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With MA, Commercial Payer COVID-19 Changes, Hospitals Face New Payment Deliberations

By Nina Youngstrom

When hospitals and other providers bill Medicare Advantage (MA) plans and commercial payers for coronavirus tests, they're supposed to be paid 100% of the negotiated rate or the default charge because the Families First Coronavirus Response Act,[1] as amended by the Coronavirus Aid, Relief, And Economic Security (CARES) Act,[2] prohibits patient cost sharing. But with so many payers and payment arrangements, something may get lost in translation, and hospitals may not realize they weren't paid the full amount and overcharge patients.

"It's a compliance issue that sticks with you even when you make the transition from Medicare to the commercial world," said attorney Jim Boswell, with King & Spalding in Atlanta, Georgia.

In addition to cost sharing, hospitals have to contend with prior authorization and other COVID-19-related policies to ensure they're paid in the months to come by MA and commercial plans and don't lose out in audits later. "When it comes to commercial insurance, it is a payer-by-payer, plan-by-plan, patient-by-patient analysis that can be extremely complicated to implement," Boswell said. There are a "huge number of payer policies" that are updated frequently, but aren't located in provider manuals, and they're affected by whether a patient's insurance is governed by the Employee Retirement Income Security Act (ERISA). Some policies are "sunsetting" at the end of May or in early June, which changes the revenue and compliance calculus considerably, although they could be extended, he said.

"A lot of this is following the bouncing ball as plans revert to what they were doing before and you don't get special leniency because of COVID-19," Boswell said at a webinar sponsored by the law firm May 22.

The exception is cost sharing for COVID-19 tests. The laws uniformly prohibit MA plans and commercial insurers from charging patients cost sharing (e.g., copays) for testing (in-person and by telehealth) during the public health emergency, and they can't require prior authorization for testing. "There are some nuances," Boswell said. For example, commercial insurers could impose cost sharing if testing is ordered for alternative diagnoses because providers don't think testing is warranted or COVID-19 tests weren't available. Also, patients covered by commercial payers may be tested at in-network or out-of-network providers and avoid cost sharing in either setting. But payment could be an issue, although the CARES Act governs the rate of payment, he said. According to Sec. 3202,[3] if health plans had a negotiated rate in place with providers for COVID-19 testing, it will apply during the public health emergency. If not, the health plan will pay the provider "an amount that equals the cash price for such service as listed by the provider on a public internet website, or such plan or issuer may negotiate a rate with such provider for less than such cash price."

There may be a difference of opinion, however, about the existence of a negotiated rate. "Codes are not listed in the fee schedule," so providers probably will contend there was no negotiated rate. The default rate in the payer-provider contract should probably apply for services not otherwise specified, Boswell said, "which will be a more advantageous route for the provider." Some payers may propose an amendment to the contract for COVID-19 testing, but providers will resist on the grounds they already have a negotiated or default rate.

Whatever hospitals are paid, "part of what you need to do to be sure you're paid correctly is track whether the plan paid the full allowable amount and not just the plan portion," he said.

On a circuitously related note, hospitals have to ensure that the cost sharing that patients are responsible for—treatment for COVID-19 patients, unless a commercial insurer chooses to waive it—is the same for patients whether they're in or out of network, said attorney Amanda Hayes-Kibreab, with King & Spalding in Los Angeles. That's one of the terms and conditions of the Provider Relief Fund[4] of the CARES Act, which prohibits hospitals from charging patients more for COVID-19 treatment when they're out of network. But compliance is easier said than done. "As an out-of-network provider, you are not privy to that contract or details of coverage and won't know the extent of the patient's cost share until after care is provided and you get an explanation of benefits," or EOB, Hayes-Kibreab said. "Therefore, as an out-of-network provider, you need to review remittance advices and EOBs and not bill patients any more than the insurer states is the patient's responsibility." She recommends hospitals send letters to "high frequency out-of-network plans" asking them to include in-network patient financial responsibility on remittance advices and EOBs because it will help hospitals bill patients the accurate amounts.

Watch for End of Prior Auth Waivers

MA and commercial payers have made numerous policy changes in response to COVID-19, said John Barnes, with King & Spalding in Sacramento. For example, Aetna voluntarily waived cost sharing for inpatient admissions for the treatment of COVID-19 or associated complications for all its MA and commercial plans, while self-funded plans have the option to do the same. Hospitals will have to dig deeper than usual to sort this out. "You are left having to decide, 'Do I bill the patient for this amount?' You have to know a lot of information about this policy," Barnes said. Is the patient's insurer self-funded (governed by ERISA), and if so, did the self-funded insurer opt in to this policy? If hospitals get this wrong, they're not balance billing, so they won't run afoul of the CARES Act, he said. But they may not be compliant with the policies of their health plans and could be paid twice.

Hospitals also may have trouble finding the policies, which are rarely mailed to providers. "In normal times, many plans maintain a provider manual," where providers can find policy changes, Barnes said. "They've been abandoned during the pandemic. A lot of policies are not in the provider manual." He said most health plans are changing policies on websites, requiring providers to constantly check them, often on a daily basis. And a national plan, like Anthem, may have policies that vary by state, Barnes said. It's a good idea to assign someone in the revenue cycle or managed care department to follow up on the policies of major payers and monitor coinsurance for high-dollar claims.

Some commercial payers waived prior authorization requirements for COVID-19 admissions or a variation of that theme, Boswell said. "It's a patchwork," he explained. Cigna, for example, waived prior authorization for transfers of non-COVID-19-infected patients from acute inpatient hospitals to in-network long-term acute care hospitals for commercial and MA plans through May 31. "The tricky part is to spot when you revert to the status quo," Boswell said. The voluntary waivers are time limited, and if they end without hospitals resuming preauthorization, they will get retrospective denials, he said.

Hospitals also should keep their eye on reimbursement from MA plans and commercial insurers, because the CARES Act suspended 2% sequestration payment reductions for claims with dates of service from May 1 through Dec. 31. Sequestration refers to across-the-board Medicare payment cuts that took effect in 2013, but MA and commercial payers also are unable to cut payments 2% if their rates are tied to Medicare. "A lot of payers have a hard time turning it off," Boswell said. "If you don't spot it, there's a risk of not getting paid."

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1 Families First Coronavirus Response Act, Pub. L. No. 116-127, 134 Stat. 178 (2020), https://bit.ly/3bTLWSj.
2 Coronavirus Aid, Relief, and Economic Security Act, H.R. 748, March 27, 2020, https://bit.ly/3bKvvIh.
3 Coronavirus Aid, Relief, and Economic Security Act, H.R. 748 § 3202, https://bit.ly/2zE6lwX.
4 Nina Youngstrom, "With Its Vague Terms, Relief Fund Has Compliance Risks; 'Look from Several Angles,'" *Report on Medicare Compliance* 29, no. 16 (April 27, 2020), https://bit.ly/3esvZUd.