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Payer - Provider Hot Topics

Recent Legislation's Impact on Payer – Provider Relations

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Trend/Themes

- Legislating Payer - Provider Relationships
- Consumer/Patient Protections
- Healthcare Cost Reduction
- Improving Efficiency

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New Expectations

- No Surprises Act
- Transparency
- Interoperability
- SDOH – Health Equity

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No Surprises Act

- Applicability
  - Group & Individual Plans
  - No Medicare, Medicaid, Tricare, CHIP, All Payer Model Agreements and Certain Specified State Laws
- Generally Prohibits Balance Billing for:
  - Out of Network (OON) ED services
  - Non-emergency Services OON Providers at Certain Participating Providers (unless notice and consent)
  - OON Air Ambulance
- Disclosure Requirements
  - Scheduled Services Good Faith Estimate – Advance EOBs
- Continuity of Care
- Provider Directory Accuracy
- Independent Dispute Resolution Process Negotiate or Else….

CMS Overview of Provider Requirements of No Surprises Act. Cms.gov

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Steps Preceding IDR

Timeline	Steps
Start	• Patient Receives OON ED Services, OON Provider Services at In-NTK Facility or OON Air Ambulance
w/in 30 Calendar Days (After Clean Claim)	• Initial Payment or Denial
30 Business Days (From Initial Payment or Denial)	• Notice and Initiation of Open Negotiations and completion

Source: Federal Independent Dispute Resolution Process Guidance for Certified IDR Entities April 2022

Independent Dispute Resolution Process Features

- Exhaustion of 30-day Negotiation Period
- Fees
  - Both Parties Pay Admin Fee
  - Losing Party Pays Certified IDR Fee
- Timeline for entire Process
  - Notice to Initiate the IDR
  - Choosing the Certified IDR Entity
  - Certified IDR Conflict Attestation
  - Submission of Offers and Payment of Fees
  - Certified IDR 30 days from selection to determine payment amount

Source: Federal Independent Dispute Resolution Process Guidance for Certified IDR Entities April 2022

IDR Considerations for Payment Determination

- **Qualified Payment Amount** (QPA) (essentially the median contracted rate of the plan)
  - Comparable to the qualified item/service;
  - Furnished in the same geographic region

  <u>Information provided by the parties on any of the following "additional circumstances" allowed under the statute:</u>
  - Level of training, experience, and quality and outcomes measurements of the provider/facility that furnished such item
  - Market share held by the non-par provider/facility or that of the health plan in the geographic region the item/service was provided Acuity of the individual receiving the item/service or complexity of furnishing the item/service to the individual
  - Teaching status, case mix, and scope of services of the non-par facility that furnished the item/service
  - Demonstrations of good faith efforts (or lack thereof) negotiations

  <u>Cannot Consider:</u>
  - Usual and customary charges
  - Billed amount
  - Payment/reimbursement rate by a public payor
    - Medicare
    - Medicaid
    - CHIP
    - TRICARE

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Implications of NSA

- Shield or Sword?
  - Consumer/Patient Protections
  - One-sided Contract Negotiations
  - Cost Reduction
- Revenue Cycle Metrics
  - AR Days
  - Registration Accuracy & Completeness
  - Cost to Collect
  - Bad Debt
  - Appeal/disputes

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Hospital Price Transparency

January 1, 2021

- **Machine Readable File**
- Single machine-readable digital file containing the following standard charges for all items and services provided by the hospital: gross charges, discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges. 45 CFR §180.50.

- **Shoppable items – consumer friendly**
- Display of at least 300 "shoppable services" (or as many as the hospital provides if less than 300) that a health care consumer can schedule in advance. Must contain plain language descriptions of the services and group them with ancillary services, and provide the discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges. 45 CFR §180.60.

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Payer Transparency

2020 Transparency Rule

Machine readable files (JSON, XML, e-format)
- Public pricing files available online
- Drug costs
- Out-of-Network claim costs
- In-Network contracted rates

Transparency tools with significant specificity
- January 1, 2023 for 500 services
- January 1, 2024 for all services

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Transparency Rule Summary

2020 Transparency Rule Tool Requirements
Transparency in coverage: Participant disclosures

Takes effect on the first plan year on or after January 1, 2023:
- Plan sponsors must make the following information available for 500 services specified by the Department of Labor:
  - Cost-sharing information from a particular provider or providers
  - Estimated cost-sharing liability
  - Amounts participants have accumulated toward deductibles and out-of-pocket limits
  - In-network negotiated rates for covered services
  - Out-of-Network allowed amounts
  - A list of items and services subject to bundled payment arrangements
  - A notice of prerequisites, such as prior authorization required, if applicable
  - Disclosure notice, including balance billing provisions, variations in actual charges, and disclosure that the estimated cost sharing is not guaranteed
  - Plan sponsors must make this information available to participants through a self-service tool on a public web page, and in paper form if requested by a participant

Takes effect on the first plan year on or after January 1, 2024:
- Plan sponsors must make the information detailed above available for all services and items.

Summary and Applicability to CAA:
- This requirement is similar to the CAA price comparison tool provision, although it is more prescriptive and comprehensive. Plan sponsors could leverage tool to meet this requirement, although it is still likely to increase administrative costs.

https://us.milliman.com/en/insight/CAA-and-other-transparency-measures-Timing-and-implications-of-surprise-billing-for-plan-sponsors

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Advanced EOB

A-EOB requires significant new functionality, workflows and outputs for payers and providers.

- **New Provider Scheduling Service: A-EOB Flow**
- CAA requires providers to give a good faith cost estimate **at the time of scheduling** any service (CAA SEC. 2799B–6).
- This cost-estimate must be provided to the payer and member.
- When a payor receives the cost-estimate, the payer must provide the A-EOB to a member.

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Interoperability

Empty Promise?

Health Information Exchange (aka Interoperability)

The real deal??

Promises of Interoperability

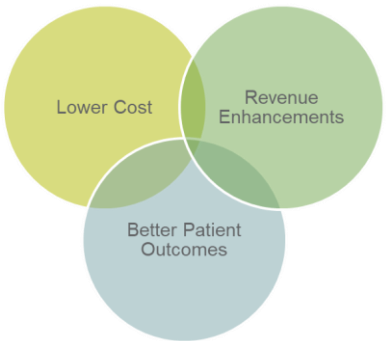
- *Increased Data Exchange will Improve Healthcare Outcomes and Reduce Costs*
  - FHIR (Fast Healthcare Interoperability Resources)
  - Lower administration costs
  - Improved Coordination of Care
  - Efficient Data Exchange Payers – Providers –Patients
    - Advance Prior Authorizations
    - Improves Decision Making
    - Improves Care Coordination

FHIR® Re-shapes Relationships

Closer relationships with Providers and Payers

APIs and FHIR based processes:

- Increases patient centricity
- Grow providers patient base
- Creates operations efficiencies
- Revenue cycle enhancements
- Low-cost support for risk coding



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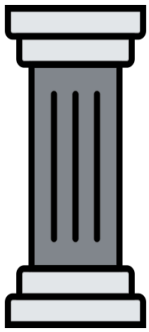
Social Determinates of Health

CMS Pillar: Health Equity



CMS' Strategy to advance Health Equity will address the health disparities that underlie our health system, by:

- Defining Health Equity
- Stakeholder Engagement
- Designing, Implementing and Operationalizing Policies and Programs that Support All Patients
- Include safety net providers and community-based organizations
- Focus on eliminating avoidable differences in health outcomes for disadvantaged and underserved

Doing this work is a team sport….
will Payers and Providers be on the same team?

Source: cms.gov Health Equity

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