CHANGE HEALTHCARE REGULATORY AND STANDARDS UPDATE

Q2 2021 Update Published: May 17, 2021

Q3 2021 Update Available: August 13, 2021

05.17.2021

CHANGE HEALTHCARE

Table of Contents

Timeline

2019	2020	2021
3/3/2019 21st Century Cure Act Rulemaking begins with publication of ONC and CMS NPRMs on Interoperability, Patient Access, **3/28/2019** CMS launches Compliance Review Program for Health Plans and Clearinghouses. **4/10/2019** CMS launches Compliance Review Provider Pilot Program.	**01/01/2020** End of Medicare HICN to MBI Transition Period. MBIs must be used in all administrative transactions. **05/01/2020** Final Rules Issued: ONC and CMS on Interoperability, Patient Access, Information Blocking. Compliance deadlines 2020 through 2023. **11/12/2020** Transparency In Coverage Final Rule issued. **12/27/2020** No Surprises Act signed into law .	**01/21/2021** CMS publishes Proposed "Proposed Modifications to the HIPAA Privacy Rule….". Comment period closed May 6. **Anticipated** • X12N finalization of version 7030/8010 TR3s (2020 or early 2021); recommend adoption to CMS • Final Rule on Attachments • CMS launch Compliance Review Program for Providers. • Final versions of proposed rules issued 12/18/2020 and 01/21/2021.

X12N v7030™ Public Comment/Review and Finalization of TR3s

Withdrawals
10/28/2019 **Final Rule Rescinding the Adoption of the Standard Unique Health Plan Identifier (HPID) and Other Entity Identifier (OEID)** Rule rescinds and deactivates the HPID and OEID as of December 27, 2019.

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Section 1

COVID-19

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Change Healthcare COVID-19 Updates and Resources Hub

- On April 1, Change Healthcare launched our **COVID-19 Updates and Resources Hub**.
- This is an online source of technology, business, and informational resources to give providers and payers guidance on how to maintain administrative, financial, and operational stability during the COVID-19 pandemic.
- Includes archive of Change Healthcare Customer Service Alerts relevant to COVID-19.
- Guidance Specific to Telehealth Benefits: https://www.changehealthcare.com/covid-19/faq-telehealth-benefits-and-coding-for-covid-19
- See the press release.

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Additional COVID-19 Resources

Change Healthcare

http://www.hipaasimplified.com:
Additional information on COVID-19, specifically related to transactions, code sets, and standards, such as general coding guidance.

Federal Government Resource Hub

- https://www.coronavirus.gov/

CDC Resource Hub

- https://www.cdc.gov/coronavirus/2019-ncov/index.html

CMS

- https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page

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Additional COVID-19 Resources, cont.

CMS Waivers & Flexibilities

- https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Resources/Waivers-and-flexibilities

AMA

- https://www.ama-assn.org/delivering-care/public-health/covid-19-2019-novel-coronavirus-resource-center-physicians
- COVID-19 General Coding: https://www.ama-assn.org/practice-management/cpt/covid-19-cpt-coding-and-guidance
- COVID-19 Vaccinations: https://www.ama-assn.org/practice-management/cpt/cpt-codes-new-coronavirus-vaccines-what-you-need-know?gclid=CjwKCAjwqliFBhAHEiwANg9szrusBMLP2-AnPWdOvtEf0PIe45VyLqwGn1s6twbkNporggAFaLeB4BoCtUwQAvD_BwE

AHA

- https://www.aha.org/2020-01-22-updates-and-resources-novel-coronavirus-2019-cov

WEDI

- https://www.wedi.org/2020/03/18/covid-19-resources-information/

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HRSA COVID-19 Uninsured Program

The Health Resources & Services Administration (HRSA) under the U.S. Department of Health and Human Services (HHS) announced a program to provide claims reimbursement to health care providers and facilities for COVID-19 testing and treatment of the uninsured.

Health care providers who have conducted coronavirus 2 testing or provided treatment for uninsured COVID-19 individuals on or after Feb. 4, 2020 can request claims reimbursement through the program electronically and will be reimbursed generally at Medicare rates, subject to available funding.

Effective May 6, 2020, Change Healthcare is accepting claim submissions to the Health Resources & Services Administration (HRSA) COVID-19 Uninsured Program via Payer ID 95964 - COVID-19 HRSA Uninsured Testing and Treatment Fund.

For more information and to get started, visit:

- COVID-19 Claims Reimbursement Website: https://coviduninsuredclaim.linkhealth.com/
- COVID-19 Uninsured Program Portal User Guide: https://chameleoncloud.io/review/2957-5e98adf692326/prod
- Frequently Asked Questions: https://www.hrsa.gov/coviduninsuredclaim/frequently-asked-questions

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HRSA COVID-19 Coverage Assistance Fund (CAF)

In May 2021, the Health Resources & Services Administration (HRSA) under the U.S. Department of Health and Human Services (HHS) announced a program to cover the costs of administering COVID-19 vaccines to patients whose health insurance doesn't cover vaccine administration fees, or it does but typically has patient cost-sharing.

While patients cannot be billed directly for COVID-19 vaccine fees, costs to health care providers for administering COVID-19 vaccines to underinsured patients will now be fully covered through CAF, subject to available funding. To be eligible for reimbursement, providers must have first submitted the claim to the individual's health plan for payment and had the claim denied or only partially paid.

Change Healthcare is participating in the CAF program and is actively establishing administrative connectivity.

For more information and to get started, visit:

- COVID-19 Coverage Assistance Fund Website: https://www.hrsa.gov/covid19-coverage-assistance
- COVID-19 Coverage Assistance Fund Portal Guide: https://www.hrsa.gov/sites/default/files/hrsa/coronavirus/caf-provider-portal-guide.pdf
- Frequently Asked Questions: https://www.hrsa.gov/covid19-coverage-assistance/frequently-asked-questions

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Section 2

ASC X12N VERSION 7030™ PUBLIC REVIEW AND COMMENT PERIOD

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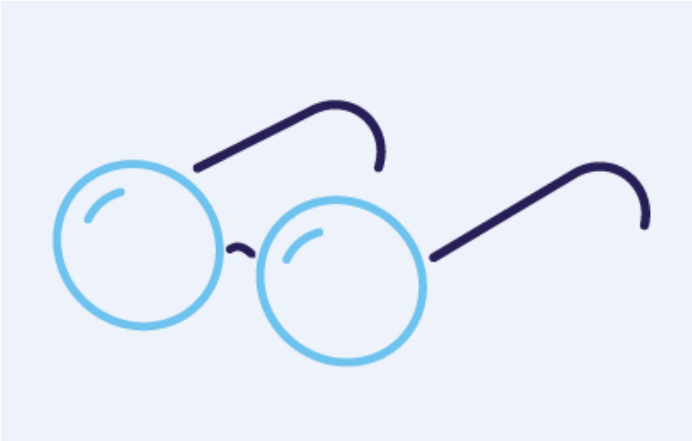
X12N Version 7030™ – Overview

X12N v7030™ Public Comment and Finalization



- Staggered public review and comment periods for version 7030™ of the X12N Type 3 Technical Reports (TR3s) began in the fall of 2016.
- Due to substantive changes resulting from comments received during the initial public comment periods, many TR3s have gone out or will go out for a second public comment period.
- It is anticipated that the functionality developed within the version 7030™ TR3s will be recommended to CMS for adoption.

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X12N Version 7030™ – Recent Public Reviews and Informational Forums

Public Reviews Completed

- Implementation Acknowledgment for Health Care Insurance (999)
- Application Reporting for Insurance (824)
- Health Care Eligibility Benefit Inquiry and Response (270/271)
- Code Value Usage in Eligibility Benefit Inquiry and Subsequent Response (TR2)

Informational Forums

Completed April 26:

- Health Care Eligibility Benefit Inquiry and Response (270/271)
- Code Value Usage in Eligibility Benefit Inquiry and Subsequent Response (TR2)

Scheduled for June 7:

- Implementation Acknowledgment for Health Care Insurance (999)
- Application Reporting for Insurance (824)

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X12N Version 7030™ – Finalized/Published

- Health Care Eligibility Benefit Inquiry and Response (270/271) – *Pending Finalization*
- Code Value Usage in Eligibility Benefit Inquiry and Subsequent Response – *Pending Finalization*
- Benefit Enrollment and Maintenance (834)
- Health Insurance Exchange: Enrollment (834)
- Health Insurance Exchange Related Payment (820)
- Health Care Claim/Payment Advice (835)
- Health Care Claim Pending Status Information (277P)
- Health Care Claim Acknowledgment (277CA)
- Health Care Claim Status Request and Response (276/277)
- Payroll Deducted and Other Group Premium Payment for Insurance Products (820)
- Additional Information to Support a Health Care Claim or Encounter (275)
- Health Care Services Request for Review and Response (278RR)
- Health Care Services Review Inquiry and Response (278IR)
- Health Care Services Review – Notification and Acknowledgment (278NA)
- Additional Information to Support a Health Care Services Review (275)
- Health Care Claim: Professional (837P)
- Health Care Claim: Institutional (837I)
- Health Care Claim: Dental (837D)
- Health Care Service: Data Reporting (837R)

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X12N Version 7030™ – Participation

Change Healthcare Encourages Your Participation

- Change Healthcare is actively participating in the v7030™ Public Review and Comment process and we encourage all entities to participate
- For updates to the public-comment period timeline, watch: www.x12.org

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Promotion of Version 7030™ TR3s to Version 8010™

For more information on the Version 8010™ promotion and on the Annual Release Cycle, watch www.X12.org

- The membership of the X12N Insurance Subcommittee has approved promoting the Version 7030™ TR3s to Version 8010™ immediately after they have been published.
- The published 8010™ TR3s for the HIPAA transactions will be recommended for adoption under HIPAA, rather than the 7030™ versions.
- The promotion to version 8010™ will align the X12N TR3s with the base X12 Standard version 8010™, which is the most recent base standard released by X12.
- From a functional perspective, there will be no substantive changes to the 7030™ TR3s, and no loss of or change to functionality added with 7030™.
- The promotion of versioning also positions X12 to begin their proposed Annual Release Cycle, tentatively slated to begin in 2021.

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X12 Annual Release Cycle

- X12 is in the process of implementing an Annual Release Cycle (ARC) for X12 products, including the X12N Insurance Subcommittee TR3s.
- The new release cycle will allow X12 to be responsive to today's rapidly-changing business environment.
- Each annual release of the TR3s will be aligned with the base X12 standard, also released annually.
- Releases will occur at the end of each calendar year.
- Public commenting on published versions will be accepted following each publication. Suggested changes will be considered for the next annual release.

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Section 3

ATTACHMENTS NPRM

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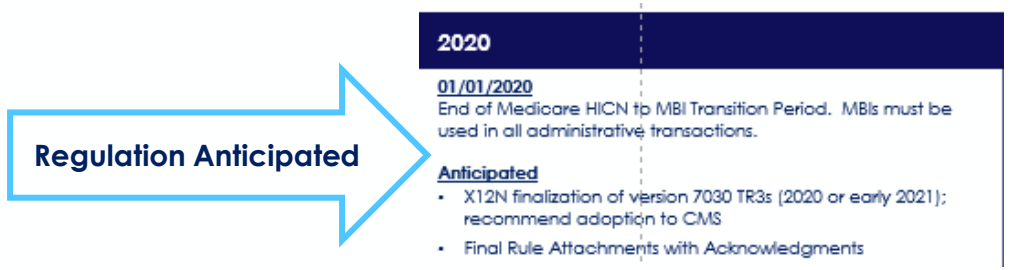
Attachments – Overview



- The Administrative Simplification provisions under the ACA include adoption of transaction standards and operating rules for Attachments.
- Electronic Attachments are electronic transactions that support the transmission of clinical documentation for claims and prior authorizations which require additional clinical information to in order to adjudicate, such as:
  - Health Care Claims/Encounters (837)
  - Health Care Services Review-Request for Review and Response (278)
- **A proposed rule establishing Attachment Standards and Operating Rules was scheduled for February 2021, per the Unified Agenda of Regulatory and Deregulatory Actions** (RIN 0938-AT38).

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Attachments – Regulatory Roadmap

- NCVHS hearing was held on Feb. 16, 2016, with NCVHS Letter of Recommendation sent to HHS on July 5, 2016.
- Unified Agenda (RIN 0938-AT38) indicate that a proposed rule is scheduled for February 2021 with Public Comment Period.
- Proposed Rule is expected to:
  - Adopt standards for health care attachments transactions and electronic signatures to be used in conjunction with health care attachments transactions.
  - Modify the standard for the referral certification and authorization transaction from ASC X12 version 5010 to ASC X12 version 6020.
  - Adopt standards for electronic signatures to be used in conjunction with health care attachments transactions.

Attachments – Recommendations

On Feb. 16, 2016, the National Committee on Vital and Health Statistics (NCVHS), advisory body to HHS, conducted hearings on the Attachment standards. The following summary recommendations were made by NCVHS to the Secretary of Health and Human Services in a letter dated July 5, 2016:

- Adopt one standard definition of "Attachment," and establish the scope of the transaction.
- Adopt a set of mature, implementable electronic standards for the health care industry to execute the Attachments transaction.
- Define a series of transaction process requirements, including consistency with adopted privacy laws and regulations.
- Take an incremental, flexible implementation approach in no less than five years inclusive of rulemaking.
- Broaden the testing, education, outreach and compliance efforts.
- Ensure alignment of the Attachment standard's regulatory requirements with those adopted for use with Electronic Health Records under the Office of the National Coordinator (ONC) for Health Information Technology's 2015 Edition Certification of Health Information Technology program (i.e., Meaningful Use) and the Medicare Access CHIP Reauthorization Act of 2015 (MACRA)/Merit-Based Incentive Payment System (MIPS).

To see the NCVHS Letter to the Secretary – Recommendations for the Electronic Health Care Attachment Standard, click here.

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Attachments – Publications

- HL7 Publications:
  - HL7 CDA® R2 Attachment Implementation Guide: Exchange of C-CDA Based Documents, Release 1 Standard for Trial Use
  - HL7 CDA ® Release 2 Implementation Guide: Exchange of C-CDA Based Documents; Periodontal Attachment, Release 1
  - HL7 CDA® R2 Implementation Guide: Orthodontic Attachment, Release 1 – US Realm (awaiting publication)
- X12, HL7, and the Workgroup for Electronic Data Interchange (WEDI) White Paper:
  - **Guidance on Implementation of Standard Electronic Attachments for Healthcare Transactions**, provides guidance on the implementation of standard electronic attachments for healthcare transactions. See the Resources page at www.wedi.org.

Attachments – Change Healthcare Readiness

- Change Healthcare announced breakthrough all-payer medical attachments capability that gives providers the ability to dramatically reduce administrative burden associated with document and data exchange with payers.
  - Press Release
  - Podcast
- For more information regarding Change Healthcare's attachments solutions visit:
  - Medical Attachments
  - Dental Attachments

Section 4

CAQH® CORE® OPERATING RULES

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CAQH® CORE® Operating Rule Restructure

This summer, CAQH® CORE® released a restructuring of their Operating Rules from *Phased*-based rule sets to a *Business Transaction*-based model.

- All Operating Rules, including those adopted under federal regulation, have been assigned new Rule numbers and have been repurposed to eliminate references to Phases.
- There were no substantive content changes to any Rules.

For details, see the CAQH® CORE® website at https://www.caqh.org/core/new-operating-rule-structure.

CAQH® CORE® Operating Rules – Federally Mandated

Operating Rules	X12 TR3	Rules Define
Eligibility and Benefits	X12/005010X279A1 (270/271)	Data content, Infrastructure, connectivity, response time, companion guide, acknowledgments*. *Adopted as Phase I and II.*
Claim Status	X12/005010X221A1 (276/277)	Infrastructure, connectivity, response time, companion guide, acknowledgments*. *Adopted as Phase II*.
Payment & Remittance	X12/005010X221A1 (835) ACH CCD+	Infrastructure, connectivity, response time, companion guide, acknowledgments*, ERA and EFT reassociation, CARC/RARC/CAGC/NCPDP Reject Reason Code uniform use; ERA and EFT enrollment.

* Regulations exclude acknowledgment-related requirements.

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CAQH® CORE® Operating Rules – Voluntary Adoption

Operating Rules	X12 TR3	Rules Define
Health Care Claims	X12/005010X222A2 (837P) X12/005010X223A3 (837I) X12/005010X224A3 (837D)	Infrastructure, connectivity, response time, companion guide, acknowledgments.
Prior Authorization & Referrals	X12/005010X217 (278)	Data content, proprietary web portal standardization, final determination timeframe, infrastructure, connectivity, response time, companion guide, acknowledgments.
Benefit Enrollment	X12/005010X220A1 (834)	Infrastructure, connectivity, response time, companion guide, acknowledgments.
Premium Payment	X12/005010X218 (820)	Infrastructure, connectivity, response time, companion guide, acknowledgments.

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CAQH® CORE® Operating Rules – Voluntary Adoption, cont.

Operating Rules	X12 TR3	Rules Define
Patient Attribution (Value-Based Payment)	X12/005010X279A1 (270/271) X12/005010X318 (834)	Single Patient Attribution requirements for the Health Care Eligibility Benefits Inquiry and Response (270/271) Attributed Patient Roster requirements for Member Reporting (834): data content, infrastructure, connectivity, response time, companion guide, acknowledgments.
Attachments: Prior Authorization	X12/005010X217 (278) X12/006020X315 (275) X12/006020X257 (824)	Requirements for Attachments relating to the Health Care Services Review – Request for Review and Response (awaiting final ballot; not yet ready for CORE® certification)
Connectivity Rule v4.4.0	Attachments: Prior Authorization	An update to prior connectivity rules. Not yet rolled to earlier operating rule sets; see www.caqh.core for additional information.

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CAQH® CORE® Operating Rules – In Development

Medical Attachments – Claims Use Case

Medical attachments relating to claims

Eligibility & Benefit

Additional data content requirements, primarily relating to service types and telemedicine

Want to get involved? Email core@caqh.org or visit www.caqh.org/core

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Change Healthcare Operating Rules Readiness

Change Healthcare clearinghouse services are **CORE Phase III Certified.** To become CORE Phase III certified entities must be CORE-certified on the earlier phases. Our CORE Phase III certification serves as Change Healthcare's exhibit of Operating Rule readiness.

The CAQH Committee on Operating Rules for Information Exchange (CAQH® CORE®) certifies and awards CORE® Certification Seals to entities that create, transmit or use the administrative transactions addressed by applicable Operating Rules. CORE Certification means an entity has demonstrated that its IT system or product is operating in conformance with a specific phase(s) of the Operating Rules.

- Change Healthcare is CORE® Phase I, Phase II, and Phase III certified, as evidenced by our Phase III seal.
- Link to Change Healthcare's CORE Phase III Seal.
- Link to our CORE Voluntary Certification (Clearinghouses tab).
- Additional information regarding the Change Healthcare Operating Rules program can be found on www.hipaasimplified.com.

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Section 5

CMS COMPLIANCE REVIEW PROGRAM

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CMS Compliance Review Program

- In late 2017, CMS launched its Optimization Pilot in preparation for a full-scale Compliance Review program

Change Healthcare was selected to participate in the Optimization Pilot and was awarded our Certificate of Completion on Oct. 4, 2018. See Change Healthcare Accreditations & Certifications for details.

- In April 2019, CMS began its formal Compliance Review program by selecting nine HIPAA-covered entities for compliance reviews. Any health plan or clearinghouse, not just those working with Medicare or Medicaid, can be selected

- Also in April, CMS launched a volunteer Provider Pilot Program to test the process for reviewing HIPAA Administrative Simplification rules compliance among providers.

For additional information, see https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Enforcements/Compliance-Review-Program.html

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Section 6

FEDERAL POLICY & REGULATIONS

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PRICE TRANSPARENCY

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PRICE TRANSPARENCY REQUIREMENTS FOR HOSPITALS FINAL RULE

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Price Transparency Requirements for Hospitals

On Nov. 27, 2019, the Price Transparency Requirements for Hospitals to Make Standard Charges Public final rule was published in the *Federal Register* with an effective date of Jan. 1, 2021, which established requirements for hospitals operating in the United States to create, update, and make public a list of their standard charges for the items and services that they provide.

Below is a summary of major provisions:

- Defines a "hospital," "items and services," and five types of "standard charges" that hospitals are required to make public. Federally owned/operated facilities are deemed to have met all requirements.
- Establishes requirements for making public a machine-readable file for all items and services provided by the hospital.
- Establishes requirements for making public 300 "shoppable" services that are displayed and packaged in a consumer-friendly manner, plus a policy to deem hospitals that offer internet-based price-estimator tools as having met this requirement.
- Establishes methods for monitoring and actions that would address hospital noncompliance.

More information on the rule can be found here.

TRANSPARENCY IN COVERAGE FINAL RULE

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Transparency in Coverage Final Rule

On Nov. 12, 2020, the Transparency in Coverage final rule was published in the *Federal Register* with an effective date of Jan. 11, 2021, with a goal of bringing greater competition to the private healthcare industry.

- Requires most group health plans, health insurance issuers in the group and individual market to disclose price and cost-sharing information to participants, beneficiaries, and enrollees.
- An initial list of 500 shoppable services (determined by CMS) will be required to be available via the internet based self-service tool for plan years beginning on or after Jan. 1, 2023.
  - The remainder of all items and services will be required for these self-service tools for plan years that begin on or after Jan. 1, 2024.
- Most non-grandfathered group health plans or health insurance issuers offering non-grandfathered health insurance coverage in the individual and group markets will be required to make publicly available three separate machine-readable files, including detailed pricing information.
  - Negotiated rates for all covered items and services between the plan or issuer and in-network providers
  - Historical payments to and billed charges from out-of-network providers
  - Detail the in-network negotiated rates and historical net prices for all covered prescription drugs by plan or issuer at the pharmacy location level.

More information on the rule can be found here.

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NO SURPRISES ACT

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No Surprises Act – Summary Overview

On Dec. 27, 2020, the No Surprises Act was signed into law as part of the Consolidated Appropriations Act of 2021, Public Law 116-260.

The No Surprises Act seeks to protect consumers from surprise medical bills and includes transparency regarding in-network and out-of-network deductibles, out-of-pocket limitations, and other health plan and provider provisions and patient protections.

Most sections of the act reflect a legislated effective date of Jan. 1, 2022. The departments of Health and Human Services, Treasury, and Labor are developing regulations to implement the many provisions of the act.

Please reference the Consolidated Appropriations Act of 2021 Bill for the full text of the No Surprises Act provisions.

On April 20, 2021, WEDI submitted comments in a letter to the HHS secretary.

No Surprises Act – Section Breakdown (Summary)

Section 102. Health insurance requirements regarding surprise medical billing.

In general, requires health plans to hold patients harmless from surprise medical bills. For certain services, patients are only required to pay their in-network cost-sharing amount (e.g., deductibles, coinsurance, copayments, or similar charges).

- Coverage of Emergency Services: This requires health insurers to cover emergency services without prior authorization regardless of whether the healthcare provider furnishing services is a participating provider or a participating emergency facility.
- Coverage of Nonemergency Services Performed by Nonparticipating Providers at Certain Participating Facilities: This prevents health insurers from imposing a cost-sharing requirement that is greater than the cost-sharing requirement that would apply if furnished by a participating provider. Cost-sharing payments count toward any in-network deductible and out-of-pocket maximums (as applicable) in the same manner as if furnished by a participating provider.

No Surprises Act – Section Breakdown (Summary)

Section 103. Determination of out-of-network rates to be paid by health plans; independent dispute-resolution process.

Encourages reimbursement resolution through open negotiation and establishes an independent resolution process through which health providers and insurers can resolve out-of-network reimbursement issues.

- Allows a 30-day open-negotiation period for providers and insurers to settle out-of-network claims.
- If the parties are unable to reach a negotiated agreement, they may access a binding arbitration process—referred to as Independent Dispute Resolution (IDR)—in which one offer prevails.
- The IDR process will be administered by independent, unbiased entities, with no affiliation to providers or insurers.

No Surprises Act – Section Breakdown (Summary)

Section 104. Health care provider requirements regarding surprise medical billing.

- Prohibits out-of-network facilities and providers from sending patients balance bills for more than the in-network cost-sharing amount, in the surprise billing circumstances defined in Sec. 102.
- Prohibits certain out-of-network providers from balance-billing patients unless the provider gives the patient notice of their network status and an estimate of charges 72 hours prior to rendering out-of-network services and the patient provides consent to receive out-of-network care. In the case of appointments made within 72 hours of receiving services, the patient must receive the notice the day the appointment is made and consent to receive out-of-network care.

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No Surprises Act – Section Breakdown (Summary)

Section 105. Ending surprise air ambulance bills.

- Patients are held harmless from surprise air ambulance medical bills. Patients are only required to pay the in-network cost-sharing amount for out-of-network air ambulances (including attributing the bill to the in-network deductible). Air ambulances are barred from sending patients balance bills for more than the in-network cost-sharing amount.
- Follows a similar open negotiation and Independent Dispute Resolution (IDR) as summarized in Section 103 to resolve out-of-network reimbursement issues.

Section 106. Reporting requirements regarding air ambulance services.

- Requires air ambulance providers to submit two years of cost and metrics data to the secretaries of HHS and Transportation and insurers to submit two years of claims data related to air ambulance services to the Secretary of HHS. Requires the secretaries to publish a comprehensive report summarizing the information submitted.
- Establishes an advisory committee to establish quality, patient safety, and clinical-capability standards for air ambulances.

No Surprises Act – Section Breakdown (Summary)

Section 107. Transparency regarding in-network and out-of-network deductibles and out-of-pocket limitations.

- Requires health plans offering group or individual health insurance to include on the participant's insurance card the amount of the in-network and out-of-network deductibles, in-network and out-of-network out-of-pocket maximum limitations, and a telephone number and website address through which plan participants can seek assistance.

Section 108. Implementing protections against provider discrimination.

- Requires the secretaries of HHS, Labor, and Treasury to issue a rule implementing protections against provider discrimination.

Section 109. Reports.

- Requires HHS to conduct a study on the effects of the provisions in the Act.
- Requires the Government Accountability Office (GAO) to submit to Congress a report on the impact of surprise billing provisions and a report on the adequacy of provider networks, to include recommendations to improve the adequacy.

CHANGE HEALTHCARE

No Surprises Act – Section Breakdown (Summary)

Section 110. Consumer protections through application of health-plan external review in cases of certain surprise medical bills.

- Allows for an external review to determine whether surprise-billing protections are applicable when there is an adverse determination by a health plan or issuer.

Section 111. Consumer protections through health-plan requirement for fair and honest advance-cost estimate.

- Requires health plans offering group or individual health insurance to provide an "Advanced Explanation of Benefits" to give patients transparency for each scheduled item or service, including:
  - The network status of the provider or facility
  - Good faith estimates of provider or facility charges, the plan's payment responsibility, and the patient's payment responsibility
  - Additional disclaimers

No Surprises Act – Section Breakdown (Summary)

Section 112. Patient protections through transparency and patient-provider dispute resolution.

- Health care providers and facilities must verify, three days in advance of service and not later than one day after scheduling of service, what type of coverage the patient is enrolled in and provide notification of the good faith estimate of the expected charges for scheduled items or services.
- Requires the Secretary of HHS to establish a patient-provider dispute-resolution process for uninsured individuals for charges that are substantially in excess of the estimate.

Sec. 113. Ensuring continuity of care.

- If a provider changes network status, "continuing care patients" have up to a 90-day period of continued coverage at in-network cost-sharing rates to allow for a transition of care to an in-network provider. The plan or issuer must notify continuing-care patients of network changes and their right to elect to receive continued transitional care.

No Surprises Act – Section Breakdown (Summary)

Section 114. Maintenance of price-comparison tool.

- Beginning on or after Jan. 1, 2022, a plan or issuer is required to offer price-comparison guidance to consumers by telephone and website to compare the amount of cost-sharing that an individual would be responsible for paying when furnished with a specific item or service by a given provider.

Sec. 115. State All Payer Claims Databases.

- Establishes a grant program for eligible states to establish or improve a State All Payer Claims Database. Grants will be awarded for a period of three years in an amount of $2,500,000 ($1,000,000 in years one and two, $500,000 in year three).
- Requires grant recipients to make data available to authorized users, including researchers, employers, health insurance issuers, third-party administrators, and healthcare providers for quality improvement and cost-containment purposes. The secretary may waive these requirements if a State All Payer Claims Database is substantially in compliance.
- Requires the secretary to establish a standardized reporting format and guidance for the voluntary reporting by group health plans to State All Payer Claims Databases of medical claims, pharmacy claims, dental claims, and eligibility and provider files that are collected from private and public payers.

No Surprises Act – Section Breakdown (Summary)

Section 116. Protecting patients and improving the accuracy of provider-directory information.

- Requires plans and issuers to establish a database and verification process to ensure up-to-date directories of their in-network providers and facilities, available to patients online, or within one business day of a telephone inquiry.
- Patients that relied on incorrect provider-network information would only be subject to in-network cost-sharing amounts.
- Plans and issuers are required to disclose patient protections against balance billing.

Sec. 117. Advisory committee on ground ambulance and patient billing.

- Requires the secretaries to establish an advisory committee for reviewing options to improve disclosure of charges and fees for ground-ambulance services to inform consumers of insurance options and protect consumers from balance billing.
- Requires a report on recommendations from the advisory committee not later than 180 days after the committees first meeting.

HIPAA PRIVACY RULE NPRM

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NPRM to Modify the HIPAA Privacy Rule

On December 10th, OCR provided advance notice of a proposed rule to modify the HIPAA Privacy Rule to support individuals' engagement in their care, remove barriers to coordinated care, and reduce regulatory burdens on the health care industry.

The proposed changes to the HIPAA Privacy Rule include:

- Strengthening individuals' rights to access their own health information, including electronic information
- Improving information sharing for care coordination and case management for individuals
- Facilitating greater family and caregiver involvement in the care of individuals experiencing emergencies or health crises
- Enhancing flexibilities for disclosures in emergency or threatening circumstances, such as the Opioid and COVID-19 public health emergencies
- Reducing administrative burdens on HIPAA covered health care providers and health plans, while continuing to protect individuals' health information privacy interests.

On January 21st, the proposed rule was formally published in the federal register with a comment window due date of March 22nd.

On March 9th, OCR announced a 45-day extension of the public comment period extending the comment window due date to May 6th, 2021.

- 1,436 comments were submitted during the public comment window.

ONC CERTIFICATION AND INFORMATION BLOCKING RULE

CHANGE HEALTHCARE

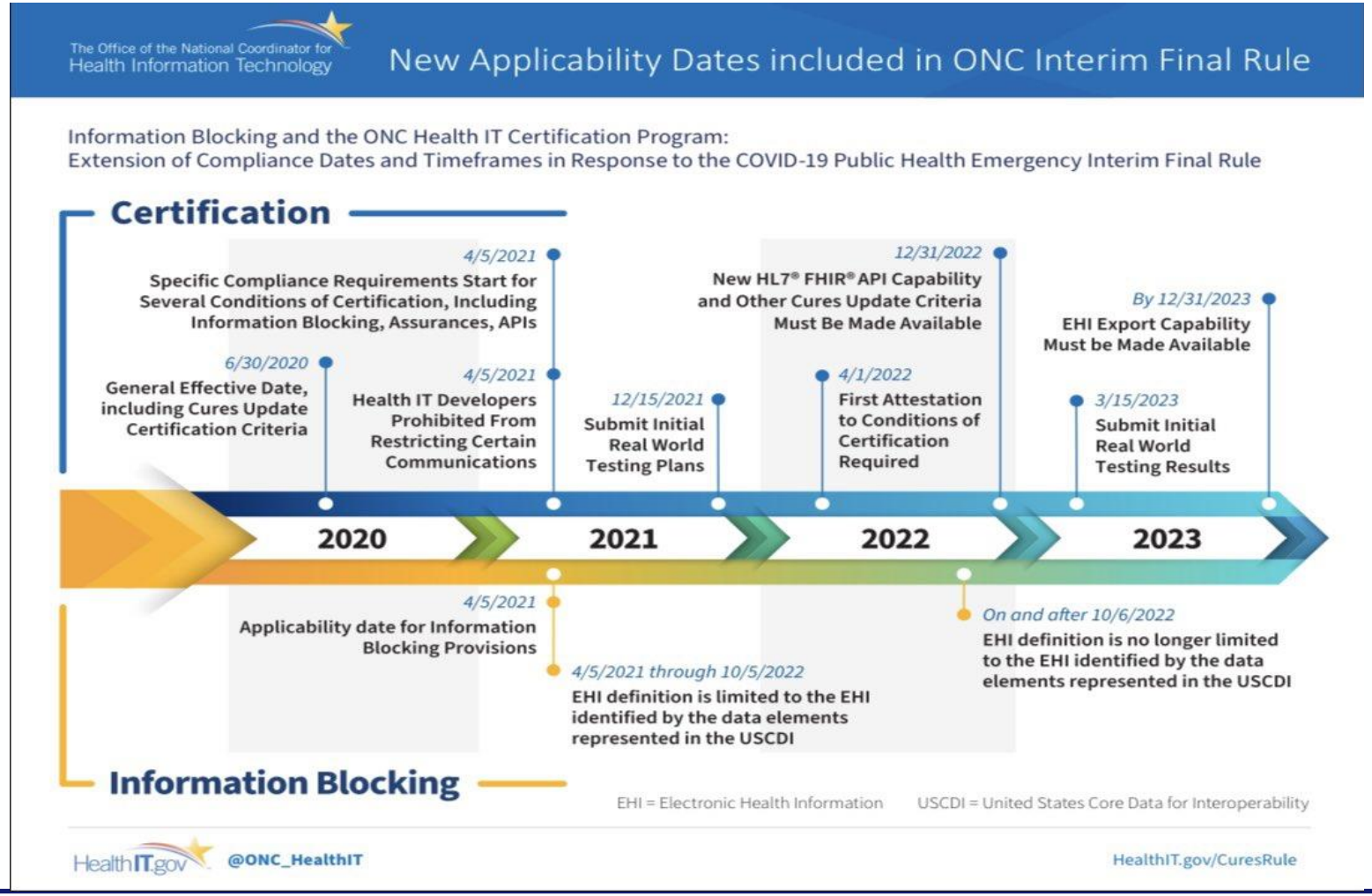
21st Century CURES Act

- Bipartisan legislation passed in 2016
- Information blocking is illegal for certain actors; penalties were created for some actors if they are found to be information blocking
- Created the definition of information blocking
- Directed the Office of the Inspector General (OIG) as the enforcement arm, including levying penalties; may only level penalties on health IT developers and health information networks (HINs)/health information exchanges (HIEs)
- Directed CMS to create penalties for healthcare providers
- Directed ONC to develop exceptions to the information blocking definition (i.e., define when choosing not to share data is allowed)
- Directed ONC to develop Conditions of Certification, including requiring open Application Programming Interfaces (APIs)

Overview of ONC's Regulation

- Final Rule published in the Federal Register May 1, 2020.
- ONC developed new certification criteria for health IT developers and established policies around what is allowed in their contracts
- ONC defined several important terms as part of the regulation, including which actors are regulated by information blocking
- ONC created a set of exceptions to information blocking that fall into two categories:
  - Withholding Electronic Health Information (EHI) – when are actors allowed to withhold EHI
  - Conditions for sharing EHI – what fees can be charged and what formats EHI data must be in

ONC Information Blocking Rule - Compliance Deadlines



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ONC Information Blocking – Interim Final Rule & Compliance Date Changes

Additional information is available at:
https://www.healthit.gov/curesrule/resources/fact-sheets

REDUCING PROVIDER AND PATIENT BURDEN BY IMPROVING PRIOR AUTHORIZATION

CHANGE HEALTHCARE

CMS NPRM to Address Prior Authorization

On December 10, CMS provided advance notice of a proposed rule to place new requirements on Medicaid and CHIP managed care plans, state Medicaid and CHIP fee-for-service programs, and Qualified Health Plans (QHP) issuers on the Federally-facilitated Exchanges (FFEs) to improve the electronic exchange of health care data, and streamline processes related to prior authorization.

This rule has been withdrawn.

Section 7

STATE POLICY & REGULATIONS

CHANGE HEALTHCARE

State Policies – What to expect in 2021 Sessions

- The Nov. 3rd elections produced no changes in party control, despite significant campaign spending and tight election outcomes. Regardless of political control, state governors and legislators will be focused on:
  - Budget deficits – all states report projected deficits for 2021, ranging from one percent (Colorado, Idaho) to as high as 26 percent (Nevada); deficits are projected for all 50 states through 2022 as well. Program cuts (eligibility, services, reimbursement) to Medicaid are likely to be considered in many states as a result;
  - Response to COVID-19 pandemic – state public health programs will be increasingly challenged by increasing COVID-19 cases and pressures on health care systems and state economies. Returns to higher levels of restriction are likely and legislators are expected to focus on a range of public health policy proposals.
- California continues to lead the nation in consumer data privacy legislation:
  - California Privacy Rights Act (CPRA) ballot measure passed on Nov. 3rd with a 15 percent majority – new law updates and clarifies provisions of the 2018 California Consumer Privacy Act (CCPA) and subsequent legislation;
  - Washington State, Texas, Oregon, Wisconsin and potentially other states are expected to consider similar privacy bills in January.

State Policies - What to expect in 2021 Sessions, cont.

- Considering what **telehealth** waivers made part of the PHE will/should be made permanent
- States will need to addressing significant revenue losses and will likely make **budget cuts** and seek cost savings/containment initiatives in high-cost programs like healthcare; e.g., cost growth targets, APCDs, price transparency, etc.
- **Public health** response will continue to be a focus, including vaccine distribution and infrastructure needs; e.g. workforce, technology, etc.
- **Mental health** policies likely to be a focus, including increased access and reducing barriers; e.g. parity policies, coverage, etc.

CHANGE HEALTHCARE

Section 8

CHANGE HEALTHCARE ACCREDITATIONS & CERTIFICATIONS

CHANGE HEALTHCARE

HHS Optimization Program Certification

- On October 4, 2018, The U.S. Department of Health and Human Services (HHS), Division of National Standards (DNS) within the Centers for Medicare & Medicaid Services (CMS), recognized Change Healthcare for successfully completing the HHS Optimization Program Pilot of Administrative Simplification transaction standards, code sets, unique identifiers, and operating rules.
- Certificate of Completion

CHANGE HEALTHCARE

Change Healthcare Accreditations & Certifications

To demonstrate our continued commitment to assure that applicable Change Healthcare products and services meet industry and regulatory requirements and expectations, we maintain several industry recognized and trusted accreditations and certifications.

Click HERE for more information.

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