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Legal and Practical Implications of Reference-based Pricing

Strategies to avert financial impact of reference-based pricing

By John Barnes and Kiel Yager

Health care providers offer discounted rates and other benefits to health benefit plans in exchange for the plans' agreement to provide steerage, prompt payment and other considerations.

When a provider is in a benefit plan's network of contracted providers, the benefit plan will pay an in-network benefit amount based on the agreed-upon discounted rate, and the member's patient responsibility is calculated according to that in-network benefit level. In this contracted situation, the provider and patient are protected:

- The provider is protected by contract provisions that specify the payment amount the hospital is entitled to receive.
- The patient is protected because the provider agrees to accept the amounts paid by the benefit plan, together with the patient responsibility amount, as payment in full.

This in-network payment contrasts with the situation that occurs when a patient seeks services from an out-of-network provider, where the patient will either have no coverage (such as when the patient has a health maintenance organization product), or will have higher patient responsibility amounts than what they would have incurred at an in-network provider. In this latter circumstance, the patient will sometimes be responsible for paying the difference between the amount paid by the benefit plan and the provider's undiscounted charges.

When plan beneficiaries seek services out of network, some benefit plans (and third-party administrators of self-funded benefit plans) employ a tactic loosely referred to as "reference-based pricing." The essence of reference-based pricing is that a benefit plan that receives a claim from an out-of-network provider does not pay the provider's undiscounted charges on the claim.

Despite the benefit plan not having a contract with the provider, the benefit plan will pay less than the undiscounted charges for the claim, often in accordance with the benefit

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plan's own self-selected, predetermined price list or pricing methodology. The reference point used to set the price may be a percentage of Medicare-allowable charges, an average of a paid claims dataset, or some other "proprietary" pricing model.

The primary concern with this reference-based pricing tactic is that the benefit plan gives itself the benefit of a discounted price for the services provided without being subject to any of the burdens that typically accompany being in contract with a provider, chief among them being payment at an in-network benefits level. Providers also report that the amount benefit plans pay under reference-based pricing is often wholly inadequate for the services provided.

With reference-based pricing, the benefit plan gives itself the benefit of a discounted price without being subject to any of the burdens that typically accompany being in contract with a provider.

This article explains the reference-based pricing method and provides preliminary steps that providers can employ to eliminate some of its deleterious effects.

Who Uses Reference-Based Pricing and Why

Third-party administrators of self-funded benefit plans are the primary users of reference-based pricing, typically on behalf of self-funded plan clients that either do not have a network of providers or have a very limited network. Reference-based pricing also is commonly employed when a benefit plan's beneficiary seeks emergency services from out-of-network providers. Fully insured plans also have sometimes employed reference-based pricing for out-of-network services. For purposes of our discussion on reference-based pricing, "benefit plans" include commercial payers and third-party administrators that employ reference-based pricing on behalf of a benefit plan.

From the benefit plan's perspective, the benefits of reference-based pricing are obvious: Employing the tactic reduces the amount the benefit plan pays for services by allowing the benefit plan to unilaterally choose the payment schedule it will use to pay claims, which will almost always be a substantial reduction from a provider's undiscounted charges. Some third-party administrators are selling reference-based pricing services as an alternative to their self-funded clients having to establish a network of providers, which some benefit plans cannot provide or do not want to provide (as creating provider networks is expensive).

One way for benefit plans to reduce costs is to employ alternative payment strategies such as reference-based pricing. But even self-funded plans that have broad networks are using the tactic when one of their beneficiaries obtains out-of-network services.

The rise of reference-based pricing was accelerated by joint guidance issued by the Health and Human Services Department, the Department of Labor, and the Department of the Treasury. The Patient Protection and Affordable Care Act (ACA) established an annual maximum out-of-pocket (MOOP) amount that patients could be responsible to pay when enrolled in a commercial or marketplace insurance plan established under the ACA. The federally mandated cap on enrolleees' out-of-pocket costs incentivized benefit plans to enter into network agreements with providers for discounted rates, because any amount in excess of the MOOP would be the benefit plan's responsibility.

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This incentive, however, was undercut by the joint guidance, which provided that any amount

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Update on Hospital Price Transparency

Hospitals must publish standard charges online starting Jan. 1

By Christopher Kenny and Matthew Horton

In the world of health care reimbursement, the term "standard charges" is practically a misnomer without additional guidance. Yet, the Centers for Medicare & Medicaid Services (CMS) is doubling down on its requirement that hospitals must make available a "list of their current *standard charges* via the internet" without providing much in the way of guidance interpreting that standard. [83 Fed. Reg. 41144, 41686 (Aug. 17, 2018) (emphasis added).]

Although the concept sounds simple enough — hospitals must publish their standard charges online — many hospitals have expressed difficulty in interpreting the term "standard charges" due to a lack of guidance from CMS. Currently, CMS suggests that hospitals can meet this standard by posting their entire chargemaster. [*Id.* at 41687.] However, the average patient is not aware of the intricacies of health care reimbursement, including deciphering the data and charge information available within a hospital's chargemaster.

Indeed, the policy reason behind price transparency is to inform the public of the price of health care services. Any requirement to publish a hospital's entire chargemaster would pose significant difficulty to accomplishing this goal. A recent CMS FAQ states that this is the agency's policy–contradicting its more permissive language in the *Federal Register*.

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Background

Section 2718(e) of the Public Health Service Act, which was enacted as part of the Patient Protection and Affordable Care Act (ACA), requires:

> Each hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act. [42 U.S.C. § 300gg-18(e).]

The statute states that hospitals must make such charges public "in accordance with guidelines developed by the Secretary." [*Id.*] CMS did not issue any such guidelines for several years until the agency stated in the fiscal year (FY) 2015 inpatient prospective payment system (IPPS) final rule that hospitals could comply with the statute by either making public "a list of the standard charges (whether that be the chargemaster itself or in another form of their choice), or their policies for allowing the public to view a list of those charges in response to an inquiry." [79 Fed. Reg. 49854, 50146 (Aug. 22, 2014).]

CMS provided additional guidance through rulemaking in the FY 2019 IPPS proposed and final rules. As finalized in the FY 2019 IPPS final rule, CMS requires hospitals to make available, effective Jan. 1, 2019, a list of their:

1. current standard charges;
2. via the internet;
3. in a machine-readable format; and
4. to update this information at least annually, or more often as appropriate. [83 Fed. Reg. 41144, 41686 (Aug. 17, 2018).]

In comparison with the above statutory authority in Section 2718(e) of the Public Health Service Act, there are only minor differences — mainly that the standard charges are in a machine-readable format. Additionally, CMS now requires that hospitals publish such information via the internet, no longer allowing the option to provide instructions for a patient to request the hospital's charges.

Current Guidance

This standard has caused many in the industry to question how CMS intends to interpret its requirements, particularly the interpretation of the term standard charges. CMS does make clear that sharing online the chargemaster itself meets the requirement for publishing a hospital's standard charges. However, chargemaster data is notoriously impenetrable, even for savvy professionals entrenched in the area of health care reimbursement.

In the FY 2019 IPPS proposed and final rules, CMS acknowledges that more specific information is needed for patients regarding their potential financial liability in order to make cost information more patient-friendly. Commonly referred to as price transparency, CMS has undertaken several efforts to encourage what it believes to be an informed patient population when it comes to overall costs, including cost-sharing amounts. These policy goals and trends are evident in the FY 2019 IPPS proposed rule when commenters remarked to CMS that:

> "[C]hargemaster data are not helpful to patients for determining what they are likely to pay for a particular service or hospital stay" and that CMS is "considering ways to improve the accessibility and usability of the charge information that hospitals are required to disclosure under Section 2718(e) of the Public Health Service Act." [83 Fed. Reg. 20164, 20549 (May 7, 2018).]

In the FY 2019 IPPS proposed rule, CMS poses several questions regarding the term standard charges, particularly how CMS should interpret that term when requiring hospitals to make public their standard charges via the internet. Some CMS-provided suggestions in the FY 2019 IPPS proposed rule for defining standard charges included:

1. the average or median rates for items on the chargemaster,

2. average or median rates for groups of services commonly billed together (such as a Medicare severity diagnosis-related group (MS-DRG)), and/or

3. average discount off the chargemaster amount across all payers, either for each item on the chargemaster or for groups of services billed together. [*Id.*]

CMS received several comments to its suggestions in the FY 2019 IPPS proposed rule about defining standard charges and the term's inherent ambiguity, but CMS elected not to elaborate on this requirement any further in the FY 2019 IPPS final rule. [83 Fed. Reg. 41144, 41687 (Aug. 17, 2018).] Instead, CMS stated "making charge information more easily accessible to patients and the public does not preclude hospitals from taking additional steps or continuing to provide the information they currently provide." [*Id.* at 41687.]

CMS stated that hospitals could meet their reporting obligations on standard charges "in the form of the chargemaster itself or *another form of the hospital's choice*, as long as the information is in machine readable format." [*Id.* at 41686 (emphasis added).] Although this appears to allow hospitals discretion to find reasonable alternatives to the chargemaster, CMS has upended any such interpretation through a recent Frequently Asked Questions (FAQ) document. [Available at: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FAQs-Req-Hospital-Public-List-Standard-Charges.pdf.*]

CMS FAQs on Standard Charges

In a short, one-page FAQ document, CMS made broad statements of general applicability about a hospital's obligation to make public their standard charges. For example, when asked what format to use when making public a list of standard charges, CMS stated:

> The format is the hospital's choice as long as the information represents the hospital's current *standard charges as reflected in its chargemaster.*

Unlike the discussion above in the preamble to the FY 2019 IPPS proposed and final rules, CMS is suggesting that the chargemaster is the hospital's standard charges. This is contradictory to its statements in the preamble, where CMS is actively seeking input on how to define the term in future guidance.

The preamble discussion in the 2019 FY IPPS final rule seems to suggest that hospitals can use an alternative format instead of the chargemaster. CMS seemed to acknowledge this by encouraging hospitals to find alternatives to providing simply the chargemaster itself.

Further, a patient may very well conclude, based on a review of raw chargemaster data, that his or her financial obligation will be much higher than it actually is. Although CMS acknowledges stakeholder concern that patients need pricing information in a more user-friendly format than what is provided in the chargemaster, CMS believes that chargemaster data is still useful to patients. Without a suitable alternative in mind, CMS, in its FAQs, defers to the chargemaster as a hospital's standard charges.

Conclusion

In light of the apparent contradiction in the preamble discussion in the FY 2019 IPPS proposed and final rules versus the recent CMS FAQs, many hospitals are unclear about their responsibilities in providing the public with standard charges information. Instead of spurring innovation in how to provide pricing data to patients, CMS has defaulted to the chargemaster data in its FAQs.

The FAQs have a tenuous, at best, connection to the statute or CMS's prior statements during notice and comment rulemaking. They also cast doubt about CMS' openness to accepting formats other than the chargemaster. As a result, many hospitals are likely to decide that publishing their chargemaster is the only acceptable method based on the guidance available to date, leaving them limited options to supplement their chargemaster data with additional, clarifying information.

Notably, CMS has not finalized enforcement mechanisms of this requirement. CMS is currently contemplating its authority and

framework for assessing civil monetary penalties. In the meantime, however, it is unclear what enforcement mechanisms exist for violations by hospitals of the publishing requirement for standard charges, let alone the particular "requirement" that they post their entire chargemaster. Hospitals should monitor this area closely as CMS needs to provide further guidance to hospitals on not only on the term standard charges but also on its enforcement authority as well. ■

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CMS Proposes Streamlining Certain Medicare Conditions of Participation

Proposals aim to reduce regulatory burdens on providers

By Isabella E. Wood

As a continuation of its effort to reduce the regulatory burdens on health care providers, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule Sept. 20, 2018, that would revise certain aspects of the Medicare conditions of participation and conditions of coverage for several provider types. [83 Fed. Reg. 47686 (Sept. 20, 2018).]

CMS estimates that the changes contained in the proposed rule would result in a total annual savings of approximately $1.1 billion using the midpoints of its estimated ranges. [83 Fed. Reg. at 47690.] In addition to seeking comments on the proposed rule, CMS sought comments on additional proposals or modifications, particularly those supported by data or evidence that would further reduce regulatory burdens.

Proposed Rule

CMS' latest regulatory burden reduction effort is focused on revising the Medicare conditions of participation and coverage. The proposed changes include revisions to regulations impacting a wide variety of providers, including hospitals, ambulatory surgery centers (ASCs), hospices and home health agencies.

CMS categorizes its proposed changes into three categories. Those categories include:

1. Proposals that simplify and streamline processes,

2. Proposals that reduce the frequency of activities and revise timelines, and

3. Proposals that reduce obsolete, duplicative or unnecessary requirements.

Proposed Changes for Hospitals

One of the advantages of multihospital systems is the ability to take advantage of economies of scale. However, certain regulations can interfere with a hospital system's ability to efficiently operate. The proposed rule seeks to combat one such instance by allowing multihospital systems to have unified and integrated quality assessment

and performance improvement (QAPI) programs and infection control programs for all member hospitals.

The proposed rule seeks to allow multihospital systems to have unified and integrated quality assessment and performance improvement (QAPI) programs and infection control programs for all member hospitals.

With respect to QAPI programs, CMS proposes adding a new standard at 42 C.F.R. § 482.21(f), which would allow a hospital that is part of a qualified hospital system to have the system governing body elect to use a unified and integrated QAPI program for all member hospitals. Each separately certified hospital within the system would have to demonstrate that:

- The unified and integrated QAPI program is established in a manner that takes into account each member hospital's unique circumstances and any significant differences in patient populations and services offered in each hospital;
- The unified and integrated QAPI program establishes and implements policies and procedures to ensure that the needs and concerns of each of its separately certified hospitals, regardless of practice or location, are given due consideration; and
- The unified and integrated QAPI program has mechanisms in place to ensure that issues localized to particular hospitals were duly considered and addressed.

Like the proposed revisions for QAPI programs, CMS also proposes that infection control programs could be unified across multihospital systems. Again, the governing board would have to elect to use a unified program and each separately certified hospital within the system would be required to demonstrate certain requirements are met.

For infection control programs, these requirements are that:

- The unified and integrated infection control program is established in a manner that takes into account each member hospital's unique circumstances and any significant differences in patient populations and services offered in each hospital;
- The unified and integrated infection control program establishes and implements policies and procedures to ensure that the needs and concerns of each of its separately certified hospitals, regardless of practice or location, are given due consideration and the unified and integrated infection control program has mechanisms in place to ensure that issues localized to particular hospitals are dully considered and addressed; and
- A qualified individual (or individuals) has been designated at the hospital as responsible for communicating with the unified infection control program and for implementing and maintaining the policies and procedures governing infection as directed by the unified infection control program.

CMS further proposes allowing hospitals flexibility in establishing a medical staff policy describing the circumstances under which a pre-surgery/pre-procedure assessment for an outpatient could be used instead of a comprehensive medical history and physical (H&P) examination. CMS believes that burdens on the hospital, practitioner and patient could be reduced by allowing hospitals to forego an H&P examination.

The hospital's policy would be required to consider: patient age; diagnoses; the type and number of surgeries and procedures scheduled to be performed; comorbidities; the level of anesthesia required for the surgery or procedure; nationally recognized guidelines and standards of practice for assessment of specific types of patients prior to specific outpatient surgeries and procedures; and applicable state and local health and safety laws.

CMS also proposes removing the requirement in 42 C.F.R. § 482.22(d), which states that a hospital's medical staff should attempt to secure autopsies in all cases of unusual death and medical-legal and educational interest. In lieu of this

requirement, CMS proposes deferring to state law regarding such medical-legal requirements.

Proposed Changes for ASCs

As one of its proposals to simplify and streamline processes, CMS proposes removing the requirement in 42 C.F.R. § 416.41(b)(3) that ASCs either have a written transfer agreement with a hospital that meets certain Medicare requirements or that all physicians performing surgery in the ASC have admitting privileges at a hospital that meets certain regulatory requirements.

ASCs have expressed concern that a growing number of hospitals are declining to work with ASCs due to competition between the hospital outpatient surgery departments and ASCs, which has created difficulty in meeting this regulatory requirement. CMS determined this requirement was duplicative and now rendered obsolete by other patient protections. For example, the Emergency Medical Treatment and Active Labor Act regulations address emergency transfers of patients from an ASC to nearby hospitals. Thus, CMS proposes removing the requirement.

CMS also proposes removing the current requirements at 42 C.F.R. § 416.52(a) that require an ASC to ensure that there is an H&P examination completed not more than 30 days before the date of the scheduled surgery. Instead, CMS proposes deferring to the facility's established policies for pre-surgical medical H&P examinations (including any associated testing) and the operating physician's clinical judgment.

CMS would still require the operative physician to document any pre-existing medical conditions and appropriate test results in the medical record that would have to be considered during and after surgery and has also retained the requirement that all pre-surgical assessments include documentation regarding any allergies to drugs and biologicals and that the H&P, if completed, be placed in the patient's medical record. However, CMS hopes its proposal will provide additional flexibility and deference to the operating physician's clinical judgment.

Proposed Changes for Hospices

CMS proposes removing the requirement in 42 C.F.R. § 418.106(a)(1), which requires that there be an individual with specialty knowledge of hospice medications on the hospice staff. CMS views this requirement as being no longer necessary for various reasons, including that hospices increasingly use pharmacy benefit management services. Because pharmacy benefit management services typically bundle drug and biologic supply services with expert advice, CMS believes it is no longer necessary to require that someone with this expertise be on the hospice staff.

CMS also proposes simplifying hospice aid training and competency requirements by revising 42 C.F.R. § 418.76(a)(1)(iv) to remove the requirement that a state licensure program meet specific training and competency requirements. Currently, 42 C.F.R. § 418.76 details requirements for the content and format of aid education, training and competency evaluations, including the number of classroom and practical training hours that must be completed, the skills that must be addressed, and the general method (exam or practical observation) used. CMS proposes eliminating these federal requirements and deferring to state requirements. CMS expects this change would streamline the hiring process for most hospices.

CMS also proposes replacing the requirement that hospices provide a copy of medication policies and procedures to patients, families and caregivers with a requirement that hospices provide information regarding the use, storage and disposal of controlled drugs to the patient or patient representative and family. This change is intended to improve patient and caregiver comprehension and to maximize the effectiveness of the education effort. ■

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Example of Reference-based Pricing

Assume an emergency patient, following care in an emergency department, is admitted for an inpatient stay and the billed amount for the entire stay is $10,000. Because the patient's insurance does not have a contract with this hospital, we will assume the hospital expects to be paid 100 percent of the billed charges—$10,000.

But the third-party administrator in this example is utilizing reference-based pricing and informs the hospital that the reference price for the inpatient stay is $4,000, which it arrived at based on a "reference price" of 125 percent of the amount Medicare would pay for the service. The patient's benefit plan states that the plan will cover 60 percent of the allowed amount, so the payment from the plan will be as follows.

- Inpatient stay following ED admit:
  - Billed charges = $10,000
  - Hospital's expected amount = $10,000
  - Reference price allowed amount = $4,000 (based on 125 percent of Medicare)
- Result = Third-party administrator will pay $2,400 (60 percent of $4,000) and issues an explanation of benefits assigning $1,600 (40 percent of $4,000) to patient responsibility.

Although the hospital's billed amount and expected amount are both $10,000, in this example, the third-party administrator will only pay $2,400, and the remaining $1,600 will be assigned as patient responsibility.

The example does not consider the possibility that the plan is a high-deductible plan. In that instance, if the patient has not met his/her deductible, the entire $4,000 set by the benefit plan would be assigned as patient responsibility.

the patient pays after the benefit plan's allowed amount in an out-of-network situation does not count toward the MOOP as long as the benefit plan uses a reasonable method to ensure adequate access to quality providers. As applied to reference-based pricing, this means that a benefit plan is going adjudicate a claim using the reference price, pay the plan's portion of the reference price, and then assign the remaining amount to patient responsibility.

Given that the amount that is the patient's responsibility does not count toward the MOOP, the practical effect of the joint guidance is that the patient's potential financial responsibility is uncapped. This hole in the regulatory scheme has encouraged the rise of reference-based pricing plans, as benefit plans employing this tactic can both reduce the amount that the plan is assigning itself to pay, while also avoiding responsibility for paying amounts in excess of the MOOP.

Identifying Reference-based Pricing and Strategies to Respond

Given the potential financial impact of reference-based pricing, providers should employ strategies to respond once reference-based payers are identified. As soon as a reference-based pricing payer is identified, the provider needs to understand what options are available to it at that point in the revenue cycle.

Nonemergency Settings

When a patient presents for nonemergency services, the patient intake process is the best opportunity to take steps to identify and address reference-based pricing. Once a patient whose benefit plan employs reference-based pricing is registered and has received services, providers' options become much more limited.

As an example, some benefit plans treat an assignment of benefits as a waiver of additional

payment above the reference price. During the patient admissions process, a patient typically will receive a conditions of admission (COA) form. Most of those COA forms contain within them an assignment of benefits. A typical example is as follows:

> I irrevocably assign and transfer to the hospital all rights, benefits and any other interests in connection with any insurance plan, health benefit plan or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the hospital of all insurance and health plan benefits payable for this hospitalization or for these outpatient services. [California Hospital Association, Form 8-1.]

When a patient seeks out-of-network services, the purpose of the COA is to allow the provider to seek payment for the services directly from the benefit plan, because without the assignment of benefits, the provider has no direct contractual right to payment from the benefit plan. The assignment takes the patient out of the middle by giving a provider a direct right to payment from the benefit plan.

The assignment of benefits that was intended to benefit the provider by giving it a right to pursue payment directly from the benefit plan is being used against it to prevent the provider from obtaining fair payment for services.

However, many benefit plans that employ reference-based pricing turn the assignment of benefits against the provider by treating the assignment as a waiver of the right to pursue additional payment over and above the reference price from either the benefit plan or the patient. So the assignment of benefits that was intended to benefit the provider by giving it a right to pursue payment directly from the benefit plan is being used against it to prevent the provider from obtaining fair payment for services.

Strict scrutiny of patients' benefit cards is the most straightforward method to identify benefit plans that treat the assignment of benefits as a waiver. Because there is no standard language being used on membership cards, providers should train intake staff to identify phrasing on benefit cards that is typically used by benefit plans that treat assignment as a waiver, such as:

— *Acceptance or deposit of any check issued by the Plan will be considered* ***accord and satisfaction*** *and will control over any other agreement. Any Assignment of Benefits shall be considered a* ***waiver*** *of the Provider's right to bill the patient additional amounts (i.e.,* ***balance billing****).*

— *Reimbursement for services performed will be up to the* ***Reasonable and Allowable Amount*** *as stated in the terms of the Plan Document, according to a* ***reference price****.*

— *Plan will pay a reference-based pricing amount up to the* ***Maximum Payable amount*** *as set forth in the member's benefit agreement.*

— *Providers shall only be reimbursed up to the Reasonable and Allowable Amount (subject to* ***value-based*** *or* ***reference-based payments****).*

After a provider identifies a benefit plan treating assignment as a waiver, providers should have a work plan developed for how to proceed. Providers can employ various strategies after they identify such benefit plans.

Even though the provider contacts the benefit plan or the third-party administrator to inquire about the reference price, the provider still may not be able to determine whether payment will be sufficient.

The most extreme strategy is to refuse to provide a nonemergency service to the member. The reason for doing so is severalfold. First, the provider may have decided that the reference price is not sufficient reimbursement for services, and it does not want to undertake the administrative

and legal cost of having to pursue payment from both the benefit plan, which is going to pay less than the provider would expect, and from the patient, who may or may not understand the implications of the practice that their benefit plan is employing.

The drawback to refusing to provide a service is that that the patient likely will be dissatisfied, especially if the service was scheduled in advance. If the provider was scheduled to provide a referred service, the patient's physician is also likely to be dissatisfied, which could impact future referral patterns. The provider could also face revenue loss, but that is not always the case, especially when the reference price is below the provider's cost or the cost of collection is significant.

Instead of refusing to provide the service, another option would be to contact the benefit plan and try to determine whether the reference price is sufficient. For example, a provider may decide that any reference price that exceeds 150 percent of Medicare-allowable charges is an acceptable payment and the provider will accept that as payment in full. The potential hindrance to employing this tactic is that plans and third-party administrators can be guarded about their reference price. So even though a patient is identified as having a reference-based pricing plan, and the provider contacts the benefit plan or the third-party administrator to inquire about the reference price, the provider still may not be able to determine whether payment will be sufficient.

A third option is to decline the assignment of benefits. There is no legal obligation for a provider to accept an assignment of benefits from members of commercial plans. A provider could decline the assignment of benefits and inform the patient that they are going to be treated as self-pay. As a courtesy, the provider can bill the patient's benefit plan. In some cases, to get the patient out of the middle, the benefit plan will pay some amount, so the patient will not be responsible for the entire balance of undiscounted charges.

In the absence of an assignment of benefits, some benefit plans will simply not make payment and will assign the entire balance to the patient. The benefit of this strategy is that the patient is notified upfront that they are being treated as self-pay and that the provider's undiscounted charges are going to be the patient's liability. This allows the patient to make a choice about whether they want to go through with obtaining the services.

If a patient is classified as self-pay, the hospital can offer him/her any applicable discounts pursuant to the hospital's financial assistance policy and can claim any unpaid amounts by the patient—both the discount and any unpaid balance—as uncompensated care on the Medicare S-10 worksheet, consistent with the hospital's policies. Such policies should specify that out-of-network patients are considered uninsured or otherwise eligible for assistance pursuant to the policy.

Physician- or Ancillary-only Limitations

Some benefit plans that use reference-based pricing issue their members a card stating that the patient's network is "physician or practitioner only," "ancillary only," or "physician and ancillary only." This is especially problematic for hospital providers, as all hospitals are going to be out-of-network for these benefit plans.

When a creditor accepts and deposits a check clearly stating "payment in full" the creditor may not seek additional payment from anyone.

A provider's options when a patient presents with one of these cards are very similar to when a patient presents with a card indicating the benefit plan treats assignment of benefits as a waiver. The provider can refuse to provide scheduled services to that member, obtain information about the reference price and make a choice about whether it is acceptable, or refuse assignment of benefits and treat the patient as self-pay.

Emergency Settings

When patients seek emergency services, providers are not able to employ intake screening strategies for nonemergency settings because the providers are prohibited from inquiring about a patient's coverage if doing so would delay providing the patient with a medical screening examination and, if needed,

stabilizing treatment, as required under the Emergency Medical Treatment and Active Labor Act (EMTALA). Therefore, providers' options are limited when they discover that an emergency patient's coverage is from a benefit plan that employs reference-based pricing.

Although refusing the assignment of benefits and treating the patient as self-pay is an option, the optics of an emergency provider notifying a patient that they will have significant financial responsibility for emergency care—when the patient had no meaningful opportunity to avoid those costs—are, of course, less than ideal. It may be that some providers will prefer to proceed normally with collecting the balance due from the patient. In some cases, the patient will seek redress from the employer benefits manager and essentially get the parties involved in a conversation about the financial responsibilities of the various parties, with the end goal being that the benefit plan pays a fair price for providing emergency services.

Benefit Plan Checks Stating Payment in Full

Some benefit plans that employ reference-based pricing will print on the check or evidence of benefit that accompanies payment a statement that the payment constitutes payment in full of the amount due or some other statement indicating that, by negotiating the check, the provider is prohibited from pursuing additional payment on the claim. This tactic is sanctioned by the Uniform Commercial Code (UCC), which provides that when a creditor accepts and deposits a check clearly stating "payment in full" or some other similar phrase, the balance owed is extinguished and the creditor may not seek additional payment from anyone for the amount due.

In states that follow the UCC, if a payment indicates that acceptance of the payment is payment in full, or any similar statement, a provider can return the check to the benefit plan and pursue the entire balance from the patient. Under the UCC, this must be done within 90 days of receipt of the payment. [*See* UCC § 3-111(c)(2).]

While many providers loathe sending money back to benefit plans, no matter how small, when a benefit plan uses reference-based pricing, the payment may be so low that the provider may receive more from seeking payment from the patient than the amount of the benefit plan's payment. Of course, seeking payment from the patient and placing perhaps a significant financial burden on them is not an easy decision.

The goal of strategies to return benefit plan checks may be to bring the parties to the table to discuss adequate payment and to remove the patient from the middle. The first step is to train staff to identify checks that indicate a reference-based pricing payer is trying to force the provider to accept the payment as payment in full.

Conclusion

Given the financial impact reference-based pricing can have on providers, it is important to understand what reference-based pricing is and what steps providers can take in response. The first step is to identify reference-based pricing payers as early as possible.

As soon as a reference-based pricing payer is identified, a provider needs to understand what options are available to it at that point in the revenue cycle. Providers do have options to avert the potential negative financial impacts related to reference-based pricing schemes, but they need to be proactive in understanding those options and in providing the necessary training and guidance to decision-makers on how to respond in each situation. ■

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