Protecting Patients from Surprise Bills: Colorado's Out-of-Network Law

April 21, 2022

CIVHC

CENTER FOR IMPROVING VALUE IN HEALTH CARE

Agenda

- Colorado out-of-network legislation rules and regulations
- Updates to Colorado's law in light of the Federal "No Surprises" Act
- Challenges and solutions to using claims data to estimate payment parameters
- Stakeholder engagement process used to refine CO APCD data methodology
- Questions/Feedback from Participants
- Housekeeping: Session is being recorded, questions via the chat box

Presenters

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Our Mission

We strive to empower individuals, communities, and organizations through collaborative support services and health care information to advance the Triple Aim: Better Health, Better Care, Lower Cost

We are:

- Non-profit
- Independent
- Objective

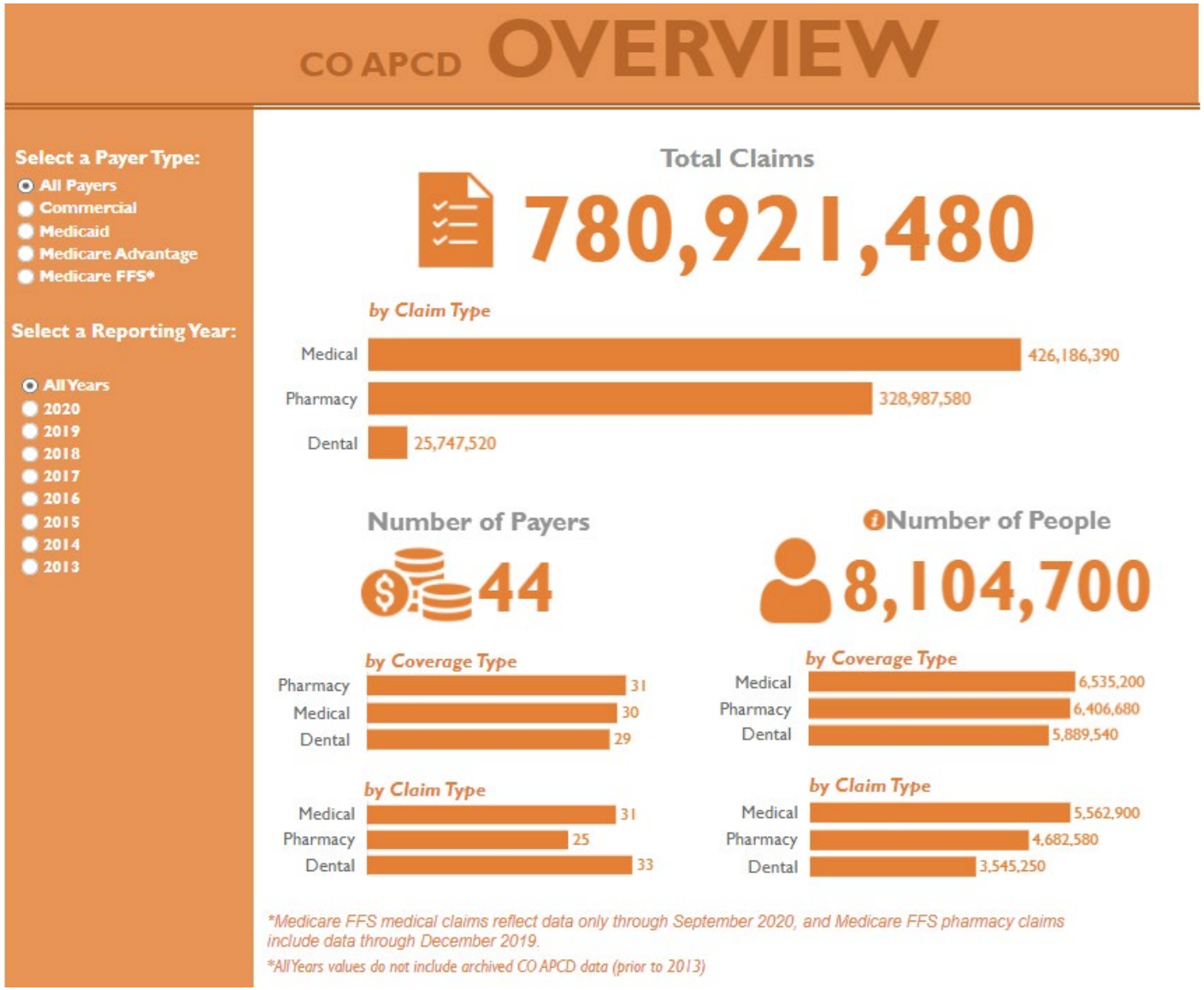
Who We Serve

Change Agents

Individuals, communities, or organizations working to lower costs, improve care, and make Colorado healthier.

What's in the CO APCD?

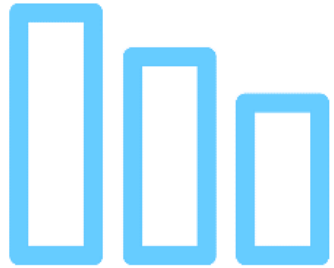
- https://www.civhc.org/get-data/whats-in-the-co-apcd/



How We Inform

Public CO APCD Data

Identify opportunities for improvement and to advance health care through public reports and publications



Non-Public CO APCD Data

Datasets and reports to address specific project needs aimed at better health, better care and lower costs

Division of Insurance

Colorado's Surprise Billing Law

Jill Mullen, Division of Insurance

HB19-1174 Out-of-Network Health Care Services

- Effective January 1, 2020
- HB19-1174 protects individuals from receiving a surprise bill when receiving emergency care from an out-of-network provider or facility, or when receiving non-emergency care at an in-network facility from an out-of-network provider.
- The bill also:
  - Establishes payment rates for out-of-network providers;
  - Requires carriers, providers and facilities to provide disclosures to consumers about receiving out-of-network care;
  - Creates an arbitration process to use to settle billing disputes between providers and carriers;
  - Requires carriers to report on the use of out-of-network providers and the impact on premiums.

HB19-1174 - Payment Framework

- Carriers must reimburse the **out-of-network provider** the greater of:
  1) 110% of the carrier's median in-network rate for that service in the same geographic area;
  2) The 60th percentile of the in-network rate for the same service in the same geographic area for the prior year based on commercial claims data from the Colorado All-Payer Health Claims Database (APCD); or
  3) A negotiated reimbursement rate.
- Carriers must reimburse the **out-of-network facility** the greater of:
  1) 105% of the carrier's median in-network rate for that service provided in a similar facility or setting in the same geographic area;
  2) The median in-network rate for the same service provided in a similar facility or setting in the same geographic area for the prior year based on claims data from the Colorado APCD; or
  3) A negotiated reimbursement rate.

HB19-1174 - Arbitration

- Arbitration may be requested if a provider believes a payment made was not sufficient given the complexity and circumstances of the services provided.
- When the parties to a billing dispute are unable to resolve the matter through an informal settlement teleconference, an arbiter is appointed.
- “Baseball arbitration”
- Losing party pays the arbitration fees

Federal No Surprises Act

- Effective January 1, 2022
- NSA's standards serve as a minimum floor of consumer protection- states can impose requirements on providers and facilities that are more protective of consumers
- Implementation and enforcement of the No Surprises Act will involve both federal and state governments.

HB22-1284 Health Insurance Surprise Billing Protections

- Post-stabilization services
- Patient Disclosures
- Notice and Consent Timelines
- Ancillary Services
- Continuity of Care

Next Steps

- HB22-1284 move through Colorado legislature
- Federal rulemaking
- Division rulemaking

Questions?

Out-of-Network CO APCD Support

- Claims data to support implementation of HB 19-1174
- Establishes payment limits to protect patients from surprise billing from out-of-network providers
- CO APCD was named as the source of data to establish amounts that out-of-network providers can bill and get paid.
- Payment amounts are calculated for each of the nine Division of Insurance (DOI) rate setting regions

Legislation Background

- Prior to 2019 several legislative attempts to address surprise billing issues in Colorado failed
- Major stakeholder groups engaged in discussions in advance of the 2019 session, data was necessary to establish payment parameters
- Data from the CO APCD was ultimately used, making this legislation possible.
- Analyses from the CO APCD provided an objective view into what was “typical” in terms of payments for in-network providers

Legislative Background

- Major stakeholders engaged in the legislative discussions included:
  - Governor's Office
  - Colorado Division of Insurance (DOI)
  - Colorado Consumer Health Initiative (CCHI)
  - Colorado Association of Health Plans (CAHP)
  - Colorado Medical Society
  - Other medical specialty associations such as: the Colorado Society of Anesthesiologists; the Emergency Medical Services Association of Colorado and practices providing neuromonitoring services

CO APCD Data Requests

- Several stakeholder groups requested data from the CO APCD to better understand potential financial impact
- CIVHC provided data to these groups, which all requested to view the data in a different way depending on their specialty or perspective
- CIVHC supported the requests and selected sets of codes and services based on feedback from these groups
- As the bill was debated, the data parameters changed frequently and all groups were challenged to understand the potential final impact
- Data from the CO APCD was critical during the legislative process

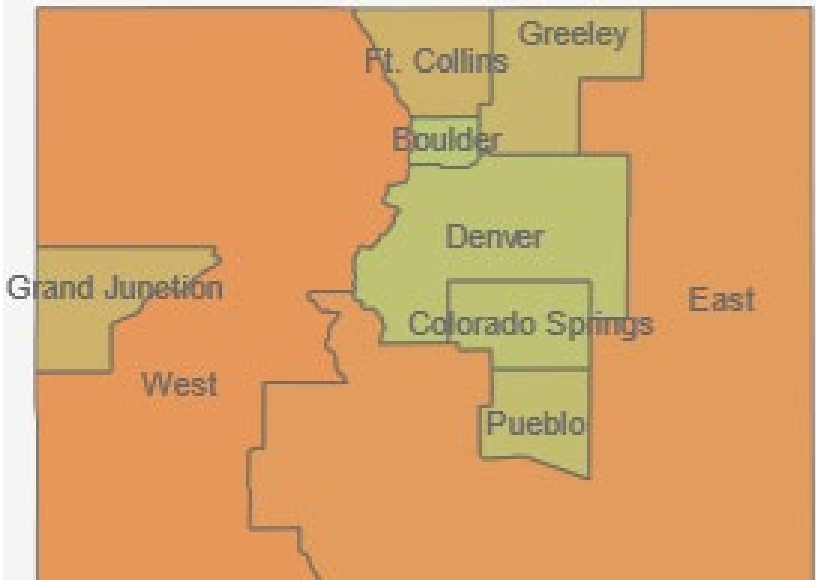
Standard Methodology

- Data set with payment schedule is produced once a year:
  - Professional Services: 60th percentile allowed amounts*
  - Emergency Services: 50th percentile allowed amounts*
- Data is reported annually with the most recent calendar year available
  - Data is provided to the DOI in December each year with the previous year's data set.

*Allowed amounts are actual paid amounts that health insurance payers and patients paid for services based on claims in the CO APCD

Standard Methodology continued

- DOI Geographic Rate Setting Regions:
  - Nine distinct regions.
  - 30 claims threshold per DOI region, or at the Statewide level.



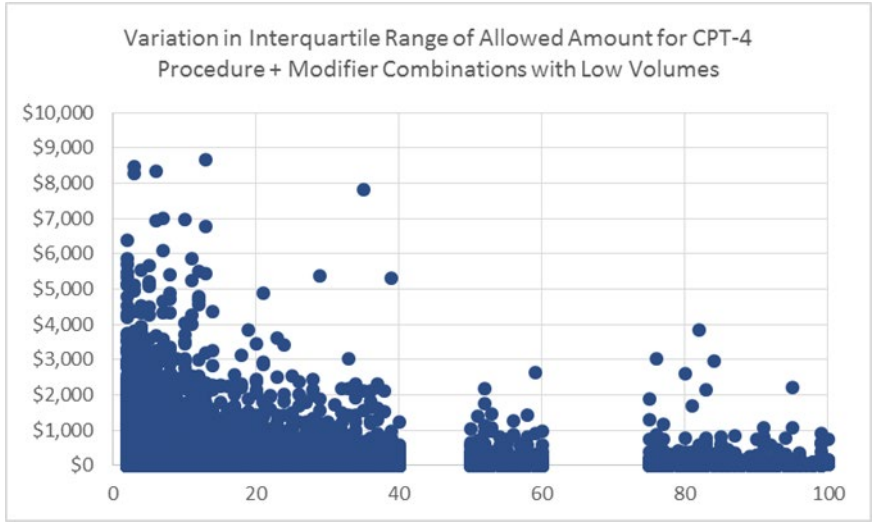
DOI Region No.	DOI Region Name
1	Boulder
2	Colorado Springs
3	Denver
4	Ft. Collins
5	Grand Junction
6	Greeley
7	Pueblo
8	East
9	West

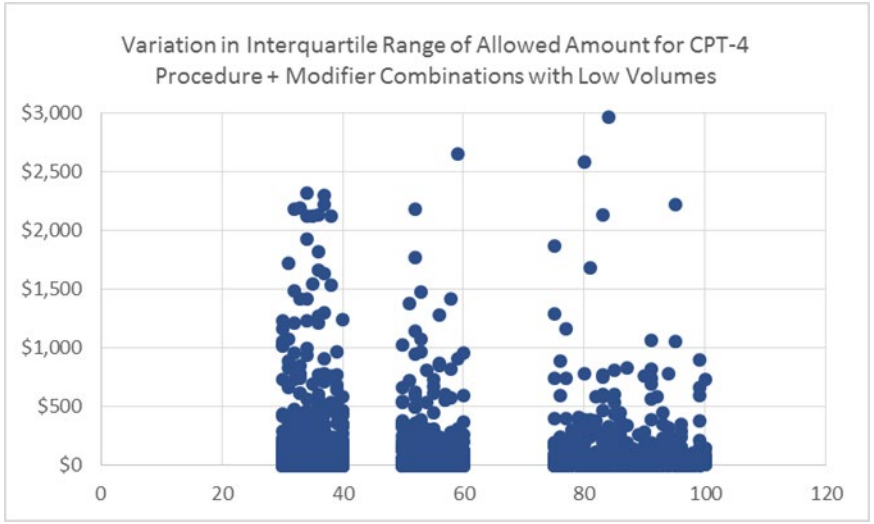
Data Method Hurdle #1: Volume

- Determining a stable rate of reimbursement requires sufficient volume
- HB-19 1174 defines a specific process for determining rate:
  - If volume of services falls below threshold in DOI region, statewide in-network CO APCD allowed amount is used
  - If statewide volume falls below threshold, fee based on the payer median is only source
  - If payer does not have an in-network rate, then goes to arbitration (Note: arbitration can be initiated for other reasons)
- Essential question: what should the volume threshold be?

Volume Threshold

- To establish a volume threshold, evaluated interquartile range of allowed amounts for CPT-4 code + modifier combinations <30, 30-40, 50-60 and 75-100 claims
- Recommended volume threshold of **30 claims**





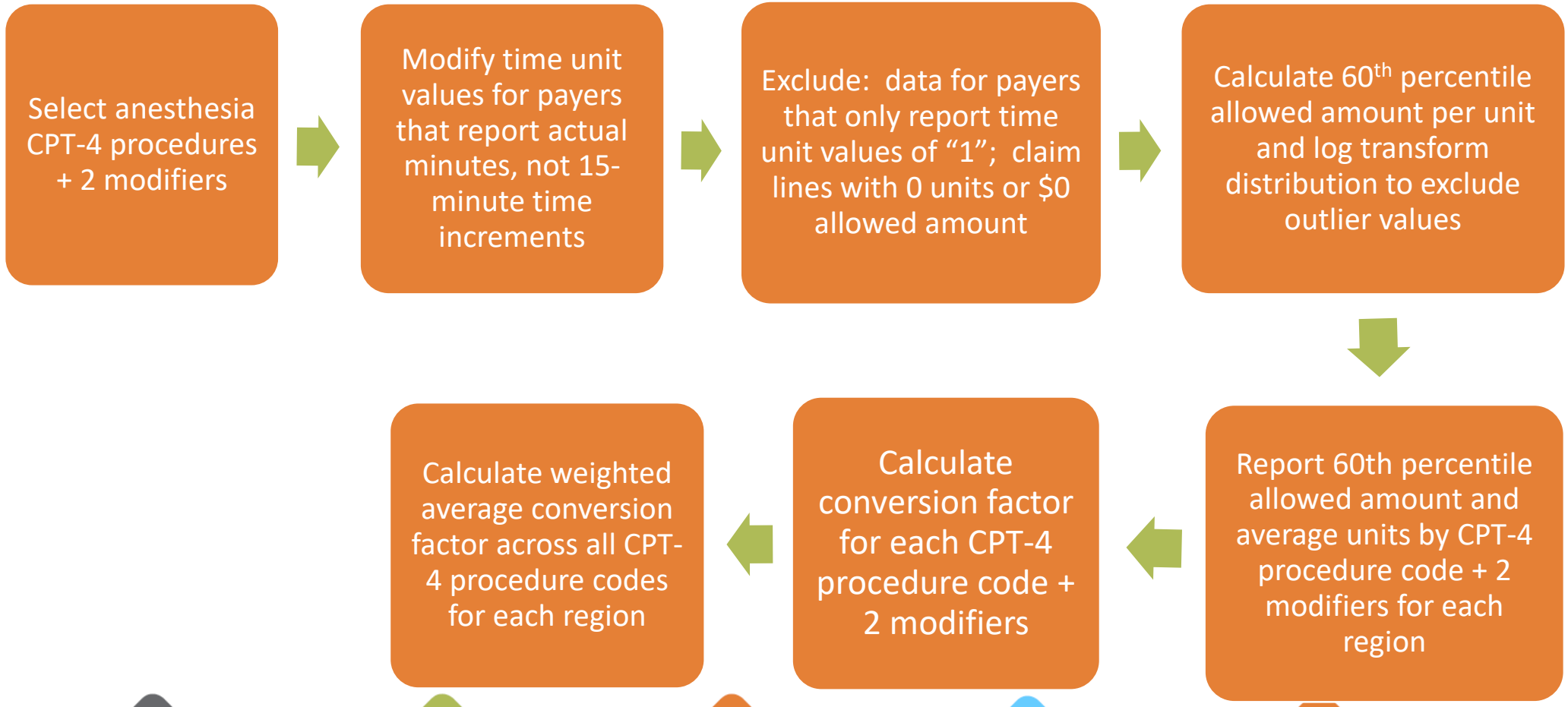
Data Method Hurdle #2: Anesthesia

- Payment based on many factors – CPT-4 procedure, provider/provider role, patient physical status and time units
- Anesthesia claims data as submitted to the CO APCD presents significant problems
  - Volume can be small for many CPT-4/modifier combinations
  - Time units are reported using different definitions (e.g., actual minutes vs. 15 minute increments)
  - Some payers hard-coded time unit values as “1”

Anesthesia Solution

- Adopted method used by state of Oregon, which is based on a calculated regional conversion factor
- Conversion factor is a dollar value, which, when combined with CPT-4 base units, modifiers and time unit values, produces the payment amount
- Establishes a mechanism for payers to enter CPT-4 procedure code + modifiers and time units to calculate CO APCD-based fee
- Uses the aggregate of all available “clean” data to report anesthesia conversion factors; low volumes less of problem
- Worked closely with payers to fix quality issues with units

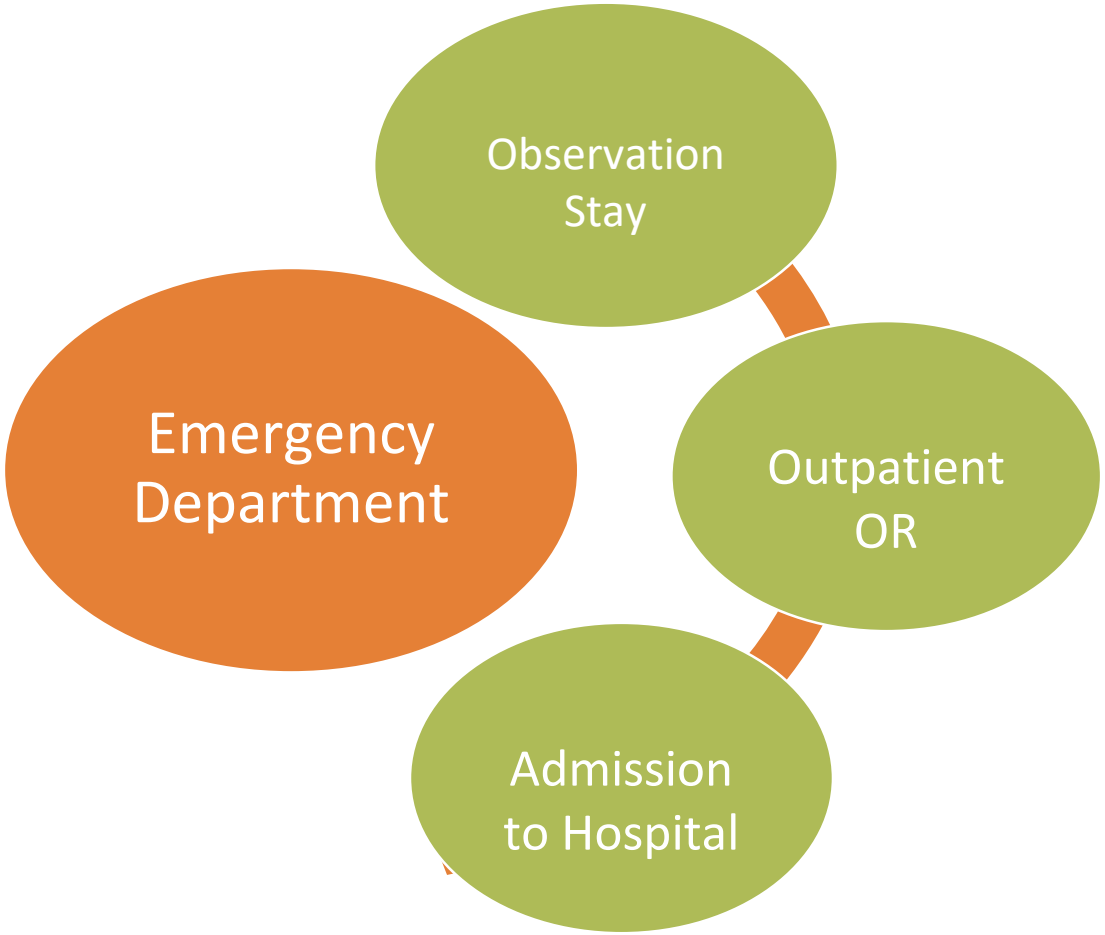
Anesthesia Fee Calculation Process



Data Method Hurdle #3: Emergency Facility Services

- Significant percentage of in-network services with $0 allowed amount – bundled services
- Services in bundles differ by payer and by emergency services evaluation & management code
- Emergency services can encompass a variety of hospital services, depending on the patient's condition and health care needs

Services Beyond the Emergency Department



Emergency Services – Case Rates

- Calculated case rates for most emergency services
- Fee schedules established for
  - Emergency room services case rate, by evaluation & management code, excluding high-cost services
  - Carve-outs for high-cost emergency services (e.g., high-cost drugs, implants, advanced imaging, nuclear medicine, cardiac catheterization, trauma activation)
  - Observation case rates, by E&M code
  - Outpatient OR case rates, CPT-4 procedure
  - Admissions from the ED, by MS-DRG

Admission from Out-of-Network ED

- Allowed amount for admissions following a visit to an out-of-network ED, defined by MS-DRG
- Challenges
  - HB 19-1174 addresses only services before stabilization
  - No mechanism to separate ED services from inpatient services acceptable to providers and payers when patient is stabilized and transferred to in-network facility
  - Low volumes for many MS-DRG
- Potential solution – attempt to split bills for ED and for inpatient services before transfer to in-network hospital

Data Method Hurdle #4: Ambulance Services

- Low volume; in-network ambulance services in the CO APCD accounted for only 20% of all commercial claims for ambulance services
- Public and private ambulance services
- Because of low volumes, heterogeneity of ambulance service providers and provider financials, CO APCD not used
- DOI developed payment formula, based on Medicare rates

2021 Addition: COVID Methodology

- Separate fee schedule was added in light of the COVID-19 Pandemic.
  - Primary reason: COVID-19 related fees are covered under an emergency order during the time period.
- COVID related services reported at 50th percentile only.
- Time period used was January 2020- June 2021 to obtain at least twelve months of data during the regulation.
  - Unique to the COVID fee schedules, and does not apply to the standard fee schedules.

COVID Methodology continued

- After collecting sufficient runout of COVID-19 claims data in the CO APCD, it was determined that COVID treatment and testing be separated:
  - **Testing split between:**
    - **Professional**: Captures tests billed on a Professional claim.
    - **Facility:** Includes any COVID tests billed on Non-emergent facility claims.
  - **Treatment split between:**
    - **Outpatient treatment:** Non Emergent OP facility claims associated with Primary Diagnosis code of U0571
    - **Inpatient Treatment:** Includes Non Emergent IP facility claims with principal Diagnosis code of U0571, and with MS-DRG codes that are billed regularly billed for COVID treatment.

Gaps in Delivering Fee Schedules

- Low volume of services
- Invalid data; exclusion of these data adds to problem of low volume
- Empirical data sometimes produces unusual results, particularly if fees are largely influenced by small number of payers
- No standard method of defining services for establishing fee schedules
- Limitations of legislation; admissions from ED

Lessons Learned

- Engage with stakeholders (consumers, state agencies, legislators, payers and providers) early
- Establish mechanism to communicate and resolve methodological challenges with all parties
- Work with payers to fix invalid data (e.g., unit values for anesthesia services)
- Potential updates in the future:
  - Additional fee schedule reference when CO APCD volumes are too low
  - Solution to problem of payment for post-stabilization for patients admitted from the ED

Published Results- Example 1

- Example of CPT Code 99213- Outpatient Evaluation &Management of an established patient.

1a. Professional excl. Anesthesia with Unit Indicator

DOI NUMBER	CPT4 CODE	MODIFIER	60th PERCENTILE	STATEWIDE USED	PER UNIT
1	99213	$	76.47	0	0
2	99213	$	88.21	0	0
3	99213	$	101.50	0	0
4	99213	$	73.26	0	0
5	99213	$	79.38	0	0
6	99213	$	83.30	0	0
7	99213	$	73.25	0	0
8	99213	$	62.91	0	0
9	99213	$	121.11	0	0

Published Results – Example 2

- Example of CPT Code 43239- Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple.

4. Outpatient OR Procedures

DOI NUMBER	CPT4 CODE	50th PERCENTILE	STATEWIDE USED
1	43239	$ 4,865.63	1
2	43239	$ 4,865.63	1
3	43239	$ 4,865.63	1
4	43239	$ 4,865.63	1
5	43239	$ 4,865.63	1
6	43239	$ 4,865.63	1
7	43239	$ 4,865.63	1
8	43239	$ 4,865.63	1
9	43239	$ 4,865.63	1

COVID Published Results – Example

- Example of Code 0202U- Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific (SARS-CoV-2), qualitative RT-PCR, nasopharyngeal swab.

COVID Professional Testing

DOI NUMBER	CPT4 CODE	MODIFIER	50th PERCENTILE	STATEWIDE USED	PER UNIT
1	0202U	$	433.94	1	0
2	0202U	$	433.94	1	0
3	0202U	$	619.91	0	0
4	0202U	$	200.00	0	0
5	0202U	$	433.94	1	0
6	0202U	$	416.78	0	0
7	0202U	$	433.94	1	0
8	0202U	$	433.94	1	0
9	0202U	$	433.94	1	0

COVID Published Results – Example

- Example of MS DRG 177- Respiratory Infections and inflammations with Major Complication or Comorbidity (MCC).

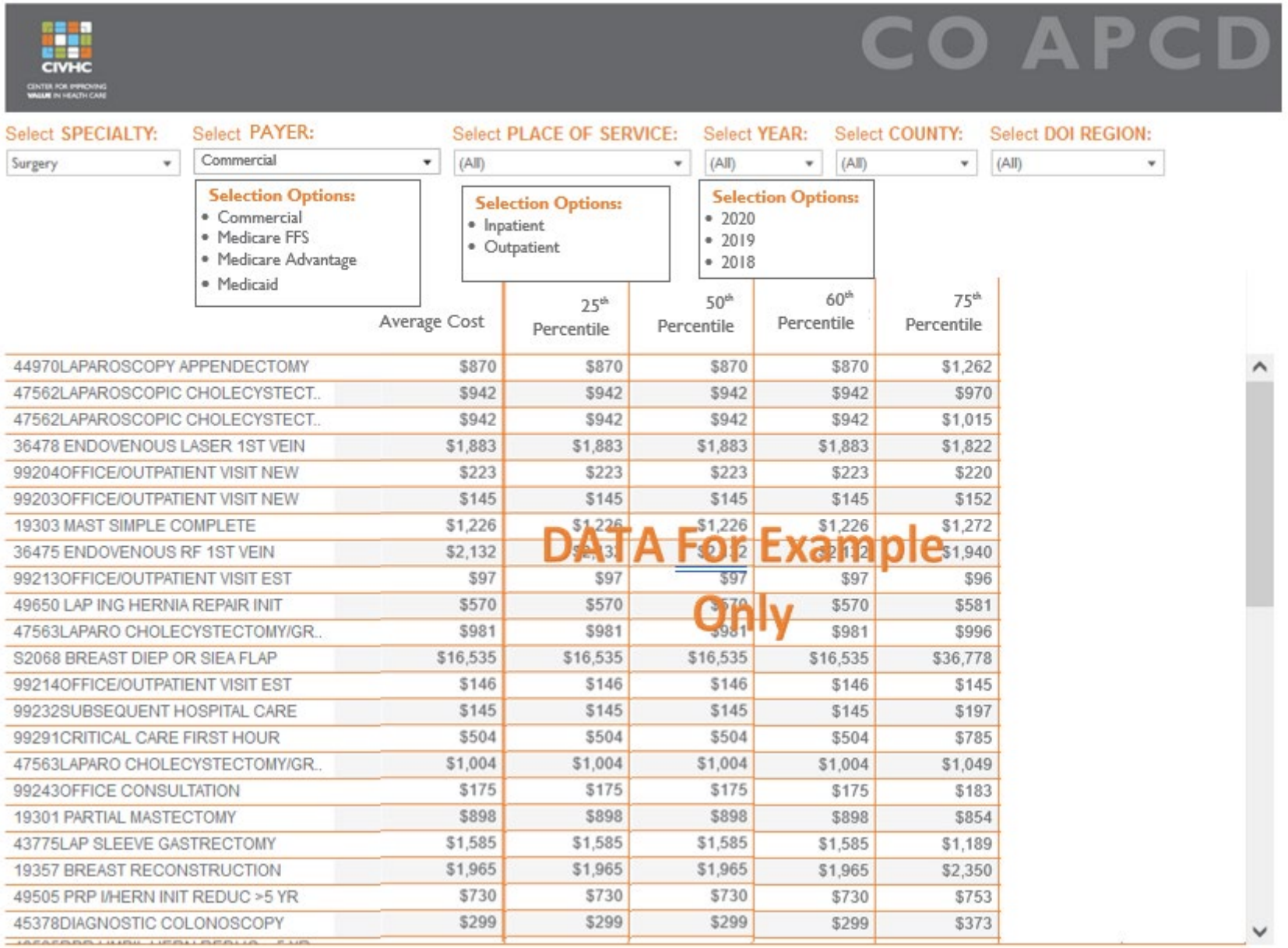
COVID Inpatient Treatment

DOI NUMBER	MSDRG CODE	50th PERCENTILE	STATEWIDE USED
1	177	$ 27,916.58	0
2	177	$ 26,450.25	0
3	177	$ 18,343.00	0
4	177	$ 28,973.81	0
5	177	$ 20,473.07	1
6	177	$ 15,251.78	0
7	177	$ 27,177.58	0
8	177	$ 15,367.78	0
9	177	$ 13,219.04	0

Future Transparency Efforts – SB22 068

- Provider Tool to View CO APCD Data
  - Enables stakeholders to view in-network payments for services (CPT, HCPCS codes with sufficient) by region (county/DOI/statewide)
  - Requires CIVHC to produce a tool to view the information online
  - First release due January 2023 and must include data from 2018 through most current year available, with annual updates
  - Allowed amounts for in-network providers at the 25th, 50th, 60th, and 75th percentile

Provider Tool Example



	Average Cost	25th Percentile	50th Percentile	60th Percentile	75th Percentile
44970LAPAROSCOPY APPENDECTOMY	$870	$870	$870	$870	$1,262
47562LAPAROSCOPIC CHOLECYSTECT..	$942	$942	$942	$942	$970
47562LAPAROSCOPIC CHOLECYSTECT..	$942	$942	$942	$942	$1,015
36478 ENDOVENOUS LASER 1ST VEIN	$1,883	$1,883	$1,883	$1,883	$1,822
99204OFFICE/OUTPATIENT VISIT NEW	$223	$223	$223	$223	$220
99203OFFICE/OUTPATIENT VISIT NEW	$145	$145	$145	$145	$152
19303 MAST SIMPLE COMPLETE	$1,226	$1,226	$1,226	$1,226	$1,272
36475 ENDOVENOUS RF 1ST VEIN	$2,132	$2,132	$2,132	$2,132	$1,940
99213OFFICE/OUTPATIENT VISIT EST	$97	$97	$97	$97	$96
49650 LAP ING HERNIA REPAIR INIT	$570	$570	$570	$570	$581
47563LAPARO CHOLECYSTECTOMY/GR..	$981	$981	$981	$981	$996
S2068 BREAST DIEP OR SIEA FLAP	$16,535	$16,535	$16,535	$16,535	$36,778
99214OFFICE/OUTPATIENT VISIT EST	$146	$146	$146	$146	$145
99232SUBSEQUENT HOSPITAL CARE	$145	$145	$145	$145	$197
99291CRITICAL CARE FIRST HOUR	$504	$504	$504	$504	$785
47563LAPARO CHOLECYSTECTOMY/GR..	$1,004	$1,004	$1,004	$1,004	$1,049
99243OFFICE CONSULTATION	$175	$175	$175	$175	$183
19301 PARTIAL MASTECTOMY	$898	$898	$898	$898	$854
43775LAP SLEEVE GASTRECTOMY	$1,585	$1,585	$1,585	$1,585	$1,189
19357 BREAST RECONSTRUCTION	$1,965	$1,965	$1,965	$1,965	$2,350
49505 PRP I/HERN INIT REDUC >5 YR	$730	$730	$730	$730	$753
45378DIAGNOSTIC COLONOSCOPY	$299	$299	$299	$299	$373

Questions and Feedback

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