Regulatory Update

February 20, 2020

Updates from the 92nd General Assembly

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1

Regulatory Update

Provider Contracting and Insurance Reform:
Updates from the 2019 Legislative Session

- Healthcare Simplification Act
- Acts Affecting Hospitals and Providers
- Acts Affecting Licensure
- Telemedicine Update

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2

Healthcare Contracting Reform

- Act 734 – Healthcare Contracting Simplification Act
- Goal – prohibit anticompetitive practices by a healthcare insurer
- Effective Date
  - Risk-based provider organizations – 1/1/2021
  - Otherwise – 9/1/2019

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3

Stricken language would be deleted from and underlined language would be added to present law.
Act 734 of the Regular Session

State of Arkansas *As Engrossed: S3/13/19 S3/14/19 S3/25/19*
92nd General Assembly
Regular Session, 2019 SENATE BILL 480

A Bill

By: Senator Irvin
By: Representative Lowery

For An Act To Be Entitled

AN ACT TO ESTABLISH THE HEALTHCARE CONTRACTING SIMPLIFICATION ACT; TO PROHIBIT ANTICOMPETITIVE PRACTICES BY A HEALTHCARE INSURER; AND FOR OTHER PURPOSES.

Subtitle

TO ESTABLISH THE HEALTHCARE CONTRACTING SIMPLIFICATION ACT; AND TO PROHIBIT ANTICOMPETITIVE PRACTICES BY A HEALTHCARE INSURER.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code Title 23, Chapter 99, is amended to add an additional subchapter to read as follows:

Subchapter 12 — Healthcare Contracting Simplification Act

4

Healthcare Contracting Reform

Five Main Reforms

1. Prohibits all-products clauses
2. Prohibits most favored nation clauses
3. Requires notice of material amendment
4. Requires access to contract
5. Requires renegotiation opportunity at least once every three years

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5

All-Products Clause

- Definition: require a healthcare provider, as a condition of participation or continuation in a provider network or a health benefit plan, to:
  - Serve in another provider network utilized by the contracting entity or a healthcare insurer affiliated with the contracting entity; or
  - Provide healthcare services under another health benefit plan or product offered by a contracting entity or a healthcare insurer affiliated with the contracting entity.

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6

All-Products Clause Prohibited

- Contracting entity shall not:
  - Offer to a healthcare provider a healthcare contract that includes an all-products clause; or
  - Amend or renew and existing healthcare contract previously entered into with healthcare provider which adds or continues all-products clause.
- Any contract which violates this provision is void.

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All-Products Clause

Exception – Same Reimbursement Rates

- This prohibition does not prohibit a contracting entity from:
  - Offering healthcare provider a contract that covers multiple health benefit plans that have the same reimbursement rate and other financial terms in contract with a healthcare provider under the same reimbursement rates and other financial terms applicable under the original healthcare contract; or
  - Requiring healthcare provider to accept multiple health benefit plans that do not differ in reimbursement rates or other financial terms for the healthcare provider

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8

All-Products Clause

Same Reimbursement Rates Exception – the focus is on the rates between the Insurer and the Provider

- A healthcare contract may include health benefit plans or coverage options for enrollees within a health benefit plan with different cost-sharing structures, including different deductibles or copayments, as long as the reimbursement rates and other financial terms between the contracting entity and the healthcare provider remain the same for each plan or coverage option including in the healthcare contract.

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All-Products Clause

This section does not authorize a healthcare provider to:

- Opt out of providing services to an enrollee of a particular health benefit plan after the healthcare provider has entered into a valid contract under this section to provide the services; or
- Refuse to disclose the provider networks or health benefit plans in which the healthcare provider participates.

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Most Favored Nation

- Definition: Most Favored Nation Clause means a provision in a healthcare contract that:
  - Prohibits, or grants a contracting entity an option to prohibit, a participating healthcare provider from contracting with other contracting entities to provide healthcare services at a lower price than the payment specified in the healthcare contract;
  - Requires, or grants a contracting entity an option to require, a participating healthcare provider to accept a lower payment in the event the participating healthcare provider agrees to provide healthcare services to another contracting entity at a lower price;

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Most Favored Nation

Definition (continued):

- Requires, or grants a contracting entity the option to require, termination or renegotiation of an existing healthcare contract if a patriating healthcare provider agrees to provide healthcare services to another contracting entity at a lower price; or
- Requires a participating healthcare provider to disclose its contractual reimbursement rates with other contracting entities.

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12

Most Favored Nation

Most Favored Nation Clause Prohibited

- A contracting entity shall not offer to, or enter into, a healthcare provider a healthcare contract that includes a most favored nation clause.
- Also shall not amend or renew existing healthcare contract previously entered into with a healthcare provider so that the contract as amended or renewed adds or continues to include a most favored nation clause.

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13

Material Amendments

Definition: "Material Amendment" is a change in healthcare contract that results in:

- A decrease in fees, payments, or reimbursement to a participating healthcare provider;
- A change in the payment methodology for determining fees, payments, or reimbursement to a participating healthcare provider;
- A new or revised coding guideline;
- A new or revised payment rule; or
- A change of procedures that may reasonably be expected to significantly increase a healthcare provider's administrative expenses.

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Material Amendments

- Contracting entity must provide the material amendment to the healthcare provider in writing at least ninety (90) days before the effective date.
- Notice shall:
  - specify the precise healthcare contract(s) to which the material amendment applies and be conspicuously labeled as "Notice of Material Amendment to Healthcare Contract."
  - Contain sufficient information about the amendment to allow a healthcare provider to assess the financial impact, if any, of the amendment.

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Material Amendments

- Not required for a Material Amendment resulting solely from a change in a fee schedule or code set if:
  - The fee schedule or code set is published by the federal government or another third party; and
  - The terms of the healthcare contract expressly states that the healthcare provider's compensation or claims submission is based on the fee schedule or code set.

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Access to Contract

- Within ten (10) business days of a healthcare provider's request, a contracting entity shall provide to the healthcare provider a full and complete copy of each healthcare contract between the contracting entity and healthcare provider – including any amendments to the healthcare contract

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Renegotiation

- A healthcare contract shall open for renegotiation and revision at least one (1) time every three (3) years.
- A party to the healthcare contract is not required to terminate the healthcare contract in order to open the healthcare contract for renegotiation of the terms.
- This section does not prohibit a renegotiation of a healthcare contract at any time during the term of the healthcare contract.

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18

Enforcement of Contracting Reform

- Contracts containing clauses in violation of these prohibitions are void.
- Violation is subject to the Deceptive Trade Practices Act and will be enforced by the State Insurance Department
- The State Insurance Department will promulgate regulations necessary to ensure compliance
  - Final Rule shall be filed with the Secretary of State on or before March 1, 2020
  - Shall be filed with the Legislative Council sufficiently in advance of March 1, 2020

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19

Act 736 – Assignment of Benefits

- An enrollee may assign to a healthcare provider the enrollee's right to receive reimbursement for service rendered by provider regardless of whether the provider is in or out of network
- Sets forth procedures required for notice to payor
- If followed, payor is required to remit payment directly to provider and may not remit payment to the enrollee.

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20

Act 300 – Payment by Gift Cards or Credit Cards

- However, a health maintenance organization or its contractor or subcontractor is prohibited from requiring a participating provider to accept a gift card, credit card, or other type of electronic payment or virtual credit as payment of a claim for healthcare services if the method of payment charges the healthcare provider a service fee to process.
- Amends "risk-sharing payment" to include the alternative payment method by gift card, credit card, or other type of electronic payment or virtual credit card as payment if the physician has given clear instructions about how to select an alternative payment method that does not result in the physician's being charged a service fee to process.

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Act 736 – Assignment of Benefits

- Procedure
  - Provider that is assigned benefits shall provide notice to the payor of the assignment of benefits with a claim for payment for healthcare services provided to an enrollee
  - If out of network, notice shall be accompanied by a complete copy of the assignment of benefits bearing the enrollee's signature and the date the assignment was executed.
- Payment
  - Payor shall promptly remit payment of claim directly to healthcare provider, giving written notice of the payment to the enrollee.
  - Claim is not paid if these provisions are satisfied and payor remits payment of the claim to the enrollee rather than to the healthcare provider and remains liable (notwithstanding incorrect payment).

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Act 736 – Assignment of Benefits

- If an assignment of benefits has been executed but the payor remits payment of the claim to the enrollee, then the payor shall remit payment of the claim to the healthcare provider under the assignment of benefits within ten (10) days of receiving notice of the incorrect payment from the healthcare provider.
- May not be waived by contract – a contractual agreement or actions that conflict or purport to waive any requirement is void.

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Act 736 – Assignment of Benefits

- Violation is subject to the Deceptive Trade Practices Act
- State Insurance Department shall enforce, and promulgate rules to ensure compliance.
- Final Rule to be filed with Secretary of State on or before March 1, 2020.
- Final Rule to be filed with Legislative Council sufficiently in advance of March 1, 2020.
- Effective 7/24/2019

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Act 300 – Payment by Gift Cards or Credit Cards

To Prohibit an Insurer From Requiring Payment for Healthcare Services Through Gift Cards, Credit Cards, or Virtual Credit Cards (effective 7/24/2020)

- A health maintenance organization or its contractor or subcontractor may pay a claim for healthcare services by any lawful method, including the alternative payment method by gift card, credit card, or other type of electronic payment or virtual credit as payment if the healthcare provider is given clear instructions about how to select the alternative payment method.

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Act 1065 – DME Agreements

To regulate durable medical equipment agreements (effective 7/24/2019)

- Adds section regulating DME agreements to the Deceptive Trade Practices Act
- A person shall not advertise that a consumer's health insurance will cover any portion of DME cost unless a licensed physician or licensed APRN has made a referral for or prescribed the DME for the consumer before an agreement to purchase DME is executed between a consumer and seller of DME
  - Unless consumer has signed a conspicuous waiver that contains no other information or agreements and clearly states that the consumer understands, health insurance may only cover cost if approved by provider

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Act 1065 – DME Agreements

- If Agreement to purchase violates this section, the Agreement to purchase is void and the consumer may receive full reimbursement.
- Transactions for DME shall have a thirty (30) day return policy
  - DME may be returned for any reason, and notice may be given to seller in writing or by phone.
  - A seller shall not deny reimbursement to consumer because the DME has not been returned.
  - Consumer shall be permitted to return DME at the expense of seller with in a reasonable time after notification of the return.

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Act 996 – Exclusion based on Adverse Professional Review Action

To amend the Patient Protection Act of 1995; and to declare an emergency (effective 4/19/2019)

- Prohibits a health insurer from excluding a physician as a participating healthcare provider based solely on an adverse professional review action, including those described in the Arkansas Peer Review Fairness Act…
- Unless a hospital's physician peer review committee concludes that the conduct of the physician adversely affected or could have affected a patient by violating the standard of care or posing a risk to the health or welfare of a patient.

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Act 964 – Prior Authorizations for Medication-Assisted Treatment

To amend the Prior Authorization Transparency Act; to prohibit prior authorization for medication-assisted treatment; and to declare an emergency (effective 4/12/2019; effective as to Arkansas Medicaid on 1/1/2020)

- Prohibits insurers from requiring prior authorization for a patient to obtain coverage of certain drugs which treat opioid addiction.
- Insurers may not impose any other requirement other than a valid prescription and compliance with the medication-assisted treatment guidelines.

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Act 964 – Prior Authorizations for Medication-Assisted Treatment

- Insurers utilizing a tiered drug formulary shall place on the lowest-cost benefit tier at least one product of the following:
  - Buprenorphine
  - Naloxone
  - Naltrexone
  - Methadone
  - A product containing both buprenorphine and naloxone
- Insurers are prohibited from considering a prescription for medication assisted treatment for the purposes of any limit imposed on the number of prescriptions for a patient.

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30

Act 940 – Audit Recoupment

To modify the time for recoupment of audits of medical providers (effective 7/24/2019)

- Adds provision that healthcare provider may submit a corrected claim for up to six (6) months after recoupment for services that were actually provided by billed in error without the intent to defraud

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31

Act 58

To require newborn screening for spinal muscular atrophy; and to mandate that insurance policies cover newborn screening for spinal muscular atrophy (effective 7/24/2019)

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Act 690 – Consent to Treatment for Homeless Minor

- Effective 4/4/2019
- Adds provision to allow local education agency liaison for homeless children and youths under the McKinney-Vento Homeless Assistance Act to consent for medical treatment when child is not in the care or custody of a parent or guardian, and not in the care or custody of the Department of Human Services

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Act 598 – Fetal Alcohol Spectrum Disorder

- Effective 7/24/2019
- Additional requirements for healthcare providers involved in delivery or care of infants to contact DHS, and to share information, regarding an infant with and affected by:
  - Maternal substance abuse resulting in prenatal drug exposure to an illegal or a legal substance; or
  - Withdrawal symptoms resulting from prenatal drug exposure to an illegal or legal substance.

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Act 975 – Death Certificate Process

- To amend the death certificate registration process for for the signature of the medical certificate of death (effective 7/24/19)
- Physicians required to complete, sign, and return medical certification to funeral director within three (3) business days. Violation results in a $250 fine.
- Requires electronic administration of death certificate registration
- Physicians must be registered for online electronic Registration of Arkansas Vital Events (ERAVE) system

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35

Act 977

To require reporting to the Department of Health of patient transfers from a lay midwife (effective 7/24/2019)

- A hospital or licensed healthcare facility shall report to ADH when a known transfer occurs of a patient from the care of a lay midwife during labor and delivery to the hospital or licensed healthcare facilty

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Act 1030 – Personal Information Protection Act Amendment

- Amended the Personal Information Protection Act to require reporting to Attorney General a breach of the security of a system that affects the personal information of more than one thousand (1,000) individuals at the time the security breach is disclosed to an affected individual, or forty-five (45) days after the person or business determines that there is a reasonably likelihood of harm to customers, whichever occurs first.
- A copy of written determination of breach and supporting documentation shall be retained for five (5) years. Such documentation is confidential and not subject to public disclosure.

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Act 1030 – Personal Information Protection Act Amendment

- Definition of Personal Information
- Note: HIPAA does not preempt – compliance with HIPAA breach notification and reporting is not sufficient to comply with this additional state requirement.

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Act 958 – National Emergency Medical Services Certification

- Requires that persons licensed to provide emergency medical services or advanced life support rescue services maintain continual certification by the National Registry of Emergency Medical Technicians

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39

Act 839 – Sexual Assault Collection Kits

- Establishes requirements concerning the collection and submission of sexual assault collection kits gathered by law enforcement agencies and healthcare providers and the testing requirements for sexual assault collection kits submitted to the State Crime Laboratory.
- A healthcare provider that has collected required victim information as part of a medical-legal examination shall enter the required victim information into a sexual assault collection kit tracking system of the State Crime Laboratory before transferring the sexual assault collection it to a law enforcement agency with jurisdiction.
- Law enforcement shall take the kit into custody as soon as possible and within three (3) business days of notice from a healthcare provider.

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Act 1032 – Maternal and Perinatal Outcomes Quality Review Committee

- Health providers may receive requests for aggregate data and information from this Committee at the Arkansas Health Department
- Reasonable access to all relevant medical records associated with a case under review by the Committee is required
- ADH shall de-identify all information provided to the legislature and shall not identify a particular facility or provider

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41

Act 804

To prohibit the requirement of, barring of, and discrimination against a physician for his or her decision to not participate in maintenance of certification (effective 7/24/2019).

- Arkansas State Medical Board shall not require any form of specialty medical board recertification or ay maintenance of certification to practice medicine in the state.
- Except as required by medical staff bylaws of a hospital, a hospital licensed by ADH shall not deny physician hospital staff or admitting privileges or employment based solely on the absence of maintenance of certification.
  - This does not prevent a hospital from requiring physicians to undergo remedial or corrective courses or training as required by a quality improvement committee.

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Act 804

- An insurer shall not:
  - Deny reimbursement to or prevent a physician from participating in any provider network based solely on a decision of the physician to not participate in any form of maintenance of certification; and
  - Discriminate with respect to reimbursement levels based solely on a decision of the physician to not participate in any form of maintenance of certification.

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Act 593 – APRN Prescriptive Authority

To Amend the prescriptive authority of an APRN (eff. 7/24/19)

- Extends APRN's prescriptive authority to Schedule II drugs if:
  - The prescription is for an opioid and the prescription is only for a five-day period or less; or
  - The prescription is for a stimulant and meets the following criteria:
    - The prescription was originally initiated by a physician;
    - The physician has evaluated the patient within six (6) months before the APRN issues a prescription; and
    - The prescription by the APRN is to treat the same condition as the original prescription.

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44

Act 862 – Financial Penalties in Alternative Payment Systems

- When determining any gain-sharing or risk-sharing for a healthcare provider based on the achievement of or failure to attain certain benchmarks, a healthcare payor doing business in this state shall use clearly expressed and identifiable benchmarks.
- At least ninety (90) days in advance of implementation, the healthcare payor shall explain to the healthcare provider the applicability of the identifiable benchmarks. All identifiable benchmarks shall be within the control of the healthcare provider to achieve or fail to attain.
- Right of enforcement

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45

Act 921 - Telemedicine Credentialing

To improve the efficiency of telemedicine credentialing in the state of Arkansas

- Adds provision specifically for the credentialing of telemedicine physicians
- If medical staff bylaws of credentialing organization require the use of a primary source verification procedure for a telemedicine physician, the credentialing organization may obtain a primary source validation by:
  - Seeking credentialing information from the board using the process established under this section (as in force previously); or…..

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Act 921 – Telemedicine Credentialing

- ….using streamlined process for credentialing and privileging telemedicine practitioners established by CMS under 42 CFR Section 482.22 if the telemedicine has been credentialed by another Arkansas Hospital within the past three (3) years.
- Board shall not classify a physician as a telemedicine physician solely for purposes of determining credentialing service fee if:
  - The physician's practice location is in Arkansas; or
  - Physician is providing services on-site at the credentialing organization that is seeking credentialing information about the physician.

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47

Act 447 – Mandatory Electronic Prescribing

To Mandatory Electronic Prescribing for Controlled Substances (effective on or after the later date of: 1/1/2021; or the certification by the Attorney General that the United States Department of Health and Human Services requires mandatory electronic prescribing)

- A prescription for a controlled substance included in Schedule III or Schedule IV shall not be filled or refilled more than six (6) months after the date of the prescription or be refilled more than five (5) times unless renewed by the practitioner.
- Practitioner shall not issue a prescription for a controlled substance included in Schedule II through Schedule IV unless the prescription is made by electronic prescription from the practitioner issuing the prescription to a pharmacy.

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Act 447 – Mandatory Electronic Prescribing

- Exceptions – may issue by written, oral, or faxed method if issued:
  - By a veterinarian; or
  - By a practitioner:
    - To be dispensed by a pharmacy located outside of state;
    - For controlled substances for which FDA requires prescription to contain certain elements not captured through electronic methods;
    - Non-patient specific prescription under standing order, approved protocol for drug therapy, collaborate drug management or comprehensive medication management, or in response to a public health emergency;
    - Under a research protocol;
    - Who has received a waiver for a specified time period from the electronic prescription requirement due to economic hardship, technological limitations that are not reasonably within control of practitioner, or other exceptional circumstances;

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Act 447 – Mandatory Electronic Prescribing

- Exceptions (continued)
  - Under circumstances in which the practitioner reasonably determines that obtaining controlled substances in a timely manner is impractical through electronic prescription and the delay would adversely impact the medical condition of the patient;
  - Electronic prescribing is not available due to temporary technological or electronic failure; or
  - When practitioner and dispenser are the same entity.

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Act 477 - Mammography

To modify coverage for screening mammography and breast ultrasound for the diagnosis of breast disease such as cancer and for the evaluation of dense breast tissue as an essential health benefit (effective 7/24/2019)

- Clarifies what types of payors are required to cover mammograms under this subsection
- Note: Act 708 of the previous legislative session (2017) mandated coverage of 3D mammography

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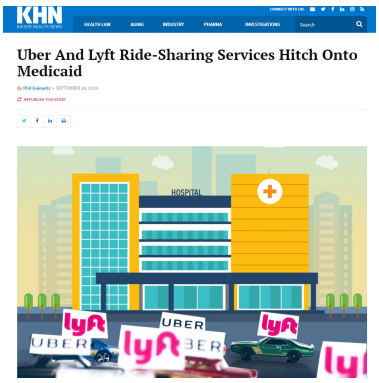
Act 952 – Ridesharing Applications

- Authorizes the Arkansas Medicaid Program to reimburse for ridesharing applications for transportation to healthcare facilities or offices of healthcare professionals



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Act 815 of 2017

Amendments to the Prior Authorization Transparency Act

- Expanded the definition of medical necessity to include any terminology a healthcare insurer may use to describe a determination based on clinical justification for a healthcare service
- Added to the definition of emergency healthcare services (which do not require prior authorization) a surgical procedure to correct a condition discovered during surgery for a condition already diagnosed

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Act 815 of 2017

- Required disclosure of review criteria
- Prior Authorization Turnaround Times
  - Non-Urgent: 2 Business Days
  - Urgent: 1 Business Day
  - Emergency: Minimum 24 Hours Following Procedure
  - Prescription Drugs: 72 Hours
- Prohibits Recession of Prior Authorization for medical necessity
  - Exception: Unless the utilization review entity notifies the provide three business days prior to the scheduled service that the authorization is being rescinded.
  - Exception: Individual was no longer covered on date of service – and insurer has provided means for provider to check patient's status up to day of service.

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Act 815 of 2017

- Guarantees payment of claims for services where prior authorization obtained unless:
  - Service not provided;
  - Claim for the service not submitted in timely fashion;
  - The patient has exhausted a benefit limitation; or
  - The utilization review entity has evidence of misrepresentation, fraud, or abuse by provider or subscriber.
- Makes authorization effective for 90 days.
- Requires insurers to implement an automated electronic process to as a voluntary alternative for providers requesting prior authorization by phone

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Act 815 of 2017

- Allows non-physician staff to review and approve prior authorizations
- Requires denial decisions be made by a physician with an unrestricted Arkansas medical license.
- Mandates a procedure for benefit inquiries (Voluntary Prior Authorization) whereby a provider can know whether a service will be covered before providing the service even if a prior authorization is not required. Response time is 10 business days.

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56

Federal Regulatory Update

- Proposed Rules
  - Stark and Anti-Kickback Reforms
- Patients Over Paperwork Initiative

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Proposed Rules – Fraud and Abuse Reform

- October 9, 2019 – Department of Health and Human Services issued two highly anticipated proposed rules to reform the Physician Self-Referral (Stark) Law and the Federal Anti-Kickback Statute regulations.
- Part of the "Regulatory Spring to Coordinated Care" initiative
- HHS said it expects the proposals to ease compliance burdens while maintaining strong safeguards to protect patients and programs from fraud and abuse.

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Proposed Rules - Background

- Stark - generally prohibits physicians from making referrals for certain healthcare services (DME) payable by federal health care programs if the physician (or immediate family member) has a financial relationship with the entity performing the service.
- Several exceptions – must meet every element of the exceptions for protection.

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Proposed Rules - Background

- Anti-Kickback – imposes criminal penalties for whoever knowingly and willfully offers, pays, solicits, or receives remuneration to induce or reward the referral of business reimbursable under a federal health care program.
- Several safe harbors – should structure arrangement to meet as many elements as possible.
- Intent-based – “one purpose” test

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Proposed Rules - Background

- Civil Monetary Penalty (CMP) Statute – prohibits beneficiary inducements and provides for the imposition of CMPs against any person who:
  - offers or transfers remuneration to a Medicare or State healthcare program beneficiary
  - that the person knows or should know is likely to influence the beneficiary's selection of the particular provider, practitioner, or supplier of any item or service
  - for which payment may be made, in whole or in part, by Medicare or a State healthcare program.

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Proposed Rules - Background

- CMS published a Request for Information (RFI) on June 25, 2018
- Sought stakeholder input to address regulatory barriers to a value-based healthcare payment and delivery system under the Stark Law.
- The OIG issued an RFI from stakeholders regarding the AKS and CMP beneficiary inducement rules in August 2018.
- CMS and the OIG considered stakeholder input from these RFIs in drafting the proposed rules.

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Proposed Changes to Stark

- Stakeholders responding to CMS's RFI stressed that providers are largely unwilling to enter into innovative arrangements that would improve focus on quality outcomes, as there is no clear exception or safe harbor for such activities.
- Proposed Modifications:
  - New exceptions for value-based arrangement
  - Revised definitions for terms such as "fair market value" and "commercially reasonable" to provide more clarity
  - New exception for donating cyber security technology and services

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Proposed Changes to AKS and CMP

- The AKS proposed rule would create the following new safe harbors for certain remuneration exchanged between or among eligible participants:
  - Care coordination arrangements aimed at improving quality and outcomes;
  - Value-based arrangements with substantial downside financial risk; and
  - Value-based arrangements with full financial risk.

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Proposed Changes for AKS

- New safe harbor for innovation models sponsored by CMS – reducing the need for separate waiver process
- Modifications to existing and widely used safe harbors for personal services and management contracts
  - Added flexibility for outcomes-based payments and part-time arrangements

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Proposed Changes to AKS

- New safe harbor for certain tools and supports furnished to patients to improve quality, outcomes and efficiency;
- Modifications to existing safe harbor for local transportation; and
- Amendment to the definition of "remuneration" that incorporates a new exception for telehealth efforts furnished to in-home dialysis patients
- New safe harbor for donating cyber security technology and services
- Removing sunset date for existing safe harbor and exception for electronic health records

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Next Steps

- CMS and OIG accepted comments to the proposed rules through December 31, 2019
- Will review comments and consider in drafting final rules
- Final rules may differ in substance, but must be a "logical outgrowth" of the issues and solutions discussed in proposed rules

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Patients Over Paperwork Initiative

- CMS announced its "Patients Over Paperwork" initiative, focusing on reducing administrative burdens while improving care coordination, health outcomes, and patients' ability to make decisions about their own care.
- Reduction in re-documentation of history and examination for E&M visits with established patients – shift toward documenting that the previous information has been reviewed and verified
- Proposed Changes - beginning January 2021
  - single payment rate for Levels 2 through 4 E&M Visits, while maintaining higher payment rate for Level 5 Visits;
  - Add-on codes for Level 2 through 4 visits for additional resources

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68

QUESTIONS?

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69