

AAHAM LEGISLATIVE UPDATE

MAY 19, 2021

Scott S. London, Esq.
Gustavo Matheus, Esq.



SCOTT S. LONDON BIOGRAPHY

- President of London Eligibility, Inc.
- Attorney since 1996
- Certified Application Counselor
- AAHAM (American Association of Healthcare Administrative Management) Board Member and Legislative Liaison- MD Chapter
- NOSSCR (National Organization of Social Security Claimants' Representatives) – Member
- Former District 11 Team Slate Treasurer
- Licensed Health Insurance Agent



GUSTAVO MATHEUS BIOGRAPHY

- Gustavo Matheus represents providers of healthcare services in areas involving reimbursement, including appealing denied claims and litigation.
- Gustavo enjoys teaching and gardening.
- He believes the COVID-19 pandemic cannot end soon enough.

MEDICAL DEBT PROTECTION ACT

HB565/SB514

When attempting to collect debt owed on a hospital bill, a hospital may not, among other things:

- Request a lien against a patient's primary residence.
- Request the issuance of or take action causing a court to issue a body attachment or an arrest warrant against a patient.
- Request a writ of garnishment of wages or file an action resulting in an attachment of wages if the patient is eligible for free or reduced-cost care.
- Make a claim against the estate of a deceased patient if the deceased patient was known by the hospital to be eligible for free care or if the value of the estate after tax obligations are fulfilled is less than half of the debt owed (however, a hospital may offer the family of the deceased patient the ability to apply for financial assistance).
- File an action against a patient or give notice to a patient until after 180 days after the initial bill was provided.
- File an action against a patient until the hospital determines whether the patient is eligible for free or reduced-cost care.

Hospitals must issue refunds for billing mistakes within 240 days.

If a hospital delegates collection activity to a debt collector, the hospital and the debt collector must be jointly and severally responsible for meeting the hospital debt collection requirements.

PRESERVE TELEHEALTH ACCESS ACT OF 2021 - HB123/SB3

Context: CMS 1135 waiver -COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers

- Increased practitioner eligibility
 - PT/OT
 - speech language pathologists
- Audio-only for certain services
 - Behavioral counseling
 - Evaluation and Management
- Telehealth's increased role in pandemic

Guiding policies:

- Expansion of telehealth capabilities – even audio-only was “instrumental in maintaining patient care”
- Shown effective in reducing disparities – health equity

PRESERVE TELEHEALTH ACCESS ACT OF 2021 - HB123/SB3

“Remote patient monitoring services” means:

- The “use of synchronous or asynchronous digital technologies”
- “To enable a distant site provider to assess, diagnose, consult, treat, educate, provide care management, suggest self-management, or make recommendations regarding the program recipient’s health care.”
- real-time and file exchanges
- Somatic, dental, and behavioral services covered
- “Medically necessary” and “appropriately delivered”
 - think: Documentation
 - think: Utilization Review
- Audio only permissible: July 2021 to June 2023
- Does not include email or facsimiles
- Medicaid and Insurance (HMO) policies

PRESERVE TELEHEALTH ACCESS ACT OF 2021 - HB123/SB3

- “This Act shall apply to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after ~~January 1, 2022~~ July 1, 2021.”
- “This act shall take effect July 1, 2021.”
- Data on healthcare usage and disparities will be collected and reported to Maryland General Assembly committees

CHIQUITA BROOKS-LASURE'S NOMINATION FOR CMS ADMINISTRATOR IS PENDING BEFORE THE SENATE FINANCE COMMITTEE

- Attorney
- Director at Manatt Health
- Served at U.S. Department of Health and Human Services in Center for Consumer Information
- Advocate for ACA, permanent waivers for Telehealth, Medicaid expansion for all states, wants better coordination for dually eligible

**CMS PROPOSED THE FISCAL 2022
INPATIENT HOSPITAL PAY RULE.
HOSPITALS WILL RECEIVE A 2.8%
PAY INCREASE**

**CMS ANNOUNCED IT WILL PROVIDE
\$80 MILLION IN GRANTS TO THE
36 FEDERAL INSURANCE EXCHANGES**

\$80M TO 36 FEDERAL INSURANCE EXCHANGES

Navigators are trained to assist people in coverage decisions and to perform outreach for ACA sign-ups.

Some navigators can also assist other types of coverage sign-ups such as Medicaid eligibility.

The cuts to navigators were part of a larger effort by the Trump administration to decrease funding for ACA outreach.

The administration argued that the ACA enrollment period was already well known but advocates of the law said that it was part of an effort to sabotage sign-ups.

- <https://www.fiercehealthcare.com>

\$80M TO 36 FEDERAL INSURANCE EXCHANGES

- Health exchange navigators get \$80M from Biden Administration for the 2022 plan year
- This reverses Trump Administration funding cuts
- 8-fold spending increase
- Bolsters the ACA through increased enrollment
- 2021 was 5% "bump" from 2020 open enrollment period.

NATIONAL AAHAM 2021 VIRTUAL LEGISLATIVE DAY JUNE 22-24

- Registration deadline is June 1, 2021
- Senate Bill 355- COVID-19 Medical Debt Collection Relief Act
- Prior Authorization

**CITY OF COLUMBUS ET AL.
V.
NORRIS COCHRAN (ACTING SEC'Y HHS)
U.S. DISTRICT COURT (MD)**

CITY OF COLUMBUS, ET AL. V. NORRIS COCHRAN

- Unpublished Opinion / Slip Copy (2021 WL 825973)
- Judge Deborah Chasnow (Bill Clinton appointment)
- Filed against Donald Trump, Alex Azar & Seema Verma
- Think politics : filed in 2018
- ACA “Sabotage Case”
- 5 cities (Baltimore, Chicago, Philadelphia, Cincinnati)
- 1 county (Montgomery, MD) – amicus brief
- 2 individuals (Stephen Vondra & Bonnie Morgan)
- HHS Notice of Benefit and Payment Parameters for 2019
 - published in April 2018
- About the money

CITY OF COLUMBUS, ET AL. V. NORRIS COCHRAN

ACA was designed to:

- Increase people having healthcare coverage
- Reduce healthcare costs
- As 'Interlocking reforms designed to expand coverage in the individual health insurance market'
- As an option away from employer-based group plans
- To ensure individuals have health insurance or pay IRS
 - avoid economic death spiral
- Allow tax credits to make premiums affordable

CITY OF COLUMBUS, ET AL. V. NORRIS COCHRAN

Affordability:

- Advance Premium Tax Credits (“APTCs”)
- “Give now and maybe pay later” – reconciliation
- Tax credits in advance
- To pay health exchange premiums

CITY OF COLUMBUS, ET AL. V. NORRIS COCHRAN

Standing:

City “plaintiffs have shown that the 2019 Rule predictably increases the uninsured rate above what it would otherwise be. There is no reasonable dispute that each of the City Plaintiffs bears the increased costs of uninsured rate increase because each operates a local health department that provides free or reduced-cost health services to uninsured and underinsured residents.”

“Individual plaintiffs have [. . .] indisputably show[n] that they have suffered an injury [. . .] fairly traceable to the challenged conduct of” HHS.

CITY OF COLUMBUS, ET AL. V. NORRIS COCHRAN

9 asserted violations of Administrative Procedures Act in the 2019 HHS publication:

- Contrary to the Law (*Chevron*) analysis:
 - Whether statute (ACA) is ambiguous?
 - Clear language of statute ends inquiry
 - If ambiguous, then "reasonableness of the agency's decision-making"
 - some degree of discretion
 - ambiguity resolved by agency
- Arbitrary and Capricious
 - Notice and Comment (Federal Register)
 - Agency must respond to significant questions and consider "all relevant factors"

CITY OF COLUMBUS, ET AL. V. NORRIS COCHRAN

Vacated provisions of 2019 Rule:

- Federal Review of Network Adequacy (remanded)
- Income Verification (remanded)
- Standardized Options (remanded)
- Medical Loss Ratio (not remanded)

All arbitrary and capricious

Medical Loss Ratio was contrary to law

CITY OF COLUMBUS, ET AL. V. NORRIS COCHRAN

Preserved provisions of 2019 Rule:

- Elimination of direct notices to taxpayers at risk of losing tax credit
- Elimination of federal oversight of insurance brokers in direct enrollment
- Revised standards for ACA navigators
- Updates to small business exchange program
- Limit of review of student insurance rate increases

AMERICAN RESCUE PLAN ACT AND SB923

Shall provide, subject to the limitations of the State budget, comprehensive medical, dental, and other health care services for all eligible pregnant women whose family income is at or below 250 percent of the poverty level for the duration of the pregnancy and for 1 year immediately following the end of the woman's pregnancy.

REVAMPING MARYLAND'S MANAGED CARE LAWS

HMO PRIOR AUTH LAW

HMO Law - Md. Ins. Art. section 15-1009:

- Preauthorized services must be paid
- Even if info given or provided was wrong, or
- Planned treatment was not substantially followed
- If HMO would have otherwise approved service

HMO PRIOR AUTH LAW

Md. Ins. Art. section 15-1009:

- Does not apply to MCOs
- 15-1005 applies to MCOs (Prompt Pay statute)
- 15-1008 applies to MCOs (Retroactive denials)
- If HMO would have otherwise approved service

MCO INPATIENT DENIALS

COMAR 10.67.06.07

A. An MCO shall provide to its enrollees:

- Medically necessary inpatient hospital services as specified in this regulation

MCO INPATIENT DENIALS

COMAR 10.67.06.07

H(1). An MCO shall pay for all medically necessary ancillary services provided on inpatient hospital days[.]

H(3). An MCO is not required to pay for ancillary services fn the entire hospitalization in section H(1) of this regulation is *appropriately denied*.

MCO INPATIENT DENIALS

COMAR 10.67.06.07

H(3). An MCO is not required to pay for ancillary services if the entire hospitalization in section H(1) of this regulation is *appropriately denied*.

“*Appropriately denied*” is interpreted by MCOs to include denials that are not based on medical necessity.

**HHS: 940K SIGNED UP VIA
HEALTHCARE.GOV
IN SPECIAL ENROLLMENT PERIOD**

SCOTT S. LONDON
SLONDON@LONDONELIGIBILITY.COM
410-685-3737

GUSTAVO MATHEUS
GMATHEUS@ANDERSONQUINN.COM
301-762-3303