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WHAT YOU NEED TO KNOW ABOUT ASSEMBLY BILL 72: INDEPENDENT DISPUTE RESOLUTION PROCESS

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Passed in September 2016 and effective July 1, 2017, Assembly Bill (AB) 72 is intended to eliminate surprise balance billing for consumers who receive non-emergency treatment from out-of-network providers at in-network facilities. To resolve payment disputes between providers and plans, the bill calls for the creation of an independent dispute resolution process (IDRP). By September 1, 2017, two months after the bill goes into effect, the legislation requires the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) to establish identical regulations "for the submission, receipt, processing, and resolution of claim payment disputes…".[1] AB 72 provides parameters that DMHC and CDI must follow when creating the IDRP in Section 1371.30 of the California Health and Safety Code, but certain items of the bill, such as the composition, day-to-day functioning, and payment structure of the IDRP, will require regulatory action from DMHC / CDI.

In the two months between when the law takes effect and when the Departments establish official regulations, they may take actions necessary to implement the law, including issuing all-plan letters "…or similar instructions."[2] Until either department releases guidance, it is unknown how the IDRP will be structured. Some potential models already exist, however, that may inform how the regulators proceed.

ABOUT AB 72

AB 72 requires the IDRP to include the following components:

- Before initiating the IDRP, the provider and plan must complete the plan's internal dispute resolution process.
- If either party initiates the process, the other party must participate.
- Providers will be allowed to bundle similar claims submitted to the same plan.
    - The legislation does not set a limit on how many claims may be bundled for one complaint.
- The deciding authority in the process must base its decision on "all relevant information."[3]
    - In a draft version of AB 72, dated August 4, 2016, this provision was more detailed, suggesting what lawmakers may have intended. Instead of simply stating that the decision must be based on "all relevant information," it said that the decision would be based on "…all relevant information, including, but not limited to, the reimbursement amount suggested by either party."[4]

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- Any decisions issued via the IDRP will be binding on both parties, although either party may appeal under "any other applicable law."[5]

- While the legislation does not explicitly say that DMHC / CDI must contract with an independent organization, there is an entire section in the legislation dedicated to establishing how the Departments must proceed should they decide to "outsource" this process.

    - DMHC / CDI may contract with one or more independent organizations to oversee the IDRP, as long as the organizations have no ties to either party in the dispute.

    - DMHC / CDI must establish conflict-of-interest standards that an independent organization must meet to oversee the IDRP.

    - DMHC / CDI may contract with the same organization(s), which will be known as "consultants."

- Both parties will be responsible for any administrative fees associated with the IDRP (although it is not clear if or how the fees may be divided between the parties).

EXISTING DMHC INDEPENDENT DISPUTE RESOLUTION PROCESS

DMHC has an IDRP in place to resolve claim payment disputes, which applies to non-contracted providers who perform emergency services. DMHC contracts with a private provider, MAXIMUS Federal Services, Inc. (MAXIMUS), to provide "…a mechanism for resolving claims disputes and to ensure that providers are paid fairly for services provided to Health Plan enrollees."[6]

The existing IDRP process is rarely used. In fact, between 2010 and 2014, there were only 32 cases. Twenty-two favored the insurer, seven favored the provider, and the remainder were partially in favor of each party.[7] Nonetheless, this information is worth examining to predict how DMHC / CDI may structure the IDRP described in AB 72. DMHC's existing process includes the following:

- Before initiating an IDRP, the provider must complete the plan's internal dispute resolution process.

- The provider must initiate the IDRP by submitting an IDRP Request Form to DMHC and the plan may choose whether to participate; the process is voluntary.

    - If the plan chooses to participate, any relevant claim information must be sent to the IDRP External Reviewer (the deciding authority).

    - If the plan declines participation, data regarding its decision and any relevant information is included in a DMHC analysis of potential unfair payment patterns by the plan.[8]

- Providers are allowed to bundle up to 50 similar claims in one IDRP Request Form.

- The contract between DMHC and MAXIMUS requires External Reviewers to be assigned cases "…based upon education, background, medical claims payment experience and clinical experience, including consideration of their expertise in the same or similar specialties that perform or evaluate the health care service at issue."[9]

- The IDRP External Reviewer must choose either the provider or the plan's suggested claim amount and may not come up with a different figure or split the difference. The IDRP External Reviewer is tasked with determining which amount is the most "reasonable and customary" for the services rendered, as defined by the DMHC regulation section 1300.71(a)(3)(B).[10] There are six criteria (also known as the Gould criteria) defined in the regulations for determining what is "reasonable and customary:"
    - The provider's training, qualifications, and length of time in practice
    - The nature of services provided
    - The fees usually charged by the provider
    - Prevailing provider rates charged in the general geographic area where services were rendered
    - Other aspects of the economics of the medical provider's practice that are relevant
    - Any unusual circumstances in the case[11]
- Decisions of the IDRP External Reviewer are non-binding.
- IDRP decisions are typically issued within 60 days of receiving provider and plan documentation.[12]
- If the IDRP determines that a plan owes a provider, the plan must pay the provider within 15 days of being notified of the decision from DMHC.[13]
- There is no filing fee for individual physicians, while hospital providers must pay filing fees to MAXIMUS contingent on how many claims they submit. This appears to be the only administrative fee required of the parties.

EXISTING DMHC INDEPENDENT MEDICAL REVIEW SYSTEM

DMHC uses an independent medical review (IMR) system to resolve disputes between a consumer and a plan regarding whether certain health care services are medically necessary. DMHC "outsources" this process to a contractor to facilitate.

- A consumer must initiate the IMR process by filing an Independent Medical Review Application with DMHC, along with any relevant paperwork.
- DMHC's IMR will be the only IMR process regarding medical necessity of covered health services and "shall resolve decisions that deny, modify, or delay health care services…" suggesting that the IMR process is binding.
- Upon determining that the consumer qualifies for an IMR, DMHC outsources the process to an independent medical review organization.
    - Notably, there are no provisions addressing the nature or composition of such an organization.

- All reviewers (the regulations do not stipulate how many reviewers there may be) must issue separate analyses of the consumer's case to explain how they reached their decision.

EXISTING NEW YORK INDEPENDENT DISPUTE RESOLUTION PROCESS

In 2015, New York passed legislation similar to AB 72, which eliminates surprise billing for consumers who receive emergency services from out-of-network providers at in-network hospitals. The legislation called for the creation of an IDRP, which is administered by private contractors.

- The provider must initiate the IDRP by completing an online application, provided by the Department of Financial Services (DFS), and sending it to the independent deciding authority (contractor) to which DFS assigns the case.
- The legislation provides clear guidelines on who is qualified to review these cases. A reviewer must:
    - Have training and experience in health care billing, reimbursement, and usual and customary consultations
    - Conduct the review with the cooperation of a practicing licensed doctor with experience in the same or similar specialty to the provider in the case
- The deciding authority must consider several factors in making its decision:
    - Whether a gross disparity exists between the provider's fee and the health plan's reimbursement for the same or similar services in the same area
    - The provider's credentials
    - The case's particular circumstances and complexity
    - The patient's characteristics
    - The usual cost of the service[14]
- All decisions will be issued within 30 days of receipt of the dispute.
- All decisions are binding, and the review is admissible in court.
- The party that loses the dispute must pay for the cost of the process, unless the parties reach a settlement, in which case the cost of the process is split between the parties.

EXISTING DHCS EMERGENCY SERVICES CLAIMS DISPUTE RESOLUTION PROCESS

California's Medicaid administrator, the Department of Health Care Services (DHCS), has an in-house process for resolving payment claims disputes between Medi-Cal managed care plans and out-of-network emergency services providers.[15]

- To initiate the process, providers must mail an "Emergency Services Claim" to DHCS within 120 days after the dispute in question.

- The plan must file a response to the provider's claim called the "Notice of Defense" with DHCS and the provider within 60 days of receipt of the claim.
- The hearing officer (an administrative law judge) may bundle claims involving the same parties in similar disputes.
- Upon the filing of the Notice of Defense, either party has 20 days to request a hearing; without a hearing request, the hearing officer renders his/her decision based on the written record.
- Similar to New York's IDRP, the hearing officer may use a medical consultant employed by DHCS. The medical consultant must have experience or qualifications relevant to the case and is charged with investigating the dispute and submitting a written report of his/her findings, which will be entered into the official hearing record.
- The burden of proof largely falls on the provider to supply a preponderance of evidence to support entitlement to relief.
- The hearing officer's ruling is final and considered to be issued by the Director of DHCS, although the Director has the final power to approve or overturn the hearing officer's decision. Either party may seek judicial review if they disagree with the Director's final decision.
- Caps are placed on the plan's financial liability to the provider and the amount the plan owes to a provider must not exceed the lower of either:
    - "The usual charges made to the general public by the provider"[16]
    - The standard Medi-Cal rates for similar services

CONCLUSION

According to the DMHC, an initial draft of the IDRP regulations will be available in June 2017. Stakeholder meetings were meant to begin as early as March 2017, although the Department announced in May that the first meeting would be on June 26, 2017. In the meantime, it is helpful to consider how the Department and other similar agencies have acted in the past in managing an IDRP, as well as how other states with similar legislation currently operate their IDRPs.

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1 California Health and Safety Code, Section 1371.30 (b)(1).
2 California Health and Safety Code, Section 1371.30 (j).
3 California Health and Safety Code, Section 1371.30 (b)(5)
4 AB 72 Draft Legislation, August 4, 2016, http://leginfo.legislature.ca.gov/faces/billVersionsCompareClient.xhtml?bill_id=201520160AB72&cversion=20150AB7294AMD.
5 California Health and Safety Code, Section 1371.30 (d)
6 Department of Managed Health Care and MAXIMUS Federal Services, Inc., "State of California, Standard Agreement, DMHC No. 16MC-SA020," March 17, 2017, P. 1.
7 Joy Han, "Response to Your Mar. 16, 2017 PRA Request (2017-0074)," Message to the author, May, 19, 2017, E-mail.
8 Department of Managed Health Care, "Independent Dispute Resolution Process Payer Decline to Participate Letter."
9 Department of Managed Health Care and MAXIMUS Federal Services, Inc., "State of California, Standard Agreement, DMHC No. 16MC-SA020," March 17, 2017, P. 3.
10 Department of Managed Health Care and MAXIMUS Federal Services, Inc., "State of California, Standard Agreement, DMHC No. 16MC-SA020," March 17, 2017, P. 1.
11 California Code of Regulations, Title 28, Section 1300.71(a)(3)(B).
12 Department of Managed Health Care, "Independent Dispute Resolution Process," April 17, 2017, P. 3.
13 Department of Managed Health Care, "Independent Dispute Resolution Process: Instructions," P. 2.
14 New York Department of Financial Services, Health Insurance Resource Center, "Protection from Surprise Bills and Emergency Services," http://www.dfs.ny.gov/consumer/hprotection.htm.
15 California Code of Regulations, Title 22, Sections 53620 – 53702.
16 California Code of Regulations, Title 22, Section 53698