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1 Emilie Alvarez, Regulations Coordinator  
2 Department of Managed Health Care  
3 Office of Legal Services  
4 980 9th Street, Suite 500  
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6 RE: Proposed Rulemaking Action Concerning Unfair Billing Patterns and Independent  
7 Dispute Resolution Process, Control No. 2006-0777

8

9 Dear Ms. Alvarez:

10 CAL/ACEP is hereby providing testimony on the proposed regulations related to the prohibition  
11 of balance billing and the independent claims dispute resolution process. However, CAL/ACEP  
12 believes that the Department of Managed Health Care (DMHC) lacks the authority to promulgate  
13 these regulations. Hence, this testimony is provided under protest.

14 The California Chapter of the American College of Emergency Physicians (CAL/ACEP)  
15 appreciates the opportunity to comment on the above-referenced rulemaking file, however, we  
16 wish to make it clear that we reject the notion that the Department of Managed Health Care has  
17 authority to promulgate these new regulations. CAL/ACEP represents more than 2000  
18 emergency physicians in California. Emergency Physicians provide emergency services and  
19 care to more than ten million Californians every year. We are obligated under the Emergency  
20 Medical Treatment and Labor Act (EMTALA) and similar state laws, and by our commitment to  
21 the health of our communities, to provide these services without regard to our patient's insurance  
22 status or ability to pay. These proposed regulations will have a profound impact on access to  
23 emergency care services in California, on the financial viability of the emergency care safety net  
24 and our professional practices; and we are gravely concerned that these regulations will have a  
25 disastrous effect on an already overburdened and under-funded emergency care services system  
26 in our State. For the reasons described below, we urge your Department NOT to adopt these  
27 regulations, as these proposals violate the law and would have significant and adverse impacts  
28 upon the health of the citizens of, and visitors to, our state. Our comments are set forth below.

## 29 I. UNFAIR BILLING REGULATION

### 30 A. No Authority for the Regulation

31 In the recent *Prospect v Saint John's and Northridge Medical Group* appellate decision, the Court  
32 held for the defendants that balance billing was not prohibited under law, and payment for  
33 emergency services at Medicare rates did not meet the standard for usual and customary  
34 reimbursement. This case is now under review by the California Supreme Court at the request of  
35 the DMHC

36

37 The DMHC has no authority in the Knox-Keene Act, or anywhere else in California law, to  
38 adopt regulations prohibiting non-contracting physicians from obtaining payment for their  
39 services. The Legislature only granted the DMHC jurisdiction to issue regulations regulating its  
40 own licensees – health plans, not individuals that have no contract or other connection with a

1 health plan. Given their EMTALA obligations under the law, emergency physicians often have  
2 no knowledge of whether a patient to whom they have provided emergency services has any  
3 health insurance, let alone whether they happen to be covered by a Knox-Keene plan. The  
4 Legislature has clearly not authorized DMHC to act in this area. In fact, the statute the DMHC  
5 relies upon for “authority” in issuing this proposal, Health & Safety Code §1371.39, expressly  
6 requires the DMHC to go to the Legislature with its recommendations with respect to “unfair  
7 billing practices.” Had the Legislature intended for the Department to directly regulate  
8 physicians’ billing practices, it would have expressly granted this authority rather than directing  
9 the department to refer this issue back for Legislative consideration.

10  
11 B. Inconsistency with Knox-Keene Act

12  
13 Further, the proposed regulations concerning “unfair billing practices” are wholly inconsistent  
14 with California law. The Knox-Keene Act is replete with references to allowing non-contracting  
15 physicians to bill enrollees for the reasonable value of their services. See, for example, Health &  
16 Safety Code §1363 (enrollees should be informed of financial liability); 28 C.C.R. §1300.63 (in  
17 event the health plan fails to pay for the non-contracting provider’s service, the member may be  
18 liable to the non-contracting provider for the cost of the service); Health & Safety Code  
19 §§1373.95 and 1373.96 (non-contracted physicians do not need to accept health plan rates);  
20 Health & Safety Code §§1374.34 and 1262.8 (recognizing right of non-contracted emergency  
21 care providers to seek reimbursement from enrollees). These statutes recognize a non-contracted  
22 physician’s common law right to seek reimbursement from the person who directly benefited  
23 from the physician’s services, and are fully consistent with the most recent, citable California  
24 court decision on this issue. See *Bell v. Blue Cross of California* (2005) 131 Cal.App.4th 211, 31  
25 Cal.Rptr.3d 688. Indeed, the *Bell* decision recognized the constitutional infirmity of the type of  
26 regulation the DMHC proposes, that is, by proposing to allow the health plans to unilaterally set  
27 rates, health plans would be empowered to pay at confiscatory levels in violation of the  
28 Constitution.

29 C. Failure to Regulate Underpayment as the Root Cause of Balance Billing

30 A 2002 California Senate Office of Research report on Growing Gaps in California’s Emergency  
31 Room Backup System (**See attachment 1**) recommended that: “Health plan enrollees and health  
32 care consumers should be better protected from the impacts of contracting and payment disputes  
33 between health plans and physicians related to on-call services and from being required to pay  
34 out-of-pocket for services that are covered by their health plans, by providing that **a payment  
35 practice that indirectly harms a health plan enrollee by causing the enrollee to pay amounts  
36 in excess of applicable co-payments, deductibles, or coinsurance for ER and on-call services  
37 that are covered by their health plan constitutes an unfair payment pattern and is subject  
38 to the remedies under the prompt payment statute.** An example would be a plan that follows  
39 a practice of paying discounted fees to non-contracting providers for on-call services, with the  
40 result that the providers bill their patients and the patients pay the remainder of the fees. **Note  
41 that the SOR correctly recommended that balance billing be considered a consequence of  
42 “unfair payment patterns”, not unfair billing.** The DMHC has failed to heed this  
43 recommendation, and instead of addressing balance billing as a by-product of claims  
44 underpayment, it is exceeding its authority by attempting to regulate physician billing.

1 D. Regulatory Double Standard

2 Of note, the California Association of Physician Groups (CAPG), an organization of capitated  
3 medical groups that subcontracts for insurance risk from Health Plans, has been the leading  
4 advocate of these proposed regulations. It is particularly frustrating for emergency care  
5 providers to have a prohibition imposed on non-contracted emergency care billing practices,  
6 when it is a well known fact that the physicians who are affiliated with CAPG's medical groups  
7 and IPAs exercise these same rights to seek payment of the balance of a bill from the patient  
8 when they provide services that are not covered under contract with a patient's health care plan,  
9 and the plan underpays the claim. The rationale for this selective enforcement by the DMHC  
10 appears to be that patients seeking emergency care have no choice in where they go for care, and  
11 that they expect the physicians at networked hospitals to be contracted as a part of their network.  
12 These are legitimate considerations, but they should be addressed directly, as indicated below,  
13 rather than by placing one-sided restrictions on good faith providers.

14 A related question regarding regulatory double standards is: why should Blue Cross and Blue  
15 Shield PPOs be allowed to benefit from the prohibition against balance billing simply because  
16 these are Knox-Keene plans? These two plans are not sold to enrollees with the same  
17 expectations of coverage as HMO products. These regulations could give these two PPO plans a  
18 distinct and unfair advantage in the PPO marketplace.

19 Emergency physicians have experienced a long and difficult history of underpayment, delayed  
20 payment and non-payment by Health Plans and Capitated Medical Groups. As the result of  
21 inaction on the part of DMHC in this area over which it has undisputed jurisdiction, CAL/ACEP  
22 members have been forced to pursue costly and time consuming resolution via litigation; and, ten  
23 years after its formation, the DMHC is only now attempting to address the issue of provider  
24 payment grievances under the auspices of its current Director. From its inception, the DMHC  
25 has had a consumer driven mission; however, the culture of the Department has been highly  
26 influenced by payers, with many staff members obtaining employment with these payers after  
27 leaving the Department. Over the long term, CAL/ACEP has no reason to believe that this  
28 culture will change, despite the best intentions of the current Director to address these problems.

29 E. Fundamental Requirement for Patient Participation in Market Based Health Insurance  
30 Relationships

31 The DMHC has asked if it is absolutely necessary to 'keep patients in the middle of these  
32 disputes' for provider's to be paid reasonably. The answer is that we have a 'third party payer'  
33 system in Knox-Keene. This means that there are three parties involved in payment and  
34 coverage related transactions: the patient, the provider and the insurer. There are times when the  
35 patient, and only the patient, is able to provide information necessary to make an appropriate  
36 determination of the reasonable value of the service provided. The non-contracting physician's  
37 only 'contract' is with the patient, and the patient in turn has the contract with the insurer.  
38 Sometimes, only the patient knows what the insurer has agreed to insure and pay for.  
39 Sometimes, only the patient can confirm why they felt they needed emergency care. Sometimes,  
40 only the patient can confirm that the care billed for was actually provided, or required. An  
41 involved consumer is essential if the DMHC is to be able to manage its regulatory function  
42 effectively.

1 However, it should be possible to minimize the need to involve patients in the resolution of these  
2 disputes over fair payment and reasonable charge. In the ideal world, these instances would be  
3 fairly uncommon, and this could be accomplished by adopting a set of preconditions that should  
4 already have been established under existing law, including: 1) honoring and enforcing the  
5 existing Gould usual and customary charge paradigm with an initial claims payment standard  
6 that resulted in most claims being paid fairly and in full; (2) responsible AB 1455 enforcement to  
7 ensure that payers met the fair and timely payment regulations; (3) effective Knox-Keene  
8 enforcement so that Health Plans would be required to develop adequate provider networks that  
9 reduce their reliance on non-contracted ER On-call specialists; and (4) focused mechanisms to  
10 address those few providers who may, in fact, overcharge. Unfortunately, the DMHC appears to  
11 have abandoned the Gould standard, despite its adoption in 2003 after an exhaustive three-year  
12 rule-making process. And, as acknowledged by the Director in legislative testimony, the  
13 Department has a less than stellar track record for enforcement of its own regulations. Instead,  
14 the Department appears to have become so distracted with RBO complaints of, and an  
15 unfounded presumption of, wide spread overcharging that it has failed to use existing  
16 mechanisms to deal with this issue, such as referral to the courts or to the California Medical  
17 Board. Even if all of these mechanisms were working the way they should, however, there  
18 would still be instances where the patient would have to play a role in the payment process - they  
19 are, after all, one of the three parties in our 'third party payer' system, and they should never be  
20 blinded from these transactions.

21 The right of non-contracted providers to bill the unpaid balance of the claim to the patient (which  
22 is in dispute), the complaints of balance billed patients, and the spotty enforcement of AB 1455  
23 fair claims payment by the DMHC, are the only reasons that HMOs and RBOs pay us at all;  
24 since these payers recognize that EMTALA requires emergency physicians to provide their  
25 services to everyone regardless of payment. If balance billing is prohibited, and if the DMHC  
26 fails to pursue enforcement of AB 1455 for HMOs and RBOs; the percentage of claims  
27 underpaid, and more significantly the amount of underpayment, will accelerate, and contracting  
28 rates will plummet. Although balance billing makes up a small fraction of emergency physician  
29 revenue, our right to seek payment of our usual and customary fees as non-contracting  
30 physicians is a linchpin in our ability to negotiate reasonable contract rates, and thus protects not  
31 only providers, but also consumers, who must rely on a viable emergency care safety net.  
32 Patients recognize the intrinsic value of the emergency services that they receive, whereas  
33 insurers only view these services as overhead; and they have little market incentive to negotiate  
34 reasonable contract rates with us, with the exception of their desire to placate their enrollees.

#### 35 F. Existing Restraints on Emergency Physician Charges

36 CAPG and the DMHC often refer to 'exclusive contracts' emergency physicians have with their  
37 hospitals, and have alleged that these physicians exploit these exclusive arrangements to resist  
38 contracting with plans or RBOs and to demand excessive contracting terms. In fact, under  
39 California law, emergency physician staffing arrangements with hospitals are NOT considered  
40 exclusive staffing arrangements because any physician may treat a patient in the ER at the  
41 patient's request, including assigned capitated physicians. In addition, emergency and other  
42 hospital-based physicians have frequently experienced coercion and threats to their staffing  
43 contracts and contractually-linked medical staff privileges from hospital administrators when  
44 they attempt to negotiate fair and reasonable contract rates with hospital-sponsored capitated

1 medical groups and other networked payers. This practice, known as “coercive contracting”,  
2 functions as a reverse kickback so hospitals can obtain more plan referrals; and even though  
3 technically prohibited under federal and state law (Health & Safety Code section 1322), is  
4 nevertheless so prevalent that it is actually written into many ER staffing contracts. Health &  
5 Safety Code section 1322 prohibits hospitals from conditioning medical staff membership or  
6 clinical privileges upon the physician's participation in a contract with an insurer, hospital  
7 service plan or health care service plan. Furthermore, the vast majority of hospitals stipulate the  
8 requirement for emergency physician groups to submit any changes in their fee schedule for  
9 hospital review and approval, (90 % of 52 hospitals in a recent emergency physician survey).  
10 These market and non-market forces already restrain emergency physician charges and  
11 undermine fair payment for these essential services. The proposed regulations would exacerbate  
12 the existing inequities by forcing these providers to look only to the Health Plans and RBOs for  
13 payment; and would only add additional coercive pressure to contract at deeply discounted rates.

#### 14 G. Alternatives to Proposed Unfair Billing Practices Regulation

##### 15 1. Requiring Adequate Provider Networks

16 Finally, there is no need for regulation of this sort. As we have already stated, the DMHC has a  
17 number of powers within its scope of authority to address what it sees as the problem—patients  
18 being placed in the “middle” of billing disputes. Health plans are getting more and more  
19 aggressive in their contracting practices, making it more and more difficult for physicians to  
20 contract with them. Despite the fact that enrollees are increasingly having significant problems  
21 finding contracted specialist and primary care physicians who are willing and able to treat them,  
22 the DMHC has not taken a single enforcement action to ensure that health plans have adequate  
23 networks of physicians to assure access to care, as required under Health & Safety Code §1367.

##### 24 2. Adopt the ‘Pay the Bill, and Dispute the Charge’ Approach

25 The DMHC also has the authority to adopt a regulation codifying a recommendation it made to  
26 health plans and RBOs in December 2003 stating that they should keep patients out of the middle  
27 of payment disputes: by either (1) paying the full charge, (2) negotiating the rate, or (3) paying  
28 the bill charged and then instituting litigation against the provider to the extent they believe that  
29 charge is unreasonable (see **Dec 10, 2003 minutes of ICE AB 1455 Team, Attachment 2**). This  
30 approach would, if implemented by the plans and their delegated payers, immediately result in  
31 the elimination of all claims sent to patients for the balance of a bill which otherwise might be  
32 underpaid by their health plan. This approach would also level the playing field for both the  
33 payer and the provider, encourage the parties to bill and pay fairly at the outset, and avoid  
34 punishing the vast majority of emergency care providers in this state whose charging and billing  
35 practices are reasonable and appropriate. In fact, CAL/ACEP has recommended just such a  
36 regulatory approach to the DMHC on several occasions in the past, and also incorporated this  
37 concept in a recent proposal to the Department supporting the use of an ICDR process as a less  
38 expensive substitute for litigation to resolve the question of excessive charges. The  
39 Department’s only response has been to express concern that this approach would result in  
40 unrestrained fee increases by emergency care providers, ignoring the impact of the constraints  
41 listed in paragraph F above.

1                                   3. Create a Trial ICDR Program as a Voluntary Alternative to Balance Billing

2 For nearly two years, CAL/ACEP has been participating in meetings with the DMHC and other  
3 stakeholders to try to develop proposals that would resolve the issues of claims underpayment  
4 without putting patients in the middle of these disputes. CAL/ACEP was the first of the  
5 stakeholders to submit a compromise proposal to the Department, and has since submitted  
6 multiple iterations and variations of these proposals in an attempt to achieve consensus within  
7 this working group. All of these proposals were predicated on the implementation of an  
8 independent claims dispute resolution process that was initially a voluntary trial program. This  
9 would have eliminated the need for regulations to establish the ICDR, but payers insisted  
10 providers accept mandatory participation in an unproven process rather than a trial program. The  
11 latest version of these proposals would actually have addressed the occasional physician that  
12 over-charges and eliminated the need for balance billing of any patients without the need for a  
13 regulation imposing restrictions on physician billing practices (**see Attachment 3**). The DMHC  
14 has never indicated why the Department rejected these proposals, and instead insists on imposing  
15 an untried and untested ICDR on providers through these regulations.

16                                   4. Replace Exploitation of the EMTALA Mandate with Fair Market Contracting  
17 for Emergency Services

18 The DMHC could also enforce the ‘adequate networks’ provisions of the Knox Keene Act to  
19 include contracts with emergency and on-call physicians. Requiring plans and their  
20 subcontracting medical groups to contract with hospital based providers at hospitals where the  
21 plan or RBO has a network relationship would substantially reduce the situations where patients  
22 may be caught in the middle of disputes over fair payment; and would have the additional effect  
23 of improving the coordination of emergency care under the managed care model. (footnote to  
24 SOR Report). The Department has repeatedly indicated that it favors more managed care  
25 contracting for emergency services; however, the DMHC has never taken action against plans or  
26 RBOs with inadequate network coverage for emergency services, and it’s policies and inactions  
27 reinforce the view that the emergency care system can be taken for granted despite these  
28 ‘adequate network’ requirements in law. This lack of enforcement is interpreted as tacit  
29 approval for Health Plans and RBOs to rely on the EMTALA obligation of emergency and on-  
30 call physicians, rather than having to negotiate fair market contracts for these services.

31                                   5. Actively Enforce Fair Payment Regulations. Reducing Claims Underpayment

32 The DMHC could also reduce the initial underpayment of claims by taking a more active  
33 approach to enforcement of AB 1455 fair payment regulations, thus reducing the instances where  
34 the payers underpay claims, leading to hundreds of thousands of disputed underpayments each  
35 year for emergency physicians alone. Last year, under the direction of current Director, the  
36 DMHC took its first and only enforcement action for claims underpayments to emergency care  
37 providers. In this action, HealthNet, a large HMO, was fined \$250,000 after underpaying  
38 emergency care providers by more than \$7 million. Health Net had to repay at least the  
39 provider’s fee or an amount equal to the 50th percentile of a usual and customary survey of fees  
40 (Ingenix Medicode database), however the repayment period was limited to only 9 months out of  
41 a multi-year damage period, and providers had to resubmit claims to receive this additional  
42 payment. As a result of the consent agreement negotiated between the DMHC and HealthNet,

1 only \$670,000 of this \$7 million was paid back to providers. Hence, HealthNet was allowed to  
2 keep more than \$6 Million of its ill-gotten gains: hardly an effective deterrent. The injured  
3 providers had no opportunity to participate in developing this consent agreement.

4 The Director of the DMHC acknowledged, in testimony to the Senate Budget Committee, that in  
5 prior years the Department had simply discarded stacks of provider complaints about plan  
6 underpayments without even reviewing them, let alone taking enforcement actions.  
7 Subsequently, a highly placed DMHC official told us that the Department's reluctance to levy  
8 substantive fines for Health Plan violations was based on the concern that these costs would be  
9 passed through in the form of higher premiums and decreased affordability for consumers. In  
10 our view, this lack of enforcement rewards continued violations of the law; whereas effective  
11 enforcement promotes a level playing field in the market place. CAL/ACEP pointed out that  
12 health plans that are compliant with the law will be rewarded with more enrollees and companies  
13 that violate the law can either get by on a smaller profit margin or lose market share as a  
14 consequence of their irresponsible behavior; but the Department continues to be a reluctant  
15 enforcer of fair payment regulations.

16 In addition, CAL/ACEP has referred a variety of additional payment complaints to the DMHC,  
17 including; (1) Blue Shield's PPO's longstanding Policy of paying patients instead of providers  
18 for non-contract emergency services, (violation of H & S Code 1371.4), (2) Inappropriate down-  
19 coding and bundling of separate services and procedures (the basis for a recently successful  
20 federal class action suit against numerous HMO's), (3) Claims denials for 'not an emergency'  
21 (also a violation of H & S Code 1371.4), and (4) Systematic delays, denials and underpayments  
22 by RBOs. In the Blue Shield case, the DMHC fined the PPO \$200,000 (being used to promulgate  
23 the proposed ICDR) and again imposed a limited scope repayment period.

24 The Department has also expressed concern that enforcement of the Gould criteria in AB 1455,  
25 as with the HealthNet consent agreement, would discourage providers from contracting with  
26 plans by raising payments to non-contracted providers, when in fact the Department has no  
27 evidence or even an indication that this would be the case. As we have stated, payment of non-  
28 contracted emergency care providers at the lesser of the provider's charge or the 50<sup>th</sup> or 75<sup>th</sup>  
29 percentile of usual and customary charges would result in full payment of between 40% and 60%  
30 of these claims (unless the payers began to resort to even more aggressive down-coding and  
31 denial of payment). If Kaiser can pay this way, why can't the remaining plans and RBOs? On  
32 average, it has taken eight to ten months for the DMHC to take any action at all on complaints  
33 submitted to the Department by CAL/ACEP members, even when the Department acknowledges  
34 that the payers have violated the laws and regulations the Department is supposed to enforce.  
35 CAL/ACEP provided information to the Department demonstrating that many RBOs and Plans  
36 respond to disputed underpayments very rarely compared to their peers (**see attachment 4,**  
37 **presentation to FSSB, 2005**), yet the Department has failed to audit these payers even as the  
38 Department insists that providers continue to submit these disputes for adjudication. The  
39 Department's dismal record of enforcement (**see attachment 5 – an email from M. Riner, MD**)  
40 is a major contributor to the continued underpayment of emergency care provider claims, and the  
41 disputes that ensue.

42



1 CAPG has resisted de-delegation, indicating that when plans take back the responsibility for  
2 paying for emergency care provider claims, the plans take too large a bite out of the cap  
3 payments made to the RBOs. This strongly suggests that this book of business, rather than being  
4 a financial drain on RBOs because of excessive provider charges; is actually a profit center for  
5 RBOs because of their ability to underpay these providers without risk of DMHC enforcement of  
6 fair payment regulations. The DMHC recently asked if RBOs should be required to meet the  
7 same safe harbor payment standard for the payment of non-contracted emergency care provider  
8 claims as the health plans. The answer is that RBOs should not be delegated the responsibility to  
9 pay the claims of these non-contracted providers in the first place.

10 Other major advantages of de-delegating payment for emergency care services is that it would  
11 limit the number of payers that non-contracting providers would have to submit claims to, and  
12 dispute underpayments with. For example, one ER physician group that treats about 15% of the  
13 ER patients in California has had to dispute some 60,000 underpaid claims a year with over 300  
14 different payers, each with their own unique rules, procedures, and contacts for the dispute  
15 process. Over 200 of these payers averaged less than 50 claims, and 10 disputed claims, per  
16 year; which makes it all but impossible to consolidate most of these disputes. This is one reason  
17 why this group employs more than 270 FTEs to bill and collect for less than 800 FTE providers.  
18 CAPG and the Department have thus far rejected these suggestions for improved contracting and  
19 partial or full de-delegation of emergency care provider claims payment.

#### 20 H. Summary

21 Sensing the opportunity to preserve the status quo of emergency services underpayment; i.e.  
22 enable continued payment of non-contracted provider claims at discounted contracting rates (per  
23 statement in ‘CAPG Update’, Volume 8, Number 6,. September 2006), CAPG requested that the  
24 DMHC amend the AB 1455 regulations, and dilute the Gould Standard to include consideration  
25 of historic rates (i.e. –historic contract rates). Each side presented data on its charge and  
26 payment experience, and CAL/ACEP, while acknowledging that there might be some outlier  
27 overcharging, provided voluminous data to show that its members charges were consistent with  
28 the usual and customary rates of all providers for non-contracted services. Despite this, and  
29 absent any evidence for its opinion, DMHC took the position that enforcement of the existing  
30 Gould Standard would raise payment levels and discourage direct contracting; and again siding  
31 with the payers, added an amendment to include ‘any relevant information’ to its draft payment  
32 standards regulation.

33 In summary, CAL/ACEP has proposed a variety of reasonable alternatives to help the  
34 Department buffer patients from claims disputes, - alternatives that would be well within the  
35 scope of the Department’s jurisdiction, and much more effective and less harmful than the  
36 proposed regulations. Throughout this controversy, the DMHC has taken an increasingly hard  
37 line against emergency care providers in the name of consumer protection, and even tried to  
38 impose the current draft regulations as emergency regulations that were subsequently withdrawn.  
39 This supports our contention that the attempt to impose these regulations is inherently unfair and  
40 unnecessary; and that instead, the Department should simply do its duty and uphold the law.

41

1 II. INDEPENDENT CLAIMS DISPUTE RESOLUTION PROCESS REGULATION

2 A. The Proposed Dispute Resolution Process is Unlawful, Untested and Unworkable

3 As stated, we believe that the proposed regulations are unnecessary and unlawful. In addition, we  
4 intend to show that the proposed ICDR process would be unworkable and would likely result in  
5 serious harm to California’s emergency services system, and hence to our patients. We feel  
6 strongly that the decision to promulgate an ICDR is more properly left to the legislature and that  
7 major policy decisions of this nature should not be decided by the DMHC or delegated to a  
8 private organization. Critical provisions such as funding, fees, standards for the appointment of  
9 the arbitrator, etc., will greatly determine whether this process is fast, fair and cost effective, as  
10 mandated by the Governor’s executive order and required by law (see Wilkinson v. Madera  
11 Community Hospital (1983) 144 Cal.App.3d 436, and clarity); and the proposal lacks the detail  
12 and clarity necessary to assure the medical community that it will work appropriately.

13 B. The Proposed Process Has Never Been Tested

14 Another major problem with the ICDR proposal is that it has never been tested and cannot  
15 substitute for the right to directly bill patients for non-contract emergency services. Under our  
16 Constitution, providers have a right to charge and collect for their services, and patients and  
17 plans have a right to contest in the courts whether the charges were reasonable. EMTALA  
18 requires that these services be provided regardless of the patient’s ability to pay; however, this  
19 does not give the state the right to exploit this mandate and impose a billing prohibition without  
20 the assurance that it has developed a “fast, fair and cost-effective alternative” (per Governor  
21 Schwarzenegger’s Executive Order). CAL/ACEP has repeatedly indicated that it is willing to  
22 participate in an ICDR pilot project; however, the Health Plans and RBOs have refused and insist  
23 that the DMHC go forward with this untested and mandatory program. We believe an  
24 independent claims dispute resolution process should be instituted on a pilot project basis first to  
25 see that it works in a manner that best protects physicians and patient access to care.

26 C. The Proposed Process Would Be Costly and Redundant

27 Further, non-contracted physicians should not be required to exhaust a plan’s internal dispute  
28 resolution process first, especially if payers are allowed to directly challenge a provider’s charge  
29 by underpaying the claim. CAL/ACEP has provided data culled from the dispute of 65,000  
30 underpaid claims by a single ER group providing about 17% of all ER physician services in  
31 California. This data (**again, see attachment 4**) demonstrates that in many instances the payer’s  
32 internal dispute process has been shown to be futile and a waste of time and money\_for  
33 physicians. Hence, the only affect of this redundancy would be to add more delay and  
34 uncompensated billing overhead, thereby deterring any legitimate resolution of disputes.

35 D. The Proposed Process Would Be Cumbersome, Overwhelmed, and Unworkable

36 In order to demonstrate why the proposed process won’t work and would devastate our  
37 emergency care system we offer the following analysis. Based on our experience, there are at  
38 least five different types of payment disputes, which occur singly and in combination; including:

- 39 • a) Payment for a service at rates below the provider’s usual and customary charge

- 1 • b) Down-coding of the provider's charged service, usually applied to the evaluation
- 2 and management service level
- 3 • c) Bundling of two or more separately billed services under a single coded service
- 4 • d) Denial of payment for a coded service, or denial of coverage as an emergency
- 5 • e) Delay of payment
- 6 •

7 Unfortunately, the payer's explanation of benefits which usually accompanies the payment to the  
8 provider often does not specify exactly why the claim was paid at less than the provider's charge.  
9 The payer often neither specifies how the paid rate was determined, which service was down-  
10 coded to what level and why the service was down-coded, why services were bundled, nor which  
11 coding rule was used to justify bundling or denial of payment for a service. Often, more than  
12 one of these four means to justify underpayment is applied to a single claim, or several claims  
13 are paid under one EOB, and the reasons for underpayment of the entire set of claims is  
14 unspecified on a claim by claim basis. This is particularly true for RBO paid claims, as RBOs  
15 are not directly regulated by the DMHC and HMOs often fail to provide oversight of their  
16 subcontractors' claims adjudication practices. Thus, for arbitration to be effective in the  
17 resolution of these disputes; the payer's EOB MUST specify exactly and specifically why each  
18 and every coded service in the claim was reduced, bundled, underpaid, or denied. In particular,  
19 down-coding of claims is difficult to address: coding of an E+M service involves documentation  
20 in the medical record, and providers are obligated to ensure that their documentation supports the  
21 level of service coded, according to published AMA CPT coding rules. Unfortunately, payers do  
22 not necessarily adhere to these rules, and rely only on the final diagnosis reported on the CMS  
23 1500 form, rather than the documentation in the medical record, to make a payment or down-  
24 coding determination. This is inappropriate because some less serious diagnoses can only be  
25 determined by excluding the more serious possibilities with often rigorous and thorough  
26 evaluations.

27 In CAL/ACEP's experience, when a particular fee schedule is agreed upon in contract, or is  
28 required as an initial payment standard to be considered compliant with AB 1455 minimum  
29 claim payment regulations (as in the recent HealthNet consent agreement); payers resort to more  
30 aggressive use of down coding, bundling, and denial of payment as a means of reducing  
31 payments to emergency care providers and enhancing their profits. This is why many emergency  
32 physicians, especially when coerced into contracting with a networked payer by their hospital  
33 administrator, try to insist on case rate contracting, by which every claim is paid at an agreed  
34 upon averaged rate regardless of the service provided, so as to eliminate disputes over down  
35 coding, bundling or denial of payment. Thus, even if the DMHC were to impose significant  
36 penalties on payers for patterns of inappropriate claims payment, which seems unlikely; any  
37 dispute resolution or arbitration program is likely to be overwhelmed with hundreds of thousands  
38 of disputed claims, requiring the careful evaluation of medical records and coding of these  
39 claims by trained coding experts.

#### 40 E. The Proposed Process Would Be Unaffordable For Emergency Physicians

41 CAL/ACEP members estimate that processing each disputed claim through the proposed ICDR  
42 process would cost the provider approximately \$20-25 per claim, or perhaps 30% less, if similar  
43 types of disputes could successfully be batched or consolidated. Based on our member's  
44 experience, the average claim underpayment for emergency physicians is about \$80. Our current

1 coding, billing and overhead costs are approximately \$15 for each Health Plan or RBO appeal,  
 2 regardless of the size of the claim. If balance billing is prohibited, it is likely that at least three  
 3 quarters of a million Knox-Keene regulated emergency physician claims a year will be underpaid  
 4 and subject to dispute. With 50 different plans, (including MediCal Managed Care Plans), 250  
 5 separate RBOs, and 160 emergency physician groups, and based on the aforementioned analysis  
 6 of one large emergency physician group's experience with the dispute process of plans and  
 7 RBOs, it will likely be necessary for emergency physician groups in California to engage in tens  
 8 of thousands of separate disputes, even if it is possible to consolidate two or even three months  
 9 worth of claims into a single dispute. The picture gets even worse if DMHC follows through on  
 10 its proposal to lower the minimum payment standards. This then is the perfect foil for large and  
 11 wealthy Health Plans and RBOs to use their vastly superior resources to drown emergency care  
 12 providers with paperwork and drive us out of business defending our claims, or force us into  
 13 accepting unreasonable contracts.

14 An analysis of one large ER physician group's experience with the dispute of underpaid claims  
 15 with Knox-Keene regulated plans and their delegated payers reveals many potential problems  
 16 with the DMHC's proposed ICDR. In 2005, California Emergency Physicians Medical Group  
 17 (CEP) disputed over 87,000 underpaid claims, and negotiated settlement agreements on another  
 18 50,000 mispaid (mostly underpaid) claims. More than 35,000 of the disputes were subject to the  
 19 Knox-Keene fair payment regulations, involving more than 200 plans, medical groups, and IPAs.  
 20 What the table below (culled from attachment 4) demonstrates is that some payers often respond  
 21 to disputes with additional payment, and others rarely do. (see table below) For the latter, it is  
 22 often a waste of time and effort to have to dispute the underpayment first with the payer.  
 23 Providers should have the discretion to go directly to the independent dispute process, and not  
 24 have to suffer the substantial cost and redundancy in the DMHC's 'chase payment twice, dispute,  
 25 and hope for payment later' proposal.

26  
 27  
 28 Using the payer's internal dispute process is as often as not a  
 29 waste of time and effort

30  
 31  
 32 Percent of time dispute resulted in any pmt

KAISER PERMANENTE	2004	1,668	\$152,939	1,172	\$0	2,840	\$152,939	58.7 %
	2005	3,524	\$276,362	1,955	\$0	5,479	\$276,362	64.3 %
	2006	1,286	\$94,887	1,187	\$0	2,473	\$94,887	52.0 %
	<b>Total</b>	<b>6,478</b>	<b>\$524,188</b>	<b>4,314</b>	<b>\$0</b>	<b>10,782</b>	<b>\$524,188</b>	<b>60.0 %</b>
DESERT MED GRP /OASIS IPA	2004	280	\$40,540	924	\$0	1,204	\$40,540	23.3 %
	2005	935	\$151,530	2,811	\$0	3,746	\$151,530	25.0 %
	2006	291	\$50,770	1,217	\$0	1,508	\$50,770	19.3 %
	<b>Total</b>	<b>1,506</b>	<b>\$242,840</b>	<b>4,952</b>	<b>\$0</b>	<b>6,458</b>	<b>\$242,840</b>	<b>23.3 %</b>
HILL PHYSICIANS	2004	1,243	\$103,450	443	\$0	1,886	\$103,450	73.7 %
	2005	2,852	\$240,474	628	\$0	3,480	\$240,474	82.0 %
	2006	282	\$24,826	162	\$0	444	\$24,826	63.5 %
	<b>Total</b>	<b>4,377</b>	<b>\$368,750</b>	<b>1,233</b>	<b>\$0</b>	<b>5,810</b>	<b>\$368,750</b>	<b>78.0 %</b>
ANCHOR MEDICAL GRP	2004	67	\$2,142	61	\$0	128	\$2,142	52.3 %
	2005	52	\$2,779	144	\$0	196	\$2,779	26.5 %
	2006	9	\$262	54	\$0	63	\$262	14.3 %
	<b>Total</b>	<b>128</b>	<b>\$5,184</b>	<b>259</b>	<b>\$0</b>	<b>387</b>	<b>\$5,184</b>	<b>33.1 %</b>
REDLANDS CMNTY HOSP	2004	21	\$2,101	171	\$0	192	\$2,101	10.9 %
	2005	23	\$2,238	103	\$0	126	\$2,238	18.3 %
	2006	9	\$1,129	53	\$0	62	\$1,129	14.5 %
	<b>Total</b>	<b>53</b>	<b>\$5,467</b>	<b>327</b>	<b>\$0</b>	<b>380</b>	<b>\$5,467</b>	<b>13.9 %</b>

1 A more recent analysis of claims disputed in January 2006 reveals that a total of 25,814 Knox-  
2 Keene related commercial claims (this number excluded Medicare Managed Care and MediCal  
3 Managed Care claims, and an additional 500 or so that were not separately codified as subject to  
4 Knox-Keene) were billed in that month. Of these 25,000+ claims, 2981 were disputed (746 are  
5 still open claims as of September, 2006). Although most of these claims were non-contracted,  
6 quite a few were disputes of contracted claims. For these disputed claims, the average percent of  
7 full charges (non-contracted) or allowable charges (per terms of the contract) that were in dispute  
8 was 38%. Only 52.4% of this disputed claims received any additional payment, and the average  
9 disputed amount paid was 46.2%. Thus, although some plans and RBOs did respond  
10 appropriately with additional payment as a result of CEP accessing the payers' internal dispute  
11 process, something like two thirds made only a partial or no payment. This additional payment  
12 averaged \$58 of the \$140 in average disputed amounts.

13  
14 In a full year, CEP would file more than 35,000 Knox-Keene related disputes, and since the  
15 claims data from this ER billing company set represents about 17% of all of California's ED  
16 patients, this would mean that more than 210,000 non-contracted commercial Knox-Keene  
17 related emergency physician claims could potentially be disputed in California. Actually,  
18 because of its wide geographic coverage in California, CEP has a very active contracting  
19 program with health plans and RBOs in the state, resulting in a far higher percentage of  
20 contracted claims than most ER groups. A more accurate prediction would be closer to 270 –  
21 300,000 non-contracted ER physician claims disputes per year.

22  
23 CEP also settled a substantial number of contracted Knox-Keene related incorrectly paid (usually  
24 underpaid) claims with contracted plans and RBOs (contracting is no guarantee of payment at the  
25 contracted rate), thus making it likely that some 400,000 Knox-Keene emergency physician  
26 claims per year are being underpaid, and could potentially be disputed with the payers internal  
27 dispute process. At least half that number, if not two thirds, (150 – 170,000) could subsequently  
28 end up in the independent claims dispute process because the payers declined to make some, or  
29 sufficient, additional payment.

30  
31 This does not count the underpaid Medicare and MediCal Managed Care claims that were  
32 disputed, or the commercial claims that are not subject to Knox-Keene fair payment rules. This  
33 also doesn't even begin to address the impact that a prohibition on balance billing might have on  
34 the frequency and rate of payments in internally disputed claims, especially if the payers can pay  
35 whatever they please, don't have to worry about balance bills, and don't have to meet the Gould  
36 criteria's usual and customary charge standard.

37  
38 Using this data, an estimate of the total amount of underpayment for commercial non-contracted  
39 Knox-Keene claims for all emergency physicians would be close to \$37 M annually. Even if  
40 two to three months of claims disputes can be consolidated with each payer by each emergency  
41 physician group, and only 70% of those disputes which resulted in payment of less than half of  
42 the disputed amount were subsequently taken to the independent claims dispute process: this  
43 means that the ICDR would have to resolve more than 80,000 consolidated claims disputes per  
44 year for emergency physician services alone. This projection doesn't even address the impact of  
45 disputes with a myriad of other emergency care provider on-call specialists, or the impact of  
46 hospital facility fee disputes. There are probably ten times as many other specialty physicians

1 and physician groups providing emergency care in California, with probably an equal number of  
2 underpaid claims, thus increasing the number of potential consolidated dispute referrals to the  
3 ICDR program to 160,000 per year. How the DMHC can possibly expect an ICDR to be able to  
4 resolve this many disputes is unimaginable. An effective ICDR in California is nothing more  
5 than wishful thinking at this point, unless the Department changes course and implements an  
6 initial claims payment standard that results in the payment of most emergency care providers'  
7 claims at their usual, customary and reasonable charge. This does not appear to be the DMHC's  
8 intent.

#### 9 10 F. The Proposed ICDR Fails to Address Contracted Claims Disputes

11 There are currently more than 10,000,000 emergency department visits in California every year,  
12 and the numbers continue to grow. Of these, approximately 1,600,000 are HMO insured patients  
13 (this and all other numbers in this review are based on extrapolation from a much smaller  
14 database, and may be off by as much as 30%). Approximately half of the emergency physician  
15 claims for HMO insured patients are covered by contracts between the provider and the HMO or  
16 the HMO's subcontracted, delegated payer (RBO). A significant percentage of these contracted  
17 claims are paid at the contract rate. When the contracted provider considers these claims to be  
18 paid inappropriately, either because the claim was not paid according to the terms of the contract,  
19 or because the payer down-coded the services billed, or bundled services together under one  
20 code, or denied payment of certain services; the payer must generally dispute the payment using  
21 the payer's internal dispute mechanism. Alternatively, the provider can sue the Plan or RBO for  
22 breach of contract, or complain to the DMHC if there is a pattern of inappropriate claims  
23 payment. However, it is not clear that the DMHC will address disputes between contracted  
24 providers, or has jurisdiction to take direct enforcement action for patterns of inappropriate  
25 claims payment against RBOs. An independent dispute resolution mechanism, short of lawsuits  
26 in the court, is needed for individual or bundled claims that the contracted provider feels are  
27 inappropriately paid; since payers often fail to overturn initial determinations on claims payment.

#### 28 G. The Cost of Disputing Small Claims is Prohibitive

29 Offering emergency care providers a dispute resolution process which imposes even more costs  
30 will not help them to obtain fair and prompt payment, particularly when it is tied to a system that  
31 will encourage health plans to challenge even more of their bills. This is particularly true given  
32 the relatively small dollar value of each claim and dispute for emergency physicians. The  
33 average emergency physician claim is about \$325. The average disputed underpayment of non-  
34 contracted provider claims is about \$70. Disputing these underpayments, first in the payer's  
35 internal dispute process, and then in the independent dispute process, is likely to add more than  
36 120 days to the provider's days in accounts receivables for these claims, and easily double the  
37 cost of billing and collections for these claims (the typical cost prior to dispute is about 12% of  
38 collections for emergency physician claims). The Arbitration Mediation & Conciliation Center  
39 believes that the cost of paying for arbiters to adjudicate these disputes would be about 20% of  
40 the disputed amount. In addition, if providers are required to participate in the payers internal  
41 dispute process first, and then participate in the ICDR process, the added cost to the provider for  
42 the clerical work to participate in these disputes, preparing the files, medical record copies, and  
43 other documentation required for the disputes, developing the arguments in support of the  
44 provider's position, and carrying the open accounts receivable through the two tiered dispute

1 process is estimated, based on feedback from several emergency physician billing companies, to  
2 be another \$30-35 per claim. **Thus, the cost of seeking fair payment for a \$70 dispute, even if**  
3 **the cost of the arbitrator were split between the provider and the payer, would amount to**  
4 **an investment of \$45 in the hope of collecting up to \$70 in additional reimbursement on an**  
5 **emergency physician's underpaid claim.** Clearly, this alone would make participation in this  
6 process financially untenable for emergency physicians, and some sort of state subsidy for this  
7 process would be needed to ensure a fair and cost-effective mechanism. The DMHC, however,  
8 failed not only to specify in the regulations how the costs of the ICDR process would be  
9 distributed and borne, but also indicated that the process would require no additional funding  
10 from the State.

11 The DMHC staff has also proposed that, to reduce the cost of dispute resolution, claims disputes  
12 should be bundled and arbitrated together as much as possible. This might be possible if a  
13 particular payer consistently denies payment for a particular code or consistently bundles two  
14 particular codes together. Unfortunately, it will be difficult if not impossible to bundle claims  
15 involving more than a single disputed issue, and claims involving more than one reason for  
16 underpayment. Furthermore, some emergency physicians receive payment from more than fifty  
17 different HMOs and RBOs, often as few as five or ten a month from any particular payer,  
18 involving payers throughout the State. Thus, bundling disputes will require either substantial  
19 delay to accumulate claims from a particular payer over a particular disputed issue, or will  
20 require delay to accumulate bundled disputes for each disputed issue for each payer; and result in  
21 ever growing accounts receivables that must be carried by these providers. Most likely,  
22 emergency physicians will simply throw up their hands trying to manage the dispute resolution  
23 process and chalk up the underpayment of most of these claims as bad debt. Of course, this will  
24 only encourage payers to even more aggressively underpay these claims, in a calculated effort to  
25 reduce their overall payments. In summary, despite the contention of the DMHC staff, arbitrated  
26 dispute resolution for emergency physician HMO covered claims is likely to be expensive,  
27 inefficient, overburdened and ineffective in resolving the issue of claims underpayment.

28 H. The Rational Alternative

29  
30 Enforcement of an initial payment standard based on the Gould criteria in AB 1455 does have a  
31 significant advantage. If emergency physician claims were paid at the lesser of the provider's  
32 charge or the 75th percentile of emergency physician charges, and arbitration reserved for  
33 disputing charges in the upper 25th percentile, many fewer claims would end up in dispute  
34 resolution and the process could focus on what is more likely to be truly excessive charges.  
35 However, in disputes over claims coding, or involving a combination of a coding or bundling  
36 dispute and a reasonable value dispute, baseball style arbitration may not be adequate to achieve  
37 a fair adjudication of the claim.

38  
39 I. Summary

40  
41 The Department of Managed Health Care's proposals to prohibit non-contract balance billing,  
42 promulgate an mandatory, untested Independent Dispute Resolution Process, and dilute the  
43 Gould Standard for usual and customary payment for emergency services are unlawful,  
44 unnecessary and unworkable. In many ways the issue of balance billing is a problem of the

1 department's own making because of its historic failure to enforce existing fair-payment laws  
2 and regulations.

3  
4 If the standards used by an arbitrator are compromised by a revision of the Gould criteria, or the  
5 arbitrators give credence to the quantum meruit arguments proposed by CAPG, or the process is  
6 so expensive or complicated that few providers are willing to access it, or the DMHC's initial  
7 payment safe harbor standards are so low that payers feel compelled to take advantage of this  
8 window to underpay every non-contracted provider's claim; then ultimately the ICDR will  
9 become a smoke screen for the manipulation of the market for emergency care services by health  
10 plans and delegated payers. These regulations do not just impact emergency physicians: they  
11 also impact other hospital based physician specialists who provide EMTALA obligated services,  
12 and these regulations will simply further drive away our on-call specialists, who are the most  
13 tenuous link in this chain of survival, and who can easily "vote with their feet".

14  
15 California's emergency departments are already operating at critical capacity. Sixty-seven have  
16 closed in the last ten years, and three more, Daniel Freeman Medical Center (Inglewood),  
17 Doctors Medical Center (San Pablo), and King Drew (Los Angeles), have just announced closure  
18 or loss of accreditation. The proposed regulations would exacerbate this situation and result in  
19 immeasurable harm to patients and to our emergency care infrastructure. Considering these  
20 risks, we recommend in the strongest possible terms that your department withdraw these  
21 proposals in deference to duly constituted legislative resolution.

22  
23 We appreciate your consideration of our comments.

24  
25  
26 Sincerely,



27  
28 R. Myles Riner, MD, FACEP  
29 President, CAL/ACEP

30 cc: California Medical Association

**Attachment 1**

**Stretched Thin**

**Growing Gaps in California's Emergency Room Backup System**

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***\*Principle 5: Contracts between public and private health plans and providers, and payments by health plans to physicians, should be sufficient to reasonably ensure the availability of on-call physicians, ensure that payments by all payers for on-call services are commensurate with the reasonable cost of providing the services, and avoid practices that shift costs of on-call coverage to other entities, including hospitals, physicians, and consumers.***

#### **Recommendations for Implementing Principle 5**

- ◆ Establish in statute a presumptive payment standard for payments by commercial health plans to non-contracting physicians who provide emergency and on-call services. The standard would be the physician's billed charges, the physician's usual charges, or a payment consistent with customary and reasonable charges for the service for the geographic area based on published surveys or databases as defined by DMHC. Provide that failure to follow the standard on a repeated basis is grounds for a finding of an unfair payment pattern.

***\*Principle 6: Health plan enrollees and health care consumers should be better protected from the impacts of contracting and payment disputes between health plans and physicians related to on-call services and from being required to pay out-of-pocket for services that are covered by their health plans.***

#### **Recommendations for Implementing Principle 6**

- ◆ Provide that a payment practice that indirectly harms a health plan enrollee by causing the enrollee to pay amounts in excess of applicable copayments, deductibles, or coinsurance for ER and on-call services that are covered by their health plan constitutes an unfair payment pattern and is subject to the remedies under the prompt payment statute. An example would be a plan that follows a practice of paying discounted fees to non-contracting providers for on-call services, with the result that the providers bill their patients and the patients pay the remainder of the fees.

**Attachment 2**

**AB 1455 Team Meeting Minutes**

Industry Collaboration Effort (ICE)

December 10, 2003

10:00 AM- 11:30 AM (Pacific Standard Time)

Presented By Co-Leaders: Mary Holloway, PacifiCare Health Systems, 714-226-8776

Keith Pugliese, Brown & Toland Medical Group, 415-972-4318

AB 1455 re: Non-Contracted Provider Balance-Billing Enrollees: The DMHC's formal position is that, should a payer pay a non-contracted provider claim an amount that is below billed charges and the non-contracted provider subsequently balance-bills then enrollee, then the payer is expected ensure that the enrollee is not in any way financially harmed or held responsible by considering one of the following three actions: 1) Try to negotiate with the non-contracted provider to agree to a rate that the provider would deem satisfactory; 2) Bring the non-contracted provider to court for a declaratory judgment action as to whether the payer's payment is unfair; or 3) Pay the claim in its entirety (i.e., "goodwill" payment). But the DMHC does not want the enrollee to pay the balance or face a collection agency.

**Attachment 3**

<u><b>Issue</b></u>	<u><b>Cal/ACEP Option 1</b></u>	<u><b>Cal/ACEP Option 2</b></u>
<p><b>1. The process to be used.</b></p>	<p>A pilot program that creates a low-cost baseball style arbitration process available to health care providers for reimbursement of non-contracted services <u>to HMO patients</u> only. A separate program for disputes in excess of \$10,000 would be developed, using other methods of arbitration to settle the disputes.</p> <p>The pilot program shall continue for 18 months; and after twelve months of data collection, the program would be evaluated by an independent consultant chosen by an appointed oversight board.</p> <p>The independent consultant would</p> <ul style="list-style-type: none"> <li>• Issue a report within three months to the oversight board</li> <li>• Evaluate the use of the program by providers</li> <li>• Evaluate the impact on provider reimbursement levels and payer payment levels</li> <li>• Make recommendations on its improvement.</li> </ul> <p>The arbitrators would consider, and select between, the initial billing and the <u>initial</u> payment for disputes over the reasonable value of services provided. The need for an ICDR was promoted on the basis that some providers overcharge, not on the basis that all provider’s charges are excessive.</p> <p>To meet the departments safe harbor standard for initial claims payment, payers should pay claims of the lesser of the provider’s charge or the 50<sup>th</sup> percentile of usual and customary charges, using a publicly available database of usual and customary charges for the most recently published year of service.</p> <p>The ‘arbiter’ will need to adjudicate disputes over coding, bundling, necessity and level of service, with the assistance of claims documentation and coding experts.</p> <p>For those disputes involving coding or bundling disputes, the arbitrator may dismiss a dispute without prejudice if the arbitrator finds that the health care provider has not attempted to resolve the matter through the payers internal dispute resolution process, or may find in favor of</p>	<p>For Option 5, CAL/ACEP has <u>underlined</u> substantive differences with CAL/ACEP’s proposed Option 4.</p> <p>A pilot program that creates a low-cost baseball style arbitration process available to health care providers for reimbursement of non-contracted services <u>to HMO patients</u> only. A separate program for disputes in excess of \$10,000 would be developed, using other methods of arbitration to settle the disputes.</p> <p>The pilot program shall continue for 18 months: and after twelve months of data collection, the program would be evaluated by an independent consultant chosen by an appointed oversight board.</p> <p>The independent consultant would</p> <ul style="list-style-type: none"> <li>• Issue a report within three months to the oversight board</li> <li>• Evaluate the use of the program by providers</li> <li>• Evaluate the impact on provider reimbursement levels and payer payment levels</li> <li>• Make recommendations on its improvement.</li> </ul> <p>The arbitrators would consider, and select between, the <u>initial</u> billing and the <u>FINAL PROPOSED</u> payment for disputes over the reasonable value of services provided. <u>Payers would be required to pay the provider’s initial charge in full, and require providers to enter into an ICDR if they felt the provider’s charges exceeded the reasonable value of the service.</u></p> <p>The ‘arbiter’ will need to adjudicate disputes over coding, bundling, necessity and level of service, with the assistance of claims documentation and coding experts.</p> <p>For all disputes, the plan may request the provider to participate in the payer’s internal dispute process, <u>and if the provider declines, the provider would be required to participate in a binding ICDR process.</u></p>

	<p>the provider if the arbitrator finds that the payer has failed to make a good faith effort to resolve the dispute through the payer's internal dispute resolution process, or utilizes pre-payment claims editing programs that been found in court to be unfair and inappropriate.</p> <p>For those disputes involving reasonable value of the provider's services only, the provider may bypass the payer's internal dispute process and go directly to ICDR.</p>	
--	--	--

<p><b>2. The standards to be followed in making a determination.</b></p>	<p>Existing Gould criteria will be used to determine the reasonable value of non-contracted services.</p> <p>The AMA CPT coding manual and standard billing protocols would b used for those disputes involving coding or level-of service disputes.</p> <p>All relevant evidence consistent with the California Evidence Code would be considered for disputes involving coding, necessity of care, and level of services, and for all claim disputes in excess of \$10,000.</p>	<p>Existing Gould criteria will be used to determine the reasonable value of non-contracted services.</p> <p>The AMA CPT coding manual and standard billing protocols would b used for those disputes involving coding or level-of service disputes.</p> <p>All relevant evidence consistent with the California Evidence Code would be considered for disputes involving coding, necessity of care, and level of services, and for all claim disputes in excess of \$10,000.</p>
<p><b>3. Whether to be administered by DMHC or a 3<sup>rd</sup> party</b></p>	<p>The pilot program shall be administered by an independent third party with an appointed Oversight Board consisting of one representative from each of the stakeholder groups.. The Board shall agree on a third party administrator who shall establish a panel of arbitrators that posses minimum qualifications as established by the Oversight Board to review both legal and medical disputes, and credential these arbitrators.</p> <p>The independent third party administrator shall collect information about the results from the dispute resolution process and present aggregate information to the DMHC and to the Oversight Board on a monthly basis.</p>	<p>The pilot program shall be administered by an independent third party with an appointed Oversight Board consisting of one representative from each of the stakeholder groups.. The Board shall agree on a third party administrator who shall establish a panel of arbitrators that posses minimum qualifications as established by the Oversight Board to review both legal and medical disputes, and credential these arbitrators.</p> <p>The independent third party administrator shall collect information about the results from the dispute resolution process and present aggregate information to the DMHC and to the Oversight Board on a monthly basis.</p>
<p><b>4. Mandatory vs. Voluntary.</b></p>	<p>Voluntary for providers / mandatory for payers.</p> <p>Since outliers may be discouraged from accessing the system after one or two failed arbitrations; information collected over the pilot project would show whether plans were continuing to</p>	<p><u>Voluntary for payers / mandatory for providers during the pilot program.</u></p>

	<p>underpay claims after losing arbitration repeatedly, and whether providers were declining to participate in the ICDR after losing arbitration repeatedly.</p> <p>Since outlier providers might be discouraged from accessing the system after one or two failed arbitrations; information collected over the pilot project would show whether and how often providers were requested by the plan to participate and chose not to; and the project should also collect data on how often the plans continued to underpay claims after losing in arbitration.</p>	
<p><b>5. Who pays for the program.</b></p>	<p>Obtain foundation funding or other grant funding for start-up costs.</p> <p>The payer shall be responsible for the entire cost of the arbitration unless the provider loses the arbitration, in which case the provider and the payer should split the cost of the arbitration, during this pilot project; since the Department has already established in policy that it is the responsibility of the payer to protect the patient from a balance bill by paying the claim in full and disputing the alleged overcharge in court. This approach will encourage providers to participate in the ICDR, rather than balance bill the patient.</p>	<p>Obtain foundation funding or other grant funding for start-up costs.</p> <p><u>The loser of the arbitration will cover the cost of the arbitration, or pay a penalty not to exceed 5% of the total contested amount for amounts less than \$10,000.</u></p>
<p><b>6. How to integrate a prohibition on balance billing.</b></p>	<p>Provider agrees not to balance bill the patient if utilizing the ICDR pilot program as outlined above.</p> <p>Before the start of the pilot program, clarification must be reached on what constitutes a “successful” program. All parties must agree that the program has succeeded in providing a fair, fast and cost effective method for resolving disputes of HMO claims before any statewide prohibition against balance billing is recommended to the State Legislature.</p> <p>The success of the ICDR should not solely be based on the level of participation in the program, but also on the financial consequence of the program: the ICDR should not facilitate a revenue or profit windfall for either payers or providers.</p>	<p><u>Balance billing would be eliminated for all HMO claims, as payment in full eliminates the need for balance billing.</u></p> <p>Before the start of the pilot program, clarification must be reached on what constitutes a “successful” program. All parties must agree that the program has succeeded in providing a fair, fast and cost effective method for resolving disputes of HMO claims before any statewide prohibition against balance billing is recommended to the State Legislature.</p> <p>The success of the ICDR should not solely be based on the level of participation in the program, but also on the financial consequence of the program: the ICDR should not facilitate a revenue or profit windfall for either payers or providers.</p>

Attachment 4

CEP AB 1455 Claim Disputes by Insurance Carrier  
Mar-Dec, 2004 pg 1 of 23

Ins Name	Paid		Unpaid		Total # Disputes	Total \$ Paid Following PDR	% Of Disputes w/ Pmts Following Dispute
	# Disputes	\$ Paid Following PDR	# Disputes	\$ Paid Following PDR			
HEALTHNET HMO	9,628	\$1,937,036	3,205	\$0	12,833	\$1,937,036	75%
KAISER SOUTHERN CALIFORNIA	840	\$87,219	2,479	\$0	3,319	\$87,219	25%
KAISER PERMANENTE	1,380	\$102,547	983	\$0	2,363	\$102,547	58%
BLUE SHIELD	1,050	\$65,013	996	\$0	2,046	\$65,013	51%
HILL PHYSICIANS	1,395	\$101,823	370	\$0	1,765	\$101,823	79%
AETNA PPO/AETNA DIRECT HMO	988	\$62,274	612	\$0	1,600	\$62,274	62%
CIGNA	688	\$78,292	840	\$0	1,528	\$78,292	45%
REGAL MEDICAL GROUP	838	\$119,531	466	\$0	1,304	\$119,531	64%
HEALTHNET PPO	800	\$147,351	358	\$0	1,158	\$147,351	69%
KAISER - ELECTRONIC - SOUTH	452	\$41,915	658	\$0	1,110	\$41,915	41%
CONVERTED MISCELLANEOUS INSKEY	313	\$43,226	681	\$0	994	\$43,226	31%
DESERT MED GRP /OASIS IPA	111	\$16,971	719	\$0	830	\$16,971	13%
UNITED HEALTHCARE	97	\$12,999	676	\$0	773	\$12,999	13%
INLAND HEALTHCARE	136	\$13,887	628	\$0	764	\$13,887	18%
PACIFICARE/HMO	297	\$41,978	400	\$0	697	\$41,978	43%
BLUE CROSS	142	\$16,469	536	\$0	678	\$16,469	21%
BAY VALLEY MED GRP	17	\$2,195	660	\$0	677	\$2,195	3%
PACIFICARE/PPO	300	\$19,744	296	\$0	596	\$19,744	50%
GREAT WEST	66	\$10,363	481	\$0	547	\$10,363	12%
REDLANDS CMNTY HOSP	18	\$1,727	519	\$0	537	\$1,727	3%
BLUE SHIELD-OUT OF STATE	69	\$4,272	458	\$0	527	\$4,272	13%
PRIMECARE OF CORONA	162	\$17,303	362	\$0	524	\$17,303	31%
CONTRA COSTA HEALTH PLAN	256	\$13,288	266	\$0	522	\$13,288	49%
JMHN/HEALTH NET	9	\$1,402	466	\$0	475	\$1,402	2%
BLUE CROSS HF	260	\$14,480	212	\$0	472	\$14,480	55%
PREFERRED IPA	214	\$6,624	246	\$0	460	\$6,624	47%
BROWN AND TOLAND MED GRP	320	\$19,607	132	\$0	452	\$19,607	71%
AFFINITY	197	\$30,360	245	\$0	442	\$30,360	45%
INLAND EMPR HLTH PLN	153	\$9,201	279	\$0	432	\$9,201	35%
**KAISER	110	\$8,741	288	\$0	398	\$8,741	28%
PRINCIPAL LIFE INSURANCE	34	\$3,361	338	\$0	372	\$3,361	9%
MOLINA MEDICAL CENTER	133	\$5,722	237	\$0	370	\$5,722	36%
SANTA CLARA-IPA	175	\$21,473	169	\$0	344	\$21,473	51%
NOBLE	30	\$2,618	279	\$0	309	\$2,618	10%
MEDICARE/PARTICIPATING PHYS	83	\$4,066	225	\$0	308	\$4,066	27%
PHYSICIANS HEALTH NETWORK	33	\$1,550	274	\$0	307	\$1,550	11%
UNIVERSAL CARE	84	\$9,475	220	\$0	304	\$9,475	28%
LAVIDA	121	\$9,669	168	\$0	289	\$9,669	42%
SHARP COMM. MEDICAL GROUP	74	\$12,453	205	\$0	279	\$12,453	27%
LA VIDA MULTI SPEC MED CTR	181	\$22,254	74	\$0	255	\$22,254	71%
JOHN MUIR/MT DIABLO HEALTH	9	\$535	245	\$0	254	\$535	4%
CARE FIRST HEALTH PLAN	27	\$958	223	\$0	250	\$958	11%
MCKINLEY MEDICAL GROUP	19	\$619	229	\$0	248	\$619	8%
PROSPECT MEDICAL GRP OF ORANGE	68	\$9,531	156	\$0	224	\$9,531	30%
BRISTOL PARK MED GRP	134	\$15,228	80	\$0	214	\$15,228	63%
COMMUNITY HEALTH	33	\$1,535	181	\$0	214	\$1,535	15%
BLUE SHIELD HMO	138	\$5,287	75	\$0	213	\$5,287	65%
**CIGNA	89	\$10,460	116	\$0	205	\$10,460	43%
PACIFICARE/SECURE HORIZONS	83	\$10,383	122	\$0	205	\$10,383	40%
DESERT VALLEY MEDICAL GROUP	21	\$4,827	181	\$0	202	\$4,827	10%
HEALTHCARE PARTNERS	84	\$12,712	117	\$0	201	\$12,712	42%

## Attachment 5

Date: Fri, 17 Mar 2006 14:17:07 -0700  
Subject: History of relations with DMHC  
From: "R. Myles Riner, M.D." <[mriner@inreach.com](mailto:mriner@inreach.com)>  
To: Monica Wagoner <[mwagoner@calacep.org](mailto:mwagoner@calacep.org)>, Irv Edwards <[iedwards@emergentmed.com](mailto:iedwards@emergentmed.com)>  
Message-ID: <[C0407563.12216%mriner@inreach.com](mailto:C0407563.12216%mriner@inreach.com)>

Monica, in addition to the Blue Cross, Blue Shield and HealthNet complaints that Irv has submitted to the DMHC, I thought it would be helpful for you to see the other complaints and requests that we submitted to the Department in the last couple of years.

Myles

1/23/06 Complaint filed electronically re underpayment by Inland HealthCare Group along with EOBs etc. - no response yet

1/06 Requested that the Department advise John Muir Medical Group that payment to non-contracting providers can not be " based on non-contracting payment guidelines at 130% of Medicare fee schedule" - copy of letter from medical group also sent. - no action taken

10/05 Requested clarification from Mr. Donohue regarding his letter to Plans and RBOs outlining four safe harbor standards for minimum payment that payers needed to meet: whether the payer must meet all four criteria, or only one of the criteria. - no response received

7/05 Request from MBSI for DMHC action against Desert Medical Group using spreadsheet and single EOB with 142 accounts that demonstrated: 54 commercial accounts that were disputed because they were paid at a so called usual and customary amount that was about 52% of charges (\$9,190 in payments on \$17,672 in charges), and other issues. Response from DMHC:

> "As you know the standard for reimbursement of non-contracted claims is the  
> reasonable and customary value of the services rendered - not "billed  
> charges". Without documentation demonstrating that your billed charges reflect  
> the reasonable and customary value of the services rendered, there is not a  
> reasonable basis to initiate further investigation or enforcement."

I.e. - we were asked to prove that our billed charges were reasonable, rather than having the payer prove that the payments met AB 1455 standards. Contrast the above quote with this from Mr. Donohue in 1/06:

- > The emergency room physicians contribute to delays, by failing to use the
- > Department's Provider Complaint Unit which was created to respond to claims
- > payment disputes. I explained in my early email, if any emergency room
- > physicians are in possession of actual claim payment determinations that they
- > believe resulted in an underpayment, to please submit the disputed claim
- > through the Department's Provider Complaint Unit with supporting documentation
- > and it will be investigated thoroughly.

6/05 Responded to DMCH request, below, to identify RBOs that are the most 'problematic' with regard to claims underpayment, inappropriate downcoding, and denials - several IPAs and Medical Groups identified - not aware of any action taken

- > Can you please identify the payors you believe clearly disregard the Gould
- > criteria in formulating their reimbursement calculations. I will then focus
- > the plans' oversight activity in this direction.

6 and 7/05 Complaints from Dr. Edwards sent regarding Chino Medical Group and Caremore Medical Group with claims data, DMHC did make contact with Chino with some resultant temporary improvement but some issues remain, Caremore issue successfully resolved by DMHC

3/05 Request to get HealthNet subcontracted delegated payers to pay non-contracted providers according the HealthNet consent agreement - no response

2/05 Provided detailed information on 63,000 disputed claims indicating and identifying many Plans and RBOs that fail to respond appropriately to most if not all disputes, compared to those that do respond appropriately to most disputes, requesting that the poorly responding payers be addressed - no known action taken.

10/04 Requested to know why, in DMHC contracting guidelines and agreements, there is not obligation for Plans to include emergency care providers in their contracted networks'. Response: It would be unfair to force plans to contract with hospital based providers.

1/04 I requested that DMHC respond in writing to Bay Valley Medical Group's deliberate misquoting of Gould criteria in letters to balance billed patients ("the prevailing provider rates ACCEPTED in the general geographic area...") to justify paying at 88% of Medicare rates - initial response from Donohue:

- > I have spoken with Bay Valley at least 4 times to address the situation. They
- > will be sending you a corrected letter that accurately sets forth the
- > criteria. I have explained to them that a benchmark of 80% level of Medicare
- > is not appropriate unless it is supported by statistically credible
- > information verifying that providers in the geographic area are billing that
- > amount. But the reference to that rate was not in its letter.
- >
- > If they don't adjust their payment methodology I will accept their offer to

- > provide the department with the statistical credible information that supports
- > their calculation.

And subsequently:

- > I spoke with Bay Valley concerning the accuracy of the criteria it listed in
- > its correspondence to a number of non-contracted providers. After speaking
- > with their attorney, Bay Valley conceded that their correspondence was
- > inaccurate and confirmed they any future correspondence to non-contracted
- > providers would accurately set forth the Gould criteria. Bay Valley also
- > indicated it would try to track down the identity of any providers that
- > received the incorrect information and forwarded a corrected letter to their
- > attention.

By the way, we also tried to get HealthNet involved with these underpaid claims, and HealthNet advised MBSI to "go ahead and send the patient to collections" if Bay Valley did not pay the underpaid portion of the claims. HN also said:

- > Court rulings have agreed that Health
- > Plans are not responsible for claims that the Medical Groups are at risk
- > for. This is an issue which CA Emergency Physicians must settle with Bay
- > Valley Medical Group.

Kevin responded to this info with:

- > It is still the position of the Department that balance billing enrollees is
- > inappropriate where reimbursement for the health care services are the
- > responsibility of the plan/IPA. You are reading too much into the a trial
- > court decision that was dismissed on a procedural basis especially when there
- > have been a number of other trial court decisions that have held to the
- > contrary.
- >
- > Trial court opinions do not have any precedential value and can not be used to
- > support other cases or situations.

To which I responded on 3/15/04: "Kevin, that is exactly the position of CAL/ACEP and the CMA: neither trial court decisions nor the legal opinion of a DMHC staff attorney can be used to support policy that has not been rendered into either regulation or signed legislation, especially when this policy would deny the civil rights of non-contracted providers. The DMHC has attempted on multiple occasions to suppress these rights, first through SB 1881, then through AB 1455, and then through emergency regulations, and in each case you have had neither the support of the executive branch, the Legislature nor, in the only case that looked specifically at this issue (Prospect vs St. Johns), the judge. By the way, the attorney in the case, Andrew Selesnick, does not feel that the judge's decision in Prospect was based on procedural issues, but was based on substantive issues of law.

The only way to effectively address this issue, and eliminate the need for balance billing, is to ensure that non-contracted providers are paid by plans appropriately, and that there is a mechanism to define what reasonable payment is. AB 1455 does not accomplish this: giving the Plans and IPAs the right to 'use' the Gould criteria, instead of mandating that these criteria be applied by an impartial judge, is no solution. The DMHC is apparently not willing to step up to the plate to address it; as evidenced in part by the clearly ineffective slap on the wrist to Bay Valley. Thus, CAL/ACEP has had to develop an equitable solution with SB 1679 (attached). If you really want a solution to balance billing, lend your department's support to this legislation, and perhaps there will never be another balance bill sent again."

Eventually, EIGHT MONTHS from the initial request, on 9/8/04, Donohue advised us that BV felt our dispute was a 'contractual dispute, implying that CEP was under contract with BV for ED services (the contract in question was for services at one of CEP's old UCCs which was no longer in operation, not for ED services), and that:

- > I did inform Bay Valley that it could not simply rely on a disputed
- > contract to determine reimbursement and that steps would need to be taken to
- > determine if the disputed contract applies to the subject claims. Bay Valley
- > will also be preparing an overview of its reasonable and customary methodology
- > for the department's review.

and:

- > I encourage both parties to work diligently towards a mutually agreeable
- > contractual arrangement which should eliminate these billing disputes.

At no time did Kevin ever tell Bay Valley in writing that they were not in compliance with AB 1455 when paying at 88% of Medicare rates, nor would he opine on whether our contract for services at the defunct UCC also covered ED services, when BV finally sent him a copy of the contract.