



October 2016

## CA Governor Signs “Surprise Medical Bills” Legislation

On September 23, 2016, California Governor Jerry Brown signed Assembly Bill 72 (Bonta, D-Oakland), which will have significant ramifications on a number of issues between health care providers and payors.

The bill applies to non-emergency services provided by out-of-network individual health care providers at in-network facilities and limits reimbursement to such providers. Delegated entities are required to comply with this bill if a health plan or health insurer delegates payment functions. The bill does not apply to Medi-Cal

managed care health plans or other plans governed by contracts with the Department of Health Care Services (DHCS). Following is a summary and analysis of key sections of the bill.

### Patient out of the Middle

#### Summary

The bill generally prohibits an enrollee or insured from owing the non-contracting individual health professional at the contracting health facility more than the in-network cost-sharing amount. This provision applies to health plan contracts and insurance policies issued, amended, or renewed on or after July 1, 2017. For patients who have out-of-network coverage, the law has an exception if the provider gets informed written consent from the patient far enough in advance of the procedure for the patient to agree to greater exposure from using an out-of-network provider. The new law sets forth several specific requirements for a provider to implement this exception to the bill.

The bill also prohibits a non-contracting individual health professional from balance billing or collecting any amount from the enrollee or insured, and requires communications to the patient about any additional amounts being pursued from the payor to inform the patient that such communications are not a bill to the patient.

#### Analysis

subject of many recent cases. Insurers and plans sometimes take the position that discounting cost sharing constitutes fraud and interference with the insurers' contracts with their members. Providers have taken the position that discounting co-insurance or co-payment

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Following are summaries of some of the key bills impacting health care providers and physicians, enacted in the recently ended California Legislative Session.

amounts is neither fraud nor interference with contract, and is no different than when plans negotiate discounts with providers. A fundamental question raised by these co-payment waiver disputes is why plans should expect a provider to extend discounts on what the plans owe but not expect the provider to extend discounts to patients on their portion.

This legislation effectively resolves the co-payment waiver issue with regard to the services provided by out-of-network physicians at in-network facilities by requiring these physicians to discount cost sharing amounts to in-network levels. This undermines the payors' argument that non-contracted physicians are committing fraud by discounting cost sharing amounts. The bills submitted by a non-contracted physician are the same whether he or she performs the services at a contracted or non-contracted facility. HLB questions how it can be fraud if in one instance the physician is required to accept a discounted rate and in the other instance he or she is choosing to accept a discounted rate.

AB 72 is just one more in the trend of California statutes encouraging or mandating providers to relieve part of the burden that patients face for the parts of their coverage that health plans do not pay.

## **Payment Rate**

### **Summary**

The legislation requires that "the plan shall reimburse the greater of the average contracted rate or 125 percent of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered."

The law further requires that each plan submit data to the DMHC concerning its contracted rate and how it arrived at the average contracted rate. "The average contracted rate data submitted pursuant to this section shall be confidential and not subject to disclosure under the California Public Records Act."

By January 1, 2019, the DMHC is required to specify a methodology that plans and delegated entities shall use to determine the average contracted rates for services. This methodology shall take into account, at a minimum, information from the independent dispute resolution process, the specialty of the individual health professional, and the geographic region in which the services are rendered. The methodology to determine an average contracted rate shall ensure that the plan includes the highest and lowest contracted rates.

The bill provides that "the amounts paid by a plan for services under this section shall not constitute the prevailing or customary charges, the usual fees to the general public, or other charges for other payers for an individual health professional."

### **Analysis**

The bill may, in effect, establish a ceiling on contract rates. Since AB 72 requires that the plan reimburse the greater of the average contracted rate or 125% of Medicare, it provides a disincentive to plans to agree to rates greater than 125% of Medicare. By refusing to contract with physicians at rates above 125% of Medicare, a plan can force all physicians (contracted and non-contracted) to accept rates at 125% of Medicare.

Given that the contract rates are confidential, it will be difficult for providers to challenge how the plans arrived at the average contracted rates. HLB has experience from prior actions of plans not accurately reporting their data to entities that calculate reimbursement amounts.

While the bill expressly states that the amounts paid by a plan for services under this legislation "shall not constitute the prevailing or customary charges, the usual fees to the general public, or other charges for other payers for an individual health professional," providers should be concerned that payment rates in the legislation may affect courts' determinations of usual and customary amounts.

## **Independent Dispute Resolution Process (IDRP)**

### **Summary**

AB 72 allows the non-contracting individual health professional or plan/insurer to appeal a claim payment dispute. The bill requires the DMHC and the California Department of Insurance (CDI) to establish an IDRP for the purpose of resolving a claim dispute between a health plan or insurer and a non-contracting individual health professional. Both parties are required to participate in the IDRP, and the parties are required to exhaust the plan's or insurer's internal process prior to initiating IDRP. The bill permits the bundling of claims for the same or similar services provided by the individual health professional.

The bill provides that the decision is binding on both parties, but also permits a dissatisfied party "to pursue any right, remedy, or penalty established under any applicable law."

### **Analysis**

The legislation is vague as to what is to be decided in the IDRP. AB 72 provides that "[i]n deciding the dispute, the independent organization shall base its decision regarding the appropriate reimbursement on all relevant information." It is questionable if the IDRP is only intended to determine whether the average contracted rate is accurate, or if it is intended to determine a fair compensation to the provider.

It is also unclear what effect a determination of an appropriate rate in the IDRP will have on litigation in

court for reasonable and customary amounts. As noted above, the bill provides that the decision is binding on both parties, but also permits a dissatisfied party “to pursue any right, remedy, or penalty established under any applicable law.”

The requirements in AB 72 that the parties exhaust the plan’s or insurer’s internal process prior to initiating IDR, and then participate in the IDR process prior to bringing litigation over the payment rate, will pose a potential timing dilemma for individual health care providers. In a recent California Court of Appeal decision, the court held that the statute of limitations for an out-of-network medical provider’s cause of action against Blue Shield expired while the provider was still navigating the plan’s voluntary internal appeals process. *Vishva Dev, M.D., Inc. v. Blue Shield of California Life & Health Insurance Company*. The court ruled that the statute of limitations begins to run from the date of the EOB. Whether the same result would occur from a mandatory appeal process remains unaddressed by the courts.

### Assignments of Benefits

#### Summary

The bill expressly requires a health plan or insurer to authorize and permit assignment of the enrollee’s or insured’s right to any reimbursement for health care services covered under the plan contract or insurance policy to a non-contracting individual health professional for these services. However, the law also confirms that payors also must follow the statute even if there is no assignment of benefits.

#### Analysis

A growing number of states have passed legislation requiring payors to accept assignments of benefits. AB 72 is another example of such a law. Many self-funded payors have ignored these laws, asserting that they are preempted by ERISA. HLB is currently involved in litigation challenging the right of these payors to ignore assignments, and make payments to the patients, based on other laws already on the books in California. This latest law on the issue adds to the trend of legislation against the refusal of some plans to pay the providers directly.

*Hooper, Lundy and Bookman has extensive experience representing providers in disputes concerning out-of-network payment, including situations like those covered in AB 72. For additional information on this bill, please contact Daron Tooch or Glenn Solomon in Los Angeles at 310.551.8111.*

## Employers Prohibited from Soliciting Certain Juvenile Criminal History

Despite requests for veto from health care provider organizations, California Governor Jerry Brown signed Assembly Bill 1843 (Stone, D-Santa Cruz) into law on September 27, 2016.

AB 1843 prohibits California employers from asking an applicant for employment to disclose information more than five years prior to application, concerning or related to a juvenile arrest, detention, processing, diversion, supervision, conviction, or other court disposition that occurred while the person was subject to the process and jurisdiction of juvenile court law. Further, employers may not seek or utilize any such information as a factor in determining any condition of employment.

Employers may, however, ask about an arrest for which applicant is out on bail or on his or her own recognizance pending trial.

There are also two exceptions specific to health care facilities regarding arrests within the previous five years. Applicants for positions with regular access to patients may be asked about any sex crimes covered by Section 290 of the California Penal Code. Applicants for positions with access to drugs and medication may be asked to disclose controlled substance arrests under Section 11590 of the California Health and Safety Code.

The narrow exceptions are troubling to hospital, skilled nursing facility and intermediate care facilities. If, for example the individual was tried as a juvenile and convicted of molestation, sodomy or rape less than 5 years ago, employers may ask applicants to disclose this information during the hiring process. However, if over 5 years, the employer cannot do so.

Perhaps more troubling and conflicting is that a health facility can never inquire into a juvenile record more than five years old that consisted of crimes under Welfare & Institutions Code Section 707b. These consist of non-sealable offenses that include arson, kidnapping, attempted murder, assault with deadly weapon, among other crimes.

In their joint veto request, the groups stated that the bill would “create a dangerous situation for our residents and patients.”

The bill goes into effect January 1, 2017.

*For more information, please contact Mark Reagan in San Francisco at 415.875.8501.*

# New Exception to the Corporate Practice Ban for Critical Access Hospitals

On September 23, 2016, California Governor Jerry Brown signed into law Assembly Bill 2024, (Wood, D-Eureka) which includes a new exception to California's ban on the corporate practice of medicine for critical access hospitals.

This new exception, which amends California Business and Professions Code Section 2401, permits federally certified critical access hospitals to *directly employ* physicians and bill for their services so long as:

- [1] The hospital's medical staff concur by affirmative vote that the employment is in the best interest of the communities served by the hospital; and
- [2] The hospital does not interfere with, control, or otherwise direct a physician's professional judgment in a manner prohibited by Section 2400 or any other law.

The new law, which has been described as an attempt to help hospitals address physician shortages in rural areas, is scheduled to sunset at the end of 2023. In order to be certified as critical access, a hospital must have no more than 25 inpatient beds, must offer 24-hour, 7-day-a-week emergency care, must be located in a rural area and typically must be at least a 35 mile drive away from any other hospital (among other requirements).

The bill goes into effect January 1, 2017.

*HLB attorneys routinely advise hospitals with respect to physician relationships. For more information, contact Ben Durie in San Francisco at 415.875.8502.*

# New Requirements for Hospital Observation Services

On September 27, 2016, California Governor Jerry Brown signed into law Senate Bill 1076 (Hernandez–D-West Covina), which establishes new requirements for hospital observation services and units beginning January 1, 2017.

According to the bill's author, SB 1076 was introduced to address what he characterized as a "growing trend" of patients being treated as outpatients under "observation

status" for extended periods of time. In his statement, the author noted that outpatient services are not subject to many of the laws and regulations designed to ensure patient safety and adequate staffing standards in acute care hospitals.

California law distinguishes outpatient medical care, as care provided for less than 24 hours, and inpatient care, in which a patient is formally admitted and will spend at least one night in the hospital. According to an analysis of the bill, third-party payers are increasingly unwilling to authorize inpatient admissions for patients who are not expected to have an extended stay at the hospital, and asking instead that these patients be kept in the hospital under "observation" as an outpatient.

This increase in observation status has been driven, in part, by the Medicare "two-midnight rule," which states that an inpatient admission, and therefore payment under Medicare Part A, is generally only appropriate when the physician expects the patient to require a stay that crosses at least two midnights. If the physician does not expect the patient to stay in the hospital for at least two midnights, the expectation is that the patient will be treated as an outpatient, under "observation," and Medicare will reimburse providers under Part B.

1. **Definition of "Observation Services."** SB 1076 defines "observation services" as outpatient services provided by a general acute care hospital that have been ordered by a provider, for those patients who have unstable or uncertain conditions, potentially serious enough to warrant close observation, but not so serious as to warrant inpatient admission to the hospital. Observation services may include the use of a bed, monitoring by nursing and other staff, and any other services that are reasonable and necessary to safely evaluate a patient's condition or determine the need for a possible inpatient admission to the hospital.

2. **Requirements for "Observation Units."** The new law establishes the following standards for observation units:

- An "observation unit" is defined as an area in which observation services are provided in a setting outside of an inpatient unit and that is not part of the hospital emergency department.
- A hospital may establish one or more observation units. Each unit must have signage identifying the unit as an outpatient area of the hospital. The signage is intended to clearly indicate to all patients and family members that the observation services provided in the unit are not inpatient services.
- An observation unit must comply with licensed nurse-to-patient ratios as required for emergency medical services.

- The legislation does not address whether an observation unit must be located in the inpatient hospital building, or, like other outpatient services, whether it can be located in a separate building on campus that is not part of the inpatient facility.

### 3. Notice Requirements for Observation Patients.

- The hospital must provide written notice to each patient assigned to an observation unit, stating that he or she is receiving observation services. This includes a change in the patient's status from inpatient to observation.
- The notice must state that, while on observation status, the patient's care is being provided on an outpatient basis, which may affect his or her health care coverage reimbursement, and may also affect eligibility for post-hospitalization skilled nursing facility reimbursement.
- The written notice must be provided "as soon as practicable."
- The legislation does not prescribe the format or specific wording of the written notice.

*For more information, please contact Steve Lipton in San Francisco at 415.875.8490 or John Hellow or Nina Adatia Marsden in Los Angeles at 310.551.8110.*

## Legislature approves transition of CCS to Managed Care in COHS Counties 7/1/17

On September 25, 2016, Governor Jerry Brown signed Senate Bill 586 (Hernandez, D-West Covina) which will allow the Department of Health Care Services (DHCS) to establish a "Whole Child Model" for children enrolled in both Medi-Cal and the California Children's Services (CCS) Program, in designated counties.

Children who qualify for CCS by virtue of having specified conditions are often among the sickest and most vulnerable children served by Medi-Cal. However, CCS services are currently carved out of the scope of services provided or arranged by Medi-Cal managed care plans. For years, the Department of Health Care Services (DHCS) has explored ways to "carve in" these CCS services to Medi-Cal-enrolled children to Medi-Cal managed care.

SB 586 allows the DHCS to implement a Whole Child Model in 21 counties served by County Operated Health Systems (COHS) no earlier than July 1, 2017. These 21 counties are Del Norte, Humboldt, Lake, Lassen, Marin,

Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo. Under the Whole Child Model, Partnership Health Plan, CalOptima, Central California Alliance for Health, Health Plan of San Mateo, and CenCal Health may provide both Medi-Cal and CCS services to children enrolled in both programs.

The Legislature included several protections for these CCS children, including plan readiness requirements, limited continuity of care requirements, comparability to the current CCS program benefit package, timely access requirements, and a rate floor for CCS providers. The rate floor applies to all CCS providers for 12 months, and to physicians and surgeons without time limitation. However, this rate floor does not prohibit plans and providers from entering into alternative payment arrangements.

Under SB 586, CCS services will continue to be carved out of Medi-Cal managed care for the remaining 37 counties until January 1, 2022.

*For additional information, please contact Felicia Sze in San Francisco at 415.875.8503.*

## Appeals Courts Get New Deadlines to Issue Decisions on Certain Elder Abuse Cases

California Governor Jerry Brown signed Senate Bill 1065 (Monning, D-Carmel) into law on September 25, 2016, which requires state appeals courts to issue decisions relating to appeals of orders denying or dismissing a petition to compel arbitration under the Elder and Dependent Adult Civil Protection Act, no later than 100 days after the notice of appeal is filed, if the filing party has been granted a trial preference.

Courts of appeal may only be granted an extension of time if good cause is shown and the extension will promote the interests of justice.

The bill also requires the Judicial Council to adopt rules implementing the new law and shortening the time within which a party can file a notice of appeal in such cases, no later than July, 2017.

This bill originally sought to preclude a party from appealing a denial of a petition to compel arbitration when claims for elder abuse or neglect were alleged in the complaint. However, after much negotiation with stakeholders, it was amended to instead expedite the timing of such appeals involving actions with such claims.

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## 2016 Edition of CHA Hospital Compliance Manual Includes Final 60-Day Rule and More...

The California Hospital Association (CHA) has released the 2016, 7th Edition of the California Hospital Compliance Manual.

The 2016 edition has been updated to reflect CMS' revised regulations of the 60-day requirement for reporting and returning overpayments, revisions to the federal self-referral (Stark) laws, modifications to CMS's "rare and unusual" exceptions to the "two midnight" rule, and more. CHA's compliance manual is the only publication written for hospital compliance officers that integrates California with federal laws regarding high-risk compliance areas.

Written by Hooper, Lundy & Bookman, PC, attorneys and CHA, the manual focuses on key components of an effective compliance program. The manual features 700 pages of content including 16 chapters, a model hospital compliance plan, and an index. To order the new manual or for more information, visit [www.calhospital.org/compliance](http://www.calhospital.org/compliance).



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