Reimbursement and Payor Dispute Update

POLSINELLI REIMBURSEMENT TEAM NEWSLETTER

Why Should I Attend the 2021 Reimbursement [Virtual] Summit?

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On February 23 and 25, 2021, Polsinelli's Reimbursement Institute is hosting its Fifth Annual Reimbursement Summit as a two-part virtual series. Please reserve time on your calendars to join us online for this multiday educational and networking event!

Similar to prior years, attendees can obtain CLE or CPE credits for attending.[1] Unlike previous years, this event will be completely online and held over two half-days, as opposed to one long day, to allow more flexibility to attend sessions. While we will miss sharing a drink and snacks with friends and colleagues, we are particularly excited about this virtual event because it will allow even more people to participate who previously may have been limited by travel or schedule restrictions.

The goal of the Reimbursement Summit has always been to focus on key health care regulatory and reimbursement developments, including recent litigation and appeals of import to health care providers, and we will maintain that focus with this year's virtual format. The Reimbursement Summit is a great education and networking opportunity for health care professionals ranging from those in the executive suite and the counsel's office to finance, reimbursement/revenue cycle, operations, and compliance.

> *If the pandemic has taught us anything, it's that our clients need to be prepared to do more with fewer resources.*

Some may think that they don't have time for another video conference. Few have time for continuing education, and finding relevant education that will actually give them tools to help drive their organization's reimbursement goals is nearly impossible. Regardless of which provider space you come from, you will find this seminar highly relevant to your day-to-day operations and strategic plans for 2021 and beyond.

Join us to hear health care reimbursement experts from Polsinelli share their in-depth knowledge on the following topics:

The Year in Reimbursement

This session will offer a high-level review of new laws and regulations from the last year — including what you may have missed while focusing on COVID-19 — affecting both small and large health care providers across the spectrum.

Strategies for Complying with Price Transparency and Surprise Billing Laws

State legislatures and the federal government have been busy the past 12 months churning out laws that impose new disclosure and billing obligations on providers, and this session will help you get your practices up to date.

Reimbursement for Innovations — Updates on Value-Based Care and other Innovation Models

Through actions of federal, state and the private sectors, "value-based" goals and methods have become more embedded in the nation's health care payment and delivery systems. These changes present opportunities and challenges for providers,

[1]States eligible for CLE or CPE credit include the following: Arizona, California, Colorado, Georgia, Illinois, Kansas, Louisiana, Missouri, Mississippi, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Tennessee, Texas, Virginia, Washington and Wisconsin.

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investors and others, and this session will explore the movement from traditional fee for service to financial and other risk-based payment models.

Reimbursement and COVID-19 — Updates on Provider Relief, Testing, Vaccinations, and What Waivers May be Here to Stay

The pandemic isn't over just because you're over it. Learn about the latest news on provider relief, reimbursement issues for testing and vaccinations, and most importantly, what waivers may be here to stay.

Effective Strategies for Telehealth Reimbursement, Now and Post-Pandemic

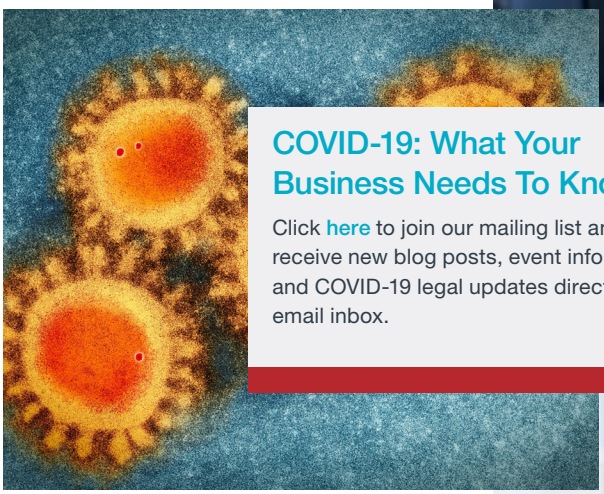
During this session, speakers will address telehealth initiatives that have been accelerated during the last year and effective strategies to help you through the rest of the pandemic and beyond.

Trends in Commercial Payor Disputes and How to Contract Around Them

Payors are under a lot of pressure to crack down on billing errors and fraud, which means more providers and suppliers are being subjected to audits and inquiries from every angle. During this session, the panelists will address the latest trends (and tricks) by payors and offer tips on how you may be able to contract around those issues in the future.

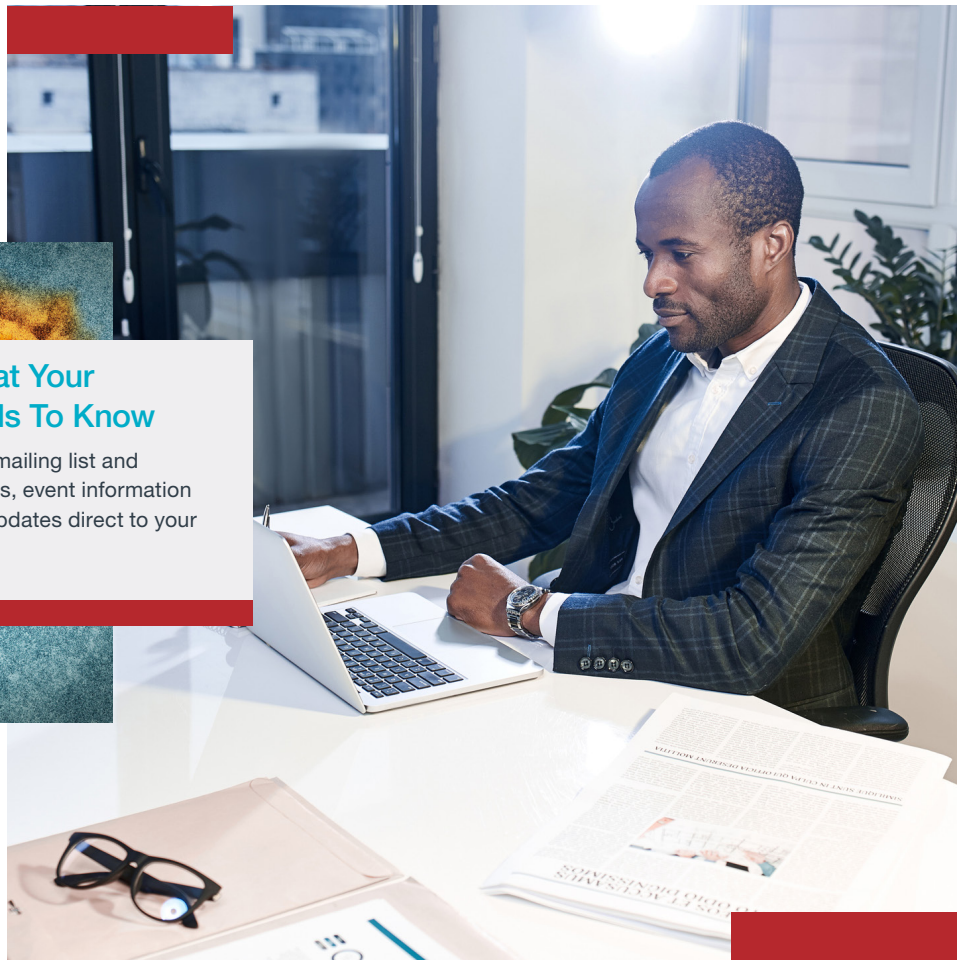
We hope everyone can join us for both days, or even just for your favorite session. Click here for more details and to register.

If you have additional questions, please email Sinead McGuire at smcguire@polsinelli.com.



COVID-19: What Your Business Needs To Know

Click here to join our mailing list and receive new blog posts, event information and COVID-19 legal updates direct to your email inbox.



Value-Based Care in 2021: Five Emerging Trends in Value-Based Care

The pace and pressure to embrace value-based care are picking up. The COVID-19 pandemic exposed the risks and limitations of reliance on fee-for-service reimbursement and, combined with the groundbreaking changes in health care delivery models and regulatory flexibility, indicate a renewed focus on value-based care. This article outlines five of the top trends to watch for in value-based care for 2021.

Top Five Trends to Watch in 2021

- Leaning In to Value-Based Care
- Continued Innovation and Disruption
- Capitalizing on COVID-19 Infrastructure
- New Opportunities for Provider Alignment
- Emphasis on Social Determinants of Health

Leaning In to Value-Based Care

One of the lessons from 2020 is that reliance on fee-for-service can leave providers vulnerable to volatility and changes in demand. As utilization plummeted during the COVID-19 pandemic, providers who had invested heavily in value-based care have been better able to weather the pandemic and the economic downturn by having a consistent source of revenue despite low utilization.[1] The rapid changes in health care driven by the pandemic only further emphasized the need for providers to lean into value-based care. Beyond the allure of steady revenue streams, new regulatory flexibilities and care delivery innovation creates an opportunity for providers to realize a more rapid rate of return on their investment in value-based care by increasing the portion of their business with value-based care reimbursement.

Continued Innovation and Disruption

While value-based care has always been an area ripe for innovation, 2021 presents a unique set of circumstances that point to a surge of innovation and disruption in both payment and care delivery models. Value-based care had been a priority for the Centers for Medicare and Medicaid Services ("CMS") under the Trump administration,[2] but there is no reason to expect a change of course away from value-based care.[3] In fact, the Biden administration's health care goals will likely require an increased emphasis on cost savings, which may result in an even greater push towards value-based care.[4] Some news outlets are reporting that Elizabeth Fowler is a front-runner to lead the Center for Medicare and Medicaid Innovation,[5] further signaling that CMS's momentum on value-based care will continue.[6] Commercial payors also continue to push towards innovative payment and care models as COVID-19 has highlighted the inequities in the health care delivery system and challenges for providers.

Capitalizing on COVID-19 Infrastructure

The COVID-19 pandemic prompted transformational changes to the health care system that portend continued opportunities to manage patient care and provide quality care in lower cost settings. As a result of the pandemic, both the federal and state governments threw open the doors to allow providers to furnish services via telemedicine and other digital health modalities during

[1] *See*, e.g. Jacqueline LaPointe, *How COVID-19 Imperiled Physician Practices and How to Save Them,* RevCycle Intelligence (May 6, 2020), revcycleintelligence.com/features/how-covid-19-imperiled-physician-practices-and-how-to-save-them; *How Value-Based Care Supports Doctors During the Pandemic*, BlueCross BlueShield of Illinois (Sept. 9, 2020), www.bcbsil.com/newsroom/category/collaborative-care/value-based-care-supports-doctors-during-pandemic.

[2] *See, e.g.* Press Release, CMS, Fact Sheet: Value-based Care State Medicaid Directors Letter (Sept. 15, 2020), www.cms.gov/newsroom/fact-sheets/value-based-care-state-medicaid-directors-letter; Press Release, CMS, CMS Announces Strong Participation in Value-Based Medicare Advantage Model for CY 2020 and New Opportunities for 2021 (Dec. 19, 2019), www.cms.gov/newsroom/press-releases/cms-announces-strong-participation-value-based-medicare-advantage-model-cy-2020-and-new; Press Release, CMS, Direct Contracting: Professional and Global (Nov. 25, 2019), www.cms.gov/newsroom/fact-sheets/direct-contracting-professional-and-global.

[3] Keith Loria, *What Will CMS Do Under the Biden Administration?*, Managed Healthcare Executive, www.managedhealthcareexecutive.com/view/what-will-cms-do-under-the-biden-administration- (last visited Feb. 10, 2021).

[4] *See, e.g.* Health Care, Biden Harris Campaign, joebiden.com/healthcare/.

[5] Shira Stein, *Obamacare Architect Is Top Pick to Lead Value-Based Care Office*, BloombergLaw: Health Law & Business News (Feb. 10, 2021), news.bloomberglaw.com/health-law-and-business/obamacare-architect-is-top-pick-to-lead-value-based-care-office

[6] *See, e.g.* Courtney Taylor, *COVID-19 May Move the Needle on Value-Based Payment*, USC Shafer (Sept. 24, 2020), healthpolicy.usc.edu/article/covid-19-may-move-the-needle-on-value-based-payment/.

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the COVID-19 public health emergency.[7] Many of the telehealth waivers have been made permanent.[8] Providers who have embraced digital health as a way to weather the pandemic will also have the opportunity to capitalize on this investment as a way to manage patient care and see a return on investment for services that are typically not reimbursable under fee-for-service arrangements.[9] CMS also created the Hospital Without Walls[10] and Acute Hospital Care at Home[11] programs to increase hospital capacity during the pandemic. Commercial payors have been eager to seize on these opportunities to promote lower-cost services.[12] Providers who have invested in these types of programs similarly provide an opportunity to provide quality care in lower cost environments, which will benefit providers who are fully engaged in value-based care.

New Opportunities for Provider Alignment

Recent changes to federal law aim to lower barriers to value-based care. In particular, CMS and the Office of Inspector General ("OIG") created new flexibility under the Stark Law and Anti-Kickback Statute for value-based arrangements to allow providers to enter into value-based care arrangements that previously may have been prohibited.[13] While the new exceptions and safe harbors still require that arrangements be carefully crafted, they provide new opportunities to align with providers and to incentivize activities that promote value-based goals that were previously unavailable. Additionally, the sweeping interoperability and information blocking rules aim to ensure that patients and providers are able to access health information, further reducing structural barriers to value-based care.

Emphasis on Social Determinants of Health

Finally, players in the value-based care space — particularly in Medicaid managed care programs — are placing greater emphasis on addressing social determinants of health.[14] Providers and payors are beginning to recognize the crucial role that nonmedical factors play in patient health.[15] By solving for these issues — such as transportation, food, housing, language services, etc. — providers and payors are able to realize significant benefits in improving patient health and outcomes while keeping medical costs relatively low. The focus on social determinants of health is an emerging trend in value-based care that is likely to grow as players seek creative ways to manage patient care through value-based arrangements.

As providers and payors emerge from the upheaval of the pandemic and the resulting revolutionary changes in health care, we can expect renewed interest in value-based care. Opportunities abound to capitalize on the changes wrought by the pandemic, as well as emerging prospects, by fully investing in value-based care.

[7] *See, e.g.*, Telehealth, Polsinelli, www.covid19.polsinelli.com/telehealth?rq=telehealth (last visited Feb. 10, 2021); General Provider Telehealth and Telemedicine Toolkit, CMS, www.cms.gov/files/document/general-telemedicine-toolkit.pdf (last visited Feb. 10, 2021).

[8] *See, e.g.* Press Release, CMS, Trump Administration Finalizes Permanent Expansion of Medicare Telehealth Services and Improved Payment for Time Doctors Spend with Patients (Dec. 1, 2020), www.cms.gov/newsroom/press-releases/trump-administration-finalizes-permanent-expansion-medicare-telehealth-services-and-improved-payment

[9] *See* LaPointe, *supra* n.1.

[10] Pres Release, CMS, Fact Sheet – Additional Background: Sweeping Regulatory Changes to Help U.S. Healthcare System Address COVID-19 Patient Surge (Mar. 30, 2020), www.cms.gov/newsroom/fact-sheets/additional-backgroundsweeping-regulatory-changes-help-us-healthcare-system-address-covid-19-patient.

[11] www.cms.gov/newsroom/press-releases/cms-announces-comprehensive-strategy-enhance-hospital-capacity-amid-covid-19-surge; www.cms.gov/files/document/covid-acute-hospital-care-home-faqs.pdf

[12] *See, e.g.* Acute Hospital at Home Program, Frequently Asked Questions, www.cchpca.org/sites/default/files/2021-01/Private%20Payer%20Telehealth%20Coverage%20Reportfinal.pdf (last visited Feb. 10, 2021); Press Release, Humana, DispatchHealth and Humana Team Up to Provide Hospital-Level Care in the Home (Feb. 1, 2021), press.humana.com/news/news-details/2021/DispatchHealth-and-Humana-Team-Up-to-Provide-Hospital-Level-Care-in-the-Home/default.aspx#gsc.tab=0.

[13] Lori Oliver, Neal Shah, Jeanna Gunville, Kathleen Sutton, *A New Framework: CMS and OIG Modernize the Stark Law and Anti-Kickback Statute*, Polsinelli (Dec. 8, 2020), www.polsinelli.com/intelligence/cms-and-oig-modernize-stark-law-and-aks.

[14] *Addressing Social Determinants of Health & Equity Through Health-Related Services*, Oregon Health Authority (Mar. 2020), www.oregon.gov/oha/HPA/dsi-tc/Documents/Health-Related-Services-SDOH-E-Guide.pdf; Social Determinants of Health Dashboard, Wa. State Dep't Health, www.doh.wa.gov/DataandStatisticalReports/HealthDataVisualization/SocialDeterminantsofHealthDashboards (last visited Feb. 10, 2021); Marrying Value-Based Payment and the Social Determinants of Health through Medicaid ACOs: Implications for Policy and Practice, Milbank Memorial Fund (May 22, 2020), www.milbank.org/publications/marrying-value-based-payment-and-the-social-determinants-of-health-through-medicaid-acos-implications-for-policy-and-practice/.

[15] Jacqueline LaPointe, *Social Determinants of Health Key to Value-Based Purchasing Success*, RevCycle Intelligence (Jan. 9, 2019), revcycleintelligence.com/news/social-determinants-of-health-key-to-value-based-purchasing-success.

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The "No Surprises" Act: Congress Enacts Legislation to End Surprise Medical Billing in Omnibus Year-End Spending Bill

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The recently-enacted Consolidated Appropriations Act, 2021 includes the long-debated "No Surprises" Act (the "Act"), which addresses how providers are paid for certain out-of-network health care services, and removes patients from the middle of out-of-network reimbursement disputes. The Act comprehensively addresses all types of commercial health plans by amending the Public Health Service Act ("PHSA"), the Employee Retirement Income Security Act of 1974 ("ERISA"), the Internal Revenue Code ("IRC"), and Federal Employees Health Benefits Program ("FEHBP"), each with substantially similar companion provisions. These provisions, summarized in brief below, will be effective January 1, 2022. Agency rules are expected to start rolling out in July 2021.

Scope

The Act applies to emergency services provided by nonparticipating facilities/providers and air ambulance services, and nonemergency services rendered by nonparticipating providers at participating facilities (unless a detailed notice and consent requirement is met). The Act covers all commercial plans governed by state and/or federal law.

Key Features

- **Prohibition on Balance Billing.** The Act prohibits out-of-network providers/facilities from balance billing patients for more than the in-network cost sharing amount for emergency services (and ancillary services), and nonemergency services rendered by out-of-network providers at in-network facilities (when the notice and consent criteria described below are not met).
- **Detailed Notice and Consent Requirements for Nonemergency Services.** The notice and consent criteria generally require nonparticipating providers/facilities to:
  - Provide a written notice to patients.
  - Obtain consent to be treated by a nonparticipating facility/provider.
  - Provide a signed copy of the consent to the patient.
- **Cost Estimate Requirement for Scheduled Services.** The Act requires a provider to give a good faith estimate of charges to the patient's health plan, generally within three days of the patient scheduling a service. The health plan is then required to provide an advanced EOB showing the provider's network status, contracted rate, good faith estimates of patient cost-sharing and the amounts the plan will pay, certain disclaimers, and other information detailed in the Act.
- **Right to Direct and Timely Payment.** The Act requires health plans to pay providers directly an initial "out-of-network rate," as specified in the Act, thereby eliminating any impact from anti-assignment clauses governed by ERISA and exempt from state law.
- **Three Possible Out-of-Network Rates:**
  - If there is an All-Payer Model Agreement in the State, then the amount specified in the Model Agreement should be used as the out-of-network rate.
  - If there is no All-Payer Model Agreement, then a state-law-specified amount would be the out-of-network rate if the state law governs each of:
    - The item/service furnished.
    - The provider/facility.
    - The plan/coverage/issuer.
  - If there is no All-Payer Model Agreement and no state law governing, then the amount that the parties agree on (including any agreements from the more formal negotiation procedures detailed later in the Act) is the out-of-network rate.
- **Patient/Provider Dispute Resolution.** The Act calls for the Secretary to establish a process by which uninsured individuals can challenge bills substantially in excess of good faith estimates provided pursuant to the cost estimate requirement above.

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- **Provider/Health Plan Dispute Resolution.** The Act sets forth a detailed dispute resolution procedure for providers and health plans that do not agree on the out-of-network rate. The procedure begins with an open negotiation process. If the provider and plan cannot reach an agreement through the open negotiation process, one party may escalate the dispute to independent dispute resolution known in the Act as the "IDR Process." Both parties must then submit their "offer", i.e. their argued price for the disputed item/service. The IDR Process is baseball-style, meaning the arbitrator must select one party's offer.
- **Information the Arbitrator May Consider:**
  - Median in-network rates.
  - Provider's training and experience, patient acuity, and the complexity of the service.
  - Good faith efforts (or lack thereof) to become an in-network provider.
  - Contracted rates during the previous four years.
  - Quality and outcomes.
  - Case mix.
  - Provider/plan market share.
  - A hospital's teaching status.
  - Any other nonprohibited information relating to the offer submitted by either party.
- **Information the Arbitrator May Not Consider:**
  - Provider's billed charges.
  - Medicare rates.
  - Medicaid/CHIP rates.
  - TRICARE rates.
- **Effect of IDR Decision.** Absent some likely rare exceptions, like fraud, the arbitrator's decision in the IDR Process is not subject to judicial review. The party who initiated the IDR Process cannot initiate another IDR Process against the same adverse party for disputes related to the same item/services during a 90-day "cooling-off" period following the arbitrator's decision.
- **Voluntary Process.** The IDR process is voluntary and does not prohibit the use of traditional litigation or other agreed dispute resolution processes.
- **Timely Bills.** The Act imposes a framework on providers and plans with the goal of sending timely bills to patients.
- **Provider Directories.** The Act takes action to make accurate provider information available to patients, so they can determine which providers are in their network.
- **All Payer Claims Databases.** The Act establishes one-time grants for states that submit applications to create State All Payer Claims Databases.

Payors Pick Up Pace in Curbing Preventable Spending on Surgical Care

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In 1982, the ambulatory surgery center ("ASC") model began to proliferate when Medicare approved this type of provider as an appropriate site of care for approximately 200 surgical procedures. Yet, despite their lower cost, nearly 40 years later, commercial and government payors have not forced the migration of outpatient surgical care to ASCs.

As such, outpatient surgical procedures remain a mainstay for many health systems to ensuring hospitals maintain a healthy financial position. However, recent trends in Centers for Medicare and Medicaid Services ("CMS") regulations as well as commercial payor reimbursement policies demonstrate new enthusiasm from payors to guide their enrolled providers and plan beneficiaries to lower-cost settings outside of the hospital and relatedly to restrict health systems and physicians from retaining elective outpatient surgical services in the hospital setting.

Illustrating this trend, some payors, such as UnitedHealthcare ("UHC") and Anthem, have promulgated policies that restrict the site of care for elective surgical procedures. UHC's policy took effect in November 2019 for fully insured groups in most states.[1] Pursuant to this policy, UHC only pays for surgical procedures performed in an outpatient hospital setting if such setting is medically necessary based on the acuity of the patient. For example, the freestanding ASC setting can be a riskier setting for patients who, based on their health condition, may have complications with anesthesia. UHC may also permit elective surgical care in the hospital setting if ASC services are not geographic accessible. UHC stated its intent to reduce costs with this new requirement. UHC estimated that steering beneficiaries toward the lower-cost setting would save beneficiaries $500 million in 2020 and would save UHC over 20% in reimbursement to providers.

Similarly and more recently Anthem, which has insurance products in 15 states, published a Clinical UM Guideline on August 20, 2020, which also limits the use of outpatient hospital surgical facilities.[2] The Anthem guidelines consider the use of outpatient hospital facilities medically necessary only if: (a) the procedure is of a level of complexity that it cannot be safely performed in a less intensive setting; or (b) the individual has a clinical condition that may compromise the safety of a lower-cost setting, such as conditions that require enhanced anesthesia monitoring,

[1]UHC, *Outpatient Surgical Procedures – Site of Service* (eff. Nov. 1, 2019), www.uhcprovider.com/content/dam/provider/docs/public/policies/index/commercial/outpatient-surg-procedures-site-service-11012019.pdf.
[2]Anthem, *Ambulatory or Outpatient Surgery Center Procedures (CG-SURG-10)* (last rev. Nov. 5, 2020) www.anthem.com/dam/medpolicies/abcbs/active/guidelines/gl_pw_a051150.html.

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medications, or prolonged recovery or where the patient is at an increased risk for complication due to severe comorbidity. All other uses of an outpatient hospital facility are not medically necessary under the policy.

Outside of value-based care initiatives, CMS has not yet adopted outpatient surgical procedure site of care policies that restrict certain cases to a nonhospital setting. CMS has, however, developed new payment policies to find ways to reduce the increasing costs associated with health care services. More specifically, for calendar year 2021, CMS added 11 procedures to the ASC-covered procedures list, including more total joint replacement procedures.[3] This is significant in multiple respects. From the hospital perspective, joint replacement procedures, which are generally considered elective and tend to have a better payor mix, have been a profitable source of income for hospitals. From a CMS program integrity perspective, the fiscal burden of joint replacements on the Medicare program is high and, along with other rising costs, threatens program solvency particularly as longevity of seniors increases and some patients begin to outlive their first joint replacement needing a second procedure later in life. As CMS has an urgent need to address the trust fund's solvency, moving surgical care that can be performed in an ASC, rather than the hospital, may be one of several crucial endeavors for the future of Medicare.

As suggested by several studies, the potential savings of moving total joint replacement procedures to ASCs is substantial, with the cost of treatment being about 40% less in an ASC when compared to hospital surgical care for the same procedure. The estimated average cost for joint replacement surgery per patient was about $12,000 for the ASC and almost $20,000 for the same procedure in the hospital. In keeping with these findings, a report from UnitedHealth Group also found that migrating half of routine total joint replacements to ASCs could yield $1 billion in savings for Medicare, and moving patients requiring joint replacement procedures to ASCs could minimize the rate of hospital-acquired infections in this population.[4] It is unsurprising, then, that certain projections suggest that by 2028 approximately 57% of joint replacement procedures will be performed at ASCs.

As in recent years, reducing the health care spend will remain a priority for federal and state government, other payors, employers and patients alike, and health systems will need to focus their surgical programs on developing and expanding strategies for lower cost ambulatory surgical care.

[3] *See* CMS, *Fact Sheet: CY 2021 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS-1736-FC)* (Dec. 2, 2020), www.cms.gov/newsroom/fact-sheets/cy-2021-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0.

[4] *See* UnitedHealth Group, *New Research Highlights the Safety and Cost Savings Associated with Ambulatory Surgery Centers* (Dec. 10, 2020), www.unitedhealthgroup.com/newsroom/research-reports/posts/2020-12-10-research-ambulatory-surgery-centers-490916.html.

Who's Going to Cover COVID Hospitalizations — Commercial Health Plans or Workers' Compensation?

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A trend is emerging. Commercial health plans are delaying and even denying reimbursement for COVID-19 hospitalizations — especially high-dollar inpatient stays. Plans are attempting to defer these claims to workers' compensation on the health plans' assertion that COVID-19 is a work-related illness.

Some hospitals defer to health plans, as it relates to these types of claims, because it is plausible that patients could have contracted COVID-19 at work and because workers' compensation is typically primary for coordination of benefits purposes. But workers' compensation is notoriously complex, and hospitals may not understand the nuances of the program enough to know when it is appropriate to challenge this type of health plan denial. Failing to appeal these denials may impact hospital reimbursement, as well as a hospital's accounts receivable days, known as "AR days," depending on the number of COVID hospitalizations and the corresponding amount in open balances. It is definitely a conundrum. The goal of this article is to provide hospitals and its business offices with a better understanding of COVID-19 as an occupational illness to enable hospitals to be better equipped to determine when it is appropriate to challenge health plans that seek to delay or deny reimbursement for COVID hospitalizations.

Demystifying Workers' Compensation With a Brief Overview

It is important to have a general understanding of workers' compensation coverage. Workers' compensation is a state-mandated insurance program that protects employers and employees from financial loss when employees suffer job-related injuries and illnesses. Virtually all employers, even small employers, must maintain workers' compensation coverage. If an employee suffers an occupational injury or illness, an employer through its workers' compensation carrier may provide missed wage replacement, temporary and permanent disability, death benefits, and supplemental benefits. But one of the basic benefits in all states is medical and hospital benefits. Each state regulates workers' compensation coverage differently, which is a critical factor with respect to COVID-19 and whether a health plan may delay or deny payment. In some states, employer premiums for workers'

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compensation policies are experience-rated, meaning that employers that file more claims pay more in premium.

Scenario

Patient X is a grocery worker who becomes ill and is eventually hospitalized with a COVID-19 diagnosis. Upon discharge, the hospital submits the bill to the health plan. The health plan fails to timely adjudicate the claim. Instead, the health plan contacts the hospital and states that it needs additional information. The health plan believes the patient is covered by workers' compensation because the patient probably acquired the virus at work. Should workers' compensation cover Patient X's hospitalization?

It's complicated.

States' Response to Classifying COVID-19 as an Occupational Illness

When it comes to COVID-19 as an occupational illness, states have responded differently. On one hand, 17 states and Puerto Rico have extended workers' compensation coverage to include COVID-19 as a work-related illness. Within this group of states, there are varying degrees of coverage.[1] The majority of these states have established COVID-19 workers' compensability presumptions for various types of workers. In these states, if a designated worker contracts COVID-19, it is generally presumed that the worker acquired the virus during the course of employment thus eligible for workers' compensation, including medical and hospital benefits. But employers can dispute this presumption and produce evidence to the contrary, if done so within a certain amount of time under state law. Hospitals are often left out of this decision-making process, which is unfortunate because hospitals may have additional information about where the worker contracted COVID-19.

On the other hand, some states still consider COVID-19 an "ordinary disease of life," similar to a cold or the flu, which means the virus is not covered by workers' compensation. Still other states have taken no action to clarify whether COVID-19 hospitalizations and treatments should or should not be covered by workers' compensation.

Workers' compensation laws were difficult to navigate prior to the pandemic, which makes the recent patchwork of legislation and executive orders classifying COVID-19 as an occupational illness even more difficult to understand. As a result, health plans may accidentally or intentionally delay or deny reimbursement.

Take Patient X, for example. Grocery workers in California may be entitled to workers' compensation.[2] But elsewhere, these same workers are not entitled to benefits. A health plan with members in several states, including California, might seek to delay or deny payment to hospitals elsewhere because the health plan is successful in ultimately denying the same COVID hospitalizations in California. Therefore, it is important for hospitals to review all claims when health plans seek to delay or deny payment for COVID hospitalizations.

Takeaways

It is complicated to determine if a patient's stay is covered by workers' compensation when faced with a health plan that attempts to delay or deny payment. If faced with this scenario, hospitals should consider the following:

- Understand your state workers' compensation laws and the coverage available for COVID-19 hospitalizations. Determine if the state where the hospital is located designates COVID-19 as an occupational illness and whether the patient's occupation falls within the state's definition of a "covered worker."
- If the patient is not eligible for coverage under workers' compensation, then the hospital should appeal the health plan's delay in or denial of reimbursement. In addition, the hospital should consider contacting the patient's employer to jointly assess whether to dispute any state presumptions that a worker contracted COVIID-19 on the job.
- If workers' compensation denies all or part of a claim, the hospital should submit the remainder of the bill to the health plan.
- As an employer, the hospital should understand whether its own workers' compensation policy is experience-rated. If so, the hospital may want to be more diligent about ensuring the hospital's health plan or health plan administrator does not inappropriately delay or deny claims based on workers' compensation coverage.

[1]States limit coverage to "covered workers," with each state defining occupations that fall within the scope of coverage.
[2]*See Cal. Labor Code § 3212.88.*

Physicians and Other Providers Can Now Sue Insurers for Double Damages Under the Medicare Secondary Payer Law

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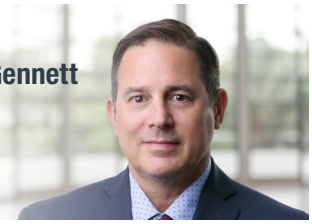
Miami



The Medicare Secondary Payer Act is a law that allows Medicare and Medicare Advantage (MA) plans to recover monies they paid for a Medicare patient's health care from other insurers who are primarily liable for the patient's health care costs.

Usually, these other insurers are auto insurers, workers' compensation insurers and general liability insurance. The law was created to protect the Medicare program from unnecessary expenditures for treating injuries that are covered under one of these other types of insurance. Generally, the other insurers are obligated to reimburse Medicare or MA plans on a voluntary basis once their liability for coverage has been established, such as when a car accident suit is settled or the insurer loses at trial. But when the insurers do not voluntarily reimburse the Medicare program for these costs, the Medicare Secondary Payer Act allows Medicare and the MA plans to sue the liable insurers directly and recover, not only the amount actually paid for the patient's treatment, but actually DOUBLE that amount. The double damages provision is designed to act as a hammer against insurers who do not reimburse Medicare in good faith. Absent the double damages award, these third-party insurers have no incentive to reimburse Medicare timely or even at all.

In November, in *MSP Recovery Claims, Series LLC v. ACE Am. Ins. Co.*, 974 F.3d 1305 (11th Cir. 2020) (MSP), a Federal Court determined that this same private right to sue the primary insurers for double damages is not limited to the Medicare program or MA plans, but is also available to physician groups and other downstream providers who remain unpaid for the cost of caring for patients covered under these policies. In a decision vigorously opposed by the insurance lobby, the Court stated that this "is a broadly worded provision that enables a plaintiff to vindicate harm caused by a primary plan's failure to meet its [Medicare Secondary Payer] primary payment or reimbursement obligations." In the MSP case, the Plaintiff was not even a downstream provider but instead was a collections agency that purchased the assignment of these claims from downstream providers and then sought to collect on them. This decision paves the way for downstream providers and shrewd business people to make insurers pay for their failure to comply with their obligations under the Medicare Secondary Payer law.

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ABOUT POLSINELLI'S HEALTH CARE PRACTICE

The Polsinelli Health Care practice represents one of the largest concentrations of health care attorneys and professionals in the nation. From the strength of its national platform, the firm advises clients on the full range of hospital-physician lifecycle and business issues confronting health care providers across the United States.

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As one of the fastest-growing health care practices in the nation, Polsinelli has established a team that includes former in-house counsel of national health care institutions, the Office of Inspector General (OIG), and former Assistant U.S. Attorneys with direct experience in health care fraud investigations. Our group also includes current and former leaders in organizations such as the American Hospital Association. Our strong Washington, D.C., presence allows us to keep the pulse of health care policy and regulatory matters. The team's vast experience in the business and delivery of health care allows our firm to provide clients a broad spectrum of health care law service.

Understanding the nuances of Medicare, Medicaid, private and other payor reimbursement is one of the greatest challenges that providers face in today's quickly changing health care world. The Reimbursement Institute's Advisors help organizations clear those hurdles in aim of providing the best care possible.

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2021 Healthcare Dealmakers Virtual Conference
May 12-13, 2021
The Healthcare Dealmakers Conference is in its 14th year and together with our sponsors, we plan to carry out this one-of-a-kind event and empower healthcare leaders from across the country by keeping this group together during the continued uncertainty surrounding COVID-19.

Med Staff Virtual Leadership Conference
March 5, 12, 19 & 26, 2021

Contact Sinead McGuire with any questions about any upcoming Polsinelli Health Care events.

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