

HB 388 - Testimony

Prepared for

**Ohio House
Finance Committee**

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Prepared by:

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Introduction

I would like to thank Chairman Oelslager, Vice chairman Scherer, Ranking Member Cera, members of the House Finance Committee, thank you for the opportunity to testify in support of HB388. My name is Tom Naughton and I am President of the MAXIMUS Federal Services Health Division. In that role my responsibilities include the oversight of over 60 independent dispute resolution programs including provider payment arbitration programs and surprise billing arbitration programs.

MAXIMUS Federal Services (MAXIMUS Federal) is a wholly owned subsidiary of MAXIMUS, Inc. MAXIMUS, Inc. is a global government services organization, based in Reston, Virginia that provides services to Federal, State, and Local government entities. We have no contracts with any commercial entities, including any health care payors or providers. We take pride in the fact that MAXIMUS has no direct or material indirect conflict of interest in helping government serve the people. This independence is part of our mission and is also a statutory requirement for our Centers for Medicare and Medicaid (CMS), Qualified Independent Contractor (QIC) contracts and the Medicaid contracts we administer throughout the United States.

MAXIMUS Federal is the largest provider of government sponsored independent benefit review programs in the United States. We process approximately 50% of all Medicare appeals on behalf of CMS. This includes processing all appeals for the Medicare Part C program; all appeals for the Medicare Part D program; all appeals for the Medicare Part B Durable Medical Equipment program; and half the appeals for the Medicare Part A program. In addition, we manage the Eligibility Appeals program for the Affordable Care Act and appeal programs for the Office of Personnel Management. In addition to our Federal work we work with more than 50 state regulatory agencies managing benefit review programs. These programs include consumer health appeals, workers' compensation appeals, disability benefit appeals and provider payment arbitration programs including surprise billing legislation.

Arbitration Frameworks

Arbitration has proven an effective means of assisting states in stabilizing their out-of-network markets and addressing surprise billing issues. Arbitration programs generally have two frameworks what I would call "discretionary arbitration" and "baseball style arbitration". In discretionary arbitration programs the arbitrator is not required to choose one party's offer and often arrives at a number between the two party's offers. In baseball style arbitration the arbitrator must select one of the two proposed offers. MAXIMUS Federal has managed discretionary and baseball style provider arbitration programs for several states. Based upon our experience we believe the provider arbitration program regulated by the New Jersey Department of Banking and Insurance provides the best framework for implementing an efficient, transparent and effective arbitration program. Set forth below, I will discuss what we believe are the necessary attributes for a successful provider arbitration program.

Arbitrators

Similar to New Jersey (one arbitration organization) and New York (three arbitration organizations) states should consider limiting the number of arbitrators. Limiting the number of arbitrators and centralizing the program allows for greater quality oversight of the program, results in more consistent decisions, assists in conflict of interest oversight and avoidance as well as allowing for cost certainty. Some states (Texas and Washington) have adopted an arbitrator certification model wherein any “qualified” arbitrator can apply to serve the program and is then added to a list which providers seeking an arbitration chose an arbitrator. Under this model states could end up with hundreds of arbitrators which will likely create oversight and efficiency challenges. For example, although an arbitrator may not have a direct conflict of interest with a specific arbitration, a party to the arbitration may know that the arbitrator historically works for providers and has a history of deciding in favor of providers. In addition, certification models generally provide the opposing party the opportunity to reject an arbitrator selected by the filing party – this framework creates the potential for parties to obstruct the process. Furthermore, the certification model does not allow for cost certainty as one arbitrator could charge \$400 per hour while another arbitrator charges \$400 per case. The certification model also has the potential to have consistency challenges as it will likely be difficult for a state to ensure all arbitrators under this model (as well as the parties) are utilizing the same claims data sets.

From our experience it is a best practice to utilize arbitrators who are knowledgeable and experienced in applicable principles of contract and insurance law and the health care industry to determine the accuracy, or inaccuracy, of the reimbursement. Although it is not necessary for arbitrators to be attorneys, it is paramount for arbitrators to have access to the appropriate specialists including certified coding specialists, physicians, nurses and other clinicians as necessary to render a determination. Under the New Jersey and New York models States can ensure the arbitration organizations, with whom they contract, have access to appropriate specialists.

States should further ensure no arbitration organization, or individual arbitrator, has any material affiliation with any insurer or provider – avoiding conflict of interest is necessary for an effective arbitration program.

Arbitrations

The most successful arbitration programs that we have managed are “mandatory”. Programs that are voluntary generally have poor utilization and do not provide a good mechanism for regulating out-of-network markets. Set forth below in *Exhibit 1 – Volume Comparison of Voluntary and Mandatory Arbitration Programs*, provides the utilization figures for voluntary and mandatory provider arbitration programs managed by MAXIMUS Federal.

Receipt Year	CA IDR Voluntary	CA IBR Mandatory	Florida Provider Appeals Voluntary	New Jersey PICPA Arbitrations Mandatory	New Jersey Surprise Billing Mandatory
2018	14	1,693	70	245	356
2019	25	1,491	38	261	2,824

Receipt Year	CA IDRPs Voluntary	CA IBR Mandatory	Florida Provider Appeals Voluntary	New Jersey PICPA Arbitrations Mandatory	New Jersey Surprise Billing Mandatory
TOTALS:	39	3,184	108	506	3,180

Exhibit 1: Volume Comparison of Voluntary and Mandatory Arbitration Programs

The entire arbitration process should be managed through a secure electronic portal. A digital process makes for ease of use and allows for complete program transparency. This provides the State the ability to understand exactly how the program is functioning in real time. This also allows parties electronic access to the entire arbitration file and avoids any question on what information has been submitted by the parties. It also allows for electronic payment and provides the State with all necessary data to evolve the program and educate stakeholders.

Information necessary for a successful arbitration includes, but is not limited to:

1. The evidence and methodology submitted by the parties to assert that their final offer amount is reasonable;
2. Individual patient characteristics;
3. The circumstances and complexity of the particular case, including time and place of service; and
4. The usual, customary and reasonable rate of the service

A number of States believe consideration of subjective provider data “The Gould Criteria” are beneficial to completing arbitrations. Such data includes the providers level of training, education, experience and specialization or sub-specialization. From our experience providers rarely submit this information. Furthermore, subjective data generally does provide value to an arbitration (e.g., should a provider receive higher reimbursement because they graduated from Harvard as opposed to Ohio State?).

The cost of arbitrations should be fixed. Similar to voluntary programs, arbitration programs that allow arbitrators to charge hourly or require the “the losing party” to pay, generally result in a lower program utilization. An arbitration, whether the amount in dispute is \$5,000 or \$500,000, can be completed in less than 30 calendar days for a cost of \$450 per arbitration or less.

Federal Legislation

The US Congress is also working on surprise billing legislation and the committees of jurisdiction recently announced they had reached an agreement. However, we still have not seen the details — including whether they have state pre-emption language that will allow states to design their own laws with respect to the health plans they regulate. States may have more flexibility than Congress to write good policy, because in Washington the need for health savings to extend the health centers and other expiring programs is driving the surprise billing policy. Because rate setting generates the largest savings in federal health subsidies, it is the central feature of the agreement (125% of median in-network reimbursement rates). There is an arbitration feature for surprise bills over \$750.

Thank you again for the opportunity to address this Committee. I welcome any further questions that you may have on the information presented today.