraph would specify that the presence of the teaching physician during procedures and E/M services may be demonstrated by the notes in the medical records made by a physician, resident, or nurse” (emphasis added)

Consult with RCM professionals & local Medicare MAC on specific areas of risk in the TP settings:

➢ What’s not changed (so far)?
  ➢ Critical care documentation by the resident ➞ critical time for the TP.

➢ Open issues:
  ➢ ACEP Reimbursement Comm. drafted a letter in 2019 to CMS seeking clarification on the new standards & CMS said “see prior guidance”

➢ Major and minor procedure requirements for TP presence and documentation? Transmittal 811

➢ What to do now? Check & double check with your Medicare MAC & obtain legal counsel guidance.
CMS finalized the ambulance certification statement proposal in the 2020 MPFS final rule.

➢ Previously PAs and NPs could certify if the attending EDP was not available.

➢ Now LPNs, social workers and case managers may be added to the list to sign a PCS if the attending physician is not available.

RCM folks—new Medicare care HICN claims reject effective as of 1/1/20

➢ Medicare MACs will reject Medicare claims filed w/ health insurance claim numbers (HICNs) w/ few exceptions.

➢ Clinicians must use Medicare Beneficiary Identifiers (MBIs) (ML Matters 8/19/19)

➢ New cards were mailed to beneies 8/19/19

➢ MACs have a secure MBI lookup function.

➢ New MBIs will include Medicare Advantage.
Definition of Shared Service

➢ "A split/shared E/M visit is defined by Medicare Part B payment policy as a medically necessary encounter with a patient where the physician and a qualified NPP each personally perform a substantive portion of an E/M visit face-to-face with the same patient on the same date of service. A substantive portion of an E/M visit involves all or some portion of the history, exam or medical decision making key components of an E/M service." CMS Transmittal 1776 (emphasis added) (see appendix)

“More Patients Over Paperwork Reforms:  Physician Self Referral Law (a/k/a Stark) & anti-kickback statute (AKS)

➢ Limits physician referral when there is a financial relationship with the entity.

➢ AKS: prohibits asking for/receiving anything of value to induce or reward referrals of services reimbursed by gov’t payors.

Three Questions:
1. Is there a referral from a physician for a designated health service (DHS)?
2. Does the physician (or an immediate family member) have a financial relationship with the entity providing the DHS?
3. Does the financial relationship fit in an exception?
Stark and AKS Reforms Oct. 2019

➢ Both sets of laws have safe harbors.
➢ Difference is that Stark is strict liability law—you’re either in a safe harbor or in violation.
➢ New guidance and new safe harbors are aimed at—
  ➢ Improved care coordination through outcome based payments that reward improvements to Pt health and reduce cost.
  ➢ e.g.--ACEP’s AUCM APM: care coordinator for follow up care &/or use of telehealth to prevent unnecessary ED visits or readmissions.
➢ Experienced healthcare counsel advice is a must here.
➢ Remember the Tuomey hospital case from a couple of years ago?
## Apples to apples comparisons:

<table>
<thead>
<tr>
<th>Specialty 93 &amp; Medicare Part B only:</th>
<th>2018 CMS Medicare Acuity %</th>
<th>2018 CMS Medicare Acuity %</th>
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<tbody>
<tr>
<td>Specialty 93 - Nurse Practitioners</td>
<td>Specialty 93 - Physician Assistants</td>
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<tr>
<td>DC</td>
<td>1.5%</td>
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<td>DE</td>
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<td>FL</td>
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<td>MD</td>
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<td>MI</td>
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### Specialty 93 & Medicare Part B only:

#### Apples to apples comparisons:

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<thead>
<tr>
<th>Mid-Level Combined</th>
<th>Specialty 93 - Emergency Physicians</th>
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<tr>
<td>DC</td>
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<td>DE</td>
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<td>FL</td>
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<tr>
<td>GA</td>
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<td>ME</td>
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<tr>
<td>MI</td>
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### Specialty 93 & Medicare Part B only:

#### Michigan

E&M Utilization By Year - Emergency Medicine

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<tr>
<td>E&amp;M %</td>
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<td>99284</td>
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<td>6.3%</td>
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<td>7.0%</td>
<td>7.4%</td>
<td>7.6%</td>
<td>8.2%</td>
<td>8.3%</td>
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Medicare Part B volumes actually declined in 2018 vs. prior years.

Medicare Advantage has grown steadily in contrast from 30% of the Medicare covered lives in 2014 to 36% in 2018.

“Patients over Paperwork” has meant real reforms in documentation, scope of practice & compliance exposure.

- Balance between changing standards to ease clinical burdens while maintaining high standards for program integrity.
- Federal False Claims Act, Stark and AKS are still w/ us and pose hurdles even in light of the new reforms.
- Partner w/ hospitals to interpret how new standards should be implemented and then ask for counsel to review.
Appendix: Growth in Medicare Advantage Covered Lives

![Medicare Advantage Enrollment Information by Year of Service](image-url)
Appendix--Is there a backlash against high deductible health plans (HDHPs)?

➢ For the 3rd year in a row, the number of employers offering only a HDHP option has declined, KHN Oct. 2019

Appendix: Case Study: How bad ass is the FCA? Ask Tuomey Regional Med. Ctr., 310 bed hospital in Sumter, SC (pop. 40K)

➢ Hospital worried over lost revenue from colonoscopies and GI procedures done in MD offices and ASCs ($8-12M loss)

➢ Part-time 10 yr. employment Ks w/ productivity bonuses, hospital paid billing costs, hospital paid PLI, other incentives & physicians could buy hospital’s health plan coverage.

➢ Physician qui tam.

➢ $237.454 Million judgment aff’d

➢ Hospital’s legal counsel forced to testify at second trial.

➢ Check out the FCA multiplier effect.

http://www.beckershospitalreview.com/legal-regulatory-issues/the-tuomey-case-12-key-points.html
## Appendix: CMS Acuity Data by Clinician Category

<table>
<thead>
<tr>
<th>Specialty 50 - Nurse Practitioners</th>
<th>Specialty 57 - Physician Assistants</th>
<th>2018 CMS Medicare Acuity %</th>
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<td>99282</td>
<td>99283</td>
<td>99284</td>
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<tr>
<td>National</td>
<td>0.7%</td>
<td>2.8%</td>
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<table>
<thead>
<tr>
<th>Specialty 51 - Emergency Physicians</th>
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